IEG WORLD BANK | IFC | MIGA
INDEPENDENT EVALUATION GROUP

INDEPENDENT EVALUATION GROUP

Have Country Assistance Strategies Capitalized on Intersectoral Linkages to Improve Health Outcomes Among the Poor?

IEG Working Paper 2010/13

Shampa Sinha and Judith Gaubatz

IEG WORKING PAPER SERIES

IEG WORLD BANK | IFC | MIGA
INDEPENDENT EVALUATION GROUP

IEG Working Paper 2010/13

Have Country Assistance Strategies Capitalized on Intersectoral Linkages to Improve Health Outcomes Among the Poor?

Shampa Sinha

Judith Gaubatz

2010
The World Bank
Washington, D.C.

Independent Evaluation Group, The World Bank Group
1818 H St., NW
Washington, DC 20433

IEG: Improving Development Results Through Excellence in Evaluation

The Independent Evaluation Group is an independent unit within the World Bank Group; it reports directly to the Bank's Board of Executive Directors. IEG assesses what works, and what does not; how a borrower plans to run and maintain a project; and the lasting contribution of the Bank to a country's overall development. The goals of evaluation are to learn from experience, to provide an objective basis for assessing the results of the Bank's work, and to provide accountability in the achievement of its objectives. It also improves Bank work by identifying and disseminating the lessons learned from experience and by framing recommendations drawn from evaluation findings.

IEG Working Papers are an informal series to disseminate the findings of work in progress to encourage the exchange of ideas about development effectiveness through evaluation.

ISBN-10: 1-60244-157-X
ISBN-13: 978-1-60244-157-6

Contact: IEG Communication, Learning and Strategies (IEGCS)
e-mail: ieg@worldbank.org
Telephone: 202-458-4497
Facsimile: 202-522-3125
http:/www.worldbank.org/ieg

Contents

Figures

Tables

ABBREVIATIONS

AAA	Analytical and Advisory Activities
AFR	Africa region
AIDS	Acquired immune deficiency syndrome
ARDE	Annual Review of Development Effectiveness
CAS	Country Assistance Strategy
CASCR	Country Assistance Strategy Completion Report
DPL	Development policy lending
EAP	East Asia and Pacific region
ECA	Eastern Europe and Central Asia region
ESW	Economic and Sector Work
FY	Fiscal Year
HIV	Human immunodeficiency virus
HNP	Health, nutrition, and population
IDA	International Development Association
IEG	Independent Evaluation Group
IMR	Infant mortality rate
LCR	Latin America and Caribbean region
LIC	Low-income country
LMIC	Lower middle-income country
MDG	Millennium Development Goal
MNA	Middle East and North Africa region
MMR	Maternal mortality rate
OED	Operations Evaluation Department (now IEG)
PPAR	Project Performance Assessment Report
PRSP	Poverty Reduction Strategy Paper
SAR	South Asia Region
TA	Technical assistance
UMIC	Upper middle-income country
WSS	Water supply and sanitation

ACKNOWLEDGEMENTS

This paper was prepared as background for the IEG evaluation of the World Bank's support for health, nutrition, and population (HNP). The authors would like to thank Martha Ainsworth for her invaluable guidance and contribution, Christoph Kurowski (peer reviewer), Arup Banerji, Monika Huppi, and Victoria Monchuk for their insightful feedback, Kavita Mathur for her very useful inputs, the HNP evaluation team for their feedback, and Marie-Jeanne Ndiaye for her excellent support in formatting and graphics. The findings, interpretations, and conclusions expressed in this paper are entirely those of the authors and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

SUMMARY

The first objective of the World Bank's 2007 Strategy, *Healthy Development,* is to improve the level and distribution of health, nutrition, and population (HNP) outcomes, particularly for "the poor and vulnerable." However, HNP outcomes are determined by many factors, not all of them actionable by the health sector. For example, better access to potable water and better hygienic practices can reduce morbidity from water-borne diseases, while greater female education and household income raise household investments in child health. Furthermore, HNP outcomes are also influenced by multiple actors. Household behaviors and actions are a critical component, along with government and donor policies. The multisectoral nature of HNP outcomes was acknowledged in the Bank's 1997 HNP Strategy; strengthening the Bank's capacity to advise client countries on an intersectoral approach to HNP is one of the 2007 Strategy's five "strategic directions". In both cases, the Bank's Country Assistance Strategies (CASs) have been seen as key vehicles for organizing multisectoral approaches to improved HNP outcomes, particularly among the poor.

This paper provides some preliminary understanding of the extent to which CASs approved over the past decade (1997-2006) have: (a) prioritized HNP outcomes as an objective, particularly among the poor; and (b) adopted multisectoral approaches to improving health outcomes – either in terms of multisectoral lending operations or coordinating lending from diverse sectors to bear on health outcomes. To this end, the paper reviewed a stratified random sample of 137 CASs approved from FY97-06 (65 percent of all CASs finalized in this period). As of May 2007, 19 of these CASs had been completed and had CAS Completion Reports (CASCRs) prepared by the Bank and reviewed by IEG. These CASCRs were reviewed to assess the extent to which HNP outcomes actually improved and planned multisectoral action actually occurred. This paper was prepared as a background study for IEG's evaluation of the World Bank's support for HNP.

While more than four of every five CASs cited HNP as a priority in general (often together with human development more broadly), only one in eight cited the HNP sector explicitly as a priority. Fewer than half of the CASs cited previous HNP analytic work as the basis for setting priorities. About three-quarters of CASs proposed new lending in the HNP sector, but this share has declined over the decade. Two-thirds specifically prioritized HNP *status* outcomes and three-quarters recognized the need to improve HNP status *of the poor*; however, only half articulated a definition of the poor, few specific targets were set, and strategies to reach the poor were not clearly identified.

There is a substantial discrepancy between theory and practice in terms of multisectoral approaches to HNP outcomes. Even though over three-quarters of CASs acknowledged the contribution of other sectors to HNP outcomes, only a little over half proposed incorporating parallel or multisectoral lending to improve HNP outcomes in any form in their country programs. Furthermore, almost none of these CASs mentioned any form of coordination of other sectors with the HNP sector. Most of the proposed multisectoral and parallel lending to improve HNP outcomes was proposed for Africa and amongst low-income countries. Almost all the multisectoral lending in Africa was HIV-related.

About a third of the completed CASs with multisectoral HNP lending strategies fully implemented them in the way originally envisaged, a third implemented them partially, and a third did not implement them at all. However, even in the cases where the proposed lending was undertaken, the health component of this lending was often omitted or the health impacts of the lending were not tracked.

These findings suggest three areas where CAS performance with respect to the pro-poor focus of HNP actions and multisectoral approaches can be improved:

- CASs need to be more specific in terms of how HNP outcomes among the poor will be addressed in implementation and how they will be measured and tracked – both in HNP and other sector operations aimed to improve HNP outcomes.
- Analytic work needs to be launched to understand better the contribution of other sectors to HNP outcomes and the value added of multisectoral approaches in different contexts.
- The institutional incentives in the Bank and countries that are inhibiting greater cross-sectoral collaboration, focus, and results on HNP outcomes need to be better understood.

1. Introduction

1.1 The first objective of the World Bank's 2007 Strategy, Healthy Development, is to improve the level and distribution of health, nutrition, and population (HNP) outcomes, particularly for "the poor and vulnerable" (World Bank 2007). This is consistent with the main objective of the previous HNP strategy, issued a decade earlier, to improve HNP outcomes among the poor. However, HNP outcomes are determined by many factors, not all of them actionable by the health sector (Table 1.1). For example, better access to potable water and better hygienic practices can reduce morbidity from water-borne diseases, while greater female education and household income raise household investments in child health. Furthermore, health outcomes are also influenced by multiple actors. Household behaviors and actions are a critical component, along with government and donor policies (Filmer 2003). The multisectoral nature of health outcomes was acknowledged in the 1997 Health Strategy and the Country Assistance Strategy (CAS) was proposed as the vehicle for coordinating the contributions of different sectors to HNP outcomes.1 The 1999 evaluation of the Bank's health, nutrition, and population (HNP) support by the Independent Evaluation Group (IEG) found that "Bank-supported programs have not placed adequate emphasis on… the intersectoral dimensions of health" and recommended that the Bank's Human Development Network and Regional Vice Presidents identify several key areas for improving intersectoral collaboration within the Bank (Johnston and Stout 1999, p. 31).[2] IEG's 2006 Annual Review of Development Effectiveness (ARDE) found evidence that cross-sectoral synergies are being under-utilized by Bank operations at the expense of obtaining stronger results.

1.2 However, there are institutional and other issues that make multisectoral action difficult. Obstacles to designing such interventions are present on both the donor and country fronts. They include factors such as the lack of sufficient incentives for operational staff and government ministries to exchange information and initiate collaborative efforts. For instance, budgetary allocations are usually made on the basis of sectoral and ministerial portfolios which often discourage staff from exploiting cross-sectoral linkages. The record of truly multisectoral operations (though not systematically evaluated) appears to be problematic. The 2006 ARDE found only 9 percent of Bank staff surveyed were satisfied with coordination across sectors in cases where multisectoral teams were created (IEG 2006, pp. 27-28).

1.3 Nevertheless, achieving the Millennium Development Goals (MDGs) in health will depend on seeking strategic complementarity of investments in different domains to improve HNP outcomes (Table 1.1). The greater need for intersectoral collaboration is explicitly recognized in the Bank's 2007 HNP strategy, and strengthening the Bank's capacity to advise client countries on an intersectoral approach to HNP results is one of the five "strategic

[1] According to the 1997 strategy, the CAS "provides an opportunity to highlight stubborn cross-sectoral issues and to establish critical links between the HNP sector and a country's poverty and fiscal agendas".(World Bank 1997, p.12).

[2] IEG/World Bank was formerly known as the Operations Evaluation Department (OED).

directions" to be launched. From the perspective of the Bank's operations, there are at least two distinct approaches:

a) multisectoral lending operations, in which inputs from different sectors are jointly implemented under a single management structure (or occasionally under a multiple management structure, but still in a single operation) for a specific objective; and

b) strategic use of complementary lending in different sectors to maximize impact on a common objective, like health outcomes.

1.4 The 2007 HNP strategy proposes a new analytical tool called the Multisectoral Constraints Assessment for Health Outcomes tool, to help country teams identify the investments and sector work most likely to result in improved health outcomes, especially among the poor, in the preparation of Country Assistance Strategies (World Bank 2007, Annex E). Such analysis might result in either multisectoral operations or strategically complementary sectoral lending. The specifics of this new analytic instrument have yet to be elaborated. To date, there has been no systematic review of the extent to which the Bank's CAS's over the past decade have already addressed HNP in a multisectoral way, and the lessons learned.

Table 1.1: Potential for Intersectoral Synergies to Achieve the Millennium Development Goals for Health and Nutrition

Millennium Development Goal	Target	Multisectoral Inputs	Country Examples	Key Sectors
Reduce maternal mortality	Improve access to emergency obstetric care	Availability of transport, roads, and referral facilities	Bangladesh, Tanzania, Vietnam	Transport, road infrastructure, health
	Reduce indoor air pollution	Improved cooking practices, fuel, and ventilation	China, Guatemala, India, Kenya	Energy, housing, health
Reduce Child mortality	Reduce diarrheal diseases in children through hand-washing, use of latrines, and proper disposal of young children's stools	Improved hand-washing practices, using soap and plenty of water	Costa Rica, El Salvador, Guatemala, Ghana, India, Nepal, Peru, Senegal	Wáter and sanitation, health, private sector (soap manufacturers)
	Reduce indoor air pollution	Improved fuel, ventilation, and childplay practices	China, Guatemala, India, Kenya, Mongolia, Nicaragua	Energy, housing, prívate health, private sector (improved stove production)
Reduce hunger and improve nutrition	Regulate food prices, raise women's income, and promote dietary diversity and food security at the household level	Improved agricultural practices, tariffs, and trade; reduced women's workload; better gender relations in intrahousehold decision-making	Bangladesh, India, Kenya, Tanzania, Vietnam	Agriculture, rural development, gender, trade

Source: World Bank 2004.

1.5 This study looks at the extent to which CASs prioritized HNP and specifically HNP status among the poor over the decade 1997-2006. The first part of the paper explores this question. Second, the study assesses the extent to which these CASs adopted multisectoral strategies to improve HNP outcomes – either in terms of multisectoral lending operations or coordinating lending from diverse sectors to bear on health outcomes. For CASs that have been completed, IEG CAS Completion Reports (CASCRs) are reviewed to assess the extent

to which health outcomes improved, especially among the poor, and the extent to which planned multisectoral action actually occurred.[3] This paper was background for the 2009 IEG evaluation of the World Bank's support for HNP.

1.6 The next section of the paper presents the methodology, review questions, and the sample of CASs and CASCRs reviewed. The subsequent two sections assess, respectively, whether HNP status was prioritized in the CASs and to what extent the CASs proposed multisectoral lending and non-lending activities. The penultimate section reviews the findings from CASCRs on the extent to which the multisectoral approaches proposed in the CASs were actually implemented, and the final section summarizes the findings.

2.1 This study relies on a desk review of a sample of Country Assistance Strategies approved between fiscal years (FY) 1997-2006.[4] Over this period, a total of 211 CASs were issued for 42 low-, 44 lower-middle and 24 upper-middle income countries, distributed regionally as in Table 2.1.[5]

Table 1.2: Distribution of Country Assistance Strategies issued in FY97-06, by Region and Year

Region	FY97-01	FY02-06	Total	Sample
Sub-Saharan Africa	29	26	55	31
Eastern Europe and Central Asia	31	29	60	29
East Asia & Pacific	12	11	23	23
Latin America and Caribbean	20	20	40	21
Middle-East and North Africa	9	10	19	19
South Asia	7	7	14	14
Total	108	103	211	137

Source: World Bank data.

2.2 In light of the large number of countries in three regions, namely Sub-Saharan Africa (AFR), Latin America and the Caribbean (LCR) and Eastern Europe and Central Asia (ECA), a review of all CASs was not possible given resource constraints, hence the study reviewed a stratified sample of CASs that includes: (a) all CASs for the regions with fewer countries namely, East Asia and the Pacific (EAP), the Middle East and North Africa (MNA) and South Asia (SAR); and (b) a random sample consisting of roughly half of all CASs for ECA, LCR and AFR. Tables presenting results by region are self-weighted; weighted results for the main variables for the whole sample, the two time periods, and by country income group are presented in Annex 2. Detailed tables by country income level and by region are in Annexes 3 and 4, respectively.

[3] This study does not assess the impact of these combined lending operations on health outcomes; this has been done in the context of field-based country case studies and Project Performance Assessment Reports (PPAR) in the course of the IEG evaluation of Bank support for HNP. Also, we do not presume that some sort of multisectoral action is necessarily warranted. Operations in other sectors may have health impacts, even if not implemented collaboratively and even without explicit HNP objectives.

[4] Fiscal year (FY) 1997 ran from July 1, 1996-June 30, 1997.

[5] A list of all of the CASs issued, by country and year, is in Annex 1.

2.3 The approved CASs were systematically reviewed to answer the following questions:

a) Is the HNP sector identified as a priority in the CAS?
   - Is improving HNP *status* a specific priority? Were targets set?
   - Does it prioritize HNP status or access *among the poor*? If so, how are the poor to be targeted? Are targets set?
   - What Bank-specific activities are proposed? (e.g., lending, analytic work)

b) Is the CAS discussion of HNP priorities informed by prior analytic work?

c) Does the CAS acknowledge the contribution of other sectors to HNP outcomes? If so, which other sectors? Does it acknowledge the contribution of HNP to outcomes in other sectors?

d) Does the CAS propose a multisectoral lending strategy to improve HNP outcomes (e.g., multisectoral lending, parallel lending by complementary sectors)?
   - If multisectoral lending, is it in the form of an investment loan or development policy lending (DPL)?
   - If parallel lending, which sectors are deemed most relevant to contributing to HNP outcomes?

e) In the event that the CAS does not adopt a multi-sectoral perspective on improving HNP outcomes, does it nevertheless propose activities in other sectors that are likely to have an impact on HNP outcomes?

2.4 As of May 2007, IEG had received and reviewed a total of 30 CAS Completion Reports (CASCR) since March 2003, when IEG formally launched the process. Nineteen of these completed and reviewed CASs were approved from FY97-06 and in the sample of approved CASs in Table 2.1. For completed CASs, the study consulted CASCRs to assess the extent to which HNP outcomes improved, especially among the poor, and the extent to which planned multi-sectoral activities occurred. As of May 21, 2007, only 19 CASs in our sample had been completed and had CASCRs available.

2.5 The findings of this paper are limited by the fact that they are based on a desk review of documents. As such, the paper aims only to investigate if the Bank implemented multisectoral approaches in HNP and whether it focused on the poor. It does not attempt to explain the reasons behind the findings. For a more contextual understanding of the paper's findings this research would need to be supplemented by interviews with task managers and Country Directors.

3. Findings

Is the HNP Sector Identified as a Priority in the CAS?

3.1 For the purposes of this review, the HNP sector was considered to have been flagged as a "priority" in the CAS if HNP issues were identified as a key component of the Bank's development strategy for a country. While some CASs are *explicit* in identifying the HNP sector as a priority sector (e.g., "five areas… were identified as subjects for special emphasis: health"[6]), others more generally point to a human development sector focus that *implicitly* includes health (e.g., "support to… those under-funded sectors critical to achieving [Millennium Development Goals]"[7]). In either case, this was usually exemplified by a substantive discussion of HNP status issues in the main text of the CAS – especially in the discussion of the CAS objectives and strategy.

3.2 **Most CAS explicitly or implicitly cited HNP as a priority sector.**[8] This was the case in more than four-fifths of CASs. The HNP sector was identified explicitly as a priority by only 13 percent of CASs but implicitly in another 69 percent (Table 3.1). There was no change in that share over the decade under review. Of those that did not prioritize the HNP sector, more than half nevertheless discussed HNP issues (but not health system issues, such as health sector finance or insurance reform).

Table 3.1: Prioritization of the HNP Sector by FY

Did the CAS mention HNP as a priority sector?	FY97-01 N = 76		FY02-06 N = 61		Total N = 137	
	No.	(%)	No.	(%)	No.	(%)
YES, o*f which:*	**62**	**(82)**	**50**	**(82)**	**112**	**(82)**
Explicit priority	9	(12)	9	(15)	18	(13)
Implicit priority	53	(70)	41	(67)	94	(69)
NO, *of which:*	**14**	**(18)**	**11**	**(18)**	**25**	**(18)**
HNP issues other than health status mentioned	6	(8)	8	(13)	14	(10)

Source: IEG CAS review.

3.3 **CASs in low-income countries (LICs) and Africa are more likely to cite HNP as a priority overall whether implicitly or explicitly, however HNP is most likely to be an explicit priority in upper-middle income countries and LCR** (Figure 3.1).[9] HNP was least likely to be cited as a priority, explicitly or implicitly, in MNA, and very unlikely to be explicitly cited in LMICs, ECA, and East Asia and Pacific.

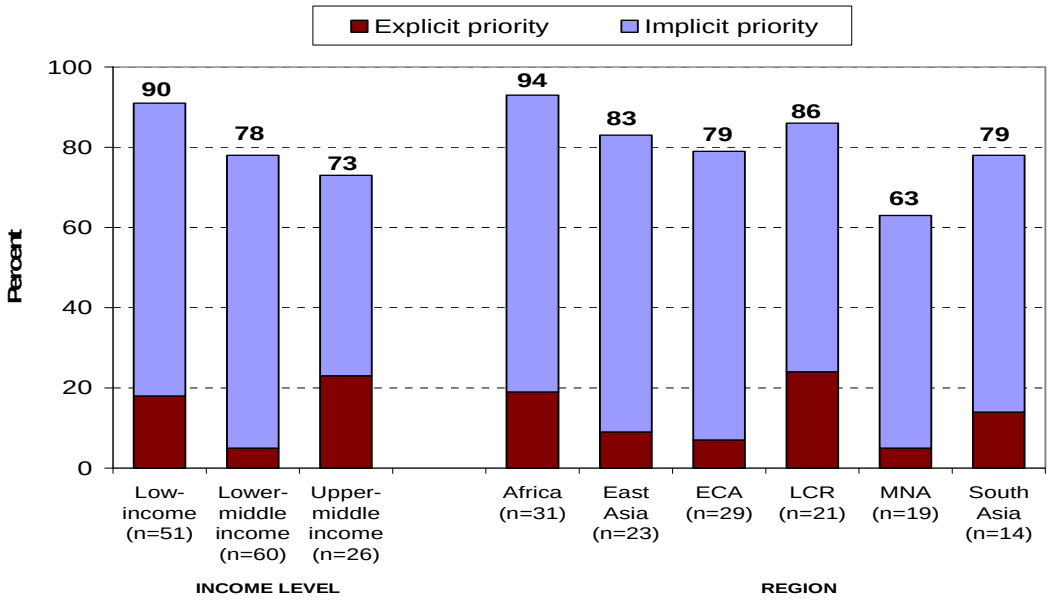
[6] Mexico CAS, April 2002.

[7] China CAS, January 2003.

[8] Any instance where the CAS specifically mentioned prioritizing HNP as one of the key pillars of its strategy was regarded as an "explicit" reference to HNP as a priority sector. Where the CAS did not mention HNP as a specific priority but prioritized human development or the expansion of coverage of basic social services, the CAS was regarded as implicitly prioritizing the HNP sector.

[9] See also Appendix C, Table C.1, and Appendix D, Table D.1.

Figure 3.1: Share of CASs that Prioritized HNP



Source: IEG CAS review.

FOCUS ON HNP STATUS

3.4 The review considered whether the CAS specifically identified HNP *status* (such as morbidity, mortality, fertility, nutritional status, prevalence or incidence of disease), as the objective, rather than other intermediate outcomes (such as vaccination rates, contraceptive use or access to health care), health sector outputs (such as number of nurses or facilities, new institutions), or inputs (such as health expenditures).

3.5 ***Most CASs prioritized improved HNP status***. HNP status was cited as the priority in two-thirds of the CASs overall (Table 3.2). Of those that did *not* prioritize HNP status, almost one-quarter nevertheless prioritized other intermediate HNP outcomes. The share of CASs that prioritized health status declined slightly over time. The most common HNP indicators cited were the infant mortality rate (IMR), maternal mortality rate (MMR), and HIV prevalence rate. Of the types of indicators cited, health indicators were most frequently cited, including mortality indicators (cited 85 times) and disease-specific indicators (cited 43 times); population indicators were cited least (cited 10 times). In addition, five of the six most commonly cited indicators are directly related to the Millennium Development Goals (MDGs), with four of those being cited more frequently over time.

Table 3.2: Prioritization of HNP Status, by FY

	FY97-01 N = 76		FY02-06 N = 61		Total N = 137	
Was HNP status prioritized?	**No.**	**%**	**No.**	**%**	**No.**	**%**
YES	**53**	**70**	**39**	**64**	**92**	**67**
Specific HNP indicators:						
Mortality						
-Infant mortality rate	22	29	12	20	34	25
--Maternal mortality rate	15	20	14	23	29	21
-Under-5 mortality rate	7	9	10	16	17	12
-Life expectancy	4	5	1	2	5	4
Disease-specific						
-HIV incidence or prevalence	9	12	14	23	23	17
-TB incidence or fatality rate	5	7	5	8	10	7
-STD incidence	1	1	2	3	3	2
-Malaria incidence	3	4	0	0	3	2
-"other" disease	1	1	3	5	4	3
Fertility						
-Total fertility rate	6	8	2	3	8	6
-Crude birth rate	0	0	1	2	1	1
-Population growth rate	1	1	0	0	1	1
Malnutrition						
-Child malnutrition	14	18	4	7	18	13
-Pregnant/nursing women or low birth weight	2	3	0	0	2	1
NO	**23**	**30**	**22**	**36**	**45**	**33**
Of which, intermediate HNP outcomes, HNP outputs or inputs were prioritized	4	5	6	10	10	7

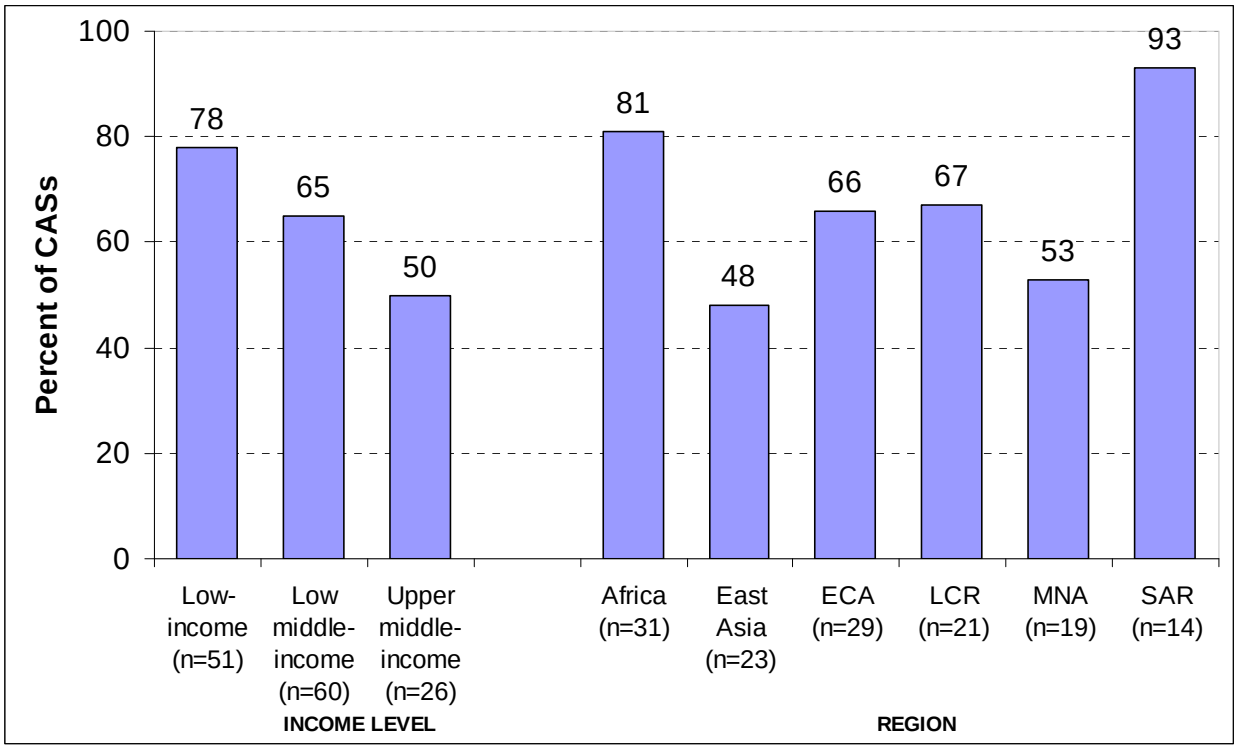
Source: IEG CAS review.

3.6 **HNP status was prioritized most often by CASs in low-income countries and in South Asia and Africa.** Seventy-eight percent of low-income country CASs prioritized HNP status as did 93 percent of South Asian and 81 percent of African CASs (Figure 3.2). Of the health indicators, Africa, Latin America and the Caribbean, and South Asia were most likely to cite the IMR and MMR, with Africa also most frequently citing life expectancy. South Asia and Africa were most likely to cite HIV incidence or prevalence, with Europe and Central Asia most likely to cite TB incidence. Of the population indicators, South Asia was most likely to cite the total fertility rate. Of the nutrition indicators, Latin America, South Asia and Africa were most likely to cite stunting and wasting. [10] Low-income countries were much more likely than countries in the other income groups to cite mortality indicators, as well as HIV incidence or prevalence, the total fertility rate, and child malnutrition.[11]

[10] See Appendix C, Table C.2.

[11] See Appendix D, Table D.2.

Figure 3.2: Prioritization of HNP Status, by Country Income Level and Region



Source: IEG CAS review.

FOCUS ON THE POOR

3.7 **The majority of CASs recognized the need to focus on HNP issues among the poor, particularly in low-income countries** (Table 3.3). Almost three-quarters of CASs overall specifically referred to health issues among the poor, a proportion that increased slightly (70 to 79 percent) over the two time periods. However, only half articulated a definition of the "poor" and less than a quarter cited a method to target the poor. The proportion of CASs that had a focus on the poor was highest among low-income countries (82 percent, Figure 3.3).[12] Regionally, East Asia and Pacific most often specified a focus among the poor (91 percent).[13]

[12] See Appendix C, Table C.3.

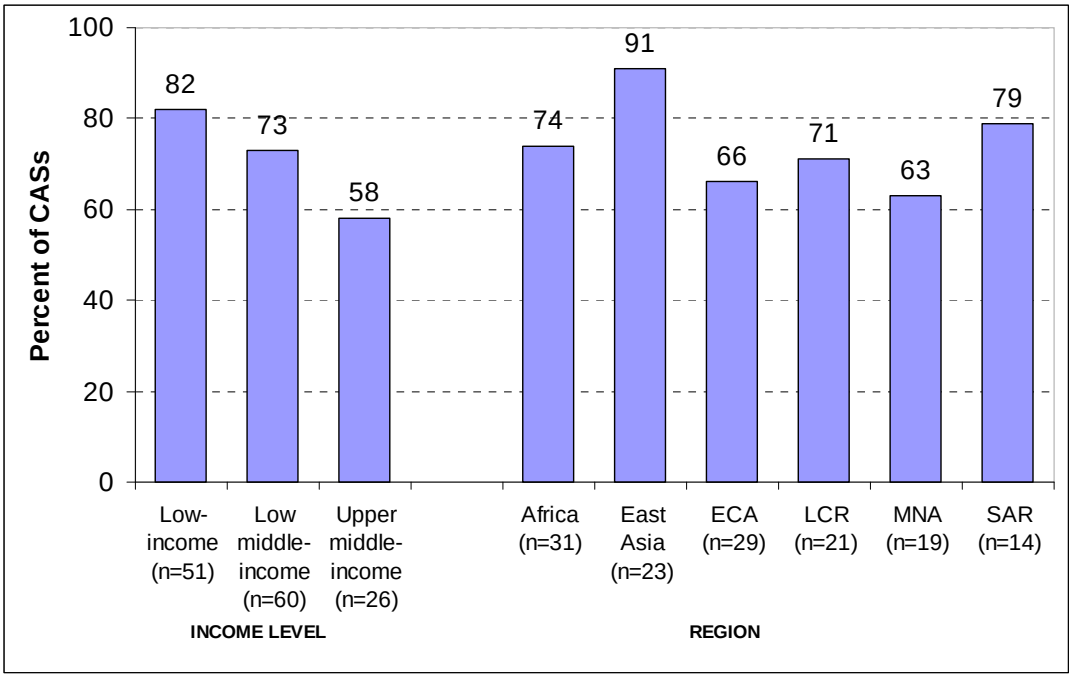
[13] See Appendix D, Table D.3.

Table 3.3: Focus on the Poor, by FY of Approval

	FY97-01 N = 76		FY02-06 N = 61		Total N = 137	
Was there a focus on health among the poor?	**No.**	**%**	**No.**	**%**	**No.**	**%**
YES	**53**	**70**	**48**	**79**	**101**	**74**
Of which, the poor were identified as:						
• Low income group	3	4	8	13	11	8
• Poor region	9	12	8	13	17	12
• Rural area	12	16	8	13	20	15
• Minority group	3	4	1	2	4	3
Of which, the poor were to be reached by:						
• Health subsidies, vouchers or cash transfers	2	3	5	8	7	5
• Increase in services used by the poor	2	3	3	5	5	4
• Reduction in insurance or user fees	2	3	2	3	4	3
• Increase in govt. budget allocation to poor areas	2	3	1	2	3	2
NO	**23**	**30**	**13**	**21**	**36**	**26**

Source: IEG CAS review.

Figure 3.3: Focus on the Poor by Country Income Level and Region



Source: IEG CAS review.

HNP OUTCOME TARGETS

3.8 The review also considered whether the CAS, in aiming to achieve HNP outcomes, set specific target values that were monitorable and attributable to the time period covered by the CAS, either in terms of average outcomes or outcomes specifically for the poor.

3.9 **Only about a third of CASs overall set specific targets for HNP outcomes, and this has not changed over time** (Table 3.4). In some cases, the CAS referred to Government or Poverty Reduction Strategy Paper (PRSP) targets instead of setting its own separate

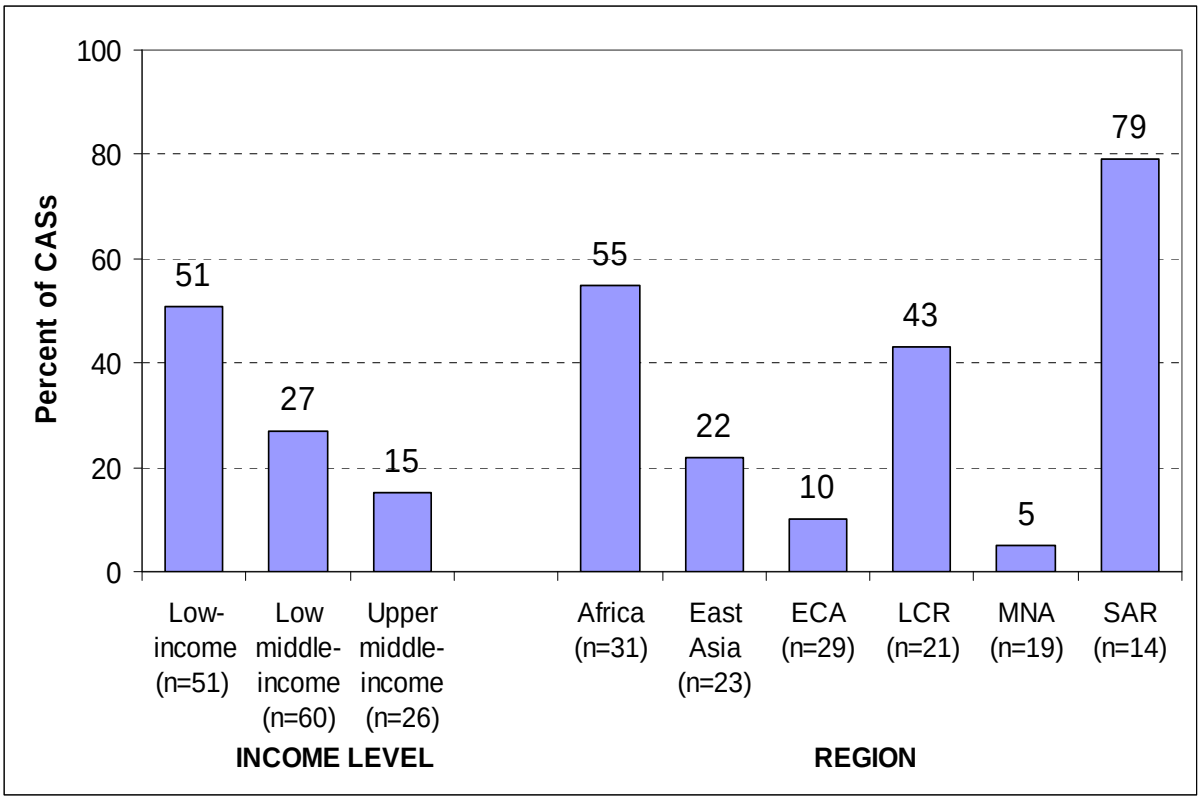
targets. In other cases, the CAS identified a specific HNP outcome to be monitored but did not cite an actual target figure to be achieved; rather, it only cited an upward or downward trend. Of those that prioritized HNP outcomes, slightly fewer than half (46 percent) set targets (not shown). South Asia, Africa, and low income countries had the highest share of CASs with specific HNP targets (more than half, Table 3.4).[14]

Table 3.4: Setting of HNP Status Targets, by FY of Approval

	FY97-01 N = 76		FY02-06 N = 61		Total N = 137	
Were targets set for HNP status?	**No.**	**%**	**No.**	**%**	**No.**	**%**
YES	**25**	**33**	**21**	**34**	**46**	**34**
Of which, only Govt. or PRSP target within CAS time frame was cited	2	3	7	11	9	7
PARTIAL - only trends (i.e. upward or downward) were cited	**5**	**7**	**4**	**7**	**9**	**7**
NO	**46**	**61**	**36**	**59**	**82**	**60**
Of which targets were to be determined upon further analysis or collaboration with government/partners	3	4	1	2	4	3

Source: IEG CAS review.

Figure 3.4: Setting of HNP Status Targets, by Country Income and Region



Source: IEG CAS review.

[14] See Appendix C, Table C.5, and Appendix D, Table D.5.

3.10 **Although the majority of CASs recognize the need to focus on HNP issues among the poor, only a few CASs set specific targets for HNP access or health status of the poor.** In fact**,** only 15 percent of CASs did this. For those that emphasized HNP issues for the poor, fewer than a quarter (22 percent) set targets specifically for the poor (not shown). However, the share of CASs that set HNP status or access targets for the poor nearly doubled (11 percent to 21 percent) over time, albeit from a low starting point. There were no differences in the propensity to set outcome or access targets for the poor by country income

3.11 About one in four CASs in Africa and LCR set HNP outcome or access targets for the poor, while this was much less likely in other regions.[15]

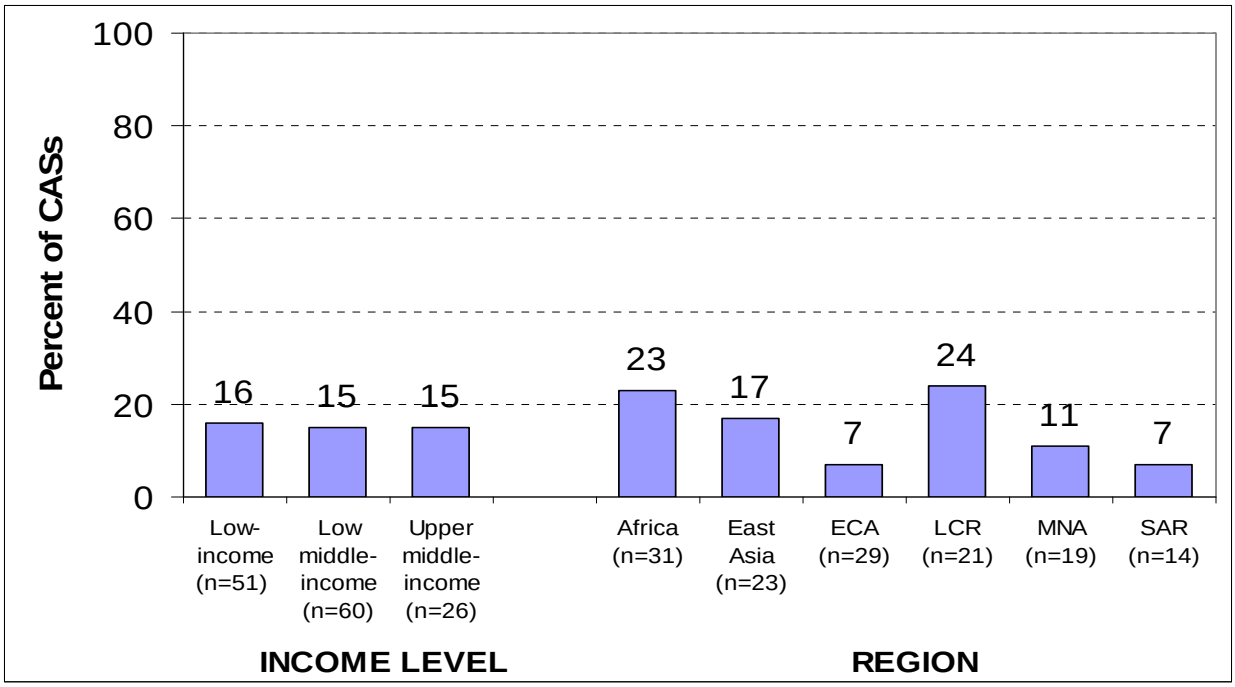
Table 3.5: Setting of HNP Targets for the Poor, by FY of Approval

Were HNP outcome or access targets set for the poor?	FY97-01 N = 76		FY02-06 N = 61		Total N = 137	
	No.	**%**	**No.**	**%**	**No.**	**%**
YES	**8**	**11**	**13**	**21**	**21**	**15**
Specific HNP status indicators:						
• Child malnutrition	2	3	1	2	3	2
• Pregnant/nursing female malnutrition	1	1	0	0	1	1
• HIV incidence or prevalence	0	0	1	2	1	1
Sub-total	3	4	2	3	5	4
Specific access indicators:						
• Availability/ coverage of services	4	5	5	8	9	7
• Household exp. on health	1	1	3	5	4	3
• Insurance coverage	1	1	3	5	4	3
• Utilization rate	0	0	4	7	4	3
• Vaccination rate	0	0	2	3	2	1
• Govt. budget alloc.	0	0	2	3	2	1
• Index rating for inequality	1	1	0	0	1	1
Sub-total	**7**	**9**	**19**	**31**	**26**	**19**
PARTIAL - only trends (upward or downward) were cited	**7**	**9**	**8**	**13**	**15**	**11**
NO	**61**	**80**	**40**	**66**	**101**	**74**
Of which targets were to be determined upon further analysis or collaboration with government/partners	2	3	1	2	3	2

Source: IEG CAS review.

[15] See Appendix C, Table C.6, and Appendix D, Table D.6.

Figure 3.5: Setting of HNP Targets for the Poor, by Country Income and Region



Source: IEG CAS review.

Is the CAS Discussion of HNP Priorities Informed by Prior Analytic Work?

3.12 **Fewer than half of CASs overall referred to prior analytic work regarding HNP issues in the discussion of HNP priorities** (Table 3.6). Among those that cited past analytic work, most cited specific pieces, while others referred more generally to "recent analytic work".[16] The proportion of CASs that refer to prior analytic work remained basically unchanged over time.

Table 3.6: Prior Analytic Work, by FY of Approval

Was there prior analytic work?	FY97-01 N = 76		FY02-06 N = 61		Total N =1 37	
	No.	%	No.	%	No.	%
YES	**32**	**42**	**28**	**46**	**60**	**44**
Of which specific work is cited	30	39	22	36	52	38
NO	**44**	**58**	**33**	**54**	**77**	**56**

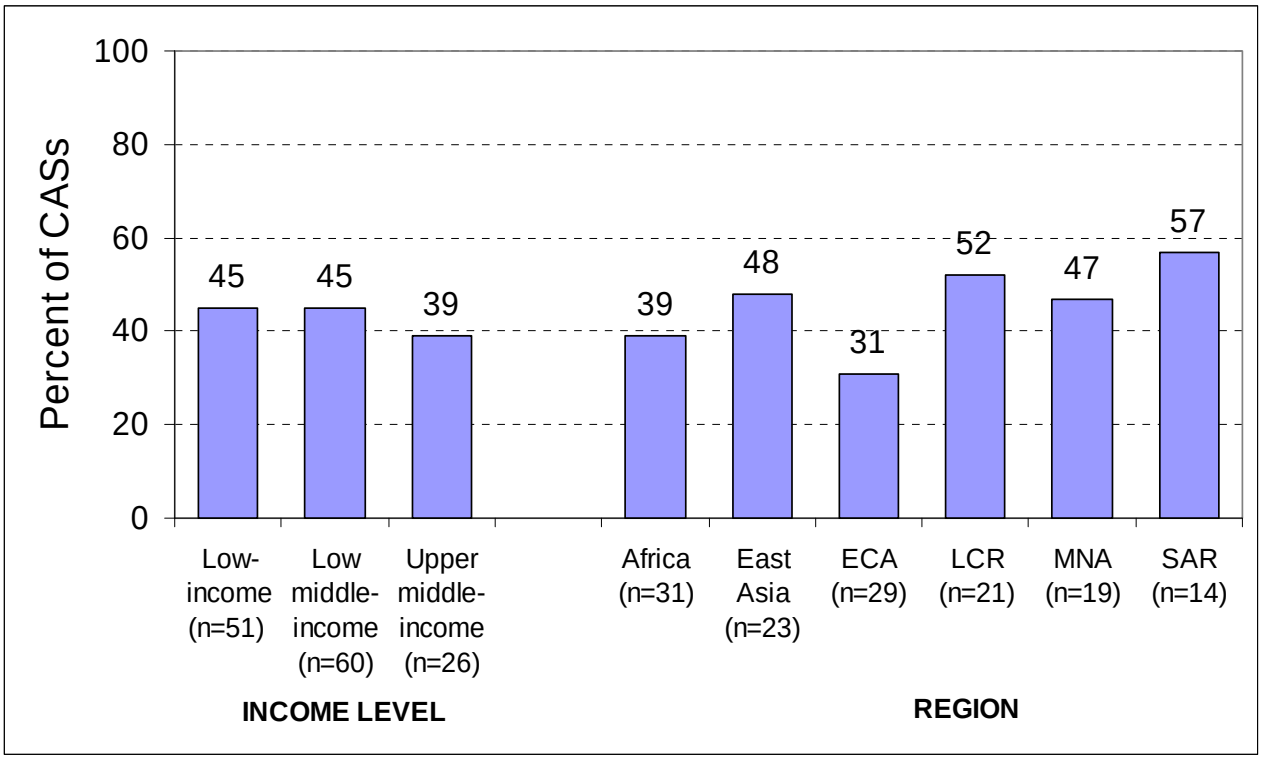
Source: IEG CAS review.

3.13 **Regionally, Latin America and Caribbean and South Asia most often cited prior analytic work.** Fifty-two percent of Latin American and Caribbean and 57 percent of South Asian CASs cited this (Figure 3.6). In contrast, CASs for AFR and ECA countries mentioned prior HNP analytic work only a third of the time. This is of particular concern, since the

[16]Pakistan CAS, April 2006.

Africa region was among those most likely to cite HNP status as a priority. Low-income and lower middle-income countries were slightly more likely to cite prior analytic work than were upper middle-income countries.

Figure 3.6: Prior Analytic Work, by Country Income and Region



Source: IEG CAS review.

Proposed Bank HNP Activities

3.14 **About three-quarters of CASs proposed new HNP lending activities, although this decreased between the first half of the evaluation period to the second** (Table 3.7). Of those that did not propose new HNP lending, over half already had ongoing HNP lending. More than half (57 percent) of CASs overall proposed new analytic work. The proportion of CASs that proposed new HNP lending decreased over time (79 percent to 67 percent), though the share that already had ongoing health lending increased slightly.

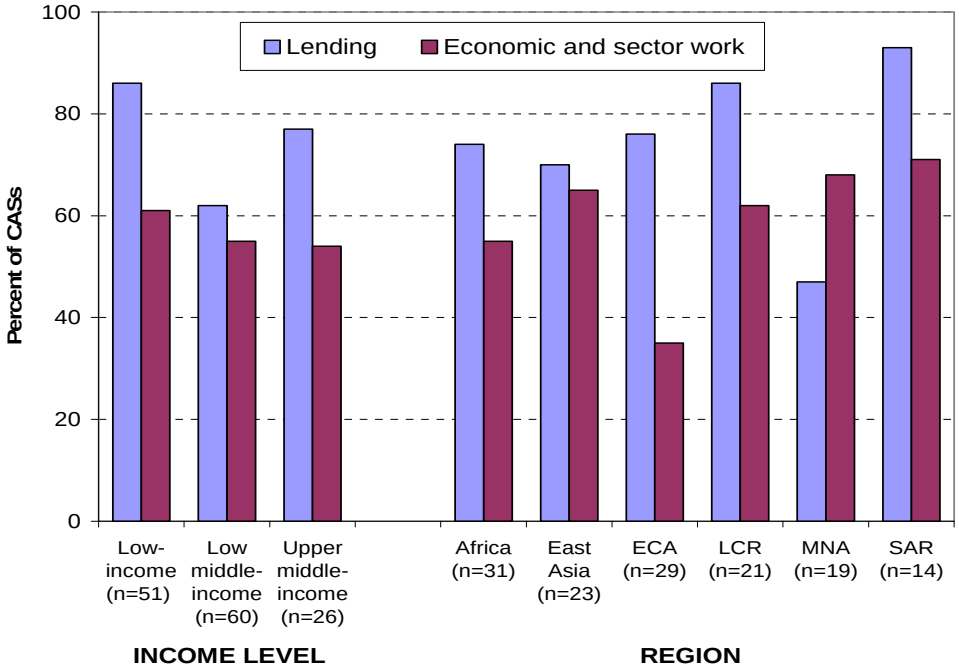
Table 3.7: Proposed HNP Activities, by FY of Approval

What Bank HNP activities were proposed?	FY97-01 N = 76		FY02-06 N = 61		Total N = 137	
	No.	%	No.	%	No.	%
LENDING	**60**	**79**	**41**	**67**	**101**	**74**
In addition to which, no new planned HNP lending, but HNP lending ongoing	8	11	10	16	19	14
ANALYTIC WORK	**40**	**53**	**36**	**59**	**78**	**57**

Source: IEG CAS review.

3.15 **The proportion of CASs that proposed new HNP lending was highest among low-income countries, South Asia and LCR** (Figure 3.7). UMICs, which had the lowest proportion of ongoing lending (4 percent), had the second highest proportion of new lending (77 percent).[17] More than half of CASs in all regions except ECA proposed new HNP analytic work.

Figure 3.7: Proposed HNP Lending and Analytic Work, by Country Income and Region



Source: IEG CAS review.

3.16 **Among the CASs that prioritized the HNP sector, most proposed future analytic work.** Nearly three-quarters of CASs (71 percent) proposed this (Table 3.8). In almost half of the CASs where future HNP analytic work was proposed, the CAS also cited previous analytic work on HNP. About one in five CASs that prioritized the HNP sector neither cited prior nor proposed future analytic work.

Table 3.8: Prior vs. Proposed Analytic Work, if Prioritized HNP Sector (N = 112)

Prior analytic work	Future analytic work					
	Proposed		Did not propose		Total	
	No.	%	No.	%	No.	%
Cited	39	35	12	11	51	46
Did not cite	40	36	21	19	61	54
Total	79	71	33	30	112	100

Source: IEG CAS review.

[17] See Appendix C, Table C.7.

Multisectoral Approaches to Improving HNP Outcomes

DOES THE CAS ACKNOWLEDGE THE CONTRIBUTION OF OTHER SECTORS TO HNP OUTCOMES?

3.17 **Most CASs acknowledged the contribution of other sectors to HNP outcomes, and this share was stable over the 10-year period,** More than three-quarters of CASs acknowledged this (Table 3.9). Water supply and sanitation (WSS) was the sector most often regarded as having an impact on HNP outcomes (half of the CASs referred to this), followed by education (22 percent) and the environment (20 percent). There were no discernable trends in the prominence of the sectors mentioned between the first and second half of the period.

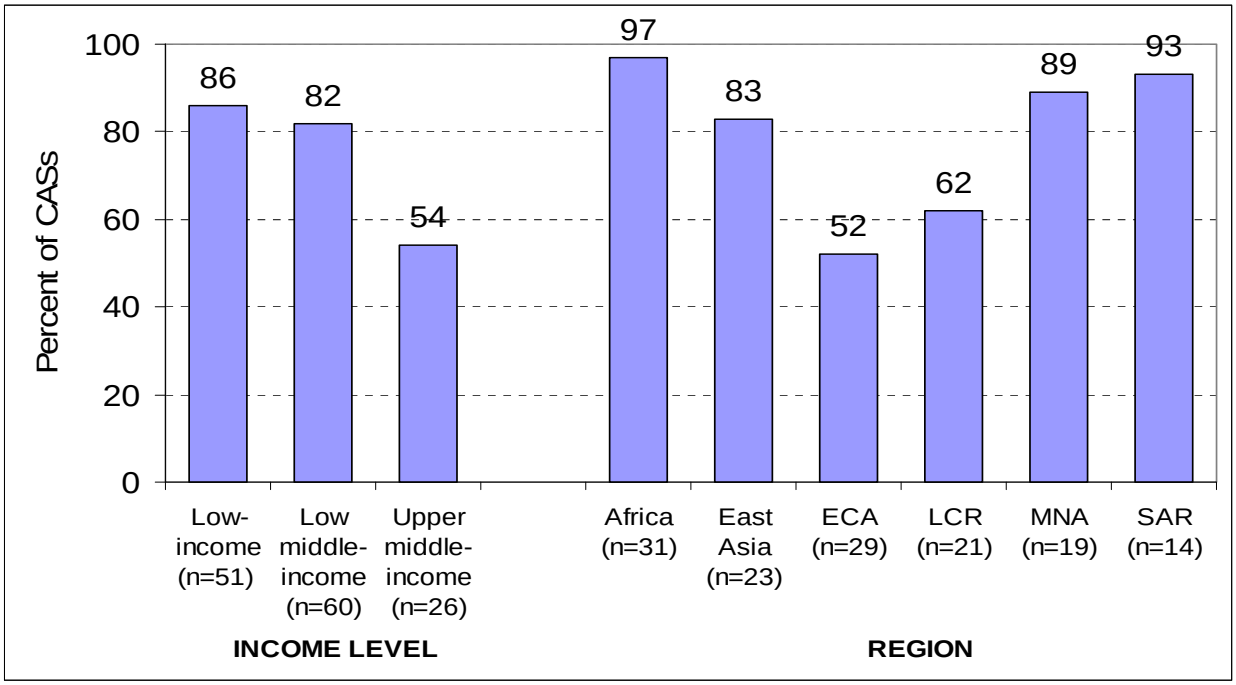
Table 3.9: Trend in CAS Acknowledgement of Other Sectors' Aontributions to HNP Outcomes, by FY of Approval

Does the CAS acknowledge the contribution of other sectors to HNP outcomes?	FY97-01 (N =7 6)		FY02-06 (N = 61)		Total (N = 137)	
	No.	%	No.	%	No.	%
YES	**60**	**79**	**47**	**77**	**107**	**78**
Of which, sectors mentioned were:						
Water Supply and Sanitation	37	49	31	51	68	50
Education	18	24	12	20	30	22
Environment	14	18	14	23	28	20
Transport/Infrastructure	14	18	9	15	23	17
Energy	4	5	4	7	8	6
Public Sector Reform	4	5	4	7	8	6
Social Security	1	1	4	7	5	4
Agriculture	2	3	1	2	3	2
Indigenous/Rural Development	2	3	1	2	3	2
Labor	1	1	1	2	2	1
Microfinance	1	1	0	0	1	1
Defense	0	0	1	2	1	1
Urban Development	1	1	1	2	2	1
NO	**16**	**21**	**14**	**23**	**30**	**22**

Source: IEG CAS review.

3.18 **Only about half of upper middle-income country strategies acknowledged multisectoral linkages to HNP outcomes, compared to more than 8 out of 10 CASs in low- and lower-middle income countries** (Figure 3.8). The importance of water and sanitation on HNP outcomes was acknowledged in nearly three-quarters of low-income country CASs, compared with fewer than half of the CASs for LMICs and UMICs. Most of the CASs in four out of six regions acknowledged the impact of other sectors on HNP outcomes. More than 80 per cent of CASs from countries in Africa, South Asia, Middle East and North Africa and East Asia acknowledged the impact of other sectors on HNP outcomes, compared with Latin America (62 percent) and Eastern Europe and Central Asia (52 percent, Figure 3.8). WSS was the sector most frequently cited as contributing to HNP outcomes in all regions, particularly in Africa and South Asia (71 percent).

Figure 3.8: CAS Acknowledgement of Other Sectors' Contributions to HNP Outcomes



Source: IEG CAS review.

DOES THE CAS ACKNOWLEDGE THE CONTRIBUTION OF HNP TO OUTCOMES IN OTHER SECTORS?

3.19 **Very few CASs acknowledged the impact of HNP outcomes on other sectors**. Fewer than a fifth of CASs acknowledged this (Table 3.10), substantially fewer than those that acknowledged causality in the other direction (78 percent). Similarly, there was little discernable difference in this proportion over time. Of the sectors, the environment -- specifically the impact of population growth on natural resources -- was the most commonly acknowledged linkage (5 percent).[18] All of the CASs concerned with this population impact were in low-income countries and almost all were in Africa (Figure 3.9). Only five percent of CASs acknowledged the impact of HNP status on poverty reduction. The HNP impacts acknowledged were in the form of increased cognitive capacity and therefore better educational outcomes and overall productivity gains.

[18]CASs that cited the impact of HNP outcomes on the environment were: Ethiopia (FY03), Mali (FY04), Niger (FY98), Rwanda (FY03), Senegal (FY98), Cambodia (FY05), Maldives (FY01).

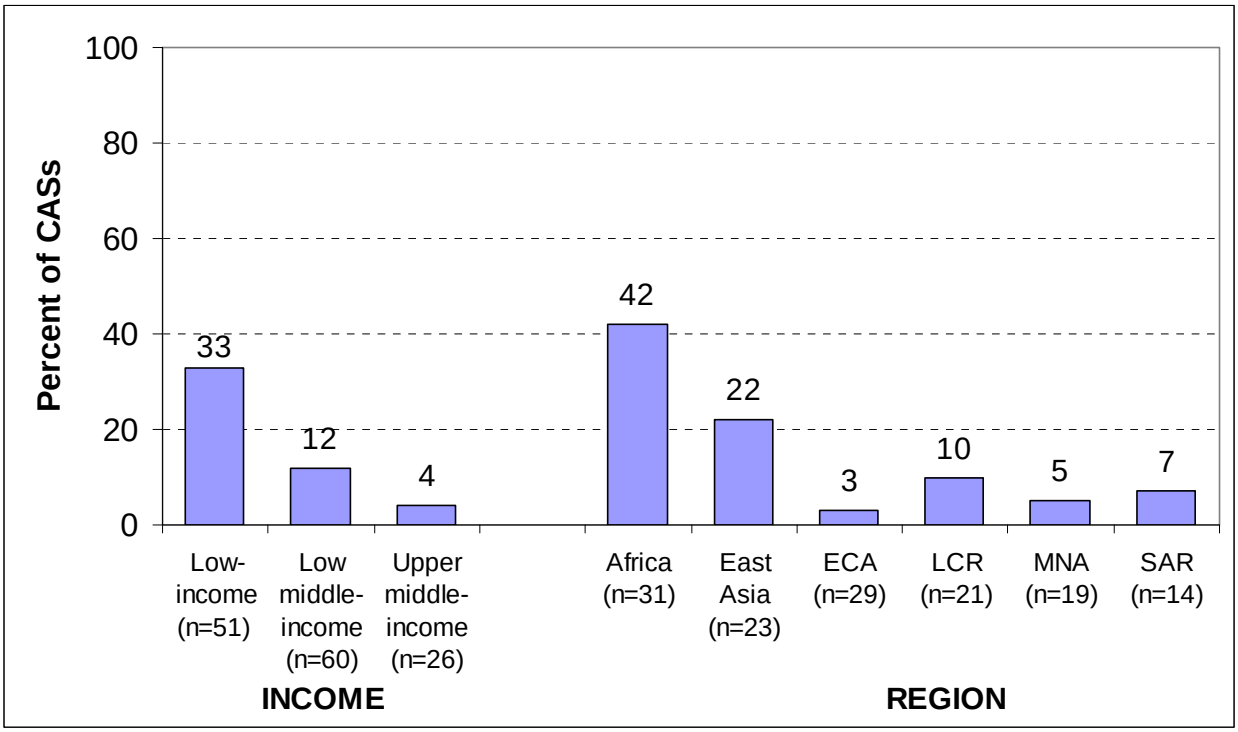
Table 3.10: Trend in CAS Acknowledgment of Contribution of HNP Outcomes to Other Development Objectives, by FY of Approval

Does the CAS acknowledge the contribution of HNP outcomes to other development objectives?	FY97-01 N = 76		FY02-06 N = 61		Total N = 137	
	No.	%	No.	%	No.	%
Yes	**12**	**16**	**13**	**21**	**25**	**18**
Of which, sectors mentioned were:						
Environment	3	4	4	7	7	5
Poverty Reduction	3	4	4	7	7	5
Education	3	4	3	5	6	4
Public Sector Reform	0	0	1	2	1	1
Agriculture	1	1	0	0	1	1
Labor	1	1	1	2	2	1
Transport/Infrastructure	1	1	0	0	1	0
No	**64**	**84**	**48**	**79**	**112**	**82**

Source: IEG CAS review.

3.20 **CASs in Africa and low-income countries were most likely to point to linkages - between HNP outcomes and other development objectives** (Figure 3.9). Low-income countries had a slightly higher share of CASs that acknowledged HNP impacts (33 percent) relative to 12 percent for LMICs and 4 percent for UMICs. Regionally, Africa still had the highest proportion of CASs that acknowledged the impact of HNP outcomes on other development objectives (42 percent), followed by East Asia (22 percent).

Figure 3.9: CAS Acknowledgement of the Contribution of HNP Outcomes to Other Development Objectives, by Country Income and Region



Source: IEG CAS review.

DOES THE CAS PROPOSE A MULTISECTORAL LENDING STRATEGY TO IMPROVE HNP OUTCOMES?

3.21 The CASs proposed to ensure that investments in other sectors are brought to bear on improving health status through two main strategies: (a) multisectoral lending operations, defined as any single operation with the objective of improving HNP outcomes that financed more than one sector; or (b) "parallel lending", in which non-HNP sectoral lending operations are explicitly brought to bear on health outcomes, including instances in which some formal collaboration may be implied with the HNP sector but lending is channeled through the non-HNP sector. Examples of operations labeled parallel lending for the purposes of the review include mention in the CAS that "the Bank is modifying the design of its water and sanitation projects to help maximize health benefits" (India, FY2001), that it intended to address nutrition issues through interventions linked with education (India FY98) or that public sector reform projects were proposed to support institutional reforms in revenue and expenditure management and improve the poverty impact of selected public programs including health (Thailand FY98). In both categories "multisectoral approaches" was interpreted liberally and included a broad spectrum of proposed actions ranging from CASs in which health components explicitly included lending in non-HNP sectors to those in which CASs simply mentioned the health benefits of lending in these sectors.

3.22 **Fewer CASs proposed multisectoral lending strategies than acknowledged multisectoral linkages**. While 82 percent of CASs prioritized HNP and 78 percent acknowledged the contribution of other sectors to HNP outcomes, only 53 percent incorporated multisectoral lending strategies, either in terms of parallel or multisectoral lending (Table 3.11). The most common strategy for including the contribution of interventions in other sectors to HNP outcomes was through parallel lending (45 percent) with multisectoral lending proposed by 17 percent of the CASs. Most CASs did not specify the type of lending instrument for multisectoral operations; only one CAS specified that it was in the form of development policy lending (DPL), 8 percent specified it was in the form of investment lending. Even fewer CASs proposed multisectoral analytic and advisory services on HNP, although those that did were far more explicit in the cross-sectoral linkages.

Table 3.11: Multisectoral Lending Atrategies for HNP Outcomes, by FY of Approval

Did the CAS propose a multisectoral lending strategy for HNP outcomes?	FY97-01 N = 76		FY02-06 N = 61		Total N = 137	
	No.	%	No.	%	No.	%
Any multisectoral lending strategy,	**38**	**50**	**35**	**57**	**73**	**53**
Of which:						
Parallel lending only	28	37	22	36	50	36
Multisectoral lending only	3	4	8	13	11	8
Both (MS plus PL)	7	9	5	8	12	9
MS lending that was HIV-related	3	4	11	18	14	10
No multisectoral lending strategy,	**38**	**50**	**26**	**43**	**64**	**47**
Of which:						
Multisectoral contribution acknowledged but no action proposed	18	24	15	25	33	24
No multisectoral contribution acknowledged	20	26	11	18	31	23

Source: IEG CAS review.

3.23 **The share of CASs proposing multisectoral strategies to achieve HNP outcomes has increased slightly over time.** Most of this increase is due to an increase in multisectoral lending operations from 13 percent in the first half of the review period to 17 percent in the latter half, almost all of which is related to HIV/AIDS. The share of multisectoral lending operations that were for HIV/AIDS overall was 61 percent, rising from 30 percent of multisectoral HNP operations in the first period to 85 percent in the second period.

3.24 **Few CASs proposed multisectoral analytic work on HNP, but multisectoral linkages were more explicit than for lending strategies.** The review recorded instances of Analytic and Advisory work (AAA - both economic and sector work and technical assistance) if the CAS explicitly referred to how it was going to address health issues in the context of other sectors.[19] Although only 5 percent of CASs proposed AAA that qualified as multisectoral in nature, those that did explicitly discussed how they would incorporate HNP issues within the scope of their work. Only CASs in the LAC and EAP regions had no multisectoral AAA incorporating HNP issues in their proposed strategies. The other regions had two multisectoral AAA products planned, except for ECA which had one multisectoral AAA planned within the review period. UMICs only had one AAA product planned whereas LICs and LMICs had three multisectoral AAA products planned. The studies planned in the review period included a study on the impact of education and training on HIV/AIDS, a water strategy paper (with a focus on health outcomes), a rural development strategy paper (also with a focus on health issues), a study on the environment (incorporating consideration of environmental health issues), a cross-sectoral human development review, a study on the health impacts of rural water supply and one on urban and indoor air quality.

3.25 **Across income levels, multisectoral strategies were incorporated in the CASs for more than two-thirds of LICs, compared with only about half in LMICs and about a quarter in UMICs** (Figure 3.10). All of the strictly multisectoral lending in LICs was related to HIV/AIDS (24 percent).[20] Of the 23 CASs that proposed multisectoral HNP lending, over half (52 percent) were in LICs. Parallel lending was most common in countries at all three income levels; multisectoral lending was not part of the strategy for improving HNP outcomes in any of the UMICs (Figure 3.11).

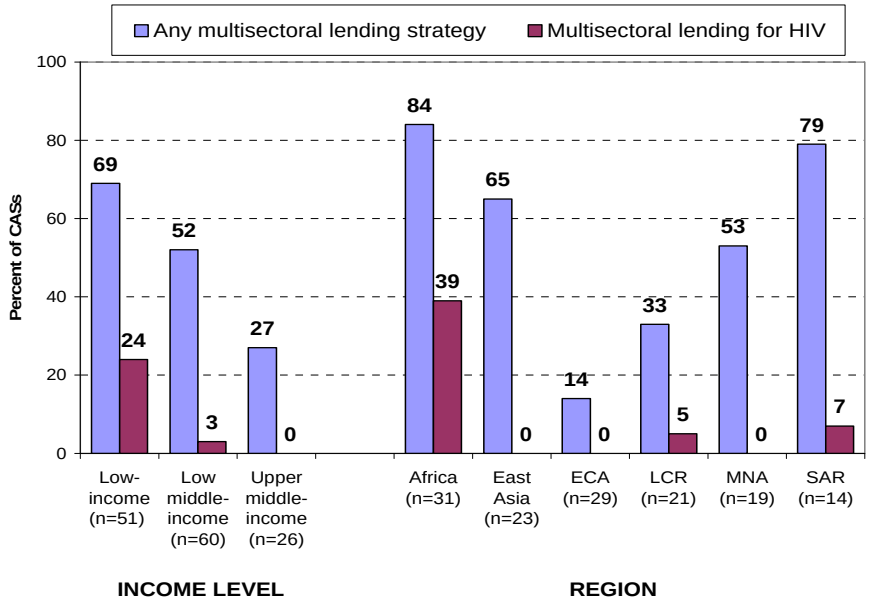
3.26 **Africa had the highest proportion of CASs that incorporated multisectoral strategies due to a higher percentage of HIV/AIDS-related multisectoral lending.** 84 percent of African CASs incorporated multisectoral lending strategies of which 39 percent of African CASs had HIV/AIDS-related multisectoral lending (Figure 3.10). Africa was the region most likely to incorporate multisectoral lending, either alone or in combination with parallel lending (Figure 3.12). In fact, *CASs in the other regions almost exclusively embraced multisectoral strategies of parallel lending: only SAR and LAC had any proposed*

[19] The authors acknowledge that this does not cover all AAA work in the evaluation period that may have met this criteria but only captures those clearly referred to in the CAS as connecting HNP issues with other sectors.

[20] Even though early childhood development (ECD) projects are generally implemented through the health sector as multisectoral projects, several CASs, such as Egypt FY2005 mentioned that they were going to be administered through the education sector. Consequently this review tabulated ECD projects as parallel lending not multisectoral lending.

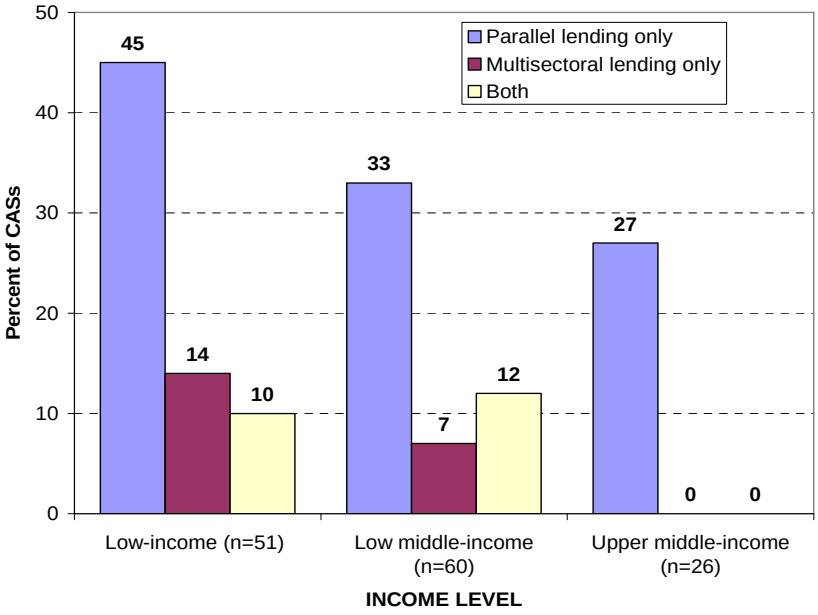
multisectoral lending. Three-quarters of the CASs in South Asia and about two-thirds in EAP proposed parallel lending to improve HNP outcomes.

Figure 3.10: Percent of CASs with Multisectoral Lending Strategies, Total and HIV-Related, by Country Income and Region



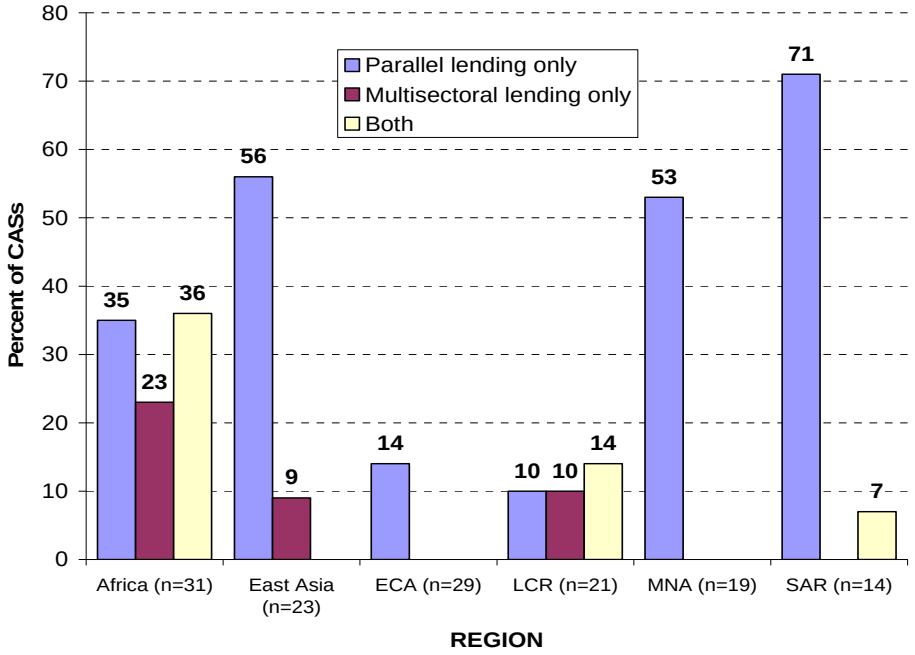
Source: IEG CAS review.

Figure 3.11: Percent of CASs with Multisectoral Lending Strategies, by Type of Multisectoral Strategy and Country Income



Source: IEG CAS review.

Figure 3.12: Percent of CASs with Multisectoral Lending Strategies, by Type of Multisectoral Strategy and Country Income



Source: IEG CAS review.

3.27 **Most parallel lending was concentrated in the water supply and sanitation sector, followed by transport or infrastructure** (Table 3.12). LICs and LMICs had a higher proportion of parallel lending than UMICs (Table 3.13). The former accounted for almost all of the parallel lending in the WSS sector to improve HNP outcomes, while UMICs were the most likely to cite public sector reform as part of such a strategy. None of the LICs had any parallel lending in public sector reform that made a reference to improvements in the HNP sector. East Asian, South Asian and African countries had a slightly higher percentage of parallel lending concentrated in the WSS sector than countries in the other regions (Table 3.14).

Table 3.12: Trends in Non-HNP Sectors Selected for Parallel Lending, by FY of Approval

Sector	FY97-01 N = 76		FY02-06 N = 61		Total N = 137	
	No.	%	No.	%	No.	%
Water and Sanitation	17	22	18	30	35	26
Transport/Infrastructure	2	3	6	10	8	6
Environment	4	5	3	5	7	5
Public Sector Reform	4	5	1	2	5	4
Education	2	3	3	5	5	4
Energy	2	3	1	2	3	2

Source: IEG CAS review.

Table 3.13: Non-HNP Sectors Selected for Parallel Lending, by Income

Sector	LIC N = 51		LMIC N = 60		UMIC N = 26	
	No.	%	No.	%	No.	%
Water and Sanitation	18	35	15	25	2	7
Transport/Infrastructure	4	8	4	7	0	0
Public Sector Reform	0	0	2	3	3	12
Environment	3	6	4	7	0	0
Energy	1	2	2	3	0	0
Education	3	6	2	3	0	0

Source: IEG CAS review.

Table 3.14: Non-HNP Sectors Selected for Parallel Lending, by Region

Sector	ECA N =2 9		EAP N = 23		SAR N = 14		LAC N = 21		MNA N = 19		AFR N = 31	
	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)	No.	(%)
Water and Sanitation	2	(7)	10	(43)	5	(36)	1	(5)	5	(26)	12	(39)
Transport/Infrastructure	2	(7)	3	(13)	3	(21)	0	(0)	0	(0)	0	(0)
Public Sector Reform	2	(7)	1	(4)	0	(0)	2	(10)	0	(0)	0	(0)
Environment	0	(0)	1	(4)	1	(7)	2	(10)	2	(11)	1	(3)
Energy	2	(7)	1	(4)	0	(0)	0	(0)	0	(0)	0	(0)
Education	0	(0)	0	(0)	2	(14)	0	(0)	3	(16)	0	(0)

Source: IEG CAS review.

FEATURES OF PARALLEL LENDING FOR HNP

3.28 In cases where the CASs incorporated parallel lending, the review considered whether or not the parallel lending entailed some form of common targeting or common management (i.e., consultations and/or implementation arrangements made coordinated with counterparts in the HNP sector).

3.29 **Most of the CASs with parallel lending did not specify or envisage any form of coordination with the HNP sector.** In almost all of the CASs that incorporated parallel lending (91 percent of the 62 CASs that had parallel lending) there was no indication that specific HNP targets would be incorporated or that coordination with the HNP sector would take place in implementing the parallel lending (Table 3.15).

3.30 **Lower middle-income countries had more instances of linkages between sectors in parallel lending operations than low- or upper middle-income countries** (Table 3.16). Only three regions had some linkages between parallel operations (not tabulated). Only Africa, East Asia and Pacific and South Asia regions had one example each of common targeting. These involved including reduction in child mortality and improvement in maternal health as a target for a WSS project (Ghana FY04), including "increased number of trips to health clinics" (inter alia) as a progress indicator for a transport project (Laos FY99), including the percentage of primary health care centers repaired in under-served areas as an indicator for infrastructure projects (Sri Lanka FY03). Of these regions, only the East Asia and Pacific region had any cases of common management of parallel operations in two CASs namely Thailand FY98 and Philippines FY02.

Table 3.15: Trends in Parallel Lending, by FY of Approval

If parallel lending was there any linkage between parallel operations	FY97-01 N = 76		FY02-06 N = 61		Total N = 137	
	No.	%	No	%	No	%
CASs with parallel lending for HNP outcomes	**29**	**38**	**33**	**54**	**62**	**45**
Yes – common targeting	1	1	2	3	3	2
Yes – common management	1	1	1	2	2	1
No /not specified in CAS	**27**	**36**	**30**	**49**	**57**	**42**

Source: IEG CAS review.

Table 3.16: Aspects of Parallel Lending, by Income

If parallel lending, was there any linkage between parallel operations	LIC N = 51		LMIC N = 60		UMIC N = 26	
	No.	%	No.	%	No.	%
CASs with parallel lending for HNP outcomes	**28**	**55**	**27**	**45**	**7**	**27**
Yes – common targeting	1	2	3	5	0	0
Yes – common management	0	0	2	3	0	0
No /not specified in CAS	**27**	**53**	**22**	**37**	**7**	**27**

Source: IEG CAS review.

CAS Implementation: HNP Outcomes and Multisectoral Approaches

3.31 In order to gauge to what extent CASs adhered to their proposed approach to HNP outcomes and multisectoral lending, we also reviewed CAS Completion Reports (CASCRs).[21] There were 19 CASCRs that corresponded with the CASs reviewed in our sample. Of these, eight were in AFR, four in SAR, two each in MNA and ECA and none in LAC.

HEALTH OUTCOMES

3.32 **HNP outcomes improved in three quarters of the completed CASs, while in a quarter HNP outcomes either deteriorated or remained unchanged.** (Table 3.17). Of the outcomes that improved, the majority of CASCRs reported improvements in infant or child mortality (58 percent), followed by maternal mortality (26 percent). Only five percent reported any improvements in nutritional outcomes and none reported improvements in population outcomes. The only CAS of the 19 CASs that had not proposed implementing a multisectoral approach (Turkey FY04) also reported a reduction in infant and child mortality.

3.33 All four CASCRs reviewed in SAR, both of the MNA CASCRs and the only ECA CASCR reported improvements in health outcomes. Six of the ten African CASCRs reviewed also reported improvements in health outcomes. None of the three CASCRs in EAP reported any improvement in health outcomes. The Indonesia FY04 CASCR reported

[21] CASCRs are the World Bank's self-assessment of the previous CAS and are prepared near the end of a CAS cycle. The CASCR is a relatively recent instrument (they commenced in FY04). Therefore even though there are more than 19 closed CASs among the sample reviewed, it was only possible to review the implementation of the CASs that had CASCRs.

improvements in outputs such as number of attended births but said that this had not translated into a decrease in maternal mortality rates at the time of the review.

Table 3.17: Trends in CAS Implementation: HNP Outcomes

Were any improvements in health outcomes reported?	FY97-01 (N = 8)		FY02-06 (N = 11)		Total (N = 19)	
	No.	%	No.	%	No.	%
Yes	**6**	**75**	**8**	**73**	**14**	**74**
Health outcomes that improved included:						
Infant and child mortality	5	63	6	55	11	58
Maternal mortality	4	50	1	9	5	26
Nutritional status	0	0	1	9	1	5
HIV/AIDS prevalence	2	25	1	9	3	16
Population growth	0	0	0	0	0	0
Polio eradication	0	0	1	9	1	5
Schistosomiasis	1	13	0	0	1	5
Leprosy	0	0	1	9	1	5
Cholera	0	0	1	0	1	5
No[a]	**2**	**25**	**3**	**27**	**5**	**26**

Source: IEG CAS review.

a. Health outcomes either remained unchanged or deteriorated.

MULTISECTORAL APPROACHES

3.34 **Eighteen of the 19 CASs whose CASCRs were reviewed had proposed a multisectoral approach (either through multisectoral or parallel lending or both) in the original CAS.** Of these, 11 had proposed parallel lending, two had proposed multisectoral lending and five had proposed both. Of the 18 completed CASs that were known (from our CAS review) to have proposed to adopt a multisectoral approach, six CASs implemented the strategy fully, and seven CASs implemented it partially (Table 3.18).[22]

Table 3.18: Implementation of Multisectoral Approaches

Multisectoral strategy	Number that proposed strategy	Extent of implementation: Fully		Partially		Not implemented	
		No.	%	No.	%	No.	%
Multisectoral lending	2	1	50	0	0	1	50
Parallel lending	11	1	9	6	55	4	36
Both multisectoral & parallel	5	4	80	1	20	0	0
Total	18	6	33	7	39	5	28

Source: IEG CAS review.

3.35 **In several of the CASs that only partially implemented their multisectoral strategy, the health component was omitted**. For example in the case of lending in water and sanitation in the Philippines FY03 CAS, there was supposed to be a health awareness campaign accompanying the lending but this was not implemented. Similarly, in the case of the Bangladesh FY01 CAS, access to safe water was increased, but due to differences in opinion between the Bank and the Government, the planned assistance to help with the public health aspects of arsenicosis did not materialize. Furthermore, health impacts of

[22] Partial implementation means that they implemented the proposed multisectoral or parallel lending partially or undertook the lending in full but did not show any evidence of intersectoral collaboration or coordination.

lending in other sectors were often not tracked even when lending was undertaken so it was not possible to gauge the value-added of a multisectoral approach. In cases where they were tracked (even ex-post), improvements were generally noted, such as in the case of the Mali (FY04 CAS) where improved sanitation was found to have an impact on reducing cholera incidence.

3.36 Multisectoral approaches in the form of parallel lending were most often implemented in water supply and sanitation (nine CASs). However, the results of this lending were usually reported in terms of outputs or intermediate outcomes, such as increased access to safe water with no data on final health outcomes.

4.1 The World Bank's 2007 HNP strategy, *Healthy Development*, commits to improving the level and distribution of HNP outcomes, especially for the poor, and advocates using intersectoral action to bring this about. It follows on the 1997 HNP strategy which also advocated improving HNP outcomes among the poor and the use of multisectoral approaches. This paper has reviewed a stratified random sample of the CASs approved from FY97-06, to assess the extent to which HNP is prioritized, especially among the poor, and the extent to which intersectoral actions were planned to achieve this. It has also looked at the small group of CASs for which there are CAS Completion Reports, to assess the extent to which both objectives were achieved.

4.2 **The need to improve the health status of the poor was well-recognized, as almost three-quarters of CASs had such a focus.** However, there was an overall lack of clarity on the means for improving health among the poor, as only a minority of CASs set up HNP status or access targets for the poor, only half set out a definition of the poor, and fewer than a quarter cited any targeting method for reaching the poor. More than three-quarters of CASs cited HNP as a priority sector, either explicitly or implicitly and most proposed new HNP lending activities, though this decreased over time. There was an emphasis on achieving health *status* outcomes, as opposed to intermediate outcomes or outputs. Only about a third of CASs set specific and monitorable targets to be achieved during the CAS period.

4.3 **To date, the CAS has not delivered on its promise as the instrument for realizing the benefits of multisectoral action to improve HNP outcomes, as envisioned in the 1997 and 2007 HNP strategies.** More than three-quarters of CASs acknowledged the contribution of other sectors to HNP outcomes but only slightly more than half proposed incorporating parallel or multisectoral lending in any form in their country programs. Furthermore, almost all of the CASs that did incorporate multisectoral approaches to HNP did not incorporate any specific HNP targets or indicate that any form of coordination with the HNP sector was envisaged. Only about a third of the completed CASs reviewed implemented multisectoral lending fully in the way originally envisaged, and another third only partially implementing the strategy. However, even where lending was undertaken as proposed, health indicators were not tracked, hence it was difficult to gauge the value-added of implementing a multisectoral approach. There was little evidence of intersectoral collaboration or coordination, even when multisectoral lending was undertaken as proposed.

4.4 Looking forward, these findings suggest several areas where CAS performance with respect to the pro-poor focus of HNP actions and multisectoral approaches can be improved.

a) CASs need to be more specific about how HNP outcomes among the poor will be addressed in implementation and how they will be measured and tracked – both in HNP and other sector operations aimed to improve HNP outcomes.
b) Analytic work needs to be launched to understand better the contribution of other sectors to HNP outcomes and the value added of multisectoral approaches in different contexts.
c) A study needs to be launched to better understand the institutional incentives in the Bank and countries that are inhibiting greater cross-sectoral collaboration, focus, and results on HNP outcomes need to be better understood.

REFERENCES

Filmer, Deon. 2003. "Determinants of Health and Education Outcomes." World Bank, Washington, DC.

IEG. 2006. *Annual Review of Development Effectiveness 2006: Getting Results.* Washington, DC: World Bank.

Johnston, Timothy, and Susan Stout. 1999. *Investing in Health: Development Effectiveness in the Health, Nutrition, and Population Sector*. Washington, DC: Operations Evaluation Department, World Bank.

Pawinski and Lalloo. 2004. "Overcoming obstacles to facilitate operational multi-sectoral relationships to improve care in HIV/AIDS." 15th International Conference on STDs and AIDS, Bangkok, Thailand Jul 11-16; Abstract no: TuPeE5332.

World Bank. 2007. *Healthy Development: The World Bank Strategy for Health, Nutrition and Population Results*. Washington, DC.

———. 2004. *"The Millennium Development Goals for Health – Rising to the Challenges."* Washington, DC.

———. 1997. *Health, Nutrition, and Population Sector Strategy Paper.* Washington, DC.

———. 1996. "AIDS Prevention and Mitigation in Sub-Saharan Africa: An Updated World Bank Strategy." Report No. 15569-AFR Human Resources and Poverty Division, Technical Department, Africa Region, Washington, DC.

———. 1995. "Regional AIDS Strategy for the Sahel." Report no. 13411-AFR, Western Africa Department, Population and Human Resources Division, Washington, DC.

APPENDIX A: TABLE OF COUNTRY ASSISTANCE STRATEGIES REVIEWED

Region	Income	Fiscal Year[a]	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	Total
East Asia and Pacific													
Cambodia	LIC	1997, 1999, 2005	X		X						X		3
Laos	LIC	1999, 2004			X					X			2
Mongolia	LIC	1998, 2004		X						X			2
Papua New Guinea	LIC	1999			X								1
Vietnam	LIC	1999, 2002, 2007			X			X					3
China	LMIC	1997, **2003**, 2006	X						X			X	3
Indonesia	LMIC	1997, 2001, **2004**	X				X			X			3
Philippines	LMIC	1999, **2002**, 2005			X			X			X		3
Thailand	LMIC	1998, 2003		X					X				2
Timor-Leste	LMIC	2005									X		1
Malaysia	UMIC	1999			X								1
11 countries		**Total CASs**	**3**	**2**	**6**	**0**	**1**	**2**	**2**	**3**	**3**	**1**	**23**
		Sample	**3**	**2**	**6**	**0**	**1**	**2**	**2**	**3**	**3**	**1**	**23**
Europe and Central Asia													
Kyrgyz Republic	LIC	1998, 2003		X					X				2
Tajikistan	LIC	1998, 2003, 2006		X					X			X	3
Uzbekistan	LIC	1998, 2002		X				X					2
Albania	LMIC	1999, 2002, 2006			X			X				X	3
Armenia	LMIC	1998, **2001**, 2004		X			X					X	3
Azerbaijan	LMIC	1999, 2003, 2006			X				X			X	3
Belarus	LMIC	1999, 2002			X			X					2
Bosnia & Herzegovina	LMIC	1998, 2000, 2005		X		X					X		3
Bulgaria	LMIC	1998, 2002, 2006		X				X				X	3
Georgia	LMIC	1998, 2004, 2006		X						X		X	3
Kazakhstan	LMIC	1998, 2001, 2005		X			X				X		3
Macedonia	LMIC	1999, 2004, 2007			X					X			2
Moldova	LMIC	1999, 2005			X						X		2
Serbia and Montenegro	LMIC	2005									X		1

Appendix A

Region	Income	Fiscal Year[a]	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	Total
Turkmenistan	LMIC	1997, 2001	X				X						2
Ukraine	LMIC	2001, 2004					X			X			2
Croatia	UMIC	1999, 2004,			X					X			2
Hungary	UMIC	1998		X									1
Latvia	UMIC	1998, 2002		X				X					2
Lithuania	UMIC	1999, 2004			X					X			2
Poland	UMIC	1997, 2003, 2005	X					X			X		3
Romania	UMIC	1997, 2001, 2006	X				X					X	3
Russia	UMIC	1997, 2000, 2002, 2007	X			X		X					3
Slovak Republic	UMIC	2001, 2004					X			X			2
Turkey	UMIC	1998, 2001, **2004**		X			X			X			3
25 countries		**Total CASs**	**4**	**11**	**7**	**2**	**7**	**7**	**3**	**7**	**5**	**7**	**60**
		Sample	**2**	**5**	**4**	**1**	**6**	**3**	**0**	**4**	**2**	**2**	**29**
Latin America and the Caribbean													
Bolivia	LMIC	1998, 2004		X						X			2
Brazil	LMIC	2000, 2004				X				X			2
Colombia	LMIC	1998, 2003		X					X				2
Dominican Republic	LMIC	1999, 2005			X						X		2
Ecuador	LMIC	2003							X				1
El Salvador	LMIC	1997, 2002, 2005	X					X			X		3
Guatemala	LMIC	1998, 2005		X							X		2
Guyana	LMIC	2002						X					1
Honduras	LMIC	2000, 2003, 2007				X			X				2
Jamaica	LMIC	2001, 2005					X				X		2
Nicaragua	LMIC	1998, 2003		X					X				2
Paraguay	LMIC	1997, 2004	X							X			2
Peru	LMIC	1997, 2003,	X						X				2
Argentina	UMIC	1997, 2001, 2004, 2006	X				X			X		X	4
Belize	UMIC	2001					X						1
Chile	UMIC	2002						X					1
Costa Rica	UMIC	2004								X			1
Mexico	UMIC	1999, 2002, 2007			X			X					2
Panama	UMIC	1999			X								1
Trinidad and Tobago	UMIC	1999			X								1

Appendix A

Region	Income	Fiscal Year[a]	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	Total
Uruguay	UMIC	1997, 2000, 2005	X			X					X		3
Venezuela	UMIC	1997	X										1
22 countries		**Total CASs**	**6**	**4**	**4**	**3**	**3**	**4**	**5**	**5**	**5**	**1**	**40**
		Sample	**4**	**3**	**4**	**1**	**1**	**2**	**1**	**1**	**3**	**1**	**21**
South Asia													
Bangladesh	LIC	1998, **2001**, 2006		X			X					X	3
Bhutan	LIC	2000, 2006				X						X	2
India	LIC	1998, 2001, **2005**		X			X				X		3
Nepal	LIC	1999, 2004			X					X			2
Pakistan	LIC	**2002**, 2006						X				X	2
Maldives	LMIC	2001					X						1
Sri Lanka	LMIC	**2003**							X				1
7 countries		**Total CASs**	**0**	**2**	**1**	**1**	**3**	**1**	**1**	**1**	**1**	**3**	**14**
		Sample	**0**	**2**	**1**	**1**	**3**	**1**	**1**	**1**	**1**	**3**	**14**
Middle East and North Africa													
Yemen	LIC	1999, 2003, 2006			X				X			X	3
Algeria	LMIC	1996, 2003							X				2
Egypt	LMIC	1997, **2001**, 2005	X				X				X		3
Djibouti	LMIC	2001, 2005					X				X		2
Jordan	LMIC	2000, 2003, 2006				X			X			X	3
Morocco	LMIC	1997, **2001**, 2005	X				X				X		3
Tunisia	LMIC	2000, 2004				X				X			2
Lebanon	UMIC	1998, 2006		X								X	2
8 countries		**Total CASs**	**2**	**1**	**1**	**2**	**3**	**0**	**3**	**1**	**3**	**3**	**19**
		Sample	**2**	**1**	**1**	**2**	**3**	**0**	**3**	**1**	**3**	**3**	**19**
Sub-Saharan Africa													
Benin	LIC	2003							X				1
Burkina Faso	LIC	**2001**, 2005					X				X		2
Chad	LIC	1999, 2004			X					X			2
Cote d'Ivoire	LIC	1998,		X									1
Ethiopia	LIC	1998, 2003		X					X				2
Ghana	LIC	1998, **2004**		X						X			2
Guinea	LIC	1998, 2003		X					X				2
Guinea-Bissau	LIC	1996											1

Appendix A

Region	Income	Fiscal Year[a]	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	Total
Kenya	LIC	1996, 1999, 2004			X					X			3
Madagascar	LIC	1997, 2004, 2007	X							X			2
Malawi	LIC	1999, 2003, 2007			X				X				2
Mali	LIC	1998, **2004**		X						X			2
Mauritania	LIC	1997, 2002, 2007	X					X					2
Mozambique	LIC	1998, **2000**, 2004, 2007		X		X				X			3
Niger	LIC	1998, 2003		X					X				2
Nigeria	LIC	2005								X			1
Rwanda	LIC	1998, **2003**		X					X				2
Sao Tome and Principe	LIC	2001, 2005					X				X		2
Senegal	LIC	1998, 2003, 2007		X					X				2
Sierra Leone	LIC	2005									X		1
Tanzania	LIC	1997, 2000, 2007	X			X							2
The Gambia	LIC	1999, 2003			X				X				2
Uganda	LIC	1997, 2001, 2006	X				X					X	3
Zambia	LIC	**2000, 2004**				X				X			2
Zimbabwe	LIC	1997	X										1
Cameroon	LMIC	2004								X			1
Cape Verde	LMIC	1998, 2005		X							X		2
Lesotho	LMIC	1998, 2006		X								X	2
Gabon	UMIC	**1999**, 2005			X						X		2
Mauritius	UMIC	1997, 2002, 2007	X					X					2
South Africa	UMIC	1999			X								1
35 countries		**Total CASs**	**6**	**11**	**6**	**3**	**3**	**2**	**8**	**9**	**5**	**2**	**55**
		Sample	**3**	**7**	**4**	**2**	**1**	**1**	**4**	**4**	**4**	**1**	**31**
TOTAL		**CASs**	**22**	**31**	**23**	**11**	**20**	**166**	**23**	**25**	**22**	**17**	**211**
		Sample	**14**	**20**	**18**	**7**	**15**	**9**	**11**	**14**	**16**	**11**	**137**

Source: IEG CAS review.

a. Bold CASs were included in the review of CASCRs.

APPENDIX B: WEIGHTED RESULTS

Variable	Entire sample	FY97-01	FY02-06	LICs	LMICs	UMICs	MICs
Poverty variables:							
Prioritization of HNP in the CAS	83	83	84	90	81	75	79
Focus on health status	68	70	68	78	68	53	63
Focus on the poor	72	69	76	84	73	57	67
HNP outcome targets	33	29	39	48	27	16	23
Prior analytic work	42	37	48	40	45	37	43
HNP outcome targets for the poor	16	12	21	19	14	16	14
Proposed HNP activities:							
Lending	75	78	69	87	64	76	69
AAA	54	49	56	60	48	53	49
Multisectoral variables:							
Contribution of other sectors to HNP outcomes	75	76	71	82	76	55	69
Impact of HNP on other sectors	32	17	18	36	10	4	8
Multisectoral lending strategies	49	49	48	67	43	26	39
Of which:							
Parallel lending	41	41	39	52	48	24	34
Multisectoral lending	18	11	26	34	10	4	9
HIV/AIDS projects	12	5	20	26	5	0	4
Sectors of parallel lending:							
Water and sanitation	22	21	25	34	21	5	16
Transport/Infrastructure	5	2	9	5	7	0	4
Public Sector Reform	4	5	3	0	3	12	7
Environment	5	5	4	5	7	0	4
Energy	2	2	4	1	5	0	3
Education	2	2	3	4	2	0	2
Aspects of parallel lending:							
Common targeting	2	1	3	4	1	0	1
Common management	1	1	1	1	1	0	1

Source: IEG CAS review.

APPENDIX C: TABLES BY INCOME GROUP

The tables in this annex have not been weighted to take into account the sampling stratification. Weighted results for the main variables by income group are in Appendix B.

Table C.1: Prioritization of HNP Sector by Country Income

Did the CAS mention HNP as a priority sector?	LIC N = 51		LMIC N = 60		UMIC N = 26	
	No.	%	No.	%	No.	%
YES, *of which:*	**46**	**90**	**47**	**78**	**19**	**73**
Explicit priority	9	18	3	5	6	23
Implicit priority	37	73	44	73	13	50
NO, *of which:*	**5**	**10**	**13**	**22**	**7**	**27**
HNP issues other than health status mentioned	1	2	9	15	4	15

Source: IEG CAS review.

Table C.2: Prioritization of HNP Status, by Income Level

Were HNP outcomes, in terms of HNP status, prioritized?	LIC N = 51		LMIC N = 60		UMIC N = 26	
	No.	%	No.	%	No.	%
YES	**40**	**78**	**39**	**65**	**13**	**50**
Specific HNP indicators:						
Mortality						
-IMR	21	41	11	18	2	8
-MMR	20	40	8	13	1	4
-Under-5 MR	10	20	5	8	2	8
-Life expectancy	2	4	2	3	1	4
Disease-specific						
-HIV incidence or prevalence	15	30	4	7	4	15
-TB incidence or fatality rate	3	6	3	5	4	15
-STD incidence	1	2	1	2	1	4
- Malaria incidence	3	6	0	0	0	0
-other endemic disease incidence	1	2	1	2	2	8
Fertility						
-TFR	7	14	1	2	0	0
-Crude birth rate	0	0	1	2	0	0
-Population growth rate	1	2	0	0	0	0
Malnutrition						
-Child malnutrition	10	20	7	12	1	4
-Pregnant/nursing women or low birth weight	1	2	0	0	1	4
NO	**11**	**22**	**21**	**35**	**13**	**50**
Of which, intermediate HNP outcomes, HNP outputs or inputs were prioritized	4	8	4	7	2	8

Source: IEG CAS review.

Appendix C

Table C.3: Focus on the Poor by Country Income

Was there a focus on health status among the poor?	LIC N = 51		LMIC N = 60		UMIC N = 26	
	No.	**%**	**No.**	**%**	**No.**	**%**
YES	**42**	**82**	**44**	**73**	**15**	**58**
Of which, the poor were identified as:						
• Low income group	4	8	5	8	2	8
• Poor region	9	18	3	5	5	19
• Rural area	8	16	10	17	2	8
• Minority group	1	2	1	2	2	8
Of which, the poor were to be reached by:						
• Health subsidies, vouchers or cash transfers	2	4	3	5	2	8
• Increase in services used by the poor	1	2	3	5	1	4
• Reduction in insurance or user fees	2	4	2	3	0	0
• Increase in govt. budget allocation to poor areas	1	2	1	2	1	4
NO	**9**	**18**	**16**	**27**	**11**	**42**

Source: IEG CAS review.

Table C.4: Prior Analytic Work, by Income Level

Was there prior analytic work?	LIC N = 51		LMIC N = 60		UMIC N = 26	
	No.	**%**	**No.**	**%**	**No.**	**%**
YES	**23**	**45**	**27**	**45**	**10**	**39**
Of which specific work is cited	21	41	22	37	9	35
NO	**28**	**55**	**33**	**55**	**16**	**62**

Source: IEG CAS review.

Table C.5: Setting of HNP Targets by Country Income

Were targets set in terms of HNP status?	LIC N = 51		LMIC N = 60		UMIC N = 26	
	No.	**%**	**No.**	**%**	**No.**	**%**
YES	**26**	**51**	**16**	**7**	**4**	**15**
Of which, only Govt. or PRSP target within CAS time frame was cited	7	14	1	2	1	4)
PARTIAL - only trends (i.e. upward or downward) were cited	**2**	**4**	**5**	**8**	**2**	**8**
NO	**23**	**45**	**39**	**65**	**20**	**77**
Of which targets were to be determined upon further analysis or collaboration with government/partners	0	0	4	7	0	0

Source: IEG CAS review.

Table C.6: Proposed HNP Activities, by Country Income

What Bank activities were proposed for HNP?	LIC N = 51		LMIC N = 60		UMIC N = 26	
	No.	**%**	**No.**	**%**	**No.**	**%**
LENDING	**44**	**86**	**37**	**62**	**20**	**77**
In addition to which, no new planned HNP lending, but HNP lending ongoing	4	8	13	22	1	4
AAA	**31**	**61**	**33**	**55**	**14**	**54**

Source: IEG CAS review.

Appendix C

Table C.7: CAS Acknowledgement of Contribution of HNP Outcomes to Other Development Objectives, by Income

Does the CAS acknowledge the contribution of HNP outcomes to other development objectives?	LIC N = 51		LMIC N = 60		UMIC N = 26	
	No.	%	No.	%	No.	%
Yes	**17**	**33**	**7**	**12**	**1**	**4**
Of which:						
Environment	6	12	1	2	0	0
Poverty Reduction	4	8	1	2	1	8
Education	4	8	2	3	0	0
Public Sector Reform	1	2	0	0	0	0
Agriculture	1	2	0	0	0	0
Labor	2	4	0	0	0	0
Transport/Infrastructure	1	2	0	0	0	0
No	**34**	**67**	**53**	**88**	**25**	**96**

Source: IEG CAS review.

Table C.8: CAS Acknowledgement of Other Sectors' Contributions to HNP Outcomes, by Income Level

Does the CAS acknowledge the contribution of other sectors to HNP outcomes?	LIC N = 51		LMIC N = 60		UMIC N = 26	
	No.	%	No.	%	No.	%
Yes	**44**	**86**	**49**	**82**	**14**	**54**
Of which, sectors mentioned were:						
Water and Sanitation	36	72	25	41	7	27
Education	18	36	8	13	3	12
Environment	11	22	18	30	3	12
Transport/Infrastructure	13	26	13	21	2	8
Energy	7	14	3	5	0	0
Public Sector Reform	3	6	3	5	2	8
Social Security	0	0	3	5	2	8
Agriculture	4	8	1	2	0	0
Indigenous/Rural Development	1	2	1	2	2	8
Labor	0	0	1	2	0	0
Microfinance	1	2	0	0	0	
Defense	0	0	1	2	0	0
Urban Development	1	2	4	7	0	0
No	**10**	**16**	**12**	**21**	**12**	**46**

Source: IEG CAS review.

Table C.9: Approaches to Multisectoral Lending, by Income

Multisectoral lending strategy for HNP outcomes	LIC N = 51		LMIC N = 60		UMIC N = 26	
	No.	%	No.	%	No	%
Any lending, *of which:*	**35**	**69**	**31**	**52**	**7**	**27**
Parallel lending only	23	45	20	33	7	27
Multisectoral lending only	7	14	4	7	0	0
Combination (MS plus PL)	5	10	7	12	0	0
MS lending that was HIV-related	12	24	2	3	0	0
No lending, of which	**16**	**31**	**29**	**48**	**19**	**73**
Multisectoral contribution acknowledged but no action proposed	9	18	15	25	9	35
No multisectoral contribution acknowledged	7	14	14	23	10	38

Source: IEG CAS review.

APPENDIX D: TABLES BY REGION

As the sampling of CASs was stratified by region, these tables do not require weighting.

Table D.1: Prioritization of the HNP Sector by Region

Was HNP mentioned as a priority sector?	AFR N = 31		EAP N = 23		ECA N = 29		LAC N = 21		MNA N = 19		SAR N = 14	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
YES, *of which:*	**29**	**94**	**19**	**83**	**23**	**79**	**18**	**86**	**12**	**63**	**11**	**79**
Explicit	6	19	2	9	2	7	5	24	1	5	2	14
Implicit	23	74	17	74	21	72	13	62	11	58	9	64
NO, *of which:*	**2**	**6**	**4**	**17**	**6**	**21**	**3**	**14**	**7**	**37**	**3**	**21**
HNP issues other than health status mentioned	1	3	2	9	4	14	1	5	6	32	0	0

Source: IEG CAS review.

Table D.2: Prioritization of HNP Status, Overall and by Region

Was HNP status, prioritized?	AFR N = 31		EAP N = 23		ECA N = 29		LAC N = 21		MNA N = 19		SAR N = 14	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
YES	**25**	**81**	**11**	**48**	**19**	**66**	**14**	**67**	**10**	**53**	**13**	**93**
Specific HNP indicators:												
Mortality												
-IMR	9	29	5	22	1	3	8	38	3	16	8	57
--MMR	10	32	5	22	1	3	5	24	3	16	5	36
-Under-5 MR	7	23	1	4	3	10	0	0	1	5	5	36
-Life expectancy	3	10	0	0	2	7	0	0	0	0	0	0
Disease-specific												
-HIV incidence or prevalence	11	35	1	4	4	14	2	10	0	0	5	36
-TB incidence or fatality rate	3	10	0	0	6	21	0	0	0	0	1	7
-STD incidence or prevalence	1	3	0	0	0	0	0	0	0	0	2	14
-malaria incidence	1	3	2	9	0	0	0	0	0	0	0	0
-other endemic disease incidence	0	0	0	0	1	3	0	0	0	0	1	7
Fertility												
-TFR	3	10	1	4	0	0	0	0	0	0	4	29
-Crude birth rate	0	0	1	4	0	0	0	0	0	0	0	0
-Population growth rate	0	0	0	0	0	0	0	0	0	0	1	7
Malnutrition												
-Child malnutrition	6	19	3	13	0	0	5	24	1	5	3	21
-Pregnant/nursing women or low birth weight	0	9	0	0	0	0	1	5	0	0	1	7
NO	**6**	**19**	**12**	**52**	**10**	**35**	**7**	**33**	**9**	**47**	**1**	**7**
Of which, intermediate HNP outcomes, outputs or inputs were prioritized	2	6	6	26	1	3	1	5	0	0	0	0

Source: IEG CAS review.

Table D.3: Focus on the Poor by Region

Was there a focus on health among the poor?	AFR N = 31		EAP N = 23		ECA N = 29		LAC N = 21		MNA N = 19		SAR N = 14	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
YES	**23**	**74**	**21**	**91**	**19**	**66**	**15**	**71**	**12**	**63**	**11**	**79**
Of which, the poor were identified as:												
• Low income group	0	0	3	13	5	17	0	0	2	11	1	7
• Poor region	6	19	4	17	1	3	4	19	1	5	1	7
• Rural area	6	19	4	17	1	3	4	19	1	5	4	29
• Minority group	0	0	1	4	1	3	2	10	0	0	0	0
Of which, the poor were to be reached by:												
• Health subsidies, vouchers or cash transfers	0	0	3	13	1	3	0	0	1	5	2	14
• Increase in services used by the poor	0	0	2	9	0	0	2	10	0	0	1	7
• Reduction in insurance or user Fees	1	3	1	4	1	3	1	5	0	0	0	0
• Increase in gov't budget allocation to poor areas	2	6	0	0	0	0	1	5	0	0	0	0
NO	**8**	**26**	**2**	**9**	**10**	**35**	**6**	**29**	**7**	**37**	**3**	**21**

Source: IEG CAS review.

Table D.4: Prior Analytic Work, Overall and by Region

Was there prior analytic work?	AFR N = 31		EAP N =2 3		ECA N = 29		LAC N = 21		MNA N = 19		SAR N = 14	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
YES	**12**	**39**	**11**	**48**	**9**	**31**	**11**	**52**	**9**	**47**	**8**	**57**
Of which specific work is cited	11	35	9	39	8	28	10	48	7	37	7	50
• Public expenditure review	1	3	4	17	2	7	2	10	1	5	1	7
• Health sector review	2	6	0	0	3	10	0	0	1	5	0	0
• Poverty assessment or PRSP	4		3	13	1	3	5	24	2	10	4	29
• Health sector strategy	0	0	3	13	0	0	1	5	0	0	0	0
• Survey data	0	0	2	9	1	3	0	0	0	0	0	0
• Social sector review	0	0	1	4	0	0	2	10	2	10	3	21
• Country economic review	2	6	0	0	0	0	0	0	0	0	0	0
NO	**19**	**61**	**12**	**52**	**20**	**69**	**10**	**48**	**10**	**53**	**6**	**43**

Source: IEG CAS review.

Table D.5: Setting of HNP Targets by Region

Were targets set in terms of HNP status, for within the CAS period?	AFR N =3 1		EAP N = 23		ECA N = 29		LAC N = 21		MNA N = 19		SAR N = 14	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
YES	**17**	**55**	**5**	**22**	**3**	**10**	**9**	**43**	**1**	**5**	**11**	**79**
Of which, explicit target for Govt. or PRSP only cited	6	19)	0	0	0	0)	0	0	0	0)	3	21
PARTIAL – Only "improvement" in certain health indicators cited	**0**	**0**	**2**	**9**	**4**	**14**	**2**	**10**	**1**	**5**	**0**	**0**
NO	**14**	**45**	**16**	**70**	**22**	**76**	**10**	**48**	**17**	**89**	**3**	**21**
Of which targets were to be determined upon further analysis or collaboration with government/partners	0	0	0	0	1	3	1	5	2	11	0	0

Source: IEG CAS review.

Table D.6: Setting of HNP Targets for the Poor, by Region

Were HNP outcome or access targets set for the poor?	AFR N = 31		EAP N = 23		ECA N = 29		LAC N =2 1		MNA N = 19		SAR N = 14	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
YES	**7**	**23**	**4**	**17**	**2**	**7**	**5**	**24**	**2**	**11**	**1**	**7**
Specific HNP status indicators:												
• Child malnutrition	1	3	1	4	0	0	1	5	0	0	0	0
• Pregnant/ nursing female malnutrition	0	0	1	0	0	0	1	5	0	0	0	0
• HIV prevalence	0	0	0	0	0	0	1	5	0	0	0	0
Sub-total	**1**	**1**	**2**	**2**	**0**	**0**	**3**	**3**	**0**	**0**	**0**	**0**
Specific access indicators:												
• Availability/ coverage of services	4	13	1	4	2	7	1	5	1	5	0	0
• Household exp. on health	1	3	2	9	1	3	0	0	0	0	0	0
• Insurance coverage	0	0	1	4	0	0	2	10	1	5	0	0
• Utilization rate	0	0	2	9	0	0	1	5	0	0	1	7
• Vaccination rate	0	0	1	4	0	0	1	5	0	0	0	0
• Govt. budget alloc.	0	0	2	9	0	0	0	0	0	0	0	0
• Index for inequality	1	3	0	0	0	0	0	0	0	0	0	0
Sub-total	**6**	**19**	**9**	**39**	**3**	**10**	**5**	**24**	**2**	**11**	**1**	**7**
PARTIAL - only trends (i.e. upward or downward) were cited	**1**	**3**	**4**	**17**	**7**	**24**	**0**	**0**	**0**	**0**	**3**	**21**
NO	**23**	**74**	**15**	**65**	**20**	**69**	**16**	**76**	**17**	**90**	**10**	**71**
Of which targets were to be determined upon further analysis or collaboration with government/partners	0	0	1	4	1	3	1	5	0	0	0	0

Source: IEG CAS review.

Table D.7: Proposed HNP Activities, by Region

What Bank activities were proposed for HNP?	AFR N = 31		EAP N = 23		ECA N = 29		LAC N =2 1		MNA N = 19		SAR N = 14	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
LENDING	**23**	**74**	**16**	**70**	**22**	**76**	**18**	**86**	**9**	**47**	**13**	**93**
No lending planned, but there was ongoing HNP lending	3	10	1	4	5	17	3	14	7	37	0	0
AAA	**17**	**55**	**15**	**65**	**10**	**35**	**13**	**62**	**13**	**68**	**10**	**71**

Source: IEG CAS review.

Table D.8: CAS Acknowledgement of Other Sectors' Contributions to HNP Outcomes, by Region

Does the CAS acknowledge the contribution of other sectors to HNP outcomes?	AFR N = 31		EAP N = 23		ECA N = 29		LAC N = 21		MNA N = 19		SAR N = 14	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No**	**%**	**No.**	**%**
YES	**30**	**97**	**19**	**83**	**15**	**52**	**13**	**62**	**17**	**89**	**13**	**93**
Of which, sectors mentioned were:												
Water and sanitation	22	71	10	43	10	34	7	33	9	47	10	71
Education	9	29	3	13	2	7	3	14	7	37	6	43
Environment	3	10	6	26	7	24	3	14	5	26	6	43
Transport/ infrastructure	4	13	1	4	5	17	1	5	4	21	7	50
Energy	2	6	1	4	2	7	0	0	1	5	2	14
Public sector reform	2	6	1	4	1	3	2	10	2	11	0	0
Social security	1	3	0	0	1	3	1	5	2	11	0	0
Agriculture	1	3	2	9	0	0	0	0	0	0	0	0
Indigenous/rural development	0	0	0	0	0	0	0	0	1	5	0	0
Labor	0	0	1	4	0	0	0	0	0	0	1	7
Microfinance	0	0	0	0	0	0	0	0	0	0	1	7
Defense	0	0	0	0	0	0	0	0	0	0	1	7
Urban development	0	0	1	4	0	0	1	5	0	0	1	7
NO	**1**	**3**	**4**	**17**	**14**	**48**	**4**	**19**	**2**	**11**	**1**	**7**

Source: IEG CAS review.

Table D.9: Multisectoral Lending Strategies, by Region

What was the multisectoral lending strategy?	AFR N = 31		EAP N = 23		ECA N = 29		LAC N = 21		MNA N = 19		SAR N = 14	
	No.	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Any lending, *of which:*	**26**	**84**	**15**	**65**	**4**	**14**	**7**	**33**	**10**	**53**	**11**	**79**
Parallel lending only	11	35	13	56	4	14	2	10	10	53	10	71
Multisectoral lending only	7	23	2	9	0	0	2	10	0	0	0	0
Both (MS plus PL)	8	36	0	0	0	0	3	14	0	0	1	7
MS lending that was HIV-related	12	39	0	0	0	0	1	5	0	0	1	7
No lending, *of which*	**5**	**16**	**8**	**35**	**25**	**86**	**14**	**67**	**9**	**47**	**3**	**21**
Multisectoral contribution acknow-ledged but no action proposed	5	16	3	13	10	34	7	33	6	32	2	14
No multisectoral contribution acknowledged	0	0	5	22	15	52	7	33	3	16	1	7

Source: IEG CAS review.