Executive Summary

The global aid architecture in health has changed over the past decade, with the adoption of the Millennium Development Goals (MDGs) and a major expansion of the levels and sources of development assistance, particularly for low-income countries. While key health outcomes such as infant survival and nutritional stunting have improved over the decade in every developing region, nearly three-quarters of developing countries are either off track or seriously off track for achieving the MDG for reducing under-five mortality. Maternal mortality is declining at only 1 percent each year, a fifth of the rate needed to achieve the goal.

There are important differences in progress across countries, within regions, and within countries, with high levels of maternal mortality and malnutrition in Africa and South Asia. Enormous challenges remain in reducing morbidity and mortality from infectious disease, the high and rising share of noncommunicable disease, pervasive malnutrition, and high fertility, with its consequences for maternal mortality, maternal and child health, and poverty.

The World Bank Group's support for health, nutrition, and population (HNP) has been sustained since 1997—totaling $17 billion in country-level support by the World Bank and $873 million in private health and pharmaceutical investments by the International Finance Corporation (IFC). Beyond country-level support, the World Bank Group participates in nearly three dozen international partnerships in HNP, with indirect benefits to countries. This report evaluates the efficacy of the Bank Group's direct support for HNP to developing countries since 1997 and draws lessons to help improve the effectiveness of this support in the context of the new aid architecture.

Though the Bank Group now funds a smaller share of global HNP support than it did a decade ago, it still has substantial ability to add value if it can do a better job of helping countries deliver results, especially for the poor. World Bank support to countries in the form of lending, analytic work, and policy dialogue has helped build government capacity to manage the sector—critically important to improving aid effectiveness, given the increasing reliance of other donors on government systems.

About two-thirds of the World Bank's HNP lending has had satisfactory outcomes, often in difficult environments, but a third has not performed well. Contributing factors have been the increasing complexity of HNP operations, particularly in Africa but also in health-reform support to middle-income countries; inadequate risk assessment and mitigation; and weak monitoring and evaluation.

The performance of IFC's health investments has improved markedly from a weak start, but there remain important gaps in investing in activities that both make business sense and are likely to yield broader benefits for the poor. Accountability for results in these projects has been weak—the accountability of Bank and IFC-financed projects to ensure that results actually reach the poor,

and the accountability of projects in the Bank's non-health sectors, such as water supply and sanitation and transport, for demonstrating their health benefits.

For the Bank Group to achieve its objectives of improving health sector performance and HNP outcomes among the poor, it needs to act in five areas: intensify efforts to improve the performance of the portfolio; renew the commitment to delivering results for the poor, including greater attention to reducing high fertility and malnutrition; build its own capacity to help countries to make health systems more efficient; enhance the contribution of other sectors to HNP outcomes; and boost evaluation to implement the results agenda and improve governance. By doing this, the Bank Group will contribute not only to meeting the MDGs but also to ensuring that the poor benefit, and that those benefits are sustained.

Since the late 1990s, when the World Bank Group was the largest source of HNP finance to developing countries, new aid donors and institutions have emerged, and development assistance for HNP has more than doubled, from an annual average of $6.7 billion in 1997/98 to about $16 billion in 2006. The international community has adopted global development targets, the most prominent of which are the MDGs, with a new emphasis on aid effectiveness, results orientation, donor harmonization, alignment, and country leadership, reflected in the 2005 *Paris Declaration on Aid Effectiveness* and the 2008 *Accra Agenda for Action*.

The World Bank Group, now one of many large players in international HNP support, accounts for only about 6 percent of the total—down from 18 percent in the 1990s—and is reassessing its comparative advantage in the context of the new aid architecture. At the same time, a call for greater engagement with the private health sector in developing countries presents new opportunities for IFC to extend its support.

The decline in its relative contribution aside, the World Bank Group commitment to HNP is still substantial. Since 1997, the World Bank (International Bank for Reconstruction and Development and the International Development Association) has committed nearly $17 billion to 605 HNP projects in more than 120 countries, sponsored analytic work, and offered policy advice. This support aimed to improve health and nutrition status and reduce high fertility; improve the access, quality, efficiency, and equity of the health system; reform health systems through changes in health finance, support for health insurance, decentralization, engaging the private sector, and other structural changes; and strengthen institutional capacity and sector management. In addition, the Bank has greatly expanded its participation in global partnerships for health; as of 2007, it was participating financially in 19 global partnerships and engaged in others ways in 15 more.

IFC has financed 68 private investment projects in the health and pharmaceutical sectors of developing countries—amounting to $873 million in total commitments—and offered advisory services on health to the private sector, including support for public-private partnerships.

The World Bank's 2007 strategy, *Healthy Development: The World Bank Strategy for Health, Nutrition, and Population Results,* aims, among other things, to improve HNP outcomes on average and among the poor; prevent poverty due to illness; improve health system performance; and enhance governance, accountability, and transparency in the sector. It points to several strategic directions or actions for the Bank to achieve the objectives, including:

- A renewed focus on HNP *results*
- Efforts to help countries *improve the performance of health systems* and to ensure *synergy with priority disease interventions*, particularly in low-income countries
- Strengthened Bank capacity to advise countries on *intersectoral approaches* to improving HNP results.

The 2002 IFC health strategy defines the sector's goals as improving health outcomes, protecting the population from the impoverishing effects of ill health, and enhancing the performance of

health services. The strategy has both business and developmental objectives, among them promoting efficiency and innovation in the health sector. It also calls broadly for increasing the social impact of IFC investments.

The Scope of the Evaluation

This evaluation aims to inform the implementation of the most recent World Bank and IFC HNP strategies to enhance the effectiveness of future support. It covers the period since fiscal year 1997 and is based on desk reviews of the portfolio, background studies, and field visits. The evaluation of the HNP support of the World Bank focuses on the effectiveness of policy dialogue, analytic work, and lending *at the country level,* while that of IFC focuses on the performance of health investments and advisory services before and after its 2002 health strategy. The themes it covers are drawn from the two strategies and the approaches adopted by international donors in the past decade. IEG has previously evaluated several aspects of the Bank's HNP support. IFC's support for the health sector has never been fully evaluated.

Bank Support to the Public Sector for HNP

Over the past decade, the World Bank directly supported HNP outcomes in countries through lending and nonlending services. The largest source of lending was from projects managed within the Bank's HNP sector units ($11.5 billion, 255 projects). Almost all HNP-managed projects were investment lending. Beyond this, about $5 billion in lending for HNP outcomes was managed by other sectors. In nonlending services, since fiscal 2000 the Bank has spent $43 million of its own budget and trust funds on HNP-related economic and sector work (ESW). The number of professional HNP staff grew by a quarter, as did the share of health specialists among HNP staff.

The World Bank's Role

Although the World Bank finances a smaller share of country-level development assistance under the new international aid architecture, it still has significant potential to add value. But the value of that support is context-specific and depends on the Bank's ability to help countries deliver results. The World Bank brings important institutional assets to bear in helping countries make health systems work better and ensuring that health benefits reach the poor: long-term, sustained engagement in the sector; international experience; a history of support for building country capacity to implement programs; large-scale, sustained financing; strong links to finance ministries; and engagement with many sectors other than health with potential to contribute to HNP outcomes. The Bank's comparative advantage in a country is context-specific, depending on health conditions, government priorities and resources, and the activities of other development partners. To deliver on its comparative advantages, the Bank needs to improve the performance of its country-level support.

The Evolution and Performance of World Bank Support

While the overall level of HNP project approvals changed little, the composition of the lending portfolio saw some major shifts. The number of HNP-managed projects approved annually rose slowly, but new commitments declined. The share of communicable disease projects doubled over the decade, reaching about 40 percent of approvals in the second half of the period, as did the share of multisectoral projects, reaching half of all approvals. The share of Africa Region projects in the HNP lending portfolio also increased. These three trends were due primarily to an increase in multisectoral projects addressing acquired immune deficiency syndrome (AIDS). Projects supporting sectorwide approaches (SWAps) in health rose to a cumulative total of 28 operations in 22 countries, about 13 percent of the project portfolio. In contrast, the share of lending with objectives to reform the health system dropped by nearly half.

Attention to population and malnutrition was low, and support for population nearly disappeared. About 1 in 10 projects had an objective to reduce malnutrition, which disproportionately affects the poor, but the share of projects with nutrition objectives dropped by half over the decade. About two-thirds of nutrition projects

were in countries with high levels of child stunting, but Bank nutrition support reached only about a quarter of all developing countries with high stunting. Lending to reduce high fertility or improve access to family planning accounted for only 4 percent of the lending portfolio, dropping by two-thirds between the first and second half of the decade, at a time when the need for such support remained high. Population support was directed to only about a quarter of the 35 countries the Bank identified as having the highest fertility (with rates of more than five children per woman). Analytic work and staffing to support population and family planning objectives nearly disappeared. Substantial analysis of population and nutrition issues rarely figured in poverty assessments, even though both issues are most acutely felt by the poor.

Two-thirds of HNP projects have had satisfactory outcomes, and the portfolio's performance has stalled. The evaluation highlights examples of good performance based on field assessments. Support for reducing malaria in Eritrea and schistosomiasis in the Arab Republic of Egypt, raising contraceptive use in pilot areas of Malawi, and reforming the health system in the Kyrgyz Republic, for example, showed good results. However, roughly a third of the HNP lending portfolio did not perform well, a share that has remained steady, while performance in other sectors has improved. The performance of HNP support in Africa was particularly weak, with only one in four projects achieving satisfactory outcomes. Complex projects—multisectoral projects and SWAps—in low-capacity environments were least likely to achieve their HNP objectives. However, health reform projects in middle-income countries also performed less well and are complex and politically volatile.

Poor-performing projects displayed common characteristics: inadequate risk analysis or technical design, inadequate supervision, insufficient political or institutional analysis, lack of baseline data on which to set realistic targets, overly complex designs in relation to local capacity, and negligible monitoring and evaluation. These problems are similar to those cited in IEG's 1999 evaluation of the HNP sector. The results of the recent Detailed Implementation Review of HNP projects in India suggest that, even among projects that achieve their objectives, field supervision needs to be intensified to ensure that civil works and equipment are delivered as specified, in working order, and functioning.

Accountability of projects for delivering health results to the poor has been weak. Improving health outcomes among the poor is among the foremost objectives of the 2007 HNP strategy. Studies of the incidence of public expenditure have shown that in most countries, public health spending favors the non-poor; mere expansion of services cannot be assumed to improve access of the poor relative to the non-poor. While many projects targeted HNP support to geographic areas with a high incidence of poverty (including rural areas) or financed services or addressed problems thought to disproportionately affect the poor, only 6 percent of all HNP projects committed to deliver better health or nutrition among the poor in their statement of objectives, for which they were ultimately accountable. A third of projects with objectives to improve general health status (such as maternal and child health) had no targeting mechanism for reaching the poor. Among closed projects with objectives to improve HNP outcomes among the poor, most measured a change in average HNP status in project areas. Very few actually measured whether the poor (individuals or poor project areas) have benefited in relation to the non-poor or in relation to those in areas not reached by the project, and even fewer demonstrated that the poor *had* disproportionately benefited. In some cases, improvements in HNP status were only measured at the national level.

The Bank delivered several high-profile analytic products on HNP and poverty over the past decade—notably the *Reaching the Poor with Health, Nutrition, and Population Services* project and the *World Development Report 2004: Making Services Work for Poor People*. Nevertheless, the share of country poverty assessments with substantial discussion of health has declined, from 80 percent in fiscal years 2000–03 to only 58 percent in 2004–06. Only 7 percent of poverty

assessments had substantial discussion of population, and major discussion of nutrition declined by more than half, from 28 to 12 percent. About a quarter to a third of Bank HNP analytic work—both ESW and research—was poverty-related, and this share has also declined in the decade since 1997.

Some aspects of monitoring have improved, but overall it remains weak, and evaluation is almost nonexistent, presenting a challenge for the HNP strategy's results orientation and commitment to better governance. Since 1997, an increasing number of projects have had monitoring indicators and baseline data when they were appraised. Yet, although nearly a third of projects supported *pilot* interventions or programs, or intended to evaluate the impact of a specific activity or program, few proposed evaluation designs in appraisal documents, and even fewer evaluations were actually conducted. Pilot projects or components without an evaluation design described in the appraisal document were never evaluated. Among the consequences of poor monitoring and evaluation and absence of baseline data were irrelevant objectives and inappropriate project designs, unrealistic targets—either too high or below the baseline value—inability to assess the effectiveness of activities, and lower efficacy and efficiency because of limited opportunities for learning. These findings are of great concern given the emphasis of the 2007 HNP strategy on results and good governance.

Approaches for Improving HNP Outcomes

The evaluation reviewed findings and lessons for three prominent approaches to raising HNP outcomes over the past decade—communicable disease control, health reform, and sectorwide approaches (SWAps). These approaches have been supported by the Bank as well as the international community and are not mutually exclusive. SWAps, for example, have included communicable disease control and health reform elements.

Support for communicable disease control can improve the pro-poor focus of health systems, but excessive earmarking of foreign aid for communicable diseases can distort allocations and reduce capacity in the rest of the health system. One of the strategic directions of the 2007 HNP strategy is to ensure synergy between priority disease interventions and strengthening the health system. The rationale for investing in infectious diseases is that they disproportionately affect the poor; their control has large, positive externalities; and control interventions have been shown to be cost-effective in many settings. Dedicated communicable disease projects have dramatically increased as a share of the overall portfolio over the past decade, and Bank support has directly built country capacity in national disease control programs. Support for communicable disease control, with the exception of AIDS projects, has shown better outcomes in relation to objectives than the rest of the HNP portfolio. Both equity and cost-effectiveness are particularly important to address in HIV/AIDS programs, given the huge commitments to that disease and that, unlike tuberculosis and malaria, HIV does not always disproportionately strike the poor. Care must be taken that, as the Bank enhances its support to systemwide reforms and SWAps, progress on communicable disease control remains a priority.

Since the initial increase in Bank-supported communicable disease control in the early 2000s, mainly for AIDS, the international community has also generously expanded funding through the Global Fund to Fight AIDS, TB, and Malaria and the (U.S.) President's Emergency Plan for AIDS Relief (PEPFAR), other bilateral contributions, and private foundations. In some low-income countries with high HIV prevalence, earmarked AIDS funds from international partners account for 30–40 percent or more of all public health funding. In an environment of scarce human resource capacity within the health system, care must be taken to balance the allocation of resources across health programs and budget lines, to ensure that large earmarked funds for specific diseases do not result in lower efficiencies or reduced care elsewhere in the health system. There is little evidence in recently approved Bank support for HIV/AIDS or the other high-priority diseases that this issue has been considered in funding decisions or in risk analysis.

Health reforms promise to improve efficiency and governance, but they are politically contentious, often complex, and relatively risky. Health system reform is central to the emphasis of the 2007 HNP strategy on strengthening health systems. About a third of HNP projects have supported reform or restructuring of the health system through changes in health finance, development of health insurance, decentralization of health systems, and regulation or engagement of the private health sector. These objectives affect efficiency and governance, which are valid objectives in their own right, even if they often do not directly affect health status in the short run. Reforms affecting health insurance help to prevent the impoverishing impacts of illness. Bank support for health system reforms has been mainly to middle-income countries, where health reform projects represent about half of the portfolio.

Many lessons have been learned over the past decade about the successes and pitfalls of support for health reform:

- First, the failure to assess fully the political economy of reform and to prepare a proactive plan to address it can considerably diminish prospects for success. Political risks, the interests of key stakeholders, and the risk of complexity—issues the evaluation case studies found to be critical—are often neglected in risk analysis in project appraisal documents for health reform projects.
- Second, reforms based on careful prior analytic work hold a greater chance of success, but analytic work does not ensure success.
- Third, the sequencing of reforms can improve political feasibility, reduce complexity, ensure that adequate capacity is in place, and facilitate learning. When implementation is flagging, the Bank can help preserve reform momentum with complementary programmatic lending through the Ministry of Finance, as it did in Peru and the Kyrgyz Republic.
- Finally, monitoring and evaluation are critical in health reform projects—to demonstrate the impact of pilot reforms to garner political support, but also because many reforms cannot work without a well-functioning management information system.

SWAps have contributed to greater government leadership, capacity, coordination, and harmonization within the health sector, but not necessarily to improved efficiency or better health results. Sectorwide approaches (SWAps) represent a reform in the way that government and international donors work together (the *approach)* to support the achievement of national health objectives (the *program).* They support the 2007 HNP strategy's objective to improve the organization, functioning, and sustainability of health systems. The *approach* promotes consensus around a common national strategy, country leadership, better harmonization and alignment of partners based on their comparative advantages, joint monitoring, the development and use of country systems, and, in many cases, the pooling of donor and government funds. The anticipated benefits include greater country sectoral leadership and capacity in managing health support, improved coordination and oversight of the inputs of all partners, reduced transaction costs, more efficient use of development assistance, more reliable support for the health sector, and greater sustainability of health programs.

The overwhelming focus of SWAps supported by the Bank has been on setting up and implementing the approach. Fieldwork found that country capacity has been strengthened in the areas of sector planning, budgeting, and fiduciary systems. However, weaknesses persist in the design and use of country monitoring and evaluation systems; evidence that the approach has improved efficiency or lowered transaction costs is thin, because neither has been monitored. Experience has shown that adopting the approach does not necessarily lead to better implementation or efficacy of the government's health programs: only a third of Bank projects that supported health SWAps have performed satisfactorily on meeting their health objectives. SWAps have often supported highly ambitious programs, involving many complex reforms and activities that exceed

government implementation capacity. An important lesson is that programs need to be realistic and prioritized and that the process of setting up the SWAp should take care not to distract the players from ensuring the implementation and efficacy of the overall health program and a focus on results. SWAps have been most effective in pursuing health program objectives when the government is in a leadership position with a strongly owned and prioritized strategy (as in the Kyrgyz Republic). When this is not the case, there is a risk that the health program implemented will be less prioritized, reflecting the favored elements of the diverse partners, weakening effectiveness (as in Ghana).

The contribution of other sectors to HNP outcomes has been largely undocumented; the benefits of intersectoral coordination and multisectoral approaches need to be balanced with their costs in terms of increased complexity. Achieving the health MDGs will require complementary actions from sectors other than health, an explicit activity proposed within the 2007 HNP strategy. The contribution of other sectors to HNP outcomes has been captured through multisectoral HNP projects (projects that engage multiple sectors in a single operation with an objective to improve HNP outcomes) and parallel lending in projects managed by other sectors, in some cases with explicit health objectives. Multisectoral HNP operations have risen from a quarter of all HNP lending to half, greatly increasing the complexity of the portfolio. Most of the increase stems from multisectoral AIDS projects. The large number of sectors involved, the lack of specificity in design documents about the roles and responsibilities of each participating sector, the relatively new institutions put in charge, and other factors affecting lower performance in Africa all contribute to lower outcomes for multisectoral AIDS projects. Other multisectoral HNP projects with fewer implementing agencies have maintained stronger intersectoral collaboration and better outcomes.

Since 1997, the Bank has invested about $5 billion in smaller HNP components in 350 projects managed by other sectors, such as social protection, education, public sector management, water supply, and transport. Both the 2007 HNP strategy and its predecessor foresaw Country Assistance Strategies as the instrument for coordinating intersectoral action to improve HNP outcomes. However, this has not occured over the past decade. Lending activities in diverse sectors such as water supply and sanitation and education have been pursued—for the most part—independently of each other and of HNP operations, although this does not mean that they have not contributed to health outcomes.

Lending programs in other sectors may contribute directly or indirectly to HNP outcomes, in some cases by including health objectives or health components in projects. For example, half of all water supply and sanitation projects claim that health benefits will be generated, and 1 in 10 has an objective to improve health outcomes. But fewer water supply and sanitation projects include health objectives today than was the case 5–10 years ago; in fiscal 2002–06, only 1 in 20 water supply and sanitation projects had an objective to improve health for which they were accountable. Interviews with water supply and sanitation staff suggested that the sector has focused primarily on what is perceived to be "their" MDG, namely *increased access to safe water*. Yet research has shown that context matters; better access to safe water does not necessarily translate into better health. In contrast, the health content of transport projects has greatly increased, particularly in the field of road safety and HIV/AIDS prevention. While trends in accident statistics are relatively well documented for road safety components, there is very little in the way of documented outputs or results for HIV/AIDS components.

Water supply and sanitation and transport projects with health components or objectives rarely involved collaboration with Ministries of Health or the Bank's HNP sector (for example, the Rural Water Supply and Sanitation Project in Nepal). Delivery of health results in these and other sectors has been generally weak, except when an explicit health objective was identified at project appraisal.

There were virtually no results reported for health activities that were retrofitted into active projects.

IFC Support for Development of the Private Health Sector

About three-quarters of health expenditures in low-income countries and half in middle-income countries are private, and half of private health spending among the poor is for pharmaceuticals. IFC has made support to private investment in health one of its strategic priorities. Health is a relatively small and recent sector of IFC operations and involves the activities of two departments: Health and Education and General Manufacturing (for pharmaceuticals).

The performance of IFC's health investments, mostly hospitals, has substantially improved, following a learning process. Before 1999, four-fifths of all health investments performed poorly, and a majority of failed project businesses contributed to financial losses. The reasons for failure included the impact of financial crises in certain regions, delays in obtaining regulatory clearances from the authorities, and IFC's weaknesses in screening and structuring health sector deals owing to lack of sector-related experience. These experiences provided important lessons about hospital investments. More recent investments have realized good financial returns and performed better in achieving intended development outcomes. An evaluative framework for IFC's Advisory Services was only recently launched, so very few health projects have been evaluated, and their results should not be used to infer the performance of the whole portfolio. However, the few health Advisory Services projects that have been evaluated have performed lower than the IFC portfolio overall.

IFC has not been able to diversify its health portfolio as quickly as anticipated. In 2002, the sector set objectives to diversify the portfolio beyond hospitals and to improve the social impact of IFC health operations. IFC has continued to finance private hospitals; the share of pharmaceuticals and other life sciences investments has grown, though more slowly than envisioned in the strategy. IFC has also financed public-private partnerships in health and expanded health Advisory Services with a focus on Africa. Investment numbers and volume increased from 2005 onward. However, to date IFC has not succeeded in financing any health insurance ventures and has financed only one project in medical education.

IFC's health interventions have had limited social impact, although efforts to broaden those impacts are increasing. IFC's investments in hospitals have targeted middle- and upper-income groups. Linkages to public insurance schemes will be necessary for IFC-supported hospitals to meet the health needs of a wider population. Expanded support to public-private partnerships, jointly with the World Bank, such as a recent output-based aid project to improve maternal care among some of Yemen's poorest people, and more strategic deployment of Advisory Services, such as recent efforts to assist social enterprises in Kenya and India, could lead to broadening of the social impact of investments in the health sector. These investments are too recent to evaluate.

Recent IFC health projects have had some positive results for efficiency, governance, and affordability. State-of-the-art facilities in some IFC-supported projects have attracted professionals with established, successful careers in developed countries. Many hospitals supported by IFC have posted fees and introduced control of doctors' side practices outside of the institutions. The majority of IFC-supported pharmaceutical projects have resulted in significant declines in the prices of generic drugs, thus enhancing affordability.

The need to collaborate closely with the World Bank's HNP sector is recognized as important in both the IFC and World Bank strategies to promote greater efficiency in the health sector through finance of private health care. The evaluation found some World Bank–IFC interaction, particularly in middle-income countries, but there is no real model of how that collaboration should occur in a situation where IFC health activities are few and very small in relation to the entire World Bank Group HNP sector in a given country.

Recommendations

The following recommendations for the World Bank and IFC are offered to help improve the implementation of their respective HNP strategies and further the mandate to reduce poverty and promote economic growth in the context of the new aid architecture.

1. **Intensify efforts to improve the performance of the World Bank's support for health, nutrition, and population.**

   - Match project design to country capacity and reduce the complexity of support in low-capacity settings, particularly in Africa.
   - Thoroughly and carefully assess the risks of proposed HNP support and strategies for mitigating those risks, particularly the political risks and incentives of stakeholders.
   - Phase health system reforms to maximize the probability of success.
   - Undertake thorough institutional analysis as an input into more realistic project design.
   - Support intensified supervision in the field by the Bank and the borrower to ensure that civil works, equipment, and other outputs have been delivered as specified, are functioning, and are being maintained.

2. **Renew the commitment to health, nutrition, and population outcomes among the poor.**

   The World Bank should:

   - Boost *population, family planning* and other support to reduce high fertility.
   - Incorporate the poverty dimension into project objectives.
   - Increase support to reduce *malnutrition* among the poor, whether from the HNP sector or other sectors.
   - Monitor health, nutrition, and population outcomes among the poor.
   - Bring the health and nutrition of the poor and the links between high fertility, poor health, and poverty back into poverty assessments.

   IFC should:

   - Expand support for innovative approaches and viable business models that demonstrate private sector solutions to improve the health of the poor, including expansion of investments in low-cost generic drugs and technologies that address problems of the poor.
   - Assess the external and internal constraints in achieving broad social impacts in the sector.

3. **Strengthen the World Bank Group's ability to help countries to improve the efficiency of health systems.**

   The World Bank should:

   - Better define the efficiency objectives of its support and how efficiency will be improved and monitored.
   - Carefully assess decisions to finance additional freestanding communicable disease programs in countries where other donors are contributing large amounts of earmarked disease funding and additional earmarked funding may contribute to distortions in the health system.
   - Support improved health information systems and more frequent and vigorous evaluation of reforms.

   IFC should:

   - Support public-private partnerships through Advisory Services to government and industry and through its investments, and expand investments in health insurance.
   - Improve collaboration and joint sector work with the World Bank, leveraging Bank sector dialogue on health regulatory frameworks to engage new private actors, and more systematically coordinate with the Bank's policy interventions regarding private sector participation in health.

4. **Enhance the contribution of support from other sectors to health, nutrition, and population outcomes.**

The World Bank should:

- When the benefits are potentially great in relation to the marginal costs, incorporate health objectives into relevant non-health projects for which they are accountable.
- Improve the complementarity of investment operations in health and other sectors to achieve health, nutrition, and population outcomes, particularly between health and water supply and sanitation.
- Prioritize sectoral participation in multisectoral HNP projects to reduce complexity.
- Identify new incentives for Bank staff to work across sectors to improve health, nutrition, and population outcomes.
- Develop mechanisms to ensure that the implementation and results for small HNP components retrofitted into ongoing projects are properly documented and evaluated.

IFC should:

- Improve incentives and institutional mechanisms for an integrated approach to health issues across units in IFC dealing with health, including the way that health in IFC is organized.

5. Implement the results agenda and improve governance by boosting investment in and incentives for evaluation.

The World Bank should:

- Create new incentives for monitoring and evaluation for both the Bank and the borrower linked to the project approval process and the midterm review. This includes requirements for baseline data, evaluation designs for pilot activities in project appraisal documents, and periodic evaluation of main project activities as a management tool.

IFC should:

- Enhance its results orientation by developing clearly specified baseline indicators and an evaluation framework that adequately measures IFC's health sector objectives and results.