

Healthy Development

The World Bank Strategy for Health, Nutrition, and Population Results

April 24, 2007

TABLE OF CONTENTS

Preface.....	9
A. Executive Summary	11
B. Introduction and Overview.....	20
The importance of HNP in socioeconomic development.	20
Significant HNP gains but large, persisting challenges.	21
The Bank role in HNP improvements in the past decade.	22
Opportunities and challenges: The new international environment and DAH.	23
A well-organized and sustainable health system is essential to achieve HNP results on the ground.	27
A shift in the driver of Bank-country relationship toward high-quality policy advice and strategic focus of Bank lending on structural HNP issues.....	28
How can the Bank best serve client countries in this new scenario?	29
Strategic Objectives: What HNP results?	30
Strategic Directions: How should the Bank support country efforts to achieve results?	31
Implementing the Bank HNP Strategy.	33
A window of opportunity for redoubled support for countries' HNP results.	34
C. Opportunities and Challenges in the New International Environment in Health.....	34
A new international environment.....	34
The new architecture for development assistance for health.	37
D. Bank Contribution and Challenges in Implementing the 1997 HNP Strategy	38
Bank contribution to the new DAH architecture.	38
Taking stock of 1997 HNP Strategy.	39
Lending trends since 1997.	39
Need to rapidly improve quality performance of HNP portfolio.....	40
Need for sharper focus of analytic and advisory activities.	42
Imbalance in HNP staff trends.	42
E. How Can the Bank Better Serve Client Countries in the New Environment?	43
Bank Comparative Advantages for HNP Results.	43
Bank comparative advantages.....	43
Knowledge and policy advice on public policy to improve public-private synergies for HNP results.	44
Providing advice and financing to strengthen health systems for HNP results.	44
Intersectoral approach for better HNP results.....	47
F. New Bank Strategic Objectives: What HNP Results?.....	48
STRATEGIC OBJECTIVE 1. Improve the level and distribution of key HNP outcomes, outputs, and system performance at country and global levels to improve living conditions, particularly for the poor and the vulnerable.	48

STRATEGIC OBJECTIVE 2. Prevent poverty due to illness (by improving financial protection).	49
STRATEGIC OBJECTIVE 3. Improve financial sustainability in the HNP sector and its contribution to sound macroeconomic and fiscal policy and country competitiveness.	51
STRATEGIC OBJECTIVE 4. Improve governance, accountability, and transparency in the health sector.	52
G. New Bank Strategic Directions: How Should the Bank Support Client-Country Efforts?.....	53
STRATEGIC DIRECTION 1. Renew Bank focus on HNP results.	54
STRATEGIC DIRECTION 2. Increase the Bank contribution to client-country efforts to strengthen health systems for HNP results.	58
STRATEGIC DIRECTION 3. Ensure synergy between health system strengthening and priority-disease interventions, particularly in LICs.	59
STRATEGIC DIRECTION 4. Strengthen Bank capacity to advise client countries on an intersectoral approach to HNP results.	61
STRATEGIC DIRECTION 5. Increase selectivity, improve strategic engagement, and reach agreement with global partners on collaborative division of labor for the benefit of client countries.	62
H. Implications for Priority Health, Nutrition, and Population Programs and Interventions .	63
A strong commitment to population, sexual and reproductive health, and maternal and child policy.	64
Opportunities for sustaining, and challenges to improving, HNP contributions to combating HIV/AIDS.	68
Repositioning nutrition to a central place in development.	70
I. Implementing New Bank HNP Strategic Directions	72
Action Plan for implementing Strategic Directions.	73
HNP Hub mission and organizational changes.	79
Rebalancing staff skill-mix.	80
Preliminary estimates of Strategy implementation costs.	80
Annexes.....	81

ANNEXES

- A. Figures and Supplementary Tables
- B. Regional/HNP Hub Action Plans
- C. Acknowledgments
- D. List of Participants in Internal Consultations
- E. List of Participants in Country Consultations
- F. List of Participants in Global Partner Consultations
- G. Questionnaire
- H. Chairman Summary Note to the Background Note on the World Bank Strategy for HNP Results, June 21, 2006
- I. New Global Health Architecture
- J. Bank HNP Global Results Framework
- K. Multisectoral Constraints Assessment
- L. What is a Health System?
- M. List of Global Partners and Partnerships
- N. HNP Contribution to Combating HIV/AIDS
- O. References

BOXES

- 1. Healthy Development: The World Bank Strategy for Health, Nutrition, and Population Results
- 2. Key Next Steps for Implementation
- 3. Could Elizabeth Have Been Saved? Why Health Systems Matter
- 4. What Are Governance and Corruption in the Health Sector?
- 5. Promising New Mechanism Linked to Results: Loan Buy-Downs for Polio Eradication Results in Pakistan
- 6. Argentina *Plan Nacer*: Health System Strengthening Built into Results-Based Lending for MCH
- 7. The World Bank Commitment to Reproductive Rights and Reproductive Health (ICPD 1994)

TABLES

- 1. Five-Year Action Plan: Renewing Focus on Results
- 2. Five-Year Action Plan: Strengthening Health Systems and Ensuring Synergy between Health System Strengthening and Priority-Disease Interventions
- 3. Five-Year Action Plan: Strengthening Bank Intersectoral Advisory Capacity
- 4. Five-Year Action Plan: Increasing Selectivity, Strategic Engagement, and Collaborative Division of Labor

ACRONYMS AND ABBREVIATIONS

AAA	Analytic and advisory activities
ACT	Artemisinin-based Combination Therapy
ADB	Asian Development Bank
AFD	French Agency for Development
AfDB	African Development Bank
AFR	Africa Region, World Bank
AHI	Avian and Human Influenza
APL	Adaptable Program Loan/Credit
APP	Africa Action Plan
AMC	Advance Market Commitment
ARPP	Annual Review of Portfolio Performance
ART	Antiretroviral therapy
ARV	Antiretroviral drug
AusAID	Australian Agency for International Development
BAPPENAS	National Development Planning Agency, Republic of Indonesia
BCOI	Binding Constraints to Outcome Improvement Process and Tools
CAS	Country Assistance Strategy
CCT	Conditional cash transfer
CDC	Centers for Disease Control and Prevention, United States
CDP	Comprehensive Development Partnership
CEM	Country Economic Memorandum
CMU	Country Management Unit
CODE	Committee on Development Effectiveness, World Bank
DAH	Development Assistance for Health
DANIDA	Danish International Development Agency
DEC	Development Economics
DFID	Department for International Development, United Kingdom
DGF	Development Grant Facility
DP	Development Partner
DPL	Development Policy Lending
ECA	Europe and Central Asia Region, World Bank
EAP	East Asia and Pacific Region, World Bank
ESW	Economic sector work
EU	European Union
FAO	Food and Agriculture Organization
GAIN	Global Alliance for Improved Nutrition
GAVI	Global Alliance for Vaccines Initiative
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHAPA	Global HIV/AIDS Program of Action
GTZ	German Agency for Technical Cooperation
HD	Human Development
HNPfAM	Health, Nutrition, and Population Network of the World Bank
HNP	Health, Nutrition, and Population
HPAI	Highly Pathogenic Avian Influenza
HR	Human resources
HSPT	Health System Policy Team
IADB	Inter-American Development Bank
IBRD	International Bank for Reconstruction and Development, World Bank Group
ICPD	International Conference on Population and Development
ICR	Implementation Completion Report

IDA	International Development Association, World Bank Group
IEG	Independent Evaluation Group, World Bank Group
IFC	International Finance Corporation, World Bank Group
IFPMA	International Federation of Pharmaceutical Manufacturers and Associations
IFPRI	International Food Policy Research Institute
ILO	International Labor Organization
ISR	Implementation Status Report
LCR	Latin America and Caribbean Region, World Bank
LIC	Low-income country
LA-LIC	Low-income countries for which DAH is a small proportion of government or total expenditures in health
HA-LIC	Low-income countries for which DAH is a large proportion of government or total expenditures in health
M&E	Monitoring and evaluation
MCA	Multisectoral Constraints Assessment for Health Outcomes
MDG	Millennium Development Goal
MENA	Middle East and North Africa, World Bank
MIC	Middle-income country
MMB	Marginal budgeting for bottlenecks
MMR	Maternal mortality rate
MOH	Ministry of Health
MTEF	Medium-term expenditure framework
NCD	Noncommunicable disease
NGO	Nongovernmental organization
NHA	National health accounts
Norad	Norwegian Agency for Development Cooperation
ODA	Official development assistance
OECD	Organisation for Economic Co-operation and Development
OECF	Japanese Overseas Economic Cooperation Fund
OOP	Out-of-pocket spending
OPCS	Operations, Policy, and Country Services, World Bank
PDO	Project development objective
PER	Public expenditure review
PEPFAR	United States President's Emergency Plan for AIDS Relief
PREM	Poverty Reduction and Economic Management Network, World Bank
PRH	Population and reproductive health
PRSP	Poverty reduction strategy paper
PRSC	Poverty Reduction Strategy Credit
PSD	Private Sector Development, World Bank
QAG	Quality Assurance Group, World Bank
R and D	Research and development
RTA	Reimbursable technical assistance
SAL	Sector Adjustment Loan/Credit
SAR	South Asia Region, World Bank
SARS	Severe Acute Respiratory Syndrome
SIDA	Swedish International Development Cooperation Agency
SMU	Sector Management Units, World Bank
SSA	Sub-Saharan Africa
SWAP	Sector-wide approach
TA	Technical assistance
TB	Tuberculosis
TF	Trust Fund
TFR	Total fertility rate

TGHE	Total government health expenditure
U-5	Children under five years of age
USAID	United States Agency for International Development
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNAIDS	Joint United Nations Program on HIV/AIDS
WBI	World Bank Institute
WHO	World Health Organization
WFP	World Food Program, United Nations

This Bank HNP Strategy was prepared by a team led by Cristian C. Baeza (Lead Health Policy Specialist, LCSHH /Acting Director, HDNHE) and composed of Nicole Klingen (Senior Health Specialist, HDNHE), Enis Baris (Senior Public Health Specialist, ECSHD), Abdo S. Yazbeck (Lead Economist, Health, WBIHD), David Peters (Senior Public Health Specialist, HDNHE), Eduard Bos (Lead Population Specialist, HDNHE), Sadia Chowdhury (Senior Health Specialist (HDNHE), Pablo Gottret (Lead Economist, HDNHE), Phillip Jeremy Hay (Communications Adviser, HDNOP), Eni Bakallbashi (Junior Professional Associate, HDNHE), Lisa Fleisher (Junior Professional Associate, HDNHE), Jessica St. John (Junior Professional Associate, HDNHE), Elisabeth Sandor (Health Specialist, HDNHE), Andrianina Rafamatanantsoa (Program Assistant, HDNHE), and Victoriano Arias (Program Assistant, HDNHE)

Special gratitude is due to Government officials of client countries, global partners, and Bank management and staff who generously provided the team with valuable recommendations and guidance on how the Bank can better support client country efforts to improve the life of those who are most vulnerable. A comprehensive list of acknowledgement is presented in annex C.

Overall guidance to the team was provided by Jacques Baudouy (Director, HDNHE-retired), Nick Krafft (Director Network Operations, HDNVP), Joy Phumaphi (Vice President, HDNVP), Jean-Louis Sarbib (Senior Vice President, HDNVP-retired), James Adams (Vice President & Head of Network, OPCVP and Vice President & Head of Network, EAPVP), Danny Leipziger (Vice President & Head of Network, PRMVP), Xavier Coll (Vice President, HRSVP), Shanta Devarajan (Chief Economist, SARVP), Steen Jorgensen (Sector Director, ESDVP), Jamal Saghir (Director, EWDDR), James Warren Evans (Sector Director, ENV), Evangeline Javier (Sector Director, LCSHD), Julian Schweitzer (Sector Director, SASHD), Michal Rutkowski (Sector Director, MNSHD), Guy Ellena (Director, IFC), Debrework Zewdie (Director, HDNGA), Kei Kawabata (Sector Manager, HDNHE), Akiko Maeda (Sector Manager, MNSHD), Anabela Abreu (Sector Manager, SASHD), Armin Fidler (Sector Manager, ECSHD), Eva Jarawan (Sector Manager, AFTH2), Fadia Saadah (Sector Manager, EASHD), Keith Hansen (Sector Manager, LCSHH), Ok Pannenberg (Senior Adviser, AFTHD), Bruno Andre Laporte (Manager, WBIHD), Elizabeth King (Research Manager, DECRG) and Susan Blakley (Senior Human Resources Officer, HRSNW).

Preface

This new HNP Strategy was prepared in two phases. The first phase of preparation was completed at a briefing to the Committee on Development Effectiveness (CODE) in June 2006, as presented in the Background Note on the New HNP Strategy, dated May 30, 2006. That briefing culminated in a process of extensive consultations with global partners, Bank staff, and management and confirmed the proposed Strategic Directions (annex H). The second phase finalized necessary technical work to address the main comments from the CODE discussion and comments received from global partners before the CODE briefing and began consultations with client countries from all Bank Regions. So far, more than 9 client countries in the field, 65 global partners, including civil society organizations and bilateral and multilateral organizations, and 160 Bank managers and staff from HNP and other sectors have been consulted.¹ The new Strategy benefits from the comments and suggestions given the team during these enriching consultations. It is intended to contribute to the decisions of client-country policy makers, Bank country teams, Bank management and global partners on country- and Region-specific strategies and Action Plans for achieving HNP results on the ground. This final strategy document includes comments and suggestions from the CODE discussion held on March 14, 2007.

This Strategy Paper does not attempt to make in-depth, specific technical recommendations on the diverse and complex range of issues involved in HNP policy today. In-depth technical recommendations must be country-context specific. Therefore, this Strategy Paper does not, for example, list specific health system reforms to improve performance in specific country contexts, nor does it recommend the best approach to support much-needed improvements in HNP in post-conflict and fragile states or propose international arrangements necessary for sustainable donor HNP financing in low-income countries. Instead, the paper outlines a new strategic vision for the World Bank in improving its own capacity to respond to these urgent questions globally and with a country focus, ensuring that this capacity will be mainstreamed in Bank lending and nonlending country support and support to global partners in areas of Bank comparative advantages.

¹ Interviews were conducted using a structured, open-ended interview technique, small group consultations, and consultations with partners at country and global levels. A questionnaire was sent to the Human Development (HD) Sector Management Units (SMUs) in all Regions, to the HNP Hub, the Global Program on HIV/AIDS, the World Bank Institute (WBI), and the International Finance Corporation (IFC) in March 2006. A consultation with the World Health Organization (WHO) was held in May 2006 in Geneva. Focus groups with randomly selected HNP staff (30 participants in all) as well as meetings with HNP teams at regional levels were organized to discuss the same set of questions. Two preliminary consultations with global partners were held on May 18 and 23 and in October and November 2006. Between September and November 2006, the strategy facilitation team visited 9 client countries (Argentina, Algeria, Armenia, Djibouti, India, Indonesia, Mali, Mexico, and Tanzania) to consult with government, civil society, academia, global partners in the field, and Bank country office staff. Additionally, the strategy facilitation team benefited from abundant information and analysis provided by Bank staff, other multilaterals, bilaterals, and foundations. The team held various discussion meetings with groups of civil society in Washington D.C.

Although this HNP Strategy does not include country-specific technical recommendations, its preparation has been informed by abundant in-depth policy work, conducted by the Bank, setting forth analysis on health financing,² on nutrition policy,³ on a Bank Global Program Action Plan for HIV/AIDS⁴ (World Bank 2006h), and a renewed commitment to population policy (World Bank 2006j).⁵ It provides the vision of the Bank on the need to strengthen health systems and, in section H, it refers to key challenges for the HNP sector in contributing to combating the HIV/AIDS pandemic, in repositioning nutrition on the development agenda, and in renewing its commitment on population policy in line with, *inter alia*, the Programme of Action of the International Conference on Population and Development (UNFPA 2004). We refer readers to this specific technical work for further in-depth technical analysis. Through the implementation of this new HNP Strategy, the Bank plans to further strengthen its analytical and operational work in these important areas.

The new Strategy identifies a plan of action and internal functional adjustments for its implementation to bring about essential improvements in Bank work on HNP. It identifies necessary changes that would allow better support for government leadership and programs as well as global partners' efforts to achieve results. Country-driven and country-owned programs are the key to good HNP results on the ground.

² Preker and Langenbrunner 2005; Angel-Urdinola and Jain 2006; Baeza and Packard 2006; Cotlear 2006; Dussault, Fournier, and Letourmy 2006; Gottret and Schieber 2006; Marek, Eichler, and Schnabl 2006.

³ Allen and Gillespie 2001; Berhman and Rosenzweig 2001; Galasso and Yau 2006; Jamison et al. 2006; World Bank 2006l.

⁴ Bell, Bruhns, and Gersbach 2006; Duflo et al. 2006; Görgens et al. 2006; Görgens-Albino and Nzima 2006; Lutalo 2006; Malek 2006; Marquez 2006; Moses et al. 2006; Wilson and de Beyer 2006a; Wilson and de Beyer 2006b; Wilson and Claeson 2006.

⁵ Additional sources: Birdsall, Kelley and Sinding 2001; Wagstaff and Claeson 2004; Campbell-White, Merrick and Yazbeck 2006; World Bank 2006j.

A. Executive Summary

Healthy Development: The World Bank Strategy for Health, Nutrition, and Population Results for the next decade updates the 1997 World Bank Health, Nutrition, and Population (HNP) Strategy in light of the momentous changes of the past decade in the international architecture of development assistance for health (DAH)⁶ and of persisting and new HNP challenges worldwide. Ten years ago, the Bank was the main financier of HNP. Today, in addition to the Bank, new multilateral organizations, initiatives, and foundations have assumed a prominent role in financing HNP, among them the Global Fund,⁷ GAVI,⁸ GAIN,⁹ and the Bill and Melinda Gates Foundation. Bilateral aid has also increased substantially. Much of this new funding is earmarked for combating priority diseases such as HIV/AIDS, malaria, tuberculosis, and some vaccine-preventable diseases; less for health system strengthening at country level, for maternal and child health, for nutrition, and for population priorities.

The ultimate objective of World Bank work in HNP, reinforced by this new Strategy, is to improve the health conditions of the people in client countries, particularly the poor and the vulnerable, in the context of its overall strategy for poverty alleviation. To achieve this objective, this new Strategy states the vision and the Action Plan necessary to strengthen Bank capacity to better serve client countries by excelling in areas of Bank comparative advantages and by improving its collaboration with global partners.

The increased awareness and expanded international financing for HNP constitute a great opportunity for the Bank to help client countries and global partners improve HNP results on the ground, particularly for the poor and the vulnerable. However, the new environment also poses significant challenges for the Bank, requiring important changes in the way the Bank operates in HNP to be able to rise to the challenges. This 2007 HNP Strategy outlines the Bank vision for improving its own capacity to respond globally and with a country focus to the urgent issues posed by these challenges.

Throughout this Strategy, the case is made for sharpening Bank focus on results on the ground; for concentrating Bank contributions on its comparative advantages, particularly in health system strengthening, health financing, and economics; for supporting government leadership and international community programs to achieve these results; and for exercising selectivity in engagement with global partners. This focus is not intended to constrain what the Bank does—country circumstances must drive Bank programs. However, a selective and disciplined framework is advocated, particularly for policy advice and knowledge generation, to ensure that the Bank is appropriately staffed and ready to support country efforts and requests for assistance in a core set of key areas

⁶ *Development Assistance for Health* (DAH) consists of all resources aimed at providing financial support to developing countries to improve the HNP conditions of their populations. DAH includes multilateral organizations such as the Bank, bilateral aid, and private philanthropic aid. Annex I presents an overview of actors and trends in DAH in the last decade.

⁷ Global Fund to Fight AIDS, Tuberculosis and Malaria.

⁸ Global Alliance for Vaccines and Immunization.

⁹ Global Alliance for Improved Nutrition.

where the Bank can play a major role. This framework is also essential for the Bank to collaborate with global partner efforts to ensure aid effectiveness.

This Strategy Paper is organized in nine sections, including this summary. Additional information is presented in 15 annexes. All figures referred to in the text are presented in annex A. Annexes B, C, D, E, F, G and H include, respectively, the regional and HNP Hub Action Plans for implementing the HNP Strategy; the acknowledgments; the list of individuals interviewed; the list of participants in the country and global partner consultations leading up to this new Bank HNP Strategy; the initial regional survey for strategic orientations and the CODE Chairman Summary Note to the Background Note on the World Bank Strategy for HNP Results, discussed with CODE on June 21, 2006.

Background

Health, nutrition, and population policies play a pivotal role in economic and human development and in poverty alleviation. For a century and a half, HNP improvements, achieved through the contributions of multiple sectors of the economy, have contributed to economic growth everywhere.

At the same time, improved economic growth has enabled improvements in health outcomes, creating a virtuous cycle—good health boosts economic growth, and economic growth enables further gains in health.¹⁰ The dramatic increases in development assistance for health and shifts in the major players involved in the global health architecture show the widespread recognition of the tight link between investments in health and economic development.

A multisectoral approach is essential for achieving HNP results. Many advances in health status achieved during the 20th century were the result of close synergy among HNP and multiple sectors of the economy such as water and sanitation, environment, transport, employment, education, agriculture, energy, infrastructure, and public administration. For example, investments in girls' education improve household decisions on nutrition and demand for basic health care. At the same time, investing in basic nutrition during pregnancy and infancy has a substantial positive effect on early childhood development, which, in turn, significantly contributes to educational attainment, employability, and future income (Bloom 2004; Jamison 2006; World Bank 2003b, 2004, and 2006j).

The Bank Contribution to HNP in the Last Decade: The 1997 HNP Strategy

The Bank has contributed substantially to HNP in client countries in the last decade (section D). Since the 1997 HNP Strategy, the Bank has decisively committed to focusing

¹⁰ Behrman and Rosenzweig 2001; Bell, Devarajan, and Gersbach 2004; Bloom, Canning, and Jamison 2004; Bloom, Canning, and Malaney 1999; Croppenstedt and Muller 2000; Fenwick and Figenschou 1972; Fogel 1994; Gallup and Sachs 2000; Glick and Sahn 1998; Jamison 2006; Shariff 2003; Smith 1999; 2005; Thirumurthy, Graff Zivin, and Goldstein 2005; Thomas 2001; Thomas, Frankenberg, Friedman, Habicht, Jones, McKelvey, et al. 2004; Thomas and Strauss 1997; Wolgemuth, Latham, Hall, Chesher, and Crompton 1982.

its work on health gains for the poor. The Bank has also played a crucial role in advocacy, awareness, and development of new international initiatives and organizations such as the Global Fund and GAVI.

As one of the world's largest single international financing organization of HNP activities in the last decade, the Bank has been a significant source of funding and has made substantial contributions in policy advice for priority-disease and HNP interventions. The Bank assisted more than 100 countries with more than 500 projects and programs, with cumulative disbursements of US\$12 billion and cumulative new lending of US\$15 billion from 1997 through 2006.¹¹ Through more than 250 Analytical Sector Work reports and advisories, the Bank also provided substantial policy and technical advice.

Despite the many excellent projects and programs in various Regions, the implementation impact of the 1997 Strategy on HNP results on the ground cannot be systematically evaluated. Focus on monitoring and evaluation (M&E) was weak during the last decade, and impact data are scarcely available.

During the last decade, the Bank has also faced significant challenges. Its total active portfolio (active commitments) in HNP decreased¹² by 30 percent from FY01 to FY06, and the implementation quality of the HNP lending portfolio had the lowest performance among all sectors in the Bank since 2001. Although the HNP sector operations are inherently complex and high risk as compared with many other sectors, much improvement is needed in the quality at entry and strategic focus of operations to improve HNP portfolio performance. In addition, the focus of Analytical and Advisory Activities (AAA) has been insufficient, with less than 35 percent of all AAA during the decade focused on areas of Bank comparative advantages.¹³

New and Persisting HNP Challenges in the New International Environment

The last three decades have brought important achievements in HNP in the developing world, *but formidable challenges persist*. Actual and potential pandemics and regional epidemics have continued to emerge, and some have expanded (e.g., HIV/AIDS, malaria, drug resistant TB, SARS, avian flu). A significant increase has occurred in premature deaths related to chronic diseases (diabetes, pulmonary diseases, hypertension, cancer) linked to the tobacco-addiction and obesity pandemics. The world population more than doubled in the second half of the 20th century, mostly from population growth in developing countries. High population growth poses significant challenges to country efforts to alleviate poverty and to facilitate access to basic services. Malnutrition is problematic not only in poor countries (with both undernutrition and obesity), but also in rich countries confronted with a rapidly growing prevalence of obesity.

¹¹ As measured by cumulative disbursements for all HNP sectoral classifications managed by the HNP Sector Board and other sectors.

¹² The active portfolio has decreased by 30 percent since FY2001, mostly due to declining IBRD lending.

¹³ Share of AAA focused on health systems performance.

The new opportunities brought about by the changes in DAH also present three special challenges: (a) the need to focus beyond increasing available financing for HNP, ensuring that additional funds produce tangible results on the ground to improve the living conditions of the people, especially the poor and the vulnerable; (b) the need to align and harmonize global partners' activities with country needs to prevent duplication, economic distortions—and excessive administrative costs—ensuring country-owned and country-led DAH; and (c) the need to ensure synergy between enhanced priority-disease financing and strengthening of health systems, essential for achieving results and improving DAH effectiveness on the ground.

Results on the Ground

In this Strategy, *HNP results* encompass not only HNP outcome indicators, such as the United Nations Millennium Development Goals (MDGs), stunting, or fertility rates but also health system performance, as reflected, for example, in financial protection¹⁴ and utilization of essential health services by the poor. Other results targeted are: empowerment of the poor (as outlined in *World Development Report—2004*), good sector governance, sector financial sustainability and its contribution to sound fiscal policy and country competitiveness; key outputs such as the proportion children immunized, proportion of children born under safe delivery conditions, and other outputs closely linked to achieving HNP MDGs; and availability of essential drugs and personnel in rural clinics. All these results are examples of Bank HNP objectives in client-country work. For these results to be achieved, a multisectoral approach is essential. Annex J presents the Bank Results Framework for HNP, which summarizes the main outcomes and outputs for the Bank in HNP. The framework is intended as the guidance for country teams for developing country-specific Results Frameworks and detailed Results Frameworks for Bank operations and programs.

Strengthening Health Systems

“Strengthening health systems” may sound abstract and less important than specific-disease control technology or increased international financing to many people concerned about achieving HNP results. But, well-organized and sustainable health systems are necessary to achieve results. On the ground, in practical terms, it means putting together the right chain of events (financing, regulatory framework for private-public collaboration, governance, insurance, logistics, provider payment and incentive mechanisms, information, well-trained personnel, basic infrastructure, and supplies) to ensure equitable access to effective HNP interventions and a continuum of care to save and improve people's lives (box 3). Strengthening health systems is not a result in itself. Success cannot be claimed until the right chain of events on the ground prevents avoidable deaths and extreme financial hardship due to illness because, without results, health system strengthening has no meaning. However, without health system strengthening, there will be no results.

¹⁴ Defined as preventing households from the impoverishing effects of illness and other health-related life cycle events.

Achieving HNP results requires a well-organized and sustainable country health system, capable of responding to the HNP needs of the community. Strengthening health systems to achieve HNP results requires a multisectoral effort at the country level. There is consensus that a major, urgent effort must be made to strengthen health systems if financial commitments enabled by the new DAH architecture are to succeed in improving the health conditions of the poor and achieve the HNP-related MDGs. The international community agrees on this principle after much debate in the early 2000s, centered on the false dichotomy between focus on priority diseases and focus on system strengthening.

To make sure people's health and daily lives are really being improved with the money invested, actual results on the ground have to be evaluated. Measuring results requires systems for close and effective monitoring and evaluation, which are effectively linked to policy design and management.

New Opportunities, Challenges, and the Bank Role in the New DAH Scenario

The new aid architecture, persisting HNP challenges, and the urgency for strengthening health systems to achieve results represent major challenges, particularly to low-income countries and fragile states. The quality of Bank policy and technical advice will be critical for client- country response to these challenges. While still strategically very important, Bank financing, at roughly US\$1.5 billion a year, is relatively small, compared with the overall large and increasing funding for the control of specific diseases. Financing no longer drives relationships with client countries. For example, as measured by new annual financial commitments for HIV/AIDS, for malaria, and for tuberculosis, Bank financing in FY2005 represented about 5 percent,¹⁵ 3 percent,¹⁶ and 7 percent,¹⁷ respectively, of total annual international commitments for each of these diseases.¹⁸ In this scenario, it is the quality of the policy and technical dialog and the strategic focus of Bank lending that will define the true magnitude of the Bank contribution to country efforts in HNP in the next decade.

It is important to highlight that, although the share of Bank financing in total DAH has decreased, Bank lending, particularly through the *International Development Association (IDA)*, is *strategically crucial to ensure much-needed health system strengthening (for which dedicated international financing is scarce), and it is essential to set the enabling environment for effective disease-specific financing to achieve results*. This was stated again and again by client countries during preparation of this new Strategy.

This new World Bank Global Strategy for HNP Results asserts the vision of the Bank role in the new global architecture in HNP (box 1). It also attempts to give Bank regional

¹⁵ World Bank 2006d and Lewis 2005.

¹⁶ World Bank 2006d and WHO 2005.

¹⁷ World Bank 2006d and WHO 2006a.

¹⁸ Commitments for each of the three diseases fluctuate considerably from year to year. FY05 data, the only data available at this time, should not be used to draw general conclusions about Bank financing for these diseases.

and country teams guidance for addressing these questions with a sharp focus on HNP results, working closely with global partners. For that purpose, it defines the strategic and operational changes necessary to assist these teams more effectively and suggests opportunities for collaborative division of labor among global partners.

Box 1
Healthy Development
The World Bank Strategy for Health, Nutrition, and Population Results

Strategic Vision

With the implementation of this new HNP Strategy, the Bank aims at bolstering client-country efforts to improve health conditions for the poor and the vulnerable and to prevent them from becoming impoverished or made destitute as a result of illness. The Bank envisions that its support and advice will help client countries achieve these HNP results in a way that also contributes to their overall fiscal sustainability, economic growth, global competitiveness, and good governance. This new Strategy is embedded in the core mission of the Bank to alleviate poverty worldwide. To achieve these objectives, countries need to articulate a response from multiple sectors that influence HNP results. The Bank, with its 19 sectors working globally in 139 countries, is uniquely positioned to support client-country efforts.

Strategic Objectives: What HNP Results?

(Section F)

1. Improve the level and distribution of key HNP outcomes (e.g. MDGs), outputs, and system performance at country and global levels in order to improve living conditions, particularly for the poor and the vulnerable.
2. Prevent poverty due to illness (by improving financial protection).
3. Improve financial sustainability in the HNP sector and its contribution to sound macroeconomic and fiscal policy and to country competitiveness.
4. Improve governance, accountability, and transparency in the health sector.

Strategic Directions: How should the Bank support country efforts to achieve results?

(Section G)

1. Renew Bank focus on HNP results.
2. Increase the Bank contribution to client-country efforts to strengthen and realize well-organized and sustainable health systems for HNP results.
3. Ensure synergy between health system strengthening and priority-disease interventions, particularly in LICs.
4. Strengthen Bank capacity to advise client countries on an intersectoral approach to HNP results.
5. Increase selectivity, improve strategic engagement, and reach agreement with global partners on collaborative division of labor for the benefit of client countries.

Long-Term Country-Driven and Country-Led Support

Country-driven and country-owned programs are the key to good HNP results on the ground. A strong country presence, country focus, and country-driven support are at the core of the Bank business model and are some of the most important comparative advantages of the Bank. Country teams working with Country Management Units (CMUs) embody the Bank country focus and its intersectoral approach to development. Strengthening and empowering CMUs to better serve client countries in collaboration with global partners working at the country level is therefore essential to ensure country-driven implementation of the HNP Strategy and, ultimately, sound HNP results.

Results on the ground, especially outcome improvements, rarely occur in the lifetime of a single project nor are they achieved by any single sector. It is long-term Bank policy advice, technical assistance, and its strategically focused lending program as a whole that can influence client-country HNP policy actions, inputs, and structural changes in the health system and influence HNP-relevant policies from other sectors. Therefore, proposed objectives and directions in this new HNP Strategy are geared to support the central role of CMUs in leading the Bank country support and in further improving the effectiveness of the Bank country focus in HNP.

Upon country demand, the Bank will continue to lend in all areas deemed necessary to improve health status and financial protection for people, especially the poor and the vulnerable. This includes support for controlling priority diseases in countries where they constitute a large part of the burden of disease. However, the Bank will increasingly endeavor to ensure that Bank operational and policy advice support for priority diseases will strengthen the health system to solve systemic constraints that impair the effectiveness of country, Bank, and international community financing in achieving HNP results.

Bank Comparative Advantages

The Bank has special strengths (*comparative advantages*) for providing policy and technical advice to client countries and global partners in their efforts to achieve HNP results (section E). The Bank will focus and enhance its capacity to generate knowledge and provide policy and technical advice in these areas. They include: its health system strengthening capacity; its intersectoral approach to country assistance; its advice to governments on regulatory framework for private-public collaboration in the health sector; its capacity for large-scale implementation of projects and programs; its convening capacity and global nature; and its pervasive country focus and presence.

Some of these strengths are fully developed in the Bank. Others, such as policy and technical advice on regulating the private sector and improving public-private collaboration for HNP results, health system strengthening capacity, and intersectoral work for HNP results, need significant strengthening if the Bank is to scale up its efforts in this area and realize its full potential for supporting client countries and the international community effectively.

Core economic and evaluation analytical capacity is also a Bank comparative advantage. The Bank will substantially increase both its analytical work on health systems and its monitoring and evaluation capacity to ensure that the renewed commitment to HNP is actually rendering results on the ground. It is also essential that this increased capacity and commitment to M&E be effectively linked to and inform policy design and policy management in the health sector.

The Bank has comparative advantages for health system strengthening mainly in the areas of health financing, insurance, demand-side interventions, regulation, and systemic arrangements for fiduciary and financial management. The Bank will actively seek collaborative division of labor with global partners, based on respective comparative advantages. For example, leading agencies such as WHO, UNICEF, and UNFPA have clear comparative advantages in areas such as technical aspects of disease control (e.g., determine what is the best drug to treat malaria, or to overcome micronutrient deficiencies), human resource training in health, and internal organization of service providers (e.g., how to run medical services in clinics or hospitals).

The Challenge of Implementation

The Board and management are currently discussing the budget allocations for FY08 and beyond as part of the four-point engagement on the budget previously agreed. In this context, management and staff are undertaking a more detailed task-based budgeting exercise as part of the normal budget cycle. The resource requirements for implementing the HNP strategy will be a function of the pace of implementation of the strategy (pace of change), the demand from countries, and the availability of resources in an environment of zero growth in the overall Bank budget. It is expected that the cost of implementing the new HNP strategy will involve a modest increase in the base budget for the HD network over the FY07 base budget, after taking into account one-off transitional adjustments. An extraordinary allocation to the HD network above the regular base budget will be utilized to finance these transition expenses, as justified.

A Window of Opportunity for Scaling-Up Support to Country HNP Results

The expanded commitment of the international community in health has opened an unprecedented window of opportunity for the Bank to further contribute to HNP results at country level and globally. Consultations in client countries and with many global and country leaders in health, including leaders of donor agencies, foundations, Ministries of Health and Finance of client countries, leaders of civil society organizations, Executive Directors of the World Bank, and management and staff from HNP and other sectors in the Bank have confirmed their expectations that Bank rise to the new challenges—and expeditiously. This Strategy presents the Bank global short- and medium-term response to meet the new challenges.

Box 2
Key Next Steps for Implementation

The following key initial steps at country level to implement the Strategic Directions and Objectives defined in the Board paper. This box outlines key country level actions to be taken in the next 18 – 24 months.

- **Launch health system strengthening assessment** – Estimate the investment and policy reform gaps.
- **Assessment of fiscal space** – Estimate the space for closing the financing gap at country level.
- **Rapidly mainstream system strengthening into priority-disease operations**
- **Multisectoral assessment of constraints to achieving HNP results (e.g. MDGs)**
- **Policy advice on health system integration** – address the challenge of country systems fragmentation and, in close collaboration with IFC, improving policy environment for public-private collaboration.
- **Scaling up of output- and / or performance-based financing**
- **Strengthen client-country capacity in monitoring and evaluation (country based) to measure results**
- **Specific agreements with WHO and the Global Fund on collaborative division of labor at country level (next 12 months)**
- **Implementing the harmonization and alignment agenda at the country level**
- **Improve the quality of the Bank HNP portfolio**

B. Introduction and Overview

1. Health, Nutrition and Population (HNP) policies play a fundamental role in economic and human development and poverty alleviation. For more than a century and a half, health, nutrition, and population contributions to the improved health status of individuals and populations have also contributed to economic growth. In turn, improved economic growth has led to better health outcomes, creating a virtuous cycle: good health boosts economic growth, and economic growth enables further gains in health.
2. *Healthy Development: The World Bank Strategy for Health, Nutrition, and Population Results* for the next decade updates the 1997 World Bank Health, Nutrition, and Population Strategy to enhance Bank capacity so that it continues to contribute to this virtuous circle in light of the momentous changes of the past decade in the architecture of development assistance for health (DAH) and of persisting HNP challenges worldwide. This 2007 HNP Strategy outlines the Bank vision for improving its own capacity to respond globally and with a country focus to the urgent issues posed by these changes and challenges. It seeks to ensure that this capacity will be mainstreamed in Bank lending and nonlending country support and support to global partners in areas of Bank comparative advantages.

The importance of HNP in socioeconomic development.

3. Health is often thought to be an outcome of economic growth. Increasingly, however, good health and sound health system policy have also been recognized as a major, inseparable contributor to economic growth.¹⁹ Advances in public health and medical technology, knowledge of nutrition, population policies, disease control, and the discovery of antibiotics and vaccines are widely viewed as catalysts to major strides in economic development, from the Industrial Revolution in 19th century–Britain to the economic miracles of Japan and East Asia in the 20th century. Sound health policy, one that sets the correct incentive framework for financing and delivering services, also has important implications for overall country fiscal policy and competitiveness (Schieber, Fleisher, and Gottret 2006).
4. Many advances in health status during the 20th century are the result of close synergy among multiple sectors of the economy. For example, investing in basic nutrition during pregnancy and infancy has a substantial positive effect on early childhood development, which, in turn, significantly contributes to educational attainment (Bloom, Canning, Jamison 2004; Jamison 2006).

¹⁹Fenwick and Figenschou 1972; Wolgemuth, Latham, Hall, Chesher, and Crompton 1982; Fogel 1994; Thomas and Strauss 1997; Bloom, Glick and Sahn 1998; Canning, and Malaney 1999; Smith 1999; Croppenstedt and Muller 2000; Gallup and Sachs 2000; Behrman and Rosenzweig 2001; Thomas 2001; Shariff 2003; Bell, Devarajan, and Gersbach 2004; Bloom, Canning, and Jamison 2004; Thomas, Frankenberg, Friedman, Habicht, Jones, McKelvey et al. 2004; Smith 2005; Thirumurthy, Graff Zivin, and Goldstein 2005; Jamison 2006.

5. The complex HNP-development dynamic operates in both directions. Higher incomes allow capacity expansion, which, in turn, allows investment in better access to safe water, sanitation, cleaner indoor environments, education, housing, diet, and health care. It also changes household decisions on fertility, usually increasing birth space—all greatly improving health outcomes. This virtuous circle means that, particularly in low-income countries (LICs), ensuring economic growth is also crucial to achieve HNP results. How equitable improvements in health outcomes will be in a growing economy will depend on an effective pro-poor public policy in the health and other sectors (World Bank 2003b, World Bank 2004).
6. Longer-lasting economic gains from better HNP can improve the investment climate and attract foreign direct investment, once labor forces no longer bear a heavy disease burden. Foreign companies are deterred from investing in countries with rampant HIV and malaria because of concerns about their own workers' health, the possibility of high turnover and absenteeism, and the potential loss of workers with “institutional knowledge” of the firm (Haacker 2004).
7. In addition to the effect of returns from improving health to improve learning, countries with demographic transition witness a “baby boom” cohort that participates in the education, labor market, and pension systems. Because the cohorts before and after the baby boomers are much smaller during the transition, the labor force is large relative to overall population size. This means less dependency and greater potential for economic growth, which, in turn, enables governments to raise investments in health and education and also to increase their economic investments (Jamison 2006; World Bank 2006j).

Significant HNP gains but large, persisting challenges.

8. The last three decades have brought impressive achievements in HNP: steep reductions in infant mortality and malnutrition in almost every country, unprecedented innovation in health technology and discoveries in medicine, and a steady decline in mortality. An aware international community has become a vocal and active financier of progress in HNP, dedicating massive financial resources to bring it about.
9. However, almost 11 million children die every year, mainly from preventable causes such as diarrhea and malaria.²⁰ Malaria kills a child somewhere in the world every 30 seconds.²¹ More than 500,000 women die during pregnancy and childbirth every year.²² In 2006, almost 3 million people died from HIV/AIDS.²³ About 380,000 of these deaths occurred among children younger than 15.²⁴ Tuberculosis is curable, and yet 1.7 million people die from it every year.²⁵

²⁰ UNICEF 2006a; Mathers, Lopez, and Murray 2006.

²¹ UNICEF 2006c.

²² UNICEF 2006b.

²³ UNAIDS 2006.

²⁴ UNAIDS 2006.

²⁵ WHO 2006a.

10. Infant and maternal mortality have marginally improved, if not worsened, in many African countries. Millions more face premature death due to both undernutrition and chronic diseases related to the obesity pandemic. The HIV/AIDS and malaria epidemics are still uncontrolled in most LICs. Illness throws millions into poverty and destitution every year (Baeza and Packard 2006). Well-organized and sustainable health systems and sound health financing policies (national and international) have proven essential to meet these challenges and achieve HNP results on the ground. Both are also vital for sound fiscal policy and country competitiveness, crucial to eradicating poverty in a global economy.
11. By 2015, noncommunicable diseases (NCD) will be the leading cause of death in low-income countries (Lopez, Mathers, Ezzati et al. 2006). Many of those deaths occur prematurely, at an early middle age of adulthood. NCDs impose a significant economic burden, not just on patients, but also on their households, communities, employers, health care systems, and government budgets. An increasing burden of NCDs in developing countries will put an enormous strain on their weak health systems. Sound health policies are essential, for example, to protect households from the impoverishing effects of catastrophic costs associated with NCD-related medical care. Furthermore, health system strengthening is vital to address the growing burden of NCDs because their management and prevention requires long-term, sustained interaction with multiple levels of the health system (World Bank *forthcoming a*).
12. Effective interventions and increased financing exist for many of the health problems afflicting the world's poor and vulnerable (Wagstaff and Claeson 2004). However, in countries with weak health systems, reaching the people needing these interventions through health service delivery mechanisms and improved basic nutrition is challenging. Strengthening health systems—so that these services can be delivered effectively, sustainably, and when needed—is critical to ensure that investments in health continue to foster economic growth to overcome poverty in generations to come.

The Bank role in HNP improvements in the past decade.

13. As one of the pillars for eradicating poverty, the World Bank has supported countries' efforts to improve health, nutrition, and population policy and results for more than three decades. However, much has changed since the last Bank HNP Strategy was approved by the Board in 1997—and for the better. In the international community, awareness of the pivotal role of HNP policy in poverty eradication, and in economic development itself, has heightened. The central importance of HNP policy to development is reflected, for example, in the emphasis given to HNP in the United Nations Millennium Development Goals (MDGs). Three of the eight MDGs target HNP outcomes, and HNP policy greatly influences results for other MDGs such as poverty, environment, education, and partnerships.
14. The Bank has substantially contributed to this increased awareness of the international community. Since the 1997 HNP Strategy, it has decisively committed to focusing its work on winning health gains for the poor. The Bank has also played a crucial role in

advocacy, awareness, development of new initiatives, and financing of priority diseases and HNP interventions. From 1997 through 2006, the Bank lent US\$15 billion and disbursed US\$12 billion in HNP for more than 500 projects and programs in more than 100 client countries, making the Bank one of the world's largest international financing organizations of HNP activities in the last decade.

15. In this new Strategy for the coming decade, the Bank envisions that it will bolster client-country efforts to improve health conditions for the poor and to prevent households from becoming impoverished or made destitute as a result of illness. The Bank envisions that its support and advice will help client countries achieve HNP results in a way that also furthers good governance and their overall fiscal sustainability, economic growth, and global competitiveness. To achieve these four objectives, client countries need to articulate responses from multiple sectors that influence HNP results. The Bank, with its 19 sectors working globally in 139²⁶ countries, is uniquely positioned to support client-country efforts. This Strategy provides guidance to country teams on steps forward to ensure effective intersectoral work for HNP results.

Opportunities and challenges: The new international environment and DAH.

16. The heightened awareness of HNP globally has dramatically changed the international architecture for Development Assistance in Health.²⁷ In addition to the Bank, new multilateral organizations, initiatives, and foundations have assumed a prominent role in financing HNP, among them the Global Fund, GAVI, GAIN, and the Bill and Melinda Gates Foundation. Innovative financing mechanisms such as UNITAID, IFFIm and AMCs have also been developed to help to improve the predictability of donor funds. Much of this new funding is earmarked for combating priority diseases such as HIV/AIDS, malaria, tuberculosis, and some vaccine-preventable diseases; less for health system strengthening. Bilateral aid, such as the United States President's Emergency Plan for AIDS Relief (PEPFAR), has also increased substantially. Thus, financial commitments from all sources have doubled in five years, from US\$6 billion in 2000 to almost US\$14 billion in 2005 (Michaud 2007) (annex A, figure A1). Annex I presents an overview of trends in DAH in the last decade.
17. The new opportunities created by the changes in DAH also present three special challenges to: (a) ensure tangible results on the ground for the money invested; (b) align and harmonize global partners' activities with country needs to prevent duplication, economic distortions—and excessive administrative costs—ensuring country-owned and country-led DAH; and (c) ensure synergy between enhanced priority-disease financing and interventions to strengthen health systems.

²⁶ In terms of lending and /or policy advice.

²⁷ Development Assistance for Health consists of all resources aimed at providing financial support to developing countries to improve health conditions of their populations. It includes multilateral organizations such as the World Health Organization, the World Bank, and UNICEF. It also includes bilateral aid and private philanthropic aid.

18. **Ensuring tangible HNP results.** *HNP results* in this Strategy Paper encompass not only HNP outcome indicators such as MDGs, stunting, or fertility rates, but also prevention of poverty due to illness (*financial protection*) and health system performance indicators such as equity in utilization of health services and in health insurance²⁸ coverage. Other results included are: empowerment of the poor, good sector governance, sector financial sustainability and its contribution to sound fiscal policy and country competitiveness; key outputs such as the proportion of children immunized, proportion of children born under safe delivery conditions, and other outputs closely linked to achieving HNP MDGs; and availability of essential drugs and personnel in rural clinics. All these results are examples of Bank HNP objectives in client-country work. They are determined not only by the inputs of the HNP sector but also by the effects of many other sectors and their interactions.
19. To make sure people's health and daily lives are actually being improved with the money invested, results on the ground have to be closely monitored and evaluated. However, both client countries and the international community have lacked effective M&E systems for gauging the impact of increased financing on people, particularly the poor in low-income countries. This lack deprives development policy makers of basic knowledge about what works and what does not, essential knowledge for effective use of resources now and for any future scaling up.
20. The Bank has not escaped this knowledge-gap dilemma. Although there are good examples of individual projects, programs, and policy advice to client countries, and research, the impact of its 1997 HNP Strategy is hard to measure. The impact on the ground of the 1997 HNP Strategy has not been systematically monitored or assessed, nor are there sufficient monitoring data to do it today. Assessment difficulties have been problematic not only for the Bank but also for most of the international community. In the past two years, the Bank has multiplied its HNP evaluation efforts, but the benefits of this effort will be useful only for assessing the impact of the new Strategy. A thorough assessment is not available at this time. However, the Independent Evaluation Group will conduct in 2008 an evaluation of the Bank's client country assistance in HNP since 1997. This evaluation will inform the implementation of this new Strategy and adjustments will be made as appropriate.

²⁸ Throughout this Strategy Paper, *health insurance* is used in its functional connotation (pooling of financial risk) and not as contributory insurance scheme à la Bismarck. Thus, the use of the term "insurance" means any effective risk-pooling arrangement, including those financed out of general taxation (pooling at societal level), contributory payroll tax-financed social insurance, and private insurance (for-profit or not-for-profit). As discussed later, the Bank does not a priori promote, or discourage, governments and communities from choosing, any of these arrangements. Specific preferences should be country-context specific. However, the Bank approaches policy dialog with client countries with a focus on policy and technical advice that provides options and supports their decision-making process for selecting and developing the most promising arrangements to achieve and sustain the strategic policy objective of improving access to services, and financial protection, particularly for the poor and the vulnerable in the specific country context.

21. The Bank also faces important challenges in the implementation of its current lending and nonlending portfolio. The active HNP portfolio (active commitments) has declined since 2001 and the quality performance of the portfolio has been the lowest among all Bank sectors. In addition, AAA is not focused enough on Bank comparative advantages (section E).
22. The Bank, as a public international organization, is accountable for its expected contributions to country HNP results, especially for results of concessional lending under IDA. The focus on increasing the link of Bank financing to results as well as on effective measurement and impact assessment is therefore essential.
23. **Harmonization and alignment.** The multiplicity of actors offering generous financing has put an additional management and administrative burden on recipient countries. Essential to overcoming this burden are the use of effective country fiduciary systems (*alignment*)—financial management, procurement, logistics (which the Bank can help strengthen)—and the implementation of the Paris Declaration (OECD/DAC 2005) on harmonization of procedures, policy advice, strategies, and program implementation at country level among Bank and other global partners. The Bank is committed to contributing to alignment and harmonization in the HNP sector at country level and will selectively strengthen its engagement with global partners (section G).
24. **Synergy between single-disease priority and health system strengthening in LICs.** For most of the last decade, the changes in DAH have gone hand-in-hand with a focus on single-priority-disease programs (e.g., HIV/AIDS, malaria) or single interventions (e.g., vaccines), often in the form of vertical programs.²⁹ However, the new DAH focus on priority diseases has encountered tight bottlenecks in LIC health systems at country and subnational levels. There is now consensus that, for the renewed commitments of client countries and the international community to realize their full potential, synergy must be ensured between efforts to strengthen the health system and a focus on priority-disease results in LICs. Focus on key priority diseases is essential in LICs, given the importance of a few priority diseases in the overall disease burden (e.g., HIV/AIDS, malaria, tuberculosis, vaccine-preventable diseases, micronutrient deficiencies, and perinatal diseases), their limited financial and fiscal space, and health system constraints. For this focus to be successful, a well-functioning health system is fundamental.

²⁹ *Verticalization* is defined as replication of key health system functions and duplication of support systems, each handling the needs (in parallel) of exclusively single-disease programs such as HIV/AIDS, or others. Verticalization creates distortions that can sap the effectiveness of resources and makes a country miss an opportunity for spillover of priority-disease financing into systemic reform positively affecting many other diseases at marginal additional cost.

Box 3
Could Elizabeth Have Been Saved?
Why Health Systems Matter

Elizabeth was Mary's seventh child. She died at the age of three due to complications of **malaria** on February 17, 2003, at a clinic in San Pedro, one of the poorest municipalities, in a hypothetical but all-too representative country. Why did Elizabeth die? What does health system strengthening have to do with saving her life? Elizabeth's death had everything to do with a broken health system in desperate need of repair.

The single disease. Why Elizabeth died perhaps seems obvious. She caught malaria, developed a cerebral form of the disease, and a common, treatable infection killed her. But why Elizabeth? Had her family not received free bed-nets to prevent the infection? Was she not diagnosed and treated in time? What?

The broken system. Finding out why Elizabeth died took so much time that Dr. Joy Macumbo, the local public health authority, almost gave up trying. So many children die every day in her district, how could she spare time to investigate just one? Finding out anything was so hard. There were *almost no records* of Elizabeth's last few hours in the hospital or of her previous health history in the clinic. Dr. Macumbo was puzzled. According to her *district data*, for three years San Pedro, Elizabeth's town, had been receiving *free bed-nets and antimalarial drugs* from the Ministry of Health (MOH). However, the district hospital was still reporting many cases of complications from malaria from the San Pedro area. Dr. Macumbo went to San Pedro to investigate.

Dr. Macumbo discovered that the health center where Elizabeth should have received the bed-nets and been diagnosed and treated early-on, had had *no health worker for at least 18 months*. Bed-nets and drugs arrived from the MOH program, but often nobody was there to distribute the nets, or nobody trained to early diagnose and treat the children was there. Some community volunteers helped *visiting health workers* catch up with distribution and treatment, but there were *no guarantees (or records)* of whether drugs had been *stored properly* (so they stay active) or *administered correctly* to San Pedro's children. In some cases there were no records of what happened to the free bed-nets. Elizabeth had either not received (or used) a bed-net, had not been diagnosed and treated in time, and / or had not received treatment at all.

Why had the health center gone so long without trained workers? Dr. Macumbo asked San Pedro's mayor—*management of health centers had been decentralized from district to municipalities* five years earlier. Any *trained health workers* San Pedro managed to hire *did not stay long in the poor town*. The mayor said the job had been advertised for months, but the few qualified applicants did not want it. Working conditions in San Pedro were much harder than in South Port, the district capital, but the *pay was the same under civil service regulations*.

To make matters worse, health workers on the center's payroll often showed up late—because, the mayor discovered, they were *moonlighting during center working hours*. Some small, private providers paid them case by case, a *supplement to their monthly salary*.

The scant records from Elizabeth's stay at the district hospital and interviews with her mother Mary and hospital staff showed that Elizabeth, with very advanced malaria complications, *had arrived at the hospital on a weekend, long after the onset of the symptoms*. Why did she arrive so late?

Elizabeth's mother said *she could not afford* to take her children to the hospital on a weekday. Dr. Macumbo was surprised—public hospital services are free in San Pedro. However, Mary said she had to sell one of her two cows, spend all her savings, and borrow money to cover expenses related to Elizabeth's sickness. A trip to the hospital takes a full day because doctors show up late, so Mary would *lose a day of work*. *She had to pay for transportation, under-the-table fees for treatment as well as for additional supplies* (antimalarial drugs are free but the supplies are not). Years ago when her first child died, Mary endured a similar financial catastrophe. The *community mutual aid scheme* she joined after the death of her second child *had gone broke* after only three years.

Around the world every day, there are thousands of cases like Elizabeth's. Strengthening health systems is vital to prevent other deaths like Elizabeth's. It is about ensuring that the international community's commitment to supply a San Pedro with bed-nets and drugs will not be wasted by the *wrong chain of events*. *Strengthening health systems is about setting up the right sequence of events so that others survive*.

The right chain of events. The right sequence of events might have saved Elizabeth. Strengthening a health system means:

- Ensuring the *right logistics* so that bed-nets (and other drugs and supplies) will reach the poor families at risk and

that antimalarial drugs will not lose potency through poor storage.

- Helping the government change *salary incentives* so that workers show up for work at health centers to diagnose and treat children, and, at a marginal cost, do well- child consultations at the same time, educate parents, and distribute micronutrient supplements to expectant mothers (to help prevent low birth weights and malnutrition, which compound the effects of malaria), and deliver other services.
- Enhancing *public-private partnerships* (e.g., with community and / or faith-based organizations) in the delivery of services to complement each other and reduce supply gaps.
- Setting the right *payment mechanisms* for providers and linking workers' salaries to both attendance and performance and reducing incentives to spend health center and hospital time on income-generating activities outside their workplace.
- Instituting *governance arrangements* that empower patients and the community to address issues such as informal payments and provider responsiveness.
- Setting the *right insurance and / or public financing mechanisms* (including donor financing) so that the cost of illness will not prevent a mother from taking a sick child for treatment and will not throw her and her family into destitution, forced to sell the few assets they possess.
- Taking advantage of *decentralized decision making and management* while, simultaneously, putting in place *compensatory mechanisms for capacity and equity issues*.
- Having many *more doctors and dedicated health professionals* like Dr. Macumbo, so that countries and districts can *identify and follow systemic problems* without needing external assistance.
- Having *information systems* that address all the key diseases so that doctors and health personnel can treat patients instead of filling out multiple, duplicative reports for each disease to each donor, government agencies.

25. In principle, there is no contradiction between a focus on a single priority disease and a system strengthening approach. When well implemented, they are complementary and synergistic, and the only practical way of addressing the multiple causes of morbidity and mortality that might at first appear to be caused only by a single disease. Increased awareness and financing offer client countries and the international community excellent opportunities to improve overall health system performance at marginal cost while concentrating the new resources on controlling priority diseases. Expanded financing has allowed considerable scaling up of HIV/AIDS treatment and is facilitating the scale-up of malaria and tuberculosis treatments. If well directed, scaling up holds great potential for improving access to priority services for the poor well beyond these three diseases in LICs. Countries and the international community have yet to take full advantage of this potential. Ensuring synergy between priority-disease and system strengthening will require a significant effort and discipline from client countries and all development partners, including the World Bank. This will be particularly challenging in Africa, the focus of most priority-disease programs, global initiatives, and funds. The role of IDA financing in health system strengthening, with its capacity to flexibly address system constraints, will be crucial to ensure this synergy and integration.

A well-organized and sustainable health system is essential to achieve HNP results on the ground.

26. "Strengthening health systems" may sound abstract and less important than specific-disease control technology or increased international financing to many people concerned about achieving HNP results, but it is not. On the ground, in practical terms, it means putting together the right chain of events (financing, governance, insurance, logistics, provider payment and incentive mechanisms, information, well-trained personnel, basic

infrastructure, and supplies) to ensure equitable access to effective HNP interventions and a continuum of care to save children like Elizabeth (box 3). Success in strengthening the system cannot be claimed until the right chain of events on the ground prevents avoidable deaths and impoverishment due to illness because, without results, health system strengthening has no meaning. However, there will be no results without health system strengthening.

27. Achieving HNP results requires a well-organized and sustainable country health system. A major, urgent effort must be made to strengthen health systems, if financial commitments enabled by the new DAH architecture are to succeed in improving health conditions of the poor and achieve the HNP MDGs in middle- and low-income countries. Improving HNP sector governance is also essential. On this, the international community agrees after much debate in the early 2000s, centered on the false dichotomy between priority-disease and system strengthening focus. Policy makers in LICs and MICs face difficult challenges to make their health systems work and to protect people from poverty caused or deepened by illness. Middle-income client-country demand for policy and technical advice also makes it clear that health system strengthening is essential to ensure and sustain more comprehensive approaches to HNP results.

A shift in the driver of Bank-country relationship toward high-quality policy advice and strategic focus of Bank lending on structural HNP issues.

28. The new DAH architecture, the persisting challenges, and the increasing importance of health systems in addressing them create a scenario in which Bank financing, though still very important, is increasingly small compared with the growing volume of disease-specific financing and no longer is the sole driver of relationships with client countries. In this scenario, it is the quality of policy and technical dialog and the strategic focus of Bank lending (particularly IDA lending) that will define the true magnitude of the Bank contribution to country efforts in HNP.
29. Strategic focus of Bank advice and lending is essential. Bank financing is strategically crucial to ensure much-needed health system strengthening (for which financing is scarce in the new DAH architecture) and to set the enabling environment for increased disease-specific financing to be effective. This was stated again and again by client countries during preparation of this new Strategy. For example, Bank financing, as measured by new annual financial commitments for HIV/AIDS, for malaria, and for tuberculosis represented in FY05, respectively, about 5 percent,³⁰ 3 percent,³¹ and 7 percent³² of total annual international commitments (figure A2).³³ That the role of Bank financing is increasingly small, compared to overall international financing for health, is true mainly for middle-income countries and low-income countries for which DAH is a minor

³⁰ World Bank 2006d and Lewis 2005.

³¹ World Bank 2006d and WHO 2005.

³² World Bank 2006d and WHO 2006a.

³³ Commitments for each of the three diseases fluctuate considerably from year to year, and FY05 data should not be used to draw general conclusions about Bank financing for these diseases.

proportion of government or total health expenditures (Low-Assistance LICs, LA-LICs). Bank financing is still an important source of financing for LICs that count on DAH to cover a large part of government expenditures on health (High-Assistance LICs, HA-LICs).

How can the Bank best serve client countries in this new scenario?

30. Within this new development assistance scenario, how can the Bank best serve client countries in their efforts to achieve their priority HNP results? How can the Bank contribute to the effectiveness on the ground of global partner's increased financial commitments? What is the role of Bank financing in the context of globally expanded financing for HNP? This new Strategy for HNP Results states the vision of the Bank role in the new global architecture in HNP. It also attempts to give Bank regional and country teams guidance for addressing these questions with a sharp focus on country-led and country-owned Bank assistance for HNP results, working closely with global partners.
31. Results on the ground, especially outcome improvements for the poor and the vulnerable, rarely occur in the lifetime of a single project, nor are they achieved by focusing on any single sector. It is long-term Bank policy advice, technical assistance, and its lending program as a whole that can influence client-country policy actions, inputs, and structural changes in the health system; HNP policy; and relevant policies from other sectors (e.g., environment, water, transport, social protection, education, agriculture). Therefore, the effectiveness of the Bank country focus in HNP is determined by the quality of policy advice and the strategic focus of Bank lending, as developed in the overall Country Assistance Strategy (CAS), to identify long-term constraints to improving outcomes and country system performance and to define a set of multiple-sector, lending and nonlending interventions to support countries' efforts. Section G outlines a strategy for ensuring that this assessment becomes standard practice in the preparation of the CAS.
32. The Bank has special strengths (*comparative advantages*) for providing policy and technical advice to client countries in their efforts to achieve HNP results. The Bank will focus and enhance its capacity to generate knowledge and provide policy and technical advice in these areas.
33. **Bank comparative advantages in helping client countries achieve HNP results.** The Bank has significant comparative advantages to help client countries improve HNP results in this new environment (section E). These advantages include: the Bank health system strengthening capacity, including its potential capacity to disseminate country experience with alternative innovations and reforms; its multisectoral approach to country assistance, which allows it to engage at national and subnational levels with all government agencies (but particularly Ministries of Finance); its capacity for large-scale implementation of projects and programs (including its financial management and procurement systems for extensive operations); its multiple financing instruments and products; its global nature, allowing facilitation of interregional sharing of experience; its core economic and fiscal analysis capacity across all sectors; and its pervasive country focus and presence. The World Bank Group also has significant potential comparative

advantages in engaging private health actors through both the Bank (International Bank for Reconstruction and Development, IBRD) and the International Finance Corporation (IFC). Some of these strengths are fully developed at the Bank; some, such as policy and technical advice on regulating private sector and improving public-private collaboration for HNP results, health system strengthening capacity, and intersectoral work for HNP results, need significant reinforcement if the Bank is to give effective support to client countries and the rest of the international community.

34. **Country-led lending in HNP.** Country focus also means that the Bank will continue to lend, upon country demand, in all areas deemed necessary to improve health status and financial protection for people, especially the poor, in client countries. This includes support for controlling priority diseases because they constitute a large proportion of the burden of disease. However, the Bank will increasingly endeavor to ensure that its priority-disease support will strengthen health systems to solve systemic constraints that impair the effectiveness of country, Bank, and international community financing in achieving HNP results.

Strategic Objectives: What HNP results?

The ultimate objective of the World Bank work in HNP and of this new Strategy is to improve the health conditions of the people in client countries, particularly the poor and the vulnerable, in the context of the Bank overall strategy for poverty alleviation. To achieve this objective, this new Strategy states the vision and the actions necessary to strengthen the Bank capacity to better serve client countries by excelling in areas of Bank comparative advantages and by improving its collaboration with global partners.

35. To contribute to improving life and health conditions of the poor and the vulnerable, the Bank will focus on client-country efforts to achieve results in four areas or Bank Strategic Objectives for HNP (section F):
- (a) STRATEGIC OBJECTIVE 1. Improve the level and distribution of key HNP outcomes, outputs, and system performance at country and global levels in order to improve living conditions, particularly for the poor and the vulnerable.
 - (b) STRATEGIC OBJECTIVE 2. Prevent poverty due to illness (by improving financial protection).
 - (c) STRATEGIC OBJECTIVE 3. Improve financial sustainability in the HNP sector and its contribution to sound macroeconomic and fiscal policy and to country competitiveness.
 - (d) STRATEGIC OBJECTIVE 4. Improve governance, accountability, and transparency in the health sector.
36. These policy objectives represent continuity as well as change as compared with the 1997 HNP Strategy. Improving health outcomes of the poor and the vulnerable, protecting households from the impoverishing effects of illness, and achieving sustainable financing are still central HNP policy objectives. There are, however, three important changes in

the new Strategy. First, improving governance and accountability is included as a new policy objective. Second, although focus on strengthening health systems is essential, this strengthening is seen as a crucial means of helping countries achieve HNP results rather than as a policy objective in itself. Third, HNP policy (e.g., regarding financing of health insurance or large scale-up for HIV/AIDS) has heavy implications for country fiscal policy and competitiveness. Therefore, linking HNP sectoral policy to these country objectives is essential.

37. As presented in *World Development Report—2004* (World Bank 2003b), good governance and accountability mechanisms are key determinants of health system performance.
38. Although demand for advice shows that most countries value results in all four areas, their relative importance varies in different Bank Regions and in LICs and MICs. In LICs, improving outcomes, particularly for the MDGs, may have greater relative importance. In MICs, the priority is increasingly on financial protection and contributions to sound fiscal policy and country competitiveness, although improving health status remains important, particularly to reduce inequities in access to services and financial protection and to address the increasing burden of premature death due to noncommunicable diseases. Governance and transparency are proving critical in all country settings.
39. Although IDA and IBRD country priorities in health system strengthening present significant similarities (e.g., the challenge of universal health insurance coverage, fiscal sustainability, public-private interface), the specific options for addressing these priorities differ significantly between the two group of countries. The Bank work needs to be able to respond to both and ensure that it generates and disseminates lessons learned and experience among both groups of countries. Improving Bank capacity for health system strengthening will include both IDA and IBRD priorities.

Strategic Directions: How should the Bank support country efforts to achieve results?

40. Five new Strategic Directions (section G) are specified to improve Bank capacity to assist client countries in achieving the HNP Strategic Objectives in the coming decade:
 - (a) STRATEGIC DIRECTION 1. Renew Bank focus on HNP results.
 - (b) STRATEGIC DIRECTION 2. Increase the Bank contribution to client-country efforts to strengthen and realize well-organized and sustainable health systems for HNP results.
 - (c) STRATEGIC DIRECTION 3. Ensure synergy between health system strengthening and priority-disease interventions, particularly in LICs.
 - (d) STRATEGIC DIRECTION 4. Strengthen Bank capacity to advise client countries on an intersectoral approach to HNP results.
 - (e) STRATEGIC DIRECTION 5. Increase selectivity, improve strategic engagement, and reach agreement with global partners on collaborative division of labor for the benefit of client countries.

41. **STRATEGIC DIRECTION 1. Renew Bank focus on HNP results.** Focus on HNP outcomes, outputs, and system performance is the key Strategic Direction of the Bank in HNP, to which the rest contribute. The cornerstone of this effort will be Bank tightening of the link between HNP-related lending and nonlending to secure demonstrable HNP results on the ground. Steps in that direction will include: (a) increasing the proportion of output-based HNP lending and implementing up-front investment in monitoring and evaluation for all Bank HNP-related lending; (b) improve quality at entry of new lending portfolio and adjust existing portfolio as needed to improve operations linkage to HNP results; (c) help launch a major effort, in coordination with global partners and global initiatives, to help client countries improve their national public health surveillance and performance monitoring systems and monitor a core set of indicators at global level; (d) partner with client countries to experiment and learn from innovation provided by country-led reforms and programs supported by the Bank; and (e) set a common global HNP Results Framework for the Bank to guide regional HNP strategies, regional HNP business plans, and overall Bank / global partner monitoring and evaluation activities on HNP results (J).
42. **STRATEGIC DIRECTION 2. Increase Bank contribution to client-country efforts to strengthen and realize well-organized and sustainable health systems for HNP results.** Achieving HNP results requires a well-organized and sustainable country health system to ensure equitable access to effective HNP interventions and a continuum of care. Policy makers in LICs and MICs face difficult challenges to make their health systems work in delivering sustainable health services and protecting people from poverty due to illness. The Bank has important comparative advantages for helping client countries strengthen their health systems (Shakow 2006), but not for all aspects of it. Collaborative division of labor with global partners (paragraph 46) is needed to respond to the wide range of demand from client countries (Shakow 2006). The Bank will step up its engagement in health system strengthening, with an unswerving commitment to making it an instrument for achieving concrete results on the ground, appropriate to the specific needs of both MICs and LICs. (For analysis of health system characteristics and challenges, see section G and annex L).
43. **STRATEGIC DIRECTION 3. Ensure synergy between health system strengthening and priority-disease interventions, particularly in LICs.** The Bank will make every effort to increase synergy between priority-disease funding and health system strengthening in Bank operations in LICs, and, upon request, will advise client countries on how to achieve this synergy with country and DAH financing. Synergy in this context means addressing priority disease-specific needs simultaneously with the key system constraints to getting the needed results for the priority disease(s) in question, while avoiding or limiting negative spillovers and maximizing positive spillovers.

Bank financing through the International Development Association plays a crucial role in HNP-enhancing interventions to ensure synergy between focus on priority diseases and health system strengthening in LICs. It also helps forestall allocative inefficiency and other distortions that can result from the allocation of large amounts of financing to a few diseases (and neglect of others).

44. **STRATEGIC DIRECTION 4. Strengthen Bank capacity to advise client countries on an intersectoral approach to HNP results.** The HNP sector alone (at country level or internationally) cannot achieve the MDGs (and other priority outcomes) or improve health system performance. These HNP results are seldom determined by any single sector.
45. Intersectorality is one of the most important comparative advantages of the Bank. It is also one of the most difficult to realize fully due to traditional compartmentalization of sectors in client countries as well as to contradictory incentives within the Bank. The Bank will therefore strengthen its intersectoral work to help client countries and the international communities achieve the best possible HNP results (section G and annex J).
46. **STRATEGIC DIRECTION 5. Increase selectivity, improve strategic engagement, and reach agreement with global partners on collaborative division of labor for the benefit of client countries.** As one of the leading global multilateral organizations in development, the Bank collaborates with many other bilateral and multilateral organizations and global HNP partnerships. Engaging and collaborating with global partners contributes both to Bank capacity to serve client countries and to global partners' own capacity. The volume of the HNP partnership portfolio has increased dramatically over the past five years, mirroring the changes in the global health architecture. As a result, Bank engagement with global partners is fragmented and requires sharper strategic direction. With the implementation of the new Strategy, the Bank will assess its engagement with its partners to ensure effective and sustainable partnerships. For example, the Bank will seek a better balance in its partnerships and its regional work on LIC and MIC priorities, particularly on health systems and will substantially increase its strategic engagement with WHO, the Global Fund, and GAVI in LICs.
47. In addition to collaborative division of labor in health system strengthening (section G), the Bank will: promote country-level collaboration for alignment and harmonization; direct Bank contributions to promoting global public goods and preventing and mitigating global public "bads" in areas of Bank comparative advantages; and increasingly transition Bank advocacy engagement with partners toward health system strengthening with sharp focus on HNP results and toward synergy between priority-disease financing and system strengthening approaches. In management of Trust Funds (TFs) and the Development Grant Facility (DGF), the Bank will increasingly concentrate on Trust Funds and grants that are directly related to the implementation of its HNP Strategic Directions at country level.

Implementing the Bank HNP Strategy.

48. To make full use of its comparative advantages in the new environment in the interests of its client countries, the HNP sector in the Bank needs to make functional and organizational changes and rebalance the skill-mix of its staff and management. Sharpening the regional and Hub HNP units' focus on results, health system strengthening, and intersectoral work will be costly in the short term. Adjustments in

skill-mix take time and effort (staff and management training; shifting recruitment toward senior health specialists in systems, economics and intersectorality skills development of core diagnostic tools). It will also require functional changes in the mission of the HNP Hub so that it becomes more oriented to support Region and country team work. Concomitantly, it will also require revitalization of the role and work of the HNP Sector Board.

49. A summary Action Plan (section I) for implementing key features, leading to the new Strategic Directions and results, is part of this Strategy. It includes: proposals and targets to improve quality at entry of the HNP portfolio; actions to restructure current at-risk portfolio; a design, pilot, and implementation plan for a new tool, the Multisectoral Constraints Assessment for Health Outcomes (MCA); proposals for improving statistical capacity and monitoring core indicators at country and global levels; a Results Framework to guide regional development of country strategies, and proposals for training and retooling HNP staff and management. It also includes key organizational changes, particularly for the HNP Network (HNPfam) and the HNP Hub. Finally, in annex B, it presents summaries of regional and HNP Hub Action Plans for strategy implementation.

A window of opportunity for redoubled support for countries' HNP results.

50. The expanded commitment of the international community in health has created an unprecedented window of opportunity for the Bank to further contribute to HNP results globally. Consultations with many global and country leaders in health, including leaders of donor agencies, foundations, Ministries of Health and Finance of client countries, Executive Directors of the World Bank, and management and staff from HNP and other sectors in the Bank have confirmed their expectations of the need for the Bank to rise to the new challenges—and expeditiously. This strategy offers guidance for the Bank short- and medium-term response to meet the new challenges.

C. Opportunities and Challenges in the New International Environment in Health

A new international environment.

51. Among the many new developments since the 1997 Bank HNP Strategy, particularly important are the: (a) increased prominence of HNP in international development policy; (b) radical changes in the international architecture of development assistance for health and proliferation in the number and influence of global organizations and partnerships; (c) insufficient attention to ensuring results on the ground and installing the monitoring and evaluation systems essential to gauge them; (d) recent revaluation by the international community of the importance of well-organized and sustainable health systems for achieving HNP results; (e) significant increases in efforts to introduce structural changes in the health system, particularly in MICs; (f) proliferation and expansion of single-disease approaches, including vertical program implementation; (g) increasing awareness, without sufficient public policy action, regarding the substantial

role of private financing and private sector delivery of health services in client countries; (h) impressive technological development in pharmaceuticals, especially vaccines and antiretroviral drugs (ARVs); and (i) persisting challenges in public health, population, and nutrition.

- (a) *Global attention to health policy and its challenges has burgeoned worldwide* in the last 10 years. The global commitment to the MDGs is one prominent example.
- (b) With the increase in global attention to health policy, *a radical change in the architecture of DAH* has occurred (paragraph 52). The number and influence of new multilateral, bilateral and private initiatives has exploded in the last decade. *The relative importance of Bank financing (in terms of volume) in HNP has decreased since 1997.* Then, the Bank was virtually the predominant HNP financing organizations. Today it is one of a group of large financiers. Annual DAH commitments increased from about US\$6 billion in 2000 to almost US\$14 billion in 2005 (figure A1). However, despite this large increase in DAH, the total is still far from the estimated amount needed to achieve the MDGs (Wagstaff and Claeson 2004).
- (c) Despite the increase in global attention to health, *too little attention has been paid to ensuring results on the ground and establishing the monitoring and evaluation systems so essential for such a focus.* Despite advances in data collection, the HNP sector (globally and within the Bank) is not much better-off today than it was 10 years ago in its capacity to generate basic, reliable, timely information on outcomes, outputs, and inputs, particularly in LICs. This lack is a major obstacle not only for results monitoring but also for countries' own policy formulation and for strengthening causal pathways among inputs, outputs, outcomes, and policy actions.
- (d) At the same time, *client countries have been ahead of the international community in pursuing system strengthening.* Efforts to introduce structural changes in health systems have significantly increased, mainly in MICs but also in LICs. Concomitantly, demand has swelled for sophisticated policy and technical advice on health financing, health insurance, and other health system functions. Client countries want to find out *how* to do it rather than *what* to do.
- (e) In the early 2000s, single priority-disease approaches also coexisted with a *significant underestimation of the importance of well-organized and sustainable health systems for achieving HNP results, but the international community has come to realize its full importance.* This realization has brought a sense of urgency about ensuring smoothly functioning health systems, now seen as a prerequisite to obtaining solid HNP results on the ground.
- (f) *Single-disease approaches have proliferated and expanded* during the last decade, hand in hand with single priority-disease approaches and often with a vertical disease-control approach. This trend has created challenges of its own, particularly in low-income countries, and especially in Africa. Multiple donors with different strategic

and operational approaches are often an extra burden on policy makers in recipient countries who have to allocate great effort to respond to this uncoordinated donor work. In many cases, concern is growing about the equity, effectiveness, and efficiency consequences of vertical implementation of single priority-disease programs nationally.

- (g) *Despite increasing awareness of the large role of private financing and delivery of health services, public policy action has been insufficient in most client countries.* Private providers deliver most ambulatory health services in most LICs, and even the poorest people often seek private care (figures A3 and A4). Nevertheless, public policy is still not attuned to ensuring public-private complementarity and synergies and effective resource use in the health sector.
- (h) *Technological development in pharmaceuticals has been impressive, especially in vaccines and antiretroviral drugs.* This development has reduced costs and improved the effectiveness of a number of priority-disease treatments (e.g., for HIV/AIDS, malaria). It has also introduced new vaccines (e.g., rotavirus and pneumococcal) with potential for cutting mortality in children under-five years of age (U-5) in LICs. This good news for the international community brings with it two important challenges. The first is to develop financing mechanisms (such as the Advance Market Commitment [AMC] mechanism³⁴) to encourage research and development (R&D) and manufacturing for LICs of much-needed technologies for which country fiscal constraints preclude demand. The second is whether and how to mainstream the new vaccines as well as how to sustain them financially in client countries.
- (i) Finally, the last three decades have brought impressive achievements in HNP, *but formidable challenges persist:*
- *Actual and potential pandemics and regional epidemics have continuously emerged, and some have expanded during the last decade (e.g., HIV/AIDS, malaria, drug-resistant TB, SARS, avian flu). There has also been a significant increase in premature deaths related to traffic accidents and chronic diseases (diabetes, pulmonary diseases, hypertension, and cancer) caused by the tobacco addiction and the obesity pandemics.* The international community has managed such threats in the past, for example, eradicating smallpox and making deep inroads into the eradication of polio. Significant advances have been made on understanding the determinants of tobacco addiction and obesity. However, HIV/AIDS, malaria, TB, obesity, and new pandemics will continue to challenge client countries in the future. Client-country public health surveillance systems must be ready to detect and respond quickly to outbreaks of infectious diseases and promote behavioral changes for obesity and effective policies to reduce tobacco consumption (e.g., tax increases for cigarettes).

³⁴ AMCs are intended to create a market-based mechanism to support research and production of vaccines for diseases that affect developing countries. Donors would guarantee a set envelope of funding at a given price for a new vaccine that meets specified requirements.

- *The world population more than doubled* in the second half of the 20th century. Ninety five percent of all population growth will occur in developing countries. Since the middle of the last century, fertility and mortality trends almost everywhere have gradually converged toward low fertility and lengthened life expectancy. The exception is the Sub-Saharan Africa Region (East, West, and Middle subregions) and many countries in the Middle East and North Africa, where total fertility rates (TFRs) are very high. The persistence of population growth in the absence of economic growth pose significant challenges to developing countries capacity to ensure access to basic services.
- *Malnutrition, now problematic in both poor and rich countries, affects the poorest people most.* Underweight and micronutrient-deficient children and overweight adults live in the same households in both developing and developed countries. Malnutrition, and its negative compounding effect on disease susceptibility, slows economic growth and perpetuates poverty through direct losses in productivity from poor physical status, as well as indirect losses from poor cognitive function and deficits in schooling and direct losses owing to increased health care costs.

The new architecture for development assistance for health.

52. Over the last 10 years, there have been profound changes in the organizations that play key roles in global health, as large private foundations (e.g., the Bill and Melinda Gates Foundation) and large global funds³⁵ have entered the scene with large amounts of grant money. Other disease-specific initiatives³⁶ were also founded and have brought new financial resources for specific diseases. Annex I presents an in-depth overview of the new DAH.
53. This successful advocacy for HNP and increase in DAH is good news. It is here to stay, and most likely expand, and has opened many opportunities for improving health conditions of the poor in low-income countries. However, it has also created major new challenges for recipient countries. Multiple donors, each with its own strategic and fiduciary approach, have put a weighty managerial and administrative burden on recipient countries. The implementation of the Paris Declaration (OECD/DAC 2005), which is designed to harmonize all donor approaches including the Bank's, is essential to improve effectiveness at the country level.
54. Determining how, in the new international environment, to make the most of the opportunities opened by increased awareness and financial commitment and minimizing distortions from DAH are essential for Bank effectiveness in HNP in the next decade.

³⁵ For example, the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccines and Immunizations (GAVI).

³⁶ For example, the Global Alliance for Improved Nutrition (GAIN), the Joint United Nations Program on HIV/AIDS (1996), Roll Back Malaria (1998), and the Stop TB Initiative (1999).

D. Bank Contribution and Challenges in Implementing the 1997 HNP Strategy

55. The Bank has substantially contributed to HNP in client countries in the last decade. Since the 1997 HNP Strategy, it has decisively committed to focusing its work on winning health gains for the poor. The Bank has also played a crucial role in advocacy, awareness, and development of new international initiatives. It contributed substantial financing and policy advice for priority diseases and HNP interventions with more than 500 projects and programs in more than 100 countries. With total cumulative lending of US\$15 billion and about US\$12 billion in cumulative disbursement, the Bank has been one of the world's largest international financiers of HNP activities in the last decade. The Bank has also provided substantial policy and technical advice through more than 250 analytical and advisory activities (AAA).
56. However, the Bank faces important challenges. Despite the good number of excellent projects and programs to its credit in different Regions, the implementation impact of the 1997 Strategy on HNP results on the ground cannot be systematically evaluated, because focus on monitoring and evaluation during the last decade was weak, and impact data are not available. Additionally, the Bank has faced an increased reduction in volume and deterioration in the quality of implementation of its current lending and nonlending portfolio since 2002. The active portfolio has declined about 30 percent since 2001, and the quality of the HNP portfolio has been the lowest performing, below all Bank sectors average for project outcomes. In addition, the focus of AAA on health systems has also been insufficient, less than 35 percent of all AAAs. Although the HNP sector operations are inherently complex and high risk as compared with many other sectors, much improvement is needed in the quality at entry and strategic focus of operations to improve HNP portfolio performance.

Bank contribution to the new DAH architecture.

57. The Bank has played a significant role in shaping the new DAH architecture. Since 1997, it has participated in the creation and is on the Board of the main global partnerships, including: UNAIDS, Roll Back Malaria, Stop TB, GAVI, Global Fund to fight HIV/AIDS, Tuberculosis and Malaria, the Health Metrics Network, the Reproductive Health Supplies Coalition, UNITAID, and others listed in annex M.
58. In addition to its contribution to these major global initiatives, the Bank has scaled up its engagement with many global partners and partnerships in HNP, mostly through the HNP Hub. Engagement with global partners is part of the Bank mission to better serve client countries by enhancing global public goods and preventing global public "bads." The HNP Hub works in specific areas with 55 organizations or initiatives at the global level, including other multilaterals, bilaterals, private foundations, and global partnerships. This extensive engagement also poses internal challenges for the Bank (section G).

Taking stock of 1997 HNP Strategy.

59. Since issuing the 1997 HNP Strategy, the Bank has played a major role in HNP globally and has contributed to client-country efforts to improve health conditions of the poor. It has done so mainly through lending and nonlending country support and through contributions to most major global health initiatives. However, taking stock of the ultimate impact of the 1997 HNP Strategy is difficult for two main reasons. First, country-level outcomes and performance results are difficult to attribute directly to Bank financing, which is often relatively small. Second, monitoring and evaluation tools for most HNP-related lending and nonlending support are lacking. The Bank has played a central role in advocacy, awareness, and financing of priority diseases and interventions in HNP in the last decade. Although there are multiple examples of excellent projects, programs, policy advice to client countries, and research, the impact of the 1997 HNP Strategy has not been systematically assessed, nor do the available monitoring data allow it.
60. The difficulties in obtaining monitoring and evaluating (M&E) data for HNP projects are not new. In 1999, an evaluation of the effectiveness of HNP projects raised concerns about Bank M&E (World Bank 1999). Additionally, the review of all Implementation Completion Reports (ICRs) of HNP projects that closed in FY04–05 revealed that only 25 percent of all HNP sector–managed projects had a satisfactorily rated M&E (World Bank 2006e). According to the same review, less than half the projects included any outcome-output indicator in their Results Framework, and less than half of those that did measured these indicators at least twice. Another review of 118 ICRs in FY03–05 found that only a few Bank-assisted projects evaluated changes in health services (42 percent), health financing (17 percent), or health status (33 percent). The review also showed that any changes measured were always positive (Subramanian, Peters, and Willis 2006).

Lending trends since 1997.

61. The Bank is still one of the world's largest single financiers of HNP activities, as measured by cumulative commitments and cumulative disbursements. Total Bank active portfolio (projects and programs) amounted to about US\$7.0 billion in FY06, reflecting a steady decrease from US\$9.5 billion in FY01. Average annual disbursements hovered around US\$1.1 billion in FY97–FY06 (figure A5). These numbers include all active lending for health, nutrition, and population (HNP sector and other sectors) by both IDA and IBRD.
62. The Bank has contributed substantially to financing client-country HNP efforts during the implementation of the 1997 HNP Strategy through both lending and projects. World Bank cumulative HNP disbursements for FY97 through FY06 stand at about US\$12 billion. Since FY97, more than 500 projects with a health component have been approved.

63. Bank lending through IBRD, however, has contracted since FY01. While annual new IBRD lending grew from less than US\$0.5 billion in FY00 to more than US\$1.0 billion in FY04, in the last two years it dropped to around US\$0.4 billion in FY06 (figure A6)—in contrast to IBRD lending in other sectors. More important, annual commitments have followed the same trend since FY01. Bank lending through IDA grew from US\$0.5 billion in FY00 to US\$0.8 billion in FY06, in line with international commitments for HNP results in LICs. However, debt relief will shrink the IDA lending envelope for a number of IDA countries because each dollar of debt relief granted those countries will cut lending proportionately.
64. A continuation of the cumulative IBRD reduction will have important implications for the Bank business model. No systematic analysis is available on the determinants of the reduction in IBRD lending, but anecdotal evidence suggests that many MICs are changing their engagement. Instead of just borrowing, they are seeking high-level Bank policy advice and knowledge or making such advice a condition for borrowing.
65. This trend may reflect either better access to favorable borrowing conditions elsewhere or MIC capacity to finance interventions with their own resources. Although this is good news, it also means that the portfolio trends confirm clients' changed expectations of the role of the Bank, as stated in most country consultations. Thus, the quality of Bank policy and technical advice increasingly drives relationships with client countries.

Need to rapidly improve quality performance of HNP portfolio.

66. The overall strategic direction and quality-control mechanism of the HNP portfolio needs reassessment. The performance of the Bank HNP sector portfolio needs major improvement. Portfolio quality, represented by project outcomes as measured by the Bank (“satisfactory” or “unsatisfactory”), has shown the lowest performance among all Bank sectors in the last five years. From FY97 through October 2006, 423 projects including HNP objectives / activities closed.³⁷ Of those, 202 were HNP Sector Board–managed projects; 221 were other sector–managed. Of all FY01–FY06 closed projects managed by the HNP sector, 66 percent were rated “satisfactory” or better in ICRs (World Bank 2006c), making HNP the worst-performing portfolio among all 19 sectors for the last five years in a row (figure A7).
67. This trend seems to be continuing. According to preliminary Quality Assurance Group (QAG) findings (World Bank 2007b), only 66 percent of the assessed HNP-managed projects were rated “moderately satisfactory” or better, compared with 90 percent of Bank-wide projects. Key determinants of poor portfolio performance in HNP are: (a) quality and readiness of the Results Framework at entry; (b) adequacy and speed of follow-up actions for nonperforming projects; and (c) attention by management. On the other hand, HNP Sector Board–managed projects seem to perform better in areas of training, capacity building, and effective use of Bank resources.

³⁷ Another 74 projects are expected to close by June 30, 2007 (38 HNP Sector Board–managed and 36 other sector–managed).

68. Projects at risk have increased steadily in the last four years (figure A8), with a recent improvement at end-October 2006. In May 2006, 34 percent of the projects and 35 percent of all commitments were at risk in the HNP sector. Despite the improvements noted in October 2006, both the percentage of projects and commitments at risk (20 percent and 23 percent, respectively) remain well above the Bank-wide averages of 14 percent and 12 percent, respectively.
69. In October 2006, 18 percent of all Bank projects that displayed unsatisfactory implementation progress or were at risk of not achieving their outcomes belonged to the HNP sector. In addition, 60 percent of these projects had important M&E deficiencies, which will make the measurement of results and project impact difficult.
70. The realism index³⁸ is 80 percent; the proactivity index³⁹ is low at 60 percent. Low proactivity needs urgent attention, because it signals that not enough is being done to put nonperforming projects back on track.
71. Within the HNP portfolio, the HIV/AIDS portfolio faces significant challenges. Major steps have been taken to improve HIV/AIDS portfolio performance. As a result, the risk rate has decreased to 18 percent. Actions taken to improve the performance include (a) changes in implementation arrangements to improve performance; (b) establishment of a core quality team for HIV/AIDS projects in Africa; and (c) project support to improve monitoring and evaluation arrangements. Improvement in multisectoral work for HNP results, improved coordination of health system strengthening work within the Bank, and further inclusion of health system strengthening in future operations, including HIV/AIDS, will help improve HIV/AIDS portfolio performance.
72. Overall, the HNP sector needs to strengthen its quality control capacity (at entry and during implementation). To do so, the right balance will have to be achieved between the Regions' responsibility for portfolio management and quality control and the responsibility of the HNP Hub and Sector Board for monitoring and assisting Regions in fulfilling their quality control task. The forthcoming evaluation of the HNP portfolio by the Internal Evaluations Group (IEG) will also contribute substantially to informing the process of strengthening portfolio quality.⁴⁰

³⁸ *Realism* is a measure of the extent to which task teams reflect potential implementation problems in their project ratings.

³⁹ *Proactivity* is a measure of steps taken to put unsatisfactory projects back on track.

⁴⁰ The IEG review is expected during 2008.

Need for sharper focus of analytic and advisory activities.

73. The Bank has invested significantly in analytic and advisory activities since FY02 (paragraph 55). For FY02–FY07,⁴¹ 380 economic sector work (ESW) and technical assistance (TA) activities were planned, and 297 have been delivered. Of those 380, 274 are ESW products and 106 are TA products addressing health, nutrition, and / or population policy and technical issues.
74. From FY02 to FY05, HNP analytic and advisory activities increased substantially (from 46 to 82 activities), but decreased again, starting in FY06, to 57 activities. This result is surprising, because AAA services were expected to increase as IBRD lending declined.
75. The current AAA portfolio shows no particular focus; it includes many aspects of health systems and HNP, but less than 35 percent of the portfolio is concentrated on Bank comparative advantages.

Imbalance in HNP staff trends.

76. Since 1997, the number of HNP sector staff has decreased by 15 percent, from 243 to 206 (figure A9). This decrease has occurred despite increasing lending and nonlending output and a massive increase in Bank engagement in global partnerships. The proportion of technical specialist staff has risen from 44 percent to 50 percent from 1997 to 2006 (mainly health specialists). The proportion of staff with economics skills has decreased from 22 percent in 1997 to 16 percent in 2006 (figures A10 and A11).⁴² The average age of staff at recruitment has fallen from 48.6 in FY00 to 39.9 in FY06 (figure A12).
77. The HNP Hub has undergone a substantial change in staffing since FY00. Regular or open-ended staff members have decreased in number by 40 percent and have been replaced by Junior Professional Associates (JPAs), Extended Term Consultants (ETCs), and seconded staff, financed mostly by donor Trust Funds in areas of specific donor interest (figure A13).

⁴¹ This time frame is used because AAA coding is accurate for those years. Earlier data are not captured properly in the Bank's data warehouse.

⁴² Only staff at grade GF and above are included in the analysis.

E. How Can the Bank Better Serve Client Countries in the New Environment? Bank Comparative Advantages for HNP Results.

78. The new DAH architecture, persisting global challenges, and trends in Bank portfolio performance consolidate a scenario in which Bank financing, though still important, is increasingly small, as compared with overall international financing for health, and no longer drives relationships with client countries. Pressures on policy makers for sound allocation of these expanded resources have intensified. In this new scenario, the quality of policy dialog and technical advice defines the magnitude of the Bank contribution to country HNP efforts, not only for middle-income countries, but also for low-aid, low-income countries.⁴³ Although this is also true for high-aid, low-income countries,⁴⁴ Bank financing is still an important source of revenue for them. In what HNP policy and technical advice areas can the Bank contribute most in this new scenario? What is the role of Bank HNP-related financing? According to feedback from client countries and global partners, Bank comparative advantages lie in addressing “structural and health system constraints” (particularly health financing, regulation, insurance, and demand-side interventions) to improve outcomes and inputs, “linkages” of the health sector with macroeconomic, fiscal policy, and labor markets, and “public sector reform, governance, and fiduciary effectiveness.” The Bank is also seen to be in a unique position for identifying and helping address multiple sectoral constraints to ensure effectiveness on the ground of the additional international funds. The feedback also indicates that the Bank has much less (or no) comparative advantages on technical issues of disease control or micro issues of provider organization such as development of training curricula for health personnel, development of new drug technology, or advice on technology and clinical approaches to single-disease treatment, except in contributing to country and global partners’ efforts to create the appropriate incentive environment for providers.

Bank comparative advantages.

79. **Bank comparative advantages in the new scenario include:** its health system strengthening and intersectoral approach to country assistance, which allows it to engage in day-to-day dialog at national and subnational levels with all government agencies, but particularly with Ministries of Finance on fiscal and macroeconomic policy; its capacity for large-scale implementation of projects and programs (with its financial management and procurement systems); its multiple financing instruments and products; its global nature, which facilitates interregional sharing of experience; its core economic and fiscal analysis capacity across all sectors; and its substantial country focus and presence. The World Bank Group also has significant potential comparative advantages in engaging private health actors through both the Bank (IBRD) and IFC. Because of its strengths in multisectoral and macro approaches to HNP policy, the Bank is also uniquely positioned to help client countries integrate in their national strategic view the full array of national

⁴³ LICs for which official development assistance(ODA)/DAH represents a very small proportion of government/sector expenditures (e.g., India)

⁴⁴ LICs for which Overseas Development Assistance (ODA) and DAH represents a very large proportion of government/sector expenditures (e.g., Tanzania).

and international initiatives for improving HNP results on the ground. Bank experience with Poverty Reduction Strategy Papers (PRSPs) is a good example of this integration role.

80. Bank comparative advantages are distinctive assets for achieving HNP results, but the Bank is not tapping its full potential in some key areas: (a) public policy toward private-public synergies in achieving HNP results at country level; (b) intersectoral approaches to HNP results; and (c) health system strengthening to improve HNP results, particularly for the poor and the vulnerable. In this section, the importance of making full use of these strengths is analyzed. The Bank approach to realizing its full potential in these areas is discussed in section G.

Knowledge and policy advice on public policy to improve public-private synergies for HNP results.

81. Private service delivery and private funding via household out-of-pocket spending dominate health systems in LICs and in many MICs. Indeed, private ambulatory basic health service provision dominates health systems in LICs (figures A3 and A4), particularly in Asia. Thus, improving HNP results requires the Bank to provide sound policy advice to client countries on how to ensure effective regulation to enhance equity and efficiency as well as synergy and collaboration between the private and public sectors to improve access to services for the poor.
82. Bank advisory capacity on health system strengthening needs to be able to provide sound, feasible, and sustainable advice on when and how to invest in in-house public service delivery infrastructure or contract out with the private sector (for-profit and not-for-profit) in LICs and MICs.
83. The Bank Group has a potential comparative advantage for contributing to client-country development of sound public policy toward the private sector, but the current tendency of the Bank HNP sector to focus on the public sector and of IFC to focus on business development for the private sector has created a vacuum in the Bank Group in terms of supporting client-country development of public policy toward the private health sector. The HNP sector, in collaboration with Private Sector Development (PSD) and IFC, will fill this vacuum in the implementation of the new HNP Strategy. The collaboration will strengthen HNP policy analysis and advisory capacity as well as its engagement with key private actors and policy makers in the areas of public-private collaboration for HNP results. This enhanced capacity aims at generating policy knowledge and lessons learned to advise client countries on options. Ultimately, decisions on specific options are for client countries to make.

Providing advice and financing to strengthen health systems for HNP results.

84. **What is a health system?** People's understanding of what constitutes a "health system" varies widely, but most specialists agree that it encompasses all country activities, organizations, governance arrangements, and resources (public and private) dedicated

primarily to improving, maintaining, or restoring the health of individuals and populations and preventing households from falling into poverty (or becoming further impoverished) as a result of illness (WHO 2000; Kutzin 2000, Baeza and Packard 2006). Annex L presents a basic discussion of what a country health system is and why its smooth functioning is essential to ensure equitable access to effective HNP interventions and a continuum of care to save and improve people's lives—to ensure results.⁴⁵ Thus, health systems are not monolithic entities. Interaction among their multiple components results (or not) in sustainable and equitable delivery of public health and medical services to the population. Figure A14 depicts the key functions of a well-organized and sustainable health system. These key functions are: health services delivery, resource (input) generation (e.g., human resource training, and generation of technological knowledge for disease control, pharmaceuticals, and medical equipment), and system oversight (*stewardship*). Country and sector governance are also key determinants of system performance.

85. Governments and partners look to the Bank for systemic policy advice on such questions as how to ensure sustainable financing and fiscal space for priority health interventions; how to pay health service providers and set up the right incentives to maximize results on the ground and ensure a presence in isolated geographical areas; how to strengthen the sector's fiduciary and financial management systems; how to set the right incentives for multiple branches of government to ensure an intersectoral approach to improving HNP outcomes, outputs, and system performance; how to design and implement health insurance; how to create the appropriate regulatory environment for effective and efficient private-public collaboration and development; how to link increased resources to results without jeopardizing medium-term flexibility in governments' management of funds, both essential for allocative efficiency in public policy; and how to reach the right balance between expanding "own" public health service infrastructure and contracting out with private providers for the needed expansion of health service supply. Both MICs and LICs consider these policy issues critical.
86. The Bank has a considerable potential comparative advantage in health system development and strengthening, but not in every aspect. Many Bank strengths in health systems stem from its multisectoral nature, its core mandate on sustainable financing, and its fiscal, general economic, and insurance analytical capacity, on regulation, and on demand-side interventions. They also come from its years of experience advising governments and financing broad health sector reforms and infrastructure projects all over the world. Finally, they come from its experienced and motivated staff working in the Regions and the Hubs (Bank technical central units). Consultations with client countries confirm this view of Bank comparative advantages.
87. However, a large part of health system advice has to do with the micro issues of health service delivery and provider organization, for which the Bank has little comparative

⁴⁵ In-depth analysis of what a country health system is and how it works is outside the scope of this Strategy Paper. Annex L refers readers to substantial analysis by the Bank and global partners.

advantage. Such issues include the organization of internal hospital or clinic incentives to raise worker productivity and responsiveness; the specifics of medical education appropriate to each country; the development of core public health functions (such as epidemiological surveillance); and the development of specific-disease control knowledge (e.g., which vaccines or drugs to use against diseases in LICs and MICs).

88. Resolution of these important micro issues, particularly internal organization of providers, though essential for achieving HNP results, lags far behind developments in health financing policy. The international community needs to intensify its efforts to make progress in this aspect of health systems where the Bank has little comparative advantage.
89. The Bank looks forward to a collaborative division of labor with global partners along each organization's comparative advantages, particularly with the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) on leadership on disease control knowledge and technology, epidemiological surveillance, and program and provider organization; with the United Nations Population Fund (UNFPA) on population, and with the Food and Agriculture Organization (FAO) and the World Food Program (WFP) on nutrition. The Bank also looks forward to close collaboration in the implementation of country-led system strengthening efforts and knowledge generation with global financing partners including bilateral agencies, regional Banks, Global Fund, GAVI, GAIN, Bill and Melinda Gates Foundation, and others.
90. The following are some of the main health system functions, system activities, and other determinants of system performance. They are listed in descending order of strength of Bank comparative advantage:
 - (a) *Health financing.* Funding policy (level, source, fiscal space); risk-pooling organization (health insurance); insurance regulation; health service purchasing and provider payment mechanisms; design of financing incentive framework for efficient allocation of R&D and human resources.
 - (b) *Fiduciary, logistical, and financial management arrangements of the system.*
 - (c) *System governance.* Accountability arrangements for providers, insurers, and government in health care investments; regulatory framework for private-public collaboration in the health sector; decisions on delegation of decision rights and market exposure for public providers; fiduciary arrangements for fiscal resource management in the public and private sectors; linkage of specific HNP sector reforms to cross-sectoral public sector reforms (e.g., civil service reforms to attract practitioners into rural areas).
 - (d) *Positively influencing household demand for effective HNP interventions.* Demand-side interventions (such as conditional cash transfers, girls' education, community-driven development, and voice and choice reforms in health service delivery).
 - (e) *Stewardship (sector oversight).* Overall sector leadership; sectoral strategic planning; provider regulation; inputs and health service quality control; epidemiological surveillance; identification of health priorities for setting mandatory basic benefits packages.

- (f) *Organization and management of providers.* How to run a clinic, hospital, or provider network; organizing village volunteers; organizing NGO or private for-profit health service delivery.
 - (g) *Technical aspects of disease control.*
 - (h) *Human resource training and creation of medical technologies and advances.* Human resources; R&D and manufacturing of drugs and supplies (beyond contributing to global financing and incentives for development and production of orphan drugs); R&D and generation of medical technology.
 - (i) *Clinical and field research on disease control intervention effectiveness and clinical protocols.* Defining effective production functions; testing them in the field.
91. Drawing on its main comparative advantages in health systems, the Bank will increasingly focus its knowledge creation on health system strengthening mainly in areas (a) through (e), above, and will actively seek advice from, and collaborative division of labor with, global partners in the other areas, particularly WHO, to include their knowledge in Bank priority-disease lending and to coordinate with WHO leadership in global epidemiological surveillance and country preparedness.

Intersectoral approach for better HNP results.

92. Good HNP outcomes and system performance are determined by multiple sectors of the economy. They are strongly influenced by income, education, access to clean water and sanitation, access to clean indoor environments, expedited transportation to facilities and providers, good country governance, and sound macroeconomic policy (figure A15). Together with basic public health interventions those factors are most likely to play a larger role than health service delivery in low-income / high-mortality country settings. Therefore, improving HNP outcomes means ensuring an effective intersectoral response to HNP performance and outcomes, both within the Bank and within client countries.
93. Intersectorality is potentially one of the Bank's most important strengths for contributing to HNP results at country level, both in other sectoral policies that influence HNP results (e.g., environmental policy effect on indoor pollution, water and sanitation) and in its role in health system strengthening.⁴⁶ Intersectorality is also the most difficult objective to realize fully, due to both Bank and client-country constraints. Strengthening health systems for HNP results, the key contribution of the Bank in the next decade, is a multisectoral endeavor. For example, improving the incentive framework for workers will require a combination of public sector reforms, health financing mechanisms, creation of fiscal space, improved fiduciary systems, and improved sectoral and country governance. For technical, governance, and economic expertise in these areas, the Bank counts on a large group of experienced professional staff (table A1).

⁴⁶ Achieving results requires a combined effort from HNP, the Bank Poverty Reduction and Economic Management Network (PREM), Social Protection, Financial Services, Private Sector Development, Information Technology, and so on.

F. New Bank Strategic Objectives: What HNP Results?

94. To achieve the Bank vision for its HNP role over the next 10 years in the new external environment, making the most of its comparative advantages, the Bank has revised its global HNP policy objectives.
95. The Bank will focus on contributing to client-country efforts to achieve results in four areas, the Strategic Objectives:
1. Improve the level and distribution of key HNP outcomes, outputs, and system performance, at country and global levels to improve living conditions, particularly for the poor and the vulnerable.
 2. Prevent poverty due to illness (by improving financial protection).
 3. Improve financial sustainability in the HNP sector and its contribution to sound macroeconomic and fiscal policy and to country competitiveness.
 4. Improve governance, accountability, and transparency in the health sector.
96. The revised Bank HNP policy objectives are both a continuation of and a departure from the 1997 HNP Strategy objectives (World Bank 1997). Three of the four Strategic Directions of the 1997 Strategy are still valid: to improve HNP outcomes for the poor, to protect households from the impoverishing effects of illness; and to work with countries to ensure sustainable financing. As a result of lessons learned in the last 10 years, however, the new policy objectives differ in two respects. First, they include improving sector governance as a key Strategic Objective. Second, they do not include health system strengthening as an objective but rather as a means for Bank country assistance to achieve all of them.
97. Strengthening health systems is a tool for achieving the HNP strategic policy objectives. The 1997 Strategy reflected knowledge of the HNP sector that was current at that time. Since then, the Bank and the international community have learned that strengthening health systems is meaningless without demonstrable improvements in outcome results, outputs, and system performance.⁴⁷ The Bank will ramp up its engagement in health system strengthening, but with an unswerving commitment to results on the ground.

STRATEGIC OBJECTIVE 1. Improve the level and distribution of key HNP outcomes, outputs, and system performance at country and global levels to improve living conditions, particularly for the poor and the vulnerable.

98. Despite important gains in reducing avoidable mortality and the prevalence and incidence of disease in the last 10 years, the world still faces enormous challenges. Achieving the MDGs by 2015 is at risk due to a combination of insufficient financing and inefficient health systems. Health indicators are worsening in fragile states. The poor—households and countries—suffer most from avoidable mortality, morbidity, and malnutrition. Sub-Saharan Africa is the epicenter of the challenges ahead, falling well short of most of the

⁴⁷ *System performance* is defined as systemic efficiency in sustaining or improving current HNP outcome and output achievements.

MDGs. In MICs, the challenge is low efficiency, poor performance, and financial difficulties.

99. Health, nutrition, and population improvements in all Regions were a striking achievement for human welfare in the 20th century (figure A16), but as discussed in section B, formidable challenges still persist.
100. Evidence-based, cost-effective interventions could drastically improve health outcomes. For example, controlling tobacco use (e.g., through taxation) has proven effective in most client countries and is the single most important intervention for reducing premature mortality due to noncommunicable diseases (UN Millennium Development Project 2005). It is also one of the few interventions that directly increase fiscal revenue in the short term. Similarly, at a cost of only US\$0.02 per dose, administering a vitamin “A” supplement every day to poor children would substantially reduce U-5 mortality in low-income / high-mortality countries.
101. The Bank is committed to supporting efforts to reduce avoidable mortality and morbidity and improve the distribution of good health within individual countries and internationally. It will do so along the lines of its comparative advantages and Strategic Directions. The international community knows the most cost-effective interventions for saving millions of lives, for example, access to safe water and sanitation. But everyone is still struggling to find the best ways of reaching the poor with these proven interventions in low-income countries, especially in Sub-Saharan Africa. A well-functioning health system is essential if these interventions are to reach the poor. Success will owe much to increased financial commitments by the international community, but money alone cannot guarantee a well-functioning health system. Bank experience in this realm, one of its comparative advantages, can contribute to solving this problem.
102. Specific areas for reduction of mortality and morbidity are summarized in the Bank HNP Results Framework (annex J). The Framework serves as guidance for the Regions and country teams setting priority targets in the context of results-based CASs, when appropriate, and for all HNP programs and projects in their respective countries. The Bank is committed to supporting client countries efforts to achieve the MDGs.

STRATEGIC OBJECTIVE 2. Prevent poverty due to illness (by improving financial protection).

103. Health shocks—illness, accidents, even normal life-cycle events such as pregnancy and old age—can throw a household into poverty or become an obstacle to overcoming it. Illness is a determinant of poverty due to both excess health expenditures and loss of income resulting from nonparticipation in the labor market (or reduced productivity). Protection against the impoverishing effects of health shocks is an important challenge in both LICs and MICs. Figure A17 presents findings in Peru, where households report health shocks as a main cause of economic distress, second only to unemployment of the breadwinner. Figure A18, recent findings in four Latin American countries (Argentina, Chile, Ecuador, and Honduras) (Baeza and Packard 2006), shows that health shocks plunge between 1 percent and 10 percent of the population into poverty every year.

Similar findings have been reported for China, Vietnam, and Thailand (Eggleston et al. 2006).

104. Household out-of-pocket private funding dominates health financing in LICs and in many MICs. Indeed, except in a few client countries, out-of-pocket expenditures account for most health expenditures in LICs, even in countries receiving large amounts of DAH (tables A2, A3, and A4). Thus, improving financial protection requires the Bank to provide sound policy advice to client countries not only about the best use of DAH but also how to pool household out-of-pocket expenditures for the non-poor so that household demand and insurers (public and / or private) offer better pooling of financial risk. In the same context, user fees have a role to play as copayment when there is evidence of excess demand. Protecting the poor from further impoverishment from out-of-pocket financing will require increased fiscal capacity, fiscal space, and, in LICs, financial support from the international community.
105. Upon client-country demand, the Bank stands ready to support countries that want to remove user fees from public facilities *if*: (a) the lost revenue from user fees can be replaced with resources that reach the facilities in a timely and fiscally sustainable manner over the long-term; (b) effective public financial management systems ensure that such financial transfer replacements will effectively reach the health facilities that need them the most and in the context of the appropriate incentive framework for the provision of services to the poor; and (c) that resource replacements will be used to pay for the delivery of effective quality services for the poor, provided at the health facilities.
106. A well-organized and sustainable health system is essential to achieve financial protection by preventing the impoverishing effects of health shocks (e.g., through health insurance) and mitigating their effects. An efficient public financing and pro-poor subsidy policy in the health sector, access to effective financial risk-pooling mechanisms (e.g., health insurance), and household access to borrowing through better financial market environments are among the interventions that can help improve financial protection. Client countries face options in organizing risk pooling, including general tax-based systems, social insurance systems (financed out of payroll-tax contributions), and / or private health insurance arrangements, including not-for-profit community health insurance.
107. Fragmentation⁴⁸ of health systems hampers systemic capacity to provide effective access to services and financial protection (WHO 2000, Gottret and Schieber 2006, Baeza and Packard 2006). Unfortunately, health system fragmentation is extensive in most client countries. The Bank will strengthen its capacity to support country efforts to improve health systems integration and reduce fragmentation. Countries have options to improve integration, including setting a common regulatory framework for public-private collaboration; to give incentives for aggregating existing pools to efficient pool sizes and

⁴⁸ *Fragmentation* is defined as multiple small (inefficient risk-pool size) insurance providers that seldom complement each other and often present significant barriers for the portability of benefits when individuals need or desire to change from one to another insurer.

improve the interactions among them; transition toward single risk pools (or very few of them), and / or transition to universal general tax–financed risk-pooling arrangements. The Bank will provide technical and policy advice for countries to identify options; support fiscal, technical, and financial feasibility assessments; and advice on pros and cons of these different options for the specific country context and preferences. Ultimately, the choice of a path to transition toward health system integration is the country’s decision.

108. Widespread (and growing) labor informality (and its substantial overlap with poverty) as well as rural population dispersal (overlapping with both informality and poverty) pose a significant challenge to improving risk pooling. Extending risk pooling to the informal and the rural population will be a key priority of both the research agenda and the operational strategic focus of HNP in health systems in the implementation of this Strategy.
109. So far, judging by the evidence, there is no “silver-bullet” for organizing risk pooling, reducing excess out-of-pocket expenditures on health care, and extending risk pooling to the informal and rural poor. Therefore, the Bank is committed to advising client countries to increase risk pooling, but it does not promote any one-size-fits-all blueprint for organizing risk pooling across countries. Decisions on risk-pooling arrangements are country-specific, often based on historical events and cultural preferences. However, risk-pooling decisions need to be guided by solid evidence, which is unfortunately lacking so far, particularly for LICs. The Bank has a significant opportunity to learn from close monitoring and evaluation of Bank-supported initiatives and programs. It also needs to assist countries in monitoring results of their initiatives to verify whether chosen arrangements actually improve financial protection for everyone, but particularly for the poor and near-poor.
110. The Bank will expand its knowledge creation and policy advice on improving financial protection. It will do so intersectorally, addressing the growing challenge of extending health insurance to the informal sector.
111. The Results Framework presented in annex J summarizes the main outcomes on financial protection. Measuring, monitoring, and evaluating financial protection outcomes is a relatively recent field. A major challenge for Bank HNP work in this field is to facilitate collaboration for research with partners and experts in this field to develop, test, and scale up monitoring of financial protection indicators. Developing such indicators and facilitating consensus on them among the international community will be a major early activity of strategy implementation in this field.

STRATEGIC OBJECTIVE 3. Improve financial sustainability in the HNP sector and its contribution to sound macroeconomic and fiscal policy and country competitiveness.

112. For governments to ensure their people’s access to essential services and financial protection, countries need to raise stable, sufficient, long-term public and private financial resources, predictably, equitably, efficiently, and in a way that minimizes

economic distortions. Health sector financing policy should also contribute to sound fiscal management, create necessary fiscal space, and foster productivity, employment, and growth. On the spending side, individuals need access to affordable basic services and financial protection; spending should maximize health outcomes and ensure equitable access and technically efficient production; cross-sectoral linkages should be explicitly addressed through planning and budget processes; and spending should be cushioned as much as possible against economic shocks in ways consistent with sound economic management.

113. Financial sustainability has different implications for LICs and MICs. For LICs, it means: (a) developing sound policy to leverage private household financing to expand participation in risk pooling (public and / or private)⁴⁹; (b) solving the DAH volatility problem, a major challenge in LICs (figures A19 and A20); and (c) ensuring sufficient economic growth to sustain and increase pro-poor fiscal policy. MICs face two main challenges: fiscal sustainability linked to systemic efficiency and potential challenges from past decisions linking social health insurance financing to labor status. The insurance-labor link can distort labor markets and labor costs through the use of payroll taxes as the main revenue-raising mechanism for social health insurance.
114. The World Bank is in a unique position to promote these objectives through its macroeconomic management, cross-sectoral purviews, and roles as a development institution, financial institution, and multisectoral knowledge-dissemination agency. The Bank's underlying charter as a development agency and bank uniquely qualify it to advise client countries on this complex menu of sectoral, fiscal space, macroeconomic policy, growth, and sustainable financing issues.
115. The Bank (HNP in working with PREM, Development Economics [DEC], and others) in collaboration with the IMF and other global partners will seek to develop, test, and support country monitoring of indicators for health sector / program fiscal sustainability, fiscal space, effects of health financing on labor markets, and other sustainability and potentially health sector-related country competitiveness determinants.

STRATEGIC OBJECTIVE 4. Improve governance, accountability, and transparency in the health sector.

116. Evidence shows that development assistance works—but mostly in countries with good governance and little corruption. Kaufman and Kraay (2003) define *good governance* as “the traditions and institutions by which authority in a country is exercised.” For the health sector, this definition means the set of relationships that hold health service providers, insurers, and governments accountable to their clients and citizens for HNP results—health outcomes, income protection, and social inclusion (World Bank 2003b, figure A21). Bardham (1997) defines *corruption* as the “use of public office for private gains.”

⁴⁹ Household private out-of-pocket health expenditures are by far the largest source of health financing for most LICs, even for those receiving large DAH.

117. Poor governance in health care delivery does not necessarily mean corruption (box 4). “Poor governance” can describe anything from haphazard management to outright dishonesty. These indicators, to cite just a few, encompass: mismanagement; staff absenteeism and low productivity; leakage of funds, drugs, and supplies; lax procurement and oversight practices; informal payments from patients; mistreatment of the poor by service providers; and patently corrupt practices ranging from petty theft to kickbacks to selling public office. Some of these events result from failure of clients’ power—patients too poor or socially deprived to claim their entitlement to services from providers, frontline professionals, and staff. Voice failures also occur, when the state simply does not care about providing services—or provides the bare minimum. There are also compact failures, in which the state fails to set incentives for public and private providers, to delineate their responsibilities, or to enforce accountability. An increasing concern in partner countries is the high transaction and administration costs of DAH governance on the ground in a very fragmented environment.

Box 4
What Are Governance and Corruption in the Health Sector?

Health care provision depends on efficiency and honesty in combining financial resources, human resources, and supplies and on delivery of services, in a timely fashion, distributed equitably and spatially throughout a country. This requires a “system” that mobilizes and distributes resources, processes and acts upon information, and motivates appropriate behavior by individual providers, health care workers, and administrators. Good governance is a critical factor in making such a system work.

Governance and accountability can be improved through actions including:

Management and performance. Incentives for sound behavior by health professionals, including performance-based pay; drug distribution to ensure that demand and supply align; databases for tracking staff, supplies, and drugs; and local oversight of medical staff.

Anticorruption measures. National anticorruption initiatives; clear rules for and audits by enforcement agencies; community oversight; and drug procurement reform.

Affordability improvements. Charging formal fees with exemptions; reorganizing staffing and performance with reward systems; and seeking alternative financing options.

Accountability tightening. Embedding accountability at every level of the system, combined with clear and transparent expectations; contracting out services and overseeing performance; calibrating performance through consumer satisfaction surveys and citizen report cards.

Accountability is the single most important element to ensure good governance—accountability to ministries, local governments, managers, and citizens. It leads to better performance on other measures but is a difficult goal to meet in any setting.

Increasing choice and alternatives for publicly subsidized health services increases empowerment of the poor vis a vis health service providers.

Source: Lewis 2006.

118. Good governance and accountability, the enforcers of honesty, are key determinants of health system performance. Building accountability for health is not easy, due to the great asymmetry of information between users and providers and the difficulty of attributing

most final outcomes to a particular service provider. It is hard, for example, for patients to know whether the medical treatment they received was effective and appropriate for their condition. To monitor health care outcomes, countries in the Organisation for Economic Co-operation and Development (OECD) have developed a rich combination of direct control over users, governmental regulatory instruments, and professional self-regulation. Yet, most LICs and many MICs are still developing their own instruments and institutional arrangements. Self-regulation is particularly underdeveloped in MICs and LICs, and many bureaucratic failures are still insufficiently addressed. The Bank will work intersectorally to strengthen governance and accountability relationships within countries, support accountability-fostering instruments and institutions, and promote strong fiduciary systems.

G. New Bank Strategic Directions: How Should the Bank Support Client-Country Efforts?

119. The new Strategic Directions will guide Bank efforts to help client countries achieve the strategic HNP results over the next 10 years. To implement these new directions, this Strategy presents an Action Plan (section I) outlining key organizational changes and incentives, new analytical tools, and a rebalancing of the skill-mix of Bank management and staff. The new Strategic Directions for Bank HNP results are:

1. Renew Bank focus on HNP results.
2. Increase the Bank contribution to client-country efforts to strengthen health systems for HNP results.
3. Ensure synergy between health system strengthening and priority-disease interventions, particularly in LICs.
4. Strengthen Bank capacity to advise client countries on an intersectoral approach to HNP results.
5. Increase selectivity, improve strategic engagement, and reach agreement with global partners on collaborative division of labor for the benefit of client countries.

STRATEGIC DIRECTION 1. Renew Bank focus on HNP results.

120. Renewing Bank focus on HNP results is the primary Strategic Direction for the Bank. All the others depart from it. As the cornerstone, the Bank will tighten the direct link between HNP-related lending and nonlending support and outcomes, outputs, and system performance. The Bank is amassing promising experience with output-based investment lending for HNP.
121. A results focus poses some short-term challenges for the Bank, despite internal consensus on the need and willingness to move toward accountability for outcomes. First, monitoring and evaluation systems have to be improved. Until recently, neither the Bank nor many client countries or global partners have systematically measured outcomes with sufficient precision, frequency, and disaggregation to be useful for M&E. Second,

achieving results (final and intermediary outcomes) on the ground depends on many actors (different levels of government, service providers, citizens, donors) and on a variety of exogenous factors. Assessing the contributions of each actor and attributing results to their individual actions is often elusive, if not impossible. Furthermore, the Bank can affect outcomes only indirectly—using its lending and nonlending services to influence domestic actors, particularly governments.

122. The Bank will substantially increase both its analytical work on health systems and its monitoring and evaluation capacity to ensure that the renewed commitment to HNP is actually rendering results on the ground. It is essential that this increased capacity and commitment to M&E also be effectively linked to and inform policy design and policy management in the health sector.
123. **Support the shift toward linking finance to HNP results.** The Bank will: (a) partner with client countries to identify opportunities to experiment and learn from innovation in results-based lending; (b) support the launch, in coordination with existing global initiatives, of a major effort to help client countries improve their national public health surveillance and performance-monitoring systems; (c) set a common global HNP Results Framework for the Bank (annex J) to guide regional HNP strategies, regional HNP implementation plans, and overall Bank monitoring and evaluation of HNP results; and (d) commit to monitoring a core group of indicators presented in the framework.
124. **Link lending to HNP results.** Financing inputs does not guarantee improvements in HNP conditions for the poor. Achieving the MDGs in lower-income countries requires sustaining and further scaling up of DAH. To achieve both—bringing lending close to results and scaling up in LICs—the Bank needs to increase output-based or performance-based investment lending and development-policy lending for policy action, mixed according to country needs and context. Some movement in this direction is occurring in HNP and vaccine “buy-downs” (box 5) and in direct payment of outcomes and outputs in maternal and child health (box 6), but it is not enough. Linking financing to results carries some risks, due mostly to bias in surveillance and monitoring reporting, introduced by perverse incentives, as well as risks due to systemic and governance fragility in many client countries. This is one reason the Bank teams up with client countries and global partners—to experiment and learn from innovation in results-based lending.
125. **Launch a major effort to improve national public health surveillance and health system performance monitoring.** The Bank will work in close collaboration with global partners to persuade client countries, and support their efforts and those of global partners, to launch a build-up of public health surveillance and health system performance-monitoring systems at country level. Launching this build-up will be one of the contributions of the Bank to HNP results in the first three years of the new HNP Strategy. A focus on results is not possible without reliable data. This contribution will be the foundation for a renewed culture, centered on the impact of HNP results within the Bank and in Bank relations with client countries. Close coordination with other

institutions such as Health Metrics Network partnership and other global initiatives will be important.

Box 5

**Promising New Mechanism Linked to Results:
Loan Buy-Downs for Polio Eradication Results in Pakistan**

The Concept. Results-based investment credits and loans are linked to the achievement of specified outputs, particularly where significant externalities or public good characteristics result in underinvestment. As an incentive, grant money from foundations and bilaterals “buy down” the loan or credit if the agreed results are achieved. There are three parts to buy-downs: (a) setting an appropriate target goal; (b) tying performance (targets) to the financial buy-down; (c) monitoring actions and evaluating outputs.

The Pilot. The buy-down mechanism was piloted in several polio eradication projects in Pakistan and Nigeria approved by the Board between 2003 and 2005. Polio eradication was selected for the pilot because of its obvious global public good characteristics. Financial support was provided by the Bill and Melinda Gates Foundation, United Nations Foundation, Rotary International, and U.S. Centers for Disease Control (CDC). The Bank is now moving forward with a modest expansion of the pilot to meet a broader range of client needs and to capitalize on country and donor interest.

How does it work? The government and the Bank identify the outputs and targets that would trigger the buy-down of the IDA credit into a grant. In the polio eradication projects, the targets are timely receipt of polio vaccine and polio coverage.

A financial incentive to achieve the targets is provided in tandem with the IDA credit. Donor funds are set aside to pay the credit fees and buy down the credit to a grant if the targets are reached. The first project is coming to a close, and an independent performance audit will occur in early FY07 to verify results. If the project’s intended benefits do not materialize, the funding remains an IDA credit, and no donor funds are awarded.

The Future. The initial pilot for polio projects was expanded by management to cover up to six health projects, and IBRD buy-downs are being explored. For buy-downs, projects must meet the following eligibility criteria:

- *Significant cross-border externalities.* The primary selection criterion is that eligible projects or project components must have significant positive cross-border externalities linked to the achievement of the MDGs.
- *Measurable outcomes.* Projects or components must have measurable and feasible outcomes that can be achieved through policy actions by the government so that the trigger-point for buying down the credit will be transparent and objective. Countries must also have adequate monitoring systems to measure these outcomes.
- *Standard Bank appraisal requirements.* Projects must meet appraisal requirements and standards applied to all projects. In particular, investment in a project using a credit buy-down must be supported by a strong political commitment by the government and be used for activities that are cost-effective, fiscally sound, and equity enhancing.

126. **Set a common global HNP Results Framework.** The Results Framework (annex J) will guide the Bank in developing regional HNP strategies and strengthening surveillance and monitoring. The framework covers health MDGs, other priority HNP outcomes, financial protection indicators, governance, and financial sustainability indicators. It is intended to guide Bank development of HNP knowledge creation and management, to direct the surveillance and monitoring initiative, and to provide general guidance to the Regions for

the preparation (or update) of their own HNP strategies and implementation plans. Developing some of the proposed outputs and outcomes will require an important effort early in the Strategy implementation (e.g. financial protection, fiscal sustainability, and governance).

127. The Bank portfolio is already focused largely on most of the proposed outcomes and outputs but has given insufficient attention to monitoring program performance and evaluating the implications of Bank and client-country trends for results. Most LICs and MICs are committed to health MDG outcomes, and the IDA-14 replenishment confirms Bank and donor commitment to the MDGs and other priority HNP outcomes. The same is reflected in most regional and Hub Vice-Presidential Unit Strategic Performance Contracts.
128. Most Bank operations already focus on health MDGs, improving reproductive health and child nutrition, as seen in the review of 116 Implementation Completion Reports for IDA and IBRD projects closed in FY01–FY05 and the review of current active portfolio Project Development Objectives (PDOs) (Subramanian, Peters, and Willis 2006). These reviews reflect the emergence of common outcome and system performance objectives in client countries across all Bank Regions. The performance objectives include addressing and reducing the noncommunicable disease epidemic, improving financial protection, improving governance and reducing corruption, and improving health sector financial sustainability in general and donor assistance and fiscal sustainability in particular. HNP outcomes included in the Results Framework potentially account for 60 percent of the total avoidable burden of disease in LICs and MICs combined.
129. The global HNP Results Framework is presented to guide the Regions in elaborating their regional strategies and identifying constraints to improving in-country performance. Its country-driven application and adaptation must be ensured, and the framework should not be understood as a prescriptive, limiting instrument. The key to making a country-led approach and the Results Framework compatible is the systematic intersectoral identification of constraints to improving HNP outcomes at country level and the subsequent design and implementation of effective sectoral interventions to overcome these constraints—tailored to individual country contexts. For example, the CAS and HNP portfolios of both Argentina and Rwanda emphasize reducing U-5 mortality, but each country has to take a different path. To reduce infant and neonatal mortality, Argentina is concentrating on improving provider incentives to expand access and quality of health service delivery for the poor mothers and children (box 6), particularly for neonatal care. In contrast, reducing U-5 mortality in Rwanda requires a much broader intersectoral approach, entailing, for example, expanding basic vaccine coverage, increasing access to basic perinatal health services, raising educational levels, expanding access to safe water and sanitation, improving access to key micronutrients, and increasing birth space (closely linked to women's participation in the labor market).

STRATEGIC DIRECTION 2. Increase the Bank contribution to client-country efforts to strengthen health systems for HNP results.

130. **Despite the Bank's potential comparative advantages, its health system capacity has not escaped the consequences of global trends in vertical and single-disease approaches.** Though still strong, current capacity in health systems is scattered throughout the Bank. To realize its full potential and to respond to growing demand from the international community, the Bank needs to raise its health system strengthening contributions to client-country efforts for HNP results in areas in which the Bank has comparative advantages.
131. Client countries have been ahead of the international community debate on health systems. In the last decade, many health system reforms have begun throughout the world. In these reforms, governments attempt to address such basic health system questions as: (a) how to ensure equitable access to effective, quality health services that respond to the needs of the community? (b) what is the right balance between investments in the HNP sector and other sectors to achieve both HNP results and much-needed economic growth? (c) what specific policies / actions are required to ensure synergy between priority-disease and system strengthening approaches? (d) what type of provider governance, contracting, financial management, procurement, and provider-payment mechanisms are necessary to ensure efficient and equitable results? (e) how should government engage and regulate a predominantly private delivery sector in LICs to improve equity, ensure consumer protection and improve public-private collaboration to achieve HNP results? (f) how can government ensure sustainable financing and improve fiscal space for priority diseases? (g) what are the public and private sector roles in the quest to expand health insurance coverage and supply of priority health services? (h) how can policy makers extend health insurance (public and / or private) to the large informal and self-employed sectors?; and (i) how can they leverage, for that purpose, most client-country high, private household (out-of-pocket) expenditures among the non-poor? These are some of the key health system challenges common to most Bank client countries.
132. Middle-income countries face additional challenges derived mostly from past decisions on health system financing and organization (Baeza and Packard 2006). Among these new challenges are to: (a) address gathering concerns about the effects of payroll-tax financing of social health insurance on labor markets; (b) regulate competing private health insurance; and (c) navigate the transition in the public sector from historical input financing to production-based (output-based) provider financing ("money follows the patient").
133. A central objective of the implementation of this new HNP Strategy is to improve Bank capacity to help client countries find the most appropriate answer to these questions for their country context to get concrete HNP results on the ground.
134. Strengthening health systems by setting the right incentives for efficiency will substantially contribute to broadening access to services. However, improving efficiency

will be insufficient in LICs; strengthening systemic delivery capacity will also entail expanding the supply of cost-effective health services, fiscal space and international financing commitment permitting.

135. Expanding health service supply capacity is particularly challenging in rural areas where high degrees of informality and poverty, usually compounded by geographical isolation, determine low levels of demand, making public investments costly and lacking incentives for private provision of services.
136. The Bank remains committed to supporting country efforts to strengthen health system infrastructure (e.g., clinics, hospitals, and medical equipment purchases). The Bank has comparative advantages in large infrastructure investments. However, client countries and country teams need to decide, case by case, Bank investments in health service delivery infrastructure in the context of allocative efficiency of country resources, in-depth analysis of all alternatives to increase service supply, and in line with the implementation of an adequate incentive framework for any new infrastructure so that HNP results on the ground are actually delivered. Investments in the absence of adequate incentive frameworks too often result in empty buildings.
137. The Bank stands ready to support client-country efforts to expand health services to the poor. To do so, an in-depth assessment of health systems policy and investment gaps is needed, to identify needs and options and set up the appropriate strategy to extend supply capacity. No country strategy to improve access to health services to its people, particularly to the poor, is complete without considering all potential alternatives to expand supply, including decisions assessing the appropriateness of investments on public sector capacity and / or expansion through publicly financed private sector provision of health service to the poor and / or private provision of privately financed services. The IFC and the Bank will further enhance their collaboration to help client countries identify best options, and, upon country request, provide financial support to implement them.
138. To realize its full potential in health systems, the HNP sector will rearticulate its health system capacity, now scattered throughout the Bank. It will strengthen its capacity in health financing (including fiscal management, health insurance, and health service purchasing)—and in system governance. It will seek more effective intersectoral collaboration with PREM (on fiscal space and management and on public sector governance) and with Financial Services and Social Protection (on health insurance). To this effect, the HNP sector will assemble a health system policy advice team, which will allow it to respond rapidly to the need for health system strengthening to obtain solid HNP results on the ground. Details on team mission, work scope, and organization are provided under the HNP Hub Action Plan (section I).

STRATEGIC DIRECTION 3. Ensure synergy between health system strengthening and priority-disease interventions, particularly in LICs.

139. Upon country demand, the Bank will continue lending for priority diseases and programs. But when doing so, it must stay sharply focused on solving systemic constraints to improving HNP results on the ground and on ensuring synergy in priority-disease treatment and system strengthening. Preliminary lessons from Argentina's maternal and child health program (box 6) suggest that this synergy can be better achieved by: (a) packaging the main priority diseases in one program / project; and (b) embedding in the project / program implementation design actions for health system strengthening (e.g., provider payment per child vaccinated or malaria patient treated). Doing so will most likely require the implementation of multiple system strengthening activities.
140. Bank financing through the IDA plays a crucial role in HNP-enhancing interventions to ensure priority-disease and system strengthening synergy in LICs. It also helps forestall allocative inefficiency and other distortions that can result from the allocation of large amounts of financing to a few diseases (and neglect of others) and to system strengthening in LICs. Technical advice and AAA can play a crucial role in strengthening health systems to remove country-identified bottlenecks that prevent increased financing from achieving its maximum impact.

Box 6

Argentina *Plan Nacer*:

Health System Strengthening Built into Results-Based Lending for MCH

Plan Nacer is a two-phase Adaptable Program Loan of about US\$440 million that supports the implementation of Argentina's public national maternal and child health program. The program ensures synergies between priority diseases and health system strengthening. It does so by directly (out of loan proceeds) paying for results (outputs and outcomes) for maternal and child health of the poorest population with structural changes and health system strengthening interventions deeply embedded in program implementation design. The program is intended to:

- Increase access to basic health services for uninsured mothers and children (up to six-years old), contributing to decrease infant and maternal mortality.
- Strengthen the health system and introduce structural changes in the incentive framework for the national-provincial and provincial-provider relationships, linking project financing with results (mainly output—health services delivered to target population—but also intermediary outcomes).

Most (85 percent) of program proceeds finance a conditional matching grant from the federal government to provinces to pay half the average per capita cost of providing a package of basic health services to uninsured mothers and children. The package covers 70 services addressing the main causes of child and maternal mortality. This capitation grant is the equivalent of financing a health insurance premium for the uninsured. Disbursements are made in two installments, if target results are met. By November 2006, more than half the originally targeted population had been enrolled (more than a half million mothers and children); and more than 2 million consultations and 20,000 deliveries had been financed by the program. Infant mortality in the target provinces has dropped.

In addition to increasing access to services, the program has had significant health system strengthening effects. To be able to achieve the targets and ensure appropriate use of funds, provinces have introduced output-based payment for providers, contracting (public and / or private sector) mechanisms, health service purchaser agencies, independent concurrent auditors, incentives to high-performing personnel, significant upgrades in monitoring and information systems, and demand-boosting actions such as linking *Plan Nacer* with conditional cash transfer programs already existing in the country.

The first two years of program implementation have been so successful that it is being expanded from the original nine provinces to the entire country, with a total beneficiary population of more than 2.2 million uninsured mothers and children.

Source: World Bank 2006k.

STRATEGIC DIRECTION 4. Strengthen Bank capacity to advise client countries on an intersectoral approach to HNP results.

141. It is universally acknowledged that reducing mortality, morbidity, fertility, and malnutrition requires intersectoral inputs and actions. However, little in-country systematic analysis has been done to document the bottlenecks in different critical sectors, set out a framework for prioritizing actions, or assess institutional constraints. Nor has this research been done within Bank lending operations. Preliminary evidence (World Bank 2006b) suggests that intersectoral approaches can greatly enhance results on the ground.
142. Effective core diagnostic tools are needed to identify intersectoral constraints to achieving HNP results. The Bank will develop, test, and implement a core diagnostic tool for systematic assessment of these multisectoral constraints at country level. The results of this process will feed into CAS preparation. The main purpose of the process will be to identify the priority HNP outcome(s), output, and performance improvements for the specific country, the binding constraints to improving that outcome and performance at national and / or subnational levels, and the key feasible multiple-sector interventions (technical, investment, policy actions) critical to overcoming these constraints. This “Multisectoral Constraints Assessment (MCA) for Health Outcomes” will be referred to as “MCA” in the remainder of this Strategy Paper. Annex K outlines the rationale and objectives of MCA, which will be developed and pilot tested in four client countries by FY2009. Country teams have no such process or tool today. Significant inputs for developing this core diagnostic tool will come from the methodological discussions in the *PRSP Sourcebook*⁵⁰ on identification of constraints to improving specific outcomes, the experience of the Africa Region with the Marginal Budgeting for Bottlenecks tool,⁵¹ the experience of the multisectoral Economic Sector Work (ESW) for Orissa state in India,⁵² and the experience of the *Recurso Peru* ESW in LAC.⁵³
143. Intersectoral identification of constraints should not be confused with a call for multisectoral investment projects across the board. One does not automatically lead to the other. In improving intersectoral work, the Bank needs to take into account the complexity that client countries face in improving their own intersectoral approach to HNP results. Given the much greater complexity and the often-difficult political economy of reform at country level, increasing intersectoral work will focus first on ensuring

⁵⁰ World Bank 2006a.

⁵¹ Soucat et al. 2004.

⁵² World Bank *forthcoming c*.

⁵³ Cotlear 2006.

intersectoral identification of different sectors' lending and nonlending activities required to improve HNP outcomes and system performance at country level. Identifying those activities to inform CAS preparation would be an important contribution to a results-based CAS and to policy dialog with client countries when defining the Strategic Directions of the CAS.

144. It will be up to the country team, based on context and needs, to decide whether to go for multisectoral projects / programs or for multiple parallel but coordinated sectoral projects or programs. In fact, considering the difficulties client countries have implementing multisectoral projects, the effectiveness of such projects should not be taken for granted and should be pursued only when the approach promises good HNP results at the country level. Identifying and coordinating HNP-related programs and projects intersectorally in a new CAS would be a big step toward the multisectoral determinants of HNP results.

STRATEGIC DIRECTION 5. Increase selectivity, improve strategic engagement, and reach agreement with global partners on collaborative division of labor for the benefit of client countries.

145. As one of the leading multilateral organizations in development, the Bank collaborates with many bilateral and multilateral organizations and global HNP partnerships. This collaboration can facilitate harmonization of development partner efforts and can reduce transaction costs for client countries in their pursuit of improving HNP results. The volume of the HNP partnership portfolio has increased dramatically over the past five years, mirroring the changes in the global health architecture. As a result Bank engagement with global partners is fragmented and needs sharper strategic direction. With the implementation of the new Strategy, the Bank will assess its engagement with its partners to ensure effective and sustainable partnerships. For example, the Bank will seek a better balance in its partnerships and its regional work on LIC and MIC priorities, particularly on health systems and will substantially increase its strategic engagement with WHO, the Global Fund and GAVI, particularly in LICs.
146. Engaging with global partners and partnerships has two main objectives for Bank work in HNP: (a) to complement Bank work in areas in which it has no comparative advantages or to complement other partners needing Bank expertise, all in direct benefit of client countries on the ground; and (b) to contribute to international community support of global public goods and prevention of global public "bads." Good examples of this type of collaboration are Bank involvement in donor harmonization, efforts to address the avian flu livestock crisis and scale up preparedness in case of a human health pandemic, and the design and launching of global financing instruments, such as the Advanced Market Commitments.
147. For areas in which the Bank has comparative advantages (e.g., health system finance, intersectorality, governance, demand-side interventions), the Bank will: (a) collaborate with partners that share all or part of these comparative advantages (e.g., IMF, regional banks, International Labour Organisation Actuarial and Financial Services) to further develop and disseminate knowledge; and (b) collaborate with other financing partners

and technical agencies (annex M) to share Bank expertise and to coordinate further development of knowledge in areas in which Bank expertise might be needed. A good example of global partnership collaboration in knowledge creation is the analytical work contributed by the Bank to the High-Level Forum (World Bank 2006a).

148. For areas of expertise and knowledge in which the Bank has no comparative advantages, the Bank will seek out effective collaboration mechanisms and pursue collaborative division of labor at the country level and with other development organizations in their respective areas of comparative advantage as discussed, for example, disease control knowledge as well as micro-organizational aspects of provision and the need for collaborative division of labor with WHO. This will ensure mainstreaming of partners' knowledge in Bank operations.
149. Different areas of expertise offer opportunities for division of labor and collaboration among global partners. However, because the failure of any of the nine key functions (paragraph 90) may compromise overall health system performance, partners need to closely monitor collaboration at the country level.
150. Many successful global advocacy organizations and partnerships have emerged in the last decade. Partnerships have potential for strengthening Bank effectiveness, but they can also "pull" the Bank policy function in directions that are not in line with its policy objectives, Strategic Directions, or comparative advantages. Engaging partners that best complement its own comparative advantages poses a great challenge to the Bank. Having contributed to the emergence, consolidation, and success of many of these advocacy organizations and partnerships, but confronted with the need for greater selectivity, the Bank will increasingly concentrate advocacy in HNP on sound intersectoral and health system strengthening policies.
151. The Bank is increasingly involved in managing a multiplicity of Trust Funds (provided by bilateral agencies or private foundations). Many of them provide substantial support for Bank country-level operations. However, the Bank is managing more and more such funds with narrow objectives that may or may not fit into its overall comparative advantages, strategic policy objectives, and country work. Managing these funds has an opportunity cost for operational and policy focus. Some of these funds have the potential to de facto steer the operational and policy priority focus of the Bank, particularly the HNP Hub. The Bank will review current and future management of Trust Funds and be selective in managing only those directly linked to its strategic objectives and comparative advantages to support country-level work.

H. Implications for Priority Health, Nutrition, and Population Programs and Interventions

152. The new environment, Strategic Objectives, and Strategic Directions discussed here apply to all HNP program areas for which the Bank provides technical and financial support, including nutrition, population, and HIV/AIDS. Some of the core policy

implications of this Strategy in nutrition, population, and on HNP's contribution to combating HIV/AIDS are examined in this section.

153. Upon country demand, the Bank will continue to support through lending and policy advice all health, nutrition and population activities necessary to improve HNP outcomes, especially for the poor and the vulnerable. The Bank will increasingly ensure that Bank operational support and policy advice for priority areas in health will strengthen country health systems. Strengthening health systems will lead to removing systemic constraints and thus improve the effectiveness of country, Bank, and international community financing to achieve HNP results. Through policy analysis and policy dialog, the Bank can also assist countries in realizing levels of investment in HNP sector and rational allocations within the sector consistent with accelerated progress towards MDG 1, 4, 5, and 6, and with other international commitments to achieving better health outcomes and greater health equity.

A strong commitment to population, sexual and reproductive health, and maternal and child policy.

154. The term “population” covers a variety of topics. Within the HNP sector two broad areas are most commonly referred to as population:
 - (a) Reproductive, maternal, and sexual health issues, and the health services that are concerned with addressing them;
 - (b) Levels and trends in births, deaths, and migration that determine population growth and age structure, and frequently have an impact on economic growth, poverty, labor markets, and other sectors.
155. The Bank commitment to population issues is embedded in the Programme of Action of the International Conference on Population and Development (ICPD 1994)⁵⁴ and identifies a number of entry points for the Bank to engage in population issues from within and outside the health sector. The Bank endorsed the Cairo Consensus in 1994 and continues to do so.
156. The ICPD called for achieving broader development goals through empowering women and meeting their needs for education and health, especially safe motherhood and sexual and reproductive health.
 - It recommends that health systems provide a package of services, including family planning, prevention of unwanted pregnancy, and prevention of unsafe abortion and dealing with its health impact, safe pregnancy and delivery, postnatal care, as well as the prevention and treatment of reproductive –tract infections and sexually transmitted diseases, including HIV/AIDS.

⁵⁴ UNFPA. 2004. *Programme of Action. Adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994*. New York: UNFPA.

Box 7
The World Bank Commitment to Reproductive Rights and Reproductive Health (ICPD 1994)

The ICPD Programme of Action includes the following:

- improving knowledge and information on reproductive health services;
- access to quality services particularly for the poor and vulnerable groups (i.e., migrants, adolescents, etc.);
- inclusion of youth in sexual and reproductive health programs, outreach and services (including provision of birth spacing methods);
- prevention of sexually transmitted diseases, including HIV;
- promotion of gender equality with particular attention to prevention of violence against women;
- that decisions concerning reproductive health be free of discrimination, coercion, and violence.

More specifically, the ICPD Programme of Action states:

“Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.

Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases.” (ICPD, Section 7.2)

“While the International Conference on Population and Development does not create any new international human rights, it affirms the application of universally recognized human rights standards to all aspects of population programs. It also represents the last opportunity in the twentieth century for the international community to collectively address the critical challenges and interrelationships between population and development. The Programme of Action will require the establishment of common ground, with full respect for the various religious and ethical values and cultural backgrounds. The impact of this Conference will be measured by the strength of the specific commitments made here and the consequent actions to fulfill them, as part of a new global partnership among all the world's countries and peoples, based on a sense of shared but differentiated responsibility for each other and for our planetary home. (ICPD, Section 1.15)

Source: UNFPA 2004

157. **Background and context to today's population issues.** In the second half of the 20th century, the world population more than doubled, reaching 6.4 billion by mid-2004. According to current projections, 95 percent of all population growth will occur in developing countries (United Nations 2003). Since the middle of the last century, fertility and mortality trends almost everywhere have gradually started to converge toward low fertility and lengthened life expectancy. The exception is the Sub-Saharan Africa Region,

where total fertility rates are still high: nearly 6 children per woman, compared with an average TFR of 2.6 in other low- and middle-income Regions (figure A22). About 200 million women who either want to space or limit their childbearing lack access to effective contraceptives. Intermediate fertility countries in South Asia and elsewhere, some with total fertility rates of 3 or 4, also continue to face challenges as they proceed through the demographic transition.

158. Africa will be the fastest growing Region, but most of the people born into the world between 2005 and 2050 will be Asians, due to the huge population size of Asia (60 percent of the world's population in 2005) and the associated population momentum. Concurrently, most countries in Europe and Central Asia are expected to grow little, and a decline in population is projected in a few. Population aging is a concern in many countries.
159. Countries can be grouped into three categories with broadly similar population issues (table A5): (a) countries with high fertility rates (TFR over 5.0), often showing little change in fertility over time; (b) countries with intermediate fertility rates (TFR ranging from 2.5 to 5.0); and (c) countries with fertility rates near replacement level and below. Individual country-level analyses of population trends will be required to identify specific constraints and remedies for policy formulation. Countries in various stages of fertility transitions face diverse challenges in the areas of sexual and reproductive health.
160. Many aspects of effective reproductive and sexual health service delivery depend on overall health system strengthening, including, planning, human resources, financing, regulation, information systems, management, and commodity procurement and logistics. There is now a robust body of evidence and experience to guide the design, delivery, and assessment of sexual and reproductive health programs. However, the determinants and consequences of demographic change need urgent study, specifically on policies and interventions affecting fertility, family planning, population aging, and utilization of other sexual and reproductive health care. Trends resulting from demographic processes—large birth cohorts in high-fertility countries, changes in the age structure resulting in large youth populations and rapidly growing elderly cohorts—all have profound implications for HNP, education, labor markets, pensions, poverty reduction, and environment.
161. **Countries with high unmet needs in sexual and reproductive health as a priority.** Despite the dramatic decline in global fertility rates, 35 countries, mostly in Sub-Saharan Africa, and a few countries in other Regions (Timor Leste, Afghanistan, West Bank-Gaza, and Yemen) still have fertility rates above 5 (United Nations 2003). Fertility rates in a number of these countries have not declined for several decades (figure A23), demonstrating their high unmet needs in sexual and reproductive health and maternal mortality reduction.
162. The rationale for Bank focus on these countries, along the lines of Bank comparative advantages, is clear from an economic growth / poverty reduction perspective as well as from equity considerations. The consensus today is that rapid population growth

constrains countries at low levels of socioeconomic development (Kelley 1988; Birdsall, Kelley, and Sinding 2001). It raises demand for public services and financial resources in countries that cannot create the fiscal space to provide either. Women endure a disproportionate burden of poor sexual and reproductive health. Their full and equal participation in development is therefore contingent on accessing essential sexual and reproductive health care, including the ability to make voluntary and informed decisions about fertility.

163. Notwithstanding, global attention to population issues has been declining (PATH/UNFPA 2006). The earlier success in reducing global fertility rates, the rise of competing priorities, the unintended loss of focus on family planning services within the broader ICPD agenda, and the changing environment have all contributed to persistently high fertility rates in some countries and declining funding for family planning (figure A24). Repositioning family planning within the ICPD agenda and, in collaboration with development partners, strengthening its visibility are important. Harmonization and aid alignment at the country level is necessary to make sure that sexual and reproductive health services are funded adequately in national budgets. A comprehensive operational and systems strengthening response is required from the Bank and its partners.
164. **Future directions for the Bank.** The Bank commitment to population issues is embedded in the ICPD Programme of Action (ICPD 1994).⁵⁵ The Bank recognizes that UNFPA and WHO are the main agencies working on the technical aspects of reproductive health issues. The Bank will work on population issues on the basis of its comparative advantages. Upon country demand, the Bank will focus its contributions in countries with high unmet needs in sexual and reproductive health in the following areas:
 - (a) assessing multisectoral constraints to reducing fertility, determining impacts of population changes on health systems and other sectors, and assisting countries in strengthening population policies;
 - (b) providing financial support and policy advice for comprehensive sexual and reproductive health services, including family planning, and maternal and newborn health;
 - (c) generating demand for reproductive health information and services, including improving girls' education and women's economic opportunities, and reducing gender disparities;
 - (d) raising the economic and poverty dimensions of high fertility in strategic documents that inform policy dialogue (such as, CASs, CEMs, and country-led PRSPs).

⁵⁵ UNFPA. 2004. *Programme of Action. Adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994*. New York: UNFPA.

Opportunities for sustaining, and challenges to improving, HNP contributions to combating HIV/AIDS.

165. **The Bank reaffirms its commitment to assist client countries and the international community in combating the HIV/AIDS pandemic.** This effort is a worldwide health priority, as articulated in 2005 through its Global HIV/AIDS Program of Action (GHAPA) for supporting the global, regional, and national AIDS response (World Bank 2006g). The pandemic jeopardizes economic development in many countries, particularly in Africa. Here, too, recent financial and political commitments for combating HIV/AIDS present new opportunities, but also new challenges. Much of the new funding is dedicated to expanding access to antiretroviral therapy. By end -2005, the number of people on ART in low- and middle-income countries amounted to 1.3 million, only an estimated 20 percent of the number needing treatment (UNAIDS 2006). Annex N summarizes the Bank vision on the HNP sector contribution to combating the HIV/AIDS pandemic.
166. **Scaling up and sustaining prevention and treatment.** Sustainable scaling up of HIV/AIDS prevention and treatment depends on health systems that can: (a) overcome increasingly worrisome health financing constraints and set the right provider incentive framework for results; and (b) solve supply bottlenecks through efficiency improvements and supply expansion, particularly in LICs. It also depends on the ability of the international community to fulfill its promises. The Bank remains committed to financing HIV/AIDS interventions, upon country demand and in concert with integrated health system strengthening projects, programs, and analytic and advisory services.
167. **Health financing constraints.** Some characteristics of development assistance for health that are relevant to HIV/AIDS cause increasing concern: the volatility and predominance of short-term commitments by the international community; increasing funding distortions; allocative inefficiencies; and the need to find effective ways of creating fiscal space for HNP in general and HIV/AIDS in particular.
 - (a) *Volatility and predominance of short-term commitments.* The amount of DAH funds countries receive varies greatly from year to year. This makes long-term planning difficult for Ministries of Health and Finance.
 - (b) *Funding distortions.* Fragmentation of donor assistance to health distorts funding, making it difficult for governments to finance systemic requirements for staff, supervision, training, management and maintenance, and expansion of access to ART.
 - (c) *Allocative inefficiencies.* With the large influx of funding for HIV/AIDS, the question arises of whether the money is being used to its maximum net benefit. Funding for prevention has not been similarly expanded. ART appears to help prevent, as well as treat, HIV infection, but preventive interventions could do more to limit new HIV infections and are more cost-effective (Hogan et al 2005; Salomon et al 2005; Bertozzi et al 2006). Might some funds be better and more equitably spent on prevention?

- (d) *Need to find effective ways to create fiscal space.* Large increases in public spending on HIV/AIDS or health initiatives that create future spending commitments must be considered in the context of governments' ability to provide resources from current and future revenues. This is a serious constraint in low-income countries. The problem is compounded if large expenditures are financed by borrowing, which requires additional revenue to service the debt and could impair overall economic growth.

Improve efficiency and, when necessary, expand supply capacity.

168. The Bank will contribute to:

- (a) *Efficiency improvements.* More funding is not enough; additional funding must be linked to improving health system efficiency, as discussed throughout this Strategy.
- (b) *Supply capacity.* The Bank remains committed to supporting country efforts to strengthen health system supply through infrastructure investments (e.g., clinics, hospitals, and medical equipment purchases), when necessary (paragraph 136).

Bank contributions to HIV/AIDS financing.

169. The Bank will contribute to financing HIV/AIDS programs and health systems in a several ways:

- (a) *Supporting increased, long-term, predictable funding.* Upon country demand, the Bank is committed to leveraging global partner funding and / or providing increased and predictable long-term financing for the health sector and HIV/AIDS.
- (b) *Creating fiscal space and reducing distortions.* The Bank will work intersectorally with client countries, the IMF, and global partners to help countries develop ways of enhancing capacity to absorb and reduce the adverse effects of fiscal shocks and create fiscal space for necessary HNP interventions, including HIV/AIDS prevention and treatment.
- (c) *Enhancing accountability.* The Bank will promote budgetary and financial reporting processes that accommodate and respond to the views of critical stakeholders within the country. The Bank will support client-country efforts to sustain specific efforts to protect the interests of poor, vulnerable, and marginalized groups, including people living with HIV/AIDS, in order to increase accountability and enhance people's voices.
- (d) *New types of financing.* The Bank will provide financial, technical, and convening capacity to countries requesting help with development of health financing systems that promote accountability, efficiency, and financial protection. This work forms the framework for financing HIV/AIDS prevention, care, and treatment at country level.

Upon country request, the Bank will also test new country-led and country-owned approaches to its own financing of HNP and HIV/AIDS.

170. Strengthening health systems is critical for scaling up and improving the effectiveness of HNP interventions, including HIV/AIDS treatment and prevention. As discussed throughout this Strategy Paper, the Bank is committed to sharpening its focus and improving its capacity to support client countries in strengthening health systems, along the lines of Bank comparative advantages. It will seek to improve system capacity to deliver services for the entire range of disease interventions prioritized by client countries. HIV/AIDS, malaria, tuberculosis, maternal and child health, reproductive and sexual health, and micronutrient interventions are prominent in the agendas of most client countries, particularly LICs.

Repositioning nutrition to a central place in development.⁵⁶

171. Malnutrition, and its negative compounding effect in disease susceptibility, slows economic growth and perpetuates poverty via three routes: (a) direct losses in productivity from poor physical status; (b) indirect losses from poor cognitive function and deficits in schooling; and (c) losses owing to increased health care costs. Malnutrition's economic costs are substantial: individual productivity losses estimated at more than 10 percent of lifetime earnings and gross domestic product forgone as high as 2 to 3 percent. Improving nutrition is therefore at least as much an economic issue as one of welfare, social protection, and human rights.
172. Investing in nutrition in early childhood lays the foundation for lifelong health and development. A well-nourished child, for example, is less likely to suffer from disease and more likely to achieve better educational attainment and labor productivity as an adult. Moreover, improving children's health has longer-lasting gains that may be discerned in the next generation of healthier and more productive people.
173. Reducing undernutrition and micronutrient malnutrition also multiplies the effectiveness of health prevention and curative interventions and directly reduces *poverty*, broadly defined to include human development and human capital formation. Undernutrition is closely connected to income poverty. Malnutrition is often two, three, or more times more prevalent among the poorest income groups than among the highest. This means that improving nutrition is a pro-poor strategy; it disproportionately increases the income-earning potential of the poor.
174. The returns on investing in nutrition are high. The Copenhagen Consensus ranked returns on nutrition interventions among the highest of 17 potential development investments (table A6). Improving nutrition is essential to reduce extreme poverty. The first MDG, for eradicating extreme poverty and hunger, recognizes this requirement.

⁵⁶ This section summarizes findings and recommendations of "Repositioning Nutrition as Central to Development: A Strategy for Large-Scale Action," published by the World Bank in 2006.

175. The key indicator for measuring progress on the nonincome poverty goal is the prevalence of underweight U-5 children. Yet most assessments of progress toward the MDGs have dwelled mainly on the income poverty target and have found most countries on track. However, of 143 countries, only 34 (24 percent) are on track to achieve the nonincome target (nutrition MDG) (table A7). No country in South Asia, where undernutrition is highest, will achieve the MDG—although Bangladesh will come close, and Asia as a whole will achieve it. More alarmingly, nutritional status is deteriorating in 26 countries, many of them in Africa where the nexus between HIV and undernutrition is strong and mutually reinforcing. And in 57 countries, no data are available to evaluate progress. A renewed focus on the nonincome poverty target, including nutrition, is central to any poverty reduction efforts.
176. **The alarming shape and scale of malnutrition.** Malnutrition is now problematic in both poor and rich countries and affects the poorest people most. In developed countries, obesity is growing fast, especially among poorer people. An epidemic of diet-related NCDs such as diabetes and heart disease is raising health care costs and reducing productivity. In developing countries, obesity is also fast emerging as a problem, on top of widespread undernutrition and micronutrient deficiencies. Underweight children and overweight adults often live in the same households in both developing and developed countries.
177. Malnutrition also occurs in many nonpoor families. People do not always know what foods are best for them or their children, and the untrained eye does not usually notice abnormally slow growth or associate it with micronutrient deficiencies. Education can play a major role in correcting malnutrition stemming from ignorance.
178. Effective interventions exist, so what is missing? Nutrition investments have been low priority for both governments and development partners for three reasons. First, there is little demand for nutrition services from communities because malnutrition is often invisible; families and communities are unaware that even moderate and mild malnutrition contributes substantially to death, disease, and low educational attainment; most malnourished families are poor and hence have little voice. Second, governments still do not recognize how high malnutrition's economic costs are; that malnutrition holds back progress toward all the MDGs, not just the nutrition MDG; and that plenty of experience has been acquired with implementing cost-effective, affordable nutrition programs on a large scale. Third, there are multiple organizational stakeholders in nutrition. Because most country financing is allocated by sectors or ministries, malnutrition can fall between the cracks in both national programs and global assistance.
179. **The Bank contribution to reposition nutrition in development.** Bank increased knowledge and policy development work on nutrition is summarized in "Repositioning Nutrition as Central to Development" (World Bank 2006). In the area of nutrition, the Bank will further contribute by: (a) expanding its capacity to generate country-specific policy knowledge and advice to identify the magnitude of malnutrition as an outcome and as a constraint to other outcomes; (b) improving its capacity to identify structural issues (e.g., failures in agricultural, taxation, rural development, water supply and sanitation,

social protection, education, community-driven development, and other policies and devising multisectoral policies to help countries beset by malnutrition address it; (c) upon country demand, supporting integration of appropriately designed and balanced nutrition policies and interventions in CASs and in client country-led PRSPs; (d) improving Bank monitoring and evaluation capacity of nutrition-enhancing interventions to ensure evidence-based learning and policy adjustments; and (e) including nutrition as one of the multisectoral parameters in the MCA tool. Beyond structural and systemic issues, the Bank will seek advice from specialized global partners for Bank in-country operations on the technical aspects of appropriate nutrition interventions.

I. Implementing New Bank HNP Strategic Directions

180. To make full use of its comparative advantages in the new environment in the service of client countries, the Bank HNP sector needs to make functional and organizational changes and rebalance the skill-mix composition of its staff and management. Strengthening Bank capacity (regional and Hub) to sharpen focus on HNP results, health system strengthening, health economics and intersectoral work is costly in the short term. The requisite skill-mix adjustment will take time and effort (through staff and management training, reorientation of recruitment toward expertise in health financing / systems / economics / intersectorality skills, development of core diagnostic tools). The adjustment will also require functional changes in the mission of the HNP Hub toward one more oriented to support Region and country team needs. Concomitantly, it will require revitalizing the role and work of the HNP Sector Board.
181. This section includes a summary Action Plan to implement key features of the HNP Strategy that lead to the new Strategic Directions and results. It includes: proposals and targets to improve quality at entry of the HNP portfolio; actions to restructure current at-risk portfolio; a design, pilot, and implementation plan for MCA; proposals for improving statistical capacity and monitoring of core indicators at client-country and global levels; a Results Framework to guide regional development of country strategies; and proposals for training and retooling HNP staff and management. It also includes key organizational changes, particularly for the HNP Network (HNPFAM) and the HNP Hub.
182. Annex J presents the Bank HNP Results Framework, which summarizes the main outcomes and outputs for the Bank in HNP. The framework is intended as the guidance for country team for developing country-specific results frameworks and detailed results frameworks for Bank operations and programs. The Results Framework links the main outcomes and outputs for the Bank with the Action Plan for Strategy Implementation.
183. The Action Plan also includes transition proposals to implement a rapid Bank response in the areas of health system strengthening. Constraints on budgets and on the availability of health system experts would preclude short-term strengthening of every Region's capacity for health system advice. Thus, the Action Plan proposes creating and locating a health system policy team in the HNP Hub to support HNP Sector Board (to take advantage of initial economies of scale) to: (a) support Regions in their health system

capacity strengthening process; (b) provide support to Regions in their policy advice to client countries through their lending and AAA work during this transitional period (initially with IDA country focus); and (c) advise the Bank and international community on next steps for developing and implementing the health system strengthening agenda. It also will include a moderate increase in senior health system experts at regional level. The Hub health systems team is envisioned as being fully functional 12 to 18 months after approval of the new Strategy, contingent on availability of transition funding.

Action Plan for implementing Strategic Directions.

184. Sharpening the focus on results will require intensifying both client-country efforts to identify, monitor, and evaluate government programs and Bank capacity to evaluate Bank-supported programs using country systems. It will also require innovation in linking lending to results to such output. Finally, it will require a significant effort to restructure nonperforming projects in the HNP portfolio to improve Bank-assessed results of closing projects. Table 1 summarizes actions to be taken by the HNP sector to sharpen its focus on results.

Table 1 Five-Year Action Plan: Renewing Focus on Results			
<i>What?</i>	<i>Baseline</i>	<i>How much and by when?</i>	<i>By whom?</i>
1. <i>Build statistical capacity</i> for client countries on priority HNP outcome indicators (disaggregated by gender and age) directly through Bank operations and / or supporting global partner's country support (e.g., MDGs). This includes the development of country-based frameworks for the collection of essential household HNP and multisectoral indicators.	Less than 10% of CASs targeting HNP results	At least 40% of new CASs targeting HNP results to be discussed with the Board in FY09 and thereafter will identify capacity and systems building activities (Bank and / or coordinated with global partners) for, monitoring, and evaluating HNP results in government programs.	Regional HNP Sector Manager and HNP country team and Country Directors with technical support from HNP Hub and Development Economics (DEC), as needed
2. <i>Pilot and evaluate impact of output-based and performance based financing</i> for HNP-related projects/programs.	4 active projects in FY06	By FY10, at least 14 active projects with most loan proceeds allocated on output-based financing. Impact evaluation plans in place for 60% of these projects or more upon	Regional HNP Sector Manager and HNP Sector Board with technical support from HNP Hub, as needed

		approval.	
3. <i>Develop Bank Global Results Monitoring Framework</i> for key outcomes, outputs, and system performance indicators to be monitored by the Bank globally. This will include indicators on gender disparities in health.	Presented with this new HNP Strategy	Strategy for global monitoring arrangement designed (in collaboration with global partners) by end-FY08. Implementation launched by end-FY09.	HNP Hub with support of HNP Sector Board, DEC, and others
4. <i>Introduce Results Frameworks</i> for all projects targeting HNP outcomes, output, and system performance, including baseline data and output targets.	Less than 25% of active projects with satisfactory Results Frameworks as of FY06	At least 70% of new projects/programs approved by the Board in FY08 and thereafter.	Regional HNP Sector Manager and country team, with technical support from HNP Hub
5. <i>Periodic data collection and updates</i> (as appropriate to specific indicators) for at least 70% of the indicators included in project Results Framework and updated periodically in Implementation Status Reports (ISRs).	Less than 15% of active projects as of FY06	At least 65% (annually) of all projects/programs approved by Board in FY08 and thereafter.	Regional HNP Sector Manager and country team, with technical support from HNP Hub
6. <i>Develop indicators (including gender- based indicators) for priority HNP outcomes</i> for which no agreed indicators exist (e.g. financial protection, governance in the health sector, and financial and fiscal sustainability).	Does not exist.	Develop indicators by end-FY08.	<i>Identification of indicator needed:</i> HNP country team and Regional HNP Sector Manager <i>Development:</i> HNP Hub in collaboration with PREM, DEC, and country teams
7. <i>Improve results in existing portfolio.</i> Review and restructure existing HNP portfolio (Project Design and / or Project Development Objective, PDO) to achieve satisfactory PDO or higher outcome at project closing.	Annual average of 66% of projects closing with satisfactory PDO or higher result (FY05 and FY06)	75% for FY09 and thereafter (each Region and total HNP portfolio)	Regional HNP Sector Manager with support from HNP Sector Board HNP Hub, IEG, DEC and Operations, Policy, and Country Services (OPCS)
8. <i>Concurrent monitoring of overall active Bank portfolio performance and PDO indicators on HNP results.</i>	Does not exist.	Develop by end-FY08; implement by end-FY09.	<i>Develop:</i> HNP Hub in collaboration with results team in OPCS/DEC and with ISG

Develop and implement central database with HNP project results based on ISR and project Results Framework data online for monitoring portfolio results and quality.			<p><i>Implement:</i> HNP Sector Board</p> <p><i>Manage:</i> HNP Hub and HNP Sector Board</p>
--	--	--	--

185. Strengthening the Bank health system capacity and synergy among systems and priority diseases will require hiring of additional health system staff for the Regions and the creation of a health systems policy team (paragraph 183) to take advantage of economies of scale and facilitate regional cross-fertilization. This team will give country teams immediate health system analytical and operations advice support in identifying actual constraints and provide recommendations on Bank, donor, and government funding needed to achieve HNP results and to help Regions refine and develop their own health system capacity in the medium term. Table 2 summarizes actions to be taken by the HNP sector to improve Bank capacity on health system strengthening.

<p>Table 2 Five-Year Action Plan: Strengthening Health Systems and Ensuring Synergy between Health System Strengthening and Priority-Disease Interventions</p>			
<i>What?</i>	<i>Baseline</i>	<i>How much and by when?</i>	<i>By whom?</i>
9. Increase support to Bank country teams to <i>identify health system constraints (including gender-specific constraints) to achieving HNP results</i> and mainstream system strengthening actions to overcome constraints in all new HNP operations (or other sectoral or global partner operations), including priority-disease interventions.	<p>Less than 25% identify health system constraints.</p> <p>Less than 45% include health system strengthening in areas of Bank comparative advantages.</p>	<p>Develop operations toolkit for rapid assessment of health system constraints for better outcomes (completed by end-FY08).</p> <p>Complete identification of 7 countries by December 2007.</p> <p>Launch on-demand support in four countries by June 2008.</p> <p>Put on-demand support in place to Bank country teams in 7 countries by June 2009.</p> <p>At least 60% of</p>	<p><i>Identify countries:</i> Regional HNP Sector Managers with support from HNP Hub.</p> <p><i>Provide support to country teams:</i> Health System Policy Team (HSPT) (see below).</p> <p><i>Support client countries in designing system strengthening interventions:</i> Country teams with on-demand support from HSPT).</p> <p><i>Support country teams in assessing health system constraints:</i> HNP Hub.</p>

		<p>projects approved in FY09 and thereafter will include assessment of health system constraints to reaching HNP results.</p> <p>At least 70% of those identifying constraints will include appropriate policy actions/investments to overcome them.</p>	
10. <i>Assemble Health Systems Policy Team (HSPT) and hire additional health system staff for the Regions. (Contingent to Budget Availability).</i>	Does not exist.	<p>Write TORs and launch recruitment process by December 2007.</p> <p>Complete recruitment by June 2008.</p> <p>Put team in place and working by December 2008.</p>	<p>HNP Hub in coordination with HD Council and HNP Sector Board. Team would be located in restructured HNP Hub.</p> <p>Regional Staff in regions.</p>
11. <i>Put in place arrangements for collaborative division of labor on health systems with global partners at global and country levels.</i>	Does not exist	<p>Dialog in place for global arrangements by December 2007.</p> <p>Launch collaborative division of labor arrangements for at least 10 countries where projects/programs include interventions requiring expertise other than Bank comparative advantages (by December 2008).</p>	<p><i>Global arrangements:</i> HNP Network Director with support from HD Vice President, HD Council, HNP Sector Board, and HSPT</p> <p><i>Country-level arrangements:</i> Country teams with support of Regional Sector Manager and HSPT</p>
12. <i>Focus knowledge creation and policy advice (AAA) on Bank comparative advantage.</i> (Increase proportion of country- and regional-level AAA, appropriate to requirements of LICs and MICs, focused on Bank comparative advantages.)	Less than 35% so focused.	<p>By end-FY08, 50% and by end -FY09 70% of new HNP sector AAA will be focused on areas of Bank comparative advantage in specific areas appropriate for LICs' and / or MICs' requirements.</p> <p>(E.g. Health system financing, demand-</p>	Regional HNP Sector Manager with support from HSPT

		side determinants of results, intersectoral contribution to HNP results, private-public collaboration)	
13. Develop and implement a training and accreditation program for Bank staff on <i>technical and operational aspects of health system strengthening</i> .	Does not exist	In place by end-FY08; 30% of HNP staff accredited by end-FY09; 60% of HNP staff accredited by end-FY10.	HNP Sector Board with support from HNP Hub, WBI, and DEC.

186. Intersectoral work for HNP results will be strengthened in two phases. First, the Bank will develop necessary tools to identify intersectoral constraints to achieving HNP results. The tools will be used to identify potential operations (whose primary objective is achieving HNP results), or identify potential actions / components (in operations whose primary objective is not HNP results) and to suggest the AAA work required to overcome the constraints. For that, the Bank will develop the Multisectoral Constraints Assessment tool. Second, the Bank, upon country demand, will further experiment with multisectoral operations when the country context lends itself to it. Table 3 summarizes actions to be taken by the HNP sector to improve intersectoral work for HNP results.

Table 3 Five-Year Action Plan: Strengthening Bank Intersectoral Advisory Capacity			
<i>What?</i>	<i>Baseline</i>	<i>How much and by when?</i>	<i>By whom?</i>
14. Develop, pilot test, and implement <i>Multisectoral Constraints Assessment (MCA)</i> tool and process. Pilot test in a number of LICs and MICs.	Does not exist.	First tool will be developed by end-FY08 and pilot tested in 2 MICs and 2 LICs by end-FY09.	<i>Development:</i> Intersectoral thematic group (all sectors concerned through respective Hub Sector Managers, led by HNP Hub Sector Manager). Ad-Hoc technical team to design instrument. <i>Selection of country pilots:</i> Virtual intersectoral thematic group and Country Directors <i>Implementation of pilots:</i> Ad-Hoc TTL from country team and Regional Sector Manager, under oversight of intersectoral thematic group.
15. <i>Identify lending and AAA in CAS.</i> MCA-identified HNP-related Bank projects/programs/components in CAS.	Does not exist.	MCA will be used to identify 40% of projects/programs with HNP results included in at least 50% of new CASs discussed with Board by FY10 and thereafter.	Regional HNP and other Sector Managers involved with support from HNP Hub and intersectoral thematic group
16. Develop, implement,	Does not	Functioning by	The thematic group would be

and manage an <i>intersectoral coordination thematic group</i> for HNP results.	exist.	December 2007.	composed of interested sectors through their respective sector Hub Managers. <i>Development:</i> HNP and other sector Hub Managers <i>Management:</i> HNP Hub Director
---	--------	----------------	--

187. To increase selectivity and achieve complementarity with global partners, the HNP sector will seek agreements with them on collaborative division of labor. The Bank will concentrate its knowledge creation and policy advice activities on its areas of comparative advantage. It will seek its partners' advice on areas in which it has limited or no comparative advantage (section G). Table 4 summarizes specific actions to be taken by the HNP sector to improve selectivity and collaborative division of labor with global partners.

Table 4 Five-Year Action Plan: Increasing Selectivity, Strategic Engagement, and Collaborative Division of Labor			
<i>What?</i>	<i>Baseline</i>	<i>How much and by when?</i>	<i>By whom?</i>
17. <i>Increase use of harmonization and alignment principles for Bank projects in at country level.</i>		By FY11, at least 81% of projects approved by Board will be based on country fiduciary systems or will have common fiduciary arrangements/rules for all participating donors.	Country teams with support of Regional Sector Manager, Regional Fiduciary Teams, and on-demand support from HSPT
18. <i>Develop overall HNP Fiscal Space assessment in priority countries</i>	Does not exist	Develop and pilot Fiscal Space assessment methodology (completed by end of FY08) Full Fiscal Space assessment in 7 priority countries in coordination with Global Partners.	HNP Hub in collaboration with DEC and PREM and with regional HD Departments Country teams with support from HNP Hub
19. <i>Review and reorient Bank grants(DGF) in HNP toward areas of Bank comparative advantages.</i>	Currently less than 1% of DGF grant financing is allocated to partners working on issues related to Bank comparative	By end-FY08, 5%, by end-FY09 30% and 50% by end- FY10 of DGF grant financing will be allocated in partnerships related to Bank comparative advantages.	HNP Sector Board with support of HNP Hub

	advantages.		
20. Realign secondments and Trust Fund management in HNP sector with Bank comparative advantages.	Currently 60% of secondments in HNP sector are in areas in which Bank has little comparative advantage.	By end-FY09, 80% of secondments to Bank and 80% of total Trust Fund financing managed by HNP sector will be in areas of Bank comparative advantages.	

HNP Hub mission and organizational changes

188. The HNP hub will facilitate HNP network implementation of the new Strategy. In order to adequately play its role, the Hub will adjust its organizational structure and functioning in four work teams as follows:
189. **Performance Monitoring and Action Team.** This team will be responsible for (a) the maintenance of a data base of HNP indicators; (b) the maintenance of a data base of health financing indicators; (c) contributions to institutional reports (GMR, CPIA, WDR, etc); (d) portfolio monitoring and quality enhancement; (e) monitoring and evaluation capacity building (staff and clients); and (f) regular updating of progress on the HNP Results Framework, including support to country teams on Results Framework development.
190. **Global Health Coordination and Partnerships Team.** The following functions will be covered: (a) coordinate work with global partnerships and initiatives; (b) facilitate selective fund raising and TF management for the HNP network; (c) DGF management support; (d) selective joint ventures around themes of convergence (comparative advantages); and (e) harmonization and alignment.
191. **Health Systems Policy Team.** The preparation of the Strategy has identified a gap in high-level health system policy skills to guide the implementation of the Bank agenda and an unmet demand from the Regions to receive timely support in their country dialog. It has also identified the need for practical and concrete advice to country teams and partners on how to overcome health system constraints to DAH effectiveness for results. This will become even more pressing with the new policy drivers of the HNP strategy. The team will: (a) provide country teams with overall policy, technical, and operational advice on health systems; (b) manage knowledge creation on health systems, (c) develop and manage technical assistance for the Multisector Constraints Assessment tool; (d) respond to country team demands on ensuring synergy between priority-disease and system strengthening approaches; and (e) advise global partners on the health system aspects for which the Bank has comparative advantages. About 50 percent of their time will be allocated to country-team support and field work.
192. The team will focus closely on the following themes identified as priorities by client countries and global partners: (a) health financing and economics, including health

insurance; (b) linkage to macroeconomic and fiscal policy; (c) health service purchasing; (d) health system governance; and (e) facilitating synergy between priority-disease and system strengthening in Bank operations.

193. **Technical Aspects of Public Health, Nutrition, and Population.** The team will support the Regions on technical aspects of core public health functions, disease control, nutrition, and population, supporting with existing in-house expertise but, more important, helping country teams establish the necessary working collaboration arrangements at country level with technical agencies such as WHO, UNICEF, UNFPA, and others.

Rebalancing staff skill-mix.

194. The staff is the single most important asset of the Bank and its most important comparative advantage. Bank personnel working on HNP results represent a wealth of multisectoral experience and knowledge from almost every country. Managing and strengthening this asset is crucial for good Bank performance on HNP results.
195. The skill-mix of the HNP sector staff has undergone important changes (paragraphs 76 and 77). Focusing on Bank comparative advantages will require rebalancing the skill-mix of staff and management in two directions through new hiring and retooling/training of staff and management: (a) increasing the proportion of economics and health systems skills and, more important, (b) increasing the proportion of staff with recognized seniority in hands-on health system experience and sufficient breadth of knowledge to encourage and lead intersectoral work for HNP results (the horizontal part of the HR “T” skills) in high-level policy dialog with government counterparts. The HNP Sector Board and HD Council will ensure that future recruitment seeks out those skills for both staff and management appointments, to reach a balance between health specialist and economics/senior systems specialist.

Preliminary estimates of Strategy implementation costs.

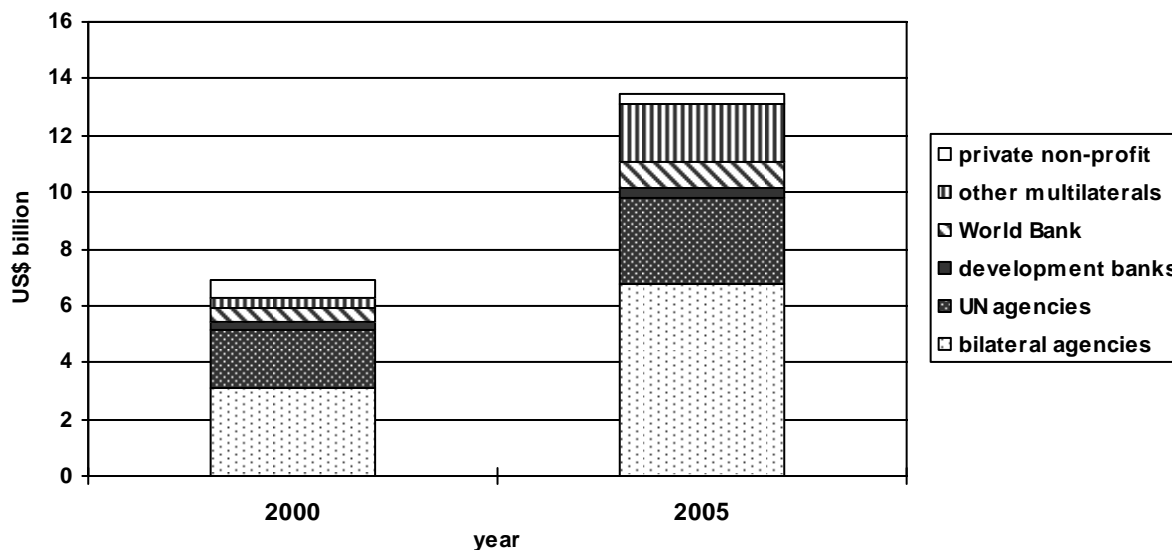
196. The Board and management are currently discussing the budget allocations for FY08 and beyond as part of the four-point engagement on the budget previously agreed. In this context, management and staff are undertaking a more detailed task-based budgeting exercise as part of the normal budget cycle. The resource requirements for implementing the HNP strategy will be a function of the pace of implementation of the strategy (pace of change), the demand from countries, and the availability of resources in an environment of zero growth in the overall Bank budget. It is expected that the cost of implementing the new HNP strategy will involve a modest increase in the base budget for the HD network over the FY07 base budget, after taking into account one-off transitional adjustments. An extraordinary allocation to the HD network above the regular base budget will be utilized to finance these transition expenses, as justified.

Annexes

- A. Figures and Supplementary Tables
- B. Regional/HNP Hub Action Plans
- C. Acknowledgments
- D. List of Participants in Internal Consultations
- E. List of Participants in Country Consultations
- F. List of Participants in Global Partner Consultations
- G. Questionnaire
- H. Chairman Summary Note to the Background Note on the World Bank Strategy for HNP Results, June 21, 2006
- I. New Global Health Architecture
- J. Bank HNP Global Results Framework
- K. Multisectoral Constraints Assessment
- L. What is a Health System?
- M. List of Global Partners and Partnerships
- N. HNP Contribution to Combating HIV/AIDS
- O. References

Annex A

Figure A1
Development Assistance for Health by Source, 2000 and 2005

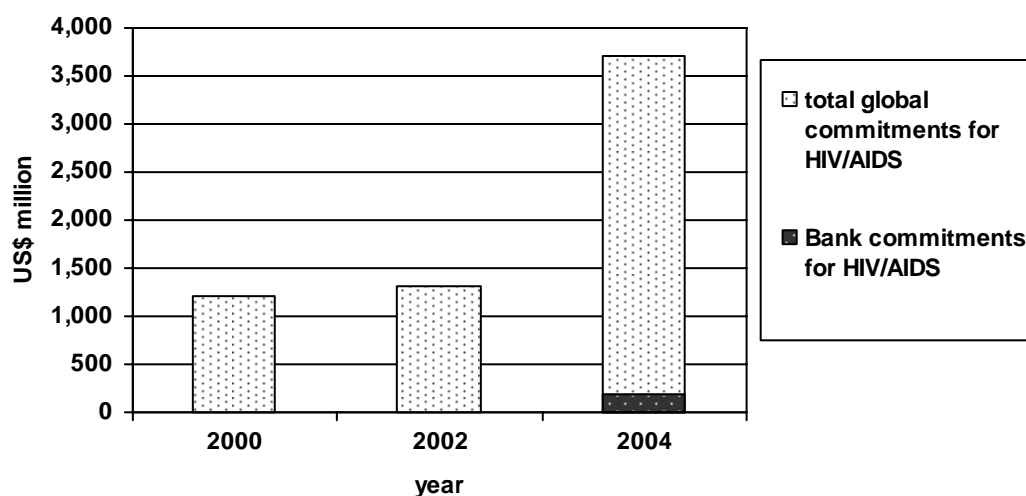


Source: C. M. Michaud 2007.

Note: "Other multilateral" includes the European Union, Global Alliance for Vaccines and Immunization (GAVI), and Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM).

"World Bank" total includes only IDA lending.

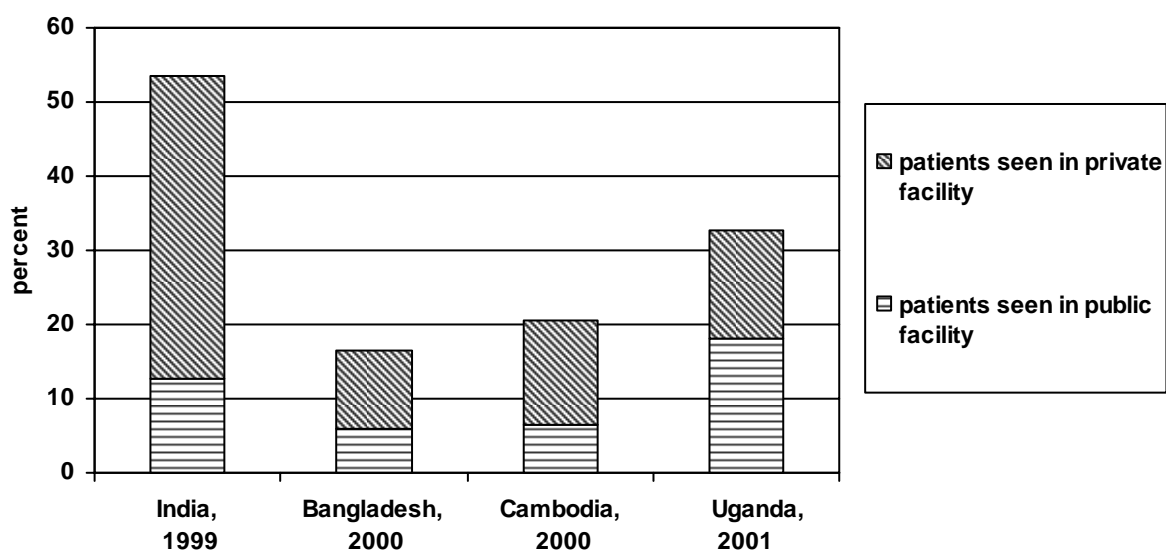
Figure A2
Total Global and World Bank Commitments for HIV/AIDS, 2000, 2002, 2004



Source: J. A. Izazola-Licea 2006.

Note: World Bank commitments reflect projects identified as having HIV/AIDS as a theme. World Bank commitments for HIV/AIDS in 2002 were approximately US\$9 million.

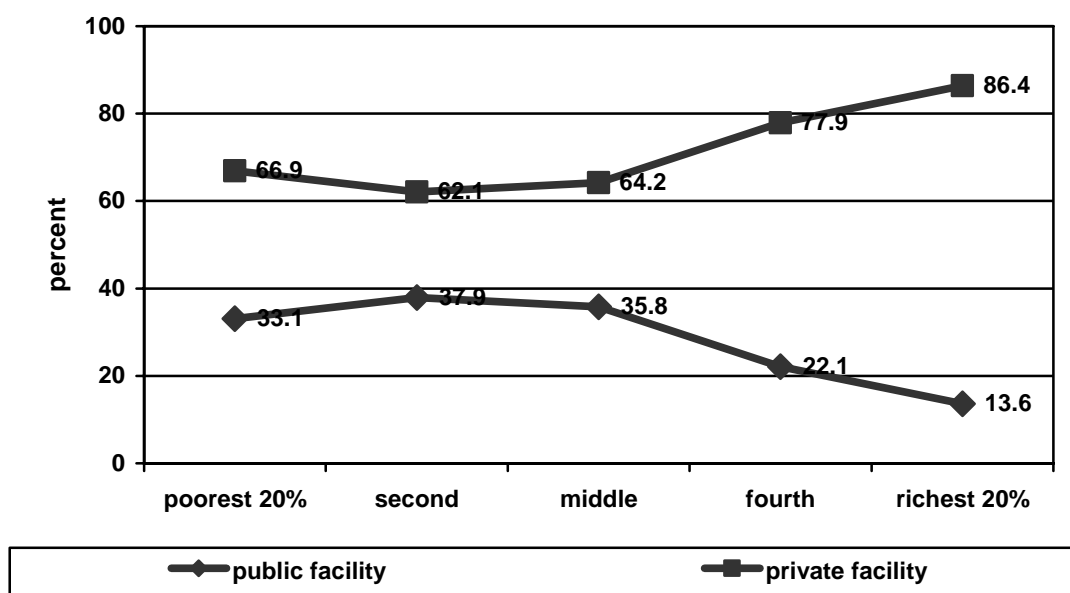
Figure A3
Treatment of Diarrhea



Source: HNP Strategy Facilitation Team. 2006. Adapted from World Bank Institute data (A. Yazbeck).

Note: Percentage of patients from poorest quintile seen in public or private facilities.

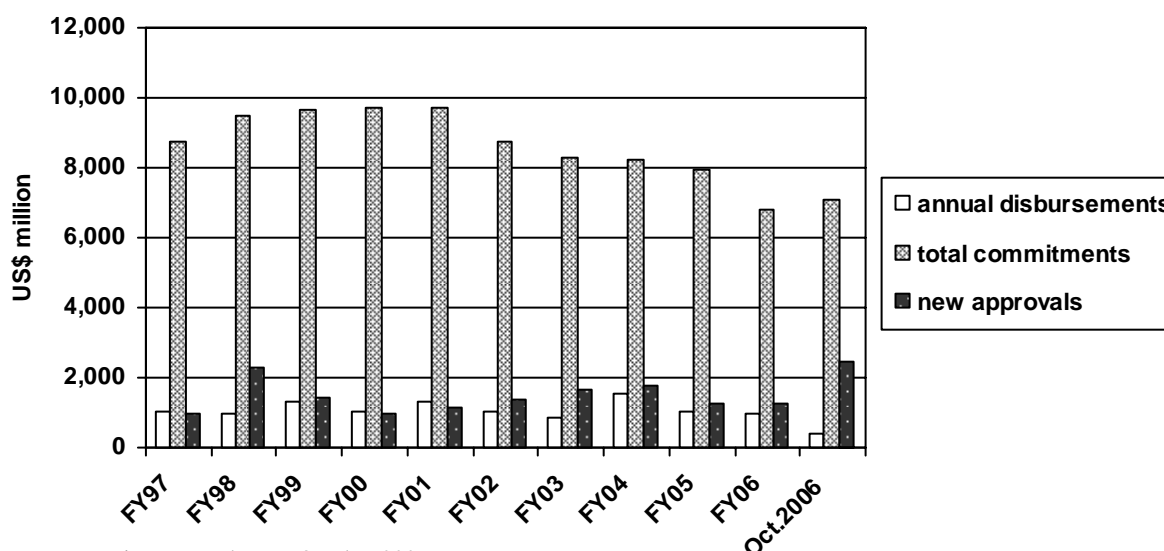
Figure A4
Who Uses Public or Private Health Facilities for Acute Respiratory Infections?
Dominican Republic



Source: HNP Strategy Facilitation Team. 2006. Adapted from World Bank Institute data (A. Yazbeck).

Note: Break-down by quintile.

Figure A5
All HNP Total Commitments, Disbursements and New Lending, FY1997–FY2006

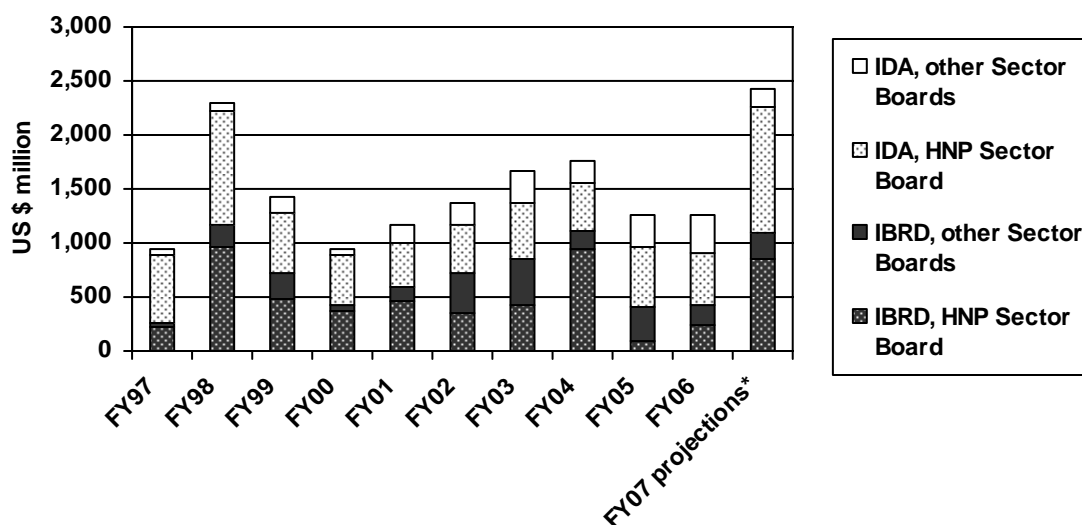


Sources: Business Warehouse, October 2006.

Note: Includes HNP Sector Board- and other Sector Board-managed lending (allocations to health, non-compulsory health finance, compulsory health finance).

For new lending, FY07 figures are projections – as of October 2006 – adjusted with the 0.7 coefficient of realism (ratio of approved new lending over target new lending at the beginning of a fiscal year as deduced by data manipulations from the past years in HNP).

Figure A6
Trends in IDA/IBRD Total New Lending for HNP, Managed by Sector Boards, FY1997–FY2006

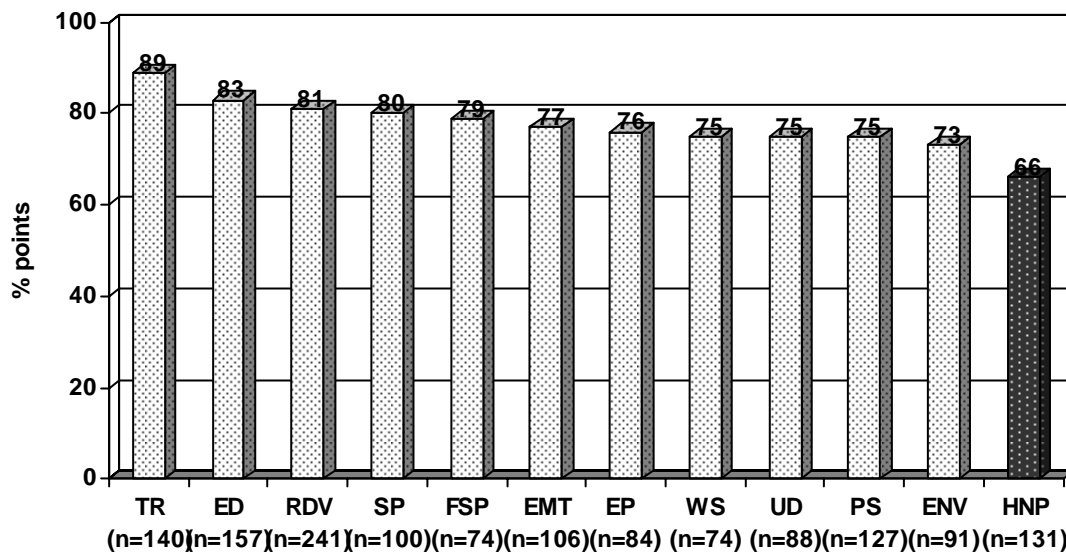


Source: Business Warehouse, HNP Quality Team, October 2006.

Note: Represents new health lending commitment trends, in US\$ million, broken down into International Development Agency and International Bank for Reconstruction and Development lending amounts.

*FY07 figures are projections adjusted with the 0.7 coefficient of realism (ratio of approved new lending over target new lending at the beginning of a fiscal year as deduced by data manipulations from the past years in HNP).

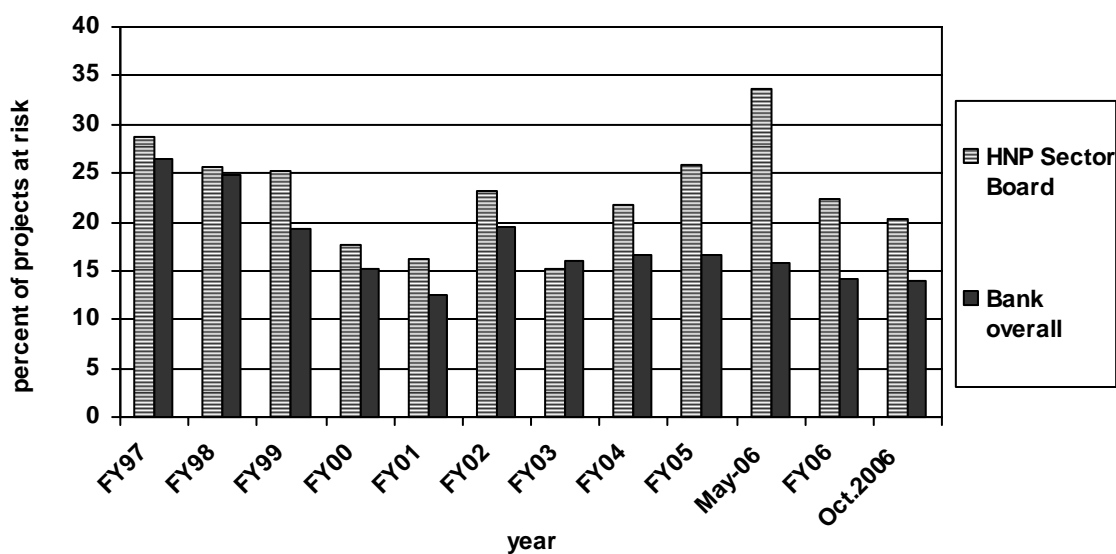
Figure A7
Project Outcomes, by Sector Board, FY2001–FY2006



Source: Based on IEG evaluations from Business Warehouse.

Note: Definition of acronyms by order of magnitude: Transport, Education, Rural Development, Social Protection, Financial Sector, Energy and Mining, Economic Policy, Water and Sanitation, Urban Development, Public Sector, Environment, and Health, Nutrition and Population.

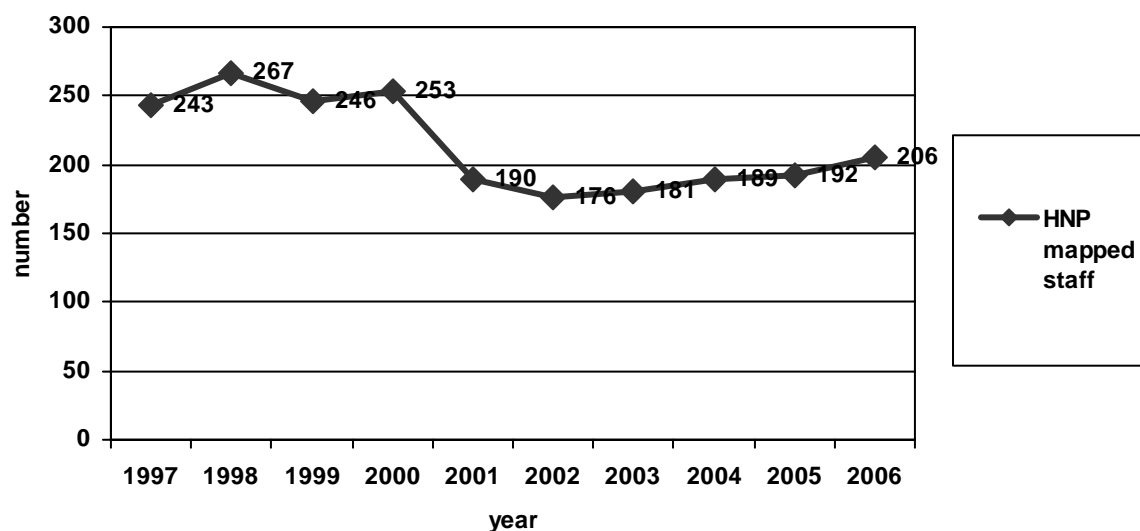
Figure A8
Trends in Portfolio Riskiness, HNP Sector Board vs. Bank Overall, FY1997-FY2006



Source: Business Warehouse, October 2006.

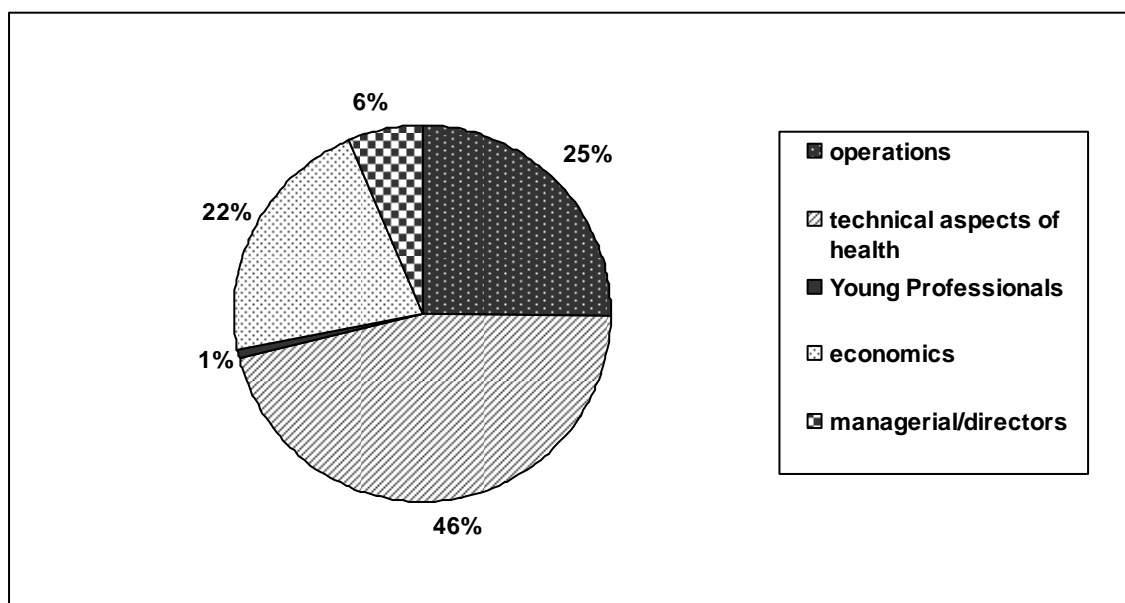
Note: Data for FY1997 – FY2006 are estimates of each fiscal year; end-October 2006.

Figure A9
Trends in HNP Mapped Staff, FY1997–FY2006



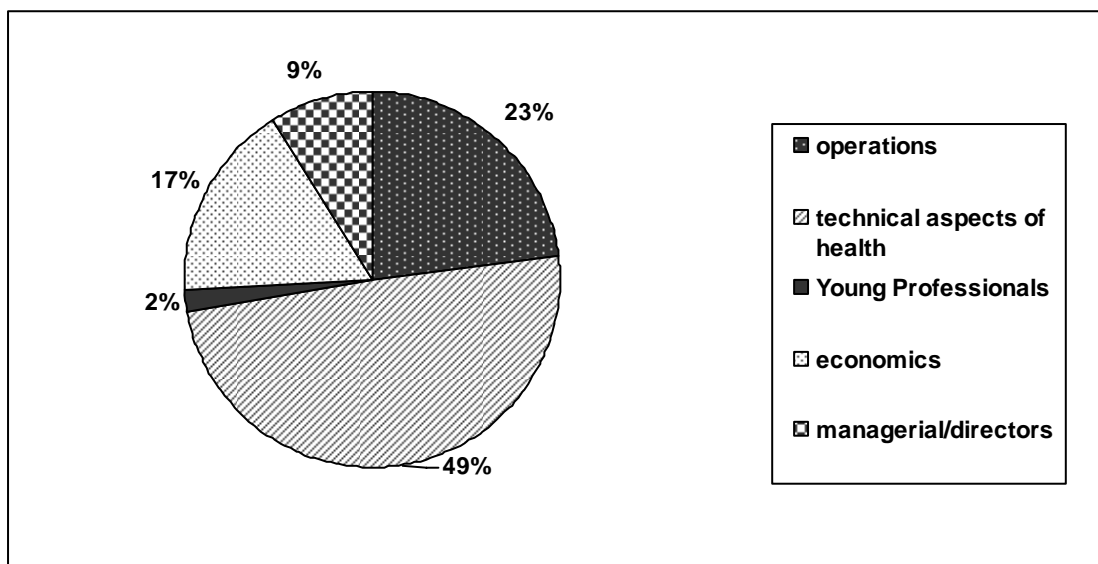
Source: Human Resources, October 2006.

Figure A10
Health Staff Composition, by Specialty, FY1997



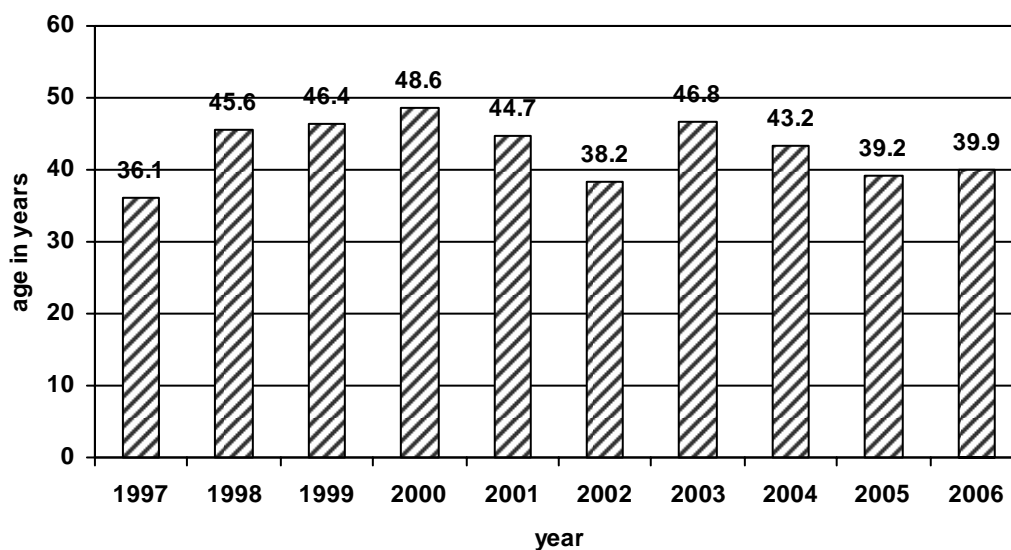
Source: Human Resources, October 2006.

Figure A11
Health Staff Composition, by Specialty, FY2006



Source: Human Resources, October 2006.

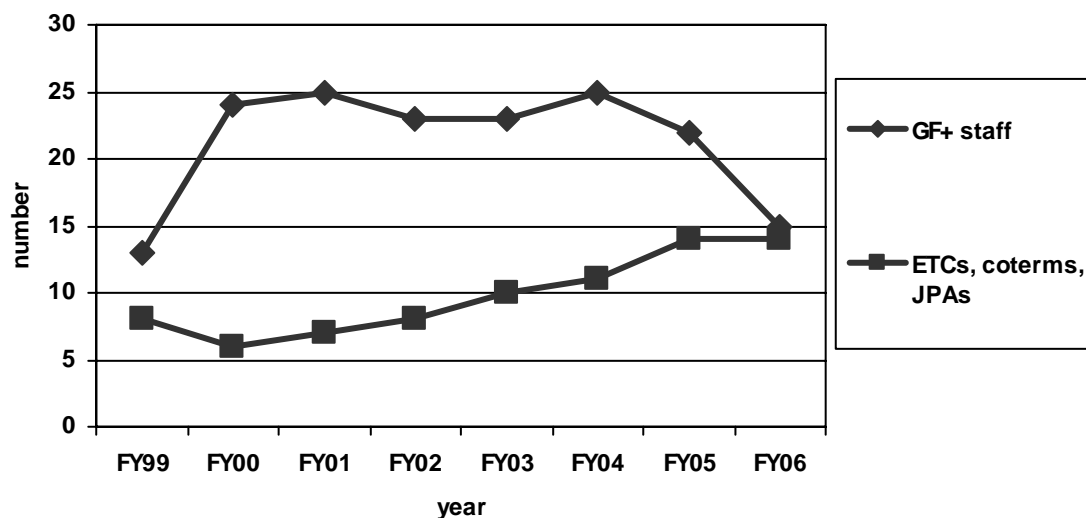
Figure A12
New HNP Hires, Average Age



Source: Human Resources, October 2006.

Note: Represents average age at hire of staff mapped to HNP.

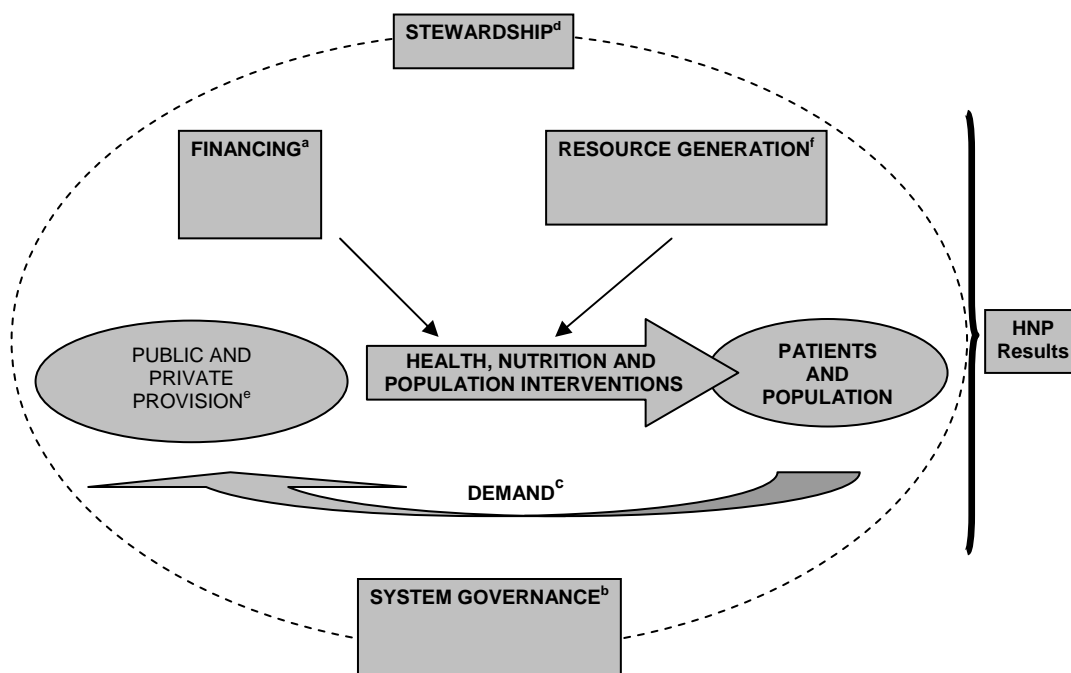
Figure A13
Staff Trends for HNP Hub, by Category, FY1999–FY2006



Source: HNP Strategy Facilitation Team, based on data from Human Resources, October 2006.

Note: “ETCs”: Extended Term Consultants; “Coterms”: Coterminous staff with open-ended or term appointments that are entirely funded from sources other than the Bank Group’s administrative budget; “JPAs”: Junior Professional Associates; “GF+ staff” represents staff with at least one master degree and 5 years or more of experience.

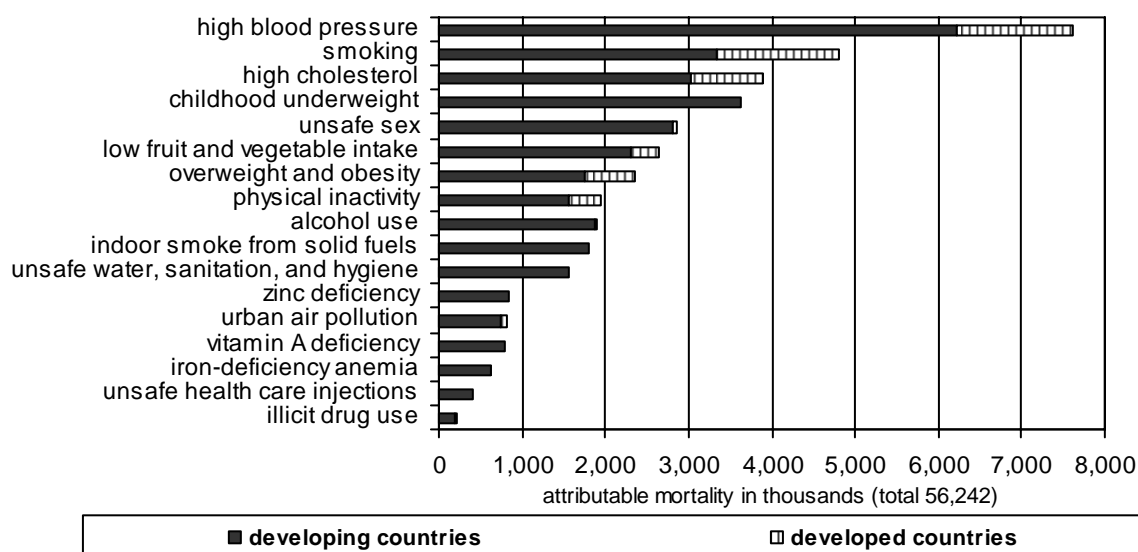
Figure A14
Health System Functions and Other Determinants of Good System Performance



Source: Based on the *World Health Report, 2000*, WHO.

- a. Includes funding (public, out-of-pocket, and DAH), contributions, pooling, and payment mechanisms.
- b. Includes financial management and procurement and “other” systems.
- c. Influenced by preferences, beliefs and behaviors.
- d. Oversight.
- e. Service delivery.
- f. Includes human resources, pharmaceuticals, and medical equipment.

Figure A15
Multisectoral Determinants of Global Burden of Disease



Source: Jamison et al. 2006.

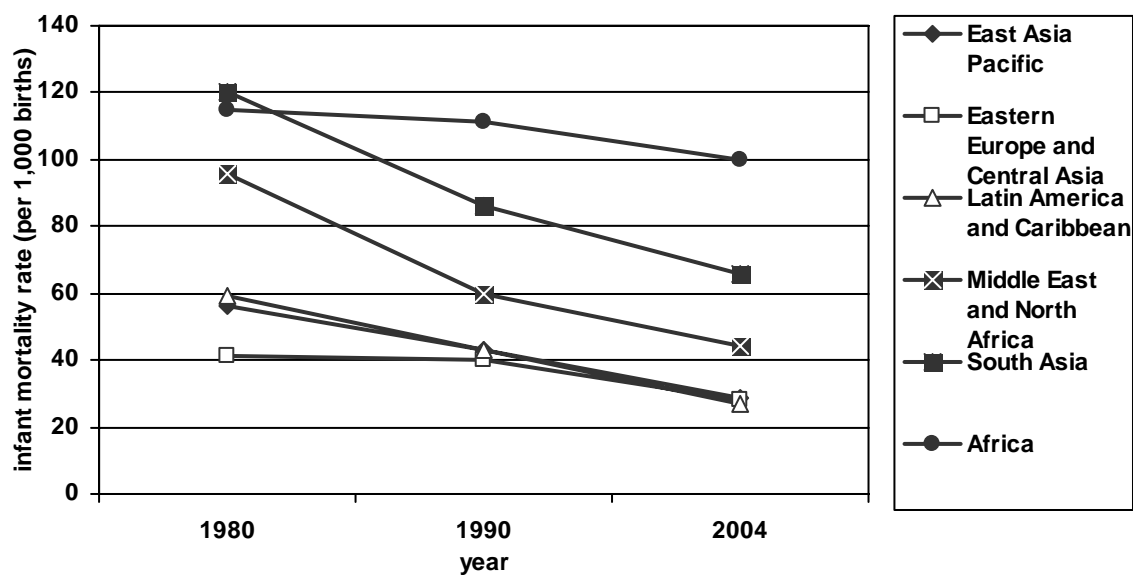
Table A1
IBRD Net Staff By Sector Mapping As Of 06/30/2006

SECTOR MAPPING	Net Staff
Environment	255
Rural Development	309
Social Development	165
Financial Sector	147
Education	181
Health, Nutrition and Population	206
Social Protection	138
Energy and Mining	133
Infrastructure	94
Transport	130
Urban Development	112
Water Supply and Sanitation	124
Financial Management	143
Operation Services	113
Poverty Reduction	171
Economic Policy	349
Poverty	76
Public Sector	101
PSD-Public Sector Development	144

Source: Human Resources, October 2006.

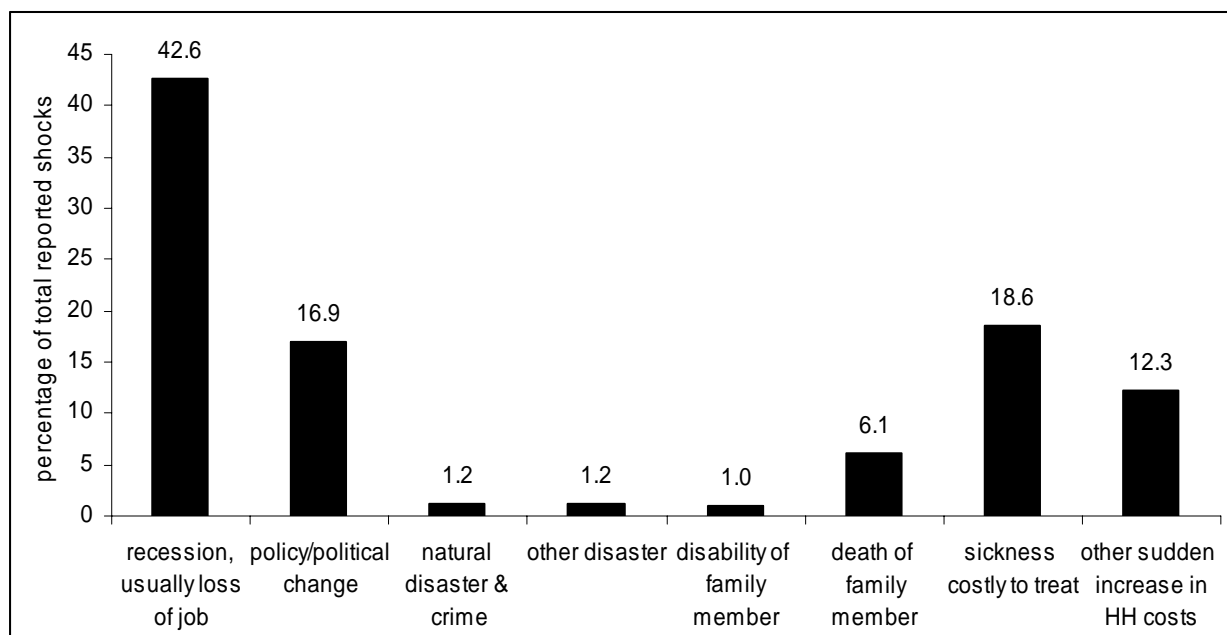
Note: These data include professional staff grade GF and above. Data do not include support staff (Administrative and Client Services [ACS], Information Solutions Network [ISN], Resource Management [RM]).

Figure A16
Trends in Infant Mortality, by World Bank Region, 1980, 1990, 2004



Source: World Bank 2001b, 2005h.

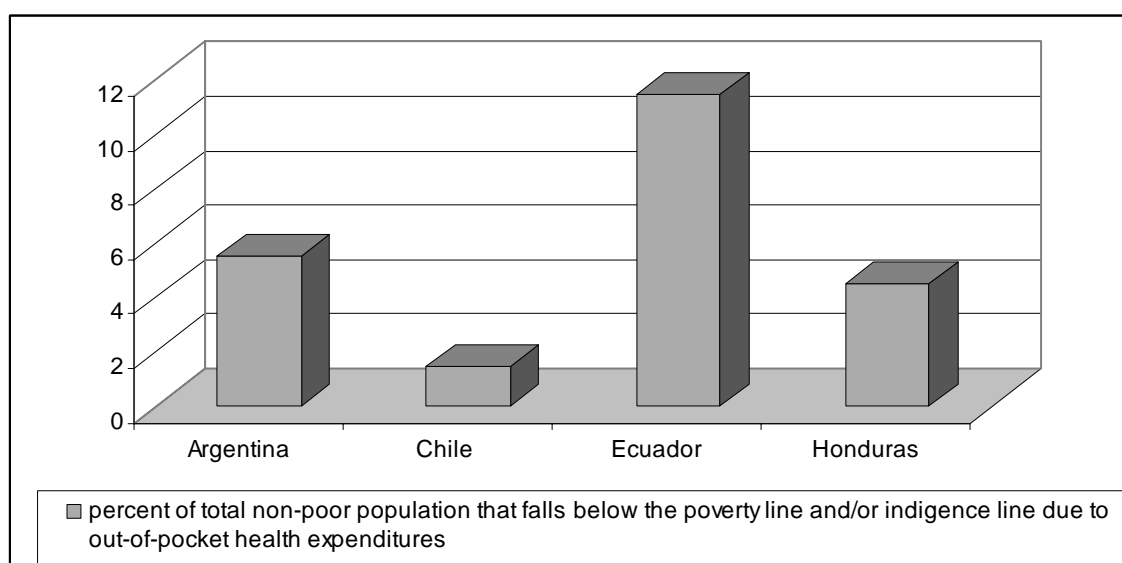
Figure A17
Most Frequent Shocks Causing Household Financial Stress, Peru



Source: Baeza and Packard 2006.

Note: Responses to survey question, "In the past three years, has your household experienced an event that has caused a significant loss of income?"

Figure A18
People Fall into Poverty due to Health Expenses



Source: Baeza and Packard 2006.

Note: Percentage of nonpoor population forced into poverty or indigence by out-of-pocket health expenses.

Table A2
Time Series Trends in Health Expenditures, Low-Income Countries, FY1999–FY2003

<i>All LICs</i>	FY1999–2003		FY1999–2003	
	<i>Fiscal expenditure</i>	<i>Private expenditure</i>	<i>External expenditure</i>	<i>Out-of-pocket expenditure</i>
1999	44.35	55.65	17.66	48.95
2000	45.07	54.93	19.70	47.77
2001	45.36	54.64	18.31	47.49
2002	46.37	53.63	16.48	46.84
2003	46.05	53.95	17.53	47.07

Source: WHO 2006b; World Bank 2005h.

Note: Total health expenditure is the sum of fiscal and private health expenditures. External resources for health are allocated to both public and private sources, but the proportion allocated to each is unknown. Out-of-pocket expenditures are one type of private expenditure, but in many low-income countries out-of-pocket spending accounts for the most private spending.

Table A3
Time Series Trends in External Expenditures for Health as Percent of Total Health Expenditures,
FY1997–FY2003

External^a							
<i>Income Level</i>	<i>1997</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>
Low-income countries	6.4	7.6	7.0	8.1	7.1	7.9	7.1
Lower-middle income countries	0.8	1.2	1.4	1.2	0.8	0.7	0.6
Upper-middle income countries	0.4	0.6	0.7	0.5	0.5	0.4	0.3
High-income countries	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Regions							
East Asia and Pacific	1.2	1.7	1.8	1.6	1.1	0.7	0.9
Eastern Europe and Central Asia	0.8	1.0	1.5	1.6	1.4	1.6	1.3
Latin America and the Caribbean	1.5	1.6	1.7	1.6	1.5	1.4	1.1
Middle East and North Africa	1.2	1.2	1.1	1.2	1.2	1.1	1.1
South Asia	3.3	3.9	2.5	3.2	2.3	2.5	2.9
Sub-Saharan Africa	12.6	16.0	16.3	18.3	17.1	17.8	14.8

Source: WHO 2006b; World Bank 2005h.

Note: The data in this table are population-weighted.

a. External resources for health are funds or services in kind that are provided by entities not part of the country in question. The resources may come from international organizations, other countries through bilateral arrangements, or foreign nongovernmental organizations. These resources are part of total health expenditures and are spent on both public and privately provided services.

Table A4
Time Series Trends in External Expenditures for Health as Percent of Fiscal Health Expenditures,
FY1997–FY2003

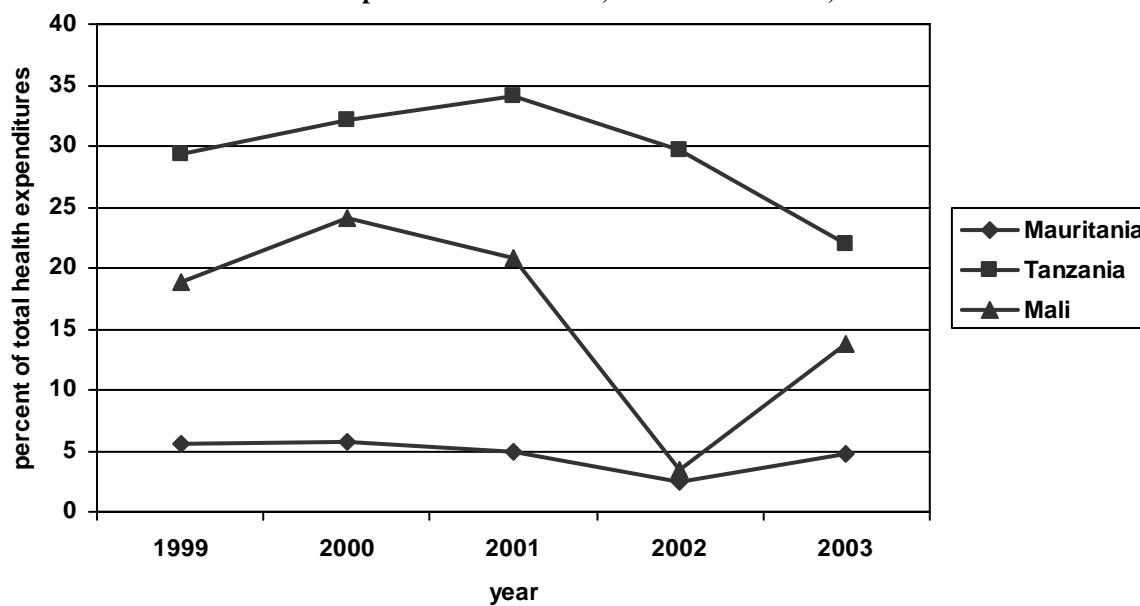
External^a							
<i>Income Level</i>	<i>1997</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>
Low-income countries	20.4	24.8	22.2	25.6	20.8	21.6	20.2
Lower-middle income countries	2.3	3.7	3.9	3.6	2.1	1.8	1.5
Upper-middle income countries	0.7	1.3	1.4	1.1	1.0	0.9	0.6
High-income countries	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Regions							
East Asia & Pacific	4.2	5.8	6.0	5.5	3.2	1.9	2.7
Eastern Europe & Central Asia	1.3	2.4	3.2	3.7	3.7	3.8	3.7
Latin America & the Caribbean	3.1	3.5	3.9	3.7	3.4	3.1	2.5
Middle East & North Africa	3.3	3.5	3.1	3.2	3.1	3.0	2.8
South Asia	15.9	13.7	9.6	13.6	8.7	10.1	10.5
Sub-Saharan Africa	27.9	48.5	45.8	49.9	44.3	44.8	37.9

Source: WHO 2006b; World Bank 2005h.

Note: The data in this table are population-weighted.

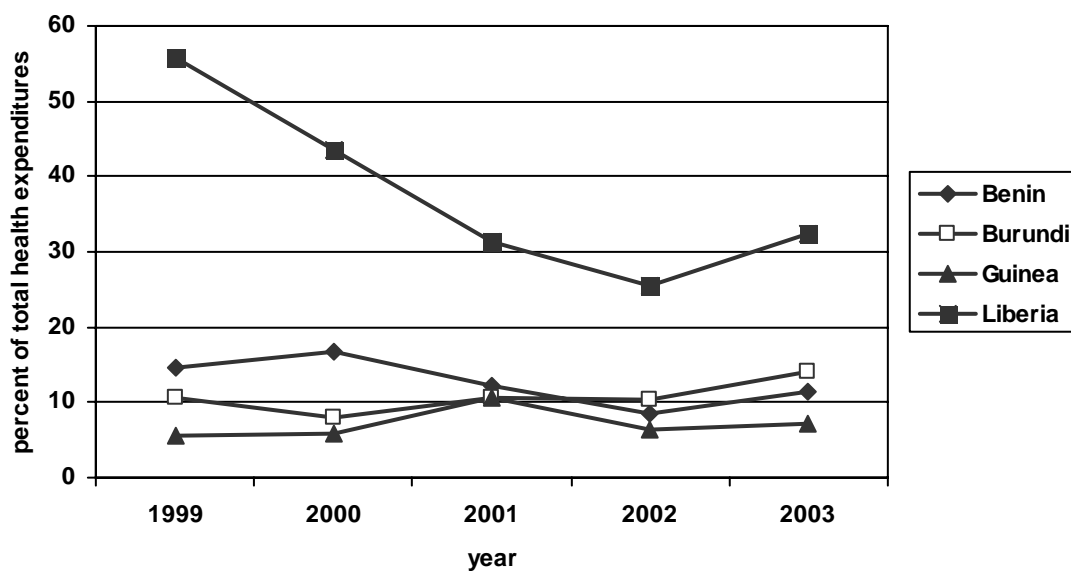
a. *External resources* for health are funds or in-kind services that are provided by entities not part of the country in question. The resources may come from international organizations, other countries through bilateral arrangements, or foreign nongovernmental organizations. These resources are part of total health expenditures and are spent on both publicly and privately provided services.

Figure A19
External Expenditures on Health, Selected Countries, 1999–2003



Source: WHO 2006b.

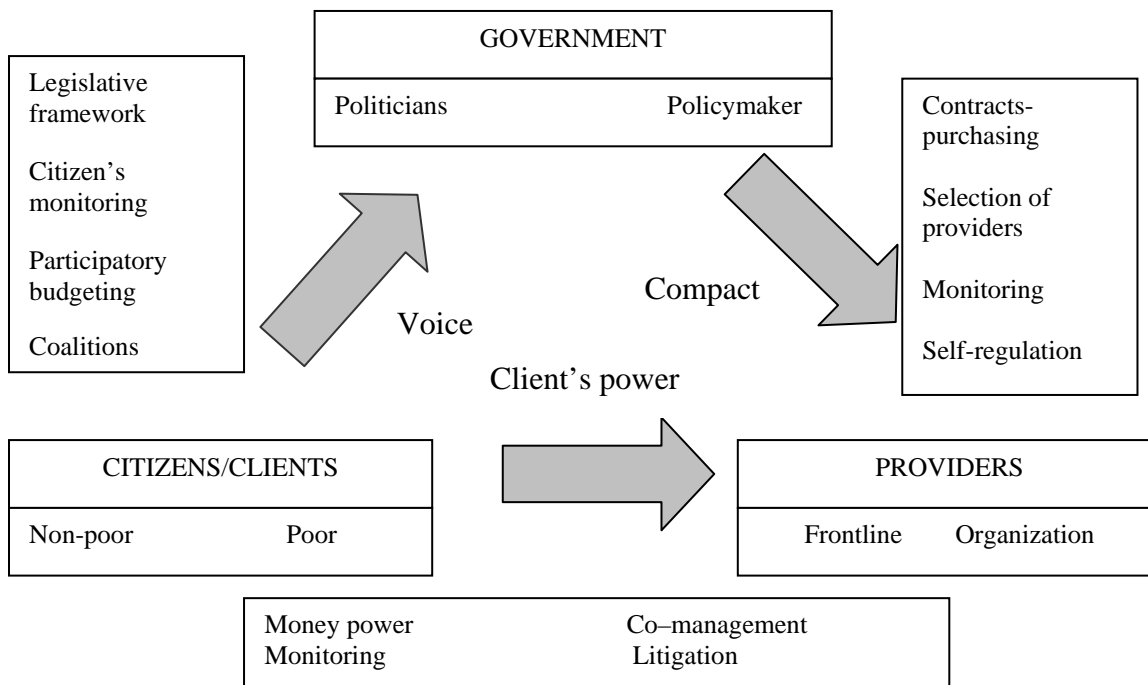
Figure A20
External Expenditures on Health, Selected Countries, 1999–2003



Source: WHO 2006b.

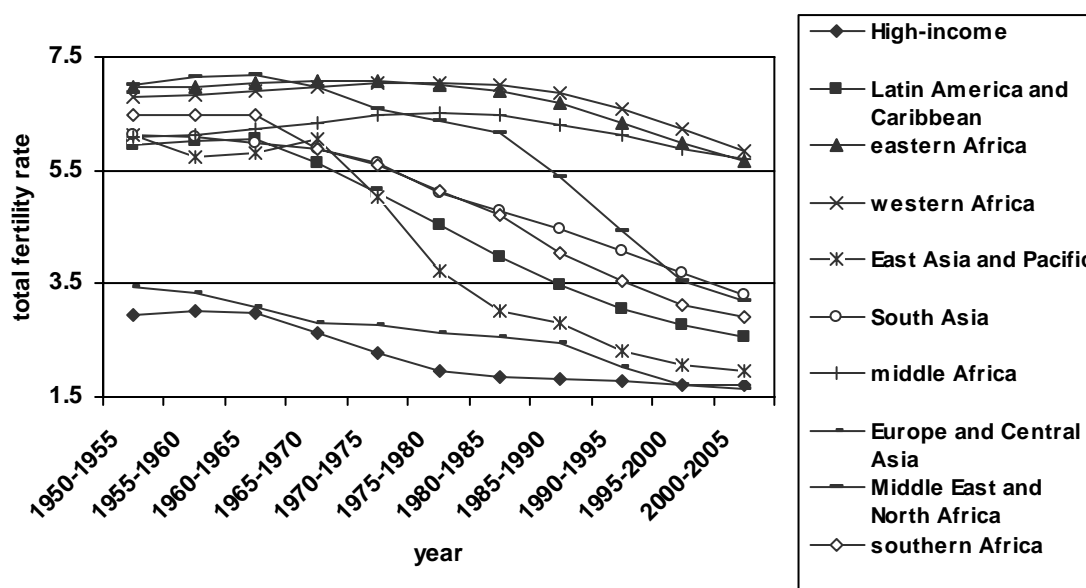
Figure A21

Creating Accountability in Health



Source: Adapted from World Bank 2003b.

Figure A22
Fertility Trends, by Geographic Region, 1950–2005



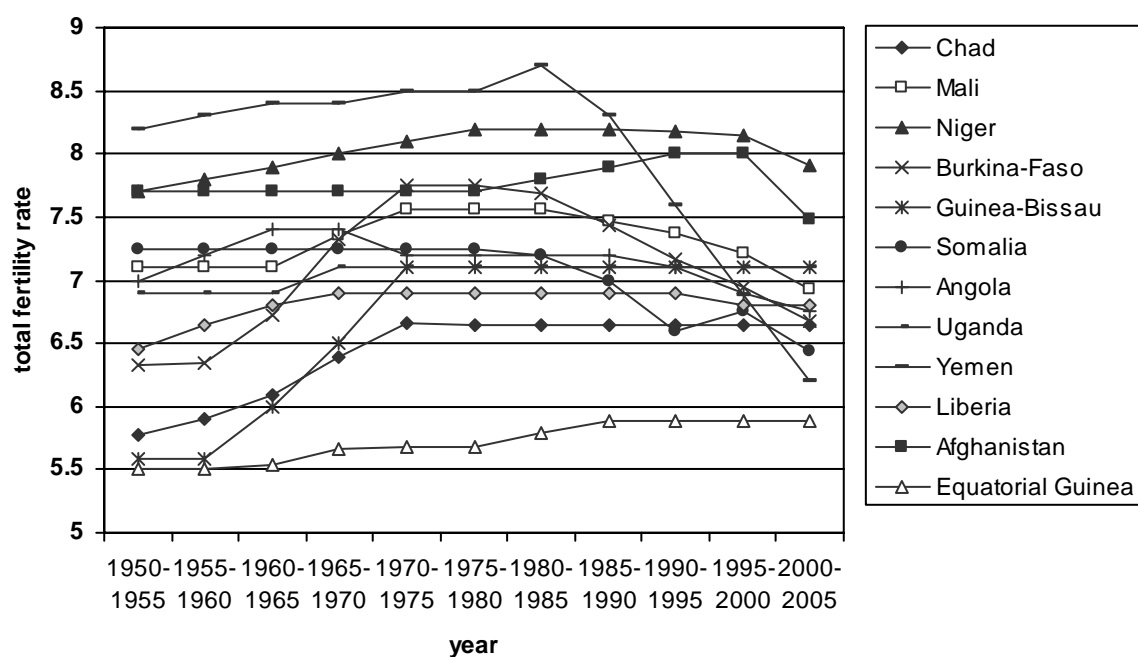
Source: UNFPA 2006.

Table A5
Some Characteristics of Countries by Fertility Rate

Indicator	Total fertility rate		
	Greater than 5 (range)	Between 5 and 2.5 (range)	Less than 2.5 (range)
Gross national income (GNI per capita, US\$)	344 [90–950]	1,110 [250–17,360]	10,502 [540–56,380]
Life expectancy at birth (years)	46 [38–61]	63 [36–79]	74 [61–82]
Under-5 mortality rate per 1,000	175 [59–283]	75 [6–156]	25 [3–106]
Primary completion rate, total (% of relevant age group)	52 [25–89]	93 [29–107]	98 [75–114]
Population age over 65 years (% total)	3 [2–3]	4 [2–10]	11 [1–20]

Sources: UN 2005; World Bank 2005h.

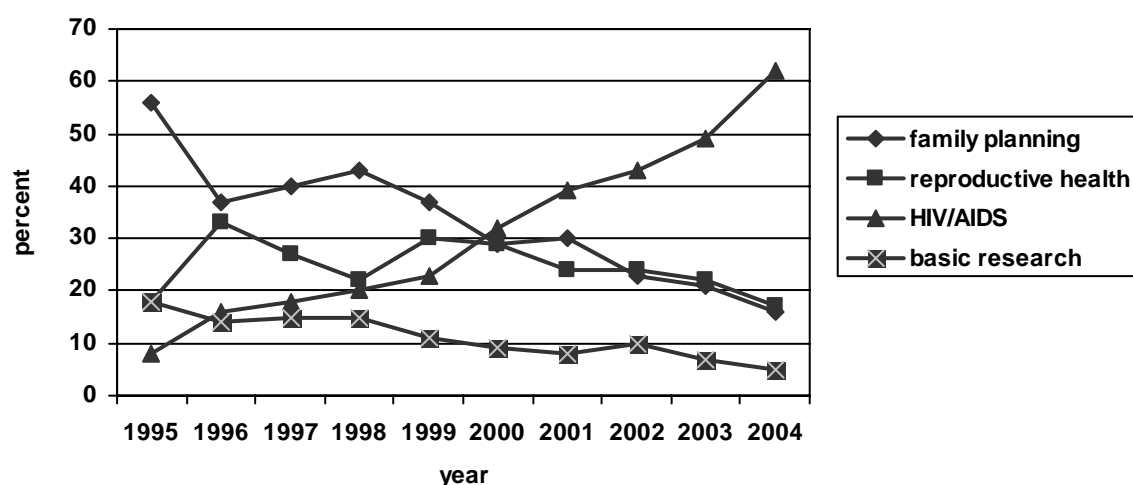
Figure A23
Fertility Trends, Selected High-Fertility Countries, 1950–2005



Source: UNFPA 2006.

Figure A24

Population Activities' Expenditures as Share of Total Population Assistance, 1995–2004



Source: UNFPA 2006.

Table A6

Nutrition Provision Rated a Top Investment by Copenhagen Consensus

<i>Rating</i>	<i>Challenge</i>	<i>Opportunity</i>
Very good	1. Diseases	Controlling HIV/AIDS
	2. Malnutrition and hunger	Providing micronutrients
	3. Subsidies and trade	Liberalizing trade
	4. Diseases	Controlling malaria
Good	5. Malnutrition and hunger	Developing new agricultural technologies
	6. Sanitation and water	Developing small-scale water technologies
	7. Sanitation and water	Implementing community-managed systems
	8. Sanitation and water	Conducting research in water and agriculture
	9. Government	Lowering costs of new business
Fair	10. Migration	Lowering barriers to migration
	11. Malnutrition and hunger	Improving infant and child malnutrition
	12. Diseases	Scaling up basic health services
	13. Malnutrition and hunger	Reducing the prevalence of low birth weight
Poor	14–17. Climate / migration	Various

Source: Bhagwati et al. 2004.

Table A7

Progress toward Non-income Poverty Target

On track (24%)			Deteriorating status (18%)		
AFR (7)	ECA (6)	MENA (6)	AFR (13)	ECA (4)	
Angola	Armenia	Algeria	Niger	Albania	
Benin	Croatia	Egypt	Burkina Faso	Azerbaijan	
Botswana	Kazakhstan	Iran	Cameroon	Russian Federation	
Chad	Kyrgyz Rep.	Jordan	Comoros	Serbia and Montenegro	
Gambia, The	Romania	Tunisia	Ethiopia		
Mauritania	Turkey		Guinea	LAC (3)	
Zimbabwe			Lesotho	Argentina	
			Mali	Costa Rica	
EAP (5)	LAC (10)	SAR (0)	Senegal*	Panama	
China	Bolivia		Sudan		
Indonesia	Chile		Tanzania	MENA (2)	
Malaysia	Colombia		Togo	Iraq	
Thailand	Dominican R.	Zambia		Yemen, Republic of	
Vietnam	Guyana		EAP (2)	SAR (2)	
	Haiti		Mongolia	Maldives	
	Jamaica		Myanmar	Nepal	
	Mexico				
	Peru				
	Venezuela				
Some improvement, but not on track (18%)			No trend data available (40%)		
AFR (14)	EAP (3)	MENA (1)	AFR (14)	ECA (17)	LAC (12)
CAR	Cambodia	Morocco	Burundi	Belarus	Belize
Congo, DR	Lao, PDR		Cape Verde	Bosnia and Herz.	Brazil
Côte d'Ivoire	Philippines	SAR (4)	Congo, Rep. of	Bulgaria	Dominica
Eritrea	Guatemala	Bangladesh*	Eq. Guinea	Czech Republic	Ecuador
Gabon	Honduras	India	Guinea	Estonia	Grenada
Ghana	Nicaragua	Pakistan	Guinea-Bissau	Georgia	Paraguay
Kenya		Sri Lanka	Liberia	Hungary	St. Kitts and Nev.
Madagascar	ECA (0)		Mauritius	Latvia	St. Lucia
Malawi			Namibia	Lithuania	St. Vincent
Mozambique	LAC (4)		São Tome and P.	Macedonia	Suriname
Nigeria	El Salvador		Seychelles	Moldova	Trinidad and Tob.
Rwanda	Guatemala		Somalia	Poland	Uruguay
Sierra Leone	Honduras		South Africa	Slovak Rep.	
Uganda	Nicaragua		Swaziland	Tajikistan	
				Turkmenistan	
			EAP (11)	Ukraine	MENA (2)
			Fiji	Uzbekistan	Djibouti
			Kiribati		Lebanon
			Marshall Is.		
			Micronesia		SAR (2)
			Palau		Afghanistan
			Papua N.G.		Bhutan
			Samoa		
			Solomon Is.		
			Timor-Leste		
			Tonga		
			Vanuatu		

Source: Author's calculations.

Note: All calculations are based on 1990-2002 trend data from WHO Global Database on Child Growth and Malnutrition (as of April 2005). Countries indicated by an asterisk subsequently released preliminary DHS data that suggest improvement and therefore may be reclassified when their data re officially released.

Source: World Bank 2006l.

REGIONAL ACTION PLANS

HNP HUB ACTION PLAN

ANNEX B

HNP HUB

The Health, Nutrition, and Population (HNP) Hub will facilitate HNP Network implementation of the new Strategy. In order to adequately play its role, the Hub will adjust its organizational structure and functioning in four work teams as follows:

Performance Monitoring and Action Team. This team will be responsible for (a) the maintenance of a database of HNP indicators, (b) the maintenance of a database of health financing indicators, (c) contributions to institutional reports (e.g., GMR, CPIA, World Development Report); (d) portfolio monitoring and quality enhancement, (e) monitoring and evaluation (M&E) capacity building (staff and clients), and (f) the regular updating of progress on the HNP Results Framework, including support to country teams on Results Framework development.

Global Health Coordination and Partnerships Team. The following functions will be covered; (a) coordinate work with global partnerships and initiatives; (b) facilitate selective fund raising and Trust Fund (TF) management for the HNP Network, (c) Development Grant Facility (DGF) management support; (d) selective joint ventures around themes of convergence (comparative advantages), and (e) harmonization and alignment.

Health Systems Policy Team. The preparation of the strategy has identified a gap in high-level health system policy skills to guide the implementation of the Bank agenda and an unmet demand from the Regions to receive timely support in their country dialog. It has also identified the need for practical and concrete advice to country teams and partners on how to overcome health system constraints to Development Assistance for Health (DAH) effectiveness for results. This will become even more pressing with the new policy drivers of the HNP Strategy. The team will (a) provide country teams with overall policy, technical, and operational advice on health systems; (b) manage knowledge creation on health systems, (c) develop and manage technical assistance for the Multisectoral Constraints Assessment (MCA) tool, and (d) respond to country-team demands on ensuring synergy between priority disease and system strengthening; (d) advise global partners on the health system aspects for which the Bank has comparative advantages. About 50 percent of the team's time will be allocated to country-team support and field work.

The team will focus closely on the following themes identified as priorities by client countries and global partners: (a) health financing and economics, including health insurance (b) linkage to macroeconomic and fiscal policy; (c) health service purchasing, (d) health system governance, and (e) synergy facilitation between priority disease and system strengthening in Bank operations.

Technical Aspects of Public Health, Nutrition, and Population. The team will support the Regions on technical aspects of disease control, nutrition, and population, drawing on in-house expertise but, more important, helping country teams establish the necessary working collaboration arrangements at country level with technical agencies such as WHO, UNICEF, UNFPA, and others.

Africa Region

Background

Health outcomes in the Africa Region are not progressing fast enough to achieve economic growth and reduce poverty (table B1), and the Region is unlikely to meet the health Millennium Development Goals (MDGs). Laboring under geographical, environmental, cultural, and political challenges, the HIV/AIDS crisis puts a heavier burden on Africa than on any other part of the world. What should be the Africa Region's response to the situation?

Table B1. Health Indicators in the Africa Region

Income group/country	GNI per capita, 2005 (US\$)	Health expenditure, 2004 (% of GDP)	External assistance, 2004 (% of total)	U-5 mortality, 2005 (per 1,000 live births)	MMR modeled estimates, 2000 (per 100,000 live births)	Prevalence of child malnutrition 2000-06 (% of underweight U-5 children)	HIV prevalence, 2005 (% of total population, ages 15-49)
LOW INCOME							
Benin	510	4.9	10.2	150	850	30	1.8
Burkina Faso	400	6.1	26.8	191	1000	38	2.0
Burundi	100	6.7	28.5	190	1000	45	3.3
Central African Republic	350	4.1	47.7	193	1100	24	10.7
Chad	400	4.2	7.0	208.3	1100	37	3.5
Comoros	640	2.8	18.3	71	480	25	0.1
Congo, Dem. Rep.	120	4.0	19.1	205	990	31	3.2
Côte d'Ivoire	840	3.8	5.0	195	690	17	7.1
Eritrea	220	4.5	59.6	78	630	40	2.4
Ethiopia	160	5.3	35.2	127.0	850	38	1.4
Gambia, The	290	6.8	23.0	137	540	17	2.4
Ghana	450	6.7	29.9	112	540	22	2.3
Guinea	370	5.3	9.5	160.0	740	33	1.5
Guinea-Bissau	180	4.8	31.6	200	1100	25	3.8
Kenya	530	4.1	18.3	120	1000	20	6.1
Liberia	130	5.6	37.8	235	760	27	n.a.
Madagascar	290	3.0	45.5	119	550	42	0.5
Malawi	160	12.9	59.4	125.3	1800	22	14.1
Mali	380	6.6	13.8	218	1200	33	1.7
Mauritania	560	2.9	20.2	125	1000	32	0.7
Mozambique	310	4.0	55.9	145	1000	24	16.1
Niger	240	4.2	21.3	256	1600	40	1.1
Nigeria	560	4.6	5.6	194	800	29	3.7
Rwanda	230	7.5	37.1	203	1400	23	3.0
São Tome and Principe	390	11.5	53.3	118	n.a.	13	n.a.
Senegal	710	5.9	12.8	118.7	690	23	0.9
Sierra Leone	220	3.3	35.4	282	2000	27	1.6

Income group/country	GNI per capita, 2005 (US\$)	Health expenditure, 2004 (% of GDP)	External assistance, 2004 (% of total)	U-5 mortality, 2005 (per 1,000 live births)	MMR modeled estimates, 2000 (per 100,000 live births)	Prevalence of child malnutrition 2000-06 (% of underweight U-5 children)	HIV prevalence, 2005 (% of total population, ages 15-49)
Somalia	n.a.	na	na	225	1,100	33	0.9
Sudan	640	4.1	5.1	90	590	41	1.6
Tanzania	340	4.0	27.1	122	1,500	22	6.5
Togo	350	5.5	8.9	139	570	n.a.	3.2
Uganda	280	7.6	25.2	136	880	23	6.4
Zambia	490	6.3	36.3	182	750	23	17.0
Zimbabwe	340	7.5	13.1	132	1,100	n.a.	20.1
MIDDLE INCOME							
Angola	1,350	1.9	9.1	260	1,700	31	3.7
Botswana	5,180	6.4	2.5	120	100	13	24.1
Cameroon	1,010	5.2	5.3	149	730	18	5.4
Cape Verde	1,870	5.2	20.7	35	150	n.a.	n.a.
Congo, Rep.	950	2.5	3.6	108	510	n.a.	5.3
Equatorial Guinea	n.a.	1.6	3.8	205	880	19	3.2
Gabon	5,010	4.5	1.3	91	420	12	7.9
Lesotho	960	6.5	8.7	132	550	18	23.2
Mauritius	5,260	4.3	1.4	15	24	n.a.	0.6
Mayotte	n.a.	na	na	n.a.	n.a.	n.a.	n.a.
Namibia	2,990	6.8	16.9	62	300	24	19.6
Seychelles	8,290	6.1	2.4	13	n.a.	n.a.	n.a.
South Africa	4,960	8.6	0.5	68	230	n.a.	18.8
Swaziland	2,280	6.3	9.5	160	370	10	33.4

Source: World Bank. (2007). *2007 World Development Indicators*. Washington, DC: World Bank.

Strategic Directions: How Should the Bank Support Country Efforts?

Renew Bank focus on HNP results

Opportunities exist for the Africa Region to help clients improve HNP outcomes through a specific focus on fiscal and economic policy. The Africa Region staff **work closely with central ministries on designing Poverty Reduction Strategies (PRSPs)**, and assist with **public sector reform** initiatives. Achieving **more efficient and equitable spending and allocation of resources** will entail evidence-based planning to target resources where they will do the most to improve outcomes and **reduce disparities between regions and groups**. Because absent or weak accountability mechanisms undermine HNP strategies, the Bank, tapping **its expertise in public sector governance**, will assist country efforts to **strengthen national and subnational accountability mechanisms**.

Strengthen health systems for HNP results

The World Bank will emphasize health systems as a key vehicle for improving HNP outcomes and protecting people from the impoverishing impact of illness. The Africa Region will draw on the Bank's global knowledge base and experience to help strengthen systems and institutional

capacity, focusing on: (a) health workforce limitations; (b) access to, and management of, pharmaceuticals; (c) institutional frameworks, including planning and budgeting capacity (d) pro-poor service delivery, and (e) expanding household demand for services.

Multisectoral action to improve HNP outcomes

Because many determinants of health lie outside the health sector, the World Bank has a unique opportunity to foster multisectoral action in the Africa Region. From the Bank's decision to emphasize multisectoral action for HIV/AIDS, lessons applicable to other diseases have begun to emerge. Areas where **collaboration will increase synergy** include: **education, agriculture and food security, water and sanitation, road safety, energy, telecommunications, and environmental actions.**

Sustainable financing of HNP interventions

Total health expenditures in Sub-Saharan Africa (SSA) average 6 percent of GDP and US\$13 per capita per year, compared with 5.6 percent and US\$71 per capita per year in other developing countries. The poorest 18 African countries spend much less, an average of only US\$2.10 per capita in 2000. Debt relief and DAH have helped lighten the health care load, and governments are trying out a variety of strategies to manage health financing. Classical health insurance is not an option in most SSA countries because formal employment is low and perceptions and practice of corruption fragment the solidarity and confidence on which insurance must be founded. However, a number of countries have started to experiment with community financing such as health funds, mutual health organizations, rural health insurance, revolving drug funds, and prepayment initiatives.

Payment remains a major obstacle to use of health services among Africa's poor, and user payments still pay for up to half of health expenditures in some SSA countries. In 2000, private expenditure represented between US\$0.50 and US\$21 per capita per year in the 38 poorest African countries. This is an issue that the Africa Region is following.

The Africa Region can help countries address efficiency and equity issues by finding the right mix of public expenditures and international financing over the medium-term. The Marginal Budgeting for Bottlenecks (MBB) instrument has been introduced in at least 10 countries. Work is also being done on contracting for services, including capitation-based payments. Deriving and disseminating lessons on public and private expenditures for health will be a priority for the Africa Region.

Implications for Operations in the Africa Region

In line with the Africa Action Plan of April 2005, the Africa Region HNP operations aim to achieve sustainable improvements on MDG-related indicators with high-impact interventions:

- Helping countries build outcome-oriented and evidence-based national strategies, plans, and budgets, building on global knowledge and experience.
- Strengthening the capacity of client countries' health systems to implement these strategies.
- Integrating the scaling-up of support to malaria control and HIV/AIDS, and interventions to combat malnutrition and child and maternal mortality.
- Helping clients mobilize domestic resources and international financing.

- Monitoring and evaluating (M&E) the impact of country strategies on the health outcomes and helping countries develop their own M&E systems.

In line with the Paris Declaration on Harmonization and Aid Effectiveness, the Africa Region will support country-level negotiations to reach agreement between the government and development partners on improving aid alignment and effectiveness.

The Region will continue to promote sectorwide approaches to help ensure that strengthened public and private health care systems are mutually reinforced by disease-specific programs. To that effect, project implementation units should be avoided and common implementation procedures should be an objective. Africa Region staff must ensure that clients receive the best possible technical support and refer them to other partners, as necessary.

HNP activities will be financed through both investment projects and development policy lending (DPL). The Africa Region's approach to the transfer of resources is shifting from free-standing projects toward programmatic lending. Adaptable Program Loans/Credits (APLs) would support long-term commitment to sector programs. PRSCs or Sector Adjustment Loans/Credits would be preferred if the government has the proper systems and procedures in place. In some settings, such as post-conflict African countries, strengthening the Bank's presence in the sector through more targeted subsectoral operations may be required before engaging the country in discussions of a sectorwide approach.

East Asia and Pacific Region

Background

As one of the most diverse regions in the world, East Asia and the Pacific (EAP) Region encompasses some of the world's least-developed countries (e.g., Cambodia, Timor Leste) and some of the most rapidly emerging economies (e.g., China, Vietnam). Countries in the Region also differ along other dimensions—size, epidemiological profile (table B2), vulnerability to natural disasters, and political stability. Yet some regional trends and patterns are discernable. Overall, the Region has seen rapid growth, both a cause and a consequence of increasing migration and urbanization, but inequalities have also widened—across individuals, urban and rural areas, and regions within countries. All these changes create both opportunities and challenges in the HNP sector.

Most countries in the Region face a double burden of disease, with non-communicable diseases becoming increasingly important, while infectious diseases persist and new and re-emerging diseases strain scarce health resources further. Moreover, the nutrition and population agendas remain important in many countries. At a system level, decentralization, rising inequalities, expanding needs and expectations, and a large private sector role in both financing and service delivery have brought health system issues to the fore. While the need for health system reform is increasingly recognized, the consequences of pandemics have also become apparent following the SARS epidemic, AHI outbreaks, and the ever-present threat of HIV/AIDS. As a result, public health surveillance and outbreak control have gained importance in many countries of the region.

Table B2. Health Indicators in East Asia and Pacific Region

Income group/country	GNI per capita, 2004 (US\$)	Health expenditure, 2004 (% of GDP)	External assistance, 2004 (% of total)	U-5 mortality, 2005 (per 1,000 live births)	MMR modeled estimates, 2000 (per 100,000 live births)	Prevalence of child malnutrition, 2000–05 (% of underweight U-5 children)	HIV prevalence, 2005 (% of total population, ages 15–49)
LOW INCOME							
Cambodia	350	6.7	28.5	87.3	450	36	1.6
Korea, Dem.Rep.	n.a.	5.6	0.0	55	67	24	na
Lao PDR	390	3.9	10.2	79	650	40	0.1
Mongolia	600	6.0	4.6	49	110	13	0.1
Myanmar	n.a.	2.2	13.1	105	360	32	1.3
Papua New Guinea	560	3.6	26.5	74.4	300	n.a.	1.8
Vietnam	540	5.5	2.0	19	130	28	0.5
MIDDLE INCOME							
China	1,500	4.7	0.1	27	56	8	0.1
Indonesia	1,140	2.8	1.3	36	230	28	0.1
Malaysia	4,520	3.8	0.1	12	41	11	0.5
Philippines	1,170	3.4	3.6	33	200	28	0.1
Thailand	2,490	3.5	0.3	21	44	n.a.	1.4

Source: World Bank. (2007). *2007 World Development Indicators*. Washington, DC: World Bank.

Strategic Directions: How Should the Bank Support Country Efforts?

Overview

The HNP Strategy in the World Bank's EAP Region calls for a focus on improved health outcomes for the poor; enhancing the performance of health care systems; and securing sustainable health care financing. Within that framework, each country team has developed a strategy for HNP that is consistent with the Country Assistant Strategy (CAS) and which responds to both demands from client countries and Bank capacity. The country-specific strategy also takes into account the role and activities of other development partners.

In a region as diverse as EAP and with a strong MIC presence, **a strong country focus is essential and will be maintained as the Bank moves forward, emphasizing HNP outcomes and results.**

- **In middle-income countries, the focus is on using various tools for innovation, learning, and addressing reform issues.** Lending is expected to continue, but it will be centered on health system strengthening and supported by a strong program of analytic work. Analytic work and lending on disease-specific issues will continue where there is demand and a strategic role for the World Bank.
- **In low-income countries, external financing from the World Bank and other development partners will play an important role relative to domestic resources.** Donor coordination is critical. As in middle-income countries, support of health system strengthening through both analytic work and lending will be important, but improved donor coordination and multi-sectoral work to address broader determinants of health outcomes are also critical elements of success. Where governance and fiduciary systems permit, development policy lending will gain importance, but investment lending is likely to remain a relevant instrument.

Renew Bank focus on HNP results

Focus on HNP outcomes and results is an integral part of both the ongoing portfolio and pipeline activities. This includes:

- *Outcome-based country strategies:* As in other regions, country strategies provide the basis for the HNP work program. Drawing on the regional strategy and the global HNP strategy, country teams in the EAP Region prepare country strategy notes for the HNP sector. These strategy notes seek to identify key constraints to improving HNP outcomes, as well as strategic areas for WB support to address these constraints, serve as the basis for dialog with government and key partners at country-level.
- *Strong Results Framework in programs and AAA work:* Some of the success stories include the Timor health program,⁵⁷ the HIV/AIDS prevention project in Vietnam that supported the development of a monitoring and evaluation framework, the National Sector Support for Health Reform Project in the Philippines that has piloted performance-

⁵⁷ Bustreo, F., Genovese, E., Omobono, E., Axelsson, H., and I. Bannon. (2005). *Improving Child Health in Post-Conflict Countries: Can the World Bank Contribute?* Washington, DC: World Bank Group.

based contracts between central and local government, and the Health Eight Project in China that has demonstrated results that have helped influence policy of rural health delivery programs in China.

- *Impact evaluation of selected programs:* The Region has invested, and will continue to invest, in selected impact evaluation efforts. These are integral to the overall knowledge generation and sharing efforts of the Bank to help inform broader policy dialog and program design.

Strengthen health systems for HNP results

Many countries in the region are exploring ways to make health financing more equitable, increase access to health care, improve the performance of both public and private health care providers, strengthen pharmaceutical systems, and address imbalances in the health workforce. Reforms in these areas are particularly challenging as they are often being implemented in contexts where governance arrangements, intergovernmental fiscal relations, and social security systems are changing at the same time. Given these challenges, client demand for support on health system strengthening, and on related governance and public sector management issues, has seen significant growth. Ongoing and planned activities include both lending and analytic work, often with strong complementarities.

Ensure synergy between health system strengthening and priority-disease interventions

The limited number of disease-specific programs in the Region reflect client demand and regional issues. Nevertheless, emphasis should be put on systemic issues and linkages to broader health sector reform.

Multisectoral action to improve HNP outcomes

Cross-sectoral collaboration is an essential element of outcome-based strategies. These collaborations can take several forms: (a) policy alignments with other sectors; (b) joint sectoral programs to achieve desired impacts on health outcomes; and (c) working with other sectors to achieve desired HNP outcomes. However, it is important to identify which cross-sectoral tasks are likely to produce the desired impacts on HNP outcomes.

Strategic partnerships

Strategic partnerships are fundamental to the EAP Strategy and are important for both analytic work and lending operations. The key for such partnerships is how they work at the country level and leverage the overall agenda. Several business models developed through the various partnerships provide the flexibility needed to respond to client and donor needs.

Diverse product lines

The EAP Region has been expanding its product line to respond to various demands and improve results. The Comprehensive Development Partnership model in Thailand (an excellent approach to work in partnership with MIC clients), the DFID-Bank partnership in China, the different partnership models and stand-alone trust-funded operations, and the various lending instruments used for cross-sectoral work all reflect the wide range of AAA, lending, and partnership products

being used. Impact evaluation is also seen as another stand-alone product line. Making sure that the different products come together at the country level is now critical to achieve the desired HNP outcomes and results.

Eastern Europe and Central Asia Region

Background

In the ECA Region, the new World Bank HNP Strategy will have to reflect real and growing differences (table B3) between countries and subregions. Implementation approaches will have to be custom-made to fit specific country and / or subregional situations. A large part of ECA HNP staff is based in the field, which increases the ability to be responsive to counterpart needs.

Table B3. Health Indicators in the Eastern Europe and Central Asia Region

Income group/country	GNI per capita, 2005 (US\$)	Health expenditure, 2004 (% of GDP)	External assistance, 2004 (% of total)	U-5 mortality, 2005 (per 1,000 live births)	MMR modeled estimates, 2000 (per 100,000 live births)	Prevalence of child malnutrition, 2000-05 (% of underweight U-5 children)	HIV prevalence, 2005 (% of total population, ages 15-49)
LOW INCOME							
Kyrgyz Republic	440	5.6	15.1	67	110	7	0.1
Tajikistan	330	4.4	9.1	71.4	100	n.a.	0.1
Uzbekistan	510	5.1	3.9	68	24	8	0.2
MIDDLE INCOME							
Albania	2,580	6.7	2.4	18	55	14	n.a.
Armenia	1,470	5.4	7.2	29.4	55	3	0.1
Azerbaijan	1,240	3.6	1.6	89	94	7	0.1
Belarus	2,760	6.2	n/a	11.5	35	n.a.	0.3
Bosnia and Herzegovina	2,440	8.3	1.3	15	31	4	0.1
Bulgaria	3,450	8.0	1.0	15	32	n.a.	0.1
Croatia	8,060	7.7	0.4	7	8	n.a.	0.1
Czech Republic	10,710	7.3	0.0	4	9	n.a.	0.1
Estonia	9,100	5.3	0.5	7	63	n.a.	1.3
Georgia	1,350	5.3	9.8	45	32	n.a.	0.2
Hungary	10,030	7.9	0.4	8	16	n.a.	0.1
Kazakhstan	2,930	3.8	0.9	73	210	n.a.	0.1
Latvia	6,760	7.1	0.3	11	42	n.a.	0.8
Lithuania	7,050	6.5	3.1	9	13	n.a.	0.2
Macedonia, FYR	2,830	8.0	1.4	17	23	n.a.	0.1
Moldova	880	7.4	4.8	16.1	36	4	1.1
Poland	7,110	6.2	0.1	7	13	n.a.	0.1
Romania	3,830	5.1	25.0	19	49	3	0.1
Russian Federation	4,460	6.0	0.1	17.5	67	6	1.1
Serbia and Montenegro	3,280	10.1	0.5	15	11	2	0.2
Slovak Republic	7,950	7.2	0.0	8	3	n.a.	0.1
Turkey	4,710	7.7	0.0	29	70	4	n.a.
Turkmenistan	..	4.8	0.4	104	31	12	0.1
Ukraine	1,520	6.5	0.7	17	35	1	1.4

Source: World Bank. (2007). *2007 World Development Indicators*. Washington, DC: World Bank.

Strategic Directions: How Should the Bank Support Country Efforts?

Renew Bank focus on HNP results

The evolving issues across the ECA Region, together with the priorities reflected in the new HNP Strategy, have resulted in a focused and quantifiable set of results-based indicators:

- HIV/TB rates in line with MDG targets.
- Nutritional MDG targets achieved in Central Asia and Caucasus.
- Premature death and disability from noncommunicable diseases reduced by 20 percent.
- Increased sector transparency and improved governance, as measured by reduction in informal payments and transparent drug procurement.
- Inequalities in access to necessary services reduced by 25 percent—particular focus on minorities.
- Health care infrastructure at sustainable levels, providing continuum of services at high-quality health and cost-effectiveness.
- Increase by 25 percent in patient satisfaction with service quality.
- Introduction by ECA countries of risk-pooling arrangements, guaranteeing minimum protection and risk mitigation for poor.
- Development by ECA countries of plans for demographic transition, including long-term care financing and service provision.
- Improved understanding, among decision makers, of public health and cross-sectoral dimension of health determinants (e.g., transport, water, infrastructure, education).

Strengthen health systems for HNP results

Improved results must also be achieved on health system issues such as transparency, governance, informal payments, access to health services, and measurement of results. The largely unfinished agenda of ensuring appropriate health infrastructure, including necessary intersectoral linkages to other types of social services, will also need priority attention. This will become increasingly important as more and more of the Soviet-era infrastructure wears out.

ECA HNP sees an increasing emphasis from counterparts on health financing and fiscal sustainability (e.g., provider payments, benefits packages, informal payments), as well as capacity building, including policy development, human resources management, health services planning (including with respect to rationalization of health facilities and services), health care management, quality improvement, national health accounts, and improved monitoring and evaluation systems. This reflects an ongoing shift from “rowing” to “steering” in the counterpart Ministries of Health, and the concomitant need for adaptation by other parts of the health system. Other evolving issues center on medical education and regulatory / governance functions (training / retraining, continuous medical education, licensing, and accreditation).

Multisectoral action to improve HNP outcomes

The **upgrading of public health/surveillance capability** is an important issue in many countries, underscored by recent developments regarding avian flu. In light of the changing demographics and rapid aging in many ECA countries, **appropriate provision and financing of long-term care** is another emerging issue with significant multisectoral implications, especially as related to

the social protection system. Many countries are interested in **private health insurance** as a way of relieving pressure on government programs, but good examples to date are scarce. Similarly, a number of countries have expressed interest in **health savings accounts** and have asked for World Bank assistance in exploring this issue.

The unfinished health infrastructure agenda will require **increased interaction with the energy and infrastructure sectors**, to ensure that proposed approaches are the most cost-effective available. Gains from energy efficiency investments alone could yield significant pay-offs in terms of freeing up resources for direct service delivery.

Strategic partnerships

Key technical partners in ECA include WHO-EURO, CDC, ECDC, OECD, and the IMF. Strategic partners would include the European Commission, the European Investment Bank, and IFC (potentially in the area of public-private partnerships). A critical partnership is the ongoing collaboration with the European Observatory on Health Systems and Financing, which is supported by the World Bank (through the Development Grant Facility).

Implications for Operations in the ECA Region

Overall, it is expected that there will be **less emphasis on direct financing of health infrastructure and equipment, but an increasing need for developing capacity for health technology assessment and attention on developing facility rationalization strategies, a large, unfinished agenda in most ECA countries.**

Ensuring **high-quality portfolio performance** is important as an accountability indicator, but also as evidence of the Bank's comparative advantage. There will also be a growing need to continue **exploring a widened range of instruments for supporting client countries**, including reimbursable TA, jointly funded programs, and subnational lending (in some countries).

Both **budget and staffing issues** are interlinked constraints to achieving these results. In the face of declining Bank budgets (resulting from reduced lending activity), maintaining policy dialog with countries across the Region becomes increasingly difficult (box B1). Perhaps even more important, **continuity and relationship management issues** must be addressed if the Bank is going to be successful. The skill set needed will include direct hands-on experience in health system reform and management, health financing, and other key areas, as well as the ability to identify needs, coherently engage in discussions with counterparts, and quickly arrange for these needs to be addressed in a substantive way. This will be a critical element for maximizing both the Bank's ongoing engagement as well as new business opportunities: improving the capacity of staff to choose the right approach to meeting counterpart needs in terms of lending instruments, nonlending support, technical assistance, and policy dialogue.

Box B1.
HNP and the MIC Agenda

The Bank, in its relations with middle-income client countries, will seek to:

- Become reestablished as their partner of choice in development knowledge and finance, for its reservoir of global expertise, range of products and services, attractive financial terms, and ability to catalyze support from other partners.
- Maintain and, where possible, increase the quality of lending and other services to meet increased demand.
- Strengthen the ability of its staff to respond to the specific needs of the diverse group of MIC countries.

These principles encourage MICs to continue or resume borrowing, by removing impediments and providing other “value-added” benefits, such as policy advice and technical assistance. But what about countries that either no longer need or want to borrow? The lack of sustained engagement, in the absence of lending, weakens business development efforts and client relations generally, thus reducing further the prospects for new lending business. This is perhaps a more critical issue in HNP, where in-depth knowledge of the sector takes time and ongoing involvement.

Source: Board Paper on “Enhancing World Bank Support to Middle-Income Countries,” September 2006.

Latin America and the Caribbean Region

Background

Following a wave of health sector reforms, countries in the Latin America and the Caribbean Region (LCR) have made great strides in the way they finance, regulate, and deliver health care. Overall, impressive gains have been made in health outcomes and services in the past 15 years, but generalizations are difficult in so widely diverse an area. Some groups have benefited far more than others from these advances, and results have been insufficient in some key areas such as malnutrition and maternal mortality (table B4).

Table B4. Health Indicators in the Latin America and the Caribbean Region

Income group/country	GNI per capita, 2005 (US\$)	Health expenditure, 2004 (% of GDP)	External assistance, 2004 (% of total)	U-5 mortality, 2005 (per 1,000 live births)	MMR modeled estimates, 2000 (per 100,000 live births)	Prevalence of child malnutrition, 2000-06 (% of underweight U-5 children)	HIV prevalence, 2005 (% of total population, ages 15-49)
LOW INCOME							
Haiti	450	7.6	14.2	120	680	17	3.8
MIDDLE INCOME							
Argentina	4,470	9.6	0.2	18	82	4	0.6
Barbados	..	7.1	2.0	12	95	n.a.	1.5
Belize	3,500	5.1	5.3	17.2	140	n.a.	2.5
Bolivia	1,010	6.8	9.1	65	420	8	0.1
Brazil	3,460	8.8	0.0	33	260	n.a.	0.5
Chile	5,870	6.1	0.1	10	31	1	0.3
Colombia	2,290	7.8	0.1	21.4	130	7	0.6
Costa Rica	4,590	6.6	0.8	12	43	n.a.	0.3
Dominica	3,790	5.9	3.0	15	n.a.	n.a.	..
Dominican Republic	2,370	6.0	1.5	31	150	5	1.1
Ecuador	2,630	5.5	0.8	25	130	12	0.3
El Salvador	2,450	7.9	1.2	27	150	10	0.9
Grenada	3,920	6.9	1.5	21	n.a.	n.a.	..
Guatemala	2,400	5.7	2.3	43	240	23	0.9
Guyana	1,010	5.3	8.2	63	170	14	2.4
Honduras	1,190	7.2	8.7	40	110	17	1.5
Jamaica	3,400	5.2	1.4	20	87	4	1.5
Mexico	7,310	6.5	0.3	27	83	n.a.	0.3
Nicaragua	910	8.2	11.3	37	230	10	0.2
Panama	4,630	7.7	0.2	24	160	n.a.	0.9
Paraguay	1,280	7.7	1.9	23	170	5	0.4
Peru	2,610	4.1	1.3	27.3	410	7	0.6
St. Kitts and Nevis	8,210	5.2	1.8	20	n.a.	n.a.	..
St. Lucia	4,800	5.0	0.7	14	n.a.	n.a.	..
St. Vincent and the Grenadines	3,590	6.1	0.1	20	n.a.	n.a.	..
Suriname	2,540	7.8	9.7	39	110	13	1.9
Trinidad and Tobago	10,440	3.5	0.2	19	160	6	2.6
Uruguay	4,360	8.2	0.3	15.1	27	n.a.	0.5
Venezuela, RB	4,810	4.7	0.0	21.3	96	4	0.7

Source: World Bank. (2007). *2007 World Development Indicators*. Washington, DC: World Bank.

Strategic Objectives: What HNP Results?

Given the heterogeneity of the Region, the scope of Bank activities is necessarily broad. Consistent with its new HNP Strategy and in line with its comparative advantages, the Bank will continue to help countries pursue four broad Strategic Objectives: improve focus on the poor to reduce inequity; strengthen government attention to public goods; improve health financing for greater equity, efficiency, and sustainability; and improve health system stewardship and governance.

Strategic Directions: How Should the Bank Support Country Efforts?

Renew Bank focus on HNP results

LCR has used the Bank's comparative advantage to help countries improve results in health and nutrition, with an emphasis on reducing inequalities by targeting the poor and most vulnerable population groups.

For example, the Bank supported *Argentina* in developing and implementing a new maternal and child health insurance program (*Plan Nacer*), targeting poor and indigenous women and children living in urban and rural parts of the nine poorest provinces. Twenty months after the project went into effect, half of the eligible population (400,000 beneficiaries) was enrolled in the program. Ten months after the federal government negotiated targets with provincial health authorities, an average of 7 out of 10 indicators had been achieved or surpassed. Similar results-based models are being employed in *Ecuador*, *Nicaragua*, and *Paraguay* in Bank-supported projects.

Strengthen health systems for HNP results

In high-middle-income and several low-middle-income LCR countries where most of the population has access to basic health care services, governments are expanding social protection in health. Other low-middle-income countries where the provision of basic services is still an important challenge are focusing on strengthening health systems to expand the supply of these services.

The Bank has supported countries' efforts to strengthen health systems by developing new organizational and institutional arrangements to extend social protection in health, with a focus on basic health care services for poor mothers and children. Some of these projects include the *Argentina* Maternal and Child Health Insurance, the Health Sector Reform in *Bahia, Brazil*, the PROCEDES Project in *Mexico*, and Maternal and Child Basic Health Insurance in *Paraguay*. The regional study *Beyond Survival: Protecting Households from Health Shocks in Latin America* (2006) has launched a regional dialog on this urgent topic.

In *Nicaragua* the Bank has worked with other development partners (UNFPA, IADB, and the governments of Austria, Holland, Finland, and Sweden) in supporting the government's national strategy and action plan to strengthen the health system to improve access to basic health care services. In *Peru*, the first Health Reform APL supported development of insurance for nearly three million mothers and children. In both countries, good results have been confirmed in coverage and equity.

During *Argentina*'s socioeconomic and political crisis that reached its peak in 2002, the Bank helped the government maintain the health system's capacity to deliver basic health services and goods to the poor and the uninsured. The Health Emergency Project was part of a

multisectoral strategy and supported the government's effort to transform this major challenge into an opportunity to strengthen the health system.

Ensure synergy between health system and priority disease interventions

The Bank works closely with governments in IDA-eligible or IBRD / IDA-mixed countries to balance single-disease and targeted programs with health system strengthening. In Honduras and Nicaragua, for example programs that prioritize mother and child health interventions are fully integrated within the national strategies and action plans to improve national health care systems. In 10 *Caribbean countries and Central America*, the Bank is supporting HIV/AIDS programs that foster complementarities between health care systems and other important actors.

Multisectoral action to improve HNP outcomes

The HNP team in LCR works actively with other sectors and departments on a broad range of analytical and operational work initiatives. Recent examples include a multisectoral analysis combining HNP, the chief economist of the Bank, Social Protection, PREM, and the government of *Mexico*, reviewing options for improving social protection in Mexico. The last Institutional and Governance Review of *Bolivia*, led by PREM with the active involvement of HNP, analyzed policy options for an inclusive decentralization process. In the *Dominican Republic* HNP and PREM coordinated action on public sector reform to improve human resource policy effectiveness and national health procurement accountability. A new basic services and employment project is being prepared in *Brazil*, where HNP worked with teams from the Water Supply and Sanitation and the Sustainable Development Sectors to design a project to improve quality of life and reduce poverty.

Malnutrition is a serious intersectoral problem that hinders economic growth and improvement of population well-being in several LCR countries. The design and implementation of conditional cash transfer (CCT) projects offered HNP an opportunity to work with Social Protection, Education, and PREM to improve health and nutritional outcomes among poor mothers and children in *El Salvador* and *Ecuador*. Nutrition work is also underway in *Guatemala* and *Peru*.

Strategic partnerships

The LCR Region will continue to engage in strategic partnerships such as the multi-organizational review of HIV/AIDS projects in the Caribbean in 2006, conducted in collaboration with the Global Fund, UNAIDS, DFID, and PAHO / WHO. In coordination with UNFPA, the Bank Maternal and Child Health Care Project in Argentina supported the launch of a new reproductive health program and procurement of inputs, giving poor women, for the first time, access to preventive and family planning services.

Implications for Operations in the LCR Region

The chief constraint on LCR health work is the declining budget, which is beginning to erode the Region's capacity. The diminishing personnel budget has already imposed a small contraction on the Unit, which, even by Bank standards, already carries a very heavy workload. This constrains

analytic work and may become a growing business impediment in a Region where the clients are technically sophisticated and expect state-of-the-art advice from the Bank.

Middle East and North Africa Region

Background

The Middle East and North Africa (MENA) Region has made significant improvements in the health status of its people (table B5). However, high rates of infant and maternal mortality, malnutrition, and micronutrient deficiencies persist in the low- income countries and among certain population groups in middle-income countries. With growing prosperity, the prevalence of lifestyle-related noncommunicable diseases is rising.

Table B5. Health Indicators in the Middle East and North Africa Region

Income group/country	GNI per capita, 2004 (US\$)	Health expenditure, 2004 (% of GDP)	External assistance, 2004 (% of total)	U-5 mortality, 2005 (per 1,000 live births)	MMR modeled estimates, 2000 (per 100,000 live births)	Prevalence of child malnutrition, 2000–05 (% of underweight U-5 children)	HIV prevalence, 2005 (% of total population, ages 15–49)
LOW INCOME							
Yemen	570	5.0	15.0	102	570	46	n.a.
Djibouti	960	6.3	34.0	133	730	27	3.1
MIDDLE INCOME							
Algeria	2,270	3.6	0.0	39	140	10	0.1
Egypt	1,250	5.9	#N/A	33	84	9	0.1
Iran	2,330	6.6	0.2	36	76	n.a.	0.2
Iraq	n.a.n.a.	5.3	2.5	125	250	16	n.a.
Jordan	2,260	9.8	7.1	26	41	4	n.a.
Lebanon	6,040	11.6	1.7	30	150	4	0.1
Morocco	1,570	5.1	0.9	40	227	10	0.1
Syria	1,270	4.7	0.2	14.5	160	7	n.a.
Tunisia	2,650	#N/A	#N/A	24	120	4	0.1
West Bank and Gaza	n.a.	#N/A	#N/A	23	100	5	n.a.
GULF COOPERATION COUNTRIES							
Bahrain	14,370	4.0	0.0	11	28	n.a.	n.a.
Kuwait	24,040	2.8	0.0	11	5	n.a.	n.a.
Oman	9,070	3.0	0.0	12	87	n.a.	n.a.
Qatar	n.a.	2.4	0.0	21	23	n.a.	n.a.
Saudi Arabia	10,170	3.3	#N/A	26	23	n.a.	n.a.
United Arab Emirates	23,770	2.9	0.0	8.5	54	n.a.	n.a.

Source: World Bank. (2007). *2007 World Development Indicators*. Washington, DC: World Bank.

Strategic Objectives: What HNP Results?

The MENA HNP Strategic Objectives reflect the varying needs of four categories of countries at different stages of economic development:

- *Yemen and Djibouti*, the two IDA countries in the Region, face the greatest challenges and are at risk of not meeting the HNP-related MDGs. In Djibouti, the HIV/AIDS epidemic is taxing the country's economic resources.

- *Middle-income countries* (Algeria, Egypt, Iran, Jordan, Lebanon, Libya, Morocco, Syria, and Tunisia) are generally on track for achieving the health MDGs but rural / urban disparities in health outcomes and gaps in health coverage persist.
- *Members of the Gulf Cooperation Council* (GCC), assisted by high oil revenues, have achieved universal access to health services and good health outcomes, but still have room for efficiency and quality improvements.
- *Conflict-affected countries* are suffering significant reversals in health status and deterioration of their health systems (West Bank and Gaza, Iraq, and Lebanon).

Strategic Objectives: What HNP Results?

The HNP business strategy for the MENA Region will need to **find an appropriate balance in responding to growing demand for knowledge products and to emergency and reconstruction operations**. Due to the availability of alternative financing, the Bank is not seen as a primary source. The HNP team will **capitalize on the Bank's extensive international knowledge base** and analytical capacity in health systems.

Strategic Directions: How Should the Bank Support Country Efforts?

Renewing the Focus on HNP Results

A regional HNP Strategy Report (ESW) is proposed for FY08 to develop a conceptual framework for defining the HNP Results Framework for the MENA Region. In parallel, the HNP team will review the portfolio to identify potential synergies and gaps in AAA and lending and to ensure timely application of the framework in upstream work on Country Assistance Strategy. A major investment will be needed to develop effective monitoring and evaluation tools for measuring HNP Results.

Strengthening health systems for HNP Results

Across the MENA Region, demand is growing for health system modernization. The challenge is to define the areas in which the Bank has a comparative advantage. The following priority areas are identified: health finance reforms to improve financial protection and access to health care; improving the performance of health service delivery systems; and enhancing the governance and stewardship role of the state in the health sector.

Many governments in the MENA Region are seeking alternatives to their centralized government-managed health system, toward a more pluralistic system that includes active private sector participation. Demand is growing in the Region for technical advice on design and implementation of effective governance and regulatory functions, particularly accountability, where the Bank has a comparative advantage.

Multisectoral action to improve HNP outcomes

Within the MNSHD department, the introduction of an HD coordinator function has contributed to a more integrated approach to Human Development (Education, Social Protection, and HNP) at country level. Under this framework, **HNP and SP teams collaborate closely** in the areas of social security administration and health insurance. MENA Region programs on youth and early

childhood development include a significant health component and offer a basis for strengthening collaboration between the **HNP and Education teams**.

Other opportunities for collaboration are being explored in the Water and Sanitation and the **Urban and Transport Sectors**. With the PREM group, the MENA HNP team will be collaborating on two priority regional themes: **gender, and governance and anticorruption**. Finally, the MENA HNP team has been seeking active partnership with **IFC** and the **Private Sector Unit** in MENA to promote private-public partnership in health.

Strategic partnerships

As part of the MENA Regional Strategy, the HNP team will expand its collaboration with **key regional partners** and continue to work with bilateral, multilateral, and private donors in partnership with the IBRD and IDA countries receiving funding from these sources. To enhance the ability of policy makers and health care managers to evaluate the impact of HNP policies and programs, the Bank is collaborating with **international organizations, nongovernmental organizations, and academic institutions** to establish a *Middle East and North Africa Health Policy Forum*, modeled on the European Observatory on Health Systems and Policies.

Addressing the needs of fragile states and conflict-affected countries

An increasing share of Bank resources and HNP staff time is being directed toward mobilizing and coordinating contributions from the donor community during reconstruction in Iraq, Lebanon, and West Bank and Gaza. In this, MENA HNP team will work closely with the new Fragile States Unit (FSU) and Conflict Prevention and Reconstruction Unit (CPRU). The Bank could play an important role in bridging the gap between short-term humanitarian operations and longer-term development activities and in ensuring adequate attention to investments in human capital in recovering countries.

Reimbursable technical assistance

Reimbursable programs in the MENA Region increased from US\$6 million in FY04 to US\$10 million in FY06, some 12 percent of the MENA FY06 budget. Most of the growth occurred under reimbursable technical assistance (RTA), now comprising about US\$7 million. RTA will continue to be a growing and important component of the MENA regional program, provided that the Bank can translate its international experience and knowledge into practical, country-tailored implementation actions. This will require access to a network of international expertise and continuous upgrading of knowledge about new developments in health system reform.

South Asia Region

Background

The South Asia Region (SAR) encompasses only eight countries (Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka), but it is home to a quarter of the world's population. The countries vary widely in size, wealth, and health problems (table B6), and dependence on international assistance. For all these reasons, the HNP SAR needs a differentiated strategic focus:

- *India, Pakistan, Bangladesh:* MDGs; focus on disadvantaged; new approaches to noncommunicable diseases (NCDs); financial risk protection.
- *Afghanistan, Nepal:* (the poorest countries) focus almost entirely on achieving MDGs.
- *Sri Lanka, Maldives, Bhutan:* more focus on NCDs; financial protection; macro-financing for HNP sector.

Table B6. Health Indicators in the South Asia Region

Income group/ country	GNI per capita, 2005 (US\$)	Health expenditure, 2004 (% of GDP)	External assistance, 2004 (% of total)	U-5 mortality, 2005 (per 1,000 live births)	MMR modeled estimates, 2000 (per 100,000 live births)	Prevalence of child malnutrition, 2000-06 (% of underweight U-5 children)	HIV prevalence, 2005 (% of total population, ages 15-49)
LOW INCOME							
Afghanistan	n.a.	4.4	6.1	257	n.a.	39	0.1
Bangladesh	470	3.1	15.1	73	380	48	0.1
Bhutan	870	4.6	14.5	75	420	n.a.	0.1
India	720	5.0	0.5	74	540	n.a.	0.9
Nepal	270	5.6	17.6	74	740	45	0.5
Pakistan	690	2.2	2.5	99	500	38	0.1
MIDDLE INCOME							
Maldives	2,390	7.7	1.6	42	110	30	n.a.
Sri Lanka	1,160	4.3	1.2	14	92	29	0.1

Source: World Bank. (2007). *2007 World Development Indicators*. Washington, DC: World Bank.

Strategic Objectives: What HNP Results?

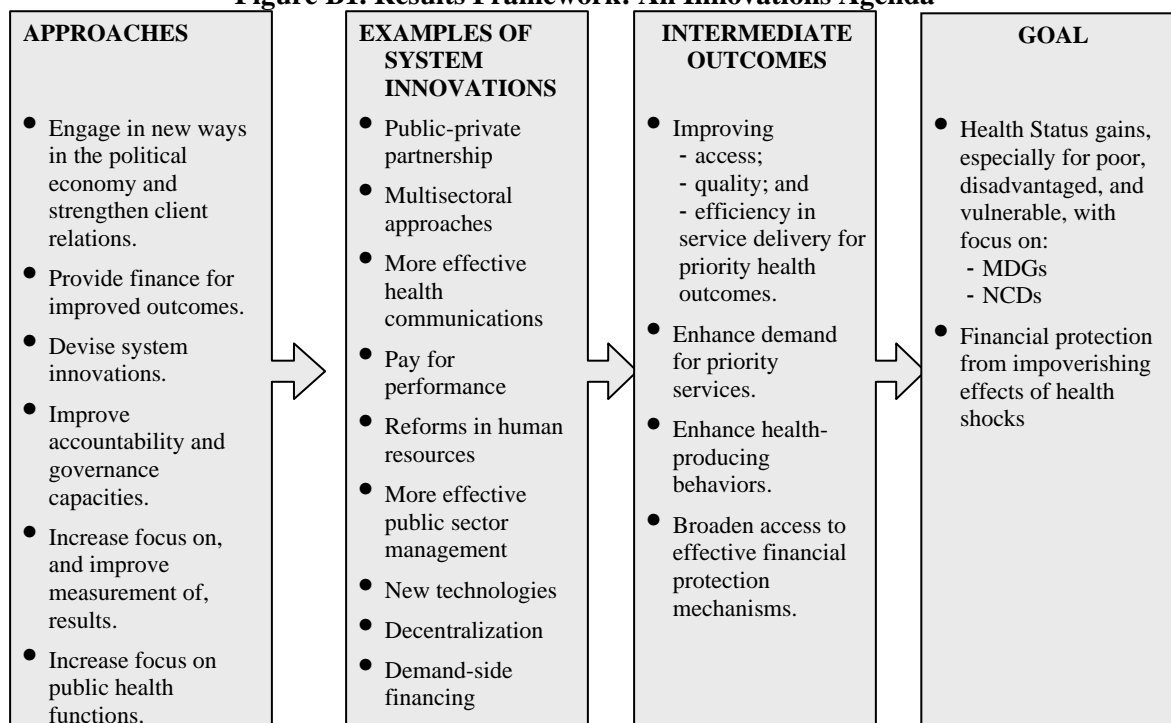
The Strategy focuses on two outcomes: (a) improved health status particularly for the poor; and (b) reducing health-related impoverishment through improved financial risk protection. Implementation of the new Strategy would lead to an HNP portfolio “make over” by 2011, resulting in more outcome-focused operations, inventive approaches aimed at strengthening health systems, probably fewer but larger operations that use innovative lending instruments, and a substantial Bank role in encouraging, analyzing, and evaluating novel approaches. The portfolio will have more sectorwide programming and will help strengthen the monitoring and evaluation systems in client countries with an aim of bolstering the results culture.

Strategic Directions: How Should the Bank Support Country Efforts?

Renewing the focus on HNP Results

The SAR HNP business plan is based on a Results Framework that links outcomes with specific strategies (figure B1). At the regional level, the strategic priorities guide analysis of how to focus the instruments available to the Bank to get results and what resources and actions need to be developed in the Region.

Figure B1. Results Framework: An Innovations Agenda



Strengthen health systems for HNP results

The Strategy recognizes several causes for the poor performance of health systems in the Region. These include (in no specific order): (a) insufficient drive for improving health outcomes from government and civil society leaders; (b) overcentralized systems in which not enough resources reach the periphery; (c) public sector service delivery that suffers from a poor incentive structure, weak management, rigid organization, and lack of accountability, and has few reasons for improving (d) human resources that suffer from inadequate supply, overconcentration in urban areas, weak management, and limited incentives; (e) insufficient engagement with the nongovernmental sector, which already provides most curative services, even for the poor; (f) high out-of-pocket costs for all, especially the poor, even in the public sector, and lack of organized financial risk protection; (g) few effective efforts to improve health- promoting behaviors; and (h) little effective targeting, to reduce health status disparities by income, gender, or geographical location.

Intersectoral approach to HNP Outcomes

The Unit suggests that regional management create a multisectoral team, led by an HNP lead specialist, to explore opportunities for operations focused on the specific role of various sectors in achieving HNP-related MDGs.

Implications for Bank Operations in the SAR Region

The SASHD HNP business plan creates space for innovation wherever possible, using all the instruments at its disposal. New staff skills and financial resources will be needed to support this innovations agenda, both from traditional Trust Fund sources as well as from new global and regional development partners, such as private foundations. The continuation of a dedicated M&E team (with a specific budget) will assist in improving M&E designs and staff knowledge.

Lending

Where possible, the **lending program** will move toward more programmatic financing, sectorwide support, or multisectoral lending in close cooperation with other development partners. The programmatic lending could take the format of development policy lending or be more broadly defined as output-based lending. In general, lending will shift away from traditional items of buildings and equipment and toward areas such as health financing linked to results / performance, financial protection, public health functions of government, and cross-cutting systems issues such as human resources. Priority would be given to MDG-related interventions.

AAA

The **analytical and advisory** work of SASHD-HNP will focus on strengthening the analytical basis for innovative approaches to service delivery and on disseminating evidence and analysis to decision makers through partnerships with WBI, other development partners, in-country institutions, and civil society organizations. Health financing will remain central, and increased attention will be given to governance and accountability.

Annex C

Acknowledgments

This Bank HNP Strategy was prepared by a team led by Cristian C. Baeza (Lead Health Policy Specialist, LCSHH /Acting Director, HDNHE) and composed of Nicole Klingen (Senior Health Specialist, HDNHE), Enis Baris (Senior Public Health Specialist, ECSHD), Abdo S. Yazbeck (Lead Economist, Health, WBIHD), David Peters (Senior Public Health Specialist, HDNHE), Eduard Bos (Lead Population Specialist, HDNHE), Sadia Chowdhury (Senior Health Specialist, HDNHE), Pablo Gottret (Lead Economist Health, HDNHE), Phillip Jeremy Hay (Communications Adviser, HDNOP), Eni Bakallbashi (Junior Professional Associate, HDNHE), Lisa Fleisher (Junior Professional Associate, HDNHE), Elisabeth Sandor (Health Specialist, HDNHE), Jessica St. John Staunton (Junior Professional Associate, HDNHE), Andrianina Rafamatanantsoa (Program Assistant, HDNHE), and Victoriano Arias (Program Assistant, HDNHE), with contributions from Rama Lakshminarayanan (Coordinator, HDNHE), Ariel Fiszbein (Adviser, DECVP), Maureen Lewis (Acting Chief Economist, HDNVP), Susan Stout (Manager, OPCR), Paul Gertler (former Chief Economist, HDNVP), John Newman (Country Manager, LCCPE), Kulsum Ahmed (Lead Environmental Specialist, ENV), Mukesh Chawla (Lead Economist, AFTH2), Alexander S. Preker (Lead Economist, Health, AFTH2), Kees Kostermans (Lead Public Health Specialist, SASHD), Samuel Lieberman (Lead Economist, EASHD), Agnes Soucat (Lead Economist, AFTHD), Jean-Jacques de St. Antoine (Lead Operations Officer, AFTH1), Dominic Haazen (Senior Health Specialist, ECSHD), Amie Batson (Senior Health Specialist, HDNHE), Meera Shekar (Senior Nutrition Specialist, HDNHE), Peter Kolsky (Senior Water and Sanitation Specialist, EWDWS), Michele Gragnolati (Senior Economist, ECSHD), April L. Harding (Senior Economist, Health, LCSHD), Olusoji Adeyi (Coordinator, HDNHE), Anne M. Pierre-Louis (Lead Health Specialist, AFTHD), George Schieber (Consultant, HDNHE), Katherine Tulenko (Public Health Specialist, EWDWP), Nicole Rosenvaigue (Senior Executive Assistant, HDNHE), Pedro Arizti (Economist, OPCR), Maria Eugenia Bonilla-Chacin (Economist, AFTH3), Feng Zhao (Health Specialist, AFTH1), John May (Senior Population Specialist, AFTH2), Jody Zall Kusek (Lead Monitoring and Evaluation Specialist, HDNGA), Peter Berman (Lead Economist, SASHD), Jan Bultman (Lead Health Specialist, ECSHD), Gerard La Forgia (Lead Health Specialist, LCSHH), Claudia Rokx (Lead Health Specialist, EASHD), Loraine Hawkins (Country Sector Coordinator, EASHD), Muhammad Pate (Senior Public Health Specialist, EASHD), Marcello Bortman (Senior Public Health Specialist, LCSHH), Aissatou Diack (Senior Public Health Specialist, AFTH2), Joana Godinho (Senior Health Specialist, LCSHH), Toomas Palu (Senior Health Specialist, EASHD), Sameh El-Saharty (Senior Health Specialist, MNSHD), Patricio Marquez (Lead Health Specialist, ECSHD), Eric de Roodenbeke (Senior Health Specialist, AFTH2), Emmanuel Malangalila (Senior Health Specialist, AFTH1), Peyvand Khaleghian (Senior Health Specialist, ECSHD), Paolo Belli (Senior Economist, Health, SASHD), John C. Langenbrunner (Senior Economist, Health, MNSHD), Shiyao Chao (Senior Economist, Health, ECSHD), Michele Gragnolati (Senior Economist, ECSHD), Pia Rockhold (Senior Operations Officer, HDNSP), Menno Mulder-Sibanda (Senior Nutrition Specialist, AFTH2), David Evans (Health Specialist, EASHD), Christoph Kurowski (Health Policy Specialist, LCSHD), Firas Raad (Health Specialist, MNSHD), Magnus Lindelow (Economist, EASHD), Monique Mrazek (Economist, Health, LCSHH), Pia Helene Schneider (Economist, Health, ECSHD), Gilles Dussault (former Senior Health Specialist), Roland Peters (Director, OPCS), Markus Kostner (Country Program Coordinator, MNCA4), Susan Hume (Country Program Coordinator, EACPQ), Preeti Ahuja (Country Program Coordinator, EAC1Q), Lilia Burunciuc (Country Program Coordinator,

AFCZA), Myla Williams (Country Program Coordinator, ECCUS), Jill Armstrong (Country Program Coordinator, AFCET), Robert Floyd (Country Program Coordinator, SACPA), Tom Buckley (Adviser, TUDUR), Patrick Leahy (Manager, CHEPG), Robert Taylor (Principal Financial Analyst, CASDR), Rita Klees (Senior Environment Specialist, ENV), Gail Richardson (Senior Operations Officer, OPCR), Katrina Sharkey (Senior Operations Officer, AFC07), Maryse Gautier (Senior Urban Management Specialist, LCSFU), Meera Chatterjee (Senior Social Development Specialist, SASES), Sudip Mozumder (Senior Communications Officer, SAREX), Ruma Tavorath (Environment Specialist, SASES), Mohini Malhotra (Regional Coordinator, WBIND), Alexandra Humme (Partnership Specialist, WBIND), Barbry Keller (Operations Officer, AFCGH), Rachid Benmessaoud (Operations Adviser, SACIN), John Underwood (Consultant, OPCCS), Mario Gobbo (Principal Investment Officer, CGMGT, former Bank staff), Sanjeev Krishnan (Investment Analyst, CGMGT, former Bank staff), Emi Suzuki (Research Analyst, HDNHE), Rifat Hasan (Junior Professional Associate, HDNHE), Alexander Shakow (Consultant), Yunwei Gai (Consultant), and Kathleen A. Lynch (Consultant).

Overall guidance to the team was provided by Jacques Baudouy (Director, HDNHE-retired), Nick Krafft (Director Network Operations, HDNVP), Joy Phumaphi (Vice President, HDNVP), Jean-Louis Sarbib (Senior Vice President, HDNVP-retired), James Adams (Vice President & Head of Network, OPCVP and Vice President & Head of Network, EAPVP), Danny Leipziger (Vice President & Head of Network, PRMVP), Xavier Coll (Vice President, HRSVP), Shanta Devarajan (Chief Economist, SARVP), Steen Jorgensen (Sector Director, ESDVP), Jamal Saghir (Director, EWDDR), James Warren Evans (Sector Director, ENV), Evangeline Javier (Sector Director, LCSHD), Julian Schweitzer (Sector Director, SASHD), Michal Rutkowski (Sector Director, MNSHD), Guy Ellena (Director, IFC), Debrework Zewdie (Director, HDNGA), Kei Kawabata (Sector Manager, HDNHE), Akiko Maeda (Sector Manager, MNSHD), Anabela Abreu (Sector Manager, SASHD), Armin Fidler (Sector Manager, ECSHD), Eva Jarawan (Sector Manager, AFTH2), Fadia Saadah (Sector Manager, EASHD), Keith Hansen (Sector Manager, LCSHD), Ok Pannenberg (Senior Adviser, AFTHD), Bruno Andre Laporte (Manager, WBIHD), Elizabeth King (Research Manager, DECRG) and Susan Blakley (Senior Human Resources Officer, HRSNW).

Special gratitude is due to:

Government officials of client countries who generously provided us with valuable recommendations and guidance on how the Bank can better support their efforts to improve the lives of those who are most vulnerable, including: Ginez Gonzales (Minister of Health, Argentina), Norair Davidyan (Minister of Health, Armenia), Angel Cordoba (Minister of Health, Mexico), Julio Frenk (former Minister of Health, Mexico), Haik Darbinyan (Ministry of Health, Armenia), Levon Yolyan (Ministry of Health, Armenia), Ara Ter-Grigoryan (Ministry of Health, Armenia), Vahan Poghosyan (Ministry of Health, Armenia), Gohar Kyalyan (Ministry of Health, Armenia), Michael Narimanyan (Ministry of Health, Armenia), Samvel Kovhannisyan (Ministry of Health, Armenia), Suren Krmoyan (Ministry of Health Armenia), Derenik Dumanyan (Ministry of Health, Armenia), Sergey Khachatryan (Ministry of Health, Armenia), Eduardo Gonzales-Pier (Ministry of Health, Mexico), Mauricio Bailon (Ministry of Health, Mexico), Jaime Sepulveda (Ministry of Health, Mexico), Jorge Roel (Office of the Chief of Cabinet, Argentina), Gerardo Serrano (Office of the Chief of Cabinet, Argentina), Carmen Odasso (Office of the Chief of Cabinet, Argentina), Walter Valle (Ministry of Health, Argentina), Leonardo Di Pietro (Ministry of Health, Argentina), Oscar Filomena (Ministry of Health, Argentina), Deepa Jain Singh (Ministry of Women and Child Development, India), N. K. Sethi (Planning Commission, India), Shri Prashant (Ministry of Finance, India), Bouaré Mountaga (Ministry of

Health, Mali), Amadou Sanguisso (Ministry of Health, Mali), Souleymane Traoré (Ministry of Health, Mali), Touré Cheikna (Mutualité Malienne), Traoré Mamadou Namory (Ministry of Health, Mali), Thiécoura Sidibé (Ministry of Health, Mali), Mahamadou Choulibaly (Ministry of Health, Mali), Ousmane Sylla (Ministry of Health, Mali), Sidi Yeya Cissé (Ministry of Health, Mali), Coulibaly Youma Sall (Ministry of Health, Mali), Cissé Djita Dem (National Council of Pharmacists, Mali), Dicko Aboubacar (SNV, Mali), Saleh Banoita Tourab (Ministry of Health, Djibouti), Simon Mibrathu (Ministry of Finance, Djibouti), Omar Ali Ismail (Executive Secretariat HIV/AIDS, Djibouti), Fatouma Kamil (Ministry of Health, Djibouti), Mouna Osman (Ministry of Health, Djibouti), Safia Elmi (Ministry of Health, Djibouti), Mohamed Ali (Ministry of Health, Djibouti), Samatee Said Hadji (Ministry of Health, Djibouti), Barihuta Tharcisse (Ministry of Health, Djibouti), Abouleh Abdillahi (Ministry of Health, Djibouti), M. Mahyab (Ministry of Health, Djibouti), Ali Hugo (Ministry of Health, Djibouti), Farhan Said Bourkad (Ministry of Health, Djibouti), Bahya Mohamed (Ministry of Health, Djibouti), Mohamed Aden (Ministry of Health, Djibouti), Nasser Mohamad (Ministry of Health, Djibouti), Bourhan Ahmed Duni (Ministry of Health, Djibouti), Abdiuaoui Youssouf (Ministry of Health, Djibouti), M. Watta (Ministry of Health, Djibouti), Hassan Kamil (Ministry of Health, Djibouti), Simon Mibrathu (Ministry of Health, Djibouti), Mugisha Kamugisha (Ministry of Finance, Tanzania), Gilbert Mliga (Ministry of Health, Tanzania), Regina Kikuli (Ministry of Health, Tanzania), Faustin Njau (Ministry of Health, Tanzania), Gabriel Upunda (Ministry of Health, Tanzania), Herman Lupogo (Tanzania AIDS Commission), Christopher Sechambe (Tanzania AIDS Commission), Beng'i Issa (Tanzania AIDS Commission), Donald Mmbando (Tanzania AIDS Commission), Willing Sangu (Tanzania AIDS Commission), Ayoub Kibao (Tanzania AIDS Commission), Dr. Bushiri (Tanzania AIDS Commission), Hashim Kalinga (Tanzania AIDS Commission), B. Muhunzi (Tanzania AIDS Commission), Emmanuel Humba (National Health Insurance Fund, Tanzania), Abdelhak Bedjaoui (Ministry of Finance, Algeria), Mohamed Messouci (Ministry of Finance, Algeria), Hedia Amrane (Ministry of Finance, Algeria), Ali Chaouche (Ministry of Health, Algeria), Leila Benbernou (Ministry of Health, Algeria), Cherifa Zerrouki (Ministry of Health, Algeria), Nacera Madji (Ministry of Health, Algeria), Leila Hadj Messaoud (Ministry of Health, Algeria), Benamar Rahal (Ministry of Health, Algeria), Benamar Regal (Ministry of Health, Algeria), Nassima Keddad (Ministry of Health, Algeria), Mosleh Bourkiche (Ministry of Health, Algeria), Ahmed Tani Abi Ayad (Ministry of Health, Algeria), Djamal Fourar (Ministry of Health, Algeria), Amar Ouali (Ministry of Health, Algeria), Faouzi Amokrane (Ministry of Health, Algeria), Zakia Fodil Cherif (Ministry of Health, Algeria), Houria Khelifi (Ministry of Health, Algeria), Djamila Nadir (Ministry of Health, Algeria), Djaouad Braham Bourkaib (Ministry of Labor, Algeria), Farida Belkhiri (Ministry of Labor, Algeria), Mr. Halfaoui (Ministry of Labor, Algeria), Mr. Muharso (Board of Health Development and Human Resources Empowerment, Indonesia), Dwi Atmawati (Board of Health Development and Human Resources Empowerment, Indonesia), Dewi Nuraini (Board of Health Development and Human Resources Empowerment, Indonesia), Rachmi Untoro (Ministry of Health, Indonesia), Rini Yudi Pratiwi (Ministry of Health, Indonesia), Dr. Erna Mulati (Ministry of Health, Indonesia), Kirana Pritasari (Ministry of Health, Indonesia), Eka Susi Ratnawati (Ministry of Health, Indonesia), Setiawan Soeparan (Ministry of Health, Indonesia), Ida Bagus Permana (Ministry of Health, Indonesia), Anhari Achadi (Ministry of Health, Indonesia), Dedi M. Masykur Riyadi (BAPPENAS), Mr. Hadiat (BAPPENAS), Mr. Haryo (BAPPENAS), Mr. Haryoko (PHP, Indonesia), Antarini Antojito (PHP, Indonesia), Sudianto Kamso (University of Indonesia), Sri Moertiningsih Adioetomo (University of Indonesia), Laksono Trisnantoro (University of Gajah Mada, Indonesia), Rossi Sanusi (University of Gajah Mada, Indonesia), Istiti Kandarina (University of Gajah Mada, Indonesia), Regina Satyawiraharja (Atma Jaya University, Indonesia), Usep Solehudin (Yayasan Pelita Ilmu – Youth Clinic), Kartono Mohammad (Koalisi untuk Indonesia Sehat), Mr. Soekirman (Koalisi Fortifikasi, Indonesia).

The following global partners for their generous advice and contributions: Anders Nordstrom (WHO), Anarfi Asamoah-Baah (WHO), Andrew Cassels (WHO), Denise Coitinho (WHO), Timothy Evans (WHO), David Evans (WHO), Salim Habayeb (WHO), Liz Mason (WHO), Eva Wallstam (WHO), Marie Paule Kieny (WHO), Monir Islam (WHO), Paul van Look (WHO), Dan Makuto (WHO), Steffen Groth (WHO), Jihane Tawilah (WHO), Edward Maganu (WHO), Noureddine Dekkar (WHO), Joe Kutzin (WHO), Gerard Schmets (WHO), Ignace Ronse (WHO), Xavier Leus (WHO), Sara Bennet (WHO), Max Mapunda (WHO), Mark Wheeler (WHO), Gerard Schmets (WHO), Menno van Hilton (WHO), Jacoba Sikkens (WHO), Nick Drager (WHO), Nicole Valentine (WHO), Christopher Powell (WHO), David John Wood (WHO), Brenda Killen (WHO), Richard Feachem (Global Fund to Fight AIDS, Tuberculosis and Malaria), Neil Squires (EU), Juan Garay (EU), Christopher Knauth (EU), Elisabeth Pape (EU), Frederika Meijer (EU), Paula Quigley (EU), Philip Constable (EU), Pascale Sztajnbok (EU), Walter Seidel (Europe Aid), Christian Collard (Europe Aid), Christian Flamant (AFD), Alain Humen (AFD), Finn Schleimann (DANIDA), Hans Martin Boehmer (DFID), Andrew Rogers (DFID), Louisiana Lush (DFID), Nick Banatvala (DFID), Michael Borowitz (DFID), Jane Pepperall (DFID), Julia Watson (DFID), Billy Stewart (DFID), Carole Presern (Foreign and Commonwealth Office, UK), Gauden Villas (Embassy of Spain, London), Meinhold Kuper (GTZ), Andre Cezar Medici (IADB), Annette Gabriel (KfW Development Bank), Helga Fogstad (Norad), Bjarne Garden (Norad), David Weakliam (Development Cooperation, Ireland), Rob de Vos (Development Cooperation, Netherlands), Reina Buijs (Ministry of Foreign Affairs, Netherlands), Marijke Wijnroks (Ministry of Foreign Affairs, Netherlands), Anno Galema (Ministry of Foreign Affairs, Netherlands), Jacqueline Mahon (Swiss Development Cooperation), Bo Stenson (SIDA), Catherine Michaud (Harvard School of Public Health), David Dunlop (AusAID), Jim Tulloch (AusAID), Michelle Vizzard (AusAID), Frederic Goyet (Ministry of Foreign Affairs, France), Jette Lund (Royal Danish Embassy), Rik Peeperkorn (Netherlands Embassy in Dar Es Salaam), Jean-Pierre Notermann (Embassy of Belgium, Mali), Karima Saleh (ADB), Jacques Jeugmans (ADB), Patience Kuruneri (AfDB), Peter Heller (IMF), Dan Kress (Bill and Melinda Gates Foundation), Armand Pereira (ILO), Michael Sichon (ILO), Assane Diop (ILO), Emmanuel Reynaud (ILO), Philippe Marcadent (ILO), Rédha Ameer (ILO), Julian Lob-Levyt (GAVI), Andrew Jones (GAVI), Akaki Zoidze (Georgia), Malegarpuru W. Makgoba (Zambia), Char Meng Chuor (Cambodia), Richard Greene (USAID), Al Bartlett (USAID), Karen Cavanaugh (USAID), Bob Emrey (USAID), Tim Meinke (USAID), Hope Sukin (USAID), Charles Llewellyn (USAID), Thomas Hall (USAID), Robert Clay (USAID), Lisa Nichols (USAID), Gregory Adam (USAID), Sergio René Salgado (UN Presidential Malaria Initiative), Pascal Villeneuve (UNICEF), Felicity Tchibindat (UNICEF), George Gonzales (UNICEF), Marie-Claire Mutanda (UNICEF), Rudolf Knippenberg (UNICEF), Peter Salama (UNICEF), Amel Allahoum (UNICEF), David Hipgrave (UNICEF), François Farah (UNFPA), Laura Laski (UNFPA), Dorothy Temu (UNFPA), Venkatesh Srinivasan (UNFPA), Kamel Sait (UNFPA), Zahidul Huque (UNFPA), Desmond Johns (UNAIDS), Pradeep Kakkattil (UNAIDS), Denis Broun (UNAIDS), Soumaya Benzitouni (UNAIDS), Joseph Annan (UNDP), Koita Nouhoum (CARE), Damayanti Soekarjo (CARE), Adjie Fachrurrazi (CARE), Glenn Gibney (PCI), Mr. Tolley (PCI), Lina Mahy (Hellen Keller International), David de Ferranti (Brookings Institution), Amanda Glassman (UN Foundation), Nils Daulaire (Global Health Council), Ruth Levine (Center for Global Development), Todd Benson (IFPRI), Eric Chevallier (Medecins du Monde), Elena McEwan (Catholic Relief Services), Carl Stecker (Catholic Relief Services), Vineeta Gupta (Stop HIV/AIDS in India Initiative), Suma Pathy (Stop HIV/AIDS in India Initiative), Ray Martin (Christian Connections for International Health), Cynthia Tuttle (Bread for the World Institute), Anna Taylor (Save the Children UK), Winifride Mwebesa (Save the Children USA), Harvey Bale (IFPMA), Patricia Scheid (Aga Khan Foundation USA), Tom Merrick (Hewlett

Foundation), Atika El Mamri (Federation of the Handicapped, Algeria), Salima Tadjine (Algerian Society of Research and Psychology), Mimi Rabehi (Association of People Affected by Cancer 'El-fedjr,' Algeria), Adel Zeddam (Algerian AIDS Association), Othmane Bourouba (Algerian AIDS Association), Mouloud Hamdis (Algerian Association for Renal Failure), Indrani Gupta (Institute of Economic Growth, India), Alok Mukhopadhyay (Voluntary Health Association of India), Dileep Mavlankar (Indian Institute of Management), Ritu Priya (Jawaharlal Nehru University, India), Atanu Sarkar (Energy and Research Institute, India), Ramnik Ahuja (Cofederation of Indian Industry), Dr. Hariharan (Indian Medical Association), Narottam Puri (MAX Health care Institute, India), Laveesh Bhandari (Indicus Analyticus).

The following Bank management and staff for their advice and recommendations: Vinod Thomas (Director General IEGDG), Geoffrey Lamb (Vice President, CFPVP-retired), Guillermo Perry (Chief Economist, LCRCE), Mustafa Nabli (Chief Economist, MNSD), John Page (Chief Economist, AFRCE), Robert Holzmann (Director, HDNSP), Hassan Tuluy (Director, MNACS), Ulrich Zachau (Director, LCRVP), John Roome (Operations Director, SARVP), Hartwig Schafer (Operations Director, AFRVP), Orsalia Kalatzopoulos (Country Director, ECCU4), Pedro Alba (Country Director, AFC09), Theodore Ahlers (Country Director, MNC01), Judy O'Connor (Country Director, AFC04), James Bond (Country Director, AFC15), Isabel Guerrero (Country Director, LCC1C), Emmanuel Mbi (Country Director, MNC03), Annette Dixon (Acting Country Director, ECAVP), Donna Dowsett-Coirala (Country Director, ECCU3), Axel van Trotsenburg (Country Director, LCC7C), Alastair McKechnie (Country Director SAC01), Tamar Atinc (Sector Director, ECSHD), Charles Griffin (former Sector Director, ECSHD), Emmanuel Jimenez (Sector Director, EAPHD), Yaw Ansu (Sector Director, AFTHD), Marilou Uy (Sector Director, FPDVP), Mayra Buvinic (Sector Director, PRMGE), Luca Barbone (Sector Director, PRMPR), Rodney Lester (Senior Adviser, FPDSN), Roberto Zagha (Senior Economic Adviser, PRMVP), Egbe Osifo-Dawodu (Sector Manager, WBIST), Dzingai Mutumbuka (Sector Manager, AFTH1), Laura Frigenti (Sector Manager, AFTH3), Jamil Salmi (Sector Manager, HDNED), Randi Ryterman (Sector Manager, PRMPS), Laura Tlaiye (Sector Manager, ENV), Elisabeth Lule (Manager, ACTAfrica), Alain Barbu (Manager, IEGSG), Hans-Martin Boehmer (Manager, SFRSI), Alassane Diawara (Country Manager, AFMML), Roger Robinson (Country Manager, ECCAR), Gaiv Tata (Country Program Coordinator, MNCA3), Alexandre Abrantes (Country Program Coordinator, LCC5A), Tawhid Nawaz (Operations Adviser, HDNOP), Adam Wagstaff (Lead Economist, DECRG), Martha Ainsworth (Lead Economist, IEG), Jeffrey Hammer (Lead Economist, SASES), Michael Mills (Lead Economist, AFTH1), Benjamin Loevinsohn (Lead Public Health Specialist, SASHD), Tonia Marek (Lead Public Health Specialist, AFTH2), Julie McLaughlin (Lead Health Specialist, AFTH1), Suneeta Singh (Senior Public Health Specialist, SASHD), Chris Walker (Lead Health Specialist, AFTH1), Susanna Hayrapetyan (Senior Health Specialist, ECSHD), Mary Eming Young (Lead Specialist, HDNCY), Janet Nassim (Senior Operations Officer, HDNHE), Nawal Merabet (Public Information Associate, MNAEX), Mikko Kalervo Paunio (Senior Environmental Specialist, ENV), Manorama Gotur (Senior Corporate Strategy Officer, SFRSI), Denise Vaillancourt (Senior Evaluations Officer, IEG), Sophia Drewnowski (Senior Partnership Specialist, GPP), Katja Janovsky (Consultant), Davidson Gwatkin (Consultant, HDNHE), and Judith Heuman (Consultant, HDNOP).

Annex D

List of Participants in Internal Consultations

Name	Title
Jean Louis Sarbib	Retired - Senior Vice President HDN
Joy Phumaphi	Vice President HDN
Nicholas Krafft	Director Network Operations HDNVP
Jacques Baudouy	Retired - Director HDNHE
Paul Gertler	Former Chief Economist HDNVP
Robert Holzmann	Director HDNSP
Evangeline Javier	Sector Director LCSHD
Michal Rutkowski	Sector Director MNSHD
Tamar Atinc	Sector Director ECSHD
Charles Griffin	Former Sector Director ECSHD
Emmanuel Jimenez	Sector Director EAPHD
Yaw Ansu	Sector Director AFTHD
Julian Schweitzer	Sector Director SASHD
Debrework Zewdie	Director HDNGA
Guy Ellena	Director IFC
Elisabeth King	Research Manager DECRG
Fadia Saadah	Sector Manager EASHD
Keith Hansen	Sector Manager LCSHD
Armin Fidler	Sector Manager ECSHD
Akiko Maeda	Sector Manager MNSHD
Anabela Abreu	Sector Manager SASHD
Egbe Osifo-Dawodu	Sector Manager WBIST
Kei Kawabata	Sector Manager HDNHE
Dzingai Mutumbuka	Sector Manager AFTH1
Laura Frigenti	Sector Manager AFTH3
Eva Jarawan	Sector Manager AFTH2
Elisabeth Lule	Manager AFTHV
Ok Pannenburg	Sr. Adviser AFTHD
Maureen Lewis	Acting Chief Economist HDNVP
Tawhid Nawaz	Operations Adviser HDNOP
Adam Wagstaff	Lead Economist Health DECRG
Pablo Gottret	Lead Economist Health HDNHE
Abdo Yazbeck	Lead Economist WBIHD
Michael Mills	Lead Economist AFTH1
Agnes Soucat	Lead Economist AFTHD
Alex Preker	Lead Economist (Health) AFTH2
Peter Berman	Lead Economist (Health) SASHD
Mukesh Chawla	Lead Economist AFTH3
Samuel Lieberman	Lead Economist EASHD
Benjamin Loevinsohn	Lead Pub. Health Specialist SASHD
Tonia Marek	Lead Pub. Health Specialist AFTH2
Kees Kostermans	Lead Pub. Health Specialist SASHD

Name	Title
Julie McLaughlin	Lead Health Specialist AFTH1
Chris Walker	Lead Health Specialist AFTH1
Jan Bultman	Lead Health Specialist ECSHD
Anne M. Pierre-Louis	Lead Health Specialist AFTHD
Gerard Martin La Forgia	Lead Health Specialist LCSHH
Claudia Rokx	Lead Health Specialist EASHD
Jean J. de St. Antione	Lead Operations Officer AFTH1
Eduard Bos	Lead Population Specialist HDNHE
Olusoji Adeyi	Coordinator HDNHE
Rama Lakshminarayanan	Coordinator HDNHE
Lorraine Hawkins	Country Sector Coordinator EASHD
David Peters	Sr. Public Health Specialist HDNHE
Enis Baris	Sr. Public Health Specialist MNSHD
Muhammad Pate	Sr. Public Health Specialist EASHD
Marcello Bortman	Sr. Public Health Specialist LCSHH
Suneeta Singh	Sr. Public Health Specialist SASHD
Aissatou Diack	Sr. Public Health Specialist AFTH2
Dominic Haazen	Sr. Health Specialist ECSHD
Amie Batson	Sr. Health Specialist HDNHE
Susanna Hayrapetyan	Sr. Health Specialist ECSDH
Joana Godinho	Sr. Health Specialist LCSHH
Toomas Palu	Sr. Health Specialist EASHD
Sameh El-Saharty	Sr. Health Specialist MNSHD
Eric de Roodenbeke	Sr. Health Specialist AFTH2
Emmanuel Malangalila	Sr. Health Specialist AFTH1
Peyvand Khaleghian	Sr. Health Specialist ECSHD
Paolo Belli	Sr. Economist (Health) SASHD
John Langenbrunner	Sr. Economist (Health) MNSHD
April Harding	Sr. Economist (Health) LCSHD
Shiyan Chao	Sr. Economist (Health) ECSHD
Michele Gragnolati	Sr. Economist ECSHD
Maria Eugenia Bonilla-Chacin	Sr. Economist AFTH3
Janet Nassim	Sr. Operations Officer HDNHE
Pia Rockhold	Sr. Operations Officer HDNSP
Meera Shekar	Sr. Nutrition Specialist HDNHE
Menno Mulder-Sibanda	Sr. Nutrition Specialist AFTH2
David Evans	Health Specialist EASHD
Christoph Kurowski	Health Policy Specialist LCSHD
Firas Raad	Health Specialist MNSHD
Feng Zhao	Health Specialist AFTH1
Magnus Lindelow	Economist EASHD
Monique Mrazek	Economist (Health) LCSHH
Pia Helene Schneider	Economist (Health) ECSHD
Davidson Gwatkin	Consultant HDNHE
George Schieber	Consultant HDNHE
Katja Janovsky	Consultant HNNHE
Gilles Dussault	Former Sr. Health Specialist

Name	Title
Jim Adams	Vice President OPCVP & EAPVP
Danny Leipziger	Vice President PRMVP
Vinod Thomas	Director General IEGDG
Xavier Coll	Vice President HRSVP
Geoffrey Lamb	Retired - Vice President CFPVP
Guillermo Perry	Chief Economist LCRCE
Shanta Devarajan	Chief Economist SARVP
Mustafa Nabli	Chief Economist & Sector Director MNSD
John Page	Chief Economist AFRCE
Hassan Tuluy	Director MNACS
Roland K. Peters	Director OPCS
Ulrich Zachau	Director LCRVP
John Roome	Operations Director SARVP
Hartwig Schafer	Operations Director AFRVP
Orsalia Kalatzopoulos	Country Director ECCU4
Pedro Alba	Country Director AFC09
Alastair McKechnie	Country Director SAC01
Theodore Ahlers	Country Director MNC01
Judy O'Connor	Country Director AFC04
James Bond	Country Director AFC15
Isabel Guerrero	Country Director LCC1C
Emmanuel Mbi	Country Director MNC03
Annette Dixon	Acting Country Director ECAVP
Donna Dowsett-Coirola	Country Director ECCU3
Axel van Trotsenburg	Country Director LCC7C
Marilou Uy	Sector Director FPDVP
Mayra Buvinic	Sector Director PRMGE
James Warren Evans	Sector Director ENV
Luca Barbone	Sector Director PRMPR
Rodney Lester	Sr. Adviser FPDSN
Roberto Zagha	Sr. Economic Adviser PRMVP
Jamil Salmi	Sector Manager HDNED
Randi Ryterman	Sector Manager PRMPS
Laura Tlaiye	Sector Manager ENV
Alassane Diawara	Country Manager AFMML
Roger Robinson	Country Manager ECCAR
Susan Stout	Manager OPCRX
Alain Barbu	Manager IEGSG
Hans-Martin Boehmer	Manager SFRSI
Markus Kostner	Country Program Coord. MNCA4
Alexandre Abrantes	Country Program Coord. LCC5A
Susan Hume	Country Program Coord. EACPQ
Preeti Ahuja	Country Program Coord. EAC1Q
Lilia Burunciuc	Country Program Coord. AFCZA
Myla Williams	Country Program Coord. ECCUS
Jill Armstrong	Country Program Coord. AFCET

Name	Title
Robert Floyd	Country Program Coord. SACPA
Gaiv Tata	Country Program Coord. MNCA3
Tom Buckley	Adviser TUDUR
Ariel Fiszbein	Adviser DECVF
Patrick Leahy	Manager CHEPG
Jeffrey Hammer	Lead Economist SASES
Kulsum Ahmed	Lead Environmental Specialist ENV
Robert Taylor	Principal Financial Analyst CASDR
Mary Eming Young	Lead Specialist HDNCY
Martha Ainsworth	Lead Economist IEGSG
Peter J Kolski	Sr. Water & Sanitation Sp. EWDWS
Mikko Kalervo Paunio	Sr. Environmental Specialist ENV
Rita Klees	Sr. Environmental Specialist ENV
Manorama Gotur	Sr. Corp. Strategy Officer SFRSI
Denise Vaillancourt	Sr. Evaluations Officer IEGSG
Gail Richardson	Sr. Operations Officer OPCR
Sophia Drewnowski	Sr. Partnership Specialist, GPP
Katrina Sharkey	Sr. Operations Officer, AFC07
Maryse Gautier	Sr. Urban Management Specialist LCSEU
Meera Chatterjee	Sr. Social Development Specialist SASES
Sudip Mozumder	Sr. Communications Officer SAREX
Katherine Anne Tulenko	Public Health Specialist EWDWP
Ruma Tavorath	Environment Specialist SASES
Mohini Malhotra	Regional Coordinator WBIND
Alexandra Humme	Partnership Specialist WBIND
Pedro Arizti	Economist OPCR
Barbry Keller	Operations Officer AFCGH
Rachid Benmessaoud	Operations Adviser SACIN
John Underwood	Consultant OPCCS
Alexander Shakow	Consultant, HRSVP
Judith Heuman	Consultant HDNOP
Mario Gobbo	Principal Investment Officer CGMGT (former Bank staff)
Sanjeev Krishnan	Investment Analyst CGMGT (former Bank staff)

Annex E

List of Participants in Country Consultations

Name	Title
BAMAKO – MALI	
Dr. Amadou Sanguisso	Division Chief of Evaluation and Cooperation, Ministry of Health
Dr. Mahamadou Coulibaly	Head of Programs, Ministry of Health
Dr. Ousmane Sylla	Head of Nutrition, Ministry of Health
Dr. Sidi Yeya Cissé	Head of Evaluation and Cooperation, Ministry of Health
Dr. Traoré Mamadou Namory	Chief of Planning, Building and Information, Ministry of Health
Dr. Coulibaly Youma Sall	Head of Statistics, Ministry of Health
Dr. Bouaré Mountaga	Director, Domestic Health, Ministry of Health
Dr. Thiécoura Sidibé	Chief, Department of Foreign Aid, Ministry of Health
Dr. Souleymane Traoré	Chief of Finance, Ministry of Health
Dr. Touré Cheikna	Associate Director General, Union of Technology
Dr Cissé Djita Dem	President, National Council of Pharmacists
Mr. Ignace Ronse	Adviser, WHO
Dr. Dicko Aboubacar	Health Adviser, SNV
Dr. Koita Nouhoum	Health Adviser, CARE
Dr. Jean-Pierre Noterman	Assistant Representative of Cooperation, Embassy of Belgium
Dr. Lisa Nichols	Head of Project, USAID
Dr. Lina Mahy	Director, Hellen Keller International
DJIBOUTI VILLE, DJIBOUTI	
Dr. Saleh Banoita Tourab	Secretary General, Ministry of Health
Mr. Ali Sillaye Abdallah	Director, Unit of Project Management, Ministry of Health
Mr. Omar Ali Ismail	Executive Secretary, VIH/SIDA, Ministry of Health
Ms. Fatouma Kamil	Head of S.S.U/BED, Ministry of Health
Ms. Mouna Osman	Head of Programs, Ministry of Health
Dr. Barihuta Tharcisse	Technical Adviser, Ministry of Health
Mr. Abouleh Abdillahi	Head of SIS, Ministry of Health
Mr. Mahyab	Technical Adviser SIS, Ministry of Health
Ms. Ali Hugo	SSB, Ministry of Health
Mr. Farhan Said Bourkad	Head of Finance Administration UGP, Ministry of Health
Ms. Bahya Mohamed	Head of Planning, Ministry of Health
Dr. Mohamed Aden	IGSS, Ministry of Health
Ms. Safia Elmi	DSRE, Ministry of Health
Mr. Mohamed Ali	SRH, Ministry of Health
Mr. Nasser Mohmad	Technical Adviser, Ministry of Health
Mr. Abdourahman	DEPCI, Ministry of Health

Name	Title
Mr. Bourhan Ahmed Duni	DAF, Ministry of Health
Dr. Abdiuaoui Youssouf	DMP, Ministry of Health
Ms. Samatee Said Hadji	Secretary of SG, Ministry of Health
Mr. Watta	PECSE, Ministry of Health
Mr. Hassan Kamil	CFPS, Ministry of Health
Mr. Simon Mibrathu	Director of External Financing and Executive Director of Islamic Development Bank
Dr. Jihane Tawilah	WHO Representative
Mr. George Gonzales	Program Officer, UNICEF
Ms. Marie-Claire Mutanda	Health and HIV/AIDS Officer, UNICEF
Mr. Christian Flamant	Regional Director, Development Agency of France
Mr. Alain Humen	Senior Project Officer, Development Agency of France
Dr. Thomas Hall	Senior Health Advisor, USAID
DAR ES SALAAM, TANZANIA	
Dr. Willing Sangu	Acting Hospital Director, Tanzania AIDS Commission
Dr. Ayoub Kibao	Amana District Hospital& Bunguruni Health Center, Tanzania AIDS Commission
Mr. Christopher Sechambe	Administrator, Tanzania AIDS Commission
Dr. Bushiri	Amana District Hospital& Bunguruni Health Center, Tanzania AIDS Commission
Major General Herman Lupogo	Executive Chairman, Tanzania AIDS Commission
Mr. Beng'i Issa	Director of Finance, Administration and Resource Mobilization, Tanzania AIDS Commission
Mr. Donald Mmbando	Director of Policy and Planning, Tanzania AIDS Commission
Mr. Hashim Kalinga	Acting Director, District and Community Response, Tanzania AIDS Commission
Mr. Muhunzi	Acting Director Advocacy and Communication, Tanzania AIDS Commission
Mr. Gilbert Mliga	Acting Permanent Secretary and Director, Human Resources, Ministry of Health
Mr. Gabriel Upunda	Chief Medical Officer, Ministry of Health
Ms. Regina Kikuli	Director Policy and Planning, Ministry of Health
Mr. Faustin Njau	Head, Health Sector Reforms Secretariat, Ministry of Health
Mr. Emmanuel Humba	Executive Director, National Health Insurance Fund
Mr. Meinholf Kuper	GTZ Health Financing Specialist, National Health Insurance Fund
Mr. Max Mapunda	WHO National Program Officer on Health Financing, National Health Insurance Fund
Mr. Mugisha Kamugisha	Commissioner, Policy Analysis Department, Ministry of Finance
Mr. Edward Maganu	WHO Representative
Mr. Charles Llewellyn	USAID
Ms. Jacqueline Mahon	Swiss Development Cooperation

Name	Title
Mr. Rik Peeperkorn	Netherlands Embassy
Ms. Dorothy Temu	UNFPA
Ms. Felicity Tchibindat	Nutritionist, UNICEF
Mr. Sergio René Salgado	US Presidential Malaria Initiative
ALGIERS, ALGERIA	
Mr. Mosleh Bourkiche	Under-Director, Ministry of Health
Mr. Ahmed Tani Abi Ayad	Under-Director, Ministry of Health
Dr. Cherifa Zerrouki	Epidemiologist, Ministry of Health
Dr. Djamal Fourar	Under-Director of Maternal and Child Health, Ministry of Health
Dr. Leila Benbernou	Director of Prevention, Ministry of Health
Dr. Zakia Fodil Cherif	Head of Nutrition Program, Ministry of Health
Dr. Houria Khelifi	Perinatal and Infant Health, Ministry of Health
Mr. Amar Ouali	Under-Director of Programs, Ministry of Health
Mr. Faouzi Amokrane	Under-Director of Studies, Ministry of Health
Mr. Nassima Keddad	Director of Programs, Ministry of Health
Ms. Nacera Madji	S/D DSS, Ministry of Health
Dr. Leila Hadj Messaoud	Interim S/D DSS, Ministry of Health
Mr. Benamar Rahal	Regional Director, Ministry of Health
Ms. Djamila Nadir	MNT Program, Ministry of Health
Mr. Ali Chaouche	Director of Studies, Ministry of Health
Mr. Abdelhak Bedjaoui	General Director of External Relations, Ministry of Finance
Ms. Hedia Amrane	Ministry of Finance
Mr. Mohamed Messouci	Ministry of Finance
Mr. Djaouad Braham Bourkaib	General Director of Social Security, Ministry of Labor
Dr. Belkhiri	Director of the Social Security Organizations, Ministry of Labor
Mr. Halfaoui	Director of Legislation, Ministry of Labor
Mr. Rédha Ameur	Head of Programs, ILO
Ms. Soumaya Benzitouni	UNAIDS
Ms. Amel Allahoum	UNICEF
Mr. Kamel Sait	UNFPA
Prof. Noureddine Dekkar	WHO
Ms. Atika El Mamri	Federation of the Handicapped
Ms. Salima Tadjine	Algerian Society of Research and Psychology
Ms. Mimi Rabehi	Association of People Affected by Cancer 'El-fedjr'
Mr. Othmane Bourouba	Algerian AIDS Association
Mr. Mouloud Hamdis	Association for Renal Failure
Mr. Adel Zeddami	Algerian Association AIDS
YEREVAN, ARMENIA	
Mr. Norair Davidyan	Minister of Health
Dr. Haik Darbinyan	First Deputy Minister of Health

Name	Title
Mr. Levon Yolyan	Deputy Minister of Health
Dr. Ara Ter-Grigoryan	Head of State Health Agency
Mr. Vahan Poghosyan	Head of Medical Care Provision Department, Ministry of Health
Dr. Derenik Dumanyan	Director, National Health Accounts
Prof. Gohar Kyalyan	Rector of Yerevan State Medical University
Mr. Michael Narimanyan	Pro-Rector of Yerevan State Medical University
Mr. Samvel Hovhannisyan	Head of Faculty of Family Medicine, Chair of National Institute of Health
Mr. Suren Krmoyan	Legal Adviser to the Minister of Health
Mr. Sergey Khachatryan	Director, Health Program Implementation Unit
MEXICO CITY, MEXICO	
Dr. Angel Cordoba	Minister of Health
Dr. Julio Frenk	Former Minister of Health
Mr. Eduardo Gonzales-Pier	Chief Economic Advisor to the Minister of Health
Mr. Mauricio Bailón	Director General of International Relations, Ministry of Health
Dr. Jaime Sepulveda	Director General of Health Coordination, Ministry of Health
Dr. Maki Ortiz	Undersecretary of Innovation and Quality, Ministry of Health
Dra. Maria de los Angeles	Head, Entitlement and Social Participation Unit, Ministry of Health
Dr. Eduardo González Pier	Head, Economic Analysis Unit, Ministry of Health
Dr. Mauricio Hernández	Sub-Secretary of Prevention and Health Promotion, Ministry of Health
Lic. Mauricio Bailón	Director General, International Affairs, Ministry of Health
NEW DELHI, INDIA	
Ms. Deepa Jain Singh	Financial Commissioner and Secretary, Ministry of Women and Child Development
Prof. N. K. Sethi	Advisor, Planning Commission
Mr. Shri Prashant	Director, Department of Economic Affairs, Ministry of Finance
Dr. Salim Habayeb	WHO Representative
Mr. Alok Mukhopadhyay	Chairman, Voluntary Health Association of India
Dr. Dileep Mavlankar	Associate Professor, Indian Institute of Management, Ahmedabad
Dr. Indrani Gupta	Reader, Institute of Economic Growth
Dr. Ritu Priya	Associate Professor, Jawaharlal Nehru University

Name	Title
Dr. Atanu Sarkar	Coordinator, The Energy and Resources Institute
Dr. Ramnik Ahuja	Health Consultant Confederation of Indian Industry
Dr. Hariharan	Assistant Secretary, Indian Medical Association
Dr. Narottam Puri Limited	Executive Director, MAX Healthcare Institute
Dr. Laveesh Bhandari	Indicus Analyticus
Dr. Billy Stewart	Health Adviser, DFID
Ms. Frederika Meijer	Health Adviser, EU
Dr. Paula Quigley	Technical Assistance Officer, EU
Dr. Robert Clay	Director, Office of Population, Health and Nutrition, USAID
Mr. Venkatesh Srinivasan	Programme Officer, UNFPA
Dr. Denis Broun	Country Coordinator, UNAIDS
JAKARTA, INDONESIA	
Dr. Muharso	Head, Board of Health Development and Human Resources Empowerment, Ministry of Health
Dr. Dwi Atmawati	Board of Health Development and Human Resources Empowerment, Ministry of Health
Dr. Dewi Nuraini	Board of Health Development and Human Resources Empowerment, Ministry of Health
Dr. Sudianto Kamso	University of Indonesia
Dr. Laksono Trisnantoro	Director, Center for Health Service Management, University of Gajah Mada
Dr. Rossi Sanusi	Centre for Health Service Management, University of Gajah Mada
Dr. Istiti Kandarina	Centre for Health Service Management, University of Gajah Mada
Dr. Regina Satyawiraharja	Center for Health Research, Atma Jaya University
Mr. Kartono Mohammad	Koalisi Fortifikasi Indonesia
Dr. Usep Solehudin	Yayasan Pelita Ilmu - Youth Clinic
Dr. Sri Moertiningsih Adioetomo	Population and Human Resources Program, Univ. of Indonesia
Mr. Soekirman	Koalisi Fortifikasi Indonesia
Dr. Anhari Achadi	Health Services Program
Dr. Sugiharto	Health Manpower Education Center, Ministry of Health
Dr. Rachmi Untoro	Children Health Improvement, Ministry of Health
Dr. Rini Yudi Pratiwi	Children Health Improvement, Ministry of Health
Dr. Erna Mulati	Children Health Improvement, Ministry of Health
Dr. Kirana Pritasari	Children Health Improvement, Ministry of Health
Dr. Eka Susi Ratnawati	Children Health Improvement, Ministry of Health
Mr. Haryoko	PHP
Dr. Antarini Antoyo	PHP
Dr. Ir. Dedi M. Masykur Riyadi	National Development Planning Agency, BAPPENAS
Dr. Hadiat	National Development Planning Agency, BAPPENAS
Dr. Haryo	National Development Planning Agency, BAPPENAS
Mr. Ida Bagus Permana	Family Planning and Reproductive Health

Name	Title
Mr. Mark Wheeler	WHO
Mr. Philip J Constable	EU
Mr. Pascale Sztajnbok	EU
Mr. Gregory Adam	USAID
Ms. Michelle Vizzard	Australian Agency for International Development
Mr. David Dunlop	Australian Agency for International Development
Mr. David Hipgrave	UNICEF
Dr. Zahidul Huque	UNFPA
Ms. Karima Saleh	ADB
Mr. Jacques Jeugmans	ADB
Ms. Damayanti Soekarjo	CARE Indonesia
Mr. Adjie Fachrurrazi	CARE Indonesia
Mr. Glenn Gibney	Project Concern International
Mr. Tolley	Project Concern International
BUENOS AIRES, ARGENTNA	
Mr. Ginez Gonzalez García	Minister of Health
Mr. Walter Valle	Secretary of Health Programs
Mr. Leonardo Di Pietro	Head of Cabinet, Advisers to the Minister of Health
Mr. Oscar Filomena	General Coordinator, Health Programs with External Financing
Mr. Jorge Roel	Director, National Programs and Projects with External Financing, Headquarters of the Cabinet Ministers
Mr. Gerardo Serrano	Director of Social Programs and Institutional Management, Headquarters of Cabinet Ministers
Ms. Carmen Odasso	National Director of Budgetary Evaluation, Headquarters of Cabinet Ministers

Annex F

List of Participants in Global Partner Consultations with Bilateral and Multilateral Partners, NGOs, Civil Society, and Faith-Based Organizations

Organization /Country	Name	Title
WHO	Dr. Timothy Evans	Assistant Director-General, Evidence and Information for Policy
WHO	Dr. Anders Nordstrom	Assistant Director-General, General Management
WHO	Dr. Anarfi Asamoah-Baah	Assistant Director-General, HIV/AIDS, TB and Malaria
WHO	Dr. Andrew Cassels	Director of MDGs, Health and Development Policy
WHO	Dr. Denise Coitinho	Director, Department of Nutrition and Health
WHO	Dr. Liz Mason	Director, Child and Adolescent Health
WHO	Ms. Eva Wallstam	Director, Gender, Women and Health
WHO	Dr. Marie Paule Kieny	Director, Initiative for Vaccine Research
WHO	Dr. Monir Islam	Director, Making Pregnancy Safer
WHO	Dr. Paul van Look	Director, Reproductive Health and Research
WHO	Dr. Dan Makuto	Director, Family and Community Health
WHO	Dr. Steffen Groth	Director, Essential Health Technologies
WHO	Mr. Gerard Schmets	Head, Regional Office for Europe
WHO	Mr. Menno van Hilten	Resource Mobilization Office
WHO	Ms. Jacoba Sikkens	External Relations Officer
WHO	Dr. Nick Drager	Senior Adviser, Department of Ethics, Trade, Human Rights and Health Law
WHO	Ms. Nicole Valentine	Health Economist, Equity and Health
WHO	Mr. Christopher Powell	Communications Adviser, Family and Community Health
WHO	Dr. David John Wood	Coordinator, Quality and Safety of Biologicals
WHO	Dr. Brenda Killen	Coordinator, Health and Development
WHO	Dr. Xavier Leus	Representative to the World Bank

Organization /Country	Name	Title
		and International Monetary Fund
UNAIDS	Dr. Desmond Johns	Director
UNAIDS	Mr. Pradeep Kakkattil	
UNDP	Mr. Joseph Annan	Senior Policy Advisor
UNICEF	Dr. Pascal Villeneuve	Chief of the Health Section Program Division
UNICEF	Mr. Rudolf Knippenberg	Principal Adviser
UNICEF	Mr. Peter Salama	Chief of Immunization and Child survival
ILO	Mr. Armand Pereira	Representative
ILO	Mr. Assane Diop	Executive Director
ILO	Mr. Michael Sichon	Director
ILO	Mr. Emmanuel Reynaud	Senior Adviser on the Informal Economy, Social Protection
ILO	Mr. Philippe Marcadent	Coordinator
UNFPA	Mr. François Farah	Chief, Population and Development Branch
UNFPA	Dr. Laura Laski	Senior Technical Adviser
United Nations Foundation	Ms. Amanda Glassman	Deputy Director, Health Financing Task Force
Global Fund to Fight AIDS, Tuberculosis and Malaria	Dr. Richard Feachem	Executive Director
AfDB	Ms. Patience Kuruneri	Principal Social Sector Analyst
AusAID	Mr. Jim Tulloch	Principal Health Adviser
DANIDA	Mr. Finn Schleimann	Chief Technical Advisor
Ministry of Foreign Affairs, France	Mr. Frederic Goyet	Chief, Office of Policies for Social Protection and Health
Royal Danish Embassy	Mr. Jette Lund	Counselor
European Union	Mr. Neil Squires	Directorate General Development
European Union	Mr. Juan Garay	Directorate Human Social Development
European Union	Mr. Christopher Knauth	Directorate-General for External Relations
European Union	Ms. Elisabeth Pape	Counselor

Organization /Country	Name	Title
Europe Aid	Mr. Walter Seidel	Senior Public Health Specialist
Europe Aid	Mr. Christian Collard	Expert
Development Cooperation, Ireland	Dr. David Weakliam	Health Adviser
Development Cooperation, Netherlands	Mr. Rob de Vos	Deputy Director-General
Ministry of Foreign Affairs, Netherlands	Ms. Reina Buijs	Head of Department
Ministry of Foreign Affairs, Netherlands	Ms. Marijke Wijnroks	Senior Health Advisor
Ministry of Foreign Affairs, Netherlands	Mr. Anno Galema	Senior Health Advisor
Norad	Mr. Bjarne Garden	Senior Adviser
Norad	Ms. Helga Fogstad	Technical Officer
International Monetary Fund	Mr. Peter Heller	Deputy Director
DFID	Mr. Hans Martin Boehmer	Deputy Director, Human Development
DFID	Ms. Louisiana Lush	Senior Health Adviser
DFID	Mr. Nick Banatvala	Global Health Adviser
DFID	Mr. Michael Borowitz	Senior Health Adviser
DFID	Ms. Jane Pepperall	Senior Health Adviser
DFID	Ms. Julia Watson	Health Economist
Foreign & Commonwealth Office, UK	Dr. Carole Presern	Counselor
Embassy of Spain, London	Mr. Gauden Villas	Counselor
IADB	Mr. Andre Cezar Medici	Specialist of the Social Programs Division
KfW Development Bank	Ms. Annette Gabriel	Health and Population Specialist
Bill and Melinda Gates Foundation	Dr. Dan Kress	Senior Program Officer
GAVI	Dr. Julian Lob-Levyt	Chief Executive Officer
GAVI	Mr. Andrew Jones	Regional Manager
Georgia	Dr. Akaki Zoidze	Deputy State Minister

Organization /Country	Name	Title
Zambia	Prof. Malegapuru W Makgoba	Vice-Chancellor, University of Kwazulu-Natal
Cambodia	Dr. Char Meng Chuor	Project Coordinator
USAID	Mr. Richard Greene	Deputy Director
USAID	Mr. Al Bartlett	Senior Child Survival Advisor
USAID	Ms. Karen Cavanaugh	Cognizant Technical Officer
USAID	Mr. Bob Emrey	Co-Manager
USAID	Mr. Tim Meinke	Senior Advisor for Donor Coordination
USAID	Ms. Hope Sukin	Health Team Leader
SIDA	Mr. Bo Stenson	Head of Section, Population and Health Division
Ellison Institute	Dr. Catherine Michaud	Senior Research Scientist
Brookings Institution	Mr. David de Ferranti	Senior Fellow
Global Health Council	Dr. Nils Daulaire	President
Center for Global Development	Dr. Ruth Levine	Director of Programs
IFPRI	Dr. Todd Benson	Research Fellow
Médecins du Monde	Dr. Eric Chevallier	Director of International Projects
Catholic Relief Services	Dr. Elena McEwan	Senior Technical Advisor for Health
Catholic Relief Services	Dr. Carl Stecker	Senior Technical Advisor
Stop HIV/AIDS in India Initiative	Ms. Vineeta Gupta	Director
Stop HIV/AIDS in India Initiative	Mr. Suma Pathy	
Christian Connections for Int'l Health	Mr. Ray Martin	Executive Director
Bread for the World Institute	Ms. Cynthia Tuttle	Program Director
Save the Children UK	Ms. Anna Taylor	Head of Health
Save the Children USA	Dr. Winifride Mwebesa	Family Planning and Reproductive Health Advisor

Organization /Country	Name	Title
IFPMA	Dr. Harvey Bale	Director General
Aga Khan Foundation USA	Ms. Patricia Scheid	Director, Programs and Partnerships
Hewlett Foundation	Mr. Tom Merrick	Consultant

Annex G

Consultation (1) HNP Sector Strategy Briefing Some Key Questions

(March 17, 2006)

- 1. Achieving priority outcomes for Bank work in HNP** (defining a Results Framework for HNP)
 - a. What are the 10 (15) priority HNP outcomes for the Bank? Which ones are more relevant for your region? On which ones has your region focused its work program over the past 4-5 years?
 - b. What are the main achievements in your region in the last 4-5 years in terms of the HNP work in general and outcome impact in particular?
 - c. Are there other priority non-HNP outcomes that the Bank HNP work contributes to? What are they? If so, on which ones has your region focused so far?
 - d. What is the rationale behind the prioritization of outcomes for your region today?
 - e. What would be the 5-10 year goals for the outcomes your region would focus on?
 - f. Measurement Challenges:
 - i. How has your region measured the outcome results in the last 5 years?
 - ii. How would your region propose to measure them in the future?
 - iii. How and how often do you collect the outcome data and report it?
 - iv. How and how often do you think it should be done in the future?
 - v. Who collects and processes the data? Who pays for it? How do you think it should be done in the future?
 - vi. How to mandate / persuade measurement at operational level (Bank and Country clients) for lending and non-lending work?
- 2. What are the key HNP issues / challenges your region would need to focus on to achieve priority outcomes in the next 5 years?**
 - a. What are the key issues that require particular attention for your region to achieve the outcomes the region has focused on or plans to focus on in the next 5 years?
 - b. Does the Bank have any comparative advantages on any of these issues? Operationally? Fiduciary? Knowledge generation? Funding?
 - c. What do you think needs to be done regarding key issues for which the Bank does not seem to have comparative advantages?
- 3. The Bank in the new donor scenario.**

In regards to the priority results your region has focused on and will focus in the next 5 years:

- a. How does the donor scenario impact the Bank's comparative advantages in the health sector and what would be the best role the Bank can play in the current donor scenario in your region?

4. What changes, if any, would be necessary in the following areas to facilitate the achievement of the priority outcomes in your region?

- a. Lending Instruments
- b. Knowledge generation and management
- c. Donor partnerships
- d. Staff skill-mix
- e. Staff and management incentive framework
- f. Incentive framework for multisectoral collaboration

5. Multi-sectoral collaboration for HNP results.

In your region:

- a. What has worked and what has not in the HNP and non-HNP Sectors collaboration for HNP results?
- b. How would you increase collaboration where it works?

Annex H

COMMITTEE ON DEVELOPMENT EFFECTIVENESS

Background Note on the World Bank Strategy for Health, Nutrition, and Population Results

Chairman's Summary

On June 21, 2006 the Committee on Development Effectiveness (CODE) considered the background note (BN) for the World Bank Strategy for Health, Nutrition, and Population Results (the Strategy). The BN serves as a basis for articulating the new directions for the strategy.

Background.

The Board considered the Health, Nutrition and Population (HNP) Sector Strategy in July 1997. The 1997 Strategy had the objectives of (i) improving outcomes for poor people and protecting the population from the impoverishing effects of ill health, malnutrition, and high fertility; (ii) enhancing the performance of health care systems; and (iii) securing sustainable health financing. In December 2005, CODE reviewed the Sector Strategy Implementation Update (SSIU) – Part Two, which included an in-depth review of the implementation of the HNP sector strategy. At this meeting, the Committee broadly endorsed the proposal to update the 1997 strategy.

The Committee recently reviewed a number of Independent Evaluation Group (IEG) evaluation reports related to the health sector, such as the World Bank's support to HIV/AIDS and Global Programs (e.g. Partnership for Child Development). As well, CODE was briefed by Management on the outcomes of the Paris High Level Forum on Health Millennium Development Goals (MDGs) in March 2006. In the past year, the Board has considered several disease-specific initiatives and action plans such as for HIV/AIDS, tuberculosis and malaria (April, 2005 and February 2006), and avian influenza (January 2006).

Summary of the Background Note.

The BN outlines the rationale for articulating the new directions for the strategy, highlighting changes in the external and internal environment since 1997. As well, it discusses the Bank's comparative advantage. The BN proposes the following: (i) a renewed focus on results; (ii) strengthened intersectoral approach; (iii) increased focus on health systems; (iv) achieving synergy between health system and single-disease approaches; and (v) working selectively with global partners, based on comparative advantages at the country level. It also identifies trade-offs and key challenges for implementation.

Overall Conclusions and Next Steps.

The Committee welcomed the BN, commending the staff for its collaborative approach, and preliminary external and internal consultations to draft it. CODE broadly supported the need for a

new direction for the strategy, with many speakers emphasizing the importance of HNP outcomes for the MDGs and the Bank's mandate to reduce poverty. It overall endorsed the proposed new directions of the strategy, especially its focus on results, strengthened health system, and emphasis on intersectoral approach.

The BN generated a rich set of comments, which staff committed to consider when preparing the strategy. Themes resonating with many speakers included: integration of nutrition and population aspects; synergies with other sectors (e.g. infrastructure, water and sanitation, education) to maximize development effectiveness; rigorous assessment of the Bank's role and comparative advantage; operational challenges (e.g. public vs. private sectors, consensus on key policies related to health systems, access and affordability of health services); results framework for HNP; and institutional challenges (e.g. staffing, resources, structure) and trade-offs.

The Committee broadly supported further consultations, especially with borrowing countries, and sharing of the BN for this purpose. Management expected to have the draft strategy ready in December 2006, which would be considered by the Committee.

The following main issues were raised during the meetings:

1. **The Proposed Direction of the Strategy.** CODE broadly supported the proposed new directions for the strategy, although a member would have liked a more positive and ambitious tone on the need and feasibility of achieving the MDGs. Responding to the comment by several speakers and the Director General of Evaluations (DGE) on the need to further integrate nutrition and population themes in the strategy, *staff noted that work is ongoing on nutrition, reproductive health is integrated in the proposed results framework, while more effort will be devoted to articulate a policy to address population health challenges.* Others suggested that gender aspects, changing demographics, social security issues, and quick response system to new epidemics, also be addressed. Several speakers sought practical implementation aspects in the strategy, linking the strategy objectives with Bank capacity. Some others stressed the importance of buy-in within the institution, and of countries for implementation. A member echoed the DGE's comment to integrate the lessons learned in the strategy.
2. **The Bank's Role.** The Committee welcomed the BN's review of the Bank's comparative advantage, although a few speakers cautioned about the use of the concept and the need to consider the demand side. Speakers wanted greater specificity regarding the Bank's role (e.g. such as in surveillance systems) vis-à-vis other global players, taking into consideration the Shakow report. They urged deeper assessment of the implications for the Bank of the changing global environment for HNP support, other development partners' strategies and capacities, critical gaps in health system support, and potential synergies within the World Bank Group (i.e. IFC, MIGA) and with external partners. *Staff elaborated on the consultations with global partners so far, and the ongoing discussions with IFC on synergies within the World Bank Group.* Several speakers observed an important role for the Bank in areas such as: leadership in harmonization and alignment, deepening the understanding of health system issues, analyzing and addressing the financing gap, and smoothing the volatility in financing.
3. **Country Focus.** Welcoming the emphasis on country ownership, a few members stressed the need to strengthen country capacity to prioritize and manage policies and programs in the health sector, and one of them urged more use of country fiduciary systems. Several speakers

supported the different approaches to low- and middle- income countries, while two speakers sought more analysis on the Bank's support in post-conflict and fragile states, including the issue of fiscal space. A member viewed regional dimensions and migration issues important, while another stressed the political economy of reform, particularly of public health workers. A number of speakers and the DGE commented on the important link between the health and other sectors (e.g. education, environment, water, and infrastructure). *Staff acknowledged the importance of intersectoral cooperation within the Bank, and also the need to strengthen cooperation between different sector ministries at the country level. They expected the proposed diagnostic tool - the Binding Constraints to Outcome Improvement – (to be piloted) would highlight the possible gains from enhanced coordination between sectors, and serve as input to policy dialogue and the Bank's country assistance strategies.*

4. **Focus on Health Systems vs. Single Disease Approaches.** Some members expressed support for a more selective Bank engagement in single-disease initiatives. Questions were raised about the criteria for selectivity and the phase out process. A few speakers suggested that the strategy elaborate on the synergies between health system strengthening (horizontal) and single-disease (vertical) approaches (e.g. HIV/AIDS). In focusing on health systems, speakers commented on their importance for low income countries; the need to address issues of access, affordability and quality; challenge of capturing the intersectoral synergies; and lack of “blueprint” policies for a good health system. *Staff reiterated the need for global conceptual agreements, but country-specific approaches. They noted the lessons learned from 1990s that there are no “blueprint” interventions, and strengthening health system is a means, not an end, to achieving better health outcomes and protecting households from poverty due to illnesses.*
5. **Focus on Governance and Accountability.** One speaker asked for clarification of the concepts of governance, accountability, and corruption in the context of the health sector. Others wondered whether there would be a sector-specific approach to addressing governance and accountability issues. A member expected a forthright discussion of governance issues in the strategy, with prominence given to these issues in the results framework.
6. **Private Sector Role.** Several speakers noted the potential contribution of the private sector in HNP, particularly in middle-income countries; opportunities for private-public partnerships, such as in provision of affordable drugs and Bank and IFC role in supporting private sector participation. A speaker mentioned the example of Unitaid, the international drug purchase facility to be partly financed by the airline tax. *Staff commented on their engagement with the private sector and on addressing issues of access and pricing of pharmaceuticals, including the Bank's involvement in the development of advance market commitments to assure the supply of certain vaccines.*
7. **Results Framework.** The Committee and IEG concurred with the proposition in the BN to sharpen the focus on results. Speakers sought outcome-oriented indicators, sound monitoring and evaluation (M&E) systems in Bank projects and in client countries, results linked to the MDG framework, adequate flexibility in the HNP results framework for country application, coordinated support among development partners for M&E, and involvement of client countries in developing indicators. The need to address data weaknesses, attribution issues associated with an intersectoral approach, and knowledge gap on experience and lessons learned was stressed. *Staff commented on the significant challenge of developing a results framework that would be meaningful and flexible to serve different country contexts, and which would capture the intersectoral approach to the health sector.*

8. **Harmonization and Alignment.** A member suggested more emphasis on harmonization and alignment in the articulating in the new directions for the strategy, while another asked whether a framework for cooperation similar to the Education for All-Fast Track Initiative was being considered for HNP. *Staff noted that consideration was being given to such an arrangement, building on the Paris Declaration on Harmonization.* Some speakers stressed coordination and collaboration while one member supported the independent operations of private institutions (e.g. Gates Foundation). Responding to a few speakers' interest in the outcome of the recent meeting in Tunis, *staff offered to brief the Committee and indicated that a summary of the meeting would soon be available on the Bank website.* Others asked about the global accountability framework for HNP, to which *staff commented on the ongoing efforts to find an appropriate forum for defining and exercising accountabilities at the global level.*
9. **Institutional Challenges.** A member enquired about the link between the fact that a third of projects in the HNP portfolio are at risk and the decrease in HNP staff, and measures to improve quality. Generally, many speakers were interested in the adjustments required to align functional responsibilities, incentives, staffing, and budget of the Bank to fast track and strengthen support for the health sector; the need for Senior Management leadership to address these issues was emphasized. Some speakers expected the strategy to be more explicit on staffing and budgetary needs. Others expected strategic priorities and institutional trade-offs to be considered as part of the broader dialogue with Management on the Medium Term Strategy and Finance Paper and the budget process.

Pietro Veglio, Chairman

Annex I

The New Global Health Architecture

Emergence of a New Global Health Architecture: Trends Since the Mid-1990s.

Global health is on the international policy agenda as it never has been before. Over the last 10 years, humanitarian concerns about the health of the world's poor, the spread of pandemics such as HIV/AIDS and fears about outbreaks of SARS and avian influenza, and the recognition that health is a key determinant of economic growth, labor force productivity, and poverty reduction have made health a central pillar of most development policies. At the same time, health is increasingly viewed as a human right, the fulfillment of which places obligations on both developed and developing countries.

During the 1990s, the global community discussed ways of renewing emphasis and strengthening action to reduce poverty and improve the health of the world's poor. The culmination of these discussions—the Millennium Declaration and the Millennium Development Goals (MDGs)—reflects the prominence of health in the global policy arena: three of the eight MDGs relate directly to health; the poverty reduction MDG is affected when citizens are pushed into poverty by catastrophic health care costs or lost earnings resulting from ill health; and several of the other goals (e.g., education, sanitation) interact directly with health outcomes. In particular, HIV/AIDS emerged as a challenge to be addressed multisectorally as the international community became increasingly concerned about it as a development issue.

With these challenges, there was a growing sense that the traditional system of bilateral agencies and international organizations acting as the primary development partners was inadequately prepared to assist the poor countries of the world scale up to achieve the MDGs. In the past decade, there have been profound changes in the organizations that play key roles in global health. Private foundations, such as the Bill and Melinda Gates Foundation, and large global funds, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and the Global Alliance for Vaccines and Immunizations (GAVI), have entered the scene with large amounts of grant money. Other disease-specific initiatives such as the Joint United Nations Programme on HIV/AIDS (1996), Roll Back Malaria (1998), and the Stop TB Partnership (1999) were also established and have brought new financial resources for specific diseases.

Never before has so much attention—or money—been devoted to improving the health of the world's poor. However, unless deficiencies in the global aid architecture are corrected and major reforms occur at the country level, the international community and countries themselves face a good chance of squandering this opportunity.

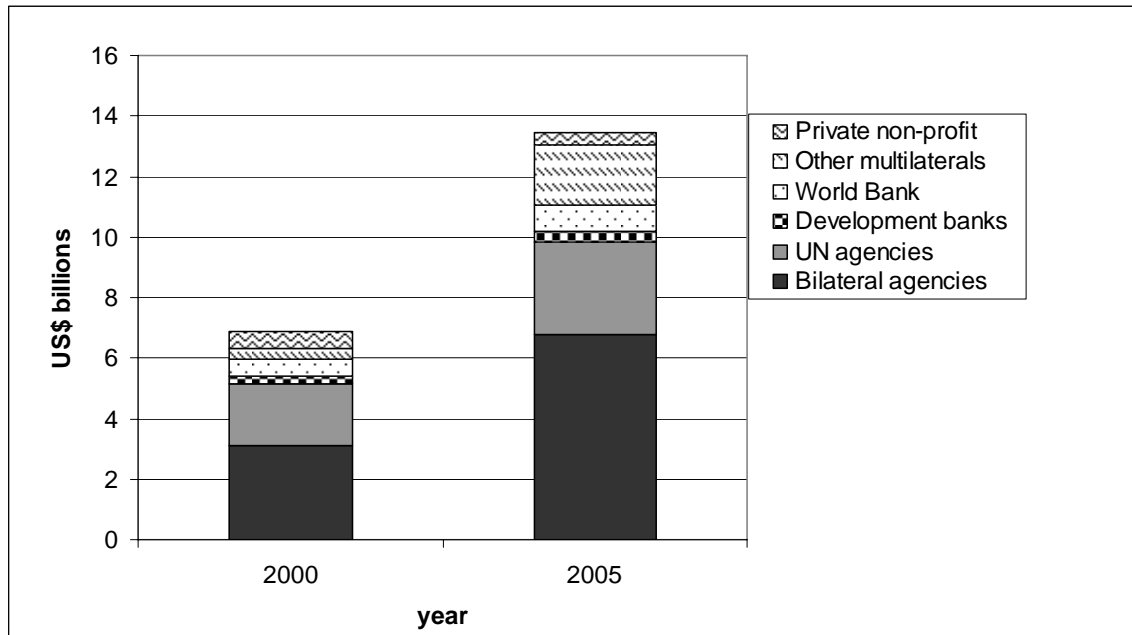
Taking Stock of HNP Financing in the World.

The donor level

As a direct and positive consequence of health's becoming a high-profile issue in the global arena and attracting new partners, development assistance for health (DAH) has increased from US\$2.5 billion in 1990 (0.016 percent of Gross National Income, or GNI) to almost US\$14 billion in 2005 (0.041 percent of GNI) (figure I1). As a proportion of official development assistance

(ODA), DAH has increased from 4.6 percent in 1990 to close to 13 percent in 2005. Much of this assistance is targeted to specific diseases or interventions, which raises issues of funding imbalances and prioritization. As a result, direct disease funding now accounts for an increasing proportion of donor aid. The latest Global Monitoring Report shows that, while the share of health aid devoted to HIV/AIDS more than doubled between 2000 and 2004—reflecting the global response to an important need, the share devoted to primary care dropped by almost half.⁵⁸

Figure I1. Development Assistance for Health, by Source, 2000–05 (US\$ billion)



Source: Catherine M. Michaud, Harvard School of Public Health, January 2007.

Fig Notes: (1) The category of ‘other multilateral’ includes the European Union, the Global Alliance for Vaccines and Immunization (GAVI), and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM). (2) World Bank total includes only IDA lending.

Most of the significant increases in development assistance for health come from bilateral donors, new global partnerships, and foundations, while contributions from the multilateral development banks and specialized UN agencies have been relatively flat.⁵⁹ Indeed, financing from bilateral donors accounted for more than 50 percent of DAH in 2005, and financing from new partners such as the Gates Foundation, GFATM, and GAVI accounted for almost 13 percent.⁶⁰

Although health-specific aid has increased, a significant gap persists between current aid volumes and estimated needs to reach the MDGs, for example. As shown in figure I2, after a decade of decline in the 1990s in both real terms and as a share of GNI, ODA has indeed increased to some 0.33 percent of GNI in 2005. However, this level falls well short of the promised Monterrey targets of 0.7 percent of GNI and of the Millennium Project projections of 0.54 percent needed to

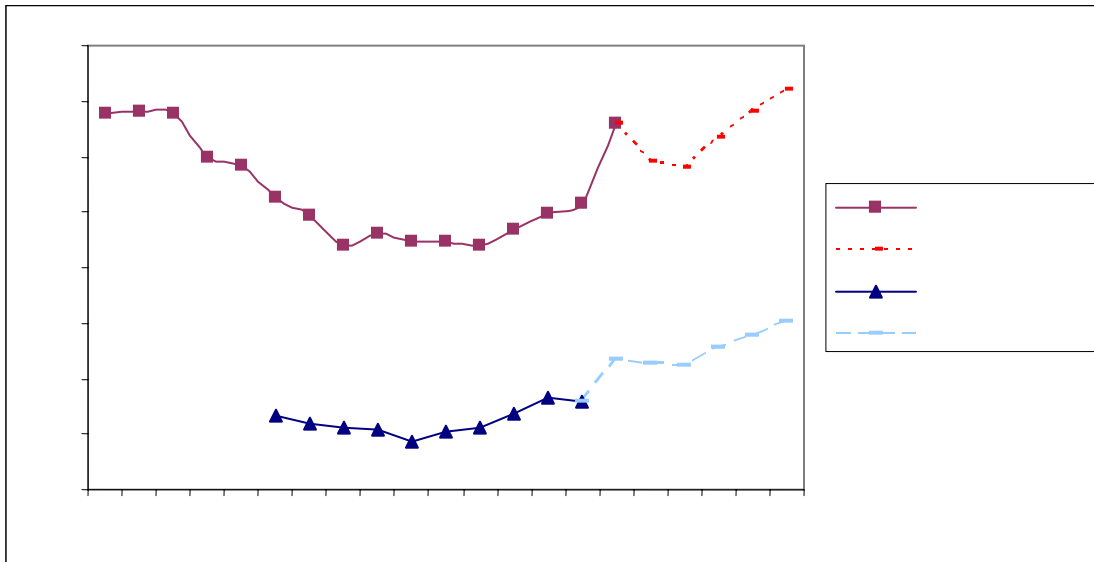
⁵⁸ Share of DAH devoted to primary care dropped from 28 percent in 1999 to 15 percent in 2004. World Bank. 2006. *Global Monitoring Report 2006: Strengthening Mutual Accountability—Aid, Trade, and Governance*. Washington, DC: World Bank.

⁵⁹ Catherine M. Michaud, Harvard School of Public Health, January 2007.

⁶⁰ C.M. Michaud. 2007. Harvard School of Public Health.

achieve the MDGs.^{61,62} Other estimates of additional external assistance to help developing countries reach the MDGs range from US\$25 billion to US\$70 billion.⁶³ These shortfalls, when coupled with the low and inefficient spending levels at the country level (discussed below), have serious implications for chances of achieving results.

Figure I2.
Net ODA as a Percent of GNI in DAC Donor Countries, 1990–2005, and
Projected, 2006–10.



Source: OECD Development Assistance Committee (DAC); projections by the OECD DAC Secretariat.

⁶¹ UN Millennium Project. 2005. *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals*. New York: UN Millennium Project.

⁶² United Nations. 2002. "Report of the International Conference on Financing for Development." March 18–22, Monterrey Mexico.

⁶³ Wagstaff, A. and M. Claeson. 2004. *The Millennium Development Goals for Health: Rising to the Challenges*. Washington, DC: World Bank.

The country level

Partially as a result of this increase in DAH, overall health spending in developing countries has also been increasing. Between 1990 and 2003, total health spending⁶⁴ in developing countries increased by more than 100 percent: from US\$170 billion in 1990 to US\$410 billion in 2003, or from 4.1 percent to 5.7 percent of developing-country GDP. However, despite these increases, domestic spending on health remains low and inefficient (table I1).

- Low-income countries spend less than 5 percent of their GDP on health, whereas middle- and high-income countries spend more than 6 percent and 11 percent, respectively. In exchange rate-based U.S. dollars, per capita total health spending was US\$24 in low-income countries and almost US\$4,000 in high-income countries, more than a hundredfold difference. Even after adjusting for differences in costs of living, the differentials are still on the order of 30 times.^{65,66}
- Some 70 percent of total health spending is out of pocket in low-income settings, declining to 15 percent in high-income settings. In Africa, out-of-pocket spending accounts for almost 50 percent of total health spending on average, and in 31 African countries, accounts for 30 percent or more of total health spending.⁶⁷ For the poor, out-of-pocket spending is the most regressive source of health sector financing and also denies all individuals the benefits of risk pooling and financial protection.

In addition, some regions' reliance on external assistance to finance health and other sectors has serious implications for sustainability and countries' abilities to plan for the long term. For example, external assistance plays a more significant role in health sector financing in Africa than in any other region, accounting for some 15 percent of all health spending on average, while in other regions, it accounts for less than 3 percent. Further, of the 23 countries globally in which external assistance accounts for more than 20 percent of all health spending, 15 (65 percent) of them are in Africa.⁶⁸ Moreover, in Africa, external assistance accounts for 55 percent of all external flows, while in the five other developing regions, worker remittances and foreign direct investment account for the bulk of external flows with external assistance accounting for only 9 percent.⁶⁹

⁶⁴ Includes external and domestic spending.

⁶⁵ Gottret, P. and G. Schieber. 2005. *Health Financing Revisited: A Practitioner's Guide*. Washington, DC: World Bank.WHO. 2006. *World Health Report*. Geneva: WHO.

⁶⁶ WHO. 2006. *World Health Report*. Geneva: WHO.

⁶⁷ Ibid.

⁶⁸ Ibid.

⁶⁹ Gottret, P. and G. Schieber. 2005. *Health Financing Revisited: A Practitioner's Guide*. Washington, DC: World Bank.WHO. 2006. *World Health Report*. Geneva: WHO.

Table II Composition of Health Expenditures in World Bank Regions and Income Categories, 2004

Regions & Income Levels	Per capita GDP (\$US)	Per capita health expenditures (\$US)	Per capita health expenditures (\$US PPP)	Total health expenditures (% GDP)	Public (% total health expenditures)	Out-of-pocket (% total health expenditures)	External (% total health expenditures)	Total Revenue to GDP ratio	Tax Revenue to GDP ratio
East Asia & Pacific	1,457	64	239	4.4	39.8	51.0	0.5	19.1	15.1
Eastern Europe & Central Asia	3,801	249	552	6.6	67.6	26.5	1.1	28.6	16.7
Latin America & the Caribbean	3,777	271	608	7.3	51.0	36.3	0.7	23.0	15.9
Middle East & North Africa	1,833	103	270	5.6	48.8	46.3	1.1	27.3	17.0
South Asia	611	27	131	4.6	18.8	76.1	1.6	15.0	9.8
Sub-Saharan Africa	732	45	119	6.3	42.1	46.3	6.8	22.9	18.2
Low-income countries	533	24	105	4.7	23.9	70.0	5.5	17.4	12.8
Lower middle-income countries	1,681	91	298	5.4	47.3	42.9	0.7	24.2	16.9
Upper middle-income countries	5,193	339	689	6.7	57.6	30.3	0.7	28.5	17.6
High-income countries	33,929	3,812	3,606	11.2	60.3	14.9	0.0	35.2	20.4

Source: World Development Indicators, IMF Government Finance Statistics

Notes: Per capita indicators weighted by population.

Revenue data reflect averages between 2000 and 2004.

Out-of-pocket health spending in Sub-Saharan Africa excludes South Africa, which, if included, changes the estimate to 26 percent of total health spending.

Low and inefficient expenditure patterns in low-income countries (LICs) are matched by their domestic resource mobilization capacity. Most LICs face enormous constraints in raising additional domestic resources: on average, LICs mobilize only 17 percent of their GDP from domestic resources.⁷⁰ Even if these countries could improve their capacity to raise resources domestically to finance health in an effort to scale up to reach the MDGs, massive increases in external assistance would be needed. Donors would still need to finance most of the gap.

Challenges in the New Global Health Architecture.

The impact of increased resources on health has been mixed, especially considering the persistence of stark imbalances between rich and poor countries in terms of disease burden, the huge unmet health needs in most developing countries, and their lack of domestic resources to cope with these needs:

- Ninety percent of the global disease burden is in developing countries that account for only 12 percent of global health spending.
- High-income countries spent more than 100 times per capita on health than low-income countries.
- Developing countries will need between US\$25 billion and US\$70 billion in additional aid per year to remove the financing constraint to scaling up to meet the MDGs.
- Further, most countries in Africa are off-track on all of the MDG health goals. More broadly, in all Bank Regions but the Middle East and North Africa (MENA) and South Asia (SAR), most countries are off-track with respect to the child mortality goal.

It is in this context that questions have arisen about the effectiveness of health spending and, concomitantly, the integrity of the global aid architecture in health.

Effectiveness of aid for health

There are at least four important manifestations of ineffective health aid at the country level:

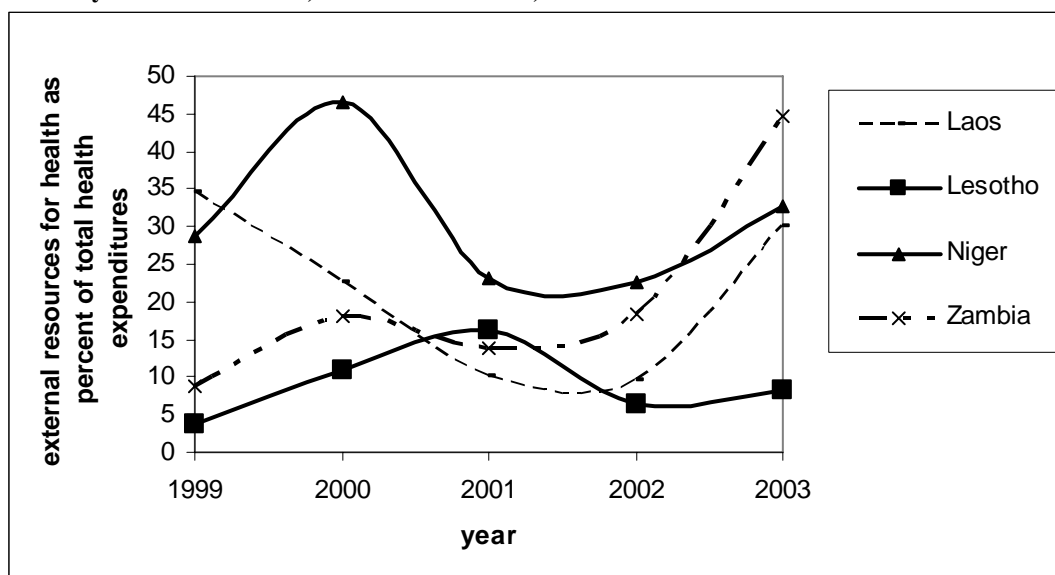
- **Aid is often not aligned with government priorities, and holistic health systems approaches are insufficiently funded.** As discussed above, health aid is often earmarked for specific purposes. Only about 20 percent of all health aid goes to support the government's overall program (i.e., is given as general budget or sector support), while an estimated 50 percent of health aid is off budget.⁷¹ As a result, many countries report difficulties in attracting sustained, flexible funding that can be used to support the health *system*: staff, infrastructure, training, management, and so on.
- **Aid can be unpredictable, short-term, and volatile.** In addition to being heavily earmarked, health aid can be very short-term and volatile (figure I3). When the amount of aid a country receives is likely to change at short notice, it is impossible for ministries of

⁷⁰ Gupta, S. et al. 2004. "Foreign Aid and Revenue Response: Does the Composition of Foreign Aid Matter?" Chapter in *Helping Countries Develop: The Role of Fiscal Policy*. Washington, DC: International Monetary Fund.

⁷¹ Foster, Mick. 2005. "Fiscal Space and Sustainability: Towards a Solution for the Health Sector." Paper presented at the World Bank/WHO conference "Third High-Level Forum on the Health MDGs," Paris, November 14–15. <http://www.hlfhealthmdgs.org/Documents/FiscalSpaceTowardsSolution.pdf>

health and finance to make long-term plans—such as employing more doctors or nurses, widening access to HIV/AIDS treatment, or scaling up health service provision—without incurring major risks of sustainability of financing for these services. A related issue, which also creates difficulties for ministries of finance and planning, is that aid can be unpredictable (disbursements do not match commitments, even where the reasons are not related to performance).

Figure I3
Volatility in Aid for Health, Selected Countries, 1999–2003



Source: World Health Organization, 2006.

- **Aid may be poorly harmonized, increasing transaction costs for government.** The high number of donors present in health, the large number of separate health programs, and large volume of resources may carry unpredictable risks and transaction costs unless they are well coordinated—both with each other and with government. A related issue is that the presence of multiple health partners may inadvertently undermine the government's broader efforts in the health sector. This is likely to affect the government's ability to deliver programs in other areas.

Integrity of the global health architecture

In addition to problems with the effectiveness of aid flowing into the health sector, some of the challenges of the new global health architecture stem from a lack of global governance and overlapping mandates of different aid agencies. Problems at the country level and the inherent complexities of the health sector also contribute to the quandaries concerning the effectiveness of external assistance for health.

Leadership at Global Level

There are more major global stakeholders in health than in any other sector and literally hundreds of different flows of public and private funds to specific countries. Issues include:

- The various international organizations and stakeholders have overlapping and unclear mandates—no single organization coordinates global health policy, financing, implementation processes, or knowledge dissemination at country or regional levels;
- Global Health Partnerships (GHPs) were initially promoted as tools to better focus health aid in areas of perceived neglect and to *simplify* the aid architecture in health, and, as a consequence, make health aid more effective. However, many observers believe—and a range of studies suggest⁷²—that this objective has not been achieved. It is recognized that GHPs have mobilized important new resources for major health threats and brought much needed political and technical focus to priority diseases or interventions. However, there is concern that the rapid creation of new institutions in health is difficult for countries to manage and further complicates donor harmonization efforts at the global level.

Finally, as in other sectors donor governments find it politically advantageous to raise aid “vertically” to show their populations that their tax monies are being spent on “good causes.” In particular, GHPs may intensify the “vertical” nature of health financing by focusing large amounts of new funding for specific, relatively narrow programs and interventions, creating separate financing and delivery silos, and leaving recipients little flexibility to reallocate funds according to their priorities or to fund health system costs, such as salaries. While this is an issue in all sectors, the consequences are particularly acute in health, because there is a need for flexible resources that can be used to support recurrent costs, other sectors that have a direct impact on health, and health systems.

Health Is a Complex Sector

Complexities in the aid architecture for health mirror the complexities of the sector itself. Creating and sustaining population health; providing financial protection from the consequences of ill-health; and managing, financing and governing the *health system* are all difficult and costly.

- Numerous nonhealth related factors affect health outcomes, necessitating complex cross-sector approaches.
- Health outcomes are reversible, if access to services is interrupted (unlike gains in education, for example).
- Individual behavior plays a critical role in health outcomes and is very difficult to influence or change.
- Measuring health outcomes—other than sentinel events such as births or death—and attributing causality to specific factors is inherently complex.
- The costly financial protection element of health financing is largely unique to the health sector (except for a few standard social protection programs such as pensions, unemployment insurance and social assistance).

⁷² Caines, Karen. 2005. “Key Evidence from Major Studies of Selected Global Health Partnerships”. Background paper prepared for the High-Level Forum on the Health MDGs, London, April 26—27; McKinsey & Company. 2005. *Global Health Partnerships: Assessing Country Consequences*. Seattle, WA: Bill & Melinda Gates Foundation; Caines, K. et al. 2004. *Assessing the Impact of Global Health Partnerships*. London: DFID Health Resource Centre.

- The bulk of the funding needed is for *long-term recurrent* costs rather than the traditional donor-financed *short-term investment* costs, raising issues of sustainability and the need for countries to create adequate fiscal space in their budgets.
- The health sector is critical in terms of both its share of the public budget and as a major source of public employment.
- Well over a hundred major organizations are involved in the health sector, globally and nationally, far more than in any other sector;
- The private sector plays a substantial, often predominant, role in both the financing and delivery of health care services and is often absent from the policy debate.
- Market failures in insurance markets and in the health sector more generally require complex regulatory frameworks and limit governments' abilities to simply rely on market mechanisms.

From Consensus on the Problems to Coordinated Action at Country Level

A consensus on the challenges has emerged, and new steps have been taken to improve the effectiveness of aid for health and streamline the new global health architecture through donor harmonization and alignment with country systems. The Paris Declaration is a key reference point for improvements in health aid: as the framework for aid effectiveness in general, it also frames efforts to improve aid for health.

UNAIDS, together with the Global Fund, bilateral donors, and other international institutions, has committed itself to harmonization and alignment in HIV/ AIDS through the concept of the Three Ones. These are: one agreed HIV/AIDS action framework for coordinating the work of all partners; one national HIV/AIDS coordinating authority with a broad-based multisectoral mandate; and one agreed country-level system for monitoring and evaluation.

Subsequent to the agreement of the Three Ones, the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors (GTT) was established. In June 2005 it presented a plan to further coordinate the HIV/AIDS response, making specific recommendations to partner governments, the United Nations system, and the Global Fund to Fight AIDS, TB, and Malaria (though not to bilateral donors). In particular, the GTT recommended the development of a scorecard-style accountability tool to examine the performance of national partners in creating a strong HIV/AIDS response and international partners in providing support according to the GTT recommendations. The scorecard is being piloted by UNAIDS in a number of countries.

Stakeholders in the health sector have responded to aid shortfalls, aid effectiveness problems, and failures in the supply of global public goods for health through the development of innovative financing methods. These are: the International Finance Facility for Immunization (IFFim), Advanced Market Commitments (AMC), and UNITAID (previously called the International Drug Purchase Facility). The innovative finance agenda is seen as an important component of a more robust and performance-driven approach to development assistance. This is particularly true, given the unintended impact that unpredictable aid has had on markets, most notably for pharmaceuticals and vaccines needed by the poorest countries.

The HLF was a series of three high-level meetings in 2004–05 among key donors and some 20 countries that looked at many of the aid-effectiveness issues raised above. It also strengthened cooperation between the WHO, the World Bank, the IMF, bilateral donors, global health partnerships and other UN agencies and has helped create a *consensus for action* around the scaling up of the agenda in health.

As donors make good on their promises to scale up development assistance between now and 2015, many will wish to invest in health. Creating effective aid architecture in health—which delivers results—helps make the case that “aid works” and should leverage further resources for the sector and perhaps overall, while a dysfunctional health architecture does the opposite. One key challenge is to demonstrate the link between the aid effectiveness agenda and better health outcomes. The Paris Declaration emphasizes progress towards harmonization and alignment, and has an in-depth monitoring and accountability process related to this objective. It does not, however, hold donors and countries accountable for development results, in health or other areas.

Taking forward the harmonization and alignment agenda in health is about *managing complexity*—recognizing that diversity can help bring results and that the health sector benefits from a range of partners with different ways of doing business. As part of the post-HLF agenda, there will be efforts at the country level to develop instruments for mutual accountability between donors and countries. These efforts will be initiated by the health community but will look beyond the sector and aim to ensure alignment of health strategies and goals and other development objectives.

Annex J – Bankwide HNP Results Framework

What results on the ground are important? Country Outcomes					How does the Bank contribute to these results?	How do we know if implementation is on track? Process Indicators		
Strategic Policy Objective	Final outcomes	How do we measure these results? Final Indicators	Multisectoral Contributions to Intermediate Outcomes/Outputs	How do we measure these results? Intermediate Indicators (Reporting Accountability of Sectors)	Bank Strategy	Country	Bank	
							Process indicator	Baseline
1) Improve the level and distribution of key HNP outcomes, outputs, and system performance at country and global levels in order to improve living conditions, particularly for the poor and vulnerable	I. Childhood mortality reduced (by income quintile) (MDG 4, Target 5 and MDG 7, Target 10)	Under-five mortality rate	<i>Water & Sanitation, Energy, Environment, Agriculture, Education, Gender, HNP:</i> Reduced neonatal, infant and under-five mortality and morbidity by increasing effective coverage with high impact interventions	<i>HNP reporting accountability:</i> 1) Immunization coverage (DPT3, Measles, Hib, Hepatitis B) 2) % pregnant women who have received a tetanus vaccine 3) % children with diarrhea that received ORT 4) % of children with ARI taken to health provider <i>Water & Sanitation reporting accountability:</i> 5) % population with access to improved water supply services <i>Energy reporting accountability:</i> 6) % of households with electricity 7) Energy from combustible renewables and waste (% of total energy)	A. Renewing Focus on Results 1. <i>Build statistical capacity</i> for client countries on priority HNP outcome indicators (disaggregated by gender and age) directly through Bank operations and / or supporting global partner's country support (e.g., MDGs). This includes the development of country-based frameworks for the collection of essential household HNP and multisectoral indicators. 2. <i>Pilot and evaluate impact of output-based and performance-based financing</i> for HNP-related projects/programs. 3. <i>Introduce Results Frameworks</i> for all projects targeting HNP outcomes, output, and system	Number of active borrowers (alternatively, percent of countries by region) who are able to measure causes of under-five mortality at disaggregated levels. Currently, fewer than 1/3 of all low- and middle income countries have vital registration systems that are complete enough to monitor trends in the under-five mortality MDG. Bank will seek to increase this to the number of countries with sound systems. National HNP outcome strategies and PRSPs with increased use of multisectoral approach to achieve results in HNP outcomes	1. At least 40% of new CASs targeting HNP results to be discussed with the Board in FY09 and thereafter will identify capacity and systems building activities (Bank and / or coordinated with global partners) for monitoring and evaluating HNP results in government programs. 2. By FY10, at least 14 active projects with most loan proceeds allocated on output-based financing. Impact evaluation plans in place for 60% of these projects or more upon approval.	1. Less than 10% of CASs targeting HNP results 2. 4 active projects in FY06 3. Less than 25% of active projects as of FY06 with
	II. Childhood malnutrition improved (MDG 1, Target 2)	Percentage of children under the age of five who are underweight, stunted	<i>HNP, Water & Sanitation, Agriculture, Environment, Energy, Education:</i> Reduced child	<i>HNP reporting accountability:</i> 8) % infants under 6 months who are exclusively breastfed 9) % of children who receive breastfeeding plus adequate			3. At least 70% of new projects / programs approved by the Board in FY08	

			underweight and stunting by increased coverage with effective interventions	complementary food (6-9 months) <i>Water & Sanitation reporting accountability:</i> See 5) above <i>Energy reporting accountability:</i> See 6) and 7) above	performance, including baseline data and output targets.		and thereafter.	satisfactory results framework.
			<i>HNP, Education, Private Sector:</i> Reduced under-five micronutrient deficit	<i>HNP reporting accountability:</i> 10) % children (6-59) months receiving at least one dose of Vitamin A supplementation 11) % households using iodized salt	4. <i>Periodic data collection and updates</i> (as appropriate to specific indicators) for at least 70% of the indicators included in project Results Framework and updated periodically in Implementation Status Reports (ISRs).	Ministries of Finance allocate resources to and within the sector on the basis of some measures of performance.	4. At least 65% (annually) of all projects/programs approved by Board in FY08 and thereafter.	4. Less than 15% of active projects as of FY06
			<i>HNP, Education:</i> Reduced prevalence of low birth weight	<i>HNP reporting accountability:</i> 12) % newborns with low birth weight	5. <i>Develop indicators</i> (including gender based indicators) for priority HNP outcomes for which no agreed indicators exist (e.g., financial protection, governance in the health sector, and financial and fiscal sustainability).	Countries have 'policy analytic capacities' within MOH or mechanisms for contracting out policy analyses, performance review functions.	5. Develop indicators by end-FY08.	5. Does not exist.
III. Avoidable mortality and morbidity from chronic diseases and injuries reduced	Adult mortality rate (15-60)		<i>HNP, Education:</i> Reduced exposure to risk factors of NCDs and Injuries	<i>HNP reporting accountability:</i> 13) Smoking prevalence among teenagers and adults 14) % of adult population with BMI above 25	6. <i>Improve results in existing portfolio.</i> Review and restructure existing HNP portfolio (Project Design and / or Project Development Objective, PDO) to achieve satisfactory PDO or higher outcome at project closing.		6. 75% for FY09 and thereafter (each Region and total HNP portfolio).	6. Annual average of 66% of projects closing with satisfactory PDO or higher (FY05 and FY06).
			<i>Infrastructure:</i> Reduced mortality/morbidity due to road traffic crashes	<i>Infrastructure reporting accountability:</i> 15) % of road network with safety rating of 3 to 4 'stars' (on scale of 4)				
IV. Improved maternal, reproductive and sexual health (MDG 5, Target 6)	Maternal Mortality Ratio Total Fertility Rate Adolescent Fertility Rate		<i>HNP, Education, Infrastructure:</i> Improved coverage with effective maternal and perinatal interventions	<i>HNP reporting accountability:</i> 16) % women with deliveries attended by skilled health personnel 17) % women with at least one antenatal care visit during pregnancy <i>Infrastructure reporting</i>	7. <i>Concurrent monitoring of overall active Bank portfolio performance and PDO indicators on HNP results.</i> Develop and implement central database with HNP project results		7. Develop by end-FY08; implement by end-FY09.	7. Does not exist.

		Increased birth spacing		<i>accountability:</i> 18) % of rural population with access to an all-season road	based on ISR and project Results Framework data online for monitoring portfolio results and quality. B Strengthening Health Systems and Ensuring Synergy between Health System Strengthening and Priority-Disease Interventions			
		<i>HNP, Gender, Education:</i> Improve Family Planning and Sexual Health		<i>HNP reporting accountability:</i> 19) Contraceptive prevalence rate among women of reproductive age 20) Unmet need for contraception 21) Prevalence rate of STIs among adults and young people (15-24 years)				
		<i>HNP:</i> Reduced incidence of cervical cancer		<i>HNP reporting accountability:</i> 22) HPV immunization coverage				
V. Reduced morbidity and mortality from HIV/AIDS, TB, malaria and other priority pandemics (MDG 6, Target 7 & 8)	Adult HIV prevalence among (a) all antenatal women; (b) women 15-24	<i>Education, Infrastructure, HNP, Gender:</i> Increased HIV/AIDS prevention and case fatality reduction	<i>HNP/GHAP reporting accountability:</i> 23) % young women and men aged 15-24 reporting the use of a condom the last time they had sex <i>Water & Sanitation reporting accountability:</i> See 5) above <i>Energy reporting accountability:</i> See 6) and 7) above	8. Increase support to Bank country teams to <i>identify health system constraints (including gender specific constraints) to achieving HNP results</i> and mainstream system-strengthening actions to overcome constraints in all new HNP operations (or other sectoral or global partner operations), including priority-disease interventions.		8. Develop operations toolkit for rapid assessment of health system constraints for better outcomes (completed by end of FY08) Complete identification of 7 countries by December 2007. Launch on-demand support in 4 countries by June 2008. Put on-demand support in place to Bank country teams in 7 countries by June 2009. At least 60% of projects approved in	8. Less than 25% identify health system constraints. Less than 45% include health system strengthening in areas of Bank comparative advantages.	
	Reduce AIDS Mortality: percent of People Living with AIDS who survive at least 12 mos after a complete ART course	<i>HNP:</i> Increased HIV/AIDS ARV treatment	<i>HNP reporting accountability:</i> 24) % men and women with advanced HIV receiving anti-retroviral therapy (ART)					

			<p><i>HNP, Agriculture</i></p> <p>Increased malaria prevention and treatment</p>	<p><i>HNP reporting accountability:</i></p> <p>25) % children who slept under an insecticide treated bednet (in malarious areas)</p> <p>26) % of children with fever in malarious areas who receive antimalarial treatment</p> <p>27) % of pregnant women in malarious areas who receive treatment or preventive treatment for malaria</p>			<p>FY09 and thereafter will include assessment of health systems constraints to reaching HNP results.</p> <p>At least 70% of those identifying constraints will include appropriate policy actions / investments to overcome them.</p>	
		Reduced TB Mortality	<p><i>HNP:</i></p> <p>Increased TB detection and treatment</p>	<p><i>HNP accountability</i></p> <p>28) % TB cases detected and cured under DOTS</p>	<p>9. Put in place arrangements for collaborative division of labor on health systems with global partners at global and country levels.</p>		<p>9. Dialog in place for global arrangements by December 2007.</p> <p>Launch collaborative division of labor arrangements for at least 7 countries where projects / programs include interventions requiring expertise other than Bank comparative advantages (by December 2008)</p>	9. Does not exist.
		Increased country readiness to detect outbreaks and prevent/contain address rapid onset of pandemic (e.g., Avian Influenza)	<p>Increased proportion of low-income countries with a functioning sentinel surveillance scheme for influenza-like illness</p> <p>Increased proportion of countries with an integrated Avian Influenza pandemic contingency plan.</p>	<p><i>HNP reporting accountability:</i></p> <p>29) # of health facilities/providers who routinely report ILI to national authorities</p> <p>30) % increase in the number of ILI reported annually (% to be defined for each country).</p> <p>31) # of specimens from sentinel surveillance sites examined and subtyped annually.</p> <p>32) Evidence of secured source of funding for outbreak investigation as per the prerequisites of the integrated AI pandemic contingency plan</p> <p>33) Evidence of simulation</p>	<p>10. Focus knowledge creation and policy advice (AAA) on Bank comparative advantage.</p> <p>(Increase proportion of country- and regional-level AAA, appropriate to requirements of LICs and MICs, focused on Bank comparative advantages.)</p>		<p>10. By end of FY08, 50% and by end of FY09 70% of new HNP sector AAA will be focused on areas of Bank comparative advantage in specific areas appropriate for LICs' and / or MICs' requirements.</p> <p>(e.g., Health system financing, demand-side determinants of</p>	10. Less than 35% so focused.

				exercises being conducted in an integrated fashion together with veterinary authorities			results, intersectoral contribution to HNP results, private-public collaboration).	
2 Prevent poverty due to illness (by improving financial protection)	VI. Improve Financial Protection (Reduce the impoverishing effects of illness for the poor or near poor)	% population falling below the poverty line due to illness	<i>HNP, PREM:</i> Reduction of out-of-pocket expenditures in health for "insurable events"	<i>HNP reporting accountability:</i> 34) % out-of-pocket expenditures in health (for a basic package of services) as a proportion of total household income	C. Strengthening Bank Intersectoral Advisory Capacity 11. Develop, pilot test, and implement <i>Multisectoral Constraint Assessment (MCA)</i> tool and process. Pilot test in a number of LICs and MICs. <i>12. Identify lending and AAA in CAS.</i> MCA-identified HNP- related Bank projects / programs / components in CAS. D. Increase selectivity, improve strategic engagement, and reach agreement with global partners on collaborative division of labor for the benefit of client countries <i>13. Increase use of harmonization and alignment</i> principles for Bank projects in IDA at country level.		11. First tool developed by end-FY08 and pilot tested in 2 MICs and 2 LICs by end-FY09.	11. Does not exist.
			<i>HNP, PREM:</i> Increase in risk-pooling schemes (contributory or non-contributory)	<i>HNP reporting accountability:</i> 35) % of lowest quintiles households participating in risk-pooling schemes (contributory or non-contributory)			12. MCA will be used to identify 40% of projects / programs with HNP results included in at least 50% of new CASs discussed with the Board by FY10 and thereafter.	12. Does not exist.
			<i>HNP, PREM:</i> Reduction in income loss due to illness	<i>HNP reporting accountability:</i> 36) % of households receiving income substitution of ill breadwinner 37) % of workers receiving treatment for common productivity reducing illness (e.g., Intestinal worms, iron deficit anemia)			13. By FY11, at least 81% of projects approved by Board will be based on country fiduciary systems or will have common fiduciary arrangement / rules for all participating donors.	
3) Improve financial sustainability in the HNP sector and its contribution to sound macroeconomic and fiscal policy and to country competitiveness	VII. Improve Funding Sustainability in the Public Sector from Both Domestic and External Sources	To be developed	To be developed	To be developed				

Note: This global HNP Results Framework is presented as guidance for the Regions, but it is essential to ensure its country-driven application and adaptation. The framework is intended to serve as guidance and support for Regions to elaborate their own HNP strategy and for country teams to help in the process of identifying constraints to improving outcomes and performance at country level. The framework should not be understood as a prescriptive, limiting instrument.

Note: The periodicity of the collection of data will vary. Not all indicators are measured annually. Countries conduct Health and Demographic Surveys 3-5 years apart.

Annex K

“The ESW Previously Known as BCOI”: Multisectoral Constraints Assessment (MCA) for Health Outcomes

Rationale I (for Countries and Country Directors)

The attention to outcomes brought about by the Millennium Development Goals (MDGs) exposed a critical gap in client-country and World Bank programs for health, nutrition, and population (HNP). While it is universally acknowledged that reducing mortality, morbidity, fertility, and malnutrition requires multisectoral inputs and actions, little analysis has been done at the country level to systematically document the bottlenecks in different critical sectors, set out a framework for prioritizing actions, or assess institutional constraints. The proposed new economic sector work (ESW) instrument is designed to address this gap in the arsenal of client countries and development agencies. The proposed ESW will: (i) systematically assess multisectoral constraints to achieving HNP Results; (ii) provide a framework for prioritization of actions; and (iii) assess institutional factors and structures for facilitating coordinated actions by the prioritized sectors. For the World Bank country program, this new ESW product line will guide CAS development for multisectoral approaches to addressing the MDGs and other health outcomes, especially for the poor.

Rationale II (for the HNP Family)

Successful knowledge institutions (e.g., consulting firms or development institutions) put a premium on quality of knowledge, standardization of core competencies, and relevance to the clients. Within the World Bank, these success factors can be seen in the way groups like PREM and Social Protection select specific ESW lines that are high in quality, focus on the comparative advantages of the World Bank, and target not only line ministries, but primarily the Ministry of Finance (MOF). For HNP to achieve similar success, the current practice of an ad hoc and unstructured ESW program has to give way to much more selectivity, based on comparative advantage and serving the need of MOFs and Bank Country Directors in addition to Ministries of Health (MOHs). The new World Bank HNP Strategy has identified two clear lines of ESW business that fit the above success criteria. One line of ESW should focus on the crucial link between the MOH and the MOF by building simple instruments that address contingent liabilities for a country's budget created by the health sector, issues around fiscal space, and issues around the allocative efficiency and the welfare impact of the health sector. The second line of ESW, addressed in this note, relates to systematic assessments of multisectoral constraints to achieving health outcomes as well as institutional frameworks to ensure coordination of inputs by different line ministries. The ultimate objective of this latter line of ESW is to provide a technical and institutional prioritization framework for Finance and Planning Ministries (and input for Bank CASs) and to help elevate MOHs from service delivery structures to a higher role of stewardship.

Objectives of the Multisectoral Constraints Assessment

Given the complex multisectoral determinants of HNP outcomes, it is critical that decisions about investments in the different sectors be guided by evidence on distribution of these outcomes, assessment of the binding constraints in relevant sectors, a prioritization framework, and an assessment of institutional factors that can help or hinder multisectoral coordination and sectoral implementation. A fully fledged application of this new ESW instrument has the following objectives (rapid MCAs take on a subset of the objectives):

- *Identifying outcome targets* by reviewing and stratifying health, nutrition, and fertility outcomes at the national and subnational levels. Outcomes include mortality (infant, child, maternal, and adult), morbidity by cause of illness / injury, nutritional status, and fertility rates. Depending on the size and organization of the country assessed and the availability of data, the outcomes will be stratified by geographic groupings and socioeconomic status, including poverty levels, wealth groups, education, gender, and different sources of country-specific vulnerability factors (minorities, tribes, social castes, and so on).
- *Investigate sector-specific constraints* by documenting the presence or absence of critical inputs for achieving the targeted HNP outcomes. Inputs include, for example, immunization rates, access to and use of attended deliveries, use of iodized salts, knowledge of and use of modern contraceptives, source of indoor cooking and heating, access to clean water, success of vector control measures, and availability of roads for emergency transport of pregnant women. The selection of constraints to be investigated is a function of the HNP outcome in question.
- *Guide decision making* by using outcome and constraint assessments to develop a country-specific prioritization framework that outlines short-, medium-, and long-term policy actions by different sectors, develops alternative cotargeting maps and mechanisms that combine poverty and health outcome data, identifies institutional and operational constraints as well as possible solutions for coordinated action, and lays out a menu of potential policy instruments.

A number of these objectives can be addressed with existing ESWs in some countries, especially if large ESWs were undertaken, but the approach tends to be ad hoc in nature and focus almost entirely on one sector (e.g., HNP or environment). Moreover, rarely are all the relevant sectors addressed at the same time to allow for prioritization and synergy. Even more challenging is to find institutional assessments or options that look at practical ways of ensuring coordination in the production and targeting of multisectoral inputs. What MCAs can do for health outcomes in any country is to assess systematically technical and institutional constraints in order to create a prioritization framework for client countries and support World Bank country teams in addressing outcomes in the CAS process.

Annex L

What is a health system? ⁷³

A “system” can be understood as an arrangement of parts and their interconnections that come together for a purpose (von Bertalanffy 1968). What sets apart a health system is that its purpose is concerned with people’s health. A health system has many parts. In addition to patients, families, and communities, Ministries of Health, health providers, health services organizations, pharmaceutical companies, health financing bodies, and other organizations play important roles. The interconnections of the health system can be viewed as the functions and roles played by these parts. These functions include oversight (e.g., policymaking, regulation), health service provision (e.g., clinical services, health promotion), financing, and managing resources (e.g., pharmaceuticals, medical equipment, information). Describing the parts, interconnections, and purpose, Roemer (1991) defined a health system as “the combination of resources, organization, financing and management that culminate in the delivery of health services to the population.” The World Health Organization (2000) redefined the main purpose in its definition of a health system as “all activities whose primary purpose is to promote, restore, and maintain health.” In recent years, the definition of “purpose” has been further extended to include the prevention of household poverty due to illness.

Many factors outside the health system influence people’s health, such as poverty, education, infrastructure, and the broader social and political environment. Because they are open to influence from outside, health systems are known as open systems. A health system’s many parts operate at many levels. Smaller systems may be self-contained and have limited scale and scope, such as those involved in running a clinic or a managing a health information system. Larger systems might involve the coming together of various smaller systems (e.g., clinics, hospitals, health promotion programs) to provide coherence at community or national level. Given the purpose, scale, and scope of a country’s health system, it is not effectively controlled centrally, and changes in a system are not predictable in great detail (even if some parts of the system appear to behave predictably). This is partly because people and organizations innovate, learn, and adapt to change and partly because reorganization occurs continually in health systems in both formal and informal ways. These features have led systems thinkers to describe health systems as complex adaptive systems (Plsak 2001). Understanding health systems as complex adaptive systems has important implications for approaches to influencing health systems to produce better health outcomes, or to do so in a more efficient or equitable manner.

Building on the definition of a health system, this annex describes the important functions of the main parts of the health system, highlighting some of the key issues for low- and middle-income countries. Interpreting the parts and functions of a health system can be done independently, but greater power comes in bringing the parts together to improve people’s health and illness-related poverty. We conclude with further discussion of how to understand health systems as complex adaptive systems and the practical implications.

⁷³ Most of the discussion and information in this annex draws (and quotes) extensively from findings and recommendation of: (a) The World Health Report (2000), “Health Systems: Improving Performance,” World Health Organization, Geneva, Switzerland, 2000; (b) Baeza C. and Packard T., “Beyond Survival: Protecting Households Against the Impoverishing Effects of Health Shocks,” World Bank, Stanford University Press, 2006; and (c) from contributions from the Health Services Team of the HNP Hub led by David Peters.

Health System Functions

Health service provision, health service inputs, stewardship, and health financing are the four main health system functions. Households' demand behavior as well as overall health sector governance largely determine how these functions perform.

Stewardship (overall system oversight) sets the context and policy framework for the overall health system. This function is usually (but not always) a governmental responsibility. What are the health priorities to which public resources should be targeted? What is the institutional framework in which the system and its many actors should function? Which activities should be coordinated with other systems outside the realm of health care, and how (e.g., highway safety, food quality control)? What are the trends in health priorities and resource generation and their implications for the next 10, 20, or 30 years? What information is needed and by whom to ensure effective decision making on health matters, including prevention and mitigation of epidemics? These questions are the core of the stewardship function. An additional central function of stewardship is generating appropriate data for policymaking. These range from public health surveillance data to health system performance and provide the basis for assessing health status, regulating the sector, and tracking health system performance, effectiveness and impact. Stewardship remains a fragile function in many Bank client countries.

Public and private health service provision is the most visible product of the health care system. The best systems also promote health and try to head off illness through education and preventive measures such as well-child consultations. All these roles and activities mean that the system has to perform a wide range of activities. "Delivering health services is thus an essential part of what the system *does*—but it is not what the system *is*" (WHO 2000).

Health service inputs (managing resources) is the assembling of essential resources for delivering health services, but these inputs are usually produced at the borders of the health system. These inputs include human resources (produced mostly by the education system with some input from the health system), medications, and medical equipment. Producing these resources often takes a long time (e.g., a trained medical doctor, a new vaccine or drug). This function is generally outside the immediate control of health system policy makers who, nevertheless, have to respond to short-term population needs with whatever resources are available. An example of this problem is the current crisis of medical education in Sub-Saharan Africa.

Health system financing includes collecting revenues, pooling financial risk, and allocating revenue (strategic purchasing of services). We briefly examine them in this annex.

- *Revenue collection* entails collection of money to pay for health care services. Revenue collection mechanisms are general taxation, Development Assistance for Health (DAH, donor financing), mandatory payroll contributions, mandatory or voluntary risk-rated contributions (premiums), direct household out-of-pocket expenditures, and other forms of personal savings. Traditionally, each method of revenue collection is associated with a specific way of organizing and pooling funds and buying services. For example, public health systems are typically financed through general taxation, and social security organizations are usually financed through mandatory contributions from workers and employers (payroll contributions).

In most countries, health financing is a mix of general taxation, mandatory social insurance contributions, and household out-of-pocket expenditure (OOP). The relative importance of each source of financing varies greatly across countries. While countries in the Organization for Economic Cooperation and Development (OECD) rely heavily on public financing (either fiscal or mandatory payroll tax), the importance of OOP is larger in middle-income countries (MICs), and it is the largest in low-income countries (LICs), where it often reaches 70 or 80 percent of total health expenditures. DAH is an important source of health financing in a number of LICs, mainly in Africa. However, DAH on average contributes only about 7 percent of all health expenditures in LICs, ranging from 3 percent in a few LICs to more than 40 percent in a few.

- *Risk pooling* refers to the collection and management of financial resources in a way that spreads financial risks from an individual to all pool members (WHO 2000). Financial risk pooling is the core function of health insurance mechanisms. Participation in effective risk pooling is essential to ensure financial protection. It is also essential to avoid payment at the moment of utilizing the services, which can deter people, especially the poor, from seeking health care when sick or injured. Each society chooses a different way of pooling its people's financial risk to finance its health care system. Most high-income countries follow one of the two main models: the Bismarck model (Bismarck's Law on Health Insurance of 1883) or the Beveridge model (from the report on Social Insurance and Allied Services of 1942—the Beveridge Report). In most developing countries, multiple and fragmented forms of risk-pooling arrangements coexist. Population participation in risk pooling is lowest in LICs and among the poor. It is also low in MICs among the informal and self-employed population. Improving financial protection in Bank client countries requires a substantial effort to increase participation in risk pooling.

Fragmentation is the most distinctive characteristic of LIC and MIC health systems. Within each system, different types of risk-pooling arrangements coexist, creating a complex set of incentives for households trying to cover their health care costs. These incentives not only shape how households decide to face potential financial losses from health shocks, but also influence life-style and economic decisions such as whether to work in the formal or informal sectors of the economy. Reducing health system fragmentation is essential to improve performance and systemic capacity to serve and protect the poor.

- *Strategic purchasing*. Strategic purchasing is the way most risk-pooling organizations (purchasers) use collected and pooled financial resources to finance or buy health care services for their members. In the practical, day-to-day interaction between purchasers and providers, the purchaser, within a regulatory framework, plays a key role in defining a substantial part of the external incentives for providers to develop appropriate provider-user interaction and health service delivery models.

Systems Thinking

When trying to intervene in any system, it is important to be able to distinguish whether its nature is primarily mechanical or adaptive. In mechanical systems, what results will occur in response to a given stimulus can be predicted, usually in great detail and under different circumstances. A mechanical system may be complex, like an automobile, but it does not show emergent behavior. Adaptive systems, on the other hand, have the freedom to respond to different stimuli in different and unpredictable ways and are interconnected with the actions of other parts of a system. Many human systems, including health systems, are adaptive. Health outcomes are not merely a product of a set of physical inputs,

human resources, organizational structure, and managerial processes. They are complex adaptive systems that have the following key characteristics (Plsek 2001):

- *Adaptable elements.* They can learn and change themselves. In mechanical systems, change is imposed, whereas under adaptive systems, they can happen from within.
- *Context.* Systems exist within systems, and this context matters, because one part of a system affects another. In health systems, changing the financing system may change availability and performance of health workforce, the use of other inputs, and the relationship with patients. In adaptive systems, optimizing one part of the system may lead to poor overall system performance. In a hospital, for example, reducing the length of stay of patients in one ward may lead to queuing and readmission in other parts of the hospital, compromising overall quality or cost.
- *Inherent order.* Systems can be orderly even if there is no central control, often because they self-organize. Health systems are self-organizing; different types of provider organizations, associations, and behaviors emerge continually, either formally or informally.
- *Not predictable in detail:* Changes are not linear or easily predictable. For example, a large health program may have little impact, but a rumor may spark a strike or a riot at a clinic. Forecasting and modeling in health systems can be done to predict effects on health and poverty, but they are not predictable in detail because the elements and relationships are changeable and nonlinear, often in creative ways. The only way to know what complex adaptive systems will do is to observe them.

What are the practical implications of viewing health systems as complex adaptive rather than mechanical systems? In the first place, giving up a mechanical approach means spending less time on blueprints and detailed plans. It also means that it is less important to search for the “correct” health financing or organizational approach for a given country or a given context. It does mean the following:

- Understand the context, look for connections between the parts (e.g., between programs, between demand and supply, across sectors), anticipating downstream consequences and identifying upstream points of leverage.
- Focus on simple rules to produce complex outcomes. Balance three types of rules that: (1) set direction (e.g., leadership and vision); (2) set prohibitions (e.g., regulations and boundary setting); (3) provide permission (e.g., setting incentives or providing resources).
- Understand how organizational structure influences behavior. How Ministries are organized, and how development assistance is provided matter a great deal. Health workers hired and trained under a centrally managed disease program will work differently from those accountable for all outpatient conditions and hired by a local health service organization.
- Use data to guide decisions. Constantly looking at how health systems perform is the best way to see how it is actually behaving and whether a project or new intervention is making a difference.

Annex M

Partners in Health, Nutrition and Population

1 - Global health partnerships and initiatives the World Bank is engaged with:

African Program for Onchocerciasis Control (APOC)
European Observatory
Global Alliance for Improved Nutrition (GAIN)
Global Alliance for Vaccines and Immunization (GAVI)
Global Forum for Health Research (GFHR)
Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)
International AIDS Vaccine Initiative (IAVI)
International Lung Health Program – International Union Against Tuberculosis and Lung Disease (IUATLD)
International Partnership for Microbicides
Joint United Nations Programme on HIV AIDS (UNAIDS)
Mainstreaming Nutrition in Maternal Child Health Program
Medicines for Malaria Ventures (MMV)
Population and Reproductive Health Capacity Program
Roll Back Malaria (RBM)
Stop Tuberculosis Partnership (Stop TB)
United Nations Standing Committee on Nutrition
West Africa Multidisease Surveillance Control
WHO Special Programme for Research and Training in Tropical Diseases (TDR)
WHO Special Programme of Research, Development and Research Training in Human Reproduction (HRP)

2 - Process/programs the Bank is part of without financial participation:

Child Health and Nutrition Research Initiative (CHNRI)
Disease Priorities and Control Program (DCP2)
Donors' Group on Adolescent Sexual and Reproductive Health and Rights
Global Alliance to Eliminate Lymphatic Filariasis
Global Alliance for Improved Nutrition (GAIN)
Health Metrics Network (HMN)
International Finance Facility for Immunization (IFFIm)
Interagency Working Group on Youth
Micronutrient Initiative
Nutrition and Gender
Reproductive Health/HIV Interagency Working Group
Reproduction Health Supplies Coalition (RHSC)
Road Traffic Injuries Research Network
UNITAID

3 - Global institutional partners:

African Union (AU)
Asian Development Bank (ADB)
European Union (EU)
Food and Agricultural Organization of the United Nations (FAO)
Inter-American Development Bank (IADB)
International Labor Organization (ILO)
Organization for Economic Cooperation and Development (OECD)
United Nations Children's Fund (UNICEF)
United Nations Development Programme (UNDP)
United Nations Population Fund (UNFPA)
World Health Organization (WHO)
World Organization for Animal Health (OIE)

4 – Bilaterals

Canadian International Development Agency (CIDA)
Dutch International Cooperation
French Development Organization
German Agency for Technical Cooperation (GTZ)
Italian Development Organization
Japan International Cooperation Agency (JICA)
Norwegian Agency for Development Cooperation (Norad)
Swedish International Development Cooperation Agency (Sida)
Swiss Agency for Development and Cooperation
United Kingdom Department for International Development (DFID)
United States Agency for International Development (USAID)
United States Centers for Disease Control and Prevention (CDC)

5 – Foundations:

Aga Khan Foundation
Bill & Melinda Gates Foundation
Ellison Institute
Ford Foundation
Hewlett-Packard Foundation
Rockefeller Foundation
Soros Foundation
United Nations Foundation
Wellcome Trust

Annex N

HNP Contributions to Combating HIV/AIDS Background Paper to the World Bank HNP Strategy

Background

HIV/AIDS is a health priority for low- and middle-income countries (LMICs). HIV/AIDS is the fourth leading cause of death and disability in LMICs (Mathers et al. 2006), and in many countries, particularly in Africa, the epidemic poses a major threat to their economic development. Although the global HIV incidence appears to have peaked, the number of new infections and deaths continues to rise (UNAIDS 2006). Recent financial and political commitments for combating HIV/AIDS have created new opportunities, but also new challenges. Much of the new funding is focused on increasing access to antiretroviral therapy (ART). In the last two years, the number of people on ART in low- and middle-income countries has more than tripled to 1.3 million by the end of 2005. Yet this represents only 20 percent of those estimated to need treatment (UNAIDS 2006). Scaling up HIV prevention and treatment in a sustainable way will depend on health systems that can deliver care, fiscal space, and the ability of the international community to provide the financing.

A comprehensive response to HIV requires action across many sectors. The health sector, however, has a unique and central contribution to make, especially in scaling up clinical aspects of prevention and treatment (e.g., voluntary counseling and testing, behavioral counseling for people with HIV, prevention of mother-to-child transmission (PMTCT), treatment of sexually transmitted infections, treatment for co-infections with tuberculosis and opportunistic infections, and ART), as well as for other public health functions such as disease surveillance and monitoring.

In 2005, the World Bank articulated its Global HIV/AIDS Program of Action (GHAPA) for supporting the global, regional, and national AIDS response. The Africa Region of the World Bank is developing an “HIV/AIDS Agenda for Action in Sub-Saharan Africa” to further articulate the Bank’s role on HIV/AIDS in the Region most affected by HIV. The HNP Strategy is intended to complement these responses. This annex to the HNP Strategy

- Identifies the main constraints of health systems in contributing to the fight against HIV/AIDS and ways of overcoming these constraints.
- Reviews the special challenges of financial sustainability in HIV/AIDS and health programs and identifies ways of overcoming these constraints.
- Outlines the key contributions that HNP sector can make to combating HIV/AIDS.

What is the relation between health system strengthening and priority-disease approaches?

The decades-old tension between health system strengthening approaches and priority-disease approaches has changed to a growing consensus that both types of approaches depend on the other to achieve their common goals (High-Level Forum 2005; Mills 2005; Peters et al. 2006; Stillman and Bennett 2005). It is also recognized that the old labeling of “vertical” versus “horizontal” schemes is not an accurate portrayal of either HIV/AIDS or health system strategies. Although many HIV/AIDS programs have created separate organizational units, with separate personnel, management, and accountability systems, the World Bank and other agencies have worked with countries to encourage programs to be broadly based and operate across sectors and civil society. By the same token, not all health system strengthening approaches are integrated “horizontally.” Projects that focus on essential drug management or strengthening health information systems may be more “vertical” than HIV/AIDS

programs when they use separate and hierarchical management and accountability structures, even if they function across diseases. In any case, important concerns remain about which approaches work best and how to find synergies between disease-specific and systems approaches.

Some have argued that priority programs such as for HIV or disease eradication should be able to strengthen health systems generally (Buve et al. 2003; Melgaard et al. 1999). Yet beyond the strength of expert opinion, there has been little evidence that these spillover effects actually occur (Peters et al. 2006). Some studies note that, although large disease control programs can be effective in addressing the specific problems they target, they can also harm the general health systems when they create duplicative and uncoordinated management entities, financing structures and reporting systems, or replace local priorities with those of donors, or distort salary and incentive structures and distract from other activities (High-Level Forum 2005; McKinsey and Company 2005; Stillman and Bennett 2005). In reviewing studies that examine approaches to strengthening specific programs and studies that attempt to strengthen a range of health services, Øvretveit and colleagues (2006) find little scientifically robust evidence for or against the view that disease-specific programs deflect overall health services from local needs. Nonetheless, they note that some strategies to deliver certain services, such as special payments to provide immunizations, can reduce the motivation to provide other services. They conclude that disease- or service-specific strategies on their own are unlikely to bring about the changes needed in health systems to achieve the Millennium Development Goals (MDGs).

Overcoming Health Systems Constraints

A number of recent studies have identified common types of constraints in health systems in low- and middle-income countries, which affect both disease-specific and health systems (Hanson et al. 2003; Oliveira-Cruz et al. 2003; Travis et al. 2004). These constraints can be examined by how they relate to the incentives environment for the health sector (table N1).

Table N1
Incentives Environment and Constraints for Health Systems in Low- and Middle-Income Countries

<i>Level of incentives</i>	<i>Examples of constraints</i>
Individuals and communities	Lack of demand; limited access to information; lack of financial resources; exclusionary social norms; fractured or weak community institutions; low community participation; limited influence over providers, health bureaucrats, and political leadership; physical barriers to care
Health service providers	Limited staff; inadequate provider skills, poor training and technical guidance; weak motivation; weak supervision and management systems; poor compensation and rewards systems; poor physical work environment (e.g., inadequate drugs, equipment, and buildings)
Health sector	Weak sector leadership and vision; inappropriate sector planning and regulatory systems; weak accountability mechanisms; purchasing and provider payment systems unrelated to performance; poor collaboration with nongovernmental organizations and private sector stakeholders; reliance on donors and donor priorities
Macro environment	Insecure or unstable social and political conditions; macroeconomic instability; poor governance and corruption; trade and migration pressures; weak sectors critical to health (education, communications, agriculture, labor); weak systems for reconciling cross-sectoral development priorities; inefficient, unresponsive, and rigid government bureaucracies; confused or insufficiently supported decentralization strategies; poor physical environment (poor roads and communications infrastructure)

There is little strong evidence to indicate which constraints are most important, or what strategies are most effective in overcoming these constraints. The reason is that the studies that comprise the evidence basis for the reviews are mostly of limited scientific value, due to flaws in study design. The studies often do not define the particular strategies under investigation or cannot attribute change to the strategies pursued (Øvretveit et al. 2006; Peters et al. 2006).⁷⁴

The HIV epidemic itself places additional pressures on weak health systems by increasing demand for health care and reducing the supply of health workers. It also reduces the supply of a given quality of health services at a given price, while increasing health expenditures (Over 2004).⁷⁵ This is likely to translate into higher national health care expenditure in absolute terms and as a proportion of national income. This leads to reduced non-HIV patients' access to other health services, unless additional expenditures are made to finance those services.

⁷⁴ The common deficiencies in research design include: (i) The strategies or intervention that are being pursued are not described in detail, so that it is hard to determine what the intervention actually consists of or whether it was implemented, and very different strategies are often given the same label; (ii) Many strategies involve multiple components that are not specified or studied in a way that would indicate which component is essential, or where there are synergies between components; (iii) Most studies do little to examine factors beyond the health system or the intervention itself that may influence the results being examined; (iv) There are limited attempts to design studies that can actually attribute results to the strategy, including use of time series, before-after data, or comparison groups and randomization.

⁷⁵ The effects in a given country will depend on factors such as its HIV prevalence, demographic patterns, costs of ART, availability of health insurance, supply of health workers, their perceived and actual risks to HIV infection, and the costs of providing services at the same level of quality (Over 2004).

Health financing constraints

The contrast between the enormous unmet health needs of poor countries and the resources they have to pay for them is well recognized. In a recent synthesis of health financing in low- and middle-income countries, Gottret and Schieber (2006) find that developing countries account for more than 90 percent of the global disease burden, but only 12 percent of global health spending. Between US\$25 billion and US\$70 billion in additional aid per year has been projected as needed to achieve the MDGs. As described by Gottret and Schieber (2006), the Bank is concerned about a number of characteristics of development assistance for health (DAH) that are particularly relevant to HIV/AIDS:

- *Volatile and short-term aid.* The amount of DAH funds countries receive varies greatly from year to year, though the reasons may differ.⁷⁶ Although funding for HIV/AIDS has increased rapidly, due largely to funding from the Global Fund to Fight AIDS, TB, and Malaria (GFATM) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), more than 70 percent of these funds are concentrated in about 25 countries, whereas donors have health programs in about 140 countries.⁷⁷ Volatile and short-term DAH makes it difficult for ministries of health and finance to make necessary long-term plans such as employing more doctors or nurses, raising wages, or expanding access to ART.
- *Funding distortions.* Fragmentation of donor assistance to health has created distortions in funding, making it difficult for governments to finance their system requirements for staff, supervision, training, management, and maintenance. For example, a government of Rwanda report identified how donor funding has helped create a six fold difference in per capita health spending between provinces (Republic of Rwanda Ministry of Finance and Economic Planning, Ministry of Health 2006). Physicians working for nongovernmental organizations (NGOs) providing HIV/AIDS services received six times the wages of MOH physicians, compromising human resources and service delivery in the public sector. The MOF argues that funding for HIV/AIDS is "disproportionate" when there is little funding for child health or other strategic objectives. The MOH says "single-issue funds and single-issue projects are being used to disburse funds through centralized allocation mechanisms that do not respond to the relative importance of needs as perceived by patients and health providers." Paradoxically, as donors move to provide more general budget support, spending on health and HIV/AIDS may decrease if governments choose different allocation priorities, particularly if they feel that donors will provide other support for health and HIV/AIDS.
- *Allocative inefficiencies.* The large influx of funding for HIV/AIDS raises the question about whether the funds are used to their maximum net benefit. The recent emphasis on expanding access to ART has not been met by a similar expansion of prevention efforts. Although ART appears to have a net beneficial effect on preventing HIV infection, and both can be relatively cost-effective, preventive interventions will have a bigger impact on reducing new HIV infections and are more cost-effective (Bertozzi et al. 2006; Hogan et al. 2005; Salomon et al. 2005). The problem is particularly striking in PEPFAR, the largest funded program for HIV/AIDS, where prevention spending is falling and constrained by requirements for abstinence-until-marriage activities (Government Accountability Office 2006). If funding continues to increase for HIV/AIDS, and ART in particular, without concomitant increases in funding for other priorities, the question must also be asked if some funds would be better spent

⁷⁶ These include the short-term commitments of donors—often no more than 12 months at a time—exchange rate fluctuations, and administrative delays by donor or recipient, and aid conditionalities.

⁷⁷ GFATM grants typically have a two-year initial phase and a three-year second phase, with funding for the second phase conditional on acceptable progress in the initial phase, although grantees can apply for concurrent grants. PEPFAR was originally announced as a five-year program, with renewal under discussion.

in other ways that can make a larger contribution to peoples' health or better address inequities. Alternative uses include programs targeted at the health of poor and vulnerable populations, other high-priority conditions that are relatively underfunded such as neonatal health, or desperately needed investments in human resources for health and other aspects of health systems.

- *Need to create fiscal space.* Large increases in public spending on HIV/AIDS or health initiatives that create future spending commitments must be considered in the context of government's ability to provide resources from current and future revenues and donors' willingness to provide long-term funding. The problem is compounded if large expenditures are financed by borrowing, which requires additional revenue to service the debt and has potential to impair overall economic growth. In the case of Rwanda, only 14 percent of the donor spending on health passes through the government. This makes it very difficult for government to diagnose fiscal problems or plan a response to manage large influxes or reductions in short-term aid (Republic of Rwanda Ministry of Finance and Economic Planning, Ministry of Health 2006).

The Bank's contributions in financing for HIV/AIDS

The Bank will specifically contribute to financing HIV/AIDS programs and health systems in several ways:

- *Providing increased, long-term, predictable funding.* The World Bank is committed to leveraging and providing increased and predictable long-term financing for HIV/AIDS and the health sector. This includes a commitment to financing recurrent costs of HIV/AIDS and health programs in ways that help them to increase their effectiveness and reduce wastage. When the World Bank funds ART programs, it will seek to do so in the context of long-term program funding, such as through Adaptable Program Loans or find new ways of funding cohorts of people on HIV treatment (e.g., 20-year horizon), rather than just through short-term projects. Shorter-term project support for HIV/AIDS and health initiatives should be selected and designed to meet shorter-term objectives, such as to test innovations, help create new institutions, support transitions in ongoing programs, or bridge especially unstable conditions.
- *Creating fiscal space and reducing distortions.* The Bank will work with client countries, the IMF, and other donors to help them develop ways of enhancing country capacity to absorb fiscal shocks and reduce their adverse effects. This would involve working with Ministries of Finance, other sectoral Ministries, and donors to ensure better complementarity of external financing flows and domestic resource mobilization. External flows should facilitate and help catalyze domestic financial resource mobilization rather than increase debt or aid dependency. The Bank will also ensure that financing and reporting procedures support local systems and are harmonized with those of other donors, as outlined in the Paris Declaration on Aid Effectiveness⁷⁸ and the "Three Ones" for HIV/AIDS programs.⁷⁹

⁷⁸ The Paris Declaration on Aid Effectiveness includes a commitment to increase support for programmatic approaches that share the following features: (i) leadership by the host country or organization; (ii) a single comprehensive program and budget framework; (iii) a formal process for donor coordination and harmonization of donor procedures for reporting, budgeting, financial management, and procurement; (iv) efforts to increase the use of local systems for program design and implementation, financial management, monitoring and evaluation.

⁷⁹ The "Three Ones" are a set of guiding principles for coordination of national partners and partners involved in HIV/AIDS control, and include: (i) one agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; (ii) one National AIDS Coordinating Authority, with a broad based multisectoral mandate; and (iii) one agreed country-level monitoring and evaluation system.

- *Enhancing accountability.* The Bank will promote budgetary and financial reporting processes that accommodate and respond to the views of critical stakeholders within the country. These processes will need to account for the interests of the poor, vulnerable, and marginalized groups, including people living with HIV/AIDS, in order to increase accountability and enhance people's voice. These processes offer important opportunities for debating and resolving concerns about allocative efficiency and equity, and for public disclosure of information and decisions over policy, financing, and program direction.
- *New types of financing.* The Bank will provide financial, technical, and convening support to countries that request help with developing health financing systems that promote accountability, efficiency, and financial protection, and which form the framework for financing of HIV/AIDS prevention, care, and treatment at the country level. The Bank will also test new approaches to its own financing of HNP and HIV/AIDS. Emphasis will be put on linking Bank financing to performance in purchasing HIV/AIDS and other health services, rather than rely on financing inputs. Such approaches accentuate the importance of using information and demonstrating results in HIV/AIDS and health sector programs.

More funding is not enough

Although additional funds will be necessary for scaling up HIV/AIDS and other health services, additional funding can also play an important role in overcoming some health systems constraints such as poor supply of drugs and equipment or weak demand for services (Hanson et al. 2003). However, there is an emerging view that funding alone is not sufficient to overcome constraints. Johnston and Stout (1999) argue that it is the continuous commitment to improvement, analysis of constraints, flexible implementation, and positive macroeconomic and governance environments that are most useful in strengthening health services. Lewis (2005) holds that the keys to effective absorption of funding for HIV/AIDS will require building up institutions and human capacity in the health sector, as well as broader governance capacity. Whitty and Doherty (2006) argue that the biggest barriers to fighting disease are not financing or political will, but the failure to match the recent investments in new drugs and tools with investments in training people and developing efficient systems to deliver them. This is exactly where the World Bank's HNP Strategy can assist countries to better tackle the HIV/AIDS and health problems they face.

Vision for HNP Contributions to Combating AIDS

In the "preferred future," countries' health sectors will make significant contributions to combating HIV/AIDS and improving their people's health, and the World Bank will help client countries

- Improve health status among vulnerable groups and the general population, including achieving the MDGs. Curbing the incidence of HIV infections across all key subgroups and the general population is a vital part of this.
- Fashion effective, equitable, accountable, affordable, and sustainable health systems that provide a full range of preventive, curative, and rehabilitative health services and make full use of public and nongovernmental health actors and engage with and contribute to institutions outside the health sector. The Bank shares the collective goals of universal access to ART for people with HIV, universal childhood immunization, antenatal care and safe deliveries for all pregnant women, provision of directly observable treatment for all TB infected, and full access to other elements of locally defined "essential packages" of care.
- Reduce the number of people plunged into poverty by health care costs.
- Help individuals and households to make informed choices about healthy life styles and use of health services.

What should the Bank do to contribute to HIV/AIDS through health systems?

The focus of health system strengthening for HIV/AIDS is to improve and expand HIV prevention, treatment, and care via the health systems that deliver these services. The HNP Strategy outlines how the Bank will focus on strengthening aspects of health systems related to its comparative advantages in financing, creating the right incentives environment, working across sectors, and demonstrating and using results in the context of countries' human and economic development.

In addition to addressing financing of HIV/AIDS and health (discussed above), the World Bank plans to strengthen health systems to contribute to HIV/AIDS by

- Integrating HIV/AIDS and health system programming to ensure that planning and financing of the health sector and HIV/AIDS programs support each other and do not create duplicative and competing structures. The Burkina Faso Health Sector Support and Multisectoral AIDS Project is an example of the way health sector and HIV/AIDS allocation decisions can be made collectively: a common lending instrument is supporting two pooled funds (one for the health sector, one for multisectoral HIV/AIDS activities), which will facilitate alignment of financing, management, and monitoring systems.
- Learning from the experiences of the AIDS Strategy and Action Plan (ASAP) service and the Global AIDS Monitoring and Evaluation Team (GAMET) program to provide task teams and country stakeholders with resources and tools to improve strategy development, engagement of civil society, and monitoring and evaluation.
- Funding interventions that are important to the HIV epidemic or the health situation that might otherwise be neglected because they are politically difficult for other agencies to finance (e.g., prevention and treatment programs for prisoners, harm reduction programs for injection drug users).
- Refraining from funding popular programs that other agencies can finance with grants (e.g., commodities for ART and prevention of mother-child transmission) or activities for which Bank support systems are inadequate (e.g., clinical trials).
- Supporting systematic identification, monitoring, and evaluation of country-based Bank assistance to HIV/AIDS programs and the health sector to ensure that:
 - Country strategies, PRSPs, MTEFs, and sectorwide approaches adequately address HIV/AIDS and other priority health concerns, the interests of the poor, and health system requirements for delivering services. These strategies will need to be appropriately budgeted and aligned with the country's macroeconomic framework and have sustainable financing that does not skew balanced development of the economy. They will also need a focused and balanced approach to demonstrating results.
 - The proposed financing and implementation arrangements for HIV/AIDS and the health sector are supportive of the "Three Ones" and the Paris Principles on Aid Effectiveness.
 - Support to specific-disease programs or institutions is contingent on identification of any potential harm to the health system (or other health programs and prior establishment of appropriate risk-mitigation strategies).

In day-to-day operations, the World Bank has numerous levers of influence to support HIV/AIDS and the health sector at country level. Table N2 outlines these levers and summarizes how they can be translated into specific actions.

Table N2
Levers of Influence for the World Bank in HIV/AIDS and Health Systems at Country Level

<i>Levers of influence</i>	
<i>Direct interventions</i>	<i>Bank actions in HIV/AIDS and health systems</i>
Financing investments and operations	<ul style="list-style-type: none"> • Provide funding for agreed public sector programs that appropriately finance HIV/AIDS programs and health systems in the context of PRSPs and MTEFs • Direct health sector financing, for capital investment (buildings, equipment) and recurrent costs (staff, training, drugs, supplies, and activities) for HIV/AIDS programs, development of health systems, and delivery of services.
Purchasing outputs/outcomes	<ul style="list-style-type: none"> • Link funding to provision of health or HIV/AIDS services, or locally relevant performance targets, affirming that results have been achieved as basis for disbursement.
Expenditure control	<ul style="list-style-type: none"> • When financing inputs, ensure that fund disbursements conform with procurement procedures acceptable to the Bank. • Assure probity of Bank funds through audits.
<i>Influencing strategies</i>	
Linking HIV/AIDS and health sector to public policy and financing	<ul style="list-style-type: none"> • Facilitate communication between Ministries of Finance and sector ministries for development of national strategies, planning, and evaluation to ensure that financing is sustainable and balanced across sectors and that the health sector and HIV/AIDS programs have a relevant role. • Bring together health with other sectors and civil society organizations over broader government reforms (e.g., civil service reforms).
Convening key actors	<ul style="list-style-type: none"> • Bring together critical players within civil society and government within country for learning, consensus building, strategy development, and planning for HIV/AIDS programs and the health sector in the context of PRSPs and MTEFs. • Network with experts and colleagues across countries to ensure that the best possible technical advice is considered. • Facilitate learning by critical players within country through communications, training, sharing materials, and dissemination of research and evaluation results.
Designing HIV/AIDS programs, health services, and their support systems	<ul style="list-style-type: none"> • Use project preparation and supervision to ensure the best available technical assistance, software, training, and support systems in the design or redesign of programs and support systems. • Focus Bank technical resources to strengthen policy and strategy cycles, financing systems, monitoring and evaluation systems, poverty concerns, and intersectoral linkages.
Monitoring and disclosing	<ul style="list-style-type: none"> • Ensure that appropriate plans for the monitoring and evaluation of health systems are developed, financed, and implemented and that the data are used for management and allocation decisions and for public disclosure and discourse. • Review performance of projects and HIV/AIDS and health sector programs for planning and disclosure purposes.

<i>Levers of influence</i>	
Providing knowledge and advice	<ul style="list-style-type: none"> • Commission or conduct studies on relevant HIV/AIDS and health policy and operational issues, such as impact evaluations of major programs and innovations. • Pooling and synthesizing information and experience on health systems, health financing, and links to HIV/AIDS with a focus on translating knowledge into local policy and practice.
Negotiating actions for disbursements	<ul style="list-style-type: none"> • Agree on actions for disbursement of Bank funds in the context of Poverty Reduction Strategy Credits that support HIV/AIDS and health sector objectives. • Ensure that agreed actions are taken by the borrower when a basis for Bank financing

Annex O

References

- Allen, L., and S. Gillespie. 2001. *What Works? A Review of the Efficacy and Effectiveness of Nutrition Interventions*. Geneva: United Nations Administrative Committee on Coordination/Sub-Committee on Nutrition (ACC/SCN); Manila: Asian Development Bank.
- Angel-Urdinola, D.F., and S. Jain. 2006. "Do Subsidized Health Programs in Armenia Increase Utilization among the Poor?" Policy Research Working Paper 4017, World Bank, Washington, DC.
- Baeza, C., and T.G. Packard. 2006. *Beyond Survival: Protecting Households from Health Shocks in Latin America*. Palo Alto, CA: Stanford University Press.
- Bardham, P. 1997. "Corruption and Development: A Review of Issues." *Journal of Economic Literature* 35 (3): 1310-46.
- Bell, C., S. Devarajan, and H. Gersbach. 2004. "Thinking About the Long-run Economic Costs of AIDS." In *The Macroeconomics of HIV/AIDS*, ed. M. Haacker, 96-144. Washington, DC: International Monetary Fund.
- Bell, C., R. Bruhns, and H. Gersbach. 2006. "Economic Growth, Education, and AIDS in Kenya: A Long-Run Analysis." Policy Research Working Paper 4025, World Bank, Washington, DC.
- Berhman, J. R., and M. R. Rosenzweig. 2001. "The Returns to Increasing Body Weight." University of Pennsylvania. http://www.vwl.uni-muenchen.de/ls_komlos/tuebingen/articles/berhman.pdf.
- Bertozzi, S., N. Padian, J. Wegbreit, L. M. DeMaria, B. Feldman, H. Gayle, J. Gold, R. Grant, and M. Isbell. 2006. "HIV/AIDS Prevention and Treatment." In *Disease Control Priorities in Developing Countries*, 2nd ed. New York: Oxford University Press; Washington, DC: The World Bank.
- Bhagwati, J., R. W. Fogel, B. S. Frey, J. Y. Lin, D. C. North, T. C. Schelling, V. L. Smith, and N. L. Stokey. 2004. "Ranking the Opportunities." In *Global Crises, Global Solutions*, ed. Bjorn Lomborg, 605-44. Cambridge, UK: Cambridge University Press.
- Birdsall, N., A. C. Kelley, and S. Sinding. 2001. *Population Matters: Demographic Change, Economic Growth, and Poverty in the Developing World*. New York: Oxford University Press.
- Bloom, D., D. Canning, and P. Malaney. 1999. "Demographic Change and Economic Growth in Asia." Working Paper 15, Center for International Development, Harvard University, Cambridge, MA.
- Bloom, D., D. Canning, and D. Jamison. 2004. "Health, Wealth, and Welfare." *Finance and Development* 41 (1): 10-5.

- Buve, A., S. Kalibala, and J. James McIntyre. 2003. "Stronger Health Systems for More Effective HIV/AIDS Prevention and Care." *International Journal Health Plan Management* 18: S41-S51.
- Caines, K., K. Buse, C. Carlson, R. de Loor, N. Druce, C. Grace, M. Pearson, J. Sancho, and R. Sadanandan. 2004. *Assessing the Impact of Global Health Partnerships*. London: DFID Health Resource Centre.
- Caines, K. 2005. *Key Evidence from Major Studies of Selected Global Health Partnerships*. London: DFID Health Resource Centre.
- Campbell-White, A., T. W. Merrick, and A. S. Yazbeck. 2006. *Reproductive Health – The Missing Millennium Development Goal: Poverty, Health, and Development in a Changing World*. Washington, DC: World Bank.
- Cotlear, D., ed. 2006. *A New Social Contract for Peru: An Agenda for Improving Education, Health Care, and the Social Safety Net*. Washington, DC: World Bank.
- Croppenstedt, A., and C. Muller. 2000. "The Impact of Farmers' Health and Nutritional Status on their Productivity and Efficiency: Evidence from Ethiopia." *Economic Development and Cultural Change* 48 (3): 475-502.
- DFID (UK Department for International Development). 2006. *Global Health Partnerships and Health Systems Strengthening*. London: DFID Health Resource Centre.
- Dow, W., P. Gertler, R. F. Schoeni, J. Strauss, and D. Thomas. 1997. "Health Care Prices, Health, and Labor Outcomes: Experimental Evidence." Working Paper Series, Labor Population Program, RAND, Santa Monica, CA.
- Duflo, E., P. Dupas, M. Kremer, S. Sinei. 2006. "Education and HIV/AIDS Prevention : Evidence from a Randomized Evaluation in Western Kenya." Policy Research Working Paper 4024, World Bank, Washington, DC.
- Dussalt, G., P. Fournier, and A. Letourmy, ed. 2006. "L'Assurance Maladie en Afrique Francophone : Amélior l'accès aux soins et lutter contre la pauvreté." Health, Nutrition and Population Working Paper Series, World Bank, Washington, DC.
- Eggleston, K., L. Ling, M. Qingyue, M. Lindelow, and A. Wagstaff. 2006. "Health Service Delivery in China: A Literature Review." Policy Research Working Paper 3978, World Bank, Washington, DC.
- Elmendorf, A.E., and K. Larusso. 2006. "Human Resources for Health and World Bank Operations in Africa: A Review of Experience." Africa Region Human Development Working Paper Series 110, World Bank, Washington, DC.
- Fenwick, A., and B. H. Figenschou. 1972. "The Effect of Schistosoma Mansonii Infection of the Productivity of Cane Cutters on a Sugar Estate in Tanzania." *Bulletin of the World Health Organization* 47 (5): 567-72.

- Fogel, R. W. 1994. "Economic Growth, Population Theory and Physiology: The Bearing of Long-term Processes on the Making of Economic Policy." *American Economic Review* 89 (1): 1-21.
- Foster, M. 2005a. "Fiscal Space and Sustainability: Towards a Solution for the Health Sector." Working Paper, World Bank, Washington, DC.
- . 2005b. "Improving the Medium to Long-term Predictability of Aid." Working Paper, World Bank, Washington, DC.
- Galasso, E., and J. Yau. 2006. "Learning through Monitoring: Lessons from a Large-scale Nutrition Program in Madagascar." Policy Research Working Paper 4058, World Bank, Washington, DC.
- Gallup, J., and J. Sachs. 2000. "The Economic Burden of Malaria." Working Paper 52, Center for International Development, Harvard University, Cambridge, MA.
- Gertler, P., and J. Gruber. 2002. "Insuring Consumption Against Illness." *American Economic Review* 92 (1): 51-76.
- Glick, P., and D. E. Sahn. 1998. "Health and Productivity in Heterogenous Urban Labour Market." *Applied Economics* 30 (2): 203-16.
- Görgens, M., N. Cosby, J. Chipeta, and R. Govindaraj. 2006. "Malawi: Developing a National Multisector HIV/AIDS M&E System." Global HIV/AIDS Program, HIV/AIDS M&E Report, World Bank, Washington, DC.
- Görgens-Albino, M., and M. Nzima. 2006. "Eleven Components of a Fully Functional HIV M&E System." Global HIV/AIDS Program, HIV/AIDS M&E Report, World Bank, Washington, DC.
- Gottret, P., and G. Schieber. 2006. *Health Financing Revisited: A Practitioner's Guide*. Washington, DC: World Bank.
- Government Accountability Office. 2006. *Global Health: Spending Requirement Presents Challenges for Allocating Prevention Funding under the President's Emergency Plan for AIDS Relief*. Report GAO-06-395. Washington, DC: United States Government Accountability Office.
- Gruber, J., and M. Hanratty. 1995. "The Labor-market Effects of Introducing National Health Insurance: Evidence from Canada." *Journal of Business and Economic Studies* 13 (2): 163-73.
- Haacker, M. 2004. "HIV/AIDS: The Impact on the Social Fabric and the Economy." In *The Macroeconomics of HIV/AIDS*, ed. M. Haacker. Washington, DC: International Monetary Fund.
- Hanson, K., M. K. Ranson, V. Oliveira-Cruz, and A. Mills. 2003. "Expanding Access to Priority Health Interventions: A Framework for Understanding the Constraints to Scaling-Up." *Journal of International Development* 15 (1): 1-14.
- High-Level Forum on the Health MDGs. 2005. *Working Group on Global Health Partnerships*. <http://www.hlfhealthmdgs.org/ReportGHPWorkingGroup28Sep05doc>.

- Hogan, D. R., R. Baltussen, C. Hayashi, J. A. Lauer, and J. A. Salomon. 2005. "Cost Effectiveness Analysis of Strategies to Combat HIV/AIDS in Developing Countries." *British Medical Journal* 331 (7530): 1431-7.
- Izazola-Licea, J. A. 2006. "National AIDS Spending Assessments," Presented at the Global Resource Tracking Consortium Conference, September 29, Geneva.
- Jamison, D. T., J. G. Breman, A. R. Measham, G. Alleyne, M. Claeson, D. B. Evans, P. Jha, A. Mills, and P. Musgrove, ed. 2006. *Disease Control Priorities in Developing Countries, 2nd ed.* New York: Oxford University Press; Washington, DC: World Bank.
- Jamison, D. 2006. "Investing in Health." In *Disease Control and Priorities in Developing Countries, 2nd ed.*, ed. D. Jamison, J. Berman, A. Meacham, G. Alleyne, M. Claeson, D. Evans, P. Jha, A. Mills, and P. Musgrove. Washington, DC: World Bank; New York: Oxford University Press.
- Johnston, T., and S. Stout. 1999. *Investing in Health: Development Effectiveness in the Health, Nutrition, and Population Sector.* Washington, DC: World Bank.
- Kaufmann, D., and A. Kraay. 2003. *Governance and Growth: Causality Which Way? Evidence for the World, in Brief.* Washington, DC: World Bank.
- Kelley, A. C. 1988. "Economic Consequences for Population Change." *Third World Journal of Economic Literature* 26 (4): 1685-1728.
- Kolsky, P., E. Perez, W. Vandersypen, and L. O. Jensen. 2005. "Sanitation and Hygiene at the World Bank: An Analysis of Current Activities." Water Supply & Sanitation Working Note 6, World Bank, Washington, DC.
- Kutzin, J. 2000. "Towards Universal Health Care Coverage: A Goal-oriented Framework for Policy Analysis." Discussion Paper, Health, Nutrition and Population, World Bank, Washington, DC.
- Leontien, L., L. W. Niessen, and A. S. Yazbeck. 2003. "Pro-poor Health Policies in Poverty Reduction Strategies." *Health Policy and Planning* 18 (2): 138-45.
- Lewis, M. 2005. "Addressing the Challenge of HIV/AIDS Macroeconomic, Fiscal and Institutional Issues." Working Paper 58, Center for Global Development, Washington, DC.
- _____. 2006. "Governance and Corruption in Public Health Care Systems." Working Paper 78, Center for Global Development, Washington, DC.
- Lopez, A. D., C. D. Mathers, M. Ezzati, D. T. Jamison, and C. J. L. Murray, ed. 2006. *Global Burden of Disease and Risk Factors.* New York: Oxford University Press; Washington, DC: World Bank.
- Lutalo, M. 2006. "IFC Against AIDS—Protecting People and Profitability." Global HIV/AIDS Program, HIV/AIDS M&E Report, World Bank, Washington, DC.
- Malek, D. 2006. "Australia's Successful Response to AIDS and the Role of Law Reform." Global HIV/AIDS Program Discussion Paper, Human Development Network, World Bank, Washington, DC.

- Marek, T., R. Eichler, and P. Schnabl. 2006A. "Allocation de Ressources et Acquisition de Services de Santé en Afrique—Qu'est-ce qui est efficace pour améliorer la santé des pauvres?" Africa Region Human Development Working Paper Series 105, World Bank, Washington, DC.
- Marek, T., C. O'Farrell, C. Yamamoto, and I. Zable. 2006B. "Tendances et Perspectives des Partenariats entre les Secteurs Public et Non-Etatique pour Améliorer les Services de Santé en Afrique." Africa Region Human Development Working Paper Series 106, World Bank, Washington, DC.
- Marquez, P.V. 2005. *Dying Too Young – Addressing Premature Mortality and Ill Health Due to Non-Communicable Diseases and Injuries in the Russian Federation*. Washington, DC: World Bank.
- Marquez, P.V. 2006. "Preventing HIV Infection in Russia: Best Practices in Harm Reduction Programs." Global HIV/AIDS Program, HIV/AIDS M&E Report, World Bank, Washington, DC.
- Mathers, C. D., A. D. Lopez, and C. J. L. Murray. 2006. "The Burden of Disease and Mortality by Condition: Data, Methods, and Results for 2001." In *Global Burden of Disease and Risk Factors*, ed. A. D. Lopez, C. D. Mathers, M. Ezzati, D. T. Jamison, and C. J. L. Murray. Washington, DC: World Bank.
- May, J. F., M. Temourov, and I. Dupond. 2006. "Lutte contre la Pauvreté au Burkina Faso. L'Importance de l'écart Urbain-Rural des Indicateurs de Santé, Population et Nutrition." Africa Region Human Development Working Paper Series 96, World Bank, Washington, DC.
- McKinsey & Company. 2005. *Global Health Partnerships: Assessing Country Consequences*. Seattle, WA: Bill & Melinda Gates Foundation.
- Melgaard, B., A. Creese, B. Aylward, J-M. Olive, C. Maher, J. M. Okwo-Bele, and J. W. Lee. 1999. "Disease Eradication and Health Systems Development." *Morbidity and Mortality Weekly Report* 48 (SU01): 28-35.
- Michaud, C. M. 2007. Data communicated by e-mail, January.
- Mills, A. 2005. "Mass Campaigns versus General Health Services: What Have We Learnt in 40 Years about Vertical versus Horizontal Approaches?" *Bulletin of the World Health Organization* 83 (4): 325-30.
- Moffett, J. K., D. Torgerson, S. Bell-Syer, D. Jackson, H. Llewlyn-Phillips, A. Farrin, and J. Barber. 1999. "Randomised Controlled Trial of Exercise for Low Back Pain: Clinical Outcomes, Costs and Preferences." *British Medical Journal* 319: 279-83.
- Moses, S., J. F. Blanchard, H. Kang, F. Emmanuel, S. R. Paul, M. L. Becker, D. Wilson, and M. Claeson. 2006. "AIDS in South Asia: Understanding and Responding to a Heterogeneous Epidemic." Health, Nutrition and Population Working Paper Series, World Bank, Washington, DC.
- Murray, C. J., and A. D. Lopez. 1996. *The Global Burden of Disease*. Cambridge: Harvard University Press.

- _____. 1997. "Alternative Projections of Mortality and Disability by Cause 1990-2020: Global Burden of Disease Study." *Lancet* 349 (9064): 1498-1504.
- OECD/DAC (Organization for Economic Cooperation and Development/Development Assistance Committee). 2005. *Paris Declaration on Aid Effectiveness Ownership, Harmonization, Alignment, Results, and Mutual Accountability*. Issued at the Paris High-Level Forum, March 2, Paris, France.
- Oliveira-Cruz, V., K. Hanson, and A. Mills. 2003. "Approaches to Overcoming Constraints to Effective Health Service Delivery: A Review of the Evidence." *Journal of International Development* 25: 41-65.
- Over, M. 2004. "Impact of the HIV/AIDS Epidemic on the Health Sectors in Developing Countries." In *The Macroeconomics of HIV/AIDS*, ed. M. Haacker, 311-44. Washington, DC: The International Monetary Fund.
- PATH/UNFPA (Program for Appropriate Technology in Health/United Nations Population Fund). 2006. *Meeting the Need: Strengthening Family Planning Programs*. Seattle: PATH/UNFPA.
- Peters, D. H., G. Bloom, M. H. Rahman, A. Bhuiya, B. Kanjilal, O. Oladepo, G. Pariyo, Z. Zhenzhong, and S. Sundaram. 2006. "Research for Future Health Systems." In *Global Forum Update on Research for Health Volume 3*, ed. S. Matlin, 133-7. London: Pro-Book Publishing.
- Preker, A. S., and J. C. Langenbrunner, ed. 2005. *Spending Wisely: Buying Health Services for the Poor*. Washington, DC: World Bank.
- Reddy, S., and A. Heuty. 2005. "Achieving the Millennium Development Goals: What's Wrong with Existing Analytical Models? Bureau of Development Policy of the United Nations Development Programme." <http://www.millenniumdevelopmentgoals.org>.
- Republic of Rwanda Ministry of Finance and Economic Planning, Ministry of Health. 2006. "Scaling Up to Achieve the Health MDGs in Rwanda. A Background Study to the High-Level Forum in Tunis, June 12 – 13, 2006."
- Revenge, A., M. Over, E. Masaki, W. Peerapatanapokin, J. Gold, V. Tangcharoensathien, and S. Thanprasertsuk. 2006. "The Economics of Effective AIDS Treatment: Evaluating Policy Options for Thailand." Health, Nutrition and Population Working Paper Series, World Bank, Washington, DC.
- Salomon, J. A., D. R. Hogan, J. Stover, K. A. Stanecki, N. Walker, P. D. Ghys, and B. Schwartländer. 2005. "Integrating HIV Prevention and Treatment: From Slogans to Impact." *PLoS Medicine* 2 (1): 50-6.
- Schieber, G., L. K. Fleisher, and P. Gottret. 2006. "Getting Real on Health Financing." *Finance and Development* 43 (4).
- Shakow, A. 2006. "Global Fund – World Bank HIV/AIDS Programs Comparative Advantage Study." Working Paper, World Bank, Washington, DC.

- Shariff, A. 2003. "Links between Macroeconomics and Health: Relevance for the South East Asia Region." Paper presented at the World Health Organization "Ministerial Consultation on Macroeconomic and Health," Geneva, October 28-30.
- Smith, J. P. 1999. "Healthy Bodies and Thick Wallets: The Dual Relation between Health and Economic Status." *Journal of Economic Perspectives* 13 (2): 145-66.
- _____. 2005. "Unraveling the SES-Health Connection." *Population and Development Review* 30 (Suppl): 108-32.
- Soucat, A., W. Van Lerberghe, F. Diop, S. Nguyen, and R. Knippenberg. 2004. "Marginal Budgeting for Bottlenecks: A New Costing and Resource Allocation Practice to Buy Health Results—Using Health Sector's Budget Expansion to Progress toward the Millennium Development Goals in Sub-Saharan Africa." Working Paper, World Bank, Washington, DC.
- Stillman, K., and S. Bennett. 2005. *System-wide Effects of the Global Fund: Interim Findings from Three Country Studies*. Bethesda, MD: Abt Associates, Inc.
- Subramanian, S., D. Peters, and J. Willis. 2006. "How are Health Services, Financing and Status Evaluated? An Analysis of Implementation Completion Reports of World Bank Assistance in Health." Health, Nutrition and Population (HNP) Discussion Paper, World Bank, Washington, DC.
- Thirumurthy, H., J. G. Zivin, and M. Goldstein. 2005. "The Economic Impact of AIDS Treatment: Labor Supply in Western Kenya." Working Paper 11871, National Bureau of Economic Research, Cambridge, MA.
- Thomas, D. 2001. "Health, Nutrition and Economic Prosperity: A Microeconomic Perspective." Commission on Macroeconomics and Health, Working Paper WG1: 7, World Health Organization, Geneva.
- Thomas, D., E. Frankenberg, J. Friedman, J. P. Habicht, N. Jones, C. McKelvey, G. Pelto, B. Sikoki, J. P. Smith, C. Sumantri, and W. Suriastini. 2004. "Causal Effect of Health on Labor Market Outcomes: Evidence from a Random Assignment Iron Supplementation Intervention." Paper presented at the Population Association of America Annual Meetings, Boston, MA, April.
- Thomas, D., and J. Strauss. 1997. "Health and Wages: Evidence from Men and Women in Urban Brazil." *Journal of Econometrics* 77: 159-86.
- Travis, P., S. Bennett, A. Haines, T. Pang, Z. Bhutta, A. A. Hyder, N. R. Pielemeier, A. Mills, T. Evans. 2004. "Overcoming Health-Systems Constraints to Achieve the Millennium Development Goals." *Lancet* 365: 900-6.
- UN (United Nations). 2003. *World Population Prospects: The 2002 Revision*. New York: United Nations.
- UN. 2005. *World Population Prospects: The 2004 Revision*. New York: United Nations.
- UN Millennium Project. 2005. *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals*. New York: UN Millennium Project.

UNAIDS (United Nations Joint Program on HIV/AIDS). 2006. *2006 Report on the Global AIDS Epidemic: A 10th UNAIDS Anniversary Special Edition*. Geneva: UNAIDS.

UNFPA (United Nations Population Fund). 2004. *Programme of Action. Adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994*. New York: UNFPA.

UNFPA. 2006. "UNFPA Global Population Policy Update." Newsletter 64.
<http://www.unfpa.org/parliamentarians/news/newsletters/issue64.htm>.

UNICEF (United Nations Children's Fund). 2006a. "Millennium Development Goals: Reduce Child Mortality." <http://www.unicef.org/mdg/childmortality.html>

_____. 2006b. "Millennium Development Goals: Improve Maternal Mortality."
<http://www.unicef.org/mdg/maternal.html>

_____. 2006c. "Millennium Development Goals: Combat HIV/AIDS, malaria, and other diseases." <http://www.unicef.org/mdg/disease.html>

Wagstaff, A., and M. Claeson. 2004. *The Millennium Development Goals for Health: Rising to the Challenges*. Washington, DC: World Bank.

Whitney, C. J. M., and T. Doherty. 2006. "New Tools to Fight Disease Should be Celebrated, But We Also Need the Systems and the People to Deliver Them." *Tropical Doctor* 36 (4): 193-4.

WHO (World Health Organization). 2000. *World Health Report 2000. Health Systems: Improving Performance*. Geneva: WHO.

_____. 2002. *The World Health Report 2002. Reducing Risks, Promoting Healthy Life*. Geneva: WHO.

_____. 2003a. *The World Health Report 2003. Shaping the Future*. Geneva: WHO.

_____. 2003b. *Social Determinants of Health: The Solid Facts, 2nd ed*, ed. R. Wilkinson, M. Marmot. Denmark: WHO.

_____. 2005. *World Malaria Report 2005*. Geneva: World Health Organization; UNICEF.

_____. 2006a. "WHO Tuberculosis Fact Sheet." <http://www.who.int/mediacentre/factsheets/fs104/en/index.html>.

_____. 2006b. *World Health Report 2006. Working Together for Health*. Geneva: WHO.

Wilson, D., and J. de Beyer. 2006a. "Male Circumcision—Evidence and Implications." Global HIV/AIDS Program, HIV/AIDS M&E Report, World Bank, Washington, DC.

_____. 2006b. "Mozambique's Battle Against HIV/AIDS and the DREAM Project." Global HIV/AIDS Program, HIV/AIDS M&E Report, World Bank, Washington, DC.

- Wilson, D., and M. Claeson. 2006. "Understanding the HIV Epidemic in South Asia." Global HIV/AIDS Program, HIV/AIDS M&E Report, World Bank, Washington, DC.
- Wolgemuth, J. C., M. C. Latham, A. Hall, A. Chesher, and D. W. Crompton. 1982. "Worker Productivity and the Nutritional Status of Kenyan Road Construction Laborers." *American Journal of Clinical Nutrition* 36 (1): 68-78.
- World Bank. 1997. *Human Development Network Strategy*. Washington, DC: World Bank.
- _____. 1999. "Investing in Health: Development Effectiveness in the Health, Nutrition, and Population Sector." Operations Evaluation Department, World Bank, Washington, DC.
- _____. 2001a. *An Analysis of Combating Iodine Deficiency: Case Studies of China, Indonesia, and Madagascar*. Washington, DC: World Bank.
- _____. 2001b. *World Development Report 2002: Building Institutions for Markets*. Washington, DC: World Bank.
- _____. 2002a. *A Sourcebook for Poverty Reduction Strategies*. Washington, DC: World Bank.
- _____. 2002b. *Supporting a Healthy Transition: Lessons from Early World Bank Experience in Eastern Europe*. Washington, DC: World Bank.
- _____. 2003a. "Health, Nutrition, and Population Sector Board Assessment." Quality Assurance Group, World Bank, Washington, DC.
- _____. 2003b. *World Development Report 2004. Making Services Work for Poor People*. Washington, DC: World Bank.
- _____. 2004. *World Development Report 2005. A Better Investment Climate for Everyone*. Washington, DC: World Bank.
- _____. 2005a. *Committing to Results: Improving the Effectiveness of HIV/AIDS Assistance*. Washington, DC: World Bank.
- _____. 2005b. "Education Sector Strategy Update." Human Development Network, World Bank, Washington, DC.
- _____. 2005c. *The Effectiveness of World Bank Support for Community-Based and -Driven Development*. Washington, DC: World Bank.
- _____. 2005d. *Improving Health, Nutrition, and Population Outcomes in Sub-Saharan Africa: The Role of the World Bank*. Washington, DC: World Bank.
- _____. 2005e. *Maintaining Momentum to 2015? An Impact Evaluation of Interventions to Improve Maternal and Child Health and Nutrition in Bangladesh*. Washington, DC: World Bank.

- _____. 2005f. *Meeting the Challenge of Africa's Development: A World Bank Group Action Plan*. Washington, DC: World Bank.
- _____. 2005g. *The World Bank's Global HIV/AIDS Program of Action*. Global HIV/AIDS Program, World Bank, Washington, DC.
- _____. 2005h. *World Development Report 2006: Equity and Development*. Washington, DC: World Bank.
- _____. 2006a. "Aid Effectiveness in Health." Paper presented at the Organisation for Economic Co-operation and Development Global Forum on Development, "Pre-Meeting on Aid Effectiveness in Health," Paris, December 4.
- _____. 2006b. *Annual Report of Development Effectiveness 2006: Getting Results*. Washington, DC: World Bank.
- _____. 2006c. *Annual Report on Portfolio Performance Fiscal Year 2005*. Washington, DC: World Bank.
- _____. 2006d. Data collected from *Business Warehouse*. Washington, DC: World Bank.
- _____. 2006e. "A Discussion of the Results and Lessons Learned from Implementation Completion Reports (ICRs) – FY04 – FY05." Working Paper, Human Development Network, World Bank, Washington, DC.
- _____. 2006f. *Global Monitoring Report 2006: Strengthening Mutual Accountability—Aid, Trade, and Governance*. Washington, DC: World Bank.
- _____. 2006g. "Health, Nutrition and Population Portfolio FY06 Retrospective: Achievements, Shortcomings and the Need for Change." Working Paper, Health, Nutrition and Population, World Bank, Washington, DC.
- _____. 2006h. *Implementation Plan for the World Bank's Global HIV/AIDS Program of Action*. Washington, DC: World Bank.
- _____. 2006i. "Literature Review: Impact of Poor Health on Productivity and Earnings." Background note prepared for the Health, Nutrition and Population Strategy, Human Development Network, World Bank.
- _____. 2006j. "Population and the World Bank: Background Paper Prepared for the HNP Sector Strategy." Working Paper, Health, Nutrition and Population, World Bank, Washington, DC.
- _____. 2006k. "Provincial Maternal-Child Health Investment Project in Support of the Second Phase of the Provincial Maternal-Child Health Program." Project Appraisal Document P095515, World Bank, Washington, DC.
- _____. 2006l. *Repositioning Nutrition as Central to Development: A Strategy for Large-Scale Action*. Washington, DC: World Bank.

- _____. 2006m. “Strengthening Bank Group Engagement on Governance and Anticorruption.” Development Committee Paper, World Bank, Washington, DC.
- _____. 2006n. “The Third Transition: Exploring the Impact of Changing Demographic Structures in Eastern Europe and the Former Soviet Union.” ECA Regional Flagship Study, Working Paper, World Bank, Washington, DC.
- _____. 2006o. *World Development Report 2007. Development and the Next Generation*. Washington, DC: World Bank.
- _____. Forthcoming a. *Public Policy and the Challenge of Chronic Noncommunicable Diseases: An Agenda for Action*. Washington, DC: World Bank.
- _____. Forthcoming b. “Seventh Quality of Supervision Assessment.” Quality Assurance Group, World Bank, Washington, DC.
- _____. Forthcoming c. “India: MDG Issues in Poor States—Reducing Child Mortality in Orissa.” Washington, DC: World Bank.
- Yazbeck, A, and C. Hayashi. 2001. “How Well are Bank-Supported Health, Nutrition, and Population Projects Designed to Benefit the Poor?” Seminar Report, World Bank, Washington, DC.