Investing in People

The World Bank in Action

DIRECTIONS IN DEVELOPMENT

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The cover photograph shows some of the students at a community girls' school in Nazeerabad, Pakistan, with their mothers and teachers. The school, which is supported by the World Bank through the Balochistan Primary Education Program, was constructed by the community in 1994, using local materials.

Contents

Foreword

It is intolerable that, as the world approaches the twenty-first century, hundreds of millions of people still lack minimally acceptable levels of education, health, and nutrition. Investing in people must therefore be the highest priority for developing countries—until human capital limitations no longer restrain growth or keep people in absolute poverty

Investing in people is at the core of the World Bank's work. Bank lending for education, health, nutrition, population, and other aspects of human resource development has increased sharply in recent years—tripling since the early 1980s—and is now averaging more than $3 billion a year. The Bank has intensified its support for effective primary services (for example, basic schooling and health care), where the impact on economic growth and poverty reduction is greatest. It has also increased its emphasis on education of girls, women's reproductive health, nutrition, early childhood development, and other urgent priorities. In addition to its lending, the Bank has expanded its other ways of helping—through policy advice, technical assistance, donor collaboration, poverty assessments, and more.

In its future work, the Bank will continue to:

- Increase its lending devoted to investments in people.
- Emphasize the basics—working with countries to increase access to better-quality, more cost-effective services.
- Give special attention to early childhood development, including immunizations, preschool education programs, and the provision of vitamins and other nutritional supplements.
- Pursue a comprehensive, integrated approach to population policy emphasizing both the demand for and the supply of family planning services, women's health (including reproductive health), and women's education.
- Further increase operations designed to remove barriers to women's participation in economic development.
- Work with all borrowers and partners in a joint effort to help attain—within the next generation—universal primary education of good quality, universal access to a minimum package of cost-effective health care, and the elimination of malnutrition.

Experience shows that improvements in the quality of life require more than investments in people. They also require economic reforms to pro-

vide stability and an enabling environment for growth. Successful countries have moved on both fronts, breaking the vicious circle of poverty and replacing it with a virtuous circle of human and economic development reinforcing each other. Investments in people, by themselves, will not be fully effective unless the overall economic policy framework for these investments is conducive and supportive. This implies macroeconomic stability, an open economy, access to world markets, the right structure of incentives, and the proper functioning of capital and labor markets. These economic policies are needed to make the investments in human capital more productive. The quality of investment is at least as important as the quantity—if not more so. The World Bank will therefore continue to assist countries in their efforts to reform their economies while also supporting their investments in people.

To capture the variety of Bank efforts to invest more in people and the range of innovation in those efforts, we have prepared this booklet—with two purposes. One is to provide, for audiences unfamiliar with the World Bank, a short introduction to how the Bank supports developing countries' efforts to improve education, health care, nutrition, family planning, and other means of promoting human development. It is not universally known that this issue is among the top priorities in the Bank's work, or that the Bank is the largest source of external financing for developing countries for education and health, or that the Bank lends significantly more for human development than for economic management and reform. Views of what the Bank is and does are often out of date by half a decade or more, so rapidly is the Bank adjusting to the new challenges of development. The 1990s have sent the pace of change into even higher gear, in the world at large and at the Bank especially, and heightened the need to provide up-to-date information to broad audiences about new developments at the Bank.

The second purpose is to present a selection of leading examples of recent Bank-supported activities in human development. Drawn from all regions of the developing world and all subsectors of human development, the examples demonstrate new approaches or reflect the lessons of past efforts. Some are still in early stages, others are advanced. In most, the Bank is providing financial support to projects—and in many, it is assisting with policy formulation and implementation and with donor coordination efforts. These examples are just the beginning—a small fraction of what the Bank is doing in the new directions outlined here.

In the end, investing in people is about enabling people to help themselves. It is also about taking action. The Bank is focusing its people—and its actions—on the powerful potential that people everywhere have to build for themselves a better future.

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Acknowledgments

This booklet is the result of a team effort led by Helen Saxenian, with major contributions from Joy de Beyer, Barbara Bruns, Leslie Elder, Peter Moock, and Harry Patrinos. The team worked under the general direction of K. Y. Amoako, Director of the Education and Social Policy Department, and David de Ferranti, Director of the Population, Health, and Nutrition Department. Staff throughout the Bank took part in selecting the examples of Bank-supported human development activities. The most important contributions came from those who spearheaded the work that led to the examples, especially Bruce Benton, Mae Chu Chang, Guy Ellena, Charles Griffin, Keith Hansen, Roslyn Hees, Althea Hill, Steen Jorgensen, Maureen Lewis, Marlaine Lockheed, John Middleton, Alexander Preker, Nicholas Prescott, Anna Sant'Anna, Christopher Shaw, Paula Valad, Pietronella van Den Oever and Eduardo Velez. Bruce Ross-Larson was principal editor, and Glenn McGrath and Andrea Retzky provided considerable support.

Acronyms and data note

BAPPENAS	Indonesian National Economic Planning Board
DAE	Donors for African Education
EDI	Economic Development Institute (of the World Bank)
FAO	Food and Agriculture Organization of the United Nations
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
NGO	Nongovernmental organization
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

Note: All dollar figures in this report are current U.S. dollars.

PART 1

World Bank support for investing in people

A brief introduction

World Bank support for investing in people

Investing in people—through education, health, nutrition, and other aspects of human development—is crucial in the struggle to raise living standards and reduce poverty in the developing world. Helping countries in this vital work is at the heart of what the World Bank does, through its financial and other assistance. And it is the cornerstone of the Bank's strategic vision for the years ahead.

Investing in people means helping people invest in themselves and their children. It means empowering households, especially poor households, to increase the quantity and quality of investments in children. For people to break the cycle of poverty and improve their lives, they must have access to adequate social services and, ideally, some choice among services delivered by governments, charitable organizations, and private providers. And for the Bank to become an effective partner in investing in people, it has to listen to investors, providers, and communities to find out what is missing and how it can assist in filling the voids.

Investing in people is a proven element of a strategy for poverty-reducing growth. The other key element is general economic policies that increase returns to labor and encourage the development of small enterprises. East Asian countries, after being economic basket cases in the 1950s, invested heavily in human development in later decades. They also got their economic policies in order. The result: dazzling progress. Sound macroeconomic and human development policies are both needed for growth. The path is not easy, and it may be harder in other countries. But the benefits of even modest steps forward in realizing human potential can be spectacular. The benefits can also touch people in very personal ways—as parents hoping to see their children grow up healthy and successful, as communities striving to solve age-old problems.

The Bank places great emphasis on working with developing countries to help them make better investments in human development. Doing that well requires the Bank also to improve continually. This booklet gives examples—brief dispatches from the front—of what the Bank and its client countries have been doing together in recent years to break new ground and learn from experience.

The examples reflect three main themes. One shows new efforts to concentrate resources on services that give the most value for money (in other words, are the most effective and generate the most benefits relative to

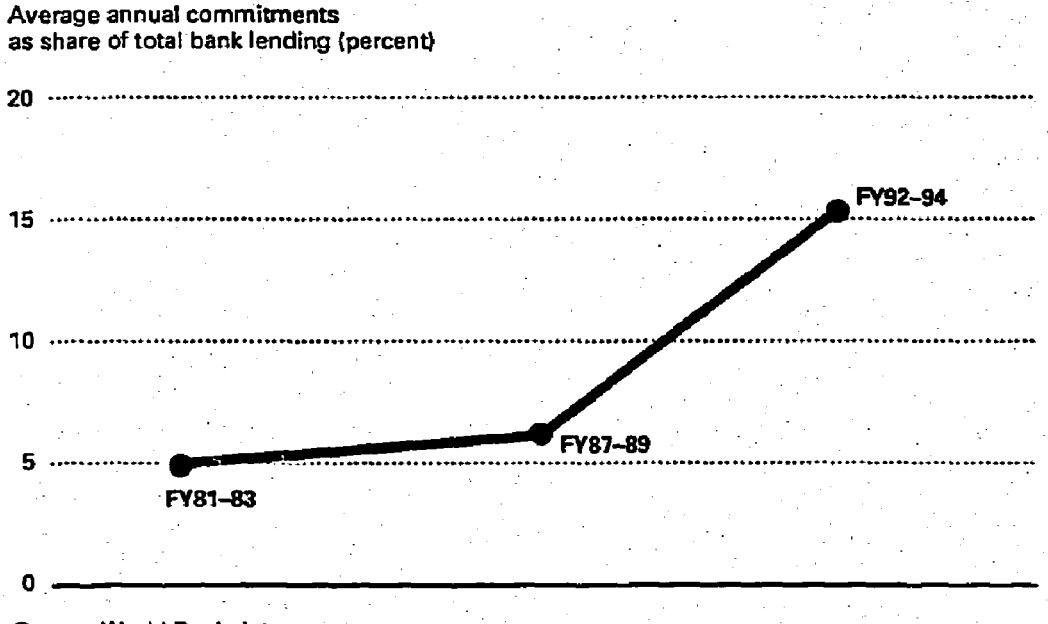
their costs). Another shows greater emphasis on listening to, learning from, and working with communities and households—the crucial participants in and beneficiaries of projects. A third shows fresh ways of using collaboration—partnership—among all interested parties to move toward common goals. After a short description of the Bank's investments in people, each of these themes is discussed.

Lending trends and strategies

The Bank has lent $28 billion to 110 countries for education, health, population, and nutrition programs since it began lending for social services in 1962. New lending is now over $3 billion a year, some 15 percent of total Bank lending (figure 1). Today, the Bank is the largest single source of external finance for education, health, and nutrition, as well as for specific types of programs (for example, support for AIDS prevention and control). The Bank is among the largest sources of financing for population and reproductive health programs.

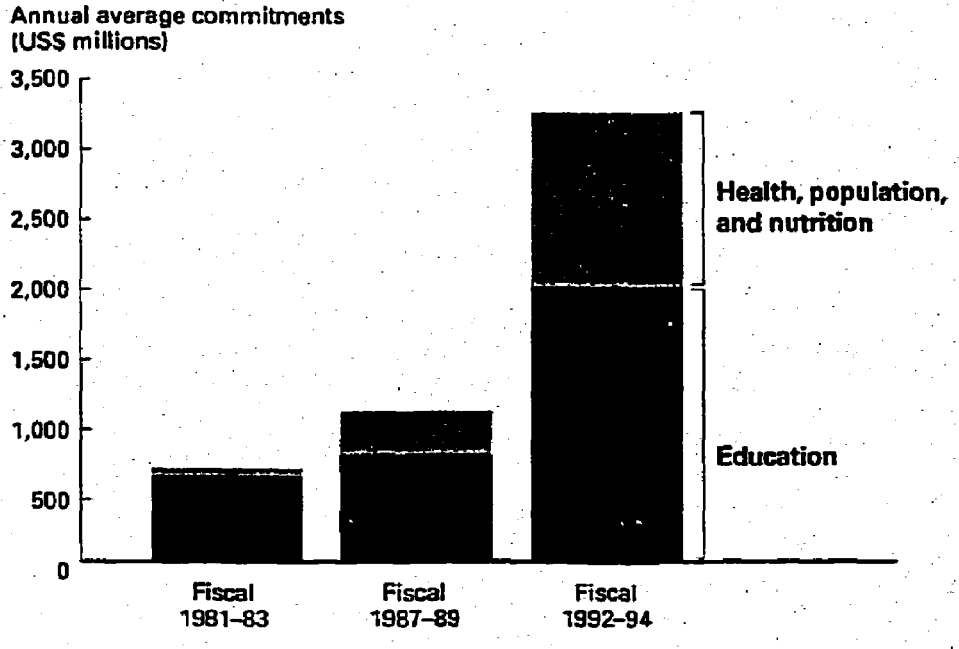
In its early years, in the 1940s and 1950s, the Bank, in accord with the development thinking of the time, concentrated on industry and infrastructure and was not involved in lending for social sectors. By the 1960s, however, the need for direct support for human development was clear and the Bank began to redirect its focus. Since the early 1980s, borrowers' demand for Bank support in the human resource sectors has risen rapidly, and annual Bank lending for human resources has more than tripled since the early 1980s (figure 2). Most recently, the Bank has placed increased emphasis on the quality of projects, not just on the growth of the portfolio.

Figure 1 Human resource lending is now 15 percent of all Bank lending



Source: World Bank data.

Figure 2 Bank lending for human resources has risen dramatically



Source: World Bank data.

The Latin American and Caribbean region has received the largest share of lending for human resources in recent years, followed by South Asia, East Asia, and Sub-Saharan Africa (figure 3). Lending for the formerly socialist economies in Europe and Central Asia, which began just recently, is expected to grow rapidly over the coming years.

Lending falls into two categories: loans from the International Bank for Reconstruction and Development (IBRD) and credits from the International Development Association (IDA). The IBRD finances its lending operations primarily from borrowing on the world capital markets, and the IDA extends assistance to the poorest countries on easier terms, largely from resources provided by its wealthier members. The IDA accounted for almost half—47 percent—of the $9.8 billion lent for education, health, population, and nutrition during fiscal 1992–94 (figure 4).

Lending is only one of the Bank's tools for assisting countries. Underpinning and complementing this lending are policy advice and technical assistance. In addition, as the examples in this booklet show, donor coordination is becoming a critically important role for the Bank—to ensure that countries get the most from their external assistance.

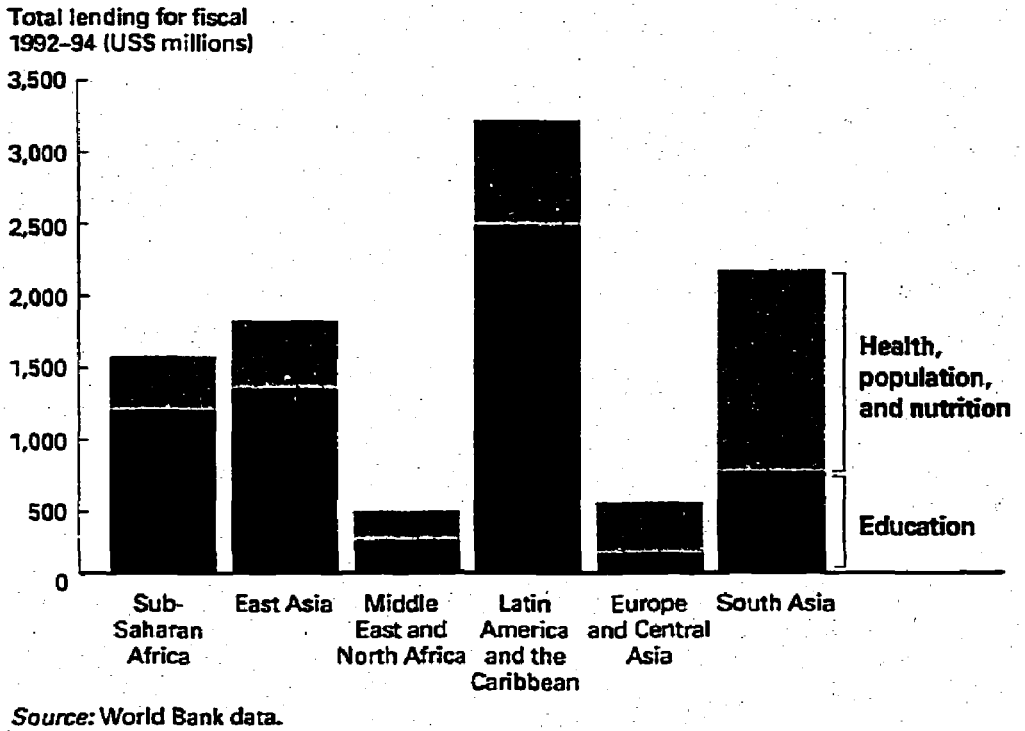
Education. The World Bank is the largest single source of education development assistance, accounting for about a quarter of all external support. Since the early 1980s, Bank education lending has tripled from $700 million a year to more than $2 billion a year, reflecting the Bank's growing recognition of the importance of education for economic and social development.

Education is a major instrument for promoting economic growth and reducing poverty in developing countries. It is central to the World Bank's

strategy to reduce poverty by promoting the productive use of labor, the main asset of the poor, and by providing basic social services to the poor. Investments in education make possible the accumulation of human capital, the key to higher incomes and sustained economic growth.

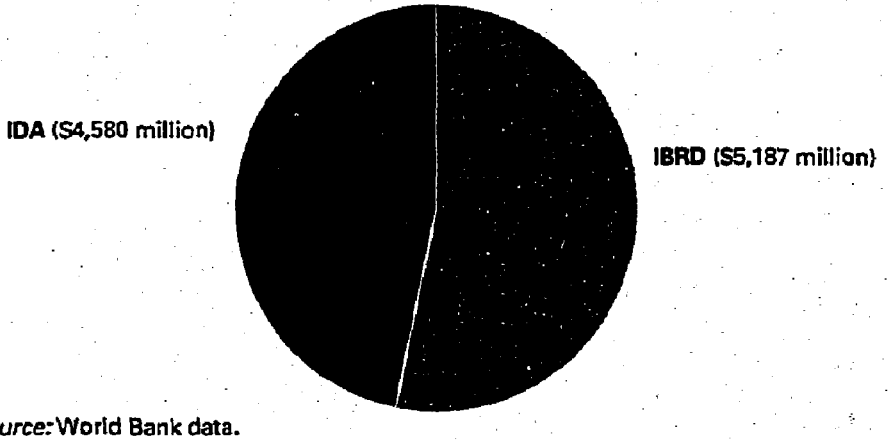
Education, especially primary and lower secondary (basic education), helps reduce poverty by increasing the labor productivity of the poor, by reducing fertility and improving health, and by equipping people with the skills they need to participate fully in the economy and in society. The economic returns to education, particularly to basic education, are high, and

Figure 3 Bank lending for human resources varies across regions



Source: World Bank data.

Figure 4 IDA credits accounted for almost half of all lending for human resources during fiscal 1992–94



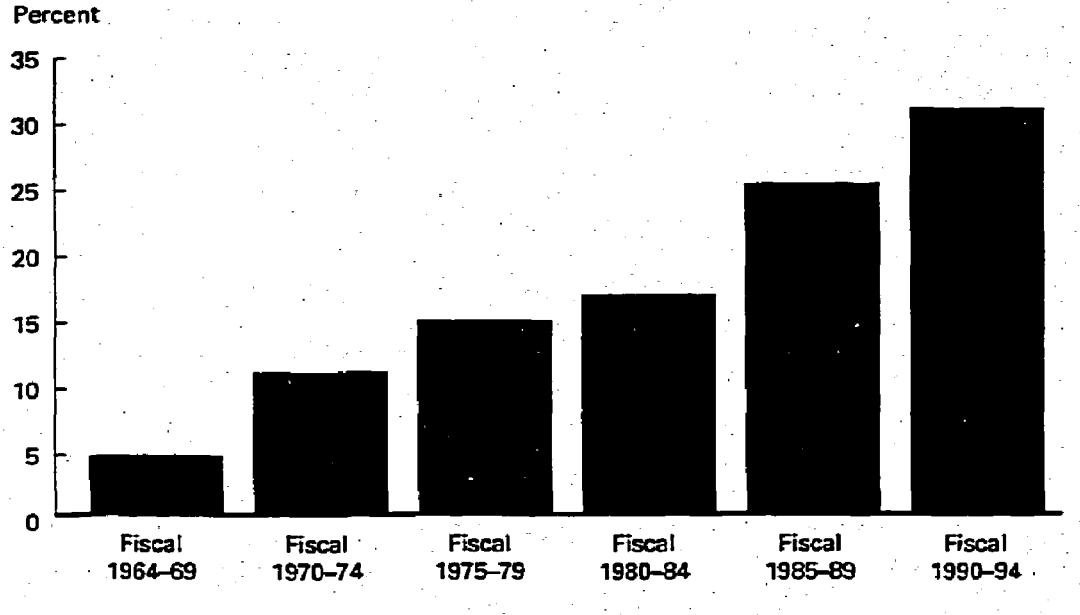
Source: World Bank data.

they are often higher than returns in the "hard" sectors that have been more traditional targets of investment, such as industry, infrastructure, and agriculture—making education a priority investment. In line with this, the emphasis of Bank lending has shifted from secondary and higher education in the 1960s and early 1970s toward primary education in the 1980s and 1990s. Primary education, the focus of 11 percent of education lending in the early 1970s, now accounts for more than 30 percent (figure 5). The focus of projects also has shifted, from school construction to other inputs that strongly influence learning—such as textbooks, teacher training, and classroom equipment—and to sector reforms important for future education quality, such as the efficiency of education administration.

The best way to achieve universal coverage of basic education is to increase educational opportunities for all. Convincing and consistent evidence from many countries demonstrates that investment in girls' education is justified on economic and efficiency grounds, as well as in terms of equity and social justice. Education leads to increases in women's income, just as it does for men. But it also leads to important benefits for women who stay at home—benefits that greatly outweigh the costs of educating girls. Fertility rates and infant mortality rates decline with increases in the level of women's education, for example, and indicators of child health improve. So, investments in girls' education have significant benefits for future generations.

Promoting education for all often requires addressing demand constraints as well as expanding the supply of classrooms. Children from very

Figure 5 The share of education lending for primary education has increased steadily



Source: World Bank data.

poor families may be kept out of school because their labor is needed at home or because parents cannot afford the costs of books or uniforms. In some countries, girls may not be permitted to attend schools if the teachers are male. Enrollments of ethnic minorities may remain low unless bilingual education is offered. In short, to increase the human capital of the disadvantaged groups who need it most, targeted approaches are often essential. In recognition of this, Bank-financed projects are seeking innovative ways to reach girls, indigenous peoples, and the very poor—to break the cycle of poverty.

Also being tried are new approaches to stimulate greater competition between public and private sector suppliers of education, in pursuit of higher quality and efficiency. Rather than supporting only government "monopolies" as suppliers of education, the Bank is working with "vouchers," community-run schools, and other instruments, in such countries as Chile, El Salvador, and Kenya, to give families more choice between public and private schools or more voice in the management of public schools.

Health, population, and nutrition. Health, population, and nutrition is one of the fastest growing areas of Bank lending, having increased fivefold

over the past six years. Between 1986 and 1993, nearly $6.7 billion were allocated to more than 100 population, health, and nutrition projects. This amount represents close to 40 percent of human resource lending in that period. Health accounts for about three-quarters of health, population, and nutrition lending (figure 6).

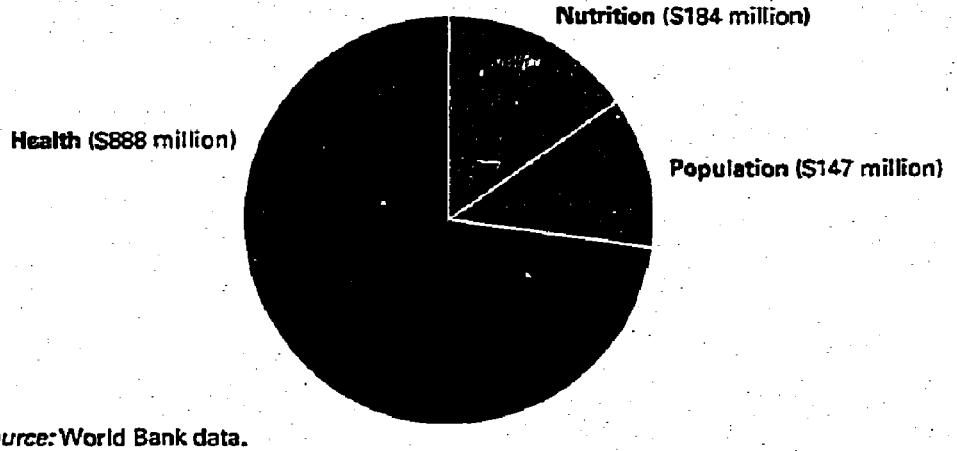
The Bank advocates a threefold approach to improving health. First, it is essential to foster an economic environment that enables households to improve health—by promoting economic growth and basic education. Second, governments need to increase the impact of their spending on health by redirecting spending toward the most cost-effective public health interventions and clinical services—and by improving the management of services. Third, governments need to encourage greater diversity and competition in the financing and delivery of health services. With policy reforms figuring more heavily, the Bank's lending for health increasingly emphasizes improving the capacity for policy formulation and for program planning, management, and financing.

Much more attention is being devoted to women's health and its effect on the health and welfare of families—and to such diseases as tuberculosis and AIDS. The Bank is the largest source of external funding for AIDS prevention and control in the developing world—with total lending now approaching $600 million to support 50 projects in nearly 40 countries.

In population, the Bank's lending is helping countries focus on three issues. The first is completing the demographic transition—the transition from high mortality and high fertility to low mortality and low fertility—in the world's poorest countries. The second is linking population more effectively to core development agendas, particularly those that empower women. And the third is broadening the scope of family planning to address a wider range of reproductive health goals. Increasingly, population projects are adding reproductive health services to existing family

Figure 6 Average health, population, and nutrition lending exceeded $1 billion a year during fiscal 1992–94

Annual average commitments, fiscal 1992–94



Source: World Bank data.

planning programs, consistent with the direction set at the recent Cairo Conference on Population and Development. More broadly, the Bank supports fertility reduction through efforts that increase the demand for smaller families. Three sets of interventions are especially effective in creating such demand: those that improve health and reduce infant mortality, those that improve access to education, particularly for girls, and most fundamentally, those that reduce poverty and raise incomes.

Reproductive health and family planning efforts should also be integrated into a broader set of social policy goals relating to family welfare, investment in human resources—particularly educating girls—and other measures to improve the role and status of women. While not denying the importance of family planning for reducing fertility, these approaches recognize the significant roles of better health and improved socioeconomic conditions in shaping reproductive decisions. They are also more consistent with the view that the objectives of population policy are to increase individual and family welfare—and to pursue societal goals such as lowering population growth rates.

Either directly or in association with infectious disease, inadequate diets account for a large share of the world's disease burden, including as much as one-quarter of that among children. Bank lending for nutrition is also growing—and nutrition projects are broadening their scope of intervention. While continuing to emphasize the provision of basic nutrition services targeted to the poor and to children under the age of three and their mothers, these projects are giving greater attention to micronutrient deficiencies, the impact of nutrition on learning, and early childhood development.

Sustained improvements in nutritional status depend on more than alleviating poverty and strengthening the health care system. In all countries, consumer education in nutrition can improve diets. Targeting education for improved caring practices to mothers and other childcare providers, particularly the promotion and protection of breastfeeding, is critical to long-term change.

Improving outcomes by concentrating resources to get the most value

Education: not just enrollments, but learning

The efficiency of primary education systems has become a paramount concern. The concept of efficiency has pedagogical, financial, and institutional dimensions, in many cases interlinked. Bank lending has captured this synergy by supporting increases in student-teacher ratios, improvements in quality, and decentralization and community participation. In Ghana, India, Mexico, and Pakistan, Bank projects that involve the community through community financing and school-based management have improved efficiency.

Ensuring adequate budgetary resources is critical for supporting primary education. Lending has supported measures to protect primary education during periods of severe macroeconomic difficulties and budgetary constraints. For example, Bank operations have rationalized post-secondary and higher education spending and attempted to redirect expenditures to primary education. In Guinea, redeploying teachers to primary schools was one approach to increasing the efficiency of existing resources.

Private sources can be encouraged to fund private institutions or to supplement the income of publicly funded institutions. But some countries prohibit private schools and universities, and others regulate them excessively. Since private schools are usually financed by household payments, such restrictions limit private spending on education that could substitute for public spending, permitting more students to enroll at publicly funded schools. In addition, private schools and universities, even though they cater to the more advantaged, promote diversity and provide useful competition for public institutions, especially in higher education.

Although greater cost recovery for education is a fiscal imperative for many countries, charging fees for students at publicly funded institutions

raises important questions of equity, access, and taxation. Scholarships and other systems can make the imposition of fees equitable, but are complex to administer at lower levels of education. At the upper secondary and higher levels, there is a much stronger case for cost recovery: the average income of students at these levels is higher, and providing scholarships or loans to the needy minority of students is easier. Moreover, such students—especially in higher education—are much closer to graduation and the labor market, lowering the risks of borrowing to finance their education.

Strategies to increase enrollments alone are not enough. Policymakers and parents in poor countries today are concerned with how well children learn—and with the quality of schools. But designing strategies to improve the cost-effective delivery of education in poor and often predominantly rural countries is not easy. The level, quality, and mix of inputs that best serve this purpose can be quite different from those in industrial countries, so the Bank is devoting considerable resources to analytical work on education policies.

Brazil's Bank-supported Northeast Basic Education Project focused on quality improvements in impoverished rural conditions and involved a major research effort to expand knowledge of what works in education and what education policies flow from this. The evaluation of the project shows that investments in school quality have such important effects on the efficiency of education systems that they can literally "pay for themselves." Having textbooks, adequate physical facilities, and teachers who know their subject matter is extremely important for student achievement. The project's evaluation also shows that class size and teachers' creden-

tials and years of experience may not improve school quality, even though these factors typically add to costs.

Information about the effects of resources on performance and about the costs of alternative inputs to education is helping the Bank formulate policies that can help borrowers improve the efficiency of their resource use. For example, in recent years, the definition of "quality primary education" has expanded to underscore the importance of student assessment systems to measure learning outcomes. Higher learning achievement is the strongest indicator of a good-quality education system, and the share of education projects supporting the development of student assessment systems has increased dramatically—from 3 percent during 1969–73 to 27 percent during 1989–93.

Creating the right structure of incentives for pupils, teachers, and school managers is also important. In Peru, with World Bank support, the government is attempting to decentralize the school system, to increase local autonomy and accountability in the day-to-day operation of schools. Several models of decentralization are being implemented and evaluated as pilots, and the results are expected to inform the design of future system-wide policies. In Chile and Colombia, voucher schemes have been implemented in Bank projects as another method of restructuring incentives in the education system.

New programs also encompass:

- Improvements in teaching and learning conditions through increased availability of textbooks and equipment. In the Philippines, the Bank helped to finance the government's program of school improvement, which has reduced the ratio of pupils to textbooks from about 10 in the late 1970s to less than 1.5 by the early 1990s.
- Structural and organizational changes at all levels where they affect classroom processes and the development of supporting institutions, such as testing services and pedagogical institutes. For example, in Hungary, higher education institutions now compete for available investment funds on the basis of the merits of their annual proposals, a change introduced by a Bank-supported project.
- Systemwide changes, not merely improvements in the operation of one or a few institutions. In Tanzania, the government lifted the ban on private schools and, with the help of the World Bank and other donors, established the National Education Trust Fund to channel resources to private schools.
- Targeting underserved ethnic minorities and indigenous people. Research shows that increasing the human capital of large minority populations will result in considerable declines in poverty. To this end, the Mexican government launched an ambitious primary education project in 10 of the country's poorest southern states, with support from one of the largest social sector loans ever financed by the Bank in Latin America. Expected project benefits include a more equal distribution of economic opportunities among Mexican children.

Following the Education for All conference at Jomtien, Thailand, in 1990, the government of India invited the Bank to be a major partner in the improvement of primary education throughout the country. This effort started in 1991 with the joint preparation of a series of studies on the quality and coverage of basic education, focusing explicitly on the determinants of educational outcomes. As a result, the government launched a major Bank-financed basic education project in the state of Uttar Pradesh in 1993. The project goals were to build institutional capacity, improve quality and school completion rates, and increase access in underserved areas. The project includes participants from all levels of society—from the most senior policymakers in New Delhi to the parents of school-age children in remote rural areas, who as members of village education committees make decisions that affect the quality of their children's schools.

In many parts of the world, fewer girls go to school, and stay in school, than boys. To reduce the opportunity costs of sending girls to school, new Bank-supported projects in India, Pakistan (page 29), Senegal, and Yemen are providing scholarships or stipends for female students. To address a major constraint on girls' schooling—the need to care for younger siblings—day care has been introduced at satellite schools in Bangladesh. In Nepal, preschool programs in Bank-supported projects have also freed girls from sibling care and are teaching basic skills to the young. In Pakistan and Senegal, Bank projects are providing free textbooks to girls—and flexible school schedules, particularly in agricultural communities, make it possible for girls to combine schooling with chores. In Bangladesh, school hours determined in consultation with village communities increased girls' enrollment and reduced dropout rates.

Health: better outcomes at lower cost

All developing country governments face difficult decisions about how to distribute their limited health care resources to meet the enormous needs of their citizens. The Bank is helping countries get more value for money by supporting policy analysis and investments that help focus public spending on highly cost-effective public health services—such as immunizations, and the prevention of AIDS and other sexually transmitted diseases—as well as on highly cost-effective clinical services, such as prenatal and delivery care and the treatment of tuberculosis. For example, short-course chemotherapy for the treatment of tuberculosis can be highly cost-effective. But despite the worldwide tuberculosis epidemic, tuberculosis control has been largely neglected by governments and donors. The India Tuberculosis Control Project is supporting changes in treatment protocols and outreach efforts to increase the impact of India's spending on tuberculosis.

World Development Report 1993: Investing in Health proposed using information on a country's disease burden and the cost-effectiveness of inter-

ventions to identify priorities for health spending. Many countries are testing this idea by developing national packages suitable for their conditions. Mexico was the first. Throughout 1993 and 1994, Mexican experts, working in close collaboration with World Bank staff, developed a national package of cost-effective health interventions. Based on the recommendations from this work, the government is reassessing what health services it will strive to make universally accessible to the poor in order to increase the impact of its health spending.

Health projects support improvements in the quality and efficiency of management and service delivery in many ways. Some of these include measures to strengthen referral between different levels of the health system, rationalize drug procurement and use, improve the quality of services in rural health clinics, and contract out services to NGOs or other private providers.

The Bank has traditionally focused attention on improving public health and clinical services at the health center and community level, but hospitals typically absorb 50–70 percent of public spending on health and cannot be ignored. Innovative Bank-financed projects are improving the efficiency of public hospitals in Chile and Tunisia (page 44) by increasing hospitals' budgetary and administrative autonomy and accountability—and are under development in Argentina and India.

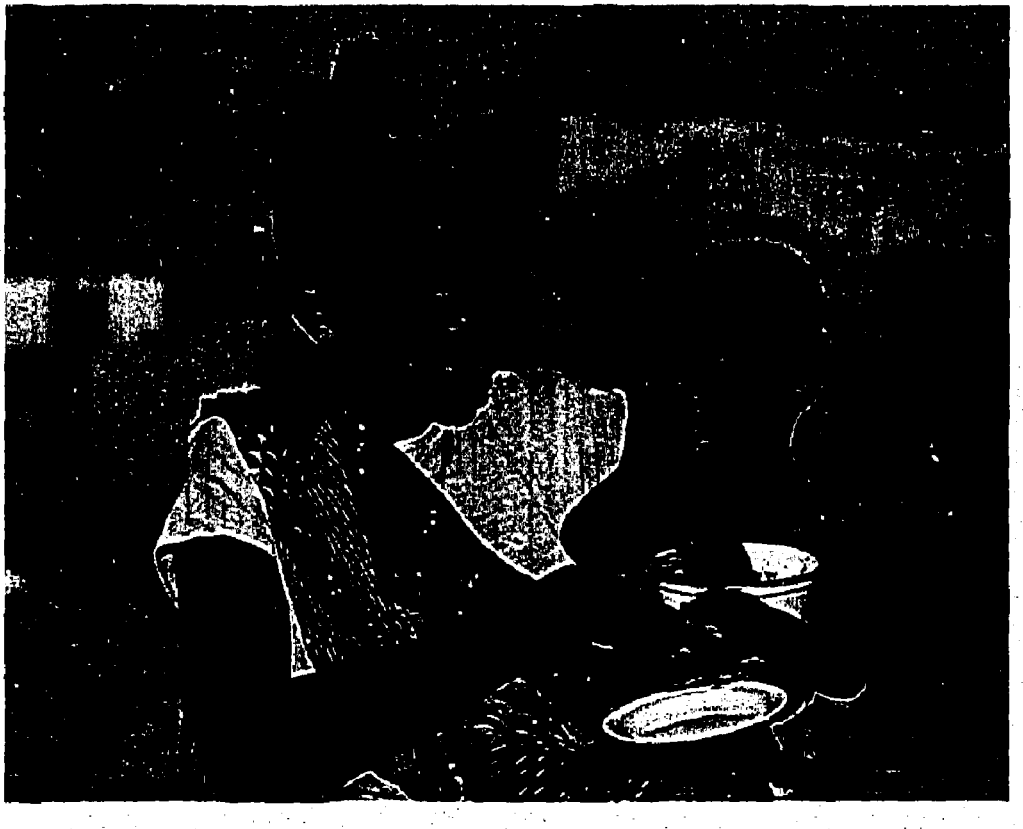
Not since the reforms that followed World War II have so many countries been engaged in radical changes to the structure and financing of their health services. Health reform is now at the center of the Bank policy analysis and project work in many middle-income countries and an increasing number of low-income countries.

One of the major challenges of health reform is not technical but political—to understand, in the local political context, what types of reform might be feasible and how major stakeholders must be brought into the process. The first step in this work is the analysis of reform options, usually in the form of technical assistance or Bank policy analysis. China, for example, recently requested Bank assistance to identify feasible health reform options. A major joint study is now identifying feasible options for health care financing whose implementation could contain health care costs and consolidate the gains in health status by assuring that adequate health services are available to all.

Such policy analysis is often followed by lending for health reform, but there is no "typical" health reform project. Bank projects are supporting innovative reforms in provider payment methods (Hungary), decentralization efforts (Chile, Estonia), and alternative models of health service finance and delivery (Costa Rica).

Nutrition: targeting the neediest mothers and children

The World Bank has invested in nutrition projects for more than 17 years, with cumulative lending for nutrition of more than $1 billion. Reflecting



the Bank's intensified commitment to poverty alleviation and investing in people, a new generation of health, agriculture, family planning, education, and women-in-development projects includes nutrition components.

The early nutrition projects, such as India's Tamil Nadu Integrated Nutrition Project in 1980, contributed to the move beyond narrow approaches—such as large-scale feeding programs—to more refined targeting, using food as medicine rather than as an income transfer and emphasizing effective behavioral change for sustainable nutrition improvement. Health projects in India and elsewhere now reflect greater emphasis on addressing low birth weight and growth faltering in children less than six months old. In addition, there is a stronger focus on maternal health and nutrition and on the improved nutrition of adolescent girls. A recent project is targeting a package of nutrition and health services to newly married couples in Bangladesh. The purpose is to influence families before the negative spiral—starting with undernourished women and prenatal nutritional insults to the fetus—begins.

Dietary deficiencies of vitamins and minerals cause learning disabilities, mental retardation, morbidity, low work capacity, blindness, and premature death, contributing a large share of the global burden of disease. Micronutrient programs are among the most cost-effective of all nutrition interventions, and the Bank is increasingly working with countries to address micronutrient deficiencies. With Bank support, China will iodize salt in its national iodine deficiency control program. This effort is projected to save 1.1 billion person-days of lost work each year. Under a

Bank-supported project, Guinea is using primary schools to distribute micronutrients and antiworm medication to schoolchildren, contributing to improvements in nutrition, the educability of school-age children, and hence the returns on investments in education.

Population and reproductive health: integrated services as the key

The Bank takes a comprehensive approach to population, a direction endorsed at the recent Cairo Conference on Population and Development, supporting fertility reduction through efforts that increase the demand for smaller families and supporting family planning services in the context of women's reproductive health.

There was consensus at the Cairo conference that population programs should provide high-quality, user-oriented services that offer a range of choices in addressing fertility regulation and other reproductive health needs. Putting the Cairo consensus into action will require testing and evaluating new approaches that respond to client needs. For example, the Philippines is planning to use NGOs to deliver reproductive health services in an upcoming Bank project. In another Bank-supported project, India is providing maternal and child health and family planning services in the urban slums of Bombay and Madras through the use, among other techniques, of street theater to educate women. In Bombay, contraceptive prevalence has increased from 20–30 percent to more than 50 percent during the life of the project. In Madras, the increase has been from 20–30 percent to 70 percent.

Listening to, learning from, and working with communities and households

There is a growing consensus that the participation of households and communities in the design and implementation of development efforts will enhance these efforts' impact and increase their sustainability. The Bank is making great efforts to find new ways to listen to, learn from, and work with communities and households. The reports in part 2 provide numerous examples of innovative efforts to support broad participation.

Participation is broadened by organizing suitable methods and procedures for local people, their associations, and their government to interact so that stakeholders can influence and share control over development initiatives and the decisions and resources that affect them. Expanding participation involves three main activities: identifying who is intended to benefit directly (or who might be adversely affected) by projects or policies, exchanging information and views with the stakeholders, and involving them in implementation and evaluation.

Given the Bank's objective of helping countries reduce poverty, the key stakeholders of Bank-supported work are often poor people, who usually lack information and power and tend to be excluded from decision-

making. Using a variety of participatory assessment techniques, the Bank and governments are defining who the poor are and learning how their survival strategies operate and what kinds of government poverty alleviation strategies are likely to benefit them.

Finding out what communities and households think—and maintaining a dialogue as interventions are developed and implemented—can be slow, difficult, costly, and threatening to vested interests. But it is well worth the cost and effort. Advances in communication technology and increasing application of anthropological and sociological techniques (focus groups, rapid surveys, and beneficiary assessments) allow more opportunities for eliciting preferences and views.

In Tanzania, the government and the Bank used two instruments for consulting households (page 63). A national household survey included questions to get an idea of how and why households use social services, how much they invest in human capital from their own budgets, how much they value social services (willingness to pay), and what they think about the services available to them. A second survey allowed more detailed data collection from a smaller number of households. Small teams of interviewers visited eight communities and held focus group discussions about social sector issues, completed week-long time logs of the activities of school-age children (to assess the opportunity cost of their time spent in school), and collected unit cost data from local service providers.

The findings: Households incur substantial private costs in using government services. Public expenditures are tilted toward the rich. House-

holds place a high value on education and have a low opinion of the performance of government services.

A key challenge of participatory development is to find mechanisms for continued involvement of stakeholders in implementation and evaluation—and to build in the flexibility to adapt to new information and changing circumstances. Among the best examples of this are the Bank-supported social funds, which enable communities to influence the use of resources directly. The Philippines established a $9 million Community Partnership for Health fund for community-level miniprojects. Local NGOs helped to identify, organize, and manage the projects with

Early childhood development

Research from both the industrial and the developing world has demonstrated that programs that focus attention on the physical, cognitive, and emotional development of young children can have far-reaching benefits for both the youngster and the society. Integrated programs of health, nutrition, and cognitive stimulation can enhance school readiness, reducing repetition and dropout and increasing the efficiency of investments in basic education. This is especially important for traditionally disadvantaged groups—the poor, ethnic and linguistic minorities, and girls. Early childhood development programs can also free siblings to attend school and offer mothers opportunities to work outside the home or as childcare providers.

Bank support for integrated early childhood interventions has focused on home- and center-based development strategies with objectives ranging from school preparedness and poverty reduction to parental education, community empowerment, and enhanced status of women.

Colombia. Low-income urban mothers are given access to credit to repair and renovate their homes so that they can establish childcare facilities for their communities. Children aged two to seven receive a daily meal and snacks, and mothers are trained in age-appropriate educational activities.

India. The Integrated Child Development Services scheme delivers supplementary nutrition, immunizations, health checkups, referral services, and early education to more than 12 million children ranging in age from six months to six years. This center-based system is using Bank support to focus on targeted assistance for tribal populations, community development, and the use of NGOs to strengthen training curriculum and methodology.

Mexico. Rural poor and indigenous parents in the country's 10 poorest states participate in weekly meetings on child development. Community educators trained under the Bank project organize these meetings. They also make home visits using illustrated guidebooks to help parents with basic health, nutrition, and developmental education. More than 1 million children will benefit from their mothers' and fathers' enhanced parenting skills.

the communities and local government agencies. The most effective projects have been small works to create or improve the communities' clean water supply, such as wells, standpipes, storage tanks, and connections to houses (page 61).

Strong community participation and parental involvement are also very evident in early childhood development projects, a relatively new area of involvement for the Bank (box). Support for early childhood development has strong links to poverty alleviation because millions of children from poor families suffer serious physical and mental impairment during their first years of life. Early childhood development components began to appear in Bank education projects in 1992 and were initially supported as part of primary education projects in Chile and Ecuador.

Collaborating with partners

As development activities have become more complex—moving from infrastructure projects to programs that require policy changes and innovations in multiple sectors—the need for strong alliances has intensified. This need is especially strong in the social sectors, which provide services to almost all citizens and cater to important personal needs—childbirth and family planning, the education of children, safeguarding health, and caring for the sick. The innovative activities and approaches in the reports in part 2 include examples of new alliances and partnerships in all spheres of social sector activity and with the full range of development actors.

With diverse local interest groups. In trying out new ways of working with clients, the Bank has tried to provide a forum for diverse local interest groups to discuss contentious issues. In Brazil, the Bank worked with an advisory group of senior Brazilian leaders in the health field to commission background papers on health care costs, quality, and regulation from Brazilian experts of different political parties and policy perspectives. Seminars and meetings with wide attendance by municipal, state, and central government officials and representatives of universities, public research groups, and the private sector brought together diverse groups that usually did not interact. One participant said: "Normally we only meet with those with whom we agree, and together we complain about the sector. This meeting has broken that tradition. We needed a respected outside force to break the ice."

With NGOs and community organizations. About half of all Bank projects—across all sectors—involve NGO participation. NGOs have a particularly important role in the social sectors. Tending to be flexible and small, NGOs have the strong field presence necessary for some types of intervention. Community organizations have particular strength as a channel for the participation of beneficiaries. The Bank supports these partnerships, and many Bank-financed projects now rely on a wide range of national and international NGOs to assist in design, implementation, and evaluation. The federal government of Brazil is using NGOs to deliver

messages and services for the first time in its AIDS and STD Control Project. NGOs submit competing proposals to the project for grants of up to $100,000 a year for AIDS prevention, testing for high-risk groups, and hospice-type care. Nearly 300 of these grants have been approved (page 67).

With ministries of finance and planning. One of the Bank's strengths is the voice it has with ministries of finance and planning. Many activities described in the reports in part 2 required the participation of these central ministries, whether in discussing social sector issues, making policy changes, or reallocating and increasing resources. Brazil's Bank-supported AIDS and STD Control Project is a good example. As a result of discussions during the project's preparation, the Ministry of Finance removed tariffs and taxes on condoms to increase competition and reduce consumer prices (page 67).

Across sectoral ministries. As the strong relations among health, nutrition, family planning, and education have become increasingly clear, social sector ministries in more and more countries are trying to work together—to take advantage of one another's personnel, expertise, service delivery systems, and access to people. The Bank-supported Gambia Women in Development Project is being jointly executed by the ministries of agriculture, education, local government, and health and the women's bureau.

Nutrition projects, in particular, are reaching out beyond the health sector, providing nutrition information, screening, and micronutrient supplements through education systems, delivering nutrition education to women along with training in business skills and credit, and getting agriculture staff to take consumption effects into account in their policies and extension advice. In Burkina Faso, the Dominican Republic, Peru, and Zimbabwe, education and health ministries are working together, in Bank-supported projects, to screen pupils for hearing, sight, nutritional, and other problems that could inhibit learning, to provide nutritional supplements, and to treat debilitating parasitic diseases. In Guinea, the Bank is assisting with a new initiative in which health staff are seconded to the education system to deliver health education, deworming, and micronutrients.

With other levels of government. There is a strong trend in many countries to decentralize authority and responsibility within government. This trend preceded today's heightened efforts in the Bank to find new, more participatory ways of working with countries, but it is often important to their success. Many innovations funded by the Bank include support for decentralization and efforts to improve communications and relations among various levels of government. In Nigeria, state-level decisionmakers evaluated and revised a stalled health project, giving a renewed and greatly improved impetus to the project activities. The enormous program of district-level research on how to improve education quality and access in India depended heavily on supportive relations among national, state,

and district education agencies (page 52). In several Latin American countries—notably, El Salvador, Nicaragua, and Peru—Bank-supported education projects are assisting efforts to draw communities and parents more directly into the control and operation of schools. The Bank is providing analytical and technical support to the design of new financing systems and to the training of local personnel to support these efforts. Preliminary findings from El Salvador indicate a high degree of success. Student access to schools in rural areas has increased. Parents are active in hiring and evaluating teachers. And they are more satisfied that the curriculum meets their children's needs.

With the private sector. The Bank is providing intellectual and practical help to governments in their efforts to decide on appropriate and complementary roles for the private and public sectors in development. The aim is to benefit from a competitive and diverse supply of services in education and health, within a well-regulated environment, while ensuring that consumers have adequate information to make appropriate choices.

Bank-supported social investment funds in 12 countries in Latin America have involved the private sector, with much of the implementation by private citizens. This partnership has proved highly effective and efficient—and popular.

Private industry is particularly important in nutrition programs. In partnership with UNICEF, the Bank is assisting the governments of several countries, including China, Indonesia, Morocco, and Pakistan, in collaborating with private industry to iodize salt. Private industry can similarly fortify other foods with vitamins and minerals. In Senegal, supplementary feeding and growth monitoring in urban areas is to be carried out in

a Bank project using local private contractors. In the Bank-supported Honduras Nutrition and Health Project, the private sector is involved in all stages of a food coupon program. Commercial banks distribute coupons to beneficiaries and redeem them directly from local merchants, nearly all of whom accept coupons against purchases of food and other basic goods (page 50).

With local experts. It is increasingly becoming the norm for Bank staff to collaborate with government staff and local academics and experts in projects and policy work. As early as 1987, two Zimbabwean Health Ministry staff were seconded as full-time members of the Bank team that researched and wrote an influential study on health finance issues. And for the Tanzania social sector review mentioned earlier, the government Planning Commission led the effort from the Tanzanian side, with the formation of a cross-sectoral steering committee, and a technical committee that ensured that the work was completed. Tanzanian consultants contributed key papers and managed the inputs of nearly 20 other Tanzanian consultants (page 63).

With other donors. The Bank has long worked with numerous donors, pooling resources, disbursed through a single financing mechanism, in jointly funded projects with joint progress reviews. Now in Mozambique, Sierra Leone, and Zambia (page 74), the Bank and other donors are joining, or proposing to join, to help finance the government's health investment program. In Sierra Leone, this collaboration helped weed out an inappropriate donor proposal to build a major new tertiary hospital. The hospital was found to be a low priority and unsustainable in the current environment—it was dropped in favor of investments in primary care.

The Donors for African Education association brings together ministers of education in Sub-Saharan Africa with nearly 50 multilateral, bilateral, and private development and donor agencies (page 81). The most important contribution of this Bank-supported initiative is to reinforce the message that donor support must fit within the framework of national strategies for education—and that donors must resist the temptation to use the leverage of their funding to try to advance their own agendas. The association has created nine working groups that have made progress on substantive issues—including ways to improve female participation in education, the teaching profession, education statistics, and textbooks and libraries.

Donor coordination can also be a powerful mechanism for addressing regional problems. The Onchocerciasis Control Program is a major effort to eradicate river blindness in West Africa (page 77). Having been instrumental in creating the program in 1974, the Bank continues to play a principal role—as leading sponsor and second largest donor—together with the WHO, the UNDP, the FAO, and 20 other donors. The program has prevented 250,000 cases of blindness—adding an estimated 1 million years of productive labor to the families and economies of West Africa and freeing up to 25 million hectares of previously infested arable land. The pro-

gram recently launched an initiative to control river blindness in the 16 African countries outside the original program areas where the disease remains endemic, using the knowledge base, expertise, and effective, environmentally safe control tools developed over the past 20 years.

Future directions for Bank operations in human resources

Investing in people implies striving to reach the point at which human capital investments no longer restrain growth or keep people in absolute poverty. Vital in this is equipping the poor to take advantage of the expanding opportunities that accompany growth. It requires extending better education, health, nutrition, and family planning to the poor and fostering early childhood development.

These concerns are crucial to the Bank's overall strategy, which in the years ahead will be guided by six main principles, as elaborated in *The World Bank Group: Learning from the Past, Embracing the Future*:

- *Selectivity*—identifying strategic actions for the Bank to help catalyze the maximum potential of its partners and get the greatest impact.
- *Partnership*—seeking alliances with other participants, whether multilateral, bilateral, governmental, nongovernmental, or private.
- *Client orientation*—responding to the real needs of clients and facilitating their participation in the design and implementation of Bank-supported programs.
- *Results orientation*—looking beyond lending commitments to maximum development impact, high-quality services, increased efficiency, and more accountability for performance.
- *Cost-effectiveness*—ensuring that scarce development resources are spent efficiently by streamlining bureaucratic processes, reducing administrative costs, and improving coordination.
- *Financial integrity*—ensuring that the Bank continues to be able to provide both the resources and the best possible service that its clients need by maintaining its high standing in the financial markets.

In applying these principles to its human resource work, the Bank will emphasize the basics, such as basic education and cost-effective health care. In middle-income countries, the policy advice and lending will be expanded beyond the basics to such areas as higher education and tertiary health care—with a view to introducing reforms that prevent waste and inequities and channel resources to more efficient and equitable services. The Bank will also give prominent attention to the quality of results: that is, to such key outcomes as learning, health, and nutrition.

In this, the Bank will focus as much on its policy advice as on its lending. The Bank provides more than just funds for the developing world. It also provides technical assistance, a forum for discussion, and a mechanism for countries to obtain the full range of assistance that they need to alter their spending patterns and reform their social sector policies. These

reforms can have a far greater impact on improving the welfare of their people than the Bank's lending, which plays a catalytic role.

The Bank will also pay explicit attention to the role of the private sector in providing education and health services—and to cost recovery and its impact on equity and efficiency. The private sector already serves a large, diverse clientele in industrial countries, often delivering services of higher quality than public providers. And public-private competition can improve the quality and efficiency of services.

The Bank will continue to involve beneficiaries in policy work and in project design and implementation—participation that is fundamental to successful investments in human development. The Bank's work in any country will depend on that client's commitment to human resource investments. Where that commitment is stronger, the focus will be on solutions to agreed upon problems. Where commitment is weaker, the focus will tend to be on identifying the causes and manifestations of poverty.

These principles for the Bank's future work in human development are intertwined with the three main themes in this booklet: improving outcomes by concentrating resources to get the most value, listening to, learning from, and working with communities, and collaborating with partners. The 17 case studies in part 2 offer concrete examples of these themes.

PART 2

Examples of Bank assistance

Reports from the field

The 17 reports from the field provide detailed examples of how the Bank is striving to listen, learn, and innovate in its support for investing in people. The reports are organized along the three main themes in this booklet.

1. Bringing Pakistani girls to the front of the class

Balochistan's new village education committees, made up entirely of parents in school catchment areas, have established 198 new rural schools that enroll 8,420 female primary students. That has boosted the enrollment rate of girls to 87 percent in these villages (three villages report rates of 100 percent), compared with 15 percent for the province as a whole.

Many in Pakistan's government and the development community have put the country's abysmal record in female education down to "cultural barriers" or "lack of parental interest." The thinking was that, even if a school were provided, parents would not send girls. The Balochistan Primary Education Program, although not yet three years old, has proved instead that parents will send their girls if schooling is provided in ways that suit their culture—if schools have female teachers and strong community roots.

Pakistan's education system compares poorly with that of other developing countries, and Balochistan Province has the country's lowest literacy rate. Gross enrollment rates in Balochistan are only 34 percent for all children and 15 percent for girls, and the quality of education is poor. Only 83,000 Balochistani girls between the ages of 5 and 10 are in school, compared with 324,000 Balochistani boys, and the province has only 625 primary girls' schools, of 7,199 schools overall.

Working with the World Bank, the Balochistan government has devised a comprehensive program to improve the entire primary education system in the province of Balochistan, with an emphasis on closing the gender gap in enrollments. The new Balochistan Primary Education Program (with IDA funds of $106 million) includes mobile training of female teachers, development of multigrade instructional materials, better management information, and management training and institutional strengthening. Community participation in most activities will address the special problems of Balochistan.

The most innovative and promising action is by newly formed village education committees. In two years, Balochistan's village education committees have established 198 new rural schools for girls that boast an

enrollment of 8,420 primary students. The female enrollment rate in these villages is 87 percent, compared with 15 percent for the entire province, and three villages even report 100 percent enrollment. In addition, 43 girls' schools previously closed for lack of teachers have reopened—and report nearly full attendance by both teachers and students.

Students seem to perform better in the new community schools than in government schools. Rather than sit quietly in the rear of the classroom and be neglected by the teacher, girls in community schools speak out freely and interact with their classmates.

One determined Pakistani woman—and some funding

The Society for Community Support for Primary Education in Balochistan began as a pilot program in March 1992—the brainchild of Quaratul-Ain Bakhteari, a highly capable Pakistani consultant intent on bringing girls' schools to the remoter regions of her country. She brought her plan to a World Bank staff member who arranged USAID grant funding for the pilot. The society's work was so successful that the government decided to generalize the pilot to the entire province—and contracted with the society to implement a provincewide community school experiment.

As one official who himself has two daughters in school remarked: "The program provides incentives to parents and community leaders to take constructive action in remote areas, where until now they have cared about female education but could not find a solution."

Now funded by the World Bank (IDA), the Balochistan government, UNICEF, the Canadian International Development Agency, USAID, and the Trust for Voluntary Organization, the society's workers go from door to door organizing parents—who are frequently unaware that their children even have a right to go to school—to form village education committees. To make sure that elites do not dominate the new schools, committee members must be elected by 75 percent of area parents.

Because of the acute shortage of qualified female teachers, normal teaching requirements have been relaxed so that candidates need not have a secondary school diploma. Potential teachers, recruited by the village education committee are expected to teach without pay for three months to demonstrate their commitment to teaching. Candidates are then trained for three months at mobile female teacher training units staffed by master trainers, some of whom hold masters degrees and have had field experience. The program's mobile teacher training avoids the cultural problem of sending teachers away to residential teacher training colleges. After graduating, the teachers become government employees, assigned to teach in the schools established by their sponsoring village education committee.

"The benefit of this approach is that the female teacher will not be transferred and, more important, will be accepted in the community," noted one female educator. If a new rural school can enroll at least 30 students (more in urban areas) during a three-month probationary period, the school is officially opened by the society, housed in a temporary building provided by the community. The village education committee then makes sure that teachers and students show up regularly for class, and this is further verified by society employees.

"The construction of a school is delayed to see whether the school on probation is sustaining or not," said Uzma Ansar, managing director of the society's office in Quetta. In many cases, however, the community has gone ahead with construction of mud-brick or adobe school buildings at its own expense. Some village committees have helped obtain furniture and learning materials from neighboring boys' schools.

To make the provincial Directorate of Primary Education more responsive to community needs, a deputy director for management has been assigned to be the directorate's link with the community. A new management information system now maps out schools, conducts surveys, and tracks teachers with an eye to gradually decentralizing the management of Balochistan's education system.

Small project—big future

Government support for the community scheme has grown with its obvious success. Throughout the formal primary education system, the government now guarantees the community teacher posts and promises to build permanent schools where trial schools survive for three years.

"Those who go through primary schools are keen to take up further education," says Nasiro Bano, a teacher training coordinator who is enthusiastic about future possibilities for the new program. "They always ask whether they will have a chance to go for middle education. In the future, the majority of primary schools constructed under the society's program could be raised to middle school level without major additional expense."

The program's expansion is hampered by the fact that many villages lack girls with enough education to be trained as teachers. Some communities have agreed that a local man can be hired as a teacher under the program, rather than miss the chance of education for their daughters.

2. Stipends to Keep Bangladeshi Girls in School

In its first year, Bangladesh's innovative program of stipends enrolled nearly twice as many girls as expected. Stipend recipients and their families signed agreements that girls would attend school a minimum number of days, achieve a minimum grade on the yearly exam, and remain unmarried through the grade 10 terminal examination. Having started in 59 subdistricts and expanded into 118, this IDA-supported project should eventually benefit 1.3 million girls.

Bangladesh launched a stipend program in 1994 to address out-of-school and in-school constraints on enrolling girls in secondary education. Addressing these constraints was intended to help close the gender gap in secondary school enrollment and ultimately improve the economic and social status of women. It is well established that female secondary education in the developing world generally produces substantial economic returns as well as social gains in the form of smaller, healthier, and better-educated families.

The IDA-supported Female Secondary School Assistance Project, covering about one-quarter of the country, provides a monetary incentive (a stipend to cover a share of personal and tuition costs in all grades and of textbook and examination fees in upper grades) to girls in grades 6 to 10. This incentive is part of an integrated package of multiple interventions to help overcome constraints on girls' access to secondary education. Other interventions include support for additional teachers needed because of enrollment increases, occupational skills training, toilets and tubewells at schools, and public awareness activities to convince parents of the benefits of girls' education.

A unique feature of the program is that the stipends are paid into personal bank accounts opened for the girls in nearby branches of a commercial bank. Girls acquire important money management skills and a measure of economic independence as they get an education. Girls receive a special passbook, prepared for the project, whose back cover shows a replica of the motivational poster equating girls' education and happiness used in the social marketing campaign.

"It is the best-designed project the IDA has ever supported in Bangladesh—and the only one to stimulate broad national interest," remarked an enthusiastic top-ranking Bangladesh government official.

Why provide a monetary incentive?

The choice of a monetary incentive was based on three factors. The Bangladesh Household Expenditure Survey of 1988–89 confirmed the need to provide funds to many families for female secondary education. About two-thirds of Bangladeshi households had little or no disposable income, and those that did invested more in their sons (73 percent of education expenditures) than in their daughters (27 percent). Many parents would have liked to educate their daughters but considered education for boys more important because girls marry and leave home. The monetary incentive addressed the fact that the costs to parents of educating girls are higher than those for boys, but that the substantial returns—gains in wages, declines in fertility, improvements in the health of the girl's own children—benefit society more than the parents.

A second factor was the successful 17-year Female Education Scholarship Project, started as a local initiative mainly to reduce fertility. From 1982 to 1992, with USAID assistance, this project benefited more than

44,000 girls in 165 schools. Enrollment, attendance, and completion levels rose in grades 6 to 10, communication and money managing skills grew among beneficiaries, and reliable income accrued to schools through timely fee payments. The country's tremendous need for female teachers and agriculture and health workers—and for all the other benefits from the education of women—called for a much larger effort.

The third factor was the government's free tuition program for girls in grades 6 to 8 in rural schools, an "in-house" demonstration of the effectiveness of a money incentive in increasing girls' enrollment and transition to the next grade. It underscored the importance of a financial administration mechanism that ensures that full program payments are made regularly, providing reliable and adequate operating funds to schools. It further suggested the desirability of a program over the full secondary cycle.

A strong start

The stipend program began with a social marketing campaign to inform the community, parents, and female students about the advantages of keeping girls in school—and that the stipend program would help families do so. Posters equated girls' happiness with their education. Leaflets targeting students and their parents encouraged girls in grades 5 and 8 to go on to the next grade, taking advantage of the stipend support for educational expenses.

A survey of parents had cited tuition, textbook, and transport costs, boys' teasing of girls, and inadequate clothing as the main constraints to sending girls to secondary school—though some parents realized that an education could help girls find jobs, marry educated men, produce educated children, and increase their prospects and self-sufficiency in life.

The success of the social marketing program, the new compulsory primary education act, the establishment of new secondary schools, and the inclusion of religious schools combined to cause a 20 percent increase in girls' secondary enrollment in one year in the original 59 subdistricts.

An innovative feature of the program is the cooperation agreements signed by the schools and the government confirming the schools' participation in the project. Parents and daughters receiving stipends also sign consent agreements guaranteeing that the student will attend at least 75 percent of the school year, obtain at least 45 percent on the annual examinations, and remain unmarried until after the grade 10 terminal examination.

Community support became so widespread that the government decided to expand the project concept into a new national program in 460 rural subdistricts. With the present support from the government (282 subdistricts), the IDA (118 subdistricts), the Asian Development Bank (53 subdistricts), and the Norwegian Agency for Development Co-operation (7 subdistricts), the stipend program is expected to benefit about 5 mil-

lion girls—six cohorts of students starting in 1994 and finishing in 2003. The program is continuing awareness-building activities, as well as providing additional teachers, revising the curriculum, introducing occupational skills training, providing books and equipment, and constructing and repairing classrooms, latrines, and tubewells.

The nationwide program to increase girls secondary education is part of a broader effort to improve the quality and effectiveness of the country's education system at primary and secondary levels. The IDA-funded General Education Project supports activities to raise primary school quality, enrollment, and attendance—especially for girls.

Countries as close as Pakistan and as far away as Tanzania are watching Bangladesh's innovative female education program. China has also expressed interest. Having realized that educated women enhance a country's opportunities for economic and social development, many other countries may seek to replicate Bangladesh's success.

3. Closing the Life Expectancy Gap in Hungary

To reverse declines in life expectancy, Hungary launched the Close the Gap Program, holding national and international competitions to decide which innovative action-oriented programs of disease prevention and health promotion it will support.

The average life span of Hungarians is significantly shorter than that of their European neighbors. Are poor diet, excessive smoking and drinking, and a sedentary lifestyle the culprits? The problem is acute enough to sound alarm bells. In response, more than $30 million of the funding for the World Bank–supported Health Services and Management Project are devoted to public health activities. Of this amount, $20 million are earmarked, under the Close the Gap Program, to support competitively selected projects intended to bring average longevity in Hungary into line with that in the rest of Europe.

One of the interventions under the public health program replicates a program that, during the late 1960s, came to the rescue of Finland, once referred to as "the sick man of Europe" because its citizens also died earlier than those of other European countries. The Finnish program was a big success. Not only did longevity among Finns improve in a short time, but the gap between Finland and other European countries was closed.

Now, assisted by Dr. Pekka Pusca, a member of the team that orchestrated the Finnish program, Hungary hopes to produce the same results. Dr. Pusca will have his work cut out for him. Hungarians have the dubious distinction of being Eastern Europe's number one consumers of meat—and, at 44 percent of adults, its most prolific smokers—according to the World Health Organization. A shocking 60 percent or more of Hungarian doctors are estimated to light up. Although fewer Hungarians are drinking strong spirits—10.5 percent, down from 11.6 percent in 1986—alcoholism is on the rise. Conservative estimates put the number of alcoholics in 1986 at 434,000, but by 1992 that figure was up to 835,000, in a population of 10.3 million.

Diet is also part of the problem. Besides traditional dishes that emphasize fatty, cholesterol-laden meats such as pork and various fried products, liberal doses of lard are typically part of the food preparation. And sour cream is eaten with abandon in a wide variety of Hungarian dishes.

"Hungarians put cream in almost everything, including soup," said Sandor Sipos, a World Bank economist—and a Hungarian. "Pork is one of the dietary staples. Everything is loaded with salt. There is very little roughage in the diet."

Although Hungary's health system consumes 5.6 percent of GDP, it has been remarkably ineffective in promoting good health and preventing disease. As a result, Hungary's life expectancy (74 years for women and 65 for men) is among the lowest in industrial countries, and mortality from cardiovascular disease, nearly the highest in the world, is increasing, particularly for males between 35 and 55. By comparison, life expectancy at birth in Western Europe is around 77 years for women and 71 years for men.

During the past two decades, life expectancy at birth has fallen by 0.9 year for Hungarian males, and life expectancy for males at age 30 by 4.2 years. During the same period, life expectancy for Hungarian females has stagnated. Improvements in child and infant mortality rates have stabilized the situation. But at the core of this grim reality in Hungary are the high and increasing mortality rates from noncommunicable adult ailments such as heart disease, stroke, and cancer.

The Health Services and Management Project is designed to support the Hungarian government in restructuring the health system to focus more on cost-effective, strategic investments in public health, selected clinical services, and reforms in health services management. The Close the Gap Program and other public health interventions have been designed to keep the health of Hungarians at the forefront of national and local debates until behavior and lifestyles change for the better.

The Close the Gap Program was designed to launch new initiatives in health promotion and disease prevention. The main objectives of the program are to:

- Stimulate innovative, action-oriented intervention programs in health promotion and disease prevention to control cardiovascular disease, cancer, and injuries.
- Establish a more substantial and incentive-driven financing mechanism for intervention programs and research in public health care.
- Foster high-quality, action-oriented programs in chronic disease prevention.
- Lay the groundwork for future public health initiatives that cannot be anticipated or launched immediately.
- Overcome the pervasive pessimism in Hungary, among the population and medical professionals alike, by demonstrating that effective action in health promotion and disease prevention could begin closing the gap in health status between Hungary and Western Europe.

The Close the Gap Committee, established to oversee the use of the funds under this program, includes prominent Hungarians—the president of the Parliamentary Committee for Social Affairs, the undersecretary of state for welfare, the dean of the Post-Graduate Medical Schools, the

dean of Economic University, and the chief medical officer of one of the regional counties. Also included are four prominent international members: the former chief medical officer from England, a renowned health promotion specialist from the United States, a leading Spanish nutritionist, and Dr. Pusca, architect of the famous program of cardiovascular disease prevention in Finland.

The committee meets every six months to advise the Hungarian chief medical officer and Hungarian leaders on key public health strategies to pursue. It oversees the resources available to the committee by deciding on major themes for the year (smoking, nutrition, or lifestyles). It also analyzes proposals. So far, the committee has met three times. During these meetings, it has launched a major national antismoking campaign and a major survey of lifestyle behavior. It has also initiated a program to control hypertension.

A big part of the antismoking campaign targets kindergarten children. The primary aim is to change not only the attitudes of the children, but also those of their teachers and members of their families. A nationwide network is expected to be implemented to advise people on how to quit smoking. Another important part of the campaign is a household survey of lifestyle risk factors, in which residents of 1,000 households responded to questions about diet, exercise, and smoking habits.

It is hoped that the Close the Gap Program, combined with other interventions under the project, will do as much to improve life expectancy in Hungary as Finland's program has done in that country in the past two decades.

4. Targeting Indonesia's Poor

Improvements in the content and regularity of the national household survey—and the analytical insights generated by the information base—have laid a strong foundation for better poverty analysis and policy formulation in Indonesia.

The World Bank is helping governments strengthen their institutional capacity for targeting the poor. A recent Bank report, *Indonesia: Public Expenditures, Prices, and the Poor,* shows how the process of report preparation can lead to continuing improvement in poverty analysis and policy. The continuous collaboration of Bank staff stationed in the field promoted consensus and helped bring quick results—better poverty data to help senior policymakers in their decisionmaking.

Policymakers in the national planning agency, BAPPENAS, recognized that antipoverty policies required better, more up-to-date knowledge about the poor and about public spending on poverty alleviation programs. Understanding that the usefulness of poverty analysis for policy depends on the quality and timeliness of the underlying data, BAPPENAS sought to improve its capacity to collect and analyze poverty data regularly.

The Bank responded initially by collaborating in strengthening the design of the existing household survey. Then, a series of analyses of household survey data were done—to show the importance of data from large-scale household surveys in analyzing poverty and designing appropriate policies. The studies addressed three main issues: measuring poverty, determining the distributional incidence of public spending, and designing pricing policies.

Improving the information

A two-step strategy was adopted to improve the household survey information system for analyzing poverty. The first step was to broaden the coverage of welfare indicators to include not only household consumption but also variables measuring educational enrollment, health status, health care use, fertility and contraceptive use, water supply and sanitation, housing, and labor. The selection of these indicators emerged from a process of consultation with sector agencies led by BAPPENAS. A new

survey design, pilot-tested in 1991, showed that the consumption questionnaire could be shortened with little loss of accuracy to allow the substitution of new questions generating a range of social indicators. The new core survey was quickly adopted and implemented on a national scale beginning in 1992.

The second step was to deepen the coverage of welfare indicators by enlarging the sample size to allow more policy-relevant disaggregations of the data. Beginning in 1993, the sample was expanded threefold, from 65,000 to 200,000 households, to generate reliable estimates of welfare indicators at the district level. This will allow much finer identification of poverty problems, support the design of more efficiently targeted poverty alleviation programs, and strengthen the capacity for decentralized planning.

Identifying the poor

Knowing where the poor live is crucial to the design of more efficient targeted programs of poverty alleviation. Analysis of the regional poverty profile using a consistent food poverty line—which takes into account differences in the cost of living between provinces—showed that the methods used in constructing the official poverty line needed to be reassessed to adjust properly for price variations in different places. The government adopted the new method in its official estimates for 1993. The results also highlighted the need to disaggregate the regional poverty profile to the district level to allow better identification of poverty pockets within the large provinces of Java, where most of the poor still live. This is now possible using the newly enlarged core survey.

Redirecting public spending

Better knowledge of who benefits from public spending programs was needed to assess the scope for redirecting public subsidies to the poor. Analyses showed that much could be done to improve the incidence of subsidies by reallocating spending to more efficiently targeted programs. More public resources were spent on poorly targeted programs—the kerosene subsidy, hospitals, and post-primary education—than on three programs found to be pro-poor—health centers and subcenters and primary education. These findings pointed to the need to rethink public spending policies. The inequities implicit in public spending on hospitals and post-primary education had not been apparent, while the pro-poor impact of health centers and subcenters had been overlooked.

Changing prices

Prices help determine the access of the poor to social services, and changes in pricing policy can be a powerful instrument for shifting public spend-

ing toward the poor. The data showed that despite subsidies, the poor face significant costs in using public services. Studies suggested that targeted changes in pricing policy could significantly raise enrollments for the poor at all levels of education.

Perfect targeting through individual means testing would be difficult and costly to administer. But geographic targeting—reducing fees in the poorest 30 percent of subdistricts, for example—could work. To help finance fee reductions for the poor, better-off students could be charged higher fees without hurting enrollment. Thus, a pro-poor reorientation of public subsidies for education could be achieved by well-designed pricing. These findings contributed to a policy debate about the need to adjust fees at junior secondary schools to help achieve the government's objective of universal basic education.

Household survey data also identified significant costs for the poor of access to public health services. The analysis pointed to four options to help shift public spending toward the poor. One: strengthen the system of individual means testing—through letters of exemption by local authorities, though these appeared to be little used by the poor. Two: use

geographic price discrimination to keep prices lower in poorer areas. Three: encourage self-selection by charging different prices for different levels of care. Four: charge higher prices to groups of the better-off, such as civil servants enrolled in the government health insurance scheme.

5. Improving the Performance of Tunisia's Public Hospitals

The emphasis may be on primary health care, but hospitals still account for a big part of health budgets. That's why Tunisia is improving the management, financing, and condition of its hospitals.

Every Tunisian lives within an hour's walk of a health facility—an excellent level of access. But the quality of public sector health services suffers from severe and worsening underfunding. The underfunding translates into shortages of equipment and supplies, insufficient maintenance, low staff morale, and ultimately to a quality of service in the entire public sector that falls short of the increasing expectations of the population.

A dedicated and enthusiastic group in the health ministry devised a program of reforms to improve the management, financing, and conditions of care in the hospitals. At the same time, the ministry is implementing broad reform to improve the quality and restore the credibility of primary and first-level health care services, so that patients will be willing to seek care at appropriate levels, easing some of the pressure on hospitals.

The World Bank is supporting both parts of the reform, in the context of broad support for the health sector and for public enterprise reform. The Hospital Restructuring Support Project, unique among Bank loans, is likely to be a forerunner of others, as many other countries face similar problems—50–70 percent of public health resources go to high-level-care hospitals, where there is often great potential for better maintenance and management of resources to reduce costs and improve the quality of care.

The reform program is tackling the problems on three fronts—better management and operation of the 22 largest hospitals and health institutions, national long-range planning of hospitals, and greater cost recovery for hospital services.

Better management and administration

After careful consideration of the legal constraints and administrative needs of public sector hospitals, legislation provided for a new organizational form—the public health establishment. The 22 largest hospitals and institutions have all been converted into public health establishments, with financial and administrative autonomy, with executive

authority vested in a general manager, answerable to a board of directors, and able to contract at the market rate for skilled managerial staff. Most new managerial positions have been filled, and training is helping equip the new managers for their jobs.

A computerized management information system has been developed to provide data on personnel, supplies, equipment, and patient files and treatments. It can keep track of services delivered and resources used and generate bills without delays. It is indispensable to proper general accounting and financial control of the hospital's activities.

A financially autonomous center for health information was created to manage, standardize, and coordinate the hospital's computer network—and to work with hospitals to develop, install, and maintain the computer system. Plans were drawn up for renovating and refurbishing administrative buildings and wards where conditions were dreadful, but progress has been slow. Essential equipment has been purchased to replace obsolete, broken, or missing equipment vital to the proper functioning of hospitals.

All the hospitals working under the new organizational format have quickly shown better performance—with reductions in average lengths of stay of patients—and budgetary savings. Better resource management has helped reduce waste and overconsumption. Speedier payments to suppliers are helping restore the financial credibility of the hospitals. Although full managerial autonomy for personnel issues has not been achieved, personnel management has improved.

Long-range hospital planning

A national 10-year strategic plan for restructuring and developing the health services network, and hospitals in particular, is being formulated—based on national health objectives, estimated future hospital needs, and financial projections—as a fully integrated part of the preparation of the ninth national development plan. Hospital master plans are being prepared for nine of the oldest and largest hospitals, to ensure that all works carried out are within a long-range and logical plan for the development and renovation of the entire hospital complex.

Better cost recovery

Consensus was reached on the aim of hospital user fees—to charge actual costs to users who can afford them out of pocket or through health insurance, in order to release public resources for use elsewhere in the public sector. Escalating demands on the health care system have been pushing costs up, and efforts to strengthen care and increase use at the lower levels require additional resources too. When the reform was initiated, it was estimated that free or highly subsidized care was being provided to about 40 percent of hospital patients, yet the government's definition of poverty

included fewer than 10 percent of the population. Another roughly 40 percent of patients belong to major health insurance programs, yet only 11 percent of the public health system resources come from these programs.

Between 1991 and 1993, the hospitals managed to increase revenues from patients by at least 64 percent and in some cases to more than 100 percent. There have been three progressive revisions of hospital tariffs, though they still fall far short of actual costs. Co-payments for insured patients have been revised, and a study of the medical welfare system is the basis for reform to target benefits more closely to those who need them. Armed with reliable data on cost and use, and having studied the health insurance system, the ministry is negotiating revised payment rates with the health insurance schemes, which should help improve public hospital finances.

Momentum—but not all smooth sailing

There have been setbacks and delays in the face of resistance to some of the reforms. Reforms are not easy to plan, and they are even more difficult to carry through when they go against overall civil service regulations. Progress depends on a dynamic and committed team effort, as well as broad political acceptability. Overall, however, despite the delays and hesitations of some in wholeheartedly preceding with the reforms, the momentum is positive, and the process is now widely seen as constructive and irreversible.

6. Integrating Reproductive Health Care in Zimbabwe

Zimbabwe's Ministry of Health is doing more to integrate family planning, maternal and child health care, and the prevention and treatment of sexually transmitted infections into a comprehensive reproductive health care service available throughout Zimbabwe.

With the triple onslaught of drought, economic contraction, and AIDS threatening to overwhelm Zimbabwe's health care system and reverse its impressive gains since independence, the open dialogue that Zimbabwe's Ministry of Health and Child Welfare established over the years with the World Bank has proved its worth. Once the urgency of the situation was recognized, both the ministry and the Bank were able to spring immediately into action.

In just nine months from the first discussions, the ministry designed and the Bank approved the $65 million Sexually Transmitted Infections Prevention and Care Project. This initiative—together with a companion project funded by the Overseas Development Administration (United Kingdom)—supports all condom, drug, diagnostic, and other attendant costs involved in the running of Zimbabwe's sexually transmitted disease program (including drugs needed to treat the additional tuberculosis cases associated with HIV infection) for the next five years. So, from 1993 to 1998, Zimbabwe's national health service will have the funds to implement its national STD program without jeopardizing its delivery of essential primary care services. By extending donor support to this vital aspect of reproductive health care, the project bridges a serious gap in Zimbabwe's health care funding.

Donors now support the full range of reproductive health care services in Zimbabwe in addition to their other long-term support for the country's extensive health care efforts. Through a decade of government-designed and -run family health projects, for instance, the Bank has coordinated donor support for a broad range of Ministry of Health programs and investments. (Many other health projects are funded through independent bilateral projects.)

Zimbabwe's family health projects have expanded and improved family planning services, trained midwives and traditional birth attendants, and supported cytology services (vital for diagnosing and treating repro-

ductive tract infections and cancers). They have also supported programs to improve maternal and child nutrition, constructed and upgraded district health facilities, and improved the alarm-and-referral system to ensure mothers and infants timely care before, during, and after childbirth.

Taking the broad view

The Sexually Transmitted Infections Prevention and Care Project reflects a new era of flexibility in the relationship between the Ministry of Health and Child Welfare and the Bank and other donors. Traditionally, support for set project activities was agreed on in advance, and monitoring focused on whether the activities were being completed. Whenever activities were dropped or added to suit changing circumstances, changes had to be requested formally, justified, and approved. The ministry and the Bank now have a more flexible and responsive approach, giving greater responsibility to the ministry.

In one innovative departure from business as usual, a November 1994 Bank team in Zimbabwe was able to suggest that savings in the project—realized when international competitive bidding enabled Zimbabwe to purchase the drugs it needed at prices far lower than expected—be reprogrammed to take care of other urgent needs within the health sector not originally covered by the project. To achieve this sort of flexibility—and in accord with the ministry's effort to move to a more integrated approach to reproductive health care—the ministry and donors have agreed to review the Sexually Transmitted Infections, Prevention and Care Project and the family health projects together as integrated support to the sector rather than as separate projects.

The cooperation and coordination of donor efforts over the past years and their more flexible new approach form a basis for moving beyond support for individual projects toward donor funding for a fully integrated sector program, perhaps following the example of Zambia.

Revamping reviews

Progress is no longer assessed by measuring line-item inputs against project appraisal forecasts. Project activities are valued for their contribution to the program as a whole and their likely impact on health outcomes—regardless of whether or not these precisely match interventions as identified during appraisal. In practice, this means reviewing not only the efforts funded by the project but also the sector as a whole. It also means signing off on any use of project funds consistent with the achievement of the project's subsectoral objectives.

Relying on the ministry's internal reviews of the sector enables the Bank to focus its efforts and expertise on policy and implementation issues of broader import. This reduces the supervision burden on the ministry and

encourages greater innovation at all levels of the health system. It is, for instance, much easier for district staff to do operational research to evaluate program effectiveness.

In another innovation, the Bank and other donors plan to limit review inquiries to no more than four carefully selected areas. Project managers, freed from detailing their achievements repeatedly, will now be able to focus on problem solving. Under the new approach, moreover, the ministry will take over more responsibility for review, reducing the average length and cost of Bank missions and cutting down on the need for consultants. The better-focused reviews should allow donors to funnel their contributions to areas where they can do the most good.

7. Food Coupons for Better Nutrition in Honduras

Honduras's program of food coupons—the Bank's first direct support for food coupons—allows poor families to buy food and to choose what food they will buy, when, and where. By its third year, the malnutrition of young children was already on the decline.

Hunger, frailty, stunted growth, disease, pregnancies that carry the risk of death for mother and child—these are the stark conditions in the poorer parts of Honduras. Countrywide, nearly half the children under five lack adequate nourishment. With the IDA's help, Honduras is trying to meet the nutritional needs of poor, pregnant, and nursing women, children under five, and children in primary school in areas with the highest malnutrition rates.

At the core of the effort is a food coupon program, part of a social safety net put into place to protect the country's most vulnerable people as Honduras undertakes economic reforms. Begun with about 182,000 participants in 1990, the program expanded its coverage to 345,000 of the estimated 430,000 children at risk of malnutrition. It marks the Bank's first direct support for financing food coupons, each worth about 20 limpiras, or $2. The effort also supports nutrition education for health workers, community groups, and mothers, concentrating on infant and early childhood feeding and primary health care services for the target group.

Because food coupons are used instead of food, avoiding traditional food distribution costs, the government saves some 30 percent, and the beneficiaries can choose the food they consume.

Targeting the poorest and most vulnerable Hondurans, the original coupon program intended to cover 30 percent of food needs. But inflation whittled that down to about 15 percent. Starting in 1995, an adjustment for inflation will maintain the value of the coupons, enabling participants to satisfy the same proportion of their food needs.

As the program proceeds, it incorporates lessons of experience. To combat the twin problems of illness and ignorance that worsen malnutrition, nutrition assistance has been combined with health care and education. By distributing coupons at health centers to qualified families, the program encourages eligible mothers to have their infants and young children checked regularly by medical personnel.

Every month, program officials pass out coupons to eligible families at about 205 health centers. In areas where there are no health centers, coupons are distributed through about 3,000 primary schools. At health centers, participants receive one coupon for every child under five, because younger children are especially vulnerable to malnutrition. Pregnant women and women who are breastfeeding each get an extra coupon. At schools, eligible families get one coupon per child enrolled in first, second, or third grade. Because of staff shortages, coupons distributed through the schools are "bunched," given out three times a year rather than once a month.

Coupons technically can be used to buy any item. "With bunching, there is the temptation to use coupons to pay for improvements of the house," says Bank project officer Anna Sant'Anna. "Maybe a falling roof, or a stove needs to be replaced. But the norm is about 80 percent for food and 20 percent for other basic items, such as medicine and children's shoes." Regardless, parents are given a clear incentive to put their children in schools and care for their health.

"You can see a big improvement in the use of social services, consultations, and baby checkups," Sant'Anna says. "In the first year, we had 23 centers, and now 205 centers are participating. And the number of children cared for in these centers is up by 155 percent." Likewise, enrollment in primary school rose by about 12 percent, and repetition and dropout rates declined.

The IDA project also supports the development and implementation of a longer-term nutrition assistance strategy for Honduras—vital in a country where the average doctor serves 2,500 people. To strengthen primary health services, the project is rehabilitating about 130 health centers and building 30 additional health centers in rural areas that lack such services. The delivery of basic health services, including essential drugs, will be improved. Some 60,000 people in rural communities will receive water supply and sanitation services vital to basic health. Health care and nutrition assistance institutions—the Ministry of Public Health and the Family Assistance Program—will be strengthened as well.

Although attempting to measure changes in malnutrition is difficult in the short term, there already are noticeable benefits. In 1993, 36 percent of first-year students in the country had either severe or moderate malnutrition, down from more than 40 percent in 1990, when the program started. Program organizers continue to innovate and are now trying to "graduate" women participants by training them in dressmaking, food processing, and work on assembly lines.

8. Enlisting Participation in India —on a Grand Scale

India turned the process of developing its District Primary Education Program into an opportunity to expand national expertise on a crucial economic and social issue—education. It also sought massive participation, helping to ensure that reform programs will be responsive to public needs and command substantial support.

More than 70,000 people took part in meetings on strengthening India's primary education programs, and the union education minister proudly boasted in 1994 that the baseline studies were "the largest ever conducted in the world." Even routine visits by World Bank experts became exercises in mutual capacity building, as Indian officials and Bank staff worked together to develop techniques the government could use later in assessing district education projects.

Improving rural education

India launched its District Primary Education Program in 1994 to help states and districts improve rural primary education for the poor, for girls, and for socially disadvantaged groups. Run by the Department of Education, the program supports state efforts to strengthen education and research agencies, as well as district efforts to build new school capacity, improve the quality of schools, and expand access to educational opportunities. The first phase will reach about 50,000 schools that serve 10 million children in seven states and 42 of 334 targeted rural districts. It is planned to expand the program steadily to reach the remaining districts in the next 15 years.

Sometimes the benefits of projects start flowing long before any funds are released. India didn't wait for project approval before starting to develop the institutional capacity to prepare education reform activities, put them into effect, and evaluate them. In addition to holding extensive consultations around the country and launching substantial research efforts, it collaborated closely with donor agencies on tasks ranging from mapping districts to determine where schools should be built—to studying such education problems as the failure of many girls to attend school.

By the time the project was approved and initial donor funds became available—$265 million from the IDA and $200 million from the European Union—Indian institutions already had greatly increased their understanding of the country's education challenges. They had also enhanced their ability to promote popular participation, conduct primary education research, and decentralize planning and management.

"That the complex planning process could be done by ourselves is a measure of the capacity and intrinsic strength that exists in the country," said the union education minister. The minister added that the capabilities built up during project development will be especially important for a "complex and holistic program, which seeks to go beyond piecemeal implementation of schemes and instead aims at transforming the primary education system."

Enlisting popular participation

The project had impressive popular participation—a long-established objective of India's education policy. More than 1,000 program planning meetings were held at the village, district, state, and national levels. Parents, teachers, nongovernmental organization staff, elected leaders, and education officials took part. Members of national and state research and development agencies also attended meetings at all levels, contributing their insights while broadening their understanding. Staff and consultants from the World Bank and other donors took part in selected meetings, listening and offering suggestions based on experience in other countries.

The extensive grassroots participation increased sensitivity to regional and cultural differences and in the process shed light on some long-running controversies. Consultations revealed, for instance, that most tribal families want their children to be taught in the appropriate regional language, not the tribal tongue.

Project research

India began its effort at education reform with a limited base of national expertise. Schools needed better knowledge of local constraints on school quality and of the special barriers faced by girls and socially disadvantaged groups.

Baseline studies by Indian researchers—covering more than 2,000 schools and 50,000 students—addressed such issues as levels of learning achievement in rural schools, constraints on attendance of girls and tribal students, and teacher performance, attitudes, and training. Other studies addressed textbook preparation and publication, teacher training, and state and national educational finances. Donor agencies, including the World Bank and UNICEF, participated in the design of studies and provided financial support.

The studies produced some dramatic findings. Tests administered to 40,000 children, for instance, showed that fewer than one-fourth of all primary school students were mastering even half the learning objectives established for them. Importantly, the studies improved understanding of the reasons for low achievement. Indian officials made the research findings widely known. The conclusions were published in newspapers and led to a national conference—and were discussed with parents and district officials. The result: a decision to tailor quality improvement strategies to local constraints as determined through the research, with periodic assessments of progress.

Decentralizing planning and management

India is a nation of considerable linguistic, cultural, and resource diversity. A "one size fits all" approach to empowerment and improvement of rural schools would be unlikely to work. To meet national policy goals for decentralized policymaking, the District Primary Education Program initiated its planning through local teams at the district level. Grassroots participation in project development contributed to state and district proposals to strengthen village education committees and provide small cash grants to teachers and community organizations for school improvement activities.

While this made participation at the lower levels of the education system easier, the teams needed to be trained rapidly in such matters as how to consult with beneficiaries, how to use information to define education problems and design appropriate intervention strategies, and how to estimate costs of various actions.

The Education Department mobilized direct technical assistance from national institutions to districts, and formal training in key technical areas for state and district staff. It also sought to develop its own capacities—and the capacities of donors—for program coordination and appraisal by assigning senior officials to work jointly with the World Bank and other donors. Indian officials, in effect, improved their evaluation techniques by observing how teams from the donor countries evaluated the program's proposals. And donor teams learned much about the dynamics of Indian education from their counterparts.

For Bank officials, this close collaboration was quite a contrast to their experience in some other countries, where government officials either insist on working entirely by themselves on project development or cede the task to experts representing the donors.

The Education Department further strengthened the national capacity to evaluate programs by requesting increasingly more sophisticated analytical work from scholars in national and state research institutions. At the end of the Bank's project cycle, staff in the newly established District Primary Education Program Bureau conducted their own appraisal of state and district proposals—in parallel with the IDA's final review.

Research capabilities built up during the development phase continue to be used. Indian researchers are now collaborating with the Bank and other donors to analyze data from 29,000 fourth- and fifth-grade students in 2,100 schools in 42 districts of eight states. Preliminary analysis confirms that the key factors determining achievement in reading and mathematics at the primary level vary widely across states and districts—a finding that supports the program's emphasis on district-level interventions to improve school quality.

9. Reaching Mexican Children Early

Mexico is improving the probability of successful school experiences for 1.2 million children in its 10 poorest states. The idea is to educate parents about ways to improve their children's development skills and to provide better opportunities for the children of poor families to succeed in school. At the heart of all this is the enrichment of the family as the child's first learning environment.

Since 1981, Mexico's Public Education Secretariat has run a nationwide program to educate parents, mainly mothers, to improve the care of and interaction with their children. Under this home-based program—prepared cooperatively with UNESCO, UNDP, UNICEF, and the World Bank—community educators train parents to stimulate their children. Parents' education is the key instrument, developed through periodic group meetings supplemented by weekly or biweekly home visits.

Community educators use illustrated guidebooks and other educational materials to teach parents the skills for caring for and stimulating children, to foster their cognitive, psychological, and social development. In this way, children of low-income families are prepared for timely school entry as well as for improved primary school attendance and performance.

Such early childhood education promotes the physical, emotional, intellectual, and social development of infants and toddlers, from birth to the age of four, and improves the school readiness skills of children.

There is also strong scientific support for a link between early education and child intellectual development and academic performance later in life. Such education can help modify inequities rooted in poverty and discrimination by giving children from disadvantaged backgrounds—especially those in rural and marginal urban areas, girls, and other children at risk—a fair start. Big differences in cognitive achievement between lower and higher socioeconomic groups can be attributed to low levels of psychological stimulation among poor children. Early childhood education increases the return on primary and even secondary school investment, raises participants' productivity and income, and lowers public expenditures.

The project is expected to stimulate the cognitive, psychomotor, and social skills of 1.2 million children under five. There will also be indirect beneficiaries, including 2 million siblings, 880,000 parents, and many communities. The main quantifiable benefit will be an increase in the primary school completion rate among participants, which will boost their lifetime earnings.

The project also creates job opportunities for about 12,000 community educators, mostly young female graduates of lower secondary education in poor rural and marginal urban areas. They receive an income transfer of about $150 a month, increasing their access to higher levels of education.

Special training in nutrition, basic health and hygiene, and family planning is included in the training of community educators—and is expected to improve family health and nutrition and reduce fertility rates.

The project is also expected to foster community development. The weekly parents' meetings and pro-childhood committees encourage parents and community officials to organize themselves and mobilize resources in support of the early childhood education program.

To get the greatest educational impact and to benefit from the resources and services of other social agencies, the project seeks cooperation with public, private, and nongovernmental agencies operating other social sector programs, particularly in health, nutrition, and population. In an unusual burst of interagency cooperation, the Health Secretariat and the Public Education Secretariat agreed to collaborate in health and nutrition efforts in communities where both agencies have programs.

10. Fueling Nigerian Women's Entrepreneurial Drive

Nigeria's pilot program of management training for rural businesswomen—most of them illiterate—is already reaping greater product diversity, stronger marketing, and higher profits. Now it's time to scale up.

Over the past five years, the World Bank's Economic Development Institute (EDI) has piloted women's grassroots management training programs in Burkina Faso, India, Malawi, Nigeria, Senegal, and Tanzania. The work has involved:

- Assessing the management training needs of grassroots women's groups in income-generating activities and in microenterprises.
- Adapting or developing training materials to address these needs.
- Identifying local partner training organizations.
- Training trainers to train grassroots women as managers.
- Providing on-site follow-up training to local women's groups.

For the Nigeria pilot, the EDI has collaborated with the Pan African Institute for Development, a regional management training organization (the Sasha Training Center), a national training institute, and a group of local NGOs to provide management training to women in three western states. Some of the NGOs are also providing microcredit and appropriate technology to the groups in the program. Monitored closely from the outset, the project has been adjusted as weaknesses or obstacles appeared—and is already making a difference.

After attending hands-on training courses, village women who run microenterprises have begun to diversify their products, cooperate with one another to market in groups, and boost their profits. The women are also entering literacy programs, learning bookkeeping, and keeping better records. Literacy was not a prerequisite for the course, but many illiterate women who took the training started to keep records with the help of their children as a result of what they had learned.

The women are purchasing raw materials in bulk and marketing their products at "important markets instead of selling small quantities to middlemen," as one of the trainers reports. And "most try to be nicer to their clients and have a more cheerful expression." In addition to being more self-confident and assertive, the women feel that their social status has

been enhanced. And other villagers who were originally skeptics, including men, are now seeking advice from the trainees.

Some of the women are considering expanding their businesses. Other changes include better cooperative group relations, more frequent and better-attended group meetings, and sounder financial operations, with more profits reinvested in the women's businesses. Significantly, women who had the training have taken out more business loans, at 30 percent interest, with a stunning repayment rate of 100 percent.

Group activities are also expanding as the women learn about economies of scale, investment, reinvestment, and diversification. For example, some of the women who traditionally prepared and sold *gari*, a manioc-based dietary staple, have reinvested the profits they realized with their newly acquired business skills. They decided as a group that they needed better care for their young children, so they opened a childcare center and hired the staff.

The women also have more egalitarian relationships with their husbands and more involvement of their children in their businesses. The training modules included "win-win" negotiation techniques, which are very popular and of particular interest to the women.

An emphasis on follow-up visits to the women in their villages gives trainers a chance to help trainees apply new skills, review accounting and record-keeping techniques, and provide more training on topics that the women did not fully understand from their initial training.

Training the trainers has been an essential part of the project. In a three-week training session, 13 trainers learned about topics they would be teaching the women and were introduced to the learner-centered approach in adult education, developing skills in the role playing and study methods they would be using. The trainers then presented four one-week course modules for local women's organizations: people management, finance and credit, microproject management, and marketing. So far, they have instructed about 225 Nigerian women in two rounds of training. New materials, developed specially for the project and written in Yoruba, have proved appropriate and effective—and will be used as models for similar projects in other regions of Nigeria, and in neighboring countries.

The scale is still small. With only eight trainers currently active out of the original 13 training project participants in a country as large as Nigeria, only a small number of the village women who need and want training can be reached. There is great demand both for more training of trainers and for more regional management training and outreach at the grassroots level. And the local men want part of the action, too, with many requesting training like that their wives received!

"The project's prospects for sustainability depend on finding new sources of support to replace World Bank–EDI funding," says project manager Pietronella Van Den Oever. Some local NGOs have shown interest, and the pilot project is being expanded. Two of the collaborating NGOs

have provided microcredit to training workshop participants and to other members of local women's organizations. In addition, one of these NGOs has provided—on credit, which has already been paid back—appropriate technology in support of women's group businesses. Now the EDI is gradually stepping back, as the local programs take promising initiatives to raise funds to sustain the project.

Motivation for continuing the program is high among both trainers and trainees. The Pan African Institute for Development coordinator and the core group of trainers have identified activities that could help the program continue. Some trainers have even used their own money to start a fund that makes continued training possible, showing how truly participatory the program is—and how well it is regarded by the local people involved.

11. Working with Poor Communities in the Philippines—for Better Health

Health projects in the Philippines are putting funds at the disposal of poor and remote communities for health-related miniprojects. Local NGOs help to identify, organize, and manage the miniprojects in partnership with the communities and local government agencies. The scheme has been so successful that it is being expanded with further donor and government funding.

The Philippines Health Development Project, which began in 1990, established the $9 million Community Partnership for Health fund for community-level health-related miniprojects. The partnership includes as members the central Department of Health (responsible for implementation), local government units (responsible for local health services under the Philippines' ambitious new devolution of powers to local government), local NGOs, and the communities themselves.

The aim of the fund was to reach 22 percent of all remote or hard-to-reach *barangays* (the smallest administrative unit of one or more villages, holding about 5,000 people on average) in the country, providing them with on-the-spot funding to improve their health according to their own perception of their health needs. Average funding for a community is about 250,000 pesos ($10,000), to be spent over a period of up to three years.

To work with each community directly in deciding on its needs and managing its miniprojects, the Department of Health and the local government units work with local NGOs to select an NGO to assume responsibility for the funds for that community and then to assist its people in preparing and carrying out its program of miniprojects. Small grants are also provided for training and support to both the NGO and community members in administration and management. Regular consultation among all the partners continues throughout the process of planning and implementation.

The most popular miniprojects have been small works to create or improve the community's clean water supply, such as wells, standpipes, pipelines, storage tanks, and connections to houses. Construction of toilets or latrines and other sanitation improvements are also frequent

choices. Another popular type of project is the creation of vegetable and herb gardens, including traditional medicinal plants for treating minor ailments. These gardens help to improve the family diet and promote child growth and nutrition.

Few problems have been encountered in the implementation and management of these projects, and five years later, the fund has been almost fully spent. The scheme has proved so popular with all partners that it had to be extended from the original target of the 15 neediest provinces to cover all 77 provinces in the country. Two very favorable internal evaluations have already been done and two more evaluations are planned—one as part of the end-of-project overall impact evaluation and another by the Bank to assess the scheme's potential for replication elsewhere.

As the project nears its close, several steps are being taken to continue and expand the funding concept. Additional funds are being contributed next year by the Department of Health and local government units to supplement project funding, and further donor assistance is being sought. The European Union alone is expected to provide another $5 million. A new urban-based health and nutrition project will provide a similar $5 million fund for poor communities in the Manila and Cebu metropolitan areas and in the city of Cagayan del Norte. A new project to promote women's health and safe motherhood will provide a $12 million fund for miniprojects related to women's health and maternal care in the 15 neediest provinces. And a proposed project to promote early child development (health, nutrition, and preschool education) would again provide a fund for related miniprojects in the community.

12. Listening to Tanzanian Communities —to Find Out What's Really Wrong

Despite faster economic growth and declining poverty, Tanzania's social indicators were not following suit. A collaborative approach to analytical work—by the Tanzanians and the World Bank—tapped national experts and local communities to come up with solid strategies for health and for education.

Possibly the best role for the Bank in some situations is as a facilitator, organizer, and manager of a process. In Tanzania, analytical work was the process, but Bank staff tried their best to let Tanzanians steer it.

In mid-1993, the Bank began discussing with various government ministries the possibility of new analytical work in health and education. The government had no interest in new studies unless they were tied to new investments, and few people could detect any added value in more analytical work, with volumes and volumes of social sector studies having been completed in the past. Almost everyone felt that the main problems and issues already were well known.

In response to both the government's weariness with outside analytical work and the need to reevaluate the assistance strategy in the face of poor results, the Bank worked with the government to design an analytical approach that would have a household focus to complement the previous work, much of which had been almost exclusively on the supply of government social services. The approach would be fully participatory and would include participation by decisionmakers in the social sectors and the expected beneficiaries of programs. And it would encourage capacity building and relevance to local conditions by ensuring that most of the work would be done in Tanzania, by Tanzanians. The goal was to develop a policy dialogue that would lead naturally to a new sector investment strategy focusing on human capital investments and outcomes rather than inputs.

Most exciting was devising a participatory approach for completing the work over six to nine months, far shorter than the normal cycle.

The Bank explored the type of household survey information available in Tanzania and discovered that, despite the many previous surveys, there was almost no detailed information on how and why households use social services, how much they invest in human capital from their own

budgets, how much they value social services, and what they think about the services available to them. So, the Bank and Tanzanian colleagues devised a national household survey of about 5,000 households with standard survey questions on expenditures, family composition, ownership, and so on, but with marketing questions as well.

To complement this survey, there was a small qualitative survey (focused area study technique) in eight villages. This survey included focus groups, unit cost estimates for local schools and health facilities, time-use logs for children for four days, and some knowledge testing of children. Its design was based in part on interim results of the household survey. For example, early tabulations showed that the average age of entry into primary school in 1993 was almost 10, three years after the children should have been in school.

To get behind these statistics required interviews of parents, children, and teachers. Parents often said that they tried to enroll their children on time, but that children were sent home by the teachers. Teachers argued that the schools were overcrowded and that the youngest children should be sent home first. But they also suggested that seven-year-olds were too

young and too small to compete with students who were much older and larger (due to late starts and repeating).

The cycle of late starting and repeating grades was thus reinforcing itself. And breaking it has become a priority because of its negative impact on schooling achievement and the resulting short exposure to school, especially for girls. This result would never have come out without consulting households and using more than one technique.

To facilitate local production and management of most of the technical work, the Bank advertised for three long-term consultants to be chosen by the government in consultation with the Bank. They were to work out of the Bank's offices in Dar es Salaam for one year, from December 1993 through December 1994. The three consultants, managed by the Bank's in-country social sector specialist, in turn managed nearly 20 additional consultants.

To engage government policymakers, the Bank followed a tactic of engagement through decentralization. Key decisions were to be made either by the government or in consultation with the government. Bank staff worked with John Zayumba, the Planning Commission's director of social services, throughout the process. His office organized the government's inputs across ministries.

The goal was to complete all the background papers and survey work in time for a top-level three-day workshop at Arusha in late April 1994. The stakes were high, the time was short, and the Tanzanians accomplished some impressive feats. Between December and April, the household survey was completed, and simple descriptive statistics were produced. The focused area study technique was designed and completed, and preliminary results written up for presentation. Nearly 20 background papers were written and reviewed. And a conference with nearly 100 participants was organized to review and discuss the major issues.

Almost all of this work was done by Tanzanians. The Arusha conference, chaired by the principal secretary of the Planning Commission and opened by the chief secretary, was attended by more than half the principal secretaries in the government—plus respected Tanzanian experts on the social sectors and representatives of the major donors in the social sectors.

The impact of this process, especially the Arusha workshop, was extraordinary. The Planning Commission did not want to wait for a written Bank report to be produced. Instead, it pushed for producing its own social sector strategy to outline the basic path forward. It also decided to begin experimenting with new approaches to the financing and governance of social services.

For the Bank, this process required being flexible enough to respond to Tanzania's needs. It therefore supported the Planning Commission's effort to complete a strategy and began working with it to restructure existing projects to experiment with pilot activities, rather than pursuing what would normally be the first priority—finishing the report.

Following the April workshop, the Bank supported the completion of the government's new strategy document outlining new principles to shape the government's future role in the social sectors. Despite the Bank's development of many ideas for pilot projects (just to get things moving), the government came to Washington with its own ideas. Its basic concept—superior to and more forward-looking than anything suggested by the Bank—ultimately won the day.

The Bank agreed to assist in developing and financing what will become a scheme of matching grants from the central government for community education trusts and community health trusts to support primary education and health services. These will be paired with facility-based management for government schools and health services. In addition, the Bank will support development of a secondary school scholarship program for girls, which may be administered locally by the community trusts. Once the kinks are worked out, the program designs will define the IDA's assistance to primary health and education services over the next several years.

A major criticism throughout the process was that Bank staff were trying to do too much too fast, especially to get adequate participation. But the fast pace helped maintain focus and interest. And it imposed the discipline of an outcome orientation on a process that could have gone on forever.

13. Partnerships Fighting AIDS in Brazil

The Brazilian government is taking bold action against AIDS—working with nongovernmental organizations, health care providers, researchers, and other Brazilian and foreign experts. A strong partnership was forged with the Bank, too, in designing a comprehensive and innovative program to combat AIDS. There is early evidence of positive impact, especially among some high-risk groups.

AIDS is the most rapidly growing adult disease in Brazil. At the end of 1994, there were 50,000 known AIDS cases and an estimated 400,000 people with HIV—the virus that causes AIDS. Cases are growing exponentially, especially among heterosexuals. And sexual activity has far overtaken intravenous drug use, blood transfusions, and homosexual practices as the main transmission method.

In response, the government, in partnership with the Bank, has developed a comprehensive program for diagnosing, preventing, and dealing with HIV/AIDS and other sexually transmitted diseases. The program is well integrated with the unified health care system and delivered through a large network of partnerships that reach across and outside the country.

Preventive efforts are at the forefront. Media campaigns, workplace education, condom distribution through many channels, outreach to commercial sex workers, needle cleaning and syringe distribution for intravenous drug users, and confidential HIV counseling and testing centers across the country are all part of the prevention.

Brazil's health professionals are being trained to diagnose and treat STDs and AIDS-related illnesses better and to direct patients to the other social services that they need. Surveillance and laboratories are being strengthened to ensure the capacity to test samples and confirm diagnoses of STDs, HIV, AIDS, and tuberculosis and to help provide the data necessary for monitoring the incidence and trends of these diseases—and the impact of efforts to control them.

The government's funding for this strong program is substantially strengthened by the Bank's loan of $160 million for the Brazil AIDS and STD Control Project. World Bank support to combat AIDS is growing

rapidly, with about $600 million committed to date, for 50 projects in 40 countries.

The power of partnerships

AIDS/HIV must be addressed through a wide range of activities that reach many different groups of people, including many who shy away from government services. So, Brazil's federal government has for the first time decided to contract with NGOs to deliver services and information.

More than 120 NGOs are active, providing critical outreach to raise awareness, counsel and advise, and help infected people cope. Through an innovative selection process recommended by the Bank, NGOs are being funded under a competitive grants program administered by the government but are evaluated and selected by an independent panel of experts. All registered Brazilian NGOs may submit grant proposals for funds to provide HIV tests and counseling, hospice-type care, or preventive efforts aimed at high-risk groups. Close to 300 grants have been awarded so far, funding about 70 percent of proposals submitted. A similar process recommended for research grants has had similar success.

State and municipal governments are responsible for operating health care and other programs that deliver HIV, STD, and AIDS services and information. The federal health ministry's HIV and STD program stands out for its progress in implementing the new policy of decentralization. Fund transfers are made to all 27 states and 42 municipalities of significant size or importance in the incidence or spread of AIDS. And collaborative epidemiological surveillance systems for HIV/AIDS, STDs, and tuberculosis have been established with each state. This is the first decentralization program that gives technical assistance to help state and municipal governments set up effective programs, along with the funds and responsibilities.

The health ministry has forged other partnerships, too. The education ministry is helping to distribute information and education materials throughout the school system. And helping to marshal funds and expertise in a concerted effort against HIV are cooperation agreements with the U.S. Centers for Disease Control and Prevention, the Southern Cone countries (Argentina, Chile, and Uruguay), UN Agencies (especially the Drug Control Program), France, Germany, Japan, the European Union, the Inter-American Development Bank, WHO, USAID, and the University of California, Berkeley.

Prompted by the Bank's proposal and encouragement, the health ministry convinced the finance ministry to swiftly lower the costs of condoms by eliminating tariffs and promoted the rescinding of federal and state taxes on sales of condoms. Taxes and tariffs had pushed up the selling price of imported condoms and protected the domestic market for the domestic producers, whose mandated use of domestically produced latex results in uneven quality and comfort. This measure, combined with

social marketing and widespread condom distribution, has dramatically increased availability and affordability, two important components in encouraging greater use of condoms.

The government also has taken a bold step in channeling funds to, and working with, marginal groups in society, such as transvestites and sex workers. These groups have a high incidence of HIV and must be reached with education, health, and other services if the epidemic is to be slowed.

New specialized outpatient services—day hospitals—provide a full range of counseling and HIV testing, observation, medical and dental care, and psychological and social support while enabling patients to continue to live at home and avoid hospitalization. NGOs and other community support organizations are being contracted to support home-based care and provide hospices and small group homes for patients who would otherwise be hospitalized or homeless. Good care is provided at far less cost than the unsustainable average of $17,000 spent on AIDS patients, who typically receive lengthy hospitalizations for want of cost-effective alternatives.

14. Results from Long Collaboration in Tunisia

Tunisia's 33 years of collaboration with the Bank in education show the shifts from technical secondary education to vocational training outside the school system, to labor market intermediation services, to sectorwide policy reforms—first for primary and secondary education, then for higher education.

The World Bank's first education loan ever went to Tunisia in September 1962. The most recent education loan to that country, supporting a reform program to help propel the economy into the information age, was approved in August 1994. Among the loan's objectives is the development of a detailed program to assess the impact of current reform efforts—an evaluation that will inform Tunisia's policymakers and Bank officials well into the next century.

Long as the country's commitment to education has been, it has changed over time to reflect new circumstances. The decades have brought modifications to the country's policies on education and training. These in turn have been reflected in the evolution of the Bank's support to Tunisia in these sectors. The results have been rewarding. Since Tunisia gained independence in 1956, it has placed major emphasis on improving its human resources. As a result, access to primary school is virtually universal. Enrollment rates for girls at all levels are close to those of boys. Adult literacy has increased from 15 percent at independence in 1956 to 65 percent today.

First phase: Manpower development and primary education

Two IDA credits in the 1960s focused on technical secondary education, which was viewed as a critical bottleneck for the development of middle-level manpower. Both supported the creation of diversified secondary schools combining technical-vocational and academic streams, a concept much in vogue at the time (although subsequently found to be inefficient) as a means to improve the employment prospects of students leaving secondary school.

The projects were classic examples of this predominantly hardware-oriented era of education lending. The second project did introduce technical assistance to support such qualitative objectives as education planning, but the hardware aspects of the project proved more successful. Moreover, even as early as the 1960s, the limits of manpower planning as a guide to project selection were becoming obvious: the labor demand that was forecast did not match actual employment outcomes.

By the mid-1970s, both the Bank and developing countries began paying more attention to improving primary education. In Tunisia, a comprehensive education planning process launched during the second project identified primary education as the priority for the third Bank-financed education project. While the planning exercise delayed development of the next project, it changed the policy discussions between the Tunisians and the Bank to focus on the education sector as a whole rather than on isolated investment projects.

Second phase: Vocational training outside the school system

By the early 1980s, with unemployment rates reaching 15 percent, promoting job creation had become a major concern for the Tunisian government. At the same time, interest was growing in vocational and technical training programs managed outside the formal education system as an alternative to the diversified schools. The Fourth Education Project focused on expanding and improving programs of the Vocational

Training and Employment Office, an autonomous agency under the Ministry of Employment.

Once again, physical aspects of the project were satisfactory, but the software components were less successful. Staff training had good results, but efforts to develop systems to plan training strategy and monitor employment outcomes were less successful. Moreover, the project's impact on the labor market could not be assessed. The experience with this project convinced the government and the Bank of the importance of building strong links between employers and training institutions—and of the need for adequate labor market analysis in designing and evaluating training programs.

Third phase: Adjustment and sectoral reform

After a decade of strong growth, the economy started to experience difficulties in the early 1980s. Despite significant decreases in the price of labor, unemployment remained high, and 60 percent of those without jobs had not completed nine years of education. Yet placement rates for vocational training graduates also were low, reflecting poor labor market links. Academic secondary and higher education were geared to meet the manpower needs of the public sector, and budget constraints on higher education had seriously eroded its quality.

To address these issues, the Tunisian government embarked on a comprehensive reform of its education, training, and employment-promotion policies. The Bank supported the effort with a series of four projects over the past five years.

Primary and lower secondary education have been restructured into a nine-year basic education cycle, and upper secondary has been refocused on core skill streams. Curricular and teaching methods have been modernized to improve the competitiveness of Tunisian graduates. Bank-financed projects also supported links between vocational training centers and enterprises—and the creation of more flexible, decentralized placement programs for the long-term unemployed.

While the government understandably has concentrated its education reform efforts on primary and secondary schools, it has also taken steps to strengthen higher education. The Higher Education Restructuring Project, approved in 1992, supports the government strategy of diversifying and modernizing higher education to make it more relevant to the labor market, increase student choice, and reduce costs per student.

Long-term commitment

The third phase of education projects in Tunisia has been especially noteworthy for the scope of the reforms being undertaken. Such changes naturally could be expected to arouse opposition, especially from teachers and staff reluctant to change working habits and skills. But the govern-

ment maintained considerable momentum articulating a coherent long-term strategy and engaging unions, employer federations, parent and teacher organizations, and others in the process. As a result, there remains a strong nauonal consensus in support of the reforms. At the same time, the government has made significant strides toward forging stronger links between education programs and the labor market by encouraging employers to become much more involved in a range of training activities.

The Bank's collaboration with Tunisia on education is far from over. Detailed project impact indicators are being developed as part of the current Secondary Education Support Project. These indicators will give future policymakers data on everything from the efficiency of the central administration and the cost-effectiveness of school maintenance efforts to test results measuring student competence in Arabic, foreign languages, social sciences, and physical sciences. With such data, policymakers will be far better equipped to evaluate, adjust, and pursue future education reforms.

15. Turning the Tables for Zambia's Health System

Since 1991, the IDA has supported a process of reform in Zambia's health sector; in 1994 it approved a $56 million loan. The donor-driven approach to projects so prevalent in Africa has been abandoned. Instead, the government is in the driver's seat, with donors jointly contributing funds to support the Ministry of Health's program. The IDA has played an important role in the dialogue and as a large concessional funder of gaps left by the six bilateral funders. New resources—and the power to use them—have reenergized health officials at all levels, and positive results in the field have come much more quickly than expected.

"Donor community funding should be seen in the context of supplementing the Zambian effort, not the other way round," says Dr. Katele Kalumba, Zambia's deputy health minister, recognizing the problems caused by the way in which donors had supported the health sector in the past 15 years. Because of the weak administrative capacity, donors (usually independent of each other) often took the lead in project identification. In Zambia (as elsewhere in Africa), the result was a barrage of uncoordinated projects, fragmented management, inefficient resource allocation, and a scattergun delivery of health services.

In 1991, a new government was elected in Zambia on a platform of change and policy reform. In health, the Zambian Strategic Health Plan was the "new broom to sweep clean." It set out the new government's vision of a successful health system, with a radical move away from excessive centralization and an expensive, inefficient, and ineffective health care system, to a decentralized, district-focused, accessible, equitable, good-quality system. As the plan states, "the sum of our health sector strategies must lead to a society in which Zambians create environments conducive to health, learn the art of being well, and provide basic-level health care for all."

From the outset, Zambia's health ministry has led the reform process. The IDA has played an important supporting role, culminating in a $537 million project that also involves six other donors. Bank staff introduced

the Zambians to planning methods that are participatory, logical, and outcome-oriented. This planning approach was used in producing a strategic plan for health reform that detailed how the new health system would operate, what inputs it required, for which areas donor support would be sought, and how the government intended to transform the existing system into the new one envisaged.

The IDA's role in this national planning of comprehensive health care reform was collaborative and supportive, without usurping the government's control and management. As a major source of concessional funds, the IDA had a strong voice in the dialogue among the donors and with government. IDA funds provide a flexibility that the policies of bilateral donors do not always permit, and they are crucial to filling the gaps left by the other donors.

As a multilateral organization, the IDA has a unique role among donors. As Dr. K. Kamanga, the permanent secretary for health, has put it, the government set the rules that the donors all agreed to, but it relies on the Bank as a referee to help ensure that all the donors play by those rules and remember their commitment to leave the government in the driver's seat.

For Zambia, the strategic plan is unique in many ways. The donor coordination encouraged by the health ministry avoids duplication. Donors are increasingly making efforts to synchronize similar missions in the interests of both information sharing and time savings for health staff.

There are other new approaches. In the past, the priority in health care had been given to satisfying central-level supervisors or meeting targets set by donors. The plan has shifted the focus to the client by making health care providers accountable to local health boards, which represent a wide spectrum of the community. Instead of working to meet specific project goals, health care providers are being encouraged to organize their skills and services to provide comprehensive health services.

Many Zambians have been bypassing the health centers to seek care at hospitals, which is expensive and often unnecessary. Only a small percentage of health care needs can be cost-effectively addressed at hospitals. Now the health center has been identified as the key link for household and patients to contact the health system.

Under the plan, a package of health services includes immunization for young children, health education, and other outreach activities. At this first point of contact between the community and the health care system, the patient will be screened, diagnosed, and either treated with basic curative care or referred to the general hospital. Prenatal and postnatal health care for mother and children, family planning counseling, contraception, and nutritional advice will also be available.

The strategic plan will be updated annually by the ministry and discussed with donors to identify areas for donor support. The six other donors—the Overseas Development Administration (United Kingdom), the Danish International Development Agency, the Swedish International Development Authority, the Dutch government, WHO, and UNICEF—

which together account for 80 percent of donor funding, have agreed to follow this system and to fund only those areas included in the core plan.

What are the results so far? Although it is early, they seem to be encouraging. The finance ministry provided a significant increase in the central government's allocation to health, up from 8 percent to 13 percent in 1994. Decentralization and resources have empowered and energized district health officials. Morale is much higher, and officials have taken initiatives to address major health problems in their areas. Immunization rates, which had fallen badly under the old system, are recovering. And thanks to preventive and educational activities by district health staff, the annual cholera epidemic was greatly muted in 1994.

Zambia is not the only African country to revitalize its health system and its relationship with health donors. Mozambique and Sierra Leone are following suit with similar initiatives, creating a new self-confidence in improving the health and care of their people. These three countries, among those with the weakest capacity, convincingly demonstrate the potential of local leadership and empowerment for serving people.

16. Controlling Riverblindness in West Africa

The near elimination of riverblindness as a public health problem and as an obstacle to socioeconomic development in a major portion of West Africa stands as one of the most remarkable achievements in the history of development assistance.

Riverblindness has long been referred to as a "plague on the land" because of its devastating impact on human health and well-being and consequent displacement of people away from some of their best arable land. Twenty years ago, the sight of abandoned villages often meant that riverblindness had heavily infected people in the area, causing them to flee.

The disease is caused by a parasitic worm transmitted from person to person by the Savannah black fly, which breeds in fast-flowing rivers. When the worm reaches adulthood in the human body, it produces millions of infant offspring. These microscopic worms migrate through the skin, causing unbearable itching, debilitation, and, eventually, blindness.

In the early 1970s, nearly 15 percent of the people in a West African subregion covering major portions of 11 countries were infected. Today, prevalence rates throughout this area, nearly three times the size of France, are less than 1 percent, and new cases are virtually nonexistent.

Riverblindness (onchocerciasis) is at bay throughout this subregion largely because of the long-term collaboration of a wide range of development partners participating in the Onchocerciasis Control Program. The program began in seven countries—Benin, Burkina Faso, Côte d'Ivoire, Ghana, Mali, Niger, and Togo—in 1974. During 1986–88, it was extended into the southern parts of Benin, Côte d'Ivoire, Ghana, and Togo and into Guinea, Guinea-Bissau, Senegal, Sierra Leone, and western Mali.

When launched in 1974, the program was the first major health project to be supported by the World Bank. It is an independent international program cosponsored by the World Bank, the World Health Organization, the United Nations Development Program, and the Food and Agriculture Organization, with funding from more than 20 bilateral and multilateral donors.

To break the transmission cycle, the program's principal tool—vector control—has been aerial spraying of black fly breeding sites over as many as 50,000 kilometers of rivers. To orchestrate these complex, highly tech-

nical control operations, a reliable communication system had to be established and maintained throughout the 11-country area. Only environmentally safe insecticides—continuously screened and monitored by an independent ecological committee—have been permitted.

Once the cycle of transmission has been broken for 12 consecutive years, the adult worms die out in the human population, removing the source of the disease. The program has now succeeded in eliminating the reservoir of parasites in the human population throughout more than 60 percent of the 11-country area.

The program has vastly improved health for the West Africans and brought significant socioeconomic benefits:

Safeguarding health. The program protects more than 30 million people from contracting the disease. About 1.5 million people who were once seriously affected, but had not yet become blind, have completely recovered and have no trace of the disease. The program has prevented 250,000 cases of blindness and is projected to prevent 600,000 cases by its conclusion in 2002.

Agricultural benefits. Twenty-five million hectares of arable land are estimated to be freed from the disease and made available for resettlement and cultivation—enough to feed 17 million additional people a year.

Labor-related benefits. One and a half million years of additional productive labor have been made available, with 5 million years of additional productive labor forecast by 2002.

Economic rate of return. The program's rate of return is estimated at 20 percent, highly respectable for Bank investment projects in any sector or region.

Safeguarding the environment. Well ahead of its time, the program was designed to closely monitor the environmental impact of its operations. Since the mid-1970s, an independent group of internationally recognized ecologists has ensured that environmental issues remain at the forefront of the program's developmental concerns. Built-in control measures safeguard the environment, and ongoing work of the sponsoring agencies includes supporting the participating countries in their policies of environmentally sustainable settlement and development in onchocerciasis-freed areas.

Capacity building in Africa. With Africans making up 98 percent of the staff of 780, the program has fostered the skills of African managers of the highest caliber and integrity. The sustained commitment of donors has gradually built a viable regional institution that is largely managed by African staff. In addition, a major effort is now under way, within the context of the program, to build local capacity in each of the participating countries to ensure that there is no recurrence of the disease. Building this local capacity has the important byproduct of strengthening primary health care systems in local communities.

The benefits flowing from the program are thus considerable, yet its annual cost averages out to less than $1 per person protected.

The program's success in controlling riverblindness in West Africa has given the international community the confidence to tackle riverblindness in 16 other African countries where the disease remains endemic

(Angola, Burundi, Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Ethiopia, Gabon, Liberia, Malawi, Nigeria, Sudan, Tanzania, Uganda, and Zaire). Addressing areas in Africa still seriously infected by the disease is made easier by the knowledge base, expertise, and effective control tools developed over the years and by the availability of a new drug, ivermectin, free of charge. A coalition of skilled technical experts, international organizations (including the World Bank, WHO, UNDP, and FAO), and nongovernmental development organizations is preparing the groundwork for a new program to control onchocerciasis in these countries that is expected to start in 1995–96.

17. New—and Sensible—Ways of Doing Business in Africa

The association of Donors to African Education is redefining how donor agencies and African ministries of education relate to one another. Set up to foster collaboration and exchanges of information by donors, it is reinforcing the capacity of African ministries to take the lead in their dealings with donor agencies. It is also helping donors to adapt their practices to support nationally driven education projects.

The Bank and other donor agencies created the Donors to African Education (DAE) to continue the policy dialogue the Bank initiated in 1987–88 in preparing its policy study on education in Sub-Saharan Africa. A framework for better donor collaboration, the new association—for whose management the Bank's Africa Region Technical Department initially—took responsibility quickly grew to some 50 development agencies, including most of the major multilateral and bilateral organizations and many private development organizations supporting African education. But it became clear that without the involvement of African ministers of education, the effectiveness of this collaboration would be limited. To accommodate this thinking, the DAE was expanded to involve both donors and African ministers of education (which an imminent name change, to be approved at the next meeting of the DAE task force in October 1995, will reflect).

The partnership among donor agencies and African ministries is changing attitudes and behavior. How the DAE fosters this process is best reflected in its objectives: strengthening policy dialogue among agencies and between agencies and governments, building institutional capacity in Africa, fostering technical skill development, and developing networks for the exchange of information, particularly networks of South-South cooperation to share successful strategies and innovations.

The DAE task force meeting, held every two years, brings together ministers of education and senior officers from the development community in a relaxed and informal manner that fosters a frank and open dialogue. Although many international meetings are "talking shops," the DAE has been a forum for genuine international exchange. At the task force meet-

ings, donors are exposed to the problems of education development from the perspective of African governments. For ministers, the meetings provide opportunities to learn from colleagues across Africa and take the best ideas home with them.

At the October 1993 task force meeting, ministers heard from African countries that had developed national education plans. They also learned of the success that this had brought these countries in improving their education systems and mobilizing international support. In response, they asked DAE members for advice on how to formulate national sector policies of their own. Requests to clarify the process of policy formation have been so strong that this will be the main theme of the next task force meeting later in 1995. Six African authors are preparing background papers for the meeting that examine how their countries have managed the process of policy formulation.

Perhaps the most innovative and powerful tools for strengthening the policy dialogue are the Caucus and the Bureau of African Ministers of Education. The DAE supports and facilitates regular meetings of these two groups—the Caucus, consisting of all African ministers of education, and the Bureau, comprising seven ministers elected by their peers to serve as the decisionmaking body for the Caucus. Both the Caucus and the Bureau have been instrumental in moving the DAE away from being just a "donors' club."

In building capacity and developing networks for information sharing, central responsibility rests with the nine thematic working groups: female participation in education (coordinated by the Rockefeller Foundation as "lead agency"), the teaching profession (Commonwealth Secretariat), higher education (World Bank), finance and education (Canadian International Development Agency), education statistics (Swedish International Development Authority), textbooks and school libraries (Overseas Development Administration, United Kingdom), education sector analysis (UNESCO), education research capacity building (International Development Research Center), and vocational education and training (International Labor Office).

Some working groups have redefined the policy debates in entire areas, as the higher education working group has done with regard to the future of African universities. Others have brought an awareness of critical issues to the forefront of ministers' thinking, as the female participation group has done on the importance of educating girls and women.

For African skill development and capacity building, the DAE operates a new program of South-South exchanges allowing African education professionals from one country to visit peers in another who have come up with creative responses to a specific concern. This program, not limited simply to study visits, has been extended through the production and distribution of a series of commissioned papers on successful experiences in African education. National teams are working on the development and implementation of a master plan (Mauritius), staff redeployment

(Guinea), and the coordination of donors (Ghana and Namibia). These papers will be disseminated widely throughout Africa and in the donor community to allow further exchanges.

An additional tool of the DAE is baseline information on the status of education in Africa. The DAE has updated the set of statistics on African education produced by the World Bank in its 1988 study, producing a statistical profile of African education in the 1980s, publishing it in booklet form and, in conjunction with USAID, converting it into a user-friendly computer package to be available later in 1995. The DAE has also assembled an inventory of all the major externally funded education projects in Africa, to help donors know what other donors are doing and allow ministers to see what is happening across the continent.