BUILDING THE FOUNDATION FOR HEALTHY SOCIETIES
Influencing Multisectoral Action for Health

Phase One

VOLUME TWO

Case Studies on Multisectoral Action

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Abstract: Improving the health of whole populations through action across sectors is at the heart of goals set by the World Bank Group to eradicate extreme poverty and to promote shared prosperity by fostering the income growth of the poorest 40 percent of the population in every country. The Bank’s 2007 HNP Strategy called for the need to leverage investments and actions in other sectors as an imperative given the shifts in the global landscape (rapid urbanization, rise in non-communicable diseases as the leading cause of death in almost every region, worrisome trends in road traffic injuries, pandemic threats, climate change to name a few), which heighten the importance of coordination between multiple sectors. The knowledge product (KP) Building Healthy Societies: Influencing Multisectoral Action for Health addresses a demand from the World Bank’s Health Nutrition and Population (HNP) Global Practice staff and management and is the first of a series aimed at inducing a paradigm shift that places the responsibility for delivering health outcomes across multiple sectors. The audience for this KP includes not only World Bank task teams but also country policy makers and stakeholders.

The objective of this KP is to equip task teams with the tools and best practices to engage more effectively across sectors to improve health outcomes. The main products of the KP are (i) the development of the Multisectoral Opportunity and Constraints Assessment Tool (MOCAT) and (ii) four high level case studies. This second volume features four high level case studies: (i) Road Safety in Argentina, (ii) Conditional Cash Transfer in Latin America, (iii) Multisectoral HIV/AIDS Responses in Thailand, Kenya, Namibia and India, and (iv) Tobacco Tax Reform in the Philippines. The selection of the case studies took into account a combination of factors including sectors involved, risk factors addressed, country income, targeting of the poor, lessons learned on successes and failures in working across sectors. Particular attention was paid in identifying case studies that would provide insight to task teams on the process to follow to engage effectively across sectors. The case studies focus on constraints to working effectively across sectors, and how some of those constraints have been overcome, while drawing on best practices in project management and evidence-based policy dialogue.

Keywords: road safety, conditional cash transfer, HIV/AIDS, tobacco tax, multisectoral action

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“...The World Bank Group will continue to step up our work on improving health through action in other sectors, because we know that policies in areas such as agriculture, clean energy, education, sanitation, and women’s empowerment all greatly affect whether people lead healthy lives...”

Excerpt from WBG President Dr. Jim Yong Kim’s speech at the World Health Assembly, Geneva, May 21, 2013
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<table>
<thead>
<tr>
<th>Acronyms</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACU   AIDS Control Unit</td>
<td>EFNEP Expanded Food and Nutrition Education Program</td>
</tr>
<tr>
<td>AER   Action for Economic Reforms</td>
<td>FCAP FCTC Alliance – Philippines</td>
</tr>
<tr>
<td>AIDS  Acquired Immunodeficiency Syndrome</td>
<td>FCTC Framework Convention on Tobacco Control</td>
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<tr>
<td>ANSV  Agencia Nacional de Seguridad Vial</td>
<td>GBD Global Burden of Disease, Injuries, and Risk Factors Study</td>
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<tr>
<td>APL   Adaptable Programmatic Loan</td>
<td>GDP Gross Domestic Product</td>
</tr>
<tr>
<td>APS   AIDS Program Secretariat</td>
<td>GP Global Practice</td>
</tr>
<tr>
<td>ARSP  Argentina Road Safety Project</td>
<td>GRSF World Bank Global Road Safety Facility</td>
</tr>
<tr>
<td>ARV   Antiviral</td>
<td>HEART Health Equity Assessment and Response Tool</td>
</tr>
<tr>
<td>BAT   British American Tobacco</td>
<td>HIA Health Impact Assessment</td>
</tr>
<tr>
<td>CARE  Cooperative for Assistance and Relief</td>
<td>HIV Human Immunodeficiency Virus</td>
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<tr>
<td>CACC  Constituency AIDS Control Committee</td>
<td>HIV/AIDS-ICC Inter-agency Coordinating Committee for HIV/AIDS</td>
</tr>
<tr>
<td>CACOC Constituency AIDS Coordinating Committee</td>
<td>HNP Health, Nutrition, and Population</td>
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<td>CBO   Community-Based organization</td>
<td>HNPFAM Health, Nutrition, and Population Family</td>
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<td>CCM   Country Coordination Mechanism</td>
<td>HPV Human Papillomavirus</td>
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<tr>
<td>CCT   Conditional Cash Transfer</td>
<td>IAS Indian Administrative Services</td>
</tr>
<tr>
<td>CoP   Community of Practice</td>
<td>IBRD International Bank for Reconstruction and Development</td>
</tr>
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<td>CMIS  Computerized Management Information</td>
<td>ICT Information and Communications Technology</td>
</tr>
<tr>
<td>CNSSS National Social Security Council</td>
<td>IDA International Development Assistance</td>
</tr>
<tr>
<td>CPF   Country Partnership Framework</td>
<td>IDU injecting drug user</td>
</tr>
<tr>
<td>CRECER National Strategy for Poverty Reduction</td>
<td>IECD information, education, and communication</td>
</tr>
<tr>
<td>CSDH  Commission on Social Determinants of</td>
<td>IHME Institute of Health Metrics and Evaluation</td>
</tr>
<tr>
<td>Health</td>
<td>IMSS Mexican Institute of Social Security</td>
</tr>
<tr>
<td>CSO   Civil Society Organization</td>
<td>IRAP International Road Assessment Program</td>
</tr>
<tr>
<td>DALYs Disability-Adjusted Life Years</td>
<td>IYCF infant and young child feeding</td>
</tr>
<tr>
<td>DDC   Department of Disease Control</td>
<td>NCD Noncommunicable Disease</td>
</tr>
<tr>
<td>DOF   Department of Finance</td>
<td>NGO Nongovernmental Organization</td>
</tr>
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<td>DTC   District Technical Committee</td>
<td>NMHP Nagaland Multisectoral Health Project</td>
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<tr>
<td>EBRD  European Bank for Reconstruction and</td>
<td></td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
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<tr>
<td>KNASP</td>
<td>Kenya National HIV/AIDS Strategic Plan</td>
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<td>KP</td>
<td>Knowledge Product</td>
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<tr>
<td>LIC</td>
<td>Low-Income Country</td>
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<td>LMICs</td>
<td>Low- and Middle-Income Countries</td>
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<tr>
<td>MAP</td>
<td>Multicountry AIDS Program</td>
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<tr>
<td>MOCAT</td>
<td>Multisectoral Opportunities and Constraints Assessment Tool</td>
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<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MDR</td>
<td>Multidrug Resistant</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>MOPH</td>
<td>Ministry of Public Health</td>
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<td>MOHSS</td>
<td>Ministry of Health and Social Services</td>
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<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
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<tr>
<td>MSM</td>
<td>Men Who Have Sex with Men</td>
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<td>MTP</td>
<td>Medium-Term Plan</td>
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<td>NABCOA</td>
<td>Namibian Business Coalition on HIV/AIDS</td>
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<tr>
<td>NAC</td>
<td>National AIDS Council</td>
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<tr>
<td>NAPC</td>
<td>National AIDS and Prevention Control Committee</td>
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<td>NACM</td>
<td>National HIV/AIDS Coordinating Mechanism</td>
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<td>NACC</td>
<td>National AIDS Control Council</td>
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<td>NACO</td>
<td>National AIDS Control Organization</td>
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<td>NACP</td>
<td>Indian National AIDS Control Program</td>
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<td>NAEC</td>
<td>National AIDS Executive Committee</td>
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<td>NAMACOC</td>
<td>National Multisectoral AIDS Coordination Committee</td>
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<tr>
<td>NANOSO</td>
<td>Namibia Network of AIDS Service Organizations</td>
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<tr>
<td>NASCOP</td>
<td>National AIDS and STI Control Program</td>
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<tr>
<td>UKHSDP-II</td>
<td>Uttarakhand Health Systems Development Project-II</td>
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<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Program on AIDS</td>
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<td>UNDP</td>
<td>United Nations Development Program</td>
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<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<td>NSF</td>
<td>National Strategic Framework</td>
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<tr>
<td>NVP</td>
<td>New Voice Association of the Philippines</td>
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<tr>
<td>OECD</td>
<td>Organization for Economic Co-Operation and Development</td>
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<tr>
<td>OPM</td>
<td>Office of the Prime Minister</td>
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<tr>
<td>PAHO</td>
<td>Pan-American Health Organization</td>
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<tr>
<td>PBGS</td>
<td>Paquete Basico Garantizado de Salud</td>
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<tr>
<td>PhP</td>
<td>Philippine Peso</td>
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<td>PH</td>
<td>Public Health</td>
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<td>PLWH</td>
<td>People Living With HIV/AIDS</td>
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<td>PPP</td>
<td>Public-Private Partnership</td>
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<td>PREM</td>
<td>Poverty Reduction and Economic Management</td>
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<tr>
<td>RACOC</td>
<td>Regional AIDS Coordinating Committees</td>
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<td>REDESA</td>
<td>Sustainable Supply Chains for Food Security</td>
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<td>RSBY</td>
<td>Rashtriya Swasthya Bima Yojna</td>
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<tr>
<td>RTA</td>
<td>road traffic accident</td>
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<td>SABER</td>
<td>System Assessment and Benchmarking for Education Results</td>
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<td>SACS</td>
<td>State AIDS Control Societies</td>
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<tr>
<td>SCD</td>
<td>Systematic Country Diagnostic</td>
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<tr>
<td>SDH</td>
<td>Social Determinants of Health</td>
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<td>SDIP</td>
<td>Safe Delivery Incentive Program</td>
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<tr>
<td>SEARO</td>
<td>South-East Asia Region of the World Health Organization</td>
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<td>SEATCA</td>
<td>Southeast Asia Tobacco Control Alliance</td>
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<td>SEDESOL</td>
<td>Secretaria de Desarrollo Social</td>
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<tr>
<td>SUS</td>
<td>Family Health Program</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TFK</td>
<td>Campaign for Tobacco-Free Kids</td>
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<td>TTC</td>
<td>Transnational tobacco companies</td>
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<tr>
<td>TTL</td>
<td>Task Team Leader</td>
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<tr>
<td>UHC</td>
<td>Universal Health Coverage</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
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<tr>
<td>TOR</td>
<td>Terms of Reference</td>
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<tr>
<td>TOWA</td>
<td>Total War Against HIV and AIDS</td>
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PART 1: SYNOPSIS OF KP

Introduction

Improving the health of whole populations through action across all relevant sectors is at the heart of the goals set out by the World Bank Group — namely, to eradicate extreme poverty by reducing the number of people living on less than $1.25 a day to 3 percent by 2030, and to promote shared prosperity by fostering the income growth of the poorest 40 percent in every country. To achieve these outcomes, the World Bank Group’s strategy has three components: (1) maximize development impact by engaging country clients in identifying and tackling the most difficult development challenges; (2) promote scaled-up partnerships that are strategically aligned with the goals; and (3) crowd in public and private resources, expertise, and ideas.

The Bank’s 2007 Health Nutrition, and Population (HNP) Sector Strategy called for interventions in other sectors to be leveraged to deliver health results, recognizing that it takes more than health services to improve HNP outcomes. The 2009 HNP Strategy implementation report identified strengthened multisectoral action as one of the areas where significant work remained to be done. The 2012 Public Health Policy Note, Connecting Sectors and Systems for Health Results, set out the vision for the Bank’s approach to public health over the next few years. The note called for a strong focus on multisectoral action and investments to address the upstream determinants of health — an imperative given the shifts in the global landscape, which heighten the importance of coordination between multiple sectors.

The Bank today has the best opportunity in decades to engage in multisectoral action — an agenda to which its leadership is strongly committed. It is a “win-win” to leverage investments in sectors beyond health that are the foundation of healthy societies, including water and sanitation, agriculture, education, social protection, transport, gender equity, and environment. For example, the availability of safe roads, reliable power, and clean water will not only improve the health of the population, it will also improve access to health facilities for the population. Multisectoral action is also a key tenet in achieving universal health coverage (UHC), the main vehicle in HNP for the Bank to reach its twin goals of eliminating extreme poverty and boosting shared prosperity by 2030. Building healthy societies is a key pillar of the UHC framework: taking an upstream approach to addressing health issues, it will be critical to the successful and sustainable achievement of the two other pillars of UHC, namely financial protection and coverage of health service delivery.

The overall goal of this Knowledge Product (KP) is to assist HNP task teams in assuming the transformational role they will have to play within the HNP Global Practice (GP) — and by extension with Ministries of Health — to promote a paradigm shift that places the responsibility for delivering health outcomes across multiple sectors. Building on more than two decades of World Bank experience in working across sectors, this KP seeks to make such efforts more systematic and pragmatic — and thus create greater impact in improved health outcomes in different country contexts. The KP examines concrete examples of how multisector collaboration has been used to optimize health and development outcomes. These examples will provide support for task team leaders (TTLs) and task teams as the HNP GP starts rolling out on July 1, 2014 — helping them engage effectively across sectors internally within the Bank and at country level.

Nested in the overall vision for healthy societies mentioned above, this KP is the first in a series aimed at catalyzing multisector action within the HNP GP, and bringing other sectors together to achieve health and development outcomes. The specific objectives of the series are the following:

- Equip task teams — and through them our client countries — with useful, practical tools and concrete “how-to” examples of relevant best practices in engaging more effectively across sectors to improve health and development outcomes.
- Increase learning and collaboration across Global Practices for health results.

Addressing demand: This KP meets a demand expressed by the HNP Sector Board during meetings held in December 2012 and April 2013. At these meetings, the Sector Board concluded that the HNP Anchor would lead in launching the work to promote the multisectoral agenda in line with the 2007 HNP strategy.
The KP also aims to address requests made by a cross-section of HNP TTLs during a focus group discussion. These requests included support for upstream engagement in multisectoral work in the Country Partnership Strategy (now Country Partnership Framework, or CPF) process, and making the case to other sectors on the rationale for their involvement in health outcomes. In addition, the TTLs identified specific products that would assist them in engaging with countries, partners, and other sectors — including an information template, fact sheets, burden of disease analyses, and review of country portfolios. This demand from the regions is now especially relevant, as the Bank’s new CPF approach will call for a cadre of staff well equipped to work in coordination across sectors.

**Main products of the KP:** The main products for this KP include a Multisectoral Opportunities and Constraints Assessment Tool (MOCAT) and four illustrative case studies highlighting concrete examples of successful engagement across.

The KP responds to the demands of the HNP Sector Board to develop a concrete package of products that is of practical use to TTLs and country teams and that meets their needs both in terms of a process for engaging other practices and sectors, and in terms of content in relation to key issues and proven solutions. The set of interrelated products include the following:

1. **The MOCAT tool:** In line with the agreed framework, the tool walks through a process that identifies specific data on the burden of disease in the context of the upstream determinants of health, engages other practices and sectors in addressing these, translates proven solutions into optimal action in the immediate and longer term, and relates these back to the achievement of the Bank’s twin goals. The other elements of the KP package inform and add content to this process.

2. **Case studies:** The suite of case studies on (i) Road Safety Management in Argentina; (ii) Conditional Cash Transfers (CCTs) and Health; (iii) Multisectoral HIV and AIDS Responses; and (iv) Best Supporting Actor: The World Bank and Tobacco Tax Reform in the Philippines are intimately related to the MOCAT process in that they offer examples of proven solutions. They are intended not only to be examples of best practice, but also to offer key learning points that could be transferred to other countries and settings.

3. **Resource sheets:** Indoor air pollution, tobacco use, undernutrition, and road traffic accidents and transport have been identified as key issues where HNP practice will become more involved going forward and these are areas where the Bank has extensive examples of best practice from its own work. Therefore, they have been selected as the areas on which to develop the first batch of resource sheets that point the TTL and team members to existing practice, relate the process of engagement to a specific topic area, and add content to it. The resource sheets do not attempt to reinvent the knowledge base that exists in the Bank, but are intended to provide pointers to that base.

4. **Background paper:** A background paper provides further content and examples of good practice in terms of multisectoral work to address the social determinants of health, and it includes examples on the double burden of obesity and undernutrition and, more broadly, on NCDs.

The four elements of the KP package are not intended to be stand-alone products but should be viewed together as a whole where the overarching process is populated with content on specific key topics through live examples and by reference to the Bank’s ongoing work and knowledge base in key areas.

**Audience:** The primary audience for the KP is World Bank Group TTLs and task teams. The secondary audience includes country directors and program leaders, and through them, stakeholders across practices and sectors.

**Case Studies**

Selection of the four case studies took into account a combination of factors, including sectors involved, risk factors addressed, country income, targeting of the poor, lessons learned or successes and failures in
working across sectors, and the extent to which the cases addressed areas of priority focus for the Bank. The selection process paid particular attention to identifying case studies that would provide insight to TTLs on the process to follow to work effectively across sectors. To ensure the quality of the final product and in response to a request by sector managers, each case study was written by a senior consultant with a good knowledge of the Bank and the subject matter. The terms of reference (TOR) template for the case studies was based on an adapted version of the Harvard Business School model for case studies, with the intention that the end products would serve both for overall knowledge purposes and for teaching applications.

In briefings to the consultants, it was stressed that the case studies needed to provide solid examples of multisectoral action in health — aimed at increasing understanding of the constraints to working effectively across sectors, and how some of those constraints have been overcome, while drawing on best practices in project management and evidence-based policy dialogue.

Summaries of the Case Studies

Case Study 2.1a  Institutionalizing Road Safety Management in Argentina

Road traffic accidents are a growing concern for health and development in most low- and middle-income countries. Recently, Argentina established a national road safety agency with sustained funding and a mandate to regulate road safety across the country. The government approached the World Bank for a loan to strengthen the capacity of the agency to effectively coordinate national road safety programs. This resulted in the Argentina Road Safety Project (ARSP), a stand-alone road safety loan aimed at implementing the Safe System approach. This study traces the history of the Bank’s engagement in road safety in Argentina to illustrate how Bank staff can encourage similar developments in other countries.

Key lessons:

• Prioritizing the development of institutional capacity over fragmented, one-off interventions is crucial for sustainable improvements in national road safety performance.

• Creating country demand for the Safe System approach should be the ongoing work of road safety advocates until focusing events create opportunities for rapid implementation.

• Understanding the relative role of different sectors can help TTLs support effective cross-sectoral action. While health sector leadership is essential for positioning road safety as a developmental priority, most activities in a balanced program require leadership from other sectors, primarily transport, infrastructure, and enforcement.
Case Study 2.1b  Conditional Cash Transfers and Health

Conditional cash transfer (CCT) programs, mainly safety net programs that transfer cash to beneficiaries in exchange for school attendance and health service utilization, are a type of multisectoral program that has an impact on health and nutrition outcomes in a variety of settings. This case study takes a closer look at one of the world's largest and longest-lasting CCT initiative, Mexico's Oportunidades program, reviewing its effects on health and nutrition, exploring how multisectoral collaboration was undertaken, and highlighting two intrasectoral collaboration challenges that have emerged over the life of the program. Finally, opportunities to enhance the health and nutrition impact of the program are discussed, in a way that will be relevant to CCT in other settings.

Key lessons:

- Formal collaborative structures at different levels of government and complementary supply-side strengthening are two key “how-to” lessons learned that emerge from more than a decade of the Oportunidades program.

- Challenges in multisectoral collaboration will emerge in any context. Lessons learned from the highlighted challenges in Oportunidades suggest the importance of aligning budget, fiscal transfer, and payment policies with technical policies, as well as going further to target supply-side strengthening in those areas where CCT beneficiaries are concentrated.

- Finally, a broad lesson learned has to do with the centrality and scope of the Oportunidades evaluation. The evaluation's rigorous design, permanence in time, and efforts to measure on both the supply and demand sides represents a best practice in CCT and in social policy in general. These allow us to use the case of Oportunidades to learn lessons both for Mexico and elsewhere.
Case Study 2.1c  Multisectoral HIV and AIDS Responses

Responses to HIV and AIDS at the global, national, and subnational levels have undergone substantial evolution and expansion since the HIV virus was first identified in the 1980s. While early interventions were confined to medical and public health approaches to curtail the epidemic, today a wide group of stakeholders plan, implement, and evaluate multisectoral responses in countries. Important lessons can be drawn from the three decades of these multisectoral experiences. This case study examines how four countries — India, Kenya, Namibia, and Thailand — developed, implemented, and sustained multisectoral responses to HIV and AIDS. The case study then identifies lessons learned for TTLs about how to engage effectively across sectors.

Key lessons:

• Ensure that national strategic plans (and their accompanying action plans) involve multisectoral participation in plan formulation, are results-oriented and costed, include frameworks for sectoral leadership and coordination, and are integrated within longer-term vision and planning frameworks.
• Understand the priorities and perspectives of all sectors and identify mutual benefits before proceeding with multisectoral action.
• Plan activities multisectorally, but implement sector-by-sector. Each implementing sector should be able to articulate what outcomes they are contributing to.
• Ensure that communities and the private sector have incentives for collaboration, such as subsidies and contracts.
• Develop frameworks and tools for systematic data sharing among sectors to facilitate reporting against multisectoral indicators.
• Institute the multisectoral response at decentralized levels through structures with some autonomy to successfully partner with multiple sectors, particularly civil society and people living with HIV.
Case Study 2.1d Best Supporting Actor: The World Bank and Tobacco Tax Reform in the Philippines

What can the World Bank do to help countries control tobacco, a man-made scourge of health and development? This case study presents and analyzes evidence from the 2012 Philippine tobacco tax reform. It discusses why tobacco control is so challenging, and describes how the Philippines’ reform actually unfolded, with an emphasis on the World Bank’s role.

The goal of the reform was to raise taxes on tobacco products to achieve three objectives: increase tax revenues, reduce smoking and related costs by discouraging tobacco consumption through price increases, and provide funding for expanding the government’s pro-poor UHC scheme. The reform succeeded by increasing taxes immediately — in 2013 the excise tax on cheaper cigarettes more than tripled versus pre-reform levels — and taxes will continue to rise as they take full effect in 2016. Already in 2013 tobacco taxes provided approximately PhP 70 billion (about US$1.65 billion) in revenues.

Key lessons:

- Tobacco is the world’s leading cause of preventable death. Yet while tobacco control policies are well known, implementing them is extremely challenging because the political economy of reform is very difficult.
- The World Bank can play a key role in supporting these reforms if staff understand the following:
  - The multisectoral nature of tobacco production, sale, and consumption.
  - The types, capacities, and roles of domestic actors.
  - How to leverage the Bank’s comparative advantages in economic and technical analyses to counter tobacco industry arguments and contribute effectively to domestic political processes.

Requests for assistance with tobacco tax reform are likely to become common because most countries are party to the WHO Framework Convention on Tobacco Control, which requires them to legislate, implement, and enforce wide-ranging measures to discourage consumption and reduce production.

Multisectoral Opportunities and Constraints Assessment Tool (MOCAT)

Introduction

The MOCAT is intended to contribute to meeting the Bank’s goals by providing guidance to task teams working in countries to support a multisectoral approach in addressing health and its upstream determinants. This tool aims to (i) propose a systematic process for HNP to close the gap between knowledge and action for multisectoral engagement; (ii) provide evidence to task teams to make the case for multisectoral action; and (iii) help to improve health equity outcomes. The tool recognizes the complexities of policy dialogue, and the need to build partnerships and negotiate with stakeholders to address drivers and opportunities for change. It reflects the iterative nature of the process of identifying and agreeing to optimal solutions to address major health problems. Although the tool is being developed within the Bank’s Country Partnership Framework (CPF) process, it is expected that it will also be of use during midterm reviews, project preparation, and in guiding policy dialogue. The HNP GP will provide support to HNP task teams to use the MOCAT, as outlined in the MOCAT Development Plan (part 3 of this KP).

The launch of the GPs has put the spotlight on the need to work across sectors. Multisectoral action has been included in the TORs of the newly appointed senior directors of the GPs, and there is renewed emphasis on the cross-cutting agenda. In health, it should be emphasized that a multisectoral approach
does not necessarily mean multisectoral projects, though it may be that projects across sectors take place in parallel or in a phased approach while addressing the major social determinants of health.

The MOCAT provides added value through its provision of a systematic approach to improve health outcomes in the context of multisectoral action. Users of the MOCAT will be able to identify priority sectors to improve a specific health outcome, and eventually to determine which investments and opportunities (both within and beyond the health sector) provide the biggest return. In addition, this approach will provide strong rationale to key stakeholders within governments, partners, and donors to mobilize other sectors for health results.

Framework and Tool Development

The toolkit consists of the following:

- A review of selected literature and tools
- Background on social determinants of health (SDH)
- The MOCAT
- Selected topic-based guidance (tobacco, road safety, nutrition, household air pollution)

The MOCAT is based on the conceptual framework provided below, using the CPF cycle as an example. An expanded version of this flowchart, outlining the purpose and expected outcome at each level, is provided in the MOCAT (see part 3 of this KP). Use of the tool will facilitate situational analysis, identification of opportunities, and the iterative development of solutions. When using the MOCAT, consideration of factors such as the social and political environment, transactions and negotiations, as well as transferability of best practices is essential, given that no “one size fits all” where solutions are concerned.
The MOCAT is meant to assist task teams to assess new opportunities to achieve health results in the following: (i) during the Systematic Country Diagnostic (SCD)/Country Partnership Framework (CPF) or project/product preparation; (ii) when assessing the portfolio of a country to identify quick wins; and (iii) at the midterm evaluation of a CPF or a project/product.

A high-caliber consultant with the right experience and expertise was hired to assist in developing the MOCAT. The development process included consultations, concept development, advisory and focus groups, a literature review, pilot testing, and production of the MOCAT toolkit (see part 3).

Consultation to develop the concept and turn it into practice

The MOCAT was developed through an inclusive process that involved senior staff from diverse sectors and regions, including the following:

- **HNP staff dialogue on multisectoral experience.** Senior HNP staff met for a dialogue to build on their experience of working multisectorally and on their knowledge of related tools to help to refine the MOCAT concept and to clarify its aims, scope, audience, added value, and timing.
- **Dialogue with TTLs and sector managers.** HNP staff and TTLs from other sectors met to discuss the new CPF, with the goal of understanding how the MOCAT may fit into this framework. Sector managers of AFR, SAS, and MENA, and the director of HNP then met with the task team to help shape the development of the MOCAT concept and consider the best way to translate it into practice.
- **Advisory group.** The KP concept review meeting proposed the formation of an advisory group to assist with the development of the MOCAT. This group comprised sector managers, senior HNP staff across regions, and staff from other sectors, (transport, water and sanitation, environment),
and was chaired by the HNP sector manager for the MENA Region. The initial meeting of the group concluded that the structure of the MOCAT was overly complicated and came across as a questionnaire designed for the purpose of data collection. A simplified version presented during the second meeting was well received, and it was acknowledged that significant progress had been made. The following observations helped to refine the tool:

- The branding focused on the negative constraints, whereas this tool should convince country directors that opportunities will be identified.
- Given the limited time available to country directors, coupled with resource constraints, compelling reasons need to be given on the benefits of the MOCAT approach.
- The role of the team in the country and their input could be clearer, and more emphasis could be placed on how local knowledge is brought in.
- It was recognized that there will be some important structural drivers to the burden of disease that the MOCAT will not be equipped to address (such as change of government).
- In the future, it would be helpful to develop an electronic version of the MOCAT.

- **Focus group:** To canvass a broad range of views, a focus group discussion and consultations with team leaders were convened. The comments regarding the purpose of the tool, adoption of a systematic approach, and general feedback have been taken into account in the redesign of the tool. Specifically, the group suggested the following:
  - The format of the framework was too “busy,” and the links between the different MOCAT domains could be better articulated.
  - The purpose of collecting different types of data and the relationship between the burden of disease and upstream drivers could be clearer.
  - More clarity was needed as to how the MOCAT would add value to the stakeholder analysis that Bank teams are expected to do as a matter of course.

- **Consultation with the Capacity Development and Results Unit of the World Bank Institute (WBI) (soon to become the Science of Delivery Unit).** This unit has recently carried out, with support from Deloitte, a thorough inventory of tools in HNP. There are valuable links that will be useful for the TTLs to consult, and these will be included in the final version of the MOCAT. The unit believes that the MOCAT is different from all the tools reviewed and is a very good example of science delivery focused on the “how to.” They have offered support to develop a fact sheet on the MOCAT to be included in their revised inventory, which will support the dissemination process.

**Literature review**

The team conducted a literature review of over 200 articles, consulted leaders in the field of the social determinants of health, and used networks to confirm that a tool equivalent to the proposed MOCAT did not exist and to import best practice into its development. The strengths and weaknesses of the tools were assessed as to their usefulness to the MOCAT process and not in terms of the purpose for which they were developed. Much of the literature identified focused on theory and emphasized the need for a practical tool. A short descriptive framework of the documents and tools that were reviewed and were considered to have the potential to complement the MOCAT are included in the toolkit.

The paper, *Research on Project Cycle Tools and Approaches in Health, Nutrition and Population*, which has been published as a result of a need identified during the Science of Delivery stocktake (FY2014)
proved to be a valuable resource in mapping the broad landscape of tools. Particularly rich areas are health financing and HIV, and these have been given due consideration in refining the MOCAT.

A background paper that highlights specific issues of multisectoral action to address the social determinants of health and the topics of NCDs and nutrition was developed from the literature review and is included in the MOCAT toolkit (see part 3 of this KP).

3.2iii. Pilot testing

The MOCAT has been tested in two states in India, and initial consultations have taken place with the HNP team leader in Madagascar where subsequent testing of the tool is planned. In India, Nagaland and Uttarakhand were selected as test sites as there was an opportunity to build on the multisectoral efforts already underway there through the Uttarakhand Health Systems Development Project-II (UKHSDP-II) and the Nagaland Multisectoral Health Project (NMHP). Preparation for pilot testing involved communication with the project teams, review and preparation of background materials and presentations, and the completion of the MOCAT tool prior to the mission. The Country Management Unit (CMU) of India is solidly committed to the concept of multisectoral action to achieve HD outcomes. Plans are in place to refine the tool based on user experience, including in Nagaland and Uttarakhand (see the MOCAT Development Plan in part 3). In the case of India, more detailed data collection will be conducted by the Institute of Health Metrics and Evaluation (IHME) in the targeted states in the near future; it will be interesting to compare the findings of the pilot testing to those of the IHME analyses.
World Bank projects in the pilot sites:

The Nagaland Multisectoral Health Project ($60 million)

Summary description: The main project objective is to improve the availability and utilization by targeted communities in Nagaland of services in several sectors that have a potential impact on health and nutrition. Main components include the following:

Component 1: Multisectoral interventions for improving health
- Innovation to improve electricity, water supply, and sanitation systems in targeted health facilities
- Community empowerment to improve health and nutrition

Component 2: Health systems capacity development
- Technical assistance and project management
- Supply chain management and infrastructure/equipment–maintenance systems
- Human resource development and management
- Information and communication technology (ICT)
- Filling gaps in health service delivery

The MOCAT pilot testing
A. Main findings:
- Through their specific remit, the MOCAT team was able to reinforce the nature and importance of a multisectoral approach with senior government officials from across sectors and to help focus their thinking on the opportunities for joint work. Feedback received from a senior health official illustrated this point.
- The engagement of the MOCAT team with stakeholders from across sectors in the margins of formal meetings and negotiations brought another perspective to the Bank’s work.
- By gathering and analyzing additional data from across sectors and highlighting gaps in knowledge, alternative data sources could be identified.
- Discussion around specific issues in the states could be informed using experience in other countries.
- Opportunities for multisectoral work were identified beyond the scope of the project.

B. Main conclusions:
- Ensure that the first stage of the framework reflected the need to consult the TTL.
- Include further steps to ensure that local voices and expertise are considered at every stage.
- Highlight the gap between published data and the situation in the state. For example, as a “dry state” the significant issue of overconsumption of alcohol was not identified at the desk-search stage.
- Suggest that solutions from international literature should only be considered once the full picture based on both desk review and a mission has been identified.

By its nature, a fact-finding mission in the context of the MOCAT process will also start to build relationships, and this initial pilot visit demonstrated this. It reinforced that the MOCAT process should be for the long term and built on sustainable relationships; further work to develop and maintain the process is recommended.

Full details of the mission are provided in part 3. The process and recommendations are highlighted below.
The process of pilot testing

The HNP GP team responsible for pilot testing the tool worked to ensure that the process added value to, and supported the work of TTLs. They also acknowledged from the outset that the knowledge and expertise on the state’s priorities and possible solutions largely reside within that state. While considerable attention was paid to ensuring as much data and background information were gathered and analyzed before the mission, the importance of the work in the country was never underestimated. Through dialogue with Bank
task teams and key stakeholders from across sectors, a picture of priorities that could be amenable to multisectoral action was developed. While this has produced a snapshot of the opportunities and constraints, the iterative nature of the MOCAT process means that it will lend itself to support the ongoing development of multisectoral relationships and joint work.

The process outlined in the MOCAT was followed:

- Discuss the relevance and appropriateness of systematic multisectoral action (such as that outlined in the MOCAT) with the TTLs, team members and stakeholders.
- Conduct a desk search of grey and published literature, and identify data on the burden of disease, upstream determinants, and related factors.
- Consider who the key stakeholders would be, and what could help or constrain their actions toward positive health outcomes.
- Consider examples from international best practice that might be relevant to the situation.
- Check data with the TTLs and task teams.
- Develop a program for engaging key stakeholders from across sectors (for example, water and sanitation, transport, employment, and education) and from government, NGOs, and service provision in liaison with the TTLs.
- Undertake the MOCAT mission (this was arranged to coincide with a visit by the wider WB project team).
- Attend meetings with policy makers from across the sectors and conduct individual interviews to fill in gaps in the data and to understand the information in the cultural and political context.
- Refine the data and identify potential priority areas for action.
- Share findings with the TTLs and discuss possible next steps.

See part volume 1 of this KP document for details of the process.

Main findings from the pilot testing in relation to the MOCAT format

Dialogue with TTLs and stakeholders

- As the MOCAT task team anticipated, the early dialogue with the TTLs is of crucial importance in understanding the relevance of the MOCAT to their country, its appropriate use, and how it could support their wider agenda.

Data collection

- The TTL is an important first informant on data sources. It is expected that there will be differences in how much good quality data are available, and this needs to be taken into account in planning the mission to ensure that the right stakeholders capable of filling the knowledge gaps are involved.

- The initial search of published and grey literature is the starting point of building a broad picture of health and its upstream drivers in a country, and it is a good basis for early discussions with the TTL. However, this data will often be incomplete, and work in the country is essential to understand the context of the data, identify priority issues that do not appear in the literature, and match what is known from international evidence of best practice to local need.

Identification of drivers

- The MOCAT is intended to be a tool used by task teams with support from the HNP GP. While there are benefits in an MOCAT team being integrated into a larger mission, including their contribution to it, this has to be balanced with the heavy demands on the TTLs' time during periods of intense activity on the ground.

Identification of proven solutions

- In preparing for the mission, international examples of good practice can be considered in broad terms, but specific solutions are best arrived at in dialogue with stakeholders.
**Engagement across practices**

- The MOCAT is closely related to the Country Partnership Framework (CPF) process, and this could present the best entry point for the tool.
- The mission is research in action, and it not only serves to develop a fuller understanding of the burden of disease, upstream drivers, and potential solutions, but it can trigger a shift in the mindset of key stakeholders who become part of the process.
- The initial audience for the MOCAT is the task team. However, the in-country process involves stakeholders from across sectors, and a second stage of the process could usefully focus on articulating the value of the MOCAT to government.
- The importance of the MOCAT as part of the long-term relationship-building process across sectors, rather than a discrete activity, was illustrated by the mission.

**Determining optimal multisectoral action**

- The MOCAT team was able to share a broad range of experience and knowledge with stakeholders as issues emerged, and this was well appreciated.

**In conclusion,** the pilot testing to date has demonstrated that the MOCAT is a useful tool and an effective way of highlighting multisectoral approaches to address specific priority issues in countries. The pilot test also confirmed that the MOCAT needs to be a live process that involves the TTL and key stakeholders from the outset; that a flexible approach is needed to fully respond to country needs; and that the MOCAT should form part of a longer-term process of relationship building and engagement.

**Dissemination Strategy**

The dissemination strategy for this KP will focus primarily on an internal audience. The MOCAT and case studies will be disseminated to allow early sharing of knowledge as well as feedback from TTLs, practitioners, and country partners. Given the timing and nature of the subproducts for this KP, dissemination activities are expected to continue during the next fiscal year. The team has developed dissemination and utilization strategies with clear communication objectives and metrics.

<table>
<thead>
<tr>
<th>MOCAT</th>
<th>Desired objectives</th>
<th>Audience</th>
<th>Dissemination channel</th>
<th>Actions needed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Educate/convey key messages of the MOCAT</td>
<td>• TTLs from different GPs</td>
<td>Training/coaching sessions</td>
<td>• Develop PPT slides</td>
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<tr>
<td></td>
<td>• In-depth understanding of the rationale behind MOCAT</td>
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<td>• 1–2 page summary of findings from the MOCAT pilot testing</td>
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<td></td>
<td>• TTL mastery of applying the MOCAT</td>
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<td>• Identify good coaches/trainers</td>
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<td>• One-on-one coaching sessions</td>
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<td>• Small-group training on use of the MOCAT</td>
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<td>• Webinars and videos</td>
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<td></td>
<td>• Educate/convey key messages</td>
<td>• Country directors</td>
<td>Fact sheets/one pager</td>
<td>• Develop short, easy-to-read fact sheets for the MOCAT with key messages and lessons learned</td>
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<tr>
<td></td>
<td>• In-depth understanding of, and demonstrate benefits of MOCAT and studies</td>
<td>• Program leaders</td>
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14
**CASE STUDIES**

<table>
<thead>
<tr>
<th>Desired objectives</th>
<th>Audience</th>
<th>Activities</th>
<th>Actions needed</th>
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</thead>
<tbody>
<tr>
<td>• Increase awareness of and utilization of the case studies</td>
<td>World Bank staff, especially TTLs</td>
<td>Push e-mails</td>
<td>• E-mails to HNPFAM</td>
</tr>
<tr>
<td>• Create awareness of how-to’s of successful multisectoral initiatives</td>
<td>World Bank staff, especially TTLs</td>
<td></td>
<td>• Targeted e-mails to Public Health Community of Practice; TTLs from other GPs, e.g., Water, Transport, Agriculture, Social Protection</td>
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<td></td>
<td>Country directors, Program leaders</td>
<td>Fact sheets</td>
<td>• Develop short, easy-to-read fact sheets for capturing the how-to of effective multisectoral action, key messages, and lessons learned</td>
</tr>
<tr>
<td>• Educate/convey key messages on the “how-to” of engaging across GPs/sectors</td>
<td>TTLs from different GPs, WB staff</td>
<td>Web</td>
<td>• Utilize HNP internal newsletter</td>
</tr>
<tr>
<td>• Create awareness of how-to’s of successful multisectoral initiatives</td>
<td>TTLs from different GPs, WB staff</td>
<td></td>
<td>• Post content on HNP KM portal</td>
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<td></td>
<td>Country directors, Program leaders</td>
<td></td>
<td>• Utilize HNP Spark site</td>
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<td>• Blogs</td>
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**CASE STUDIES AND MOCAT (Joint action)**

<table>
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<tr>
<th>Desired objectives</th>
<th>Audience</th>
<th>Activities</th>
<th>Actions needed</th>
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<tbody>
<tr>
<td>• Create awareness and encourage use of the MOCAT beyond the HNP GP</td>
<td>TTLs from different sectors, WB staff</td>
<td>Events</td>
<td>Disseminate fact sheets for the MOCAT with key messages</td>
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<td>Examples. Half-day event to disseminate MOCAT and case studies; plus other events involving other GPs</td>
<td>Disseminate fact sheets for capturing the how-to of effective multisectoral action</td>
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<td>Presentations on the MOCAT</td>
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**METRICS**

- Surveys to gather feedback on the KP products (including during training for the MOCAT)
- Anectotal feedback
- Case Study downloads
- Requests for the MOCAT

**Next Steps for the KP**

As stated in the introduction, this is the first phase of development of the KP: Building the Foundation for Healthy Societies: Influencing Multisectoral Action for Health. Indeed, bringing about a change in mindset to embrace action beyond the health sector, both within the Bank and at country level, requires a long-term...
engagement and sustained momentum. To this end, proposed steps for phase two of the KP include the following:

- Refining the MOCAT based on the pilot testing and further assistance to the TTLs in Nagaland and Uttarakhand.

- Testing in different country contexts, including Madagascar, taking into account the CPFs schedule for fiscal year 2015 and beyond. This, over time, will create a critical mass and help institutionalize the MOCAT.

- Preparing more case studies to continue to provide TTLs with the “how to” to help them develop more intersectoral collaboration and action.

- Embedding, as needed, HNP staff in other sectors to help make the case for these sectors’ roles in promoting health.

- Developing a training curriculum on the Social Determinants of Health with the Institute of Health Equity based at the University of London.

- Carrying out analytical work on attributable risk modeling of the Social Determinants of Health, which could build on the World Bank’s multisectoral work on nutrition, as well as on return on investment. This will help determine priority actions in other sectors to maximize impact for health results.

Subsequent phases of the KP will require that staff time be set aside to assist task teams with data collection, analysis, and testing of the MOCAT. In addition, some incremental variable resources will be needed for (i) the preparation of additional case studies to highlight knowledge in multisectoral action; (ii) use and refinement of the MOCAT in countries with upcoming CPFs; (iii) conducting attributable risk modeling and return on investment analysis; and (iv) app development. Further details are provided in part 3 of this KP, under the MOCAT Development Plan.

Abstract: Road traffic crashes are a large and growing concern for health and development in most low- and middle-income countries. While infectious diseases are declining, most countries have struggled to reduce road traffic injuries. In contrast, almost all OECD countries have seen declining road traffic injuries since the 1970s after they began implementing the Safe System approach, which relies on strong national institutions to manage safety in all parts of the transport system, including roads, vehicles, and road users.

Recently, Argentina established a national road safety agency with sustained funding and a mandate to regulate road safety across the country. The government approached the World Bank for a loan to strengthen the capacity of the agency to effectively coordinate national road safety programs. This resulted in the Argentina Road Safety Project (ARSP) – a stand-alone road safety loan aimed at implementing the Safe System approach. This Case Study traces the history of the World Bank’s engagement in road safety in Argentina to illustrate how the Bank’s staff members can encourage similar developments in other countries.

Key Lessons

1. Prioritizing the development of institutional capacity over fragmented, one-off interventions is crucial for sustainable improvements in national road safety performance.
2. Creating country demand for the Safe System approach should be the ongoing work of road safety advocates until focusing events create opportunities for rapid implementation.

Understanding the relative role of different sectors can help effective cross-sectoral action. While health sector leadership is essential for positioning road safety as a developmental priority, most activities in a balanced program require leadership from other sectors, primarily transport, infrastructure, and enforcement.
Introduction

In 2008, President Cristina Fernandez Kirchner of Argentina sent a national road safety bill to Congress that was passed unanimously. The bill created a new national road safety agency with sustained funding and a mandate to manage road safety across the country. The process was reminiscent of actions in the 1960s by several OECD countries that successfully transitioned to an era of coordinated government action on road safety management. Though OECD countries had seen a rising road death toll since the birth of the automobile, this period ushered in steady improvements that have continued until today.

Over the last decade, the World Bank, through its Global Road Safety Facility (GRSF), has promoted a vision of managed road safety – a Safe System approach – for low- and middle-income countries, modeled after the experience of OECD countries. However, with very few exceptions, these countries have not adopted this paradigm and their road death tolls continue to rise unabated. Conversations at the World Bank about road safety often devolve into frustration over the difficulties in working across the sectoral boundaries of health, transport, public security, infrastructure, and education, among others. Yet, the World Bank’s experience in Argentina is remarkably different. Not only did the country successfully transition to the new road safety paradigm, it approached the World Bank for a stand-alone loan to strengthen the capacity of its new road safety agency. Why did this happen in Argentina? What can World Bank staff learn from this experience? Can other countries be coaxed into walking the same path? If so, how?

Overview of Argentina

Today, Argentina is a middle-income country with one of South America’s largest economies. It is vast, stretching 4,000 kilometers from hot, wet, and swampy sub-tropical regions in the northeast to the sub-Antarctic region of Patagonia in the south.2 Argentina is a country of immigrants. Almost all (97 percent) of its 42 million inhabitants are descendants of Europeans who arrived over the last 150 years. Prior to Spanish colonization in the 1500s, the land was sparsely populated by indigenous people. The Spanish American wars of the 19th century led to the Argentine Declaration of Independence in 1816, followed by a period of political instability from which the modern nation state emerged. The Constitution of Argentina was modeled after the US Constitution, and has evolved through a struggle between federalists and centralists.3 This tussle for power would be a core issue for Argentina and continues to reverberate in modern times as the nation considers how to manage safety in its transport sector.

In recent decades, Argentina has had a troubled political and economic history, marked by boom-and-bust economic cycles and frequent periods of military rule.4 Nevertheless, the period since 2003 has been relatively stable. The dominant ideology that pervades politics in Argentina is Peronism, named after Colonel Juan Peron, which promotes social justice, economic independence, and political sovereignty. Peron, who was elected to power in 1946 with strong support from labor unions, nationalized the railroads and other utilities, and financed public works on a large scale. In 1955, he was ousted by a military coup, but Peronists regained power in 1973 when the country returned to democratic control. Peron died in 1974 and, two years later, another military coup established General Jorge Videla as dictator. The “Dirty Wars” that followed were a period of wide-scale human rights abuses against political dissidents, and included kidnapings, forced “disappearances”, and extrajudicial murders. A decade later, a failing economy, widespread corruption, and a military defeat in the Falklands/Malvinas War had deeply eroded the legitimacy of the military regime. In 1983, Argentina returned to being a representative democracy under civilian control.

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Unfortunately, the new democratic government inherited a failing economy, a deepening foreign debt crisis, record budget deficits, and hyperinflation running at over 900 percent. In 1989, Carlos Menem took office as president and started a period of economic austerity and reforms that privatized public utilities, including gas, electricity, and water. A dramatic influx of foreign direct investments helped stabilize inflation, but public debt continued to grow. In 1998, a severe recession set in, leading to economic collapse in 2001. Argentina defaulted on its US$81 billion sovereign debt and half the population was driven into poverty. Street rioting and general strikes halted work in much of the country as people protested government spending cuts, curbs on bank withdrawals, and delayed pension payouts. In 2003, Nestor Kirchner was sworn in as president and oversaw a period of economic stability, which helped consolidate his power. In 2007, he backed his spouse, Christina Fernandez de Kirchner, who campaigned and won the presidency in large part on her husband’s record of reducing poverty and unemployment after the recession. Argentina was affected by the global financial crisis in 2008 but seemed to recover in 2010. Today, in 2014, worries remain about economic stability.5

This boom-and-bust economic and political history had an important effect on decentralization of political power, resources, and responsibilities to subnational units of government – an issue this case study will show is closely tied to road safety in the country (figure 1.1). Globally, countries have seen a trend towards dispersion of political power driven partly by a decline in credibility of the centralized state. In Latin America, the transition from military centralism to civilian control was another important driver of devolution of power to the provinces.2,6 Decentralization of power can have important advantages because local governments may know and be able to respond to the needs of people much better than a central government. However, in certain arenas of specialized knowledge, such as road safety, centralization is important for developing technical expertise. Furthermore, successful action in road safety usually involves large-scale programs with coordinated action by government bodies across the nation, requiring a strong central agency with the authority to manage road safety.

In addition to political decentralization, the deep economic crisis of the 1980s was followed by fiscal decentralization. For instance, the 1989 transport sector reforms involved decentralization of expenditure and financing to local governments.3,7,8,8 In addition, Carlos Menem’s economic reforms in the 1990s were also a substantial move towards privatization of the financing and execution of transport sector projects, such as road building works. In 1991, nearly 9,000 kilometers of roads, representing about 70 percent of the national roads with the highest traffic volume, were privatized.9 Private contractors were allowed to build, maintain, and operate roads in exchange for the right to charge tolls to road users. Thus, government’s role in road infrastructure shifted towards regulation of privatized monopolies.6 However, despite these fiscal reforms, Argentina continues to have an unusually low proportion of paved roads. According to the World Economic Forum’s Global Competitiveness Report 2013-2014, the quality of Argentina’s road infrastructure ranks 103rd of all countries, while neighboring Chile ranks 27th.4,10

Public Health in Argentina

Paralleling these developments in the transport sector, the 1990s saw several efforts at restructuring the health sector towards managed care and market-oriented policies. However, the overall management and structure of the sector changed relatively little. Argentina continues to have a fragmented health system that gives substantial administrative power to sub-national health authorities. Employment-related social insurance schemes ("Obras Sociales") cover roughly half the population. However, about 40 percent of the population is not insured and relies on the public hospital network, which is underfunded and usually unable to provide adequate care. The 2001 economic collapse had a large impact on public health. Many people lost their jobs and hence their employment-based insurance. The uninsured were left with a reduced capacity to pay for health care. Infant mortality, which had been dropping steadily, rose slightly and did not begin to fall again until 2004. Thus, improving access to health services has been an important priority for the health sector. In 2005, the Argentine government launched Plan Nacer, supported by US$ 435.8 million in loans from the World Bank, to provide public health insurance to uninsured pregnant women and children.

Despite setbacks, health in Argentina has undergone a dramatic and rapid epidemiological transition mirroring that of wealthy nations, even more so than in other countries in the region. The health profile has shifted away from mostly infectious diseases of childhood to non-communicable diseases (NCDs) and injuries that affect adults (figure 1.2, and appendix I). In 2010, NCDs and injuries accounted for 18 of the

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top 20 causes of health loss\textsuperscript{16} in Argentina.\textsuperscript{17} Eight of the ten leading causes of health loss in Argentina are the same as those in high-income countries, with ischemic heart disease, stroke, depression, and lower back pain occupying the top four ranks in Argentina as well as in all high-income countries grouped together. Road injuries rank sixth in Argentina and eighth in high-income countries. Addressing the major risk factors of non-communicable diseases, such as tobacco use, alcohol abuse, inactivity, and unhealthy diet, has been as difficult in Argentina as it has been in high-income countries.\textsuperscript{18}

Road transport impacts health in Argentina through several mechanisms. Injuries in crashes have the most direct and visible health impact. In addition, motor vehicle emissions are an important contributor to air pollution, which causes a broad range of acute and chronic health effects, ranging from minor physiologic disturbances to death from respiratory and cardiovascular diseases. In 2010, outdoor air pollution from all causes was responsible for 1,676 deaths in Argentina due to stroke, ischemic heart disease, lower respiratory infections, chronic obstructive pulmonary disease, and lung cancer.\textsuperscript{16,19} Of these deaths, 278 were due to emissions from motor vehicles.\textsuperscript{20} Finally, motorization is an important contributor to physical inactivity, which is linked to many of the same non-communicable diseases that are affected by vehicular emissions. In 2010, physical inactivity caused 24,858 deaths in Argentina,\textsuperscript{18} although it is not known how many of these can be attributed to motor vehicles.

**Burden of road traffic injuries in Argentina and globally**

Road traffic crashes killed 1.3 million people and injured an additional 78.3 million in 2010, globally.\textsuperscript{21} The issue began to emerge as a global health priority in the late 1990s, when global and regional rankings first showed road traffic crashes as among the leading causes of health loss.\textsuperscript{22} Further, although most global regions have witnessed vast and sustained improvements in infectious diseases, road traffic injuries have continued to increase. The global road traffic death toll grew by 46 percent over the last two decades.\textsuperscript{20}

\textsuperscript{16} Health loss is measured in disability adjusted life years lost (DALYs) – a summary measure of population health that allows comparison of the health burden across all diseases and injuries. Estimates form Health loss in this study are from the 2010 Global Burden of Disease study.


In Argentina, Global Burden of Disease 2010 (GBD-2010) estimated that there were 6,067 road traffic deaths and 341,000 non-fatal injuries, of which 39,000 were severe enough to warrant hospitalization. In comparison with other diseases, road traffic crashes were the sixth-leading cause of health loss (figure 1.2). Although official government statistics of road traffic deaths were lower at 5,094 deaths due to differences in definitions and underreporting, the magnitude of the death toll was a cause of serious concern. Furthermore, the long-run trend in road traffic deaths showed no signs of a sustained downturn. Between 1980 and 2010, road deaths had increased by about 20 percent with trends that broadly tracked the economic and political cycles (figure 1.1). Thus, road traffic deaths fell by almost 30 percent between 1981 and 1988 as the economy of Argentina contracted, then rose by 70 percent over the next decade as the economy bounced back. From 1998 to 2002, deaths fell again by about 25 percent, before rising again by about 30 percent from 2002 to 2008, in concert with a rebounding economy. In 2008, the new national road safety plan, which is the focus of this case study, was instituted. Remarkably, road traffic deaths have been declining since then even though the economy appears to have remained stable.

Argentina’s road traffic death rate, although lower than that in the poorest regions of the world, is nevertheless more than three times that of Sweden, the United Kingdom, and the Netherlands, which are widely regarded as the countries with the best road safety performance. These countries, like most OECD countries, have witnessed steadily declining road traffic death rates for over four decades. For instance, in 1970, the road traffic death rates in Sweden (16.3 per 100,000) and the UK (14.0 per 100,000) were similar to the current road traffic death rate in Argentina (14.2 per 100,000). The death rate in the Netherlands (24.6 per 100,000) was substantially higher. Yet, these countries in Western Europe were able to substantially reduce the burden of road traffic crashes dramatically (appendix II). By 1990, road traffic crashes were the sixth-leading cause of health loss in Western Europe, and by 2010 had declined to the twelfth-leading cause of health loss due to a 36 percent decline in road injury DALYs. In contrast, the public health burden of non-communicable diseases like COPD, depression, lung cancer, and diabetes, which were ranked similarly to road traffic injuries in 1990, grew. Remarkably, Western Europe had managed to find a way to control road traffic injuries, while still struggling to control non-communicable diseases.

Global Road Safety Policy History

Road safety performance in most OECD countries has had a remarkably similar history. Prior to 1970, road traffic deaths in these countries had been rising steadily. In part, the dramatic increases in road traffic deaths were driven by the rapid expansion of highway infrastructure which occurred during the post World War II rebuilding of Europe and the construction of the Interstate Highway System in the United States. More importantly, road safety efforts prior to the 1960s were pervaded by the belief that crashes were caused by reckless drivers. Most research focused on understanding the psychology of accident-prone drivers, and most interventions focused on behavior change. However, the 1960s saw a shift from the “nut behind the wheel” paradigm to regulation of systemic risk in a technological system. For instance, in the United States, a coalition of engineers, lawyers, medical doctors, and congressional representatives helped create a political movement that led to the passage of the Motor Vehicle Safety Act of 1966, followed by the establishment of the National Highway Traffic Safety Administration with a mandate to regulate road safety. Thus, the 1960s saw a reinterpretation of the problem of road safety by society in OECD countries, and a repositioning of the solution within the regulatory authority of the state.

In the decades that followed, a new science of road safety evolved in OECD countries called the Safe System approach, which aimed to improve and manage safety in all parts of the transport system, including roads, vehicles, and road users. The Safe System approach assumes that people make mistakes and crashes are inevitable. The goal of the designers of the system is to ensure that these system failures are forgiving. If one part of the system fails, other parts should still protect against deaths and serious injuries. For instance, road infrastructure is designed to remove hazards and include barriers; vehicle speeds are managed at safe levels; vehicles are designed to avoid crashes and reduce transfer of energy to humans; and road users are kept alert and aware of risks. Perhaps most importantly, Safe System recognizes that interventions cannot be deployed efficiently without robust management at the three levels.

Sources: GBD-2010, IRTAD

At the core of the framework are institutional management functions, which produce interventions, which in turn produce road safety results.

Although the *Safe System* vision had been deployed with remarkable success in OECD countries, there was relatively little application of these ideas to low- and middle-income countries. In part, this was because road safety was not considered a priority development issue. However, once the first Global Burden of Disease study in the late 1990s identified road traffic injuries as a leading cause of death in developing economies, recognition of road safety began to increase. In 2004, the World Report on Road Traffic Injury Prevention, issued jointly by the World Bank and the World Health Organization, was an important milestone in shaping subsequent global road safety efforts. Notably, the report highlighted the importance of applying the managed road safety approach in low- and middle-income countries, and recommended several important institutional processes to help countries transition to a *Safe System* approach.

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The momentum generated by the World Report on Road Traffic Injury Prevention resulted in a series of resolutions from the UN General Assembly and the World Health Assembly calling for global action on road safety in 2004, 2005, 2008, 2010, 2012, and 2014.\textsuperscript{30, 31,32,33,34,35} The 2012 UN resolution proclaimed the period between 2011 and 2020 as the Decade of Action to stabilize and reverse the rising trend in road traffic deaths in low- and middle-income countries. The resolution urged countries to adopt the Global Action Plan developed by the UN Road Safety Collaboration.\textsuperscript{36} The guiding principle underlying the action plan was the \textit{Safe System} approach, presented as five pillars: building road safety management capacity; improving the safety of road infrastructure and broader transport networks; further developing the safety of vehicles; enhancing the behavior of road users; and improving post-crash care.

Meanwhile, in the year following the launch of the World Report on Road Traffic Injury Prevention, the World Bank established the Global Road Safety Facility (GRSF). The GRSF was led by Tony Bliss, a leading...
figure in the development and application of Safe System thinking to country settings. The GRSF was supported by a grant from the World Bank Development Grant Facility and several other donors, including the FIA Foundation, the Dutch government, and the Swedish and Australian international development agencies. Bliss was a transport economist who had arrived at the World Bank in 2002. As general manager of the Strategy Division of the New Zealand Land Transport Safety Authority, Bliss had previously led the development and delivery of a remarkably successful national road safety plan. Between 1990 and 2011, New Zealand reduced its road traffic death rate from 21.4 per 100,000, which put it among the high-income countries with the worst road performance, to 6.5 per 100,000. Notably, Bliss’s work in New Zealand has been influential in shaping the Safe System approach as it evolved in OECD countries.37, 38,39

Under Bliss’s leadership, the World Bank Development Grant Facility’s team developed a framework for the roll out of the Safe System approach to low- and middle-income countries. In a brief 2004 World Bank Transport Note, Bliss provided guidance on how to implement the recommendations of the World Report.40

In 2009 and 2013, Breene and Bliss published detailed guidelines that provided a practical approach to implementing the Safe System approach and building capacity for countries at varied levels of development to manage road safety. 28,37 The guidelines emphasized a staged approach to road safety, built on a long-term strategy that simultaneously focused on building institutional capacity and scaling up investments in road safety programs. They stressed the importance of focusing interventions first in parts of the road network with the highest concentration of injuries to maximize efficiency. Operationally, they recommended nine distinct steps for conducting a review of a country’s capacity and included detailed procedures and checklists for each step. These steps focused on identifying weaknesses in institutional capacity that impeded the ability to deliver road safety. For road safety actions, the guidelines emphasized a long-term investment strategy that aimed to continuously improve national road safety performance through successive projects based on results. Appendix III presents more details on the relationship between the guidelines, Safe System projects, and the UN Decade of Action.

Thus, the new vision of road safety at the World Bank was informed by its history in OECD countries. The Safe System approach had allowed OECD countries to successfully manage their road safety problem, which had seemed intractable prior to the 1970s, much like it seems today in low- and middle-income countries. Almost all OECD countries have seen steadily declining road traffic deaths for over four decades now. The 2004 World Report and the declaration of a Decade of Action by the UN provided the impetus to spread this vision to low- and middle-income countries.

The World Bank's Country Partnership Strategy for Argentina focuses on sustainable growth with equity, social inclusion, and improved governance. The country strategy places a strong emphasis on improving infrastructure to help economic growth and alleviate poverty. Therefore, it is not surprising that road infrastructure projects are featured prominently in the Bank’s Argentina portfolio. The Bank has long viewed roads as the ultimate enabler for its development objectives of ending poverty and fostering shared prosperity. Lowering the costs of transport improves access to jobs, food, hospitals, and schools, and thus helps eradicate poverty, improve health, and provide education. Addressing road safety is also consistent with the core objectives of the World Bank because research shows that not only are injuries more common among the poor, they disproportionately kill and disable young wage earners, often driving families into poverty. Nevertheless, operationalizing road safety in traditional World Bank projects has been a challenge in Argentina and in most low- and middle-income countries.

Typically, road projects aim to reduce the time and cost of travel. Thus, their primary components focus on improving quality of roads by paving, resurfacing, adding shoulders, sidewalks, and related civil works. Such changes have an important impact on the risk of road traffic injuries. For example, reducing travel time is often achieved through increasing vehicle speed. Unless road safety is explicitly considered in the infrastructure plans, higher speed could increase both the likelihood of crashes as well as the severity of resulting injuries. Most road-building projects do include some road safety considerations, but addressing safety is not the main goal for these projects. Thus, safety management is usually neglected and safety impacts of the projects are uncertain.

Regardless, road infrastructure projects are poorly suited for addressing the core issue impeding road safety in Argentina. The most important barrier to implementing nationwide road safety interventions was decentralization, which left the national government in a weak position to lead coordinated action by the provinces and municipalities. This was also a core issue that the Bank had sought to address in its health sector projects in Argentina. For instance, the Argentine Constitution gives the authority to manage population health and deliver health care to provincial governments. Thus, a key focus of the World Bank loan for the Essential Public Health Functions Project was to strengthen the Argentine Ministry of Health’s capacity to coordinate the actions of provinces. This included creation of two directorates within the national ministry, and a funding mechanism to transfer resources from the ministry to the provinces based on results. Similarly, the Bank’s loan in support of Plan Nacer had also aimed to renegotiate the relationship between the provinces and the national government. This was done using funding to lock-in important institutional changes that allowed more efficient program implementation. These attempts at institutional reform in the Argentine health sector dovetailed well with the Safe System paradigm for road safety that was now being promoted by the World Bank. Staff members from the transport and health sectors at the World Bank country office in Argentina had commiserated often about these issues. They were ready to mobilize when the events of 2006-08 created an opportunity to make rapid progress in road safety.
Events Leading Up to the 2010 Argentina Road Safety Project

The Santa Fe Tragedy

On October 8, 2006, a truck crashed into a bus in the province of Santa Fe, killing nine students and a teacher.\textsuperscript{46} The students had been returning from a solidarity mission to Chaco, an impoverished province of the country, where they had distributed food and clothes to poor children. The truck driver was not properly licensed and was drunk. He had been drinking at a roadside bar while watching a soccer match and had consumed more than three times the legal limit of alcohol. The incident received extensive coverage on national news, with television stations interrupting regular programming to give updates on the tragedy. President Nestor Kirchner's government sent an airforce transport plane to Santa Fe to bring the remains of the victims back to the capital.

The event became known as the \textit{Tragedia de Santa Fe} (the Santa Fe Tragedy) and became a watershed in the history of road transport in Argentina. The national Ministry of Education incorporated October 8 into the school calendar as the national day of student solidarity. The families of the students founded a group, the Family and Friends of the Tragedy of Santa Fe, which would play an important role in pressing for a major shift in road safety perception and policy.

Mass casualty road traffic crashes occur fairly regularly across the region, including in Argentina. They don't always evoke such a strong reaction from civil society and, even when they do, they are usually quickly forgotten. For instance, only a few months earlier, a tour bus in neighboring Chile had plummeted into a canyon killing 12 tourists.\textsuperscript{47} In 2002, a bus carrying Roman Catholic pilgrims had plunged into a gorge in Catamarca, Argentina, leaving 47 dead including many children.\textsuperscript{48} However, while similar events around the world have failed to galvanize action, the Santa Fe Tragedy ignited a road safety revolution in Argentina.

Concerns around road safety were not new in Argentina. In fact, legislators and advocates had made several attempts previously at trying to address road safety. In 1995, a National Traffic Act was passed in the face of the dramatic growth in traffic deaths during the recovery after the 1988 economic collapse.\textsuperscript{49} A few years later, the government developed a national road safety plan. However, there was a fundamental problem that blocked the ability of the government to undertake coordinated action in road safety. Namely, regulatory power for many important issues, including regulating traffic and health, is under the jurisdiction of provincial governments. Thus, implementing coordinated national road safety programs would require persuading multiple layers of governments across the country to respond together. Creating common traffic rules, unified data systems, and a harmonized policing strategy, had hopeless prospects in this environment.

A New Road Safety Law and a New Government Agency

The Santa Fe Tragedy created a unique opportunity to attempt to cut through the jurisdictional barriers. In the months that followed, President Nestor Kirchner, who was close to the end of his term, used the tragic event to push through a new vision. He charged the Federal Road Safety Council to develop new legislation on road safety. The council, which had representation from all provincial governments, also received substantial input from the newly mobilized victim groups.\textsuperscript{48} In August 2007, a new law, the Federal Agreement on Traffic and Road Safety, was signed by the federal government and the provinces. A few

\begin{thebibliography}{99}
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\end{thebibliography}
months later, Christina Kirchner, the spouse of Nestor Kirchner, was elected president. She brought the law to Congress as one of the first items on her policy agenda, and the law was unanimously approved. Political opposition to an issue that had gathered so much attention in civil society would have come at a very high political price. Thus, a different outcome was unlikely.

Next, adherence to the new law needed to be ratified by each of the provincial legislatures. This would be an arduous process requiring sustained pressure from politicians, bureaucrats, and advocacy groups. It took four years before all the provinces were onboard. Pressure from the victims groups played a critical role. As an example, the province of Santa Fe was among the last to ratify. In part, the reason was that local officials and legislators felt that they had already been working to address road safety with some success. However, in September 2010, tragedy struck again in Santa Fe. A van carrying children from a dance troupe collided with a truck, leaving 14 dead. In the intense media coverage that followed, road safety advocates appeared on television, blaming the event on the government for not ratifying national legislation. The province of Santa Fe rapidly fell in line and ratified the national law.

Arguably the most important aspect of the 2008 law was the creation of a new federal national road safety agency, the Agencia Nacional de Seguridad Vial (ANSV). The law gave ANSV jurisdiction over regulating road safety and also established a secure funding stream for ANSV, allocating 1 percent of all vehicle insurance fees. Sustained funding is, of course, important because it allows long-term investment in road safety programs. Equally importantly, a secure funding stream for the lead agency buffers it against political currents and waning commitment to road safety. Specific tasks for ANSV included the coordination of security officers and drivers licensing. Partly for this reason, ANSV was located in the Ministry of Interior, which was led by Minister Florencio Randazzo, who was a vocal champion for road safety and had been instrumental in the creation of the agency. Felipe Rodriguez Laguens was appointed as chief administrator of the road safety agency. Rodriguez Laguens had previously served as the secretary of municipal affairs in the province of Buenos Aires, where he had built a reputation as an excellent negotiator and consensus builder. Therefore, he was the perfect candidate for negotiating power with provinces, which was the first hurdle that confronted the agency. Within months of his appointment, Rodriguez Laguens traveled to Washington DC along with senior staff members to discuss the possibility of getting a World Bank loan.

**Role of the World Bank**

It is important not to overstate the role of the World Bank in the process that led to the passage of the 2008 law. Nevertheless, the Bank played an important advisory role that allowed it to quickly mobilize technical and financial resources to help the fledgling road safety agency. Bank staff had tried unsuccessfully to get more traction for the road safety components built into their road infrastructure projects. Similarly, their colleagues in the health sector had struggled in trying to elevate road safety to the health policy agenda in Argentina. However, the road safety problem confronting Argentina now was not about interventions but about institutional reform. The issue resonated strongly with the Bank’s work on health sector reforms in Argentina. Institutional reform was also a core concept of the new road safety paradigm that the Bank’s transport sector was promoting. In fact, the Safe System approach legitimized the view that institutional strengthening was needed before interventions could be applied, providing a common vision for the health and transport sectors. Bank staff members, including Bliss, had traveled on several occasions prior to 2008 to promote the vision and to discuss the experience of other countries with the Safe System approach.

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52 Notably, in 2012, the Ministry of Interior became the Ministry of Interior and Transport in the aftermath of a high-profile train crash in Buenos Aires that left 51 dead. The event called into question the ability of the Ministry of Federal Planning to handle transport services, highlighting once again how influential mass casualty events can be in galvanizing political action that shapes government institutions.
Thus, when the issue of a Bank loan for ANSV first arose, there was already a shared understanding of the main problems and the framework for a solution.

From 2008 to 2010, the World Bank engaged deeply with the ANSV, culminating in a loan for the Argentina Road Safety Project (ARSP). The two-stage Adaptable Programmatic Loan (APL) focused primarily on building institutional capacity for road safety in Argentina.\(^{53}\) The ANSV team visited the World Bank in November 2008 for technical discussions related to the loan. It is important to note that this was a critical period for ANSV when many institutional processes were being solidified. For instance, ANSV spent much of its first year in appointing administrators to lead its various divisions and units. Thus, the dialogue between ANSV and the Bank was occurring while ANSV was in the midst of deciding how to operationalize its mission. Therefore the Bank engagement was helpful in shaping the agency’s strategic goals and its road safety management priorities.

During this period, the Bank’s GRSF mobilized several grant funding mechanisms to help lay the groundwork for the loan and for ANSVs future work.\(^{50-54}\) The first of these was a grant for conducting road safety capacity management reviews in the provinces of Santa Fe and Cordoba using the GRSF’s appraisal tool. These reviews systematically evaluated the weaknesses in institutional processes that can hinder the ability to implement the successful execution of road safety programs. Next, GRSF gave a grant to the International Road Assessment Program (IRAP) to conduct safety ratings of three national highway corridors in the provinces of Formosa, La Pampa, and Corrientes that had high crash rates, and sections of the provincial road network in the province of Cordoba. IRAP inspections assess the safety of road infrastructure based on the presence of key attributes (for example, sidewalks, guard rails, and median barriers). IRAP thus assigns a safety star rating to the road much like new car assessment programs provide star ratings for the crashworthiness of cars. IRAP assessments also identify the changes that need to be made to infrastructure to make the road a five-star top-performing road. Thus, the subsequent ARSP loan included a component to implement IRAP recommendations for road improvement. ARSP considered these roads as road safety demonstration corridors that showcased how much highway improvements can contribute to improved road safety.

It should be noted that the Bank has promoted the implementation of these tools for several years through a growing number of grants. Road safety capacity assessments are encouraged when countries show an interest in reforming institutions. IRAP rating is encouraged usually as a precursor to road-building loans with the expectation that the loan would include implementation of the IRAP recommendations. What made the World Bank’s engagement in road safety in Argentina special was that these tools were tailored and deployed in support of a stand-alone road safety project that aimed to implement the Safe System approach.

Similarly, the Bank brokered a relationship between ANSV and the International Road Traffic Accident Database Group (IRTAD), which is a permanent working group of the International Transport Forum of the OECD. From 2010 to 2012, the Bank formalized a twinning partnership between ANSV and its counterpart in Spain, the Dirección General del Trafico, through a GRSF grant aimed at building capacity in data systems. The partnership helped build ANSV’s data observatory, identify suitable indicators, and develop a standardized data collection form (“Orange Form”) to be used in all provinces. This work on improving data systems also built an important connection between the health, transport, and public security sectors in Argentina. Prior research had already shown that police data systems substantially underreported both deaths and non-fatal injuries, making them an unreliable source for tracking national road safety performance. Thus, one important function of the road safety observatory was to improve quality of

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reporting by linking the police data with health sources, including death registers and hospital administrative records.

Another important role for the health sector emerged in making the business case for the loan. All Bank loans go through an economic appraisal, which is an important process, although by no means the most important or most difficult process. The main benefits flowing from the loan to Argentina were related to health improvements due to avoided deaths and disability. Since health is not a conventional market good, placing an economic value on improved health requires turning to the theory of welfare economics.\(^{55}\) In an analogous way, most transport infrastructure projects, such as roads, tunnels, and bridges, are primarily public sector projects with no market pricing mechanism. As a result, the economic evaluation is typically done using a cost-benefit analysis. The key metric for the economic evaluation is the internal rate of return, which is the rate at which monetized benefits to the population are realized following the investment.

However, despite the conceptual parallels in costing methods, results from economic appraisals in the health and transport sector cannot be compared because of vast differences in how these are implemented. For a typical road-building project, the economic appraisal may involve estimating reduced vehicle operation costs due to reduced congestion, shortened travel distances, and reduced wear and tear on vehicles due to improved road surfaces.\(^{56}\) In addition, transport projects often result in lower travel times, which is also monetized during the economic evaluation. In contrast, the economic benefits of health projects are typically assessed by estimating net health loss in healthy life due to death or disability, followed by applying an estimate of the economic value of a unit of healthy life. The latter may be calculated from aggregating the economic losses borne by society, such as medical costs and labor losses, or through estimates of how much people are willing to pay to avoid ill health.\(^{54}\)

Thus, the Bank’s health and transport sector staff worked together to estimate the economic benefits from ARSP using health-costing methods even though these methods are rarely applied to the Bank’s transport projects.\(^{52}\) However, since the bulk of the loan focused on institution building and not on specific interventions, it was only possible to estimate benefits for a small portion of the loan. These were the components that were related to improved safety on demonstration corridors and financial incentives for provinces to implement safety interventions. The appraisal estimated that 391 deaths and 913 serious injuries could be avoided due to these two components over a period of five years. The cost-benefit analysis yielded an internal rate of return ranging from 123 percent to 225 percent based on two methods for costing health.\(^{52}\)

It is worth noting that the estimated benefits from the ARSP loan are large when compared with infrastructure projects, although this point should not be overstated. The average internal rate of return on all World Bank road projects between 1983 and 1992 was 29 percent.\(^{57}\) Similarly, an assessment of 91 loans by the European Union and 15 loans by the European Bank for Reconstruction and Development (EBRD) found that the average internal rate of return was 18.6 percent and 23.5 percent, respectively.\(^{58}\) However, the differences in methods for valuing benefits in health and transport projects are so large that such direct comparisons of the internal rate of return only provide crude insights.

**World Bank Loan to Argentina**

By 2010, the first phase of the APL loan for the Argentina Road Safety Project was in place (box 1.1).\(^{52}\) Not only did the loan reflect a shared vision for road safety in Argentina, the loan components targeted the most difficult political and institutional challenges faced by the ANSV. In fact, what is immediately apparent from

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\(^{57}\) Canning D, Bennathan E. *The Social Rate of Return on Infrastructure Investments*. World Bank research project “Infrastructure and Growth: A Multicountry Panel Study” (RPO 680-89); 2000

box 1.1 is that this road safety loan is not a “Christmas tree” that simply includes a list of everyone’s favorite interventions. In fact, if viewed solely through the lens of effective interventions, some of the project components would seem questionable. In contrast, the key components of the project were picked to serve an overarching vision of strengthening the lead agency and helping to legitimize its authority to deliver interventions in the long term.

Consider, for instance, that an important component of the loan focuses on creating national registries: a driver license registry, and a traffic records and violations registry. The effect of such actions on injury rates is impossible to measure through high-quality impact evaluation studies. Investing in registries is unlike the numerous road safety interventions (seat belts, helmets, and guardrails), which are amenable to such evaluation. In fact, many road safety researchers would likely argue that in isolation such registries have no direct impact on road safety. However, such components of the ARSP were not meant to be viewed in isolation. Nor were there attempts made to characterize the health benefits of such components in the economic appraisal. Instead, the primary purpose of these components was to strengthen the leadership role of the national road safety agency and place the provincial and local governments in productive partnerships. This is not to say that the registries do not have a useful function in the management and administration of road safety. They undoubtedly do. However, their role in the ARSP was much less about their direct impact on road safety outcomes, and more about strengthening the capacity of the lead agency to guide coordinated action with the provinces.

The ARSP created the opportunity for provinces and municipalities to undertake specific road safety interventions through an Incentive Fund. However, even in this component, strengthening the ANSVs role as lead agency and coaxing the provinces to cooperate was a core objective. This built on the Bank’s previous experiences in health sector reform in Argentina discussed earlier. In fact, adherence to the 2008 law was made a precondition for the provincial governments before they could get access to the Incentive Fund. The funding aimed to speed up the roll-out of road safety action plans by providing performance-
based reimbursements for implementing road safety interventions from a pre-determined list. By 2014, hundreds of such interventions had already been financed by the incentives fund. These include the development of local strategic plans replicating national plans, mass media campaigns, infrastructure improvements, and road safety workshops. In addition, the ARSP focused on increasing the participation of civil society by funding 25 road safety projects in 2010 and 2011. The plethora of small projects has helped to keep road safety at the forefront of government agendas at the provincial and municipal levels.

**Looking Forward: Lessons learned to inform work on global road safety**

*Putting institutions ahead of interventions*

This case study highlights several important themes that can help understand how road safety was institutionalized in Argentina. First, it emphasizes the importance of the *Safe System* approach, which sees strengthening institutions as an important precursor to implementing interventions and large-scale road safety programs. There is a parallel here with the long-lasting debate in public health between proponents of vertical programs for single diseases (for example, HIV or malaria) versus horizontal programs that strengthen health systems and hence address multiple diseases. In this context, *Safe System* resembles the diagonal approach that has been promoted by the World Bank Strategy for Health, Nutrition, and Population Results because it seeks to strengthen institutions while simultaneously implementing the most important interventions. This approach has allowed OECD countries to successfully regulate road safety even though they continue to struggle with other multi-sectoral health issues such as tackling NCDs. Thus, rolling out the *Safe System* approach to all low- and middle-income countries should be the main priority for road safety advocates. This requires prioritizing the development of institutional capacity to deliver road safety over implementing fragmented one-off road safety projects.

**Creating Country Demand For Road Safety: Not A Chicken Or Egg Story**

Why did Argentina successfully transition to the *Safe System* trajectory when most low- and middle-income countries have not? It is certain that Argentina’s creation of a road safety agency was a key development that allowed the World Bank to engage rapidly and effectively. This leaves one wondering about what comes first: a political climate conducive to road safety institutions or engagement by World Bank to develop capacity? This case study highlights that this is the wrong question to ask. Instead, this story is about advocates for road safety in Argentina walking alongside Bank staff members toward the adoption of the *Safe System* approach. As concerns about road safety grew in Argentina, Bank staff members offered a vision and helped tailor a solution to the needs of the country. In fact, Bank staff members were promoting the *Safe System* approach in meetings and discussions well before the national road safety agency was created. Although their role in the political process triggered by the Santa Fe Tragedy was likely minimal, their prior engagement made it possible for them to move rapidly toward strengthening the national road safety agency and helping it incorporate best practices as it formed and established itself.

Thus, the second key theme of the case is about creating demand for road safety. Where there is no demand for road safety, the fundamental objective of road safety advocacy is to create it. Depending on how road safety is viewed in the country, this may require sensitizing the government and the public about the scale of the impact on health and wellbeing, while simultaneously promoting a comprehensive vision of the institutions needed to manage road safety. As countries show interest, the World Bank guidelines for road safety capacity management appraisals can help chart the path forward. As road safety institutions in countries become stronger, so does the ability of the World Bank to ensure safety components in their transport, health, and infrastructure projects. For instance, the European Bank for Reconstruction and Development (EBRD) is able to enforce stringent guidelines for road safety as part of its road loans. However, the EBRD operates in a fairly mature market for road safety. In the absence of such maturity, the goal of safety advocates is to nudge and coax countries onto a responsible developmental trajectory.

The Relative Role of Transport and Health Professionals

A third major theme of this case study is the relative role of health and transport professionals in institutionalizing road safety management in countries. It is too simplistic to think that road safety faces special challenges because it doesn’t have champions in either sector. In fact, there are many transport and health professionals who are highly motivated to address road safety but have struggled in the face of difficult institutional barriers. This case study highlights that within the Bank a key obstacle is that typical loans in either sector are poorly suited to adequately address the most pressing road safety issues. However, the new focus on stand-alone road safety loans addresses this problem by placing the central focus on road safety and by directly targeting the structural impediments to road safety in the country.

What is the relative role of the health sector in promoting stand-alone road safety projects? The health sector can help play an important role in prioritizing the problem, even though its role in implementation is secondary to other sectors. The health sector enjoys a privileged position in convincing the development community about the need to focus on particular priorities. Arguments about improving health speak loudly to the core development interests of the World Bank, its donor community, and to country governments. Thus, the health sector is best positioned to play a leadership role in making the business case for investing in road safety. This requires characterizing the scale of the health impacts, estimating economic losses, and using such evidence to help elevate the issue to an important developmental priority.

Thus, arguments about health are essential for creating demand for road safety. However, when it comes to implementation, the role of the health sector is comparatively limited, focusing on providing post-crash medical care, identifying risk factors, and monitoring and evaluation. Most activities in a balanced national road safety program will require leadership from other agencies, primarily transport, infrastructure, and enforcement. As a result, in most countries, including Argentina, national road safety agencies are positioned within Ministries of Transport or Interior Affairs, rather than the Ministry of Health.60 Thus, while the health sector needs to play a leadership role in creating the demand for road safety, health sector interventions must also be integrated and subsumed into the broader vision of road safety management through strong institutions from multiple sectors.

Conclusion

Revolutions are hard to predict and nearly impossible to engineer, even when they seek to address a vital health concern like road safety, which has many supporters. The story of road safety in Argentina provides an encouraging example of what we can do. Professionals, who cared deeply about improving safety worked for years to raise awareness, develop solutions, and disseminate good ideas to potential champions, while being cognizant of the political winds. Thus, when the road safety revolution came to Argentina, they were able to step in quickly and help shape the new institutional processes that would deliver a safer world for future generations.

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Appendixes

Appendix I: Health profile of Argentina in 2010

Leading Causes of Health Loss (DALYs) in Argentina over the Life Course

<table>
<thead>
<tr>
<th>Under 5</th>
<th>5-14 years</th>
<th>15-49 years</th>
<th>50-69 years</th>
<th>70+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Preterm birth complications</td>
<td>1 Major depressive disorder</td>
<td>1 Ischemic heart disease</td>
<td>1 Ischemic heart disease</td>
<td></td>
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<tr>
<td>2 Congenital anomalies</td>
<td>2 Asthma</td>
<td>2 Stroke</td>
<td>2 Stroke</td>
<td></td>
</tr>
<tr>
<td>3 Lower respiratory infections</td>
<td>3 Low back pain</td>
<td>3 Lung cancer</td>
<td>3 Lower respiratory infections</td>
<td></td>
</tr>
<tr>
<td>4 Neonatal encephalopathy</td>
<td>4 Drug use disorders</td>
<td>4 Diabetes</td>
<td>4 COPD</td>
<td></td>
</tr>
<tr>
<td>5 Neonatal sepsis</td>
<td>5 Self-harm</td>
<td>5 COPD</td>
<td>5 COPD</td>
<td></td>
</tr>
<tr>
<td>6 Infant mortality</td>
<td>6 Neck pain</td>
<td>6 COPD</td>
<td>6 COPD</td>
<td></td>
</tr>
<tr>
<td>7 Stillbirths</td>
<td>7 Anxiety disorders</td>
<td>7 Major depressive disorder</td>
<td>7 Major depressive disorder</td>
<td></td>
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<tr>
<td>8 Meningitis</td>
<td>8 Demenestias</td>
<td>8 Demenestias</td>
<td>8 Demenestias</td>
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<tr>
<td>9 SIDS</td>
<td>9 Other musculoskeletal injuries</td>
<td>9 Other musculoskeletal injuries</td>
<td>9 Other musculoskeletal injuries</td>
<td></td>
</tr>
<tr>
<td>10 Drowning</td>
<td>10 Lower respiratory infections</td>
<td>10 Lower respiratory infections</td>
<td>10 Lower respiratory infections</td>
<td></td>
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<tr>
<td>11 Road injury</td>
<td>11 Seizures</td>
<td>11 Seizures</td>
<td>11 Seizures</td>
<td></td>
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<tr>
<td>12 Protein-energy malnutrition</td>
<td>12 Liver</td>
<td>12 Liver</td>
<td>12 Liver</td>
<td></td>
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<tr>
<td>13 Homicides</td>
<td>13 Migraine</td>
<td>13 Migraine</td>
<td>13 Migraine</td>
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<tr>
<td>14 Cardiomyopathy</td>
<td>14 Stroke</td>
<td>14 Stroke</td>
<td>14 Stroke</td>
<td></td>
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<tr>
<td>15 Interpersonal violence</td>
<td>15 Bipolar disorder</td>
<td>15 Bipolar disorder</td>
<td>15 Bipolar disorder</td>
<td></td>
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<tr>
<td>16 Syphilis</td>
<td>16 Chronic kidney disease</td>
<td>16 Chronic kidney disease</td>
<td>16 Chronic kidney disease</td>
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<tr>
<td>17 Tinea</td>
<td>17 COPD</td>
<td>17 COPD</td>
<td>17 COPD</td>
<td></td>
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<tr>
<td>18 Leukemia</td>
<td>18 COPD</td>
<td>18 COPD</td>
<td>18 COPD</td>
<td></td>
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<tr>
<td>19 Eczema</td>
<td>19 COPD</td>
<td>19 COPD</td>
<td>19 COPD</td>
<td></td>
</tr>
<tr>
<td>20 Others</td>
<td>20 Lower respiratory infections</td>
<td>20 Lower respiratory infections</td>
<td>20 Lower respiratory infections</td>
<td></td>
</tr>
</tbody>
</table>

Source: GBD-2010

Distribution of Health Loss (DALYs) in Argentina by Cause

This is a square pie chart. Area of each square is proportional to the size of health loss. Injuries are shaded green; NCDs are shaded blue; Communicable, maternal, nutritional, and neonatal causes are in red.
Appendix II: Long-Term Road Safety Performance of OECD Countries

Source: Author’s compilation from multiple sources, including IRTAD\textsuperscript{11} and WHO Mortality Database\textsuperscript{61}


Recommendations of the 2004 World Report on Road Traffic Injury Prevention

1. Identify a lead agency in government to guide the national road traffic safety effort
2. Assess the problem, policies and institutional settings relating to road traffic injury and the capacity for road traffic injury prevention in each country
3. Prepare a national road safety strategy and plan of action
4. Allocate financial and human resources to address the problem
5. Implement specific actions to prevent road traffic crashes, minimize injuries and their consequences and evaluate the impact of these actions
6. Support the development of national capacity and international cooperation


Nine Steps in the World Bank Country Road Safety Capacity Management Review

1. Set review objectives
2. Prepare for review
3. Appraise results focus at system level
4. Appraise results focus at interventions level
5. Appraise results focus at institutional management functions level
6. Assess lead agency role and identify capacity-strengthening priorities
7. Specify investment strategy and identify Safe System implementation projects
8. Confirm review findings at high-level workshop
9. Finalize review report

Source: World Bank Road Safety Management Capacity Review and Safe System Projects

Components of Safe System Projects

1. Capacity-strengthening priorities:
   • Lead agency
   • Crash database development
   • Other institutional reforms

2. High-risk corridors and areas to be targeted with good practice interventions:
   • Infrastructure safety improvements
   • General deterrence-based traffic safety enforcement programs, supported by intensive publicity and awareness campaigns (for example, speed, alcohol, safety belts and helmets, and fatigue)
   • Improved post-crash response and emergency medical and rehabilitation services

3. Policy reforms (for example, driver licensing, vehicle safety standards)

4. Project management arrangements:
   • Lead agency role
   • Coordination

5. Monitoring and evaluation system:
   • Performance targets for high-risk corridors and areas
   • Procedures
   • Reporting arrangements

Source: World Bank Road Safety Management Capacity Review and Safe System Projects

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Appendix IV: Components of the Argentina Road Safety Project

Component 1: Institutional Capacity Building

1.1: Support to strengthen ANSV institutional capacity
(i) Creation of a national driver license registry system
(ii) Creation of a national traffic records and infractions registry system
(iii) Preparation of ANSV’s Strategic Plan for the years 2010 to 2015

1.2: Communication, awareness and education campaigns
(i) Development and implementation of a plan for national communications and education campaigns
(ii) Development of road safety education kits for teachers, students, and the general population
(iii) Provision of assistance for the design, evaluation and implementation of communication and educational campaigns through different mass media
(iv) Provision of communication, awareness and education grants to eligible NGOs for related-subprojects
(v) Non-pecuniary support to related corporate social responsibility initiatives
(vi) Provision of training and carrying out of road safety workshops and educational seminars

1.3: Improve emergency response capacity
(i) Diagnosis of current capabilities and protocols of emergency crash services on national roads
(ii) Design of action plans, improved protocols and guidelines for emergency response
(iii) Design and implementation of improved emergency coordination systems across partner agencies (for example, police, ambulance services, hospitals, insurance companies)
(iv) Training for emergency response personnel
(v) Acquisition of equipment to facilitate the work of road crash emergency personnel, including communications equipment, to enhance response capability

1.4: Strengthen capacity of the traffic control and enforcement agencies
(i) Delivery of training modules
(ii) Acquisition of alcoholmeters, speed control radar guns, and other fixed or mobile radar technology
(iii) Development of a national plan for speed control, including the implementation of speed controls, radar and photo recording systems for exclusive traffic safety purposes, as directed by the ANSV traffic control force

1.5: Project management including support for ANSV operational staff, supervision activities, and other operational expenditures to support project management for the duration of the project, including concurrent audits for specific sub-components (1.2 and 2.2) during project implementation.

Component 2: Demonstration Corridors and Incentive Fund Program

2.1: “Safe Corridors” demonstration program
(i) Support for the implementation of pilot interventions aimed at improving the safety of road infrastructure and operations
(ii) Improvement of road safety awareness through education and communication campaigns
(iii) Acquisition of technological equipment to support improved safety behaviors (for example, speed limit compliance, seat belt usage, helmet usage, reduced drunk driving)
(iv) Support to improve emergency and post-crash response activities.
2.2: Incentive Fund for the implementation of road safety policies and practices to finance innovative provincial and municipal road safety initiatives that would otherwise not be funded due to competing demands for limited financial resources.

Component 3: Road Safety Monitoring and Evaluation System within the National Road Safety Observatory

(i) Road safety information systems in the National Registry of Road Safety Statistics
(ii) Road network monitoring systems (including the design and development of a crash management system)
(iii) Road crash data collection and reporting systems
(iv) Coordination between the National Road Safety Observatory and the International Road Traffic Accident Database Group (IRTAD)
(iv) Monitoring and evaluation capabilities of ANSV
(v) Quality control audits of national road crash data
(vi) Road crash research studies relevant to the National Road Safety Observatory.

Source: ARSP Project Appraisal Document52
References


Conditional Cash Transfers and Health
Amanda Glassman, Kate McQueston

Abstract: Conditional cash transfer (CCT) programs — mainly safety net programs that transfer cash to beneficiaries in exchange for school attendance and health service utilization — are a type of multisectoral program that have had an impact on health and nutrition outcomes in a variety of settings. This case study takes a closer look at one of the world’s largest and longest-lasting CCT initiatives, Mexico’s Oportunidades program, reviewing its effects on health and nutrition, exploring how multisectoral collaboration was undertaken, and highlighting two intrasectoral collaboration challenges that have emerged over the life of the program. Finally, opportunities to enhance the health and nutrition impact of the program are discussed in a way that will be relevant to CCT in other settings.

CCT and Multisectoral Collaboration, Key Lessons:

- Formal collaborative structures at different levels of government and complementary supply-side strengthening are two key “how-to” lessons learned that emerge from more than a decade of the Oportunidades program.
- Challenges in multisectoral collaboration will emerge in any context. Lessons learned from the highlighted challenges in Oportunidades suggest the importance of aligning budget, fiscal transfer and payment policies with technical policies, as well as going further to target supply-side strengthening in those areas where CCT beneficiaries are concentrated.
- Finally, a broad lesson learned has to do with the centrality and scope of the Oportunidades evaluation. The evaluation’s rigorous design, permanence in time, and efforts to measure on both the supply and demand sides represents a best practice in CCT and in social policy in general. These allow us to use the case of Oportunidades to learn lessons both for Mexico and elsewhere.

Key Opportunities to Enhance Impact:

- Adjusting the Oportunidades health model to new disease realities and contexts.
- Connecting better with insurance/subsidy programs on the supply-side, in this case Seguro Popular.
- Dealing with poor or variable quality on the supply-side by using new incentives for quality and accountability.
- Taking advantage of the program’s targeting of rural communities to promote community-wide public health interventions, such as removing stagnant water, among others.
- Focusing on adolescents as a risk group for health and nutrition behaviors.
- Connecting better with other relevant sectors beyond education and health.
World Bank policies call for a strong focus on multisector action and investments in support of health outcome improvements. Future capacity for dialogue with clients requires examples of multisector collaboration that have yielded health as well as broader development outcomes with practical “how-to” examples of successfully engaging across sectors.

Conditional cash transfers (CCTs) are a type of multisectoral program that have had an impact on health and nutrition outcomes. CCTs have two main objectives: first, to provide a safety net to smooth the consumption of the extreme poor (alleviating short-term poverty); and second, to increase the human capital investment in poor households (alleviating long-term poverty). Payments are usually provided to women, and compliance with conditions is verified by the program. Transfers are generally sized to close the gap between average consumption in the bottom quintile of the income distribution and the extreme (or food) poverty line. Initially based in Latin America, CCT programs now operate around the world, and are regarded as successful social protection strategies.

Most CCT programs are broad, aiming to alleviate poverty and increase human capital through transfers that are conditioned on a combination of school attendance, use of well-child visits, and vaccination and/or use of nutritional supplements. However, “narrow” CCT programs that transfer cash only for the utilization of specific services are becoming more common; for example, India’s Janani Suraksha Yojana (JSY) and Nepal’s Safe Delivery Incentive Program (SDIP) specifically target maternal and newborn health improvements.

Although programs differ in their specific design features, CCTs usually share the following key features: (i) cash transfers that are conditioned on the utilization of a service, as mandated under the program; (ii) health and nutrition information, education, and communication (IEC), usually in the form of educational talks given to groups of beneficiary women; (iii) ex ante identification (“targeting”) of recipient communities or households, usually using a combination of geographic targeting and household-based targeting via proxy means tests; and (iv) verification of compliance with conditions.

Conceptually, CCT programs work to enhance health and nutrition on both the demand (households) and supply (providers) sides. On the demand-side, as income increases via the cash transfer and as knowledge is enhanced via education/IEC interventions, household-level outputs such as improved nutrition and feeding may be affected by CCTs, as could better newborn and child care, such as longer-duration and exclusive breastfeeding. At the health system level, demand-side outputs such as utilization of specific services (for example, antenatal care or well-child visits) may be affected via both the reduction in costs associated with care-seeking and increased knowledge resulting from education/IEC program components. Increased demand for services may also trigger improvements in the supply of services via greater provider responsiveness (for example, less absenteeism).

To support such improvements, some CCT have included components to support the supply-side. In its initial phase, Nicaragua’s Red de Protección Social, for example, contracted nongovernmental organizations to provide an essential package of services to CCT beneficiaries and nonbeneficiaries in intervention communities. Similarly, India’s JSY program has a supply-side component, including incentive payments to community-level health workers for bringing pregnant women to a designated facility

63. However, in African unconditional cash transfer programs, geographic targeting has been combined with community-based targeting, with results not dissimilar to proxy means tests (N. Hypher and F. Veras. 2012. Does Community-Based Targeting Really Work in Cash Transfer Programmes in Africa? http://www.ipc-undp.org/pub/IPCOnePager148.pdf.
for delivery. Together demand-side and supply-side outputs — mediated by contextual factors — are expected to jointly generate improved health and nutrition outcomes.

This case study will look at the experience of CCT through the lens of one program — Oportunidades (initially PROGRESA) in Mexico (referred to as Oportunidades for the rest of this document) — as a way to inform discussions within the Bank, within country teams, and with the Bank’s client countries. The case study highlights how a social protection intervention helped with health and nutrition; how working across sectors was achieved; major reasons for success and failure; as well as features of government leadership and outcomes achieved.

We focus on Oportunidades as one of the longest-running, best-documented CCT programs that is mainly funded by government but that has received important support and accompaniment from the World Bank and the Inter-American Development Bank (IDB) since its inception. While Oportunidades rolled out over two decades, many other countries adopted CCT programs, incorporating many — though not all — key features of the program. Since the 1990s, for example, more than 44 programs have been launched, including large-scale efforts in Argentina, Brazil, Chile, Colombia, Costa Rica, El Salvador, Ecuador, Honduras, Nicaragua, Peru and Uruguay as well as outside the region. With a new government elected in Mexico in 2012, Oportunidades itself is at a critical stage, having completed and reported on a 10-year evaluation in 2010 of the program’s effects on poverty, consumption, education, health, nutrition, and labor market participation, as well as its targeting efficiency in urban and rural settings.

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Ten Years of Evaluation

In health, the short-term evaluation found effects on food consumption and service utilization of various kinds. Oportunidades has also shown positive effects on beneficiaries' health in terms of reducing anemia in some groups, low height for age among children, child morbidity, reduced pregnancy and sexually transmitted diseases among adolescents and young adults and reduced adult obesity (see table 1.1 in Exhibits for a complete list of health and nutrition-related evaluation studies on the program).

Evaluations of the short-term effects of Oportunidades in education have found that the program increased school enrollment among children ages 9 to 15, increased school re-entry rates, and decreased school dropout and repetition rates. The program’s evaluation of longer-term effects did find a lack of impact of the program on achievement test scores, possibly due to problems with the evaluation sample due to heavy migration. Other studies have found that the effects of school enrollment were larger for girls than for boys.

Having expanded rapidly to urban areas from 2007 to 2008, the program’s targeting efficiency has declined over time given the dynamism of income among urban households and a proxy means test to identify beneficiaries that was better suited to rural rather than urban characteristics. Further, Oportunidades’ poorest beneficiaries in urban areas were found to be more likely to drop out from the program because of noncompliance with conditions in health.

Finally, the 10-year evaluation also examined quality on the supply-side in health, finding particularly disappointing results in rural areas in Secretary of Health clinics, where only vaccination, management of diarrhea complications, and well-child visits seemed to be delivered effectively, and very little else was available or even commodities stocked (results were better in Mexican Institute of Social Security [IMSS] Solidaridad clinics where some beneficiaries received services).

The program was also found to do well as a consumption smoothing policy instrument; during the financial, food price–, and H1N1-related economic downturns, the program’s inflation-adjusted benefits remained stable as did household consumption of the poor, which may also have had knock-on effects for health and nutrition (though these latter effects are not documented). Oportunidades has also fared well on head-to-head evaluations with other poverty alleviation programs funded by the Mexican government such as Procampo.

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Overview of Mexico

Mexico is a federal republic made up of 32 federal entities, including its Federal District, Mexico City.\(^{73}\) Mexico is bordered by the United States to the north, and Guatemala and Belize to the south. Internally, each state is divided into municipalities — 2,438 in total.\(^{74}\) While states and municipalities have the ability to levy property taxes — the majority of their funding is received by direct transfers from the federal government — often half or more of their total revenues.\(^{75}\) Most importantly to this case study, health and education functions and spending are almost totally deconcentrated/decentralized to the states, and the federal government has limited leverage and accountability over the use of this funding.

For much of the last century, Mexico’s population has been growing, though the pace of growth has slowed as fertility rates drop rapidly. As of 2010, information from the National Institute of Statistics and Geography (INEGI) tallies the Mexican population at over 112 million, and estimates for 2013 place the population at over 116 million.\(^{76}\) Mexico has high rates of urbanization, with the urban population comprising 78 percent of the total population.\(^{77}\) The majority (60 percent) of the Mexican population is identified as mestizo, with smaller proportions identified as Amerindian, white, or other.\(^{78}\)

In 2012, GDP per capita in Mexico was US$9,749.\(^{79}\) According to official estimates, in 2010, about 13.4 percent of the population lived in extreme poverty.\(^{80}\) Multidimensional poverty rates have fallen slightly in recent years, from 46.1 to 45.5 percent from 2010 to 2012.\(^{81}\) There is significant variation in GDP per capita by state, which ranges from an average of US$23,130 (Federal District) to US$3,657 (Chiapas) as of 2007.\(^{82}\)

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78. Ibid.  
**Economy**

Mexico is the second-largest economy in Latin America and a member of the OECD.\(^83\) Mexico’s economy has been characterized by volatility, in addition to its dependence on the United States in terms of exports and capital and labor exchange.\(^84\) In 1994, the peso crashed, leading to reduced spending on health and significant increases in poverty. Following the crisis, mortality rates — particularly among the elderly and the very young — were found to be 5 to 7 percent higher than in the years before.\(^85\)

The Mexican economy has also experienced several shocks in recent years. In 2007, a steep rise in corn prices caused by international speculation and growing demand for corn ethanol, caused the “Tortilla Crisis,” as prices of the staple food increased as much as three to four times in some regions.\(^86\) Following this, the global financial crisis, in combination with reductions in tourism caused by the H1N1 virus — totaling losses of $3 billion — led to severe contractions of the national economy in 2008–09.\(^87\)

More recently, Mexico’s economy has experienced a strong recovery, with growth fluctuating between 5.1 percent in 2010 to 3.8 percent in 2012.\(^88\) Growth slowed in 2013 (to 1.1 percent) with deceleration driven by reduced export demand and domestic investments.\(^89\)

**Demographics/Educational Attainment**

School enrollment levels have increased at all levels in Mexico, and significant proportions of children complete primary and secondary school. Enrollment levels in pre-primary and primary school are both currently over 95 percent. Secondary school enrollment is lower, averaging a 67 percent net enrollment ratio.\(^90\) Only about half of students complete secondary school, and a quarter reach higher education.\(^91\)

Mexico spends over 5 percent of GDP on education — a significant amount in total, but still resulting in low spending per student.\(^92\) In 2007, Mexico spent US$2,111 PPP per primary school student, compared to an OECD average of $6,741 PPP. Lack of resources is another key issue; over 75 percent of public schools and over 95 percent of indigenous schools lack library facilities or a computer. Perhaps as a result, the quality of education delivered to students has not been high. For every student that achieved an “excellent” test score on the ENLACE exam, 53 were scored as “insufficient” in reading and 23 were scored as

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‘insufficient’ for math. Mexican students ranked in the bottom third of 65 countries on the OECD’s 2009 PISA exam. Even so, overall literacy is high, 91.5 percent among adults, and 97.1 among youth ages 15 to 24.

Health

Life expectancy at birth in Mexico is 77 years. As of 2010, the top three causes of premature death in terms of years of life lost included ischemic heart disease, diabetes, and chronic kidney disease. This represents a significant shift in the burden of disease in the last two decades; in 1990 the primary causes of premature death were diarrheal disease, lower respiratory infections, and preterm birth complications. The large burden of NCDs is largely driven by risk factors including high body mass index, high fasting plasma glucose, and dietary risks. As of 2011, Mexico has met or exceeded expectations on the status for the Millennium Development Goals on all but two indicators — hunger and maternal health. Table 1.2 provides an overview of health system and epidemiological indicators.

The Oportunidades Program

PROGRESA was established in 1997 in rural communities with the purpose of breaking the intergenerational poverty cycle by improving human capital accumulation in poor, rural communities by providing cash transfers, conditional on behaviors relating to nutrition, health, and education. The program was rolled out in conjunction with both randomized and nonexperimental evaluation designs. In 2001 the program was renamed Oportunidades, and as of 2010 the program has cumulatively reached over 30 million beneficiaries. Annually, the program reaches approximately five million households, or 18 percent of the total population. Currently, Oportunidades is the longest-running CCT program globally, and one of the largest.

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97. Ibid.
The program works through three main channels. First, it provides cash transfers for families conditional on school attendance. The amount of this payment varies depending on the number and ages of children, and payments are higher for girls in higher levels of school. Payments are made to the female head of the household. Second, the program conditions payment on the use of certain types of health services. Health care services are provided by the Ministry of Health (MOH) and the Mexican Institute of Social Security (IMSS). Finally, the program provides nutritional supplements for all children under age two, as well as for pregnant or lactating women, and malnourished children between the ages of two and four.

**Oportunidades: How-To of Multisectoral Collaboration**

In Mexico, prior to the mid-1990s, inefficiencies and lack of achievement were prevalent in large, publicly funded programs — including subsidized food prices and electricity subsidies, and in-kind subsidies were primarily received by nonpoor, urban populations. In addition, efforts to combat poverty were managed by more than 10 different agencies, lacking coordination and leaving significant gaps in program coverage. In 1995, a task force was established by President Ernesto Zedillo to address increases in poverty that had resulted following the 1994 economic crisis, resulting in a pilot program in three cities in southern Mexico. The program was also motivated by an effort to phase out an in-kind subsidy for tortillas, a basic staple of the Mexican diet. Over the next two decades, the program was maintained and expanded nationally and now reaches about 21 percent of the total population.

From its start, Oportunidades required close collaboration between different levels of government and different sectors to identify beneficiary households, provide the health and education services that are conditioned by the program, and to verify whether these conditions have been met by beneficiary households. While Oportunidades is led, administered, and implemented by the federal Social Development Ministry (Secretaria de Desarrollo Social or SEDESOL), state-level program offices (“delegations”) were set up to manage operations and day-to-day coordination with state-level health and education departments, which are directly charged with providing health and education services in general and to program beneficiaries. Led by SEDESOL/Oportunidades, a technical committee for national coordination was set up and encompasses all federal agencies involved in the provision of services to Oportunidades beneficiaries, including the SSA (Health and Assistance Ministry at state-level), SEP (Public Education Ministry), IMSS (Mexican Institute of Social Security), and others.

In recent years, efforts have been made to dovetail supply-side strengthening efforts in health and education with Oportunidades beneficiaries. The Seguro Popular — a capitated health transfer to states launched in 2003 — used Oportunidades beneficiary lists to identify Seguro Popular enrollees in a first phase. The SEP’s School Quality Program is instructed to deploy to communities with a large share of Oportunidades beneficiaries on a priority basis, while a summer tutoring program run by CONAFE also gives priority to Oportunidades beneficiaries. In addition, programs similar to Oportunidades (scholarship programs and others) are instructed to minimize duplications in coverage.

Formal collaborative structures at different levels of government and complementary supply-side strengthening are two key “how-to” lessons learned that emerge from more than a decade of Oportunidades work.

However, intersectoral coordination is an ongoing challenge. Here we provide two examples on the health side to illustrate the challenges of collaboration across sectors: health benefits packages to be provided to beneficiaries and supply-side quality differentials by state. Both examples illustrate the potential for social protection and health sectors to work synergistically to reach the poor, but also the pitfalls that can occur if

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104. Ibid.
105. UNDP 2011.
106. Ibid.
policy and budgetary incentives are not aligned in the same direction. While the example comes from Mexico, similar issues have emerged in other settings as well.

On health benefits, the Oportunidades manual included a list or package of health services (Paquete Basico Garantizado de Salud — PBGS) that was to be provided to program beneficiaries by the health department at state level (SSA in Spanish acronym) or IMSS Solidaridad clinics. About 8 percent of Oportunidades/SEDESOL’s budget was transferred to the SSA or IMSS-Oportunidades to cover the variable costs — mainly medicines — associated with the PBGS. This funding was transferred directly from the Treasury to the SSA in the program’s name, and the National Social Security Council (CNSSS) retained a portion to purchase medicines centrally and passed the remainder on to the states. However, neither the list nor the associated payment had been adjusted significantly since the program’s start, and there was little accountability or tracking of how the monies were used or what services were provided beyond the conditions themselves. Further, 27 CAUSES interventions were also required to be provided “progressively” to Oportunidades beneficiaries who were not enrolled in Seguro Popular, yet the funding to SSA for uninsured Oportunidades beneficiaries was not modified substantially. As a result neither funding nor incentives are aligned for greatest impact.

Funding and quality differentials at the state-level also affect the impact of the program. While some cash transfer programs are lenient in terms of conditionality, Oportunidades has rigorous compliance measurement with regard to meeting health conditions, which can disadvantage rural areas with limited access to health services. The health impact of Oportunidades has been most pronounced in areas with direct access to services; remote areas with limited health infrastructure have seen less progress — leading to lower coverage of key services for the most vulnerable populations. Research from Lozano et al. (2006) has found disparities at the state level in the effective coverage of health interventions and in terms of the type of interventions. Just over 20 percent of areas with communities of more than 40 percent indigenous people have direct access to health services. For the health centers that are available in rural areas, low-quality services, inadequate facilities, lack of access to medicines and high staff turnover reduce the effectiveness of health services and create distrust of the health system. Research from Alvarez (2007) finds lower survival rates of beneficiaries receiving medical care provided by the Secretary of Health versus those receiving care from the Mexican Institute of Social Security (IMSS) Solidaridad program. This research also shows that the extreme poor and indigenous populations have higher rates of dropping out of the program than other populations, perhaps due to higher opportunity costs of reaching more distant health facilities.

Challenges in multisectoral collaboration will emerge in any context. Lessons learned from the highlighted challenges in Oportunidades suggest the importance of aligning budget, fiscal transfer, and payment policies with technical policies, as well as going further to target supply-side strengthening in those areas where CCT beneficiaries are concentrated.

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Finally, a broad lesson learned has to do with the centrality and scope of the Oportunidades evaluation. The evaluation’s rigorous design, permanence in time, and efforts to measure on both the supply and demand sides represent a best practice in CCT and in social policy in general, and allow us to use the case of Oportunidades to learn lessons both in Mexico and elsewhere.

**Developments and Opportunities**

The program is at a crossroads. While the health and nutrition effects of the program are amply documented (summarized in table 1.1 in Exhibits), there are clear opportunities to further improve outcomes, particularly among the poorest beneficiaries. Among the options are the following:

**Adjusting the health model:** Given the drop out of poorest beneficiaries due to lack of compliance with health conditions and disappointing results on some outcomes, there is an opportunity to take a new look at the conditions and the health model in general. The conditions for disbursement of the nutrition grant focused on maternal and child health care, although the disease transition has advanced quickly in all segments of the population. Indeed, one study found that the program was actually increasing the prevalence of body mass index and blood pressure among beneficiary women. The health talks or *platicas* continued to be given by health clinic staff using flipcharts and medical diagrams, and had not been evaluated. Finally, the expansion of the program into urban areas led to saturated clinics with long lines and beneficiaries complaining that clinic hours were not convenient given that most beneficiaries worked outside the home six or more days a week.

**Connecting better with Seguro Popular:** While Seguro Popular tried to give priority to Oportunidades beneficiaries in its initial phase, Seguro Popular was extended most where health facilities had received accreditation to provide the CAUSES benefit plan. In general, these facilities were not located in the communities where most Oportunidades beneficiaries lived, and as a result, Oportunidades beneficiaries were very slowly affiliated to Seguro Popular. Even now, 2012 household survey data show that only 76 percent of Oportunidades beneficiaries are enrolled in Seguro Popular. This is a missed opportunity for the health sector, since Oportunidades has better poverty targeting than Seguro Popular in both rural and urban areas.

**Dealing with poor or variable quality on the supply-side:** Unlike CCT programs elsewhere, supply-side readiness to provide the Oportunidades list of services was not analyzed in any detail at the start of the program. A 2008–10 evaluation of SSA health clinics used by beneficiaries in 2007 — using “vignettes” — classified almost half as “low or medium-low” quality. State differentials in access and quality of care have already been noted, as have sociocultural barriers to utilization. Yet results-based financing experience via the Bank’s Health Results Innovation Trust Fund suggests that greater financial, reputational, measurement, or other kinds of incentives exist to motivate better quality and accountability for service provision on the supply-side. More can be done to marry these demand- and supply-side incentives in multisectoral collaboration around CCT.

**Mobilizing communities for health and nutrition:** Oportunidades has always had a significant community mobilization component; in the early days of the program, community mothers would organize beneficiary women to pick up payments, attend health talks, comply with conditionality, and occasionally undertake community projects (for example, clean ups). However, these actions rarely included community

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works that mattered for health, such as getting rid of standing water, putting in concrete floors (in spite of
the existence of a well-evaluated program to install concrete floors known as Piso Firme), and the like.

**Adolescents as a risk group:** Increasingly the program’s evaluation surveys and broader household
surveys identified a group of at-risk school-age youth that neither studied nor worked (known as nini — ni
estudien, ni trabajen). *Oportunidades* both pioneered new ways of measuring health risk behaviors among
adolescents using technology-based surveys, and also detected effects of the program on risk behaviors
and contraceptive use themselves. The program also experimented with transfers to teens themselves, to
assess whether they would be more likely to stay in school if they, rather than their mothers, were
responsible for complying with conditions and receiving the cash transfer. More could be done to tailor
outreach and communications to this age group.

**Connecting with other relevant sectors:** While *Oportunidades* had state-level multisectoral commissions
in place, there was continuous difficulty in generating genuine incentives for intersectoral collaboration due
to limited real-time data and accountability on the performance of the supply-side (in both education and
health). Further, connections between the program and other kinds of related infrastructure and social
programs were weak at the state-level (water, concrete floors). The program also faced challenges in
coordinating with other federal programs such as child care and mental health, among others. However, a
great achievement of the program related to the use of identification/registries and savings accounts for
other programs, including Seguro Popular.

**Looking Forward**

As World Bank teams look to enhance incentives for effective multisectoral action for health, CCT or social
cash transfer programs are good places to start. The programs already illustrate how increasing income in
poor households can help with consumption and utilization, and finer tuning and greater effectiveness on
the sector-specific issues might make a major difference for health impact at a relatively modest additional
cost.

*Oportunidades*’ data- and evaluation-rich experience also illustrates the many ways in which a CCT could
enhance health and nutrition impact and create synergies with the supply-side investments that are
ongoing. Indeed, a recent paper on Brazil suggests that drops in infant mortality were associated with the
synergistic effects of that country’s Family Health Program (SUS) and CCT (*Bolsa Familia*), particularly for
impoverished and underserved populations.116 Yet making these synergies a reality will require clear
mandates and political support at the highest level as well as the alignment of budgetary and political
incentives across sectors at different levels of government to reach health and nutrition goals.

**Discussion Questions:**

- How could the program do better at addressing the noncommunicable disease burden and its
  prevention and management?
- How could better incentives and strengthened accountability be created between the program, the
  Treasury, and the Ministry of Health at both federal and state levels?
- What does the *Oportunidades* experience suggest for multisectoral collaboration in other settings?
- What are the implications for the composition and focus of World Bank policy dialogue and project
teams?

Health* 103 (11): 2000–06.
### Table 1.1 Evaluations of Health and Nutrition Outcomes and Outputs Associated with Oportunidades

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Study authors, year</th>
<th>Effect size</th>
<th>CI</th>
<th>Link to paper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate prenatal monitoring</td>
<td>Barber and Gertler 2009</td>
<td>0.081</td>
<td>0.030 – 0.132</td>
<td><a href="http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2846434/">Link</a></td>
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<td>Adult complete vaccination coverage</td>
<td>Salinas-Rodríguez and Manrique-Espinoza 2013</td>
<td>0.055</td>
<td>0.028 – 0.083</td>
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<tr>
<td>Any STI (youth)</td>
<td>Gutierrez 2012</td>
<td>Boys: -0.18</td>
<td>Boys: -0.45 – 0.00</td>
<td><a href="http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1982065&amp;download=yes">Link</a></td>
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<tr>
<td></td>
<td></td>
<td>Girls: 0.03</td>
<td>Girls: -0.11 – 0.12</td>
<td></td>
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<td>Births attended by skilled personnel</td>
<td>Urquieta et al. 2009</td>
<td>0.114</td>
<td>0.020 – 0.208</td>
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<td>BMI</td>
<td>Fernald et al. 2008</td>
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<td>BMI-for-age</td>
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<td>Caesarean section</td>
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<td>-0.010 – 0.112</td>
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<td>Child behavioral problems</td>
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<td>Effect size</td>
<td>CI</td>
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<td>0.19 – 0.74</td>
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<td>0.48 – 0.99</td>
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<td>Height-for-age</td>
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<td>Hemoglobin values</td>
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<td>1.18 – 1.67</td>
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<td>Stunting</td>
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<td>Tetanus toxoid for mother</td>
<td>Barber and Gertler 2009</td>
<td>0.368</td>
<td>-0.220 – 0.956</td>
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<td>Table 1.2 Health System and Epidemiological Indicators</td>
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<td></td>
<td>199 5</td>
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<td>200 6</td>
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<tr>
<td><strong>Heath financing</strong></td>
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<tr>
<td>Health expenditure per capita</td>
<td>177. 21</td>
<td>328. 48</td>
<td>478. 44</td>
<td>515. 03</td>
</tr>
<tr>
<td>(current US$)</td>
<td></td>
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<tr>
<td>Health expenditure, public (%)</td>
<td>2.17  2.36</td>
<td>2.64  2.57</td>
<td>2.62  2.74</td>
<td>3.10  3.10</td>
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<td>of GDP</td>
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<td>Health expenditure, private (%)</td>
<td>2.98  2.71</td>
<td>3.23  3.11</td>
<td>3.15  3.10</td>
<td>3.33  3.23</td>
</tr>
<tr>
<td>of GDP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health expenditure, total (%)</td>
<td>5.15  5.07</td>
<td>5.87  5.68</td>
<td>5.78  5.84</td>
<td>6.43  6.33</td>
</tr>
<tr>
<td>of GDP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Burden of disease</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average life expectancy</td>
<td>—</td>
<td>—</td>
<td>75</td>
<td>75</td>
</tr>
<tr>
<td>Immunization, DPT (% of children ages 12–23 months)</td>
<td>91</td>
<td>97</td>
<td>98</td>
<td>98</td>
</tr>
<tr>
<td>Incidence of tuberculosis (per 100,000 people)</td>
<td>46</td>
<td>31</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>Prevalence of HIV among adults age 15 to 49 (%)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>.3</td>
</tr>
<tr>
<td>Antiretroviral therapy coverage among people with advanced HIV infection (%)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Malnutrition prevalence, height for age (% of children under 5)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>15.5</td>
</tr>
<tr>
<td>Malnutrition prevalence, weight for age (% of children under 5)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>3.4</td>
</tr>
<tr>
<td>Maternal mortality ratio (national estimate, per 100,000 live births)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>61.9</td>
</tr>
<tr>
<td>Low birthweight babies (% of births)</td>
<td>—</td>
<td>7.56</td>
<td>8.4</td>
<td>8.2</td>
</tr>
<tr>
<td>Mortality rate, neonatal (per 1,000 live births)</td>
<td>13.3</td>
<td>10.5</td>
<td>8.4</td>
<td>8.2</td>
</tr>
<tr>
<td>Mortality rate, under 5 (per 1,000 live births)</td>
<td>34.7</td>
<td>25.4</td>
<td>19.5</td>
<td>18.9</td>
</tr>
</tbody>
</table>

60
<table>
<thead>
<tr>
<th>Country infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians (per 1,000 people)</td>
</tr>
<tr>
<td>1.6</td>
</tr>
<tr>
<td>Hospital beds (per 1,000 people)</td>
</tr>
<tr>
<td>1.2</td>
</tr>
</tbody>
</table>

Source: World Bank Data Bank, Global Health Observatory Data Repository
http://apps.who.int/gho/data/?theme=country&vid=13600.
Multisectoral HIV and AIDS Responses: Lessons for Task Team Leaders
Laura Frost, Beth Anne Pratt

Abstract: Responses to HIV and AIDS at the global, national, and subnational levels have undergone substantial evolution and expansion since the HIV virus was first identified in the 1980s. While early interventions were confined to medical and public health approaches to curtail the epidemic, today a wide group of stakeholders plan, implement, and evaluate multisectoral responses in countries. Important lessons can be drawn from the three decades of these multisectoral experiences. This case study examines how four countries — India, Kenya, Namibia, and Thailand — developed, implemented, and sustained multisectoral responses to HIV and AIDS. The case study then identifies lessons learned for task team leaders about how to engage effectively across sectors.

How to Work across Sectors Effectively: Key Lessons

- Ensure national strategic plans (and their accompanying action plans) involve multisectoral participation in plan formulation, are results-oriented and costed, include frameworks for sectoral leadership and coordination, and are integrated within longer-term vision and planning frameworks.
- Understand the priorities and perspectives of all sectors and identify mutual benefits before proceeding with multisectoral action.
- Plan activities multisectorally, but implement sector-by-sector. Each implementing sector should be able to articulate what outcomes they are contributing to.
- Ensure communities and the private sector have incentives for collaboration, such as subsidies and contracts.
- Develop frameworks and tools for systematic data sharing among sectors to facilitate reporting against multisectoral indicators.
- Institute the multisectoral response at decentralized levels through structures with some autonomy in order to successfully partner with multiple sectors, particularly civil society and people living with HIV.

The AIDS response is among the most successful public health initiatives of the past 50 years. People living with HIV, affected communities, scientists, and policy makers joined in common cause, driven by the urgency and scale of the pandemic…. New global, regional, and national institutions were created to ensure HIV prevention and treatment. Pioneering mechanisms of inclusion and accountability enabled affected communities to participate meaningfully in governance processes. Citizen activism spurred unprecedented political leadership…. In a spirit of global responsibility, Western governments and the private sector played vital parts in scaling up HIV treatment worldwide.

Michel Sidibé and Kent Buse, UNAIDS

Introduction

Responses to HIV and AIDS at the global, national, and subnational levels have undergone substantial evolution and expansion since the HIV virus was first identified in the 1980s. While early interventions were confined to medical and public health approaches, today a wide group of stakeholders plan, implement, and evaluate multisectoral responses in countries. Multisectoral approaches to HIV and AIDS are those that seek to reduce HIV prevalence, provide treatment and care, and mitigate the impacts of the epidemic on affected populations by employing an appropriate mix of health- and nonhealth-based interventions and involving a broad array of stakeholders, including communities, in their design and implementation.118 AIDS programs are often the first large-scale chronic disease initiatives in low- and middle-income countries (LMICs), offering local and effective multisectoral models that can be emulated, adapted, and expanded to tackle other chronic conditions predominantly associated with noncommunicable diseases (NCDs).119 As access to antiretroviral therapy expands, the HIV response is evolving from a disease-specific emergency response to a chronic disease management challenge, which needs to be addressed within the context of other chronic health conditions. This epidemiological transition, coupled with a fast-growing number of people with other chronic diseases, has considerable implications for health systems and societies.120 For instance, leveraging the resources and models and learning from the experiences (positive and negative) of multisectoral HIV/ AIDS programs could benefit other chronic conditions; and a greater emphasis on strengthening health systems through universal coverage, stronger primary health care, integrated chronic care delivery, and community-based interventions is likely to be valuable for any condition. It is also important to acknowledge and address the potential risks of setting up yet another multisectoral but vertical program in resource-constrained countries — and to promote integration.121

This case study examines how four countries — India, Kenya, Namibia, and Thailand — developed, implemented, and sustained multisectoral HIV and AIDS responses. It assesses how governments in these countries structured their multisectoral response; how they engaged public sector entities, civil society, and the private sector; their achievements; the challenges they encountered in the multisectoral response; and their results. The case study highlights lessons learned for task team leaders at the World Bank about how to support countries in working effectively across sectors.

The case study begins with an overview of the emergence and development of multisectoral approaches to HIV and AIDS, and the involvement of global institutions including the World Bank. It then moves to a discussion of the multisectoral response undertaken by the four case study countries, with particular attention to governance structures, policies and national strategies, integrated data systems, and implementation. The study concludes with a summary of experiences across the four countries and lessons learned for working effectively across sectors. The case study is based on published and unpublished documents, as well as interviews with key informants.

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Section I. The Emergence and Development of Multisectoral Approaches to HIV and AIDS

The Birth of Multisectoral HIV/AIDS Responses

In the late 1970s, doctors in central Africa began to notice a spike in uncommon infections and health conditions. Pneumocystis carinii, cryptococcal meningitis, Karposi’s sarcoma, and a wasting disease of unknown origin were not only proliferating among their patients, but also killing them at an alarming rate. By the time the HIV virus was definitively identified in 1985, HIV/AIDS was widespread across many parts of Africa, and a handful of cases had already been detected in Asia.122 Fifteen years later, an estimated 34 million people were infected with the virus, another 18 million were estimated to have died, and AIDS was officially the world’s fourth-biggest killer.123

In many countries, the initial response to the disease was led and financed by the Ministry of Health, and was designed as an emergency program focused primarily on blood safety protocols.124 Efforts expanded in the late 1980s through the early 1990s to include provision of clinical services to sick patients in hospitals, measurement of seroprevalence, and prevention campaigns. In February 1987, WHO established its Global Program for AIDS to provide technical assistance to countries, limited financing for national public education campaigns and HIV surveillance, and some support for blood screening and care and counseling.125 Civil society mobilization against HIV and AIDS grew; many individuals who were themselves HIV positive were key leaders in the movement.

In spite of these early efforts, many countries experienced enormous increases in the number of people living with HIV (PLWH), accompanied by increasing death rates and rising numbers of orphans. In Asian countries, very high prevalence rates were concentrated among commercial sex workers, men who have sex with men (MSM), injecting drug users (IDUs), and other high-risk groups, leading to fears that HIV/AIDS would spill over into the general population. In African countries, heterosexual transmission had already led to a devastating generalized epidemic — the impact of which was increasingly felt across all social and economic strata. As the epidemic spread, there was growing realization by both political leaders and global technical experts in the mid-1990s that HIV/AIDS was a long-term issue necessitating a comprehensive public health response. Countries began implementing behavior change interventions, the prevention and treatment of sexually transmitted infections, risk- and harm-reduction programs for IDUs, and interventions to reduce mother-to-child transmission.126

Recognizing that the impact of HIV/AIDS was now felt across most sectors of society, countries started extending these public health interventions through nonhealth government ministries at the national and subnational levels, and engaging civil society and the private sector as key partners in the fight against the epidemic. Initially, Ministries of Health utilized these sectors as venues through which to channel public health efforts to reduce prevalence. Many stakeholders in these sectors were motivated to participate by the need to protect their own interests and operations.127 Over time, as nonhealth sectors gained more experience with programming and a better understanding of the impact of HIV and AIDS, the multisectoral approach was fine-tuned to provide a more comprehensive package of HIV and non-HIV services to target populations across multiple sectors of government and society.128

122. By “identified” we refer to the recognition by the international community that the viruses LAV and HTLV-III were the same virus, from the same source, and were the cause of AIDS. See J. L. Marx. 1985. “A Virus by Any Other Name.” Science 227 (4693): 1449–51.
124. Gavian et al. 2006, see note 60.
127. Ibid.
128. Ibid.
Creating Innovative Mechanisms for Governance at Global and National Levels

In an effort to improve coordination of multisectoral action, the United Nations began a discourse to mobilize key agencies whose mandate could accelerate country responses to HIV. In 1995, WHO’s Global Program on AIDS ended, and in January 1996, the Joint United Nations Program on AIDS (UNAIDS) was launched as a cosponsored program of existing UN agencies, with its secretariat in Geneva.

UNAIDS initially brought together six diverse, multisectoral UN and UN-specialized agencies (WHO, UNDP, UNICEF, UNFPA, UNESCO, and the World Bank) concerned with the impact of HIV and AIDS on the health and economic, social, and cultural welfare of countries. Additional agencies later joined, including the International Labor Organization, World Food Program, and the UN Office on Drugs and Crime. UNAIDS was designed to involve all sectors that can affect, or be affected by, the epidemic. As Peter Piot, the first executive director of UNAIDS, stated at the program’s launch: “It has become clear that this epidemic is too complex to be tackled by one single approach. In institutional terms, in the UN system that means that it has to be dealt with by several agencies, in a coordinated manner.”

UNAIDS established a UN Theme Group on HIV/AIDS in each country so that representatives of the sponsoring agencies could share information and plan and monitor activities among themselves, and with national-level partners. UNAIDS also encouraged and provided technical support for countries to create multisectoral national AIDS strategies.

Following the adoption of the UN Millennium Development Goals in 2000, government representatives met at the UN General Assembly Special Session dedicated to HIV/AIDS to secure global commitment to better coordinate and integrate national, regional, and global AIDS responses, and to set ambitious targets. The session resulted in the 2001 United Nations General Assembly Special Session (UNGASS) Declaration of Commitment, which included within it a directive to countries to integrate AIDS responses into their development frameworks at national, sectoral, and local levels through mainstreaming. Mainstreaming HIV is a process that enables development actors to address the causes and effects of AIDS in an effective and sustained manner, both within their workplace (internal mainstreaming) and through their usual work (external mainstreaming).

The UN’s commitment to mainstreaming, and the multisectoral response more generally, was reaffirmed a decade later in the UN General Assembly’s 2011 Political Declaration on HIV and AIDS.

At the country-level, in recognition of the need for a multisectoral response, many governments created new coordinating mechanisms in the middle to late 1990s to better target efforts beyond the health sector. National HIV/AIDS coordinating mechanisms — referred to in this case study as NACs — were established. In some countries these were placed within Ministries of Health, but many countries located them outside these ministries and under the direct supervision of the executive office (such as the Office of the Prime Minister or President). Multisectoral in design, NACs were set up to oversee strategic planning, decision making, coordination, and resource allocation around HIV and AIDS across sectors.

Financing a Multisectoral HIV/AIDS Response

In 2000, the World Bank supported the multisectoral HIV and AIDS response with the launch of its Multicountry AIDS Program (MAP) for Africa. The MAP’s goal was to increase access to HIV prevention, care, and treatment programs, and emphasize local responses and multisectoral actions. It was designed to be a fast, comprehensive, multisectoral, and renewable instrument to finance the public

and private sectors. By mid-2006, $805 million had been disbursed, with a significant amount of funding going to civil society as well as to the public sector and NACs. This funding helped promote and facilitate a multisectoral response in many countries, and contributed to increased political commitment, the mobilization of additional resources for NACs, and the decentralization of the HIV response. Many projects, however, struggled to perform due to their complex design — including the large number of sectors involved — resulting in reduced clarity and responsibility of each sector. Other challenges included the reliance on newly created and inexperienced NACs and insufficient focus on monitoring and evaluation systems.

By 2002, the Global Fund to Fight AIDS, Tuberculosis and Malaria was established. The availability of Global Fund financing had implications for the coordination of multisectoral responses at the national level, especially through its establishment of multi-stakeholder Country Coordinating Mechanisms (CCMs) for the development and submission of grant proposals. CCMs were important in that they expanded the participation of civil society in governance of the HIV/AIDS response, but they also created added complexity to the AIDS architecture in countries. While the roles, functions, and responsibilities between NACs and CCMs were distinct on paper, in practice, they sometimes had overlapping members, and this led to conflict of interests in some instances. They have also been perceived as weakening the role of NACs in some countries, especially those in which the majority of HIV funding comes from the Global Fund.

The number of global actors involved in the multisectoral response was therefore growing, and global funding for HIV quadrupled between 2001 and 2005. However, the planning and implementation of these global initiatives were often done in isolation and required governments to spend time on each partner’s separate reporting requirements. In response, UNAIDS, developing countries, and partners agreed to the “Three Ones” principles in 2004, which called for one agreed-upon national framework of action against AIDS in each country that unifies all partners; one national AIDS coordinating authority with a broad-based multisectoral mandate; and one agreed-upon country-level monitoring and evaluation system.

By 2012, the United States was the largest donor for HIV (both bilateral and multilateral), accounting for almost two-thirds (63.9 percent) of disbursements by donor governments. The United Kingdom was the second-largest donor (10.2 percent), followed by France (4.8 percent), Germany (3.7 percent), and Japan (2.7 percent). The type of financing has evolved over time with donor governments now providing multiple types of financing instruments and other assistance with an emphasis on accountability and results-based financing.

The achievements and challenges of multisectoral responses can be further examined through the lens of four country case studies.

132. Ibid.
133. Ibid.
134. Ibid.
138. Ibid.
Section II. The Process of Developing and Sustaining Multisectoral Responses in Four Countries

Four case studies — India, Kenya, Namibia, and Thailand — provide a detailed look at the emergence and development of multisectoral HIV and AIDS responses at national and subnational levels. The countries were selected on the basis of their diverse economic and epidemic profiles (concentrated, generalized, and mixed epidemics) and the different degrees of success in achieving multisectoral results.

<table>
<thead>
<tr>
<th>INCOME CLASSIFICATION</th>
<th>Lower-middle-income</th>
<th>Low-income</th>
<th>Upper-middle-income</th>
<th>Upper-middle-income</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADULT HIV PREVALENCE (%)</td>
<td>0.3</td>
<td>6.2</td>
<td>13.4</td>
<td>1.2</td>
</tr>
<tr>
<td>EPIDEMIC PROFILE</td>
<td>Concentrated epidemic among sex workers, MSM, and IDUs in a large and populous country</td>
<td>Mixed epidemic; high-risk groups are sex workers, also MSM and IDUs</td>
<td>Generalized epidemic with one of the highest prevalence rates in the world</td>
<td>Growing epidemic among IDUs, sex workers, and MSM, threatening a generalized epidemic</td>
</tr>
</tbody>
</table>

Source: Compiled by author

For each country case study, particular attention is given to governance structures, policies and national strategies, data systems, and implementation, as well as lessons learned in engaging across sectors.

142. UNAIDS 2013.
Country Case Study: India

Background

India, in South Asia, is the second most populous country in the world with 1.2 billion people. It is a lower-middle-income country with a democratic government and the fourth-largest economy in the world. A federation with 35 states and territories, 640 districts, and 5,924 subdistricts, the HIV response in India is complicated by "the country’s scale; the diversity, size, and mobility of the populations at risk; and the highly stigmatized nature of HIV."143

HIV was first detected in India in 1986 and has evolved into a diverse and heterogeneous epidemic concentrated among sex workers, men who have sex with men (MSM), and injecting drug users (IDUs).144 The country’s first National AIDS Committee was established in 1987 as a small unit within the Directorate General of Health Services in the Ministry of Health and Family Welfare. The initial response focused on surveillance in high-risk areas and blood screening. As the epidemic spread, there was recognition that a broader response was required, with a dedicated division within the Ministry of Health and Family Welfare.

The Structure of the Multisectoral Response

In 1992, the first HIV/AIDS program — the Indian National AIDS Control Program (NACP-1) — was launched with funding from the World Bank. Under NACP-1 (1992-1999), the National AIDS Control Organization (NACO) was established within the Ministry of Health and Family Welfare to steer the program. The placement of NACO within the Ministry of Health and Family Welfare ensured collaboration between central and state health ministries. NACO was also empowered to function independently in day-to-day administrative and functional matters.145

At the subnational level, State AIDS Control Cells were established in states and union territories, embedded within respective Directorates of Health Services. Under the program’s second phase, NACP-II (2000–06), State AIDS Control Cells were converted to registered societies — called State AIDS Control Societies (SACS) — directed by senior officers of the Indian Administrative Services (IAS) and with representation of nongovernmental organizations (NGOs) and community-based organizations (CBOs) on executive committees. One of SACS’ key functions is to select and fund NGO and CBO partners for service delivery, thereby shifting NACO’s role from direct service delivery to strategic leadership.

Through these national and subnational structures, the government response has evolved and intensified over the course of four phases of the NACP (NACP-I, 1992–99; NACP-II, 2000–06; NACP-III, 2007–12; and NACP-IV, 2013–17) (see figure 1.1 below).146


68
In 1998, NACO formalized the HIV sentinel surveillance system for collecting prevalence data. In 2012–13, data were collected in 763 sites. A Computerized Management Information System (CMIS), installed in all SACS, collects monthly information on all HIV and AIDS programs implementing targeted interventions, including those programs of NGOs and CBOs. NACO guides the overall data system and designs protocols. The SACS then adapt these, and collect and analyze the data.

**Key Sectors**

The NACP focuses on prevention and treatment, and policies and programs to mitigate the impact of AIDS and to change the societal factors that influence vulnerability to HIV in the long term.147 This response depends on involvement from multiple sectors:

- **Public sector**: Internal mainstreaming of HIV/AIDS prevention in all ministries and departments of the government; external mainstreaming is promoted by NACO in priority ministries.
- **Civil society**: NACO and SACS contract NGOs and CBOs to deliver targeted interventions for HIV prevention among high-risk groups.
- **Private sector**: Many companies across India conduct workplace programs. NACO has begun formalizing public-private partnerships with some companies for prevention and treatment programs.

**Achievements**

- **Establishment of semi-autonomous, effective governance structures at national and subnational levels**: Once converted to societies, SACS improved their accountability and became more efficient in their disbursement of funds, communication with partners, and overall decision making.148 The autonomy of SACS provided a “space where multiple sectors could come together outside of government.”149 The relative autonomy of NACO and SACS has allowed these organizations to avoid bureaucratic delays in addressing the epidemic and respond more quickly. NACO and the SACS are led by officers from the Indian Administrative Services (IAS), rather than technical health leaders. IAS officers are senior public administrators with experience working across sectors with a variety of agencies.150 Working closely with technical teams, they have brought these skills to the management of NACO and SACS.

- **Steady expansion of NGOs and CBOs in delivering targeted interventions**: In 2006, NGOs and CBOs were involved in 1,080 projects, and their involvement has increased throughout the NACP phases.

- **Promotion of internal and external mainstreaming in the public sector**: Internal mainstreaming of HIV/AIDS has been achieved in all 31 ministries and departments of the government. Each public sector body has one dedicated HIV/AIDS unit with at least one focal staff person, and a situation assessment report and five-year action plan. Under NACP-III, external mainstreaming was attained with many of the prioritized ministries. For example, the Red Ribbon Express with the Ministry of Railways (see box 1.1 above) has made its journey three times — in the first journey, the train

150. Ibid.
travelled to 180 stations in 22 states, reaching 6.2 million people with train services and outreach.\textsuperscript{151}

The project has had strong political support from both national and state levels, and helped mobilize people to visit the train and its related outreach activities. Engaging with the public sector in external mainstreaming has been successful in India when there has been political will at the highest levels, open discussion of the topic, and implementation of large-scale strategies.\textsuperscript{152}

- **Collection and utilization of data from multiple sectors:** India has been particularly successful in using the evidence collected from surveillance and the Computerized Management Information System (CMIS) to make ongoing policy, programmatic, and resource allocation decisions.\textsuperscript{157} NACO’s role in designing and overseeing the monitoring and evaluation (M&E) system ensures standardization of the data collected.

### Box 1.2 Example of Multisectoral Action: Engaging Nonhealth Public Sector Entities in India

On World AIDS Day in 2005, Prime Minister Dr. Manmohan Singh stated, “the National AIDS Control Programme must move out of the narrow confines of the health department and become an integral part of government departments and programs to create a national response, which alone can help reverse the epidemic.”\textsuperscript{153} Under NACP-II, the prime minister constituted the National Council on AIDS, comprising 31 ministries, chief ministers, civil society representatives, networks of PLWHA, and private sector organizations. In the first year, the focus of activities was on integrating HIV into the ongoing activities of ministries. The National Council on AIDS met only once, in February 2006, as it was difficult to coordinate such a large group.\textsuperscript{154} But NACO, SACS, and technical experts provided support to ministries for setting up an HIV focal unit, developing reporting lines, training staff, and developing a workplace policy. This support, as well as commitment from the highest political level to mainstreaming, led to internal mainstreaming in all 31 ministries.

Mainstreaming was further expanded with the launch of the NACP-III, in which a separate cell was established within NACO to anchor its mainstreaming efforts. The mainstreaming strategy broadened to two additional areas: (1) access to services by leveraging service delivery of nonhealth actors; and (2) mitigation of impact through social protection. NACO prioritized 17 ministries for its expanded strategy, based on whether they have large human resources, involve at-risk populations, and/or have social security schemes that could be leveraged.\textsuperscript{155} One major initiative has been the Red Ribbon Express project of the Ministry of Railways, the largest social mobilization effort in the world.\textsuperscript{156} The Red Ribbon Express is a train that comprises seven coaches with HIV education and awareness, counseling and training services, HIV testing, and treatment of sexually transmitted diseases.

### Challenges

- **Leveraging and formalizing partnerships with the public and private sectors:** NACP-IV marks the first time that the Indian government will provide more funds for the program (63 percent) than external partners; this has led to a renewed focus on how to leverage public and private sectors through formalized agreements.\textsuperscript{158} Partnerships with ministries in HIV mainstreaming efforts have thus far been ad hoc as NACO had not initially envisaged the need to formalize agreements. With the start of NACP-IV, however, MOUs with priority ministries and the private sector began to be

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\textsuperscript{151} Ibid.

\textsuperscript{152} Ibid.


\textsuperscript{154} Interview with UNDP (United National Development Programme) official, March 26, 2014.

\textsuperscript{155} Ibid.

\textsuperscript{156} NACO 2012.

\textsuperscript{157} Interview with UNAIDS official, March 23, 2014; Sgaier et al. 2012.

\textsuperscript{158} Interview with UNDP (United National Development Programme) official, March 26, 2014.
formalized; these are being followed by agreements on action and monitoring plans. Still, no matter how important formalized agreements and action plans are, the multisectoral response must continue to emphasize efforts at the ground level, by providing the space for communities to take the lead on pressing issues.\textsuperscript{159}

- **Collecting data from public sector mainstreaming activities:** Monitoring the activities of the nonhealth public sector and the private sector has been a challenge in some instances since some partners do not consider this a priority and data reported tends to be in different formats.\textsuperscript{160} More extensive data on mainstreaming activities may come as formalized agreements and action plans — including monitoring and evaluation frameworks — are drawn up with priority ministries.

*Impact*

HIV prevalence at the national level in India started to decline in the late 1990s. Between 2001 and 2012, new adult HIV infections decreased by more than 50 percent.\textsuperscript{161} The prevalence rate among adults age 15 to 49 declined from 0.4 percent in 2001 to 0.3 percent in 2012.\textsuperscript{162} In 2012, an estimated 2.1 million people between the ages of 15 to 49 years were living with HIV,\textsuperscript{163} and the estimated coverage of antiretroviral therapy was 51 percent in 2011.\textsuperscript{164} National-level estimates mask substantial regional variation. Some states, such as Tamil Nadu and Karnataka, have mature epidemics involving leveling off or declining HIV prevalence, while other states — particularly those in the North and Northeast — face emerging epidemics among high-risk groups.\textsuperscript{165}

*Looking Forward*

India is currently integrating HIV and AIDS services within the country's health care system, including counseling and testing centers and services for treatment and prevention of mother-to-child transmission. The Planning Commission for the 12th five-year plan for the health sector proposed to merge NACO with the National Rural Health Mission. This has raised concerns within the Ministry of Health and Family Welfare that integration of NACO could reverse gains made thus far in the multisectoral HIV and AIDS response. Particular concerns are that health workers in the National Rural Health Mission are overburdened and will require sensitization to the needs of PLWHA and high-risk populations.

\textsuperscript{159} Interview with UNAIDS official, March 23, 2014.
\textsuperscript{160} Interview with UNDP (United National Development Programme) official, March 26, 2014.
\textsuperscript{162} Ibid.
\textsuperscript{164} UNAIDS 2013.
\textsuperscript{165} World Bank 2013.
Country Case Study: Kenya

Background

Kenya is a low-income country in East Africa with a stable economy and a devolved system of government brought in by the new constitution of 2010. In 1984, the first case of HIV was detected in the country. Over the next fourteen years, Kenya experienced a growing generalized epidemic, spread primarily through heterosexual transmission. By 1998, 13.9 percent of Kenyans were infected with HIV, with prevalence rates varying greatly across regions.166 High-risk groups such as commercial sex workers, men who have sex with men (MSM), and injecting drug users (IDUs) were also disproportionately affected, accounting for 33 percent of all new infections. Sectors such as education and agriculture were hit hard by loss of productivity due to illness among HIV-positive workers and by healthy people having to leave work to care for the sick.

In 1985, the government established the AIDS Program Secretariat (APS) to coordinate the HIV/AIDS response.167 Two years later, the APS was transformed into the National AIDS Control Committee and was placed under the direction of the Ministry of Health. The first five-year plan (1987–91) was developed with a focus on awareness-raising, clinical response, and capacity building of programs.168 This initial response, however, was not sufficient and prevalence rates continued to grow.

167. Ibid.
168. Ibid.
The Structure of the Multisectoral Response

By the late 1990s, there was recognition in Kenya, like elsewhere in Africa, that both a new institutional framework and a broader and more coordinated response were required. In 1997, Parliament produced the *Sessional Paper No. 4 on AIDS* that set forth a framework for a government multisectoral response to HIV. In 1999, President Moi declared AIDS a national disaster and the National AIDS Control Council (NACC) was established under the Office of the President to coordinate multisectoral activities and address national-level issues of harmonization and governance. At district and community levels, District Technical Committees (DTCs) and Constituency AIDS Control Committees (CACCs) played a similar role. Implementation of specific HIV/AIDS control and prevention activities remained in the Ministry of Health’s program that had been expanded into the National AIDS and STI Control Program (NASCOP).

NACC’s multisectoral HIV response has been developed within five-year Kenya National HIV/AIDS Strategic Plans (KNASPs) since 2000, the fourth of which will commence in 2014. In 2001, the Inter-Agency Coordinating Committee for HIV/AIDS (HIV/AIDS-ICC) was created to serve as a multisectoral consultative forum. This was followed by the establishment of the Joint HIV and AIDS Program Review Process (JAPR) in 2002, which serves as an annual review process for stakeholders to assess the past year’s performance, build consensus, and set priorities and objectives for the coming year.

With the multiplicity of stakeholders involved in the response, a robust data system was necessary to track progress in implementing the national response to HIV. A National HIV and AIDS Monitoring, Evaluation and Research Framework was created in 2009 as a tool to support the implementation of KNASP III.

**Key Sectors**

The multisectoral response under KNASP focuses on the following sectors:

- **Public sector**: The public sector is responsible for preventing new infections, improving quality of life, and mitigating the impact of HIV and AIDS among staff and customers. AIDS Control Units (ACUs) were set up in all ministries representing sectors hard hit by the AIDS crisis.
- **Civil society**: NACC estimates that over 18,000 civil society organizations are engaged in providing HIV and AIDS services in Kenya.169
- **Private sector**: NACC partners with the private sector for workplace programs, advocacy, fundraising support, or in-kind contributions.

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169. Ibid.
Between 2001 and 2005, NACC set out to mainstream HIV/AIDS activities in all ministries. World Bank MAP financing supported this work. The effort succeeded in increasing the number of AIDS Control Units (ACUs) in ministries from 2 in 2001 to 35 in 2005. ACUs developed information and education materials and used these to create general awareness about HIV/AIDS among staff. In addition, all ministries developed a budget line for the operating costs of an ACU. Despite these successes, the impact of the ACUs was generally limited to internal mainstreaming, rather than expanding HIV/AIDS activities into core service delivery programs of ministries.

With support from the World Bank and UK’s Department for International Development (DfID) — through a component of the $135 million Total War Against HIV and AIDS (TOWA) project (2007–14) — NACC sought to expand HIV and AIDS programs in priority ministries with an emphasis on external mainstreaming. A few ministries successfully implemented programs, such as the Ministry of Roads and Public Works, which had a permanent secretary who was very engaged with the mainstreaming effort.

The majority of the targeted ministries, however, were unclear about how to use the funds and the type of programs to implement. One World Bank official noted that it would have been helpful to share documented successes from the region with ministries to give them an idea about programs to implement. A second challenge was that many ministries did not have the capacity to implement activities, since the ACUs had other responsibilities and were only able to focus on mainstreaming activities part-time. In addition, ACUs generally operated at a low level within the ministries. Finally, those HIV programs that were implemented were done sector-by-sector, rather than working together and across sectors, which could produce a multiplier effect. As one NACC official stated, “I think we missed an opportunity here. We should have defined the work from the perspective of the social determinants of health. Then we could have identified synergies for sectors to work together and achieve better outcomes.” A review of mainstreaming under KNASP III summarized that the greatest lesson learned was that HIV and AIDS programs should not be planned or implemented in isolation.

As a result of these challenges, the funding allocation under TOWA for public sector mainstreaming was reduced from the initial allocation of $8.00 million to $3.65 million. Only 61 percent of the reduced allocation was disbursed, and the remaining funds were reprogrammed.

171. Interview with World Bank official, March 31
172. Ibid.
174. Interview with National AIDS Control Council (NACC) official, March 21.
175. Ibid.
Achievements

- **NACC governance:** A survey published in 2009 of 20 key informants found that the NACC is perceived as successful in defining policies and developing national strategic frameworks, mobilizing political leadership and government commitment, and including civil society and PLWHA through mechanisms such as the HIV/AIDS-ICC.\(^{177}\)

- **Internal mainstreaming in the public sector:** Internal mainstreaming efforts succeeded in increasing the number of ACUs in ministries from 2 in 2001 to 35 in 2005. By 2014, more than 95 percent of public sector bodies had established appropriate workplace programs.\(^{178}\)

- **Increased civil society involvement under KNASP III:** An estimated 18,455 civil society organizations were supported by NACC and funded by external donors.\(^{179}\)

- **Development of a national data system:** A National HIV and AIDS Monitoring, Evaluation and Research Framework was developed in 2009 through a participatory and consultative multisectoral process between key government agencies, development partners, professional bodies, and institutions and implementers.\(^{180}\) Along with nonroutine data sources and the routine Health Management Information System (managed by the Ministry of Health), two additional routine data sources were developed to generate information for national core indicators: (1) Community-Based Program Activity Report System (COBPAR) for quarterly reporting of all community-based HIV and AIDS activities, collected by NACC and its subnational structures (the CACCs and DTCs); (2) Public and Private Sector Reporting System, capturing both workplace programs and external mainstreaming activities implemented by private and public sectors, coordinated by the Ministry of Planning, National Development and Vision 2030.

Challenges

- **NACC effectiveness:** In the early 2000s, NACC suffered from a lack of transparency and poor operational effectiveness, including vague legislation, an unclear coordination mandate over government sectors, and a poor relationship with the Ministry of Health.\(^{181}\) Based on several investigative reviews, in 2005 NACC started to implement an Action Plan with a new management team. Steps taken were implementation of a risk management policy to manage fraud and corruption risks, development of a monitoring and evaluation system in spite of resource constraints, launch of the Community-Based Program Activity Report System (COBPAR) for reporting of all community-based HIV and AIDS activities, collected by NACC and its subnational structures (the CACCs and DTCs); (2) Public and Private Sector Reporting System, capturing both workplace programs and external mainstreaming activities implemented by private and public sectors, coordinated by the Ministry of Planning, National Development and Vision 2030.

- **Limited internal mainstreaming in the private sector:** This has been a particular challenge in the informal sector, where only 24 percent of workplaces reported having policies.\(^{183}\) In the formal sector, workplace programs were primarily in large corporations.

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179. Ibid.
181. Morah and Ihalainen 2009.
• **Limited external mainstreaming in the public sector:** As shown in box 1.3 above, the majority of ministries targeted for external mainstreaming were unclear about how to use the funds and the type of programs to implement. Other challenges were limited capacity and authority of ACUs and planning of programs sector-by-sector, rather than across sectors in synergistic programs.

• **Low reporting rates and variable quality of data from nonhealth public sector bodies:** Reports of mainstreaming activities from public sector entities have been increasing since 2008 (see figure 1.2) but are still low at an average rate of 44 percent in the second quarter of 2013. There are also concerns about data quality in these reports, specifically in terms of completeness, accuracy, and double reporting; stakeholders also noted minimal feedback on data collection under KNASP III.  

**Impact**

Kenya has made notable progress in its HIV and AIDS response since the first case of HIV was detected in 1984. Since 2008, 63 percent of the approximately 800,000 targeted men have been circumcised in two priority counties (Nyanza and Nairobi). Programs that tackle coinfection of HIV/tuberculosis and HIV/sexually transmitted infections have been expanded. Antiretroviral therapy has been extended to 81 percent of eligible HIV-positive adults. Since 1999, the country has seen prevalence rates drop to 6.1 percent. New HIV infections have decreased from 140,000 to 98,000 between 2001 and 2012. In the same time period, deaths from AIDS decreased by over 40 percent, from 130,000 to 57,000. Current challenges include gender, age group, and geographical disparities. Women account for 57.7 percent of all adults living with HIV; while among persons age 15 to 49 years, the prevalence among women is about 8.0 percent, almost twice that of men (4.3 percent). There are also significant regional variations in prevalence across the country — as high as 15.1 percent in Nyanza and as low as 2.1 percent in Eastern North province.

**Looking Forward**

Recent political developments in Kenya have major implications for future directions of the country’s multisectoral HIV and AIDS response. A new government led by President Uhuru Kenyatta came to office in April 2013. NACC was moved out of the Office of the President and became a parastatal within the

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184. Ibid; Interview with National AIDS Control Council (NACC) official, March 21
187. Ibid.
188. Ibid.
189. Ibid.
Ministry of Health. As one NACC official stated, “Given that much of the HIV/AIDS response is in the health sector, there were compelling reasons to move back to the Ministry of Health. However, now we have to ensure that we continue to work with nonhealth sectors.” Under KNASP III there were strained relations between NACC and NASCOP due to intrusions on each other’s mandates; this undermined effective coordination. It remains unclear how NACC and NASCOP will be linked in the next phase.

Furthermore, the design of KNASP IV must take into account provisions in Kenya’s new Constitution, particularly the system of devolved government with 47 lower-level county governments. These counties are responsible for some functions that were overseen at the national-level, including the provision of health care. Entities such as the ACUs in nonhealth ministries are being assessed to see if they fit into plans for devolution. Decisions will have to be made about the decentralized structures of the NACC and whether to establish these in each county. In sum, it remains unclear how the devolution process will operate in practice. These uncertainties are creating a difficult environment for the development of the new five-year national HIV/AIDS strategic plan, a key next step in Kenya’s multisectoral HIV and AIDS response.

192. Interview with National AIDS Control Council (NACC) official, March 21
194. Interview with National AIDS Control Council (NACC) official, March 21
Country Case Study: Namibia

Background

Namibia is an upper-middle-income country in southern Africa with a strong governance structure and a growing economy driven by mineral wealth. However, it is also one of the most unequal countries in the world. Poverty, political and economic marginalization, as well as participation in industries at high risk of HIV/AIDS, such as mining and fishing, help drive a generalized HIV epidemic that in some parts of the country has reached a prevalence rate of over 37 percent.\textsuperscript{196} AIDS has been the leading cause of death in the country since 1996, accounting for 23 percent of all deaths in 2013.\textsuperscript{197}

The first case of HIV was diagnosed in Namibia in 1986. The country’s initial response was to establish an AIDS Advisory Committee. With independence in 1990, the President launched the National AIDS Control Program to focus on prevention, treatment, and coordination of activities with nonhealth ministries and NGOs.\textsuperscript{198} Unlike many African countries that placed national HIV/AIDS coordinating bodies outside the Ministry of Health, the Namibians established it within the Ministry of Health and Social Services (MoHSS). The first national AIDS strategic plan — called the Medium-Term Plan (MTP I, 1992–98) — was developed. Under MTP I, the National AIDS Control Program supported prevention activities undertaken by organizations outside the MoHSS but did not fully integrate a multisectoral approach.\textsuperscript{199}

The Structure of the Multisectoral Response

By 1999, the health response alone was not sufficient to tackle the growing prevalence rate in the country,

\begin{footnotesize}
\begin{enumerate}
\item Integrated data systems are vital for guiding the multisectoral response, but Kenya’s experience demonstrates that collecting data from nonhealth public sectors is challenging.
\item Kenya’s stand-alone NACC, initially located outside the health sector, was in a good position to coordinate a broad array of stakeholders but suffered from tensions with the Ministry of Health because of resentment and a lack of clarity over roles. Kenya has now relocated the NACC within the Ministry of Health. Key challenges are to clarify how NACC and NASCOP will work together, and to ensure a continued multisectoral approach.
\item Nonhealth public sector entities targeted for external mainstreaming are often unclear about how to use funds and the types of programs to implement. One way to address this is to share documented successes of external mainstreaming from the region, to give public sector entities some examples of potential activities.
\item The planning of HIV/AIDS activities with nonhealth sectors must proceed multisectorally, rather than in isolation, to identify synergies for sectors to work together and achieve better outcomes.
\end{enumerate}
\end{footnotesize}
The MTP II created provision for the National AIDS Control Program to be replaced by a new institution — the National AIDS Coordination Program (NACP) — which was to work across sectors and improve capacity at the national and subnational levels for planning, managing, and monitoring HIV activities. MTP II also required the establishment of partnerships with the private sector and civil society for program implementation. However, by 2003, a review of MTP II suggested that partnership and mainstreaming activities were uncoordinated, lacked a clear strategy, and were underfunded.

As one way to better engage these sectors, the government involved broad multi-stakeholder consultations in the planning process for MTP III (2004–09), taking into account stakeholder perspectives across multiple drafts of the document. Every ministry, through its permanent secretary and HIV focal persons, developed its own objectives and activities for the five-year period. Under MTP III, four institutions were established to coordinate the multisectoral response at the national level: (1) the National AIDS Council (NAC), led by the MoHSS and comprising ministers and regional governors, was the national coordinator of the response and ensured adherence to policies and adequate resources; (2) the National Multisectoral AIDS Coordination Committee (NAMACOC), responsible for multisectoral leadership and coordination, was led by MoHSS and comprised permanent secretaries and equivalent representatives from regions, the private sector, and civil society bodies; (3) the National AIDS Executive Committee (NAEC), responsible for coordination of planning, implementation, and monitoring and evaluation, was led by MoHSS with membership from key stakeholder groups; and (4) the Sector Steering Committees, which oversaw the response in various development sectors.

At the subnational level, the Regional AIDS Coordinating Committees (RACOCs) coordinated the regional response and the Constituency AIDS Coordinating Committees (CACOCs) were community-based structures for facilitating community planning and participation in implementation. The RACOCs and CACOCs were structures under the Ministry of Regional and Local Government, Housing and Rural Development.

Under MTP III, Namibia launched its first costed national monitoring and evaluation plan for HIV and AIDS. The plan sought to develop and strengthen a sustainable national monitoring and evaluation system with support and alignment of all development partners. A special unit in MoHSS facilitates the coordination of the multisectoral monitoring and evaluation system; at the subnational level, RACOCs have monitoring and evaluation desks.

**Key Sectors**

Namibia’s HIV and AIDS response involves the following sectors:

- **Public sector**: The development of workplace programs in the public sector began under MTP III, led by the Office of the Prime Minister (OPM).
- **Civil society**: Civil society organizations are active in HIV/AIDS service provision in Namibia and are coordinated by the Namibia Network of AIDS Service Organizations (NANASO).
- **Private sector**: Many companies in Namibia conduct workplace programs; their activities are coordinated by the Namibian Business Coalition on HIV/AIDS (NABCOA).

**Achievements**

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200. Ibid.
201. Ibid.
202. Ibid.
Integration of the national AIDS strategy within a longer-term vision and planning framework, specifically Vision 2030 (a broad framework to guide five-year development plans), National Development Plans, and Poverty Reduction Strategy Papers. The purpose of Namibia’s current strategic plan for HIV/AIDS is to detail a strategic orientation that helps sectors better understand their mandate within the larger vision and plan for development.

Promotion of internal mainstreaming of HIV and AIDS in public and private sectors under MTP III. A progress report for 2006–08 found that of 28 government bodies, 17 had HIV and AIDS activities.204 According to NABCOA in 2010, there were 104 private companies that had workplace programs, reaching 37,742 employees.205 Studies in 2007 and 2008 found that workplace programs in the private sector are mostly in medium to large-scale companies (those with 100 or more employees), and predominately in multinational companies.

Establishment of an integrated data system for the multisectoral response: Namibia’s data system integrates indicators for international and regional commitments (for example, indicators for reporting for the UNGASS Declaration of Commitment on HIV/AIDS). It relies on data from routine and nonroutine data sources such as the Health Information System, led by the MoHSS, which collects data from health facility–based services. Data from nonhealth facility–based services are collected by a wide range of stakeholders, primarily from the communities, and inputted into the System for Program Monitoring (SPM).

Challenges

Inadequate guidelines and resources for coordination of the multisectoral response: Review of the MTP III noted successes with coordination in the health sector but identified significant challenges with coordination of the broader response involving private sector, development partners, and civil society. Guidelines, roles, and responsibilities for coordinators and implementers were unclear.206 Of the national-level structures, only NAEC held regular meetings; NAC and Sector Steering Committees never met during the MTP III period.207 Performance of the RACOCs and CACOCs suffered from inadequate human, financial, and technical resources. Box 1.5 below outlines the process that Namibia has undertaken to address these governance challenges.

Insufficient capacity for ensuring a functional, integrated data system: Namibia has encountered challenges in finding skilled and experienced staff at all levels of the health system and in nonhealth sectors to ensure a functional, integrated data system.208

The potential for internal and external mainstreaming in public and private sectors has not been fully realized. A progress report for 2006 to 2008 found that of 28 government bodies, 11 had no workplace programs.209 No definitive national standard/minimum package for a comprehensive workplace program existed, meaning public and private sectors rely on their own capacity, resources, and commitment to develop workplace programs. Of the workplace interventions in the public and private sectors that were implemented, the majority involved activities and services that were supported freely by the government and development partners — adoption of policies, capacity building, and prevention interventions such as condom distribution. Interventions that required some form of financial, time, or human resource investment by the employer were limited.210

206. Ibid.
207. Ibid.
208. Ibid.
**Impact**

Namibia has made tremendous progress with its response since the first case of HIV was diagnosed in 1986. National prevalence has declined from 22.0 percent in 2002 to 19.4 percent in 2004 to 13.3 percent in 2012. Although an estimated 220,000 people are living with HIV/AIDS, antiretroviral therapy coverage is now 91 percent and estimated new infections have declined from 23,000 in 2001 to 10,000 in 2012. Estimated AIDS deaths declined from 9,300 to 5,000 between 2001 and 2012, while new infections among children declined from 3,100 to less than 1,000 over the same period. In 2012, the percentage of pregnant women receiving antiretrovirals for preventing mother-to-child transmission was 94 percent, and services integrating HIV and sexual and reproductive health, and HIV and tuberculosis, have become commonplace. Despite these successes, HIV prevalence remains at a high level, burdening the health system and posing formidable challenges to development.

**Box 1.6 Addressing Governance Challenges in Namibia**

Namibia’s fourth strategic plan—renamed the National Strategic Framework (NSF) for HIV and AIDS (2010/11-2015/16)—seeks to address problems encountered with coordinating the multisectoral response by clarifying roles and responsibilities, building capacity of coordination structures, and incorporating the NAMACOC into an expanded NAEC to reduce the number of governance structures. Sector Steering Committees are responsible for facilitating workplace programs and mainstreaming HIV and AIDS in development programs in 14 sectors. Under NSF, the Sector Steering Committees are to work with umbrella networks such as NANASO (civil society) and NABCOA (private sector). This restructured governance structure seeks an expanded multisectoral response to HIV and AIDS which, the NSF argues, remains the greatest development challenge for Namibia.


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211. UNDP (United National Development Programme) 2006.
213. Ibid.
214. Ibid.
Looking Forward

A current and future challenge for Namibia is to ensure continued funding for its multisectoral HIV and AIDS strategy. In 2008–09, the government funded 45.5 percent of the nation’s HIV response (over 28 percent of the total health budget) and development partners provided the remaining funds.\textsuperscript{215} Since Namibia attained upper-middle-income status in 2009, donors have been gradually withdrawing support, with implications for the sustainability of both public sector and civil society programs. Therefore, the country has undertaken a series of steps to identify additional domestic resources for HIV funding. In costing the National Strategic Framework (2010/11–2015/16), domestic sources of financing were identified for each target of the strategy.\textsuperscript{216} Also, in 2010 the Office of the President directed the MoHSS to consult with the Ministry of Finance on creating concrete proposals for sustainable domestic sources of financing for HIV. This was followed in 2011 with a National Sustainable Financing Study. The study proposed four actions: (1) private sector contributions through workplace programs; (2) the institution of an airline tax of US$5 per passenger on outbound flights; (3) mainstreaming of HIV funding, requiring nonhealth ministries to allocate 2 percent or more of their budgets to HIV activities by 2020–21; and (4) health insurance schemes to cover services for people with HIV (now implemented).\textsuperscript{217}

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{215} UNAIDS. 2013. \textit{Efficient and Sustainable HIV Responses: Case Studies on Country Progress}. Geneva: UNAIDS.
\item \textsuperscript{216} Ibid.
\end{itemize}
\end{footnotesize}
**Country Case Study: Thailand**

**Background**

The Kingdom of Thailand is an upper-middle-income, Southeast Asian country that has experienced sustained industrialization and economic growth since the Asian financial crisis of 1997. Thailand detected its first case of HIV in 1984, after which the epidemic spread, first among intravenous drug users (IDUs), and then among commercial sex workers and men who have sex with men (MSM).

The government’s HIV/AIDS response began in 1987. The Department of Communicable Disease Control in the Ministry of Public Health (MoPH) set up a National Advisory Committee on HIV/AIDS — the first of its kind in Asia — and developed a short-term program. Funding, however, remained low and the response was not systematic. By 1989, the epidemic had taken hold among commercial sex workers and within the Royal Thai Army. The Cabinet approved a three-year Program for the Prevention and Control of AIDS (1989–91) that focused primarily on a public health response to the epidemic and the improvement of surveillance systems. Surveillance showed evidence that prevalence levels of HIV among brothel-based sex workers had reached 15 percent, and 3 percent among new army conscripts. Surveillance also demonstrated that high-risk behavior, such as visiting sex workers and having sex without condoms, was extremely high throughout the country.

**The Structure of the Multisectoral Response**

Faced with an emerging generalized epidemic, the country created an institutional framework in the early 1990s to respond more effectively with the involvement of multiple sectors. A National AIDS Prevention and Control Committee (NAC) was formed under the Office of the Prime Minister in 1991, chaired by the new Prime Minister, Anand Panyarachun. This reorganization suggested political commitment and ensured that the HIV and AIDS response was not simply the brief of the MoPH. NAC also established provincial and regional committees to help improve multisectoral action at subnational levels. Within NAC, an AIDS Policy and Planning Coordination Bureau was established to coordinate policies, information, financing, and monitoring and to bring together a wide range of stakeholders.

In 1992, NAC in partnership with the National Economic and Social Development Board drew up the first five-year National AIDS Plan (1992–96). This plan formally institutionalized the HIV/AIDS response into the country's five-year national development plan, and served as the primary policy framework for Thailand’s multisectoral approach. Faced with limited assistance from donors, the country contributed domestic financing toward the response — domestic funding as a percentage of total funding for HIV grew from 72 percent in 1991, to 90 percent in 1993, to 95 percent in 1996.

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219. Ibid.
221. UNDP (United National Development Programme) 2004.
222. Ibid.
In 1994, recognizing that the multisectoral approach no longer needed special political support from the Prime Minister’s Office, the role of coordination was shifted back to the Department of Disease Control (DDC) in the MoPH. It was felt that the multisectoral approach had taken hold, and the AIDS Policy and Planning Coordination Bureau was no longer needed. NAC continued as the central policy-making body; it was still chaired by the prime minister; the director-general of the DDC/MoPH became the secretary.

**Key Sectors**

With the institutional structure and strategic plan in place, multisectoral efforts unfolded in the early 1990s with an emphasis on inducing behavior change among the population.

- **Public sector**: The first National AIDS Plan requested public sector ministries to create AIDS plans and budget lines for mainstreaming HIV/AIDS activities, as well as appointing an AIDS focal person.
- **Civil society**: Government engaged civil society, important entities for advocating for the rights of PLWHA and implementing HIV prevention, in policy formulation and priority-setting.
- **Private sector**: The private sector’s Thailand Business Coalition on AIDS began workplace programs in 1993.

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Box 1.7 Key Messages from Namibia’s Multisectoral HIV and AIDS Response

- **Effective coordination of nonhealth sectors** requires clear guidelines, roles, and responsibilities for coordinators and implementers.
- **National strategic plans** are most successful when they involve multisectoral participation in plan formulation, are costed, include frameworks, and are integrated within longer-term vision and planning frameworks so stakeholders can better understand their mandate within the larger vision.
- **Workplace interventions in the public and private sectors** have tended to focus on services that require limited investment by the organization. In Namibia’s experience, interventions that required some form of financial, time, or human resource investment by the employer were rarely implemented due to limited funding or capacity. Ensuring a definitive national standard/minimum package for a comprehensive workplace program can help sectors, which do not have the capacity or resources to design their own programs.

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223. Ibid.
Achievements

- **Political leadership** from the Prime Minister early in the HIV and AIDS response provided the foundation for a successful multisectoral response.

- **Nationwide implementation of the 100% Condom Program**, with the involvement of multiple sectors (see box 1.7 above). Between 1989 and 2002, condom use rates in sex work increased from 14 to 90 percent (see figure 1.3 below). Millions of people are believed to have been protected by the program.227

- **Involvement of the country's social health insurance schemes in HIV/AIDS prevention and treatment.** By 2006, beneficiaries in the government’s Universal Coverage Scheme, which covers 75 percent of Thailand’s population, were entitled to free antiretroviral treatment and voluntary HIV counseling and testing. The country’s other two social health insurance schemes — the Civil Servant Medical Benefit Scheme and the Compulsory Social Security Scheme — also provide this coverage.

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224. Interview with World Bank official, April 4, 2014.
Challenges

- **Early plans to mainstream HIV and AIDS in the public sector were not fully implemented.** A few ministries — Office of the Prime Minister, the Ministry of Defense, the Ministry of Education, and the Ministry of the Interior — began to conduct activities. But others had a difficult time understanding how to incorporate HIV/AIDS activities into their work and lacked sufficient funds for these activities.228

- **Financing shortages:** The Asian economic crisis of 1997 took its toll on HIV initiatives across the country. The multisectoral response began to unravel as nonhealth ministries with HIV and AIDS initiatives could no longer afford these activities in their budgets. Treatment and care of AIDS patients was prioritized along with blood safety and breast milk protection, but behavior change initiatives were cut back drastically, with 2001 funding levels targeting prevention reaching only half of what they were in 1997.229

- **Challenges in moving from a vertical to horizontal HIV and AIDS response:** Development of the fourth National AIDS Strategic Plan (2007–11) engaged multiple sectors during the plan’s formulation through task forces that together analyzed and synthesized issues across 23 topics.230 The plan emphasized integration into sectors’ policies, strategic approaches, and activities, and integration at provincial and local levels. This emphasis was driven by new government reforms that involved devolution of authority to lower governance levels. At the central level, the role of DDC/MoPH shifted from coordination and budget support into a technical support role. The role of implementation moved to local administrative organizations. The budget for clinical services and prevention was integrated into the budget of the social health insurance schemes. An evaluation of the national AIDS response under the fourth National AIDS Strategic Plan found that problems were encountered in translating the plan into action, as there was no mechanism for guiding or motivating implementers to apply the plan, and no earmarked budget for support.231 Implementation was thus dependent on interest and awareness of each partner. Furthermore, many strategic managers did not understand the concept of integration, and no one was steering the process.

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229. Ibid.
231. Ibid.
**Impact**

Thailand is one of 26 countries that have seen adult incidence cases decline by more than 50 percent since 2001.\textsuperscript{232} The number of adults age 15 to 49 living with HIV/AIDS has declined from 1.8 percent of the population in 2001, to 1.1 percent in 2012.\textsuperscript{233} New HIV infections have declined from 143,000 in 1991, to 24,000 in 2001, to 8,800 in 2012.\textsuperscript{234} Since 2001, the number of young people age 15 to 24 living with HIV has stabilized at 0.3 percent, while the number of estimated AIDS deaths declined from 61,000 to 21,000 between 2001 and 2012.\textsuperscript{235} The estimated antiretroviral therapy coverage is 76 percent.\textsuperscript{236} Challenges remain with 440,000 people living with HIV in 2012, and infections occurring through unsafe sex, particularly among MSM, female sex workers and their clients, and IDUs. Since young people demonstrate limited knowledge of AIDS and engage in risky behavior, there remain concerns of a resurgence of the epidemic.

**Looking Forward**

In 2009, 93 percent of the budget for HIV/AIDS was from domestic sources, and three-fourths of this was allocated for treatment. Domestic financing came primarily from the National Health Security Office, which manages the Universal Coverage Scheme, and the social welfare program of the Department of the Comptroller-General. The Global Fund was the main external donor, and most of this financing went for prevention interventions, including those implemented by civil society. As Global Fund financing may not be sustainable over the long term, there is an increased focus in Thailand on the need to mobilize domestic funds for prevention. The fifth National AIDS Strategic Plan for 2012–16, called “AIDS Zero,” prioritizes the creation of an HIV prevention fund, with the goal of generating funds for prevention domestically. Thailand is one of the first countries to develop an “investment case” to help the government make decisions about priority investments and interventions for the next phase in its multisectoral HIV and AIDS response.\textsuperscript{237}

\textsuperscript{233} Ibid.
\textsuperscript{235} UNAIDS 2013.
\textsuperscript{236} Ibid.
\textsuperscript{237} Ibid.
Box 1.9 Key Messages from Thailand's Multisectoral HIV and AIDS Response

- **Political leadership**, like that from Prime Minister Anand Panyarachun, can galvanize a national multisectoral response by mobilizing support and resources across sectors to raise the profile of HIV responses, encouraging harmonization of activities, and breaking down HIV-related stigma and discrimination.

- **Governance models for national HIV/AIDS coordinating bodies should be flexible to allow them to transform as epidemics evolve and local circumstances change.** In Thailand, the role of coordination was shifted in 1994 from NAC to the Department of Disease Control in the MoPH once it was recognized that the multisectoral approach had taken root and no longer needed special political support from the Prime Minister's Office.

- **While national strategic plans are necessary, they are not sufficient.** Thailand's experience with its fourth National AIDS Strategic Plan shows that an action plan, with mechanisms for guiding and motivating implementers to apply the plan, is needed to ensure implementation will proceed.

- **Multisectoral action is more successful when the convener of sectors is a respected entity with authority.** The provincial governor's involvement in convening meetings of brothel owners and workers was key to the success of Thailand's 100% Condom Program in its pilot stage.

- **Multisectoral action is more effective when the priorities of all sectors are understood and mutual benefits across sectors are identified.** In the pilot of the 100% Condom Program, the provincial governor understood the priorities of the brothel owners and emphasized to them that the program would promote sex worker safety but not hurt profits.
Section III. Summary of Country Experiences, Lessons Learned, and Future Directions

Summary of Country Experiences

The four country case studies demonstrate that experiences in planning, implementing, and evaluating multisectoral approaches to HIV and AIDS are unique to each country context, as summarized in table 1.1 below:

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<th>Table 1.2 Multisectoral HIV and AIDS Responses: Country Experiences</th>
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<td><strong>MAIN PROBLEM FACED</strong></td>
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<tr>
<td>INDIA</td>
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<tr>
<td>Concentrated epidemic among sex workers, MSM, and IDUs in a large and populous country</td>
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<tr>
<td>• NACO within the Ministry of Health and Family Welfare</td>
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<tr>
<td>• SACS (registered societies) at state level</td>
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<td>• Establishment of effective and semi-autonomous governance structures within the health ministry, led by IAS officers</td>
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<td>• Promoting mainstreaming in the public sector with support by NACO, SACS, and</td>
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<td>• Data submitted by nonhealth sector entities have low reporting rates and are of variable quality.</td>
<td>• Early efforts to mainstream HIV and AIDS in the public sector were not fully implemented because of limited understanding of activities by nonhealth ministries and insufficient budget</td>
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<td>• Increase in civil society involvement in HIV and AIDS activities</td>
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Lessons Learned

Despite the differences between the four countries, their experiences offer a number of important cross-cutting lessons about how to engage across sectors, as detailed in table 1.2 below. Many of these lessons are highlighted in recent reviews of the coordination and management of HIV and AIDS responses with the purpose of informing the post-2015 development agenda.238
Future Directions

The current challenge for multisectoral HIV and AIDS responses is to sustain and improve upon the impressive gains made. This must be done in the context of decreasing donor funding in many countries. Countries are reviewing and modifying their national HIV/AIDS coordinating mechanisms — some are merging duplicative mechanisms and others are integrating stand-alone NACs into Ministries of Health.  

Other functions related to the HIV and AIDS response, such as implementation and financing, are also being integrated into existing institutions.

To help facilitate more focused and strategic use of scarce resources, UNAIDS is promoting a new investment framework for the global HIV and AIDS response with three key components. The first component consists of six basic program activities essential to an adequate response. The second focuses on critical enablers that underpin the success of these basic program activities — social enablers.

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that create environments conducive to HIV responses and program enablers that generate demand for programs. Finally, the third component involves recognition that HIV responses need to be aligned with country development objectives and support social, legal, and health systems. In applying the framework, countries are encouraged to prioritize activities through a strategic, multisectoral approach based on country data on the status of the epidemic and currently implemented programs.

It is imperative that changes made to HIV and AIDS responses in this changing national and global context protect and enhance multisectorality, acting on lessons learned of the past three decades.
Abstract: What can the World Bank do to help countries control tobacco, a man-made scourge of health and development? This case study presents and analyzes evidence from the 2012 Philippine tobacco tax reform in an overview of why tobacco control is so challenging and three sections that discuss the situation in the country before the reforms, present a role-playing exercise to familiarize task team leaders with the political economy and intersectoral nature of tobacco tax reform, and describe how the reform actually unfolded, with an emphasis on the World Bank’s role.

The goal of the reform was to raise taxes on tobacco products to achieve three objectives: increase tax revenues, reduce smoking and related costs by discouraging tobacco consumption through price increases, and provide funding for expanding the government’s pro-poor Universal Health Coverage scheme. The reform succeeded by increasing taxes immediately — in 2013 the excise tax on cheaper cigarettes more than tripled versus pre-reform levels — and taxes will continue to rise as they take full effect in 2016. Already in 2013 tobacco taxes provided approximately PhP 70 billion (about US$1.65 billion) in revenues. The taxes are indexed to prevent erosion by inflation, as well.

Key Lessons

- Tobacco is the world’s leading cause of preventable death
- Tobacco control policies are well known, but implementing them is extremely challenging because the political economy of reform is very difficult
- The World Bank can play a key role in supporting these reforms if staff understand:
  - The multisectoral nature of tobacco production, sale, and consumption
  - The types, capacities, and roles of domestic actors
  - How to leverage the Bank’s comparative advantages in economic and technical analyses to counter tobacco industry arguments and contribute effectively to domestic political processes
- Requests for assistance with tobacco tax reform are likely to become common because most countries are party to the WHO Framework Convention on Tobacco Control, which requires them to legislate, implement, and enforce wide-ranging measures to discourage consumption and reduce production.
INTRODUCTION

Philippine Tobacco Tax Reform and the World Bank

What can the World Bank do to help countries control tobacco, a man-made scourge of health and development? The evidence presented here focuses on the successful 2012 tobacco tax reform in the Philippines, a place deemed “Marlboro Country” by some analysts because it is one of the most important tobacco markets in Asia and home to one of the world’s most powerful pro-tobacco lobbies, which until the last reform had covertly dictated government policies for nearly half a century (Alechnowicz and Chapman 2004: Page and West 2012). In this document, the Philippine case is used to illuminate the complex politics that surround tobacco control and to identify the important role played by staff members of the World Bank as they supported the government and civil society organizations advocating for higher taxes on tobacco. Because the tobacco industry is driven by just a few transnational tobacco companies (TTCs), there are patterns in the Philippine case common to tobacco control politics in most countries, including the industry’s main arguments and the tactics it used to interfere with the legislative process.

This document is designed to serve two objectives. The first is to help task team leaders (TTLs) and senior managers understand the dynamics of tobacco tax reform and provoke discussion of the potential roles of the World Bank, along with the internal capacities and structures that would be needed to most effectively realize those roles. This is a forward-looking exercise informed by the Philippine case and intended to clarify the political and multisectoral environment through which technical solutions must be navigated if they are to be implemented. As such, it is an exercise in thinking about how to conceptualize tobacco tax reform and how to support countries trying to control tobacco.

The second objective is to analyze what actually happened in the Philippine case. Although many of the precise details are grounded in the history, politics, economics, personalities, and circumstances of the Philippines, these features are important to understanding the nuances of politics and to show crucial aspects of the Bank’s approach that enabled it to positively influence the reform.

Nine Percent of the World’s Premature Death

Tobacco is the world’s leading cause of preventable death, accounts for hundreds of billions of dollars in economic costs annually; yet cigarettes remain legal, and control efforts have had little success in most low- and middle-income countries (LMICs) (WHO 2011). The deleterious effects of smoking have been well known to health authorities for decades (Wynder et al. 1953; Doll and Hill 1954; US Department of Health and Human Services 2014). Even the net negative economic aspects of tobacco production and consumption have been recognized for many years, as articulated prominently by the World Bank’s landmark 1999 book Curbing the Epidemic (Jha 1999). Effective tobacco control policies are well known and widely documented (WHO 2008). Nonetheless, this evidence has not turned the tide: smoking has increased in LMICs over the last decade, and tobacco use accounts for one in eleven premature deaths worldwide (Giovino et al. 2012; Marquez and Farrington 2013).

Why is Tobacco Control so Difficult?

Much of the difficulty of controlling tobacco relates to its complex political economy; the uneven distribution of its benefits and costs; and the experience, skills, and resources used by the industry to promote and defend its interests. The cultivation, processing, distribution, and sale of tobacco generate vast economic resources. At the six largest tobacco companies, which account for about 80 percent of the industry, 2010 revenues were US$346 billion and reported profits topped US$35 billion (Eriksen et al. 2012). These resources create a broad range of economically vested parties, including tax authorities, farmers, marketing firms, the media, distributors, and retailers, plus beneficiaries of industry sponsorship and philanthropy. Economic benefits for these groups accrue quickly, but the full costs of smoking express themselves only over decades, which presents challenges for accurately accounting for its true impact. These costs include both health and economic aspects, such as asthma and impoverishment in the short run; and cancer, death, and large social and economic burdens in the longer term. Also, control advocates often approach tobacco
with typical public health tools, which are not well suited to understanding or countering the industry's influence in politics and economics, or addressing taxation or smuggling issues (Bump and Reich 2013).

Tobacco control is further complicated by the industry’s efforts to avoid meaningful restrictions. The lengths to which the industry has gone can be difficult to understand for those not familiar with tobacco control. For decades, the industry worked covertly to infiltrate the World Health Organization and keep tobacco control off its agenda (Zeltner et al. 2000; WHO 2009). The industry attempted to collaborate with the World Bank to redirect Curbing the Epidemic; when those efforts were rebuffed, it hired consultants and public relations firms to produce seemingly independent alternatives without disclosing its sponsorship (Mamudu et al. 2008a). Tobacco firms worked through third parties to promote an ineffective alternative to WHO’s Framework Convention on Tobacco Control (Mamudu et al. 2008b; Weishaar et al. 2012). Formerly secret industry documents also show that tobacco firms have supported smuggling to weaken regulators by denying them tax revenues (Collin et al. 2004), including prioritizing investment in Cambodia as a base for smuggling into other Asian countries (MacKenzie et al. 2004a). The tobacco industry secretly sponsored an academic research institute in Thailand to intentionally confuse the evidence on secondhand smoke and thereby forestall regulation in Asia (MacKenzie and Collin 2008). The industry has also interfered with domestic legislative processes, threatened LMIC governments with trade-related lawsuits, and used its influence in developed countries to seek trade-related advantages in other markets (MacKenzie et al. 2004b; Flores et al. 2006; Grüning et al. 2012; Smith et al. 2013).

The Framework Convention on Tobacco Control

Since the early 2000s much of the contest over tobacco control has been shaped by the WHO Framework Convention on Tobacco Control (FCTC), which was ratified by the World Health Assembly in 2003 and took effect in 2005 (WHO 2005). As of mid-2014, 178 countries were party to the treaty (WHO 2014). The FCTC was envisioned in the mid-1990s as a mechanism to counter the growing power of the globalizing tobacco industry (Yach and Bettcher 2000). It was designed as a binding treaty without reservation clauses because the industry had proven so adept at manipulating legislation, circumventing regulation, and contesting control initiatives at all levels. The terms of the FCTC therefore offer relatively little flexibility to ratifying nations. At its core the treaty has articles designed to reduce demand for tobacco through price and tax increases; nonprice measures such as package and labeling requirements, advertising bans, spatial restrictions on smoking, and cessation programs, as well as supply-reduction measures to counter smuggling; reduce sales to minors; and promote economic alternatives to tobacco production, processing, and sale. Parties are also required to commit financial resources, share information, and cooperate with one another on anti-tobacco research and litigation (WHO 2005).

Trade disputes have been one of the most important battlegrounds over FCTC implementation (Mamudu et al. 2011; Collin 2012; Jarman et al. 2012; Drope and Lencucha 2013). In general, the industry and its advocates have used trade-related litigation, or the threat of such litigation, to argue that FCTC implementation violates free-trade obligations. For instance, Australia, the United States, and Uruguay have all had to defend litigation contesting their ability to regulate cigarette packaging and labeling, which is mandatory under the FCTC, but which the tobacco industry views as a violation of free trade (Mackey et al. 2013).

How This Document Is Organized

The two objectives of this document are advanced in three main sections following this introduction. The first discusses the primary features of tobacco in the Philippines from the mid-1990s until 2011. This period corresponds to the passage of the previous tobacco tax regime and to the beginning of the most recent reform. The section explains the industry's position, the regulatory framework under which it operated, and shows how it was able to prosper in spite of attempts to reduce its profitability and control its primary product. The second section discusses why tobacco tax reform reached the Philippine government’s policy agenda and then presents a role-playing exercise for readers to consider how to navigate the tobacco tax reform, including considering how the World Bank could assist in the process. The exercise is based on three central challenges that were overcome during the reform. As part of the exercise, the section identifies the primary players in the 2011–12 reform, along with their interests and capacities. These include actors...
from the tobacco and alcohol industries, diverse groups within the Philippine government, several civil society organizations, and external entities such as the World Bank. The third section presents an analysis of how the Philippine reform actually happened, centered on the tactics used by proponents to successfully defeat the tobacco industry and its supporters — a powerful pro-tobacco lobby that some have called “the strongest” in Asia (Alechnowicz and Chapman 2004).
Section I: Tobacco and Regulation in the Philippines

A Strong Lobby

High smoking rates in the Philippines reflect several factors, beginning with a strong domestic industry, low tax rates, and low prices, plus intensive marketing and lobbying efforts by tobacco companies starting in the early 1990s. Fortune Tobacco was founded in the 1960s and was the dominant tobacco firm in the Philippines until it was sold to Philip Morris in 2010. Over the decades, Fortune used its political and economic influence to keep taxes low, and promote smoking by linking its products with the underpinnings of local culture, such as Catholicism (Simpson 2001; Alechnowicz and Chapman 2004). Transnational tobacco companies were not major rivals to Fortune for most of the 20th century, but in the late 1980s TTCs began turning away from their home markets in developed countries, where anti-tobacco regulation was strengthening, in favor of the developing world, where regulations were weak or nonexistent and where economic development was increasing the buying power of billions of potential new customers (Mackay 1994). TTC strategy focused on winning the brand allegiance of men, many of whom already smoked a local brand, and expanding the market by recruiting women and children (Connolly 1992).

The template for TTC expansion in the 1990s was underwritten by strategies they had used in the Philippines for decades. At least since the 1960s, TTCs had used their economic power to influence the political process, delaying, weakening, or preventing regulation through contributions to politicians and well-connected businessmen, much as Fortune had. TTCs had also influenced popular perceptions of the consequences of tobacco use by overtly and covertly supporting consultants and public figures to dispute the link between smoking and lung cancer, to promote discussion of other possible causes of lung cancer, to prevent labeling disclosures on tobacco packs, and to contest the consequences of secondhand smoke, among other things. This strategy included recruiting seemingly independent, apparently credible technical experts with affiliations to Philippine universities, the American Lung Association, and WHO to advance the industry's position (Alechnowicz and Chapman 2004).

Modest Tax Reform, 1997

The Philippine tax reform of 1997 can be understood in the context of a shift in tactics by domestic and international tobacco companies. In the 1980s and earlier, the standard practice was to emphasize the economic aspects of tobacco and flatly deny any link between cigarettes and ill health, but eventually that strategy was abandoned in favor of a new one based on the appearance of collaboration. But companies began to embrace regulation as a means of burnishing their public image, but worked diligently behind the scenes to ensure that regulations would not actually harm their business (Assunta and Chapman 2004b). For instance, companies agreed to sponsor anti-tobacco youth programs, but these were actually “stealth marketing” campaigns that promoted tobacco to children (Landman et al. 2002; Assunta and Chapman 2004a; Sebrié and Glantz 2007). Other initiatives centered on ghostwriting legislation (Patel et al. 2007) or funding research on liver disease to distract attention from conditions that could be more easily linked to tobacco use (Muggli et al. 2008).

Although the 1997 reforms did establish an excise tax on both tobacco and alcohol, they included provisions that favored the industry in general, and in particular favored the companies that were established in the marketplace at the time; the largest firm overall was Fortune Tobacco and the largest TTC was Philip Morris, maker of the Marlboro and other popular brands.

The first provision was that the tax rates were fixed based on 1996 net prices, and those tax rates were sporadically adjusted, meaning that over time their value would be eroded by inflation. By 2011, the real tax rate per pack had declined by about 40 percent versus the initial rate set in 1997, while over the same period the number of packs sold per year more than doubled. These trends, along with the dramatic change after the 2012 reform, are shown in calculations by the Department of Finance (figure 1.1 below):
A second calculation by the Department of Finance shows the relative decline in alcohol and tobacco taxes by percent contribution to GDP since they went into effect in 1997 (and the immediate impact of the 2012 reform) (figure 1.2 below):

The second provision concerned a system of multiple tax tiers and a grandfathering clause. The tiers were set by a “price classification freeze,” that established tax rates based on net retail price tiers in 1996, but
was not subject to revision (SEATCA 2013). Lower-priced brands in 1996 were assessed lower taxes, which over time had the effect of driving consumption toward that market segment rather than discouraging smoking through uniformly higher taxes. Further, brands whose taxes were set by the 1997 reforms (based on prior year net retail prices) were grandfathered into the system, which was favorable to established brands because rates were low and not fully indexed for inflation.

However, new brands would be taxed at a rate established at the time of market entry, which protected existing competitors and disadvantaged new entrants. In 2012, the tax on Philip Morris’s Marlboro brand was about 7 Philippine pesos (PhP), or about 16.7 US cents per pack at 2012 average exchange rate of roughly PhP 42/USD. By contrast, British American Tobacco’s (BAT’s) primary brands — Dunhill, Lucky Strike, Kent, and Pall Mall — were not sold in the Philippines in 1996. BAT wanted to introduce these brands, but faced per-pack taxes four times higher than those on Marlboros, about PhP 28 or US$0.67.241 BAT’s general manager complained to the Philippine press about needing to “level the playing field,” citing this tax provision and Philip Morris’s “monopoly,” referring to Philip Morris Philippines Manufacturing and its partner Fortune Tobacco, whose combined market share was over 90 percent (Domingo 2012).

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241. Per-pack tax figures based on interview source.
Low Prices, High Consumption

Mainly because of low taxes, consumer prices for cigarettes in the Philippines were the lowest in Asia, according to a 2010 survey by the Southeast Asia Tobacco Control Alliance (SEATCA), an ASEAN regional alliance of tobacco control organizations and activists. SEATCA found that the per-pack price of cigarettes in the Philippines was only 13 percent of that in Singapore’s highly taxed market, and was about half the price of packs in less developed regional neighbors such as Cambodia and Laos (figure 1.3 below).

Raising taxes to increase the price of cigarettes is a proven control measure, and the reverse is also true — lower prices increase consumption (Abedian et al. 1998; Jha 1999; WHO 2008). Under the regime of very low taxes and ineffective control measures, smoking prevalence in the Philippines ranked among the world’s highest. Nearly half (47.3 percent) of adult men reported using tobacco in 2011, as did 9 percent of women (WHO 2013).

Tax Problems, Health Problems, and the Need for Reform

Although the link between prices and consumption is well demonstrated, the 1997 reforms were intended as a revenue-generation measure alone. The tax regime was designed by the Department of Finance; the Department of Health was not involved, and health consequences were not considered (SEATCA 2012). However, even as a revenue-generation measure, the 1997 reform performed poorly. As show above in figures 1.1 and 1.2, revenues declined over time on a per-pack basis and as a percent of GDP even as cigarette sales climbed. Because the rates were fixed to old pack prices, they functioned essentially as ad valorem taxes tied to three price tiers, all of which declined in importance as inflation rose. This was not what the Philippine government had envisioned — in fact, the excise taxes of 1997 were designed to close loopholes in earlier ad valorem taxes. Those had been ineffective because tobacco companies sold their products to shell company intermediaries, enabling them to calculate taxes based on artificially low, nonmarket transactions (Alechnowicz and Chapman 2004). In the tobacco tax reform efforts before 2012, fiscal authorities had allowed effective rates to trend lower despite some occasional increases.

Assessing the tax revenues associated with the production and sale of tobacco yields an incomplete economic picture because it does not account for the health costs attributable to consumption, which have personal, social, and moral dimensions too. As tobacco consumption rose in the 1990s and stabilized at a high level in the 2000s, health consequences worsened. This trend is likely to continue because much of the market growth was due to the recruitment of younger women and children. For instance between 1994 and 2002 the proportion of young women who tried smoking rose from 17 to 30 percent (Alechnowicz and
Chapman 2004), and over the four years measured by the 2007 Global Youth Tobacco Survey, tobacco use by schoolchildren age 13 to 15 increased by 40 percent (to 27.3 percent) (SEATCA 2012).

According to Global Burden of Disease estimates for the Philippines, between 1990 and 2010 the Disability-Adjusted Life Years (DALYs) lost to problems potentially caused by tobacco grew sharply. The burden of chronic obstructive pulmonary diseases increased 40 percent, lung cancer increased 20 percent, ischemic heart diseases and strokes each increased about 85 percent, and the losses due to hypertensive heart disease grew by about 160 percent (IHME and HDN 2013). Although the exact share of these increases caused by tobacco has not been calculated for every condition, it is likely to be very significant. For instance, an analysis of the 2008 population of the Philippines found that smoking was responsible for 65 percent of the lung cancer burden, nearly all of which was due to premature mortality — 173,100 DALYs were caused by smoking, of a total of 267,787 lung cancer DALYs due to all causes (Bilano et al. 2014). The rising toll of tobacco has happened in parallel with increasing involvement of TTCs in the Philippine market, for instance the number of employees working for Philip Morris in the Philippines grew from 65 in 1999 to about 4,000 in 2012, reflecting acquisitions, mergers, and growth (Page and West 2012).

Government financial data show a stark picture of both the government’s apathy toward control and the overwhelmingly negative economics of tobacco for the public coffers. In 2011, the most recent year for which data are available, the government received PhP 25.4 billion in tobacco excise taxes and PhP 9.4 billion in value added taxes, for a total of PhP 34.8 billion (about US$809 million using the 2011 average exchange rate of 43 PhP/US$) in revenues (WHO 2013). (Import duties and other taxes paid by tobacco companies were not reported.) However, these total tax revenues were dwarfed by the costs imposed by tobacco. For 2011 the Department of Finance calculated health care costs, productivity losses, and premature deaths to estimate the economic costs of smoking: PhP 177 billion (just over US$4.1 billion) — more than five times as much as combined excise and value added tax revenues. That same year, spending on tobacco control programs was reported as PhP 1 million, or about US$23,250, less than three thousandths of 1 percent of excise and value added tax revenues (WHO 2013).

As tobacco companies continued to prosper under the 1997 tax rules, the Philippine government was disadvantaged both by declining revenues due to eroding tax rates and by rising long-run health costs. Between the 1997 and 2012 reforms the government did not meaningfully regulate the industry or reduce tobacco use, despite the appearance of actions that could have achieved these ends. A 1999 Clean Air Act and a 2003 Tobacco Regulation Act had only temporary effects (Page and West 2012). The government signed in 2003 and ratified in 2005 the WHO Framework Convention on Tobacco Control (FCTC), which committed the government to act against tobacco, but by 2012 many important measures had not been implemented.

For these reasons of finances and health, tobacco was an urgent issue.

SECTION II: MANAGING THE POLITICS OF TOBACCO REFORM

This section asks you to adopt the perspective of a senior official in the Philippine Department of Finance (DoF) with the objective of developing strategies for successful tobacco tax reform and analyzing the possible roles of different actors. The DoF perspective is important because tax reform is fundamentally a domestic political process; adopting an insider’s view permits you to assess the complete process, including the potential role of the World Bank and other actors outside the Philippine government. Your task as a senior official in the DoF is to coordinate all parties and shepherd the reform through all legislative stages. The present case study distills this process into three central challenges as outlined below. For each one you are asked to identify a general strategy and decide what roles to assign to each actor.

This section sets the stage with an account of how tobacco tax reform reached the national policy agenda and a brief background on the mechanics of new tax legislation in the Philippines. It then outlines three principal challenges in the reform: finding a tax rate that balances fiscal needs and political realities,

242. Presentation by Undersecretary of Finance
navigating the proposed bill through the Ways and Means Committee of the Lower House, and negotiating passage in both houses of Congress. To inform your consideration of these challenges, the section then discusses the primary actors and their positions. Achieving a successful reform will mean adopting a position that can appeal to enough actors and finding a strategy that can maximize their strengths to overcome the opposition of the tobacco industry.

**Tobacco Reaches the National Policy Agenda**

Philippine President Noynoy Aquino was elected in June of 2010 after running on a populist platform that promised economic growth, zero tolerance for corruption, and no new taxes. During the campaign, then-Senator Aquino was approached by an advocacy group promoting universal health coverage (UHC), which had been law in the Philippines since 1987, but remained unrealized. In the weeks before the election Candidate Aquino embraced UHC, promising to provide health care for all Filipinos if elected (Porcalla 2010).

The competing pledges of no new taxes and the expansion of health care left President Aquino searching for revenues that could be extracted with existing mechanisms. Tobacco tax reform appealed to him and his advisors for several reasons, including the potential to both raise revenues and reduce health costs. Also, the tobacco industry was perceived largely as foreign, which was true because Philip Morris had just acquired Fortune Tobacco, the largest local firm, and controlled over 90 percent of the market. Increasing the tax burden on a foreign business was viewed as much more viable politically than increasing it for local businesses, an important distinction in domestic politics. Further, since tobacco taxes already existed, adjusting them could be communicated to the electorate as simply closing loopholes, which would not violate the “No new taxes” pledge. And because he intended to expand health coverage by funneling money to the country’s government-sponsored insurance fund, increased tax revenues was the only solution required, as opposed to building more hospitals, reforming payment systems, changing benefit packages, or other extremely challenging elements of health reform. These were among the reasons, President Aquino committed to tobacco tax reform.

After the election, additional impetus for tobacco tax reform came in response to pressure from the alcohol lobby. This related to a dispute filed with the World Trade Organization (WTO) in 2010 by the European Union and the United States against the Philippines. The EU and the United States alleged that Philippine taxes on distilled spirits unfairly discriminated against imported products. The taxes in question were calculated according to the base ingredient in the spirit, for example, sugar cane, wheat, potato, and so on, including “nondesignated” bases. The alleged effect was to levy little or no tax on domestically produced spirits and apply high tariffs on imports. In 2011 the WTO upheld the complaint and obliged the Philippines to adopt equal tax treatment on alcohol production regardless of origin (WTO Dispute DS403 2013). To comply with the WTO decision, the Philippines had to amend its alcohol tax laws to be nondiscriminatory. Accordingly, domestic alcohol firms faced both a tax increase and the elimination of their competitive advantage over imported products. They viewed this prospect very negatively and used their resources to lobby against it. The Aquino administration sought to diffuse some of this pressure by packaging tax reforms for alcohol and tobacco together as “sin tax reforms” (Chave et al. 2014). This is how tobacco tax reform reached the national policy agenda.

**Mechanics of New Tax Legislation**

As background for the exercise below, this paragraph describes the mechanics of new tax legislation in the Philippines. The Philippine government’s legislative branch has two houses, the upper and the lower, also called the Senate and House of Representatives, respectively. New tax legislation must originate in the Ways and Means Committee of the lower house, after which it goes to the floor of the lower house, then to the Ways and Means Committee of the Senate, the Senate floor, and if successful to a bicameral reconciliation committee. Successful bills are then forwarded to the president for signature into law.
Three Challenges in the Philippines Tobacco Tax Reform

There are three challenges, all of which are connected and all of which overlap in practice. As explained more fully below, these are (1) to produce a tax rate that balances tax revenues, consumption reductions, and political feasibility; (2) to guide a bill based on the rate through the lower house’s Ways and Means Committee; and (3) to negotiate passage by both houses of a final bill that still preserves the tax rate.

- **Challenge 1: Tax rates.** You need to determine the right tax rate, which involves forecasting the price elasticity of cigarettes, the potential revenues under different scenarios, and the impact on farmers, distributors, retailers, and others who may lose income if smoking declines. Although the calculation itself is a technical exercise, it includes assumptions that are highly political and will be contested in the public domain. You do not have the expertise to do the calculation yourself and are not sure if your department’s own findings are accurate. Consider which partners you will consult and what you want them to do to help you model tax rates and defend them in public against the attacks of the tobacco lobby and its allies.
  - What will you ask the World Bank and other actors to do?
  - What capacities would each actor need for an optimal response?

- **Challenge 2: Ways and Means Committee.** You need to gain influence among the chairman and members of the Ways and Means Committee of the lower house such that they will forward a tobacco tax bill to the house floor. Although you have the strong support of the president, this is not enough to remake the committee or ensure passage. Identify partners who may be able to change the balance of power on the committee and suggest strategies they will use. Public perception is very important in this process.
  - What will you ask the World Bank and other actors to do?
  - What capacities would each actor need for an optimal response?

- **Challenge 3: Passage in both houses.** You will need political strategies to ensure passage of the bill by the full membership of both houses. Identify the possible partners who may be able to sway enough legislators, and speculate about the strategies they will use. For the legislators not yet committed to one side or the other, public perception of the tax reform is paramount.
  - What will you ask the World Bank and other actors to do?
  - What capacities would each actor need for an optimal response?

Actors and Interests in Tobacco Tax Reform

This section reviews important actors, their interests, and the strategies they used to influence tobacco tax reform. It covers the tobacco industry, civil society organizations, and multilateral agencies. The narrative description is followed by stakeholder tables showing the positions, interests, and capacities of these and other potentially relevant institutions, individuals, and groups. Consider solutions to the three challenges above as you read about them.

In general, the tobacco industry will oppose meaningful reform and marshal all of its resources to advance its interests, although sometimes different interests between competing firms can be exploited. Based on experiences elsewhere, you know the tobacco industry will invoke two arguments in hopes of building support for its positions. First, the industry will argue that raising taxes will hurt Philippine farmers who grow tobacco. This argument will link tobacco with popular issues such as the well-being of farmers, economic vibrancy in the agriculture sector, and job creation in general. As a related economic argument, Philip Morris may also threaten to relocate its factories to another country. Second, the industry will predict that higher taxes will lead to smuggling. Smuggling hurts the government by depriving it of tax revenues and by creating more health costs because the smuggled cigarettes are cheaper and will drive up consumption. This argument will portray the industry as a cooperative partner operating fully within the law and seeking pragmatic solutions.

While making these arguments, the industry will use its economic power to engage allies, including many involved with the production and sale of tobacco. Others will support the industry’s positions because they
benefit from its donations or other lobbying efforts. The industry will try to influence the legislative process through lobbying campaigns, by providing ghostwritten alternative bills and talking points based on misleading, secretly sponsored research, and by arranging testimony from witnesses with views agreeable to its position. Tobacco firms will promote an image of cooperation by agreeing to tax increases that will not adversely affect their business or can be avoided. The industry’s objective is to maintain profitability by keeping taxes low and ensure future growth by avoiding measures that would hinder efforts to recruit new smokers, which would include higher taxes and anti-smoking regulations.

The industry will also attempt to directly influence the legislative process. Over at least the past two decades, Fortune, Philip Morris and its allies influenced legislation by focusing lobbying efforts on the Ways and Means Committee of the lower house. By ensuring pro-industry stances there, tobacco companies were able to forestall legislation they viewed unfavorably. In some cases bills were not brought before the committee, and in other cases they were voted down. With no other possible source for fiscal legislation, the Ways and Means Committee holds exceptional sway over tobacco tax reform.

However, there are differences of position within the tobacco industry. Following its purchase of Fortune Tobacco, Philip Morris is by far the dominant player with 90 percent market share. Philip Morris favors the existing tax regime but may agree to a modest increase. BAT would like to enter the market and to pay taxes similar to those of Philip Morris. For this reason BAT opposes the current regime, which favors Philip Morris, and would like equal treatment. Other TTCs and a few local firms will observe the reform, but are not expected to attempt to influence it.

The government’s experience with tobacco tax reform has not been successful, but since the last attempt in 1997, several civil society organizations have developed relevant capacities and constituencies. First, there is Action for Economic Reforms (AER), which was founded in 1996 and is focused on tax reform in general as a development issue. AER has experience with taxes and in its early days in 1996 and 1997 advocated for tobacco tax reforms. AER played an important role in moving the regime from ad valorem taxes, which the industry had been partially avoiding by undervaluing their products, to specific excise taxes as passed in 1997. However, in hindsight, AER realized that the industry had successfully coopted the excise tax design, leading to revenue declines over time and conveying advantages to existing tobacco firms by de facto imposing higher rates for new firms wishing to enter the market. AER’s central expertise is taxation, but it has realized that overcoming industry resistance will require a large coalition that can link taxes and health. AER has attracted international support for its push into tobacco from Bloomberg Philanthropies and the Campaign for Tobacco Free Kids (TFK), representing the largest funder of anti-tobacco work and one of the most influential global advocacy organizations in tobacco control. In the Philippines, AER has strong links with the Department of Finance because of its work on taxation.

There are also several prominent CSOs focused on health, including Health Justice, the FCTC Alliance-Philippines (FCAP), the Southeast Asia Tobacco Control Alliance (SEATCA), and New Vois Association of the Philippines (NVAP), a cancer patients’ advocacy group. The health CSOs have advocated for tobacco control for many years with some success, but have not turned the tide against the industry. In part, this has been because the government has considered tobacco an economic issue, and these organizations do not have any tax expertise and do not have working relationships with the Department of Finance. However, these CSOs did play a major role in the ratification of the FCTC by the Philippine Senate in 2005, and in recent years tobacco control advocates have become much more sophisticated in the Philippines and elsewhere. Formerly secret industry documents publicized by lawsuits in the United States have equipped control advocates to understand a great deal about how the industry operates and how it has resisted regulation. Vibrant international networks coordinated by TFK and other organizations behind FCTC have done much to even the playing field by sharing strategies, coordinating activities, and providing financial support. However, these remain health CSOs, and their main expertise is in that area. Their authority is technical in health and medicine and normative in other areas. They have good links with the Department of Health. As adherents to the FCTC, these CSOs are very reluctant to engage with the tobacco industry, except in completely transparent settings, such as public hearings, believing that any other contact could serve to legitimate the industry and its positions, and could falsely imply shared ground between their health objectives and those of the industry.
There are three multilateral agencies that could be engaged to support the reform. Headquartered in Manila, the Asian Development Bank has expertise in economic issues and is an important regional institution. It has not been engaged with tobacco reforms in the past.

The World Health Organization is a leading agency in tobacco control and has led a strong push to control tobacco through its FCTC treaty, the articulation of sound control policies in its MPOWER Reports, and keeping the issue visible by repeated documentation of the harms of smoking and monitoring and publicizing the progress against tobacco around the world. At its Geneva headquarters WHO has a unit that produces tax simulation models. At its regional office in Manila WHO has capacities in health matters and in designing advocacy campaigns. WHO has good access to the local and international media.

The World Bank has very high legitimacy in fiscal and economic policy dialogue and has high credibility in the eyes of the Philippine public. Its pronouncements and analyses carry great weight. However, in the years since its 1999 book *Curbing the Epidemic*, the World Bank’s role in tobacco control has been in analytical work with limited engagement in policy. Based on its comparative advantages, the Bank’s 2007 health, nutrition, and population (HNP) strategy identifies tobacco tax policy as an institutional strength, but, prior to 2011, its engagements in this area have been limited. The World Bank has strong links with the Department of Finance and has access to all parts of the executive branch.

To structure an analysis of how to manage the politics of reform, the following table lists relevant stakeholders, their positions, and their capacities. The narrative above and the table that follows were constructed using interviews with several participants in the process and a review of proprietary documents from their organizations. The actors mentioned were all important in the reform, although this account is not exhaustive and some details are simplified for the purposes of discussion.

<table>
<thead>
<tr>
<th>Supportive actors</th>
<th>Type and interests</th>
<th>Capacities</th>
</tr>
</thead>
<tbody>
<tr>
<td>President Aquino</td>
<td>Chief executive of the country. Wants to raise tobacco tax revenues to fund universal health care</td>
<td>Can marshal public support and help frame debate. Can facilitate cooperation within the executive branch. Can praise and support legislators, but is less able to criticize and undermine them.</td>
</tr>
<tr>
<td>Action for Economic Reforms (AER)</td>
<td>CSO focused on tax reform to promote development</td>
<td>Long experience with economic analyses. Can coordinate health and fiscal groups. Can conduct public relations campaigns, including negative ones, to influence legislators. Can engage tobacco companies. Strong links with DoF. Tax expertise and increasing tobacco expertise from experience in 1997 and links with Bloomberg and TFK.</td>
</tr>
<tr>
<td>SEATCA</td>
<td>Nongovernmental regional alliance of tobacco control organizations and advocates from countries of the Association of Southeast Asian Nations</td>
<td>Strong advocacy for tobacco control, health. Performs analyses, can draw on regional partners for strategies, information, and coordinated action.</td>
</tr>
<tr>
<td>Health Justice, New Vois Association, FCTC Alliance Philippines, and other CSOs</td>
<td>CSOs focused on tobacco control, cancer, and other health issues.</td>
<td>Strong advocacy for health. Have links with medical profession. Skilled at health advocacy campaigns. Can lobby the legislature. Experience in tobacco control and can access expertise of international tobacco control organizations. Will not</td>
</tr>
</tbody>
</table>
### Supportive actors

| World Health Organization | Multilateral; wants to control tobacco, promote health. | High normative authority. Can conduct some economic analyses, but lacks authority in fiscal discussions. Skilled at advocacy, high normative authority. |
| Asian Development Bank | Multilateral; wants to promote development and is secondarily interested in health. | Can conduct economic analyses. Interest in tobacco control not clear. Well known in the Philippines and has good access to the government. |
| World Bank | Multilateral; wants to promote development, health. | Can conduct economic analyses, has high authority in fiscal discussions. Has history of interest and expertise in tobacco control, and is likely to become engaged if requested. |
| About 20 percent of the membership of both houses of the legislature | Legislators with a pro-health record, some have anti-tobacco record. | A distinct, important minority. Can help activate citizens and move legislation forward. |

### Opposing Actors

<p>| Philip Morris Manufacturing Philippines | Transnational tobacco company with large domestic presence. Wants to preserve market advantages, maintain low taxes, undermine reform. | Tremendous economic power, extremely committed to its positions, deeply experienced in tobacco reform, well integrated into Philippine politics. Has strong connections to all aspects of the tobacco trade, the agricultural sector. Has over 50 years of experience in influencing Philippine policies in its favor. |
| British American Tobacco | Transnational tobacco company. Wants to enter Philippine market, pay low taxes, and undermine reform other than elements that would help it gain same tax status as Philip Morris. | Tremendous economic power, extremely committed to its positions, deeply experienced in tobacco reform, but not established in the Philippines. |
| Tobacco farmers | Agricultural businesses and employees. Want to protect their economic interests. | Exercise influence on legislators and can organize to express positions to the public. |
| Chair, Ways and Means Committee, lower house | Legislator. Will advance Philip Morris’s position as his own. | Has complete control over the introduction of all fiscal bills because of ability to set the committee’s agenda. Has a long and deep relationship with Philip Morris. |</p>
<table>
<thead>
<tr>
<th>Supportive actors</th>
<th>Type and interests</th>
<th>Capacities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members, Ways and Means Committee, lower house</td>
<td>Legislators. Many are allied with Philip Morris. Some are not.</td>
<td>About half of legislators are pro-tobacco and can be expected to vote according to the interests of the industry.</td>
</tr>
<tr>
<td>Around 30 percent of other legislators in both houses</td>
<td>Legislators with tobacco connections and some record of support for the industry.</td>
<td>Very unlikely to support meaningful reforms, but some could switch sides under the right conditions. Likely to influence constituents against the reform, obstruct passage in Congress.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neutral or unengaged actors</th>
<th>Type and interests</th>
<th>Capacities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citizenry of the Philippines</td>
<td>Citizens. Want liberties, economic growth, health. Busy with their own affairs</td>
<td>Hold all electoral power, but are largely unengaged and remain divided on most issues. After a decade of work by activists, most recognize that smoking harms health. Most citizens support UHC, and may have nationalistic pride.</td>
</tr>
<tr>
<td>Legislators in both houses</td>
<td>Legislators. Can be swayed. Most lean slightly pro-tobacco.</td>
<td>Can influence citizen opinion. Their support is crucial to passage of reforms.</td>
</tr>
<tr>
<td>Tobacco farmers</td>
<td>Agricultural businesses and employees. Want to protect their economic interests.</td>
<td>Exercise influence on legislators and can organize to express positions to the public.</td>
</tr>
<tr>
<td>Other industries</td>
<td>Businesses. Likely to be mildly supportive of the tobacco industry, but not engaged yet. Could become engaged if there are opportunities or risks.</td>
<td>High economic power, some ability to shape citizen perceptions. Likely to support UHC because their workers will benefit.</td>
</tr>
<tr>
<td>Television, print media</td>
<td>Media. Interested in popular stories. Can become engaged in some issues</td>
<td>Has high power to shape citizen perceptions. Can be engaged though advertising and by reporting.</td>
</tr>
<tr>
<td>Medical profession</td>
<td>Health interests. Would probably support reforms to reduce smoking, but largely not paying attention.</td>
<td>Highly influential voice of authority on health matters. Have unparalleled access to their own patients.</td>
</tr>
</tbody>
</table>
Section III: How the Tobacco Tax Reform Succeeded

After contentious debate and intense politicking, increased excise taxes were passed for tobacco and alcohol, raising sufficient resources to fund Aquino’s UHC plan. Calculations by the Department of Finance and the World Bank show that in the final version of the law sin taxes’ additional revenues would rise by 45 percent as the law takes effect between 2013 and 2017 (figure 1.4).

The successful passage of the sin tax law represented a major victory for the government of the Philippines and all members of its coalition, along with the citizenry. How this happened is reflected in solutions to the three problems posed above.

Challenge 1: Tax Rates

The executive branch calculated that its UHC goals would require raising an additional PhP 60 billion in annual revenue, of which a large portion was expected to come from reformed tobacco taxes. In this sense, the Aquino administration had its own guidelines for how much money it wanted to raise. Deriving the appropriate tax rate was therefore a question of forecasting the price elasticity of cigarette demand — an estimate of how much higher taxes would have to be to depress demand — and setting a per-pack tax rate that would produce the desired revenue at the expected sales volume. The Bureau of Internal Revenue made its own calculation, and the lead manager in the reform solicited input from others from the World Bank, WHO, and AER, all of which turned out to be very similar.
As expected, the tobacco industry raised strong objections. First, it claimed that higher taxes would harm Philippine tobacco farmers, a politically powerful implication. To help the government undermine this claim, the World Bank quickly produced an analysis of tobacco production. The analysis found that 80 percent of tobacco grown in the Philippines was exported, and therefore not subject to the impacts of lower domestic consumption after the reform. Second, the industry claimed that higher taxes would lead to smuggling problems. Another technical analysis by the World Bank helped defuse this issue by showing that even with higher taxes Philippine prices would still be too low to attract smuggled cigarettes from other countries.

A key feature of the success of this analytic work was that it occurred very quickly and was adjusted to changing political realities. As the industry and its allies produced arguments designed to weaken the reform, the government was able to respond credibly by drawing on World Bank studies to support its position and validate its forecast of the consequences of raising taxes on tobacco. Because the studies were coming from the World Bank, they carried great weight, particularly in financial discussions.

The Bank’s ability to understand these requests and respond quickly reflected some capacities that it had built specifically for tobacco tax issues and also the Philippine reform, rather than just its longstanding strengths. When the Philippine government contacted the Bank’s country office about the reforms, there were few staff members there or in Washington with experience on tobacco, and it was unclear whether its support should be led by a tax specialist or a health specialist. There were broad competencies in taxation, but these were strongest in income taxes and VATs, and tariffs as a general part of trade taxes. Excise taxes were not part of the mainstream expertise. Available staff members trained in health areas lacked this expertise too. However, the year before the Philippine reforms HNP leadership had consulted with Bloomberg Philanthropies as part of a general plan to strengthen the Bank’s capacities on tobacco taxes. Those discussions produced an arrangement to hire an economist with experience working on tobacco taxes with the Campaign for Tobacco Free Kids (TFK) and other tobacco control organizations. TFK and Bloomberg were also providing financial and technical support to several anti-tobacco groups in the Philippines, including AER, meaning that the new hire helped connect the Bank with partners with working relationships and a long track record of tobacco control activities. This helped unlock the Bank’s expertise in other areas also crucial to the politics of reform, including agriculture, taxes, and health — all of which were needed to understand tobacco’s multisectoral impact.

There were also contextual factors that greatly supported the reform and increased the Bank’s ability to assist. One was that the government of the Philippines was committed to the reform and was very interested in the Bank’s analytic support. Another was that Poverty Reduction and Economic Management (PREM) leadership in the Philippines office was eager to work on tobacco tax reform because they had been building capacity in anticipation of such a scenario, but had not yet utilized it in a major initiative. There were also factors partially reliant on chance, including good personality matches between the Bank staff members and the main actors in the Philippine government and the lead CSOs, and the fact that these professionals from diverse backgrounds shared similar views on the principle of tobacco control.

Challenge 2: Ways and Means Committee

When the reform effort began, the Ways and Means Committee of the lower house was firmly under the control of pro-tobacco legislators, as it had been for decades. The chairman belonged to President Aquino’s party. Initially the chairman maneuvered to avoid introducing the reform legislation and attempted to substitute alternatives that favored Philip Morris’s position. AER engaged him in dialogue, but could not change his position, and instead began to lobby for his removal as chairman. AER succeeded in provoking this change in late 2011 by drawing attention to his awkward refusal to introduce a bill championed by a president from his own party. Although President Aquino could not call for the resignation himself, many observers inferred from AER’s campaign that the president no longer supported the chairman. It is likely that this perception led to the resignation, even though President Aquino remained silent on the matter. The new Ways and Means chair was a relatively young legislator, not well known to either side of the tobacco divide.

In many ways, tobacco control activists were simply extremely lucky with the ascendancy of the new chairman, who staunchly supported higher taxes on tobacco and resisted attempts by Philip Morris to
influence his thinking. One figure that circulated among legislators was that Philip Morris was prepared to spend PhP 5 billion on lobbying efforts (about US$119 million at 2012’s average exchange rate of PhP 42/US$), although it is unclear how much was actually spent. In any case, the new chairman of the Ways and Means Committee was opposing a powerful interest group. In one early hearing, he was surprised to discover that representatives of Philip Morris were informed about his private briefings. He began to suspect that one or more committee staff members may have been sharing documents with the industry. The chairman quickly shifted his requests for analytic support to CSOs and his own analysts elsewhere. In his role as chairman, he introduced the president’s reform bill to the committee, but by then pro-tobacco legislators were watching carefully and prepared to vote it down. To pass the bill out of committee even without a majority, the chairman engineered a vote as a “blitz screen.” At his request a colleague, rather than he himself, called for the vote to avoid attracting attention. Enough of the pro-tobacco legislators were absent or insufficiently attentive to the topic at hand that the ambush succeeded and the bill proceeded to the House floor. “You have to know your enemy — we applied the art of war,” commented one senior official from the Department of Finance.

In the Senate a similar process unfolded. There the Ways and Means chairman had been a longstanding ally of the tobacco industry. Rather than introduce a version of the House bill, the chairman introduced his own bill that advanced a tobacco-friendly tax structure. Anti-tobacco CSOs quickly identified the bill as talking points prepared by Philip Morris. These activists publicized the legislation with a slogan that combined the chairman’s name with that of Philip Morris, held press events, and coordinated a response by medical groups led by the Philippine College of Physicians and several health CSOs, successfully provoking him to tender his resignation as chairman. As in the House, this allowed a strong reform bill to proceed to the full chamber.

**Challenge 3: Passage in Both Houses**

The politics of passing the tobacco tax reform through both houses was a more general struggle to convince a sufficiently large contingent of swing legislators, rather than the committee-level contest to overcome specific veto points controlled by Philip Morris. As the bills reached the floors of both houses, the Department of Finance and CSO partners conducted extensive political mapping analyses in which they forecast the position of every legislator. Using green for supportive positions and red for opposition positions, these analysts defined a yellow group in the middle that could have voted either way. They focused their efforts on the yellow group.

In the campaign to win sufficient support from legislators in the yellow group there were three important compromises. The first of these responded to the sentiment that tobacco was singled out unfairly. Some legislators felt that the other important sin industry — alcohol — was receiving preferential treatment. This perception was easy to sustain because President Aquino’s family was connected to the country’s largest brewer, and his political support was very strong in sugar growing areas, which provides a key input for brewed and distilled alcohol products. To blunt this criticism, alcohol excise tax increases were also proposed, but as the debate wore on, congressional leaders compromised to earn the votes of legislators from sugar-producing areas by significantly reducing the increases on alcohol.

There were several instances in which the politics of passing the reforms seemed likely to favor a weaker tax regime. The House bill was weaker than the Senate bill, and after both were passed it appeared that the committee reconciling the two versions would approve final legislation more favorable to the alcohol industry. With World Bank support, the Department of Finance was able to provide rapid analyses of the revenue and consumption forecasts implied by tax rates as they were proposed by different legislators and committees. These forecasts were crucial in securing support for a final bill that significantly raised tobacco taxes because they clarified future scenarios under each proposal and thereby helped delineate the minimum rates to achieve the government’s goals.

With tax increases on both tobacco and alcohol earmarked for UHC, the main CSOs promoting the reform were able to deepen the medical community’s support. Physicians had been supportive from the beginning, but the revenue forecasts showed such large potential increases in government health spending that they attracted much more support and more active engagement. Executive branch strategists used their interest
to engage a “white army,” referring to the typical white coat of care providers. This group had been active in tobacco control in the Philippines for many years and had significant public authority. As the 2012 reforms wended their way through the legislature, strategists identified the personal physicians of congressmen and then provided guidance for lobbying efforts by the white army, taking advantage of the personal authority of physicians and leveraging the medical weight of a patient visit for national policy reform.

Because BAT was disadvantaged by the old price classification scheme, it was supportive of reforms, whereas Philip Morris was strongly opposed to any such change. AER was able to divide the positions of these two companies by convincing BAT to support large tax increases on the condition that the same excise tax rate would apply to packs from all manufacturers. This swung more support toward reform.

AER’s ploy was highly contentious within the CSO coalition. Many health CSOs interpreted FCTC guidelines strictly and maintained that with very few exceptions contact with a tobacco company was unethical. Further, they were convinced by long experience that any reform supported by a tobacco company was bound to be ineffective in the long run. Some were fearful that AER had been captured by the industry, and one health CSO made treasonous charges against its employees. Although some suspicions remained, this rift was healed through an appeal to the Campaign for Tobacco Free Kids, which supported several organizations in the coalition. TFK drew on its credibility with all members to validate the approach taken by AER. The prominent anti-tobacco lawyer Dick Daynard — one of the pioneers of successful reform in the United States — was also engaged through common connections to Bloomberg Philanthropies and TFK. Daynard was able to keep the coalition together by convincing the health CSOs that AER and the reform bills had not been compromised by BAT. The Bank’s tobacco economist, who had worked with TFK in other control campaigns, also helped smooth relations.

The contentious politics of passing major tax reform were extremely fluid in the fall of 2012 when bills were under discussion in both houses. The World Bank committed its support by sending its tobacco control economist for the duration of the congressional proceedings, however long they may have continued. Others at the Manila country office were also on call and could produce on-demand analytic support for the reform. Senior officials praised the work of the team. Having a tobacco specialist was essential because “ordinary Bank staff would have had a hard time because of the complexities.” Speaking in particular about the country economist, officials praised the long-term working relationships that had developed over months of intensive work on tobacco.

Although the Bank had had technical answers from the beginning, it could not play a leading role in Philippine domestic politics because it could have become a “lightening rod” for criticisms and an easy target for the “imperialist” label due to its perceived ties to the United States and the capitalist world economy. For these reasons, officials did not always disclose the Bank as the source for every analysis it produced. The chief strategist for reforms attributed part of the ultimate success to the Bank’s support, saying there “was really a total commitment from the Bank in helping us” although it was not necessarily in the front lines. Crucial was the “just in time analytic support — the World Bank helped us do our homework. The tobacco industry has its playbook,” and the government drew on Bank support to keep up. Contrasting the successful tobacco experience with previous ones, a government official observed that the Bank “needs to get out of their ivory tower and really engage all the stakeholders,” focus on politically viable analyses rather than technically perfect ones, and “be willing to play a supporting role.”

Reform proponents in Congress and in the executive branch also won support from some of the tobacco farming areas by agreeing to earmark some additional tax revenues for those areas and to phase in the tax increases more slowly than had been proposed initially. The Bank was able to model the effect of phasing in the increases on different timescales, which helped proponents negotiate a solution that was slower than they wanted but still generated enough revenue to pay for UHC on the schedule required by President Aquino, and still attained the ultimate goal of the tax reform by setting taxes high enough to reduce tobacco consumption and thus have a positive health impact.

In the reform the World Bank played a primary role in providing political support for the government’s positions and analytic support to help understand the implications of different proposals and counter industry arguments. With its high public standing and authority in fiscal affairs, the Bank provided important
political legitimacy for the reforms by praising their contributions to macroeconomic stability and health. Working mainly behind the scenes, the bulk of the Bank’s work was in analytic support to help the government and its allies project the significance of policy alternatives and to refute claims designed to protect the tobacco industry. Examples of this work are included in part 1.

Figure 3.1 in the tobacco case study shows tax revenue forecasts under different reform proposals, which quantified and demonstrated in clear terms the significance of the proposed rates. A standard industry argument against tax increases is that it will lead to more smuggling. Figure 3.2 was prepared by the Bank and the DoF to compare post reform retail prices with those in neighboring countries, which would be potential sources for contraband cigarettes. As shown in table 1A.1 in the annex, even after tax hikes Philippine tobacco prices remained lower or similar to those in other places, meaning that smuggling would not be profitable, and belying the industry threat. Another common industry argument is that tax increases will hurt farmers. Analyses led by the World Bank showed these claims to have limited importance for the reform. For instance, most of the tobacco produced in the Philippines was sold for export, meaning that it would not be affected by domestic tax changes (figure 1A.2). The tobacco industry also attempted to bolster its importance by claiming inflated numbers of tobacco farmers and their dependents — about 1.8 million people — but Bank calculations based on several sources revealed this figure to be about three times as many as even a very generous estimate (table 1A.2).

To help the government estimate the social consequences of the reform, the Bank assessed the poverty and equity impact by income and product consumption habits (table 1A.3). The Bank also helped link the expected tax revenues to the financing gap for President Aquino’s Universal Health Coverage plan to inform the government’s negotiating position on the minimum acceptable increases (figure 1A.3). These examples help illustrate the importance of analytic work as an input into domestic political processes and show something of the breadth of sectors involved in tobacco tax issues.
CONCLUSIONS

The Philippine case shows how complex tobacco tax reform can be technically difficult, politically contested, economically contentious, and multisectoral. Earlier sections discuss some of what the World Bank did to support the government and its partners; this conclusion draws attention to how the Bank was able to do it. Interviews with Bank staff members and their counterparts suggest five factors that facilitated success across many sectors:

1. Government leadership and collaborative spirit: The strong leadership of President Aquino was mentioned repeatedly by interviewees in all organizations. The staunch support of the country’s chief executive was necessary to keep the reform on the policy agenda and propel it forward. Against the fully entrenched industry, interviewees felt that any lesser commitment would have failed. Of equal importance for the Bank, the executive branch was also very interested to engage other partners with experience in tobacco reform. Both the government’s leadership on tobacco tax reform and its willingness to collaborate with others combined to create a window of opportunity in which the Bank could effectively provide support.

2. PREM leadership viewed the reform as important: The PREM unit in the country strongly supported the tobacco tax reform and was eager to help because it viewed it as important to growth. In the global economic slowdown that started in 2008, demand for Philippine exports lessened, leading PREM to forecast that a protracted slowdown would harm the country’s growth unless domestic consumption and/or public spending were able to fill some of the gap. Since higher tobacco taxes would increase government revenues, PREM saw the reforms as one way to facilitate the increased public expenditure needed for growth. PREM was therefore particularly well motivated to assist in the process.

3. HNP had built tobacco tax capacity: Although HNP strategy had included tobacco tax reform as of 2007, the Bank had not been involved in major policy initiatives before the Philippine case. But the year before the Philippines requested Bank support, HNP had been working to build its capacities in tobacco taxes, and had hired new staff members with relevant expertise. Accordingly, when the request came, it was seen as a very timely opportunity to demonstrate HNP’s capacities.

4. PREM and HNP shared objectives: Cooperation between PREM and HNP was facilitated by their shared interest in tobacco tax reform, both for economic reasons — emphasized by PREM — and health reasons — emphasized by HNP.

5. Strong interpersonal relationships: The long and difficult process of shepherding the reform through its many stages was sustained by a shared mission, camaraderie, and friendship. Interviewees from civil society organizations, the government, and the World Bank fondly recalled and uniformly praised the strong working relationships and friendships that developed over long days, weekends at work, meals together, and the occasional beer. “We broke bread together.” “You build the trust, you do the work…. It is a kind of war.” This transformed institutional relationships into personal ones that inspired dedication, commitment, and trust in the high-stakes reform. Partners from government, CSOs, and the Bank “were marching shoulder to shoulder, so to speak,” recalled the lead CSO’s chief strategist. From the government’s perspective, the trust between partners was essential to the reform’s success. Speaking of the World Bank, one official said, “If you want to be effective as an adviser you have to be friends with the person you are advising. There has to be an equality — not ‘I am superior because I have a PhD in something.’ Particularly those who come from the Young Professionals program…they need to be…” The World Bank “cannot be the main actor” in domestic policy processes, but they can be — and were in the Philippine sin tax reforms — “the best supporting actor.”

EPILOGUE

As enacted, the 2012 sin tax reforms are projected to meet the government’s objectives of increasing revenues, discouraging consumption of tobacco and alcohol, and proving funds for UHC expansion, but there is no guarantee that the tax code will not be revised again. The next presidential election in 2016 may lead to a further round of discussions, and both the tobacco and alcohol industries are likely to press for more lenient terms in 2017 and beyond as the current reforms take full effect. It is also likely that both
industries will attempt to adjust their products and activities to reduce their tax liabilities and promote consumption. A strong monitoring framework will be required to ensure that tax rates remain high enough to maintain revenues and reduce consumption, and public vigilance will be required to ensure that sin tax revenues go to fund UHC as pledged.
REFERENCES


ANNEX 1: EXAMPLES OF THE BANK’S ANALYTIC WORK

All figures and tables provided by the World Bank.

Figure 1A.1 “Baseline” Revenue Projections By Various Sin Tax Reform Policy Proposals

Table 1A.1 Cigarette Retail Prices in Philippines and Neighboring Countries (Calculations by Department of Finance and World Bank)

<table>
<thead>
<tr>
<th>Similar GDP per capita</th>
<th>Most popular local brand</th>
<th>Most popular foreign brand</th>
<th>GDP capita 2010 (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indonesia Philippines</td>
<td>A Mild (PMI) Fortune (PMFTC)</td>
<td>Marlboro (PMI) Marlboro (PMFTC)</td>
<td>2,946</td>
</tr>
<tr>
<td></td>
<td>1.18 0.28</td>
<td>1.24 0.63</td>
<td>2,140</td>
</tr>
<tr>
<td>Higher GDP per capita</td>
<td>Most popular local brand</td>
<td>Most popular foreign brand</td>
<td></td>
</tr>
<tr>
<td>China Thailand</td>
<td>Baisha Krogthip</td>
<td>Marlboro Marlboro</td>
<td>4,421</td>
</tr>
<tr>
<td></td>
<td>0.74 1.76</td>
<td>2.37 2.36</td>
<td>4,608</td>
</tr>
<tr>
<td>Lower GDP per capita</td>
<td>Most popular local brand</td>
<td>Most popular foreign brand</td>
<td></td>
</tr>
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<td>----------------------</td>
<td>--------------------------</td>
<td>---------------------------</td>
<td></td>
</tr>
<tr>
<td>Vietnam</td>
<td>Vinataba (Vinataba)</td>
<td>White Horse (BAT)</td>
<td></td>
</tr>
<tr>
<td>Lao PDR</td>
<td>A Deng (LTL)</td>
<td>Marlboro (PMI)</td>
<td></td>
</tr>
<tr>
<td>Cambodia</td>
<td>ARA (BAT)</td>
<td>555 (BAT)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.63</td>
<td>0.74</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.75</td>
<td>1.46</td>
<td></td>
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<tr>
<td></td>
<td>0.25</td>
<td>1.19</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>795</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1,177</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>122</td>
<td></td>
</tr>
</tbody>
</table>

Sources: Asean Tobacco Tax Report: Regional Comparisons and Trends, Southeast Asia Initiative on Tobacco Tax (SITT) Resource Center of the Southeast Asia Tobacco Control Alliance (SEATCA), February 2012 and World Bank-World Development Indicators.

Figure 1A.2 Philippines Tobacco Production, Export and Proportion of Export to Production

Table 1A.2 Estimations of Tobacco Farming Employees and Dependent Family — Austria and Asuncion Assumptions

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Farmers</td>
<td>55,000</td>
</tr>
<tr>
<td>Family members</td>
<td>220,000</td>
</tr>
<tr>
<td>Full-time workers</td>
<td>55,000</td>
</tr>
<tr>
<td>Family members</td>
<td>220,000</td>
</tr>
<tr>
<td>Description</td>
<td>Value</td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Number of landlords</td>
<td>5000</td>
</tr>
<tr>
<td>Family members</td>
<td>22,000</td>
</tr>
<tr>
<td>Total number of people directly involved and their dependents</td>
<td>577,000</td>
</tr>
<tr>
<td>Product</td>
<td>Which products do the poor now use?</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td><strong>Cigarettes</strong></td>
<td>Poor tend to smoke more, and cheaper, cigarettes. Poor are unlikely to purchase premium cigarettes.</td>
</tr>
<tr>
<td></td>
<td>Marlboro: up by 59% (+18.69 pesos per pack)</td>
</tr>
<tr>
<td><strong>Alcohol</strong></td>
<td>Poor tend to choose high-alcohol, cheaper beer when drinking beer</td>
</tr>
<tr>
<td>Beer:</td>
<td>Premium beer: up by .63% (+0.5 pesos per liter)</td>
</tr>
</tbody>
</table>
**Spirits:** Poor tend to choose spirits over beer for greater effect and lower cost

**Gin San Miguel:** Consumption likely to balance out, as (1) beer use decreases, but (2) informal products replace taxed spirits

**Neutral:** Some reduce consumption but maintain same monthly expenditure

**Negative:** Some purchase the same amount of spirits at higher prices, diverting resources

**Positive:** Some reduce significantly or quit, freeing resources for non-sin goods/services

**Mild positive:** Youth drinking deterred/deferred

**Uncertain:** Some shift to nontaxed similar goods

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**On balance:** Household consumption effects are mixed, but trending toward positive

**Positive:** More poor receive better health care

**Enhanced by:** Awareness campaigns of public health services; support for users who are strongly addicted

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**Negative:** More drinkers choose spirits over beer, experience worse health

**Mild positive:** Few reduce significantly or quit, improving health over long term

**Positive:** More poor receive better health care

**Positive, enhanced by support policies/campaigns required**

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Figure 1A.3 KP-UHC Financing Gap and Fiscal Scenarios
Improving the health of whole populations through action across sectors is at the heart of goals set by the World Bank Group to eradicate extreme poverty and to promote shared prosperity by fostering the income growth of the poorest 40 percent of the population in every country. The Bank’s 2007 HNP Strategy called for the need to leverage investments and actions in other sectors as an imperative given the shifts in the global landscape (rapid urbanization, rise in non-communicable diseases as the leading cause of death in almost every region, worrisome trends in road traffic injuries, pandemic threats, climate change to name a few), which heighten the importance of coordination between multiple sectors. The knowledge product (KP) Building Healthy Societies: Influencing Multisectoral Action for Health addresses a demand from the World Bank’s Health Nutrition and Population (HNP) Global Practice staff and management and is the first of a series aimed at inducing a paradigm shift that places the responsibility for delivering health outcomes across multiple sectors. The audience for this KP includes not only World Bank task teams but also country policy makers and stakeholders.

The objective of this KP is to equip task teams with the tools and best practices to engage more effectively across sectors to improve health outcomes. The main products of the KP are (i) the development of the Multisectoral Opportunity and Constraints Assessment Tool (MOCAT) and (ii) four high level case studies.

This second volume features four high level case studies: (i) Road Safety in Argentina, (ii) Conditional Cash Transfer in Latin America, (iii) Multisectoral HIV/AIDS Responses in Thailand, Kenya, Namibia and India, and (iv) Tobacco Tax Reform in the Philippines. The selection of the case studies took into account a combination of factors including sectors involved, risk factors addressed, country income, targeting of the poor, lessons learned on successes and failures in working across sectors. Particular attention was paid in identifying case studies that would provide insight to task teams on the process to follow to engage effectively across sectors. The case studies focus on constraints to working effectively across sectors, and how some of those constraints have been overcome, while drawing on best practices in project management and evidence-based policy dialogue.

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