"EFFECTIVE STATES AND ENGAGED SOCIETIES: CAPACITY DEVELOPMENT FOR GROWTH, SERVICE DELIVERY, EMPOWERMENT AND SECURITY IN AFRICA"

CAPACITY BUILDING IN THE HNP SECTOR: IMPLEMENTING THE STRATEGIC OPTIONS FOR BETTER HEALTH IN AFRICA

By

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Kofi Amponsah and Gilles Dussault

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Health, Nutrition and Population (HNP) Discussion Paper

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Health, Nutrition and Population (HNP) Discussion Paper

Capacity Building in the HNP Sector
Achieving the Strategic Options for Better Health in Africa

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A Background Report Prepared for the Operational Taskforce on Capacity Development in Africa
led by Callisto Madavo, Former Vice President of the Africa Region, Submitted June 2005

Abstract: The Africa region has the highest burden of disease and lowest spending levels per capita on health care in the world. Achieving better health and protecting people against the impoverishing effects of illness requires both more money and better spending. Capacity building will be central to achieving these objectives. As demonstrated by the report, the focus on strengthening capacity in the HNP sector of the Africa region is not new. Yet several past initiatives have been disappointing. Too often long lead time has been used as an excuse for the apparent disconnect between efforts expended on capacity building and getting results on the ground. In reality, some past efforts would probably have failed even if given significantly more time to have an impact. This is partially because they focused on too narrow a range of capacity building activities and partially because they focused more on process than results. This reports recommends an expanded definition of capacity building to include strengthening of the underlying institutions and organizations, in addition to the traditional focus on management and infrastructure. This includes ensuring that there is a strong government role in the stewardship function, that sustainable financing is channeled through risk sharing arrangements, that input generation takes full advantage of the drive and innovation of the private sector, and that service providers are allowed the autonomy and required accountability to provide high quality care for specified population groups. There is a need for political commitment at the highest level to achieving such outcomes and willingness to take on vested interests who may benefit from maintaining the status quoe. And the report recommends linking capacity building efforts with small but perceivable improvements that ordinary people and the public can see with their own eyes when they next use the reformed health services. The report: (a) analyzes activities undertaken through Bank operations, ESW and WBI since the beginning of 1990s, selected case studies, and focus group interviews; (b) summarizes lessons learned (successes and failures); and (c) makes recommendations on the way forward.

Keywords: Health care management, disease control priorities, complexity, scarcity, change, Millennium Development Goals

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PREFACE

Capacity building is the ability of people, institutions and societies to set and achieve objectives, perform functions and solve problems. It involves skills, incentives, organizational structures, resources, and an enabling environment. The ultimate goal of capacity development is to support the development of better skilled and oriented individuals, more responsive and effective organizations and institutions, and a better policy environment for pursuing development objectives.

The Operational Taskforce on Capacity Development in Africa

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The findings, interpretations and conclusions expressed in the paper are entirely those of the authors, and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

INTRODUCTION

The Africa region has the highest burden of disease and lowest spending levels per capita on health care in the world. Achieving better health and protecting people against the impoverishing effects of illness requires both more money and better spending. Capacity building will be central to both mobilizing additional resources and achieving value for money.

This is not a new topic. Over the course of the past 20 years there have been several significant initiative in the Africa region to improve capacity in financing and delivering quality health services. Major landmarks during the early 1990s include the work done for "Better Health in Africa" and subsequent follow up. The 1993 World Development Report helped focus local policy makers on focusing scarce resources on cost effective interventions. The 1997 HNP Sector Strategy emphasized the importance of strengthening resource mobilization at the country level, while the Commission on Macro Economics and health encouraged donors to play a greater role. More recently, the Africa region has been a key focus for the work done on poverty alleviation under the Poverty Reduction Strategy Programs and Credits and improving human development under the Millennium Development Goals. The Marginal Budgeting approach has a particular focus on overcoming capacity constraints to effective service delivery. Many of these initiatives have now been summarized concisely in the Africa HNP strategy, Improving Health, Nutrition, and Population Outcomes in Sub-Saharan Africa.

The core recommendations from these policy initiatives are being translated into the Bank's analytical work, lending operations, and capacity strengthening undertaken by World Bank Institute.

But there have also been failures. During the early 1990s a initiative called the African Capacity Building Foundation was set up precisely to strengthen institutional capacity. Hundreds of millions of dollars were spent through this organization. Despite this and other past efforts, many countries still face major impediments including brain-drain and retention issues, corruption and resource misallocation, and weak engagement of civil society in partnering for sustainable development. And the "knowledge Bank" which started with a bang during the late 1990s is now at serious risk of ending with a "whimper" as lending targets and process oriented quality indicators continue to dominate the budget process, staffing patterns and the overall performance rewards rather than true outcome oriented development indicators.

To address these problems, the Africa Region of the Bank has launched an Operational Taskforce on Capacity Development to review and update the Bank's approach to helping develop the capacities of African states and societies to secure the economic and social fundamentals of poverty reduction. The Taskforce— led by Mr. Callisto Madavo and supported by a Working Group drawn mainly from operational units in the Africa Region and the World Bank Institute — focused on the practical and operational challenges of improving the responsiveness, efficiency, and efficacy of Bank support for Africa's ongoing capacity development efforts. It is expected that such improvements would also serve as a catalyst for the larger international effort to scale up support to capacity development in Africa. The HNP Sector is one of the core areas that will be examined by this report.

This report on capacity building in the HNP sector in the Africa region will: (a) review the current situation through an analysis of activities undertaken through Bank operations, ESW and WBI since the beginning of 1990s, selected case studies, and focus group interviews; (b) summarize lessons learned (successes and failures); and (c) make recommendations on the way forward.

SITUATIONAL ANALYSIS

In the past capacity building has often referred to as strengthening management and ensuring that there are enough human and other resources available to deliver the needed programs and interventions.

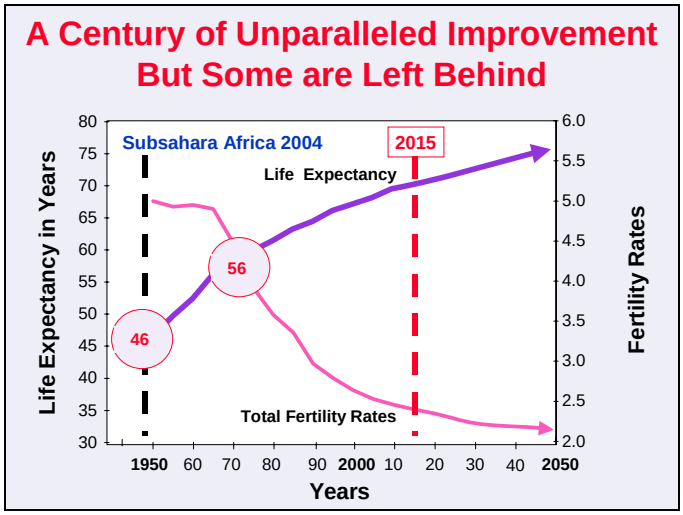
The Operational Taskforce on Capacity Development in Africa has expanded this definition to include "the ability of people, institutions and societies to set and achieve objectives, perform functions and solve problems. It involves skills, incentives, organizational structures, resources, and an enabling environment. The ultimate goal of capacity development is to support the development of better skilled and oriented individuals, more responsive and effective organizations and institutions, and a better policy environment for pursuing development objectives."

This more expanded definition of capacity building works well for the health sector where the links between the determinants of good health and financial protection against the cost of illness are complex. In fact, more money and increased capacity to use scarce resources efficiently and equitably will be critical in moving towards the health-related targets under the Millennium Development Goals (MDGs) in the Africa region.

KEY ISSUES

Impressive Overall Progress

Advances in health financing and delivering effective heath services has impressive during the past few years. The increase in life expectancy and the decrease in fertility throughout the world have been greater in the past 40 years than during the previous 4,000 years (see Figure 1). Life expectancy is almost 25 years longer today than at similar income levels in 1900. Yet the Africa region has left significantly behind in this process. These gains in health are partly the result of improvements in income and education, with accompanying improvements in nutrition, access to contraceptives, hygiene, housing, water supplies, and sanitation.



As described by the World Bank in its 1997 *Sector Strategy for Health, Nutrition and Population* and the World Health Organization (WHO) in its *2000 World Health Report*, the achievements in health

during the 20th Century are also the result of new knowledge about the causes, prevention, and treatment of disease, and policies that make known interventions more accessible.

Slow Progress in Achieving the Millennium Development Goals

During recent years, the MDGs have become a quantitative set of targets for poverty reduction and improvements in health, education, gender equality, the environment and other aspects of human development (see Box 1 and Annex I).[1] To help focus national and international priority-setting, the goals and targets that were selected were intended to be limited in number, be stable over time, and communicate clearly to a broad audience. Yet the Africa region has already fallen significantly behind other regions in achieving these goals both in terms of the needed money and the capacity to spend scarce resources in such a way that they achieve maximum impact in terms of health gains and financial protection against the cost of illness.

Among all the MDGs, it is the health goals – maternal and child health – that are the most seriously off track in the Africa region (Figure 2). The MDG for maternal and child health calls for reducing maternal mortality by three- quarters and under under-5 child mortality rates by two-thirds of their 1990 levels by 2015. Despite past achievements, millions of childhood deaths occur annually due to vaccine-preventable diseases and malnutrition. Millions of couples still lack options in family planning, and 30 percent of the world is still without access to safe water and sanitation. Nor surprisingly, maternal mortality is low in the Latin American and Eastern European regions where skilled attendants and equipped medical facilities are readily available, while high maternal mortality occurs in the Africa and South Asia regions where they are not.

The difficulty many low income countries have in tracking maternal mortality provides a good illustration of the direct impact has on achieving the health related MDG goals. Deaths related to pregnancy and child birth occurs infrequently and often outside the formal health system compared with other health problems. This leads to a small sample size which is made worse by underreporting. The last estimate of maternal mortality for 1995 estimated that 500,000 die annually during pregnancy and childbirth, most of them from conditions that could be prevented or treated in equipped medical facilities. Although anecdotal evidence indicates that maternal mortality is particularly poor in the Africa region, data is often lacking to understand the reasons why and learn from lessons that might help improve a capacity in this era in the future.

Past work on this topic have already identified several bottlenecks in capacity building that countries in the Africa region face in reaching the MDGs, especially in terms of ensuring that the poor and other vulnerable populations having adequate access to needed health services and being protected against the impoverishing effect of illness.

[1] The proposal to develop such a set of goals was first made by the Ministers of Development from the OECD Development Assistance Committee (DAC) in 1995 Oecd (1996). Shaping the 21st Century: The Contribution of Development Co-operation. Paris, OECD. The General Assembly of the United Nations incorporated these goals in the Millennium Declaration in September 2000, while setting new targets for reducing the proportion of people suffering from hunger, increasing access to improved water sources, improving the lives of slum dwellers, and reversing the spread of HIV/AIDS, malaria, tuberculosis, and other major diseases (United_Nations (2000). A Better World for All: Progress Toward the International Development Goals. New York, United Nations.and United_Nations (2001). Road Map Towards the Implementation of the United Nations Millennium Declaration. New York, United Nations.)

Tracking infant and child mortality is more reliable. Yet progress towards achieving this goal is seriously off track as well. This is particularly vexing, since much is also know about the causes of infant and child mortality. Furthermore, progress already made in some countries, even at very low income levels, indicates that effective interventions are already readily available and affordable to most countries providing that money is matched by a capacity to implement needed programs.

Part of the problem is that progress in achieving under 5 mortality targets relies significantly on both non specific intersectoral actions and specific health care interventions (preventive and curative services). The former includes activities such as poverty programs, nutrition, education, gender equality, access to clean water, improved sanitation systems and insecticide treated bednets. Many of these activities require focused government policies across different sectors, coordination and ongoing monitoring and evaluation of progress. This is often lacking at low – income levels and in settings with severely constrained management and institutional capacity, notably in Africa and South Asia. Even with growth these regions will continue to be seriously off track in the MDGs (see figure ***).

Growth is Not Enough

	Poverty Headcount % living on less than 1/day		Primary Education Enrollment %		Infant Mortality per 1000	
	Target	2015 Growth alone	Target	2015 Growth alone	Target	2015 Growth alone
EAST ASIA	14	3	100	100	14	33
ECA	1	1	100	100	9	22
LAC	8	7	100	100	14	30
MENA	1	1	100	92	20	46
SA	22	18	100	87	29	70
AFRICA	24	40	100	64	33	87

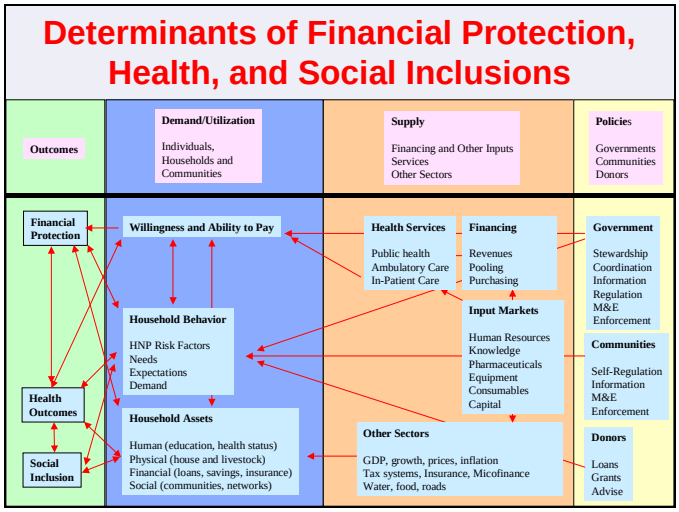
But even with good general hygiene and other preventive and health promotion measures, children get sick and need medical interventions. Many interventions are as simple as oral hydration during diarrhea, vaccination and antibiotics at the time of complicated upper respiratory infections. Health providers with only basic skills are able deal with most of the conditions of childhood using simple protocols such as those available through integrated management of childhood illness. Other interventions, skilled birth attendants, inpatient care at the time of complicated pregnancies and knowledge about the appropriate treatment and referral at the time of trauma and other more serious illnesses .

Many of the old and a few new scourges of poverty are still ravaging low- and middle-income countries, threatening both human welfare the also the potential for medium term growth. In 2000, there were 34.7 million adults and 1.4 million children with HIV/AIDS, million adults and children with TB and there are 300-500 million cases of malaria each hear with 1-2 million deaths, mainly in children under 5 year of age. The incidence or new cases of HIV/AIDS and TB infections is still increasing global targets under the MDG being severely off track.

Weak Capacity to Address the Key Determinants of Better Health, Financial Protections

In striving to achieve the health related MDGs, countries often have a weak capacity to influencing the key proximal and distal determinants of better outcomes in three areas: (a) mobilizing financial resources to promote better health and to diagnose, prevent, and treat known illness; (b) protecting individuals and households against the catastrophic cost of illness; and (c) giving the poor a voice in their own health.

Major constraints have been identified in: (a) the ability to tracking of key outcome indicators relating to improved financial protection, health, and social inclusion: (b) factors that have a positive influence over demand and utilization; (c) the supply of health services and related sectors; and (d) policy actions by governments, civil society, the private sector, and donors.



- **Outcome indicators.** Much work is still needed to develop a meaningful set of indicators for improving health, protection against impoverishment, and combating social exclusion. This is a major unfinished agenda in capacity building in the Africa region.

- **Demand and utilization in influencing financial protection**. There is a complex interplay between household assets (human, physical, financial, and social), household behavior (risk factors, needs and expectation for services), ability and willingness to pay, and the availability of insurance or subsidies (Soucat et al. 1997). Most countries in the Africa region still lack the capacity to influence household and community behavior in improving health and in reducing the financial risks in the Africa region

- **Supply in health system and related sectors.** There is a hierarchy of interest from non-health sector factors in improving financial protection—such as GDP, prices, inflation, availability of insurance markets, effective tax systems, credit, and savings programs—to more traditional parts of the health system (a) preventive and curative health services; (b) health financing; (c) factor markets (inputs such as human resources, pharmaceuticals, medical equipment, consumable supplies, knowledge and research); and (d) effective and quality health services (preventive, ambulatory, and in-patient). In respect to the latter, weak capacity related to organizational, institutional and management factors in the Africa contribute to the incentive environment of health financing and service delivery systems in addition to the more commonly examined determinants such as input, throughput, and output factors (Harding and Preker 2001).

- **Policy actions by governments, civil society and the private sector.** Finally, through their stewardship function, governments have a variety of policy instruments that can be used to strengthen the health system, the financing of services, and the regulatory environment within which the system functions (Saltman and Ferroussier-Davis 2000). This includes regulation, contracting, subsidies, direct public production, and ensuring that information is available. In countries with weak government capacity, civil society and donors often play this role with resulting weakness in .

ROLE OF THE WORLD BANK

Capacity building has been a major focus of most past Bank involvement - analytical work, lending and training. Analytical work has focussed more on policy and institutional dimensions. Investment projects have focussed more on management dimension and inputs. Swaps and PRSC focus more on policy and institutional dimensions. HIV/AIDS or Maps have focussed more on the organizational dimension. Training has focussed mainly on the policy and management dimensions.

The following section summarizes some of the key observations made through both a global and Africa regional review of capacity building related to achieving better health outcomes, financial protection against illness and social inclusion of the poor and vulnerable populations. A more detailed review of the capacity building efforts carried out by WBI in the Africa region is found in Annex II. A more detailed review of the lending portfolio in the Africa region from 1990 to 2005 is found in Annex III.

RATIONALE FOR BANK INVOLVEMENT

Investing in people and helping countries build better capacity in achieving human development outcomes is at the center of the World Bank's mission as it moves into the 21st century, reflecting the fact that no country can secure sustainable economic growth or poverty reduction without a healthy, well nourished, and educated population.

What Developing Countries Say they Need in terms of Capacity Builiding

To address the HNP poverty agenda, improve the performance of health services, and secure affordable and sustainable financing for the sector, most countries say they need assistance in building capacity from the international community in the form of both broad international experience, and country-focused policy advice and financing.

Yet responding directly to client demand in the HNP sector is not straightforward. First, it is necessary to reconcile the divergent views of the various interest groups — the Bank's clients (typically the ministries of health and finance), stakeholders (local communities, health care providers, and insurance companies), beneficiaries (patients, the poor, women, children, and other vulnerable groups), and other development partners.

Second, many countries have health, nutrition, and population problems precisely because governments introduced the wrong policies in the past or lack a capacity to introduce known and effective policies in the future. Often they failed to implement good policies and were unable to harness non-governmental resources effectively. Even small changes in outcome may take as long as 10 to 15 years to realize, extending beyond the average government's term and commitment to reform or the lending cycle of most world Bank analytical work, projects and technical assistance. Keeping a focus on medium term action has been a major problem of countries, the Bank and other international donors alike.

Finally, when financial assistance to the HNP sector is sought in the form of credits and loans to strengthen capacity building, this strategy must be carefully balanced with the medium-term returns to such investments and the opportunity cost of not investing in other spheres of the economy that impact on health, nutrition, and population outcomes.

Role of the International Community

None of the international organizations can address all the capacity building needs of today's complex health, nutrition, and reproductive challenges alone. This is especially true since overseas development assistance from the world's richest countries (US$6 to 8 billion annually) remains far inferior to the estimated US$30 to 60 billion global funding gap (WHO 2002).

The Bank works with many other international organizations (FAO, ILO, UNAIDS, UNDP, UNFPA, UNICEF, WHO), regional banks (AsDB, AfrDB, EBRD, and IDB), the EU, bilateral organizations and NGOs, and the private sector. Partnerships in the Africa region, though present, remains weak despite the heightened recent focus on this region of the world.

The Bank's strengths are its global expertise, its multi-sectoral macro-level country focus, and the ability to mobilize large financial resources (either directly or through partnerships). For technical expertise in specific areas of the HNP sector such as disease control, the Bank has not been as effective as it might have been in seeks assistance from its UN sister agencies and other international partners. Notable successes at the country level in the Africa region have been through the Sector Wide Approaches (SWAPs), Poverty Reduction Strategy Paper (PRSPs) and Multi-donor Budget Framework discussions (See Foster 2004).

THE BANK'S INVOLVEMENT IN HNP

The Bank's role in the HNP sector during the past 25 years has been one of growing engagement and learning in two key areas.

First, the Bank has contributed to the generation and dissemination of global knowledge on health, nutrition, and population issues through regional and global studies, operational research and analysis, and shared international experiences.

Second, underpinned by the knowledge base that it has accumulated in this work, the Bank has been instrumental in catalyzing development change at the country level through its main non-lending activities (described below) and its financing instruments.

Third, Bank has been very active in supporting capacity building efforts at the country level through a range of activities lead by the World Bank Institute.

Generation and Dissemination of Global and Regional Knowledge

Cross-Cutting Policy Studies

Many of the Bank's past policy studies in the HNP sector have focused on the role of the state and non-governmental sectors in addressing the health, nutrition, and population needs of the poor, performance of health systems, and sustainable financing.

Noteworthy early Bank policy papers which had a major focus on the need for increased capacity building include: (a) the *1970 Sectoral Programs and Policies Paper*, which included recommendations on improving capacity related to population policies; (b) the *1973 Sector Program Paper* which included recommendations on improving capacity related to Bank nutrition activities; and (c) the *1975 Health Sector Policy Paper* which was the first Bank analytical report to address capacity issues related to the health sector. All made reference to the specific needs of the Africa region.

The *1980 Health Sector Policy Paper* was the first attempt to set out a solid rationale for free-standing Bank investments in the health sector, drawing links between health sector activities, poverty alleviation, and family planning. The influential *1980 World Development Report on Human Resources* highlighted the importance of capacity strengthening the health sector, along with education and social protection, to poverty alleviation strategies.

The *1984 World Development Report: Population and Development* emphasized the importance of strengthening the role of governments in reducing mortality and fertility. The 1987 policy study, *Financing Health Services in Developing Countries: An Agenda for Reform*, tackled the policy themes of strengthening capacity in health financing based on observed inefficient and inequitable public spending on health care and recurrent cost financing. This report highlighted the particularly weak capacity of African countries in mobilizing needed funding for the health sector, leading to a recommendation that user fees be considered as a supplement to government financing.

The theme of strengthening the role of governments and capacity building was repeated in the Bank's seminal piece on the HNP sector, the 1993 *World Development Report: Investing in Health*. This report has already had a substantial impact on national and international debates on specific areas of capacity building in low- to middle-income countries, and on priorities for the Bank's work. Several of the subsequent World Development Reports also had section which dealt with the need for improved capacity to achieve results in their respective areas of focus: 1992 report on *Development and the Environment*, 1996 report on *From Plan to Market*, 1997 report on *The Role of the State*, 2000 report on *Attacking Poverty*, 2002 report on *Building Institutions for Markets*, and 2004 report on *Making Services Work for Poor People*.

The Bank has also been a major partner in several seminal products that have discussed various dimensions of capacity building led by other organizations. Notable inputs were provided for the *2000 World Health Report on Health Systems Performance*, the *2002 Report of the Macro Economic Commission on Health*, and the *2004 report Human Resources for Health: Overcoming the Crisis* all led by the WHO.

Specific to the Africa region, the 1998 Report *Better Health In Africa* documented lessons learned and best practice about capacity building in four major areas:

- African households and communities need the knowledge and resources to recognize and respond effectively to health problems. Threats to health should be made known and countered through public and private services.

- Human and financial resources must be used more productively by reforming health care systems. Correcting sources of waste and inefficiency must take top priority

- Cost-effective packages of basic health services can do much to meet the needs of households and reduce the burden of disease. Networks of local health centers and small hospitals in rural and periurban areas can facilitate delivery.

- Additional funds totaling $1.6 billion a year can help those living in Africa's low-income areas obtain basic health services. Cost-sharing can make an important contribution to health equity and the sustainability of health services.

The recent 2004 strategic policy options for *Improving HNP Outcomes in Sub-Saharan Africa: Implications for World Bank Operations* highlights how many African client countries are searching for the right strategic answers to address their long-term health challenges and are requesting the Bank's support in those efforts. This report is intended to assist in setting a strategic agenda for finding the right answers — through country-level analytical work and evaluation of global and regional experiences. It summarizes and consolidates a multiyear effort begun in 2002 by the Africa Region's Health, Nutrition and Population Family to strengthen the knowledge base and consensus on critical challenges in health development in Africa and to focus lending and analytical work around critical strategic challenges where the Bank has a comparative advantage. It also seeks to encourage efforts to organize operations and staff to more efficiently and effectively support client countries and complement efforts by other organizations to assist countries develop a capacity to improve health outcomes among the poor in Africa.

In addition to such major policy reports, the Bank has also published numerous other books, technical notes, and working papers that deal with capacity building issues in the HNP sector. Efforts have been made recently to experiment with shorter, more focused, and less resource-intensive products as well as outsourcing some of this research.

Operational Research and Analysis

About a quarter of the approximately US$80 to 100 million allocated to the Bank's Special Grants Program (SGP) is devoted to HNP sector activities that often include an important capacity building component. Recent HNP-related programs supported by the SGP include the Special Program of Research, Development, and Training in Human Reproduction, the WHO/UNDP/World Bank Tropical Diseases Research Program, the International Health Policy Program, the WHO Ad Hoc Review on Health Research, and the Global Micronutrient Initiative.

Improving the capacity for country-specific research and analysis of HNP issues is supported through an allocation of US$50 and US$75 million per year through Bank loans and credits. This is 5 to 6 percent of total lending and by far the largest source of external research funding for HNP in client countries, with US$10 to 15 million being focused in the Africa region.

The Bank's Policy Research Department has several staff working on HNP-related issues and has conducted a number of HNP studies in recent years. Its HNP research expenditure is around US$1 million per year or 8 percent of that department's total research budget of about US$15 million.

Capacity Building and Sharing of International Experiences through the HNP Network Anchor and WBI

The Bank's World Bank Institute (WBI) – formerly the Economic Development Institute (EDI) – provides training and seminars for senior policymakers in client countries on HNP issues. The former Learning and Leadership Center (LLC) of the Bank focused on training for Bank staff. The HNP Family of the HD Network, established in 1996, leads HNP knowledge management work in the Bank. All three groups are making increasing use of partnerships and electronic technologies to maximize their impact.

The WBI Flagship Course on *Health Sector Reform and Sustainable Financing* which was initiated in the fall of 1997 — along with several regionally-based partner institutes — focuses on the economic, political economy, and institutional issues central to HNP reforms. This program has been expanded over time to include population and reproductive health (HIV/AIDs), poverty, and the MDGs.

The overall goal of the revised Health and AIDS Program for the Africa region is to strengthen the capacity of client countries to combat HIV/AIDS and achieve critical health, nutrition, and population outcomes, contributing towards realization of the Millennium Development Goals for health. The Program aims to complement Bank lending with an effective learning program for client countries, Bank staff, and staff from other donor agencies in order to (see Annex II for a more complete inventory of the activities of WBI in capacity building in the Africa region):

- strengthen national institutional capacities to lead in designing, implementing and sustaining strong health components of national programs and Poverty Reduction Strategy Papers (PRSPs), with particular emphasis on combating HIV/AIDS and improving HNP outcomes of the poor and socially vulnerable.

- clarify the role of government in the health sector, including policy and stewardship functions as well as facilitation of the public/private collaboration in financing and provision of services;

- ensure that the Health sector is an engine of change and not a victim of reform;

- improve Bank/client country dialogue on HIV/AIDS, health, nutrition, population & reproductive health issues, as reflected in Country Assistance Strategies (CASs) and PRSPs

- support capacity building of national training institutions to achieve a sustainable increase both in knowledge and know how in the critical areas needed for achieving the MDGs for health.

International conferences and scientific meetings organized by both the Bank and other organizations also provide training opportunities for Bank staff and client countries. The Bank was a participant in the 1990 UNICEF-led World Summit on Children in New York, the 1991 International Meeting of Partners for Safe Motherhood in Washington, DC, the 1994 International Conference on Population and Development in Cairo, the 1995 World Conference on Women in Beijing, the 1996 International Conference on Early Childhood Development in Atlanta and the 1997 International Conference on Innovations in Health Financing in Washington, DC. And the Bank was a co host for the 2004 High Level Forum in Abuja on Achieving the MDGs in the health sector, the 2005 Strategic Options Conferences for Improving Health in Sub-Sahara Africa in Livingstone, Zambia and Hammamet, Tunesia.

The Bank encourages its client countries to participate in such international conferences and scientific meetings in an effort to strengthen institutional capacity and to provide an opportunity for shared learning.

Areas for Improvement in the Role of the Bank as a Global Knowledge Broker

Although many Bank policy studies have had an impact on development, concern has been expressed that some lack operational relevance, that most take a long time to develop, and that they are resource-intensive both in terms of direct cost and the opportunity cost of staff drawn away from other work. Research and training — undertaken directly by the Bank or supported indirectly through loans and grants — must also remain relevant to the emerging development priorities in the HNP sector, and to the operational needs of staff and client countries. The research undertaken through lending is typically not designed or supervised by staff with training or skills in research. The "knowledge Bank" which started with a bang during the late 1990s is now at serious risk of ending with a "whimper" as lending targets and process oriented quality indicators continue to dominate the budget process, staffing patterns and the overall performance rewards rather than true outcome oriented development indicators. Such pressures often make it difficult for staff to take full advantage of the training opportunities available at the Bank and elsewhere.

Notable areas for improvement include the following:

- Most activities were initiated by WBI, rather than client or operations requested. This is changing rapidly as more country focused work is done.

- Large parts of the Region have not been covered (many Anglophone countries, Portuguese-speaking countries, post-conflict Francophone countries). This is also changing as new activities are already planned to reach those "neglected" countries.

- No strong partnership has been created for the dissemination of the Flagship program. In Francophone Africa, a good relationship was built with CESAG, which had developed the capacity to offer a good portion of the program in an autonomous manner, with two staff members well trained, and a good network of national and regional collaborators. The Institut de Santé, the part of CESAG with which WBI had been partnering, suffered from management problems which have led to the departure of the staff involved in the Flagship and in the Reproductive Health course. It is not in a position to be a partner any more (see Box). On the Anglophone side, no partnership has been established (there was an attempt to engage Witswatersrand University in the late 1990's, but it did not succeed). A Center for health management studies is being created in Abuja, as a potential regional hub and WBI partner.

- Activities have tended to be ad-hoc, but this is changing now that the Africa Region has defined its Strategic options, and that WBI has developed mechanisms to better aligned on country needs, such as participation to CAS.

- Training has focused mainly on the policy and management dimensions. Courses on institutional development and organizational reform that are now common in other regions of the Bank have not been given yet in the Africa region.

In conclusion, there is a need to move from a retail to wholesale approach in capacity building – "building a capacity to build capacity". WBI should be a wholesaler not retailer. Furthermore, the Bank's knowledge-creation and dissemination model should be based on" (a) its operational pillar (the vast practitioner experience from country-level policy dialogue) and (b) its research/teaching pillar (DEC, Networks and WBI)

Catalyzing Change at the Country Level

It is at the country level that the Bank's global experience, multi-sectoral macro-level country focus, and financial resources are brought together in an effort to catalyze development change in the HNP sector as in other sectors. Both the Bank's non-lending activities, in the form of country-specific economic and sector work (ESW), and its financing in the form of loans, credits, and grants, are used to promote needed systemic reforms and maximize the impact of policy advice.

Country-Specific Policy Advice and Client Dialogue

The Country Assistance Strategy (CAS) has become the Bank's central vehicle for development assistance in low- and middle-income countries. It provides an opportunity to highlight stubborn cross-sectoral issues, and to establish critical links between the HNP sector and a country's poverty and fiscal agendas. Since the CAS sets the agenda for the Bank's future work (both studies and lending) in the HNP sector, inputs based on country-specific sectoral analysis and assessments of the effectiveness of past lending operations are a critical part of the CAS process.

In the future, HNP staff need to work more closely with other staff from the HD Network and country teams to ensure adequate links between the HNP sector and the Bank's poverty alleviation and macro-economic strategies. For example, the analytical framework used to underpin most CAS, PRSP and Medium Term Expenditure Framework (MTEF) recommendations does not include quantitative variables for human capital or labor productivity, both of which are influenced by HNP outcomes and educational attainment. Furthermore, reluctance to address politically sensitive topics is often a key reason for not addressing deep-rooted systemic issues that impact on the HNP sector. These problems undermine the Bank's comparative advantage as a multi- sectoral agency and diminish the impact of its macro-level focus on the HNP sector.

Examples of these problems include the fact that many CASs fail to address financial sustainability and manpower issues in the HNP sector as an integral part of public finance and civil service reforms. Furthermore, the CAS could be more explicit about discouraging client countries from subsidizing unhealthy agricultural products and wasting public resources on untargeted food compensation programs. Finally, given the emerging chronic disease epidemic, client countries should be encouraged to use taxation instruments to combat tobacco abuse.

Most of the Bank's policy advice in the HNP sector still rely on shared international best practice and adapting applicable lessons to country-specific settings. For example, the approach to population issues is largely guided by the recommendations of the 1994 International Conference on Population and Development in Cairo. A similar approach is used in the disease control and nutrition areas. This is considered the best way to address the complex issues faced in the HNP sector. In the case of tobacco, international best practice is reflected in the 1992 Bank policy of not supporting any tobacco production, processing, or marketing, while actively encouraging tobacco control (Operational Directive 4.76).

Issues relating to the political economy of reform, behavior changes, and social marketing require more attention in the future. A prerequisite for improvement in this area is to make staff more sensitive to the practical constraints faced by politicians and bureaucrats in countries trying to implement HNP reforms.

Country-Specific Analytical Studies in HNP Sector

Country-specific analytical studies — economic and sector work (ESW) — are an important part of the Bank's non-lending work in HNP. These studies allow Bank staff to learn about the health, nutrition, and population issues and investment needs in individual client countries. They are a critical input for both the CAS and client dialogue. Many client countries with only moderate financial needs seek to gain access to the technical expertise mobilized during the Bank's investment project cycle in the hope of addressing their capacity problems through such outside assistance.

In addition to the several hundred country-specific sector studies and Staff Appraisal Reports completed by the end of FY05 Bank wide and several dozen in the Africa region, there have been hundreds of shorter working documents and country strategy papers have been written on selected HNP topics. Recently the Africa region has been very active in producing Country Strategy Reports, many of which have repeatedly highlighted the persistent capacity problems in the Africa region.

Several recent analysis of the impact of the Bank's activities shows that most of the foreign aid to the HNP sector simply substitutes for government spending. The real source of aid effectiveness in HNP is, therefore, the reforms resulting from policy advice and capacity building that accompany lending, not the loans themselves. In light of this finding, past and future cuts in the budget and staff-time allocated to analytical work continue to be extremely worrisome.

Other notable weaknesses in the Bank's past analytical work in HNP relate to the scant attention paid to the political economy of reform and its economic, regulatory, and institutional underpinnings. More work is also needed to translate international experience with reform into practical solutions at the country and local level. In the past, even when best practice information was available in some of these areas within the Bank's vast knowledge base, this information was not always readily accessible to Bank staff.

Financing (Loans, Credits, and Grants)

Bank financial support for the Human Development (HD) sector began with education lending in the 1960s. This was followed by lending to the HNP sector in the 1970s and 1980s, and later broadened to include social investment funds, employment funds, training programs, social transfers (pensions and safety nets), and early childhood development.

By the end of FY04, 20 to 25 percent of the annual US$15 to 20 billion in new Bank loans continue to be directed to the HNP, education, and social protection sectors. In addition to these direct human development activities, an additional 23 percent of total Bank lending is devoted to the agriculture, water supply and sanitation, environment, and rural/urban development sectors, which also impact on health, nutrition, and population outcomes. This breakdown is about the same for the Africa region.

Since the Bank's first loan of US$2 million to family planning activities in Jamaica in 1970, its activities in the HNP sector have grown to the point where it is now the largest single external financier in low- to middle-income countries, with a cumulative portfolio value of over US$24.2 billion in 1996 prices. In 1976 the first nutrition loan went to Brazil, and in 1981 Tunisia was the first country to borrow for a project to expand basic health services.

By FY05 in the Africa region, there were 51 active HNP projects in 31 countries with total commitments of 1,764.87 million (2000 prices), and 24 completed projects (see Annex). About 55.21 percent of Bank financing from FY2000 to 2005 in HNP was IDA credits, targeted to poor countries. Total overseas development assistance to HNP for the period from in 2003 was about 9.2 billion annually in 2000 prices (excluding Bank loans).

Although the HNP portfolio value has expanded rapidly during the past 15 years, there is considerable variation from year to year. FY2004 was a record high, with US$1199.9 million in new commitments, compared with approximately US$776.11 million in FY90.The marked increase in FY2004 was caused by the approval of five large loans, ranging from US$57 million to US$ 675 million, compared to the US$58 million average loan size per HNP project and US$ 81 million Bank average.

Based on the planned pipeline, there will be continued growth in the HNP sector during FY2005 - FY08, with an expected annual lending of over US$165.0 million**:** and approximately 5 new projects per year, after discounting by 40 percent for the usual loan drop rate. Disbursements have followed these trends, growing five-fold from US$15.2 million in FY90 to US$313.3 million in FY2004. The growing portfolio will yield anticipated annual disbursements well above the US$*** million mark during the next three years.

There are important sub-regional differences in the HNP portfolio (AFTH1, AFTH2 and AFTH3).The three sub regions are the biggest users of HNP financing. AFTH1 is by far the Bank's biggest HNP client with current net total commitment of $US1649.0 million. New approaches are needed to prevent lending in some countries from falling, such as Mauritania and *** become ineligible for IDA credits.

Bank Performance in Lending to the HNP Sector

Early Bank policy advice, lending, and credits to the HNP sector focused mainly on helping countries strengthen their basic health, nutrition, and population programs. The benefits of interventions in the HNP sector often appear years after specific activities have occurred, and factors outside the sector influence outcomes. It has therefore been difficult to attribute improvements in health status, nutrition, and fertility that have occurred during the past 20 years directly to policy advice and investments made by the Bank.

This early Bank involvement in the HNP sector appears to have been most successful in focusing on capital investment needs, developing infrastructure, and providing supply inputs. Modest success was also achieved in geographic targeting and addressing certain diseases of the poor, partly because policy advice and credits provided under IDA were automatically directed towards poorer countries. This approach was consistent with national HNP policies and a broad international consensus that increasing access to basic services would automatically help improve outcomes.

Capital investments and the supply of inputs (human resources, pharmaceuticals, equipment, consumable supplies, infrastructure, etc) are, however, only a small part of the story of capacity building in the health sector. Encouraging health seeking behavior and demand is an equally important factor, because goods must be consumed and services used to be effective. People's perceptions about quality and effectiveness of care, the attitudes of health care providers, and the availability of essential consumables such as drugs, have a dramatic impact on utilization. And carelessness in program management and execution, such as a momentary break in a vaccination cold-chain or lack of judgment on when to refer complicated obstetrical cases, can make entire programs ineffective. These factors, which are highly influenced by the availability of adequate recurrent financing, have not receive sufficient attention during the Bank's early involvement in HNP. Only the recent generation of SWAPs and PRSCs have been effective at shifting attention to recurrent expenditure issues.

An earlier review by the Operations Evaluation Development (OED) of 120 ongoing projects between FY70 and FY95, and other assessments, have indicated that — although inputs are important to

the functioning of basic programs — an input-oriented approach does not achieve the institutional, I management, and systemic changes needed to sustain impact over the long run.

First, only 17 percent of completed HNP projects were classified as contributing substantially to institutional development. Several factors seemed to be responsible for this observation: poorly specified institutional development objectives; lack of country commitment; lack of borrower ownership especially in rural areas; inadequate planning and management capacity; inadequate incentives, regulations, information, and communication strategies; poor involvement of non-governmental partners; and lack of attention to monitoring and evaluation. Unrealistic project objectives, complex designs, lack of continuity, and inadequate supervision were other contributing factors.

Second, only 44 percent of completed HNP projects are rated by OED as likely to be sustainable. Poor quality of economic and institutional analysis during project preparation contributed to this failure. This included inattention to country macro-economic factors, under-estimates of recurrent costs implications, insufficient funding to operate constructed facilities, overly optimistic economic benefit assumptions leading to financial sustainability problems, and poor treatment of intersectoral issues such as civil service, labor market, food subsidy, and tobacco, alcohol, and food taxation policies.

Third, there was often a lack of continuity between the Bank's sectoral policy recommendations and the design of HNP projects. It is instructive to note that, although an increasing number of ongoing projects examine non-governmental roles, none of the 68 completed HNP projects included financing for privately-owned facilities or activities. Furthermore, health systems performance issues were dealt with mainly through public sector interventions, with little attention to the substitution effect and crowding out of private providers. Private sector regulatory and quality control issues were rarely addressed, and few projects have focused specifically on resource mobilization issues.

Finally, an OED review of 68 Project Completion Reports done at the same time indicate that only 59 percent of these projects had satisfactory ratings, compared with 81 percent in education and 58 percent Bank-wide. Few of these projects provided objective documentation of the impact of project investments on health, fertility, or nutrition outcomes. Since attribution of impact to specific project activities is difficult, input/process/output variables were usually tracked rather than outcomes.

Since this OED review, these observations have led the Bank to focus more on systemic reforms, both in the case of broad health systems/financing reforms and in the case of more targeted interventions. Newer HNP projects have kept pace with the 80 percent Bank-wide average in terms of success in development objectives and implementation progress. Causes for concern include the number of projects at risk, lack of realism, a tendency for ratings to deteriorate as the portfolio matures, and the failure of the current peer review system to prevent these problems. Furthermore, there was a significant drop in the resources per project allocated to supervision activities leading to a reduction in the technical assistance that can be provide directly during implementation. Recent increases in attention to quality enhancement and assurance, have not reversed these trends.

A detailed review of the 51 health projects in the Africa region during the period 1990 to 2005 confirmed many of these trends but also revealed some significant changes during recent years. The review included, PAD/SAR and ICRs, was undertaken of traditional investment project, SWAPs and HIV/AIDS operations. For completed projects, the PAD/SAR and ICRs were compared to determine whether project development objectives proposed in the PAD/SAR were achieved, and how projects have helped clients build their capacities over the period (1990-2005) under review. With regard to ongoing projects, the project design was assessed for both relevance and efficacy of meeting the objectives to building a sustainable capacity. The following summarizes the key observations from this review (see

Annex III for a more detailed discussion of the review and key conclusions). The projects were assessed against the following framework on a scale of 1 to 5, with one being the weakest and 5 being the strongest (see Annex III for more details on this analysis).

Key performance Indicators

Country Context
Public Sector Strengthening
Development of democratic inst.
Emphasis on country ownership
Institutional Environment
Legal framework:
Regulatory instruments
Administrative procedures
Customs and practices
Organizational structures
Organizational forms/ownership
Decision rights
Linkages: vertical and horizontal
Management attributes
Management skills
Leadership
Visions and values
Strategic Thinking and planning
Managerial culture
Management of value chain
Change management
Focus on client needs
Autonomy and decision making
Accountability
Performance appraisal
Management incentives
Management tools
Infrastructure
HR
Equipment
Pharmaceuticals
Facilities

Institutional Environment

Most projects have not properly addressed the following institutional features which are pre-requisite for creating an enabling environment for building sustainable institutions for long-term capacity development. Consequently, managers who have acquired substantial management skills are not encouraged to effectively work in these weak institutions.

Legal framework. The legal framework which are rules established through legislation is generally weak. Our analysis revealed that only 17.6% percent of 51 projects reviewed (please see annex 1) did very much in strengthening the health sector legal framework. This depicted a dismal performance of projects in addressing this issue because health laws (which are found in acts of Parliament or delegated legislation made under those acts) are to a large extent statutory rather than common laws.

Regulatory instruments. Regulatory instruments which are tools to respond quickly to economic and social needs by not having to go through parliamentary procedures for enactment and amendment of laws have not been given much attention across the region. For instance, only 7 out the 51 projects studied paid much attention to the development of regulatory instruments. (Please refer to annex 1). This impedes decentralization of service delivery, since the district health authorities are not given much empowerment to carry out their duties. Regulations of most of the decentralized districts still need to be issued and promulgated by the government, usually through the Ministry of Health of Cabinet ministers.

Administrative procedures. Administrative procedures are regulations such as guidelines, instructions and letters of interpretations issued by purchasers (health insurance funds, ministries of health, local health authorities, private insurance companies, etc. They are important for health care purchasers and providers who want to make sure that due regulation and procedures are followed so that resources could be used in an efficient and effective way. In many countries, the emphasis has been on the development of guidelines rather than on their implementation. Not much attention has been given to the development and implementation of these procedures in project designs across the continent. For instance, in our analysis, we noticed that, 24 projects representing 47.1 percent of total projects reviewed did not do much in the development of these procedures.

Customs and practices. On the whole, projects have not done much to address these important informal practices which have a great deal of impact on institutional development. Customs and practices, which characteristically are repeated and socially derived, consist of established patterns or behaviors, which are passed down from generations to generations. Under the counter or informal payments to health care providers are typical examples of these informal practices. They are caused by low incentives to staff. Only two percent of the entire 51 projects reviewed seamed to address this issue.

Organizational structures

Organizational reforms/ownership. At the organizational level, projects have done pretty good in reforming organizational structures and laying more emphasis on ownership. For instance, 21 projects out of the 51 projects reviewed did a great deal of work in restructuring organizations, which have resulted in strengthening decentralization.

Decision rights. Health authorities at the district level are being given much more decisions rights in their deliberations. As shown in annex 1, 17 projects representing about 33.3 percent of projects reviewed did much better in strengthening organizational decision-making.

Linkages: vertical and horizontal. Generally, there is much more linkages within organizations , and to the external environment (district, regional, and national levels). In reviewing the documents, it was found that approximately 45.1 of projects did better in building strong organizational linkages.

Management attributes

Management skills. Much has been done by projects in strengthening management skills particularly in the areas of leadership, strategic thinking, and accountability. Out of the 51 projects studied, 43.1 percent, 49 percent, and 49 percent did much in leadership, strategic thinking, and accountability respectively.

Management incentives. Unlike management skills, management incentives have not been given much attention. Consequently, the sector is characterized by brain drain and low morale of workers. Increasingly, health professionals leave to either seek greener pastures elsewhere or leave the profession altogether. We noticed in annex 1 that only 12 out of the 51 projects reviewed have done well in this area.

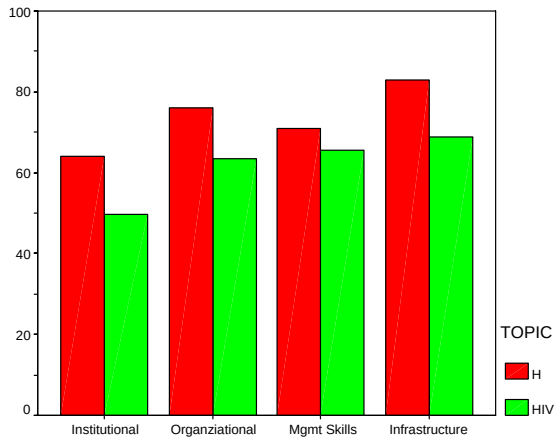
Management tools. Projects have done pretty much better in helping clients build formidable management tools such as planning, information technology, budgeting etc. We discovered in our analysis that 30 projects representing about 58.8 per cent of the total projects reviewed have performed well strengthening management tools.

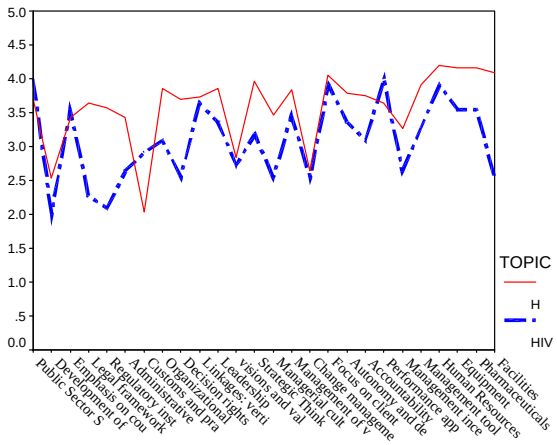
Infrastructure (human resources, equipment, pharmaceuticals, and facilities)

In general, the Bank has done so well in infrastructure development across the region. In the area of Human resources, projects have done marvelously well in providing training for health care staff at all levels. An extremely high percentage of projects across the continent have strengthened human resources. As high as 62.7 per cent of the 51 projects studied have helped clients in strengthening human resources. With regard to equipment, projects have supported clients in equipping newly built hospitals, health centers, clinics, health posts etc. As much as 23 projects out of the total number of projects studied did much better in this area. Provision of pharmaceuticals has excellently been executed by many projects. As much as 22 projects have done so well in stocking facilities with drugs and all kinds of pharmaceuticals. Over the period under review, more and more facilities (hospitals, health centers, clinics, health posts, training institutions, etc. have been constructed, rehabilitated, and renovated across the region. As depicted in annex III total of 32 projects representing total percentage of 62.8 rank high in our ratings.

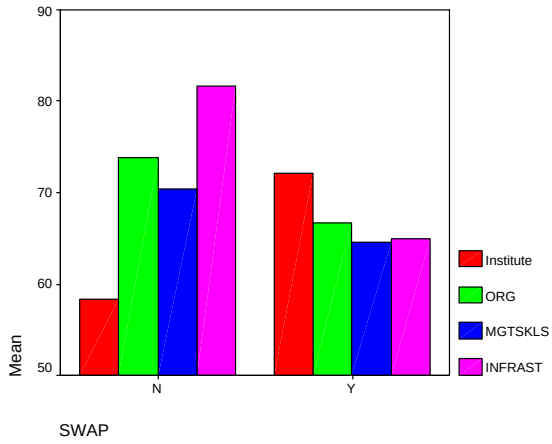
Analysis by program

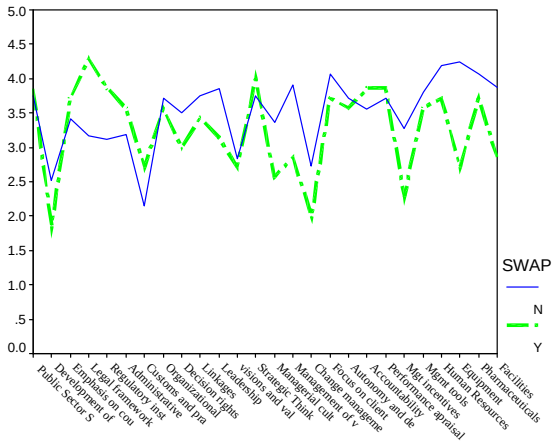
Health versus HIV/AIDS. Two major programs, health and HIV/AIDS projects were compared in order to know how best the Bank has been able to strengthen client efforts in building institutional, organizational, management, and infrastructure capacities. The results are graphically shown in Figure *** and *** below. In general Health did pretty much better in building capacity at all the three levels than HIV/AIDS. HIV/AIDS programs have performed well in organization, management and infrastructure levels but comparatively less in institution.



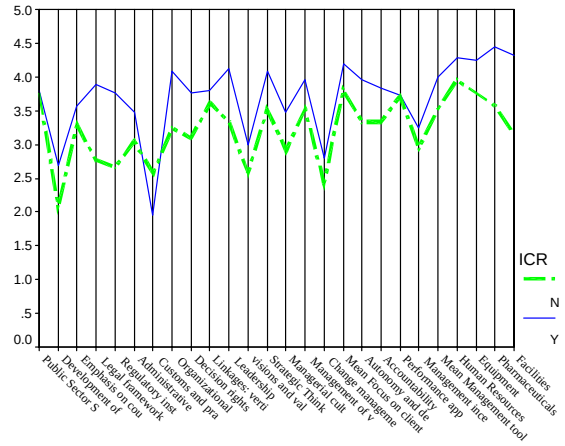


SWAP versus Non-SWAP. Seven of the total numbers of projects reviewed were SWAPs. As shown in figures *** and *** below, the Swaps performed better in institutional development than the non-SWAPs, but relatively less at organization, management and infrastructure levels.





Projects with ICR versus Projects without ICR. In order to get real picture of what has been done on the ground, we examined project performance by comparing the PADs/SARs with the ICRs. In general, projects with ICRs gave much better picture about project performances than those without ICRs in institutional, organizational, management and infrastructure development.. As indicated in figure *** below, better performances of projects are more pronounced in infrastructure and management but comparatively less at institution and organization levels in both projects with ICRs and those without ICRs (projects which have not yet been completed).



In conclusion, unlike earlier Bank wide projects which focused more on infrastructure and management training, since the mid 1990s, most lending operations in the Africa region have include some focus on capacity building. But some significant differences are noted among the different types of operations. Investment projects have focused more on the management dimension and inputs. Swaps and PRSC focus more on policy and institutional dimensions. HIV/AIDS or Maps have focused more on the organizational dimension.

In addition to this assessment of the performance of specific investment projects, it is useful to observe that many of the Bank's adjustment operations, PRSCs and operations in other sectors have some health, nutrition, and/or population content. These often try to address difficult inter-sectoral and systemic issues such as targeting of the poor, civil service reform, sustainable rural development, decentralization, food policies, protection of social expenditure, cost containment, and tax policy. A thorough assessment of the HNP impact of these projects still needs to be undertaken.

Box. Four Outstanding Countries

Four countries (Botswana, Tanzania, Burkina Faso, and Rwanda) which have been mentioned in the task force concept note as having incredible capacity achievements and development were selected, in our study, for in-depth review. The results are explicitly shown in figure 6 below. The countries are categorized as follows:

. Sustaining capacity to perform: **Botswana** represented by the red line graph;
. Building momentum for comprehensive transformation: **Tanzania** represented by the green line graph;
. Service delivery resource management, and investment climate as entry points: **Burkina Faso** represented by the blue line graph ;
. Building the basics after conflict: **Rwanda** represented by the violet line graph.

Our observations are that, the four countries are all doing pretty much good in management, with Botswana being outstanding in institutional, organizational and infrastructure levels (See Annex III for a more detailed discussion of specific country profiles).

Learning From Experience

Achieving better results requires that the lessons learned through recent reviews of the portfolio by the Quality Assurance Group, the OED, and others be used to improve both the existing portfolio and the quality of new projects. In the past, the lessons learned were often not systematically applied when restructuring old projects or designing new operations. Staff skills-mix and staff-lending ratios also did not keep abreast of portfolio growth and changing priorities.

Recently, the concepts of projects at risk, proactively scores and realism scores have been used to address problems early and work with clients to build capacity through the Bank's lending operations. Often capacity issues are at the root of poorly performing operations. This includes problems of civil unrest or refugee dislocation, slow and uneven implementation in federated states and other decentralized settings, inability to implement complex project design, and capacity problems relating to procurement, disbursement, and local counterpart funds.

Many of the relevant lessons have been highlighted in past analyses and a working paper on quality assurance. The past decade may be seen as one of rapid growth and learning in HNP. In 1997, the Sector Strategy for HNP highlighted many of these problems. These are highlighted in the Box below. Few of the recommendations require changes in current policies or procedures, but most require affirmative action.

Recommendations for Getting Results in HNP from the 1997 Sector Strategy Paper

Ensure quality during project preparation

- **participatory approaches** to encourage client, beneficiary, and stakeholder ownership
- **sectoral analysis** to secure solid knowledge about the issues and options being addressed, linking these to the macro- context of the country in question
- **economic analysis** to inform choices among options, taking into account their costs and impacts
- **institutional analysis** to ensure a realistic assessment of policymaking and implementation capacity
- **sustainability analysis** to assess financial viability, risks, and alternatives (including exit strategies)
- **monitoring and evaluation** to keep projects on track and to draw lessons from experience

Adapt lending policies and procedures to client needs

- test out project ideas on a small scale (**pilot operations**), to learn and incorporate lessons of experience
- use **a process rather than a blueprint approach** for health reform projects
- use a **wider range of instruments**
- accommodate the **highly decentralized nature of the social sectors**
- modify the financing of **recurrent costs**
- extend innovations in **procurement** rules to social sector operations and be more flexible in their application.

Develop and support staff

- build staff capacity through **expanded training, improved incentives, and recruitment of the best**
- strengthen the **professional network and knowledge-sharing system** and **reward excellence** familiarize others with HNP sector issues, especially

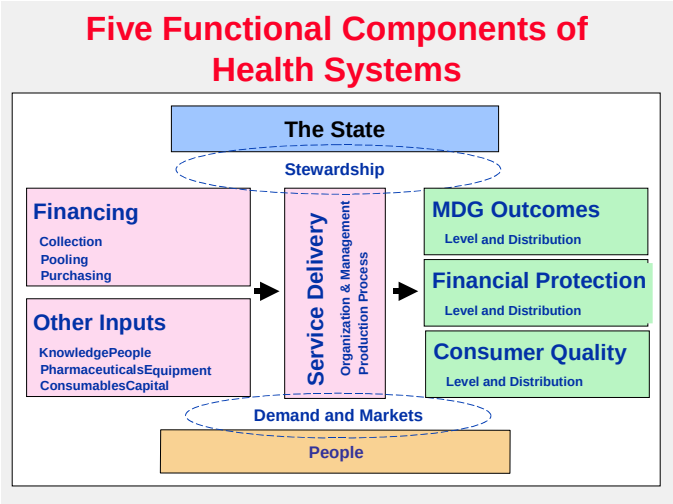
THE WAY FORWARD

Much is already known about the specific program interventions that are needed to progress towards achieving the Millennium Goals. To be effective, interventions need to be underpinned by a well functioning health systems. This includes strong government stewardship (policy making, coordination, regulations, contracting, information dissemination and monitoring and evaluation systems) health care financing (prepaid revenue collection, risk pooling and resource allocation/purchasing mechanisms) input generation and management (human resources, research, pharmaceuticals, medical technology, consumables and capital), effective and responsive service delivery systems (public health and curative services) and the market forces created by demand for service by individuals and households. Many known effective and affordable interventions do not get to the children or household that need them due failures in the health system. Once again, improved policies and significant additional financial resources are needed to address these problems in the underlying health systems.

International experience indicates that the underlying causes of failure to progress towards the Millennium Goals are well known, and affordable drugs, surgeries and other interventions are often available. But, because of weakness in the core functions of health systems – **stewardship role of the state, markets, financing, generation of inputs, provision of services and demand from households** – potentially effective policies and programs often fail to reach the poor.

The financing function includes the collection and pooling of revenues, and the use of these revenues through purchasing or budget transfers to service providers. The resource generation function includes the production, import, export, distribution and retail of human resources, knowledge, pharmaceuticals, medical equipment, other consumables and capital. The service delivery function includes both population-base and personal clinical services provided by the public sector and private sector (non-profit and for-profit).

These core functions are influenced by governments through their stewardship function and the population through demand from households and markets. The combined effect of these five factors lead to either good or poor performance in health outcomes, financial protection, and responsiveness to consumer expectations (see Figure ***). Strengthening of capacity in the HNP sector requires balanced action across all these key areas. Unfortunately policies and Bank support often only address one or two.



Trends in the Stewardship role of Governments

There is a growing consensus that to address current capacity problems, requires a better match between the role of state and the private sector, and their respective capabilities – getting the

fundamentals rights. In most countries this means a re-balancing of what is already a complex mix of public and private roles in the health sector.

International experience suggests a need for a continued significant role of the state in the health sector. But it casts doubt on the nature of public intervention pursued by many governments especially in the area of the public production of health services.

The range of possible actions that can be taken by governments to improve efficiency or equity — from least to most intrusive — is extensive. These include:

- providing information to encourage behavior changes needed for improvements in health outcomes;
- developing and enforcing policies and regulations to influence public and private sector activities;
- issuing mandates or purchasing services from public and private providers;
- providing subsidies to directly or indirectly pay for services; and
- producing (in-house) preventive and curative services.

In many countries, for reasons of both ideological views and weak public capacity to deal with information asymmetry, contracting, and regulatory problems, governments often try to do too much – especially in terms of in-house service production – with too few resources and little capability.

Parallel to such public production, the same well-intending governments often fail to:

- develop effective policies and make available information about personal hygiene, healthy life-styles, and appropriate use of health care;
- regulate and contract with private providers;
- ensure that adequate financing arrangements are available for the whole population; and
- secure access to public goods with large externalities for the whole population.

This argues for a strengthening the stewardship function of governments in securing equity, efficiency, and quality objectives through more effective policy making (***steering***), regulating, contracting, and ensuring that adequate financing arrangements are available for the whole population. At the same time, it also argues for greater private sector capacity in providing health services (***rowing***).

Trends in Health care Financing

In health care financing, blind faith in the market is no more likely to resolve the complex problems that face the health sector than a naive belief in government. The approaches used to mobilize resources, pool risks, and allocate resources to providers can have a significant impact on both access to needed health care and financial protection against the cost of illness.

Some people are much sicker than others. Sharing of risks across population groups is a fundamental aspect of social protection in the health sector. Furthermore, people use health care most during childhood, the childbearing years, and old age — when they are the least productive economically. Income smoothing across the life-cycle can, therefore, also contribute to social protection in the health sector.

Yet as in 19th century Europe, when health care was still in a primitive stage of development, direct out-of-pocket health expenditure continues to be a distinctive feature of many low- and middle-income countries. Household payments can account for as much as 80 percent of total health expenditures because of: nontrivial user fees charged in public facilities (official and unofficial); high co-payments

required in health insurance schemes; and use of private health services (hospitals, clinics, diagnostics, medicines, and health care providers). This undermines the financial protection that could be provided by the health sector even in low-income settings.

Experience has shown that strong action is needed by the public sector to take advantage of the substantial resources that can be mobilized through private channels, while at the same time ensuring social protection for vulnerable groups. This dimension is often ignored in the health sector

Recent reform trends in strengthening capacity of the health care financing function have included:

- Informal resource mobilization and risk pooling arrangements to cover rural and informal sector workers in low-income countries where government capacity to undertake these activities is limited;
- Expansion of formal risk pooling arrangements where social insurance and general revenues play a functional role in health care financing for the poor.[1]
- More strategic resource allocation and purchasing arrangements to get the best value for money spent on health care by ensuring that: (i) the poor and other excluded population groups are fully covered [for whom to buy]; (ii) both basic and catastrophic care is covered [what to buy], (iii) there is an active competition between the public and private sector on price, quality, and volume when selecting providers [from whom to buy]; and (iv) the payment mechanisms used provide strong performance incentives for the provider selected [how to pay for services?].[2]

Trends in the Generation of Inputs

In recent decades developing countries have invested heavily in health. This increase in financial resources has led to a parallel increase in inputs such as human resources, knowledge, pharmaceuticals, medical equipment, consumables, and capital stock. Yet significant variations remain in inputs in absolute levels, in terms of the input mix, and distribution of resources among countries and across regions that imposes serious constraints on the performance of the health services in many of the world's poorest countries.

For some inputs, such as the manufacturing pharmaceuticals and specialized medical equipment, barriers to entry are often created by patents and licensing requirements, manufacturing standards, large up-front investment costs, expensive research, and long development periods. This gives the manufacturers of these inputs considerable market power that they can abuse by manipulating prices and demand if checks and balances are not put in place to prevent such behavior. For these inputs, stronger policy measures are usually needed such as anti-trust legislation, limited formularies, generic drug strategies, bulk purchasing, and high technology assessments.[3] Yet most of these items can still be obtained from private producers. By procuring these items on the international market countries can ensure that local producers remain competitive.[4]

Public production of consumables, pharmaceuticals and medical equipment usually leads to low quality, lack of innovation, outmoded technology, inefficient production modalities and distribution holdups. Most countries that have used a state production model for inputs have fallen considerably behind in productivity and technology.[5] Such public production of physical inputs is still common in many low- and middle-income countries.

The story for capital stock is more complicated. In the case of small clinical facilities, such as ambulatory clinics, laboratories, pharmacies, small cottage hospitals, and social care, the capital requirements are small and providers are often able to finance these themselves or through small personal

loans in parallel to public investments. In the case of large hospitals, most countries have in the past relied heavily on public investments. Investment decisions in this area have long-term consequences that may last 30-40 years and longer. Once built, hospitals are very difficult to close for political reasons. Strong public policies are therefore also needed in this area.

The need for strong public policies, however, does not necessarily mean public financing of capital stock. Increasingly, many countries are looking to the private sector to support investments in capitals stock even when the resulting facilities will be used to meet social objectives and supported by public financing of running costs.

In the case of training of specialized labor and the generation of knowledge, the story is similar. There is a need for strong public involvement in setting the agenda but private capital can often be mobilized to support investments in both training and research activities.

Markets often give the wrong signal about the level (surpluses and shortages), mix, distribution and quality of inputs. This is especially true in the case of human resources, pharmaceuticals, medical equipment and capital stock where the development or training phase is very long and where the consequences of bad investment decision last for years. The resulting input imbalances both nationally and internationally can have a significant impact on the equity and other aspects of performance of health systems (see Figure 6).

Recent reform trends in strengthening capacity of the input generation function have included:

- Improved access by the poor to appropriate levels, mix and distribution of essential inputs such as quality drugs, vaccines, and other consumables; anti-trust and anti-corruption measures to ensure a level playing field and enhanced competitive environment in the production, import, export, distribution and retail of inputs by private sector; and support other international efforts in the development of new vaccines and orphan drugs that benefit the poor;
- Better understanding of human resources issues, especially related to civil service reforms and labor adjustment issues;
- New approaches to dealing with capital stock, including de-appreciation and re-investment strategies.

Trends in Service Delivery

Much remains to be learned about how to improve the performance of service providers (public health and clinical services). This remains one of the least well understood of all health care reforms. Recent reform trends in strengthening capacity of the service delivery function have included

- Management reforms affecting the production process in terms of inputs, throughput, and outputs (interventions)
- Changes incentive regime, structure and linkages among the organizations that produce the services;
- Changes in institutional environment or formal and informal rules under which providers have to operate

Management Reforms

Many attempts have been made to address the problems in existing publicly run health services through new management reforms. These reforms have included efforts to strengthen the managerial expertise of health sector managers—both through training of existing staff, and through changes in

recruitment policies to focus more on managerial skills. Commonly, efforts are made to introduce improved information systems, to facilitate effective decision-making. In some systems, clinical directorates have been created, and benchmarking of departmental performance has been introduced.

Often such efforts are part of the growing trend to try to reform public services by applying recent "best practice" management techniques learned in the private sector. Frequently, attempts are made to introduce business process re-engineering, patient-focused care, quality improvement techniques and better clinical management.[6] Attempts to implement these new management practices have been seriously constrained by the public sector context in which public provider organizations operate. Where attempts have been made to apply private sector recruitment and compensation policies, civil service constraints have often blocked or undermined them.

A critical barrier to applying "best practice" principles from the private sector is the broad lack of control that public sector managers have over factors of production. Thus, although methods for reinvigorating private organizations have sometimes been successfully transferred to public hospitals and systems, in most cases, these attempts have been impeded by the common constraints generated by public sector control structures.[7] Indeed, the attempts to apply private sector management principles to public delivery of health services has added to the momentum behind the organizational reforms discussed below.

Organizational Reforms

The growing awareness of the structural nature of problems in service delivery, has increasingly led policy-makers in many countries to introduce more radical organizational reforms in the public sector.[8]

The *initial wave* in reforms of public services often includes a divestiture of state assets, or privatization, which is concentrated on commercial enterprises. Success in this area leads to a *second wave* — the divestiture of public infrastructure and utilities. Finally, as confidence is gained in these two areas, divestiture of state assets continues, with a focus on non-governmental and private management and investment in health, education, and pensions systems — the *third wave*.[9] These reforms are usually designed to improve the incentive environment by *altering the distribution of decision-making control, revenue rights, and hence risk* among participants.

In the health sector, there is a wide range of organizational reforms. Some focus on changing the mapping of functions across agencies, for instance, creating health insurance agencies that collect premiums and purchase health services. Or, endowing providers with "fund-holding" or purchasing authority—thus integrating funding with service provision. Decentralization is another common organizational reform in the health sector, a reform that shifts decision-making control and often revenue rights and responsibilities from central to lower-level government agencies.

Three well known reforms in the hospital sector include hospital *autonomy, corporatization,* and *privatization*.[10] These reforms shift decision-making control to the provider organizations themselves, make them responsible for their profits and losses, and expose them to market or market-like pressures to improve performance. They also attempt to create new incentives and accountability mechanisms to encourage management to use that autonomy to improve the performance of the facility. The final critical factor characterizing these organizational reforms is the degree to which "social functions" delivered by the hospital shift from being implicit and un-funded to specified and directly funded. These reforms are summarized in

Institutional Reforms

The final set of reforms in service delivery affect the institutional environment or formal and informal rules under which providers have to operate. Four institutional factor are particularly pertinent. They include:

- The stewardship role of governments vis a vis the service provider;
- The governance arrangement or relationship between the owner and the organizations;
- The payment system used to reimburse providers;
- And the behavior of patients as consumers of health care.

Recent reforms in this respect include: (a) transfer of ownership to a decentralized, autonomous, corporatized, or privatized entity; (b) purchaser-provider splits; and (c) insurance mechanisms to protect against adverse effects of user fees charged directly by providers. These institutional factors and their associated reforms are summarized in the Figure 8 below.

CONCLUSIONS

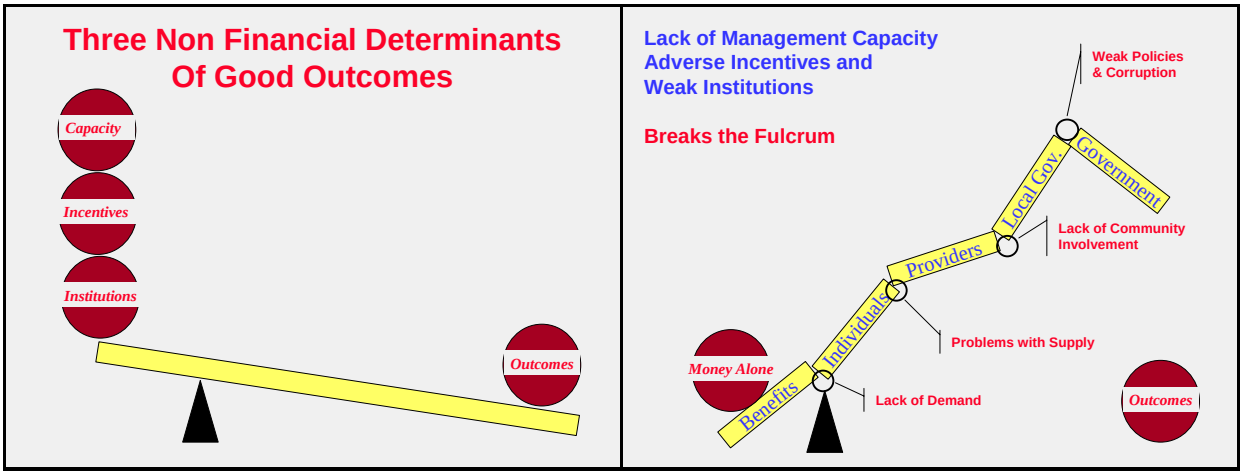
In Africa reaching the key health related development goals will require: (a) more money - no amount of capacity building or will be enough without more resources; (b alignment of incentives so that scarce resources are used efficiently; and (c) much greater capacity to use both existing and additional resources more effectively.

To achieve this it will be important to move away from single solution operations and move towards a portfolio approach. In addition it will be crucial the Bank to work closely with its other international partners who often have greater skills in the capacity building area than Bank staff.

Several systemic factors in the health system may also act as drivers of improved outcomes. These include:

- management capacity
- organizational incentives
- institutional environment; and
- infrastructure

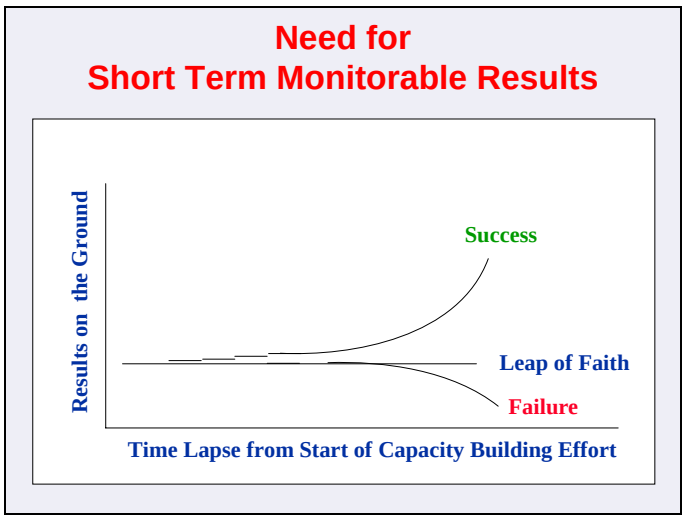
Many countries that currently fail to make progress towards the MDGs are plagued by weak management capacity, negative organizational incentives, lack of a strong regulatory environment to ensure quality control and deal with the private sector etc, and inadequate infrastructure. Often they ignore the demand side of utilization of health services. Critical supply chains such as in the case of pharmaceuticals and vaccines are broken. And top down centralized control over public services exclude participation by the private sector, communities and household in the care that they are receiving.



The exact contribution of institutional, organizational, management and infrastructure variables to the MDGs has not yet been quantified. And the cost of reforms in this area are highly context sensitive, making it risky to apply estimates from one setting to another. An early attempt has been made by WHO to quantify the benefits of health systems in terms of the level and distribution of health outcomes, financial fairness and responsiveness to patient expectations in terms of quality and ethical dimensions of care (World_Health_Organization 2000). Unfortunately, as in the case of cost effectiveness, this initiative has been met by great resistance from the international development community and countries themselves.

RECOMMENDATIONS

Capacity building efforts must be subject to the same standards outcome orientation as other areas of health policy. Long lead time can no longer be used as an excuse for the observed disconnect between capacity building efforts and results on the ground. Time, effort and valuable resources should no longer be squandered on activities for which there is little more than wishful thinking that there will be an impact sometime in the distant future. There is a need to move to a system whereby capacity building efforts are matched with small but perceivable improvements in key outcome indicators not leaps of faith (see figure *** based on Levy 2004)



This review of capacity building in the HNP sector of the Africa region makes several recommendations, some which are particularly focused at the country level, and some which are focused at the Bank and international donor community:

Country Level Recommendations

- there is a need to build capacity across all four dimensions in a balanced way
- there are no quick fixes when it comes to capacity building (need to be in it for the long haul)
- yet capacity building efforts must also be results not just process oriented and build on small but perceivable improvements in key outcome indicators (capacity building efforts that are not accompanied by discernable results cannot be deemed successful)

The Bank and Donor Community

- Bank fads that tend to emphasize one instrument or one subsector at a time should be avoided since they may lead to unbalanced and counterproductive outcomes (a programmatic approach would be preferable to traditional investment operations where fungibility of funding is a major problem or blunter budget support operations where tracking causality is almost impossible
- There is a need to scale up capacity building efforts by moving from a retail to wholesale approach (strengthening the institutions, organizations and managers needed to strengthen capacity not just training individuals)
- more analysis needed to fully understand the links between strengthening capacity and getting results on the ground

ANNEX I
TERMS OF REFERENCE

Background

The Africa region has the highest burden of disease and lowest spending levels per capita on health care in the world. Achieving the health related MDGs will require both more money and better spending. Capacity building will be central to both mobilizing additional resources and achieving value for money.

This is not a new topic. Over the course of the past 20 years there have been several significant initiative in the Africa region to improve capacity in financing and delivering quality health services. Major landmarks during the early 1990s include the work done for "Better Health in Africa and subsequent follow up." The 1993 World Development Report helped focus local policy makers on focusing scarce resources on cost effective interventions. The 1997 HNP Sector Strategy emphasized the importance of strengthening resource mobilization at the country level, while the Commission on Macro Economics and health encouraged donors to play a greater role. More recently, the Africa region has been a key focus for the work done on poverty alleviation under the Poverty Reduction Strategy Programs and Credits and improving human development under the Millennium Development Goals. The Marginal Budgeting approach has a particular focus on overcoming capacity constraints to effective service delivery. Many of these initiatives have now been summarized concisely in the Africa HNP Strategy.

The core recommendations from these policy initiatives are being translated into the Bank's lending operations and ESW as well as training and capacity strengthening undertaken by World Bank Institute.

But there have also been failures. During the early 1990s a initiative called the African Capacity Building Foundation was set up precisely to strengthen institutional capacity. Hundreds of millions of dollars were spent through this organization. Despite this and other past efforts, many countries are still face major impediments including brain-drain and retention issues, corruption and resource misallocation, and weak engagement of civil society in partnering for sustainable development.

The World Bank has launched an Operational Taskforce on Capacity Development in Africa, to review and update the Bank's approach to helping develop the capacities of African states and societies to secure the economic and social fundamentals of poverty reduction. The Taskforce— led by Mr. Callisto Madavo and supported by a Working Group drawn mainly from operational units in the Africa Region and the World Bank Institute — will focus on the practical and operational challenges of improving the responsiveness, efficiency, and efficacy of Bank support for Africa's ongoing capacity development efforts. It is expected that such improvements would also serve as a catalyst for the larger international effort to scale up support to capacity development in Africa. The HNP Sector is one of the core areas that will be examined by this report.

Definition

Capacity has been defined by the Task Force as "the ability of people, institutions and societies to set and achieve objectives, perform functions and solve problems. It involves skills, incentives, organizational structures, resources, and an enabling environment. The ultimate goal of capacity development is to

support the development of better skilled and oriented individuals, more responsive and effective institutions, and a better policy environment for pursuing development objectives."

Objectives

The objectives of the review would be the following:

- To review the current situation of capacity building in the HNP sector of the African region
- To summarize lessons learned by identifying both success and failure stories
- To make recommendations on how to take this important work forward both as recommendations for the Task force and more broadly our future work in the HNP sector

Tasks

The following tasks would be undertaken during the review:

- A portfolio analysis of capacity building activities that have been supported through Bank's lending operations and ESW in the HNP sector since the early 1990s
- An analysis of the capacity building activities undertaken during the same time period by the World Bank Institute
- Selected focus group interviews with Bank staff who have been active in supporting capacity building activities
- Two or three illustrative case studies

Deliverables

Summary Report and recommendations

Time line for assignment

The assignment will span over the period from April 18, 2005 to May 31, 2005.

Staff Time Requirement

The following staff would provide inputs for the assignment

Main Report

Alexander Preker (TTL) 1 SW

Portfolio Review

Kofi Amponsah (4 SW)
Kassem Kassak (Consultant)
Rama Lakshminarayanan (TTL) 1 SW

WBI Review

Gilles Dussault (TTL) 1 SW
Stephane Legros (1 SW)
Program Analyst (2 SW)

Country Case Studies

Kassem Kassak (Consultant) – 6 SW
Julie McLaughlin (1 SW)

Non Staff Budget

Task Force	US$7-10,000 (for Case study travel and analysts)
HNP Anchor	US$5,000 (for Portfolio Review)

ANNEX II.
ROLE OF WBI IN AFRICA REGION

1- Objectives

The overall goal of the Health and AIDS Program of WBI is to strengthen the capacity of client countries to combat HIV/AIDS and achieve critical health, nutrition, and population outcomes, contributing towards realization of the Millennium Development Goals for health. The Program aims to complement Bank lending with an effective learning program for client countries, Bank staff, and staff from other Donor agencies in order to:

- strengthen national institutional capacities to lead in designing, implementing and sustaining strong health components of national programs and Poverty Reduction Strategy Papers (PRSPs), with particular emphasis on combating HIV/AIDS and improving HNP outcomes of the poor and socially vulnerable.
- clarify the role of government in the health sector, including policy and stewardship functions as well as facilitation of the public/private collaboration in financing and provision of services;
- ensure that the Health sector is an engine of change and not a victim of reform;
- improve Bank/client country dialogue on HIV/AIDS, health, nutrition, population & reproductive health issues, as reflected in Country Assistance Strategies (CASs) and PRSPs
- support capacity building of national training institutions to achieve a sustainable increase both in knowledge and know how in the critical areas needed for achieving the MDGs for health.

2- Target audiences

Target audiences include public and private sector leaders, parliamentarians, policymakers, representatives of civil society, community leaders, the media, trainers and academics and professionals involved in the financing, planning and implementation of health care policies and interventions in Bank client countries. The training and learning products developed by the Program are also offered to staff from the Bank and other donor agencies. 5,318 persons have been reached via WBI activities in Africa, and another 400 participated in activities outside Africa, thus totaling 5,718 African participants.

Table: Number of participants to WBI HNP-AIDS activities, per country, per year (2002-2005)

Country	FY02	FY03	FY04	FY05	TOTAL
Angola	9		3	2	14
Benin	41		33	72	146
Botswana			5	5	10
Burundi			36		36
Burkina Faso	9		49	31	89
Cameroon	7		16	5	28
Central Africa Republic	2			1	3
Chad	12		13	9	34
Comoros	2		1		3
CapeVerde			5		5
Congo	8		21	8	37
Congo, Democratic Republic of			25	3	28
Cote D Ivoire	38		40	2	80
Djibouti			1	6	7
Eritrea			3	7	10
Estonia			3	3	6
Ethiopia	112	51	40	97	300
Gabon	5	11	9		25
Gambia	7	3	35	4	49
Ghana	82	39	115	582	818
Guinea	32	32	27	7	98
Guinea Bissau			2		2
Kenya	38	29	85	493	645
Liberia			12	3	15
Lesotho		5	5	3	13
Madagascar		3	27	13	43
Malawi	32	12	41	14	99
Mali	17	52	23	20	112
Mauritania	6	91	25	30	152
Mauritius			2		2
Mozambique	26	6	23	11	66
Namibia	1		6	10	17
Niger	13	18	17	9	57
Nigeria	27	36	649	301	1013
Rwanda		13	39	13	65
Senegal	141	72	41	131	385
Sierra Leone		3	13	7	23
Somalia		3	8	2	13
South Africa	54	13	51	99	217
Sudan			7	9	16
Swaziland	2	2		6	10
Tanzania	70	36	26	173	305
Togo	7	20	30	3	60
Uganda	73	66	88	131	358
Zambia	9	8	62	35	114
Zimbabwe	29	2	43	16	90

Total number	**911**	**626**	**1805**	**2376**	5718

3- Programs

WBI launched its HNP Program in 1997 to support sector reforms which the Bank's assistance. The initial sub-component was the "**Health sector reform and sustainable financing**" sub-program, which focused on the financing (mobilization and allocation of resources, payment mechanisms) and organization of health care delivery systems (decentralization, public-private partnerships), and the policy process leading to reform.

In 1999, the program added a new sub-component on reproductive health, to support the implementation of the Cairo Agenda, which came out of the International Conference of Population and Development (ICPD) of 1994, at which 179 countries participated. The resulting sub-program was labeled "**Adapting to change: Population, reproductive health, and health sector reform**", which aimed at strengthening the skills and capacity of key actors to make their population and reproductive health programs more efficient, equitable and financially sustainable. In 2003, this sub-component has been relabeled "**Achieving the Millennium Development Goals: Poverty Reduction, Reproductive Health and Heath Sector Reform**".

From 2000, when the focus of the international community was brought more explicitly on poverty reduction and the MDGs, WBI moved in the same direction by developing two learning sub-programs. One on **Gender, Health and Poverty,** launched in 2000. The main objective of this initiate was to raise awareness of how interventions in different sectors work through gender and interact to influence health, and poverty. The second one on **Health Outcomes and the Poor,** launched in 2002 as a web-based course. This serves as an introduction to the role of the health sector in designing and implementing Poverty Reduction Strategies.

Furthermore, given the high important of Human Resources for health (Policies and practices) as one of the key issues contributing to ill performance of the health system, the HNP team launched another learning program on this topic in 2004. The main objective of this new sub-program is to help countries address the Human resources bottlenecks which are among the most critical obstacles to their efforts to improving the performance of health services delivery systems: expanding the workforce, ensuring that it has adequate skills mix and is effectively deployed, as well as creating an enabling working environment and managing migratory flows.

Finally, in 2004-2005**,** in orde to respond to the countries commitment to achieving the MDGs, WBI developed a *new learning program on Achieving the Health MDHs and other Health Outcomes. This program* offers a comprehensive approach of the multi-sectoral determinants of health under the PRSPs and Sector-wide approaches (SWAPs) processes. This new program will first be piloted at a Global level in Washington in the Fall 2005 and then be implemented shortly in Africa at the country level starting with Nigeria and Ethiopia.

Another major learning program in WHIHD is the **Leadership Program on AIDS. As of July 1, 2005 this program will merge with the** HNP program in order to ensure more integration and achieve synergies. The Leadership Program on AIDS was launched in 2001. It includes the following activities:***Managing the Procurement and logistics of HIV/AIDS Drugs and Related Supplies***, a comprehensive face-to-face course that addresses issues related to procurement of HIV/AIDS drugs and other supplies, to enhance the capacity of country level implementation agents and key staff of the development partners in procurement, logistics, and supply management of ARVs and to enhance harmonization of policies, procedures and practices at the country level, ***Capacity Building to Accelerate implementation***, which aims at strengthening the capacity of policy makers and development partners to

design, implement and manage comprehensive HIV/AIDS responses; ***Knowledge sharing through GDLN to strengthen HIV/AIDS Programs***, a program which uses Video conferencing to increase knowledge sharing and south-south collaboration; ***Rapid Results Initiative to Accelerate Implementation,*** aimed at jump-starting major change efforts and enhancing implementation capacity in times of crisis by unleashing existing creativity and capacity, accelerating the learning cycle and providing a structured methodology for building and practicing management disciplines that are required for translating intent into action.

4- Activities:

Health sector reform and sustainable financing:

1 course in English in 1999
3 regional courses in French in 2000, 2001, 2002, offered at CESAG in Senegal
1 national course in French (Mauritania) in 2003
2 national courses in English (Nigeria) 2004-2005, with a focus on health insurance
5 workshops on health insurance (in French, 15 countries targeted), 2002-2004
DL series on health insurance (in French, 15 countries targeted), 2002-2005
2 DL courses on health financing in French, 2004, 2005
Conference on health insurance ((in French, 15 countries present), 2004
5 workshops on contracting in the health sector, in French, 2003-2005
1 hospital course in French in Dakar

Reproductive health and sector reform:

Training of Trainers activity for Francophone countries, 2000
3 regional courses in French, 2002, 2004, 2005
2 regional courses in English, 2004, 2005
1 national course, 2004 (Nigeria)

Gender, Health and Poverty:

2 regional courses in French, 2002
2 national courses in French, 2003 (Mali, Niger)
3 regional courses in English, 2002

Health Outcomes and the Poor:

5 global courses in English with large African participation in 2003-2005

Human Resources for health (Policies and practices):

1 multilingual course targeting Burkina Faso, Ghana, Malawi, Mozambique, Tanzania, Zambia, 2004

Leadership in AIDS Program:

7 national activities (Aids and strategic communication, Malawi-2003, Zambia- 2004, AIDS Competence program, Nigeria-2004, Re-Engineering of the NACA, Nigeria-2004, Physicians' response

to AIDS, Ethiopia-2004, Aids, Journalists and Orphans, Zambia-2004, Rapid Results Initiative to Accelerate implementation, South-Africa-2005)

Managing the Procurement and logistics of HIV/AIDS Drugs and Related Supplies

7 regional activities, 2004-2005

5- Strategy: WBI activities in Africa have included traditional face-to-face courses, as well as distance learning via videoconferencing and web based courses. Five main capacity development strategies, which sometimes overlap, have been used:

- *Training of trainers*: in the Francophone Health financing and sector reform program, efforts to build the capacity of CESAG to deliver the program autonomously have progressed well (in 2002-2003, CESAG delivered more than 80% of the contents), but failure to strengthen the organization and to help it retain staff has resulted in loosing all that capacity when the 3 main trainers left CESAG in succession for "greener pastures" (See below).
  The learning program specifically developed for the region on contracting in the health sector is delivered with two institutions with a regional reach, and aims at training some of their staff to be able to fully deliver this program on their own within 2-3 years. At the École Natioanle d'Économie Appliquée (ENEA), Dakar, 4 staff are involved, and 2 at the Institut de Recherche en Santé Publique(IRSP), Ouidah, Benin.The same sub-program has launched a Training of Trainers activity which has targeted 4 countries in 2005 (Madagascar, Mali, Senegal, Chad), and these trainers have designed a one-year national program to be implemented in 2005-06.
  The Francophone Adapting to change program has also put the emphasis on Training the Trainers, and has succeeded in delivering its courses mainly with African trainers.

- *The development of networks of organizations* (combined with Training of Trainers) is the strategy adopted by the Reproductive health and sector reform. The objective was to engage the main organizations involved in the field, as well as a few training institutions, in the design and delivery of the program. Development costs have been high, but now the Francophone program has already conducted 3 courses in an autonomous and self-sustaining manner. Efforts to replicate the model in English-speaking Africa are going on.

- *The development of communities of practitioners*: this was done in various ways, such as maintaining the links between participants to courses through a newsletter and a on-line discussions (Adapting to change), by promoting the participation of country teams (all programs) instead of isolated individuals, and by re-inviting the same participants, and maintaining the contact with them by videoconference (sub-program on health insurance in French). This strategy is also requires much time and financial resources, which have not been available through traditional sources.

- *Multidimensional approach,* i.e. proposing a set of complementary activities to address the various dimensions of specific capacity needs, and to produce a synergy effect. For example, training on the topic of contracting in the health sector proposes different activities which target the various actors in the field: Ministries of health, NGOs, providers, policy makers (which resulted in 2 countries adopting a contracting policy, and four more engaging in the process of doing so) and eventually staff of technical and financial agencies. It has also adopted an ToT approach which is expected to produce a multiplying effect (four country teams – Chad,

Madagascar, Mali, Senegal- already committed to deliver a training program prepared during a ToT event in May 2005.

- *Rapid response to country demands*: An example is the Nigerian Flagship learning program was launched in 10 months in 2004 in response to requests from the Federal Ministry of Health. Two courses were delivered, in October 2004 (Health Financing and Provider Payment Mechanisms) and May 2005 (Health Insurance Implementation). A WBI partner was identified, the Center for Health Systems Studies and Development, recently created in Abuja by the Federal MOH to become a leader in capacity building in support of sector reform. This Center will host the WBI Flagship and the new Health MDGs programs in FY06.After the May 2005 course, a MoH official commented: *"It was not until participating in this course that I fully appreciated the significant impact that the Flagship program has in moving forward the policy agenda. By your ability to attract all the key players in the reform process (…), and put them in a room together for a week of shared learning and dialogue, the implementation of the Social Insurance program in Nigeria was greatly enhanced. The level of discourse, the active participation, and the openness of all parties could not have happened without your tremendous efforts in structuring and organizing this excellent program. Several of the participants have written to me to express similar sentiments"*

6- Resources

WBI HNP-AIDS has a small team comprising of 4 GG-GH professionals, one research analyst, one learning analyst, one operations officer, 3 program assistants, complemented by one half-time GG staff on loan from the French government, one JPO, one ETC, and several short term consultants. The equivalent of approximately 3 full-time staff works on Africa which might not be enough to respond to the demand from the region. In addition to the human resources working on the region, the financial resources are also limited. The Bank Budget includes the salaries, plus an amount of about $110,000. Finally, few donor agencies such as the Swiss, Irish, Dutch, Hewlett Packard and other support the program in Africa. However, to raise the needed funding requires major investment from staff.

7- Partnerships :

The region benefits from several types of partnerships which include both financial and institutional partners.

1/ Financial : Trust Funds (Switzerland, France, Ireland, the Netherlands), Foundations (Hewlett Packard), Joint Africa Institute

Box: A special type of financial partnership: the Joint Africa Institute (JAI)

The Joint Africa Institute (JAI) was established in April 1999 by the African Development Bank (AfDB), the International Monetary Fund (IMF), and the World Bank to enhance economic and financial training opportunities in Africa. The JAI offers policy-related training primarily to African government officials, representatives of the private sector, civil society, academics, and researchers. Training topics vary from financial programming and policies and macroeconomic management to economic growth and poverty alleviation, good governance, public finance, money and banking statistics, financial sector issues, health economics, and rural development. JAI collaborates with the 3 founding institutions to make high-level learning opportunities available. It contributes funding for the travel of participants, for logistical support, and for the preparation and delivery of activities. The institutions contribute contents and trainers.

WBI-HNP joined forces with JAI in 2002 to develop a program on health insurance targeting 14 Francophone countries. Country teams met face-to-face three times, and were regularly in contact by videoconferencing in between meetings. A conference on "L'amélioration de l'accès aux services de santé en Afrique francophone: le rôle de l'assurance » was organized in April 2004, and attracted 190 persons. A book summarizing the contributions of the workshops and of the conference is in preparation.

The collaboration with JAI was unique in that it allowed WBI to better target participants, as it had funds to invite them, and also to engage in a process which could go beyond the usual one-time activity. This was critical in building a small community of professionals engaged in the development of health insurance in their country. The question which WBI now faces is how to continue providing support to this community, as it now requires resources to organize itself more formally and engage in more technical work. Also, JAI was able to provide valuable logistical support in French, which enabled WBI staff to concentrate their work on the development of learning materials and strategies.

2/ Academic Institutions: CESAG, ENEA, IRSP, Swiss Tropical Institute, Intellfit African Training Centre, Center for Health Management Studies (Abuja, Nigeria).

The **Adapting to change** Program for Africa, first targeted French-speaking countries and invested considerable efforts in building a partnership of institutional stakeholders, with a view to creating a synergy between NGOs, international agencies , and training institutions interested in reproductive health. Currently the network (see Box) is composed of 14 members, and is autonomously developing national and regional training activities.

Box : Partners of the «S'ADAPTER AU CHANGEMENT :Atteinte des Objectifs du Millénaire et Réduction de la Pauvreté par les *Réformes du Système de Santé* et la *Santé de la Reproduction*» course

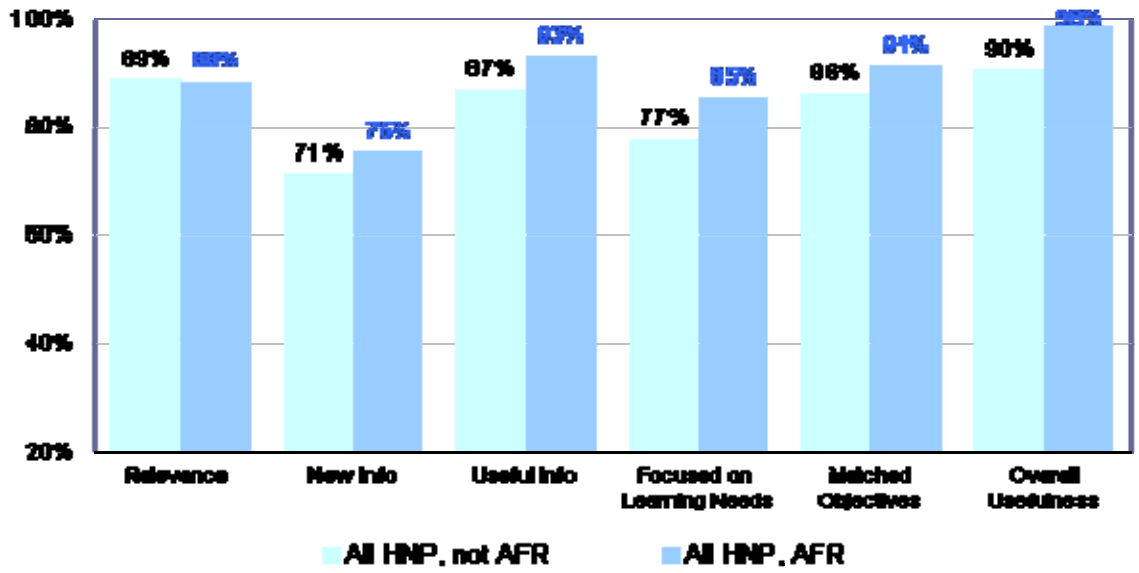
- Centre d'Etudes et de Recherche en Population et Développement (CERPOD) de l'Institut du Sahel (INSAH/CILSS), Bamako, Mali,
- Banque Mondiale, Bureau de Bamako/Mali,
- Fédération Internationale pour la Planification Familiale (IPPF) au Kenya,
- Centre de Formation et de Recherche en matière de Population (CEFORP) du Bénin
- Centre Africain d'Etudes Supérieures en Gestion (CESAG) de Dakar,
- Institut de Santé et de Développement (ISED) du Sénégal,
- Organisation Mondiale de la Santé (OMS) de Genève,
- Organisation Mondiale de la Santé (OMS/AFRO), Brazzaville
- Centre d'Etudes de la Famille Africaine (CEFA) au Togo,
- Centre Régional de Formation en Santé de la Reproduction (CEFOREP) de Dakar,
- Centre International de Formation en Recherche Action (CIFRA) de Ouagadougou
- Ecole Nationale de la Statistique et de l'Economie Appliquée de Côte d'Ivoire
- Harvard School of Public Health (HSPH)
- Advance-Africa

A similar effort is undergoing in English-speaking Africa, notably with the support of the African Population Advisory Council (APAC), and the Commonwealth Regional Health Community Secretariat (CRHCS).

8- **Quality**

All WBI activities are evaluated by participants (Level 1 evaluation). Compared to other programs and to activities in other regions, the Africa program performs very well, as illustrated by the evaluation results of FY05:

Respondent Ratings AFR vs. not AFR, Health, Nutrition and Population Program FY05 YTD March 31



Level 2 evaluations, which measured learning gains are routinely conducted, but are not tabulated, as comparisons between activities and aggregation of data are not meaningful, since this is an instrument designed for utilization at activity level. Level 3 (Impact on individual participants) and level 4 (impact on the environment) have not been conducted. This leaves open the question of the contribution of WBI to capacity development. Anecdotal evidence tends to show that many participants have move professionally, but it would be impossible to ascribe their mobility to their participation to our activities. The same applies to policy changes which have been observed, and which may have been influenced by participation to WBI activities. In-depth case studies of activities which have very specific objectives (in relation to insurance, contracting, procurement practices, rapid results) would probably be the best way to measure impact.

8- **Challenges and lessons learned**

Looking back at the 5 years of interventions in Africa, independent observers would easily agree that much was accomplished, with limited resources. Client satisfaction (not documented here because of lack of time and resources) is perceived to be high, which leads to conclude that WBI HNP-AIDS does well what it does. As we reflect on contributions to capacity development, we need to ask ourselves: "are we doing the right things?" In the past 4-5 years, WBI has tended to measure success in terms of number of activities and products delivered, the number of participants, and participant satisfaction. While recognizing that these indicators say little about quality of contents or about impact on capacity development, for lack of better indicators, WBI has given value to what was easier to measure. Taking a broader approach to capacity development, i.e. as the "Strengthening of aptitude of **institutions**, **organizations, and individuals** to solve problems, take sound decisions, define priorities, plan, implement policies that enable them to achieve their mission", we can identify some challenges that remain to be tackled:

- Continue **moving from a supply to a demand-driven program**. Most past activities were initiated by WBI rather than client or operations. However, this modus operandi is changing rapidly because a year ago WBI adopted a new strategy for capacity building. This strategy entails identifying few countries in each region (in Africa the countries are: Burkina Faso, Chad, Ethiopia, Ghana, Madagascar, Nigeria, Senegal, Tanzania) and design and deliver customized learning program to respond to the specific country needs. This approach is expected to have a greater impact on the sector at hand. However, all demands cannot be satisfied as WBI devotes only limited resources to each country focus program, and HNP-AIDS needs to compete with 13 other programs. Furthermore, demands emanating form the sector TTLs or from the HD division of the Africa Region, which now has defined its "Strategic options" (*Improving HNP Outcomes in Sub-Saharan Africa: Implications for World Bank Operations*, World Bank, 2004*)*, do not necessarily make the list of priorities decided in consultation with the country directors, thus leading to an unconsolidated demand. A good deal of energy is, hence, needed to coordinate with operations colleague form the sector and to negotiate with WBI's Regional Capacity Enhancement Team which conducts the dialogue with country directors.

- Large **parts of the Region have not been covered**: many Anglophone countries, the Portuguese-speaking countries, post-conflict Francophone countries. This is also changing as new activities are already planned to reach those "neglected" countries, but serious resource constraints will limit our capacity to reach out to these countries.

- **No strong partnership has been created for the dissemination of the Flagship program**. In Francophone Africa, a strong relationship was initially built with the Centre Africain d'Études Supérieures en Gestion (CESAG) which had developed the capacity to offer a good portion of the

program in an autonomous manner, with three staff members well trained, and a good network of national and regional collaborators. The Institut de Santé, the part of CESAG with which WBI had been partnering, suffered from management problems which have led to the departure of the staff involved in the Flagship and in the Reproductive Health course. It is not in a position to be a partner any more (see Box). On the Anglophone side, no partnership has been established (there was an attempt to engage Witswatersrand University in the late 1990's, but it did not succeed). A Center for health management studies is being created in Abuja, as a potential regional hub in West Africa. Partnership building requires staff time and also additional resources, beyond resources for the delivery of activities, to help the partner institution to develop. The lesson learned from the CESAG case is that the strengthening of the capacity of trainers is necessary, but not sufficient. If WBI or the Bank are not able to also provide institutional support, for instance in the form of access to professional development activities, to research funds and technical assistance, help to recruit additional staff, retention measures, substantial efforts invested in building the capacity of trainers may be lost.

BOX: Capacity development: the need to go beyond individuals

The challenge for WBI is to go beyond the delivery of learning activities and to help build strong institutions which will carry out that work on a continuous basis. Africa is a special case as the number of institutions with which partnerships can be established are few in the health sector (outside South-Africa, there is almost no schools of public health). Second, the staff of those institutions is very solicited, and retention is a problem. One example is that of CESAG, which offers programs in health services management and health economics. CESAG became a partner of WBI in 2000 and collaborated in the delivery of two programs (Health sector reform and sustainable financing, Adapting to change). With the technical support of the Swiss Tropical Institute and of WBI, it gradually developed the capacity to offer a range of learning activities, relying almost exclusively on its own staff and on part-time trainers. For various reasons, CESAG was not offering a positive work environment and the 3 senior trainers left: one in 2004 to go WHO, one in 2004 to Family Health International, one in 2005 to become an independent consultant and to complete a PhD, which CESAG had not supported.

9- The future

Capacity development needs are overwhelming in Africa, and the question for WBI is where its limited resources can contribute the best added value. Training individuals, however professionally done, is not a viable strategy: (1) the needs are too important in volume; (2) mobility at government and civil society level, including emigration to richer countries or employment by international agencies. Strategies should consider: (1) to focus more systematically on the development of training African institutions, with a view to creating regional and national centers of excellence which will then respond to capacity building needs. (2) to go beyond the strengthening of the competences of individuals, and ensure the development of strong and viable institutions, which offer a work environment that retains its high performing staff and provides them with the means to produce at a high level of excellence.

This type of approach would require more resources, but also a different way of working with our clients, including adopting a longer term perspective, designing flexible strategies which are monitored and adapted accordingly, ensuring the building of strong work relationships between WBI staff and their partner institutions (visiting once or twice a year will not do). WBI is clearly moving towards a country focused approach, but this should not be incompatible with the above proposals.

ANNEX III.
ANALYSIS OF THE AFRICA LENDING PORTFOLIO 1990-2005

1. Introduction

I.1 Background

1.1.1 The Africa region compares unfavorably with the rest of the world in terms of health outcomes. (See table1 below).

Table 1: Unfavorable health outcomes for strengthening Health Sector Capacity

	Life expectancy at birth **Year** **2003**	**Child malnutrition** **% underweight**	**Under 5 mortality rate** **Per 1000**	**Prevalence of HIV** **% of ages 15-49**
Africa	46	-	171	7.20
Europe and Central Asia	68	-	36	0.70
Latin America and the Caribbean	71	9	33	0.70
Middle East and North Africa	69	13	53	0.10
South Asia	63	48	92	0.80
East Asia and Pacific	70	15	41	0.20

Source: 2005 World Development Indicators database, World Bank, 16 April 2005

1.1.2 Achieving the health related Millennium Development Goals (MDGs) will require both more resources and better spending. Capacity building will be central to both mobilizing extra resources and achieving the value for money.

1.1.3 Like many developing countries, African countries are faced with the lack of capacity to carry out and manage programs designed to reach the MDGs. In this regard, developing this capacity is a major challenge and top priority to ensure proper sustainable development.

1.1.4 Over the past 15 years, the World Bank and its developing partners have been actively involved in initiating and coordinating capacity building activities to help African countries keep the pace towards reaching the MDGs. Nevertheless, it is believed that these countries are still facing myriad of problems related to brain drain, retentions, corruption and resource misallocation, and the shy engagement of the civil society in partnering for sustainable development.

1.1.5 The Africa Region HNP sector has carried out a plethora of health projects in Africa in the past fifteen years, which have substantial capacity building activities incorporated in them. More recently, capacity building has become a major matter of concern in many Bank operations. As the HNP continues its developmental efforts in Africa, it is important to examine its portfolio of health activities so as to know how projects have addressed key issues related to capacity building.

1.1.6 The review covers four main areas of capacity building: institutional environment, management attributes, organizational structures, and infrastructure The institutional environment specifically delves into how projects have been able to strengthen institutions through the following: legal framework, regulatory instruments, administrative procedures, and customs and practices. In section 3.2, we examine how projects have strengthened capacity of client countries in the following areas of management attributes, management skills, management incentives, and management tools. Finally, we address organizational structures, which include organizational reforms, and structural linkages (vertical and horizontal) and infrastructure: human resources, equipment, pharmaceuticals and facilities.

1.1.7Institutional environment:

(i) *Legal framework*: Among the main sources of formal institutions are rules established through legislation. Ideally, law normatively translates a defined policy on the scope and content of health care into a formal written document with definitions and procedures. Health law is largely statutory rather than common law and is therefore found in acts of Parliament or delegated legislation made under those acts. Especially in democratic states, the legislature is the primary rulemaking authority holding the power to enact laws. Legislation cannot cover all issues, and therefore, the same laws often delegate the regulatory, monitoring and enforcement authority. This is recognition of the complex processes involved and is affecting a broad range of actors and raising the demand for control and monitoring mechanisms. In Australia, for example, local Governments traditionally play a strong role in monitoring and in implementing legislation. The regulation through government might vary between jurisdictions and involves many regulatory instruments such as regulations, instructions, decrees, etc. (National Public Health Partnership 2002).

(ii*) Regulatory instruments*: Usually, laws delegate legislative authority to governmental authorities (ministries and autonomous public entities) with a mandate to expand and detail the law through general and specific regulatory powers. The idea is to have institutions issued by administrative authorities while they are carried out according to the intent of the law by consulting stakeholders and getting their technical assistance. The law can delegate regulatory functions to ministries and other public entities but also to private entities. This is for instance in the case of professional associations that have the legal power to issue licensing and to conduct continuous education programs as conditions for re-licensing.

Based on the idea that laws should provide the larger framework for the provision of health care, regulatory instruments are much less comprehensive. They are a tool to respond quickly to economic and social needs by not having to go through parliamentary procedures for the enactment and amendment of laws. For example, in Mexico, State Governments issue regulations for the purchase of health care services. In Chile, the Ministry of Health issues norms for the purchasing of health care supplies and equipment in Colombia technical regulations that control the purchasing of syringes are issued by the Ministry of Health. In the USA, in the State of Minnesota, the Department of Human Services has issued model contracts for the purchase of health care services.

Increasingly, regulatory agencies are granted full regulatory powers for issuing regulations. E.g. the Superintendency of Previsional Health (private health care financing and delivery system) in Chile has full regulatory powers. The National Health Fund in Chile for instance has its own regulations. The purchasing of health care services from private providers is based on contracts whereas from public providers it is based on management agreements. However, in most former Soviet Union countries there is reluctance to grant regulatory powers to decentralized entities. Their regulations need to be issued and promulgated by the government, usually the Ministry of Health or in the other case by the Cabinet of Ministers.

(iii*) Administrative Procedures:* Purchasers such as social health insurance funds, ministries of health, local health authorities, private insurance companies and managed care organizations issue administrative procedures to acquire health care goods and services. These forms of administrative regulation such as guidelines, instructions and letters of interpretation are becoming an increasingly relevant source. They are important for health care purchasers and providers that want to make sure that due regulation and procedures are followed so that resources are used in an efficient and effective way.

Administrative procedures need to have a formal foundation. For example, social health insurance funds issue internal regulations and procedures in the constituting laws. Also private insurance companies issue internal procedures and include them in the terms and conditions of health insurance polices. Within the framework of what is permissible under insurance laws and regulations hospitals issue internal regulations and guidelines.

In many countries, the legal system enables the medical profession to take that lead in developing clinical protocols. E.g. in New Zealand, they are developed by a range of professional groups such as IPAs, specialist societies or associations, and hospitals. Still, in most countries the focus has rather been on the development of guidelines than on their implementation. For that reason direct involvement of medical professions not just in the development but also in the implementation of appropriate health care standards will increase the chance that guidelines are followed effectively in practice. (Or 2002)

(*iv)Customs and practices*: Informality such as customs and practices play a significant role in purchasing health care goods and services. As mentioned earlier customs are based on unspoken understanding. They are courses of action characteristically repeated under like circumstances and to a large extent socially derived. They consist of established patterns or behavior that can be objectively verified within a particular social setting and are being memorized and passed down from generation to generation. Customs and practices to not function through written documents; their high regulatory power comes through routines, norms or social contracts.

In some countries where attempts have been made to strengthen primary health care especially as gatekeepers for access to secondary level of care, the remuneration for the primary care physicians and nurses are low. For instance in Mongolia, institutions such as real incentives and penalties for self-referrals by-passing the primary health care system are badly implemented or simply not enforced. In these situations, customs and informal practices play a bigger role and the remuneration and pricing system works based on communal and informal understandings.

1.1.8 Organizational structures

(i) Organizational reforms: The growing awareness of the structural nature of the problems in public services delivery has increasingly led policy makers in some countries to make organizational reform a core component of the health sector. These changes are designed to improve the incentive environment by altering the distribution of decision-making control, revenue rights, and hence risk among participants in the health sector. There is a wide range of organizational reforms. Some focus on changing the mapping of functions across agencies, for instance, creating health insurance agencies that collect premiums and purchase health services. Or, endowing providers with fund holding or purchasing authority-thus integrating funding with service provision. Decentralization is another common organizational reform in the health sector, a reform that shifts decision-making control and often revenue rights and responsibilities from central to lower level government agencies.

(ii*)Decision rights:* The organizational reforms vary substantially in the amount of autonomy given to managers, the mechanisms, used to generate new incentives, and accountability. Each reform can be

characterized by the magnitude of control shifted from the hierarchy, or supervising agency to hospital. Critical decision rights transferred to management may include control over: inputs, labor, scope of activities, financial management, clinical and no clinical administration, strategic management (formulation of institutional objectives) market strategy and sale.

(*iii)Linkages(vertical and horizontal):* the real experience in applying these reforms to other r sectors point to critical linkages among the important elements of these reforms. Governance reforms must be aligned with each other. For instance, managers given incentives to cut cost must have the ability to alter the use of the key cost drivers including labor. In addition to being internally consistent, the governance changes must be aligned with critical elements of the external environment.

1.1.9 Management attributes:

(i) Leadership: Leadership is what gives an organization its vision and its ability to translate that vision into reality. Leadership is about creating change and coping with change imposed from outside. Successful leaders are able to steer through competitive, volatile and sometimes chaotic environments in such a way their firms come out ahead.

(ii) Vision and values: typically a good leader provides a vision and set directions, based on opportunities and rewards that lie around the corner. They are good at articulating this vision and communicating broad directions to their subordinates

(iii) Strategic thinking and planning: Strategies are plans for the informed by lessons from the past and which try to anticipate opportunities and threats in the future. People in strategic ways that increases the chance of achieving desired objections.

(i) Management of value chain: The relationship between suppliers and, consumers and competitors- the value chain- can have a profound impact on performance o f an organization. In the health sector, the way supply and distribution chains, are either managed or mismanaged can have a significant impact on access and quality of the services s provided through clinics and hospitals. Efficient management of the value chain-including suppliers who supply the suppliers- is considered and essential part of getting maximum value for the end user at least possible cost.

(v) Change management: good leaders are not resistant to change; they are very responsive to changing environment.

(vi) Focus on client needs: a good leader keeps focus on clients

(vii) Autonomy and decision-making: staff is able to take initiative and work independently. Empowering staff to do their job more independently means mangers are able to fee up their own time to engage in strategic thinking, providing leadership and providing coaching for staff. Staff empowerment includes; encouraging staff to develop a capacity to play a more active role in the organization (skills), and enabling staff to take more and bigger decisions without having to ask for permission (autonomy)

(ix) Accountability: Management accountability means action in accordance with the will of those that the manger represents

(ix)Performance appraisal: performance appraisal allows direct feedback which links reviews of salary increases, promotions, transfers, demotions and severance to performance, thereby increasing transparency.

(x) Management incentives: provision of inspiration and motivation to staff. High performance depends on people who are motivated to do something because they want to do it and do it better than anyone else. Motivating staff is therefore one of the most critical management tasks. It requires an understanding of what drives people, clear communication, settings good examples, providing encouraging feedback, and rewards for success.

(xi) Management tools: good management practices rely one range of management tool which include the availability of information technology that allow managers to have access to data and

information, much better access to reliable data and information, and the use of regulations and contracts as powerful management instruments.

1.2Objective and scope

1.2.1 The purpose of this review is to:

Assess the Bank's efforts in capacity development at institutional, organizational, management and infrastructure levels in the HNP sector over the last fifteen years.
Come out with key recommendations and suggestions as to how to develop strong capacity in our countries for sustainable development.

1.2.2 A total of 51 projects from 31 countries across the region were reviewed. (Please see annex 3 for details). The review focused primarily on in-depth study of HNP operations in four countries(Botswana, Tanzania, Burkina Faso, and Rwanda) selected by the capacity development task force as having made remarkable headway in capacity building in the Region. In addition, projects in Uganda, Ghana, Benin, Equatorial Guinea, Kenya were selected for a detailed study.

2. The Need for a Sustainable Capacity Building in the HNP in Africa

2.1 Public Sector reforms in African countries
Public sector reforms are key to success in development in African countries. One of the critical conditions for solid growth for African countries is the adoption and implementation of effective public policies. In this regard capacity building is central to the formulation of good policies. Over the past fifteen years, the health sectors of developing countries have, also been subject to almost continuous reforms from both national policymakers and the international development community. Some of these reforms are motivated by technological advances such as the discovery of new ways to diagnose, prevent and treat various major health care challenges. The Ministries of Health, within the broad objectives of the public sector reform, need to strengthen their capacities at all levels of service delivery. The Health Sectors in Africa, plagued with ceaseless exodus of health care professionals need to adequately build its human, organizational and institutional capacity in order to address the underlying causes of this trend.

2.2 Emergence of democracy in Africa
As democracy is spreading all over Africa, governments are expected to show high level of accountability and transparency which are the bedrocks of good governance. Democracy will strengthen both central and local governments. This in turn will facilitate strong decision making which will give more decision rights to the decentralized local governments. The primary objectives of the HNP sector are to assist countries to develop formidable decentralized health systems. Decentralization therefore is given much attention in all projects in the Region. And for decentralization processes to sustain there is the need to effectively build capacity at all levels of the health systems.

2.3 Emphasis on greater county ownership of development strategies and programs
Changes in the way donors do business in developmental efforts of countries have led to country ownership of their own development strategies. The CAS and the PRSP have variously demonstrated the need for country ownership of development agendas. With ownership and commitments, countries will be capable of championing their own development programs. Ownership goes with strong commitment of people at the helm of affairs in the sector. And for countries to be able to own their own development agendas, they must build their capacities for development.

3. Summary of findings

3.1In general, the performance of health projects is higher than that of HI/AIDS at all levels of capacity building.

3.2Bank's efforts in the HNP sector have been more pronounced at infrastructure and management levels than institutional and organization levels with health projects investing heavily in infrastructure than the HIV/AIDS projects.

3.3. Capacity development efforts in Health and HIV/AIDS projects have generally been centered on training and other human resources related activities. But brain drain and the flight of health care professionals and workers are rampant across the sector.

3.4 The Bank has not properly addressed this nagging issue to help clients reverse the trend. Many studies have recommended provision of incentives to staff as a concrete ways of resolving the problem. But little has been done to create real incentives.

3.5 The Bank's traditional approach of providing technical assistance to clients has not been effective.

3.6 In recent years, many projects particularly the MAP projects have given much attention to capacity building by given separate components for capacity building in project designs. But there are no clear, distinct, and achievable indicators of capacity building incorporated in the project designs.

3.7 The HIV and AIDS Capacity Building and Technical Assistance Project in Lesotho is in the right direction. But its key indicators are not realistic enough to achieve the stated objectives. (Please refer to page 8 of the PAD).

4. A Portfolio Analysis of Capacity Building activities in the HNP Sector of the Africa Region

4.1 Institutional Environment

Projects have not properly addressed the following institutional features which are pre-requisite for creating an enabling environment for building sustainable institutions for long-term capacity development. Consequently, managers who have acquired substantial management skills are not encouraged to effectively work in these weak institutions.

4.1.1 Legal framework

The legal framework which are rules established through legislation is generally weak. Our analysis revealed that only 17.6% percent of 51 projects reviewed (please see annex 1) did very much in strengthening the health sector legal framework. This depicted a dismal performance of projects in addressing this issue because health laws (which are found in acts of Parliament or delegated legislation made under those acts) are to a large extent statutory rather than common laws.

4.1.2 Regulatory instruments

Regulatory instruments which are tools to respond quickly to economic and social needs by not having to go through parliamentary procedures for enactment and amendment of laws have not been given much attention across the region. For instance, only 7 out the 51 projects studied paid much attention to the development of regulatory instruments. (Please refer to annex 1). This impedes decentralization of service delivery, since the district health authorities are not given much empowerment to carry out their duties.

Regulations of most of the decentralized districts still need to be issued and promulgated by the government, usually through the Ministry of Health of Cabinet ministers.

4.1.3 Administrative procedures

Administrative procedures are regulations such as guidelines, instructions and letters of interpretations issued by purchasers (health insurance funds, ministries of health, local health authorities, private insurance companies, etc. They are important for health care purchasers and providers who want to make sure that due regulation and procedures are followed so that resources could be used in an efficient and effective way. In many countries, the emphasis has been on the development of guidelines rather than on their implementation. Not much attention has been given to the development and implementation of these procedures in project designs across the continent. For instance, in our analysis, we noticed that, 24 projects representing 47.1 percent of total projects reviewed did not do much in the development of these procedures. (Please see annex 1)

4.1.4 Customs and practices

On the whole, projects have not done much to address these important informal practices which have a great deal of impact on institutional development. Customs and practices, which characteristically are repeated and socially derived, consist of established patterns or behaviors, which are passed down from generations to generations. Under the counter or informal payments to health care providers are typical examples of these informal practices. They are caused by low incentives to staff. Only two percent of the entire 51 projects reviewed seamed to address this issue. (Please see annex 1)

3.2: Organizational structures

4.2.1 Organizational reforms/ownership

At the organizational level, projects have done pretty good in reforming organizational structures and laying more emphasis on ownership. For instance, 21 projects out of the 51 projects reviewed did a great deal of work in restructuring organizations, which have resulted in strengthening decentralization. (Please see annex 1).

4.2.2 Decision rights

Health authorities at the district level are being given much more decisions rights in their deliberations. As shown in annex 1, 17 projects representing about 33.3 percent of projects reviewed did much better in strengthening organizational decision-making.

4.2.3Linkages: vertical and horizontal

Generally, there is much more linkages within organizations, and to the external environment (district, regional, and national levels). In reviewing the documents, it was found that approximately 45.1 of projects did better in building strong organizational linkages. (Please refer to annex 1).

4.3Management attributes

4.3.1 Management skills

Much has been done by projects in strengthening management skills particularly in the areas of leadership, strategic thinking, and accountability. Out of the 51 projects studied, 43.1 percent, 49 percent, and 49 percent did much in leadership, strategic thinking, and accountability respectively. (Please see annex 1 for detailed analysis).

4.3.2 Management incentives

Unlike management skills, management incentives have not been given much attention. Consequently, the sector is characterized by brain drain and low morale of workers. Increasingly, health professionals leave to either seek greener pastures elsewhere or leave the profession altogether. We noticed in annex 1 that only 12 out of the 51 projects reviewed have done well in this area. (Please see annex 1)

4.3.3 Management tools

Projects have done pretty much better in helping clients build formidable management tools such as planning, information technology, budgeting etc. We discovered in our analysis that 30 projects representing about 58.8 per cent of the total projects reviewed have performed well strengthening management tools. (Please refer to annex 1)

4.4 **Infrastructure (human resources, equipment, pharmaceuticals, and facilities)**

In general, the Bank has done so well in infrastructure development across the region. In the area of Human resources, projects have done marvelously well in providing training for health care staff at all levels. An extremely high percentage of projects across the continent have strengthened human resources. As high as 62.7 per cent of the 51 projects studied have helped clients in strengthening human resources. With regard to equipment, projects have supported clients in equipping newly built hospitals, health centers, clinics, health posts etc. As much as 23 projects out of the total number of projects studied did much better in this area. Provision of pharmaceuticals has excellently been executed by many projects. As much as 22 projects have done so well in stocking facilities with drugs and all kinds of pharmaceuticals. Over the period under review, more and more facilities (hospitals, health centers, clinics, health posts, training institutions, etc. have been constructed, rehabilitated, and renovated across the region. As depicted in annex 1 a total of 32 projects representing total percentage of 62.8 rank high in our ratings.

5. Analysis by program

5.1 Health versus HIV/AIDS

Two major programs, Health[2] and HIV/AIDS projects were compared in order to know how best the Bank has been able to strengthen client efforts in building institutional, organizational, management, and infrastructure capacities. The results are graphically shown in fig 1 and 2 below. In general Health did pretty much better in building capacity at all the three levels than HIV/AIDS. HIV/AIDS programs have performed well in organization, management and infrastructure levels but comparatively less in institution.

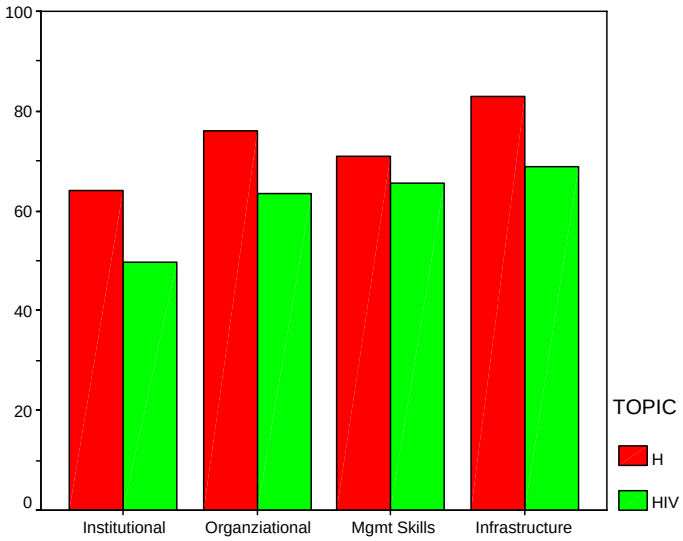


Fig. 1

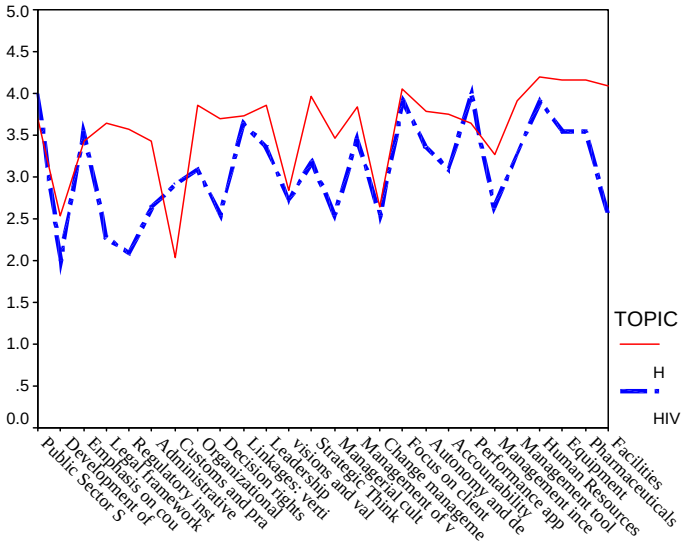


Fig. 2

5.2 SWAP(Y) versus Non-SWAP(N)

Seven of the total numbers of projects reviewed were SWAPs. As shown in figures 3 and 4 below, the Swaps performed better in institutional development than the non-Swaps, but relatively less at organization, management and infrastructure levels.

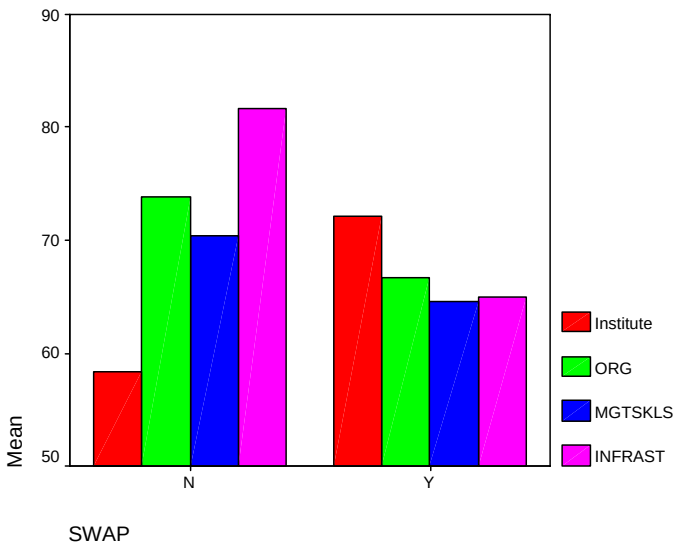


Fig 3.

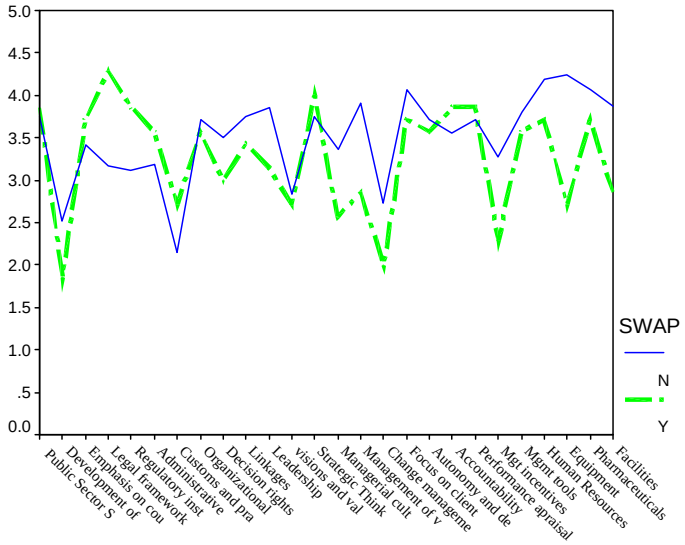


Fig. 4

6. Projects with ICR(Y) versus Projects without ICR(N)

In order to get real picture of what has been done on the ground, we examined project performance by comparing the PADs/SARs with the ICRs. In general, projects with ICRs gave much better picture about project performances than those without ICRs in institutional, organizational, management and infrastructure development.. As indicated in figure 5 below, better performances of projects are more pronounced in infrastructure and management but comparatively less at institution and organization levels in both projects with ICRs and those without ICRs.

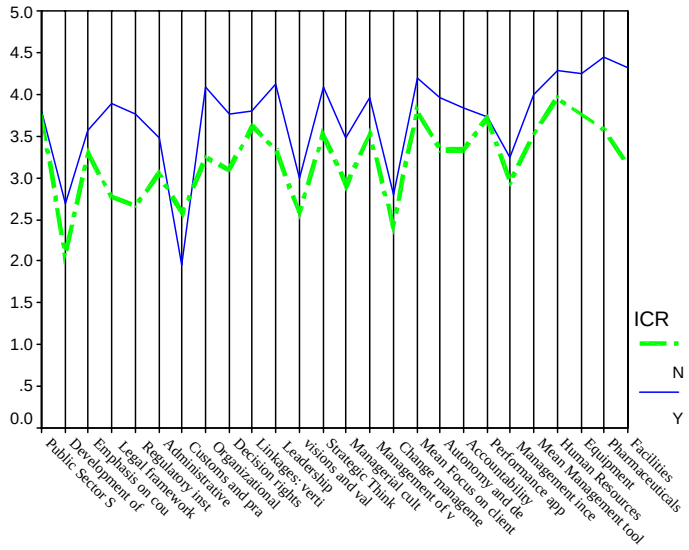


Fig. 5

7. **<u>In-depth review of selected countries</u>**

7.1 Four Outstanding Countries

Four countries (Botswana, Tanzania, Burkina Faso, and Rwanda) which have been mentioned in the task force concept note as having incredible capacity achievements and development were selected, in our study, for in-depth review. The results are explicitly shown in figure 6 below. The countries are categorized as follows:

- Sustaining capacity to perform: **Botswana** represented by the red line graph;
- Building momentum for comprehensive transformation: **Tanzania** represented by the green line graph;
- Service delivery resource management, and investment climate as entry points: **Burkina Faso** represented by the blue line graph ;
- Building the basics after conflict: **Rwanda** represented by the violet line graph.

Our observations are that, the four countries are all doing pretty much good in management, with Botswana being outstanding in institutional, organizational and infrastructure levels.

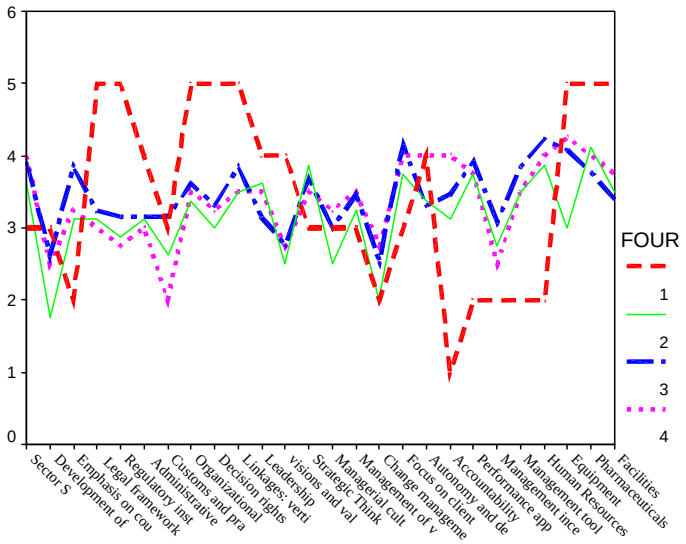


Fig 6

7.2 Projects in selected few countries

In Uganda, Ghana, Burkina Faso and Benin, tremendous progress has been made in decentralizing health service delivery as part of the ministries of health efforts to improve access to quality of health care. The following projects are examples of projects that have succeeded in reorganization, restructuring, and decentralization of the health system of the countries. (Please read the ICR of these projects to obtain detailed facts about achievements)

7.2.1 District Health Project(Project ID P002971-Uganda

Approved by the Board of Directors on February 7, 1995 and became effective on July 17 in the same year, the *Uganda District Health Project* is one of the outstanding projects in the Region. The project was extremely successful in building the capacity of the Ugandan health sector in totality. It supported the Ministry of Health in developing its institutional, organizational, management, and infrastructure capacities. Project outcomes were fantastic and all the development objectives were met. The project helped strengthen the capacities of the MOH in:

- Identification of cost effective services;
- Implementation of cost-effective services to selected districts;
- Provision of district level supporting services;
- Testing of resource mobilization and efficient use options;
- Supporting PHC activities;
- Improving collaboration with private sector and NGO providers etc;

An interesting initiative financed and supported by the project was *Community Based Income generation for Financing Health Services.* This initiative was intended to generate income for community dwellers so that they could pay for health care after the introduction of user-fees. (Please see annex 2 of the Implementation Completion Report (ICR) of the Project prepared in June 2003 for detailed description of achievements and outcomes).

7.2 Health Sector Support Project(Project ID-P000949)- Ghana

The Ghana Health Sector Support Project, which became effective in June 18, 1998 and closed in June 2002 provided support to GOG/MOH in:

- Improving access, quality, and efficiency of primary health services;
- Strengthening and re-orientation of secondary and tertiary service delivery to support PHC;
- Developing a program to train adequate number of health teams;
- Improving capacity for policy development and analysis, resource allocation, performance monitoring and evaluation, and regulation of service delivery and health professionals.
- Strengthening national support systems for human resources, logistics and supplies, financial management, and health information;
- Promoting private sector involvement;
- Strengthening intersectoral collaboration.

A remarkable achievement of the project is the creation of Ghana Health Service as an autonomous entity for managing health care delivery.
(Please refer to the ICR of the project for more detail)

7.3 Population and Health Project(Project ID P000118)- Benin

The Project became effective in September 1995. The project has succeeded in supporting the Government of Benin (GoB/MOH) to transform the health systems of the country. In particular, the project provided support to:

- Development and expansion of the family planning programs and services;
- Improvement in the quality and efficiency of priority health services;
- Strengthening and streamlining sector management and administration;
- Strengthening the partnership for health and;
- Project management, monitoring and evaluation.

(Please see the ICR report no. 26250 of the project for more details).

7.3 Health and Nutrition Project(project ID P000287- Burkina Faso

The Health and Nutrition Project became effective in October, 1994. The project satisfactorily achieved its objectives and provided support to the government of Burkina Faso to successfully advance its decentralization agenda; establish a strong essential drug program; and build capacities at all levels of health care system. (For more detailed, please read the ICR (report no. 23519) of the project).

Notwithstanding the incredible achievements of the above-mentioned projects, the following projects failed to achieve their desired objectives.

7.1 Health Improvement Project (Project ID)- Equatorial Guinea

This project performed very poorly. The project achievements were rated as unsatisfactory. After a long period of seven years with an investment of US$4.4 million:

- The institutional strengthening component was not achieved;
- The development and implementation of health strategy was not realized;
- The MOH's capacity to deliver priority health programs was very weak;
- The development of the health sector's human resources was very limited

(Please see the ICR of the project for detailed description of outcomes).

7.2. Health Rehabilitation Project (Project ID P001339)- Kenya

According to the ICR of the project, the project successfully supported the GoK in rehabilitating Kenyatta National Hospital (KNH). But the principal objective of reducing the hospital's burden on the MOH budget was not achieved, primarily because the Nairobi Area Health Services (NAHS) component of the project failed to achieve its objective of becoming the principal provider of primary and secondary care in the Nairobi area, thus allowing the decongestion of KNH. (Please see the ICR of the project for more details).

8. Conclusions and recommendations

8.1 Over the years, projects have variously tried to address capacity building issues concentrating mainly on training. But we believe that the Bank has yet to adopt a holistic approach to building capacity in client countries. Building a sustainable long-term capacity requires strong institutional, organizational and managerial environment.

8.2 In strengthening institutions, project designs must comprehensively include strategies to establish sound legal framework, regulatory instruments, administrative procedures, and customs and practices. These four elements are indispensable for strong institutional development.

8.3 Organizational restructuring must encompass how to transfer real ownership to clients, making them have absolute decision rights, helping them build strong linkages (vertical and horizontal). The decentralization of health care delivery, which many projects have been trying to address over the years, will be much more successful if restructuring focuses on client needs.

8.4 Strategies for effective, comprehensive, and realistic management incentives need to be mapped out if the problem of retention and brain drain is to be resolved. This will ensure full and efficient utilization of rehabilitated and reconstructed facilities in the countries and hence better health outcomes

8.5 Although the Bank has done a lot in the infrastructure development, it must not relent in its efforts of building more infrastructures equipped with modern equipment across the region. Building a comprehensive and sustainable infrastructure requires the investment of more resources.

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Annex 1 Results of institutional, organizational, management, and infrastructure analysis

1. Institutional environment

Legal framework

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	1	2.0	2.0	2.0
	1	6	11.8	11.8	13.7
	2	4	7.8	7.8	21.6
	3	12	23.5	23.5	45.1
	4	19	37.3	37.3	82.4
	5	9	17.6	17.6	100.0
	Total	51	100.0	100.0	

Regulatory instruments

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	1	2.0	2.0	2.0
	1	4	7.8	7.8	9.8
	2	6	11.8	11.8	21.6
	3	18	35.3	35.3	56.9
	4	15	29.4	29.4	86.3
	5	7	13.7	13.7	100.0
	Total	51	100.0	100.0	

Administrative procedures

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	2	3.9	3.9	3.9
	2	5	9.8	9.8	13.7
	3	24	47.1	47.1	60.8
	4	17	33.3	33.3	94.1
	5	3	5.9	5.9	100.0
	Total	51	100.0	100.0	

Customs and practices

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	6	11.8	11.8	11.8
	1	9	17.6	17.6	29.4
	2	17	33.3	33.3	62.7
	3	8	15.7	15.7	78.4
	4	10	19.6	19.6	98.0
	5	1	2.0	2.0	100.0
	Total	51	100.0	100.0	

2.Organizational structures

Organizational forms/ownership

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	4	7.8	7.8	7.8
	3	16	31.4	31.4	39.2
	4	21	41.2	41.2	80.4
	5	10	19.6	19.6	100.0
	Total	51	100.0	100.0	

Decision rights

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	5	9.8	9.8	9.8
	2	4	7.8	7.8	17.6
	3	15	29.4	29.4	47.1
	4	17	33.3	33.3	80.4
	5	10	19.6	19.6	100.0
	Total	51	100.0	100.0	

Linkages: vertical and horizonta

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	3	5.9	5.9	5.9
	3	16	31.4	31.4	37.3
	4	23	45.1	45.1	82.4
	5	9	17.6	17.6	100.0
	Total	51	100.0	100.0	

3. Management attributes

Leadership

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	1	2.0	2.0	2.0
	1	1	2.0	2.0	3.9
	2	2	3.9	3.9	7.8
	3	17	33.3	33.3	41.2
	4	22	43.1	43.1	84.3
	5	8	15.7	15.7	100.0
	Total	51	100.0	100.0	

Strategic Thinking and planning

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	1	2.0	2.0	2.0
	3	17	33.3	33.3	35.3
	4	25	49.0	49.0	84.3
	5	8	15.7	15.7	100.0
	Total	51	100.0	100.0	

Accountability

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0	1	2.0	2.0	2.0
	1	3	5.9	5.9	7.8
	3	16	31.4	31.4	39.2
	4	25	49.0	49.0	88.2
	5	6	11.8	11.8	100.0
	Total	51	100.0	100.0	

Management tools

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	4	7.8	7.8	7.8
	3	11	21.6	21.6	29.4
	4	30	58.8	58.8	88.2
	5	6	11.8	11.8	100.0
	Total	51	100.0	100.0	

4. Infrastructure

Human Resources

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	3	5.9	5.9	5.9
	3	3	5.9	5.9	11.8
	4	32	62.7	62.7	74.5
	5	13	25.5	25.5	100.0
	Total	51	100.0	100.0	

Equipment

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	1	2.0	2.0	2.0
	2	3	5.9	5.9	7.8
	3	7	13.7	13.7	21.6
	4	23	45.1	45.1	66.7
	5	17	33.3	33.3	100.0
	Total	51	100.0	100.0	

Pharmaceuticals

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	2	3	5.9	5.9	5.9
	3	9	17.6	17.6	23.5
	4	22	43.1	43.1	66.7
	5	17	33.3	33.3	100.0
	Total	51	100.0	100.0	

Facilities

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	1	2.0	2.0	2.0
	2	9	17.6	17.6	19.6
	3	9	17.6	17.6	37.3
	4	16	31.4	31.4	68.6
	5	16	31.4	31.4	100.0
	Total	51	100.0	100.0	

Ratings

0= Non-existence, 1= Very little done, 2= A little bit, 3= Not much, 4=much, 5=Very much

- Foster Strong Leadership
- Provide a Clear Corporate Vision and Strategy for Achieving it
- Never Stop Learning, Innovating, or Changing
- Focus on the People – Clients and Staff
- Motivate Staff;
- Empower them with Skills, Autonomy and Accountability: and
- Evaluate their Performance

Annex 2
Key performance Indicators

Public Sector Strengthening	*Management incentives*
Development of democratic inst.	*Management tools*
Emphasis on country ownership	*Infrastructure*
Institutional Environment	HR
Legal framework:	Equipment
Regulatory instruments	Pharmaceuticals
Administrative procedures	Facilities
Customs and practices	
Organizational structures	
Organizational forms/ownership	
Decision rights	
Linkages: vertical and horizontal	
Management attributes	
Management skills	
Leadership	
visions and values	
Strategic Thinking and planning	
Managerial culture	
Management of value chain	
Change management	
Focus on client needs	
Autonomy and decision making	
Accountability	
Performance appraisal	

Annex 3

Projects

Country	Year	Project Title	Project ID	Document(s) Reviewed
Tanzania	1990	Health and Nutrition Project	P002774	PAD
Ghana	1991	Health and Population Project II	P000897	SAR
Madagascar	1991	MG- National Health Sector SII (F91)	P001520	PAD
Mali	1991	Health/Population/RU	P001727	PAD,ICR
Malawi	1991	PHN Sector Credit	P001646	PAD,ICR,
Rwanda	1991	Supplemental Credit for Health and Population Project	P002237	PAD, ICR
Togo	1991	Health and Population Sector Adjustment Program	P002864	SAR
Zimbabwe	1991	Second Family Health Project	P003302	SAR, ICR
Equatorial Guinea	1992	Health Improvement Project	P000649	PAD/SAR,ICR
Kenya	1992	Health Rehabilitation Project	P001339	PAD,ICR,
Mauritania	1992	Population and Health Project	P001855	PAD
Niger	1992	Health Nutrition and Population Project	P001976	PAD/SAR.ICR
Sao Tome and Principe	1992	Health And education Project	P002542	PAD/SAR.ICR
Angola	1993	Health Project	P000048	PAD,ICR
Burkina Faso	1994	Health and Nutrition Project	P003559	PAD/SAR,ICR
Burkina Faso	1994	Health and Nutrition Project	P000287	PAD,ICR
Burkina Faso	1994	Population and Aids Control Project	P000308	PAD,ICR
Guinea	1994	Health/Nutrition sector Project	P001070	PAD,ICR
Comoros	1994	Population and Human Resource Project	P000596	SAR,ICR
Chad	1994	Health and Safe Motherhood Project	P000509	SAR,ICR
Uganda	1994	Sexually Transmitted Infection Project	P002963	PAD,ICR

Country	Date	Project Title	Project ID	Document Reviewed
Burundi	1995	Health and Population II	P000216	PAD,SAR
Benin	1995	Health and Population Project	P000118	PAD,ICR
Cameroon	1995	Health, Fertility and Nutrition	P000411	PAD,ICR
Kenya	1995	Sexually Transmitted Infection Project	P001333	PAD,ICR
Chad	1995	Population and Aids Control Project	P035601	PAD,ICR
Uganda	1995	District Health Project	P002971	PAD,ICR
Mozambique	1996	MZ- Health Sector Recovery SIL	P001792	PAD,ICR

Country	Date	Project Title	Project ID	Type of Document
Sierra Leone	1996	Integrated Health Sector Investment Project	P002422	PAD,ICR
Botswana	1996	First Family Health Project	P000145	PAD,ICR
Niger	1997	Confronting HIV/AIDS Epidemics in East Asia and the Pacific (EAP)	P001999	PAD,ICR
Senegal	1997	Endemic Disease Project	P04167	PAD,ICR
Eritrea	1998	Health Project	P043124	PAR,SAR
Ghana	1998	Ghana Health sector Support Project	P000949	PAD,ICR
Gambia, The	1998	GM-Participatory HNP SIL	P000825	PAD,SAR
Guinea Bissau	1998	National Health Development Program	P035688	PAD,SAR
Comoros	1998	Health Project	P052887	PAD,ICR
Madagascar	1998	Second Community Nutrition Project Review	P001568	PAD,ICR
Mauritania	1998	Health Sector Investment Project	P035689	PÄD
Senegal	1998	Integrated Health Sector Development Project	P002369	PAD,SAR
Uganda	1998	Child Nutrition Project SIL	P040551	PAD
Ethiopia	1999	Health Sector Development Project	P000756	PAD,SAR
Guinea	1999	Population and Reproduction Health Project	P041568	PAD,ICR
Mali	1999	Health Sector development Program	P040652	PAD,SAR
Malawi	1999	Population and Family Planning Project	P036038	PAD,ICR

Country	**Year**	**Project Title**	**Project ID**	**Document Reviewed**
Lesotho	2000	Health Sector Reform Project	P053200	PAD
Madagascar	2000	Second Health Sector Support Project	P051741	PAD
Chad	2000	Health Sector Support	P055122	SAR
Cameroon	2000	Multi Sectoral HIV/AIDS Project	P073065	PAD
Ethiopia	2000	Multi-Sectoral HIV/AIDS	P069886	PAD
Ghana	2000	AIDS Response Project	P071617	PAD
Gambia, The	2000	HIV/AIDS Rapid Response Project	P060329	PAD
Kenya	2000	Decentralization, Reproductive Health and HIV/AID	P066486	PAD
Uganda	2001	HIV/AIDS Control Project	P072482	SAR
Burkina Faso	2001	HIV/AIDS Disaster Response Project	P071433	SAR, ICR
Burundi	2002	BI-Multi-Sectorial and Orphan APL Project	P071371	PAD
Benin	2002	BI-HIV/AIDS Multi-sector APL	P073118	PAD
Central African	2002	CAR: HIV/AIDS	P073525	PAD

Country	Year	Project Title	Project ID	Document Reviewed
Republic				
Cape Verde	2002	CV: HIV/AIDS APL	P074249	PAD
Madagascar	2002	MG: Multi Sectoral HIV/AIDS Prevent Project	P072987	PAD
Nigeria	2002	Second Health Systems Development Project	P070290	PAD
Nigeria	2002	HIV/AIDS Program Development	P070291	PAD
Sierra Leone	2002	Sierra Leone HIV/AIDS Response Project	P073883	PAD
Senegal	2002	Nutrition Enhancement Program	P070541	SAR

Country	Year	Project Title	Project ID	Document(s) Reviewed
Senegal	2002	HIV/AIDS Prevention and Control Project	P074059	PAD,
Burundi	2003	Second Health and Population Project	P078111	PAD
Ghana	2003	Health Sector program Support II	P073649	PAD
Mozambique	2003	HIV/AIDS Response Project	P078053	PAD
Niger	2003	Multi-sector STI/HIV/AIDS Project	P071612	PAD

Country	Year	Project Title	Project ID	Document(s) Reviewed
Comoros	1993	Population and human Resource project	P000596	PAD,ICR,
Kenya	1990	Fourth Population Project	P001312	PAD/SAR, ICR
Tanzania	1990	Health and Nutrition Project	P002774	PAD/SAR,ICR
Ghana	1990	Second Health and Population Project	P000897	PAD/SAR,ICR
Madagascar	2004	Health Sector Improvement Project	P001520	SAR, ICR
Angola	2005	AO-HAMSET SIL	P083180	PAD
Guinea Bissau	2005	Suppl. for National Health Development Program	P088282	PAD
Lesotho	2005	LS- HIV/AIDS Capacity Building TAL	P087843	PAD
Malawi	2005	Health Sector Support SIM	P083401	PAD
Nigeria	2005	HIV/AIDS Program Development Project	P070291	PAD

Annex 4: List of countries

1 Benin
2 Botswana
3 Burkina Faso
4 Burundi
5 Cameroon
6 Chad
7 Comoros
8 Equatorial Guinea
9 Eritrea
10 Ethiopia
11 Gambia, The
12 Ghana
13 Guinea-Bissau
14 Guinea
15 Kenya
16 Lesotho
17 Madagascar
18 Malawi
20 Mauritania
21 Mozambique
22 Niger
23 Nigeria
24 Rwanda
25 Sao Tome and Principe
26 Senegal
27 Sierra Leone
28 Tanzania
29 Togo
30 Uganda
31 Zimbabwe

Annex 5: Score Sheet
Explanation of abbreviations used in the table below

1. **Countries:**

NI= Niger, ML= Malawi, ET= Ethiopia, MZ- Mozambique, RW= Rwanda, NG= Nigeria, MD= Madagascar, BU= Burundi, SL= Sierra Leone, BF= Burkina Faso, GH= Ghana, TA= Tanzania, CH= Chad, GM= Gambia, GU= Guinea, KE=Kenya, GB= Guinea Bissau, CO= Comoros, TO=Togo, BT= Botswana, MT= Mauritania, ST= Sao Tome and Principe, UG= Uganda, ZM= Zimbabwe, SN= Senegal, MI= Mali, LS= Lesotho, ER=Eritrea EG= Equatorial Guinea

2. **Titles:**

EY= Effective year, CT=Country, SW=Swap, TP= Topic, ICR= Implementation Completion Report, PSS= Public Sector Strengthening, DDI= Development of Democratic Institutions, ECO= Emphasis on Country Ownership, LF= Legal framework, RI= Regulatory instruments, AP= Administrative Procedure, CP= Customs and Practices, OR= Organizational Reforms, DR= Decision Right, LK= Linkages(vertical and horizontal), LD= Leadership, VV= Vision and Value, ST= Strategic Thinking and Planning, MC= Managerial Culture, MVC= Management of Value Chain, CM= Change Management, FCN= Focus on Client Needs, AUD= Autonomy and Decision Making, AC= Accountability, PA= Performance Appraisal, MI= Management Incentives, MT= Management Tools, HR= Human Resources, EQ= Equipment, PH= Pharmaceuticals, FT= Facilities, N=No, Y= Yes, H= Health, Nutrition and Population projects, HIV= HIV/AIDS, STD projects.

ID	EY	CT	SW	TP	ICR	PSS	DDI	ECO	LF	RI	AP	CP	OR	DR	LK	LD	VV	ST	MC	MVC	CM	FCN	AUD	AC	PA	MI	MT	HR	EQ	PH	FT
1	1990	TA	N	HN	Y	3	0	2	0	0	2	2	2	1	2	2	0	4	1	3	0	2	1	0	4	2	4	5	3	5	5
2	2000	TA	Y	H	Y	3	2	2	4	3	2	0	4	4	3	4	2	3	2	3	2	4	4	4	2	1	3	5	1	5	2
3	2003	TA	Y	H	Y	4	2	5	5	5	4	4	4	2	4	3	3	5	2	2	2	4	3	3	4	2	4	2	2	4	4
4	2003	TA	Y	HIV	N	4	0	2	4	2	3	4	3	1	3	3	3	3	2	2	0	3	4	3	4	2	2	2	2	3	2
5	1991	GH	N	HP	N	3	0	1	1	1	3	3	2	2	3	0	0	4	1	3	1	3	1	1	2	2	3	4	5	4	5
6	1997	GH	Y	H	Y	5	1	5	5	4	3	2	2	1	2	1	1	4	2	4	2	3	1	4	4	2	4	4	3	3	2
7	2000	GH	N	HIV	N	4	3	4	1	1	1	3	3	3	4	3	3	3	1	2	4	4	3	1	4	1	3	5	4	4	1
8	2003	GH	Y	H	Y	4	3	4	3	4	4	4	4	4	4	2	3	4	2	1	2	4	4	4	4	2	4	4	2	2	2
9	1994	BF	N	H	Y	4	5	5	5	5	4	5	5	5	5	5	5	4	5	5	5	5	5	5	4	5	4	5	5	4	5
10	1994	BF	N	H	Y	5	4	5	4	4	3	3	5	4	4	5	4	4	4	5	3	5	4	5	5	3	4	4	5	5	5
11	2001	BF	N	HIV	N	4	3	3	4	3	4	4	4	3	4	4	2	3	4	4	3	4	4	3	4	3	4	4	3	4	2
12	1996	SL	Y	H	Y	4	4	4	5	5	5	3	4	5	4	5	4	5	4	5	5	4	5	5	5	4	4	5	5	5	4
13	2003	SL	N	H	N	4	4	3	4	4	4	3	3	4	3	4	3	4	4	4	4	3	4	4	3	4	4	4	4	4	4
14	2002	BU	N	HIV	N	4	0	4	1	1	1	3	3	3	4	3	3	3	4	4	3	4	4	3	4	3	4	4	4	3	3
15	1998	MD	N	N		3	2	4	2	2	2	2	3	3	4	3	3	3	4	3	2	4	4	3	4	4	3	4	4	3	2
16	1991	MD	N	H	Y	4	3	3	4	4	3	4	4	4	4	9	3	4	3	5	3	5	4	4	4	3	5	4	5	4	5
17	2001	NG	N	HIV	N	4	0	4	4	2	3	4	3	1	3	3	3	4	2	4	3	4	3	3	4	2	2	4	3	4	2
18	2002	NG	N	H	N	3	1	2	4	4	3	2	3	2	3	3	2	3	3	4	3	4	3	4	4	2	4	4	4	3	4
19	1991	RW	N	HP	Y	4	2	3	4	3	3	2	4	3	3	4	3	4	5	3	2	4	5	5	4	2	3	4	5	4	5
20	2003	RW	N	HIV	N	4	3	4	1	1	2	2	3	3	4	3	2	3	1	4	3	4	4	3	4	2	3	4	4	4	4
21	1996	MZ	N	H	N	4	3	3	4	4	3	2	4	4	4	3	3	4	4	3	3	4	4	4	3	3	4	4	4	4	3
22	2003	MZ	N	HIV	N	4	2	3	3	3	4	2	3	3	3	4	3	3	3	4	3	4	3	4	4	3	4	4	4	4	3
23	1998	ET	N	H	N	3	1	2	3	3	3	4	3	4	4	4	2	4	3	4	3	4	3	4	3	4	3	4	4	4	4
24	2003	ML	N	HIV	N	4	3	4	2	2	3	4	3	1	4	3	3	3	2	2	1	4	1	3	4	3	3	4	4	3	2
25	2004	ML	Y	H	N	3	1	4	4	4	4	2	4	4	4	4	3	4	4	3	1	4	4	4	4	3	4	4	4	4	4
26	1991	ML	N	HP	N	4	2	4	3	3	3	1	3	4	3	4	2	3	3	3	2	4	3	4	3	4	4	4	4	4	4
27	1997	NI	N	H	Y	4	2	3	4	3	3	0	3	4	3	3	2	4	4	4	2	4	4	4	3	3	3	4	3	2	4
28	2003	NI	N	HIV	N	4	3	4	1	3	2	2	3	3	4	3	2	3	3	4	2	4	4	4	4	3	3	4	4	3	3
29	2001	UG	N	HIV	N	4	2	3	1	2	3	2	2	4	4	4	3	4	2	4	3	4	3	3	4	4	4	4	3	3	3
30	1995	UG	N	H	Y	4	4	5	5	5	5	3	5	5	5	5	4	5	4	4	3	5	5	4	5	4	4	5	5	5	5
31	1994	UG	N	HIV	N	4	3	4	3	3	3	2	4	3	3	4	3	3	4	4	3	4	4	4	4	3	4	4	4	4	3
32	1991	MI	N	H	Y	4	4	5	3	4	4	2	5	5	5	5	4	5	5	5	4	5	5	4	4	4	4	3	4	5	4
33	1995	BE	N	HP	Y	4	4	4	4	4	4	4	5	5	5	6	4	5	4	5	4	5	5	4	5	5	5	5	6	5	5
34	1992	EG	N	H	Y	3	2	3	3	3	3	2	3	3	3	3	2	2	3	4	2	4	3	3	3	3	3	4	5	5	5
35	1992	MT	N	H	Y	5	4	5	4	4	4	2	5	5	5	4	3	5	4	5	4	5	5	5	4	5	5	5	5	5	5
36	1997	SN	N	H	Y	3	2	2	4	4	3	2	3	3	2	4	2	3	3	3	2	4	4	3	0	3	4	5	5	4	4
37	2002	SN	N	HIV	N	4	1	4	4	3	4	1	4	4	4		4	3	4	4	3	3	4	4	4	4	3	4	4	4	4	3
38	2000	LS	N	H	N	4	3	4	3	3	4	1	4	4	4	4	3	4	4	4	2	4	4	4	4	3	4	4	4	4	3
39	1992	KE	N	H	Y	3	2	2	2	3	3	0	4	4	3	4	3	4	3	3	2	3	2	4	3	4	5	5	5	5	5
40	1990	ST	N	H	Y	3	2	3	3	3	3	0	4	3	4	3	3	3	3	4	3	4	4	4	3	3	4	4	5	5	4
41	2001	GM	N	HIV	N	4	3	4	2	2	3	1	4	2	4	4	3	4	2	4	3	4	4	3	4	3	4	4	4	4	3
42	1994	CO	N	HP	Y	4	2	4	5	5	4	0	5	5	5	5	4	5	4	4	3	4	5	4	4	5	4	5	5	5	5
43	2004	GB	N	H	N	3	2	3	3	3	3	1	4	4	4	4	3	4	3	4	2	4	3	3	4	4	4	4	4	3	4
44	2000	CH	N	H	N	4	4	4	4	4	4	1	4	4	4	4	3	4	4	4	2	4	4	4	4	4	4	4	4	4	4
45	1994	CH	N	H	Y	4	4	4	5	5	5	2	5	5	5	5	4	5	5	5	4	5	5	5	5	5	5	5	5	5	5
46	1992	ZB	N	H	Y	3	2	2	4	3	3	1	4	3	3	3	2	3	3	3	2	4	3	3	3	1	2	3	4	4	4
47	1994	GU	N	H	Y	4	2	3	5	4	4	1	5	5	5	5	4	4	5	5	3	5	5	4	4	4	5	5	5	5	5
48	1995	CA	N	H	Y	3	2	3	3	3	3	1	4	3	3	4	3	4	4	4	3	4	4	3	4	3	4	4	4	5	5
49	1992	TO	N	H	Y	4	3	3	4	4	3	0	4	3	4	4	3	4	3	5	3	4	4	3	3	3	4	3	4	5	4
50	1993	BT	N	H	Y	4	4	3	4	5	4	5	4	5	5	3	3	4	3	3	4	3	5	5	4	4	5	3	4	5	4
51	1998	ER	N	H	N	3	3	4	3	4	2	3	4	4	3	3	4	3	4	3	4	3	4	4	2	3	4	3	3	3	3

ANNEX IV
CAPACITY DEVELOPMENT IN TANZANIA

BACKGROUND

The United Republic of Tanzania is located in Eastern Africa on the Indian Ocean with an estimated population of 36 million residing in 26 regions. In 1964, and after the independence of Zanzibar from the UK, Tanganyika and Zanzibar united to form Tanzania. The Republic is among the poorest in the world and its economy depends heavily on agriculture forming close to 43% of the GDP which averages around $220 per capita. The health situation is drastic as it is characterized with high infant mortality rate, over 100 per 1000 live births and a life expectancy of around 45 years at birth. The Arusha Declaration of 1967 mandated the state to provide, free of charge, all social services. Given that Tanzania was a socialist state, it nationalized mission facilities and outlawed private practice. However, by the end of the eighties, the health situation was getting worse with poor quality services and shortages in human resources and supplies. This was amidst global changes in political economy with the downfall of socialism and the call for global economic reforms. Consequently, socialist regimes started exploring self-sufficiency strategies with an outward look towards public-private partnerships. With commitment to universal coverage, the Tanzanian government focused on improving primary care by expanding the number of health facilities and increasing the involvement of the private sector.

Since the early sixties, the Bank has committed close to 5 billion US dollars in credits and grants to support the Tanzanian government in its development plan. Of which, $1.7 billion were committed in 2004 to 25 projects mainly in the Education, Energy, Transport, and Health Sectors. The Health sector received close to $140 million in credit and xxx in grants to support projects with the main objective of improving the financing, quality, access, and utilization of health services in an effort to maximize the impacts on health outcomes especially among the poor, women and children. Most of these projects had on its agenda strengthening the human resources capacity as well as developing the institutional and organizational capacities to improve the quality and the delivery of health services.

The purpose of this case study is to examine the role of the Bank in the capacity development efforts as part of the health sector reform aid to Tanzania. The study's analytical framework will examine the three different but inter-related levels in terms of capacity development; institutional, organizational and managerial (Table 1). The case study will attempt at exploring the extent to which Tanzania, given the Bank grants and credits, was able to develop the capacities in each of the three levels and their subsequent impact on strengthening the public sector and the promotion of democracy and ownership.

Table 1. Framework for analyzing capacity building

Institutional Environment	Legal framework Regulatory instruments Administrative procedures Customs and practices
Organizational structures	Organizational forms (configuration, ownership) Incentive regime (extent of decision rights, market exposure, financial responsibility, accountability, etc.) Linkages (extent of horizontal and vertical integration or fragmentation)
Management attributes	Management skills (leadership, planning, change, focus on client needs, decision making, accountability, performance appraisal, etc.) Management incentives Management tools (financial, health information, behavior) Infrastructure (HR, equipment, supplies, facilities)

SITUATIONAL ANALYSIS

In the early nineties, the government with the assistance from the Bank headed a health sector reform initiative to ensure that efficient and effective health services are provided to the community at large. The initiative was detailed into strategies that covered various sub-sectors in health involving various units and organizations within the ministry and its peripheral affiliates. The reform was perceived as ambitious and cumbersome given the constraints in human and financial resources needed to implement the reform. The reform addressed these deficiencies by instituting financing mechanisms and giving priorities to capacity development at the institutional level as well as the technical level in terms of the management of the health facilities and the delivery of quality services to help launch and sustain the reform. The project faced some setbacks in the early phases due to poor supervision and lack of administrative capacity. This was not an easy task, as little was done on the legal framework. Although the national health policy was drafted in 1990, it was not finalized until 2002. Furthermore, despite recruiting some consultants to help in structuring the administrative system, procedures remained bureaucratic to the extent it hampered major reform efforts in restructuring the health system including procurement, and maintenance of capital stock. Nevertheless, following some administrative restructuring in the Ministry and the Bank's task team leadership, a restructuring in the project put the reform back on track. This was tremendously assisted by the political and macro-economic stability in the country which provided the appropriate environment to gradual progress in the reform pace. The country assistance was reshaped using sector wide approach strategy which then helped in developing some capacity for managerial functioning at the institutional and organizational structures.

To keep with its vision of universal coverage, the government continued advocating primary care as a cost effective approach making sure that resource mobilization and allocation was set in place. In essence, the Bank focused in its support of the reform on strengthening the budgetary framework and examining appropriate financing options including community health funds, national health insurance funds (Box 1) and user fees. While the financing mechanisms were envisaged as alternative approaches to sustain the reform, the budgetary framework was seen as a mean of ensuring appropriate budget allocation as well as increasing transparency and accountability. Within that, the plan was set to decentralize management of health services to local authorities- starting with 37 districts and the establishment of District Health Boards-, to provide block grants against District Health Plans, and to build capacity of district management and health workers. The reform calls on the district councils to mobilize resources at the district level and as their income has proportionally increased the proportion of government subsidies will be incrementally diminished. While the onset of the Bank supported projects

were to assist in human resources capacity building, it was noticed that in the past five years there was more focus in the funded project on facility development and procurement of supplies, more specifically pharmaceuticals. Little attention was given to management incentives and unlike in the early stages of the support, little attention was given to workforce training. On their end, districts have been gradually taking charge of identifying capacity needs but their major challenge is financing the capacity building initiatives and the training of human resources. In that, the districts are looking for support by the government and the donor agencies to assist in such initiatives.

The ultimate goal of this reform was to have the government shift its role from being the financier and the provider of care to becoming a regulator, policy maker, and a facilitator allocating resources based on standardized performance and outcome measures. In that spirit, the districts are pushing forward to becoming fully autonomized organizations with decision rights and appropriate systems of transparency and accountability to the government as well as the users. There are lots of challenges as they progress gradually on their way to achieving that status.

The policy changes and the implementations so far have made their impact on the health of the nation. This can be substantiated by the increase in the satisfaction of the population with the quality of health services. Despite the fact that immunization coverage and utilization rates have been on the rise, infant mortality rate has yet to drop. However, it has not increased which has a significant value in a country plagued by an HIV/AIDS epidemic and procurement problems in malaria treatment. Controlling for these circumstances, one would have seen an improvement in life expectancy at birth and child mortality rates.

LESSONS LEARNED

The Tanzanian experience and the Bank involvement in the reforming of the health sector has been a success story in capacity building. A careful examination of the political history of the country and its socialist regime to the current debates on the multiplicity of health financing schemes is indicative of the development in the capacity of the leadership in all sectors but particularly in health and the developing capacity of its stakeholders.

The Sector Wide Approach and the MTEF were instrumental in the capacity development at all levels of management. Pulling resources into SWAps have been a good learning experience to Tanzania. At the institutional level, a Sector-Wide Approach Committee, chaired by the permanent secretary of the Ministry coordinates all the donor-assisted activities. In addition, a Basket Financing Committee (BFC) was established which is scheduled to meet quarterly to review the implementation progress and expenditures, monitor achievements against performance indicators, review and approve plans and budgets, and approve release of funds for the next quarter. The committee consists of senior officials from MOF, MOH, and local governments, as well as one representative from each donor contributing to the pool of funds. One of the key elements in the reform is the disbursement of funds to district councils empowering them to manage the district health services. This led to the devolution of decision rights to the councils to mobilize, manage and account for health resources and implement health activities in line with their plans and budget allocations based on local needs and capacities. The Council has to submit quarterly reports, budget plans and financial statements to the Regional Secretariat as periodically indicated by the BFC. This budgetary framework and managerial functions required appropriate managerial capacity at the institution level and all the way to the individual capacity. Members of the BFC as well as their Council counterparts had or acquired managerial skills in planning and decision making, accountability and performance appraisal, and resource mobilization and allocation. This has to be credited to a greater extent to the SWAps and MTEFs and their advocacy for legal and budgetary frameworks.

Furthermore, the reform brought about debates on the appropriate national health financing policy. With the introduction of financing schemes, local and international organizations, governmental and nongovernmental, had to work together to develop the capacity of the communities to manage these schemes to facilitate the provision of health services. Not only districts and facility managers benefited from this capacity development but also the communities which were involved in budgeting, planning and managing health funds. Furthermore, the policy change has resulted in the emergence of local relevant networks and associations such as the Tanzania Network of Community Health Funds (TNCHF) and the Association of Private Hospitals in Tanzania (APHTA). These networks are still in their infancy developing capacities of their members, though with light funding and no needs assessment. Furthermore, universities in partnerships with local health facilities took part in this capacity development by seeking community participation in the evaluation of the health funds and their impact on health outcomes. The results of such debates and research projects were disseminated through publications and conferences. One such exercise took place in May 3-6, 2005 where two back to back conferences were held on healthcare financing and health insurance schemes in Tanzania in an effort to explore options which would financially sustain equitable access to essential health care. The conference was attended by 180 participants representing officials from the MoH, providers, and health financing schemes in Tanzania as well as regional and international experts. This activity was valuable in bringing together national, regional and international experiences in health financing as it opened a policy debate on the various alternatives in financing healthcare which was experienced in Tanzania, Kenya, Ghana and Uganda as well in other parts of the world. The discussion also debated the evidence in evaluating the success or failure of the schemes which covered the research methodology and applications used in assessing the impact on the health outcomes. The advantage of such events go beyond the immediate knowledge sharing and the responsiveness to clients needs for consultancy on future action plan as they also provide a medium for the various stakeholders to share in the decision making and the ownership of national policy changes.

These successes were facilitated by the political stability in the republic and the commitment to the reform agenda, at the presidential and parliamentary levels. This support was translated by instituting a Planning and Policy Unit which is viewed as far more organized than its regional counterparts. Furthermore, Permanent Secretaries have a long tenure (5-6 years) which helps in following through on strategies and plans which again has not been observed in other African health ministries.

THE CHALLENGES FOR THE FUTURE

There are several aspects that need to be addressed by the GoT, the Bank and other partners in successfully carrying forward the reform to achieve its goals and objectives. One major challenge, that was and remained, is the shortage of human resources as a key capacity for the reform. In recent reports, the supply in the health workforce was decreasing from 67,000 in the mid 90's to less than 50,000 in 2002, despite an annual population growth of 3%. This has a substantial impact on the management of and the delivery of health services. With scarcity of resources, the services are trusted to the few who are available, who even if qualified can not be expected to cover all bases and respond to the national needs with efficiency and effectiveness. Similarly, the reform calls for major administrative changes in the management of the services, the health funds and the health system. Most of the managers at the central and district levels probably were not trained on such functions under decentralization.

Capacity building initiatives over the past decade have been crucial in training managerial capacity through short term courses, local or international, and graduate studies. It is perceived that regional or international courses such as the Flagship courses are greatly appreciated and valued for

sharing their regional and international experiences and in building networks for future collaboration. However, local courses attended or coordinated with regional and international experts were also deemed important. These provide a better opportunity to bring in a wider audience including all stakeholders, and not only officials, to discuss and debate national experiences and outlook for viable options in reforming the health sector. Furthermore, the advantage of short term courses, as opposed to graduate work, is that it provides on the job needed skills, though in increments while to a certain extent it ensures little brain drain. As for graduate studies, the advantage is that it provides better capacity development as the candidate has to focus on advancing their knowledge and skills rather than being distracted by work tasks and responsibilities during training. On the other hand, though limited but it had opened the door for some trainees to join either the private sector in the quest for better work environment and financial returns, or explore the option of migration.

The challenge for the future is the new generation of human resources for health. The historical context of the country built a national loyalty that has led a lot of the trainees in the past to come back and join the Ministry and the health system. It is believed that neither salary nor working condition were the incentives that kept technically-trained Tanzanians but rather the challenge in developing and sustaining the Tanzanian health sector. However, there is a fear that this might not be the case for the next generation which has been more exposed to more developed societies, via much available information media, satellite and internet, and are looking for better living and work opportunities than their predecessors.

Moreover, there is an insufficient and unbalanced mix of human resources coupled with inadequate human resources management and coordination at the civil service level. This is characterized by de-motivation of staff due to unclear personnel management systems, absence of systematic incentive structures, and poor working environment. Furthermore, there seems to be an absence of rational deployment of existing staff. The MOH and the Local Governments have not succeeded to establish workable system that would ensure filling vacant health posts at health facilities. This left the same few to attend conferences and training modules triggered by many reasons including a sizeable per diem which to some might reach one-third their monthly salary. Aside from that, the mere fact that the few are in conferences should draw flags of impact on productivity and hence the value of these courses in the institutional capacity building and functioning.

Another challenge that has to be addressed is the language of training. While it might not be perceived as a serious issue, communication in English is not usually a strong element in the training of locals. In fact, the first encounter of English in their schooling does not start until the secondary level of education. Further, the proportion of high school graduates going to college is very low. For that, careful attention has to be given to the attendees especially when international experts are used in the training. The speed of speech and the use of colloquial terms and scientific jargon have to be carefully watched to ensure comprehensibility. Perhaps, this adds a value to local training using local language to improve the value of the training and the sense of ownership.

CONCLUSION

Capacity development has been on the agenda of the reform since its inception in the early nineties. System and human resources capacity development are two main themes in the sector strategy. However, a major constraint to the implementation of this strategy is the shortage of human resources and the recruitment lag in filling vacant posts. These could be resolved at the national level by reforming the civil service especially in instituting appropriate incentive mechanisms and capacity development initiatives targeted at improving the infrastructure as well as the managerial capacities of mid-level managers and supervisors. To help facilitate this, there are concerted efforts on capacity

building at the national level in the form of networks and associations. In addition, at the regional level there is an East and Southern Africa National Health Accounts Network as well as an active regional network of nurses and midwives. Future capacity development funds have to take these local and regional capacities into consideration as they might address better local needs and provide ownership to such efforts.

Box 1. The Capacity of the National Health Insurance in Tanzania

In 1999, the Government of Tanzania supported by a World Bank grant instituted a compulsory National Health Insurance Fund (NHIF) to cover all civil servants (Act of Parliament No 8, 1999). However, the Act did not take effect until July 2001 as government employees started paying their dues with employer contributions to the NHIF. The main aim of the Fund is to sustain equitable access to quality health services to all employees in the public sector. The Fund is outsourced by the MOH to be operated by a semi-independent board and management team. However, the Fund faced major difficulties during the first year of its inception due to deficiencies in the administrative procedures, lack of managerial skills and mostly due to low awareness among its stakeholders who at first hesitated to enroll. This did not discourage the management of the NHIF which went forward to plan advocacy campaigns to raise awareness and understanding of the scheme in the hope of increasing enrollment.

On a different front, the management had to engage in developing its infrastructure and managerial functioning. The action plan targeted improvement in registering and book keeping information about its clientele. For that, special identity cards were issued to all members. To help facilitate the provision of quality services, the Fund expanded the number of its offices to the zonal areas to help in improving claims payments, increase customer awareness, accelerate the process of accrediting health facilities, and be closer to the front line to be able to monitor and evaluate services and respond better to customer needs. Yet in the eyes of its Director General, the Fund still needs further capacity development in managerial functioning especially in such areas as decision making, accountability, performance appraisal, and managerial culture. In his opinion, there is too much focus on inputs with little attention to outcomes, despite the fact they have been responsive to stakeholder demands, which is apparent in their strategy to improve services and increase coverage. The management feels comfortable with the level of trust and empowerment given to them in terms of decision rights and autonomy, however, there is little capacity among current operational managers to assume leadership and they are missing managerial skills which would help them better in adapting to new circumstances. Notwithstanding that, the Director has a positive outlook at the expansion and success of the Fund. He is hopeful that institutional changes are proceeding at an acceptable pace with the Ministry's support without overlooking the financial and human resources constraints in the health industry. Further, he firmly believes that the operational managers and staff in the Fund are amenable to improvement as they are willing to learn with appropriate capacity development.

The NHIF is prospering and is often used as a model to its neighboring health systems in financing health and in managing social insurance schemes. To date, close to 170,000 members have been enrolled accounting for more than 500,000 beneficiaries. The NHIF legislation empowered the Board of Directors to review the benefit offered for the purpose of improvement or enhancement of its package. The NHIF benefits package includes out patient services, all drugs prescribed to beneficiaries attending accredited facilities, and in-patient services which includes accommodation, medication, examinations, investigations and all types of surgery which ranges from minor to specialized operations.

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