DEVELOPMENT

COMMISSION OF THE EUROPEAN COMMUNITIES
Directorate-General Information, Communication, Culture

EUROPE
INFORMATION

DE 60 □ April 1989

THE EUROPEAN COMMUNITY AND HEALTH IN THE THIRD WORLD

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Manuscript completed in January 1989

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GLOSSARY

CEC	Commission of the European Communities
EDF	European Development Fund
NGO	Non-Governmental Organisation
STD	Science and Technology for Development
WHO	World Health Organisation
MECU	Million ECU

THE EUROPEAN COMMUNITY AND HEALTH IN THE THIRD WORLD

The improvement of health in the Third World is an issue of great importance in both human and economic terms. Apart from the obvious humanitarian importance of providing a healthy environment capable of supporting the physical and psychological development of a people and alleviating human suffering, there are also important economic repercussions. The scourge of diseases such as malaria, schistosomiasis and tuberculosis, not to mention the more recent AIDS epidemic, coupled with the burden of infectious diseases and malnutrition, weigh heavily on developing countries, sapping them of both human and financial resources. The relative good health of a country is one of the conditions determining the ability of the country to pursue its own development and is therefore an important axis of the Commission's policy of encouragement of self-supported, self-sustained development.

Health is therefore a vital sector of development action in the Third World and one in which the Commission of the European Communities has been a major donor since its foundation in 1957. The amount of aid given through the European Development Fund (EDF) has increased steadily over the years from 48.4 MECU for the first EDF (1963-1969) to 125.7 MECU for the fifth EDF (1980-1985) and is still on the increase. It could be pointed out that aid to this sector has decreased as a percentage of total EDF aid, however, this is in part due to a diversification of aid through other channels : emergency aid, cofinancing of non-governmental organisations (NGO) projects, aid to refugees and special programmes such as the AIDS control programme and the science and technology for development (STD) programmes. It should also be noted that the actual number of projects as well as their geographical scope have increased. During this time much has been done to improve the efficiency and effectiveness of aid given in this sector and policy has been constantly revised and improved to this end.

In fact, despite the money that has been poured into this sector over the years little real improvement has been made in health in the Third World. This is particularly true in the case of Africa where in several cases the situation has actually deteriorated. According to UNICEF infant mortality rates, generally a good indicator of the general health of a population, have risen in a number of instances. This is due to several factors. In general the proportion of national budgets spent on health is stagnating and in some cases even deteriorating. The public sector health budget is a percentage of a national budget, which is itself in regression as a result of the economic world crisis and the effects of structural adjustment.

The budgetary restrictions as well as poor management of existing resources for health in the developing countries mean that

running costs can often barely be met, far less investments in infrastructure be made by national governments. Health coverage therefore remains very low - rarely exceeding 30-35% of the population. What services exist are generally concentrated in urban areas whereas the majority of the population lives in rural areas. Facilities are therefore often inaccessible to the poorest members of the population. Bad living conditions, poor diet, lack of clean water and sanitation and the accumulation of refuse are other factors which must be considered as they are the root cause of much ill-health. It is evident that many factors are involved and that health problems need to be tackled on many fronts at the same time.

By building on past experiences and learning from its mistakes, the Community is gradually moving towards a more integrated and comprehensive health policy which, it is hoped, will lead to long-term, concrete improvements in the health systems of the Third World.

A brief history of EC aid to health

In the 1960s and '70s aid was concentrated primarily in investments in infrastructure and equipment. In the first EDF (1963-1969) building and equipment accounted for over 90% of total aid given to the health sector. Perhaps more significantly, funds were often concentrated on the building of large hospitals, generally located in the capital cities, as in Mogadiscio, Somalia (600 beds), Nouakchott, Mauritania (450 beds) and Ampefiloha Hospital in Tananarive in Madagascar (730 beds). It should be noted that this tendency was generally true of donors worldwide and was in part due to the demands of recently independent states who expressed the legitimate need to create a basic health infrastructure filling the gaps left by the departing colonial powers.

However, it soon became obvious that severe problems were being experienced in putting certain projects into operation. Mogadiscio hospital, for example, was still not operating in 1964, two years after its completion. Such hospitals were often badly adapted to the environment for which they had been created, and lacking the necessary supporting infrastructure, proved difficult for governments to run and maintain. Local budgets for health were largely insufficient, and a shortage of trained personnel capable of running and maintaining the hospital meant that further aid had to be provided.

Similar experiences of this nature, coupled with the realisation that little real headway was being made in the general improvement of health in these countries led the international donor community to reassess its aid to this sector.

The turning point

In the late 1970s an evaluation team was set up by the EC to evaluate the results of the development programme. One of the first areas to be examined was that of health and health related projects (sanitation, water supply, etc.). In 1978 a report was compiled showing the results of this investigation.

The report showed that existing health policy was proving to be unsatisfactory in many areas and, rather than improving the health situation in developing countries, was in some cases creating added burdens on national government budgets for health, thereby becoming a liability on further development in this sector.

It was decided that the building of 'cathedrals in the desert' must stop and a more structured and comprehensive approach be adopted. Particular problems lay in the lack of sufficient long-term planning. How would projects be financed in the long run ? Would sufficient local resources be available to permit their continued functioning after international aid had stopped ?

From the report a number of basic principles were established. These were adopted in full by the ACP States at the Conference of Freetown in December 1978 and later revised in 1986.

During the same period,the World Health Organisation (WHO) established a new plan of action around the theme 'HEALTH FOR ALL BY THE YEAR 2000'. The new policy, based on Primary Health Care (PHC), was launched at the international conference at Alma Ata in September 1978 and submitted to by the international community as a whole. The PHC strategy advocated at this conference was incorporated into the basic principles adopted by the ACP and the EC at the Freetown conference.

The Alma Ata definition of PHC clearly incorporates concern for equal access to health care (equity), the need to provide good health care (efficacy), the need to use resources well (efficiency) and the involvement of the local community (empowerment). The Alma Ata declaration states the following;

"Primary health care is essential health care based on practical, scientifically sound and basically acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination."

The late '70s therefore marked a real turning point in EC and international policy towards health in developing countries and laid down the basis for current EC policy in this area.

Current EC policy on health in the Third World

Current EC policy on health in developing countries is based on the Primary Health Care (PHC) strategy defined at Alma Ata. This means using and extending where necessary existing health care structures to support the development of primary health care. The aim of the community must be to create structures that work and that will continue to work after aid has been stopped. It is therefore necessary to adopt an integrated approach which will allow an overall rationalisation of health care in developing countries. In order to do this it is necessary to consider many aspects at once.

The priority aims of EC policy will be the following:

1. To increase the coverage levels of health care, particularly at primary level, through the rationalisation of structures. This implies that hospitals must offer more specialised care to support a network of basic health services.

2. To improve cost-effectiveness through the rationalisation of the use of local financial and human resources.

3. To improve the general supporting structure of the health system. This includes such areas as maintenance, pharmaceutical supplies and environmental health.

4. To rationalise the use of manpower resources.

Infrastructure

There has been a noticeable reduction in the number of new buildings being created by the EDF (39% of EDF 5). Emphasis is instead being placed on the rehabilitation of already existing buildings (31%) and diversification in the type of projects financed. What new constructions have been financed are justified by the need for decentralisation and a fairer distribution of services available between rural and urban areas. The long-term aim is to establish an efficient referral system which will rationalise health services and mean that newly created buildings operate within a sound structure, not in a vacuum.

It has been shown that Primary Health Care systems have a much better chance of success if they are introduced into health services which are already well developed and rationalised and which are aimed at fulfilling the needs of the majority. A viable health centre for rural areas can only be established if it is integrated into an already existing health system with an efficient referral system.

Current policy emphasises the strengthening of the intermediate level of the health system, usually at the district level. This needs to include a referral hospital and a network of health centres. For this strategy to work efficiently it is necessary to break down the excessive centralisation which exists in most countries. The CEC is therefore keen to encourage and support decentralisation measures at district level, and the development of national and regional strategies for the organisation and management of the health sector.

Benin

The Ouemè and Mono projects in Benin (EDF 5 & 6) are a good example of this strategy of strengthening of the district level. The health services are set out in the form of a pyramid, with the community health centres (village dispensaries) as the first level of consultation; the district health centres (staffed by a doctor and equipped with a small operating theatre) at the second level and the provincial hospitals, all offering specialised services unavailable elsewhere (e.g. gynecology and obstetrics, paediatrics, ophthalmology etc.)

In Ouemè, the rehabilitation and equipment of Porto Novo Hospital, has been used to introduce standardised treatment schedules. This experience will later be used and built on to reinforce the lower levels. In Mono, on the contrary, the impetus towards the rationalisation of therapeutic and diagnostic services has come from the second level district health centres. This structure necessitates a real delegation of responsability and power to the district level, under the guidance and supervision of the Ministry of Health. It also offers a structured framework in which the actions of other international donors can be incorporated more effectively.

Chad

The Commission has adopted an original approach in Chad where the CEC funds periodic seminars in the capital to bring together the top officials of the Ministry of Health and the District Health Officers. Such contacts between field staff and the Ministry were previously non-existent. It is hoped that through the increased participation of all levels a national policy of organisation and management of the health services will evolve which will be able to continue the work initiated through the EC programme and which in addition will have greater legitimacy and will be better accepted by the population.

Operational research

Operational research forms an important part of Community policy on health in the Third World and much research work has been funded in this area both through the EDF and in the context of the STD programmes.

Several studies have been carried out on the organisation and management of health services and methods of financing. The creation of a viable system of financing the recurrent costs of this sector is one area which has been given particular attention and which is of great importance for the long-term viability of the programmes presently being put in place.

It is necessary that the methods of financing the health sector be adapted to the socio-economic and political context of each country, but as a general guideline the Commission stresses the importance of:

1. The financial accessibility of health care for the population.

2. A marked improvement in services prior to or parallel to the introduction of user fees in the health sector.

It is believed that an improvement in the financing systems can lead to an increase in the number of users which, in turn, will see a significant improvement in the financial balance of the health services.

Benin

In July 1987, the Commission carried out a study on the financing of hospitals in Benin. The recommendations made in this case were innovatory in that they allowed hospitals to apply financial mechanisms (fee structure, daily rates etc.) which were suited to their particular circumstances. However there were certain basic elements of the proposed policy:

- the reduction of tariffs in order to increase levels of occupation, which were in many cases unacceptably low;

- the introduction of a daily room rate which would include all costs;

- the introduction of an accounting service for each hospital department as well as a system for spreading fixed costs over each ward;

- a stricter management of the treasury.

Lesotho

In Lesotho, a study financed by the Commission on the methods of financing the health system in this country recommended interalia, the introduction of differential national fees which would encourage a more rational use of the facilities by the population. It was suggested that a higher charge be made for the use of secondary level facilities if the patient had not been referred upward from the first level. This system would serve both to:

1. help finance the basic health services by those who prefer to use systematically hospital services staffed by specialist doctors;

2. reduce the workload of the doctors at second level (usually overworked) and also increase the responsibilities, and thus job satisfaction of workers at the first level.

Development of human resources

A shortage of appropriately trained local personnel is evident in most of the countries of the Third World and is a factor which considerably hinders the development of self-supporting health systems in these countries. One of the principles put forward in the revised basic principles in 1986, was that personnel needs should be planned and an evaluation of training needs carried out. It is evident that a rationalisation of training facilities needs to be undertaken so that greater attention can be given to the specific needs of, and realities of work in, the community concerned.

It is often the case, for instance, that fewer doctors and more medical assistants are needed. Doctors require higher salaries and, used at the lower levels of the health system, find that they are overqualified and soon lose motivation.
Incentives and career possibilities for health personnel need to be improved. This would involve the provision of a more supportive working environment and better salaries, particularly in the more remote rural areas where facilites are often extremely basic. The provision of housing for personnel forms part of this policy.

Maintenance

The CEC is one of the rare international donors to support the establishment of hospital maintenance units for the upkeep of buildings and equipment. This is nevertheless a vital element in ensuring the continued viability of facilities. In many cases facilities soon become run down and, in the extreme cease to operate because of a lack of spare parts as well as the necessary expertise to repair equipment, both basic and medical. The setting up of maintenance teams is becoming a standard component of health projects, particularly where hospitals are concerned.

In Guinee-Conakry the EC helped finance and set up a team of mobile maintenance experts. They were trained, supplied with vehicles and a system of supply of spare parts was put in place.This project was particularly succesful as it enabled the team to serve not only one hospital but also the outlying peripheral structures.

Pharmaceutical supplies

The acquisition and distribution of essential drugs represents a major problem in many Third World countries. The expense of the acquisition of essential drugs is an extra burden on the balance of payments problems in these countries and difficulties in distribution often lead to misuse of what little supplies exist (ie.through over-prescription). It is hoped that research carried out in the framework of the STD programmes will lead to the development of some drugs of local origin which will help to alleviate the problem in this area.

Access to medicines is crucial for the future of the health services because it is a condition of their effectiveness and also of the confidence that the population places in them. The Commission therefore considers this a priority area and is encouraging the adoption of the essential drugs policy recommended by the WHO.

The Commission intends to help national governments to put in place a policy which will ensure the production of essential drugs and their national distribution through :

- political support for national essential drugs policy and for reform of national drug procurement procedures;
- financing of central, regional and district level warehouses for pharmeceutical goods;
- aid to the production and packaging of essential medicines;
- technical assistance.

- an organisation of markets for essential drugs which will interest the private sector by offering a sufficiently large market to compensate for narrow profit margins.

Niger

An important part of the aid given by the EC to Niger within the framework of the sixth EDF will be allocated to the pharmaceutical sector (9.2MECU). This will help to encourage the production of several medicines; to finance technical assistance to the National Office of Pharmaceutical and Chemical products; and to finance the importation of large quantities of essential drugs. It is hoped to use remaining funds to set up an efficient distribution system.

Chad

In Chad, the EC is supporting the national pharmacy (technical assistance (TA), drugs, logistical support) as part of a wider health sector programme for the strengthening of district level services. In this case a national institution is being given extensive support enabling it to take over the job formerly being done by an NGO (Médecins sans Frontiéres). The setting up of a radial distribution system with a central warehouse supplying the districts and the districts in turn supplying the smaller dispensaries is an important aspect of this project.

Environmental Health

Environmental factors have a major impact on the health of a community and must therefore be considered as an aspect of health policy. Sanitation and water supply projects are of particular importance in this connection. Many water-borne diseases such as bilharzia and river blindness could be better controlled through the development of better sanitation facilities and water supply systems and instruction in community and personal hygiene. The implications for health of other development projects undertaken by the Community should also be taken into account (ie. the implications of water irrigation projects for health, notably the spread of malaria and schistosomiasis). In the Nile Basin a potentially successful programme met with disaster when malaria spread through the population following the introduction of an irrigation system which allowed the breeding of mosquitos in the irrigation channels.

THE ACP/EEC AIDS CONTROL PROGRAMME

AIDS (Acquired Immune Deficiency Syndrome) represents a major public health priority worldwide. It is not only a major problem of developed countries but represents a serious threat to the countries of the Third World where poorly developed health structures and a lack of adequate facilities, together with a lack of information on the disease, mean that these countries are particularly at risk. It is therefore necessary that efforts are mobilised and coordinated worldwide to ensure that the epidemic is contained, and that existing health structures in Third World countries are supported and, if possible, improved in order to be able to meet the added demands being placed on them.

Failure to control the spread of the AIDS virus may have a significant negative impact on other health services and related programmes as well as on the future development of these countries. Approximately 90% of AIDS cases affect those between the ages of 20 and 50 and the incidence of the transmission of the virus from mother to child is increasing. Morbidity and mortality are therefore affecting the most productive age groups as well as generations of unborn children.

The ACP/EEC AIDS Control Programe approved by the Commission in July 1987 represents a contribution to the Special Programme on AIDS (SPA) led and coordinated by the WHO. The WHO's Special Programme is based on the definition and establishment of medium- and long-term National AIDS Control Programmes in all countries affected by the disease. The National Plan will provide a framework in which needs can be identified and appropriate support measures implemented rapidly and efficiently.

The EC's programme is intended to support and strengthen the national AIDS Control Programmes of the ACP countries concerned. Help will be provided in both the development and implementation stages of the national plan, as well as in the area of operational public health orientated research and the applied research into the virus included in the Commission's STD Programmes.

It should be recognised that, although some emergency measures may need to be taken in a more spontaneous way, the AIDS challenge is one which needs to be met on a long-term developmental basis. It is essential that existing health services and structures be strengthened and that AIDS control activities be integrated into primary health care systems thereby ensuring their long-term impact and viability.

The ACP/EEC AIDS Control Programme has been allocated a budget of 35 MECU for a period of three years until mid-1990. So far specific areas of EC responsibility have been identified as follows:

1. Reduction of the risk of transmitting the disease through blood transfusions by ensuring that blood used for transfusions is clean (ie. provision of adequate blood screening facilities), and the reduction of the spread of the disease through sexual transmission by control of sexually transmitted diseases in general.

2. Information and education campaigns.

3. Operational research into :

- planning and design of prevention and control campaigns;

- estimating the size of the epidemic and ways in which the virus is transmitted;

- screening techniques.

In addition the EC is also responsible for the coordination of bilateral aid given by Member States. A special Task Force has been set up to generally coordinate activities, examine requests, liaise with WHO and administer the programme rapidly and flexibly.

Cameroon

Aid from the EC has been used to improve the conditions of the collection, analysis and storing and use of blood, in the two major transfusion centres in Cameroon - Laquintinie Hospital in Douala and Yaoundé Central Hospital. This aid takes the form of the enlargement and renovation of the buildings concerned, the setting up of a system of recruitment of regular and voluntary donors and the allocation and retraining of extra personnel to these units. The necessary funds will be allocated to Douala to enable it to become a centre of reference for AIDS cases and to Yaoundè to enable it to fulfill its potential as a reference laboratory for immunohematology.

The Caribbean

The Caribbean has one of the highest levels of AIDS cases per capita in the world. The majority of the Caribbean islands have now responded to the Commission's offer of help and aid is now being channelled to this area through the Caribbean Epidemiological Centre (CAREC). Aid in this instance has included the supply of AIDS testing kits, funds for the enlargement of facilities, technical assistance for the setting up of information campaigns on the virus and training in the care and support of AIDS patients and their families.

SCIENCE AND TECHNOLOGY FOR DEVELOPMENT

In 1980 the second United Nations Conference for Science and Technology for Development (UNCSTD) adopted a list of conclusions which became known as the 'Vienna Programme of Action'. The conference drew attention to the urgent need to mobilise scientific and technological resources worldwide in aid of the developing countries.

In response to this the European Communities adopted, in December 1982, a first research and development programme for 'Science and Technology for Development'. This first programme covered the period 1983-1986 and was allocated an overall budget of 40 MECU to be divided between two sub-programmes: 'Tropical and Sub-tropical Agriculture' and 'Medicine, Health and Nutrition in Tropical and Sub-tropical Areas'.

The programme proved to be particularly succesful in increasing the links between the various science and research bodies working in the field of development, and thereby contributed greatly to the fight against the fragmentation of efforts and the dispersion of resources which jeopardize the efficiency and quality of research work worldwide. A second STD programme was therefore adopted in December 1987 to cover the period 1987-1990. With a budget of 80 MECU, double that of the first, it represented a reinforcement and continuation of the first.

The specific objectives of the STD programmes are as follows:

1. To increase the research and development efforts of industrialised countries and encourage the establishment of joint projects with developing countries.

2. To introduce a scientific and technological dimension to the development activities of the Community as a result of the growing awareness of the place of science and technology in the process of economic and social development.

3. To establish greater cooperation among scientists in the various Member States and the developing countries with a view to facilitating the complementarity of research and methodologies and ensuring easier access to the different networks of scientific relationships established by the Member States with their Third World partners.

and as a special objective of the second programme:

4. To develop the indigenous scientific and technical research capacities in developing countries.

The STD programmes represent an important form of aid from the Community towards health in the Third World. Several important advances have been made in the development of new methods of

diagnosis and treatment of tropical and sub-tropical diseases, notably: the validation of new tests for studying the resistance of malaria parasites to chloroquine; the development of new methods of diagnosing leprosy using mono-clonal antibodies; advances in research into the treatment and prevention of sleeping sickness.

The second programme has seen the allocation of 25 MECU to the sub-programme 'Medicine, Health and Nutrition', and it is hoped that significant advances will be made in the capacities for control and prevention of tropical diseases and AIDS and the development of self-sustainable health systems in the Third World.

An important aspect of the STD programmes is that they are designed to dovetail with operations carried out by the major international organisations (ie.WHO) and they are not restricted to countries with whom the Community has signed cooperation agreements but are open to all developing countries.

Subprogramme: 'Medicine, Health and Nutrition in Tropical and Sub-tropical Areas'

OUTLINE OF PROGRAMME

Medicine

Research into the prevention and control of:

Transmissible diseases: Parasitological (malaria, schistosomiasis, sleeping sickness), Bacterial (leprosy, tuberculosis), Viral (hepatitis, haemorrhagic fevers, sexually transmitted diseases and in particular AIDS).

Non-transmissible diseases: Genetic disorders and acquired diseases.

Health

Health services research: Operational research concerning health care delivery systems appropriate for the rural or urban environment of developing countries. Planning, management, financing, evaluation. Local community participation.

Environmental health: concerning water related diseases and living conditions.

Traditional medicine: Research into various tropical plants and their possible use as a source of drugs to combat tropical diseases.

Nutrition

Identification of nutritional deficiencies and requirements and planning of intervention strategies.

Study of the impact of agricultural, food and socio-economic strategies on nutrition.

Study of relationships between production, storage systems, food habits and state of health of population.

Research into bioavailability of nutrients.

EC COOPERATION WITH NON-GOVERNMENTAL ORGANISATIONS

In addition to the EC's health programme proper, substantial aid is allocated to the health sector through the intermediary of Non-governmental Organisations (NGOs) such as Mèdecins Sans Frontiéres (MSF), OXFAM, and the Red Cross. The Community's policy of cofinancing development projects carried out in the Third World by European NGOs was initiated in 1976, with the aim of supporting "the expression of "non-official" European solidarity with the least favoured populations of the Third World". Budget article 941 was created with an initial budget of 2,5MECU to be allocated to the cofinancing, in collaboration with European NGOs of:

1. Development projects carried out in the Third World.

2. Actions aimed at sensitizing European public opinion.

Since 1976 the budget for this sector of Community aid has risen steadily to a total of 62MECU in 1987, roughly 20% of which was used in health related projects.

The aid given by the Commission to NGOs enables a large number of actions to be undertaken in aid of the developing countries outside the framework of the Community programme proper and thus leads to a flexible and diversified approach whilst at the same time permitting a degree of coordination and rationalisation of activities carried out in this domain.

EMERGENCY AID

Emergency aid has been used in several instances to finance medical intervention in situations where it was considered a matter of absolute urgency to supply help immediately rather than wait for a programme to be adopted. This has been the case, for instance, with outbreaks of diseases such as yellow fever and malaria, where it is necessary to control and contain the disease immediately before it gets out of hand. (In 1987 Nigeria benefited from 950,000ECU emergency aid to combat the yellow fever epidemic in that country).

Other examples of emergency aid in the area of health are seen in the aid given to help in the fight against AIDS in Burundi (185,000ECU) and Uganda (350,000ECU) and, more recently, the Emergency aid allocated to Bangladesh after the flood disaster, 900,000ECU of which has been largely designated to medical needs.

The Community does not execute emergency aid directly but channels it through various external agencies. Over 60% of emergency aid in 1987 was channeled through various NGOs and the Red Cross and the remainder through government agencies and agencies of the United Nations.

Almost three quarters of emergency medical aid (where speed in execution is particularly important) is in fact channeled through NGOs and the Red Cross.

Table 1: Health projects as a percentage of overall EDF aid

	Health MECU	Total EDF MECU	Health as % of total EDF
EDF 1	48 422	581 25	8.33
EDF 2	26 542	680 00	3.90
EDF 3	32 608	815 00	4.00
EDF 4	62 822	2 175 00	2.89
EDF 5	125 726	4 365 00	2.88

Table 2: Quantitative analysis by type of project (in%)

	Building	Equipment	Research, medicines, technical assistance, etc.
EDF 1	80.3	14.4	5.3
EDF 2	64.1	18.7	17.2
EDF 3	69.6	20.7	9.7
EDF 4	58.6	32.2	9.2

Table 3: Number of health projects

	Number	% of total of all 5 EDFs
EDF 1	58	26 %
EDF 2	25	11 %
EDF 3	23	10 %
EDF 4	41	18 %
EDF 5	79	35 %