HNP DISCUSSION PAPER

Investing in the Best Buys

A Review of the Health, Nutrition, and Population Portfolio, FY 1993-99

Mariam Claeson, Tazim Mawji and Christopher Walker

December 2000

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Health, Nutrition and Population (HNP) Discussion Paper

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ACRONYMS

ARI	Acute Respiratory Infections
BCG	Bacillus Calmette-Guérin
CDD	Control of Diarrheal Diseases
DOTS	Directly Observed Treatment Short-course
EOC	Essential Obstetric Care
FRESH	Focusing Resources on Effective School Health
HNP	Health, Nutrition, and Population
HSD	Health Systems Development
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
MMR	Maternal Mortality Rate
NGO	Non-Governmental Organization
PAD	Project Appraisal Document
PCD	Project Concept Document
PRSP	*Poverty Reduction Strategy Paper: HNP Sourcebook*
RCH	Reproductive and Child Health
SAR	Staff Appraisal Report
SWAps	Sectorwide approaches
SSP	*HNP Sector Strategy Paper*
STD	Sexually Transmitted Disease
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WDR	World Development Report
WHO	World Health Organization

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The comments by the HNP Sector Board members helped to finalize the report and to initiate actions to implement the recommendations and further the understanding of the factors involved in defining and investing in the "best buys."

FOREWORD

This review of the "best buys" in the Health, Nutrition, and Population portfolio, FY1993–99, shows that content as well as process must receive attention in health systems development in order to achieve increased access to quality health services. The report suggests that significant gains can be made and measured within existing lending by increasing our efforts to identify and invest in the best buys.

The report describes the Bank's mixed lending for the best buys, ranging from direct support to public health and clinical services (i.e., investment in disease control programs) to health systems strengthening (i.e., investment in surveillance and pharmaceutical systems, managerial and technical capacity building) that indirectly support delivery of basic services. This partly explains the difficulty quantifying the financial investment in specific best buys, which this study does not attempt to do. Neither does the report prescribe that the public health and clinical services included in this study are the only best buys or that all projects should invest in them. The choice will depend on the project's outcome objectives, the major risks to health identified among the poor, and the context.

For example, if maternal mortality rates are high, attention has to be given to essential obstetric care and other key elements that determine maternal mortality but for which coverage rates are low. If child mortality rates remain high, an integrated approach that includes all major killers as well as nutritional determinants needs to be defined to make a difference in health outcomes. If HIV/AIDS is an important problem, then multiple interventions, as defined in the report, are required. Just more of the same will not do.

The participatory process involved in the preparation of this report and the recommendations that evolved from wide consultations with operations staff have resulted in actions to increase our investment in the best buys. For example, fact sheets on the best buys are being prepared for use in knowledge management, training, and distance learning. The best buys are included in the *Poverty Reduction Strategy: HNP Source Book* and in the simplified guidelines used in PRSP training activities in the context of the Heavily Indebted Poor Countries initiative. For two of the best buys, costing tools for planning have been prepared and field-tested in collaboration with partners. Work is also under way with partners to scale up some of these critical interventions for improving health outcomes of the poor, for example, immunization coverage.

The Health, Nutrition, and Population network is developing its roster of resource persons with technical competence in the specific intervention areas. The World Health Organization and other partners are seconding technical specialists in the promotion of best buys in reproductive health services, tuberculosis control, school health, immunization, integrated management of childhood illness and nutrition, and malaria treatment and prevention. The World Health Organization and the Bank have conducted joint training to build capacity for technical input in Bank operations—resulting in

intensified collaboration at country level and increased investment in the best buys. The project-specific information generated in this study is being organized by region, to be shared with all the regions to deepen review and analysis of factors influencing the portfolio.

We hope this report will be a timely contribution to our ongoing efforts to enhance the quality and improve the performance of our portfolio, in collaboration with our clients and partners.

James Christopher Lovelace
Director
Health, Nutrition and Population
Human Development Network

EXECUTIVE SUMMARY

The major conclusions of this report are:

- Within the existing Health, Nutrition, and Population (HNP) portfolio, major gains toward achieving improved health outcomes of the poor can be made by focusing more explicitly on the core set of interventions that make up the "best buys," linking project inputs with health outcomes.

- Information is limited on the public health and clinical services in which the Bank invests. A major strategy of the HNP sector is to increase access to basic services for the poor; however, knowledge is insufficient about the definition and coverage of those services.

- Overall, an estimated 38 percent of the new HNP projects in FY1993–99 are known to support the provision of at least one of the best buys in public health and clinical services in client countries, according to project documents and validation by task managers and sector specialists.

- The Bank is the largest source of external assistance in major areas of public health such as in reproductive and child health services, school health, and HIV/AIDS programs. There are consistent gaps in the comprehensive set of interventions defining quality that are needed to achieve the full potential effect on health outcomes, for example, the lack of essential obstetric services in reproductive health programs.

- A major thrust in the HNP sector is health reform or health systems development (HSD). Only about 20 percent of health reform projects have defined the basic services that could facilitate linking project budget allocations with health outcomes. However, some HSD projects support public health functions that are critical for sustainable implementation of the best buys, for example, surveillance and pharmaceutical systems.

The recommendations to the HNP network are to:

- Share the review findings with task managers and technical specialists in the form of a short and concise guide on the best buys. This guide should be linked to the knowledge management system and training in basic public health and Poverty Reduction Strategy work.

- Review the data in greater depth at regional level to better understand why some projects explicitly define and/or support the best buys and other do not. Spreadsheets with the report data organized by region should be distributed to the HNP Sector Board members for their follow up with regional staff.

- Examine a few large countries as case studies to establish good practice and to show the role of process and content in selecting and setting priorities for best buys.

INVESTING IN THE BEST BUYS—A Review of the Health, Nutrition, and Population Portfolio, FY1993–99

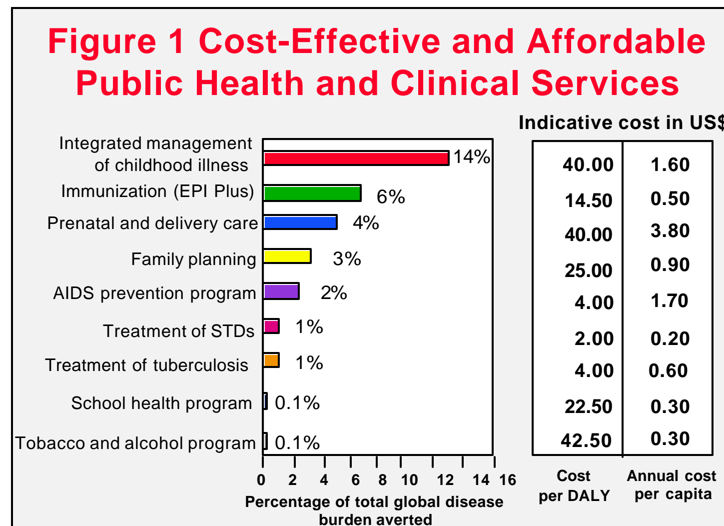
"Doing the right thing as well as doing it right"

1. Introduction

The Bank's Health, Nutrition, and Population (HNP) objectives are to assist countries in improving the health of the poor; to protect the population from the impoverishing effects of illness, malnutrition, and high fertility; and to enhance the performance of health care systems. A major strategy to meet these objectives is to promote equitable access to preventive and curative services that are affordable, effective, well managed, of good quality, and responsive to clients' needs (1,2World Bank 1993a and 1997a).

Public health and clinical services that are affordable, effective, and of good quality were identified in the 1993 *World Development Report: Investing in Health (WDR),* in the *HNP Sector Strategy paper (SSP),* and in the World Bank Institute Flagship Course on Health Sector Reform and Sustainable Financing module: Designing a Benefits Package (World Bank 1993a, 1997a; McLaughlin 1997; and Bobadilla and Cowley 1995). Figure 1 illustrates some potentially cost-effective and affordable public health and clinical services.

Figure 1 Cost-Effective and Affordable Public Health and Clinical Services

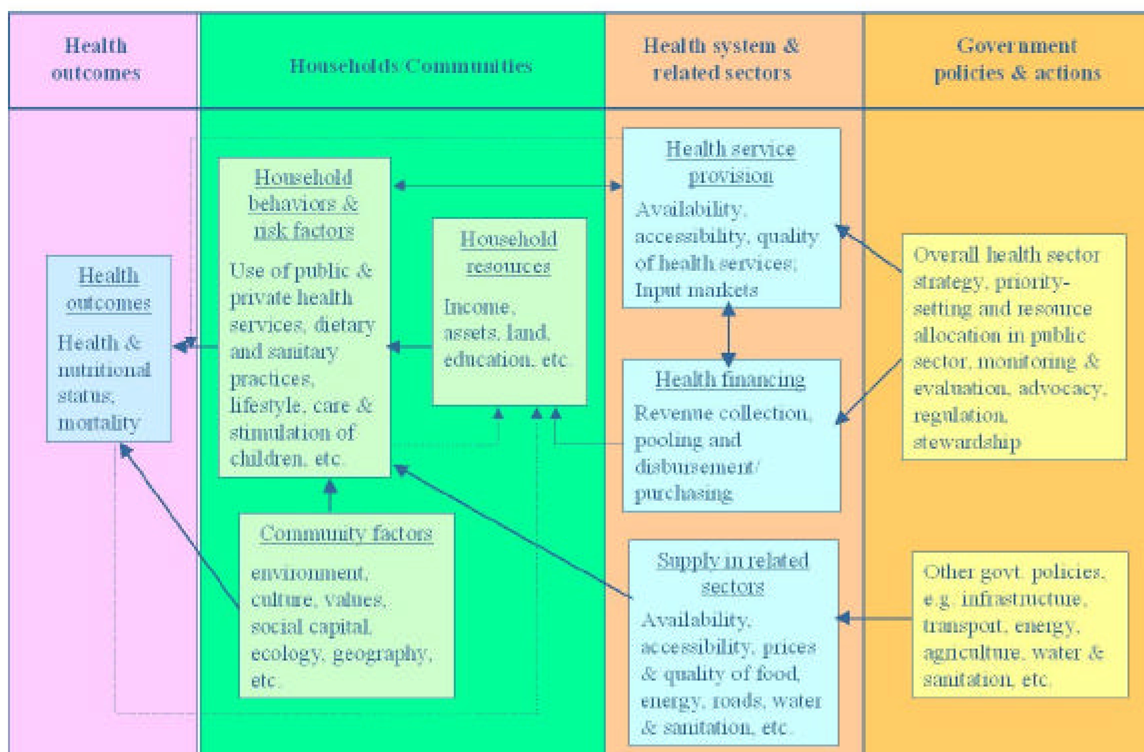


DALY disability-adjusted life years
Source: World Bank 2000a. HNP Sector Strategy Paper, World Bank, 1997.

These programs and services represent the state-of-the art in public health knowledge and technology, e.g., in AIDS prevention programs, family planning, immunization (EPI Plus), integrated management of childhood illness (IMCI), prenatal and delivery care, school health programs, treatment of sexually transmitted diseases (STDs), tuberculosis, and tobacco and alcohol programs. They rank high in terms of their potential to avert a large part of the global disease burden and in their relatively low cost per disability-adjusted life year and annual cost per capita. Some interventions that make up these public health programs and clinical services have been developed, based on well-designed efficacy, effectiveness, and feasibility studies. Other core interventions, however, still need to be more clearly defined and tested. Some of the cost-effectiveness estimates will need further validation through well-designed research studies of impact and cost-effectiveness. In some intervention areas, such studies are already in progress. A few of these programs and services have been widely implemented. Others are still being introduced and need to be expanded beyond small-scale operations.

In addition to affordability and cost-effectiveness, common elements of all of the priority-ranked public health and clinical services—the best buys—are their likelihood (causal or plausible) to influence health outcomes significantly, their feasibility of implementation, and their relevance for the health status of the poor, as shown in Figure 2 (Claeson, et al., 2000). This review focuses on the critical link between health policies (identification and priority setting of basic health services at different levels of care) and health services provision and use. Some of the best buys include household behavioral change interventions (e.g., AIDS prevention, integrated management of childhood illness at community level, and school health).

Figure 2 Determinants of Health Outcomes



Source: World Bank 2000a.

As shown in the figure, effective implementation depends on multiple factors that influence behavioral change at community and health facility level. Establishing standards and treatment protocols for different levels of care and referral, training guidelines and educational messages, and building managerial and technical capacity are all necessary, but insufficient, steps in effective implementation of most essential preventive and curative services. To ensure effective implementation, all basic preventive and curative services need to be reviewed in the context of national priorities. They should then be adapted to local needs and contextual factors and be made widely available—especially among the poor.

Focusing on health outcomes in policy dialogue and planning is one way to ensure that the best buys in public health and clinical services are identified and made available. Optimally, health reform and sectorwide approaches provide the context for such policy dialogue and priority setting, as does district-level planning procedures that are guided by local needs and informed choice. In the context of debt reduction, the *Poverty Reduction Strategy Paper: HNP Sourcebook (PRSP)* provides a process for such a dialogue, priority setting, and enhanced efforts to increase access to the best buys.

Finding out the extent to which the target populations *effectively utilize* essential public health and clinical services would require well-designed household surveys, which are beyond the scope of this study. The information available in Bank project documents is scarce. Task team members, the primary sources of detailed information, often acknowledge that they do not know the extent to which specific, discrete interventions are being implemented

The common disconnect between economic analysis and the stated developments goals and outcomes, and outputs and project inputs, often make assessment of project *impact* difficult. This has proven to be a major challenge in attempts to assess the impact attributed to specific interventions and programs and in efforts to more broadly evaluate the sector (Stout, et al., 1997). The task is also made difficult by the lack of commonly agreed definitions and descriptions of public health and clinical services, the absence of a standard framework for evaluation and monitoring, and sometimes by a discrepancy between project documentation and intent and what actually happens on the ground.

This study assesses one of the prerequisites for an effective HNP portfolio on the ground: project identification of technically sound and potentially cost-effective public health and clinical interventions that benefit the poor. Although this study of "content" does not investigate in depth the "hows" and "whys," it explores some of the answers to why only part of the current HNP portfolio includes state-of-the-art public health and clinical services to help bridge the gap between knowledge and practice.

This review tries to assess whether or not we are "doing the right thing" to complement the work of others in operations and in health systems development who are trying to ensure that we are "doing it right."

2. Objectives and Rationale

The objectives of the study are to:

- Assess the extent of the Bank's support to basic services and the identification and implementation of the best buys.
- Identify factors contributing to technical quality and state-of-the-art planning and implementation of basic services.
- Recommend ways of improving the quality of services that the Bank supports in its HNP portfolio, thereby increasing the likelihood of significantly influencing health outcomes.

Several issues triggered this review of best buys in the Bank's HNP portfolio:

First, the need to better understand the magnitude of the Bank's support to essential public health and clinical services—the best buys—and their influencing factors. Task team leaders and members, other technical staff and managers in the Bank as well as partner agencies, and donors often request information about the Bank's support to specific programs or interventions. HNP standard data bases and project documents are commonly used as the primary source of such information. However, when operations staff are asked to provide information, they often describe a much more complete picture—not always reflected in the project preparation and supervision reports but sometimes confirmed by special reports with only limited circulation. Thus, one of the primary purposes of this review is to flesh out the picture of the HNP portfolio content.

Second, there is a common perception that some health problems are being adequately addressed, notably childhood communicable diseases and maternal and child healthcare services. This notion is often reinforced by global epidemiological projections (Murray and Lopez 1996). However, when these projections are reviewed from a poverty perspective, a different picture emerges, one in which the unfinished agenda of maternal and child health and nutrition remains prominent among the poor in most parts of the developing world (Gwatkin and Guillot 2000).

Third, *WDR-93* recommendations have been around for quite a while. But, to what extent have the affordable and potentially cost-effective interventions that were recommended been incorporated into the Bank's business? The answer to this question has become increasingly relevant because the primary health care strategy's lack of measurable impact is sometimes attributed to shortcomings in the specific interventions identified in the *WDR* instead of to flaws in the application of implementation strategies, service delivery modalities, institutional arrangements, or other health system development factors. Without knowing the extent to which the best buys have been implemented, valid judgments about their effectiveness and impact—or lack thereof—cannot be made.

Fourth, health reform and sectorwide approaches (SWAps) provide new opportunities and challenges for implementation of public health and essential services. The extent to which the health reform process and SWAps are guided by health outcomes and a defined set of basic services has become increasingly important to many client countries, partners, and donors. Many HNP projects finance health systems development and structural reform functions that potentially increase coverage of basic services. A definition of the basic services can guide those functions and reform elements such as improving access to necessary pharmaceuticals; strengthening surveillance and health information systems; identifying manpower requirements, service delivery mechanisms and logistics; and sustaining financing of these basic services. This requires close interaction between partners, between technical program managers and policy/decision makers in ministries of health, and between the disciplines represented in a project team.

Finally, why do some projects give attention to the technical aspects of basic services and the quality of specific interventions, and others do not?

3. Defining Essential Public Health and Clinical Services

To assess the Bank's investment in the best buys in public health and clinical services in FY1993–99, this review included a set of interventions derived from *WDR-93* (Table 1) that ranked high in terms of disability-adjusted life years averted, affordability, and cost-effectiveness. These interventions were used as markers of quality. Several challenges were encountered in trying to assess the implementation rate of this specific set of potentially cost-effective interventions and programs—especially as we were more interested in knowing what projects actually did than in what they were intending to do.

A major constraint derives from *WDR-93* itself. Some of the core interventions in public health programs included in the *WDR* list are not clear. Although they are reported to have a significant impact on disease burden at a specified cost, they are not clearly defined in the literature nor could public health specialists consulted clarify them. For example, the specific cost-effective elements of school health programs or tobacco and alcohol control programs were difficult to ascertain. In the absence of clear definitions, the basis for cost-effectiveness analysis is nebulous. In the case of school health and integrated management of childhood illness (IMCI), for example, the analysis was based on extrapolations and estimates, not on implementation experience. Since *WDR-93,* Bank-supported operations research in school health has documented that, in various settings, the financial cost of delivering a minimal package of school health services, the best buy, is less than US$1.00 per child per year, resulting in measurable improvements in both health status and educational achievement (World Bank 1997a and b). Similar efforts to validate the integrated management of childhood illness cost-effectiveness estimates are under way (Bryce 2000).

These public health and clinical services rank high, as measured in disability-adjusted life years averted and based on available efficacy, effectiveness, and cost data. *As the evidence base grows for other potential basic interventions, including other nutrition, noncommunicable diseases, and early child development interventions, it will be important to revisit and review this list and to include other nonhealth outcome measures (such as school and work performance measurements).*

To assess Bank support of the best buys, strict criteria were used to define the quality interventions derived from *WDR-93.* The definitions in Table 1 were established in consultation with technical specialists and documents (11 - WHO 1996a and b, 1998, and 1999a and b15).

Table 1 Definitions of Cost-Effective Public Health and Essential Clinical Services

Public health and clinical services	*Definition of* ***core*** *interventions*
Tuberculosis treatment	Directly observed treatment short-course; case detection by sputum smear microscopy among symptomatic patients; standardized treatment regimen of six to eight months; directly observed treatment for at least initial two months
Reproductive health/safe motherhood[a]	Family planning, prenatal and delivery care, clean/safe delivery by skilled birth attendant, post partum care, and essential obstetric care
Family planning	Information and education; availability and correct use of contraceptives
School health program	Health education and nutrition intervention(s), e.g., deworming, micronutrient supply, school feeding[b]
Integrated management of childhood illness	Case management of acute respiratory infections, diarrhea, malaria, measles, and malnutrition; immunization, feeding/breastfeeding counseling, micronutrient and iron supplementation, antihelminthic treatment and referral
HIV/AIDS prevention program	Education on safe behavior, condom promotion, STD treatment, safe blood supply
Treatment of sexually transmitted diseases	Case management using syndromic diagnosis and standard treatment algorithm
Immunization (EPI Plus)	BCG at birth; oral polio vaccine at birth, 6,10, 14 weeks; diphtheria at 6, 10, 14 weeks; hepatitis B at birth, 6 and 9 months(optional); measles at 9 months; tetanus toxoid for women of child bearing age
Malaria treatment and prevention[c]	Case management (early assessment and prompt treatment), and selected preventive measures (e.g., insecticide-treated nets)
Tobacco control[d]	Tobacco tax; information and education

a. Prenatal care only was identified among the most cost-effective interventions in *WDR-93*. We have included a broader definition of reproductive health/safe motherhood interventions
b. Since this study was initiated, school health has been further defined in the Focusing Resources on Effective School Health (FRESH) initiative. This definition represents a subset of interventions.
c. Malaria treatment and prevention are not included among the cost-effective interventions in the *WDR-93* but are included in this study.
d. *WDR-93* combined tobacco and alcohol programs. Tobacco is reviewed separately in this study.

4. Methodology and Process

The review of best buys was conducted in three phases. The process was as important as the final product and included: in-depth interviews (in 1998); two consultations (in November 1998 and May 2000) with Bank staff for review, discussion, and inputs to the final document; and a discussion of the draft report by the HNP Sector Board (in July 2000).

Phase 1, document review. The initial phase of the study included a thorough examination of all HNP staff appraisal reports (SARs), project appraisal documents (PADs), and some project concept documents (PCDs) from FY1993 to FY1999—152 projects in total. It was recognized that projects might include a basic service component, even if not explicitly outlined in the project documents. Therefore, the preliminary findings were supplemented by other evaluations conducted by sector staff, by monitoring the Bank's portfolio in specific areas (e.g., tuberculosis, safe motherhood, IMCI, HIV/AIDS, school health, tobacco), and by interviewing task managers responsible for the projects. In addition to SARs, PADs, and PCDs, special studies, sector work, operations manuals, and reports were reviewed to further identify basic service components and sector work relevant to the study (Roseberry 1996; World Bank 2000, 1998, 1997c, 1995, and 1993b). The findings were summarized in a spreadsheet and in project summaries for each HNP project in FY1993–99 (see analysis below). Although the summary spreadsheet was widely reviewed and checked by technical specialists, a few additional projects that do invest in basic services may have been missed.

Phase 2, in-depth interviews. The second phase of the review included in-depth interviews with 20 task managers and task team members for 17 HNP projects between 1993 and 1999 in all regions. The projects were drawn by at random from a list of active projects and discussed during open-ended interviews, guided by a questionnaire. The interviews took an average of an hour and a half, ranging from 40 minutes to two hours. All interviewees were very informative and provided in-depth knowledge and a wide range of operational experiences. This qualitative information contributed significantly to the conclusions and recommendations of this report.

Phase 3, internal Bank consultations. Two seminars were organized to discuss the preliminary findings and the implications of the Bank's work and to finalize the conclusions and recommendations. The first seminar included a small group of senior task managers, organized by the Public Health Thematic Group in November 1998. The second was cohosted by the Health Systems Development and Public Health Thematic Groups (May 2000). The recommendations were finalized after discussion by the HNP Sector Board (July 2000).

Analysis. The document review findings, fed into a spreadsheet to facilitate analysis, are summarized in Table 2. The categories included in the spreadsheet and used in the analysis covered basic project information, review of indicators, and detailed information on project design and components (e.g., health reform/nonhealth reform, basic services component, defined interventions, and fulfillment of best-buys criteria in Table 1). The information has already been widely shared within the Bank, used in other portfolio reviews, and included in several reports.

5. Findings and Discussion

1.1 Best Buys in the HNP Portfolio

According to project documentation, the Bank provided direct support to basic services in 74 percent (112/152) of the HNP projects approved in FY1993–99. Support to basic services was implemented as part of the health reform agenda in 54 percent (31/57) of new health reform projects, as shown in Table 2. Among the projects with a basic services component, 96 percent (107/112) described the specific services or interventions in the SARs, PADs, or PCDs.

Of the projects that did invest in the provision of basic services, we were interested in knowing the extent of those services that were best buys. Overall, an estimated 38 percent (58/152) of the new HNP projects in FY1993–99 are known to support the provision of at least one of the best buys in public health and clinical services in client countries. The other projects (62 percent) invest in services that do not meet the criteria for best buys (see below) or lack information about what the basic services are. In some countries, the government, with or without support from donors, might be implementing the best buys although the Bank does not support or refer to it in project documentation. Some best buys were not widely promoted until the mid-1990s, for example, in the direct observed treatment short course (DOTS) and later IMCI.

A list of HNP projects approved in FY1998 that define and invest in the best buys is shown in Annex A. Most are projects in low-income countries, but the list includes some middle-income countries (e.g., China and Egypt). These and other projects investing in the best buys can provide useful lessons on *how to* identify, select, and set priorities for best buys and how to reach consensus on those services with all key stakeholders as an essential step in the health reform process.

In conclusion, we need to know more about what kinds of basic services the Bank invests in. Since a significant number of projects support increased access to basic services in order to improve health outcomes, this provides an opportunity to increase the proportion of projects investing in the best buys.

Reproductive health services. The proportion of support to basic services that constitute quality and represent the best buy in reproductive health varies, depending on definitions. In support to reproductive health services, 53 percent (80/152) of HNP projects have broadly defined safe motherhood components. Twenty-five percent (20/80) of these components include all the reproductive health/safe motherhood interventions that make up the best buy. This suggests that 25 percent of all reproductive health projects in FY1993–99 included the best buy: combined family planning, prenatal and delivery care, clean/safe delivery by trained attendants, post partum care, and essential obstetric care (EOC).

A thorough review of the projects investing in reproductive health/safe motherhood showed that the interventions most often lacking are safe deliveries and EOC. Integration is often lacking between maternal health services and other reproductive health services, notably family planning. That is the case in the eight new projects in FY1999 investing in reproductive health. Four of them did not include safe deliveries and/or essential obstetric care; one did not include antenatal care; four did not include family planning. Two projects did not specify the components. In these circumstances, it is important to review the overall country program to assess whether the gap is addressed in another project or included in overall sector funding. This also underlines the necessity for increasing investment in the continuum of care in reproductive health, from family planning and antenatal care at community level, to essential and emergency obstetric care at the facility and referral levels to provide the best buy and significantly reduce maternal mortality.

Several recent developments help to address this problem and to bridge the equity gap in maternal mortality. A fully integrated approach is being developed and field tested, integrated management of pregnancy and childbirth (IMPAC), modeled on IMCI. More attention is being paid globally to making pregnancies safer and broadening access to essential obstetric services as an integral part of reproductive health care. In the safe motherhood action plan, any project in a country with a high maternal mortality rate (MMR) that does not explicitly include essential obstetric care requires an explanation, for example, that EOC is covered by another project.

Family planning. Family planning services were supported in 47 percent (71/152) of HNP projects, although the family planning component in many of these projects is not described in detail. In many projects, the family planning component does not include both components that define quality (information and education, and availability and use of a wide range of contraceptive methods). We were unable to quantitatively assess the proportion of family planning projects that provide the best buys, due to limited project documentation and knowledge about the projects among sector specialists.

Among the challenges in family planning services are the functional linkages with other reproductive/maternal health interventions. Most task managers interviewed felt that the major constraints are institutional and a result of the common separation between population/family planning and other reproductive health services that persist despite the global policy change agreed at the Cairo Conference in 1993.

Table 2 Summary: HNP Best Buys Portfolio Review, by FY1993–99

	FY1993		FY1994		FY1995		FY1996		FY1997		FY1998		FY1999		Total	
No. of new HNP projects	**24**		**17**		**26**		**23**		**15**		**25**		**22**		**152**	
	No.	*Percent*	*No.*	*Percent*	*No.*	*Percent*	*No.*	*Percent*	*No*	*Percent*	*No*	*Percent*	*No*	*Percent*	*No*	*Percent*
Health reform	4	17	2	12	10	37	12	52	4	27	14	56	11	50	57	38
Basic services	19	79	16	94	20	74	14	61	11	73	20	80	12	55	112	74
Health reform with basic services	1	25	2	100	7	70	5	42	2	50	10	71	4	36	31	54
Basic services with definition of interventions	19	100	16	100	16	80	13	93	11	63	20	100	12	100	107	96
Reproductive health	12	50	13	76	13	50	10	43	5	33	17	68	10	45	80	53
Reproductive health/ **safe motherhood best buys**	**3**	**25**	**3**	**23**	**2**	**15**	**2**	**20**	**2**	**40**	**8**	**47**	**0**	**0**	**20/80**	**25**
Child health	12	50	12	71	10	38	11	48	5	33	20	80	7	32	77	51
IMCI	**3**	**25**	**1**	**8**	**1**	**10**	**1**	**9**	**2**	**40**	**10**	**50**	**5**	**71**	**23/77**	**30**
RCH	11	46	11	65	10	37	9	39	4	27	15	60	6	27	68	45
R&CH best buys	**0**	**0**	**1**	**9**	**1**	**10**	**0**	**0**	**0**	**0**	**5**	**33**	**0**	**0**	**7/68**	**10**
Tuberculosis	3	13	6	35	6	23	8	35	4	27	9	36	5	23	41	27
Tuberculosis DOTS	**2**	**67**	**1**	**17**	**2**	**33**	**4**	**50**	**3**	**75**	**5**	**56**	**1**	**20**	**18/41**	**44**
HIV/AIDS	5	21	7	41	6	23	7	30	4	27	7	28	8	36	44	29
HIV/AIDS best buys	**1**	**20**	**2**	**29**	**2**	**33**	**1**	**14**	**1**	**25**	**1**	**14**	**2**	**25**	**10/44**	**23**
STDs	4	17	9	53	7	27	8	35	8	53	9	36	6	27	51	34
STDs best buys	**0**	**0**	**1**	**11**	**3**	**43**	**1**	**13**	**0**	**0**	**1**	**11**	**1**	**17**	**7/51**	**14**
Malaria	3	13	2	12	3	12	5	22	5	33	10	40	3	14	31	20
Malaria best buys	**1**	**33**	**0**	**0**	**1**	**33**	**0**	**0**	**2**	**40**	**4**	**40**	**1**	**30**	**9/31**	**29**
Family planning	15	63	11	65	12	46	10	43	4	27	14	48	7	32	71	47
Tobacco	0	0	0	0	2	8	2	9	0	0	0	0	2	9	6	4
Immunization	5	21	8	47	10	38	8	35	2	13	14	52	6	27	52	34
School health	0	0	1	6	0	0	1	4	0	0	1	4	0	0	3	2
Best buy (at least one)	**9**	**38**	**5**	**29**	**6**	**23**	**6**	**26**	**8**	**53**	**17**	**68**	**7**	**31**	**58**	**38**

Child health services. In all, 51 percent of projects (77/152) include a child health component, most commonly control of acute respiratory infections (ARI) and control of diarrheal diseases (CDD) services—good buys. The development of more effective and efficient integrated child health services, building on the CDD and ARI program experiences and incorporating nutrition, immunization, and other preventive services, is not well reflected in the Bank's HNP portfolio until FY1998, as shown in Table 2. Integrated management of childhood illness is a new approach to child health, gradually introduced in countries since the early 1990s. Ten new projects support the introduction of IMCI in FY1998 (Bangladesh, Brazil, Dominican Republic, Egypt, Gambia, Indonesia, Madagascar, Mauritania, Philippines, Tanzania, Uganda), though only mentioned in a few SARs and PADs. Fifteen percent (23/152) of the projects invest in child health best buys in FY1993–99.

Overall, 44 percent (67/152) of HNP projects in FY1993–99 provide support to both reproductive and child health (RCH). Of these RCH projects, 10 percent (7/67) include the best buys in both reproductive/maternal (safe motherhood) and child health (IMCI).

Immunization. Thirty-four percent (52/152) of the projects invest in immunization. Most of the investment is in comprehensive primary care development, including EPI programs. We could not assess the proportion of projects that fund the best buy (those that support the EPI guidelines and provide at least the six-vaccine package). Some projects include a few of the vaccines, for example, tetanus toxoid. A few new projects in FY1993–99 include new vaccines: the China Basic Health Services Project financed hepatitis B vaccine and the Bolivia Health Sector Reform introduced hepatitis B and *Haemophilus influenzae type b* vaccines. Two projects support monitoring and verification systems, the Brazil Disease Surveillance and Control Project and the Argentina Public Health Surveillance and Disease Control Project, which aims to strengthen detection, investigation, and control of invasive meningococcal disease. Currently, 59 projects invest in and support immunization with wide ranges in coverage rates.

Tuberculosis. Treatment of tuberculosis is financed in 27 percent (41/152) of the Bank's HNP projects. According to project documentation, 44 percent (18/41) of Bank-supported TB projects use the best buy direct observed treatment short course (DOTS). DOTS is central to the strategy that reduces emergence of resistant strains and patient relapse. It also lends itself to incorporation in primary care services where supervised treatment can be provided once diagnosis has been confirmed. Currently, 15 projects support tuberculosis in the context of health reform; of these 6 health reform projects include DOTS.

An in-depth review of the TB/DOTS portfolio shows a mixed picture that applies to all best buys and helps to illustrate how difficult it is to assess actual investment in best buys in the HNP portfolio. Some projects have large scale and explicit support for DOTS (e.g., in Bangladesh, Cambodia, China, India, and Vietnam). Other projects indicate support for DOTS in the PADs, but DOTS have not yet been launched in the country (Brazil HIV/AIDS and Macedonia health sector transition projects). In some cases, TB support has been given in project implementation, though not mentioned in the PAD (e.g., the Philippines Urban Health and Nutrition Project). Other projects mention support to TB, but it is unclear whether funds were dedicated for DOTS (e.g., Côte d'Ivoire integrated health project). In some cases, support might be given indirectly through health systems strengthening, which will ultimately be very important for effective TB control (e.g., Egypt health sector reform project) or on a small scale (e.g., Peru basic health/nutrition and Senegal endemic disease control). This range of scenarios is similar for other best buys and should be taken into account when reviewing these data.

HIV/AIDS. The HIV/AIDS problem is addressed in 29 percent (44/152) of HNP projects, as documented in SARs and PADs in FY1993–99. Out of these projects, 23 percent (10/44) meet the quality criteria of best buys. HIV/AIDS is a multisectoral problem, and several projects that might support some HIV/AIDS interventions have been launched in other sectors. However, among the HNP projects reviewed, the HIV/AIDS interventions are often not described in project documentation or known by sector specialists. This makes reliable best-buy assessment difficult for FY1993–99. While the Bank has identified the need for a broader multisectoral approach to HIV/AIDS prevention and control, it is important to ensure that the current and future HNP portfolio includes the best buy (i.e., information/ education, condom promotion, STD treatment, and safe blood supply) among the core elements—reviewed, given priority, and adapted to the local context—irrespective of the source of funding and the sectors involved.

This review estimates that 77 percent of the HIV/AIDS projects or project components miss one or more of the best-buy interventions. Condom promotion is the most frequent intervention; safe blood supply and proper STD treatment are less frequently included.

Currently, there is a significant increase in new HIV/AIDS projects. Under the umbrella Multi-Country HIV/AIDS Program in the Africa Region (MAP) several projects are becoming active in FY01 (Cameroon, Eritrea, Ethiopia, Gambia, Ghana, Kenya, Nigeria, Uganda, Zambia). New HIV/AIDS projects are also launched in Bangladesh, Russia and Ukraine.

STD treatment. STD treatment is supported in 34 percent (51/152) of the HNP projects. About 85 percent of support to STD control goes to HIV/AIDS programs of which 14 percent (7/51) report that they meet the criteria for best buys in STD treatment. The control of STDs is rarely an integral part of reproductive health services, antenatal care, or family planning services. The syndromic approach is seldom promoted in the projects reviewed.

Tobacco. Tobacco information, education, and communication interventions are included in 4 percent (6/152) of new HNP projects in FY1993–99. In these countries, taxation strategies are not supported. However, the Bank supports a wide range of operations research studies on tobacco in this period.

School health. In FY1999, of the 2 percent (3/152) of HNP projects that have a school health component, one meets the quality criteria. However, most school health projects are part of the Bank's education sector portfolio, not included in this review. A recent review suggests that 40 Bank projects incorporate school-based health and nutrition. School health is a small component (4 to 10 percent) of basic education projects, although innovative approaches, including the best buys in school health, are recognized as essential to child development. Other examples of projects for school-age children are projects using community funds (Philippines, Tanzania) and a project exploring ways to improve health in out-of-school youth (Colombia). Support for school health has also been increased since the review by the creation of a partnership with WHO, the United Nations Educational, Scientific, and Cultural Organization (UNESCO), and the United Nations Children's Fund (UNICEF) that seeks to focus resources on effective school health (FRESH). This partnership aims to support the goal of universal education and seeks to ensure that all schools have effective health policies, adequate sanitation, a skills-based approach to health education, and appropriate school-based health delivery services. FRESH also provides a mechanism for rapidly introducing HIV/AIDS prevention activities through schools.

Malaria. Of new Bank projects in the HNP sector in FY1993–99, 20 percent (31/152) have a malaria component. Twenty-nine percent (9/31) of them meet the best-buy criteria (Table 1) and include both recommended prevention and treatment strategies. A separate review of malaria projects and modalities confirms the findings of this study (World Bank Malaria Team 1998. Examples of best practices include the freestanding India malaria control project and the Laos health systems reform project, which support the best buys: early detection, prompt treatment, and vector control. In addition, malaria activities are small components of basic services in several countries, including: Benin, Côte d'Ivoire, Ecuador, Equatorial Guinea, Guinea-Bissau, Mexico, Morocco, Nicaragua, Niger, and Vietnam. Currently, malaria activities are ongoing in 35 countries. The Roll Back Malaria movement, launched in late FY1999—after the preparation of almost all the projects reviewed here, including the ones approved that year—provides a coherent strategy, including the best buy and innovative delivery mechanisms to increase access.

As in the case of TB and other priority public health program areas, investments in malaria control show a mixed picture. For example, the projects in FY1999 ranged from investment in early diagnosis and treatment of malaria and related research and training (Brazil Disease Surveillance and Control), to communicable diseases surveillance (Maharashtra Health Systems Development), to malaria prevention, hospital treatment, and capacity building for coordination, monitoring and evaluation, and research (Mali Health Sector Development). All these investments are critical for sustainable malaria control and good buys in public health. However, it would be useful to know in all HNP projects, the extent to which the government, non-governmental organizations (NGOs), and other partners identify and address all aspects of the best buy in malaria control. That would help to ensure maximum impact on the malaria burden and to assess the Bank's contribution and value added in ensuring direct or indirect support to early case management and selected preventive measures in malaria control.

1.2 Evaluating Impact and Monitoring Progress of Best Buys

In the FY1993–99 HNP portfolio, 33 percent (50/152) of the new projects have specified health development outcomes such as the infant mortality rate (IMR), the under 5 mortality rate and MMR, and 40 percent (20/50) of these projects have specified targets that the projects are working toward. A larger proportion of the HNP projects, 71 percent (108/152), have service coverage indicators. Of these, 50 percent (54/108) have set coverage targets that they aim to achieve. Although some of these indicators are useful for monitoring purposes, they are often less useful for evaluating project impact. A logical evaluation framework is required to assess impact, with clear relationships between project inputs, service coverage indicators (proximate determinants to health outcomes), and health outcomes (Figure 2), and with carefully selected, reliable, and measurable standard indicators. In addition, it requires a standard terminology that is often missing (e.g., "impact," "outcomes," and "outputs" are often used without clear distinction). Another major constraint to evaluating the impact of best buys in the HNP portfolio is the need to control for other factors that influence health outcomes, a problem of attribution, not unique to Bank projects.

In addition, many of the best buys lack useful, standardized indicators and methods for monitoring and evaluation at community and health facility levels. For example, IMCI has had an elaborate set of health facility indicators to assess whether health workers can follow the IMCI standard protocols, but useful indicators to evaluate effective utilization at household level have only recently been agreed on.

1.3 Findings from Key Informant Interviews

Twenty task managers and team members were interviewed about HNP projects that they had prepared and/or were supervising. Of the task managers and team members, 11 had been involved with the project from preparation through implementation, 7 began working on the project after implementation, and the rest worked on the projects during preparation only. The interviewees were economists (9) and public health specialists (9) or had other training (8). Of the projects randomly selected for the structured interviews, 6 were health reform projects, 10 had a basic services component, and 6 included a disease burden or cost-effectiveness analysis in the project preparation phase. The purpose of the interviews was to learn about factors that influence technical aspects of project preparation and implementation, specifically basic services and the selection and setting of priorities for public health and clinical interventions.

Bank constraints to technical quality. According to the task managers, the major constraints to ensuring that quality public health and clinical services were included in project preparation or assessed during supervision were budgetary constraints (especially limited supervision budget), disbursement pressure, lack of problem analysis/sector work, and lack of technical skills. They noted that sector investment projects were often more costly than other types of health projects. In addition to disbursement pressure, task managers often noted lack of management incentives to focus on quality. Although many felt the need for increased technical support, they did not have sufficient budget to pay for it. A technical issue that came up in discussions was the need for closure on outstanding major technical issues such as consensus on standard indicators. Several task managers reported spending a lot of time seeking trust funds or grants and felt that they—and their sector leaders—had insufficient time and resources to focus on quality.

Bank reward for technical quality. Almost all (14) the interviewees reported “no” reward for focusing on technical aspects and quality in project preparation and supervision. The 4 who said "yes" thought that quality was rewarded by the HNP Sector Board, supportive peer reviewers, Quality Assurance Group, and clients. Almost all interviewees mentioned their personal professional satisfaction and client feedback as their main reward. Some commented that the Bank keeps changing parameters for judging projects.

The Bank’s role in technical discussions. Almost all interviewees felt it was the Bank’s role to participate in discussions with clients on technicalities such as basic services and their content as part of a broader health policy dialogue or to ensure that such discussions take place between client and other partners. However, among the major constraints to engaging in the process of defining and supervising the best buys were: countries’ lack of implementation capacity; lack of technical assistance; lack of time and the heavy work load on the project team; project terms of reference that do not reflect this as priority; and the perception that management does not consider it necessary or important.

Constraints to provision of quality basic services. Several project and country-specific constraints to the identification, setting of priorities, and implementation of basic services were mentioned. These included: the clients' resistance to external specialist input; countries' lack of knowledge about the state of the art; lending instruments ("the sector investment project is like an empty shell without management capacity, without interventions, and without outputs to monitor"); financial limitations on a basic package with only $4 per capita for health; and, weak country managerial capacity.

Views on indicators. A uniform response from interviewees was that general development goals and health impact indicators were useful for discussions on the overall directions of projects, as yardsticks and for long-term planning and policy dialogue. As expected, IMR was found more useful than MMR. However, for project evaluation and monitoring purposes, proxies, services or process indicators were mentioned as more useful. Examples of useful monitoring indicators were case fatality rates and service coverage rates.

Partnerships. Almost all task managers had involved partners in project preparation and supervision (except in one project) and found it useful. The list of partners included the Australian Agency for International Development, the Overseas Development Assistance Program, the Pan American Health Organization, the Swedish Agency for Development Cooperation, the U.S. Agency for International Development, the United Nations Fund for Population, UNICEF, WHO Headquarters, WHO African Region, Abt Associates, the Population Council, and local and international NGOs.

Solutions. The interviewees proposed solutions to identified problems. Some of the solutions were general recommendations that task managers should work with clients as partners, be flexible, and use the project documents (SARs) as working documents. Other recommendations were related to improving staff performance (some have already been addressed): to include clients' and field staff in staff performance evaluation, judge staff performance against work plans, and include leadership and quality in the terms of reference for sector managers; involve sector managers in technical discussions and in project process; and, mentor new and inexperienced task managers to build their confidence and skills.

Among the skills that task managers felt they needed the most were more problem solving skills and field experience. They also listed recommendations for the HNP network (some are already being addressed): develop a consultant roster; provide terms of reference for consultants; and bring in more external specialists (secondments) to the network. The anchor was urged to take part in divisional meetings and to continue its efforts to be more demand driven. Finally, regarding partnerships, more partnering and interaction are needed with other agencies and subcontractors on the ground to ensure improved quality, including content and other specifics of quality services.

6. Conclusions and Recommendations

The major conclusions are:

- Within the existing HNP portfolio, major gains toward improved health outcomes for the poor can be made by sharpening focus on the core set of interventions that make up the best buys, linking project inputs with health outcomes.

- Information on the public health and clinical services that the Bank invests in is limited. A major strategy of the HNP sector is to increase access to basic services for the poor; however, knowledge about the definition and coverage of those services is insufficient.

- Overall, an estimated 38 percent of the new HNP projects in FY1993–99 are known to support the provision of at least one of the best buys in public health and clinical services in client countries, according to project documents and validation by task managers and sector specialists

- The Bank is the largest source of external assistance in major areas of public health such as in reproductive and child health services and HIV/AIDS programs. There are consistent gaps in the comprehensive set of interventions that define quality and that are needed to achieve the full potential effect on health outcomes, for example, the lack of essential obstetric services in reproductive health programs.

- A major thrust in the HNP sector is health reform or health sector development. However, only about a quarter of health reform projects have defined the basic services that could facilitate linking project budget allocations with health outcomes.

The recommendations to the HNP network are to:

- Share the review findings with task managers and technical specialists in the form of a short and concise guide on the best buys. A guide that can be linked to the knowledge management system and training in basic public health and Poverty Reduction Strategy should be prepared.

- Review the data in greater depth at regional level; find out why a most projects do not support the elements defined as the best buys. A series of spreadsheets with the report's information organized by region should be distributed to the HNP Sector Board members for their follow up with regional staff.

- Examine a few large countries as case studies to establish good practice examples for selecting and setting priorities for best buys, focusing on both process and content.

References

Bobadilla, J.L., and P. Cowley. 1995. "Designing and Implementing Packages of Essential Health Services." *Journal of International Development* 7(3): 543–54.

Bryce, J. 2000. "Integrated Management of Childhood Illness (IMCI): The Evidence From the Lifecycle Approach." Training module presented at Human Development Learning Week, World Bank, Washington.

Claeson, M.; C.C. Griffin; T.A. Johnston; M. Mclachlan; A.L.B. Soucat; A. Wagstaff; and A.S. Yazbeck. 2000. *Poverty Reduction Strategy Paper HNP Source Book*. Washington: World Bank, Human Development Network.

Gwatkin, D.R., and M. Guillot. 2000. *The Burden of Disease Among the Global Poor. Current Situation, Future Trends, and Implications for Strategy.* Washington: World Bank, Human Development Network and Global Forum for Health Research.

McLaughlin, J. 1997. *Designing an Essential Package of Health Services in Zambia: A Case Study. Module 5: Designing a Benefits Package.* Washington: World Bank, Human Development Eastern and Southern Africa.

Murray, C.J.L., and A.D. Lopez, eds. 1996. "The Global Burden of Disease." World Health Organization, Geneva.

Roseberry, Wendy. 1996. *AIDS Prevention and Mitigation in Sub-Saharan Africa: An Updated World Bank Strategy.* Washington: World Bank, AFTHR.

Stout, S.; A. Evans; J. Nassim; and L. Raney. 1997. "Evaluating Health Projects. Lessons from the Literature." *World Bank Discussion Paper* No. 356. World Bank, Washington.

World Bank. 2000a. *Poverty Reduction Strategy Paper: HNP Source Book.* Washington: World Bank.

———. 2000b. *Intensifying Action Against HIV/AIDS in Africa. Responding to a Development Crisis.* Washington: World Bank, Africa Region.

____. 1998. *Honduras: Toward Better Health Care for All.* A World Bank Country Study. Washington: World Bank.

———. 1997a. *Sector Strategy, Health, Nutrition and Population.* Washington: World Bank, Human Development Network.

———. 1997b. "India: New Directions in Health Sector Development at the State Level: An Operational Perspective." Report No. 15753-IN. South Asia Country Department II, Population and Human Resources Division, Washington.

———.1997c. "Honduras: Improving Access, Efficiency, and Quality of Care in the Health Sector." Report No. 17008-HO. Latin America and the Caribbean Region, Central America Country Management Unit, Human Development Department, Washington.

_____. 1995. "India: Policy and Finance Strategies for Strengthening Primary Health Care Services." Report No. 13042-IN. South Asia Country Department II, Population and Human Resources Division, Washington.

———. 1993a. *World Development Report 1993: Investing in Health.* New York: Oxford University Press.

———. 1993b. "Republic of Yemen Health Sector Review." Report No. 11439-YEM. Europe, Middle East and North Africa Region, Country Department III, Population and Human Resources Division, Washington.

World Health Organization. 1999a. "What is DOTS? A Guide to Understanding the WHO-Recommended TB Control Strategy Known as DOTS." Communicable Disease Cluster, Geneva.

_____. 1999b. *Integrated Management of Childhood Illness Information.* Geneva: WHO, Department of Child and Adolescent Health and Development and Health Systems and Community Health.

_____. 1998. "Fact Sheet Number 94: Malaria." Tropical Disease Research Division. Geneva. http://www.who.int/inf-fs/en/fact094.html.

———. 1996a. *Immunization Policy, Expanded Programme on Immunization.* Geneva: WHO, Global Programme for Vaccines and Immunization.

_____. 1996b. *Safe Motherhood. Mother-Baby Package: Implementing Safe Motherhood in Countries.* Geneva: WHO, Maternal Health and Safe Motherhood Programme Division of Family Health.

ANNEX A.

Best Practices—New HNP Projects in FY 98 Investing in Best Buys

IMCI—8

Bangladesh Fifth Health and Population Project
Dominican Republic Provincial Health Services
Egypt Health Sector Reform
Gambia Participatory Health Project
Ghana Health Sector Support Project
Madagascar Nutrition Project
Mauritania Health Sector Investment Project
Philippine Early Childhood Development

Safe Motherhood—8

Bangladesh Fifth Health and Population Project
Dominican Republic Provincial Health Services
Egypt Health Sector Reform
Gambia Participatory Health Project
Indonesia Safe Motherhood Project
Madagascar Nutrition Project
Nicaragua Health Sector II
Senegal Integrated Health Systems Project

Family Planning—14

Bangladesh Fifth Health and Population Project
China Basic Health Services Project
Comoros Health Project
Dominican Republic Provincial Health Services
Egypt Health Sector Reform
Gambia Participatory Health Project
Ghana Health Sector Support Project
Guinea-Bissau National Health Development
Indonesia Safe Motherhood Project
Madagascar Nutrition Project
Mauritania Health Sector Investment Project
Nicaragua Health Sector II
Pakistan Social Action Program Project II
Senegal Integrated Health Systems Project

TB—5

Bangladesh Fifth Health and Population Project
China Basic Services Project
Egypt Health Sector Reform
Ghana Health Sector Support Project
Guinea-Bissau National Health Development

Immunization—14

Albania Health Recovery and Development Project
Bangladesh Fifth Health and Population Project
China Basic Health Services Project
Dominican Republic Provincial Health Services
Egypt Health Sector Reform
Eritrea Health Project
Ghana Health Sector Support Project
India Women and Child Health Development
Mauritania Health Sector Investment Project
Nicaragua Health Sector II
Pakistan Social Action Program Project II
Philippines Early Childhood Development Project
Senegal Integrated Health Systems Project
Uganda Nutrition and Early Childhood Development

Malaria—4

Bangladesh Fifth Health and Population Project
Comoros Health Project
Ghana Health Sector Support Project
Pakistan Social Action Program Project II

HIV/AIDS—1

Bangladesh Fifth Health and Population Project

STDs—1

Bangladesh Fifth Health and Population Project

School Health—1

Madagascar Nutrition Project

Tobacco—None

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