



FROM CATASTROPHE TO CATALYST

Can the World Bank make COVID-19 a turning point for building universal and fair public healthcare systems?

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COVID-19 has exposed the widespread failure to invest in strong and universal public health systems, putting millions of lives at risk and dramatically widening health inequalities. Oxfam analysed the World Bank's emergency health funding to 71 countries in response to the pandemic. While its response has been rapid and significant, we find the World Bank has missed vital opportunities to strengthen public health systems so they can tackle COVID-19 and deliver health for all in the future. Oxfam's research finds that 89% of projects do not plan to support any action to remove financial barriers, including user fees, that exclude millions from life-saving care; and two-thirds lack any plans to increase the number of healthcare workers. An urgent course correction is needed to help countries effectively fight the pandemic and build fairer, more resilient universal healthcare systems.

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For further information on the issues raised in this paper please email advocacy@oxfaminternational.org

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Cover photo: Nishi Stephen, a staff nurse at a primary health clinic in Bihar state, eastern India. (2018). Photo: Atul Loke, Panos/Oxfam

SUMMARY

The COVID-19 pandemic has plunged countries around the world into an extreme health and economic crisis. In countries that lack free quality healthcare for all, people in poverty are more likely to go without testing or treatment, and the pandemic could push up to half a billion *more* people into poverty.¹ The International Monetary Fund (IMF),² World Bank and Organisation for Economic Co-operation and Development (OECD) have all warned that COVID-19 is likely to lead to an increase in inequality in almost every country, in what the World Bank President has called an ‘inequality pandemic’.³

COVID-19 has shown the world how our health is fundamental to our collective security, safety and prosperity. The pandemic has also exposed long-standing and fatal cracks in health systems, especially in low- and middle-income countries, that have seen their public finances hollowed out by decades of austerity policies and a rigged global economic regime.

Today, these nations face vastly increased demand for health services, alongside the brutal financial squeeze of recession,⁴ burgeoning debt,⁵ and further austerity measures.⁶ The pandemic is overwhelming health systems, and reducing access to other life-saving services, especially for people in poverty and women. In Kenya, for example, maternal health resources and workers have been redeployed to tackle the virus,⁷ and globally, reduced perinatal care due to COVID-19 could cause maternal deaths to increase by between 8% and 39% each month.⁸

In response to this crisis, the World Bank has stepped up, and provided rapid and substantial financial support to low- and middle-income countries. In March 2020, it announced \$6bn in initial health funding through the COVID-19 Fast Track Facility, part of \$160bn in broader pandemic financing across sectors. In April the Bank’s Board of Directors approved a COVID-19 Strategic Preparedness and Response Program (SPRP), providing a framework for recipient-country projects under a Multiphase Programmatic Approach (MPA). This framework underlines the importance of rapid disease response and containment measures as well as broader health system strengthening, and indicates support for investing in prevention, health workers, and removing financial barriers to healthcare.

OUR RESEARCH

In this context, Oxfam reviewed the SPRP MPA programme framework, and the 71 country project documents available as of 30 June 2020,⁹ to analyse whether the first phase of World Bank COVID-19 funding does enough to support key areas of the public health response to the pandemic and to build resilient and fair universal healthcare systems for the future.

Specifically, we assessed the extent of support for water, sanitation and hygiene (WASH) services and public health promotion as key aspects of prevention; action to remove financial barriers to healthcare; expanding the supply of healthcare workers; and the role of the private sector in the public health response.

We found that the World Bank’s COVID-19 health funding was strong in some of the areas we assessed, particularly in disease prevention. However, we found the

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A STRONG COMMITMENT TO PREVENTION, WITH ONE MAJOR GAP

Investing in prevention should be a key part of any country's public health response to the pandemic. Many World Bank projects have an entire component or components focused on prevention activities, including testing, and PPE and training for health workers. Our research looked specifically at WASH, and public health promotion -- such as raising awareness of preventive behaviour, health and hygiene -- as key components of prevention.

Many low- and middle-income countries have a mountain to climb to ensure clean water and handwashing facilities for all. For example, in 2019, one in three people globally were going without safe and reliable water services. This puts lives at risk and exacerbates gender inequality; women and girls spend 200 million hours every day collecting clean water,¹⁰ and the pandemic has increased this burden.

Oxfam's research found a high level of commitment to prevention activities, with widespread support for WASH interventions and public health promotion in World Bank projects and a strong emphasis on handwashing. We found 82% of projects (58 of 71), include some support for the provision of WASH supplies and/or facilities, and 85% (60 of 71) include action on public health promotion. These measures can save countless lives and help stop the spread of the virus.

However, it is concerning that so few projects support WASH interventions in public places and community spaces, as recommended by the WHO.¹¹ The majority of projects only support action in health facilities, and just two specify interventions that will benefit the wider community. The World Bank must therefore urgently review this gap in its support by identifying countries where the need exists and responding where there are no other relevant WASH operations.

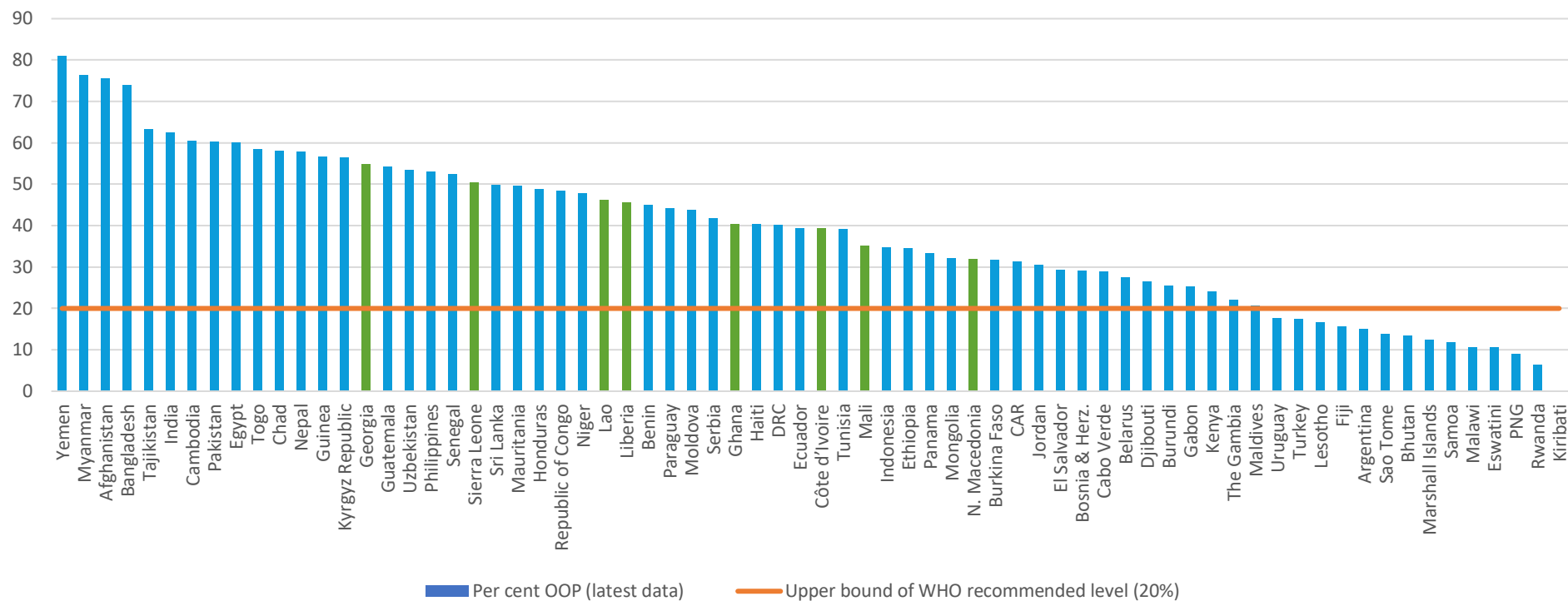
FREE HEALTHCARE: A FATAL BLIND SPOT

Health user fees and other out-of-pocket health expenditure put the lives of the poorest at greatest risk.¹² Every year, user fees prevent one billion people from accessing healthcare,¹³ and countries with higher levels of out-of-pocket spending on health have a higher rate of premature deaths.¹⁴ Women and girls are at greatest risk; they are more likely than men to lack the means to access fee-charging medical services.¹⁵

The extreme and widespread health risks of COVID-19 make it all the more urgent that all financial barriers to accessing healthcare are removed, as the World Health Organization (WHO) highlighted in its June 2020 guidance.¹⁶ It warned that fees not only block access to healthcare but can cause avoidable deaths and increased transmission.

Figure 1: Out-of-pocket expenditure as percentage of current health expenditure, compared to WHO suggested maximum threshold

For 70 of the 71 countries analysed; no data available for Kosovo



Source: Oxfam graph using data from WHO Global Health Observatory (retrieved Sept 2020). Countries receiving support from the World Bank to reduce financial barriers are highlighted in green.

However, we found that just 8 of the 71 World Bank COVID-19 health projects include any plans to remove financial barriers to accessing health services, and that even these have significant shortcomings. For example, none of the 8 specify that fee waivers will cover *all* health services as the WHO recommends,¹⁷ and the two that commit to covering health insurance contributions, indicate that this will only be a short-term measure.

Only 8 of 71 World Bank COVID-19 health projects include any plans to remove financial barriers to accessing health services.

As many as 56 of the 70 project countries for which data is available, have out-of-pocket spending on health above the WHO's 'safe' threshold (see Figure 1).¹⁸ This demonstrates a substantial and pressing need that the World Bank effort has not addressed. In fact, 25 projects specifically identify high out-of-pocket payments for health as a major issue but fail to take any action to tackle them.

These findings reveal a significant failure of the World Bank to support countries to remove healthcare user fees. It was the World Bank which pioneered the introduction of user fees under structural adjustment programmes in the 1980s and 1990s.¹⁹ This has caused huge and avoidable suffering in many countries.²⁰ Yet despite moving away from this approach and acknowledging that user fees are 'unjust and unnecessary,'²¹ it has taken insufficient action to support their removal at country level, an issue which was also raised in the most recent Independent Evaluation Group report on health financing.²² The COVID-19 pandemic should be a pivotal moment for the World Bank to change course and drive the removal of these deadly charges in countries across the world.

FALLING SHORT ON VITAL ADDITIONAL HEALTH WORKERS

Nurses, doctors, community health workers, and other crucial personnel like cleaners and porters, are the backbone of any public health system. They are essential to achieving quality universal healthcare, and to tackling the COVID-19 pandemic. COVID-19 has shown the world how reliant we are on these frontline health heroes. Seventy percent of health workers are women.²³ As of September 2020, at least 7,000 health workers have paid the ultimate price and have given their lives in the fight against this disease.²⁴ Health worker shortages put lives at risk, and exacerbate gender inequality, as even more unpaid care work falls to women and girls when adequate healthcare is unavailable.²⁵

Almost half the projects (34 of 71) include some level of commitment to either mobilizing additional health workers or providing pay to health workers. However, it is a very significant concern that the remainder do not. It is hard to imagine effectively supporting a country's health system response to COVID-19 without providing any support to recruit additional health workers or fund decent pay to retain them, yet over half the projects did not.

Even before COVID-19 hit, there was a shortage of 17.4 million health workers worldwide, mostly in low- and lower-middle income countries.²⁶ In 70% of the project countries for which data is available,²⁷ the number of nurses is below the WHO's minimum recommended level of 27.4 per 10,000 people.²⁸ Thirty-four countries are not even halfway to meeting this minimum.²⁹ In the context of such substantial health worker shortages, compounded by an unprecedented global pandemic, more investment is urgently needed. It is therefore particularly

Two-thirds of country projects do not include any plans to increase the number of health workers.

disappointing that two-thirds of country projects do not include any plans to increase the number of health workers, and that the 25 projects which *do*, have substantial shortcomings. For example, in a number of cases extra health workers are only being supported temporarily, and no project specifies a large number of additional workers.

COVID-19 represents a huge opportunity to start to address these health worker shortages and the World Bank must now act rapidly to remedy this critical gap in its support.

ARE PRIVATE ACTORS SERVING THE PUBLIC INTEREST?

Achieving equitable healthcare for all in low- and middle-income countries relies on investment in strong and accountable universal *public* health systems. While the private sector can play an important role in tackling the COVID-19 crisis, especially where it has the lion's share of intensive care facilities and large numbers of trained health workers, it also brings with it significant challenges and risks, not least that profit is often put before patients' needs and rights.

The WHO has recommended that governments engage the private sector and civil society to provide surge capacity, and maintain public sector oversight of supplies, financing, and public *and* private health workers.³⁰ Any publicly funded assistance for private sector involvement should be in support of a government-led public health response, and in the public interest.

Oxfam's research found that 23% of projects (16 of 71) indicate the possibility of support to the private sector to engage in health service provision. In 7 cases this specifically includes for-profit private actors, and in numerous others the role of non-state actors is described in such vague terms that it cannot be discounted. This level of project support for private sector engagement appears to go beyond that envisaged in the agreed framework guiding the World Bank's COVID-19 health response.

Of significant concern, given known and well-evidenced risks of engaging private health actors, is that project documents do not provide enough clarity or detail on planned support to the private sector to allow for proper scrutiny. This is particularly worrying where planned support is significant, as is the case for Ghana and Mali. There is also a lack of commitment to ensuring that private sector facilities and services supported by the projects will be made available free of charge to all patients, in line with WHO guidance.³¹ Finally, it is a major shortcoming that the World Bank does not stipulate safeguards or minimum standards to ensure the private sector's role is transparent and accountable; works in the public interest; and does not undermine public health system strengthening.

TIME FOR AN URGENT COURSE CORRECTION

There is a need for an urgent and significant course correction in the World Bank COVID-19 response to help countries effectively fight the pandemic and build the foundations for fairer, more resilient universal healthcare systems. The pandemic should mark a turning point for the World Bank's health policies, with unequivocal and vocal support for quality healthcare for all, free at the point of use, built on a

strong foundation of a paid and fully protected health workforce and universal comprehensive primary healthcare. The World Bank has not yet seized this opportunity, but it can and must still do so -- never has the case been stronger. It must take decisive action now to ensure the COVID-19 catastrophe becomes a catalyst for fulfilling the right to health for all.

RECOMMENDATIONS

The World Bank should:

- Send a strong, clear and public message that all countries should make healthcare free by removing user fees and other direct payments for all essential healthcare for the duration of the pandemic and for the long-term and that it will provide financial support to countries to achieve this.
- Urgently redress the gaps in World Bank support for additional health workers and for their decent work, pay and protection.
- Maintain strong and consistent support for public health promotion and the improvement of WASH in health facilities. Review and where needed scale up support for improving access to WASH services for wider communities.
- Introduce minimum standards and safeguards for any financial support provided to the private sector for the COVID-19 emergency response.
- Cancel all debt payments owed to the Bank for the duration of the pandemic, to ensure that countries can devote their limited resources to responding to the crisis and building resilient public health systems. Provide current and ongoing emergency financing to low-income countries as grants, and to middle-income countries as concessional loans. Avoid diverting funds for the COVID-19 response from existing essential public services, and strive to make pandemic response funding additional to existing resource flows.
- Ensure full inclusion of civil society stakeholders at the local and national levels in the design and implementation of COVID-19 projects, including women's rights organizations and those representing disadvantaged or vulnerable groups.

Donor governments should:

- Urgently scale up aid to health, both for the emergency pandemic response and for building universal public health systems with services free at the point of use. Make fair-share contributions to the World Bank's International Development Association (IDA) COVID-19 funding request, while ensuring that the Bank provides debt relief to countries in addition to its pandemic assistance.
- Use their Board representation at the IMF to ensure it is not encouraging or requiring governments to adopt austerity measures during or after the COVID-19 pandemic that could limit governments' fiscal space to support health services and public healthcare workers.

All governments should:

- Urgently scale up investments in resilient and fair universal healthcare systems, including by removing fees for healthcare, hiring the additional health workers needed and their pay and protection, and ensuring access to clean water for all.
- Improve domestic revenue mobilization focused on building fair and progressive tax systems to increase financing available for health and other essential public services.

1 INTRODUCTION

1.1 CONTEXT

The COVID-19 pandemic has plunged countries around the world into an extreme health and economic crisis, the effects of which will be felt for decades to come. It is also putting the lives and livelihoods of the poorest people at greatest risk.³²

As of November 2020, there have been more than 56 million confirmed cases of COVID-19 and 1.35 million confirmed deaths worldwide.³³ In countries that lack free quality healthcare for all, the poorest people are most likely to go without testing or treatment. As household budgets are squeezed, health user-fees and other associated costs, such as transport and medicine, will become increasingly unaffordable. The poorest are also most likely to miss out on other life-saving health services because of the extreme strain that COVID-19 is placing on already under-resourced health systems. This wider impact of the pandemic is putting millions of additional lives at risk and is already unravelling slow and hard-won improvements in health outcomes. Up to 80 million children could go without routine immunizations for diseases such as measles,³⁴ and it is estimated that globally, maternal deaths could increase by between 8% and 39% each month as a result of reduced perinatal care due to COVID-19.³⁵ Half a million more lives could be lost if access to anti-retroviral treatment is disrupted for a period of six months.³⁶

Overall poverty and inequality levels are also expected to rise significantly as a consequence of the pandemic. The World Bank has reported that poverty is rising for the first time in twenty years.³⁷ New research estimates that half a billion people around the world could be pushed into poverty by the pandemic, undoing decades of progress.³⁸ The International Monetary Fund (IMF),³⁹ World Bank and Organisation for Economic Co-operation and Development (OECD) have also warned that COVID-19 is likely to lead to an increase in inequality in almost every country, in what the World Bank President has called an 'inequality pandemic'.⁴⁰ This increase in economic inequality will push the number of people living in extreme poverty even higher.

The pandemic is also exacerbating gender inequality. Women have picked up a significant proportion of the additional unpaid work required to care for the sick, look after children at home and collect additional water to allow regular handwashing.⁴¹ Women living in poverty, especially those facing multiple forms of discrimination, are the most likely to lose access to healthcare as a result of falling incomes and prohibitive healthcare costs.⁴² Sexual and reproductive services that women and girls rely on are being reduced as health systems become overstretched. In Kenya, for example, maternal health resources and workers have been redeployed in the effort to tackle the virus.⁴³ Women also make up the majority of low-paid health and care workers on the frontline, and therefore face the greatest risk of infection.⁴⁴

Unprecedented restrictions have caused economic activity to virtually grind to a halt, leading to what the World Bank has characterized as 'the deepest global recession in eight decades'.⁴⁵ For low- and middle-income countries, this comes on top of a growing debt crisis. Going into the pandemic, 64 countries were spending more on external debt payments than on public healthcare,⁴⁶ and low-income countries are losing \$33.7bn in debt payments to private and multilateral creditors in 2020 alone, including \$3.77bn just to the World Bank.⁴⁷ To make matters worse, the IMF is

pushing at least 67 low- and middle-income countries to adopt austerity measures in the aftermath of the pandemic that could lead to deep cuts in public healthcare systems and public sector workers such as doctors and nurses.⁴⁸

Coronavirus has shown the world how our health is fundamental to our collective security, safety and prosperity. Yet only one in six countries was spending enough on health before the pandemic hit.⁴⁹ These increasing economic pressures will make it even harder for governments to invest in the urgently needed healthcare, social protection and economic stimulus measures that are essential to help all citizens survive this crisis, and to curb rising poverty and inequality. In lower-income countries, where public budgets have been starved and health systems chronically underfunded for decades,⁵⁰ this poses a particularly potent threat. It amounts to reduced spending power at a time of significantly increased need.

The World Bank's rapid response to COVID-19

In this context, the World Bank is playing an important role in providing additional support to countries in dire financial straits. World Bank funding has the potential to enable such countries to invest in policies and interventions that will help them better respond to COVID-19 and achieve universal quality healthcare as soon as possible.

The World Bank's policy advice and financing to countries for health has been problematic in the past, particularly its push to implement punitive user fees for healthcare as a 'cost recovery' measure in the 1980s and 90s.⁵¹ Although the Bank has now moved away from promoting this approach, it led to widespread and avoidable suffering in many countries.⁵² The World Bank and its International Finance Corporation (IFC) have also drawn considerable criticism, including from Oxfam,⁵³ for promoting a greater role for the for-profit private sector in healthcare. However, in recent years the World Bank has also been a champion for universal health coverage, and for investment in health as a means of building 'human capital'. It is now one of the few remaining donors providing general support for national health systems. As such, it remains a critically important and influential player in global health. Crucially, the Bank can quickly mobilize the scale of funding needed in the context of a global pandemic.

There is no doubt that the World Bank has provided important and timely financial support to low- and middle-income countries to bolster their response to the pandemic. In March, it announced \$6bn in initial funding to help countries coping with the health impacts of the outbreak through its COVID-19 Fast Track Facility.⁵⁴ As part of this, on 2 April 2020, the World Bank Board approved the COVID-19 Strategic Preparedness and Response Program (SPRP), and signed off the first 25 countries to benefit.⁵⁵ The SPRP sets out a framework to guide the content of all recipient country projects under a Multiphase Programmatic Approach (MPA).⁵⁶ By 30 October, COVID-19 response projects under the auspices of this SPRP MPA had been approved for a total of 84 countries.⁵⁷ Additional countries also received emergency health support through the reprogramming and redeployment of funds in existing World Bank projects, bringing the total number of countries receiving support to more than 100.

The speed and breadth of this response is highly commendable, as is the indication that a further package of financial support will be available in the coming period. As early as March 2020, the World Bank publicly declared its capacity to provide up to \$160bn over the first 15 months of the crisis, and \$330-350bn by the end of June

2023.⁵⁸ This broader financing package, however, will not be focused solely on health. The World Bank COVID-19 Crisis Response Approach Paper⁵⁹ released in June 2020 describes the Bank's response as having four pillars: saving lives; protecting the poor and vulnerable; ensuring sustainable business growth and job creation; and strengthening policies, institutions and investments for building back better. Beyond the initial emergency 'relief' stage, the strategy envisions continued support for the health response by 'strengthening health systems for pandemic readiness'; however, it indicates that this will happen through ongoing implementation of the original health MPA and the regular health project pipeline, which is subject to country demand.

Subsequently, in October 2020 the Bank approved an envelope of \$12bn for developing countries to finance the purchase and distribution of COVID-19 vaccines, tests, and treatments. Part of the broader \$160bn in pandemic financing, this vaccine plan will also provide 'financing and technical support so that developing countries can prepare for deploying vaccines at scale' – which could potentially include further support to health systems. In an exceptional move, the Bank has also asked its donors for \$25bn in supplemental funding for the International Development Association (IDA), its fund for the poorest countries, in order to boost its ability to provide financing during COVID-19,⁶⁰ some of which could support health.

New funding would be welcome and is urgently needed. However, lessons must be learned from the first phase of the pandemic response. Civil society organizations have raised concerns about transparency and accountability in current WB COVID-19 projects, particularly that they have not adequately included local and national civil society representatives in consultations, and that marginalized groups are being left out of project design.⁶¹ Civil society engagement and oversight can help prevent cases of corruption, which have been reported for example in government procurement of COVID-19 medical supplies in Kenya.⁶²

Given the ongoing implementation of SPRP projects, the new vaccine initiative, and possible new funding, it is particularly important to assess whether the first phase of pandemic response support does enough to strengthen low- and middle-income country health systems that are under substantial pressure due to the pandemic. It is also crucial to assess the quality of financial support the World Bank is providing, to ensure that the urgency of the situation doesn't lead to any erosion of standards that could undermine health systems in the future or cause equity to be overlooked.

It is also important to acknowledge the important role of sovereign governments to lead their pandemic response according to their priorities and context; in this sense, the World Bank's role should be to provide sufficient financing as well as technical and policy guidance that prioritizes tackling poverty and inequality in the context of an effective pandemic response.

Getting the COVID-19 response right

In March 2020, at the beginning of the pandemic, Oxfam called for debt cancellation for low- and middle-income countries to enable an immediate doubling of health spending. We also called for five priority actions to strengthen public health systems⁶³ to better tackle COVID-19, and move more quickly to deliver effective, equitable healthcare for all. They are:

1. **Prevention:** Huge investments must be made in prevention, including public health promotion and communication; community engagement and education;

equal access to water, sanitation and hygiene (WASH) facilities, especially for handwashing; as well as free testing for all.

2. **Health workers:** Recruitment of ten million new health workers who are well paid, trained and protected, with personal protective equipment (PPE) for all workers. This should include recruitment drives for community health workers and out-of-work healthcare professionals; and free education and training for all urgently needed cadres of health workers to boost long-term capacity.
3. **Free quality healthcare:** Governments should urgently remove all financial barriers to people accessing all essential healthcare from all providers, and deliver free COVID-19 testing and treatment to all who need it.
4. **Making private work for public:** Governments should requisition or find other transparent and accountable routes to utilize private healthcare facilities at cost, to increase COVID-19 response capacity and to meet ongoing essential healthcare needs.
5. **Vaccines and treatments for all:** Global agreement must be reached that vaccines and treatments, when approved for use, will be a global public good, available for free to all who need them, and that rich countries will provide enough funding to make these available rapidly to everyone.

Oxfam's recommended priority interventions come from its experience that resilient health systems, free at the point of use, are essential for the provision of universal health coverage, which in turn is vital to uphold the right to health and ensure a prompt response to disease outbreaks. These areas are also essential to fighting gender inequalities in healthcare access and outcomes, as well as promoting gender equality more broadly. COVID-19 has demonstrated, as Ebola did before it, that when the essentials of a healthcare system are missing it cannot respond effectively or equitably to such crises.

Weak public health systems mean that the indirect health impacts of such crises can be catastrophic, particularly for women and the poorest and most marginalized people. The World Bank underlines this in its MPA, citing evidence that in the 2014-16 Ebola epidemic in West Africa, 'more people died because of disruptions of day-to-day healthcare than died from the disease'.⁶⁴ Women and children were hit hard by Ebola: childhood immunizations decreased substantially and the number of pregnant women giving birth in health facilities dropped by over 80% in some areas.⁶⁵ Teenage pregnancies increased, meaning more pregnant girls were forced to drop out of school.⁶⁶

To mount an effective and equitable response to the pandemic, COVID-specific interventions must therefore be accompanied by investment in public health systems that can deliver universal quality healthcare as soon as possible.

1.2 METHODOLOGY

The aim of this research is to investigate the strengths and weaknesses of the World Bank's initial health response to COVID-19 against a number of Oxfam-identified priority health interventions, and to make evidence-based recommendations to inform the implementation of this initial response as well as any future support. Many of these identified priorities are also present in WHO's pandemic response guidelines.

To this end, this paper reviews the quality of support that the World Bank has agreed to provide to countries as part of its COVID-19 Strategic Preparedness and Response Program (SPRP). Oxfam reviewed the full text of the SPRP MPA framework to identify the specific actions it indicates that individual country projects can support. We then reviewed the 71 country project documents that were available as of 30 June 2020, covering 71 countries;⁶⁷ these were Project Appraisal Documents (PADs), or Project Information Documents (PIDs) where PADs were unavailable. To ensure as comprehensive a review of these documents as possible, we used key-word searches to identify all relevant content in the specific project components as well as in other sections (for example in the context, risk analysis, indicators and project summary sections). Our analysis of the interventions supported through the SPRP is based solely on these planning documents; we did not take into account how projects have been implemented on the ground.

The analysis focused on specific interventions related to the first four of Oxfam's five priority interventions outlined above. We searched for content in the project documents relating to:

1. **Prevention:** specifically public health promotion, and provision or improvement of WASH supplies and facilities.
2. **Free healthcare:** specifically fee waivers for all health services, and other measures to remove financial barriers to access.
3. **Health workers:** specifically mobilization of additional health workers, and supporting salaries and other pay (e.g. bonuses and indemnity payments).
4. **Private sector involvement:** support being channelled to the private sector, especially where it could play a role in health service provision.

In addition to their importance for the pandemic response and for health systems, we selected these areas of focus because they are areas where Oxfam has strong programme and policy expertise, and where we have historically concentrated our advocacy efforts. For example, in the area of prevention we included a focus on WASH because of Oxfam's decades-long experience in this area in addition to its importance for disease control. We also chose these priorities because they have important gender impacts and have often received inadequate attention, funding or scrutiny. Our analysis also paid specific attention to the World Bank's inclusion of gender in the SPRP MPA framework and considered the differential impact on women of the project interventions (or lack thereof).

It should be noted that in many cases the country project documents use vague language and provide limited detail. We sought to judge country documents fairly by giving the benefit of the doubt where it is likely, rather than categorically stated, that a positive measure is being supported. For example, we counted Lao among the projects taking action on financial barriers to health services, even though the Lao project frames support for fee waivers only as something that might happen. These judgement calls are further explained or footnoted in the relevant 'findings' sections.

Finally, due to its focus on specific interventions, this study should not be read as a comprehensive evaluation of the World Bank's COVID-19 response. It does not capture or analyse a number of other interventions, such as support to diagnostics and testing, disease surveillance and information systems, health facilities or medical supplies and equipment – all of which are important areas of the pandemic response included in the SPRP framework document. Additionally, this review only focused on COVID-19 SPRP projects and does not capture other forms of World

Bank support for health, such as pre-existing health projects and budget support. However, the picture it provides is valuable as it gives an indication of the level of priority these key areas are receiving in the pandemic response.

2 RESEARCH FINDINGS

2.1 ANALYSIS OF THE WORLD BANK'S COVID-19 SPRP FRAMEWORK

The COVID-19 SPRP agreed on 2 April 2020 uses a Multiphase Programmatic Approach (MPA) – a World Bank instrument that allows an overall programme to be approved by the Board of Directors under a common framework, and delegates approval of individual projects within that programme to World Bank management. This speeds up project approvals but also reduces Board oversight. The SPRP MPA framework document sets out how the World Bank intends the funding provided to countries under this programme to be spent. As such, the interventions and approaches that are given priority in the MPA framework have a very strong influence on project design and priorities in recipient countries. At the same time, the framework allows projects to be tailored to specific country contexts and affords flexibility to adjust priorities during implementation.

What does the SPRP MPA say on key priorities?

The MPA Programme's stated objective is 'to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health preparedness'. It includes support for a wide range of interventions. It envisions broad support for emergency response, which covers clinical capacity and disease surveillance systems including labs and diagnostics, health and hygiene measures, health system strengthening, and social and financial support to households. Other measures include strengthening zoonotic disease information systems, provision of supplies and equipment, upgrading infrastructure, technical support on governance and legislation, and community engagement. The framework also indicates support for implementation management, and monitoring and evaluation of the project.

We analysed the SPRP MPA framework in the four priority areas selected for this research, where it outlines a number of specific interventions which projects may support. We also looked at the treatment of gender in the MPA as a cross-cutting area and its integration across the planned interventions.

On prevention

The MPA framework expresses clear support for investment in prevention measures, and states that prevention is expected to be a 'key focus' for country projects. Critical prevention measures supported include disease monitoring and surveillance, laboratory capacity, health information systems and data, public health promotion and WASH, among a number of other interventions. For the purposes of this review, we focused on WASH and public health promotion.

Component 1 specifies support for public health promotion, with an emphasis on social distancing measures and references to complementary measures such as handwashing, distribution and use of masks, and wider community engagement to slow the spread of the pandemic. It also includes support for the provision of WASH supplies and facilities in healthcare settings *and* in wider communities as part of this prevention response, although it should be noted that only the former (WASH in health facilities) is specified in the intermediate result indicators. Community access to WASH is particularly important in reducing women's unpaid care work collecting clean water to facilitate handwashing, so this could have been better prioritized through the results indicators. However, there are repeated mentions of handwashing promotion and services. Overall, this provides a sound basis for countries to prioritize spending on important prevention activities.

On health system strengthening, including free healthcare, and health workers

Crucially, the MPA framework also emphasizes the importance of longer-term health system strengthening, even in the context of an emergency response. For example, it states that 'a false dichotomy between COVID-19 emergency response and health system strengthening priorities should be avoided' and refers to the importance of interventions that will benefit countries 'during normal times and in a pandemic'. The programme description also includes a health system strengthening element, under which it groups support for healthcare workers and addressing financial barriers to accessing healthcare among other areas. It specifies that financial support can be provided for measures to remove financial barriers (such as health user-fee waivers), to mobilize additional health personnel, and to pay health worker salaries and benefits. It is positive that the World Bank identifies these important and progressive actions to strengthen health systems.

However, the MPA's commitments in this area fall short in two ways. First, health system strengthening is situated under Component 1: Emergency COVID-19 Response, which the document describes as 'supporting priority containment and mitigation activities'. Therefore, action on free healthcare and health workers – essential elements of both short-term and longer-term health system strengthening – are framed only as part of the short-term response. This could significantly limit the ambition of countries, by implying that any investment in free healthcare and in health workers should be focused only on temporary measures.

Second, the MPA fails to clearly articulate and give sufficient priority to specific progressive actions on both free healthcare and health workers.

For example, measures to 'reduce/eliminate financial barriers... to seek and utilize needed health services' are wrapped together with wider cash transfers to 'mitigate economic impact on households' under a subcomponent focused on 'Social and Financial Support to Households'. The World Bank could have chosen to make user-fee waivers and other measures to specifically remove barriers to accessing health services a standalone priority, emphasizing that these should be introduced *in addition* to other cash and in-kind transfers, in line with World Health Organization (WHO) guidance on COVID-19 response.⁶⁸ Also, while there are results indicators to measure the number of COVID-affected households provided with 'cash transfers' and with 'food and basic supplies', disappointingly there is no indicator on fee waivers or other measures specifically to remove financial barriers to healthcare. The MPA could have also highlighted the importance of removing financial barriers for *all* health services, rather than just COVID-related services, in line with WHO guidance.⁶⁹

The World Bank SPRP MPA states:

'a false dichotomy between COVID-19 emergency response and health system strengthening priorities should be avoided'

Measures to increase the number of health workers or to support their pay and other benefits are also absent from the MPA's indicators. In addition, the MPA's vague language in relation to health workers has been adopted (often word for word) by many country projects, making it impossible to assess the extent of their planned interventions. For example, on health workers, the MPA states that Component 1 will 'enable countries... to mobilize surge response capacity through trained and well-equipped frontline health workers', making it unclear whether the intention is to mobilize *additional* health workers. Similarly, the MPA states that projects can support 'operational expenses such as those related to mobilization of health teams and salaries, and hazard / indemnity pay'. Unfortunately, this allows projects to refer to 'operational expenses related to mobilizing health teams' without specifying whether the expenses are for salaries/pay or something else.

On private sector involvement

The MPA framework says relatively little on the role of the private sector. It does not highlight the need for private sector actors to provide additional capacity to respond to COVID-19, and to provide this and other health services free of charge to patients, in line with WHO guidance.⁷⁰ It does, however, include a welcome emphasis on support for a public sector health response and the strengthening of public health systems, except in a very small number of fragile contexts.

For example, the document states that project implementation is 'expected to be through (recipient) government systems', but that 'there are a selected few country contexts where implementation is likely to require working through third parties', specifically mentioning Yemen, Somalia and South Sudan. This suggests an option to support private provision, including potentially by for-profit actors, but only to a very limited degree.⁷¹

On gender

The MPA framework does include analysis of the gendered impacts of the pandemic, including that women are at higher risk of infection in their role as carers – both in their formal capacity as healthcare workers and also as unpaid carers in households – and experience greater difficulty in accessing essential healthcare services. It states an intention, in the design of country projects, to 'consider and address gender norms and roles that influence differential vulnerability [of women] to infection, exposure to pathogens, and treatment accessibility.' However, it does not do enough to translate these considerations into project components that explicitly seek to address gender inequalities in the COVID-19 response, and there are no specific indicators that address or include gender.

Importantly, it does cite support for fee waivers for healthcare as an intervention that can address women's reduced access to essential healthcare. Where the MPA refers to essential healthcare, however, it omits a focus on the specific and additional needs of women, in particular sexual and reproductive health and rights such as family planning, maternal health and safe abortion services. During the Ebola epidemic, women's health suffered massively, with high rates of maternal death.⁷² The World Bank could help countries to learn from this experience by emphasizing fee-free access to sexual and reproductive health services as a priority within the maintenance of essential healthcare during the pandemic.

Throughout the MPA, there is limited recognition that the success of important containment measures like social distancing, school closures and other aspects of

lockdowns drastically impact and depend heavily on women's unpaid care work. Finally, while the MPA does reference women's groups as stakeholders that can help with community engagement to build trust and ensure the effectiveness of COVID-19 responses, it does not include plans to consult with women's groups on project design and implementation, and its broader plans for consultation with local non-government stakeholders in these areas are thin.

Given that the MPA is explicitly used to provide shared objectives and approaches for a large set of projects, the fact that it did not take its gender analysis further by developing gender-specific actions and indicators could signal that gender equity is not a high priority in the pandemic response.

2.2 PREVENTION

'A key focus' of the response

Investing in prevention is key. Governments must scale up testing and contact tracing, as well as specific prevention activities, to control the virus. We chose to assess how the World Bank performs in its support for two essential elements of prevention: the provision or improvement of water, sanitation and hygiene (WASH) supplies and facilities, and public health promotion.

Providing essential WASH supplies and facilities in healthcare settings is critical to protecting patients and frontline health workers. This is undoubtedly an area where more investment is urgently needed; in 2019, just 55% of healthcare facilities in least developed countries (LDCs) had basic water services.⁷³

However, stopping the spread of COVID-19 will also require larger-scale interventions in public and community spaces. In 2019, as many as one in three of the world's people did not have access to safe and reliable water services, and three billion people did not have access to basic handwashing facilities (soap and water) in their home.⁷⁴ Giving everyone the means to wash their hands can save countless lives and is crucial to stopping the spread of the virus. It is also vital for fighting gender inequalities. Lack of access to clean water and other hygiene interventions disproportionately affects women,⁷⁵ and the task of obtaining (clean) water amounts to 200 million hours every day for women and girls around the world.⁷⁶ During the pandemic the pressure on women and girls to collect water is even higher, given the increased need for handwashing.

The WHO's 2020 guidance to countries on infection prevention and control includes clear recommendations to this effect. It stipulates that countries should, 'Support access to WASH services in public places and community spaces most at risk', and 'Ensure hand hygiene stations are available, supplied and functioning at all gathering places (markets, clinics, places of worship, public facilities and transport stations).'⁷⁷

Extensive public health promotion – including raising awareness of the importance of handwashing, social distancing and other measures that protect individuals and stop the spread of the virus – is also an essential component of prevention. The same WHO guidance includes an entire pillar dedicated to actions that governments should take on risk communication and community engagement.⁷⁸

We assessed the 71 country projects' investment in WASH supplies and/or facilities and commitments to public health promotion activities for prevention. Both of these are strongly and clearly supported in the MPA, as is the importance of handwashing.

Findings

All but 2 of the 71 projects⁷⁹ include action on public health promotion or investment in WASH, and 69% (49 of 71) include commitments to taking action on both of these key elements of prevention.

WASH supplies and facilities

Fifty-eight of the 71 projects include some action to support the provision of WASH supplies and/or facilities. While many of the projects do not specify which WASH interventions they will support, at least 24 of the 58 commit to improvements in water supply or safe water provision, and 44 of them include investment in waste management or waste disposal.

Examples of specific planned WASH interventions in these 58 projects include:

- **Kyrgyz Republic's** project states that points of entry 'that lack adequate handwashing facilities, restrooms or other basic health and hygiene conditions will be updated to a basic level', and specifies 'provision and/or repair of handwashing and hygiene facilities' in 'up to 30 ICUs and 100 isolation rooms in 24 designated hospitals'.
- **Pakistan's** project will 'address the differentiated needs of women (e.g. access to menstrual hygiene products, safe sanitation facilities)'.⁸⁰
- In **Senegal**, the project will support 'basic handwashing as well as strengthening medical waste management and disposal systems in permanent and temporary healthcare facilities', including 'supplies/kit for handwashing facilities'.
- **Sierra Leone's** project 'will promote local production of Alcohol Base Hand Rub (ABHR) sanitizers and liquid soap' in addition to other actions.⁸¹
- The project in **Papua New Guinea** includes training for health workers on waste management, and provision of 'supplies and consumables as well as equipment for infection prevention... and incinerators for waste management'.

However, in a number of these 58 projects, the information provided implies that only a very limited intervention is planned. For example, in 9 of the 58 projects, the only action on WASH is on waste management or disposal,⁸² and in Ethiopia's project this is restricted to support for 'drugs and medical supplies for case management and infection prevention, including production of hand sanitizer'.

Also, in the majority of the 58 projects it is stated or implied that support for WASH supplies and/or facilities will be only be provided in health facilities. In 6 of these, WASH support is particularly limited in that it will only benefit health workers (through provision of 'hygiene materials' for health workers in Gabon, Georgia, Honduras, Togo and Uruguay, and 'alcohol gel' for health workers in Argentina).

Only 6 of the 58 country projects specify WASH support that goes beyond health facilities. Burundi⁸³ and the Kyrgyz Republic⁸⁴ include WASH provision at ports of entry; Chad⁸⁵ will support hygiene supplies for quarantined households and people in isolation; and North Macedonia⁸⁶ will provide hygiene products for people on means-tested benefits.

Out of those 6, only 2 projects specify support for WASH interventions that will benefit the wider community. Burkina Faso's project includes provision of 'handwashing facilities in public spaces including public standpipes, schools, markets, transport stations... and to health care facilities', and the Central African Republic project includes a 'large-scale WASH endeavor' involving hand-washing stations at 'all major identifiable points of population convergence in the communities', as well as water provision.

Public health promotion

Sixty of the 71 projects include public health promotion, such as raising awareness of preventive behaviour, health and hygiene, and other safety measures; 32 of these 60 specifically mention promoting handwashing.

Beyond this, the projects provide varying levels of detail, with some containing entire components dedicated to public health promotion and others just a short mention. Some of the more specific commitments include:

- **Belarus** will 'implement effective communication campaigns for mass awareness and education of the population on how to tackle the COVID-19 emergency'.
- **India's** project states that 'a community campaign for schools and parents will be supported to provide information about how to protect themselves and promote hygiene practices', and includes promotion of 'proper handwashing and cooking standards'.
- **Liberia** includes 'COVID-19 sensitization campaigns conducted in all counties', and support for 'the training and equipping of... Community Health Assistants / hygiene promoters'.
- **Tajikistan's** project includes training journalists and 1,000 community volunteers 'to increase awareness of preventive measures'.

Analysis

The high level of commitment to prevention activities in the 71 country projects is very encouraging, as investing in prevention during the emergency response phase of COVID-19 is crucial. The MPA identifies that strengthening the country's basic prevention response is expected to be a key focus of the projects, and we found this to be the case.

Many projects have an entire component or components focused on prevention activities, including testing, PPE and training for health workers, as well as investments in WASH supplies and facilities, and public health promotion.

Most projects – 82% (58 of 71) – include some action to support the provision of WASH supplies and/or facilities, and 85% (60 of 71) include action on public health promotion, with a strong commitment to handwashing. This demonstrates the important role that World Bank funding is playing in awareness raising and provision of essential WASH supplies and facilities. This will help save lives and minimize the impact of COVID-19.

However, it is surprising and concerning that the targeting and scale of planned WASH interventions are so limited, with the majority only supporting action in health facilities. Given the lamentable state of WASH in many low- and middle-income countries, and the importance of handwashing in stopping the spread of the virus

Oxfam found a high level of commitment to prevention activities across the 71 projects reviewed, specifically in public health promotion and WASH in health facilities.

and saving lives, it is clearly inadequate that only 2 of the projects specify support for WASH interventions that will benefit the wider community. There is also a clear risk that the lack of widescale WASH interventions will worsen gender inequality, as women and girls are less likely to have access to clean water and hygiene facilities,⁸⁷ and more likely to take on the additional unpaid work of obtaining clean water.

The World Bank must urgently review this gap to determine whether there is sufficient investment being made in WASH at the wider community level in other operations, and ensure this is built into project design moving forward where needed.

2.3 FREE HEALTHCARE

An equity and public health imperative

It is well evidenced that health user fees and other out-of-pocket health expenditure fuel deep economic, health and gender inequalities, and put the lives of the poorest people disproportionately at risk.⁸⁸ Every year, user fees prevent around one billion people from accessing healthcare,⁸⁹ and countries with higher levels of out-of-pocket spending on health also have a higher rate of premature deaths.⁹⁰ Women and girls living in poverty are most likely to miss out on essential care and treatment.⁹¹ In many societies, their low social status and lack of control over finances means they are last in line to benefit from medical care when fees are charged.⁹²

Despite the globally agreed sustainable development goal to reduce out-of-pocket spending on health in order to improve access and financial protection, such payments are rising,⁹³ and are increasing fastest in Africa.⁹⁴ User fees are charged for all levels of healthcare in two-thirds of African countries.⁹⁵ COVID-19 is making things far worse: health systems and incomes are under increased strain, meaning more people are unable to afford fee-charging healthcare. This also undermines efforts to control the pandemic, as it leads to cases going undiagnosed and untreated.

The WHO has underlined the importance of making healthcare free in its COVID-19 guidance since the start of the pandemic.⁹⁶ In June 2020, the WHO issued further and categorical advice that 'People should not pay user fees (including co-payments) at the point of care for essential services during the COVID-19 outbreak' because they 'present a substantial barrier to people seeking and receiving needed care, which can result in avoidable morbidity and mortality and in increased transmission during an outbreak.'⁹⁷

Lessons from the 2018 Ebola outbreak bear this out. The DRC enacted a free healthcare policy in response to that crisis, which improved healthcare utilization across the board. For example, visits for treatment of pneumonia and diarrhoea more than doubled, and there was a 20-50% increase in women giving birth at a clinic. However, these gains were immediately lost once free healthcare was removed.⁹⁸

Making healthcare free is crucial to improving health outcomes and achieving the sustainable development goals, tackling gender inequalities and controlling the spread of COVID-19. It should therefore be a priority for governments and donors.

'People should not pay user fees (including co-payments) at the point of care for essential services during the COVID-19 outbreak' because they 'present a substantial barrier to people seeking and receiving needed care, which can result in avoidable morbidity and mortality and in increased transmission during an outbreak.'

The World Bank itself has broken with its past support for user fees, imposed through its structural adjustment programmes in the 1980's and 1990's, and in 2013 its then President Jim Yong Kim called healthcare user fees 'unjust and unnecessary.'⁹⁹

While the MPA does not strongly prioritize addressing financial barriers to healthcare (as discussed in 2.1), the document *does* specify that 'financing would be provided for fee-waivers to access medical care'. Oxfam assessed the 71 country projects to identify how many include fee waivers or other measures to remove financial barriers to accessing health services.

Findings

Sixty-three of the 71 projects (89%) do not include any plans to support the removal of financial barriers to health services. This is despite the fact that in 25 of the 63 cases where no action is taken, the project documents identify that high levels of out-of-pocket payments for health are a major issue in the country in question.

This means that just 8 of the 71 projects do include some form of commitment to remove financial barriers to accessing health services.

Of those 8, 5 projects include support for fee waivers (Georgia, Ghana, Lao, Mali and Sierra Leone). However, shortcomings are evident in these project documents. None of the 5 explicitly state that the waivers will cover all health services, and in 3 cases (Georgia, Lao and Mali) the measure only covers COVID-19 services and/or people affected by the disease.¹⁰⁰ Lao's project document has two other weaknesses. First, it frames fee waivers as a possibility rather than a definite plan; and second, the measure would be targeted based on income, rather than universal and available to all.¹⁰¹

A further 2 projects (Côte d'Ivoire and North Macedonia) commit to covering health insurance contributions. These also have shortcomings. In both countries the measures will be temporary, for three and nine months respectively, neither of which is sufficient to cover the period in which the damaging health and income-related impacts of COVID-19 will be felt. In the case of Côte d'Ivoire, it is also implied that the measure will only be for people affected by COVID-19.¹⁰²

Finally, 1 project (Liberia) makes a non-specific commitment to support 'mechanisms to eliminate financial barriers for families who seek and utilize needed health services'. This is based on language from the MPA, and no further explanation is provided. It is so vague that it is impossible to identify what specific interventions will be introduced, whether they will cover COVID-related or all health services, and whether they will be temporary or permanent.

Analysis

It is very disappointing that just 11% of the projects assessed (8 of 71) are funding measures that will specifically tackle financial barriers to accessing health services. This is a significant missed opportunity to contain the spread of COVID-19, support the poorest people to overcome greater cost barriers to accessing healthcare in very risky times, and mitigate the rise in income, gender and health inequalities exacerbated by this pandemic. Unfortunately, even these 8 projects are not doing enough.

89% of projects do not include any plans to support the removal of financial barriers to health services, such as user fees.

Despite the WHO's advice that countries should be supported to make *all* health services free, none of the 8 projects that support action to address financial barriers to healthcare specify that they will do this. In fact, it is likely that 4 of them will only cover COVID-19 related services or people affected by COVID-19.

The MPA could have done much more to encourage countries to invest in the right actions by highlighting the importance of making *all* healthcare free, in line with WHO guidance, and by making fee waivers and other specific measures to remove barriers to accessing health services a prominent, standalone priority, rather than wrapping them together with cash transfers. Twenty of the 71 projects include support for cash and/or in-kind transfers, and while these may in some circumstances make an indirect contribution to addressing financial barriers to healthcare, on their own they are not enough to do so. At a moment when millions have lost their jobs or livelihoods, cash transfers are even more essential for providing urgently needed support to households to prevent worsening poverty and hunger. They are not a substitute for removing fees for healthcare.

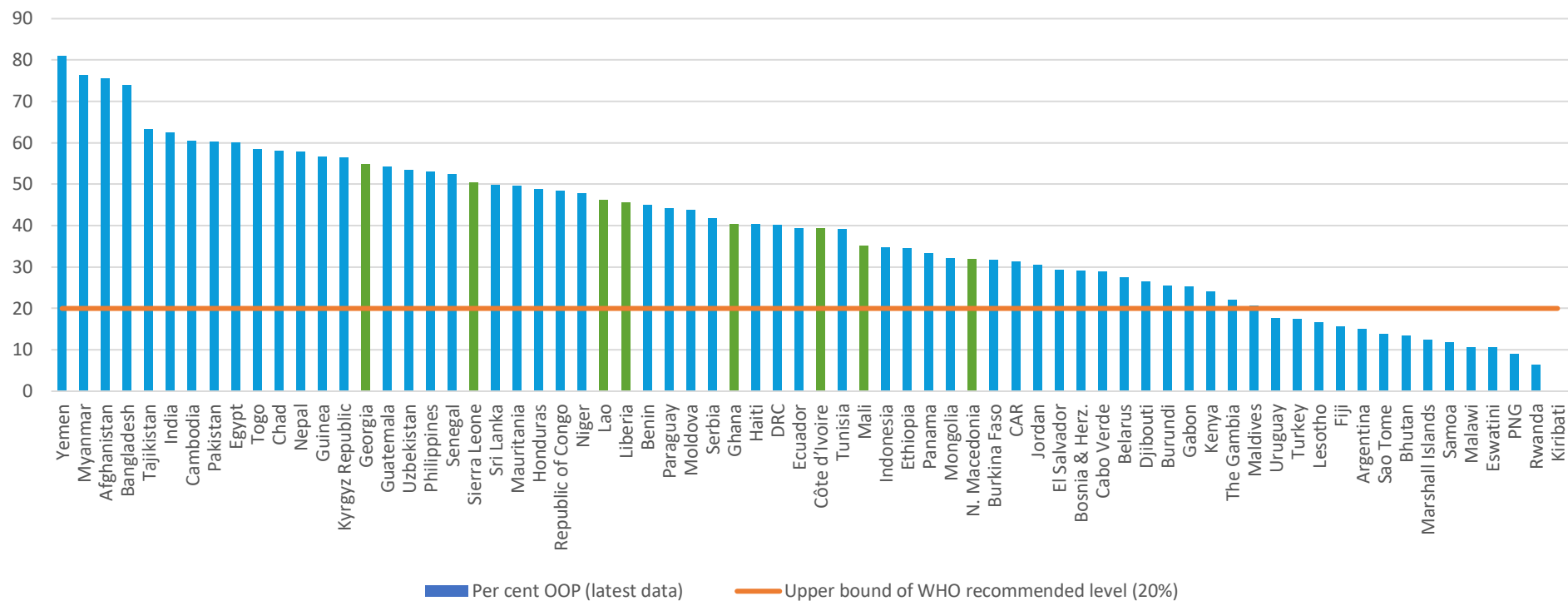
In addition, a closer look at the projects alongside available WHO data on financial protection for health in the project countries¹⁰³ reveals significant failings and inconsistencies in the quality and depth of the World Bank's approach to financial protection (Figure 1).

Fifty-six of the 70 projects (80%) for which data is available have out-of-pocket spending above 20% of total health expenditure, which is the upper bound of the WHO's 15-20% suggested threshold to ensure that 'financial catastrophe and impoverishment falls to negligible levels'.¹⁰⁴ While this crisis response from the World Bank comes on top of its existing health programmes and projects, the high level of out-of-pocket payments in 80% of project countries demonstrates a pressing and unmet need. All 8 of the projects where the World Bank is supporting some action to remove financial barriers for healthcare (marked in green in Figure 1) are well above the WHO's maximum threshold, ranging from 32% in North Macedonia to 55% in Georgia. Yet there are 35 countries with *higher* out-of-pocket payments than North Macedonia where the World Bank is not supporting any action in its crisis response. This suggests that the World Bank has failed to apply any rigorous or consistent standard to guide its action on tackling cost barriers to healthcare.

Our analysis suggests that user fee removal remains a significant blind spot for the World Bank. This echoes the Independent Evaluation Group's most recent evaluation of World Bank support to health financing, which concluded that 'support to reduce user payments was limited' and that work to improve financial protection 'lacked the necessary fiscal and equity analysis'.¹⁰⁵ The urgency of action to remove financial barriers to healthcare could not be clearer, particularly during the COVID-19 pandemic, and the World Bank's limited action in this area is of deep concern.

Figure 1: Out-of-pocket expenditure as percentage of current health expenditure, compared to WHO suggested maximum threshold

For 70 of the 71 countries analysed; no data available for Kosovo



Source: Oxfam graph using data from WHO Global Health Observatory (retrieved Sept 2020). Countries receiving support from the World Bank to reduce financial barriers are highlighted in green.

2.4 HEALTH WORKERS

The crucial role of health workers

It is impossible for health systems to function or to provide quality healthcare without a sufficient number of trained health workers. However, thanks in large part to historical and ongoing economic conditionality imposed by the IMF to ‘contain’ or reduce the public sector wage bill,¹⁰⁶ low- and middle-income countries have underinvested in the recruitment, training and retention of public sector health workers. This has played a significant role in undermining health systems, reducing access to healthcare services and increasing unpaid care work in the home when family members are ill – work which is carried out predominantly by women and girls.¹⁰⁷

Even before COVID-19, the World Bank and WHO found there to be a shortage of 17.4 million health workers worldwide in 2013 in low- and lower-middle income countries.¹⁰⁸ They estimated a gap of 6.9 million health workers in South-East Asia and 4.2 million in Africa.¹⁰⁹ In 2017 the WHO estimated that more than 23 million additional health workers were needed to achieve the health targets of the globally agreed Sustainable Development Goals.¹¹⁰

More than 23 million additional health workers were needed to achieve the health targets of the globally agreed Sustainable Development Goals.

Given the additional burden the pandemic is placing on health systems and the additional work it creates for unpaid carers, it is more important than ever that urgent action is taken to increase the number of public sector health workers and provide decent pay, rewards and working conditions to fairly compensate and retain them. Given that women make up 70% of the health workforce globally, and shoulder the majority of unpaid care work, action on these issues – or lack of it – will have a significant impact on gender equality.

Despite some unclear wording in the MPA (as discussed in 2.1), it does specifically state that support will be provided to ‘mobilise additional health personnel’ and cover ‘operational expenses’ including ‘salaries, and hazard / indemnity pay’. We assessed the 71 country projects to investigate the level of commitment to mobilizing additional health workers and providing salaries and other pay. We paid special attention to mention of support for salaries, as securing external support for this is often particularly challenging for countries. We did not examine interventions to increase and improve pay and conditions for the millions of health sector support workers, such as cleaners and porters, which is key to responding to the pandemic, achieving healthcare for all, and ensuring decent work for all in the health sector. This was partly a matter of focus, and partly because information on these ancillary workers was so scant in the documents.

Findings

Only 48% of the projects (34 of 71) include some action to mobilize additional health workers and/or to provide salaries or other pay. This means that 52% of projects (37 of 71) do not plan to support either of these things.

Additional health workers

Just 35% of the projects (25 of 71) include support for mobilizing *additional* health workers, implying that the funding will help them to recruit extra health personnel.¹¹¹

These 25 projects vary in the level of detail they provide and the strength of the commitment they make to investing in additional health workers. This is illustrated by the following examples:

- **Kenya's** project description includes 'increasing the number of health workers required to meet the additional demands for surveillance, rapid response and case management'. However, the project indicators imply that this will be a small number (300) of 'surge capacity health workers contracted and deployed for case management'.
- **Kosovo's** project commits to a similarly small number of health workers, and to taking them on temporarily; it will 'Mobilize approximately 400 medically qualified professionals who are not currently working in the publicly funded healthcare system and final year medical students... for up to six months.'
- The **Marshall Islands** project makes various mentions of financing health workers;¹¹² taken together, these *could* be interpreted as funding additional workers, but this is not explicitly stated.
- **Nepal's** project description states it will finance 'contract workers'. It does not provide any further detail, although the language implies that the additional workers are temporary.
- **North Macedonia's** project description also strongly implies that any additional health workers will be temporary; it will 'finance surge staffing (additional staff who will be hired on a short-term basis...)'.

In addition to the 25 projects that specify they will support additional health workers, a further 14 projects use the MPA's language (as discussed in 2.1) 'to mobilize surge response capacity through trained and well-equipped frontline health workers'. However, these 14 projects do not specify that this means recruitment of additional health workers, or indicate elsewhere in the project document that this is the intention.

Health worker pay and benefits

Six of the 25 projects that include some commitment to mobilizing additional health workers also specify that they will fund health worker salaries: they are Afghanistan, Bangladesh, Haiti, Kyrgyz Republic, Lao and North Macedonia.¹¹³ Of these 6, all but North Macedonia include some form of bonus or top-up payments for health workers.

Overall, 30% of the projects (21 of 71) include some kind of bonus, top-up or hazard pay for health workers. However, in 7 of these 21 projects, this comes with no commitment to mobilizing additional health workers or to covering health worker salaries.

There are also 2 projects (Indonesia and Georgia) which do not include plans to mobilize additional health workers, but are funding salaries and other pay for *existing* health workers. In the case of Indonesia, the project will finance 'hospital recurring costs such as salaries and top-ups' for existing staff who are being redeployed to

focus on COVID-19. Georgia's project will cover salaries of 'idle capacity' in public and private health facilities that have been designated to receive COVID-19 patients to 'ensure standby readiness'. In other words, the project will pay existing staff to remain in post, to help ensure there is capacity to cope with increased demand.

Three of the 71 projects use the MPA's language (as discussed in 2.1), stating they will support 'operational expenses related to mobilization of health teams', but without specifying whether this includes health workers' salaries or other pay. These are Bhutan, which *is* mobilizing additional health workers, and the Republic of Congo and DRC, which do not plan to do so.

Analysis

It is positive that almost half the projects (34 of 71) include some level of commitment to mobilizing additional health workers and/or providing pay to health workers. However, it is a very significant concern that the remainder do not.

It is particularly disappointing that 65% of projects have no plans to support increasing the number of much-needed health workers – and that the 25 projects which *do*, have significant shortcomings. For example, in a number of projects extra health workers are only being taken on temporarily, and none of them specify a large number of additional workers.

65% of projects have no plans to support increasing the number of much-needed health workers.

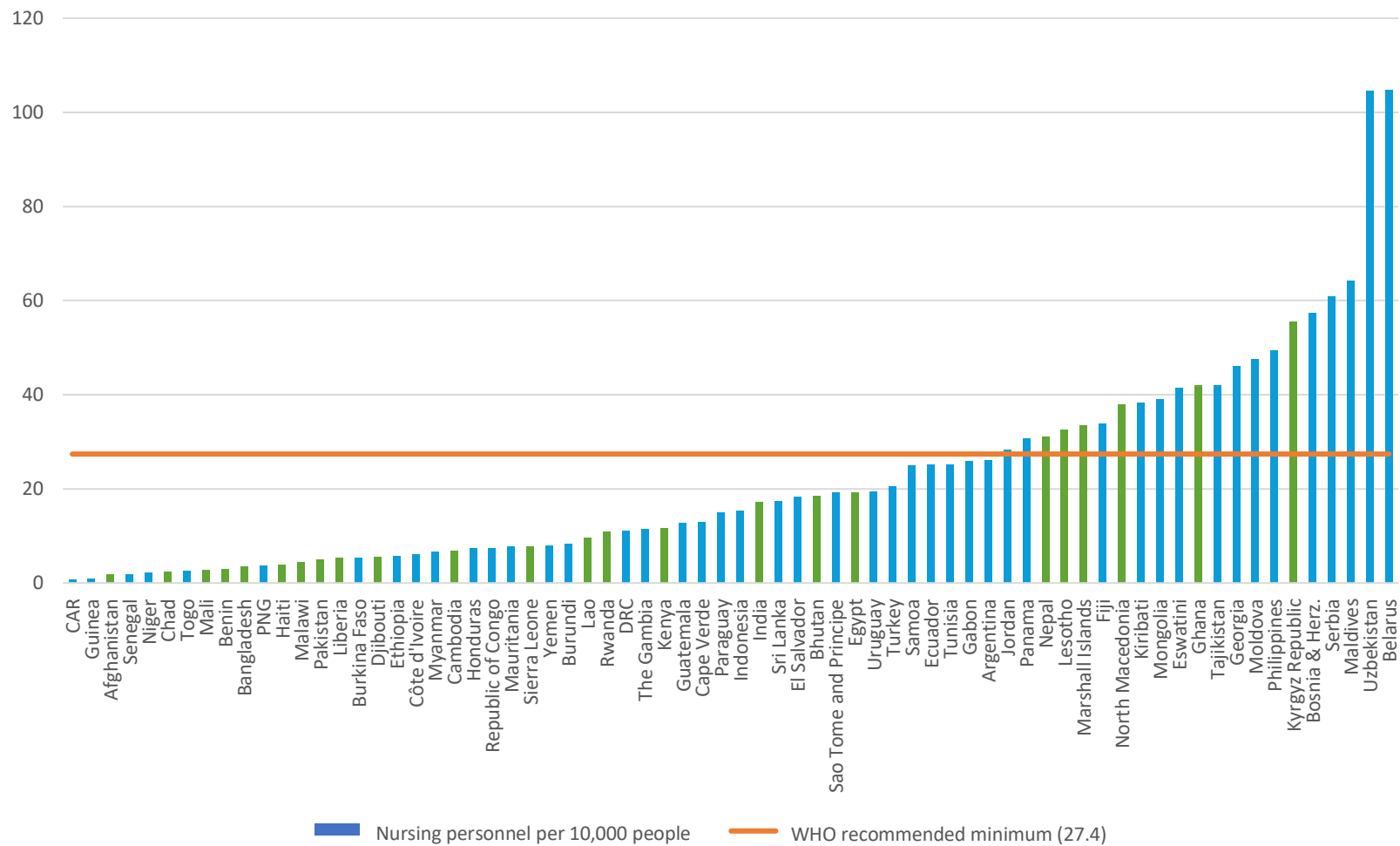
A comparison of country projects against the available WHO data on health worker density raises some significant questions about the scale and consistency of the World Bank's approach to bolstering the health workforce (see Figure 2).

Figure 2 compares the number of nurses per 10,000 people in the 70 project countries for which this data is available¹¹⁴ to the WHO's minimum recommended level of 27.4.¹¹⁵ In 70% of countries (49 out of 70), the ratio of nurses is lower than this threshold. Some countries are far below it: 34 are not even halfway to meeting the minimum target, and at the very bottom end of the range, the Central African Republic has just 0.72 nurses per 10,000 people. Figure 2 shows that the countries taking action to mobilize additional health workers under this World Bank operation (shown in green¹¹⁶) are not necessarily those with the greatest level of need. They are found right across the spectrum, ranging from Afghanistan, with a very low nursing personnel density of 1.76 per 10,000 people, to the Kyrgyz Republic, which has far higher coverage at 55.5 per 10,000.

Although some pre-existing World Bank health programmes may be supporting countries to improve the supply of healthcare workers, the ongoing high levels of need in project countries creates the impetus for more urgent action, especially in the context of the pandemic. Our findings lead us to conclude that the first tranche of World Bank COVID-19 funding is far from adequate in boosting health worker numbers, and has not consistently directed such support to the countries facing the most critical shortages.

Figure 2: Nursing personnel density compared with WHO recommended threshold

For 70 of the 71 countries analysed; no data available for Kosovo



Source: Oxfam graph using data from WHO National Health Workforce Accounts Data Portal (retrieved Sept 2020).

Note: Countries receiving World Bank support to mobilize additional health workers are shown in green.

Box 1: Missing health workers in Malawi

Malawi has one of the lowest numbers of nurses relative to its population of the countries Oxfam reviewed – just 4.4 nurses per 10,000 people in 2020.¹¹⁷ This is less than one-sixth of the WHO's recommended minimum ratio.¹¹⁸ The WHO estimates that by 2030 Malawi will face a shortage of 40,000-50,000 nurses.¹¹⁹ Redressing this gap would require increasing today's nursing workforce by more than 500%.

The World Bank's COVID-19 project for Malawi¹²⁰ provides \$7m to support the government in its pandemic response to 'prevent the spread of COVID-19 through surveillance and containment strategies', and 'strengthen the capacity of the public health system for preparedness [to] respond to COVID-19' and other health threats. It explicitly recognizes health worker capacity, shortage and maldistribution as significant challenges to the health system and its ability to respond to the pandemic. Yet while the project provides some response and is therefore counted in Oxfam's research as taking positive action on increasing health worker numbers, the response is extremely limited. The project includes elements of health worker training related to COVID-19 as well as 'surge capacity' for disease surveillance and control and general clinical capacity. However, the only related target or indicator is for 388 'surge capacity health workers' to be contracted and deployed. It is also unclear if this is redeployment from elsewhere in the system or truly new, additional workers.

The President of Malawi issued a directive on COVID-19 that included a target of recruiting 2,000 health workers and increasing risk allowance for existing health workers. As of April 2020, the Ministry of Health has reportedly hired 755 workers including laboratory technicians and nurses, but there has been no public update on progress since. Malawi's health budget is currently heavily dependent on donor support: 75% of it was funded by external sources in 2017/18.¹²¹ In the face of such urgent need for more health workers and such limited domestic resource in Malawi to pay for it, it is of considerable concern that the World Bank and the Government of Malawi did not appear to work together to increase the scale of support for health workers in the World Bank response, or document other donor contributions to this effort. The limited action in Malawi and the lack of World Bank support in many other countries with similar shortages raise significant questions as to why health workers have not been a higher priority in the World Bank's COVID-19 response.

The overall lack of clarity in the project documents around recruitment and pay of health workers is also very concerning. It makes it difficult to determine exactly what countries are planning, or to assess the quality and scale of interventions in this important area. It also makes it impossible to understand the direct impact on frontline health workers, the vast majority of whom are women. We found only 3 projects (Kenya, Kosovo and Malawi) which specified the number of additional workers the project will mobilize, and none of the projects detail how much funding is being spent on recruiting and paying health workers. The use of vague language drawn from the MPA, as described in 2.1, is a significant factor contributing to this lack of clarity.

Finally, while Oxfam's research did not assess the volume and quality of interventions to support unpaid carers in their homes and communities, the absence of any significant mention of their support, reward and protection needs in the MPA is a cause for concern. It poses the risk that these will have been, at best, under-considered within the country projects.

2.5 PRIVATE SECTOR INVOLVEMENT

Ensuring the private sector acts in the public interest

The private sector – both for-profit and not-for-profit healthcare actors – can play an important role in helping to tackle COVID-19 in low- and middle-income countries. Given the scale and spread of the virus, and the fact that private hospitals often have the lion's share of intensive care facilities as well as large numbers of trained health workers, it is important to mobilize their resources in the public interest. The WHO has recommended that in their COVID-19 response, governments engage the private sector and civil society to surge capacity, mobilize and manage public and private health staff according to need, and ensure that facilities have the necessary supplies and financing to meet the needs of all patients.¹²²

The pandemic has further demonstrated the crucial and central role that publicly provided health systems can and must play in protecting peoples' health, and the damage caused by starving them of funding. Governments and donors must ensure that any financial support to the private healthcare sector does not come at the expense of investment in public health systems. The pandemic has also illustrated the dangers of significant reliance on profit-seeking healthcare providers in particular. For example, in many countries, for-profit providers have shut their doors during the pandemic; others are denying services to people with COVID-19 or overcharging for COVID-related services.¹²³ This is despite WHO guidance that user fee removal should apply to *all* healthcare providers,¹²⁴ and that private sector tests, treatment and care should be free of charge to patients.

In many countries, for-profit providers have shut their doors during the pandemic; others are denying services to people with COVID-19 or overcharging for COVID-related services.

Public funding support for private healthcare actors – especially the for-profit sector – must be subject to robust government oversight to ensure it is in the public interest. Contracts and partnerships should only be entered into with providers that have a track record of good-quality care and upholding patient and worker rights. Any such agreements should only take place in contexts where there is sufficient regulatory capacity and experience to ensure standards are met. Financing arrangements should be temporary, flexible according to need, and based on true at-cost prices of provision. Crucially, there must be full transparency from governments and donors about the details of any support to private healthcare actors, so that these investment decisions can be monitored and duty bearers held to account. Wherever possible, this information should be in the public domain.¹²⁵

The MPA framework does not describe how this World Bank COVID-19 support might help to mobilize or requisition private services in support of a public health response, nor does it mention these critical areas of affordability, regulation, transparency and accountability. It does, however, focus its support on investment in public health systems, with funding for private sector implementation or service provision seemingly only envisaged in a small number of fragile settings.

Oxfam reviewed the 71 country projects to assess the level and type of support being channelled to the private sector, especially where it could play a role in health service provision. Given the particular risks of channelling public financing to for-profit private providers,¹²⁶ we paid special attention to any proposed support to these actors.

Findings

The role of the for-profit private sector

Seventeen of the 71 projects (24%) indicate the possibility of support for private for-profit actors to play a role in the implementation of project activities, beyond the provision of medical supplies and equipment. These projects either strongly imply they are supporting *for-profit* actors, or use vague wording that makes it a possibility.

- It is strongly implied in Sierra Leone and Chad's projects, as private actors are mentioned *in addition to* not-for-profit actors. The former states 'private firms with substantial experience in public health emergencies, NGOs, and UN Agencies would be contracted to implement some project activities'. The latter refers to project execution through 'UN agencies and NGOs' and 'other stakeholders like the private sector'. It is strongly implied in Turkey's project, which states activities 'may be outsourced to third parties' but seems to exclude not-for-profit actors, also noting 'the Government has not involved nongovernmental organizations in the pandemic response'.
- It is implied by the Burkina Faso and Mali projects, both of which specifically mention partnership with 'the private sector', and in Jordan's project, which states the government could 'enter into an agreement with... private entities, or other third parties'. It is also implied by the language in Georgia, Ghana, India, Lesotho and Uruguay's projects, which refer to private facilities, hospitals or healthcare providers.
- The final 6 projects use vague language that could include the private for-profit sector. Belarus, Bosnia and Herzegovina, Ethiopia, Kyrgyz Republic and Lao refer to outsourcing activities to 'third-parties', and the Marshall Islands mentions the mobilization of 'service providers'.

In 7 of these 17, it is implied that private for-profit actors will or could be supported through this World Bank operation to play a role in health service *provision*.

- **Georgia's** project will 'transfer funds directly to public and private facilities that are designated to receive COVID-19 patients to compensate them for idle capacity and ensure standby readiness to provide COVID-19 care'.
- **Ghana's** project includes 'contracts for private management of newly established infectious disease centers and medical villages'. The project budget includes leasing 12 private health facilities 'to be used as a treatment center' at a cost of \$900,000 per month, as well as other leasing, refurbishing and running costs (that may relate to these private facilities) totalling at least a further \$2.34m. No further detail is provided about these arrangements.
- **India's** project states that the government will 'hire or deploy additional healthcare providers as needed to surge India's capacity for diagnostic and intensive care treatment services for COVID-19'. The PAD states that project benefits will include 'improving access to life-saving healthcare through improved facilities for COVID-19 treatment in both public and private hospitals'.
- **Lesotho's** project explains that the government pays the Queen Mamohato Memorial public-private partnership Hospital (QMMH)¹²⁷ for up to 24,000 patient referrals each year including infectious diseases and epidemics (and specifically the use of ICU beds); it says the project can support 'exceptional services' that 'require additional financing from the Government' but also notes potential challenges due to ongoing financial sustainability problems with the PPP.¹²⁸

- **Mali's** project states that 'Across all components, the project will promote partnership with the private sector to improve areas of known weaknesses in the provision of public goods across all project activities.'
- In the case of the **Marshall Islands** the implementation arrangements state that the government has requested to contract a not-for-profit which will 'mobilize international experts/service providers'. These providers could include private for-profit actors.
- **Uruguay's** document says 'Most of the project's proceeds (approximately 85 percent) will be used to support payments for defined COVID-19 related outputs provided by private and public HSPs' (Health Service Providers).

The remaining 10 of the 17 projects do not provide enough information to ascertain whether or not the private sector is being supported to engage in health service provision (Belarus, Bosnia and Herzegovina, Burkina Faso, Chad,¹²⁹ Ethiopia, Jordan, Kyrgyz Republic, Lao, Sierra Leone and Turkey). Their project documents state that the private sector will be supported to engage in the implementation of project activities, but do not specify which activities¹³⁰ or what role the sector will play. This doesn't rule out a role for for-profit private actors in providing healthcare.

The role of the not-for-profit private sector

There are also a number of projects that could support the not-for-profit private sector to play a role in implementing project activities. In total, 26 of the 71 projects leave the door open to this, 9 of which are among those discussed above, as they *also* suggest the option of support to for-profit private actors.¹³¹

In 10 of these 26 projects, it is possible that not-for-profit actors could receive support to engage in health service *provision*. This is implied in the language of 6 projects (Afghanistan, Central African Republic, Gabon, Marshall Islands, Mauritania, and Sao Tome and Principe). In a further 4 projects (Chad, the Maldives, Papua New Guinea and Yemen¹³²), the UN and/or NGOs play such a large role in the project that it is likely they will be involved in some form of health service provision.

Private provision and free services

Overall, there are 16 country projects where private actors will or could play a role in health service *provision*.¹³³ Only 3 of these (Georgia, Ghana and Mali) are also supporting some kind of fee waiver, and only Georgia makes it explicit that the fee waiver will guarantee free access to services provided by 'public and private medical facilities'. In the case of Ghana and Mali, no mention is made of the waivers covering private health services. So while a significant level of private health service provision is implied across the projects, there is a very low level of commitment to ensuring they are free of charge.

Analysis

The extent of private sector engagement in the World Bank's COVID-19 support goes far beyond the MPA's guidance, which suggests that implementation through 'third parties' would be limited to a small number of fragile contexts.

Of the 71 projects, 16 (23%) will or could support the private sector to play a role in health service provision. Seven of these indicate that this includes for-profit private

actors. The true scope of for-profit private sector provision may be even wider, given that private sector health activities in numerous other projects are described in such vague terms that service provision cannot be discounted.

While this is not inherently problematic, and private sector health resources can contribute positively to a public sector response to COVID-19, our assessment of the MPA and the 71 project documents give rise to two major concerns.

First, in projects indicating that the private sector will or could play a role, there is a worrying lack of detail. In most cases this means it is impossible to adequately assess the nature or extent of private sector interventions, or even how likely they are to take place. The lack of clarity is particularly concerning in some of the country projects that indicate a significant role for the private sector. This is most clearly illustrated in the examples of Ghana, Chad and Mali.¹³⁴ In Mali, the project indicates general and sweeping support for the private sector, without detailing what this might be.

There is also insufficient information to assess whether private sector facilities and services supported by the projects will be made available to all, without fees or other cost barriers. Just three countries where the private sector will play a role in service provision are also implementing fee waivers, and Georgia is the only one to specify that this will cover the private sector.

Box 2: High costs for COVID-19 care in India's private sector

The World Bank's problematic lack of attention to financial barriers in the private sector is clearly illustrated by the India project, which plans to engage 'private laboratories to expand capacity to test and manage Covid-19', and to improve 'access to life-saving health care through improved facilities for COVID-19 treatment in both public and private hospitals'. India's project documents make reference to the important role of the private sector in providing services both in rural and urban areas, but the significant challenge of financial barriers – including frequent excessive charging by private sector providers – is not mentioned. Many state governments in India have now capped the cost of COVID-19 testing in the private sector, providing some relief for patients, but during the pandemic it has been widely reported that many private providers have charged exorbitant fees for PPE kits, gloves, medicines and hospital beds,¹³⁵ and that patients admitted for 10-15 days with COVID-19 have racked up bills of between \$5,000 and \$22,000.¹³⁶

Given that both for-profit and not-for-profit actors can charge user fees and medicine costs that reduce access, especially for those on middle to low incomes as well as for women, girls and marginalized groups, this is a major concern.

Secondly, it is a significant failing that neither the MPA nor the country projects stipulate safeguards to ensure that the private sector's role supports a public health response to the crisis and doesn't undermine public health system strengthening. The World Bank should have set out a number of minimum conditions, including:

- Private sector actors that are supported to provide health services do so free of charge with fair and at cost compensation to ensure they are accessible for everyone.
- Any private sector role funded through this operation is temporary and based on contractual arrangements that are fair to the public purse and do not

Neither the MPA nor the country projects stipulate safeguards to ensure that the private sector's role supports a public health response to the crisis and doesn't undermine public health system strengthening.

generate private sector profits.

- Any support for private sector involvement in the implementation of project activities is fully transparent, with details open to public scrutiny.
- Any support for private sector providers is conditioned on minimum standards and regulatory enforcement, with appropriate safeguards and redress systems in place to respond to poor-quality standards of care, violation of patient rights, price gouging and other forms of abuse.

3 CONCLUSION

COVID-19 has starkly exposed the widespread failure to invest in strong and universal public health systems. As a result, millions of lives are at risk and health inequalities are dramatically widening. The World Bank has provided important and timely financial support to countries to bolster their responses to COVID-19, and should be commended on the speed and breadth of this support. Oxfam's research found that the World Bank's COVID-19 health funding was strong in some of the areas we assessed, particularly the scale of support for public health promotion. However, our findings show that the Bank has fallen short in some critical areas that warrant immediate attention.

It is welcome that 69% of projects include action on both public health promotion and WASH, and that much attention is given to improving WASH within health facilities. However, it is a significant concern that only 2 of the 71 projects specify WASH interventions for the benefit of the wider public and communities.

The potential for World Bank support for the removal of financial barriers to health services, including through fee waivers, is included in the project framework document, yet 89% of country projects do not plan to support any action on this. And despite the well-documented dramatic shortfalls in human resources for health across the vast majority of low- and middle-income countries, two-thirds of projects do not include plans to increase the number of health workers.

The biggest losers from these critical intervention gaps will be women and girls living in poverty. They make up the overwhelming majority of low-paid and unpaid health and care workers on the frontline, putting them at increased risk of infection. They are also disproportionately responsible for collecting water, which is essential for handwashing, and are most likely to be denied healthcare when fees are charged.

The World Bank's support to private actors within the country projects appears to go further than envisaged in the MPA. In all cases, even where the role of the private sector appears potentially significant, the lack of detail or information provided is concerning. The risks of partnering with the for-profit private sector in health, particularly in a public health context, are well known.¹³⁷ Despite this, there is an absence of conditions or stipulations to ensure that private actors receiving support will provide services free of charge in line with WHO guidance, that minimum standards and safeguards for patients exist and can be enforced, or that contracts are transparent, accountable, and based on at-cost prices.

RECOMMENDATIONS

Oxfam's findings suggest the need for an urgent and significant course correction in the World Bank COVID-19 response to help countries effectively fight the pandemic, protect health gains made over the last two decades and build the foundations for fairer, more resilient universal healthcare systems. The pandemic should mark a turning point for the World Bank's health policies, with unequivocal and vocal

support for quality healthcare for all, free at the point of use, built on a strong foundation of a paid and fully protected health work force and universal comprehensive primary healthcare.

The World Bank should:

- Send a strong, clear and public message that all countries should make healthcare free by removing user fees and other direct payments for all essential healthcare for the duration of the pandemic and for the long-term – including, but not limited to, COVID-19 diagnostics, treatment and care – and that it will provide financial support to countries to achieve this.
- Urgently redress the gaps in World Bank support for additional health workers and for their decent work, pay and protection. Immediately assess needs and if necessary, deploy additional financing for countries for interventions to pay and protect existing and additional health workers including community health workers, and to ensure the recognition, reward and protection of unpaid care workers in their homes and communities.
- Maintain strong and consistent support for public health promotion and the improvement of WASH in health facilities. Review and where needed, scale up its support for improving access to safe water, adequate sanitation and improved hygiene for wider communities in public places, including schools, or in homes.
- Introduce minimum standards and safeguards for any financial support provided to the private sector for the COVID-19 emergency response, including that user fees are removed and services are provided to governments at cost; that contracts are transparent and open to public scrutiny; and that quality standards and patient rights are upheld and can be enforced.
- Cancel all debt payments owed to the Bank for the duration of the pandemic, to ensure that countries can devote their limited resources to responding to the crisis and building resilient public health systems. It should avoid further indebtedness by making sure that current and ongoing emergency financing is provided to low-income countries as grants, and to middle-income countries as concessional loans. The Bank should avoid diverting funds for the COVID-19 health response from existing projects that are providing essential health and other public services, and should strive to make pandemic response funding additional to existing resource flows.
- In the longer term, it should support countries to build fairer and more progressive tax systems and clamp down on tax dodging, to increase domestic financing available for health and other essential services.
- Ensure full inclusion of civil society stakeholders at the local and national level in the design and implementation of COVID-19 projects, including women's rights organizations and those representing disadvantaged or vulnerable groups; provide accessible, timely information about projects that is understandable to communities. Ensure that intersecting inequalities of gender, income, race, ethnicity and disability are proactively addressed in the design of new projects and redress these gaps in SPRP projects.

Donor governments should:

- Urgently scale up aid to health, both for the emergency pandemic response and for building universal public health systems with services free at the point of use. Make fair-share contributions to the World Bank's International Development Association (IDA) COVID-19 additional funding request, to maximize grants for

countries while ensuring that the Bank provides debt relief to countries in addition to its pandemic assistance.

- Use their Board representation at the IMF to ensure it is not encouraging or requiring governments to adopt austerity measures during or after the COVID-19 pandemic that could limit governments' fiscal space to support health services and public healthcare workers.

All governments should:

- Urgently scale up health spending to fight the pandemic and build resilient universal healthcare systems. Specifically, ensure that healthcare is available to all people free of charge; invest in the additional health workers needed and their pay and protection; prioritize the health needs of women and redress other inequalities in access and outcomes; ensure adequate oversight and regulation of privately-provided health services; deliver clean water and sanitation for all communities; and ensure investments in other prevention activities.
- Improve domestic revenue mobilization focused on building fair and progressive tax systems to increase financing available for health and other essential public services.

NOTES

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- 81 It also states that 'support would be provided for ensuring safe water and basic sanitation in the designated health facilities and laboratories for COVID-19, as well as to strengthen medical waste management and disposal systems'.
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- 84 The Kyrgyz Republic's project states that ports of entry 'that lack adequate handwashing facilities, restrooms or other basic health and hygiene conditions will be updated to a basic level'.
- 85 Chad's project includes 'basic hygiene supplies/toiletries such as soap and a towel, to quarantined households and those of people in isolation... and treatment centers'.
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- Specific wording in the PAD: 'The poverty targeting mechanism of the on-going conditional cash transfer (CCT) project – Reducing Rural Poverty and Malnutrition in Lao PDR (RRMP) (P162565) could be leveraged to identify poor families and make them eligible for free healthcare under the National Health Insurance Fund. Home quarantine of suspected cases and contacts can be made into a condition to qualify for CCT through the RRMP.'
- 102 Côte d'Ivoire's Project Appraisal Document (see point 30):
<http://documents1.worldbank.org/curated/en/197511589210291563/pdf/Cote-dIvoire-COVID-19-Strategic-Preparedness-and-Response-Project.pdf>
- Specific wording in the PAD: Sub-component 1.3 'will support COVID-19 patients, their families, and contacts under isolation by covering costs related to... three months of Universal Health Coverage (Couverture Maladie Universelle, CMU) premiums to all beneficiaries of financial support in the form of cash transfers, which will systematically be enrolled in the CMU. This action will promote the enrollment of households, increase the risk pool, and expand financial risk protection for households and communities impacted by COVID-19.'
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- 110 Ibid.
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- 112 The project components include financing for 'consultant lab staff' and 'clinical surge support to add provider capacity', and the sustainability section mentions that the project will support 'the mobilization of human resources' with the support of the Pacific Island Health Officers' Association.
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<http://documents1.worldbank.org/curated/en/353011587944635065/pdf/Marshall-Islands-COVID-19-Emergency-Response-Project.pdf>
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- 116 Twenty-four of the 25 countries receiving World Bank support to mobilize additional health workers are indicated in green in the graph. There is no data on nursing density available for the 25th country taking action – Kosovo – and therefore it does not appear in the graph.
- 117 World Health Organization (2020) State of the World's Nursing 2020 - Fact Sheet Malawi <https://apps.who.int/nhwportal/Sown/Files?name=MWI>
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- 129 It is notable that the language in Chad's project document implies strong support for engaging private actors in implementation. It states: 'The immediate response will be mostly executed through relevant UN agencies and NGOs... and, where possible, other stakeholders like the private sector will be considered'.
- 130 Project activities are varied. They include, for example, health worker training, institutional and organizational capacity building, health and hygiene promotion, surveillance and testing, project management and monitoring and evaluation. They are also often vague in themselves.
- 131 They are: Bosnia and Herzegovina, Belarus, Chad, Ethiopia, Jordan, Krygyz Republic, Lao, Marshall Islands and Sierra Leone.
- 132 Yemen is an exceptional case among the 71 projects reviewed, as it is the only one where no funding will be channelled through the government; the WHO is the implementing entity for the entire operation. This is consistent with ongoing World Bank operations in Yemen more broadly.
- 133 The Marshall Islands project document implies that both for-profit and not-for-profit actors could be involved in provision, and is therefore included both in the 10 projects where for-profit actors could be involved in provision and in the 7 projects where not-for-profit actors could be involved in provision. This is why the total here – across both for-profit and not-for-profit – is 16 rather than 17.
- 134 For example: Ghana's project mentions support to the private sector for health service management, and includes some substantial figures in the budget that could be funding the for-profit private sector. However, it is not possible to assess these arrangements more closely, as the detail is so scant. Chad and Mali's projects imply it is desirable for 'the private sector' to play a role, without detailing what this might be. This is particularly concerning in the case of Mali, as the project indicates general and sweeping support for the private sector, saying 'Across all components, the project will promote partnership with the private sector.'
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