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Health Sector Policy

"Affordable Quality Health Services for Human Development"

Social Infrastructure Division

Economic and Social Infrastructure Department (ESID)

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Abbreviations

AWD	:	Acute Watery Diarrhea
BED	:	Board of Executive Directors
CAE	:	Country Assisted Evaluations
CBOs	:	Community Based Organizations
COMCEC	:	Committee for Economic and Commercial Cooperation of OIC
CRS	:	Country Relations and Services Directorate
CVDs	:	Cardio Vascular Diseases
EPR	:	Emergency Preparedness and Response
FRP	:	Financial Risk Protection
GOED	:	Group Operations Evaluation Department
GVC	:	Global Value Chain
HSP	:	Health Sector Policy
ICD	:	The Islamic Corporation for the Development of the Private Sector
IsDB	:	Islamic Development Bank
IRTI	:	Islamic Research and Training Institute
ISFD	:	Islamic Solidarity Fund for Development
ITFC	:	Islamic Trade Finance Corporation
LLF	:	Lives and Livelihood Fund
MC	:	Member Country
MCPS	:	Member Country Partnership Strategy
MENA	:	Middle East and North Africa
MHPSS	:	Mental Health and Psychosocial Support
MNCH	:	Maternal, Neonatal and Child Health
NCD	:	Noncommunicable Diseases
OIC	:	Organization of the Islamic Cooperation
OOP	:	Out-of-Pocket expenditure
PHC	:	Primary Health Care
PPER	:	Post Project Evaluation Reports
PHCPI	:	Primary Health Care Performance Initiative
PPP	:	Public-private Partnership
R&D	:	Research & Development
SESRIC	:	Statistical, Economic and Social Research for Islamic Countries
SDGs	:	Sustainable Development Goals
SHPA	:	Strategic Health Programme of Action
UHC	:	Universal Health Coverage
UNOCHA	:	United Nations Office for the Coordination of Humanitarian Affairs
WASH	:	Water, Sanitation and Hygiene
WYE	:	Women and Youth Empowerment

Purpose, objectives and background

1. The benefits of investing in health are significant and are not limited to improving the health of the population alone. A report by the Lancet Commission on *Investing in Health (2013)* lays out the channels by which health improvements have a direct impact on gross domestic product, productivity (healthy people are more productive and less likely to take sick days), education (healthier children are more likely to go to school), investment (people are more likely to save when life expectancy is longer), access to natural resources (can be affected positively by a reduced risk from endemic diseases) and demographics (temporary impact on ratio of working-age to dependent people).
2. The IsDB health policy is intended to guide all IsDB health programs and operations, focusing on the need to attain Universal Health Coverage (UHC) in member countries within the context of delivering Primary Health Care (PHC). The UHC will remain the cornerstone of program development within the IsDB Member Countries (MCs) to align with the international consensus.
3. International consensus supports health sector goals that focus on improving the health status, financial protection and responsiveness to citizen satisfaction with the health system while promoting equity in all these objectives. These objectives can be achieved by improving access to, and the quality of, health services and efficiency in the use of scarce resources. These objectives are promoted internationally by the Sustainable Development Goal 3¹ (SDG 3) and the commitment to work towards achieving the UHC. These objectives are in alignment with the current broad strategic objectives of the Islamic Development Bank (IsDB), especially the President's Five Years Program (P5P) which focuses on competency, linkages, innovation in financing and results delivery.
4. IsDB has committed to achieving these objectives that have been historically cited in many health reform programs and international agreements including the commitments to achieving the SDGs, PHC goals and UHC. Recently, the SDG3+ initiative and the Global Action Plan for Healthy Lives and Well-Being (GAP) are pushing this commitment even further.

¹ Sustainable Development Goal 3 of the 2030 Agenda for Sustainable Development is to “ensure healthy lives and promoting well-being for all at all ages”. The associated targets aim to reduce the global maternal mortality ratio, end preventable deaths of newborns and children, end the epidemics of AIDS, tuberculosis, malaria and other communicable diseases, reduce mortality from non-communicable diseases; strengthen the prevention and treatment of substance abuse, halve the number of deaths and injuries from road traffic accidents, ensure universal access to sexual and reproductive health-care services, achieve universal health coverage, and reduce the number of deaths and illnesses from hazardous chemicals and pollution.

5. The policy is centered on the theme: "*Affordable quality health services for human development*".
6. The policy highlights the IsDB's vision for the health of the population in MCs, framed within the core Sharia principles of '*doing no harm*' and capitalizing on the inherent advantage of our Islamic identity to provide health programs in MCs. The Bank will support efforts that prioritize, promote and protect people's health and psychosocial well-being through Primary Health Care (PHC) systems that provide quality, safe, comprehensive, integrated, accessible, available and affordable services for everyone everywhere with compassion, respect and dignity by well-trained, skilled and motivated health professionals. This service shall be provided in conducive environments in which individuals and communities are empowered and engaged in maintaining and enhancing their health and psychosocial well-being in all conditions (fragile circumstances, inclusive), working collaboratively with partners and stakeholders, using community engagement and a "whole of society approach" that aligns with effective support to related national policies, strategies and plans (such as water and sanitation, climate change, agriculture etc.).
7. The Bank will support the achievement of SDG 3 and all related SDGs. In this regard, the Bank will expand the niche for exploring the use of Islamic finance tools to contribute to the financing gap for the SDG 3 targets and related indicators.
8. The IsDB health policy is also informed by the strategic health documents of sister institutions such as Organization for Islamic Cooperation (OIC), Multilateral Development Bank (MDBs) and specialized agencies. The global UHC approach which has been adopted by the World Bank and its multi-partner Primary Health Care Performance Initiative (PHCPI), the Africa Development Bank's Africa Health Transformation Program, the World Health Organization's (WHO) Vision for Universal Health Coverage, the Asian Development Bank (ADB) Strategy 2030, all of which have set the course for these institutions and agencies to respond effectively to the changing needs and challenges in the health sector.

Definitions

9. **Universal Health Care (UHC)**² means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

² https://www.who.int/health_financing/universal_coverage_definition/en/

10. **Primary Health Care (PHC)**³ is a whole-of-society approach to health and well-being centered on the needs and preferences of individuals, families and communities. It addresses the broader determinants of health and focuses on the comprehensive and interrelated aspects of physical, mental and social health and wellbeing.
11. **Quality of Care**⁴ is defined as, “the extent to which health care services provided to individuals and patient populations improve desired health outcomes.” In order to achieve this, health care needs to be safe, effective, timely, efficient, equitable and people-centred.
12. **Article 25 of *The Universal Declaration of Human Rights***⁵ stipulates that (1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihoods in circumstances beyond his control and; (2) Motherhood and childhood are entitled to special care and assistance.
13. **Financial protection**⁶ is achieved when direct payments made to obtain health services do not expose people to financial hardship, and do not threaten living standards. UHC prioritizes substituting pooled financial resources (insurance or tax-based funding) for individual *out-of-pocket* (OOP) payments for access to appropriate health services.

Scope

14. The context of this Health Policy is to provide direction for the Bank to support strengthening the health systems within IsDB MCs where many of the low-income countries and lower-middle income countries⁷ are not yet on course to achieve the SDG 3 and related SDGs. These same countries have high prevalence of communicable diseases and weak programs to address maternal, neonatal and child health (MNCH) within a context of varying levels of fragility and conflicts.

³ <https://www.who.int/news-room/fact-sheets/detail/primary-health-care>

⁴ Standards for improving quality of maternal and newborn care in health facilities. Geneva: World Health Organization; 2016 (http://www.who.int/maternal_child_adolescent/documents/improvingmaternal-newborn-care-quality/en/, accessed 30 January 2017).

⁵ <https://www.un.org/en/universal-declaration-human-rights/>

⁶ https://www.who.int/health_financing/topics/financial-protection/en/

⁷ using the World Bank income categories

15. The Technical Study (TS) conducted as part of the MCs situation assessment; provided evidence for the development of this document and will further guide the development of its operational strategy. The Technical Study has shown that many of the IsDB upper middle-income countries⁸ are not on track to achieving SDGs or are still far from reaching the high-income country standards of health status in the global north, especially in relation to Maternal Neonatal and Child Health (MNCH), and that there were huge health and economic disparities across MCs and within the same country.
16. The Technical Study findings also showed that there are prevalent fragile situations⁹ in some IsDB MCs, with few countries being in a crisis stage, some undergoing reformation and transition while others building resilience. The study noted that despite the economic stability of some of the IsDB MCs, the health status indicators of all IsDB MCs evidenced health inequities that exist even in the “high income countries”. Arguably, the Bank’s project financing did not target vulnerable low-income populations who live in these high to middle-income countries. Moreover, the IsDB health portfolio of operations were not being implemented under any consistent and clear policy guidance, with more health financing going to middle-income countries than to low-income countries, even in the face of the need in these poorer countries to access funds and their inherent poor ability to absorb the IsDB ordinary financing. It is also to be noted that the support for health operations is skewed towards hospitals construction and equipment supplies, despite the dire need for PHC services in these Low-income countries.
17. This policy will target initiatives that, therefore, include addressing financial insecurity, especially the high Out – of – Pocket (OOP) health expenditure, improving access to quality care for the most vulnerable and low-income populations in MCs, and delivering the most benefit with the least cost in a people-centered sustainable value creating manner.
18. The policy will mainstream impact investing, which is the approach of intentionally pursuing both profit and purpose through Global Value Chain (GVC) concept, as a core and growing area of interest to the Bank. Within the world of investment, the concept of impact investing has become more popular with the need highlighted in the SDGs to fill the critical resource gaps and explore improved value chain delivery systems. IsDB is focusing on this approach and looks to establishing new partnerships and alliances to reduce the cost of health service delivery in MCs, adapting Islamic financing instruments and tools while empowering more people to take ownership and deliver high quality services.

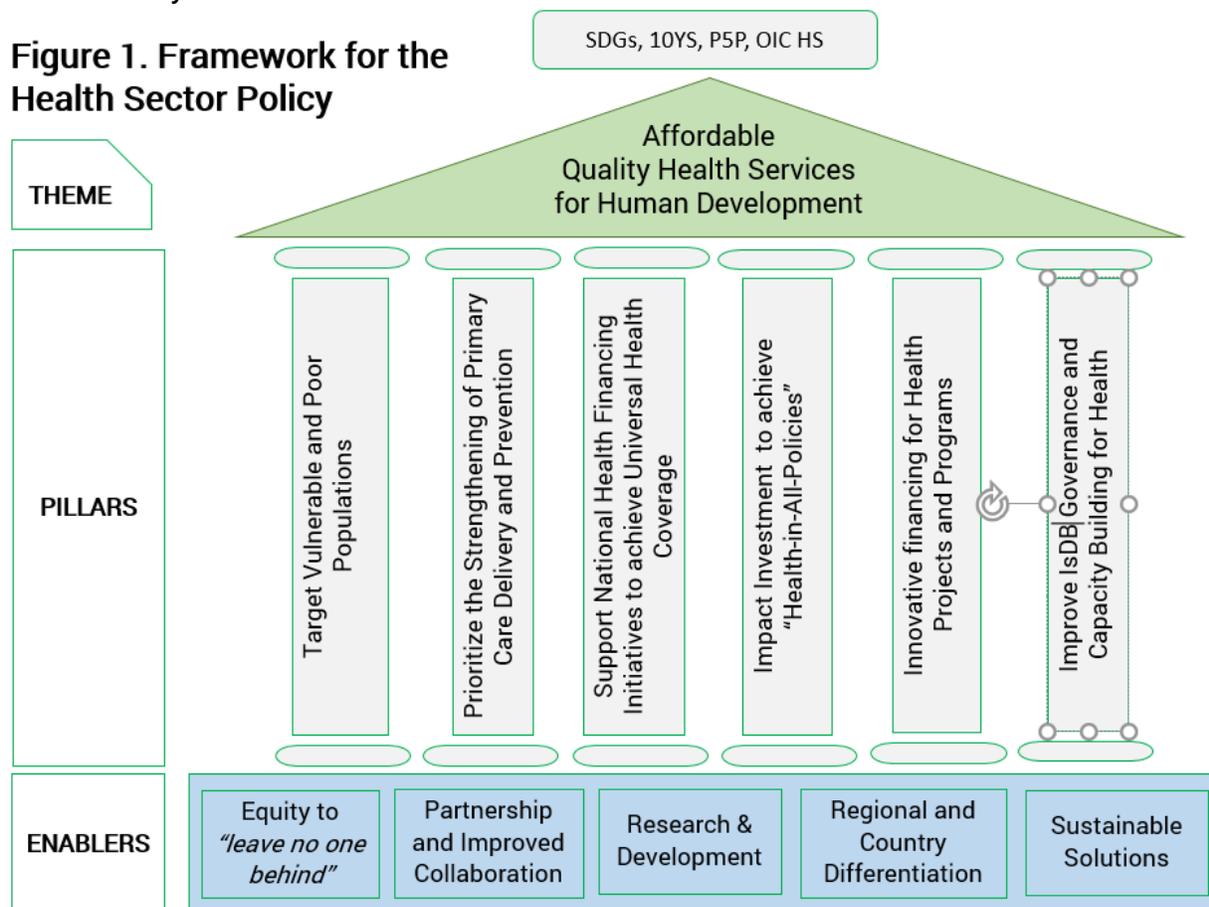
⁸ Upper middle-income MCs in this category include:

⁹ <http://www.worldbank.org/en/topic/fragilityconflictviolence>

19. The IsDB health policy is designed to emphasize the IsDB support for strengthening PHC, diseases prevention and control, MNCH, and financial risk protection to facilitate achieving UHC in MCs, especially in the low and lower-middle income countries where greater health status problems occur, and greater need to address health financing and health system strengthening.
20. This policy is applicable to all IsDB financed health or health-related operations, and those in partnership with other development institutions, multilaterals and donor organizations. It will indicate areas of imperative investments by the Bank, with core accountability and delivery for high impact on health system objectives. It will indicate thematic focus where the Bank will collaborate with other development partners based on its comparative advantage and niches for laudable investments to be singled out for support based on strong evidence and relevance.
21. This policy is within the context of Shariah and health as a *fundamental human right*, and will support the attainment of the needed pre-conditions for achieving the ethical principles of "*leaving no one behind*"; through partnership and improved collaboration, research and knowledge development for evidence-based decision making, health system resources provision, global 'health' value chain development and sustainability strategies.
22. The expected results will be achieved through a purposeful six-pronged approach where IsDB will: i) target the "*last mile*" focusing on the most vulnerable, hard-to-reach and poor population groups to deliver health services from a '*Rights perspective*', which honors the fundamental principles of equity and social justice; ii) support the provision of primary care services, both at the community and facility level, through routine, new and innovative means to ensure access to a minimum package of services for all and address global health issues through preventive and primary care approaches in both the public and private sectors; iii) support schemes to adequate and sustainable financing of the delivery of universal availability of affordable, efficient and quality PHC, ensuring health security in the face of global health threats including climate change; iv) integrate social development efforts by implementing impact investment, and ensuring GVC and "*health in all sectors*" delivery mechanisms are in place; v) explore and pilot the ever growing Islamic Finance for health and seek new innovative and data-driven tools and mechanisms to ensure highest impact of investments; and vi) support the improvement of governance and capacity building for health within the Bank, building and acknowledging the competence required for leadership in the sector, and adopting innovation and data-driven modalities to achieve and measure these desired changes.

23. The Health Policy is articulated on six pillars, promoting SDG-3 and related targets, and contributing to its realization. All the pillars directly support the OIC Strategic Health Program of Action (SHPA) 2014-2023, the P5P and 10YS. The four mandatory enablers are necessary to ensure effective operationalization and implementation of the Policy.

Figure 1. Framework for the Health Sector Policy



The policy is founded on the following pillars:

A. Target vulnerable and poor populations

24. Following the global commitments to achieving SDGs and UHC, this pillar focuses IsDB health policy on health system performance issues, diseases prevention and control, MNCH, and financial risk protection among low income and vulnerable populations. Projects and programs should prioritize low-income countries and lower-middle income countries, and the vulnerable and poor populations in upper-middle income countries and high-income countries including countries most affected by climate hazards. In this regard, IsDB will join the SDG3+ initiative¹⁰ to focus its health efforts and align with those of other donors.

¹⁰ The SDG3+ initiative is included in the Global Action Plan for Healthy lives and Well-being for All (GAP) that is an historic commitment by 12 leading health and development organizations, among them are GAVI, GF, WB, UNAIDS, UNDP, UNFPA, UNICEF

B. Prioritize the strengthening of PHC delivery and prevention, with limited and exceptional support for tertiary care and specialized hospitals

25. PHC is the cornerstone of a sustainable health system and health-related SDGs, to reduce inequalities and contribute to the improvement of well-being and socio-economic development, as well as social stability and security in all countries¹¹. The Declaration of Alma-Ata in 1978 was a landmark in the history of global health. Forty years later, in 2018 the *Global Conference on Primary Health Care* and its associated Declaration renewed a commitment to PHC in pursuit of *health and well-being for all, leaving no one behind*. The focus on PHC is critical at this moment for three reasons: 1). The features of PHC allow the health system to adapt and respond to a complex and rapidly changing world; 2). With its emphasis on promotion and prevention, addressing determinants, and a people-centered approach, PHC has proven to be a highly effective and efficient way to address the main causes of, and risk factors for, poor health, as well as for handling the emerging challenges that may threaten health in the future; and 3). UHC and the health-related SDGs can only be sustainably achieved with a stronger emphasis on PHC.
26. Majority of MCs, especially in Africa are still grappling with what has been described as the unfinished agenda of the MDGs, addressing the burden of communicable, maternal, neonatal, and childhood diseases, and malnutrition, coupled with the dramatic shift in the patterns of disease, as a result of population ageing and unhealthy environments contributing to unhealthy lifestyles. Across all countries, the proportion of disability-adjusted life years lost to NCDs grew from 44% to 61% between 1990 and 2016, with the fastest rises in low- and middle-income countries¹².
27. Addressing these increasingly complex health needs in a cost-effective manner calls for a multisectoral approach that integrates health-promoting and disease-preventing policies, solutions that are responsive to communities, and health services that are people-centered – in short, PHC. Consequently, the Bank's shall devote major portions of concessionary financing toward PHC and disease

and WHO, to accelerate progress towards SDG3 and other health-related targets (SDG3+). The joint vision and commitment to enhance the way the organizations work together to support countries was released in October 2018 in Berlin.

¹¹ G7 Health Ministers declaration 2019: Last accessed 0n 02 - 08- 2019 on <https://www.gouvernement.fr/en/for-an-inclusive-evidence-based-and-sustainable-g7-action-in-global-health>.

¹² A VISION FOR PRIMARY HEALTH CARE IN THE 21ST CENTURY: Towards universal health coverage and the sustainable development goals; Technical Series on PHC © World Health Organization and the United Nations Children's Fund (UNICEF), 2018

prevention interventions. The Health Policy will reinforce PHC through the lens of global health issues and prioritizing prevention in all health operations. Within this Policy approach, there are many initiatives that could be encouraged including strengthening reproductive maternal, newborn, child, adolescent health (RMNCAH), immunization, access to WASH services, nutrition, community health, mental health and emergency preparedness and response for epidemics/pandemics, prevention, screening and treatment of NCDs i.e. Cancer and Cardio Vascular Diseases (CVDs). Choices about priorities in PHC should be made based on the burden of disease and identified gaps in national PHC, cost-effectiveness of needed care and specific systematic barriers to access to comprehensive quality services.

28. The Bank may support investments in secondary level hospitals and specialized centers that support referrals from PHC facilities and, only in exceptional cases, support investments in projects or programs for NCDs or similar specialized care when these diseases are a major health burden, and where critical treatment for these conditions are unavailable or inaccessible to vulnerable populations.
29. PHC projects and programs to include components that work toward significantly improving the human resource requirements, capacity building and adequate allocation for providing the quality care needed.

C. Support national health financing initiatives to achieve UHC

30. IsDB is committed to support government programs to achieve the globally recognized objective of financial risk protection (FRP) through UHC. This can be addressed by providing technical assistance to help design alternative national health financing oriented toward reducing OOP expenses, “pro-poor” through new “pooling” mechanisms such as social health insurance, national health insurance, and equity funds amongst others. Carefully designed and implemented demand creation initiatives, including education, communication, and awareness raising to ensure stakeholder participation, satisfaction and capacity development sustainable programs will be required to ensure successful reformation of the system.
31. Programs supporting financing options for MCs that address high OOP expenditure and seek alternative pooling mechanisms include several alternative options in health financing, such as: Waqf, Zakat funds, tax revenues (especially of items such as beverages, tobacco, processed meats, fast food brands, etc. known to promote disease and harm) in support of national fund for health, equity funds, social health insurance mechanisms that pool government, social impact bonds, employer and beneficiary contributions; community financing mechanisms especially for PHC;

and private insurance. The technical assistance needed for developing appropriate efficient and equitable health financing mechanisms should be included in the process of supporting these national initiatives for health.

32. Carefully designed and implemented demand creation initiatives by civil society and the private sectors, will ensure stakeholders participation and capacity development for successful reformation of the system. This will support the downstream end of the GVC and ensure service uptake. The Bank would also use its relationship with the Ministries of Finance to advocate for health system reforms and for increasing budgets for health sector investments.
33. The Bank would continue expanding its network of developers, such as SDG3+ initiative, public-private partnership (PPP), and operationalize the already signed framework agreements with key partners i.e. GAVI, Global Fund, Merieux Foundation, Bill and Melinda Gates Foundation (BMGF) etc. with the aim of mobilizing additional resources, and leveraging their financing capabilities in support of PHC for UHC.

D. Innovate financing for health projects and programs

34. The requirements of ordinary financing mechanisms of the Bank have limited the Bank's ability to provide adequate funding for health in low-income countries and lower-middle income countries and encouraged investments in hospitals that have large construction and equipment components. The current IsDB innovative financing tools and mechanisms including ISFD, Triple-win innovative financing, Lives and Livelihoods Fund (LLF) have provided an opportunity for additional concessional financing, through grants and soft loans for MCs. Nonetheless, the role of ISFD may be refocused for development of human capital i.e. Health and Education to build upon the gains achieved from the ISFD support for MNCH, Alliance for Avoidable Blindness (AFAB), and Obstetric Fistula (OF) programs.
35. Moreover, innovations should be sought to allow investment using more concessionary funding and partnerships including public-private partnership (PPP) that can create more flexible funding mechanisms to encourage targeted PHC and prevention projects, programs and system reforms especially for low-income countries.
36. The Bank will also support health research agenda proffering solutions to health problems in the Global South in the following areas: i) increasing investment, ii) creating partnerships and networks, and iii) making environments in low- income countries more conducive to research and innovation.

37. In addition to adopting potential financing models, including but not limited to new Islamic financing models, to provide doable and lasting solutions that directly address the misalignment of finance for health and the tangible advantage of investing in the health of the people such as Waqf, Zakat, Sukuk and Micro-Takaful.

E. Achieve impact investment through support for other sectors and thematic policies

38. The health policy would promote collaborations with the other sectors i.e. WASH, Energy, Transportation, and Education to achieve “Health-in-All-Policies” (HiAPs) as part of the Bank’s GVC approach, and vice versa. This Health Policy will mainly support the Bank’s GVC orientation through three types of initiatives: 1) enabling other major investments by addressing issues of occupational health and beneficiary communities’ health where the investments occur, 2) promoting national economic development in Health sector industries that can gain comparative advantage such as the local pharmaceutical industry, medical tourism, vaccines and other health commodities production, and 3) leveraging the five GVCs selected industries for MCPS towards creating health sector initiatives to serve the ecosystems and populations (human capital) who would benefit from such GVCs, hence aligning with human capital development with respect to health and education. Moreover, investments in the health sector itself support broader economic development by providing a healthier and more productive workforce, and by creating a “demographic dividend” that increases the GDP, reducing fertility and increasing the size of the productive population in relation to its dependents.

39. Related to GVC, HiAPs is an approach to public policies across sectors that systematically considers the health implications of decisions, seeks synergies, and avoids harmful health impacts to improve population health and health equity. This is in consonance with the core principles of Sharia, the basic tenet that guides Islamic financing. HiAPs is founded on health-related rights and obligations and contributes to strengthening the accountability of policymakers for health impacts at all levels of policymaking. It emphasizes the consequences of public policies on health systems, social determinants of health, and wellbeing.

40. The Health Policy should also support thematic policies of Climate Change, Human Development, Women and Youth Empowerment (WYE), Public-Private Partnerships (PPP), increasing civil society participation thorough use of NGOs, building the Climate Resilience of health systems and promoting innovations in south-to-south cooperation through the Reverse Linkages program.

41. Integrated actions for improved health will be encouraged by convening investors for health using various platforms and modalities for partnership development. A robust role is anticipated to be played by private investors especially in Public-Private Partnerships within the region. Support for system regulation of practices is key to sustainability for both public and private funded health systems.

F. Improve IsDB governance and capacity building for health

42. The case to invest in health needs comprehensive understanding of health systems throughout the Bank. Specialized capacity development will be required for both internal and external stakeholders including the MCs. Effective and appropriate health sector operations require staff with strong technical abilities and experience in the health sector and the technical staff and MCs counterparts need to be held accountable for achieving objectives and reaching performance indicators. Technical expertise, governance, organization and accountability mechanisms need to be developed and utilized in all health projects design and implementation. Expertise is needed to guide policy and implementation with valid data and skilled analysis for evidence-based decision making.

43. In situations of public health emergencies and pandemics response, the Bank will collaborate with other major national and international actors with emphasis on the relevant UN agencies e.g. WHO, UNICEF, United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA), UNDP etc. to ensure appropriate communication and evidence to support decision-making. Building the capacity of vulnerable, especially in fragile and conflict affected MCs, will increase their adaptive capacity to eminent risks, protecting resources and strengthening livelihoods. Responding to such situations will mean the right resources (technical manpower, skills and financing) is made available to meet the needs. Building the capacity of NGOs and CBOs in MCs will enhance efficiency and timeliness of the response operations.

44. Data on health status and health system performance has been incomplete in many MCs. The Bank would support MCs efforts to improve the Health Management Information Systems (HMIS) for effective data collection, and reflection of the national health status and performance data and information into the international data banks (including SDG Dashboard, World Bank Development Indicators, Global Burden of Disease, PHC performance indicators, etc.) to have up-to -date and relevant country data and for benchmarking with other countries. This will enhance quality and timeliness of the decision-making process.

45. Projects and program financing will be based on sound principles of sustainability, with highly developed risk and mitigation strategies. This should involve clear

commitments for increasing local funding over the life of the project, co-financing with both public and private sector organizations, commitment to refresher and continued training, and continuing maintenance budgets, or as applicable.

46. The Health Policy will promote governance and improve regulatory framework and efficiency by emphasizing the importance of leveraging the expertise, procurement, and economy of scale capabilities of UN and other specialized Agencies.

Guiding principles

At the center of this Health Sector Policy are the following guiding principles/enablers:

47. *Equity "leave no one behind"* is in accordance with Sharia and fundamental human rights. This is also hinged on the need to ensure adequate awareness of the target populations in their various niches and ensure the strategic communication and behavior changes needed to effect engagement, participation and service uptake¹³. It will also require interaction with other core principles to ensure the use of technology, innovation, partnerships to reach "the last mile" of those most in need of the health services.
48. *Partnership and Improved Collaboration*: Working within the existing IsDBG entities to ensure internal coherence of operations, collaboration with the Organization for Islamic Cooperation (OIC) as well as cooperation with numerous diverse stakeholders at national, regional and international levels, each with complementary responsibilities and capabilities to engage new activities with the aim of expanding access to complex healthcare service delivery including the public and private sectors within the MCs.
49. *Research and Development (R&D)* is a primary mechanism through which the health services and industry seek to meet unmet health needs, and the IsDB will support such initiatives in its MCs, ensuring R&D is built into all its operations, especially within the context of GVC. This will depend on providing the required expertise and innovation within MCs to source inputs and services through innovation and

¹³ The Islamic identity of IsDB provides a key comparative advantage for designing and implementing health programs for Muslim populations. Prior experience with the Islamic Advisory Group (IAG) for Polio Eradication in the Pakistan Polio Eradication Initiative, including communication and recognition by host populations, which has proven the tangible benefits such as Pro-Polio vaccination behavior change communication has provided significant improvements in uptake of vaccines. Local actors such as the Imams and other highly respected Religious leaders have ensured ownership of the polio program, directly attributable to the people's (beneficiaries) trust that the intervention is Sharia compliant and is supported by Islamic institutions. The experience has led to the IAG subsequently expanding its role to improve uptake of broader MNCH initiatives. IsDB health projects will systematically capitalize on this advantage to maximize their impact, as well as improve the visibility of the Bank's health interventions.

improved leverage. In addition, R&D will provide beneficiaries with access to more information, training of medical practitioners, telemedicine, e-health, and measuring the change for leveraging and scaling up proven effective interventions.

50. *Sustainable Solutions* to ensure health systems resource requirements are available. Affordable and assessable, in a manner that promotes growth and national ownership, are important for the *Global South*. Impact investment is tied to all the above-mentioned principles and will stand to achieve the level of collaboration, research and development, focus on competency and a central desire to achieve “*leaving no one behind*” at the heart of the IsDB health delivery model. GVC analysis in the health sector and mapping of actors and stakeholders will also enable increased competitiveness and potential markets within the health sector in the MCs.

51. *Regional and Country Differentiation*: Applying this Health Policy will require attention to the appropriateness of the technical activities to the economic, social and cultural context of the country or region of the project. For instance, activities that are successful in high income countries will need to be modified in low income countries where the burden of disease, the available economic resources, and the social and educational levels are different. In addition, the political context will also determine what is acceptable since it implies political decisions that will adopt the policies and influence the implementation of programs. Changes in political administrations often also change the national support for the implementation of policies adopted by previous administrations. As is noted in the Policy, natural emergencies and conflicts especially in fragile states will also limit the options for health programming, often requiring short-term and rapid responses, with sustainable long-term capacity building.

Roles and responsibilities

52. The main responsibilities of key stakeholders involved with the Policy implementation will be defined by the vertical and horizontal organizational structure at the Headquarters (HQ) and in the field. Specific details will be elaborated in the operational strategy. Health operations or program design will be carried out mainly at the country level once the Office of the IsDB Governor has issued an official request that meets the IsDB standards for acceptability. Adopting a highly integrated and collaborative approach, IsDB will engage with the core entities as appropriate, to enable the Bank deal with increased requests for support in health.

53. The Global Practice (GP) departments will ensure quality review, alignment with the global practices i.e. SDGs relevant goals, the alignment of projects to the policy objectives, and that the response framework is adapted to suit the operations of the Bank in case of emergencies, while the Health Operations Team Leaders (OTLs) based in the Regional Hubs (RHs) will be responsible for overseeing the project implementation in line with these policy guidelines as well as those for procurement and disbursement of funds. Support for project design, preparation, appraisal and evaluation is also a central role of Health team at all levels including GPs.
54. The Bank will utilize in-house expertise to carry out relevant assessment and project evaluations. A growing role of data intelligence will be built into the core competencies of the health team to ensure projects are effectively monitored and evaluated during implementation and after completion.
55. The Health teams (at HQ and Regional Hubs levels) will support country policy and program initiatives, to ensure adequate policy alignment where support from IsDB may be required. In addition, efforts by the GP Health and OTLs will be exerted to mainstream health components into various programs deemed to support health related indicators in other sectors.
56. There will be a broad interaction within the Bank's Country Program Complex (CPC) sectors and thematic units including Global Practices departments, CRS departments, Project Procurement (PPR) and the other relevant units. The group-wide collaboration will include the Islamic Cooperation for the Development of the Private Sector (ICD), the Islamic Solidarity Fund for Development (ISFD), Islamic Research and Training Institute (IRTI), International Islamic Trade Finance Corporation (ITFC) amongst others. This broad collaboration is expected to build up to scale during implementation of the Policy and will follow the principles of GVC and HiAP.
57. Stakeholders, including national and international partners, will collaborate on investments based on comparative advantage. This will involve highly collaborative engagement on all parts and timely/qualitative delivery of outputs etc. Key quality indicators to measure the levels and types of partnerships engagement will be built into these engagements during implementation of this policy. Partnership as a key component of the Bank's P5P strategic objectives is an important aspect of building sound social infrastructure for high impact investment.

58. Wide dissemination of knowledge products and best practices is the role of all actors, duly acknowledging core roles of the various actors. Credible use of advocacy and program communication should derive from evidence tied to the best practices and global priorities.

Related policies

59. The Policy derives from the P5P designed to support the implementation of the IsDB's Ten-year Strategy (10YS). This policy will result in the delivery of the targeted interventions in support of the SDG-3, and the health-related indicators in the other SDGs.

60. The operational strategy would be developed to implement this policy that would imply proposition of specific objectively verifiable Core Sector Indicators for all health operations and interventions, to be monitored and evaluated both at beneficiary communities' level as well as the Bank level.

61. During the Member Country Partnership Strategy (MCPS) development process, the Policy will provide IsDB proposition to guide the discussions with MCs and negotiating areas of implementation with partners and stakeholders.

62. At the operational level, the Policy is embedded in the ESID and will guide integration of Health into all thematic and sector policies to effect implementation of HiAPs. Some of such applicable policies include Fragility and Resilience Policy, Crowd Engagement, Climate Change, Knowledge Management, Reverse Linkage, Women Empowerment and Civil Society Engagement.

Version history

63. This is the first Health Sector policy in the history of IsDB. It will be reviewed periodically (5 years) to assess the value added to implementation and the overall impact in achieving the SDG targets and attaining human development in IsDB MCs. These reviews will highlight lessons learned, results achieved, challenges experienced and best practices identified to support the scale up and resource leveraging within the global and South-South Cooperation.

64. The Policy shall be effective from the date of its approval by the IsDB Board of Executive Directors (BED).