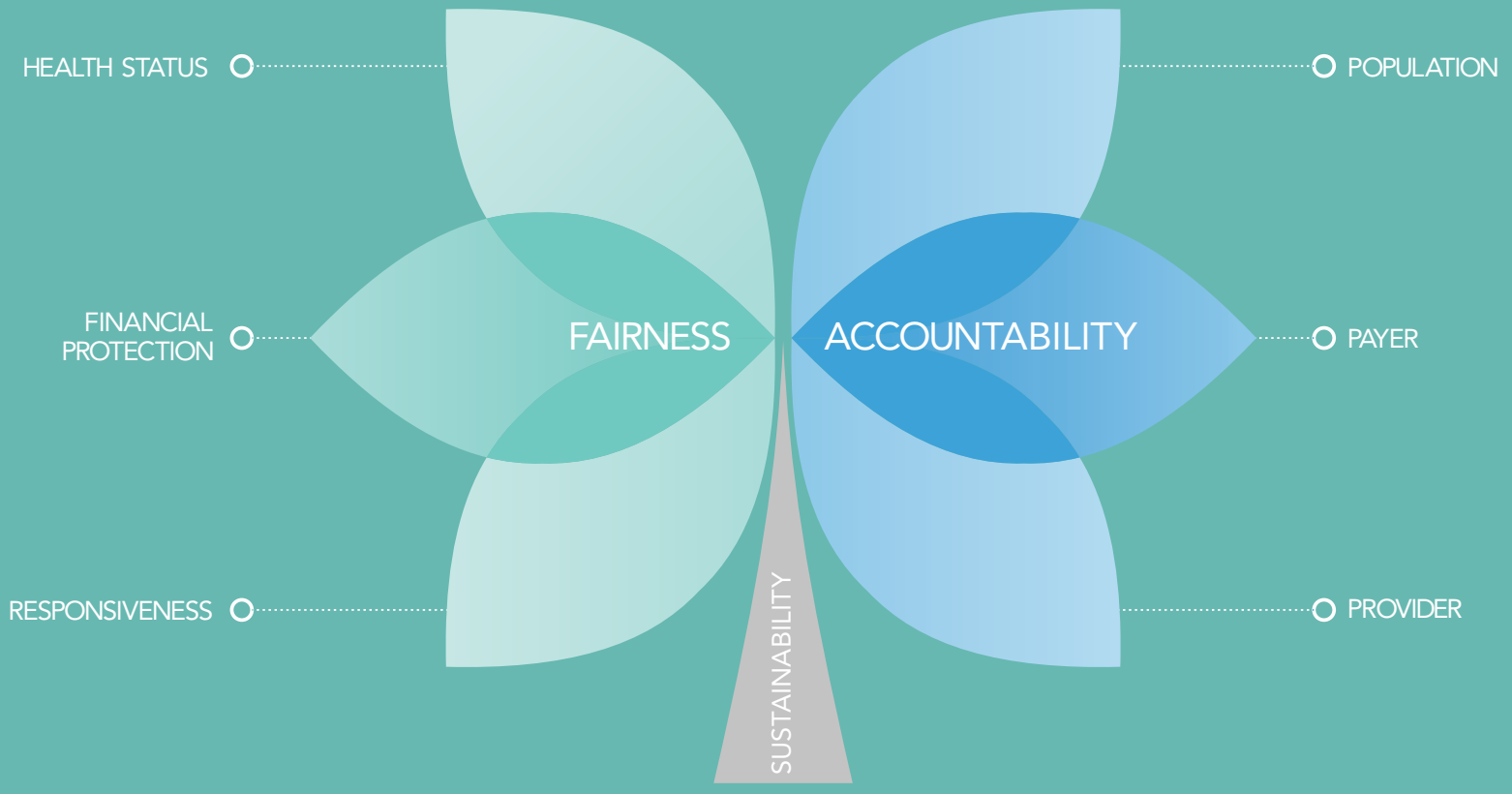
Fairness and Accountability: Engaging in Health Systems in the Middle East and North Africa

The World Bank Health Nutrition and Population Sector Strategy for MENA (2013-2018)



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Fairness and Accountability: Engaging in Health Systems in the Middle East and North Africa

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Equité et Redevabilité: S'engager en Faveur des Systèmes de Santé au Moyen-Orient et en Afrique du Nord (MENA)

La Banque mondiale Stratégie en Matière de Santé, Nutrition et Population dans la Région Moyen-Orient et Afrique du Nord (2013-2018)

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Foreword

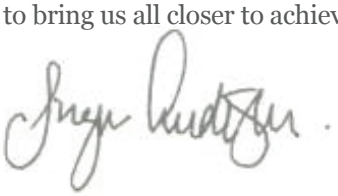
A month ago at our Annual Spring Meetings, we, the World Bank Group (WBG), committed ourselves to the two intertwined goals of ending extreme poverty by 2030 and boosting shared prosperity in each of our client countries. While strong and sustainable economic growth is necessary to reach these goals, it is not sufficient; the fruits of growth need to be shared across the whole society in a fair and inclusive manner. Indeed, Egypt and Tunisia, two countries where the uprisings in the Middle East and North Africa (MENA) began, were actually experiencing solid economic growth prior to their respective revolutions, yet without tangible improvements in many peoples' lives. This resulted in the widening of political and socio-economic polarization.

In his closing speech at the same Spring Meetings, Jim Yong Kim, President of the World Bank Group, singled out health and education as two sectors where our client countries need to step up their investment to improve opportunities for all society, but particularly for the poor and disenfranchised. While investing in health has its own intrinsic value in all societies, it is also a sound investment in building "healthy" human capital for improved productivity, competitiveness and economic growth, as well social inclusion, poverty reduction, and wealth creation.

The new Health, Nutrition, and Population Strategy for the Middle East and North Africa region is a very timely initiative in light of the transformative socio-political changes in the region, and of the World Bank Group's renewed commitment to ending poverty and reducing inequality. The strategy has been inspired by the aspirations of the people in the Arab World for fairness and accountability, adopting these two principles as its organizing framework to guide all future WBG engagement in the health, nutrition and population sectors in the region. It also builds on and reinforces the MENA Region's four-pronged strategy of strengthened governance, economic and social inclusion, job creation, and accelerated sustainable economic growth.

Aligning the Strategy with the demands of the people is essential. What is also needed is to align our resources – financial, human, and knowledge – towards the same end, and tailoring them for technically feasible, financially sustainable, and socio-culturally acceptable solutions on the ground.

I invite you all to partner with us in our relentless pursuit for better health and development outcomes in the region to bring us all closer to achieving our goals of eliminating poverty and boosting shared prosperity!



Ms. Inger Andersen
Vice President, Middle East and North Africa Region
The World Bank, May 2013

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Finally this strategy is grateful to the people of the MENA region, whose bravery and desire for change was the impetus for this document. With this strategy we look forward to a new partnership in the region towards the shared aspirations of fairness and accountability and to translate them into high performing health systems and improved health and wealth.

*** World Bank Group MENA countries include Algeria, Bahrain, Djibouti, Egypt, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Libya, Malta, Morocco, Oman, Qatar, Saudi Arabia, Syria, Tunisia, UAE, Palestinian Territories, Yemen**

List Of Abbreviations

ADB	Asian Development Bank
AfDB	African Development Bank
AHIF	Avian and Human Influenza Facility
CCT	Conditional Cash Transfer
DALY	Disability Adjusted Life Years
DPL	Development Policy Loan
ECD	Early Childhood Development
ECSH1	Eastern Europe and Central Asia Region, Heath Nutrition Population Sector of World Bank
EIDS	Emerging Infectious Disease
GCC	Gulf Cooperation Council
GDP	Gross Domestic Product
GPAI	Global Program for Avian Influenza
HDNHE	Health Nutrition and Population Anchor Unit of World Bank
HiAP	Health in All Policies
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
HMIS	Health Management and Information Systems
HNP	Health Nutrition and Population
HPAI	Highly Pathogenic Avian Influenza
HRITF	Health Results Innovation Trust Fund
HRH	Human Resources for Health
HROST	Health Reform Options Simulation Toolkit
IBRD	International Bank for Reconstruction and Development
ICSID	International Center for the Settlement of Investments Disputes
ICT	Information and Communication Technology
IDA	International Development Association
IEC	Information Education and Communication
IFC	International Finance Corporation
IsDB	Islamic Development Bank
MCH	Maternal Child Health
MENA	Middle East and North Africa
MENA HNP	MENA Health Nutrition Population

MDG	Millennium Development Goal
MIGA	Multilateral Investment Guarantee Agency
MNSHH	Middle East and North Africa Region, Heath Nutrition Population Sector of World Bank
MSNHD	Middle East and North Africa Region, Human Development Sector of World Bank
NCD	Non Communicable Disease
NHA	National Health Accounts
NGO	Non-Governmental Organization
ODTA	Open Development Technology Alliance
OECD	Organization for Economic Cooperation and Development
OOP	Out-of-Pocket
P4R	Program-for-Results
PBR	Patients' Bill of Rights
PDA	Personal Digital Assistant
PER	Public Expenditure Reviews
PETS	Public Expenditure Tracking Surveys
QSDS	Quantitative Service Delivery Surveys
RAS	Reimbursable Advisory Services
RBF	Results Based Financing
SARS	Severe Acute Respiratory Syndrome
SMS	Short Message Services
SUN	Scaling Up Nutrition
UN	United Nations
UNICEF	United Nations Children's Fund
UNICO	Universal Coverage Assessment Tool
WBI	World Bank Institute
WBIHS	World Bank Institute, Health Systems Group
WHO	World Health Organization

Executive Summary

The World Bank's commitment to building fair and accountable health systems in MENA in response to the voices of the people.

Standing at a moment of exceptional possibility

The Arab Awakening that started in December 2010 called for freedom, social justice, and improved accountability for a dignified life and well-being. The voices of citizens' that reverberated across the Middle East and North Africa (MENA) region brought about a wave of change in the social and political order, resulting in major constitutional or legal reforms.

Yet, political and legal reforms alone are insufficient to meet the demands of the people. They want fair and accountable governance in all spheres of life, whether it be enrolling one's child in school, applying for a business permit, or seeking care in a public hospital. Fairness and accountability are even more relevant in health care. When illness strikes, the patient and her family need not only be shielded against unexpected and impoverishing expenses, but also be protected from receiving inappropriate, unnecessary, and low-quality services. They should also be treated with the same degree of respect and care regardless of being rich or poor, university graduate or barely literate, connected to "the powers that be" or not. Indeed, many believe that profound dissatisfaction with the inequality of opportunity to seek and receive quality health services has been one of the major root causes behind the political upheaval.

Evidence from the region suggests there is considerable space for improvement in health care. Globally, MENA countries have some of the lowest levels of government spending on health care. Between 2006-2011, MENA governments spent on average 8.2 per cent of their budget on healthcare, but double that amount on education (18 per cent). This has resulted in high out of pocket expenses with households in the Maghreb and Mashreq paying almost forty per cent of all health care costs, forcing people to forgo care or face impoverishment due to medical expenses.



Given the low priority of health it is not surprising that access to care is inequitable and quality of care is perceived to be poor. An urban woman in MENA is almost twice as likely to have a skilled attendant at birth and have access to contraceptives as compared to her rural sister. In addition, the burden of non communicable diseases is rising which can threaten the health and wealth of future generations. Obesity is endemic with four MENA countries having among the world's highest male and female obesity rates (Kuwait, Egypt, UAE, Bahrain) and tobacco use among men is high with increasing rates among young women. Road traffic accidents are the leading killers of young men in the region, and depression the leading cause of morbidity among the region's women. At the same time poorer parts of MENA still have high levels of malnutrition (close to 60 per cent of children in Yemen are stunted) and a high burden of maternal and child mortality. These conditions can be reduced or mitigated through the creation of more responsive health systems prioritizing lower cost prevention efforts in the present versus more costly treatments in the future.

What are fair and accountable health systems?

To protect, promote, and preserve the health of its people, health systems in the region must aspire to become more fair and accountable. Fairness in health and health systems refers to the absence of systematic disparities in health that could be avoided through prevention and care; the just distribution of the burden of costs of health care according to people's ability to pay; and an equitable response to the nonmedical needs, rights, and expectations of those seeking and obtaining health care—that is for a dignified interaction with the provider.

Accountability refers to the obligation to ensure that health care services are timely, effective, safe, appropriate, cost-conscious, and patient-centered. The nexus of accountability in health care governs the interaction among three key players: populations, payers, and providers. Safeguarding fairness and accountability requires that the health system is fiscally sound and sustainable.

What does fairness in health systems mean in practice for the World Bank? Fairness in health outcomes refers to the World Bank engaging in and assisting in efforts to prevent and control diseases of the poor, address socio-cultural obstacles that compromise effective delivery of essential maternal and child health services, mainstream gender for more patient-centered care, and promote health of the youth by reducing risks and hazards associated with smoking, alcohol abuse, and road traffic injury—programs the World Bank has experience implementing. Fairness in financial protection entails providing fiscally sound and responsible advice and financial support to expand health insurance and coverage to the poor, to the unemployed, and the informally employed to reduce out-of-pocket expenses. Fairness in responsiveness refers to the World Bank supporting practices that enhance patients' experiences with the health system by upholding patients' rights to privacy, anonymity, and confidentiality, and by respecting their non-medical expectations and providing high quality care regardless of their socio-economic status or personal attributes.

How can accountability in health systems be improved through World Bank support? The governance and accountability nexus where the population interacts with providers on one hand and with payers on the other has the government and its institutions at the center. The World Bank can assist MENA governments in creating health systems and institutions that are more accountable to the people. The World Bank can advise and financially support policies, mechanisms, and tools that increase transparency in health care so the public and patients are fully informed of service quality and care outcomes to make informed decisions of where to seek care and to address their grievance in case of medical errors or dissatisfaction with system responsiveness. The World Bank can support government initiatives that will increase the value of health care to the citizens, as tax or premium payers, or as actual purchasers at the point of service. People need to be fully informed of where their dinars or dirhams or pounds go, how they are spent, and what they buy to improve their health. The World Bank can support participatory or representational initiatives ensuring that citizens and patients have a voice in how their money could be better spent to provide more value. It can also ensure that mechanisms are in place so that patients are fully informed for active and purposeful engagement, either directly with providers, or indirectly through their agents, be it public or private insurers or purchasers. The World Bank can assist countries in improving accountability of payers through its technical and financial support in setting up health management information systems resulting in transforming passive payers into active purchasers through evidence-based negotiations with providers. This can be achieved by reducing costs through incentivizing preventive and primary care, pharmaceutical reform, or addressing fragmentations in health care delivery. Finally, accountability of providers refers to those interventions that modulate performance through financial and non-financial provider incentives, workforce planning to meet human resources for health, and by setting up alternate organization of care modalities in low resource settings.

What is the World Bank's comparative advantage in building fair and accountable systems?

The World Bank is uniquely positioned to work with countries on health system reforms in MENA. It is invested in all the countries of the region across a multitude of sectors adding synergy to sector-specific interventions, including the health sector. Its macroeconomic remit, and insight into the economic, financial, and fiscal health of each country, and of the whole region, allows for more grounded and tailored assistance. For example, a request to strengthen human resources for health will mobilize data, information, knowledge, and insight that the Bank has gained in job creation, gender, employment, international migration, remittances, higher education, and labor markets through decades of experience around the world. An inquiry about passing a new law on health insurance may trigger an assessment of a health facility's readiness to respond to the surge in demand for care, and its ability

to carry out accurate actuarial analyses to estimate future health expenditures and their fiscal impact on the government budget under various forecasting scenarios of economic growth and revenues. The World Bank engages with multiple governmental and nongovernmental stakeholders and capitalizes on its global and regional convening power to tailor the most appropriate and feasible solutions. The World Bank also supports building and strengthening of institutions for long-term sustainability of policies and institutional reforms.

The World Bank, building on its unique four decades of experience in strengthening and transforming health systems in some 150 countries, stands ready to mobilize its lending support as well as deep technical expertise to assist countries in the MENA region. A diverse set of financial instruments are tailored to respond to needs for investment or policy-based lending, or programmatic and results-based financing. Similarly, as a "Knowledge Bank" the World Bank is ready to share its deep technical expertise through a set of instruments that will allow MENA countries to engage in evidence-based policy dialogue, or benefit from tailored recommendations to diagnose and resolve sector specific challenges.

How will the strategy be implemented?

The new Health, Nutrition, and Population (HNP) Strategy for MENA comes at a time when the policy and political space for reforming health systems to respond to these demands is wide open. Accordingly, the new strategy takes a fundamentally different route from its antecedents as it intentionally refrains from defining high priority areas for action with respect to diseases, risk factors, or system issues. Instead, it lays out a set of principles against which the worthiness of all future World Bank engagements and their performance will be assessed, that is, the extent to which World Bank advisory and analytical activities, and its financial support contributes to improving fairness and accountability in health and health systems in a sustainable manner.

The MENA HNP Strategy is envisioned as a dynamic "living" strategy, rather than as a static document, providing a compass for prioritization of World Bank engagements in line with regional and client country needs. Its implementation spans three phases. Phase one will involve an intensive engagement process aimed at listening to client needs and clarifying the issues and options towards building and maintaining fairer and more accountable health systems. Phase two entails development of country specific engagement plans in each country. Phase three consists of actual implementation of the strategy, spanning over a period of about four years.

With shrinking fiscal space and the impatience of the people in the Arab world for urgent improvements, the time is right for a transformative longer-term strategy to implement a fairer and more accountable health delivery system. Since MENA's health systems are in the early stages of reform, the region, could avoid repeating some of the mistakes made by OECD countries in their quest for universal access, higher quality, and efficiency. MENA could also leapfrog some evolutionary reforms thanks to a much better understanding of health systems, improved technology, organizational and behavioral sectoral knowledge, and the "science of delivery." With strong leadership and firm commitment, MENA countries could innovate in ways to render some of these steps obsolete in their pursuit of better access to quality care. In response to the "voices of the people", the World Bank is committed to working with governments, nongovernmental actors, the private sector, and above all, the people to realize their aspirations of better health and development outcomes through the MENA HNP Strategy.



1. Introduction: Standing at a Moment of Exceptional Possibility



The World Bank is committed to supporting the peoples' call for fair and accountable high-performing health systems in the Middle East and North Africa.

Developing a new strategy inspired by revolutionary changes. The Middle East and North Africa is experiencing revolutionary social and political change since December 2010. The peoples' calls for social justice, inclusive governance, and transparency is an impetus for the World Bank to propose a new strategy for engagement in the countries of MENA to help reform their systems to achieve fair access to high-quality services, including health care, for a better quality of life for all.

Building high-performing health systems. Many health systems in MENA are in a protracted state of institutional reform. Opting for incremental changes has resulted in modest improvements in access to quality health care, especially for the poor and vulnerable. Mounting economic pressures and shrinking fiscal space stemming from the recent global and regional crises—and the growing impatience of the citizenry for tangible improvements in service delivery—offer a window of opportunity for trans-

formative reforms in health systems. With visionary leadership and firm commitment, the region could leapfrog towards fairer and more accountable health systems, bypassing many of the intermediate stages the Organization for Economic Cooperation and Development (OECD) countries had to go through.

Operationalizing fairness and accountability in healthcare delivery. All health systems aspire to the principles of fairness and accountability. A health system is fair to the extent that it mitigates, if not eliminates, avoidable inequities in health and health care by better targeting of services to those most in need, protecting the poor from financial consequences of health events, and responding to people's expectations for humane, respectful, and dignified care. A health system is accountable to the extent that its institutions, healthcare facilities, and professionals can be held to account for their performance in providing timely, effective, safe, appropriate, cost-conscious and patient-centered care. Recognizing the explicit demand for fair and accountable governance in all spheres of life, including healthcare, as expressed by the masses in the Arab world, this strategy adopts fairness and accountability as its guiding principles and organizing framework.

Reducing poverty and increasing shared prosperity through investments in health. While health has its own intrinsic value, it also contributes to generating wealth. Investment in health is a centerpiece of the World Bank's development agenda to alleviate poverty and reduce disparities. Reducing poverty by improving financial protection against unpredictable and catastrophic medical expenses has long been a key objective. There is a growing recognition that improvements in health lead to a healthier labor force, hence to increased productivity and competitiveness, especially in countries which are set to benefit from the demographic dividend as most MENA countries are. With shrinking fiscal space for health, unfavorable risk factor profiles, and a growing burden of NCDs, it is more important than ever to continue to invest in preventative and primary care to safeguard gains and to ensure the well-being of future generation.

Creating fair and accountable health systems in line with the World Bank Group[1] goals. Under new leadership, the World Bank Group has adopted two corporate goals: to end extreme poverty and to boost shared prosperity sustainably. In order to meet these goals, countries need robust, inclusive economic growth, and to drive growth, they need to build human capital through investments in health, education and social protection for all their citizens. The World Bank's MENA region supports these goals through its four-pillar regional strategy of strengthened governance, economic and social inclusion, sustainable growth, and job creation. The World Banks' Health Nutrition Population Network strategy aligns World Bank and regional goals by aiming to reduce inequalities in health, improve financial protection of the poor, and ensure fiscal sustainability, while contributing to the growth and competitiveness of the economy. Consistent with, and building on the Bank Group strategy and the specific regional and HNP strategies, the new MNA HNP strategy sets the rules of engagement in the health sector by enshrining the principles of fairness and accountability through sustainable development.

Enhancing effectiveness as a "solutions bank". Multi sectoral interventions in health and human development are central to poverty alleviation and growth. The World Bank has amassed a wealth of knowledge to apply custom solutions to human development challenges in MENA. The MENA HNP strategy was designed to meet the region's needs and the people's aspirations based on the World Bank's external consultations, review of poll findings, and extensive research. It is committed to recognizing the diversity of client[2] needs, emphasizing transformative products and services and privileging emphasis on the "science of delivery" (what will work rather than what could

work, and how to best deliver it) to craft the right mix of targeted programs to achieve solutions while strengthening health systems.

Responding to country needs. Country-level engagement will be determined in dialogue and discussion with counterparts, driven by country needs, and based on the Bank's comparative advantage in addressing those needs. This engagement will be framed by the principles of fairness and accountability which will be applied to the health system goals of improving health status, financial protection and responsiveness; and suggest interventions grouped along health system functions of stewardship/governance, financing, resource generation, and service delivery. Flexible financial and technical products will respond to each country's needs, incorporating country-specific political, financial, fiscal and implementation risks, and where possible, mitigation measures.

Standing at a moment of exceptional possibility. Rising demands for better delivery of health services coupled with deficiencies in health system performance precipitated regional discussions for transformational changes in health systems. Given the peoples' prioritization of health and equity, political momentum can be seized to intensify inclusive dialogue towards achieving comprehensive health sector reforms. Energized by the sweeping changes in the region, the World Bank has recalibrated its engagement to lend its support to the people and new governments in MENA for better health and development outcomes by upholding the principles of fairness and accountability as the compass of this new engagement.

To do so, the MENA HNP strategy responds to four key questions. Why is the World Bank developing a health strategy for MENA? How can MENA health systems be made more fair and accountable? What the World Bank products will contribute to improving fairness and accountability in MENA? How will the World Bank implement the strategy in MENA?

1 The World Bank Group consists of the International Development Association (IDA); International Bank for Reconstruction and Development (IBRD); International Financial Corporation (IFC); Multilateral Guarantee Agency (MIGA) and International Center for the Settlement of Investment Disputes (ICSID). The World Bank (often referred to as 'the Bank' in this document) only includes IDA and IBRD.

2 The "client" refers to the country-level counterpart (usually the government but can also include civil society, private sector, NGOs etc), and the "beneficiary" refers to the citizenry.



2. Why is the World Bank Developing a Health Strategy for MENA?

A health strategy responding to the diverse needs of MENA countries to assist governments in meeting their populations' health needs fairly and accountably.

2.1. Development context and challenges

Calling for increased fairness and accountability. December 18, 2010 marked the start of civil uprisings in Tunisia, Egypt, Libya, Yemen, Bahrain, Syria, Algeria, Iraq, Jordan, Kuwait, and Morocco. The slogans reverberating from Tahrir Square during the January 25, 2011 Revolution in Egypt were for "Aish, Horeya, Adala Igtema'eya" (or bread, freedom, and social justice). Good governance, particularly fairness and accountability, were demanded by the protestors. As governments seek to define new national priorities, the basic demands of their populations are even more pertinent (Figure 2.1).

Prioritizing delivery of health care. Health closely follows education as a top priority (Figure 2.2). People hold their governments responsible for providing health care. To maintain legitimacy, elected representatives will need to enact and implement policy reforms to address the people's priorities in a timely manner.

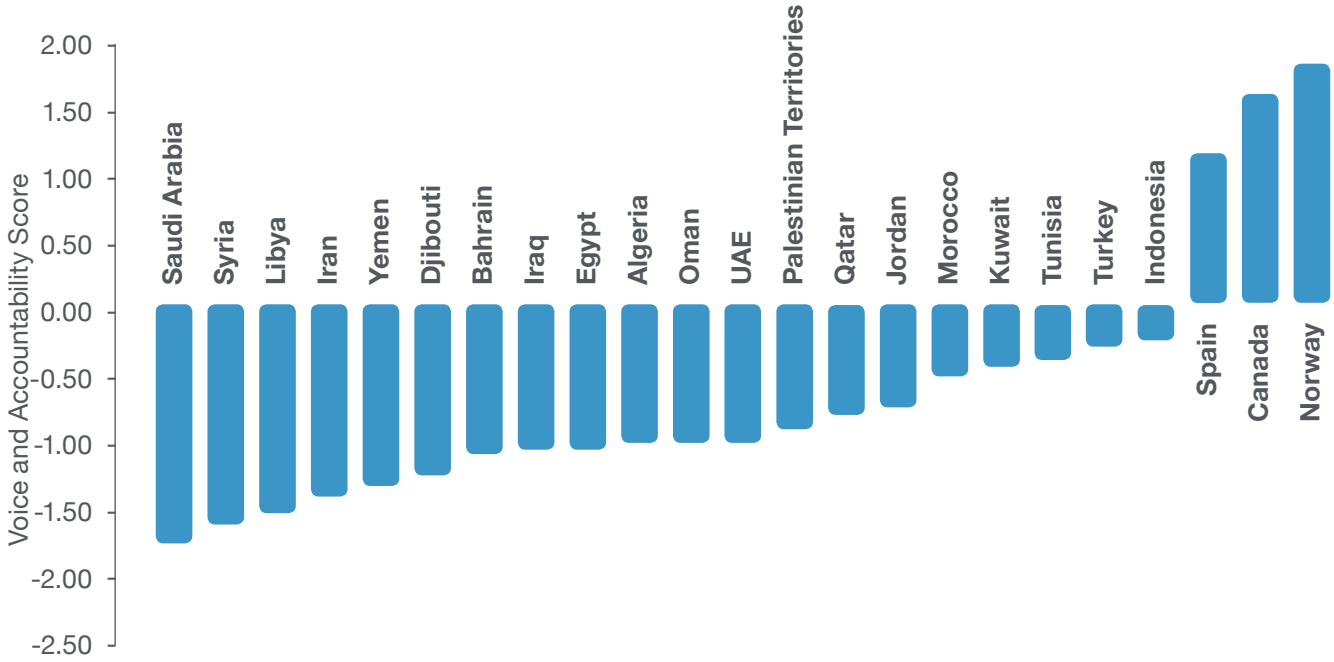
Shrinking fiscal space for public sector programs. The global economic crisis, and political changes across MENA, has reduced global trade, disrupted normal economic life, curtailed domestic business activity, and reduced the fiscal space for public services (Figure 2.3). Foreign direct investment in Egypt fell from USD 6.5 bn in 2009 to negative levels two years later. Yet governments either expanded public sector employment, or increased salaries, benefits, and consumption subsidies in response to social demands and pressure. These public sector measures are likely to become unsustainable over the medium- to long-term.

Reaping the potential benefit of a demographic dividend. Over the next three decades, MENA countries could reap the benefits of a demographic dividend due to an expanding workforce (Figure 2.4 and 2.5). Lessons from Asia and Latin America indicate that these benefits are contingent on a healthy, educated work force with established institutions to harness the productivity of the youth bulge.

High youth unemployment driving instability. The global economic downturn, starting in 2007, has exacerbated regional unemployment. In 2008, one in ten adults and one in four youth were unemployed despite having high levels of education (World Bank, 2012; Figure 2.6).

Vulnerability of women to employment shocks. Three out of four working-age women do not participate in the labor force and constitute 80–90 per cent of MENA's inactive population (Gatti et al., 2013). Female labor force participation in MENA countries is half the global average with increasing unemployment seen among women in certain MENA countries like Egypt in recent times.

Figure 2.1. Voice and accountability metrics for MENA countries

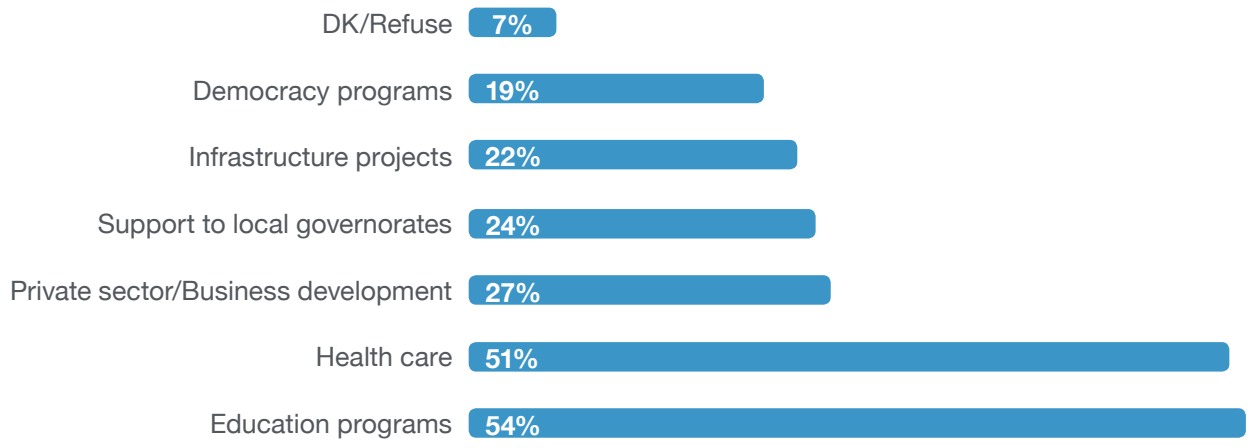


Voice and Accountability Score reflects perceptions of the extent to which a country's citizens are able to participate in selecting their government, as well as, their freedom of expression, freedom of association, and a free media. It ranges from -2.5 to +2.5 with positive scores indicative of greater voice and accountability.

Source: World Bank, 2012

Figure 2.2. Opinion poll data from Egypt

Of the following list of issues, which are the top two in need of the greatest investment? (multiple response)



Source: International Republican Institute (IRI), 2011.

Pockets of poverty underlying high levels of wealth. MENA has a population of 355 million, with 85 per cent living in middle-income countries, 8 per cent in high-income countries, and 7 per cent in low-income countries. While the region's overall share of the poor is small, high levels of deprivation exist even among middle-and high-income countries when income and multidimensional poverty are considered, i.e. people's well-being along 10 indicators—nutrition, child mortality, years of schooling, school attendance, cooking fuel, sanitation, water, electricity, flooring, and assets (Kakwani and Silber, 2008).

Rising temperatures compounding problems due to water scarcity. The MENA region has the lowest fresh-water resource endowment in the world making it particularly vulnerable to the effects of climate change (Verner, 2012). The past thirty years has seen a 0.5 – 1.5°C increase in temperatures and increase in droughts from once every 10 years to 5-6 events every 10 years today (Maghreb) which may exacerbate the current regional instability.

Looming food insecurity. MENA countries are net food importers and rely on imports to meet about 50 per cent of their food needs. Gulf countries import 100 per cent of their staple foods, and Yemen imports 80 per cent of its cereals. International food price increases are likely to increase poverty in the short run, acutely affecting the poor in urban areas, the rural landless, and the small and marginal farmers.

Removing subsidies may affect the poor without social assistance in place. Many countries are considering reducing or eliminating unsustainable food and fuel subsidies, which tend to be regressive by benefitting the better off. Unless appropriate targeted social assistance programs are in place, removing these subsidies could lead to poor, near-poor, and otherwise vulnerable groups at risk of impoverishment with potential consequences of malnutrition and ill health.

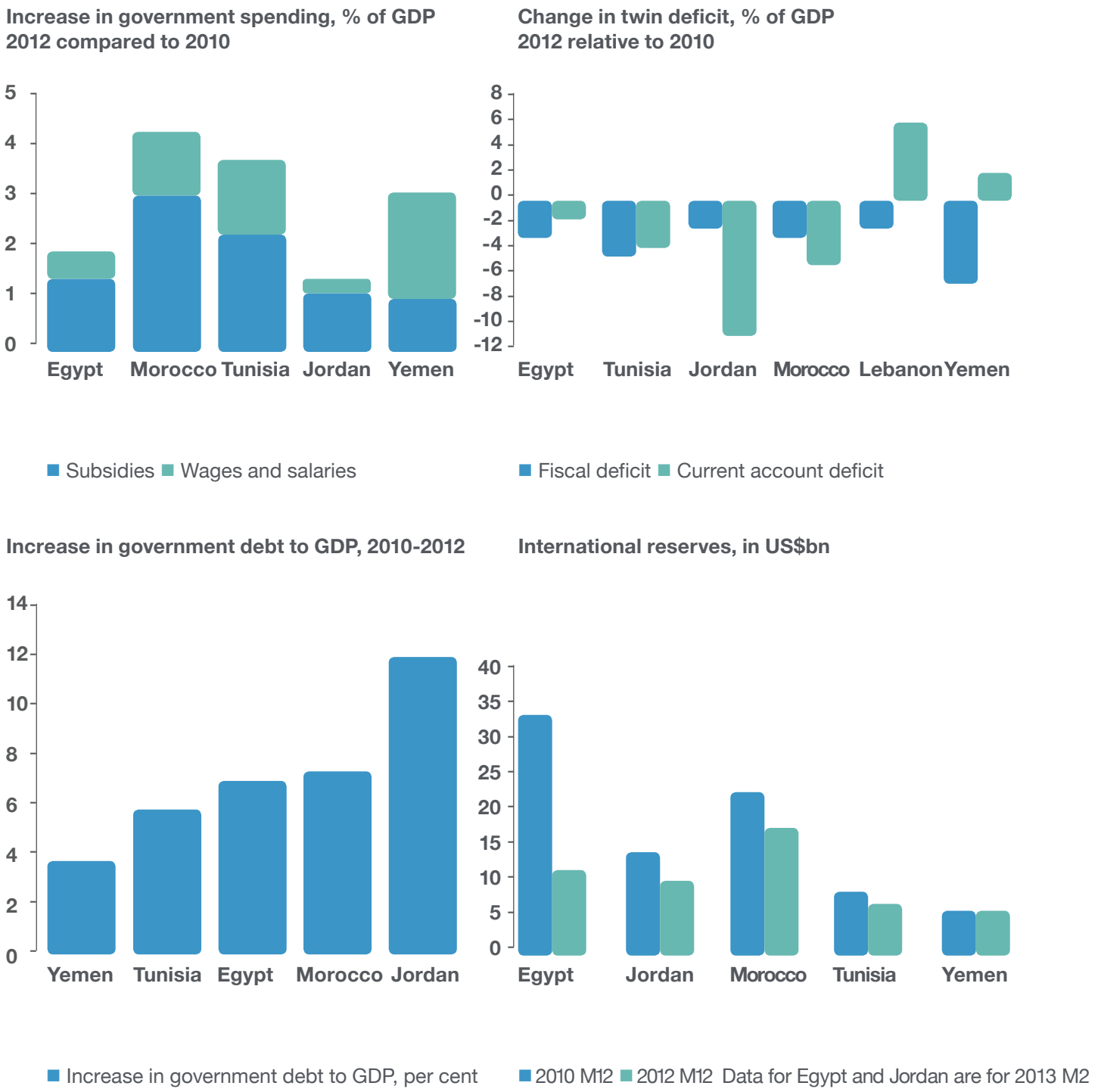
Creating resilient health systems despite conflict. The ongoing conflicts in MENA require special consideration in health care programming, particularly for refugees. As of May 2013, active conflicts raged in Syria, the Palestinian Territories, Iraq, Libya, and Yemen. Nearly a million Syrians have sought safety in Lebanon, Jordan, and neighboring countries over the past year. Refugee populations have special physical and mental health requirements, as well as disability care needs. The sudden influx of people in host countries is straining existing health systems and political stability. MENA's health system reforms must prioritize the development of flexible and resilient health systems to respond quickly and adequately to the human suffering caused by regional conflicts.

2.2. Health and health system challenges

Living longer in better health. Human longevity and health have improved impressively over the past century, adding years to life and life to years. While improved wealth, hygiene, and sanitation have contributed to the life span, so have advances in medical knowledge, technology, and system innovation. In the last fifty years, average life expectancy in MENA has increased by over twenty-five years (World Bank, 2012).

Meeting Millennium Development Goals. MENA child mortality has declined rapidly over the past three decades, but remains high in Yemen and Djibouti, with under five mortality of 78.5 and 91.2 deaths per 1,000 live births, respectively (World Bank, 2012). Maternal mortality is an important indicator of the overall effectiveness of health care systems. Mothers' access to reproductive health services and mothers' inability to make reproduc-

Figure 2.3. MENA fiscal snapshot



Source: World Bank, 2013

tive health decisions also remains high in some countries—resulting in 97 maternal deaths per 100,00 live births in Algeria, 100 in Egypt, 100 in Yemen, and over 200 in Djibouti (The World Bank, 2012).

Increasing burden of non communicable diseases. MENA countries face a rapid rise in non communicable (NCDs) diseases and injuries as a share of the total disease burden as countries transition from traditional to modern health risks (Figure 2.7 and 2.8). The top three causes of morbidity and mortality in MENA are ischemic heart disease (7.4 million disability adjusted life years (DALYs)), low back and neck pain (6.2 million DALYs), and unipolar depressive disorder (5.3 million DALYs) (Lozano et al., 2013; Murray et al., 2013; Wang et al., 2013). Tobacco consumption is a major risk factor for adults aged 15-59 years, especially men, but also increasingly for young women. In Egypt alone, according to estimates, a comprehensive and effective tobacco control program could prevent about 11 per cent of premature excess deaths a year, amounting to 621,960 lives saved over a period of 20 years (World Bank, 2010). Both men and women exhibit high prevalence of obesity, high cholesterol, and high blood pressure—a group of risk factors with a common pathway to premature cardiovascular disease and mortality.

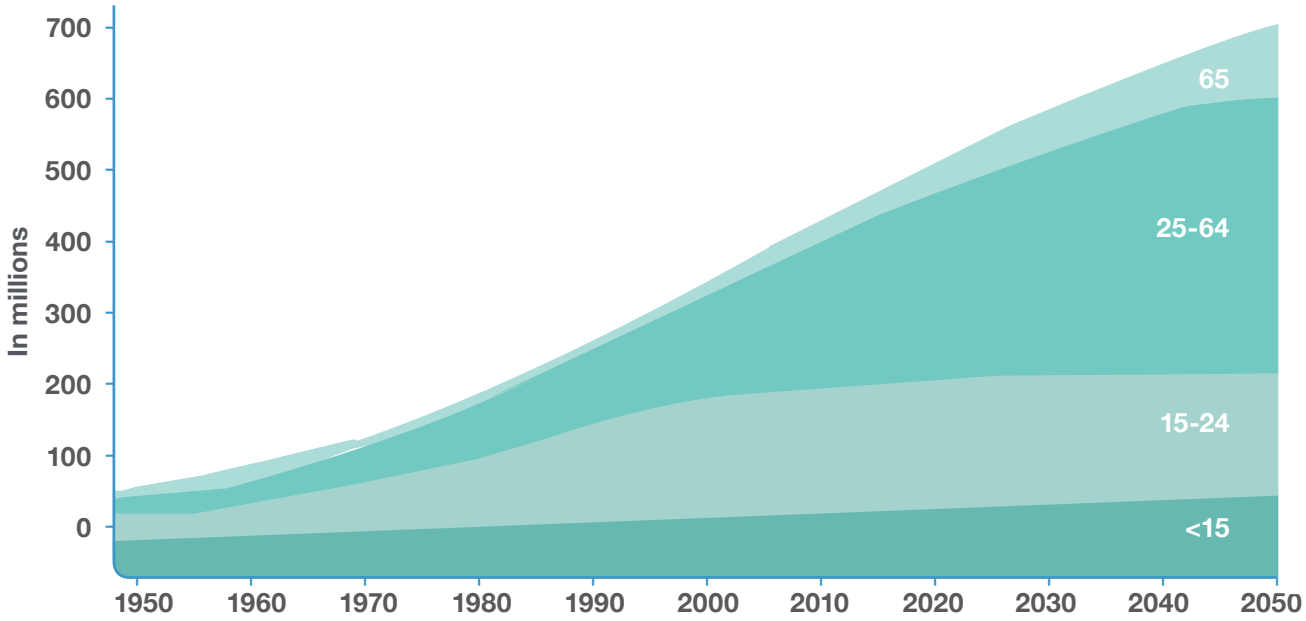
Growing double burden of malnutrition-under nutrition and obesity. MENA countries suffer from both under nutrition and obesity (Figure 2.9). MENA countries ranking in the global top twenty for female obesity include Kuwait (55.2 per cent), Egypt (48.0), UAE (42.0), Bahrain (37.9), and Jordan (37.9) and for male obesity include Kuwait (29.6) UAE (24.5), Saudi Arabia (23.0), Egypt (22.0), and Bahrain (21.2) (The Economist, 2013). Given the link between obesity and diabetes, hypertension, heart disease, stroke, and many other chronic diseases, this has serious consequences on future health spending and labor productivity. A high burden of child under nutrition remains a problem in Djibouti, Egypt, Iraq, Kuwait, Libya, Morocco, Syria, and Yemen which can impair cognitive development in early childhood and impair performance, productivity, and earnings later in adult life. Moderate to severe stunting is reported in up to 53 per cent of children in Yemen, in over 30 per cent of children in Iraq and Djibouti, and in 28 per cent of children in Egypt (UNICEF, 2008).

Persisting health inequalities due to income. Inequities based on income, gender, degree of urbanization, and age persist in MENA—potentially contributing to social unrest and political instability. Rates of maternal mortality and malnutrition are high, especially among poor populations, with a two- to six-fold difference in mortality rates and access to antenatal care between the poorest and richest income quintiles (Figure 2.10). There are large disparities in early childhood development indicators between advantaged and disadvantaged children across MENA countries (Figure 2.11).

Failing to address the health needs of youth. The youth in MENA have special health needs which are not being met. Smoking rates are high among youth—In Lebanon, 65.8 per cent of boys and 54.1 per cent of girls aged 13-15 years are smokers (World Bank, 2010). Injuries and deaths due to road traffic accidents disproportionally affect youth and are among the highest globally. Giving the growing size of the youth population this needs to be urgently addressed.

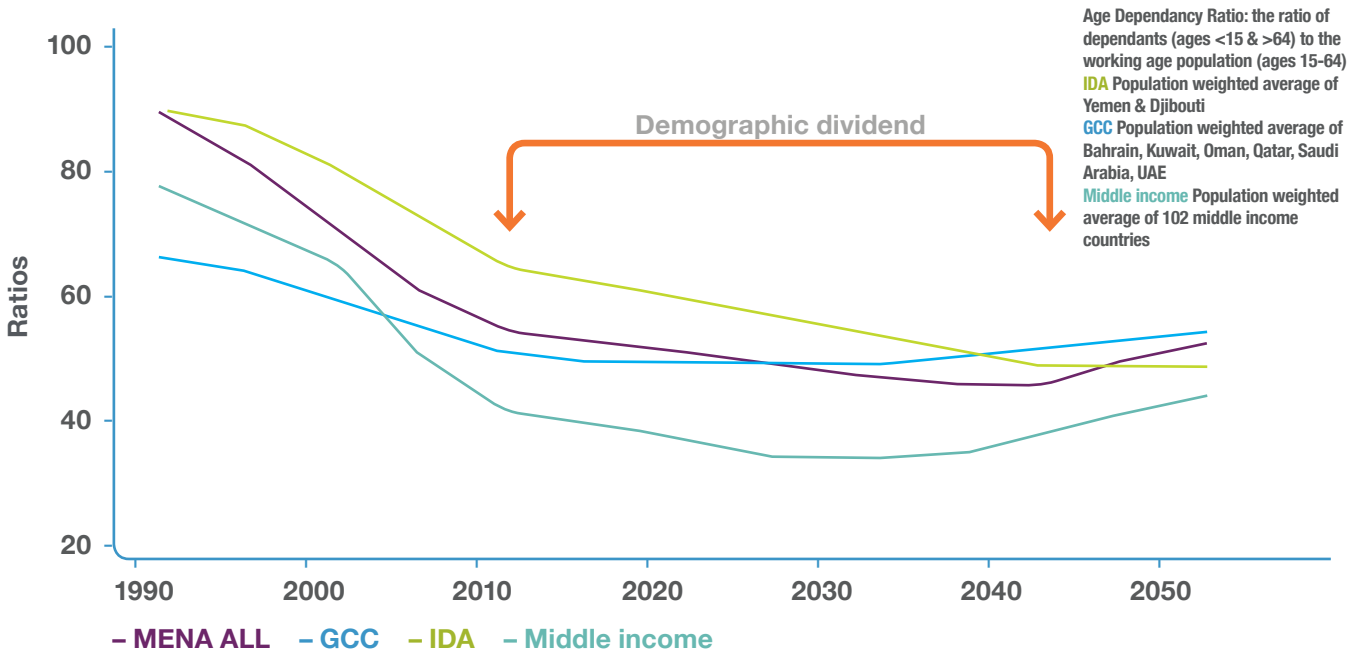
Meeting the health needs of women. Diabetes and cardiovascular disease are on the rise in MENA, especially among women. Women have a higher burden of disease from mental health conditions–major depressive disorder is the leading cause of DALYs, and anxiety is in the top ten causes. High body mass index, blood pressure, and glucose levels are the main risk factors for death and disability, while physical inactivity and iron deficiency closely

Figure 2.4. Population growth in MENA by age group, 1950-2050



Source: United Nations, 2005

Figure 2.5. Dependency ratios for MENA countries



Age Dependancy Ratio: the ratio of dependants (ages <15 & >64) to the working age population (ages 15-64)
IDA Population weighted average of Yemen & Djibouti
GCC Population weighted average of Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, UAE
Middle income Population weighted average of 102 middle income countries

Source: World Bank, 2012

follow (Murray et al., 2013). Unhealthy diets combined with the inability to exercise due to socio-cultural contexts place women at a heightened risk for NCDs.

Low public financing for health compromising access and quality. Most MENA countries are classified as middle-income countries, but their health systems are not delivering results commensurate with wealth levels. Government financing for health remains low, making the region a global outlier for its low spending, despite its income status (see Figure 2.12). Between 2006-2011, MENA governments spent on average 8.2 per cent of their budget on health care, but double that amount on education (18 per cent) (Tandon et al, 2013).

High out-of-pocket health spending leading to impoverishment. Despite wealth levels, health insurance coverage and financial protection is limited. While nominal coverage levels are relatively high, through subsidized government services or social security schemes, out-of-pocket (OOP) health payments are also high often leading to financial impoverishment (Figure 2.13). Estimates for the Arab world (excluding GCC) suggest that 5.5 to 13 million individuals face catastrophic health expenditures each year (Jabbour et al. 2012). This situation results in individuals forgoing health care due to costs, as reported by 12 per cent of individuals in Egypt, 20 per cent in Lebanon, and 37 per cent in Yemen (Elgazzar et al., 2010).

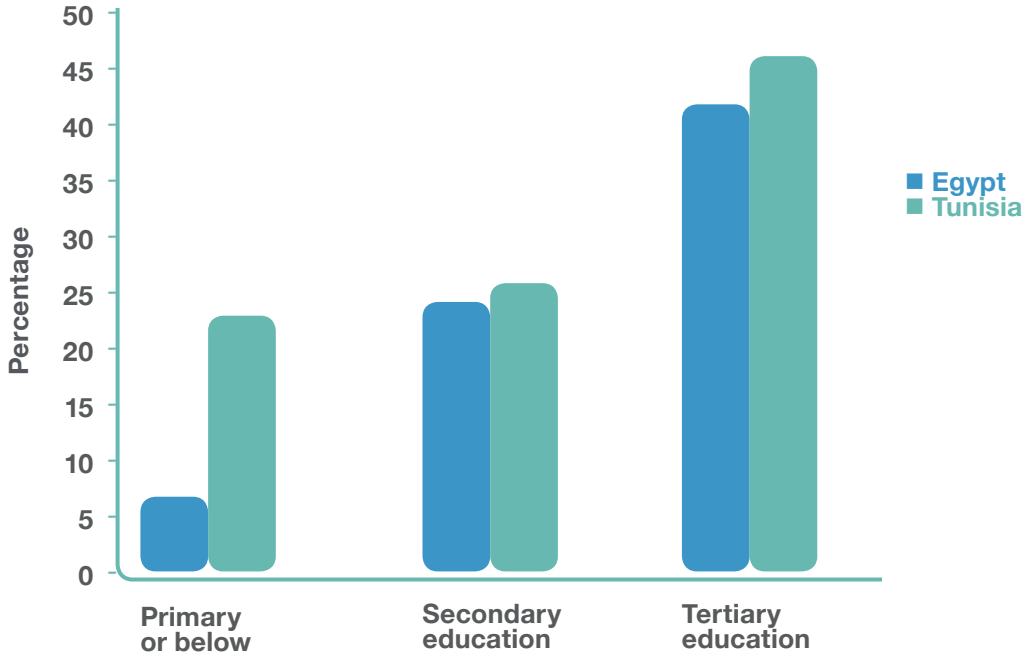
Responding poorly to patients' needs. Patient experiences at health facilities across the region are characterized by long waiting lines, absent providers, lack of privacy and confidentiality, and informal payments (Jabbour et al., 2012; Zaky et al., 2007). Satisfaction with health services is low region-wide. A recent World Bank report on reproductive health rights in Egypt (Rabie et al., 2012) suggested clinics suffered from limited privacy for patient examinations, lack of female physicians in almost half of clinics, and high physician turnover.

Compromising care due to lack of consistency in technical quality. While many countries in the region have relatively high coverage rates for immunization and mother and child health services, chronic disease care and management, prescribing behavior, health education, and referral patterns seldom measure up to international standards and people's expectations. In many cases, actual health practice differs from evidence-based practices due to poor oversight and lack of accountability. Studies from Egypt show room for improvement with regard to patient safety (Aboul-Fotouh et al., 2012). Intensive care units (ICUs) and wards in Jordanian teaching hospitals indicated a 35 per cent reported incidence of medication errors (Mrayyan, 2012). A synthesis of 31 studies in Saudi Arabia showed variation in quality of care—high standards for immunization, maternal health and epidemic control, but poor care for chronic disease management, prescribing patterns, health education, referral patterns, and some areas of interpersonal care (Al-Ahmadi and Roland, 2005).

Low capacity for measuring and evaluating health projects and identifying potential threats. There are few independent assessments of patient and provider safety. Electronic patient recording is almost non-existent, which seriously undermines informational continuity in health care. In the region national surveillance and early warning systems are weak. In rural areas, what data exists on illnesses and causes of death are mostly incomplete and unreliable.

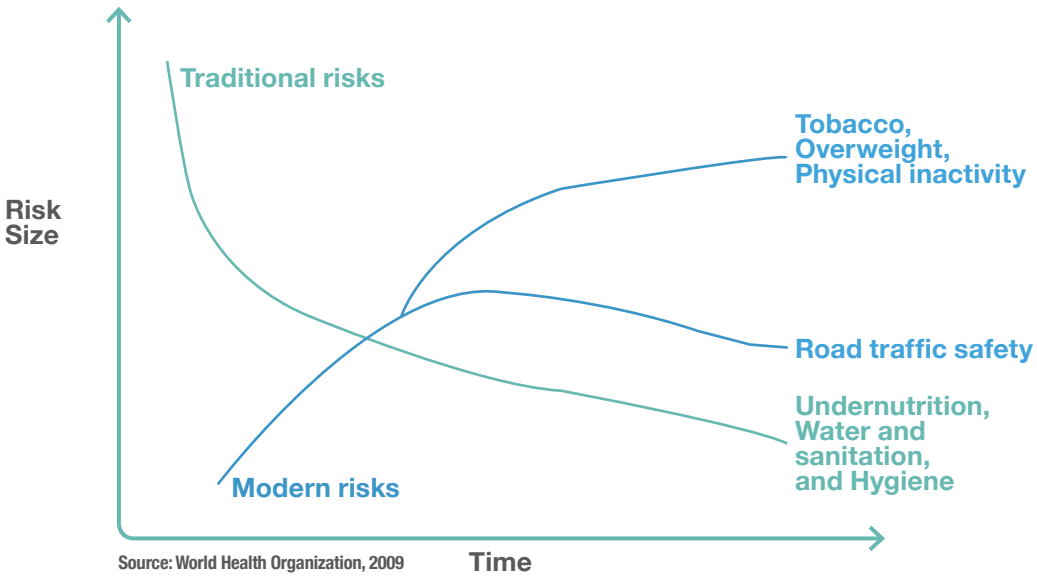
Variation in human resources for health resulting in shortages. MENA countries have one-third the nurses and half the doctors as OECD countries, but there is great variation. GCC countries like Qatar have nurse density

Figure 2.6. Youth unemployment in MENA, ages 15-29, 2010



Source: Gatti et al., 2013

Figure 2.7. Transition over time from traditional to modern health risks



Source: World Health Organization, 2009

equivalent to European countries (74 nurses and midwives for 10,000 of population), while Morocco, Yemen, and Djibouti have less than 10 (Jabbour et al., 2012). Poor countries in MENA suffer from a lack of recruitment, deployment and retention strategies, emigration of skilled health personnel, and an absence of reliable data on human resources for health, hindering improved policy formulation and decision-making. The existing workforce is often misaligned across specialties, regions, and sectors, with most specialists congregated in urban areas. In Egypt, over 88 per cent and in Lebanon over 70 per cent of physicians are specialists as compared to general practititioners (Jabbour et al., 2012). HRH resources also tend to be concentrated in urban areas, which may not always match population need. In Yemen, approximately 70 per cent of all health workers were concentrated in the three main cities (Sana'a, Aden, and Taiz) where only 35 per cent of the population resides (Jabbour et al, 2012).

2.3. World Bank's comparative advantage in MENA

Approaching country needs based on a multi sectoral and systems-based approach. Health is affected by, and affects, many factors, including determinants linked to education, sanitation, roads, agriculture, environment, and infrastructure (Macinko et al., 2009). The World Bank consists of teams of experts across different sectors including education, social protection, gender, infrastructure, water and sanitation to create tailored health care solutions. Particular to the challenges in MENA, The World Bank has the ability to work with governance and public sector experts to create more accountable health systems; agriculture experts to work towards more nutritious foods; social protection experts to help induce health care seeking behavior of the poor; gender experts to develop projects that can reduce maternal mortality; transportation experts to reduce road traffic fatalities; and public finance experts to help mainstream health into fiscal and taxation policies to combat non communicable diseases.

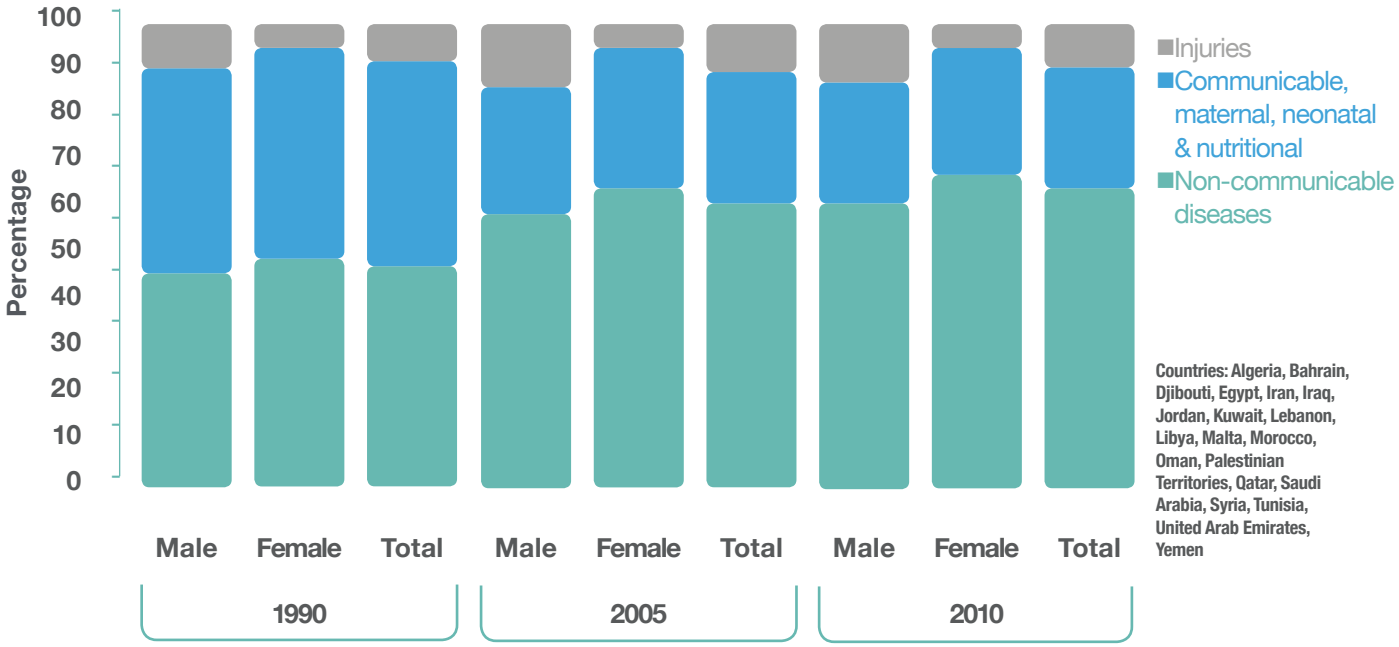
Providing a unified platform of public and private sector support as one World Bank Group. As part of the larger World Bank Group, The World Bank works with the International Finance Cooperation (IFC) to catalyze the private sector in the delivery of health care including investing in hospitals, clinics, labs, pharmaceutical manufacturing, and insurance through stand-alone investments or public private partnerships. In MENA, IFC offers an Islamic finance facility, investments in training of the health workforce, and investments in hospitals.

Engaging with diverse stakeholders to achieve health and development goals. The World Bank coordinates interaction between donors, e.g. bilateral aid agencies, United Nations, humanitarian groups, foundations, and other development banks to provide financial and other assistance to recipient countries. Activities range from simple information sharing and brainstorming, to co-financing projects, and joint strategic programming in partnership with UN agencies, such as the World Health Organization or other IFIs, including the Islamic Development Bank (IsDB), Asian Development Bank (ADB), and African Development Bank (AfDB). Regional GCC development banks also partner with the Bank to improve regional health status.

Drawing from global experience to provide technical expertise. The World Bank's value to MENA is its wealth of health sector experience in more than 150 countries over several decades. The Bank has extensive low and middle-income country experience implementing health sector reforms in Latin America, Central Europe, and East Asia. Its global expertise in impact evaluation, governance, and public sector reform are particularly relevant.

Sharing global best practices through diverse training opportunities. The World Bank shares it global development expertise through organized trainings, e-learning, South-South knowledge exchange events,

Figure 2.8. Composition of DALYs in MENA 1990-2010



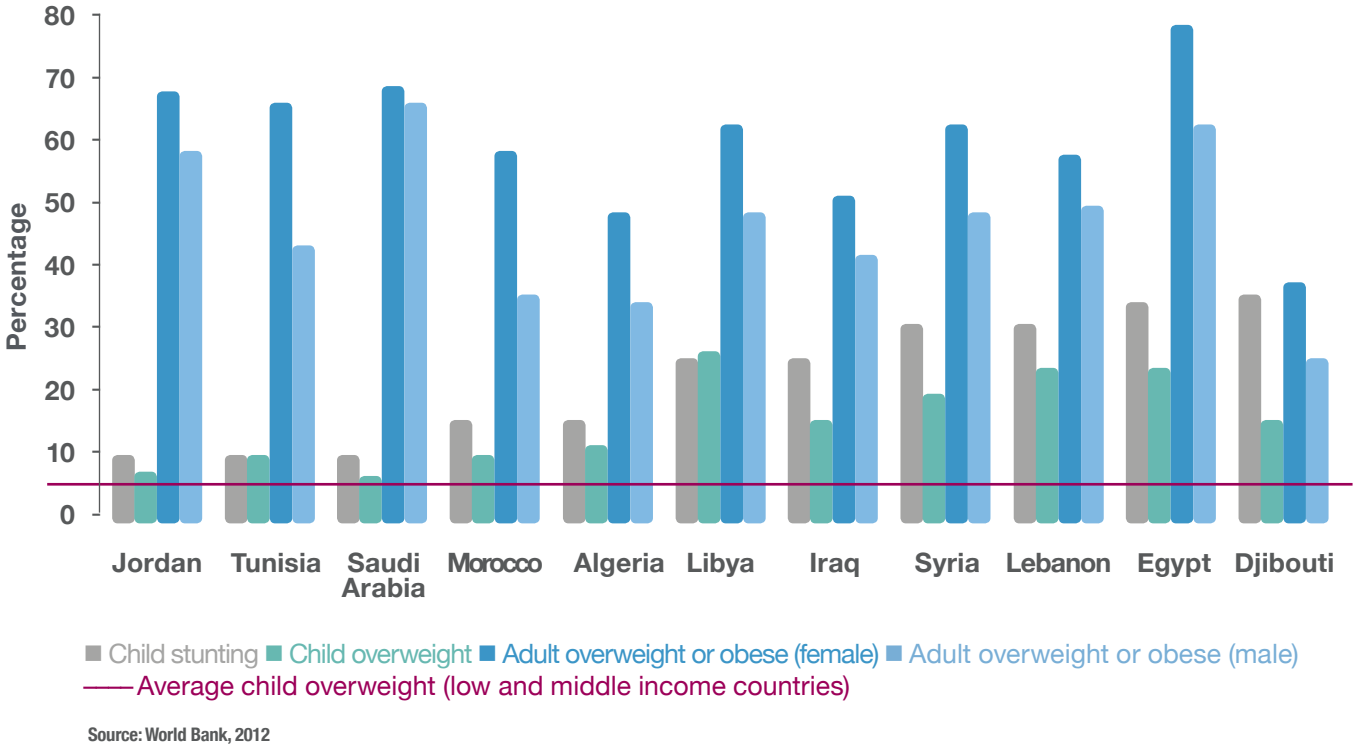
Source: Lozano et al., 2013

Voices of the people: Corruption

"You need to pay the staff to get good service... this is not a bribe, it is social assistance... look at how much those poor souls earn... next to nothing!"

Medical practitioner, Egypt

Figure 2.9. Dual burden of malnutrition among women and children in MENA



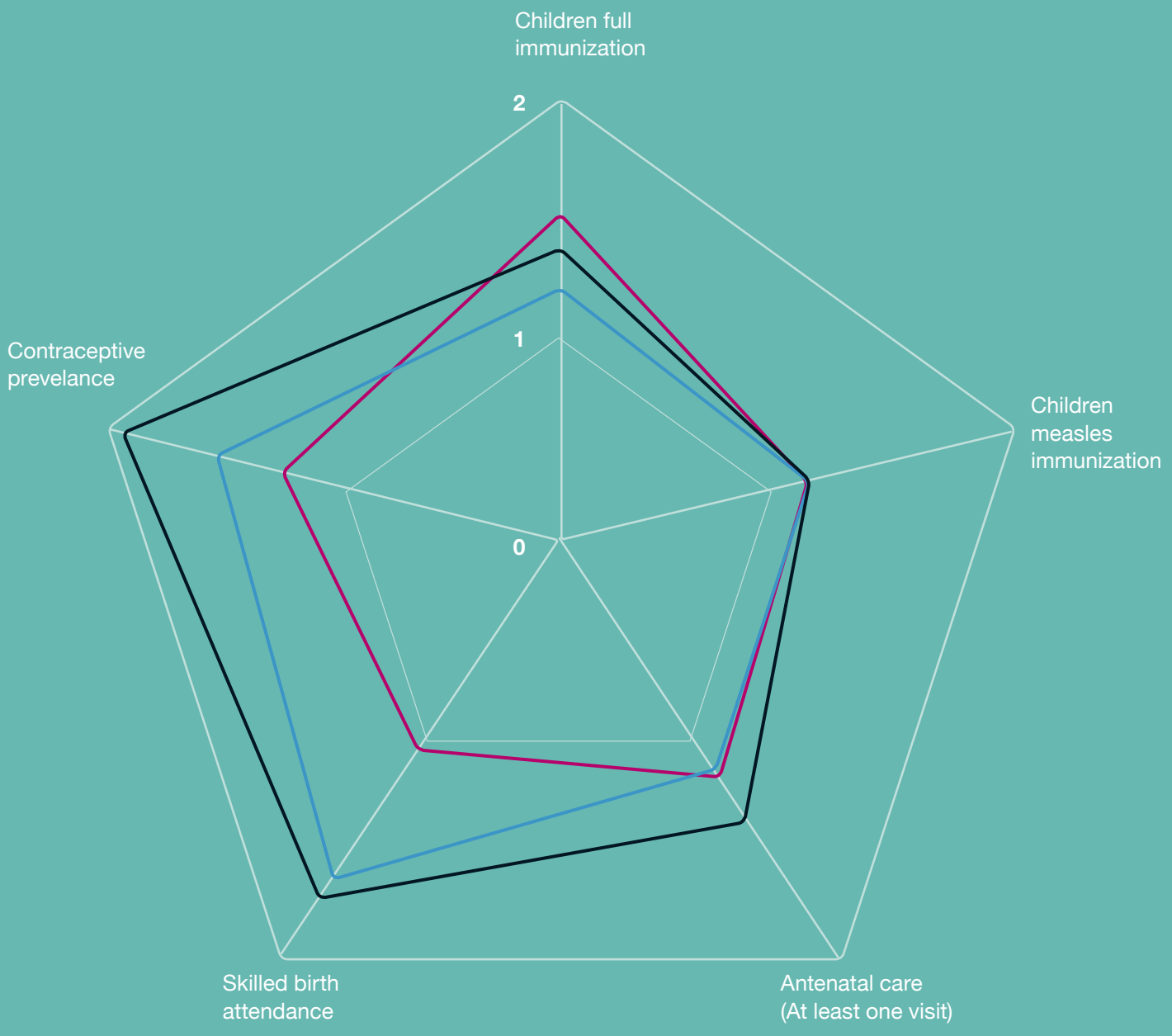
Source: World Bank, 2012

Voices of the people: Corruption

"The corruption in the health sector has not been addressed. Corruption in health and medicine is still present till this moment."

Young man, Yemen

Figure 2.10. Urban/Rural Ratios in Coverage



MENA* **Lower Middle Income***** **Upper Middle Income****

Unweighted averages (where available)

*** Djibouti, Egypt, Iraq, Jordan, Morocco, Syria, Yemen**

**** Azerbaijan, Belarus, Bosnia and Herzegovina, Brazil, Colombia, Gabon, Jamaica, Kazakhstan, Montenegro, Namibia, Peru, Serbia, South Africa, Thailand, Turkey**

***** Albania, Armenia, Belize, Bolivia, Cameroon, Congo, Côte d'Ivoire, Georgia, Ghana, Guatemala, Guyana, India, Honduras, Indonesia, Laos, Lesotho, Mongolia, Nicaragua, Philippines, Moldova, Senegal, Swaziland, Syria, Timor-Leste, Ukraine, Uzbekistan, Vanuatu, Viet Nam, Yemen, Zambia**

Source: World Health Organization, 2013.

Voices of the people: Pharmaceutical Quality

"The quality of medicines is so poor that I would not even buy a pack of paracetamol from a local pharmacy."

Senior government official, MENA country

workshops, study tours, platforms, and communities of practice. These include training on universal health coverage, maternal health, right to health, and pharmaceutical procurement. The World Bank Institute's Flagship Program on Health Sector Reform and Sustainable Financing brings government officials and practitioners together to discuss and learn about the current issues.

Analyzing the health sector through innovative products. Timely accurate information is a starting point for policy dialogue and helps build a country's ability to evaluate its health sector, health care policies, financial, management and program delivery systems, physical and human infrastructure needs, and governance practices. The Bank applies the latest tools to provide cutting-edge policy relevant economic and sector analyses and can advise governments in preparing technical documents, such as draft legislation, institutional development plans, country-level strategies, and implementation action plans.

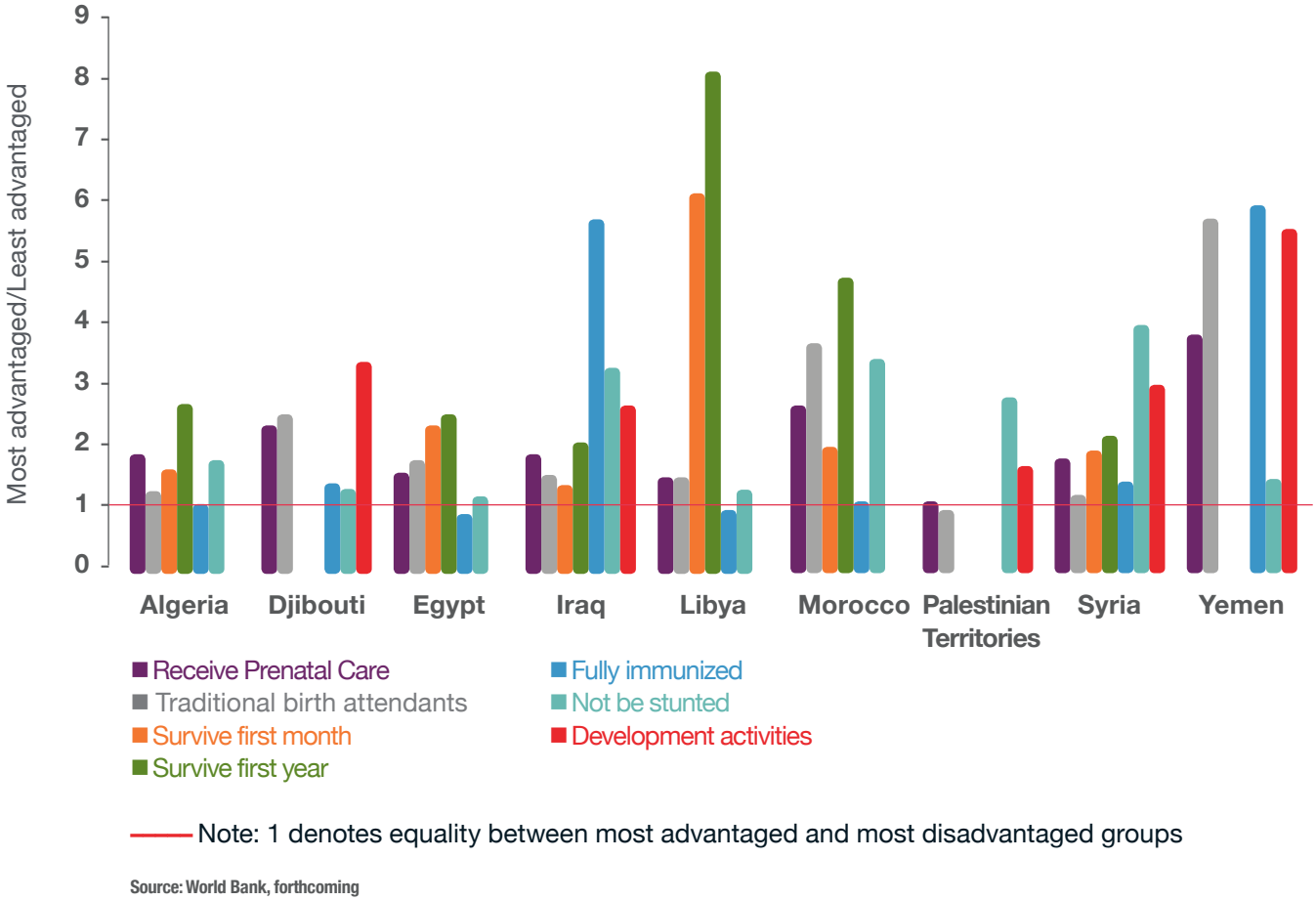
Determining effectiveness through impact evaluation. The Bank measures its results in poverty reduction through impact evaluations that assess change in the well-being of individuals, households, firms, or communities attributable to a project, program, or policy. Impact evaluations establish a demonstrated basis for improving ongoing programs and are essential to inform spending and prioritization decisions.

Providing innovative financial products situated to diverse needs. The World Bank funds three basic operations: investment operations, development policy lending, and Program-for-Results. Investment operations provide funding to governments through International Bank for Reconstruction and Development (IBRD) loans or International Development Association (IDA) credits and grants for specific economic and social development projects in many sectors. Development policy operations provide untied, direct budget support to governments for policy and institutional reforms to achieve specific development results. Program-for-Results operations support government programs by strengthening institutions and building capacity. The instrument links the disbursement of funds directly to the delivery of defined results.

Providing insight and expertise for the post-2015 MDG agenda. The World Bank is an active stakeholder in shaping the post-2015 agenda. The emerging consensus on health-specific goals suggests focusing on healthy life expectancy, reducing mortality, morbidity, and disability, emphasizing social, economic, and environmental determinants, and achieving universal health coverage. The World Bank is a global leader in this agenda with several flagship products, such as preparedness tools, courses, and analytical pieces, to support countries' efforts to achieve these goals.

Committing to supporting MENA in the short, medium, and long term. The World Bank is committed to supporting the changes in the region. It is responding to short- and medium-term economic challenges, and supporting policy and institutional reforms that channel the momentum of rapid political transformation into lasting improvements in governance, voice, and inclusion. Successful transformative change will fulfill the long-term potential of the MENA region, allowing the people to benefit from the many opportunities presented by the ongoing democratic and demographic transitions.

Figure 2.11. Income inequality in early child health indicators in MENA[3]



Source: World Bank, forthcoming

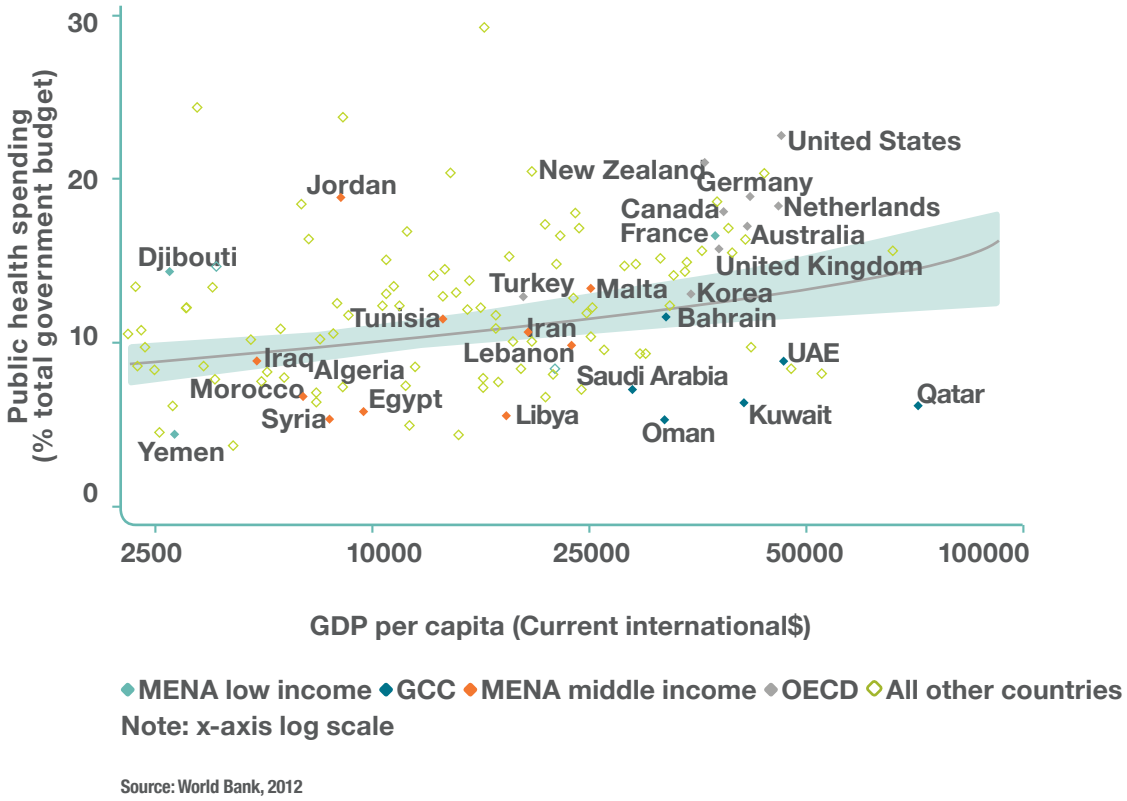
Voices of the people: Quality of care

"Honestly, there is a box at the clinic that says 'complaints,' but if you insert your complaint, the clinic director will open the box and throw it away."

Young woman, Egypt

3 The least advantaged individual lives in a rural area, has illiterate parents—or an illiterate household head and is from the poorest fifth of households. The most advantaged individual lives in an urban area, has parents or a household head with secondary education, and is from the richest fifth of households.

Figure 2.12. Public health expenditure as share of total government expenditure versus GDP per capita (2010)



Source: World Bank, 2012

Voices of the people: Quality of care

"A public hospital is where you lose your life... a private one is where you lose your money..."

Middle-aged woman, Egypt

Voices of the people: Quality of care

"We select a facility, not based on the quality of services, but based on whom you know."

Health professional, Cairo

Voices of the people: Access to care

"Basically there are no health services for the people."

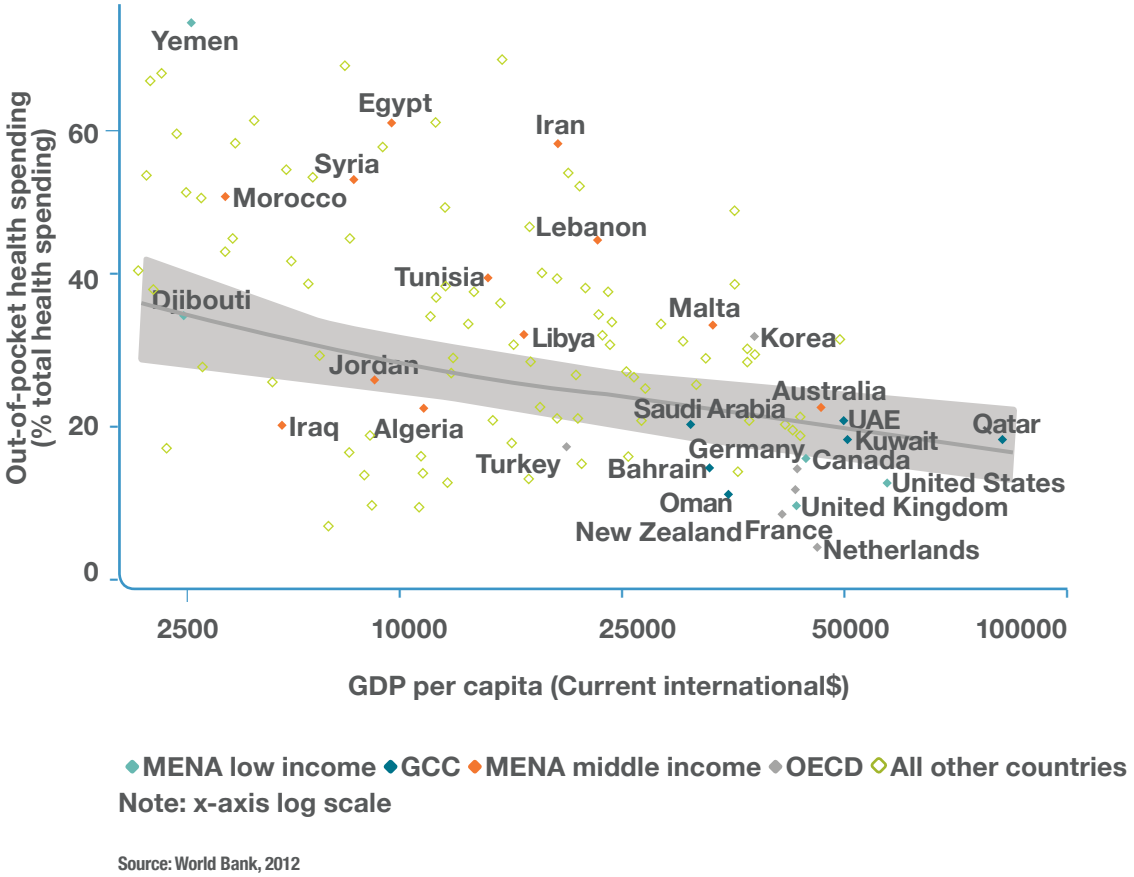
Young woman, Yemen

Voices of the people: Access to care

"I hope that in my lifetime I will see decent health care in my country–so I do not have to travel overseas for even a basic colonoscopy."

Senior government official, MENA country

Figure 2.13. Out-of-pocket spending for health care



Note: x-axis log scale

Source: World Bank, 2012

Voices of the people: Quality of care

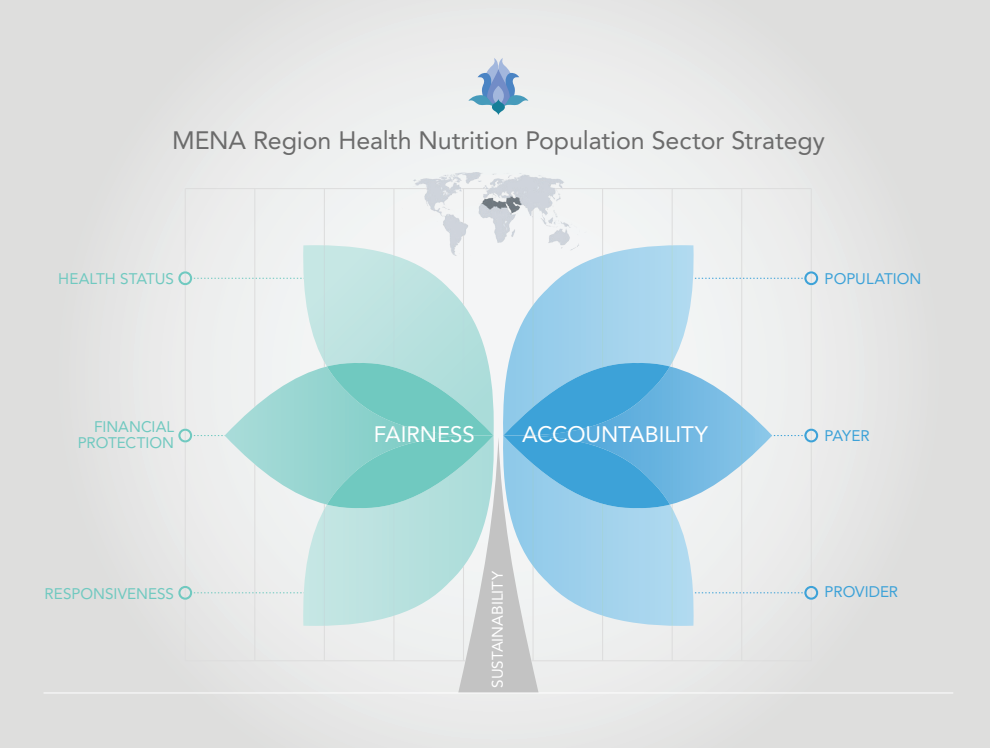
"Hospitals and clinics have very sophisticated equipment, but what good is that if they are not working half the time... Or even when my children need it?"

Middle-aged man, Egypt



3. How can MENA Health Systems be Made More Fair and Accountable?

Figure 3.1. Overarching framework of MENA HNP strategy



Applying the principles of fairness and accountability to build an effective and sustainable health system at the service of the people.

3.1. Creating an equitable health system for MENA

Encapsulating equity and efficiency through fairness. Fairness in health and health systems refers to the absence of systematic disparities in health that could be avoided through prevention and care; the just distribution of the burden of costs of health care according to people's ability to pay; and an equitable and timely response to the interpersonal needs, rights and expectations of those seeking and obtaining health care for a dignified interaction with the provider and the health system.

Fairness in achieving health system goals. The health system has three goals—health status, financial protection, and responsiveness (Roberts et al., 2003; WHO, 2000). This translates to health outcomes in level and equitable distribution, fairness in the burden of paying and financing health care, and equitable responsiveness to the needs of the entire population.

Targeting to reach vulnerable populations. To attain fairness in health outcomes, both in level and distribution, well-targeted mechanisms are necessary to provide services to those most in need. Targeted programs can ensure that health status, financial protection, and responsiveness can be increased for vulnerable populations. In MENA, vulnerability may take several forms. Depending on the context, it may encompass a dimension due to gender endangering health of women and children; age dimension, assuming that the youth, because of their perceived physical health or their reluctance to seek health counseling, do not have health and health care needs; place of residence, because of major inequalities in access to care in rural areas and poor urban settlements; the poor, who due to lack of health insurance are often un-

able to afford high quality care; ethnic and religious minorities, not necessarily by design, but rather because of the mismatch between their non-medical expectations which may vary from those of the majority; and refugees and internally displaced populations with special needs, who are often disadvantaged in accessing high quality and appropriate health care and have poorer health outcomes.

3.1.1. Fairness in health outcomes

Intensifying efforts on diseases of poverty. The poor in MENA bear a higher burden of disease—rates of infant mortality and maternal mortality are higher among low-income groups, and overall life expectancy is lower across and within countries. Diseases of poverty in the region include, among others, malnutrition, acute respiratory infections, diarrhea, and parasitic infections (e.g. schistosomiasis, leishmaniasis). Again differences in occurrence and mortality can be within a country or between countries. Malnutrition rates are higher in Upper Egypt than Lower Egypt, while schistosomiasis and parasitic infections are more prevalent in lower-income countries like Yemen.

Overcoming bottlenecks in maternal and child health. Regional declines in infant and maternal mortality at an aggregate level disguise the reality in vulnerable populations. The poor, the less education, and those living in rural areas continue to suffer a larger share of maternal and child deaths. Interventions must be prioritized to target these populations and increase their access to timely health care for example through the provisions of vouchers and conditional cash transfers.

Mainstreaming gender into NCD programs. Women have a higher burden of certain diseases than men. For example, obesity in MENA tends to be a gendered phenomenon partly due to social cultural norms that may make it more difficult for women to exercise regularly and have an active lifestyle. NCD country action plans should include interventions specially targeted to women.

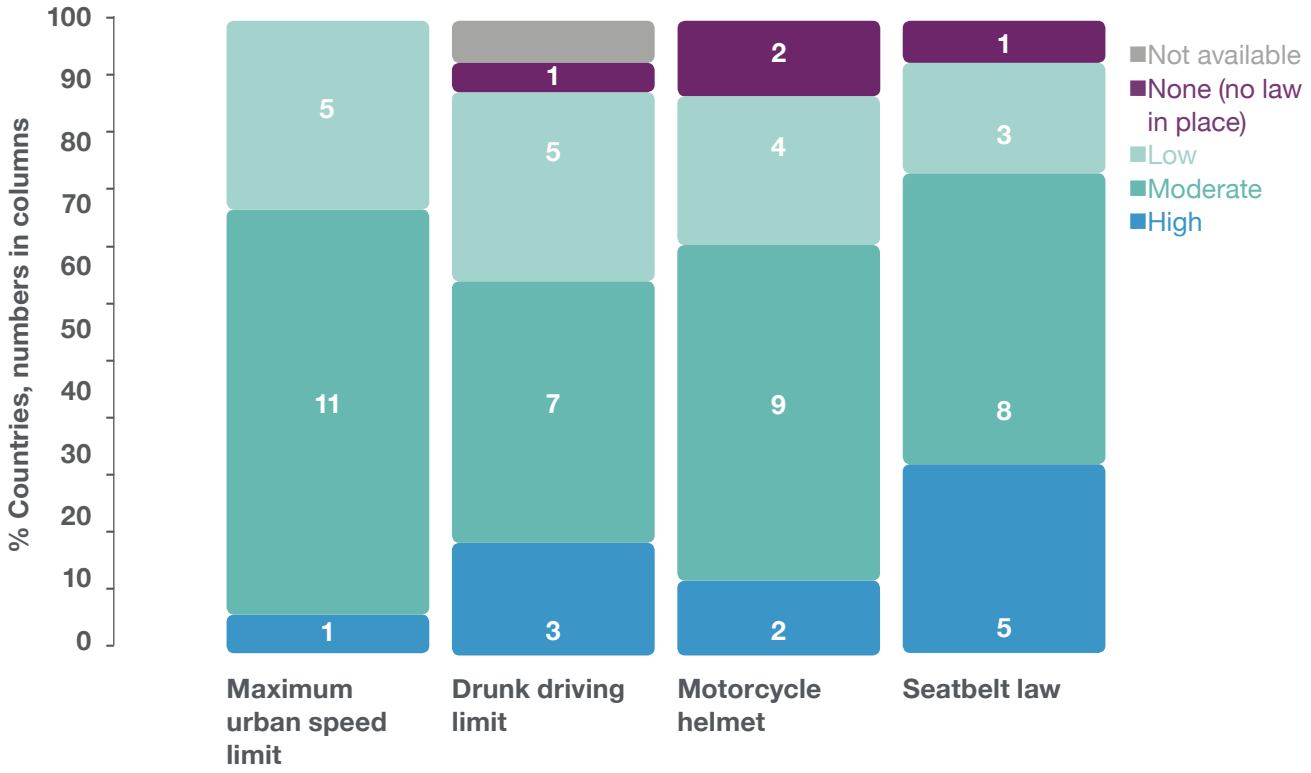
Addressing road traffic injuries in youth. Youth comprise a large subset of the MENA population and bear the highest burden of disease for some conditions. Road traffic accidents are the third highest killer in the region and the largest cause of disease and disability for male youth in MENA with also a high toll on children after their first year of life. Compliance with road safety legislation is low (Figure 3.2). Effective road safety interventions require inter-sectoral collaboration in transportation, infrastructure, enforcement, and emergency and trauma care.

Tackling high tobacco use by youth. High tobacco use is a risk factor for NCDs, with serious health consequences later in life (Figure 3.3). Tobacco use rates are rising fast among young women. The MENA region lags in implementing proven effective measures to curb smoking including promoting a tobacco-free environment including enforcing graphic labeling on packaging and taxing tobacco products (World Bank, 2010).

3.1.2. Fairness in financial protection

Increasing health coverage for vulnerable groups. While most constitutions in MENA enshrine the right to health care, many populations remain unable to access care. Groups lacking insurance or formal coverage include workers in the informal sector and in small and medium enterprises, the urban poor, and migrant workers (especially in the GCC). Given the effects of the economic crises, vulnerable groups are predicted to grow in the short term, making it imperative to scale up universal coverage.

Figure 3.2. Road safety compliance levels in 17 MENA countries, 2010



Source: World Health Organization, 2009b.
Note: Enforcement scores represents concensus based on professional opinion of respondents, on a scale of 0 to 10, where 0 is not effective and 10 is highly effective. "Low" refers to scores 1–3, "moderate" for scores 4–7, and "high" for scores 8-10. Numbers on bars represent number of countries.

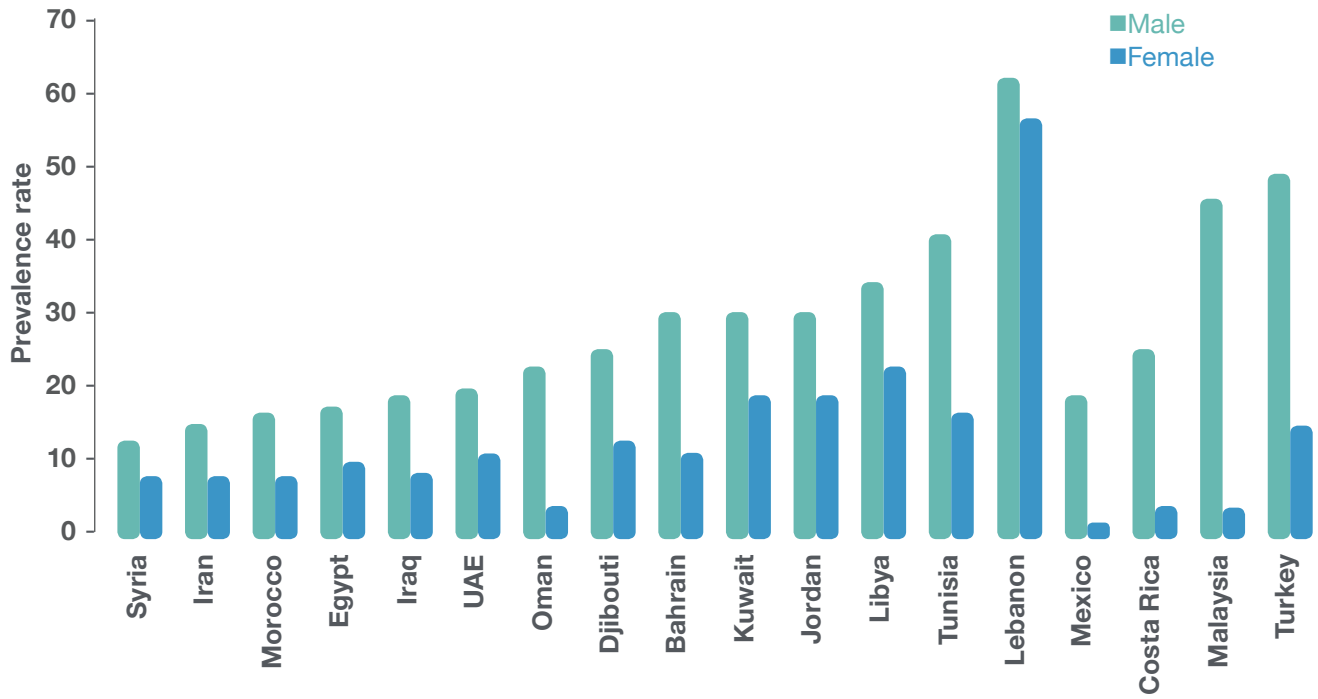
Reducing high out-of-pocket expenses. Out-of-pocket (OOP) expenses remain high in MENA, even for groups "covered" by health insurance schemes, often due to pharmaceutical expenses, informal payments, diagnostic services, as well as indirect costs (loss of revenue due to absenteeism, transportation costs, etc.) On average OOP payments account for about half of total health spending. Households pay an average of 6 percent of their total household expenditure on health, mostly on medications. Between 7 to 13 per cent of households have high OOP payments, or catastrophic expenditures equal to at least 10 per cent of household spending. Indeed, poverty rates may increase by up to 20 per cent after accounting for health care spending (Elgazzar et al, 2010).

3.1.3. Fairness in patient responsiveness

Responsiveness as referring to the interaction with the health system. Responsiveness refers to how people interact with the health system as a whole at a personal level, not only with the providers. As such it comprises eight domains which can be divided into the following interpersonal domains—dignity, autonomy, communication, and confidentiality, and structural domains—quality of basic amenities, choice, access to social support networks, and prompt attention (Murray and Evans, 2003).

Evaluating responsiveness using a rights-based approach. Human rights, as recognized under international law, embodies a number of core principles, including participation, accountability, non-discrimination, and transparency—domains that map to the responsiveness of health systems. Incorporating a human rights perspective

Figure 3.3. Smoking prevalence among MENA youth, 2008



Source: World Bank, 2010

in the provision of health services requires a paradigm shift from satisfying needs to fulfilling rights and can help improve responsiveness of health systems.

Creating more responsive systems through training, regulation, and feedback loops. Anecdotally, and from the few studies available, the responsiveness of health care is perceived to be below standard in MENA. International experience has shown that the responsiveness of health systems can be improved by training of providers and administrators, implementing patient sensitive regulation such as creating a patient's bill of rights, setting up complaint mechanisms, and carrying out beneficiary surveys.

3.2. Creating an accountable health system for MENA

Defining accountability as responsibility and answerability. Accountability refers to the obligation to demonstrate and take responsibility for performance to ensure that health care services are timely, effective, safe, appropriate, cost-conscious and patient-centered. The nexus of accountability in health care governs the interaction among three key players-- people, payers, and providers. The concept of accountability goes beyond being responsible for proper allocation, disbursement and use of financial resources–it also includes responsibility for respecting existing rules and regulations, performance standards and agreed results to gauge health system performance, and answerability to the people in a pluralistic institutional and political platform in alignment with prevailing societal values and choices and expectations for participatory and representational health system governance (Brinkerhoff, 2003; Siddiqi et al, 2009; Veillard et al, 2011).

Compromising accountability due to asymmetric information. While accountability is important in all spheres of public life, it poses specific challenges in the health sector because of the asymmetry of information between providers, payers, and the users of health services; the often non-discretionary nature of the need for health care; and the divergence in the interests and incentives of public and private stakeholders.

Basing accountability on a platform of transparency. Since the collection, use, and dissemination of information is essential to eliminate corruption, fraud, and waste; ensure appropriate and quality care, and is the basis of an accountable health system, the production of information and the process of transparency underlie all accountability efforts. The collection, analysis, and use of information as a routine part of the health system's functioning constitute an integral foundation on which to build an accountable system and to benchmark comparable health systems.

Tracking emerging epidemics with epidemiological surveillance. MENA requires an epidemiological surveillance system to track hidden epidemics, identify emerging infections, and predict future epidemics before they take hold. This system is especially relevant for nascent epidemics like HIV that can spread quickly, or for newly emerging zoonotic diseases.

Monitoring health care delivery through routine systems. Routine monitoring systems allow the systematic tracking of health inputs and outputs. By setting up health management and information systems (HMIS), the delivery of health care can be tracked in real time. Monitoring allows resource allocation to be more efficient and identifies gaps and weaknesses in service delivery.

Tracking health expenditures to ensure efficiency. Tracking the flow of health expenditures through a system of national health accounts aids transparency and efficiency. It also identifies and curtails waste, fraud, and corruption. The World Bank supports public expenditure tracking surveys (PETS) and Quantitative Service Delivery Surveys (QSDS), which can be used to follow the flow of funds in a health program. These systems track governance quality, public expenditure efficiency and equity, and service delivery performance.

Gauging health program effectiveness through impact evaluations. Evaluation of health projects must occur during project implementation and not as an afterthought. Building evaluations into the design and implementation of health interventions enables the gauging of cost effectiveness and population-level impact of interventions.

3.2.1. Accountability to the people

Providing transparent information and grievance redress mechanisms. Accountable health systems provide beneficiaries with full transparent information, including informing beneficiaries if they are covered for health related expenses, the level of expenses covered, and what expenses are not covered. Grievance redress mechanisms are included which ensure that patients can demand their rights and provide feedback to providers about service delivery.

Making patients' aware through Bill of Rights. Patients' Bill of Rights (PBR) improve quality of health care and promote health systems accountability to beneficiaries. The PBR consists of a contract between the patient and provider detailing what services and standards of care a patient can expect at a health facility. This includes the right to safe, effective, patient centered, timely, efficient and equitable care, including availability of essential drugs, presence of physicians during working hours, appropriate staffing of auxiliary health staff, privacy and confidentiality, and the ability to seek services without informal payments. In return, patients are expected to maintain appointments, behave in an orderly manner, and adhere to treatment guidelines. In theory, PBRs are available in some MENA countries, but awareness appears limited (Alghanim, 2012).

Promoting social accountability through Citizens' Report Cards. Introducing a Citizens' Report Card to improve health service accountability is a multi-stage process. Local citizens' surveys determine their experience at the local health facility. The data is benchmarked to comparator areas. The results are shared with citizens and then providers. They then agree on a compact that establishes provider actions and how citizens can work with providers to improve health service delivery.

Defining minimum health benefits package to assist the most vulnerable. The right to health care is enshrined in the constitutions of most MENA countries. As part of the global movement towards universal coverage, Tunisia, Morocco, Egypt, and GCC countries are striving to increase health coverage. Global evidence with scale up of universal coverage suggests that accountability is enhanced when governments or regulatory bodies define minimum benefit packages. These serve to protect the most vulnerable from the effect of catastrophic payments and help define the term "health insurance coverage."

Tracking patient safety information to improve quality. Patient safety issues are not national priorities in most MENA countries. Key indicators such as adverse drug effects, nosocomial infection, and other iatrogenic errors are not monitored regularly or publicly reported. The magnitude of the problem therefore remains largely unknown. Most countries have introduced some standards for clinical guidelines and protocols. But few countries have prioritized the development of national guidelines based on epidemiological trends analysis or linked the guidelines to performance evaluation and payment or resource allocation mechanisms (World Bank, 2010).

3.2.2. Accountability of payers

Delivering efficient health care for payer accountability. Payers can be held accountable through a compact with providers and patients. The payer is aware of the value for each health care dollar spent and has mechanisms to negotiate payments. Providers and patients in turn have bargaining power with payers if information is available and transparent.

Incentivizing prevention and primary care. Incentives can be applied to inter-sectoral policies for behavioral risk factors like tobacco use, physical inactivity, risky driving, and inappropriate diet. Interventions to improve an individual's health like screening, counseling, and primary care services for behavioral change are cost effective, especially if well targeted to high-risk populations, and if indirect costs due to productivity loss are tallied (Jamison and Bank, 2006).

Prioritizing primary prevention through leadership. The region has high literacy rates and good media coverage, which can facilitate mass public information education and communication (IEC) programs. School enrollment rates are high for targeted school based interventions on tobacco control, diet, and nutrition. Institutional capacity for improved road safety exists. Leadership is essential to establish vision and strategies for effective advocacy for healthier public policies.

Reducing cost through pharmaceutical reform. Pharmaceutical costs are a major driver of high OOP expenses. Introducing reforms, such as the creation of eligible drug lists and formularies and preventing the counterfeiting of drugs, can keep costs low and improve the quality of medicines. Creating centralized systems for pharmaceutical procurement in GCC can reduce costs. Harmonizing generic drug regulation at the regional or sub-regional levels will mainstream and monitor generic drug policies in health operations.

Reducing health system fragmentation to enhance accountability. Fragmented health systems in MENA create inefficiencies. Separating health care payments from health provision can reduce costs by making insurance funds independent of the Ministries of Health and creating management boards to be held accountable to.

3.2.3. Accountability of providers

Employing incentives to increase accountability of providers. A health system in which providers are held accountable is cognizant of the patient's and population's needs and is structured to provide incentives to providers to fulfill those needs. This is important to reorient the system from a curative to a preventive system, from a system of sickness to one focusing on promoting and preserving the health of the population.

Planning to meet human resource needs. Workforce planning is necessary to assess the human resource needs of the health system and then train the workforce in the necessary skills. Tertiary and vocational education programs need to train youth to increase skilled community health workers, social workers, and lab technicians filling HRH gaps and reducing youth unemployment. Incentives can be used to attract and retain providers to rural areas and prevent their rapid exodus. Continuous training and accreditation systems are needed to maintain quality standards region-wide.

Training providers for the rising NCD burden. In most MENA countries, the burden of disease is shifting to non-communicable diseases. Health systems must adapt to this growing challenge. High-performing health systems prevent ill health, prioritize primary health care, use information technology to improve coordination, and teach patients to self-manage their conditions (Ham, 2010). Nurses can play a pivotal role in the prevention, treatment, and management of NCDs.

Providing incentives to improve quality. To improve quality of care, physician incentives need to be better understood in the system's context. Means to incentivize physicians include pay for performance systems in which physicians are reimbursed based on the achievement of certain outputs and quality standards, e.g. correctly prescribing medications and performing basic diagnostic algorithms.

3.3. Creating fiscal and political sustainability for MENA

Rooting a fair and accountable system in fiscal and political sustainability. The burden of NCDs and an ageing population will increase the demand for health care. Coupled with shrinking fiscal resources this will require a health system to be sustainable and anticipate future needs, prioritize how to meet those needs, ensure regular funding flows to support them, and innovate efficient methods to keep health costs in check. Political will must be transformed into institutional sustainability to maintain the momentum of reform.

Creating fiscal space to allow for sustainability. Fiscal space in MENA countries is unlikely to widen for the health sector from economic growth in the short run. Allocating a larger share of government revenues to health and/or expanding the revenue base for health is possible by contributory or earmarked tax revenues, e.g. sin taxes applicable to tobacco, alcohol, and unhealthy food products, and by increasing the health system's efficiency by focusing on preventive health care.

Prioritizing expenditure for the most vulnerable. With current economic contractions, health funding must be prioritized, especially in non-GCC countries. To prioritize expenditures based on burden of disease, cost effectiveness, and political considerations, the World Bank can assist MENA governments in a transparent and consultative priority setting exercise.

Reducing segmentation in health insurance pools. The region has segmented health systems and multiple risk pools operating independently, with limited coordination or harmonization of rules across the different funds. The segmentation increases the administrative complexity and overall health system costs and creates barriers to citizens' mobility in the labor market. It also hinders risk sharing between the healthy and the sick, the rich and the poor, and the young and the old. Introducing consistent and transparent rules and regulation across the different health funds or health subsystems will facilitate monitoring and evaluating of the different risk pools.

Creating political and institutional sustainability to ensure continuity. While political champions are critical to initiating a reform process, political and institutional sustainability is necessary to ensure that the reform agenda is maintained. Stakeholder analysis and mapping exercises are useful to understand the political landscape and to chart the committed key players necessary to ensure the sustainability of reforms.

3.4. Summarizing recommended interventions for fairness, accountability, and sustainability

Mapping recommended interventions to health system functions. A health system has four major functions—stewardship, financing, resource generation, and service delivery, each with a set of sub-functions. Mapped to each function are specific interventions to realize the principles of fairness and accountability (Table 3.1).

Table 3.1. Means to build fair, accountable, and sustainable health systems

	Potential areas of assistance for improved fairness and accountability		
Health system functions	**Domains/ sub-functions**	**Financial assistance**	**Technical assistance**
Governance/ Stewardship	**Vision, strategy and policies for better health**	**Technical Assistance (TA) loans/credits/ grants**	**Analytical and advisory assistance to Ministries of Health for issuance of long term sectoral vision statements and mid- and long-term sectoral development strategy and investment plans.**
	Health in all Policies (HiAP); advocacy and influence across all sectors for better health	**Policy based lending (loans/ credits/grants)**	**Analytical and advisory activities leading to multi-sectoral policy design and interventions on tobacco control, road traffic injuries, healthy diet and physical activity.**
	Good governance supporting achievement of health system goals	**TA loans/ credits/grants**	**Analytical and advisory support for consensus, ownership and shared accountability (e.g. formulation of national charters for health and health system, White Papers); decentralization; and public administration reform.**
	Alignment of system design with health system goals	**Policy based lending (loans/ credits/grants)**	**Analytical and advisory support for institutional (re)alignment towards achievement of universal health coverage (i.e. harmonization of functions and entitlements, virtual or institutional merger of various insurance schemes, financial management); and higher performance in health care (i.e. accreditation of health facilities, licensing of health professionals); and essential public health functions (i.e. disease preparedness and response)**

Table 3.1. Means to build fair, accountable and sustainable health systems

	Potential areas of assistance for improved fairness and accountability		
Health system functions	**Domains/ sub-functions**	**Financial assistance**	**Technical assistance**
Governance/ Stewardship	**Make use of legal, regulatory and policy instruments to steer health system performance**	**Policy based lending (loans/ credits/grants)**	**Analytical and advisory support for drafting, review, and implementation of judicial and regulatory pieces (i.e. laws, decrees, circulars, procedures, guidelines, protocols, etc.) pertaining to health care and public health (i.e. defining eligibility/entitlement criteria for health care coverage, technical standards and specifications for facilities and services, defining basic benefits package, tobacco taxation, food and nutrition guidelines, environmental health air and water quality standards, etc.)**
	Generate, compile, manage, apply and disseminate health intelligence and evidence	**Investment (IPF) and Program based Results (P4R) lending**	**Technical support for epidemiological surveillance (i.e. bio-behavioral surveillance for HIV/AIDS and (re) emerging diseases); design and implementation of health information management systems (HIMS); and of other instruments and tools (e.g. quality of care and cost assessment for tracer conditions, PER, PETS, BIA and QSDS); impact evaluation; and Citizens' Report Cards.**
Financing	**Sources of funds and revenue collection**	**Policy based lending (loans/ credits/grants)**	**Analytical and advisory support for a fair, transparent and accountable distribution of the entitlements and the burden of financing through state, and other public and private sources of funding (e.g. tax-based - income, consumption, sin taxes, or contributory); fiscal space assessment; medium term expenditure frameworks; open budgeting; definition of the boundaries for complementary and supplementary private insurance; definition of user fees and co-payments for specific services; monitoring financial risk and burden of private health expenditures on households, including impoverishment, as a result of catastrophic health expenditures.**

Table 3.1. Means to build fair, accountable and sustainable health systems

	Potential areas of assistance for improved fairness and accountability		
Health system functions	**Domains/ sub-functions**	**Financial assistance**	**Technical assistance**
Financing	**Pooling**	**Policy-based and investment lending (IPF)**	**Analytical and technical assistance towards the virtual or structural merger of public, para-public health insurance schemes, assessment of inter-populational and inter-generational fairness in the distribution of tax- or premium-based contributory schemes and out of pocket payments according to different segments of the populations' capacity to pay with a view to universal health coverage.**
	Purchasing/ contracting/ provider payment	**Policy-based lending**	**Policy-based lending and analytical and advisory assistance for institutional and managerial arrangements for the separation of functional responsibilities (oversight/regulatory, purchasing/ payment and service provision); modes of provider payment (e.g. salary, fee-for-service, capitation, DRGs, etc.) and their impact on access, use, productivity, comprehensiveness, continuity and quality in health care and in overall system performance; transition from passive payment to active purchasing; public administration reform and decentralization.**
Resource Generation	**Health care technologies (medical equipment, consumables, pharmaceuticals, IT hardware and software)**	**Policy-based, investment (IPF) and P4R lending**	**Technical assistance for procurement and distribution of medical devices pharmaceuticals, price setting, essential drug lists, rational use of pharmaceuticals, health care technology assessment, cost-effectiveness and cost-benefit analysis, use of ITC in health care (tele-health, e-health, e-prescription and e-invoicing, etc).**

Table 3.1. Means to build fair, accountable and sustainable health systems

	Potential areas of assistance for improved fairness and accountability		
Health system functions	**Domains/ sub-functions**	**Financial assistance**	**Technical assistance**
Resource Generation	Human resources	P4R and investment (IPF) lending	Technical assistance for production, deployment, in-service and formal training, licensing and retention of health professionals, especially incentivizing providers in rural areas; training primary care teams to manage NCDs; developing managerial and technical cadres for health care management.
Service Delivery	Population health	P4R and Results-based Financing (RBF)	Analytical and advisory assistance for health promotion (e.g. smoking, proper diet and nutrition, physical activity, food safety and security, water supply and sanitation, prevention and control of occupational and environmental health hazards, etc.) and disease prevention (e.g. obesity, hypertension control, etc.) disease-specific interventions e.g. HIV, avian influenza, parasitic diseases such as schistosomiasis and leishmaniasis).
	Primary care	P4R, RBF and investment lending	Technical assistance for maternal and child health and nutrition (voucher schemes, unconditional and conditional cash transfers (CCTs)); investment in primary and emergency care facilities in rural underserved areas; standard treatment protocols and disease management programs for most prevalent NCDs.
	Curative/ rehabilitative care	P4R, RBF and investment lending	Technical assistance to improve access to high quality inpatient and emergency care in underserved areas; assessment of quality of care and costing of major inpatient episodes of care; and hospital management.



4. What World Bank Products Will Improve Fairness and Accountability in MENA?

World Bank financial, technical and capacity building products to address key health issues relevant to MENA countries.

The World Bank has worked for decades to improve the health sector in over 150 countries.[4] This expertise can contribute to incorporating fairness and accountability into MENA's health systems and health states.

To translate the principles of fairness and accountability in the health sector, the World Bank offers a broad range of financial and non-financial products to help countries achieve their HNP goals. For example, to improve fairness in the health system the Bank has funded programs for expanding health services for underserved groups, improving maternal and child health, and expanding health insurance for the poorest. To improve accountability, it has provided financial, technical, and training products to support institutional reform, capacity building programs, and social accountability.

This section highlights global examples of the World Bank's engagement in key health issues facing MENA countries—non communicable diseases, malnutrition, early childhood development, provider payment mechanisms, governance in health systems, and maternal and child health—based on a mix of financial, technical, and training assistance (provided through the World Bank Institute).

4.1. Non communicable diseases (NCDs)

4.1.1. Financial products

Most investment projects include components on policy development, disease and risk factor surveillance, prevention interventions, and improved clinical management of NCDs. In China, the Health Seven Project introduced state-of-the-art behavioral risk factor surveillance surveys and implemented innovative NCD interventions targeting at-risk behaviors, which served as a forerunner to a national NCD intervention program.

Policy reforms supported by Development Policy Loans (DPLs) also can support NCD planning. DPLs can assist with strategy development, capacity building, including changing service delivery models and human resources management, and by reducing government subsidies and/or raising taxes on NCD determinants such as tobacco and alcohol.

4.1.2. Technical products

Numerous studies exist to respond to NCDs at global, regional, and country levels. The World Bank provides technical assistance to support national diagnoses of NCD risk factors and prevention and control plans. It has supported regional workshops for countries to share strategies to cope with increased NCDs.

4 A detailed listing of World Bank support in the HNP sector can be found at http://www.worldbank.org/en/topic/health

4.2. Emerging infectious diseases (EIDs)

4.2.1. Financial products

The Bank supports countries' response to disease specific EIDs by strengthening the overall public health system. Clients often use Bank-supported projects as platforms to pilot innovative measures before scaling them up nationwide. In emergencies, a streamlined process gives client countries timely access to financial resources and technical assistance. In 2004, the Bank prepared the "SARS and Other Infectious Diseases Response Project" in China in only seven weeks.

4.2.2. Technical products

Strategy development, policy options, tool development, impact assessment, introduction of new methods and systems, evaluation, and dissemination of best practices are some of the Bank's available technical products. Since 1998, World Bank staff have written over 500 technical reports on HIV/AIDS, including "Characterizing the HIV/AIDS Epidemic in the Middle East and North Africa: Time for Strategic Action".

The Bank helps clients' access financial resources by coordinating assistance among donor agencies at global, regional, and country levels. The Bank created two mechanisms to prevent epidemics of Highly Pathogenic Avian Influenza (HPAI)–the Global Program for Avian Influenza (GPAI), and the Avian and Human Influenza Facility (AHIF). Countries can access loans and credits through GPAI and grants from HPAI with a fast-track procedure.

4.3. Malnutrition

4.3.1. Financial products

The Bank provides financial support for a range of nutrition initiatives, such as micronutrient supplements for children, micronutrient fortification, deworming, and other nutrition programs at schools, and community-based nutrition promotion. It spearheads the Scaling Up Nutrition (SUN) initiative to expand nutrition programming, especially in countries with a high burden of malnutrition and leverages its global expertise in governance, social protection, agriculture, education, and health to work with clients to reduce malnutrition with a coordinated multisectoral response. In addition, it has financed and supported programs focusing on pregnancy and the first two years of life (first 1,000 days), many of which rely on community-based integrated approaches. In Yemen, the Bank is supporting a comprehensive package of integrated nutrition interventions targeting acute malnourished children in the poorest and most affected areas. The integrated approach fulfills the local communities' demand to increase utilization rates at adequately supplied health facilities to manage referred cases of severely malnourished children based on nationally approved criteria and guidelines.

Mainstreaming nutrition into agriculture and rural development is a key area of Bank engagement. The Djibouti Crisis Response Employment and Human Capital Social Safety Nets Program combines short-term employment with nutrition interventions for the poor and vulnerable. In Yemen, the Bank will pilot the introduction of conditional cash transfers in selected areas in Hodeida to determine the transfers' impact on increasing service utilization, nutrition knowledge, and household behavior change.

4.3.2. Technical products

The Bank's economic sector work (ESW) has assisted many countries in understanding trends and patterns of malnutrition, to assess the economic rationale for investing in nutrition, and to determine the characteristics of effective nutrition programs for their country. The Bank has championed nutrition-sensitive agriculture policies to maximize the impact of nutrition outcomes for the poor, while minimizing the unintended negative nutritional consequences of agricultural interventions and policies, especially on women and young children.

4.4. Early childhood development

4.4.1. Financial products

The World Bank has financed and supported a number of ECD-focused programs including community-based interventions that target the most vulnerable children, focusing on improving early stimulation and nutrition through parenting education; integrating informal early childhood opportunities into existing services for women and families; and promoting preschoolers' health, nutrition, and school readiness. Multisectoral and decentralized projects have been designed to increase coverage of ECD activities and foster institutional integration of the ministries involved.

4.4.2. Technical products

The World Bank provides a number of technical products to address ECD. The System Approach for Better Education Results—Early Childhood Development (SABER-ECD)—utilizes a comprehensive approach for multi-sectoral data collection and analysis to assess existing policies for establishing an enabling environment for ECD.

4.5. Maternal and child health

4.5.1. Financial products

The World Bank offers innovative support for countries seeking to improve maternal and child health (MCH). In Yemen, the World Bank financed the delivery of MCH services in poor rural areas through its Health and Population Project (USD 35 million). It funds the Yemen's Safe Motherhood Project (USD 4 million), which provides output-based disbursements to NGOs and the private sector for a package of quality maternal care for poor women. The Improving Health Sector Performance Project in Djibouti (USD 7 million) supports improved delivery of MCH services by incentivizing public providers using performance-based financing mechanisms globally.

4.5.2. Technical products

A current World Bank initiative is learning events for policy makers and other stakeholders to share how MCH goals can be reached by increasing access to services and improving service delivery through results-based financing mechanisms.

4.6. Expanded access and universal health care

4.6.1. Financial products

The World Bank has been a strong supporter of countries seeking to expand health care coverage. In Mexico, the Bank financed the *Seguro Popular* program, which provides health insurance to more than 50 million Mexicans.

The most recent loan of $1.25 billion supported the addition of 10 million beneficiaries to the program and helped Mexico achieve universal health coverage.

4.6.2. Technical products

The World Bank provides a range of technical assistance products to support health coverage expansion, including the universal coverage assessment tool (UNICO), and the universal coverage capacity assessment tool (UNICAT). These tools help countries determine their readiness for implementing universal health coverage reforms and provides global comparisons and benchmarks based on an extensive study of the experiences of countries that have significantly expanded coverage.

The World Bank Institute's (WBI) provides a one-week training course for health policy makers, "The Challenge of Universal Health Coverage–Health System Strengthening and Sustainable Financing." This course is offered in collaboration with Harvard University experts and is targeted to mid-level and high-level health and finance policy makers around the world.

4.7. Provider payment systems

4.7.1. Financial products

The World Bank has extensive experience providing financial support to initiatives to improve provider payment systems. In Turkey, it has been financing a ten-year program aimed at increasing the effectiveness of the Social Security Institution and assisting the Ministry of Health in formulating and implementing reforms in provider payments and health system performance, with a focus on output-based financing mechanisms. In Ghana, the Bank has been assisting the Ministry of Health to improve its insurance schemes by piloting a capitation scheme, reviewing the current case-mix (diagnosis related groups) payment mechanism, and exploring options to streamline and improve its efficiency and management.

4.7.2. Technical products

The World Bank also offers technical support in provider payment systems. In collaboration with several partners, it developed a guide to assess the current provider payment situation, and a "how-to manual" for designing and implementing health care provider payment systems.

4.8. Governance and accountability

4.8.1 Financial products

The World Bank has financed a number of programs in several countries, which focus on improving governance and accountability in health care service delivery, mainly through its Program for Results (P4R) instrument. It has also supported efforts to strengthen participatory decision making and accountability using information and communication technology solutions. In Brazil, the Bank's Open Development Technology Alliance (ODTA) supported financial operations in which mobile short message service (SMS) was used to invite, mobilize, and sensitize populations around participatory budgeting. In the area of promoting citizen feedback on public service delivery, call centers were used to vet client satisfaction with the quality of maternal and child health (MCH) services. In India, a system relying on the use of personal digital assistant (PDAs) was used to monitor client satisfaction with maternal health services.

4.8.2. Technical products

The World Bank has a number of non-financial products that support better governance and accountability. WBI has supported the creation and capacity development of multi-stakeholder coalitions, focusing on governance and social accountability in health, using a rights-based approach. This initiative is being implemented in Uruguay, Costa Rica, and Brazil. To strengthen transparency and access to information, the World Bank has supported several initiatives, such as the mapping of health results; the Open Data Initiative; and the health "BOOST"—an analytical tool that can be easily used by government and citizens to examine trends in resource allocation and utilization.

4.9. Fiscal space

4.9.1. Financial products

Development Policy Loans have supported policies to increase the allocation of public spending to the health sector and introduce new payment mechanisms for providers. Reforms supported by these operations have included introducing purchasing arrangements between health insurance agencies and hospitals, pharmaceutical pricing and reimbursement policies to improve efficiency, and increasing resources to primary care and prevention as a share of public spending. In MENA, Bank-supported reforms in Tunisia have included policies to strengthen public expenditure monitoring and access to information on budget allocation and execution. Performance contracts also have been introduced to improve efficiency of resource use.

4.9.2. Technical products

The Bank has provided technical assistance to assess and improve fiscal space through policy and technical analysis. The Bank has developed tools to improve economic evaluations of health system sustainability, such as Public Expenditure Reviews (PER), which assess overall spending patterns and fiscal space constraints; Public Expenditure Tracking Surveys (PETS), which assess the degree of efficiency and equity in public service delivery; and Health Reform Options Simulation Toolkit (HROST), which provide actuarial modeling and simulations of the impact of various reform options on the future. These tools have been used by most countries worldwide. In MENA, the Bank has provided technical assistance on National Health Accounts (NHA), health insurance evaluations, and PERs in Morocco, Tunisia, Egypt, Lebanon, Libya, and Jordan.

4.10. Quality of health care

4.10.1. Financial products

Shifting the emphasis from improving infrastructure towards instituting incentives and policies for providers to maximize quality and value-for-money—the "citizen-oriented" platform—is a paradigm shift for the MENA health sector. Countries launching quality improvement strategies for the health sector tied to provider incentives have generally been more successful at generating and sustaining improvements than those that have taken a more traditional, infrastructure-focused approach.

The World Bank has supported a number of lending operations in middle-income countries and grant-financed projects in low-income countries that adopt similar approaches through "results-based-financing" (RBF) and "program-for-results" (P4R) operations. Projects include Brazil's *Bolsa Familia* and Health System Improvement Project and Argentina's *Plan Nacer* Project on maternal and child health. Other projects support Mexico's *Opportunidades* Program and Indonesia's and Yemen's Safe Motherhood Projects. Tunisia's Governance

Opportunity and Jobs Development Policy Loan supported the introduction of accreditation to certify performance and quality in service delivery. The Bank is supporting similar accreditation and certification programs for Indonesia's Health Professional Education Quality Project and India's Uttar Pradesh Health Systems Strengthening Project.

4.10.2. Technical products

The World Bank, through technical assistance and capacity-building programs, supports knowledge exchange on global best practices and technical training for strengthening quality through good governance. Technical assistance in Tunisia, Morocco, Egypt, and Lebanon has included training and analysis on accreditation mechanisms, performance monitoring, contracting, and health insurance reform options.

These are just a sampling of Bank ways in which expertise in fairness and accountability can be used to improve health systems and health status in populations. Depending on the need of the client, flexible tools, training and assistance can be provided leveraging the World Bank's multi sectoral platform and global experience.



5. How Will the World Bank Implement the MENA HNP Strategy?

Implementing the HNP strategy in MENA by providing diverse products and engaging with clients over a five year phased implementation period.

The previous sections have made the case for a renewed World Bank engagement in the health sector in MENA and described how the principles of fairness and accountability will be applied to the health sector. Key health concerns in MENA were discussed and examples were given of products from the Bank's global health sector experience. This chapter explains how the HNP strategy will be implemented in terms of choices of World Bank products, engagement with clients, partners and multiple stakeholders, and the time frame for implementation. The strategy is envisioned as a dynamic document and a robust performance management framework will be used to monitor and adjust strategy implementation.

5.1. Choice of World Bank Group products to operationalize the MENA health strategy

Providing multiple products to support strategy implementation. The World Bank has a range of financial and technical knowledge and advisory products to support the strategy's implementation and improve fairness and accountability in health systems. The selection of products will be based on client needs and preferences. The conditions in the region will require an agile demand driven and tailored technical and financial support model resulting in country level action plans.

Paying for outputs through Program-for-Results (P4R). Tailoring support to clients' needs and timeline, linking support more closely to results, focusing on developing and scaling up targeted solutions, and fostering sustainable change are important tenets of the World Bank's new strategy of engagement with MENA clients. P4R is the first World Bank financing instrument to link disbursements to achievement of specific pre-agreed results and has been successful used in the health sector.

Providing global expertise of the World Bank Group through reimbursable advisory services (RAS). Many MENA countries have used advisory services, including Reimbursable Advisory Services (RAS) to ensure fast targeted knowledge transfers from the World Bank. Similarly, innovative knowledge services such as just-in-time policy notes, diagnostic work to better understand the location of underserved groups and how well they are being served, joint activities with the International Finance Corporation (IFC), or use of or use of Multilateral Investment Guarantee Agency (MIGA) guarantees, put World Bank Group's policy advice, knowledge resources, and convening power at the disposal of countries when needed.

Financing health system delivery through investment operations. The World Bank will continue to finance projects to increase health service access and quality for underserved populations, such as women and children, and rural communities. With investment lending funds, including sub-national loans, borrowers can finance a range of interventions to improve government institutional capacity to deliver health services to underserved populations, improving health infrastructure, such as rural

health clinics, as well as the direct delivery of health services. Investment operations can also be crucial for dealing with health issues for conflict-affected populations. From the longer running conflicts in the Palestinian Territories to more recent needs due to the conflict in Syria, the World Bank can play an important role with partner organizations to support emergency health programs.

Supporting policy changes through development policy lending. In the health sector development policy lending (DPL) can be used to support a wide range of important policy and institutional reforms. The availability and cost of pharmaceuticals, for example, can be addressed through policy reforms that enable price competition, bulk procurement, local production or with generics and licensing. Changes to tax policies relating to NCD risk factors, e.g. tobacco use and obesity, have proven effective in many countries. Outside the health sector, countries may consider including health-related measures in DPLs developed for other sectors. General public administration DPLs can include measures that support accountability and financial management in the health sector by requiring standardized data collection and information access or enabling medium-term budgeting. DPLs concerned with competitiveness and job creation can explore steps for stemming the emigration of health professionals or helping individuals with NCDs continue to work, e.g. by ensuring access to diabetes care.

Supporting evidence-based policy through knowledge activities. The World Bank supports development with a wide range of research, analytical, and technical tools. Whether knowledge tools are provided in conjunction with technical assistance loans, reimbursable advisory services, trust fund grants, or other means, data generation is expected to be a crucial component of the World Bank's support to all of the region's countries. The MENA region lacks health related data, making disease surveillance, and monitoring and evaluation difficult. The World Bank has experience working with clients to build this type of data generation capacity. The World Bank can furthermore coordinate knowledge-sharing and benchmarking efforts at the sub-regional and global levels.

Funding specific operations through earmarked trust funds. Grants and loans to support high-priority development objectives may be available through trust funds and other financial and administrative arrangements that the World Bank has developed with other donors. Depending on the source, the funds can be used to finance many types of projects for investment operations and knowledge activities. The US$550 million Health Results Innovation Trust Fund (HRITF) is a multi-donor HNP trust fund that supports results-based financing (RBF) in IDA countries to achieve the health MDGs and is being used in Yemen and Djibouti. The HRITF provides country pilot grants for country programs and knowledge and learning grants to support technical dialogue and learning for RBF design. It also supports implementation and evaluation grants to learn from successful (and unsuccessful) global experiences, while contributing to local and global evidence-based policy-making.

World Bank Institute's capacity building and training. The World Bank's financial and non-financial products are complemented by services provided by the World Bank Institute (WBI). The Institute connects practitioners and institutions to help them find suitable solutions to their development challenges. WBI support falls into three areas which can improve fairness and accountability.

(1) *Open Knowledge*: Connecting stakeholders and development practitioners to global knowledge and learning about the "how" of reform through structured learning (face-to-face, e-learning) and knowledge exchange, e.g. supporting peer-to-peer learning and helping to broker knowledge exchanges among developing countries.

(2) *Collaborative Governance*: Enabling government and nongovernment stakeholders to mobilize for collective action, overcome political economy challenges, and bring about change through four business lines—Open Government and Open Aid, Capacity Building for Nongovernmental Actors, Citizen Engagement through ICT, and Multi-stakeholder Collaborative Action.

(3) *Innovative Solutions*: Scanning and incubating innovations to tackle key development challenges by developing tools, methods, and online platforms to facilitate an open and collaborative process among governments, citizens, and other stakeholders through Competitions and Challenges, WB Innovation Labs, and Development Marketplace.

Along with interventions that address crosscutting issues of better governance, accountability and transparency, all three areas of WBI support can contribute to health goals by increasing fairness, in terms of health status, financial protection and responsiveness; accountability between patients, providers, and payers; and fiscal, political and institutional sustainability.

5.2. Engagement with clients and facilitation of partnerships

Listening to client needs. The World Bank has developed the MENA HNP Strategy to reengage in MENA's health sector to support the people's desire for fair and accountable systems. The strategy focuses on client-tailored knowledge, results, and ongoing client consultations, jointly identifying and prioritizing issues, and developing solutions to provide sustainable services to the population.

Promoting multi-sectorality in health. Core HNP-led operations achieved through multi-sectoral interventions will be mainstreamed into broader country assistance strategy discussions, policy reform programs, and capacity building initiatives. Key policymakers will be briefed on the economic and fiscal implications of improving health outcomes—better public finances, increased competitiveness, and improvements in household wealth

Facilitating cross-country engagement. The World Bank can facilitate regional and sub-regional opportunities to provide multi-country technical assistance, cross-country benchmarking, develop and implement coordinated projects to meet the needs of vulnerable groups such as women and youth to benefit from economies of scale and knowledge sharing.

Utilizing technology to support accountability, voice, and inclusion. The technologies and principles that facilitated the recent social movements in the region can support improvements in health outcomes. Social media can contribute to provider accountability while commitment to the principle of open access to information can facilitate efforts to improve public expenditure effectiveness. The World Bank aims to contribute to these efforts by supporting information access reforms, while coordinating standardized data collection and reporting methods and enabling cross-country comparisons.

Partnering with diverse stakeholders. The World Bank will work with partners and stakeholders to achieve country goals, including country and local governments, civil society, NGOs, parliamentarians and political stakeholders, private sector, academia, and youth groups. CSOs or NGOs or academics may be well placed to participate in knowledge development and activity monitoring. The Bank will coordinate working arrangements with other

UN organizations such as WHO, regional development banks, global partnerships, and bilateral donors to leverage the greatest financial support and knowledge transfer and to allocate resources from an institution's comparative advantage.

5.3. Timeline of implementation

Implementing a three-phase timeline. The MENA HNP strategy is a three-phase process proceeding from dissemination and awareness building to implementation and monitoring and evaluation.

Phase 1: Engaging with clients on strategic focus. Between May and December 2013 (short term), the World Bank will engage intensively with the client to listen to needs, build knowledge, and share ideas. The process will center on a series of policy events, held at the country and sub-regional (group) level to provide opportunities to discuss how client needs can be best addressed through the new strategy, which will feed into the development of country engagement plans. These plans will map the needs of the country to the strategic objectives; suggest suitable technical and financial products for future engagement; and will provide strategic HNP input to Country Partnership Strategies under preparation or mid-term reviews. The plans will include a detailed section on country specific political, financial, and implementation risk and, where possible, suggest mitigation measures.

Phase 2: Developing tailored recommendations and multi sectoral action plans. Between January and June 2014 (medium term), the World Bank will proceed with strategy implementation, focusing on developing and scaling up tailored recommendations to individual country needs. The World Bank will also explore the potential for regional "diagonal" strategies that address shared health challenges, e.g. women's health and NCDs in collaboration with several countries simultaneously.

Phase 3: Preparing and implementing financial and technical products aligned with recommendations. Between June 2014 and June 2018 (long term), the World Bank will prepare and implement financial and technical activities while monitoring and evaluating the strategy, and expanding support based on client demand. Lessons learned will be captured from the previous phases and the strategy and client engagement adjusted as needed.

5.4. Conclusion

Creating a dynamic document with mid-course corrections. The MENA HNP Strategy is envisioned as a dynamic evolving strategy, rather than as a static document. It will serve as a guide to prioritize activities and resources to meet regional and client country needs, while allowing for active management and timely adjustments. Managing and tracking the strategy will be achieved by a carefully tailored and adjustable impact monitoring and measuring framework. Given the fast changing socio-political regional situation, monitoring and measuring is especially important to draw lessons for continuous learning and improvement

Anticipating potential risks to implementation. The MENA region faces several risks that could pose credible threats to the implementation of the HNP strategy. These include political risks such as civil strife, conflict and political transition; financial risks such as economic crises and constrained fiscal space; and implementation risk due mainly to instability, institutional weaknesses and absorptive capacity. Given the heterogeneity of these risks, they will be individually considered in each country engagement plans. Even though the mitigation of several of these risks lies outside the ambit of the World Bank, recognition of their existence coupled with proactive country engagement will be imperative.

Committing to translating the aspirations of the people into fair and accountable health systems. The MENA HNP Strategy provides a compass for prioritization of the World Bank's engagement in line with regional and client country needs. The World Bank has heard the "voices of the people" and is ready and willing to help governments, nongovernmental actors, the private sector, and above all, the people to realize their aspirations of better health and development outcomes through the MENA HNP Strategy.

Poverty, Health and the Human Future: The World Bank Promise

Dr Jim Yong Kim, World Bank Group, President

"..To free the world from absolute poverty by 2030, countries must ensure that all of their citizens have access to quality, affordable health services. As countries advance towards universal health coverage, there are two challenges we at the World Bank Group especially want to tackle with you. First, let's make sure that no family, anywhere in the world, is forced into poverty because of health care expenses. Second, let's close the gap in access to health services and public health protection for the poorest 40 per cent of the population in every country.

Let me tell you five specific ways the World Bank Group will support countries in their drive towards universal health coverage.

First, we'll continue to ramp up our analytic work and support for health systems. Universal coverage is a systems challenge, and support for systems is where the World Bank Group can do the most to help countries improve the health of your people.

Our second commitment is that we will support countries in an all-out effort to reach Millennium Development Goals 4 and 5, on maternal mortality and child mortality. Reaching these two MDGs is a critical test of our commitment to health equity.

Our third commitment is that with WHO and other partners, the World Bank Group will strengthen our measurement work in areas relevant to universal health coverage.

Fourth, we will deepen our work on what we call the science of delivery. This is a new field that the World Bank Group is helping to shape, in response to country demand. It builds on our decades of experience working with countries to improve services for poor people.

Fifth and finally, the World Bank Group will continue to step up our work on improving health through action in other sectors, because we know that policies in areas such as agriculture, clean energy, education, sanitation, and women's empowerment all greatly affect whether people lead healthy lives.

We can do so much more. We can bend the arc of history to ensure that everyone in the world has access to affordable, quality health services in a generation. Together, let's build health equity and economic transformation as one single structure, a citadel to shelter the human future.

Now is the time to act."

Excerpts from speech at the World Health Assembly, Geneva on May 21, 2013.

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