REGIONAL ACTION PLANS

HNP HUB ACTION PLAN

ANNEX B

HNP HUB

The Health, Nutrition, and Population (HNP) Hub will facilitate HNP Network implementation of the new Strategy. In order to adequately play its role, the Hub will adjust its organizational structure and functioning in four work teams as follows:

Performance Monitoring and Action Team. This team will be responsible for (a) the maintenance of a database of HNP indicators, (b) the maintenance of a database of health financing indicators, (c) contributions to institutional reports (e.g., GMR, CPIA, World Development Report); (d) portfolio monitoring and quality enhancement, (e) monitoring and evaluation (M&E) capacity building (staff and clients), and (f) the regular updating of progress on the HNP Results Framework, including support to country teams on Results Framework development.

Global Health Coordination and Partnerships Team. The following functions will be covered; (a) coordinate work with global partnerships and initiatives; (b) facilitate selective fund raising and Trust Fund (TF) management for the HNP Network, (c) Development Grant Facility (DGF) management support; (d) selective joint ventures around themes of convergence (comparative advantages), and (e) harmonization and alignment.

Health Systems Policy Team. The preparation of the strategy has identified a gap in high-level health system policy skills to guide the implementation of the Bank agenda and an unmet demand from the Regions to receive timely support in their country dialog. It has also identified the need for practical and concrete advice to country teams and partners on how to overcome health system constraints to Development Assistance for Health (DAH) effectiveness for results. This will become even more pressing with the new policy drivers of the HNP Strategy. The team will (a) provide country teams with overall policy, technical, and operational advice on health systems; (b) manage knowledge creation on health systems, (c) develop and manage technical assistance for the Multisectoral Constraints Assessment (MCA) tool, and (d) respond to country-team demands on ensuring synergy between priority disease and system strengthening; (d) advise global partners on the health system aspects for which the Bank has comparative advantages. About 50 percent of the team's time will be allocated to country-team support and field work.

The team will focus closely on the following themes identified as priorities by client countries and global partners: (a) health financing and economics, including health insurance (b) linkage to macroeconomic and fiscal policy; (c) health service purchasing, (d) health system governance, and (e) synergy facilitation between priority disease and system strengthening in Bank operations.

Technical Aspects of Public Health, Nutrition, and Population. The team will support the Regions on technical aspects of disease control, nutrition, and population, drawing on in-house expertise but, more important, helping country teams establish the necessary working collaboration arrangements at country level with technical agencies such as WHO, UNICEF, UNFPA, and others.

Africa Region

Background

Health outcomes in the Africa Region are not progressing fast enough to achieve economic growth and reduce poverty (table B1), and the Region is unlikely to meet the health Millennium Development Goals (MDGs). Laboring under geographical, environmental, cultural, and political challenges, the HIV/AIDS crisis puts a heavier burden on Africa than on any other part of the world. What should be the Africa Region's response to the situation?

Table B1. Health Indicators in the Africa Region

Income group/country	GNI per capita, 2005 (US$)	Health expenditure, 2004 (% of GDP)	External assistance, 2004 (% of total)	U-5 mortality, 2005 (per 1,000 live births)	MMR modeled estimates, 2000 (per 100,000 live births)	Prevalence of child malnutrition 2000-06 (% of underweight U-5 children)	HIV prevalence, 2005 (% of total population, ages 15-49)
LOW INCOME							
Benin	510	4.9	10.2	150	850	30	1.8
Burkina Faso	400	6.1	26.8	191	1000	38	2.0
Burundi	100	6.7	28.5	190	1000	45	3.3
Central African Republic	350	4.1	47.7	193	1100	24	10.7
Chad	400	4.2	7.0	208.3	1100	37	3.5
Comoros	640	2.8	18.3	71	480	25	0.1
Congo, Dem. Rep.	120	4.0	19.1	205	990	31	3.2
Côte d'Ivoire	840	3.8	5.0	195	690	17	7.1
Eritrea	220	4.5	59.6	78	630	40	2.4
Ethiopia	160	5.3	35.2	127.0	850	38	1.4
Gambia, The	290	6.8	23.0	137	540	17	2.4
Ghana	450	6.7	29.9	112	540	22	2.3
Guinea	370	5.3	9.5	160.0	740	33	1.5
Guinea-Bissau	180	4.8	31.6	200	1100	25	3.8
Kenya	530	4.1	18.3	120	1000	20	6.1
Liberia	130	5.6	37.8	235	760	27	n.a.
Madagascar	290	3.0	45.5	119	550	42	0.5
Malawi	160	12.9	59.4	125.3	1800	22	14.1
Mali	380	6.6	13.8	218	1200	33	1.7
Mauritania	560	2.9	20.2	125	1000	32	0.7
Mozambique	310	4.0	55.9	145	1000	24	16.1
Niger	240	4.2	21.3	256	1600	40	1.1
Nigeria	560	4.6	5.6	194	800	29	3.7
Rwanda	230	7.5	37.1	203	1400	23	3.0
São Tome and Principe	390	11.5	53.3	118	n.a.	13	n.a.
Senegal	710	5.9	12.8	118.7	690	23	0.9
Sierra Leone	220	3.3	35.4	282	2000	27	1.6

Income group/country	GNI per capita, 2005 (US$)	Health expenditure, 2004 (% of GDP)	External assistance, 2004 (% of total)	U-5 mortality, 2005 (per 1,000 live births)	MMR modeled estimates, 2000 (per 100,000 live births)	Prevalence of child malnutrition 2000-06 (% of underweight U-5 children)	HIV prevalence, 2005 (% of total population, ages 15-49)
Somalia	n.a.	na	na	225	1,100	33	0.9
Sudan	640	4.1	5.1	90	590	41	1.6
Tanzania	340	4.0	27.1	122	1,500	22	6.5
Togo	350	5.5	8.9	139	570	n.a.	3.2
Uganda	280	7.6	25.2	136	880	23	6.4
Zambia	490	6.3	36.3	182	750	23	17.0
Zimbabwe	340	7.5	13.1	132	1,100	n.a.	20.1
MIDDLE INCOME							
Angola	1,350	1.9	9.1	260	1,700	31	3.7
Botswana	5,180	6.4	2.5	120	100	13	24.1
Cameroon	1,010	5.2	5.3	149	730	18	5.4
Cape Verde	1,870	5.2	20.7	35	150	n.a.	n.a.
Congo, Rep.	950	2.5	3.6	108	510	n.a.	5.3
Equatorial Guinea	n.a.	1.6	3.8	205	880	19	3.2
Gabon	5,010	4.5	1.3	91	420	12	7.9
Lesotho	960	6.5	8.7	132	550	18	23.2
Mauritius	5,260	4.3	1.4	15	24	n.a.	0.6
Mayotte	n.a.	na	na	n.a.	n.a.	n.a.	n.a.
Namibia	2,990	6.8	16.9	62	300	24	19.6
Seychelles	8,290	6.1	2.4	13	n.a.	n.a.	n.a.
South Africa	4,960	8.6	0.5	68	230	n.a.	18.8
Swaziland	2,280	6.3	9.5	160	370	10	33.4

Source: World Bank. (2007). *2007 World Development Indicators*. Washington, DC: World Bank.

Strategic Directions: How Should the Bank Support Country Efforts?

Renew Bank focus on HNP results

Opportunities exist for the Africa Region to help clients improve HNP outcomes through a specific focus on fiscal and economic policy. The Africa Region staff **work closely with central ministries on designing Poverty Reduction Strategies** (PRSPs), and assist with **public sector reform** initiatives. Achieving **more efficient and equitable spending and allocation of resources** will entail evidence-based planning to target resources where they will do the most to improve outcomes and **reduce disparities between regions and groups.** Because absent or weak accountability mechanisms undermine HNP strategies, the Bank, tapping **its expertise in public sector governance, will assist country efforts to strengthen national and subnational accountability mechanisms.**

Strengthen health systems for HNP results

The World Bank will emphasize health systems as a key vehicle for improving HNP outcomes and protecting people from the impoverishing impact of illness. The Africa Region will draw on the Bank's global knowledge base and experience to help strengthen systems and institutional capacity, focusing on: (a) health workforce limitations; (b) access to, and management

of,pharmaceuticals; (c) institutional frameworks, including planning and budgeting capacity (d) pro-poor service delivery, and (e) expanding household demand for services.

Multisectoral action to improve HNP outcomes

Because many determinants of health lie outside the health sector, the World Bank has a unique opportunity to foster multisectoral action in the Africa Region. From the Bank's decision to emphasize multisectoral action for HIV/AIDS, lessons applicable to other diseases have begun to emerge. Areas where **collaboration will increase synergy** include: **education, agriculture and food security, water and sanitation, road safety, energy, telecommunications, and environmental actions.**

Sustainable financing of HNP interventions

Total health expenditures in Sub-Saharan Africa (SSA) average 6 percent of GDP and US$13 per capita per year, compared with 5.6 percent and US$71 per capita per year in other developing countries. The poorest 18 African countries spend much less, an average of only US$2.10 per capita in 2000. Debt relief and DAH have helped lighten the health care load, and governments are trying out a variety of strategies to manage health financing. Classical health insurance is not an option in most SSA countries because formal employment is low and perceptions and practice of corruption fragment the solidarity and confidence on which insurance must be founded. However, a number of countries have started to experiment with community financing such as health funds, mutual health organizations, rural health insurance, revolving drug funds, and prepayment initiatives.

Payment remains a major obstacle to use of health services among Africa's poor, and user payments still pay for up to half of health expenditures in some SSA countries. In 2000, private expenditure represented between US$0.50 and US$21 per capita per year in the 38 poorest African countries. This is an issue that the Africa Region is following.

The Africa Region can help countries address efficiency and equity issues by finding the right mix of public expenditures and international financing over the medium-term. The Marginal Budgeting for Bottlenecks (MBB) instrument has been introduced in at least 10 countries. Work is also being done on contracting for services, including capitation-based payments. Deriving and disseminating lessons on public and private expenditures for health will be a priority for the Africa Region.

Implications for Operations in the Africa Region

In line with the Africa Action Plan of April 2005, the Africa Region HNP operations aim to achieve sustainable improvements on MDG-related indicators with high-impact interventions:

- Helping countries build outcome-oriented and evidence-based national strategies, plans, and budgets, building on global knowledge and experience.
- Strengthening the capacity of client countries' health systems to implement these strategies.
- Integrating the scaling-up of support to malaria control and HIV/AIDS, and interventions to combat malnutrition and child and maternal mortality.
- Helping clients mobilize domestic resources and international financing.
- Monitoring and evaluating (M&E) the impact of country strategies on the health outcomes and helping countries develop their own M&E systems.

In line with the Paris Declaration on Harmonization and Aid Effectiveness, the Africa Region will support country-level negotiations to reach agreement between the government and development partners on improving aid alignment and effectiveness.

The Region will continue to promote sectorwide approaches to help ensure that strengthened public and private health care systems are mutually reinforced by disease-specific programs. To that effect, project implementation units should be avoided and common implementation procedures should be an objective. Africa Region staff must ensure that clients receive the best possible technical support and refer them to other partners, as necessary.

HNP activities will be financed through both investment projects and development policy lending (DPL). The Africa Region's approach to the transfer of resources is shifting from free-standing projects toward programmatic lending. Adaptable Program Loans/Credits (APLs) would support long-term commitment to sector programs. PRSCs or Sector Adjustment Loans/Credits would be preferred if the government has the proper systems and procedures in place. In some settings, such as post-conflict African countries, strengthening the Bank's presence in the sector through more targeted subsectoral operations may be required before engaging the country in discussions of a sectorwide approach.

East Asia and Pacific Region

Background

As one of the most diverse regions in the world, East Asia and the Pacific (EAP) Region encompasses some of the world's least-developed countries (e.g., Cambodia, Timor Leste) and some of the most rapidly emerging economies (e.g., China, Vietnam). Countries in the Region also differ along other dimensions—size, epidemiological profile (table B2), vulnerability to natural disasters, and political stability. Yet some regional trends and patterns are discernable. Overall, the Region has seen rapid growth, both a cause and a consequence of increasing migration and urbanization, but inequalities have also widened—across individuals, urban and rural areas, and regions within countries. All these changes create both opportunities and challenges in the HNP sector.

Most countries in the Region face a double burden of disease, with non-communicable diseases becoming increasingly important, while infectious diseases persist and new and re-emerging diseases strain scare health resources further. Moreover, the nutrition and population agendas remain important in many countries. At a system level, decentralization, rising inequalities, expanding needs and expectations, and a large private sector role in both financing and service delivery have brought health system issues to the fore. While the need for health system reform is increasingly recognized, the consequences of pandemics have also become apparent following the SARS epidemic, AHI outbreaks, and the ever-present threat of HIV/AIDS. As a result, public health surveillance and outbreak control have gained importance in many countries of the region.

Table B2. Health Indicators in East Asia and Pacific Region

Income group/country	GNI per capita, 2004 (US$)	Health expenditure, 2004 (% of GDP)	External assistance, 2004 (% of total)	U-5 mortality, 2005 (per 1,000 live births)	MMR modeled estimates, 2000 (per 100,000 live births)	Prevalence of child malnutrition, 2000–05 (% of underweight U-5 children)	HIV prevalence, 2005 (% of total population, ages 15–49)
LOW INCOME							
Cambodia	350	6.7	28.5	87.3	450	36	1.6
Korea, Dem.Rep.	n.a.	5.6	0.0	55	67	24	na
Lao PDR	390	3.9	10.2	79	650	40	0.1
Mongolia	600	6.0	4.6	49	110	13	0.1
Myanmar	n.a.	2.2	13.1	105	360	32	1.3
Papua New Guinea	560	3.6	26.5	74.4	300	n.a.	1.8
Vietnam	540	5.5	2.0	19	130	28	0.5
MIDDLE INCOME							
China	1,500	4.7	0.1	27	56	8	0.1
Indonesia	1,140	2.8	1.3	36	230	28	0.1
Malaysia	4,520	3.8	0.1	12	41	11	0.5
Philippines	1,170	3.4	3.6	33	200	28	0.1
Thailand	2,490	3.5	0.3	21	44	n.a.	1.4

Source: World Bank. (2007). *2007 World Development Indicators*. Washington, DC: World Bank.

Strategic Directions: How Should the Bank Support Country Efforts?

Overview

The HNP Strategy in the World Bank's EAP Region calls for a focus on improved health outcomes for the poor; enhancing the performance of health care systems; and securing sustainable health care financing. Within that framework, each country team has developed a strategy for HNP that is consistent with the Country Assistant Strategy (CAS) and which responds to both demands from client countries and Bank capacity. The country-specific strategy also takes into account the role and activities of other development partners.

In a region as diverse as EAP and with a strong MIC presence, **a strong country focus is essential and will be maintained as the Bank moves forward, emphasizing** HNP outcomes and results.

- **In middle-income countries, the focus is on using various tools for innovation, learning, and addressing reform issues**. Lending is expected to continue, but it will be centered on health system strengthening and supported by a strong program of analytic work. Analytic work and lending on disease-specific issues will continue where there is demand and a strategic role for the World Bank.

- **In low-income countries, external financing from the World Bank and other development partners will play an important role relative to domestic resources**. Donor coordination is critical. As in middle-income countries, support of health system strengthening through both analytic work and lending will be important, but improved donor coordination and multi-sectoral work to address broader determinants of health outcomes are also critical elements of success. Where governance and fiduciary systems permit, development policy lending will gain importance, but investment lending is likely to remain a relevant instrument.

Renew Bank focus on HNP results

Focus on HNP outcomes and results is an integral part of both the ongoing portfolio and pipeline activities. This includes:

- *Outcome-based country strategies:* As in other regions, country strategies provide the basis for the HNP work program. Drawing on the regional strategy and the global HNP strategy, country teams in the EAP Region prepare country strategy notes for the HNP sector. These strategy notes seek to identify key constraints to improving HNP outcomes, as well as strategic areas for WB support to address these constraints, serve as the basis for dialog with government and key partners at country-level.

- *Strong Results Framework in programs and AAA work:* Some of the success stories include the Timor health program,[1] the HIV/AIDS prevention project in Vietnam that supported the development of a monitoring and evaluation framework, the National Sector Support for Health Reform Project in the Philippines that has piloted performance-based contracts between central and local government, and the Health Eight Project in

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[1] Bustreo, F., Genovese, E., Omobono, E., Axelsson, H., and I. Bannon. (2005). *Improving Child Health in Post-Conflict Countries: Can the World Bank Contribute?* Washington, DC: World Bank Group.

China that has demonstrated results that have helped influence policy of rural health delivery programs in China.

- *Impact evaluation of selected programs:* The Region has invested, and will continue to invest, in selected impact evaluation efforts. These are integral to the overall knowledge generation and sharing efforts of the Bank to help inform broader policy dialog and program design.

Strengthen health systems for HNP results

Many countries in the region are exploring ways to make health financing more equitable, increase access to health care, improve the performance of both public and private health care providers, strengthen pharmaceutical systems, and address imbalances in the health workforce. Reforms in these areas are particularly challenging as they are often being implemented in contexts where governance arrangements, intergovernmental fiscal relations, and social security systems are changing at the same time. Given these challenges, client demand for support on health system strengthening, and on related governance and public sector management issues, has seen significant growth. Ongoing and planned activities include both lending and analytic work, often with strong complementarities.

Ensure synergy between health system strengthening and priority-disease interventions

The limited number of disease-specific programs in the Region reflect client demand and regional issues. Nevertheless, emphasis should be put on systemic issues and linkages to broader health sector reform.

Multisectoral action to improve HNP outcomes

Cross-sectoral collaboration is an essential element of outcome-based strategies. These collaborations can take several forms: (a) policy alignments with other sectors; (b) joint sectoral programs to achieve desired impacts on health outcomes; and (c) working with other sectors to achieve desired HNP outcomes. However, it is important to identify which cross-sectoral tasks are likely to produce the desired impacts on HNP outcomes.

Strategic partnerships

Strategic partnerships are fundamental to the EAP Strategy and are important for both analytic work and lending operations. The key for such partnerships is how they work at the country level and leverage the overall agenda. Several business models developed through the various partnerships provide the flexibility needed to respond to client and donor needs.

Diverse product lines

The EAP Region has been expanding its product line to respond to various demands and improve results. The Comprehensive Development Partnership model in Thailand (an excellent approach to work in partnership with MIC clients), the DFID-Bank partnership in China, the different partnership models and stand-alone trust-funded operations, and the various lending instruments used for cross-sectoral work all reflect the wide range of AAA, lending, and partnership products being used. Impact evaluation is also seen as another stand-alone product line. Making sure that the different products come together at the country level is now critical to achieve the desired HNP outcomes and results.

Eastern Europe and Central Asia Region

Background

In the ECA Region, the new World Bank HNP Strategy will have to reflect real and growing differences (table B3) between countries and subregions. Implementation approaches will have to be custom-made to fit specific country and / or subregional situations. A large part of ECA HNP staff is based in the field, which increases the ability to be responsive to counterpart needs.

Table B3. Health Indicators in the Eastern Europe and Central Asia Region

Income group/country	GNI per capita, 2005 (US$)	Health expenditure, 2004 (% of GDP)	External assistance, 2004 (% of total)	U-5 mortality, 2005 (per 1,000 live births)	MMR modeled estimates, 2000 (per 100,000 live births)	Prevalence of child malnutrition, 2000-05 (% of underweight U-5 children)	HIV prevalence, 2005 (% of total population, ages 15-49)
LOW INCOME							
Kyrgyz Republic	440	5.6	15.1	67	110	7	0.1
Tajikistan	330	4.4	9.1	71.4	100	n.a.	0.1
Uzbekistan	510	5.1	3.9	68	24	8	0.2
MIDDLE INCOME							
Albania	2,580	6.7	2.4	18	55	14	n.a.
Armenia	1,470	5.4	7.2	29.4	55	3	0.1
Azerbaijan	1,240	3.6	1.6	89	94	7	0.1
Belarus	2,760	6.2	n/a	11.5	35	n.a.	0.3
Bosnia and Herzegovina	2,440	8.3	1.3	15	31	4	0.1
Bulgaria	3,450	8.0	1.0	15	32	n.a.	0.1
Croatia	8,060	7.7	0.4	7	8	n.a.	0.1
Czech Republic	10,710	7.3	0.0	4	9	n.a.	0.1
Estonia	9,100	5.3	0.5	7	63	n.a.	1.3
Georgia	1,350	5.3	9.8	45	32	n.a.	0.2
Hungary	10,030	7.9	0.4	8	16	n.a.	0.1
Kazakhstan	2,930	3.8	0.9	73	210	n.a.	0.1
Latvia	6,760	7.1	0.3	11	42	n.a.	0.8
Lithuania	7,050	6.5	3.1	9	13	n.a.	0.2
Macedonia, FYR	2,830	8.0	1.4	17	23	n.a.	0.1
Moldova	880	7.4	4.8	16.1	36	4	1.1
Poland	7,110	6.2	0.1	7	13	n.a.	0.1
Romania	3,830	5.1	25.0	19	49	3	0.1
Russian Federation	4,460	6.0	0.1	17.5	67	6	1.1
Serbia and Montenegro	3,280	10.1	0.5	15	11	2	0.2
Slovak Republic	7,950	7.2	0.0	8	3	n.a.	0.1
Turkey	4,710	7.7	0.0	29	70	4	n.a.
Turkmenistan	..	4.8	0.4	104	31	12	0.1
Ukraine	1,520	6.5	0.7	17	35	1	1.4

Source: World Bank. (2007). *2007 World Development Indicators*. Washington, DC: World Bank.

Strategic Directions: How Should the Bank Support Country Efforts?

Renew Bank focus on HNP results

The evolving issues across the ECA Region, together with the priorities reflected in the new HNP Strategy, have resulted in a focused and quantifiable set of results-based indicators:

- HIV/TB rates in line with MDG targets.
- Nutritional MDG targets achieved in Central Asia and Caucasus.
- Premature death and disability from noncommunicable diseases reduced by 20 percent.
- Increased sector transparency and improved governance, as measured by reduction in informal payments and transparent drug procurement.
- Inequalities in access to necessary services reduced by 25 percent—particular focus on minorities.
- Health care infrastructure at sustainable levels, providing continuum of services at high-quality health and cost-effectiveness.
- Increase by 25 percent in patient satisfaction with service quality.
- Introduction by ECA countries of risk-pooling arrangements, guaranteeing minimum protection and risk mitigation for poor.
- Development by ECA countries of plans for demographic transition, including long-term care financing and service provision.
- Improved understanding, among decision makers, of public health and cross-sectoral dimension of health determinants (e.g., transport, water, infrastructure, education).

Strengthen health systems for HNP results

Improved results must also be achieved on health system issues such as transparency, governance, informal payments, access to health services, and measurement of results. The largely unfinished agenda of ensuring appropriate health infrastructure, including necessary intersectoral linkages to other types of social services, will also need priority attention. This will become increasingly important as more and more of the Soviet-era infrastructure wears out.

ECA HNP sees an increasing emphasis from counterparts on health financing and fiscal sustainability (e.g., provider payments, benefits packages, informal payments), as well as capacity building, including policy development, human resources management, health services planning (including with respect to rationalization of health facilities and services), health care management, quality improvement, national health accounts, and improved monitoring and evaluation systems. This reflects an ongoing shift from “rowing” to “steering” in the counterpart Ministries of Health, and the concomitant need for adaptation by other parts of the health system. Other evolving issues center on medical education and regulatory / governance functions (training / retraining, continuous medical education, licensing, and accreditation).

Multisectoral action to improve HNP outcomes

The **upgrading of public health/surveillance capability** is an important issue in many countries, underscored by recent developments regarding avian flu. In light of the changing demographics and rapid aging in many ECA countries, **appropriate provision and financing of long-term care** is another emerging issue with significant multisectoral implications, especially as related to the social protection system. Many countries are interested in **private health insurance** as a way

of relieving pressure on government programs, but good examples to date are scarce. Similarly, a number of countries have expressed interest **in health savings accounts** and have asked for World Bank assistance in exploring this issue.

The unfinished health infrastructure agenda will require **increased interaction with the energy and infrastructure sectors**, to ensure that proposed approaches are the most cost-effective available. Gains from energy efficiency investments alone could yield significant pay-offs in terms of freeing up resources for direct service delivery.

Strategic partnerships

Key technical partners in ECA include WHO-EURO, CDC, ECDC, OECD, and the IMF. Strategic partners would include the European Commission, the European Investment Bank, and IFC (potentially in the area of public-private partnerships). A critical partnership is the ongoing collaboration with the European Observatory on Health Systems and Financing, which is supported by the World Bank (through the Development Grant Facility).

Implications for Operations in the ECA Region

Overall, it is expected that there will be **less emphasis on direct financing of health infrastructure and equipment, but an increasing need for developing capacity for health technology assessment and attention on developing facility rationalization strategies, a large, unfinished agenda in most ECA countries**.

Ensuring **high-quality portfolio performance** is important as an accountability indicator, but also as evidence of the Bank's comparative advantage. There will also be a growing need to continue **exploring a widened range of instruments for supporting client countries**, including reimbursable TA, jointly funded programs, and subnational lending (in some countries).

Both **budget and staffing issues** are interlinked constraints to achieving these results. In the face of declining Bank budgets (resulting from reduced lending activity), maintaining policy dialog with countries across the Region becomes increasingly difficult (box B1). Perhaps even more important, **continuity and relationship management issues** must be addressed if the Bank is going to be successful. The skill set needed will include direct hands-on experience in health system reform and management, health financing, and other key areas, as well as the ability to identify needs, coherently engage in discussions with counterparts, and quickly arrange for these needs to be addressed in a substantive way. This will be a critical element for maximizing both the Bank's ongoing engagement as well as new business opportunities: improving the capacity of staff to choose the right approach to meeting counterpart needs in terms of lending instruments, nonlending support, technical assistance, and policy dialogue.

Box B1.
HNP and the MIC Agenda

The Bank, in its relations with middle-income client countries, will seek to:

- Become reestablished as their partner of choice in development knowledge and finance, for its reservoir of global expertise, range of products and services, attractive financial terms, and ability to catalyze support from other partners.
- Maintain and, where possible, increase the quality of lending and other services to meet increased demand.
- Strengthen the ability of its staff to respond to the specific needs of the diverse group of MIC countries.

These principles encourage MICs to continue or resume borrowing, by removing impediments and providing other "value-added" benefits, such as policy advice and technical assistance. But what about countries that either no longer need or want to borrow? The lack of sustained engagement, in the absence of lending, weakens business development efforts and client relations generally, thus reducing further the prospects for new lending business. This is perhaps a more critical issue in HNP, where in-depth knowledge of the sector takes time and ongoing involvement.

Source: Board Paper on "Enhancing World Bank Support to Middle-Income Countries," September 2006.

Latin America and the Caribbean Region

Background

Following a wave of health sector reforms, countries in the Latin America and the Caribbean Region (LCR) have made great strides in the way they finance, regulate, and deliver health care. Overall, impressive gains have been made in health outcomes and services in the past 15 years, but generalizations are difficult in so widely diverse an area. Some groups have benefited far more than others from these advances, and results have been insufficient in some key areas such as malnutrition and maternal mortality (table B4).

Table B4. Health Indicators in the Latin America and the Caribbean Region

Income group/country	GNI per capita, 2005 (US$)	Health expenditure, 2004 (% of GDP)	External assistance, 2004 (% of total)	U-5 mortality, 2005 (per 1,000 live births)	MMR modeled estimates, 2000 (per 100,000 live births)	Prevalence of child malnutrition, 2000-06 (% of underweight U-5 children)	HIV prevalence, 2005 (% of total population, ages 15-49)
LOW INCOME							
Haiti	450	7.6	14.2	120	680	17	3.8
MIDDLE INCOME							
Argentina	4,470	9.6	0.2	18	82	4	0.6
Barbados	..	7.1	2.0	12	95	n.a.	1.5
Belize	3,500	5.1	5.3	17.2	140	n.a.	2.5
Bolivia	1,010	6.8	9.1	65	420	8	0.1
Brazil	3,460	8.8	0.0	33	260	n.a.	0.5
Chile	5,870	6.1	0.1	10	31	1	0.3
Colombia	2,290	7.8	0.1	21.4	130	7	0.6
Costa Rica	4,590	6.6	0.8	12	43	n.a.	0.3
Dominica	3,,790	5.9	3.0	15	n.a.	n.a.	..
Dominican Republic	2,370	6.0	1.5	31	150	5	1.1
Ecuador	2,630	5.5	0.8	25	130	12	0.3
El Salvador	2,450	7.9	1.2	27	150	10	0.9
Grenada	3,920	6.9	1.5	21	n.a.	n.a.	..
Guatemala	2,400	5.7	2.3	43	240	23	0.9
Guyana	1,010	5.3	8.2	63	170	14	2.4
Honduras	1,190	7.2	8.7	40	110	17	1.5
Jamaica	3,400	5.2	1.4	20	87	4	1.5
Mexico	7,310	6.5	0.3	27	83	n.a.	0.3
Nicaragua	910	8.2	11.3	37	230	10	0.2
Panama	4,630	7.7	0.2	24	160	n.a.	0.9
Paraguay	1,280	7.7	1.9	23	170	5	0.4
Peru	2,610	4.1	1.3	27.3	410	7	0.6
St. Kitts and Nevis	8,210	5.2	1.8	20	n.a.	n.a.	..
St. Lucia	4,800	5.0	0.7	14	n.a.	n.a.	..
St. Vincent and the Grenadines	3,590	6.1	0.1	20	n.a.	n.a.	..
Suriname	2,540	7.8	9.7	39	110	13	1.9
Trinidad and Tobago	10,440	3.5	0.2	19	160	6	2.6
Uruguay	4,360	8.2	0.3	15.1	27	n.a.	0.5
Venezuela, RB	4,810	4.7	0.0	21.3	96	4	0.7

Source: World Bank. (2007). *2007 World Development Indicators*. Washington, DC: World Bank.

Strategic Objectives: What HNP Results?

Given the heterogeneity of the Region, the scope of Bank activities is necessarily broad. Consistent with its new HNP Strategy and in line with its comparative advantages, the Bank will continue to help countries pursue four broad Strategic Objectives: improve focus on the poor to reduce inequity; strengthen government attention to public goods**;** improve health financing for greater equity, efficiency, and sustainability; and improve health system stewardship and governance.

Strategic Directions: How Should the Bank Support Country Efforts?

Renew Bank focus on HNP results

LCR has used the Bank's comparative advantage to help countries improve results in health and nutrition, with an emphasis on reducing inequalities by targeting the poor and most vulnerable population groups.

For example, the Bank supported ***Argentina*** in developing and implementing a new maternal and child health insurance program (*Plan Nacer*), targeting poor and indigenous women and children living in urban and rural parts of the nine poorest provinces. Twenty months after the project went into effect, half of the eligible population (400,000 beneficiaries) was enrolled in the program. Ten months after the federal government negotiated targets with provincial health authorities, an average of 7 out of 10 indicators had been achieved or surpassed. Similar results-based models are being employed in ***Ecuador, Nicaragua****,* and ***Paraguay*** in Bank-supported projects.

Strengthen health systems for HNP results

In high-middle-income and several low-middle-income LCR countries where most of the population has access to basic health care services, governments are expanding social protection in health. Other low-middle-income countries where the provision of basic services is still an important challenge are focusing on strengthening health systems to expand the supply of these services.

The Bank has supported countries' efforts to strengthen health systems by developing new organizational and institutional arrangements to extend social protection in health, with a focus on basic health care services for poor mothers and children. Some of these projects include the ***Argentina*** Maternal and Child Health Insurance, the Health Sector Reform in ***Bahia*, *Brazil,*** the PROCEDES Project in ***Mexico***, and Maternal and Child Basic Health Insurance in ***Paraguay***. The regional study *Beyond Survival: Protecting Households from Health Shocks in Latin America* (2006) has launched a regional dialog on this urgent topic.

In ***Nicaragua*** the Bank has worked with other development partners (UNFPA, IADB, and the governments of Austria, Holland, Finland, and Sweden) in supporting the government's national strategy and action plan to strengthen the health system to improve access to basic health care services. In ***Peru***, the first Health Reform APL supported development of insurance for nearly three million mothers and children. In both countries, good results have been confirmed in coverage and equity.

During ***Argentina***'s socioeconomic and political crisis that reached its peak in 2002, the Bank helped the government maintain the health system's capacity to deliver basic health services and goods to the poor and the uninsured. The Health Emergency Project was part of a

multisectoral strategy and supported the government's effort to transform this major challenge into an opportunity to strengthen the health system.

Ensure synergy between health system and priority disease interventions

The Bank works closely with governments in IDA-eligible or IBRD / IDA-mixed countries to balance single-disease and targeted programs with health system strengthening. In Honduras and Nicaragua, for example programs that prioritize mother and child health interventions are fully integrated within the national strategies and action plans to improve national health care systems. In 10 ***Caribbean countries and Central America***, the Bank is supporting HIV/AIDS programs that foster complementarities between health care systems and other important actors.

Multisectoral action to improve HNP outcomes

The HNP team in LCR works actively with other sectors and departments on a broad range of analytical and operational work initiatives. Recent examples include a multisectoral analysis combining HNP, the chief economist of the Bank, Social Protection, PREM, and the government of ***Mexico***, reviewing options for improving social protection in Mexico. The last Institutional and Governance Review of ***Bolivia,*** led by PREM with the active involvement of HNP, analyzed policy options for an inclusive decentralization process. In the ***Dominican Republic*** HNP and PREM coordinated action on public sector reform to improve human resource policy effectiveness and national health procurement accountability. A new basic services and employment project is being prepared in ***Brazil***, where HNP worked with teams from the Water Supply and Sanitation and the Sustainable Development Sectors to design a project to improve quality of life and reduce poverty.

Malnutrition is a serious intersectoral problem that hinders economic growth and improvement of population well-being in several LCR countries. The design and implementation of conditional cash transfer (CCT) projects offered HNP an opportunity to work with Social Protection, Education, and PREM to improve health and nutritional outcomes among poor mothers and children in ***El Salvador*** and ***Ecuador.*** Nutrition work is also underway in ***Guatemala*** and ***Peru***.

Strategic partnerships

The LCR Region will continue to engage in strategic partnerships such as the multi-organizational review of HIV/AIDS projects in the Caribbean in 2006, conducted in collaboration with the Global Fund, UNAIDS, DFID, and PAHO / WHO. In coordination with UNFPA, the Bank Maternal and Child Health Care Project in Argentina supported the launch of a new reproductive health program and procurement of inputs, giving poor women, for the first time, access to preventive and family planning services.

Implications for Operations in the LCR Region

The chief constraint on LCR health work is the declining budget, which is beginning to erode the Region's capacity. The diminishing personnel budget has already imposed a small contraction on the Unit, which, even by Bank standards, already carries a very heavy workload. This constrains analytic work and may become a growing business impediment in a Region where the clients are technically sophisticated and expect state-of-the-art advice from the Bank.

Middle East and North Africa Region

Background

The Middle East and North Africa (MENA) Region has made significant improvements in the health status of its people (table B5). However, high rates of infant and maternal mortality, malnutrition, and micronutrient deficiencies persist in the low- income countries and among certain population groups in middle-income countries. With growing prosperity, the prevalence of lifestyle-related noncommunicable diseases is rising.

Table B5. Health Indicators in the Middle East and North Africa Region

Income group/country	GNI per capita, 2004 (US$)	Health expenditure, 2004 (% of GDP)	External assistance, 2004 (% of total)	U-5 mortality, 2005 (per 1,000 live births)	MMR modeled estimates, 2000 (per 100,000 live births)	Prevalence of child malnutrition, 2000–05 (% of underweight U-5 children)	HIV prevalence, 2005 (% of total population, ages 15–49)
LOW INCOME							
Yemen	570	5.0	15.0	102	570	46	n.a.
Djibouti	960	6.3	34.0	133	730	27	3.1
MIDDLE INCOME							
Algeria	2,270	3.6	0.0	39	140	10	0.1
Egypt	1,250	5.9	#N/A	33	84	9	0.1
Iran	2,330	6.6	0.2	36	76	n.a.	0.2
Iraq	n.a.n.a.	5.3	2.5	125	250	16	n.a.
Jordan	2,260	9.8	7.1	26	41	4	n.a.
Lebanon	6,040	11.6	1.7	30	150	4	0.1
Morocco	1,570	5.1	0.9	40	227	10	0.1
Syria	1,270	4.7	0.2	14.5	160	7	n.a.
Tunisia	2,650	#N/A	#N/A	24	120	4	0.1
West Bank and Gaza	n.a.	#N/A	#N/A	23	100	5	n.a.
GULF COOPERATION COUNTRIES							
Bahrain	14,370	4.0	0.0	11	28	n.a.	n.a.
Kuwait	24,040	2.8	0.0	11	5	n.a.	n.a.
Oman	9,070	3.0	0.0	12	87	n.a.	n.a.
Qatar	n.a.	2.4	0.0	21	23	n.a.	n.a.
Saudi Arabia	10,170	3.3	#N/A	26	23	n.a.	n.a.
United Arab Emirates	23,770	2.9	0.0	8.5	54	n.a.	n.a.

Source: World Bank. (2007). *2007 World Development Indicators*. Washington, DC: World Bank.

Strategic Objectives: What HNP Results?

The MENA HNP Strategic Objectives reflect the varying needs of four categories of countries at different stages of economic development:

- *Yemen and Djibouti,* the two IDA countries in the Region, face the greatest challenges and are at risk of not meeting the HNP-related MDGs. In Djibouti, the HIV/AIDS epidemic is taxing the country's economic resources.

- *Middle-income countries* (Algeria, Egypt, Iran, Jordan, Lebanon, Libya, Morocco, Syria, and Tunisia) are generally on track for achieving the health MDGs but rural / urban disparities in health outcomes and gaps in health coverage persist.

- *Members of the Gulf Cooperation Council* (GCC), assisted by high oil revenues, have achieved universal access to health services and good health outcomes, but still have room for efficiency and quality improvements.

- *Conflict-affected countries* are suffering significant reversals in health status and deterioration of their health systems (West Bank and Gaza, Iraq, and Lebanon).

Strategic Objectives: What HNP Results?

The HNP business strategy for the MENA Region will need to **find an appropriate balance in responding to growing demand for knowledge products and to emergency and reconstruction operations.** Due to the availability of alternative financing, the Bank is not seen as a primary source. The HNP team will **capitalize on the Bank's extensive international knowledge base** and analytical capacity in health systems.

Strategic Directions: How Should the Bank Support Country Efforts?

Renewing the Focus on HNP Results

A regional HNP Strategy Report (ESW) is proposed for FY08 to develop a conceptual framework for defining the HNP Results Framework for the MENA Region. In parallel, the HNP team will review the portfolio to identify potential synergies and gaps in AAA and lending and to ensure timely application of the framework in upstream work on Country Assistance Strategy. A major investment will be needed to develop effective monitoring and evaluation tools for measuring HNP Results.

Strengthening health systems for HNP Results

Across the MENA Region, demand is growing for health system modernization. The challenge is to define the areas in which the Bank has a comparative advantage. The following priority areas are identified: health finance reforms to improve financial protection and access to health care; improving the performance of health service delivery systems; and enhancing the governance and stewardship role of the state in the health sector.

Many governments in the MENA Region are seeking alternatives to their centralized government-managed health system, toward a more pluralistic system that includes active private sector participation. Demand is growing in the Region for technical advice on design and implementation of effective governance and regulatory functions, particularly accountability, where the Bank has a comparative advantage.

Multisectoral action to improve HNP outcomes

Within the MNSHD department, the introduction of an HD coordinator function has contributed to a more integrated approach to Human Development (Education, Social Protection, and HNP) at country level. Under this framework, **HNP and SP teams collaborate closely** in the areas of social security administration and health insurance. MENA Region programs on youth and early

childhood development include a significant health component and offer a basis for strengthening collaboration between the **HNP and Education teams**.

Other opportunities for collaboration are being explored in the Water and Sanitation and the **Urban and Transport Sectors**. With the PREM group, the MENA HNP team will be collaborating on two priority regional themes: **gender, and governance and anticorruption**. Finally, the MENA HNP team has been seeking active partnership with **IFC** and the **Private Sector Unit** in MENA to promote private-public partnership in health.

Strategic partnerships

As part of the MENA Regional Strategy, the HNP team will expand its collaboration with **key regional partners** and continue to work with bilateral, multilateral, and private donors in partnership with the IBRD and IDA countries receiving funding from these sources. To enhance the ability of policy makers and health care managers to evaluate the impact of HNP policies and programs, the Bank is collaborating with **international organizations**, **nongovernmental organizations, and academic institutions** to establish a *Middle East and North Africa Health Policy Forum,* modeled on the European Observatory on Health Systems and Policies.

Addressing the needs of fragile states and conflict-affected countries

An increasing share of Bank resources and HNP staff time is being directed toward mobilizing and coordinating contributions from the donor community during reconstruction in Iraq, Lebanon, and West Bank and Gaza. In this, MENA HNP team will work closely with the new Fragile States Unit (FSU) and Conflict Prevention and Reconstruction Unit (CPRU). The Bank could play an important role in bridging the gap between short-term humanitarian operations and longer-term development activities and in ensuring adequate attention to investments in human capital in recovering countries.

Reimbursable technical assistance

Reimbursable programs in the MENA Region increased from US$6 million in FY04 to US$10 million in FY06, some 12 percent of the MENA FY06 budget. Most of the growth occurred under reimbursable technical assistance (RTA), now comprising about US$7 million. RTA will continue to be a growing and important component of the MENA regional program, provided that the Bank can translate its international experience and knowledge into practical, country-tailored implementation actions. This will require access to a network of international expertise and continuous upgrading of knowledge about new developments in health system reform.

South Asia Region

Background

The South Asia Region (SAR) encompasses only eight countries (Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka), but it is home to a quarter of the world's population. The countries vary widely in size, wealth, and health problems (table B6), and dependence on international assistance. For all these reasons, the HNP SAR needs a differentiated strategic focus:

- *India, Pakistan, Bangladesh:* MDGs; focus on disadvantaged; new approaches to noncommunicable diseases (NCDs); financial risk protection.
- *Afghanistan, Nepal: (*the poorest countries) focus almost entirely on achieving MDGs.
- *Sri Lanka, Maldives, Bhutan:* more focus on NCDs; financial protection; macro-financing for HNP sector.

Table B6. Health Indicators in the South Asia Region

Income group/ country	GNI per capita, 2005 (US$)	Health expenditure, 2004 (% of GDP)	External assistance, 2004 (% of total)	U-5 mortality, 2005 (per 1,000 live births)	MMR modeled estimates, 2000 (per 100,000 live births)	Prevalence of child malnutrition, 2000-06 (% of underweight U-5 children)	HIV prevalence, 2005 (% of total population, ages 15-49)
LOW INCOME							
Afghanistan	n.a.	4.4	6.1	257	n.a.	39	0.1
Bangladesh	470	3.1	15.1	73	380	48	0.1
Bhutan	870	4.6	14.5	75	420	n.a.	0.1
India	720	5.0	0.5	74	540	n.a.	0.9
Nepal	270	5.6	17.6	74	740	45	0.5
Pakistan	690	2.2	2.5	99	500	38	0.1
MIDDLE INCOME							
Maldives	2,390	7.7	1.6	42	110	30	n.a.
Sri Lanka	1,160	4.3	1.2	14	92	29	0.1

Source: World Bank. (2007). *2007 World Development Indicators*. Washington, DC: World Bank.

Strategic Objectives: What HNP Results?

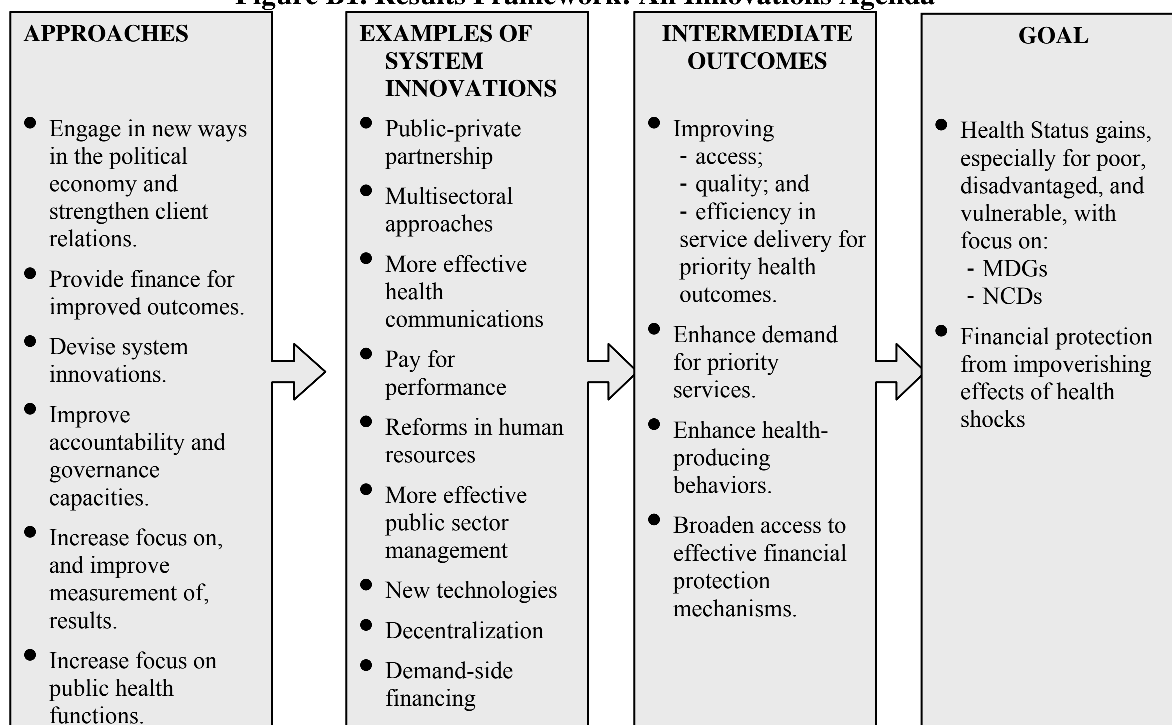
The Strategy focuses on two outcomes: (a) improved health status particularly for the poor; and (b) reducing health-related impoverishment through improved financial risk protection. Implementation of the new Strategy would lead to an HNP portfolio "make over" by 2011, resulting in more outcome-focused operations, inventive approaches aimed at strengthening health systems, probably fewer but larger operations that use innovative lending instruments, and a substantial Bank role in encouraging, analyzing, and evaluating novel approaches. The portfolio will have more sectorwide programming and will help strengthen the monitoring and evaluation systems in client countries with an aim of bolstering the results culture.

Strategic Directions: How Should the Bank Support Country Efforts?

Renewing the focus on HNP Results

The SAR HNP business plan is based on a Results Framework that links outcomes with specific strategies (figure B1). At the regional level, the strategic priorities guide analysis of how to focus the instruments available to the Bank to get results and what resources and actions need to be developed in the Region.

Figure B1. Results Framework: An Innovations Agenda



Strengthen health systems for HNP results

The Strategy recognizes several causes for the poor performance of health systems in the Region. These include (in no specific order): (a) insufficient drive for improving health outcomes from government and civil society leaders; (b) overcentralized systems in which not enough resources reach the periphery; (c) public sector service delivery that suffers from a poor incentive structure, weak management, rigid organization, and lack of accountability, and has few reasons for improving (d) human resources that suffer from inadequate supply, overconcentration in urban areas, weak management, and limited incentives; (e) insufficient engagement with the nongovernmental sector, which already provides most curative services, even for the poor; (f) high out-of-pocket costs for all, especially the poor, even in the public sector, and lack of organized financial risk protection; (g) few effective efforts to improve health- promoting behaviors; and (h) little effective targeting, to reduce health status disparities by income, gender, or geographical location.

Intersectoral approach to HNP Outcomes

The Unit suggests that regional management create a multisectoral team, led by an HNP lead specialist, to explore opportunities for operations focused on the specific role of various sectors in achieving HNP-related MDGs.

Implications for Bank Operations in the SAR Region

The SASHD HNP business plan creates space for innovation wherever possible, using all the instruments at its disposal. New staff skills and financial resources will be needed to support this innovations agenda, both from traditional Trust Fund sources as well as from new global and regional development partners, such as private foundations. The continuation of a dedicated M&E team (with a specific budget) will assist in improving M&E designs and staff knowledge.

Lending

Where possible, the **lending program** will move toward more programmatic financing, sectorwide support, or multisectoral lending in close cooperation with other development partners. The programmatic lending could take the format of development policy lending or be more broadly defined as output-based lending. In general, lending will shift away from traditional items of buildings and equipment and toward areas such as health financing linked to results / performance, financial protection, public health functions of government, and cross-cutting systems issues such as human resources. Priority would be given to MDG-related interventions.

AAA

The **analytical and advisory** work of SASHD-HNP will focus on strengthening the analytical basis for innovative approaches to service delivery and on disseminating evidence and analysis to decision makers through partnerships with WBI, other development partners, in-country institutions, and civil society organizations. Health financing will remain central, and increased attention will be given to governance and accountability.