Approach paper:

Evaluation of the World Bank's Assistance for Health, Nutrition, and Population

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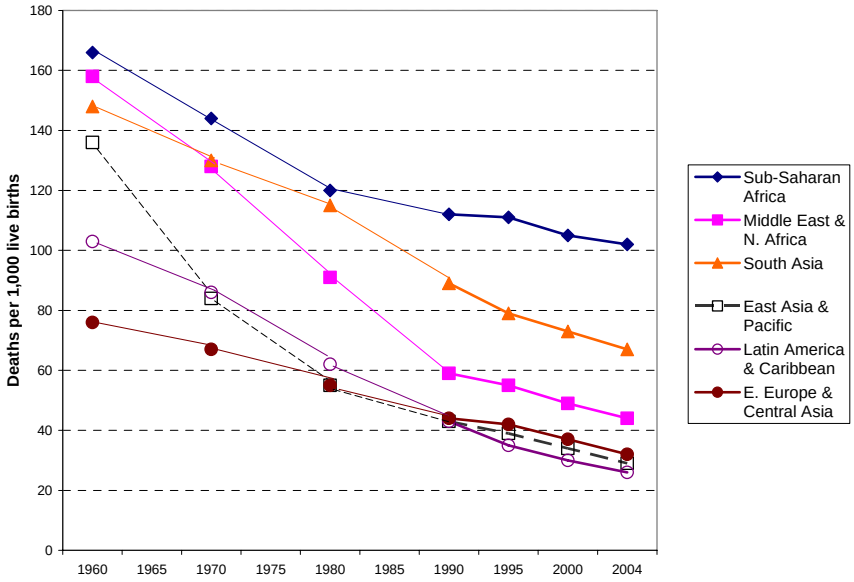
Background

1. **Trends in health, nutrition, and population (HNP) outcomes in developing countries.** There have been substantial improvements in key health outcomes like infant mortality rates in every developing region since 1960 (Figure 1). The prevalence of stunting among children under five has declined dramatically in Asia and Latin America since 1980, though only modestly in Africa.[1] These improvements have been attributed to rising average levels of income and education, coupled with improvements in health technology and expanded public health interventions.[2] However, average outcomes conceal important differences in progress across countries within regions. Under-five mortality rates in thirty countries have stagnated or increased since 1990;[3] in some countries, high fertility rates have remained constant or even increased slightly since the 1990s.[4] Despite some progress in Bangladesh and India, undernutrition remains extraordinarily high in South Asia, while in 26 countries, primarily in Africa, nutritional status is declining.[5] Communicable diseases remain significant challenges to low- and middle-income countries, while the threat of non-communicable diseases, particularly for middle-income countries, is formidable.[6]

Figure 1. Decline in infant mortality rates in developing countries, 1960-2004



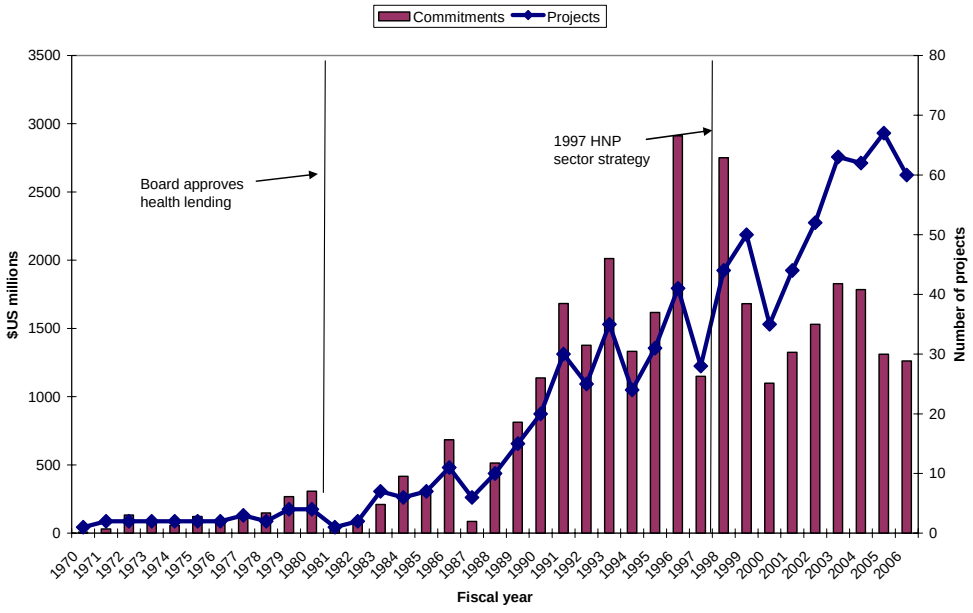
Source: UNICEF 2006

2. Average outcomes at the national level also mask disparities between the poor and non-poor within countries. In some, outcomes have improved disproportionately among the poor, while in others it has improved primarily among the non-poor (Annex A, Figure A-1). The gaps in HNP outcomes between the poor and non-poor, even when closing, often remain substantial, in part reflecting lower access of the poor to public services.[7]

3. **The relation between health and poverty reduction.** Poor health and malnutrition contribute to low productivity of the poor; improving HNP outcomes is thus seen as a major way of reducing poverty. However, poverty is also a prime cause of poor health – the poor have low access to preventive and curative care (both physically and financially), are more likely to be malnourished, have unsafe water and sanitation, lack education, have many closely spaced births, and engage in activities that may put them at higher health risks. Thus, public action to improve health, nutrition, and population status and the productivity of the poor is tied to many different actions – preventive and behavioral as well as curative; actions affecting both the supply and demand for services;[8] actions within the mandate of the ministry of health, as well as of other sectors.[9]

4. **World Bank Group's support for health, nutrition, and population.** Since 1970, the World Bank has committed more than US$32 billion to improve health, nutrition, and population outcomes in 131 countries (Figure 2).[10] This includes lending managed by the HNP sector board as well as HNP components of projects managed by other sector boards. In addition, the International Finance Corporation (IFC) has cumulatively committed $644 million to the private sector in the health and pharmaceutical sectors of developing countries since its formation in 1956.[11]

Figure 2. Trends in HNP commitments and project approvals, FY70-06



* The commitment for the entire project is attributed to the FY of approval and is in constant 2006 dollars.

5. The World Bank's policies, strategies, and lending for HNP have evolved in phases.[12] During the 1970s, the emphasis was on improving access to family planning services, because of concern about the adverse effects of rapid population growth on economic growth and poverty reduction. A handful of nutrition projects was also approved. During the second phase, from 1980-86, the Bank directly financed health services, with the objective of improving the health of the poor by improving access to low-cost primary health care. However, systemic constraints were encountered in providing access to more efficient and equitable health services. During a third, "health reform" phase, from 1987-1996, the Bank strove to improve health finance and reform health systems.

6. The strategy that has guided the sector for the past decade was issued in 1997 at the same time that the Bank was reorganized and the HNP sector board within the Human Development Network was formed.[13] The Bank had cumulatively committed $11.6 billion for HNP activities in 237 projects, of which 94 had closed.[14] It was the major source of external finance for HNP to developing countries and was playing an important role in international health policy debates. The 1997 *Health, Nutrition, and Population Sector Strategy Paper* aimed to help client countries: (1) improve the health, nutrition, and population outcomes of the poor and protect the population from the impoverishing effects of illness, malnutrition and high fertility; (2) enhance the performance of health care systems; and (3) secure sustainable health care financing. Each of these objectives was associated with explicit strategies (Table 1). The sector sought to achieve greater impact on these objectives through: emphasizing the strategic policy directions in Country Assistance Strategies (CAS); underpinning lending with analysis and research; increasing selectivity; improving client services; and improving its own and borrower capacity to monitor and evaluate progress. The strategy identified the Bank's strengths in the sector vis-à-vis the international community as its global expertise from the developing world, its multi-sectoral, macro-level country focus, and its ability to mobilize large financial resources, either directly or through partnerships.

7. **Findings from past evaluations of HNP support.** In 1999, IEG evaluated the development effectiveness of support for HNP since 1970.[15] The evaluation found the Bank had been more successful in expanding health service delivery systems (physical objectives) than in improving service quality and efficiency, or achieving policy and institutional change. The lending portfolio had grown rapidly and projects were complex, particularly in countries with the weakest institutional capacity. The overarching recommendation was that the Bank be more selective in its engagement and focus on improving the quality of HNP operations, particularly through stronger monitoring and evaluation (M&E) and institutional analysis. In addition, the evaluation specifically recommended: strengthening health promotion and inter-sectoral interventions; renewed emphasis on economic and sector analysis; a better understanding of stakeholder interests; and strategic alliances with regional and global development partners.

8. Since 1999, IEG has issued two major evaluations that included important components of the Bank's HNP support. The 2004 evaluation of the Bank's approach to global programs,[16] including those in health, recommended that the Bank engage more

selectively in global programs, favoring those that exploit the Bank's comparative advantages and provide global public goods, and that the links between global programs and the Bank's regional and country operations be strengthened. The 2005 evaluation of the Bank's support for the fight against HIV/AIDS[17] found that while the Bank had contributed to raising political commitment and improving access to services, evidence of results on the ground in terms of health behaviors and outcomes is thin because of a failure to monitor and evaluate. It recommended that the Bank improve the effectiveness of support by: (a) being more strategic and selective, focusing on efforts likely to have the largest impact for their cost; (b) strengthening locally-adapted institutions to manage the long-term response; and (c) investing heavily in M&E capacity and incentives, as the basis for evidence-based decision-making.

Table 1: The Bank's 1997 HNP sector objectives and strategies

Objective	Strategies
1. **Improve the HNP outcomes of the poor and protect the population from the impoverishing effects of illness, malnutrition, and high fertility**.	▪ Greater use of targeting mechanisms;[a] emphasis on the most vulnerable; support for preventive public health activities with large externalities ▪ Stimulate demand for health services among the poor ▪ Improve population policy, family planning, and other reproductive health services to increase the demand for smaller family size and reduce unwanted fertility ▪ In low-income countries, make food more affordable, increase the efficiency of food markets, provide nutrition safety nets. ▪ Address multi-sectoral issues affecting health indirectly,[b] support social policies for greater gender equality, improved status of women. ▪ Improve donor coordination/harmonization in very low income countries via sector-wide approaches ▪ Support inter-country and regional approaches to HNP issues
2**. Enhance the performance of health care systems** by promoting equitable access and use of population-based preventive and curative services that are affordable, effective, well managed, of good quality, and responsive to clients	▪ Raise efficiency in use of scarce resources (through better policymaking, governance, market incentives, public-private mix of services, management, decentralization, accountability) ➢ In *low-income countries*, where most health care is provided by the private sector: provide health services with large externalities (preventive public health services), essential clinical services for the poor, and more effective regulation of the private sector. ➢ In *middle-income countries* and *low-income countries* in which health care is predominantly provided by the public sector: promote greater diversity in service delivery by funding civil society and non-governmental providers on a competitive basis; use quasi-market mechanisms[c] to improve public sector performance and quality participation by the private sector. ▪ Improve the effectiveness of government policymaking, sectoral management, outcome evaluation and regulation, to generate knowledge about improving access, the effectiveness of interventions, efficiency in managing services, quality control, and responding to client needs.
3. **Secure sustainable financing**	▪ Help countries secure sustainable *recurrent* financing for HNP, using a mix of taxation instruments and co-payments tailored to each country. ➢ In *low-income countries*, complement public resources with community-based and international assistance. ➢ In *middle-income countries*, use taxation instruments to mobilize financial resources and expand risk pooling. ▪ Help governments to maintain effective expenditure control ▪ Ensure that the HNP budget envelope is used on effective and quality care that benefits those who need it the most; develop improved budget allocation processes at the national and local level

Source: World Bank 1997, pp. 17-19.

Notes: a. For example, targeting: the poorest individuals and households; poor regions or vulnerable groups; HNP problems that mainly affect the poor (communicable diseases, childhood illness, high fertility, maternal and prenatal conditions); services and/or providers used by the poor. (World Bank 1997, pp. 6-7) b. For example, food and agriculture policies, environment, water supply, sanitation, transportation. c. For example, vouchers, contracting out service provision to the private sector, and obtaining greater client feedback.

9. *Healthy Development: The World Bank Strategy for Health, Nutrition and Population Results* was launched in the spring of 2007. Its objectives are similar to the 1997 strategy, stressing the need to improve HNP outcomes on average and among the poor through improving health system performance and inter-sectoral approaches (see Annex B). However, the new strategy does not draw on evidence of the efficacy and lessons from the past decade. The Bank's assistance during that period ($14 billion in commitments and 547 approved projects) has not been systematically evaluated to date.[18]

Rationale for the proposed evaluation

10. **The evaluation of HNP support over the past decade will provide valuable evidence on the efficacy and lessons of experience from the 1997 HNP strategy and remain highly relevant for improving the effectiveness of implementation of the new 2007 HNP sector strategy and of the Bank's support for achieving the Millennium Development Goals** (MDGs, Box 1)**.**

Box 1: HNP and the Millennium Development Goals

In September 2000, world leaders at the United Nations Millennium Summit agreed to a set of "time-bound and measurable goals and targets for combating poverty, hunger, disease, illiteracy, environmental degradation and discrimination against women", to be achieved by the year 2015. Among the eight Millennium Development Goals (MDG), five involve explicit health and nutrition targets:

Goal	Target
Eradicate extreme poverty and hunger	Reduce by half the proportion of people living on less than a dollar a day and the proportion who suffer from hunger[a]
Reduce child mortality	Reduce by two-thirds the mortality rate of children under 5
Improve maternal health	Reduce by three-quarters the maternal mortality ratio
Combat HIV/AIDS, malaria, and other diseases	Halt and begin to reverse the spread of HIV/AIDS and the incidence of malaria and other major diseases
Ensure environmental sustainability	Reduce by half the proportion of people without sustainable access to safe drinking water

a. The key indicator for measuring hunger is the prevalence of underweight children under age five.

While there is no explicit goal involving population and reproductive health,[19] improving outcomes and access to services in all three HNP sub-sectors is key to achieving all of the MDGs, including the goals of eradicating extreme poverty, universal primary education, and empowering women**.**

11. The proposed HNP evaluation would provide an opportunity to evaluate a number of issues that were explicit objectives, strategies, or challenges in the 1997 strategy and that remain part of the 2007 strategy:

- The continued low outcome ratings of projects managed by the HNP sector relative to those managed by other sectors[20] and weakness of M&E[21]

- The effectiveness of alternative strategies and approaches in improving HNP outcomes among the poor, such as the emphasis on communicable diseases of the poor, country-level partnerships, as embodied in sector-wide approaches (SWAPs), and reforms to improve the efficiency and equity of the health system.

- The extent to which the Bank has capitalized on inter-sectoral approaches to improve HNP outcomes and, where tried, their effectiveness and lessons.

12. The evaluation will also inform the implementation of the new HNP strategy concerning several new issues that were not anticipated in 1997:

- The impact of the increase in investments in single-disease programs by the Bank and other donors on HNP outcomes among the poor, on the efficient functioning of health systems and the synergy between health systems and vertical disease programs.[22]

- The Bank's changing role and value added, in light of the dramatic increase in development assistance for health (DAH) and the emergence of many new public and private grant sources.[23]

Evaluation Objectives and Scope

13. The objectives of the evaluation are to: (1) assess the development effectiveness of the Bank's support in improving health, nutrition, and population outcomes, particularly among the poor, since the 1997 HNP strategy; and (2) identify lessons from that experience to improve the efficacy of the Bank's support in the next decade. The evaluation provides a major opportunity to compare the varied experiences of national governments supported by the Bank, in an effort to learn how context, Bank-financed inputs, and other factors affect the success or failure of policies, programs, and approaches.

14. The evaluation will establish the trends in lending and development effectiveness for country-level Bank support to all three sub-sectors – health, nutrition, and population. It will focus primarily on support managed by the HNP sector (which constitutes the bulk of lending commitments), supplemented by analyses of relevant support from other sectors with an objective of improving HNP outcomes (notably water supply and sanitation projects and multi-sectoral Poverty Reduction Support Credits, PRSC), particularly among the poor. As IEG has recently assessed the Bank's support for global and regional programs,[24] including those in health, the current study will evaluate the Bank's HNP support at the country level. In the context of the evaluation, "support" includes policy dialogue, analytic work, and lending.

Main evaluation questions

15. The main task of the evaluation is to assess the *development effectiveness* of the World Bank's support for HNP outcomes over the past decade – in terms of its relevance, efficacy and efficiency. What have been the objectives of this support? Has the support been relevant, addressing the borrower's priorities and the Bank's strategies? How effectively has the support contributed to achieving its objectives? Have the programs and policies supported been efficient in design, cost-effective in implementation? Have the weaknesses identified in the 1999 OED evaluation been satisfactorily addressed?

What accounts for the declining outcome ratings of the HNP sector in the past decade compared with other sectors?

16. Beyond these fundamental portfolio-wide issues, the evaluation will address four questions linked to the priorities of the former and current HNP strategies:

17. **First, how effective has been the Bank's support in improving health, nutrition, and population outcomes among the poor?** To what extent have Bank projects and analytic work explicitly addressed HNP outcomes in general, and specifically among the poor? How have projects gone about targeting the poor? To what extent have the Bank's country strategies taken into account the potential contribution of sectors beyond HNP to improve outcomes? What strategies or approaches have been used in different settings? Have they succeeded in improving the access of the poor to HNP services? Have they improved HNP outcomes, on average or among the poor?

18. **Second, what lessons have been learned about the efficacy, advantages, and disadvantages of various approaches in different settings?** Examples of these approaches include:

- Programs to "strengthen" or "reform" the health system, including decentralization, health insurance, regulatory frameworks and contracting with the private sector, and health finance reform;
- Sector-wide approaches, designed to improve ownership, reduce transaction costs and improve the allocation of resources;
- Control of communicable diseases that disproportionately affect the poor; and
- Approaches relying on inter-sectoral contributions or collaboration[25]

19. **Third, what have been the revealed "strengths", "value added", "comparative advantages" or "contributions" of World Bank support for HNP in developing countries over the past decade, and how is that changing?** What has been the contribution of the Bank's HNP support – in terms of policy dialogue, analytic work, and lending – relative to the counterfactual of no Bank support? How do the views of government and of other partners differ in this regard? How significant has the Bank's finance of HNP been in relation to overall finance of the sector? How effectively has the Bank used its support to leverage policy reform? How, if at all, has this picture changed over the past decade, given: (a) the surge in DAH, most of it in grant form, and the emergence of new actors; and (b) the new emphasis on working through country-level partnerships?

20. **Finally, in light of the focus of the new HNP strategy on results,[26] the evaluation will examine the extent to which the Bank's HNP support has monitored results and used evaluation to improve the evidence-base for decision-making.** What share of Bank projects have been designed in the absence of baseline information on outputs, financing or outcomes that are an objective of the project? How frequently are relevant outputs and outcomes tracked over time, in a manner that allows an analysis of trends? Are pilot projects being evaluated before they are generalized? Is evaluation

being used as a management tool? What are the main constraints to better M&E for HNP support? In projects with good M&E where decisions are guided by evidence, what incentives or capacity-building activities were associated with this result, for the Bank and/or the Borrower?

Evaluation design

21. The evaluation will compile evidence from the literature and the portfolio of Bank support and will collect new data from the field in the form of additional Project Performance Assessment Reports (PPAR) and case studies in 4-6 countries. Surveys of staff and stakeholders will also be conducted, as appropriate. The HNP evaluation will be coordinated closely with the parallel IEG evaluation of Poverty Reduction Support Credits (PRSC), which will examine in greater depth the efficacy and lessons learned with respect to achieving HNP results through this multi-sectoral development policy lending tool. These will constitute the primary 'building blocks' for the evaluation.

22. **Desk studies** will include, but not be limited to:

- A review of the World Bank's objectives and strategies in the HNP sector and an assessment of the objectives, strategies, and development effectiveness of the portfolio of projects with HNP objectives, managed by the HNP sector board and other selected sectors.
- Analysis of the extent to which HNP outcomes among the poor have been explicitly addressed in Country Assistance Strategies and the extent to which CASs have brought to bear the contribution of diverse key sectors in improving HNP outcomes, where appropriate. This analysis will also be informed through review of CAS Completion Reports and IEG Country Assistance Evaluations (CAE).
- An inventory of analytic work in HNP, and an assessment of the extent to which it has been brought to bear on the objectives of the 1997 strategy.
- An analysis of trends in HNP outcomes among the poor in low- and middle-income countries receiving Bank HNP support, using data from Demographic and Health Surveys (DHS) and Living Standards Measurement Surveys (LSMS).
- Review of the literature on the main themes of the evaluation, such as: the advantages, disadvantages, and efficacy of SWAPs; vertical disease programs and health systems; the efficacy of foreign aid for health; and other evaluation themes.

23. **Field work**. Additional evidence will be collected from the field through two instruments: (a) "enhanced" PPARs on recently completed projects that exemplify the various approaches to improve outcomes among the poor; and (b) country case studies, in countries where there are no recently completed projects suitable for a PPAR and where non-lending support has dominated. In both cases, the field work will assess the objectives, strategies, and achievements of the entire portfolio of support for improving HNP outcomes (in HNP and other key sectors) over the past decade to directly address the relevant evaluation questions. Through data collection and interviews, the field studies will attempt to establish a "results chain" linking inputs to outputs, outcomes, and

impacts, and will assess the likely 'value added' of the World Bank's support, relative to the counterfactual of no Bank support.

24. The countries selected for in-depth field work for the HNP evaluation will be drawn from the tentative list of countries below, which is based on a preliminary review of the relevance of the HNP portfolio in each country to the main evaluative questions and an attempt to ensure regional coverage and inclusion of both low and middle-income countries (Table 2).

Table 2. Countries under consideration for in-depth field work, HNP evaluation

	Developing region					
Country income	**Africa**	**Latin America**	**East Asia & Pacific**	**Eastern Europe & Central Asia**	**Middle East and N. Africa**	**South Asia**
Low	Eritrea[b,c] Malawi[b,c,e] Senegal[b,c,d,e,f] Zambia[a,b,c]	Bolivia[c,d]		Kyrgyz Republic[a,b,c] Tajikistan[b,c]		Nepal[a,c,d,e]
Middle		Argentina[b,c,f] Dominican Republic[b,c] Peru[c,d,f]	China[b,c,f]		Egypt[b,c,e]	

Note: IEG has already conducted extensive fieldwork in Ghana (PPARs on three HNP projects, including a sector-wide approach, population, health reform, and communicable disease support) and Bangladesh (PPARs on 3 projects, including a sector-wide approach, health reform, population, and nutrition support, and an impact evaluation of maternal and child health and nutrition interventions).

a. Support that featured a "sector-wide approach".
b. Support in the form of a communicable disease component or freestanding disease project.
c. Support with a "health reform", health financing, or health insurance focus.
d. Support as part of multi-sectoral programmatic lending.
e. Support with population/reproductive health objectives.
f. Support with nutrition objectives.

25. **Peer review.** All of the intermediate outputs (background studies, portfolio reviews, case studies, PPARs) will be subjected to formal peer review and made available at least in draft form for comment. Peer reviewers from within and outside IEG and the Bank will also be identified to review and provide feedback on the overall, consolidated evaluation report before it is finalized.

Relation to other IEG and partner activities

26. The design and field work for the HNP evaluation will be closely coordinated with and will draw on findings from the parallel IEG evaluation of PRSCs, which will examine the efficacy of this multi-sectoral programmatic lending instrument in terms of achieving HNP outcomes under varying country conditions, in parallel with or as a substitute for traditional investment projects.[27] The HNP evaluation will also draw on findings from other recently completed PPARs of HNP projects with objectives or strategies relevant to the evaluation;[28] HNP impact evaluations;[29] working papers;[30] CAEs; and thematic evaluations.[31]

27. IEG-IFC will be evaluating the IFC's technical assistance and investment support to the private sector for health, including the pharmaceutical sector, and its findings will be incorporated in the report, as appropriate. In particular, the case studies for the HNP evaluation will consider the synergy between the IFC and World Bank investments and policy advice, in countries in which both of these agencies have been active.

28. The HNP evaluation will take into consideration findings of other recent or ongoing evaluations of HNP or disease control of other bilateral and multilateral donors[32] as well as evaluations of Bank-supported reforms or interventions in the published literature.[33]

External Advisory Panel

29. An External Advisory Panel of 3-4 experts will be identified at the evaluation's inception and convened twice: (a) to comment on Phase I outputs and advise on issues of research design for the field work; and (b) to comment on the case studies and first draft of the final report. They will collectively submit a statement on the final evaluation report, to be included as an annex.

Timing and budget

30. The evaluation will take place in two phases over 15 months, according to a timeline that balances the need for immediate results to guide the implementation of the new HNP strategy with the need for high-quality, in-depth field work to discern the relevant lessons from this complex and evolving sector (see the timeline, Annex D).

- During the first phase, from June–October 2007, key desk reviews will be completed, including reviews of lending and analytic work, analysis of the inter-sectoral use of the CAS for HNP outcomes, literature reviews and background papers. This will culminate in a workshop on the findings and the release and dissemination of an in-depth review of the HNP portfolio in October 2007. Also during the first phase, background work will be conducted on the short list of countries identified for case studies, on the basis of which a selection can be made.
- Issues raised by the portfolio review and background studies will then be addressed through field work in the second phase, in the form of country case studies and enhanced PPARs, from October 2007 – February 2008, with the write-up of the draft final report consolidating Phase I and II results, through May 2008.[34]

Peer review and review meetings by the External Advisory Panel and IEG management will take place in June 2008. Taking into account revisions, submission to and review by World Bank management, and follow-on revisions, the target date for submitting the final report to CODE is in the first half of **October 2008**.

31. The total cost of the evaluation, including contingencies, is estimated at $796,600, of which $200,000 is to be funded under the Norad Partnership.[35] Dissemination costs, which are difficult to estimate at this stage, would add another $100,000-$150,000.

Dissemination

32. The interim outputs and final report will be disseminated widely to internal and external audiences. With respect to internal dissemination, copies will be made available to all staff members and interim and final outputs will be presented to the relevant sector boards and to staff at Human Development Week. With respect to external dissemination, the report will be provided to relevant policymakers in borrower countries and opportunities will be sought to disseminate the report at the Annual Meetings of the World Bank and at international professional meetings. Resources will be sought to make the full-length report available in French and Spanish, and the summary in additional languages.

Endnotes

[1] Shekhar and others 2006, p. 5.
[2] See, for example, Jamison 2006; Levine and others 2004.
[3] http://www.unicef.org/publications/index_23557.html
[4] Wagstaff and Claeson 2004, p. 36.
[5] Shekhar and others 2006, p. 3.
[6] Jamison and others 2006, p. 60
[7] Gwatkin, Wagstaff and Yazbeck 2005; Filmer 2003.
[8] For example, improving the quality and affordability of services, on the supply side, and providing information and incentives for behavior change, on the demand side.
[9] For example, provision of safer drinking water and better sanitary facilities.
[10] In constant 2006 dollars equivalent; in current dollars, total HNP lending was nearly $26 billion.
[11] IEG-IFC will be conducting a review of IFC's health and pharmaceutical sector portfolio for this study (see paragraph 27).
[12] Fair (forthcoming).
[13] World Bank 1997.
[14] World Bank 1997, Table E.2, pp. 74-77. This was about $13.5 billion in 1996 prices (p. 14).
[15] Johnston and Stout 1999. At that time, IEG-World Bank was known as the Operations Evaluation Department (OED).
[16] OED 2004, Lele and others 2004.
[17] OED 2005a.
[18] Of this amount, roughly $10 billion in 237 projects were managed by the HNP Sector Board.
[19] Universal access to reproductive health information and services (a goal of the 1994 International Conference on Population and Development in Cairo) was initially proposed as one of nine international development goals (IDGs). However, it was controversial and dropped when the IDGs were transformed into the Millennium Development Goals at the Millennium Summit in 2000 (White and others 2006, p.5)
[20] In the last 5-year period, only about two-thirds of projects managed by the HNP Sector Board were rated moderately satisfactory or better on outcomes, compared with 79 percent of projects managed by other sector boards. Both Bank and Borrower performance ratings for HNP projects are also significantly lower than for other sectors, while ratings on Institutional Development Impact are roughly just as low for HNP as for other sectors (53 percent substantial or better). See Annex A, Tables A-2 through A-5.
[21] The 1997 strategy advocated improved monitoring of development impact as one of the major internal World Bank actions to achieve greater impact (World Bank 1997). Both the IEG evaluations of HNP and HIV/AIDS highlighted a continuing lack of incentives for M&E, and hence the inability to link the inputs and outputs or projects or programs financed by the Bank to results on the ground (OED 1999, 2005a). Subramanian and others (2006) found that fewer than half of projects completed in the past 3 fiscal years produced measures of a trend in health service, financing, or health status outcomes over time. None

reported changes in the equity of use of health care. Among those that reported trends, virtually all reported positive trends, suggesting the possibility of selective reporting.

[22] Over the past five years, single-disease or single-condition projects represented nearly 40 percent of all new project approvals managed by the HNP Sector Board (Annex A, Figure A-6). Nearly 80 percent of single-disease/condition projects were for HIV/AIDS.

[23] The World Bank is no longer the single largest external source of HNP financing for low- and middle-income countries, as it was in the late 1990s. There has been a surge in bilateral support for HNP, as well as the emergency of new sources of funding, e.g., the Global Fund to Fight AIDS, TB and Malaria (GFATM), the President's Emergency Program for HIV/AIDS Relief (PEPFAR), the Global Alliance for Vaccines and Immunization (GAVI), the Bill and Melinda Gates Foundation, and the Clinton Foundation.

[24] OED 2004, Lele and others 2005, IEG 2007a.

[25] These approaches include: (a) multi-sectoral projects; (b) the positioning of separate projects in key sectors that collectively will improve health outcomes; and (c) projects in other sectors that sought to achieve health objectives.

[26] The 2007 strategy adopted a detailed results framework for the entire sector.

[27] The country cases for the PRSC evaluation will be selected from among the following list (all of which had HNP objectives in the PRSC): Armenia, Benin; Burkina Faso; Ghana; Lao PDR; Madagascar; Mozambique; Nicaragua; Rwanda; Tanzania; Uganda; and Vietnam.

[28] In particular, recent PPARs on projects financing SWAPs in Bangladesh and Ghana (see Annex C).

[29] Particularly the impact evaluation in Bangladesh (OED 2005b).

[30] Chamarbagwala and others 2004; Goh 2001; Johnston 2002; Lele and others 2004.

[31] In particular, evaluations of HIV/AIDS, Global Programs, Social Funds, Community-Driven Development, Low-Income Countries under Stress (LICUS), regional programs, transport, and others. See IEG 2006, 2007a, 2007b, and OED 1998, 2002, 2004, 2005a, 2005c.

[32] In particular: ongoing or completed evaluations of HIV/AIDS programs by DFID, Norway, and the US (PEPFAR); the recently completed evaluation of the African Development Bank's health portfolio; and the ongoing DAC joint evaluation of the Tanzania health SWAP.

[33] For example, the evaluation of the Integrated Management of Childhood Illness (IMCI, Bryce and others 2005), health reform in Mexico (e.g., Gakidou and others 2006), and projects or interventions in China (Dye and Watt 2004, Wagstaff and Yu *in press*, Xianyi and others 2005).

[34] This timing will also allow the HNP evaluation to benefit from the findings of the field-based case studies conducted for the PRSC evaluation.

[35] The Norwegian Trust Fund will be funding research assistance, portfolio reviews, background papers, two meetings of the External Advisory Panel, and partial funding of the case studies/field work.

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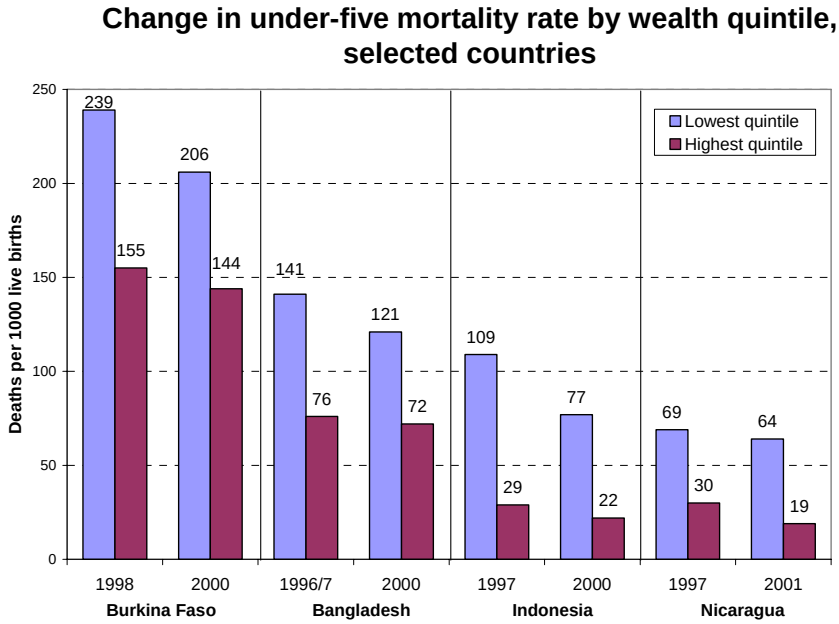
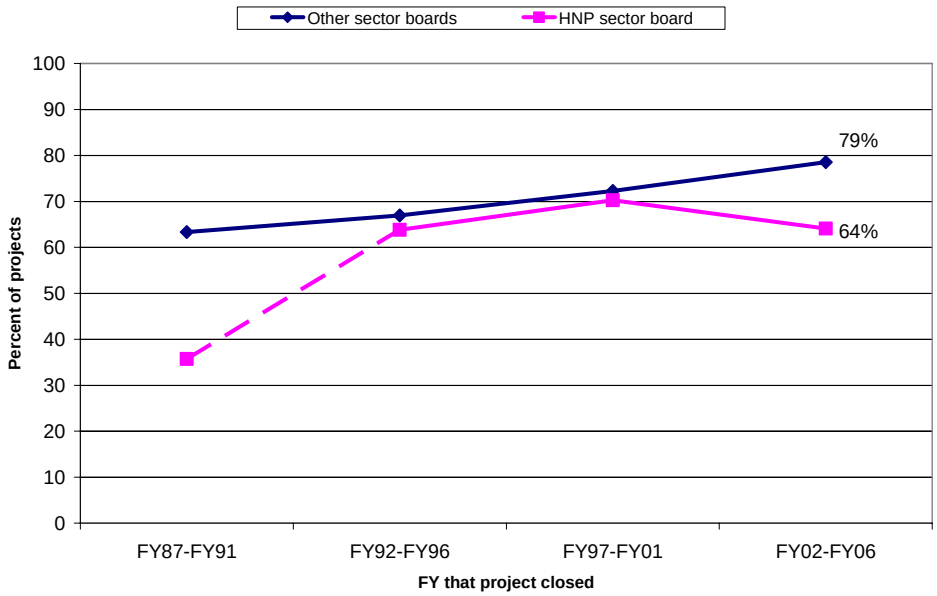
Annex A: Figures

Figure A-1. Change in under-five mortality rate by wealth quintile, selected countries



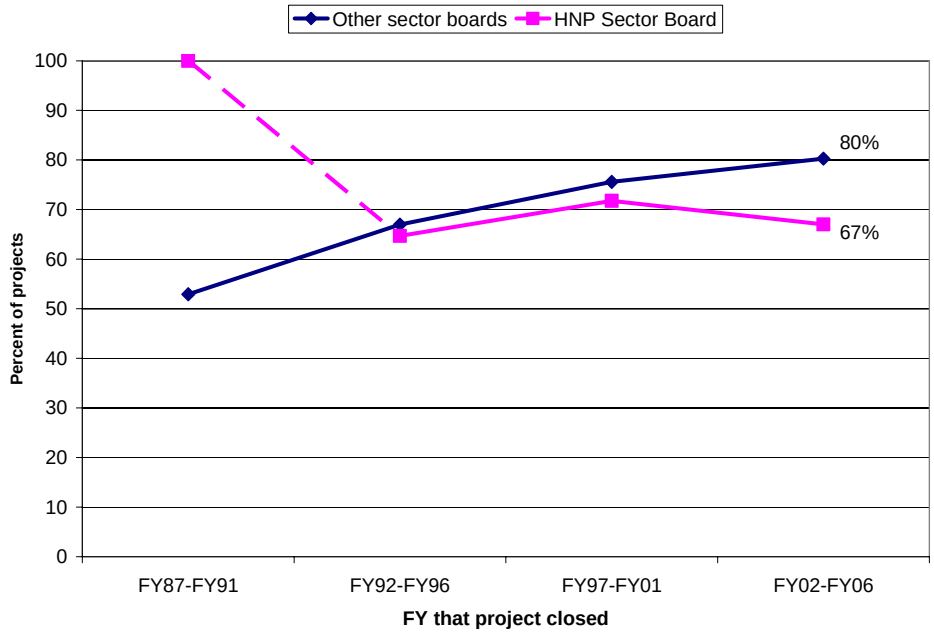
Source: Analysis of Demographic and Health Surveys (DHS), as reported on the *Reaching the Poor* website (www.worldbank.org/povertyandhealth).

Figure A-2. Percent of closed projects with outcome ratings of moderately satisfactory or better, HNP Sector Board and other sector boards



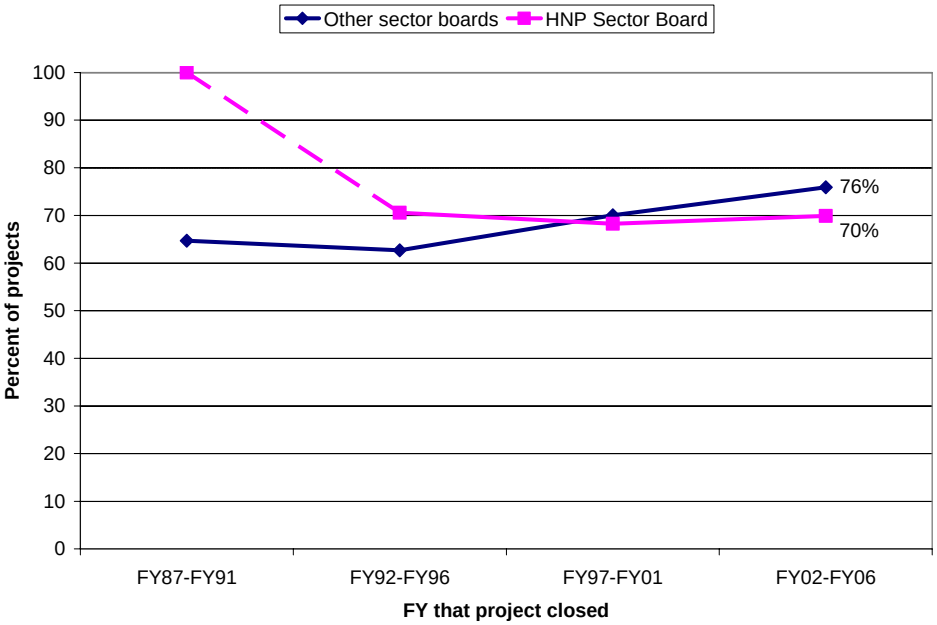
Note: Only 14 projects managed by the HNP sector closed in FY87-91.

Figure A-3. Percent of closed projects with Bank Performance rating of Satisfactory or higher, HHP Sector Board (HSB) and Other Sector Boards (OSB)



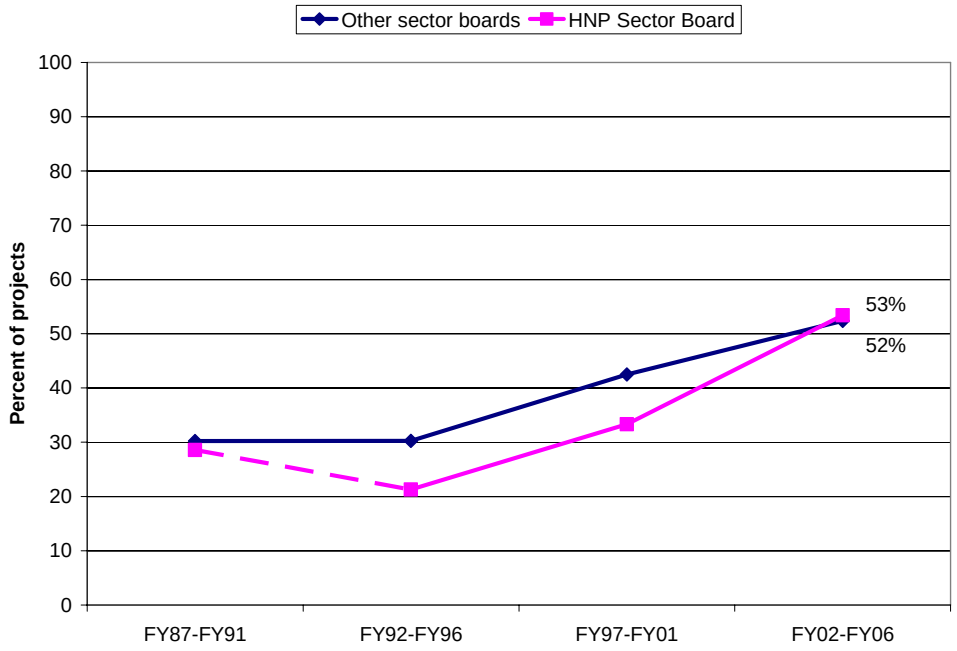
Note: Only 14 projects managed by the HNP sector closed in FY87-91.

Figure A-4. Percent of closed projects with Borrower Performance rating of Satisfactory or higher, HNP Sector Board (HSB) and Other Sector Boards (OSB)



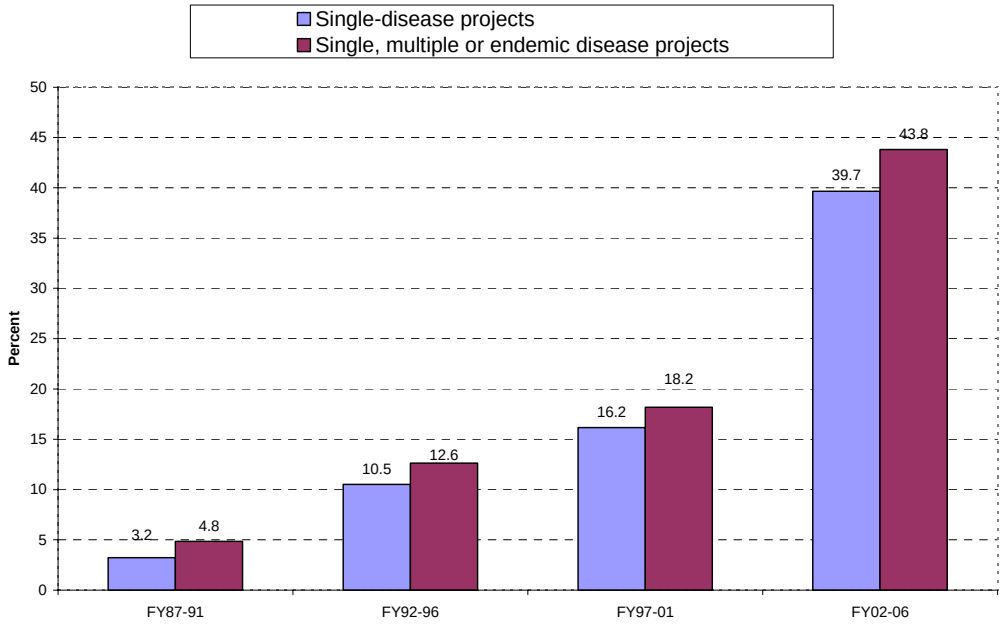
Note: Only 14 projects managed by the HNP sector closed in FY87-91.

Figure A-5. Percent of closed projects with Institutional Development Impact ratings of Substantial or higher, HNP Sector Board and Other Sector Boards



Note: Only 14 projects managed by the HNP sector closed in FY87-91.

Figure A-6. Single and multiple disease projects* as a percent of all approved HNP Sector Board Projects, FY87-06



* Freestanding disease projects -- excludes HNP projects with disease components.

Annex B: Objectives, strategies, and main features of the 1997 and 2007 HNP strategies

	1997 HNP Strategy	2007 HNP Strategy
Objectives	(1) **Improve health, nutrition, and population outcomes of the poor**, and protect the population from the impoverishing effects of illness, malnutrition, and high fertility (2) **Enhance the performance of health care systems** by promoting equitable access to preventive and curative HNP services that are affordable, effective, well-managed, of good quality, and responsive to clients. (3) **Secure sustainable financing** by mobilizing adequate resources, broad risk-pooling mechanisms, effective control over public and private expenditure	**(1) Improve the level & distribution of key HNP outcomes, outputs and system performance** at the country and global levels in order to improve living conditions, particularly for the poor and vulnerable. **(2) Prevent poverty due to illness** **(3) Improve financial sustainability in the HNP sector** and its contribution to sound macroeconomic and fiscal policy and to country competitiveness. **(4) Improve governance, accountability and transparency** in the health sector.
Strategies	**Objective 1**: ▪ Design and monitor programs that improve outcomes of the poor, by: use of targeting mechanisms;[a] emphasis on the most vulnerable; support for preventive public health activities with large externalities ▪ Stimulate demand for health services among the poor ▪ Improve population policy, family planning, and other reproductive health services to increase the demand for smaller family size and reduce unwanted fertility ▪ In low-income countries, make food more affordable, increase the efficiency of food markets, provide nutrition safety nets. ▪ Address multi-sectoral issues affecting health indirectly,[b] support social policies for greater gender equality, improved status of women. ▪ Improve donor coordination/harmonization in very low income countries via sector-wide approaches • Support inter-country and regional approaches to HNP issues **Objective 2:** Sector-wide reforms. ▪ Raise efficiency in use of scarce resources (through better policymaking, governance, market incentives, public-private mix of services, management, decentralization, accountability) ➢ In *low-income countries*, where most health care is provided by the private sector: provide health services with large externalities (preventive public health services), essential clinical services for the poor, and more effective regulation of the private sector. ➢ In *middle-income countries* and *low-income countries* where health care is predominantly provided by the public sector: promote greater diversity in service delivery by funding civil society and non-governmental providers on a competitive basis; use quasi-market mechanisms[c] to improve public sector performance and quality participation by the private sector.	*The 2007 HNP strategy does not appear to update the strategies for countries to achieve these objectives. It does mention, with respect to objective (2), the need to improve financial protection.*

	1997 HNP Strategy	2007 HNP Strategy
	▪ Improve the effectiveness of government policymaking, sectoral management, outcome evaluation and regulation, generating knowledge about improving access, the effectiveness of interventions, efficiency in managing services, quality control, and responding to client needs **Objective 3**: ▪ Help countries secure sustainable *recurrent* financing for HNP, using a mix of taxation instruments and copayments tailored to each country. ➢ In *low-income countries*, complement public resources with community-based and international assistance. ➢ In *middle-income countries*, use taxation instruments to mobilize financial resources and expand risk pooling. ▪ Help governments to maintain effective expenditure control • Ensure that the HNP budget envelope is used on effective and quality care that benefits those who need it the most; develop improved budget allocation processes at the national and local level	
Bank's comparative advantages	The Bank's "strengths" (p. 10): • Global expertise • Multi-sectoral, macro-level country focus • Ability to mobilize large financial resources (either directly or through partnerships) The Bank's 'value added' in HNP: "one assessment of the impact of the Bank's activities shows that most foreign aid to the HNP sector simply substitutes for government spending. The real source of aid effectiveness in HNP is, therefore, the reforms resulting from policy advice that accompany lending, not the loans themselves." (p. 13)	The Bank's "special strengths (comparative advantages) for providing policy and technical advice to client countries and global partners…" include its: (p. 21) • "health system strengthening capacity in areas of health financing, insurance, demand-side interventions, regulation, and systemic arrangements for fiduciary and financial management." • "intersectoral approach to country assistance" • "advice to governments on regulatory framework for public and private collaboration" • "capacity for large-scale implementation of projects and programs" • "convening capacity and global nature" • "pervasive country focus and presence" "[C]ore economic and evaluation analytical capacity is also a Bank comparative advantage". The Bank has little comparative advantage in "the micro issues of health service delivery and provider organization" (p. 47)
Bank's actions	(1) **Sharpen strategic directions**: resources for HNP participation in CAS preparation; reverse cutbacks in country sector work; link Bank's research agenda to HNP priorities; selectivity in operations (2) **Greater impact** (improve quality)—(a) emphasize strategic policy directions (CAS) in high-level policy dialogue; (b) underpin lending w/analysis and research (rigorous pilot projects that are evaluated, more sectoral analysis); (c) increasing selectivity (complementarity w/donors, concentrate on poorest countries); (d) improving client services (help desks/databases, closer scrutiny of the portfolio & restructuring, more flexible lending instruments – *SWAPs and DPLs*); (e) Monitoring development impact (measuring outcomes, development of performance indicators for health	**(1)** Renew Bank focus on **HNP results.** **(2)** Increase Bank contribution to client-country efforts to strengthen and realize **well-organized, sustainable health systems for HNP results.** **(3)** Ensure **synergy between health system strengthening and priority-disease interventions**, particularly in LICs. **(4)** Strengthen Bank capacity to advise client countries on an **intersectoral approach to HNP results.** **(5)** Inrcease selectivity, improve strategic engagement, and reach **agreement with global partners on collaborative division of labor** for the benefit of client countries. The strategy also describes a decline in staff with

	1997 HNP Strategy	2007 HNP Strategy
	systems) (3) **Empowering Bank HNP staff** (4) **Building partnerships**	economics skills and the decline in experienced staff. However, no explicit solution is proposed.
Multi-sectoral ap-proaches	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" – it sets the agenda for the Bank's future work at the country level in the HNP sector, including sectoral analysis and lending. However, "currently, the analytical framework used to underpin most CAS recommendations does not include quantitative variables for human capital or labor productivity, both of which are influenced by HNP outcomes and educational attainment". • CASs don't address financial sustainability and manpower issues in the HNP sector as part of discussions on public finance and civil service reforms. • CAS needs to discourage subsidies of unhealthy agricultural products & untargeted food compensation programs. • Need to encourage use of taxation instruments to combat tobacco use.	To achieve HNP results on the ground "countries need to articulate a response from multiple sectors that influence HNP results". (p. 20). Strengthening "Bank capacity to advise client countries on an intersectoral approach to HNP results" is one of the strategic directions.
Monitor-ing and evalua-tion	More attention to monitoring outcomes. Annex A has issues and indicators, but indicators for performance of health systems are weak. Bank "will work with other organizations to develop more effective indicators, increase incentives to encourage their use, and include monitoring and evaluation components as integral parts of project design." (p. 21)	"HNP results encompass not only HNP outcome indicators… but also health system performance, as reflected, for example, in financial protection and utilization of essential health services by the poor." (p. 18) "Measuring results requires systems for close and effective monitoring and evaluation, which are effectively linked to policy design and management." (p. 19) The strategy includes a detailed Results Framework for the sector, intended as a guideline (not a template).

Annex C: IEG Project Performance Assessment Reports on HNP projects

Bangladesh: Fourth Population and Health Project (Credit 2259) and Health and Population Program Project (Credit 3101), June 23, 2006; Integrated Nutrition Project (Credit No. 2735), June 13, 2005.

Brazil: First and Second AIDS and STD Control Projects (Loan Nos. 3659 and 4392), April 27, 2004.

Cambodia, Kingdom of: Disease Control and Health Development Project (Credit No. N005-KH), April 21, 2004

Chad: Population and AIDS Control Project (Credit No. 2693), March 7, 2005

Estonia: Health Project (Loan No. 3835), November 14, 2001.

Ghana: AIDS Response Project (GARFUND, Credit No.3458), June 20, 2007; Second Health and Population Project (Credit No. 2193) and Health Sector Support Program (Credit No. 2994), forthcoming.

Hungary: Health Services and Management Project (Loan No. 3597), December 12, 2001.

India: National AIDS Control Project (Credit No. 2350), July 2, 2003.

Indonesia: HIV/AIDS and STDs Prevention and Management Project (Credit No. 3981), June 13, 2005.

Kenya: Sexually Transmitted Infections Project (Credit No. 2686), October 15, 2002.

Romania: Health Services Rehabilitation Project (Loan No. 3409), February 27, 2002.

Russian Federation: Health Reform Pilot Project (Loan No. 4182), March 2007.

Uganda: District Health Services Pilot and Demonstration Project (Credit No. 2679), April 3, 2006, and Sexually Transmitted Infections Project (Credit No. 2603), June 14, 2005.

Vietnam: Population and Family Health Project (Credit No. 2807), July 5, 2006.

Zimbabwe: Sexually Transmitted Infections Prevention and Care Project (Credit No. 2516), June 21, 2002.

Annex D. Timeline for preparation of the evaluation

Activity	Timing
Phase I – Portfolio reviews	
Approach paper to CODE	June 2007
Portfolio reviews, CAS analysis & background papers	May – October 2007
Workshop and deliverables for Phase I	**October 2007**
Phase II – Field work	
External Advisory Panel meeting	September 2007
Field work: Case studies and PPARs	October 2007-February 2008
Workshop on case study findings[a]	February 2008
Writing the first draft of the final report	March – May 2008
Draft final report to IEG management	**June 2, 2008**
Review/revisions of the final report	
External Advisory Panel meeting	June 9, 2008
Review by IEG management	June 9, 2008
Report to WB management	July 30, 2008
Comments received from WB mgt	September 15, 2008
Final report to CODE	**October 15, 2008**
Dissemination	
Publication of the report/launch	Tbd[a]
Dissemination to internal and external audiences	January – March 2009

a. Workshop to be held jointly with the IEG PRSC evaluation case study team.

b. Timing depends on the timing of the CODE meeting. Likely by January 2009.