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WASHINGTON D.C TO NEW DELHI: The World Bank's influence in maternal and child health over the last five decades

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Declaration

I declare that this thesis is of my own composition. The work presented here has not been submitted for any other degree or professional qualification.

Signed:

Date: 25.06.2020

Abstract

Introduction: The World Bank is one of the biggest external funders for maternal and child health in India and the world. Despite being a major actor in the global landscape for maternal and child health, there is no comprehensive analysis of the Bank's historical involvement and influence in this area. This study thus documents the contributions and limitations of the Bank's involvement in maternal and child health globally over the last five decades, and examines its influence nationally through the case study of a Bank-funded flagship project in India.

Methods: I used a mixed methods research design for this study, consulting primary and secondary sources of data. For analysing the Bank's historical involvement in maternal and child health over the last five decades, I consulted and analysed documents, archival records, and financial datasets from the World Bank, as well as relevant published literature and grey reports. For the case study of the Bank's influence in maternal and child health at the national-level in in India, I conducted 30 key informant interviews, and reviewed project documents, archival records, and published literature. I analysed the India case study using a conceptual framework of donor influence developed based on theoretical and empirical literature.

Results: Globally, the Bank contributed $24.6 billion for 484 maternal and child health projects in low-and-middle-income countries from 1970 to 2018, $1.4 billion in trust funds from 2005 to 2015, and $106 million in special health programmes from 1987 to 2014. The Bank solidified its role for maternal and child health through its cooperation with donors, UN agencies, and NGOs, to form partnerships and global health initiatives. The Bank's conceptualisation of maternal and child health has evolved from being purely instrumental to now being considered for its intrinsic value albeit along with the economic case of improving productivity and economic growth by saving lives of women and children. Over the years, the Bank has moved from employing a selective programmatic approach towards a more

comprehensive agenda as demonstrated by the increase in its lending for projects on health systems strengthening and multi-sectoral issues.

This study also found a shift in the Bank's focus on public sector provision of maternal and child health services from the 1970s until the mid-1980s, to its promotion of private sector involvement, and its current support of public-private partnerships. The limitations of the Bank's involvement in this health area primarily revolved around its promotion of privatisation and the reduced role of the state in financing and service provision, which undermined the access, availability and quality of health services for women and children, especially from socio-economically vulnerable communities.

In India, the Bank used a range of resources and mechanisms to exert its influence over the Ministry of Health and Family Welfare to achieve six policy outcomes for maternal and child health viz. target-free policy for family planning, priority for reproductive and maternal health, decentralised planning, financial monitoring system, strengthened procurement system, and increased domestic financing. Contextual issues including political, economic, social, and organisational factors shaped the India-Bank interactions and subsequently, the process of donor influence. Ultimately, despite the influence of the Bank, the sustainability of the policy outcomes lies within the remit of the domestic agency.

Conclusion: In order to be more responsive in this area, leaders within the Bank will need to consider reforms: such as framing maternal and child as a basic human right with intrinsic value, aligning its financing with countries that have the highest burden of maternal and child mortality, supporting countries with sustainable strategies for domestic resource mobilisation, increasing its support for health systems strengthening, and most importantly, including local voices and perspectives to inform its programmes.

Lay summary

India is one of the fastest growing economies and still it accounts for 17% and 20% of maternal and child deaths in the world. The World Bank, an international financial institution, is the largest external funder for maternal and child health in India and the world. Yet there is no comprehensive analysis of the Bank's involvement and influence in maternal and child health, globally or in India. I used a mixed methods approach by consulting primary sources of data such as archival records, key informant interviews, and financial datasets, and secondary sources including published articles and grey literature reports. First, I analysed the Bank's policies, programmes and financial flows from 1970 to 2018, to document its historical involvement in maternal and child health, and analyse its contributions and limitations. Second, I examined the influence of the Bank in maternal and child health at the country level in India, through the case study of the Bank-funded Reproductive and Child Health project.

The Bank contributed to maternal and child health through its financial resources (lending $24.6 billion for country projects from 1970 to 2018); partnerships (Taskforce for Child Survival and Safe Motherhood Initiative) and global health initiatives (Gavi, the Vaccine Alliance and Global Financing Facility); and through its knowledge products (World Development Report). The Bank's approach for maternal and child health has moved from being selective (focusing on specific issues and interventions) to comprehensive (funding health systems strengthening and multi-sectoral issues). Over the years, it has also shifted its focus from public sector provision for maternal and child health services to current espousal of public-private partnerships. In India, the Bank used its resources and mechanisms to its exert its influence over the Ministry of Health and Family Welfare to achieve six policy outcomes for maternal and child health. This study thus offers a conceptual framework and methodological roadmap to examine external donor influence over a domestic agency in a low-and-middle income country setting.

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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
AMC	Advanced Market Commitment
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
BMGF	Bill and Melinda Gates Foundation
BJP	Bharatiya Janata Party
CMR	Child Mortality Rate
CSSM	Child Survival and Safe Motherhood
CSO	Civil Society Organisation
DAH	Development Assistance for Health
DALY	Disability Adjusted Life Year
D.CP	Disease Control Priorities
DFID	Department for International Development
EmOC	Emergency Obstetric Care
GAVI	Gavi, the Vaccine Alliance
GBD	Global Burden of Disease
GDP	Gross Domestic Product
GFF	Global Financing Facility
HIV	Human Immunodeficiency Virus
HNP	Health, Nutrition and Population Sector
HRITF	Health Results Innovation Trust Fund
IBRD	International Bank for Reconstruction and Development
ICDS	Integrated Child Development Services
ICSID	International Centre for Settlement of Investment Disputes
ICRR	Implementation Completion Results Report
IDA	International Development Association
IEG	Independent Evaluation Group
IFC	International Finance Corporation
IHME	Institute for Health Metrics and Evaluation
IMR	Infant Mortality Rate

INGOS	International Non-Governmental Organisation
IPV	Inactivated Polio Vaccine
IUD	Intrauterine Device
JSY	Janani Suraksha Yojana
LMICS	Low and Middle-Income Countries
OECD	Organisation for Economic Cooperation and Development
MCH	Maternal and Child Health
MIGA	Multilateral Investment Guarantee Agency
MoHFW	Ministry of Health and Family Welfare
MMR	Maternal Mortality Rate
NGOS	Non-Governmental Organisation
NHSRC	National Health Systems Resource Centre
NRHM	National Rural Health Mission
PA	Project Agreement
PforR	Program-for-Results Financing
PMNCH	Partnership for Maternal, Newborn and Child Health
PPP	Public-Private Partnership
RBF	Results Based Financing
RCH	Reproductive and Child Health Project
RMNCH	Reproductive, Maternal, Newborn, and Child Health
RTI	Reproductive Tract Infection
SCOVA	Standing Committee for Voluntary Action
STI	Sexually Transmitted Infection
U.K.	United Kingdom
UN	United Nations
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UPA	United Progressive Alliance
U.S.	United States of America
USAID	United States Agency for International Development
WDR	World Development Report
WHO	World Health Organisation

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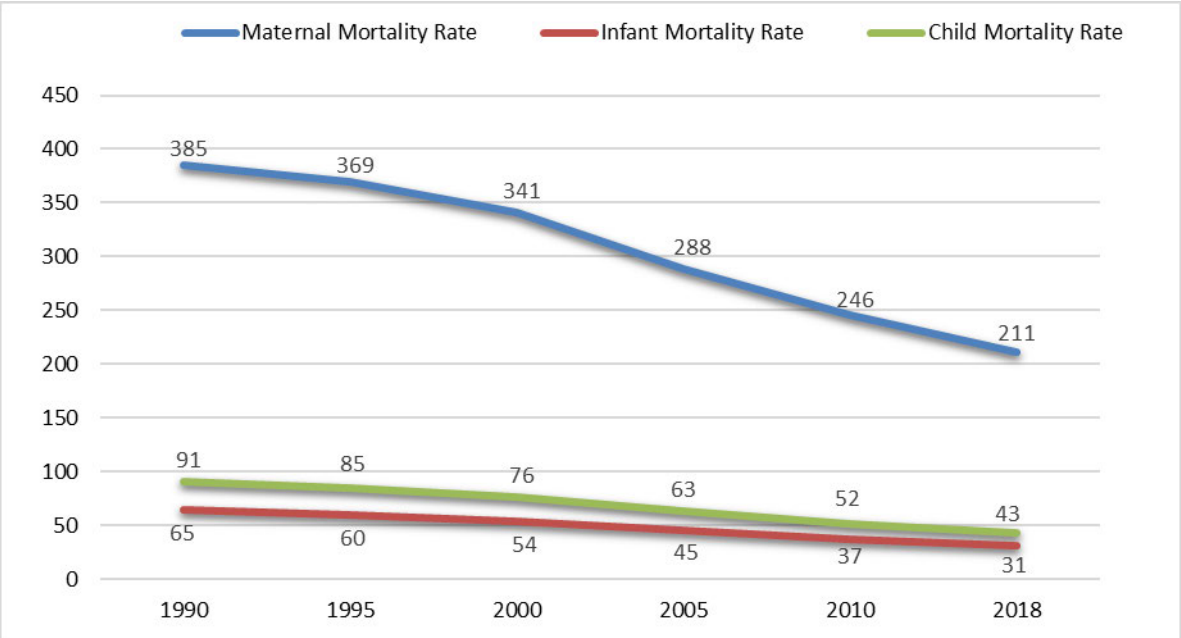
Chapter 1 Why study the World Bank's influence in maternal and child health?

1.1 Background

Since 1990, the global maternal mortality rate has dropped by 45%, from 385 deaths per 100000 live births to 211 deaths (MMEIG, 2019). Similarly, under-five child and infant mortality halved in this same period, falling from 65 to 29 deaths and 91 to 39 deaths per 1000 live births (UNICEF, 2019) (see figure 1.1). This major decline in maternal and child mortality can be partly attributed to political priority, mobilised civil society, and increased development assistance for health generated by the Millennium Development Goals adopted in the year 2000 and the recent Sustainable Development Goals of 2015 (Cha, 2017). Both these global declarations placed maternal and child health on the political agenda of governments as well as bilateral and multilateral aid organisations, private philanthropic organisations, and public-private partnerships (Marten, 2018; Smith and Shiffman, 2016; Shiffman and Sultana, 2013; Hafner and Shiffman, 2013).

Figure 1.1: Global estimates of maternal, infant and child mortality from 1990 to 2018 (Source: MMEIG, 2019; UNICEF, 2019)



Despite these gains, each day around 810 women and 15,000 infants die from causes related to pregnancy, child birth, and postnatal conditions (UNICEF, 2019; WHO, 2019). Haemorrhage alone leads to over a quarter of all maternal deaths; hypertensive disorders, sepsis, and complications of abortion account for another third; many of these deaths can be avoided with timely antenatal and emergency obstetric care (Graham et al., 2016). Similarly, the most common causes of child deaths – pneumonia, diarrhoea and malaria – are preventable (WHO, 2017). Nearly 99% of the maternal and child deaths occur in low-and-middle-income countries (LMICS), with the highest burden in the Sub-Saharan African region (MMEG, 2019).

India alone accounts for 17% and 20% of all maternal and child deaths worldwide (MMEIG, 2019; UNICEF 2019). Despite investments and major programmes by the government of India, (Vora et al., 2009) the pace of declines in fertility, maternal, infant and child mortality in the country has been slow and has fallen short of national and international targets (Paul et al., 2011). India continues to record a high burden of maternal and child mortality: each year, the country reports 989000 child deaths – nearly the population of Stockholm – and almost 45000 maternal deaths (UNICEF 2019; MMEIG, 2019).

The World Bank, an international financial institution, has been the largest external financial contributor for maternal and child health (MCH) projects in India (World Bank, 2019a; Ministry of Finance 2008). The Bank is also, arguably, an important player in the global landscape for MCH. Since its first ever loan of $2 million for a health project in Jamaica in 1970, the Bank has been lending for MCH indirectly through family planning and nutrition projects, and directly through its health services programmes in LMICS (Prah Ruger, 2005). Between 2003 and 2013, the International Development Association– the Bank’s lending arm for developing countries – was among the top ten donors for MCH, contributing $565 million in the year 2013 (Grollman et al., 2017). Over the last five decades, the Bank disbursed financial resources for 484 MCH projects in 106 countries (Fernandes and Chen, 2019).

Despite the Bank's being a major actor for MCH in India and the world, no comprehensive published document or analysis within the grey literature examines

the organisation's historical involvement and influence in this area. A wide range of scholars, including historians, political scientists, and anthropologists have studied the history of the Bank as an institution, with little attention to its role in global health specifically (Woods 2006; Mallaby 2004; Nelson 1995). Kapur and colleagues (1997) have written an authoritative, two-volume history on the World Bank; however, this extensive work does not contain any chapters relating to health. A few scholars have also critically analysed the Bank's role in perpetuating health inequities through structural adjustment programmes (Birne, 2009; Breman and Shelton, 2006) and have commented on its involvement in disease control campaigns in South Asia (Bhattacharya and Dasgupta, 2009).

I conducted a formative scoping review of published articles and grey literature reports on the World Bank and MCH and found that none of the publications have analysed the Bank's historical involvement in MCH globally or in India, over the last five decades. First, I conducted searches through six online, global health databases including PubMed, Scopus, ASSIA, IBBS, Global Health, and Web of Science, using the search terms 'World Bank' AND 'reproductive OR maternal OR child'. I carefully reviewed the abstracts of the results from the search to identify any article that provided an assessment of the Bank's role and influence in MCH over five decades. I found that a third of all articles made a cursory reference to Bank funding or Bank-produced data on health indicators (Nuhu et al., 2018; Ng et al., 2015; Pinzón-Rondón et al., 2015). These were followed by studies tracking the development assistance for health with mentions of the Bank's lending (Pitt et al., 2018; Grollman et al., 2017), and publications describing events developed or sponsored by the Bank (Henderson et al., 1988; Mahler 1987). A handful of articles provided independent evaluations of Bank-funded, country-level projects on population, MCH, and nutrition (Coburn et al., 2016; Chimhutu et al., 2015; Baird et al., 2011).

A similar search within grey literature from publically accessible, online databases of the Bank and other relevant organisations, found three types of reports. First, reports published by the Bank, which described the implementation of its funded MCH projects and evaluated performance against planned objectives (World Bank, 2005). Second, documents authored by the Bank in collaboration with other development organisations, that described the epidemiological burden of MCH at the global,

regional and country-level and offered evidence-based reviews of impactful interventions or ‘best buys’ to achieve improved health outcomes (World Bank, 2016; WHO 2015; Claeson et al., 2000). The third type of documents reviewed and discussed the Bank’s work in individual sectors – including health, population, safe motherhood and child survival – over specific periods of time (Amparo Gordillo-Tobar 2017; Robinson et al., 2007; Fair 2002). However, none of these reports offered a historical analysis of the Bank’s involvement in MCH over time.

Therefore, through this dissertation, I seek to trace the World Bank’s historical involvement in MCH over the last five decades, since it first began investing in the health sector in the 1970s, and explore its contributions and limitations of its involvement. More importantly, in doing so, I aim to examine its influence in this area. The concept of *influence* broadly refers to the ability of an actor to be a compelling force on the behavior of another actor (Cox and Jacobson, 1973). In this dissertation, I define *influence* as the Bank’s ability as an external donor to direct the decisions of national health policymakers for the area of MCH. For anyone interested in improving MCH in today’s rapidly changing political climate and the development aid environment, studying the Bank’s role in this area matters because of its considerable financial contribution at the global level and its pervasive influence on donors and borrowing countries.

A history of the Bank’s involvement in MCH can help to answer several important questions: How does this institution justify its investments in this area, how does it frame its policies and practice, what have been the triggers for prioritisation and investment in selected regions, what kind of financing mechanisms have been promoted, how is a Bank-funded project designed and implemented at the country-level, how does the Bank influence donors and borrower governments and how is it in turn shaped by them, and what are the contributions and limitations of the Bank’s involvement in this area. A historical analysis of the role of the World Bank can cast fresh light on how an economic institution conceptualised MCH, and influenced the ways in which national governments implement health policies and programmes for improving the lives of mothers and children around the world.

While the aforementioned historical analysis is much needed within global health scholarship, for the purposes of a doctoral research project it would be difficult if not impossible to examine every MCH-related programme or activity funded or implemented by the Bank. This caveat calls for a two-tiered approach to study the Bank's role and influence in MCH. First, at the global-level, I will analyse the Bank's programmes and overall financial contributions for MCH over time and construct a historical timeline of the Bank's involvement in this area. Second, at the national-level, I will examine the Bank's influence over domestic policy makers through the case study of a Bank-funded MCH project in India viz. the Reproductive and Child Health (RCH) project. India offers a particularly interesting case for this doctoral study because of its longstanding relationship with the Bank. The country has been the largest recipient of Bank funds for health projects including MCH (World Bank, 2020), and also has one of the largest burden of maternal and child mortality in the world, with 32,000 maternal and 8,82,000 child deaths recorded in 2019 (MMEIG, 2019; UNICEF 2019). Furthermore, the RCH project serves as a worthy case for analysis, as it was one of the first major national-level MCH programmes in India, and the Bank being a lead donor with the overall contribution of $641 million, worked closely with the Indian Ministry of Health and Family Welfare in implementing the project across all states in the country for fifteen years. More importantly, the RCH project promoted a paradigm shift from the existing demographic, target-based family planning focus to a reproductive approach based on the needs of the woman. Thus, through this two-tiered approach, the study will construct a comprehensive picture of the Bank's historical involvement in MCH at the global-level, and provide a detailed case study of its influence in this area at the country-level in India.

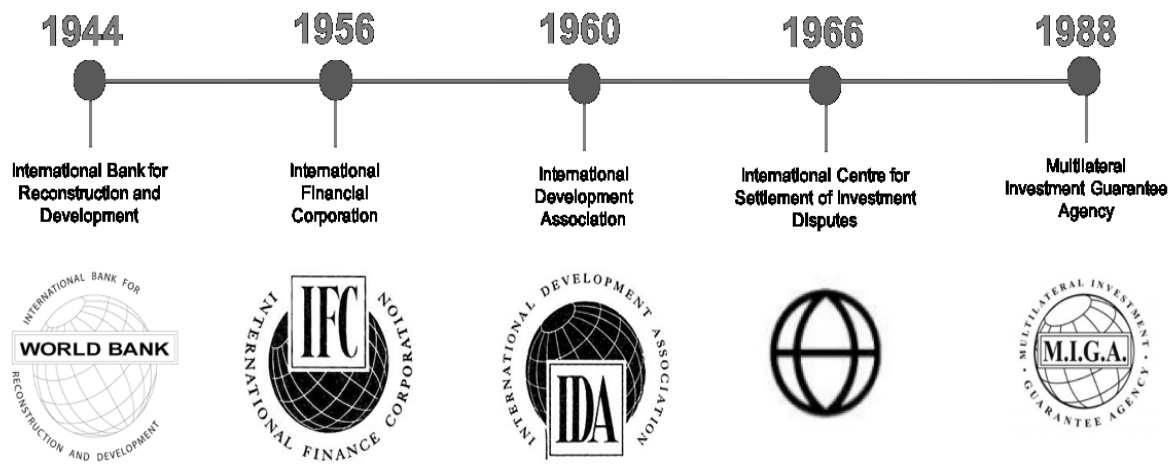
This chapter begins with an orientation to the World Bank, where I outline its structure, mechanisms for governance and financing, services, and its role in global health and MCH. Next, I define the concept of MCH, describe its critical components including evidence-based interventions and the global financing landscape for this area. The chapter proceeds with an orientation to the relationship between India and the Bank and the Bank-funded RCH project. Next, I outline the aims, questions, and contributions of this dissertation. I conclude with an overview of the remainder of the dissertation.

1.2 The World Bank

Structure

The World Bank was established in 1944 as the International Bank for Reconstruction and Development, with the goal of reconstructing Europe after World War II. Since then, the Bank has evolved into a leading development institution aimed at poverty alleviation and economic growth. The World Bank Group comprises five agencies: International Bank for Reconstruction and Development (IBRD), International Finance Corporation (IFC), International Development Association (IDA), International Centre for Settlement of Investment Disputes (ICSID), and the Multilateral Investment Guarantee Agency (MIGA) (World Bank, 2019b) (Figure 1.2). IBRD is the Bank's original lending arm, providing loans, guarantees, risk management products, and advisory services to governments of middle-income and creditworthy low-income countries.

Figure 1.2: Five agencies of the World Bank Group (Source: GoC, 2007)



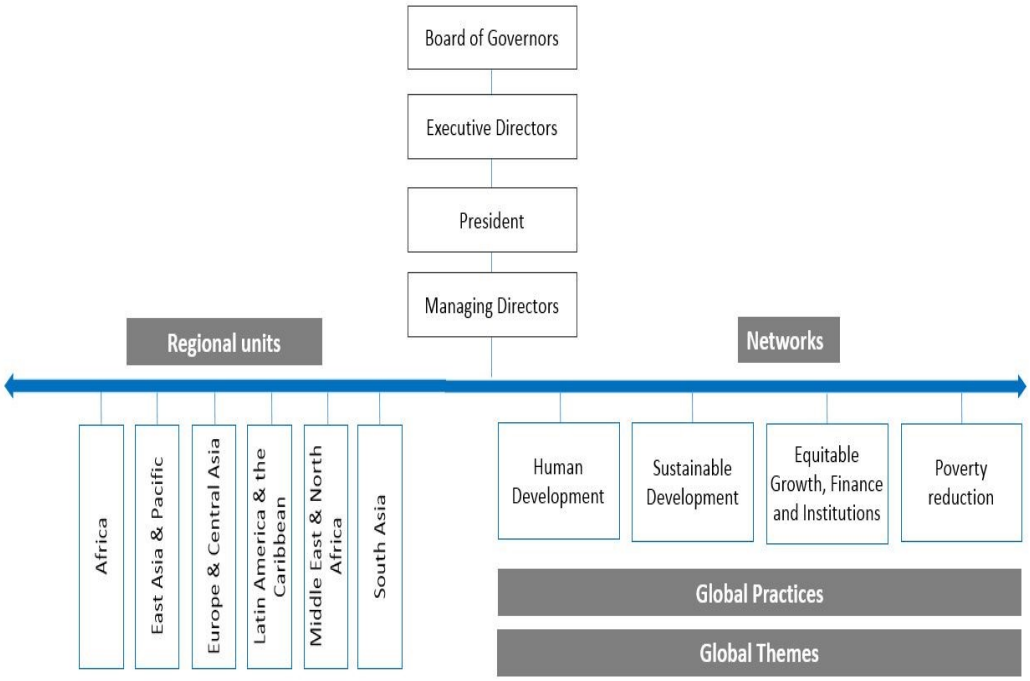
The IFC, founded in 1956, lends to private companies and financial institutions in developing countries. In 1960, IDA was set up to provide credits (concessional loans with zero or low interest charge) and grants to governments of the poorest countries. The ICSID was established in 1966 for the settlement of international investment disputes by conciliation, arbitration or fact-finding. Finally, in 1988, the MIGA was created to serve as a multilateral political risk insurance provider to promote foreign investment through guarantee. The IBRD and IDA together make up the World Bank.

For this dissertation, I will only analyse the role of the World Bank in maternal and child health i.e. IBRD and IDA. Further on, I will use the word 'Bank' to refer to the World Bank.

Governance

The Bank is made of 189 member countries or shareholders represented by a Board of Governors that meets once a year. Each member country has one representative, who could be a minister of finance or development, on the Board of Governors. The Board of Executive Directors handles policy decisions and loan approvals. This board comprises five representatives of the largest shareholders in the bank — France, Germany, Japan, the United Kingdom, and the United States — and 19 representatives of the remaining countries after they have been grouped into constituencies along geographical lines. Chaired by the World Bank Group President, the Board of Executive Directors meet twice a week to oversee policy and financial decisions. Loan approvals are passed by a majority decision, with each country's voting power being proportional to the size of its economy (World Bank, 2018c).

Figure 1.3: Governance structure of the World Bank (Source: Adapted from World Bank 2019c and Abbasi 1999)



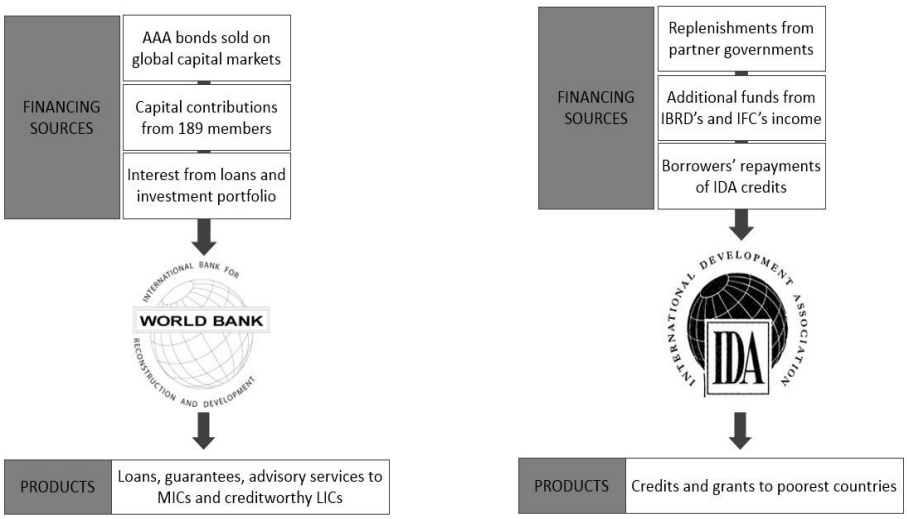
The United States wields 17% of the vote, effectively giving it the power of veto to any changes in the Bank's capital base and articles of agreement, which requires 85% of the vote. The G7 countries (Canada, France, Germany, Italy, Japan, United Kingdom, and United States) control 45% of the votes (Clinton and Sridhar, 2017). The World Bank operates day-to-day under the leadership and direction of the President, managing directors and senior management staff, and the vice presidents in charge of the regional units and networks as illustrated in the figure 1.3.

The regional units are supported by global practices i.e. 14 groups with Bank experts that work on technical development areas. Six vice presidents head the regions — Africa, East Asia and Pacific, Europe and Central Asia, Latin America and Caribbean, Middle East and North Africa, and South Asia. The regional teams execute projects under the four networks and are supported by global practices which include health, nutrition and population, agriculture, education, finance, environment, poverty, transport, water, and jobs and developments (World Bank, 2019d). For this dissertation, I will specifically focus on the Bank's maternal and child health-related efforts executed through its global practice of the Health, Nutrition and Population (HNP) unit.

Financing mechanisms

Unlike other UN agencies, such as the World Health Organization (WHO), the Bank both raises funds on global capital markets and receives funds from its member states (Clinton and Sridhar, 2017). The IBRD raises most of its funds by issuing AAA bonds sold on the global capital markets; it is also funded by the capital contributions from its 189 members and the income generated from its interest bearing loans and investment portfolio (World Bank, 2019e). AAA is the highest possible rating that may be assigned to an issuer's bonds by any of the major credit rating agencies. IDA is funded largely by replenishments or contributions from the governments of its richer member countries made every three years, with additional funds from IBRD's and IFC's income and from borrowers' repayments of earlier IDA credits (IDA, 2019). Although the Bank calls for the replenishments, they are overseen by donors (e.g. United States, United Kingdom, and Japan) and not the Bank or IDA recipients (Sridhar et al., 2017).

Figure 1.4: Financing sources and products of the IBRD and the IDA (Source: The author has developed this figure)



Services

Over the last five decades, the Bank has grown rapidly to provide financial leadership in the development sector, from a modest start with four loans totalling $497 million in 1947 to 302 commitments worth $60 billion in 2015 (World Bank, 2015). The Bank provides financing for development projects to LMICS through several products (World Bank, 2019f). Through the IBRD, the Bank primarily offers loans to middle-income and credit worthy low-income countries, while IDA gives credits (concessional loans) and grants to poor countries.

The Bank uses three major channels to provide financing to LMICS. First, it provides investment project-based lending, wherein countries are offered loans, credits or grants from IBRD or IDA, to implement a specifically designed project with planned objectives and outcomes. Second, the Bank offers development policy financing or budgetary support wherein it directly transfers financial resources into the recipient-country government's treasury for a specific sector such as health or education – or for unearmarked, general budget support. Third and more recently, trust funds have become an increasingly used channel by the Bank to fund development activities. Trust funds essentially refer to resources contributed voluntarily from donors and held separately from the Bank's core budget (i.e. IDA and IBRD) to support specific

projects and activities, particularly for global health (Winters and Sridhar, 2017). Apart from providing financial lending, the Bank deploys others services including its substantial research and knowledge outputs, economic analyses, technical assistance, and policy advice to borrowing countries, all of which have become as important as its financial role (Kirk, 2010; Prah-Ruger, 2005).

Changing role in global health

The Bank established its footing in global health by lending and offering technical assistance to LMICS through its Population Projects Department in 1970, which was reorganised to the Population, Health and Nutrition Department in 1979, and finally renamed to its current form of the Health, Nutrition and Population (HNP) sector (HNP, 2000). Led by President Robert McNamara, the Bank funded country-level projects for population control and nutrition in the 1970s (Fair, 2008). This initial lending for population was primarily demographic in nature (World Bank, 1972), while the nutrition projects aimed to address human development; both these efforts were targeted at eventually improving productivity and economic growth in countries. Through these early projects on population and nutrition, the Bank funded health services that directly and indirectly affected the health of mothers and children in LMICS.

The Bank's HNP started funding stand-alone health projects in 1981. Within five years, the Bank became the largest lender for health projects in LMICS, moving from $13 million in 1981 to $404 million in 1986 (Measham, 1986). In this decade, the Bank solidified its commitment for MCH through two global partnerships with UN agencies and private foundations viz. the Taskforce for Child Survival and the Safe Motherhood Initiative (TFGH, 2018; Herz and Measham, 1987). In 1988, the Bank set up its first freestanding lending project to tackle AIDS, in Zaire, followed by a disbursement of $500 million in loans and credits to eight freestanding projects to support national AIDS control programmes in the next ten years. Though not huge, this represented the largest amounts of money spent in the fight against AIDS in that decade (World Bank, 2005). Although the Bank increased its cooperation and lending for health in the 1980s, it also simultaneously implemented structural adjustment programmes in LMICS affected by economic crises, by introducing

market-based reforms including deregulation, privatisation, budget cuts in social sectors including health and education, introducing user fees for health care, and withdrawing subsidies. Over time, these structural reforms have been associated with poor health outcomes, debt crises and social injustice in poor countries (Breman and Shelton, 2006).

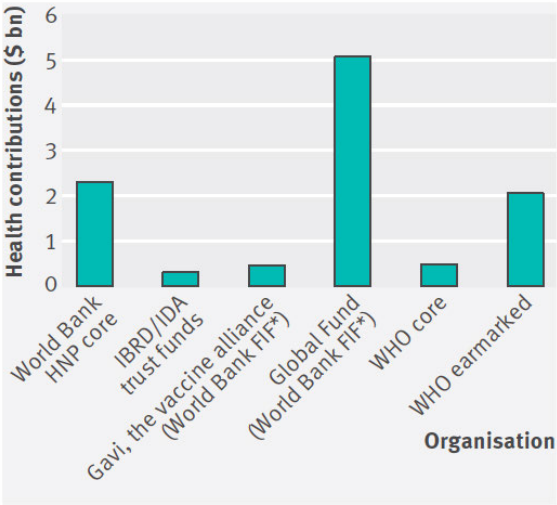
In the 1993, the Bank published its 'World Development Report: Investing in Health', which became a milestone as, for the first time; the Bank had applied its intellectual power in its flagship annual report to define appropriate policies for health and to urge for increased investments in this sector, thereby giving it greater exposure, legitimacy and influence in the global health arena (World Bank, 1993). This report popularised the use of disability-adjusted life years or DALYs, a metric used to assess the cost-effectiveness of health interventions. This publication was also controversial as it recommended private sector delivery of health care and user fees as a means for financing delivery, reflecting its allegiance to structural adjustment and market-based policies (Clift, 2013).

From 2000 onwards, the Bank has become increasingly involved in global health initiatives. While a general definition of a global health initiative is still subject to discussion (Biesma et al., 2009), I use the description by Cruz and McPake (2011), who define it as a model for financing and implementing health programmes in various countries and in different regions of the world that supported by multilateral or a bilateral donor; alternatively, they can also be established as a public-private partnership. The prime examples of Bank-led global health initiatives include Gavi, the Vaccine Alliance (set up in 2000), the Global Fund to Fight AIDS, Tuberculosis and Malaria (2002), the Health Results Innovation Trust Fund (2007), and the Global Financing Facility (2015). Both GAVI and the Global Fund follow the trust fund model, where the Bank acts as a trustee or supports project implementation using financial resources contributed voluntarily from donors and held separately from its core budget (Clinton and Sridhar, 2017). While GAVI works to improve vaccine coverage in LMICS, the Health Results Innovation Trust Fund and the Global Financing Facility are two of the more recent examples of Bank trust funds, aimed at improving reproductive, maternal, newborn, child and adolescent health in high-burden countries (Fernandes and Sridhar, 2017).

Since its first ever loan for a health project in Jamaica in 1970 to the present, the Bank has become one of the largest external funders of global health, committing more than $1 billion annually in lending to improve health, nutrition, and population in LMICS (IHME, 2019; Prah-Ruger 2005). In 2018, the Bank contributed $2.3 billion for global health, constituting 6.7% of the total development assistance for health (DAH) ($38.9 billion) that year (IHME, 2019). From 1970 to 2018, the Bank financed a total of 1,608 health projects, committing an overall $51 billion over time (World Bank, 2019a).

The Bank has gradually challenged the normative authority of the World Health Organization (WHO) and displaced it as the major player in global health; this shift can be attributed to five key reasons. First, the Bank's lending supersedes the budget of the WHO, and it magnifies its contributions with matching funds from borrower governments and partner donors (see figure 1.5). For instance, in the year 2013, Bank financing for health from its HNP core budget and its trust funds surpassed WHO's combined budget (core and voluntary) (Sridhar et al., 2017). Second, due to its financial clout, the Bank has direct access to policy makers in Ministries of Planning and Financing in borrowing countries to advocate its agenda and when necessary, leverage health sector reforms. By contrast, WHO's influence as a specialised health agency is largely confined to the Ministries of Health (Buse and Gwin, 1998).

Figure 1.5: Financial commitments by the World Bank and WHO in 2013 (Source: World Bank, 2013)



Third, the Bank has legitimised its intellectual leadership by producing broadly accepted concepts such as human capital, DALYs, and cost-effectiveness, and wide-ranging research and economic analyses (Tichenor and Sridhar, 2019). Fourth, the Bank cooperates closely with other global health organisations, initiatives and actors, best demonstrated by its involvement in founding the Global Fund to fight AIDS, TB and Malaria and GAVI, the Vaccine Alliance. Finally, the Bank has a powerful network of people who move in and out of the bank to positions in ministries of finance and health in-country (Sridhar et al., 2017; Kirk, 2010).

The Bank has significantly raised the profile of health on domestic policy agendas, and injected needed financial resources into the sector (Buse and Gwin, 1998). However, its efforts have, in many cases, been driven by its focus on return on investment and productivity (Sridhar et al., 2017), which go against the premise of health as a human right and as such should be accessible and available to all. Studying the Bank's role in MCH can therefore offer a deeper understanding of how this institution works in this area, what drives its involvement, and how it influences policies and programmes in the borrowing countries.

1.3 Maternal and child health

Defining maternal and child health

Mortality reduction remains a primary goal for maternal and child health; however, mortality only represents the tip of the iceberg. For every woman who dies of pregnancy-related causes, 20 or 30 others experience acute or chronic morbidity or illness, often with permanent conditions that undermine their normal functioning (Graham et al., 2016). Likewise, pneumonia, diarrhoea and malaria not only kill newborns and infants, but are also responsible for high rates of morbidity that can impair growth and development and have long-lasting effects on children (WHO and UNICEF, 2010). Malnutrition is another major cause of child morbidity, with alarming rates of infants and young children globally suffering from stunting, wasting and more recently obesity. Maternal and child health thus goes beyond mortality. It covers several life stages of women and infants, and entails their wellbeing as much as the absence of morbidity and mortality.

WHO defines maternal health as ‘the health of women before and during pregnancy, at childbirth and during the postpartum period’, and child health as ‘the health of children at birth, neonatal, infant and under-5 years’ (WHO, 2017). In this dissertation, I include the ‘reproductive’ phase and define MCH as the health of women and children in the spectrum of life stages ranging from reproductive age, pregnancy, birth, post-partum, neonatal, infant and under-5 period of a child’s life. I employ this broader definition for two reasons. First, a woman’s reproductive health is a vital indicator of her health in the later stages of pregnancy and childbirth and post-partum period (Black et al., 2016). Second, this life stage approach is useful for understanding connections over time as health events at one stage influence health at a later stage across the life span and influence the next generation through the life cycle. Maternal and child health thus encompasses health care dimensions of reproductive health, family planning, prenatal, natal, and postnatal care in order to reduce morbidity and mortality (WHO, 2018).

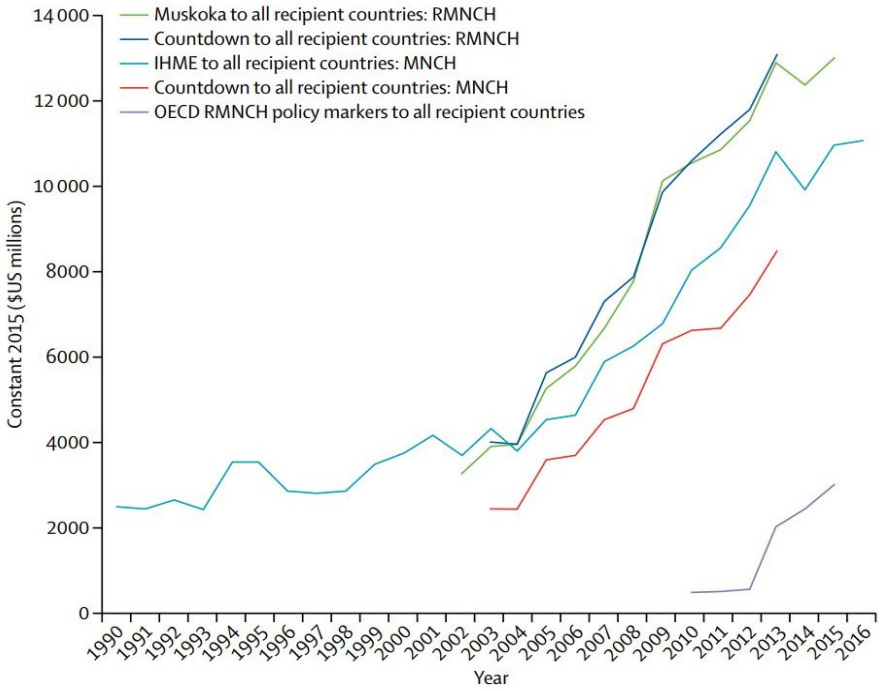
Financing landscape

Four initiatives have attempted to estimate the total external financing for MCH over time, with the most prominent one being the Institute of Health Metrics and Evaluation (IHME) (see figure 1.6). First, as per IHME estimates, MCH received most (42%) of the development assistance for health (DAH) between 1990 and 2018 (IHME, 2019). Funding for this area totalled $186 billion over the 28-year period, with the U.S, private philanthropy including Bill and Melinda Gates Foundation, and the UK being the top three donors. In 2017 alone, MCH received $12.5 billion, up by 2% from the previous year, and representing nearly 32% of the total DAH across all health areas.

Second, the Countdown to 2030 estimated a rise in donor disbursements for reproductive, maternal, newborn and child health (RMNCH) from $4 billion in 2003 to $13 billion in 2013, totalling $91 billion over this period (Pitt et al., 2018). Third, the Muskoka initiative launched at the G8 Summit in Muskoka, Canada in 2010 as a mutually agreed approach for G8 countries to monitor their own financial support for MDGs 4 and 5 of reducing maternal and child mortality, reported total funding of $117 billion for RMNCH from 2002 to 2015. Finally, the Organisation for Economic

Co-operation and Development's (OECD) Creditor Reporting System provides a total estimate of $9 billion in RMNCH funding from 2010 to 2015. Despite the differences in the RMNCH aid flows owing to the differences in estimating methods, time periods, and the availability of donor financial reporting data, these figures establish the significant priority that MCH receives in terms of funding at the global level.

Figure 1.6: Development assistance for health across focus area from 1990 to 2016 (Source: Pitt et al., 2018)



Historically, funding for RMNCH spiked in 1994. This was also the year when the International Conference on Population and Development in Cairo pushed national governments and development agencies to commit politically and financially towards a more need-based response to reproductive health as compared to the target-based population control approach (UN, 1994). Even bigger increases in RMNCH funding have occurred since the year 2000, following the political priority raised by the Millennium Development Goals, and the injection of resources by the proliferation of new global health actors such as Bill and Melinda Gates Foundation and partnerships including the Global Fund to Fight AIDS, Tuberculosis and Malaria, GAVI, the Vaccine Alliance and the Global Financing Facility. Over the last ten years, the Bank has become one of the biggest channels for MCH funding, representing 20% of all multilateral aid (Pitt et al., 2018).

While researchers and data producing organisations and initiatives have documented total MCH aid flows over time, and a few have also captured the Bank's contribution to this area over certain time periods, there is a gap in the knowledge in terms of the Bank's overall financial flows for this area over the last five decades. This dissertation also tasks itself with documenting the Bank's total financial commitments and disbursements to MCH over time and unpacking key trends to discuss the Bank's role in the global financing landscape for this health area.

1.4 India and the Reproductive and Child Health Project

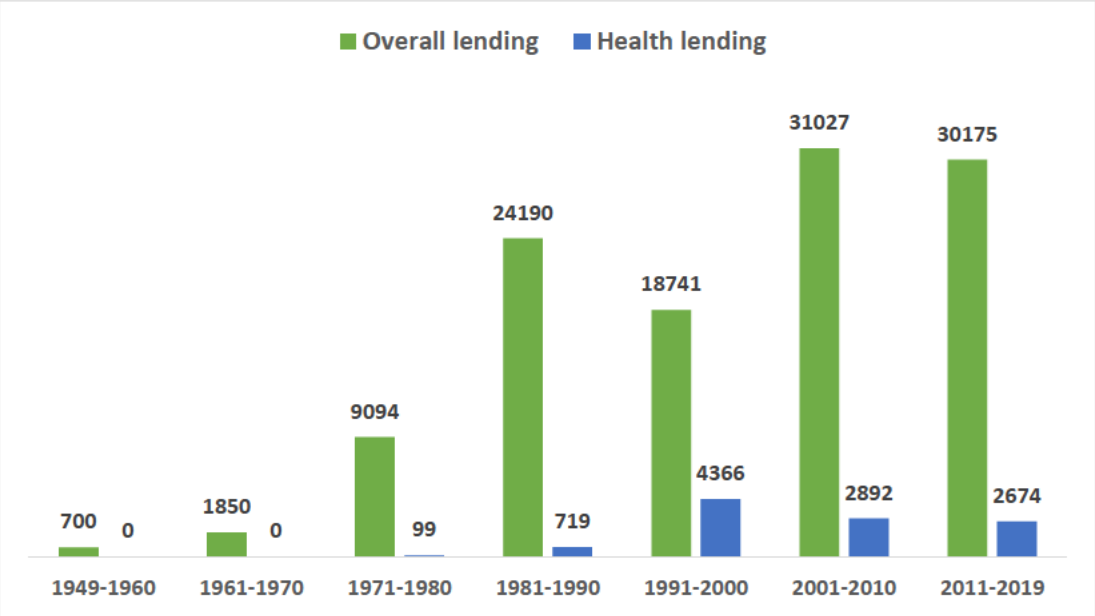
I chose India for the country case study to explore the influence of the World Bank in MCH at the national level for four reasons. First, India is the Bank's oldest client. India's relationship with the Bank goes back to the institution's inception in 1944. India was among the 17 original participants of the 1944 Bretton Woods conference, which conceived the idea of the IBRD. In fact, it was the Indian delegation, which first suggested the name IBRD. The Bank set up its first country office in India in 1957 and has maintained a continuous presence in India since then, longer than in any other country (World Bank, 1957).

Second, India is the Bank's biggest client. Bank lending to India began in 1949. Starting with a commitment of $700 million in the first decade of its lending, Bank commitments for projects in the country have dramatically risen over time, peaking at $31 billion between 2001-2010 (see figure 1.7). As of 2019, the country's cumulative borrowing stood at around $113 billion in combined assistance from the IBRD and IDA for 708 projects (World Bank, 2019g). India is also the largest recipient of Bank lending for health and MCH projects. Since 1972, the Bank's HNP sector has committed $9.7 billion in financial assistance for 64 health projects in the country, forming nearly ten percent of the overall Bank financial assistance for the country.

Finally, while its maternal and child mortality rates have been on the decline, India continues to have one of the largest burdens of maternal and child deaths in the world. The Bank has been involved in family planning and nutrition projects in the country since the 1970s, and also funded two of India's major national-level programmes for MCH. Given the Bank's longstanding technical and financial

presence in the country, it would thus be valuable to explore the interactions between the Bank and the Government of India, and in doing so, examine Bank's influence over any MCH-related outcomes in the country.

Figure 1.7: World Bank overall and health sector commitments in India from 1949 to 2019 (In USD million) (Source: The author has developed this figure based on the analysis of financial data from the Bank's Projects and Operations database as of December 2019)



When I began my initial literature search on Bank-funded MCH efforts in India, I was confronted with several questions. The most important one, I thought, was how I could offer a robust, objective and a nuanced assessment of the Bank's influence in MCH in a vast and diverse country like India, as it has 29 states, each of which could be a country on its own and whose health systems vary in managerial capacity, funding, and health outcomes.

I decided to tackle this challenge in two ways. First, I conducted a scoping review of the Bank-funded health projects in India, and explored any MCH-related activities within these projects, to get a contextual understanding of the Bank's involvement in this area. Second, I identified a flagship, Bank-funded MCH project implemented across all the states in India, which allowed for an introspection of the Bank's influence in MCH policy and practice at the national-level. Based on this strategy, the Reproductive and Child Health (RCH) project emerged as a strong candidate for a case study.

I chose the RCH project as a worthy case for analysis for the following reasons. First, financially, the RCH project was one of the biggest MCH projects for the Bank as well as the Government of India. With a total financial contribution of $641 million, it was the Bank's largest MCH project in India and second largest in the world, after the Provincial Maternal Child Health Sector Adjustment Loan in Argentina, which received $750 million from 2003 to 2007 (World Bank, 2019). The RCH project was implemented in two phases i.e. 1997 to 2004 and 2006 to 2012; and it witnessed a changing donor environment across these two phases. In the first phase of this project, the Bank disbursed 84% of the total project cost of $309 million, while in the second phase; the Government of India took the lead by contributing nearly half of the total cost of $2.2 billion. The second phase also ushered in new donors, such as the Department for International Development (DFID) and United Nations Population Fund (UNFPA). This project thus offers a unique opportunity to examine the Bank's influence under different financing circumstances.

Second, the RCH project promoted a shift in the way MCH services were delivered in the country. It actioned India's decision to comply with the provisions from the International Conference for Population and Development, and switched the focus from a vertical, target-based approach through family planning and immunisation programmes, to a more needs-based reproductive and child approach. The project also introduced a package of essential MCH services including services for reproductive tract infections and sexually transmitted diseases, emergency obstetric care, and medical termination of pregnancy (World Bank, 1996; Measham and Heaver, 1996). An analysis of the RCH project can determine the Bank's role in the design and implementation of these policy and programmatic shifts in the country and also explore the current status of these changes within the Indian health system.

Third, the RCH project was a national-level programme i.e. it was implemented across all the states in India unlike other Bank-funded health projects that are implemented in selected states. In India, the health system operates at three broad administrative levels viz. central (national), state (province), and district (local). The national scale of the RCH project thus allows for an in-depth examination of the Bank's managerial approach in a big country with several states. It also offers the

potential to understand how the Bank works at the three administrative levels and what the extent of its influence is at each level.

Finally, when we look at the Bank's performance rating of the RCH project, documents reveal an 'unsatisfactory' rating for the first phase, moving to a 'moderately satisfactory' rating for the second phase. In 2005, former Bank President Paul Wolfowitz suspended a major loan for the RCH project in response to allegations of fraud and corruption in the procurement process (Mallaby, 2006). Despite the controversy around corruption and not achieving the expected planned health outcomes in the first phase, this project was funded for a second phase with a six-fold increase in project costs as well as financial support from new donors. These developments through the course of the project offers a chance to explore the relationship between the Bank and the Government of India under challenging conditions.

1.5 Research aims, questions and contributions

In light of the gap in the literature, I aim to make a novel research contribution by exploring and examining the influence of the World Bank in the area of maternal and child health over a period of five decades.

I do so by first describing and discussing the Bank's historical involvement in MCH from when it first started lending for health projects in 1970 to 2018. This component represents the task of tracing the Bank's policies, programmes and its overall financial assistance for MCH, understanding the key actors and events, exploring the development of ideas, and discussing international cooperation, all of which will aid in constructing a timeline of the Bank's involvement in this area and how it conceptualised MCH and justified its efforts over time. A synthesis and critical interpretation of the evolution of the Bank's involvement in MCH sets the stage for the next component of this study. At this second level, I examine the process in which the Bank influences MCH at the country-level, in India, through the case of a national-level flagship programme – the RCH project, implemented over a period of 15 years, from 1997 to 2012.

Thus, in trying to understand the World Bank's involvement and influence in MCH, this dissertation answers the following research questions:

1. What can be said about the role of the World Bank in MCH over the last five decades, in terms of its financial investments, knowledge, technical assistance, and cooperation?
2. What interests drove the Bank's involvement in MCH over time?
3. How has the Bank conceptualised MCH over time?
4. What can be said about the Bank's influence in MCH in India through its involvement in the RCH project?

I unpack the objectives of the study below:

- I trace the Bank's major policies and initiatives for MCH across five distinct phases starting in 1960 to 2018.
- I track the Bank's overall financial flows for MCH projects in low-and-middle-income countries from 1970 to 2018. An analysis of the Bank's policies and its financial flows for MCH will help explain the drivers and justifications for its involvement in this area and how it conceptualised MCH over time.
- For the case study of India, I first describe the India-Bank relationship from the 1940s to the present to set the context for analysing the RCH project. I then describe the process of the design and implementation of the RCH project and discuss the Bank's role in the same. Finally, I use a conceptual framework of donor influence to examine the process and the degree of the Bank's influence in MCH in the country.

This study adopts a historical perspective as, globally, it looks at the Bank's efforts in MCH over a period of five decades, and nationally, in India, it examines a project that ran for more than a decade. The historical context is critical since I am not only interested in the policy decisions, but also want to understand their genesis and long-term ramifications. A cross-sectional approach would not provide that understanding. A historical approach is thus useful because, policies do not crystallise at a particular point in the decision process but evolve, through complex interactions among various interest groups (Gorden et al., 1993). Such an approach also allows us to review both historical and contemporary responses to global health

problems, and enables us to think critically about the role of contextual factors that have shaped policy and health outcomes over time.

Through this study, I aim to make empirical, conceptual, and methodological contributions to the health policy literature in LMICS including the works of Gill Walt (Walt, 2008, 1994), Lucy Gilson (Gilson et al., 2011; Erasmus and Gilson, 2008) and Jeremy Shiffman (Shiffman and Ved, 2008). Empirically, this study will, to the best of my knowledge, present the first extensive analysis of the Bank's involvement in MCH at a global level as well as in a country setting. As discussed earlier in this chapter, while scholars have studied the World Bank as an international financial institution, there has been very little focus on its role in health over time. The Bank's collective efforts in MCH in particular have not been analysed. This study thus uses multiple sources of data (as detailed in the chapter three - Methods) to provide a critical account of the Bank's influence through its contributions and limitations for MCH over five decades.

I propose to develop a conceptual framework of donor influence from the existing health policy literature and then empirically test this framework using the country case study of India and the RCH project. Several studies have highlighted the problems that can arise from a dominant donor influence in the health policy processes of LMICS, including overshadowing of national health priorities, overlooking strengths and absorptive capacities of national health systems, and their ability to sustain progress after the funding ends (Travis et al., 2002; Ollila 2005; Khan and Coker, 2014). External donor influence can also raise challenges in terms of accountability and ownership over policy and programmes (Okuonzi and Macrae, 1995).

While scholars have raised concerns about the influence of donors over health systems in LMICS (Khan and Coker 2014; Biesma et al., 2009; Shiffman 2008; Yamey 2002), to date only limited work has explored the process of donor influence and the implications of power imbalances at different stages of the policy process in aid-recipient countries (Khan et al., 2016; Chima and Homedes 2015; Hanefeld 2010; Spicer et al. 2010; Okuonzi and Macrae 1995). Moreover, to the best of my knowledge there has been no published study, which has explicitly presented a conceptual framework of external donor influence over a national health agency and

tested it in a country setting. Understanding multiple stakeholders including national policy actors, experiences of donor influence, and what mechanisms underpin the relationships of LMIC institutions with donors, is crucial to strengthening national ownership of health policies. Hence, this doctoral study develops such a conceptual framework of donor influence, which can be applied in other LMIC settings to improve our understanding of the donor-recipient country relationship and enable effective governance, national ownership, and policy and programme implementation.

Methodologically, I aim to provide a roadmap to study an international institution's role in a health area at the global level, and specifically examine the process and degree of its influence at the national level. This study uses a mixed methods research design including both quantitative and qualitative data sources (as detailed in the chapter three - Methods). In doing so, it therefore presents a systematic approach to designing research, collecting and critically analysing data on donor influence, which can aid health policy scholars to conduct similar research in LMICS. Additionally, this study also adds to the growing literature on how to do health policy analysis (Walt, 2008; Erasmus and Gilson, 2008).

1.6 Overview of the dissertation

This dissertation contains nine chapters. The remainder of the dissertation is organised in the following manner. Chapter Two presents a scoping review of the theoretical and empirical literature on external donor influence at the institutional level in a country setting. This review acts as a starting point for understanding the concept of donor influence, exploring its application in health policy analysis in LMIC settings, and identifying the components to develop a conceptual framework for this study.

Chapter Three explains the methods used for this study. It begins with the ontological and epistemological approaches adopted, followed by the rationale and description of the mixed-methods research design. The chapter then systematically describes each research method in detail, discusses my positionality within the study, and the ethical dimensions of studying powerful actors and the process of influence, and concludes with the strengths and caveats of this research.

Chapter Four will explore the origins and evolution of the Bank's work in MCH. In doing so, it discusses the Bank's MCH policies and programmatic approaches over the last five decades, within the broader context of major global health trends and events. This chapter will also identify key actors, events, and ideological trends that determined the Bank's conceptualisation of MCH and its investments in this area. Chapter Five tracks the Bank's financial flows through its core budget and extra-budgetary funds from 1970 to 2018, and situates it within the larger environment of development assistance over time. It will unpack key financial trends to discuss the Bank's role in MCH at the global level and its changing programmatic and financing approaches.

Chapters Six to Eight examine the Bank's efforts in MCH in India. Chapter Six will describe the India-Bank relationship vis-à-vis the health sector and MCH from the 1940s to the present, thereby establishing the background for understanding and analysing the RCH project. Chapter Seven traces the process of the two phases of the RCH project. By using multiple sources of data such as archival records, project documents, financial datasets, and qualitative interviews, this chapter reconstructs the timeline of events in the project design and implementation, discusses interactions and underlying dynamics between Bank and national actors and other relevant partners. Chapter Eight uses the conceptual framework of donor influence to analyse the RCH project and examines the process, including the resources and mechanisms, used by the Bank to influence the Indian Ministry of Health and Family Welfare for MCH-related policy outcomes. Furthermore, this chapter also presents a novel scale to ascertain the degree of the Bank's influence and a sustainability index for each of the MCH-related outcomes.

Chapter Nine summarises the key findings from this study and discusses its implications. It discusses the applicability of the framework of donor influence in other LMIC settings. Finally, the chapter describes the contributions of this thesis and outlines futures areas for research, concluding with reflections on the Bank's relevance for MCH.

Chapter 2 Conceptual framework of donor influence in health policy

2.1 Introduction

In this thesis, I set out to examine the World Bank's influence in maternal and child health over the last five decades, since its foray in the health sector in 1970s. While studying the influence of an international institution like the Bank at the global level can be difficult, I decided to specifically examine the Bank's influence at the country level in India. In this chapter, I review the existing theoretical and empirical literature for any theories or frameworks on donor influence in health policy. The aim is to use such a framework to analyse the data from the case study of the Reproductive and Child Health (RCH) Project in India, and uncover the process of the Bank's influence in maternal and child health at the country level.

This chapter has four parts. In the first part, I define the concept of donor influence and discuss the way in which I use it in the thesis. In part two, I describe a theoretical framework for public policy i.e., Walt and Gilson's policy triangle framework (1994), which can be used to guide this analysis. In the third part, I briefly describe the relevant empirical studies on donor influence at the institutional level in low-and-middle-income countries (LMICS) receiving aid or technical support from external organisations. In part four, I bring together the insights from the relevant theoretical and empirical literature and present a conceptual framework of donor influence, which I will use to analyse of the case study of the RCH project.

To the best of my knowledge, this is a novel conceptual framework that draws from both theoretical and applied health policy literature in LMICS, and offers a potential roadmap to study the process in which an external donor can exert its influence over a domestic agency at the country level, to achieve health policy outcomes. I conclude this chapter by discussing how this framework will be used to analyse the case study of the RCH project.

2.2 The concept of donor influence

The term ‘influence' broadly refers to the ability of an actor to be a compelling force on the behaviour of another actor (Cox and Jacobson, 1973, pg.25). Influence, as a concept, has been studied in several fields. Social psychologists define influence as intentional and unintentional efforts to change another person's beliefs, attitudes, or behavior (Gass, 2015; Turner, 1991). Unlike persuasion, which is typically intentional and requires some degree of awareness on the part of the target, influence may be inadvertent or accidental (Cialdini, 1984). The field of organisational and management studies discuss intra and inter organisational influence that is understood as the capacity of an organisation to affect the behaviour of its own staff and other organisations, respectively (Pfeffer, 2017; Kipnis et al., 1980).

Scholars within the field of international relations (Hast, 2016; Holsti, 1964; Singer, 1963) have viewed influence as being instrumental, and as a means to an end, and implies a base of capabilities that an actor uses or mobilises to use in their efforts to influence the behaviour of another actor. In global health policy literature, researchers have discussed influence as the ability of bilateral or multilateral organisations to direct the decisions or priorities of national health policymakers (Khan et al., 2018; Wickramasinghe et al., 2018; Harmer et al., 2013). While these are just a few of the ways in which influence is understood and do not represent all the possible conceptions of this concept, these do serve as a starting point to draw from and define the concept of donor influence for the purpose of this thesis.

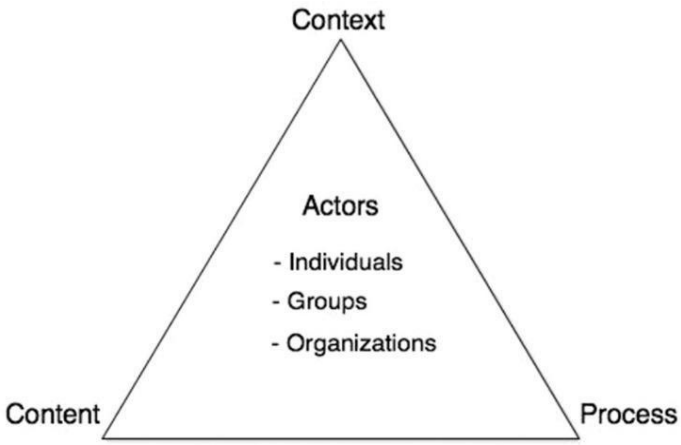
For this thesis, I adopt the Khan et al’s (2018) definition of donor influence as the ability of an external organisation to shape or direct the priorities or decisions of policy makers in a domestic organisation at the country level, to achieve certain goals. Essentially, donor influence is inter-organisational in that it infers a relationship between actors in the donor organisation and the domestic organisation. Donor influence is also instrumental, which means that it results in the attainment of certain outcomes, which could be defined by either of the two organisations or even external actors. Moreover, the ability to influence implies the capacities of a donor organisation that it uses to shape or direct the priorities or decisions of policy makers

in a domestic organisation to achieve certain policy, programmatic or health outcomes.

2.3 Theoretical literature

In my reading of theoretical literature on how health policy emerges and unfolds in LMICS, I identified Walt and Gilson's policy analysis triangle framework (1994), and found this to be relevant to understand donor influence within this process. Gill and Wilson developed the policy triangle framework specifically for health, although its relevance extends beyond this sector. They noted that health policy research focused largely on the content of policy, neglecting actors, context and processes. Their policy triangle framework is grounded in a political economy perspective, and considers how all four of these elements interact to shape policy-making (see figure 2.1). These four factors cannot be considered and analysed separately. Actors are influenced (as individuals or members of groups or organisations) by the context within which they live and work; context is affected by many factors such as instability or ideology, by history and culture; and the process of policy making – how issues get on to the policy agendas, and how they fare once there – is affected by actors, their position in power structures, their own values and expectations. The content of policy reflects some or all of these dimensions (Buse et al., 2005, pg.9).

Figure 2.1: Policy triangle framework (Walt and Gilson, 1994)



The health policy analysis triangle has subsequently been widely used to understand multiple policy experiences in multiple LMIC settings, with applications that encompass both quite simple descriptive narratives and fuller and more explanatory

analyses (Gilson and Raphaely, 2008). This framework has also been widely applied in in other sectors such as food, energy and environment policy. Etiaba et al (2015) used the policy triangle framework to study the role of contextual factors, actors and the policy process in the development of the national oral health policy and possible reasons why this current approved policy succeeded. The policy triangle offers a clear roadmap to identify any content (i.e., policy changes) for maternal and child health in India and examine the context, actors, and process, and in doing so, to explore the influence of the Bank. However, I wanted to unpack the component of the process within which the Bank exerts its influence. Hence, I consulted the empirical literature for fill this gap.

2.4 Empirical literature

I conducted a scoping review of published peer-reviewed articles using search terms of ‘donor influence’ and ‘health’ in six online global health databases including ASSIA, IBBS, Global Health, PubMed, Medline, Scopus, and Web of Science. I found 35 articles that described empirical studies on an aspect of health policy in a LMIC and contained the term ‘donor influence’. I carefully reviewed these articles and found that authors examined how a health policy was prioritised (agenda setting), formulated, and implemented, as well as broader processes of policy change. Studies discussed the various stages of the health policy process such as priority setting (Fischer and Larson, 2016; Colebrander et al., 2014), policy formulation (Gautier and Ridde, 2017) resource allocation (Asante et al., 2009), and policy implementation (Sieleunou et al., 2014; Dodd and Olive, 2011; Ozvaris, 2004; Buse 1999) in LMICS. While the authors examined or studied in part, the role and influence of a donor over national policy makers or stakeholders (such as non-governmental organisations and research institutes) at the country level, none of the articles explicitly presented a conceptual framework of donor influence.

I deductively analysed these articles using the four components of the policy triangle framework i.e., content (policy change), context, actors, and process. I then inductively identified two additional themes under the component of process viz. resources and mechanisms. Resources refer to any objects of value, while mechanisms are strategies or means in which these resources can be deployed by

donor organisations (Pawson and Tilly, 1997). I used this analysis of the empirical studies to develop a conceptual framework of the process of donor influence over a domestic agency to achieve certain policy outcomes, as described in the following segment.

While this conceptual framework helped to identify the components of the donor influence process, it also raises the question about the concept of power and where it lies within this process. Power is often defined synonymously as influence, in terms of it being the ability of one actor to shape the thinking or actions of another actor (Moon, 2020). Based on my reading of the literature on the concept of power (Moon, 2020; Dahl, 2005; Barnett and Duvall, 2005; Lukes 2004; Foucault 1979) and the empirical studies that form the base for the conceptual framework, I understand power as an actor's use of resources or the act of not using these, to shape another actor's actions with respect to policy decisions. Influence, then is broader concept that encompasses power (i.e. use of resources) and mechanisms, to achieve the goals of policy decisions and actions.

2.5 Conceptual framework

This conceptual framework describes the process in which a donor organisation exerts its influence over a domestic organisation in a country, to achieve certain outcomes i.e., health policy changes (see figure 2.2). This process of influence is implemented by actors within each organisation. The donor and domestic organisations are shaped by contextual factors at the country level. The donor's influence implies its capabilities to shape or direct the priorities or decisions of policy makers in a domestic organisation. These capabilities include resources and mechanisms that actors in a donor organisation use in this process of influence over policy makers in the domestic organisation. Gill et al (2004) argued in their analysis of policy transfer of tuberculosis and sexually transmitted disease policies from international to national levels that this health policy transfer is a long adaptive process, made up of several iterative loops. They showed how research and clinical practices developed in one or more countries are adopted, adapted, and taken up by international organizations which then mobilize support for particular policies, market, and promote them. Although the components in the conceptual framework for this study have been arranged in a linear manner, it is important to consider that

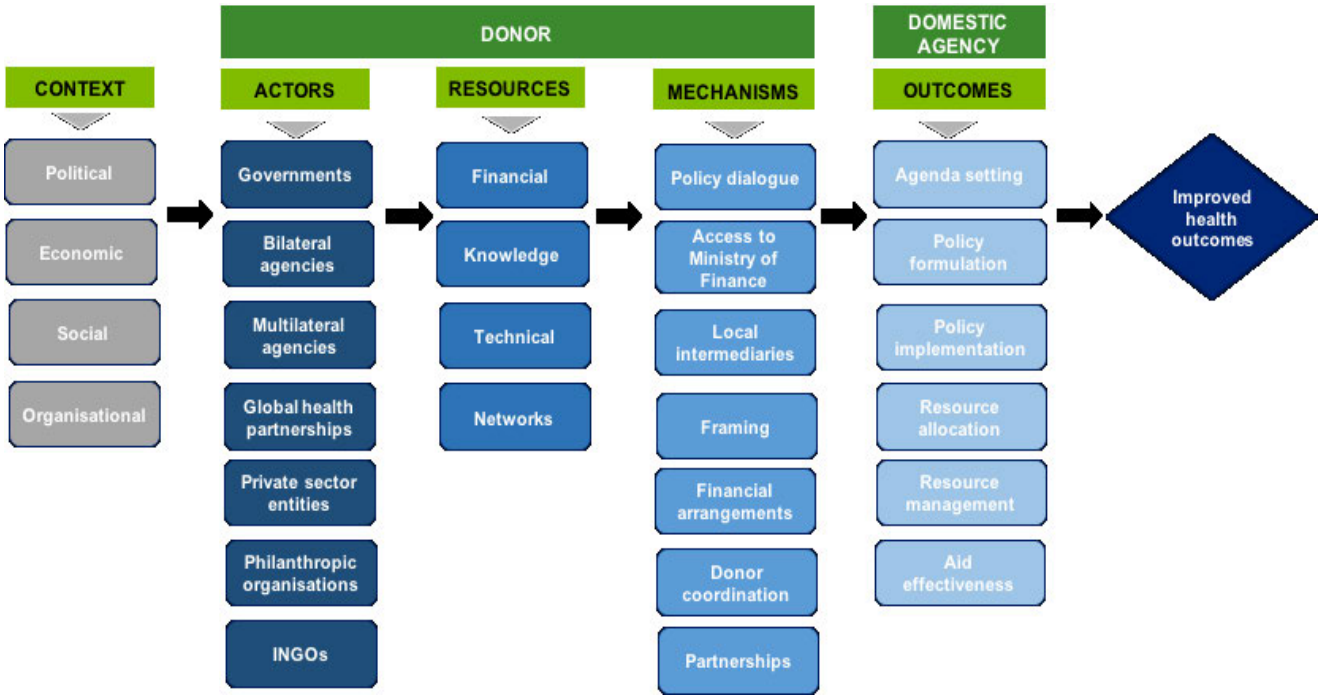
the policy influence is a dynamic process and that while donors can influence this process, they can also be influenced in turn by domestic actors and the contextual factors at the country level.

CONTEXTUAL FACTORS

Politics

As Walt (1994) argued politics is at the heart of health policy making. The influence of the political situation and politicians in the country, is substantial, especially in the policy agenda setting process, as illustrated by studies conducted in Bangladesh (Buse 1999), Pakistan (Husain et al., 2007), Niger (Dalglish et al., 2015), and Uganda (Colebrander et al., 2014).

Figure 2.2: Conceptual framework of donor influence in health policy



Owing to unstable politics in Bangladesh, donors questioned the legitimacy of successive administrations with respect to accountability, and this in turn accounted for the low levels of trust placed by donors in the government, predisposing them to exercise great caution in the aid relationship (Buse 1999). In Uganda, the influential political executive cited the formal prioritization of election promises over established programmes in the annual health budget as an example of political rather than evidence-based priority setting (Colebrander et al., 2014). Other political factors such

as the ideology of the leading political party, change in government, and election year; historical events; social unrest; and international agendas either serve as a source of power or act as barriers for policy actors to influence policy (Koduah et al., 2014).

Economic situation

National economic growth, economic crises, austerity measures, and financial constraints, tend to affect national policy-makers' decisions to accept the influence of donors, particularly through financial resources. National stakeholders in Pakistan did not consider HIV to be the top health priority in the country, yet major external donor funding for the program was accepted as a political decision to improve the exchange reserves for social and economic benefit (Husain et al., 2007). Similarly, in Turkey, owing to limited government budget from the 1970s to 1990s, the Ministry of Health relied entirely on the support of USAID for procuring contraceptive products and asked other international agencies for financial support for its reproductive health programmes (Ozvaris et al., 2004).

Organisational factors

Facilitating factors and barriers at the organisational level can also shape the interactions between the donors and the domestic agencies. When studying the role of the World Bank in Bangladesh, Buse (1999) found that when the strategic, administrative and implementation capacity of governments is perceived by donors as being weak or inadequate, it affects their confidence in the government and serves to legitimise their greater role in the policy process. In Uganda, donors considered the planning and coordination role of the Ministry of Health as weak, and therefore, proceeded to interact directly with the technical programmes and units at the local levels bypassing central government (Jeppsson, 2002). Governance issues such as corruption in recipient governments is another organisational factor that often raises questions about government accountability and affects donor perception and confidence (Buse, 1999). Donaldson (2002) found that despite certain organisational characteristics of bureaucratic civil service in India displayed through as delayed processes and regular transfers, a few civil servants stepped up and threw in their personal energy, championing the adoption of the target-free

reproductive health policy. In their analysis of the development of integrated community case management for childhood illness policy in Kenya, Juma et al (2015) found that bureaucratic considerations among government officials around community health workers dispensing antibiotics seemed to be a factor slowing the policy development.

ACTORS

Ideally, state governments are expected to lead and control the health policy process in their country, and determine what goes into a policy and how it gets financed and implemented. However, studies have commonly pointed out the involvement and influence of external actors other than policy makers in the national government, including bilateral agencies such as USAID (United States Agency for International Development) or SIDA (Swedish International Development Cooperation Agency); multilateral aid agencies like the World Bank or African Development Bank; global health partnerships such as the Global Fund to Fight AIDS, Tuberculosis and Malaria; private corporations including pharmaceutical companies, philanthropic foundations like the Rockefeller Foundation and Bill and Melinda Gates Foundation, and international non-governmental organisations such as PATH and Médecins Sans Frontières.

OUTCOMES

Policy outcomes can be defined by actors in the donor or the domestic organisation or by external actors or organisation. Studies have examined policy outcomes such as agenda setting (Fischer et al., 2016), policy formulation (Gautier and Ridde, 2017), policy implementation (Foller, 2013), resource allocation (Husain et al., 2007), resource management (Walt et al., 1999), aid coordination (Buse 1999), aid effectiveness (Dodd and Olive, 2011). These outcomes are finally aimed at achieving improved health outcomes in recipient countries.

RESOURCES

Financial

The promise of aid through budget support, grants, and loans, allowed international donors to shape governments' priorities, institutions, and policies (Fischer et al., 2016; Bowen et al., 2014; Colebrander et al., 2014; Asante and Zwi, 2009; Buse and Gwin, 1998; Zaidi, 1994). In Ghana, international donors used financial support as leverage to determine what got on the agenda and in the maternal fee exemption policy (Koduah et al., 2014). In Afghanistan, USAID, World Bank, European Commission and United Nations agencies funded the Basic Package of Health Services, a national health policy. In doing so, the donors were able to influence the components of this policy (Haidari et al., 2014). Sieleunou et al (2017) found that a readily available loan of US$25 million from the World Bank served as a catalyst for placing a performance based financing project on the national agenda in Cameroon. In countries that are heavily dependent on donors for their health sector budget, health programmes designed and financed by national governments, may still be vulnerable to the influence of donor priorities (Mutero et al., 2014; Sridhar and Gómez 2010; Gomez, 2007).

Providing financial resources can also create a cycle through which donor influence gets exerted over national health policy, and the implementation of this policy makes additional funding possible. Barrett and Tsui (1999) analysed USAID's funding of population activities in 114 less developed countries over 20 years and concluded that adopting a population policy increased the likelihood of a country receiving international aid and the amount received. However, financial resources do not always offer donors with the expected influence and leverage. In their study on aid effectiveness in Viet Nam, Dodd and Olive (2011) found that donors provided resources directly to the government in return for access to and influence over strategic policy discussions. However, this arrangement did not function as planned i.e., the budget support 'bought' only limited leverage over policy decisions.

Knowledge

Donors use knowledge-based resources to make convincing arguments and legitimise health issues, thereby moving governments towards their desired policy agenda setting (Jardali et al., 2014; Ulikpan et al., 2014; Buse and Gwin, 1998). Donors have been perceived to have greater proficiency than national agencies in conducting research and using data to develop strong policies and plans (Khan et al., 2018). This intellectual expertise indicates influence gained through the ability to produce, interpret and disseminate knowledge and information to policy actors (akin to what Shiffman has termed 'epistemic power' in global health agenda setting) (Shiffman, 2014). Robert and Ridde (2013) discuss how donors use information politics, which is the capacity to quickly mobilise politically relevant information and use it in interactions with relevant national policy makers.

Nabyonga-Orem et al. (2014) reported the generation and use by donors of a variety of evidence to "push" the user fee exemption policy in Uganda. Storeng et al. (2017) wrote about how the Malawi office of INGO Ipas used DFID funding to work with the Ministry of Health's reproductive health unit to disseminate the public health evidence upon which the government could interpret the benefits and consequences of legal change. Dalglish et al. (2015) found that in Niger, international donors packaged and delivered scientific arguments in support of integrated community case management (a policy to provide basic care for poor rural children sick with malaria, diarrhoea and pneumonia) to national policymakers, whose input was limited mainly to operational decisions. Similarly, Khan et al. (2018) reported that donors' ability to produce, interpret and disseminate knowledge gave them a major advantage in influencing health policy decisions in Cambodia and Pakistan.

Technical

Donors provide technical assistance to recipient countries, in the form of consultants, training and research. These resources are usually aimed at facilitating policy or project implementation and strengthening local capacity. In many cases, international consultants are brought in to lead and train national teams, promoting donor influence through their own legitimacy and authority. Ozvaris et al. (2004) reported that the USAID only funded US based agencies for providing technical

assistance to the Ministry of Health for implementing the national reproductive health policy. Sridhar (2009) offers the example of the World Bank, noting that some recipient governments choose not to take the technical assistance, as more than half of the committed funds are spent on international consultants or training workshops that may not necessarily have a tangible benefit.

Networks

Donors often use their networks and bring other bilateral and multilateral donor agencies on board, to align efforts towards a common agenda in recipient countries. Through their networks, donors can use leverage politics, which is the ability to solicit more powerful stakeholders to influence policy decision-making (Robert and Ridde, 2013). Apart from offering financial resources through credits (loans) and grants, the World Bank is also able to bring in matching funds from client governments as well as co-financing from other donors, thus tripling or quadrupling the funds to the programmes it supports (Buse and Gwin, 1998). Global health partnerships such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Vaccine Alliance are striking examples of network-based influence in recipient countries.

MECHANISMS

Policy dialogue

Donors use policy dialogue i.e., they engage policy makers from the national and state government, representatives from other international donor agencies, and other relevant national stakeholders, and have iterative discussions about a health problem and work towards a concrete outcome (Fischer et al., 2016; Walt et al., 1999; Buse 1999). Policy dialogue can take the form of personal contact, consultative meetings, events, workshops, secondments, seminars and subsidised consultancies. Policy dialogue has increasingly become a common mechanism for donors like the World Bank and DFID, to present its arguments backed by evidence, and build a strong case for financing a particular health area (Watson and Pierce, 2008; Buse and Gwin, 1999).

Access to ministries other than health

Donors gain influence over the health sector through their access to other government sectors, which serves as an intersectoral leverage (Lin and Gibson, 2003). Godlee (1994) wrote about the declining influence of the WHO over member states, and argued that while the WHO has country offices within the national ministries of health, its representatives have no direct contact with other more powerful departments whose policies impact on health, such as education, employment, home affairs, and finance. The World Bank on the other hand, is often perceived by other donors (and also by recipient government) to hold more sway with the government, especially with their access to senior decision makers in ministries of planning and finance in recipient administrations with the political clout to champion the agenda, and access to large-scale resources to finance—and, when necessary, leverage reform (Walt et al., 1999; Buse and Gwin, 1998).

Khan et al. (2018) found that donors used their influence over national and international trade and tourism to influence domestic health priorities. In Pakistan, public and private stakeholders felt that the threat of travel and trade restrictions introduced by international organisations if polio was not controlled was important in placing polio high on the national agenda. Similarly, policy actors in Cambodia reported that the way donors and UN agencies portrayed the country globally mattered because it has a direct impact on international reputation and tourism, therefore, making high-level national policy makers pay attention to donor priorities.

Local Intermediaries

Studied have reported that donors work with local intermediaries – or 'brokers'– to secure partnerships with like-minded individuals in government and civil society, to translate global health goals into terms more likely to be acceptable at the local level (Lewis & Mosse, 2006; Watkins & Swidler, 2013). Storeng et al. (2019) found that, in Malawi, the DFID-funded INGO Ipas identified 'like-minded' individuals including commissioners from across the ministries of health and justice, tribal leaders, as well as religious councils, to form a Special Law Commission to review the abortion law, which went on to become an influential mechanism for bringing a previously taboo topic of abortion into the public realm, and moving the law towards fruition.

Donors also fund NGOs and civil society actors, and employ them as channels to influence health policy in countries. Working through local NGOs, can allow donors access into local communities, bypassing government procedures and pathways (Schurmann and Mahmud, 2009). Local NGOs that work with the health ministry are often seen as part of the government and not the donor; such advantages that can help donor influence, especially in sensitive health areas such as reproductive health and abortion (Storeng et al., 2019). Donors fund NGOs and CSOs for service delivery roles, and can influence their work in recipient countries by governing the programme agenda through their funding constraints, regulations and capacity development choices (Williamson and Rodd, 2016; Dyke et al., 2014).

Framing of health issues

This mechanism refers to the way in which a health issue is conceptualised and presented to national stakeholders. Frames provide the cognitive means of making sense of the social world, but discordance among them forms the basis of policy contestation (Koon et al., 2016). Reich (1995) wrote about symbolic politics that affected the international health policy agenda through the capacity of individuals and organisations to use images and language as symbols that can create and quell issues, and discussed the case of UNICEF, wherein the imagery of child health and the strong language of ‘child survival’ was employed with great success for social mobilization and fund raising at the global level. Storeng et al. (2019) reported the INGO’s use of terms like ‘pandemic’ to describe abortion in Malawi, and gain traction for reproductive health policy within national networks. Framing is similar to the concept of policy image (Baumgartner and Jones, 1993), i.e., the way in which a given problem and set of solutions are conceptualised. One image may predominate over a long period of time, but may be challenged at particular moments as new understandings of the problem and alternatives come to the fore.

Financing arrangements

Donors can exert their influence over domestic organisations through the use of financial arrangements such as negative sanctions such as conditionalities attached to lending (Okuonzi and Macrae, 1995) and earmarking budgetary support (Reinsberg 2017; Colebrander et al 2014). Asante and Zwi (2009) reported that in

Ghana, international donors influenced resource allocation not just because they contributed substantially to the health budget, but also through certain financial arrangements such as earmarking funds for specific health priorities in selected districts.

Donors use negative sanctions such as suspension of funds, or more, likely, not meeting pledged funds. Buse and Gwin (1998) found that in Bangladesh, the World Bank used negative sanctions such as withholding further credit for health activities due to the lack of government progress in addressing sectoral inefficiencies. These funds were released only after the Ministry of Health drew up a strategy document in consultation with the Bank and other donors, and committed to a sector-wide approach in line with the Bank's recommendation. Donors also use inducement or positive sanctions such as additional resources or certain perks. Donaldson (2002) reported that the World Bank used an additional loan as an incentive to induce the Indian Ministry of Health and Family Welfare to accept and formulate its recommended policy on removal of targets for the national family planning programme.

Donor coordination

Aid coordination is another mechanism through which donors can dominate health policy discussions in recipient countries (Gilson et al., 2012; Brown et al., 1998; Okuonzi and Macrae, 1995). In Bangladesh, the World Bank formed an alliance with bilateral and multilateral donors in the country and led a donor consortium, through which it exerted its influence over the adoption of a sector-wide approach (Buse 1999; Buse and Gwin 1998). Donor coordination can also be problematic, as demonstrated in Tanzania, where tensions emerged between two groups of donors, with each preferring different financing modalities for the national health policy, thereby delaying the policy formulation (Chimhutu et al., 2015).

2.6 Conclusion

In this chapter, I have thus presented a novel conceptual framework for studying the process of donor influence over a domestic agency to achieve health policy outcomes. This framework draws from the theoretical literature and from empirical

studies on health policy analysis in LMICS. This framework has several components. First, there are actors from within the donor organisation and the domestic agency at the country level. Actors from external agencies could also shape this process of donor influence. Second, actors from the donor organisation and domestic agency work with each other to achieve certain change i.e., policy outcomes for a health area. Based on the literature, I found that donors use financial, knowledge, technical, and network-based resources and a range of mechanisms to exert their influence over the domestic agency. Furthermore, several contextual factors at the country level also shape this process of donor influence. I will use this conceptual framework to guide the analysis of the data from the Bank-funded Reproductive and Child Health project in India. In doing so, I will examine the Bank's influence in maternal and child health at the country level.

Chapter 3 Methods

3.1 Introduction

In this chapter, I present an overview of the methods used for this research study. I aim to study the World Bank's involvement and influence in maternal and child health at a global level as well as at the country level in India. Given the scope of an international institution such as the World Bank and the complex nature of the research questions, I decided to use a mixed methods research design, consulting multiple sources of data, to ensure depth and breadth of understanding and corroboration (Johnson et al., 2007). First, I briefly reflect on the paradigm that guides the mixed methods research design. This is followed by a description of the methods of data collection and the approach for analysing the data. Then, I discuss the ethical considerations and reflect on my positionality. I conclude by outlining the strengths and limitations of this study.

3.2 Paradigm and Research Design

Fishman writes that ‘‘all knowledge is knowledge from some point of view’’ (Fishman, 1978, p. 531). This notion is particularly important in a doctoral research study, as the point of view or paradigm reflects the researchers' epistemological understanding of the world, and directs the research efforts. Kuhn (1962, p.23) describes a paradigm as an “accepted model or pattern”, as an organizing structure, a deeper philosophical position relating to the nature of social phenomena and social structures. Morgan (2007) goes further to review four versions of the paradigm concept: paradigm as a world view, paradigm known as an epistemological stance, paradigm as shared beliefs among members of a specialty area, and paradigm as model examples of how research is done in a given field.

This doctoral study recognises the importance of a paradigm, and conceptualises it as beliefs and practices that influence how researchers select their questions and methods they use to study them. It views a paradigm as a roadmap that can help the researcher align their choices with their values (Shannon-Baker, 2016). For this study, I employ the paradigm of pragmatism. This paradigm places primary

importance on the research question, and emphasises communication and shared meaning-making in order to create practical solutions to social problems (Tashakkori and Teddlie, 2003). The pragmatic researcher is able to maintain subjectivity in their reflections on research and objectivity in data collection and analysis (Morgan, 2007). Pragmatism, accepts, philosophically, that there are singular and multiple realities that are open to empirical inquiry and orients itself toward solving practical problems in the real world (Creswell & Plano Clark, 2007, pp. 20-28; Rorty, 1999). This paradigm promotes an underlying belief in complementarity, that is, qualitative and quantitative approaches can be combined in order to complement their inherent advantages and disadvantages. Thus, most pragmatic researchers often use a mixed-methods approach, by using quantitative methods to measure some aspects of the phenomenon in question and qualitative methods for others (Feilzer, 2010). The most important question for the pragmatic approach, is whether the research has helped “to find out what [the researcher] want[s] to know” (Hanson, 2008, p. 109).

This pragmatic epistemological stance thus guides my choice of using a mixed methods research design for this study. Mixed-methods research is an approach that draws from primary and secondary sources of data and can integrate quantitative and qualitative methods, data collection and analysis in a single study or a program of enquiry (Creswell, 2003). A mixed methods approach is best suited for this doctoral study for several reasons. First, the research questions in this study necessitate an objective enquiry as well as an interpretive analysis. For example, in trying to answer the research question around the World Bank’s contributions and limitations in maternal and child health in terms of its financial investments, technical assistance, and cooperation, I outline two objectives. I, first, trace the Bank’s policies and programmes for this health area over five decades, which requires an interpretive analysis; then, I track the Bank’s financial flows to estimate its financial contributions to this area over time, which demands an objective enquiry. Second, a mixed methods approach offers the scope for complementarity, in that, it seeks elaboration and clarification of findings from one method such as document review with the findings from another method such as interviews (Greene et al., 1989). Third, this approach provides a contextual understanding by drawing from qualitative

data, thereby offering a context to better understand the quantitative findings (Bryman, 2006). For instance, a qualitative analysis of the Bank's policies and programmes for maternal and child health will provide a context to better understand its financial flows for this area. Fourth, this approach helps to fill any gaps emerging from one source of data and corroborate findings from across multiple sources of data, thereby facilitating triangulation of the findings (Greene, 2007). Finally, mixed methods research offers credibility, as by using multiple sources of data, this approach reduces the chance that interpretation of the data will be misleading and enhances the integrity of the findings (Creswell and Plano Clark, 2007).

Within this overarching mixed-methods research design, I also employed a case study component to answer the research question around the World Bank's influence in maternal and child health at the country level in India. This case study examines the Bank-funded Reproductive and Child Health (RCH) Project. A case study approach primarily investigates the 'how' and 'why' questions in a research study (Yin, 2009), which makes it relevant for this doctoral research, as I am interested in understanding the how and why of the Bank's influence in maternal and child health in India. This case study uses multiple sources of data to trace the design and implementation of the RCH project, examine the relationships among actors and agencies, and corroborate events in the timeline of the project (Gilson, 2011; Thomas, 1998). I use the conceptual framework of donor influence, as developed from the theoretical and empirical literature (described in Chapter Two), to analyse the data on the RCH project. In doing so, this case study thus explores the concept of donor influence, the process in which the Bank exerts its influence at the country level, and the extent of this influence.

3.3 Sources of data

I consulted primary and secondary sources of data for this study including (i) published articles, (ii) grey literature reports, (iii) archival records, (iv) financial datasets, (v) interviews. In table 3.1, I list each of the nine chapters of this thesis, and outline the corresponding objectives of each chapter as well as the source of data used. In the following segments, for each source, I will describe the method of data collection and the approach for analysis.

Table 3.1: List of thesis chapters by their objectives and sources of data

CHAPTER	OBJECTIVES	SOURCES OF DATA				
		PRIMARY DATA			SECONDARY DATA	
		Archives	Interviews	Financial datasets	Published articles	Grey literature
Chapter 1	To introduce the research topic, discuss the gap in the literature, describe the research question and objectives.			X	X	X
Chapter 2	To describe the conceptual framework of donor influence to be used for the analysis of the case study of the RCH project.				X	
Chapter 3	To describe the research design, methods, ethical considerations, and strengths and limitations of this study.				X	X
Chapter 4	To trace the MCH-related policies and programmes of the Bank from 1970 to 2018.	X			X	X
Chapter 5	To track the Bank's financial flows for MCH from its core budget and extra-budgetary funds from 1970 to 2018.			X	X	X
Chapter 6	To describe the relationship between India and the Bank from 1944 to 2018, thereby providing a context for examining the RCH project.		X		X	X
Chapter 7	To trace the design and implementation of the RCH project implemented from 1997 to 2012.	X	X		X	X
Chapter 8	To examine the RCH project, explore the process of the Bank's influence, and ascertain the degree of this influence.	X	X		X	X
Chapter 9	To summarise the key findings and discuss the implications and recommendations.				X	X

3.3.1 Published articles

I conducted a literature review of published peer-reviewed articles for three components of this study. The first component was a review of the empirical literature on donor influence over health policy, which enabled me to develop a conceptual framework for data analysis and interpretation (as described in Chapter Two). The second component was a review of articles on the World Bank and reproductive, maternal, newborn and child health (RMNCH). The third component was a review of articles on the World Bank and the Reproductive and Child Health Project in India. I conducted a search using the following search terms in eight global health databases including ASSIA, IBBS, Global Health, PubMed, Medline, Scopus, Web of Science, and ProQuest Dissertations and Theses Global.

Search terms:

Search component 1: Donor influence over health policy

1. 'influence' AND 'donor' AND 'health'
2. 'influence' AND 'World Bank' AND 'health'

Search component 2: World Bank and RMNCH

1. 'World Bank' AND ['reproductive' OR 'maternal' OR 'newborn' OR 'child']
2. 'World Bank' AND 'population'
3. 'World Bank' AND 'safe motherhood'
4. 'World Bank' AND 'child survival'

Search component 3: World Bank and Reproductive and Child Health Project

1. 'World Bank' AND 'India' AND 'health'
2. 'World Bank' AND 'India' AND 'population'
3. 'World Bank' AND 'India' AND ['reproductive' OR 'maternal' OR 'newborn' OR 'child']
4. 'World Bank' AND 'Reproductive and Child Health Project'

Abstracts of any article that contained any of the above listed search terms in the title and or abstract, was in English language, and was peer-reviewed, was included in the first round of analysis. Each abstract was reviewed, and if found relevant, the complete article was downloaded and saved in a separate folder. All duplicate articles were manually removed. The shortlisted articles were keyword searched for relevant text, and only those articles with relevant text for each of the search components was included in the final review. Reference lists of shortlisted articles were also reviewed for any additional articles. The review of published scientific literature found a total of 165 relevant articles that were included in my analysis.

3.3.2 Grey literature

I reviewed relevant grey literature documents such as annual reports, strategy reports, working papers, policy briefs, and factsheets from the World Bank 'documents and reports' database, its Independent Evaluation Group repository, relevant websites of the Government of India and international and national stakeholder organisations, and Google Scholar. Essentially, I reviewed any document that described or examined the World Bank's role in RMNCH at the global level or at the country level in India, and included in my analysis, those documents that were relevant to the research questions. The search strategy and inclusion criteria similar to that of published scientific literature review, was used to identify grey literature reports. A total of 40 relevant documents were saved for thematic analysis.

3.3.3 Archival records

Relevant historical documents held at the Archives of the World Bank (Washington, D.C), were reviewed and analysed. I consulted the World Bank Archives staff via email correspondence with a request to visit the Archives and review relevant documents. I shared a list with the Archives staff of the search terms emerging from the published and grey literature review, including 'Reproductive', 'Maternal', 'Newborn', 'Child', 'Reproductive and Child Health Project', 'India', 'Safe Motherhood', was given to the Archives staff, to review and prepare a list of available archived documents. On

receiving a list of available archived documents from the World Bank staff, I reviewed, identified and requested for access to relevant documents. Once the Bank Archives staff confirmed access for the requested documents, I sought an appointment to visit the Archives. While at the World Bank Archives, I reviewed a total of 120 archived folders containing documents such as aide memoires, correspondence memos, and research and strategy reports. Each document was carefully reviewed, and if found relevant, a photograph was taken for further analysis. A total of 62 archival documents were finally shortlisted to be included in my analysis (see Appendix 1).

Each shortlisted archival document was carefully read, and relevant information was extracted and included in an excel sheet. Each shortlisted archival document was treated as an independent case. For each case, information such as identification details (such as document number and date), type of document (such as aide memoire, strategy report, and correspondence memos), category (such as reproductive health or population control), key actors (sender and receiver of document), and key points, were extracted into the sheet. 'Key points', included any text on reproductive, maternal, newborn, and child health (RMNCH), such policy, strategy, programme, financing, evaluation or any other relevant topic under this area.

The archival records essentially provided information about two areas. First, archives described the World Bank's day-to-day involvement and key actors in its initiatives for maternal and child health in the 1980s viz. the Special Programme of Research, Development and Research Training in Human Reproduction, the Taskforce for Child Survival and the Safe Motherhood Initiative. Second, relevant archival records also provided information on the Bank's role (through its global and country office staff) in the initiation, design and implementation of the first phase of the Reproductive and Child Health project in India. I carefully reviewed these information and used these in the next step of analysis for chapters four (Bank's policies and programmes for maternal and child health), seven and eight (RCH case study).

3.3.4 Financial datasets

I consulted five types of financial data for this study: (i) Development assistance for health for RMNCH from 1990 to 2018 sourced from the Institute of Health Metrics and Evaluation (IHME), (ii) World Bank's financial flows through country-level RMNCH projects from 1970 to 2018, (iii) World Bank's financial flows through regional and global-level special health programmes for RMNCH, (iv) World Bank's financial flows through its RMNCH-related trust funds from 2005 to 2011, and (v) World Bank's financial flows for IDA, IBRD and Health from 1970 to 2018. These financial data have been analysed and presented in Chapter Five (i.e., tracking the Bank's financial flows for RMNCH).

Institute for Health Metrics and Evaluation

Development assistance for health (DAH) has been defined as 'financial and in-kind contributions made by channels of development assistance – that is, by institutions whose primary purpose is providing development assistance to improve health in developing countries' (IHME, 2011). I analysed financial data from IHME for two reasons. First, I sought to document the global financing landscape for RMNCH, including the Bank and other major donors. Second, I wanted to compare the DAH from IHME with similar financial data from the World Bank, and comment on the level of congruence between these two sources.

I downloaded the publically accessible DAH dataset from the IHME website (IHME, 2019b). This dataset provided financial disbursements from donors for a range of health areas including RMNCH, from 1990 to 2018. First, I extracted all the financial information for the area of RMNCH into a separate excel sheet, and analysed the data for key trends including overall disbursements, major donors, major recipients by geographic region and country, and financial disbursement by programmatic areas. Second, I extracted financial information for RMNCH that was channelled through the World Bank into another excel sheet, and analysed the data for similar trends as above.

WORLD BANK

The World Bank finances its RMNCH work from its core budget and its extra-budgetary funds. From its core budget, the Bank finances RMNCH activities in two ways: (i) country-level projects through credits (concessional loans) and grants, and (ii) regional and global-level special health programmes through grants. From its extra-budgetary funds, the Bank channels grants through trust funds.

Country-level projects

The World Bank lists all of its country-level RMNCH projects on two of its publically available databases: (i) project operations database[1] and (ii) development topics database[2]. Both these databases were searched for RMNCH projects from January, 1970 to December, 2018. First, the project operations database was consulted, and a total of 320 projects under the two relevant themes of 'population and reproductive health' and 'child health' were identified. Second, the development topics database was consulted, and a total of 400 projects under the relevant theme of RMNCH were identified. The lists of projects identified from both the databases were cross-checked and duplicates were excluded. A total of 484 Bank-funded RMNCH projects were included for data analysis. The final list of selected RMNCH projects consists of two types of projects i.e. Active (ongoing projects) and Closed (completed projects). For all the closed RMNCH projects, the Implementation Completion Results Report was downloaded from the World Bank website to obtain financial and programmatic information for each project, and saved in a separate folder for analysis at a later stage. In the case of all the active projects, the project agreement document was downloaded and saved.

[1] World Bank Projects and Operations Database available here: https://projects.worldbank.org/
[2] World Bank Development Topics Database available here: https://www.worldbank.org/en/topic/reproductivematernalchildhealth

I developed a coding questionnaire in Excel (see Appendix 2), which included variables such as project identification details, duration, total project costs, financial commitment and disbursement, Bank fees and interest rates, repayment by borrower governments, co-financing amounts by development partners, project objectives and themes, and project performance ratings. The coding questionnaire was first tested on ten projects, to check for feasibility and to include any additional variables. In this step, each project document was an independent case, and information from this document was extracted to answer each variable in the questionnaire. Each project was classified into a programmatic theme, based on the project objectives. In the case, where a project had multiple objectives which were relevant for different categories, the theme with the greatest emphasis was used for categorisation. All the variables with financial data were quantitatively analysed by running frequencies and means on Excel. All the variables with descriptive data were categorised in meaningful codes, and represented in meaningful graphs and charts. I engaged the support of a researcher, Adriel Chen - a fourth-year medical student from the Edinburgh Medical School, for this component of data collection on country-level projects. This was a voluntary, non-financial arrangement, and Adriel Chen used this work as part of his annual research project. I designed the data collection and analysis plan, and the data coding tool, while Adriel Chen downloaded reports for 484 Bank-funded RMNCH projects, extracted relevant data, and coded it into the coding questionnaire. I conducted the data analysis for this component.

Special health programmes

Since 1980, the Bank started funding the Special Grants Programme, releasing grants for health and development activities at the regional and global level. This programme was consolidated in 1998 under the Development Grant Facility. First, I reviewed relevant archival records to obtain financial flows for the Special Grants Programmes that were specific to RMNCH activities (De Ferranti, 1996). Second, I extracted RMNCH-related

financial data from the Development Grant Facility report from 1998 to 2014 (as information was not available after this year) (World Bank, 2014).
I analysed the total financial contributions for RMNCH activities through this channel for each year from 1987 to 2014 and reported the key trends.

Trust Funds

The World Bank channels these voluntary trust funds in three ways. First, there are trust funds financed by IBRD and IDA. These funds are either implemented by the World Bank or a recipient such as a country's Ministry of Health or a non-governmental organisation. Second, financial intermediary funds, which are more flexible and complex financing mechanisms that support global or regional partnerships, including the African Programme for Onchocerciasis Control, Global Fund to Fight AIDS, Tuberculosis and Malaria and GAVI, the Vaccine Alliance. In the case of this type of trust funds, the Bank either plays the role of a trustee, managing resources from other donor agencies, or it can also act as a major donor itself. The third type of trust funds is financed by the International Finance Corporation (IFC), and provides advisory services to businesses and governments, aimed at promoting private sector investments in developing countries (Winters and Sridhar, 2017).

The first step involved identifying and downloading the two publically available World Bank excel datasets for all the three aforementioned types of trust funds. The first excel dataset titled 'Paid In Contributions to IBRD/IDA/IFC Trust Funds based on FY of Receipt' (available here), contained financial information for 11446 trust funds financed by IBRD, IDA and IFC, as recorded from 2005 to 2015. The second excel dataset titled 'Financial Intermediary Funds Commitments' (available here), contained financial information for 17589 Financial Intermediary Funds, as recorded from 1991 to 2013. The second step involved classifying health from non-health trust funds, by carefully reviewing trust fund titles and consulting additional sources such as the World Bank trust fund directory as required.

The third step entailed categorising the health trust funds by a thematic area including (i) health systems strengthening (ii) avian and human influenza (iii) HIV/AIDS, tuberculosis and malaria (iv) neglected tropical diseases (v) reproductive, maternal and child health (vi) tobacco (vii) health promotion and (viii) non-allocable. In the fourth step, I scanned the health trust funds from (i) IBRD/IDA (ii) IFC and (iii) FIFs, to identify trust funds categorised under the 'maternal and child health' (MCH) theme. A total of 36 MCH trust funds were identified in the first (IBRD/IDA) dataset, while the financial intermediary funds dataset had one MCH trust fund. The IFC dataset contained no MCH trust funds. Finally, I conducted a descriptive analysis of all the 37 MCH-related trust funds, presenting key trends on total financial contributions, major donors, and programmatic areas.

Steps one to three i.e., downloading trust fund datasets, identifying health trust funds, and categorising health trust funds into thematic areas, were executed by Janelle Winters, a doctoral researcher affiliated with the Global Health Governance Programme at the University of Edinburgh, working on a larger Wellcome Trust-funded project that this doctoral study is also part of. Janelle Winters was assisted in data management by Iona Frost and Shu-Han Chen, graduate students, who conducted this work as part of their dissertation research for a Master's in Public Health degree at the University of Edinburgh. Informed consent was gained from the aforementioned researchers to use the raw data from steps one to three.

Overall Bank lending for IDA, IBRD and Health

I extracted the Bank's overall financial disbursement for IDA, IBRD and its Health Sector (Health, Nutrition and Population) from 1970 to 2018 from its annual reports for the same period. I compared the Bank's financial flows for RMNCH from the above sources and compared this with the Bank's total lending for health sector and its overall lending (IDA and IBRD) from 1970 to 2018, to get a sense of the proportion of the Bank's overall and health sector lending that was allocated to RMNCH.

3.3.5 In-depth interviews

I used purposive sampling to select the key informants for the in-depth interviews. The sampling framework was based on the need to select the most productive participants to answer the research question around the Bank's influence over MCH in India. I decided to select informants from the World Bank, the Ministry of Health and Family Welfare (MoHFW) and any donor agencies in the Reproductive and Child Health (RCH) project, as well as external actors such as academics and womens health advocates who were very involved in the RCH project and also featured in the literature. I identified the majority of the key informants from the peer-reviewed and grey literature and the archives as well as through snowballing, where few informants led me to other potential participants.

I conducted in-depth interviews with a purposively selected sample of 30 key informants in two settings i.e., Washington D.C in the U.S. and New Delhi in India. Washington D.C is home to the World Bank Group Headquarters. The World Bank Country Office and Ministry of Health and Family Welfare (MoHFW) are based in its capital city of New Delhi. I identified former staff, who were closely involved in the design and implementation of the Reproductive and Child Health Project (RCH), and current staff, that were working on existing RMNCH projects in India. These interviews served two purposes: First, they provided rich data on the process of the design and implementation of the RCH project and the existing situation of RMNCH in the country after the closure of the project. Second, and more importantly, these interviews helped to fill in any information gaps that emerged after the review of archival records and the published and grey literature. In serving these two purposes, the interview data also guided the overall research question of exploring and examining the process and degree of the Bank's influence in India.

Informants from the World Bank were of two types. First, there were informants that had worked at the Bank headquarters in Washington D.C., and would visit the Bank's country office in New Delhi as part of their bi-annual missions for the RCH. This group of informants held the position of senior health specialists, and either worked in the capacity of a country team leader or a regional director of health for the South Asia region. Second, there were informants, senior health specialists, who were stationed at the Bank's country office in New Delhi. Within these two groups, I identified a total of eight former and current staff members.

I interviewed three types of informants from the MoHFW, all of whom had either worked closely on the RCH or were working on existing RMNCH projects. First, there were informants who were Indian Administrative Services officers that had served as secretaries of the MoHFW at the central government level. This is the second highest position in the national health ministry after the health minister. Second, there were informants, health specialists that had served as directors of the maternal and child health department at the central government and state government level. Third, there were informants from National Health Systems Resource Centre (NHSRC), a central government funded unit that provides technical assistance to the MoHFW, and had worked on components of the RCH project.

Apart from the World Bank, UNFPA and DFID were the other donor agencies that financed the second phase of the RCH project. I approached former and current staff from both of these international agencies to get a comprehensive picture. I got approvals for interviews from three informants from UNFPA (one former and two current staff); however, I was not able to gain interviews from potential informants from DFID. Apart from the World Bank and the MoHFW, I also interviewed four informants, academics and womens health advocates, who were closely involved in the discussions

around the RCH project and published critical reports, articles and books around the World Bank's involvement in MCH projects in India.

Table 3.2: Description of informants by institution

No	Institution	Number of informants
1	World Bank (Washington D.C.)	8
2	World Bank (India Country Office)	4
3	MoHFW (Health Secretaries)	3
4	MoHFW (Directors of MCH Department)	6
5	MoHFW (NHSRC)	2
6	UNFPA	3
7	Women's health advocates and academics	4

Once identified, potential informants were contacted via email or telephone, informed about project objectives, and requested for interviews. Appointments were sought for face-to-face interviews. In case, a personal meeting was not impossible, a Skype or telephonic interview was arranged. A semi-structured interview guide with open-ended questions was developed in English, for each type of informant group (see Appendix 2). Although, I had an idea of the broad questions I wanted to discuss, I started each interview by asking informants to recount their experience, achievements, and trajectory within their institution. These initial discussions helped to build a rapport. I also adapted the interview guide to correspond with the experience and institutional background of each informant.

After gaining confirmation and an appointment, an information sheet was emailed in advance and read out to each informant, describing the purpose of the study, and how the findings will hopefully help policy makers and practitioners. Informants were made aware about confidentiality and reminded of the voluntary nature of participation. At the start of each interview, informants were asked for their consent to audio-record the interviews. The interview commenced only after gaining signed consent from the informants. All the interviews were conducted in English language, based on the preference of the informant, and lasted for 45 to 60 minutes on an

average. I transcribed the recorded audiotapes of all the interviews in English. Additionally, I also made notes after the completion of each interview, which formed part of the interview data. After the transcription, I familiarised myself with the text by carefully reading the interview transcripts and notes multiple times and noting my impressions. I used the conceptual framework of donor influence (developed in Chapter two) to deductively analyse the interview data and organise the findings into categories defined in the framework. The categories along with supporting quotes were checked again and to ensure robustness of interpretation. These findings have been presented in Chapters six to eight (India case study).

3.4 Triangulation of findings

I followed the process of triangulation for this study i.e., integrating findings from quantitative and qualitative methods (Cathain et al., 2010). For each chapter, based on the research objective and the overarching question, I ensured triangulation, by first listing the findings from each data source on the same page and considering where findings from each component agreed (convergence), offered complementary information on the same issue (complementarity), or appeared to contradict each other (discrepancy or dissonance) (Farmer et al., 2006; Foster 1997). This study also recognises that explicitly looking for disagreements between findings from different methods is an important part of this process. Disagreement is not a sign that something is wrong with a study. Any apparent “inter-method discrepancy” was explored to gain a better understanding of the research question (Fielding and Fielding, 1986). I found that drawing from a combination of sources such as documents, archival records and interviews offered more complementarity and helped me to construct a comprehensive narrative. All the combined findings and any new emerging themes were then organised meaningfully under each chapter.

3.5 Ethical considerations

The primary documentary sources (e.g. archival records, project reports, financial datasets, and published literature) are all publicly available and hence there were no ethical concerns associated with their procurement and analysis. Even with regards to the qualitative research component, this study raises no special ethical issues. Standard practices of ethics approval, informed consent, voluntary participation, confidentiality, and appropriate data storage were employed. These are described in detail below:

Ethics approval

I applied for a formal ethical review at the Usher Research Ethics Group at the Usher Institute of Population Health Sciences and Informatics of the University of Edinburgh. This application consisted of (i) Self-Audit Checklist for Level 1 Ethical Review, (ii) Level 2/3 form, (iii) Research study protocol, (iv) Participant information sheet, (v) Consent form for participants, (vi) Interview schedule. I was granted ethics approval in October 2017, after which I began contacting potential informants for interviews.

Informed consent

Prior to the interview, I shared with every participant an information sheet that clearly explained the aims of the study, interview procedure, and how the findings will be used. This sheet contained the email address of a senior staff at the University of Edinburgh, in case participants wish for further information or have a complaint regarding the researcher's conduct. I explained the voluntary nature of participation by informing the participant that they were free to withdraw from the research at any time without giving a reason; likewise, it was clear that the potential participant had the right to refuse participation, or to later withdraw from the study at any point, if that was their wish. In terms of confidentiality, I discussed with each participant, the level of anonymisation required, and how they would be referred to in project outputs. I also gained consent for audio recording of interview from all the informants. Before the interview commenced, I discussed the consent

form with the participant, and upon the satisfaction of the latter with said form, both the researcher and the participant signed two copies of it, one for the participant and the other for the researcher's records. In the case of a telephonic or Skype interview, the researcher emailed the consent form to the participant and requested them to send an electronically signed copy via email.

Data storage

After the conduct of interviews, I downloaded and electronically stored all the interview data files including audio files, transcripts, notes and any raw data, in a private folder on the University of Edinburgh server, which was password protected. I kept paper copies of all data files securely in a locked cabinet in my office in the Usher Institute of Population Health Sciences and Informatics. I maintained consent forms separately from the data files, and stored these in another secure cabinet in my office at the Usher Institute. To maintain anonymity, I gave an identification code for interview data for each informant instead of their name and personal details. On passing the doctoral research programme, I will shred all paper copies of the data files. I will also delete all the electronic transcript files in the private folder. I will transfer all the electronic data files in the private folder in my University server to a private folder in my Supervisor's password protected University server, for five years from the completion date of the PhD programme for the purpose of any further publications. All the electronic files will then be deleted from the researcher's University server. After the five-year period following PhD completion, all electronic files will be deleted from the Supervisor's University server.

3.6 Positionality

One of the issues facing health policy analysts is their positionality or in other words, how they are viewed or 'situated' as researchers, their institutional base, perceived legitimacy, and prior involvement in policy communities (Walt et al., 2008). A researcher's positionality is critical to their ability to

access the policy environment and conduct meaningful research, especially in policy analyses that require engaging with policy elites (Shiffman, 2007). Keeping this aspect in mind, I think it is important to reflect on my situation as an ‘insider’ and an ‘outsider’ during this research study, and how it impact my analysis.

My previous work experience as a health researcher and programme manager on maternal and child health projects across four states in India, gave me an ‘insider’ status as I was routinely exposed to the debates and challenges around this area and was familiar with the organisational structures of the Ministry of Health and Family Welfare (MoHFW). This experience helped me appreciate the maternal and child health situation in India and enter the research study with an informed perspective. I was also able to use the contacts I had developed from my previous work experience, to identify potential informants within the MoHFW. Furthermore, my doctoral research was based in the University of Edinburgh and was part of a larger research project funded by the Wellcome Trust. This association with an international university and a global research charity like the Wellcome Trust enhanced my credibility and helped me gain access more easily, particularly to my informants in India, as I was perceived as being an independent researcher. Since I was part of a larger research project that studied the World Bank, I benefited from the initial contacts established by senior team members. Although, I did find it challenging to make contact and gain interviews with some Bank staff.

Finally, as a social sciences researcher, I also had an ‘outsider’ status as many of my informants were experts, in that they were either medical doctors or development specialists. Although, I felt that being an outsider in this respect actually prompted me to ask a lot of general questions that helped me understand the issues better. Furthermore, several of my informants were senior in age and professional position, and viewed me as a young student

and a non-expert, which I conceived as a benefit, as they were candid and more willing to have in-depth conversations.

3.7 Strengths and limitations

This study has four main strengths. First, it is among the very few (if not the first) to explore the World Bank's involvement and influence in maternal and child health (MCH) over time. Studies have examined and evaluated the Bank's involvement in MCH projects in different countries over specific periods of time (Coburn et al., 2016; Chimhutu et al., 2015; Baird et al., 2008). However, I intend to contribute to the literature on the World Bank and global health, by documenting the contributions and limitations of the Bank's involvement in MCH at the global level over a period of five decades, and by exploring the process of its influence in this area at the country level in India. Second, the case study of the RCH project in India allowed me to capture multiple perspectives including those of domestic policy makers and government officials, donor agency representatives, and academics and civil society stakeholders, which helped to explore the context and complexities within which donor-recipient relationships work, thus allowing me to provide an in-depth account of the process of World Bank's influence in a high-burden, aid-recipient country.

Third, by using a mixed methods approach, I offset the weaknesses of quantitative and qualitative research methods and draw on the strengths of both (Bryman 2006). While studying the World Bank over a period of time, it was of great help to consult multiple sources of data, as some sources helped to fill the information gaps that existed in others, thereby helping me to document a more comprehensive account. Relying on multiple data sources also enhanced the credibility of the findings. Finally, I contribute to the scholarship in the field of health policy analysis by presenting a conceptual framework of donor influence in health policy at the country level. The application of this framework in the case of India and resulting findings, thus provide a roadmap for health policy researchers to explore and examine

the process of external donor influence in similar settings.

This study also has certain limitations. The decision to focus on one actor within the complex system for maternal and child health was made on pragmatic grounds. Given the duration of the doctoral research project, it was feasible to focus on the World Bank as it allowed for an in-depth analysis of the institution's evolving position on maternal and child health, and the justifications for the same. However, this approach could have also introduced potential biases such as an over attribution of influence to the Bank compared to the other agencies involved in this area. Another limitation is the lack of investigation of what the other actors in this area did and why, and how this would have affected the Bank's role. I attempted to address these limitations by carefully reviewing the data and discussing the role of the Bank vis-à-vis other actors, and verifying the claims of the Bank's role through triangulation of multiple data sources. Furthermore, as I attest in Chapter 8, this thesis can at best appraise the likely contribution of the World Bank and rather than attribution.

I used the World Bank Archives as one of my sources for primary data. While it was a useful source for historical information on the Bank's involvement in MCH initiatives in the 1980s, particularly around key actors and justifications for certain policy decisions, this method did have its limitations. These archives are not searchable on any online platform; the World Bank archivist had to physically plough through hard copies of documents based on the search terms provided by me. Archived folders have titles with a limited description which further complicates the search and retrieval process, in the sense that one may not really know what information is in the file merely based on its title Moreover, I spent two weeks (fulltime) in the archives based on my available funding for international travel, accommodation and maintenance; which limited my ability to consult any additional archival records. The Bank's internal access to information policy restricts disclosure of certain types of files such as those containing financial information. Finally,

the Bank archives also have a 20-year restriction policy, as a result of which I was not able to access any files that were archived in the past 20 years. This restriction policy implied that I could not access any of the Bank documents for the second phase of the RCH project in India, which ran from 2005 to 2012. Altogether, these internal policies and procedures may have restricted my access to obtaining all the possible relevant archival documents for my research. A question that emerges from the aforementioned limitations around the archival research is whether it is an effective method for future researchers to study international institutions such as the World Bank in particular. The answer really depends on the context of the researcher. If the researcher is able to spend more time at the archives based on their location and funding, and has the ability to scour through an extensive list of archival records over a period of a couple of months at the least, it can definitely be a fruitful methods for uncovering data for their research questions.

Access was also a limitation in the case of financial datasets for Bank trust funds. Similarly, in terms of secondary data, I may have missed out on certain articles and reports that may not have been published in English or available on online databases and search platforms. However, the use of multiple sources of data has helped to fill these gaps.

Another limitation could have been the choice of informants for the qualitative interviews. This purposive sampling created a natural limitation in who participated in this study. Though, I tried my best to identify relevant stakeholders from the archival documents and literature, and also verified these potential names through snowballing technique, used as I conducted interviews. Qualitative interviewing also has an inherent bias, wherein informants may have the proclivity to say what is expected to be heard irrespective of whether or not these represented their actual views or intentions. I attempted to address this bias to an extent, by providing complete information about the research aims and implications and my affiliation, and by building rapport to encourage real accounts. I interviewed

former retired officials and, in this case of respondents, memory (or lack of it) could have affected some of their responses. In this case, I sent the interview questions well in advance of the actual interview allowing the informants' time to recollect and jot down their thoughts. Finally, I verified the findings from the interviews by triangulating these with other sources, thereby helping to enhance its integrity.

Researcher subjectivity is a prime feature of this mixed methods study. While this subjectivity could be a potential bias emerging from reliance on the researcher as the primary instrument of data collection and analysis (Guba and Lincoln 1981), this could also be viewed as a strength, as this method does not attempt to eliminate what cannot be discounted. It acknowledges all the factors involved and helps to provide a comprehensive picture. Finally, this study enables an in-depth case of a Bank-funded project in India. While the findings from this case study cannot be generalised to all the other countries where the Bank operates, it would be interesting to examine whether the results found in this study would be applicable in other aid-recipient countries in similar settings.

Chapter 4 Tracing the World Bank's policies and programmes for maternal and child health from 1960 to 2019

4.1 Introduction

In this chapter, I explore the origins of the World Bank's work in maternal and child health (MCH) and trace its involvement in this area at the global level over five decades, from 1960 to 2019. I analyse the Bank's policies and programmes related to maternal and child health in this period. In doing so, I include in my analysis external events and actors as the Bank does not function in a silo; rather, it operates within a dynamic and ever-changing political environment, crowded with multiple actors at the global, regional and local level. I categorise the Bank's efforts into five phases and in each phase it has adopted a different and distinct approach towards its work in maternal and child health. Although, the Bank was first involved in maternal and child health indirectly through its lending for population control and nutrition projects in the 1970s, I begin the first phase from 1960 to offer a context for its entry into this area.

This chapter relies on three sources of data including (i) MCH-related documents published by the World Bank (such as health policy papers, health sector review, and strategy reports), (ii) Archival records from the World Bank Archives based in Washington D.C, including correspondence memos, project proposals, minutes of meetings, research and strategy reports, (iii) Published scientific and grey literature that reported any aspect of the Bank's work in MCH. Through this analysis, I identified major maternal and child health-related policies, programmes and partnerships led or supported by the Bank during each of the five phases of its involvement. In this chapter, I thus attempt to answer two key questions: (i) how has the World Bank conceptualised MCH over time; and (ii) what has been the Bank's programmes and financing approach for MCH.

4.2 Phase 1: The expansion of the population control movement (1960 – 1968)

The global population control movement flourished in the 1960s, driven by the United States (U.S.) population control establishment, which consisted of the United States Agency for International Development (USAID), private foundations including the Ford Foundation, Rockefeller Foundation and Milbank Foundation, and international non-governmental organisations like the International Planned Parenthood Federation and Population Council (Conelly, 2005; Hartmann, 1981). The World Bank became a part of this establishment in the late 1960s (Kapur et al. 1997), and in the subsequent years, it forayed into maternal and child health through its population control projects.

The U.S. began releasing federal grants for family planning programmes in the country as early as 1964 (Bailey, 2012). In his second State of the Union Address on January 4, 1965, U.S. President Lyndon Johnson stated: “I will seek new ways to use our knowledge to help deal with the explosion in world population and the growing scarcity in world resources” (United States Senate, 1965, pg. 10). In the wake of this address, USAID launched its first population and family planning program in 1965. In the same year, at an event to mark the twentieth anniversary of the United Nations (UN), President Johnson remarked, “less than five dollars invested in population control is worth a hundred dollars invested in economic growth”, further endorsing the population control agenda at an international level (UN, 1965). While Whaley-Eager (2017) showed how the U.S. propagated the norm of population control as the best way to expedite development in the “third world” until the 1970s, Wilmoth and Ball (1992) argued that the U.S. government’s accelerated interest in regulating the population size of developing countries could have been linked to a particular anxiety that rapidly growing, poor countries in Asia would serve as fertile ground for communist revolutions.

Throughout the 1960s, international events promoted political priority and financial investments towards population control programmes in the world: developing countries established national family planning policies, the Second World Population Conference focused on fertility as part of development planning policy, the International Conference on Human Rights passed a resolution declaring family planning as a human right, and the United Nations Fund for Population Activities (UNFPA, now the UN Population Fund) began its operations (Sinding, 2007). By 1968, the Ford Foundation had funded $100 million through its population work in three areas in developing countries: research and training in reproductive biology; the establishment and/or expansion of university population studies centers in the United States; and assistance to population programs (Harkavy et al., 1968).

In 1968, Paul Ehrlich, a biologist from Stanford University, published the book titled “The Population Bomb” that predicted imminent population explosion and ensuing disaster (Ehrlich, 1968). This book equated overpopulation to a ticking bomb and asserted the many dangers of population growth including the starvation of millions of people and war; it was meant to raise the alarm on an urgent crisis, and was promoted as such by the U.S. population-control movement (Orleans-Reed, 2008). Ehrlich advocated for population control programmes that placed the good of the whole society over the needs or desires of the individual. He urged the U.S to intervene for the “plight of the less fortunate fellows on Earth” in order to help the Westerners to survive.

Ehrlich and the U.S population control establishment drew from Neo-Malthusian ideology that overpopulation was putting pressure on the resources for the current and future generations, and hence it needed to be urgently controlled (Hoff, 2018; Connelly, 2005). Since the late 1700s, Thomas Malthus, a British clergyman-turned-economist and one of the earliest advocates of population control, wrote that, unless restrained by “preventive checks” (abstinence, delayed marriage, and restricting marriage

against persons suffering poverty or perceived as defective) and “positive checks” (which lead to premature death such as disease, starvation and war), human populations would double every twenty-five years (Malthus, 1798).

Neo-Malthusian or modern day proponents of population control reinterpreted this Malthusian logic, selectively applying it only to the poor majority in the developing countries, and in some cases, to ethnic minorities in developed countries (Hartmann, 1981). Thus, in this Neo-Malthusian agenda, women from poor communities in developing countries and from ethnic groups in developed countries became the target of global population control efforts, and sterilisation served as the dominant birth control method promoted through these programmes (Hvistendahl, 2005; Hartmann, 1981).

The World Bank thus entered the stage within this historical context of concerns over population. However, before its active involvement in 1968, the Bank undertook two initiatives in this phase, which demonstrated its limited stance on population control. First, in 1958, driven by the growing debate by development economists, the Bank financed a landmark study on the economic impact of demographic trends in India (Coale and Hoover, 1958), concluding that India, as well as other low-income countries, would realize "immediate economic advantages" from a reduction in fertility. While some Bank officials agreed with Coale and Hoover's conclusion, in general, they did not see a role for the Bank itself in helping to limit population growth (Kapur et al., 1997). Second, in 1967 and early 1968, under the presidency of George Woods, information on population trends and policies began to be included in all country economic reports; even more significantly, borrowers' population policies were to be regarded as one indication of their commitment to economic growth (Woods, 1968; World Bank, 1968).

4.3 Phase 2: Population control and nutrition as a gateway to maternal and child health (1968 – 1979)

Population control – 1968

It was not until 1968 when Robert McNamara became President that the World Bank assumed an active role in the population field, primarily by the means of financing population projects. In April of 1968, soon after his election as the fifth President of the World Bank, Robert McNamara addressed his first Annual Meeting of the Board of Governors and made an announcement that would preoccupy him for the coming years. He argued that the "rapid growth of population is one of the greatest barriers to economic growth and social wellbeing of the people of our member states", urging the World Bank to take on new initiatives to address this crisis (Lewis et al., 1991; Maddux, 1981). This was a time when there was an overall weariness in developed countries over foreign assistance and the World Bank had not yet started lending for the social or health sector (Crane and Finkle, 1981).

McNamara's enthusiasm and approach for promoting population control can be better understood by reflecting on his life before the World Bank. In 1940, after graduating with an MBA and working for PriceWaterhouse, McNamara became (at 24 years old) the youngest and highest paid associate professor at the Harvard Business School. Soon after, he served in the U.S Office of Statistical Control during the World War II, with one of his major responsibilities being the analysis of U.S bombers' efficiency and effectiveness. In 1945, Henry Ford II hired ten World War II veterans known as the "whiz kids" including McNamara, to reform his money-losing company's chaotic administration through modern planning, organization, and management control systems. By the end of his career with Ford, McNamara left as the first President of the Motor Company from outside the Ford family (Zaleznik, 2005). He continued to remain associated as the

trustee of the Ford Foundation, an organisation that was firmly established in the global population control movement (Teltsch, 1982). Note that the Ford Foundation was one of the major proponents and financiers of population control activities in developing countries (Harkavy, 1995). In 1961, McNamara was appointed the U.S Secretary of Defense, where he was credited with ushering in systems analysis, and often times austere cost-cutting measures for the management of the vast military establishment (Rosenzweig, 2010). Over time, he became an influential member in the Johnson Administration. McNamara's deep interest in population control thus seems to have stemmed from his roles with the Ford Foundation and the U.S. government and the Ford Foundation (Harkavy, 1995; Crane and Finkle, 1981), and at the World Bank, he approached this issue with his characteristic management lens and his strive for maximizing efficiency (Kapur et al., 1997).

In 1970, McNamara established the Population Projects Department in the World Bank and approved the first loan of $2 million for family planning in Jamaica (World Bank, 1970), marking the Bank's indirect foray into lending for health. This first population loan financed the expansion of Kingston's principal maternity hospital and construction of 10 rural maternity centres. Similarly, the early population loans given to Tunisia, Indonesia and Malaysia, predominantly focused on "hardware projects" that constructed urban maternity hospitals and developed postpartum programmes as channels for recruiting family planning acceptors (World Bank, 1975).

While McNamara kept pushing the population control agenda, senior leaders and development economists did not consider this area bankable enough for the Bank to engage in a sufficiently significant way (Kapur et al., 1997). Senior health staff therefore reasoned that population growth thwarted efforts to increase per capita income and raise living standards and fertility reduction would help to correct this (World Bank, 1972), thereby justifying population projects by quantifying the economic benefits of its lending in this sector. The Bank financed family planning programmes that were implemented

independently or integrated into existing maternal and child health service delivery in borrower countries. Additionally, these projects mainstreamed family planning through other sectoral programmes. For instance, in 1978, the Bank made a population loan to Malaysia, which supported the Ministry of Agriculture's efforts to provide family planning information in conjunction with its activities to raise the socioeconomic status of women in rural areas through vocational training (World Bank, 1989).

Nutrition – 1971

By 1971, McNamara turned his attention to nutrition after being influenced by the work of prominent American nutritionist, Alan Berg (Sridhar, 2007). In January 1972, the Bank released a report titled 'Possible Bank Actions on Malnutrition Problems' that led to the establishment of a Nutrition unit within the Population Projects Department, which was then renamed as the Population and Nutrition Projects Department (Fair, 2008). McNamara hired Alan Berg to lead this department (Kapur et al., 1997). In 1973, Berg published 'The Nutrition Factor' where he advocated three major benefits of investing in child nutrition – (i) savings on medical costs through reduced demand for curative medical services (ii) reduced productivity losses caused by the debility of the labour force (iii) extension of productive working years (Berg, 1973). In line with the arguments made by Berg, the Bank released a policy paper recommending a more active role for itself in nutrition and rationalised its lending by linking nutrition with improved productivity and economic growth, thereby illustrating its capacity for return on investment (World Bank, 1973).

In 1976, the Bank eventually approved its first loan worth $19 million for nutrition to Brazil followed by another major loan to India in 1980 under the Tamil Nadu Integrated Nutrition Project (Fair, 2008). For the Bank's specialists, hunger—in line with neoconservative attitudes—was perceived as a matter of individual choice and not an outcome of structural factors as well. Behavioural change through the nutrition-related education for the

mother, dietary supplementation and growth monitoring of the child was the response to undernutrition (Sridhar, 2007; World Bank, 2006). Pre-school children were the primary beneficiaries of Bank-funded nutrition projects as improving their nutrition and investing in their human capital would have the strongest impact on productivity. A woman was targeted during the nine months of pregnancy and six months of lactation due to her role as a mother or future mother of a healthy member of the workforce. Her nutritional status was valued instrumentally, not intrinsically. Targeting lactating mothers ensured a healthy infant for the first six months and breastfeeding, which had contraceptive effects, thus fulfilling dual goals of child nutrition and fertility reduction (Philips and Sanghvi, 1996). Furthermore, nutrition was also an uncontroversial way of addressing family planning, as community health workers who spoke to mothers about nutrition could also approach the topic of family planning (Berg, 1973).

Health Sector Policy – 1975

In 1975, the Bank published its first health sector policy paper where it made a link between improvements in health conditions and economic progress (World Bank, 1975). While this paper appreciated the positive health consequences of Bank-funded projects, it maintained that the Bank would not lend directly for health projects due to the concerns over the feasibility of low-cost health care systems, the lack of governments' political will to institute significant reforms, and questions related to the Bank's role in the sector (Stout et al., 1997). While this policy paper did not directly discuss maternal and child health, cursory references were made to maternal and child mortality within the context of fertility reduction and integrating family planning and maternal and child health services. In 1979, the Population and Nutrition Projects Department was renamed the Population, Health, and Nutrition Department (Fair, 2008).

4.4 Phase 3: Major partnerships for maternal and child health (1980 – 1989)

Health Sector Policy – 1980

The Bank started lending directly for stand-alone health projects following a new policy it adopted in 1980 (World Bank, 1980). During the fiscal years of 1981 to 1986, total Bank lending for health reached $1 billion for 35 projects, making it one of the largest lenders for health projects in LMICS (Measham, 1986). This new health sector policy identified maternal and child health care as one of the first areas for lending. Maternal and child health care included family planning, prenatal care, screening for difficulties in delivery, safe delivery, neonatal care and immunization.

Special Programme of Research, Development and Research Training in Human Reproduction – 1984

The Special Programme of Research, Development and Research Training in Human Reproduction (HRP) was set up within the World Health Organization (WHO) in 1972, and funded mainly by European donors and the United Nations Population Fund (UNFPA) to conduct and promote research on human reproduction, with a particular emphasis on developing countries (Diczfalusy, 1986). While the World Bank got involved with the HRP in an advisory role right from its establishment, in 1984, it started co-sponsoring this programme along with UNDP, UNFPA, UNICEF and WHO, marking the Bank's first major global collaboration for maternal and health (Nassim, 1991).

The Bank's interest and financial support in the HRP resulted from its heavy involvement in population projects as well as a concern over the adverse changes in the challenging financial, political, and legal environment of reproductive research in the 1980s (Nassim, 1991). Correspondence memos between senior Bank health specialists showed their apprehension over the declined global funding for contraceptive research and development

(amounting to a 20% reduction in real terms between 1975 and 1983), which mainly resulted from the industry withdrawal from the field due to product liability concerns, and dissatisfaction with the restrictive and prolonged regulatory approval process (World Bank, 1986a). Furthermore, Bank staff also raised concerns about the leadership of the WHO, led by Director General Halfdan Mahler at the time, and its inadequate ability to attract the required financial support from governments in low-and-middle-income (LMICS) and donors, as well as the dominance of European donors (World Bank, 1986b). Financial involvement in the HRP thus gave the Bank greater control in the research agenda setting, management direction and programmatic decisions. The Bank continues to remain a co-sponsor of the HRP with an annual contribution of $2 million representing 10% of the programme's total funding (Nassim, 1991). Over time, Bank involvement strengthened the HRP's links with governments, facilitated its access to ministries outside the health sector and helped to sustain donor commitments (Benagiano, 2012).

Task Force for Child Survival – 1984

In 1984, the Bank entered another major partnership with the WHO, UNICEF, Rockefeller Foundation and UNDP, and co-sponsored the Task Force for Child Survival, which aimed to raise immunisation coverage in developing countries (Foege, 2018). Three major events raised international attention for child immunisation and set the stage for the formation of this taskforce. First, in 1977, WHO launched the Expanded Immunisation Programme, aimed at making immunisation against diphtheria, pertussis, tetanus, poliomyelitis, measles, and tuberculosis available to every child in the world by 1990 (Keja et al., 1988). Second, in 1982, James Grant, the Executive Director of UNICEF, launched the 'Child Survival and Development Revolution' in his annual State of the World's Children Report (UNICEF, 1982), presenting a selective package of four interventions to avert child deaths from preventable causes, including Growth monitoring, Oral rehydration, Breastfeeding and Immunization also known as the GOBI strategy. Third, in 1983, Robert

McNamara and Jonas Salk (creator of the inactivated polio vaccine – IPV) created the International Committee to Protect the World's Children, in association with Leopold Senghor (former president of Senegal) and H.F. van den Hoven (Vice-Chairman of Unilever Ltd) (World Bank, 1984a).

While this international committee viewed immunisation as a step towards building primary health care, McNamara consistently underscored the resulting reductions in child mortality as a contribution to alleviate demographic pressures. McNamara and Salk sought the endorsement of WHO and UNICEF. Despite the existing institutional rivalry between UNICEF and WHO around their respective vertical (GOBI package) and horizontal (primary health care championed at Alma-Ata) approaches to achieving health, the two organisations saw the benefits of becoming part of the initiative owing to the political momentum it created and the potential for increased financial resources for each of their immunisation efforts (World Bank 1984b; WHO, 1983).

The Rockefeller Foundation and UNDP joined this initial group of actors including the World Bank, WHO and UNICEF, and formed the Taskforce for Child Survival in 1984 (World Bank, 1984b). The task force was led by Dr. William Foege, an American epidemiologist credited with the successful campaign to eradicate smallpox in the 1970s (WHO, 2008), and had its Secretariat based at Emory University. This inter-agency partnership generated political priority for immunisation; raised financial resources implemented through WHO and UNICEF's immunisation programmes; and responded to requests from LMICS by facilitating responses of various international agencies. While the task force initially began its work in Colombia, Senegal and India, it now coordinates child health-related efforts in 154 countries, and has been renamed Task Force for Global Health (Task Force for Global Health, 2019; World Bank, 1985a).

The Bank played the primarily role of a financier, by contributing 10% of the annual budget of the Task Force, as compared to UNICEF that funded nearly

50% of the initiative; offered inputs in the form of economic analyses, budgeting, evaluations, secondments of its own economists and co-sponsoring short-term consultants to work with ministries of health in programme countries (World Bank, 1984c,d,e). Bank leadership and senior health specialists viewed the task force as a mechanism to increase the Bank's visibility and credibility as a development agency and as an entry point to deliver other priority child health interventions including family planning (World Bank, 1985a).

Safe Motherhood Initiative - 1987

In 1987, the World Bank along with WHO and UNFPA co-sponsored an international conference in Nairobi, where it launched the Safe Motherhood Initiative, which would go on to become the Bank's first major global partnership for maternal health (Mahler, 1987). Storeng (2010) argued that the creation of the Safe Motherhood Initiative was part of a broader effort to revive political commitment for the primary health care approach or the 'health for all' agenda as against the rising support for vertical and selective approaches.

In 1978, WHO and UNICEF convened the Alma-Ata conference on primary health care where member states affirmed health for all through a comprehensive agenda that recommended shifting resources from hospitals to primary health centres, building a cadre of mid-level health providers and community health workers to replace the shortage of clinical doctors, and to ensure a strong referral system wherein secondary and tertiary hospitals and facilities supported primary health centres (Cueto, 2004; WHO and UNICEF, 1978). Soon after the Alma-Ata declaration, Walsh and Warren (1979), both representatives of the Rockefeller Foundation, published an article in the New England Journal of Medicine, that promoted 'selective primary health care' for developing countries with limited financial resources, an approach that funded a small number of measurable and cost-effective interventions, which targeted the biggest sources of mortality and morbidity. In the same

year, the World Bank and Rockefeller Foundation convened a conference in Bellagio, Italy, that legitimised this concept of ‘selective primary health care’ (Cueto, 2004).

By the mid-1980s, maternal health was neglected as a result of the turn towards selective approaches and investments in specific child health interventions, triggering an international response. Rosenfield and Maine (1985) wrote an influential article in the Lancet that compellingly described the lack of attention to maternal health over child health and discussed how maternal mortality urgently required investments in the health system and could not be tackled through selective and single bullet approaches such as those used for improving child health.

Furthermore, in the same year, WHO’s first inter-regional meeting on maternal mortality reduction announcing that a half million women died annually of pregnancy-related complications sounded the much-needed alarm to the magnitude of this problem (WHO 1990). Two Bank specialists, Barbara Herz (Former Division Chief, Women in Development) and Anthony Measham (Former Division Chief, HNP) took keen interest in these international debates around the neglect of maternal health, and led the discussions for an inter-agency-supported conference on galvanising political support and financial commitment for reducing maternal mortality. The result was the Nairobi conference of 1987 which launched the Safe Motherhood Initiative (Measham, 2018).

Herz and Measham were the main authors of the Safe Motherhood Initiative’s policy (Herz and Measham, 1987). This policy recommended a combined preventive and therapeutic approach whereby pregnant women and mothers would receive health care in a three-tiered system – family planning and prenatal care at the village level, delivery at the maternity centre or district level hospital and obstetric emergencies referred to specially equipped facilities. The policy also recommended that primary level interventions be delivered by community-based health workers including

traditional birth attendants (TBA). Involving TBAs was based on the assumption that they would be supported by formally accredited and adequately staffed biomedical health care providers at higher levels of care.

Note that around this time, while Bank staff including Bank President supported seemingly vertical initiatives such as the Task Force for Child Survival, certain other Bank specialists also led the Safe Motherhood Initiative, which as Storeng (2010) argued, was framed as an ethical, development, and social justice imperative that challenged the existing disease-specific, vertical and neoliberal bias in international health. A closer reading of the Initiative's policy document (Herz and Measham, 1987) demonstrated the instrumental value that continued to be assigned to maternal health. It described maternal mortality as impacting the family through the loss of someone to care for, nourish and raise children, and contribute to the household income, and affecting the economy through the loss of women's productivity. Safe Motherhood was thus an economic and social investment rather than being an intrinsic need in itself.

The Nairobi conference resulted in the setting up of an Inter-Agency Group for the implementation of the Initiative, consisting of representatives from WHO, UNICEF, UNFPA, UNDP, the Bank and international NGOs (Storeng, 2010). A series of international, regional and national Safe Motherhood Conferences followed (Starrs, 1997). Bank-funded safe motherhood projects increased from 10 in 1987 to 150 across 29 countries in 1999, with an annual commitment of $385 million between 1992 and 1999—30% of total bank HNP lending (World Bank, 1999).

Structural Adjustment Programmes – 1980s

This decade also witnessed the rise of the Bank's Structural Adjustment Programmes (SAPs) in response to the debt crisis in developing countries (Abbasi, 1999). Each year during 1980-1986, there were 48 countries with adjustment lending from the Bank - a number that had risen to 59 by 1988 (Kapur et al., 1997). SAPs included a range of fiscal and policy measures,

such as cuts in consumption and public spending to reduce inflation and public debt - including cuts in the health and social sector spending; a greater involvement for private industry in all sectors; decentralisation; and a lower profile for central governments. These conditionalities had to be implemented by borrowing country governments to avail further Bank loans (Di et al. 2007; Segall 2003; Navarro 1998; McPake 1993).

Alongside SAPs, the Bank (along with the WHO and some bilateral donors) promoted health sector reforms in low-income countries during the 1980s to mid-1990s (Standing, 2002). A 1985 Bank publication stated that “the conventional and still growing faith that healthcare should be totally paid for and administered by government needs to be vigorously challenged” (de Ferranti, 1985). This influential paper thus recommended cost recovery to finance health care, along with risk-sharing instruments ranging from formal insurance to community-based cooperatives, public-private mix for financing and providing health services, and structuring subsidies and their incentives. Another Bank paper in 1987 promoted fee payment for health services, privatisation of large parts of health services and introduction of private insurance programmes, as well as decentralisation of the management of health care (World Bank, 1987).

Several studies linked SAPs with a detrimental impact on maternal and child health outcomes by undermining access to quality and affordable healthcare through user fees and cuts in public spending, as well as by adversely affecting social determinants of health, such as income and food availability (Thomson et al., 2017; Ridde, 2008; Breman and Shelton, 2006; Abbasi, 1999). Towards the end of this decade, internal Bank reviews acknowledged the negative health outcomes of SAPs and the need to identify ways for borrower countries to protect the poor and vulnerable during adjustment periods (Elbadawi et al., 1992; McCleary, 1990).

4.5 Phase 4: Institutionalisation of a selective approach for maternal and child health (1990 – 1999)

Child Vaccine Initiative - 1990

In 1990, the Bank co-sponsored another partnership for child health i.e. the Child Vaccine Initiative, along with WHO (as the lead agency), UNICEF, UNDP, and the Rockefeller Foundation. While the task force for child survival focused on generating demand for immunisation in developing countries, the Child Vaccine Initiative worked on the supply side, by coordinating between the UN agencies, governments, and the public and private pharmaceutical industry for setting priorities for global vaccine development and delivery, and organising efforts to produce efficient and effective vaccines (Muraskin, 2002; Cadell, 1997). This Initiative received a total annual grant of $2.5 million from all the agencies, to conduct its work through task forces that examined strategic, logistic, and policy issues relevant to the industrial development and introduction of child vaccines (Institute of Medicine (US) Committee on the Children's Vaccine Initiative, 1993).

By the mid-1990s, this Initiative was absorbed into WHO, and increasingly faced competition with the agency's own Global Programme for Vaccines and Immunization. Being housed in Geneva, the Initiative received technical direction from WHO, disproportionate to other donors (Muraskin, 1998). While the pharmaceutical industry had agreed to deliver a temperature-stable polio vaccine, the Initiative later declined this proposal that it had originally requested, primarily due to fears within the WHO and UNICEF around the lack of community acceptance of such a vaccine (Cadell, 1997). Furthermore, tensions between the industry and WHO increased due to ideological differences owing to the agency's position of vaccines as a public right versus the industry's profit motive (Muraskin, 2002).

Bigger developments were to follow. In 1997, at a meeting held at the Bellagio Centre, Seth Berkeley (then the acting director of the health division

of the Rockefeller Foundation) suggested to Jacques-Francoise Martin (chief proponent of the Child Vaccine Initiative and former CEO of leading pharmaceutical companies - Pasteur-Merieux, Chiron, and Biocene) greater industry involvement as a way to address the weakening of the Initiative (Muraskin, 2002). These discussions stirred Martin to draft a paper, which proposed reinvention of the initiative with strong leadership, focused targets, new sponsors for raising adequate financial resources and greater industry involvement (Martin, 1997). Martin took this paper to WHO, UNICEF, UNDP and the Rockefeller Foundation; while WHO was unhappy with the plan as the leadership felt that it would take over its own programmes, no concrete outcomes emerged from discussions with the other partners (Muraskin, 2002). Finally, Martin approached Richard Feacham (then the Director of HNP) with this proposal, who responded positively, and organised a high-level summit led by the former Bank President James Wolfensohn in Washington D.C in 1998. This meeting, attended by the heads of UN agencies, industry representatives and international health leaders, signalled the Bank's ultimate commitment for child health. By leveraging technical support from UN agencies, partnering with the private sector for vaccine development, and offering tiered financial resources and vaccines to developing countries, the Bank positioned immunisation as a national economic investment (Glassman and Temin, 2016).

Another inter-agency meeting was held in Bellagio in 1999, where the majority of the actors including the Bank, recommended a public-private partnership for vaccines and immunisation under a strengthened Child Vaccine Initiative (Muraskin, 2002). However, at this meeting itself, WHO announced that it was going to dismantle the Child Vaccine Initiative after eight years of its functioning (Gavaghan, 1999); senior WHO leaders justified this action by labelling the existing Initiative as superfluous (World Bank, 1999). The death of the Child Vaccine Initiative was followed up by a new global alliance for immunisation in 1999 when the Bill and Melinda Gates Foundation's Children's Vaccine Program offered a seed grant of $750

million to this existing inter-agency group to launch GAVI, the Vaccine Alliance (Glassman and Temin, 2016).

World Development Report – 1993

In 1990, the Bank commissioned Chris Murray, Alan Lopez and Dean Jamison to conduct the Global Burden of Disease (GBD) Study which was aimed to be "a comparative, comprehensive, and detailed study of health loss worldwide to provide the basis for objective assessments about the probable benefits of applying packages of interventions" (Murray and Lopez, 2017). While Murray and Lopez worked at WHO, Dean Jamison was a senior health economist at the Bank. The team's work culminated in the publication of the 1993 World Development Report (WDR) (World Bank, 1993a).
This WDR was influential as it urged governments and the international development community to invest in health and also introduced the DALYs or Disability Adjusted Life Years, a metric developed by the GBD team to quantify morbidity over time and assess the cost-effectiveness of health interventions (Tichenor and Sridhar, 2019; Prah-Ruger, 2005). However, this report continued to promote user fees and an increased role for the private sector in health care (Clift, 2013).

The WDR drew heavily from another influential Bank publication – 'Disease Control Priorities for Developing Countries' (DCP-I), which promoted highly cost-effective interventions to be included in every country's essential clinical package (World Bank, 1993b). The WDR and the DCP-I were influential for maternal and child health as four out of five sets of the recommended intervention packages were for women of reproductive age (prenatal and delivery care, family planning, case management of sexually transmitted diseases) and children under the age of five (management of the sick child covering diarrhoea, acute respiratory infections, immunisation and nutrition). Through the WDR, the Bank reinforced priority setting through the use of DALYs and cost-effective interventions, thereby institutionalising the selective approach to health care. The report also encouraged governments that could not afford comprehensive public health services to provide a minimum

package of low-cost, selective or “basic” public health services, supplemented by a package of “essential clinical services,” leaving “non-essential services” to the private sector (World Bank, 1993a, pg. 6).

International Conference for Population and Development – 1994

In 1994, the Bank endorsed the Cairo consensus that came out of the International Conference on Population and Development (Robinson and Ross, 2007). This consensus recommended governments to drop the existing demographic and family planning targets and provide comprehensive reproductive health care based on individual choice and reproductive rights, which included family planning; safe pregnancy and delivery services; abortion where legal; prevention and treatment of sexually transmitted infections; information and counseling on sexuality; and elimination of harmful practices against women (such as genital cutting and forced marriage) (UN, 1994). This conference was a highly political event in that there was an unprecedented involvement of women’s groups and NGOs in formulating national policy statements; initial opposition by the Vatican followed by their partial agreement to the Consensus with formal reservations around artificial contraception and abortion; and the U.S. support of abortion as a reproductive right for women (McIntosh and Finkle, 1995; Cohen and Richards, 1994). Amidst this highly charged political environment, the Bank’s endorsement of the Cairo Consensus meant that it supported the transition from a demographic motivation for population programmes towards individual choice and reproductive rights.

However, critics argued that this shift was more of a semantic declaration as the population control establishment including the Bank, realised that the demographic goal of reducing fertility could not be attained without taking into account women’s ability to make decisions regarding reproduction and fertility, and hence the change in language from population control to reproductive health could have been a rebranding of reducing fertility

(Hartmann, 2016; Rao, 2004). This gap in rhetoric and practice was confirmed by the Bank's own 1999 health sector report, which stated that a Bank-funded reproductive and child health project in India "offered practical ways to promote family planning without emphasising on sterilisation targets" (World Bank, 1999, pg. 3).

Safe Motherhood 2.0 – 1997

Despite the momentum created by the International Conference on Population and Development in 1994, the Safe Motherhood Initiative struggled in its implementation (Maine and Rosenfield, 1999; Weil and Fernandez, 1999). Most of the Safe Motherhood programmes, including those funded by the Bank, focused exclusively on low-technology and largely preventive actions at the community-level, including antenatal screening for high-risk pregnancies and training traditional birth attendants (AbouZahr, 2003; Campbell, 2001), gradually reducing the Initiative to the selective and vertical approach that it had originally denounced (Storeng, 2010).

Storeng (2010) argued that the Safe Motherhood Initiative failed to find an institutional home due to the differing ideological and implementation approaches to maternal health of different agencies, which could explain its weak implementation. While WHO emphasised a comprehensive agenda of strengthening health systems, other agencies defined safe motherhood differently, focusing on specific activities including antenatal care, family planning, training of traditional birth attendants, immunisation, and child nutrition. Additionally, macro-level factors such as the economic crisis and Bank-led structural adjustment programmes meant that governments had to endure cuts in the health sector budget affecting the nature of maternal health programmes (Breman and Shelton, 2006). While governments pushed for investments in hospitals and donors had a bias for community based care, the first referral level in between, where attention was needed and recommended by the SMI, was neglected and squeezed out of health budgets (Task Force on Child Health and Maternal Health, 2005).

As a response to the dismal performance of the Safe Motherhood Initiative, the Inter-Agency Group including the Bank, convened a technical consultation in 1997 in Colombo, Sri Lanka, that brought together safe motherhood specialists, programme planners and decision-makers from international and national agencies (AbouZahr, 200). While in 1987, maternal mortality was framed as a social problem, in the 1997, it was reconceptualised as a public health issue and a medical challenge. Saving women's lives, rather than improving women's health and social status more broadly, were redefined as the Initiative's ultimate outcomes (Weil and Fernandez, 1999). The Inter-Agency Group promoted skilled birth attendants and emergency obstetric care as essential interventions for reducing maternal mortality, and in doing so, it clearly departed from its previous emphasis on the inter-related nature of health and social policies, and focused on a set of recommendations that appeared much more selective than comprehensive in nature (AbouZahr, 2003). Storeng (2010) reasoned that emergency obstetric care or EmOC as the 1997 consultation called it, was essentially a reformulation of the original set of recommendations from 1987, only this time around it was presented as a research-driven policy solution giving it more credibility. However, even a selective intervention like EmOC would need investments for a strengthened health system.

4.6 Phase 5: Proliferation of global health initiatives (2000 – 2019)

GAVI, the Vaccine Alliance – 2000

In 2000, the Bank facilitated the creation of GAVI, the Vaccine Alliance, alongside other international partners through its lead involvement in the Children's Vaccine Initiative towards the end of the previous decade (IEG 2014). GAVI is a public-private partnership aimed at increasing access to child immunisation in poor countries (IEG, 2014). This alliance supports

recipient countries through four phases over a period of five years, starting with initial self-financing where the country pays $0.20 per vaccine dose while GAVI supports the rest of the cost, to the final phase where the country gradually takes over from GAVI and fully finances its immunisation efforts (Kallenberg and Cornejo, 2015). GAVI does not have a presence at the country level and relies heavily on its partners like WHO for technical guidelines, planning and evaluation, and UNICEF, for procuring vaccines and delivering it on-ground in the recipient country. As of 2018, GAVI has reached over 700 million children and prevented more than 10 million future deaths in the process (GAVI, 2019).

The Bank holds a permanent seat on the GAVI Board that establishes all policies, oversees operations, and monitors implementation. However, since 2008, GAVI evolved from an informal alliance to a corporate entity, and now, the three founding UN partners—UNICEF, WHO, and the World Bank—are represented by three votes on a 28 vote corporate Board (World Bank, 2014). Moreover, the Bank acts as a trustee and manages the GAVI funds for immunisation programmes (World Bank, 2011). Essentially, it supports the operations of two major financial mechanisms that generate funds for GAVI viz. the International Financing Facility for Immunisation (IFFIm) and Advanced Market Commitment (AMC). The IFFIm takes bilateral donor pledges and converts them into usable cash resources by selling vaccine bonds in the capital markets. Through the AMC, donors commit to purchase pneumococcal vaccines at a price that covers development costs and provides some profits for the drugs' manufacturers with the provision that they are distributed only in LMICS, to preserve the relatively higher prices in the higher-income countries. The Bank also takes on the financial risk associated with donor default. Finally, since GAVI does not have an in-country presence, the Bank acts as its development partner in some of the programme countries (IEG, 2014).

GAVI's vertical focus on immunisation more than its involvement with the private sector, has been its major criticism over the years (Clinton and

Sridhar, 2017; Garrett, 2007). GAVI tried to respond to this criticism by financing health systems strengthening efforts as well. However, Storeng (2014) and Marchal et al. (2009) argued that Gavi's support for this area could have been an exercise in public relations to quell its critiques and appease its 'systems-oriented' donors such as Norway and the UK, as most of its notion of health systems strengthening was narrow in that it only strengthened components needed to achieve immunisation goals.

Over time, the Bank has become apprehensive about GAVI's vertical approach, accelerating the introduction of new and sometimes costly vaccines in low-income countries, the changing influence of the founding partners, and the growing autonomy of the GAVI Secretariat after its 2008 governance reform (IEG, 2014). Despite this strain and caution, the Bank continues to support this alliance, mostly in the way of financial policy and management. Indeed, Gavi foresees a larger role for the Bank in the future in the form of supporting governments with domestic vaccine financing upon graduating from Gavi support (IEG, 2014).

Partnership for Maternal, Newborn and Child Health - 2005

In 2005, the Safe Motherhood Initiative merged with two global child health initiatives viz. the Healthy Newborn Partnership (based at Save the Children USA) and the Child Survival Partnership (hosted by UNICEF in New York) to form the 'Partnership for Maternal, Newborn & Child Health' (PMNCH, 2009). Entering this grand alliance was seen as a survival strategy for the Safe Motherhood Initiative amidst the rising proliferation of global health initiatives, the competition for donor priority and funding for child health (Storeng, 2010; Shiffman and Smith, 2007). The Partnership contributed through knowledge building, advocacy and enabling accountability in LMICS to reduce maternal and child mortality. Furthermore, its 'continuum of care' policy that linked care from pregnancy through birth, newborn and child and, in place, the various levels of home, community, and health facilities, was endorsed by the WHO and widely accepted in national government policies (WHO, 2011). Over the years, however, the Partnership struggled to find a formidable position in the

increasingly competitive global health landscape, owing to unequal power relationships illustrated by skewed representation of developing country and local actors in its governance mechanisms; donors' continued focus on child health and vertical, short-term solutions; limited commitment to integration; and different interpretations of the 'continuum of care' (Storeng, 2010).

The Bank continues to support the Partnership as a funder and holds a permanent seat on its Board (PMNCH, 2019). It plays a similar role in UNFPA's Trust Fund for maternal and child health, set up in 2008. In the same year, the Bank also joined the H6 partnership along with UNFPA, UNICEF, UN Women, WHO, and UNAIDS, to support maternal and child health activities in 27 high-burden countries (H6 Partnership, 2019). While the Bank started out primarily as a funder and key governing member of these global health initiatives, it soon employed these experiences to establish its own global initiatives for maternal and child health. In 2007, the Bank first launched the Health Results Innovation Trust Fund and a few years later in 2015, it set up the Global Financing Facility.

Health Results Innovation Trust Fund - 2007

In 2007, the Bank launched the Health Results Innovation Trust Fund to finance and evaluate interventions for reproductive, maternal, neonatal and child health (RMNCH) in high-burden countries. This Fund introduced the 'results-based financing' mechanism, wherein health providers are paid on achieving planned goals for RMNCH. The governments of Norway and UK have committed $575 million into this Fund, which is disbursed as grants along with IDA credits to high-burden countries (World Bank, 2007). As of 2019, the Fund has supported RMNCH programmes in 28 countries and conducted 24 impact evaluations and eight mixed methods evaluations. Through these 28 projects, the HRITF has released a total of $1271 million in IDA credit and $313 million in grants, setting a ratio of 1:4 for credit and grant disbursement (Tanner, 2019).

A little more than a decade after its establishment, the Fund has had a substantial impact on how governments and aid agencies think and talk about health care financing, and the term ‘results-based financing’ or RBF is now well-established in the policy language (Bauhoff and Glassman, 2017). Indeed, the Bank has used several strategies to diffuse the RBF mechanism in the health policy environment. First, it funds impact evaluations that provide robust evidence and offers credibility and even legitimacy to this mechanism. Second, it organises annual dissemination workshops for RBF champions from recipient countries and provides educational resources including online courses and toolkits (World Bank, 2019a; Paul et al., 2018). Finally, the Bank has included this mechanism in its other global health initiatives such as the Global Fund and the Global Financing Facility (World Bank, 2019a). More importantly, it has converted this mechanism into an official financing instrument called ‘Program-for-Results’ (PforR) used in 99 active projects totalling $40.3 billion of financing (World Bank, 2019b).

Does RBF work in achieving its planned goals for maternal and child health? The Bank’s own evaluation has shown that, overall, the evidence base is narrow, in that while in many projects, RBF has improved quality and availability of medical supplies and equipments, it has increased service coverage only in a few projects, and none of these improvements have led to the planned maternal and child health outcomes. Negative effects of this mechanism included difficulty in communicating the RBF structure to health workers and low health worker morale on non-payment (Kandpal, 2016). Furthermore, the Bank’s Independent Evaluation Group raised concerns about the lack of effectiveness of the RBF model and stated that Bank had made decisions to scale up regardless of weak, inconclusive or incomplete pilot results (World Bank, 2014).

External evaluations have been more critical, calling RBF projects expensive (Anthony et al., 2017; Nonkani et al., 2016; Borghi et al., 2015), uncertain and ineffective (Paul et l., 2018; Wiysonge et al., 2017), and stating that they have negatively affected health worker morale (Alonge et al., 2017).

Moreover, critics have argued that RBF programmes are donor-driven and may weaken health systems (Paul et al., 2018; Valters and Whitty, 2017). It seems, then, that RBF programmes can have big opportunity costs in terms of a complex management and implementation of payment reforms and results verification system, without producing sustainable results. Although it presents itself as a comprehensive approach, critics have also argued that RBF programmes under this Fund have monopolised attention and focused policy dialogue on short-term, selective interventions while diverting attention from broader process reforms such as human resource management; transparency in use of financial resources; accountability; performance of public financial management; and integration of programmes into national health programming (Paul et al, 2018; Fox et al., 2014; WHO, 2011). The Bank's recent strategy reports (World Bank, 2018, 2017) have admitted the need for more research to assess the effectiveness of the RBF and to study how RBF interacts with the health system, thereby acknowledging the significance of structural determinants in the performance of this mechanism. Notwithstanding the uncertain results from the evaluations of the Health Results Innovation Trust Fund, the Bank launched the Global Financing Facility, another trust fund that promotes the RBF mechanism.

Global Financing Facility - 2015

In 2015, the Bank launched the Global Financing Facility (GFF), a multi-donor trust fund for supporting programmes in reproductive, maternal, newborn, child, adolescent health and nutrition (RMNCAH-N) across 62 high-burden countries (World Bank, 2015). Through the Global Financing Facility, the Bank emphasises on saving the lives of women and children and helping countries achieve economic growth (GFF, 2019).

I reviewed publically available GFF documents and related peer-reviewed articles and summarised the key attributes of this Bank-funded trust fund as well as its advantages and potential concerns (Fernandes and Sridhar, 2017). I found that, similar to the Health Results Innovation Trust Fund, the

GFF seeks financial resources from donors which go into a trust fund; grants from this fund are then matched with IDA or IBRD credits and offered to countries that are willing to invest these resources for RMNCAH-N. Apart from offering credits and grants, the GFF also works with governments to raise domestic financing, brings donors working in a country together to align their financial resources, and enlists private sector money (World Bank, 2015). As of June 30, 2019, contributions to the GFF Trust Fund total US$992.8 million, of which $629 million is committed for 33 projects in 27 countries and is combined with an additional $4.8 billion IDA/IBRD (World Bank, 2019).

The governance of the GFF gives substantial decision-making authority to the Bank and the donors. At the heart of the GFF is an investors group, which mobilises financing, and within this group is the trust fund committee that decides which countries and projects are funded. The investors group consists of bilateral donors (7), UN agencies (4), global health initiatives (3), organisations representing private sector (3) and civil society (3), recipient countries (3) and private foundations (2) (GFF, 2019). However, the trust fund committee is composed only of those donors that contribute to the GFF Trust Fund (World Bank, 2015).Compared to its predecessor, the GFF does have advantages (Fernandes and Sridhar, 2017). It finances interventions across the RMNCAH-N continuum thereby benefiting women and children across each life stage. As a senior Bank health specialist recounted, “It is difficult to raise funds for strengthening health systems as it does not have a face. But RMNCAH-N does have a visual. It elicits an image of a malnourished woman and her crying child. This visual gets attention and helps to raise resources” (Konstermans, 2018). Furthermore, by specifically including adolescents, who have previously been overlooked, the GFF can tackle preventable and treatable sexual and reproductive health problems, resulting in health gains for this group in later years. The GFF also moves beyond interventions in service delivery, and finances other health system components across its country projects including human resources,

information systems (through civil registration and vital statistics and disease surveillance systems), governance (through support in reforms and fiduciary management) and essential medical products and technologies (through support in pharmaceutical reforms and procurement of medicines and equipments).

Moreover, the GFF also finances multi-sectoral interventions (secondary education, water and sanitation, gender-based violence, social protection) which can aid the upstream determinants of health and lead to improvements in population health. Finally, the GFF has reported an increase in domestic resources mobilisation for maternal and child health in some of its programme countries: Cameroon has committed to raising its health budget allocation to primary health care from 8% to 22% by 2020; Liberia is planning to raise money for health through alcohol taxes; while Mozambique, Sierra Leone and Senegal are planning to raise domestic resources through sin taxes on tobacco products (World Bank, 2018).

A recent publication in the BMJ (co-authored by staff from the World Bank, Gates Foundation and private sector consultants) estimated that raising $2.6 billion for the GFF Trust Fund, by 2030, would lead to the mobilisation of $50-$75 billion additional funds that would help to avert 34.7 million deaths – including preventable deaths of mothers, newborns, children and stillbirths (Chou et al., 2018). Despite the positive cases of domestic resource mobilisation and the overly-optimistic modelling by Chou et al. (2018), the total amount of additional financial resources, particularly those contributed by governments, mobilised under by the GFF model over the four-period (2015-2019) since its inception is unclear, which raises questions about its claims of being an innovative model for increasing resources (Usher, 2018). Another problematic aspect has been reported from Mozambique, wherein Bank-led revisions in the country's health financing strategies planned within the framework of GFF funding include the introduction of user fees (MSF, 2017; Ministrerio da Saude, 2014).

So far, the majority of private sector engagement in the GFF has come in the form of health service delivery, as reported in Cameroon, Democratic Republic of Congo and Nigeria. However, the GFF has also attracted private financing through ‘performance loan buy-downs’ and ‘sustainable development bonds’ (World Bank, 2018; World Bank, 2019). The International Finance Corporation finances ‘performance loan buy-downs’, a grant used to buy down the interest on an IBRD loan on achievement of planned indicators. For instance, Guatemala has received a $10 million loan buy-down to service interest on $90 million in IBRD credits for child nutrition.

Through sustainable development bonds, private investors can provide finance that is invested by the Bank in capital markets and in return, they receive interest payments and their money back at the end of a set period. These funds go to an IBRD pool that is made available by the GFF to middle-income countries eligible for IBRD funding to access through loans and loan buy-down grants. So far, these bonds have raised CAD $1.2 billion from institutional and retail investors in Europe and Japan interested in social investments for maternal and child health. While employing private capital through bonds and loan-buy downs can be a novel way to increase financial resources for maternal and child health, these options need to be considered with caution (Stein, 2019). Bonds do follow priorities of where investors can earn the most, and not necessarily those of public health.

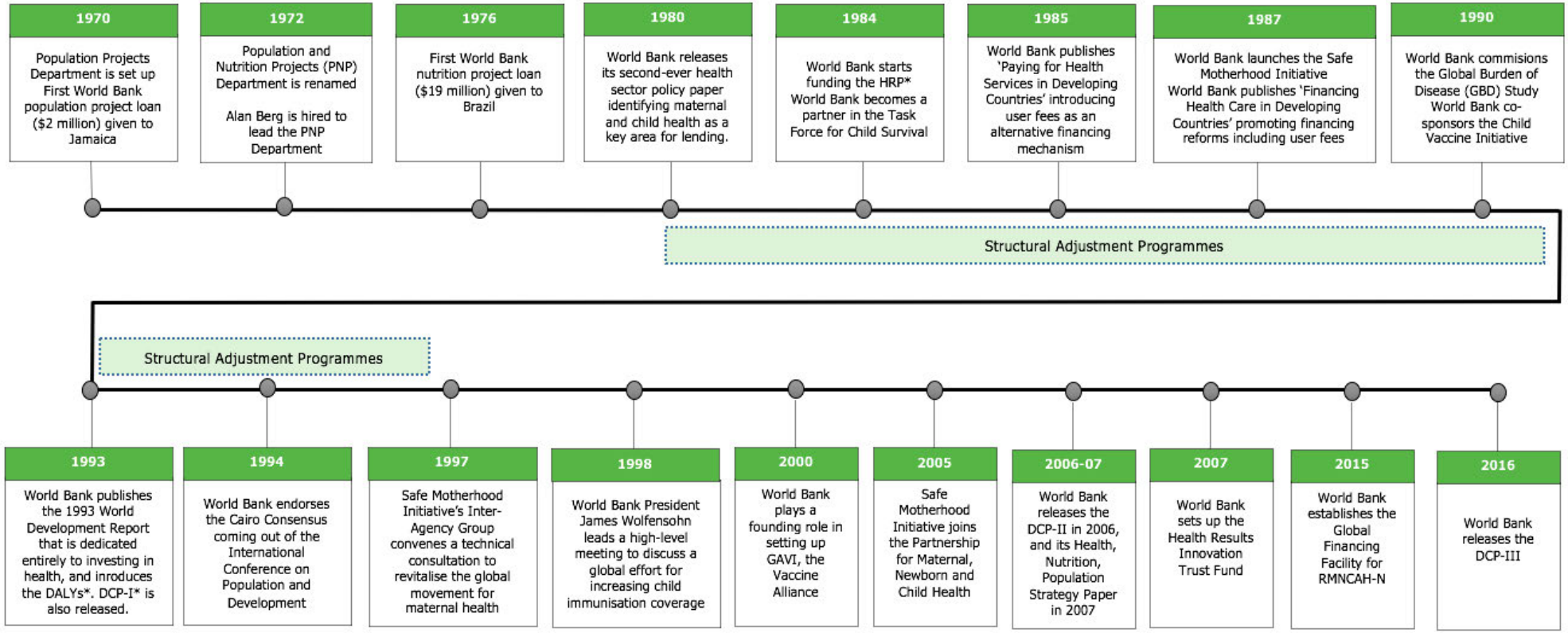
Furthermore, profits generated from the bonds are lost to the private sector. If the government was using its own money to invest in health, it could use the profits for the public good. Both the bonds and loan buy-downs are only offered to countries eligible for IBRD lending, limiting access to resources by countries that do not meet this eligibility but have a high burden of maternal and child mortality and morbidity. Finally, involving the private sector to provide finance for health could be supplementary to sustainable strategies such as working with governments to improve and increase their general taxation or sin taxes (like in the cases of Liberia, Mozambique, Sierra Leone and Senegal) and helping them regulate their private markets can be a more

sustainable financing route that would also result in country ownership to investments in the health sector. Another challenging aspect of the GFF is that it promotes the results-based financing mechanism, which has shown to have results that can be uncertain, expensive and ineffective (Paul et al., 2018; Kandpal, 2016). Who stands accountable if planned health indicators are not achieved due to structural determinants including a weak health system? Will country governments have to forfeit the private capital investments or will community-level health workers have to pay the price through cuts in payments or incentives? These questions need to be reflected upon so that mitigation measures can be built into the GFF.

4.7 Conclusion

In this chapter, I have shown how the World Bank entered the global health landscape in the late 1960s and forayed into lending for maternal and child health (MCH) See figure 4.1 for a timeline of the key events in the World Bank's involvement in maternal and child health from 1970 to 2019. I categorised the Bank's involvement in MCH through its policies and programmes over the last five decades into five distinct phases starting form 1960-1967, when the global population control movement expands in the 1960s, amidst the context of eugenic legacies, which sets the stage for the Bank's entry in this area. In the second phase (1968-1979), the Bank started lending for population control and nutrition projects in LMICS, often using existing MCH and nutrition programmes and to further its family planning goals in aid-recipient countries. In the third phase (1980-1989), the Bank decided to lend directly for health projects and identified MCH as one of its focus areas for lending; it collaborated with international agencies and played a key role in setting up three major global partnerships for MCH; and reforms that negatively affected the implementation of and access to MCH programmes.

Figure 4.1: Timeline of key events in the World Bank's involvement in maternal and child health from 1970 to 2019



*HRP: Special Programme of Research, Development and Research Training in Human Reproduction
*DALY: Disability Adjusted Life Years
*DCP: Disease Control Priorities in Developing Countries

In the fourth phase (1990-1999), the Bank institutionalised a selective approach for MCH by promoting a package of cost-effective interventions through its influential World Development Report of 1993; revitalised the Safe Motherhood movement; and facilitated the Child Vaccine Initiative. In the fifth phase (2000-2019), the Bank played a founding role in three major global health initiatives for MCH, shifting from its traditional project-based financial support towards multi-donor trust funds and results-based financing.

How did the Bank conceptualise maternal and child health over time?

The World Bank's conceptualisation of maternal and child health has evolved from being purely instrumental to achieve demographic goals and productivity to currently being intrinsic albeit along with the rationale for economic growth. Since 1968, under the presidency of Robert McNamara, HNP began funding population control and nutrition projects, which indirectly financed maternal and child health services. In the 1970s, maternal and child health had an instrumental rather than an intrinsic value at the Bank. Family planning services were funded with a rationale wherein pregnant women and mothers were viewed as conduits for reducing fertility that would control the population, raise living standards and ultimately contribute to economic growth. The Bank's demographic agenda sharply contested individual reproductive rights. This demographic agenda, advanced through lending for population projects, viewed women rather than men as being responsible for reproductive behaviours, did not offer them with any choice of contraceptive methods and were, in many cases, coerced into sterilisation (Gupte, 2017; Connelly, 2005; Rao, 2004). Child health was considered important at the Bank as healthy children would become productive members of the country's workforce, thereby increasing productivity and economic growth. When family planning projects failed to get acceptance from governments or in communities, nutrition projects were used as an uncontroversial gateway to increase the receptivity of mothers to advice on family planning (Sridhar, 2016; Crane and Finkle, 1981; Berg, 1973). Thus, in these initial years, the

Bank viewed maternal and child health with an overriding concern with productivity and economic growth (Sridhar, 2011).

In the 1980s, the Bank began directly funding maternal and child health services. It advocated a broader view of reducing maternal mortality as an ethical and socially just imperative (Storeng, 2010). However, towards the end of the 1980s, HNP specialists tried to adopt an intrinsic value for maternal health through the Safe Motherhood Initiative. While the Initiative earnestly argued for safe motherhood as an ethical, social justice and developmental imperative (Storeng, 2010), Bank documents also framed maternal mortality as impacting individuals through the loss of someone who would have otherwise contributed to the household through caring for children and family members, and the economy through productive labour (Herz and Measham, 1987). Thus, maternal health was still considered at the Bank as a vital social and economic investment rather than funding health as a right of the individual woman.

In the early 1990s, however, following the International Conference on Population and Development, the Bank adopted the reproductive health approach, illustrating a shift in its thinking from population control and demographic targets towards individual choice and reproductive rights of the woman. In doing so, the Bank included in its policies and programmes not just mothers but all women of reproductive age, and also supported abortion services (wherever legal) as a reproductive right. While this new approach that the Bank adopted in its funded projects seemed to place an intrinsic value on the reproductive health of a woman, it was still grounded in fertility regulation. In its 1993 World Development Report, family planning services alone were stated as a necessary input to improve women's health, and fertility control per se thus became the key to an essential health services package that the Bank promoted (World Bank,1993).

Since 2000, the Bank had played a leading role in global health initiatives for maternal and child health. It has pulled together all its previous programme

elements from family planning and nutrition to maternal and child health, included adolescent health into this mix, and placed these within the larger continuum of RMNCAH-N: reproductive, maternal, newborn, child and adolescent health and nutrition. Through its Global Financing Facility, the Bank views RMNCAH-N as an entry point to achieving universal health coverage and health systems strengthening, as it finances multi-sectoral and cross-cutting interventions that go beyond health service delivery and target different components of the health system. Through global health initiatives like GAVI and the Global Financing Facility, the Bank frames maternal and child health as having an intrinsic value by focusing on saving lives of women and children. However, it continues to justify investments for this area using the rationale for economic growth.

What can be said about the Bank's financing approach for maternal and child health?

Since the last decade, the Bank has also used innovative financing mechanisms as a strategy to maintain its influence in MCH as well as remain relevant and competitive in the current global health landscape. A prime example of its innovative financing mechanisms is results-based financing (RBF), wherein payments are released on the achievement of planned project outputs as against the traditional payments made to attain inputs. Even though internal Bank reviews and external assessments show that RBF carries risks, especially in countries with weak and fragile health systems, the Bank continues to promote this mechanism through the maternal and child health projects funded by its Global Financing Facility (GFF).

Furthermore, while other innovative mechanisms like sustainable development bonds bring in private sector capital, these resources are pooled to finance credit (loans) or loan buy-downs which ultimately go back to the World Bank's coffer (with the exception of grants). While the GFF has been technically supporting governments to increase their domestic resources for maternal and child health for the long term through mechanisms like budget reallocation, financial management and sin taxes,

domestic resource mobilisation needs to be the primary approach rather than a focus on pro-private solutions. However, if countries are supported to achieve complete financial self-sustenance for their health, the Bank's role as a financial service provider might be questioned.

Chapter 5 Tracking the World Bank's financial flows for reproductive, maternal and child health from 1970 to 2018

5.1 Introduction

In this chapter, I track the World Bank's financial flows for reproductive, maternal, and child health (RMNCH) from 1970 to 2018. I will use these financial trends to discuss the Bank's changing role in maternal and child health at the global level vis-à-vis its financial contributions, and comment on its evolving programmatic and financing approach for this area.

This chapter has three parts. In the first part, I describe the global landscape of development assistance for RMNCH from 1990 to 2018, where the Bank features as a major financier. For this section, I use publically available financial data on the development assistance for RMNCH from 1990 to 2018 from the Institute for Health Metrics and Evaluation (IHME, 2019a). Through an analysis of IHME data, I report how much financial resources was allocated for RMNCH, where it came from (i.e. major donors), and where it went (i.e. programmatic areas and recipient countries). I then analyse the RMNCH funding that was channelled through the Bank and report on similar themes; specifically, total financial disbursements, distribution of funds by donors, programmatic areas, and recipient countries.

In the second part of the chapter, I examine the Bank's own databases, and present an analysis of its financial flows for RMNCH from 1970 to 2018 through its core budget and its extra-budgetary funding. Through its core budget, the Bank provides IDA and IBRD credits for health projects at the country level. Additionally, the Bank provides voluntary grants from its core budget for special health programmes executed at the regional and global level. For the country-level projects, I examined two databases on the World Bank website viz. the Project and Operations database and the Development Topics databases, and I included and analysed 484 RMNCH projects

approved from 1970 to 2018. I also examined the Bank's annual financial contributions for its special health programmes, available from 1980 to 2014, and reported key trends related to grants for maternal and child health. The Bank also uses extra-budgetary funds to finance its health work. Donors, including bilateral and multilateral aid agencies and private foundations, voluntarily contribute these extra-budgetary funds, which are earmarked for specific regions and health priorities and held separately from the Bank's core budget. These extra-budgetary funds are channelled through a lending mechanism known as trust funds, which have been on the rise since the early 1990s (Eichenauer and Knack, 2016). For this analysis of extra-budgetary funds, I analysed two available Bank datasets with financial information on the three major types of trust funds.

Consequently, through this analysis of the Bank's core budget and extra-budgetary funds, I report on how much financial resources have been allocated to RMNCH through country-level projects, special health programmes, and trust funds from 1970 to 2018, and where this money has gone i.e. programmatic areas, geographic regions, and recipient countries. Additionally, for the country-level projects, I also report findings on the Bank's co-financing partner agencies, the interest rates and fees it charges recipient countries, and the proportion of repayments made by countries.

In the third part of this chapter, I compare the Bank's financial flows for RMNCH (as outlined in part two) with its total lending for the health, nutrition and population (HNP) sector and with its overall lending (IBRD+IDA) from 1970 to 2018. This comparative analysis gives us a sense of the proportion of the Bank's RMNCH lending to its total health sector and its overall budget, reflecting the significance that the Bank attaches to this health area. I have detailed the methods and limitations for each of these three parts of the financial analysis in the chapter three (Methods) of this thesis.

I attempt to answer four key questions through this chapter: (i) What is the role of the World Bank in terms of financing for maternal and child health at the global level?; (ii) What does the Bank's lending for maternal and child

health tell us about its conceptualisation of this area?; (iii) Is there a match between the countries that the Bank funds and the countries that actually have the largest burden of maternal and infant mortality?; and, (iv) What do these financing trends tell us about the Bank's evolving approaches for financing maternal and child health?

5.2 Global funding for reproductive, maternal and child health from 1990 to 2018: how much, where it comes from and where it goes

In this first part of the chapter, I present the findings from the analysis of the development assistance for reproductive, maternal, newborn and child health (RMNCH) from 1990 to 2018 as extracted from the IHME dataset (IHME, 2019a). Development assistance for health refers to the financial and in-kind contributions made by international institutions - such as bilateral aid agencies and private philanthropic foundations - to developing countries aimed at improving health outcomes (IHME, 2011). First, I report the key trends from the overall development assistance for RMNCH; specifically, total funding, major donors, programmatic areas and recipients. Second, I report similar trends from the total development assistance for RMNCH channelled through the World Bank.

Overall development assistance for RMNCH from 1990 to 2018

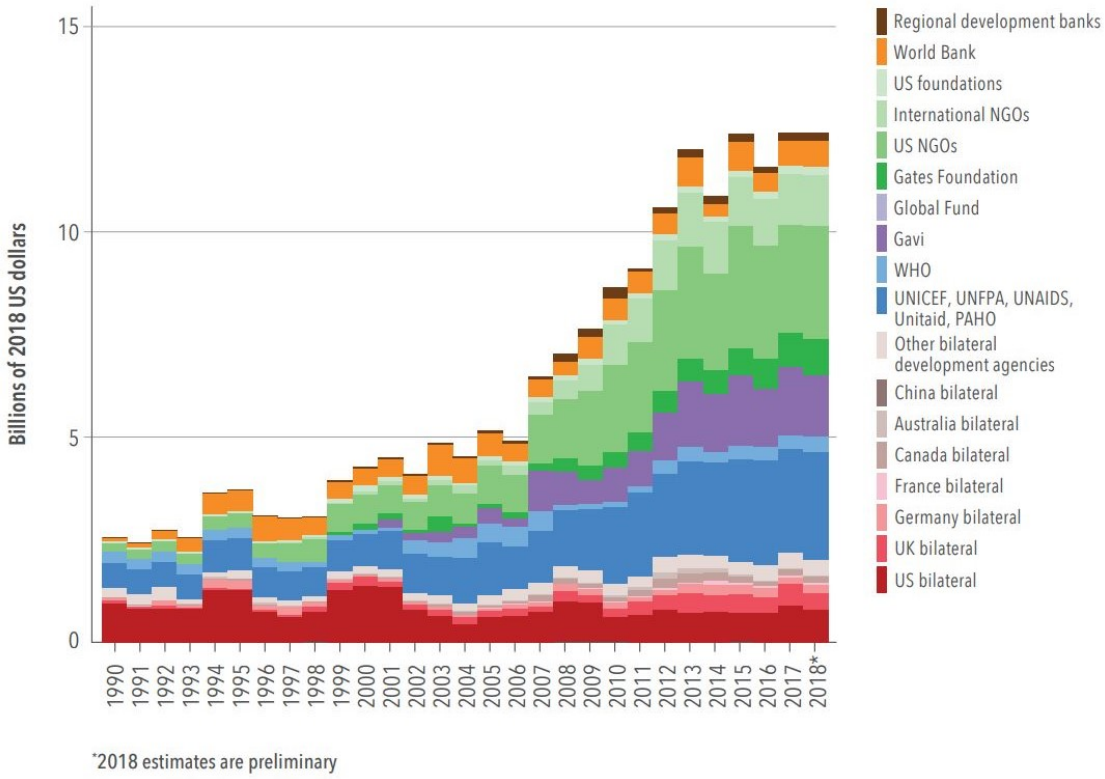
Total development assistance

RMNCH received 42% or $186 billion of the overall development assistance for health from 1990 to 2018. Of this total amount, newborn and child health received the major share (56%) as compared to reproductive and maternal health (44%). RMNCH funding has risen from 2003 onwards, with an annual increase of 5% since 2010.

Major channels

RMNCH received funding through six major channels: (i) bilateral aid agencies, (ii) multilateral agencies, (iii) public-private partnerships, (iv) development banks, (v) non-governmental organisations (NGOs) and foundations, and (vi) UN agencies. United States (U.S.) NGOs were the biggest channel for RMNCH with $39 billion or 21% of the total funding over time, while the Bank was the fifth largest channel for RMNCH funding with a total of $15 billion.

Figure 5.1: Channels for development assistance for reproductive, maternal, newborn and child health, 1990-2018 (Source: IHME, 2019b)



Major donors

With $55 billion, the United States (U.S.) has been the single largest funder for RMNCH, representing 26% of the total development assistance for this health area over this 28-year period. In 2018, a total of $12.5 billion was allocated for RMNCH, representing 32% of the total development assistance for health. The U.S. continued to be the single largest funder, channelling

$2.9 billion (23.2%), followed by private foundations (excluding the Bill and Melinda Gates Foundation and corporate donations) with $1.5 billion (12%); the Gates Foundation with $1.31 billion (10.5%); and the United Kingdom (UK) with $1.28 billion (10.2%).

Programmatic areas

A programmatic area is essentially a theme or a type of programme that receives funding under a health (RMNCH) category. A review of the RMNCH funding across programme areas from 1990 to 2018 showed a shift in focus from family planning to vaccines. In the early 1990s, family planning received a major share of the overall RMNCH funding. In 1995, maternal health programmes received higher funding compared to family planning; this could be attributed to the influential International Conference for Population and Development in 1994, which promoted a shift from target driven family planning projects to comprehensive reproductive and maternal health efforts (Robinson and Ross, 2007). Post 1995, while family planning continued to remain a major area for RMNCH funding, health systems strengthening started to receive increased funding, especially towards the end of the 1990s. Since 2000, funding for vaccines witnessed a dramatic rise, mainly due to the rise of GAVI, the Vaccine Alliance. In 2018, vaccines received the largest share of RMNCH funding ($2.8 billion or 22.5%), followed by health systems strengthening ($2.7 billion); maternal health programs ($1.4 billion); family planning ($1.3 billion) and nutrition ($1.1 billion).

Geographic regions

IHME coded the majority of the RMNCH funding (41%) under an ‘unallocated’ geographic region, wherein it was not specified from the sources as to where the financial resources were allocated. Sub-Saharan Africa received the next highest share (20%; $42.2 billion), while $32.4 billion (15%) went to ‘Global’ projects. South Asia received $20.5 billion whereas the Latin America and Caribbean region was allocated $10.1 billion. North Africa and the Middle East region received $7.9 billion or 4% of the funding.

Overall development assistance for RMNCH channelled through the World Bank from 1990 to 2018

Total development assistance

A total of $15 billion of development assistance for RMNCH was channelled through the World Bank from 1990 to 2018. Similar to the global trend, newborn and child health received $9.2 billion or 61% of the overall funding directed through the Bank, while reproductive and maternal health received $5.8 billion.

Figure 5.2: Development assistance for reproductive, maternal, newborn and child health channelled through the World Bank, 1990-2018 (in USD millions) (Source: The author has developed this figure based on an analysis of IHME data)

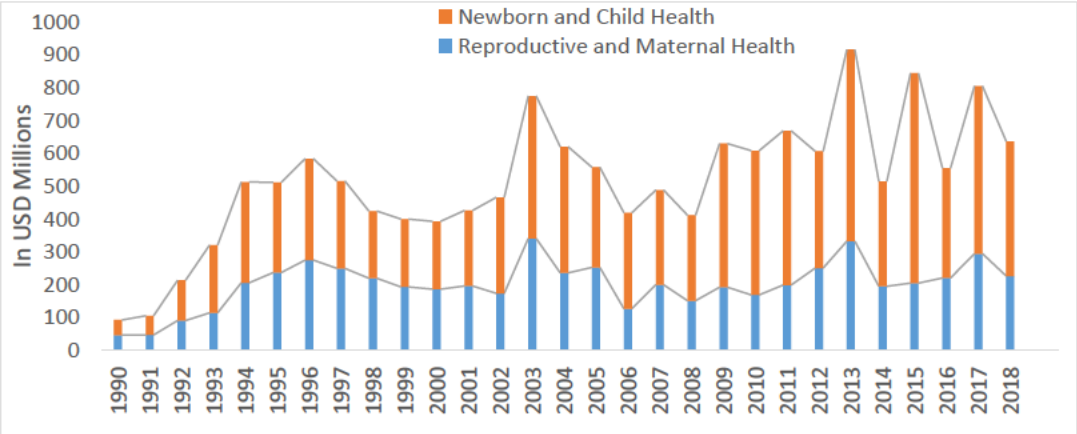
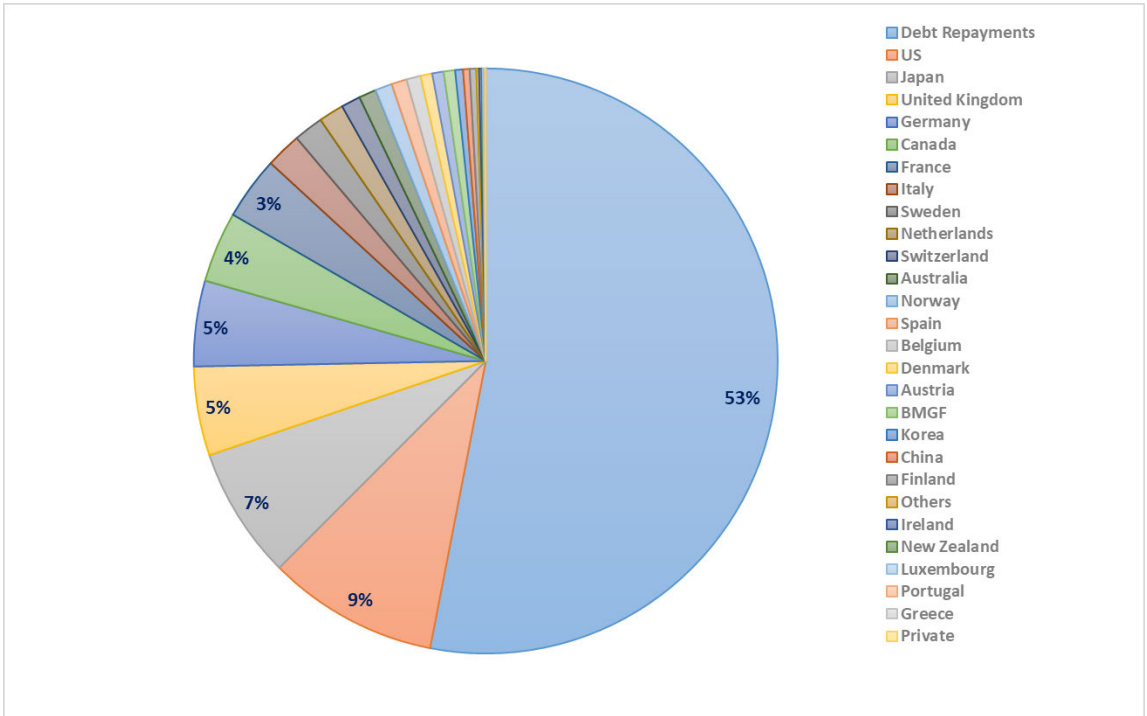


Figure 5.2 shows the annual development assistance for RMNCH channelled through the Bank from 1990 to 2018. This funding saw a six-fold rise from $94 million in 1990 to $638 million in 2018, and witnessed major peaks around three periods: in 1996 ($585 million), in 2003 ($776 million) and in 2013 ($917 million). While the first peak in funding could be attributed to the global political priority for RMNCH garnered by the 1994 International Conference on Population and Development, the second rise from 2000 onwards could be explained by the formation of GAVI, the Vaccine Alliance and the increase in funding for child vaccines. The Bank's Global Financing Facility for maternal and child health, set up in 2015, could have triggered the increase in resources for this area in the last four years.

Major donors

The biggest donor of RMNCH funding channelled through the Bank is the Bank itself. Debt repayment i.e. IDA or IBRD loans repaid by the recipient countries, was the largest source of development assistance for RMNCH channelled through the Bank (53% or $7.9 billion). Figure 5.3 presents the share of the total development assistance for RMNCH channelled through the Bank from each of the 28 sources (donors) from 1990 to 2018. The legend of the figure presents an ascending order of sources with the largest to the least share of contributions. IHME's methodology report specifies that the data on the sources for Bank funding for RMNCH was obtained through personal correspondence with Bank operational analysts (IHME, 2019c). This type of information - i.e. the source of Bank lending for RMNCH - is not available on its own databases.

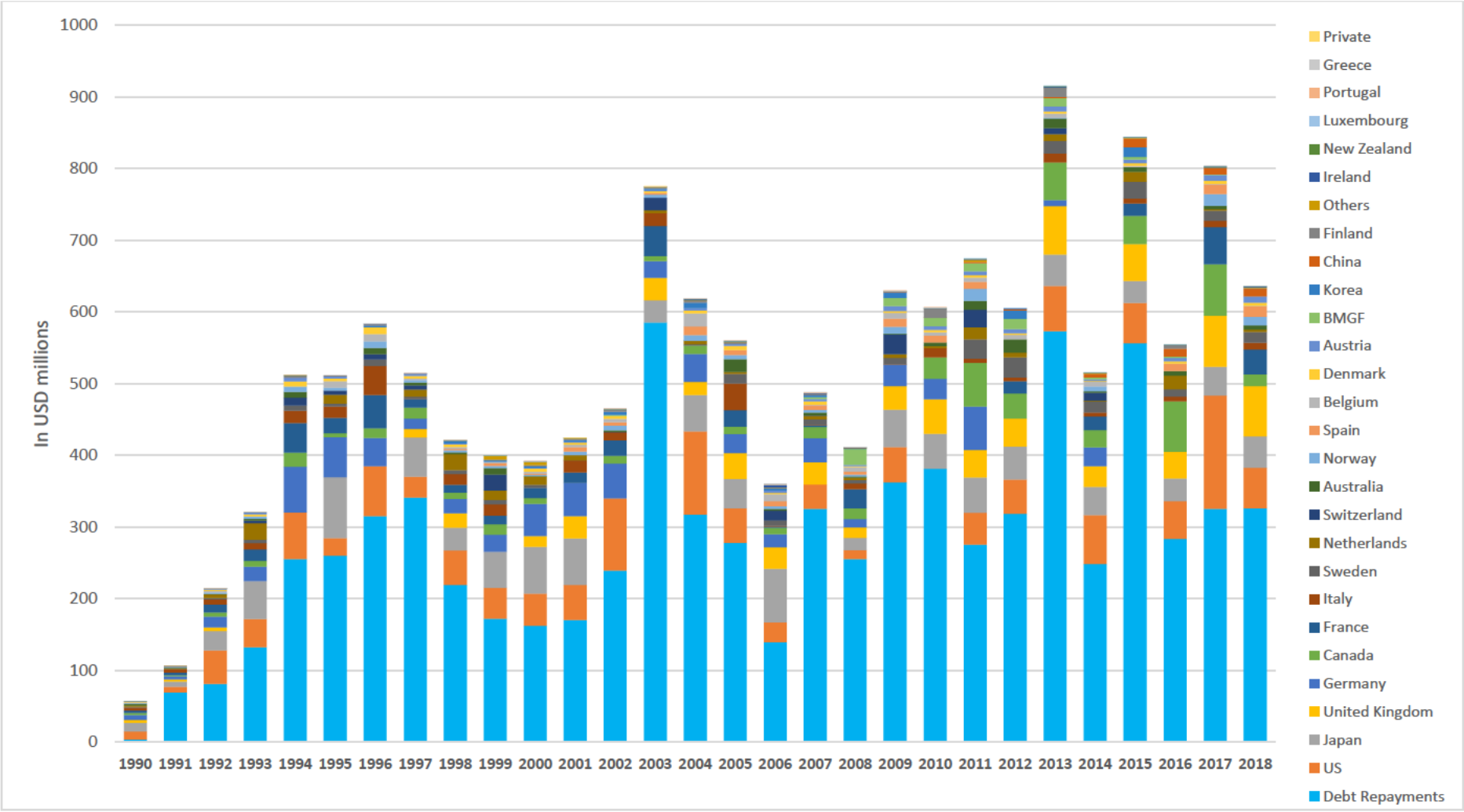
Figure 5.3: Total development assistance for reproductive, maternal, newborn and child health channelled through the World Bank by sources (Source: The author has developed this figure based on an analysis of IHME data)



The Group of Seven (G7), which consists of most advanced economies in the world, also features as the top seven sources after the Bank's debt repayments. The U.S. leads this group with a total contribution of $1.4 billion or 9%, followed by Japan ($1 billion, 7.2%), U.K ($739 million, 4.9%), Germany ($711 million, 4.7%), Canada ($586 million, 3.9%), France ($523 million, 3.4%) and Italy (296 million, 1.9%). The Bill and Melinda Gates Foundation started funding RMNCH in 2000, with a total of $94 million or 0.6% of the overall RMNCH disbursement. China is another recent entrant, since 2008, with a total contribution of $54 million. Private sources reported less than a million for RMNCH.

Figure 5.4 illustrates the annual RMNCH funding from 1990 to 2018 by the sources. In the legend of this figure, sources with the largest share of contributions are listed at the bottom moving towards sources with the least share of funding. While the share of RMNCH funding by the Bank's debt repayments have generally stayed consistent, the contributions of bilateral donors have fluctuated over time. The highest annual contributions from the U.S. have been reported in 2004 ($114 million) and recently in 2017 ($158 million). Japan has contributed an annual average of $40 million while the U.K. and Germany have allocated an average of $26 million each year. Although the share of funding by the U.K. has been rising from 2015, no funding has been reported by Germany in this four-year period. Canada increased its RMNCH funding since 2010, contributing between $30 million to $70 million since 2010. Norway's total funding for RMNCH from 1990 to 2018 was $139 million with an annual average contribution of $5 million. I further examined which programme areas received financial contributions by each of the major sources (donors). The U.S. provided the majority of the RMNCH funding for family planning from 1990 to 2018 ($14 million or 11% of the total assistance for this component), followed by Canada ($13 million). In the case of child nutrition, which received a total of $2.7 billion of development assistance, the top four donors were the U.S. ($210 million), Japan ($172 million), U.K ($107 million), and Germany ($105 million).

Figure 5.4: Development assistance for reproductive, maternal, newborn and child health channelled through the World Bank by sources from 1990-2018 (in USD millions) (Source: The author has developed this figure based on an analysis of IHME data)



For child vaccines, the majority of funding was reported from the Gates Foundation ($66 million), followed by Japan ($14 million), and Germany ($13 million). Canada funded $81 million or 15% of the total contributions for health systems strengthening, making it the largest funder of this component, followed by Sweden ($65 million) and Australia ($23 million). While the Gates Foundation contributed $16 million for health systems strengthening, the U.K and U.S. allocated $14 million respectively, for this component.

Programmatic areas

Around 71% ($11.6 billion out of the total $15 billion) of the development assistance for RMNCH channelled through the Bank was categorised under the programmatic area of 'Other'. Child nutrition received the next biggest share of 18% of the RMNCH funding ($2.7 billion), followed by maternal health ($574 million, 4%), health systems strengthening ($479 million, 3%), and childhood vaccines ($285 million, 2%). Family planning received $126 million (0.84%) while human resources got 0.47% or $70 million of the total RMNCH funding.

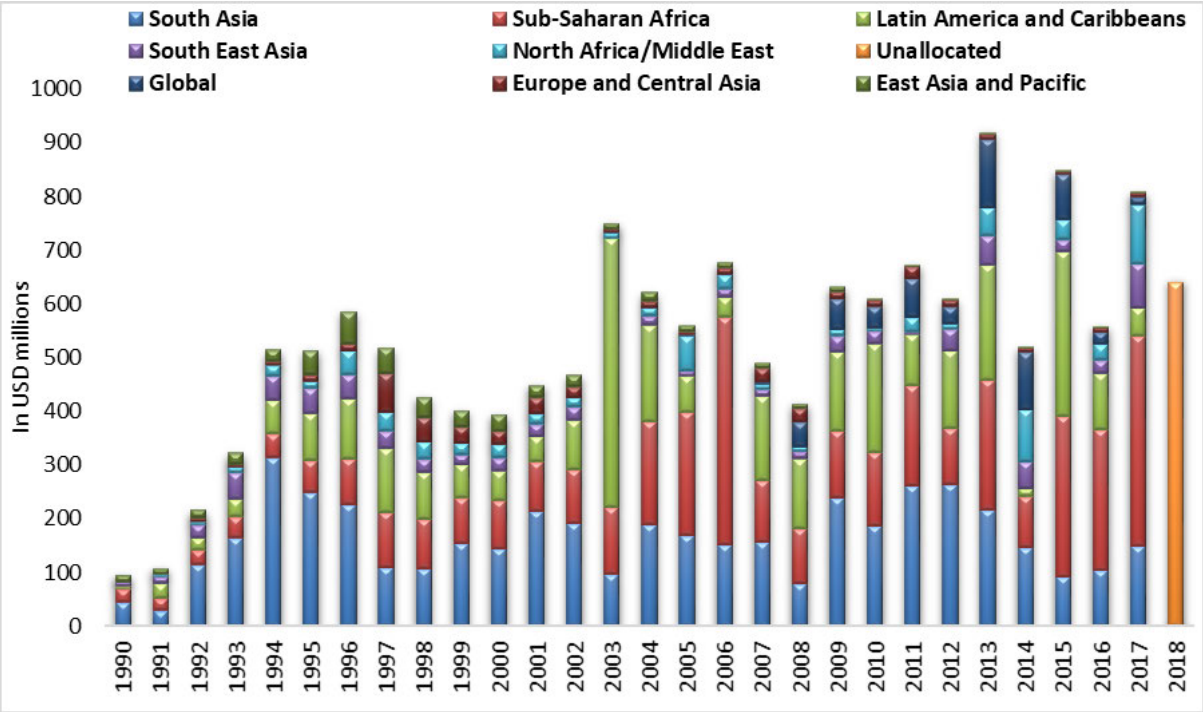
Recipients - geographic regions and countries

South Asia received the largest share (30%) of the RMNCH funding channelled through the Bank from 1990 to 2018, totalling to $4.5 billion. Sub-Saharan Africa and Latin America and the Caribbean regions were the second and third largest recipients in this time period with $3.8 billion (25%) and $3.1 billion (21%) respectively. South East Asia received a total of $784 million while North Africa and the Middle East region was allocated $760 million. Global projects (with no specified geographic regions) received $617 million was allocated to global projects.

A closer look at the annual RMNCH funding by geographic regions reveals three key findings (see figure 5.5). First, while South Asia started as the biggest recipient for the Bank's RMNCH funding, it was taken over by Sub-Saharan Africa after 2000. Second, Latin America and the Caribbean region, which has a comparatively lesser burden of maternal and child mortality than South Asia and Sub-Saharan Africa, received some of the largest annual RMNCH funding over the last 15 years. In 2003, this region received $502 million, which is the highest ever annual RMNCH funding for any region. Third, RMNCH funding for North Africa and the Middle East region

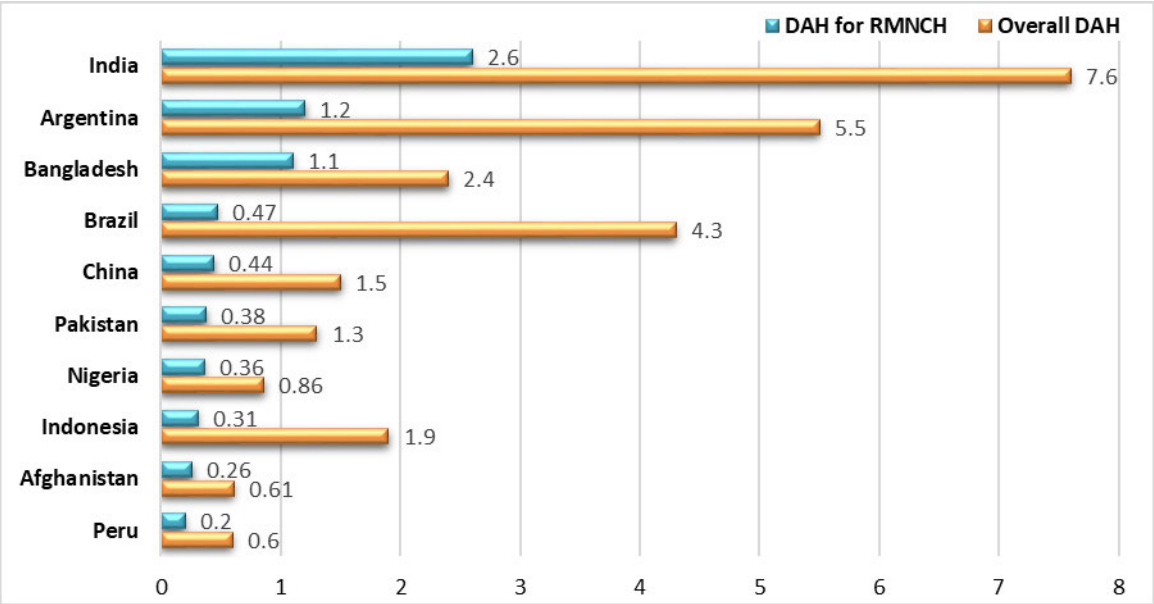
has been growing, especially since 2012, possibly driven by conflicts and humanitarian crises.

Figure 5.5: Development assistance for reproductive, maternal, newborn and child health channelled through the World Bank by geographic regions from 1990-2018 (in USD millions) (Source: The author developed this figure based on an analysis of IHME data)



See figure 5.6 for the top ten country recipients with the highest overall RMNCH funding channelled through the Bank. India received the highest overall Bank funding for RMNCH, with $2.6 billion (17%), followed by Argentina ($1.2 billion), Bangladesh ($1.1 billion), Brazil ($0.47 billion), and China ($0.44 billion). Five countries from this top ten list are middle-income countries (Argentina, Brazil, China, Indonesia and Peru) while two are low-income countries with fast growing economies (India and Nigeria). Many of these top ten recipient countries have also received the highest overall development assistance for health. Nearly half (45%) of the overall development assistance for health for top recipients such as Afghanistan, Bangladesh and Nigeria, went towards RMNCH. Is there a coherence or a match between the top aid recipient countries and the countries that have the highest burden of maternal and infant mortality? Table 5.1 helps to answer this question.

Figure 5.6: Top ten recipient countries with highest overall DAH and development assistance for reproductive, maternal, newborn and child health channelled through the World Bank from 1990-2018 (in USD billion) (Source: The author developed this figure based on an analysis of IHME data)



Countries such as Bangladesh, India, Indonesia, and Pakistan have a high number of maternal and infant deaths and they need financial priority to tackle this burden. However, Indonesia is a middle-income country while India is an emerging economy, and both countries can most definitely fund RMNCH programmes through their domestic resources rather than external funds, if they have the political will. Furthermore, Sub-Saharan Africa has some of the highest maternal and infant mortality rates. Yet, Nigeria, a fast growing economy, is the only country from this region that received a large amount of Bank funding for RMNCH. Sub-Saharan countries like Sierra Leone, Central African Republic, and Chad, which have some of the highest maternal and infant mortality rates in the world, received less than 1% of the overall development assistance for RMNCH funding ($12.1 million, $12.7 million, and $86 million, respectively). Similarly, Somalia, which has the sixth and third highest rates of maternal and infant mortality in the world, only received $0.1 million or 0.001% of the overall RMNCH funding. Finally, Latin American and middle-income countries like Argentina, Brazil and Peru, have comparatively lower rates of maternal and infant mortality, and yet, have received the highest amounts of external funding for RMNCH.

Table 5.1: Top ten countries with highest overall Bank lending for RMNCH along with top ten countries with high burden of maternal and infant mortality

No	Top ten countries by DAH for RMNCH (1990-2018)[a]	Top ten countries with highest maternal mortality rate (2015)[b]	Top ten countries with highest number of maternal deaths (2015)[b]	Top ten countries with highest infant mortality rate (2018)[c]	Top ten countries with highest number of infant deaths (2018)[c]
1	**India** 174 (45000) 32 (802000)	**Sierra Leone** 1360	**Nigeria** 58000	**Central African Republic** 88	**India** 802000
2	**Argentina** 52 (390) 9 (7000)	**Central African Republic** 882	**India** 45000	**Sierra Leone** 82	**Nigeria** 466000
3	**Bangladesh** 176 (5500) 27 (82000)	**Chad** 856	**Democratic Republic of Congo** 22000	**Somalia** 80	**Pakistan** 330000
4	**Brazil** 44 (1300) 13 (3900)	**Nigeria** 814	**Ethiopia** 11000	**Chad** 73	**Democratic Republic of Congo** 233000
5	**China** 27 (4400) 8 (133000)	**South Sudan** 789	**Pakistan** 9700	**Democratic Republic of Congo** 70	**Ethiopia** 133000
6	**Pakistan** 178 (9700) 61 (330000)	**Somalia** 732	**Republic of Tanzania** 8200	**Lesotho** 67	**China** 133000
7	**Nigeria** 814 (58000) 65 (466000)	**Liberia** 725	**Kenya** 8000	**Mali** 66	**Indonesia** 105000
8	**Indonesia** 126 (6400) 21 (105000)	**Burundi** 712	**Indonesia** 6400	**Equitorial Guinea** 65	**Bangladesh** 82000
9	**Afghanistan** 396 (4300) 52 (59000)	**Gambia** 706	**Uganda** 5700	**Nigeria** 65	**Angola** 65000
10	**Peru** 68 (420) 12 (7000)	**Democratic Republic of Congo** 693	**Bangladesh** 5500	**Benin** 64	**Afghanistan** 59000

[a] This first column lists the top ten recipient countries that received the highest overall Bank financing for RMNCH from 1990 to 2018. In this column, each row has the name of country followed by the maternal mortality rate (number of maternal deaths) and the infant mortality rate (number of infant deaths).
[b] These columns contain the latest available estimates for maternal mortality rate and number of maternal deaths for 2015, retrieved from WHO, 2015.
[c] These columns contain the latest available estimates for infant mortality rate and number of infant deaths for 2018, retrieved from UNICE, 2018.

5.3 World Bank's financial flows for reproductive, maternal and child health from 1970 to 2018

In this second part of the chapter, I analyse the World Bank's financial flows for reproductive, maternal and child health (RMNCH) from 1970 to 2018 from its core budget and extra-budgetary funds, using the Bank's own publically available datasets. First, I report key trends from the Bank's financial flows for RMNCH through its core budget i.e. through its country-level projects and its special health programmes. Through its country-level projects, the Bank provides IDA or IBRD credits (loans) to a country to implement planned RMNCH activities, and it offers grants through its special health programmes to implementing agencies at the regional or global level. Second, I present key trends from the Bank's financing for RMNCH through its extra-budgetary funds i.e. trust funds. Largely, I answer similar questions as discussed in the first part of the chapter: i.e. how much money, where it came from, and where it went.

5.3.1 Core budget: country-level projects

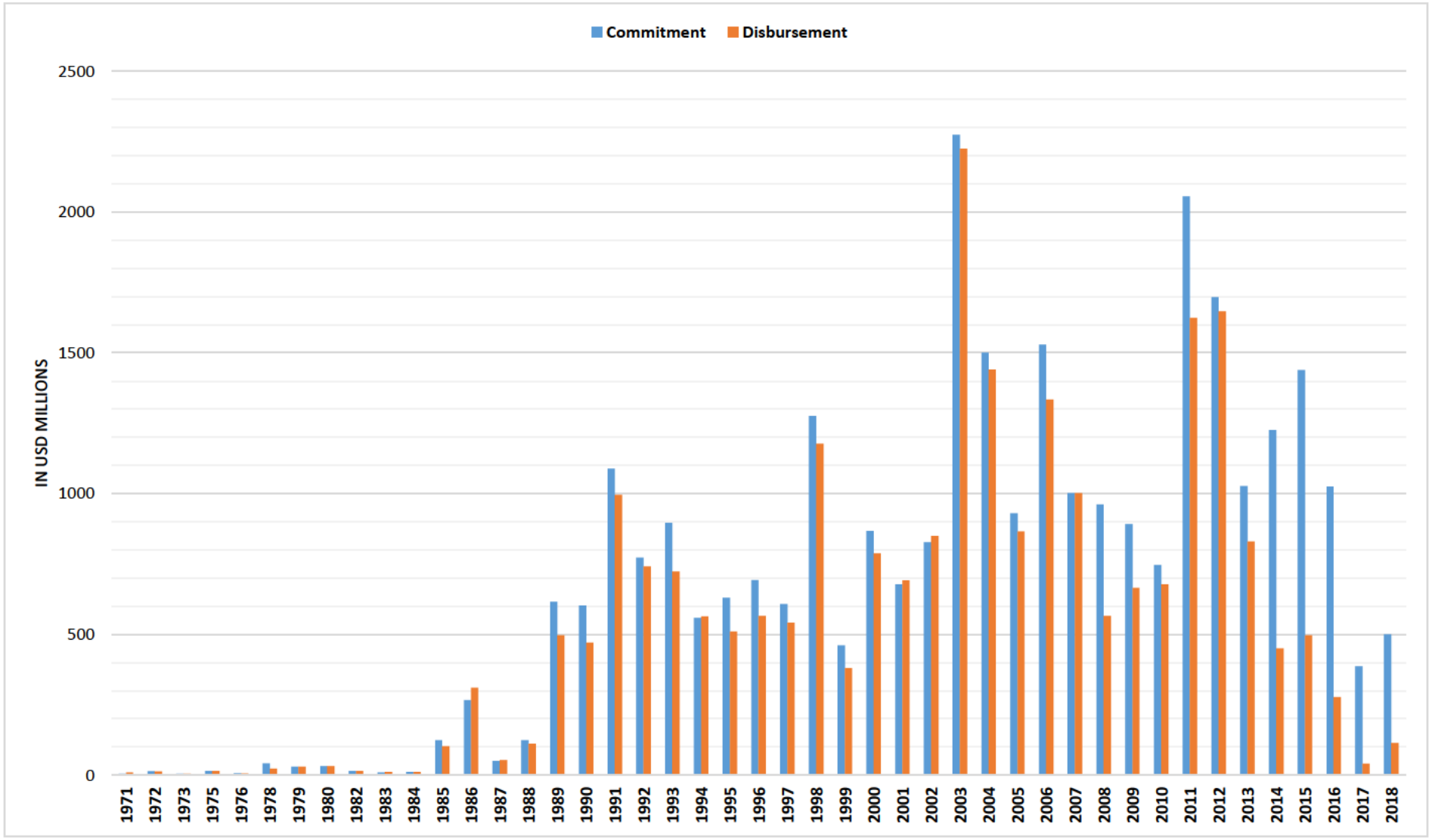
Total commitment and disbursements

The Bank's Health, Nutrition and Population (HNP) division financed 484 projects for RMNCH from 1970 to 2018. The overall costs of these 484 projects was $68 billion. Of this total amount, the Bank committed $30.6 billion and disbursed $24.6 billion. Commitment refers to an amount that is pledged by a donor when the project is approved, while disbursement is the actual amount that is released by the donor. See table 5.2 for Bank commitment and disbursement for RMNCH projects for each decade from 1970 to 2018, and figure 5.7 for an annual breakup of these financial commitments and disbursements.

Table 5.2: World Bank commitment and disbursements for maternal and child health from 1970 to 2018 (in USD million)

YEARS	COMMITMENT	DISBURSEMENT
1970-1979	117	101
1980-1989	1248	1143
1990-1999	7692	6778
2000-2009	11446	10479
2010-2018	10105	6159
Total	**30608**	**24660**

Figure 5.7: HNP's commitments and disbursements for reproductive, maternal, newborn and child health from 1970-2018 (in USD millions)

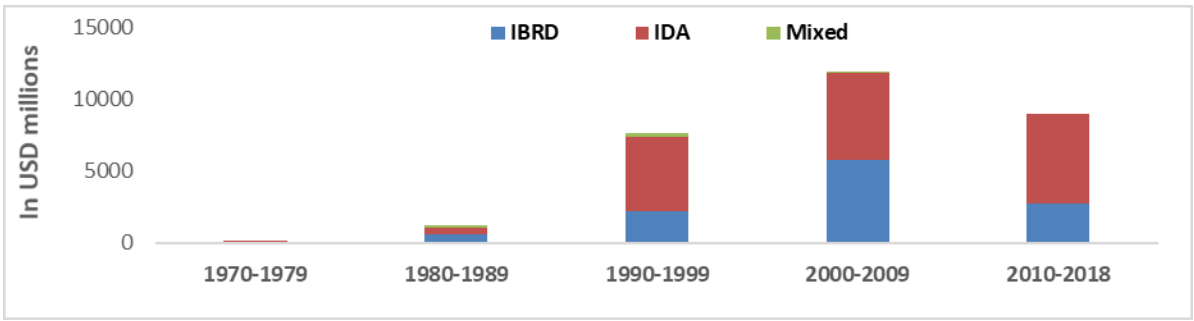


In the 1970s, Bank lending was solely focused on population control and a handful of nutrition projects. A tenfold increase in Bank commitment and disbursement for RMNCH projects was observed in the next decade (the 1980s), which could be explained the Bank's policy decision to start lending for stand-alone health projects with a focus on financing maternal and child health services, as well as the Bank's Safe Motherhood Initiative in 1987. Bank lending for RMNCH projects witnessed an eightfold rise in the 1990s. In the year 1998, Bank commitment ($1.27 billion) was as much as what it committed in the previous decade from 1980 to 1989. In 2003, the Bank committed and disbursed its highest ever amount for RMNCH to the tune of $2.2 billion. In the last eight years, the Bank's commitments declined by 10% from the previous decade; however, this apparent decline could be due to incomplete or ongoing financial reporting in the database. Over time, while the total amount of Bank lending for RMNCH projects increased with every passing decade, the proportional rise between the decades declined.

Source of the Bank's financial flows for RMNCH

Within the Bank itself, the financial resources for country-level projects come from IDA, IBRD, or a blend of resources from both these units. IDA funded the majority (60%) of the Bank's commitments for RMNCH projects from 1970 to 2018, while IBRD funded 37% (see figure 5.8). While IBRD did increase its funding between 2000-2009 owing to loans made to middle-income countries in Latin America, it appears that RMNCH projects will continue to receive a bulk of their funding from IDA, as the majority of the burden of maternal and child mortality lies in poor countries in Sub-Saharan Africa and South Asia served by IDA.

Figure 5.8: World Bank commitments for MCH projects over time by funding sources of IDA and IBRD



Organisations that co-financed RMNCH projects with the Bank

Each of the RMNCH projects analysed in this chapter have been financed either entirely by the Bank or in collaboration with other partner organisations including the borrower country governments, bilateral aid agencies such as USAID, DFID, and Norwegian Agency for International Development, development banks such as African Development Bank and Asian Development Bank, UN agencies such as WHO and UNICEF, and trust funds (see table 5.3). Additionally, there were sources that were unidentified in the database. For this segment, I only analysed disbursement data, as some co-financiers only reported disbursement and not commitment.

Two-thirds (61%) of all the RMNCH project costs at appraisal (i.e. $68 billion) from 1970-2018, came from co-financiers despite these being Bank-led projects. Worldwide, borrower governments contributed the largest share (73%) of the disbursements by co-financiers as well as 46% of the total project costs. In South Asia, borrower governments were the biggest financers of RMNCH projects, contributing 64% ($18.4 billion), while the Bank disbursed 36% of the total project costs ($24.6 billion of $68.5 billion). However, in the Middle East and North Africa (72%, or $1.1 billion) and the Latin America and the Caribbean region (61%, or $7.4 billion), the Bank provided the majority of the disbursements.

Bilateral agencies were the third major co-financiers of the total project costs after borrowing governments and the World Bank, disbursing a total of $4.2 billion. The United Kingdom's DFID was the leading bilateral co-financier, with a total disbursement of $921 million, followed by the government agencies of Netherland ($175 million), Sweden ($124), Australia ($138 million), and Norway ($105). The next major shares of co-financing came from unidentified sources ($3.8 billion) and trust funds ($2.5 billion) such as the Global Financing Facility, Global Fund to Fight AIDS, Tuberculosis and Malaria and GAVI, the Vaccine Alliance. Trust funds were most active in South Asia and Sub-Saharan Africa, contributing a total of $763 million and $1 billion in disbursements. UN agencies contributed less than 1% ($171 million) of the total project costs.

Table 5.3: Total disbursements for RMNCH projects by co-financing organisations and by geographic regions, 1970-2018

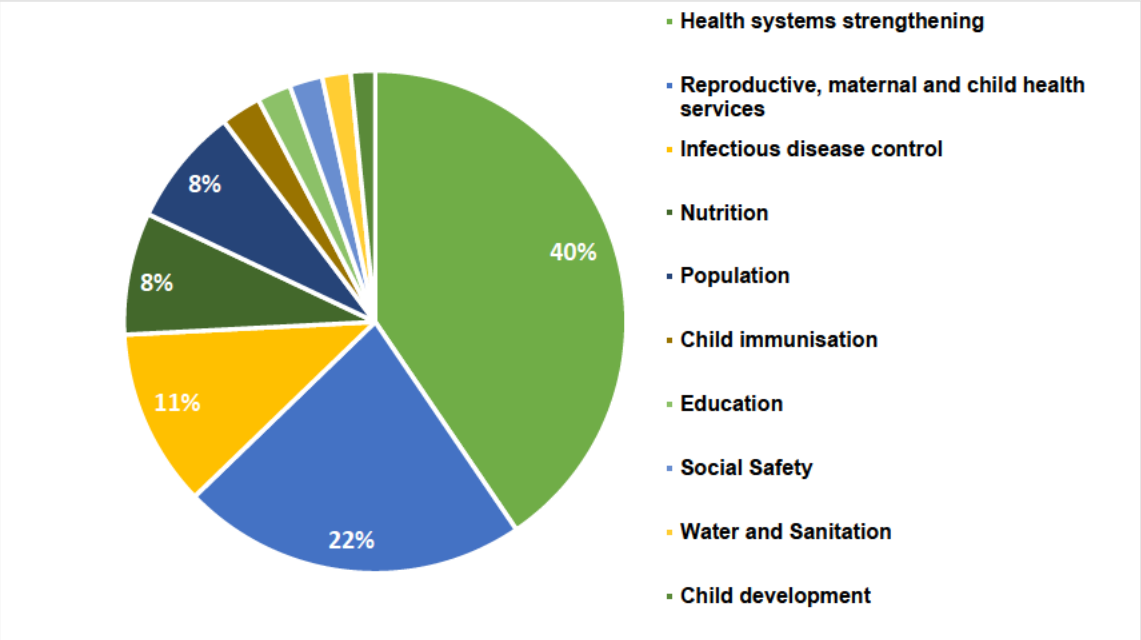
Region	Total Project Cost (appraisal)	Total Bank Funding (disbursement)	Borrower Governments	Bilateral Agencies	Development Banks	UN Agencies	Trust Funds	Unidentified Sources/ Other Sources	Additional Financing	Total Co-financier disbursements (excluding World Bank contributions)
East Asia and Pacific	4498	2665.49	1768.65	367.14	112.40	13.90	155.90	59.63	117.40	2595.02
Europe and Central Asia	2423.09	896.84	1036.76	76.91	75.12	2.07	24.80	0.38	75.44	1291.48
Latin America and Caribbean	12377.39	7397.29	4415.27	152.12	142.30	23.70	92.75	2.71	357.85	5186.7
Middle East and North Africa	1825.68	1108.53	363.74	5.22	0.00	13.97	39.67	2.62	28.68	453.9
South Asia	33116.06	6736.72	18783.90	2242.69	180.25	97.18	1237.94	323.55	999.85	23865.36
Sub-Saharan Africa	14331.68	5855.681	4964.72	1369.54	91.94	20.24	1021.15	293.90	1623.99	9385.48
TOTAL	**68571.90**	**24660**	**31333**	**4214**	**602**	**171**	**2572**	**683**	**3203**	**42778**

Note:
[1] Bilateral agencies are government organisations that receives funding from its home country's government to then be used toward a developing country. For example, USAID and DFID. Development banks in this analysis include the African Development Bank and the Asian Development Bank. U.N agencies include WHO, UNICEF and UNFPA.
[2] Unidentified sources are those sources with no name or label provided in the World Bank dataset.

Programmatic areas that received Bank lending for RMNCH

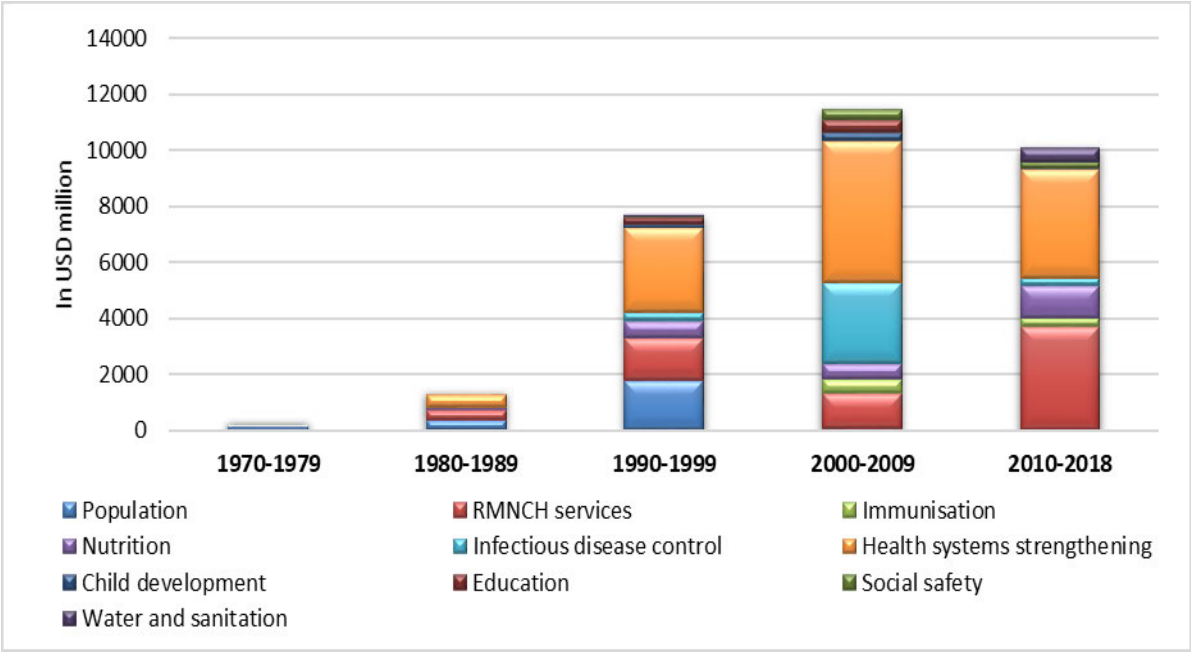
I examined all the 484 RMNCH projects and coded each project with a programme area towards which the majority of funds were disbursed. Figure 5.9 displays a distribution of the total Bank commitment by programme areas. Around 40% or $12.3 billion of the total commitment for RMNCH projects was allocated for 'health systems strengthening' followed by 'RMNCH services' with 22% or $6.8 billion. Infectious disease control projects received the next biggest share of Bank commitment (11% or $3.4 billion). Nutrition and population control projects received 8% of the total share respectively, while childhood immunisation received 3% or $793 million.

Figure 5.9: Total Bank commitments for RMNCH projects by programmatic areas, 1970-2018 (in USD millions)



A closer look at the Bank lending for RMNCH by each decade offers a clearer picture about its evolving approach for this area (see figure 5.10). The first decade of Bank lending from 1970 to 1979 focused on population control projects implemented in Jamaica, Tunisia, Indonesia, Malaysia, Bangladesh, Egypt and Korea, which financed the construction and staffing of healthcare infrastructure and the service delivery of family planning services. The Bank also funded its first nutrition project in this decade with a loan of $19 million to Brazil in 1976.

Figure 5.10: HNP's commitments for reproductive, maternal, newborn and child health channelled through the World Bank from 1970-2018 by thematic areas (in USD millions)



In the 1980s, while the Bank continued to fund population control and nutrition projects, it also forayed into financing stand-alone health projects and within this, it financed the programme areas of health systems strengthening and RMNCH services. Projects that funded RMNCH services emphasised the provision of family planning. Additionally, 12% of RMNCH projects in this decade, included cost recovery or user fees in their strategy, in that user fees were instituted in government health policy and implemented at the secondary or tertiary-level health care facilities.

Three key trends emerged from the Bank's financing for RMNCH projects in the 1990s. First, these projects started funding infectious disease control activities, particularly for HIV/AIDS and Tuberculosis. Second, the share for health systems strengthening increased to $3 billion. The early projects that financed health systems strengthening activities funded building of health facilities, medical equipments, vehicles, and training of health care workers, and in some cases, supply of medicines. In the later part of this decade, these projects financed the development of health information, procurement and management systems. Third, population control received its largest ever share of financial commitment - $1.78 billion -, which was more than that allocated to RMNCH services ($1.5 billion). Five out of 121 projects in this decade also financed water and sanitation, education and early child

development. Between 2000 and 2009, health systems strengthening received the highest commitment with $5 billion. Commitment for infectious disease control activities also increased substantially to $2.9 billion. However, the share of RMNCH services declined slightly to $1.2 billion. Population control activities received its lowest ever commitment ($69 million), while child immunisation was allocated $495 million. In the last eight years (2010-2018), 'health systems strengthening' continued to receive the majority of the Bank's commitment ($3.8 billion), followed by RMNCH services ($3.6 billion). Projects that financed health system strengthening in this decade, implemented reforms in health financing and human resources. This period also recorded the highest ever commitment for nutrition-focused projects ($1.1 billion). None of the projects in this period funded any population control activities.

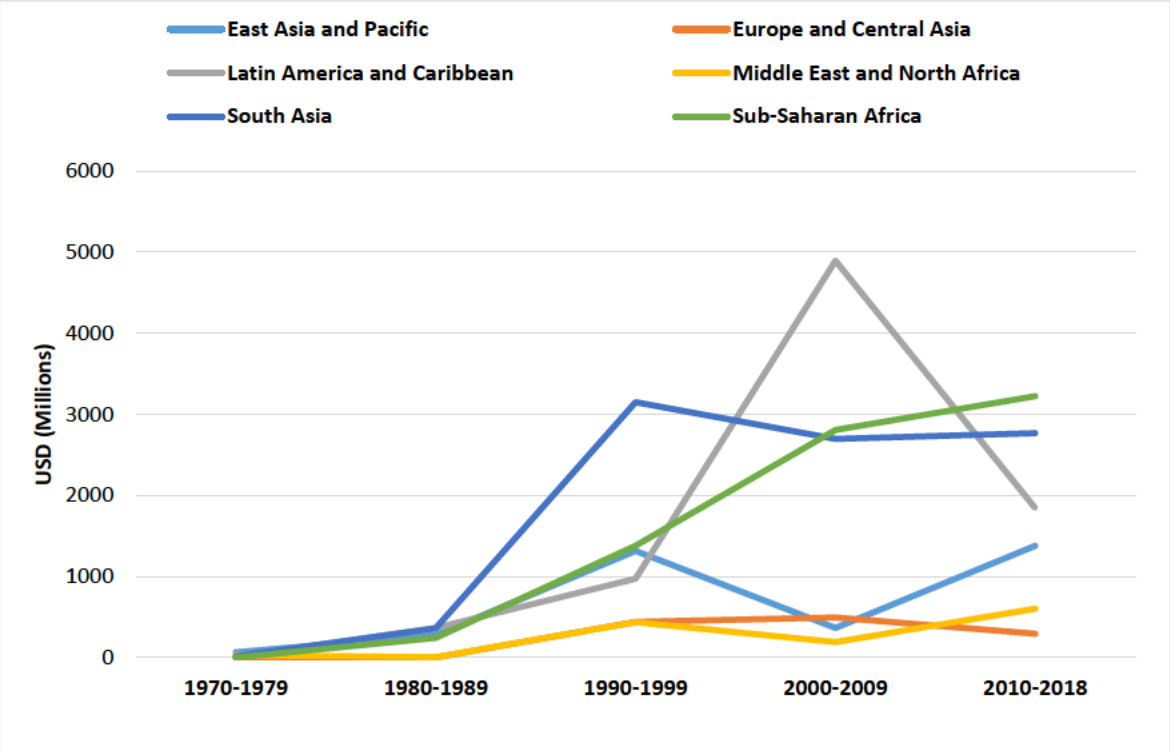
Recipients – geographic regions and countries

South Asia and Latin America and the Caribbean regions received the highest overall commitment for RMNCH with $8.9 billion and $8 billion respectively, followed by Sub-Saharan Africa with $7.6 billion. In terms of the overall disbursement, the Latin America and Caribbean region recorded the highest overall amount with $7.3 billion followed by South Asia ($6.7 billion), Sub-Saharan Africa ($5.8 billion), East Asia and Pacific ($2.6 billion), Middle East and North Africa ($1.1 billion) and Europe and Central Asia ($800 million).

Figure 5.11 presents a break-up of the Bank commitments for RMNCH for each of the six geographic regions by each decade. In the first decade of lending, the majority of the Bank commitment ($65 million; 55%) went to the East Asia and Pacific region, through population projects in Indonesia, Malaysia and Korea. Between 1980 and 1989, the biggest share of Bank commitment (29%) went to the regions of Latin America and the Caribbean ($363 million) and South Asia ($360 million). Brazil and Colombia received major commitments in the Latin America and the Caribbean region in this period, while India, Bangladesh and Sri Lanka were the major South Asian recipients. Additionally, in this decade, commitments for the Middle East and North Africa region dropped to $4 million from $30 million in the previous decade. Between 1990 and 1999, overall Bank commitments rose and South Asia emerged as the biggest recipient of funds ($3.1 billion; 41%) followed by the Sub-Saharan Africa ($1.3 billion) and East Asia and Pacific ($1.3 billion) regions.

In the next decade, from 2000 to 2009, while the commitment for South Asia, East Asia and Pacific and the Middle East and North Africa regions declined, lending for projects in Latin America and the Caribbean region ($4.8 billion) saw a sharp rise. In the last eight years, the Sub-Saharan Africa ($3.2 billion) and South Asia ($2.7 billion) received the maximum amount of commitments.

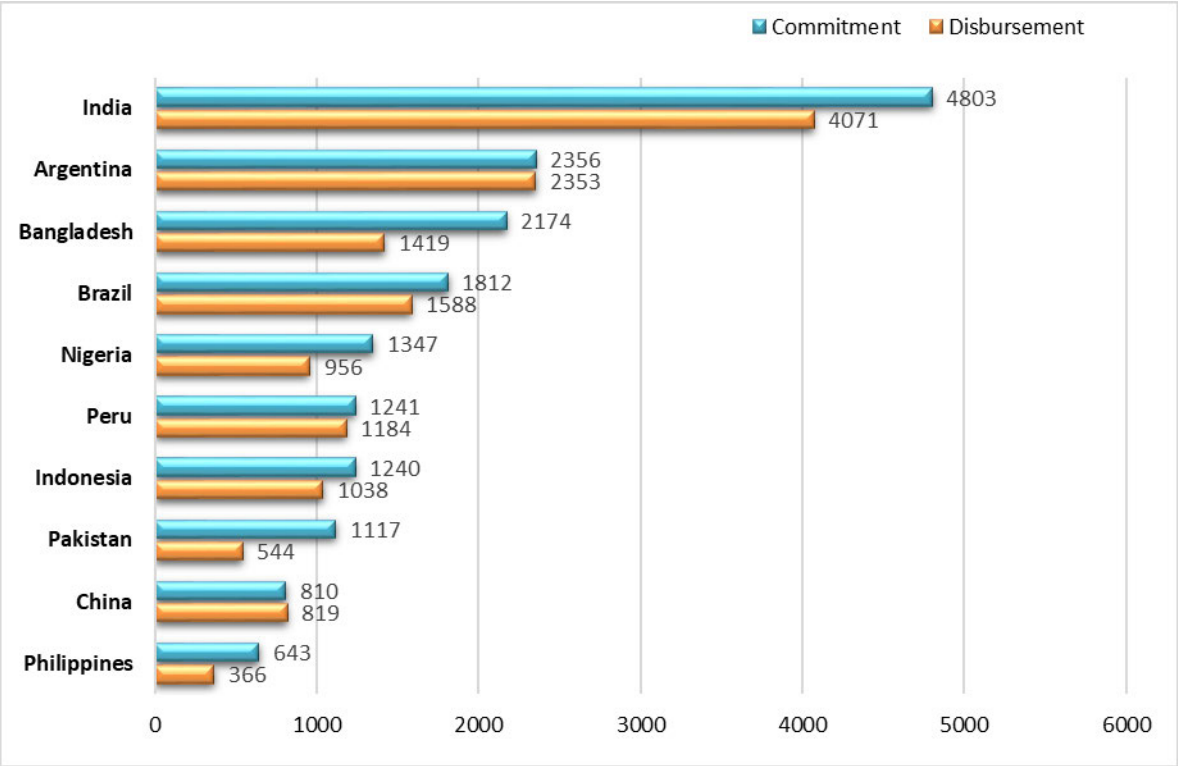
Figure 5.11: World Bank commitments for maternal and child health across geographic regions from 1970 to 2018 (in USD millions)



Currently, three trends have emerged with respect to the Bank's lending for RMNCH to geographic regions. First, there has been a substantial rise in the Bank's lending for Sub-Saharan Africa, which has the highest burden of maternal and infant mortality. Second, funding for South Asia seems to have peaked - while commitments for the Latin America and Caribbean region have dived. Third, funding for Middle East and North Africa and East Asia and Pacific is also gradually rising.

A closer look at the Bank's lending for RMNCH by countries offers more detail (see figure 5.12). This list of top ten recipients is similar to the list extracted from IHME data with the only exception of Philippines in the place of Afghanistan (see table 5.1 on page 107).

Figure 5.12: World Bank commitments and disbursements for maternal and child health projects from 1970 to 2018 by top ten country recipients (in USD millions)



Some of the major recipient countries with the highest overall Bank funding for RMNCH projects (such as Bangladesh, India, Indonesia, and Pakistan) have a high number of maternal and infant deaths and require financial investments in this area. However, countries from the Latin American region including Argentina, Brazil and Peru have a comparatively lesser burden of maternal and infant mortality (MMEIG, 2019; UNICEF, 2019), and yet, they received high amounts of Bank funding. Furthermore, middle-income Latin American recipients, as well as countries like China and India, have growing economies and could very well fund RMNCH programmes with their domestic resources rather than external funds from the Bank. Most importantly, several Sub-Saharan African countries (with the exception of Nigeria), which have some of the highest maternal and infant mortality rates in the world, do not receive Bank funding commensurate with their burden of disease. The countries in this region are also poor and have had a slow rate of repayment on their loans (7% of all their loans have been repaid so far). This finding raises the question about whether Bank funding matches with the burden of disease or the country's ability to repay loans.

Commitments by the type of investment instrument

Half (257 of 484) of the RMNCH projects and the majority of the financial commitment ($13.9 billion; 45%) were channelled through a 'specific investment loan' (see table 5.4). This instrument funds the development of infrastructure, consultant services, management and training programmes. The next big chunk of commitments ($5.8 billion) was released through a similar instrument (Investment Project Financing), albeit with an emphasis on poverty reduction and sustainable development. Both these instruments constituted 65% of the total Bank commitment for RMNCH, focused on project-based lending wherein financial resources were channelled for individual country level projects implemented by the national Ministry of Health of the borrower government.

Table 5.4: Number of Bank-funded maternal and child health projects by the type of investment instrument (in USD million)

TYPE OF INVESTMENT INSTRUMENT	NUMBER OF PROJECTS	COMMITMENT (USD MILLION)
Specific Investment Loan	257	13925
Investment Project Financing	76	5874
Adaptable Program Loan	51	2212
Sector Investment and Maintenance loan	32	3069
Emergency Recovery Loan	19	886
Development Policy Lending/Loan	17	2305
Technical Assistance Loan	8	9
Programmatic and Sector Structural Adjustment Loan	8	985
Program-for-Results	5	1100
Learning and Innovation Loan	4	15
Poverty Reduction Support Credit	3	240

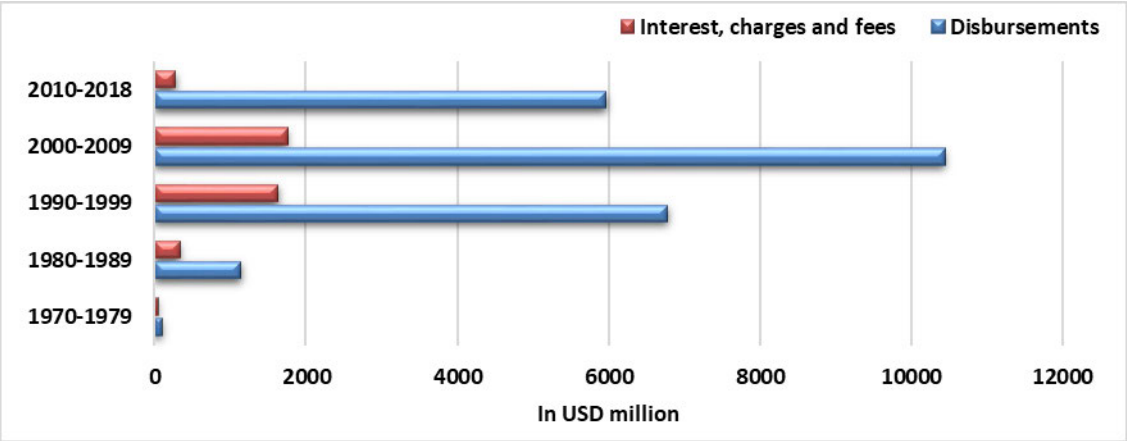
In the case of the Sector Investment and Maintenance Loan, the third largest channel in terms of total commitment (10%), resources were allocated towards the borrowing country's health sector as against an individual project. Eight projects, with a total commitment of $985 million, were funded through structural adjustment loans. Such loans are now called 'development policy loans' and offer quick disbursement of loans to support government policy reform (Ravallion, 2015). These development policy loans, which support government implementation of policies and institutional actions, were released in the early noughties and represented 7% of the total

RMNCH commitment ($2.3 billion). Between 2003 and 2005 all the structural adjustment loan projects, except one to India in 1992, went to Latin American and the Caribbean countries of Argentina, Bolivia, Colombia, Ecuador, Dominican Republic and Peru. The structural adjustment and development policy loans together represented $3.2 billion (10.4%) of the overall RMNCH commitment. Emergency recovery loans were channelled in the last ten years, most of them released for countries in Sub-Saharan Africa, including Sudan, South Sudan, Cote d'Ivoire, The Gambia, and Liberia. While only five projects were financed through the Program-for Results mechanism, the commitment for these projects was comparatively high at $1.1 billion. Since 2013, the Bank has been using the 'Program-for-Results' instrument for projects in Ethiopia, Morocco, Nigeria, Tanzania and Vietnam, channelling almost $1 billion over a span of five years.

Interest and charges on Bank disbursements for RMNCH projects

The Bank charged an overall $4 billion in interests and fees on its total lending of $24.4 billion for RMNCH projects (excluding grants of $219 million) (see figure 5.13). In its first decade of lending, interests and fees constituted 46% ($46 million) of the total amount disbursed ($101 million). In the next decade, these charges constituted 29% of the total lending. Interest and charges as a percentage of the total lending have relatively declined in the next three decades: 24% during 1990-1999, 17% during 2000-2009, and 4% during 2010-2018.

Figure 5.13: World Bank disbursements (without grants) and interest, charges and fees from 1970 to 2018 (in USD million)



Repayments by borrower countries

Borrowing country governments have repaid $8.6 billion (i.e. 35%) of the total Bank disbursements for RMNCH projects ($24.4 billion). Countries have repaid 80% of the Bank disbursements from 1970 to 1979.For the next decade, countries have repaid 71% of the total Bank disbursements. Repayments by borrower countries as a percentage of the total disbursement reduced with each decade after: 55% during 1990-1999, 37% during 2000-2009, and 3% during 2010-2018 (see figure 5.14).

Figure 5.14: World Bank disbursements (without grants) and repayments by borrower governments from 1970 to 2018 (in USD million)

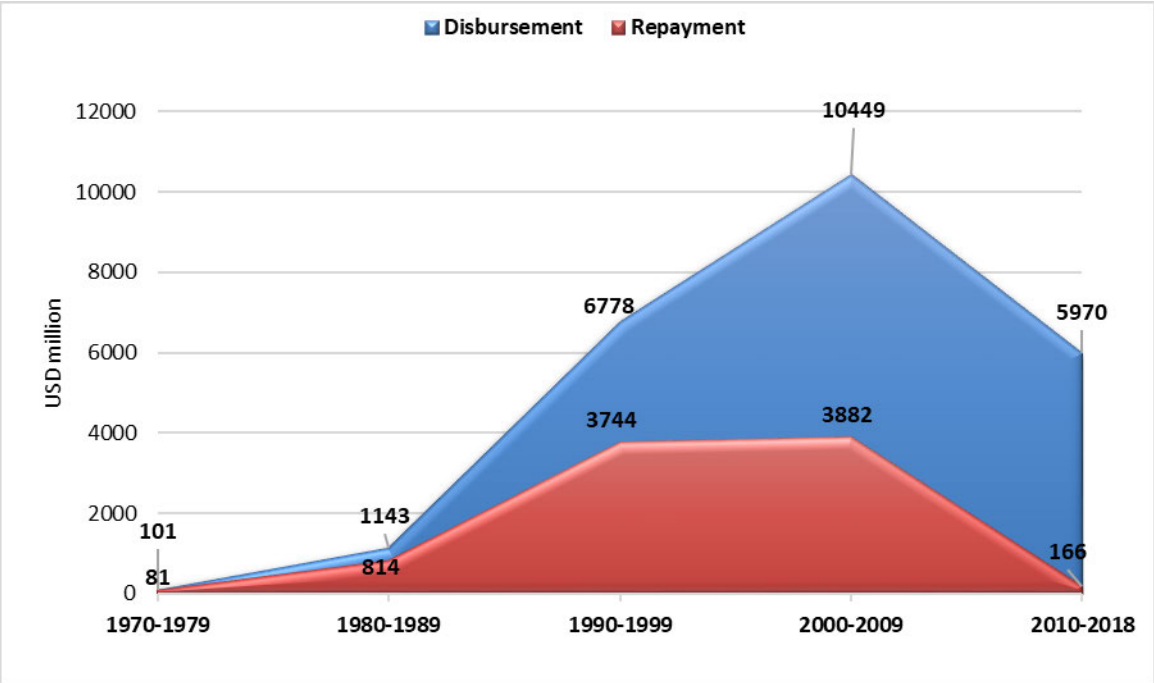


Table 5.5 details repayments by geographic regions. While the Latin America and the Caribbean region received the highest disbursement, as well as interest and other charges, countries in this region also repaid 55% of their total loans. Similarly, countries in the regions of Europe and Central Asia and East Asia and Pacific also repaid half of their loans (56% and 49% respectively). South Asia and Sub-Saharan Africa were charged a lower amount of interest and fees (13% and 7% of total disbursements) compared to other regions. Borrower countries in the South Asia region repaid a third of their Bank loans (29%), while countries in the Sub-Saharan African region paid back 7% of their loans.

Table 5.5: World Bank commitment, disbursement, interest and repayments from 1970 to 2018 (in USD millions)

Region	World Bank Commitment	World Bank Disbursement	World Bank Disbursement (without grants)	Interest and fees (% of Bank disbursement without grants)	Repayment (% of Bank disbursement without grants)
East Asia and Pacific	3401	2665	2655	649.53 (24%)	1302 (49%)
Europe and Central Asia	1228	897	897	168.57 (19%)	505 (56%)
Latin America and Caribbean	8080	7397	7397	1726.14 (23%)	4063 (55%)
Middle East and North Africa	1261	1108	1108	191.55 (17%)	450 (41%)
South Asia	8986	6737	6566	885.65 (13%)	1914 (29%)
Sub-Saharan Africa	7648	5856	5818	421.001 (7%)	453 (7%)
TOTAL	**30608**	**24660**	**24441**	**4042**	**8687**

Table 5.6 presents disbursements, interest and fees and repayments by the top recipient countries. Indonesia and Philippines have been charged the highest amounts in interest and fees on their total loans (34% and 19% respectively), followed by China (18%). These countries may have received IBRD loans that levy a higher rate of interest and fees as compared to IDA credits. While Brazil and India have been charged 17% and 15% of their total loans, Argentina has the lowest interest and other fees as a percentage of Bank disbursement (5%).

In the case of repayments by the top borrowers, China has the highest repayment rate, having paid back 75% of its loans. China is followed by Indonesia, Brazil and Pakistan that have repaid nearly half of the Bank disbursements. Peru comes in fifth with a repayment of 38% of its Bank disbursements, followed by India at 35%. While Argentina has the lowest amount of interest and fees, it also has the lowest rate of repayment of its loans (11%).

Table 5.6: World Bank commitment, disbursement, interest and repayments from 1970 to 2018 (in USD millions)

No	Top borrower countries	Bank Commitment	Bank Disbursement without grants	Interest, fees and charges (% of Bank disbursement without grants)	Repayments (% of Bank disbursement without grants)
1	India	4803	4071	597 (15%)	1422 (35%)
2	Argentina	2356	2353	110.6 (4.7%)	258 (10.9%)
3	Bangladesh	2174	1419	193 (14%)	235 (16%)
4	Brazil	1812	1588	273.7 (17%)	670 (42%)
5	Nigeria	1347	956	102.56 (11%)	191 (20%)
6	Peru	1241	1184	171 (14%)	453 (38%)
7	Indonesia	1240	1038	357 (34%)	467 (45%)
8	Pakistan	1117	544	71.78 (13%)	227 (42%)
9	China	810	819	151 (18%)	612 (75%)
10	Philippines	643	366	68.93 (19%)	121 (33%)

Performance ratings of Bank-funded RMNCH projects

A total of 331 of 484 projects had performance ratings for project outcomes, World Bank, borrower government and the implementing agency. A highly satisfactory rating means that no shortcomings were observed while highly unsatisfactory performance denotes severe shortcomings.

I found that around 70% of all projects had an overall satisfactory (including satisfactory, moderately satisfactory and highly satisfactory) performance rating for project outcomes, the Bank, borrower government and the implementing agency. Around 40% of all projects provided a satisfactory performance rating for all the four categories. A higher number of projects received a moderately satisfactory performance rating for borrower governments (29%) as compared to the Bank (14%). Furthermore, a higher number of projects gave implementing agencies with a highly satisfactory rating than the Bank or the borrower government. Although project reports provided these performance ratings, little information was available on the detailed criteria for how ratings were assigned. There was no way of ascertaining why the performance of the Bank or borrower government or implementing agency was satisfactory in a project versus moderately satisfactory or unsatisfactory.

5.3.2 Core Budget: Special Health Programmes

Apart from lending for country-level projects, the Bank also provided grant-based funding for special health programmes that were implemented at the global or regional level, in many cases with technical assistance from the WHO. In the 1980s, the Bank started the Special Grants Programme that released grants for projects in agriculture and health among other development areas (World Bank, 1985). In 1998, the Bank consolidated its grant making in a single mechanism under the Development Grant Facility. This Facility releases grants using the IBRD administrative budget, which makes it part of the Bank's core budget (World Bank, 2014).

The Bank released grants amounting to $106.57 million for special maternal and child health-related programmes from 1987 to 2014 (see table 5.7). The Special Grants Programmes released grants worth $35.42 million, while the Development Grant Facility ($71.15 million) funded the rest. Information for the financial contributions by the Development Grant Facility is only available up to 2014.

Half of the all the grant money ($50.81 million) was allocated to the Special Programme of Research, Development and Research Training in Human Reproduction, which is housed in the WHO. The Population and Reproductive Health Capacity Building Program, which was the next biggest recipient of grants ($37.72 million), built the capacity of civil society organisations to develop and implement culturally appropriate interventions for population and reproductive health. While the annual reports of the Development Grant Facility provided the annual financial contributions for these special RMNCH programmes, there was no further information on the geographic distribution of these grants.

Table 5.7: Financial contributions allocated through grants for special health programmes (in USD millions)

Special Health Programmes	1987-1996	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Research, Development and Research Training in Human Reproduction	18.5	2.5	2.5	2	2	2	2	2	2	2	2	2	1.5	1.85	1.62	1.62	1.52	1.2
Population Reproductive health capacity building program	5.8	2.1	2.1	2	2	2	2	2.2	2.2	1.42	1.2	1.2	1.2	1.2	1.05	1.05	1	1
Global micronutrient initiative	3.1	1.2	2	1.2	1.2	1.2												
UN ACC Sub-committee on nutrition	0.74	0.1	0.1															
Safe motherhood	5.34																	
Taskforce for child survival	0.94																	
Vaccines			0.3															
Children's Vaccine Initiative	1	0.4																
Network Improved Reproductive and Health		0.6																
Mainstreaming Nutrition in Maternal and Child Health Programmes									1.3	1.3	1.24							
Bridging the Knowledge Gap for Results in maternal newborn and child health																		1.2
TOTAL	**35.42**	**6.9**	**7**	**5.2**	**5.2**	**5.2**	**4**	**4.2**	**5.5**	**4.72**	**4.44**	**3.2**	**2.7**	**3.05**	**2.67**	**2.67**	**2.52**	**2.2**

5.3.3 Extra-budgetary Funding: Trust funds

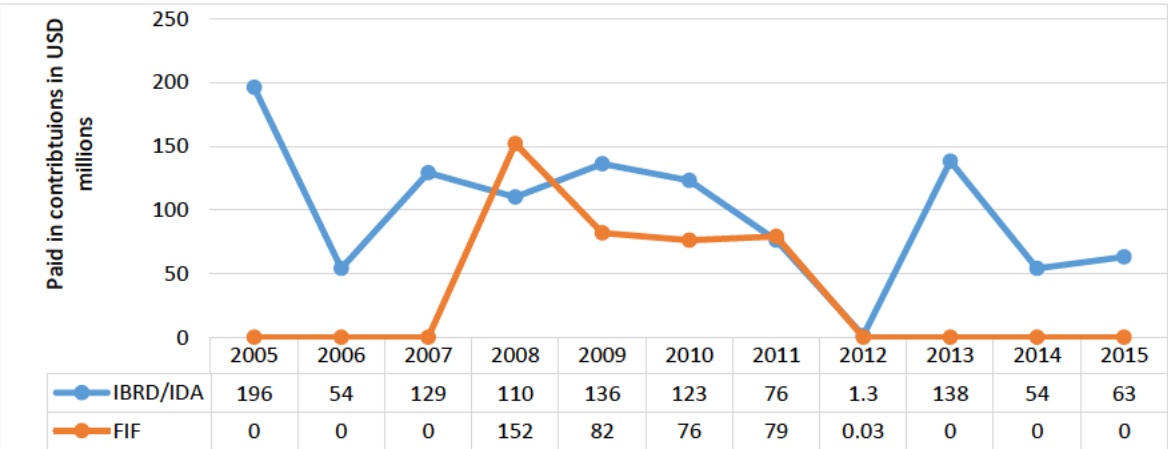
Total number of trust funds

The Bank channels its extra-budgetary funds through three types of trust funds: (i) trust funds financed using IBRD/IDA resources, (ii) financial intermediary funds that support global or regional partnerships, and (ii) and trust funds financed by the International Finance Corporation. Financial information for all the three types of trust funds was available from 2005 to 2015. First, 443 IBRD/IDA trust funds financed health-related programmes, of which 36 trust funds funded RMNCH activities (see table 5.8). Second, there were two financial intermediary trust funds for health; i.e. Global Fund to fight AIDS, Tuberculosis and Malaria, and GAVI, the Vaccine Alliance. Of these, I classified GAVI as a RMNCH-related trust fund (as it finances child immunisation). Finally, while the International Finance Corporation financed 33 health-related trust funds, none of which funded RMNCH activities.

Total financial contributions

From 2005 to 2015, IBRD/IDA trust funds approved a total financial contribution of $1.08 billion, while GAVI pledged $391 million, thereby bringing the Bank's total financial contributions for RMNCH through its trust funds to $1.4 billion. While the financial contributions for these trust funds have fluctuated over time, it is difficult to assert if these represent actual trends or if they just are a result of reporting in particular years (figure 5.15).

Figure 5.15: Total financial contributions for MCH-related IBRD/IDA trust funds and financial intermediary funds by the year of approval

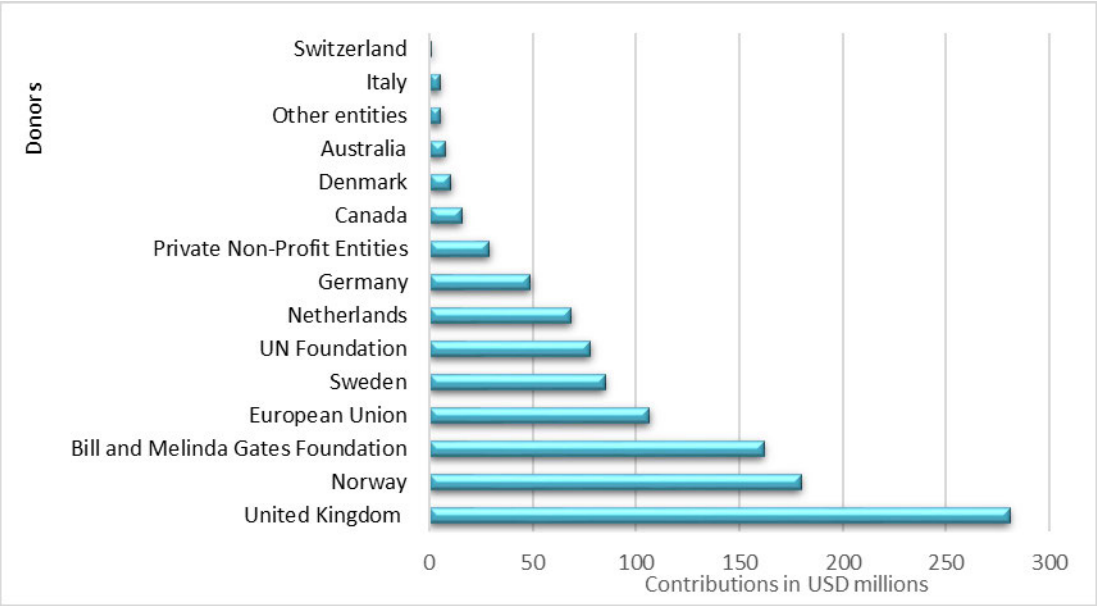


	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
IBRD/IDA	196	54	129	110	136	123	76	1.3	138	54	63
FIF	0	0	0	152	82	76	79	0.03	0	0	0

Major donors

Information about donors was only available for the IBRD/IDA trust funds. Four of the seven G7 countries–UK, Germany, Canada and Italy–feature as top donors of the IBRD/IDA trust funds (figure 5.16). This list also features private entities including the Bill and Melinda Gates Foundation ($162 million; 14%) and private not-profit organisations ($29 million or 3%). The U.S., which is the biggest global donor for RMNCH, did not contribute through Bank trust funds, while other major bilateral donors like the U.K, Germany, France, Canada and Italy prefer this mechanism.

Figure 5.16: Total financial contributions for MCH-related IBRD/IDA trust funds by donor



Programmatic and geographic areas

Child vaccines received the highest amount of financial resources from trust funds ($656 million), followed by health systems strengthening ($390 million), RMNCH services ($279 million) and family planning ($131 million). South Asia received the majority (55%, $597 million) of the funding for IBRD/IDA trust funds, while Sub-Saharan Africa received 2.6% or $29 million of these funds. Nearly 26% of the funds from IBRD/IDA trust funds and GAVI trust fund did not provide information where the money was allocated. This lack of information on the geographic distribution of trust funds is problematic in that it lacks transparency, is difficult to track and consequently ultimately affects accountability.

5.4 Reproductive, maternal, newborn and child health as a proportion of the World Bank's overall lending

In this section of the chapter, I present the Bank's total financial commitments for RMNCH and compare it with the Bank's total lending for health and IBRD and IDA (see table 5.8). The Bank's total financial commitments for RMNCH are from its country-level projects, as discussed in the second part of this chapter. I extracted the Bank's overall commitments for the health sector (which is its Health, Nutrition, Population/ HNP division) from a publically accessible dataset on the World Bank website, and for its financial commitments for IBRD and IDA, I retrieved financial information from the Bank's annual reports from 1970 to 2018.

Table 5.8: World Bank's financial commitments for RMNCH, health and its overall lending (IBRD and IDA) from fiscal years 1970 to 2018 (in USD millions)

	1970-1979	1980-1989	1990-1999	2000-2009	2010-2018	TOTAL
Total World Bank funding for RMNCH	117	1248	7692	11446	10105	30608
Total World Bank funding for Health	337	2104	13582	15287	26075	57383
Total World Bank funding (IBRD and IDA)	53495	155755	230427	232941	387008	1059626
RMNCH as a percentage of Health funding	34.7%	59.3%	56.6%	74.8%	38.7%	53.3%
RMNCH as a percentage of total World Bank funding	0.2%	0.8%	3.3%	4.9%	2.6%	2.8%
Health as a percentage of total World Bank funding	0.6%	1.3%	5.8%	6.5%	6.7%	5.4%

The Bank committed a total of $30.6 billion for RMNCH projects from 1970 to 2018. Over this period, RMNCH accounted for half or 53% of the entire Bank lending for its health sector projects. Financial commitments for RMNCH projects as a percentage of the Bank's health sector funding started at 35% in 1970-1979, rising to nearly 60% in 1980-1989, peaking to 75% in 2000-2009, and settling at 39% in 2010-2018. The

overall financial commitments for RMNCH as a share of the Bank's health sector lending highlights the significance of this area for the Bank.

Within the Bank, the health sector claims a relatively small proportion of its overall financial commitments ($57 billion or 5.4% of $1059 billion). Over time, health sector commitments as a proportion of the Bank's overall lending rose from 0.6% in 1970-1979 to 6.7% in 2010-2018. The Bank's overall lending (IBRD+IDA) has risen from $57 billion in 1970-1979 to $387 billion in 2010-2018. Although health forms a minor share of the Bank's total spending, it has been on the rise and so has the Bank's overall IBRD and IDA commitments. If the share of Bank spending for the health sector grows, so does RMNCH.

5.5 Conclusion

What is the role of the World Bank in terms of financing reproductive, maternal, newborn and child health at the global level?

The World Bank is the fifth largest channel for development assistance for reproductive, maternal, newborn, and child health (RMNCH) in the world, disbursing a total of $15 billion from 1990 to 2018. This is an estimate from IHME data. As per the Bank's own databases, it disbursed an overall $26.1 billion from 1970 to 2018. The discrepancy in the estimates from these two sources can be explained by two reasons. First, IHME data covered a time period of 1990 to 2018, while the Bank data covered a longer duration (i.e. 1970 to 2018). Second, the Bank data included both core budget and its extra-budgetary funding, while the IHME data only included funding from the Bank's core budget. Regardless of the difference in the estimates and methodologies used to derive them, globally, the Bank remains a major external financier for RMNCH. Even within the Bank, RMNCH holds a significant position in its health sector financing: 53% of the Bank's total health sector lending went to RMNCH. Despite representing a small share of global financial lending compared to private capital flows (Ravallion, 2015), World Bank lending has been increasing in absolute terms. This means that developing countries will continue to look towards the World Bank for financial resources, indicating its complementarity rather than substitutability in the financial market and - more importantly - its relevance as a major financial player for RMNCH.

While the Bank is a major funder for RMNCH, who funds the Bank?

IHME data showed that debt repayments from borrowing countries funded half (53%; $7.9 billion of $15 billion) of the Bank's overall disbursements for RMNCH projects from 1990 to 2018. Borrowing countries also co-financed 46% of the overall RMNCH project costs while the Bank, bilateral aid and UN agencies and other development banks funded the rest. Borrowing countries are thus the major financiers of Bank-funded RMNCH projects. This is directly, through their financial contributions towards the overall project costs, as well as indirectly, through their debt servicing to the Bank that is channelled towards project financing. Bilateral aid agencies were the second biggest source of funding for RMNCH projects channelled through the Bank. The U.S. was the leading bilateral donor with $1.4 billion or 9% of the overall Bank disbursement, followed by Japan (7%; $1.2 billion) and the U.K (5%; $739 million).

This analysis also showed how donors have differing preferences for financing channels and programmatic priorities. For instance, major donors like the U.S. prefer to fund RMNCH through country-level projects, whereas donors like the U.K. and Norway prefer both country-level projects as well as trust funds. Moreover, the U.S. financial contributions for RMNCH mostly went towards selective interventions in family planning and nutrition, while Canada and Sweden, for example, mainly funded health systems strengthening programmes.

What does the Bank's lending for RMNCH over time tell us about its conceptualisation of this area?

The Bank focused on population control in the first decade of its lending for RMNCH projects, financing physical infrastructure and service delivery for family planning. Following the adoption of its 1980 policy to invest in standalone health projects, the Bank began lending for projects that financed nutrition and RMNCH services. Offering maternal and child health services seemed to make family planning more palatable to the borrower country governments as well as the communities that the projects served. Towards the late 1980s and early 1990s, Bank-funded RMNCH projects started financing health systems strengthening activities. This early version of the Bank's health system strengthening activities financed building of physical infrastructure, medical equipments and vehicles, training of health workers, and maternal and child health service delivery. Health systems strengthening also

included health information and management systems in the late 1990s. In 2000-2009, RMNCH projects were used as a platform to fund infectious disease control, particularly HIV/AIDS and tuberculosis. In recent decade (2010-2018), most of the RMNCH projects funded health systems strengthening activities, which also included reforms for health financing and human resources in its remit.

Three insights emerge from this thematic analysis of the Bank's country-level projects. First, the Bank used the maternal and child health platform to advance selective aspects of family planning, nutrition, and infectious disease control in the first three decades of its lending. While the funding for family planning and infectious disease control declined in the recent years, nutrition continued to get financial support, with its highest overall commitment of $1.1 billion reported in 2010-2018. Nutrition also received increased interest in the recent years by former Bank President Jim Kim (Taylor, 2017), and has been associated as a driver for economic development and thereby a key component of the Bank's human capital project (Verburg, 2019). Maternal and child health will thus continue to be viewed as a channel that is visual enough to provoke empathy and garner support to advance other health interests including nutrition, health systems strengthening and universal health coverage.

Second, the Bank has moved beyond its initial focus on demographic goals through family planning, and is now funding a comprehensive approach in relation to its emphasis on health systems strengthening. Within its health systems strengthening activities, the Bank has evolved from financing physical infrastructure, training of health workers, and service delivery, to include broader and underfunded components such as health information and management systems, and reforms for health financing and human resources. This move falls in line with the Bank's renewed strategic focus on health system strengthening (World Bank, 2007).

Third, since the 1990s, the Bank has included projects in education, water and sanitation, and social safety, in its databases as RMNCH projects. This classification could either indicate the Bank's growing adoption of a multi-sectoral approach for improving maternal and child health or an internal error in project coding in its

databases. The increasing number and corresponding financial commitments for these multi-sectoral projects over time would appear to support the former argument.

Is there a match between the countries that the Bank funds and the countries with the highest burden of maternal and infant mortality?

Sub-Saharan Africa and South-Asia have the highest burden of maternal and child deaths in the world. India and Nigeria account for nearly 20% of all the maternal and child deaths. India and Nigeria were also among the top ten recipients of Bank funding for RMNCH projects. Most of the top ten recipients were lower-middle-income countries (India, Bangladesh, Pakistan, Nigeria and Indonesia) with high numbers of maternal and infant deaths in absolute terms. This reflects a certain level of alignment of resource allocation with the burden of maternal and child mortality. However, countries like India, Indonesia, and Nigeria are fast growing economies and could finance their maternal and child health programmes using domestic resources rather reliance on external funding from the Bank. Furthermore, this list of major recipients also features upper-middle income countries including Argentina, Brazil, China, and Peru, which have a relatively lesser burden of maternal and child mortality compared to Sub-Saharan African low-income countries like Democratic Republic of Congo, Chad, Mali and Somalia. These high-burden countries in Sub-Saharan Africa, have received less than 1% of the Bank's overall resources for RMNCH. This misalignment raises the concern that Bank funding for RMNCH hinges on the economic status of the borrowing country and its ability to repay credits (concessional loans) rather than the health burden.

Countries that need financial support to improve their RMNCH status are low-income nations, especially those in Sub-Saharan Africa. These countries have not received adequate financing commensurate with their maternal and child health burden. Even with the existing credits they have received, their repayment rates are low. Furthermore, grants constitute a miniscule share of the overall Bank funding to these high-burden countries. The Bank maintains and expands its revenues through profits from its primary service of lending. This finding reflects the tension of the Bank to stay relevant in the business of lending while also tending to the needs of low-income countries with a high burden of maternal and child mortality and deficient fiscal capacity to repay loans with interest.

What do these financial trends tell us about the Bank's current approach for financing maternal and child health?

Traditionally, the Bank financed RMNCH through country-level projects wherein credits and grants were disbursed, and project outputs and in some cases, outcomes were monitored. Since the last two decades, the Bank has adopted two new financing approaches for RMNCH i.e. trust funds and results-based financing mechanism (also promoted through the instrument of Program for Results). Increasing Bank contributions through trust funds signal a move from country-level project based financing towards trust funds. What does this shift mean? The Bank funds it country-level projects through its core budget of IBRD and IDA credits, wherein donors replenish funds, which are allocated to borrower countries based on their needs. In the case of trust funds, donors voluntarily contribute grants towards areas that they prioritise, which may not necessarily match the needs of the recipient countries that get the allocated resources. This finding highlights the need for safeguards and checks to ensure that funds, channelled through the core budget or extra budgetary mechanisms, must first serve the needs of the communities in the borrower countries.

Next, the recent rise in the number of Bank-funded RMNCH projects funded through 'Program for Results' (PforR), an instrument that links disbursements with the achievement of results, is telling about its financing approach for this area. Since 2013, the Bank has approved five PforR projects for RMNCH with an overall commitment of $1.1 billion. PforR projects also command an increasing share of the Bank's overall lending; as of April 2019, there were 99 active PforR operations totalling $40.3 billion of Bank financing (World Bank, 2019). As compared to the two commonly used instruments of 'Investment Project Financing' and 'Development Policy Financing', the financing instrument of PforR is being lauded as an innovative mechanism for addressing the changing needs of the borrowing clients, as it goes beyond just measuring proofs of expenditures or reforms, but actually measures results making it attractive for both donors and client countries (Liverani, 2018; Sadaah, 2015).

While this 'innovative' mechanism of results-based financing promoted through the PforR instrument could help the Bank stay relevant in an increasing competitive

lending market, it should be implemented with caution. The Bank's own evaluation of results based financing for RMNCH projects (Kandpal, 2016) showed that while service coverage increased and quality of care improved, it did not lead to the planned maternal and child health outcomes. Furthermore, external evaluations found results based financing projects to be expensive, uncertain and ineffective. Finally, formulating disbursement-linked indicators requires competence, especially on the part of the borrowing government. The Bank's own internal review of PforR (World Bank, 2015) found that governments often found this process challenging and required capacity building. Moreover, achieving planned results on time requires a certain level of competence, adherence to standards and resources. Despite prior agreements, borrowing governments can find it challenging to deal with structural issues like corruption, which can hinder implementation and affect the results. While immediate outputs can be monitored while the project is being implemented, measuring results can take time. Although, a positive finding is that recently, in 2017, the Bank acknowledged that more research was needed to assess the effectiveness of results based financing schemes; most importantly, it recognised that the impact of such a mechanism will ultimately depend on contextual conditions in each country (World Bank, 2017).

Is there an alignment between the Bank's policies and programmes and its financial flows for maternal and child health over the last five decades?

In my analysis of the World Bank's policies and programmes for maternal and child health (MCH) over the last five decades (chapter four) and the Bank's financial flows for this area for the same period (chapter five), I found an alignment over key findings. First, both these sources confirmed the Bank's initial focus on population control and nutrition in the 1970s. In the next decade, the Bank's policies and financial flows signalled an increase in overall lending for stand-alone health projects that funded MCH services. The Bank's Safe Motherhood Initiative launched in 1987 was followed up with an increase in lending for MCH projects. Further, as the Bank promoted structural adjustment policies in its seminal reports in the 1980s, the financial dataset also showed that nearly 12% of projects in this decade included cost recovery through user fees; highlighting further alignment between its policies and practice. Since 2000, with the advent of GAVI, the Vaccine Alliance, the Bank's lending for immunisation projects began to rise. Finally, since 2010, Bank has

promoted trust funds and the mechanism of results-based financing for MCH, which are also clearly reflected in its increased financial flows through trust funds and projects under ‘Program for Results’ ($1.1 billion over a span of five years). While this linkage between chapters four and five demonstrate an alignment between the Bank’s technical policies and programmes and its funding for maternal and child health, it also highlights triangulation through the use of these two methodological approaches.

Chapter 6 India and the World Bank: A client-lender relationship

6.1 Introduction

India is the biggest client of the World Bank. This client-lender relationship can be traced back to the creation of the World Bank in 1944, when the Indian delegation played a key role in shaping the Articles of Agreement of the International Bank of Reconstruction and Development and its sister organisation, the International Monetary Fund, in ways that would include the interests of developing countries (Zanini, 2001). In 1949, the Bank approved its first loan for a railway project in the country. Almost a decade later, in 1957, the Bank set up its first Resident Country Office in New Delhi (World Bank, 1957). By 1958, loans to India represented 10% of the Bank's overall lending (Kraske, 1997). India's need for long-term, low-cost, and flexible financing provided the Bank with a major impetus to set up the International Development Association in 1960 (Kapur et al., 1997). Even the concept of the Bank's highly criticised structural adjustment loans stemmed from its failed negotiations with the Indian government in 1966 over leveraging lending to modify macro-economic policies (Lele and Bumb, 1995). Between 1945 and 2019, India was the largest recipient of Bank loans, including its lending for health projects - amounting to an overall $115 billion in IBRD and IDA credits (World Bank, 2015). Over time, this client-lender relationship has seen its share of ups and downs, and transformed from aid-dependence towards a cautious partnership (Kirk, 2010).

In this chapter, I will discuss this evolution of the India-Bank relationship vis-à-vis the health sector and the area of maternal and child health from the origins of the Bank in the 1940s to the present. I present the India-Bank relationship across four historical phases, and in each phase, I describe the key events, including policies, programmes and financing. While this chapter is not a comprehensive history of the India-Bank relationship, it offers a background to situate the Bank within the maternal and child health (MCH) landscape of India. More importantly, it provides a context to explore and examine the Bank's influence in MCH vis-à-vis the Reproductive and Child Health project.

This chapter discusses the India-Bank relationship through four phases: (1) Independent India (1947-1969), (2) Population control years (1970 – 1990), (3) Economic liberalisation (1991- 2004) and (4) Post National Rural Health Mission (2005-present). Each phase is characterised by an important political or socio-economic event in the country. The first phase begins in 1947 when India gained independence from British rule and determined the future path for its public health system and MCH for the next few decades. This phase also marks the Bank's entry in India, through its lending for development projects as well as its influence over the country's economic policy. Phase two commenced in 1970 when the Bank began lending for population control, thereby foraying into the Indian health sector. The third phase starts in 1991 when the government of India embarked on an economic liberalisation programme based on the Bank's structural adjustment loans, which had a deep impact on its health sector.

The final phase began in 2005 when the government of India launched the National Rural Health Mission, a historic effort to increase the national health budget, expand public health infrastructure and improve MCH; the launch of this mission also marked a change in the India-Bank relationship. I conclude the chapter by summarising the Bank and the Indian government's approach for MCH in the country, thereby setting the stage for the analysis of the Reproductive and Child Health project in Chapter 7. Here, I have synthesised data from relevant published articles, books, publically available reports from the Indian Ministry of Health and Family Welfare, and publically available reports, interviews, oral histories, and financial datasets from the World Bank.

Some existing scholarship has described the history of the World Bank in India (Prabhu, 2016; Kirk, 2010; Dash, 2000), and critically commented on the Bank's role in the Indian health sector; e.g., its lending for family planning, nutrition and HIV/AIDS programmes (Sridhar, 2008; Qadeer 2008, 2001; Rao, 1999; Banerji, 1994). Through this chapter, I add to this growing literature by presenting a historical account of the Bank's work in MCH in India over five decades, and also argue how the Bank's role in this area cannot be understood without appreciating its broader involvement in the economy, politics and governance, and health system of the country

6.1 Phase 1: Independent India (1947 to 1968)

Maternal and child health services in independent India

In the 20th century, prior to Indian independence, maternal and child health services were predominantly delivered through three routes viz. women medical missionaries from the U.S. and the U.K. (Harrison, 1994; Balfour and Young, 1929), charitable trusts by colonial philanthropists (Lal, 1994), and health facilities set up by Indian social reformers and philanthropists (Ramana, 2007). Despite the growing number of health facilities, the access to maternal and child health services continued to be restricted due to poverty, caste discrimination, long distances to reach urban based medical institutions, and the systematic discrimination of women in a patriarchal society (Lal, 1994). After gaining independence in 1947, the Indian government embarked on an ambitious programme for providing health for all its citizens, with primary health care at the heart of this plan, despite severe financial constraints and colossal dimensions of health problems (Rao, 2017; Banerji, 1994).

The 1943 Bhore Committee Report, an authoritative document on the health system in independent India (Duggal, 1991), recommended an NHS-styled public funded health system that would provide health services for all citizens regardless of the ability to pay (Government of India, 1946). The Bhore Committee Report endorsed a three-tiered health delivery system viz. primary health centres at the village level, secondary health facilities at the sub-district and district level and tertiary hospitals at the regional level, and kept MCH at the heart of primary health centres (Duggal, 1991). This recommended three-tiered system, which resembles the existing public health infrastructure in India, took the government close to ten years to build (Rao, 2017). However, with less than 5% of the national budget invested in health, Bhore's ambitious recommendations for MCH were yet to take off (Singh, 1997; Qadeer, 1995). Instead of MCH, family planning got national and international political priority and the majority of the financial resources. In 1952, India set up the world's first national family planning programme (Visaria and Chari, 1999).

World Bank begins lending to India

The World Bank officially started business with India a year after its independence, in 1948 when it sent its first mission of experts to the country, and approved the first

loan of $34 million for a railways project in 1949 (World Bank, 2001). As a newly independent country, India decided to tread on a socialist model of development, wherein all of its sectors were nationalised. The first ten years of the India-Bank relationship was amiable, with the IBRD providing loans to India's public sector for agriculture, railways, steel and power projects (Kirk, 2010). Up to June 1958, Bank lending to India amounted to $400 million, representing 10% of all Bank lending to that point (Kraske, 1997). In 1958, India was in need of capital owing to a crisis of foreign exchange and balance of payments, and looked towards bilateral donors and the World Bank for financial assistance. In response, the World Bank coordinated international donors including the U.K., U.S., West Germany, Canada and Japan, and formed the Aid India Consortium and pledged an initial assistance of $2 billion (Akita, 2014). The Indian administration led by Jawaharlal Nehru (first Prime Minister and Leader of the Indian National Congress) accepted this kind of multilateral aid coordination as it saw the Bank as an impartial donor and wanted to stay away from undue international influence owing to its colonial history (Mason and Asher, 1973). The U.S. played a key role in the initial years of this multilateral aid coordination to India (Kux, 1992).

Financial crisis, aid consortium and the devaluation debacle

The optimistic client-lender relationship began to unravel after the financial crisis of 1958. Worried that the economic progress in India was not reaching the expected levels even after regular doses of aid, the Consortium members convened a meeting in 1963 and emphasised the need to stimulate private foreign investments, relax controls, liberalise the pricing system, and raise interest rates (Akita, 2014). Many of these asks around reducing the role of the state in the economy would have been non-negotiable for India at that point, as the government emphasised on public sector-led development. Apart from the growing financial crisis, India also struggled with a war (with China), droughts, and a major political setback with the death of Prime Minister Nehru in 1964. Amidst this climate, the Bank on the insistence of Consortium, sent a mission to India to examine its national economic condition and make policy recommendations for improvement (World Bank, 1970). The Indian officials were reluctant to submit to such external scrutiny, but they were informally persuaded by the Bank on the grounds of mobilising additional and much-needed financial resources from the consortium (Mason and Asher, 1973, pg.196).

This mission, led by economist Bernard Bell, provided two major recommendations. First, it pushed for a move from heavy industry towards modernising agriculture, increase private and foreign investment and - most importantly - the devaluation of the Indian rupee. Second, it argued for the mounting of a “massive, energetic and reorganised population control programme” (Bell, 1965, pg.10). While the Indian government devalued its currency (Indian rupee, Rs.) by 57% from Rs. 4.76 to Rs. 7.50 to a U.S dollar, it abandoned the rest of the proposed reforms due to widespread political opposition (Mukherji, 2000). Despite the devaluation, not all of the promised financial resources were disbursed, which left the India-Bank relationship sour and strained for years to come (Kirk, 2010; Denoon, 1968). While the first recommendation of the Bell Report was partially implemented, the second one was accepted wholeheartedly (Connelly, 2006). Population control thus became the medium through which the Bank entered the maternal and child health landscape in India, albeit informally at first.

Population control backed by international donors

The Indian family planning programme, established in 1952, adopted the clinic-based model of setting up clinics for those who needed such services, and emphasised on the rhythm method of contraception (Visaria and Chari, 1998). The first two health ministers of India (Rajkumari Amrit Kaur and Sushila Nayar) were disciples of Mahatma Gandhi, and influenced by Gandhian restrictions against artificial means of contraception on moral grounds, they promoted the natural ‘rhythm’ methods against modern birth control (Ensminger, 1971). This model did not work due to lack of consideration of individual needs, high illiteracy and mortality rates, nascent transport and communication networks, and poverty (Maharatna, 2002). As a result, there was a shift towards an extension approach, wherein family planning committees and leaders would generate the demand for contraception in every village and town (Raina, 1962).

Amidst this shift in 1950s, international agencies including the Bank, started influencing India’s family planning policies and programmes, which inevitably affected MCH (Gwatkins, 1979). USAID, Ford Foundation and Rockefeller Foundation employed several hundreds of staff in India and funded research projects, institutes, training, commodities (contraceptives and vehicles) (Connelly,

2006; Harkavy et al., 1968). Key consultants from these organisations penetrated decision making units of the Indian government including the Planning Commission and the Ministry of Health and advised key Indian officials (Minkler, 1977; Ensminger, 1958). Towards the late 1950s, Sheldon Segal (Rockefeller Foundation and Population Council) advised Lieutenant Colonel B.L Raina, the director responsible for both MCH and family planning in India (Gupta et al., 1992).

The Bank first began prescribing for India's population programme in 1965. On the insistence of the Aid India Consortium, the Bank set up a three-member committee consisting of Sheldon Segal (Rockefeller Foundation and Population Council), Sam Keeny (USAID), and Conrad Taeuber (U.S Census Bureau) in 1965 to examine India's efforts in population control, which recommended that Colonel Raina divert his attention from MCH and give unconditional priority to family planning (IBRD, 1965a). The Consortium also advised the Indian government to introduce a target and incentive-based approach for family planning across all the states (Cargill, 1973). The Bank team insisted that "no mass program has reached its target without defining it in terms of quotas. The targets must be related to money and manpower appointed, in the field, and at work on the job for which they were intended" (IBRD, 1965b, pg. 47). Furthermore, based on the results from a demographic study it funded in the 1960s along with USAID and WHO, the Bank also recommended the integration of family planning with MCH on the grounds that it would be more cost-effective and efficient than providing family planning separately (Keilmann et al., 1983). However, the implications for replicating these findings in a diverse country like India were not studied (Faruqee, 1983).

The year 1966 was a critical time for Indian politics, the economy, and the health sector. Jawaharlal Nehru's daughter Indira Gandhi was sworn in as the Prime Minister in January 1966. Two months later, Gandhi flew to the U.S. and met President Lyndon Johnson to negotiate aid for food owing to the ongoing financial crisis and widespread drought and famine in the country (Reyes, 2006). Gandhi was given food aid on the condition that she push certain reforms, which would convince the Aid India Consortium (led by the U.S.) that India was serious about its economic growth (Ahlberg, 2007; Reyes, 2006). After returning home, Gandhi approved the devaluation of the Indian rupee and an invigorated population control programme in

the country (Conelly, 2006). The Ministry of Health was renamed the Ministry of Health and Family Planning (Gupta, 1992). Following the Bank's recommendation for a target and incentive-based family planning approach over MCH, the Ministry of Health and Family Planning provided all the states Rs. 11 for every Intrauterine Devices (IUD) insertion, Rs. 30 per vasectomy, and Rs. 40 per tubectomy (later increased to Rs. 90) (Gupta, 1992; Narain, 1966). More than half (60%) of the national health budget was allocated for family planning. India's family planning budget witnessed a mammoth jump from Rs. 30 million in 1956 to Rs. 829 million in 1966 (Government of India, 1966). In the same year, the Indian government's Mukherjee Committee handed in the final blow when it recommended family planning to be integrated into MCH service delivery, and for mass IUD programmes to be delivered through primary health centres. These political and policy developments meant that financial resources for MCH were deviated for family planning. More importantly, at the ground (village) level, frontline health workers were now given family planning-related performance targets and incentives, which took away their focus from MCH services (Vora, 2009; Mavalankar, 2008).

By 1967, 1.8 million Indians agreed to sterilisation or IUDs (Mukherji, 1967). Because of the ongoing drought and famine, several poor men and women underwent sterilisation as the incentives however small offered financial relief. The drive to reduce fertility rapidly and at minimal cost made it difficult to maintain standards, including medical screening and sterile instruments (Connelly, 2006; Gupta, 1992). The insertion of IUDs led to complications in women, including prolonged bleeding, perforated uterus and ectopic pregnancy (Ledbetter, 1984). Although the Population Council, a major backer of IUD technology, received reports of the emerging IUD side effects from its projects in South and South East Asia, key officials like Alan Guttmacher believed that these side effects were less important than the fact that IUDs could be promoted in a mass program with few medical personnel (Reed 1978; Nelson and Guttmacher, 1963).

This mindless and indiscriminate race to control the population had the most grievous impact on the health of women who were poor and from lower caste groups (Basu, 1985). Later evaluations by the National Planning Commission showed how the family planning programme had become coercive in some states (Planning

Commission, 1971). In the state of Maharashtra, officials eliminated the posts of field workers and educators who worked on MCH, in order to free up money for incentive payments for sterilisation. With the lack of incentive and provision for ethical and medical standards for contraceptive treatment and follow up care, coupled with rising untreated complications from IUD insertions and botched up sterilisations, India's family planning programme fell into disgrace (Connelly, 2006).

6.2 Phase 2: Population control drive (1970-1988)

World Bank begins lending for population control projects

Robert McNamara expanded targets for lending after he took over as the President of the World Bank in 1968. The Bank's overall lending for India witnessed a massive rise during the McNamara years ($700 million by 1960 to $9 billion by 1980) (Ridker and Musgrove, 1999). Post 1966, lending for development projects in India increased without much of policy interference owing to the devaluation debacle. India's ongoing population control drive and Prime Minister Indira Gandhi's political slogan of 'Garibi Hatao' (reduce poverty) struck a chord with McNamara as population control and poverty reduction became his focus areas at the Bank (Kraske, 1997; Kapur et al., 1997). Gandhi soon found a supporter in McNamara, and loans for population control followed. In 1972, the Bank disbursed its first loan for population control in India (World Bank, 1973). From 1973 to 1990, the Bank funded a whole series of nine population control projects with a total commitment of $632 million and disbursement of $528 million.

While the early population projects were designed to integrate population control activities into MCH services. In actuality they ended up emphasising sterilisation and expanding facilities, and gave little importance to increasing demand or improving the quality of services, and thus had little impact on reducing fertility rates (Ridker and Musgrove, 1999). The Bank's formal lending for population control in India came at a time when the Indian government, hard-pressed by international donor agencies such USAID, Ford Foundation and Rockefeller Foundation, conducted mass sterilisation camps and IUD drives. Population control had diverted political priority and financial and human resources from MCH, and the Bank supported this

diversion through its consistent project funding and policy prescription through donor coordination (Connelly, 2006; Hvistendahl, 2005; Kraske, 1997). The Indian government got its biggest show of Bank support when McNamara visited New Delhi amidst the emergency period in 1976, and congratulated the health minister Karan Singh for his country's focused efforts towards population control (World Bank, 1976).

Emergency declared in India

Prime Minister Indira Gandhi declared a state of national emergency in India as a response to political and economic problems facing her government, ceasing civil liberties from June 1975 to January 1977 (Kapoor, 2015). This two-year period also witnessed the most aggressive population control drive in the country with more than 8 million sterilisations (Gwatkin, 1979). The distinctive feature of this draconian drive was not the novelty of the contraceptive techniques as drives for mass adoption of sterilisation and IUD had been ongoing in the previous decade; instead, it was the vigour and urgency with which this drive was carried out (Conelly, 2006). For the first time, officials of all government bodies were involved and mandated with quotas to get men and women sterilised, and failure on meeting these targets was met with mild to extreme disincentives including loss of food rations, salaries and even employment (Panandikar et al., 1978). While men and women died from botched and unsafe sterilisations (around 1800 death claims were reported), several people, especially those from the Muslim and lower caste communities died from the violence emerging from coercive attempts to sterilise men (Government of India, 1978).

By the time the emergency was lifted off and the population control drive ended, millions had suffered harassment by implementing government officials, thousands had died, Indira Gandhi was booted out of power in the 1977 national elections, and the family planning programme fell into complete disarray (Gwatkin, 1979). Vasectomies became stigmatised due to the violence incurred on men who were forcefully taken into sterilisation camps. As a result, the onus of sterilisation, the most commonly used form of contraception in India, has until today fallen on women (Connelly, 2006; Hvistendahl, 2005). After the new government took over in 1977,

family planning became such a contentious matter that the Ministry of Health and Family Planning was renamed the Ministry of Health and Family Welfare.

The Bank, UNFPA, the International Planned Parenthood Federation and the Swedish International Development Agency, among others, continued funding India's population control projects throughout the emergency period in India (Connelly, 2006). Two decades later, Bank health specialists Ronald Ridker and Philip Musgrove (1999) wrote that the Bank had little influence on the direction of the population control programme as the Indian government's approach was firmly established long before Bank involvement. They argued that the Bank was generally poorly positioned to suggest improvements or alternatives. However, one of my interviewees, a former Bank staff who worked in the India office between 1973 and 1975, suggested otherwise:

> I was concerned about the sterilisation campaign in 1972 as we had financed the first population project and we were in the midst of preparing a second population project. It seemed to me that the Bank should not be preparing such a project while the government was adopting this extreme measure. So, I talked to some of my colleagues involved in the field of population during the supervision mission and also drafted a memorandum which expressed my concerns and my perceptions of what was going on and the risks with the government's announced population policy. The population adviser gave a legalistic response, and said that it would be premature for the Bank to take a position at this stage. Another response was from the head of the Resident Mission, who felt that I was getting into ethical issues that the World Bank was all about economics and finance, and so he was not very supportive of my raising the alarm and was not about to about to confront the government about what was happening.

The informant explained that while the senior staff at the Bank, including the President, were well aware of the coercive measures being used by the Indian government for population control during the 1970s, they decided not to interfere

with the hope that this would finally contain the burgeoning Indian population and keep the international donors satisfied.

World Bank lending shifts towards nutrition projects

When the population projects did not show the planned results, the Bank shifted its attention towards nutrition and child health. In 1980, the Bank funded the Tamil Nadu Integrated Nutrition Project with a loan of $32 million (World Bank, 1980), which was aimed at reducing child undernutrition rates through the behavioural change of mothers by the way of growth monitoring, supplementary feeding and nutrition counselling. Sridhar (2008) analysed the Tamil Nadu Integrated Nutrition Project and argued that by focusing on growth monitoring and nutritional education for the mother alone, the Bank design for tacking undernutrition did not consider structural factors such as inadequate purchasing power and gender inequality that constricted individual agency. Despite these gaps and mixed results, the Bank lauded this project as a success and granted funding of $95 million for a second phase of this project in 1990 (Ridker and Musgrove, 1999).

Prior to the Tamil Nadu Integrated Nutrition Project, the Indian government had launched the Integrated Child Development Services (ICDS) programme in 1975 which offered a similar package of services including supplementary nutrition, immunisation, and routine health check-ups for children under the age of six, pregnant women and lactating mothers at community based centres (Sachdev and Dasgupta, 2001). This nutrition programme was discontinued in 1978; but the Bank revived it back in 1990 with financial support, and continued to support four phases with a total commitment of $606 million. Over time, the Bank committed close to $1.5 billion for all the nutrition projects in the country (HNP, 2019).

UNICEF-backed child immunisation gets a head start

Child immunisation picked up in a big way in India in the 1970s. Following the WHO's policy recommendation of universal immunisation at the Alma Ata conference, India launched the Expanded Programme of Immunization in 1978 (renamed the Universal Immunization Program in 1985). It provided six basic vaccines to all infants and the tetanus vaccine to pregnant women (Lahariya, 2014). Being a UNICEF-backed programme, child immunisation received increasing

amount of financial resources from the Indian government as well as international donors (Madhavi, 2005).

MCH policies versus reality

In the 1980s, the Indian government prioritised MCH in two of its major national policies viz. health policy of 1983 and the seventh five-year development plan of 1985 (Government of India, 1985; 1983). In both these policies, MCH was listed as one of the key focus areas to be advanced through the delivery of MCH services along with family planning and nutrition, training of traditional midwives (dais), skilled child birth strengthening of referral services in obstetrics, gynaecology and paediatrics, providing abortion services across primary health centres, and the promotion of breastfeeding through information campaigns. These programmes were much-needed and in the right direction for tackling the high rates of maternal and child mortality. However, implementation of these services was weak and not geographically balanced, in that health facilities in urban areas were better staffed and equipped compared to rural counterparts. Furthermore, major funding for health programmes from the central government continued to be deviated towards selective interventions of family planning and child immunisation (Nundy, 2005). While globally, the Bank had started lending for stand-alone health projects in the early 1980s, it did not move beyond population and nutrition in India. In an OED evaluation, Zanini (2001) wrote that the Bank was not able to establish a dialogue or lending programme in health and education due to the government's resistance to foreign advice in these sectors. The beginning of the 1990s changed this equation and created conditions for the Bank's lending for health and MCH projects in the country, although in a climate of structural adjustment.

6.3 Phase 3: Economic liberalisation (1991 to 2004)

Structural adjustment loans and economic reforms

In 1991, India struggled with a mounting financial crisis brought on by a heavy dependence on foreign imports especially oil, external borrowing to finance these deficits, debt servicing, inadequate exchange rate adjustments (Ghosh, 2006). The crisis worsened with the 1990 Gulf war, after which the Government of India had to airlift and rehabilitate hundreds of thousands of Indian workers from the Middle East

leading to a decline in remittances. Exports and foreign aid flagged as well (Cerra and Saxena, 2002; Joshi and Little, 1994). This period also saw domestic political instability with widespread communal violence brought on by a Bharatiya Janata Party (BJP; the BJP and the Indian National Congress are the two major national parties in India) campaign to build a Hindu temple at the site of a mosque in Ayodhya and the assassination of former Prime Minister Rajiv Gandhi (Guha, 2008). By June 1991, the financial crisis had hit the country so hard that the government only had reserves that would cover two weeks of imports (Ahluwalia et al., 2002). Amidst this economic and political crisis, the Indian government approached the International Monetary Fund and Bank for loans, which were accompanied by structural reforms including removal of public sector exclusivity in all but six industries and investment caps on large corporations, abolition of industrial and import licensing, and massive budget cuts in social sector spending (Ghosh, 2006).

This financial crisis and the subsequent structural adjustment reforms changed the public health landscape as well as the India-Bank relationship. First, the central health budget was slashed by 20% in 1992-1993; there was also a 30% cut in the rural drinking water budget, 40% cut in rural sanitation, and 42% cut in the national malaria programme budget (Banerjee, 1994). These budget cuts led to the deterioration of primary health care as staff, medical supplies, equipments and overall health service delivery were massively underfunded. Second, these macro-economic reforms allowed national and international private investments into secondary and tertiary health care. This marked the beginning of the burgeoning of the private health care sector in India (Qadeer, 2000). After India gained independence in 1947, private health sector accounted for only 5-10% of total patient care. By 2002, the private health sector provided for 82% of outpatient visits, 58% of inpatient expenditure, and 40% of births in institutions (Government of India, 2002).

Bank's response in the wake of structural reforms

Close on the heels of the 1991 economic reforms and subsequent public sector budget cuts, the Bank released a working paper titled 'India: Health Sector Financing Coping with Adjustment Opportunities for Reform' (World Bank, 1992), where structural adjustment was described as an opportunity to evaluate India's flagging public health system and transform it into an efficient system with the redirection of

funds and programmes. The paper recommended that the Indian government restore its national public health budget, define an effective package of health services at the primary health care level, increase spending for disease control, introduce cost recovery in hospitals and medical education, and support hospitals in becoming semi-autonomous and self-financing.

The Bank assisted the Indian Ministry of Health and Family Welfare in implementing the majority of its own recommendations from the 1992 paper in the following ways. It increased lending for health projects in India, specifically for MCH, disease control, and health systems development. In doing so, it prompted the government to increase its own spending in these areas by co-sponsoring these projects and of course, by taking on the IDA credits in the first place. Bank lending for health projects as a proportion of its overall assistance to India rose from 3% in 1986-1990 to 21% in 1996-2000 (Zanini, 2001, pg.18), and this dramatic increase was a by-product of the financial crisis and the subsequent structural reforms. When the Indian economy opened up for private investments, Bank lending for public sector development projects declined and IDA credits were diverted towards social sector projects including health and education, to maintain its lending targets in India (Zanini, 2000). The Bank justified these new health projects as a soft cushion for the public health system in the face of structural adjustment and budget cuts (Zanini, 2001; World Bank, 1997).

Bank co-sponsors two major programmes for maternal and child health

First, in 1992, the Bank co-sponsored the first major national programme for MCH in India i.e. the Child Survival and Safe Motherhood Programme, through IDA credits of $214 million along with $68 million in grant money from UNICEF and $47 million domestic financial resources from the Indian government (World Bank, 1991). While the child survival component of the programme was an extension of the ongoing child immunisation programme, the safe motherhood component promoted emergency obstetric care as a key strategy for maternal mortality reduction (Mavalankar, 1999). Through this programme, the Bank promoted a selective package of MCH services including antenatal care, deliveries by trained personnel including traditional birth attendants, institutional deliveries, and breastfeeding, birth spacing, child immunisation, and management of acute respiratory infections and

diarrhoea (World Bank, 1991). Note the change in language: ‘family planning’ had become ‘birth spacing’ within project documents. Also, this selective package approach was driven by the Bank’s 1993 World Development Report, which recommended governments to focus on a selective package of cost-effective health interventions around MCH and infectious disease control (World Bank, 1993, pg. 6). While the Child Survival and Safe Motherhood Project likely contributed to improved child health outcomes (specifically, higher rates of immunisation coverage), the planned maternal health outcomes were not realised (institutional deliveries barely increased from 25% to 32% over the project period). Evaluations by the Bank and external experts reported the failure to increase childbirth facilities and overall weak programme implementation (World Bank, 1997; Huque et al., 1996).

As the Child Survival and Safe Motherhood Project was nearing its end, in 1997, the Indian Government launched the Reproductive and Child Health Project (RCH). This was another national level programme for maternal and child health, which was implemented across all the states from 1997 to 2004 with an overall budget of $309 million, of which the Bank disbursed $255 million. The first phase of this project (RCH-I) aimed to reduce maternal and child mortality through institutional deliveries, and thus, funded essential obstetric care, blood storage units, transport to birth facilities, access to safe abortion, and treatment of reproductive and sexually transmitted diseases, and also recommended the inclusion of the private sector for MCH service delivery (World Bank, 1997). Towards the end of RCH-I, the realisation that a ‘one size fits all approach’ - i.e. what works in one state may not work in another - was dwelled upon by Bank staff in India (World Bank, 2005).

Perhaps, this realisation may have pushed the Bank to fund state-level health systems projects, where Bank staff had greater control over the project implementation. The Bank began funding state-level health systems development projects in the mid-1990s, and by 2019 it had committed $2.6 billion and disbursed a total of $1.3 billion for this area (HNP, 2019). Perhaps the most striking outcome of these state-level health projects was the introduction of user fees in public-funded secondary hospitals and tertiary care facilities (Prinja et al., 2012; MoHFW, 2000; Bir, 2000). By the end of this phase, Bank lending for health in India had managed to redefine family planning as reproductive and child health approach, endorse

selective primary health care through an essential package of services for its MCH projects, focus on immunisation for infant mortality, and promote user fees for secondary and tertiary care (Qadeer, 2000).

6.4 Phase 4: National Rural Health Mission (2005-2019)

The Indian Government funds its first major national health programme

After coming to power the United Progressive Alliance (formerly the Indian National Congress party) launched the National Rural Health Mission (NRHM) in 2005, which was, in financial terms, the biggest ever national health programme designed and crafted in-house in the country without any donor influence (Rao, 2017; MoHFW, 2005). The NRHM was revolutionary, as for the first time, a national programme aimed to increase government spending for health from 0.9% to 2-3% of the GDP. This Mission was designed to integrate the existing vertical programmes; it promoted decentralisation by giving states more control and flexibility over planning and financial resources; and most importantly, community health worker called ASHA (Accredited Social Health Activists) were recruited in every village, serving as the link between communities and the public health system, thereby generating demand for public health services.

NRHM raised the political and financial priority for maternal and child health, more so for maternal health. It funded the conditional cash transfer scheme called ‘Janani Suraksha Yojana’, giving poor pregnant women cash incentives for giving birth in a health facility; ASHA’s also received performance-based financial incentives for referring pregnant women to the facility. Furthermore, increased funding through the NRHM strengthened public health infrastructure and human resources, especially at the primary care-level (Rao, 2017), and introduced insurances schemes for households below the poverty line, all of which are paid by the government and implemented by private insurance companies (La Forgia and Nagpal, 2012; Kuruvilla et al, 2006).

Bank funds the second phase of the Reproductive and Child Health project

The Bank approved funding for the second phase of the Reproductive and Child Health Project (RCH-II) in 2005. However, due to a corruption allegation in RCH-I,

the Bank President Paul Wolfowitz ordered an independent investigation that confirmed the charges, and then suspended loans for RCH-II and other health and infrastructure projects in the country (Padmanabhan, 2006), much to the ire of Indian government officials as well as Bank staff from the country office (Guha and Yee, 2007; Mallaby, 2006). Although, the funds for RCH-II were released in 2006, this second phase of the project took shape within a controversial climate. RCH-II was launched in 2006 with an overall funding of $2.2 billion, more than 50% of which was provided by the Indian government, followed by $452 million by DFID, $375 million in IDA credits, and $20 million by UNFPA (World Bank, 2006). RCH-II was quite similar to RCH-I in terms of its objectives, in that it focused on increasing institutional deliveries, immunisation rates, and contraceptive prevalence (Vora et al., 2009). The project also implemented novel strategies including upgrading of community health centres into first referral units for emergency obstetric and child care services; making community health centres and 50% of primary healthcare centres operational 24 hours 7 days a week for delivery services and new-born care; empowering non-specialist Indian Medical Officers to undertake emergency obstetric procedures and to administer anaesthesia; and generating demand for institutional delivery through the implementation of the Janani Suraksha Yojana (World Bank, 2012).

Bank's current health portfolio in India

The Bank's health operations in India have changed over time. Unlike its previous mission approach where experts from Washington D.C would very briefly, prepare a report with recommendations, and then present these to the Indian officials to implement, the current team in the country office in New Delhi is more deeply engaged in the day-to-day operations of Bank-funded health projects (Coarasa, 2018). The Bank has also been drifting away from MCH and focusing almost entirely on state-level health systems development projects, with the exception of a couple of national level projects for infectious disease control and nutrition. Sarkar (2016) analysed the Bank's health systems development projects and reported that in this phase, these projects have primarily focused on budget reallocation (fiscal space management) and engaging the private sector in insurance provision and service delivery.

The Bank's move away from lending for MCH could be explained by several factors. First, since 2005, the Indian government has demonstrated a greater political priority for maternal and child health through the launch of the NRHM and the subsequent increase in the central budget for this area. The Ministry of Health and Family Welfare started implementing two major conditional cash transfer schemes to increase institutional deliveries and ensure postnatal care viz. the Janani Suraksha Yojana (2006) and the Janani Shishu Suraksha Karyakram (2011) (Government of India, 2019). In 2013, the Ministry also launched its RMNCH+A strategy that funds high-impact interventions across the life stages of reproductive, maternal, newborn, child and adolescent health in high priority districts (Government of India, 2013).

Second, the corruption in RCH-I followed by the independent investigation and the suspension of funds soured the relationship between the Bank's country staff and the Indian government officials in the Ministries of Finance and Health during the RCH-II. My interviewees who worked in the Bank India office confirmed this outcome. Third, post-2000, major players have entered the MCH landscape in India including the UK Department for International Development (DFID), the Bill and Melinda Gates Foundation, Norwegian Agency for Development Cooperation, and Swedish International Development Corporation Agency, adding to the list of existing donors such as UNICEF and UNFPA; these donors offer grants unlike the Bank's credits, and over the last two decades have established a strong foothold in selected states in the country (Taneja et al., 2019).

India's growing economic status is also affecting the way the Bank does business in the country, especially its health and MCH portfolio. In 2015-2016, India gave more aid ($1 billion) than it received ($0.2 billion) (Ministry of External Affairs, 2017). In a video interview from 2016, Former Indian Minister of Finance Arun Jaitley (2014-2019) spoke with gratitude about the Bank's financial assistance for poverty alleviation, strengthening infrastructure and fighting natural disasters - especially in the early years of the India-Bank relationship. Towards the end of this interview, Jaitley added: "We are an integral part of IDA and now contribute to the extent of $200 million. We were earlier the recipients and now we are donors" (World Bank, 2016). Indian officials now present the country as a net donor rather a recipient.

Bank staff are cognisant of the changing perceptions of their counterparts in the Indian government, and this is changing the way they work with them.

A case in point is the Global Financing Facility, which is the Bank's major global financing initiative for MCH. While this Facility is now operational in 36 countries, it has no mark in India despite the existing burden of maternal and child mortality and the longstanding borrowing relationship. My interviews with Bank staff reported that while discussions to include India in the list of recipient countries for the Global Financing Facility had begun, senior government officials in the Ministry of Finance (which ultimately takes loan-related decisions) were offended about being treated as a recipient and offered small sums of money. Subsequently, negotiations fell through and India did not get to be a part of the GFF. A current Bank staff asserted:

> It can be hard for people at the global level to understand that India is different. India does not want to be treated as a recipient any longer. It is a huge country and if I were to interpret this sentiment…You would never treat China like this, so why give us such a treatment. We are India. We are 1.3 billion people. We are an emerging power.

One cannot ignore the evolving political context in India and its influence on the Bank's lending decisions for the country. In 2004, the United Progressive Alliance (UPA) won the national elections on the promise of implementing pro-poor policies, the major one being for health, and maternal and child health in particular. The political party implemented its promise when it launched the National Rural Health Mission, increased the central government budget for MCH, and worked with the Bank to co-finance and implement RCH-II. The ruling United Progressive Alliance (formerly Indian National Congress) party lost the national elections to the Bharatiya Janata Party in 2014, and yet again, in 2019. Prime Minister Modi picked sanitation as his key social focus area and launched the Swachh Bharat Abhiyan (Clean India Mission): a nation-wide campaign to eradicate open defecation in the country (a problem that plagued more than 60% of the population at the time). Soon after, the Bank released a $1.5 billion IBRD loan for this mission (World Bank, 2015).

Since 2017, India's Planning Commission, now known as the 'Niti Aayog' under the BJP government, embarked on consultations with the World Bank, to set up public-private partnerships (PTI, 2018). As of 2 January 2020, the Niti Aayog released a proposal wherein government district hospitals and the attached medical will be leased out to the private sector to ensure efficient service delivery. The Bank will play a key financing role in implementing this PPP. If this proposal is passed by the Parliament, then designated district hospitals will have to set aside half of its beds at a market price and the rest at a regulated or subsidised rate, which will generate resources but also push out poor households that are unable to pay (PTI, 2020). More importantly, policy decisions such as these need to be piloted and assessed along the lines of equity considerations before implementing it at scale across the country (Rao, 2017). During the UPA rule, the Bank funded maternal and child health projects in India, especially pushing service delivery at the primary health care level. However, under the BJP, the Bank currently has no MCH projects in its country portfolio, instead, it is mainly funding state-level health systems development projects and advancing the current government's goals of increasing privatisation and PPPs in the public health sector.

Finally, while Bank lending for health has fluctuated over time, its overall lending for India has been stable at best (Ministry of External Affairs, 2017). India is currently facing an economic slowdown (Agrawal and Salam, 2019; Chakravarty, 2019), and has in the recent past, urged for a significant expansion of the Bank's capital, to avoid a decline in its lending (Mukul, 2009). Amidst this economic climate, it seems like the India-Bank relationship will endure and the Bank will continue to be a relevant financing actor in the country, however, the approaches it will use for public health and maternal and child health will need to be examined.

6.5 Conclusion

In this chapter, I have shown how India and the Bank have grown together and have a longstanding relationship. India played a key role in the formation of the World Bank (IBRD) and provided a significant impetus to form the International Development Association (IDA). Not long after its independence, India emerged as the leading borrower of the Bank, and as of 2019, it continues to remain the largest

client of the Bank. Through this historical account of the India-Bank relationship, I have demonstrated that the involvement and influence of the World Bank in MCH in the country cannot be understood without an appreciation of the organisation's broader involvement with the country's economy, politics and governance, and its public and private health sector.

Economy

The Bank first entered India through its financial support for the newly independent country's economy. In economic terms, the Bank's relationship with India can be understood in three broad phases. The country's economic position in each phase has shaped its tendency to respond to the Bank's advice for the economy as well as for maternal and child health. In the first phase, until the 1970s, India struggled financially and was heavily reliant on external capital from the Bank, as well as major bilateral donors that were mediated by the Bank through the Aid India Consortium. In these early years of this relationship, by lending for infrastructure projects, conducting analytical work, and offering advice on economic policies, the Bank gained access within the Indian government circles, especially in the ministries of finance and planning. However, much of this foreign aid was tagged with conditions, primarily around economic policies and population control measures. The Bank along with international donors, pressured the Indian government to implement a target and incentive-based approach for family planning, which had far-reaching impacts the delivery of MCH services in the country.

In the second phase, which lasted until the 1990s, the country's balance of payments remained fragile and external financial crises loomed large. At this point, on one hand, the Bank offered the Indian government loans conditional on structural adjustments mainly around privatising the economy and substantial cuts in public sectors including health. On the other hand, it co-sponsored two major programmes for maternal and child health, as a buffer from the effects of budget cuts in the public health sector. Several studies have shown how the Bank promoted private sector delivery of health services and user fees at secondary and tertiary health facilities, which affected the access for maternal and child health services. In the third phase, since the late 1990s, the Indian economy has been growing, and the government has increased its own domestic spending for maternal and child health. The Bank's

role has now changed from being a lender to a development partner at the central and increasingly at the state government level. Despite its relatively low levels of lending for maternal and child health, the Bank continues to indirectly shape this area through its policy prescriptions such as public-private partnerships.

Politics and governance

In the years after independence, the Indian Congress Party, led by Indira Gandhi, gained the support of the World Bank as they pushed the population control agenda from the late 1960s until the 1980s. President McNamara's visit to New Delhi at the height of the emergency period in 1976, demonstrated the soft power that India has over the Bank as its biggest borrower. In 1991, it was the Congress-led government that implemented the Bank-prescribed economic reforms of privatising major public sectors and cutting public health and social sector budgets. It also helped that India's finance minister, Manmohan Singh, who was responsible for the economic liberalisation in 1991, served at the World Bank for long periods of time. Over time, the mandates of the political party that won the elections and formed the government at the central (for e.g. UPA's focus on maternal and child health versus BJP's focus on sanitation) and the state level shaped the Bank's lending decisions as well as the implementation of the funded projects.

Furthermore, governance issues such as corruption in the RCH project strained the India-Bank relationship, as senior politicians and bureaucrats threatened to cut ties with the Bank altogether after the suspension of loans. While the Bank did release its funds for RCH-II in due time, it demanded that the government ensure the required steps in strengthening existing governance practices in the health sector. Although there have been formal agreements to do so, since then, the Bank staff have found it challenging to engage with Indian government officials for increased lending for maternal and child health. This could be partly due to government officials' perception of external interference in sovereign areas such as governance as well as the growing competition with other international players in the Indian health landscape.

Public and Private health sector

The Bank's role in maternal and child health in a country must be understood in terms of its involvement in the public as well as the private health sector. The Bank first forayed into the Indian public health landscape through its policy prescriptions, followed by its lending, for projects in population control. First, the Bank prescribed a target and incentive-based approach to increase the uptake of family planning services. This policy measure provided the impetus for mass sterilisation and IUD insertion drives in the country, which had a detrimental impact on the health of many women - especially those who were poor, vulnerable and from lower caste groups, due to the side effects and inadequate operative and post-operative care. Second, it recommended that the Ministry of Health integrate family planning into MCH services. This measure diverted greater financial and human resources towards family planning and away from MCH. Both these measures meant that pregnant women and women of reproductive age received free public health services primarily to avail family planning, and only if they suffered from serious complications during pregnancy and childbirth. By the end of the 1960s, the majority of the pregnant women still gave birth at home and maternal mortality was at a staggering 1352 per 100000 live births. Child health was practically ignored. Until the late 1980s, Bank health lending was limited to population control and nutrition projects. While population projects aimed at reducing fertility, nutrition projects focused on improving productivity, both of which would eventually lead to economic growth.

Following the economic liberalisation programme in 1991, and in line with its World Development Report, the Bank recommended that India's public health sector focus on providing an essential package of health services covering MCH and infectious disease control, while the secondary and tertiary health care be opened up to private investments. Several Bank-funded health projects in the 1990s also promoted user fees as a cost recovery mechanism in hospitals, a policy measure adopted by the Indian government in 2000. While Bank-funded public health sector projects provided a package of MCH services, its other health projects reduced the role of the state government in the healthcare provision in the country. The connection between the inception and meteoric growth of the private health care sector in India and the structural adjustment reforms in the 1990s stand out as major areas for reflection (Banerji, 1997). While policy makers cannot ignore the role of the vast network of the

private health sector for improving MCH in India, one has to also reflect on the consequences that unregulated private healthcare provision can have on the equitable availability and access for MCH services.

Since 2005, the Indian government has taken greater control of its MCH programmes, primarily by increasing its own spending through the National Rural Health Mission, while the Bank's lending for MCH in the country has gradually reduced over time. Currently, the majority of the Bank's health lending in the country is focused on state-level health system development projects. More importantly, the Bank has been working closely with the Indian Planning Commission (Niti Aayog) to implement public-private partnerships, wherein several public district hospitals will be leased out to private entities for management.

Through this review of the literature in this chapter, I have thus traced the evolution of the Bank's focus on public sector provision of maternal and child health services in India from the 1970s until the mid-1980s, to its promotion of private sector involvement, and its current support of public-private partnerships.

Chapter 7 Tracing the design and implementation of the Reproductive and Child Health Project

7.1 Introduction

This chapter forms the first part of a two-part process to examine the World Bank's influence at the country-level for maternal and child health. In this chapter, I describe the process of the design and implementation of the Reproductive and Child Health (RCH) Project in India, which ran in two phases i.e. Phase I from 1997 to 2004 and Phase II from 2006 to 2012. This first part will facilitate an understanding of why and how the RCH project was designed and implemented. In doing so, it will thus offer us insights for the second part i.e., to identify any policy outcomes for maternal and child health where the Bank had an influence, and to uncover the process in which the Bank exerted its influence over the Indian Ministry of Health and Family Welfare to achieve these outcomes.

For this chapter, I used process-tracing, which is a method that is commonly used in qualitative social science inquiry and involves analysis of several sources of information to uncover processes and examine causality (Yin, 1994). I introduce key agencies and actors that appear throughout the narrative of the RCH project. Agencies include donors viz. the World Bank, the Department for International Development (DfID), United Nations Population Fund (UNFPA); and the country-level nodal agency for public health in India (i.e., the Ministry of Health and Family Welfare (MoHFW). Actors include the staff from each of these aforementioned agencies. I analysed three sources of data for this chapter: (1) RCH project documents by the World Bank and the Ministry of Health and Family Welfare, (2) Archival records from the World Bank Archives such correspondence memos, project proposals, and research reports, and (3) Qualitative interviews with former and current staff from the Bank, Ministry of Health and Family Welfare, UNFPA; women's health advocates; and academics. Data collection and analysis for this chapter have been described in detail in Chapter Three (Methods) of this thesis.

7.1 RCH Phase 1: 1997 to 2004

Design

The first project can be traced back to 1989 when Bank health specialist Susan Stout reviewed India's family planning programme. Stout concluded that the programme was not reaching couples that had unmet need, health workers saw the provision of sterilisation services as their main job, and the emphasis on targets and permanent methods of sterilisation took away attention from other spacing methods and the provision maternal and child health services (Stout, 1989, p. 25). My interviewee, a former member of Bank staff, pointed out that this report was never officially published by the Bank due to objections from the Indian government officials, but that it nevertheless was read by Bank specialists working on health projects in India.

Despite this report, there were no further discussion between the Bank staff and the Indian government, until 1992, when the Bank co-sponsored the Child Survival and Safe Motherhood programme (World Bank, 1992). This programme helped to fill in the cash gap faced by the Indian Ministry of Health and Family Welfare (MoHFW) owing to public health sector budget cuts, which in turn was driven by the conditionalities imposed by the structural adjustment loans from the Bank and the IMF (Banerjee, 1994). By 1994, there was growing evidence from local demographers and researchers on the ineffectiveness of the target-based system for decline in fertility, swelling activism from women's health groups around the Cairo conference as well as receptive Indian Administrative Services (IAS) officers who were in senior decision-making positions. Most importantly, the government of India wanted a loan for their tenth population project. All these factors made the officials in the MoHFW responsive to the Bank's advice to review the public health sector.

In October 1994, a 17-member team - including nine health and population control specialists from the World Bank headquarters in Washington D.C, five consultants, and three staff from the Population Council - conducted a health sector review and visited four states in India (Measham and Heaver, 1996; World Bank, 1995a). A second team visit in February 1995 resulted in the publication of a report titled 'India's family welfare program: moving to a reproductive and child health approach'

with policy recommendations for the MoHFW. The key recommendation was the adoption of a target-free approach for family planning, wherein women were framed as 'clients' that could choose from a range of contraceptive options based on their own needs rather than being coerced through government targets (World Bank, 1996). Other recommendations included provision of a range of reproductive, maternal and child health services such as treatment for reproductive and sexual tract infections, emergency obstetric care, inclusion of private providers, and an overall increase of the national budget for maternal and child health (Measham and Heaver, 1996).

Bank staff from the headquarters, first circulated this report to the Ministry of Finance and then to the MoHFW (World Bank, 1996a). During my interviews with former Bank staff who were part of this mission it was reported that getting the Ministry of Finance's approval on this report was a crucial step in processing the loan for the RCH project. Former staff from the MoHFW also reported that the Bank agreed to design the RCH project as a platform to implement its main recommendation of a target-free policy for family planning. For their cooperation with the sector review and approval of the RCH project, officials in the MoHFW got Bank loans for the first phase of the RCH project ($255 million) as well as the tenth population project ($250 million) (Donaldson, 2002; World Bank, 1996).

Soon after approval from the finance and health ministries in March 1996, the Bank convened a meeting in New Delhi with officials from the MoHFW and representative of international partner agencies including WHO, UNICEF, USAID and UNFPA (World Bank, 1996b,c). While the MoHFW was receptive to a paradigm shift from a demographic focus to the RCH approach, all the partner agencies except for UNICEF, provided consensus on moving ahead with this proposed approach (World Bank, 1996d). My interviewees from the Bank narrated how representatives from UNICEF felt that the best way forward was to extend the ongoing Child Survival and Safe Motherhood (CSSM) programme with a focus on immunisation. A former Bank staff articulated UNICEF's reservation in the quote below.

> UNICEF was the leader in child health and had a good rapport with the Government of India. Their rationale was that talking to India about women and women's empowerment will get you

> nowhere but if you talk about the child that is everyone's business and everyone has a sympathetic ear for that. So the best point of entry was to talk about child survival. The Bank had started with child survival and as an afterthought; safe motherhood was added to that. The time was right. The Government wanted to shift away from targets. I adamantly refused UNICEF's direction towards child survival alone. I said, 'we have to go with the world trends and reproductive health, so you take reproductive and child health together and you get the RCH package. So, that battle ended up with the Government of India buying into our idea of reproductive and child health rather than an extension of CSSM-II.

In April 1996, the Government of India adopted a target-free approach for its family planning programme (Government of India, 1996), and in 1997, the Board of the World Bank approved the first phase of the RCH project with an overall credit of $255 million towards the total project cost of $309 million, and the Government of India financed the rest of the project costs (World Bank, 1997). RCH-I aimed to reduce maternal and infant morbidity and mortality, and unwanted pregnancies, leading to the stabilisation of population growth. Despite the negotiations around reproductive rights and health and the need to move away from target-based family planning approach, note that the end goal of this project was to ultimately, stabilise the population in the country.

RCH-I had three objectives: (1) improving management performance, (2) delivering an essential package of reproductive and child health services, and (3) improving health care access in selected disadvantaged districts. The essential package of RCH services included the treatment for reproductive and sexual tract infections, provision of contraceptive methods, antenatal care, institutional deliveries, postnatal check-ups, immunisation, and treatment for acquired respiratory infections and diarrhoea (World Bank, 1997).

Implementation

A senior health specialist based in Washington D.C, led the RCH-I, and was supported by three consultants at the Bank's country office in New Delhi. RCH-I was implemented by the MoHFW at three levels. At the centre-level, the MoHFW was responsible for monitoring policy implementation, financial management and the bulk procurement of drugs and equipment. The MoHFW was led by health secretaries who were IAS officers (civil servants or bureaucrats). At the state-level, the state health department was responsible for training staff, financial management and monitoring of activities in their districts. At the district-level, the district health team implemented the planned activities and relied on the State and the Centre for financial and technical support (World Bank, 1997; 2005). RCH-I was a centralised programme in that the power to make policy, programmatic and financial decisions rested with MoHFW staff at the central government.

This project was designed to be implemented in selected districts across all the states in India. MoHFW communicated with individual states to submit proposals to meet the planned objectives of RCH-I. The Bank advised the MoHFW to appoint up an ad-hoc panel of senior government officials to review RCH proposals submitted by the states (World Bank, 1997). A former Bank staff recounted how it was initially difficult to get all the states on board to submit their RCH proposals, owing to the varying levels of managerial and financial capacities and political will across the states. However, they also discussed the power of the central government over the states in India.

> The joint secretary called all the states and said that, 'each state, please put up a proposal and explain how you are going to address the problem (maternal and child health)'. The central government will sit with the Bank and then see how to work it out. She personally insisted that the top man from each state (health secretary) should come to Delhi and make the presentation personally. If they did not come personally, there would be no money for that state. When we looked at the proposals, the states that were most in need had the weakest proposals and the weakest state had no proposal at all. They did not even put up a proposal neither did they bother to come.

> She picked up the phone and blasted them saying, ‘you are losing this much money. Make yourself available within the next four hours.’ She was very fierce with them. I had to sit back and just watch the interaction between the central government and the states.

Around RCH-I, the central government allocated 90% of the funds for health programmes in each state, while the states paid the remaining 10% of the costs. States in the country were categorised into three groups - A, B, and C - based on the burden of maternal and child morbidity and mortality as well as their financial and managerial capacities. States in Group A included Tamil Nadu, Kerala, Karnataka, Andhra Pradesh, Maharashtra, and Punjab, and were more affluent than states in Groups B and C, which at the time received greater central government funding. A former member of Bank staff reported mild dissatisfaction with the final selection of districts and attributed this factor for the outcomes of this project.

> So, in terms of the strategy, if I would look back at it now, I would say, we chose the really poor performing districts but I would say that it would have been better if we chose the not-so poor performing, middle but a little bit lower, where you know you can actually start showing results. Unless you can show results people get disappointed. People move away from the thought and they do not want to continue. Do not always select punishment situations. Select a situation where you know you can show a change. Select a situation where it is not really at the top but it is at a place where you can work, you know the ambience, environment, conditions are not so difficult that it would be like you are pulling teeth.

Bank staff’s involvement in RCH-I was limited to overall financing, liaising with the MoHFW at the central level to plan and finalise activities for each state, and bi-annual supervisory visits. The state health department with oversight from the MoHFW, controlled the actual implementation of these RCH activities in the selected districts.

Outcomes

Maternal, infant, and child mortality declined from the start to the end of RCH-I (1997-2004) (IIPS, 1998; 2007). The maternal mortality rate dropped from 540 deaths per 100000 live births to 301. Infant mortality rate decreased from 71 deaths per 1000 live births to 58, and child mortality dropped from 102 to 76. While the decline in mortality rates looked promising, RCH service-related indicators did not increase as planned (IIPS, 2007). The proportion of pregnant women that received the recommended three antenatal visits recorded a modest increase from 44% to 52%. Although the percentage of institutional deliveries increased from 40% to 47%, the proportion of deliveries in public health facilities funded by RCH-I declined from 24% to 18% while deliveries in private facilities rose from 9% to 21%. Postnatal visits declined from 14% to 12%. Full immunisation coverage barely rose by a percentage point from 42% to 43%. Furthermore, care seeking for children under the age of three years suffering from diarrhoea dropped from 65% to 58%. A positive result was seen in the declining incidence of polio cases from 1931 in 1998 to 133 in 2004. These results indicated that despite the increased funds, RCH-I did not increase the number of women who sought RCH services in public health facilities.

In terms of contributions to the health system, RCH-I led to 60% of districts planning their maternal and child health activities, which was a positive result as previously the central government would conduct this planning. However, districts still did not have any fiscal autonomy to hire staff or make any required purchases, and would have to wait for approval from the state and central government, causing delays (Government of India, 2005). Furthermore, in all states, SCOVAs (standing committee for voluntary action) were established to track and monitor financial flows from the central government to the district level. Work began on computerising procurement systems, but it was only completed for the MoHFW at the central government by the time RCH-I ended (World Bank, 2005).

My interviewees from the MoHFW stated that while RCH-I provided a range of health services for women and children, the burden of providing these services ultimately fell upon the inadequately and ill-equipped primary health facilities and frontline health workers such as the Auxiliary Nurse Midwife (ANM). Before RCH-I, the ANM was incentivised to increase the numbers of women who accepted family planning

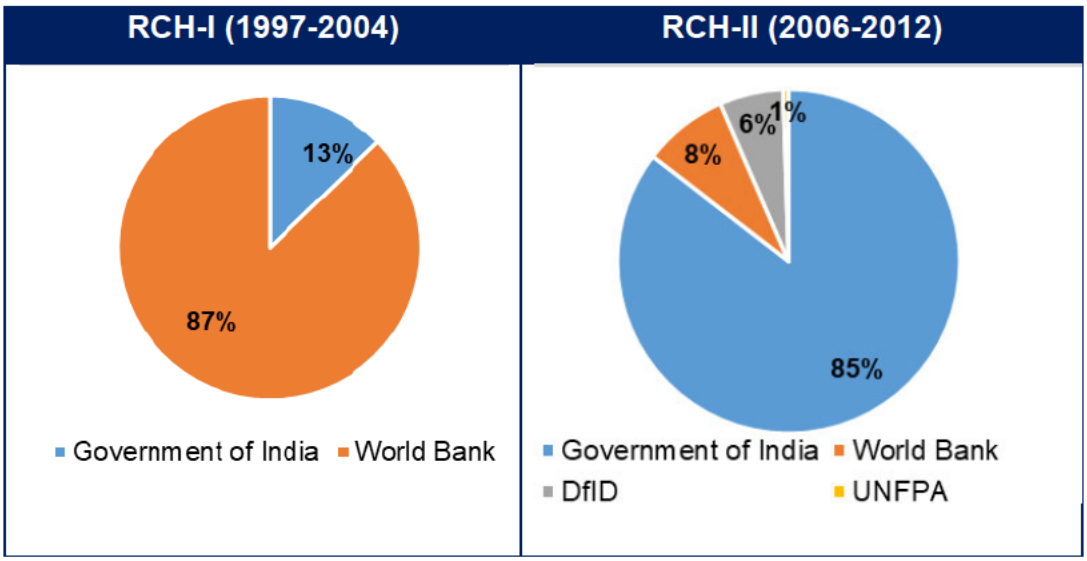
and children who were immunised. After RCH-I, she was given the added tasks of providing services for reproductive tract infections and sexually transmitted diseases along with the ongoing antenatal, childbirth, postnatal, and immunisation services, albeit without any additional technical, supervisory or financial support.

7.2 RCH Phase II (2006-2012)

Design

The design of RCH-II took place in 2003, and it differed considerably from its predecessor in terms of its financing and the scope of involvement of the Bank and the government of India. The Bank provided 87% of the overall funding for RCH-I; in the second phase of the project, the government of India financed the majority (i.e. 85%) of the project costs (figure 7.1). DfID and UNFPA entered RCH-II as new donors, financing 6% and 1% of the total project costs respectively. My interviewees from the Bank, MoHFW and UNFPA unanimously expressed that being a major financier put the government in the driver's seat in terms of the design and implementation of RCH-II. This was unlike the previous phase of the project, which bore heavy donor imprints.

Figure 7.1: Proportion of financial disbursements by donors for RCH-I and RCH-II (Source; World Bank, 2012; 2005)



RCH-II had three broad objectives: (1) improving essential RCH services, (2) providing technical assistance by setting up a national health systems resource

centre and by strengthening procurement systems, and (3) polio eradication (World Bank, 2006). Additionally, RCH-II aimed to reduce the disparities in the utilisation of RCH services geographically (i.e. in 8 high burden states) and among poor households. Nearly 30% of the RCH-II was dedicated to child immunisation programmes.

Two significant events took place around the design of RCH-II. First, in April 2005, the government of India under the newly elected United Progressive Alliance (formerly the Indian National Congress), launched the National Rural Health Mission (Government of India, 2005). This national programme increased the domestic health budget and introduced several schemes to generate demand for maternal and child health, such as community health workers called ASHAs in every village, and the Janani Suraksha Yojana, a conditional cash transfer scheme for institutional deliveries. Most of my interviewees noted that this kind of political and financial support vis-à-vis the NRHM raised the profile of maternal and child health in India like never before.

Second, in 2005, a corruption investigation in RCH-I led to the Bank management suspending funds for RCH-II and other health and public infrastructure projects (INT, 2007; Volcker, 2007). While my interviewees who worked with the MoHFW refrained from discussing the corruption scandal, former Bank staff who held leadership positions in HNP at the Bank headquarters in Washington D.C and in India were candid about their experiences. A former Bank staff recounted his assignment in the country post the corruption episode.

> When I first got to India around RCH-II, there was a rocky relationship between the Bank and the Ministry (of Health). I had some of the most acrimonious meetings of my career in those times. That had nothing to do with the HNP staff in the country office. It was an independent investigation set up by a former Bank President. The Bank really screwed up the investigation and it caused a lot of animosity.

Former Bank staff from the country office confirmed that the Bank management in Washington D.C did not consult with them about the suspension of funds,

highlighting the lack of communication between the different units within the Bank. My interviewees further explained that Bank managers in the country as well as at the headquarters generally knew about instances of corruption in government projects in India, but did not take any concrete actions. Corruption in India was a complex and difficult issue to address and as it would affect Bank business in that it would delay or stall ongoing discussions around policy agreements, programmes and most importantly, loan approvals. Bank funds for RCH-II were released in 2006; soon after, the Bank and MoHFW agreed on a Governance and Accountability Action Plan, which included measures to revamp the procurement system in the country (World Bank, 2006).

Implementation

My interviewees from the MoHFW and the Bank, spoke about four novel elements in RCH-II, which they felt contributed to improved project implementation as compared to the previous phase. First, the MoHFW, the Bank and other donors agreed to promote decentralisation in that state governments were given administrative and financial autonomy unlike in RCH-I, wherein the central government retained all the decision-making powers. The MoHFW and Bank staff supported state governments to develop project implementation plans and budgets. Additionally, state governments signed memorandums of understanding with the central government to ensure the utilisation of funds for the planned RCH activities, thereby increasing ownership and accountability. A former Bank staff who was closely involved in RCH-II recounted his team's efforts in achieving decentralisation.

> There was a conscious direction from the start about the lessons learned in RCH-I. In the first phase, RCH was a smaller project. While it involved a paradigm shift, it was centrally driven. There was an emphasis on line items and executing activities. In RCH-II, the focus shifted to decentralisation at the state and district level. There were discussions around flexibility of financial resources to the states and districts. We had a hands-on approach. We prepared manuals to help states write project proposals.

Second, former Bank staff claimed credit for convening donors and convincing them to create a flexible pool of donor resources at the central government-level, which could be disbursed to state governments. My interviewees from the MoHFW and UNFPA - as well project reports - corroborated Bank leadership for donor coordination and pooled donor financing (Government of India, 2012; World Bank, 2012; DfID, 2009). The third novel aspect was the MoHFW's joint review missions, which was a workshop attended by all the project partners to discuss progress and challenges, and share best practices across the states. The Bank convened two joint review missions each year of the RCH-II; the first joint review mission focused on the eight high focus states, while the second review invited all the remaining states.

Finally, RCH-II offered flexible funding for state governments to implement innovations to increase the uptake of RCH services. The Janani Suraksha Yojana, a conditional cash transfer scheme, was one such innovation. Though this, pregnant women from households living below the poverty line were entitled to cash incentives for giving birth in health facilities. While the Bank promoted Janani Suraksha Yojana as it was a performance-based financing initiative, this scheme was launched by the MoHFW under the National Rural Health Mission. RCH-II received major boost from the overarching NRHM, which increased the overall national financial budget, and strengthened infrastructure and human resources.

Outcomes

By the end of RCH-II, the national maternal mortality rate dropped from 254 deaths per 100000 live births to 167, and the infant mortality rate declined from 57 deaths to 1000 live births to 40 (Government of India, 2019). The proportion of decline in the maternal mortality rate by the end of RCH-I was greater, whereas the drop in the infant mortality rate was comparatively larger after RCH-II (see table 7.1). Maternal and infant mortality rates also showed sharpest declines in eight states, including Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, and Rajasthan. These had the highest burden of maternal and child deaths in the country and are the poorest in terms of GDP (Government of India, 2001). RCH-II recorded a substantial increase in the uptake of three health services: institutional deliveries (39% to 79%), post-natal checks (40% to 62%), and full immunisation of children under 24 months (36% to 62%). Additionally, the highest coverage of these services was observed

among beneficiaries from poor households and belonging to lower castes and tribes (IIPS, 2017). RCH-II thus managed, to an extent, to reduce the disparities in utilisation of RCH services in high-burden states and among beneficiaries from poor households and lower castes.

Table 7.1: Maternal and infant mortality rates in India before and after RCH

Time periods	Maternal mortality rate (MMR)	Difference in MMR between time periods	Infant mortality rate	Difference in IMR between time periods
Pre-RCH-I (1997)	398	-	71	-
End of RCH-I (2006)	254	144	57	14
End of RCH-II (2013)	167	87	40	17

Sources of data: Government of India, 2019.

The rise in institutional deliveries can most likely be attributed to the government-funded conditional cash transfer scheme - Janani Suraksha Yojana - as well as the community health workers (ASHAs) introduced under the National Rural Health Mission (Doke, 2016). Thus, the increase in full immunisation coverage could be explained by the rise in Bank funding for the national immunisation programme via RCH-II. In its evaluation report, the Ministry of Health and Family Welfare (2012) reported that the varying management capacities and political will across the states continued to act as a barrier and facilitator for the implementation of RCH-II and the subsequent improvements in outcomes. While the performance of RCH-II was comparatively better than its predecessor with respect to health and service indicators, the corruption investigation and subsequent financial scrutiny of the central and state governments' created a tense environment. Former staff from the Bank told me that as a result of this tension, the MoHFW was reluctant to discuss another project after RCH-II, pushing the Bank to shift towards state-level health projects. One informant, a current Bank staff, articulated this tension in the quote below:

> Unfortunately, this whole corruption and the investigation affected the environment in which we worked. So, the government said, fine, we have got the RCH-II, we will finish it…but, after this…..we will use our IDA for other sectors. It is too time consuming and so much of a problem with corruption. That is why after the second phase, you will see that there was

a bit of lull with the Bank and the Ministry. It is only now that the government is opening up for a bigger discussion.

7.3 Conclusion

In this chapter, I have traced the process of the design and implementation of both the phases of the RCH project. In doing so, I have introduced the major actors and described the changes that took places across these two phases. By the time RCH-I concluded in 2004, maternal and infant mortality declined and deliveries in public facilities saw a minimal increase. Despite the decline in mortality rates, there was no improvement in health service uptake, owing to ambitious planning, weak programme implementation and heavily centralised planning with little decision-making autonomy at the state level.

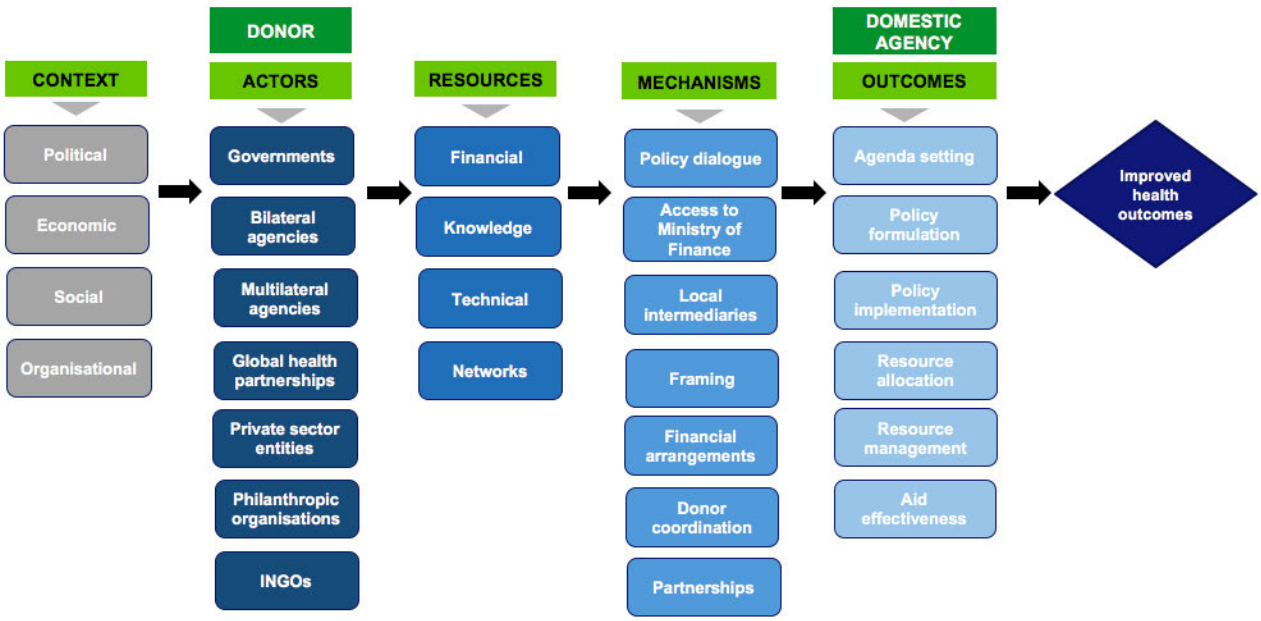
Compared to RCH-I which was donor-driven (particularly by the Bank), the second phase of this project was led by the Indian government. RCH-II achieved a greater decline in maternal and child mortality and institutional deliveries recorded a massive jump. While RCH-II showed improved health outcomes, challenges persisted, especially with respect to state-level planning and managerial capacities, and governance. This understanding of the RCH project thus sets the context to examine the Bank’s influence in maternal and child health in the country.

Chapter 8 Ascertaining the World Bank's influence in India through the Reproductive and Child Health Project

8.1 Introduction

This chapter forms the second part of a two-part process to examine the World Bank's influence at the country-level for maternal and child health. In this chapter, I explore the process in which the Bank exerts its influence over the Indian Ministry of Health and Family Welfare (MoHFW) vis-à-vis the Reproductive and Child Health (RCH) Project, to achieve certain outcomes for maternal and child health. In doing so, I uncover this process of donor influence including the resources and mechanisms used by the Bank, and also ascertain the degree of the Bank's influence over a domestic nodal agency. For this chapter, I use the framework of donor influence in health policy (as conceptualised and described in Chapter Two) to analyse data on the RCH project from multiple sources. This framework has four components: (1) outcomes, (2) resources, (3) mechanisms, and (4) contextual factors (see figure 8.1).

Figure 8.1: Conceptual framework of donor influence in health policy

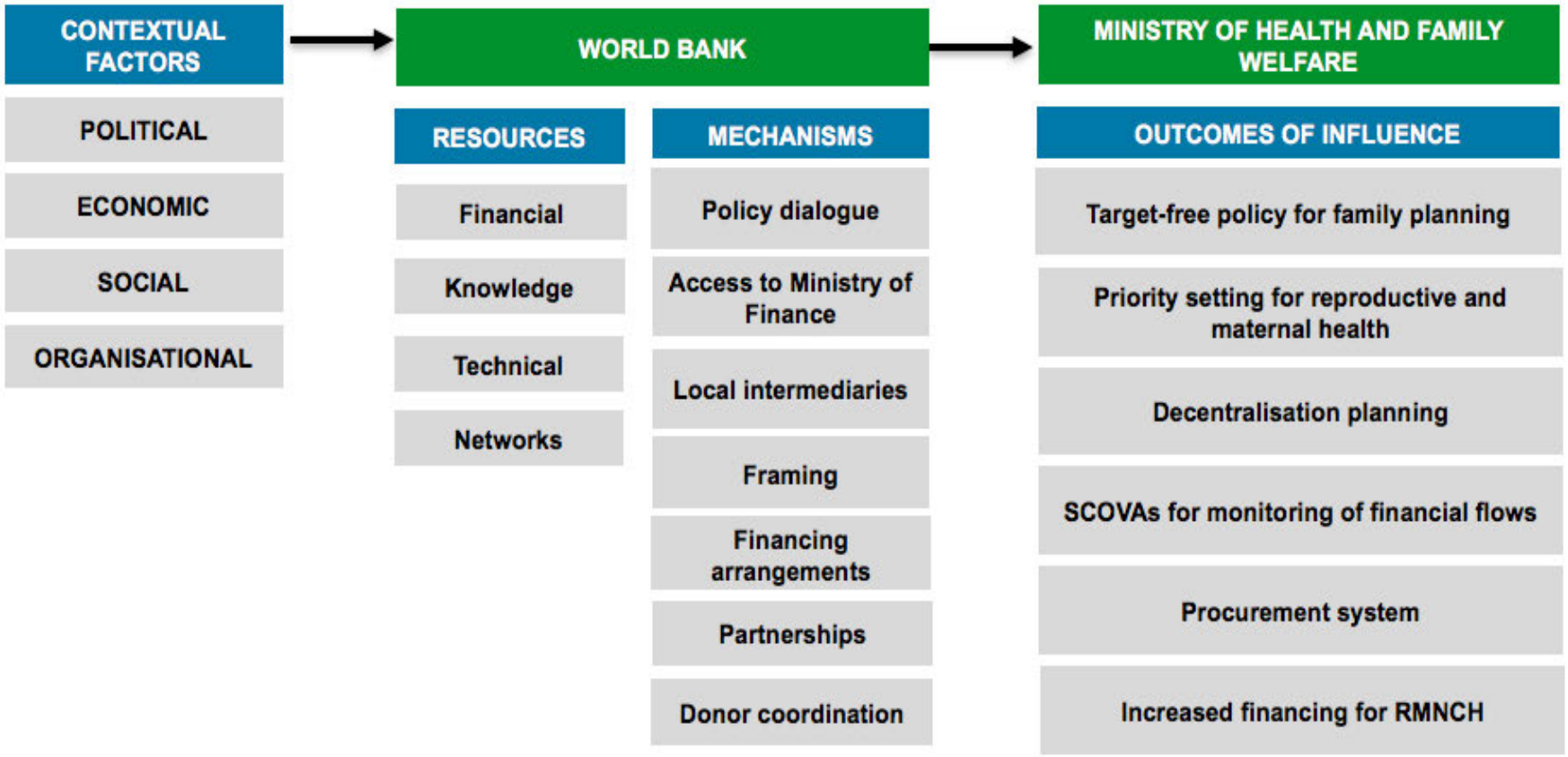


The starting point for this analysis was identifying what the Bank actually influenced i.e., what were the *outcomes* of the Bank's influence. Maternal and child mortality in India declined after each phase of the RCH project end. While RCH-I was not able to increase the number of women and children utilising reproductive, maternal, and child health services, after RCH-II ended, a substantial increase was reported in the uptake of institutional deliveries (39% to 79%) and child immunisation (36% to 62%) (IIPS, 2017, 2007). It is impossible to trace the Bank's precise influence over each of these maternal and child health mortality outcomes and service coverage indicators. Guided by the conceptual framework, I looked for health policy outcomes (i.e., any decision, plan, or action undertaken to strengthen the health system or facilitate programme implementation and service delivery) where the Bank had played a role in.

I followed a two-step process to identify such policy outcomes. First, I carefully reviewed project implementation reports and evaluations published by the MoHFW and the Bank (Government of India, 2012, 2005; World Bank 2012, 2005, 1997, 1996), and I identified six policy outcomes raised in these documents. Second, I verified these six policy outcomes through my interviews with staff from the Bank and the MoHFW. The six policy outcomes included: (1) target-free policy for family planning, (2) priority setting for reproductive and maternal health, (3) decentralisation, (4) financial monitoring system, (5) strengthened procurement system, and (6) increased domestic financing for reproductive, maternal, newborn and child health. The six policy outcomes are significant for maternal and child health in the country as these facilitate programme implementation and enable effective service delivery, which will subsequently impact health outcomes.

After ascertaining the *outcomes*, I deductively analysed the interview data to identify the other components of the framework viz. resources, mechanisms, and contextual factors. I defined *resources* as any objects of value and *mechanisms* as any strategy (Pawson and Tilly, 1997) used by the Bank to exert its influence over the MoHFW to achieve the policy outcomes. Additionally, contextual factors are elements within a country that can affect the interaction between the donor and the domestic agency, thereby impacting the external donor's influence. I deductively analysed the data using this framework, and organised the findings for each of the six policy outcomes.

Figure 8.2: The process of the World Bank's influence over the Ministry of Health and Family Welfare vis-à-vis the RCH project



In figure 8.2, I present a diagram to illustrate the process of the Bank's influence on the MoHFW vis-à-vis the RCH project.

After uncovering the process of the Bank's influence for each policy outcome, I developed a scale for ascertaining the degree of influence that the Bank had for each policy outcome. I define influence as the ability of one organisation to direct the decisions of another organisation to reach a certain goal or an outcome. However, when measuring one organisation's influence over another we need to distinguish between attribution and contribution. Attribution is like causality, where a change is solely due to one organisation's intervention, whereas, contribution is the idea that an organisation's influence is one of the many factors, which contributed to a change (Aidleap, 2015). In social science, especially in health policy research in a country, it is impossible to precisely ascertain attribution to an organisation in a dynamic environment with multiple actors and factors. Furthermore, claims to precisions via attribution in bioscience can also be overstated and thus problematic to achieve in the first place (Cartwright, 2007).

So, at best we can arrive at the possible contribution of an organisation, which acknowledges that the organisation's influence could be one of the many factors that could have contributed to a change. Bearing in mind that we can only appraise the likely contribution of the Bank rather than attribution towards the six outcomes, I developed a scale to ascertain the degree of the Bank's influence for each policy outcome (see table 8.1). By using this scale of donor influence, we can grasp the extent to which the Bank influenced a particular outcome while also realising the role of other domestic or international actors in this process.

Table 8.1: Degree of donor influence

Degree	Explanation
No influence	There was no influence and change would have happened anyway
Partial influence	The Bank supported/promoted the outcome which was initiated and led by other actors
Substantial influence	The Bank led the outcome albeit with the support of other actors
Major influence	The Bank was the main driver of this outcome

Furthermore, I developed a sustainability index for each outcome, which informs us if a particular outcome is still being achieved or has been discontinued. This index has three stages. First, the outcome could be in an 'ideational' stage, where it exists as an idea or a concept but has not moved further to being implemented in practice such as through a policy or a programme. Second, the outcome could be at the 'implementation' stage, where it is being practiced in some form. Third, the outcome could be at the 'institutionalisation' stage, where it has been established as a convention or a norm within an institution i.e., MoHFW, such that it continues to be implemented even after donor leaves (i.e. funding or technical support ends).

In the following segments of the chapter, I describe the Bank's process of influence for the six outcomes. For each outcome, I discuss the resources and mechanisms used by the Bank, followed by the degree of the Bank's influence, and the sustainability of that outcome. Finally, I discuss the organisational barriers within the Bank and the MoHFW and the contextual factors at the country level that affected this process of influence.

I conclude the chapter by summarising the key findings emerging from this country case study of the RCH project. Essentially, I attempt to answer five questions: (1) What was the World Bank's overall influence vis-à-vis the RCH project? (2) What resources and mechanisms did the Bank use to exert its influence? (3) What factors affected this process of influence? (4) What can be said about the sustainability of the outcomes influenced by the Bank? (5) What does this country case study tell us about the ways in which the Bank conceptualised maternal and child health?

8.2 Process of donor influence

8.2.1 Outcome 1: Target-free policy for family planning

Outcome

In 1965, it was the Bank, among other international agencies, that pressurised the MoHFW to adopt the target-based approach for family planning in the first place (Visaria and Chari, 1998, p. 80). However, towards the late 1980s Bank specialists were moving away from targets, which was evident in Stout's review of India's family planning programme (Stout, 1989). Amidst a financial crisis and in need of low-cost

loans to support its family planning programme, the MoHFW agreed to a public health sector review by the Bank, which resulted in the recommendation of a target-free policy for family planning in India. The government's adoption of this policy was quickly followed up by two Bank loans: one for the RCH project that would implement this policy, and the other for a population project.

Resources

Bank staff first used *knowledge-based* resources, including its 1989 report by specialist Susan Stout to highlight the ineffectiveness of the target-based approach for family planning. The 1995 report recommended a target-free reproductive health approach. While these reports supported the Bank's advocacy for this outcome, ultimately, it was the Bank's *financial resources* in the form of loans for the RCH project and the population project that played a major role in convincing the MoHFW towards adopting a target-free policy.

Mechanisms

Bank staff used four mechanisms to influence this outcome: policy dialogue, local intermediaries, financial arrangements, and partnerships. First, Bank staff conducted *policy dialogue* through activities such as the sector review (field visits and analysis) and consultation meetings with senior government officials in the MoHFW over a period of two years (1994-1996) (Measham and Heaver, 1996; World Bank, 1995b). Second, Bank staff worked closely with *local intermediaries*; i.e. senior IAS officers in the MoHFW including health secretaries V.K Shunglu, J.C Pant, and Y.N Chaturvedi, who were receptive to change and played a leading role in passing the target-free policy (World Bank, 1996e,f). Former secretary J.C Pant was keen to close the loan deal with the Bank for the population and RCH project, since he was scheduled to retire and wanted to leave a legacy. Third, the Bank got a receptive MoHFW to sign up for the RCH project by inducing it with the financial arrangement of loans worth $505 million for population control and RCH (Donaldson, 2002). Fourth, Bank staff used their *partnerships* with other donors, women's health advocates, and NGOs, and encouraged discussions of the target-setting system and its consequences within these circles. The Bank also funded the Indian NGO 'HealthWatch' for a study on unsafe abortions, which was presented to the MoHFW as evidence to advocate for the target-free policy and expansion of safe abortion services.

Degree of Influence

The Bank had partial influence on this outcome. While the Bank used loans as a lever to push for this reform, it did so along the same lines that many women's health advocates and local demographers had been urging and that senior government bureaucrats had become convinced was appropriate. So, the Bank's arguments fell on fertile ground. But for them to become effective, senior Indian policy makers had to accept on the donor's point of view.

Sustainability of the Outcome

Despite, being adopted by the Government of India in 1996 and included it in its National Population Policy in 2000, the target-free policy still remains at an *implementation* stage. This is because several state governments have formulated their own population policies, and only a handful of states in the country follow a target-free approach for family planning (Bhattacharya, 2007). A senior former official from the Ministry of Health and Family Welfare highlighted the contextual challenges in implementing this policy.

> Some of us in the Ministry had been strongly voicing the removal of targets which has had such a long history in the country as you will be aware. Of course, the Bank came in and offered loans, but it was not easy to implement this target-free policy across the states. Adopting the policy is one thing, but explaining it to the states and then trying to get this done at the district level with little guidance was challenging.

8.2.2 Outcome 2: Priority setting for reproductive and maternal health

Outcome

Most of my interviewees from across different organisations stated that the Bank influenced the RCH project through placing reproductive and maternal health on the national health agenda during RCH-I and maintaining this priority through RCH-II. Former staff from the MoHFW and the Bank reflected that in the absence of RCH-I, the Indian government would probably have continued its focus on child immunisation and family planning, with little attention to reproductive and maternal

health services. A former staff of the MoHFW articulated this possibility in the quote below:

> UNICEF wanted a continuation of immunisation services, but the Bank insisted on including safe motherhood components. You see…UNICEF was an important actor for child health, so we had these debates. But, the positive thing about the joint consultations with the Bank team was that they kept us all focused on maternal health.

Similarly, a former staff of the Bank asserted:

> I think if the Bank had not been in India, then the government would have gone down the same line of WHO and UNICEF and followed child survival and immunisation route, which was basically the welfare of the child and the continued focus on family planning. The Bank can rightly take credit for that. Don't get me wrong. There were many agencies that were working on it, but the Bank had the clout and the money to make the difference.

For RCH-II, the Bank galvanised the support of donor agencies like DfID and UNFPA, to promote reproductive and maternal health in India. The National Rural Health Mission was a homegrown programme that was fully designed and funded by the Indian government without any donor inputs or influence. Despite the NRHM, former staff from the MoHFW credited RCH-II for keeping reproductive, maternal, and child health on 'top of mind' of the domestic policy makers, as illustrated in the quote below from a former staff from the MoHFW who was closely involved in the design and implementation of the NRHM:

> NRHM, if I may say so, did come from the RCH route. RCH helped me to understand the area of maternal and child health. The presence of these luminaries [at the Bank] kept RCH on the agenda. I mean….otherwise, it would have taken a back seat, you know.

Resources

Bank staff used financial, technical, and network-based resources to influence the priority setting for reproductive and maternal health. First, the Bank's *financial resources* in the form of loans for RCH-I and the population project amidst ongoing financial crisis, made the MoHFW more acquiescent to the Bank's discussions on expanding reproductive and maternal health services (Donaldson, 2002). Second, Bank staff used *technical resources* in the form of local consultants that worked with the MoHFW and state governments to coordinate planning and implementation of RCH-I (World Bank, 1996b). Third, Bank staff used its existing *networks* and marshalled the technical and financial support of donors like DfID and UNFPA for RCH-II.

Mechanisms

First, Bank staff used *policy dialogue* through consultation meetings with senior officials in the MoHFW. Bank health specialists from Washington D.C, attended these consultation meetings and argued for the introduction of services for RTI and STIs into the existing package of services for maternal and child health services. Second, former Bank staff explained how they linked reproductive and maternal health to improved child health outcomes, and felt that this strategic *framing* of the reproductive, maternal and child health continuum facilitated the buy-in for the RCH project from the MoHFW. Third, the Bank had exclusive *access to officials in the Ministry of Finance*, owing to their ongoing IDA lending for other public sector projects. For every health project that the Bank funds, it has to first be approved by the Ministry of Finance, which will then officially request for a loan for the MoHFW. My interviewees with former staff at the Bank reported that they shared a good relationship with Manmohan Singh (Finance Minister during RCH-I and former Bank staff), which they felt was advantageous to secure an approval for the RCH project.

Fourth, Bank staff used their strong relationships with *local intermediaries* (top-level officials) in the MoHFW, to engage state governments to submit proposals and subsequently implement the RCH project. Fifth, the Bank used *financial arrangements* such as quick and flexible disbursement of resources to enlist the support of state governments in implementing both the phases of the RCH project.

Sixth, Bank staff used their *partnerships* with UN agencies, INGOs and NGOs, to advocate for the expansion of reproductive health services in the country. A former Bank staff in a leadership position recounted that some of these partnerships also provided a public relations function for the Bank:

> Whatever we did was hand in glove with WHO and UNICEF. Some of the things we did, it was cloaked as if it were UNICEF. The Indian government had to convince the naysayers who believed that UNICEF was doing a great job but the World Bank was evil. We had a wonderful partnership, a huge one, posing as if it were done by UNICEF, as if the Bank were barely involved.

Degree of Influence

The Bank had a partial influence on this outcome. While the Bank offered the much-needed financial resources and initiated discussions for the RCH project in a window when the conditions in the country were ripe for change, domestic policy makers in the MoHFW along with local researchers, women's health advocates, and civil society organisations were the main drivers for this outcome as they championed for prioritising reproductive and maternal health since the late 1980s, much before Bank lending for RCH. While acknowledging the role of the Bank, a current official in the Ministry of Health and Family Welfare gave prominence to several factors for raising the priority of reproductive and maternal health in the country:

> The World Bank was an important player through the RCH projects. They (projects) pushed the thinking within the ministry. But, you have to consider this long period of change in the country. We started with the NFHS (national level household surveys) that showed such high maternal mortality rates and raised the alarm among the government officials and parliamentarians. Then, we had the Congress government led by Dr Manmohan Singh…it took special interest in maternal and child health and the NRHM was created.

Sustainability of the Outcome

This priority for reproductive and maternal health has been *institutionalised* by the MoHFW in two ways. First, through the National Rural Health Mission in 2005, the MOHFW has raised the political attention and domestic financial resources for this area (Government of India, 2005). Second, in 2013, the MoHFW published a RMNCH+A strategy that funds interventions in targeted high burden districts across the country (Government of India, 2013).

8.2.3 Outcome 3: Decentralisation for the RCH project

Outcome

One of the major challenges of RCH-I was that it was centrally driven with little decision-making autonomy with state governments. My interviewees reported that during the design process for RCH-II, the Bank along with DfID and UNFPA promoted decentralised planning for RCH programmes at the state and district level. A former Bank staff recounted the need for decentralisation as the biggest lesson learned from RCH-I:

> There was a conscious effort to start from the lessons learned in the first phase. Both the Government of India and the Bank thought that decentralising maternal and child health operations to the states, districts and communities was vital for the success of the project, so both the sides spent considerable time in the design of RCH-II to facilitate that change.

Donor-led negotiations during the design of RCH-II provided a nudge to the MoHFW, which was already debating the introduction of this reform as recommended by the Planning Commission in 2001 (Government of India, 2002). In 2005, the government-funded National Rural Health Mission officially decentralised the public health planning process by offering state governments the power to develop their own state and district plans along with flexible funds to implement these plans (Government of India, 2005).

Resources

Bank staff first used their existing *networks* to convene donors that were already working in different states in the country (DFID, 2009; Government of India, 2012). A former Bank staff who worked closely on RCH-II, felt that the collective voices of the donors and their support for decentralisation made a difference in the planning discussions with the MoHFW. Second, Bank staff used *knowledge-based* resources in the form of manuals and guidelines to help state governments in developing state and district implementation plans.

Mechanisms

Bank staff engaged in *policy dialogue* through consultation meetings with officials from the MoHFW and state governments, where they promoted the signing of a Memorandum of Understanding between the government of India and individual states to enhance state ownership and accountability for RCH implementation (World Bank, 2012). Bank staff engaged in *donor coordination* and used the *financial arrangement* of pooled donor funding for RCH-II, which offered flexible funds for state governments to make timely purchasing decisions and fund innovative schemes that would not have been possible within the framework of the MoHFW's existing financial arrangements.

Degree of influence

The Bank had a partial influence on this outcome of decentralisation. While the Bank staff promoted decentralisation during the design of RCH-II, it was really the government that drove home the decentralisation reform through the National Rural Health Mission. At best, the Bank along with DfID provided a significant nudge for the MoHFW to implement a reform that was already being debated within government circles and recommended by the national planning commission much before RCH-II.

Sustainability of the Outcome

The National Rural Health Mission made decentralised planning as one of its key principles, thereby *institutionalising* this reform. Under this Mission, the government created a national program coordination committee at the central-level, the state health mission at the state-level and the district health mission at the district-level

(Government of India, 2005). These specially designated teams at the three levels, have the autonomy to plan and manage RCH programmes as well as the flexibility of financial resources to make expenditures as required.

8.2.4 Outcome 4: SCOVAS - Platform for monitoring financial flows

Outcome

During the implementation of RCH-I, Bank staff supported the MoHFW in establishing state-level societies called SCOVAs (Standing Committees for Voluntary Action). These were essentially platforms equipped with an accountant and a statistical clerk to monitor funding flows from the central government through the state government to the district. RCH-I funded all except one state government to set up SCOVA's at the state and district-level. A total of 118 local consultants were recruited to work in SCOVAs in various states.

Resources

Bank staff mainly employed their *technical resources* in the form of financial consultants who advised officials in the MoHFW and the state governments on the process of establishing SCOVAs, and *knowledge-based* resources such as manuals and guidelines to assist state governments in setting up these platforms.

Mechanisms

First, Bank staff used *policy dialogue* through consultation meetings during the design of RCH-I to raise the lack of any information system on funds flow in the public health sector and advocate for new institutions to address this intractable issue. Second, Bank staff used their relationships with *local intermediaries* in the MoHFW, who once convinced, drove the concept of SCOVAs into reality.

> He [senior MoHFW official] was able to make Bank lending additive in a way that was never done before. Prior to the 1990s, the Planning Commission would ask the Ministry of Health – 'Tell us what you are going to do and then we will find the money for you. Where we find the money from is none of your business.' When I went to India, sometimes, states would

> use the health money to pay for power or electric subsidies. They [MoHFW senior officials] created financing tools to shield the money for health and enable better implementation.

Degree of Influence

The Bank had substantial influence over this outcome. While the Bank introduced the platform of SCOVAs to monitor and track financial flows, in the RCH-I design period, these new institutions would not have been realised without the major drive from senior officials at the MoHFW, who engaged state governments to apply for funding to set up SCOVAs in their individual states.

Sustainability of the Outcome

SCOVAs currently stand at the *implementation* level in terms of sustainability. All the states in the country have SCOVAs, but with varied levels of implementation and impact. In southern Indian states, SCOVAs function well; however, in certain states they perform at a sub-optimal level due to lack of clarity of roles and inadequate number of trained and qualified staff. Most importantly, while SCOVAs help to monitor and track financial flows, they serve as a temporary solution to the larger problem of weak financial management capacity and accountability within certain states (Government of India, 2012).

8.2.5 Outcome 5: Strengthened procurement system

Outcome

Following its internal investigation over the corruption in RCH-I, the Bank suspended the loan for RCH-II. This made the MoHFW acquiescent towards the Bank's recommendations on strengthening procurement as a measure to tackle corruption (Kirk, 2010). First, Bank staff persuaded the MoHFW to employ UNOPS (United Nations Office or Project Services) as a central procurement agency for RCH-II. Second, the Bank and the MoHFW agreed on a comprehensive Governance and Accountability Action Plan to address the procurement deficiencies in the public health sector. In line with this plan, the MoHFW set up the Empowered Procurement Wing at the central government-level, computerising the entire procurement process

for increasing competition and transparency. By the end of RCH-II, thirteen states set up state-level procurement agencies. A former staff member of the Bank credited it with revamping procurement system vis-à-vis RCH-II:

> Using the web to have information given out, allowing enough time for vendors to participate, and the whole review process….we did these things and strengthened the central government's procurement capacity. A separate cell (Empowered Procurement Wing) was set firmly established at the central level. Pharmaceutical procurement is one of the biggest areas for corruption, so that (Empowered Procurement Wing) was a big thing. This system wasn't only for maternal and child health; it got replicated all over the public health system.

A former staff from the MoHFW reaffirmed the Bank's contribution in this outcome.

> One area that I can certainly say where the Bank led the way was the procurement system. Procurement definitely became more robust after RCH-II

Resources

Bank staff used their financial, technical, and network-based resources to influence this outcome. First, the Bank used its *financial resources* in that it suspended its loans, which pressurised the MoHFW to adopt the Bank's recommendations on procurement. Second, the Bank's *technical* experts advised the MoHFW on revamping its procurement system. The Bank also engaged the services of a British consulting firm called 'Crown Agents' to conduct a procurement capacity review of the MoHFW and Indian states, to inform the setting up of procurement agencies at the central and state-level (Narayana, 2015). Third, the Bank used its existing *networks* within the UN system in getting UNOPS enlisted as the MoHFW's central procurement agency. A Bank evaluation report (World Bank, 2012) as well as interviews with former Bank staff reported that involving UNOPS to procure on behalf of the Bank facilitated better oversight of transparency and quality.

Mechanisms

First, Bank staff used *policy dialogue* through consultation meetings, where they employed the independent investigation report as evidence to argue for a change in the existing procurement system. More importantly, Bank staff used the *financial arrangement* of suspension of funds for RCH-II as well as other health and public infrastructure projects to induce the MoHFW to introduce a revamped procurement system. Subsequently, the Governance and Accountability Action Plan got listed as one of the major project objectives for RCH-II. A former member of Bank staff's comment below elucidates the Bank's position in this negotiation:

> The corruption situation placed the Bank in a better seat. It was easier to get the ministry to agree to streamline its procurement system and create these changes.

Degree of Influence

The Bank was the main driver for this outcome. Without the Bank's push and technical assistance, the changes in procurement would not have been implemented. A former MoHFW staff member confirmed the Bank's leading role for this outcome:

> The Bank got in some good practices. In the case of procurement and financial audits, that was their biggest strength and value addition. Perhaps, the government would have not invested in these systems, without the Bank.

Sustainability of the Outcome

This outcome stands at the *implementation* level in terms of sustainability. The Empowered Procurement Wing at the central government level, responsible for procuring a selected number of goods and services, functions well. However, at the decentralized level, only 13 states have established state procurement agencies and not all of these comply with procurement procedures (Government of India, 2012).

8.2.6 Outcome 6: Increased financing for reproductive, maternal and child health

Outcome

By the time RCH-II came to an end in 2012, the government of India increased its central budget for the MoHFW and RCH programmes. This central budget refers to the financial resources allocated to MoHFW, which is distributed across the states based on the burden of health outcomes. Additionally, each state government also contributes to its own public health budget from its own revenues. Table 7.4 shows the central government budget for public health (MoHFW), reproductive and child health programmes (from within the MoHFW budget), and a supplementary component of RCH flexible pool, which was initiated under RCH-II and contains financial resources pooled by donors funding RCH programmes in the country.

Table 8.2: Central government budget allocations (in USD millions) Sources: (World Bank, 2012; Government of India, 2019)

Budget heads	1997-1998	2005-2006	2012-2013	2018-2019
	RCH-I	RCH-II	Post RCH-II	Current
MoHFW	384	2137	6898	7646
RCH (MoHFW)	225	1097	2691	2101
RCH Flexible pool (Donors)	-	123	869	734

Resources

Bank staff used their knowledge, financial, and network-based resources to influence this outcome of increased central government funding for RCH. First, in 1996, just before RCH-I was approved, the Bank used its knowledge-based resource in the form of an influential report that recommended an increase in the domestic budget for RCH. Second, the Bank got the government of India to invest in the RCH project by borrowing a total of $630 million in IDA credits. Third, during the design of RCH-II, Bank staff used their existing *networks* to involve donors such as DfID and UNFPA in RCH-II, and created a flexible pool for donor financing for RCH programmes in the country.

Mechanisms

Bank staff conducted *policy dialogue* with the MoHFW to place increased domestic financing on the national health agenda. Bank staff used their *access to the Ministry of Finance* to persuade the central government to borrow IDA credits for the RCH programme. Finally, *donor coordination* was used by the Bank staff to create the *financial arrangement* of flexible pool for RCH, which supplemented the overall RCH budget and helped to reduce duplication efforts by donors. A former staff member from the MoHFW reaffirmed the contribution of the Bank-led donor coordination in the quote below.

> Another thing that happened, which was good in a sense….the Bank reached out to the other development partners in the country. For RCH-II, it was one team, a huge team, about 40 plus people including the ministry (of health) and all the donors. It was one team…where we could actually talk to all the donors in one place. I think that was a major part of the Bank's technical support.

Degree of Influence

The Bank had a partial influence on this outcome. At best, Bank staff played a supporting role by convincing the government to borrow IDA credits for RCH and by promoting a flexible pool for donor financing. As a former Bank staff said, "India would have eventually done this themselves, but for maternal and child health, we did give them a push". However, this overall increase in the RCH budget was primarily driven by the government of India, when it decided to launch the National Rural Health Mission, which ultimately increased the overall domestic budget for public health and maternal and child health.

Table 8.3: The process of World Bank's influence over the MoHFW vis-à-vis the RCH project

Components	OUTCOMES					
	Target-free policy for family planning	Priority for reproductive and maternal health	Decentralisation of planning for health programmes	SCOVA – Platform for monitoring financial flows	Strengthened procurement system	Increased financing for reproductive, maternal and child health
Resources						
Financial	X	X			X	X
Knowledge	X		X	X		X
Technical		X		X	X	
Networks		X	X		X	X
Mechanisms						
Policy dialogue	X	X	X	X	X	X
Access to Ministry of Finance		X				X
Local intermediaries	X	X		X		
Framing		X				
Financial arrangements	X	X	X		X	X
Donor coordination			X			X
Partnerships	X	X				
Influence Score						
No influence						
Partial influence	X	X	X			X
Substantial influence				X		
Major influence					X	
Sustainability Index for Outcomes						
Ideational						
Implementation	X			X	X	X
Institutionalisation		X	X			

Sustainability

This outcome stands at the implementation level in terms of sustainability. Currently, the central government budget for RCH remains constant and the flexible donor pool still exists, albeit without current funding from the Bank. While the financing situation at the central government-level looks promising, the RCH budget continues to vary across states in the country. For example, the state of Tamil Nadu spends a higher amount for RCH per capita as compared to the states of Uttar Pradesh and Bihar, which have the highest burden of maternal and child mortality (Ministry of Health and Family Welfare, 2018). Institutionalising this outcome will require advocacy for all the states in the country to increase their domestic budgets including per capita expenditure for RCH programmes.

8.2.7 Contextual factors

Political

Most of my interviewees across informant groups, expressed that the political situation at the centre or in the state was a make or break factor for the RCH project implementation. At the central government-level, the newly elected United Progressive Alliance (Congress) Party demonstrated political priority for maternal and child health through the launch of the National Rural Health Mission. At the state government-level, certain states such as Tamil Nadu and Kerala, are known historically for their welfare oriented public policies and strong political commitment for maternal and child health (Drèze and Sen, 2013). A former staff from the Bank credited the change in political leadership in Bihar as a major contextual factor for the improvement in the maternal and child health landscape of a state.

Economic Status

India's economic status shaped its negotiating position with the Bank. During RCH-I, India was in a financially weak position and needed loans to keep its family planning and maternal and child health programmes. As a result, RCH-I was donor-driven, giving the Bank tremendous influence over

programme design. By 2005, India had become an emerging economy and was able to finance its own National Rural Health Mission, which subsumed the RCH-II. By financing 85% of the project costs of RCH-II, India was in the driver's seat, in terms of decision-making around the design and implementation of the project.

Social

Gender affected the RCH project outcomes. The position of Indian women in the family and community is still weak; thus, gender norms have implications for women's autonomy over their reproductive health as well as their health-seeking behaviours. While Bank staff pushed for the novel introduction of services for reproductive tract infections, sexually transmitted diseases, and abortions across all public health facilities, they did not consider or try to address the social determinants that affect women's autonomy to actually use these health services (Simon-Kumar, 2007). Moreover, the caste system is one of the biggest determinants of poor maternal and child health outcomes (Sanneving et al., 2013). RCH-II tried to address this contextual factor by targeting pregnant women from poor households (as lower castes households are some of the poorest in the country) for the cash incentive scheme for institutional deliveries. However, it did not tackle this issue on the service provision side, where community health workers and other medical staff who belong to lower castes often face caste-based discrimination by peers, supervisors, and clients (women and their families) from upper castes.

Organisational barriers - World Bank

My interviews highlighted four organisational challenges within the World Bank, which acted as barriers in implementing the RCH project and affected the Bank's level of influence over the outcomes for maternal and child health in India. *First*, while Bank staff have access to top-level officials in the ministries of finance and health, in the case of India, this access was limited to the central government-level and to some extent, in a few states with ongoing Bank-funded health projects. Bank staff had little or no access at the

district and local community-level, because of which they were unable to oversee day-to-day project implementation or engage in mid-course corrections wherever required. Bank staff valued their access to and their accompanying influence over the central government as this entity was the real client responsible for repayment of Bank credits.

Herein lies the second organisational challenge: i.e. the Bank staff's preoccupation with monitoring the disbursement, utilisation, and repayment of loans, which often took away attention and resources from programmatic tasks. The MoHFW described the Bank's performance in RCH-II as "suboptimal in terms of its traditional advisory and programme support, and predominantly that of a lending institution" (Government of India, 2012, p.13). As a former Bank staff eloquently put it,

> At the end of the day, the Bank is a bank. You know….it makes its money by lending, so that is always going to be the focus.

The inherent nature of the Bank's technical assistance proved to be the third organisational barrier. A former staff from MoHFW highlighted that implementing Bank-funded projects came with its share of long and sometimes time-consuming procedures and reporting that had to be completed in the English language, which was a challenge for certain states in North India. Furthermore, the Bank hired local consultants who worked alongside staff from the MoHFW. While consultants were used to bypass the government's long delays in approval for hiring, conflicts often arose between these consultants and the local district-level MoHFW staff in some states. This was because the latter were remunerated much less despite being more knowledgeable about local conditions and responsible for all the field implementation. Moreover, the Bank maintained control over the RCH project from its headquarters in Washington D.C, with team leaders being based there and conducting bi-annual supervisory visits to India. Former staff from the Bank and MoHFW expressed that this long-distance style of

management, which is characteristic of the Bank's technical assistance, was problematic for a vast country like India that has 29 states, each of which could be a country in itself. Former Bank staff expressed how, often times, they felt overwhelmed at the size of public governance in the country.

Finally, the World Bank is not a monolithic agency. It is made up of multiple entities such as the management and the global HNP team based in Washington D.C, the regional and country-level HNP teams. Each of these units may have different priorities, which can act as a barrier in implementing a health project at the country level. The Bank's response to the corruption investigation during RCH-II illustrated this challenge of conflicting priorities between the Bank's multiple units. Bank management in Washington D.C were primarily concerned about governance and protecting financial resources from being wasted, and immediately suspended funds without consulting the HNP staff in India. The HNP staff in India would have addressed this issue in a different way, though; they were more concerned about maintaining their relationship with the ministries of finance and health as this would inevitably affect future lending as well as their own performance targets.

Organisational barriers - Ministry of Health and Family Welfare

Five organisational barriers at the MoHFW-level emerged from the analysis of the interviews. First, the central MoHFW and state health departments are led by elected members of parliament who are advised by civil servants, i.e. Indian Administrative Services (IAS) officers. IAS officers are thus the top-level decision-makers when it comes to health policies and programmes in India. Former staff from the MoHFW (many of whom were retired IAS officers themselves) and the Bank complained that recurrent transfers of IAS officers, which is a characteristic feature of the Indian civil service, led to a loss in momentum and majorly affected project implementation, as articulated by a former MoHFW staff member below:

> I stayed for four years in the ministry, so I could do something. Short tenures are common, for which the Bank is not responsible, we fellows are. You get some really good officers, you work with them, make progress, and then they are transferred...that was a big loss. With frequent change of personnel, the money goes down the drain.

Second, former staff from the MoHFW pointed out that at the state and district-level, public health programmes are typically managed by medical doctors. However, the Indian medical education system does not train medical doctors in public health management, and the lack of such kind of training was reflected in the inefficient management of RCH project. Third, the majority of my interviewees spoke at length about how the success of any health project relied heavily on the management capacity, organisational culture, and leadership in the state health department. A former Bank employee recounted what they saw as the difference between state capacities:

> Tamil Nadu had good management systems and managers. You go to Bihar and you would find the exact opposite. They did not know how many midwives or community health workers they employed, at grassroots people were not paid, no one in clinics, no human being or medicines. If the leadership in the (state) health department were interested in improving maternal and child health, then things would move ahead; if they resisted change, then activities would get stalled. We tried…

Fourth, the MoHFW has a weak central human resources system, which inevitably affected project implementation (Government of India, 2012). While the RCH project enabled the MoHFW and state governments to increase the

number of contractual staff, their productivity and morale were affected due to delay in renewal of contracts and payments, poor service conditions and increments, ineffective appraisal system, and lack of regular and updated skill-based training. Finally, weak governance and accountability in some states, especially in the form of corruption, was a major organisational barrier. A former staff from the MoHFW shared their reasoning for the widespread corruption within the public health sector.

> It starts with the officers being poorly paid. Some of them think that the way to get ahead is to not rock any boats. It can be difficult even if you didn't want to participate in collusion because you could get blackballed. I think in some ways it works like the mob system.

On being asked if the governance practices promoted by the Bank - such as procurement and financial monitoring - had made any difference to the corruption levels, many of my interviewees said that while the process of change had begun, it would require influential persons from within the central and state governments to take charge and build accountability. More importantly, endemic corruption was said to be symptomatic of the larger problem of weak stewardship by the MoHFW. Several former Bank staff admitted that they found it rather difficult to approach this issue of stewardship after the corruption investigation. This discomfort was articulated by a former member of Bank staff as follows:

> When I was there, it was kind of a non-starter as you couldn't use the words governance or stewardship. These words would stand for corruption. During the investigation, some officials just hated us, not us, but what the Bank stood for. So, it was very hard for us to have any engagement on the theme of stewardship because that became the code work for corruption or

anti-corruption. The Bank talks a lot about it globally but it is not clear how to address it in a country project.

8.3 Conclusion

In this chapter, I traced the process of the design and implementation of the RCH project in India and showed how the World Bank exerted its influence over the Ministry of Health and Family Welfare to achieve six outcomes for improving maternal and child health in the country. These were: (1) a target-free policy for family planning, (2) priority for reproductive and maternal health, (3) decentralisation for public health programmes, (4) SCOVA platform for monitoring financial flows, (5) a strengthened procurement system, and (6) increased central funding for reproductive, maternal, and child health. I summarise below the six major findings emerged from this analysis in this chapter.

What was the World Bank's overall influence vis-à-vis the RCH project?

The Bank had a *partial influence* on most (four out of six) of the outcomes, which means that the Bank supported or promoted an outcome that was initiated and driven by other domestic or international actors. The Bank had a *substantial influence* on one outcome i.e. SCOVA platform for monitoring financial flows, wherein it led the outcome but with the support of other actors. There was only one outcome over which the Bank had a *major influence*; i.e. a strengthened procurement system. The Bank was the main driver for this outcome, and on the basis of my data it does not seem feasible that it would have occurred without the Bank's intervention.

What resources and mechanisms did the Bank use to exert its influence?

Bank staff employed four types of resources to exert its influence: financial, technical, knowledge and network-based. Furthermore, Bank staff used these resources through a range of mechanisms to influence the six outcomes; specifically: policy dialogue, access to the ministry of finance,

local intermediaries, framing, financial arrangements, donor coordination, and partnerships.

Policy dialogue, mainly through consultation meetings, was the most commonly used mechanism. Bank staff engaged senior officials from the MoHFW and state governments and promoted or supported the outcomes. *Financial arrangements* were the second most commonly used mechanism by the Bank. These arrangements included: (i) inducement by disbursing a loan for a population project and getting the MoHFW to sign up to the RCH project, (ii) quick and flexible disbursement of financial resources for state governments, and (iii) negative sanction by suspension of loans for RCH-II as well as other health and public infrastructure projects to get the MoHFW to adopt governance practices.

Bank staff also used their connections with *local intermediaries* in the MoHFW to initiate discussions around the outcomes. Given their presence in India since the 1950s and the longstanding borrowing relationship, Bank staff got a seat on the table with *local intermediaries* in the MoHFW, which was an advantage over other international and local actors. Archival records showed how the Bank staff from Washington D.C and the India country office were in regular correspondence with top-level IAS officers from the MoHFW, who ultimately enabled the 6 outcomes.

What can be said about the sustainability of the outcomes influenced by the Bank?

For any outcome to be sustainable, it has to move from an ideational (concept) stage to being implemented, and then finally, it must be institutionalised, which implies that it has to be written into the system and continually practiced. I showed how four outcomes are still in the implementation stage where they are practiced in a few and not all the Indian states, while two outcomes – namely, priority for RCH and decentralisation for RCH programmes - have become institutionalised, which means that they are present or practiced across all the Indian states. A key finding here is that

while the Bank exerted its influence over these outcomes, ultimately it can only do so much as it is the domestic nodal agency i.e. the MoHFW and its state health departments that implement and institutionalise outcomes.

What factors affected this process of influence?

The Bank and the MoHFW do not work in a silo; instead, they operate and take decisions within a dynamic and constantly changing environment. This process of donor influence is thus affected by contextual factors at the country-level as well as barriers at the organisation-level. In the case of contextual factors, consider RCH-I where the MoHFW was more receptive to the Bank's recommendations and the major reason for this acquiescence was India's weak economic situation and its subsequent need for steady cash to run its health programmes. The Bank's loans during this window thus gave it tremendous influence over the design of RCH-I. In RCH-II, though, India was able to finance the majority of the project costs; this improved economic position of the Indian government appears to have reduced the Bank's influence.

This process of donor influence is also affected by structural barriers that exist within both the organisations. For Bank staff, meeting lending targets in a country takes precedence over programmatic goals. As a result, they pay more attention to financial management tasks such as engaging ministries of health and finance to apply for loans, and monitoring the disbursement, utilisation and repayment of loans. Because of its primary position as a lending agency, the Bank has access to the central government wherein it can influence policy and programme design to a certain extent. Yet, it has no access or influence at the district and local community-level. I found that at no point in the design and implementation of the RCH project did Bank staff conduct any participatory consultations with the beneficiaries (women, children, and families) or the frontline health cadre (such as ASHAs, ANMs and Anganwadi workers) that actually drive most of the health programmes in the communities. This lack of inclusion of the voice of local communities

could be because the Bank considers the central government of a country as its client rather than the actual beneficiaries of the policies or programmes that it tries to influence. Even if the Bank attempts to redress its own organisational challenges, it cannot really change the structural deficiencies within the Ministry of Health and Family Welfare such as the power imbalance between central and state governments, varying capacities across states, recurrent transfers of IAS officers, and weak governance and stewardship.

What does the RCH project tell us about the Bank's conceptualisation of maternal and child health?

After the realisation that the target-based approach that it previously endorsed, was not effective in reducing India's population, the Bank pursued the RCH project, and used it as a platform to advance population control albeit with a new language i.e. *reproductive and child health*. RCH-I was donor-driven, and the Bank had substantial influence over its design. While the RCH-I project document explicitly stated its overall objective as stabilising population growth (World Bank, 1997, p.1), another Bank document described RCH-I as a project that offered practical ways to promote family planning without emphasising on sterilisation targets (World Bank, 1999, p. 7).

Through the RCH-I, the Bank promoted a shift from a focus on demographic targets to a reproductive approach which was based on the needs of the client. Three issues arose with this rhetoric and subsequent practice. First, the client was the married woman, rather than a couple and unmarried women and men. Second, the client was offered narrow opportunities of choice; specifically, sterilisation and intrauterine device, and sparingly, the oral contraceptive pill. These matched the intention of providers wanting to limit births. Third, reproductive health services including treatment for reproductive tract infections and sexually transmitted diseases were provided without training health staff in gender sensitivity (Santhya, 2003). More

importantly, RCH-I lacked any consideration of the social determinants that affect a woman's autonomy over her own reproductive health (Simon-Kumar, 2007). Finally, in RCH-II, after the corruption investigation, a Bank evaluation raised caution to lend more money to this area in India and also proposed lending for immunisation instead, wherein financial resources were easier to control through existing procurement systems and also showed immediate results (World Bank, 2012, p. 25). My interview with a former Bank employee confirmed this caution and shift towards immunisation. Furthermore, RCH-II allocated around 30% of its total budget to polio operations (World Bank, 2006).

At best, the World Bank appears to have had a catalytic influence over the Ministry of Health and Family Welfare. This was mainly through its financial resources and arrangements, especially during a window when the Indian government was in a weak economic position. However, if the Bank wants to continue to stay relevant in a country like India and actually improve health indicators, it will need to rethink its intervention-focused and metrics-oriented approach for reproductive, maternal and child health. More importantly, the Bank will need to redress and reform its own organisational barriers and shift its engagement beyond the central government to the state, district, and local community levels.

Chapter 9 Discussion and Conclusions

9.1 Introduction

In this thesis I have sought to study the influence of the World Bank in maternal and child health over the last five decades, starting from 1970, when the Bank forayed into lending for health. I studied this overarching research aim at two levels. First, at the global-level, I examined the Bank's contributions to this area from 1970 to 2018. Second, at the country-level, I explored and ascertained the process and degree of the Bank's influence in this area through the Reproductive and Child Health Project in India. Drawing on multiple sources of data including archival records, financial datasets, published scientific and grey literature, and qualitative interviews with thirty actors, I have provided an account of the World Bank's involvement in maternal and child health at the global-level, and an assessment of its influence at country-level. To my knowledge, this doctoral research is the first study that offers such an examination of the World Bank's contributions and limitations, and the level of its influence in the field of maternal and child health. I also developed a novel conceptual framework of donor influence and used this to appraise the World Bank's involvement in India. In this chapter, I will unpack the key findings from my study and discuss its implications; describe the conceptual, empirical and methodological contributions of this thesis; outline the future avenues for research; and conclude with reflections on the World Bank's relevance for maternal and child health.

9.2 Key findings

9.2.1 How has the World Bank's conceptualised maternal and child health over time?

Three key findings around the Bank's conception of maternal and child health have emerged from this doctoral research. First, the Bank's conceptualisation of maternal and child health has evolved over time. In the first two decades of

Bank lending for population control and nutrition, maternal and child health had an instrumental value as lending for this area was justified with an economic rationale. Women of reproductive age were viewed as conduits for reducing fertility, while healthy children were seen as productive members of a country's workforce, and reduced fertility and improved productivity would ultimately lead to economic growth. However, with the Safe Motherhood Initiative in 1987, Bank health specialists framed maternal health as an ethical, social justice and developmental imperative (Storeng, 2010), albeit having multiplier effects for child and household health, societal productivity, and economic growth (Herz and Measham, 1987). In the 1990s, despite the Bank's wholehearted participation in the International Conference for Population and Development and its subsequent espousal of the shift from population control towards a voluntary reproductive and child health, its financial flows for this decade showed the highest ever commitment for population control projects ($1.78 billion). This gap in rhetoric and practice demonstrated that the Bank's approach for reproductive and child health was still grounded in fertility regulation, in that birth control was now shifted from the domain of family planning into the realm of individual rights and reproductive health. Since the 2000s, through its global health initiatives for MCH, the Bank aimed to save the lives of women and children, while also linking these goals to increased economic growth for participating countries (GFF, 2019; World Bank, 2007).

Second, the Bank has moved from a selective to a comprehensive approach for maternal and child health. The Bank started out with a selective approach by focusing on population control and nutrition projects in the 1970s, which continued through the 1980s, through its funding for selective programmes such as training of traditional birth attendants and child immunisation. In the 1990s, the Bank institutionalised this selective approach by promoting an essential package of interventions for reproductive, maternal and child health through its country-funded projects, which were cost-effective and reduced the highest number of DALYs (disability adjusted life years). Getting governments to eliminate spending on any discretionary clinical services and

just focusing on a cost-effective package for the poor (World Bank, 1993) was problematic as it ignored other health ailments that burdened women and children in their reproductive and pregnancy phase, such as tuberculosis. This selective approach also went against the agenda of health as a basic human right and the role of the state in the universal provision of health, as advocated in the Alma Ata conference in 1978 (WHO and UNICEF, 1978). Currently, through its global health initiatives like the Global Financing Facility, the Bank promotes a comprehensive approach for maternal and child health as demonstrated by its increased funding for interventions across the RMNCAH-N continuum, health systems strengthening, and multi-sectoral areas including education, water and sanitation, and gender-based violence.

A third finding is the shift over time of the Bank's focus on public sector involvement in the 1970s and mid-1980s to promoting the private sector in the 1990 and currently embracing the public-private partnership model, which has implications for the delivery of maternal and child health services. Until the mid-1980s, the Bank emphasised on public sector provision of maternal and child health services. However, after its influential publications from the mid-1980s onwards (World Bank, 1993; World Bank, 1987; de Ferranti, 1985), the Bank promoted private sector involvement for health service provision, especially at the secondary and tertiary level. While private sector involvement was justified to improve the efficiency and quality of health care, this approach crowded out poor individuals who were not able to afford the direct (user fees) and indirect (loss of wages and transport) costs of health care. Currently, the Bank promotes public-private partnerships (PPPs) through Gavi and the Global Financing Facility. In PPPs, private entities provide public health services, bearing significant risk and management responsibility, and get remunerated based on performance (Leigland, 2018). PPPs do have benefits in that they raise financial resources for maternal and child health services, incentivise private sector to deliver services on time as they are linked with payments, and fulfill the demand for health services especially in areas with no public health infrastructure or capacities (World

Bank, 2016). However, with PPPs, costs for paying the private sector have to be borne by the state or the individual, and these costs could fluctuate. Furthermore, evaluations of Bank-led PPPs have shown how this mechanism can be costly for governments and can take away limited financial resources that could have been used to strengthen primary health care facilities (Webster, 2015; Marriott 2014; Ravindran, 2011).

A promising finding is that over the years, the Bank has moved from a selective approach for maternal and child health programmes towards a more comprehensive agenda as demonstrated by the increase in its lending for health systems strengthening and multi-sectoral issues. Furthermore, the Bank has also shifted from a focus on public sector provision of maternal and child health services from the 1970s until the mid-1980s, to private sector involvement promoted by its World Development Report. The Bank currently promotes public-private partnerships through its global health initiatives for maternal and child health.

9.2.2 What can be said about the World Bank's influence in maternal and child health at the country-level in India?

The Bank exerted its influence over the Indian Ministry of Health and Family Welfare (MoHFW) vis-à-vis the Reproductive and Child Health (RCH) Project, to implement six policy outcomes for maternal and child health. These were: (1) target-free policy for family planning, (2) priority for reproductive and maternal health, (3) decentralised planning of maternal and child health programmes, (4) SCOVA platform for monitoring of financial flows, (5) strengthened procurement system, and (6) increased financing for maternal and child health. In a scenario where the Bank was missing from the Indian landscape, would the MoHFW still have implemented these outcomes for maternal and child health? While it is difficult to respond to such a counterfactual question, through this study, I showed that at best, the Bank's influence was catalytic, in that it nudged the MoHFW to implement six policy outcomes, many of which were already being considered within the government circles.

Overall, the Bank had a *partial influence* over four out of six policy outcomes, where it supported or promoted an outcome that was initiated and led by other actors. Furthermore, the Bank had a *substantial influence* over the outcome of SCOVA, a platform for monitoring financial flows from the central government to district level; where it led the outcome, albeit with the support of other actors. Finally, the Bank had a *major influence* over one outcome - strengthened procurement system, wherein it was the main driver of this outcome. Note that the Bank had the maximum influence (i.e. *major* and *substantial*) on areas like financial monitoring and procurement systems where it has financial and technical expertise.

The Bank exerted its influence over the MoHFW by using four types of its resources (financial, technical expertise, knowledge products, and networks) and seven types of mechanisms for exerting influence. These were: policy dialogue, access to the ministry of finance, local intermediaries, framing, financial arrangements, donor coordination, and partnerships. As illustrated in the India case, the Bank's biggest competitive advantage are its financial resources and arrangements and its longstanding lending relations in countries, which enable Bank staff with the access to local intermediaries or policy-makers in the central government.

Even with these resources and mechanisms at its disposal, the Bank's ability to influence a domestic nodal agency is shaped by the contextual factors in a country (such as politics, economy, and societal barriers) and the structural barriers within its own organisation as well as in the domestic agency. The biggest organisational impediment for the Bank is its primary goal of lending that drives its decisions to finance and design projects in a certain way, and can also take away time and attention from project design and supervision. Bank staff in the India country office were often preoccupied with coordinating loan requests from the MoHFW to meet lending targets that were set in Washington D.C, and monitoring the disbursement, utilisation and repayment of these loans, and safeguarding resources from corruption. Amidst the corruption scandal, the Bank's evaluation of RCH-II expressed

caution to lend more money for health projects in the country and also proposed lending for selective interventions like child immunisation as it was easier to monitor the procurement and implementation of such areas (World Bank, 2012, p.28).

Moreover, despite its financial muscle, technical expertise, and intellectual power, the Bank's HNP staff were still a small team and the vast scale of public sector governance in a country like India made it challenging to control every aspect of the project implementation, supervision, and mid-course corrections. This finding underscores the need for the Bank to reconsider its approach for designing maternal and child health projects in big countries. Instead, the Bank should support district or state-level projects as against national-level programmes, as this will offer scope for greater engagement with the government's district implementation teams and local communities, which is where health services ultimately get delivered.

Most importantly, the India case study raised the issue of the complete absence of the voice of women and children, local communities, and frontline health workers in the Bank's consultation processes during the design and implementation of the RCH project. The MoHFW is at fault here as well, as Bank-funded projects are designed and implemented through joint consultations between government officials from the MoHFW and Bank staff. It is vital that the Bank and the MoHFW consult the actual beneficiaries of maternal and child health services and the local and district-level service providers and project managers ahead of any project design, as this will ensure that the ground reality including local needs, barriers and facilitators is understood and is used to inform the project. While the government of India is the Bank's client with respect to borrowing and repaying of loans, the Bank needs to view local communities as the more important client if it wants to ensure effective project implementation and impact health outcomes.

Finally, Bank staff need to be cognisant of the reality that despite their ability to influence (i.e., in the form of its resources and mechanisms at disposal), the sustainability of the policy and subsequent health outcomes ultimately

lies within the remit of the domestic agency and that the structural barriers within this agency. Thus, Bank staff need to work closely with their counterparts in the domestic agency and offer technical advice to address structural barriers. In the case of India, such barriers include the lack of continuity of senior Indian Administrative Services officers (policy makers), weak human resource policies, and institutional capacities at the state-level.

Finally, the analysis of the Bank-funded Reproductive and Child Health project at the country-level in India, showed that the Bank focused on technical interventions with little attention to addressing the social determinants of maternal and child health. Here, the Bank pursued a 'clinic model' with the assumption that once this package with services for RTI and STIs were provided, women would come to the health facility and avail of these services, thereby realising their reproductive rights. However, this approach failed to examine or target the social determinants at play - such as gender norms, poverty, caste, class, and education - that affect women's autonomy over reproductive health in several LMICS with deeply patriarchal societies (Sanneving et al., 2013; Qadeer, 1998). Moreover, by ignoring the social determinants, the onus of improving reproductive and child health is placed entirely on the individual woman.

9.2.3 What does the country case study tells us about the Bank's position for maternal and child health at the global level?

While the India case study provides insights around the Bank's influence in maternal and child health at the country level, it also offers an opportunity to examine if the country-level findings reinforce or depart from what the Bank's rhetoric and practice for this health area. Overall, the India case study confirms and reinforces most of the Bank's technical approach and financing decisions for maternal and child health made globally.

To begin with, the India country experience in the 1960s informed the World Bank's foray in population control in the 1970s. First, in the 1960s the Bank

initiated policy prescriptions for population control to the government of India, including incentivising a target-driven approach and integrating population control activities into maternal and child health services. In the 1970s, the Bank used its experiences in India to inform its global approach, by mainstreaming population control into existing public health and maternal and child health platforms in other country level projects (1978 Malaysia loan is a case in point). Throughout the 1970s and 1980s, Bank lending in India focused on population control and nutrition, which reinforced what the Bank was doing at the global level.

In the 1990s, the Bank's projects in India reinforced two major policy decisions that it promoted globally. First, the Bank-funded Child Survival and Safe Motherhood and Reproductive and Child Health (RCH) projects implemented a package of essential health interventions and promoted the private sector for non-essential health services, just as it endorsed in its influential 1993 World Development Report (WDR). Furthermore, in this decade, the Bank espoused the shift from a target based population control to a voluntary reproductive and child health approach globally through its participation in the International Conference for Population and Development, and promoted the same in the RCH project in India. However, this semantic rhetoric for an individual, needs-based reproductive approach was not aligned with actual practice at the global or country level in India. Globally, in this decade, the Bank allocated its highest ever financial commitment for population control projects. Similarly, in India, Bank documents clearly stated that the RCH project was ultimately aimed to stabilise the country's population and it offered practical ways to promote family planning without emphasising sterilisation targets.

Since the 2000s, globally, the Bank has increased its financing for health systems strengthening through its maternal and child health projects. Financing for this thematic area has been seen in the Bank's MCH projects in India as well. Finally, the India case study also reinforces the Bank's evolving

financing approach for maternal and child health. Over the last five decades, globally and in India, the Bank has moved from lending for public sector provision of maternal and child health services from the 1970s until the mid-1980s, to its promotion of private sector involvement, and its current espousal of public-private partnerships.

9.2.4 Has the World Bank been a progressive actor for maternal and child health over time?

As of my informants, a former World Bank staff, said, “At the end of the day, the Bank is a bank. You know….it makes its money by lending, so that is always going to be the focus.” This eloquent quote drives home the fact that the Bank has a mandate of economic growth and to achieve this, it will continue to use its primary tool of intervention i.e. loan financing. Almost 99% of the Bank’s funding for maternal and child health to low and middle income countries is in the forms of loans that carry interest and fees. Lending as a characteristic feature of the Bank has been a major constraint in its operations for maternal and child health. In chapter five, I have shown how Bank financing for MCH has been allocated to countries that not only have a high disease burden but also a fiscal capacity to repay loans. Lending can also increase the risk of debt distress among borrower governments.

Despite this internal constraint, the World Bank has, to some extent, been a progressive actor for maternal and child health over the last five decades. It has done so in two ways. First, financially, the Bank was the fifth largest channel for overall development assistance for maternal and child health, and disbursed a total of $24.6 billion through its country-level projects from 1970 to 2018. Half (53%) of the Bank’s health sector funding is allocated to maternal and child health, highlighting the significant position of this health area within the Bank. Through its country-level projects, the Bank has engaged borrower country governments and other donors to expend their financial resources. In so doing, it has increased net contributions to this area. The Bank has got country governments to invest its own domestic resources along with its IDA and IBRD credits (loans) and grants in RMNCH

programmes, thereby raising the political priority and overall country-level financing for this area. Additionally, the Bank has provided grants for RMNCH through its special health programmes and trust funds.

Second, the Bank has also played a key role in advancing maternal and child health through its cooperation with international stakeholders such as the UN agencies, international donor agencies, and NGOs. It has done so through its partnerships including the Special Programme of Research, Development and Research Training in Human Reproduction, Taskforce for Child Survival, Child Vaccine Initiative, and the Partnership for Maternal, Newborn and Child Health, and global health initiatives such as Safe Motherhood, GAVI, Health Results Innovation Trust Fund, and the Global Financing Facility. These partnerships and global health initiatives have raised the political priority for maternal and child health globally, and subsequently increased international and domestic financial resources for this health area across several high-burden countries.

However, certain internal factors have limited the World Bank's relevance in the area of maternal and child health: structural adjustment policies, risks carried by the Bank's trust funds and its innovative financing mechanisms, and the use of its normative and epistemic power to advance these mechanisms despite the lack of adequate evidence.

First, by promoting measures such as structural adjustment programmes, cost-recovery, and reducing the role of the state through increasing private sector involvement, the Bank undermined the access to and availability of health services for women and children, especially from socio-economically vulnerable communities. Despite the Bank's own acknowledgment of the negative consequences of the structural adjustment programmes (Elbadawi, 1990; McCleary 1990), the institution maintains a neutral stance about user fees illustrated in its HNP strategy where it favors both user fees where needed as well free care at point of service (World Bank, 2007).

Second, the Bank's increasingly used channel of trust funds and its innovative financing mechanisms including results-based financing (RBF), performance loan buy-downs, and sustainable development bonds, carry significant risks. While trust funds, like the HRITF and GFF, have increased overall financing for maternal and child health, their governance structures highlight a power imbalance that puts powerful donor states and philanthropic organisations in the driver's seat to select interventions and recipient countries that ultimately receive funding. While RBF has been promoted as an effective funding mechanism and can be used for interventions that are easy to monitor, internal Bank and external evaluations have demonstrated how this mechanism can have big opportunity costs without producing sustainable results. Furthermore, effective implementation RBF ultimately depends on the country capacity and context, and can pose a significant risk to a borrowing country when limited public resources (through Bank credits) are spent on areas with less proven impact. The performance loan buy-down, i.e. grants to buy down interest on a Bank loan, is problematic because these financial resources essentially make a round trip from the World Bank in Washington to the borrowing country and then back to the Bank as repayment for old debts, thereby not really serving the interests of the beneficiaries in the country: women and children. Sustainable development bonds, which are accessible only by countries eligible for IBRD credit, really cater to the interests of the private sector and short-change the borrowing governments, as they will be driven by donor priorities of profit rather than the need of a particular country.

Finally, the Bank has used its normative and epistemic power to influence and promote its ideas as legitimate, the most effective, and sometimes, the only way ahead, despite lacking concrete evidence. Through its health policy papers and reports (World Bank 2010, 2007, 1993, 1973), the Bank has couched within its economic language an instrumental and reductionist value for maternal and child health, such that this area is viewed as a mean to an end. The Bank's health financing reports from 1985 and 1987, as well as the

World Development Report from 1993, promoted neoliberal frameworks including cost recovery through user fees and reducing the role of state through private sector involvement and public-private partnerships. This has affected the access and affordability of quality health services to women and children, especially those who are poor and marginalised. Finally, despite the weak and inconclusive evidence on results-based financing from internal reviews as well as external studies, the Bank continues to produce knowledge for this mechanism through impact evaluations and increase its legitimacy and credibility through annual dissemination workshops and online courses and toolkits for government officials from borrower countries.

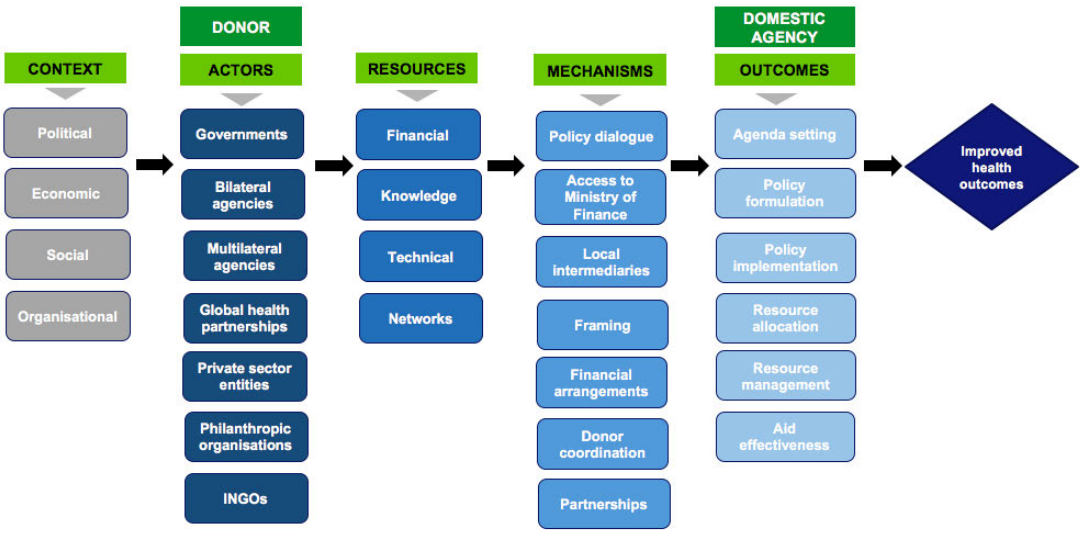
9.3 Contributions of this research study

Through this thesis, I have made the following conceptual, empirical and methodological contributions to the global health policy literature.

9.3.1 Conceptual

As shown in Chapter Two, while several empirical studies have examined or studied in part, the influence of institutional donors on any health policy area, none of the articles explicitly presented a conceptual framework for donor influence. In this thesis, I have developed and presented a novel conceptual framework of donor influence at the country level. This framework draws from theoretical literature and empirical studies on health policy from LMICS. This framework has four key components i.e., (1) contextual factors (2) resources (3) mechanisms and (4) policy outcomes of influence. Thus, this conceptual framework can be used to study the process in which an external donor exerts its influence over a domestic agency to achieve certain health policy outcomes, and what kind of contextual factors shape this process of influence.

Figure 9.1: Conceptual framework of donor influence in health policy in LMICS



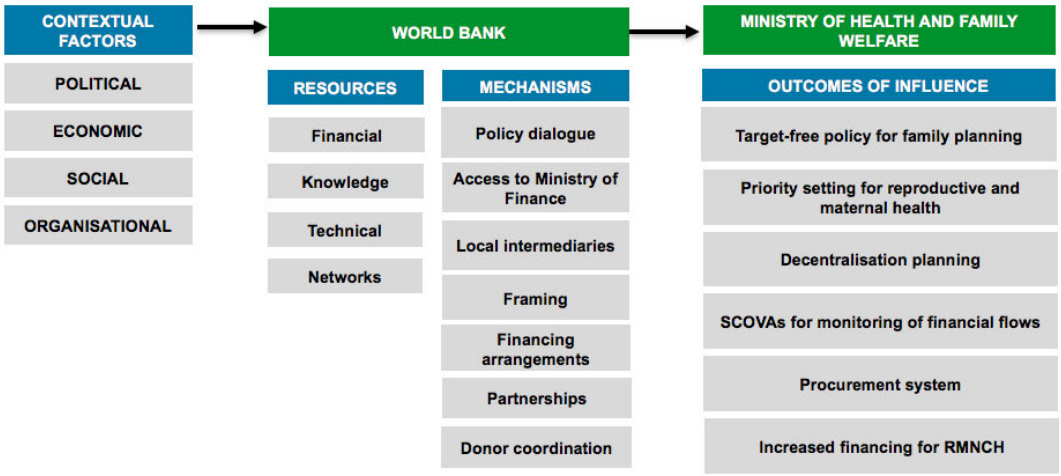
9.3.2 Empirical

I used the aforementioned conceptual framework of donor influence to better understand the role of the World Bank in the Reproductive and Child Health Project in India. First, I examined data from multiple sources including project reports, archival records and qualitative interviews, to trace the process of the design and implementation of the RCH project from 1997 to 2012. Second, I identified six major policy outcomes emerging from the data, which were verified by additional published and grey literature reports. Third, I analysed the data using the four key components of this conceptual framework: (1) contextual factors (2) resources (3) mechanisms and (4) policy outcomes of influence. Thus, I documented the process in which the World Bank used resources and mechanisms to influence the Ministry of Health and Family Welfare for six policy outcomes for maternal and child health.

Apart from unpacking the process of donor influence, I also discussed the degree of influence that a donor can have over a domestic agency – (i) no influence (donor had no influence), (ii) partial influence (donor supported or promoted an outcome that was initiated and led by other actors), (iii)

substantial influence (donor led the outcome, albeit with the support of other actors), and (iv) major influence (donor was the main driver of the outcome). Furthermore, I also developed a sustainability index, which informs us if a particular outcome is still being implemented or has been discontinued after a donor leaves.

Figure 9.2: Empirical framework of donor influence in health policy in LMICS



This framework of donor influence can be applied to other LMIC settings to examine the process of an external donor over a domestic agency and indicate the degree of the donor influence, as well as the sustainability of the outcomes it influenced. While I studied positive policy outcomes in this case study, this framework can also be used to study any emerging unsatisfactory or detrimental policy outcomes. Finally, this framework can help researchers and policy-makers examine the process of donor influence as well as identify the contextual factors, in particular the organisational barriers, which can then help with effective policy and programme implementation. This framework can thus be used retrospectively and prospectively.

9.3.3 Methodological

Through this study, I have also demonstrated a methodological approach to study an international organisation in global health at two levels. First, at the global level, I examined the contributions and limitations of the World Bank's

involvement in maternal and child health over a period of five decades by analysing its policies, programmes, and financing flows for this area. I conducted a scoping review of published and grey literature and Bank documents that discussed any maternal and child health-related policy, programme or activity funded or supported by the Bank. Similarly, I identified relevant archival records from the World Bank's Archives in Washington D.C. I extracted and analysed the Bank's financial flows for maternal and child health over the designated time period. Finally, I analysed the data under five chronological phases. In each phase, I discussed the Bank's major policies and programmes, corresponding financial flows, justifications for the Bank's involvement and the implications of the same. In doing so, I thus examined the major contributions as well as the limitations of the Bank's involvement in this area.

The twofold analysis of the Bank's policies and programmes for maternal and child health (chapter four) and its financial flows for this area (chapter five) demonstrated alignment over key findings, thereby also illustrating triangulation. This methodological approach to study an international institution has been collaboratively developed by the Global Health Governance Programme at the University of Edinburgh, and has been used to study the World Bank's role in tuberculosis and gender over time (Rahi et al., 2018; Winters et al., 2018; Mukaigawara et al., 2018). Second, through the conceptual framework and empirical analysis of the World Bank's influence for maternal and child health at the country-level, I have provided a roadmap to study the process in which an international organisation influences another organisation to achieve outcomes for a health area.

9.4 Avenues for future research

This study offers the potential for two areas of future research. First, the conceptual framework of donor influence developed in this thesis can be used to study the World Bank's influence on maternal and child health in another LMIC setting. This will help to further test and refine the framework,

thereby increasing its applicability and contributing to the field of health policy research. Such a study will first need to identify the two organisational units of analysis i.e. the donor (World Bank) and the domestic nodal agency in a country or state (province) setting. This study will also need to identify a donor-funded or supported programme or activity in the selected setting within a time frame, through which the donor's influence can be examined. A mixed methods research design is recommended for this study, wherein multiple sources of data are consulted, such as organisational documents, archival records, published and grey literature, and qualitative interviews of stakeholders. Triangulating findings from multiple sources ensures a rigorous approach that ensures completeness of data and provides a more comprehensive picture of the results than either approach could do alone, thereby increasing confidence in the findings (Heale, 2013).

While in this study, I interviewed stakeholders from the World Bank, domestic agency at the central government level (Ministry of Health and Family Welfare), and peripheral agencies, the future study could include stakeholder interviews at the state government and district level as well as in local communities to study the perception of donor influence of the donor agency, the domestic nodal agency at its different administrative levels, as well as of the local communities. Qualitative stakeholder interviews will help to identify policy outcomes of influence, which can then be verified by other sources. Additionally, interviews will also provide rich data on the process of influence (probing for resources, mechanisms, and contextual factors).

In this study, I analysed the Bank-funded reproductive, maternal and child health projects executed by the HNP practice. Future research needs to examine the World Bank's involvement in maternal and child health through other channels within the Bank. This can be done in three ways. First, a content analysis of all Bank-funded health projects in a selected country can be conducted to track the amount of money allocated to the thematic area of maternal and child health and trace the corresponding programmatic approach used. This design will allow us to gauge the Bank's influence on

maternal and child health vis-à-vis the overall health lending. Second, this similar approach can be used to study maternal and child health efforts in other global practices such as education, water and sanitation, and social protection. Third, further research can analyse maternal and child health-related projects, programmes, and trust funds financed by the International Finance Corporation. Such research can examine the role of the International Finance Corporation in this area; and more importantly, explore the pathways between private sector involvement and consequences on the access, affordability, and quality of maternal and child health services and subsequent health outcomes.

9.5 Recommendations

The World Bank is undoubtedly a major player in the global landscape for maternal and child health. It has contributed to shaping country-level policies and programmes and global health initiatives for this area, through its financial resources, and its cooperation with international donors and UN agencies. The Bank's overall significance as a lending agency for maternal and child health and its role as a progressive actor for this area will continue given the rise in its IDA and IBRD financing over time. However, leaders within the institution will have to consider certain programmatic and financing reforms in order to stay responsive in the field of maternal and child health.

While the Bank will keep framing maternal and child health as an economic case as it is primarily a financial institution that aims to help countries achieve economic growth, it will need to shift to a larger focus on considering maternal and child health for its intrinsic value first. Most of the maternal and child deaths occur due to preventable causes; these avoidable deaths are potential violations of human rights constituting social injustice. If and when an international financial institution like the Bank frames maternal and child health as a human right rather than primarily as an agent for economic development, other development agencies and borrowing country governments will follow suit. If maternal and child health is conceived

primarily for its intrinsic value, governments and donors will be rigorous in their pursuit of these goals regardless of whether this area is a trend or priority at the global level. Furthermore, a human rights-based approach will push governments and donors to aim for more than just providing access to and availability of health services, but also ensuring the acceptability and quality of such services (Kruk and Pate, 2019), and targeting social determinants to create an enabling environment for women and children to use such services.

The Bank will need to reorient its programmatic approach for maternal and child health by engaging beneficiaries, local communities, frontline health providers and district-level health managers to include local voices and perspectives to inform its project design. Interventions for improving maternal and child health outcomes will have to address health systems strengthening rather than the selective approach. Moreover, interventions will have to work on increasing individual agency and efficacy to access health services. For this, the Bank will need to consider and target the social determinants of maternal and child health such as poverty, class (income), caste, gender, tribes, education, even regional differences (rural versus urban). The Bank can leverage its intellectual power and support country governments to create a local repository of knowledge on the intersection between maternal and child health and social determinants and pathways to address these factors for effective interventions. Furthermore, the Bank will have to include multi-sectoral convergence in their maternal and child health projects at the country-level. Other programmatic reforms include the need to review of the implementation capacity of the domestic nodal agency in a country before approving a project. This step can facilitate an active discussion between the Bank and the country government to address capacity building as well as any contextual barriers that could impede the implementation of the project. In big countries such as India, the Bank must revise its scope of assistance and implement state and even district level projects rather than national-level efforts.

In terms of financing reforms, the Bank will need to realign its financing for the low income countries that have the highest burden of maternal and child mortality. Given the weak evidence base and risks for the government from the results-based financing and public-private partnerships, the Bank should promote these mechanisms with caution and use it only as a supplementary strategy to finance maternal and child health projects where appropriate. Instead, it should focus on developing sustainable strategies for raising domestic financial resources such as budgetary reallocation and strengthening tax capacity while avoiding the accumulation of unsustainable debt. The inherent nature of the Bank in terms of its multilateral nature, it wide membership, professional staff, and its production of knowledge, has given the institution a kind of legitimacy in that it is seen as apolitical and credible when advising and lending to borrower governments. However, is it legitimate for the Bank to exert its influence in maternal and child health?

As a financial partner, the Bank continues to play a significant role in this area globally and in India, which does make it legitimate for the Bank to exert influence to achieve sustainable goals such as a strengthened public health system, increased access, availability and affordability of maternal and child health. Although, as this thesis has shown, the Bank has also used its normative and epistemic power and its legitimacy to promote neoliberal frameworks and ideas (such as structural adjustment policies, results based financing mechanism) despite the evidence on its negative consequences or ineffectiveness. As argued by Shiffman (2014), what is needed is a scrutiny of such problematic ideas and policies when promoted without proper evidence and assessment by other actors involved, in particular the borrowing governments, as well as accountability mechanisms.

At the end of the day, the World Bank is a lending institution, and maintaining and expanding its business and raising profits from its lending is a predominant motive. Neoliberal policies are still a central component of the World Bank agenda (Stein, 2014; Storey, 2000), and this works against the

social justice frameworks that are much needed for maternal and child health and universal health coverage. This existential tension between the Bank's lending culture and its goals for improving maternal and child health is difficult to address. However, one way to start could be by including health in all of the Bank's lending. Similar to the 'Health in All Policies' (WHO, 2013), this recommendation proposes that for every Bank-funded project, the health implications of decisions including unintended negative consequences on access to health services, must be considered and addressed. While ambitious, such a reform could help to strengthen health systems through all of the Bank's operations and over time, support its credibility as a responsible development partner in global health.

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Appendices

APPENDIX 1: SHORTLISTED ARCHIVAL FOLDERS FROM THE WORLD BANK ARCHIVES

NO	FOLDER NUMBER	FOLDER TITLE	YEARS
1	1850806	Bernard R. Bell Files – India Family Planning - Correspondence	1964-1967
2	1837050	India – General – Economy – Population Control and Family Planning – Correspondence 01	1966-1968
3	1242231	United Nations Liaison Files – Population – Family Planning – Volume 1	1969-1975
4	30321110	United Nations Liaison Files – Population – Family Planning – Volume 1	1976-1983
5	1103504	World Health Organization – Special program of research development and research training in human reproduction (URP) – 1v	1978-1984
6	1103496	World Health Organization – General - Correspondence	1979-1986
7	1103421	Maternal and child health - Correspondence	1980-1980
8	1103408	Jason L Finkle/Crane Barbara Papers - Correspondence	1980-1984
9	1057528	Operational Policy – Population, Health and Nutrition – World Health Organization/International Bank for Reconstruction and Development Cooperative Program – 1981-1983	1982-1982
10	30159498	Policy and Research Unit –Population, Health and Nutrition. 2.2 Health financing, Volume 2	1982-1984
11	1103362	Contraceptive Research and Development – Correspondence – Volume 1	1982-1985
12	1103348	Annual meetings Seminar – John Evans – Correspondence August 1982	1982-1986
13	1102888	Anthony R Measham Papers - Correspondence	1982-1986
14	1103398	Alden Winship [AW] Clausen – Ernest Stern – Correspondence - PHND	1982-1986
15	1103483	United States Agency for International Development – Population - Correspondence	1983-1983
16	1046814	Policy and Research Unit – 14.2 – Population, Health and Nutrition. Input to Mr. Clausen Speeches Volume 1	1983-1984
17	1103354	Bellagio – Correspondence – Volume 1	1983-1984
18	1103909	Clausen	1984-1984
19	30159500	Policy and Research Unit – 14.2 – Population, Health and Nutrition. Input to Mr. Clausen Speeches Volume 2	1984-1984
20	30117088	Bellagio II – Conference of the Task Force on Child Survival – Volume 1	1984-1985

21	1104165	Policy and Research Unit – Population, Health and Nutrition. Strategy - Correspondence	1984-1986
22	1104166	Policy, Health and Nutrition. Work program - Correspondence	1984-1987
23	1102907	Maternal Mortality and Morbidity - Correspondence	1985-1985
24	1104167	Policy, Health and Nutrition. Objectives - Correspondence	1985-1985
25	1065148	Operational Policy – Population, Health and Nutrition – World Health Organization/International Bank for Reconstruction and Development Cooperative Program – 1984/1986 Volume 1	1985-1985
26	1103007	Task Force for Child Survival – Minutes of the Task Force – February 11 -12, 1986	1985-1986
27	1103897	Bellagio – Health Research for the Developed Word , Priorities and Strategies	1985-1987
28	30158265	World Health Organization – Volume 2	1985-1987
29	1103414	International Planned Parenthood Federation [IPPF] - Correspondence	1985-1987
30	1103454	Population, Health and Nutrition. External Strategy - Correspondence	1986-1986
31	405191	Reducing Maternal Deaths in Developing Countries – May 1986 – Lynn Weston – Population, Health and Nutrition Department	1986-1986
32	1102909	Proposed Conferences on Maternal Mortality - Correspondence	1986-1986
33	1103005	Safe Motherhood Conference – Donor Funding Correspondence	1986-1986
34	1103008	Task Force for Child Survival - Correspondence	1986-1986
35	1103012	World Health Organization / World Bank Strategy Meeting	1986-1986
36	30197617	Safe Motherhood Conference – Donor Funding Correspondence 1986/1987	1986-1987
37	30197606	Task Force for Child Survival - Bellagio	1986-1987
38	30197642	Contraceptive Research and Development – Correspondence – Volume 2	1986-1987
39	1104168	Policy, Health and Nutrition. Workshop - Correspondence	1986-1987
40	30197618	Safe Motherhood Conference – Donor Funding Correspondence	1986-1987
41	1102921	Safe Motherhood Conference – Press Files	1986-1987
42	1102920	Safe Motherhood Conference – Press Kit	1986-1987
43	30197619	Safe Motherhood Initiative – Proposals for Action	1986-1987
44	1102918	Safe Motherhood Conference - Correspondence	1987-1987
45	1123256	Presidential Speeches – Safe Motherhood Conference in Nairobi, February 10, 1987 - Speech	1987-1987
46	30197621	Safe Motherhood Conference – Donor Funding – Proposals for Action	1987-1987

47	1134203	Bellagio 3 – Conference of the Task Force on Child Survival - Correspondence	1987-1988
48	30251943	Child Survival and Safe Motherhood Project – India – Credit 2300 – P010387 - Correspondence	1990-1997
49	30158255	UN – World Health Organization – Correspondence – Volume 2	1991-1992
50	1293930	STUDY: POPULATION AND THE WORLD BANK – IMPLICATIONS FROM EIGHT CASE STUDIES – 1v	1991-1992
51	1720799	India – Aid Coordination – Trust Fund Agreement [TFA] – Maternal and Child Health - Correspondence	1991-1994
52	30084048	Reproductive and Child Health Project – India – Credit N018 – P010531 – General Correspondence – January 1995 – April 1995	1995-1995
53	30084053	Reproductive and Child Health Project – India – Credit N018 – P010531 – General Correspondence – May 1995 – June 1995	1995-1995
54	30083639	Reproductive and Child Health Project – India – Credit N018 – P010531 – Supervision – May 1995 – September 1995	1995-1995
55	30083638	Reproductive and Child Health Project – India – Credit N018 – P010531 – Supervision – October 1995 – November 1995	1995-1995
56	30251923	Reproductive and Child Health Project – India – Credit N018 – P010531 – Correspondence Volume 1	1995-1996
57	30083640	Reproductive and Child Health Project – India – Credit N018 – P010531 –Supervision - December 1995 – February 1996	1995-1996
58	30083629	Reproductive and Child Health Project – India – Credit N018 – P010531 – Supervision – March 1995 – April 1996	1996-1996
59	30083641	Reproductive and Child Health Project – India – Credit N018 – P010531 – Supervision – July 1996 – August 1996	1996-1996
60	30083633	Reproductive and Child Health Project – India – Credit N018 – P010531 – Supplemental Documents – January 1996 – June 1996	1996-1996
61	300083569	Reproductive and Child Health Project – India – Credit N018 – P010531 – Andhra Pradesh	1996-1997
62	1688826	Partnership, Conference, and Seminar Files-Safe Motherhood – Seminar Papers	1998-1998

APPENDIX 2: IN-DEPTH INTERVIEW GUIDE

1. Can you talk about your role at the [Institution]?
2. How did you start working on maternal and child health projects? Can you think of any memorable projects or activities in this area?
3. Can you comment on the state of government-funded maternal and child health services before 1990s?
4. How did you get involved in the Reproductive and Child Health (RCH project?
5. Can you talk about the design of the RCH project?
6. How was the RCH project implemented? Can you talk about differences (if any) in the implementation of the two phases of the RCH project?
7. Can you think of any challenges faced during the implementation of the RCH project?
8. How would you describe the World Bank's involvement in the project?
9. Can you comment on the relationship between the Bank and the Ministry of Health and Family Welfare during the RCH project?
10. Can you think of any best practices that were introduced into the health system through the RCH project? What do you think was the Bank's role in each of these practices? Do these practices continue to exist?
11. Were there any limitations around the Bank's approach for the RCH project?
12. In the current period, what do you think is the role of donor institutions like the World Bank in improving maternal and child health in the country?

APPENDIX 3: STUDY INFORMATION SHEET FOR INTERVIEW PARTICIPANTS

A STUDY OF THE WORLD BANK'S INVOLVEMENT AND INFLUENCE IN MATERNAL AND CHILD HEALTH

Background: The World Bank is one of the largest external donors in global health, with a total financial contribution of $2.2 billion for health-related projects in the year 2015.The Bank is also a major funder for reproductive, maternal, newborn and child health (RMNCH). The World Bank's involvement in RMCH can be traced back to 1970, when it released its first health loan of $2 million to Jamaica for a population control project. Between 1970 and 1980, Bank loans amounting to $401 million were released for 22 population control projects across the world. Since its first health loan in 1970 till the present, the World Bank has provided loans, credits, and grants to fund around 400 RMCH projects under its Health, Nutrition and Population (HNP) sector, with financial commitments amounting to nearly $21 billion. While the World Bank is an influential institution in the global financing landscape for maternal and child health, there is no comprehensive analysis that traces the Bank's involvement and influence in this area over the last five decades since its first health loan in 1971. This doctoral study aims to fill this gap in the global health literature on the World Bank and maternal and child health, and also provide a methodological contribution on studying the influence of a global institution in health. This doctoral research study forms part of a larger Wellcome-Trust funded project on the World Bank and Global Health, led by Dr. Devi Sridhar at the Global Health Governance Programme, Usher Institute of Population Health Sciences, University of Edinburgh.

Research aims and objectives: This study has two broad aims. First, it aims to construct the evolution of the Bank's involvement in maternal and child health at the global level, over the last five decades. At the second level, this study will zoom into the country case of India and examine the Bank's influence in maternal and child health policy and practice, through an

analysis of the Reproductive and Child Health project, implemented from 1997 to 2012.

Methods: The study will use a mixed-methods approach, consulting primary and secondary sources of data. Archived records at the World Bank and other relevant organizational sources will be consulted and thematically analysed. Qualitative interviews will be conducted with a purposively selected sample of key informants from the World Bank (Headquarters and India office), Indian Ministry of Health and Family Welfare, and relevant organizations. A quantitative analysis of World Bank-funded projects for maternal and child health (MCH) will be conducted to track financial and technical assistance in this area from 1970 to the present. Additionally, financial datasets from other relevant sources such as IHME, will be analysed to examine the Bank's investments within the larger landscape for MCH funding. Finally, secondary sources including published articles and relevant grey literature reports will be thematically analysed.

About the researcher: Genevie Fernandes is a PhD student based at the Global Health Governance Programme, University of Edinburgh. Prior to this role. She worked for 9 years as a researcher and program manager on maternal and child health, HIV/AIDS and tobacco control projects across 4 states in India. Her postgraduate training is in sociology and public health, and her undergraduate degree is in psychology and anthropology.

Funding agency: The doctoral study is part of a larger research project titled 'The Economic Gaze: The World Bank's Influence in Global Public Health', funded by the Wellcome Trust (Principal Investigator: Professor Devi Sridhar).

What about the ethical aspect of this research?

This study has been granted an ethics approval from the Usher Research Ethics Group, University of Edinburgh. In the interview, I will discuss with you and gain your consent on the level of anonymization you require, and how you will be referred to in the project outputs. Any information I have about

you and everything you say in the interview will be kept confidential. Your name and contact details will be kept separately from your interview transcript. I will be the only researcher with access to the transcripts.

If I agree to take part in this study, what will happen if I change my mind?

Even if you agree to participate, you can change your mind at any time and withdraw from the study by writing to me at genevie.fernandes@ed.ac.uk. I would then delete and destroy all notes or recordings (if any) of your interview.

Who should I speak to if I still have questions?

If you have any questions at all about this research you can contact me directly at genevie.fernandes@ed.ac.uk (or on the phone: +44 7424964961 [UK] and +91 9819047767 [India]).

Who should I contact if I have a complaint?

If you have a serious complaint about any aspect of this research study or researcher, please contact Professor Sarah Cunningham-Burley (Professor of Medical and Family Sociology / Dean of Molecular, Genetic and Population Health Sciences) at sarah.c.burley@ed.ac.uk

Thank you very much for your consideration.

APPENDIX 4: CONSENT FORM FOR INTERVIEW PARTICIPANTS

A STUDY OF THE WORLD BANK'S

INVOLVEMENT AND INFLUENCE IN MATERNAL AND CHILD HEALTH

Supported by wellcome trust

THE UNIVERSITY of EDINBURGH

CONSENT FORM

Please read each statement and **initial** the boxes.

- I confirm that I have read and understood the information sheet provided for this study. ☐
- I have had the opportunity to ask questions and have had these answered to my satisfaction. ☐
- I understand that my participation in this study is voluntary and that I am free to withdraw at any time without giving a reason. ☐
- I agree to take part in an interview as part of this study. ☐
- I understand that the interview will be recorded and then transcribed. ☐
- I understand that the information given in this interview forms part of a research project and that my words may be used in publications, reports and presentations - but that I will not be directly identified in these. ☐
- I understand that the audio recording will be kept after the end of the study, and that the transcript of the interview may be used by Dr Pickersgill in future research on related issues. ☐

Participant's Name (Printed): _____

Participant's signature: _____ Date: _____

Researcher's (Genevie Fernandes) signature: _____ Date: _____

Thank you for agreeing to take part in this study.

Your contribution is very much appreciated.

APPENDIX 5: ABSTRACT ACCEPTED FOR ORAL PRESENTATION AT A CONFERENCE

The following abstract based on findings from Chapter Five (i.e., Tracking the World Bank's financial flows for RMNCH) was accepted for an oral presentation at the International Health Conference, St Hugh's College Oxford, 26th – 28th June, 2019.

TITLE: Tracking the World Bank's Financing for Reproductive, Maternal, Newborn, and Child Health Projects from 1970 to 2017.

AUTHORS: Adriel Chen, Genevie Fernandes and Devi Sridhar

ABSTRACT: The World Bank is one of the largest funders for Reproductive, Maternal, Newborn and Child Health (RMNCH). We searched, coded and analysed 581 Bank-funded RMNCH projects from its online databases. Bank commitments and disbursements for RMNCH amount to a total of $29.8 billion and $24.5 billion, comprising of 58% of its total health lending over time. South Asia received the largest overall commitment ($8.3 billion). Thematically, Bank lending for RMNCH has evolved from family planning, to nutrition and infectious disease control, with a renewed focus on health systems strengthening; while also moving from project-based financing to a trust fund approach.

APPENDIX 6: PUBLISHED ARTICLE ON THE WORLD BANK AND THE GLOBAL FINANCING FACILITY IN THE BMJ

Fernandes, G. and Sridhar, D. (2017). World Bank and the Global Financing Facility. BMJ 2017; 358, j3395.The author (Genevie Fernandes) contributed to this publication in the conceptualisation, data collection and analysis, and writing the manuscript.

World Bank and the Global Financing Facility

In the fourth article of the series, **Genevie Fernandes** and **Devi Sridhar** describe the bank's new investment model for advancing reproductive, maternal, newborn, child, and adolescent health and nutrition

At the World Economic Forum this year, World Bank President Jim Kim proposed the Global Financing Facility (GFF) to donors as an innovative model for investing in reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N).[1] The World Bank believes that business as usual is not enough to close the annual financing gap of $33.3bn (£25.4bn; €28.4bn) to meet the 2030 sustainable development goals for RMNCAH-N.[2] Its latest offering—the GFF—is designed as a catalyst to close this gap, as every dollar invested by donors will be linked with $4 of bank credits, multiplying the effect of donor contributions in countries where action is needed the most.[2] Since its inception in July 2015 and implementation in seven high burden countries to date,[3 4] the GFF has been lauded and criticised in equal measure.[5 6] In this article, we explain the origins and mechanism of the GFF, and discuss the benefits and some initial concerns about this investment model.

KEY MESSAGES

- The Global Financing Facility (GFF), a multidonor trust fund, is the World Bank's latest investment model aimed at closing the annual financing gap of $33.3bn to meet the 2030 sustainable development goals for reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N)
- The GFF offers 62 high burden countries grants if they agree to invest their IDA or IBRD credits in results focused RMNCAH-N interventions, thereby matching each $1 of grant with $4 of bank finance
- Benefits of the GFF include promotion of universal health coverage and strengthening of health systems through increased mobilisation and harmonisation of development financing and domestic public and private resources.
- While the GFF model incentivises borrowing for RMNCAH-N, it also works with countries rising from low to middle income status to develop sustainable strategies for increasing domestic financing

Origins of the GFF

The GFF is a multidonor trust fund managed by the World Bank with financial commitments from bilateral donors and private foundations of more than $1bn (fig 1).[7] The GFF is based on the existing Health Results Innovation Trust Fund (HRITF) managed by the World Bank and supported by Norway and the UK through commitments of $575m from 2007 to 2022.[8]

The HRITF supports results based financing interventions whereby providers are paid on achieving planned indicators to improve the coverage and quality of maternal and child health services. Country programmes under the HRITF are financed by linking grants from the trust fund with credit from the World Bank's concessional lending arm—the International Development Association (IDA).[8] Evaluation of the HRITF showed that while results based financing improves service coverage and quality, albeit with variations across interventions, the key recommendation of a strategic, scaled, and sustainable framework that views results based financing as an entry point for tackling health system problems is not always easy to implement, especially in weak health systems.[8-10] The GFF grew out of this recommendation under the leadership of World Bank president Jim Kim and Tim Evans, the senior director of the health, nutrition, and population sector.[11 12]

Mechanism and governance of the GFF

The GFF retains two key features of its precursor—the HRITF. Firstly, the model focuses on results, and, secondly, it links grants with credits from the World Bank's lending arms—the IDA and the International Bank for Reconstruction and Development (IBRD).

Globally, the GFF seeks finance from donors to be disbursed as grants, and nationally, it links these grants with credits from the IDA or IBRD for RMNCAH-N projects in 62 high burden, low, and lower middle income countries.[2] For each $1 of grant, the GFF matches around $4 in credits from the IDA or IBRD, depending on the income level of the recipient country. This translates to a financial arrangement whereby countries choosing to invest credits from their national IDA/IBRD allocation in RMNCAH-N projects will be offered a grant from the GFF trust fund. While the grant encourages countries to use their IDA/IBRD credits for RMNCAH-N, this spending is substitutive and does not provide additional public expenditure in this area, as IDA/IBRD credits are essentially a country's own resources, although borrowed, which are invested in RMNCAH-N instead of other sectors. However, the GFF aims to form country driven partnerships for aligning financial resources from the GFF with additional investments from government, development, and private partners to meet RMNCAH-N goals.[2]

The governance of the GFF gives substantial decision making authority to the bank and the donors. At the heart of this structure is an investors group, which mobilises financing, and within this group is the trust fund committee, that decides which countries and projects are funded (fig 2). A GFF secretariat, staffed within the bank, manages and monitors the trust fund. GFF trust fund financing is integrated into IDA/IBRD country projects approved by the World Bank board.[13]

Membership of the investors group is based on financial or in-kind (technical or advocacy based) contributions, and institutional authority to align resources for RMNCAH-N projects, while donors form the trust fund committee members.[13] The investors group is chaired by the president of the global development programme of the Bill and Melinda Gates Foundation, and comprises one or two representatives from recipient and donor governments, international organisations (Gavi (the Vaccine Alliance) and the Global Fund to Fight AIDS, Tuberculosis and Malaria), private organisations (Merck for Mothers, Grand Challenges

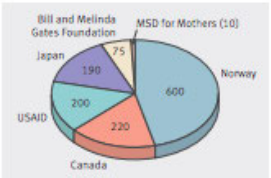

Fig 1 | Main contributions to the Global Financing Facility in $m[8] (MSD=Merck for Mothers)

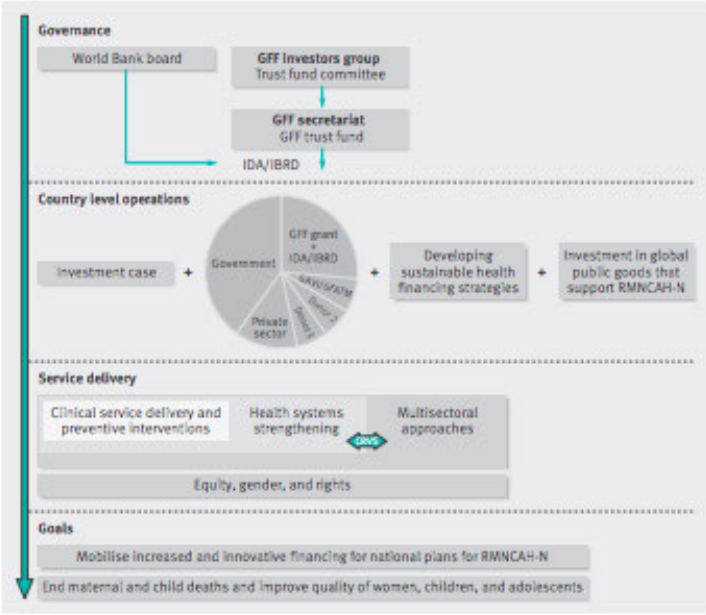

Fig 2 | Framework of the Global Financing Facility, adapted from the Global Financing Facility (GFF)=business plan.[3] CRVS= civil registration and vital statistics; GFATM= Global Fund to Fight AIDS, Tuberculosis and Malaria; IBRD=International Bank for Reconstruction and Development; IDA=International Development Association; RMNCAH-N=reproductive, maternal, newborn, child, and adolescent health and nutrition.

Canada, and Philips), private foundation (Gates), civil society (African Health Budget Network, Plan International, Population Council, RESULTS, and World Vision), and multilateral organisations (Unicef, UNFPA, World Bank, and WHO).[14]

Mobilising money for the GFF

Sixty two high burden countries that are willing to invest their IDA/IBRD funds in RMNCAH-N projects can apply for a GFF package. An investment case is the starting point of the GFF process. World Bank country staff work with recipient governments to develop an investment case, which identifies areas for action, corresponding obstacles, appropriate evidence based interventions, and costing, with an emphasis on alignment with national priorities. Design of the investment cases is financed by the GFF trust fund. The GFF trust fund committee and the World Bank board review the case and decide on approval and disbursement of funds.[3] As of April 2017, 16 countries had begun the GFF process and nine country projects have been approved, with a total commitment of $292m in grants and $1301m in IDA/IBRD financing[6 15] (v 1). While 12 of the 16 GFF countries received funds from the HRITF, the criteria for selecting frontrunner countries for GFF financing are unclear.

The GFF mobilises finances in four ways. Firstly, complementary financing is employed, whereby partners (donors) with in-country programmes, such as GAVI and the Global Fund, are encouraged to align their financial resources to meet mutual RMNCAH-N goals, thereby increasing efficiency and avoiding duplication of efforts. Secondly, the GFF works to increase government expenditure on RMNCAH-N through mechanisms ranging from technical assistance in managing public finances to making mobilisation of domestic resources a legal requirement. Thirdly, GFF grants are matched with credits from IDA/IBRD. The fourth route enlists domestic and international private sector resources through pathways such as development impact bonds, whereby investors provide capital for an intervention to reach planned outcomes, and funders (government and donors) pay only when the intervention succeeds.[2]

Table 1 | Approved financial commitments from the GFF trust fund and IDA/IBRD [16]

Recipient country	GFF Trust Fund $m	IDA/IBRD $m
Cameroon	27	100
Democratic Republic of Congo	50	350
Ethiopia	60	150
Guatemala	9	100
Kenya	40	150
Liberia	16	16*
Nigeria	20	125
Tanzania	40	200
Uganda	30	110
Total	**292**	**1301**

*To be confirmed. GFF=Global Financing Facility; IBRD=International Bank for Reconstruction and Development; IDA=International Development Association.

Interventions covered by the GFF

The GFF finances preventive and clinical interventions for RMNCAH-N, health systems strengthening, and multisectoral projects, with demonstrated effectiveness and focus on dealing with equity, gender, and rights. Apart from mobilising financing for the investment case, the GFF also works with countries rising from low to middle income status and thereby graduating from IDA to IBRD, to develop sustainable health financing plans. The GFF is building a global evidence base for health financing strategies for RMNCAH-N, and a centre of excellence on civil registration and vital statistics using funding from the Canadian government.[2] The GFF will invest in strengthening national monitoring and evaluation systems. It will include independent evaluations at the national and global level measuring the short term impact on efficiency, domestic resource mobilisation, and donor alignment, and the long term effect on coverage of interventions and health outcomes.[4]

Advantages of the GFF model

The GFF is 23 months old and still a work in progress. Nevertheless, there are five reasons why it could become a game changer in financing for maternal, child, and adolescent health and nutrition. Firstly, the GFF has the support of political leaders from leading donor and recipient countries and from the heads of key donor organisations, including the Gates Foundation.[5] Secondly, this model uses RMNCAH-N as an entry point for ensuring a basic healthcare package for women, children, and adolescents through a strengthened primary healthcare delivery system, thereby accelerating country level efforts towards universal health coverage.[15]

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Thirdly, it invests in broader health systems strengthening, such as the health workforce, supply chain management, and information systems, while also including multisectoral investments in education, water supply, and sanitation, which aid the upstream determinants of health and lead to improvements in population health.[2] Fourthly, by specifically including adolescents, who have previously been overlooked, the GFF can tackle preventable and treatable sexual and reproductive health problems, resulting in health gains for this group in later years. Finally, the GFF can use the bank's and financial expertise, coupled with political backing, to support governments in domestic resource mobilisation for RMNCAH-N.

Concerns about the GFF model

This investment model is not without potential disadvantages. Having the traditional set of donor agencies making key decisions can influence the selection of countries, choice of interventions, and disbursement of funds. Although this limitation has been tackled to an extent by the recent approval of the civil society engagement strategy,[16 17] a detailed action plan needs to be rolled out across all national GFF projects to ensure stronger civil society involvement.

Although the GFF's attempt to bring all national stakeholders and donors around the table advances the agenda of aligning goals and harmonising financial resources for RMNCAH-N, it may also become a risk to implementation. For instance, donors within a country may not be willing to commit to complementary financing based on the investment case, and development of a strong investment case itself is contingent on the capacity of the bank staff and the recipient government counterparts and the inter-relationships between the two. Mitigation of such risks needs to be built into the GFF.

The GFF focuses on results, and in investment cases of some countries, such as Ethiopia, it links disbursement with the achievement of progress indicators.[15] This can be problematic if measures are not built in to overcome any negative effects of failure to achieve results, ranging from demotivation of health workers to irregular payments. Furthermore, although grants have stimulated potential domestic resources in some cases, there is a risk that increases in external assistance might displace domestic government health spending.[18] The GFF can mitigate this risk by monitoring government health expenditures and establishing collaborative (and not prescriptive) goals based on the country context, to maintain or increase public spending.

If the GFF does attract increased contributions from sovereign bilateral donors, this shift in financing could also affect core contributions to the IDA and IBRD replenishments and, subsequently, project funding for other health areas. Furthermore, while leveraging and multiplying the effect of their contributions may be valuable for bilateral donors, foundations, and philanthropic groups, involvement from the private sector will require return on investment, and this is an area which the GFF will need to explore and fine tune its approach based on lessons from the frontrunner countries.

Conclusion

The World Bank's involvement in maternal and child health has evolved from family planning in the 1970s[19] to child survival and safe motherhood in the 1980s,[20] to advocating reproductive and child health in the 1990s,[21] to more recently, adopting the RMNCAH approach covering life course interventions for women, children, and adolescents.[2] With the addition of an 'N' to include nutrition, it is increasingly clear that the comprehensive RMNCAH-N framing could be the bank's strategy to broaden the appeal of investments in strengthening health systems. The GFF presents an attractive avenue for such investments, with an emphasis on domestic resources. This investment model also takes the bank into the heart of domestic resource mobilisation by allowing it to work closely with governments on improving efficiency and revenue generation, and prioritising health in budgets.

Contributors and sources: GF is a researcher from India, and currently, a PhD student at the University of Edinburgh, studying the role and influence of the World Bank in maternal and child health over the past four decades. DS holds a Wellcome Trust investigator award on the role of the World Bank in global health and is the coauthor of *Governing Global Health: Who Runs the World and Why?* (OUP, 2017). Data analysed for this series included World Bank financial datasets, archival sources, publications and reports, and staff interviews. GF collected the data, analysed it, and drafted the initial version of the paper. DS helped conceptualise and design the study and revised the draft.

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