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# Investing in Health Development Effectiveness in the Health, Nutrition, and Population Sector



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**ENHANCING DEVELOPMENT EFFECTIVENESS THROUGH EXCELLENCE AND INDEPENDENCE IN EVALUATION**

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# Investing in Health Development Effectiveness in the Health, Nutrition, and Population Sector

Timothy Johnston  
Susan Stout



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Director-General, Operations Evaluation: *Robert Picciotto*

Director, Operations Evaluation Department: *Elizabeth McAllister*

Manager, Sector and Thematic Evaluations: *Gregory Ingram*

Task Managers: *Susan Stout and  
Timothy Johnston*



## ENGLISH FOREWORD

The World Bank began lending for population in the 1970s and to health in 1980, and has since committed over \$14 billion to support health, nutrition, and population (HNP) activities in 92 countries. The growth in lending has accelerated, and the Bank's emphasis has evolved from expanding HNP service delivery capacity to encouraging systemic reform. The Bank is now the major source of external finance for the sector in the developing world, and the policy influence of its nonlending services is potentially significant.

This volume is based on a review of the HNP evaluation literature, a desk review of the World Bank's HNP portfolio, four country case studies (Brazil, India, Mali, and Zimbabwe), and consultations with Bank staff, borrowers, NGOs, and donors. The HNP Sector Board has broadly endorsed the findings and recommendations of the review.

The overarching recommendation of the review is that the Bank should seek to do better—not more—in the HNP sector. The rapid growth of the portfolio, together with complex challenges posed by health system reform, require consolidation with a focus on selectivity and quality. OED recommends substantial improvement in monitoring and evaluation of project and sector performance and increased attention to institutional development in project design and supervision. It also recommends strengthened efforts in health promotion and intersectoral interven-

## ESPAÑOL PREFACIO

El Banco Mundial comenzó a otorgar préstamos para el sector de población en los años setenta, y para el de salud en la década de 1980, y desde entonces ha comprometido más de US\$14.000 millones en respaldo de actividades de salud, nutrición y población en 92 países. El ritmo de crecimiento del financiamiento se ha acelerado y el Banco, que en un principio centró la atención en aumentar la capacidad para prestar esos servicios, ahora fomenta la reforma sistémica del sector. En la actualidad el Banco es la principal fuente de financiamiento externo para este sector en el mundo en desarrollo, y la influencia en materia de políticas de sus servicios no crediticios puede llegar a ser significativa.

El presente estudio está basado en un examen de los análisis sobre la evaluación de los proyectos, un estudio técnico de la cartera de proyectos de salud, nutrición y población, cuatro estudios de casos prácticos (Brasil, India, Malí y Zimbabwe), y en consultas con funcionarios del Banco, prestatarios, ONG y donantes. La Junta Sectorial de Salud, Nutrición y Población ha aprobado ampliamente las observaciones y recomendaciones del examen.

La principal recomendación que se formula en el examen es que el Banco debería tratar de mejorar sus operaciones, y no de aumentar su número. El acelerado crecimiento de la cartera, sumado a los complejos desafíos que plantea la reforma del sistema de salud, hacen necesaria su consolidación con miras a la selectividad

## FRANÇAIS PRÉFACE

La Banque mondiale a procédé à ses premières opérations de prêts au titre de projets ayant trait à la population dans les années 70 et ses premiers projets dans le domaine de la santé en 1980 ; depuis lors, elle a engagé plus de 14 milliards de dollars pour financer des activités dans le secteur santé, nutrition et population dans 92 pays. Le rythme de ses opérations s'est accéléré et la Banque qui, au départ, s'efforçait d'accroître les capacités disponibles pour fournir des services de santé, nutrition et population vise maintenant à promouvoir une réforme des systèmes. Elle est la principale source de financement extérieur de ce secteur dans le monde en développement, et ses services hors prêts peuvent avoir un impact sensible sur les politiques de la santé.

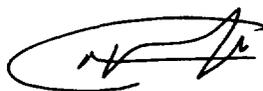
L'étude présentée dans ce volume repose sur un examen des analyses consacrées à l'évaluation des projets, un examen sur dossier du portefeuille de la Banque dans le secteur santé, nutrition et population, quatre études de cas (Brésil, Inde, Mali et Zimbabwe), et des consultations avec les services de la Banque, des emprunteurs, des ONG et des bailleurs de fonds. Le groupe technique pour le secteur santé, nutrition et population s'est prononcé en faveur des conclusions et recommandations de cet examen.

L'examen recommande avant tout que la Banque s'efforce d'accroître la qualité — et non le volume — de ses opérations. Étant donné la rapide expansion de son portefeuille,

**ESPAÑOL** tions; a renewed emphasis on economic and sector work; greater understanding of stakeholder interests, and the forging of strategic alliances with development partners at the regional and global levels.

**ESPAÑOL** y la calidad. El DEO recomienda mejorar considerablemente el seguimiento y la evaluación de los resultados de los proyectos y del sector, y prestar más atención al desarrollo institucional a la hora de diseñar y supervisar los proyectos. Recomienda asimismo intensificar los esfuerzos para promover la salud y las intervenciones intersectoriales; volver a poner el acento en los estudios económicos y sectoriales; comprender mejor los intereses de las partes involucradas, y establecer alianzas estratégicas con los asociados en el desarrollo a nivel tanto regional como mundial.

**FRANCAIS** conjugée aux difficiles problèmes soulevés par la réforme du système de santé, la Banque doit recentrer ses activités en mettant l'accent sur la sélectivité et la qualité. L'OED recommande d'améliorer sensiblement le suivi et l'évaluation des projets et les résultats du secteur, et de prêter davantage attention au développement institutionnel au niveau de la conception et de la supervision des projets. Il recommande également d'intensifier les efforts de promotion de la santé et d'accroître les interventions intersectorielles ; de mettre encore plus l'accent sur les études économiques et sectorielles ; de mieux comprendre les intérêts des parties prenantes et de forger des alliances stratégiques avec les partenaires au développement au niveau régional et mondial.

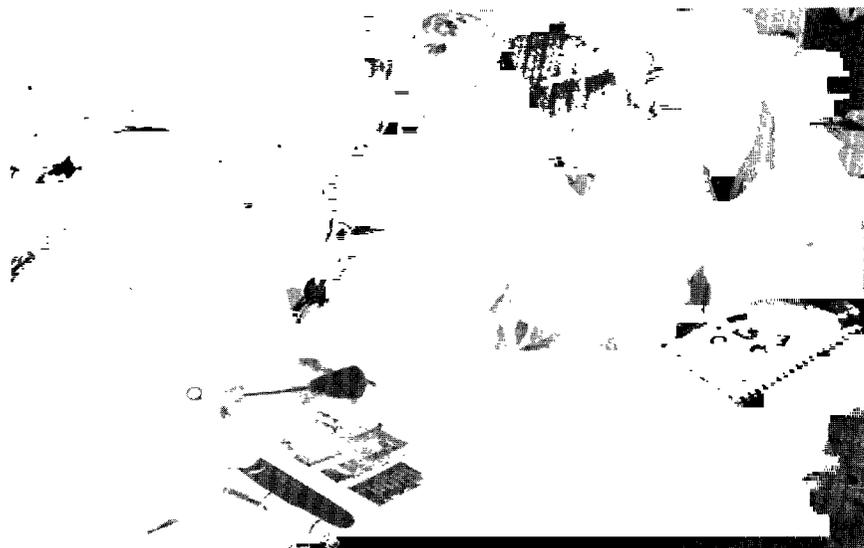


Robert Picciotto  
Director-General, Operations Evaluation Department

ENGLISH

## EXECUTIVE SUMMARY

World Bank lending to the health, nutrition, and population (HNP) sector, begun in the 1970s, has grown from a modest start to a total 1998 portfolio of US\$14 billion. The Bank is now the world's largest international financier of HNP, with average annual commitments of \$1.3 billion, and has



played an increasingly important role in international and borrower health policy debates. Since the early 1990s, the Bank's operational emphasis has shifted from expanding the public provision of basic services toward improving health policies and promoting health sector reforms. With the current generation of projects, the Bank and its partners are attempting to address underlying constraints to sector performance, while remaining cognizant of the difficulty of improving health sector effectiveness and efficiency,

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## RESUMEN

El financiamiento del Banco Mundial para el sector de salud, nutrición y población se inició en los años setenta y, tras un comienzo moderado, se ha convertido en una cartera que en 1998 llegó a un total de US\$14.000 millones. El Banco es en la actualidad la principal fuente internacional de financiamiento para

este sector, con una cifra anual media de compromisos de US\$1.300 millones, y su participación en los debates sobre la política de salud a nivel internacional y con los prestatarios ha adquirido cada vez más importancia. Desde principios de los años noventa, el énfasis de las operaciones del Banco se ha desplazado de la ampliación del suministro de servicios básicos por el sector público a la mejora de las políticas de salud y la promoción de las reformas del sector. En la generación actual de proyectos, el Banco y sus asociados están intentando abordar las limitaciones básicas que influyen en los resultados del sector, al

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## RÉSUMÉ ANALYTIQUE

La Banque mondiale s'est lancée dans des opérations de prêt dans le secteur santé, nutrition et population dans les années 70, et le montant total des projets réalisés à ce titre dans son portefeuille, limité au départ, a atteint 14 milliards de dollars en 1998. La Banque est maintenant la plus importante source de financement internationale de ce secteur, puisqu'elle engage en moyenne 1,3 milliard de dollars par an et joue un rôle croissant dans les débats consacrés à la politique de la santé par les instances internationales et les pays emprunteurs. Depuis le début des années 90, la Banque recentre son action, qui consistait jusque-là à élargir la portée des services de base assurés par le secteur public, pour privilégier l'amélioration des politiques de la santé et encourager une réforme du secteur. Dans le cadre des projets actuels, la Banque et ses partenaires s'efforcent de remédier aux obstacles fondamentaux sans oublier, toutefois, qu'il est difficile d'améliorer l'efficacité et l'efficience du secteur de la santé, même dans les pays développés. Le présent volume fait la synthèse de la première évaluation globale des activités poursuivies par la Banque dans ce secteur. L'étude de l'OED a donné lieu à un examen sur dossier du portefeuille d'opérations dans le secteur santé, nutrition et population de la Banque et de quatre études de cas (Brésil, Inde, Mali et Zimbabwe), et couvre des projets achevés et en cours.

### Performance des opérations

L'OED, qui a évalué les 107 projets réalisés dans le secteur santé, nutrition et population entre les exercices 75 et 98, a

even in developed countries. This volume offers a synthesis of the first comprehensive assessment of the Bank's experience in the sector. The OED study included a desk review of the Bank's HNP portfolio and four country case studies (Brazil, India, Mali, and Zimbabwe), and encompasses both completed and ongoing projects.

### Project Performance

Of the 107 HNP projects completed between FY75 and FY98, OED rated 64 percent satisfactory, compared with 79 percent for non-HNP projects. But efforts by the Bank and sector staff to improve performance may be showing results: 79 percent of projects completed in FY97/98 satisfactorily achieved their development objectives, close to the Bank average of 77 percent. Although only half of all completed HNP projects were rated as likely to be sustainable, this figure rose to two-thirds in FY97/98. Yet high rates of completion of physical objectives disguise difficulties the Bank has encountered in achieving policy and institutional change in HNP. OED rated institutional development as substantial in only 22 percent of completed HNP projects, a figure that rose to only 25 percent in FY97/98, well below the Bank average of 38 percent for the same period. Improving institutional development performance is therefore a priority for the Bank's HNP sector.

### Major Evaluative Findings

The World Bank has made important contributions to strengthening health, nutrition, and population policies and services worldwide. Through its financing, the Bank has helped expand

tiempo que reconocen las dificultades que plantea aumentar la eficacia y eficiencia en el sector de salud, incluso en los países desarrollados. En esta publicación se presenta una síntesis de la primera evaluación integral de la experiencia del Banco en este sector. El estudio del DEO comprendió un estudio técnico de la cartera de proyectos de salud, nutrición y población del Banco y cuatro estudios de casos prácticos (Brasil, India, Malí y Zimbabwe), y abarca los proyectos terminados y los que están en ejecución.

### Resultados de los proyectos

De los 107 proyectos de salud, nutrición y población terminados entre los ejercicios de 1975 y 1998, el DEO calificó como satisfactorios al 64%, en comparación con el 79% de los proyectos correspondientes a otros sectores. Con todo, los esfuerzos del Banco y del personal que trabaja en ese sector orientados a mejorar los resultados comienzan a surtir efecto: el 79% de los proyectos terminados en el ejercicio de 1997/98 lograron alcanzar satisfactoriamente sus objetivos de desarrollo, porcentaje cercano al 77%, que es el promedio del Banco. Se estimó que tan sólo la mitad de todos los proyectos de salud, nutrición y población terminados tenían probabilidades de ser sostenibles, pero esa cifra aumentó a dos tercios en el ejercicio de 1997/98. Sin embargo, las elevadas tasas de consecución de los objetivos físicos ocultan las dificultades con que ha tropezado el Banco para lograr cambios institucionales y en materia de políticas en ese sector. El grado de desarrollo institucional fue calificado como considerable por el DEO en tan sólo el 22% de los proyectos terminados, cifra que aumentó apenas al 25% en el ejercicio de 1997/98 y

jugé que 64 % d'entre eux avaient donné des résultats satisfaisants, contre 79 % pour les projets menés dans d'autres secteurs. Il se pourrait toutefois que les efforts déployés par les services de la Banque et les secteurs pour améliorer les résultats commencent à porter leurs fruits : 79 % des projets achevés durant l'exercice 97/98 ont atteint leurs objectifs de développement, soit un pourcentage proche de la moyenne de 77 % observée pour la Banque. Bien que la moitié seulement de tous les projets dans le secteur santé, nutrition et population menés à terme aient été jugés pouvoir produire des résultats durables, cette proportion est passée à deux tiers durant l'exercice 97/98. Il est vrai que le pourcentage élevé de réalisation des objectifs physiques masque les difficultés qu'a rencontrés la Banque lorsqu'elle s'est efforcée d'induire des modifications institutionnelles et politiques dans le secteur. L'OED a jugé que le développement institutionnel n'était substantiel que pour 22 % des projets achevés dans le secteur santé, nutrition et population ; or, ce pourcentage n'était toujours que de 25 % pour l'exercice 97/98, soit un niveau bien inférieur à la moyenne observée pour la Banque (38 %) pour la même période. Le secteur santé, nutrition et population de la Banque doit donc chercher en priorité à améliorer les résultats en matière de développement institutionnel.

### Principales conclusions de l'évaluation

La Banque mondiale a largement contribué à renforcer les politiques et les services dans le secteur santé, nutrition et population dans le monde entier. Grâce à ses financements, elle a aidé à élargir la portée géographique des services de santé de base, à promouvoir la fourniture d'une formation utile aux

**ENGLISH** geographical access to basic health services, sponsored valuable training for service providers, and supplied other important inputs to basic government health services. The Bank also has used its lending and nonlending services to promote dialogue and policy change on a variety of key issues, including family planning, health financing, and nutrition strategies. Clients appreciate the Bank's broad strategic perspective on the sector, and the Bank has taken a growing role in donor coordination. Despite an initial focus on government health services, the Bank is increasingly focusing on issues of private and nongovernmental organization (NGO) service delivery, insurance, and regulation. In recent years, the Bank also has placed greater emphasis on client ownership and beneficiary assessments in project design and supervision.

Several broad concerns emerge regarding the Bank's performance to date. First, the Bank has been more successful in expanding health service delivery systems than in improving service quality and efficiency or promoting institutional change. Although the quality of institutional analysis has improved in recent years, the Bank is often better at specifying *what* practices need to change than *how* to change them or *why* change is difficult. Paradoxically, Bank project designs are usually the most complex—with a greater number of components and organizational units—in countries with weak institutional capacity. The Bank is adopting increasingly sophisticated approaches to the promotion of sector reform, but the institutional problems being addressed are growing in difficulty. Yet experience has demonstrated that realistic objec-

**ESPAÑOL** que está muy por debajo del promedio del Banco, de 38%, correspondiente al mismo período. En consecuencia, una prioridad de los proyectos del Banco en el sector de salud, nutrición y población es la mejora de los resultados en materia de desarrollo institucional.

### Principales conclusiones de la evaluación

La contribución del Banco Mundial al fortalecimiento de las políticas y servicios de salud, nutrición y población en todo el mundo ha sido importante. El financiamiento otorgado por el Banco ha permitido ampliar la cobertura geográfica de los servicios básicos de salud, patrocinar valiosas actividades de capacitación para los proveedores de servicios y proporcionar otros insumos necesarios a los servicios básicos de salud del sector público. El Banco también ha utilizado sus servicios crediticios y de otro tipo para promover el diálogo y la reforma de las políticas con respecto a diversas cuestiones fundamentales, como la planificación de la familia, el financiamiento de la salud y las estrategias de nutrición. Los clientes valoran la amplia visión estratégica del Banco con respecto al sector, y el Banco ha asumido un papel más preponderante en la coordinación de las operaciones de los donantes. En un comienzo el Banco se concentró en los servicios de salud del sector público, pero en medida creciente ahora está centrando la atención en la prestación de servicios por el sector privado y las ONG, los seguros y la reglamentación. En años recientes, el Banco también ha puesto mayor énfasis en la identificación de los clientes con los proyectos y las evaluaciones de los beneficiarios en la etapa de diseño y

**FRANÇAIS** prestataires de services et à fournir d'autres intrants importants aux services de santé de base du secteur public. La Banque a eu également recours à ses opérations de prêts et à ses services hors prêts pour encourager le dialogue et des réformes dans divers domaines importants, et notamment les stratégies en matière de planning familial, de financement de la santé et de nutrition. Les clients accueillent favorablement le cadre général dans lequel la Banque remplace la stratégie pour le secteur, et l'institution participe dans une mesure croissante à la coordination des opérations des bailleurs de fonds. Bien qu'elle ait, au départ, mis l'accent sur les services de santé du secteur public, la Banque s'intéresse désormais de plus en plus au problème de la prestation des services par le secteur privé et les organisations non gouvernementales (ONG), l'assurance de ces services et leur réglementation. Depuis quelques années, elle déploie de plus amples efforts pour obtenir l'adhésion des clients aux projets et l'opinion des bénéficiaires au niveau de la conception et de la supervision des projets.

Plusieurs commentaires généraux peuvent être formulés à l'égard de la performance de la Banque à ce jour. Premièrement, l'institution a mieux réussi à étendre la portée des systèmes de prestation de services de santé qu'à améliorer la qualité et l'efficacité des services ou à encourager des réformes institutionnelles. Bien que la qualité de ses analyses institutionnelles se soit récemment améliorée, la Banque sait souvent mieux indiquer *quelles* sont les pratiques qu'il importe de modifier qu'expliquer *comment* les modifier ou *pourquoi* il est difficile de les modifier. Paradoxalement, les projets de la Banque sont généralement plus complexes — en ce sens qu'ils ont

**ENGLISH** tives, together with increased attention to *whys* and *hows*, increases the likelihood of achieving institutional objectives.

Second, during project implementation, the Bank typically focuses on providing inputs rather than on clearly defining and monitoring progress toward HNP development objectives. Because of weak incentives and undeveloped systems for monitoring and evaluation (M&E) within both the Bank and borrower governments, there is little evidence regarding the impact of Bank investments on system performance or health outcomes. The Bank therefore has not used its lending portfolio to systematically collect evidence on what works, what does not, and why. Methodological challenges can make it difficult to conclusively link project interventions with changes in HNP outcomes or system performance. But experience shows that effective M&E design—including the selection of a limited number of appropriate indicators, attention to responsibilities, and capacity for data collection and analysis—enhances the focus on results and increases the likelihood of achieving development impact.

Third, with some notable exceptions, the Bank has not placed sufficient emphasis on addressing determinants of health that lie outside the medical care system, including behavioral change and cross-sectoral interventions. The incentives and mechanisms for intersectoral approaches are currently weak, both within the Bank and in borrower governments, so priorities for intersectoral work must be chosen carefully. The Bank has a fundamental responsibility, however, to more ef-

**ESPAÑOL** supervisión de los proyectos. Se pueden formular varias observaciones generales en lo que respecta a la actuación del Banco hasta la fecha. En primer lugar, el Banco ha logrado resultados más satisfactorios en la ampliación de los sistemas de prestación de

servicios de salud que en el mejoramiento de la calidad y eficacia de los servicios o la promoción de cambios institucionales. Si bien la calidad del análisis de las instituciones ha mejorado en los últimos años, el Banco suele ser más eficaz en identificar *cuáles* son las prácticas que deben modificarse, y no tanto en decidir *cómo* deben cambiarse o en determinar *por qué* son difíciles de cambiar. Curiosamente, el diseño de los proyectos del Banco suele ser más complejo—en el sentido de que comprenden muchos componentes y requieren la intervención de un gran número de unidades administrativas—en los países en que la capacidad institucional es más deficiente. El Banco está adoptando enfoques cada vez más complejos para promover la reforma del sector, pero la dificultad de los problemas institucionales que debe abordar va en aumento. Con todo, la experiencia ha demostrado que cuando los objetivos son realistas, y cuando se presta más atención al *cómo* y al *porqué*, hay más probabilidades de alcanzar los objetivos institucionales.

En segundo lugar, durante la ejecución de los proyectos el Banco normalmente se ocupa de proporcionar insumos y no de definir claramente y vigilar los progresos para alcanzar los objetivos de desarrollo en materia de salud, nutrición y población. Como no hay suficientes incentivos y los sistemas de seguimiento y evaluación tanto del Banco como de los gobiernos prestatarios no están plenamente desarrollados, las pruebas del impacto de las inversiones del Banco en el

**FRANÇAIS** davantage de composantes et font intervenir un plus grand nombre d'entités administratives — dans les pays dont les capacités institutionnelles sont limitées. La Banque poursuit des méthodes

de plus en plus élaborées pour promouvoir la réforme sectorielle, mais les problèmes institutionnels auxquels elle est confrontée sont de plus en plus délicats à résoudre. Or, on a vu à l'expérience que la probabilité d'atteindre les objectifs institutionnels est d'autant plus élevée que les objectifs adoptés sont réalistes et que l'on s'efforce de trouver des réponses aux *pourquoi* et *comment*.

Deuxièmement, pendant la phase d'exécution d'un projet, la Banque s'efforce généralement de fournir des intrants plutôt que de définir clairement les objectifs de développement pour le secteur santé, nutrition et population, et de suivre les progrès accomplis en ce domaine. Étant donné l'insuffisance des incitations et les carences des systèmes de suivi et d'évaluation tant à la Banque que dans les pays emprunteurs, on ne dispose guère d'informations sur l'impact des investissements de l'institution sur la performance du système ou les résultats obtenus dans le domaine de la santé. La Banque ne tire donc pas de son portefeuille de prêts des informations sur les activités qui donnent de bons résultats, celles qui n'en donnent pas et les raisons d'être de cet état de fait. Pour des raisons méthodologiques, il peut être difficile d'établir une relation probante entre les interventions poursuivies et l'évolution des résultats enregistrés dans le secteur ou de la performance du système. On a toutefois pu observer que l'adoption d'une structure efficace de suivi et d'évaluation — grâce, notamment, au choix d'un petit nombre d'indicateurs pertinents et à l'importance accordée

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fectively link its macroeconomic dialogue with sector dialogue, particularly on issues of health financing, the health work force, and civil service reform.

Finally, promoting health reform requires strategic and flexible approaches to support the development of the intellectual consensus and broad-based coalitions necessary for change, but the Bank is still in the early stages of adapting its instruments to emphasize learning and knowledge transfer. System reform is difficult and time-consuming, and stakeholders outside ministries of health can determine whether reforms succeed or fail. This highlights the importance of realism in setting project objectives, strong country presence, stakeholder analysis, and a more strategic use of the Bank's convening role. While incremental approaches are not always more appropriate, the Bank may have been excessive in its encouragement of overly ambitious reforms.

### Implications for Current and Future Work

In 1997 the Bank released its *Health, Nutrition, and Population Sector Strategy Paper*, which will guide the Bank's work in the sector over the next decade. The strategy identifies three objectives for the Bank: (i) improve the health, nutrition, and population outcomes of the poor; (ii) enhance the performance of health care systems; and (iii) secure sustainable health care financing. The strategy paper incorporated preliminary findings from the OED review, and sector leadership has already initiated a number of activities to address the issues raised.

Several concerns will need to be addressed, however, if the strategy

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desempeño de los sistemas o en los resultados en materia de salud son escasas. Por lo tanto, el Banco no se ha valido de la cartera de préstamos para recopilar sistemáticamente pruebas de lo que da resultado, lo que no funciona y las razones correspondientes. Los problemas metodológicos pueden dificultar la tarea de vincular categóricamente las intervenciones en el marco de los proyectos con los cambios en los resultados relativos a la salud, nutrición y población o el desempeño del sistema. No obstante, la experiencia indica que con un seguimiento y evaluación eficaces —que incluya la selección de un número limitado de indicadores adecuados y la atención a las responsabilidades y a la capacidad de recopilación y análisis de los datos—es posible centrar más la atención en los resultados y aumentar la probabilidad de que las operaciones tengan un impacto en el desarrollo.

En tercer lugar, salvo algunas excepciones importantes, el Banco no ha puesto suficiente atención a los factores determinantes de la salud que escapan al ámbito del sistema de atención médica, como las modificaciones del comportamiento y las intervenciones intersectoriales. Tanto el Banco como los gobiernos prestatarios no tienen los incentivos y los mecanismos adecuados para adoptar enfoques intersectoriales, de manera que las prioridades de la labor intersectorial deben establecerse con mucho cuidado. No obstante, el Banco tiene la responsabilidad fundamental de vincular más eficazmente su diálogo macroeconómico con el diálogo sectorial, sobre todo en lo que respecta al financiamiento de la salud, los trabajadores de la salud y la reforma de la administración pública.

Por último, para promover la reforma del sector de salud es preciso aplicar enfoques estratégicos y flexibles

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aux fonctions et aux capacités de collecte et d'analyse des données — permet de mieux cibler les résultats et d'accroître la probabilité que les opérations aient un impact sur le développement.

Troisièmement, à quelques importantes exceptions près, la Banque ne porte pas une attention suffisante aux facteurs déterminants de la santé qui ne relèvent pas du domaine médical, et notamment la modification des comportements et les interventions intersectorielles. Les incitations et mécanismes applicables aux approches intersectorielles sont très limités pour l'instant, tant à la Banque que dans les pays emprunteurs, de sorte qu'il importe d'établir avec soin l'ordre des priorités pour ces opérations. Il est toutefois crucial que la Banque relie mieux son dialogue de politique macroéconomique et son dialogue sectoriel, notamment dans les domaines du financement de la santé, du personnel sanitaire et de la réforme de la fonction publique.

Enfin, pour promouvoir une réforme de la santé, il est nécessaire de poursuivre une approche stratégique et souple de manière à parvenir à un consensus sur les questions de fonds et bâtir les vastes alliances nécessaires au changement ; toutefois, la Banque commence seulement à adapter ses instruments pour mettre l'accent sur les transferts de savoir et de connaissances. Les réformes systémiques sont l'aboutissement d'un processus difficile et long, dont le succès ou l'échec peut être déterminé par les parties prenantes hors du ministère de la Santé. Il est donc manifestement crucial de fixer des objectifs réalistes pour les projets, de maintenir une présence importante sur le terrain, d'analyser les informations des parties prenantes et de faire un

**E** is to meet its goals. First, although the need for improved system performance and reforms is manifest in many client countries, the Bank is increasingly engaged in areas—such as public regulation of private insurers—where it has little experience and where no clear *right* models exist. Second, current approaches may be successful, but the emphasis on institutional reform means that the Bank is doing more of what it has done least well in the past. An aggressive program to develop appropriate standards, instruments, and staff training for HNP institutional analysis is necessary, together with encouragement of realism in setting institutional objectives.

Third, the rapid growth in the size and ambition of the HNP portfolio has coincided with only modest growth in the number of staff, stagnation in supervision resources, and declining funding for analytic and advisory work. Staff are overprogrammed, particularly in relation to the time-intensive demands of participatory approaches, partnerships, and consensus building. This imbalance calls for a more flexible allocation of administrative resources and greater selectivity by management regarding priority countries, sector activities, and instruments.

Fourth, to achieve the sector goal of improving HNP outcomes for the poor, the Bank will need to place stronger emphasis on poverty targeting, measuring HNP outcomes, and assessing the poverty impact of its investments and policy advice. Intensive experimentation, learning, and sharing of experiences within the Bank and with clients and partners must receive higher priority.

**E** que permitan formar el consenso intelectual y las coaliciones de amplia base que se requieren para el cambio; sin embargo, el Banco recién está empezando a adaptar sus instrumentos para intensificar la adquisición y la transferencia de conocimientos.

La reforma de los sistemas es una tarea difícil y prolongada, y su éxito o fracaso lo pueden determinar las partes interesadas distintas de los ministerios de salud. Lo anterior subraya la importancia de fijar objetivos realistas para los proyectos, de mantener una sólida presencia en el país, de analizar la información de los interesados y de aprovechar más estratégicamente el poder de movilización que tiene el Banco. Aunque no siempre es conveniente proceder en forma progresiva, es posible que el Banco se haya excedido en promover reformas demasiado ambiciosas.

#### **Consecuencias para las operaciones actuales y futuras**

En 1997 el Banco emitió el Documento de estrategia para el sector de salud, nutrición y población, que orientará su labor en dicho sector en el próximo decenio. En la estrategia se establecen tres objetivos para el Banco: i) mejorar los resultados obtenidos para los pobres en el sector de salud, nutrición y población; ii) mejorar los sistemas de atención de salud, y iii) establecer un sistema de financiamiento sostenible para la atención de salud. En el documento de estrategia se tuvieron en cuenta las observaciones preliminares del examen preparado por el DEO, y los responsables del sector ya han iniciado diversas actividades para abordar los problemas planteados.

Sin embargo, para que se puedan alcanzar las metas que establece la estrategia habrá que actuar en diversos ámbitos. Primero, si bien es evidente que

**F** usage plus stratégique du pouvoir de mobilisation de la Banque. S'il ne vaut pas toujours mieux procéder de manière progressive, il se peut en revanche que la Banque ait par trop encouragé des réformes excessivement ambitieuses.

#### **Conséquences pour les opérations actuelles et futures**

En 1997, la Banque a publié un document de stratégie pour le secteur santé, nutrition et population, qui guidera ses travaux dans ce secteur au cours des dix prochaines années. La stratégie identifie les trois objectifs que doit poursuivre la Banque :

i) améliorer les résultats obtenus pour les pauvres dans le secteur de la santé, nutrition et population ; ii) renforcer la performance des systèmes de soins de santé ; et iii) mettre en place un système de financement viable des soins de santé. Le document de stratégie sectorielle faisait état des conclusions préliminaires de l'examen de l'OED, et les responsables sectoriels ont déjà entrepris diverses activités pour s'attaquer aux problèmes posés.

Pour que la stratégie puisse atteindre son objectif, il faudra toutefois agir sur plusieurs plans. Premièrement, bien qu'il faille manifestement améliorer la performance du système et procéder à des réformes dans de nombreux pays clients, la Banque poursuit un nombre croissant d'opérations dans des domaines — tels que la réglementation par l'État des assureurs privés — dans lesquels elle n'a guère d'expérience et où il n'existe pas de modèles *établis*.

Deuxièmement, même si les initiatives entreprises donnent de bons résultats, la place importante accordée aux réformes institutionnelles signifie que la Banque intervient de plus en plus dans le domaine où elle a obtenu les moins bons résultats dans le passé. Il est nécessaire

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### Moving Forward

To improve the effectiveness of future Bank efforts, OED suggests that the Bank give priority to the following, in both its internal processes and its interactions with borrowers:

- *Enhance quality assurance and results orientation.* To improve HNP portfolio quality, the HNP Sector Board and regional technical managers should strengthen their role in monitoring portfolio quality, project results, and quality assurance. Routine quality assurance mechanisms should be enhanced to provide timely support to task teams in project design and supervision. To strengthen results orientation, the Bank should continue efforts to develop standards and good practice examples for M&E, and increase staff training. But strengthening incentives to achieve results and *use* information, both within the Bank and in client countries, is critical to enhancing borrower M&E capacity. Increased experimentation with and learning from performance-based budgeting mechanisms in Bank projects would be an important step.
- *Intensify learning from lending and nonlending services.* In light of the institutional challenges facing the health sector and weak institutional performance, the Bank should seek to establish appropriate tools, guidelines, and training programs for institutional and stakeholder analysis in HNP. This should include strengthening analytic work on major

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en muchos países clientes hay que mejorar los sistemas e introducir reformas, el Banco interviene cada vez más en áreas —como la regulación estatal de los aseguradores privados— en las que su experiencia es escasa y no existen modelos *establecidos*.

Segundo, incluso si los enfoques actuales surten efecto, el acento que se pone en las reformas institucionales significa que el Banco está interviniendo más en ámbitos en los que ha sido menos eficaz en el pasado. Hace falta aplicar un programa enérgico para establecer normas y crear instrumentos adecuados, e impartir capacitación al personal para realizar análisis institucionales del sector de salud, nutrición y población. Además, es necesario ser más realistas a la hora de fijar los objetivos institucionales.

Tercero, el acelerado aumento del tamaño y la envergadura de la cartera de proyectos de salud, nutrición y población ha estado acompañada de un incremento moderado del número de funcionarios, el estancamiento de los recursos destinados a la supervisión y la disminución de los recursos financieros para estudios analíticos y actividades de asesoría. El personal enfrenta una sobrecarga de trabajo, sobre todo si se tiene en cuenta el tiempo que se debe dedicar a los enfoques participatorios, las asociaciones de esfuerzos y la formación de consenso. Este desequilibrio hace necesaria una mayor flexibilidad en la asignación de los recursos administrativos y una mayor selectividad por parte de la administración en lo que respecta a los países, sectores, actividades e instrumentos que revisten más prioridad.

Cuarto, para alcanzar los objetivos sectoriales que se ha fijado, a saber, mejores resultados para los pobres en materia de salud, nutrición y población,

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de poursuivre un programme intensif pour formuler des normes appropriées, créer des instruments et former le personnel pour procéder à des analyses institutionnelles du secteur santé, nutrition et population, tout en encourageant la formulation d'objectifs institutionnels réalistes.

Troisièmement, la rapide expansion du volume et de l'envergure du portefeuille d'opérations dans le secteur santé, nutrition et population s'est accompagnée d'un faible accroissement des effectifs, d'une stagnation des ressources de supervision et d'une diminution du financement des travaux analytiques et des services de conseil. Le personnel est surchargé, notamment si l'on considère le temps qui doit être investi dans les approches participatives, les partenariats et la formation de consensus. Pour réduire ce déséquilibre, la direction devra assurer une allocation plus flexible des ressources administratives et déterminer de manière plus sélective les pays, activités sectorielles et instruments auxquels il convient de donner la priorité.

Quatrièmement, pour pouvoir atteindre l'objectif qu'elle s'est fixé, à savoir améliorer les résultats obtenus pour les pauvres dans le secteur santé, nutrition et population, la Banque devra accorder une importance accrue au ciblage de la pauvreté, à la détermination des résultats et à l'évaluation de l'impact de ses investissements et de ses conseils sur la pauvreté. Il lui faudra accorder une plus haute priorité à la poursuite d'expérimentations intensives, ainsi qu'à l'acquisition et au partage de connaissances tant dans ses services qu'avec ses clients et partenaires.

### Orientation pour l'avenir

L'OED suggère que, pour accroître l'efficacité de ses efforts à l'avenir, la

institutional challenges and providing flexible support to task teams facing difficult institutional problems. To strengthen the analytic base for Bank advice and lending, management should increase funding for advisory and analytic services and shift some of the budget for those services from country departments to regional technical managers. The HNP Sector Board and technical managers should strengthen their role in enhancing the quality of advisory and analytic services, and encourage more intensive use of project experience as a source of both questions and answers.

- *Enhance partnerships and selectivity.* To strengthen strategic selectivity, Bank management and the HNP Sector Board should undertake a review of current staffing, lending, and administrative resources in light of the 1997 sector strategy and the recommendations above. The goal should be to establish priorities, assess resource implications, and reduce conflicting mandates. Selectivity also requires effective partnerships. The Bank should select a few strategic areas for enhanced sectoral coordination, with particular focus on macroeconomic dialogue and health work force issues. In client countries, the Bank could use its prestige and convening role to encourage communication and collaboration among government ministries, and between government and other partners. At the international level, the Bank could strengthen its partnership with

el Banco deberá intensificar sus esfuerzos por llegar a los pobres, medir los resultados y evaluar el impacto de sus inversiones y asesoría sobre políticas en la pobreza. Se debe dar mayor prioridad a la experimentación intensiva, la adquisición de conocimientos y el intercambio de experiencias dentro del Banco y con los clientes y asociados.

### Recomendaciones para el futuro

A fin de aumentar la eficacia de los esfuerzos que emprenda el Banco en el futuro, el DEO recomienda dar prioridad a los siguientes aspectos, tanto en sus procedimientos internos como en su interacción con los prestatarios:

- *Intensificar la garantía de calidad y la orientación hacia los resultados.* Para mejorar la calidad de la cartera de proyectos de salud, nutrición y población, la correspondiente Junta Sectorial y los directivos técnicos regionales deberían intensificar su función de vigilancia de la calidad de la cartera, los resultados de los proyectos y la garantía de calidad. Habría que mejorar los mecanismos habituales de garantía de calidad, a fin de apoyar oportunamente a los equipos a cargo del diseño y la supervisión de los proyectos. Para intensificar la orientación hacia los resultados, el Banco debería proseguir su labor de promoción de los ejemplos de normas y prácticas recomendadas en materia de seguimiento y evaluación, y aumentar la capacitación que imparte al personal. No obstante, si se ha de mejorar la capacidad de seguimiento y evaluación de los prestatarios, es indispensable

Banque s'efforce en priorité, aussi bien dans le cadre de ses opérations internes que dans celui de ses interactions avec les emprunteurs, de :

- *Renforcer l'assurance de la qualité et améliorer l'orientation des résultats.* Pour améliorer la qualité du portefeuille d'opérations dans le secteur santé, nutrition et population, la Commission technique du secteur et les directeurs techniques régionaux devraient accroître leur contribution au suivi de la qualité du portefeuille, aux résultats des projets et à l'assurance de la qualité. Il conviendrait de renforcer les mécanismes normalement utilisés pour s'assurer de la qualité des opérations de manière à fournir un appui rapide aux équipes chargées de la conception et de la supervision des projets. Pour améliorer l'orientation des résultats, la Banque devrait continuer de s'efforcer de formuler des normes et de produire des exemples de bonnes pratiques dans le domaine du suivi et de l'évaluation, et aussi d'intensifier les efforts de formation. Il ne sera toutefois possible de renforcer les capacités de suivi et d'évaluation des emprunteurs qu'en incitant mieux les services de la Banque et les pays clients à obtenir des résultats et à exploiter les informations disponibles. Il sera important, à cet égard, de recourir dans une mesure accrue à des mécanismes de budgétisation assortis de critères de performance et d'en tirer les leçons qui s'imposent dans le cadre des projets de la Banque.
- *Tirer de plus amples enseignements des opérations de prêts et des services hors prêts.* Étant donné les carences et les

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the World Health Organization (WHO) and other interested agencies to address such priorities as strengthening M&E and performance-based health management systems in client countries.

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ofrecer mayores incentivos para obtener resultados y *aprovechar* la información disponible no sólo en el propio Banco sino también en los países clientes. Una medida importante sería probar en mayor medida

mecanismos de presupuestación basados en los resultados de los proyectos del Banco, y obtener enseñanzas de dicha experiencia.

- *Adquirir más conocimientos a partir de los servicios crediticios y no crediticios.* En vista de los problemas y deficiencias institucionales que enfrenta el sector de salud, el Banco debería procurar establecer herramientas, directrices y programas de capacitación adecuados para realizar análisis de las instituciones y de las necesidades de las partes interesadas en el sector de salud, nutrición y población. Esta labor debería incluir el fortalecimiento de los estudios analíticos sobre los principales desafíos de tipo institucional, y un respaldo flexible a los equipos responsables que enfrentan dificultades en ese ámbito. A fin de fortalecer la base analítica de la asesoría y el financiamiento que proporciona el Banco, la administración debería aumentar los recursos financieros para la prestación de servicios de asesoría y análisis y traspasar una parte del presupuesto para esos servicios desde los departamentos a cargo de países a los directivos técnicos regionales. La Junta Sectorial de Salud, Nutrición y Población y los directivos técnicos deberían tener una mayor participación en la mejora de la calidad de los servicios de asesoría y análisis, y promover un aprovechamiento

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problèmes institutionnels dont souffre le secteur de la santé, la Banque devrait s'efforcer de mettre en place les instruments, directives et programmes de formation nécessaires à la

poursuite d'une analyse des institutions et des besoins des parties prenantes dans le secteur santé, nutrition et population. Il faudrait, pour ce faire, renforcer les travaux analytiques consacrés aux principaux problèmes d'ordre institutionnel et offrir un appui flexible aux équipes de projet qui se heurtent à de graves problèmes en ce domaine. Pour permettre à la Banque de baser ses conseils et ses opérations de prêts sur des analyses plus solides, la direction de l'institution devrait accroître les ressources affectées aux services de conseil et d'études et réaffecter une partie du budget consacré à ces services des départements-pays aux directions techniques régionales. La Commission technique du secteur santé, nutrition et population et les directeurs techniques devraient contribuer dans une mesure accrue à améliorer la qualité des services de conseil et d'analyse et encourager les services de la Banque à utiliser l'expérience accumulée dans le cadre des projets pour examiner diverses questions et tenter d'y répondre.

- *Renforcer les partenariats et procéder de manière plus sélective.* Pour procéder de manière plus sélective, la direction de la Banque et la Commission technique du secteur santé, nutrition et population devraient entreprendre un examen de l'état des effectifs, des opérations de prêt et des ressources

más intensivo de la experiencia derivada de los proyectos que les permita examinar diversas interrogantes e intentar darles respuesta.

- *Incrementar las asociaciones y la selectividad.* A fin de incrementar la selectividad estratégica, la administración del Banco y la Junta Sectorial de Salud, Nutrición y Población deberían emprender un examen de la actual dotación de personal, el financiamiento y los recursos administrativos teniendo en cuenta la estrategia sectorial de 1997 y las recomendaciones antes enunciadas. El objetivo sería establecer prioridades, evaluar las repercusiones en lo que respecta a los recursos, y reducir los mandatos incompatibles. La selectividad también exige la formación de asociaciones eficaces. El Banco debería seleccionar unas pocas áreas estratégicas en las cuales sea necesario mejorar la coordinación sectorial, poniendo especial énfasis en el diálogo macroeconómico y los asuntos relativos a los trabajadores de la salud. En los países clientes, el Banco podría aprovechar su prestigio y poder de movilización para alentar la comunicación y la colaboración entre los ministerios, y entre el gobierno y otros asociados. En el plano internacional, podría fortalecer su alianza con la Organización Mundial de la Salud (OMS) y otros organismos interesados para abordar temas prioritarios como el reforzamiento de la supervisión y la evaluación, y los sistemas de administración de la salud basados en los resultados en los países clientes.

administratives eu égard à la stratégie définie pour le secteur en 1997 et aux recommandations présentées ci-dessus. Ce faisant, elles devraient chercher à définir des priorités, évaluer les objectifs qui peuvent être poursuivis avec les ressources disponibles et réduire le nombre des missions inconciliables. Pour procéder de manière plus sélective, il leur faudra aussi constituer des partenariats efficaces. La Banque devrait choisir quelques domaines stratégiques dans lesquels elle renforcera la coordination sectorielle et mettra plus particulièrement l'accent sur le dialogue de politique macroéconomique et les questions ayant trait au personnel de santé. Dans les pays qui sont ses clients, la Banque pourrait utiliser son prestige et son pouvoir de mobilisation pour encourager la communication et la collaboration entre les ministères nationaux, et entre le gouvernement et d'autres partenaires. Au plan international, la Banque pourrait renforcer son partenariat avec l'Organisation mondiale de la santé (OMS) et d'autres institutions intéressées pour poursuivre certains objectifs prioritaires tels que le renforcement des activités de suivi et d'évaluation et la mise en place de systèmes de gestion de la santé assortis de critères de réalisation dans les pays clients.

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## ABBREVIATIONS AND ACRONYMS

AFR	-	Africa Region
APL	-	Adaptable Program Loan
ARDE	-	Annual Review of Development Effectiveness
CAS	-	Country Assistance Strategy
CDF	-	Comprehensive Development Framework
CPR	-	Contraceptive prevalence rates
DAC	-	Development Assistance Committee
DEC	-	Development Economics and Chief Economist
EAP	-	East Asia and Pacific Region
ECA	-	Europe and Central Asia Region
ESAP	-	Economic Structural Adjustment Program
ESW	-	Economic and sector work
FHP2	-	Second Family Health Project (Zimbabwe)
FW	-	Family Welfare Program (India)
HIV	-	Human immunodeficiency virus
HNP	-	Health, nutrition, and population
IBRD	-	International Bank for Reconstruction and Development (World Bank)
ICB	-	International competitive bidding
ICDS	-	Integrated Child Development Services (India)
ICR	-	Implementation Completion Report
IDA	-	International Development Association
IEC	-	Information, Education, and Communication
IMR	-	Infant mortality rate
LAC	-	Latin America and the Caribbean Region
LIL	-	Learning and Innovation Loans
MCH	-	Maternal and Child Health
M&E	-	Monitoring and evaluation
MNA	-	Middle East and North Africa Region
MOH	-	Ministry of Health
MOHFW	-	Ministry of Health and Family Welfare (Zimbabwe)
NGO	-	Nongovernmental organization
OED	-	Operations Evaluation Department
PCU	-	Project coordinating unit
PDS	-	Health Development Project (Projet de Développement Sanitaire) (Mali)
PMU	-	Project management unit
PPAR	-	Project Performance Audit Report
PPM	-	Pharmacie Populaire du Mali
PSPHR	-	Health, Population, and Rural Water Project (Mali)
QAG	-	Quality Assurance Group
RCH	-	Reproductive and Child Health Project (India)
SAR	-	Staff Appraisal Report
SAS	-	South Asia Region
SIP	-	Sector Investment Program
SUS	-	Sistema Unica da Saúde (Brazil)
STI	-	Sexually transmitted infection
SWAP	-	Sector-wide Approach
TA	-	Technical assistance
TINP	-	Tamil Nadu Integrated Nutrition Project (India)
UNICEF	-	United Nations Children's Fund
WHO	-	World Health Organization





# Introduction and Evaluative Framework

The multiplicity of interactions among the determinants of health status outcome and the performance of health systems make assessing the Bank's impact on the health, nutrition, and population (HNP) sector a challenge. This study seeks to evaluate the relevance, effectiveness, efficiency, institutional impact, and sustainability of nearly 30 years of Bank lending and nonlending services in HNP.

The past 200 years have witnessed remarkable changes in human demographic patterns, including a shift from high, relatively uncontrolled fertility to low, controlled fertility throughout large parts of the world. Mortality also declined rapidly, and the rate of decline has accelerated in the past 30 years. Fertility rates fell by over 40 percent globally and by close to 50 percent throughout much of the developing world, although they remain high in some areas. Despite this remarkable progress, much remains to be done. This is implicit in the focus that the Development Assistance Committee (DAC) has placed on several key health outcomes (such as reductions in infant, child, and maternal mortality and improved access to reproductive health services) in its effort to build consensus on goals and targets for the twenty-first century.

The World Bank has been active in the HNP sector since 1970; by the close of fiscal 1997, it had committed more than \$14 billion to lending in the health sector and had initiated activities in 92 countries. The pace of growth in sector activities has accelerated significantly in the past seven years. The Bank is now the major source of external finance for the sector in the developing world, and its advice and research influence policies at many levels.

In 1996, OED initiated a study to assess the effectiveness of this body of work and to distill lessons for future strategy in the sector. This volume, the third and final report of the exercise, synthesizes the findings and conclusions of these studies and recommends steps the Bank might take to strengthen its performance in the sector.<sup>1</sup> The report is deliberately summary in nature. (Readers seeking details on the problems of evaluation in the sector or on OED's evaluation of the Bank's performance are referred to the earlier reports.)

## **Health Outcomes and the Health System**

As shown in figure 1.1, morbidity, mortality, nutritional status, and fertility are determined by an array of factors in addition to health services. The most important are income, education, and the quality of the environment—including access to safe housing, clean water, and sanitation. The next most important are individual and community practices related to nutrition, sanitation, reproduction, alcohol and tobacco use, and other health-

**The Bank is now the major source of external finance for the sector in the developing world.**

related behaviors, which are in turn related to social and economic status and culture (Lerer and others 1998). Finally, HNP interventions can reduce the burden of disease or shorten disease duration, either through preventive services and encouraging healthy behavior or by

**Prevention is often—although not always—more cost-effective than treatment.**

providing curative care. Increased understanding of the causes of disease and improved interventions for both preventive and curative services—such as antibiotics and vaccination—have improved HNP outcomes throughout the world. Pre-

vention is often—although not always—more cost-effective than treatment, but strong demand for curative services can lead to a disproportionate emphasis on the medical care system, in both public policy and the market for health care.

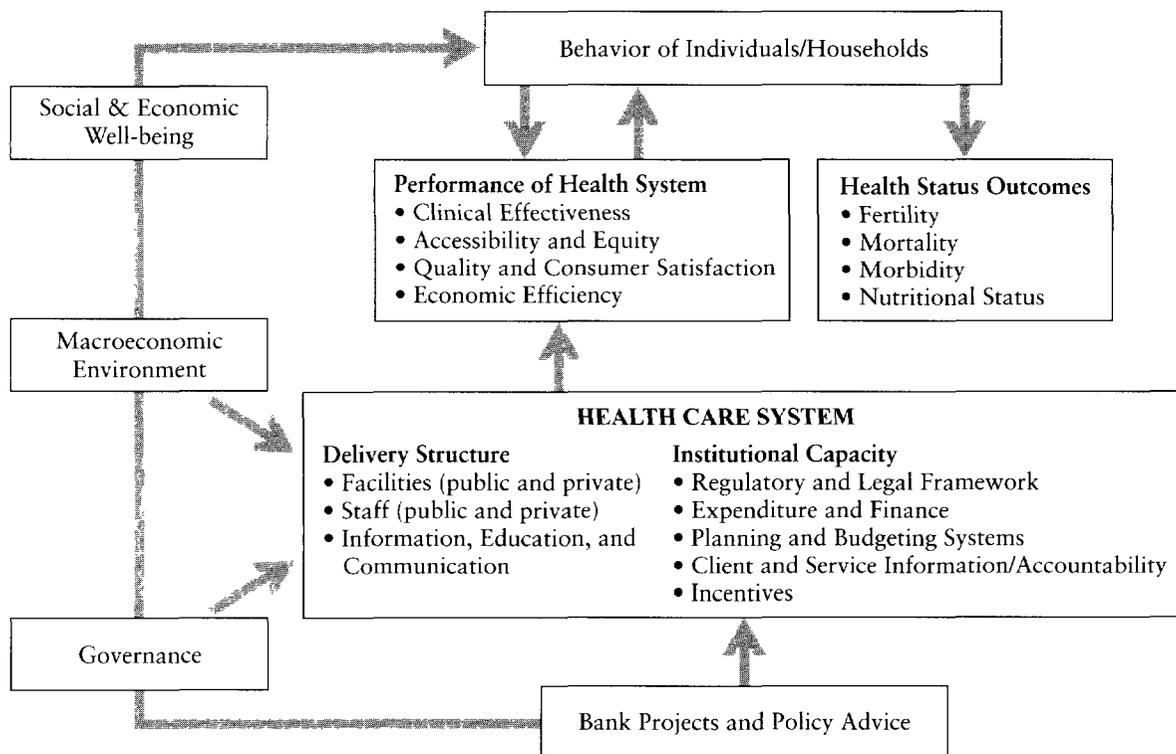
All health systems share a number of institutional characteristics. First, they include multiple players, often with conflicting interests and priorities. Second, because health outcomes are complex, it is more difficult to monitor the performance of health facilities or staff than it

is to follow activities in such areas as finance or telecommunications (Israel 1987). Third, interactions among consumers and providers are shaped by information asymmetries and ritual: health practitioners often assume the role of “expert,” while consumers have more information about their actual condition and health practices. Fourth, because of information failures, consumers are typically more willing to pay for curative services than for prevention and health promotion, and demand for health care usually increases with income, creating a bias in health markets and public spending toward urban curative care. Important preventive services are often underfinanced as a result. Finally, the performance of health systems is strongly influenced by external factors such as macroeconomic performance and civil service procedures. Improving policy and outcomes in this sector is far from a simple matter of applying administrative and technological expertise to stable and predictable epidemiological and medical challenges.

**Evaluating the Bank’s Performance**

Figure 1.1 shows two major pathways of World Bank influence on the health sector and health outcomes in a country. The first is lending and policy advice directed

**FIGURE 1.1. ACHIEVING CHANGE IN HNP**



**BOX 1.1. HNP EVALUATION LITERATURE**

 ED's review of the evaluation literature (Stout and others 1997) found that the literature on the evaluation of family planning programs is wider and more tractable than that for health, nutrition, and disease control programs. But in all three areas, the evaluation literature is dominated by studies of the efficacy of specific interventions (for

example, programs to improve the treatment of a particular disease), rather than by evaluations of the performance of health systems. Evaluation in the health sector is further constrained by the paucity of reliable local estimates of health outcomes, and, more fundamentally, by the conceptual and philosophical problems of valuing life. A growing body of work is developing tools to enable the application

of economic analysis to setting health priorities (World Bank 1993a). Yet these methods are best suited for analysis of selected interventions in specific settings, and provide little guidance on linking the findings of technically sound economic analysis to particular institutional and political contexts.

Nevertheless, with the growing interest in and emphasis on enhancing HNP system perfor-

mance and efficiency in developed and developing countries, health officials and international partners are increasingly grappling with the challenges of monitoring and evaluating clinical effectiveness, economic efficiency, and consumer satisfaction with health system performance (Durch, Bailey, and Stoto 1997; McPake and Kutzin 1997; Aday and others 1993).

at the health system, which in turn may affect the system's delivery structure and institutional capacity. Through these activities, the Bank (or other sources of finance or knowledge) can attempt to improve the accessibility, quality, and efficiency of health services, or to influence behavior through health-promotion activities. Alternatively, the Bank can influence the health sector and health outcomes indirectly through its macroeconomic policy advice and influence on national governance, as well as through the mix and effectiveness of investments in other sectors. Although this review focuses primarily on the Bank's HNP activities, it also touches on the influence of Bank macroeconomic advice on health sector performance.

An evaluation of the development effectiveness of the Bank's HNP work faces two major challenges. First, the multiple determinants of health outcomes make it difficult—at both the individual and the population levels—to link a specific health intervention with changes in health, nutrition, or fertility status. Second, the Bank is only one of a multitude of actors involved in HNP in any given country, and its lending and advice are invariably mediated through national or local institutions and governments. Neither of these challenges to attribution is easily resolved (see box 1.1).

But at the same time, this does not excuse the Bank or policymakers from attempting rigorous evaluation. The

approach of this study, and of the supporting case studies, has been to make plausible judgments about the relevance and effectiveness of the Bank's work at various stages of the causal chain shown in figure 1.1. The study team conducted extensive interviews and focus groups with relevant Bank and borrower officials, health workers, and consumers, and sponsored background research papers on key topics. Where data allowed, the case studies compiled household or facility-based data to assess the impact of selected Bank interventions on health outcomes or health system performance, examining changes over time or among project and nonproject districts.

This review seeks to address three fundamental questions. First, have World Bank HNP projects and policy advice been *relevant* to promoting improved outcomes and health system performance (did the Bank “do the right things”)? Second, have Bank-supported interventions been *effective* and *efficient* in achieving their stated objectives (did the Bank “do things right”)? Third, has the Bank been effective in strengthening health care *institutions*, and have Bank interventions been financially and institutionally *sustainable*?

**Have World Bank HNP projects and policy advice been *relevant, effective, and efficient*?**





# Evolution of Bank HNP Strategy and Lending

The Bank's HNP strategy has evolved from relatively modest investments in population and family planning in the 1970s, to direct lending for primary health care in the 1980s, to health system reform in the 1990s. Bank lending to HNP has expanded dramatically during this period. Through its current emphasis on health sector reforms and health financing, the Bank is attempting to address some of the underlying constraints that limited the effectiveness of earlier efforts.

Since 1970 the Bank has lent \$14 billion in support of HNP operations—three-quarters of this sum since 1990. Total commitments in HNP grew from about \$500 million in the first decade of experience to about \$1 billion from 1981 to 1987. More than \$11 billion has been approved since 1990. The HNP portfolio is thus relatively young; by fiscal 1997 only a third of projects were complete and evaluated. The average size of Bank projects has grown from less than \$20 million in the 1970s to about \$75 million today. More than half of HNP lending has been in the form of International Development Association (IDA) credits, the highest percentage among the social sectors.

HNP activities are integrated in many projects, which makes it difficult to determine the amount of lending to each subsector. An estimated one-third of HNP lending supported population and reproductive health, while Bank projects helped mobilize about \$2 billion for nutrition programs. South Asia has received the greatest volume of lending (27 percent of the total), but Africa has the largest number of projects. The Bank's HNP portfolio is highly concentrated in a few countries: five countries (Bangladesh, Brazil, China,

India, and Indonesia) account for half of the lending since 1970. The performance of projects in these countries therefore strongly influences the average performance of their respective regions, and of the HNP portfolio as a whole.

The content of specific HNP investments reflects, with a substantial time lag, the Bank's evolving policy perspective. Investments in HNP evolved from single-purpose efforts to improve family planning programs in the 1970s, to efforts to expand health system capacity and expand delivery of primary health care in the 1980s, and, more recently, to encourage broad sector reforms. Less than 20 percent of all projects in the early 1980s focused on health system reforms, compared with nearly half of the projects approved since FY95. The Bank also sponsored a number of stand-alone population, nutrition, and disease control projects in the 1980s and 1990s.

**The Bank's HNP portfolio is highly concentrated in a few countries.**

### 1970s: Early Population Projects

The World Bank began lending for population and family planning activities in the early 1970s. The rationale was demographic. Rapid rates of population growth were considered a major threat to development progress in many developing countries; narrow, focused population and family planning programs were believed to be

**In early loans, the Bank essentially engaged in conventional bank lending.**

necessary to slow population growth. In keeping with this view, in the *1975 Health Sector Policy Paper*, the Bank's first formal HNP policy statement, it was stated that the Bank would lend only for family planning and population, and not di-

rectly for health, although health activities could be part of population or other development efforts.<sup>1</sup> In these early loans, the Bank essentially engaged in conventional bank lending, providing finance to expand government programs. Where these programs were relatively effective in addressing consumer demand (as in Bangladesh or Indonesia), Bank projects were relatively successful, but where the government programs were weak (as in India), the projects had less impact (OED 1992).

The Bank's approach in the 1970s sought to expand the supply of, and increase access to, publicly provided family planning services. Despite clear evidence of the relatively significant role of private (nongovernmental and commercial) providers in many countries, Bank project designs tended to support public provision of services, relying on its policy analyses and nonlending work to alert borrowers to the potential role of private providers. The Bank typically asserted an "unmet need" for family planning services, based on various surveys of women, and assumed that increased geographical access to services would lead to increased use. This approach had three major failings: it did not assess the actual demand for the services to be provided; it did not consider whether increased public provision would result in a net increase in health service availability (or merely displace consumers from other facilities); and it did not address the underlying constraints affecting the quality of public service provision.

### 1980s: Direct Lending for Primary Health Care

Its *1980 Health Sector Policy Paper* committed the Bank to direct lending in the health sector. The primary instrument for executing this policy was the investment

loan, usually with a geographic focus, although by the late 1980s the Bank increasingly sought to improve the coherence of donor efforts by financing "umbrella" projects that included financing from several donors. The Bank strategy addressed a genuine need in many borrower countries for improved access to basic health services, particularly in rural areas. The interventions supported in these projects—maternal and child health, family planning, and nutrition education—addressed a significant portion of the burden of disease for the poor. The projects also usefully promoted the integration of basic health services—both with family planning and with other health programs, such as immunization.

These family health or basic health projects, however, were remarkably similar in design and approach across regional and country settings.<sup>2</sup> The large number of project components contributed to project complexity, a particular challenge when many health ministries were administratively weak and borrowing from the Bank for the first time. The Bank responded by including "capacity building" components in most projects, and by relying increasingly on project management units to facilitate project implementation, sometimes isolating the "project" from the rest of the ministry. These projects, like the earlier population projects, usually failed to effectively address underlying quality issues in government health services, and typically provided for little interaction with private, nongovernmental, or traditional health providers (except for traditional midwife training).

### 1990s: Health Financing and Health System Reform

A number of factors in the late 1980s and the 1990s brought about a shift in Bank strategy, and led to an increased emphasis on health financing and health service reform (see box 2.1). First, efforts to expand infrastructure and staffing for primary health care services in the 1980s coincided with the onset of economic crisis in much of the developing world. Budget pressures, together with continued inefficiencies in government health spending, threatened the quality and sustainability of expanded government primary health care systems. Second, disappointment with the progress of specific investment projects in bringing about systemic change—together with a rising trend toward health sector reforms in industrial countries—led to a growing international consensus on the need for health sector reform in developing countries. Third, the HIV/AIDS epidemic and the demographic transition

in middle-income countries created new challenges for disease control. Finally, the challenges facing health systems increasingly diverged among regions. In much of Africa and Asia, communicable diseases and access to services are still problems, while in Central Europe and Latin America, issues of cost-escalation and the burden of an aging population and high-cost chronic diseases have come to the fore (Prescott 1997).

The Bank's increased emphasis on health financing and health system reform is consistent with its comparative advantage in the sector, and has focused

attention on the constraints to providing efficient and effective health services in client countries. The Bank's efforts have helped to raise awareness regarding health financing issues in borrower countries and internationally; contributed to international debates on the cost-effectiveness of various interventions; encouraged the development of strategies for, and adoption of, health system reforms; and, in many aid-dependent countries, helped improve donor coordination in the sector. The major shortcoming of Bank strategy has been inadequate focus on *how* to effectively improve HNP

### BOX 2.1. BANK HNP POLICY STATEMENTS IN THE PAST DECADE

The Bank's 1987 study *Financing Health Services in Developing Countries* placed health financing at the center of its policy dialogue with borrowers. Even in the absence of severe budget constraints, the study argued, new approaches to health care financing were required to improve both the efficiency and the equity of health care. The paper proposed four reforms: implement user charges at government health facilities; introduce insurance or other risk coverage; use nongovernmental resources more effectively; and introduce decentralized planning, budgeting, and purchasing for government health services. At the country level, the Bank spon-

sored sector studies on health financing and raised health financing issues in policy dialogue, and occasionally conditioned its loans on making health financing reforms.

The *World Development Report 1993: Investing in Health* looked at the role of government and the market in health and examined the most appropriate ownership and financing arrangements to improve health outcomes, reach the poorest, and contain costs. The report stressed a three-pronged approach. First, governments should foster an environment that enables households to improve health. Second, government health spending should be made more effective by reducing expenditures on the less cost-effective interventions and expanding basic public

health programs and essential clinical services. Third, diversity and competition in the provision of health services and insurance should be promoted. The Bank's 1993 publication *Disease Control Priorities in Developing Countries* was an important contribution to international discussions, and led to increased Bank support for project lending for disease control.

In 1997 the Bank released its *Health, Nutrition, and Population Sector Strategy* paper, which will guide the Bank's work in the sector over the next decade. The strategy identifies three objectives: (i) improve the health, nutrition, and population outcomes of the poor; (ii) enhance the performance of health care systems; and (iii) secure sustainable health care financing. The paper

also incorporated preliminary findings from the OED review regarding overall portfolio performance. As a supplement to the HNP strategy, in 1999 the Bank released a *Population and Reproductive Health Strategy* paper (a nutrition strategy paper is planned for fiscal 2000). The paper describes how the Bank is responding to the integrated approach to population and reproductive health agreed upon at the 1994 Cairo conference. These strategy papers articulate an appropriate vision for Bank engagement in the sector. The challenge will be to make strategic decisions on areas of emphasis, and to allocate lending, staff time, and administrative resources accordingly.

efficiency, effectiveness, and equity—including the institutional and political factors that influence cost-effectiveness and the pace and feasibility of system reforms. The institutional sophistication of the Bank's approaches has increased, but so has the complexity of the challenges addressed. Given the lack of agreement on the right configuration of an effective health system and wide variation in country context, the Bank's increased focus on knowledge management is appropriate, but further emphasis on flexible instruments and analytical and advisory services may be needed.



# Project Performance and Determinants

The percentage of HNP projects rated as satisfactory by OED is below the Bank average, but performance has improved in recent years. Institutional development impact remains the weak point of the portfolio—less than a quarter of projects substantially achieve their institutional objectives. Borrower performance and country context are the two most influential factors in project performance. Of the factors the Bank can control, three stand out: assessment of borrower institutions and capacity, strong supervision, and attention to monitoring and evaluation.

Although the performance of the Bank's HNP portfolio has improved recently, it has historically been below the Bank average. Many factors behind this record are beyond the Bank's control. But on the operational level, a closer analysis of the record shows that weaknesses in the design and supervision of Bank projects have contributed to disappointing performance.<sup>1</sup>

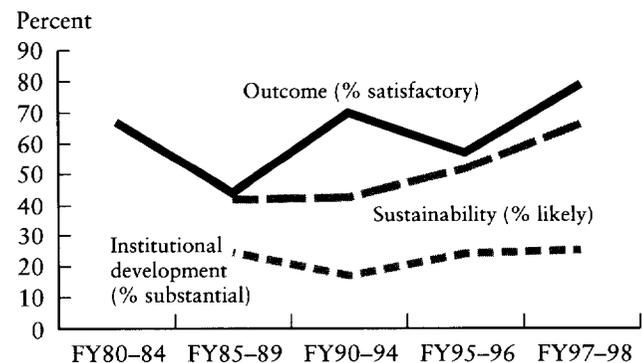
## Project Performance Trends

Of the 107 HNP projects completed between FY75 and FY98, OED rated 64 percent satisfactory, compared with 79 percent for non-HNP projects (figure 3.1).<sup>2</sup> Recent efforts by the Bank and sector staff to improve performance appear to be showing results, however—79 percent of projects completed in FY97/98 satisfactorily achieved their development objectives, close to the Bank average of 77 percent. Few of the more recent sector reform projects have been completed, so the performance consequences of the current strategy remain uncertain. But in mid-1999, the Bank's portfolio monitoring system listed a third of HNP projects as at risk, above the Bank average of 24 percent, which suggests that recent improvements should not be a cause for complacency.

Although only half (52 percent) of all completed

HNP projects were rated as likely to be sustainable, this figure rose to two-thirds in FY97/98. Improvements in sustainability appear to flow from a combination of improved economic situations in many borrower countries (prior to the recent Asia crisis), increased Bank attention to the recurrent cost implications of investments, and greater emphasis by the Bank and borrowers on client ownership.

**FIGURE 3.1. OUTCOME AND SUSTAINABILITY IMPROVING, BUT INSTITUTIONAL PERFORMANCE IS WEAK**



Source: OED data.

Yet high rates of completion of physical objectives disguise difficulties the Bank has had in achieving policy and institutional change in HNP. OED has consistently rated institutional development as substantial in only about a quarter of completed HNP projects; for FY97/98 this is well below the Bank average of 38 percent. Institutional impact thus remains the Achilles' heel of the HNP portfolio.

### **Borrower Performance and Country Context**

All Bank projects are financed through loans to governments, and responsibility for implementation rests primarily with those governments. Not surprisingly, evidence from the case studies, Implementation Completion Reports (ICRs), and an econometric model of determinants of project performance<sup>3</sup> indicates that *borrower performance* is the most important determinant of project outcome.<sup>4</sup> Yet borrower performance is not exogenous: it is also influenced by the Bank's assessment (and encouragement) of borrower project ownership, the fit between project design and borrower capacity, and the effectiveness of supervision. OED ratings of borrower performance in project preparation improved from 63 percent satisfactory in the early 1990s to 92 percent satisfactory in FY97/98 (roughly comparable to Bank averages). In contrast, borrower implementation performance fell from 71 percent to 58 percent satisfactory over the same period. Although the reasons for the decline in borrower implementation performance are not entirely clear, they could be partly the result of inadequate assessment of implementation capacity and shortcomings in Bank supervision.

**Experience illustrates the importance of political and social institutions in the achievement of project and policy objectives.**

*Country context* is the second most important influence on performance, particularly the overall quality of borrower institutions.<sup>5</sup> In countries where high levels of corruption prevail or legal mechanisms for contract enforcement are weak, resources from Bank investments can be diverted, or the project must put in place cumbersome procedures to increase accountability. Country experience also illustrates the importance of political and social institutions in the achievement of project and policy objectives. For example, cultural beliefs and low

levels of female literacy create a formidable challenge to increasing the use of family planning in rural Mali, and the complexities of the Brazilian political system complicate health reform efforts. Although national institutions evolve slowly, the results suggest that the Bank needs to understand the institutional context, and make choices regarding appropriate instruments and objectives. This includes choosing *not to lend* when governance is particularly bad—as when the Bank stopped lending to Nigeria in the mid-1990s after several failed HNP projects.

### **Bank Performance**

Although borrower performance and country context are the most important determinants of project outcome, a number of important factors—including project design and supervision—are under Bank control. According to OED assessments of completed projects, Bank performance in HNP project appraisal and supervision has improved from only about 60 percent satisfactory in the early 1990s (10 to 15 percent below the Bank averages) to over 75 percent satisfactory for projects exiting in FY97/98—equal to the Bank average for supervision, and above the Bank average (66 percent) for project appraisal. This still falls short, however, of the Strategic Compact goal of 100 percent satisfactory Bank performance by 2001. OED's review found that the quality of project preparation and supervision in the HNP sector has improved over the past decade in a number of respects, but weaknesses remain in several key areas.

#### *Institutional Analysis*

The Bank confronts a number of inherently difficult institutional challenges in the HNP sector, including many that have not been adequately resolved in developed countries. In addition, ministries of health are often administratively weak, particularly in areas such as financial management. Yet these difficulties alone do not explain the Bank's disappointing performance in institutional development. Other factors are at work:

- *The Bank often does not adequately assess borrower capacity to implement planned project activities.* This was the factor most commonly cited in ICRs as contributing to poor project performance, including 69 percent of projects rated unsatisfactory (see Annex B).
- *In seeking to promote institutional change and build borrower capacity, the Bank often does not*

*adequately analyze the constraints underlying current performance.* Although institutional analysis has improved since the mid-1990s, it remains weak, particularly in relation to the much more daunting systemic reforms the Bank is now promoting.

- *Weak analysis contributes to a lack of clarity in the articulation of institutional development objectives*, including whether the instruments chosen are the best to bring about change. Bank projects have traditionally addressed capacity constraints through the provision of training and additional resources, although a growing number of projects (particularly in Latin America and the Caribbean and Europe and Central Asia) are focusing on improving incentives or regulations.
- *The absence, until recently, of appropriate indicators for institutional goals* has contributed to the tendency to assert that “capacity was built” because training or technical assistance was provided, reducing the focus on the ultimate objectives.

The econometric model found that the quality of institutional analysis during project preparation has a significant influence on project outcome—improved

analysis is therefore likely to yield better outcomes. Although some institutional issues require sophisticated analysis, the criteria used by OED merely asked whether project designers appeared to have thought through relevant institutional issues (Stout and others 1997). Experience from HNP projects that successfully achieved institutional objectives could be more widely replicated (box 3.1). This suggests that the Bank’s institutional development performance in HNP could be raised to a level that equals or exceeds current Bank averages if staff and management commitment to achieving institutional goals were strengthened and standards and tools for institutional analysis were developed, and staff trained in their use.

**We know little about what the Bank has “bought” with its investments.**

#### *Monitoring and Evaluation of HNP Outcomes*

Although nearly all World Bank project design documents *assert* that the project will improve HNP outcomes, system performance, or health service access for the poor, few ICRs provide evidence that these development objectives were actually achieved. Not

### **BOX 3.1. LESSONS FROM SUCCESSFUL INSTITUTIONAL DEVELOPMENT**

 Of the 73 HNP projects completed between FY91 and FY98, only 13 were rated by OED as having substantially achieved their institutional objectives. These projects shared several characteristics:

- *Consistent commitment to achieving institutional objectives*, including the promotion of consensus among

stakeholders regarding priorities and approaches, and, if necessary, developing strategies to anticipate and soften resistance.

- *Project designs based on a solid analysis of the underlying constraints* to improved performance—through some combination of sector work, evaluation of previous experience, and dialogue with key

stakeholders. Designers then developed realistic strategies to address these constraints, including attention to the proper sequencing of interventions.

- *Flexible project implementation*, with regular reviews of progress toward institutional objectives, and proactive attention to problems by Bank staff and borrowers. About half the projects that

substantially achieved institutional goals were significantly modified during implementation.

- *A governance and macroeconomic context that was supportive of institutional and organizational development.* If this was not present, the above factors were particularly important.

only do we know little about what the Bank has “bought” with its investments, but when progress toward objectives is not measured, they are less likely to be achieved.<sup>6</sup>

Most HNP project designs currently identify key performance indicators, and intentions for monitoring and evaluation (M&E) have improved in recent years. But the overwhelming problem noted in ICRs is that the data required were not collected or analyzed, at least not in a manner that allowed assessment of impact. Two-thirds of unsatisfactory projects reported that the Bank gave inadequate attention to M&E during project design and implementation.

Both OED and the Quality Assurance Group (QAG) have found that monitoring and evaluation is weak throughout the Bank, but the gap between M&E intentions and actual implementation is a particular

problem for HNP. Project designs often give primary responsibility for implementing M&E to the borrower, but do not adequately consider how data will be collected or analyzed, the incentives and capacity of borrowers to do so, or the appropriate balance between the use of internal monitoring systems and external (including rapid assessment) evaluations.

A number of projects have sought to improve borrower M&E capacity—some successfully. But the Bank has tended to place excessive emphasis on providing equipment and training, and has underestimated the time required to achieve agreement among various bureaucratic stakeholders on indicators, to clarify roles and responsibilities for data collection and analysis, and to strengthen incentives to use evaluative information in decisionmaking.<sup>7</sup> The challenges of M&E are more difficult for system reform than for targeted interventions,

### BOX 3.2. LESSONS FROM SUCCESSFUL M&E

Although the Bank’s record in M&E is disappointing, a number of projects have demonstrated successful approaches to assessing the effectiveness of project interventions, strengthening borrower health information and disease surveillance systems, or monitoring progress toward sector-wide objectives.

- *The Brazil Amazon Basin Malaria Control project* helped to train malaria field-workers and strengthen disease surveillance systems. Together with a shift in strategy from eradication to control,

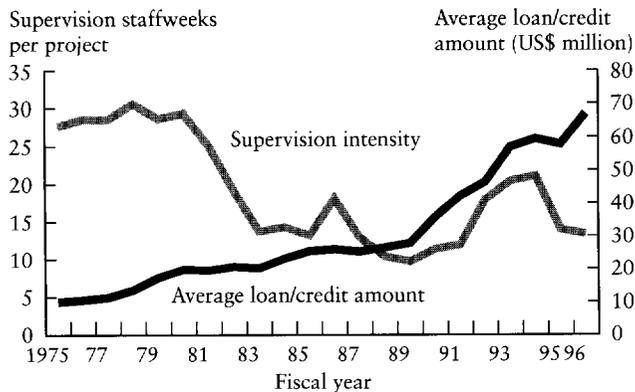
early treatment, and case management, this effort contributed to a decline in malaria incidence and fatality rates.

- *The Tamil Nadu Integrated Nutrition project* in India established a community-based system for regularly monitoring the growth and weight of children under age 3, with targeted feeding (and education in feeding practices for mothers) for children found to be malnourished. The project significantly reduced severe malnutrition in the target group. The monitoring system both contributed to and documented the

impact.

- In Mali, the *Health and Rural Water Supply project* (1991–98) eventually helped to establish a nationwide health information system, although data were not available until the final years of the project. This illustrates the importance of balancing long-term efforts to strengthen borrower monitoring capacity with provisions for periodic external qualitative or quantitative assessments, including rapid assessments (WHO 1993).
- In the current sector-wide health reform programs in Bangladesh and

Ghana, government and donors (including the Bank) agreed—after lengthy negotiations—on a limited number of national indicators that will serve as benchmarks for joint annual reviews of sector performance. Remaining challenges include a better linking of system performance indicators to HNP outcomes and ensuring that national indicators create incentives for performance at lower levels of the system (Adams 1998).

**FIGURE 3.2. SUPERVISION INTENSITY AND PROJECT SIZE**

Source: OED data.

but lessons from HNP projects with successful M&E are broadly applicable (see box 3.2).

#### *Quality of Supervision*

Although responsibility for project implementation rests with borrowers, the quality of Bank supervision has an important influence on project outcome (see Annex B). ICRs for 69 percent of unsatisfactory projects reported that supervision was inadequate, compared with only a third of satisfactory projects. The case studies and ICRs suggest that effective supervision requires a team with an appropriate skill mix; continuity among team members; strong managerial skills and client orientation; proactive recognition and solution of problems; and an appropriate balance among high-level policy dialogue, attention to implementation issues, field supervision, and consensus-building among stakeholders. Recent QAG supervision reviews found that supervision ratings for HNP project implementation performance tended to be excessively optimistic, and that few of the HNP projects reviewed based supervision assessments on progress toward the achievement of development objectives. The HNP sector is also slow to restructure problem projects. Yet an apparent factor behind recent increases in HNP project outcome ratings was the restructuring of a number of problem projects that had languished during the early 1990s.

The impact of resource constraints on the quality of supervision has been a source of growing tension between Bank HNP staff and Bank management. QAG and OED analyses found no simple link between supervision quality and quantity (measured by total staffweeks), although a minimum level of resources is

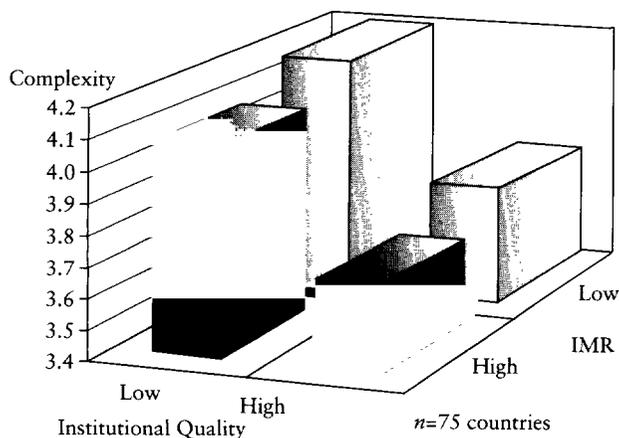
clearly necessary. But discussions with staff confirm a widespread feeling that supervision budgets have declined in real terms in recent years, and that pressures to “do more with less” are having a negative impact on quality. Staff cite reductions in the number of technical specialists included on supervision missions and in the time and budget available for priorities such as stakeholder consultation or advisory and analytical services. Senior management has asserted that overall HNP supervision budgets have been constant, and, at the aggregate level, average supervision budgets in the Bank’s Human Development Network averaged close to \$52,000 per project in FY94–98.

OED was unable to resolve the apparent conflict between staff perceptions and aggregate trends. But it is clear that the sector faces a serious problem of

**The sector faces a serious problem of multiplying tasks and mandates.**



Mother nursing baby in India.

**FIGURE 3.3. GREATER COMPLEXITY IN DIFFICULT SETTINGS**

Source: OED data and World Bank 1997d.

multiplying tasks and mandates, with inadequate guidance from management regarding priorities or selectivity, particularly with growing project size and the increased challenges of promoting sector reforms, institutional development, and stakeholder consultation (see figure 3.2).

#### *Complexity of Project Designs*

As discussed in Chapter 1, health systems include a wide array of public and private stakeholders, and achieving improvements in HNP outcomes may require multiple interventions. If project designs are too simple—for example, financing only infrastructure and training, or ignoring key ministries or agents—they risk not meeting their development objectives.

**Notably lacking in most Bank analysis is an adequate assessment of demand for health services.**

Although the econometric model found no linear correlation between complexity and project outcome, about half the ICRs for projects rated unsatisfactory concluded that the project design was too complex.

The number of project components is an important aspect of complexity, although the number of agencies involved may matter more. OED found that HNP project designs tend to be more complex in countries with low institutional capacity, and where the pace of change in infant mortality is slow (figure 3.3).<sup>8</sup> The challenge is to get

complexity “right,” combining assessment of the capacity of implementing organizations with greater effort to prioritize and sequence interventions, and to reduce the burden of Bank procedures, particularly when capacity is limited.

#### *Economic Analysis*

Although the econometric model found that institutional analysis has a greater influence on project outcome, economic analysis remains an important foundation for effective project design and policy advice. The Bank’s HNP sector leadership has established guidelines for economic analysis that call for analysis of alternative interventions, the justification for public sector involvement, cost-effectiveness or cost-benefit analysis, assessment of recurrent cost impact, risk analysis, and assessment of poverty impact, among other measures (Preker, Brenzel, and Ratta 1997).

OED’s assessment of HNP project appraisal documents found that economic analysis has improved in the past several years, but that it remains below the standards established by the sector. This is consistent with QAG findings on HNP quality at entry. Recently designed projects are more likely to assess the cost-effectiveness of the intervention, possible alternatives, or reasons for public sector involvement. Risk analysis has improved somewhat, but is still discussed very generally, with limited sensitivity analysis or consideration of exit strategies. Project documents commonly suggest that borrower institutional capacity and commitment to project goals are the major risks, to be addressed by training and technical assistance. Assessment of health care markets could be strengthened to better assess the relative roles of public and private providers and consumer demand (Hammer 1996).

#### *Consumer Responsiveness*

The majority of HNP projects include objectives that can only be met through client-responsive services (Heaver 1988). Yet notably lacking in most Bank analysis is an adequate assessment of demand for health services. The Bank has increased its attention to health consumers in the past few years, but a minority of project design and completion documents provide basic data on current levels of service utilization (in both the public and private sectors) or consumer satisfaction. Overall, only 40 percent of all project design documents provided evidence on consumer demand, and only 2 percent estimated consumer response to the proposed interventions. Although



Mother and baby, Pernambuco Mother and Child Hospital in Recife, Brazil.

beneficiary surveys and consultations have become more common, only 4 of 224 projects documented the presence of beneficiary decisionmaking power in project design.

#### *Sustainability*

Almost 40 percent of ICRs reported that shortages of recurrent expenditure adversely affected project implementation and prospects for sustainability. Despite recent improvements in project sustainability ratings, project appraisal documents often do not realistically estimate the recurrent cost burden of Bank project investments. The Bank, therefore, sometimes contributed to the recurrent cost problems it emphasized in its policy dialogue. The realism of recurrent cost assessments of investments has improved in the past five years, but the assessments still tend to be optimistic. The move toward sector-wide programs in low-income countries increases the likelihood that the recurrent costs of Bank lending will be considered in relation to other donor or government investments (Peters and Chao 1998). The Bank has also shown greater flexibility in allowing loans to be used for recurrent costs, such as drugs, but caution remains advisable to prevent Bank loans from being treated as grants.

#### *Linking Inputs to HNP Outcomes for the Poor*

Although the Bank usually focuses on poor regions, or diseases that most affect the poor, it has been weaker in analyzing the factors that lead to ill-health among the poor and in selecting interventions that are likely to achieve the maximum impact on their overall disease burden. Project design documents typically describe the disease burden, list project activities, and then assert that

significant improvements in health outcomes will be achieved. Design documents, however, seldom present a coherent analysis of *how* project interventions will translate into improved health outcomes for the poor. Consequently, the Bank usually presents overly optimistic projections of health impact and, more important, often does not consider whether alternative approaches would effect a greater impact on the disease burden of the poor.<sup>9</sup>

All four country case studies and the portfolio review found that Bank investments and policy advice tend to focus on the medical care system, while greater aggregate health improvements may be achieved through health education and behavior change initiatives, or through intersectoral interventions such as water and sanitation (Lerer and others 1998). Intersectoral interventions can be difficult to implement, however, and incentives for intersectoral coordination are weak within the Bank and most borrower governments. They must be chosen carefully, and adequate time must be allocated for supervision.

In addition, prevention is not always more cost-effective than curative approaches, as demonstrated by the Amazon Basin Malaria Control project (see box 3.2).

#### *Ownership and Stakeholder Analysis*

Recent project documents are more likely to include evidence of borrower ownership in project identification and design, but many still simply assert that the project is consistent with borrower priorities, or discuss central government commitment, but not that of local government or the beneficiaries. Few Implementation Completion Reports or design documents discuss or elaborate on Bank efforts to stimulate ownership. Yet projects that can point to specific evidence of borrower ownership are more likely to achieve their objectives (Johnson and Wasty 1993). Greater participation and work with a range of stakeholders is characteristic of more recent projects, and some task teams undertake stakeholder analysis, but do not document findings to avoid jeopardizing reformers.

Projects tend to be more successful in achieving their institutional development goals when they are strongly supported by relevant borrower agencies and key stakeholders. Differences of policy opinion across

**Factors that lead to ill-health among the poor, selecting interventions that are likely to achieve the maximum impact on their overall disease burden.**

government can seriously undermine institutional development goals. Such differences are common in sector reform efforts (Reich 1997).

The challenges of health reform require strategic and flexible approaches to support the development of the intellectual consensus and broad-based coalitions necessary for change. System reform is difficult and time-consuming, and stakeholders outside ministries of health can determine whether reforms succeed or fail. In practice, the Bank has often focused primarily on dialogue with government officials, particularly in ministries of health, without taking advantage of its convening role to build consensus among stakeholders.

**Weak coordination and turf battles among ministries and ministerial subunits are common in developed and developing countries alike.**

Some recent efforts give greater emphasis to these priorities. In addition, the Bank has frequently failed to develop sufficient understanding to anticipate responses to reforms, including which measures are likely to be adopted, which may be resisted, and possible changes in content that may be made in the course of policy debate and implementation.<sup>10</sup> Experienced

task managers are well aware of the political dimensions of reform, but staff have limited skills and tools for stakeholder and political analysis.<sup>11</sup>

*Participation*

Developing mechanisms to increase the voice of communities in the management of health services is key to improving service quality and consumer responsiveness. Despite the interest in community participation and mobilization during the primary health care focus of the 1980s, subsequent Bank project documents tend to confuse participation with charging consumers for services. Community-based management and financing of health services—as advocated in the 1988 Bamako Initiative—is one means to improve service quality and client responsiveness. But community mobilization is time-intensive and context-specific. Even among projects that plan to encourage local participation, descriptions of local and traditional participatory structures are rare.

The Mali case study found that successfully establishing community-managed health services requires

close attention to the design and nurturing of participatory structures. Yet even in communities where local committees managed the local health center, women were usually underrepresented, and community members did not always think the committees represented their interests. The Bank is not always well-placed to directly foster local participation or strengthen mechanisms for consumer voice, but it can emphasize these issues in policy dialogue or encourage direct or parallel financing for enhanced participation through international partners or local nongovernmental organizations (NGOs).<sup>12</sup>

*Coordination*

Because health is a popular sector with many donors, ministries of health—particularly in aid-dependent countries—frequently have been undermined by a proliferation of projects and vertical programs. In the 1980s, the Bank began to encourage other donors to finance projects jointly, and in the 1990s it has taken the lead in building consensus among donors for sector-wide approaches, and in helping governments develop the policy framework for sector programs (Peters and Chao 1998). Despite these efforts, some partners express concern that inadequate field presence can hinder the Bank's ability to coordinate effectively.

In addition to the challenge of donor coordination, weak coordination and turf battles among ministries and ministerial subunits are common in developed and developing countries alike. Weak linkages among ministries of finance and planning and sectoral ministries, in particular, can hinder both internal planning and budgeting and the external coordination of partners (van de Walle and Johnston 1996). Such problems are not easily resolved, but the case studies suggest that the Bank can facilitate improved relationships among government units, particularly through its convening power and its relationships with both ministries of finance and sectoral ministries.<sup>13</sup> But improving coordination within governments or among donors can be difficult and time-consuming. The Bank and its partners need to establish appropriate strategies, priorities, and divisions of responsibilities in this area.

**Institutional Factors Influencing Performance**

Few observers inside or outside the Bank dispute the importance of defining and monitoring objectives, careful institutional assessment, or the political nature of health

reform. The vast majority of Bank HNP staff are knowledgeable and dedicated. What, then, are the underlying sources of these difficulties, and why do they persist? We focus here on three major areas: quality assurance, M&E, and learning and intellectual leadership.<sup>14</sup>

#### *Quality Assurance*

In recent years, the Bank's HNP sector has focused attention on issues of quality in the portfolio by establishing an HNP quality committee and lead quality adviser and by sponsoring training programs on quality at entry and supervision. Yet routine quality assurance and monitoring mechanisms remain weak, particularly under the current matrix management system. Reasons appear to include:

- *Lack of clear lines of responsibility and accountability for quality.* Nominal responsibility rests with the HNP Sector Board and lead technical specialists, but budget and staff allocation decisions are made by the country departments. The HNP Board's recent decision to strengthen its role in quality assurance, including the establishment of a benchmarking system to regularly monitor portfolio performance, will be an important step.
- *Regional technical advisers are overburdened,* and are often unable to give sustained time and attention to reviewing the quality of project design, supervision, and economic and sector work.
- *Managerial accountability mechanisms such as QAG are not balanced by mechanisms to provide early and collegial support to task teams* during project design and supervision, or to build quality assurance into the overall project cycle. The project design peer review process is not functioning effectively.
- *Staff are reluctant to restructure projects* because of continued high transaction costs, and a perception among HNP staff that management views restructuring as an admission of failure. Restructuring occurs, but often not until a new task manager has been appointed.

#### *Monitoring and Evaluation*

M&E has been weak throughout the Bank, despite repeated exhortations from OED (OED 1994). In addition to the methodological issues discussed earlier, several factors have constrained Bank and borrower M&E performance:

- *Low priority is given to M&E by Bank management,* and there is little incentive for staff to become involved. Many staff report that their managers rarely express interest in reviewing development progress.
- *The Bank's core business processes and incentives remain focused on lending money rather than on achieving impact.* Until incentives are adjusted, progress will remain sporadic. The Comprehensive Development Framework pilots currently under way offer an opportunity to shift Bank processes and procedures toward achieving development results.
- *Forums for staff to discuss and review progress toward development objectives,* or to recognize and reward evidence of HNP development impact, are lacking. Staff still perceived that rewards were linked primarily to project approval and disbursement.
- *In most client countries, health monitoring systems are either weak or rarely used in policy decisionmaking,* and national or local budgets are seldom linked to monitoring data. Consequently, there is little demand for information, and few incentives for its collection.
- *Few Bank client countries have the "information infrastructure" necessary to routinely and reliably measure health status outcomes* through vital registration systems and up-to-date censuses. Despite significant Bank and donor investments in household surveys, the Bank and its partners have given little attention to these routine systems.

#### *Learning and Intellectual Leadership*

The Bank's Human Development Network and HNP Sector Board are ahead of some other parts of the Bank in attempting to respond to President Wolfensohn's call for a "Knowledge Bank."

The Network has established systems for knowledge management, and focused on strengthening staff skills in key areas. The Bank's ability to provide intellectual leadership, however—both internationally and at the country level—is being compromised by several trends:

#### **Regional research is difficult to fund.**

- *Few staff have explicit training in organizational, institutional, or stakeholder analysis, and they*

*have few tools to undertake such analysis during project design.* Developing operationally relevant training and tools is an important challenge, as is balancing staff analytical skills with the need for practical implementation experience.<sup>15</sup>

- *Resources for economic and sector work (ESW) have declined in the past five years relative to the lending portfolio.* This has placed the Bank in the position of embarking on ambitious sector reforms in many countries without first establishing a strong empirical foundation to guide the process. Reviews by QAG and DEC (Development Economics and Chief Economist) have raised concerns regarding the uneven quality and impact of sector work, and inconsistent links between these efforts and the lending program.
- *Borrowers are often reluctant to use loan money for technical assistance* and the Bank has few grant resources available outside of project preparation funds. Staff (particularly in IBRD countries) report that this limits their ability to engage in policy dialogue and stakeholder consultation.
- *Staff now rely heavily on external grant facilities to fund project preparation and analytical work, but application for such funds is time-consuming and the grants carry a number of restrictions in the use of their funding.* Since all budgets now reside in country departments, regional research is difficult to fund, although many issues would be more effectively and efficiently addressed through regional studies, particularly in Europe and Central Asia (ECA) and Africa.
- *HNP staff have not made wide use of new lending instruments such as Adaptable Program Loans (APLs) and Learning and Innovation Loans (LILs).* Despite growing interest, staff report that while such instruments often require extra staff time, additional resources are not provided, and administrative requirements have reduced their intended flexibility. In addition, some borrowers are reluctant to accept small loans, or are concerned that *flexible* instruments could give the Bank discretion to reduce future funding.



# Development Effectiveness of HNP Investments and Policy Dialogue

Bank investments have provided valuable support in expanding and strengthening the building blocks of borrower health systems, including facilities and staff. The impact of these investments, however, has often been reduced by continued problems with service quality and underfinancing of basic HNP services. The Bank tended to conceptualize projects as injections of capital and technical expertise, and provided policy advice based on normative prescriptions, without fully appreciating the incentives, institutions, and external constraints

governing sector performance. Recent approaches are more sophisticated, with greater attention to the institutional dimensions of reform, but the challenges being addressed are also more difficult.

Completed projects and the OED country case studies are rich sources of information about the extent to which Bank-sponsored HNP projects have achieved HNP development objectives. Throughout the 1970s and 1980s, a major goal of Bank HNP projects was to support the expansion and strengthening of health service delivery systems. This remains an important goal today in many countries. In recent years the Bank has turned more attention to promoting enhanced health system performance, and it has gained experience with measures to improve HNP service delivery and to secure sustainable health system financing.

The discussion here applies broadly to the Bank's work in HNP. Boxes 4.1 and 4.2 provide further detail on the Bank's experience in nutrition and reproductive health, respectively. Although the discussion focuses primarily on shortcomings in Bank effectiveness—and

thus on areas where improvement is needed—the Bank's performance in HNP must be considered in the context of the challenges posed by any effort to improve performance in the social sectors.

## **Strengthening the HNP Service Delivery Structure**

### *Expanding Access to Health Services*

Expanding physical access to health services has been a major goal of Bank HNP lending for the past two decades.<sup>1</sup> Even recent health reform projects typically devote substantial portions of expenditure to construction, and geographical access remains a challenge in some poor countries. Client governments generally place high priority on infrastructure development when requesting Bank assistance, and these investments are usually appreciated by consumers and providers.

OED found that Bank projects usually are successful in expanding geographical access to government health and family planning services, but often experience delays (two years on average) or problems with uneven quality. Ministries of health often are inexperi-

enced in construction, and ministries of construction, which frequently implement civil works, typically have limited experience with health facilities, and are vulnerable to inefficiencies and graft. Careful attention to design, site selection, and supervision—and the funding of architectural consultants—can improve the quality and cost-effectiveness of civil works. In the longer term, enhancing the capacity of ministries of health to evaluate facility design and supervise construction can enhance the quality of health infrastructure investments, although in some contexts, third-party contracting may be preferable.

Increased physical access to government health services often does not lead to increased use of services, however, at least not at the levels anticipated during project design. Several factors explain why. First, service quality—including the availability of trained providers, provider attitudes, and drug availability—is a key determinant of consumer demand. Family planning and maternal and child health (MCH) clinics

constructed with Bank support in Brazil, India, and elsewhere were often underutilized because of poor service quality. Second, if new or upgraded facilities are not located near catchment populations, or are placed near competing facilities (such as mission hospitals), their net impact on utilization is reduced (as in Zimbabwe). Inadequate planning or political influences can lead to inappropriate site selection, while establishing transparent technical criteria can reduce distorting political influences. If poor consumers prefer private or NGO services, then encouraging improved access to, and quality of, private service delivery or health insurance may be appropriate. Bank efforts in this area are recent, however, and generally confined to Latin America and the Caribbean (LAC) and Eastern and Central Europe (ECA).

#### *Strengthening Referral Systems*

A functioning referral system helps to mitigate the risks associated with ill-health and can increase service

### **BOX 4.1. BANK EXPERIENCE IN NUTRITION**

nutritional status is an important determinant of health status, and several decades of experience have demonstrated that targeted nutrition programs can measurably improve protein-energy malnutrition and micronutrient deficiencies for children and mothers. But nutrition programs in many borrower countries are hindered by a number of factors, including an overreliance on expensive and poorly targeted feeding programs and weak mechanisms for intersectoral coordina-

tion. Changing from food entitlements to more targeted nutrition programs can be politically difficult, however. The OED case studies demonstrate a wide variation in Bank nutrition activities, from a relative neglect of nutrition issues in Brazil and Mali, to significant contributions in India and Zimbabwe (see Annex A).

The Bank's nutrition efforts have been constrained both by inconsistent attention to nutrition across portfolios at the country level and by the uncertainty of Bank staff and governments as to how to intervene effectively and efficiently to improve nutrition. This is

a consequence of the Bank's relatively small nutrition staff; the difficulty of integrating the intersectoral aspects of food policy and a nutrition program into standard health investments; and, sometimes, concern that adding a nutrition component will create excessive project complexity.

Where the Bank has given priority to nutrition issues, it has helped to raise the profile of nutrition within ministries of health and ministries of finance (as in Zimbabwe). Nutrition subcomponents of projects are often co-financed by other donors, but the source of financing seems to matter less than

the attention given to nutrition in policy dialogue, and the Bank's success in introducing targeting and nutritional impact monitoring into government programs. This suggests that a strengthened strategic approach to nutrition could help increase the Bank's impact. The HNP sector is in the first stages of developing a nutrition strategy, beginning in 1999 with a comprehensive assessment of lessons of experience from past nutrition efforts. This evaluation is being undertaken jointly with UNICEF.

efficiency. Reducing maternal mortality, for example, depends on the ability of providers at lower levels to identify and refer high-risk pregnancies to higher-level facilities. Improving service efficiency, in contrast, calls for treating basic ailments in primary care facilities. Strengthening a referral system requires attention to several factors, including service quality at each level, provider training in referral protocols, and consumer demand patterns. Bank-sponsored projects use several approaches to strengthen referral systems, including investments in facilities, staff training, and equipment at primary and first-level referral facilities; provision of transportation and communications equipment; and policy advice to encourage progressively higher fees at each level, unless a patient is referred.

The case studies and other project experience demonstrate that Bank investments in facilities, equipment, transport, and communications equipment have enhanced referral effectiveness and efficiency in many countries. The major constraints, not surprisingly, tend to be on the "software" side, including inadequate training in referral at the primary level (India), shortages of qualified physicians at the first or second referral levels (Zimbabwe, Mali), and continued consumer preferences for higher-level care, which leads to continued bypassing (Brazil). Changing price signals can enhance referral efficiency, but only if the service quality is adequate at the primary levels, yet the Bank has tended to emphasize changes in fee structures before a focus on service quality. The Bank is only beginning to address the difficult issues of private sector referral and public/private linkages.

#### *Health Staffing and the Health Work Force*

The Bank has invested heavily in the training of health staff and health managers, both through direct financing of training and by helping to establish or upgrade borrower training programs. The goals of training often include improving provider technical skills; increasing the number of trained providers, particularly in underserved areas; and enhancing overall provider motivation and performance. Bank training investments are usually appreciated by providers, and in many countries have contributed to improvements in technical proficiency, the introduction of new approaches, and enhanced quality of care. But the quality and relevance of training—which is often provided through government institutions—can vary considerably. Typical problems include excessive emphasis on



Nurse/healthworker preparing to inoculate child, Harare, Zimbabwe.

memorization, inadequate hands-on practice, and difficulties in attracting and retaining trainers, often because of inadequate pay and poor career prospects. Training systems do not change overnight, but the Bank needs to address such issues during design and implementation, and to give greater attention to assessing the quality and impact of training.

Bank training investments also have been consistently undermined by inadequate attention to the health labor market and performance incentives for providers in both the public and private sectors. Each of the country studies concluded that health work force issues are perhaps the most pressing challenge facing the respective health systems. Where a large private sector exists, civil service pay often is not competitive, particularly for doctors and staff with technical or specialized training, which contributes to attrition or moonlighting. Providers often have few incentives to work in rural areas. In the public sector, low morale and lack of client-orientation often results from dissatisfaction with terms of service, inadequate supervision, or the limited ability of consumers to demand improved service. Private providers often overprescribe and have few incentives to provide preventive care. In such contexts, training investments often produce little change in the number of providers serving poor populations, and have only a marginal impact on the quality of care. The Bank has neglected these issues in

**Inadequate attention to the health labor market and performance incentives for providers in both the public and private sectors.**

its projects and policy dialogue, however, at least until very recently (see below).

#### *Essential Drugs and Equipment*

Drug availability is an important determinant of service utilization rates. The Bank has sought improvement through several means, including direct procurement of drugs, establishment of revolving drug funds at both national and community levels, and pharmaceutical reform efforts. Drug procurement was a common sub-component of Bank health investment projects in the 1980s, but the onset of the HIV/AIDS epidemic led the Bank to finance several large drug procurement projects, primarily to finance the purchase of drugs to combat sexually transmitted infections (as in Kenya, Uganda, and Zimbabwe). Bank requirements for inter-

national competitive bidding (ICB) for major drug procurements can produce substantial cost savings for governments, and generally lead to improved drug supplies. Yet the rapid design and implementation of these programs, often without adequate training for local staff in Bank procurement procedures and ICB, often led to bottlenecks and delays in the drug procurement and distribution process. Bank clients frequently complain of the complexity and rigidity of Bank procurement procedures, particularly for the procurement of medical equipment and pharmaceuticals. Procurement issues often take up a substantial portion of the time of Bank HNP specialists, time that could be spent on policy dialogue or implementation issues. Procurement delays can also appear when the Bank rejects improperly prepared bids, which may stem from

### **BOX 4.2. BANK SUPPORT FOR POPULATION AND REPRODUCTIVE HEALTH**

ver the past 25 years, the Bank's reproductive health focus has shifted from an exclusive emphasis on fertility reduction to an integrated approach (see box 2.1). Several decades of international experience have shown that while socioeconomic factors—particularly income and female education—are key determinants of demand for family planning services, the provision of quality and client-responsive reproductive health services, together with effective information programs, can contribute to increased contraceptive prevalence and fertility

reduction. Bank-sponsored population projects and policy dialogue have contributed to the development of population policy, supported the expansion of family planning service delivery, and encouraged integration of family planning with health services (as in Bangladesh and Zimbabwe). The Bank's emphasis until the early 1990s was primarily on the expansion of existing government programs; thus the impact varied considerably depending on the quality and client-responsiveness of these programs (OED 1992). The weaknesses in Bank population investments are similar to those identified for the overall HNP portfolio in this

report, including a relative neglect, until recently, of private and NGO channels for service delivery.

Implementation of an integrated reproductive health approach faces both bureaucratic and programmatic challenges. Many developing countries—with donor support—initially established organizations independent of ministries of health to deliver family planning services, and later established additional organizations to promote HIV prevention. Bangladesh is attempting to reintegrate these programs as part of a sector-wide program, with support from the Bank and other donors. An unresolved issue in countries with high HIV

prevalence is how to reconcile the emphasis on non-barrier contraceptive methods advocated by family planning programs with the prevention of HIV and sexually transmitted infections (STIs). Improving reproductive health may require strengthening overall health system performance (for example, improving referral systems to reduce maternal mortality). Yet population and reproductive health specialists inside and outside the Bank have expressed concern that the current emphasis on health system reform should not lead to neglect of reproductive health programs (PAI 1998).

corrupt practices, suggesting the importance of both training in procurement and ensuring adherence to rules for transparency.

The Bank has also supported the establishment of community-managed revolving drug funds to help alleviate the persistent shortage of essential drugs in local clinics and to increase the participation of communities in the management and provision of health services. Experience in Mali and elsewhere has demonstrated that the success of community initiatives depends on progress in national pharmaceutical reform, particularly in increasing the availability of affordable essential drugs. Unless affordable drugs are available, low-income communities cannot sustain the drug funds. Using Bank loans to capitalize national or regional revolving drug funds can be an effective way to improve drug availability, but only if such investments are preceded by sufficient institutional reforms to ensure efficiency and accountability. Communities also require ongoing training and support to establish effective management systems, and oversight to ensure that prices remain equitable and revenues are used appropriately (UNICEF 1998).

#### *Health Promotion and Behavior Change*

As noted in Chapter 3, although behavior change and intersectoral health promotion efforts are essential to improved HNP outcomes, Bank-financed interventions have generally given inadequate emphasis to these priorities. Many of the Bank's basic health and family planning projects included information, education, and communication (IEC) or health promotion subcomponents designed to change consumer beliefs and behaviors. These initiatives have provided valuable equipment and training, and often heightened the priority of health education. But Bank health promotion efforts frequently have been constrained by several factors. First, project designs have emphasized IEC without adequate attention to the broader policy and regulatory changes—often outside the health sector—that are frequently necessary for success. Second, the design of IEC efforts has consistently emphasized the *I* (information) aspect, with less attention to health education and counseling, which usually have a greater impact on behavior (Nutbeam and Harris 1998). Third, IEC campaigns sponsored by the Bank have often been poorly executed—with little or no field testing of messages or materials, or targeting of specific groups—and implemented by units in health ministries with little experience in marketing or behavior change. The

Bank only recently began to finance and promote social marketing through the private or non-profit sectors.

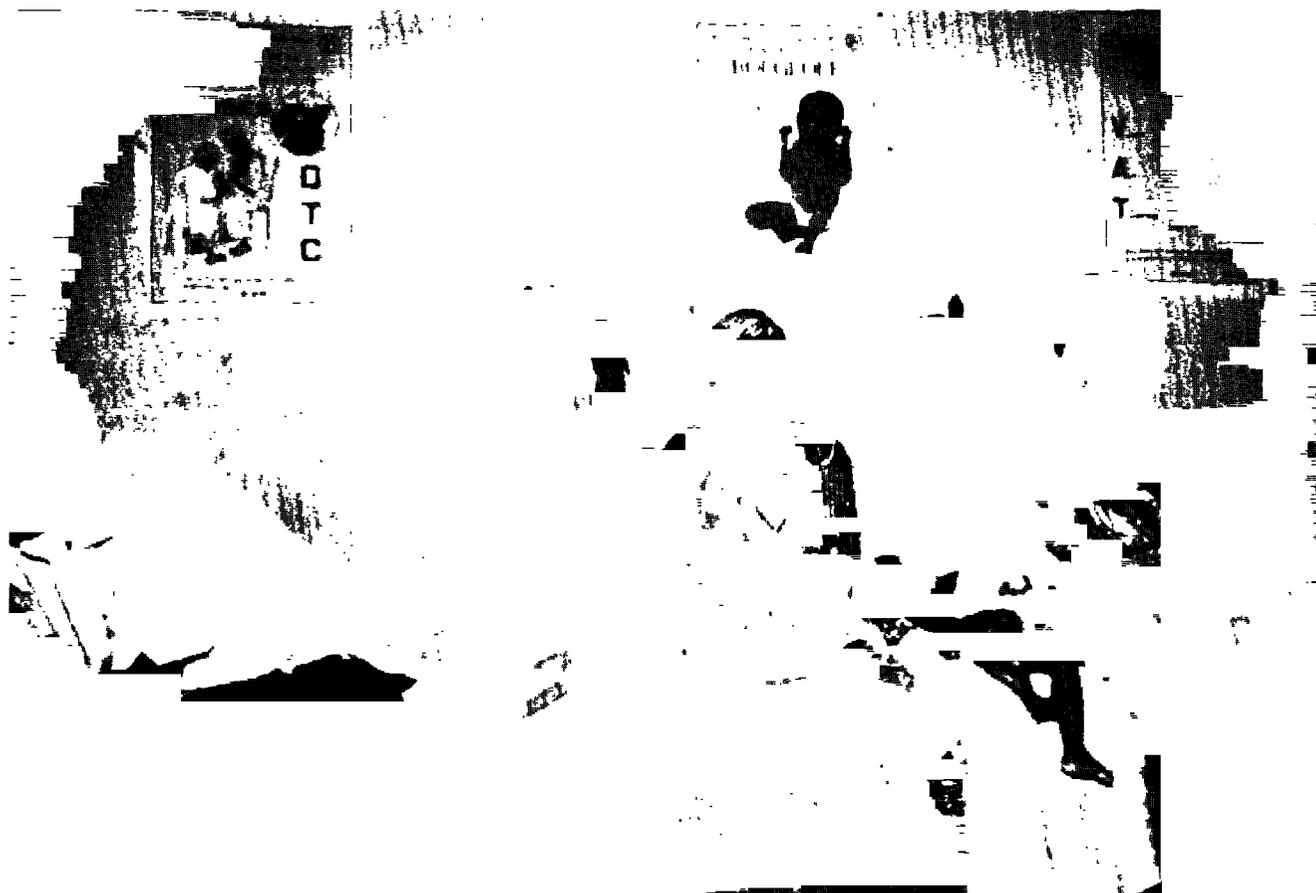
Yet when the Bank has made behavior change a priority in its interventions, the results have been encouraging. Some of the Bank's more recent HIV/AIDS projects highlighted behavior change, including successful efforts to encourage NGOs to direct and manage educational efforts in Brazil and India. The Bank's recently launched anti-tobacco campaign (with WHO and other partners) emphasizes changes in taxation and other national policies. Since these efforts are relatively new, the Bank should give priority to evaluating the effectiveness and impact of the various health promotion approaches.

#### *Private Sector Quality and Equity*

Until the early 1990s, the Bank paid relatively little attention to private (nonprofit, for-profit, and traditional) providers of health or family planning services. Yet private spending often constitutes more than half of all health spending, and may represent a majority of the health spending by the poor. The nature and extent of the private sector varies considerably among countries and regions, however, as does the extent of government financing or regulation of private provision. Qualified private practitioners generally prefer urban areas, and focus on middle- or upper-income consumers, or those with health insurance. Although consumers (including the poor) often prefer private providers because service is perceived to be of better quality, clinical quality can vary substantially in many countries (there has been a proliferation of clinicians with unknown or questionable clinical skills). Even qualified providers often feel substantial pressure to prescribe drugs and have few incentives to provide preventive services.

Regulatory or quality assurance mechanisms for private provision are weak or nonexistent in many developing countries, but professional associations may strongly resist a broadened government regulatory mandate. The Latin America Region is increasingly engaged in such issues, but few projects have been completed or evaluated. Recent Bank policy statements have called for a better balance of public and private roles in health (box 2.1). The challenge now is to build

**Behavior change and intersectoral health promotion efforts are essential to improved HNP outcomes.**



Health clinic in Mali.

a solid empirical foundation on the optimal balance in different country contexts, and the processes by which changes can be achieved.

### **Enhancing Health System Performance**

The Bank has taken a variety of approaches to enhancing the quality and efficiency of health services, although, until recently, the general focus was on improving the performance of government health services. Recent OED research supports the argument that the Bank has not considered a sufficiently wide menu of institutional approaches to enhance performance (Girishankar 1999).

#### *Decentralization and Devolution*

The Bank has widely recommended decentralization, contracting out, and separating the purchaser from the provider as institutional arrangements that will improve system performance and the efficiency of government health services (World Bank 1993). Many health delivery systems are overly centralized and unresponsive to local needs, and governments often provide

services less efficiently and effectively than the private or nonprofit sector. But the actual impact on performance depends on the details of design and implementation, and the wider institutional and political context. State and local governments may be more responsive to local populations, but they may also be more sensitive to the demands of local elites, and prefer expenditures for hospitals rather than for primary health care.

The case studies found that the Bank—at times—has promoted decentralization without sufficient regard for the administrative or political implications, or without giving the necessary attention to determining what responsibilities should be devolved to which levels of the health ministry or local government. Even in successful examples of decentralization, the Bank has tended to underestimate the training and technical support needed to help districts undertake their new responsibilities (as in Mali). Similarly, the case studies found that separation of purchase and provision alone does not guarantee improved efficiency (Brazil, India). In sum, decentralization, devolution, and contracting out services may enhance

system performance, but the Bank needs to take a more nuanced approach to help borrowers determine the appropriate levels for various services, the appropriate sequencing of reforms, and training requirements.

#### *Strengthening Organizational Capacity*

If policies and institutions are the rules of the game, then organizations and individuals are the players, and their success depends on their ability to work within the rules (or by circumventing them; North 1990). Bank HNP capacity building initiatives tend to focus on symptoms rather than on the root constraints on performance, although this is unique neither to the Bank nor to the HNP sector (Grindle 1997). The Bank's efforts to improve organizational performance have invariably fallen under the category of "capacity building," which typically involves the provision of training, technical assistance, and other resources. These may be needed, and if inadequate skills and technical capacity are the major performance constraints, improved performance can result. Not surprisingly, when inadequate skills are not the major constraints, these efforts have little impact.

The lack of clarity regarding objectives has contributed to a complete absence—until very recently—of any indicators of organizational capacity or performance. ICRs tend to assert that capacity was built in a given organization because workshops were attended, staff were trained, and computers were provided. This focus on inputs also contributes to a lack of attention to proper sequencing, which is often essential to achieving results.

#### *Rules for Resource Transfers*

The rules that govern the transfer of resources between levels of government, from government to private providers, or from insurance companies to providers, fundamentally structure the incentives for health care delivery. Until recently, few project design documents or sector studies gave attention to understanding how these rules and processes operate in a given setting (as distinct from normative assessments of how they should operate), or to changing them. The Reforsus project in Brazil attempted to improve health system efficiency by paying more to hospitals or providers who provide cost-effective services. OED analysis of this case, however, suggests that this strategy is unlikely to work, because it does not account for political influences on the rate-setting process or the mechanisms by which payment to hospitals would influence the treatment decisions of individual providers. This

does not suggest that all such Bank efforts are similarly flawed, but that the level of institutional, political, and technical sophistication necessary to achieve results is considerable, and has exceeded the prevailing practice of the Bank. On the positive side, in several countries (India and Indonesia) the Bank leveraged improvements in district-level performance by working with central or regional government to establish performance-based criteria for financing district health plans and programs, sometimes on a competitive basis.

#### *Health Work Force Reform*

As noted earlier, all of the country studies concluded that health work force issues were perhaps the dominant constraint facing the HNP sector. But with a few exceptions, the Bank has conducted very little sector research on those issues. The standard Bank response has been either to proceed with capacity building and training, even though the fundamental capacity and performance problems relate to staff incentives or high turnover, or to try to strengthen health work force planning capacity within ministries of health. Bank efforts to accomplish the latter have often met with limited success, largely because conditions of service are determined by finance ministries or public service commissions.

Bank macroeconomic dialogue and HNP strategy and investments have often been poorly coordinated with civil service reform and health work force issues. In both Zimbabwe and Mali, the health sectors were adversely affected by the civil service reduction programs that accompanied economic adjustment; at the same time, Bank projects required additional staff. HNP staff are increasingly aware of the importance of health work force constraints, but often do not have adequate mechanisms or sufficient sector analysis of the issues to elevate their concerns into the macroeconomic dialogue.

Recent Bank policy reform projects have more explicitly recognized the constraints inherent in the civil service, and have sometimes supported health ministries in proceeding ahead of government on key reforms. In some cases, this has included devolving health staff to

**State and local governments may be more responsive to local populations, but they may also be more sensitive to the demands of local elites.**

local government, or taking health staff out of the civil service (as in Zambia). These efforts may help address a key constraint to improved government services, but they also create other problems, including staff resistance and attrition because of reduced job security or lack of career mobility, late or nonpayment of salaries by local governments (often in the hope that they will be bailed out by central government), or increased use of ethnic or political criteria in hiring. The HNP sector has identified health work force issues as a priority for further research, but a concerted effort will be necessary to develop consistent and effective approaches to these difficult matters (Martinez and Martineau 1998).

### Health Financing

The Bank's health financing efforts have sought to improve the quality, efficiency, and sustainability of public and private health services. Overall, the case studies and portfolio review found that the Bank has played an important role in raising awareness in borrower countries regarding the equity and efficiency

**HNP sector studies of health financing, public expenditure reviews, and related documents are often key sources of information for officials.**

implications of health expenditure and resource mobilization patterns, and Bank diagnosis of the health financing challenges has generally been good. HNP sector studies of health financing, public expenditure reviews, and related documents are often key sources of information for officials, both inside and outside the

government. The Bank's recommendations for addressing the problems, however, often have given inadequate attention to the institutional challenges inherent in implementation. As a result, the Bank's record in achieving effective change has been mixed.

### *Allocative Efficiency*

The Bank has consistently pointed out the high percentage of government health expenditures allocated to urban tertiary care in many developing countries, and has called for a shift toward more cost-effective primary care interventions and for services likely to benefit the poor (World Bank 1993). But while acknowledging that spending patterns are often the result of pressure by urban elites, the Bank has not always developed effective strategies to

address the political dynamics that underlie inequities and resource misallocations. In Brazil, for example, the politics of the Brazilian budget process create consistent underfinancing of basic health services, and key preventive programs often receive their allocations only in the final months of the fiscal year. As an external agency, and a relatively small player in large countries such as Brazil, the Bank alone certainly cannot influence such dynamics, but could better account for them in its strategy, sector work, and lending program.

### *Cost Recovery*

The Bank's advocacy of increased cost recovery for HNP services has generated considerable controversy and a substantial literature (Nolan and Turnbat 1995). About 40 percent of all projects—nearly 75 percent in Africa—included some provision to establish or strengthen the user fee system. The Bank has argued that cost recovery can improve the quality and sustainability of services (particularly if fees are retained), and that the poor are often willing to pay more for improved services (World Bank 1994). The initial implementation experience followed one of two somewhat distinct paths, depending on whether the country adopted Bamako Initiative-style community management of fee revenues, as in parts of West Africa, or if fees were implemented through the existing government system, as in much of East and Southern Africa (Gilson 1997).

The Mali and Zimbabwe case studies mirror this experience. In Zimbabwe, fees were increased at the primary and secondary levels during the early 1990s, but because the Ministry of Finance did not approve fee retention until 1998, the overall impact on service quality and utilization by the poor was negative. In Mali, the financing of community-managed health centers significantly expanded drug availability and access to rural health services. Utilization rates remain low overall, however, and cost recovery has not proved to be an effective means to fund preventive services or individual disease interventions (UNICEF 1998). Although asserting that the poor should be protected from fee increases, the Bank has often failed to propose administratively feasible methods to protect the poor. Bank advice on user fees has generally become more nuanced in recent years—for example, arguing that essential preventive services should be provided free of charge—but the Bank is still widely perceived to be an unabashed advocate for increased cost recovery (Watkins 1997).



Children in Brazil

#### *Links to Macroeconomic Dialogue*

The Bank has not always effectively linked its health financing dialogue with macroeconomic dialogues. The onset of economic crisis in much of the developing world led to the adoption of Bank-sponsored economic stabilization and adjustment programs in many countries. Initially, the Bank and IMF did not give adequate attention to protecting expenditures for social services, and some countries experienced reductions in health budgets. By the late 1980s, however, partially in response to global criticism, the Bank and IMF became more proactive in attempting to protect social expenditures and staff in the design of adjustment programs. Since the early 1990s, the Bank has included the protection or expansion of the social expenditure—as appropriate—as an important component of its macroeconomic and sector policy dialogue. The Bank has experienced some success, particularly in smaller countries, in encouraging increased allocations to health or in shifting public resources toward basic and preventive care. Issues of equity and efficiency and government health expenditures, however, are still not ad-

equately captured in Country Assistance Strategies or macroeconomic discussions.

#### *Hospital Financing and Reform*

While tertiary hospitals and the billing of private insurance companies are often a major source of lost revenue, the Bank has had limited success in encouraging improved cost recovery at these levels. Initially, the Bank merely raised the issue of hospital or insurance billing in the context of sector work or dialogue, but gave little attention to supporting or encouraging actual changes. The Bank has advocated reductions in tertiary hospital expenditures—sometimes successfully, particularly in aid-dependent countries—but without providing the advice and support to help hospitals become financially sustainable.<sup>2</sup> Hospital reform has now come onto the Bank's HNP agenda, but it is proving to be institutionally and politically challenging. The HNP sector currently is developing improved indicators and analytical tools for hospital reforms, which will need to be complemented by intensive sharing of experiences (Over and Watanabe 1999; Preker and Harding 1999).

**The Bank has experienced some success in encouraging increased allocations to health.**

#### *Risk Pooling and Insurance*

Resource mobilization and risk pooling through strengthened social or private insurance arrangements has emerged as a major focus of Bank HNP efforts in middle-income countries, particularly in LAC and ECA (World Bank 1997c). Because most of these projects have been approved in the past few years, there is limited evaluation of their relevance and effectiveness. This will need to be a priority for the HNP sector and OED in the coming years.

#### **Instruments and Strategies for Reform**

##### *Strengthening the Policy Framework*

The Bank has contributed to improving the coherence of health policy in many countries, and many borrowers consider the Bank's broad strategic view of the sector a major asset. The Bank played a particularly important role in encouraging borrower governments to adopt formal, written policies on key sector issues (such as population), and in the development of sector-wide health policies in the 1990s. The Bank sometimes undermined local ownership by allowing staff or

consultants to dominate the policy development process, but in recent years it has placed greater priority on ensuring that government officials take the lead. In small, aid-dependent countries, however, the risk remains that the development of national policies can become excessively linked to Bank project deadlines.

#### *Focusing on the "How" of Reform*

Bank policy advice and reform strategy are too often insufficiently grounded in empirical evidence or institutional analysis of the country context. The Bank has been better at specifying what needs to be done than

why problems persist and how to address them. As a result, the Bank has a tendency to promote standard solutions to health system problems, without giving sufficient attention to local institutions or details of

**The Bank has perhaps encouraged overly ambitious reforms.**

implementation. Conversely, when the Bank begins to tackle the *how* questions, through its policy advice, research, or lending—as in India since the 1990s—its influence and impact increase.

#### *Incremental versus "Big Bang" Approaches*

The Bank is increasingly engaged in reform issues that have no commonly agreed solutions or universal models, limited evidence about what works, and are areas of limited Bank experience (Nelson, in press). These include health insurance reform, regulation of the private sector, pharmaceutical policy, health work force reform, and the appropriate balance between public and private roles in health service financing and delivery. Incremental approaches may therefore be more appropriate, built on solid research, pilots, and focused efforts to learn from experience. The Bank, however, has perhaps encouraged overly ambitious reforms, although the choice ultimately depends on borrower judgments of country circumstances.

#### *Large versus Small Countries*

There is considerable difference in the Bank's role in health system reform in larger or middle-income countries, and the role it assumes with smaller, aid-dependent borrowers. In the former, Bank assistance usually represents only a fraction of government health spending; in the latter, the Bank and donors collectively may represent

nearly all the health investment budget and a substantial portion of recurrent spending. In large countries, the Bank must use its lending program and policy advice to investigate, demonstrate, and advocate more effective approaches to health financing. In small, poor countries, the Bank needs to give careful attention to recurrent implications of investment programs, and take care to be consultative and not to push for policy changes without sufficient consideration to their likely impact in a low-capacity context.

#### *Linking Instruments to Objectives*

The case studies and portfolio review found that the Bank has relied excessively on investment loans, even though they are often ineffective vehicles for promoting complex policy reforms. A number of other instruments are available, each with strengths and drawbacks. Two recently developed loan instruments—Learning and Innovation Loans (LILs) and Adaptable Program Loans (APLs)—allow the flexibility and learning necessary for effective health system reform, but a relatively small (although growing) number of HNP projects have made use of these instruments. The Bank also has approved a number of large sector adjustment loans in past few years. These can help tip the balance in favor of a particular reform effort if conditions for tranche release are transparent and negotiated among a variety of stakeholders. But experience with structural adjustment lending suggests that conditionality alone is ineffective in promoting broad-based systemic reform (Nelson and Eglington 1993).

The rapid growth of sector-wide approach (SWAp) programs to encourage policy reform and increased donor coherence is an important innovation. SWAps are characterized by government-led partnerships, where government and donor investments fall under a sector-wide policy and expenditure framework (Peters and Chao 1998). Although they can bring much-needed coherence to a sector, SWAps require a strong government policy vision, a high degree of confidence among government and partners, and can entail higher risk than single investments (Walt and others 1999). The emphasis on strengthening national policies is consistent with the Bank's comparative advantage, but constraints to performance may lie elsewhere. The recent enthusiasm for SWAps therefore should not obscure the need for thorough examination of the appropriate instrument, or mix of instruments, for the context and objectives.



# Recommendations

Achieving institutional change and improving health system performance are inherently difficult, both technically and politically. Although the Bank is only one of many players, it can increase its impact in the HNP sector by strengthening portfolio quality assurance and results orientation, intensifying learning from lending and nonlending services, enhancing strategic selectivity within the Bank, and strengthening partnerships with other donors, client governments, and civil society organizations.

The overarching recommendation to emerge from the study is: *Do better, not more*. After a decade of rapid growth in HNP lending and a widening health policy reform agenda, this review suggests that the Bank needs to focus on consolidation—both of lessons learned and portfolio quality—and making strategic choices about where to engage and how to allocate scarce resources, particularly staff time. The HNP sector is engaged in a number of activities to address issues raised in this report. The following are recommendations that OED believes can further strengthen the development effectiveness of the Bank's work in the HNP sector.

## **Increase Strategic Selectivity**

*The 1997 HNP Sector Strategy provides an effective vision for the sector, but there is a growing disconnect among HNP strategies, mandates, and available resources.*

## *Recommendations:*

By the end of calendar year 1999, Bank management and the HNP Sector Board should establish priorities and guidelines for staffing, lending, and administrative resources (including project supervision and ESW) in light of the overall objectives of the 1997 sector strategy. Particular attention should be given to (a) how the issues raised in this OED assessment will be addressed, including the budgetary implications; (b) how the sector plans to focus activities and budgets to sustain quality in light of staff overprogramming and pending declines in administrative budgets under the Strategic Compact; and (c) how country directors will be brought on board with the recommendations and guidelines.

## **Do better, not more.**

**Strengthen Quality Assurance and Results-Orientation**

*Despite improvements in many areas, HNP lags behind the Bank average on several key quality indicators, and it is not currently on target to meet Strategic Compact goals.*

*Recommendations:*

The HNP Sector Board, in conjunction with regional sector leaders, should strengthen its role in monitoring and bolstering portfolio quality and results orientation: (a) establish a regular system to review portfolio quality indicators, including identification of priorities for remedial action; (b) establish supportive mechanisms to help task teams improve performance; (c) in conjunction with Bank management, identify steps to strengthen routine quality assurance mechanisms; and (d) in annual reports on the HNP sector strategy, present more evidence regarding progress toward sector goals.

*Assessing the impact of health interventions can be challenging, but excessive Bank focus on inputs and the low priority given to M&E are also to blame.*

*Recommendations:*

To strengthen Bank performance in M&E, management should (a) identify a core group of HNP staff and consultants with experience in implementing HNP M&E who could be available to assist other staff during project design and supervision; (b) develop a “good practices” manual of M&E design for use in decisionmaking, both at the project and systemic levels, including lessons from partner organizations; (c) in collaboration with the World Bank Institute, develop M&E case studies and training modules; (d) periodically give recognition to task teams that can demonstrate measurable results from Bank-supported activities; and (e) in parallel with the Comprehensive Development Framework (CDF) pilots, report by the end of fiscal 2000 on how Bank business practices and procedures could be modified to allow greater results-orientation in Bank lending, and to increase internal incentives for monitoring and reporting on results.

**The Bank needs to give greater attention to borrower capacity and incentives for evaluating health system performance.**

*The Bank needs to give greater attention to assessing borrower capacity and incentives for evaluating health system performance, and to building borrower M&E capacity.*

*Recommendations:*

To strengthen borrower capacity and the incentives for M&E in the HNP sector, sector strategies and project designs should include (a) assessments of borrower incentives and capacity for M&E and (b) where appropriate, recommendations and measures to better enable borrowers to monitor and report results, including strengthening health information and vital registration systems, and a description of the role of the Bank relative to other partners in this process.

*Strengthening borrower incentives for analysis and use of evaluative data in health policy and budget decisions is essential to improved M&E performance.*

*Recommendations:*

The Bank should seek ways to strengthen the incentives for monitoring, evaluation, and results-orientation within client countries by (a) promoting wider experimentation with and use of performance-based budgeting systems in its lending and policy dialogue, particularly in the CDF pilot countries; (b) producing a preliminary “lessons learned” paper on experience in performance-based budgeting in HNP, in conjunction with partner organizations, including implications for the CDF by the end of fiscal 2000; and (c) the Bank should increasingly engage independent evaluative organizations, preferably based in borrower countries or regions, to provide periodic assessments of Bank-financed activities.

**Enhance Learning and Increase Institutional Development Impact**

*Although promoting institutional change in the HNP sector can be difficult, Bank performance in achieving HNP institutional development objectives has been disappointing.*

*Recommendations:*

To strengthen the institutional development effectiveness of the Bank’s work in HNP, management should (a) develop appropriate tools, guidelines, and training

programs for institutional and stakeholder analysis in HNP, both for targeted interventions and systemic reforms, in coordination with PSM and other internal and external partners; (b) clarify the requirements for institutional analysis in project appraisal documents; and (c) establish a core of HNP staff and consultants with experience in institutional design and stakeholder analysis who would be available to assist other staff.

*The Bank must establish a strong analytic and empirical base to provide effective guidance on how to enhance health system performance.*

*Recommendations:*

To strengthen the analytic base for Bank advice and lending: (a) management should increase funding for HNP sector work; (b) the Sector Board should sponsor operational research and provide good practice guidelines on improving the effectiveness and efficiency of ESW and other Bank advisory and analytic services; and (c) management should shift some the ESW budgets from country departments to regional technical managers to encourage regional research on priority issues.

**Enhance Partnerships**

*Promoting systemic change in HNP requires understanding stakeholder interests and building coalitions for reform. Although borrowers necessarily take the lead, the Bank needs to play these roles more effectively.*

*Recommendations:*

To increase the Bank's ability to sustain a continued presence in borrower country health policy debates, and to develop long-term partnerships with various stakeholders in client countries, (a) the Bank should continue its current efforts to base sector specialists in countries or regions, with a clear mandate for collaborative policy dialogue with stakeholders inside and outside government; and (b) for projects and reform

programs that require intensive stakeholder consultation, country directors and sector managers should ensure that these time requirements are reflected in project preparation and supervision budgets.

*Bank-supported programs have not placed adequate emphasis on health promotion and the intersectoral dimensions of health.*

*Recommendations:*

To strengthen the Bank's effectiveness in health promotion and in addressing the intersectoral dimensions of health: (a) the Bank's Human Development Network and Regional vice presidents should identify several key areas for improving intersectoral collaboration *within* the Bank, including coordination of macroeconomic and sectoral dialogue on social sector work force issues; HIV/AIDS prevention and mitigation; and key health promotion activities (defined on a regional basis); and (b) the HNP Network should strengthen staff skills in health promotion and establish "good practice" guidelines and examples for task managers.

**Systemic change requires understanding stakeholder interests and building coalitions for reform.**

*Effective partnerships are necessary to address several of the above issues.*

*Recommendations:*

The Bank should strengthen work with HNP development partners (such as WHO, UNICEF, and bilateral donors) in several key areas, including strengthening HNP M&E systems and incentives and assessing progress and strategies on the current generation of health sector reforms.



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# ANNEXES

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## ANNEX A: PRÉCIS OF CASE STUDIES

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### HEALTH CARE IN BRAZIL: ADDRESSING COMPLEXITY

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World Bank health programs in Brazil have been relevant, but results have been uneven, according to a recent study by the Operations Evaluation Department (OED). Bank-supported programs have helped to control the spread of serious tropical diseases, improved access to health services in poor areas, and contributed to the construction of a system for epidemiological surveillance. But while projects in disease control and basic health services have targeted important and relevant concerns, critical challenges remain to be addressed, including persistent inequities and inefficiencies in the financing of health services. In order to be a more effective partner in tackling the considerable challenges of the Brazilian health sector, the Bank should work to establish the kind of strong and consistent presence that is required to build—gradually, but persistently—a broad-based coalition for reform.

#### **The Strategy**

The Bank has financed 10 projects in Brazil's health, nutrition, and population sector; carried out major field research; and served as a policy interlocutor for the government. Its health strategy has focused on three main concerns: providing resources to expand the accessibility of basic medical services in poor or marginal areas; offering policy advice and studies on methods to improve the efficiency and efficacy of the health care system; and financing projects to control endemic diseases such as malaria, schistosomiasis, and AIDS. The strategy appears appropriate in the Brazilian context—that of a middle-income country with a relatively high degree of poverty, a health care system known for inefficiency and inequity, and a population that is exposed to a variety of endemic diseases.

The Bank's strategy has evolved over time—expanding access to basic services was a primary emphasis in the 1980s and early 1990s, but by the mid-1990s Bank lending and policy dialogue increasingly focused on improving system efficiency and efficacy. Because Bank lending represents less than 1 percent of annual health expenditures in Brazil, the Bank's effectiveness depends on its use of lending and policy advice to leverage wider changes in Brazil's health system.

Several shortcomings are evident in Bank strategy, however. First, many of the health posts constructed to improve health care access for the poor are underutilized, short of qualified staff, and lack the facilities needed to serve their increasingly demanding and urban population

of consumers. Second, it is not clear whether the Bank's research and efforts to transform the health care delivery system in Brazil sufficiently took into account the system's complex politics, institutions, and political economy. This may have made the Bank's ambitions broader, and effectiveness more transitory, than they would have been with a clearer picture of the country context in view. And third, the Bank's focus on endemic diseases neglected other, noncurative, health needs of the aging and increasingly urbanized population.

#### **Basic Health Care**

##### *Child Health and Nutrition*

Brazilian children have become much healthier in the past two decades. Infant mortality rates and childhood height-for-age charts, two good indicators of the general health of children, show significant improvements in recent years. The changes have been brought about by a complex interaction of improvements in purchasing power; maternal education; access to health care, including oral rehydration therapy; community infrastructure and water supply; and individual behavior, such as increased breastfeeding and fewer short-interval births.

But despite the recent improvements, serious regional inequalities persist: children in the Northeast, the poorest, most rural, and most traditional region of the country, are much less healthy, and their health is improving more slowly, than children in other areas. While more than 10 percent of children nationwide still

suffer severe growth retardation, or “stunting,” in the Northeast the figure rises to almost 18 percent, and in the rural Northeast, one in four children is affected.

Despite significant attention from the Brazilian government and international donors, including the Bank, the Northeast has not kept pace with health improvements in the other regions. This cannot be explained by differences in income; it is the legacy of greater improvements in access to health care for children and mothers, maternal education, and reproductive practices in the more urban areas.

#### *Fertility and Women's Reproductive Health*

Brazil's fertility decline has been dramatic. The number of births per woman fell from 5.8 in 1970 to 2.3 in 1996, despite the near absence of a government population policy. The speed of the decline in fertility has been more rapid than in India; Bangladesh; Mexico; and, by some measures, Indonesia, a country with an active population policy. Recent declines in total fertility have been particularly remarkable in the Northeast. Although government interest in family planning and reproductive health has increased considerably in recent years, previous indifference limited the Bank's role.

Lower fertility rates have contributed to the recent improvements in childhood health by reducing the risks associated with short birth intervals and high parity, and have reduced demand for immunization, prenatal care, and birth attendance, ultimately lessening the pressure on the health system and making care more accessible.

Although it is unclear why Brazilian women began to have fewer children, it appears to be a demand-side story. Social scientists identify the high rate of abortion and contraceptive use as the most important determinants of lower fertility. The two most popular methods of limiting fertility are female sterilization and the pill. The health consequences of these practices have been complex and damaging: legal restrictions, financial incentives, cultural norms, and misinformation frequently lead women to use delivery as an occasion for sterilization, which is one reason that the cesarean delivery rates in Brazil are the highest in the world, and maternal mortality is unusually prevalent.

#### *Northeast Basic Health Services Projects*

The World Bank financed two Northeast Basic Health Services projects beginning in the mid-1980s, as part of the Brazilian government's 15-year development plan

for the Northeast region. The projects built health care facilities, encouraged management improvements at the federal and state levels, and provided technical skills training for the development of new *basic health care modules* and programs of comprehensive care for women and children.

Partly as a result of a difficult political and macroeconomic context, these projects evolved into facilities construction and medical equipment programs. They succeeded in expanding access to basic health services but did not transform the mode of basic health care delivery within that system. Child health improved during the life of the projects, and access to health care played a significant role in that improvement. But because the projects did not include an adequate monitoring and evaluation system, it is difficult to assess their impact on these trends.

The evidence suggests that the projects' contribution may have been limited—they disbursed slowly until 1994, and by this time most of the improvement in child health had already occurred. Many of the clinics remain underutilized, and focus group sessions suggest that consumers are dissatisfied with service quality, and increasingly prefer to visit doctors rather than nurses at clinics. The projects were negatively affected by the poor labor market for health care providers, and hampered by the Bank's inadequate understanding of the political forces in the sector and their institutional context.

#### **Infectious and Parasitic Diseases**

The use of oral rehydration therapy has brought about a recent sharp decline in diarrhea among children. Diseases preventable through vaccination are largely under control, although sustaining highly successful vaccination programs will be a challenge, given the inefficiencies in the purchase and distribution of pharmaceuticals. Tuberculosis is on the rise as a result of the AIDS epidemic, increasing worldwide immigration, and relative neglect by the international public health community during the 1970s and 1980s. Leprosy incidence, while falling in most countries, is on the rise in Brazil.

Endemic parasitic diseases continue to threaten rural and remote areas, and malaria is almost exclusively an illness of the Amazon region. In the Northeast, urbanization and the government's endemic disease program are lowering the threats of leishmaniasis, schistosomiasis, and Chagas' disease. Yellow fever, which disappeared from Brazil in mid-century, has again become a threat to parts of the country. Dengue

and cholera, thought to be under control, have resurfaced in recent years. The AIDS epidemic, originally the most intense among bisexual and homosexual men, is increasingly affecting women, heterosexuals, and intravenous drug users.

#### *Disease Control Projects*

Bank-financed disease control projects have focused on diseases—malaria, leishmaniasis, schistosomiasis, Chagas' disease, and AIDS—that are significant problems in Brazil, strike young people, and disproportionately afflict poor and marginalized groups. At least two of the four World Bank disease-control projects have contributed to declines in the incidence of those diseases and mitigated their effects on afflicted individuals. The Endemic Disease project and the Second Malaria Control project helped to slow the spread of disease and promoted treatment programs. Although not all the reductions in incidence can be attributed to the projects, they certainly contributed. The First Malaria Control project did not reduce the incidence of malaria in Rondonia, however, and was rated unsatisfactory.

Although the First Malaria Control project underestimated the importance of institutional strengthening and behavior change in public health, subsequent disease control projects have helped build Brazil's human, physical, and information systems for disease surveillance. The Brazilian government, with significant Bank support, has expanded its ability to combat infectious and parasitic diseases in a modern, more comprehensive manner. Instead of relying on vector eradication, which may not be possible, the government has shifted its emphasis to encompass overall disease control, stressing the importance of behavioral changes by individuals through information campaigns, community mobilization, leadership by authorities, and the treatment of those infected.

With support from the Bank, the government has

launched a National AIDS Prevention and Treatment program that is increasing capacities for surveillance, treatment, institution building, and prevention by working with NGOs. The program has been well-designed and effectively implemented. It is too early to tell, however, whether the project has slowed the rate of increase in disease incidence.

#### **Chronic and Degenerative Diseases**

New demographic patterns emerge as a country modernizes and develops—leading to what is known as the *epidemiological transition*. Infant mortality and fertility decline, life expectancy rises, and infectious and parasitic diseases are no longer the leading causes of death. These new demographic patterns emerged in Brazil's South and Southeast regions decades ago, and by 1980 all regions were undergoing the transition. By 1980, cardiovascular disease had become the leading cause of death in all major regions, and almost all states (table 1). The prevention and treatment of conditions more common among the aging—including screening for cancer, treatment of strokes, and care for long-term and chronic conditions that require expensive treatments—will require reform of the health care system in the coming years. To make the necessary investments in medical infrastructure, equipment, and training, it will be necessary to ration free and universal health care, rely more heavily on private financing, or do both.

In 1989, the World Bank sponsored high-quality analytic work that identified priorities for improving adult health, including maternal health and promotion of healthy behaviors, such as exercise, diet, smoking cessation, and injury prevention. The Bank, however, was unable to develop public health projects with the Government of Brazil to address these concerns.

#### **The Health Care System in Brazil**

The constitution of 1988, following a decades-long social movement to combat the inequitable health care

**TABLE 1: THE LEADING CAUSES OF DEATH: PROPORTIONATE MORTALITY IN BRAZIL (PERCENT OF ALL DEATHS), 1994**

	South	Southeast	Center-West	North	Northeast	Overall
Circulatory diseases	32.6	30.6	27.1	17.9	19.5	27.6
External causes	11.8	9.8	17.6	13.9	9.7	12.1
Neoplasms	15.2	11.9	9.9	7.8	6.3	9.3
Respiratory diseases	10.7	10.6	7.7	6.4	5.9	9.2
Glandular, metabolic, and immune interruptions	4.0	6.5	4.1	3.4	3.9	5.2
Infections and parasites	3.2	4.1	6.4	7.0	6.4	4.8
Unknown causes	9.5	12.5	12.8	28.3	37.0	17.0

policies of the departed military regime, mandated a free, universal health care system, Unica da Saúde (SUS). SUS contracts out a large majority of inpatient care and a substantial portion of outpatient services to a network of private and philanthropic hospitals, clinics, and other facilities. The government manages and owns just 31 percent of the hospital beds it supports and has slowly been decentralizing control of publicly owned facilities to states and municipalities. Privately financed health care has grown rapidly: 25–26 percent of Brazilians are covered by private plans. These plans vary widely in quality and price, but generally exclude coverage of expensive, catastrophic conditions, leaving that job to the public system, and are subject to almost no regulatory oversight.

Although Brazil's health system might appear to be efficient—it substantially “separates financing from the provision of services”—it is instead inching toward crisis. The public system is severely underfinanced, resulting in regional inequalities, rationing of services, and a perceived decline in quality. The hyperinflation of the late 1980s and early 1990s and the irregular flow of resources to health have contributed to the evolution of a fee structure for medical treatment that has not kept pace with costs, and payment can be sporadic. Doctors frequently must work at several sites to make ends meet. Stories of long lines for hospital services, mistakes in emergency care, strikes and walkouts by medical professionals, arbitrary triage, and other crises are reported daily in the press.

The structure of the health system in Brazil provides weak incentives for quality and cost-effectiveness. The government is only now beginning to develop information, monitoring, and evaluation systems for the health care system; it will be some time before that data can be tied to incentives and other quality assurance mechanisms.

Local governments have been given wide responsibilities under decentralization to manage all aspects of health care, but they do not necessarily have the capacities and incentives to deliver coordinated and cost-effective services. In addition, the old military regime left a legacy of an exclusionary and highly centralized health system that has little capacity and is unresponsive to local needs and Brazil's enormous regional diversity. The system is distorted and expensive, expenditures do not target the poor, the health lobby is strong and well-organized, institutions are fragmented, medical training encourages specializa-

tion and high-technology care, and Brazil has one of the lowest ratios of nurses to doctors in the developing world.

#### *Promoting Health Sector Reform*

In the mid-1980s, the Bank sought to support health decentralization through the São Paulo Basic Health project. The project design did not adequately account for complexities in state politics and federal-state relationships, however, which limited its impact.

The current health sector reform project, Reforsus—cofinanced by the World Bank and the Inter-American Development Bank—is predicated on a much more sophisticated understanding of economic incentives than earlier projects. It has established an innovative instrument to disburse grants to health facilities on the basis of competitive bids. Reforsus also aims to improve the efficiency of the health care system by changing government payment systems, so that doctors and hospitals will be paid more when they provide particularly cost-effective services. Unfortunately, this strategy may not work. Partly as a result of interest group pressure, rates continue to be set in a nontransparent process, and a variety of other rules also influence the payments providers receive. As a result, the behavior of doctors may not change significantly.

Given the complexity of the Brazilian health system and the interests at stake, reforms will require commitment, persistence, and the nurturing of relationships with strategically important partners over at least a 10-to-15-year period. Changing the education of health care providers alone will take more than a generation. To date, the Bank has no long-term strategy for—and has little experience in—coalition-building. And the Bank's sector studies, although of high quality, are not widely disseminated. A visible, permanent, and informed presence in Brazilian policy debates should be the first step in becoming involved in the reform of the health system.

#### **Recommendations**

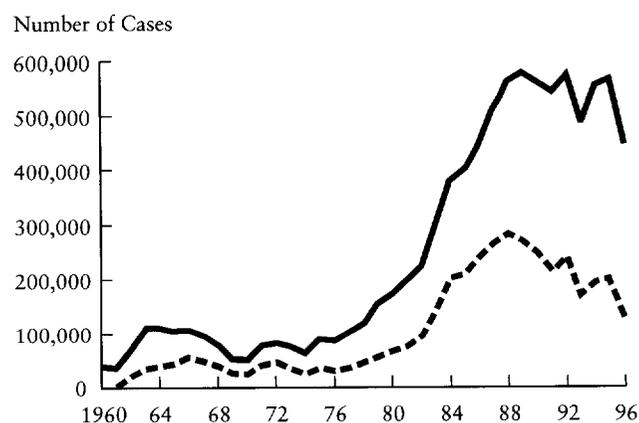
- *Coalition building.* The Bank must grapple with the difficult, institutionally embedded problems of the Brazilian health sector. Problems require long-term solutions in areas such as medical education, the labor market for health care providers, and the political economy of budgeting. The Bank must adopt at least a 10-year timeframe for reform, first achieving a highly

visible, permanent, and informed presence in Brazilian policy debates.

- *Regulation of private health care.* The private sector might provide health care more efficiently and effectively to poorer and middle-income segments of the population with the implementation of appropriate regulation and targeted subsidies.
- *Providing basic health care services.* New approaches are needed in the financing of programs that address the needs and health conditions of poor and marginalized citizens. The Bank should encourage and pilot such innovative projects.
- *Chronic and degenerative diseases.* The prevention and treatment of conditions associated with the epidemiological transition will require the health system to expand, improve, and develop new delivery systems. The Bank could be useful in experimenting with ways to reduce the incidence of lifestyle-related risk factors among poor and marginal groups.

- *Measures of health system performance.* If health providers and systems are to be held accountable for the quality of services they offer, monitorable indicators of health system performance must be implemented.

**FIGURE 1: THE EPIDEMIOLOGY OF MALARIA IN BRAZIL, 1960–96**



## MALARIA: A CASE OF BANK INVOLVEMENT

The Brazil Amazon Basin Malaria Control project was initiated in response to a dramatic upsurge of malaria in the Amazon Region. The program had two goals: first, to reduce the prevalence of malaria to a level that no longer represented a public health problem and to reduce the risk of reintroduction in areas of low prevalence, and, second, to enhance the organizational efficiency and responsiveness of SUCAM,

Brazil's leading federal public health agency at that time.

During the program period, the incidence of both strains of malaria—*P. vivax* and *P. falciparum*—among indigenous peoples in the region fell significantly. The decline coincided with a shift in project strategy from malaria eradication to malaria control and management, with a particular focus on reducing the incidence of *falciparum* cases and treating those infected with the strain, which was responsible for

malaria deaths. Malaria rates had begun to fall before the shift in strategy, however, which clearly signals that additional factors—perhaps including the earlier introduction of mefloquine—were at work. Other events also are probable contributors to the falling rates, including migration; land-settlement patterns; and a slowdown in the arrival of oldminers, loggers, and other fortune-seekers, fertile targets for the parasite, in the Amazon area.

The effort to deal

with malaria is emblematic of the Bank's work on specific diseases in Brazil. The early malaria work focused exclusively on eradicating malaria-carrying mosquitoes, without much effect. The second phase addressed the motives and incentives of patients, health care providers, and other key actors; promoted behavioral change; and targeted rapid diagnosis and treatment, with good results.



## HEALTH CARE IN INDIA: LEARNING FROM EXPERIENCE

The World Bank has emerged as the world's largest lender in the health, nutrition, and population (HNP) sector of developing countries. The Bank also plays a major role advising on national health policies. But in India, where the Bank has invested more in HNP than in any other country—US\$2.6 billion—over the past three decades, progress, particularly for the poor, has been slow and uneven. While India's health status has improved substantially, it still is not on a par with other countries at a comparable level of development. The root causes of this halting progress are poverty and low levels of education, particularly among women, but public health programs bear a share of the responsibility.

The Operations Evaluation Department (OED) found that, in the 1970s and 1980s, the Bank supported government programs that were seriously flawed. But in 1988 the Bank began to work more collaboratively with Indian experts to identify determinants of program constraints, as well as possible solutions. This enabled the Bank to push for better programming and policies and to propose new ways to address fundamental problems in the Indian health system. The results of this more recent approach have been encouraging. This experience with innovative projects, sector work, and policy dialogue in India's HNP sector offers important lessons for improving health in countries around the world.

### Getting It Right

In analyzing why health progress in India has not been as rapid as it has in other settings, and why age-specific mortality and disability rates remain higher than in other countries and regions (table 1), OED identified a number of factors, including: (1) a population growth rate that puts a strain on government resources; (2) per capita public health expenditures that are half those of comparable countries and one-third the estimated cost of an essential package of health services; (3) inadequate funding of programs used mainly by the poor, and limited access for the poor to the programs that are available; (4) insufficient provision of safe drinking water and sanitation; (5) poor quality of service, as a result of supply shortages, absenteeism, improper staff behavior, unrealistically large workloads, and low staff morale, and consequent underutilization of facilities; (6) inadequate mobilization of private and NGO resources; (7) excessive focus (until recently) on sterilization and use of financial incentives to achieve targets; and (8) inadequate focus on maternal and child health. The tenuous quality of public

health assistance is reflected in the observation that 80 percent of health spending is for private health services, and that the poor frequently bypass public facilities to seek private care.

In addition, inadequate management and personnel policies limit the effectiveness of many initiatives. At the national level, management is highly centralized, leading to a uniform, inflexible approach throughout the country, despite major interdistrict disparities in fertility, health, and cultural and institutional characteristics. This overcentralization contributes to weaknesses in local service delivery, with local managers often unable to provide adequate support, supervision, and training to front-line workers. These problems are compounded by personnel policies that fail to provide incentives for better performance or for learning new skills.

Another reason for poor performance is that the limited resources devoted to health have not been used strategically. Many programs have failed to effectively target the most vulnerable groups. Nutritional supplements in some programs, for example, have been available to everyone, reducing the quantities available for poor women and children.

And finally, there has been a tendency to allocate expenditures to India's 25 states on a per capita basis, ignoring the enormous differences in their need and capacity to utilize such resources. Indeed, these states are as diverse in language, religion, level of development, administrative efficiency, and quality of governance as the nations of Latin America or Africa. The size and diversity of the country thus present unique challenges for the design and management of health programs. Clearly, one-size-fits-all programs do not belong here.

### Evolution of Programs and Projects

Since the early 1970s, the Bank has funded 23 HNP projects in India, while also sponsoring important sector work and engaging the government in an ongoing policy dialogue. From rather simple beginnings, support has evolved slowly, in phases, as the Bank and the government have learned to tackle the weaknesses and limitations of India's health system in increasingly sophisticated ways.

### Population

In the area of population policy, Bank support has been separated into three distinct phases. Early projects, carried out from 1972 through 1988, had the narrow aim of helping the government carry out its Family Welfare Program. While designed to integrate family planning and maternal and child health services, in actuality the program emphasized sterilization and the expansion of facilities. The program gave little emphasis to increasing demand or improving the quality of family planning services, which reduced its impact on both contraceptive prevalence and total fertility rates. The Bank had little influence on the direction of this program. The government's approach was firmly established long before Bank involvement, the Bank's lending represented only 3.6 percent of total program funding, and the Bank was generally poorly positioned to suggest improvements or alternatives.

In 1987, a new and somewhat larger Bank team—one with a wider view of human resource development—undertook a series of sector studies that offered excellent diagnoses of the problems in India's population program. Yet the impact of the initial studies was limited. Over time, however, the Bank's sector work increased in influence, in large part because the Bank involved the government in selecting and designing the studies, and local experts were hired to carry them out.

The sector studies helped to generate important

policy changes, including a new emphasis on outreach, maternal and child health, temporary contraceptive measures, and education campaigns, which became the basis of the Bank's newer population projects. The Bank also began to focus on high-fertility states and urban slums—areas with the greatest need.

Despite these improvements, it was more difficult to reorient practices and programming than either the Bank or the government had anticipated. Staff who designed these initiatives were perhaps too optimistic about what could be accomplished in states with weak administrations. Project development also suffered from the failure to involve local stakeholders in project design. Had there been more effective stakeholder participation, project feasibility and risk might have been more accurately gauged.

Another shift came in 1996, when the government dropped sterilization and numerical targets as the focus of its population program, adopting a "target-free" approach that gave greater emphasis to meeting women's reproductive health needs. The immediate result of the new policy was a reduction in contraceptive acceptance rates, in part because previously exaggerated rates were now more realistically reported. Recent data suggest that acceptance rates are recovering. To help this new policy succeed, the Bank is designing support programs that are based on need, that closely monitor results, and that provide timely feedback.

The design of the recent Reproductive and Child Health Project, for example, is based on related sector work and consultations with stakeholders and NGOs. This project offers practical ways to promote family planning without emphasizing sterilization targets and allows for different implementation models in different situations. It also introduces some elements of performance-based budgeting to increase accountability and puts monitoring and client feedback at the center of the

**TABLE 1: BURDEN OF DISEASE: DISABILITY-ADJUSTED LIFE YEARS (DALYS) PER THOUSAND POPULATION LOST TO MORTALITY AND DISABILITY IN INDIA, CHINA, AND TWO REGIONS, 1990**

Country or Region	Mortality	Disability	Total	Percent of DALYs lost, ages 0–4
India	235	103	339	45
China	104	80	184	24
Other Asia and Islands	168	92	260	38
Middle Eastern Crescent	209	91	300	50

project. These features should bring about improvements in program effectiveness.

### **Nutrition**

The Bank has supported two quite different nutrition programs. The first, the Tamil Nadu Integrated Nutrition project (TINP), was an innovative program that operated from 1980 to 1997. Designed by Bank staff and Indian consultants, it focused on changing the way mothers feed themselves and their infants and preschool children. Mothers kept records of their children's weight, and received nutrition education, primary health care, supplemental feeding, and other medical interventions when necessary. Considerable care was taken in designing work routines, training and supervising staff, and ensuring that supplemental feeding was targeted only at underweight children. The program was quite successful in reducing severe malnutrition, but less so in reducing moderate malnutrition. This difference may suggest that improvements in feeding practices can only go so far, and that further gains require poverty reduction as well.

Despite the relative success of the Bank's Tamil Nadu project, the Indian government showed little interest in continuing or expanding it. Rather than pressing for its expansion, in 1990 the Bank also began to support the government's predominant initiative for preschool children, the Integrated Child Development Services (ICDS) program. The Bank advocated incorporation of elements of the Tamil Nadu project into ICDS, which was meant to be a holistic child development program, offering nonformal preschool education for children 3 to 6 years of age; supplemental nutrition, immunization, and regular health checkups for children ages 0 to 6; and nutrition and health education for pregnant and nursing women. Outcomes thus far have been disappointing. The TINP experience seems to have been lost on India, although the design has been used in other parts of the world.

While ICDS was eventually able to reach 80 percent of the development blocks in the country, it had no mechanisms to ensure that its services and supplemental food actually reached those most in need. In addition, workers were inadequately trained and were overextended, and the program's outreach, health, and educational components were often neglected. As a result, the Bank rates its ICDS projects as unsatisfactory. While the Bank originally attributed program flaws to rapid expansion and implementation problems, it now appears that significant changes in direction are required. Yet the

program has developed widespread political support, in part because of its widely distributed benefits. Bank staff involved in designing the next iteration of the project are trying to find practical ways to implement such changes.

### **Health Projects**

The Bank began to support freestanding health projects in the early 1990s. Until that time, the government funded primary care on its own and did not seek policy advice from the Bank in the health sector. Financial difficulties in the early 1990s and new leadership in the Ministry of Health and Family Welfare, however, provided an opening for the Bank to fund two types of projects: disease-specific interventions and broader, state-level health system reforms.

#### *Disease Control Projects*

The Bank's 1993 study, *Disease Control Priorities in Developing Countries*, stimulated interest among Indian health officials to request Bank support to develop a series of disease control programs. The projects have introduced important innovations, such as greater integration of the private sector and nonprofit registered societies into the government's health efforts and new ways of fighting cataract blindness, tuberculosis, leprosy, and malaria. Implementation experience varies widely, but there have been notable successes.

The Bank was instrumental in bringing the Indian government to move against AIDS seven years ago, and the Bank-financed National AIDS Control project has established state and national HIV control programs, instituted better diagnosis and treatment, and moved to change risky behaviors. Over 90 percent of the blood supply is now tested for AIDS, a threefold increase. While it is not easy to determine the exact number of HIV cases averted, an estimated one-third of a million cases may have been prevented.

To fight the resurgence of tuberculosis, the Bank has supported the introduction of Directly Observed Treatment, which now covers 115 million TB sufferers. The Cataract Blindness Control project has surgically restored sight to 8 million people, and 30 percent of these surgeries were performed with the advanced IOL method. And leprosy victims have benefited from the National Leprosy Elimination project—almost 12 million have been cured. It is estimated that 18 of 32 Indian states/UT will eliminate leprosy by the end of 2000, an additional 8 states by end-2002, and the final 5 states by end-2005.

These programs have focused on diseases that, while serious, together represent only about 6 percent of the mortality and morbidity burden. Cardiovascular disease, cancer, trauma, mental illness, and tobacco-related diseases have yet to be addressed. These illnesses will almost surely be more difficult to handle, they are less concentrated among the poor, and the government has yet to come up with proposals for their management.

#### *State Health Reform Projects*

State personnel policies and management systems play a fundamental role in determining system performance and health outcomes. To gain leverage over these critical determinants of success and to tailor programs to each state's needs and capabilities, the Bank has initiated four state-level health reform projects since 1995. These projects also offer the Bank a long-sought opportunity to influence the more fundamental determinants of how the public health system works at the state level, where the Bank can provide assistance that is tailored to the locality.

The first state-level effort was the Andhra Pradesh First Health Referral System project, a \$159 million project approved in 1995. Its aim is to establish meaningful referral systems, provide training and equipment to strengthen management of the state public health system, introduce a cost-recovery mechanism, and improve resource allocation. The Second State Systems project extends the principles of the first project to three other states. It is the largest health project the Bank has ever funded (\$350 million), and is showing signs of being too large and complex to be managed satisfactorily. Subsequent projects in Orissa and Maharashtra each focus on one state. Activities range from increasing access to primary care in remote areas, to establishing a new institution to manage the hospital system, to improving service quality at community health centers, focusing on maternity cases. The Maharashtra project also includes an innovative component to establish a new, specialized hospital that operates according to modern hospital management practices.

Supervision reports indicate that these projects are progressing satisfactorily. The Andhra Pradesh project, in particular, is progressing well, with some elements— notably management and monitoring and evaluation— rated highly satisfactory. There has been a modest increase in the share of the state budget spent on health and a slight increase in the proportion spent on primary

and secondary care, but no evidence yet of significant progress on cost recovery or referral. The Second State Systems project is progressing better in some states than in others.

The use of different approaches tailored to the needs of individual states provides a unique opportunity to learn what does and does not work in different settings. But OED's study concludes that plans for monitoring and evaluation must be further strengthened if this is to take place.

#### **Looking Toward the Future**

The difficulties experienced in gaining the desired results from HNP projects in India before 1988 can be attributed to a number of factors: there were no freestanding health projects; population projects were usually supply-oriented; the Bank was not forceful enough in addressing weak performance or in pressing for policy changes; and the Bank did little sector work to identify the most pressing issues and needs.

Specific factors that inhibited the success of projects included:

- Lack of adequate information
- The Bank's image of itself as a provider of hardware and infrastructure rather than a developer of human resources
- Resistance from Indian counterparts to addressing systemic issues
- Shortages of resources and effective managers
- Focus on the public sector and on expanding the public health system
- Application of a single model to areas with very different characteristics
- Inadequate attention to changing health-related behavior
- Neglect of important determinants of health and demographic status, such as the education of women.

After 1988, however, sector work helped to initiate a policy dialogue. This led to important changes in approach, including a focus on health system reform, a shift from family planning to maternal and child health, and a more collegial and collaborative relationship between the Bank and the government.

A number of factors contributed to this change in approach, including evidence that old approaches were not working; pressures to pay more attention to the needs

of women; and, perhaps most important, a deterioration in economic conditions in 1990–91, which increased the government's interest in acquiring foreign assistance. Also significant was a renewed acceptance of decentralization, which allowed the development of promising state system reform projects. While there is some controversy over how instrumental the Bank has been in effecting policy changes, it was prepared with new kinds of projects when the opportunity arose.

Most criticisms of the Bank's program pertain to its first 20 years; the program as it is now constituted is essentially on the right track. There are, however, several cross-cutting areas where there is room for additional analysis and improvement.

*Referral* is arguably the crucial feature of a well-functioning health system. Programs promoting a referral system must improve the functioning and skills of health workers at the secondary and primary levels and develop linkages among them. They must also address the transport and communications problems that constrain development of an effective referral system. Flexibility in programming as well as additional study of relations among institutions at different levels, both public and private, will be needed to build good referral systems in India.

*Information, education, and communication* (IEC) are also necessary, since many health problems can only be remedied by changing behavior. While the Bank has encouraged the government to allocate more technical and financial resources to IEC, this area of health programming continues to be relatively neglected, and government IEC programs are often not well implemented. The Bank must continue trying to build IEC into new projects, using a client-oriented approach to formulate messages, train outreach workers in interpersonal communication and counseling, carefully research campaigns, and monitor impact.

In addition, *personnel problems*, *performance incentives*, and *accountability* continue to be difficult challenges in improving service delivery quality. The

Bank has done little in this area except to provide managerial and technical training, which fails to get at the heart of the problem. Complementary changes in management practices, work routines, and career development policies—including incentives for staff to get more training—are needed to permanently modify the behavior of health workers. This cluster of problems needs careful, detailed study.

*Accountability for performance* in the Indian health sector is also weak. Performance-based budgeting, by linking disbursements to performance, would better engage implementing agencies in designing and managing programs and increasing accountability. The Bank is promoting performance-based budgeting in some new projects, and must carefully study and test initiatives that use it.

Another cross-cutting issue is the need to *better integrate NGOs and the private sector*, which provide the vast majority of health services, into health sector programming. Efforts to incorporate NGOs and private organizations have had mixed results. These efforts have been most successful when such organizations work alongside government agencies in complementary rather than competitive roles, and where government staff are sympathetic and effective managers. A strategy needs to be developed to involve the private sector that considers the division of labor, pricing and subsidy policies, licensing and regulation of private providers and health insurers, and appropriate training programs. The Bank has little experience with these challenges in India, but can help by examining experience in other countries and in other sectors in India; encouraging the private provision of services, where appropriate; and encouraging and evaluating experimental programs.

Finally, it is clear that India's diverse health problems, needs, and health sector capabilities require multiple approaches. The Bank should therefore continue to support decentralization and experimentation in order to better meet the needs of individual states.



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## HEALTH CARE IN MALI: BUILDING ON COMMUNITY INVOLVEMENT

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The assistance provided by the World Bank to the health sector in Mali has contributed to improved access to rural health services and increased availability of affordable essential drugs, according to a recent Operations Evaluation Department (OED) study. Lessons learned through an early, unsuccessful health project in the country helped the Bank and its partners identify key strategies—including establishing a community-managed health sector with services financed through cost recovery, reforming the state pharmaceutical agency, and creating a regulatory framework to promote essential generic drugs. Remaining challenges include increasing the utilization of health services, addressing malnutrition, alleviating staff shortages in the community sector, and improving the equity of government health expenditures.

### Background

Mali is one of the poorest countries in the world. Most of the population engages in rain-fed cultivation of subsistence crops, but the country's climate is harsh and unpredictable, with an ever-present threat of drought. The adult literacy rate is less than 20 percent, among the lowest in the world. Education services are poorly developed, particularly at the primary level. School enrollment among girls is less than one-third the Sub-Saharan average, and up to 80 percent of school-age children in rural areas do not attend primary school.

These indicators are important because poor economic conditions and low incomes depress demand for health services, and foster conditions that make the population susceptible to disease and ill health. The low level of education, particularly among girls, exacerbates health and nutrition indicators for children and contributes to low contraceptive use and high fertility rates.

As in most other Sub-Saharan countries, the main health problems are infectious and parasitic diseases, and the leading causes of death are such preventable diseases as malaria, measles, tetanus, acute respiratory infections, and diarrhea. The burden of disease falls disproportionately on children and women of reproductive age, and health indicators are worse in rural areas than in urban centers. Malnutrition is a severe problem; one-third of children under age 5 and one-fourth of infants under 6 months of age are stunted. And the emerging problem that must now be targeted is the spread of the HIV virus, which currently infects 5 percent of the population, a figure that is on the rise.

When the Bank first embarked on health sector operations in Mali 20 years ago, the country was faced with a centralized health system that was unresponsive to the population. Government policy was biased toward urban, curative health care, leaving a splintered and inaccessible system for the rural majority of the population. A state-owned monopoly controlled the distribution and cost of drugs, rendering them inaccessible to all but a few. Although the government in the mid-1980s ended guaranteed employment for medical school graduates and opened up the sector to private practice, it fixed fees at rates that most could not afford, and created a pool of unemployed practitioners. An added influence was the prevailing attitude toward health care: the population was accustomed to tending to its own needs with the guidance of indigenous practices and beliefs.

The Bank's assistance in addressing these problems has yielded substantial dividends, but stubborn obstacles remain. The Bank's policy dialogue and sector analysis helped the government develop a national health policy, which established a framework for expanded access to rural health services and increased availability and affordability of essential generic drugs. At the same time, the government still has not let go of its urban bias, and does not devote an appropriate share of expenditures to primary health care or the rural sector. The Bank's lending and project operations also helped the government create a workable community-based health care system that has extended coverage to rural areas through a more coordinated network of donors and NGOs, but overall utilization remains low, and it is difficult for

clinics to recruit practitioners and provide a clear career path for health professionals. The Bank, government, and other partners are well aware of these unresolved issues, and are now engaged in a comprehensive Sector Investment Program (SIP) to address them.

### **The Bank's Work in the Mali Health Sector**

The policy dialogue and preparatory work leading to the approval in 1983 of the Bank's first health project in Mali—the Health Development Project (PDS)—represented the first time that government had participated directly in the preparation of a donor project. The project and its strategy drew on a 1981 epidemiological study that showed that villagers visited government dispensaries only an average of once every two years. Three-quarters of the sample population had not visited at all during the year preceding the survey. It also found that the average number of visits was a function of the distance from the dispensary—critical in a country that is predominantly rural.

The survey suggested that the population at greatest risk—children and pregnant women—was not receiving priority in treatment. People relied primarily on traditional healers and herbal medicines for the treatment of illnesses. Although modern drugs were sold by the government pharmaceutical parastatal, they were overpriced and in chronically short supply. Moreover, donor agencies and NGOs were attempting to expand services at the rural level, but lack of coordination, staff shortages, and inadequate financing for recurrent costs reduced their impact and sustainability.

The PDS was designed to enhance service delivery by working with the existing government health system to construct additional health centers and train new staff. But significant implementation delays hindered nearly every component. Among other problems, the NGO contracted to construct facilities performed poorly. The project piloted community-managed revolving drug funds to help address chronic drug shortages in rural areas. But because efforts to reform the pharmaceutical parastatal and reduce drug prices were unsuccessful, drugs provided by village pharmacies remained unaffordable for most, and the pharmacies could not achieve financial viability. Although a disappointment for both the government and the Bank, the PDS—together with pilot programs sponsored by other partners—provided valuable lessons that prepared the way for a significant shift in Bank and government strategy in the early 1990s.

### *Cost Recovery*

The failure of the Bank's first project and an international shift in the development model for health prompted a reconsideration of the country's health sector strategy. The principles of the new strategy were based on models of community participation and cost recovery articulated in the Bamako initiative, endorsed by the African ministers of health in 1987. Under the initiative, the Ministry of Health began work with UNICEF in 1989 to develop an action plan for Mali that would include community-managed cost recovery to enhance the availability of health care services. The first step was to develop a national plan for the decentralization of health planning and management, the provision of essential drugs, and community involvement in the management and financing of local health centers.

Based on the PDS experience, Bank staff were convinced that the community-financed health center approach could work, assuming that a reliable supply of low-cost essential drugs could be guaranteed. The Bank proceeded by developing strong alliances with government policymakers and with UNICEF and other donors. The Bank provided advice and technical assistance during policy development, but, perhaps more significantly, it made the approval of a well-defined national health policy a condition for further support. This condition gave additional momentum to the policy development process, and tied the policy to the new project.

Although the national policy was developed by a small team of technocrats from the Ministry of Health, the government's strong ties with the Bank led some donors to call it a "Bank policy." Yet the policy survived the civil unrest and political transitions of the early 1990s—including four ministers of health and the transition to a democratically elected government in 1994—because of the strong support of senior civil servants at the Ministry of Health.

The new policy shifted the organizational model for rural service delivery away from the administrative structures of the state. It introduced the partnering of the public sector with the communities to broaden access to health services, including community management of health centers and revenues from cost recovery. The policy also called for reform of the pharmaceutical sector, including the restructuring of the pharmaceutical parastatal (PPM) to supply only essential and generic drugs, and allowing the private sector to import and sell drugs.

### *Confronting Essential Issues*

The Health, Population, and Rural Water Project (PSPHR), initiated in 1991, set out to resolve the conundrums of rural access, drug cost, and health care coordination. It helped establish and expand the new community health system in four districts and in the capital, and was cofinanced by several other donors, with parallel financing and technical support from UNICEF. The involvement of UNICEF—particularly the presence of a senior UNICEF technical specialist in each region—was crucial in the development of district health plans and the supervision of the new community clinics. Although civil unrest initially delayed project implementation, the 1994 democratic transition gave additional momentum to health service decentraliza-

tion, increased community participation, and weakened entrenched opposition to pharmaceutical reform.

The project significantly increased access to health facilities and, with pharmaceutical reform, increased the supply of affordable drugs. By 1998, nearly 300 new community health centers had been established, one-third of which were financed by PSPHR, and the percentage of the population living within 15 kilometers of a health facility increased from 17 percent in 1995 to 39 percent. The community clinics have been largely successful in improving service coverage and client satisfaction, and have been able to use cost recovery to finance most wage and non-wage recurrent costs. In addition, community management committees were established for some established government clinics, although staff continue to be

## REFORM OF THE PHARMACEUTICAL SECTOR

When the Bank became involved in Mali's health sector in the early 1980s, it was recognized that pharmaceutical reform was essential. The PPM earned profits in spite of inefficient purchasing policies because the demand for drugs was strong. But the drugs that PPM imported were expensive, brand-name specialty drugs, often in short supply. Overstaffed, PPM was rife with opportunities for illicit drug sales and other corruption. Drugs were sold at a subsidized discount to government facilities, but at full price elsewhere. Together with illegal imports, this contributed to a thriving black

market in drugs, often of dubious quality.

The government was initially reluctant to lose the profits from PPM, and, not surprisingly, PPM was strongly resistant to any kind of reform. But by the late 1980s, the failure of the Bank's PDS and other similar initiatives helped convince senior officials within the Ministry of Health that pharmaceutical reform was necessary.

The Bank realized that the obstacles to reform were not simply a lack of capacity, and in the policy dialogue for the PSPHR it emphasized the need to change the regulatory framework. Other donors and NGOs had grown sufficiently frustrated with PPM's inefficiency to call for its abolition. But Bank staff resisted, suggesting that

it would be politically infeasible to do so, and that the large drug procurements planned for the PSPHR could not be handled immediately by an NGO.

As part of the National Health Policy, government, the Bank, and other partners developed a "contract plan" that would guide the pharmaceutical sector toward four reforms—private competition in retail drug sales, the introduction of a larger share of generics into the government and community health sectors, limits on sales mark-ups, and the restructuring of PPM, including the elimination of 200 positions.

In the early 1990s, liberalization gained support as alternative channels for drug imports

emerged, creating competitive pressures in the sector. As the PSPHR began to expand the community health sector, the demand for generic drugs increased, putting additional pressure on the government to fully implement the reforms.

By 1993 the PPM had begun purchasing essential generics through international competitive bidding (ICB). By the mid-1990s, drug prices had fallen to as little as 20 percent of their previous levels, and they continued to decline, even after the 1994 CFA devaluation.

employed by the government. About half of all clinics nationwide continue to be owned and managed by the Ministry of Health.

The Bank pressed for the restructuring of PPM, removal of constraints to private competition, and a shift by the PPM toward the purchase of essential generic drugs as conditions for project approval. Although progress was initially slow, the eventual introduction of international competitive bidding (ICB) sharply reduced official prices for drugs, and prices have continued to decline, even with the CFA devaluation in 1994. Generics are now widely available, and prices are low enough to allow community health centers to cover recurrent costs from drug sales. Most specialty drugs are now provided by the private sector.

Finally, the decentralized planning process initiated under the project allowed services to be planned and delivered closer to the beneficiaries, and reduced the burdens and bottlenecks at the central level. The PSPHR provided an “umbrella” for the support of several donors along with the Bank, and, together with the national policy, helped improve the coordination of donor and government activities.

### The Challenges Ahead

Since the first community-managed clinics were established in the mid-1990s—just before the most recent Demographic and Health Survey (DHS)—it is too soon to correlate the PSPHR with changes in health indicators in Mali. Evidence suggests some modest improvements in the past decade, however. Both child and infant mortality declined slightly, but still remain high, even in the context of the substantial regional rates. One-fourth of children still die before age five. The percentage of children fully vaccinated in rural areas increased from 0 to 24 percent, largely because rural DTC3 coverage increased. The percentage of women with at least one prenatal visit during pregnancy increased from about one-third in 1987 to half in 1995, and tetanus vaccination coverage increased from 18 to 50 percent. Data also suggest that some health practices—including birth attendance by trained medical personnel and the percentage of children treated for diarrhea—have improved.

The prevalence and severity of malnutrition among children provides a notable contrast to the successes cited. The number of children suffering from malnutrition is daunting—23 percent of Mali’s children are wasting according to the 1995/96 DHS—and prevalence of malnutrition is comparable to that found

in countries just emerging from famine or civil conflict (see table below). Both stunting and wasting have been common since the late 1980s, and may have increased in the past decade (although the data from the 1987 DHS may not be reliable). An analysis of the 1995/96 DHS data suggests that more than half of mortality among children under age 5 could be attributable to malnutrition (15 percent to severe malnutrition, and 42 percent to mild to moderate malnutrition). It is abundantly clear that increasing access to health services without improving nutrition will not significantly improve child health.

### WHY PROGRESS IS SO CRITICAL: THE INCREASE IN MALNUTRITION IN MALI

	1987	1998–89	1995–96
Stunting (ht/age)	24%	27%	30%
Wasting (wt/ht)	11%	18%	23%
Undernourished (wt/ht)	31%	43%	40%

### Utilization Must Follow Accessibility

Although the Bank and the government have made substantial progress in improving physical access to health services in rural areas and increasing the use of curative and preventive services in the catchment areas of the community health centers, utilization rates remain low. In 1996, Malians visited a government or community health center for curative services only 0.16 times on average. Utilization rates are somewhat higher at community-managed health centers, but they remain well below the expected average rate of one visit per year.

While the PSPHR also included efforts to strengthen the first-level district referral system, several constraints remain in the referral system between the community centers and districts, including unavailable or very expensive transport; inadequate training for clinic staff on referral protocols; and, sometimes, inadequate skills at the district level to deal with referrals.

The stubbornly low utilization rates, which have resisted efforts to improve geographic access, are the product of several factors. Costs remain a deterrent for many, despite the reduced prices for essential generic drugs. Physical access is still a problem, particularly during the rainy season, because much of the popula-

tion must still walk more than a few kilometers to get to the clinics. Community outreach remains weak—health center staff often wait for users to come to them. The family planning component of the PSPHR (sponsored by USAID and relying on service delivery by NGOs) was not well integrated with the community health center component. Many potential consumers still prefer traditional medicine, and attitudes change slowly in a traditional rural society. And, finally, the decision to seek care depends on who controls household resources—often, the man.

#### *Staff Recruitment Is Essential*

Because government clinics continue to function in parallel with community clinics, a major constraint in the community health sector is the difficulty of attracting and retaining qualified health staff. There is currently no job security, pension benefit, or opportunity for career advancement, and the centers are often located in remote areas. While staff employed by community health centers are often more responsive to community needs, most health professionals express a strong preference for government service. For all these reasons, the vacancy rate for professional staff is high; some centers have remained without a nurse for more than a year. Since the salaries are determined by the communities, potential staff members are drawn to the urban areas or the better-off regions. In addition, professional training emphasizes curative services rather than public health promotion.

#### *Government Health Spending Is Still Biased Toward Urban Areas*

The financing of basic and preventive health services in Mali faces several fundamental challenges and constraints. The foremost is the ability of the government to mobilize resources for health, given a per capita annual income of US\$250. The government has historically generated only about 10 percent of GDP in revenue.

Government provides less than one-fifth of total resources for health—far less than households (at 50 percent) or external aid (25 percent). But even the money that the government does allocate to health spending is not being used efficiently or with equity. The majority of the government's limited resources are spent for urban-based tertiary care and central administration. Public subsidies remain highest, and cost recovery lowest, at urban tertiary facilities; the opposite obtains at rural facilities. Although public subsidies for higher-level care could be considered a form of

social insurance for serious illness, those benefiting from these services are largely from the upper-income brackets. And despite an increase in donor support to rural areas in the past decade, the growing dependence on donors is creating its own problems. Most strikingly, primary health care and health education programs were funded entirely by donors in 1997.

#### *Next Steps*

With the right framework in place—an accessible, coordinated service delivery system in rural areas, and the broader, increased availability of essential generic drugs—the government can now pursue the broader goal of providing a responsive, practical health care system for all. The prospects are sound. The government has taken the lead role throughout project and policy preparation, which has enhanced capacity-building at the Ministry of Health and “learning by doing” throughout the sector.

In 1998, the government completed a 10-year strategic plan for the sector, together with a 5-year investment program, which are to guide both government and donor programs. These plans were prepared in conjunction with the next phase of Bank support—the Sector Investment Program (SIP)—which will support the government's strategy and address the remaining sectorwide issues. The SIP will form the framework for several donor programs, although most donors will continue to manage funds separately.

The SIP includes four broad components. The first is the construction, renovation, and equipping of community health clinics at the village and district level, and some renovation and equipping of regional and national hospitals. The second comprises management and technical training of the health sector workforce. The third calls for expanding health insurance and cost-sharing mechanisms, and the fourth will entail restructuring government hospitals to improve cost recovery, cost-effectiveness, and technical efficiency. The program also seeks to improve district health management, including referral services; strengthen management information systems; increase community involvement in health centers, and develop management modules for hospitals.

#### **Lessons to Guide Future Initiatives**

The Bank's support has progressed over the past 20 years from a (unsuccessful) health pilot project in a single region, to a nationwide “umbrella project” that embodied

a new national health policy and was cofinanced by several donors, to an SIP under a national strategy that is to encompass all investment in the sector. This progression has corresponded with increased government willingness to establish sectoral strategies and priorities.

Although the Bank strongly encouraged government to take a sectorwide approach, government has full ownership of the program. Among donors, the Bank has taken a leadership role, but has worked to bring in other partners. Government officials have reported that the Bank has been effective in linking its support to key sector reforms and issues. Some donor-partners have expressed concerns, however, that the policy development and SIP appraisal processes were unduly influenced by the Bank's timetable and agenda. Given the Bank's influence in Mali's health sector, it must be cautious and collaborative to ensure that it does not dominate the policy process. The Bank must also engage in more rigorous monitoring and evaluation, particularly when new service delivery mechanisms are piloted for nationwide replication.

Other lessons from experience in Mali may also be helpful to the Bank's new SIP project work:

- Curative services alone will not improve health outcomes. They must be combined with appropriate health education and outreach programs, family planning promotion, and nutritional surveillance and intervention, and they must be integrated effectively with those offered by NGOs.
- The cost-recovery mechanism of community-based facilities for curative care does not create incentives for locally based health promotion activities. Strengthening these activities will be necessary to achieve further improvements in health and nutritional status.
- Incorporating health sector concerns effectively into macroeconomic and budgetary dialogue will continue to require regular communication between Bank macroeconomic and sector specialists, and sufficient sector work to match priorities with sector budgets and staffing patterns.
- The community-based agenda must move beyond access—by targeting continued cost barriers, inadequate outreach, and preferences for traditional medicine or self-treatment.
- Establishing a community sector outside government may have made providers more responsive to community centers, but uncertain job security and career paths must be addressed if community-based facilities are to attract and retain a full cadre of health professionals.

## MEETING THE HEALTH CARE CHALLENGE IN ZIMBABWE

The World Bank has usually “done the right thing” in the Zimbabwe health sector, but has not always “done things right,” according to a recent Operations Evaluation Department (OED) study. Bank policy advice and project support have been well-crafted to address Zimbabwe’s epidemiological profile and health sector needs, and have helped integrate family planning into health services, improve service quality, and increase facility deliveries, inpatient attendance, and contraceptive prevalence, among other benefits. But programs have often encountered difficulties in implementation. As Zimbabwe confronts the combined challenges of severe financial constraints and the growing AIDS epidemic, a reexamination of Bank work in the sector is appropriate in preparation for the next phase of Bank support.

### Background

Over the past 15 years, the World Bank has provided policy advice and project support to health, nutrition, and population (HNP) programs in Zimbabwe, and in 1991 became involved in the design and support of Zimbabwe’s Economic Structural Adjustment Program (ESAP). The Bank’s initial effort in the sector—a 1986 loan to support improvement in the quality and availability of health services in 8 target districts, including expansion of infrastructure and in-service training for nurses—was expanded in 1991 to include an additional 16 districts. A 1993 loan funded the acquisition of drugs to treat sexually transmitted infections (STIs), as well as medical supplies and laboratory equipment.

Bank project support and policy advice have proven valuable to the Zimbabwe health sector, but the impact on health system performance and health outcomes has been undermined by economic stagnation and a devastating AIDS epidemic. Flaws in the design of ESAP contributed to strains on the health sector, particularly with regard to civil service reform and health sector staffing. Yet the government’s failure to control the budget deficit—and its financing of that debt by borrowing domestically at high interest rates—has led to escalating interest payments that now equal one-fourth of all government revenue. This mounting debt threatens to lead Zimbabwe into deeper economic crisis, and without a concerted effort at deficit reduction, it will further undermine the health sector.

Zimbabwe is faced with the world’s most severe AIDS epidemic. According to UNAIDS, 26 percent of the adult population in Zimbabwe is infected with the HIV virus that causes AIDS, and the percentage may still be

increasing. The implications for the nation’s health system, economy, and society are staggering. This is particularly tragic, because although AIDS cannot be cured, it can be prevented through modifications in sexual practices. Yet government has not offered leadership in behavior change, the strategy is not focusing on the most cost-effective approach (working with those most likely to transmit the virus), and several high-transmission areas in the country have not yet benefited from intervention.

### Health and the Health System

In the decade following independence in 1980, Zimbabwe experienced some of the most rapid improvements in HNP indicators in all of Sub-Saharan Africa. Infant mortality declined from 90 per thousand in 1980 to 53 per thousand in 1988. Household incomes increased only modestly during this period, however, suggesting that the government’s strong emphasis on basic health and family planning services, health education, and community outreach, bolstered by a strong focus on prevention, were responsible for the improvements.

In the 1990s, health and health service indicators stagnated or declined under the combined burdens of AIDS, economic crisis, and drought, although fertility continued to decline. After a decade of decline, both infant and adult mortality are increasing, as are opportunistic infections such as tuberculosis. Although economic crisis may have a role in weakening the health system, these increases in mortality are primarily attributable to AIDS (see figure 1). Although HIV/AIDS is best addressed through prevention and behavior change, declining per capita health spending and growing demands for curative care have weakened the

preventive focus that characterized the successful programs of the 1980s.

**Impacts**

*ESAP and Health*

Zimbabwe's 1991 ESAP liberalized the economy but failed to control the government's budget deficit, which has averaged nearly 10 percent of GDP annually since independence. Economic liberalization without deficit reduction contributed to economic stagnation and limited job creation. Higher costs for food and social services, combined with declining formal sector wages and the lingering effects of severe drought in 1991-92, have left many of the poor worse-off than before adjustment began. Although both the government and the Bank tried to protect spending for health and education, large budget deficits fueled inflation and led to growing interest payments, which contributed to declines in real health spending and real wages for health workers. These interest payments—three-quarters of which are for domestic debt—now represent over three times the government spending on health (see figure 2). Program design failed to give priority to deficit reduction (for example, by cutting taxes), but the government regularly missed deficit targets by implementing unbudgeted programs (such as the recent payments to war veterans).

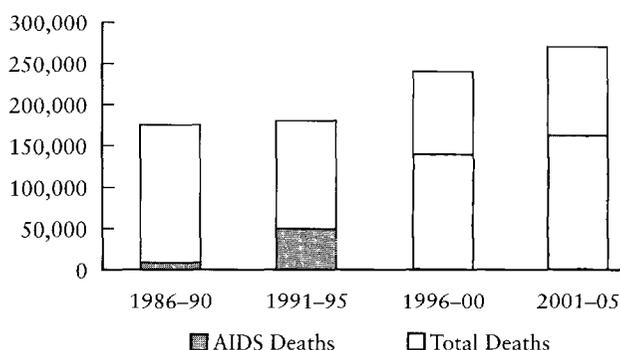
Although health workers were protected from retrenchments, downsizing of Ministry of Health (MOH) administrative and maintenance staff reduced efficiency and added to morale problems without generating significant savings.

Although macroeconomic policies and performance have had a greater influence on the health sector than Bank project lending, the Bank has not effectively linked health sector investments and strategies to macroeconomic dialogue, particularly in health staffing and civil service reform. To prevent further deterioration in the public health sector, government must give priority to reducing the budget deficit and restructuring debt service. In the medium-term, the budget for health will remain constrained, and it will be necessary to focus on increasing efficiency and making the difficult choices necessary to fund priorities such as AIDS prevention and basic services for the poor.

*Health Financing and Cost Recovery*

Bank work in health financing led to increased cost-recovery efforts, but it has had limited success in

**FIGURE 1. DEATHS OF CHILDREN UNDER 5**

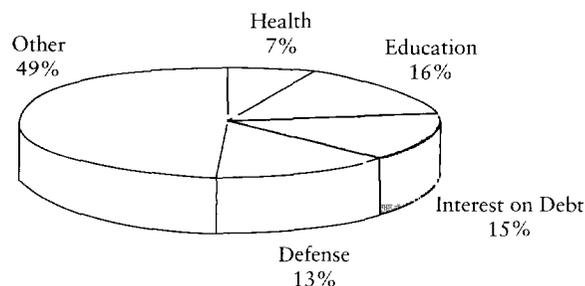


Source: NACP 1997.

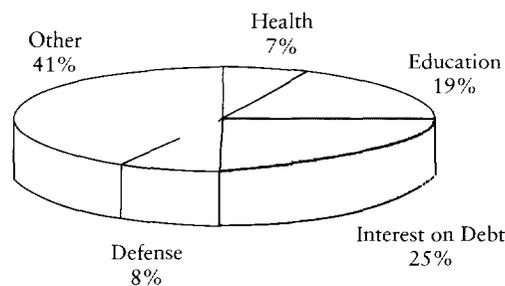
mobilizing additional resources for health, improving quality and efficiency, and protecting the poor. The Bank persuaded the MOH to increase user fees in the early 1990s, but the Ministry of Finance (MOF) did not permit fee retention at health facilities until late 1997. Because fees were not retained, the quality of care did not improve. The Bank encouraged adoption of an exemption system to protect the poor from increased cost recovery in the social sectors, but shortcomings in

**FIGURE 2. GOVERNMENT EXPENDITURE ALLOCATIONS, 1989/90 AND 1996/97**

**Expenditure 1989/90: Z\$6,446 m**



**Expenditure 1996/97: Z\$6,247 m (1990 Z\$)**



design and implementation of the system meant that the program reached only a small percentage of the intended beneficiaries. Following fee increases, attendance for some preventive services shifted from hospitals to clinics, suggesting improved efficiency, but outpatient attendance by the poor declined in response to the fee increases, as prices increased and quality declined. In 1995, the government—with Bank agreement—abolished fees at rural health facilities, stating that the revenue collected did not justify administrative costs. Service quality rather than cost is a major concern for the rural poor, but cost has become a major barrier for the urban poor; in a recent survey 40 percent of the urban poor gave “too expensive” as the reason for not seeking treatment when ill.

Ironically, total cost recovery declined—from 3 to 2 percent of the MOH budget—primarily because government made little progress in improving hospital billing. The government continues to lose millions of dollars through inadequate billing of medical aid societies (health insurance companies) for expenses of insured patients in government central hospitals. This experience suggests that the Bank must complement its broad policy recommendations with detailed dialogue on implementation, give greater attention to the institutional context, and coordinate sector and macroeconomic dialogue. Now that facilities are allowed to retain fees, hospital cost recovery has increased substantially, but billing remains inadequate. In the coming years, local districts and communities may wish to experiment with community-managed health centers, in which fee revenues are used to purchase drugs and improve service quality.

#### *Strengthening Health Service Delivery*

Bank support for expanding district infrastructure and staff training through the First Family Health Project (1986–91) improved service quality and contributed to increased facility deliveries, inpatient attendance, and contraceptive prevalence, but has had no measurable impact on outpatient attendance or disease patterns. Outpatient attendance in project districts actually declined following facility completion in 1991, coinciding with drought, increased fee enforcement, and drug shortages, which suggests that improved infrastructure and training alone will not improve service quality or access.

The impact of upgraded facilities on maternal attendance varied considerably, depending on the appropriateness of site selection. In genuinely

underserved districts, such as Tsholotsho, maternal deliveries increased markedly following facility completion, while in others, deliveries stagnated and inpatient attendance fell, usually because the upgraded government hospital was near a mission hospital that was preferred by many patients. Domestic political influences and Bank insistence on upgrading existing facilities contributed to inappropriate site selection.

The Second Family Health Project (FHP2) improved facility design and site selection and built 16 district hospitals for the cost of the original 8. For FHP2, the Bank placed an architect within the MOH to ensure maximum efficiency in facility design. International competitive bidding (ICB) yielded construction costs that were 40 percent below government estimates, and facilities were completed on time, and below budget, in 1998. But the severe shortage of health personnel is making it difficult to staff the new facilities and threatens to undermine their impact. Once construction began, it was impossible—contractually or politically—to delay the projects or to reduce the number of hospitals pending resolution of staff shortages. This emphasizes the importance of flexibility in project design and of focusing on service quality and staffing issues rather than facility construction in the next phase of Bank support.

The Bank has been well-positioned and effective in promoting the integration of key HNP interventions. The in-service nurse training supported by the Family Health Projects improved staff skills and contributed to the integration of nutrition and family planning into health services. The percentage of women obtaining contraceptives in health facilities has increased since the late 1980s, which is partly attributable to Bank-sponsored training in family planning. Project efforts to improve the quality of maternal delivery services in rural areas was undermined, however, by high turnover of trained nurse-midwives, who were often promoted or hired by the private sector soon after training.

#### *Health Work Force*

The current staff shortages were created by recent political decisions by government (abolishing training for state-certified nurses and firing striking health workers), high turnover of health staff, and the absence of effective manpower planning. Erosion of real wages in the public sector and increasing workloads have contributed to turnover and low morale, as has rapid growth of private health care—primarily serving urban

populations—in the 1990s. Although Bank staff periodically raised concerns regarding health staffing, they were not effective in addressing the institutional constraints to action. The Bank has supported technical assistance for work force planning and discussed health staffing during supervision missions, but did not sponsor sector work (research) on health staffing issues until 1998. Responsibility for health personnel is divided among several ministries (MOH, MOF, and the Public Service Commission), and the Bank did not use its leverage at the macroeconomic level to elevate and add urgency to the dialogue. The MOH, Bank, and donors have made health staffing a priority for future support, but all parties should ensure that remediation is coordinated.

To address staff shortages, government will need to establish economic stability (to reduce inflation and prevent further budgetary declines) and develop a comprehensive health staffing strategy. The challenge is that budget constraints will not permit significant increases in personnel expenditures. Designing and implementing the strategy will require negotiation among the stakeholders, including the MOH, MOF, Public Service Commission, and health professionals. The Bank could assist by providing analysis and facilitating consensus among stakeholders.

#### *AIDS and STIs*

The presence of an STI considerably increases the likelihood that an individual will contract the HIV virus. Treating STIs can thus be one component of an AIDS prevention strategy. In the early 1990s, declines in the government's drug budget and growing demand for antibiotics led to critical drug shortages. Through the STI Project, the Bank has financed half of the government's drug budget for the past five years. Bank support for the purchase of STI drugs closed a major financing gap, contributed to significant cost savings in drug procurement, and initially increased drug availability. Bottlenecks later emerged that reduced drug availability, undermining program effectiveness. STI drug availability increased to 89 percent in the first two years of the project, but fell to 73 percent in 1996, primarily because of reversals of government contract awards by Bank procurement specialists and delays in registering drugs purchased through ICB. Government staff did not initially receive adequate training in Bank procurement procedures, and Bank supervision of procurement was initially inadequate to resolve the bottlenecks. Increased supervi-

sion and management attention by both government and Bank staff contributed to a recovery in STI drug availability to 87 percent in 1998.

Projects with a major pharmaceutical component require up-front training for both government and Bank staff—with periodic follow-up training—to avoid bottlenecks that could interrupt drug availability. Bank procurement procedures could be streamlined to reduce the burden on borrowers, but the cost savings achieved through ICB are essential to ensure drug availability in the face of tight budgets and growing demand for drugs.

The AIDS epidemic is the most serious problem facing the health system and, along with the deficit, the economy as a whole. But treating STIs is resource intensive, and unless done in conjunction with a concerted campaign to change sexual practices, it is unlikely to have a significant impact on AIDS. Bank-funded research has helped raise awareness in Zimbabwe regarding the seriousness of the AIDS epidemic, and the Bank has cosponsored innovative community AIDS prevention initiatives. The government's response, however, has not been commensurate with the scale of the epidemic, which may claim 1 million lives in the next decade. Experience elsewhere has shown that strong leadership and political commitment can halt the growth of the epidemic and save hundreds of thousands of lives. Recent pilot experiments in Zimbabwe show that HIV transmission rates among high-risk groups can be reduced by 30 percent or more in just a few years. The government has developed a multisectoral strategic plan to combat AIDS; the challenge now is to implement it.

#### **Conclusions**

The Bank can increase its effectiveness in the sector by fitting program design to accommodate institutional and political constraints and to take advantage of existing capacities. It can also build on its record of effectiveness in promoting integration of programs and cooperation among government ministries to address the increasingly complex challenges confronting Zimbabwe. The approach would be particularly useful in establishing a comprehensive health staffing strategy. Because budget constraints will not permit significant increases in personnel expenditures, the design and implementation of the strategy will require negotiation among the many stakeholders.

To prevent further deterioration in the public

health sector, government must give priority to reducing the budget deficit and restructuring debt service. Until this has been accomplished, maximizing efficiency and redistributing available funding can do much to achieve greater balance and effectiveness in service provision. Government must also take immediate steps to give priority to AIDS prevention—particularly to substantially increase the public and private resources devoted to behavior change—and mount an effective intersectoral response to the epidemic.

The challenges of the next decade are considerable, but Zimbabwe has the tools, the experience, the innovative spirit, and the support of partners—including the Bank—needed to meet them. Past successes clearly demonstrate that once the decision is made to take on a problem, remarkable progress can be realized.



## ANNEX B: PROJECT OUTCOME—SOURCES OF INFORMATION

The inputs to this study included a statistical model that was used to test the impact of factors related to country context, project design, and implementation on project outcome.<sup>1</sup> Another tool was an analysis of lessons cited in Implementation Completion Reports (ICRs). This annex describes the results of those analyses.

### Modeling HNP Project Performance

Consistent with the OED *Annual Review of Development Effectiveness* (OED 1998), the model included three categories of variables: borrower performance, country context, and Bank performance.

*Borrower performance*, as rated by OED at project completion, is the most important determinant of project outcome. Borrower implementation performance appears to be most important element, followed by appraisal performance and compliance with conditions.

*Country context*, particularly the quality of borrower institutions—including the level of corruption—is strongly correlated with project outcome. *Macroeconomic policy*, represented by an indicator for the openness of the economy, was not significantly correlated with project outcomes (although it is significant for the entire Bank portfolio, and experience suggests that economic performance can also be a significant

influence in the health sector).

*Quality of Bank project appraisal*, as rated by OED at project completion, is most strongly associated with satisfactory outcomes, closely followed by Bank *supervision quality*. Although quality seems to matter more, the number of staffweeks spent on preparation and supervision may contribute to improved outcome, even controlling for quality. *Quality of institutional analysis* during project preparation, including assessment of ownership and demand for health services, was significantly correlated with project outcomes, while economic analysis was not. A review of individual projects found that those with strong institutional analysis also tended to have good economic analysis, and both contributed to success. Those that focused on economic justifications without consideration of the institutional context were more prone to failure.

### Lessons from OED Review of ICRs

As an exercise independent of the econometric model, OED reviewed ICRs for 80 projects completed through FY97, and tabulated the most frequently cited lessons. Table A-1 lists the percentage of all projects that cited a given lesson, for both satisfactory and unsatisfactory projects. The data should be treated with some caution, however. Terms such as capacity and complexity have

TABLE 1: LESSONS CITED BY TASK MANAGERS IN ICRS

Lesson	Percentage of ICRs citing lesson		
	All Projects	Satisfactory	Unsatisfactory
<i>Project Design</i>			
Need better assessment of capacity	44	26	69
Project was too complex	36	24	52
Need better assessment of government commitment	34	19	55
Need more realistic objectives	30	21	41
Need stronger economic analysis	21	12	34
Need more detailed implementation plan	23	17	31
<i>Project Implementation</i>			
Need stronger Bank supervision	49	33	69
Problems with project management	54	50	59
Need better coordination	33	26	41
Among government entities	26	26	31
Among donors	11	12	10
Undermined by lack of counterpart funds	39	36	41
Inadequate maintenance	30	33	24
Problems, delays created by procurement	23	26	17
<i>Monitoring and Evaluation</i>			
Inadequate attention to M&E	54	48	62
Indicators not clearly specified	31	29	34
Inadequate attention to M&E in implementation	31	29	34

Source: OED data.

different meanings to different authors, and there may be a bias in unsuccessful projects to attribute failure to factors such as low capacity or excessive complexity. Still, the findings are illustrative, particularly of the extent to which similar problems have recurred in the portfolio.

## ANNEX C: LEDGER OF OED RECOMMENDATIONS AND MANAGEMENT RESPONSE

### OED Recommendation

#### *Increase Strategic Selectivity*

By the end of calendar year 1998, Bank management and the HNP Sector Board, in consultation with staff and partners, should establish priorities and guidelines for staffing, lending, and administrative resources (including project supervision and ESW) in light of overall objectives in the 1997 sector strategy. Particular attention should be given to: (a) how the issues raised in this OED assessment will be addressed, including budgetary implications; (b) how the sector plans to focus activities and budgets to sustain quality in light of staff overprogramming and pending declines in administrative budgets under the Strategic Compact; and (c) how country directors will be brought on board with the recommendations and guidelines.

#### *Enhance Quality Assurance and Results-Orientation*

The HNP Sector Board, in conjunction with regional sector leaders, should strengthen its role in monitoring and strengthening portfolio quality and results-orientation. Measures would include: (a) establishing a regular system of reviewing portfolio quality indicators, including identifying priorities for remedial actions; (b) establishing supportive mechanisms to help task teams improve performance; (c) in conjunction with Bank management, identifying steps to strengthen routine quality assurance mechanisms; and (d) in annual reports on the HNP sector strategy, increasingly present *evidence* regarding progress toward sector goals.

The Bank should seek ways to strengthen the incentives for monitoring, evaluation, and results-orientation within client countries through: (a) promoting wider experimentation with and use of performance-based budgeting systems in its lending and policy dialogue, particularly in the Comprehensive Development Framework (CDF) pilot countries; (b) by the end of FY00, producing a preliminary "lessons learned" paper on experience in performance-based budgeting in HNP, including implications for the CDF, in conjunction with partner organizations; and (c) the

### Management Response

*Increasing strategic selectivity is an important part of the sector/region management's continuing responsibilities, and is already part of their regular discussions on work programming.* Management has been working for some time to allocate resources in line with the priorities identified in the HNP Sector Strategy Paper. Additional focus was provided by the Sector Board in the Fall of 1998 with the agreement to concentrate on five priority public health areas. OED's proposal for even greater attention to selectivity is timely and welcome. The Sector Board has prepared an Action Plan with appropriate process and outcome indicators to address the priority issues raised by OED. The Sector Board will address priorities for staffing, lending, and administrative resources in a paper to be prepared in FY00.

*Management recognizes quality assurance as a high priority. The HNP Sector Board recently approved a program to strengthen its activities in portfolio quality monitoring and enhancement.* The program includes regular Sector Board discussions of portfolio quality, enhancing direct support for task teams, experimenting with different types of support panels, and staff training. The sector is taking this subject very seriously and has already started implementation of several of these measures. The Sector Board will monitor progress in accordance with Strategic Compact and OED indicators set out in the above-mentioned Action Plan, and will review evidence of progress toward sector priorities in its Annual Strategy Progress reports.

*Management endorses the need to develop and implement more effective systems of, and capacity for, HNP project monitoring and evaluation in client countries. However, the recommendations on monitoring and evaluation, taken together, would involve a large-scale effort, with significant resource implications.* This recommendation on strengthening incentives for monitoring and evaluation and greater results orientation is closely linked to the recommendations to enhance country monitoring and evaluation capacity (discussed two items below). Beyond

Bank should increasingly engage independent evaluative organizations, preferably based in borrower countries or regions, to provide periodic assessments of Bank-financed activities.

To strengthen Bank performance in monitoring and evaluation, management should: (a) identify a core group of HNP staff and consultants with experience implementing HNP monitoring and evaluation who could be available to assist other staff during project design and supervision; (b) develop a “good practices” manual of M&E design and use for decisionmaking, both at the project and systemic levels, including lessons from partner organizations; (c) in collaboration with the World Bank Institute, develop M&E case studies and training modules; (d) periodically give recognition to task teams that demonstrate measurable results from Bank-supported activities; and (e) in parallel with the CDF pilots, report by the end of FY00 on how Bank business practices and procedures could be modified to allow greater results-orientation in Bank lending, and to increase internal incentives for monitoring and reporting on results.

To strengthen borrower capacity and incentives for monitoring and evaluation in the HNP sector, sector strategies and project designs should include: (a) assessments of borrower incentives and capacity for monitoring and evaluation and (b) where appropriate, recommendations and measures to better enable borrowers to monitor and report on results, including strengthening health information and vital registration systems, and a description of the role of the Bank relative to other partners in this process.

#### *Intensify Learning from Lending and Nonlending Services*

To strengthen the institutional development effectiveness of the Bank’s work in HNP, management should: (a) in coordination with PSM and other internal and external partners, develop appropriate

what can be done to strengthen incentives for monitoring and evaluation through individual operations and in CDF countries in our continuing HNP work program, work in this area, including performance-based budgeting, will be phased in systematically, later in the sector’s Action Plan.

*Agreed. Monitoring and evaluation is weak in the HNP sector and should improve.* Management sees as an immediate priority the development of effective—and above all practical—monitoring and evaluation tools and good practice information for the HNP sector, and their dissemination through training, both of Bank staff and counterparts. Implementation is scheduled to start in the coming financial year. Nonetheless, because of the intrinsically complex and long-term nature of the HNP sector, this is a difficult subject, and one in which making progress will take significant continuing efforts.

*This is closely linked to the recommendations to enhance borrower monitoring and evaluation capacity (discussed two items above), and similar considerations apply.* The sector will do what it can through individual operations to give attention to the issue in project designs and sector strategies, and to support borrower capacity development; priority will be given to CDF countries and other countries with special needs. But systematically addressing this issue will need to await the completion of higher-priority work as identified in the Action Plan. For implementation, this topic will be combined with its companion item above.

*Management agrees that strengthening institutional effectiveness is a high priority for better overall sector and project performance.* However, it is also an area where the HNP sector literature is weak, and where there are few well-established, pragmatic guidelines, and little good practice to draw

tools, guidelines, and training programs for institutional and stakeholder analysis in HNP, both for targeted interventions and systemic reforms; (b) clarify the requirements for institutional analysis in project appraisal documents; (c) establish a core of HNP staff and consultants with experience in institutional design and stakeholder analysis, who could be available to assist other staff.

To strengthen the analytic base for Bank advice and lending: (a) management should increase funding for HNP sector work; (b) the Sector Board should sponsor operational research and provide good practice guidelines on improving effectiveness and efficiency of ESW and other Bank advisory and analytic services; and (c) management should shift some of the ESW budgets from country departments to regional technical managers to encourage regional research on priority issues.

#### *Enhance Partnerships*

To increase the Bank's ability to sustain a continued presence in borrower country health policy debates, and to develop long-term partnerships with various stakeholders in client countries: (a) the Bank should continue its current efforts to base sector specialists in countries or regions, with a clear mandate for collaborative policy dialogue with stakeholders inside and outside government; and (b) for projects and reform programs requiring intensive stakeholder consultation, country directors and sector managers should ensure that these time requirements are reflected in project preparation and supervision budgets.

To strengthen the Bank's effectiveness in health promotion and in addressing the intersectoral dimensions of health: (a) the Bank's HD Network and regional vice presidents should identify several key areas for improving intersectoral collaboration *within* the Bank, including coordination of macro-economic and sectoral dialogue on social sector work force issues, HIV/AIDS prevention and mitigation, and key health promotion activities (defined on a regional basis); and (b) the HNP network should strengthen staff skills in health promotion

upon. OED's recommendations will be taken up progressively as we strengthen capacity in this area, and the Sector Board will ensure that knowledge and practice gains are incorporated in project design and appraisal documents.

*Management accepts the need to examine whether ESW is adequately underpinning lending operations.* Good ESW is the foundation of sound project design. A clearer picture is needed of the amount and effectiveness of ESW, and whether analytical work is being undertaken through non-ESW channels. Management believes, therefore, that without further study it would not be appropriate to make specific budget allocations to HNP ESW. This topic will be taken up fully in FY01.

*Management agrees that posting of HNP staff to the field normally strengthens policy dialogue and links with stakeholders.* The numbers have increased substantially over the last two years. However, much depends on the individual country circumstances, the degree of HNP involvement in that country, and on regional policy. It is management's view that the HNP sector has a creditable record in reaching out to stakeholders during project preparation and supervision. The Sector Board will look again at this topic in FY02.

*Health promotion is a somewhat neglected area throughout the sector, not just in Bank work.* When done well, it can be highly cost-effective. As suggested by OED, staff need increased technical support in this area, and this will be taken up by the Sector Board as a medium-term priority. On the second issue, management accepts that important determinants of health lie outside the health sector. *Intersectoral collaboration is important, but notoriously difficult for any sector to achieve.* Limiting the scope of work to a few key areas will be essential to achieving

and establish “good practice” guidelines and examples for task managers.

The Bank should strengthen work with HNP development partners (such as WHO, UNICEF, bilateral donors) in several key areas, including strengthening HNP M&E systems and incentives and assessing progress and strategies in the current generation of health sector reforms.

concrete results. Work in both these areas will be taken up as a medium-term priority.

*Management accepts the spirit of this recommendation, but not as expressed.* A great deal of work is currently going into partnerships with many organizations on a broad range of issues. Management will continue these partnerships and seek to strengthen them, but not as a separate “partnership” activity.

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**ANNEX D: REPORT FROM THE COMMITTEE ON DEVELOPMENT EFFECTIVENESS (CODE)**


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**Development Effectiveness in Health, Nutrition, and Population: Lessons from World Bank Experience**

The Committee met on June 9, 1999, to discuss the report *Development Effectiveness in Health, Nutrition, and Population: Lessons from World Bank Experience* (SecM99-322), together with the draft management response (CODE99-40). The Committee thanked OED for an excellent report and management for a candid and constructive response, and appreciated the collaboration between OED, the Sector Board, and the Regions. The Committee recognized the need for a phased implementation of OED's recommendations but stressed the importance of beginning the implementation process immediately. In that regard, the Committee welcomed management's action plan to address these recommendations.

The OED review assesses the Bank's involvement in the health, nutrition, and population (HNP) sector over the last 30 years, from early population projects in the 1970s, to direct lending for primary health care in the 1980s, to a focus on health financing and system reform in the 1990s. Today the World Bank is the single largest external financier in the health sector in developing countries. The study found that although 79 percent of HNP projects completed in FY97/98 had satisfactory outcomes, some major weaknesses persist.

The report confirmed that the Bank overall has been successful in expanding health systems, providing inputs, improving treatment within the medical care system, and promoting dialogue on major policy issues such as the financing of health systems and HIV/AIDS. The Bank has not been as effective in improving service quality, efficiency, institutional development, and monitoring and evaluation systems, and addressing determinants of poor health that lie outside of the health system, such as how to promote behavioral change.

The main issues discussed by the Committee included:

**Strategic Selectivity.** The Committee recognized the magnitude of the problems in the sector, but also agreed with the emphasis on "doing better, not more" and the importance of partnerships with other actors in the sector to maximize impact.

**Quality Assurance.** The Committee stressed the critical importance of enhancing monitoring and evaluation in the sector, both within the Bank and in borrowing countries. Members acknowledged that

strengthening borrower capacity for monitoring and evaluation is a long-term challenge, but it is a priority that needs to be worked on now. Management reported that several actions were already under way to improve quality. The HNP Board had already appointed a lead person on quality assurance, hired implementation specialists, established peer review panels, and training was underway in the Regions. An action plan was being developed with outcome indicators to track progress in quality enhancement.

**Analytical Work on Institution Building and other Cross-Sectoral Linkages.** The Committee stressed the fundamental importance of strengthening the analytical base in this sector, particularly with respect to institution building and public sector reform, and the linkages between health and other sectors. More analytical work is also needed on the impact of cost recovery on the poor, and the role of the private sector in the financing of health services.

**Bank Organizational Issues.** The Committee noted that there are a number of positive lessons emerging from the close collaboration between OED and the HD network in the HNP sector, and from how the Sector Strategy has been developed and is being implemented, and that other networks could learn from this experience.

**Next Steps.** The Committee looks forward to effective dissemination of this report and management's action plan.



Jan Piercy, Chairperson  
July 23, 1999



# ENDNOTES

## Chapter 1

1. The first report in the series—*Evaluating Health Projects: Lessons from the Literature* (World Bank Discussion Paper No. 356)—surveyed the literature on the evaluation of health projects and presented a design for this study. The second stage of the study, “Lessons from Experience in HNP” (Report No. 18642), describes the evolution and performance of the HNP lending portfolio, based on a review of the 224 HNP projects approved between FY70 and FY97. In addition, OED conducted a series of four country sector evaluations, which examined the history and performance of HNP nonlending and lending activities in Brazil (Report No. 18142), India (Report No. 19537), Mali (Report No. 18112), and Zimbabwe (Report No. 18141).

## Chapter 2

1. The Bank did not want to “dilute” its family planning efforts, and was initially uncertain of its role in international health, particularly relative to that of the World Health Organization (WHO).

2. Project designs included a broadly standard package of inputs: financing for new or upgraded facilities (usually about two-thirds of the Bank financing); training for health or family planning staff; technical assistance and training for the central ministry; vehicles and equipment; and, often, an information, education, and communication (IEC) component. Projects sometimes also financed drugs or a small nutrition component.

## Chapter 3

1. The discussion in this chapter draws on reviews of project completion documents, OED assessments of project design quality, an econometric model of project outcome (see Annex B), the OED country case studies, and data from the Bank’s Quality Assurance Group (QAG).

2. OED rates a project as “satisfactory” if it achieved most of its stated objectives. The poor project performance in the late 1980s probably reflects weak institutional design in the first generation of Bank health projects and shortfalls in funds for recurrent costs as a result of economic crisis in many borrower countries.

3. See Annex B for a description of the model and detailed results.

4. In Brazil, for example, a number of Bank HNP projects languished in the 1980s, but the overall portfolio improved considerably in the 1990s when the government, with strong encouragement from the Bank, agreed to make a concerted effort to improve implementation. In India, Bank efforts to encourage changes in the government’s HNP strategy made little headway until—following a financial crisis in 1991—the government committed itself to reevaluating its approach to the sector.

5. Institutional quality encompasses the formal and informal rules governing the behavior of individuals and organizations in a society, not merely the capacity of particular individuals or organizational units (World Bank 1997d).

6. Methodological problems can make it difficult to attribute changes in outcomes to specific (Bank-financed or other-

wise) interventions, and both developed and developing countries are still in the early stages of developing systems and indicators to monitor the efficiency, efficacy, and client responsiveness of health facilities or systems. Yet plausible conclusions regarding project effectiveness, system performance, and HNP outcomes are possible using existing systems and methodologies (McPake and Kutzin 1997).

7. For further discussion of health information systems in developing countries, see Sandford and others 1992.

8. OED used a crude measure of complexity, which combined the total number of project components with the number of government ministries directly involved, to assess a complexity “score” for each project. The measure of institutional quality is taken from the *World Development Report 1997*.

9. The HNP sector has recognized this problem, and has initiated a number of research and operational activities to improve the poverty focus of the Bank’s work.

10. The path and opportunities for policy change depend on several factors, including whether it occurs in a time of political crisis or transition, the political and technical skills of key technocrats and political leaders, and the characteristics of the reform itself, which indicate the type of conflict and opposition generated (Grindle and Thomas 1991).

11. For an example of a computer-based instrument for stakeholder analysis of health sector reforms, see Reich and Cooper 1996.

12. Parallel financing from UNICEF in Mali funded technical specialists to train district health officers in community mobilization. This proved successful, although NGOs might have more efficiently and effectively mobilized communities.

13. In Zimbabwe, for example, the Bank helped strengthen the hand of the Ministry of Health in its dealings with the Ministry of Construction, both by placing an architect in the Ministry of Health and by convening regular meetings during supervision visits to jointly solve implementation problems.

14. This section draws primarily on the results of OED-sponsored GroupWare sessions with Bank HNP staff, together with analysis of trends in the HNP portfolio, QAG findings, and the OED country case studies.

15. In response to the findings and recommendations of this study, the Bank’s HNP Sector Board has given priority to developing or adapting institutional assessment tools for HNP staff (see Annex C). A number of tools and methodologies already exist, however, or are in the process of being developed. These include a toolkit for assessing the capacity of an education ministry to implement a project (Orbach 1999), which could be adapted to the health sector. OED developed a computer-based organizational capacity self-assessment toolkit, focused on the planning, management, and delivery of basic health services. The questionnaire for this toolkit, by Michael Bernhardt, is annexed in Stout and others 1997. The Bank’s HNP Network is in the process of developing a toolkit for assessing private sector health service delivery. The Bank’s Poverty Reduction and Economic Management Network (PREM) is developing general tools for assessing governance, budgetary, and service delivery systems, which could be further adapted to the social sectors. Outside the Bank, the International Development Research

Center has developed a comprehensive toolkit for organizational self-assessment (Lusthaus and others 1999), and the U.S. Agency for International Development's MEASURE Project is developing an institutional and organizational assessment methodology for the health sector.

#### **Chapter 4**

1. This emphasis on expanding access to government services was consistent with the objectives of the 1978 Health for All conference.

2. In Kenya, Bank support helped improve efficiency and cost recovery at Kenyatta National Hospital, but the percentage of the health budget going to the hospital increased rather than decreased over the life of the project.

#### **Annex A**

The Précis that appear in this Annex are reprints of OED Précis 176 (Zimbabwe), 187 (India), 188 (Mali), and 189 (Brazil). Copies of individual Précis are available from OED.

#### **Annex B**

1. The study used a probit model, with OED outcome ratings from 80 projects completed by FY97 as the dependent variable. Independent variables were drawn from several sources, including ex post OED ratings for Bank and borrower performance (appraisal and implementation); institutional quality ratings from the *World Development Report 1997*; and the corruption index from the *International Country Risk Guide*. In addition, the study constructed summary indicators for the quality of economic and institutional analysis, based on OED ratings of project appraisal reports for all projects approved through FY97 (see Stout and Johnston 1998). In the text, "significant" implies a confidence level of 95 percent or more.

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