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From Population Lending to HNP Results: The Evolution of the World Bank's Strategies in Health, Nutrition and Population

Background Paper for the IEG Evaluation of World Bank Support for Health, Nutrition, and Population

Mollie Fair

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Background paper for the IEG evaluation of World Bank support for health, nutrition, and population

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ABBREVIATIONS AND ACRONYMS

ACTafrica	AIDS Campaign Team for Africa
AAA	Analytic and Advisory Activities
AIDS	acquired immune deficiency syndrome
BNWPP	Bank-Netherlands Water Partnership Program
BSSA	Basic Social Services for All
CAS	Country Assistance Strategy
CDC	Center for Disease Control and Prevention
CDF	comprehensive development framework
CIDA	Canadian International Development Agency
CVI	Children's Vaccine Initiative
DAH	development assistance for health
DALY	disability-adjusted life year
DANIDA	Danish International Development Agency
DHS	Demographic and Health Survey
DFID	Department for International Development (United Kingdom)
DOTS	directly observed therapy, short course
EAP	East Asia and the Pacific
ECA	Eastern Europe and Central Asia
EDI	Economic Development Institute
ESSD	Environmentally and Socially Sustainable Development
FAO	Food and Agricultural Organization of the United Nations
FPSI	Finance, Private Sector and Infrastructure
FWCW	Fourth World Conference on Women
GAIN	Global Alliance for Improved Nutrition
GAMET	Global HIV/AIDS Monitoring and Support Team
GAVI	Global Alliance for Vaccines and Immunization
GBD	global burden of disease
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GHP	global health partnership
GNP	gross national product
GOBI	growth monitoring, oral rehydration, breastfeeding, and immunization
GTT	Global Task Team
HDN	Human Development Network
HNP	Health, Nutrition, and Population
HIPC	heavily indebted poor country
HIV	human immunodeficiency virus
IAVI	International AIDS Vaccine Initiative
IBRD	International Bank for Reconstruction and Development
ICPD	International Conference on Population and Development
ICR	implementation completion report
IDA	International Development Association
IEG	Independent Evaluation Group

IFC	International Finance Corporation
IFFim	International Finance Facility for Immunization
IFPRI	International Food Policy Research Institute
IHR	International Health Regulations
IMCI	Integrated Management of Childhood Illness
IMF	International Monetary Fund
INDEPTH	An International Network of field sites with continuous Demographic Evaluation of Populations and their Health in developing countries
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
IWRM	Integrated Water Resources Management
KAP	knowledge, attitudes and practices
LAC	Latin America and the Caribbean
LIC	low-income country
LSMS	living standards measurement survey
M&E	monitoring and evaluation
MAP	Multi-Country HIV/AIDS Program
MCA	Multisectoral Constraints Assessment
MDG	Millennium Development Goal
MEASURE	Monitoring and Evaluation to Assess Use and Results
MIC	middle-income country
MMV	Medicines for Malaria Venture
MNA	Middle East and North Africa
MSF	*Médecins sans frontières*
MTEF	medium-term expenditure framework
NGO	non-governmental organization
OCP	Onchocerciasis Control Program
OED	Operations Evaluation Department
ODA	official development assistance
PAHO	Pan-American Health Organization
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	primary health care
PHN	Population, Health, and Nutrition
PHR	Population and Human Resources
PPFA	Planned Parenthood Federation of America
PREM	Poverty Reduction and Economic Management
PRS	poverty reduction strategy
PRSC	poverty reduction support credit
PRSP	poverty reduction strategy paper
PSI	Population Services International
QAG	Quality Assurance Group
RBM	The Roll Back Malaria Partnership
RPP	Reaching the Poor Program
SARS	severe acute respiratory syndrome
SIDA	Swedish International Development Cooperation Agency
SIP	sector investment program

SSA	Sub-Saharan Africa
SWAp	sector-wide approach
TB	tuberculosis
TFI	Tobacco Free Initiative
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNECA	United Nations Economic Commission for Africa
UNESCO	United Nations Economic and Social Council
UNF	United Nations Foundation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNITAID	International Drug Purchase Facility
USAID	United States Agency for International Assistance
WHO	World Health Organization
WDR	World Development Report
WFP	World Food Program
WSP	Water and Sanitation Program
WSS	water supply and sanitation

EXECUTIVE SUMMARY

This paper reviews the evolution of the World Bank's strategies in the Health, Nutrition, and Population (HNP) sector in relation to both internal and global events, as background for the forthcoming evaluation by the Independent Evaluation Group (IEG) of the Bank's support for HNP. It summarizes the objectives, priorities, and strategies in HNP as expressed in official documents and revealed implicitly by its lending and non-lending activities. Special emphasis is placed on analysis of the period since the release of the 1997 HNP Strategy, which has guided the sector over the last decade. However, the report also reviews the Bank's earlier experiences in HNP, so as to provide a context for understanding the World Bank's current strategies. Detailed timelines annexed to the paper help to put the Bank's strategies and actions in the context of the evolution of global HNP themes.

The World Bank's policies, strategies, and lending for HNP have evolved in phases over the past thirty-five years. During the 1970s, the emphasis was on improving access to family planning services, because of concern about the adverse effects of rapid population growth on economic growth and poverty reduction. A handful of nutrition projects were also approved. During the second phase, from 1980-86, the Bank directly financed health services, with the objective of improving the health of the poor by improving access to low-cost primary health care. However, systematic constraints were encountered in providing access to more efficient and equitable health services. The Bank nevertheless remained committed to the sector, as health increasingly was recognized both as an economic imperative and a desirable end in itself. During a third "health reform" phase, from 1987-1996, the Bank strove to improve health finance and reform entire health systems.

The strategy that has guided the sector for the past decade was issued in 1997 at the same time that the Bank was reorganized and the Human Development Network was formed. The 1997 *Health, Nutrition and Population Sector Strategy Paper* signaled the beginning of the "health reform and health outcomes" phase. It aimed to help client countries: (1) improve the HNP outcomes of the poor and protect the population from the impoverishing effects of illness, malnutrition, and high fertility; (2) enhance the performance of health systems; and (3) secure sustainable health financing. The sector sought to achieve greater impact through emphasizing strategic policy directions in Country Assistance Strategies, underpinning lending with analysis and research, increasing selectivity, improving client services, and stronger monitoring and evaluation.

By the late 1990s, the Bank was the largest financier of development assistance for health, and thus largely influential in setting priorities in global health. However, the international donor community's commitments to reduce poverty and improve health outcomes surged at the end of the twentieth century. In the first years of the new century, in the "global targets and partnerships phase", the objectives of the Bank's HNP support remained the same, but the Bank has attempted to reposition itself in the changing global health landscape and redefine its role to participate in partnerships to meet global targets

while maintaining support to client countries to improve HNP outcomes, especially for the poor.

The recently approved updated HNP strategy, *Healthy Development: The World Bank Strategy for Health, Nutrition and Population Results* (2007), embraces many of the same objectives and approaches of the 1997 strategy, while putting greater emphasis on results, but it was adopted without the benefit of evidence of the efficacy and lessons arising from the past decade of HNP support, totaling $15 billion. This suggests that an evaluation of the HNP support of the past decade is timely and relevant in pointing to ways of improving the effectiveness of the new strategy. Priority questions for the evaluation include: (1) To what extent has the Bank's support contributed to improving HNP outcomes among the poor? (2) What lessons have been learned about the efficacy, advantages, and disadvantages of different approaches to improving health, such as sector-wide approaches, health system reform, multi-sectoral approaches, and the emphasis on communicable diseases that disproportionately affect the poor? (3) What has been the revealed 'value added' or comparative advantages of the Bank in supporting HNP, and how has that been changing? (4) To what extent has the Bank's HNP support monitored results and used evaluation to improve the evidence-base for decision-making?

1. INTRODUCTION

1.1 The World Bank's lending and non-lending activities in the Health, Nutrition and Population (HNP) Sector can be divided into six distinct phases, each with clear rationale, objectives, and strategy to guide its lending and non-lending activities. Whereas thirty-five years ago the World Bank's HNP lending was focused narrowly on population activities with a demographic rationale, it is currently involved in nearly all areas of health to improve HNP outcomes for the poor and vulnerable.

1.2 Drawing from HNP strategy and policy papers as well as evaluations of the Bank's work, this paper traces the evolution of the World Bank's strategies in the HNP sector. While it will focus on the decade since the release of the 1997 HNP Strategy, an overview of Bank's earlier policies, strategies and experience is necessary to explain the context of its more recent strategies as well as to understand its comparative advantages in the sector. The phases were influenced significantly by external events in international health and development as well as internal Bank-wide events. Level of commitment to the sector and the Bank's established priority areas have also been influenced heavily by the contemporary evidence concerning the relationship between health, economic growth, and poverty reduction. Annex A summarizes the objectives, rationale, and strategies of each the six phases of the Bank's work in the HNP. Annex B provides summaries of the key objectives and strategies of key HNP documents and strategy papers from 1997-2006, as well as a summary of *World Development Report 1993: Investing in Health*, which was highly influential on the Bank's work. Annexes C and D are timelines of important events in the World Bank's work in the HNP sector and Global HNP events, respectively.

1.3 Although the World Bank's mission and HNP policies continue to evolve and the global health architecture has changed dramatically in recent years, the need for the Bank to advocate evidence-based policies and employ the most effective approaches to facilitate and sustain improvements in HNP outcomes remains. This review aims to explain the evolution of the World Bank's objectives and strategies in the HNP sector, providing a basis to evaluate its support over the past decade. The forthcoming IEG evaluation of the World Bank's HNP support from 1997-2006 will provide valuable evidence on the efficacy and lessons of experience from the 1997 HNP Strategy. The evaluation's conclusions will be highly relevant for improving the effectiveness of implementation of the new 2007 sector strategy and of the Bank's support for achieving the Millennium Development Goals (MDGs).

2. POPULATION LENDING: 1970-1979

2.1 Dating back to the 1950s and throughout the 1960s, World Bank leadership expressed concern over the negative consequences of population growth on economic

development.[1] However, the Bank remained focused on its mission to promote economic growth primarily through investments for infrastructure and public utilities. As the family planning movement "flourished" in the mid-1960s, development economists ". . . played the critical role when they persuaded policy makers in the United States and some European governments, and soon thereafter in the World Bank, that rapid population growth was a major hindrance to economic development (Sinding 2007, p.1).[2]

2.2 By the late 1960s, the Bank committed itself to population control. In 1968, Robert McNamara, the Bank's fifth president, argued that there was no alternative to the World Bank's involvement in what he described as the "crisis" of population growth (World Bank Group Archives 2005). The first distinct phase of the Bank's work in the HNP formally commenced in 1970 with the approval of the first population loan to Jamaica for $2 million to support a family planning program.[3] The primary rationale for the Bank's population and family planning lending was demographic: ". . . limited experience available has already shown that if an adequate service can be provided . . . the results will be demographically significant" (World Bank 1972a, p. 317). It was believed that population growth would limit social and economic progress. The objective of the Bank's work in this new sector was to support governments to reduce rapid population growth through family planning programs that would lower high fertility.[4] Beginning in 1972, Bank operations focused particularly on countries with large populations and high fertility rates where the effects of a reduction in fertility rates would be most significant. The Bank's strategy for 1972-1975, as stated in the "Population Planning" chapter of the *World Bank Operations: Sectoral Program and Policies*, was to gather experience through its family planning programs to "establish the usefulness of its project approach in dealing with the population problem" (World Bank 1972a, p. 317). Fertility reduction was justified based on the premise that population growth thwarted efforts to increase per capita income and raise living standards.

2.3 Over the 1960s, the World Bank engaged in a broader range of activities, so that by 1970 it was lending for population, education and water supply, areas traditionally viewed as consumption sectors (as opposed to productive sectors). Given that economic growth was the World Bank's overall objective, work in population was rationalized by emphasizing its contribution to productivity: "Lending for education and water supplies reflected a similar tension between their perceived "social" or not strictly productive nature and the continuing conviction that all Bank investments and advice should seek the maximum contribution to economic growth" (Kapur 1997). Due in part to this

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[1] Concerns over population growth were discussed at the Seventh Annual Meetings in Mexico City in 1952, yet there was significant resistance to the World Bank becoming involved in an area outside of its original mandate to support postwar reconstruction and economic development.

[2] Throughout the 1960s developing countries established national family planning policies, the Second World Population conference focused on fertility as part of development planning policy, the United States Agency for International Development (USAID) began to finance family planning programs, the International Conference on Human Rights passed a resolution declaring family planning as a human right, and the United Nations Fund for Population Activities (UNFPA, now the UN Population Fund) began operations.

[3] For a detailed description of the project in Jamaica and the process to approve the loan, see King 2007.

[4] The total fertility rate (per woman) in developing countries dropped from an average of 5.4 between 1970-1975 to 2.9 between 2000- 2005. In low income countries, the rates dropped from 5.7 to 3.7(UN 2003).

tension, the first five years of the Bank's work in population was characterized by "hardware" projects that emphasized the construction of urban maternity hospitals and development of postpartum programs as channels for recruiting family planning acceptors (World Bank 1975). However as the Bank's objectives broadened to include poverty reduction throughout the 1970s, the need to justify lending in the social sectors purely with productivity arguments was reduced.

2.4 In fact, the World Bank's commitment to address population occurred at a time when a new climate of development thinking was emerging and it became increasingly evident that stimulating economic growth alone was not sufficient to reduce absolute poverty (Gollard and Liese 1980) (Box 2-1). A need to focus more deliberately on the poor, redistribute growth, and meet people's basic needs emerged. International organizations played an increasingly more prominent role in creating partnerships and programs to address health issues in developing countries, mainly with a basic services approach. The adoption of the Alma Ata Declaration at the International Conference on Primary Health Care in 1978, a major milestone, marks the point from which health was considered a fundamental human right, a social goal, and an economic imperative (Bloom and Canning 2003). Furthermore, it declared the rights of individuals and communities to participate in health care decisions, set a target for governments to ensure essential health care for their populations by the year 2000, and popularized the primary health care (PHC) approach by declaring it the means by which to ensure that the "health for all" target was met.

Box 2-1: Factors in the 1970s Leading to Increased Commitment to Health

A background paper for the 1980 World Development Report (WDR), *Health Problems and Policies in Developing Countries (1980),* identified five changes in the 1970s that were critical to shifting development thinking and bringing increased interest to the health:

- Economic development and health improvement seen as necessary to lower fertility rates;
- Focus shifted away from human resource development to improve productivity and toward distributing benefits from economic growth;
- Concern for human rights and meeting basic needs emerged in the mid-1970s "reorienting development programs to alleviate further the symptoms of poverty";
- Evidence of low-cost and effective means to reduce disease; and
- Support for basic health services emerged and supported broadly by the international community.

Source: Golladay and Liese 1980

2.5 As poverty reduction gained importance as a development goal, Bank President Robert McNamara emphasized the importance of addressing basic problems affecting the daily lives of the poor. Nutrition was one of the areas that most interested McNamara (Kapur and others 1997). A 1973 nutrition policy paper argued that while evidence for the economic justification for nutrition projects was still preliminary, better nutrition would "imply a more equitable distribution of income. . . encourage more effective population planning . . . [and] improve the level of well-being" (World Bank 1973). The Bank explored its potential role in human development issues, and throughout the decade, several reports, partnerships, and new initiatives signaled that the World Bank would

expand its HNP activities.[5] Although the Bank's official focus in the early 1970s was on population, work related to nutrition and other health issues was dispersed throughout several of the World Bank's departments. In addition to the Population Projects Department, there was a nutrition unit in the Agriculture and Rural Development Department, and the Office of Environment and Health Affairs under the Office of the Vice President of Policy focused on risk prevention and minimization which led to health concerns, particularly with respect to water projects.[6] By 1972, health components were included in agriculture, population, and education projects (Kapur and others 1997); the number of projects containing health components increased from five to twenty between fiscal years 1969 and 1973 (World Bank 1975).

2.6 The 1975 *Health Sector Policy Paper* was the first formal policy statement specifically addressing health issues (World Bank 1975). It made a link between economic progress and improvements in health conditions. It also drew attention to the considerable differences in health levels at the international level, as well as noting equally substantial disparities between the rich and the poor within countries. The paper presented two policy options for the World Bank: (i) to increase health benefits within present patterns of lending; or (ii) to begin lending for basic health services. In both cases consideration for the health benefits of projects would increase. However, in the first case these benefits would be supplementary objectives, as opposed to the primary objectives in the second option. Although the policy acknowledged that health programs should be included in broad programs for socioeconomic improvement that reduce mortality and fertility, the Bank chose to pursue the first option in 1975. Perceived obstacles to lending for basic health services that initially deterred the Bank included: concerns over the feasibility of low-cost health care systems, the lack of governments' political will to institute significant reforms, and questions related to the Bank's proper role in the sector, (Stout and others 1997). Thus, the policy limited Bank operations in health to components of other projects, including population and family planning projects, yet did not preclude the adoption of the second option when the Bank felt prepared to move into financing basic health services (World Bank 1975).

2.7 Perhaps the decision to finance basic health services came sooner than expected, as the Board approved the first loan in nutrition for $19 million to Brazil in 1976.[7] From 1975 -1978, "the Bank provided technical and financial assistance to forty-four countries for seventy health components of projects in other sectors . . . prepared seven health sector studies and several population sector studies and established working relationships with the World Health Organization and other major agencies working in the health sector" (Stout and others 1997, p. 30). In 1979, the Population Projects Department was renamed the Population, Health, and Nutrition (PHN) Department and shortly after a new

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[5] In 1971, the World Bank and WHO established a Cooperative Program to address issues related to water supply, waste disposal, and storm drainage. In 1973, the Bank took the lead in mobilizing international funds and cooperation to create the highly successful Onchocerciasis (River Blindness) Control Program. Furthermore, a 1972 paper, *Possible Bank Actions on Malnutrition Problems,* called for the Bank to play a more active role in nutrition (World Bank 1972b). The Bank was also instrumental in founding the UN Subcommittee on Nutrition in 1977.
[6] Bernhard Liese, personal communication, October 2007.
[7] This was the "Nutrition Research and Development Project" completed in 1983.

policy paper was released to outline the changes to come in the Bank's next phase of lending.

3. PRIMARY HEALTH CARE: 1980 - 1986

3.1 The second distinct phase of the Bank's HNP activities, marked by the 1980 *Health Sector Policy Paper,* formally committed the Bank to direct lending in the health sector (World Bank 1980a).[8] The policy paper recognized the importance of providing services to the poorest groups in the society and drew a tighter link between health sector activities, poverty alleviation, and family planning. The rationale for the 1980 policy was similar to that of the 1975 policy: due to market failures in the provision and financing of services, there was a justifiable need for government to ensure more equitable distribution of services (Stout and others 1997). Investment in costly tertiary facilities, inaccessible by the poorest, was deemed inappropriate and a reorientation towards PHC was pursued to bring about health gains as well as cost savings. The main objective of the Bank's work during the PHC Phase was to broaden access to cost-effective health care. The strategy focused on meeting the need for basic health services, especially in rural areas, with projects to develop basic health infrastructure, train community health workers and paraprofessional staff, strengthen the logistics and supply of essential drugs, provide maternal and child health care, and improve family planning and disease control (Box 3-1).

Box 3-1: Main Features of HNP (PHN)[9] Projects 1980-1985

According to the1986 R*eview of PHN Sector Work and Lending in Health*, 14 of 19 (74 percent) of the "first generation" of HNP health projects shared the main features of the prototypical project. It sought to:

- Increase coverage, efficiency and effectiveness of basic health services (including family planning and nutrition) mainly in rural areas;
- Strengthen capacity to plan, implement, monitor and evaluate health services;
- Improve human resource development in the health sector;
- Strengthen the physical infrastructure, mainly at the primary level; and
- Increase sector knowledge through studies.

The other projects types were: manpower (1) institutional development (1), urban health services (1), and tropical disease control (2).

Source: Measham 1986, p. v

3.2 Engaging in direct lending for health projects reflected a new commitment for the Bank to deal with "nearly all aspects of development . . . though (the World Bank) began with a primary focus on project promotion and selected inputs to GNP growth, the Bank has steadily broadened its own terms of reference" (Kapur and others 1997). The Bank's outlook on development had evolved beyond solely economic growth to incorporate human development. In fact, *The World Development Report 1980: Poverty and Human Development* asserted that while growth is vital for poverty reduction, alone it is not

[8] The first loan for health was approved in 1981 to Tunisia (World Bank 1997a).
[9] The acronym PHN (Population, Health, Nutrition) was used for the sector and its activities 1980- 1997 when it was re-ordered to HNP.

enough (World Bank 1980b). Human development, including health and education, complement poverty alleviation approaches and were seen increasingly as both morally and economically justifiable. The WDR maintained that human development programs must: increase political support for programs; address financial constraints; develop administrative strength; and ensure service usage (World Bank 1980b). Although Mexico's 1982 default and the resulting economic crisis initially re-focused the Bank's attention on market-oriented reforms and decreased emphasis on social programs, given the long-term timeframe necessary for recovery in many of the affected countries, it remained clear throughout the 1980's that social sector policy was highly relevant to financial sustainability (Nelson 1999).

3.3 In the early 1980s, international organizations and private foundations launched several initiatives focused on providing basic services to promote PHC that received considerable support. [10] Recent success with the eradication of smallpox in the late 1970s, and approaching polio eradication in the Americas demonstrated that vertical and categorical programs could make a mark. The demand for health loans increased and by 1984, the World Bank's lending for PHN reached 1.6% of its total lending, compared to the historical average for population and nutrition projects of one percent (Measham 1986). The World Bank, by now a key participant in several international health partnerships,[11]recognized that its areas of comparative advantage in engaging governments, programming, and sectoral analysis could contribute to the extension of health care coverage in developing countries. It is noted in a review of the Bank's work in HNP from 1980-1985, that: "heavy investment in sector work has paid handsome dividends in sector knowledge and experience, in enhanced credibility within borrowing countries and the Bank, and increased lending." (Measham 1986, p. iii) (Figure 3-1).

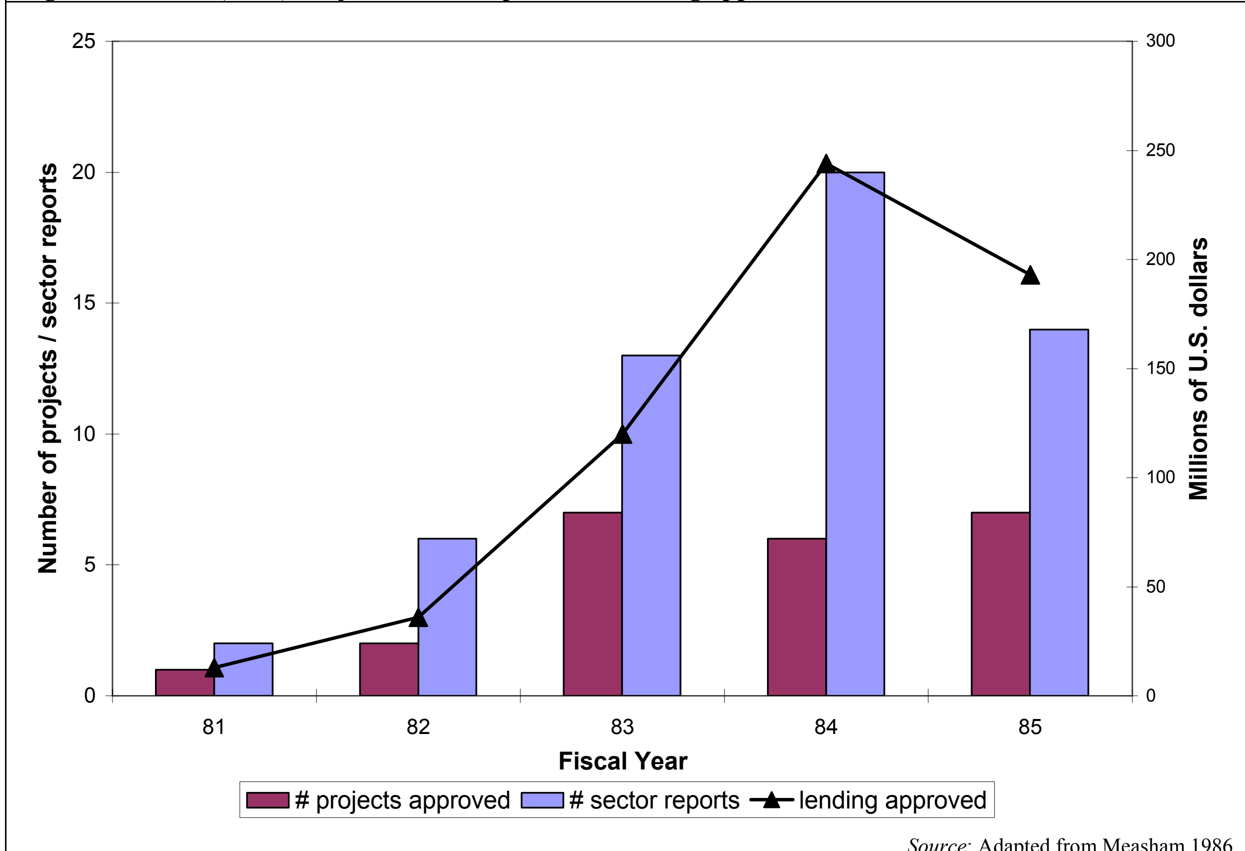
3.4 Population projects remained a prioritized item on the agenda, thanks to Bank experience in the area as well as the *World Development Report 1984: Population and Development* (World Bank 1984).Whereas the prior Phase emphasized the demographic rationale behind population programs, by 1984 the benefits of these programs were considered far more comprehensive: "(Family planning) benefits, moreover, do not depend on the existence of demographic objectives" (World Bank 1984, p.127). The report argued that appropriate public policies existed to affect decision-making on family size and that there was evidence that those policies were effective. WDR 1984 made the case that the benefits of family planning included: improved health, particularly for women and infants; greater availability of choices and opportunities, especially for women; and offered the greatest potential benefits to the poorest, who have higher mortality and fertility rates. While noting the recent expansion of family planning services, WDR 1984 pointed out that most services fail to reach rural populations and

[10] These include the declaration of the International Drinking and Water Supply and Sanitation Decade (1981-1990); UNICEF's Child Survival and Development Revolution that introduced GOBI, a program focused on four components: growth monitoring, oral rehydration, breastfeeding, and immunization (1982); the Task Force for Child Survival and Development to achieve universal child immunization by 1990 (1985); and Rotary International's PolioPlus Program (1985).

[11] By the mid-1980s, the Bank was a partner of the Onchocersiasis Control Program and the Task Force for Child Survival and Development, a co-sponsor of the WHO Special Programme for Research and Training in Tropical Diseases (TDR) , and had initiated the UNDP-World Bank Water and Sanitation Program,

that quality is often poor. It went beyond considering only policy and poverty as the factors influencing fertility, and paid considerable attention to the influence of decision-making at the family level as one of the ultimate determinants of fertility. This had important implications for the roles of social values and norms, and educational opportunities (particularly for girls) as well as knowledge and information on family planning programs. Additionally, it supported the integration of basic health services with family planning and other programs, such as immunization.

Figure 3-1: HNP (PHN) Projects, sector reports and lending approved FY81- 85



Source: Adapted from Measham 1986

3.5 Promotion of food supply and proper nutrition were included as basic elements of PHC by the Declaration of Alma Ata. Nutrition projects could serve as catalysts to bring policy attention to the issue, and reinforce efforts in the sector as they contribute to the development of primary health care and family planning programs (Berg 1987a). Although the sub-sectors of population, health and nutrition were more separate at this time within the Bank structure and operations than they are currently, there was increased recognition, such as in the WDR 1980, that a "seemless web" of interrelations connected them at the core to increasing the incomes of the poor (World Bank 1980b). The Bank's early rationale for investing in nutrition programs was that malnutrition had adverse effects on development, that most governments were not reaching the poor (especially the rural poor) with nutrition benefits, and that few central ministries had the resources or the organizational capacity do so (Berg 1980). The Bank's early work in nutrition was described as "learning by doing" (Berg 1987a). It financed high-priority experimental

projects and focused heavily on evaluation and analysis to identify effective interventions. Each of the four freestanding nutrition projects approved between 1976 and 1980 was designed to test a different approach, although they shared common features; they included institution-building and several operational components among them, usually nutrition delivery through primary health care services, some form of supplementary feeding or food subsidy program, and a nutrition education components (Berg 1987a). "Nutrition Review" (Berg 1987a), a review of the Bank's early experiences in nutrition, argued that the projects, particularly those implemented by the PHN Department had been successful in general, yet that overall, projects had been too complex and attempted to deal with too many of the causes of nutrition.[12] It advised that the Bank continue to pay more attention to institution-building to address poor management, which was identified as a factor limiting project achievement (Berg 1987a).

3.6 Shortcomings identified in the Bank's nutrition work were representative of overall weaknesses in the sector. The combination of fairly complex projects with the frequently weak administrative capacities of recipient governments led the Bank to invest more in capacity building. However, the capacity building provided was often not sufficient to bridge the gap between project expectations and requirements, and the reality on-the-ground, and did not address broader sectoral issues (Nelson 1999). Despite increased commitment to global health and important achievements during this phase, the health systems necessary to sustain and support such gains were "seriously deficient and often deteriorating" (Berman and Bossert 2000, p. 11). While the Bank could address some of the project-specific concerns with improved internal Bank policies to ensure greater attention to project design and context, many of the weaknesses identified demonstrated the limitations of introducing an approach dependent on weak health systems and unstable financing.

4. HEALTH REFORM: 1987- 1996

4.1 The Health Reform Phase began with the 1987 internal reorganization of the World Bank under which PHN became a division of the Population and Human Resources (PHR) Department,[13] and with the release of *Financing Health Services in Developing Countries: an Agenda for Reform*.[14] The Bank established two new objectives in this phase: to improve health finance by making it more efficient and equitable, and to reform health systems. A rationale emerged that systemic constraints

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[12] The Population Projects Department began to implement nutrition projects in 1976, but due to the productive elements within nutrition projects, they were shifted to Agriculture and Rural Development. When direct health lending was established in 1980, most of the activities and staff were transferred to the PHN Department. The "Nutrition Review" found freestanding nutrition projects managed by the PHN Department to be successful overall, but those undertaken as components and sub-components in other sectors less successful. This justified recommendations that: "nutrition components should only be considered for non-PHN projects if they are directly related to basic project objectives, can compensate for changes caused by the project that may be nutritionally negative, can be used to prepare for a future free-standing nutrition project, or can contribute to expanding programs already developed in country" (Berg 1987a, p. 80).

[13] This reorganization decentralized the formerly centralized PHN Department.

[14] *Financing Health Services in Developing Countries* was published December 31, 1986 and is thus relevant to this phase.

needed to be addressed in order to provide access to more efficient and equitable health services. Although no official sector strategy was released, the new objectives were evident through key policy papers and lending: "the Bank is now broadening that dialogue, both with borrowers and other lending agencies, to encourage consideration of new financing approaches to rethink prevailing strategies and the concepts on which they are based" (World Bank 1986a, p. 49). As the World Bank's emphasis on the social sectors continued to grow, its spending on health, nutrition and population increased sevenfold from the late 1980s to the late 1990s (Nelson 1999).

4.2 As efforts to expand PHC in the previous Phase coincided with slow economic growth and budget deficits in the 1980s, increasing concern arose over how to ensure adequate financing for human development. The emergence of the AIDS epidemic along with evidence of changing health needs attributed to the demographic transition promised to radically change the scenario for disease control in middle income countries (MICs), making the case for health reforms to strengthen the capacity of health systems to deal with such challenges. The focus on reform was also stimulated by evidence that different regions and countries needed health care systems with different features (OED 1999a).

4.3 Policy dialogue with governments on health system strengthening and health financing were maintained to be a comparative advantage of the Bank. Throughout this Phase, the Bank sponsored sector studies on health financing (OED 1999a). Debate over the role of governments, markets, and the private sector became the focus of World Bank policy dialogue and lending for health sector reform. Whereas in the early 1980s less than one fifth of health projects included explicit reform or "systemic" objectives, this number quickly multiplied to approximately one third of all health projects in the late 1980s and continued to grow to nearly one half of all health projects in the late 1990s (OED 1999b) (Figure 4-1).[15] This pattern was very much aligned with the Bank's overall focus at the time on fiscal decentralization, privatization and improving the effectiveness of public sector management (Stout and others 1997).

4.4 *Financing Health Services in Developing Countries: An Agenda for Reform*, addressed a policy theme identified but not prioritized in the 1975 and 1980 Policy Papers. It argued that: "Fostering improvements in health sector finance is among the most valuable contributions the World Bank can make to better health care in low income countries" (World Bank 1986a, p. 51). The paper proposed four policies to improve the efficiency and equity of health care: (i) implementing user fees at government health facilities; (ii) promoting insurance or risk coverage to mobilize resources while protecting households from health shocks; (iii) utilizing nongovernmental resources more effectively; and (iv) decentralizing planning, budgeting and purchasing. The Bank's promotion of user fees came under substantial attack and continues to fuel debate in health financing (Gottret and Schieber 2006). At the time, expansion of user fees was proposed to improve service delivery efficiency, improve access for the poor by

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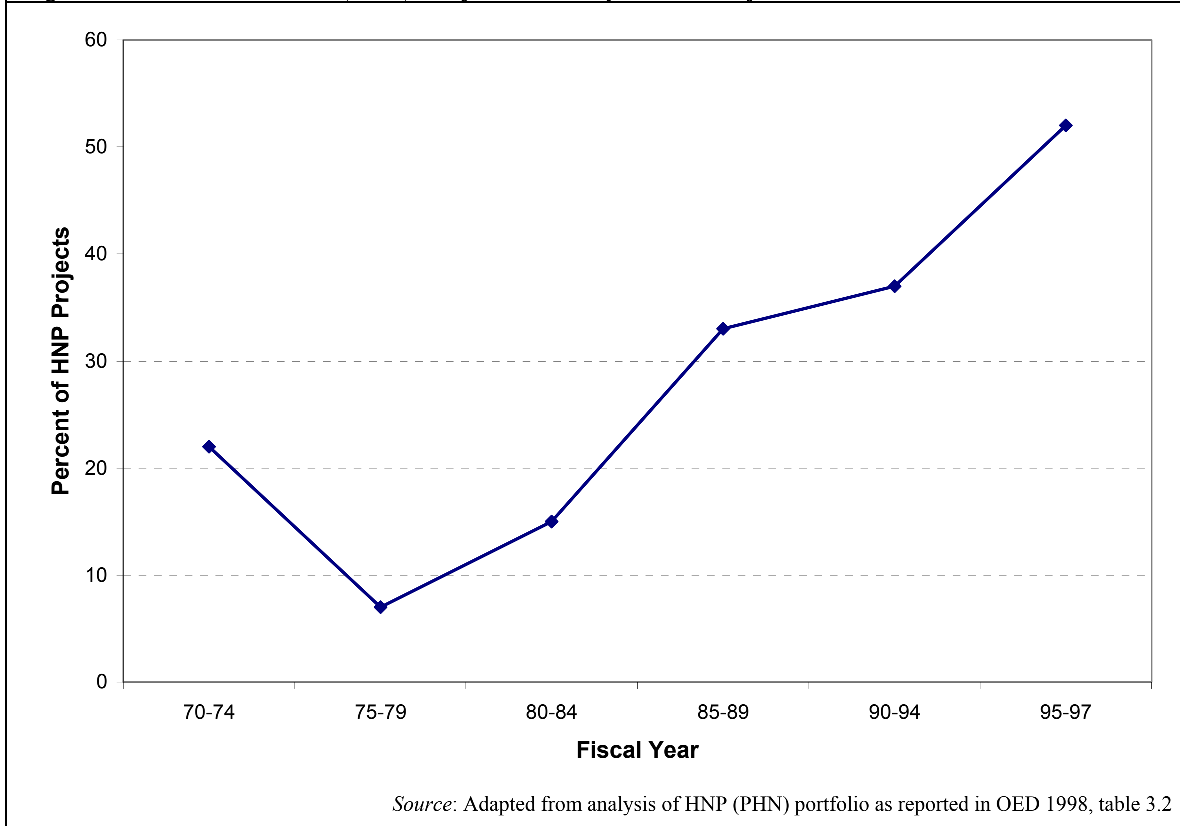
[15] Objectives classified by the study as "systemic" were those including objectives related to major organizational change of system-wide financial reform. Projects with "non-systemic" objectives may have included elements of institutional and/or organizational change but typically approached them on a smaller-scale (OED 1998).

Figure 4-1: Percent of HNP (PHN) Projects with "Systemic" Objectives



Source: Adapted from analysis of HNP (PHN) portfolio as reported in OED 1998, table 3.2

substituting public services at modest fees for higher-priced and less-accessible private services, and generate revenue to improve health care quality; the paper provided several alternatives to safeguard the poor from unaffordable costs (World Bank 1986a). The World Bank was not alone in its support for cost recovery. In fact, The Bamako Initiative, launched in 1987 by African Ministers of Health at the WHO Regional Assembly, advocated many of the same principles promoted by the World Bank during this phase (Box 4-1).

4.5 *The World Development Report 1993: Investing in Health* evaluated the roles of governments and markets in health, as well as ownership and financing arrangements to improve health and reach the poor (World Bank 1993). The Report advocated a three-pronged approach to guide policies to improve health in developing and formerly socialist countries. First, it recognized the importance of health decision-making at the household level, arguing that governments should pursue economic growth policies that benefit the poor and permit improved decision-making through economic empowerment. Second, it promoted redirecting government spending on health toward cost-effective programs, including prevention, promotion and outreach, in addition to a minimal package of essential clinical services that particularly benefit the poor. Last, it encouraged greater diversity and competition in health finance and service delivery. Acknowledging the growing influence of the international community on setting health priorities, it called for improved coordination to shift donor money toward public health, essential clinical care, and health research.

Box 4-1: The Bamako Initiative 1987

The Bamako Initiative's main principles:

- **Bottom-up action by communities** is needed to complement top-down health policy reforms where public institutions are weak;
- **Community financing of health centers** can generate sufficient income to cover the recurrent, non-salary costs of basic health units;
- **Even poor households will pay modest charges for health care**, provided they perceive the services to be of good quality, which they usually gauge in terms of the availability of essential drugs and positive health worker attitudes;
- **Governments can make a package of affordable essential health services of reasonable quality** available to the majority of the population if the package is cost-effective, a well functioning district health system exists and a community financing scheme is in place
- **Active participation of users is decision-making and control of health system resources increases public accountability** of health services, improves management and enables communities to identify with the health system, all of which generates a feeling of ownership and belonging essential to mobilizing community resources and ensuring sustainability

Source: UNICEF 1995 , p. 5

4.6 *Disease Priorities in Developing Countries*, a highly influential publication from this Phase, provided information on disease control interventions for the most common diseases and injuries in developing countries (Jamison and others 1993). A companion publication to the WDR, it was a timely contribution presenting evidence on the most cost-effective interventions for essential health service packages. Evidence-based decision-making was an important current that emerged during the Health Reform Phase and implied more sector studies and analysis. It also required improved systems for monitoring and evaluation (M&E) to collect data at the project and sector levels.

4.7 These publications were seminal to the transition from the PHC to the Health Reform Phase, the most dramatic transition in terms of shifting the Bank's objectives, rationale, and strategies. Although there was a surge in the funds available for HNP, population and nutrition had to compete for centrality in projects.[16] This had to do in part with at least three factors: (i) the trend in increased lending for health reform objectives; (ii) decentralization of the PHN Department into the regions which to some degree reduced the institutional space for the population and nutrition sub-sectors and staff; and (iii) population and nutrition strategies that advocated for comprehensive approaches that went beyond the health sector and health systems. [17]

4.8 Although slowing population growth rates and reducing unwanted fertility remained objectives, the Bank's population agenda did become far more comprehensive as a response to the international community's adoption of a Program of Action to improve women's sexual and reproductive health at the International Conference on Population and Development (ICPD) in Cairo in 1994 (Box 4-2). Whereas population policy had formerly meant policy to reduce population growth through family planning and demographic targets, the ICPD "was a move toward a holistic approach to

[16] According to the 1997 HNP Strategy document, *cumulative HNP lending* increased from less than one percent of the World Bank's total cumulative lending in FY86 to over three percent in FY96. Eleven percent of the annual lending for FY96 was to the HNP sector, although this was extremely high do to approval of five abnormally large loans.

[17] As lending for more comprehensive programs increased, it became more difficult to track.

reproductive health" (White and others 2006, p. 3). A 1994 policy paper on population prepared for the ICPD, *Population and Development: Implications for the World Bank* supported "an emerging consensus . . . that population policy objectives should be integrated with broad social development goals and that population program strategies should build on linkages between demographic behavior and social and economic progress" (World Bank 1994a, p. 1). The World Bank emphasized the need to focus on providing the poor with access to high-quality and user-oriented services, improve educational opportunities for women, and raise the economic and social status of women. The policy paper argued that population strategies must be country-specific, and linked to other complementary policies and to the core development agenda; it also recommended that the Bank conduct research and engage in policy dialogue to consider the significance of other demographic issues besides population growth. According to a 1997 report by Population Action International (PAI), the Bank's lending for population and reproductive health had increased in recent years but had not kept pace with overall growth of the sector. In fact, new loan commitments for family planning activities alone dropped below $100 million a year in fiscal years 1995 and 1996 compared to annual averages roughly twice as much in the early 1990s.[18] As projects became more comprehensive, "reproductive health and family planning activities [became] small and often marginalized components" (Conly and Epp 1997, p. vii).

Box 4-2: Major Objectives of the International Conference on Population and Development (ICPD)

The following are five of the major development objectives expressed at the ICPD:

- Bridge the gender gap in education;
- Promote equity for women;
- Reduce maternal mortality and morbidity;
- Increase universal child survival; and
- Provide universal access to reproductive health and family planning services.

Source: World Bank 1997a, Annex B

4.9 By 1987, some 55 nutrition-related research studies had been undertaken or financed by the Bank (Berg 1987a). They demonstrated that improvements in nutrition were possible even without major increases in income and that several efficacious and affordable means existed by which Bank projects could contribute to addressing malnutrition. The 1987 publication, *Malnutrition: What Can Be Done? Lessons from World Bank Experience,* proposed that the Bank pursue three types of projects, those that: (1) alleviate critical short-term nutritional needs; (2) improve food distribution and make expenditure on food and the food marketing system more efficient; and (3) fortify food staples with vitamins and minerals or provide these micronutrients through food supplementation projects (Berg 1987b). The WDR 1993 recognized micronutrient programs as among the most-cost effective of all health interventions. *Enriching Lives: Overcoming Vitamin and Mineral Malnutrition in Developing Countries* (World Bank 1994c), a follow-up to WDR 1993, argued that poverty alleviation and strengthening health systems alone were not sufficient to solve micronutrient deficiency problems. It advocated a comprehensive approach that focused on social mobilization, using market incentives and regulation to encourage fortification of foodstuffs and water, and

[18] The PAI report used data provided by the World Bank for its calculations.

distribution of pharmaceutical supplements through public and private channels when necessary. Despite evidence of the cost-effectiveness of these interventions and a series of conferences in the early 1990s that set nutrition-related targets,[19] lack of strong leadership among the international organizations and political commitments among governments remained central challenges to the World Bank and international community's progress in addressing nutrition (Chen 1986, World Bank 2006).

4.10 The Bank reaffirmed its focus on poverty with the 1990 WDR. The report identified a two-fold strategy to reduce poverty by focusing on broad-based growth and addressing basic social services, including health and education, to ensure that the poor are able to take advantage of income-generating activities. The report was recognized to have played an important role in highlighting the social dimensions of poverty following the "lost decade" of the 1980s, yet it was noted that ". . . many of the details of how the Bank could disaggregate social groups, reach and engage the poor, and help overcome the social and institutional barriers to participation in the economy and society, had yet to be fully articulated" (Davis 2004, p. 10). However, by the end of this phase and into the next, important evidence was gathered on the extent to which public spending on health actually reaches the lowest income groups (Yazbeck and others 2005). The development of a wealth index that uses household assets as a measure of relative economic status instead of consumption or income (which are more time-consuming and expensive to collect) facilitated this research and allowed for greater analysis of the distribution of health outcomes and health system outputs (Filmer and Pritchett 1998,Yazbeck and others 2005). This made measuring the effectiveness and equity of health interventions that target the poor much more feasible.

4.11 A review of the World Bank's completed projects from 1970- 1995 showed that the HNP Sector's average rating for the portfolio was lower than the averages of projects managed by other sectors (Box 4-3). Moreover, the HNP Sector's embrace of Bank-wide

Box 4-3: Findings from OED's 1999 Evaluation of the HNP Sector

The Operations Evaluation Department (OED), now the Independent Evaluation Group (IEG), recognized the value of the Bank's support for HNP to raise awareness of health reform and finance, to develop reform strategies, and to improve donor coordination. However, a review of the HNP portfolio showed that **only 61 percent of completed HNP projects from FY 1970-1995 were rated moderately satisfactory or better** compared to 79 percent of projects managed by other sectors.

Main findings:

- The Bank was more successful expanding health service delivery systems than improving service quality and efficiency or promoting institutional change
- Projects were too complex, particularly in counties with the least capacity
- The Bank did not focus enough on determinants of health outside the medical care system, such as behavioral change and cross-sectoral interventions
- Most HNP projects identified key performance indicators, but the gap between intentions for M&E actual implementation and collection of data was particularly problematic

Recommendations for internal processes and interactions with borrowers:

- Enhance quality assurance and results orientation
- Intensify learning from lending and non-lending services
- Enhance partnerships and selectivity

Source: OED 1999a

[19] These included the World Summit for Children (1990), International Conference on Nutrition (1992), and the World Food Summit (1996). The World Bank also helped to establish the Micronutrient Initiative in 1992.

priorities to increase participation, partnerships and focus on the client signaled a need for an updated strategy. At the conclusion of this Phase, unprecedented international attention was on the World Bank and donor community to address debt relief, HIV/AIDS, and the effectiveness of development assistance.

5. HEALTH OUTCOMES AND HEALTH SYSTEMS: 1997-2000

1997 HNP SECTOR STRATEGY

5.1 In 1996, President James Wolfensohn outlined a Strategic Compact to renew the World Bank and promote a more comprehensive framework to strengthen its mission to reduce poverty and promote economic growth (Box 5-1).[20] A reorganization of the World Bank in 1997 intended to promote better Bank-wide balance between maintaining both a "country-focus" and "sectoral excellence," created the Health, Nutrition and Population Sector Board (OED 1999a).[21] The start of a new phase was marked by this reorganization, along with the release of the *1997 Health, Nutrition, and Population Sector Strategy Paper*.

Box 5-1: Key Elements of the Strategic Compact

During the so-called "Compact period" (1997-2000) the following key elements became the framework for reshaping the Bank's activities and reinforced the use of new approaches in the HNP sector:

- Improving resource mobilization;
- Promoting increasingly integrated approaches;
- Building partnerships and sharing knowledge; and
- Restructuring the Bank to be closer to clients through responsive and high-quality products.

Sources: World Bank Group Archives, Wolfensohn Timeline

5.2 The central premise of the *1997 Health, Nutrition, and Population Sector Strategy Paper* was that: "Investing in people is at the center of the World Bank's development strategy as it moves into the 21st century, reflecting the fact that no country can secure sustainable economic growth or poverty reduction without a healthy, well nourished, and educated population" (World Bank 1997a, p. 10). The strategy identified the Bank's strengths in the sector vis-à-vis the international community as its global expertise from the developing world, its multisectoral, macro-level country focus, and its ability to mobilize large financial resources, either directly or through partnerships.

5.3 The three stated objectives of the *1997 Health, Nutrition, and Population Sector Strategy Paper* were to help client countries: (i) improve the health, nutrition, and

[20] Launched in April 1997, the Strategic Compact was a compact "between the Bank and its shareholders; to invest $250 million in additional resources over a three-year period to deliver a fundamentally transformed institution—quicker, less bureaucratic, more able to respond to continuously changing client demands and global development opportunities, and more effective and efficient in achieving its main mission—reducing poverty" (World Bank 1997b, p. 1).

[21] In 1997, the PHN Department was renamed HNP. Although the three components remained the same, their order reflected the shift in the sector's priorities.

population outcomes of the poor, and protect the population from the impoverishing effects of illness, malnutrition and high fertility; (ii) enhance the performance of health care systems by promoting equitable access to preventive and curative HNP services that are affordable, effective, well-managed, of good quality, and responsive to clients; and (iii) secure sustainable health care financing by mobilizing adequate resources, broad risk-pooling mechanisms, and effective control over public and private expenditures.

5.4 The strategy has been described as one of the measures taken by the Bank to "gear up to promote institutional reform" in order to better support the long-term process of health reform in partner countries (Nelson 1999, p. 56). The objectives did not depart drastically from priority areas established in the previous Phase (health systems and finance reforms). However, the effects of the Bank's more comprehensive approach to development and poverty reduction during this phase were evident by the inclusion of improving health *outcomes* for the poor as a strategic objective, and experimentation with new approaches and tools, such as sectorwide approaches and the Poverty Reduction Strategy (PRS). "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 settings" (Claeson and others 2000).

5.5 The advance of survey methods described above, including more widespread use of Demographic and Health Surveys (DHS), and greater availability of data provided further evidence that health outcomes and service use were closely related to economic status (Wagstaff 2000).[22] This sparked increased recognition that inequalities in health outcomes between rich and poor were unjust—not only between countries but within countries: "Closing inter-country and intra-country gaps between the poor and better of by securing greater proportional improvements amongst the poorer groups, is not simply a poverty issue- it is also a question of social justice and equity" (Wagstaff 2000). Thus, consistent with the World Bank's overall reinforced commitment to reducing poverty, the HNP sector responded by establishing improvement of HNP outcomes for the poor as an "absolute priority".

5.6 In addition to the prioritization of health outcomes for the poor, this strategy departed from previous phases in its emphasis on: stimulating demand for health services; promoting client-generated and driven strategies; intersectoral collaboration; and greater flexibility and responsiveness by the Bank to respond to client countries. Furthermore, the HNP sector's strategy to achieve its three objectives was far more explicit than previous strategies (Table 5-1). The following four sections summarize the plans outlined by the strategy paper in four action areas: (i) sharpening strategic directions; (ii)achieving greater impact; (iii) empowering Bank staff; and (iv) building more strategic partnerships[23]

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[22] In 2000, Gwatkin and others published a series of 44 country reports on *Socio-Economic Differences in Health, Nutrition and Population* analyzing DHS data disaggregated by wealth quintiles based on an asset index (Gwatkin and others 2000).

[23] The strategies and recommendations that follow were those laid out by the strategy paper but do not necessarily represent the course taken; evidence from the IEG evaluation will shed light on the Sector's actual lending and non-lending trends, and results over the last decade.

Table 5-1: The Bank's 1997 HNP Sector Objectives and Strategies

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

Notes:

a. For example, targeting: the poorest individuals and households; poor regions or vulnerable groups; HNP problems that mainly affect the poor (communicable diseases, childhood illness, high fertility, maternal and prenatal conditions); services and/or providers used by the poor. (World Bank 1997a p.. 6-7).

b. For example, food and agriculture policies, environment, water supply, sanitation, transportation.

c. For example, vouchers, contracting out service provision to the private sector, and obtaining greater client feedback.

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

SHARPENING STRATEGIC DIRECTIONS

5.7 Each of the strategy's objectives were associated with specific recommendations for policy at the country-level, as well as strategies for the Bank to more effectively support implementation of these policies and programs. Use of targeting mechanisms, providing equitable access to quality services, and promoting multisectoral collaboration were the primary country-level strategy areas recommended to achieve the first objective. The use of targeting was advocated to reach low-income groups, vulnerable populations and specific geographic locations, and to address poverty-related diseases, and services used by the poor. The strategy encouraged governments to promote high-impact activities, particularly basic health services and public health activities with large externalities, including investments is communicable disease control. While an emphasis on providing basic health services was somewhat reminiscent of the PHC approach, a fundamental difference was the focus on demand-side factors. The strategy argued that while targeting would help to promote more equitable access to services, improving the quality of services was fundamental to stimulate demand among the poor and ensure

service use. The third critical dimension of this strategy was its emphasis on maintaining policy oversight in sectors outside of health, including areas such as rural and urban development, social policy, education, agriculture and the environment.

5.8 To do its part to contribute to achievement of the first objective, the strategy committed the Bank to working closely with governments to encourage them to provide or mandate affordable and cost-effective services for the poor. It would also work with other sectors to encourage "healthy" policies across sectors, such as tobacco and alcohol control and taxation, appropriate food subsidies, road safety and environmental issues. At the Bank, the strategy indicated that Human Development Network (HDN) would pursue closer working relationships with two newly formed networks, the Poverty Reduction and Economic Management (PREM) Network and the Environment and Socially Sustainable Development (ESSD) Network, to promote the inclusion of pro-poor HNP interventions into poverty alleviation and rural development programs.

5.9 To achieve the strategy's second objective, enhancing the performance of health care systems, the 1997 document recommended sector-wide reforms and more effective use of non-governmental resources. A high-performing system would be one that ensured equitable access to preventive and curative health services that were affordable, cost-effective, efficient, of good quality, and responsive to consumer choice. While sector-wide reform was deemed necessary for countries with systemic problems, the new approach emphasized that reforms would vary between countries, particularly between low and middle-income countries. Moreover, emphasis on promoting cooperation across several ministries to enhance the sustainability and comprehensiveness of reforms was encouraged. While the previous phase encouraged governments to work with nongovernmental providers, in this phase, harnessing the resources of private and nongovernmental providers was a fundamental means to promote greater diversity in service delivery systems. Incentives would be used to encourage public and private sectors to improve efficiency and effectiveness, and quality through competition. Working increasingly with nongovernmental resources necessitated increased attention to regulations, monitoring, and licensing.

5.10 The 1997 strategy committed the Bank to work increasingly with governments, NGOs and civil society to strengthen policymaking, governance, accountability, management and M&E. It also committed the Bank to foster partnerships with nongovernmental providers and help to encourage an environment in which they could contribute knowledge regarding strategies to improve access, the effectiveness of certain interventions, control quality, and response to client needs. To improve its understanding of divestiture of social assets, described by the paper as the final phase of successful reform experiences, and to improve financing to nongovernmental recipients, the HNP sector proposed to collaborate with the International Finance Corporation (IFC) as well as the Finance, Private Sector, and Infrastructure (FPSI) Network, which was formed in 1996.

5.11 The strategy to help countries secure sustainable recurrent financing for HNP, the third objective, included using a mix of taxation instruments and co-payments tailored at the country level. In low-income countries, the emphasis was on complementing public

resources with community-based and international assistance. Use of taxation instruments to mobilize financial resources and expand risk pooling was promoted for middle-income countries. The sector recommended that governments maintain effective expenditure control and ensure that the HNP budget envelope was used on effective and quality care that benefited those who most needed it. Furthermore, the need to develop improved budget allocation processes at the national and local levels was a priority. Once again, the need for multisectorality was echoed in the recommendation that multiple ministries, particularly ministries of finance and social security, cooperate at the country-level to implement the country-driven health finance strategies.

5.12 The strategy paper advocated that the Bank work with governments to strengthen their policymaking role and involvement in health care financing, especially in countries where health care expenditures were less than three percent or greater than seven percent of GDP. It would also encourage the incorporation of national health accounts and other relevant data in policymaking processes. At the country level, the Bank would work with ministries of social security, finance, and health to pursue this objective, as well as with the PREM Network within the Bank.

ACHIEVING GREATER DEVELOPMENT IMPACT

5.13 The 1997 strategy indicated that the sector would aim to achieve greater development impact by: emphasizing the strategic policy directions in Country Assistance Strategies (CAS)[24]; underpinning lending with analysis and research; increasing selectivity; improving client services; and improving both Bank and borrower capacity to monitor and evaluate progress.

5.14 The CAS was promoted as “a key instrument for delivering the Bank’s message about HNP priorities during high-level country dialogue,” particularly in countries with systemic HNP problems (World Bank 1997a, p. 19). As noted in the strategy, the use of CASs was intended to contribute to increased selectivity by focusing dialogue on HNP issues that require broad systemic and multisectoral interventions, the Bank’s areas of comparative advantage. Most importantly, use of the CAS was consistent with the country focus emphasized by the strategy paper and reflective of the Bank’s broader efforts to “get closer” to the client with new tools and instruments.

5.15 As the Bank’s global expertise and ability to mobilize financial resources were also identified as areas of comparative advantage, it was logical that the Bank would want to underpin lending with analysis and research to strengthen its HNP knowledge base. The strategy advocated that the research agenda be linked to operational priorities in order to facilitate the systemic application of lessons learned and to improve the project design process. This was closely related to the “renewed effort” to strengthen and integrate monitoring and evaluation into project design. Other efforts highlighted by the 1997 strategy to achieve greater impact included improving supervision of projects,

[24] A Bank-wide reform of the Country Assistance Strategy, a major document for policy dialogue and strategy formulated at the country team level, was undertaken in 1997 to increase their client focus and strategic selectivity.

streamlining procedures, and conducting client satisfaction surveys to ensure responsiveness and maintain close relationships with clients.

EMPOWERING BANK STAFF

5.16 As the World Bank pushed for client-driven strategies and responded to calls for increased accountability, it paid greater attention to the impact of factors at the Bank that influenced HNP outcomes in developing countries. The 1997 strategy described the HNP Sector's plan to streamline processes, empower staff, and recruit staff with an appropriate skill mix in order to be most responsive to the client countries. It did not provide a detailed breakdown of the types of staff members to be recruited, but indicated that those sought would have "broad skills needed to deal with a wider range of products" and practical experience in the HNP sector, along the ability to work effectively on policy issues, including a solid understanding of political economy and reform (World Bank 1997a, p. 21).

STRENGTHENING PARTNERSHIPS

5.17 At the time the strategy paper was written, the Bank was the single largest external source of HNP financing in LICs and MICs, had experienced positive results from partnerships (such as river blindness control), and sought to enhance its contributions through HNP through new relationships and approaches . Thus, one of the objectives of the 1997 strategy was to build relationships with partners based on comparative advantages both at country and global levels. Priority areas for strengthening partnership included: research and development (R&D); knowledge sharing in nutrition and reproductive health; pharmaceutical, vaccine and biotechnology research; and searching for an AIDS vaccine. The strategy also sought to ensure that clients were included in, and benefited from such collaborative efforts.

POPULATION AND NUTRITION

5.18 The 1997 strategy identified high fertility and malnutrition as key health and social challenges in low-income countries. It described a broad range of needed social policies, and noted that traditional values and attitudes may need to be addressed in order to stimulate demand for services to lower fertility and improve nutrition. In terms of population, it emphasized the need for effective population policies to improve family planning and reproductive health services to increase demand for smaller families and reduce unwanted fertility. Subsequently, *Population and the World Bank: Adapting to Change* (1999), argued that the Bank's work in population should increasingly take advantage of policy dialogue to address demographic concerns (World Bank 1999b). It identified countries in which attention to population and reproductive health was expected to have a critical impact on poverty and development, and argued that population perspectives should be included in those countries' CASs. The Bank's work remained guided largely by the ICPD Program of Action.

5.19 In the case of nutrition, the 1997 HNP strategy paper recognized that strengthening health systems would not be sufficient to reduce malnutrition. The next

generation of nutrition action plans needed to include: comprehensive food policy reforms, heavy investment in communications for behavioral change in nutrition, greater involvement of private food industry, and reduced reliance on untargeted, stand-alone food distribution programs (World Bank 1997a). Encouraging governments to address "often-neglected multisectoral issues such as food and agricultural policies, environment, water supply, sanitation and transportation" would have a direct impact on health (World Bank 1997a, p. 18).

5.20 Given widespread recognition of the development impact of population and nutrition interventions at a time of increased support for multisectoral approaches, channeling population and nutrition into high-level dialogues and CASs was promoted. However, there was one basic, yet critical challenge to the efficiency and effectiveness of mainstreaming these issues into broader development strategies: limited resources and competing priorities at a time when support for HIV/AIDS soared and new partnerships and arrangements to address global health were sought. Although population and nutrition remained central to the Bank's HNP strategy, high-level specialist positions in the anchor, those of Senior Nutrition Adviser and Senior Population Adviser, were eliminated when the advisers left their positions in the late nineties and in 2005, respectively, and were not replaced.[25]

NEW INSTRUMENTS AND APPROACHES

5.21 While the 1997 strategy paper committed the sector to new approaches, increased international attention to and debate over the effects of globalization and development assistance helped to cement both sectoral and Bank-wide commitment to new approaches. Financial crises in East Asia, Russia and Brazil, a new initiative to provide debt relief (Heavily Indebted Poor Countries (HIPC) Initiative), and protests at the World Trade Organization Annual Meetings in Seattle in 1999 brought unprecedented attention to the Bank's work and role in international development and finance. The World Bank and other international financial institutions were pressured to continue efforts to enhance accountability and to implement approaches that altered traditional donor-client relationships. Nearly a decade later, many of the approaches and instruments developed in the late 1990s are at the core of the HNP sector's work today.

5.22 The HNP sector's approach to "mainstreaming" HNP targets and reforms into broader development strategies became a focus, given: (i) the Bank's perceived comparative advantage in engaging governments in high-level policy dialogue; (ii) emphasis on participation and ownership; (iii) the HNP strategy's focus on multisectoral interventions; and (iv) HNP sector's goals to build partnership and improve donor coordination. Use of the CAS was advocated in the 1997 strategy as the main country-level vehicle for ensuring that HNP issues were discussed in national-level dialogues and planning, and promoting a multisectoral approach to achieving HNP outcomes.

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[25] The Senior Nutrition Adviser was replaced by a Senior Nutrition Specialist, a lower staff grade level position, and has never been upgraded. In 2005, when the Adviser for Population and Reproductive, Maternal and Child Health left the position, she was not replaced.

5.23 Another important policy instrument, implemented two years after the release of the HNP strategy, was the Poverty Reduction Strategy (PRS). Strong commitment to poverty reduction led to the PRS which was developed jointly by the World Bank and the International Monetary Fund (IMF).[26] It was designed as a tool for client countries to promote dialogue and consensus on a country-formulated development agenda, an important building block for the operationalization of the Comprehensive Development Framework (Box 5-2). Intended to strengthen country ownership and accountability for development strategies while enhancing the poverty focus of country programs, the PRS serves as comprehensive and coordinated framework for the Bank and IMF, as well as other development partners (Gottret and Schieber 2006). Beginning in 1999, Poverty Reduction Strategy Papers (PRSPs) intended to integrate HNP objectives into broader, country-led development strategies for the Bank's poorest client countries, promoting ownership and accountability.

Box 5-2: Four Principles of the Comprehensive Development Framework (CDF)

Whereas the Strategic Compact was an internal strategy, the CDF was articulated in 1999 to redefine the Bank's approach to development and its relationship with client countries. The CDF's four inter-related principles are:

- Long-term holistic development agenda;
- Broad-based country ownership;
- Country-based partnership; and
- Accountability for development results.

Source: World Bank Web site. http://intresources.worldbank.org/CDFINTRANET/Resources/10things.pdf

5.24 Several alternative approaches to traditional project funding also gained prominence in the 1990s. Among them, the Sectorwide Approach (SWAp) was widely supported both within in the Bank and among the international donor community. The SWAp emerged over the 1990s as a response to two parallel trends: (i) a shift in macroeconomic dialogue from structural adjustment to public expenditure management, with a focus on government provision of core public services; and (ii) heightened recognition that project effectiveness was often limited by policies, institutions, and economic environments (Cassels 1997). The approach was designed to: "improve a country's overall policy-making processes and budget and public expenditure management by capturing all funding sources and expenditures and putting resource allocation decisions into a medium-term budget and expenditure framework based on national priorities" (Gottret and Schieber 2006, p.152). Given these features, the approach seemed very relevant to the HNP sector's goals of strengthening health systems, improving regulation, and making health financing more sustainable.

5.25 Improving aid effectiveness through donor coordination was a core reason that the HNP sector identified building partnerships as a goal in 1997 (World Bank, 1997a, p. 22). As the single largest external source of HNP financing in LICs and MICs in the 1990s and at a time when the Bank was attempting to work more strategically in its areas of comparative advantage, the Bank felt it had a lot to offer and gain from international

[26] From 1999, in order to qualify for debt relief under the Heavily Indebted Poor Countries (HIPC) initiative, governments of low-income countries were required to prepare PRSPs.

initiatives and partnerships. In fact, the strategy paper advocated strengthening partnerships to "enhance" the Bank's contribution to global health in the 21st century (World Bank 1997a).

5.26 By 2000, the HNP sector increasingly used new approaches, some of which did not exist only a few years earlier, to pursue the objectives established in 1997. For example, the Bank embraced participation in global health partnerships, many of them single-disease or single-priority in scope. There is a continuing debate over the extent to which such initiatives contribute to or detract from the objective of health system strengthening and sustainable finance (Table 5-2). Although fighting communicable diseases was prioritized by the 1997 HNP strategy given that they disproportionately affect the poor, this provided to be a challenge considering substantial opportunity costs in terms of resources and staff time dedicated to strategies to strengthen entire systems and other priorities.

Table 5-2: Advantages and Disadvantages to Single-disease/priority Programs

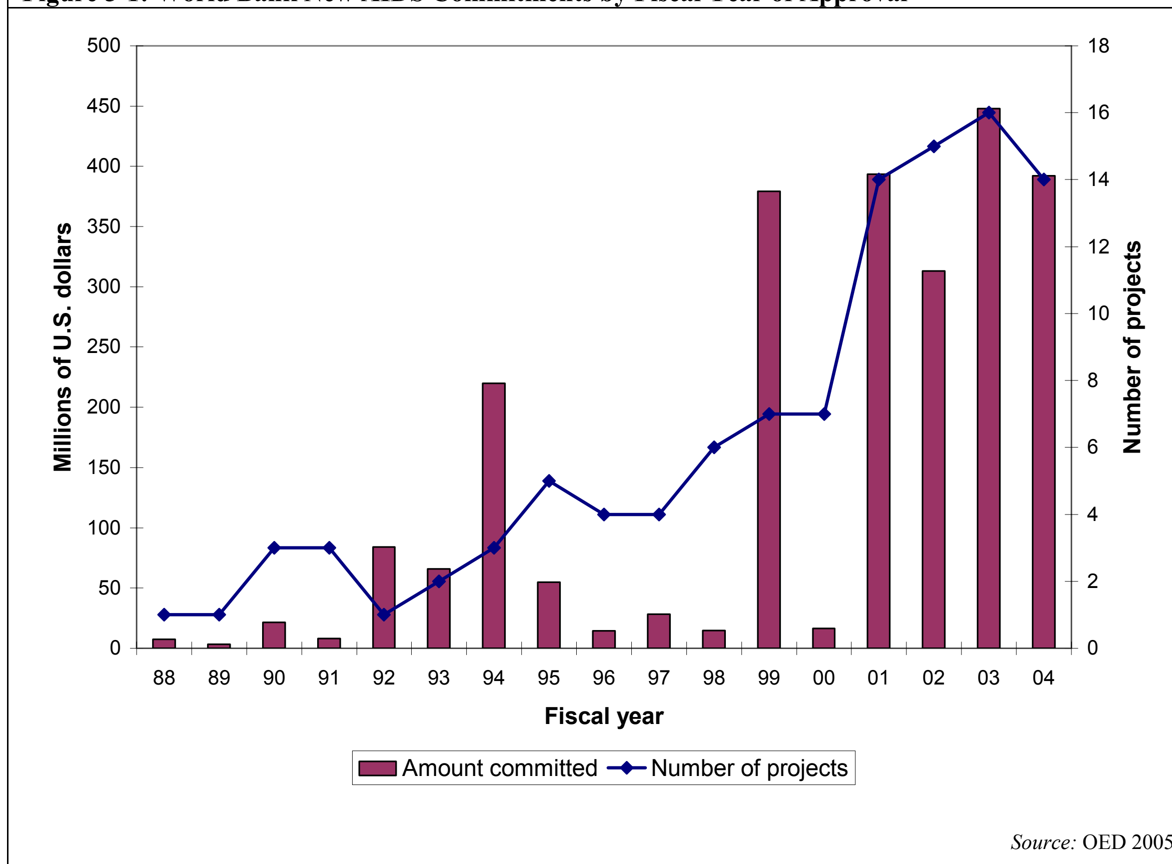
Advantages:	**Disadvantages:**
• Highly effective in increasing awareness of global health concerns; • Significantly increase the funds available for their area of focus; • More effective in delivering services to targeted populations than government; • Not limited by systemic constraints.	• Disrupt country's health system; • Expenditures not sustainable within country's budget; • Not accountable to recipient country; • Fragment outreach.

Source: Lewis 2005

5.27 Another example of the rapid changes that occurred over the first few years of the 1997 strategy's implementation, is the Bank's support for HIV/AIDS, an issue hardly mentioned in the *Health, Nutrition and Population Strategy Paper.* In 1998, less than one year after the strategy's release, high-level Bank management broadened its commitment to fighting HIV/AIDS and raising demand for HIV/AIDS support by borrowers (OED 2005); Bank financial commitments to HIV/AIDS rose dramatically (Figure 5-1). This led to even higher levels of support for HIV/AIDS in the following phase and influenced the framing of other single-theme health issues such as malaria and malnutrition in subsequent strategies in terms of broad threats to development.

As the Bank was undergoing significant institutional change in the late 1990s, the context of the international community's work in HNP changed quickly and demanded even greater flexibility and innovation on the Bank's part. There were several challenges to adopting new instruments and approaches: administrative requirements that could limit the intended flexibility of new instruments; performance criteria that were, in some cases, inappropriate for measuring institutional reform; some managers accustomed to more traditional projects who may have been reluctant to approve projects with more open and undefined budgets; and concern that shifts in decision-making responsibilities and cuts in regular staff that could lead to increased use of younger and less experienced consultants (Nelson 1999).

Figure 5-1: World Bank New AIDS Commitments by Fiscal Year of Approval



Source: OED 2005

6. GLOBAL TARGETS AND PARTNERSHIPS: 2001-2006

6.1 Throughout the most recent phases of the World Bank's work in HNP, its objectives have remained largely consistent: improving health outcomes, especially among the poor; systems strengthening; and securing sustainable financing. However, the Bank's approach to working with client countries and its relationships with global partners have changed in response to changes in global health, including endorsement of the Millennium Development Goals (MDGs) and large increases in development assistance for health (DAH). During the Global Targets and Partnerships Phase (2001-2006), the Bank's objectives and rationale for HNP activities remained unchanged from the previous phase. The 1997 strategy continued to guide the sector, but major external events and the Bank's commitments to specific targets and working in partnerships caused the Bank to alter its strategy in practice to reach those objectives. This phase highlighted tensions over the role of heavily-financed single-priority and single-intervention programs within weak health systems.

6.2 Several key challenges facing the Bank and international community prompted this shift in strategy. First, the international community's adoption of the MDGs established new explicit targets for international health and development (Table 6-1). Second, DAH increased substantially from the late 1990s to the early 2000s due largely to the third factor, the proliferation of global partnerships (World Bank 2006a). These

global partnerships, created to address global public goods in health, significantly increased the need for donor coordination and the flow of resources. In addition to the unprecedented global commitment to reducing poverty and the intensification of efforts to fight HIV/AIDS, the beginning of the 21st century was a time in which vulnerability to epidemics and pandemics was heightened. With the emergence of Severe Acute Respiratory Syndrome (SARS), and then Avian Influenza, health became an incontestable priority high on the global agenda. Both the Bank and the international community looked for new approaches to address persisting and emerging health issues.

Table 6-1 The Health-Related MDGs

Goal 1	**Eradicate extreme poverty and hunger:** Halve the proportion of people who suffer from hunger between 1990 and 2015, with progress measured in terms of the prevalence of underweight children under five.
Goal 4	**Reduce child mortality:** Reduce the under-five mortality rate by two-thirds between 1990 and 2015
Goal 5	**Improve maternal health:** Reduce the maternal mortality ratio by three-quarters between 1990 and 2015.
Goal 6	**Combat HIV/AIDS, malaria, and other diseases:** Halt and begin to reverse the spread/ incidence of these diseases by 2015.
Goal 7	**Ensure environmental sustainability:** Halve the proportion of people without sustainable access to safe drinking water by 2015.

Source: United Nations. 2004. Millennium Development Goals. www.un.org/millennium goals.

MILLENNIUM DEVELOPMENT GOALS

6.3 The Bank-wide commitment to the MDGs had significant implications for the HNP sector: "The goals are increasingly providing the strategic underpinning of Bank assistance to countries in programs in health and multisectoral budget support" (Wagstaff and Claeson 2004). The MDGs have been integrated into sectorwide and programmatic instruments, loans and grants have been reoriented to achieve the MDG outcomes, and the MDGs have been used to build M&E capacity. The Bank has highlighted the importance of comprehensive strategies to achieve the targets and has identified institutional weakness as a major factor limiting progress. This has allowed the Bank to contribute to the achievement of the MDGs while adhering, to some degree, to its system-wide approach (Wagstaff and Claeson 2004).

6.4 The World Bank's commitment to achieving the health MDGs was entirely consistent with the 1997 strategy's objective to improve health outcomes for the poor. However, the MDGs address only average outcomes, not their distribution. Average health outcomes can improve while they worsen absolutely for the poor, or improve at a slower rate for the poor than for the non-poor (Gwatkin 2002). There was thus a risk that the new emphasis on achieving the MDGs would weaken the Bank's prior commitment

to ensuring that health outcomes also improve among the poorest groups within countries.[27]

LEVELS OF DEVELOPMENT ASSISTANCE FOR HEALTH

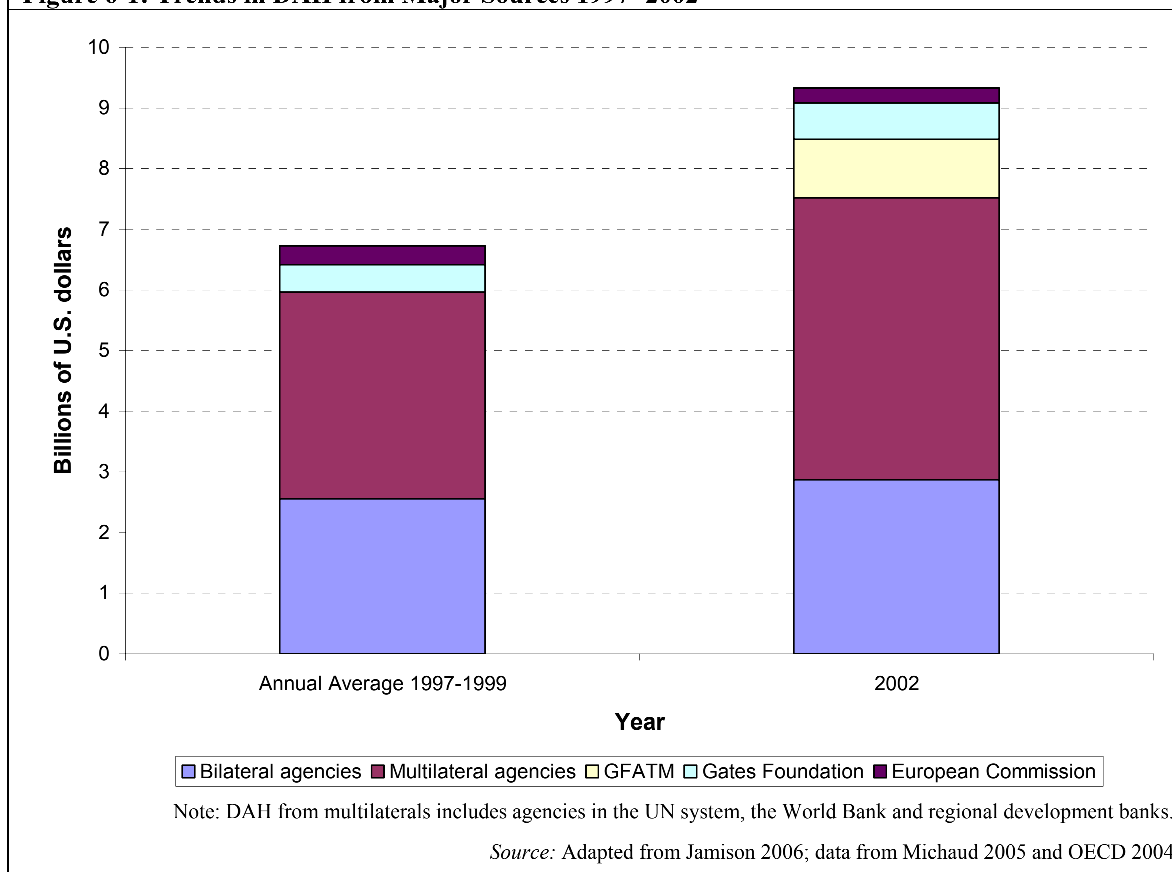
6.5 Official development assistance (ODA) declined during the 1990s. However DAH rose in real terms and as a proportion of ODA over the same decade.[28] By 2002, DAH commitments from external sources rose from an annual average of US $6.7 billion in 1997-99 to about US$9.3 billion in 2002 (Jamison and others 2006) (Figure 6-1). This jump is a result of the priority given to health by the international community, which has led new actors to become involved in global health. Over the past decade, bilateral organizations played increasingly important roles in contributing to international health programs through UN organizations, technical assistance, and government-to-government agreements. Furthermore, the funding and priorities of non-governmental organizations and foundations, as well as corporations have become increasingly influential (Walt and Buse 2006).

6.6 Priority areas also changed. HIV/AIDS, immunization and new health product development have received higher priority (Jamison and others 2006). Important areas that have not benefited substantially from recent funding include shortages and low productivity of health workforces, and weaknesses in health management information systems and in supply chains for drugs and commodities (Jamison and others 2006).

6.7 The role of the Bank relative to other donors has also been affected. The World Bank is no longer the top funder of DAH in developing countries in the aggregate,[29] which brings increased attention to the contributions of its non-lending activities, such as policy dialogue, sector and economic analysis. *Improving Health, Nutrition and Population Outcomes in Sub-Saharan Africa: The Role of the World Bank* exemplifies the World Bank's heightened attention to its areas of comparative advantage (World Bank 2004a). It emphasizes the need to integrate macroeconomic and health policy, promote multisectoral policies, and strengthen health systems, including innovative approaches to achieve sustainable health finance. Furthermore, it focuses on the importance of improving M&E capacities to provide an expanded knowledge base for evidence-based decision making. The preface notes that to the extent that the Bank limits its work to its areas of comparative advantage, international and national partners are critical to ensuring a comprehensive effort to assist countries to develop strategies to improve health outcomes for the poor.

[27] One issue that could be examined in a review of the Bank's lending portfolio is whether the commitment in projects to improve HNP outcomes among the poor has been in any way weakened as a result of the emphasis of MDGs on average outcomes.
[28] ODA includes grants from bilateral government channels and UN agencies plus net flows from development banks.
[29] It remains the major funder of DAH in some countries, however.

Figure 6-1: Trends in DAH from Major Sources 1997- 2002



Note: DAH from multilaterals includes agencies in the UN system, the World Bank and regional development banks.

Source: Adapted from Jamison 2006; data from Michaud 2005 and OECD 2004

GLOBAL HEALTH PARTNERSHIPS

6.8 The proliferation of global health partnerships (GHPs) over the past decade peaked in 2001making them an important feature in the global health architecture (Brugha 2005). Maximizing its strategic advantages and engaging in selective partnerships were key elements of both the Strategic Compact and 1997 HNP strategy. By 2004, the Bank supported eleven GHPs which varied in their objectives, from financing mechanisms to advocacy, research, and technical cooperation (Lele and others 2004) (Box 6-1).[30] Although GHPs were promoted to better focus health aid and to simplify the aid architecture in health, concerns have arisen that recently created global institutions with overlapping and unclear mandates complicate donor harmonization (Caines 2005, OED 2004).

[30] These included: the Research and Development in Human Reproduction Program; the Special Programme for Research and Training in Tropical Diseases; the Joint United Nations Program on HIV/AIDS (UNAIDS); the Global Forum for Health Research; Roll Back Malaria (RBM); the Population and Reproductive Health Capacity Building Program; the Stop TB Partnership; the Global Alliance for Vaccines and Immunization (GAVI); Medicines for Malaria Venture (MMV); the Global Alliance to Eliminate Lymphatic Filariasis; and the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM).

Box 6-1: OED´s findings on Global Health Programs[31]

The underlying conclusion of a two-phase evaluation of the World Bank's approach to global programs carried out by the OED, including evaluation of six health partnerships, was that the Bank had not been selective enough in its engagement. A case study of the six World Bank supported GHPs prepared for the evaluation found that:

- All six programs were consistent with the Bank Management's declared criteria for involvement in global programs.
- The synergy between global programs and Bank country assistance strategies and experience on the ground was weak in all but a few countries and programs.
- There was an imbalance between resources for specific health initiatives and for building the long-term health delivery system in developing countries.

Sources: OED 2004, Lele 2004

6.9 The Bank's high level of participation in GHPs has led it to reassess the costs and benefits of participation, especially in terms of meeting the HNP sector's objectives. Further, because many GHPs are single-disease or single-intervention in focus, a question lingers over how best to balance the value added of these programs with the Bank's systems approach. Participation in GHPs has also been criticized as detracting from the poverty emphasis of the Bank: "most GHPs claim to be pro-poor, although they lack specific indicators for equity aims" (Caines 2005, p. 2).

POPULATION AND NUTRITION

6.10 During most of this phase, the Bank's work in population continued to be guided by the pre-MDG publication, *Population and the World Bank: Adapting to Change*. Whereas the ICPD shifted the international community's attention toward a broad view of reproductive health, competition from other health issues, particularly HIV/AIDS, and the exclusion of reproductive health from the MDGs are major challenges to ensuring adequate funding and advocacy. Reproductive health was the only International Development Goal not included as an MDG, despite the fact that many of the MDGs can not be achieved without population and family planning activities and outcomes. *Reproductive Health: the Missing Millennium Development Goal* (2006) evaluates many of the changes since the ICPD and insists that "the reproductive health community needs to better understand these changes to assess their impact on ICPD implementation and to develop the capacity and skills to take advantage of the changes and mitigate any negative impacts that they have already produced" (White and others 2006). It argues that the ICPD rights-based approach has been ineffective overall, and promotes a new focus on expected outcomes and the extent to which investments in reproductive health services

[31] In the literature on GHPs, the concept of GHP is broad and its main criterion is a "collaborative relationships among multiple organizations in which risks and benefits are shared in pursuit of a shared goal" (Buse 2004). The World Bank's definition of a global program (not specific to global health programs) as set forth in OED 2004, is similar but more narrow in stipulating that the initiatives must cut across more than one region of the world. In a case study (Lele 2004) of "global health programs" that contributed to the OED's 2004 evaluation, the six "global health programs"evaluated and the other five cited are also referred to as "partnerships.". Annex G of the 2007 HNP strategy includes separate lists of the 19 "Global Health Partnerships and Initiatives" in which the Bank is involved and a separate list of fifteen "Process/Programs without Financial Participation." This would indicate that currently within the HNP Sector at the World Bank, "partnership/initiative" is used to refer to programs which are directly financed. This paper adopts the broad definition of global health partnership.

save lives, reduce suffering and help to address problems that challenge societies and cultures. Building the weak evidence base is a critical component of the approach, which recognizes the power of advocacy to affect change and improve health outcomes, particularly for poor women.

6.11 *Repositioning Nutrition as Central to Development: A Strategy for Large-Scale Action* uses the inclusion of nutrition in the MDGs as a platform to advocate increased investment in nutrition programs (World Bank 2006). The justification for Bank engagement remained unchanged since the mid 1980s: substantial evidence that malnutrition undermines economic growth, and the existence of well-tested and cost-effective approaches to reduce it. More recent research provides further evidence related to the most effective program targeting. The paper is consistent with the HNP sector strategy, as it prioritizes approaches that reach the poor and vulnerable at strategic stages in their development, working intesectorally, supporting action research and learning-by-doing, and "mainstreaming" nutrition into development strategies. The paper argues that funding should come through normal financing channels instead of a special nutrition fund, and it provides the framework for making policy choices in nutrition and a methodology to identify priority countries for action.

THE PLACE OF THE POOR

6.12 While the Bank's underlying objective in this phase remained to improve health outcomes for the poor, the effects of its pursuit of a strategy shaped largely by the MDGs and GHPs despite concerns over their lack of pro-poor orientation are yet to be seen. The strategy of this phase was also influenced by the *WDR 2004: Making Services Work for Poor People,* which highlighted the importance of accountability of public policy and public services to the poor. The *WDR 2004* argues that services for the poor work when we curtail corruption and take a comprehensive view of development, and thus, supports the need for institutional changes to strengthen relationships of accountability (World Bank 2003a). Although this is somewhat similar to the rationale of the Health Reform Phase, the critical difference is that the *WDR 2004* stresses the importance of the accountability between the poor and providers, the poor and policymakers, and between policymakers and providers. This focus on the role of the poor themselves in "making services work for the poor" is critical, especially to improve health outcomes and on the importance of information which has been commonly underplayed in much of the Bank's work, although it is reminiscent of principles from both Alma Ata and the Bamako Initiative.

7. SYSTEM STRENGTHENING FOR RESULTS: 2007

7.1 *Healthy Development: The World Bank Strategy for Health, Nutrition and Population Results* sets forth the Bank's objectives for the next decade and the strategies to achieve them (World Bank 2007a). The document emphasizes that the dramatic changes in the global health architecture require the Bank to reposition itself to more

effectively support countries to improve health outcomes, yet adheres closely to the objectives and strategies to achieve them established in the 1997 strategy.[32]

7.2 In the midst of the new global health architecture described by the paper, the strategy identifies the Bank's comparative advantages as: providing policy and technical advice to both countries and partners, particularly to address "structural and health systems constraints"; its economic and evaluation analytic capacity; its intersectoral approach; and its capacity to implement large-scale programs, among others (World Bank 2007, p. 43). The Bank's rationale for its next phase of activity in the HNP sector is that, given these areas of comparative advantage, it has a unique role to respond at the global level while maintaining its country-level focus and improving collaboration with partners.

7.3 The strategy's four stated objectives are to: (i) improve the level and distribution of key HNP outcomes, outputs, and system performance at the country and global level in order to improve living conditions, particularly for the poor and vulnerable; (ii) prevent poverty due to illness; (iii) improve financial sustainability in the HNP sector and its contribution to sound macroeconomic and fiscal policy, and to country competitiveness; and (iv) improve governance, accountability and transparency in the health sector. To reach these objectives, the strategy advocated that the Bank engage with partners within a disciplined framework to support client countries to implement comprehensive, intersectoral approaches that focus on achieving results.

7.4 The sector's current focus on results distinguishes it from previous strategies, as "results" is used to encompass HNP outcomes, outputs, and system performance. This shift away from focusing exclusively on HNP outcome indicators (e.g., MDGs), is a response to the complexity, and long-term nature involved in making sustainable improvements in HNP (World Bank 2007a, p. 14). The strategy argues that linking non-lending and lending activities is fundamental to improving results on the ground. This entails scaling-up output-based lending, implementing up-front M&E, providing support to strengthen national surveillance and monitoring, partnering with countries to learn more about the results of reforms, and implementing a detailed HNP Results Framework to guide M&E in Bank and global partner strategies. The Results Framework includes outcome indicators for each of the four objectives along with measures to track multisectoral contributions along with the Bank's contributions to results, and process indicators for both countries and the Bank. The "common global" framework was designed to guide the development of results-based regional strategies and business plans as well M&E activities, and to be adaptable. The development of the Framework and its centrality in the new strategy demonstrates that M&E remains a priority despite the sector's chronic difficulty in implementing effective M&E (OED 1999, Subramanian and others 2006).

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[32] In 2006 the World Bank's Committee on Development Effectiveness (CODE) noted that the 1997 HNP Strategy was out of date given that it did not account for changes in the global health architecture and DAH; this prompted the sector to draft *Healthy Development.*

7.5 Reconfirming the commitment to multisectorality made in 1997, the 2007 strategy recognizes that bottlenecks in critical sectors must be addressed in order for any multisectoral initiative to be effective. A new line of economic and sector work (ESW), the Mutlisectoral Constraints Assessment (MCA) tool, will be introduced to identify constraints in the relevant sectors, provide a framework to prioritize actions, and assess the best means to facilitate coordination between sectors. The MCA is intended to systematically deepen country-level analysis of institutional and technical constraints in order to guide the development of multisectoral approaches in Country Assistance Strategies.

7.6 Strengthening health systems remains central to the 2007 strategy. However, whereas system strengthening was formerly an objective, in 2007 it is viewed as the primary means to achieve the objective of improving the health conditions of people in client countries, particularly the poor and vulnerable. The HNP Sector's continued emphasis on the centrality of health system strengthening will affect the staff and resources dedicated to single-disease and single-intervention issues, as well as population and nutrition. In contrast to the 1997 strategy, however, the 2007 strategy directly addresses the tensions between single-disease and systems strengthening approaches. It asserts that the two approaches can be complementary if they are well implemented, but does not provide a detailed strategy or recommendations on how this can be achieved or how it can be measured. The strategy does, however, provide a five-year plan that advocates hiring additional staff that are experts in health system issues and creating a health system policy team to provide analysis and advice to country teams (World Bank 2007a, p.75).

7.7 Notwithstanding some uncertainty on the priority assigned to population and reproductive health leading up to the 2007 strategy, *Healthy Development* confirms the Bank's "strong" commitment to continue its work in this area. It prioritizes lowering high fertility in 35 countries with total fertility rates over five, most of them in Sub-Saharan Africa, maintaining that population growth is a constraint for economic growth and poverty reduction. Although it declares a "renewed commitment for population policy" adhering to the Bank's commitments to the 1994 ICPD, the strategy does not consider how changes since 1994 have affected the likelihood of achieving results through this framework. It argues that other agencies, such as WHO and the United Nations Population Fund (UNFPA), have comparative advantage in providing technical assistance in this area, that the Bank's role will be to increase demand for population and reproductive health services and information multisectorally, by strengthening education and economic opportunities for girls and women, and addressing gender disparities.

7.8 The Bank's most recent publication dedicated to population, *Population Issues in the 21st Century: The Role of the World Bank* (2007b) differentiates between the two main areas under the population umbrella: (i) reproductive, maternal and sexual health, and the services that address them; and (ii) factors that determine population and age structure, including births, deaths, and migration. The technical discussion paper provides an overview of the demographic context globally, trends by region, and issues in high, medium and low-fertility countries, giving emphasis to Sub-Saharan Africa. It is a call for the Bank to broaden its focus and recognize its comparative advantage in addressing

the demographic and non-medical side of population: ". . . [the World Bank's] involvement in many sectors can produce synergies that will allow faster progress than a more narrow focus on family planning services" (World Bank 2007b).

7.9 The 2007 strategy's rationale for continued investment in nutrition is that: "improving nutrition is at least as much of an economic issue as one of welfare, social protection, and human rights" (World Bank 2007a, p. 70). The Bank's work in nutrition will be guided by the 2006 *Repositioning Nutrition as Central to Development: A Strategy for Large-Scale Action.* Malnutrition is problematic in both poor and non-poor countries; diet related non-communicable diseases present new challenges to health systems and financing. The 2007 strategy paper describes that the Bank will contribute to "repositioning" nutrition by generating country-specific knowledge, improving its capacity to identify structural issues, integrating multisectoral approaches (upon country demand), improving M&E, and incorporating nutrition as a dimension of the MCA tool. Similar to the population subsectors reliance on specialized partners for technical assistance, the Bank will consult with specialized global partners for advice beyond structural and systemic issues as the Bank's comparative advantage in nutrition does not include technical aspects of nutrition interventions.

7.10 The 1997 HNP strategy explicitly sought to improve outcomes for the poor, while the 2007 strategy aims to improve both average outcomes (given its focus on the MDGs) and outcomes among the poor. Thus, commitment to improve outcomes for the poor is reaffirmed but the scope is broadened, which could affect the focus on and resourced dedicated to reaching the most vulnerable. Furthermore, although accountability is one of the strategy's core objectives and the strategy recognizes the critical need articulated by the WDR 2004 to empower the poor to improve accountability in order to improve service delivery, it does not explore strategies to empower patients given its difficulty in practice. Although it is true that ". . . everyone is still struggling to find the best ways of reaching the poor with these proven interventions in low-income countries," the importance of the poor in determining their own health outcomes has diminished in the 2007 strategy (World Bank 2007a, p. 51). The HNP sector appears to have returned to many of the strategies of the Health Reform Phase, most evident through its emphasis on the central role of strengthening health systems along with promoting improved financial protection to improve health outcomes. While these are critical aspects to ensure the delivery of services, the strategy de-emphasizes the individual or household decisions as the fundamental determinants of health outcomes, relative to the importance of health systems.

8. CONCLUSIONS

8.1 Throughout the recent phases, the World Bank's objectives remained largely consistent: improving health outcomes, especially among the poor; strengthening health systems; and securing sustainable financing. The Bank's approach to achieving those objectives changed more dramatically. Work with client-countries has become more participatory and client-driven; the World Bank has pursued more coordinated relationships with other donors; and the emphasis on multisectoral approaches has increased. While *Healthy Development's* (2007) close adherence to the 1997 strategy

would appear to validate the strategies and approaches that the sector introduced in 1997, no systematic evaluation of the efficacy of HNP support has been undertaken since OED's 1999 evaluation, *Investing in Health.* In other words, the most recent strategy was not built on evidence of the efficacy or lessons from the past decade of experience in achieving similar objectives.

8.2 This review of the Bank's objectives and strategies, particularly over the past decade, suggests four priority areas of investigation for an evaluation of the Bank's HNP support.

8.3 **First, how effective has been the Bank's support in improving HNP outcomes among the poor?** To what extent have Bank projects and analytic work explicitly addressed HNP outcomes in general and particularly among the poor? In projects with this objective, how have they gone about targeting the poor? To what extent have the Bank's country strategies taken into account the potential contribution of sectors beyond HNP to improve HNP outcomes? What has happened to population and nutrition policies and interventions that go beyond the health system? What strategies or approaches have been used in different settings? Have they succeeded in improving the access of the poor to HNP services? Have they improved HNP status on average, or among the poor?

8.4 **Second, what lessons have been learned about the efficacy, advantages, and disadvantages of various approaches in different settings?** In particular: (a) programs to reform the health system, including through decentralization, health insurance, regulatory frameworks and contracting with the private sector, and health finance reform; (b) sector-wide approaches, designed to improve ownership, reduce transactions costs and improve the allocation of resources; (c) control of communicable diseases that disproportionately affect the poor; and (d) approaches relying on inter-sectoral contributions or collaboration. Which of these approaches have worked, which have not, and why, in different country contexts? Clearly, context is a very important part of understanding this, and thus, developing this understanding will help to identify the validity and best contexts for using specific approaches.

8.5 **Third, what have been the revealed "strengths", "valued added", or "comparative advantages" of World Bank support for HNP in developing countries over the past decade, and how is that changing?** The areas in which Bank's contributions have had the most impact should be determined based on evidence of effectiveness from the last ten years. This is particularly relevant in light of the Bank's objective of building partnerships, as well as the rapid expansion of GHPs, the number of donors and the resources currently available for international health. What has been the contribution of the Bank's HNP support, in terms of policy dialogue, analytic work and lending, relative to the counterfactual of no Bank support? How effective has the Bank used its support to leverage policy reform? How, if at all, has the Bank's contribution changed over the past decade in light of the surge in DAH, most of it in grant form, the emergence of new actors, and the emphasis on working through country-level partnerships? Has the latter helped to highlight or mute the Bank's comparative advantages and potential contributions?

8.6 **Finally, to what extent has the Bank's support monitored results and used evaluation to improve the evidence-base for decision-making in HNP?** The new HNP strategy emphasizes results, but OED's 1999 evaluation of HNP support found M&E to be very weak. A recent review of projects completed over the past three fiscal years found that the sector has been overwhelmingly unsuccessful in tracking its own progress (Subramanian and others 2006, p. iii). Particularly given the World Bank's emphasis on improving HNP outcomes, including MDG targets, as well as its new push for "results," the evaluation needs to address: What share of projects have been designed in the absence of baseline information on outputs, financing or outcomes that are an objective of the project? Has the share of Bank projects with baseline data improved over time, and if so, why? How often are relevant outputs and outcomes traced over time in a manner that allows an analysis of trends? Are pilot projects being evaluated before they are implemented on a larger scale? Are evaluation results being used as a management tool? What are the main constraints to better M&E in the context of HNP support?

8.7 Evaluation of these issues, central to the World Bank's recent objectives and approaches, would provide valuable evidence on the efficacy and lessons of experience from the 1997 HNP strategy. Moreover, it would provide useful lessons for the HNP sector's implementation of the 2007 strategy, as well as broader ones to influence the global health community's future strategies and approaches. The World Bank's experiences over the past thirty-five years show that innovation, flexibility and selectivity are critical to ensure that the Bank maintains or builds strong and effective relationships with client countries and partners while keeping a close eye on achieving results in the priority areas that it establishes.

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ANNEX A: OBJECTIVES, RATIONALE, AND STRATEGIES 1970 – 2007

	Population Phase 1970-1979	Primary Health Care Phase 1980-1986	Health Reform Phase 1987- 1996	Health Outcomes and Health Systems Phase 1997-2000	Global Targets and Partnerships Phase 2001 - 2006	HNP Results Phase 2007
Objectives	**To reduce rapid population growth:** To implement projects that support governments to reduce rapid population growth through family planning programs that lower high fertility.	**To broaden access to PHC:** emphasis on provision of universal, low-cost basic health care.	**To improve health financing,** "a fundamental cause of poor approaches" to key challenges in the health sector (World Bank 1986a). **To implement health policy reforms** that: (i) foster an environment that enables households to improve health, (ii) improve government spending on health; and (iii) promote diversity and competition (World Bank 1993).	**To** (i) **improve HNP outcomes for the poor** and protect the population from the impoverishing effects of illness, malnutrition, and high fertility; (ii) **enhance the performance of health systems**, especially their capacity to provide equitable access to services; and (iii) **secure sustainable health financing** (World Bank 1997a).	Objectives do not change, but are framed by the commitment to achieve MDGs. Objectives for specific issues are established by action plans for HIV/AIDS, malaria, and nutrition.	**To**: (i) **improve level and distribution of key HNP outcomes (e.g MDGs), outputs, and system** performance at country and global levels in order to improve living conditions, particularly for the poor and vulnerable; (ii) **prevent poverty due to** illness (by improving financial protection); (iii) **improve financial sustainability** in the HNP sector and its contribution to sound macroeconomic and fiscal policy and to country competitiveness; (iv) **improve governance, accountability, and transparency** in the health sector (World Bank 2007a).
Rationale	**Demographic:** "In the long run, fertility reduction can be achieved only with the right combination of social and economic development, cultural and political attitudes, and easy availability of contraceptive facilities. . . However, the limited experience available has already shown that if an adequate service can be provided, including public information and a variety of acceptable methods, the results will be demographically significant even if inadequate to achieve the desired reduction in fertility. "(World Bank 1972a, p. 317).	**Economic growth and poverty reduction:** "Human development- education and training, better health and nutrition, and fertility reduction- is shown to be important not only in alleviating poverty directly, but also in increasing incomes of the poor, and GNP growth as well" (World Bank 1980b, p. iii).	**Economic growth, poverty reduction, and humanitarian**: "Fostering improvements in health sector finance is among the most valuable contribution the World Bank can make to better health care in low income countries" (World Bank 1986a, p. 51). "If developing countries governments and key donors accept the challenges and embrace the key health policy reforms . . . improvements in human welfare in the coming years will be enormous. A large share of the current burden of disease . . . will be prevented. And people around the world, especially the more than 1 billion people now living in poverty, will live longer, healthier, and more productive lives (World Bank 1993, p. 171).	**Poverty reduction, humanitarian, economic growth: "**Good health, nutrition, and reproductive policies, and effective health services are critical links in the chain of events that allow countries to break out of the vicious circle of poverty, high fertility, poor health, and low economic growth, replacing this with a virtuous circle of greater productivity, low fertility, better health, and rising incomes" (World Bank 1997a, p. v).	Rationale does not change but a rationale to support global programs emerges.	**Poverty reduction, humanitarian, economic growth:** "HNP policies play a fundamental role in economic and human development and poverty alleviation. . . . Good health boosts economic growth, and economic growth enables further gains in health." Given changes that occurred since the 1997 strategy, the Bank will improve "its own capacity to respond globally and with a country focus to the urgent issues posted by these changes and (persisting worldwide HNP) challenges" (World Bank 2007a, p. 20).
Strategies	Work with governments to implement projects to provide a more equitable distribution of population and family planning services, and gather information to establish the usefulness of the project approach.	Work with governments and provide direct lending for health projects to improve access to primary health care to provide a more equitable distribution of services (including population and family planning services). Meet the need for basic health services, especially in rural areas, by developing basic health infrastructure, training community health workers and paraprofessional staff, strengthening the logistics and supply of essential drugs, providing maternal and child health care, and improving family planning and disease control.	Support governments to implement health sector reforms that establish the proper role for governments, quasi-markets and the private sector in health. Foster improvements in health sector financing by promoting: (i) user fees at government health facilities; (ii) insurance or risk coverage to mobilize resources while protecting households from health shocks; (iii) more effective utilization of nongovernmental resources; (iv) decentralized planning, budgeting and purchasing (World Bank 1986a).	Provide policy advice and financial support that is guided by country-specific approaches by: (i) sharpening strategic directions; (ii) achieving greater impact; (iii) empowering HNP staff; and (iv) building partnerships (World Bank 1997a).	Same strategy but with increased focus on single disease priorities and engagement in global programs. In order to better align the Bank's country assistance strategies with the MDGs: (i) integrate goals in sectorwide and programmatic instruments; (ii) reorient and increase Bank loans and grants to achieve the MDGs; and (iii) use MDGs to monitor and evaluate capacity (Wagstaff and Claeson 2004).	Support country efforts to achieve results by: (i) renewing Bank focus on HNP results; (ii) increasing Bank contribution to client-country efforts to strengthen and realize well-organized and sustainable health systems for HNP results; (iii) ensure synergy between health system strengthening and priority-disease interventions, particularly in LICs; (iv) strengthen Bank capacity to advise client countries on an intersectoral approach ; (v) increase selectivity, improve strategic engagement, and reach agreement with global partners on collaborative division of labor for the benefit of client countries (World Bank 2007a).

ANNEX B: SUMMARIES OF KEY HNP DOCUMENTS AND STRATEGY PAPERS, 1997-2007

1. ***World Development Report 1993: Investing in Health*** justifies the need for increased investment and political commitment to health by establishing a link between improved health, productivity, economic growth and development (World Bank 1993). The Report calculates the Global Burden of Disease (GBD) using the disability life-adjusted year (DALY) to quantify the loss of healthy life from disease and disability. These assessments are used to evaluate cost-effectiveness of specific interventions and set priorities for health spending. The Report proposes a three-pronged approach to government policies in developing and formerly socialist countries for improving health: (i) pursue economic growth policies that benefit the poor and enable households to make decisions to improve health; (ii) redirect government spending on health to cost-effective programs and a minimal package of essential clinical services that will particularly benefit the poor; and (iii) promote greater diversity and competition in the finance and delivery of health services. Noting that aid for health declined in the 1980s, the Report argues that the international community must do more to improve donor coordination to support broad health system reform, shift donor money towards public health programs and essential clinical care, and support health research.

2. ***The 1997 Health, Nutrition, and Population Sector Strategy Paper*** identifies the World Bank's objectives as: (i) improving the HNP outcomes of the poor; (ii) enhancing the performance of health systems, especially their capacity to provide equitable access to services; and (iii) securing sustainable health care financing (World Bank 1997a). The strategy establishes four action areas to accomplish these objectives. The first action area is facilitating improved strategic decision-making to develop country-specific strategies with short and medium term activities designed to accomplish longer-term HNP outcomes. Country Assistance Strategies (CAS) will be used to mobilize multisectoral involvement to formulate strategies that address decentralization, partnerships, and public involvement in sustainable financing. The country-level reform strategies will be informed by sector studies and research. The second action area is achieving greater impact through improving client services and responsiveness through expanding the knowledge base, improving project processes, and enhancing the role of monitoring and evaluation at both the project and sector levels. In order to accomplish these objectives, the Strategy's third action area is to bring Bank staff closer to clients. The last action area is to build selective partnerships based on the Bank's comparative advantages. The 1997 Strategy demonstrates the Bank's position that institutional and systemic changes are fundamental for improving health outcomes for the poor, improving health system performance, and achieving sustainable financing.

3. ***Confronting AIDS: Public Priorities in a Global Epidemic*** (1997)**, a Policy Research Report issued by Development Economics and the World Bank's Chief Economist,** presents evidence of the economic impact of AIDS, social and economic determinants, and the effectiveness of interventions in developing countries (World Bank

1997c). The report demonstrates the rationale for government commitment to controlling AIDS from epidemiological, public health, and public economic perspectives. It presents priorities for countries at different stages in the epidemic and argues that country strategies must be immediate, concerted and focused. All countries must consider their resources as well as the stage of the epidemic to determine cost-effect strategies to prioritize provision of public goods and promote safe behavior for high-risk populations. The report also calls on countries to improve access to cost-effective health care for AIDS patients, and to develop activities to promote behavior change and prevent discrimination. Donors must base their support on evidence of country-specific effectiveness for interventions, and finance key international public goods, including research on HIV incidence and best practices, along with development of affordable vaccines and appropriate medical technologies. The report suggests that activities and policies be integrated with poverty reduction programs, and that the country-context and resources determine priorities and the roles of government, NGOs, the private sector, and external donors.

4. The objective of ***A Health Sector Strategy for the Europe and Central Asia Region*** (1999) is to respond to changes in the health care systems of transition countries by providing a guide to support regionally appropriate, intersectoral health system reforms (World Bank 1999a). The key priorities identified are: (i) promoting wellness and reducing the prevalence of avoidable illness; (ii) creating affordable and sustainable delivery systems; and (iii) maintaining functioning health systems during the reform process. The strategy argues that governments should work with multiple stakeholders to build consensus around a vision for the desired health care system. The implementation of the systemic reform must be undertaken in carefully sequenced and coordinated subsectoral reforms that are guided by the long term vision. To facilitate the process of selecting a phased primary program of overall reform, the ECA region will compile a structured menu of options for subsectoral reforms, as well as define a research agenda on relevant health-related questions affecting transition countries. The strategy suggests that professional groups and institutions be entrusted to lead certain quality-related subsectoral reforms in the sake of maximizing the rate of the reform. In order to further support this strategy, the Bank proposes several internal reforms including: redefinition of activities to support the best policy advice, streamlining of business processes, and ensuring sufficient staff and resources to meet its commitments.

5. The World Bank's population strategy, ***Population and the World Bank: Adapting to Change*** (1999) is shaped largely by its commitment to the 1994 ICPD and by the Bank's emphasis on health sector reform in the 1990s (World Bank 1999b). It responds to significant changes in population growth, age and spatial distribution, and the emergence of HIV/AIDS since the Bank began its lending for population in the 1970s and recognizes that country context, and decision-making at the community and family level are key determinants of population outcomes. The strategy's principal objective is to increase the Bank's effectiveness to build population policies and programs that contribute to poverty reduction at the household and country levels. It commits to assisting countries to pursue these goals by: linking population to poverty reduction and human development, advocating for cost-effective policies that give adequate

consideration to country context, building on analysis and dialogue, providing sustained support, and strengthening skills and partnerships at country and global levels. The strategy establishes mechanisms, such as the Bank-wide Population and Reproductive Health Thematic Group, to ensure that population and reproductive health components are incorporated into broader development strategies. Furthermore, it stresses that population and reproductive health outcomes must be tracked to ensure the quality of program and operational effectiveness.

6. ***The World Bank Strategy for Health, Nutrition and Population in the East Asia and Pacific Region*** (2000) closely adheres to the sectoral goals of 1997 HNP Sector Strategy (World Bank 2000a). The overall objective of the strategy is broad: to improve the Bank's effectiveness in HNP in the region. The strategy urges selectivity and flexibility on behalf of the Bank to develop new approaches, as necessary, based on lessons learned and experience in the region. The strategy prioritizes: improving outcomes for the poor; enhancing the performance of health care systems; and securing sustainable financing. Specifically, it argues that efficient, equitable and sustainable intersectoral approaches must be developed to target the poor's key health problems as increased public health service use is promoted among poor and vulnerable populations. Furthermore, it argues that increased health spending and reallocation to public health programs must be accompanied by a strengthening of the capacities of the Ministries of Health in regulation, control and education of consumers, and monitoring and evaluation. The strategy supports country efforts to decentralize, work with the private sector to provide services, and expand sustainable social insurance programs. However, the recommendations remain broad and emphasize that specific strategies must be developed at the country level to respond to varying health priorities and policy climates. Improving portfolio quality and client services, supporting work in the sector with research and analysis, and strengthening partnerships are identified as the key ways for the World Bank to contribute to progress in these priority areas.

7. ***Intensifying Action against HIV/AIDS in Africa: Responding to a Development Crisis*** (2000) is an important strategy document for the Africa region (World Bank 2000c). The failure of governments to act in spite of longstanding evidence is described as a "crisis," affecting all development efforts due to the severity of the epidemic in the region. The strategy prioritizes: increased advocacy to strengthen political commitments to fight HIV/AIDS; mobilization of resources; and a strengthened knowledge base. It advocates increased resources and technical support to assist African partners and the World Bank to mainstream HIV/AIDS into all sectors (creating a regional team, ACT*africa*) to facilitate a multisectoral approach and maximize benefits from relationships and influence with national governments. The strategy urges greater support for prevention targeted at general and specific audiences, along with activities to improve care and treatment. In countries with lower HIV prevalence, behavior change initiatives targeted at high-risk populations must be the first area of focus, followed by broader approaches to reach other at-risk populations. In high HIV prevalence countries, the strategy advocates strengthened interventions targeted to high-risk populations and then extended to all vulnerable groups, as well as quick movement to provide care for those affected by HIV/AIDS to mitigate the effects of the epidemic. A key component of

the strategy is to improve the quality of data available to: (i) provide evidence of the devastating effects of the epidemic and the urgency to respond; (ii) determine the effectiveness of activities; and (iii) assist governments to understand the severity of the epidemic in their country/region and then design the most appropriate prevention, care and treatment programs based on the data.

8. ***World Development Report 2004: Making Services Work for Poor People*** calls attention to the frequent failure of basic services, particularly health, education, water, and sanitation, to reach the poor and their potential to improve outcomes (World Bank 2003a). Services fail poor people in four critical ways: (i) only a small portion of national budgets are spent on services for the poor; (2) if spending is allocated to the poor, often it does not reach them; (3) if spending does reach the poor, weak incentives for providers often lead to poor quality service; and (4) due to poor service quality or limitations to accessing them, demand is often is weak. In order to address these barriers to service delivery, the report advocates that the poor are put at the center of service provision. It argues that services for the poor can be improved by enabling the poor to monitor service delivery and quality, improving pro-poor advocacy and representation in policymaking, and providing incentives for providers to serve the poor. While institutional change is fundamental to strengthen relationships of accountability, the report emphasizes that institutional changes are often long-term processes that must be tailored to the local context. The WDR extends its message to the donor community, emphasizing that in order to improve service reform and accountability at the country-level, that aid effectiveness and development outcomes must be prioritized.

9. ***Improving Health, Nutrition, and Population Outcomes in Sub-Saharan Africa: The Role of the World Bank*** (2004) notes that positive trends in health indicators have slowed or reversed in Sub-Saharan Africa (World Bank 2004a). The strategy argues that the World Bank must use its comparative advantage to work with governments and partners to strengthen the capacity of countries to improve health outcomes. Nutrition and population must remain central issues in development in Sub-Saharan Africa and accordingly, the report presents a regional guide to shape strategy formulation at the country or sub-regional level. Its priorities are aligned with the Bank's comparative advantages: integrating macroeconomic and health policy; promoting multisectoral polices that contribute to health outcomes; strengthening health systems; and developing appropriate and innovative approaches to achieving sustainable health finance. As the Bank moves away from project support in the HNP sector and towards sector-wide approaches (SWAps) and budget support, improved M&E is fundamental to track health outcomes and ensure the effectiveness of these approaches. Moreover, it argues that at the country and regional levels, decision-making must be based on an expanded knowledge base including results from M&E, best practices from regional and global experiences, and analytic work.

10. ***Rolling Back Malaria: The World Bank Global Strategy and Booster Program*** (2005) outlines the five-year Booster Program for Malaria Control and rationale for initiating the strategy (World Bank 2005a). The Program's immediate objectives are to increase coverage of malaria-specific interventions, improve outcomes, contribute to

developing health systems, and build capacity in several sectors. With a focus on targeting poor and vulnerable groups, the World Bank will attempt to meet its corporate commitment primarily with efforts to support countries to: develop and implement cost-effective programs that target poor and vulnerable groups; mitigate the negative consequences of malaria; and reduce morbidity, productivity losses, and mortality. It also aims to address the challenges of regional and global public goods. Described as a "new business model", it prioritizes flexibility, giving countries choices in financing mechanisms and modes of implementation. For example, the Program allows for cofinancing with other sources, country-by-country partnerships with the GFATM, grants or performance-based buy-downs. In terms of implementation, it also does not adhere closely to any mode, and suggests possibilities including: enhancing PRSCs and SWAps to support malaria control; country or subregional level malaria control projects; and combined HIV, TB and malaria control projects. The report, however, does advocate strongly that malaria control is included in PRSCs and health SWAps to address the issue in the medium- to long-term, while simultaneously supporting intensive programs to ensure rapid increases in coverage. There is an emphasis on measurable results and "closing the gap between learning and doing." At the country level, it is argued that the results emphasis will ensure that strategies remain results-driven and strengthen country capacity in monitoring and evaluation. The Bank will establish clear programs and budgets, and track its commitment to malaria control in order to assess its effectiveness. The business model creates a Bank-wide Malaria Task Force, composed of individuals from corporate units, networks, operational vice presidential units and the IFC, to increase the scale and impact of Bank support at country level, and improve the institutional knowledge base on the economics of malaria, channeling this into work on poverty reduction strategies. A high-level Steering Committee formed by the vice presidents of several regions and units along with the Senior Vice President and Chief Economist, will be established to provide institutional oversight and guidance.

11. ***The World Bank's Global HIV/AIDS Plan of Action*** (2005) outlines a three-year working plan to strengthen the response to the HIV/AIDS epidemic at the country, regional and global levels through lending, grants, analysis, technical support and policy dialogue (World Bank 2005b). This Plan of Action contributes to the Bank and international community's overall objective of reversing the spread of HIV/AIDS. It establishes five action areas: strengthening national HIV/AIDS strategies; continuing to fund national and regional programs to strengthen health systems; accelerating implementation by improving coordination; strengthening country monitoring and evaluation and evidence-informed responses; and knowledge generation and shared impact evaluation. Although its top priority is to prevent new infections, it argues that an effective response to HIV/AIDS also must include treatment and care. The Bank will work with client countries and development partners including civil society and people living with AIDS in its next phase of work on the epidemic. The plan identifies several constraints that commonly limit the effectiveness of resources devoted to fighting HIV/AIDS. These include: poor planning; lack of surveillance and monitoring and evaluation information; implementation constraints; health systems without adequate capacity to manage additional resources and responsibilities; programs that are limited in scope; and political, social and economic climates that do not deal well with controversial

services or marginalized groups. Due to a surge in resources dedicated to fighting the epidemic, along with increased knowledge of how to tackle it and increased awareness, HIV/AIDS is no longer classified as a "crisis" but instead as a broad, long-term development issue that must be addressed with harmonized and coordinated action to promote common approaches.

12. ***Reproductive Health: The Missing Millennium Development Goal*** (2006) argues that despite a surge in the levels of attention and funding dedicated to reproductive health in the years following the 1994 International Conference on Population and Development (ICPD), that it is no longer a priority on the international community's agenda (White and others 2006). As the title of the report indicates, the goal to provide universal access to reproductive health information and services was dropped from the agenda when the MDGs were adopted in 2000. Opponents of the goal argued that it promoted abortion and undermined family values, and thus in order avoid further controversy and ensure consensus, it was eliminated. Consequentially, this decision has jeopardized funding and support for reproductive health. Citing evidence that services are failing the poor, particularly women, the report employs an adapted version of the "pathways" framework to assess factors and several levels which influence reproductive health. It argues that too often individual and family decisions and actions, the demand side of medical care, are overlooked despite their instrumental role in achieving health outcomes. The report maintains the validity of the rights-based approach, but argues that because it has not been successful overall, that a more practical approach could contribute more effectively to the achieving the underlying objectives. It asserts that reproductive health advocates need to understand how to face the challenges and opportunities that have arisen due to changes in the international health landscape including, the emergence of disease-specific global initiatives (particularly HIV/AIDS), health sector reforms and new financial aid modalities. It suggests an approach that focuses on expected outcomes and the extent to which investments in reproductive health services save lives, reduce suffering and help address socially and culturally challenging programs. Building the evidence base, which has been weak, is a critical component of the approach which recognizes the power of advocacy to affect change and improve health outcomes, particularly for poor women.

13**.** ***Health Financing Revisited: A Practitioner's Guide*** (2006) reviews the policy options and tools available for health finance in low-income and middle-income countries. Due to demographic and epidemiological transitions, health care financing is particularly urgent because these changes will alter quantity and type of health services needed, and put more pressure on the health care systems (Gottret and Schieber 2006). The guide details the features, strengths and weaknesses of different mechanisms for revenue collection, risk pooling, resource allocation and purchasing. Its objective is to provide an overview of health finance tools and policies to assist policy makers and stakeholders design, implement, and evaluate effective health finance reforms. Key priorities in health financing for both LICs and MICs include: (i) mobilizing increased and sustainable government health spending; (ii) improving governance and regulation to strengthen the capacity of health systems and ensure that investments are equitable and efficient; and (iii) coordinating donors to make more flexible and longer-term commitments that are aligned with the development goals of a country. The publication

advocates that LICs and MICs consider the options available for health financing and formulate appropriate policies based on their specific country-context, case studies, and lessons learned from high-income countries. Moreover, it advocates that decisions concerning specific products and services be evaluated along the lines of effectiveness and cost-effectiveness. Fundamental to improving and ultimately achieving sustaining health financing, is strengthening government capacity to raise revenue along with its accountability and absorptive capacity for donor funding. Last, because sustainable financing depends on political stability, the international community must work with countries to formulate sound macroeconomic policy, develop tools to improve public sector management (such as PRSPs, PRSCs, MTEFs), and develop clear rules regarding compliance with international contracts.

14. ***Repositioning Nutrition as Central to Development: A Strategy for Large-Scale Action*** (2006) makes the case that malnutrition is the world's most serious health problem and largest contributor to child mortality (World Bank 2006). It argues that due to the threat to health and development posed by malnutrition, countries must take the lead to reposition nutrition on their agendas. The international community needs to provide both incentives to establish nutrition as a priority and resources to scale-up successful interventions. The report prioritizes: developing approaches that reach the poor and most vulnerable at strategic stages in their development; scaling up proven and cost-effective programs; reorienting ineffective programs; improving nutrition through deliberate activities in other sectors; supporting action research and learning by doing; and mainstreaming nutrition into development strategies (CASs, SWAps, MAPs, PRSPs). To support effective work in these priority areas, the development community must: coordinate its efforts to strengthen commitments to nutrition, focus on agreed-on set of priority countries for investment and another set for researching best practices, and provide support for nutrition initiatives with large-scale programs as opposed to smaller-scale projects. The report argues that funding should come through normal financing channels instead of a special nutrition fund. It also provides a framework for making policy choices in nutrition and a methodology for determining how to prioritize countries for action in nutrition.

15. ***Population Issues in the 21st Century: The Role of the World Bank (2007*** differentiates between the two main areas under the population umbrella: (i) reproductive, maternal and sexual health, and the services that address them; and (ii) factors that determine population and age structure, including births, deaths, and migration (World Bank 2007b). The report focuses on the second area, stating that it was written as a follow-up to an early draft of the 2007 HNP strategy to emphasize areas not covered comprehensively in the background strategy note submitted. It provides an overview of the demographic context globally, trends by region, and issues in high, medium and low-fertility countries, giving emphasis to Sub-Saharan Africa. Also, it highlights the multisectoral dimensions of fertility. After establishing the need to address population issues, the report argues that the Bank's action in this area is rational given the relationships between population and economic growth and poverty reduction. It also argues that this is in-line with the Bank's focus on improving outcomes for the poor and vulnerable, as these populations experience the highest fertility rates and lowest

contraception use rates, and would gain from targeted efforts. The report then broadens its scope to look at the global policy context for population, including the challenges and opportunities generated by the MDGs, ICPD, and recent trends in total population assistance. According to the report, there has been a shift in funds towards STD/HIV/AIDS expenditures and away from family planning, other reproductive health assistance, and basic research. After reviewing the Bank's support for population and reproductive health assistance, the report concludes: (i) lending has increased over the past decade with lending for high fertility countries remaining relatively constant; (ii) that approximately half of high fertility countries had population and reproductive Analytical and Advisory Activities (AAA); and (iii) efforts to mainstream these areas into Country Assistance Strategies need to be intensified; and (iv) most PRSPs addressed population growth to some extent, but this did not mean that population policies were necessarily enacted. The final section of the report lays out priorities for strategies in low, middle and high-fertility countries given the Bank's areas of comparative advantage: multisectoral and health systems approaches, its capacity for large-scale implementation; its core economic, fiscal, and cross-sectoral analysis capacity across sectors; substantial country focus and presence; and its capacity to engage private sector health actors.

16. ***Healthy Development: The World Bank's Strategy for Health, Nutrition and Population Results*** (2007) the most recent sector strategy, identifies new challenges that have emerged since 1997, and reflects shifts in the international community and Bank's approaches to health (World Bank 2007a). Its overall objective is to use a selective and disciplined framework to redouble efforts to support client countries to: (i) improve level and distribution of key HNP outcomes (e.g MDGs), outputs, and system performance at country and global levels in order to improve living conditions, particularly for the poor and vulnerable; (ii) prevent poverty due to illness (by improving financial protection); (iii) improve financial sustainability in the HNP sector and its contribution to sound macroeconomic and fiscal policy and to country competitiveness; (iv) improve governance, accountability, and transparency in the health sector. Whereas strengthening health systems was one of three priorities in the 1997 Strategy, the 2007 Strategy emphasizes that health system strengthening is a crucial means to achieving results in each of the other priority areas. The Bank will advocate for and support the elaboration of country-driven and owned strategies that take intersectoral approaches. Efforts will be focused in areas of comparative advantage which include providing policy and technical advice in areas related to health system strengthening and finance to client countries and global partners; promoting intersectoral approaches for country assistance; and capacity to implement large-scale programs. Due to the Bank's many commitments to global partners, it will attempt to work more selectively with key partners in order to ensure that it is able to maintain close relationships with client countries. The Strategy emphasizes the importance of tightening the link between HNP-related lending and non-lending support with outcomes, output and health system performance. The importance of effective monitoring and evaluation linked to design and management is fundamental to the strategy. The Bank will sharpen its focus on results by supporting improved national public health surveillance and performance monitoring systems, and implementing the Global Results Framework.

ANNEX C: WORLD BANK HNP TIMELINE

YEAR	BANK-WIDE EVENTS	HNP SECTOR EVENTS	HNP PUBLICATIONS and STRATEGIES	HNP PARTNERSHIPS and COMMITMENTS
1952	Economic Survey Mission to Jamaica to study the country's development requirements considers the effects of rapid population growth. (March) (1)	Concern over the impact of population growth on development discussed at Seventh Annual Meetings in Mexico City. Chairman of the Board of Governors argues that the World Bank is well placed to combine sound banking principles with creative efforts to address population growth issues. (September) (1)		
1961	World Bank begins lending for water supply and sanitation projects. (2)			
1968	Robert McNamara becomes World Bank President. (April) (1) McNamara calls for governments to develop strategies to control population growth. He admits that there is no alternative to the World Bank's involvement in "this crisis." (October) (1)	Economics Department's Special Studies Division reorganized to create a Population Studies Division headed by E.K. Hawkins. (3) Population Projects Department established under the Office of the Director of Projects. (November) (4) K. Kanagaratnam is asked and accepts to head Population Projects Department; however he is unable to start immediately, and in the interim George C. Zaidan becomes the first division chief of the new department. (3)		
1969	McNamara calls for emphasis on population planning, educational advances, and agricultural growth in his Annual Meetings address. He highlights the need for development in nutrition, water supply, and literacy. (September) (1)			
1970		First Population loan approved for $2 million to support Jamaica's family planning program. (June) (1)		
1971	In his Annual Meeting address, McNamara emphasizes the importance of addressing the basic problems affecting the daily lives of people in developing countries, including nutrition, employment, and income distribution, among others. He describes			World Bank/WHO Cooperative Program established to address water supply, waste disposal, and storm drainage. (September) (1)

YEAR	BANK-WIDE EVENTS	HNP SECTOR EVENTS	HNP PUBLICATIONS and STRATEGIES	HNP PARTNERSHIPS and COMMITMENTS
1971	malnutrition as a major barrier to human development. (September) (1)			
1972	A Bank-wide reorganization creates a senior vice president of operations with five regional vice presidents and a vice president for project staff. (August) (1)	As a result of the reorganization, Population and Nutrition Projects (PNP) Department and several others with too few staff for decentralization are grouped in the Central Operation Projects Department and provide technical services to the regions. (4)	*Possible Bank Actions on Malnutrition Problems* is released. It is influential in calling attention to the Bank's role in addressing malnutrition. (January) (5*) *Sectoral Programs and Policies Paper* includes recommendations on population policies. It points to the economic effects of population growth in developing countries, describes the Bank's efforts to assist member countries to reduce population growth rates, and outlines its future program in population assistance. (March) (6*)	World Bank participates in an advisory capacity in WHO's Special Program of Research Development and Training in Human Reproduction (HRP). (7)
1973	McNamara uses his address at the Annual Meetings to emphasize the need to incorporate population planning into development strategies. (September) (1)	The Board of Executive Directors approves McNamara's proposal for the Bank take the lead in mobilizing international funds for an onchocersiasis (river blindness) control program. (May) (1)	A nutrition policy paper makes the case for investment in nutrition and proposes that the Bank "assume a more active and direct role in nutrition." (8*)	World Bank convenes Meeting of Onchocersiasis Control Program in Paris with WHO, FAO, UNDP. The purpose of the meeting is to formulate a strategy to fight river blindness. (June) (1)
1974		Funds to cover the first year of the Onchocersiasis (river blindness) Control Program are mobilized. (March) (1)	*Population Policies and Economic Development* analyzes the impact of population growth on the fight against poverty. (August) (9*)	WHO, FAO, UNDP and the World Bank implement the Onchocersiasis Control Program (OCP) which is endorsed by the seven governments of West African the countries most affected by the disease. (March) (1)
1975			*1975 Health Sector Policy Paper* published. As the first formal HNP policy statement, it establishes that lending will be only for family planning and population. (10*)	World Bank co-sponsors the Tropical Research Program along with WHO, UNICEF and UNDP to coordinate a global effort to combat diseases that affect the poor and disadvantaged through research and development, and training and strengthening. (1)
1976		First loan in nutrition, $19 million to Brazil, is approved. (June) (1)		
1977				World Bank helps to found and becomes a member of the UN Subcommittee on Nutrition (SCN). (11)
1979		The Population, Health and Nutrition Department (PHN) is established. The Bank approves a policy to consider funding stand-alone health projects and health components of other projects. (July) (2) John R. Evans appointed PHN Department Director. (12)		World Bank and UNDP initiate the UNDP-World Bank Water and Sanitation Program (WSP) to analyze cost-effective strategies and technologies to bring clean water to the poor. (1)

YEAR	BANK-WIDE EVENTS	HNP SECTOR EVENTS	HNP PUBLICATIONS and STRATEGIES	HNP PARTNERSHIPS and COMMITMENTS
1980	*WDR 1980: Poverty and Human Development* highlights the importance of health sector, education, and social protection to alleviate poverty. Part of the report describes the role of human development programs its effects on productivity and population growth. (August) (13*)		*1980 Health Sector Policy Paper* commits the Bank to direct lending in the health sector. The strategy focuses on the need for basic health services, especially in rural areas, and describes the links between the health sector, poverty alleviation, and family planning. (14*)	
1981		First loan to expand basic health services made to Tunisia. (15)		
1983		John N. North becomes Director of the PHN Department. (12)		
1984	*WDR 1984: Population and Development* emphasizes the role of governments to reduce mortality and fertility. (16*) Research department launches the first Bank-sponsored Living Standards Measurement Survey (LSMS) in Cote D'Ivoire. LSMS surveys are multi-topic household surveys capable of linking the level and distribution of welfare at the household level to health care decisions, the availability and quality of health services, and HNP outcomes. (17)			World Bank partners with The Rockefeller Foundation, UNDP, UNICEF, and WHO to establish the Task Force for Child Survival and Development, a campaign to achieve the goal of universal child immunization by 1990. (1)
1985		Fred Sai appointed Senior Population Adviser. (18)		
1986	Barber Conable appointed as the Bank's 7th President. (July) (1) A "Poverty Task Force" composed of senior staff is established to review the Bank's work and propose new activities. (19)		*Poverty and Hunger: Issues and Options for Food Security in Developing Countries* argues that food insecurity is caused mainly by poor people's lack of purchasing power. It asserts that the role for international donors is to provide assistance to develop and financing to support improved policies to reduce food insecurity, as well as addressing international trade factors that contribute to food insecurity. (20)	

YEAR	BANK-WIDE EVENTS	HNP SECTOR EVENTS	HNP PUBLICATIONS and STRATEGIES	HNP PARTNERSHIPS and COMMITMENTS
1987	President Conable announces an internal reorganization to be completed by September. (May) (1)	PHN becomes a division of the Population and Human Resources (PHR) Department. Technical departments, including PHN units, are created within each region, and country departments are created within regions, combining the functions formerly divided between programs and projects departments. (21) Ann O. Hamilton is appointed PHR Department Director. (12) Dean T. Jamison is appointed Chief Manager of PHN Division. (12)	*Financing Health Services in Developing Countries: An Agenda for Reform* argues that government expenditures should shift towards providing health services for the poor. The policy study addresses themes of inefficient public spending on health care and recurrent cost financing. (May) (22*)	World Bank cosponsors the Safe Motherhood Conference in Nairobi, Kenya. The Bank pledges to take specific steps to address issues affecting women, and the Safe Motherhood Initiative is launched. (February) (1)
1988		First free-standing AIDS project approved in Zaire. This is also the first approved free-standing Bank project for a single disease. (21) Anthony Measham becomes PHN Chief Manager. (12)	*Acquired Immunodeficiency Syndrome (AIDS): The Bank's Agenda for Action* is prepared by the Africa Technical Department. It was not formally adopted by the Bank management as a strategy but released as a working paper. (23*)	World Bank becomes a funder of the WHO's HRP. (24)
1989	The IDA Debt Reduction Facility established to reduce the stock of debt owed to commercial creditors by IDA-only countries. (August) (1) Bank finances the first freestanding NGO-implemented project for grassroots development in Togo. (19) First social fund project approved. (1)		*Sub-Saharan Africa: From Crisis to Sustainable Development* calls for a doubling of expenditure on human resource development: food security, primary education, and health care. (November) (25*)	
1990	The IBRD approves the largest loan at this point in its history (nominal terms) to Mexico to support a debt-reduction program, and the Debt-Reduction Facility for IDA-only countries undertakes its first operation in Bolivia. (19)	Steve Sinding becomes Senior Population Adviser. (26)		
1991	Lewis T. Preston is appointed as the 8th president of the World Bank. (September) (21)			World Bank joins with UNDP, UNICEF, WHO, and Rotary International to form the Children's Vaccine Initiative (CVI). CVI's goal is to vaccinate every child in the world against viral and bacterial diseases. (27)

YEAR	BANK-WIDE EVENTS	HNP SECTOR EVENTS	HNP PUBLICATIONS and STRATEGIES	HNP PARTNERSHIPS and COMMITMENTS
1992	A report of the Task Force on Portfolio Management (the "Wapenhans Report") is transmitted to the Executive Directors and is a major factor in the Bank's impetus to re-double its efforts toward effective implementation of lending projects. (1)	Bank issues a statement that abortion is an issue which countries themselves must address and denies advocating the legalization of abortion in Latin America. (March) (1)		World Bank participates in International Conference on Nutrition in Rome. (December) (15)
1993	*WDR 1993: Investing in Health* evaluates the roles of governments and markets in health, as well as ownership and financing arrangements to improve health and reach the poor. It introduces the DALY to calculate the Global Burden of Disease, and argues that the international community must commit to addressing health issues. (June) (27*)	*AIDS in Asia,* the first Regional AIDS support unit is established in the East Asia and Pacific Region. (21) Janet de Merode becomes Director of the PHN Division. (12)	*Disease Control Priorities in Developing Countries* provides information on disease control interventions for the most common diseases and injuries in developing countries to help them define essential health service packages. The publication eventually leads to increased Bank lending for disease control. (October) (28*)	
1994	A policy paper, *Water Resources Management,* proposes a new approach to managing water resources. The approach advocates a comprehensive policy framework and treatment of water as an economic good, along with decentralized management and delivery structures, greater reliance on pricing and fuller participation by stakeholders. (29*)	David de Ferranti becomes Director of PHN Division. (12)	*Better Health in Africa,* directed to both Bank and external audiences, argues that because households and communities have the capacity to use knowledge and resources to respond to health problems, policy makers should make efforts to create an enabling environments that stimulate "good" decision making. It also points out that health reforms are necessary, that cost-effective packages of services can meet needs, and that changes in domestic and international financing for health are necessary. The publication was never approved as an official strategy, but the World Bank supported an independent 'Better Health in Africa' Expert Panel, that worked to disseminate key messages to African policy makers. (30*)	Bank participates in International Conference on Population and Development (ICPD) in Cairo and commits to its plan of action. (31)
1995	James Wolfensohn is appointed as the ninth World Bank president. (June) (1) *The Broad Sector Approach to Investment Lending: Sector Investment Programs* defines sector investment programs (SIP), analyzes experience with the new lending instrument and advocates for more learning and support of SIPs, particularly in Africa. (32)	The Human Development Department is established and David de Ferranti serves as Department Director. Richard Feachem (Health), Jorge Barrientos (Implementation), Alan Berg (Nutrition) and Thomas Merrick (Population) are appointed as managers/advisers. (July) (4,12)		The Bank hosts a conference to launch the African Program for Onchocersiasis Control, a follow-up to a successful project launched in the 1970s. Sponsored by governments, NGOs, bilateral donors and international institutions, it implements community-based drug-treatment programs in 16 African countries. (December) (1)

YEAR	BANK-WIDE EVENTS	HNP SECTOR EVENTS	HNP PUBLICATIONS and STRATEGIES	HNP PARTNERSHIPS and COMMITMENTS
1995		Learning and Leadership Center-Human Development Network training week initiated to provide staff with intensive training focused on topical issues in the HNP sector. (15)		The Bank participates in the Fourth World Conference on Women in Beijing (FWCW) and agrees to: reduce the gender gap in education and ensure that women have equitable access and control over economic resources. (31)
1996	*World Bank Participation Sourcebook* launched. Wolfensohn announces that the Bank will involve NGOs, the private sector, community groups, cooperatives, women's organizations, and the poor and disadvantaged in decision-making processes. (February) (33) In his Annual Meetings address, Wolfensohn defines the key elements of the Strategic Compact to renew the Bank Group and improve development effectiveness: improving resource mobilization; taking more integrated approaches; building partnerships and sharing knowledge; and restructuring the Bank to be closer to clients through responsive and high-quality products. (October) (33) The Bank announces that three new networks will be created: Environmentally and Socially Sustainable Development (ESSD), Finance, Private Sector and Infrastructure (FPSI), and Poverty Reduction and Economic Management (PREM). (December) (1) *Poverty Reduction and the World Bank: Progress and Challenges* in the 1990s is released and vows to redouble Bank's efforts to ensure success in its mandate to help countries reduce poverty. The Bank says that it will judge itself and staff by their contributions to achieving this goal. (June) (1) The Bank and IMF launch the HIPC Initiative, creating a framework for creditors to provide debt relief to the world's most poor and indebted countries. The HIPC Trust Fund and HIPC Implementation Unit are established. (November) (1)	World Bank sponsors tobacco-related and non-communicable disease conference in Washington, DC. (June) (1) The Flagship Program on Health Sector Reform and Sustainable Financing is initiated by the Economic Development Institute (EDI, now World Bank Institute) to provide knowledge and training on options for health sector development, including lessons learned and best practices from country experience. Course is offered at regional and country levels. (1)		Special UN Initiative for Africa launched; Bank partners with UN to promote an expanded program of assistance to Sub-Saharan Africa and improve cooperation between the Bank and the UN. Bank commits to take special responsibility for mobilizing resources for basic health and education reforms. (March) (1) Wolfensohn announces Bank's support for the G-7's declaration and objective of providing an exit strategy for heavily indebted countries. Bank pledges $500 million to a trust fund for debt relief as its the initial contribution. (June) (33) World Bank co-sponsors The Joint UN Program on HIV/AIDS (UNAIDS) with UNDP, UNESCO, UNFPA, UNICEF, and WHO. (21) World Bank becomes a donor to the newly formed International AIDS Vaccine Initiative (IAVI). It is established to ensure the development of an HIV vaccine for use around the world. (35)

YEAR	BANK-WIDE EVENTS	HNP SECTOR EVENTS	HNP PUBLICATIONS and STRATEGIES	HNP PARTNERSHIPS and COMMITMENTS
1996	The Bank announces that three new networks will be created: Environmentally and Socially Sustainable Development (ESSD), Finance, Private Sector and Infrastructure (FPSI), and Poverty Reduction and Economic Management (PREM). (December) (1) Quality Assurance Group (QAG) established with the expressed purpose of improving the quality of the Bank's operational work within the broad context of alleviating poverty, and achieving development impacts. (34)			
1997	*World Development Indicators 1997,* the first edition, is published. Wolfensohn describes that the publication is an example of the World Bank's role in disseminating knowledge to facilitate decision-making in development. (April) (33) The Strategic Compact period, a three year organization renewal process is launched. (April) (1) Bank reorganization leads to the creation of Bank-wide "anchor" units to provide quality support to the Regions. The reorganization was designed to promote balance between "country focus" and "sectoral excellence." (21)	The Human Development Network (HDN) is formed, along with the HNP Sector Board, when Bank reorganization groups sector staff into regional sector units or departments. Sector staff works with county departments in a matrix relationship. This allows Regional managers working in the HNP Sector to come together. (21) David de Ferranti serves as Vice President and Head of HDN. Richard G.A. Feachem is named HNP Director and serves as Chair of the Sector Board. (12) World Bank organizes and hosts an International Conference on Innovations in Health Financing. (36)	The 1997 *Health, Nutrition, and Population Sector Strategy Paper* emphasizes the importance of institutional and systemic changes to improve health outcomes for the poor, improve health system performance, and achieve sustainable financing in the health sector. (September) (15*) *Confronting AIDS: Public Priorities in a Global Epidemic* makes the case for government intervention to controlling AIDS in developing countries from epidemiological, public health, and public economics perspectives. The report advocates that donors base their support on evidence of country-specific effectiveness for interventions, and finance key international public goods. (November) (37*)	World Bank collaborates with UN Economic Commission for Africa and UNICEF to organize the Forum on Cost Sharing in the Social Sectors of Sub-Saharan Africa. 15 principles for cost sharing in health and education are agreed upon at the Forum. (38) The World Bank and The Danish Ministry of Foreign Affairs co-host a meeting for donor agencies in Copenhagen to discuss sector-wide approaches. At the meeting the term SWAp is coined, a SWAp guide is commissioned, and an Inter-Agency Group on SWAp is formed. (32)
1998	President Wolfensohn's address at the Annual Meetings warns that financial reforms are not sufficient, that human needs and social justice must also be sought. (1) *Assessing Aid: What works, what doesn't and why* concludes that there is a role for foreign aid and that properly managed aid can contribute toward improving people's lives. It argues that institutional development and policy reforms along with strong three-way partnership among recipient countries, aid agencies, and donor countries can improve the impact of foreign assistance. (39*)	The World Bank launches AIDS Vaccine Task Force to speed up deployment of effective and affordable AIDS vaccine. It supports high-level dialogue with policymakers and industry, both "push"' and "pull" strategies to generate investments in R&D, and sponsors studies of potential demand for a vaccine in developing countries. (April) (1) The World Bank Institute develops a course and learning program titled "Adapting to Change" as a response to the ICPD. (40) Christopher Lovelace appointed Director of the HNP Sector. (12)		The World Bank partners with WHO and Smith Kline Beecham to initiate a Program to Eliminate Elephantiasis by distributing drugs free of charge to governments and collaborating organizations. (January) (1) The World Bank, WHO, UNDP and UNICEF launch Roll Back Malaria to provide a coordinated global approach to halve malaria by 2010. (41)

YEAR	BANK-WIDE EVENTS	HNP SECTOR EVENTS	HNP PUBLICATIONS and STRATEGIES	HNP PARTNERSHIPS and COMMITMENTS
1999	Wolfensohn calls for development partners to adopt a Comprehensive Development Framework, which aims to improve the effectiveness of development activities and move beyond individual projects, promoting national leadership and consensus and requiring a commitment to expanded partnership, transparency, and accountability. (January) (33) Bolivia becomes the pilot country for the CDF with two loans for health and institutional reform. (June) (1) In preparation for WDR 2000/2001, the Bank launches the *Voices of the Poor* study to gather information from 60,000 participants in 60 countries. The study focused on perceptions of a quality of life; pressing problems and priorities; the quality of interactions with key public, market and civil society institutions in their lives; and changes in gender and social relations. (September) (42*) Wolfensohn unanimously appointed for second term as World Bank president. (September) (33) Wolfensohn explains the link between corruption and poverty, outlining the World Bank's response at International Anti-Corruption Conference in Durban. He states that the Bank will position corruption as a central issue to development, apply external pressures for change at the country level while encouraging internal pressures for change, and create partnerships to address corruption issues. (October) (33) The World Bank and IMF announce that concessionary lending to 81 eligible poor countries will be based on poverty reduction strategies, initiating the PRSP process. (43) Enhanced HIPC launched. HIPC initiative is modified to provide deeper and broader relief, faster relief, and to create a more direct link between debt relief and poverty reduction through Poverty Reduction Strategy Papers. (1)	The AIDS Campaign Team for Africa (ACT*africa)* unit is created to help mainstream HIV/AIDS activities in all sectors. (21) Eduardo A. Doryan is appointed HDN Vice President. (12)	*Population and the World Bank: Adapting to Change* is shaped largely by its commitment to the 1994 ICPD and by an emphasis on health sector reform in the 1990s. Its objective is to address population issues with a people-centered and multisectoral approach that improves reproductive health through access to information and services, and recognizes the importance of contextual factors such as gender equity and human rights. (January) (31*) The Bank's new strategy to fight HIV/AIDS in Africa in partnership with African government and Joint UN Program on HIV/AIDS (UNAIDS) approved by Regional Leadership Team. (May) (21) *A Health Sector Strategy for the Europe and Central Asia Region* responds to changes in the health care systems, particularly in transition countries, by providing a guide to support regionally appropriate, intersectoral health system reforms. Key priorities are identified as: (i) promoting wellness and reducing the prevalence of avoidable illness; (ii) creating affordable and sustainable delivery systems; and (iii) maintaining functioning health systems during the reform process. (September) (45*)	The World Bank partners to establish The Global Alliance for Vaccines and Immunization (GAVI), a public-private partnership, to ensure financing to save children's lives and people's health through widespread vaccinations. (46)

YEAR	BANK-WIDE EVENTS	HNP SECTOR EVENTS	HNP PUBLICATIONS and STRATEGIES	HNP PARTNERSHIPS and COMMITMENTS
1999	The OED releases an evaluation of the HNP Sector that suggests that the Bank improve knowledge management, develop more flexible instruments, and support increased economic and sector work to help countries to identify challenges and improve the efficiently, effectiveness and equity of health reforms. It agues than projects had been too complex, had neglected institutional analysis and that monitoring and evaluation was almost non-existent. It urged that the Sector "do better, not more," that is be more selective to do a few things better rather than too much with poor results. (44)			
2000	World Bank announces a plan to work with Church groups in Africa to fight poverty and AIDS. (March) (1) Thousands of demonstrators protest The Development Committee's Spring meetings in Washington, which were conducted in spite of the protests. The Development Committee renewed its pledge to speed up debt relief and to support the fight against AIDS. (March) (1)	Wolfensohn addresses the UN Security Council and calls for increased resource allocation to fight a "War on AIDS", noting the epidemic's devastating effects on the developing world, especially Africa. (January) (33) The first Multi-Country AIDS Program (MAP) is approved by the Board and provides a $500 million envelope for financing HIV/AIDS projects in Africa. (September) (21)	The overall objective of the *World Bank Strategy for Health, Nutrition, and Population in East Asia and the Pacific Region* is to improve the Bank's effectiveness in health, nutrition and population in the region. The strategy urges selectivity and flexibility to develop new approaches, as necessary, based on lessons learned and experience in the region. It prioritizes: improving outcomes for the poor, enhancing the performance of health care systems, and securing sustainable financing. (June) (47*) World Bank and WHO issue a publication, *Tobacco Control in Developing Countries*. It argues that a reduction in tobacco use is essential to improve global health. (August) (48*) *Intensifying Action Against AIDS in Africa* emphasizes the importance of increased advocacy to strengthen political commitment to fighting HIV/AIDS, mobilization of resources, and strengthening the knowledge base. It advocates allocation of increased resources and technical support to assist African partners and the World Bank to mainstream HIV/AIDS into all sectors. (August) (49*) World Bank releases 44 country reports on *Socio-Economic Differences in Health, Nutrition and Population.* The reports stress that the poorest sectors of the population must receive adequate healthcare. (November) (50*)	At the World Economic Forum, Wolfensohn urges world leaders to support GAVI and its campaign for children. (January) (33) At the Second World Water Forum, Wolfensohn pledges the Bank's support to ensure that everyone has water services for health, food, energy, and the environment. The approach he outlines emphasizes participatory institutions as well as technological and financial innovation. (March) (1) At the XIIIth International AIDS Conference, the World Bank pledges $500million. The Multi-count AIDS Program, developed with UNAIDS, helps countries to implement national HIV/AIDS programs. (July) (1) The Bank-Netherlands Water Partnership Program (BNWPP) is established to improve water security by promoting innovative approaches to Integrated Water Resources Management (IWRM), and thereby contribute to poverty reduction. (51)

YEAR	BANK-WIDE EVENTS	HNP SECTOR EVENTS	HNP PUBLICATIONS and STRATEGIES	HNP PARTNERSHIPS and COMMITMENTS
2001	*WDR 2000/2001*: *Attacking Poverty* emphasizes that insecurity, in income or health services, is one of many deprivations suffered by poor. (52*) The World Bank announces that it will join the UN as a full partner to implement the Millennium Development Goals and to put these goals at the center of the development agenda. (September) (1) WB makes a Declaration of Commitment at Special Session of the UN General Assembly reaffirming pledges made by world leaders to halt and reverse the spread of HIV/AIDS by 2015. (June) (33) The Water Supply and Sanitation Program (WSP) Council is created to oversee program activities and guide strategic development in water and sanitation. (53) Board of Executive Directors approves a gender and development mainstreaming strategy. (54) First poverty reduction support credit (PRSC) approved. (1)	Bank announces it will build upon current programs and follow the Caribbean Regional Strategic Plan of Action for HIV/AIDS, devoting up to $150 million to the fight against HIV/AIDS in the Caribbean. (April) (21) Joseph Ritzen appointed HDN Vice President. (June) (1) Leadership Program on AIDS launched by WBI to build capacity for accelerated implementation of HIV/AIDS programs. (21)	Sub-regional HIV/AIDS strategy for Caribbean. *HIV/AIDS in the Caribbean: Issues and Options* released. (January) (55*)	The Bank and partners gather in Washington, DC to further commit to operationalize the Amsterdam Declaration. The Global Plan to Stop TB calls for the expansion of access to DOTS and increased financial backing for the program from governments throughout the world. (October) (56) The Bank's Water and Sanitation Program forms the Private-Public Partnership for Hand washing with the London School of Hygiene and Tropical Medicine, the Academy for Educational Development, USAID, UNICEF, the Bank-Netherlands Water Partnership and the private sector. (57) The Bank becomes a trustee of the Global Fund to Fight HIV/AIDS, TB, and Malaria (GFATM), a financing mechanism established to foster partnerships between governments, civil society, the private sector, and affected communities to increase resources and direct financing towards efforts to fight HIV/AIDS, TB, and malaria. (58) In cooperation with the Gates Foundation and Dutch and Swedish Governments, The World Bank Health and Poverty Thematic Group initiates the Reaching the Poor Program (RPP). RPP is an effort to find better ways to ensure that the benefits of HNP programs flow to disadvantaged population groups through research, policy guidance, and advocacy. (1) The Bank joins the Rockefeller Foundation, Sida/SAREC, and Wellcome Trust to launch the INDEPTH Network, an international platform of sentinel demographic sites that provides health and demographic data, and research to enable developing countries to set evidence-based health priorities and policies. (59) The Bank and USAID co-host the Annual Meetings of the *Global Partnership to Eliminate Riverblindness* in Washington. The partners pledged to eliminate riverblindness in Africa by 2010. (1)

YEAR	BANK-WIDE EVENTS	HNP SECTOR EVENTS	HNP PUBLICATIONS and STRATEGIES	HNP PARTNERSHIPS and COMMITMENTS
2002	Wolfensohn presents a seven point Post-Monterrey Action Plan to the Development Committee on how to boost development aid and effectiveness, and translate Monterrey commitments into results. (April) (33) From this point, Country Assistance Strategies (CAS), the main vehicle for making strategic choices about program design and resource allocations for individual countries, were based on PRSPs in LICs. (July) (60) IDA announces that 18-21 percent of IDA would be in grants and available for specific activities and for the debt-vulnerable poorest countries. (July) (1)	$500 million is approved for the second stage of its Multi-Country HIV/AIDS Program for Africa (MAP). (February) (1) WBI's course "Adapting to Change" becomes "Achieving the MDGs: Reproductive Health, Poverty Reduction, and Health Sector Reform." (40)	The HNP Sector Board presents an HNP strategy update to the Board . The Powerpoint presentation reviews trends in project lending and objectives, AAA, QAG ratings, IFC lending for HNP, and staffing. The update reconfirms the sector's commitment to the objectives in the 1997 strategy. It also emphasizes that greater country selectivity and diversity in lending instruments will be pursued along with efforts to: sharpen the focus on quality and effectiveness, work more closely with clients and communities, and improve training for staff and their allocation to ensure the appropriate skills mix. (March) (61)	The Global/HIV AIDS program is created along with the Global Monitoring and Evaluation Team (GAMET). GAMET is housed at the World Bank and supports efforts with UNAIDS to build country-level monitoring and evaluation capacities as well as coordinate technical support. (June) (21) First phase of Bank-Netherlands Water Partnership- Water Supply and Sanitation initiated. (51) Global Alliance for Improved Nutrition (GAIN) created at a special UN session for children. The World Bank is a key partner, mainly managing Trust Funds and program implementation. (62)
2003	*World Bank Annual Report* describes the Bank's commitment toward meeting the MDGs and emphasizes its commitment to four priority sectors including: HIV/AIDS, water and sanitation, health, and education for all. (September) (1)	Jean-Louis Sarbib assumes HDN Vice Presidency. (July) (12) Board approves first pilots of buy-down mechanism in several polio eradication projects in Pakistan and Nigeria. Projects were financed by Gates Foundation, UNF, Rotary International, and the CDC. (63)	Regional AIDS strategy for ECA published: *Averting AIDS Crises in Eastern Europe and Central Asia* (September) (64*)	The Bank and PAHO inaugurate the "Health Partnership for Knowledge Sharing and Learning in the Americas." The initiative promotes the use of technology to share expertise in order to meet the MDGs across the region. (October) (1)
2004	*Water Resources Sector Strategy: Strategic Directions for World Bank Engagement* is published. The strategy highlights the centrality of water resource management and development to sustainable growth and poverty reduction. It argues that the World Bank is perceived to have a comparative advantage in the area. It emphasizes the need to tailor Country Water Assistance Strategies to be consistent with country context, CASs and PRSPs. (January) (65) Reaching the Poor Program-sponsored global conference for researchers to disseminate evidence of how well health and other social programs reach the poor and to produce policy guidelines based upon the evidence. (February) (66) The Bank sponsors an event for 35 African ambassadors, Harmonizing Approaches to Health in Africa, to intensify efforts to improve women's health in Africa and plan follow-up activities. (April) (1)		Regional HIV/AIDS strategy for EAP published: *Addressing HIV/AIDS in East Asia and the Pacific*. (January) (69*) *Improving Health, Nutrition, and Population Outcomes in Sub-Saharan Africa- The Role of the World Bank* notes that positive trends in health indicators have slowed or reversed in Sub-Saharan Africa. It argues that the Bank must use its comparative advantage to work with governments and partners to strengthen the capacity of countries to improve health outcomes. Nutrition and population must remain central issues in development in Sub-Saharan Africa and accordingly, the report presents a regional guide to shape strategy formulation at the country or sub-regional level. (December) (70*)	WHO and the Bank co-sponsor the 1st High-Level Forum on the Health MDGs. Heads of development agencies, bilateral agencies, global health initiatives, and health and finance ministers agree on 4 action areas: 1) resources for health and poverty reduction papers; 2) aid effectiveness and harmonization; 3) human resources; 4) monitoring performance. (January) (1)

YEAR	BANK-WIDE EVENTS	HNP SECTOR EVENTS	HNP PUBLICATIONS and STRATEGIES	HNP PARTNERSHIPS and COMMITMENTS
2004	The OED releases an evaluation of the Bank's approach to global programs, *Addressing the Challenges of Globalization.* The evaluation recommends that the Bank separate oversight of global programs from management, improve standards of governance and management of individual programs, reevaluate selection and exit criteria, strengthen links between global programs and country strategies, and strengthen evaluations and review of global programs within the Bank. (67*) WDR 2004: *Making Services Work for Poor People* identifies good governance and accountability mechanisms as key determinants of health system performance. (68*)			
2005	Paul Wolfowitz is unanimously approved by the Board of Executive Directors as the World Bank's 10th President. (March) (1) In his speech at the Annual Meetings, Wolfowitz emphasizes the importance of leadership and accountability, civil society and women, and the rule of law as well as focusing on results. When speaking on the importance of health on the development agenda, he emphasizes the World Bank's commitment to fight malaria with the same intensity as HIV/AIDS. (September) (71) An IEG evaluation of the Bank's HIV/AIDS Assistance, *Committing to Results: Improving the Effectiveness of HIV/AIDS Assistance*, is released. It finds that the Bank's support has raised commitment and access to services but the effect on the spread of HIV and survival is unclear. It recommends that the Bank: help governments to be strategic and selective, and prioritize high-impact activities and the highest risk behaviors; strengthen national institutions to manage and implement long-run responses; and improve monitoring and evaluation to strengthen the local evidence base for decision making. (21*)	When the Adviser for Population and Reproductive, Maternal and Child Health (Elizabeth Lule) is appointed as manager as of ACTAfrica, the Adviser position is eliminated. (January) (72)	*Rolling Back Malaria: The World Bank Global Strategy and Booster Program* provides the basis and rationale for initiating the 5-year Booster Program for Malaria Control. Its objectives are to increase coverage, improve outcomes, and build capacity. Described as a "new business model", it prioritizes flexible, country-driven, and results-focused approaches. (January) (41*)	World Bank partners to launch the Health Metrics Network launched, a global partnership to improve the quality, availability and dissemination of data for decision-making in health. (June) (73)

YEAR	BANK-WIDE EVENTS	HNP SECTOR EVENTS	HNP PUBLICATIONS and STRATEGIES	HNP PARTNERSHIPS and COMMITMENTS
2006	Task Force on Avian Flu for Africa established to manage the information, communication, and coordination aspects of the response to avian influenza. It supports country teams to prepare individual country operations, helps coordinate the region's response with the global and Bank-wide funding programs, with donors, and mobilize additional funding as necessary. (74)	Cristian Baeza appointed as Acting HNP Director (February) (75)	*Repositioning Nutrition as Central to Development: A Strategy for Large-Scale Action* aims to position nutrition as a priority on the development agenda at both the country and international levels to bolster increased commitments and investment to fight malnutrition. It prioritizes: approaches that reach the poor and most vulnerable at strategic stages in their development; scaling-up proven and cost-effective programs; reorienting ineffective programs; improving nutrition through deliberate activities in other sectors; supporting action research and learning by doing; and mainstreaming nutrition into development strategies. (January) (76*) *Health Financing Revisited: A Practitioner's Guide* reviews the policy options and tools available for health finance in low and middle income countries. Key priorities include: (i) mobilizing increased and sustainable government health spending; (ii) improving governance and regulation to strengthen the capacity of health systems and ensure that investments are equitable and efficient; and (iii) coordinating donors to make more flexible and longer-term commitments that are aligned with the development goals of a country. (May) (77*)	World Bank co-sponsors the International Pledging Conference on Avian and Human Influenza in Beijing to assess financing needs at country, regional and global levels. (January) (74) World Bank joined the IMF and the African Development Bank in implementing the Multilateral Debt Relief Initiative (MDRI), forgiving 100 percent of eligible outstanding debt owed to these three institutions by all countries reaching the completion point of the HIPC Initiative. The MDRI will effectively double the volume of debt relief already expected from the enhanced HIPC Initiative. (78)
2007	Paul Wolfowitz resigns as World Bank President. (June) (79) Robert Zoellick becomes 11th World Bank President. (July) (80)	Joy Phumaphi becomes Vice President of the Human Development Network. (February) (81) Julian Schweitzer becomes HNP Sector Director. (October) (82)	The objective *of the 2007 World Bank Strategy for Health, Nutrition and Population Results* is to use a selective and disciplined framework to redouble efforts to support client countries to: improve HNP outcomes, especially for the poor; protect households from illness; ensure sustainable financing; and improve sector governance and reduce corruption. (April) (63*) *Population Issues in the 21st Century: The Role of the World Bank* focuses on levels and trends in births, deaths, migration and population growth and related challenges. After analyzing global and regional trends, as well as those for lending for population, the report outlines the Bank's areas of comparative advantage. It concludes that the Bank must focus analytical work on population issues, and collaborate with the	World Bank signs agreement to join the International Health Partnership. The Partnership aims to improve the work of donor and developing countries and international agencies to create and implement plans and services that improve health outcomes for the poor. (September) (84)

YEAR	BANK-WIDE EVENTS	HNP SECTOR EVENTS	HNP PUBLICATIONS and STRATEGIES	HNP PARTNERSHIPS and COMMITMENTS
2007			private sector and global partners to develop and mainstream multisectoral population policies appropriate for low, middle and high fertility countries. (April) (83*)	

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ANNEX D: GLOBAL HNP EVENTS TIMELINE

YEAR	INTERNATIONAL ORGANIZATIONS	BILATERAL AGENCIES and DEVELOPMENT BANKS	FOUNDATIONS/ NGOs	PUBLIC-PRIVATE PARTNERSHIPS	DEVELOPING COUNTRIES	EXTERNAL EVENTS
1951	WHO has been in existence for three years. (1) Brock Chisholm (Canada) serves as WHO Director-General. (2)		A grant from the Planned Parenthood Federation of America (PPFA) supports work to develop the oral contraceptive pill. (3)			Malaria eradicated in the US. (4)
1952			The International Planned Parenthood Federation (IPPF) is formed by national family planning associations from eight countries. (3) Ford Foundation becomes active in population programs. (5) John D. Rockefeller convenes a group of scientists to discuss demographic concerns. This leads to the creation of the Population Council. (6)		The first national population policy is established by India. (7)	World population passes 2.6 billion. (8)
1953	Marcolino Gomes Candau (Brazil) becomes WHO Director-General. (2)					
1954	UN organizes The First World Population Conference to exchange scientific information on population variables, their determinants and their consequences. The conference, held in Rome, resolved to generate information on the demographic situation of the developing countries and to promote the creation of regional training centers which would help to address population issues and to prepare specialists in demographic analysis. (August- September). (9)		The Population Council begins financial support to the Population Reference Bureau. (6) Ford Foundation grants $600,000 to the Population Council. (6)			Polio vaccine created. (3) Cigarette smoking reported to cause cancer. (3)

YEAR	INTERNATIONAL ORGANIZATIONS	BILATERAL AGENCIES and DEVELOPMENT BANKS	FOUNDATIONS/ NGOs	PUBLIC-PRIVATE PARTNERSHIPS	DEVELOPING COUNTRIES	EXTERNAL EVENTS
1955	WHO submits a proposal for the eradication of malaria worldwide at the World Health Assembly. (4)				India establishes the world's first national family planning program and requests assistance from the Population Council. (6)	
1958	UN has established regional centers for demographic training and research in Bombay, India, and in Santiago, Chile, with support from the Population Council. (6)					
1959					Pakistan establishes family planning services with assistance from the Population Council. (6)	
1960			By 1960, IPPF conducts fieldwork in Africa and Latin America. (3)			The oral contraception pill goes on sale in the U.S. (3) World population passes 3 billion. (8)
1961	The Food and Agricultural Organisation (FAO) and the UN General Assembly approve parallel resolutions that establish the World Food Programme (WFP) on a three-year experimental basis. (10)	After passing the Foreign Assistance Act, the US Congress authorizes research on family planning issues, including the provision of family planning information to couples who request it. (11)	Population Council provides support to initiate the Taichung family planning experiment in Taiwan. (6)			
1962			Population Council holds first international conference on intrauterine devices (IUDs) and facilitates granting of royalty-free licenses for manufacture of the Lippes Loop IUD for use in public programs worldwide. (6)		South Korea requests assistance from the Population Council. (6)	
1963	UN establishes a regional center for demographic training and research in Cairo, Egypt with support from the Population Center. (6)				The Governments of Tunisia and Turkey request advice from Population Council on establishing family planning programs. (6)	Trials being carried out on intrauterine devices (IUDs), oral contraceptives, and Depo-Provera, an injectable contraceptive. (3)

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1964			IPPF gains consultative status from the United Nations Economic and Social Council (Unesco). (3)			
1965	A report of the United Nations Advisory Mission to India, the most intensive family planning study ever undertaken by the UN, provides evidence that the UN is prepared to provide assistance in the field. (3) The Second World Population Conference is held in Belgrade and organized by the International Union for the Scientific Study of Population (IUSSP) and the UN. The conference focuses on the analysis of fertility as part of a policy for development planning. (August- September) (9)	USAID begins financing family planning programs. The United States government adopts a plan to reduce birth rates in developing countries through its War on Hunger and investments in family planning programs. (11)	The Population Council and Ford Foundation co-sponsor the First International Conference on Family Planning Programs in Geneva. (6) The Population Council launches the International Postpartum Project, involving 138 institutions in 21 countries. (6)			
1966		SIDA is a leading agency in promoting population and family planning programs. It was one of few countries to provide official assistance for family planning and was instrumental in persuading the UN to become more involved in family planning. (3) USAID funds the Population Council's Demographic Division (later Policy Research Division) to initiate a major effort to measure and evaluate family planning programs. (6)			The Indian government introduces targets for numbers of contraceptive acceptors. Health workers in primary health centers are assigned targets for sterilization and other methods in order to meet demographic targets. (12) The Romanian government bans all forms of modern contraception and abortion. (3)	China's Cultural Revolution begins. (3)
1967	WHO launches an intensified plan to eradicate smallpox (13)		IPPF holds the first ever international conference in Latin America (Chile) where population and family planning were explosive topics. (3)			First successful human heart transplant. (3)

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1967			Manoff International (now Manoff Group) is established to use mass media to create public awareness of urgent health problems and to communicate information about practical programs that met those challenges. It begins its work in India. (14)			UK Parliament passes the Abortion Bill, legalizing abortion on mental or physical health grounds. (3)
1968	International Conference of Human Rights in Tehran passes resolution recognizing family planning as a human right. (3)	USAID makes its first purchase of contraceptives for distribution in developing countries. (11)				The Papal Encyclical Humanae Vitae condemns all methods of artificial contraception. (3) World population passes 3.5 billion. (8)
1969	United Nations Fund for Population Activities (UNFPA) begins operations administered by UNDP. (15)					
1970	World Bank approves its first population loan for $2 million to support Jamaica's family planning program. (16)		By 1970, the Population Council had sponsored knowledge, attitudes, and practices (KAP) studies in Argentina, Brazil, Chile, Costa Rica, El Salvador, Ghana, Haiti, Jamaica, India, Indonesia, Lebanon, Mexico, Pakistan, Peru, South Korea, Sri Lanka, Taiwan, Thailand, Tunisia, Turkey, Uruguay, and Venezuela. (6) Population Services International (PSI) founded to demonstrate that social marketing of contraceptives in the private sector could succeed under differing circumstances and on different continents. (17)			
1971	WHO and UNICEF form Joint Committee on Alternative Approaches to Meeting Basic Health Needs of Populations in Developing Countries. (18)	USAID's Office of Population begins supporting reproductive health training and international surveys. (11)	IPPF's Middle East and North Africa Region convenes first international Muslim conference on family planning. 80 scholars and specialists from 23 countries endorse			Surgeons develop the fiber-optic endoscope for looking inside the human body. (3)

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1971	International Conference on Nutrition, National Development and Planning held at MIT, which gives impetus to food and nutrition planning. (19)		family planning. (3) Medecins Sans Frontiers (MSF) founded. (20)			
1972	UNFPA is placed under the UN General Assembly's direct authority and raised to the same status as UNDP and UNICEF. (15)	USAID launches the World Fertility Survey (WFS) to gather comparative data at the global level. (21)	IPPF launches Community-Based Distribution of Contraceptives Programme to increase the availability and lower the costs of contraceptives. (3) International Nutrition Planning Program created at MIT funded by the Rockefeller Foundation and USAID. (19)	Population Council launches maternal and child health care and family planning programs in rural areas of Indonesia, Nigeria, the Philippines, and Turkey with support from World Bank and UNFPA. (6)		
1973	Halfdan T. Mahler (Denmark) becomes WHO Director-General. (2)	USAID prohibits promoting or funding abortion under The Helms amendment to the 1961 Foreign Assistance Act. (11)				Famine strikes Ethiopia. (16) U.S. Supreme Court legalizes abortion. (3)
1974	WHO creates the Expanded Program on Immunization (EPI) to improve vaccine delivery by providing support and guidance. (22) WHO, FAO, UNDP and the World Bank implement the Onchocersiasis Control Program (OCP) which is endorsed by the seven governments of the West African countries most affected by the disease. (March) (16) WFP co-ordinates the first-ever multi-national airlift of food aid, drawing on the resources of 12 national air forces, to West Africa in response to a drought. (10)	USAID funds the Population Council's first operations research project, field-based research studies to experimentally test and evaluate innovative ways to deliver family planning and reproductive health services in developing countries. (6)	IPPF launches The Law and Planned Parenthood Project to work with Family Planning Associations to reform outmoded and restrictive laws, regulations and policies that act as barriers and bottlenecks to the provision of family planning services. (3)			World population passes 4 billion. (8)

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1974	The UN organizes The Third World Population Conference in Bucharest, Romania, which is attended by representatives from 135 countries. It focuses on the relationship between population issues and development. The main outcome of the conference is the World Population Plan of Action, which states that social, economic and cultural development of countries are its essential aim, that population variables and development are interdependent, and that population policies and objectives are an integral part of socio-economic development policies. (August) (9)					
1975	World Bank, WHO, UNICEF, and UNDP co-sponsor the Tropical Research Program to coordinate a global effort to combat diseases that affect the poor and disadvantaged through research and development, and training and strengthening. (23)	African Development Bank begins interventions in the health sector. (24)	Ford Foundation, Rockefeller Foundation and the International Development Research Centre of Canada launch the International Food Policy Research Institute (IFPRI). (25) IPPF and Unesco establish the International Audio-Visual Resource Service to promote the use of communication media within family planning programs. (3)			
1976	UNICEF Executive Board commits to a basic services approach and works with WHO on alternative approaches to health care. (26) World Bank makes its first loan in nutrition for $19 million to Brazil. (19)	The US Food and Drug Administration approves the Population Council's Copper T200 IUD, the first-ever New Drug Application sponsored by a nonprofit research organization. (6)	IPPF launches Planned Parenthood - Women's Development, a major program to integrate family planning education and services with other projects to improve the status of women. (3)			Ebola breaks out in Zaire (318 human). This was the first recognition of the disease. Another outbreak occurs in Sudan (284 human cases). (27)

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1977	The Sub-Committee on Nutrition is established as recommended by the UN's Administrative Committee on Coordination (ACC), comprised of the heads of the UN Agencies. Its mandate is to promote cooperation among UN agencies and other partners to eliminate malnutrition. (28)	USAID supports creation of Contraceptive Prevalence Surveys, a survey program more focused that the WFS, designed to quickly provide basic indicators on family planning and fertility. (21)	The Rockefeller Foundation creates an international network of biomedical research groups to study the "great neglected diseases" of the developing world, including sleeping sickness, leprosy, malaria, schistosomiasis, hookworm, river blindness, and childhood diarrhea. (29) Testing of the Trials of Improved Practices (TIPS) approach developed by the Manoff Group is tested in a World Bank Nutrition Communication Behavior Change (NCBC) project in Indonesia. (14)			
1978	At the International Conference on Primary Health Care (PHC) in Alma-Ata, the concept of Primary Health Care as a strategy to reach the goal of Health for All in 2000 is defined and granted international recognition. (30)	The Asian Development Bank begins lending and providing technical assistance in the health sector. (31)				The first outbreak of tuberculosis resistance to formerly effective drugs is reported in Mississippi. (32)
1980	UNFPA becomes full member of the Administrative Committee on Coordination (ACC), which brings together the executive heads of all UN organizations to coordinate the work of the UN system. (15)		The Rockefeller Foundation launches the International Clinical Epidemiology Network (INCLEN) to establish centers at 40 medical schools in 18 developing countries, to train physicians to conduct research on serious health problems in their countries. The objective of INCLEN is to develop more cost-effective health policies. (29) PSI begins to market oral rehydration salts. (17) The Population Council launches infant feeding practices studies in Colombia, Indonesia, Kenya, and Thailand. (6)		China announces its "One Child Family" policy. (3)	WHO announces eradication of smallpox. (16)

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1981	1981-1990 is declared as the International Drinking and Water Supply and Sanitation Decade. During this decade, an additional 1.2 billion people gained access to safe water and approximately 770 million gained access to adequate sanitation. (26)		Population Council begins operations research in Asia. (6)	IPPF, UNFPA and the Population Council hold the "Family Planning in the 80s" conference in Jakarta, Indonesia. It is the first world conference on the subject to be jointly sponsored by the three major organizations. (3)		World population passes 4.5 billion. (8) First reported case of gay-related immunodeficiency disease (GRID) in France. (16) Scientists identify Acquired Immune Deficiency Syndrome (AIDS). (16)
1982	UNICEF launches its Child Survival and Development Revolution (CSDR), introducing GOBI, the acronym for its four basic program components: growth monitoring, oral dehydration, breast-feeding and immunization. (26)		IPPF publishes a country-by country analysis of government policies on fertility and family planning which shows that 86 countries actively support the provision of family planning information and services. (3)			Latin American debt crisis begins when Mexico defaults on international debt. (1)
1984	The International Conference on Population expands the World Population Plan of Action. The human rights of individuals and families, conditions of health and well-being, employment and education are among key issues highlighted in the Declaration signed at the Conference. Other significant issues are the intensification of international cooperation and the pursuit of greater efficiency in adopting policy decisions relating to population. (9)	The "Mexico City policy" is announced by US President Reagan. It prohibits non- U.S., nongovernmental organizations receiving USAID family planning assistance funding (either directly or through sub-awards) from using their own or other non-USAID funds to provide or promote abortion as a family planning method (including support to IPPF). (11) USAID-sponsored WFS has conducted surveys of fertility, family planning, and infant and child mortality in more than 60 countries. USAID launches the Demographic and Health Survey (DHS) project. It combines the qualities of the WFS and the CPS and adds important questions on maternal and child health and nutrition. (21)	The Ford Foundation requests a review of its work in population. Three strategic areas for the future are outlined: (1) encouraging smaller families by controlling infant mortality and providing opportunities for women; (2) enhancing the effectiveness of family-planning programs; and (3) encouraging leaders to support efforts to reduce population growth. (5) Save the Children begins comprehensive child survival programs in Bangladesh, Ecuador, Indonesia, Zimbabwe and Bolivia. (33) The Population Council's Copper T 380A, now known as ParaGard, is approved by the US Food and Drug Administration (6) OXFAM launches the Hungry for Change campaign. (34)	The Rockefeller Foundation, UNDP, UNICEF, WHO and World Bank establish the Task Force for Child Survival and Development, a campaign to achieve the goal of universal child immunization by 1990. (27)		Famine becomes acute in Ethiopia leading to worldwide fundraising efforts. (1) American and French medical research teams independently discover HIV, the virus believed to cause AIDS. (16)

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1985	At a ceremony to commemorate the UN's fortieth anniversary, nations recommit to achieving targets for Universal Child Immunization (UCI) by 1990. (November) (27) WHO announces that AIDS has reached epidemic proportions. (3) PAHO launches an initiative to eradicate polio in the Americas by 1990. (35)		The Rockefeller Foundation undertakes a grants program to help African, Asian, and Latin American scientists collaborate on biomedical research relating to the use of contraceptives. (29) Rotary International establishes PolioPlus Program. (35)	IPPF and UNICEF reach an agreement to collaborate and develop activities linking family planning and child survival. (3)		
1986			The Carter Center begins to provide technical and financial assistance to national Guinea worm eradication programs. (36) IPPF establishes an AIDS Prevention Unit and develops guidelines for Family Planning Associations to promote information, education, and condom use. (3)			
1987	Several important events positioned AIDS as a high-priority on the international agenda. This includes: the establishment of the WHO-Global Program AIDS; debate on AIDS at the UN General Assembly; and the World Health Assembly's approval of a "Global Strategy for the Prevention and Control of AIDS." (37) The Bamako Initiative is promoted by UNICEF and WHO and adopted by African health ministers to Increase the availability of	The African Development Bank's first health sector policy guidelines prepared. It prioritizes: health service management and planning, health manpower planning, control of communicable diseases, procurement and distribution of essential drugs, health care delivery, and population and nutrition. It emphasizes the importance of providing training and technical assistance to administrators to improve planning and management capabilities of health programs. (24)	Rotary International launches a campaign to raise US $120 million to fight polio which provides the necessary impetus to begin the polio eradication initiative. (33) DKT International, a social marketing organization, is incorporated. (40)	IPPF, the Population Council, UNICEF), WHO, UNFPA sponsor an international conference on Better Health for Women and Children through Family Planning (6)		World population passes 5 billion. (8)

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1987	resources for essential drugs. The initiative proposes decentralization, national drug policies and provision of essential drugs. It also advocates a combination of financing depending on the country context, and stresses the need for community and individual participation in health planning. (38) The Safe Motherhood Inter-Agency Group sponsors the first international Safe Motherhood Conference in Nairobi, Kenya to draw attention to the dimensions and consequences of poor maternal health in developing countries and to mobilize action to address high rates of maternal death and illness. (39)					
1988	The World Health Assembly passes a resolution to eradicate polio by the year 2000. (35) The Global Polio Eradication Initiative is launched by the WHO, Rotary International, U.S. Centers for Disease Control and Prevention, and UNICEF. (35) Hiiroshi Nakajima (Japan) becomes WHO Director-General. (2)		IPPF sets target that 450 million couples will be able to use family planning by the year 2000. (3) PSI pioneers condom social marketing for HIV prevention in Zaire (now the Democratic Republic of Congo), along with a complementary mass media campaign that promoted abstinence, fidelity and correct and consistent condom use. (17) Freedom from Hunger launches its first Credit with Education program in West Africa. It combines microcredit loans to very poor women with vital health and business education. (41) The Rockefeller Foundation inaugurates a tropical disease research program in			The French Minister of Health orders the new abortion pill, RU-486, back on the market when manufacturers threaten to withdraw it. He calls it "the moral property of women". (3)

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1988			cooperation with the World Health Organization. (29) Carter Center forms The International Task Force for Disease Eradication to evaluate disease control and prevention and the potential for eradicating infectious diseases. (36)			
1989	UN General Assembly adopts the Convention on the Rights of the Child. (26)					The Berlin Wall falls and symbolizes the end of the Cold War. (November) (19) Polio outbreaks in China. (35)
1990	UNICEF presents an initiative to improve the *State of the World's Children* at the World Summit for Children. At the Summit, the intersectoral nature of effective nutrition strategies was highlighted and A Declaration on the Survival, Protection and Development of Children and Plan of Action establish specific quantitative nutrition goals to be achieved by 2000. (26) UNDP's first Human Development Report declares "human beings to be both the means and ends of development." (26)		Save the Children establishes its Women/Child Impact (WCI) as the uniting program framework for its international programs. WCI emphasizes that empowering women is key to improving the well-being of children (33) DKT International becomes active in social marketing projects in Ethiopia and the Philippines. (40)			Ornidyl, a new drug treatment for African sleeping sickness, is approved by WHO. (16) 80% childhood immunization worldwide is reached. (35) Germany is reunited. (19)
1991	International Meeting of Partners for Safe Motherhood in Washington, DC. (42) Rockefeller Foundation, UNDP, UNICEF, WHO, and the World Bank form the					The Soviet Union officially ceases to exist. (December) (19) The last indigenous case of polo occurs in the Americas in Northern Peru. (35)

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1991	Children's Vaccine Initiative (CVI) to protect the world's children against viral and bacterial diseases. CVI's goal is to vaccinate every child in the world against these common, preventable childhood illnesses. (29)					
1992	At the International Conference on Nutrition in Rome The World Declaration on Nutrition and Plan of Action for Nutrition, which serves as a guide to the technical issues of nutrition policy and programmed development, is announced. (December) (42)		The Rockefeller Foundation's Population Sciences program initiates a 10-year program that aims to make quality family planning and reproductive health available to every couple in the world who wants it. (29) Micronutrient Initiative established at the International Development Research Centre to initiate and sustain concerted international efforts to eliminate micronutrient malnutrition. (43) Population Council launches the Expanding Contraceptive Choice program (6)			The female condom becomes available. (3)
1993		US President Clinton rescinds the Mexico City policy. USAID and its cooperating agencies spearhead Maximizing Access and Quality (MAQ), an initiative to improve reproductive health service delivery and better serve clients. (11)	Save the Children launches a 10-year plan to link community-based approaches with national and global programs for children in need. (33) IPPF develops a poster, The Rights of Clients, to be displayed in clinics and inform clients of their rights to information, access, choice, safety, privacy, confidentiality, dignity, comfort, continuity and opinion. (3)			World population passes 5.5 billion. (8)

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1994	International Conference on Population and Development (ICPD) in Cairo. Its program of action which endorses reproductive health as a human right, advocates provision of a package of services to meet reproductive health needs, and draws a connection between reproductive health, rights and other development issues. (42) UNFPA named lead UN organization to follow-up and implement the ICPD's Program of Action. (44) WFP's governing body adopts a Mission Statement which declares its ultimate objective as eliminating the need for food aid. It recognizes that food aid is only one way to promote food security and that it should be used to support economic and social development. It prioritizes targeted interventions for the poorest and establishes that WFP will concentrate in its areas of comparative advantage on the aspects of development to which food aid interventions are the most useful. (December) (10)	USAID releases "Strategies for Sustainable Development" that formulates the Agency's comprehensive approach to fighting HIV/AIDS. The five priority areas are: (1) environmental protection; (2) democracy building; (3) stabilizing population growth and protecting human health; (4) promote broad-based economic growth; and (5) provide humanitarian assistance and aid post-conflict transitions. (March) (45) DANIDA declares population as one of three priority thematic areas in its strategy for development policy towards 2000. (46) The Asian Development Bank releases a population strategy to increase assistance to limit population growth and help countries to deal with the basic needs of growing populations. The strategy involves three main action areas: (1) improving opportunities for and the status of women; (2) protecting reproductive rights and health; and (3) ensuring equitable access to family planning. (31)	Bill and Melinda Gates consolidate their giving to address two main initiatives: Global Health and community needs in the Pacific Northwest. (47)		China launches its first National Immunization Days, immunizing 80 million children. (35)	Mexican financial crisis sends shockwaves throughout Latin America. (17) Americas are certified polio-free. (35)
1995	Fourth World Conference on Women (FWCW) in Beijing focuses on economic and social issues affecting women's participation in civil society, emphasizing links between the status of women and their population and reproductive health outcomes. (44)		IPPF launches The Charter on Sexual and Reproductive Rights, its Bill of Rights, which identifies 12 key areas based on recognized international human rights law with additional rights that IPPF believes are implied by them. (3)	The African Program for Onchocersiasis Control (APOC), a joint international partnership program of governments, non-governmental organizations, bilateral donors and international agencies, is launched at ceremonies in Washington. APOC was	India organizes its first National Immunization Days, immunizing 87 million children. (35)	

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1995	At the World Summit for Social Development (WSSD) in Copenhagen, leaders reach consensus on the importance of positioning people as central in development. UNDP, UNESCO, UNFPA, UNICEF and WHO back the 20/20 initiative to generate resources to ensure access to basic social services for all by the end of the century. (March) (26) UN Administrative Committee on Coordination establishes the Task Force on Basic Social Services for All (BSSA) to coordinate a UN system response to the recommendations from recent conferences. (October) (42)		With Rockefeller Foundation funding, the Population Council establishes the African Population and Health Research Center. (6) PSI launches maternal and child health products, and insecticide-treated mosquito nets for malaria prevention. (17)	modeled on the original highly-successful Onchocersiasis Control Program which was started in 1974. APOC began work in sixteen African countries, using a drug treatment donated by Merck & Co. (December) (16)		Ebola outbreak in Democratic Republic of Congo (315 human cases). (27)
1996	World Food Summit in Rome emphasizes the need to focus policies in five intersectoral areas in order to address malnutrition and implement effective policies. The Rome Declaration on World Food Security is adopted which declares access to food as a basic right and sets the target of reducing the number of the world's undernourished in half by 2015. (42) Six co-sponsors (UNDP, UNESCO, UNFPA, UNICEF, World Bank and WHO) establish the Joint UN Program on HIV/AIDS (UNAIDS) (37)	African Development Bank releases a revised health sector strategy to better address challenges, including HIV/AIDS, and emphasize the importance of institution strengthening. (24) The Board of Executive Directors at the Inter-American Development Bank approves a strategy to support health reform to improve the efficiency of health institutions in Latin America and the Caribbean. (50)	The Rockefeller Foundation convenes experts in HIV/AIDS to explore the feasibility of bringing together industry, philanthropy, development and health agencies to collaborate in finding an AIDS vaccine that would be affordable and available throughout the world. (29) IPPF and the BBC pioneer an educational broadcasting project, The Sexwise radio series and books, produced and written in 11 languages, reach over 60 million listeners in Africa, the Arab world, Latin America, South East Asia and China. (3)	The International AIDS Vaccine Initiative (IAVI) is founded to ensure the development HIV vaccines for use throughout the world. It is a global not-for-profit, public-private partnership that researches and develops vaccine candidates, conducts policy analyses, and serves as an advocate for the field. (52) The Rockefeller Foundation and the Sweden International Development Cooperation Agency (SIDA) establish the Global Health Equity Initiative to support research, raise awareness and build capacity to address health inequalities. (29)	Nelson Mandela officially launches the Kick Polio Out of Africa campaign. (35) In response to ICPD Cairo, the Indian government introduces a target-free approach to family planning. (12)	Results from clinical trials show the effectiveness of triple-antiretroviral therapy for AIDS. (16)

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1996	United Nations Special Initiative for Africa is launched by UN Secretary General Boutros Boutros-Ghali, the heads of several UN agencies, and President Wolfensohn. The new initiative defines an expanded program of assistance to Sub-Saharan Africa and a partnership that aims to reduce the fragmentation of development efforts among donors. (March) (48) WHO and UNICEF present Integrated Management of Childhood Illness (IMCI) as a strategy to improve child health emphasizing prevention and health promotion. (49)	The Danish Ministry of Foreign Affairs and World Bank co-host a meeting for donor agencies in Copenhagen to discuss sector-wide approaches. At the meeting the term SWAp is coined, a SWAp guide is commissioned, and an Inter-Agency Group on SWAp is formed. (51)				
1997	The UN Economic Commission for Africa collaborates with UNICEF and the World Bank to organize a conference on cost sharing in Addis Ababa. At the Forum on Cost Sharing in the Social Sectors of Sub-Saharan Africa, 15 principles for cost sharing in health and education are agreed upon at the conference. (June) (53) UNFPA begins to develop Common Country Assessments to pinpoint critical concerns and challenges facing individual countries. (15)	DHS is folded into USAID's multi-project MEASURE program as MEASURE *DHS+*, which incorporates traditional DHS features, expands the content on maternal and child health and adds biomarker testing to numerous surveys. (21) CIDA's *Strategy for Health* sets top priorities as supporting sustainable national health systems, and improving women's health and reproductive health. (56)	IPPF, representing the Inter Agency Group for Safe Motherhood, hosts the Technical Consultation on Safe Motherhood in Sri Lanka. At the Consultation a two-year campaign to revitalize it and garner support from sectors outside the health community is launched. (3) Global Forum on Health Research launched to direct more funds for health research on issues affecting people in developing countries. (58)			The East Asian economic crisis begins. (July) (37) *El Nino* effect produces extreme weather conditions. (16) Over 30 million people worldwide are living with HIV or AIDS. (3)

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1998	WHO establishes the Tobacco Free Initiative (TFI) to reduce the tobacco-caused global burden of disease. (July) (54) Safe Motherhood Inter-Agency Group meeting in Washington declares a world-wide call to action for maternal health. (April) (20) World Bank, WHO, UNDP and UNICEF launch Roll Back Malaria (RBM) Partnership to provide a coordinated global approach to halve malaria by 2010. (55) UNFPA and IPPF launch the Face to Face Campaign, a three-year campaign to build support for increased domestic and international funding for services that will allow women around the world to exercise their basic human rights including, and in particular, their reproductive rights. (3) Gro Harlem Bruntdland (Denmark) becomes WHO Director-General. (2)	The French Development Agency becomes involved in the health sector, focusing primarily on HIV/AIDS and contagious diseases. (57) Save the Children is named lead agency of PVO/NGO Networks for Health Project, a five year $51 million USAID-funded international partnership supporting comprehensive health programs for women and children. (33)	UN Foundation created and announces that its grants will focus mainly on children's health, women and population, and the environment. (59)	World Bank partners with WHO and Smith Kline Beecham to initiate the Cooperative Program to Eliminate Elephantiasis by distributing drugs free of charge to governments and collaborating organizations. (January) (20)		Hurricane Mitch devastates the Caribbean Coast. (20) In Russia, the ruble is devalued and international loans go unpaid; it is the most difficult economic year since the collapse of the Soviet Union. (16) Asian currencies and stock markets continue to plunge, creating an economic crisis for the continent. (16)
1999	A special session of the UN General Assembly, the ICPD+5, is convened to assess the progress achieved and challenges encountered in implementing strategies on population and development since the Program of Action was adopted at the 1994 ICPD. (June - July) (9)	Asian Development Bank releases a health strategy. Its overall approach is to assist countries to ensure that citizens have broad access to basic preventive, promotive, and curative services that are cost-effective, efficacious, and affordable. The strategy argued that increased access to basic services would have	MSF launches campaign for access to essential medicines. (20) UNF announces $51million investment in UN programs focusing on children's health. (59)	Medicines for Malaria Venture (MMV), a public-private non-profit partnership, is launched. It aims to bring together the public, private and philanthropic sectors to fund and manage the discovery, development and registration of new medicines to treat and prevent malaria. (November) (61)		WTO protests in Seattle. (17) World population passes 6 billion. (8) Japan approves the oral contraceptive pill after almost 4 decades. (3)

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1999	The International Benchmarking Network for Water and Sanitation Utilities (IBNET) is initiated by the World Bank (in the late 90s). It is the world's largest database for water and sanitation utilities performance data which allows tracking of infrastructure improvements, and measures the efficiency of service delivery for water supply and sanitation. (60)	significant impact on morbidity and mortality in the short to medium term and provide the foundation for more comprehensive health services in the long term. (31)	Bill and Melinda Gates Foundation donates $8.8 million to IPPF for a global program to improve the quality of care in sexual and reproductive health services. (3)	The Public-Private Infrastructure Advisory Facility (PPIAF) is established to help developing countries improve the quality of their infrastructure, including water and sanitation, through private sector involvement. (July) (62) The Global Alliance for Vaccines and Immunization (GAVI), a public-private partnership, is established to ensure financing to save children's lives and people's health through widespread vaccinations. (1)	At the African Summit on Roll Back Malaria in Abuja, Nigeria, African leaders from 44 malaria-endemic countries sign the Abuja Declaration. The Declaration is commitment to intensify efforts to halve the burden of malaria by 2010. (April) (16)	
2000	WHO Director General establishes the Commission on Macroeconomics and Health to assess the place of health in global economic development. (January) (63) The international community agrees upon eight Millennium Development Goals, each with a number of targets and indicators, to be achieved by 2015. These goals represent a global agreement to address inequality. The goals are identical to the International Development Goals, except that the reproductive health goal was not included in the MDGs. (September) (1) WHO reports blood supplies in two-thirds of the world may be tainted, thereby contributing to the spread of AIDS, hepatitis, and other diseases. (16)	G-8 meets in Japan and pledges to end extreme poverty and the spread of infectious diseases, such as AIDS and malaria. Debt relief initiative gains momentum among wealthy nations. (16) The UK and Netherlands donate an additional US$ 90 million to Global Polio Eradication Initiative. DFID provided US$ 50 million for operational costs, surveillance, OPV and personnel, and the Netherlands contributed US$ 50 million for surveillance. (37)	Bill and Melinda Gates Foundation donates $750 million to GAVI for the support of research and delivery of vaccines. (65) UNF awards $21million to UN programs that focus on improving the lives of adolescent girls. (59) The first trial of Community-based Therapeutic Care (CTC) is carried out in Ethiopia. Developed by Valid International, the model is an alternative to the traditional therapeutic center model which has been ineffective for dealing with malnutrition in large-scale humanitarian crises. (66)	The GAVI vaccination campaign, The Children's Challenge, is officially launched at the World Economic Forum. (January) (65) The Amsterdam Declaration to Stop TB calls for accelerated action from ministerial delegations of 20 countries with highest burden of TB. (March) (67) GAVI begins its first round of global vaccine deliveries, sending approximately 650,000 doses of vaccines against diphtheria, tetanus, whooping cough and hepatitis B to Mozambique. (April) (17)		Jubilee 2000, an organization lobbying for international debt relief, holds a protest march in Washington, DC, timed to coincide with the World Bank's Spring Meetings. (17) Mozambique, Bangladesh and India hit by some of the worst flooding in 100 years. (17) Ebola outbreak in Uganda (425 human cases in 2000-20001). (27)

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2000		DFID releases *Better Health for Poor People,* a strategy paper that establishes meeting health targets as a central objective to be achieved through effective partnerships and bilataral programs based upon country-context. (64)				
2001	Commission on Macroeconomics and Health presents *Macroeconomics and Health: Investing in Health for Economic Development* to the Director-General of WHO. It calls for an increase in development assistance for health and for the World Bank to move support from credits to grants. (December) (68)	Denmark launches a Plan of Action for international assistance to fight HIV/AIDS. The plan was based on "Partnership 2000", a strategy which identified the fight against HIV/AIDS as one of four priority areas for Danish development assistance. (69) US President G.W. Bush reinstates the Mexico City policy. The policy does not restrict organizations from providing post-abortion care or from treating injuries or illnesses caused by legal or illegal abortions. (11) The World Bank and USAID co-host the Annual Meetings of the *Global Partnership to Eliminate Riverblindness* in Washington. The partners pledged to eliminate riverblindness in Africa by 2010. (December) (16) DFID releases its first formal HIV/AIDS strategy, which is designed to inform divisional and country-level plans. (70)	OXFAM launches Cut the Cost Campaign which aims to increase the availability of affordable medicines for the poor. (34) UNF establishes a special account for the Global AIDS and Health Fund to accept donations from individuals, corporations, and others who want to contribute to the fight against HIV/AIDS. (59) The Bill and Melinda Gates Foundation pledges $20 million to accelerate the elimination of Lymphatic filariasis (LF), also know as Elephantiasis. The grant will be channeled through a World Bank Trust Fund. (February) (16)	GAVI sends approximately 650,000 doses of vaccines against diphtheria, tetanus, whooping cough and hepatitis Mozambique. (April) (16) The Global Fund to Fight HIV/AIDS, TB, and Malaria, a financing mechanism, is established to foster partnerships between governments, civil society, the private sector, and affected communities to increase resources and direct financing towards efforts to eradicate HIV/AIDS, TB, and malaria. (71) Partners gather in Washington, DC to further commit to operationalize the Amsterdam Declaration. The Global Plan to Stop TB is launched, calling for the expansion of access to DOTS and increased financial backing for the program from governments throughout the world. (October) (67) The Measles Initiative is formed by the American Red Cross, UNF, UNICEF, WHO, CDC and the International Federation of Red Cross and Red Crescent Societies. It works with countries implement high quality, one-time-only catch-up measles vaccination campaigns. (72)		Western Pacific region certified polio-free. (35)

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2002	The World Summit on Sustainable Development is held in Johannesburg. A plan of implementation approved at the summit included specific goals to recommit reduce poverty and hunger, and improve access and effective use of water supply and sanitation services, among others. (September) (73) International Conference on Financing Development in Monterrey focuses on ways to finance attainment of MDGs and heads of state adopt the "Monterrey Consensus." (1) UN Secretary General, Kofi Annan, commissions The Millennium Project. A private advisory body headed by Professor Jeffrey Sachs, it aims to recommend a concrete action plan for the world to meet the Millennium Development Goals. (74)	Donations from Canada, Japan, the Netherlands, the United Kingdom and the United States close The Global Polio Eradication Initiative's 2002-2005 funding gap. (35) DFID passes the International Development Act which establishes poverty elimination as the overarching purpose of its work. (75)	Ford Foundation expands its work in sexual and reproductive health, launching a new global initiative on human sexuality. Its goal is to support the emergence of regional resource centers that develop knowledge about sexuality, translate knowledge into practice and foster public understanding. (5) A $20 million grant from the Bill and Melinda Gates Foundation supports continued lab work and clinical trials of the Population Council's lead candidate microbicide, Carraguard. (6) Rotary International launches second fundraising campaign to eradicate polio. (35)	The Global Public-Private Partnership for Handwashing with Soap is formed by the London School of Hygiene and Tropical Medicine, the Academy for Educational Development, USAID, UNICEF, the World Bank-Netherlands Water Partnership, and the private sector. (73) Global Alliance for Improved Nutrition (GAIN) created at a special UN session for children. Established by a Swiss foundation, its main sources of funding are the Gates Foundation, USAID and CIDA (Canada). The World Bank is a key partner. (76) The International Partnership for Microbicides is formed to accelerate the development and availability of safe and effective microbicides for women in developing countries. It is a non-profit, product development partnership. (77)		European region certified polio free. (35) Polio outbreak in India. (35)
2003	Leaders of multilateral development banks, international and bilateral organizations, and donor and recipient country representatives gathered in Rome for the High-Level Forum on Harmonization. They committed to the Rome Declaration on Harmonization, establishing a program of activities to improve the management and effectiveness of aid. (February) (78)	New guidelines update USAID's 1999 Programmatic Technical Guidance on integrating family planning and maternal/child health with services for preventing HIV/AIDS and other sexually transmitted diseases. The guidelines include new information about effective integration of family planning into HIV programs and HIV counseling and services into family planning programs. (11)	Clinton Foundation secures price reductions for HIV/AIDS drugs from generic manufacturers to benefit developing countries. (71)	Bank, Gates Foundation, Rotary International, and UNF launch the Investment Partnership for Polio to eradicate polio by 2005. The Partnership will provide funding to convert an IDA credit into a grant once participating governments have achieved project objectives. (April) (16)		Severe acute respiratory syndrome (SARS) recognized after epidemic begins November 2002 in China and lasts through July 2003. (February) (80)

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2003	At the MDG meeting in Ottawa, a Framework for Action to Accelerate Progress on HNP MDGs is endorsed. (May) (76) WHO and UNAIDS launch the "3 by 5" initiative. The initiative sets a global target to provide 3 million people living with HIV/AIDS in developing countries with ART by the end of 2005. (December) (79) UNFPA launches the Campaign to End Fistula, working in more than 35 countries to prevent and treat fistula, and to help rehabilitate and empower women after treatment. (15) World Health Assembly endorses Framework Convention on Tobacco Control. The international treaty developed by the WHO includes provisions to implement comprehensive bans on tobacco advertising, and enforce labeling regulations. (1) Lee Jong-wook (South Korea) becomes WHO Director-General. (2)	USAID's new MEASURE DHS project expands data collection efforts and access to and use of demographic and health data on developing countries. (21) Inter-American Development Bank's Board approves a Social Development Strategy. It aims to link reforms to health objectives; prioritize public health issues and the efficiency, equity and quality of community services; encourage decentralization when possible; correct deficiencies in resources and supplies; and balance prevention and disease control. (50)	Population Council and Acrux sign a joint agreement with to develop a women's spray-on contraceptive. (6)			Global measles deaths drop to an estimated 530,000 from 873,000 in 1999. (56)
2004	Key donors recommit to strengthening country efforts to lead national AIDS responses and endorse the "Three Ones" principle. This is: one framework for coordination, one National AIDS Coordinating Authority, and one country-level monitoring and evaluation system. (April) (81)	US Congress appropriates resources to support the President's Emergency Plan for AIDS Relief (PEPFAR). A five-year, $15 billion commitment to fight HIV/AIDS with a multifaceted approach in fifteen countries. (82) DFID launches UK's new strategy to fight HIV/AIDS which outlines its plan to work with developing countries, other donors and multilateral		Donors fund over $3 million to eradicate river blindness at a River blindness Conference in Africa. (June) (20)		Reports of human cases of avian flu A (HN51) from Vietnam, Thailand, Cambodia, China, Indonesia, Turkey, Iraq, Azerbaijan, Egypt, and Djibouti. (January) (84)

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2004	WHO and the Bank co-sponsor the 1st High-Level Forum on the Health MDGs. Heads of development agencies, bilateral agencies, global health initiatives, and health and finance ministers agree on 4 action areas: 1) resources for health and poverty reduction papers; 2) aid effectiveness and harmonization; 3) human resources; 4) monitoring performance. (January) (16)	organizations to coordinate international efforts, close the funding gap and improve health, education and human rights for the poorest and most vulnerable. An HIV/AIDS treatment and care policy, new sexual and reproductive health and rights position paper, and policy and plans to increase access to essential medicines in developing countries are also launched in conjunction. (70) The Inter-American Development Bank releases its first health strategy. Its two primary objectives are: (1) to improve the health of the population and attain health objectives through improved public policy to reduce risk and improve health systems; and (2) to reduce inequities in health status by improving access for the poor and socially excluded. (50)	Population Council and Schering AG partner to create the International Contraceptive Access Foundation. (6)	At the Second Stop TB's Partner Forum in New Delhi, partners reaffirm their commitments to meeting the 2005 targets and develop a global plan to guide efforts to meet MDG targets for TB by 2015. (March) (67) Health Metrics Network launched. It is a global partnership of countries, development agencies, foundations, and global health initiatives that aims to improve the quality, availability and dissemination of data for decision-making in health. (June) (83)	World leaders present The World Leaders Statement to the UN-Deputy Secretary General which reaffirms the commitments of all of the 179 original governments to 1994 ICPD Plan of Action. (October) (59)	A massive earthquake near the Indian Ocean causes tsunamis which devastate large parts of India, Sri Lanka, Indonesia, Thailand and other Indian Ocean states. There are nearly 140,000 casualties in dozens of Asian and African nations, and millions are left homeless. (16) Results from seven years of country-based evaluations of the IMCI strategy indicate some of approaches the basic expectations were not met. Several lessons for child survival strategies emerged related to the need for targeting, providing adequate guidelines, training and supervision, and public accountability for coverage. (85)
2005	The Millennium Development Project presents its final report, *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals,* to the Secretary-General. The Millennium Project is asked to continue operating in an advisory capacity through the end of 2006. (January) (74) International Health Regulations (IHR 2005) are revised and adopted by the World Health Assembly. It is an international legal instrument to prevent, protect against, control and provide a public health response to the international spread of disease. (86)	At the Gleneagles Summit, G-8 nations pledge to increase aid for developing countries by $50 billion a year by 2010, of which at least $25 billion more per year is promised to Africa. (July) (87) Swedish government declares HIV/AIDS as one of top four priority areas for its budget bill in 2005; SIDA declares HIV/AIDS as one of its three Strategic Priorities for 2005-2007. (88)	The Clinton Foundation launches the Clinton Global Initiative and establishes Global Health as one of four focus areas. (89)			Devastating earthquake in India and Pakistan kills over 25,000. (92)

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2005	Adopting the Paris Declaration on Aid Effectiveness, development institutions establish goals and measurable targets designed to improve the ownership, harmonization, alignment, and mutual accountability of aid effectiveness. (March) (87)	Denmark releases new strategy for 2005-08 which recommits to fighting HIV/AIDS with a particular focus on Sub-Saharan Africa. (69)	Bill and Melinda Gates Foundation donate $750 million to GAVI to support childhood vaccinations globally over 10 years. (90)	Global Task Team (GTT) on improving AIDS Coordination among International Donors and Multilateral Institutions is formed to accelerate progress to achieve the "Three Ones". It developed recommendations to streamline, simplify and harmonize donor procedures and practices, to reduce the burden on countries, and improve the effectiveness of country-led responses. It also reached agreements on improved coordination between the Global Fund and the World Bank, and the division of labor among the UNAIDS co-sponsors. (March) (91)		
2006	International Pledging Conference on Avian and Human Influenza is held in Beijing to assess financing needs at country, regional and global levels. The international community pledges US$1.9 billion in financial support and discusses coordination mechanisms at this conference. (January) (93) Geneva Global Partners Conference on Avian and Human Pandemic Influenza sets key areas for action to respond to the Avian and Human Pandemic Influenza and makes an urgent call for financing. (November) (94) WHO publishes new international Child Growth Standards which demonstrate that growth to age five is influenced primarily by nutrition, feeding practices, environment, and health care. (95)	The International Drug Purchase Facility, UNITAID, is established by Brazil, Chile, France, Norway, and the UK to guarantee a reliable and sustainable supply of drugs and diagnostics for most common diseases. (September) (95) DFID establishes an inter-ministerial group on health capacity in developing countries. (96) DFID provides support (2006-2009) to the Tropical Health Education Trust fund to support partnerships to develop their potential in strengthening health systems, brokering new partnerships and promoting good practices. (96) Building Partnership for Development (BPD) in Water and Sanitation is established as an international cross-sector learning network to	The Bill and Melinda Gates Foundation reorganizes into three programs—Global Development, Global Health, and United States—and a core-operations group. (47) U.S. investor Warren Buffett pledges to give 10 million Berkshire Hathaway class B shares to the Bill and Melinda Gates Foundation. (47) Ford Foundation announces $45 million initiative for HIV/AIDS to ensure that global investments in medicine and technology are matched by a focus on the social, political and cultural factors of the disease. (5)	The International Finance Facility for Immunization Company (IFFim), established to accelerate the availability of funds to be used by GAVI in the world's 70 poorest countries, announces its inaugural bond. (July) (100)		World population estimated to be 6.5 billion. (8) Global measles deaths fall by 60% from 1999. (59)

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2006	Anders Nordstrom (Sweden) becomes WHO Director-General. (2)	improve access to safe water and effective sanitation in poor communities. DFID, the Dutch Ministry of Foreign Affairs, the French Development Agency are among primary donors along with private companies. (97) DFID and the World Bank establish the Global Partnership on Output-Based Aid (OBA), a multi-donor trust fund. It aims to fund, design, demonstrate and document OBA approaches to improve the sustainable delivery of basic services where, especially where policy concerns would justify public funding to complement or replace user-fees. The IFC, the Netherlands Government, and Australian Government Overseas Aid Agency (AusAID) join in the first year. (99)				
2007	Scaling Up for Better Health initiative launched to accelerate progress towards the health MDGs. This initiative was the result of the conclusions drawn by the High-Level Forum for the Health MDGs. (99) Margaret Chan (Hong Kong) becomes WHO Director-General. (2) Multilateral and inter-governmental organizations establish the Africa MDG Steering Group. It will coordinate and redouble efforts to support the MDGs, focusing on implementation to accelerate existing commitments to reaching the goals across Africa. (101)	Prime Minister of Norway launches the Global Campaign for the Health Millennium Development Goals, which encompasses several interrelated activities working to reach the health MDGs. The Campaign focuses on child and maternal health, MDGs 4 and 5. (September) (102) British government pledges 100 million pounds to UNFPA to achieve universal access for reproductive health at Women Deliver conference in London. (103)		High-level Meeting of second replenishment conference of GFATM donors together in Berlin where they commit $9.7 billion to GFATM. (September) (104)	Burundi, Cambodia, Ethiopia, Kenya, Mozambique, Nepal and are the first countries to join the new International Health Partnership. The International Health Partnership is composed of developing and donor countries along with major health agencies and foundations. Its objectives are to improve the way that international agencies, donors and poor countries work together to develop and implement health plans, creating and improving health services for poor people and ultimately saving more lives. (106)	The revised International Health Regulations, adopted in 2005 by the World Health Assembly, enter into force on 15 June. (107)

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