THE WORLD BANK OPERATIONS EVALUATION DEPARTMENT

Global Health Programs, Millennium Development Goals, and the World Bank's Role

Addressing Challenges of Globalization: An Independent Evaluation of the World Bank's Approach to Global Programs

Case Study

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Abbreviations and Acronyms

AIDS	Acquired immune deficiency syndrome
ARV	Antiretroviral
CCM	Country Coordinating Mechanism (for the GFATM)
CCO	Committee of Cosponsoring Organizations of UNAIDS
CDC	Centers for Disease Control and Prevention
CGIAR	Consultative Group on International Agricultural Research
CMH	WHO Commission on Macroeconomics and Health
COHRED	Council on Health Research for Development
CPA	Country program advisor (UNAIDS)
DALY	Disability-adjusted life year
DFID	Department for International Development
DGF	Development Grant Facility (World Bank)
DOTS	Directly observed treatment short course strategy
ECOSOC	Economic and Social Council of the United Nations
EPI	Expanded program of immunization
ESW	Economic and sector work
FY	Fiscal year
GAVI	Global Alliance for Vaccines and Immunization
GDF	Global TB Drug Facility
GFATM	Global Fund to Fight AIDS, TB and Malaria
GLOBAL FORUM	Global Forum for Health Research
GMI	Global Micronutrient Initiative
GPG	Global public good
GPPPs	Global public policies and programs
GTZ	Gesellschaft für Technische Zusammenarbeit (German Technical Cooperation)
HBC	High-burden country
HDN	Human Development Network (World Bank)
HDR	Human Development Report (UNDP)
HIPC	Heavily-indebted poor country
HIV	Human immunodeficiency virus
HNP	Health, Nutrition, and Population (World Bank)
HRP	Special Program of Research, Development and Research Training in Human Reproduction
IAVI	International AIDS Vaccine Initiative
IBRD	International Bank for Reconstruction and Development
ICR	Implementation Completion Report
IDA	International Development Association
IDRC	International Development Research Center
IDU	Injecting drug user
IFAD	International Fund for Agricultural Development
IFPMA	International Federation of Pharmaceutical Manufacturers Association
IPR	Intellectual property rights
IPT	Intermittent Preventative Treatment
ITN	Insecticide treated net
ILO	International Labor Organization
IMCI	Integrated Management of Childhood Illness
IMF	International Monetary Fund
ITM	Insecticide treated material
LF	Lymphatic filariasis
LSHTM	London School of Hygiene and Tropical Medicine
M&E	Monitoring & evaluation
MAP	Multi-country HIV/AIDS Program (supported by the World Bank)
MD	Managing Director
MDB	Multilateral Development Bank
MDG	Millennium Development Goal
MDR-TB	Multi-Drug Resistant Tuberculosis
MMV	Medicines for Malaria Venture
MSF	Médecins Sans Frontière
NGO	Nongovernmental organization
ODA	Official development assistance
OECD	Organization for Economic Cooperation and Development
OED	Operations Evaluation Department (World Bank)
PATS	Partnership Approval and Tracking System
PEPFAR	President's Emergency Plan for HIV/AIDS Relief
PLWHA	Person(s) living with HIV/AIDS
PRH	Population and Reproductive Health Capacity Building Program
PPAR	Project Performance Assessment Report
PRSP	Poverty Reduction Strategy Paper
PSI	Private Sector Development & Infrastructure Network (World Bank)
QAG	Quality Assurance Group (World Bank)
RBM	Roll Back Malaria
RCS	Research capability strengthening
SARS	Severe acute respiratory syndrome
SDC	Swiss Development Corporation
SSP	Sector Strategy Paper (World Bank)
STAC	Scientific and Technical Advisory Committee (TDR)
STI/STD	Sexually transmitted infection/disease
SWAP	Sector-wide approach
TAG	Technical advisory group (Stop TB Partnership and WHO)
TAP	Treatment Acceleration Program (World Bank)
TB	Tuberculosis
TDR	Special Program for Research and Training in Tropical Diseases
TRIPS	Trade-related aspects of intellectual property rights
UBW	Unified Budget and Work-plan of UNAIDS
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDCP	United Nations Drug Control Program
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session, in particular for AIDS in June 2001
UNICEF	United Nations Children's Fund
VP	Vice presidency
WDR	World Development Report (World Bank)
WHO	World Health Organization
WTO	World Trade Organization

Contents

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The OED review team consulted participants of the annual Global Forum for Health Research meeting, which included developing and developed country participants and health experts. In October 2001 the team consulted senior World Health Organization (WHO) officials in Geneva and specialists at the London School of Hygiene and Tropical Medicine and the Department for International Development (DFID) in London. An OED mission to Geneva in June 2002 consulted the Director General and senior staff of WHO and senior staff of the ILO, ITC, UNAIDS, UNCTAD, UNDP, UNHCR, and WTO. The OED team thanks those who participated in these discussions and in follow-up communications for graciously sharing their ideas. Annex B provides a full list of people consulted.

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Preface

The global programs evaluation and its case studies. At the request of the World Bank's Board of Directors, the Bank's Operations Evaluation Department (OED) has been conducting an evaluation of the Bank's involvement in global programs. This is the first independent evaluation the Bank has conducted of its global program portfolio. The Phase 1 Report entitled *The World Bank's Approach to Global Programs* focused on the strategic and programmatic management of the Bank's global portfolio of 70 programs in five Bank Networks (a cluster of closely related sectors) and was presented to the Committee on Development Effectiveness (CODE) in June 2002. The second phase, of which this report forms a part, is based on case studies of the Bank's involvement in 26 global programs (see list on the next page) and will also be presented to CODE.

A meta-evaluation of the Consultative Group on International Agricultural Research (CGIAR), the first of the 26 case studies, was presented to CODE in April 2003. (Both the Phase 1 Report and the CGIAR meta-evaluation are available on OED's external web-site at www.worldbank.org/oed/gppp.) While the remaining 25 case studies will not be presented to CODE individually, the case studies are being distributed to partners of programs to obtain and reflect their feedback in the final versions of each report before being disclosed to the public. Written comments provided by partners on the final version of the case studies will also be disclosed.

Approval of global programs. Since November 2000, the Bank's involvement in all new global and regional programs has had to be approved at the initial concept stage, based upon the six approval criteria in Annex A, Figure A.1, by the managing director responsible for the Network or Regional Vice Presidential Unit advocating the Bank's involvement. Such approval then authorizes the respective VPU to enter into agreements with partners and to mobilize resources for the program – whether from the DGF, trust funds, or the Bank's administrative budget. Both before and after November 2000, the Bank's participation in some high-profile programs – such as the Global Environment Facility, the Multilateral Fund for the Implementation of the Montreal Protocol, the Prototype Carbon Fund, and the Global Fund to Fight AIDS, TB, and Malaria – has been considered and approved by the Bank's Executive Board.

Oversight and management of global programs. Within the Bank's matrix management structure, Network Vice-Presidents are responsible for overseeing and managing their portfolios of global programs. They are responsible for establishing priorities among programs in their Network, for ensuring their coherence with the Bank's strategy for each sector, for sponsoring applications for DGF grants, for managing those programs that are housed inside the Bank, for fostering links to the Bank's country operations, and for promoting synergy among programs within the Network, with the rest of the Bank, and externally with partners.

Regional Vice-Presidents are similarly responsible for overseeing and managing the portfolio of regional programs and partnerships in their respective regions. While regional programs are not covered in this OED evaluation, many global programs have strong regional dimensions. These regional issues of global programs are treated in this review as well as the links between the network management of global programs and the Bank's country-level economic and sector work, lending, and policy advice.

List of 26 Case Studies in Phase 2 of OED's Evaluation of the Bank's Involvement in Global Programs

Acronym/ Short Form	Full Name	Operational Start Date	Size (US$ millions)[1]
Environment & Agriculture			
1. CGIAR	Consultative Group on International Agricultural Research	1972	395.0
2. GEF	Global Environment Facility	1991	387.53
3. MLF	Multilateral Fund for the Implementation of the Montreal Protocol	1991	158.6
4. ProCarbFund	Prototype Carbon Fund	2000	6.5
5. CEPF	Critical Ecosystem Partnership Fund	2000	20.19
6. GWP	Global Water Partnership	1997	10.25
7. GIF	Global Integrated Pest Management Facility	1996	1.3
Health, Nutrition & Population			
8. TDR	Special Programme for Research and Training in Tropical Diseases	Dec 1975	47.4
9. Global Forum	Global Forum for Health Research	Jan 1998	3.10
10. UNAIDS	Joint United Nations Programme on HIV/AIDS	Jan 1996	95.0
11. RBM	Roll Back Malaria	Nov 1998	11.4
12. Stop TB	Stop TB Partnership	July 1999	20.8
13. GAVI	Global Alliance for Vaccines and Immunization	Oct 1999	124.1
Infrastructure & Private Sector Development			
14. WSP	Water and Sanitation Program	March 1978	12.4
15. ESMAP	Energy Sector Management Assistance Programme	Jan 1982	7.58
16. CGAP	Consultative Group to Assist the Poorest	August 1995	12.67
17. infoDev	The Information for Development Program	Sept 1995	6.07
18. PPIAF	Public-Private Infrastructure Advisory Facility	Dec 1999	15.61
19. CA	Cities Alliance	Dec 1999	13.25
Social Development & Protection			
20. PostConFund	Post-Conflict Fund	1998	10.60
21. UCW	Understanding Children's Work	2000	0.56
Trade & Finance			
22. IF	Integrated Framework for Trade-Related Technical Assistance	1997	2.71
23. FSAP	Financial Sector Assessment Program	May 1999	10.46
24. FIRST	Financial Sector Reform & Strengthening	July 2002	4.64
Information & Knowledge			
25. GDN	Global Development Network	Dec 1999	18.67
26. World Links	World Links for Development	1998	6.5

/1 FY04/CY03 Expenditures. For the following cases updated, audited data was not readily available so the previous fiscal or calendar year expenditures were used: Global Integrated Pest Management Facility, Water & Sanitation Program, Integrated Framework for Trade-related Technical Assistance.

Internally and externally managed programs pose different sets of oversight and risk management issues for the Bank, both of which are being explored in the Phase 2 Report. Of the 70 global programs supported by the Bank in 2002, about 30 were managed inside the Bank, 30 were managed by partner agencies outside the Bank, and 10 were self-standing independent legal entities. Information on the internally and externally managed programs is not uniformly available.

The primary focus of this background paper, as of the other case studies, is on the Bank and on the strategic role that it has played, and might play in the future, to ensure the development effectiveness of global health programs. Yet, since the Bank is only one partner among many, it is difficult to evaluate the Bank's role without assessing the nature, performance and impact of the each global partnership as a whole and the effect that the partnership has had on the performance of the Bank and vice versa. Moreover the Bank's role in their governance and management is not as direct and as strong as it is in the case of programs that the Bank chairs and houses. A specific focus of this background paper is on the interface between *specific* global programs and related Bank-financed health sector operations. But this is not an evaluation of the Bank's health sector activities as a whole.

The Bank's financial support for global health programs – including oversight and liaison activities, and linkages to the Bank's regional operations – comes from the Bank's gross income (for DGF grants), the Bank's administrative budget, and Bank-administered trust funds. In the case of the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria (GFATM), not evaluated in this report, the Bank is a "limited" trustee.

Evaluation sources and instruments. The OED evaluation team has conducted a meta-evaluation of previous evaluations of these six programs and a comprehensive review of secondary information sources, including program documents, annual reports, DGF documents, trust fund documents, sector strategies, and literature reviews. In addition, the team has gathered primary source information from stakeholder interviews, surveys of program partners, and field visits to developing countries and program partners.

Key interlocutors included Bank managers of task teams and global programs, senior World Bank managers (Network and Regional Vice-Presidents, sector and country directors, and sector managers), and Bank staff involved in the DGF secretariat and Trust Fund Operations. Outside the Bank key informants included staff of the World Health Organization, TDR, Global Forum for Health Research, UNAIDS, RBM, the Stop TB Partnership, GAVI, and GFATM. Other stakeholders interviewed included representatives of bilateral and development cooperation organizations (DFID, SDC, CIDA, USAID), private foundations (Rockefeller and Gates), for-profit companies, nongovernmental organizations, and academic institutes.

Surveys and interviews were conducted of Bank task managers of global programs, of operational managers and task managers of Bank lending and of members of the governing boards and advisory committees of four of the six global health programs. UNAIDS and RBM partners were not formally surveyed because their independent external evaluations were being completed when the OED review got underway A total of 261 partners involved in the governance of the four global health programs were sent questionnaires. The overall response rate was 24 percent and varied by programs (TDR and GAVI, over 50 percent; Global Forum, 28 percent; and the Stop TB Partnership, 16 percent). Because of uneven response rate and small samples, survey results are not presented, but the qualitative comments received in response to questionnaires and interviews conducted provided useful feedback.

Visits were made to Botswana, China, Ethiopia, Kenya, Malawi, Ghana, India, the Philippines, South Africa, Thailand, and Vietnam to obtain the views of stakeholders of a number of global programs. The objectives of the field visits were:

- To explore the global/national interface in the health sector and solicit views of government officials and the Bank's development partners;
- To discuss key issues of concern to stakeholders in developing countries.
- To review the implementation experience and outcomes of the global health programs in developing countries.

The stakeholders were asked their views about prioritization, partnerships, participation, governance, management and financial mechanisms, risks and risk management, monitoring and evaluation, balance and complementarities between global and country-level operations, impact and sustainability. The list of those consulted is in Annex B.

Relationship to other evaluations. OED conducted a major evaluation of the Bank's health sector activities in 1999 and routinely assesses the outcome of projects in the health sector. OED currently has an evaluation of the Bank's activities related to HIV/AIDS in progress. The Bank's Quality Assurance Group conducts evaluations of *country-level* analytic and advisory activities and the quality of Bank operations at entry and supervision. As input into its decision making for grant support, the DGF expects the Bank's Networks to review global programs in their sectors for their consistency with sector strategies. It also expects periodic independent external evaluations of the global programs it supports. Five global health programs in which the World Bank is a partner – TDR, Global Forum, UNAIDS, RBM and the Stop TB partnership – have undergone external evaluations within the past five years. The GAVI Board has conducted a number of its own evaluations on specific aspects of its program. This OED evaluation draws on the results of these external evaluations, yet differs from them in several respects. First, it looks across the six global health programs to compare and draw cross-cutting lessons pertaining to *global health program issues, basing these lessons on the information that was available from evaluations, other documents, and interviews*. Second, it benefits from the perspectives obtained from assessing global programs in various other sectors to identify generic issues across sectors, which results will be presented in the Phase 2 Report. Third, it focuses *specifically on the role of the Bank* in the global program partnerships to learn lessons from such information that the Bank routinely collects and utilizes to assess the need for its involvement in global programs.

However, many of the processes that systematically and routinely apply to the Bank's country-level investment operations – such as preparation, appraisal, negotiations with borrowers, routine oversight, mid-term reviews, self-evaluations by Bank staff and borrowers, and independent evaluations of outcomes, Bank and borrower performance – do not exist for global programs. Similarly, many of the concepts and definitions used in global programs are new, vaguely defined, and not uniformly interpreted by all concerned. Basic information on financing arrangements and on the roles and responsibilities of the Bank as a partner are not always clear or easily available. Hence, this OED evaluation has had to explore new and often untested ground, attempting to clarify concepts and then apply them. These case studies are not intended to be a full-fledged independent evaluation of each global program, nor of the Bank's entire health sector activities pertaining to the activities of the 26 global programs. The case studies relied on information which already existed and which OED could collect. Based on the recommendations of OED's Phase 1 Report and the CGIAR Meta-Evaluation, Bank Management and OED are in the process of putting in place systematic processes, procedures, and reporting arrangements for global programs. These previous reports, the case studies, and the Phase 2 Report are based on their lessons are all intended to assist in this effort. The case studies that

underlie OED's Phase 2 Report were distributed in draft for comment to program partners. Their feedback is reflected in this final version being disclosed to the public.

Executive Summary

GENESIS, OBJECTIVES, AND ACTIVITIES

1. The health sector has replaced environment at the forefront of global partnerships in terms of resource mobilization. A combination of factors has put global health issues, especially communicable diseases, on a "war footing." These include increased awareness of cross-border spillovers from globalization; the technological, communication and transport revolutions; the ethical imperative of alleviating the socio-economic effects of a heavy disease burden in developing countries; and the perceived failure of traditional international organizations to address health challenges effectively. Additional factors include the growing importance of private philanthropy, the necessity of mobilizing additional public resources, the need for better harmonization of aid among donors and international organizations, and the adoption of the Millennium Development Goals (MDGs) because global collective action and global partnerships are increasingly viewed as the way to address these multiple global challenges and opportunities that no single actor can address alone, and global health partnerships have increased in number and scope.

2. In fiscal 2004 the World Bank supported 11 global health partnerships. The Bank is important in these partnerships because it is the largest lender and grantor of funds to the health sectors of developing countries, having lent nearly $20 billion and disbursed $15 billion over the 1990-2004 period. The Bank is able to bring macroeconomic and multi-sectoral expertise to bear at the country level and has been the founder or co-sponsor of these partnerships. Six of the 11 were evaluated as part of OED's evaluation of the World Bank's Approach to Global Programs: the Special Programme for Research and Training in Tropical Diseases (TDR; started in 1975), UNAIDS (1996), the Global Forum for Health Research (Global Forum; 1997), Roll Back Malaria (RBM; 1998), the Stop TB Partnership (1999), and the Global Alliance for Vaccines and Immunization (GAVI; 1999). Their collective total program expenditures in fiscal year 2004 were $308 million. In fiscal 2004 the Bank, through its Development Grant Facility (DGF), contributed $11.2 million from its gross income to the six programs.

3. The six programs vary greatly in their objectives, activities, age, and size. They are evolving continuously in response to their own and others' experience. The dynamic global context is also influencing their activity. This evaluation set out to better understand their objectives and activities, to assess their impacts on the efficiency and effectiveness of the health sector strategies of the Bank and its client countries, and to ascertain the Bank's role in the partnerships in increasing the relevance of the programs to the Bank's client countries.

4. Each of the partnerships conducts a range of activities, but the programs are of two basic types. Two of the six programs are financing mechanisms at the global and/or country levels, and the remaining four engage in a combination of advocacy and related technical cooperation, also at the global and country levels. TDR coordinates and supports health research at the global level on the diseases of the poor and strengthens research capacity by financing collaborative research and training. GAVI, along with the financing mechanism called the Vaccine Fund, has a combined annual expenditure of $124.1 million in FY04, and is the largest program. A public-private partnership, GAVI provides country assistance for: (i) immunization services to strengthen countries' delivery capacity, (ii) promote new and under-

used vaccines (hepB, Hib and yellow fever), and (iii) improve injection safety. Though it is an alliance of donors, GAVI's financing mechanism at the country level has operated independently of other donor funding for child immunization and been catalytic in various ways. At the global level GAVI also finances research on vaccines.

5. The remaining four programs engage in combinations of advocacy and technical cooperation. The Global Forum for Health Research, the smallest program with expenditures of $ 3.1 million in 2003, advocates increased expenditures on health research by analyzing the causes and consequences of the low level of health research in developing countries, measuring and disseminating information about trends in health research funding, developing tools for priority setting, and funding some public-private research partnerships of its own.

6. UNAIDS, RBM, and Stop TB, with annual expenditures of $ 95 million, $ 11.4 million and $ 20.8 million in 2003, *advocate specific approaches* to mitigate AIDS, malaria, and tuberculosis, respectively. Through technical cooperation at the global and country levels, each promotes specific strategies to understand the extent, causes and changes in the incidence of the three diseases, and to prescribe ways to address them. The Stop TB partnership also operates a small Global Drug Facility to make quality drugs available to developing countries at competitive prices. RBM is developing a specialized facility for malaria-related drugs and supplies. All three programs have been mobilizing political support and additional financial resources at the global and country levels for the prevention and treatment of these diseases. The partnerships are intended to help achieve scientific consensus on the causes and consequences of the diseases, develop coherent global responses for effective action, and ensure the best strategic use of the partnering agencies' individual and collective resources. UNAIDS, for example, supports the "Three Ones" principle: one action program, one national authority, and one monitoring and evaluation system. To varying degrees, the programs are meant to provide strategic information, tracking, monitoring and evaluation of progress to mobilize financial resources and solicit support of all interest groups. In addition to promoting aid coordination, the Stop TB partnership and, to a lesser extent, RBM, aim to achieve effective diagnosis, treatment and cure of patients, to stop TB and malaria transmission, and to foster development of new preventative, diagnostic, and therapeutic tools and strategies to stop emerging threats such as TB/HIV linkages, multi-drug resistant tuberculosis (MDR-TB) and malaria. To varying degrees each also develops *technical* guidelines and tools, including *technical* monitoring of program implementation at the country level, *technical* support, capacity building, and training.

PROGRAMS' DESIGN AND IMPLEMENTATION

7. Collectively, the programs raise a question about what constitutes a global "program," whether it includes the activities of the partners at the global level alone, or also their activities at the country level. There are at least three aspects to this issue.

8. First, if properly harnessed, partnering in such programs offers the Bank and its client countries some clear benefits; for example, bringing global information and knowledge, technical and financial expertise, as well as political and social consensus and financial resources to address neglected diseases and issues in a concerted manner. But partnerships also have costs (both financial and staff costs as well as opportunity costs by influencing priorities), particularly considering the very limited capacities and resources available in developing countries. The partnership is justified if the benefits of partnering are greater than its costs.

Moreover, when there are multiple such global partnerships, the opportunity cost of duplicating several similar efforts must be considered in relation to their collective benefits and costs including activities forgone.

9. Second, there is a challenge to balancing the value added of each of the highly focused, specific "vertical" programs by successfully integrating them into the health system priorities and capacities of developing countries. Another challenge is achieving consensus among partnering agencies to harmonize aid-funded activities in a manner that results in sustainable outcomes without leading to aid dependency.

10. Third, most global programs reflect the trend away from a shareholder model consisting of donors and recipients and toward greater stakeholder participation at all levels. This poses collective action challenges because the cost of effectively organizing participation increases with the number and types of actors, and these costs must be weighed against benefits. For example, at the global level all six programs have developing country representatives on their governing bodies, five have NGO representatives, and three have industry representatives. Having NGOs involved in partnerships has strengthened the focus on socially desirable outcomes as well as posed institutional, prioritizing challenges. Public-private partnerships have presented opportunities as well as risks. A systematic assessment of the design and implementation of global programs from these perspectives seems warranted.

11. The UNAIDS partnership is a "big tent" approach. Its co-sponsorship by nine UN organizations and the World Bank is meant to achieve global and country-level consensus on fighting HIV/AIDS as a multi-sectoral challenge rather than simply as a health sector issue. GAVI, an alliance of the Bill and Melinda Gates Foundation, international agencies, and bilateral donors is run on business principles, in that further grant funding is related to outcomes on the number of children immunized.

12. The six global health programs also have very different concepts of "membership" or "partnership," ranging from very close to very open consultative membership models. Programs vary greatly in their location and in the autonomy of the partnership. The Global Forum and UNAIDS are independent legal entities located in Geneva and are relatively autonomous. UNICEF is the legal entity for GAVI, but GAVI too is relatively autonomous. In the case of TDR, RBM and Stop TB, WHO is the legal entity, but each has been working toward greater autonomy from the WHO.

EXTERNAL EVALUATION FINDINGS

13. To achieve impacts at the country level all three ingredients provided by the six programs are needed: (i) sound technical approaches based on research and development, scientific know how, technologies and products, (ii) political and social consensus that action is needed, and (iii) financing to ensure that institutional and other capacity exists in the countries to carry out program activities, to evaluate their results and to adjust solutions to ensure their long-term sustainability. But monitoring and evaluation tools are not adequate to assess the impacts of advocacy, technical assistance, and capacity building programs. Outcomes and impacts are easier to assess for programs with financing mechanisms. For example, when TDR and the Vaccine Fund mobilize global science to conduct research on the diseases of the poor, when the Stop TB partnership funds procurement of drugs for the treatment of patients, and when GAVI finances child immunization, more information on impacts is available.

14. Overall, however, global health programs have had a stronger record of independent and external evaluations *at the global level* than have programs in other sectors. Five of the six programs have been independently and externally evaluated. GAVI has had no independent evaluations, though its Board has conducted a number of program assessments to provide input to GAVI management. Evaluations of the newer programs have focused on governance and management arrangements. For older programs more evidence is available on outcomes and impacts. Overall, evaluation findings are leading to improvements in the design and implementation of programs at the global level. Yet evidence of country-level impacts and sustainability of the messages being advocated by the programs is weak because monitoring and evaluation at the country level has generally been weak. GAVI has addressed this better than any other program.

OED FINDINGS

Relevance: Are the Objectives of the Programs Right?

15. All six programs are broadly consistent with the Bank Management's declared criteria for involvement in global programs. In principle they are consistent with the four Development Committee criteria: an international consensus that global action is required, a clear potential for value added to the Bank's development objectives, the need for Bank action to catalyze other resources, and a significant comparative advantage for the Bank to be involved in such an activity. In addition, all six programs are consistent with the Bank's global foci for global programs since communicable diseases is one of the five global public goods priorities established by Bank Management, and support for the health sector in developing countries is one of the Bank's five corporate advocacy priorities. All six programs are multi-country programs, potentially providing global public goods in the form of information and knowledge.

16. TDR, the Vaccine Fund, and, on a small scale, the Global Forum are mobilizing global science and financing research with a focus on the poor, a clear public good. Research and development of new products and technologies often involve economies of scale in production and cross-border spillovers in their benefits. They require long-term, consistent and predictable financial support. Research of relevance to the poor is under-funded because of a lack of market for its products. UNAIDS, RBM, and the Stop TB partnership are providing public goods via information and knowledge. They all support "international advocacy for reform agendas to improve policies at the national level"—another of the Bank's declared criteria.

17. Finally, the programs have the potential to strongly complement the Bank's country-level activities. Only GAVI's immunization activities and, on a smaller scale, the Global Drug Facility country-level financing activities, are similar to those financed by the Bank's country operations—potentially running up against the DGF's subsidiary criterion. The Bank membership in these partnerships provides it with access to new and potentially innovative approaches and technical knowledge, including for scaling up its own operations. The Bank in turn has considerable relevant country operational experience in a range of circumstances, which, in principle, it can mobilize and share with the global programs. Such synergy between the global programs and Bank country assistance can increase the relevance of the global approaches to the Bank's client countries and in turn help articulate the needs of those countries to global programs.

Efficacy and Efficiency: Have the Programs Achieved Their Stated Objectives Cost-Effectively?

18. Each program was assessed not simply on its declared objectives but also on the way it had articulated its intended value added. Thus, GAVI's strategic framework and work plan sees the program's value added as strengthening health service delivery, ensuring access to vaccines and related products, securing long-term financing, and strategic planning. UNAIDS sees its value added as providing leadership and advocacy for responding to the HIV/AIDS epidemic, making available strategic information to guide efforts against AIDS worldwide, tracking, monitoring and evaluating the epidemic and of responses to it, engaging civil society, developing partnerships and mobilizing resources. The recent Stop TB evaluation sees its value added as developing investment mechanisms, identifying funding gaps and priorities, and coordinating and mobilizing partners, among other things.

19. Since their establishment in 1999 GAVI and the Vaccine Fund have committed more than $1 billion to 69 developing countries for immunization. Apart from the additionality of funding and technical assistance in support of immunization, evidence collected from countries such as Kenya, Malawi and China indicates that GAVI has made important contributions in three areas: (i) the introduction of new and improved vaccines, such as for Hepatitis B, (ii) stimulating the market for new multivalent vaccines by guaranteeing funding, and (iii) helping to improve the delivery system by introducing cold chains, the use of auto-disposable syringes, data quality audits, performance-based reward systems, and financial sustainability analysis. By bringing substantial resources to the effort, GAVI stimulated considerable enthusiasm for immunization, which had stalled for lack of grant resources and a lack of effective demand for borrowing even IDA resources. GAVI galvanized its international partners. The Vaccine Fund is also financing the development of vaccines for rotavirus and pneumococcus. But GAVI has informed countries that its program is phasing out in 2006, and it has launched a global campaign through the International Financing Facility (IFF) aimed at doubling official development assistance by 2015, specifically to scale up immunization with funding between $ 4 billion and $ 8 billion over 10 years. By substantial "front-loading" and by floating bonds underwritten by GAVI's partners, funding for immunization is meant to accelerate availability of new vaccines, secure better prices for products, support system improvement to ensure immunization systems are able to absorb the new vaccines, and scale up coverage to 90 percent in every country. According to GAVI, even with an investment of $ 4 billion annually, the initiative could prevent more than 5 million future deaths in adulthood due to hepatitis B. The details of the criteria for funding, disbursement mechanisms, the financial architecture, the future reductions in vaccine prices, and absorptive capacity of poor countries are not yet known.

20. The GAVI/Vaccine Fund not only offers important lessons for scaling up, but also raises issues about the financial sustainability of results at the country level *without continued grant aid commitments on an assured, predictable long-term basis,* the reason why the GAVI program did not get underway in India initially. Several African grant recipient countries have indicated to GAVI after implementing the program that they cannot afford to sustain it without assured external funding. Although GAVI's declared objective was to expand the coverage of the ongoing immunization programs in developing countries as well as to introduce new (multivalent) vaccines, GAVI proposes to continue to focus mainly on promoting the new vaccines, the unit cost of which is several times that of the cheaper, older, single vaccines used

in poor countries. Timely and reliable supply of the necessary volume of new vaccines has been a problem. Even with the considerable reduction in prices, the costs of the new combination vaccines are too high for most poor developing countries to afford. Had GAVI simultaneously promoted the more affordable vaccines, as was its declared goal, while improving the effectiveness of their delivery, and concurrently worked on the increased supply and the reduced prices of the newer improved vaccines, the program would have been more easily scalable and sustainable.

21. Affordability of new drugs is also an issue for the AIDS, TB and malaria programs, although there are qualitative differences in the three cases. Relative to GAVI, monitoring of impacts has been far weaker, despite, in the case of HIV/AIDS, considerable UNAIDS support for the Bank to lead the coordinated monitoring and evaluation effort. Treatment and cure of TB and malaria are essential for the prevention of those diseases; in the case of AIDS, although drug treatment is important to ensure longer healthy life, the impact of treatment on prevention is less clearly established. Hence, the recurrent financial implications of treatment are different in the three cases, and they are high and perpetual in the case of HIV/AIDS once treatment is commenced. The ethical, political and socioeconomic costs of discontinuing treatment are also considerable as are those of providing treatment. In all three cases the affordability of drugs for affected households is also an issue. Unlike GAVI, which is a financing mechanism, many of the other programs are advocacy programs alone. Even with substantially reduced prices, for anti-retroviral (ARV) drugs for example and even with increased Bank (and more recently Global Fund for Aids, TB and Malaria) funding, the longer-term financial sustainability challenges are daunting for HIV/AIDS. Predictable, long term, continued external funding is needed in all but a few middle-income countries, as is the timely supply of quality, affordable drugs and an appropriate diagnostic and treatment regime.

22. Advocacy has substantially increased global awareness of the need to address communicable diseases, but mainly shifted expenditures from the relatively stagnant global ODA to health, and within health to communicable diseases. Among the six programs reviewed, the impacts of UNAIDS' global advocacy on shifting World Bank health expenditures have been by far the most far-reaching. New World Bank commitments to HIV/AIDS alone grew by an average annual rate of 17.9 percent since 1990, including Bank commitments to multi-country HIV/AIDS programs (MAPS) in Africa starting in 1999. Commitments to HIV/AIDS and other communicable diseases together increased by an average annual rate of 8.18 percent. By comparison, Bank commitments to child health and immunization increased at the rate of only 2.8 percent annually (mostly in East Asia and the Pacific, and South Asia Regions) although in China and in countries in Africa GAVI had considerable impact on improving the quality of the immunization delivery system.

23. Bank commitments to the overall health sector increased at an average rate of 3.4 percent, so in several countries health system capacities expanded much less rapidly than commitments to communicable disease lending. Disbursements to the health sector increased at the annual rate of 17.4 percent, a positive development, in part due to the rapidly disbursing adjustment and sector lending in the health sector.

24. A great deal of the increase in the Bank's HIV/AIDS lending is directly attributable to the advocacy by UNAIDS, particularly in Africa. UNAIDS and partnerships in TB and malaria also achieved substantial increases in financing for those three diseases through the establishment of GFATM, although the RBM partnership has had relatively less impact on the

level of Bank lending. WHO is similarly stressing the importance of treatment for HIV/AIDS together with prevention and care through the 3 by 5 Initiative, and the Stop TB partnership has contributed to lending and technical inputs in China and India.

25. While considerable progress has been achieved through advocacy, global programs in communicable diseases also underscore that the weakest links are the health system and financial capacity of developing countries to sustain the programs, particularly in the poorest countries. Thus, while there are many more self-standing HIV/AIDS projects, and much progress achieved in gaining understanding of the extent of HIV/AIDS and the ways to treat it, evidence is weak on the capacity of developing countries to effectively deliver messages, testing, care and medicines at affordable prices. Multi-sectoral approaches at the country level have so far not worked well, and the financial and institutional sustainability of the approaches and the effectiveness of the delivery systems have not benefited from the kind of practical operations research that is much needed.

26. Like UNAIDS, RBM must rely on donor partners to provide finances and technical support to operationalize their prescriptions in small, malaria-endemic, low-income countries with poor health delivery systems. Unlike UNAIDS, however, RBM has lacked a clear country-level focus. Moreover, there is more agreement on what *strategy* to follow on malaria than on how to make the *instruments work.* Insectide-treated nets require subsidies and effective targeting of supplies to the poor; intermittent preventive treatment (IPT) of malaria requires a strong, well-organized public sector health delivery system and an effective community-level mechanisms for delivery. Artemisin-based combination therapy (ACTs) to address drug resistance, which countries have adopted at the urging of the WHO costs $1 to $3 per episode—many times the cost of locally available drugs and supply has been sporadic. Diagnostic tests are beyond the capacity of delivery systems and means of most. The RBM program is developing evidence on where malaria is being effectively controlled and why and its transferable lessons for other countries, but it is still limited and warrants more and better interdisciplinary, multisectoral, operational and empirical research to promote effective control and eradication strategies. The 80 World Bank project implementation completion reports the OED global team reviewed indicated that information on results of completed projects is strong on inputs, for example, on the distribution of insecticide-treated bed nets, but weak on outputs, outcomes and impacts.

27. The external evaluation of the Stop TB Partnership and other evidence OED collected suggests that while attribution is still a challenge for this partnership it has been more successful than the RBM partnership. In only three years the program had built a broad network of well over 300 partners, heightened political support, and marshaled widespread commitment to a detailed Global Plan to the Stop TB. The program has also supported longer-term work on diagnostics, drugs, and vaccines; operationalized the Green Light Committee for second-line TB drugs; and made operational a complex Global Drug Facility covering grant-making, procurement, and partner mobilization for technical assistance for first-line drugs. The most successful TB programs have been in China and India. Yet, evidence is needed on outcomes and impacts, particularly in Africa where TB is increasingly associated with HIV/AIDS. The partnership's declared targets by 2015, once again, depend on funding since the Stop TB Partnership has an effective overall approach to address the problem. Hence more is needed from the partner organizations such as the World Bank (in the provision of finance), and WHO (in technical and operational support) for the actualization of country plans and their

implementation. If cross-border TB transmission is to be contained on a global scale, financial and technical assistance is needed, not just in the high burden countries but in all affected areas implying more staffing and institutional support from the World Bank and WHO.

28. TDR's achievements demonstrate that additional funding does not always follow performance. TDR, even with its small resources, has contributed substantially to the development of new and improved tools for the control of several tropical diseases. The program has leveraged support from other private and public bodies to develop candidate vaccines for malaria, leishmaniasis, and schistosomiasis; and strengthened research capacity in developing countries through collaborative research with scientists in developing and advanced countries. TDR's research publications have an impressive record of citation in scientific journals, reflecting their high quality. However, its already small funding at $ 47.4 million in 2003 has stagnated in real terms over the past 10 years and has become more restricted. Yet, the program's research mandate has expanded from 8 to 10 tropical diseases together with growing expectations among TDR's donors that it should achieve quicker results and impacts. Some of the funding issues are related to the organizational design and implementation, with funders preferring greater autonomy in the governance and management of programs.

29. Global Forum's budget of about $ 3 million is small in relation to its objective of addressing the low level of health research funding in developing countries. A significant share of Global Forum's $ 3 million budget is devoted to the annual meetings to provide networking opportunities for a cross-section of decision makers, policymakers, researchers, public health managers, NGOs, and the private sector from developed and developing countries. The impact of networking is difficult to assess and has not yet been done. There is some evidence that the Forum has increased recognition of the importance of research, but its impact on growth in relevant health research funding is difficult to establish as is the impact of Global Forum's analytical methods on research priority-setting globally or at the country levels. Even to convert the recently reported growth in public-private partnerships into usable products for the poor needs substantially larger investments. This means that founders and partnering agencies need to mobilize more resources for health research that benefits the poor, on a long-term predictable basis.

Bank Performance

30. As the co-founder of all six programs, the Bank is a member of the governing bodies of all six. Global research programs such as TDR and Global Forum do not require a direct link to Bank operations. Nevertheless, TDR's research has influenced adjusting Bank investments in health in several countries. Moreover, efforts by the Bank, working with its international partners, to mobilize financial and scientific resources at the global level (and complementary investments in support of health research at the national level) on diseases of the poor would improve the prospects for achieving the MDGs. For well over 30 years, working with partners, the Bank has exercised stronger leadership more consistently, both globally and at the country level in mobilizing resources for research in agriculture than it has in health research. This has paid off. Both international and national agricultural research has been better funded, with demonstrated high rates of return and large-scale impacts on poverty and hunger, particularly in Asia. By contrast, the Bank's financial commitments to health research of public goods nature both internationally and nationally in developing countries have been small and sporadic.

31. Reconciling global advocacy for increased investments in communicable disease with country priorities presents major challenges. In the decentralized Bank, poverty reduction strategies are meant to be country-driven and, with a limited amount of aid, must cope with the competing investment priorities of developing countries. Within the Bank, staffing, budgetary resources and incentives have been insufficient to link global programs with country activities. As a result, linkages of global programs to Bank country operations are spotty. They are stronger in the case of UNAIDS, particularly in Africa, and in TB in China and India, but they are weak overall, especially on malaria. DGF, which provides funding to the global programs, does not systematically track how and how well the global programs it supports contribute to the Bank's country assistance strategies. OED's global program review of 26 programs suggests that overall linkages between global programs and the Bank's country operations have been weaker for programs where the Bank is not an implementing agency than where it is. All global health program partnerships reviewed in this study which are externally managed are worthy of the Bank's continued and stronger support. The Bank has recently taken steps to increase coherence in its global programs, and strengthen country linkages, for example, to develop a malaria strategy. Yet, stronger linkages are needed between global and country activities to ensure that advocacy, finances and technical cooperation achieve sustainable approaches by monitoring and evaluating the realism and impacts of advocacy and technical cooperation within the health systems of the Bank's client countries.

FINDINGS AND LESSONS

- Advocacy can dramatically increase global expenditure in specific areas of benefit to developing countries and stimulate global consensus, major agreements, and global information and knowledge, as well as increase financial resources for the benefit of developing countries.

- Global and national research in health of benefit to the poor has a high payoff, but being a public good it is under-funded at both global and national levels and deserves greater support.

- Global health programs have a strong record of independent evaluations. Even so, for methodological reasons it is more difficult to assess the impacts of advocacy programs than of programs with concrete, focused objectives and financing mechanisms.

- What constitutes a "program" has become a crucial question for harmonization of aid; whether it encompasses the activities of the partners at the global level alone or also of partner activities at the country level.

- Adding value on the ground in client countries is a joint product of both global and country activities, and there is an encouraging trend toward increased participation of a broader range of stakeholders. Yet, partnerships have worked better at the global level than at the country level.

- While the Bank has supported a variety of global programs in health, the synergy between global programs and the Bank country assistance strategies and experience on the ground is weak in all but a few countries and few programs. It

needs to increase with more systematic tracking of development experience on the ground.

- The sustainability of outcomes of many of the drug and vaccine delivery approaches promoted by the global programs is in question, even with reduced prices, without additional external grant funding on a consistent, long-term and predictable basis.

- A lack of balance between resources for specific health initiatives and for building the long-term health delivery systems in developing countries is an issue faced by all global health programs.

- A few global health initiatives that mobilize global knowledge and finance are well grounded in the reality of the development assistance experience of the Bank, its international partners and country clients. Programs that are well-funded on a long-term, consistent and predictable basis would be more effective than the current myriad, small, under-funded programs.

1. Introduction and Context: Global Health Programs, MDGs, and the World Bank's Role

1.1 Developing countries shoulder a staggering burden of ill health: 38 million people are living with HIV/AIDS, 300 million malaria cases are diagnosed every year, and an estimated 8 million people contract tuberculosis annually. Millions die of these three scourges alone and millions of children go unvaccinated against illnesses that have been nearly banished from the developed world. But developing countries also face myriad other health issues which are less visible internationally. The disease burden has far-reaching socioeconomic costs. Competing demands, limited resources and weak health systems pose a huge challenge for them in priority setting. Developed countries are also vulnerable: the rapid and unexpected spread of SARS highlighted the growing economic consequences of communicable diseases in the era of globalization.

1.2 Hence, a combination of factors has put developing country health issues, particularly communicable diseases, on a "war footing" at the global level: the ethical imperative of alleviating the socio-economic effects of a heavy disease burden, especially for the poor, an increased awareness of cross-border spillovers prompted by the forces of globalization, the communication and transport revolutions, the perceived failure of traditional international organizations to address health challenges on the scale needed with speed, effectiveness, and inclusion of the needed diverse interest groups, the growing necessity for better harmonization of aid among the numerous donors and international organizations, and the adoption of the Millennium Development Goals (MDGs). Spurred by the advocacy of the programs themselves, these factors have resulted in many global health initiatives and helped shift spending priorities for global development assistance toward the health sector, with a strong focus on communicable diseases.

1.3 The World Bank was supporting 12 global health initiatives when the study got underway and supported eleven in fiscal year 2004.[1] Six of these programs were reviewed as part of this evaluation, which forms part of a larger OED assessment of the World Bank's involvement in global programs being carried out at the request of the Bank's Board.[2] The larger OED evaluation is based on case studies of 26 Bank-supported global programs (Box 1), including the 6 health programs reviewed in this report. By understanding the nature of each partnership – while maintaining a steady focus on the Bank's role in each partnership – the objective of the broader global evaluation is to draw strategic, programmatic, and

1. In addition to the six programs reviewed in this report, the other five programs DGF supports are: (1) the Research and Development in Human Reproduction Program (started in 1972), (2) the Population and Reproductive Health Capacity Building Program (1998), (3) Medicines for Malaria Venture (1999), (4) Global Alliance to Eliminate Lymphatic Filariasis (2000), and (5) Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (2002). The Global Macronutrient Initiative (GMI) was phased out from DGF support in 2003. Although the International AIDS Vaccine Initiative (1996) is a separate program in its own right, the Bank has channeled funds to it through the Global Forum for Health Research.

2. The Board discussions of global programs during the design phase on OED's global evaluation identified seven major evaluation issues of concern to the Board: (1) selectivity, (2) monitoring and evaluation, (3) governance and management, (4) partnerships and participation, (5) financing, (6) risks and risk management, and (7) linkages to country operations. Both the Phase 1 Report and the meta-evaluation of the CGIAR are on the evaluation web site: www.worldbank.org/oed/gppp.

program-specific lessons for the Bank, based on case study implementation experience. The purpose of the evaluation is to enhance the Bank's development effectiveness, both as a global partner and where appropriate by linking global program activities to its regional and country operations more effectively to enhance results on the ground.

1.4 Each case study addresses four major issues, which correspond to the four chapters of the present report:

1. The overarching global relevance of each global program, including the nature of the international consensus for the program
2. The outcomes, impacts, and value added of global program activities, both to developing countries and to the Bank, including the linkages between global and country-level activities
3. The governance, management, and financing of the global program, including risk management, and their influence on the efficiency of the global program
4. The World Bank's performance in the numerous roles that the Bank plays as a partner in each program, including its support for country-level activities.

These four issues also correspond to the four standard OED criteria of relevance, efficacy, efficiency, and Bank performance, appropriately adapted for global programs.

1.5 To address these four issues, OED distilled 20 questions from the evaluation questions raised by the Bank's Board, from the current eligibility and approval criteria for global programs established by the Development Committee and Bank Management, and from the eligibility criteria for grant support from the Bank's Development Grant Facility (DGF).[3] Although the case studies review each program as a whole, they focus primarily on the Bank's role and performance in realizing its comparative advantage relative to other partners in the respective programs. The present report represents a comparison across the six selected health programs which provides insights in four broad areas: (1) the Bank's role in individual global health program partnerships, (2) cross-cutting lessons on global health programs for the Bank's future role in health partnerships, (3) generic issues and lessons for global program design, implementation, and assessment, and (4) major gaps, if any, in the health sector where global collective action may be needed.

Box 1. What are Global Programs?

Global programs are defined as partnerships and related initiatives whose benefits are intended to cut across more than one region of the world and in which the partners:

- Reach explicit agreements on objectives
- Agree to establish a new (formal or informal) organization
- Generate new products or services
- Contribute dedicated resources to the program.

1.6 This report is based on a meta-analysis of all available evaluations of the six programs, a review of the related literature, and investigations into the objectives, design, implementation, and results of the programs. OED also interviewed stakeholders, including Bank managers and staff concerned with the programs, sectors, Networks, and countries; surveyed and interviewed program partners; and visited partnering agencies and developing

3. See Annex A for the list of 20 questions as well as a complete explanation of the evaluation methodology and criteria.

countries (see Annex B).

OVERVIEW OF THE SIX PROGRAMS

1.7 The programs reviewed include the Special Programme for Research and Training in Tropical Diseases (TDR; started in 1975), UNAIDS (started in 1996), the Global Forum for Health Research (GLOBAL FORUM; started in 1997), Roll Back Malaria (RBM; started in 1998), the Stop TB Partnership (started in 1999), and the Global Alliance for Vaccines and Immunization (GAVI; started in 1999) (see Figures 1 and 2 for their ages and sizes in terms of their annual expenditures, and Annex Table 1 for the six programs at a glance). Collective assessment of these programs is equivalent to keeping up with a rapidly moving train. Not only is the global health context in which the programs operate highly dynamic, but each program is also in the process of change in response to the changing external context and its own implementation experience – changes which this assessment has attempted to capture.

Programs' Objectives and Activities

1.8 **TDR,** the oldest program and a financing mechanism for health research, coordinates and supports health research on the diseases of the poor and strengthens research capacity through collaborative research and training (see Annex Table 2 for the programs' goals and objectives). With the vast changes in the global health scene, the growing importance of public-private partnerships, and the growing share of "designated" funding – reaching 50 percent of donor contributions in 2003 – TDR is currently reassessing the "special" nature of its long-term role, governance structure, financing and partnership strategies in a changed external environment. Some of the public-private partnerships it financed are also spinning off into programs in their own right. Its leadership has also changed.

1.9 **GAVI,** also a financing mechanism, is the largest program in terms of expenditures. It is supported by the Vaccine Fund, a financing mechanism, which received a start-up grant of US$ 750 million from the Bill and Melinda Gates Foundation along with a call for matching funds from other partners. GAVI is a public-private partnership that provides multi-year grant financing to developing countries to purchase under-utilized vaccines, to enhance developing countries' delivery capacity, and thereby to increase the use of and access to existing and new vaccines. The Vaccine Fund also provides grants (US$ 60 million to date) to accelerate R&D and develop knowledge for priority new vaccines and technologies. One of GAVI's several innovations is the use of performance-based funding to national health systems combined with technical assistance and a modest amount of material assistance to strengthen delivery capacity. Based on its operational experience and in collaboration with its alliance partners including the Bank, GAVI and the Vaccine Fund are in the process of defining their combined long-term strategy and resource mobilization, exploring the optimal management structure for the two (including the possible merger of the GAVI secretariat and the Vaccine Fund management) and ways to strengthen partnerships with international organizations such as the WHO. With the knowledge of the health systems of developing countries acquired in the first few years and their access to the highest policy makers of developed and developing countries, GAVI and the Vaccine Fund are also exploring their role in strengthening the overall global health system as it affects developing countries. Overall, GAVI provides three types of country support: (i) immunization services support (to strengthen countries' delivery capacity) in the form of non-targeted cash contributions, (ii)

new and under-used vaccines (hepB, Hib and yellow fever), and (iii) support for injection safety.

1.10 GAVI has informed countries that it proposes to phase out in 2006, but the partners of GAVI have been in discussion with the United Kingdom, France and other donors to explore using the principles of the International Financing Facility to fund Immunization, resulting in a proposal for an International Finance Facility for Immunization (IFFIm)[4]. The idea is to bring substantial "front-loaded" funding for immunization to accelerate increased availability of new vaccines, secure better pricing, support system improvements required to ensure that immunization systems are able to absorb the new vaccines and scale up coverage to 90 percent in every country. Different scenarios for potential levels of funding varying between US$4, billion and US$8 billion over ten years have been developed. Even at the lowest level of investment GAVI estimates that the lives of more than 5 million children could be saved over the 10-year period and more than 5 million future deaths due to hepatitis B in adulthood could be prevented.

Figure 1. Age of Health Programs Evaluated

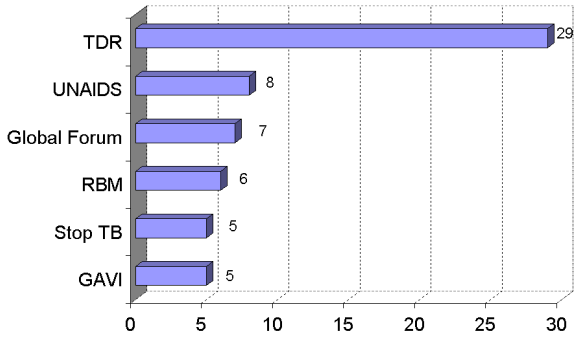
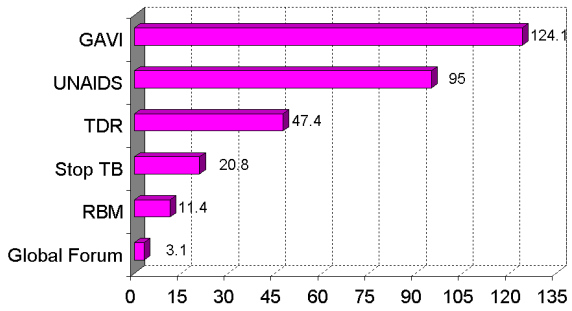


Figure 2. Size of Health Programs Evaluated



Expenditures for GAVI and Stop TB include disbursements from the Vaccine Fund and the Global Drug Facility, respectively. Expenditures are in US$ Millions for FY04. Sources are respective program audited financial statements.

[4] Following the UN International Conference on Financing in Monterrey in 2002, in January 2003, the United Kingdom Treasury and the Department for International Development (DFID) launched a proposal for an International Finance Facility (IFF) as a financing mechanism. Designed to "frontload" aid by borrowing through bonds issued in the international capital markets against long-term pledges of Monterrey commitments, IFF is intended to produce up to an additional US$50 billion a year for disbursement to the poorest countries until 2015. Bonds would be repaid in the years following 2015. Pre-Monterrey commitments would be unaffected and the IFF would use existing channels to provide aid. The purpose is to help meet the Millennium Development Goals, between now and 2015. Although donors are committed to reaching the target of 0.7 percent ODA/GNI, a number have fiscal constraints that will not allow them to increase aid levels in the short to medium term. The IFF is meant as a complement to donors' long-term commitment to 0.7 percent ODA/GNI. IFF would package donor aid commitments and issue debt in the capital markets on the basis of these commitments to improve stability and predictability of funding flows, better match expenditures with needs and provide additional new resources for global health. It could also help ensure the market for drugs and vaccines, which would stimulate their more assured and increased supply, and help develop health delivery systems in developing countries on a long-term basis, two of the several key constraints identified in this report

1.11 The **Global Forum for Health Research**, the smallest of the six programs, is a program established to focus on the causes and consequences of the 10/90 gap in health research (only 10 percent of the world's funding for health research has been estimated to be devoted to the conditions responsible for 90 percent of the global burden of disease). The Global Forum monitors developments in research funding with a particular focus on the world's poor, undertakes the development of tools to identify research priorities, and facilitates networks and partnerships (between the public sector, private commercial sector and civil society organizations) in health research. Under its new leadership, the Global Forum has also redefined its strategy and engagement with developing countries.

1.12 **UNAIDS**, **RBM**, and the **Stop TB** partnership advocate specific approaches and strategies to mitigate AIDS, malaria, and tuberculosis, respectively, and through their advocacy help to mobilize additional resources to support the prevention and treatment of these diseases.[5] UNAIDS was established to develop stronger political commitment in developed and developing country members of the UN system to address the causes and consequences of the epidemic, to develop a coherent UN system-wide response for effective action, and to ensure the best strategic use of the agencies' individual and collective resources, including those of the World Bank. The agency provides strategic information, tracking, monitoring and evaluation of progress to mobilize financial resources and solicit support of all interest groups to develop an effective response. Following an evaluation of its work during the first five years and with rapid changes in the status of countries with respect to their HIV/AIDS burden, new actors and increased global financing for HIV/AIDS, UNAIDS has also been wrestling with issues of its strategic directions and functions, including particularly its role in helping to improve action on the ground, as well as advocacy, facilitation and support of harmonization at the country-level.

1.13 RBM was established to generate political support and provide technical assistance and training in support of malaria control. The Stop TB partnership was established to ensure effective diagnosis, treatment and cure of patients, to stop TB transmission, to reduce the inequitable toll of TB, and to foster development of new preventative, diagnostic, and therapeutic tools and strategies to stop TB – such as the DOTS (directly observed therapy short course) strategy to interrupt TB transmission. It identifies key emerging threats such as TB/HIV linkages and multi-drug resistant tuberculosis (MDR-TB), while also developing technical guidelines and tools, including technical monitoring of program implementation at the country-level, technical support, capacity building, and training. The Stop TB partnership operates the Global TB Drug Facility which finances drug procurement and provides direct procurement services using financing from other sources (including the World Bank). This financing mechanism is intended to enable safe and efficient drug supply for countries facing supply constraints and to learn lessons on increasing quality drug access at competitive prices. Both RBM and the Stop TB partnership have had recent changes in leadership. In response to recent evaluations, RBM is redefining itself, attempting to put in place more

[5] The term "advocacy" used throughout this paper derives from the five corporate "advocacy" priorities and the five global public goods priorities established by Bank Management and contained in the Bank's *Strategic Directions Paper for FY02-04*, March 28, 2001 (see Annex A). This refers to activities undertaken to create reform conditions in developing countries, to distinguish them from investments to provide public goods, although programs also "advocate" increased investments in specific activities. Some commentators argued that the term "advocacy" does not do justice to the range of activities of the global health programs discussed in this review.

structured governance and more focused operational strategies to achieve its goals. The Stop TB partnership is refining its governance and business practices and building up further country partnership efforts.[6]

Governance and Management

1.14 All six programs are complex partnerships involving a range of partners at both the governance and activity levels. Collectively, they offer useful insights into the issues of global governance and management in at least three respects. First, their governance structures reflect the growing trend towards stakeholder participation at all levels (see Table 1 and Annex Tables 3 to 5). Participation fosters legitimacy, relevance and ownership, but also poses collective action challenges. In different ways the programs are attempting to address the challenge of reconciling legitimacy with efficiency.

1.15 Second, the rapid growth in global programs provides an opportunity for systematic cross-program learning with regard to the principles of good governance and management and enhancing effectiveness, rather than each new program learning from its own experience alone.[7]

1.16 Third, program proliferation seems justified if the benefits of partnering in multiple global programs are greater than their costs. This is a particularly important issue for developing countries given their limited human, financial and institutional resources. Global programs are intended to help *increase* all these resources, and to ensure the effective and efficient use of current and future resources. Nevertheless, to increase the value added of programs to developing countries, programs need to increase coordination *among* themselves, realization of which already seems evident in interlocking board memberships, for example, between TDR and RBM, between TDR and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and between the Global Forum and GFATM, and the memorandum of understanding between UNAIDS and GFATM. There is also an active partnership between GAVI/Vaccine Fund and WHO, and between GAVI, UNICEF, WHO, and the World Bank, etc. Yet the genesis, history, and culture of each program results in complex partnership arrangements and a range of organizational forms that may pose challenges for cross-program learning and coordination. At the country-level Bank instruments such as sector-wide adjustment programs also offer an opportunity to increase synergy among different "vertical" programs.

6. Stop TB was more focused both in its messages and approaches than RBM; the evaluation pointed to a number of weaknesses in its program. See Chapter 2 and Annex C for details.

7. The proliferation of programs led the Bank's Executive Board to suggest that OED conduct this review to learn lessons. See OED's Phase 1 Report. Global health program evaluations have already informally embarked on this process. See Chapter 2 and Annex C. This process could become more systematic, routine and institutionalized.

1.17 UNAIDS illustrates how the organization and management of each program is unique. It has ten UN agency co-sponsors, and a slightly larger governing board than the other programs, which includes NGO observers (Table 1). Its Program Coordinating Board meetings are a "big tent" approach to achieve inclusion, political mobilization and commitment.[8] While already engaged in 70 countries operationally, GAVI has a very different board structure than UNAIDS and a more business-like governance style. At the activity level, the Stop TB Partnership involves the network of more than 200 entities, comprising international organizations, industrial and developing countries, scientific organizations, foundations and NGOs, potentially enabling exchange of technical information and lessons learnt on a large scale.

Table 1. Composition of the Governing Boards of the Six Programs

Program	*TDR*	*GLOBAL FORUM*	*UNAIDS*	*RBM*	*Stop TB*	*GAVI*
Size of governing board	31	20	33	20	31	16
Industrial country governments and agencies	11	4	8	3	10	3
Developing and transition country governments and agencies	16	4	14	7	4	3
UN organizations including the World Bank	4	3	6 /1	3	3	3
Industry Representatives	0	1	0	1	1	2 /2
NGOs	0	4	5 /3	1	3	1
Research institutions	0	1	0	1	0	2
Foundations	0	0	0	1	1	2
Other	0	3 /4	0	3 /5	9 /6	0

/1 15th meeting of the UNAIDS Program. Coordinating Board took the decision that in accordance with the Economic and Social Council resolution 1995/2, six Co-sponsors participate in the Program Coordinating Board as members in any one year, with the selection to be decided upon by the Co-sponsors.

/2 One representing industrialized countries and the second representing developing countries.

/3 Three NGOs are from developing countries and two from industrialized/transition countries. They participate in meetings of the PCB, but do not have the right to take part in the formal decision-making process nor the right to vote (see ECOSOC resolution 1995/2).

/4 GFATM, TDR, and the Lancet (all voting members).

/5 GFATM and RBM Executive Secretary are non-voting, ex-officio Members. UNDP is an observer.

/6 Six chairpersons of Stop TB working groups and six regional representatives (2 from industrialized countries and 4 from developing countries), as well as a representative from a community affected by TB, a representative of another international organization, and the WHO Chair of STAG.

8. UNAIDS' Program Coordinating Board meetings are attended by as many as 200 people. The CGIAR, with its many component parts each with different interests, faced huge collective action challenges and difficulties in reaching consensus in large, open, general meetings. It has reduced its six monthly general membership meetings to a single annual meeting, restricted participation in business meetings to members, and added to the single annual business meeting of members a smaller executive committee that is intended to meet up to four times a year. While the latter has not been granted the right to make decisions by the general membership, it is intended to make the annual meetings more decision-oriented and expedite decisions between annual meetings.

1.18 The effectiveness of a partnership is a function of how, and how well, the partnership is defined at each level, and how clearly the linkages, responsibilities, and accountabilities are delineated for each of the partners at each level and within their own organization. But as noted in OED's Phase 1 Report, because of the diversity of programs, it is often difficult to determine who is a partner and who is a participant, or who has what kind of authority conferred on them to exercise influence, as distinct from who really exercises influence (Box 2).[9]

Box 2. What Are Partnerships? Who Are Members and Partners?

- **Partnership:** An agreement between two or more parties to work together for a common purpose, with the parties committing resources (financial, technical, personnel, or reputation) to agreed objectives, to be implemented in accordance with the terms of the agreement.
- **Member:** Those who in some sense "own" the program and who have joint rights and responsibilities for the program.
- **Partner:** Members who are entitled to participate in the governance of the program, either directly or through a representative governance structure.
- **Participant**: Intermediaries who help to implement the program, generally at the country-level, and who are not partners or contributors to the core program.
- **Beneficiaries:** The ultimate beneficiaries of the program at the national or local level.

1.19 The six global health programs have quite different concepts of "membership" or "partnership." The Global Forum does not have formal membership. Its annual forum meetings are attended by hundreds of participants. The Stop TB partnership has an "open door" membership policy for partners. Partner contributions range from sharing new ideas and best practices, data and other information to committing actual resources in the form of funding, technical expertise, staff time, in-kind contributions (drugs and medical supplies), or assistance with marketing, media or networking. UNAIDS, based on the Declaration of Commitment to HIV/AIDS which was adopted by the General Assembly, advocates a broad-reaching partnership framework among all stakeholders. Its modus operandi not only refers to the participants in its governance meetings, but also extends to civil society, including faith-based organizations (FBOs), the business community, and people living with HIV/AIDS. TDR has a limited membership of cooperating parties present at its governance level but its activities span a large number of diseases, issues and countries. Similarly, GAVI's membership exists only at the governance level.

1.20 The six programs also differ in their location and autonomy. The Global Forum and UNAIDS are independent legal entities located in Geneva. WHO is the legal entity for TDR, RBM, and the Stop TB partnership, and UNICEF for GAVI. But GAVI has been relatively autonomous from UNICEF since the outset, and TDR has been striving for greater autonomy from WHO. Following their recent evaluations, RBM and the Stop TB partnership have also been seeking greater autonomy and greater clarity in the roles, responsibilities, and accountabilities of their governing bodies and management, and have been working on establishing more accountable working group structures. OED obtained a range of opinions on how far or how well these reforms are going in various programs.[10] The new governance and management challenges faced by the health programs are discussed further in Chapter 3.

9. The OED meta-evaluation of the CGIAR contains a detailed analysis of this issue.

10. The range of opinions is not surprising. OED based its meta-evaluation of the CGIAR on 700 reports conducted by independent external panels, a survey of 265 stakeholders, and over 100 interviews that noted a

The Bank's Roles

1.21 The Bank plays a number of different roles in the six global health programs (Annex Table 6). It was the founder or co-founder of all six programs, and is a member of the governing body of all six.[11] It is also the largest lender to the health sector in developing countries. The Bank provides financial contributions to the six programs (US$ 11.2 million in the current fiscal year) from its gross income through the Bank's Development Grant Facility (DGF).[12] In comparison with some of the other 20 programs reviewed by OED, these financial contributions to the six global programs have been relatively small – overall about 6 percent of their total program budgets. Since the inception of the DGF in FY1998, the Bank's financial contributions from the DGF to the HNP sector have amounted to less than 9 percent of the nearly US$1.9 billion of loans, credits, and grants the Bank has committed to the health sector during the same period.

1.22 With such small financial contributions to the global programs, why is their performance important to the Bank? First, the Development Committee and the Bank's partners see the Bank's comparative advantage not just in making financial contributions to the global programs, but in contributing to their overall strategic direction and usefulness to the Bank's client countries by helping to mobilize support from others to global health. Even more importantly, both the Development Committee and the partners see the Bank's role as *complementing* global advocacy and approaches with country-level policy analysis, dialogue and investments to enhance results on-the-ground (Box 3). Bank lending to HIV/AIDS and communicable diseases has increased considerably as shown in Chapter 2. There have been more than 500 projects with health sector components since 1990, and more than one hundred with HIV/AIDS components. The Bank plays a major role among the UNAIDS cosponsors for coordination at the country-level of monitoring and evaluation of HIV/AIDS activities. The Global AIDS Monitoring and Evaluation Team (GAMET) provides technical assistance to countries to increase M&E capacity. Most Bank-funded health operations that support TB control

Box 3. What Is the Bank's Comparative Advantage?

"A significant comparative advantage for the Bank" is arguably the most important criterion for the Bank's participation in individual global programs, since three sets of criteria include reference to this – the overarching criteria endorsed by the Development Committee, the approval criteria established by Bank Management, and the eligibility criteria for grant support from the DGF (see Annex A).

The Bank's Strategic Directions Paper for fiscal 2002-2004 identified three comparative advantages for the Bank **at the global level** – global mandate and reach, convening power, and ability to mobilize financial resources – and three **at the country-level** – multi-sectoral capacity, expertise in country and sector analysis, and in-depth country-level knowledge.

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lack of consensus on a variety of issues, stressing the importance of objectives, factually based assessments even of perspectives, and the reasons behind those perspectives.

11. As discussed later in Chapter 3, as a founder the Bank has permanent status on boards, although the terminology used in programs varies greatly on this issue.

12. The Bank's gross income comes from returns on investments and interest on loans to borrowing countries. In FY04, the Board authorized allocations out of the Bank's gross income of US$55 million to the International Development Association, US$240 million to the Highly-Indebted Poor Country initiative, US$25 million to the Low-Income Countries Under Stress Initiative, and US$178 million to the Development Grant Facility (DGF).

promote the use of the DOTS strategy and Bank lending to TB has increased substantially since the establishment of the Stop TB Partnership. But this has occurred in a situation of slow growth in overall health sector lending, as discussed further in Chapter 2. Through systematic learning, partners can obtain knowledge of where and what kinds of impacts on the ground the HIV/AIDS approaches, the DOTS strategy, or the malaria control programs are having, and the obstacles they face country-by-country and overall. Moreover, arrival of the Global Fund for HIV.AIDS, Malaria and TB and the US President's Emergency Plan for HIV/AIDS Relief (PEPFAR) as significant funding mechanisms have added to the complexity of coordinated approaches including in their M & E. The lessons from the Bank implementation experience could help improve the design, implementation and effectiveness of individual global partnerships and make them more relevant to the needs of developing countries. Since every partnership is attempting to reform and increase their country orientation there can be more informed mutual learning. The long-term financial sustainability of the new health expenditures prompted by advocacy of global programs is the major issue, unless the necessary additional external aid is available to meet the recurrent implications. This issue has not received the attention it deserves. With its knowledge of the macroeconomic situation of the client countries, of external ODA levels and prospects, the Bank is in a unique position to make important contributions in this area.

1.23 Second, there is the issue of overall priorities with respect to the Bank's engagement in global programs and relatedly of synergy among the various health sector programs. With only US$147 million of DGF funds available to allocate among 50 global programs in fiscal year 2004, competition for the grant resources the Bank provides to global and regional programs is strong. Moreover, as this review illustrates, decisions about the allocation of the Bank's gross income increasingly include demand for results from global programs in a larger strategic context beyond the impacts of individual programs.

1.24 Of particular importance in this process are the overall health sector needs and priorities of developing countries themselves and the role of the Bank's DGF funding in addressing issues of concern to them. The relationship of the Bank's health sector lending pattern to global health programs, if any, the meaning of the past trends and particularly their future implications were highly debated in the Bank when this draft was prepared. Yet, there was strong consensus on the overall conclusion of this report that greater synergy *among* the global health programs the Bank supports, stronger relationships between global programs and the Bank's ongoing country operations, and better links with the activities and needs of developing countries would increase the relevance and ownership of global programs by the developing countries themselves, and accelerate results on the ground. Yet, what precisely this broad consensus means, or indeed how to go about achieving this synergy among programs and at the country-level remains debatable and will undoubtedly be debated for some time before the issues are resolved.

CONSISTENCY OF GLOBAL HEALTH PROGRAM OBJECTIVES WITH BANK PRIORITIES

1.25 OED assessed the relevance of the 26 case study programs, including the six global health programs, against three sets of criteria Bank Management has established for its engagement in global programs:

1. The overarching criteria for the Bank's involvement in global programs endorsed by the Development Committee in September 2000 (Annex A, Figure A.1).

2. The Bank's strategic focus for global programs established by Bank Management in March 2003 – that the program (1) provides global public goods, (2) supports international advocacy for reform agendas that significantly address policy frameworks relevant for developing countries, (3) is a multi-country program that *crucially depends on highly coordinated approaches*, or (4) mobilizes substantial incremental resources that can be effectively used for development.[13]
3. The subsidiarity criterion established by the DGF in October 1998 – that the program does not compete with or substitute for regular Bank instruments.

1.26 All six programs are broadly consistent with all these criteria. First, they are consistent on the face of it with the four Development Committee criteria – namely, an international consensus that global action is required (Annex Table 7), a clear potential value added to the Bank's development objectives, the need for Bank action to catalyze other resources, and a significant comparative advantage for the Bank. Four of the six programs directly address two Millennium Development Goals outlined in Annex Table 8 (Goal 4 to reduce child mortality and Goal 6 to combat HIV/AIDS, malaria, and other diseases), and they indirectly address Goal 5 to improve maternal health. The other two programs, TDR and the Global Forum, also indirectly address Goals 4, 5, and 6.[14] However, even the broad international consensus that is reflected in the 2000 Millennium Declaration and the MDG goals does not necessarily ensure country ownership, priority, or capacity. Even the most effective country-level activities of global programs encounter challenges in reconciling the goals of various other competing global programs, and particularly with the developing country health system priorities and capacities, issues which are discussed in the chapters that follow.

1.27 Second, all six programs are consistent with the Bank's global foci for global programs, since communicable diseases is one of the five global public goods priorities established by Bank Management, and support for the health sector in developing countries is one of the five corporate advocacy priorities (Annex A, Figure A.1). Based on an analysis of their activities (Table 2 at the end of this chapter), all six programs are **multi-country programs,** potentially **providing global public goods** and **supporting international advocacy** for reform agendas to improve policies at the national level. TDR, the Vaccine Fund, and to a lesser extent the Global Forum are financing research and development for new products and technologies – a clear global public good (Box 4). UNAIDS, RBM, and the Stop TB partnership are providing a global public good by developing approaches to containing communicable diseases with widespread application and providing this specialized information and knowledge to developing countries.[15]

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13. A global program has to meet only one of these criteria to be considered eligible for Bank involvement. As demonstrated in Figure A.1, "providing global public goods" and "supporting international advocacy" are direct references to the Bank's global public goods and corporate advocacy priorities as enunciated in the Strategic Directions Paper for FY02-04, March 28, 2001. By contrast, each global program is supposed to meet, at the concept stage, all six of the approval criteria for global programs established by Bank Management in April 2000.

[14] The Global Forum for Health Research says it indirectly addresses all 8 MDGs. A premise of the Forum meeting in Mexico in 2004 is that all 8 MDGs are somehow health-related, and none will be achieved without more health research.

15. As will become clearer in Chapter 2, the extent to which knowledge is a global public good in the context of the World Bank's mission of sustainable poverty alleviation must be established through empirical research, since useful knowledge is contextual. It must be relevant and accessible to the intended beneficiaries to achieve positive outcomes and impacts in the Bank's client countries.

Box 4. What are Global Public Goods, National Public Goods and Merit Goods In Health Is Complex and Interacting: Definitions and Clarifications

Public goods are distinguished from private goods by non-rivalry and non-excludability. Non-rivalry means that many people can consume, use, or enjoy a public good at the same time: one person's consumption does not reduce the benefits that others can derive from consuming the same good at the same time. Non-excludability means that it is difficult to exclude from consumption those who do not pay for, or otherwise contribute to, the cost of supplying the good.

Global public goods are distinguished from national and local public goods by their reach. Their public characteristics of non-rivalry and non-excludability spill across national boundaries. People in more than one country can benefit from the provision of a global public good, whether or not they contributed to the cost of supplying the good. For national and local public goods, however, only those who live in a given country or in a given locality can benefit from the provision of such public goods.

Merit goods are goods whose value derives not simply from the economic norm of consumer sovereignty, but from some alternative norm that overrides rational choice by individual persons or, in the case of foreign assistance, individual nations. The concept of merit (or demerit) goods should not be confused with that of public goods, since it transcends the distinction between public and private goods (based on non-rivalry and non-excludability). When donors direct development assistance to certain uses, rather than providing pure, untied assistance to developing countries, they are implicitly attaching merit to their own preferences, whether the assistance is tied to the provision of public or private goods.[a]

In the health sector, there is considerable ambiguity on what constitutes a public good, and even more ambiguity about what constitutes a global public good, since this also depends on the level of development, technological options, and social choices. The fight against communicable diseases, for example, requires important investments in global public goods, beyond the means or incentives of any single government and beyond the sum total of national-level programs (WHO 2001). Similarly, scientific knowledge, which enables the production of medicines and vaccines, is a global public good as it potentially enables the sick across several regions to be treated. With respect to HIV/AIDS, both prevention and treatment have increasingly been considered global public goods, on a variety of grounds, including because it will increase the life span, facilitate HIV prevention, strengthen overall health sector and can be funded by external assistance that may not be available for other expenditures. This will reduce the impact of the AIDS pandemic on the national and eventually global economic growth.

Treatment and cure of TB, malaria, and immunization is essential for the prevention of those diseases; in the case of AIDS, although drug treatment is important to ensure longer healthy life, the impact of treatment on prevention is less clearly established. Hence, the recurrent financial implications of treatment are different in each case and they are perpetual in the case of HIV/AIDS once treatment is commenced and considerable depending on scale.

To the extent that free or subsidized treatment through *public intervention* is provided on ethical, humanitarian or equity grounds, it is of course a merit good. The likely effects of treatment on facilitating prevention and containing spread are complex, and empirical evidence, while possible to develop, is limited for developing countries. Prevention of mother-to-child transmission through treatment of HIV positive pregnant women, of transmission through sexual contact or exchange of body fluids, and of transmission through exchange of needles clearly have public good aspects. Selectively targeted treatment will therefore contain negative spillovers and it also has public good aspects. However, critics of blanket coverage of treatment argue that in a situation of constrained financial, human, and management resources, such treatment can also cause a false sense of security, encourage risky sexual behavior among some of those infected, increase disease resistance, increase expectations and public sector financial, human and institutional commitments to delivery of treatment, to the detriment of prevention, to the detriment of the rest of the health sector issues needing attention, and to the needs of the rest of the economy. Sustainability of investments in treatment is by far the issue of greatest importance. In the case of poor countries, even if aid is available only for treatment and even if it is not otherwise fungible, given the inherently unpredictable nature of aid, rapid expansion of treatment will increase aid dependence on a long-term basis without its assured supply. Therefore, any public intervention in treatment by developing countries should be considered carefully and targeted to facilitate prevention and after examining what is realistically affordable on a long-term sustainable basis (Mead Over, Peter Haywood, Julian Gold, Indrani Gupta, Subhash Hira, Elliot Marseille, HIV/AIDS Treatment and Prevention In India, Modeling the Cost and Consequences, World Bank, 2004).

Public intervention in immunization is considered a public good on three grounds: (1) the spread and incomplete course of treatment in the absence of public provisions, (2) that some interventions (such as vector control and information) are pure public goods, and (3) on equity grounds, since immunization-preventable diseases disproportionately affect the poor. While most non-informational services involved are private in nature (rival and exclusionary), there are substantial social externalities associated with immunization. For example, the polio vaccine is unique because it exhibits both characteristics of public goods – oral vaccine allows the virus to multiply in the child's intestine and is released in much larger quantities in excreta. The attenuated virus competes in the environment with the circulating wild virus which is responsible for polio – making benefits both non-rival and non-exclusionary and therefore a public good (Hammer 1996).

a. Musgrave 1987.

1.28 Third, the programs are strongly complementary to Bank country-level activities. Only GAVI's immunization activities and on a smaller scale the Global Drug Facility are financing country-level investments. They are similar to those financed by the Bank's country operations – potentially running up against the DGF's subsidiarity criterion. But the Bank's DGF grant contributions support the secretariat activities of these two programs – not the investment activities of the larger GAVI/Vaccine Fund and the Global Drug Facility. On the contrary, Bank membership in GAVI and the Stop TB partnership potentially provides it with access to the new and innovative approaches and technical knowledge of both programs, including for scaling up its own operations. The Bank similarly has considerable operational experience in these areas, which it can share with the global programs. After very weak initial links with Bank operations that OED noted, the synergy between the two may be becoming stronger, although there is still further scope to realize its full potential.

1.29 In a short period since its establishment in 1999, GAVI and the Vaccine Fund have committed more than US$1 billion to 69 developing countries for immunization programs, and together their partners have launched a global Campaign for Child Immunization to increase the vaccine and immunization services by 2004 to the 30 million children in the world's poorest countries currently without such access. The Vaccine Fund is also financing the development of vaccines for rotavirus and pneumococcus. Each is a cause of significant mortality in developing countries. GAVI is also adding value to developing countries by providing substantial *additional financial resources* and technical assistance to the planning and implementation of immunization programs. To a much smaller extent the Global Drug Facility is doing the same with the DOTS strategy, although for the reasons outlined below its true incrementality to overall ODA is less clear, unlike in the case of GAVI/VF.

1.30 Through research and advocacy, TDR, UNAIDS, RBM, and the Global Forum provide new information, technologies, and tools to developing countries. UNAIDS' primary function is distilling and disseminating strategic information, or information that truly guides policy and strategy. It monitors country-level HIV/AIDS strategies and programs and gathers, analyzes, and disseminates information on the evolving HIV/AIDS epidemic and responses to it, including epidemiological data collection and analysis, needs assessment, and it promotes harmonization of M & E efforts. UNAIDS also assesses country-by-country and overall global HIV/AIDS resource needs and flows, information used by various agencies to map strategies, policies and approaches. At the country-level, UN Theme Groups provide support to national policies and plans, identify and disseminate best practice, and provide support for implementation, monitoring and evaluation. UNAIDS indicates that it undertakes country capacity building for skills to determine resource needs, resources available, as well as epidemic modeling and estimates. RBM and the Stop TB partnership pursue some similar approaches on a less ambitious scale.

1.31 Although GAVI and the Vaccine Fund engage in advocacy at the global level on a large scale, as does TDR for tropical disease research, advocacy, broadly interpreted, is the major component of four of the six global health programs (Global Forum for Health Research, UNAIDS, RBM and the Stop TB partnership). These programs do not have their own financing or a financing mechanism attached to them, except to provide technical assistance on a small scale, training and tool development to effect action on the ground. In these cases, advocacy, broadly defined, is intended to stimulate partner activities, and the success of these programs depends to a considerable extent on the actions carried out by the partners (both donors and stakeholders in developing countries) in their own independent activities. While TDR and GAVI

also engage in advocacy, the financing available to them enables them to translate their messages into action on the ground. The Stop TB Partnership's small-scale financing mechanism – the Global Drug Facility – for procuring drugs for developing countries achieves the same objective. RBM is also initiating its own drug procurement facilities.

1.32 Impacts of advocacy tend to be by far the most difficult to assess. For these programs it includes information collection and dissemination, technical cooperation, capacity building and training. Evaluation tools for these activities are poorly developed, and not often applied as documented later, although this kind of activity has been a perennial in overseas development assistance. Furthermore, simultaneous actions by many actors on similar issues compound the challenge of establishing causality and attribution. Yet the evidence indicates that global advocacy has been successful in increasing global awareness of the importance of dealing with communicable diseases and shifting global ODA expenditures from other areas (such as the environment) to health. Among the six programs reviewed, the impacts of UNAIDS' global advocacy have been by far the most far reaching. Among other things, UNAIDS has influenced patterns of Bank lending – discussed in Chapter 2 – and other donor assistance to HIV/AIDS, and promoted the establishment of GFATM. Simultaneously, the WHO is stressing the importance of treatment together with prevention and care.[16]

1.33 These collective efforts have stimulated the recent agreement (between the Clinton Foundation, WHO, UNICEF and the World Bank involving pharmaceutical companies in India and South Africa) to increase drug supply and access of developing countries to quality anti-retroviral (ARV) drugs at affordable prices. Roll Back Malaria and the Stop TB Partnership have similarly been successful in ensuring that malaria and tuberculosis are included in GFATM and in promoting World Bank lending in those two areas. GFATM, for which the World Bank is a limited trustee, disbursed nearly US$200 million during its first two years of operation (in 2002 and 2003) and is projecting disbursements of about US$750 million in 2004.[17] And GAVI and the Vaccine Fund have been working actively to develop pilot programs in the context of the International Financing Facility (IFF) proposed by the UK chancellor, Gordon Brown. The World Bank has supported this initiative in principle and is assessing the financial feasibility of this proposal.

1.33 It is unclear so far how much of the increased public funding going to global health programs reviewed is truly additional, as distinct from being reallocated from existing ODA. Among the programs reviewed, overall, philanthropic sources of funding, particularly from the Bill and Melinda Gates Foundation seem clearly to be the *new significant additional* source of funds to overall ODA.[18] Most of the Gates funds are allocated to global health. Hence the

16. In a speech in September 2003 to health ministers from the African Region, the Director-General of the WHO, emphasized the urgent need for treatment for people living with HIV/AIDS and announced WHO's commitment to the "3 by 5 Plan" – to provide three million people living with AIDS with antiretroviral medicines by the end of 2005.

17. By way of comparison, this is equivalent to about 60 percent of the total expenditures of 70 global programs supported by the Bank in 2001, the year before GFATM started.

18. Since its inception, the Gates Foundation has directed nearly half of its US$6 billion in grants to the health sector, and nearly 80 percent of this to global partnerships in health. The Soros Foundation has contributed US$ 200,000 and US$ 250,000 to the Stop TB Trust Fund for two years. The US President's Emergency Plan for HIV/AIDS Relief (PEPFAR) of US$ 15 billion over 5 years to 14 countries from which funds to the GFATM are provided provides US$10 billion in new money.

importance of understanding the interaction between the public and the private sector funding and programming of ODA to health and its potential impact on enhancing aid effectiveness and resource mobilization for MDGs as a whole.

Table 2. OED's Analysis of the Activities of Each Program, According to the Bank's Four Strategic Foci and OED Subcategories

Activities	*High or substantial*	*Modest*
Providing global public goods		
• Implementing conventions, rules, standards & norms		
• Financing R&D for new products and technologies	TDR, GAVI, Global Forum	
• Financing country-level investments to deliver global public goods		
• Promoting common approaches to mitigating communicable diseases	UNAIDS, RBM, Stop TB	
Supporting international advocacy for reform agendas to improve policies at the national level		
• Advocacy	UNAIDS, GAVI, Global Forum, Stop TB, RBM	TDR
• Supporting national-level policy, institutional & technical reforms	UNAIDS, GAVI	RBM, Stop TB, Global Forum
• Financing country-level investments to deliver national public goods	GAVI	Stop TB
Coordinated multi-country programs		
• Generation and dissemination of information and knowledge	UNAIDS, TDR, GAVI, RBM, Stop TB	Global Forum
• Capacity building	GAVI, TDR, UNAIDS	Stop TB, RBM
• Improving donor coordination	GAVI, UNAIDS, Stop TB	RBM, Global Forum
Mobilizing substantial incremental resources		
• Directly	GAVI	TDR
• Indirectly	UNAIDS	Stop TB, RBM, Global Forum

Definitions:

"Rules" are generally formal. **"Standards"** can be formal or informal, and binding or non-binding, but **"implementing standards"** is more than simply advocating an approach to development in a sector. In general, there should be some costs associated with non-compliance with standards. These can be of many types, including exposure to a financial contagion, bad financial ratings by the IMF and other rating agencies with consequent impacts on access to private finance, lack of access to OECD markets for failing to meet food safety standards, or even the consequences of failing to be seen as "progressive" in international circles.

"New products and technologies" are generally physical products or processes – the hardware as opposed to the software of development.

"Financing country-level investments" refers primarily to physical and institutional investments of the type found in Bank loans and credits, not the financing of studies.

"Promoting common approaches to mitigating communicable diseases" may involve a range of activities intended to develop approaches to containing communicable diseases with widespread application and to provide this specialized information and knowledge to developing countries.

"Advocacy" comprises pro-active interaction with policy-makers and decision-makers concerning approaches to development in a sector, commonly in the context of global, regional, or country-level forums. Intended to

create reform conditions in developing countries, as distinct from physical and institutional investments in public goods, this is more pro-active than generating and disseminating information and knowledge.

"Supporting national-level policy, institutional, and technical reforms" is more directed to specific tasks than advocacy. This represents concrete involvement in specific and ongoing policy, institutional, technical reform processes in a sector from deciding on a reform strategy to implementation of new policies and regulations in a sector. It is more than just conducting studies.

"Financing country-level investments" refers primarily to physical and institutional investments of the type found in Bank loans and credits, not the financing of studies.

"Generation and dissemination of information and knowledge" comprises two related activities. The first is gathering, analyzing, and disseminating information on, for example, the evolving HIV/AIDS epidemic and responses to it, including epidemiological data collection and analysis, needs assessment, resource flows, and country readiness information. The second is the systematic assembling and dissemination of knowledge (not merely information) with respect to best practices in a sector on a global basis. These activities alone do not constitute advocacy.

"Capacity building" refers to building the capacity of human resources through pro-active training (in courses or on-the-job) as well as collaborative work with the active involvement of developing country partners.

"Improving donor coordination" should be an active process, not just the side effect of other program activities. This may involve resolving thorny inter-agency issues that need addressing.

"**Mobilizing substantial incremental resources**" should be an active process, not simply for the sake of the program. The mobilized resources do not necessarily have to flow through the program itself, for example, in the case of private sector investments in infrastructure. There should be clear performance indicators to illustrate how this will be measured and attributed to the program, as and when resources get mobilized.

2. Striving for Results: Assessing the Outcomes and Impacts of Global Health Programs

QUALITY OF MONITORING AND EVALUATION ACTIVITIES

2.1 OED's meta-review of the programs' monitoring and evaluation processes used a standard framework (Box 5). Overall, among the global programs OED reviewed, global health programs have a strong record of independent and external evaluations – five of the six programs having been independently and externally evaluated (Annex Table 10). The GAVI Board has also commissioned a number of assessments of various aspects of its program. But there has been no independent evaluation of GAVI. Evaluations of the newer programs have understandably focused relatively more on governance and management arrangements compared to outcomes and impacts. Additional findings of the evaluations and of OED's field visits are summarized in Annex C.

2.2 The assessment of outcomes and impacts needs to take into consideration how the programs view themselves as adding value. GAVI's strategic framework and work plan sees the value added of the program as strengthening health service delivery, ensuring access to vaccines and related products, securing long-term financing, and strategic planning. UNAIDS sees its value added in providing leadership and advocacy for effective action in responding to the epidemic, making available strategic information to guide efforts against AIDS worldwide, tracking, monitoring and evaluating of the epidemic and of responses to it, engaging civil society, developing partnerships and mobilizing resources to support an effective response. According to UNAIDS, its functions are fostering public accountability, guardianship of ethical and technical soundness of programs and promoting the 'Three Ones' principles - consisting of one action program, one national authority, and one monitoring and evaluation system - for effective and efficient country-driven responses. The recent Stop TB evaluation sees the value added of the program as developing investment mechanisms (including information on resource flows for TB), identifying funding gaps and priorities, and coordinating and mobilizing partners.[19]

Box 5. Assessing the Quality of Monitoring and Evaluation Processes

OED assessed the quality of monitoring and evaluation in the 26 case study programs according to the following five criteria:

- Clear and coherent program objectives and strategies that give focus and direction to the program, and provide a basis for evaluating the performance of the program
- The use of a results-based management framework with a structured set of (quantitative or qualitative) output, outcome, and impact indicators
- Systematic and regular processes for data collection and management
- Independence of program-level evaluations
- Effective feedback mechanisms to reflect evaluation findings on strategic focus, organization, management, and financing of the programs

Source: These criteria are based upon OED's standards of best practice as identified in OED documentation.

2.3 Evaluation findings are leading to improvements in program design and implementation.[20] Taken together, the evaluations raise at least three sets of issues:

- Methodological challenges in determining what constitutes a global program, how to assess its outcomes and impacts using a uniform evaluation framework, and how to ensure more even coverage of key evaluation issues.
- Measurement challenges in establishing baselines and causal chains, in assessing intermediate outcomes such as changes in the behavior of partners and intended beneficiaries (for example, in response to knowledge acquired with regard to HIV/AIDS), and in evaluating ultimate impacts on patients treated, disease transmission stopped, and outbreaks controlled.
- How advocacy work and approaches promoted by individual programs (such as the use of country-coordinating mechanisms, competitive procurement arrangements, and monitoring and evaluation) could be coordinated not simply within a single program

[19] The responsibilities of UNAIDS and WHO have evolved organically over time with considerable ambiguity and overlap in some areas.

20. Overall, the global health programs also rated high on their reporting arrangements of program-level evaluations to their governing bodies and their follow-up of evaluation findings.

but *among* programs, and better integrated into the health system priorities of developing countries to achieve more sustainable results.[21]

2.4 Evaluations vary in their coverage of issues in part due to differences in the programs' age, objectives and needs. There are also differences in reporting requirements and arrangements. For instance, the different ways in which programs report their incomes and expenditures makes comparisons across programs difficult (Annex E). The establishment of common international standards across global programs in financial reporting and in monitoring and evaluation would enable inter-program comparisons of program efficiency and effectiveness. For example, GAVI states that it has distributed 98 percent of the resources it has mobilized, has tried to use performance-based allocations in providing funding for child immunization, and has been attempting to establish baselines, conduct data quality audits, and provide assistance for improved monitoring and evaluation. There are surely comparative operational lessons to be learned across programs in achieving cost-effective delivery systems. The Bank's recent report on MDGs in the health sector identifies some of these.

2.5 The improvement of their monitoring and evaluation systems seems a task that the three global programs on communicable diseases could undertake jointly. Individual program evaluations have already begun to look across programs to derive lessons with regard to governance and management.[22] A key to understanding impacts of global programs are changes at the country-level on the ground in such things as improved health outcomes for or changed behavior of beneficiaries, or increased institutional capacity to deliver services. However, collecting information on performance indicators to determine results on the ground at the country-level is challenging, even for the Bank. The OED global team analyzed OED reviews of 80 Implementation Completion Reports (ICRs) of World Bank-financed health operations and 10 recently completed Project Performance Assessment Reports – several of these involving HIV/AIDS, tuberculosis and malaria components, covering all regions of the world, and covering the 1993-2003 period. A persistent theme in OED reviews of ICRs was inadequate monitoring and evaluation processes and the consequent difficulties in ascertaining program performance and in attributing results to Bank operations. This was true even when outcomes were generally positive. Weak monitoring and evaluation processes are not unique to the health sector. But this review also offered several examples (such as Cambodia) where even the most concerted monitoring and evaluation effort would have benefited from more professional input into data collection and analysis.

2.6 Outcomes and impacts are easier to assess in principle when programs undertake tangible activities, for example, when TDR and the Vaccine Fund mobilize global science to conduct research on the diseases of the poor, when the Stop TB partnership funds treatment for patients, and when GAVI finances child immunization programs. Depending on their age and maturity, some of these activities already have considerable independently evaluated achievements to their credit (reported below and in more detail in Annex C). Nevertheless overall monitoring and evaluation tools are inadequate to assess the impacts of advocacy,

21. The Memorandum of Understanding between UNAIDS and GFATM and increased cooperation between Stop TB Partnership and GFATM is encouraging from this perspective.

22. The evaluations of RBM and Stop TB Partnership based their recommendations on comparisons with other programs.

technical assistance, and capacity building programs. Hence UNAIDS' effort to improve harmonization through a single strategic framework, improve governance, accountability, and monitoring and evaluation is important. Yet, the challenges faced in harmonization are enormous (Box 6) since donors insist on separate reporting arrangements.

2.7 A particular challenge for advocacy programs, well demonstrated by UNAIDS, is what constitutes a "program." Which outcomes should be attributed to program activities when partner commitments are vaguely defined, when these are not reflected in "the program," or when other partners undertake similar activities independently of each other – such as the establishment of national coordinating councils as part of World Bank lending conditions (also being promoted by UNAIDS), while GFATM is concurrently promoting country coordinating mechanisms.[23] In this regard, UNAIDS argues that it is necessary to highlight the importance for all partners – UN agencies, bilateral and multilateral financing institutions, donor aid agencies – to subscribe to and uphold the 'Three Ones' principles and the mutual accountability framework that these principles call for. A consistent message from developing countries in OED's overall review of global programs – in both health and in other sectors – is that while many programs are established to enhance consensus and improve donor harmonization, performance indicators focus largely on improving the behavior of developing countries. Far too little effort is made to build the performance of donors and international agency partners into monitoring and evaluation systems – a challenge well highlighted by UNAIDS and discussed in this and subsequent chapters (Box 6). An additional challenge in obtaining firm partner commitments – for example, from the Bank to increase its lending to HIV/AIDS – is convincing countries of the importance of

Box 6. UNAIDS Funded and Bank Administered Monitoring and Evaluation of HIV/AIDS Programs Faces the Challenge of Donor Coordination

UNAIDS formed the Global HIV/AIDS Monitoring and Evaluation Support Team (GAMET) at the World Bank to facilitate efforts to build country monitoring and evaluation capacities and coordinate technical support in this field because most countries lack the capacity for M & E. GAMET has made progress in its first year of operation, including establishment of an advisory board to structure and provide guidance across agencies. Also put in place are a country support team, a network of consultant experts (the majority from Africa) in monitoring-and-evaluation capacity building, and training in number of countries for the design and implementation of a new management development intervention to provide an accountability framework. Yet a recent Bank report on MDGs in health notes that each of the agencies participating in the GAMET initiative faces tensions between their internal requirements for monitoring and evaluation – and their desire to facilitate a coordinated approach at the country-level. The donors are under pressure to show impact in the near term, which can undercut even the best intentions to rely on country-based systems. The trade-off between donors spending staff time for work on coordinating approaches and building country capacity, and not on fulfilling fiduciary responsibilities to monitor their own programs, generates additional problems. Notwithstanding these obstacles, GAMET is a worthy experiment and it is worth watching the extent to which donors would be able to help develop a common approach for monitoring and evaluating national HIV/AIDS programs by putting nationals in the drivers' seat and establishing processes and capacities to help them be more accountable for their own destiny. The first step towards this goal has been taken by the agreement of the UNAIDS Cosponsors and donors on a single national monitoring and evaluation framework – one of the 'Three Ones' principles, although implementation has been a challenge.

Source: Development Committee 2003, Staff and country interviews.

[23] An Interim Review of the Multi-Country HIV/AIDS program in Africa, carried out jointly by the World Bank, DFID, UNAIDS and MAP International of the first phase of the Multi-Country HIV/AIDS Program for Africa (Benin, Burkina Faso, Ghana, Malawi, Mozambique and Sierra Leone) points out that there is no single M and E system, and different donors focus on different things.

these investments since country assistance strategies are increasingly demand-driven (see below and Chapter 4 for further discussion of this issue).

2.8 Notwithstanding these measurement and attribution challenges, the advocacy work of UNAIDS, RBM, and the Stop TB partnership has increased global awareness about these diseases, established global networks, and increased global financial resources devoted to prevention and treatment – more in the case of HIV/AIDS and more in some regions than others – as trends in the Bank health sector lending, discussed below, illustrate. Yet overall country-level implementation bottlenecks seem to be considerable, in no small measure due to weak links between global and country programs within donor organizations like the Bank, the lack of the "right" partners at the table as noted in OED's field visit to Ethiopia, and pervasive capacity constraints as noted in Botswana and even in India (Annex C).

2.9 Global programs emphasize that they bring specialized information and knowledge both to donors and recipient countries. The collective action challenge for each is to gain efficiency through coordination. The Bank and other partner agencies can help increase coordination among programs in their own agencies, between programs and their own country-level activities, at the country-level among programs in a similar area (such as TDR and Global Forum for Health Research, and UNAIDS, RBM, and Stop TB for communicable diseases), and among partner agencies *at* each of these levels. Such steps may reduce competition among programs for funding and for attention from donors and countries and reduce demands on the capacity of developing country health systems, while increasing their effectiveness. A consistent theme in the findings of evaluations summarized in Annex C is that country-level coordination, information sharing, and capacities are the areas which now need greater attention and focus.

2.10 Thanks in part to advocacy, including by global programs such as UNAIDS, Bank practices and processes show improvement in some of these areas. Similar performance indicators for the Bank and other partners and cosponsors, their routine monitoring and public disclosure of progress would provide incentives for donor harmonization while also informing stakeholders on factors, if any, inhibiting progress. This is an area in which the WHO-hosted High Level Meeting in Geneva in January 2004 and the efforts of programs such as UNAIDS may be bearing fruit, as in the agreement announced at the 2004 spring meetings of the World Bank and the IMF that the major OECD donors would better coordinate their efforts at the country-level to fight the AIDS epidemic. As advocated by UNAIDS for some time, the agreement provides for the consistent and coherent application by all partners of the 'Three Ones' principles. If implemented together, these would support the emergence of sustainable country-led responses through, among others, enhanced donor coordination and effective management and use of resources.

KNOWN OUTCOMES AND IMPACTS OF THE SIX PROGRAMS [24]

Health Research is Under-funded and Poorly Coordinated at the Global and Country-levels

2.11 Research and development of new products and technologies entail economies of scale and scope in production and cross-border spillovers of benefits. Research requires financial support on a consistent predictable basis.[25] Private investors do not expect a market for products developed based research on the diseases of the poor and cannot expect to recoup their profits. Yet, the World Development Report of 1993 which placed the concept of the DALY's (disability adjusted life year that essentially computes years lost to the "burden of disease") on the map in health policy analysis, attributed the spectacular improvements in health status of the poor, in part to new knowledge, because improvements occurred even in the face of modest income increases in many countries in the 20th century.[26] Hence there is broad consensus that research on the diseases of the poor is a classic public good and has been severely under-funded. Kramer has identified two kinds of funding to generate new knowledge: public funding for research through a variety of mechanisms, termed the "push" programs, and assuring market for the products of research once they are developed using a "pull" approach.[27] Both approaches are at work in global health initiatives.

2.12 **TDR's** evaluations identify three important program outcomes: contributing to the development of new and improved tools for the control of several tropical diseases; leveraging support from other bodies to develop candidate vaccines for malaria, leishmaniasis, and schistosomiasis; and strengthening research capacity in developing countries through collaborative research with scientists in developing and advanced countries.[28] TDR's research publications have an impressive record of citation in scientific journals, reflecting the high quality of its research. However, at US$ 47.4 million in 2003 its funding has stagnated in real terms over the past 10 years and has become more restricted, while the program's research mandate has expanded from 8 to 10 tropical diseases together with growing expectations among TDR's donors that it should achieve quicker results and impacts (see Annex E for details on TDR finances). In the face of the rapidly changing external environment, this oldest of global health programs has been facing fundamental issues about its scope, strategic objectives and role in global research, its funding and partnership strategies, the quality of the technical reviews, method of work, governance and management. TDR's case demonstrate that funding does not always follow performance. The issues TDR is facing are similar to those faced by the CGIAR and articulated in the OED's meta-evaluation of the CGIAR, although the CGIAR has been able to mobilize considerably greater donor funding over a substantially long period.

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24. The section draws heavily on Annex C, which provides more details of the programs' outcomes and impacts based upon their own evaluations.

25 The Commission on Macroeconomics and Health recommended global health research expenditures should reach US$3 billion annually. Some of those OED interviewed questioned the basis of the Commission's estimates while others considered the level unrealistic in the current climate.

26 Jamison, Dean. (2001).

27 Kremer, Michael. (2001).

28 OED was able to ascertain these collaborative arrangements between TDR and research scientists in the case of China, India, Malawi and Kenya.

2.13 **Global Forum's** budget at about US$3 million is small. Its activities include annual meetings that promote networking, development of analytical tools for multidisciplinary research, funding and incubating public-private research partnerships through the use of venture capital, and a communication strategy using a website. A significant share of Global Forum resources are devoted to the annual meetings (see Annex E for Global Forum finances). The meetings provide an opportunity for a cross-section of decision makers, policymakers, researchers, public health managers, NGOs, and the private sector from developed and developing countries to exchange experiences and scientific findings and network on health problems and priorities. Given the current evaluation tools, assessing the impact of networking is not easy and has not yet been done. An issue faced by the Global Forum is much like that faced by the Global Development Network (GDN), also reviewed as part of the OED review, namely the need to know the *relative* return to annual meetings to promote networking compared to the return to promoting public-private partnerships or developing analytical tools. GDN's external independent evaluation asked this allocative question of relative returns *among* GDN program activities and concluded that the opportunity cost of the time the secretariat spent on organizing annual meetings both in time and resources was perhaps too large relative to the benefit.[29] It recommended that networking meetings should perhaps be held every two or three years and resources should instead be reallocated from annual meetings to financing research by nationals of developing countries.

2.14 Global Forum participants from developing countries conveyed to OED that they benefited from networking and knowing about best practices and appreciated the importance of conducting research and the use of research tools. But the Global Forum was unable to either finance their research or to help in mobilizing funding to finance the research. Global Forum's new leadership proposes more focused annual meetings as per the recommendation of its external evaluation (for example, on MDG goals in 2004), prioritizing and working closely with the World Summit on Health Research. The Global Forum is now improving its priority setting process, its communication strategy, reassessing its engagement with developing countries, and tracking the impacts of these activities on its stated goals, e.g., how many developing countries use its websites, or in how many countries the policy analytical tools on resource allocations have been adopted and applied with what results.

2.15 A sentiment shared by the individuals OED surveyed was that the Global Forum's objective to help close the 10-90 gap was too ambitious relative to its resources and staff and the other activities it performed. They wondered if, with the current structure, functions and funding levels, the Global Forum could make a major dent on mobilizing resources or achieving a significant impact. A more focused, goal-oriented approach, using the collective convening power of the principal partnering international organizations and actors in health research is needed to mobilize significant levels of research funding at the global and the country-levels. The Forum's focus on MDGs seems to be a good start.

Investments in Health Research

2.16 Although TDR's research funding has not increased much, and although global health research expenditures are nowhere near the US$3 billion annually recommended by the Commission on Macroeconomics and Health, recent evidence (incomplete at the time of writing) assembled by the Global Forum, suggests that health research expenditures have

[29] GDN did not accept the recommendations of the external review about holding less frequent annual meetings.

increased since the early 1990s. Some of this increase is directed at the research on communicable diseases in poorer countries and the poorer populations. According to the Global Forum, overall financing for health research may have increased in real terms since 1990 from US$30 billion to slightly over US$100 billion in 2001, with a reportedly stable share of the public sector, of slightly less than half (44 percent) in the total research expenditures in the overall increase.[30] High-income countries conduct nearly 95 percent of this research with the US share in the estimated public expenditures being similar to that of the public sector share in the total about 44 percent or about US$27.5 billion, US$24 billion annually from pharmaceutical companies, and US$1 billion from the Gates Foundation, some of which finances public private partnerships. These public-private partnerships were estimated by the Global Forum to amount to about US$200 million annually.[31] But a report on the major consultation conducted by the Initiative on Public-Private Partnerships for Health issued at the time of issuance of this report indicates that roughly US$2 billion have been pledged to new not-for-profit ventures in the last 5 years to research on diseases of the poor.[32] This report on the consultation stresses that product development requires a long-term commitment, and that drug development can take over ten years and hundreds of millions of dollars. Even more resources are needed for vaccine development.[33] Initial estimates of the additional financing required for health research through 2007 for these drugs and vaccines is estimated to exceed US$ 1.0 billion. The consultation concluded that current donors may be at the limit of their funding, given their other responsibilities and priorities, and many of the traditional sources of support for developing country health improvement (such as other bilateral aid agencies, and domestic research agencies of industrialized countries) have not yet been willing to support these new efforts.

2.17 According to the Global Forum research, investments by middle-income developing countries, such as Brazil and Cuba, are coming close to reaching 2 percent of the health expenditures. India has undertaken to do the same.[34] It is difficult to determine how much of the research of high-income countries is of relevance to the poor. A small portion of the US research, e.g. the US$ 65 million from the Fogarty Foundation to NIH, is of direct benefit to developing countries, although other US research also has positive spillovers. The remaining research expenditures include ODA to developing countries' health sector development of US$ 3.66 billion annually, an unknown portion of this is said to be allocated to research for the benefit to developing countries. New sources of financing are being explored by

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[30] Estimates of global health research expenditures should be interpreted with caution. The Global Forum has revised its 1998 estimate of US$73.5 billion to US$84.4 billion based on updated methodology and some "new found" money.

[31] Communication with Global Forum.

[32] Widdus, Roy, and White, Katherine. (2004).

[33] The report indicates that, as more and more candidate products enter the final stages of drug development, the expensive phases of clinical trials, including large Phase III efficacy studies, the guaranteed availability of sufficient funding becomes ever more critical. Thus, long-term assurance of sufficient funding is essential to ensure that products will result from these initiatives.

[34] Public-private partnerships include, among others, the Medicines for Malaria Venture (MMV to select and finance most promising research on anti-malarial medicines on a competitive basis with the budget of US$ 18 million in 2003. The Drugs for Neglected Diseases (DNDi) established with the budget of US$ 30 million from MSF, the International Partnership for Microbicides (IPM) with funding of US$ 100 million from five European countries to undertake research to prevent HIV transmission, Canada's CDNUS$100 million for the WHO program to treat 3 million people living with AIDS by 2005, and CDNUS$70 million for the Global Fund for AIDS, Tuberculosis, and Malaria.

developing countries. Brazil and Colombia have reportedly imposed taxes on tobacco and alcohol to finance health research.

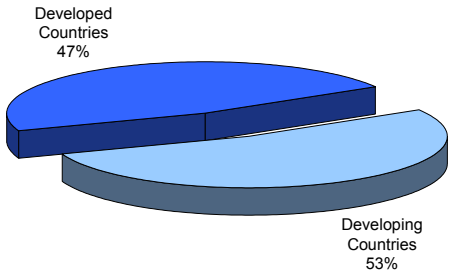
2.18 Proposals are also under consideration for establishing a collaborative research network between advanced industrial and developing countries that involve large and middle-income countries such as Brazil, Mexico, India and China, i.e., countries with national funds, the research institutions and the necessary human capital to conduct research.[35] Proponents of this network model suggest that international organizations such as the World Bank and WHO could assist by investing in health research in developing countries. To ensure scientific quality, they propose that the participating Councils of Medical Research should collaboratively agree on research priorities. They prefer a merit-based, peer reviewed system for funding research rather than the CGIAR model which they consider to be the donor-driven (as opposed to science-driven), or the one recommended by the Commission on Macroeconomics and Health.

2.19 Who and what should determine research priorities and how scientific probabilities of success, and science quality should be balanced with societal needs and preferences in allocating resources have been challenges for research in many fields, and global health research is no exception. Even at the national level setting research priorities based on the burden of disease and research gaps relative to the needs of the politically more powerful urban populations remains a challenge. While the Global Forum has developed a methodology for research priority-setting by national health research systems, it is unclear in how many countries it is being used in priority-setting and making allocative decisions. Priorities of national councils of medical research, much like public health expenditures in developing countries, tend to be driven by the disease burden of the urban and elite populations and to focus on medical rather than social science research. Currently, there is no process of priority-setting for health research for development at the global level.

[35] Keusch, Gerald T. (2003).

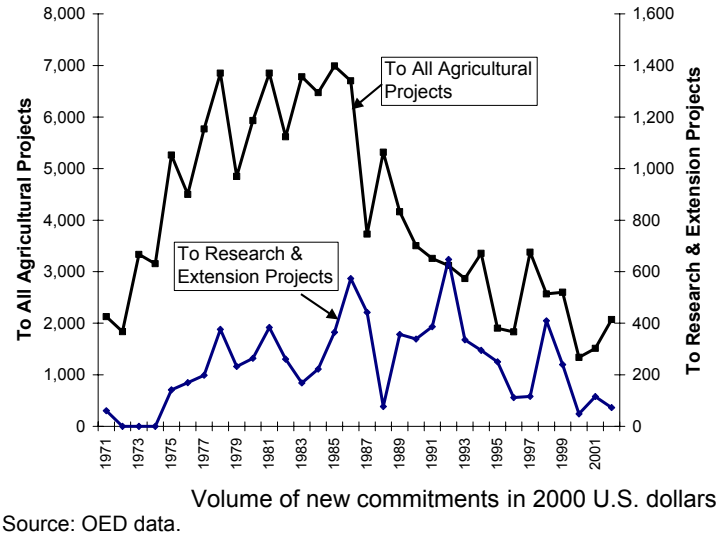
2.20 Notwithstanding this considerable impact of advocacy and the promise of increased effective demand for medicines prompted by the increased ODA, research experts have stressed three areas needing attention. As outlined above, the first is the large resource needs for investment in product development once research investments begin to deliver promising results, second more investment in surveillance, and third epidemiological and operations research. Insufficient investment in the last two areas requiring the public sector to fund, if not carry out research—which could easily be carried out by research institutions and non-governmental organizations- is in part because neither developing country governments nor donors yet appreciate the full importance of this investment and the need for its funding on long-term predictable basis.[36] Thus, the balance of public sector health research expenditures between developed and developing countries is still more lop-sided than in agriculture. In agriculture, developing countries' share had nearly reached half (Figure 3), in part due to the substantial increase in donor investments in national agricultural research in developing countries through self standing agricultural research projects. Such investments have not materialized in the case of health research even in large countries.[37] Even in the case of agriculture donor investments have peaked (Figure 4).

Figure 3. Global Public Agriculture Research Expenditures, 1995: $21.7 Billion



Source: Pardey and Beintema 2001

Figure 4. Bank Lending to Agriculture Declined Dramatically in the 1990s



Source: OED data.

[36] In field interviews OED conducted, health sector scientists in developing countries indicated that there is more funding to conduct research from international agencies than meets the eye, but it is almost always short-term, unpredictable and "to answer the questions they want us to answer, not the ones which we think need answering to improve domestic policy and implementation." See Annex C for more evidence on this issue.

[37] Jamison explained the lack of success in health relative to agriculture as being a result of the "continued, often genuinely bitter fights between the research community and the control community" in health, leading to a certain level of resistance and disarray unlike in the agricultural community that "has gotten behind research programs more effectively." See Jamison, Dean. (2001).

2.21 Who should finance surveillance, epidemiological, operational, and data collection research on the scale needed on a sustainable basis remains unresolved. Although WHO as the leading technical agency has advocated for increased surveillance funding, money has not been forthcoming on the scale needed. Surveillance can be argued to be both a global and a national public good. Some financing for these components in Bank-funded health projects is typically included in overall health sector investments. Currently, estimates of Bank funding for these components are not readily available. OED interviews of Bank staff suggest that such funding is limited. To provide the necessary technical and financial resources vital to developing country health systems, such that developing countries can strengthen their own health research and surveillance capacity, the Bank and WHO need to work together with other partners, as did the World Bank and private foundations and bilateral donors with FAO in the case of agricultural research.

Global Investments by GAVI/Vaccine Fund Are Offering Important Learning for Scaling Up and Sustaining Results to Achieve MDG Targets

2.22 GAVI has achieved success in all three areas of its activity: (i) immunization services support (to strengthen countries' delivery capacity) in the form of non-targeted cash contributions, (ii) new and under-used vaccines (hepB, Hib and yellow fever), and (iii) support for injection safety. The GAVI immunization campaign is run like a business model. Although it had no independent external evaluations by the time this report was completed, the GAVI Board commissions its own assessments in various aspects of its work to learn lessons and provide input into its strategic planning and business planning. A key recurring theme from fieldwork interviews which an external evaluation of GAVI identified is "broad satisfaction with GAVI's achievements and a strong conviction that GAVI does add value, even if the work to define that value is not yet complete." GAVI has brought a level of coordination that never existed before. And a considerable level of resources. For an entity as young as it is, it is very functional" according to the external evaluation. These observations are supported by OED's knowledge of GAVI programs in China, Kenya, Malawi, and India with some caveats highlighted below.

2.23 As of March 2004, the **Global Alliance for Vaccines and Immunization**, supported by the Vaccine Fund and other donors, had committed grant funding of over US$1 billion to 69 countries for immunization services covering six childhood diseases (diphtheria, polio, tuberculosis, pertussis, measles, and tetanus). GAVI reports it has vaccinated 10.5 million children against Hepatitis-B, 3.2 million against Haemophilus influenza type b (Hib), and 600,000 against yellow fever. It has helped governments improve planning, implementing, and monitoring capacity to deliver immunization services, and is promoting aid coordination.[38]

2.24 GAVI has relied heavily on multi-valent vaccines on grounds that (1) these new vaccines would reduce demand on the health delivery systems of developing countries made by multiple (single) vaccinations, (2) stimulate demand for new and improved vaccines in developing countries, and (3) prod pharmaceutical companies to increase vaccine supply. But developing and producing vaccines has needed longer lead time, the supply of new vaccines

[38] GAVI estimates that with its support, countries have cumulatively vaccinated 35.5 million children against hepatitis B; 6 million children against Hib; 2.7 million children against yellow fever; and 8 million more children have access to basic vaccines.

could not always be timely or reliable, and despite considerable reduction in the prices of these patented multivalent vaccines, the prices remain several times those of traditional vaccines. All but a few middle income countries, particularly the small poor countries, lack the necessary resources to procure and deliver multivalent vaccines, beyond the period of GAVI's financial support. This led GAVI to introduce systematic financial sustainability analysis in several countries. GAVI's support for the immunization program would come to an end in 2006, and, countries in turn, would not have the resources to continue the program without external support.

2.25 Some of those familiar with the history of the immunization program indicated to the OED team that in the early stages some argued that GAVI should support EPI's low-cost, single vaccine approach to expand and maintain coverage, as well as exploring the introduction of new vaccines. But, GAVI was mainly interested in the new vaccines. Its large funding resulted in a 'partnership of convenience, with the players coming to the table because of the availability of significant sums of money and not with a view to expand coverage sustainably. The fiscal difficulty of replicating the multivalent vaccine program in several states without first expanding the traditional, lower cost immunization program was one reason given to OED by those familiar with the child immunization program in India as to why India was reluctant to agree to the GAVI program at the beginning. Learning from its experience, GAVI is now operating in the state of Andhra Pradesh in India. With a sharp, focused effort in a single state, GAVI states it is the first time that the hepatitis B vaccine was added to the routine immunization schedule. The financial sustainability of the project was dealt with at the outset as it was designed to have a graduated increase in the share of contributions of the Andhra Pradesh government over time. By 2002, the government had taken on board 20 percent of total costs and, by 2003, 40 percent of the costs. The government was to take on 100 percent of the costs through its own resources by 2005.

2.26 GAVI's performance based system also faced challenges at early stages, exposing GAVI to the development reality on the ground[39]. Audits conducted in 2001 and 2002 revealed that most countries had dilapidated information systems or none at all. But then GAVI systematically began to tackle the issue of performance based monitoring with the establishments of baselines and changes in immunization rates. GAVI delayed implementation of the performance-based system issuing the first reward payments in 2003.[40] To ensure a robust basis for calculating the rewards, countries began implementing

[39] The World Bank's experience in China and India had demonstrated that the more developed regions of the countries with better institutions and infrastructure had higher coverage. When campaigns were initiated to raise immunization rates in poorer, difficult to reach regions, over-reporting on immunization became a problem in both countries. Sometimes, immunization campaigns diverted attention from other activities.

[40] According to GAVI, countries overwhelmingly chose to adopt the combination vaccines (one injection combining several antigens such as DTP-hepB or DTP-hepB-Hib). They reduce the demand on the health delivery systems by reducing the number of injections given. However, some combination vaccines were in short supply and with a lead time of several years it will take additional time before the supply can correspond with the need, before competition ensures that prices move down to maturity levels. The financial sustainability planning that is part of the country support process has revealed that many poor countries will find it difficult to ensure the continued financing of some of these vaccines unless prices decline. Work is underway to ensure the sustainability of new vaccines on a wider scale. The immunization services support is provided as non-targeted cash to improve the health and immunization system. After the third year of investment support these contributions are based on performance, i.e. on additional children being reached with immunizations. The first nine countries received their first performance rewards at the end of 2003.

immunization data quality audits with GAVI's help to provide a diagnosis of the reporting system. The audits have revealed deficiencies in the reporting systems in many countries, and the alterative baselines developed under GAVI, and the more traditional one used by the governments have also raised issues of assessing progress which are being tackled by GAVI since financial transfers for awards depend on agreement on performance.

2.27 Learning from a combination of its own experience, board commissioned studies and experts in the field GAVI considerably changed its strategy. Over time working more actively with partners such as the World Bank, GAVI has been addressing, among other things, health system financing capacity and reform issues in developing countries while also undertaking long-range planning for the supply of and demand for vaccines, their financial sustainability, and competitive procurement of vaccines from multiple suppliers. GAVI's business-like approach to improving the management of the delivery system have, among other things, included cold chains, the use of auto-disposable syringes, and their disposal, data quality audits, the Hep B vaccine, financial sustainability analysis, the introduction of new and improved vaccines, and an effort to stimulate the market for vaccines.

2.28 Some stakeholders OED consulted stressed that GAVI built on decades of earlier infrastructure and strategies based on collaboration among WHO and UNICEF, the US CDC, etc., in particular by the Expanded Programme on Immunization and then the Universal Childhood Immunization effort. With the considerable funding which GAVI was able to bring, it was able to energize donors and implement Children's Vaccine Initiative which had been largely mapped out (1990-1999), but which lacked funding on a scale GAVI brought. With the funding came the motivation among the partners to collaborate. But in its initial enthusiasm GAVI was slow to learn from the operational experience of its partners.[41]

2.29 How GAVI's immunization program will fair when GAVI phases out in 2006 remains to be seen. New *grant financing* has not been easy for GAVI to mobilize, notwithstanding the contribution of US$750 million by the Bill and Melinda Gates Foundation and the initial expectation that donors would match it, the high visibility child immunization campaign, and the well recognized and publicized benefits of immunization to the children and the delivery systems of developing countries which GAVI has effectively undertaken. IFFIm holds the best promise to continue the program. The scale of resources raised and the choice of vaccines would determine the breadth of the immunization services. Interesting questions are: Will GAVI's business approach be financially sustainable without external aid on a long-term assured basis? Will it create effective demand for vaccines in developing countries? Will it stimulate predictable supply of new and improved vaccines on a large enough scale that developing countries can afford them and still meet MDG targets? The IFF proposal is meant to address these questions.

2.30 The GAVI approach would benefit from an objective, independent assessment of its potential to help the development community on a much larger scale and on a sustainable basis. It would be particularly useful if the experience of several other GAVI partners that are also engaged in immunization was reviewed at the same time to learn collective lessons for

[41] GAVI's reported initial emphasis on the small, least developed countries, mostly in Africa, and the lack of any involvement of the Bank's staff experience in operations from East or South Asia where the Bank had financed the most immunization programs may also have contributed to this phenomenon. HDN staff indicate that interaction between GAVI and Bank operations has since increased considerably.

workable, sustainable approaches, e.g., to better understand the demand for and the supply of existing mechanisms, e.g. World Bank loans, IDA and grant funds for immunization, the strengths GAVI has brought to bear in addition to finances, among other issues.

Global Programs in Communicable Diseases Underscore That the Weakest Links Are at the Country-level

2.31 **UNAIDS's** mission is "to lead, strengthen and support an expanded response aimed at preventing the transmission of HIV, providing care and support and reducing the vulnerability of individuals and communities to HIV/AIDS, and alleviating the impact of the epidemic."[42] The external evaluation of UNAIDS carried out in 2002 concluded that there had been clear progress with developing national strategic plans – 19 African countries had set up national HIV/AIDS councils or commissions at senior levels of government and across the region, and 94 countries, including 40 in Africa, had completed national strategic AIDS plans, many with monitorable indicators, multi-sectoral responses and in consultation with persons living with HIV/AIDS (PLWHA), civil society, the private sector and the donor community,"[43] improved donor coordination and cooperation, and established plans for capacity development of national structures, especially in the health system. But research to evaluate the relevance and effectiveness of HIV/AIDS interventions had been limited, including understanding of the prevention and control efforts to stimulate behavior change and develop effective implementation. As the external evaluation observed, the challenge for UNAIDS is to find a new balance between its advocacy role and its functions in information provision, capacity building and technical support, particularly at the country-level.

2.32 UNAIDS has made considerable progress in addressing each of these areas, for instance through the provision of funding to nationals for training, policy planning, technical support and institutional development by working with the ten cosponsors, IFAD, the regional Banks, civil society and the private sector.

2.33 In the course of the OED review, UNAIDS raised by far the most debate on the issue of balancing advocacy and independent assessment of best practice material particularly at the country-level, based on peer-reviewed quality analysis, as well as the balance of effort on prevention and treatment. Demands on UNAIDS to demonstrate more results on the ground have intensified, as a result of a combination of factors: continuing new HIV-positive cases, the huge depletion of human and institutional capacity in severely affected countries, the evidence of increased feminization of the epidemic, and the reluctance of several governments including some large countries in Asia to face the challenge. UNAIDS is expected to provide more effective messages to policy makers and more operational tools to countries to fight the epidemic.[44] Clearly, country-level action matters most for the 38 million people who are HIV-positive, less than 1 million of whom are reported to have access to anti-retroviral drugs (ARVs). While by no means a silver bullet, the agreement on generics offers the opportunity for numerous poor countries to address issues of treatment and care provided all the major hurdles on increased supply of drugs, with the necessary quality assurance procedures are in place, and provided more external assistance is available in support of the

42. UNAIDS official program website.

43. UNAIDS/PCB 2002.

44. See the report of Dr. Nafis Sadik to the UNAIDS Program Coordinating Board meeting in June 2003.

long-term recurrent implications of expanding public access to treatment. The agreement can also set an example for global policy reforms and agreements of a similar nature in other areas affecting the poor, e.g. vaccines and other drugs, and beyond health, agricultural subsidies and trade barriers. However, a number of questions have been posed to UNAIDS by some of its stakeholders and were well summarized in the proceedings of the PCB meeting in June 2003:

- How to deliver tools to political leaders to address the crucial leadership gap in developing countries to achieve behavioral changes needed to prevent further spread of the disease and turn the tide of the growing disease burden?
- How to reduce the stigma and increase the willingness and means of households to pursue testing or treatment which currently seems to constrain the effective demand for services and drugs?
- Even with the support of private vendors, community organizations and NGOs, how to better assess needs and improve delivery capacity given the weak, under-funded, and overstretched health delivery systems in most countries?
- How to address the low financing levels (international and domestic), even considering increased international aid levels and reduced drug prices?
- How to address the wide information gaps on a variety of fronts, including monitoring and evaluation?
- Overall, how to deal with the different priorities of developing and developed country governments to the containment of HIV/AIDS and communicable diseases relative to the formers' other pressing development priorities in health and other sectors?

2.34 A vigorous debate has ensued within and about UNAIDS as to how best it should focus– going beyond its highly effective advocacy role at the global level – to help achieve more rapid *country-level* strategies and outcomes, a debate stimulated in part by UNAIDS' evaluation, the new financing mechanisms such as GFATM, WHO's 3 by 5 Initiative and the new agreements on generic drugs. These issues are discussed further in the section on governance.

2.35 The benefits of malaria control in improved labor productivity, well-being, and lives saved have been demonstrated to be substantial, especially for pregnant women and children. **RBM's** strategy is the promotion of insecticide-treated nets (ITNs), Intermittent Preventive Treatment (IPT) of pregnant women to reduce low birth weight in the newborn and maternal anemia, and combination therapy due to widespread resistance to commonly used drugs like chloroquine. The independent external evaluation of RBM was perhaps one of the strongest in its coverage of issues in identifying the importance of the role of partners. It contrasted the initial ambitious program goals of reducing the malaria burden by 50 percent by 2010 with the absence of clear, monitorable, realistic objectives; lack of clarity in the responsibilities of the individual partners; and slow progress in achieving country-level buy in, insufficient political mobilization, inconsistent quality of technical advice and the lack of country-by-country *operational* strategies to achieve the goals. It analyzed the activities of a number of RBM partners, including particularly that of the Bank in fostering a more proactive malaria control program and found partner responses wanting. It stressed the importance for RBM of developing concrete focused operational plans by working with them.

2.36 The RBM program has been restructured substantially on the basis of these recommendations. Nevertheless, weaknesses remain and they are outlined in Annex C. RBM

now has a clearer strategy, a focus on selected countries and has put in place a stronger governance structure, with clearer roles, responsibilities, and accountabilities between the board, secretariat, working groups, regions, with more focused participation of "beneficiary countries" on its governance. The roles of WHO and those of the partnership are being clarified, and a Malaria Medicines and Supplies Service (MMSS) is being established. Nevertheless, it remains to be seen if designers of the restructured RBM recognize the challenges in correcting the weaknesses identified by the evaluation. For instance, at the country-level, there is more agreement on what *strategy* to follow on malaria than on how to apply the *instruments* RBM promotes in practice on the ground. ITNs require subsidies and effective targeting of supplies to the poor; IPT requires a strong, well-organized public sector health delivery system and an effective community-level mechanisms for delivery. Combination therapy to address drug resistance, which countries have adopted at the urging of WHO costs US$1 to US$3 per episode – many times the cost of locally available drugs. Diagnostic tests are beyond the capacity of delivery systems and means of most. Moreover, like UNAIDS, RBM must rely on donor partners to operationalize solutions in small, malaria-endemic, low-income countries. OED noted that information reported in many of the 80 World Bank Project Implementation Completion Reports is largely on inputs, particularly on the distribution of bed nets and less on outputs, outcomes and impacts. Assessing where malaria is being effectively controlled, why and what its transferable lessons for other countries are seems to warrant more and better interdisciplinary, multisectoral, on-the-ground empirical research than seems currently supported to promote effective actionable control and eradication strategies.

2.37 The external evaluation of **The Stop TB Partnership** observed that in only three years the program has built and is sustaining a broad network of partners; has heightened political support; and marshaled widespread commitment to a detailed Global Plan to the Stop TB Partnership. The program has also supported longer-term work on diagnostics, drugs, and vaccines, operationalized the Green Light Committee for second-line TB drugs and made operational a complex Global Drug Facility covering grant-making, procurement, and partner mobilization for technical assistance for first-line drugs.

2.38 The evaluation concluded that the Stop TB Partnership adds value through large health benefits compared to the US$5 million annual cost of the partnership. The evaluation reported that the partners are generally highly supportive given the partnership's achievements in a relatively short period of three years. The US$15.6 million Global Drug Facility (GDF) in 2003 was not included in the evaluation because a separate evaluation had been conducted earlier by McKinsey & Co. The cost of DOTS for six months may range from as low as US$20 up to US$400 for multi-drug therapy treatment – GDF improves access to drugs at prices reduced by 20 to 30 percent, and has provided 1.9 million patient treatments to date. Prospects of securing long-term financing to sustain the GDF – US$ 20-30 million per year starting in 2004 – are uncertain and despite obtaining support for GFATM, the evaluation observed that notwithstanding its considerable achievements more will need to be done in actual implementation in affected countries, including those not considered high burden countries, if the targets are to be met on time. A report outlining progress, identifying constraints and making more than 70 recommendations was to be provided to the Coordinating Board at its New Delhi meeting. Subject to these caveats, if, among other things, the GDF concept is adequately funded, the Stop TB Partnership may hold a promise of positive impacts. Only 16 countries – and only 2 of the 20 high-burden

countries – are reported to have reached the World Health Assembly targets. As in the case of Roll Back Malaria, the evaluation of the Stop TB Partnership too considered its targets too ambitious compared to ground realities of competition for financing, the need for better financial planning and more country-based business-oriented strategies. The realism of the targets will depend largely on the availability of funding since the Stop TB Partnership has an effective approach to address the problem. The ability of poor households to afford the treatment without a subsidy is also an issue (see Chapter 4 for Bank's operational experience in China and India).

2.39 The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) provides funding for TB and malaria control. But changes in donor funding priorities seem to have intensified competition for limited resources, and increased uncertainty over funding flows to other global programs. In addition, the Global Fund also faces funding uncertainties. GFATM was at the formative stage when the OED evaluation got under way and GFATM resources had not yet started flowing. In OED's field visits to Botswana officials noted considerable competition for time and attention in the preparation of GFATM proposals. Even in a large country such as India, the differing operational procedures of the Bank and other donor-funded AIDS program activities from those of GFATM were posing a challenge. Consultation between the Bank's field offices, local stakeholders, and GFATM appears to be increasing but seems spotty.

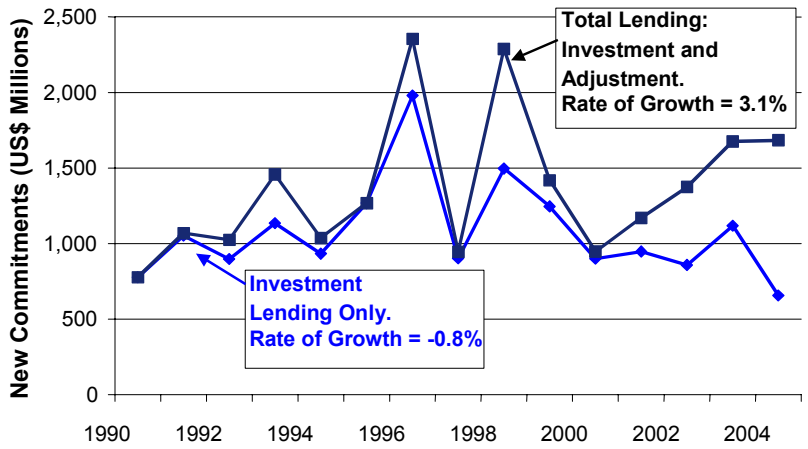
2.40 While the situation at the country-level remains ambiguous GFATM has become a significant player at the global level. It is teaming up with UNAIDS, the Clinton Foundation, World Bank, UNICEF and WHO in a generic AIDS drugs financing partnerships.

2.41 To conclude, the multiplicity of global initiatives beyond the six reviewed in this report has increased total resources and speeded resource commitments in addition to introducing an element of healthy competition to traditional organizations and influencing their operations. But as a World Bank paper titled "Progress Report And Critical Next Steps in Scaling Up: Education for All, Health, HIV/AIDS, Water and Sanitation" in April 2003 pointed out, "donors tend to concentrate on the implementation of narrow systems which enable them to monitor results on a project-by-project rather than national or programmatic level, thereby weakening incentives for using results measures in decision making." From the viewpoint of developing countries, the multiplicity of initiatives stress the importance of increased coordination among programs to minimize the high cost of accessing resources imposed on developing countries, which have to develop the knowledge and internal capacity needed to adhere to the rules and regulations of the myriad global initiatives.

2.42 The ultimate impacts of at least some of the six programs will likely be determined in part by the practical results of the recent global agreements on policy issues such as intellectual property rights and investment and trade rules concerning the production and distribution of both generics and patented medicines at affordable prices. Those factors, in turn, will critically influence the political will, investment choices, and program outcomes in developing countries. At the country-level, Stop TB Partnership, UNAIDS, GAVI, and RBM face many common issues: constrained health budgets, reliable and timely availability of drugs, and weak institutional capacity for surveillance, epidemiological research, and treatment. UNAIDS disseminates information on best practices. But to be useful to the users to know what is working and why and its lessons for replication or scaling up, the information needs to be scientifically validated by peer-reviews by analysts, going beyond reporting based on self assessment by programs and their various donor partners. It also

needs to be accessible in languages users can understand. The programs need to coordinate their efforts to help resolve certain common issues across programs, such as the establishment of base lines and measurements of progress through systematic monitoring and evaluation, management of logistics, drug supply and delivery systems, and pricing and distribution policies, including the appropriate roles of the public and private sectors and community organizations. Evaluations and experience to date suggests that the biggest challenge, however, remains the application and adaptation of the principles that underpin best practices to a wide range of situations and contexts.

Figure 5. World Bank Health Sector Lending Fluctuated Around US$1.4 Billion until 2004, but is Increasing



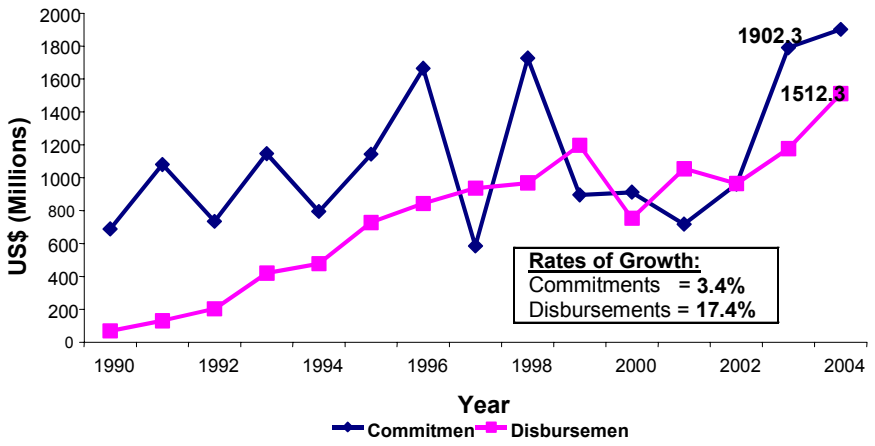
IMPACTS OF GLOBAL HEALTH PROGRAMS ON THE BANK

2.43 Impacts on the ground in developing countries are generally a joint product of both global and country activities, and each global health program considers advocacy to increase funding as an important aspect of its value added. Therefore, the impacts of the global health programs on Bank lending and other donor support to developing countries are an important issue. This section focuses only on the Bank. While UNAIDS has attempted such an exercise for all donors related to HIV/AIDS and the Stop TB Partnership for TB, OED was not able to assemble such information systematically for all donors for all programs.

2.44 Overall Bank lending to the health sector (including investment and adjustment lending) has fluctuated around US$ 1.4 billion a year in nominal terms since 1990 (Figure 5), putting strong pressure on health system capacities, as lending to communicable diseases (discussed below) has increased rapidly (Figure 7). The sharp peaks in 1996 and 1998 are the result of a few large loans to large countries in those years. However, regional patterns are more varied. New commitments to Africa increased by 7.8 percent a year between 1990 and 2004, and to Latin America and the Caribbean by 7.5 percent a year, while new commitments to the other four regions have stagnated or declined. HDN staff observe that past trends are no indication of future patterns. For example, after considerable increase in lending to HIV/AIDS in Africa, capacity constraints may be binding whereas lending may take off in other regions. In the case of Africa, the increase has been largely through investment lending and largely due to commitments to HIV/AIDS projects (Annex D). In the case of Latin America, this has been largely due to a few major health sector adjustment loans in the recent

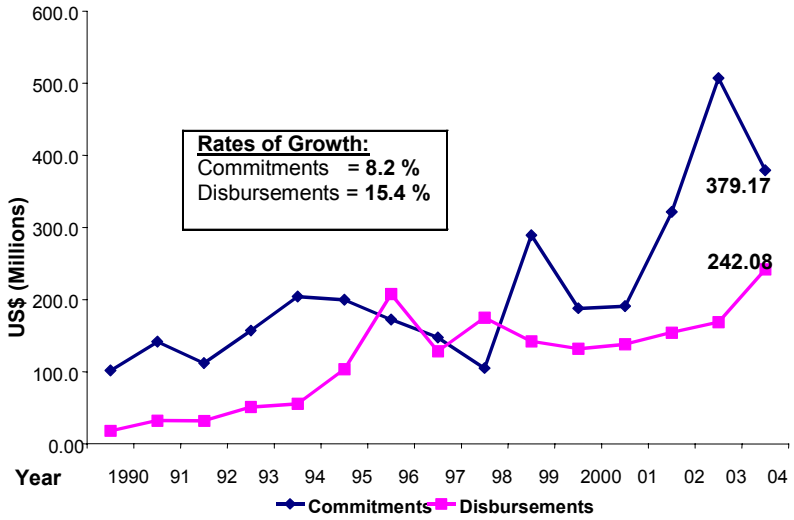
period. Overall, health sector disbursements have increased steadily an average annual rate of 17.4 percent since 1990 (Figure 6).[45]

Figure 6. Annual Disbursements for the Health Sector Are Growing More Rapidly Than New Commitments



2.45 The impact of global program advocacy seems to have been more striking on the thematic components of health lending than on overall lending. New commitments to HIV/AIDS and other communicable diseases have grown by an average of 8.18 percent a year since 1990 (Figure 7).[46] Lending to HIV/AIDS alone (Annex D, Table D.3) grew by an average of 17.9 percent annually, mostly due to increased commitments to multi-country HIV/AIDS programs (MAPS) in Africa. Lending to child health increased by 2.8 percent a year (mostly in East Asia and the Pacific, and South Asia Regions). Lending to improve health system performance – still the largest component of health sector lending – fluctuated around US$500 million a year. Lending to population and reproductive health, and to nutrition and food security – which could, to some extent, help in combating communicable diseases – actually declined. This changing composition of Bank lending from prevention to treatment in the face of stretched health delivery systems raises a question as to whether outcomes

Figure 7. New Commitments to HIV/AIDS and Other Communicable Diseases Have Grown Rapidly



[45] The same trend, calculated between 1993 and 2004, yields an annual growth rate of only 8.7 percent.

[46] These estimates are based on a classification of World Bank lending activities as reported by the Bank's Business Warehouse. A more detailed assessment of the amounts committed and disbursed for HIV/AIDS is underway in OED's evaluation of the Bank's assistance to HIV/AIDS. The data presented here may diverge from the data presented in that report due to differences in definitions and periods covered.

achieved in the areas of communicable diseases are sustainable unless the Bank, other major donors, and governments make more investments in health system support to increase the absorptive capacity of developing countries to utilize the new resources to fight communicable diseases rapidly and effectively. OED's evaluation of the health sector had also stressed the critical importance of investing in health system performance. This may explain in part why disbursements to HIV/AIDS and other communicable diseases have yet to increase as dramatically as commitments (Figure 7).[47]

2.46 An additional impact of global advocacy has been to address HIV/AIDS as a multisectoral issue, rather than as a health sector issue alone. Here again, the impact on the Bank, while considerable, has mostly taken place in the Africa region and its effectiveness has been questioned by a number of those OED interviewed. The Implementation Completion Reports of "component projects" supports these concerns, suggesting that inclusion of HIV/AIDS components in non-health projects (e.g. transportation projects to increase information to truck drivers) does not necessarily ensure their effectiveness unless it is associated with well informed design, implementation and oversight, and it is accompanied by strong technical inputs which only the public delivery systems involving the ministries of health can provide. The review of MAPS referred to earlier, and the Treatment Acceleration Program (TAP) in Burkina Faso, Ghana and Mozambique, being designed at the time of completion of this report, acknowledge that multi-sectoral approaches have frequently dis-empowered the ministries of health.[48] With the exception of large countries such as China and India, lending to TB and malaria is done as components of larger health sector projects rather than as self-standing projects and both appear to have been less effective than in the large countries with health system capacities.

2.47 Overall, however, disease-specific activities cannot be supported over the long run without strengthening on-the-ground support for developing systems of surveillance, testing, diagnosis and prevention. This calls for emphasis on prevention to contain future spread as well as on treatment and care, capacity for delivering, targeting, monitoring and fine-tuning access to information and treatment, and evaluating results. HIV/AIDS poses qualitatively different challenges in this regard in terms of long-term commitment to public delivery of treatment than do other communicable diseases from the reasons highlighted in Box 4. The delivery of treatment being financed by donors following reduced prices and new breakthrough global agreements on the supply of ARV drugs is facing the challenge of the weak delivery systems, long-term financial sustainability and increased aid dependency.

2.48 Beyond the fast growth in lending volumes to HIV/AIDS and communicable diseases more generally, advocacy has enhanced World Bank processes and actions (however, perhaps relatively more in Africa), including increased policy dialogue, budgetary support, new lending instruments in the form of MAPS, sector and programmatic lending approaches, retrofitting of Bank projects in transport and other sectors to provide multisectoral responses, more responsive and rapid procurement and disbursement procedures, for HIV/AIDS and the

47. It could also be the effect of loan maturation. The portfolio of commitments to HIV/AIDS is more recent.

48. The Regional HIV/AIDS treatment acceleration program also provides US$4.6 million to WHO to build country capacity for treatment related issues in the countries, the first such support out of World Bank grants to countries.

Global Drug Facility, among others.[49] The collectivity of these activities have contributed to UNAIDS' more direct efforts to reduce the "denial factor" in some developing countries, particularly successful in Uganda, Senegal, Malawi, Kenya, Botswana, and more recently in South Africa. Dialogue among co-sponsors and partners has increased at all levels in Africa. These are major achievements in a short time span. But dialogue is not always accompanied by changes in donor practices, as indicated in Box 6. The understandable short-term approach of donors does not always effectively complement the medium to long-term needs of development. This tension is all the more evident given the impact AIDS has on the capacity of country systems. Clearly more is needed particularly in the area of policy analysis, fiscal sustainability of the advice being given, greater emphasis on prevention and spread of new infections. The HIV/AIDS increase in lending commitments has been the most significant in Africa where the disease has reached crisis proportions, although audits suggest that Bank projects in countries such as Brazil, Thailand, India and Cambodia have perhaps made more important and more lasting contributions. However, where HIV/AIDS is still less visible, so is progress in Bank lending in support of preventing the spread.

2.49 As to economic and sector work, the OED global team noted an important sector report on India which through modeling explored the fiscal and financial feasibility of the ARV treatment under three different scenarios. The report concluded that cost-effectiveness is achieved only if ARV treatment is associated with high quality medical care, early treatment through widespread testing and counseling, strengthened prevention efforts and avoidance of risky sexual behavior.[50] More such concrete empirically-based analysis is needed, even if it raises controversial issues, to advance an informed debate and improve and fine-tune country-level strategies.

2.50 Although the RBM program may have helped to reduce complacency about malaria among donors and some African governments and has now brought greater resources through GFATM, its results in controlling malaria so far are not clear. In contrast, within a short time, the Stop TB Partnership has been more successful than RBM in achieving concrete results on the ground, in terms of the number of patients diagnosed and treated, attracting the attention of high-level policymakers and helping to increase Bank lending to countries such as China and India in support of the DOTS strategy and other related issues of multi-drug resistance.[51] The greater success of the TB partnership may be in part because the strategy is clearer medically, is more focused on the capacity of the health ministries and health delivery system, and hence more easily applicable. The effort has been concentrated in large and middle-income countries with greater internal technical and logistical capacity where self-standing lending operations could be financed by the Bank. Furthermore, vigorous political, medical and financial mobilization have gone hand in hand.

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49. Recent Project Performance Audits Reports for Brazil, India and Cambodia carried out by OED suggest that the Bank played an important role in each of these countries by providing funds for physical infrastructure, institutional capacity building, laboratories, sentinel surveys, etc.

[50] Over, Mead. et al. (2004).

[51] There was often difficulty in separating the impacts of the partnership with the activities of WHO for those the OED team interviewed, which suggested that the Stop TB partnership was simply an effective instrument for WHO to get its messages across effectively by mobilizing a variety of partners including the international partners such as the World Bank, the health community, e.g., in China and the civil society in India.

2.51 Overall, however, the recent shift of all six programs towards more concrete strategies to achieve sustainable results on the ground seems to result from the fact that, with the few notable exceptions, they have been more effective in *global advocacy than country-level results*. This seems to be a result of a combination of factors: ambitious program goals in relation to the overall financial and institutional capacity and commitment of countries notwithstanding the successful deployment of "business like" strategies (GAVI and Stop TB). Lack of concrete business-like strategies (UNAIDS, RBM and Global Forum), and limited funding (Stop TB and TDR) have been the more binding constraints for others.

3. Governance, Management, Partnerships and Participation

GOVERNANCE FUNCTIONS, PRINCIPLES AND MODELS

3.1 This evaluation considered five core functions of governance: (1) strategic direction, usually exercised by the governing body, (2) oversight of the management unit that is responsible for the day-to-day management of the program, (3) consultation with other stakeholders, both formal and informal and through technical, scientific, or professional advisory bodies, (4) risk management, including various risks identified in Bank work, namely, reputational risks, fiduciary risks, conflict of interest risks, unfair advantage risks, governance risks, and non-performance risks, and (5) evaluation and audit.

3.2 The evaluation also adapted a set of four inter-related corporate governance principles developed by the Business Sector Advisory Group of the OECD, as follows:[52]

- **Clear roles and responsibilities** – of the officers and bodies that govern and manage the program and of the mechanisms to modify and amend the governance and management of the program in a dynamic context,
- **Transparency** – the program provides both shareholders and stakeholders with the information they need in an open and transparent manner (such as decision-making responsibilities, accountabilities and processes, accounting, audit, and material non-financial issues).
- **Fairness** – the program does not favor some immediate clients over others (such as Bank staff, participating agencies or program secretariats, specific countries or their agencies, municipal agencies, local authorities, private service providers, NGOs, and community organizations).
- **Clear accountability** – of the program for the exercise of power over resources to the program's stakeholders, including international organizations, donors, developing countries, the private sector, and NGOs.

3.3 Assessing the governance outcomes of the six programs according to these principles has been difficult. While some external evaluations (such as the Stop TB evaluation) have used the standard OED criteria of relevance, efficacy, and efficiency to assess overall

52. The Business Sector Advisory Group found a similar diversity of private sector corporate governance models, with a particular dichotomy between the "shareholder" tradition in Anglo-American countries and the "stakeholder" tradition in continental European countries and Japan. They concluded that regardless of the model, these four underlying principles were part of a well-functioning corporate governance system, and enshrined these in the OECD Principles of Corporate Governance, endorsed by ministers at the OECD Council meeting at ministerial level in May 1999.

program outcomes, these evaluations have not explicitly assessed the performance of the programs' governance functions according to these four governance principles, although most evaluations have implicitly assessed the clarity of roles, responsibilities, and accountabilities. OED has also faced asymmetric information problems in the case of global health programs since these are not housed in the Bank. Moreover, as pointed out in Chapter 1, a number of programs are reassessing their organizational arrangements and functions. Finally, comparisons across programs are challenged by the considerable range in the complexity of the governance arrangements of the programs, given the broad variation in the scope of their activities. This chapter of the report provides an assessment based on information available to OED.

3.4 Global health programs operate at several levels. OED focused on the aspects of governance, partnerships, and participation, with a particular emphasis on the role and performance of the Bank. OED's purpose is to understand the interaction among these aspects, the nature of partnership commitments, the extent to which each program utilizes the respective comparative advantages of its partners, and the value added of the partnership in exploiting economies of scale and scope and building specialized expertise beyond what the partners can achieve acting through partnerships at the country-level alone.

Box 7. Shareholder and Stakeholder Models

In a shareholder model, membership on the governing and executive bodies is limited to organizations who sponsor or pay for the program – in the case of global programs, typically international/regional organizations like the United Nations and the World Bank, bilateral donors, and private foundations. In the stakeholder model, membership is extended to other groups – such as developing countries, NGOs, and the commercial private sector – who are potentially affected by the program and who therefore have a stake in its effective functioning to achieve their interests. This means involvement not simply in implementation of program activities but also in defining the program's strategic direction.

The Bank has moved toward a stakeholder model, for example, in the country-owned Poverty Reduction Strategy Papers, by involving broad stakeholder participation in the formulation of PRSPs. The Bank's Board has also begun to give more attention to the issue of the voice of developing and transition countries in the international financial architecture, including that of the international financial institutions. For example, the Bank has given a more direct voice in IDA replenishment consultations to IDA recipient countries and worked with IDA Executive Directors and their domestic constituencies to bring in recipient perspectives.

3.5 Overall, the six global health programs (along with some of the global environmental programs OED has reviewed) demonstrate an increasing tendency toward **shareholder models** as opposed to **stakeholder models** of governance (Box 7). All have developing country representatives on their governing body, five have NGO representatives, and three have industry representatives (Table 1 in Chapter 1). However, programs such as TDR that are focused on strategic scientific research to develop drugs or vaccines for specific diseases have tended to involve fewer stakeholders than programs such as the Global Forum and UNAIDS that are promoting applied multi-disciplinary research. In the latter case, this involves concerted political mobilization, knowledge generation, information collection and dissemination, monitoring the AIDS pandemic, and evaluating impacts. Thus, it is no accident that UNAIDS was among the first UN bodies to include participation of civil society on its Program Coordinating Board. Global Forum, UNAIDS, RBM, and the Stop TB Partnership all use large annual meetings to promote involvement, political support, and commitment.

3.6 Although broader membership is intended to enhance legitimacy in comparison with shareholder models, the involvement of diverse interests at the governance level can also result in collective action problems, thereby dissipating individual members' sense of ownership. To varying degrees, all six programs face the challenge of balancing legitimacy, relevance, and ownership on the one hand (resulting in principle from broad stakeholder involvement) with the need for efficiency in decision-making with regard to strategy formulation, rapid implementation, and demonstrating results on the ground (areas which have traditionally been a hallmark of shareholder models). All six global programs are wrestling with the issues of increasing efficiency, scaling up, and demonstrating impacts in relation to the goals which they have established for themselves. Each in its own way is moving towards more business-like conduct of its operations, the need for which their evaluations have stressed.[53]

3.7 UNAIDS faces the challenge of collective action due to the sheer number of the program's partners, their broad scope and activities, difficulties of donor coordination at the country-level and the limited capacities of developing countries. The minutes of the June 2003 meeting of the UNAID's Program Coordinating Board (PCB) acknowledge that "developing a more coherent position throughout the vast and complex UN system" remains a challenge. There is agreement in the PCB about the need for UNAIDS to adapt to the changing global context, to clarify the roles of the PCB and the Committee of Cosponsoring Organizations (CCO), and to develop better instruments for feedback between country and global levels.

3.8 The Bank, as one of the key co-sponsors has a strong and special relationship with UNAIDS. It has supported UNAIDS activities by being more responsive to HIV/AIDS in its country operations. Financial contributions from UNAIDS to the Bank are also enabling the Bank to play an active operational role in coordinating UNAIDS monitoring and evaluation efforts. The Gates Foundation has also made financial contributions to the Bank to support child immunization activities. RBM and the Stop TB Partnership have financed secondees working in the Bank's health sector anchor and the Africa region. But as many commentators have emphasized to OED, these relationships have evolved organically. They have depended more on inter-personal interactions and chemistry rather than on the Bank's institutional strategy and commitment. The Bank has not allocated the necessary budgetary resources nor provided sufficient institutional support, staff incentives, and well articulated performance standards to enable Bank staff to carry out the Bank's potentially substantial responsibilities associated with being a founding and permanent member of these partnerships. UNAIDS argues that one of the evident challenges has been the inconsistency on the part of country-level Bank staff to appreciate the Bank's identity as a UNAIDS Cosponsor and, the Bank's responsibility to contribute towards a strong and well-functioning UN Theme Group on HIV/AIDS. According to the program, this has resulted in unequal performances of the World Bank within the UN Theme Group, reflecting the tension between a decentralized

53 GAVI's business-oriented approach is noticeable in the conduct of its board meetings to measuring ultimate outcomes. Over a short period of time, the program has shifted its attention from a work plan of the narrowly focused objective of increasing immunization rates, to addressing the more upstream, broader and longer-term issues of health delivery system capacity and financial sustainability, the development of performance indicators and their vigorous implementation, the uses of data quality audits, and a performance-based system of fund disbursement.

country driven Bank expected to deliver global outcomes through global partnerships requiring global strategies (see also Chapter 4 on the Bank's performance).[54]

CLARITY OF ROLES AND RESPONSIBILITIES

In-House Secretariats

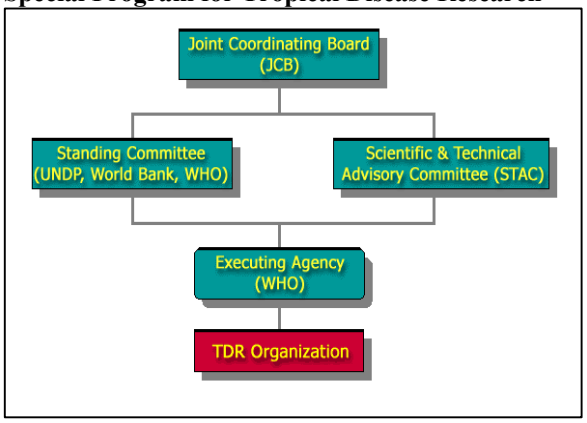
3.9 A widely discussed governance and management issue is whether new global initiatives will help achieve wider and faster development impacts, if they are independent entities in their own right as opposed to being housed in an existing international organization such as the World Bank or the WHO. It is important to understand under which circumstances they are likely to be more efficacious, efficient, accountable and responsible, and in a better position to deliver results.[55]

[54] UNAIDS financial contributions to the Bank are through the Unified Budget and Work plan.

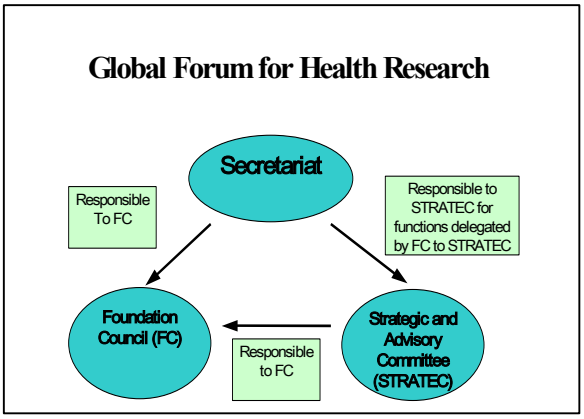
55. See OED's Phase I Report and OED 2003b.

Figure 8. Diversity in Governance & Management of Global Health Programs

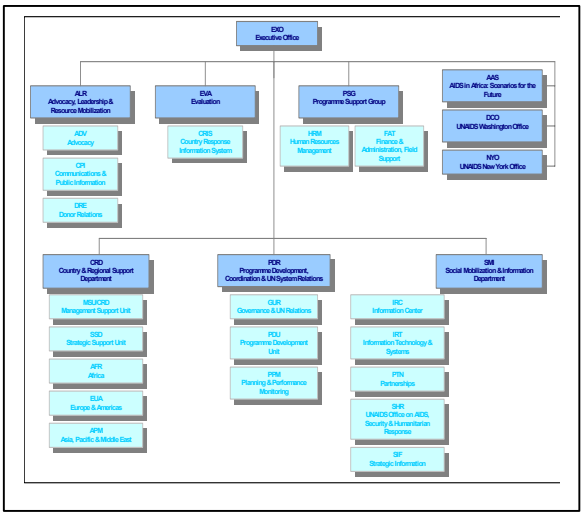
Special Program for Tropical Disease Research



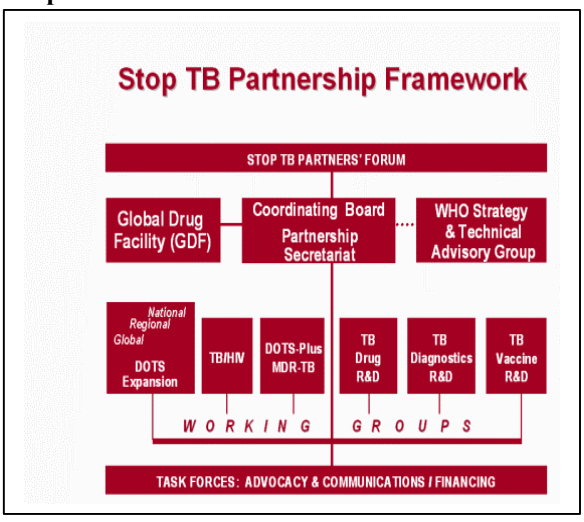
Global Forum



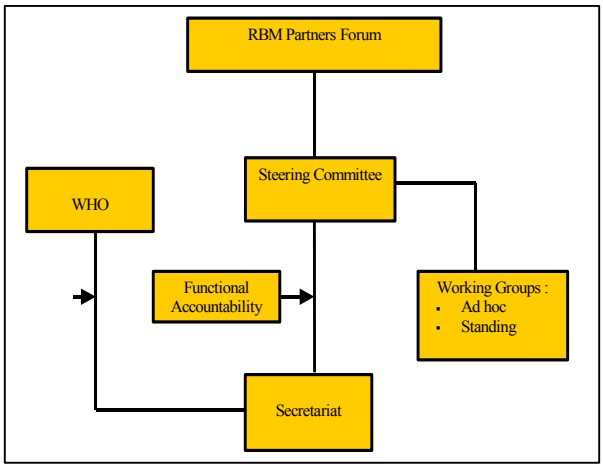
UNAIDS



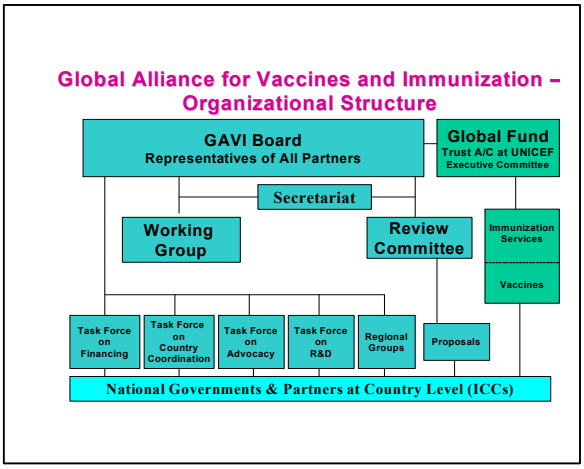
Stop TB



Roll Back Malaria



Global Alliance for Vaccines & Immunization



Source: Websites of respective programs.

3.10 A number of interacting factors determine performance, making it difficult to arrive at firm conclusions with regard to the relationship between program design and implementation on the one hand and results on the other. However, the diversity of programs offers a number of useful insights into organizational and management issues. Programs housed in existing international organizations enjoy human resource benefits (such as UN passports, diplomatic visas, and tax-free salaries) and do not have to establish their own administrative, procurement, and financing rules and procedures from scratch. Nevertheless, locating the secretariat of a global program inside a UN agency like WHO raises issues similar to those faced by secretariats housed inside the World Bank (such as the CGIAR and CGAP).[56] These include: (1) the challenge of maintaining an independent arm's length relationship from the host organization, (2) ambiguous reporting and accountability relationships between the host organization on the one hand and the governing body of the program on the other, (3) reconciling accountability to the membership with the specific interests of the organization that provides the program with legitimacy and support, and (4) the difficulty in articulating explicit exit strategies where necessary and appropriate.

3.11 The Global Forum for Health Research is registered as a non-profit organization under Swiss law and is operationally autonomous, while UNAIDS is a cosponsor, created as a joint program of the United Nations that addresses issues relating to the AIDS pandemic. GAVI,[57]which is housed in UNICEF, enjoys greater autonomy than programs housed in WHO, such as TDR,[58] the Stop TB Partnership, or RBM. This seems due in part to the substantial share of funding the program receives from the Gates Foundation.

3.12 While TDR, RBM, and The Stop TB Partnership have benefited from the WHO's authorizing environment, its global convening power, technical expertise, administrative infrastructure, and network of field offices, all three programs – like those global programs that are housed in the World Bank – have faced what the management literature calls the "**two masters**" problem. (Michael Davis and Andrew Stark, 2000) Their respective external evaluations analyze this phenomenon well. Each program has faced ambiguities in the functional roles and responsibilities of their program boards vis-à-vis the WHO departments where the programs are housed. Over the period of this review, TDR has been striving to achieve greater autonomy from WHO. It has been addressing a number of searching issues regarding the appropriate composition and the role of its Joint Coordinating Board (JCB) in the development of strategic directions and goals, the role and powers of its Standing Committee of cosponsors, and the strategic role of its Scientific and Technical Advisory Committee (STAC) in setting long-term research priorities and strategies. RBM and the Stop TB Partnership have been addressing similar issues. The 2003 Stop TB evaluation suggests that issues concerning the grade level and position of the program's executive director may have been helped by an agreement in WHO about the grade level and recruitment process of

56. See OED 2003b.

57. While GAVI benefits from some of UNICEF's infrastructure, the program's executive secretary reports to the board chair, its day-to-day operations are relatively autonomous from UNICEF, due to the involvement of the Gates Foundation and its US$750 million contribution to the Vaccine Fund. The Director-General of WHO is currently the chair of GAVI's board.

58. The World Health Organization is the executing agency of TDR, the Director-General of WHO appoints the director of TDR, and the communicable disease cluster within the WHO is responsible for the functioning of the TDR.

the RBM executive director. The nature of support of WHO for their secretariats and their relationship with the regular work of WHO vis-à-vis their accountability to the boards of the partnerships are issues, which are being addressed. It is too early to know the likely impacts of these changes.

3.13 Unlike in the case of global health programs, the Bank chairs almost all the global programs housed in the Bank. In contrast, the governing bodies of TDR, RBM, and the Stop TB Partnership are chaired by partner members of the organization, for a 3-year rotating term in the case of TDR, and 2-year rotating terms for RBM and the Stop TB partnership. The latter is a good practice. It facilitates more of arm's length relationship with WHO. Provided the chairs selected exercise good leadership, remain in their positions long enough to provide the necessary independent strategic perspectives based on global knowledge and practices, and are assessed for their performance, the partnership between existing traditional international organizations and global programs can add considerable value to the tasks of the international organizations. The TDR and the Stop TB partnerships appear to have achieved this notwithstanding the tensions highlighted in their evaluations.

The Role of Board Members & the Link to Financing

3.14 In reviewing the programs' frameworks and guiding documents, it was not always easy to assess whom the board members are expected to represent – themselves in an individual capacity, the views of their own organizations, or the views of the constituencies that they represent on the governing body.

3.15 The relationship between Board membership dues and participation is another issue. It is explicit in some cases but not in others. GAVI requires member contributions that it uses to finance its operating costs. Developing countries members are not expected to contribute.[59] Other programs do not seem to have a requirement.

3.16 Because of its funding from the Gates Foundation, GAVI has had a higher degree of freedom to innovate, to make speedy decisions, to deliver on its promises, and to take risks of one kind or another other in comparison with the other five programs that are more dependent on public sector funding.[60]

3.17 The different responsibilities of permanent or renewable members versus rotating members also need to be articulated by the governing bodies of the programs. Founding members or permanent members, including particularly the international organizations such as the WHO and the World Bank, implicitly have a greater responsibility to ensure the effectiveness and sustainability of a program in the long-term. Budgetary and human resource support from their respective organizations is a critical element of such responsibility.

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59. The requirement to make a specific financial contribution as a precondition for Board membership can either signify the ownership and commitment of board members to the sustainability of the program or be a barrier to entry for developing countries lacking the financial resources to join, depending on the level of contribution and the extent to which it is enforced.

60. Bill Gates has often emphasized this point in speaking about the involvement of his foundation in global health.

The Scientific/Technical Advisory Committees and Their Diverse Roles

3.18 Scientific and technical advisory committees can play a crucial role in bringing the best of scientific know-how, helping programs establish their overall direction and strategy, in facing major analytical challenges, in managing risks, and in ensuring the professional integrity of alternative approaches the programs could pursue. Some programs have incorporated such advisory bodies into their formal governance structures, while others have established formal or informal working groups to perform this function. Whatever the arrangements, some of these advisory bodies seem to function better than others in improving the quality of their programs.

3.19 TDR's Scientific and Technical Advisory Committee (STAC) has historically been a strong guiding influence which has ensured TDR's continued relevance to the needs of its developing country clients. It consists of 15 to 18 scientists and other technical personnel who serve three-year terms in their personal capacities to represent the broad range of biomedical and other disciplines required by TDR activities, who are selected based on their scientific or technical competence by WHO in consultation with the Standing Committee, and who are endorsed by the JCB. Meeting annually, the STAC reviews TDR's scientific, technical and operational issues, and reports its findings directly to the Joint Coordinating Board (JCB). According to stakeholders interviewed by the OED team, the effectiveness of the STAC and the technical assessments have been consistently high but have been questioned in recent years.

3.20 The Foundation Council of the Global Forum for Health Research is assisted by a Strategic and Technical Advisory Committee (STRATEC), which is composed of six members selected from among the Council Members for three-year terms. The committee has two responsibilities: (1) generating new ideas and assisting the Council in breaking down its broad interventions into specific strategies and inputs for work plans and budgets, and (2) conducting technical reviews of the Secretariat's project proposals before they are submitted to the Council.

3.21 The original design for RBM stated that WHO, operating as the secretariat for the partnership, would provide technical leadership to the partnership and technical support to the WHO member states at the global level. In addition, the program established Technical Support Networks (TSNs) to provide specialized support to country operations and to address specific technical criteria for malaria control. More particularly, the TSNs were to provide (1) needs assessments and interventions at the district and national levels; (2) prevention and control of malaria epidemics; (3) malaria control in complex emergencies; and (4) the implementation of insecticide-impregnated bed-net programs and the monitoring of resistance. While these networks were designed to support both the countries and the implementing agencies at the county level, the 2002 evaluation of RBM noted that "TSNs are seen by most partners as performing poorly, and there is uncertainty concerning their role, organization, and precise purpose." Furthermore, "only four TSNs are active; those on complex emergencies, epidemic control, drugs, and insecticide treated nets. The TSNs have

merged, or been unclear about, the distinct roles of standard setting and direct support to countries."[61]

3.22 For the Stop TB Partnership, WHO, as the host organization, is supposed to guide the partnership in global health policy issues while providing it with scientific and technical advice through the WHO Scientific and Technical Advisory Group (STAG). The Stop TB partnership has also established working groups to provide a focus for coordinated action in issues relating to DOTS expansion, in combating HIV-related TB and multi-drug resistant TB, and in developing new tools, drugs, diagnostics, and vaccines. While each working group has independent governance mechanisms, all work under the umbrella of the Stop TB Partnership.

3.23 GAVI does not have a technical advisory body. Rather, it has drawn on technical agency the U.S. Centers for Disease Control – is responsible for the research and technical health aspects of the GAVI Alliance. Its stated roles are (1) to represent the knowledge and experience of the research community to the GAVI board, (2) to keep the research community apprised of relevant policy directions being assumed by GAVI partners, and (3) to provide technical staff for operations and help build capacity for research and development. In addition, GAVI has established a Working Group that is responsible for the implementation of the decisions of the GAVI Board,[62] and four task forces that are designed to address specific issues of concern to the board.[63]

Box 8. GAVI's McKinsey Study Called for Increased Representation of Developing Countries

A 2003 McKinsey study commissioned by the GAVI Board suggested that "increased representation from developing countries would strengthen the active involvement of beneficiary country governments in GAVI policy making, facilitate the task of effective networking and make consultation more meaningful, strengthen country ownership and leadership, and increase peer pressure to perform better."

The report argued that GAVI can meet its 80 percent district level coverage goal before 2010 by encouraging and supporting countries to pursue their own realistic national targets rather than by trying to accomplish what has been achieved in a neighboring country given health system capacity limitations between countries. GAVI has since taken a number of steps, including changes to its board composition to increase developing country involvement, to address the issue.

Source: McKinsey and Co. 2003a.

PARTNERING WITH DEVELOPING COUNTRIES, CIVIL SOCIETY, AND THE PRIVATE SECTOR

Involving Developing Countries in Governance Increases Program Relevance, Ownership and Development Effectiveness, But Their Effective Involvement Remains a Challenge

3.24 The inclusion of developing

61. Roll Back Malaria, *Achieving Impact: Roll Back Malaria in the Next Phase*, August 2002, p. 14. Additional issues related to the field implementation of RBM highlighted by some of the commentators on earlier drafts of this review are discussed in the Annex.

62. The Working Group is comprised of middle-level managers in the GAVI partner institutions, who are responsible for translating GAVI priorities into their respective agency work plans.

63. Presently only the Financing Task Force, co-chaired by the World Bank and the Vaccine Fund, is operational. The former task forces, which were funded and managed by their respective lead agencies and included representatives of the relevant partner agencies, were the Advocacy and Communications Task Force chaired by UNICEF; the Implementation Task Force co-chaired by WHO; and the Research and Development Task Force co-chaired by WHO, NIH and Chiron Vaccines.
http://vaccinealliance.org/home/General_Information/About_alliance/Governance/whoweare.php#wg.

countries' voices in governance and decision-making is a particularly important issue for increasing the relevance, accountability, and fairness of global programs (Box 8). Obtaining informed and thoughtful input from developing countries is both important and complex, not only because the relationship between the donors and the recipients tends to be so unequal but also because it does not always benefit sufficiently from involving the *right* stakeholders. The importance of the right board membership, both individually and collectively as a composite body, applies to board memberships generally. It was emphasized to OED by all stakeholders, i.e., developing countries, professionals in industrial countries, bilateral donors and international organizations.

3.25 Like the larger convention-based environmental programs – the Global Environment Facility and the Multilateral Fund for the Implementation of the Montreal Protocol – examined in OED's overall review, the six global health programs have made considerable effort to engage developing country perspectives. OED case studies demonstrate that the participation of developing countries in some of the environmental programs has fundamentally shaped those programs to deliver both national and global benefits.

3.26 However, in interviews with developing country program members, the OED team also learned that developing country board members have limited in-country support structures, lack clear terms of reference for the exercise of their board functions, and are not always provided the systematic training or information on the conduct of their independent responsibilities at the global level. The decision of some global health programs to lengthen board terms from two to three years should enhance developing country members' capacity to gain experience and perform their governance roles more effectively.

Partnerships with NGOs Could Benefit from an Objective Assessment and Well Informed Institutional Strategies

3.27 The health sector has seen major changes in the roles of NGOs as formal and informal partners in global programs and country activities. NGOs have played important roles in shaping the global agenda and individual programs, both directly and indirectly. They have carved out an increasingly formal role in the global partnerships. Being members of the governing board of UNAIDS, they have also acquired a vice chairmanship in the Global Fund.[64] UNAIDS, other global programs, and many Bank-supported health projects in developing countries are also partnering with NGOs at the country/activity level.[65]

3.28 There is little systematic evaluation of impacts of NGOs in the health sector partnerships. Bank experience at the country-level in the health sector operations suggests both a mixed response of governments to NGO involvement, and a mixed record of NGO performance. It is a result of a combination of issues related to power sharing, capacities, expectations, constituencies and accountabilities. This record is neither surprising nor is it different from that for other types of stakeholders, e.g., the private sector. Given the substantial current and likely future roles of NGOS and civil society organizations more generally however, it would be instructive to conduct an objective assessment of their contributions to the participatory processes.

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64. The GFATM board chose the board member representing a developed country NGO as vice-chair at its meeting on March 18-19, 2004 – the first time that a nongovernmental representative has been chosen as the program's chair or vice-chair.

[65] The vice-chair of the Global Forum represents the International Planned Parenthood Federation, an NGO.

3.29 Some anecdotal evidence the OED team has been able to gather indicates that when the Bank has a constructive engagement with NGOs which have relevant developing country knowledge, capacities and experience, engagement with them advances the cause of poverty alleviation and sustainable development. NGOs have been ahead of international organizations in their activism on such issues as affordable access to drugs, the plight of orphans and refugees living in conditions that do not meet international health and environmental standards, values, and norms. Their activism has energized action in developed countries and empowered civil society organizations in developing countries to be more proactive in problem-solving, for example, by spearheading a global campaign to make existing drugs for HIV/AIDS (including ARVs), multi-drug resistant tuberculosis, and others affordable to the populations of developing countries. Through lobbying and court cases, they have taken up the issues of preferential pricing for drugs and drug donations to developing countries. They confronted the research-based international pharmaceutical industry by advising developing countries of the potential to exercise their rights under international trade and IPR agreements (such as the parallel importation of essential medicines, and invoking the Trade-Related Intellectual Property Rights [TRIPS] provisions related to compulsory licensing). While the Bank and the WHO were slow to take a position on these issues, they have come to strongly support increased access to drugs.

3.30 Yet global interventionist approaches, when not accompanied by empowerment and support of national organizations in developing countries, raise issues of legitimacy of NGO activism, and when not accompanied by increased external aid resources to translate their desires into workable actions, do not necessarily result in the most appropriate or the most sustainable solutions. Appropriately supported local actors are able to devise more effective and realistic solutions attuned to on-the-ground realities in developing countries and to bring more sustainable, holistic, and appropriate approaches.

Public-Private Partnerships Present Opportunities as Well as Risks and Call for Harmonization of Approaches Within and Among International Organizations

3.31 Many stakeholders remain skeptical about the motives of private corporations that engage in partnerships with international organizations, even when the efforts have been demonstrated to have substantial public goods benefits, as in the case of the onchocerciasis program. In this program, Merck's pharmaco-philanthropy (through the Ivermectin donation program) had positive impacts on poor West Africans with river blindness and it promoted a favorable corporate image. Where similar partnerships have not developed, as in the case of the schistosomiasis drug Praziquantel, potential health gains have not been achieved in developing countries. In the latter case, although public-private collaboration occurred during the development phase of Praziquantel, an effective partnership for its donation and distribution did not emerge, which substantially limited the number of people in developing countries who could benefit from the partnership.[66] This failure demonstrates the importance of clearly articulating partnership goals and regularly reporting on them as they evolve. Lucas correctly argues that the partnerships require clearly defined public health goals as well as a strategic plan for addressing

66. Private firms working through partnerships, for example, are suspected of merely seeking future profits and markets, or trying to control the agendas of international organizations, or to benefit from tax deductions and subsidies for their new products.

the problem. The success of a partnership, he says, depends in part on the availability of technological alternatives and in part on the collaborative efforts of several partners.[67]

3.32 The complexity of public-private partnerships in global programs has increased as the importance of IPR regimes has grown (Box 9). As the international discussion on increased access to affordable, reliable drugs and vaccines has advanced, there is potential through public-private partnerships to bring new products to the large and as yet untapped market of the poor and needy in developing countries. Although generating effective demand for them either through a more assured and predictable supply of aid for poor countries or through increased incomes and access among the poor in the middle-income countries remain issues, so do issues of their pricing and their licensing arrangements for production. Hence, the role of public-private partnerships has changed from simple donations to market creation, assured supply, and affordable prices. The same applies to the patented varieties of crops.[68]

Box 9. Lack of Effective Demand Limits the Potential for Commercial Private Sector Funding for Vaccine and Drug Research

Vaccine and drug development and dissemination is severely under-funded, despite general agreement on the long-term benefits of child immunization. In addition, historically it has taken about 15 years between the development of a vaccine and its introduction in developing countries.

Experts in the financial markets have offered a number of innovative approaches to the distribution and financing problems facing vaccines:

- Auctioning a basket of options to manufacturers as a way of accelerating the decline in average cost
- Issuing tax-exempt debt
- Using project financing
- Securing commitments for future payments or guarantees from end users, the World Bank, the Gates Foundation, and other third-party payers.

But they also stress the absence of a viable market and the large risks for pharmaceuticals in justifying the large investments in production capacity. Therefore, the only possible solution would seem to be increased funding, either through philanthropic contributions such as the Gates Foundation or through increased public sector financing of research – a large-scale TDR or some of the new vaccine initiatives such as MMV or IAVI.

3.33 Of the six global health programs reviewed, GAVI, the Global Forum, and restructured RBM include industry representatives on their governing bodies. Many programs have also forged interactions with the private sector *at the activity level.* TDR, for example, works with the private sector in a number of its activities. But there is considerable variation in the clarity, consistency, and transparency with which information on public-private partnerships is reported

67. According to Lucas, there has been an "honest recognition by the public sector" of the "unique, unrivalled monopoly" of the pharmaceutical industry in drug and vaccine development…(and that) they own the ball. If you want to play, you must play with them" (Lucas 2000). New developments in biotechnology are making drug and vaccine discovery and development increasingly expensive, as are changes in intellectual property rights. Concomitantly, extensive consolidation of the pharmaceutical industry has led to reduced competition. Yet, some global programs have also increased demand for vaccines and anti retroviral drugs and encouraged pharmaceuticals to produce products for the new and emerging markets in developing countries, thereby fostering competition and reducing prices.

68. Lele, Uma. (2003).

in global programs.[69] To develop appropriate policies in this regard, it is necessary to distinguish commercial private sector entities with and without *direct* commercial interest, as this has quite different implications for conflicts of interest. In the cases of GAVI and RBM, pharmaceutical associations or vaccine manufacturers' associations with or without actual or potential interests in the markets for products and services serve on the governing bodies.

3.34 When commercial, private sector representation on the governance of global programs brings in significant amounts of new money or new products or opportunities to developing countries at affordable prices to the poor, this presents considerable advantages and potential value added. But it also poses challenges of accountability for public investors, including international organizations like the World Bank, as well as potential unfair advantage risks that need to be monitored and managed. OED has concluded that continuing Bank involvement in health partnerships at the global level is important because the programs demonstrate potential win-win for both investors and developing countries, and because they strive to achieve important global public goods. But the Bank and its partners also needs to develop internal capacity to assess and manage risks.

3.35 The policies on public-private partnerships of international organizations such as the World Bank and WHO are still at a formative stage, and are not coherent either within the Bank or across partnering international organizations. Within the Bank, the policy varies by Network and sector. On the one hand, industry representatives have served on the governing bodies of GAVI, the Global Forum, and the re-structured RBM. On the other hand, the six infrastructure and private sector development global programs housed in the Bank do not generally accept financial contributions from, or invite commercial private companies (as opposed to private foundations) to sit on their governing bodies because of concerns about potential conflicts of interest, although these programs do work with private sector service providers *at the country-level*.

3.36 WHO guidelines[70] on partnership with commercial enterprises posit the following basic criteria: (1) relationships should be aligned with WHO's strategy (should contribute to improving public health); (2) relationships should be established on the basis of an exchange of clear, written agreements indicating the contribution (financial or otherwise) of each party to the relationship; and (3) the public health gains should be commensurate with the time and expense involved in establishing and maintaining the relationship. A broad sharing and debating of such guidelines and experience among international organizations would enable the adoption of a common code of conduct on private sector partnerships and their monitoring across the various UN organizations and international and regional banks –

69. State-funded US land grant institutions, in contrast, are expected to routinely report research conducted through public-private partnerships to the university offices that engage patent lawyers to negotiate contracts for such research.

70. At its 105th session, WHO's Executive Board emphasized the need for preparing guidelines for a fully transparent public-private partnership for health and to avoid conflict of interest arising in any such relationship. These guidelines, after being discussed with member states and NGOs in official relation with WHO, were submitted to the 107th Executive Board of WHO in November 2002. The paper, "Guidelines On Working With The Privates Sector To Achieve Health Outcomes," is available at the WHO website. Some or all of these guidelines can also apply to a variety of other institutions, including state-run enterprises, associations, foundations, and non-profit organizations, such as academic institutions.

potentially an important step in harmonization to achieve the Millennium Development Goals.[71]

Founding International Organizations Retain a Large Role and an Overwhelming Share of the Responsibility in Governance

3.37 Notwithstanding the increasing involvement of other partners in the governance of global programs, the Bank and other international organizations exercise a large degree of formal and informal influence over the strategic direction of the global programs, and continue to bear an important share of responsibility for oversight, consultation, risk management, and evaluation. For the Bank, however, its degree of responsibility is less for most global health programs which are external to the Bank than for the global programs housed inside the Bank.

3.38 For all "in-house" programs – whether inside the Bank, WHO, or UNICEF – it becomes difficult for organizations that house them to be both judge and advocate, to acknowledge the need for reforms and press for them while also making the case for continued funding to the Bank and donors. Having an external chair for TDR, GAVI, RBM, and TDR is a good thing, since this increases the ability of the Bank and other international organizations to press for reforms on a scale or speed that might be warranted, while reducing their exposure and risks.

3.39 Other conflicts of interests are *organizational* in the sense that they arise from the design of the Bank's relationships with the global programs that it supports.[72] These include staffing issues, inadequate budgetary resources and incentives for the staff involved in global partnerships, and the efforts of Network vice presidents to keep DGF resources within their own Networks, which counters the objective of allocating grants based on which programs add the most value to achieving the Bank's institutional mission of a world without poverty. At best, these factors pose the risk of non-performance of these important partnerships for the Bank's clients. At worst, they have the potential to damage the Bank's reputation in the various roles that it plays in global programs, particularly for those programs in which the Bank has been a founder and or has a high degree of strategic, fiduciary, and reputational exposure.

4. World Bank Performance As a Global and Country Partner

4.1 The World Bank has played several roles in the six health sector programs reviewed in this assessment: founder, convener, co-sponsor, donor, member of program governing bodies, and lender to developing countries. One criterion for Bank support is that a global program must have a clear strategic rationale consistent with the relevant Bank **sector strategy**. The Bank's Human Development Network has the responsibility for developing a strategy that identifies the linkage between its global program portfolio and the Bank's health sector activity. A Bank-wide health sector strategy was prepared in 1997.

4.2 The strong global response in the area of communicable diseases in the context of a regionally decentralized Bank presents a special challenge in reconciling country priorities with global advocacy for increased investments of programs such as UNAIDS in a situation

71. In particular, targets 17 and 18. See Annex Table 8.

72. David, Michael, and Stark, Andrew. (2001).

of competing investment priorities. Nevertheless, the technical inputs, knowledge and information, and capacity-building efforts of global programs enhance ongoing Bank and country activities.

4.3 Each region of the World Bank has its own health sector strategy for the Bank which attempts to respond to perceived country needs and priorities in the region. The Bank's regional and country operations staff have responsibility for country economic and sector work, working with increasingly country driven Poverty Reduction Strategy Papers, Country Assistance Strategies, and preparation, processing and oversight of investment operations.

4.4 Because of the crisis proportions of the epidemic, the Bank's Africa region has provided perhaps the most comprehensive multisectoral operational response to HIV/AIDS on an emergency footing. But as indicated earlier, some dispute the efficacy or effectiveness of these multisectoral operations. Some countries in Latin America and in South and East Asia have been more advanced in addressing prevention in the context of treatment for HIV/AIDS, and in dealing with the role of HIV/AIDS in the overall health sector strategies. Examples include Brazil's aggressive approach to HIV/AIDS treatment through domestic production of generic drugs followed by an active prevention effort; Thailand's intense information and condom use campaign on HIV/AIDS prevention; and China, India, and Cambodia's ongoing efforts of varying degrees on HIV/AIDS, tuberculosis, and immunization. While the countries deserve credit for their initiatives, the Bank has proactively supported and enhanced these various activities with lending operations.

4.5 The Bank has supported TB control in more than forty countries, and most Bank projects promote the DOTS approach to control TB. India and China, which together carry nearly 40 percent of the world's TB burden, have the two largest self-standing TB projects, approved in 1997 and 2002, respectively.[73] As China graduated from IDA lending, the Bank regional staff worked closely with the Stop TB Partnership to help mobilize DFID funds to improve the terms of the Bank's loan and make the TB project attractive for the government. Links between the Stop TB partnership and Bank lending for TB control in India have been strong and are becoming stronger with a new lending operation in the pipeline.[74] In short, due to the trend over the last decade toward more country-driven strategies and approaches, the Bank's response has varied by regions as its health activities have been driven by country priorities.

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73. The Bank's appraisal report for the 2002 project in China outlined well the links between Stop TB, the Bank's operations, and China. While the Government of China announced its support for the global Stop TB campaign at the Amsterdam conference in March 2000, Chinese provinces face severe fiscal challenges in financing the Stop TB program given the government's wholesale shift from a public to a private sector health delivery system as part of its reform program. The appraisal report also observes that global programs such as Stop TB can operate synergistically with Bank lending to deal with multi-drug resistant tuberculosis (MDR-TB) which poses one of the gravest risks to the control of TB. However, Bank documents indicate that the costs of treating MDR-TB are more than 100 times greater in some settings and even then only 60 percent of patients are cured compared with 95 percent of those with non-drug resistant TB.

74. The Bank's task team leader for the ongoing TB project has been participating in the Stop TB DOTS expansion group and was on the organizing committee for the Global Stop TB Partners' Forum in New Delhi in March 2004. India's Principal Secretary of Health serves on the Stop TB Coordinating Board. Working with a range of Stop TB partners, especially the Bank, India's TB program has shown the fastest global DOTS scale up – covering 800 million people and treating 3 million people under DOTS to date. As a result of India's work and that of some other high burden countries, global case detection increased last year at a rate double that of the average between 1995 and 2000.

4.6 A December 2003 Bank report on the Millennium Development Goals for Health contains a comprehensive treatment of the current state of knowledge on the status of the health MDGs and on the policies and strategies required for governments, partners, and communities to scale up effective interventions more rapidly. It provided a basis for discussions at a WHO-hosted January 2004 high level meeting of donor and developing country policy makers, leading to agreements among participants to work on harmonization, human resources, resource mobilization and the reconciliation of the MDGs focus with the PRSP framework in countries.

4.7 One of the core functions of HDNHE, which provides leadership to the health sector in the Bank, is to manage the Bank's involvement in global partnerships. A global unit was established to address HIV/AIDS issues. However, although there are considerable interactions between AIDS and TB, and between AIDS and maternal and child care (areas in which there are also global programs), these interactions have not yet been sufficiently addressed internally in the Bank through coordination among different global programs. A limited number of well-coordinated global programs – as part of regional health strategies, followed by a rolling global strategy – might enable the Bank to better help developing countries achieve coherence between the goals of global programs and country needs.[75] The appointment of a disease-control coordinator for global programs in the anchor is a good start in the process of strengthening link between global programs with country operations and among programs.

4.8 In assessing the linkage between global programs and the Bank's country operations, OED distinguished between types of programs to determine the extent to which the programs need or would benefit from linkages to the Bank's country operations in achieving their objectives. Research programs such as TDR and Global Forum do not require a direct link to Bank operations, although Bank resource mobilization efforts at the global level and complementary investments in support of health research at the national level would increase their effectiveness. For the four other programs, stronger linkages with the Bank operations could improve their effectiveness and enhance mutual feedback. In its overall review, OED found that linkages between global programs and the Bank's country operations are stronger where the Bank is an implementing agency of the global programs (i.e. regional Bank staff are implementing global program activities) than where the Bank is not an implementing agency – which is the case for GAVI, UNAIDS, RBM, and the Stop TB partnership. Anchor staff tend to be outward-oriented towards the global programs. Budgetary resources and incentives for Network anchor and operational staff to develop internal synergies are often limited. Since 1998 the Bank has experienced a 15 percent reduction (from 230 to 200) in the number of professional staff in the HNP sector[76] and a shortage of health policy analysts, health economists, health specialists, and development and financing experts. Frequent changes in the HNP anchor managers have also contributed to a lack of continuity. Where the Bank is not the implementing agency of particular global programs, it needs to make special efforts,

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75. As discussed in chapter 2, improved coordination could occur at three levels inside the Bank: (1) among programs at the level of the health sector anchor, (2) between the anchor and the Bank's country operations, and (3) at the country-level among programs in a similar area, such TDR and the Global Forum in health research, and UNAIDS, RBM, and Stop TB in communicable diseases. OED did not fully assess the effectiveness of these linkages because the present review is not a review of the Bank's health sector operations.

76. According to the data provided by the HNP sector to OED, the ratio of staff to the HNP portfolio has declined by 40 percent over the past decade.

including budgetary resources and staff incentives, to link global programs to country operations to enhance the synergy and value of both.

4.9 While information on the nature of the linkages between global programs and country operations and how these could enhance the Bank's development effectiveness is expected to be provided in the Partnership Approval and Tracking System (PATS) forms and the DGF applications for grant support, such information is often spotty. In reality, linkages have been stronger for programs such as UNAIDS and GAVI, in part because UNAIDS and the Gates Foundation have contributed resources to the Bank to operationalize their concerns. RBM and the Stop TB partnership have also financed secondees working in the Bank's health sector anchor and the Africa region. But even for HIV/AIDS, linkages are strong largely in Africa. For malaria control, the linkages with country operations also seem to be strong in some African countries, for example, with respect to the import and subsidization of bed nets, but weaker in other countries such as India where the Bank has had the largest malaria control project. In order to increase the ownership, relevance, and linkages, where appropriate, the Bank should allocate its own budgetary resources for anchor and regional staff to operationalize the content of global programs in the Bank's regional operations for those programs the Bank chooses to engage in.

4.10 The Bank is financing immunization activities in 49 countries. But synergy between GAVI and the Bank's regional operations could be stronger. The Bank is beginning to utilize its considerable global and country-level comparative advantage in persuading developing countries to work jointly with it and the GAVI alliance to achieve results in the way it is beginning to do in the case of polio eradication.

4.11 Previous OED reviews have stressed the importance of monitoring and evaluation to better understand the impacts of these investments and factors that explain impacts. They have also emphasized the need for the Bank to maintain an arm's length relationship with global programs to ensure their clear independence, accountabilities and responsibilities. Therefore, these OED findings on linkages present a challenge. Global programs, whether externally managed or housed in the Bank, need independence to bring new knowledge and technologies to the Bank. Yet, externally implemented programs are by and large less well linked to the Bank operations than those for which the Bank is an implementing agency.

4.12 There is scope for improving linkages by strengthening the analysis of program experience and enhancing their reporting. First, the reasons why the Bank is engaged in these global programs and the value they can add to the Bank's country-level activities need to be articulated more clearly. Second, the balance of Bank lending between communicable diseases and health system support needs exploration. The current approach may not be sustainable without more support for national health systems. Third, the programs could be better coordinated among themselves and with the Bank's country-level activities. Applications for DGF support should be expected to explain the expected current (and future expected) roles of global programs and their linkages to the Bank's regional and country-level objectives and operations. Fourth, Country Assistance Strategies should indicate which global programs add value to them, and anchor staff should be encouraged to report this information as a basis for continuing DGF support for the programs.

4.13 The Bank serves as a co-sponsor of two global programs, TDR and UNAIDS. Co-sponsors form standing committees, which meet more regularly and report to their governing

bodies. They have typically played a variety of important roles in the governance of global programs. Yet the distinction between co-sponsors and other partners seems to be becoming less pronounced in the case of TDR, while the roles of co-sponsors seems to be increasing in importance in UNAIDS. In general, the co-sponsorship member function and roles, responsibilities and obligations of co-sponsors may need to be more clearly defined for all co-sponsors including the Bank. The Bank may need to work even more proactively with its partners than it has in the case of TDR and UNAIDS to clarify these roles, and to determine its strategic role in partnerships. The Bank should engage in periodic self-assessment of the extent to which it fulfils its role, given the growing demand for results. In the case of complex programs, such as UNAIDS, the need to further clarify the respective roles of the Program Coordinating Body, the cosponsor representatives, and the cosponsor governing bodies has already been identified.[77]

4.14 A Bank representative serves on the governing bodies of all six programs. In principle, it should be easier for this person to exercise the oversight function in the case of the health programs, which are externally managed and therefore at arm's length from the Bank, than for those global programs that are housed inside the Bank. Yet, it is often unclear among Bank staff members serving on the boards of programs the extent to which their role is to advocate the programs within the Bank or to ensure that the programs serve the Bank's strategic objectives, by strengthening the programs and ensuring links to Bank country operations. To perform both these functions requires clear terms of references and budgetary resources for both anchor and country operational staff. Overall, across the 26 global programs reviewed by OED, despite a strong stated commitment, the Bank has not clearly prioritized it engagement in global programs in terms of their value added to client countries and their links to the Bank's country operations, and it has not allocated sufficient budgetary resources to achieve such linkages. The Bank would benefit from establishing clear terms of references for the board function and consistently ensuring the appointment of senior bank staff who can represent the Bank's larger institutional interests and who have sufficient mandate and budget resources to perform their external and internal linkage functions to country operations effectively.

4.15 The Bank's Development Grant Facility (DGF) provides grant support to global and regional programs through two separate windows in order to differentiate those programs (Window 1) that the Bank plans to support over the medium- to long-term and those programs (Window 2) that the Bank will support for a maximum of three years. Since the DGF adoption of a two-window approach, TDR, GAVI, the Global Forum and UNAIDS have been classified as Window 1 programs that receive long-term support and RBM and the Stop TB partnership as Window 2 programs. In its overall review, OED finds that some Window 2 programs (such as RBM and the Stop TB partnership) seem deserving of longer-term support. OED suggested that the Bank should improve the current criteria and procedures relating to the DGF's Window 2 in order to foster a more flexible, rational, and informed approach to funding programs based on their ex ante importance to Bank clients and their demonstrated value added over time.

5. Lessons and A Way Forward

77. PCB Working Group on UNAIDS Governance, Report to the PCB, 19 May 2003.

(1) Advocacy can dramatically increase global expenditure in specific areas of benefit to developing countries and stimulate global consensus, major agreements, and global information and knowledge, as well as increase financial resources for the benefit of developing countries.

(2) Global and national research in health of benefit to the poor has a high payoff, but being a public good it is under-funded at both global and national levels and deserves greater support.

(3) Global health programs have a strong record of independent evaluations. Even so, for methodological reasons it is more difficult to assess the impacts of advocacy programs than of programs with concrete, focused objectives and financing mechanisms.

(4) What constitutes a "program" has become a crucial question for harmonization of aid; whether it encompasses the activities of the partners at the global level alone or also of partner activities at the country-level.

(5) Adding value on the ground in client countries is a joint product of both global and country activities, and there is an encouraging trend toward increased participation of a broader range of stakeholders. Yet, partnerships have worked better at the global level than at the country-level.

(6) While the Bank has supported a variety of global programs in health, the synergy between global programs and the Bank country assistance strategies and experience on the ground is weak in all but a few countries and few programs. It needs to increase with more systematic tracking of development experience on the ground.

(7) The sustainability of outcomes of many of the drug and vaccine delivery approaches promoted by the global programs is in question, even with reduced prices, without additional external grant funding on a consistent, long-term and predictable basis.

(8) A lack of balance between resources for specific health initiatives and for building the long-term health delivery systems in developing countries is an issue faced by all global health programs.

(9) A few global health initiatives that mobilize global knowledge and finance are well grounded in the reality of the development assistance experience of the Bank, its international partners and country clients. Programs that are well-funded on a long-term, consistent and predictable basis would be more effective than the current myriad, small, under-funded programs.

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Annexes

Contents

List of 26 Case Study Programs

Acronym/ Short Form	Full Name	Operational Start Date	Size (US$ millions)[1]
Environment & Agriculture			
1. CGIAR	Consultative Group on International Agricultural Research	1972	395.0
2. GEF	Global Environment Facility	1991	387.53
3. MLF	Multilateral Fund for the Implementation of the Montreal Protocol	1991	158.6
4. ProCarbFund	Prototype Carbon Fund	2000	6.5
5. CEPF	Critical Ecosystem Partnership Fund	2000	20.19
6. GWP	Global Water Partnership	1997	10.25
7. GIF	Global Integrated Pest Management Facility	1996	1.3
Health, Nutrition & Population			
8. TDR	Special Programme for Research and Training in Tropical Diseases	Dec 1975	47.4
9. Global Forum	Global Forum for Health Research	Jan 1998	3.10
10. UNAIDS	Joint United Nations Programme on HIV/AIDS	Jan 1996	95.0
11. RBM	Roll Back Malaria	Nov 1998	11.4
12. Stop TB	Stop TB Partnership	July 1999	20.8
13. GAVI	Global Alliance for Vaccines and Immunization	Oct 1999	124.1
Infrastructure & Private Sector Development			
14. WSP	Water and Sanitation Program	March 1978	12.4
15. ESMAP	Energy Sector Management Assistance Programme	Jan 1982	7.58
16. CGAP	Consultative Group to Assist the Poorest	August 1995	12.67
17. infoDev	The Information for Development Program	Sept 1995	6.07
18. PPIAF	Public-Private Infrastructure Advisory Facility	Dec 1999	15.61
19. CA	Cities Alliance	Dec 1999	13.25
Social Development & Protection			
20. PostConFund	Post-Conflict Fund	1998	10.60
21. UCW	Understanding Children's Work	2000	0.56
Trade & Finance			
22. IF	Integrated Framework for Trade-Related Technical Assistance	1997	2.71
23. FSAP	Financial Sector Assessment Program	May 1999	10.46
24. FIRST	Financial Sector Reform & Strengthening	July 2002	4.64
Information & Knowledge			
25. GDN	Global Development Network	Dec 1999	18.67
26. World Links	World Links for Development	1998	6.5

/1 FY04/CY03 Expenditures. For the following cases updated, audited data was not readily available so the previous fiscal or calendar year expenditures were used: Global Integrated Pest Management Facility, Water & Sanitation Program, Integrated Framework for Trade-related Technical Assistance.

Other Abbreviations and Acronyms

AfDB	African Development Bank
AIDS	Acquired immunodeficiency syndrome
ARD	Agriculture & Rural Development Department
ARV	Anti-retroviral
AsDB	Asian Development Bank
BB	Bank budget
CBD	Convention on the Conservation of Biodiversity
CCD	UN Convention on Combating Desertification
CDC	United States Center for Disease Control and Prevention
CEO	Chief executive officer
CG	Consultative Group
CI	Conservation International
CIDA	Canadian International Development Agency
CIT	Global Information and Communication Technologies
CODE	Committee on Development Effectiveness
DANIDA	Danish International Development Agency
DC	Development Committee
DEC	Development Economics vice presidency
DFID	Department for International Development
DGF	Development Grant Facility
DOTS	Directly-Observed Treatment/Therapy Short Course
ECOSOC	UN Economic and Social Council
ENV	Environment Department
ESSD	Environmentally and Socially Sustainable Development vice presidency
EU	European Union
EWD	Energy and Water Department
ExCo	Executive Committee
FAO	Food and Agriculture Organization of the United Nations
FSE	Financial Sector vice presidency
FY	Fiscal year
GPP	Global programs and partnerships
HDN	Human Development vice presidency
HIV	Human immunodeficiency virus
ICT	Information and communications technology
IDB	Inter-American Development Bank
IFAD	International Fund for Agricultural Development
ILO	International Labor Organization
IMF	International Monetary Fund
INF	Infrastructure vice presidency
IPM	Integrated pest management
ITC	International Trade Center
JCB	Joint Coordinating Board
LAC	Latin America & Caribbean Region
LDC	Least-developed country
MAP	Multi-country AIDS Program
MD	Managing director
MDG	Millennium Development Goals
NARS	National agricultural research system

NGO	Non-government organization
NORAD	Norwegian Agency for Development
OECD	Organization for Economic Co-operation and Development
OED	Operations Evaluation Department
OEG	Operations Evaluation Group
OEU	Operations Evaluation Unit
OP	Operational Policy
OPCS	Operations Policy and Country Services
OPEC	Organization of Petroleum Exporting Countries
PCB	Program Coordinating Board
PREM	Poverty Reduction and Economic Management Network
ROSC	Reports on Observance of Standards and Codes
SDV	Social Development Department
SGP	Special Grants Program
SIDA	Swiss International Development Agency
SSP	Sector Strategy Paper
TA	Technical assistance
TAC	Technical Advisory Committee
TB	Tuberculosis
TF	Trust fund
TUD	Transportation and Urban Development Department
UN	United Nations
UNCED	United Nations Conference on Environment and Development
UNDP	United Nations Development Programme
UNEP	United Nations Environment Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFCCC	United Nations Framework Convention on Climate Change
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VPU	Vice Presidential Unit
WFP	World Food Programme
WHO	World Health Organization
WMO	World Meteorological Organization
WSSCC	Water Supply and Sanitation Collaborative Council
WTO	World Trade Organization

Annex A. Evaluation Framework for Phase 2 Report and 26 Case Studies

1. The Phase 2 Report and each case study follows a common outline and addresses 20 evaluation questions (Table A.1) that have been derived from OED's standard evaluation criteria (Table A.2), the 14 eligibility and approval criteria for global programs (Table A.3), and the 8 eligibility criteria for grant support from the Development Grant Facility (Table A.4).

2. The sheer number of these criteria, some of which overlap, can be daunting even to an evaluator. Hence the OED evaluation team has reorganized these criteria into four major evaluation issues, which correspond to the four major sections of each report (Table A.1):

- The overarching global relevance of the program
- Outcomes and impacts of the program and their sustainability
- Governance, management, and financing of the program
- The World Bank's performance as a partner in the program

3. These four issues correspond roughly to OED's evaluation criteria of relevance, efficacy, efficiency, and Bank performance, **appropriately interpreted and expanded for the case of global programs**. In the case of global programs, **relevance** must be measured not only against individual borrowing countries' priorities and Bank priorities, but also in terms of the interplay between global challenges and concerns on the one hand and country needs and priorities on the other. The former are typically articulated by the "global community" by a variety of different stakeholders and are reflected in a variety of ways such as formal international conventions to which developing countries are signatories; less formal international agreements reached at major international meetings and conferences; formal and informal international standards and protocols promoted by international organizations, NGOs, etc.; the Millennium Development Goals; and the Bank's and the Development Committee' eligibility criteria for global programs. While sponsorship of a program by significant international organizations may enhance "legitimacy" of a global program in the Bank's client countries, it is by no means a sufficient condition for developing country ownership, nor for ensuring its development effectiveness. "Relevance" and ownership by the Bank's client countries is more assured if the program is demanded by them. On other hand some "supply-led" programs may also acquire ownership over time by demonstrating substantial impacts, as in the case of the internet. Assessing relevance is by far the most challenging task in global programs since global and country resources, comparative advantages, benefit, costs, and priorities do not always coincide. Indeed the divergence of benefits and costs between the global level and the country level is often a fundamental reason for the provision of global public goods. Evaluating the relevance of global action to the Bank's client countries is however important because the global *development* agenda is becoming highly crowded and resources to finance it have remained relatively stagnant, therefore highlighting issues of selectivity.

4. For the global programs that have been operating for some time, **efficacy** can be assessed not only in terms of program outcomes but more crucially in terms of impacts on the ground in developing countries. Outcomes and impacts in turn depend on the clarity and evaluability of each program's objectives, the quality of the monitoring and evaluation of results and, where appropriate, the effectiveness of the links of global program activities to the country level.

5. Since global programs are partnerships, **efficiency** must include an assessment of the extent to which the benefit-cost calculus in collective organizational, management and financing arrangements is superior to achieving the same results by the individual partners acting alone. The

institutional development impact and the sustainability of the program itself (as opposed to that of the outcomes and impacts of the program's activities) are also addressed in this section of each report.

6. Finally, this being an OED evaluation, it focuses primarily on the **Bank's strategic role and performance** in playing up to its comparative advantage relative to other partners in each program. The Bank plays varied roles in global programs as a convener, trustee, donor to global programs, and lender to developing countries. The Bank's financial support to global programs – including oversight and liaison activities and linkages to the Bank's regional operations – comes from a combination of the Bank's net income (for DGF grants), the Bank's administrative budget, and Bank-administered trust funds. In the case of the Global Environmental Facility (GEF) the Bank is a trustee and in the case of the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria (GFATM), a "limited" trustee. In the case of GEF and MLF the Bank is also an implementing agency. Thus, the assessment of Bank performance includes the use of the Bank's convening power, the Bank's trusteeship, Bank financing and implementation of global programs, and, where appropriate and necessary, linkages to the Bank's country operations. Bank oversight of this entire set of activities is an important aspect of the Bank's strategic and programmatic management of its portfolio of global programs.

7. The first column in Table A.1 indicates how the four sections and 20 evaluation questions addressed in the Phase 2 Report and case studies relates to the eight evaluation issues that were raised by the Bank's Executive Board in the various Board discussions of global programs during the design phase of OED's global evaluation and identified in the OED's Evaluation Strategy paper:[1]

- Selectivity
- Monitoring and evaluation
- Governance and management
- Partnerships and participation
- Financing
- Risks and risk management
- Linkages to country operations

8. The third column in Table C.1 indicates how the four sections and 20 evaluation questions relate to OED's standard evaluation criteria for investment projects (Table A.2), the 14 criteria endorsed by the Development Committee and established by Bank management for approving the Bank's involvement in global programs (Table A.3), and the 8 criteria for grant support from the Development Grant Facility (Table A.4).

9. The 14 **eligibility and approval criteria** for the Bank's involvement in global programs have evolved since April 2000 when Bank management first proposed a strategy to the Bank's Executive Board for the Bank's involvement in global programs and include the *four overarching criteria* endorsed by the Development Committee, and the *four eligibility criteria* and *six approval criteria* presented by Bank management to the Bank's Executive Board. Each global program must meet at least ***one*** of the four relatively more substantive eligibility criteria and ***all six*** of the relatively more process-oriented approval criteria. The first two eligibility criteria relate directly to the Bank's global public goods and corporate advocacy priorities (Table A.3). Although the six approval criteria resemble the topics covered in a project concept or appraisal document for Bank lending operations, unlike for Bank lending operations, there is currently only a one-step approval process for new global

1. OED, The World Bank and Global Public Policies and Programs: An Evaluation Strategy, July 16, 2001, page 21. "Partnerships and participation" were originally listed as two separate evaluation issues in the evaluation strategy document. "Monitoring and evaluation" is now interpreted more broadly to include not only an assessment of the monitoring and evaluation procedures of each program but also the findings of previous evaluations with respect to the outcomes and impacts of each program, and their sustainability.

programs – at the concept stage and not at the appraisal stage. And new global programs only have to be approved by the Bank managing director responsible for the Network proposing a new program, not by the Bank's Executive Board.

10. While the approval of new global programs is logically separate from and prior to their financing (whether from the DGF, trust funds, or other sources), the eight **DGF eligibility criteria** for grant support from the DGF (Table A.4) were actually established in 1998. Twenty out of the 26 case study programs and about two-thirds of the Bank's total portfolio of 70 global programs have received DGF grants.

Table A.1. Key Evaluation Issues and Questions

Evaluation Issues	Evaluation Questions	Reference
Section I. Overarching Global Relevance of the Program		
1. Selectivity	**1. Relevance.** To what extent are the programs: • Addressing global challenges and concerns in the sector • Consistent with client countries' current development priorities • Consistent with the Bank's mission, corporate priorities, and sectoral and country assistance strategies?	A modification of OED's relevance criterion (Table C.2) for the purpose of global programs. The third bullet also relates to managing director (MD) approval criterion #1 regarding a "clear linkage to the Bank's core institutional objectives" (Table C.3).
	2. International consensus. To what extent did the programs arise out of an international consensus, formal or informal: • Concerning the main global challenges and concerns in the sector • That global collective action is required to address these challenges and concerns?	Development Committee (DC) criterion #4 (Table C.3).
	3. MD eligibility criteria. To what extent are the programs: • Providing global and regional public goods • Supporting international advocacy to improve policies at the national level • Producing and delivering cross-country lessons of relevance to client countries • Mobilizing substantial incremental resources?	The four bullets correspond to the four MD eligibility criteria (Table C.3).
	4. Subsidiarity. To what extent do the activities of the programs complement, substitute for, or compete with regular Bank instruments?	DGF eligibility criterion #1 (Table C.4).
Section II. Outcomes, Impacts, and their Sustainability		
	5. Efficacy. To what extent have the programs achieved, or are expected to achieve, their stated objectives, taking into account their relative importance?	OED's efficacy criterion (Table C.2).

Evaluation Issues	Evaluation Questions	Reference
2. Monitoring and evaluation	**6. Value added**. To what extent are the programs adding value to: • What the Bank is doing in the sector to achieve its core mission of poverty alleviation and sustainable development • What developing and transition countries are doing in the sector in accordance with their own priorities?	The first bullet corresponds to DC criterion #1 (Table C.3).
	7. Monitoring and evaluation. To what extent do the programs have effective monitoring and evaluation: • Clear program and component objectives verifiable by indicators • A structured set of quantitative or qualitative indicators • Systematic and regular processes for data collection and management • Independence of program-level evaluations • Effective feedback from monitoring and evaluation to program objectives, governance, management , and financing?	MD approval criterion #6 (Table C.3), since effective communications with key stakeholders, including the Bank's Executive Directors, requires good monitoring and evaluation practices.
	8. Sustainability of outcomes and impacts. To what extent are the outcomes and impacts of the programs resilient to risk over time?	OED's sustainability criterion (Table C.2).
Section III. Organization, Management, and Financing of the Program		
3. Governance and management	**9. Efficiency**. To what extent have the programs achieved, or are expected to achieve: • Benefits more cost-effectively than providing the same service on a country-by-country basis • Benefits more cost-effectively than if the individual contributors to the program acted alone?	A modification of OED's efficacy criterion for the purpose of global programs (Table C.2). The first bullet also relates to MD eligibility criterion #3 (Table C.3) and DGF eligibility criterion #3 (Table C.4).
	10. Legitimacy. To what extent is the authorizing environment for the programs effectively derived from those with a legitimate interest in the program (including donors, developing and transition countries, clients, and other stakeholders), taking into account their relative importance.	A modification of OED's evaluation criteria (Table C.2) for the purpose of global programs.
	11. Governance and management. To what extent are the governance and management of the programs: • Transparent in providing information about the programs • Clear with respect to roles & responsibilities • Fair to immediate clients • Accountable to donors, developing and transition countries, scientists/professionals, and other stakeholders?	MD approval criterion #5 (Tables B.3) and DGF eligibility criterion #5 (Table C.4).

Evaluation Issues	Evaluation Questions	Reference
4. Partnerships and participation	**12. Partnerships and participation**. To what extent do developing and transition country partners, clients, and beneficiaries participate and exercise effective voice in the various aspects of the programs: • Design • Governance • Implementation • Monitoring and evaluation?	DGF eligibility criterion #8 (Table C.4).
5. Financing	**13. Financing**. To what extent are the sources of funding for the programs affecting, positively or negatively: • The strategic focus of the program • The governance and management of the program • The sustainability of the program?	MD approval criterion #4. (Table C.3). The third bullet also relates to OED's sustainability criterion (Table C.2).
	14. Bank action to catalyze. To what extent has the Bank's presence as a partner in the programs catalyzed, or is catalyzing non-Bank resources for the programs?	DC criterion #2 (Table C.3) and DGF eligibility criterion #4 (Table C.4).
	15. Institutional development impact. To what extent has the program established effective institutional arrangements to make efficient, equitable, and sustainable use of the collective financial, human, and other resources contributed to the program.	A modification of OED's institutional development impact criterion (Table C.2) for the purpose of global programs.
6. Risks and risk management	**16. Risks and risk management**. To what extent have the risks associated with the programs been identified and are being effectively managed?	MD approval criterion #3 (Table C.3).
Section IV. World Bank's Performance		
7. Linkages to country operations	**17. Comparative advantage**. To what extent is the Bank playing up to its comparative advantages in relation to other partners in the programs: • At the global level (global mandate and reach, convening power, mobilizing resources) • At the country level (multi-sector capacity, analytical expertise, country-level knowledge)?	DC criterion #3 (Table C.3), MD approval criterion #2 (Table C.3), and DGF eligibility criterion #2 (Table C.4).
	18. Linkages to country operations. To what extent are there effective and complementary linkages, where needed, between global program activities and the Bank's country operations, to the mutual benefit of each?	MD approval criterion #1 (Table C.3) regarding "linkages to the Bank's country operational work."
	19. Oversight. To what extent is the Bank exercising effective and independent oversight of its involvement in the programs, as appropriate, for in-house and externally managed programs, respectively.	This relates to DGF eligibility criterion #6 on "arm's length relationship" (Table C.4). Both questions 17 and 18 together relate to OED's Bank performance criterion (Table C.2).
	20. Disengagement strategy. To what extent is the Bank facilitating effective, flexible, and transparent disengagement strategies, as appropriate?	DGF eligibility criterion #7 (Table C.4).

Table A.2. Standard OED Evaluation Criteria

Criterion	Standard Definitions for Lending Operations	Possible Ratings
Relevance	The extent to which the project's objectives are consistent (1) with the country's current development priorities and (2) with current Bank country and sectoral assistance strategies and corporate goals (expressed in Poverty Reduction Strategy Papers, Country Assistance Strategies, Sector Strategy Papers, Operational Policies).	High, substantial, modest, negligible.
Efficacy	The extent to which the project's objectives were achieved, or expected to be achieved, taking into account their relative importance.	High, substantial, modest, negligible.
Efficiency	The extent to which the project achieved, or is expected to achieve, a return higher than the opportunity cost of capital and benefits at least cost compared to alternatives.	High, substantial, modest, negligible.
Legitimacy /1	The extent to which the authority exercised by the program is effectively derived from those with a legitimate interest in the program (including donors, developing and transition countries, clients, and other stakeholders), taking into account their relative importance.	High, substantial, modest, negligible.
Institutional development impact	The extent to which a project improves the ability of a country or region to make more efficient, equitable and sustainable use of its human, financial, and natural resources through: (a) better definition, stability, transparency, enforceability, and predictability of institutional arrangements and/or (b) better alignment of the mission and capacity of an organization with its mandate, which derives from these institutional arrangements. IDI includes both intended and unintended effects of a project.	High, substantial, negligible, modest.
Sustainability	The resilience to risk of net benefits flows over time.	Highly likely, likely, unlikely, highly unlikely.
Outcome	The extent to which the project's major relevant objectives were achieved, or are expected to be achieved, efficiently.	Highly satisfactory, satisfactory, moderately satisfactory, moderately unsatisfactory, satisfactory, highly unsatisfactory
Bank performance	The extent to which services provided by the Bank ensured quality at entry and supported implementation through appropriate supervision (including ensuring adequate transition arrangements for regular operation of the project).	Highly satisfactory, satisfactory, unsatisfactory, highly unsatisfactory.
Borrower performance	The extent to which the borrower assumed ownership and responsibility to ensure quality of preparation and implementation, and complied with covenants and agreements, toward the achievement of development objectives and sustainability.	Highly satisfactory, satisfactory, unsatisfactory, highly unsatisfactory.

/1 This represents an addition to OED's standard evaluation criteria in the case of global programs, since effective governance of global programs is concerned with legitimacy in the exercise of authority in addition to efficiency in the use of resources.

Figure A.1 Selectivity and Oversight of Global Programs

Selectivity Criteria for Bank Involvement in Global Public Goods: Endorsed by Development Committee (September 2000) /1

1. An emerging international consensus that global action is required
2. A clear value added to the Bank's development objectives
3. The need for Bank action to catalyze other resources and partnerships
4. A significant comparative advantage for the Bank.

Approval Criteria for Bank Involvement in Partnership Initiatives Beyond the Country Level: Established by Bank Management (November 2000) /2

1. A clear linkage to the Bank's core institutional objectives and, above all, to the Bank's country operational work
2. A strong case for Bank participation based on comparative advantage
3. A clear assessment of the financial and reputational risks to the Bank and how these will be managed
4. A thorough analysis of the expected level of Bank resources required, both money and time, as well as the contribution of other partners
5. A clear delineation of how the new commitment will be implemented, managed, and assessed
6. A clear plan for communicating with and involving key stakeholders, and for informing and consulting the Executive Directors.

Global Public Goods Priorities /3

Communicable diseases
- HIV/AIDS, tuberculosis, malaria and childhood communicable diseases, including the relevant link to education
- Vaccines and drug development for major communicable diseases in developing countries

Environmental commons
- Climate change
- Water
- Forests
- Biodiversity, ozone depletion and land degradation
- Promoting agricultural research

Information and knowledge
- Redressing the Digital Divide and equipping countries with the capacity to access knowledge
- Understanding development and poverty reduction

Trade and integration
- Market access
- Intellectual property rights and standards

International financial architecture
- Development of international standards
- Financial stability (incl. sound public debt management)
- International accounting and legal framework

Strategic Focus for Oversight of Global Programs: Established by Bank Management (March 2003)

a. Provide global public goods

b. Support international advocacy for reform agendas which in a significant way address policy framework conditions relevant for developing countries

c. Are multi-country programs which crucially depend on highly coordinated approaches

d. Mobilize substantial incremental resources that can be effectively used for development.

Corporate Advocacy Priorities /3

Empowerment, security, and social inclusion
- Gender mainstreaming
- Civic engagement and participation
- Social risk management (including disaster mitigation)

Investment climate
- Support to both urban and rural development
- Infrastructure services to support private sector development
- Regulatory reform and competition policy
- Financial sector reform

Public sector governance
- Rule of law (including anti-corruption)
- Public administration and civil service reform (incl. public expenditure accountability)
- Access to and administration of justice (judicial reform)

Education
- Education for all, with emphasis on girls' education
- Building human capacity for the knowledge economy

Health
- Access to potable water, clean air and sanitation
- Maternal and child health

/1 From the Development Committee Communiqué issued on September 25, 2000. Both the Development Committee and Bank Management envisaged global programs as being the principal instrument for Bank involvement in providing global public goods.

/2 Global programs are expected to meet all six approval criteria.

/3 These are the five corporate advocacy priorities and the five global public goods priorities (and bulleted sub-categories) from the *Strategic Directions Paper for FY02-04*, March 28, 2001. Within the Partnership Approval and Tracking System (PATS), global programs are expected to identify, for tracking purposes, their alignment with at least one of these ten corporate priorities.

Table A.3. Eligibility Criteria for Grant Support from the Development Grant Facility

1. Subsidiarity	The program contributes to furthering the Bank's development and resource mobilization objectives in fields basic to its operations, but it does not compete with or substitute for regular Bank instruments. Grants should address new or critical development problems, and should be clearly distinguishable from the Bank's regular programs.
2. Comparative advantage	The Bank has a distinct comparative advantage in being associated with the program; it does not replicate the role of other donors. The relevant operational strengths of the Bank are in economic, policy, sector and project analysis, and management of development activities. In administering grants, the Bank has expertise in donor coordination, fund raising, and fund management.
3. Multi-country benefits	The program encompasses multi-country benefits or activities which it would not be efficient, practical or appropriate to undertake at the country level. For example, informational economies of scale are important for research and technology work, and operations to control diseases or address environmental concerns (such as protect fragile ecosystems) might require a regional or global scope to be effective. In the case of grants directed to a single country, the program will encompass capacity-building activities where this is a significant part of the Country Assistance Strategy and cannot be supported by other Bank instruments or by other donors. This will include, in particular, programs funded under the Institutional Development Fund, and programs related to initial post-conflict reconstruction efforts (e.g., in countries or territories emerging from internal strife or instability).
4. Leverage	The Bank's presence provides significant leverage for generating financial support from other donors. Bank involvement should provide assurance to other donors of program effectiveness, as well as sound financial management and administration. Grants should generally not exceed 15 percent of expected funding over the life of Bank funding to a given program, or over the rolling 3-year plan period, whichever is shorter. Where grant programs belong to new areas of activities (involving, e.g., innovations, pilot projects, or seed-capital) some flexibility is allowed for the Bank's financial leverage to build over time, and the target for the Bank grant not to exceed 15 percent of total expected funding will be pursued after allowing for an initial start-up phase (maximum 3 years).
5. Managerial competence	The grant is normally given to an institution with a record of achievement in the program area and financial probity. A new institution may have to be created where no suitable institution exists. The quality of the activities implemented by the recipient institution (existing or new) and the competence of its management are important considerations.
6. Arm's length relationship	The management of the recipient institution is independent of the Bank Group. While quality an arm's length relationship with the Bank's regular programs is essential, the Bank may have a role in the governance of the institution through membership in its governing board or oversight committee. In cases of highly innovative or experimental programs, Bank involvement in supporting the recipient to execute the program will be allowed. This will provide the Bank with an opportunity to benefit from the learning experience, and to build operational links to increase its capacity to deliver more efficient services to client countries.
7. Disengage-ment strategy	Programs are expected to have an explicit disengagement strategy. In the proposal, monitorable action steps should be outlined indicating milestones and targets for disengagement. The Bank's withdrawal should cause minimal disruption to an ongoing program or activity.
8. Promoting partnerships	Programs and activities should promote and reinforce partnerships with key players in the development arena, e.g., multilateral development banks, UN agencies, foundations, bilateral donors, professional associations, research institutions, private sector corporations, NGOs, and civil society organizations.

Source: DGF documentation.

Annex B. People Consulted

Global Health Programs (HNP) Case Study

Gaere	Elizabeth	Representative	DfiD	Accra
Adjei	Sam	Director of Medical Services	MOH	Accra
Melville	George	Country Representative	WHO	Accra
Alemseged	Eskendir	Civil Engineer	African Development Bank	Addis Ababa
Namakando	George	Principal Macroeconomist	African Development Bank	Addis Ababa
Shaaeldin	Elfaith	Resident Representative,	African Development Bank	Addis Ababa
Alem	A.	Health worker	City Hospital	Addis Ababa
Tekle	Ms.	Senior Nurse supervisor	City Hospital	Addis Ababa
Tekalegne	Agonafer	Head	CRDA (National NGO umbrella organization)	Addis Ababa
Herzig	Peter	Health Project Advisor	GTZ	Addis Ababa
Labahn	Thomas	Director	GTZ	Addis Ababa
Seidel	Bjorn	Deputy Director	GTZ	Addis Ababa
Azene	Girma	Head of Planning	MOH	Addis Ababa
Seifu	Yohannes	Head, Health Services and Training	MOH	Addis Ababa
Wit	Klaas	First Secretary, Economic	Netherlands Embassy	Addis Ababa
Broek	Antonius	Deputy Resident Representative	UNDP	Addis Ababa
Nyambi	S.	Resident Representative for UNDP	UNDP	Addis Ababa
Sheth	Mahandra	Representative	UNICEF	Addis Ababa
Jancloes	Michel	Executive Director	WHO	Addis Ababa
Oedi		Sr. Health Officer	WHO	Addis Ababa
Gebreselassie	O.	Senior Health Specialist	World Bank Office	Addis Ababa
Singh	Surjit	Resident Representative	World Bank Office	Addis Ababa
Plasai	Valaikanya	Faculty and Malaria Expert, College of Public Health	Chulalongkorn University	Bangkok
Chareonsuk	Sompong	Country Program Advisor	UNAIDS	Bangkok
Melgaard	Bjorn	WHO Representative	WHO	Bangkok
Laruelle	Jacques		DGC	Belgium
Gaseitsiwe	D.M.	Director of Economic Affairs	Ministry of Finance and Development Planning, Government of Botswana	Botswana
Molomo	Batho	Director of Strategic and Contingency Planning	Ministry of Finance and Development Planning, Government of Botswana	Botswana
Hutt	Janine		CIDA	Canada
Rockhold	Pia		MOFA(Danida)	Denmark

Rantona	Koketso	Executive Director	Community Solutions	Gabarone
Agizew	Tefera	PMO	Epidemiology Unit	Gabarone
Koosimile	Boitshwarelo	Technical Assistant (TB)	Epidemiology Unit	Gabarone
Moakofni	Kentse	Senior Nursing Officer, Malaria	Epidemiology Unit	Gabarone
Mwansa	R.A.	PHS I	Epidemiology Unit	Gabarone
Phindela	Thandie	Principal Health Officer, Malaria	Epidemiology Unit	Gabarone
Khan	Banu	National AIDS Coordinator	NACA	Gabarone
Mandevu	Rose	Chief Health Officer, AIDS/STD Unit	National AIDS Control Program, MOH	Gabarone
Percy	Fiona	AUSAID Advisor	National AIDS Coordinating Agency	Gabarone
Rahman	Mafizur	STI Program Coordinator and Head	National STI Referral Training & Research Center, MOH	Gabarone
Jere	Ackim	Project Manager, Statistics Training	SADC	Gabarone
Odirile	Elliott	Statistician	SADC	Gabarone
Saint-Victor	Rosalind	Country Program Adviser	UNAIDS	Gabarone
Kamau	Macharia	Resident Representative	UNDP	Gabarone
Kalilani	Jean	WHO Representative	WHO	Gabarone
Godal	Tore	Executive Director	GAVI	Geneva
Nabarro	David	Executive Director	GAVI	Geneva
Currat	Louis	Executive Secretary	Global Forum for Health Research	Geneva
De Francisco	Andres	Head, Scientific Operations	Global Forum for Health Research	Geneva
Hayward	David	Head, Finance and Information	Global Forum for Health Research	Geneva
Widdus	Roy	Project Manager	Global Forum for Health Research	Geneva
Herbert	Brad	Associate	Global Fund for ATM	Geneva
Hentschel	Chris	CEO	MMV	Geneva
Venugopal	P.V.	Director, International Operations	MMV	Geneva
Carael	Michel	Chief, Evaluation Program Development & Coordination	UNAIDS	Geneva
Piot	Peter	Executive Director	UNAIDS	Geneva
Sherry	Jim	Program Manager	UNAIDS	Geneva
Aitken	Denis	Chief of Cabinet	WHO	Geneva
Alnwick	David	Program Manager, RBM	WHO	Geneva
Bellah	Ahmed	TDR Scientific Officer	WHO	Geneva
Binh Khanh	Nguyen	Planning Officer, Budget and Management Reform	WHO	Geneva
Blas	Erik	Program Manager	WHO	Geneva

Brundtland	Gro Harlem	Director General	WHO	Geneva
Clark	John Paul	Roll Back Malaria Project	WHO	Geneva
Dragger	Nick	Director, Reproductive Health & Research	WHO	Geneva
Guindon	Emmanuel	Economist (Tobacco), Non-Communicable Diseases	WHO	Geneva
Heymann	David	Executive Director, Communicable Diseases	WHO	Geneva
Janovsky	Katja	Director, Strategies for Cooperation and Partnership	WHO	Geneva
Kumaresan	Jacob	Executive Secretary, Stop TB	WHO	Geneva
Lee	J. W.	Director General	WHO	Geneva
Morel	Carlos	Director, TDR	WHO	Geneva
Pang	Tikki	Director, Evidence for Policy Unit	WHO	Geneva
Pradhan	Namita	Senior Policy Analyst, Office of the Director General	WHO	Geneva
Rabeneck	Sonya	Technical Secretary	WHO	Geneva
Raviglione	Mario	Coordinator, TB Strategy & Operations	WHO	Geneva
Saxena	Abha	Consultant, Evidence for Policy Unit	WHO	Geneva
Smith	Ian	Adviser to the Director-General	WHO	Geneva
Suzuki	Yasuhiro	Executive Director, Health Technology and Medicines	WHO	Geneva
Tanvir	Mehreen	Consultant, TDR	WHO	Geneva
Van Look	Paul	Director, Reproductive Health & Research	WHO	Geneva
Korte	Rolf		GTZ	Germany
A.	Tung	Chairman	Nationals AIDS Committee	Hanoi
Zessler	Laurent	Country Program Advisor	UNAIDS	Hanoi
Ryan	Jordan	Resident Representative	UNDP	Hanoi
Brudon	Pascale	WHO Representative	WHO	Hanoi
Nguyen	Mai Thi	Health Specialist	World Bank Office	Hanoi
Rees	Helen	Director, RHRU	Baragawanath Hospital	Johannesburg
Pick	William	Head, School of Public Health	Witwatersrand University	Johannesburg
Price	Max	Dean, Medical School	Witwatersrand University	Johannesburg
Schneider	Helen	Director, Center for Health Policy	Witwatersrand University	Johannesburg
Asquitu	Joanne	Evaluation Officer	DfiD	London
Mittal	Onkar	Health and Population Department	DfiD	London

Sabey	Steven	Health and Population Department	DfiD	London
Bennett	Steve	Infectious Disease Epidemiology Unit	London School of Hygiene & Tropical Medicine	London
Brugha	Ruairi	Health Policy Unit	London School of Hygiene & Tropical Medicine	London
Cleland	John	Head, DFID-funded Safe Passages to Adulthood	London School of Hygiene & Tropical Medicine	London
Godfrey-Faussett	Peter	Head, DFID funded TB Program	London School of Hygiene & Tropical Medicine	London
Haines	Andy	Dean	London School of Hygiene & Tropical Medicine	London
Hayes	Richard	Professor, Epidemiology & International Health	London School of Hygiene & Tropical Medicine	London
Meek	Sylvia	Malaria Consortium	London School of Hygiene & Tropical Medicine	London
Mills	Anne	Professor, International Health Policy	London School of Hygiene & Tropical Medicine	London
Timaeus	Ian	Center for Population Studies	London School of Hygiene & Tropical Medicine	London
Walt	Gill	Professor, International Health Policy	London School of Hygiene & Tropical Medicine	London
Zaba	Basia	Center for Population Studies	London School of Hygiene & Tropical Medicine	London
Hemmer	Robert		MAE	Luxembourg
Palmer	Kevin	Regional Adviser in Vector-borne and Parasitic Diseases	WHO, WPRO	Manila
Schapira	Allan	Regional Adviser in Malaria	WHO, WPRO	Manila
Postma	Sjoerd	Representative	DANIDA	New Delhi
Martineau	Tim	Senior Health Adviser	DfiD	New Delhi
Nair	Dinesh	Health Adviser	DfiD	New Delhi
Bulusu	Saraswati	National Program Officer	Global Micronutrient Initiative	New Delhi
Sankar	Rajan	National Program Officer	Global Micronutrient Initiative	New Delhi
Schaetzel	Thomas	Regional Coordinator and Senior Program Specialist	Global Micronutrient Initiative	New Delhi
Gupta	Deepak	Joint Secretary, MOHFW	Government of India	New Delhi
Khatri	G.R.	Deputy Director General (TB)	Government of India	New Delhi
Malhotra	S.	Asst. Commissioner (CH)	Government of India	New Delhi
Garg	Subhash Chandra	Director of the Bank Fund	Government of India, Ministry of Finance	New Delhi
Kelkar	Vijay	Minister	Government of India, Ministry of Finance	New Delhi
Saxena	N.C.		Government of India, Ministry of Finance	New Delhi

Arora	V.K.	Director	LRS Institute of TB and Allied Diseases	New Delhi
Nagpaul	Dr.	President	TB Association of India	New Delhi
Bhatnagar	P.C.	Senior Coordinator, Community Health and Development	VHAI	New Delhi
Roy	Taposh	Director, Health	VHAI	New Delhi
Shiva	Meera	Chairman	VHAI	New Delhi
Heywood	Peter	Lead Health Specialist	World Bank Office	New Delhi
Ramana	G.N.V.	Senior Health Specialist	World bank Office	New Delhi
Singh	Suneeta	Senior Public Health Specialist	World Bank Office	New Delhi
Sudahakar	K.	Senior Health Specialist	World Bank Office	New Delhi
Moock	Joyce Lewinger	Associate Vice President	Rockefeller Foundation	New York
Yacoob	May		UN Foundation	New York
Barbour	Paul	Economic Adviser	DfiD	Pretoria
Balfour	Thuthula	Director	SADC Health Sector Coordinating Unit	Pretoria
Ijsselmuiden	Carel	Director	School of Health Systems, University of Pretoria	Pretoria
Russell	Michele	Regional HIV/AIDS Program Coordinator, S. Africa	USAID	Pretoria
Shasha	Welile	WHO Liaison Officer	WHO	Pretoria
Martin	Gayle	Health Specialist	World Bank Office	Pretoria
Omar	Fayez	Country Director	World Bank Office	Pretoria
Sackey	James	Economist	World Bank Office	Pretoria
Borkar	M.B.	Executive Director	Serum Institute of India	Pune
Dhere	R.M.	Director	Serum Institute of India	Pune
Dodwadkar	S.M.	Director	Serum Institute of India	Pune
Jadhav	S.S.	Executive Director	Serum Institute of India	Pune
Carlsson	Barbro		SIDA/SAREC	Sweden
Svensson	Par		SIDA/SAREC	Sweden
Berger	Martine		SDC	Switzerland
Meyers	Richard	Senior Operations Officer	HD Sector Unit, EAPHD, The World Bank	Washington, D.C.
Habayeb	Salim	Lead Public Health Specialist	SASHD, World Bank	Washington, D.C.
Ehmer	Paul G.	Deputy Officer	USAID	Washington, D.C.
Barat	Lawrence	Technical Specialist	World Bank	Washington, D.C.
Batson	Amie	Sr. Health Specialist	World Bank	Washington, D.C.
Carter	Michael	Analyst	World Bank	Washington, D.C.
Hecht	Robert	Sector Manager	World Bank	Washington, D.C.
Hoben	Christopher	Former Operations Advisor	World Bank	Washington, D.C.
Lovelace	J. Christopher	Senior Manager	World Bank	Washington, D.C.
Nassim	Janet	Senior Operations Officer	World Bank	Washington, D.C.

Nawaz	Tawhid	Lead Operations Officer	World Bank	Washington, D.C.
Pannenborg	Ok	Senior Health Advisor	World Bank	Washington, D.C.
Ritzen	Jo	Vice President	World Bank	Washington, D.C.
Saxenian	Helen	Lead Economist	World Bank	Washington, D.C.
Stout	Susan	Lead Monitoring and Evaluation Specialist	World Bank	Washington, D.C.
Tannan	Nandita	Operations Analyst	World Bank	Washington, D.C.
Tzannatos	Zafiris	Advisor	World Bank	Washington, D.C.
Upadhyay	Jagadish P.	Lead Project Officer	World Bank	Washington, D.C.
Weil	Diana	Sr. Public Health Specialist	World Bank	Washington, D.C.
Zewdie	Debrework	Program Director	World Bank	Washington, D.C.
Carty	Lisa	Manager	Gates Foundation	Washington, DC
Marsten	Hilary	Research Analyst	Gates Foundation	Washington, DC
Carter	Michael	Country Director	World Bank	Washington, DC
Liese	Bernhard	Senior Health Advisor	World Bank	Washington, DC
Walker	Christopher	Lead Specialist	World Bank	Washington, DC

Annex C. Assessing Results: What Do We Know About the Outcomes and Impacts of the Global Health Programs Based on Their Evaluation Reports?[2]

11. As the global community has become increasingly results-oriented, it is useful to review the results of the global health programs based on their most recent evaluations. OED supplemented these results with field visits, surveys and interviews of stakeholders. Five of the six programs reviewed in this evaluation are less than eight years old and thus too new to lend themselves to a full impact evaluation. Independent external evaluations existed on five of the six programs: the Special Program for Tropical Disease Research (TDR),[3] the Global Forum for Health Research, Roll Bank Malaria, UNAIDS and the Stop TB Partnership. Progress reports and studies were also available on the Global Drug Facility and various components of GAVI and UNAIDS.[4] UNAIDS. This annex is not an exhaustive review of all this material, *nor of all the recent changes the programs have undertaken in response to these evaluations, some of which are touched upon in Chapter 2*. Rather, it is intended to highlight a few key findings of the specific external evaluations which the boards of the programs commissioned to assess their implications for the role of the World Bank as a partner.

SOME OVERARCHING ISSUES

Determining What Constitutes A Program Influences What Is Evaluated

12. The evaluations raise several overarching issues. The **UNAIDS** evaluation raised the question: what exactly constitutes "the program" and how should its scope be defined? Is "the program" the activities of the secretariat or the activities of all partners? Additionally, should it include the field activities of developing countries? These are crucial questions. Aid harmonization and health system performance level issues are being confronted by all programs at the country level. What the

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[2]. This annex draws on, but OED does not assume responsibility for, the accuracy of the information reported in the reports reviewed and summarized here. The more recent information on the programs, when it was available, is reported in the main body of the report.

[3]. The most recent External Review of TDR was carried out, at the request of the Joint Coordinating Board (JCB), in 1998.

[4]. The external evaluation of Stop TB's Global Drug Facility was conducted by McKinsey & Co. in April of 2003. There exist several other reports on Stop TB, including a review of implementing global TB control by the 2nd Ad Hoc Committee on the TB Epidemic, convened by the DOTS Expansion Working Group, the establishment of the Trust Fund Task Force of the Board, Dr Philip Hopewell's Secretariat project on Re-examining the Roles and Responsibilities of the Stop TB Working Groups, and consultancy on resource mobilization by Finlay Craig reported in the Caines et al. evaluation. For GAVI, at least three evaluative reviews were available. A study, not authorized by GAVI, and conducted by Save the Children and the London School of Hygiene and Tropical Medicine in 2002, Lessons Learned: New Procurement Strategies for Vaccines (Mercer Management Consulting), to the GAVI Board in June 2002, Project to Accelerate Development and Introduction of Pneumococcal Conjugate and Rotavirus Vaccines (McKinsey & Co.) , June 2002. A review of GAVI Task Force work plans (John Marshall, consultant), April 2002, Developing Successful Global Health Alliances (McKinsey & Co.), April 2002.

stakeholders view as "the program," affects their expectations of the realization of program objectives and achievements, as well as the level of their own commitment for action, i.e., whether at the global level alone, or including the actions of their offices at the country level. Similarly program performance indicators and the data on actual (and perceived) costs and benefits are determined by the definition of a "program." Other programs also face this issue.

13. Evaluations stress that several programs have had too ambitious objectives relative to the reality of their funding, strategy or work plans for implementation. Until RBM was restructured, it aimed to halve the incidence of malaria by 2005. The Stop TB partnership, aimed to have 70 percent of people with infectious TB diagnosed and cure 85 percent by 2005. Had more funding been available, the DOTS approach could perhaps have been implemented more rapidly. GAVI's pace of implementation had to be slower because of unanticipated problems in the supply of new vaccines.

14. Setting ambitious objectives can energize constituencies, help raise funds, stimulate vaccine or drug supply, but it can also detract from using the available funds sustainably from the viewpoint of developing countries to develop realistic strategies.[5]

15. Most programs lack a baseline against which to assess performance. After considerable effort, the difficulties of establishing baselines on child immunization, and the lack of reliable immunization records led GAVI to adopt a more pragmatic approach of seeking reporting on incremental coverage of vaccinations achieved, performing data quality audits and providing technical assistance to help build health system level capacity, even going beyond child immunization. Overall, however, GAVI has had a number of pluses: (a) concrete objectives, (b) strong performance orientation, (c) incremental financial resources, and (d) quality technical advice to assist applicants to build their capacity. As a result developing countries have had a strong sense of ownership of the program. GAVI evaluations have nevertheless raised issues of costs, financial sustainability, and the integration of the initiative with the activities of the national ministries of health. Each program is beginning to face similar challenges.

16. Simultaneity, endogeneity (cause and effect), and attribution all pose complex evaluation challenges. Programs with financing and concrete activities, such as GAVI and TDR are more readily "evaluable" than the advocacy programs. The latters' outputs are more measurable. The behavioral impacts of the collection and dissemination of information, of technical assistance, training and capacity building

[5] Some reviewers of earlier drafts observed that agencies/organizations that criticize the initiatives once their lack of achievements begin to surface, were often involved in helping set the original objectives. They argued that founding members of RBM should have played a more active role in getting the partners to critically assess initial goals and objectives. Partners were active in GAVI for several years and could have required that the Global Fund examine the experiences and lessons learnt from GAVI. Donor countries did not do all they could to learn lessons, harmonise global strategies, minimize transaction costs and ensure coordination of technical assistance. Interagency politics is complex and many partners felt compelled to avoid doing anything that might cause a loss of global momentum or interest.

are often more difficult to determine or measure in the case of advocacy programs such as UNAIDS, RBM, Stop TB, or the Global Forum for Health Research.

Box C.1. Stakeholders Have Varying Perceptions of UNAIDS's Role

- It represents the combined effort of the United Nations system on HIV/AIDS, including activities at global, regional, and the country level.
- It represents the common activities of the UNAIDS partners.
- It represents the Geneva-based Secretariat of UNAIDS with its country outposts.

Source: Five Year Evaluation of UNAIDS, 2002

17. Relevance of the information, the effectiveness of its exchange, and the extent to which developing countries have the capacity to access and utilize the new information and knowledge to achieve better or faster outcomes is not sufficiently explored in evaluations (Box C.1). Evidence raises questions about the extent to which the prescribed solutions of partnerships are appropriate, relevant, implemented and working in the specific conditions of developing countries. Program evaluations devote less attention to the content of the message than to the processes, and they focus less on assessing relevance or impacts on the ground in terms of behavioral changes of policymakers, government officials or the citizens. What is frequently reported relates to outputs (the number of best practice cases on the website, the number of leaflets distributed, and to a limited extent on outcomes). Exceptions are TDR and GAVI. The TDR evaluations highlight the considerable positive impacts of TDR research on developing, and then helping to make more broadly accessible, the drugs and treatments needed by relevant populations in partnership with the private sector and developing countries. GAVI reports on the number of children vaccinated.

18. A common, agreed upon evaluative framework does not currently exist for the analysis of *the quality of the partnership*, and its impacts on program governance and management, and on the relevance of interventions and outcomes . Nor do evaluations address questions of selectivity, duplication and transaction costs, either for the partners or for developing countries. Under-estimation of these real costs of operating an effective partnership can result in a less than full realization of the program's potential.

Evaluating the Program Evaluations from the Perspective of the World Bank's Role as a Partner

19. The evaluation of RBM was the strongest in exploring the concept of a program and the roles and performance of its key partners such as the WHO, the World Bank, UNICEF, UNDP, bilateral donors, regional development banks, and individual governments. It examined program relevance and whether or not the program as designed was suited to achieve the program's declared objectives. The evaluation also compared the efforts of the RBM partnership with similar programs in the global health sector. The evaluation of the Stop TB partnership similarly compared the Stop TB Partnership with other programs. The RBM evaluation was unique however because it made *specific and concrete recommendations for each partner, including the Bank.*

20. The TDR external evaluation observed that it was neither a scientific review of the program nor a financial audit. OED's global evaluation has considered the assessment of the program's quality of science, changes in it over time and its relevance to developing countries important. The focus of the assessment was on the contributions of the TDR's disease portfolio to the generation of scientific knowledge, tools for disease control, to strengthening research capacity, and recommendations for positioning TDR in the future. Using the bibliometric technique, the evaluation examined TDR's impact on science and undertook case-studies to review TDR's contribution to the development of tropical disease control tools and treatments.

21. While being among the stronger evaluations, even these two evaluations could have been more informative. In the case of RBM, the evaluation carried out case studies in just three countries. Furthermore, evaluations could have included wider and more systematic reporting of stakeholder perspectives via surveys and impact studies (see Annex I for further details regarding the reporting arrangements of all the program evaluations).

22. The **UNAIDS** evaluation was meant to assess the extent to which the program has met its goals and core objectives (Box 2.2), and the degree to which these goals are realistic given the program's structure and mandate. It also provided conclusions and recommendations on governance, management and the functions that may provide improved performance for the sustainability of the program. Rich in examining the progress, relevance, and achievement of the UNAIDS objectives, in addition to literature reviews and stakeholder interviews, the evaluation drew on 9 country field visits, a self-evaluation questionnaire, and discussions with co-sponsors. But the evaluation lacked in the analysis of the content of the policy, institutional or behavioral changes, or the activities and roles of the co-sponsors in any significant way and it was weak on addressing UNAIDS' country-level performance.

23. Lastly, the evaluation of the Global Forum for Health Research was based on a literature and document assessment, stakeholder interviews, and a partner survey distributed to over three thousand persons to assess the annual forum meeting, analytical work for priority setting, communications and information, monitoring and evaluation, and external relations with the WHO and COHRED.[6] The focus of the evaluation was primarily on examining the Global Forum's core activities as they help to reduce the 10/90 gap. The evaluation team was asked to comment on the role of the Forum in relation to the WHO and other key partners to optimize the Forum's impact on health research. Its terms of reference did not include issues of governance, finance or the involvement of developing countries.

[6]. The evaluation notes that of the three thousand persons to whom the questionnaires were sent electronically, nearly 1000 bounced back. Overall, only 200 responses were complete which corresponds to a 10 percent response rate.

PROGRAM-SPECIFIC RESULTS

Global Research Programs

The Special Programme for Research and Training in Tropical Diseases (TDR)

24. The evaluation identified the three significant impacts of TDR: (a) the development of a number of new tools to combat disease, (b) a strong sense of comparative advantage in product development, and (c) a strengthening of research capacity in developing countries. The highlights of its success include the use of ivermectin for the treatment of onchocerciasis, multi-drug therapy for leprosy, and the fumigant canister for the vector control of Chagas disease. A study by Welcome Trust found TDR to be the fourth largest financer of malaria research globally. It had the highest number of acknowledgements per million dollar invested with 85 percent of TDR funded papers cited at least once in ongoing malaria research.[7]

25. In product development, TDR has increased networking and exchange of information, and it has a unique access to an international network of experts and institutions for collaboration in large-scale field trials. This allows it more credible scientific reputation in research, capacity development and convening authority, with unparalleled pro-bono response by scientists, illustrated in the development of candidates vaccines for malaria, leishmaniasis, and schistosomiasis.

26. In research capacity strengthening through direct capacity building or through participating in research, TDR is credited with training of individual scientists, the establishment of independent research units and centers, a clear transfer of modern technology and methods to research groups in developing countries, and uncontestable evidence of scientific productivity and contribution to national health research and disease control needs. TDR researchers are also strengthened.[8]

27. Yet, key challenges include the very limited availability of resources and the short-term time frame in which TDR operates, with its supporters underestimating the real costs of sustained development, unrealistic expectations and time frames, and limited resources given TDR's disease portfolio and the urgent need to develop tools for disease surveillance and vector control. The evaluation noted a concern about "the financial strain in light of the yet unfulfilled need for further tool development, which could not only produce drugs and vaccines but other tools useful for monitoring and surveillance of interventions" and observed that "TDR is not a pharmaceutical company and will need

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[7]. TDR has had a strong record in research capacity strengthening. By the end of 2002, TDR had supported 1,200 individuals from more than 400 institutes in 80 developing countries working with partners in academia and in the public sector, including governments, international organizations, and others. In a few cases, however, TDR alone has financed and directly overseen the development of products itself, from discovery to field use, contracting out various stages of the process to public or private sector laboratories.

[8]. For example, the capacity established in connection with the Miltefosine trials in India was through research. The Indian institutions have been strengthened to undertake similar trials.

assistance from industry to bring products through the full continuum of development until registration."[9]

28. TDR's contribution to enhancing Bank activity is useful in assessing its direct or indirect role in improving returns to Bank operations and developing countries and its role as a co-sponsor.[10] TDR was involved in advising and executing a large portion of the China schistosomiasis control program, and the Bank used the TDR output (MDT treatment for leprosy) in its India Leprosy programs.[11]

29. While applauding TDR's unique contributions, stakeholders OED surveyed recommended that, in keeping with a results-based approach to tool development, in addition to the well established peer review process in TDR, the program should examine the feasibility of conducting ex-post evaluations of different strategies, value-for money audits, and the development of performance frameworks as a basis for reporting to its governing bodies.

Global Forum For Health Research (Global Forum)

30. The impact of Global Forum activities was assessed in terms of Global Forum's five core activities: the annual Forum meetings, analytic work, funding research initiatives, communications, and monitoring in the evaluation in 2001.

31. The 2001 evaluation found that the annual forum meetings in which 700 participated with 300 paying their way were useful for networking but need to be more focused, prioritizing and reducing the number of topics, and increasing participation for developing countries on the program by 50 percent. The evaluation regarded its **analytical work** as a priority that makes significant impact. It considered the range of the analytical work impressive but questioned the scope and quality given the paucity of in-house capacity. It noted the need for a clear link of research to the annual Forum meetings and suggested the need for impact assessment of the analytical work, e.g. tools for developing health research priorities in assisting policymakers in decision making in both developed or developing countries for health sector allocations.

32. The Global Forum has developed an alliance between health systems and policy research and fostered several **research initiatives** by bringing in new public and private sector partners, and mobilizing new sources of money. The evaluation noted a need for transparency in the Forum's framework for selecting research initiatives, as well as in the budget and the disengagement process. Its activity in **communication**

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[9]. See the External Evaluation of TDR. 1998.

10. For example, the India Leprosy control project, the India Malaria Project (multi-drug resistant treatment), China schistosomaisis control and the China TB Project, OCP programs in Africa, and other Malaria Programs across Africa, etc.

[11]. The TDR evaluation notes "the Ministry obtained a loan from the World Bank to fund its schistosomiasis control program. The World Bank and the Chinese Government invited TDR to participate in a Joint (TDR/Chinese Government) Research Management Committee (JRMC) to oversee the scientific integrity of operational research relating to schistosomiasis control. TDR provides technical expertise for research funded under the Bank loan."

has entailed a network of over 9,000 partners (both institutions and individuals), to build a network to exchange health research information. The 10/90 Report on Health Research has been published biannually and distributed broadly in paper as well as electronic copies. All publications are available on the website www.globalforumhealth.org, which receives some 300,000 hits per month. The Global Forum is actively involved in **monitoring and evaluation** of research-related materials. The performance indicators expected to be used by the Global Forum in assessing its development effectiveness include knowledge about the gap among researchers, policymakers, and donors.

33. Of the initiatives promoted by the Forum, MMV attributed its success to Global Forum's intervention. The lack of formal criteria to assess the progress of initiatives and the time and resources used for achieving progress was highlighted as an issue by the evaluation. The Global Forum's impact on resource allocations could not be assessed due to a lack of data. The Global Forum has a revised work program and a strategy that respond to these findings of the evaluation as reported in chapter 2.

The Global Alliance for Vaccines and Immunization (GAVI)

34. The Caines report focused on operations of the GAVI Board, Working Group and Secretariat and their relationship with Alliance partners and with the Vaccine Fund (VF). While there are as yet few reports on GAVI's outcomes and impacts at the country level, other reports including by McKinsey and Marshall have identified the strategic implications of the country experience that seem to have been significant in determining GAVI's long-term direction. The Caines report stressed the tremendous enthusiasm and support for GAVI and its achievements at the level of coordination and a level of resources. At the same time, it stressed the need for fine-tuning the alliance work from a voluntary group of officials to a more business-like, managed system, a phenomenon that applied to other Partnership Secretariats. The report also stressed the need to strengthen GAVI's structure and interactions with partners to transit from an initial phase of global-level activity, including the development of policies and procedures, *to one of implementation* with greater demands at regional and country levels and greater delegation of authority without becoming bureaucratic. It stressed the adoption of the important basic managerial principles including a compelling goal and focused scope, with a clear understanding of the Alliance's added value and what is required to capture this value (senior champions in partner organizations, an accountable Alliance leader and clear lines of accountability including partner commitments, performance measures and milestones, and detailed operating and funding plans).[12]

35. Many of these features are reflected in GAVI's most recent strategy and work plans with a clear statement of its own expectation of the value added. Although GAVI and the Vaccine Fund are more operational than most programs, even GAVI has faced the

[12] Some commented that the major constraint was that the leadership of EPI at WHO saw limited value in pursuing a systems-based approach to the delivery of health interventions, preferring a vertical programme at the country level. EPI managers were concerned about diluting concentration or diverting resources away from a focus on the objective of increased coverage.

issue of defining what is a "program" – not an entity in its own right – but merely a facilitating agent of other more operational partners and hence the need for its secretariat to remain "lean" while changing from a program to immunize children to one influencing larger health system delivery, supply, demand and financing issues.

36. Following the findings of a number of other external evaluations commissioned by GAVI, the GAVI work plan 2004-2005 builds upon the strategic framework of ten priority areas in four clusters of strengthening health service delivery, ensuring access to vaccines and related products, securing long-term financing, and strategic planning. Responsibilities are assigned to each partner to develop the work plan and not necessarily for implementing the proposed activities. Using the resources of the Vaccine Fund it proposes to work more strategically with the industry so to develop and manufacture products needed by developing countries, a clear comparative advantage for GAVI. The responsible partner or entity is expected to lead, with implementers for each activity having a strong role in planning. Ministries of Health in developing countries are to be supported by their Inter-agency Coordinating Committees (ICCs) that will have an important role to play in many activities. The global level lead partner is to be responsible for overall coordination and monitoring.

37. GAVI has seen its own role as providing early results, innovation and added value, while relying on the basic service delivery infrastructure of developing countries which can respond and absorb the additional resources. Because countries that are unlikely to reach their immunization targets face multiple system-wide barriers such as political/financial commitment, physical infrastructure, monitoring, management, human resources, and social mobilization, it has recognized that it is neither feasible nor cost effective to address these system barriers through an isolated focus on immunization-specific action.[13] Addressing these issues at the country-level by working with governments is clearly the Bank's comparative advantage. GAVI has established clear targets on data quality audits, removal of system level barriers, and in collaboration with Inter-agency Coordinating Committees (ICC), and is attempting to involve a variety of public and private stakeholders. The outcomes and impacts of this activity have not yet been independently evaluated.

38. GAVI has recognized that in certain large countries which have significant challenges and large numbers of unimmunized children, GAVI partners can work individually with the countries and identify the most appropriate role for the alliance. The program is developing a more focused, large country initiative, developing information on best practice, and offering workshops for mutual learning among developing countries.

39. It is beginning to address the problem of unpredictable supply of vaccines by working with multiple suppliers, improving competitive process as well as issues of supply management in developing countries.

[13] Some commentators argued that many African countries want IMCI and are working actively to implement it. Therefore, it is incumbent upon global partners to get behind such initiatives, especially those that are attempting to integrate diverse health interventions in a coherent and evidence-based manner.

Programs in Communicable Diseases

UNAIDS (Joint United Nations Programme on HIV/AIDS)

40. UNAIDS' substantial impacts at the global level and on Bank lending, policy advice and procedures towards its mission "to lead, strengthen and support an expanded response aimed at preventing the transmission of HIV, providing care and support and reducing the vulnerability of individuals and communities to HIV/AIDS, and alleviating the impact of the epidemic" are outlined in chapter 2.[14] The five-year external evaluation of UNAIDS carried out in 2002 noted that the UNAIDS Secretariat has been effective and instrumental in developing consensus over policy and programming at the global level. There had also been clear progress with developing national strategic plans - 19 African countries have set up national HIV/AIDS councils or commissions at senior levels of government and across the region, and 94 countries, including 40 in Africa, have completed national strategic AIDS plans. "In a majority of cases they (national plans) have objectives with monitorable indicators; have introduced a measure of a multisectoral response and have been prepared in consultation with PLWHA, civil society, the private sector and the donor community."[15] UNAIDS's projects at reducing HIV vulnerability in Central and Western Africa cover 17 countries. The Bank-funded West Africa Initiative has produced a manual for organizations implementing HIV prevention and care projects with sex workers and their clients and a research action tool on migration and HIV/AIDS. These projects have stimulated interest in Central African counties, which are now initiating similar projects.

41. The evaluation considered that "in some countries, UNAIDS together with UNICEF and the World Bank is promoting a district level approach (Mali, Uganda, Burkina Faso, Zambia, Thailand, etc)."[16] However, "a major limitation to these efforts has been the lack of strategic restitution or application of knowledge and skills gained during training, conferences, study tours."[17] Though there has been a substantial contribution to policy development by the World Bank, it has come with a degree of isolation of the Bank from the other cosponsors, a situation the Bank has remedied to a substantial degree.

42. Two immediate benefits from the creation of national strategies have been to improve donor coordination and cooperation, albeit from a low base and plan for capacity development of national structures, especially in the health system. But the evaluation did not specify countries where the committees are working well or the reasons why and the lessons learned. It also did not assess the effectiveness of the national plans and the HIV/AIDS councils.

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[14]. UNAIDS Website.

15. UNAIDS Five-Year Evaluation. 2002.

[16]. Ibid, p. 52.

[17]. Ibid, p. 52.

43. UNAIDS' advocacy work had been innovative, flexible and adaptive. The evaluation observed that it had given less emphasis to sponsor research to evaluate the relevance and effectiveness of HIV/AIDS interventions. Prevention and control efforts are constrained by the lack of evidence of effectiveness of interventions and "the program has not yet met the challenge of understanding and disseminating how to stimulate behavior change and develop effective implementation [and that] a challenge for UNAIDS is to find a new balance between its advocacy role and its functions in information provision, capacity building and technical support."[18]

44. UNAIDS regularly publishes reports on the global incidence and prevalence of the disease, as well as on how the epidemic changes across the world's regions. These figures are widely circulated, particularly in international advocacy circles. However, only in a few countries, where ground-level surveillance is of high quality, is the information reliable. High-quality national-level surveillance of disease incidence is a high priority investment needed to prevent, control, and reduce disease incidence.

45. At the country level, UNAIDS's role and influence was overall less noticeable and more dependant on the talent of the country program advisor (CPA). The UN Theme Group is the main instrument of UNAIDS coordination on HIV/AIDS. The UNAIDS Country Program Advisers are responsible for providing practical support to the United Nations Theme Group on HIV/AIDS, along with the co-sponsors who are supposed to work together in theme groups, and assist government and civil society groups in implementing strategic action plans to tackle the epidemic. The theme groups are also major advocates for setting up national HIV/AIDS councils and national strategic planning process for HIV/AIDS. The UNAIDS impact at the country level can therefore also be assessed by examining how and to what extent the theme groups are contributing to an effective national expanded response. UN Theme groups had worked well as a means of stimulating inclusiveness and ownership among its members, including governments, NGOs, and OECD donors, and they have provided a valuable forum to share information for tackling HIV/AIDS. Yet, country by country performance on how well they work is mixed.

46. Mobilizing resources is one of the strategic priorities of Theme Groups, several of which have included that strategy as part of their integrated work plan. The external evaluation noted that while the Secretariat's Program Acceleration Funds (PAF) had provided the impetus to some Theme Groups to help consolidate the operations, build partnerships, and leverage additional funds, "their record has been mixed" in terms of both focus and purpose.[19] No systematic quantitative information was offered in the evaluation of these resources or the specific purposes where these have been used effectively to leverage additional resources or assisted the Theme groups to better perform at the country level.

47. Developing and disseminating information on best practice by UNAIDS is a global public good. Much depends on the relevance of the information, effectiveness of

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[18]. Ibid, p. 52.

19. During 2000-2001 a total of $16 million was allocated to 96 countries, ranging in size from $30,000 to $600,000.

exchange, and the extent to which the exchange is building and developing country capacity to access new knowledge. Since 1996, UNAIDS and its cosponsoring organizations have documented and published a collection of best practices initiatives. More than 153 documents were available online, in print version, or in CD-ROM in 2002. The UNAIDS Secretariat disseminates these documents to people and organizations included in its mailing list. However, the evaluation observed that the distribution was insufficient and demand for translations exceeds supply, especially in Spanish, Portuguese, Arabic, Russian, and local languages. The collection of best practice and related materials was also not readily available at the local level.[20] During the OED team's field visits, government health officials in one country observed that they received more information on AIDS from FAO than from UNAIDS.

48. The evaluation considered "the visibility of financial assistance had improved in countries that participated in the Multi-Country AIDS Programme (MAP) and the World Bank support to National AIDS Commissions had been beneficial in spreading multisectoral involvement and disbursement procedures under the MAP had helped channel funds to grass root actors." Yet "very little progress had been made" in providing governments with more comprehensive financial and technical support, and "the mechanisms that do exist, namely the Integrated Work plan and UN Development Assistance Framework, are judged to lack strategic perspective and are not responsive to country needs."[21] "Financial information was opaque and difficult to access."[22]

49. During the UNAIDS stakeholder workshop to review and clarify the result of the evaluation, stakeholders lauded the broad-based approach, transparency, methods, and the richness of documentation of the evaluation but noted that the report had raised concerns about the need to strengthen country level operations and rapidly move to scale-up; to generate more specific and evidence-based recommendations, especially in areas to improve synergy and coordination between the Secretariat and co-sponsors for country-level capacity strengthening, potential for UN reform, increased synergy with MAP and the GFATM; and to ensure an adequate reflection of the increased co-sponsor commitment and activities at both the global and country levels.[23]

50. Some discussants noted that there was too much focus in the evaluation on the role of the Secretariat and too little analysis of its current and future structure, too little attention to the factors that may have contributed to the failures or successes of national HIV/AIDS responses. Some argued that the evaluation did not provide key strategic recommendations, or detailed analysis of the monitoring and evaluation of the program. Progress to strengthen involvement of sectors other than health at the country level was mixed. While a majority of countries had multisectoral strategies,

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20. Five Year Evaluation of UNAIDS, 2002.

[21]. Ibid, p. 52.

[22]. Ibid, p. 52.

[23]. See the September 2002 Stakeholder workshop discussions on the draft final report on the 5-Year Evaluation of UNAIDS.

the role of other sectors and the link between sectoral objectives and national strategy was not always clear.

51. OED field visits concluded that lack of concrete country-based evidence made it difficult to assess the impacts of some of the efforts of UNAIDS. For example, in Ethiopia bilateral donors noted that they were not included in the Inter-agency Thematic Group but were only given a seat at the technical working group, which had very little "implementation voice." Interviews with NGOs in Ethiopia also suggested that they were "not trusted" by the government and were not involved in the implementation of the UNAIDS supported HIV/AIDS activities, while health ministry officials, considered NGOs to have high overhead and administrative costs to run AIDS control activities. The OED completion report for the first AIDS project in Kenya points out the government's mistrust of NGOs and the lack of willingness to channel funds through them. However, some bilateral donors, almost exclusively, and the GFATM to a small extent, channel funds through NGOs.

52. The World Bank has been assigned the responsibility to achieve harmonization of monitoring and evaluation across different organizations.[24] OED evaluation of the first generation of HIV/AIDS projects should help identify the extent and causes of successes in country-by-country and cross-country outcomes in a way that will assist this effort.

Roll Back Malaria

53. The evaluation noted that while RBM had some accomplishments to its credit in the areas of advocacy, resource mobilization, and consensus building relating to malaria-control activities at the global level, the impact of the partnership at the country level was "sub-optimal." RBM had set unrealistic targets.[25] In Africa RBM's target by 2001 was to introduce and develop a plan for action in 50 percent of the 42 malaria countries in the region, and to increase coverage of ITNs to 25 percent in 80 percent

[24]. The UNAIDS committee of co-sponsoring organizations has created a 'convening agency' concept and designated agencies for coordination in fourteen key thematic areas, with the Bank being responsible for coordinating monitoring and evaluation.

[25] Commentators observed that this, in part, reflects disagreement among the global-level partners on how fast policy changes can be implemented by an external alliance. Partners at global level often did not share the same perceptions, and compared to national leaders, on the constraints to effectively managing country level processes. Also, insufficient attention was given to nurturing changed attitudes and perceptions at the highest levels of government. Country representatives (national EPI & malaria managers, Ministers of Health and Finance, heads of national training institutes, etc) were not brought in during the early global-level discussions to develop strategic goals, thus missing an opportunity to provide a "reality check" to objectives being set. By not taking a significant percentage of the participants from experienced national health systems experts, human resource managers, educators and development economists, global initiatives often set goals and objectives that were poorly aligned the political and social realities on the ground. It was assumed that having a good template for a strategic plan would lead to its immediate adoption at the country level. No one gave much thought as to how a poorly functioning system, with a rudimentary mechanism for supervision and knowledge dissemination would cope with new national policies. Even less thought was given to weak governance and legal institutions, or to the difficulty of regulatory change when it threatened vested political interests.

Rush to "show results" led to not recognizing opposition by countries to the use of long lasting bednets, the use of advisors, etc.

of the 42 countries. A lack of precise malaria-related data has been a constraint. In many countries, there is considerable diversity in the regional malaria incidence, treatment and anti-malarial coverage is often reported as a national aggregate. Until the national data management and reporting systems in countries improves, it will be hard to measure impact of improved malaria control activities. Further, even with good malaria control, overall child/maternal morbidity & mortality may not go down, if famine, conflict or other external factors common in malaria-endemic countries come into play. The 2001 targets did not come close to being achieved and probably will not be achieved until 2005 or later. RBM had completed development and appraisal activities in 15 countries, provided technical assistance to four countries, Congo, Liberia, Sudan, and Somalia, in complex emergency situations, and advocated the reduction of taxes and tariffs on essential malaria commodities in 16 African countries during 2000-2003.[26] The targets for later years needed to be more realistic.

54. Some examples of under-performance at the country level cited by those interviewed included:

- Lack of advocacy with the result that, malaria was still afforded a low priority within the national governments and their health sectors in countries such as Tanzania and Cameroon.
- Lack of link between RBM activities and the major health sector planning and implementation of sector-wide approaches (SWAPS), and engagement with private providers and budgetary cycles, including National Malaria Control Programs (NMCPs) of the countries.
- Lack of integration of RBM activities with the Country Strategic Plans - integrating RBM activities with IMCI, reproductive health, and other health system activity, the broader development processes, such as PRSPs, or where there is integration in PRSPs, how it is to be achieved in practice. [27]
- There is confusion among partners and within WHO about identifying or developing clear plans of action in the focus countries to scale up malaria control activities to establish any significant evidence of decrease in the burden of disease. Some felt that the RBM Partnership Secretariat tends to be sidelined. Instead of giving the Secretariat the needed independence, as UNICEF provides GAVI, the RBM Secretariat is placed under the organizational control of WHO's RBM Technical Department with the result that funding proposals must go through the WHO bureaucratic chain, causing significant delays. The Secretariat cannot act independently, but must support WHO initiatives, which are vertical and do not explicitly foster a health systems approach. Some interviewed argued that making the

26. Roll Back Malaria DGF application, 2003.

[27] Some commentators argued that the PRSP process does not include the division or department heads. By not exploring the perceptions of national programme managers of their real operational constraints, strategies are developed that tell what needs to be done, but rarely shows how it can be done in a given environment. Making a more explicit effort to involve key partners and technocrats in all phases of the PRSP development would help avoid this problem, help effectively track actual versus planned budgets, and increase accountability without threatening country ownership.

RBM Partnership Secretariat an independent body, hosted by WHO but not controlled by it (much as GAVI is positioned at UNICEF) would go a long way toward giving RBM the independence required to foster a non-partisan and common strategy among all partners supporting national malaria control programmes).

- Shortcomings in the M&E system of RBM include the lack of clarity on the definition of indicators, aggregation problems at international level and lack of guidance in RBM guidelines. Some MDG indicators for malaria, as well as the Abuja targets for 2005 and Abuja Goals for 2010 are not measurable. In others they do not clearly reflect the realities, such that even greatly improved malaria control efforts may not lead to a significant decrease in malaria-related morbidity and mortality in the short run. For example, ITN coverage needs to approach almost 80 percent of coverage, and must be coupled with greatly improved case management (access to quality ACTs that are taken correctly) before malaria incidence will fall.[28]

55. The program's loose governance structure introduced inefficiencies in decision-making. Inadequate and inconsistent technical advice contributed to the lack of accountability within the partnership. To meet its targets, the evaluation recommended major reforms in the Roll Back Malaria global architecture including: (a) a reorganization of the RBM Secretariat[29] (b) the creation of an independent governance board, and (c) a reconstitution of the technical support network. In addition the evaluation suggested two important tactical changes, (1) the selection of 8-12 focus countries that show a high degree of commitment and can make rapid progress in the next three years, and (2) the appointment of 'Country Champions.'[30] The Roll Back Partnership made significant changes in the structure and functioning of the RBM Partnership including: (a) the establishment of an RBM Governance Board to set the strategic direction of the RBM Partnership and oversee the activities of the RBM Secretariat; (b) the de-linking of the WHO Technical Malaria functions from the RBM Secretariat; (c) the establishment of multi-partner working groups to develop guidance on strategies for scaling up RBM interventions; and (d), the

[28] But once the high levels are achieved, malaria incidence can drop dramatically. Also, according to some good malaria control, without simultaneous increases in access to potable water, good sanitation and high EPI vaccination coverage will not reduce child mortality. Similarly, without greatly improved Ante-Natal Care and access to skilled birth attendants, maternal mortality incidence may not decrease greatly. One explanation given to OED of the reasons RBM is moving slowly was that it is attempting to promote malaria control through a sector-wide approach, and is meeting resistance (both at the global level and the national level) from other programmes who are afraid that a more integrated approach to scaling up access to health interventions is adopted, their programs will "lose power").

[29] Some commentators suggested that without an independent source of funds to allow the freedom to engage in long-term development of sub-regional and national partnership networks, and the convening authority to bring together technical experts to develop strategic options, including cost-effectiveness studies, RBM will not be able to fulfill its mandate. The annual budget would need to be approved and funded, without requiring WHO approval of expenditures already contained in the approved annual workplan. From this viewpoint, WHO shapes funding decisions, RBM cannot be in a position to reflect and act upon a broad consensus representing all its partners.

[30] Only Kenya has had a true CPA, but he is under-resourced. Uganda was hiring a Senior Administrator, a process taking almost a year to get through the various levels of government and partner approval. And the CPA in Rwanda of a junior rank to the national malaria control manager had no convening authority or ability to move ahead with an integrated agenda at the national level in the focus countries.

establishment of the four Interagency, Inter-Country Teams in the Africa Region are to coordinate technical and programmatic support to countries referred to as "Sub-Regional Networks" (SRNs), for Central, Eastern, Southern and Western Africa. The 4 "SRNs" teams are only partially functioning. They do not have adequate resources, both financial and technical (especially a pool of readily available expertise in health and development economics, finance or health systems). They have limited ability to work with sub-regional partners to develop relevant options for malaria control. Unlike HIV/AIDS there are fewer self standing malaria control projects. Most are components in the health sector projects, hence the data maintained by HDN for the 1991-2002 period are ball-park estimates. According to data HDN had supplied to OED, the Bank had committed around $276 million through 32 projects which were a combination of some self-standing and many mostly malaria component projects in 27 countries. Three countries, India, Madagascar, and Vietnam, received about three-quarters of this lending including a $120 million of IDA credit for malaria control in India, in 1997, the largest single Bank loan for malaria control, implementing RBM strategies, including integrated early detection and prompt treatment; selective vector control, use of medicated mosquito bed nets, and epidemic response in 100 districts in 7 states.

56. While the project improved some of the strategies advocated by RBM, such as early detection and treatment of malaria, decreased use of DDT, and the use of a better surveillance system, it was less effective in shifting the traditional program of residual spraying of houses with DDT to more selective and appropriate approaches to vector control;[31] there was little progress with ITN, even with an overall increased trend in resistance to the insecticide; the ability to detect and control epidemics of malaria remained weak; and the state level and community levels lacked institutional capacity for malaria control.

57. The RBM evaluation indicated that there was a “clear consensus” among other partners that the Bank needed: (a) to raise the profile of malaria on the overall development agenda and in national priority setting; (b) to bring the financing needs of RBM to the attention of Ministries of Finance; (c) to ensure that PRSP and HIPC processes gave appropriate weight to malaria, that monies assigned for malaria needed to be available for use in practice; and (d) to ensure that IDA funds were available in individual countries where needed to finance (if necessary on a long-term basis) some of the costs of malaria control. However, the evaluation noted that the Bank was not fulfilling this role. Furthermore, the Bank was not sufficiently active as an advocate for malaria in the broader development discussions and with the Ministries of Finance.[32]

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[31] Some DDT use is supported by evidence, especially if there are tight enough controls to limit environmental contamination and avoid cross-over use to the agricultural sector. The RBM Secretariat and WHO have recently put out guidelines for the safe and appropriate use of DDTs in areas where DDT-based IRS is significantly more effective in reducing malaria deaths among children and other vulnerable groups, though this remains debated).

[32] Some argued that the Bank has access to the highest levels of decision-makers, helping to ensure the political support necessary to allow longer-term health investments to be seen through to completion. Only the Bank and the IMF are positioned to change the perceptions of Ministers of Finance that malaria control and other evidence-based interventions are not public costs, but investments that generate significant socio-economic

58. At the time there was no full-time staff person assigned to Roll Back Malaria at the World Bank HQ (excepting the CDC secondee). "The senior RBM focal person at the Bank has no budget to pay for his time or his staff's time in attending meetings and ensuring that the Bank is a fully participating partner, coupled with the fact that World Bank country offices frequently do not have health specialists assigned to them, and the World Bank's ability to make substantive contributions to the RBM Partnership are limited."[33]

59. Overall, the RBM Evaluation found that the Bank was a more effective and committed partner early in the life of RBM and that it "needed to reengage in the partnership with the same enthusiasm and commitment as was evident in the earlier years."[34] The evaluation proposed that: (a) senior Bank management must recognize that Bank collaboration in RBM is a corporate priority and a small budget must be created (estimated to be around $600,000 per year) to fund the costs of this participation to allow for the creation and support of an RBM Team at the Bank;[35] (b) the Bank should be an active participant in the process of selecting focus countries; and (c) the Bank should make an effort to educate other partners, both in Bank procedures (especially with regard to IDA lending cycles) and on PRSP, HIPCs, and related materials. It concluded that "the RBM Partnership cannot be effective without the commitments from the World Bank and without the effective delivery of those contributions."[36]

60. The OED teams' field visits and interviews with nationals in Africa and India confirmed these observations. The Bank has since established a global unit, provided it some resources, appointed a senior full time staff member giving him the responsibility for promoting specific communicable diseases, mobilized expertise from WHO and elsewhere and begun to develop global strategies, for example, for malaria proactively relating these strategies to MDGs.

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returns. They argued that the partners rarely have the capacity to make strong "economic" arguments that can convince sceptical finance ministries of the return on investment that can be generated by effective malaria control programmes.

[33]. Roll Back Malaria External Evaluation, 2002.

[34]. Ibid 66. The evaluation noted that "UNDP has been a silent partner" and that "this trend could continue." This would be unfortunate considering the possible advantages that UNDP can potentially contribute, for example, as a convener of the PRSR process at the country level.

[35]. The evaluation proposed that the RBM Team could consist of a proportion (say 20 percent) of the senior RBM focal point at the Bank, plus two more junior World Bank staff who would work more or less full-time on RBM. The RBM Team at the Bank would also include a staff member seconded to the RBM Secretariat at WHO. In addition, the evaluation noted that the best location for this RBM Team in the Bank "is probably within the Africa Vice-Presidency, although it is important that it supports malaria work in other regions and is able to represent the World Bank's participation in malaria control globally, and not just in Africa. These latter requirements suggest an alternative location in the Health, Nutrition and Population Anchor" (RBM Evaluation, 2002).

[36]. Roll Back Malaria External Evaluation, 2002.

The Stop TB Partnership

61. McKinsey and Co., at the request of the Stop TB board, evaluated the Global Drug Facility (GDF), a major component of Stop TB[37] (Box 3.2). The independent evaluation of the Global Stop TB Partnership reported the views of the partners that the Partnership has both added value to what they were already doing and has moved swiftly to introduce widely appreciated new initiatives such as the Global Drug Facility (GDF) and the Green Light Committee.

62. Its strategic objectives to address the main constraints to effective TB control were identified in close consultation with high burden countries. The evaluation considered them to be clear and well defined, and specifically directed towards the intended problems and policy priorities of the principal stakeholders (in relation to UN MDG targets and indicators). Its major achievements and value added are reported in chapter 2 and not repeated here.

63. The evaluation concluded that while the partners have expressed strong commitment to sustaining the Global Stop TB Partnership and its mission and strategy continue to command support, the Partnership currently faces challenges in two areas given that only 16 countries have reached the World Health Assembly targets for 2005.

64. The report identified intensified competition for limited resources and increased uncertainty over funding flows and called for a more effective funding strategy, and for a stronger and political mobilization advocacy. It also stressed the need to build bridges to the AIDS Initiatives given the Partnership's focus of activities on DOTS expansion, DOTS-Plus for MDR TB, TB and HIV/AIDS. It considered the aim of secured long term financing of $20-$30m per annum starting from 2004 to sustain the Global Drug Facility in its present form to be realistic in current circumstances.

65. It acknowledged that the global health partnerships raise sensitive institutional issues, balancing the need for inclusiveness and loosely-knit structures with a necessity for a business-like approach and oversight. That tension had become more apparent in the Stop TB Partnership, as the initial enthusiasm and compromises of start-up had given way to the accountability demands of sustainable operations commanding substantial resources.

[37]. The evaluation is being principally funded by DFID and the Open Society Institute/Soros Foundation and was completed in April 2003.

Annex D. World Bank Lending to Health, Nutrition, and Population

Table D.1. New Commitments and Annual Disbursements, 1990-2004

	Number of New Projects with HNP Components /1		New Commitments (US$ Millions)		Annual Disbursements (US$ Millions) /2
	Entire projects	HNP components only	Entire projects	HNP components only	
1990	18	12.0	972	777	102.8
1991	27	16.0	1,932	1,068	174.6
1992	26	12.9	2,287	1,025	254.7
1993	35	19.1	3,211	1,458	496.9
1994	27	15.9	1,664	1,037	667.5
1995	33	20.1	2,292	1,267	841.4
1996	44	22.3	3,532	2,354	939.6
1997	31	14.6	1,576	945	1,131.8
1998	57	25.0	5,179	2,287	1,231.5
1999	61	22.0	3,820	1,418	1,629.0
2000	44	19.0	2,634	947	1,126.6
2001	52	20.0	3,274	1,170	1,486.6
2002	57	21.0	5,839	1,375	1,461.1
2003	77	28.2	5,011	1,676	1,609.4
2004	35	10.5	3,538	1,259	1,873.3
Total	624	278.5	46,762	20,062	15,026.5

Source: World Bank Business Warehouse (data downloaded on April 16, 2004)

/1 The sum of health, compulsory health finance, and non-compulsory health finance sectors.

/2 Total disbursements by each project in each year are weighted by the proportion of health sector lending in each project.

Figure D.1. World Bank Lending to Health, 1990-2004

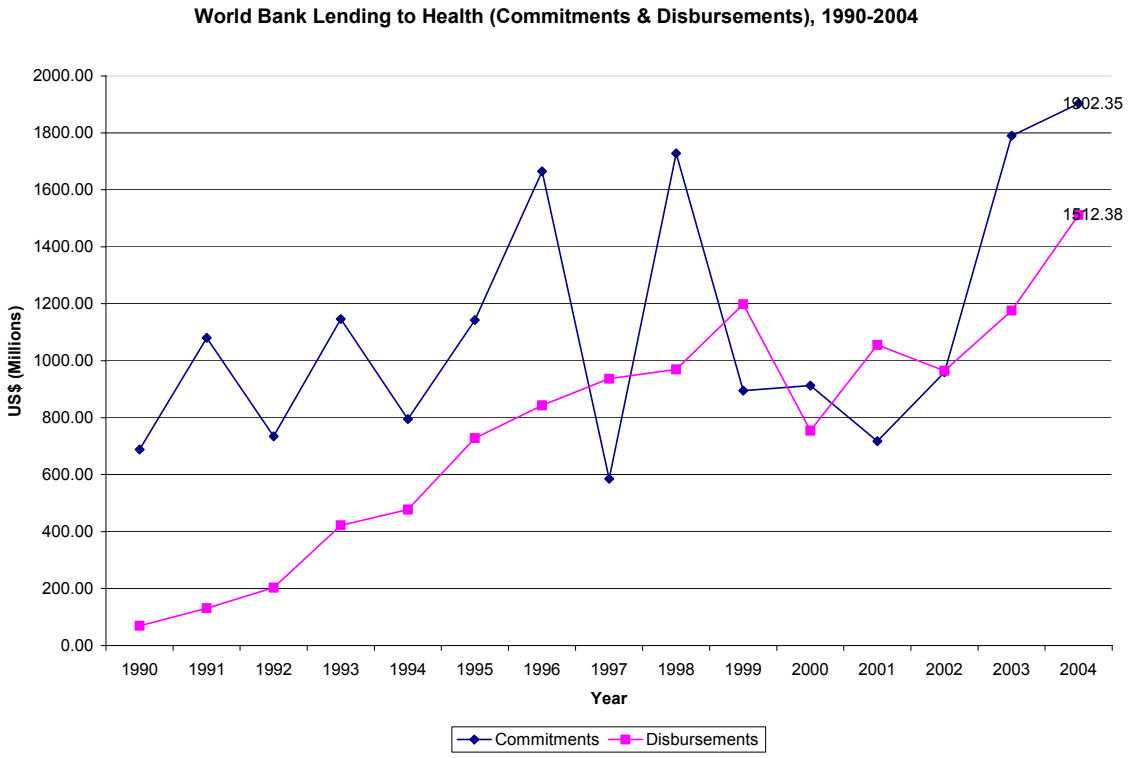


Table D.2. New Commitments by Region, 1990-2003
(US$ Millions, HNP Components Only)

	Africa	East Asia & Pacific	Europe & Central Asia	Latin America & Caribbean	Middle East & North Africa	South Asia	Total
Adjustment Lending							
1990							0.0
1991	16.1						16.1
1992	73.2			30.0	24.8		128.0
1993			131.0	16.2		175.0	322.2
1994	72.3	31.4					103.7
1995							0.0
1996	12.4			353.5	8.0		373.9
1997	31.7		10.8	0.3			42.8
1998	0.6			790.7			791.3
1999	0.3	67.3	48.9	55.6			172.1
2000	3.2	7.2		36.4			46.8
2001	43.2		3.0	122.3	2.4	52.5	223.4
2002	59.2		54.0	325.6		78.0	516.8
2003	70.5	15.0	17.0	408.9	18.0	29.0	558.4
2004	45.5		54.8	755.5			855.8
Subtotal	**428.1**	**120.9**	**319.4**	**2,894.9**	**53.2**	**334.5**	**4,151.3**
% of Total	13.2%	5.6%	15.9%	42.2%	5.4%	7.0%	20.7%
Investment Lending							
1990	166.4			307.8	120.0	182.8	777.0
1991	157.5	175.3		328.0	65.8	325.6	1,052.2
1992	74.4	132.9	274.0	24.8	26.0	364.9	897.0
1993	100.6	213.0	116.7	224.6	182.3	298.3	1,135.5
1994	131.0	160.0		290.8	3.8	347.5	933.1
1995	239.0	247.6	195.3	321.3	32.5	231.7	1,267.4
1996	188.2	265.8	410.8	675.3	81.9	357.9	1,979.9
1997	55.9	48.9	95.9	162.4	7.5	532.1	902.7
1998	208.3	136.5	31.3	211.2	145.7	762.9	1,495.9
1999	177.6	182.8	94.0	374.1	104.2	313.1	1,245.8
2000	129.4	61.3	150.6	148.8	101.4	308.3	899.8
2001	290.8	99.9	26.0	458.1	2.6	69.1	946.5
2002	356.0	192.9	12.7	256.3	40.1		858.0
2003	355.6	118.2	279.9	167.9	4.6	191.0	1,117.2
2004	183.2	10.6	4.7	19.0	13.5	172.4	403.4
Subtotal	**2,813.9**	**2,045.7**	**1,691.9**	**3,970.4**	**931.9**	**4,457.6**	**15,911.4**
% of Total	86.8%	94.4%	84.1%	57.8%	94.6%	93.0%	79.3%
1990	166.4			307.8	120.0	182.8	777.1
1991	173.7	175.3		328.0	65.8	325.6	1,068.3
1992	147.6	132.9	274.0	54.8	50.7	364.9	1,024.9

1993	100.6	213.0	247.6	240.8	182.3	473.3	1,457.6
1994	203.2	191.4	0.0	290.8	3.8	347.5	1,036.6
1995	239.0	247.6	195.3	321.3	32.5	231.7	1,267.3
1996	200.6	265.8	410.8	1,028.7	89.9	357.9	2,353.7
1997	87.6	48.9	106.7	162.7	7.5	532.1	945.4
1998	208.9	136.5	31.3	1,001.9	145.7	762.9	2,287.2
1999	177.9	250.1	142.8	429.6	104.2	313.1	1,417.8
2000	132.7	68.5	150.6	185.1	101.4	308.3	946.6
2001	333.9	99.9	29.0	580.4	5.0	121.6	1,169.7
2002	415.2	192.9	66.7	581.9	40.1	78.0	1,374.7
2003	426.1	133.2	296.9	576.9	22.6	220.0	1,675.7
2004	228.7	10.6	59.6	774.5	13.5	172.4	1,683.4
Total Lending	3,242.1	2,166.4	2,011.2	6,865.1	984.9	4,792.0	20,061.8
% of Total	**16.2%**	**10.8%**	**10.0%**	**34.2%**	**4.9%**	**23.9%**	**100.0%**

Figure D.2. World Bank Health Sector Lending Fluctuated Around $1.4 Billion until 2003, but is Increasing

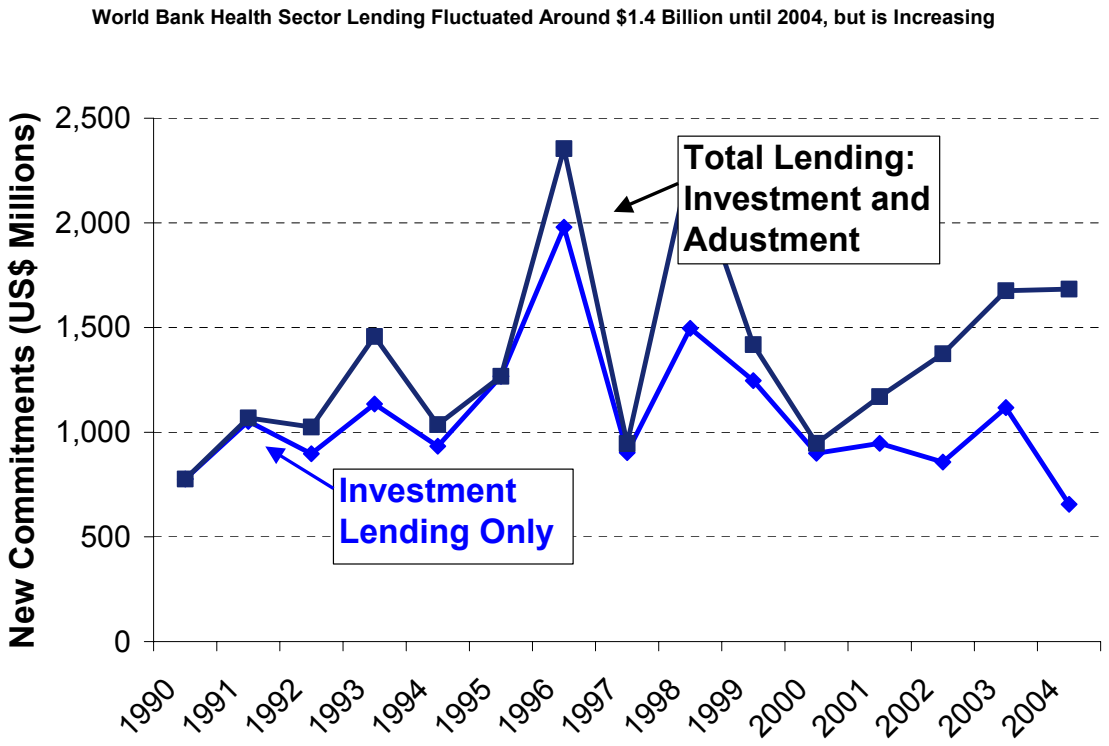


Figure D.3. World Bank Lending to Health, By Region and Lending Instrument, 1990-2004

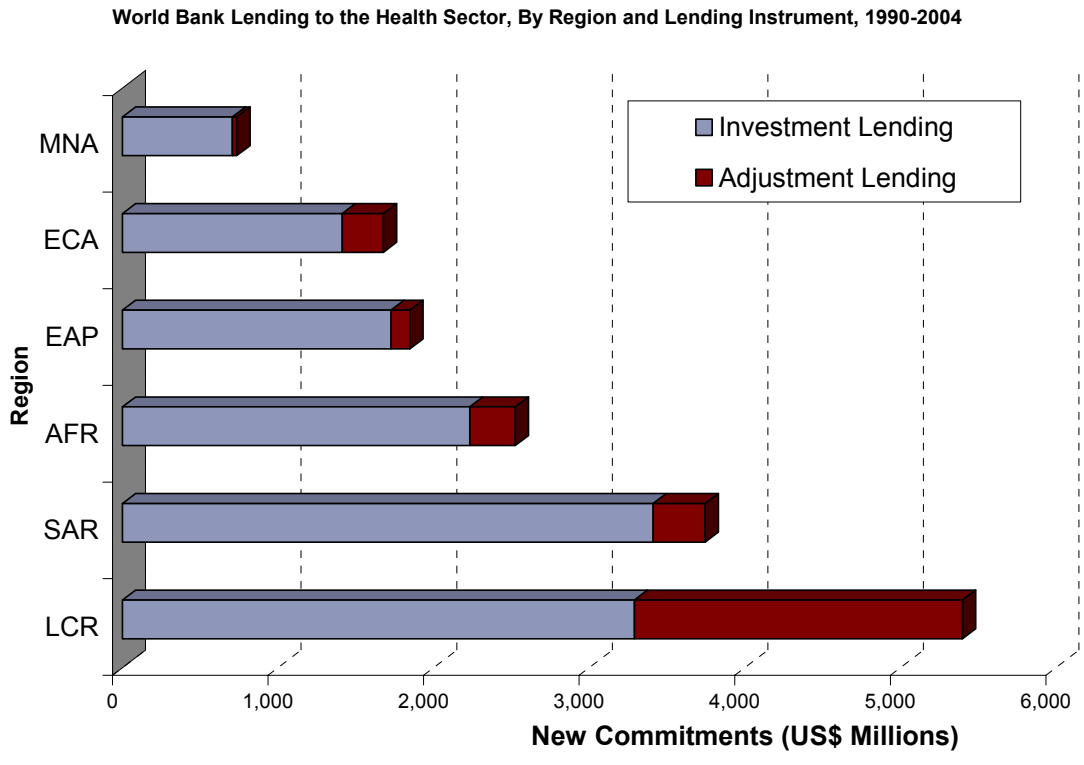


Table D.3. New Commitments by Theme, 1990-2004 (US$ Millions)

	Child Health	Health System Performance	HIV/AIDS	Injury/Non-Communicable Diseases	Nutrition & Food Security	Other Communicable Disease	Population & Reproductive Health	Total
1990	155.1	198.6	11.3		57.7	90.5	174.9	687.9
1991	113.0	410.8		30.0	167.0	141.8	217.9	1080.5
1992	133.2	265.0	33.6		23.2	78.4	201.0	734.4
1993	173.6	338.2	71.3	200.0	126.1	85.8	151.4	1146.4
1994	76.0	278.7	132.6	38.9	46.5	71.9	150.5	795.1
1995	75.1	526.9	20.1	4.5	201.8	179.8	134.5	1142.7
1996	76.0	1125.6	20.4	7.8	69.0	151.9	214.2	1664.9
1997	111.5	145.0	22.0	14.5	62.3	125.7	104.1	585.3
1998	208.8	971.2	15.5	5.1	288.9	89.6	148.6	1727.7
1999	42.9	382.7	136.9	2.4	24.9	152.1	153.3	895.1
2000	152.9	330.0	67.0	85.6	95.0	121.1	60.8	912.5
2001	75.1	316.2	153.6	1.9	39.5	37.6	93.3	717.1
2002	129.8	336.5	193.9		43.5	127.7	128.4	959.8
2003	224.4	502.4	324.5	159.6	199.7	182.5	196.7	1789.7
2004	337.7	546.5	209.9	314.7	32.0	169.3	292.3	1902.4
Total	**2085.0**	**6674.1**	**1412.5**	**865.0**	**1477.1**	**1805.7**	**2421.9**	**16741.3**
1990-2004 Growth	2.88%	3.19%	n.a.	n.a.	-1.85%	2.05%	-1.44%	3.42%

Figure D.4. World Bank Lending to HIV/AIDS, 1990-2004

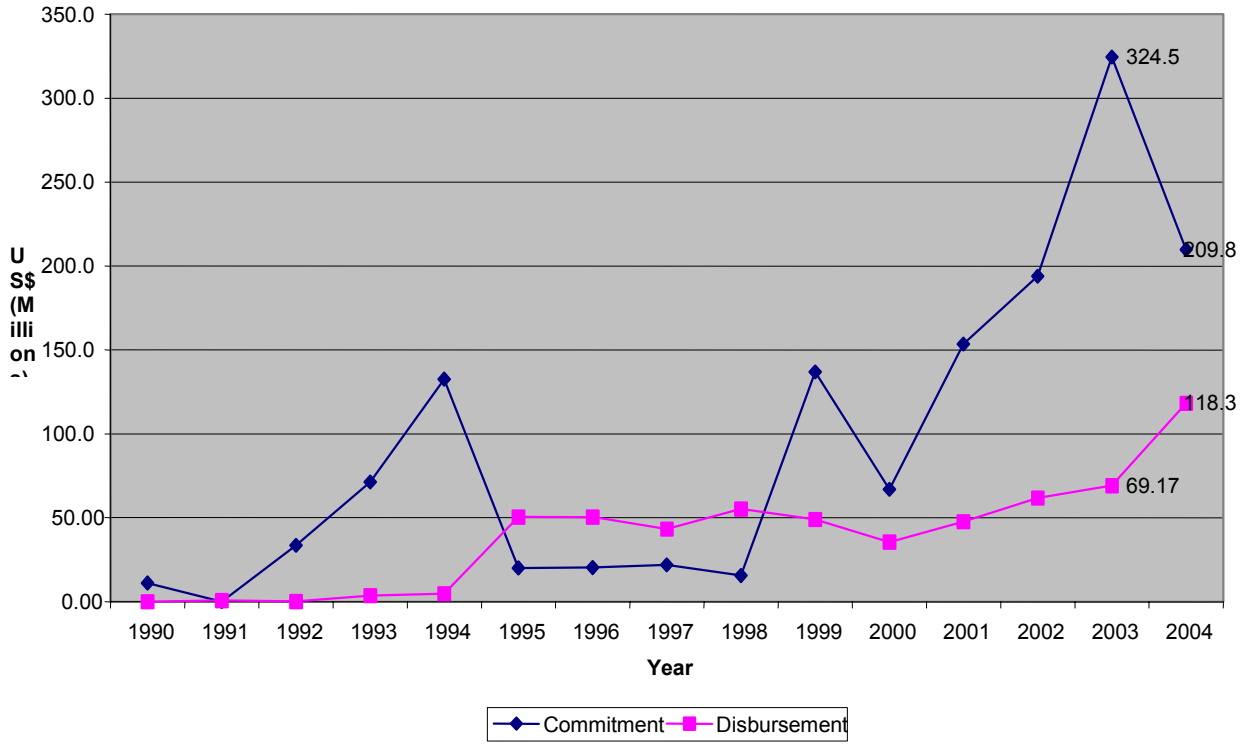
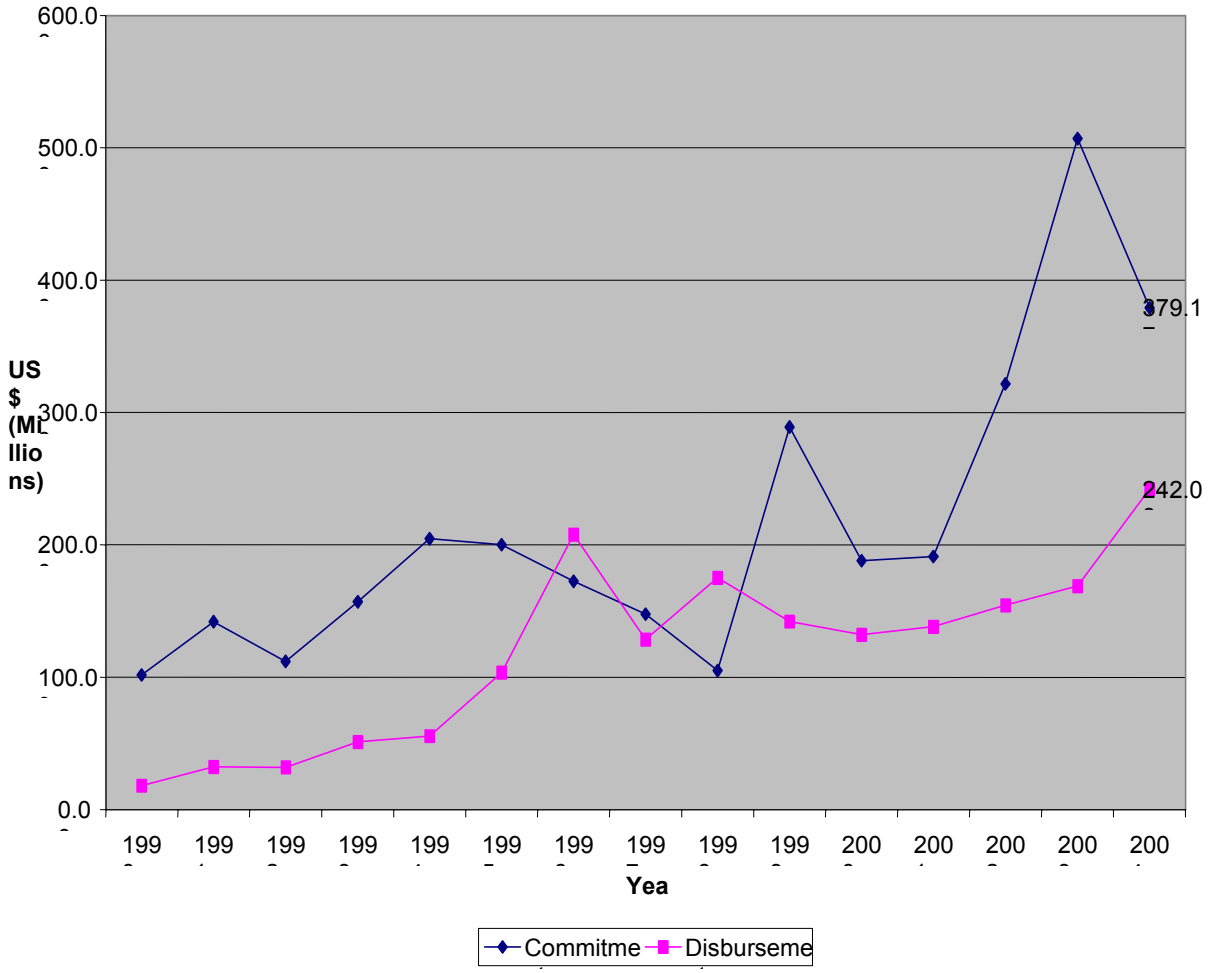


Figure D.5. World Bank Lending to HIV/AIDS and Other Communicable Diseases, 1990-2004



Annex Table 1. Global Health Programs at a Glance

Program	Operational start date [38]	Independent legal entity	Location	World Bank Corporate Priorities[39]		2003 Program expenditures ($ millions)	DGF status	FY04 DGF grant ($ millions)	Country-level TA	Retailing grants
				Major category	Sub-category					
1. Special Programme for Research and Training in Tropical Diseases (TDR)	Dec. 1975	No	WHO	Communicable diseases	HIV/AIDS, TB, malaria & childhood diseases	47.4 [40]	Window 1	2.50	Yes	Yes
2. Global Forum for Health Research	January 1998	Yes	Geneva	Communicable diseases	Vaccines & drug development	3.07	Window 1	0.85	No	Yes
3. UNAIDS (Joint United Nations Programme on HIV/AIDS)	January 1996	Yes	Geneva	Communicable diseases	HIV/AIDS, TB, malaria & childhood diseases	95.0 [41]	Window 1	4.00	Yes	No
4. Roll Back Malaria	Nov. 1998	No	WHO	Communicable diseases	HIV/AIDS, TB, malaria & childhood diseases	11.4	Window 2, Moving to Window 1	1.50	Yes	No
5. Stop TB Partnership	July 1999	No	WHO	Communicable diseases	HIV/AIDS, TB, malaria & childhood diseases	20.8 [42]	Window 2, Moving to Window 1	0.70	Yes	Yes

38. Refers to the Bank's fiscal year (July to June) unless otherwise specified.

39. As indicated on the Partnership Approval and Tracking System (PATS) form. This refers to the five Global Public Good Priorities and the five Corporate Advocacy Priorities that were established in the Strategic Directions Paper for FY02-04, March 28, 2001.

40. $95.2 million for the 2002/03 biennium.

41. $190.0 million for the 2002/2003 biennium.

42. Includes $5.6 million disbursed by the Global Drug Facility in 2002 and $15.6 million in 2003.

Program	Oper-ational start date [38]	Indepen-dent legal entity	Location	World Bank Corporate Priorities[39]		2003 Program expendi-tures ($ millions)	DGF status	FY04 DGF grant ($ millions)	Country-level TA	Retailing grants
				Major category	Sub-category					
6. Global Alliance for Vaccines and Immunization [43]	October 1999	No	UNICEF	Commu-nicable diseases	Vaccines & drug development	124.1 [44]	Window 1	1.50	Yes	Yes

43 The Vaccine Fund is an independent legal entity – a 501(29) non-profit corporation under U.S. law.

44. Includes $14.5 million expensed by GAVI and $109.6 million disbursed by the Vaccine Fund.

Annex Table 2. Goals and Objectives of Global Health Programs

	Mission/Goal	Development Objectives
1. Special Programme for Research and Training in Tropical Diseases (TDR)	To help coordinate, support, and influence global efforts to combat a portfolio of major diseases of the poor and disadvantaged.	*Research and Development:* • To improve existing and develop new approaches for preventing, diagnosing, treating, and controlling neglected infectious diseases. • Readily integrating into the health services of these endemic countries and focusing on the health problems of the poor. *Training and Strengthening:* • To strengthen the capacity of developing endemic countries to undertake the research required for developing and implementing these new and improved disease control approaches.
2. Global Forum for Health Research	The *vision* of the Global Forum is a world in which health research is recognized as a global public good and a critical input in health system development, where priority is given, at the global and national levels, to the study of those factors with the largest impact on people's health and to the effective delivery of research outcomes for the benefit of all people, particularly the poor. Its *central objective* is to help correct the 10/90 gap in health research and focus research efforts on the health problems of the poor by bringing together key actors and creating a movement for analysis and debate on health research priorities, the allocation of resources, public-private partnerships and access of all people to the outcomes of health research.	• Contribute to the efforts to measure the 10/90 gap, monitor developments and disseminate pertinent information regarding this gap, including on its causes and consequences. • Support the development of priority-setting methodologies to identify research priority areas,, including in sectors other than health which have a crucial role to play in the promotion of health. • Identify and debate critical, controversial and burning issues affecting the 10/90 gap in health research. • Give special consideration to the health problems of the poor. • Ensure that gender analysis is consistently and systematically applied to all work on the 10/90 gap. • Be a platform for debate and synthesis review of efforts in the field of research capacity strengthening, paying special attention to the needs of the national health research systems. • Support concerted efforts and the development of networks/partnerships (between the public sector, private commercial sector and civil society organizations) in the priority sectors of health research, when appropriate and when the benefits of joint action are larger than the sum of individual actions.

	Mission/Goal	Development Objectives
3. UNAIDS (Joint United Nations Programme on HIV/AIDS)	As the main advocate for global action, UNAIDS leads, strengthens and supports an expanded response to the epidemic. This response has four goals: • To prevent the spread of HIV • To provide care and support for those infected and affected by the disease • To reduce the vulnerability of individuals and communities to HIV/AIDS • To alleviate the socioeconomic and human impact of the epidemic	The partnership aims to build stronger political commitment in all sectors of society to promote a sense of urgency among the public and create a more supportive environment while providing the political and strategic guidance to enhance the coherence and coordination of the global response to HIV/AIDS by providing: • Leadership and advocacy for effective action on the epidemic • Strategic information to guide efforts against AIDS worldwide • Tracking, monitoring and evaluation of the epidemic and of responses to it • Civil society engagement and partnership development • Mobilization of resources to support an effective response
4. Roll Back Malaria	To halve the world's malaria burden by 2010.	Provision of an enabling environment (e.g., political commitment; development and implementation of appropriate recruitment and career policies; provision of facilities and resources; strengthened training institutions). Intensification of training and retraining of personnel. Technical support mechanisms (e.g., information, communication and supply systems to support trained personnel, supervision, monitoring and evaluation).
5. Stop TB Partnership	To increase access, security, and support to: • Ensure that every tuberculosis patient has access to treatment and a cure; • Protect vulnerable populations from tuberculosis; • Reduce the social and economic toll that tuberculosis exerts on families, communities, and nations.	To expand its current strategy—DOTS—so that all people with TB have access to effective diagnosis and treatment. To adapt this strategy to meet the emerging challenges of HIV and TB drug resistance. To improve existing tools by developing new diagnostics, new drugs, and a new vaccine. To strengthen the Global Partnership to Stop TB so that proven TB-control strategies are effectively applied.

	Mission/Goal	Development Objectives
6. Global Alliance for Vaccines and Immunization/ The Vaccine Fund	The Global Alliance for Vaccines and Immunization is a public - private partnership committed to one goal: saving children's lives and people's health through the widespread use of vaccines. The GAVI partners created *The Vaccine Fund* to provide long-term financing to the world's poorest countries to strengthen health systems and introduce new and under-used vaccines.	To fulfill its mission of protecting children of all nations and of all socioeconomic levels against vaccine-preventable diseases, GAVI has established six strategies: • Improve access to sustainable immunization services. • Expand the use of all existing safe and cost-effective vaccines, and promote delivery of other appropriate interventions at immunization contacts. • Support the national and international accelerated disease control targets for vaccine-preventable diseases. • Accelerate the development and introduction of new vaccines and technologies. • Accelerate research and development efforts for vaccines needed primarily in developing countries. • Make immunization coverage a centerpiece in international development efforts.

Annex Table 3. Global Health Programs: Members of the Governing and Executive Bodies

Program	International/ regional organizations [45]	Industrialized countries	Developing countries	Foundations	Commercial private sector	Civil society organizations [46]	Others
1. Special Programme for Research and Training in Tropical Diseases Joint Coordinating Board (30 members)	UNDP, World Bank, WHO, UNICEF (2003) (co-sponsors)	Belgium, Canada, Denmark, Germany, Japan, Luxembourg, Netherlands, Norway, Portugal, Switzerland, Sweden, UK, USA	Argentina, Armenia, Bangladesh, Brazil, Burkina Faso, Cameroon, China, Cuba, India, Kuwait, Laos, Malaysia, Saudi Arabia, Thailand	–	–	–	–
2. Global Forum for Health Research Foundation Council (20 members currently out of maximum of 20)	GFATM, TDR, World Bank, WHO	Canada, Denmark, Netherlands, Norway, Sweden, Switzerland	India, National Institute of Medical Research (Tanzania), Academy of Sciences (Russia),	Gates, Rockefeller	–	Asian-Pacific Research and Resource Center for Women, Center for Research and Advanced Studies, International Federation of Pharmaceutical Manufacturers Association, International Planned Parenthood Federation, International Women's Health Coalition	–

45. Refers to international and regional **public sector** organizations only, including the World Bank.

46. Broadly defined to include NGOs, umbrella organizations, professional and trade associations, etc. that are independent of the state or governments and without a commercial, for-profit motive.

Program	International/ regional organizations [45]	Industrialized countries	Developing countries	Foundations	Commercial private sector	Civil society organizations [46]	Others
3. UNAIDS (Joint United Nations Programme on HIV/AIDS) Program Coordinating Board (35 members)	ILO, UNDP, UNESCO, UNFPA, UNICEF, UNODC, World Bank, WFP, WHO (co-sponsors)	Canada, Denmark, Germany, Ireland, Japan, Portugal, Spain, Sweden	Bahamas, Brazil, Burundi, China, Cote d'Ivoire, Guatemala, India, Kenya, Myanmar, Pakistan, Philippines, Romania, Russian Federation, Tunisia, Zambia	Canadian Foundation for Drug Policy, Hong Kong AIDS Foundation	–	AAL HDN Organizacion de SIDA-Redla+ (Argentina), Abraco (Portugal), Faith, Hope, and Love (Guatemala), Ghana HIV/AIDS Network	–
4. Roll Back Malaria Steering Committee (15 members currently out of a maximum of 17)	UNICEF, World Bank, WHO (co-sponsors)	Italy, Netherlands, USA	Ghana, DR Congo, India, Senegal, Zambia		Bayer Pharamaceutical	Health and Nutrition International	Executive Secretary of RBM Secretariat, The Executive Director of the Global Fund for ATM
5. Stop TB Partnership Coordinating Board (27 members)	UNICEF, World Bank, WHO (co-sponsors)	Canada, Japan, Netherlands, UK, USA	Brazil, India, Mexcio, Nigeria, Pakistan, Philippines	Soros	–	Six chairpersons of the working groups	Six regional representatives
6. Global Alliance for Vaccines and Immunization GAVI Board (16 members)	UNICEF, World Bank, WHO	Canada, Centers for Disease Control (USA), Institut Pasteur (France), UK	India, Mongolia, Mozambique, Serum Institute of India	Gates, UN Foundation, Vaccine Fund,	Wyeth-Ayerst Global Pharmaceuticals	Sierra Leone Red Cross	–
Executive Committee (7 members)	UNICEF, World Bank, WHO	One rotating member	One rotatiing member	Gates, Vaccine Fund			

Annex Table 4. Chairs, Program Managers, and Bank Oversight of Global Health Programs

Program	Location	Governing Body (& Executive Body, if applicable)	Chair of Governing Body	Program Mange-ment Unit	Program Manager (and title)	World Bank Program Oversight[47]	Current Bank Unit	Comments
1. Special Programme for Research and Training in Tropical Diseases	WHO	Joint Coordina-ting Board	Dr J. Larivière (Canada) Vice Chair Professor N.K. Ganguly, (India)	Secretariat	Dr. R Ridley (Executive Director ad interim)	Ok Pannen-borg (Sr. Adviser)	AFTHD	• Member chair of JCB for 3-year rotating term • Executive Director heads secretariat; appointed by the Director-General of WHO; and reports to JCB • JCB meets annually • Bank's overseer is JCB member
2. Global Forum for Health Research	Geneva	Foundation Council	Richard Feachem (GFATM)	Secretariat	Stephen Matlin	Robert M. Hecht (Sector Manager)	HDNHE	• Independent, part-time chair of Foundation Council for 3- year term • Executive Director heads secretariat, and reports to Foundation Council • Bank's overseer is Foundation Council member • See TDR comment regarding oversight
3. UNAIDS (Joint United Nations Programme on HIV/AIDS)	Geneva	Program Coordina-ting Board	Brain Chituwo (Zambia)	Secretariat	Peter Piot (Executive Director)	Debrework Zewdie (Program Director)	HDNGA	• Member chair of PCB for 3-year rotating term. • Executive Director heads secretariat, and reports to PCB • Bank's overseer is PCB member • See TDR comment regarding oversight

47. Person who is immediately responsible for oversight of the program from the point of view of the World Bank, as distinct from the person who is managing the program.

Program	Location	Governing Body (& Executive Body, if applicable)	Chair of Governing Body	Program Mange-ment Unit	Program Manager (and title)	World Bank Program Oversight[47]	Current Bank Unit	Comments
4. Roll Back Malaria	WHO	Steering Committee	George Amofah (Ghana)	Secretariat	Fatoumata Nafo-Traoré (Executive Director)	Ok Pannen-borg (Sr. Adviser)	AFTHD	• Member chair of Steering Committee for 2-year rotating term • Executive Director heads secretariat, and reports to WHO for administrative purposes and Steering Committee for operational purposes • Bank's overseer is Steering Committee member • See TDR comment regarding oversight
5. Stop TB Partnership	WHO	Coordina-ting Board	Ernest Loevinsohn (CIDA)	Secretariat	Marcos Espinal (Executive Director)	Diana Weil (Sr. Public Health Specialist)	ECCKG/ HDNHE	• Member chair of Coordinating Board for 2-year rotating term • Executive Director heads secretariat, and reports to WHO for administrative purposes and Coordinating Board for operational purposes • Bank's overseer is Coordinating Board member • See TDR comment regarding oversight

Program	Location	Governing Body (& Executive Body, if applicable)	Chair of Governing Body	Program Mange-ment Unit	Program Manager (and title)	World Bank Program Oversight[47]	Current Bank Unit	Comments
6. Global Alliance for Vaccines and Immunization	UNICEF	The Board The Executive Committee[48]	Chair of both: Dr Lee Jong-wook, Director-General (WHO)	Secretariat	Tore Godal (Executive Secretary)	Amie Batson (Sr. Health Specialist)	HDNHE	• Member chair of GAVI Board for 2-year rotating term • Executive Secretary heads secretariat, and reports to GAVI Board • Executive Committee established in July 2003 • Bank's overseer is GAVI Board member • See TDR comment regarding oversight

48 The Executive Committee of the GAVI Board, established in July 2003, facilitates closer supervision and implementation of GAVI's activities; it streamlines operations by removing most day-to-day management responsibilities, which allows the Board to focus on larger issues and decisions. Membership includes all five renewable members (WHO, UNICEF, the World Bank, the Vaccine Fund and the Gates Foundation) and one rotating member each from developing and industrialized country governments.

Annex Table 5. Governance and Management Arrangements of the 26 Case Study Programs in OED's Overall Phase 2 Report

Classification Scheme

I. Line management within the Bank
   A. Standard multi-donor trust fund (Post-Conflict Fund)
   B. Programmatic trust fund
   C. Carefully coordinated parallel partner activities (FSAP)

II. Secretariat inside the Bank
   A. Bank as lead partner (Prototype Carbon Fund, WSP, ESMAP, CGAP, infoDev, PPIAF, Cities Alliance)
   B. Independent governance structure (GEF)

III. Secretariat functions shared between the Bank and an external organization (CGIAR, FIRST)

IV. Secretariat inside external organization
   A. External organization as lead partner (CEPF, Global IPM Facility, RBM, Stop TB, UCW, IF)
   B. Independent governance structure (GAVI, TDR)

V. Independent external entity
   A. Not a legal entity
   B. Legal entity (MLF, Global Forum, GWP, UNAIDS)
   C. Legal entity with close identification with the Bank (GDN, World Links)

Phase 2 Case Study Programs: Models of Governance and Management Arrangements

	I. Bank Line Management			II. Internal Secretariat		III. Shared Secre-tariat	IV. External Secretariat		V. Independent External Entity			
Program (and size)[49]	A	B	C	A	B		A	B	A	B	C	Comments
Environment & Agriculture												
1. Consultative Group on International Agricultural Research ($380 Million)						**X**						• World Bank is the legal entity[50] • Program does not have a written charter. • CGIAR secretariat in Bank, Science Council secretariat in FAO, and 16 centers (14 in developing countries) • Staff are Bank, FAO, and Center employees, respectively. • No agreed annual replenishments. • Bank policies apply to funds channeled through Bank.
2. Global Environment Facility ($447 million)					**X**							• World Bank is the legal entity • Program is implementing an international convention • GEF Secretariat in Bank, but with an independent governing council to whom CEO reports. • UNDP, UNEP, and World Bank are implementing agencies. • GEF staff are Bank employees. • Bank personnel and procurement policies apply to funds channelled through the Bank, i.e. the secretariat and Bank-implemented GEF portfolio.
3. Multilateral Fund for the Implementation of the Montreal Protocol ($101 million)										**X**		• MLF is the legal entity – an intergovernmental organization under Canadian law. • Program is implementing an international convention • Secretariat in Montreal, cost-shared between UNEP and the Government of Canada. • UNDP, UNEP, UNIDO, and World Bank are implementing agencies. • MLF staff are MLF employees. • UNEP personnel and procurement policies apply.

49. FY03 (or latest fiscal year) expenditures in parentheses.

50. While the World Bank is the legal entity at the System level, the 16 international agricultural research Centers are their own independent legal entities.

Annex Table 5

	I. Bank Line Management			II. Internal Secretariat		III. Shared Secre-tariat	IV. External Secretariat		V. Independent External Entity			
Program (and size)[49]	A	B	C	A	B		A	B	A	B	C	Comments
4. Prototype Carbon Fund ($5.01 million)				**X**								• World Bank is the legal entity • Does program have a written charter? • Secretariat in Bank • Do Bank staff outside the secretariat supervise Prototype Carbon Fund projects? • Prototype Carbon Fund staff are Bank employees • Bank's personnel and procurement policies apply
5. Critical Ecosystem Partnership Fund ($25.5 million)							**X**					• Conservation International (CI) is the legal entity – an NGO under U.S. law • Does program have a written charter? • Secretariat in CI (Washington, D.C.) • Bank safeguard and procurement policies apply. • CI's administrative management practices apply to management and disbursement of grants.
6. Global Water Partnership ($10.3 million)										**X**		• GWP is the legal entity – an intergovernmental organization under Swedish law • Does program have a written charter? • Secretariat in Stockholm (not in SIDA) – initially located in World Bank. • GWP staff are GWP employees • GWP personnel and procurement policies apply.
7. Global Integrated Pest Management Facility (n.a.)							**X**					• FAO is the legal entity • Does program have a written charter? • Secretariat in FAO (Rome) • GIF staff are FAO employees. • FAO personnel and procurement policies apply.

Annex Table 5

	I. Bank Line Management			II. Internal Secretariat		III. Shared Secre-tariat	IV. External Secretariat		V. Independent External Entity			
Program (and size)[49]	A	B	C	A	B		A	B	A	B	C	Comments
Health												
8. Special Programme for Research and Training in Tropical Diseases (TDR) ($47.4 million)								**X**				• Although WHO is the legal executing agency, TDR has an independent governance structure and external chair. • Program has a written MOU (first adopted in 1978, amended in 1988, proposed changes in 2003). • Secretariat in Geneva (moved physically out of WHO headquarters in Oct 2002). Joint Coordinating Board (JCB) with 31 members is the top governing body. • Scientific and Technical Advisory Council (15-18 members) meets annually. • TDR staff are WHO employees; TDR Director appointed by the WHO Director-General • WHO personnel and procurement policies apply.
9. Global Forum for Health Research ($3.10 million)										**X**		• Global Forum is the legal entity – a NGO under Swiss law • Program has legally binding Statutes and By-laws as a registered Swiss foundation. • Secretariat in Geneva • GF staff are GF employees • GF personnel and procurement policies apply.
10. UNAIDS (Joint United Nations Programme on HIV/AIDS) ($95.0 million)										**X**		• UNAIDS is the legal entity – a UN specialized agency with its own governing body, created by UN ECOSOC resolution • Program has a written charter • Secretariat in Geneva • UNAIDS staff are UNAIDS employees • UNAIDS personnel and procurement policies apply.
11. Roll Back Malaria ($11.4 million)							**X**					• WHO is the legal entity • Program has a written charter • Secretariat in WHO. • RBM staff are WHO employees • WHO personnel and procurement policies apply.

Annex Table 5

	I. Bank Line Management			II. Internal Secretariat		III. Shared Secre-tariat	IV. External Secretariat		V. Independent External Entity			
Program (and size)[49]	A	B	C	A	B		A	B	A	B	C	Comments
12. Stop TB Partnership ($20.8 million)							**X**					• WHO is the legal entity • Program has a written charter • Secretariat in WHO. • Stop TB staff are WHO employees • WHO personnel and procurement policies apply
13. Global Alliance for Vaccines and Immunization ($124 million)								**X**				• Although UNICEF is the legal entity, GAVI has an independent governance structure and external chair. • Program has a written charter • GAVI Secretariat housed in UNICEF. • GAVI staff are UNICEF employees • UNICEF personnel and procurement policies apply • The Vaccine Fund, the GAVI finance mechanism, is an independent charitable body under U.S. law with its own governance structure.
Infrastructure												
14. Water and Sanitation Program ($12.4 million)				**X**								• World Bank is the legal entity • Program has a written charter • Secretariat in World Bank. • WSP staff are Bank employees • Bank personnel and procurement policies apply.
15. Energy Sector Management Assistance Programme ($6.01 million)				**X**								• World Bank is the legal entity • Secretariat in World Bank • ESMAP staff are Bank employees • Bank personnel and procurement policies apply.
16. Consultative Group to Assist the Poorest ($13.2 million)				**X**								• World Bank is the legal entity • Program has a written charter • Secretariat in World Bank • CGAP staff are Bank employees • Bank personnel and procurement policies apply

	I. Bank Line Management			II. Internal Secretariat		III. Shared Secre-tariat	IV. External Secretariat		V. Independent External Entity			
Program (and size)[49]	A	B	C	A	B		A	B	A	B	C	Comments
17. The Information for Development Program (infoDev) ($8.90 million)				**X**								• World Bank is the legal entity • Program has a written charter • Secretariat in World Bank • InfoDev staff are Bank employees • Bank personnel and procurement policies apply.
18. Public-Private Infrastructure Advisory Facility ($14.5 million)				**X**								• World Bank is the legal entity • Program has a written charter • Secretariat in World Bank. • PPIAF staff are Bank employees • Bank personnel and procurement policies apply.
19. Cities Alliance ($9.67 million)				**X**								• World Bank is the legal entity • Program has a written charter • Secretariat in World Bank • Cities Alliance staff are Bank employees • Bank personnel and procurement policies apply.
Social Development & Protection												
20. Post-Conflict Fund ($13.7 million)	**X**											• World Bank is the legal entity and the only partner at the governance level • Does program have a written charter? • Secretariat located in Bank. • Prototype Carbon Fund staff are Bank employees • Bank personnel and procurement policies apply.
21. Understanding Children's Work ($0.56 million)							**X**					• UNICEF is the legal entity • Does program have a written charter? • Secretariat located in Florence • UCW staff are whose employees? • Which UNICEF policies apply?
Trade & Finance												

Annex Table 5

	I. Bank Line Management			II. Internal Secretariat		III. Shared Secre-tariat	IV. External Secretariat		V. Independent External Entity			
Program (and size)[49]	A	B	C	A	B		A	B	A	B	C	Comments
22. Integrated Framework ($2.71 million)							**X**					• WTO is the legal entity • Does program have a written charter? • Secretariat located in WTO • UNDP manages the trust fund and World Bank is the principal implementing agency • IF staff are WTO employees • Whose personnel and procurement policies apply?
23. Financial Sector Assessment Program ($12.9 million)			**X**									• World Bank and IMF are the legal entities • Joint IMF-Bank program, coordinated through an Interagency Financial Sector Liaison Committee • Staff are Bank and IMF employees • Bank and IMF personnel and procurement policies apply.
24. Financial Sector Reform & Strengthening ($0.78 million)						**X**						• World Bank is the legal entity? • Program has a written charter • Management Unit is located in London and Coordination Unit is located in World Bank • Staff are employees of their respective organizations • Respective personnel and procurement policies apply.
Information & Knowledge												
25. Global Development Network ($10.9 million)											**X**	• GDN is the legal entity – an NGO under U.S. law • Spun off from the World Bank • Program has a written charter • Secretariat presently located in Washington, D.C., but moving to New Delhi • 11 regional research networks are implementing agencies for regional activities • GDN staff are GDN employees • GDN personnel and procurement policies apply
26. World Links for Development ($3.96 million)											**X**	• World Links is the legal entity – an NGO under U.S. law • Spun off from the World Bank • Program does not have a written charter • Secretariat in Washington, D.C. • Staff are World Links employees • Own personnel and procurement policies apply.

Annex Table 6. World Bank's Roles in Global Health Programs

Program	Founder or co-founder	Chair of governing body	Member of governing body	Housed in World Bank	Implementing agency	Funding [51]	TF trustee	TF manager [52]	Lender to the sector	Convener of initiatives in the sector [53]
1. Special Programme for Research and Training in Tropical Diseases (TDR)	Yes	No	Yes	No	No	DGF	No	No	Yes	Yes
2. Global Forum for Health Research	Yes	No	Yes	No	No	DGF	No	No	Yes	Yes
3. UNAIDS (Joint United Nations Programme on HIV/AIDS)	Yes	No	Yes	No	No	DGF	No	No	Yes	Yes
4. Roll Back Malaria	Yes	No	Yes	No	No	DGF	No	No	Yes	Yes
5. Stop TB Partnership	Yes	No	Yes	No	No	DGF	Yes	No	Yes	Yes
6. Global Alliance for Vaccines and Immunization	Yes	No	Yes	No	No	DGF	No	No	Yes	Yes

51. Financial contributions to the program itself, not including BB resources spent on oversight and liaison activities.

52. Involves responsibility for oversight and management of how the trust fund resources are utilized.

53. The World Bank takes the initiative to organize meetings and conferences in the sector on issues related to but outside the scope of the program in order to advocate change, reach consensus and/or mobilize resources with respect to emerging issues in the sector.

Annex Table 7. Relationship of Global Health Programs to International Conventions/ Conferences/Agreements

Program	Convention/Agreement	Role
1. Special Programme for Research and Training in Tropical Diseases (TDR)	Chiang Mai Declaration 2000	Strongly endorsed the TDR/WHO global strategy for prevention and control of dengue and dengue hemorrhagic fever.
2. Global Forum for Health Research		
3. UNAIDS (Joint United Nations Programme on HIV/AIDS)	UN Special Session on HIV/AIDS 2001	The UN General Assembly adopted a Declaration of Commitment on HIV/AIDS and fully endorsed the UNAIDS program
4. Roll Back Malaria (RBM)	Abuja Summit 2000 Okinawa Summit 2000	Both Summits endorsed actions synonymous with those proposed by the RBM Partnership.
5. Stop TB Partnership	Amsterdam Declaration 2000	Formally recognized the efforts of the Stop TB Initiative and endorsed the program.
6. Global Alliance for Vaccines and Immunization (GAVI)	Dakar Declaration 2000.	The Summit formally requested that the partners of the GAVI and the Vaccine Fund continue to assist countries in the mobilization of additional financial resources for health and immunization.

Annex Table 8. Relationship of the 26 Case Study Programs to Millennium Development Goals

Goals	Targets	Direct relationship[1]	Less direct relationship[2]
1. Eradicate extreme poverty and hunger	1. Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day.		CGAP, Global Forum
	2. Halve, between 1990 and 2015, the proportion of people who suffer from hunger.	CGIAR	Global Forum
2. Achieve universal primary education	3. Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.		UCW, Global Forum
3. Promote gender equality and empower women	4. Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015.		Global Forum
4. Reduce child mortality	5. Reduce by two thirds, between 1990 and 2015, the under-five mortality rate.	GAVI	TDR, UNAIDS, RBM, Stop TB, Global Forum
5. Improve maternal health	6. Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.		TDR, Global Forum, UNAIDS, RBM, Stop TB, GAVI
6. Combat HIV/AIDS, malaria and other diseases	7. Have halted by 2015 and begun to reverse the spread of HIV/AIDS.	UNAIDS, GFATM[3]	Global Forum
	8. Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.	RBM, Stop TB, GFATM	TDR, Global Forum, GAVI
7. Ensure environmental sustainability	9. Integrate the principles of sustainable development into country policies and programs and reverse the losses of environmental resources.	GEF, MLF, ProCarbFund, ESMAP	CEPF, GWP, GIF, Global Forum
	10. Halve by 2015 the proportion of people without sustainable access to safe drinking water and sanitation.	WSP	GWP, PPIAF, Global Forum
	11. Have achieved, by 2020, a significant improvement in the lives of at least 100 million slum dwellers.	Cities Alliance	Global Forum
8. Develop a global partnership for development	12. Develop further an open, rule-based, predictable, non-discriminatory trading and financial system		IF, FSAP, FIRST, Global Forum
	13. Address the special needs of the least developed countries	IF	Global Forum
	14. Address the special needs of landlocked countries and small island developing states.		Global Forum

Goals	Targets	Direct relationship[1]	Less direct relationship[2]
	15. Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term.		Global Forum
	16. In cooperation with developing countries, develop and implement strategies for decent and productive work for youth.		Global Forum
	17. In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries.		TDR, UNAIDS, RBM, Stop TB, GAVI, GFATM, Global Forum
	18. In cooperation with the private sector, make available the benefits of new technologies, especially information and communications.	InfoDev	PPIAF, World Links, Global Forum
Programs not directly or indirectly related to any MDGs		PostConFund, GDN	

1. The stated objectives of these programs are directly related to specific MDG targets, although their outputs are only part of the ingredients needed to achieve the MDGs.

2. The objectives of these programs are also related to the achievement of the MDGs in the sense that the goods and services the programs provide are important ingredients needed to achieve particular MDG targets.

3. GFATM, not included in this review, is by far the largest such effort to make investible resources available to developing countries for halting the spread of AIDS, TB, and malaria. International AIDS Vaccine Initiative similarly is attempting to develop vaccines for HIV/AIDS.

Annex Table 9. Recent Sector Strategies and OED Sector Studies Relating to Global Health Programs

Network/ Sector	Type of Report	Date	Title	Principal author (if applicable)
Health, Nutrition & Population	Bank sector strategy	**September 1997**	Health, Nutrition and Population: Sector Strategy	
		December 2003	The Millennium Development Goals for Health: Rising to the Challenges	
	Regional sector strategy	**June 2000**	The World Bank Strategy for Health, Nutrition, and Population in the East Asia and Pacific Region	
	Regional sector strategy	**September 1999**	A Health Sector Strategy for the Europe and Central Asia Region	
	Regional sector strategy	**No date**	World Bank: Middle East And North Africa Region Strategy Paper	
	OED sector strategy Review	**July 1999**	Investing in Health Development Effectiveness in the Health, Nutrition, and Population Sector	Susan Stout

Annex Table 10. Most Recent Program-Level Evaluations of Global Health Programs

Program	Date	Commissioned by	Reported to	Conducted by	Title
1. TDR	October 1998	TDR Joint Coordinating Board (JCB)	TDR JCB	H. Wigzell, F.K. Nkrumah, G.T. Castillo, J. Amor, W.P. Thalwitz, H.G. Boyer	Final Report: Third External Review of TDR
2. Global Forum	Dec. 2001	Global Forum Foundation Council	Foundation Council	Fred Binka, Jan Holmgren, Nimala Murthy	Findings from the External Evaluation: A Report to the Foundation Council
3. UNAIDS	October 2002	UNAIDS Program Coordinating Board (PCB)	UNAIDS PCB	Derek Poate (leading a four-person team)	Five-Year Evaluation of UNAIDS, Final Report
4. RBM	August 2002	UK DFID	DFID and the RBM Steering Committee	R. Feachem (leading a seven-person team)	Achieving Impact: Roll Back Malaria in the Next Phase
5. Stop TB Partnership	December 2003	Stop TB Partnership	Coordinating Board	Karen Caines et al. Institute for Health Sector	Independent External Evaluation of the Global Stop TB Partnership

Program	Date	Commissioned by	Reported to	Conducted by	Title
	April 2003	Coordinating Board Stop TB Partnership Coordinating Board	Coordinating Board	Development London, U.K. McKinsey & Co.	Review of the Global Drug Facility[54]
6. GAVI	June 2002	GAVI Board	GAVI Board	Karen Caines, Hatib N'jie	Report of the External Review of the Functions and Interactions of the GAVI Working Group, Secretariat, and Board /1

54 The McKinsey review of the Global Drug Facility and GAVI's external review are not full program evaluations.

Annex Table 11: Management of Global Health Programs

	TDR	Global Forum	UNAIDS	RBM	Stop TB	GAVI
Secretariat	Implements the agenda and activities of the TDR Program. The team consists of about 27 full-time staff and is administratively housed in Geneva outside of the World Health Organization's headquarters.[55]	Responsible for implementing the activities and reaching the objectives of the Global Forum while operating within Forum policies and orientations. The team currently consists of 13 full-time and support staff and is administratively housed in Geneva.	The UNAIDS Secretariat serves the whole program and is responsible for bringing the activities of the program to fruition. The total staffing of the Secretariat, including fixed and short-term employees, currently is more than 250. The Secretariat is primarily headquartered in Geneva, but there are other administrative posts in all regions of the world.56	Responsible for implementing the activities of the RBM Partnership. The Secretariat is hosted by the Communicable Disease Cluster of the World Health Organization in Geneva. It serves as the coordinating body of the partnership and is accountable to the RBM Governing Board. The Secretariat oversees four key areas: global advocacy and communication, partner coordination, strategy, planning, and monitoring and evaluation, and resource and financing.57	Supports the Stop TB partners in fulfilling the vision and mission of the partnership. To demonstrate the nature of the partnership, the Secretariat is staffed by secondments from partner organizations, and activities of the Secretariat are usually carried out in collaboration with specific partners. The Secretariat is administratively housed in Geneva.58	Facilitates coordination between the partners and manages the review of country proposals to the Vaccine Fund. The Secretariat reports to the GAVI Board. Currently, the team is administratively housed within the European Regional Office of UNICEF in Geneva.59
Business Planning	Scientific and financial reporting measures are in place to ensure that donors are satisfied with the implementation of the program. The	The Foundation Council and STRATEC define the objectives, policy guidelines, and budget for the Secretariat, which is responsible for	UNAIDS' annual work-plan and budget is reviewed and approved by the Program Coordinating Board.61	Roll Back Malaria's annual work-plan and budget is reviewed and approved by the RBM Governing Board	Stop TB's annual workplan and budget is reviewed and approved by the Stop TB Coordinating Board.	The Secretariat collaborates with the Working Group to prepare an annual work plan, subject to the review and approval to the GAVI Board. The members

55. TDR web site. Secretariat Information Page

56. UNAIDS web site. Overview of Structure.

57. External evaluation of RBM.

58. Stop TB web site. Governance Structure. Secretariat Section.

59. GAVI web site. Governance Section. Secretariat.

	TDR	Global Forum	UNAIDS	RBM	Stop TB	GAVI
	Scientific and Technical Advisory Committee reviews all scientific matters; all program expenditures are reviewed and approved by the Joint Coordinating Board.60	reaching these objectives within Forum policies and orientations				of the Working Group are responsible for implementation of the plan.62
Budget Allocation Process	At the annual meeting of the Joint Coordinating Board, the 30 JCB members meet with the STAC and Secretariat to review TDR's activities, discuss new issues and challenges, and agree on the program's strategic direction. TDR's funds, grants, and resource allocations are subject to review and approval by the Joint Coordinating Board, which has fiduciary oversight for the program.	Twice a year, the 20 members of the Foundation Council (which includes members of STRATEC) meet to review the Global Forum's priorities, events, and challenges. In addition, they discuss new issues and agree on the direction of the Forum. Financial matters are subject to review and approval by the Foundation Council, which has fiduciary oversight for the Global Forum.	Plans of action and budget are systematically reviewed and approved by the Program Coordinating Board. The PCB also reviews the plans of action for each period. The PCB then makes recommendations to the cosponsoring organizations. The UNAIDS co-sponsoring agencies — through the Committee of Co-sponsoring Agencies — monitor the activities of the program, as do external reviewers.	The RBM Governing Board is responsible for setting goals and objectives for the RBM Partnership. It coordinates the input of all other partner agencies as is accountable to this broader partnership through the biannual RBM Partners Forums. The RBM Governing Board meets to review RBM's activities, discuss new issues and challenges, and agree on the program's strategic direction for the future. Issues relating to funds are subject to review and approval by the RBM Governing Board, which holds fiduciary responsibility for the	At the annual meeting of the Coordinating Board, member of the partnership meet to review Stop TB's activities, discuss new challenges and important issues, and agree on the partnerships' future outlook. Investment funds, grants, and financial allocations are the responsibility of the Coordinating Board, which has fiduciary oversight for the partnership. In essence, partnership activities are supervised by a broad consensus-building process through the Partners' Forum and communications by the Secretariat, and	At the annual meeting of the GAVI Board, the 20 members meet with representatives from the Working Groups, Task Forces, and the Secretariat, to review GAVI's activities and discuss current events. GAVI's investment funds, grants, allocations, and disbursements are reviewed and approved by the GAVI Board, which has fiduciary responsibility for the program. The GAVI Board has agreed that each member of the Alliance will contribute $300,000 annually for the functioning of the Secretariat. The Executive Secretary is accountable for the use of these funds

60. TDR web site. Operations procedures.

61. UNAIDS. PCB Modus Operandi

62. GAVI. Who We Are: Overview of the Operations Function in the GAVI Secretariat, 30 May 2000.

	TDR	Global Forum	UNAIDS	RBM	Stop TB	GAVI
				program.	then a work-planning process involving all Working Groups and the Coordinating Board.63	according to the appropriations approved by the GAVI Board. The funds are administered as a trust account within UNICEF and therefore are not considered to be income to UNICEF. Funds are disbursed through UNICEF Geneva at the request of the Executive Secretary.64
Reporting	The main reporting mechanisms to the Joint Coordination Board and others are the Annual Report, external evaluations, the program web site, a newsletter, multiple publications, the Annual TDR Joint Coordinating Board Meeting, and interim Executive Committee meetings. In addition, the Secretariat reports to and interacts with the JCB and STAC constantly about new ideas, ongoing activities, and other developments through e-mail, telephone calls, and meetings.	The main reporting mechanisms to the Foundation Council and other stakeholders are the annual Forum meeting, the annual Operations Report, multiple publications, and the website. Additionally, the Secretariat communicates with the Foundation Council and STRATEC effectively through e-mail, telephone calls, and other meetings.	A PCB monitoring and evaluation plan calls for regular reporting to the partners in UNAIDS. The plan calls for processes to assess the outputs, outcomes, and impacts of the program. The reviews and evaluations are shared with partners at various forums and the reviews are disseminated widely through a consultative process. Reporting to the PCB and others is accomplished through the Annual UNAIDS Report, the annual meeting of the PCB, and other mid-	The Secretariat reports on overall progress to the RBM Governing Board. Information is also exchanged at the annual global partners meetings as well as through RBM Reports, external evaluations, and other circulated material. In addition, the Secretariat interacts with the Board to discuss new developments through e-mail and by telephone.	Stop TB disseminates information via several outlets: a weekly Stop TB web alert, a monthly report, and a web site where documents produced are accessible. Financial reports produced by WHO are also made available, as are work-planning documents and progress reports produced by the Secretariat. Other documents and reports prepared by the Working Groups are also available. Other reporting mechanisms include	The main reporting mechanisms of GAVI are its web site, the Annual Report, the Annual Alliance Meeting, and various documents and publications. There is also communication between the Secretariat and the Board via e-mail, phone calls, and small meetings.

63. Stop TB web site. Governance Structure. Procedure Section.

64. GAVI. Who We Are: Overview of the Operations Function in the GAVI Secretariat, 30 May 2000.

	TDR	Global Forum	UNAIDS	RBM	Stop TB	GAVI
	meetings.		year progress reports and publications. In addition, the Secretariat interacts with the PCB constantly about new ideas, ongoing activities, and other developments by phone, e-mail, and through smaller meetings.		the Annual Stop TB Partners Meeting as well as the frequent communication between the Secretariat and the Stop TB Coordinating Board.	

Annex Table 12. Stated Exit Strategies of Global Health Programs

Program	Regarding the program	Regarding the Bank's involvement in the program	Regarding DGF Funding
Special Programme for Research and Training in Tropical Diseases (TDR)	Because of the time needed to develop new therapeutic agents and the specific epidemiological features of some diseases, the TDR has an open-ended time frame. However, through its internal review mechanism the program "exits" from diseases once tools have become available. Examples include leprosy, onchocerciasis, and to a large extent, schistosomiasis.	The Bank has been involved with TDR since its inception, with a full understanding that combating the disease that the program targets will take a long-term commitment.	
	Window 1.		
Global Forum for Health Research	The Global Forum for Health Research works to correct the 10/90 gap in health research. The 10/90 gap has also been highlighted by the Commission on Macroeconomics and Health. The program is a long-term endeavor.	The Bank has been involved in the Global Forum since its inception as a financial donor, catalyst of additional resources, and legitimizing force. Moreover, the Bank channels some of its funds through the Global Forum for use by other programs and organizations. Presently, there is no strategy for Bank disengagement from the program.	Window 1.
UNAIDS	HIV/AIDS will require a long-term commitment from the UNAIDS Cosponsors and partner organizations.	The Bank has been involved in UNAIDS from the outset. It is a co-sponsor of the program and appears as a permanent member on the UNAID Program Coordinating Board. There is presently only a partial strategy for Bank disengagement from the program – based on partnership progress as monitored by	Window 1.

		the Sector Board.	
Roll Back Malaria	Sustaining program activities will be accomplished through increased recognized credibility of the institution and of the activities, which will increasingly be supported by other financiers, and beneficiary countries themselves	The Bank has been involved in RBM since the program's inception as a co-sponsor and appears as a permanent member on the RBM Governing Board. There is presently no stated disengagement strategy on behalf of the Bank regarding the program.	Moved from Window 2 to 1.[65]
Stop TB Partnership	The Stop TB Initiative was launched as a two-year activity, 1999-2000. However, as its work program has evolved, its partners have agreed that it must continue to operate at least until 2005.	The Bank has been involved in Stop TB since the program's inception and appears as a permanent member on the Stop TB Coordinating Board. Through the Global Plan to stop TB, the World Bank and other partners have made commitments to help meet 2005 interim targets and the 2025 targets to reverse the TB epidemic. There is no stated disengagement strategy on behalf of the Bank regarding the program.	Moved form Window 2 to 1. [66]
Global Alliance for Vaccines and Immunization	Childhood immunization is seen to be the most cost-effective health intervention. There exist 33 million annual un-vaccinated children, and the program has strong financial support from the Gates Foundation and other international agencies, including UNICEF and the Bank, to not only immunize, but also establish the basic infrastructure to carry out child immunization programs for the near future.	The Bank has been involved in GAVI since the program's inception as a co-sponsor and permanent member on the GAVI Board. There is no stated disengagement strategy on behalf of the Bank.	Window 1.

65 As a Window 2 program, Roll Back Malaria hit the three-year limit for Window 2 programs in FY04. The program requested extending DGF support to the RBM Malaria Partnership beyond FY04 until FY15 under the Window 1. DGF indicates that RBM is considered important for Bank's clients by the Sector Boards and Networks because it is closely aligned with sector priorities and essential for sustaining Bank engagement. Thus, the Sector Board requested longer-term DGF support starting in FY05.

66 As a Window 2 program, Stop TB hit the three-year limit for Window 2 programs in FY04. It was proposed that DGF financing continue at a level that enhances the Bank's active engagement with key agencies and demonstrates Bank commitment to overcoming obstacles to meeting the MDGs (#8). DGF indicated that Stop TB is considered important for Bank's clients by the Sector Boards and Networks because it is closely aligned with sector priorities and essential for sustaining Bank engagement.

Annex Table 13. Financing of Global Health Programs

	Program Expenditures (US$ millions)		Donor Contributions (US$ millions)		World Bank DGF Allocation (US$ millions)			World Bank Share[67]	
Program	**2002**	**2003**	**2002**	**2003**	**FY02**	**FY03**	**FY04**	**2002**	**2003**
1. TDR	47.8	47.4 [68]	30.5	35.9	2.50	2.50	2.50	8.2%	7.0%
2. Global Forum for Health Research	2.73	3.10	3.11	3.43	0.70	0.85	0.85	22.5%	24.8%
3. UNAIDS	95.0	95.0 [69]	92.0	118.7	4.00	4.00	4.00	4.3%	3.4%
4. RBM	11.4	11.4	53.5	28.3	1.50	1.50	1.50	2.8%	5.3%
5. Stop TB/Global Drug Facility	10.5	20.8 [70]	12.7	21.6	0.70	0.70	0.70	5.5%	3.5%
6. GAVI/Vaccine Fund	101.3	124.1 [71]	n.a	n.a.	1.50	1.50	1.50	1.5%	1.2%
Total	**268.5**	**301.7**	**292.7**	**331.6**	**10.9**	**10.9**	**11.2**	**3.7%**	**3.4%**

67. Of total financial contributions to the program in each year.

68. $95.2 million for the 2002/03 biennium.

69. $190.0 million for the 2002/2003 biennium.

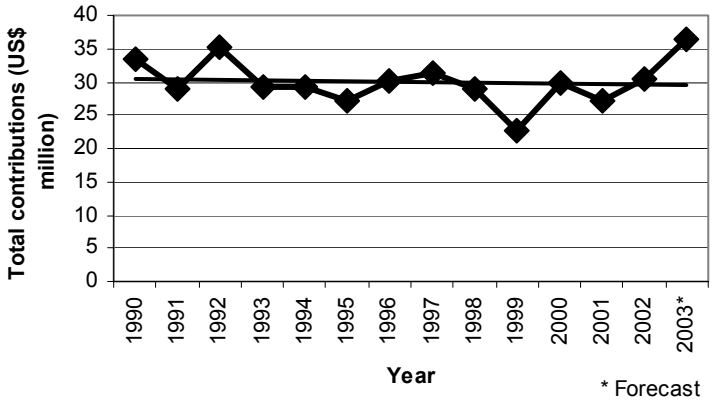
70. Includes $5.6 million disbursed by the Global Drug Facility in 2002 and $15.6 million in 2003.

71. Includes $14.5 million expensed by GAVI and $109.6 million disbursed by the Vaccine Fund.

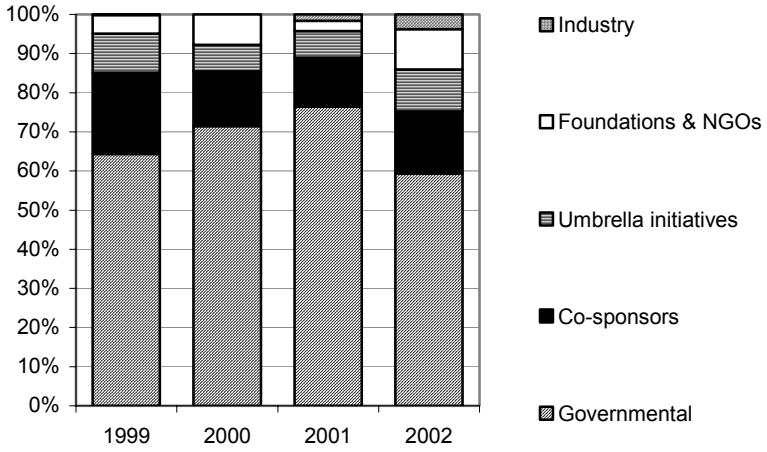
Annex E. Additional Information on Financing of Global Health Programs

THE SPECIAL PROGRAMME FOR RESEARCH AND TRAINING IN TROPICAL DISEASES

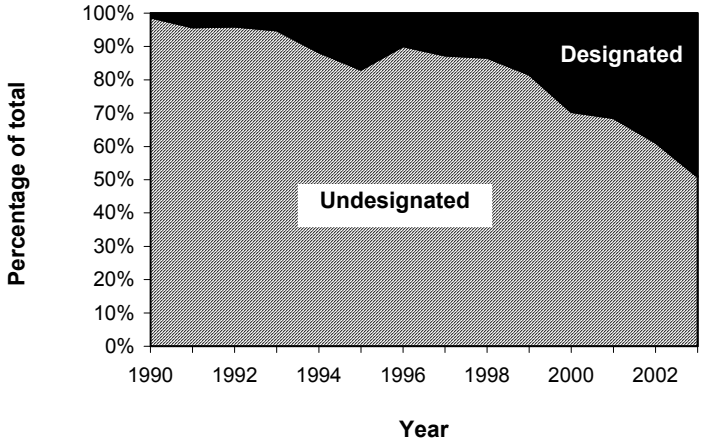
Total budget has been stable over the period 1990-2002.



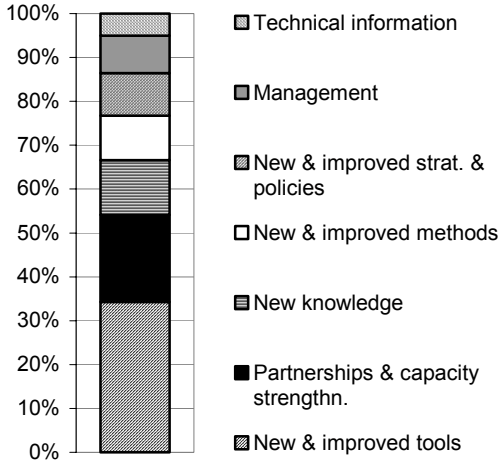
Governmental sources have historically made up the largest share of funding. The share provided by industry has grown but remains small (4% in the 2002 budget).



Percentage of designated funds has been growing, especially since 2000.

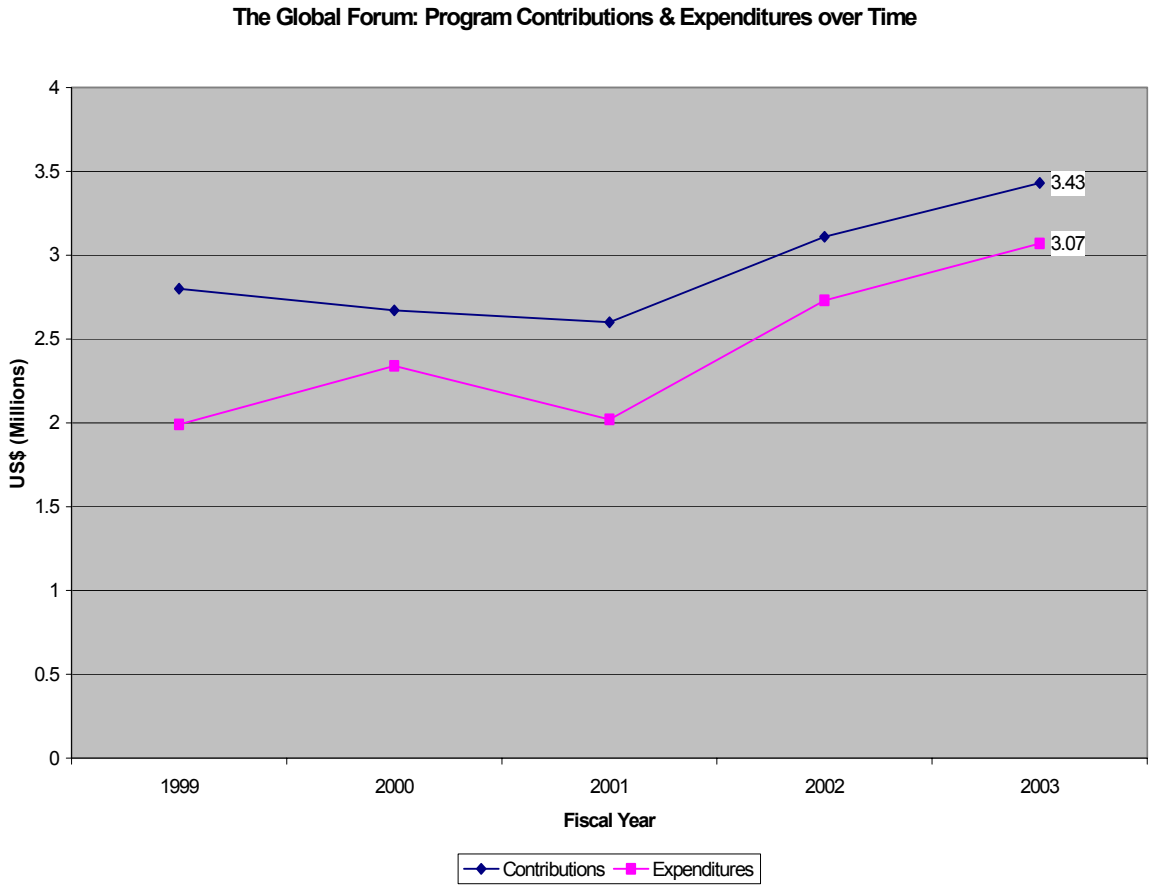


The largest share of the current budget goes to developing new and improved tools.

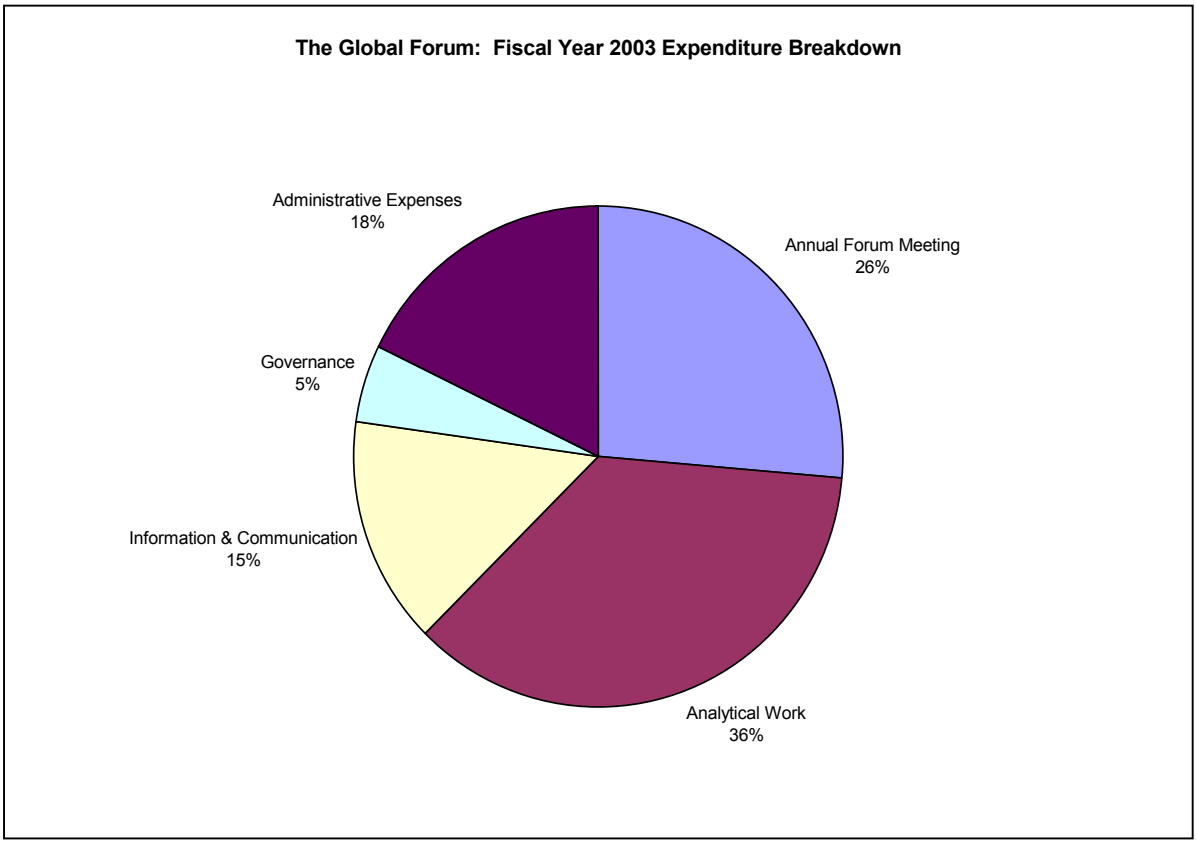


THE GLOBAL FORUM FOR HEALTH RESEARCH

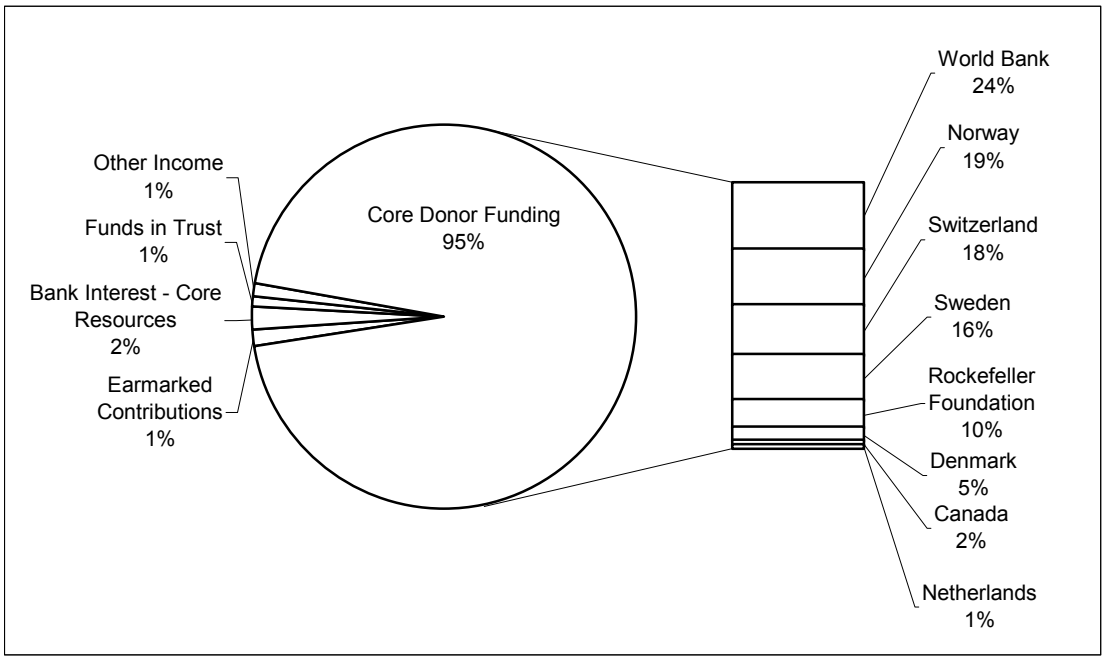
Contributions and expenditures have been constant over the past four years.



A large proportion (43%) of the annual expenditure is for the Annual Meeting, secretariat, and governing and advisory bodies.



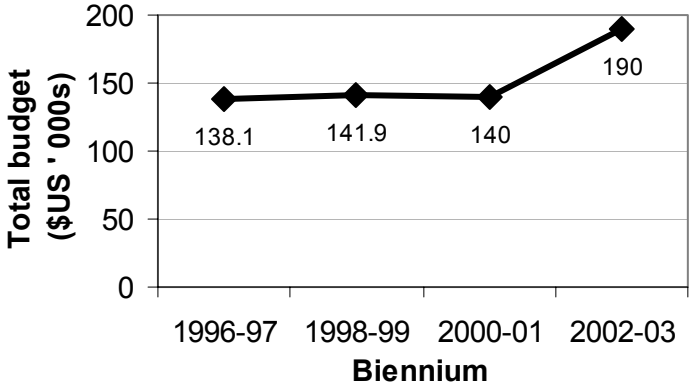
Most of the funding comes from a few leading donors, including the World Bank, which provides the largest share. The only private financing comes from the Rockefeller Foundation.



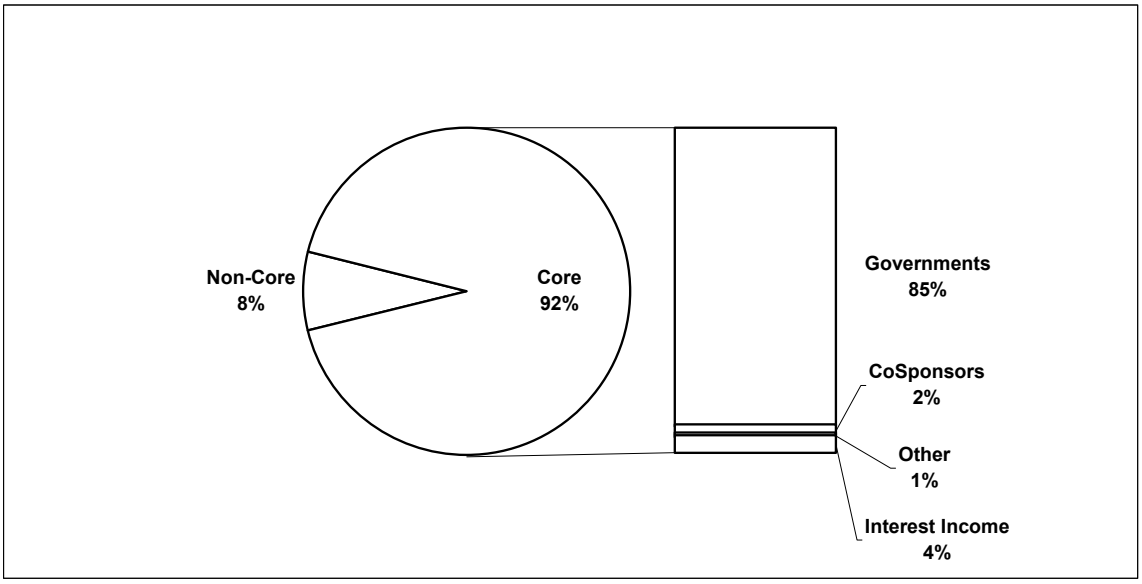
UNAIDS

The budget was constant from 1996 to 2001, but rises sharply in 2002-03.

About a quarter of the resources are concentrated on strengthening national planning and coordination activities.



Governments provide 100% of the non-core funding, which is used to expand or implement new global or regional activities, and 85% of the core funding, which goes directly to program activities.

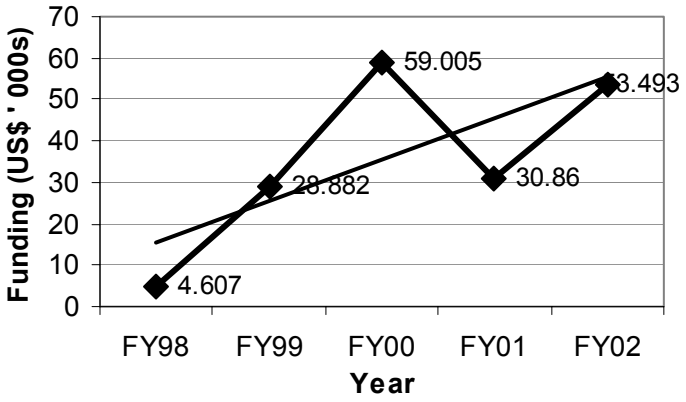


Providers of funding (2000-2001)

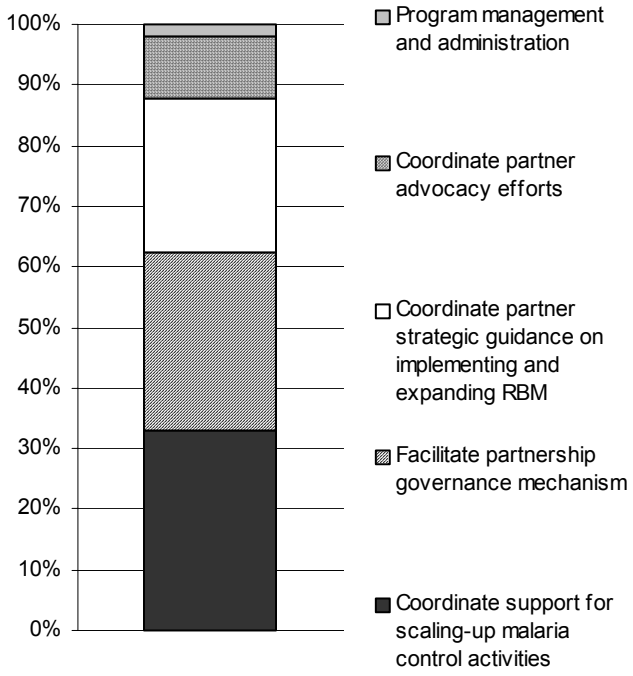
Core Funds		***Non-Core Funds***	
Netherlands	35200247	Norway	2126425
USA	35000000	Japan	1585880
Norway	18313488	Denmark	911662
UK	8940977	UK	835142
Sweden	8606422	Netherlands	825269
Finland	6975659	Germany	762984
Denmark	5979904	European Comm.	751217
Belgium	5093310	Sweden	683015
Japan	4800000	Luxembourg	617039
Canada	4445898	USA	600000
Switzerland	3597257	France	533972
Italy	3511164	Belgium	504556
Australia	1780440	Canada	491479
Germany	1710840	Finland	388600
France	1405898	Russian Federation	336000
Luxemburg	852651	Italy	110000
Spain	814855	Australia	103060
Canton de Geneve	712873	Ireland	37949
Russian Federation	664000	Switzerland	8714
Ireland	470048		
Flemish Community	390979	Total	12212963
China	199980		
Brazil	100000		
Korea	100000		
Thailand	91715		
Poland	20000		
Andorra	19450		
Monaco	14000		
Congo	8000		
Uganda	1500		
Total	149,821,555		

ROLL BACK MALARIA

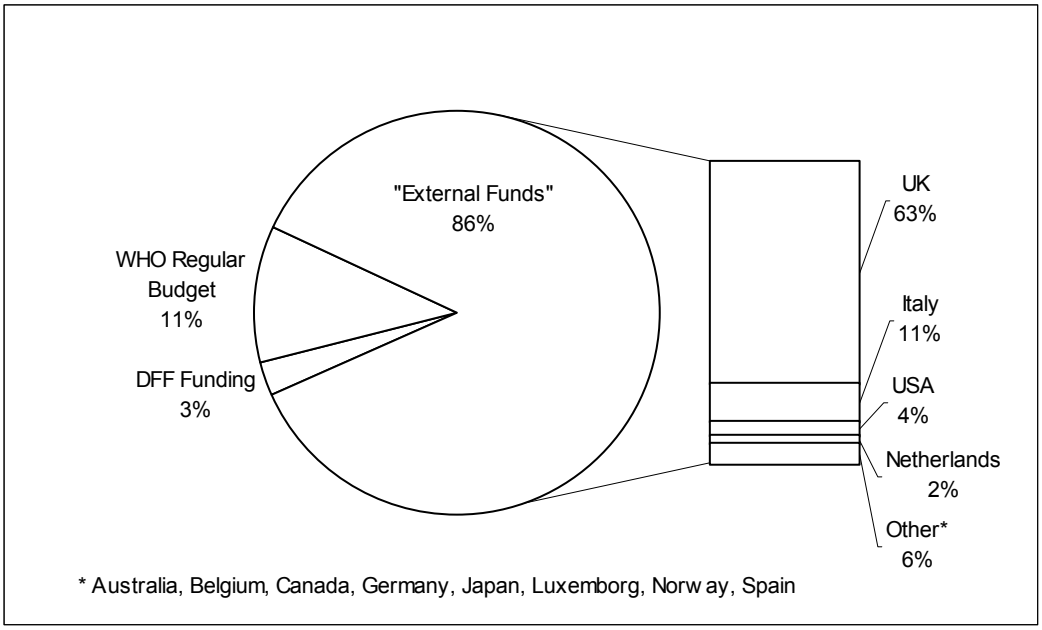
Funding has increased sharply since 1998.



Coordination of partner efforts comprises a large part of the program expenditure.

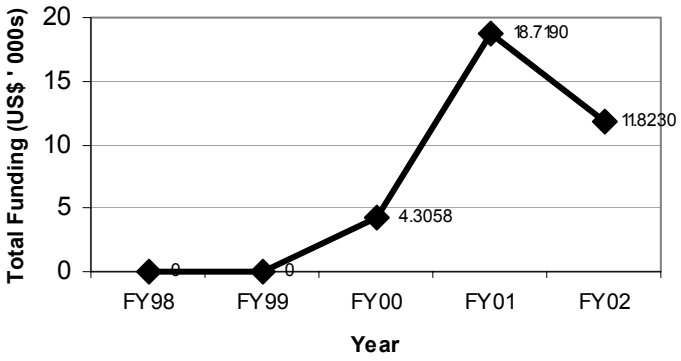


The U.K. provides the largest share of funding.

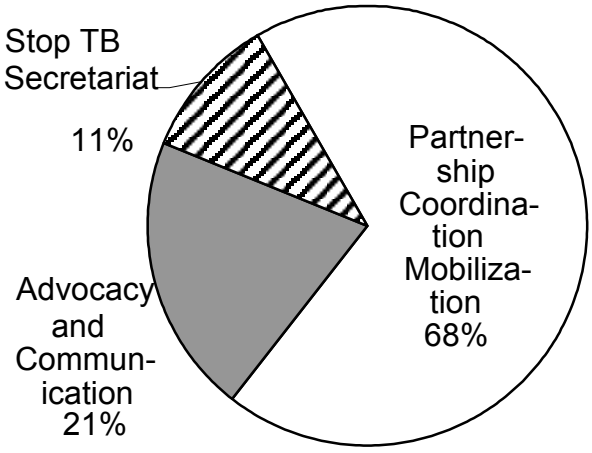


STOP TB PARTNERSHIP

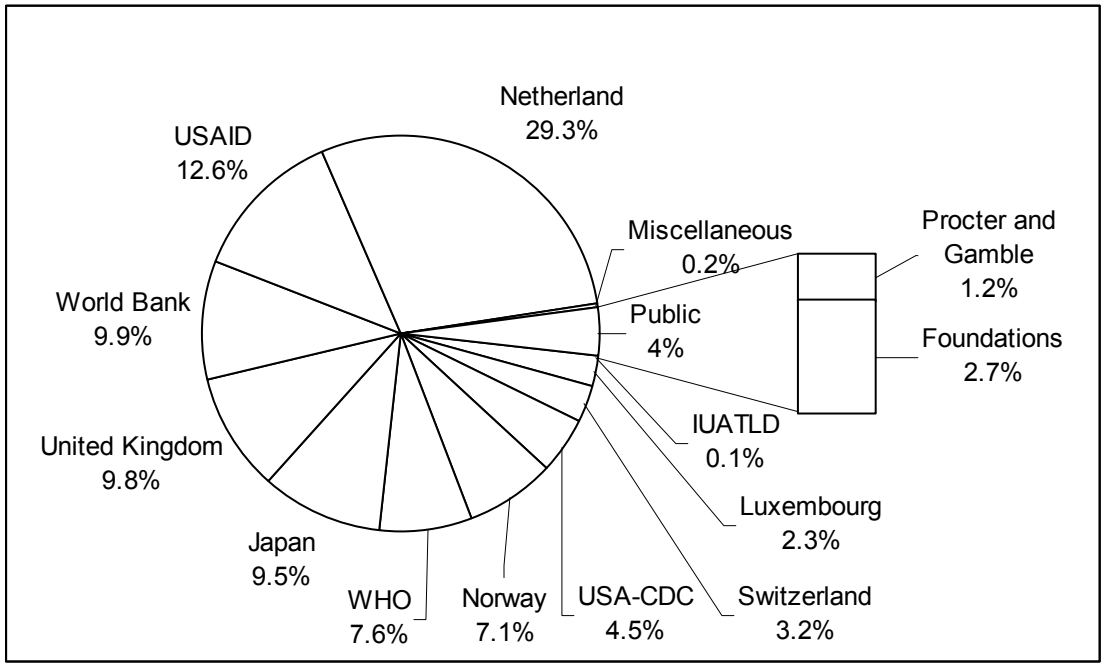
Funding has fluctuated over a wide range.



A majority of the budget goes to partnership coordination and mobilization activities.

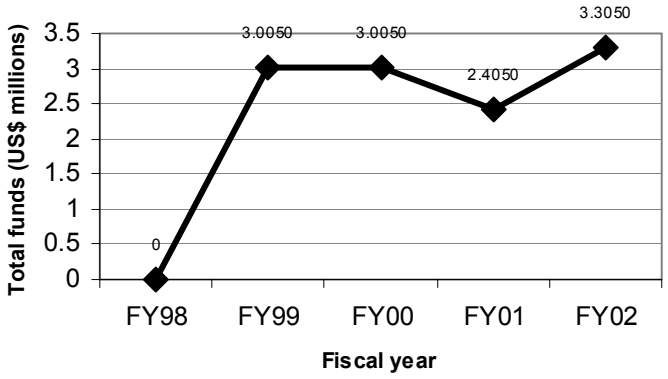


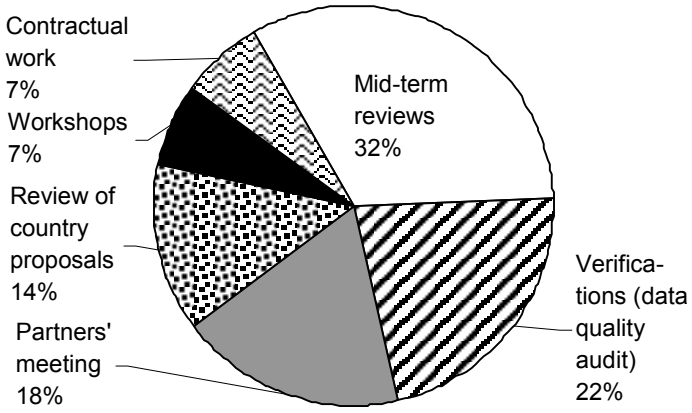
The Netherlands is the largest donor; private funding accounts for only about 4 percent of the total.



GLOBAL ALLIANCE FOR VACCINES AND IMMUNIZATION

Funding for the GAVI Secretariat has been stable at about $3.6 million per year since 1999. A third of the budget is for mid-term review activities





A third of the budget is contributed by the private sector.