Report No. 19266

DEVELOPMENT EFFECTIVENESS IN HEALTH, NUTRITION, AND POPULATION

LESSONS FROM WORLD BANK EXPERIENCE

May 10, 1999

Sector and Thematic Evaluations Group
Operations Evaluation Department

Document of the World Bank

Abbreviations and Acronyms

AFR	Africa Region
ARDE	Annual Review of Development Effectiveness
CAS	Country Assistance Strategy
CPR	Contraceptive prevalence rates
EAP	East Asia and Pacific Region
ECA	Europe and Central Asia Region
ESW	Economic and sector work
HIV	Human immunodeficiency virus
HNP	Health, nutrition, and population
ICR	Implementation Completion Report
IEC	Information, education, and communication
IMR	Infant mortality rate
LAC	Latin America and the Caribbean Region
M&E	Monitoring and evaluation
MNA	Middle East and North Africa Region
NGO	Nongovernmental organization
OED	Operations Evaluation Department
PCU	Project coordinating unit
PMU	Project management unit
QAG	Quality Assurance Group
PPAR	Project Performance Audit Report
SAR	Staff Appraisal Report
SAS	South Asia Region
TA	Technical assistance

Director-General, Operations Evaluation	:	Mr. Robert Picciotto
Director, Operations Evaluation Department	:	Ms. Elizabeth McAllister
Manager, Sector and Thematic Evaluations	:	Mr. Gregory K. Ingram
Task Managers	:	Ms. Susan Stout and Mr. Timothy Johnston

Contents

Acknowledgments ... iii

Executive Summary ... v

1. Introduction and Evaluative Framework ... 1

Health Outcomes and the Health System ... 1

Evaluating the Bank's Performance ... 2

2. Evolution of Bank HNP Strategy and Lending ... 3

1970s: Early Population Projects ... 4

1980s: Direct Lending for Primary Health Care ... 5

1990s: Health Financing and Health System Reform ... 5

3. Project Performance and Determinants ... 7

Project Performance Trends ... 7

Borrower Performance and Country Context ... 8

Bank Performance ... 8

4. Development Effectiveness of HNP Investments and Policy Dialogue ... 17

Strengthening the HNP Service Delivery Structure ... 17

Enhancing Health System Performance ... 21

Health Financing ... 23

Instruments and Strategies for Reform ... 25

5. Recommendations ... 26

Increase Strategic Selectivity ... 27

Strengthen Quality Assurance and Results Orientation ... 27

Enhance Learning and Increase Institutional Development Impact ... 28

Enhance Partnerships ... 29

References ... 30

Excerpts from HNP Staff Responses in GroupWare Sessions ... 35

Sources of Information on Project Outcome ... 37

Executive Summaries from Case Studies ... 39

Brazil ... 39

India ... 44

Mali ... 49

Zimbabwe *53*

Figures

1.1. Achieving change in HNP 2
3.1. Outcome, sustainability are improving, but institutional performance is weak........................ 7
3.2. Supervision intensity is not keeping pace with growth in project size 12
3.3. High complexity prevails in difficult settings 12

Boxes

1.1. HNP Evaluation Literature 3
2.1. Bank HNP Policy Statements in the Past Decade 6
3.1. Lessons from Successful Institutional Development 10
3.2. Lessons from Successful Monitoring and Evaluation 11
4.1. Bank Experience in Nutrition 18
4.2. Bank Support for Population and Reproductive Health 21

Acknowledgments

This paper is the result of an effort by the Operations Evaluation Department to assess close to 30 years of the Bank's experience in the population, health and nutrition sectors. We would like to thank the entire management group of OED for the opportunity to work on this effort and their guidance and support throughout the effort. We would like especially to thank Roger Slade. The preparation and completion of this study would not have been possible without his foresight and patience, and not least, good humor. Ms. Jacintha Wijesinghe helped to manage the resources necessary for completing the effort, and kept the study team mindful, if not fully responsive too, its deadlines. Several external advisors contributed to the study at various stages, including Jose-Luis Bobadilla, Rodolpho Bulatao, Henry Mosley, Joan Nelson, and Amy Tsui. Many Bank staff, contributed as reviewers and sources of frank feedback and reactions at various stages of the study, we would like to acknowledge in particular efforts of Anwar Bach Baoub, Caroline, Cederlof, Xavier Coll, Ed Elmendorf, Alison Evans, Navin Girishankar, Salim Habayeb, Keith Hansen, Evangeline Javier, Cornelius Kostermans, Maureen Lewis, Christopher Lovelace, Jane Nassim, Tawhid Nawaz, Hope Phillips, Alex Preker, Wendy Roseberry, Jean-Jacque de St. Antoine, Richard Skolnick, Fatoumata Traore-Nafo, and Christopher Walker. Last, we would like to thank the many task team leaders and managers who took time from busy schedules to participate in the focus group discussions of the study and its recommendations.

This report was prepared by the HNP Cluster of the Sector and Thematic Evaluations Group of the Operations Evaluation Department. The overall OED study was task managed by Susan Stout. This report was co-authored by Timothy Johnston and Susan Stout. The report is based on a comparative assessment of performance in the HNP Lending Portfolio, *Lessons from Experience in HNP*, completed by a team including the authors and Laura Raney, Varun Gauri , Janet Nassim and Diana Qualls and on four sector reviews, authored by Varun Gauri (Brazil), Timothy Johnston (Zimbabwe), Timothy Johnston, Sheila Dohoo Faure, and Laura Raney (Mali) and Ronald G. Ridker and Philip Musgrove (India). William Hurlbut edited the report and prepared the graphs and manuscript. Marcia Bailey provided administrative support.

Executive Summary

1. Since the 1970s, World Bank lending to the health, nutrition, and population sector (HNP) has grown from a modest start to a total portfolio of US$14 billion in 1998. The Bank is now the world's largest international financier of HNP, with average annual commitments of $1.3 billion, and has played an increasingly important role in international and borrower health policy debates. Since the early 1990s, the Bank's operational emphasis has shifted from expanding the public provision of basic services toward improving health policies and promoting health sector reforms. With the current generation of projects, the Bank and its partners attempt to address underlying constraints to sector performance, while remaining cognizant of the difficulty of improving health sector effectiveness and efficiency even in developed countries. This paper synthesizes the first comprehensive assessment of the Bank's experience in the sector. The OED study included a desk review of the Bank's HNP portfolio and four country sector studies (Brazil, India, Mali, and Zimbabwe), and encompasses both completed and ongoing projects.

Project Performance

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

Major Evaluative Findings

3. The World Bank has made important contributions to strengthening health, nutrition, and population policies and services worldwide. Through its financing, the Bank has helped expand geographical access to basic health services, sponsored valuable training for service providers, and provided other important inputs to basic government health services. The Bank also has used its lending and non-lending services to promote dialogue and policy change on a variety of key issues, including family planning, health financing, and nutrition strategies. Clients appreciate the Bank's broad strategic perspective on the sector, and the Bank has taken a growing role in donor coordination. Despite an initial focus on government health services, the Bank is increasingly focusing on issues of private and NGO service delivery, insurance, and regulation. In recent years, the Bank also has placed greater emphasis on client ownership and beneficiary assessments in project design and supervision.

4. Several broad concerns emerge regarding the Bank's performance to date. First, the Bank has been more successful in expanding health service delivery systems than in improving service quality and efficiency, or promoting institutional change. Although the quality of institutional analysis has improved in recent years, the Bank is often better at specifying *what* practices need to change *than* how to change them or *why* change is difficult. Paradoxically, Bank project designs are usually more complex—with a greater number of components and organizational units—in countries with weak institutional capacity. The Bank is adopting increasingly

sophisticated approaches to promoting sector reform, but the institutional problems being addressed are increasingly difficult. Yet experience shows that realistic objectives, together with increased attention to *why's* and *how's,* increases the likelihood of achieving institutional objectives.

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

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

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

Implications for Current and Future Work

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

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

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

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

Moving Forward

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

13. ***Enhance quality assurance and results orientation.*** To improve HNP portfolio quality, the HNP Sector Board and regional technical managers should strengthen their role in monitoring portfolio quality, project results, and quality assurance. Routine quality assurance mechanisms should be enhanced to provide timely support to task teams in project design and supervision. To strengthen results orientation, the Bank should continue efforts to develop standards and best practice examples for M&E, and increase staff training. But strengthening incentives for achieving results and *using* information, both within the Bank and in client countries, is critical to enhancing borrower M&E capacity. Increased experimentation with and learning from performance-based budgeting mechanisms in Bank projects would be an important step.

14. ***Intensify learning from lending and non-lending services.*** In light of the institutional challenges facing the health sector and weak institutional performance, the Bank should seek to establish appropriate tools, guidelines, and training programs for institutional and stakeholder analysis in HNP. This should include strengthening analytic work on major institutional challenges, and providing flexible support to task teams facing difficult institutional problems. To strengthen the analytic base for Bank advice and lending, management should increase funding for advisory and analytic services, and shift some of the budget for those services from country departments to regional technical managers. The HNP Sector Board and technical managers should strengthen their role in enhancing the quality of advisory and analytic services, and encourage more intensive use of project experience as a source of both questions and answers.

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

1. Introduction and Evaluative Framework

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

1.1 The past 200 years witnessed a remarkable change in human demographic patterns—a shift from high, relatively uncontrolled fertility to low, controlled fertility throughout large parts of the world. Mortality also declined rapidly, and the rate of decline accelerated in the past 30 years. Fertility rates fell by over 40 percent globally and by close to 50 percent throughout much of the developing world, though they remain high in some settings. Despite this remarkable progress, much remains to be done. This is implicit in the focus the Development Assistance Committee (DAC) has put on several key health outcomes (such as reductions in infant, child, and maternal mortality and improved access to reproductive health services) in its effort to build consensus on goals and targets for the 21st century.

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

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

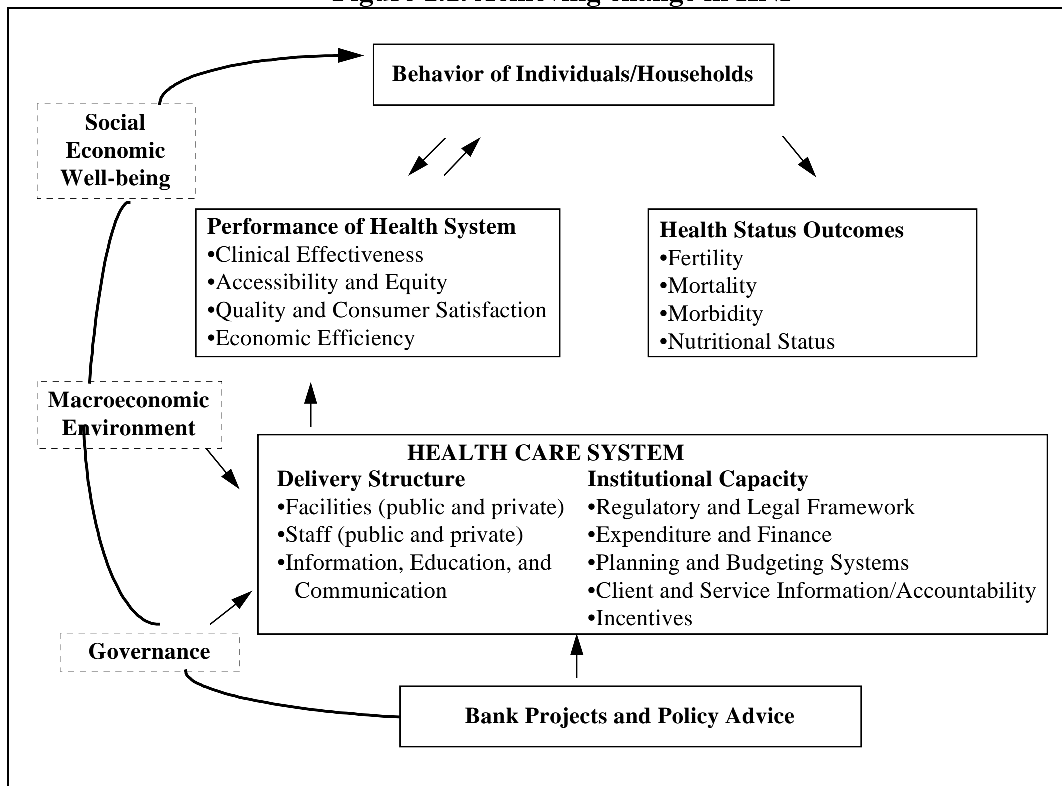
Health Outcomes and the Health System

1.4 As shown in Figure 1.1, morbidity, mortality, nutritional status, and fertility are determined by an array of factors in addition to health services. The most important are income, nutritional status, education, and the quality of the environment—including access to safe housing, clean water, and sanitation. The next most important are individual and community practices related to nutrition, sanitation, reproduction, alcohol and tobacco use, and other health-seeking behaviors, which are in turn related to social and economic status and culture (Lerer et al. 1998). Finally, HNP interventions can reduce the burden of disease or shorten disease duration either through preventive services and encouraging healthy behavior, or providing curative care. Increased understanding of the causes of disease and improved interventions for both preventive and curative services—such as antibiotics and vaccination—has improved health, nutrition, and population outcomes throughout

1. The first report in the series— *Evaluating Health Projects: Lessons from the Literature* (World Bank Discussion Paper, No. 356)—surveyed the literature on the evaluation of health projects and presented a design for this study. The second stage of the study, "Lessons from Experience in HNP" (Report No. 18642), describes the evolution and performance of the HNP lending portfolio, based on a review of the 224 HNP projects approved between fiscal 1970 and fiscal 1997. In addition, OED conducted a series of four country sector evaluations, which examined the history and performance of HNP non-lending and lending activities in Brazil (Report No. 18142), Mali (Report No. 18112), Zimbabwe (Report No. 18141), and India (forthcoming).

the world. Prevention is often (although not always) more cost-effective than treatment, but strong demand for curative services can result in a disproportionate emphasis on the medical care system both in public policy and the market for health care.

Figure 1.1. Achieving change in HNP



1.5 Health systems in all countries share a number of institutional characteristics. First, they include multiple players, often with conflicting interests and priorities. Second, because health outcomes are complex, it is more difficult to monitor the performance of health facilities or staff than in activities such as finance or telecommunications (Isreal 1987). Third, interactions among consumers and providers are shaped by information asymmetries and ritual, with health practitioners often assuming the role of "expert," while consumers have more information on their actual condition and health practices. Fourth, because of information failures, consumers are typically more willing to pay for curative services than for prevention and health promotion, and demand for health care usually increases with income, creating a bias in health markets and public spending toward urban curative care. Important preventive services are therefore often under-financed. Finally, the performance of health systems themselves is strongly influenced by external factors such as macroeconomic performance and civil service procedures. Improving policy and outcomes in this sector is far from a simple matter of applying administrative and technological expertise to stable and predictable epidemiological and medical challenges.

Evaluating the Bank's Performance

1.6 Figure 1.1 shows two major pathways through which the World Bank can influence the health sector and health outcomes in a country. The first is through lending and policy advice directed at the health system, which in turn may affect the delivery structure and the institutional capacity of the system. Through these activities, the Bank (or other sources of finance or knowledge) can attempt to improve the accessibility, quality, and efficiency of health services, or influence behavior through health promotion activities. Alternatively, the Bank can influence the

health sector and health outcomes indirectly, through its macroeconomic policy advice and influence on national governance as well as through the mix and effectiveness of investments in other sectors. Although this review focuses primarily on the Bank's HNP activities, it also touches on the influence of Bank macroeconomic advice on health sector performance.

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

Box 1.1. HNP Evaluation Literature

OED's review of the evaluation literature (Stout et al. 1997) found that the literature on the evaluation of family planning programs is wider and more tractable than that for health, nutrition, and disease control programs. But in all three areas, the evaluation literature is dominated by studies of the efficacy of specific interventions (for example, programs to improve the treatment of a particular disease) rather than evaluations of the performance of health systems. Evaluation in the health sector is further constrained by the paucity of reliable local estimates of health outcomes, and more fundamentally, by conceptual and philosophical problems with valuing life. A growing body of work is developing tools to enable the application of economic analysis to setting health priorities (World Bank 1993). Nevertheless, these methods are best suited for analysis of specific interventions in specific settings, and provide little guidance on linking the findings of technically sound economic analysis to particular institutional and political contexts.

Nevertheless, with the growing interest in and emphasis on enhancing HNP system performance and efficiency in developed and developing countries, health officials and international partners are increasingly grappling with the challenges of monitoring and evaluating clinical effectiveness, economic efficiency, and consumer satisfaction with health system performance (Dorch et al. 1997; McPake and Kutzim 1997; Aday et al. 1993).

1.8 But at the same time, this does not excuse the Bank or health policy makers from attempting rigorous evaluation. The approach of this study, and of the supporting case studies, has been to make plausible judgments about the relevance and effectiveness of the Bank's work at various stages of the causal chain shown in Figure 1.1. The study team conducted extensive interviews and focus groups with relevant Bank and borrower officials, health workers, and consumers, and sponsored background research papers on key topics. Where data allowed, the case studies compiled household or facility-based data to assess the impact of selected Bank interventions on health outcomes or health system performance, examining changes over time or among project and non-project districts.

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

2. Evolution of Bank HNP Strategy and Lending

The Bank's HNP strategy has evolved from relatively modest investments in population and family planning in the 1970s to direct lending for primary health care in the 1980s and to health system reform in the 1990s. Bank lending to HNP has expanded

dramatically during this period. Through its current emphasis on health sector reforms and health financing, the Bank is attempting to address some of the underlying constraints that limited the effectiveness of earlier efforts.

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

2.2 Health, nutrition, and population activities are integrated in many projects, making it difficult to determine the amount of lending to each subsector. An estimated one-third of HNP lending supported population and reproductive health, while Bank projects helped mobilize about $2 billion for nutrition programs. South Asia has received the greatest volume of lending (27 percent of the total), but Africa has the largest number of projects. The Bank's HNP portfolio is highly concentrated in a few countries: five countries (India, Brazil, China, Indonesia, and Bangladesh) account for half of the lending since 1970. The performance of projects in these countries therefore strongly influences the average performance of their respective regions and of the overall HNP portfolio.

2.3 The content of specific HNP investments reflects, with a substantial time lag, the Bank's evolving policy perspective. Investments in HNP evolved from single-purpose efforts to improve family planning programs in the 1970s, to efforts to expand health system capacity and expand delivery of primary health care in the 1980s and, more recently, to encourage broad sector reforms. Less than 20 percent of all projects in the early 1980s focused on health system reforms, compared to nearly half of projects approved since fiscal 1995. The Bank also sponsored various stand-alone population, nutrition, and disease control projects in the 1980s and 1990s.

1970s: Early Population Projects

2.4 The World Bank began lending for population and family planning activities in the early 1970s. The rationale was demographic: rapid rates of population growth were considered a major threat to development progress in many developing countries; narrow, focused population and family planning programs were believed to be necessary to slow population growth. The Bank therefore declared in its 1975 *Health Sector Policy Paper,* the Bank's first formal HNP policy statement, that it would lend only for family planning and population, and not directly for health, although health activities could be part of population or other development efforts.[2] In these early loans, the Bank essentially acted as a bank, providing finance to expand government programs. Where these programs were relatively effective in addressing consumer demand (as in Bangladesh or Indonesia), Bank projects were relatively successful, but where the government programs were weak (as in India), the projects had less impact (OED 1992).

2.5 The Bank's approach in the 1970s sought to expand the supply of, and increase access to, publicly provided family planning services. Despite clear evidence of the relatively significant role of private (nongovernmental and commercial) providers in many countries, Bank project designs tended to support public provision of services, relying on its policy analyses and non-

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

lending work to alert borrowers to the potential role of private providers. The Bank typically asserted "unmet need" for family planning services based on various surveys of women, and assumed that increased geographical access to services would lead to increased use of services. This approach had three major failings: it did not assess the actual demand for the services to be provided; it did not consider whether increased public provision would result in a net increase in health service availability (or merely displace consumers from other facilities); and it did not address the underlying constraints affecting the quality of public service provision.

1980s: Direct Lending for Primary Health Care

2.6 Its *1980 Health Sector Policy Paper* committed the Bank to direct lending in the health sector. The primary instrument for executing this policy was investment loans, usually with a geographic focus, although by the late 1980s the Bank increasingly sought to improve the coherence of donor efforts by financing "umbrella" projects that included financing from several donors. The Bank strategy addressed a genuine need in many borrower countries for improved access to basic health services, particularly in rural areas. The interventions supported in these projects—maternal and child health, family planning, and nutrition education—addressed a significant portion of the burden of disease for the poor. The projects also usefully promoted the integration of basic health services—both with family planning and with other health programs (such as immunization).

2.7 These family health or basic health projects were remarkably similar, however, in design and approach across regional and country settings.[3] The large number of components in the projects contributed to project complexity, a particular challenge when many health ministries were administratively weak and borrowing from the Bank for the first time. The Bank responded by including "capacity building" components in most projects, and by increasingly relying on project management units to facilitate project implementation, sometimes isolating the "project" from the rest of the ministry. These projects, like the earlier population projects, usually failed to effectively address underlying quality issues in government health services, and typically provided for little interaction with private, nongovernmental, or traditional health providers (except for traditional midwife training).

1990s: Health Financing and Health System Reform

2.8 A number of factors in the late-1980s and 1990s brought about a shift in Bank strategy, and an increased emphasis on health financing and health service reform (see Box 2.1). First, efforts to expand infrastructure and staffing for primary health care services in the 1980s coincided with the onset of economic crisis in much of the developing world. Budget pressures, together with continued inefficiencies in government health spending, threatened the quality and sustainability of expanded government primary health care systems. Second, disappointment with the progress of specific investment projects in bringing about systemic change—together with a growing trend toward health sector reforms in industrial countries—led to growing international consensus on the need for health sector reforms in developing countries. Third, the HIV/AIDS epidemic and the demographic transition in middle-income countries created new challenges for disease control. Finally, the challenges facing health systems increasingly diverged among regions. In much of Africa and Asia, communicable diseases and access to services are still

---

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

problems, while in central Europe and Latin America, issues of cost-escalation and the burden of an aging population and high-cost chronic diseases have come to the fore (Prescott 1997).

2.9 The Bank's increased emphasis on health financing and health system reform is consistent with its comparative advantage in the sector, and has focused attention on the constraints to providing efficient and effective health services in client countries. Through its efforts, the Bank helped raise awareness regarding health financing issues in borrower countries and internationally; contributed to international debates on the cost-effectiveness of various interventions; encouraged the development of strategies for and adoption of health system reforms; and in many aid-dependent countries helped improve donor coordination in the sector. The major shortcoming with Bank strategy has been inadequate focus on *how* to effectively improve HNP efficiency, effectiveness, and equity. The institutional sophistication of the Bank's approaches has increased, but so has the complexity of the challenges addressed. Given the lack of agreement on the "right" configuration of an effective health system and wide variation in country context, the Bank's increased focus on knowledge management is appropriate, but further emphasis on flexible instruments and analytical and advisory services may be needed.

Box 2.1. Bank HNP Policy Statements in the Past Decade

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

The *World Development Report 1993: Investing in Health* looked at the role of government and the market in health and examined the most appropriate ownership and financing arrangements to improve health outcomes, reach the poorest, and contain costs. The report stressed a three-pronged approach. First, governments should foster an environment that enables households to improve health. Second, government health spending should be made more effective by reducing expenditures on the less cost-effective interventions and expanding basic public health programs and essential clinical services. Third, diversity and competition in the provision of health services and insurance should be promoted. The Bank's 1993 publication *Disease Control Priorities in Developing Countries* was an important contribution to international discussions, and led to increased Bank support for disease control project lending.

In 1997, the Bank released its *Health, Nutrition, and Population Sector Strategy* paper, which will guide the Bank's work in the sector over the next decade. The strategy identifies three objectives: (i) improve the health, nutrition, and population outcomes of the poor; (ii) enhance the performance of health care systems; and (iii) secure sustainable health care financing. The paper also incorporated preliminary findings from the OED review regarding overall portfolio performance. As a supplement to the HNP strategy, the Bank in 1999 released a population and reproductive health strategy paper (a nutrition strategy paper is planned for fiscal 2000). The paper describes how the Bank is responding to the integrated approach to population and reproductive health agreed upon at the 1994 Cairo conference. These strategy papers articulate an appropriate vision for Bank engagement in the sector. The challenge will be to make strategic decisions on areas of emphasis, and to allocate lending, staff time, and administrative resources accordingly.

3. Project Performance and Determinants

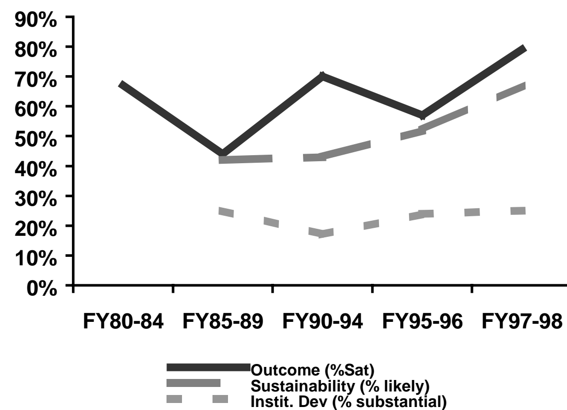
The percentage of HNP projects rated as satisfactory by OED is below the Bank average, but performance has improved in recent years. Institutional development impact remains the weak point of the portfolio—less than a quarter of projects substantially achieve their institutional objectives. Borrower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

3.1 Although the performance of the Bank's HNP portfolio has improved recently, it has historically been below the Bank average. Many factors behind this record are beyond the Bank's control. But on the operational level, a closer analysis of the record shows that weaknesses in the design and supervision of Bank projects have contributed to disappointing performance.[4]

Project Performance Trends

3.2 Of the 107 HNP projects completed between FY75 and FY98, OED rated 64 percent satisfactory, compared to 79 percent for non-HNP projects (Figure 3.1).[5] Recent efforts by the Bank and sector staff to improve performance appear to be showing results, however; 79 percent of projects completed in FY97/98 satisfactorily achieved their development objectives, similar to the Bank average of 77 percent. Few of the more recent sector reform projects have been completed, so the performance consequences of the current strategy remain uncertain. But the Bank's portfolio monitoring system currently lists a third of HNP projects as "at risk," above the Bank average of 24 percent, which suggests that recent improvements should not be a cause for complacency.

Figure 3.1. Outcome, sustainability are improving, but institutional performance is weak



Source: OED data

3.3 Although only half (52 percent) of all completed HNP projects were rated as likely to be sustainable, this rose to two-thirds in FY97/98. Improvements in sustainability appear to be due to a combination of improved economic situations in many borrower countries (prior to the recent Asia crisis), increased Bank attention to the recurrent cost implications of investments, and greater emphasis by Bank and borrowers on client ownership.

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

5. The poor project performance in the late-1980s probably reflects weak institutional design in the first generation of Bank health projects and shortfalls in funds for recurrent costs as a result of economic crisis in many borrower countries.

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

Borrower Performance and Country Context

3.5 All Bank projects are financed through loans to governments, and responsibility for implementation rests primarily with governments. Not surprisingly, evidence from the case studies, completion reports, and econometric model of determinants of project performance[6] indicates that *borrower performance* is the most important determinant of project outcome.[7] Yet borrower performance is not exogenous: it is also influenced by the Bank's assessment (and encouragement) of borrower project ownership, and the fit between project design and borrower capacity, and the effectiveness of supervision. OED ratings of borrower performance in project preparation improved from 63 percent satisfactory in the early 1990s to 92 percent satisfactory in FY97/98 (roughly comparable to Bank averages). In contrast, borrower implementation performance fell from 71 percent to 58 percent satisfactory over the same period. Although the reasons for the decline in borrower implementation performance are not entirely clear, they could be partly the result of inadequate assessment of implementation capacity and shortcomings in Bank supervision.

3.6 *Country context* is the second most important influence on performance, particularly the overall quality of borrower institutions.[8] In countries where high levels of corruption prevail or legal mechanisms for contract enforcement are weak, resources from Bank investments can be diverted or the project must put in place cumbersome procedures to increase accountability. Country experience also illustrates the importance of political and social institutions for the achievement of project and policy objectives. For example, cultural beliefs and low levels of female literacy create a formidable challenge to increasing the use of family planning in rural Mali, and the complexities of the Brazilian political system complicate health reform efforts. Although national institutions evolve slowly, the results suggest that the Bank needs to understand the institutional context, and make choices regarding appropriate instruments and objectives. This includes choosing not to lend when governance is particularly bad—as when the Bank stopped lending to Nigeria in the mid-1990s after several failed HNP projects.

Bank Performance

3.7 Although borrower performance and country context are the most important determinants of project outcome, a number of important factors—including project design and supervision—are under Bank control. According to OED assessments of completed projects, Bank performance in HNP project appraisal and supervision has improved from only about 60

---

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

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

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

percent satisfactory in the early 1990s (10 to 15 percent below the Bank averages) to over 75 percent satisfactory for projects exiting in FY97/98—equal to the Bank average for supervision, and above the Bank average (66 percent) for project appraisal. This still falls short, however, of the Strategic Compact goal of 100 percent satisfactory Bank performance by 2001. OED's review found that the quality of project preparation and supervision in the HNP sector has improved over the past decade in a number of respects, but weaknesses remain in several key areas.

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

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

- *In seeking to promote institutional change and build borrower capacity, the Bank often does not adequately analyze the constraints underlying current performance.* Although institutional analysis has improved since the mid-1990s, it remains weak, particularly in relation to the much more daunting systemic reforms the Bank is now promoting.

- *Weak analysis contributes to a lack of clarity in the articulation of institutional development objectives,* including whether the instruments chosen are the best to bring about change. Bank projects have traditionally addressed capacity constraints through the provision of training and additional resources, although a growing number of projects (particularly in LAC and ECA) are focusing on improving incentives or regulations.

- *The absence, until recently, of appropriate indicators for institutional goals* has contributed to the tendency to assert that "capacity was built" because training or technical assistance were provided, reducing the focus on the ultimate objectives.

3.9 The econometric model found that the quality of institutional analysis during project preparation has a significant influence on project outcome—improving analysis is therefore likely to improve outcomes. Although some institutional issues require sophisticated analysis, the criteria used by OED merely asked whether project designers appeared to have thought through relevant institutional issues (Stout et al. 1997). Experience from HNP projects that successfully achieved institutional objectives could be more widely replicated (Box 3.1). This suggests that the Bank's institutional development performance in HNP could be raised to equal or above the current Bank averages through strengthening staff and management commitment to achieving institutional goals, developing standards and tools for institutional analysis, and training staff in their use.

3.10 ***Monitoring and Evaluation of HNP Outcomes.*** Although nearly all World Bank project design documents *assert* that the project will improve HNP outcomes, system performance, or health service access by the poor, few implementation completion reports provide evidence that these development objectives were actually achieved. Not only do we know little about what the

Box 3.1. Lessons from Successful Institutional Development

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

- *Consistent commitment to achieving institutional objectives,* including the promotion of consensus among stakeholders regarding priorities and approaches, and if necessary, developing strategies to anticipate and soften resistance.
- *Project designs based on a solid analysis of the underlying constraints* to improved performance—through some combination of sector work, evaluation of previous experience, and dialogue with key stakeholders. Designers then developed realistic strategies to address these constraints, including attention to the proper sequencing of interventions.
- *Flexible project implementation*, with regular reviews of progress toward institutional objectives, and proactive attention to problems by Bank staff and borrowers. About half the projects that substantially achieved institutional goals were significantly modified during implementation.
- *A governance and macroeconomic context that was supportive of institutional and organizational development*. If not, the above factors were particularly important.

Bank has "bought" with its investments, but when progress toward objectives is not measured, they are less likely to be achieved.[9]

3.11 Currently, most HNP project designs identify key performance indicators, and intentions for M&E have improved in recent years. But the overwhelming problem stated in ICRs is that the data required were not collected or analyzed, at least in a manner that allowed assessment of impact. Two-thirds of unsatisfactory projects reported that the Bank gave inadequate attention to monitoring and evaluation during project design and implementation. Both OED and QAG have found that monitoring and evaluation is weak throughout the Bank, but the gap between M&E intentions and implementation is a particular problem for HNP. Project designs often give primary responsibility for implementing M&E to the borrower, but do not adequately consider how data will be collected or analyzed, the incentives and capacity of borrowers to do so, or the appropriate balance between the use of internal monitoring systems and external (including rapid assessment) evaluations. A number of projects have sought to improve borrower capacity—some successfully. But the Bank has tended to place excessive emphasis on providing equipment and training, and underestimated the time required to agree upon indicators among various bureaucratic stakeholders, clarify roles and responsibilities for data collection and analysis, and strengthen incentives for using evaluative information and decision-making. The challenges of M&E are more difficult for system reform than for targeted interventions, but lessons from HNP projects with successful M&E are broadly applicable (see Box 3.2).

3.12 ***Quality of Supervision.*** Although responsibility for project implementation rests with borrowers, the quality of Bank supervision has an important influence on project outcome (see Annex B). ICRs for 69 percent of unsatisfactory projects reported that supervision was inadequate, compared to only a third of satisfactory projects. The case studies and ICRs suggest that effective supervision requires a team with an appropriate skill mix; continuity among team members; strong managerial skills and client orientation; proactive recognition and solution of problems; and an appropriate balance between high-level policy dialogue, detailed attention to implementation issues, field supervision, negotiation and consensus-building among

9. Methodological problems can make it difficult to attribute changes in outcomes to specific (Bank-financed or otherwise) interventions, and both developed and developing countries are still in the early stages of developing systems and indicators to monitor the efficiency, efficacy, and client responsiveness of health facilities or systems. Yet plausible conclusions regarding project effectiveness, system performance, and HNP outcomes are possible using existing systems and methodologies (McPake and Kutzin 1997).

Box 3.2. Lessons from Successful Monitoring and Evaluation

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

- The Brazil Amazon Basin Malaria Control project helped to train malaria field workers and strengthen disease surveillance systems, which—together with a shift in strategy from eradication to control, early treatment, and case management—contributed to a decline in malaria incidence and fatality rates.
- The Tamil Nadu Integrated Nutrition project in India established a community-based system for regularly monitoring the growth and weight of children under age 3, with targeted feeding (and education in feeding practices for mothers) for children found to be malnourished. The project significantly reduced severe malnutrition in the target group. The monitoring system both contributed to and documented the impact.
- In Mali, the Health and Rural Water Supply project (1991-98) eventually helped establish a nationwide health information system, although data were not available until the final years of the project. This illustrates the importance of balancing long-term efforts to strengthen borrower monitoring capacity with provisions for periodic external qualitative or quantitative assessments, including rapid assessments (WHO 1993).
- In the current sector-wide health reform programs in Bangladesh and Ghana, government and donors (including the Bank) agreed—after lengthy negotiations—upon a limited number of national indicators that will serve as benchmarks for joint annual reviews of sector performance. Remaining challenges include better linking system performance indicators to HNP outcomes, and ensuring that national indicators create incentives for performance at lower levels of the system (Adams 1998).

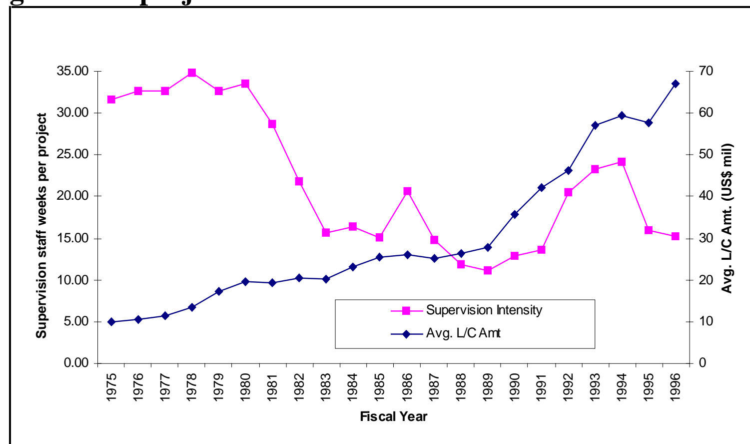
stakeholders. Recent QAG supervision reviews found that supervision ratings for HNP project implementation performance tended to be excessively optimistic, and that few of the HNP projects reviewed based supervision assessments on progress toward achieving development objectives. The HNP sector is also slow to restructure problem projects. Yet an apparent factor behind recent increases in HNP project outcome ratings was the restructuring of a number of problem projects that had languished during the early 1990s.

3.13 The impact of resource constraints on supervision quality has been a source of growing tension between Bank HNP staff and Bank management. QAG and OED analyses found no simple link between supervision quality and quantity (measured by total staff weeks), although a minimum level of resources is clearly necessary. Discussions with staff confirm a widespread feeling, however, that supervision budgets have declined in real terms in recent years, and that pressures to "do more with less" are having a negative impact on quality. Staff cite reductions in the number of technical specialists included on supervision missions, and in the time and budget available for priorities such as stakeholder consultation or advisory and analytical services. Senior management has asserted that overall HNP supervision budgets have been constant, and at the aggregate level, average supervision budgets in the Bank's Human Development Network averaged close to $52,000 per project from FY94-98. OED was unable to resolve the apparent conflict between staff perceptions and aggregate trends. But it is clear the sector faces a serious problem of multiplying tasks and mandates with inadequate guidance from management regarding priorities or selectivity, particularly with growing project size and the increased challenges of promoting sector reforms, institutional development, and stakeholder consultation (see Figure 3.2).

3.14 ***Complexity of Project Designs.*** As discussed in Chapter 1, health systems include a wide array of public and private stakeholders, and achieving improvements in HNP outcomes may require multiple interventions. If project designs are too simple—for example, financing only infrastructure and training, or ignoring key ministries or agents—they risk not meeting their development objectives. Although the econometric model found no linear correlation between complexity and project outcome, about half the ICRs for projects rated unsatisfactory concluded that the project design was too complex. The number of project components is an important

aspect of complexity, although the number of agencies involved may matter more. OED found that HNP project designs tend to be more complex in countries with low institutional capacity, and where the pace of change in infant mortality is slower (Figure 3.3).[10] The challenge is to get complexity "right," combining assessment of the capacity of implementing organizations with greater effort to prioritize and sequence interventions, and to reduce the burden of Bank procedures, particularly when capacity is limited.

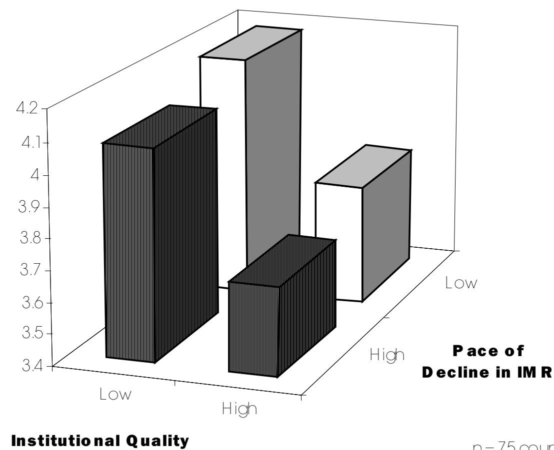
Figure 3.2. Supervision intensity is not keeping pace with growth in project size



Source: OED data

3.15 ***Economic Analysis.*** Although the econometric model found that institutional analysis has a greater influence on project outcome, economic analysis remains an important foundation for effective project design and policy advice. The Bank's HNP sector leadership has established guidelines for economic analysis, which calls for, among other things, analysis of alternative interventions, the justification for public sector involvement, cost effectiveness or cost-benefit analysis, assessment of recurrent cost impact, risk analysis, and assessment of poverty impact (Preker et al. 1997). OED's assessment of HNP project appraisal documents found that economic analysis has improved in the past several years, but that it remains below the standards established by the sector—consistent with QAG findings on HNP quality at entry. Recently designed projects are more likely to discuss the cost-effectiveness of the intervention, possible alternatives, or reasons for public sector involvement. Risk analysis has improved somewhat, but still is usually discussed very generally, with limited sensitivity analysis or consideration of exit strategies. Project documents still commonly suggest that borrower institutional capacity and commitment to project goals are the major risks, to be addressed by training and technical assistance. Assessment of health care markets could be strengthened to better assess the relative roles of public and private providers, and consumer demand (Hammer 1996).

Figure 3.3. High complexity prevails in difficult settings



Source: OED data and World Bank 1997d

3.16 ***Consumer Responsiveness.*** The majority of HNP projects include objectives that can only be met through client-responsive services (Heaver 1988). Yet notably lacking in most Bank analysis is an adequate assessment of demand for health services. The Bank

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

has increased its attention to health consumers in the past few years, but a minority of project design and completion documents provide basic data on current levels of service utilization (in both public and private sector) or consumer satisfaction. Overall, only 40 percent of all project design documents provided evidence on consumer demand, and only 2 percent estimated consumer response to the proposed interventions. Although beneficiary surveys and consultations have become more common in recent years, only four (of 224) projects documented beneficiary decision-making power over project design.

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

3.18 ***Linking Inputs to HNP Outcomes for the Poor.*** Although usually focusing on poor regions or diseases that most affect the poor, the Bank has been weaker in analyzing the factors leading to ill health and selecting interventions that are likely to achieve the maximum impact on the overall disease burden for the poor. Project design documents typically describe the disease burden, list project activities, and then assert that significant improvements in health outcomes will result. Design documents, however, seldom present a coherent analysis of *how* project interventions will translate into improved health outcomes for the poor. Consequently, the Bank is usually over-optimistic in its projections of health impact and, more important, often does not consider whether alternative approaches would yield a greater impact on the disease burden for the poor. All four country studies and the portfolio review found that Bank investments and policy advice tend to focus on the medical care system, while greater aggregate health improvements may be achieved through health education and behavior change initiatives, or intersectoral interventions such as water and sanitation (Lerer et al. 1998). Intersectoral interventions can be difficult to implement, however, and therefore must be chosen carefully and allocated adequate time for supervision. Prevention is not always more cost-effective than curative approaches, however, as demonstrated by the Amazon Basin Malaria Control project (see Box 3.2).

3.19 ***Stakeholder Analysis.*** Recent project documents are more likely to have evidence of borrower ownership and participation in project identification and design, but many still simply assert that the project is consistent with borrower priorities, or discuss central government commitment but not that of local government or beneficiaries. Few project completion reports or design documents discuss or elaborate on Bank efforts to stimulate ownership. Greater participation and work with a range of stakeholders is characteristic of more recent projects, and some task teams undertake stakeholder analysis but do not document findings to avoid jeopardizing reformers.

3.20 Projects tend to be more successful in achieving their institutional development goals when strongly supported by relevant borrower agencies and key stakeholders. Differences of policy opinion across government can seriously undermine institutional development goals. Such differences are common in sector reform efforts.

3.21 The challenges of health reform require strategic and flexible approaches to support the development of the intellectual consensus and broad-based coalitions necessary for change. System reform is difficult and time-consuming, and stakeholders outside ministries of health can determine whether reforms succeed or fail. In practice, the Bank often has focused primarily on dialogue with government officials, particularly in ministries of health, without sufficient to using its convening role to build consensus among stakeholders. Some recent efforts give greater emphasis to these priorities. In addition, the Bank often has not developed sufficient understanding to anticipate responses to reforms, including which are likely to be adopted, which resisted, and possible changes in the content in the course of policy debate and implementation.[11] Experienced task managers are well aware of the political dimensions the reform, but staff have limited skills and tools for stakeholder and political analysis.

3.22 ***Participation.*** Developing mechanisms to increase the "voice" of communities in the management of health services is key to improving service quality and consumer responsiveness. Despite interest in community participation and mobilization during the primary health care focus of the 1980s, subsequent Bank project documents tend to equate "participation" with charging consumers for services. Even among projects that plan to encourage local participation, descriptions of local and traditional participatory structures are rare. The Mali case study found that establishing community-managed health centers requires close attention to the design and nurturing of participatory structures. Yet even in communities where local committees were managing the local health center, women were usually under-represented, and community members did not always see the committees as representing their interests. The Bank is not well-placed to directly foster local participation or strengthen mechanisms for consumer voices, but it can emphasize these issues in policy dialogue or encourage direct or parallel financing for enhanced participation through international partners or local NGOs.[12]

3.23 ***Coordination.*** Because health is a popular sector with many donors, ministries of health—particularly in aid-dependent countries—frequently have been undermined by a proliferation of projects and vertical programs. The Bank began in the 1980s to encourage other donors to finance projects jointly, and in the 1990s has taken the lead in building consensus among donors for sector-wide approaches, and in helping governments develop the policy framework for sector programs (Peters and Chao 1998). Despite these efforts, some partners express concern that inadequate field presence can hinder the Bank's ability to coordinate effectively. In addition to the challenge of donor coordination, weak coordination and turf battles among ministries and ministerial sub-units are common in developed in developing countries alike. Weak linkages among ministries of finance, planning, and sectoral ministries in particular can hinder both internal planning and budgeting, and external coordination of partners (van de Walle and Johnston 1996). Such problems are not easily resolved, but the case studies suggest that the Bank can facilitate improved relationships among government units, particular through its convening power and relationships both with ministries of finance and sectoral ministries.[13] Improving coordination within governments or among donors can be difficult and time-

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

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

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

consuming, however, so the Bank and partners need to establish appropriate strategies, priorities, and division of responsibilities.

Institutional Factors Influencing Performance

3.24 Few inside or outside the Bank dispute the importance of defining and monitoring objectives, careful institutional assessment, or the political nature of health reform. The vast majority of Bank HNP staff are knowledgeable and dedicated. What then are the underlying sources of these difficulties, and why do they persist? We focus on three major areas: quality assurance; monitoring and evaluation; and learning and intellectual leadership.[14]

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

- *Lack of clear lines of responsibility and accountability for quality*, with nominal responsibility resting with the Sector Board and lead technical specialists, but with budgets and staff allocation decisions made by the country departments. The HNP Sector Board's recent decision to strengthen its role in quality assurance, including establishing a benchmarking system to regularly monitor portfolio performance, will be an important step.
- *Regional technical advisers are overburdened*, and are often not able to give sustained time and attention to reviewing the quality of project design, supervision, and ESW.
- *Managerial accountability mechanisms such as QAG are not balanced by mechanisms to provide early and collegial support to task teams* during project designed and supervision, and to build quality assurance into the entire project cycle. The project design peer review process is not functioning effectively.
- *Staff are reluctant to restructure projects* because of continued high transaction costs, and a continued perception among HNP staff that restructuring is seen by management as an admission of failure. Restructuring occurs, but often after changes in task managers.

3.26 ***Monitoring and Evaluation.*** Monitoring and evaluation has been weak throughout the Bank, despite repeated exhortations from OED (OED 1994). Aside from the methodological issues discussed earlier, several factors constrained Bank and borrower M&E performance:

- *Low priority given to M&E by Bank management*, and weak staff incentives. Many staff report that their managers rarely express interest in reviewing development progress.
- *The Bank's core business processes and incentives remain focused on lending money rather than achieving impact*. Until these incentives are adjusted, progress will remain sporadic. The Comprehensive Development Framework pilots currently underway offer an opportunity to shift Bank processes and procedures toward achieving development results.
- *An absence of forums for staff to discuss and review progress toward development objectives*, or to recognize and reward evidence of HNP development impact. Staff still perceived that rewards are linked primarily to project approval and disbursement.

---

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

- *In most client countries health monitoring systems are either weak or rarely used in policy decision making*, and national or local budgets are rarely linked to monitoring data. Consequently, there is little demand for information, and few incentives for its collection.
- *Few Bank client countries have the "information infrastructure" necessary for routinely and reliably measuring health status outcomes* through vital registration systems and up-to-date censuses. Despite significant Bank and donor investments in household surveys, the Bank and partners have given little attention to these routine systems.

3.27 ***Learning and Intellectual Leadership.*** The Bank's Human Development Network and HNP Sector Board are ahead of some other parts of the Bank in attempting to respond to President Wolfensohn's call for a "knowledge Bank." The Network has established various systems for knowledge management, and focused on strengthening staff skills in key areas. The Bank's ability to provide intellectual leadership both internationally and at the country level is being compromised, however, by several trends:

- *Few staff have explicit training in organizational, institutional, or stakeholder analysis, and few tools to undertake such analysis during project design.* Developing operationally relevant training and tools is an important challenge, as is balancing staff analytical skills with the need for practical implementation experience.
- *Resources for economic and sector work (ESW) have declined in the past five years relative to the lending portfolio*. The Bank therefore is embarking on ambitious sector reforms in many countries without having first established a strong empirical foundation to guide the process. Reviews by QAG and DEC have raised concerns regarding uneven quality and impact of sector work, and inconsistent links to the lending program.
- *Borrowers are often reluctant to use loan money for technical assistance* (particularly in IBRD countries), and the Bank has few grant resources available outside of project preparation funds. Staff (particularly in IBRD countries) report that this limits their ability to engage in policy dialogue and stakeholder consultation.
- *Staff now rely heavily on various external grant facilities to fund project preparation and analytical work, but these are time consuming to apply for and have a number of restrictions on the use of funds*. Since all budgets now lie with country departments, regional research is difficult to fund, even though many issues would be more effectively and efficiently addressed through regional studies, particularly in ECA and Africa.
- *HNP staff have not made wide use of new lending instruments, such as Adaptable Program Loans (APLs) and Learning and Innovation Loans (LILs).* Despite growing interest, staff report that while such instruments often require extra staff time, additional resources are not provided; and administrative requirements have reduced their intended flexibility. In addition, some borrowers are reluctant to accept small loans, or are concerned that "flexible" instruments could allow the Bank to reduce future funding.

4. Development Effectiveness of HNP Investments and Policy Dialogue

Bank investments have provided valuable support to expanding and strengthening the "building blocks" of borrower health systems, including facilities and staff. The impact of these investments, however, has often been reduced by continued problems with service quality and under-financing for basic HNP services. The Bank tended to conceptualize projects as injections of capital and technical expertise, and provided policy advice based on normative prescriptions, without fully appreciating the incentives, institutions, and external constraints governing sector performance. Recent approaches are more sophisticated with greater attention to the institutional dimensions of reform, but the challenges being addressed are also more difficult.

4.1 Completed projects and the OED country case studies are rich sources of information about the extent to which Bank-sponsored HNP projects have achieved HNP development objectives. Throughout the 1970s and 1980s, a major goal of Bank HNP projects was to support the expansion and strengthening of health service delivery systems. This remains an important goal today in many countries. In recent years the Bank has turned more attention to promoting enhanced health system performance, and it has gained experience with measures to improve HNP service delivery and secure sustainable health system financing. The discussion below applies broadly to the Bank's work in HNP; Boxes 4.1 and 4.2 provide further detail on the Bank's experience in nutrition and reproductive health, respectively. Although the discussion focuses primarily on shortcomings in Bank effectiveness—and thus areas where improvement is needed—the Bank's performance in HNP must be considered in the context of the challenges posed by *any* efforts to improve performance in the social sectors.

Strengthening the HNP Service Delivery Structure

4.2 ***Expanding Access to Health Services.*** Expanding physical access to health services has been a major goal of Bank HNP lending for the past two decades. Even recent health reform projects typically devote substantial portions of expenditure to construction, and geographical access remains a challenge in some poor countries. Client governments typically place high priority on infrastructure development when requesting Bank assistance, and these investments are usually appreciated by consumers and providers. OED found that Bank projects usually are successful in expanding geographical access to government health and family planning services, but often with delays (two years on average) or problems with uneven quality. Ministries of health often are inexperienced in construction, and ministries of construction—which often implement civil works—typically have limited experience with health facilities, and are vulnerable to inefficiencies and graft. Careful attention to design, site selection, and supervision—and the funding of architectural consultants—can improve the quality and cost-effectiveness of civil works. In the longer-term, enhancing the capacity of ministries of health to evaluate facility design and supervise construction can enhance the quality of health infrastructure investments, although in some contexts third-party contracting may be preferable.

4.3 Increased physical access to government health services often does not lead to increased use of services, however, at least at the levels anticipated in project design. Several factors explain why. First, service quality—including the availability of trained providers, provider attitudes, drug availability—is a key determinant of consumer demand. Family planning and MCH clinics constructed with Bank support in Brazil, India, and elsewhere were often under-

utilized because of poor service quality.[15] Second, if new or upgraded facilities are not located near catchment populations, or are placed near competing facilities (e.g., mission hospitals), their net impact on utilization is reduced.[16] Inadequate planning or political influences can lead to inappropriate site selection, whereas establishing transparent technical criteria to determine site selection can reduce distorting political influences. If poor consumers prefer private or NGO services, then encouraging improved access to, and quality of, private service delivery or health insurance may be appropriate, although Bank efforts are recent and mostly in LAC and ECA.

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

Box 4.1. Bank Experience in Nutrition

Nutritional status is an important determinant of health status, and several decades of experience have demonstrated that targeted nutrition programs can measurably improve proteins-energy malnutrition and micronutrient deficiencies for children and mothers. Nutrition programs in many borrower countries are hindered by a number of factors, however, including an over-reliance on expensive and poorly targeted feeding programs, and weak mechanisms for intersectoral coordination. Changing from food entitlements to more targeted nutrition programs can be politically difficult, however. The OED case studies demonstrates a wide variation in Bank nutrition activities, from a relative neglect of nutrition issues in Brazil and Mali, to significant contributions in India and Zimbabwe (see Annex C).

The Bank's nutrition efforts have been constrained both by inconsistent attention to nutrition across portfolios at the country level, and by uncertainty by Bank staff and governments as to how to intervene effectively and efficiently to improve nutrition. This is a consequence of the Bank's relatively small nutrition staff, the difficulty of integrating the intersectoral aspects of food policy and nutrition program into standard health investments, and sometimes concerns that adding a nutrition component will create excessive project complexity. Where the Bank has given priority to nutrition issues, it has helped to raise the profile of nutrition within ministries of health and sometimes with ministries of finance (as in Zimbabwe). Nutrition sub-components of projects are often co-financed by other donors, but the source of financing seems to matter less than the attention given to nutrition in policy dialogue, and the Bank's success in introducing targeting and nutritional impact monitoring into government programs. This suggests that a strengthened strategic approach to nutrition could help increase the Bank's impact. The HNP sector is in the first stages of developing a nutrition strategy, beginning in 1999 with a comprehensive assessment of lessons of experience from past Bank nutrition efforts.

4.5 Based on the case studies and other project experience, Bank investments in facilities, equipment, transport, and communications equipment have enhanced referral effectiveness and

---

15. In Brazil and India, OED analyses using available household and facility data found either small or no difference in health, nutrition, or fertility outcomes between project and non-project districts or regions for basic health and population projects designed in the 1980s. Although such comparisons present methodological challenges, the studies attributed these results primarily to the projects' lack of success in achieving relative improvements in the quality of health care in the target districts, failure to make significant innovations in health care delivery, and to the fungibility of project funds.

16. In Zimbabwe, OED found that increases in utilization depended strongly on the appropriateness of site location. In those districts that were genuinely under-served, the number of obstetric cases attended by a trained provider increased significantly, despite higher maternity fees, but those that were poorly situated experienced no change.

efficiency in many countries. The major constraints, not surprisingly, tend to be on the "software" side: either inadequate training in referral at the primary level (India), shortages of qualified physicians at the first or second referral levels (Zimbabwe, Mali), and continued consumer preferences for higher-level care, which leads to continued bypassing (Brazil). Changing price signals can enhance referral efficiency, but only if the service quality is adequate at the primary levels, yet the Bank has tended to emphasize changing fee structures before focusing on service quality. The Bank is only beginning to address difficult issues of private sector referral, and public/private linkages.

4.6 ***Health Staffing and Workforce.*** The Bank has invested heavily in training for health staff and health managers, both through direct financing of training and through helping to establish or upgrade borrower training programs. The goals of training often include improving provider technical skills; increasing the number of trained providers, particularly in underserved areas; and enhancing overall provider motivation and performance. Bank training investments are usually appreciated by providers, and in many countries have contributed to improvements in technical proficiency, the introduction of new approaches, and enhanced the quality of care. The quality and relevance of training—which is often provided through government institutions—can vary considerably, however. Typical problems include excessive emphasis on memorization, inadequate hands-on practice, and difficulties in attracting and retaining trainers, often because of inadequate pay and poor career prospects for trainers. Training systems do not change overnight, but the Bank needs to address such issues during design and implementation, and give greater attention to assessing the quality and impact of training.

4.7 Bank training investments also have been consistently undermined by inadequate attention to the health labor market and performance incentives for providers in both the public and private sectors. Each of the country studies concluded that health workforce issues are perhaps *the* most pressing challenge facing the respective health systems. Where a large private sector exists, civil service pay often is not competitive, particularly for doctors and staff with technical or specialized training, contributing to attrition or moonlighting from public health services. Providers often have few incentives to work in rural areas. In the public sector, low morale and lack of client-orientation often results from dissatisfaction with terms of service, inadequate supervision, or limited ability of consumers to demand improved service. Private providers often over-prescribe and have few incentives to provide preventive care. In such contexts, training investments often result in little change in the number of providers serving poor populations, and only marginal impact on the quality of care. The Bank has neglected these issues in its projects and policy dialogue, however, at least until very recently (see below).

4.8 ***Essential Drugs and Equipment.*** Drug availability is an important determinant of service utilization rates. The Bank has sought to improve drug availability through several means, including direct procurement of drugs, establishment of revolving drugs funds at both national and community levels, and pharmaceutical reform efforts. Drug procurement was a common sub-component of Bank health investment projects in the 1980s, but the onset of the HIV/AIDS epidemic led the Bank to finance several large drug procurement projects, primarily to finance the purchase of drugs to combat sexually transmitted infections (e.g., in Kenya, Uganda, and Zimbabwe). Bank requirements for international competitive bidding (ICB) for major drug procurements can contribute to substantial cost savings to governments and usually improved drugs supplies over what would have prevailed without the project. Yet the rapid design and implementation of these programs, often without adequate training for local staff in Bank procurement procedures and international competitive bidding, often led to bottlenecks and

delays in the procurement and drug distribution process.[17] Bank clients frequently complain of the complexity and rigidity of Bank procurement procedures, particularly for the procurement of medical equipment and pharmaceuticals. Procurement issues often take up a substantial portion of the time of Bank HNP specialists, which could be spent on policy dialogue or implementation issues. Procurement delays can also result when the Bank rejects improperly prepared bids, which may stem from corrupt practices, suggesting the importance of both training in procurement and ensuring rules for transparency.

4.9 The Bank also has supported the establishment of community-managed revolving drug funds to help alleviate the persistent shortage of essential drugs in local clinics, and to increase the participation of communities in the management and provision of health services.[18] Experience in Mali and elsewhere has demonstrated that the success of community initiatives depends on progress in national pharmaceutical reform, particularly in increasing the availability of affordable essential drugs. Unless affordable drugs are available, low-income communities can not sustain the drug funds. Communities also require ongoing training and support to establish effective management systems, and oversight to ensure that prices remain equitable and revenues are used appropriately (UNICEF 1998).

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

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

---

17. In Zimbabwe, following declines in drug availability in 1996, increased supervision attention by both government and Bank staff contributed to a recovery in pharmaceutical supplies in 1998. In addition, the government adopted aspects of Bank bidding procedures for its own procurements, although this has not been the case in all client countries.

18. In Africa, the 1988 Bamako Initiative—sponsored by UNICEF, WHO, and the World Bank—called for the establishment of national essential drugs programs, community drug funds, and community-managed health centers. Although now widespread in West Africa, community drug funds remain rare in East and Southern Africa.

Box 4.2. Bank Support for Population and Reproductive Health

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

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

Implementing an integrated reproductive health approach faces both bureaucratic and programmatic challenges. Many developing countries—with donor support—initially established organizations independent of ministries of health to deliver family planning services, and later established additional organizations to promote HIV prevention. Bangladesh is attempting to reintegrate these programs as part of a sector-wide program, with support from the Bank and other donors. An unresolved issue in countries with high HIV prevalence is how to reconcile the emphasis on non-barrier contraceptive methods advocated by family planning programs with HIV and STI prevention. Improving reproductive health may require strengthening overall health system performance (e.g., improving referral systems to reduce maternal mortality). Yet population and reproductive health specialists inside and outside the Bank have expressed concern that the current emphasis on health system reform should not result in neglect of reproductive health programs (PAI 1998).

4.12 ***Private Sector Quality and Equity.*** Until the early 1990s, the Bank paid relatively little attention to private (nonprofit, for-profit, and traditional) providers of health or family planning services. Yet private spending often constitutes more than half of all health spending, and may represent a majority of the health spending by the poor. The nature and extent of the private sector varies considerably among countries and regions, however, as does the extent to which government finances or attempts to regulate private provision. Qualified private practitioners generally prefer urban areas, and focus on middle- or upper-income consumers or those with health insurance. Although consumers (including the poor) often prefer private providers because service is perceived to be of better quality, clinical quality can vary substantially (with a proliferation in many countries of clinicians with unknown or questionable clinical skills). Even qualified providers often feel substantial pressure to prescribe drugs and have few incentives to provide preventive services. Regulatory or quality assurance mechanisms for private provision are weak or non-existent in many developing countries, but professional associations may strongly resist a broadened government regulatory mandate. The Latin America region is increasingly engaged in such issues, but few projects have been completed or evaluated. Recent Bank policy statements have called for a better balancing of public and private roles in health (Box 2.1). The challenge now is to build a solid empirical foundation on the optimal balance in different country contexts, and the processes by which changes can be achieved.

Enhancing Health System Performance

4.13 The Bank has taken a variety of approaches to enhancing the quality and efficiency of health services, although until recently most focused on improving the performance of government health services. A recent OED paper argues, however, that the Bank has focused excessively on government services, and not considered a sufficiently wide menu of institutional approaches for enhancing performance (Gririshankar 1998).

4.14 ***Decentralization and Devolution.*** The Bank has widely recommended decentralization, contracting out, and separating the purchaser from provider as institutional arrangements that improve system performance and efficiency of government health services (World Bank 1993). Certainly, many health delivery systems are overly centralized and unresponsive to local needs, and governments often provide services less efficiently and effectively than the private or nonprofit sector. But the actual impact on performance depends on the details of design and implementation, and the wider institutional and political context. State and local governments may be more responsive to local populations, but they may also be more sensitive to the demands of local elites, and prefer expenditure on hospitals rather than primary health care.

4.15 The case studies found that the Bank at times has promoted decentralization without sufficient regard for the administrative or political implications, or giving sufficient attention to what responsibilities should be devolved to which levels of the health ministry or local government. Even in successful examples of decentralization, the Bank has tended to underestimate the degree of training and technical support needed to help districts undertake their new responsibilities.[19] Similarly, the case studies found that separation of purchase and provision alone does not guarantee improved efficiency.[20] In sum, decentralization, devolution, and contracting out the services *can* enhance system performance, but the Bank needs to take a more nuanced approach to help borrowers determine the appropriate levels for various services, the appropriate sequencing of reforms, and training requirements.

4.16 ***Strengthening Organizational Capacity.*** If policies and institutions are the rules of the game, then organizations and individuals are the players, whose success depends on their ability to succeed within the rules (or by circumventing them, North 1990). Bank HNP capacity building initiatives tend to focus on symptoms rather than the root constraints on performance, although this is unique neither to the Bank nor to the HNP sector (Grindle 1997). The Bank's efforts to improve organizational performance have invariably fallen under the category of "capacity building," which typically involves providing training, technical assistance, and other resources. These may be needed, and if inadequate skills and technical capacity are the major performance constraints, improved performance can result. Not surprisingly, when inadequate skills are not major constraints, these efforts have little impact. The lack of clarity on objectives has contributed to a complete absence—until very recently—of any indicators of organizational capacity or performance. Implementation Completion Reports tend to assert that "capacity was built" in a given organization because workshops were attended, staff were trained, and computers were provided. This input focus also contributes to lack of attention to proper sequencing, which is often essential to achieving results.

4.17 ***Rules for Resource Transfers.*** The rules that govern the transfer of resources between levels of government, from government to private providers, or from insurance companies to providers, fundamentally structure the incentives for health care delivery. Until recently, few project design documents or sector studies gave attention to understanding how these rules and processes operate in specific settings (as distinct from normative assessments of how they should operate), or to changing them. The Reforsus project in Brazil attempted to improve health system efficiency by paying more to hospitals or providers who provide cost-effective services. OED

---

19. In Mali, the Bank provided support for a successful of devolution of authority for planning and program management from the central ministry to districts. The Bank, however, underestimated the degree to which district health officials needed sustained technical support to develop their first district health plans. A key to the success of this program, therefore, was a parallel technical assistance package provided by UNICEF (not planned for in the original Bank project design), which placed a full-time technical specialist in each of the country's five regions.

20. Poorly designed or implemented contracts can lead to further inefficiencies and reduced transparency. Furthermore, ministry of health officials often have limited experience in designing or managing contracting mechanisms.

analysis of this case, however, suggests that strategy is unlikely to work, because it does not account for political influences on the rate-setting process, or the mechanisms by which payment to hospitals would influence the treatment decisions of individual providers. This does not suggest that all such Bank efforts are similarly flawed, but that the level of institutional, political, and technical sophistication necessary to achieve results is considerable, and exceeds what has previously prevailed in the Bank.[21] On the positive side, in several countries (India and Indonesia) the Bank leveraged improvements in district-level performance by working with central or regional government to establish performance-based criteria for financing district health plans and programs, sometimes on a competitive basis.

4.18 ***Health Workforce Reform.*** As noted earlier, all of the country studies concluded that health workforce issues were perhaps the dominant constraint facing the HNP sector. But with a few exceptions, the Bank has conducted very little sector work on those issues. The standard Bank response has been either to proceed with capacity building and training even though the fundamental capacity and performance problems relate to staff incentives or high turnover, or to try to strengthen health workforce planning capacity within ministries of health. Bank efforts to accomplish the latter have often met with limited success, largely because conditions of service are determined by finance ministries or public service commissions. Bank macroeconomic dialogue and HNP strategy and investments have often been poorly coordinated with respect to civil service reform and health workforce issues. In both Zimbabwe and Mali, the health sectors were adversely affected by the civil service reduction programs that accompanied economic adjustment.[22] Meanwhile, Bank projects required additional staff. HNP staff are increasingly aware of the importance of health workforce constraints, but often do not have adequate mechanisms or sufficient sector analysis of health workforce issues to elevate their concerns into the macroeconomic dialogue.[23]

4.19 Recent Bank policy reform projects have more explicitly recognized the constraints inherent in the civil service, and have sometimes supported the health ministry in proceeding ahead of government on key reforms. In some cases, this has included devolving health staff to local government, or taking health staff out of the civil service. These efforts may help address a key constraint to improve government services, but they also create other problems. These include resistance and attrition from staff because of reduced job security or lack of career mobility, late or non-payment of salaries by local governments (often in the hope they will be bailed out by central government), or increased use of ethnic or political criteria in hiring. The HNP sector has identified health workforce issues as a priority for further research, but a concerted effort will be necessary to develop consistent and effective approaches to these difficult issues (Martinez and Martineau 1998).

Health Financing

4.20 The Bank's health financing efforts have sought to improve quality, efficiency, and sustainability of public and private health services. Overall, the case studies and portfolio review

---

21. The Bank's research department is undertaking a study on provider payment systems, which should help better inform future Bank efforts in this area.

22. Although health and education professional staff were supposed to have been protected, flaws in the designs of both programs contributed to shortfalls in professional and technical staff, counterproductive cuts in maintenance and administrative staff, and increased turnover of senior policymakers.

23. Although health workers usually represent less than 10 percent of the government wage bills, salaries for health professionals are often linked politically to those of teachers, which together constitute over half the aggregate wage bill in many countries. Thus, social sector wages are often affected by efforts to control government expenditures.

found that the Bank has played an important role in raising awareness in borrower countries regarding the equity and efficiency implications of health expenditure and resource mobilization patterns, and its diagnosis of the health financing challenges generally has been good. HNP sector studies of health financing, public expenditure reviews, and related documents are often key sources of information for officials inside and outside of government. The Bank's recommendations for addressing the problems, however, often have given inadequate attention to the institutional challenges inherent in implementation. As a result, the Bank's record in achieving effective change has been mixed.

4.21 ***Allocative Efficiency.*** The Bank consistently has highlighted the high percentage of government health expenditures allocated to urban tertiary care in many developing countries, and called for a shift toward more cost-effective primary care interventions and for services likely to benefit the poor. But while acknowledging that spending patterns are often the result of pressure by urban elites, the Bank has not always developed effective strategies for addressing the political dynamics that underlie inequities and resource misallocations. In Brazil, for example, because of the politics of the Brazilian budget process, basic health services are consistently under-financed, and key preventive programs often receive their allocations only in the final months of the fiscal year. As an external agency and a relatively small player in large countries such as Brazil, the Bank certainly cannot influence such dynamics alone, but it could better account for them in its strategy, sector work, and lending program.

4.22 ***Cost Recovery.*** The Bank's advocacy of increased cost recovery for HNP services has generated considerable controversy and a substantial literature (Nolan and Turnbat 1995). About 40 percent of all projects included some provision to establish or strengthen the user fees system—nearly 75 percent in Africa. The Bank has argued that cost recovery can improve the quality and sustainability of services (particularly if fees are retained), and that the poor are often willing to pay more for improved services (World Bank 1994). The initial implementation experience followed two somewhat distinct paths, depending on whether the country adopted Bamako Initiative–style community management of fee revenues, as in parts of West Africa, or if fees were implemented through the existing government system, as in much of East and Southern Africa (Gilson 1997). The Mali and Zimbabwe case studies mirror this experience. In Zimbabwe, fees were increased at primary and secondary levels during the early 1990s, but because the ministry of finance did not approve fee retention until 1998, the overall impact on service quality and utilization by the poor was negative. In Mali, the financing of community-managed health centers significantly expanded drug availability and access to rural health services. Utilization rates remain low overall, however, and cost recovery has not proved to be an effective means to fund preventive services or specific disease interventions (UNICEF 1998). Although asserting that the poor should be protected from fee increases, the Bank has often failed to propose administratively feasible means to protect the poor. Bank advice on user fees has become generally more nuanced in recent years, but the Bank is still widely perceived to be an unabashed advocate for increased cost recovery (Watkins 1997).

4.23 ***Links to Macroeconomic Dialogue.*** The Bank has not always effectively linked its health financing dialogue with macroeconomic dialogue. The onset of economic crisis in much of the developing world led to the adoption of Bank-sponsored economic stabilization and adjustment programs in many countries. Initially, the Bank and IMF did not give adequate attention to protecting expenditures for social services, and some countries experienced reductions in health budgets. By the late 1980s, however, partially in response to global criticism, the Bank and IMF became more proactive in attempting to protect social expenditures and staff

in the design of adjustment programs.[24] Since the early 1990s, the Bank has included the protection or expansion of social expenditure—as appropriate—as an important component of its macroeconomic and sector policy dialogue.[25] Particularly in smaller countries, the Bank has experienced some success in encouraging increased allocations to health or shifting public resources toward basic and preventive care. Issues of equity and efficiency and government health expenditures, however, still are not adequately captured in Country Assistance Strategies or macroeconomic discussions.

4.24 ***Hospital Financing and Reform.*** While tertiary hospitals and improved billing of private insurance companies are often a major source of lost revenue, the Bank has not had much success to date in encouraging improved cost recovery at these levels. Initially, the Bank only raised the issue of hospital or insurance billing in the context of sector work or dialogue, but gave little attention to supporting or encouraging actual changes. The Bank has advocated reductions in tertiary hospital expenditures—sometimes successfully, particularly in aid dependent countries—but without providing advice and support to help hospitals become financially sustainable. Hospital reform has now come onto the Bank's HNP agenda, but it is proving to be institutionally and politically challenging. The HNP sector currently is developing improved indicators and analytical tools for hospital reforms, which will need to be complemented by intensive sharing of experiences.

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

Instruments and Strategies for Reform

4.26 ***Strengthening the Policy Framework.*** The Bank has contributed to improving the coherence of health policy in many countries, and many borrowers consider the Bank's broad strategic view of the sector a major asset. In particular, the Bank has played an important role in encouraging borrower governments to adopt formal written policies on key sector issues (such as population), and the development of sector-wide health policies in the 1990s. The Bank sometimes undermined local ownership by allowing staff or consultants to dominate the policy development process, but in recent years has placed greater priority on ensuring that government officials take the lead. In small, aid-dependent countries, however, the risk remains that the development of national policies can become excessively linked to Bank project deadlines.

4.27 ***Focusing on the "How" of Reform.*** Bank policy advice and reform strategy is too often not sufficiently grounded in empirical evidence or institutional analysis of the country context. The Bank has been better at specifying *what* needs to be done than *why* problems persist and *how* to address them. As a result, the Bank has a tendency to promote standard solutions to health system problems without sufficient attention to local institutions or details of implementation.

---

24. Although the Bank has been widely criticized for encouraging social sector budget cuts during adjustment programs, cross-country comparisons find that in the medium to long term, social sector budgets were better protected in adjusting countries than in countries that did not adjust (OED 1996).

25. In Mali, for example, after falling in the 1980s, health spending as a percentage of total government spending increased steadily during the 1990s. In Zimbabwe, however, although the Bank and government protected social sector spending as a percentage of the discretionary budgets, the government's failure to close the large budget deficit led to rapidly escalating domestic interest payments, which contributed to erosions in real health spending.

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

4.28 ***Incremental versus "Big Bang" Approaches.*** The Bank is increasingly engaged in reform issues for which there are no commonly agreed solutions or universal models, limited evidence about what works, and in which the Bank itself has limited experience (Nelson 1999). These include health insurance reform, regulation of the private sector, pharmaceutical policy, health workforce reform, and the appropriate balance between public and private roles in health service financing and delivery. Incremental approaches may therefore be more appropriate, building on solid research, pilots, and focused efforts to learn from experience. The Bank, however, has perhaps excessively encouraged "big bang" reforms, although the choice ultimately depends on borrower judgments of country circumstances.

4.29 ***Large versus Small Countries.*** The Bank's role in health system reform differs considerably between larger or middle-income countries, and smaller aid-dependent borrowers. In the former, Bank assistance usually represents only a fraction of government health spending, whereas in the latter, the Bank and donors collectively may represent nearly all the health investment budget and a substantial portion of recurrent spending. In large countries, the Bank must use its lending program and policy advice to investigate, demonstrate, and advocate more effective approaches to health financing. In small poor countries, the Bank needs to give careful attention to recurrent implications of investment programs, and take care not to push for policy changes without sufficient consideration to their likely impact in a low-capacity context.

4.30 ***Linking Instruments to Objectives.*** The case studies and portfolio review found that the Bank has relied excessively on investment loans, even though these often are not effective vehicles for promoting complex policy reforms. A number of other instruments are available, each with strengths and drawbacks. Learning and Innovation Loans (LILs) and Adaptable Lending Program Loans (APLs) were developed precisely to allow the flexibility and learning necessary for effective health system reform, but a relatively small (but growing) number of HNP projects have made use of these instruments. The Bank also has approved a number of large sector adjustment loans in past few years. These can help tip the balance in favor of a particular reform effort, if conditions for tranche release are transparent and negotiated among a variety of stakeholders. But experience with structural adjustment lending suggests that conditionality alone is ineffective at promoting broad-based systemic reform (Nelson and Eglington 1993). The rapid growth of sector-wide approach (SWAp) programs for encouraging policy reform and increased donor coherence is an important innovation. SWAps are characterized by government-led partnerships, where government and donor investments fall under a sector-wide policy and expenditure framework (Peters and Chao 1998). Although they can bring much-needed coherence to the sector, SWAps require a strong policy vision by government, high-degree of confidence among government and partners, and can entail higher risk than single investments. The emphasis on national policies is consistent with the Bank's comparative advantage, but constraints to performance may lie elsewhere. The recent enthusiasm for SWAps thus should not cloud the need for thorough examination of the appropriate instrument, or mix of instruments, for the context and objectives.

5. Recommendations

Achieving institutional change and improving health system performance is inherently difficult, both technically and politically. Although the Bank is only one of many players, it can increase its impact in the HNP sector through strengthening portfolio quality assurance and result orientation, intensifying learning from lending and non-lending

services, and enhancing strategic selectivity within the Bank and strengthening partnerships with other donors, client governments, and civil society organizations.

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

Increase Strategic Selectivity

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

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

Strengthen Quality Assurance and Results Orientation

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

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

5.4 ***Issue:*** *Assessing the impact of health interventions can be challenging, but excessive Bank focus on inputs and low priority given to monitoring and evaluation are also to blame.*

> **Recommendations:** To strengthen Bank performance in monitoring and evaluation, management should: a) identify a core group of HNP staff and consultants with experience implementing HNP monitoring and evaluation, who could be available to assist other staff during project design and supervision; b) develop a "good practices" manual of M&E design and use for decision making, both at the project and systemic levels, including lessons from partner organizations; c) in collaboration with the World Bank Institute, develop M&E case studies and training modules; d) periodically give recognition to task teams who can demonstrate measurable results from Bank-supported activities; e) in parallel with the CDF pilots, report by the end of fiscal 2000 on how Bank business

practices and procedures could be modified to allow greater results-orientation in Bank lending, and to increase internal incentives for monitoring and reporting on results.

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

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

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

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

Enhance Learning and Increase Institutional Development Impact

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

Recommendations: To strengthen the institutional development effectiveness of the Bank's work in HNP, management should: a) in coordination with PSM and other internal and external partners, develop appropriate tools, guidelines, and training programs for institutional and stakeholder analysis in HNP, both for targeted interventions and systemic reforms; b) clarify the requirements for institutional analysis in project appraisal documents; c) establish a core of HNP staff and consultants with experience in institutional design and stakeholder analysis, who would be available to assist other staff.

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

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

Enhance Partnerships

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

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

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

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

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

> **Recommendations:** The Bank should strengthen work with HNP development partners (e.g., WHO, UNICEF, bilateral donors) on several key areas, including strengthening HNP monitoring and evaluation systems and incentives; and assessing progress and strategies on the current generation of health sector reforms.

References

Abbasi, Kamran. 1999. "The World Bank and World Health: Health Care Strategy." *British Medical Journal,* Vol. 318, April 3,1999.

Adams, Isaac. 1998. "Country Experience: Sectorwide Approach to M&E in the Health Sector in Ghana." in *Evaluation Capacity Development in Africa: Selected Proceedings from a Seminar in Abidjan*. African Development Bank and the Operations Evaluation Department, Washington, D.C.

Aday, Lu Ann, Charles E. Begley, David R. Lairson, Carl H. Slater. 1993. *Evaluating the Healthcare System: Effectiveness, Efficiency, and Equity.* Health Administration Press, Chicago.

Belli, Pedro. 1996. "Handbook on Economic Analysis of Investment Operations." World Bank, Washington, D.C.

Castro, Claudio de Moura, and Phil Musgrove. "On the Non-existence of 'The Social Sector': Or Why Education and Health Are More Different than Alike." Sustainable Development Department, Inter-American Development Bank, Washington, D.C.

Dayton, Julia. 1998. "World Bank HIV/AIDS Interventions: Ex-ante and Ex-post Evaluation." World Bank Discussion Paper No. 389.

Durch, Jane, Linda Bailey, Michael Stoto, eds. 1997. *Improving Health in the Community: A Role for Performance Monitoring.* Committee on Using Performance Monitoring to Improve Community Health, National Academy Press, Washington D.C.

Filmer, Deon, Jeffrey Hammer, and Lant Pritchett. 1998. *Health Policy in Poor Countries: Weak Links in the Chain.* Policy Research Working Paper 1874. Poverty and Human Resources, Development Working Group, World Bank, Washington D.C.

Gauri, Varun. 1998. *The Brazil Health System: Impact Evaluation Report*. Report No. 18142. Operations Evaluation Department, World Bank, Washington, D.C.

Gilson, Lucy. 1997 "The Lessons of User Fee Experience in Africa," *Health Policy and Planning*, Vol. 12, No. 4.

Girishankar, Navin. 1998. "Reforming Institutions for Service Delivery: A Framework for Development Assistance with an Application to the HNP Portfolio." Operations Evaluation Department, World Bank, Washington, D.C.

Grindle, Mirilee S., ed. 1997. "Getting Good Government: Capacity Building in the Public Sectors of Developing Countries." Harvard University Press, Cambridge, MA.

Grindle, Merilee S, and John W. Thomas. 1991. *Public Choices and Policy Change: The Political Economy of Reform in Developing Countries.*

Hammer, Jeffrey S. 1996. "Economic Analysis for Health Projects." Policy Research Working Paper No. 1611. World Bank, Washington, D.C.

Heaver, Richard. 1988. *Reaching People at the Periphery: Can the World Bank's Population, Health, and Nutrition Operations Do Better?* Working Paper Series 81. World Bank, Population and Human Resources Department, Washington, D.C.

Isreal, Arturo. 1987. *Institutional Development: Incentives to Performance.* World Bank, Washington, D.C.

Jamison, Dean, W. Henry Mosely, Anthony Measham, and Jose Luis Bobadilla. 1993. *Disease Control Priorities in Developing Countries.* Oxford University Press and the World Bank, Washington, D.C.

Johnston, Timothy. 1998. *The Impact of World Bank Support to the HNP Sector in Zimbabwe.* Report No. 18141. Operations Evaluation Department, World Bank, Washington, D.C.

Johnston, Timothy, Sheila Dohoo Faure, and Laura Raney. 1998. *The World Bank and the Health Sector in Mali: An OED Country Sector Report*. Report No. 18112. Operations Evaluation Department, World Bank, Washington, D.C.

Lerer, Leonard, Alan Lopez, Tord Kjellstrom, and Derek Yach. 1998. "Health for All: Analyzing Health Status and Determinants." *World Health Statistics Quarterly,* Vol. 51, No. 1.

Martinez, Javier, and Tim Martineau. 1998, "Rethinking Human Resources: An Agenda for the Millennium." *Health Policy and Planning,* Vol. 13, No. 4.

McPake, Barbara, Joseph Kutzin. 1997. "Methods for Evaluating Effects of Health Reforms." World Health Organization, Geneva.

Morgan, Peter and Ann Qualman. 1996. "Institutional and Capacity Development, Results-Based Management and Organisational Performance." Political and Social Policies Division, Policy Branch, Canadian International Development Agency.

Musgrove, Phillip and Ronald Ridker. 1999. *Case Study of World Bank Activities in the Health Sector in India.* Operations Evaluation Department, World Bank, Washington, D.C.

Nelson, Joan M. 1999. "Reforming Social Sector Governance: A Political Perspective" in Tulchan, Joseph and Alison Garland, eds. *The Politics and Administration of Social Development in Latin America*. Lynn Reinner Press (forthcoming).

Nelson, Joan M., and Stephanie J. Eglinton. 1993. *Global Goals, Contentious Means: Issues of Multiple Aid Conditionality.* Overseas Development Council, Washington D.C.

Nolan, Brian, and Vincint Turnbat. 1995. *Cost Recovery in Public Health Services in Sub-Saharan Africa.* Economic Development Institute, World Bank, Washington D.C.

North, Douglas. 1990. *Institutions, Institutional Change, and Economic Performance*. Cambridge University Press, Cambridge, England.

Nutbeam, Don, and Elizabeth Harris. 1998. *Theory in a Nutshell: A Practitioner's Guide to Commonly Used Theories and Models in Health Promotion.* Department Of Public Health and Community Medicine, University of Sydney, Sydney, Australia.

Operations Evaluation Department (OED). 1998. *Annual Review of Development Effectiveness.* World Bank, Washington, D.C.

__________. 1996. *Social Dimensions of Adjustment.* World Bank, Washington, D.C.

__________. 1994. *An Overview of Monitoring and Evaluation in the World Bank.* Report No. 13247. World Bank, Washington, D.C.

__________. 1992. *Population and the World Bank: Implications from Eight Case Studies.* World Bank, Washington, D.C.

Overseas Development Council. 1998. "Rx for Global Health Cooperation Beyond 2000: Report on the Conference on Global Health Cooperation Beyond 2000." Washington, D.C.

Pavignani, Enrico and Joaquim Ramalho Durao. 1997. "Aid, Change and Second Thoughts: Coordinating External Resources to the Health Sector in Mozambique." Department for International Development, London.

Pelletier, David L., and Roger Shrimpton "The Role of Information in the Planning, Management, and Evaluation of Community Nutrition Programs." Cornell University, Ithaca, NY.

Peters, David, and Shiyan Chao. 1998. "The Sector Wide Approach in Health: What is It? Where Is Its Leading?" *International Journal of Health Planning and Management*, Vol. 13, pp. 177-190.

Piccioto, Robert and Eduardo Wiesner. 1998. *Evaluation and Development: The Institutional Dimension.* Transaction Publishers for the World Bank, London.

Population Action International (PIA). 1997. "Falling Short: The World Bank's Role in Population and Reproductive Health." Washington, D.C.

Preker, Alexander, Logan Brenzel, and Annu Ratta. 1997. "Project and Economic Analysis in the Health, Nutrition and Population Sector: A Conceptual Framework and Portfolio Review." Human Development Network, World Bank.

Prescott, Nicholas, ed. 1997. *Choices in Financing Health Care and Old Age Security*. World Bank Discussion Paper No. 392, Washington D.C.

Schieber, George J. 1995. "Preconditions for Health Reform: Experiences from the OECD Countries." ELSEVIER, Heath Policy 32 (1995) 279-293.

Stout, Susan, Alison Evans, Janet Nassim, and Laura Raney. 1997. *Evaluating Health Projects: Lessons from the Literature*. World Bank Discussion Paper, No. 356. Operations Evaluation Department, World Bank, Washington, D.C.

Stout, Susan and Timothy Johnston. 1998. *Lessons from Experience in HNP*. Report No. 18642. Operations Evaluation Department, Washington, D.C.

UNICEF. 1998. *Implementing Health Sector Reforms in Africa: A Review of Eight Country Experiences.* Division of Evaluation, Policy, and Planning, New York.

Valdez, Joseph, and Bamberger, Michael. 1994. *Monitoring and Evaluating Social Programs in Developing Countries.* Economic Development Institute, World Bank, Washington D.C.

Van de Walle, Nicolas, and Timothy Johnston. 1996. *Improving Aid to Africa*. Overseas Development Council, Washington, D.C.

Walt, Gill and Lucy Gilson. 1994. "Reforming the Health Sector in Developing Countries: The Central Role of Policy and Analysis." *Health Policy and Planning*. Oxford University Press.

Watkins, Kevin. 1997. "Cost-Recovery and Equity in the Health Sector: Issues for Developing Countries." Oxfam UK & Ireland Policy Department, London.

Williamson, John, ed. 1994. *The Political Economy of Policy Reform.* Institute for International Economics, Washington, D.C.

World Bank. 1999. *Population and the World Bank: Adapting to Change*. Human Development Network, Washington, D.C.

__________. 1997a. *Confronting AIDS: Public Priorities in a Global Epidemic*. Washington, D.C.

__________. 1997b. *Health, Nutrition and Population Sector Strategy.* Human Development Network, Washington, D.C.

__________. 1997c. *Innovations in Health Care Financing: Proceedings of a World Bank Conference, March 10-11.* World Bank Discussion Paper No. 365, Washington, D.C.

__________. 1997d. *World Development Report 1997: The State in a Changing World*. Washington, D.C.

__________. 1996. "Performance Monitoring Indicators: A Handbook for Task Managers." Operations Policy Department, Washington, D.C.

__________. 1994. *Better Health in Africa: Experience and Lessons Learned.* Washington, D.C.

__________. 1993. *World Development Report 1993: Investing in Health*. Washington, D.C.

__________. 1987. *Financing Health Services in Developing Countries.* Washington, D.C.

World Health Organization (WHO). 1997. "Monitoring Reproductive Health: Selecting a Short List of National and Global Indicators." Division of Reproductive Health. Geneva.

__________. 1994. *Global Comparative Assessments in the Health Sector.* Geneva.

__________. 1993. "Rapid Evaluation Methods (REM) of Health Services Performance: Methodological Observations." Bulletin of the World Health Organization, Vol. 71, No. 1.

Excerpts from HNP Staff Responses in GroupWare Sessions

In mid-1998, OED conducted a series of GroupWare sessions with Bank HNP staff from various regions. Following a brief presentation of preliminary findings from the study, staff were given a series of questions asking them to explain whether they agreed with OED findings, and if so, what they saw as the primary source of the problems. The GroupWare sessions were facilitated by two professional facilitators. Staff each had access to a computer terminal, in which they anonymously typed responses to the questions, which then appeared on the screens of everyone in the group. Excerpts from the response are given below, by major topic.

How can the Bank improve the quality at entry of HNP projects?

- "Give me time to think, and the budget to get help and expertise I need."
- "Resources allocated for preparation need to fit the situation and not just be standard amount....projects in low capacity situations require more resources and more varied expertise."
- "Provide adequate financial resources and time to properly prepare the project. This also means taking into account the differences in types of projects, and less reliance on coefficients."
- "Asking for improved quality at entry, especially of complex or innovative projects, while cutting preparation budgets doesn't make sense..."
- "Additional budget to include process of learning, not just product production"
- "Recognition that stakeholder involvement requires time and preparation funds rarely available..."
- "The good news is that the rules are fairly well known in advance- as member of a team you can get access to the sort of questions and criteria that will be used to test the quality of the proposal... The bad news is that there is such a premium on getting things done quickly and within budget that there is really no opportunity to get genuine or detailed participation and involvement for the intended beneficiaries."
- "Provide time and resources for a good analysis of the sector, needs, problems...."

Are economic and sector work (ESW) resources adequate?

- "There is a feeling that people will get more kudos for doing good lending that doing good sector work."
- "We need to expand our definition of ESW. There is a lot more demand for short, brief Bank analysis and less for the major, long Bank reports.."
- "With the Country Directors holding the purse strings, the prospects for ESW work is minimal, particularly when budgets are reduced and there is reliance on WPAs. For two-country, subregional or regional work, it is hopeless."
- 'Unequivacably NO!.... ESW is like R&D in a corporation. We need to be constantly researching new and better ways of going about the development business. Borrowers should not and do not agree to finance this kind of function...There should be rigorous review process involving dialogue with borrowers, but the resources need to be available

How can the Bank improve institutional development and system reform efforts?

- "Insist on strong professional backgrounds for all team members, don't rely on half-day courses to create technical expertise."
- "Bank staff/consultants need better skills at institutional analysis and project/program management. ....application of these skills ...difficult as these 'lessons learned' do not resonate with Bank staff at various levels. Discussions of political realities and how best to address them can often be met with suspicion, particularly since it seems to get a project approved, you need to produce whatever is considered at the time a 'model' Bank document. Projects on the ground get fitted to the Bank reality rather than their own."
- "The Bank needs to take seriously the professional qualifications required for sound political analyses; the 'softness' of this issue invites amateurism."
- "In HNP, all have higher degrees, are good at conceptualizing but few have any experience in the hard work of implementing in the inhospitable political and logistical situations. The Bank should put a stop to hiring intellectuals and have a period of only hiring implementers with an successful track record."

How should supervision reporting be strengthened?

- "Less writing, more discussions of the issues...at the moment, you go on a mission and come back and no one even discusses your findings with you!"
- "As things stand, task team leaders have good reasons not to report the true state of affairs. With mechanization having gone haywire in terms of portfolio monitoring, 'automatic' remedies are triggered and those are often counterproductive.."
- "For a while, SARs had a required annex on supervision plans...these are ignored by managers in allocating budget and makes a joke of any such planning."

Why are plans for M&E in HNP often not implemented ?

- "It is not seen as a priority by the borrower.."
- "M and E takes time, and implementing units don't have that time."
- "Basically, because there is no real market for such information within the Bank and not much of one for the Borrower. Resources aren't available to carry out monitoring, much less real evaluation. When mid-term reviews don't receive additional supervision resources, a signal is sent that no one will be worried about the outcome."
- "We need to make the product high quality and link it to operations for governments to see the advantage."
- "No budget, no time, constant bombardment with other tasks."
- "Because they are regarded as mere ritual by many staff. Technical professionals often do not feel any need to confirm what they already know."
- "I think it relates to the 'approval culture' that is still alive and well in the Bank. Managers focus more on delivering projects and incentives are structured to reward new project development. Careers are not penalized for inadequate attention to M and E...If the Bank wants more priority to M and E, it must restructure the allocation of resources and reward/incentive system."
- "There is a strong disincentive in the Bank to identify problems which no one can solve."

Sources of Information on Project Outcome

The inputs to this study included a statistical model that was used to test various factors related to country context, project design, and implementation on project outcome.[26] Another tool was an analysis of lessons cited in Implementation Completion Reports. This annex describes the results of those analyses.

Modeling HNP Project Performance

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

Main Findings:

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

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

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

Lessons from OED Review of ICRs

As a separate exercise from the econometric model, OED reviewed implementation completion reports for 80 projects completed through FY1997, and tabulated the most frequently-cited lessons. In the table below, the percentage that each lesson was cited is tabulated for all projects, and for satisfactory and unsatisfactory projects. The data should be treated with some caution, since terms such as “capacity” and “complexity” have different meetings to different authors, and because of a possible bias in unsuccessful projects to attribute failure to factors such as low

---

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

capacity or excessive complexity. Still, the findings are illustrative, particularly of the extent to which similar problems have recurred in the portfolio.

Lessons cited by task managers in ICRs

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

Source: OED data

Executive Summaries from Case Studies

Brazil

The World Bank has financed 10 projects in the health, nutrition, and population (HNP) sector in Brazil. It has also undertaken significant field research, including four major sector studies since 1989; conducted sector work in the related areas of social security and poverty; and been a policy interlocutor for the Government of Brazil. This study evaluates the development effectiveness of that work.

The study follows a framework for the assessment of development effectiveness that guides the larger study. Policy advice can be provided through a range of activities, such as formal and informal sector work, discussions during project preparation, supervision, and evaluation, as well as through direct channels such as the Bank's work in generating and disseminating policy through its policy, research, and knowledge management activities. Projects exert influence through transfer of resources for specific goods and services, as well as to the degree their implementation arrangements embody "rules of the game" that influence the institutional environment. The Bank can have a direct effect on the *service delivery structure* (public and private facilities, service providers) through such steps as investing in new facilities or the development of health manpower and also on the financial, regulatory, and accountability systems that constitute the *institutional arrangements* that govern the sector. Its investments outside of the sector (and/or through investing in marketing and information elements of the service delivery structure) can influence the demand for services and health-related behaviors.

This study of the Bank's experience in Brazil addresses two groups of questions. First, what was the Bank's overall strategy for health in Brazil, and was it the right one? The study examines the Bank's strategy against two criteria: whether it was relevant to the sector and country, and whether it was well built—that is, premised on solid research and the right evidence. Second, what were the outcomes of this body of work? Of course, improved health outcomes are the ultimate goal, and a good strategy increases the likelihood they will be achieved.

The study is based upon a review of World Bank sector studies and project documents, extensive interviews with World Bank staff, government officials, and other stakeholders during three visits to Brazil, as well as on a series of papers commissioned as background to the study.

Relevance of the Bank's Strategy

The Bank's strategy for health in Brazil has focused on three main concerns: it provided resources for expanding the accessibility of basic health services in poor or marginal areas; it offered policy advice and studies for improving the efficiency and efficacy of the health care system; and it financed projects to control endemic diseases such as malaria, schistosomiasis, and AIDS. That strategy appears *prima facie* relevant to a country like Brazil, which has a high degree of poverty and inequality for a middle-income country, has a health care delivery system known for inefficiency and inequity, and suffers from a variety of tropical diseases.

But a close examination of the Bank's work in Brazil raises some questions. It is not clear, for instance, whether the construction of clinics and health posts—critical elements of the Bank's strategy in the late 1980s and early 1990s to improve the effectiveness of the system—was the best means to improve access. Many of the health posts are underutilized, short of qualified staff,

and lack the facilities to satisfy increasingly demanding and increasingly urban consumers, who instead often go directly to hospitals and clinics.

Epidemiological Relevance. Trends in health status are encouraging, though Brazil now faces developed-country problems as it continues to confront the traditional public health challenges in the interior and marginal areas. Children are much healthier now than in the past, and more of them are getting healthier faster, apparently because of improvements in purchasing power, maternal education, utilization of health services, community infrastructure and water supply, and individual behavior. Despite the recent improvements, sharp regional inequalities persist: children in the Northeast are much less healthy than children in the Center-South, and the health of children in the rural Northeast is improving most slowly. Differential access to maternal education, health care and water, and new reproductive patterns explain why the health of children in the rural Northeast continues to lag. Brazil's fertility decline has been dramatic and has in all likelihood reduced the prevalence of the factors associated with risks to childhood health. Induced abortion must have been instrumental when the fertility decline accelerated in the late-1960s and early-1970s because the pill and the rhythm method were then the only widely known contraceptive techniques, and given the prevailing inadequacy of contraceptive information at the time, their efficacy was probably limited. Diarrhea among children declined sharply and diseases preventable through vaccination are largely under control in Brazil. Increasing incidence rates of tuberculosis and leprosy are symptomatic of weaknesses in Brazil's public health system. Endemic parasitic diseases continue to threaten rural and remote areas.

The World Bank's past strategy for improving childhood health in the rural Northeast has underachieved**.** Although the Bank financed major investments designed to expand access to primary health care in the rural Northeast from the mid- to late-1980s to the present—projects in which maternal child health was a high priority at the time of appraisal—those investments did not help the region keep pace. Neither the Brazilian government, Brazilian NGOs, nor international organizations such as the World Bank can claim credit for Brazil's fertility decline, despite the latter's efforts to encourage the development of population policies in the 1980s. Government policies, women's groups, and international agencies were ambivalent, actively opposed, or marginal to population policy in Brazil until the fertility decline had already become an established fact. In recent years those three actors have all helped to raise the awareness of and access to birth control alternatives, but the explanation of the fertility decline, though still not clearly understood, is undoubtedly a demand-side story.

An epidemiological transition is said to occur in a country when, as a result of modernization and development, infant mortality and fertility decline, life expectancy increases, and infectious and parasitic diseases are no longer the leading causes of death. As early as 1980, "post-transitional" conditions became the leading causes of death in every region of Brazil. By 1980 cardiovascular disease became, and remains, the leading cause of death in each major region and in almost all states. These are not diseases of the rich alone. Indeed, both the prevalence of these diseases and of the risk factors associated with them, such as smoking, poor diet, and lack of exercise, are generally higher among the poor, who are relatively uneducated and are less likely to be reached by information campaigns. The Bank's sector work includes a major analysis of the determinants of adult mortality that outlined these issues, but the Bank has not been successful in following up this analysis through specific investments.

Institutional Relevance Most health economists would not object to the broad structure of Brazil's health care system. Following the dictum, the Brazilians go a long way toward "separating the financing from the provision of services." The government health care system, called the Sistema Unica da Saúde (SUS), contracts out large majority of inpatient care and a

substantial portion of outpatient services to a network of private and philanthropic hospitals, clinics, and other facilities. All told, the public sector manages and owns only 31 percent of the hospital beds it supports. Despite the ostensibly efficient structure of the health system, in reality it is experiencing incoherencies and critical problems, if not a crisis. Severe underfinancing of the public system results in regional inequalities, arbitrary rationing in facilities, and a perceived decline in quality. Aggravating the problem of scarcity, the political economy of budgeting for health in Brazil weakens the sector.

The World Bank has not developed a strategic response to the causes or the consequences of underfinancing in the Brazilian health sector. The Bank's response to date has been primarily to provide financing for unmet needs, such as for basic health services in the Northeast, health infrastructure, and endemic diseases. While providing financing can be a valuable contribution, Brazil can access the private capital markets with relative ease; it is difficult to know whether or not the government would have obtained the funds for Bank-financed projects from other sources.

Decentralization is an eminently political issue, and has taken a variety of shapes within the Brazilian health system over the past 20 years. The Bank sought to support health decentralization in the mid-1980s through the São Paulo Basic Health Project, but the complexity of politics in that state, and of federal state relationships resulted in a project that was not well articulated with the evolving governance structure. Investments in the Northeast supported decentralization through technical and managerial training. The recent health sector reform, Reforsus, supports decentralization by encouraging managerial development as well, but its emphasis on setting national cost-effectiveness priorities places its strategy in conflict with the objective of local autonomy and regional diversity in SUS prices.

Despite efforts to make it more equitable and effective, the system remains distorted and expensive. Because health care is free in Brazil and because health manpower and facilities remain more concentrated in the wealthier regions, government health expenditures are not well targeted to the poor. Although it has targeted much of its investments in the poorest regions of Brazil, the Bank has not developed a long-term strategy for confronting the institutional dynamics that underlay the misallocation of resources in the Brazilian health sector.

Project Impact on Health Outcomes

The second part of the study assesses the outcomes of the two main kinds of World Bank health projects in Brazil, the control of endemic diseases, and the provision of basic services, based on a detailed analysis of two projects selected to represent the Bank's investments in both areas.

Malaria Control and Disease-specific Projects. The Brazil Amazon Basin Malaria Control project responded to a dramatic upsurge of malaria in the Amazon Region and sought to improve the health of native Indian peoples living in that area. The annual incidence of the two strains of malaria found in the project area fell significantly during the life of the project. The severity of malaria also declined between 1989 and 1996, resulting in a decline in deaths from the disease. Existing evaluations from the World Bank, including the ICR, attribute a significant portion of these accomplishments to the Amazon Malaria Control Program and to project funds particularly to the decision by project leadership beginning in late 1992 to change the strategy from malaria eradication to malaria control and case management. The existing evaluations argue that this change in strategy was responsible for most of the project's achievements.

OED's analysis shows that of the overall reductions in malarial mortality, severity, and case fatality from the peak in the late 1980s to 1996, about 70 percent occurred before project strategy began to change in 1992. That case fatality in most states was falling even before the project became effective suggests that a cause in addition to the change in strategy, perhaps the prior introduction of mefloquine, was responsible for saving lives. External factors such as migration and land-settlement patterns might have contributed to the reduction in malarial incidence as well the endemic disease control program and the Bank's project support to the program.

Basic Health Projects The two Northeast Basic Health Services projects were part of the Brazilian government's 15-year development plan for the Northeast Region, whose social and development indicators lagged behind the country as a whole. The projects built health care facilities, encouraged management improvements at the federal and state levels, and provided technical skills training for the development of new "basic health care modules" and programs of comprehensive care for women and children.

Partly as a result of a difficult political and macroeconomic context, these projects evolved into facilities construction and medical equipment programs. They succeeded in expanding access to basic health services but did not transform the mode of basic health care delivery within that system. Existing evaluations of the projects find that these design problems limited the projects' impact, although child health in the region improved significantly during the life of the project, and access to health care played a significant role in that improvement. It is difficult, however, to determine how much of the expanded access to immunizations, prenatal care, and attended births are attributable to the project because the project did not include a detailed and specific system for monitoring and evaluation. It is reasonable to assume that the project itself did not contribute significantly because it disbursed very slowly until 1994, then shifted priorities and a significant portion of the net improvement in child health had already occurred by 1994. In addition, the health of rural children in the Northeast, which the original project design had targeted, did not improve as fast as the health of rural children in other regions. Although the projects were adequately designed given the state of the art and the consensus among health planners at the time, focus group work makes it apparent that they did not take into account the changing demands of increasingly urban consumers. In retrospect, it is apparent that provision of basic health care entails not merely more training and facilities but realigning incentives in the sector. In particular, it requires intervening in the current labor markets for health providers and in the process of policy formation and consensus building in the sector.

Key Findings

The key evaluative findings of the study are:

- *The World Bank's disease control and basic health services projects have targeted important and relevant concerns*. Access to health care remains difficult in Brazil. The diseases the Bank's projects have focused on—malaria, leishmaniasis, Chagas' disease, schistosomiasis, and AIDS—are significant problems in Brazil, strike young people, and disproportionately afflict poor and marginalized groups.

- *At least two of the four World Bank disease-control projects have contributed to declines in the incidence of those diseases and mitigated their effects on afflicted individuals*. The endemic disease project and the second malaria control project helped to slow the spread of disease and promoted treatment programs. Although it would be rash to attribute all of those

reductions in incidence to the projects, they certainly contributed. The first malaria control project did not reduce the incidence of malaria in Rondônia and was unsatisfactory. It is too soon to tell whether the AIDS project has slowed the rate of increase in disease incidence.

- *The World Bank's first malaria control project in Brazil underestimated the importance of institutional strengthening and behavior change in public health, but subsequent disease control projects have helped build Brazil's human, physical, and information systems for disease surveillance*. The second malaria project shifted strategies midstream to emphasize treatment and control over eradication, and the Northeast endemic disease project worked to strengthen public health capacities of state and local governments. The current AIDS project is pioneering collaboration between the government and nongovernmental organizations (NGOs) to promote safe health behaviors. No project to date, however, has included good measures of the performance of the disease surveillance and health care systems.

- *The World Bank's analytic work identified contemporary challenges in adult health in Brazil, but the Bank has been unable to follow up with projects that address them*. The sector work identified maternal health and the promotion of healthy behaviors, such as exercise, diet, smoking cessation, and injury prevention, as critical areas where public health activities might cost-effectively improve health and reduce the burden on the health care system. The Bank was not able to develop public health projects addressing these concerns with the Government of Brazil.

- *There is no evidence that the World Bank's basic health services projects for the Northeast promoted overall health system performance, economic efficiency, or substantial improvements in consumer satisfaction with health services*. In addition, they did not help the health of children in the rural Northeast catch up to the rest of the country. They did help to build a working relationship with the Government of Brazil after a difficult period of misunderstanding. They also helped to build the infrastructure for health care in the region, but they (rightly but belatedly) abandoned their original strategy for basic care, built on rural health posts, late in the implementation process. Consumers remain frustrated with the quality and accessibility of health care in the region, and human resources bottlenecks remain a significant problem.

- *The World Bank's current strategy for sector reform in Brazil, the Reforsus project, suffers from weaknesses in the analysis of and response to a complex political and institutional environment.* The early HNP projects in Brazil were unsatisfactory and suffered from lapses in "borrower commitment and institutional capacity"; in other words, the World Bank conceptualized those projects as injections of financial and technical resources without examining the political and economic incentives that would govern how those resources would be used. The current Reforsus sector reform project is predicated on a more sophisticated understanding of economic incentives. It aims to improve the efficiency of the health care system by paying doctors and hospitals more when they provide particularly cost-effective services. That strategy is unlikely to work, however, because the actual rates at which the government reimburses providers will continue to bear little relation to the real cost of services, because those rates continue to be set in a non-transparent process, and because a variety of other rules also influence the payments providers receive. In the end, incentive payments made to hospitals and municipalities may not change the behavior of doctors. In addition, the continued use of one set of reimbursement rates to distribute resources to the various states and municipalities makes it difficult for the ministry to set national programmatic priorities across Brazil's diverse regions. In short, Reforsus remains

primarily a infrastructural investment project because its strategy does not address several key problems in the political economy of health care in Brazil.

- *The World Bank has not developed a long-term strategy for confronting the mis-allocation of resources in the Brazilian health sector*. Brazil's health care expenditures need to be targeted more closely on cost-effective interventions and should encourage more innovative approaches to both preventive and curative care. A particularly strong health care lobby, the government's use of "contingency" restrictions to reduce the public health budget, and the traditional training of health care professionals are deeply entrenched obstacles to such reforms. These cannot be overcome quickly, nor can an external agency such as the World Bank hope to affect them alone. If the World Bank is to address this critical issue in the Brazilian health sector seriously, it should develop a strong and consistent presence in Brazilian health issues, the kind of presence necessary to build, gradually and persistently, a broad-based coalition for reform.

Recommendations

- The World Bank should adopt a long-term strategy of coalition building to grapple with the difficult, institutionally embedded problems of the Brazilian health sector.

- The World Bank should initiate sector work and perhaps an institutional development project on the regulation of private health care in Brazil.

- The World Bank should continue to finance projects that address the needs and health conditions of the poor, but it should pilot new approaches for providing basic health care services.

- The World Bank should study and finance health projects that focus on the chronic and degenerative diseases that are increasingly affecting the poor of Brazil.

- The World Bank should support the development and implementation of monitorable indicators of health system performance in Brazil.

India

Introduction

Fertility, mortality and morbidity have slowly and steadily declined in India since independence but remain unacceptably high by Indian standards as well as by comparison to what some countries with comparable or lower incomes have achieved. While the root causes are poverty and low levels of education, the public health programs bear some of the responsibility. These programs have faced a series of well-recognized problems, the most serious of which are inadequate access by the most vulnerable groups, poor quality of primary and secondary facilities, which has resulted in their under-utilization, and until recently, excessive focus on sterilization and inadequate focus on maternal and child health.

Since 1972, the Bank has assisted the government in its attempt to correct these problems. This assistance has come in the form of 23 projects to which the Bank contributed over $2.6 billion,

plus studies (sector work) and policy dialogue, in the health, nutrition and population sectors. This study provides an assessment of this program. It does so by first reviewing the projects and sector work that the Bank funded and then by taking up a number of special issues in more depth.

Evolution of Programs and Projects

Early population projects (1972-1988). During this period, the Bank funded five population projects. For the most part they consisted of helping the government carry out its preconceived family planning-cum-maternity and child care (MCH) program, since 1976 known as the Family Welfare (FW) Program. The Bank had little influence on the direction of these plans for several reasons: (a) The government's approach to the country's population problem was firmly established long before the Bank became involved. (b) The Bank's lending program, while large by Bank standards, was only 3.6 percent of total expenditures on the FW program. (c) While combined donor inputs were more significant—in the range of 12–14 percent—the government discouraged efforts at donor coordination and the Bank did little to resist this approach. (d) The overall goal of these projects was to accelerate the extension of the service delivery network for the FW program in specific districts; but with a couple of exceptions, these projects did not make significant differential improvements in project districts compared to non-project districts, among other reasons because inputs other than infrastructure were largely neglected, no attempt was made to apply different delivery models in project districts, and project districts continued to operate under the same personnel and recurrent budget constraints as non-project districts. (e) The Bank assigned few people to work on this sector, had limited field presence, undertook no comprehensive sector work in this field prior to 1988, and did little to develop alternative approaches to service delivery or to encourage the involvement of other sectors (e.g., education or health) that could have helped generate demand for smaller families. It was therefore ill-prepared to make practical, constructive suggestions for system improvements or alternative approaches. To be sure, the government encouraged this low-key, passive approach and might have been very unhappy with a more proactive stance. But the Bank appears to have gone along with what the government wanted, even during the emergency period of 1975/76 when official promotion of sterilization reached a peak, without much of a struggle.

Sector Work (1988-1998). After the reorganization of the Bank in 1987, a new team took over operations in this sector. This led, among other things, to a rapid expansion of sector work. For the most part, these studies have taken up the proper subjects and are an excellent source of information and diagnosis of problems. Their principal weaknesses are a tendency to provide policy recommendations that are too general, to make judgments about facts without comparing to other countries, and an inadequate analysis of underlying (sociological, political, institutional) forces that explain why things work the way they do. Later sector work is better in these areas and appears to have had more influence on policy. One reason for this is that task managers made a point of involving the government in selecting and designing the studies and local consultants in their execution. This change in style is at least as important as content and soundness of analysis in explaining their greater influence.

Later Population projects (1988-1998). In January, 1987, India and the Bank agreed on a sector strategy to guide future operations which included: (a) greater emphasis on outreach, (b) greater emphasis on temporary methods versus sterilization, (c) increased attention to MCH, (d) less project resources for expansion of the system and more for enhancing quality of service delivery, training and IEC, and (e) priority to improving these services in urban slums and backward, high fertility states not covered by previous projects. It has taken some time for these principles to be reflected in projects, but by the end of this period it is fair to say that all of them have been fully incorporated. In addition the last project to be started, the Reproductive and Child Health Project

(1997-2003) includes other attractive features. Its design is clearly based on related sector work and consultations with stakeholders; it attempts to spell out in practical ways how various initiatives—for example, the dropping of sterilization targets—might be implemented; it encourages the development of different implementation models in different situations; it introduces some elements of performance-based budgeting; and it builds monitoring and client feedback into the heart of the project. These and other initiatives speak to nearly all the problems of the FW program identified in earlier projects and studies. These features should result in a significant improvement in outcome, but it is too early in the life of this project to know whether this will be the case.

Nutrition Projects. The Bank has supported two, quite different, nutrition programs. The first, the Tamil Nadu Integrated Nutrition Project, designed largely by Bank staff and consultants, was an innovative program that focused on changing the way mothers feed themselves and their pre-school children, rather than on feeding per se. Considerable care was taken in designing work routines and in training and supervising staff. This program, supported by two Bank-funded projects, has been well monitored and evaluated. The principal conclusions are that it was well implemented and quite successful in reducing severe malnutrition.

The second program, Integrated Child Development Services (ICDS), initiated before TINP, has become the government's predominant program for preschool children. It is meant to be holistic, offering non-formal preschool education, supplemental nutrition, immunization and health checkups for children age 0-6, and nutrition and health education for pregnant and nursing mothers. Recent assessments suggest that the program is having only modest positive effects: food and other inputs are not regularly available at all sites, the most vulnerable groups—children under three and pregnant and nursing women—are underrepresented at the centers, most food is taken home (rather than being consumed at the center, as in TINP) where it is shared with other family members, and field workers are inadequately trained and overextended with the result that the outreach, health and educational components of the program are often neglected. A more adequate budget, a second field worker per center, more narrow targeting and some decentralization of management would ameliorate many of these problems.

The GOI has shown no interest in continuing the TINP model, despite its relative success. Rather than pressing for this, the Bank decided to support ICDS and try to influence it to incorporate the more attractive elements of TINP. The Bank has provided support for ICDS through three free-standing projects and components in at least two others. Outcomes to date have been disappointing. The TINP experience seems to have been lost on India, and with it, a clear emphasis on malnutrition as a leading risk for ill health, although it has affected the design of some nutrition projects in other parts of the world.

Free-standing Health Projects. The first free-standing health project was funded in 1992. Today, this portfolio consists of two types of projects: five specific disease control projects and four state systems projects with several more in the planning stage. Fundamentally, the disease control projects are meant to assist the government with its vertical programs. In the process, they have brought to bear Bank experience elsewhere, introduced new treatment protocols, and attempted in different ways to involve the private sector and non-governmental agencies. The result has been a significantly more rapid decline in prevalence of leprosy and cataract blindness than would otherwise have occurred, an increase in the pace of detection and treatment of tuberculosis, substantial improvement in the safety of blood transfusions and modest improvements in protective behavior amongst some high-risk groups, but, so far at least, no visible impact in slowing the AIDS epidemic and no progress in bringing malaria under control.

The prevalence of leprosy and cataract blindness have been reduced faster than would otherwise have occurred, and both may be eliminated as major public health problems. In tuberculosis, the pace of detection and treatment have increased, but the disease is still far from being controlled. The first AIDS project succeeded in greatly improving the safety of blood transfusions and appears to have increased protective behavior in some high-risk groups, but has not yet had a visible impact in slowing the epidemic. The only project with no success to show yet is that of malaria control.

The state systems projects provide the Bank with a long-sought opportunity to influence more fundamental determinants of how the public health system works, to do so at the level of the states, which are responsible for health care, and where the Bank can have more leverage than is possible at the national level, and to provide assistance tailored to the vastly different circumstances in different states. The first of these project focused on improving secondary hospitals in one state. This improvement is a necessary, though not sufficient, step towards establishing an adequate referral system between primary and secondary institutions. The other projects are extending the principles of the first but in some cases adding more work at the primary level, again with a goal of establishing a working referral system.

The Big Break and Its Causes. Much of the above can be summarized by comparing projects, sector work and style of operations before and after about 1988. Before this time there were no free-standing health projects, population projects were for the most part supply-oriented, the Bank's stance was to support the government program without seriously pressing for the policy changes it believed to be necessary, and there was almost no sector work. Since 1988 sector work has flourished and raised policy issues that are being taken seriously, health projects have been added to the portfolio, serious efforts have been made to shift the balance within the FW program from FP to MCH, contraceptive targeting was dropped, and health and state system reform projects have proliferated. This sea-change resulted from a number of factors: evidence that old approaches were not working, the emergence of some new, cost-effective treatments for some diseases, the emergence of new diseases, pressures to pay more attention to what women actually want, changes in personnel in both the Ministry and the Bank, and perhaps most importantly, the deterioration in economic conditions in 1990-91 which increased the government's interest in acquiring foreign assistance and led to an agreement that assistance obtained by the MOHFP would be considered additional to its plan budget, thus giving the Ministry a strong incentive to acquire such assistance.

Selected Topics

In addition to the historic approach, this study took a second cut through the evidence by considering a number of special topics and issues, two concerned with components included in nearly all HNP projects (training and IEC), three concerned with policy initiatives the Bank has been advocating for some time (dropping sterilization targets, decentralization and involvement of NGOs and the private sector) and two involving efforts to assess the extent and determinants of overall progress. While the historic approach indicates that recent programs and projects are much better designed and executed than earlier efforts, this second view of the situation suggests that many serious problems remain.

The empirical studies suggest that quality of primary services provided by the government did not improve significantly between 1987 and 1996, that income, education and the overall quality of state administration are more important than specific public health interventions, and in particular, Bank interventions in specific districts, in explaining differences in demographic and health indicators during the period 1981-1991. The papers on training and IEC argue that the

Bank's main contribution has been to expand capacity; the Bank's efforts to improve quality have not accomplished much and it has devoted inadequate attention to content, monitoring and evaluation and feedback of results. The paper on changing signals in the FW program investigated events shortly after the immediate drop in contraceptive rates that appears to have resulted from the change in policy. It found that rates were beginning to recover and that staff were beginning to emphasize temporary methods and MCH. But the clients interviewed perceived little change in behavior of health personnel. The study of Bank efforts to involve NGOs in the sector concludes that progress in this direction has been very slow. The study of decentralization concludes that little authority over budget and personnel has yet been given to local agencies. It also questions the wisdom of doing so, in contrast to devolution to state and district level.

The studies are more cautious in their conclusions than is possible in this brief summary and all need to be qualified in important ways. Most important, given the improvements in programs and projects in recent years, repeating these studies five years from now would probably yield more positive results. But it is sobering, nonetheless, to observe how little progress has been made despite the considerable efforts extended during the first two decades of the Bank's involvement. And the studies caution against excess optimism about how much these new initiatives can accomplish in a country as large and complex as India.

Conclusions and Policy Implications

Our overall assessment is that the Bank is now on the right track, but that it took an inordinately long time to get there. Reasons for this include resistance on the part of the government prior to the early 1990s and the Bank's rather cautious approach to India, which for a long time manifested itself in continuing to support expansion of programs it knew to be seriously flawed, willingness to continue funding even when project goals were not achieved or agreements not met, and failure to insist on adequate monitoring and evaluation to come to hard judgements about performance. This reluctance to enforce reasonable performance standards may be related to the reluctance, or inability, of the MOHFW to do so *vis-à-vis* the states, which have responsibility for implementation of most projects. Recent instances where the Bank or the MOHFW has taken a firm stand and obtained real improvements are encouraging and, one hopes, will stiffen the backbone of both organizations. The performance-based allocation mechanism built into the RCH project is also encouraging.

The report concludes by focusing on the following policy implications.

- Project outcomes are more dependent on personalities and style of operations than we had anticipated. Large bureaucracies like the Bank and the MOHFW are reluctant to admit this, hoping no doubt that work plans, rules and regulation will insulate programs from the exigencies of personnel assignments and different operating styles. But in incident after incident it is difficult to explain outcomes without taking these factors into account. In designing projects, more conscious attention should be devoted to these issues.
- Closely related is the neglect of personnel issues in project implementation, by the Bank and perhaps also by the MOHFW. These issues include policies and practices regarding compensation, assignment and transfer, promotion and demotion, work rules and supervision, all of which determine the incentives that govern how individuals do their job. Provision of plant, equipment, supplies and even training will not accomplish much if these incentives are incorrect.

- Sector work and project design need to take more account of field conditions, not just to make sure that project designs are realistic but to find solutions to implementation problems. A case in point is the need to understand the incentives that determine performance of workers in direct contact with clients. The related tendency to add initiatives before older ones are adequately implemented needs to be resisted. Thus, for example, we need to ensure that family planning is not neglected in the wake of the reproductive health initiative and that basic, simple, services for the poor are not neglected in the wake of the attention being paid to secondary hospitals.
- There needs to be more focus on determinants of health status that are outside the traditional confines of the health sector. Transport, communications, environmental pollution, and health education are examples. Civil service rules and regulation as they affect health workers is another.
- The establishment of an effective referral system requires more than upgrading skills and facilities at both ends of the chain; it also requires good transport and communications and the willingness on the part of the referral hospital to make the system work. The latter cannot be done without supervising some aspects of lower level operations and that may require some institutional changes. It probably also requires that qualified staff at the referral hospital be assigned this function on a full-time basis.
- Mobilizing the private (profit and non-profit) sector to serve public health goals raises issues about using public money to buy private services, which implies the need for contracting, accreditation, regulation, referral, and appropriate division of labor between the public and private sectors—all complex issues that other countries are wrestling with as well. The Bank can help by encouraging experimentation with different approaches in the projects it funds and by bringing to bear information on how these issues are resolved in other countries.
- The recent initiatives to introduce performance-based budgeting into projects needs to be extended and intensified. In principle, it could help the government resolve one of its most perplexing problems, how to make the system more accountable.

Mali

This Sector Impact Study evaluates the World Bank's contribution to the development of the health sector in Mali over the past 20 years. In that time the Bank has financed three projects and undertaken policy dialogue that contributed to the development of a national health policy for the country. The Mali case represents some of the challenges faced by the Bank and its partners in attempting to improve health and health system performance in a low-income country with a poor and widely-dispersed population.

The health system in Mali historically focused on curative urban-based care, with limited basic curative or preventive health services in rural areas. Various donor agencies and NGOs attempted to provide rural services, but inadequate coordination, staff shortages, and inadequate financing for recurrent costs reduced impact and sustainability. A parastatal drug agency maintained a monopoly on drug imports and sales, and sold only high-priced specialty pharmaceuticals, making drugs unaffordable for the majority. In addition, the low levels of girls' primary education contributed to weakened health indicators—including high fertility rates, low contraceptive prevalence rates, and high child mortality. Child malnutrition is also a serious problem.

The Bank's first lending to the health sector was in the early 1980s for a pair of projects, Health Development (PDS) and Rural Water Supply. The objective of PDS was to extend primary health care services to the village level, and to improve the supply and reduce the cost of drugs. The rural water project worked in concert with PDS to achieve improved health by installing water pumps and wells, and organizing communities to maintain them. While Rural Water Supply achieved its objectives, PDS failed to achieve most of its objectives. That failure, together with promising results from pilot community-managed health clinics, led to Bank participation in the development of Mali's national health policy and to the implementation of that policy through the 1991 Health, Population, and Rural Water project (PSPHR).

The policy restructured Mali's health sector to establish a new community health system that would deliver primary health care services at the village level. Responsibility for planning and supervising local health services was decentralized to district health teams. The success of this strategy depended on improved planning and supervision at the district level, and on ensuring a reliable supply of low-cost essential drugs. The World Bank, UNICEF, and other partners advised in this policy process, but it was led by government.

Principal Findings

The Bank's emphasis on meeting the basic health needs of the country's rural population was appropriate, and the establishment of the community health sector was a strategic response to financial and structural constraints prevailing in the Mali health sector. The Bank's efforts to improve the supply and affordability of essential drugs also addressed a major constraint to the effectiveness and efficiency of the Mali health system, and was key to the viability of the community health sector. The community health strategy, however, left unaddressed significant constraints to improved health for the majority rural population. Despite progress in expanding rural health services, overall utilization remains low. In addition, inefficiencies, inequities, and urban bias remain in the government health sector. Yet starting first with the community sector--and not trying to fix everything at once--was probably the right strategic choice.

In the 1980s, the World Bank and IMF macroeconomic dialogue focused on restraining government spending and internal adjustment. Together with fiscal stringency and continued economic stagnation, this inattention to social sector concerns contributed to a decline in government health financing. By the early 1990s, communication between sector and macroeconomic staff improved, and the Bank included in its macroeconomic dialogue calls for increased budget allocations to health and basic education. The Bank also began to raise concerns regarding the equity and efficiency of government health spending and health staffing patterns. The civil service reduction targets in the structural adjustment program, however, depleted basic health staff and senior health policy positions, with negative repercussions for the health sector and project implementation. Government significantly increased funding for health by the mid-1990s, and the Bank eventually relaxed its restrictions on recruitment for the social sectors.

The Bank's health financing policy dialogue in the 1990s focused on increasing overall budget allocations to health, reducing the cost of drugs, encouraging cost-recovery for health services, and improving the efficiency and equity of government budget allocations within the sector. The Bank's dialogue on the latter was constrained by difficulties in interpreting government health budget categories, and inadequate support for sector work and operational research. The forthcoming Sector Investment Program plans to address health staffing and sector efficiency issues.

The Bank's initial efforts to reform the pharmaceutical sector failed because the problem with the Pharmacie Populaire du Mali (PPM) was perceived as inadequate capacity, rather than an inappropriate regulatory and incentive structure. The Bank subsequently made restructuring of PPM and removing constraints to private competition a condition for PSPHR support, and required that PPM shift toward the purchase of essential generic drugs. Progress was slow initially, but with the introduction of international competitive bidding, official drug prices dropped sharply, and continued to decline despite the 1994 CFA devaluation. Generics are now widely available, and prices are low enough to allow community health centers to cover recurrent costs from drug sales. Shortages persist at the regional distribution depots, however, and many community health centers rely on a recently established nonprofit drug agency to maintain their stocks. Bank conditionality may have focused excessively on reform of PPM, however, rather than on essential drug availability.

The PSPHR project helped establish and expand the new community health system in four districts and in the capital, and was cofinanced by several other donors, with parallel financing from UNICEF. Technical support from UNICEF was particularly crucial to help districts develop health plans and supervise the new community clinics. The project significantly increased access to health facilities and, with pharmaceutical reform, increased the supply of affordable drugs. The community clinics mostly have been successful in improving service coverage and client satisfaction and are able to cover much of the recurrent costs of running the clinics through cost-recovery.

The new system has several limitations. First, despite some improvements, utilization rates remain low, apparently because of financial barriers to access and continued preference by many clients for traditional services or self-medication. Second, the clinics provide primarily curative health services, with little involvement in provision of family planning, promotion of clean water and sanitation, nutritional monitoring, or health and nutrition education and preventive activities. Local NGOs provide some of these services, but they are not integrated with the health centers. Third, the clinics are not linked to the traditional sectors, including traditional healers. Fourth, there is currently no clear career structure for health professionals at the clinics, and the community clinics have had difficulty attracting and retaining staff. Finally, although most of the clinics show a "surplus," revenues are not sufficient to cover long-term maintenance and other costs such as replacement of equipment. Although government and the World Bank have acknowledged that continued subsidies will be necessary, the recurrent implications for national budget allocations have not been adequately assessed.

By encouraging government to take a lead role in project and policy preparation, the Bank has contributed to capacity building and "learning by doing." The MOH's capacity to plan and manage health projects and services has improved since the Bank's first investments in the early 1980s. The key role of the Project Coordinating Unit within the MOH in both policy and project implementation, however, sometimes has resulted in a blurring of responsibilities within the ministry.

The Bank's contribution to monitoring and evaluation has been mixed. The PDS was unsuccessful in establishing a regional project monitoring system. Although the PDS was supposed to be a pilot, it was not evaluated until after PSPHR was designed and approved. With support from USAID, the PSPHR helped establish a national monitoring system in 1996—a three-year process that rationalized and consolidated a variety of vertical information systems. This was an important achievement, but because it was not initiated earlier, it is difficult to assess the impact of the project over time. Periodic PSPHR review meetings provided a useful forum for discussing a variety of project and sector issues among government and partners.

PSPHR provided no funding for operations research, however, so that a number of key sector issues were not investigated until preparation began in 1996 for the next phase of support.

In 1998, government completed a 10-year strategic plan for the sector, together with a 5-year investment program, which are to guide both government and donor programs. These plans were prepared in conjunction with the next phase of World Bank support, a sector investment program (SIP), which supports the government's strategy and addresses a number of sector-wide issues. In preparation for the SIP, the Ministry of Health prepared a number of studies with support from the Bank and other donors. The SIP plans to further expand the community health sector, improve hospital efficiency and autonomy, and expand private health insurance, among a variety of initiatives. The SIP will form the framework for several donor programs, although most donors will continue to manage funds separately.

The SIP attempts to address a number of issues raised in this evaluation, including human resources, sector efficiency, and nutrition, and sets ambitious targets for improvements in health system and HNP indicators. In trying to address so much at once, however, the program runs the risk of excessive complexity. The Bank, government, and partners may need to prioritize as implementation proceeds, and continue to monitor whether the proposed interventions are the most efficient and effective means to improve HNP outcomes. Some donors also expressed concern that Bank timetables and agenda excessively influenced the policy process and program design. Although government has retained its leadership role, the Bank must be cautious and collaborative to ensure that it does not excessively drive the agenda.

Lessons

- Community-financed health centers, combined with a reliable supply of essential generic drugs, can help extend basic care to previously underserved populations and improve responsiveness to local consumers. Yet improving physical access to health services does not necessarily lead to increased service utilization.

- During fiscal adjustment, the Bank and government must pay attention both to protecting overall allocations to the social sectors and to the efficiency of expenditures within the social sectors.

- While rural cost recovery can be important to sustain local services, the funds raised typically are small relative to overall government health spending, which often remains focused on urban curative care.

- Pharmaceutical reform and improving the availability of essential generic drugs requires first a careful diagnosis of the institutional and political constraints to change, followed by negotiated agreements to shift the regulatory and incentive structure for the public, private, and nonprofit sectors.

- Shifting a previously-centralized health delivery system to one based on district-level planning and community participation requires changing incentives together with intensive technical support both for districts and communities.

- Establishing a community sector outside of the government civil service can help make providers more responsive to community concerns, but can also create problems with attracting and retaining staff if job security and career paths are unclear.

- The Bank should give greater emphasis to rigorous monitoring and evaluation, and operations research, particularly when piloting new service delivery mechanisms that are then scaled-up nationwide.

- In aid-dependent countries, the Bank can help increase the coherence of donor activities by supporting the development of national health strategies and through funding instruments such as umbrella projects or sector investment programs.

Zimbabwe

This Sector Impact Study assesses the relevance and impact of World Bank policy advice and project support to health, nutrition, and population in Zimbabwe over the past 15 years, including the influence of macroeconomic dialogue and policies on the health sector. The Bank's first loan sought to improve the quality and availability of health services in eight target districts, including expansion of infrastructure and provide training, and a follow-on loan in 1991 expanded the program to an additional 16 districts. A 1993 loan funded the acquisition of drugs for treating sexually transmitted infections (STIs), as well as medical supplies and laboratory equipment. The Bank has also sponsored policy dialogue and sector work on health financing and cost recovery, population, and nutrition. In addition, the Bank provided key advice and financial support for the Economic Structural Adjustment Program (ESAP).

The government's strong emphasis on prevention and integrating primary health care, family planning, and nutrition contributed to rapid improvements in health, fertility, and nutrition outcomes during the 1980s, but the changes predate Bank investments. In the 1990s, health and health service indicators stagnated or declined under the combined burdens of AIDS, economic crisis, and drought, although fertility continued to decline. Zimbabwe now has one of the highest HIV prevalence rates in the world, which threatens to reverse the health progress made in the 1980s. Bank-sponsored projects provided valuable support to the health sector, but impact was overwhelmed by these larger trends. Even though HIV/AIDS is best addressed through prevention and behavior change, declining per capita health spending and growing demands for curative care have weakened the preventive focus of the MOH.

Principal Evaluative Findings

The Bank has usually "done the right things" in the Zimbabwe health sector, but has not always "done things right." Bank policy advice and project support have generally been relevant to Zimbabwe's epidemiological profile and health sector needs, but they have often experienced difficulties in implementation. The Second Family Health Project (1991-98) was an exception; it was effectively implemented ("did things right"), but the design was not sufficiently flexible to adapt to rapid changes in the health sector, particularly critical shortages of health staff.

Zimbabwe's 1991 economic structural adjustment program liberalized the economy but failed to control the budget deficit, which together contributed to strains on the health sector and on the poor. High budget deficits fueled inflation and led to growing interest payments, which in turn contributed to declines in real health spending and real wages for health workers. Although health workers were protected from retrenchments, reductions in MOH administrative and maintenance staff reduced efficiency and added to morale problems. The Bank encouraged

adoption of an exemption system to protect the poor from increased cost-recovery in the social sectors, but shortcomings in design and implementation meant that the program reached only a small percentage of intended beneficiaries. Economic liberalization without deficit reduction contributed to economic stagnation and limited job creation. Higher costs for food and social services, combined with declining formal sector wages and lingering effects of severe drought, have left many of the poor worse off than before adjustment began.

Bank health financing sector work led to increased cost-recovery efforts, but it had limited success in mobilizing additional resources for health, improving quality and efficiency, or protecting the poor. The Bank persuaded the Ministry of Health to increase user fees in the early 1990s, but the Ministry of Finance did not permit fee retention until late 1997. Because fees were not retained, facility quality did not improve and bypassing of clinics continued. Total cost recovery declined as a percentage of the MOH budget, primarily because government made little progress in improving hospital billing. Attendance for some preventive services shifted from hospitals to clinics, suggesting improved efficiency, but outpatient attendance by the poor declined following fee increases, as a consequence both of increased prices and declining quality. The Bank must complement its broad policy recommendations with detailed dialogue on implementation, give greater attention to the institutional context, and coordinate sector and macroeconomic dialogue.

The Bank has been well-positioned and effective in promoting the integration of key HNP interventions. Bank sector work and project support contributed to the integration of nutrition and family planning into health services. The percentage of women obtaining contraceptives in health facilities increased since the late 1980s, which is partly attributable to Bank-sponsored family planning training.

Bank support for expanding district infrastructure and staff training has improved service quality and contributed to increased facility deliveries, inpatient attendance, and contraceptive prevalence, but has had no measurable impact on outpatient attendance or disease patterns. Outpatient attendance actually declined following facility completion in 1991, coinciding with drought, increased fee enforcement, and drug shortages, suggesting that improved infrastructure and training alone are inadequate to improve outpatient utilization.

The impact of upgraded facilities on maternal attendance varied considerably depending on the appropriateness of site selection. In genuinely underserved districts, maternal deliveries increased several times over following facility completion, while in others, deliveries stagnated and inpatient attendance fell. Domestic political influences and Bank insistence on upgrading existing facilities contributed to inappropriate site selection.

The Second Family Health Project (FHP2) improved on facility design and site selection and built 16 district hospitals for the cost of the original 8. For FHP2, the Bank placed an architect within the MOH, who worked to ensure maximum efficiency in facility design. International competitive bidding resulted in construction costs 40 percent lower than government estimates, and facilities were completed on time and nearly on budget by the end of 1997. Unfortunately, the government health system faces a severe shortage of health personnel, which is making it difficult to staff the new facilities, and threatens to undermine their impact. No strategic evaluation was undertaken during FHP2 design to assess whether building an additional 16 district hospitals was still appropriate, and the “blueprint” investment nature of the project limited the Bank’s flexibility to respond to rapid changes in the sector.

The staff shortages are the result of recent political decisions by government (abolishing training for State Certified Nurses and firing striking health workers), high turnover of health staff, and the absence of effective health manpower planning. Erosion of real wages in the public sector and increasing workloads have contributed to turnover and low morale. Although Bank staff periodically raised concerns regarding health staffing, they were not effective in addressing the institutional constraints to action. The Bank has supported technical assistance for work force planning, and raised concerns regarding health staffing during supervision missions, but did not undertake formal sector work until 1998. Once construction began, it was not possible contractually or politically to delay construction or reduce the number of hospitals pending resolution of staff shortages. Responsibility for health personnel is divided among various ministries (MOH, Ministry of Finance, and the Public Service Commission), and the Bank did not use its leverage at the macroeconomic level to elevate and add urgency to the dialogue. The MOH, Bank, and donors have made health staffing a priority for future support, but all parties should ensure that the various responses are coordinated.

Bank support for the purchase of STI drugs closed a major financing gap, contributed to significant cost savings in drug procurement, and initially increased drug availability. Other bottlenecks later emerged that reduced drug availability, undermining program effectiveness. STI drug availability increased to 89 percent in the first two years of the project, but then fell to 73 percent in 1996, primarily because of reversals of government contract awards by Bank procurement specialists, and delays in registering drugs procured through international competitive bidding (ICB). Government staff did not initially receive adequate training in Bank procurement procedures, and Bank supervision of procurement was initially inadequate to resolve bottlenecks. Increased supervision and management attention by both government and Bank staff contributed a recovery in STI drug availability in 1998.

Bank-funded research has helped raise awareness in Zimbabwe regarding the seriousness of the AIDS epidemic, and the Bank has cosponsored innovative community AIDS prevention initiatives. The government's response, however, still is not commensurate with the scale of the epidemic, which may claim 1 million lives in the next decade.

Lessons and Recommendations

- Macroeconomic policies and performance have had a greater influence on the health sector than Bank project lending, but the Bank has not effectively linked health sector investments and strategies to macroeconomic dialogue, particularly regarding health staffing and civil service reform. Political leaders, however, have not demonstrated commitment to deficit reduction. To prevent further deterioration in the public health sector, government must give priority to reducing the budget deficit and restructuring debt service. In the medium-term, the budget for health will remain constrained, so government and partners will need to focus on increasing efficiency and redistributing existing expenditure.

- The AIDS epidemic is the most serious problem facing the health system and, along with the deficit, the economy as a whole. Government and political leaders must give greater priority and visibility to AIDS prevention, and establish an effective intersectoral response to the epidemic. Experience elsewhere has shown that strong leadership and political commitment can halt the growth of the epidemic and save hundreds of thousands of lives.

- Bank advice has usually been technically sound, but implementation of recommendations has sometimes faltered because of inadequate attention to institutional or political constraints. The Bank often has not adequately assessed the ability of borrower institutions to cope with the size of Bank projects, or the demands of policy changes. In particular, the Bank initially recommended establishing an exemption system to protect the poor from health fee increases without considering the administrative viability of such a system. The Bank and government therefore should give greater attention to adapting programs to existing capacities. By establishing clear technical criteria for equity and efficiency during project design and implementation, the Bank can reduce, but not eliminate, distorting political influences.

- The Bank has been particularly effective when it has promoted integration of programs or cooperation among various government ministries, but it needs to use its potential influence as facilitator more widely and strategically, particularly now that the challenges facing the sector are more complex and require cooperation from a wide range of stakeholders.

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

- The Bank could better balance efforts to promote efficiency and cost savings (for example, through large projects and international competitive bidding for procurement) with the need to maintain flexibility and achieve impact. Flexibility of lending instruments in a changing environment is a major determinant of project effectiveness, but flexible design should not substitute for clear strategy.

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

- The AIDS epidemic is the most serious problem facing the health system and, along with the deficit, the economy as a whole..

- Preventive and community-based approaches were fundamental to the rapid health improvements of the 1980s, and could be applied more vigorously to the challenges of the 1990s, particularly HIV/AIDS and malaria.

- Although umbrella projects and sector-wide approaches can help improve coherence of donor activities, they require a strong strategic vision from government and negotiated agreements among all parties to be effective.

Ledger of OED Recommendations and Management Response

OED Recommendations	*Management Response*
Increase Strategic Selectivity By the end of calendar year 1998, Bank management and the HNP Sector Board, in consultation with staff and partners, should establish priorities and guidelines for staffing, lending, and administrative resources (including project supervision and ESW) in light of overall objectives in the 1997 sector strategy. Particular attention should be given to: a) how the issues raised in this OED assessment will be addressed, including budgetary implications; b) how the sector plans to focus activities and budgets to sustain quality in light of staff over programming and pending declines in administrative budgets under the strategic compact; c) how country directors will be brought on board with the recommendations and guidelines.	*Increasing strategic selectivity is an important part of the sector/region management's continuing responsibilities, and is already part of their regular discussions on work programming.* Management has been working for some time to allocate resources in line with the priorities identified in the HNP Sector Strategy Paper. Additional focus was provided by the Sector Board in the Fall of 1998 with agreement on concentrating on five priority public health areas. OED's proposal for even greater attention to selectivity is timely and welcome. The Sector Board has prepared an Action Plan with appropriate process and outcome indicators to address the priority issues raised by OED. The Sector Board will address priorities for staffing, lending and administrative resources in a paper to be prepared in FY2000.
Enhance Quality Assurance and Results Orientation The HNP Sector Board, in conjunction with regional sector leaders, should strengthen its role in monitoring and strengthening portfolio quality and results orientation, including: (a) establish a regular system of reviewing portfolio quality indicators, including identifying priorities for remedial actions; (b) establish supportive mechanisms to help task teams improve performance; (c) in conjunction with Bank management, identify steps to strengthen routine quality assurance mechanisms; (d) in annual reports on the HNP sector strategy, increasingly present *evidence* regarding progress toward sector goals.	*Management recognizes quality assurance as a high priority. The HNP Sector Board recently approved a program to strengthen its activities in portfolio quality monitoring and enhancement.* The program includes regular Sector Board discussions of portfolio quality, enhancing direct support for task teams, experimenting with different types of support panels, and staff training. The sector is taking this subject very seriously and has already started implementation of several of these measures. The Sector Board will monitor progress in accordance with Strategic Compact and OED indicators set out in the above-mentioned Action Plan, and will review evidence of progress towards sector priorities in its Annual Strategy Progress reports.
The Bank should seek ways to strengthen the incentives for monitoring, evaluation, and results-orientation within client countries through: a) promoting wider experimentation with and use of performance-based budgeting systems in its lending and policy dialogue, particularly in the Comprehensive Development Framework (CDF) pilot countries; b) by the end of FY2000, producing a preliminary "lessons learned" paper on experience in performance-based budgeting in HNP, in conjunction with partner organizations, including implications for the CDF; c) the Bank should increasingly engage independent evaluative organizations, preferably based in borrower countries or regions, to provide periodic assessments of Bank-financed activities.	*Management endorses the need to develop and implement more effective systems of, and capacity for, HNP project monitoring and evaluation in client countries. However, the recommendations on monitoring and evaluation taken together, would involve a large-scale effort, with significant resource implications.* This recommendation on strengthening incentives for monitoring and evaluation, and greater results orientation is closely linked to the recommendations to enhance country monitoring and evaluation capacity (discussed two items below). Beyond what can be done to strengthen incentives for monitoring and evaluation through individual operations and in CDF countries in our continuing HNP work program, work in this area, including performance-based budgeting, will be phased in systematically later in the sector's Action Plan.

Enhance Quality Assurance and Results Orientation (continued)	
To strengthen Bank performance in monitoring and evaluation, management should: a) identify a core group of HNP staff and consultants with experience implementing HNP monitoring and evaluation, who could be available to assist other staff during project design and supervision; b) develop a "good practices" manual of M&E design and use for decisionmaking, both at the project and systemic levels, including lessons from partner organizations; c) in collaboration with the World Bank Institute, develop M&E case studies and training modules; d) periodically give recognition to task teams who demonstrate measurable results from Bank-supported activities; e) in parallel with the CDF pilots, report by the end of FY2000 on how Bank business practices and procedures could be modified to allow greater results-orientation in Bank lending, and to increase internal incentives for monitoring and reporting on results.	*Agreed. Monitoring and evaluation is weak in the HNP sector and should improve.* Management sees as an immediate priority the development of effective - and above all practical - monitoring and evaluation tools and good practice information for the HNP sector, and their dissemination through training, both of Bank staff and counterparts. Implementation is scheduled to start in the coming FY. Nonetheless, because of the intrinsically complex and long-term nature of the HNP sector, this is a difficult subject and one on which making progress will take significant continuing efforts.
To strengthen borrower capacity and incentives for monitoring and evaluation in the HNP sector, sector strategies and project designs should include: (a) assessments of borrower incentives and capacity for monitoring and evaluation; and (b) where appropriate, recommendations and measures to better enable borrowers to monitor and report on results, including strengthening health information and vital registration systems, and a description of the role of the Bank relative to other partners in this process.	*This is closely linked to the recommendations to enhance Borrower monitoring and evaluation capacity (discussed two items above) and similar considerations apply.* The sector will do what it can through individual operations to give attention to the issue in project designs and sector strategies, and to support Borrower capacity development; priority will be given to CDF countries and other countries with special needs. But systematically addressing this issue will need to await the completion of higher priority work as identified in the Action Plan. For implementation, this topic will be combined with its companion item above.
Intensify Learning from Lending and Non-Lending Services	
To strengthen the institutional development effectiveness of the Bank's work in HNP, management should: a) in coordination with PSM and other internal and external partners, develop appropriate tools, guidelines, and training programs for institutional and stakeholder analysis in HNP, both for targeted interventions and systemic reforms; b) clarify the requirements for institutional analysis in project appraisal documents; c) establish a core of HNP staff and consultants with experience in institutional design and stakeholder analysis, who could be available to assist other staff.	*Management agrees that strengthening institutional effectiveness is a high priority for better overall sector and project performance*. However, it is also an area where the literature for the HNP sector is weak, and where there are few well-established pragmatic guidelines and little good practice to draw upon. OED's recommendations will be taken-up progressively as we strengthen capacity in this area, and the Sector Board will ensure that knowledge and practice gains are incorporated in project design and appraisal documents.
To strengthen the analytic base for Bank advice and lending: a) Management should increase funding for HNP sector work; b) the Sector Board should sponsor operational research and provide good practice guidelines on improving effectiveness and efficiency of ESW and other Bank advisory and analytic services; c) Management should shift some the ESW budgets from country departments to regional technical managers to encourage regional research on priority issues.	*Management accepts the need to examine whether ESW is adequately underpinning lending operations*. Good ESW is the foundation of sound project design. A clearer picture is needed of the amount and effectiveness of ESW, and whether analytical work is being undertaken through non-ESW channels. Management believes, therefore, that without further study it would not be appropriate to make specific budget allocations to HNP ESW. This topic will be taken up fully in FY2001.
Enhance Partnerships	

To increase the Bank's ability to sustain a continued presence in borrower country health policy debates, and to develop long-term partnerships with various stakeholders in client countries: a) the Bank should continue its current efforts to base sector specialists in countries or regions, with a clear mandate for collaborative policy dialogue with stakeholders inside and outside government; b) for projects and reform programs requiring intensive stakeholder consultation, Country Directors and Sector Managers should ensure that these time requirements are reflected in project preparation and supervision budgets.	*Management agrees that posting of HNP staff to the field normally strengthens policy dialogue and links with stakeholders.* The numbers have increased substantially over the last two years. However, much depends on the individual country circumstances, the degree of HNP involvement in that country, and on regional policy. It is management's view that the HNP sector has a creditable record in reaching out to stakeholders during project preparation and supervision. The Sector Board will look again at this topic in FY2002.
To strengthen the Bank's effectiveness in health promotion and addressing the intersectoral dimensions of health: a) The Bank's HD Network and regional vice president's should identify several key areas for improving intersectoral collaboration *within* the Bank, including coordination of macroeconomic and sectoral dialogue on social sector workforce issues; HIV/AIDS prevention and mitigation; and key health promotion activities (defined on a regional basis); b) the HNP network should strengthen staff skills in health promotion and establish "good practice" guidelines and examples for task managers.	*Health promotion is a somewhat neglected area throughout the sector, not just in Bank work.* When done well, it can be highly cost-effective. As suggested by OED, staff need increased technical support in this area and this will be taken up by the Sector Board as a medium-term priority. On the second issue, management accepts that important determinants of health lie outside the health sector. *Intersectoral collaboration is important but notoriously hard for any sector to achieve.* Limiting the scope of work to a few key areas will be essential to achieving concrete results. Work in both these areas will be taken up as a medium term priority.
The Bank should strengthen work with HNP development partners (e.g., WHO, UNICEF, bilateral donors) on several key areas, including strengthening HNP monitoring and evaluation systems and incentives; and assessing progress and strategies on the current generation of health sector reforms.	*Management accepts the spirit of this recommendation, but not as expressed.* A great deal of work is currently going into partnerships with many organizations on a broad range of issues. Management will continue these partnerships and seek to strengthen them, but not as a separate "partnership" activity.

World Bank User
P:\HNP\PHASE3\HNP3TEXT\7th Draft\Backup Gray cover.DOC
05/11/99 11:50 AM