Case Study of World Bank Activities in the Health Sector in India

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Sector and Thematic Evaluations Group
Operations Evaluation Department
Abbreviations and Acronyms

ANM  Auxiliary nurse midwife
CSSM  Child Survival and Safe Motherhood project
DALY  Disability-adjusted life years
GDP  Gross domestic product
GOI  Government of India
HNP  Health, nutrition, and population
ICDS  Integrated Child Development Services project
ICR  Implementation Completion Report
IDA  International Development Association
IEC  Information, education, and communication
IPP  India Population Project
MCH  Maternal and child health
MOHFW  Ministry of Health and Family Welfare
NGO  Nongovernmental organization
NIPCCD  National Institute of Public Cooperation and Child Development
OED  Operations Evaluation Department
PHC  Primary health center
PCR  Project Completion Report
RCH  Reproductive and Child Health project
SAR  Staff Appraisal Report
TINP  Tamil Nadu Integrated Nutrition Project

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Preface

Over the past two decades, the World Bank has emerged as the world’s largest lender in the health, nutrition, and population (HNP) sector. In addition, the Bank plays a major role in providing advice on national health policies. This Country Sector Impact Study is one of four undertaken by the World Bank’s Operations Evaluation Department (OED) as part of a comprehensive assessment of the Bank’s development effectiveness in the HNP sector. The other study countries are Mali, Zimbabwe, and Brazil. India was selected for study because of the country’s size and because it has the Bank’s largest HNP program.

This study is based on a review of the literature, including government and World Bank sector and project documents; interviews with World Bank staff, government officials, health workers, and clients; and the papers and proceedings of “The World Bank’s Role in the Health System of India,” a workshop held in New Delhi. The papers presented at the April 1998 workshop were commissioned by OED for this study. A list of the papers appears in the Appendix to this report. Both World Bank staff and officials of the Indian Ministry of Health and Family Welfare reviewed drafts of the study. This report incorporates their comments.

Ronald Ridker was the task manager for this study; he and Philip Musgrove are the authors of this report. Susan Stout directed the overall OED assessment, William Hurlbut edited the report, and Benjamin Crow and Marcia Bailey assisted with administration and document formatting. The authors are very grateful for the assistance of the Bank’s New Delhi Resident Mission, particularly Anthony Measham who provided excellent advice and suggestions at all stages of this effort and Sandra D’Souza for so effectively handling the logistics for the workshop, and the India HNP Sector Unit, especially Richard Skolnik, Tawhid Nawas, and Indra Pathmanathan, plus colleagues in OED and the Bank’s Human Development Network, for the time and effort they spent answering our questions and critiquing our drafts.
Summary

1. Fertility, mortality, and morbidity have slowly and steadily declined in India since independence but remain unacceptably high. While the root causes are poverty and low levels of education, the public health programs bear some of the responsibility. These programs have faced a series of well-recognized problems, the most serious of which are inadequate access by the most vulnerable groups, poor quality of primary and secondary facilities, which has resulted in their under-utilization, and until recently, excessive focus on sterilization and inadequate focus on maternal and child health.

2. Since 1972, the Bank has assisted the government in its attempt to correct these problems through 23 projects to which the Bank contributed over $2.6 billion, plus studies (sector work) and policy dialogue. This study evaluates this program by first reviewing the projects and sector work that the Bank funded and then by taking up a number of special issues in more depth.

Evolution of Programs and Projects

3. From 1972 to 1988, the Bank funded five population projects that primarily consisted of helping the government carry out its Family Welfare Program, a family planning-cum-maternity and child care (MCH) program. The Bank had little influence on the direction of these programs, among other reasons because the government only wanted assistance expanding its existing program and the Bank had little leverage because its inputs were small and it did little to develop viable alternatives prior to 1988. The overall goal of these projects was to accelerate the extension of the service delivery network for the Family Welfare Program in specific districts. With a couple of exceptions, however, the projects did not make significant differential improvements in project districts compared to non-project districts, among other reasons because inputs other than infrastructure were largely neglected, no attempt was made to apply different delivery models in project districts, and project districts continued to operate under the same personnel and recurrent budget constraints as non-project districts.

4. After the reorganization of the Bank in 1987, a new operational team took over and rapidly expanded sector work. These studies have generally taken up the proper subjects and are an excellent source of information and diagnosis of problems. The most recent sector work is generally better than earlier work at analyzing the underlying (sociological, political, institutional) forces that explain why things work the way they do. One reason for this is that task managers made a point of involving the government in selecting and designing the studies and local consultants in their execution. This change in style is at least as important as content and soundness of analysis in explaining their greater influence.

5. In January 1987, India and the Bank agreed to a five-point sector strategy: (i) increased emphasis on outreach; (ii) increased emphasis on temporary methods versus sterilization; (iii) increased attention to MCH; (iv) fewer project resources for expansion of the system and more for enhancing quality of service delivery, training, and IEC; and (v) priority to improving these services in urban slums and backward, high fertility states not covered by previous projects. It has taken some time for these principles to be reflected in projects, but all of them have now been fully incorporated.
6. The Bank has supported two, quite different, nutrition programs. The first, the Tamil Nadu Integrated Nutrition Project, designed largely by Bank staff and consultants, was an innovative program that focused on changing the way mothers feed themselves and their preschool children, rather than on feeding \textit{per se}. This program has been well implemented and quite successful in reducing severe malnutrition.

7. The second program, Integrated Child Development Services (ICDS), initiated before TINP, has become the government's predominant program for preschool children. It is meant to be holistic, offering non-formal preschool education, supplemental nutrition, immunization, and health checkups for children age 0–6, and nutrition and health education for pregnant and nursing mothers. Recent assessments suggest that the program is having only modest positive effects.

8. The GOI has shown no interest in continuing the TINP model, despite its relative success. Rather than pressing for this, the Bank decided to support ICDS and try to influence it to incorporate the more attractive elements of TINP. The Bank has provided support for ICDS through three free-standing projects and components in at least two others. Outcomes to date have been disappointing. The TINP experience seems to have been lost on India, and with it, a clear emphasis on malnutrition as a leading risk for ill health, although it has affected the design of some nutrition projects in other parts of the world.

9. The first free-standing health project was funded in 1992. Today, this portfolio consists of two types of projects: five specific disease control projects and four state systems projects with several more in the planning stage. These projects bring to bear Bank experience elsewhere, introduce new treatment protocols, and attempt to involve the private sector and nongovernmental agencies. They have resulted in a significantly more rapid decline in prevalence of leprosy and cataract blindness than would otherwise have occurred, an increase in the pace of detection and treatment of tuberculosis, substantial improvement in the safety of blood transfusions, and modest improvements in protective behavior among some high-risk groups, but, so far at least, no visible impact in slowing the AIDS epidemic and no progress in bringing malaria under control.

10. The state systems projects provide the Bank with an opportunity to influence more fundamental determinants of how the public health system works, to do so at the level of the states, which are responsible for health care, and where the Bank can have more leverage than is possible at the national level, and to provide assistance tailored to the vastly different circumstances in different states. The first of these projects focused on improving secondary hospitals in one state. This improvement is a necessary, though not sufficient, step toward establishing an adequate referral system between primary and secondary institutions. The other projects are extending the principles of the first but in some cases adding more work at the primary level.

11. Much of the above can be summarized by comparing projects, sector work and style of operations before and after about 1988. Before this time there were no free-standing health projects, population projects were usually supply-oriented, the Bank’s stance was to support the government program without seriously pressing for the policy changes it believed to be necessary, and there was almost no sector work. Since 1988, sector work has flourished and raised policy issues that are being taken seriously, health projects have been added to the portfolio, serious efforts have been made to shift the balance within the FW program from family planning to MCH, contraceptive targeting was dropped, and health and state system reform projects have proliferated. This sea-change resulted from a number of factors: evidence that old approaches were not working, the
emergence of some new, cost-effective treatments for some diseases, the emergence of new diseases, pressures to pay more attention to what women actually want, changes in personnel in both the ministry and the Bank, and perhaps most important, the deterioration in economic conditions in 1990/91 which increased the government’s interest in acquiring foreign assistance and led to an agreement that assistance obtained by the MOHFP would be considered additional to its plan budget, thus giving the ministry a strong incentive to acquire such assistance.

Selected Topics

12. In addition to the historic approach, this study considered several special topics and issues, two concerned with components included in nearly all HNP projects (training and IEC), three concerned with policy initiatives the Bank has been advocating for some time (dropping sterilization targets, decentralization, and involvement of NGOs and the private sector) and two involving efforts to assess the extent and determinants of overall progress. While the historic approach indicates that recent programs and projects are much better designed and executed than earlier efforts, this second view of the situation suggests that many serious problems remain.

13. The empirical studies suggest that the quality of primary services provided by the government did not improve significantly between 1987 and 1996, that income, education, and the overall quality of state administration are more important than specific public health interventions in explaining differences in demographic and health indicators during the period 1981–91. The Bank’s main contribution has been to expand capacity. Its efforts to improve quality have not accomplished much and it has devoted inadequate attention to content, monitoring and evaluation, and feedback of results. Another study shows that shortly after the immediate drop in contraceptive rates brought about by a change in policy, rates were beginning to recover and staff were beginning to emphasize temporary methods and MCH. But clients perceived little change in behavior of health personnel. The study of Bank efforts to involve NGOs and the private sector concludes that progress in this direction has been very slow. The study of decentralization concludes that little authority over budget and personnel has yet been given to local agencies. It also questions the wisdom of doing so, in contrast to devolution to state and district level.

14. The studies are more cautious in their conclusions than is possible in this brief summary and all need to be qualified in important ways. Most important, given the improvements in programs and projects in recent years, repeating these studies five years from now would probably yield more positive results. But it is sobering, nonetheless, to observe how little progress has been made despite the considerable efforts extended during the first two decades of the Bank’s involvement. And the studies caution against excess optimism about how much these new initiatives can accomplish in a country as large and complex as India.

Conclusions and Policy Implications

15. The Bank is now on the right track, but it took an inordinately long time to get there. Reasons for this include resistance on the part of the government prior to the early 1990s and the Bank’s rather cautious approach to India, which for a long time manifested itself in continuing to support expansion of programs it knew to be seriously flawed, willingness to continue funding even when project goals were not achieved or agreements not met, and failure to insist on

1. The discussion of these issues is based on commissioned papers and their review in a special workshop that took place in April, 1998. These papers are listed in the appendix and available on request from OED.
adequate monitoring and evaluation to come to hard judgments about performance. This reluctance to enforce reasonable performance standards may be related to the reluctance, or inability, of the MOHFW to do so vis-à-vis the states, which have responsibility for implementation of most projects. Recent instances where the Bank or the MOHFW has taken a firm stand and obtained real improvements are encouraging and, one hopes, will stiffen the backbone of both organizations. The performance-based allocation mechanism built into the RCH project is also encouraging.

16. The report concludes by focusing on the following policy implications.

- Project outcomes are more dependent on personalities and style of operations than anticipated. Large bureaucracies like the Bank and the MOHFW are reluctant to admit this, hoping no doubt that work plans, rules, and regulation will insulate programs from the exigencies of personnel assignments and different operating styles. But in incident after incident it is difficult to explain outcomes without taking these factors into account. In designing projects, more conscious attention should be devoted to these issues.
- Closely related is the neglect of personnel issues in project implementation, by the Bank and perhaps also by the MOHFW. These issues include policies and practices regarding compensation, assignment and transfer, promotion and demotion, work rules and supervision, all of which determine the incentives that govern how individuals do their job. Provision of plant, equipment, supplies and even training will not accomplish much if these incentives are incorrect.
- Sector work and project design need to take more account of field conditions, not just to make sure that project designs are realistic but to find solutions to implementation problems. A case in point is the need to understand the incentives that determine performance of workers in direct contact with clients. The related tendency to add new initiatives before older ones are adequately implemented needs to be resisted. Thus, for example, we need to ensure that family planning is not neglected in the wake of the reproductive health initiative and that basic, simple, services for the poor are not neglected in the wake of the attention being paid to secondary hospitals.
- There needs to be more focus on determinants of health status that are outside the traditional confines of the formal medical care system. Transport, communications, environmental pollution, and health education are examples. Civil service rules and regulation as they affect health workers is another.
- The establishment of an effective referral system requires more than upgrading skills and facilities at both ends of the chain; it also requires good transport and communications and the willingness on the part of the referral hospital to make the system work. The latter cannot be done without supervising some aspects of lower level operations and that may require some institutional changes. It probably also requires that qualified staff at the referral hospital be assigned this function on a full-time basis.
- Mobilizing the private (profit and non-profit) sector to serve public health goals raises issues about using public money to buy private services, which implies the need for contracting, accreditation, regulation, referral, and appropriate division of labor between the public and private sectors—all complex issues that other countries are wrestling with as well. The Bank can help by encouraging experimentation with different approaches in the projects it funds and by bringing to bear information on how these issues are resolved in other countries.
- The recent initiatives to introduce performance-based budgeting into projects needs to be extended and intensified. In principle, it could help the government resolve one of its most perplexing problems, how to make the system more accountable.
1. Introduction and Background

1.1 This study, one of four undertaken by the World Bank’s Operations Evaluation Department (OED) as part of a comprehensive assessment of the Bank’s development effectiveness in the health sector, evaluates the Bank’s assistance to the Government of India in health, nutrition, and population (HNP). More precisely, it attempts to determine the relevance, effectiveness, and efficacy of the Bank’s three contributions: the projects it supported, the sector work it sponsored, and the policy dialogue it conducted. In doing so, it follows the framework for these studies laid out in *Evaluating Health Projects: Lessons from the Literature* (Stout et al. 1997).

1.2 An eclectic method was employed to develop the relevant evidence. It comprised a review of the literature, including official documents of the Government of India (GOI) and the Bank; interviews with government and Bank officials, health workers, health service clients, and researchers; and commissioned studies. This multidimensional approach has resulted in a richer array of evidence, and more confidence in the results, than would have been possible with a simpler study design. Even so, the results do not provide a pure picture of the Bank’s independent contribution as it was only one among many actors—and often not the most important one—attempting to influence events in the health field. Thus, in the end, this review is as much an assessment of the Indian program as it is an assessment of the Bank’s contribution to that program.

1.3 The core of this report is contained in Chapters 2 and 3. Chapter 2 focuses on the general nature of GOI and Bank programs and inputs, how they have changed over time, and what is known about the impact of individual projects. The discussion is organized chronologically and by type of project and study undertaken and draws primarily on Bank documents. Chapter 3 focuses on some issues that have arisen in more than one project. This discussion draws primarily on a series of papers commissioned by OED from Indian researchers and discussed at an April 1998 workshop in New Delhi. The topics treated include the quality of Family Welfare services and its dropping of targets for sterilization; training and IEC components; relation of Bank projects to NGOs and the private sector; and decentralization. The final chapter presents conclusion and implications derived from these two complementary views of the situation. The remainder of this introductory chapter sketches the background and summarizes the progress that has been made since 1970, about the time when the Bank first became involved with India’s HNP program.

1.4 Many other themes or issues might have been taken up, particularly those concerning differential effects among population groups: women versus men, the poor versus the non-poor, scheduled castes and tribes versus the rest of the population. We have not explored these topics in detail, partly because the portfolio addresses them systematically in design and partly because of lack of differential information on outcomes. Several of the issues we do treat, however, illuminate the degree to which the intention of helping the poor has been realized. Where women are concerned, the issue is more complex: the Indian program and the Bank projects that have supported it are heavily concentrated on women, but almost exclusively on their role as mothers. This emphasis does not necessarily do anything to give women favored treatment for non-reproductive health. Some other questions, such as the overall balance of the portfolio and its effectiveness, are taken up later: Chapter 3 includes a statistical analysis of effects over the decade 1981–91 (comparable data are not available for earlier or later periods), and Chapter 4 briefly discusses whether the Bank has given the right relative emphases to population, nutrition, and health.
Health Status in India: Improving but Still Poor

1.5 India's demographic and health profile is typical of low-income countries where much of the population has little formal education, subsists on foods of low nutritional value, and lives in polluted, unsanitary environments with minimal protection from the elements. The crude death rate is low—because of the young age structure of the population—and has been declining. But the age-specific mortality rates remain high. The leading causes of death before the age of 45 are respiratory infections, diarrheal diseases, perinatal causes, preventable childhood diseases (especially measles and tetanus), maternal complications, and road accidents. After age 45, cardiovascular diseases and malignancies become more important. Tuberculosis, one of the most important killers, is concentrated in middle age. Birth rates are also declining from relatively high levels but not rapidly enough to slow the population growth rate significantly given the declining death rates. Figure 1.1 shows the effect on the population growth rate of the declines in birth and death rates. For India as a whole, the growth rate has declined substantially from 2.20% per year in 1971 to 1.85% per year in 1996. This still leaves the overall growth rate too high for such a poor, densely populated country. The figure also indicates considerable variance among the 15 major states identified. On one side are Kerala and Tamil Nadu where the demographic transition from high to low birth, death, and population growth rates has nearly been completed. On the other side are the northern states of Uttar Pradesh, Madhya Pradesh, Rajasthan, Bihar, Orissa, Assam, and Jammu and Kashmir where birth, death, and growth rates remain unacceptably high by both Indian standards and by comparison to countries at comparable income levels: a comparison with six other countries is shown in Figure 1.2. India's experience is very similar to that of Bangladesh and Indonesia. For most of the period studied, the three countries simply followed the same path, with an interval of about five or six years between one country and another for the same combination of birth and death rates. India has not done as well as China, which used coercive measures to reduce the birth rate, and Sri Lanka, which has social and economic conditions similar to those of Kerala and Tamil Nadu. But it has done better than the Philippines and Pakistan.

1.6 Data on disease burden that allows India to be compared to other parts of the world are available for 1990. They show that India has somewhat higher mortality and disability burdens than other regions (Table 1.1). High infant mortality and prevalence of childhood malnutrition in India account for the large share of total health loss that falls on children under the age of five; only the Middle East, including Pakistan, looks worse by this measure.

Table 1.1. Burden of disease: disability-adjusted life years (DALYs) per thousand population lost to mortality and disability, India, China, and two regions, 1990

<table>
<thead>
<tr>
<th>Country or Region</th>
<th>DALYs per 1,000 Population lost to</th>
<th>Percent of Total Lost at Ages 0–4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mortality</td>
<td>Disability</td>
</tr>
<tr>
<td>India</td>
<td>235</td>
<td>103</td>
</tr>
<tr>
<td>China</td>
<td>104</td>
<td>80</td>
</tr>
<tr>
<td>Other Asia &amp; Islands</td>
<td>188</td>
<td>92</td>
</tr>
<tr>
<td>Middle Eastern Crescent</td>
<td>209</td>
<td>91</td>
</tr>
</tbody>
</table>

Source: Murray and López 1996, Appendix tables "c, d, e, and h; 8c, d, e, and h; and 8c, d, e, and h."
Figure 1.1. Crude birth and death rates, per thousand, and crude population growth rates, percent annual, 1970–96, India and 15 principal states

The number, which identifies a state, marks the level of crude birth and death rates in 1971. The lines show the changes in those variables to 1981 and then to 1991 and 1996. For Rajasthan (4) and West Bengal (8) only the changes 1981–96 are shown; rates are not available for 1971. The rates for all India are indicated by the darkest line in the center of the chart.


Source: ASCI 1998
What is most striking about India is its diversity and size. Variation in birth, death, and growth rates is clearly shown in Figure 1.1, but it is true of other dimensions as well. India is a subcontinent divided into 25 states that differ from each other in language, religion, level of development, administrative efficiency, and quality of governance, as well as demographic and health characteristics, by more than the nations of Latin America or Africa, each of which has only a fraction of India’s population.

**Approach to Improving Health Status: Expanding Coverage**

These two features, size and diversity, combined with low income and a weak education base, has made coping with the country’s health situation extremely difficult. At independence, the government inherited a rudimentary health system largely designed to protect the colonial population from the worst vicissitudes of the climate. The government promised free basic health care for all and, in the 1950s, began developing a network of primary health centers (PHCs) to deliver a basic package of family planning and maternal and child health services, and initiated a series of vertical disease control programs. Subcenters were added to this network in the 1960s, and community health centers (first-level hospitals) were added in the mid-1980s. Table 1.2 shows the pace at which these centers were established. It also shows what fraction of the population could have been served, if each center covered the number of people corresponding to the norms established by the Ministry of Health and Family Welfare (MOHFW). The number of
subcenters and PHCs has increased rapidly. They now cover about 70% of the population, assuming they are located where they are accessible to the target clientele. The number of community health centers has increased more slowly; by the mid-1990s there were only enough to reach about a fourth of the population, or for each one to serve an average of 250,000 to 275,000 people, about three times as many as intended.

Table 1.2. Number of primary health centers, subcenters, and community health centers and potential population coverage, 1969–95

<table>
<thead>
<tr>
<th>Plan Period and Year</th>
<th>Primary Health Centers</th>
<th>Subcenters</th>
<th>Community Health Centers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Coverage (%)</td>
<td>Number</td>
</tr>
<tr>
<td>Inter-Plan Period, 1969</td>
<td>4,919</td>
<td>22,826</td>
<td>22,826</td>
</tr>
<tr>
<td>4th, 1974</td>
<td>5,283</td>
<td>17–26</td>
<td>33,509</td>
</tr>
<tr>
<td>5th, 1979</td>
<td>5,484</td>
<td>47,112</td>
<td>84,590</td>
</tr>
<tr>
<td>6th, 1985</td>
<td>7,284</td>
<td>19–29</td>
<td>84,590</td>
</tr>
<tr>
<td>7th, 1990</td>
<td>18,981</td>
<td>48–72</td>
<td>131,900</td>
</tr>
<tr>
<td>8th, 1995</td>
<td>22,156</td>
<td>48–72</td>
<td>131,900</td>
</tr>
<tr>
<td>Population to be Served (Norm)</td>
<td>20–30,000</td>
<td>3–5,000</td>
<td>80–120,000</td>
</tr>
</tbody>
</table>

Source: ASCI 1998, tables 1 and 4

1.9 In 1990, India spent 6.0% of its GDP on health, about US$21 per capita. This is high compared to countries with comparable incomes. However, a relatively small fraction of this expenditure—1.2% of GDP, or about US$4.20—is spent by the public sector. This is about half the public health expenditures made by comparable countries and one-third of the estimated cost of an essential package of health services (Bobadilla et al. 1994, Table 2). Most of these public expenditures are made by the states, not by the central government. Foreign assistance accounts for about 8% of public expenditures. This too is low compared to other large Asian countries (except China), where aid is typically 15% or more of public spending.

1.10 This picture applies to India and its various states as whole units: the data required to determine the health status of the poor and how it has changed over time are not available. It is likely, however, that improvements have been much slower for this group than the averages indicate. First, while real per capita income has at least doubled since 1970, reducing the percentage of the population living below the poverty line, the growth of population, plus shifts in the distribution of income, have doubled the absolute numbers of poor people. Second, much of the increase in health care expenditures over the period has gone into tertiary care units, largely unavailable to the poor. Third, it is very likely that the bulk of the people living in areas not covered by public health facilities are in this impoverished group. Together, these points suggest that progress for the poor has been disappointingy slow. This needs to be kept in mind when assessing the efforts that have been made to alleviate the situation, which we begin to do in Chapter 2.

2. Evolution of Programs and Projects

2.1 The evolution of Bank-financed projects and sector work in population, health, and nutrition in India can be usefully viewed as an attempt to cope more effectively with the weaknesses and limitations of India’s programs. There is consensus among analysts that the
following factors have seriously limited the effectiveness of these programs, especially the population and MCH efforts, during the past several decades:

- Inadequate access to public facilities by the most vulnerable groups, poor women and children
- Inadequate funding, especially for programs used mainly by the poor, and within these programs, especially for non-salary operating costs
- Poor quality of care (a result of shortages of supplies, too few female staff, absenteeism and improper behavior of staff, unrealistically large workloads, and low morale) largely as a consequence, under-use of existing facilities
- Weak management, which tends to apply a uniform, inflexible approach throughout the country despite major inter-district disparities in fertility, health, cultural, and institutional characteristics, and which provides inadequate support, supervision, and training to frontline workers
- Inadequate mobilization of private and nongovernmental organization (NGO) resources
- Excessive focus on sterilization and use of financial incentives and other pressures to achieve targets, and inadequate counseling and poor service for birth spacing needs
- Inadequate focus on maternal and child health (MCH), including inadequate procedures for detecting pregnancy complications and for referring cases to higher levels, and inadequate, inaccessible, and insensitive services at facilities capable of treating such complications.

2.2 These are the persistent problems that Bank-funded projects, sector work, and policy dialogue have attempted to help solve. Since 1972, the Bank has provided US$2.6 billion for 23 projects in population, health, and nutrition (Table 2.1). The review of these efforts that follows suggests that from rather simple beginnings, they have addressed these problems in increasingly complex, sophisticated ways. But the problems persist, and partly for analytical reasons and partly because the more promising projects are ongoing, there are few signs that most of these projects are having a significant impact.


2.3 During this period, the Bank funded five population projects. For the most part these projects consisted of helping the government carry out its preconceived family planning-cum-maternity and child care (MCH) program, since 1976 known as the Family Welfare Program. For a variety of reasons, the Bank had little influence on the direction of this program.

- The government’s approach to the country’s population problem was firmly established long before the Bank became involved.
- The lending program, while large by Bank standards, was only 3.6% of total expenditures on the Family Welfare Program.

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2. See, for example, the Project Appraisal Document for the Reproductive and Child Health Project.

3. This analysis draws on Chapter 3 of an Operations Evaluation Department study, Population and the World Bank, Implications from Eight Case Studies, 1992.
<table>
<thead>
<tr>
<th>Approval-Completion</th>
<th>Ln./Cr. Number</th>
<th>Project Name</th>
<th>Project Status</th>
<th>Project Cost ($M)</th>
<th>Loan ($M)</th>
<th>OED Report</th>
<th>Rating</th>
<th>Sustainability</th>
</tr>
</thead>
<tbody>
<tr>
<td>1973-1980</td>
<td>Cr. 312</td>
<td>Population (Karnataka, Uttar Pradesh)</td>
<td>Completed</td>
<td>Na</td>
<td>21.2 Audit</td>
<td>Sat.</td>
<td>Na</td>
<td></td>
</tr>
<tr>
<td>1980-1989</td>
<td>Cr. 1003</td>
<td>Tamil Nadu Integrated Nutrition</td>
<td>Completed</td>
<td>Na</td>
<td>32.0 Impact</td>
<td>Sat.</td>
<td>Likely</td>
<td></td>
</tr>
<tr>
<td>1980-1988</td>
<td>Cr. 981</td>
<td>Second Population (IPP2) (Uttar Pradesh, Andhra Pradesh)</td>
<td>Completed</td>
<td>Na</td>
<td>46.0 Audit</td>
<td>Unsat.</td>
<td>Likely</td>
<td></td>
</tr>
<tr>
<td>1983-1982</td>
<td>Cr. 1426</td>
<td>IPP3 (Karnataka, Kerala)</td>
<td>Completed</td>
<td>Na</td>
<td>70.0 PCR</td>
<td>Sat.</td>
<td>Uncertain</td>
<td></td>
</tr>
<tr>
<td>1985-1994</td>
<td>Cr. 1623</td>
<td>IPP4 (West Bengal)</td>
<td>Completed</td>
<td>89.9</td>
<td>51.0 PCR</td>
<td>Sat.</td>
<td>Likely</td>
<td></td>
</tr>
<tr>
<td>1988-1996</td>
<td>Cr. 1931</td>
<td>IPP5 (Bombay, Madras)</td>
<td>Completed</td>
<td>77.2</td>
<td>57.0 ICR</td>
<td>Sat.</td>
<td>Likely</td>
<td></td>
</tr>
<tr>
<td>1992-1996</td>
<td>Cr. 2300</td>
<td>Child Survival and Safe Motherhood</td>
<td>Completed</td>
<td>214.5</td>
<td>214.5 ICR</td>
<td>Sat.</td>
<td>Likely</td>
<td></td>
</tr>
<tr>
<td>1989-1997</td>
<td>Ln. 3108/</td>
<td>IPP6 – Family Welfare Training and Systems</td>
<td>Completed</td>
<td>113.3</td>
<td>11.3 ICR</td>
<td>Sat.</td>
<td>Likely</td>
<td></td>
</tr>
<tr>
<td>1990-1998</td>
<td>Cr. 2057</td>
<td>Development (Uttar Pradesh, Andhra Pradesh, Madhya Pradesh)</td>
<td>Completed</td>
<td>139.1</td>
<td>95.8 ICR</td>
<td>Marginally Sat.</td>
<td>Likely</td>
<td></td>
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<tr>
<td>1990-1997</td>
<td>Ln. 3253/</td>
<td>Integrated Child Development Services (ICDS) (Orissa, Andhra Pradesh)</td>
<td>Completed</td>
<td>157.5</td>
<td>106.0 ICR</td>
<td>Unsat.</td>
<td>Likely</td>
<td></td>
</tr>
<tr>
<td>1990-1998</td>
<td>Ln. 3199/</td>
<td>IPP7 (Training)</td>
<td>Completed</td>
<td>156.7</td>
<td>96.7 ICR</td>
<td>Sat.</td>
<td>Likely</td>
<td></td>
</tr>
<tr>
<td>1992-1994</td>
<td>Cr. 2448</td>
<td>Social Safety Net Sector Adjustment Program</td>
<td>Completed</td>
<td>500.0</td>
<td>- ICR</td>
<td>Sat.</td>
<td>Likely</td>
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**Most Recent Supervision Rating**

<table>
<thead>
<tr>
<th>IP</th>
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Source: World Bank data

PCR = Project Completion Report; ICR = Implementation Completion Report; IP = Implementation progress; DO = development objective

While combined donor inputs were more significant—in the range of 12 to 14%—the government discouraged efforts at donor coordination and the Bank did little to resist this approach.

The overall goal of these projects was to accelerate the extension of the service delivery network for the Family Welfare Program in specific districts. With a couple of exceptions, the projects did not make significant differential improvements in project districts compared to non-project districts. Among the reasons for this were neglect of inputs other than infrastructure, absence of any attempt to apply different delivery models in project
districts, and project districts that continued to operate under the same personnel and recurrent budget constraints as non-project districts.

- The Bank assigned few people to work on the sector, had limited field presence, undertook no comprehensive sector work before 1988, and did little to develop alternative approaches to service delivery or to encourage the involvement of other sectors (such as education) that could have helped generate demand for smaller families. It was therefore ill prepared to make practical, constructive suggestions for system improvements or alternative approaches.

The government encouraged this low-key, passive approach and might have been very unhappy with a more active approach. But the Bank appears to have complied with what the government wanted during this period, even during the Emergency Period of 1975/76 when official promotion of sterilization reached a peak, without a struggle.4

Sector Work (1988–98): Improved Diagnosis

2.4 After the 1987 reorganization of the Bank, a new and somewhat larger team, with a renewed commitment to human resource development, took over operations in this sector. This led, among other things, to a rapid expansion of sector work. Box 1 lists the more visible results of these efforts. For the most part, these studies have taken up opportune and useful subjects and are an excellent source of information and diagnosis of problems (Dubey 1995). They could have been better, however. Their principal weakness is a tendency to make policy recommendations that are too general. For example, while the documents concerned with family planning make the case for dropping targets, they say little about what mechanisms should be used to hold staff accountable for performance. Similarly, others argue persuasively in favor of decentralization and involvement of the private sector, but say little about how these can be done while avoiding the pitfalls they may entail. Other weaknesses include a tendency to draw judgments about facts (for example, whether a certain degree of progress is large or small) without adequate comparisons to experiences elsewhere and an inadequate analysis of the underlying political, institutional, and sociological forces that explain why things work the way they do.

<table>
<thead>
<tr>
<th>Box 1. World Bank health sector studies, 1988–98</th>
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<tbody>
<tr>
<td>Strengthening the Role of Non-Governmental Organizations in the Health and Family Welfare Program in India (1990)</td>
</tr>
<tr>
<td>India: Health Sector Financing: Coping with Adjustment—Opportunities for Reform (1992)</td>
</tr>
<tr>
<td>Improving Women’s Health in India (1996)</td>
</tr>
<tr>
<td>India’s Family Welfare Program: Toward a Reproductive and Child Health Approach (1996)</td>
</tr>
<tr>
<td>India: New Directions in Health Sector Development at the State Level: An Operational Perspective (1997)</td>
</tr>
<tr>
<td>India: Wasting Away, the Crisis of Malnutrition in India (1998)</td>
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2.5 More recent sector work appears to have had more influence on policy than earlier work. Cases in point are the 1996 review of the Family Welfare Program that was the basis for the

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4. Senior Bank officials expressed their concern privately, but the Bank’s public position was business as usual.
Reproductive and Child Health project and the 1997 study, *New Directions in Health Sector Development*, which provided the intellectual underpinning for the state systems projects. One reason the later studies have been more influential is that they made a point of involving the government in the selection and design of studies and involving local consultants in their execution. In contrast, earlier studies tended to be designed and executed by Bank staff with limited consultation. This change in style is as least as important as content and soundness of analysis in explaining the greater influence of later sector work.


2.6 In January 1987, India and the Bank agreed on a sector strategy to guide future operations in the population field. That strategy included (a) more emphasis on outreach than on static, facility-based operations; (b) a shift in focus from sterilization to temporary contraceptive methods; (c) increased attention to MCH elements of the program; (d) fewer project resources for expansion of the system and more for enhancing quality of service delivery, training, and information, education, and communication (IEC); and (e) priority to improving these services in urban slums and backward, high-fertility states not covered by previous projects. The next four population projects were designed with these principles in mind. These projects also operated at the state level rather than the district level, where the Bank believed it had a greater chance to influence policies.

2.7 The Sixth and Seventh India Population Projects (IPP6, 1986–97, and IPP7, 1990–98), which focus on training, are the only ones from this period to be completed. Despite the new strategy, they appear to have had considerably more success in expanding delivery infrastructure and training systems than in improving their functioning. As in past projects, these projects constructed and upgraded numerous primary health centers and subcenters and trained numerous staff members, but the quality and performance of the training program remained weak, efforts to strengthen MCH and IEC were not very productive, and little progress was made in shifting the contraceptive mix and in giving more emphasis to MCH (the next chapter details the training and IEC issues). These shortcomings largely resulted from excessive optimism among Bank staff, and perhaps among staff of the Ministry of Health and Family Welfare (MOHFW), about what could be accomplished in states with weak administrations. On the Bank’s side this optimism might have been encouraged by the ability to work at the state level rather than at the district level. It may also have resulted from a failure to involve stakeholders in significant ways in the design of the project; had there been more effective stakeholder participation, the feasibility and risks associated with these projects might have been more accurately gauged.

2.8 IPP8 (1992–01) is supporting the government’s Urban Revamping Scheme in the slums of four major cities and is focused on improving outreach, training, IEC, and management. It is also attempting, with varying degrees of success, to involve stakeholders and NGOs. IPP9 (1994–01), besides helping construct public health centers and subcenters, is upgrading community health centers to serve as first referral units for obstetric emergencies. This is the first project to recognize the importance of referral for a properly functioning health system. The goals and design of these projects are appropriate and relevant, but they are too new and disbursing too slowly to judge their effectiveness or impact.

2.9 Lack of significant progress in shifting the balance within the Family Welfare Program toward MCH, and within MCH toward safe motherhood, resulted in large part from a system of contraceptive targeting and incentives that emphasized the importance of family planning and
sterilization. Child Survival and Safe Motherhood (CSSM, 1992–97) was the first project to make this policy shift its central goal. It was also the first to operate on a national scale. A second goal was to assist the sector during a time of financial stringency by disbursing quickly. This was accomplished by providing sizable funding for drugs and other recurrent supplies and by shortening the duration of the project from the typical five years to three and a half years. The third goal, strengthening the delivery system, involved components similar to previous projects. While additional support to existing programs brought considerable progress in protecting children and women against specific problems like measles, tetanus, and anemia, new interventions and efforts to shift the focus of the programs in the new directions outlined above fared poorly. Reasons for this include the complexity and size of the project, which overtaxed the managerial capacity of the MOHFW; the weak financial position of a number of state governments during this period, which resulted in long delays in release of funds; an unforeseen shortage of anesthetists for the first referral units; and a top-down managerial style that worked well for more traditional immunization programs but not for the newer interventions, which depend on clients taking the initiative to request services. Since many of these problems could have been anticipated, the fundamental problem was a weakly designed project, a factor that may have resulted from efforts to push this project through quickly and make it quick-disbursing.

2.10 The most recent project to get under way is the Reproductive and Child Health project (RCH, 1997–03). This project can be viewed as an attempt to get the initiatives of the CSSM properly and fully implemented, increasing the emphasis on women and on the poor. It does this by deviating from CSSM and earlier population projects in a variety of useful ways. Its design is more clearly based on related sector work and consultations with stakeholders and NGOs. It suggests practical ways that the new initiatives, such as the dropping of sterilization targets, will be implemented. It allows for different implementation models in different situations. It introduces some elements of performance-based budgeting. And it builds monitoring and client feedback into the heart of the project. In these respects, the project is an advance over previous ones. These and other initiatives introduced by this project speak to nearly all the problems of the Family Welfare Program identified in earlier projects and studies.

2.11 While very promising, it is still too soon to know how much difference these initiatives will make. As noted in the supervision report covering the first year of operations, while substantial progress was made with several difficult elements—most notably decentralized planning based on local needs assessments—there have been serious problems with drug procurement and training coordination at the national level and with program implementation at the district and sub-district level, with the consequence that disbursement has been very slow. The MOHFW and the Bank are threatening to restructure the national components and to reprogram funds at the state level if these problems are not quickly resolved.

Nutrition Projects: Nutritional Status versus Child Development

2.12 The Bank has supported two quite different nutrition programs. The first, the Tamil Nadu Integrated Nutrition Project (TINP), was an innovative program that focused on changing the way mothers feed themselves and their infant and preschool children, rather than on feeding per se. The basic tools for this were a record of weight gain or loss recorded on a child’s health card kept by the mother and supplemental feeding when called for by the health card. Other components included nutrition education, primary health care, and medical interventions when feeding proved inadequate. Considerable care was taken in designing work routines and in training and supervising staff. This program has been supported by two Bank-financed projects.
Evaluation studies, particularly of TINP1,5 have concluded that the program was implemented well and that it was quite successful in reducing severe malnutrition, but less successful in reducing moderate malnutrition. This difference may suggest that improvements in feeding practices can go only so far, that further improvement requires reductions in poverty as well.

2.13 The second program, which the Bank started supporting in 1990, is the Integrated Child Development Services (ICDS). This program was designed and initiated by the central government before TINP, in 1975, and has become its predominant program for preschool children. It has so far achieved 80% of its goal to cover all development blocks in the country. It is meant to be a holistic child development program, offering non-formal preschool education for children 3 to 6 years old as well as supplemental nutrition, immunization, and regular health checkups for children age 0 to 6, and nutrition and health education for pregnant and nursing women. It was originally meant to target the poor (by careful placement of its centers) and to provide supplementary feeding only to those in need; in fact, the whole range of services is provided to anyone showing up and requesting them. Targeting is essentially by self-selection rather than by distinctions among those who do show up. While adequate statistical evaluations have not been done to date, assessments suggest that the program is having only modest positive effects.6 This appears to have several causes. First, food and other inputs are not regularly available at all sites. Second, the most vulnerable groups—children under three and pregnant and nursing women—are underrepresented at the centers. Third, most food is taken home (rather than being consumed at the center, as in TINP) where it is shared with other family members.7 Finally, field workers are inadequately trained and overextended with the result that the outreach, health, and educational components of the program are often neglected. A more adequate budget, a second field worker per center, more narrow targeting, and some decentralization of management would ameliorate many of these problems.

2.14 The GOI has shown no interest in continuing or expanding the coverage of the TINP model, despite its relative success. Rather than pressing for this, the Bank decided to support ICDS and to try to influence it to incorporate the more attractive elements of TINP. The TINP centers have been absorbed by the ICDS program as it has expanded in Tamil Nadu, and the Bank has gone on to provide support for ICDS through two free-standing projects—ICDS1 (1990–97) and ICDS2 (1993–00)—plus components in other projects, most notably the Social Safety Net Project (1992–94) and the Andhra Pradesh Economic Restructuring Project (1998, ongoing). Despite this support, the Bank has had virtually no success in persuading the government to modify the ICDS program by adopting elements from TINP. To date, the TINP experience seems to have been lost on India, and with it a clear emphasis on malnutrition as a leading risk for ill health, although it has affected the design of some nutrition projects in other parts of the world.

5. See, for example, OED's Impact Evaluation Report of TINP1 (December 1994) and its citations of other studies.

6. To date there have been no evaluations of ICDS projects with proper "before and after" data on participants and matched controls. But Levinson (1998, footnote 12) reports on a 1993 World Bank study that simulated such data from existing materials and concluded that the percentages of severe and moderate malnutrition would have been 4.45 and 8.1 percentage points higher, respectively, in the absence of the program.

7. According to Levinson (1998, p. 12), food provided for mothers is meant to be consumed at home. The mother or an older sibling typically picks up for home consumption food intended for children less than three years old. Even food provided to older children in the childcare program is often consumed at home. And there is no mechanism for ensuring that the double ration provided for children with severe malnutrition is actually consumed by those children.
2.15 Nearly all of the Bank's support for ICDS has been for expansion and strengthening of the existing program, not for revisions or structural changes. The justification for this has been that most of the flaws in the program arise from its excessively rapid expansion, shortages of resources and training, and managerial weaknesses, all of which can be fixed without radical changes. But it is becoming increasingly evident that continued expansion and strengthening of the existing program will not suffice. There are some signs that the Bank has accepted this message. The latest supervision report for ICDS2 rates achievement of this project's development objectives as unsatisfactory. The ICR for ICDS1 rates this project's achievement as unsatisfactory and recommends significant changes in direction. The recently completed sector report on malnutrition in India presents a strong criticism of efforts to date and adds additional recommendations (World Bank 1998a). The designers of ICDS3 (now called the Women and Child Development Project) are trying to find ways to implement these recommendations.

Free-standing Health Projects: Moving Beyond Family Planning

2.16 While the Board of Executive Directors authorized the Bank to develop and fund free-standing health projects in 1980, more than a decade passed before the first project of this type was initiated in India. For most of this period, the MOHFW wanted no assistance in this area, the argument being that the GOI should be able to fund primary care itself and did not need policy advice in this area. But with the financial difficulties of the early 1990s and a change in the leadership of the ministry, this attitude changed. Indeed, it was agreed that from that time on the Bank would plan to fund one new health project per year. The reasons for this change of attitude are discussed more fully below (paras. 2.30–2.33). The projects are of two types: disease-specific interventions and health system reforms.

Specific Disease-Control Projects: Opportunities for Large or Rapid Gains

2.17 The Bank is currently supporting disease-specific projects to control AIDS, leprosy, cataract blindness, tuberculosis, and malaria. It is interesting that benefit-cost analysis and notions about which projects are appropriate for public funding (e.g., because of externalities, poverty, or failure of private providers) played hardly any role in their selection. Collectively, these diseases account for only 6% of the mortality and morbidity burden imposed by all diseases, and others that were proposed and rejected (cardiovascular disease, cancer, trauma, mental illness, and tobacco-related diseases) sometimes account for more (Murray and Lopez 1996). Rather, the selection had more to do with feasibility, adequacy of project design, the existence of new treatment protocols, and the seriousness of government commitment. Thus, for example, a cardiovascular project was rejected because it involved mostly hardware, and a tobacco control project was rejected because the government continues to subsidize tobacco production. In all cases, major public programs already existed; the projects are designed to accelerate those programs and improve their effectiveness. Considerations about the proper division of labor between public and private sectors never seriously entered into the decisions.

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8. For TB and leprosy, the change in control strategy is primarily a matter of newer and more potent drugs used in combination to overcome pathogen resistance and ensure higher cure rates. The revised protocol for TB cuts treatment time in half, provides for directly observing the patient's consumption of drugs, and depends on sputum-positive identification of infectious cases rather than on chest x-rays. For cataract blindness, the only non-communicable disease in the group, the change in protocol introduced a simpler and more effective ambulatory surgery. Potentially the most important change in strategy, however, comes with the AIDS control project, which introduces an emphasis on "core" or high-risk groups instead of relying on undifferentiated attention to the public.
2.18 The Bank has made three important contributions with these projects. First, it brought to bear its experience with similar projects (in the case of AIDS, TB, and malaria) in other countries. For example, the Indian project benefited from the demonstration, in a Bank project in Brazil, that treating malaria can be more cost-effective than trying to prevent it, and that nearly all the gains come from preventing deaths, not simply cases (Akhavan, Abrantes, Gusmão, and Musgrove 1998). Similarly, Bank experience with AIDS control in Brazil, Thailand, and several African countries has shown the importance of concentrating on high-risk groups and of adapting IEC to particular sub-populations (Ainsworth and Over 1997). Second, together with the World Health Organization, the Bank supported an exercise to estimate the burden of disease in India, as well as in other countries, which for the first time has focused attention on the heavy burden of disability and adult ill-health, both of which have been underestimated or ignored. Third, the Bank promoted changes in strategy and technical approach by bringing the most knowledgeable world experts in each disease to work on project design. How many of these activities the government would have undertaken without Bank assistance is not known, but almost certainly it would have taken substantially more time.

2.19 All five projects were well-designed from a medical/technical point of view. It is harder to judge some of their other features, in which they differ considerably. For example, they propose to involve the private health care sector in different forms and to different degrees. The TB control project, recognizing that tubercular patients seek treatment from private physicians about half the time, is intended to persuade the latter to adopt the more effective but also more demanding strategy of directly observed treatment, rather than simply prescribing medication and failing to ensure that it is taken properly. The cataract blindness project not only aims to change the principal form of surgery most private ophthalmologists are trained to practice, it also tries to get private and NGO practitioners to take over most of the surgery. The malaria project does not involve private practitioners in treatment, but brings in NGOs to help with IEC and with the distribution of insecticide-impregnated bed nets. Finally, the AIDS control project involves private physicians (to reach patients with sexually transmitted diseases, who are at greater risk for HIV infection) and NGOs, which may be better able than the MOHFW to reach particular risk groups and bring about behavior change. The Bank has for years urged greater integration of the private sector in the government’s health efforts; these projects will provide tests of how readily that can be done, and which kinds of collaboration work best.

2.20 A novel element of some of the disease control projects is the use of nonprofit registered societies to advise on the design or help with the implementation. The District Blindness Control Societies are extensively involved in the cataract project; 277 District Leprosy Societies are similarly incorporated in the leprosy project; and in Tamil Nadu, the state AIDS cell was converted into a Registered Society so it would have more autonomy and could accelerate implementation. In some cases, it has been used to bypass state budgeting procedures and thereby speed up disbursement and implementation. The use of registered societies for this purpose can be criticized because of the possibility that accountability is weakened and because it avoids the hard work of reforming state procedures. In any event, their usefulness is probably limited to narrowly specified tasks, as discussed in para. 3.17.

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9. The rationale is the reverse, that such societies are meant as temporary expedients while reforms in state procedures are being implemented. They may reduce the pressure to reform, in return for faster progress than would occur by waiting for the whole system to improve.
Implementation experience has varied widely. The leprosy control project is credited with reducing prevalence by more than 70% between 1992 and 1998, from 19.5 to 5.3 per 10,000 population, so it may be possible in a few years to reach the target of 1/10,000. Progress on its more novel elements—prevention of disability and care for those already disabled—has not been satisfactory. The cataract blindness project is achieving very satisfactory results measured by the number and effectiveness of operations performed. It has not fully replaced the old surgical techniques, but the target that at least 90% of cases should result in restored sight is being met in all states except Uttar Pradesh, where a rising rate of unsatisfactory outcomes has temporarily raised the estimated prevalence of blindness. The first AIDS project is proceeding satisfactorily but with great variation in the response of state and local governments, depending largely on attitudes about the disease and its seriousness. However, there is no clear evidence yet that the epidemic has slowed appreciably, and in some areas—but not yet in any state as a whole—it has progressed from “concentrated” to “generalized.” In five states, HIV prevalence is estimated to be between one and 5% of the adult population, against a country-wide average of 0.9%. The TB project, perhaps the best designed of these projects from a technical perspective, was slow in starting because of delays in the selection of an independent organization to handle procurement of drugs, a condition of effectiveness. Despite these delays, the project is doing a good job identifying and treating cases. In contrast, the malaria project is far behind schedule and not doing well because of managerial problems, the solution to which, many believe, is decentralization to the state or district level; the project was almost suspended in May 1999.

No decision has been made on the future of this approach. So far, only the AIDS project has gone into a second phase, which appears necessary because of the lack of progress against the epidemic. Other diseases may require a second project—tuberculosis is a candidate—while control if not elimination may be achieved with a single project in other cases. A few other
diseases, perhaps including some that were initially rejected, may also merit this approach. From one perspective, these projects were stopgaps—relatively easy to design and implement while the more complex state systems projects were being developed. Now, it may make sense to plan specific disease control programs within that context. Otherwise, there is a risk of inadvertently introducing distortions in spending between diseases and across regions. There is no consensus on the right balance between fighting particular diseases and improving the overall performance of health systems, so retaining both efforts in the portfolio is reasonable for both India and the Bank. In deciding this issue, more thought needs to be given to the question of what public funds should be used for—what should be left to the private sector, whether public funds should be used to introduce new protocols to the private as well as the public providers, and similar issues. The next round of sector studies appears to be taking up this issue.

**Health System Reform Projects: Trying to Make Referral Work**

2.23 These projects provide the Bank with a long-sought opportunity to influence more fundamental determinants of how the public health system works, to do so at the state level where ultimate control of these determinants is lodged and where the Bank can have more leverage than is possible at the national level, and to provide assistance that is more tailored to the vastly different circumstances found in different states. Earlier projects, while often limited to implementation in certain states or districts, focused on expanding or upgrading central government programs in those regions, not on the factors under state control. A case in point is the ICDS program. Both practical and political considerations led the central government to provide program and budget inputs uniformly, without regard to differences among states other than the size of their population. But these projects are implemented by the states, which means that each state’s personnel policies and management systems play a fundamental role in determining outcomes, and states may take district-level plans into account. These are outside the control of the central government, and by extension, any influence that the Bank might have when it operates through the central government. The only way around this for the Bank is to provide assistance directly to the states.

2.24 In 1995, the central government and the Bank began taking this approach through the Andhra Pradesh First Referral Health Systems Project (1995–02), the first of four state system reform projects that the Bank has funded so far. Referral is arguably the most important element in creating a quality health care system. This project focused on the establishment of one of the prerequisites for a meaningful referral system, the upgrading of staff and facilities at secondary-level hospitals so they are capable of receiving and properly treating patients referred from the primary level. A significant amount of the funds in this project were also used to expand these hospitals. The project also provided training and equipment to strengthen management of the state public health system at various levels and attempted to introduce a cost-recovery mechanism and improve sectoral resource allocation. Significant funds in this project were used to expand bed capacity in these first-line hospitals. This is a more questionable component given current emphasis in all other sectors on privatization.15

2.25 The project did little or nothing to provide the other prerequisites for an effective referral system. One of these additional prerequisites is a set of adequately functioning PHCs, which to a large extent means PHCs appropriately staffed by doctors. A component covering this problem

15. The PAD does not provide a satisfactory explanation for this component.
was left out of this project because of concerns that the state might not have adequate implementation capacity and funds to hire the requisite number of doctors. However, it was included in the Andhra Pradesh Economic Restructuring (APER) project, initiated in 1998, which by improving the primary level at the same time that capacity is developed at the secondary level, is meant to increase the effectiveness of referral. A further prerequisite for an effective referral system is a mechanism to link secondary and primary institutions by encouraging interaction among their staffs. Ideally, doctors at the first referral level would have some supervisory responsibilities for the PHCs so that doctors at the lower level can get questions answered, understand what services are available at the next level, and gain confidence in deciding who to treat and who, when, and where to refer. Part of the problem in developing this element is that staffs of the two sets of institutions report to different administrative units. This problem was not tackled in either Andhra Pradesh project, though it is clear that if there is another project of this kind in the state it will be on the agenda.

2.26 The second project, State Health Systems Development Project II (1996–02), extends the principles of the first project to three other states, Karnataka, Punjab, and West Bengal. With an expected cost of US$417 million (with IDA contributing US$94.6 million), it is the largest health project the Bank has ever funded and probably too large and complex to satisfactorily manage. It is probably for this reason that the next two projects included only one state each: the Orissa Health Systems Development Project (1998–04) and the Maharashtra Health Systems Development Project (approved by the Board in December 1998 but not yet effective). While these projects, like the first, include components to improve quality, access and effectiveness of health services at the first referral level, to strengthen management systems and to improve sector finances and resource allocation, the content of these components varies somewhat from state to state. Some funds for upgrading PHCs and increasing access to primary care in remote areas are included for West Bengal, Karnataka, and Orissa; the Karnataka subproject includes several pilot and experimental components; the Punjab subproject includes the establishment of a new institution, the Punjab Health Systems Corporation, similar to what existed in Andhra Pradesh before its project and which was used so effectively to manage the hospital system and implement the project. The Orissa project, because of that state’s high infant mortality rates and maternal mortality rates, focuses on improving service quality at community health centers and PHCs where most maternity cases go. The Maharashtra project includes an innovative component to establish a new, specialized hospital established as a trust and operated according to modern hospital management practices.

2.27 It is interesting to note that, in contrast to the disease control projects, none of these projects uses registered societies to manage the flow of funds. Instead, they rely on the establishment of special arrangements with the existing state budgetary institutions. In Karnataka, where this is done using the equivalent of letters of credit, it seems to be working quite well.

2.28 Supervision reports indicate that the Andhra Pradesh project is progressing well, with some elements—notably management and monitoring and evaluation—rated as highly satisfactory. There has been a modest increase in the percent of the state budget spent on health and a slight increase in the proportion spent on primary and secondary care, but no evidence as yet of significant progress on cost recovery or referral. Spending on drugs and on maintenance has increased, with consequences for drug availability and the condition of hospitals. 16 Sanitary

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16. In the case of drugs, spending rose 60% per bed-year. For equipment, there has been a reduction in the backlog of needed repairs, and the share of x-ray equipment that is out of order has been brought down from about 22% to only 2-
services have also been contracted out at some of the hospitals, with improvements in cleanliness and patient satisfaction.

2.29 The second state systems project is progressing satisfactorily, better in Karnataka and Punjab than in West Bengal, where some physical investment have been delayed. In Punjab, the new institution to manage hospitals has experienced some initial problems and resistance from established institutions but appears to be taking root. In West Bengal, where there is a significantly greater emphasis on decentralization, problems related to shortages of competent staff are emerging. Efforts to increase state spending on health and allocate more to primary and secondary levels appear to be bearing fruit. As in Andhra Pradesh, progress is considered satisfactory in drug availability, equipment maintenance, quality assurance—that is, the creation of quality assurance groups in the hospitals—and information systems. However, there are still no estimates of outputs as a result of the project, much less of outcomes: no measurable objectives are explicitly linked to referral and there are no indications yet of any changes in the relationship between the secondary and the primary levels of care. The difference with Andhra Pradesh, where there is the beginning of attempts to integrate these levels and test whether referral is really improving, may be due to the project in that state starting one year earlier and being complemented by the APER project, with its emphasis on the primary level.

2.30 While a few broad principles guide these projects, the specific activities appear to have been selected opportunistically, with somewhat different approaches used in different states. Since there are no reliable guides for system reform efforts and the circumstances of the states differ so much, this is not a bad strategy. Moreover, it presents a unique opportunity to learn what works and does not work in different circumstances. The situation is sufficiently rich in potential insights as to warrant an especially intensive monitoring and evaluation effort that continues throughout the life of these projects. The type of monitoring and evaluation included in these projects, even if implemented well, is not up to the mark for this purpose.

2.31 More generally, it can be asked whether the Bank has struck the right balance among activities designed primarily to reduce fertility, improve nutritional status, reduce the burden of disease and improve the working of the health system—that is, has it given the appropriate relative weights to H, N, and P? There is no clear or agreed answer to this question, but two conclusions can be ventured. One is that the Bank waited too long to encourage projects and studies devoted to health rather than population, following an over-emphasis in the Indian program. Some of what is possible to achieve now in health projects was not feasible before, because the drugs and techniques needed, as for treating tuberculosis and leprosy, were simply not yet developed. But an earlier emphasis on health might have bolstered the population activities rather than competing with them, both by improving child survival and by increasing demand, especially from women. The second conclusion is that nutrition has been under-valued, despite the Bank's success in the TNIP projects. Much of what was best in those projects, and particularly the effectiveness in reducing malnutrition, has been diluted in the ICDS projects. The other child development components of that program do matter, but the burden of disease due to malnutrition is so large, and the effectiveness of targeted programs so well documented, that the

3% These are two of the perennially underfinanced elements of the system, and the situation had been worsening as the share of salaries in total spending increased. That such changes can be accomplished fairly quickly and without massive re-allocation of resources only underscores the inefficiency in which the Indian public hospital sector has been operating for years.
more general anti-poverty components almost surely make a much smaller contribution to child health.

**The Big Break and Its Causes**

2.32 Except for the experience with the nutrition projects, there are large differences in the character of projects, sector work, and style of operations before and after about 1988. Before that date there were no free-standing health projects, population projects were usually supply-oriented, the Bank supported the government program without seriously pressing for the policy changes it believed to be necessary, and almost no sector work was undertaken. After that date sector work has flourished and raised policy issues that are being taken seriously; health projects have been added to the portfolio; serious efforts have been made to shift the balance within the Family Welfare Program from family planning to MCH; contraceptive targeting was dropped; health and system reform projects have proliferated; and the Bank, with MOHFW blessing, has begun working directly with state administrations.

2.33 A number of factors came together to cause these changes. Evidence that old approaches were not working, the emergence of some new, cost-effective treatments for some diseases, the emergence of new diseases, pressures to pay more attention to what women actually want, and changes in personnel in both the ministry and the Bank all contributed. In addition, and perhaps most influential in determining the timing of these changes, the deterioration in economic conditions in 1990/91 increased the government's interest in acquiring foreign assistance and led to an agreement that assistance obtained by the MOHFW would be considered additional to its plan budget, thus giving the MOHFW a strong incentive to acquire such assistance. The decentralization amendments added to the Indian Constitution also played a role in that they resulted, in about 1992, in the government dropping its long-standing opposition to the Bank and other donors dealing directly with state governments, thus allowing the development of the state system reform projects.

2.34 *What was the Bank's role?* Interviews conducted for this study elicited a range of opinions about the Bank's contribution to these changes, and about the degree to which the Bank changed its approach. According to some, the Bank was just as much to blame as the government for the inertia and narrowness of the portfolio before 1991. Others credit the Bank with having urged change well before then but say that it got nowhere until the government was ready for a different *modus operandi*. Bank staff support the latter view: in their recounting, the Bank had for some years been knocking on a closed door, which suddenly opened.

2.35 What does not seem to be in doubt is that when the opportunity came, the Bank was prepared. It was convenient that IDA loans were being concentrated on "social" projects, and that the Bank did not have many projects in the pipeline and therefore needed to develop new projects. It "responded absolutely magnificently," in the words of a former secretary of health, and quickly, with projects of a completely new kind. For the staff who participated in this change and designed the new round of projects, the crisis of 1990/91 was an opportunity to expand the portfolio, to put to use the ideas developed in studies since the late 1980s, and to deepen their relations with Indian counterparts.
3. Selected Topics

3.1 These topics were selected for discussion because of their importance to the Bank’s program in India and the availability of information. Two, training and IEC, concern important components of nearly all projects in the HNP sector. Three concern policy initiatives the Bank has been advocating for some time: changing signals in the Family Welfare Program, NGOs and the private sector, and decentralization. The final two, quality of family welfare services and overall impact of Bank-funded projects, are based on studies that try to assess progress using sample survey and statistical methods. These discussions are largely based on background papers prepared for and presented at an April 1998 workshop in New Delhi sponsored by OED.17

Training

3.2 While every Bank-financed project in the HNP sector includes a training component, and sometimes such components are quite large, there have been few methodologically proper assessments of the impact on staff performance or quality of services provided. Most ICRs indicate that training components were satisfactorily implemented. Typically, though, this means that the targets for construction, preparation of training materials, and number of persons attending training sessions were achieved or surpassed. Also typically, the SAR for the next project complains about the quality of the training provided in previous projects. The problems repeatedly mentioned include inadequate selection and training of trainers, course content not based on trainees’ needs, insufficient time devoted to field work and practicing new skills, weak management of training programs, inadequate in-service training programs, and lack of programmatic guidance and leadership provided to the many small training institutes. Both government and Bank documents indicate an awareness of these problems, yet the problems remain unsolved.

3.3 The Bank’s main contribution in the training field has been to provide infrastructure and funds to expand training capacity. Resources have also been put to good use in training health providers in new initiatives. The Bank has been less successful in pressing for policy and institutional changes. TINP I is an exception. That project was particularly successful because it integrated training with supervision and normal work routines. Trainers were actively involved in supervision, so they had first-hand knowledge of the problems that needed correction. Despite its success, this approach has not been used in other projects because (rightly or wrongly) it was not considered feasible in larger projects. Neither was it considered necessary in the disease-specific projects since training in these cases is inherently easier: there, the goal is to impart technical knowledge to health personnel who are already reasonably well trained. The training components of the state health system projects include promising features—for example, a distance learning sub-component in Andhra Pradesh—but they do not include efforts to establish statewide training policies that would enhance the prospects for sustainability of the training activities.

3.4 There is a tendency, whenever and wherever a problem is identified during project development, to throw in some training to correct it without thinking out in advance whether training alone will do the job. This works reasonably well where the training imparts information desired by the trainees and encouraged by the system. In most cases, though, a package of changes is required to modify behavior permanently. Without such changes—for example, in

17. These papers are listed in the appendix to this report and are available on request from OED.
management practices, work routines, and career development policies—training can be a waste of time and resources. The Bank has an obligation to encourage the complementary changes required to ensure the application of the knowledge gained in training and to refrain from providing resources for training when the knowledge gained is unlikely to be used effectively.

**Information, Education, and Communications Programs**

3.5 IEC has been a relatively neglected component of HNP projects, certainly compared to expansion of the system, procurement of drugs, and training. This neglect is reflected in budget allocations, personnel assignments, the scope and nature of the programs, and lack of attention to monitoring and evaluation. It is unfortunate since the solution of nearly all problems in the sector requires behavior change. Indeed, in some areas—such as AIDS—where behavior change is of the essence, IEC is almost the only acceptable policy instrument available.

3.6 The Bank’s main contribution in this field, until recently, has been to prod the government into taking IEC more seriously. Apart from this, its resources have done little more than help the government expand weak and ineffective programs, with the result that considerable resources were wasted. For example, evaluations of IEC programs for family planning, some as early as 1973, found that while the programs were effective in creating awareness and probably induced some couples who were already motivated to limit their family size to adopt modern family planning methods, it had no perceptible effect on the behavior of the much larger numbers who were not so motivated. More recently, the Bank appears to be insisting that lessons from the few successful programs be incorporated into future projects. Evaluation and assessment of impact, however, are still not being given appropriate weight.

3.7 The lessons being incorporated include the following:

- IEC can influence behavior, but only if it is recognized as central to the mission of the project and provided with adequate technical and financial resources, as happened in TINP I and in the Universal Immunization Program.
- A simple top-down approach to selecting messages is likely to be a waste of time; instead, careful research before deciding what to do and a decentralized, client-oriented mode of operation is critical.
- Interpersonal communication and counseling, which should be considered part of IEC along with mass media, have greater potential for generating behavior change than do mass media; outreach workers should be trained in its techniques and carefully supervised.
- Since there are no blueprints that can be applied in this area, research, monitoring and evaluation, with adequate channels for feedback to program managers, is critical.
- Most important, a major program to widely disseminate practical information about self-care and consumer information about health service providers is sorely needed in India and could be more cost-effective in many areas than, for example, the establishment of additional health centers or the training of additional doctors.

**Changing Signals in the Family Welfare Program**

3.8 For 30 years, the government’s family welfare program has emphasized the provision of family planning supplies and services at the expense of MCH and other interventions that might have affected desired family size. It has focused on sterilization rather than temporary methods of
contraception, the establishment of targets for the number of “acceptors” that staff was expected
to achieve, and use of monetary incentives and administrative sanctions to achieve these targets.
For almost as many years, this program has been criticized for being coercive, neglecting
temporary methods, ignoring factors inducing parents to want large families, and in later years,
becoming ineffective and counterproductive. Finally, in March 1996, after a period of
experimentation, the MOHFW changed this policy and adopted the “target-free approach.” This
approach envisions that projections of “expected work load” prepared initially by field workers
based on their perception of client needs, will replace top-down targets.

3.9 The immediate result was a drop in contraceptive acceptor rates, in part because of a
decrease in the exaggeration of reported performance but also because of the confusion created
by the change in policy. Recent data and interviews with staff suggest that these rates are
recovering and that more emphasis is, in fact, being placed on temporary methods and on MCH
components. But clients who were interviewed in the same study reported no change in the
behavior of health personnel toward them.

3.10 A necessary condition for the success of this new policy is the establishment of an
effective system for developing work programs based on needs and monitoring results and
providing timely feedback. The RCH project includes a component to do this. High priority needs
to be given to this activity.

3.11 The Bank deserves credit for continuously pointing out the problems with the earlier
approach. Until recently, though, it did not propose practical alternatives or take advantage of
opportunities to force the issue through the projects it funded. It is unfortunate that it took so long
to reach this point.

18. Annual data, available for selected districts through fiscal year 1996/97, the year that TFA became national policy,
indicate that sterilizations, which had been increasing steadily for a number of years, declined marginally in 1995/96
and by 14% in 1996/97. IUDs increased marginally in 1995/96 and decreased by 17% in 1996/97. Pills showed small
increases in both years. Condoms, on the other hand, showed small decreases in both years, but they had been on a
declining path for several earlier years and may have been affected by the government’s ceasing its free distribution
system at about this time. Data for April through January, which permit the analysis to be extended to 1997/98, show
some increases in sterilizations and IUDs in 1997/98 but not by enough to recover to the 1995/96 level. Pill use
increased at an accelerating rate. Condoms continued to decline though at a somewhat slower rate. More than three-
fourths of these declines occurred in Bihar, Madhya Pradesh, and Uttar Pradesh, among the most backward and
conservative of states. On the other hand, data from two districts of Uttar Pradesh, which had been target-free from
1995 and have been relatively better performers all along, showed little or no evidence of declines in contraceptive
acceptance rates and some evidence of improvements in health system performance (for example, percent of pregnant
women receiving IFA tablets and tetanus toxoid and percent of infants receiving full immunization doses).

19. In many ways, TFA has been a prerequisite for the effective operation of the Family Welfare Program for many
years. IPP6 provides an excellent example of this point. Its goal was to assist in improving the efficiency and
effectiveness of the Family Welfare Program by taking into account the fact that needs for services vary greatly
depending on age, parity, sex, socioeconomic status, and cultural environment, and it planned to do that by providing
training to help field staff identify such differences and better match services to these needs (SAR, para. 3.01, p. 16).
But since field staff activities were being controlled by centrally determined, method-specific contraceptive targets
focused on sterilization, whatever staff learned about matching services and needs in training courses was bound to go
to waste.

Of course, it may not have been a total waste since at least senior officials and administrators involved in designing
and implementing IPP6 were sensitized to the great disparities between needs and services provided. But this benefit
was not the goal of this project and could hardly be used as a justification for the resources put into this project.
NGOs and the Private Sector

3.12 For the past decade the Bank has encouraged the government to involve NGOs and the private sector in its programs, on grounds that, in the right circumstances, these organizations can deliver higher quality, more client-oriented and efficient HNP services than most government organizations. Background papers for this report reviewed a number of attempts to involve NGOs or the private sector to determine how successful they have been and to what extent the anticipated benefits are being derived.

3.13 There have been few serious efforts at involvement and fewer cases where a significant degree of involvement has occurred. Reasons for this slow progress often involve mutual suspicions of the other’s motives (for example, NGO fears that they will not be paid on time and government fears that the private sector will “take the money and run” or charge exorbitant fees) and misunderstandings (for example, about their terms of reference, reasons for involvement, and division of costs and revenues). Many of these problems should dissipate as experience in working together accumulates.

3.14 When NGOs have been involved, their impact on the quality of services provided has been mixed. The best experiences seem to occur when NGOs and the private sector work alongside government organizations in complementary rather than competitive roles—for example, being used as intermediaries or to test new approaches rather than operating primary health centers—and where sympathetic and effective managers are assigned by the government to work with the private sector. Having the public and private sectors trying to do exactly the same thing appears to work best in the disease control projects, which involve highly specific services that private practitioners and NGOs were already providing.

3.15 A number of interesting efforts at collaboration are being tried under the RCH and state health systems projects—including, for example, inviting private physicians to use public health center facilities that are understaffed and permitting them to charge a small fee. These efforts remain tentative and sporadic, however. A strategy for involving the private sector, which includes consideration of the proper division of labor, pricing and subsidy policies, licensing and regulation of private providers and health insurers, and proper training programs needs to be developed. The Bank has recently initiated a sector work program on issues pertaining to the private sector that should be helpful in this regard.

Decentralization

3.16 In India, decentralization can mean transfer of powers and resources either to lower levels of government or to nongovernmental organizations. Bank documents have advocated such transfers of power for more than 15 years, though generally without much practical specificity. Before April 1993, when several constitutional amendments came into force that sanctioned decentralization to lower levels of government and their locally elected bodies, or panchayats, no Bank-financed project included any decentralization initiatives. A background paper for this

20. The most extensive involvement has occurred in the blindness project, where project design basically copied the work of an NGO.

21. This observation is consistent with the findings of “NGOs in Bank-supported Projects: an OED Review,” Report No. 18399, September 14, 1998.
report investigated how six projects initiated after 1992 in different states have dealt with decentralization and fared since these amendments.

3.17 Local governments do not seem to be playing any significant role in the projects investigated, partly because their responsibilities are ill-defined. They are supposed to evaluate health personnel performance but they have no say in recruitment, assignment, or performance sanctions. There is no evidence that their oversight has systematically improved performance. The only instance in which panchayats have been assigned to administer Bank funds is in the Malaria Control Project, where their role is largely limited to IEC and distribution of insecticide-impregnated bed nets. In the RCH project, they are expected to help promote community participation, but funds for this purpose go not to them but to a specially designated implementation body. Indeed, it is not clear that it would be advisable to assign panchayats a more substantial role. While more accountability might result, more inequities (where panchayats are controlled by local elites) and breakdowns between levels of government (where they are controlled by different political parties) could also result.

3.18 A more widely used mechanism for decentralization is the Registered Society. Such societies are technically competent, apolitical bodies established by law for specific purposes. As noted in Chapter 2, district-level societies are being used extensively for implementation of the disease control projects. While their performance has not been evaluated, the combination of technical expertise and relative freedom from bureaucratic restrictions ought to improve results, but their usefulness is probably limited to narrowly focused projects. For broader tasks, consideration should be given to transferring authority to existing public health facilities, for example, local hospitals, and perhaps holding them responsible for overseeing or managing lower-level facilities within their catchment area. An example of such an arrangement between a municipality and a private hospital is given in Chapter 4; such arrangements need to be tried in the public sector as well.

Quality of Family Welfare Services

3.19 All Bank-financed projects in the HNP sector have called for and attempted in various ways to improve the quality of services provided in public health facilities. Yet complaints about poor quality persist and the vast majority of the population continues to use more costly private services instead of primary and secondary public facilities, despite the ever-increasing density of public facilities. (This is not a perfectly accurate picture of the situation since “private services” often consist of public doctors providing services for a fee after hours.)

3.20 What is happening to service quality in public institutions over time? To answer this question, a study was made of two large sample surveys undertaken by the Indian Council of Medical Research 10 years apart. The 1987–89 survey paints a dismal picture of the physical condition, availability of medicines and supplies, and quality of services provided in public health centers and subcenters. The 1996–97 survey found some improvements in the availability of supplies and the performance of auxiliary nurse midwives (ANMs), but the study concludes that absolute quality of care remains far from adequate.

3.21 What explains the persistence of this situation? The most important factors, according to the study, are pressures to meet sterilization targets, which have led to neglect of other aspects of primary care, poor training, and excessively large ANM workloads. Other important factors include absence of adequate supervisory and referral systems and personnel problems. An
example of the latter is the perverse incentives resulting from paying public doctors low wages and then permitting (or not effectively prohibiting) them to provide services for a fee after hours, which reduces their incentive to provide adequate public care. The improvement in ANM performance observed over the 10-year period probably results from the increase in facilities and staff during that period, which reduced the ANM patient load to more reasonable numbers, plus better training, for which projects like CSSM can take some credit. Targets were dropped too late in the period to have any effect on the outcome. Personnel problems continue unabated.

3.22 The Bank has been correct in calling attention, early and often, to the need to focus more on quality than system expansion, on more and better training, and on the problems created by excessive focus on sterilization. But it has continued to fund system expansion and training programs despite their flaws and has not become engaged with the personnel problems.\textsuperscript{22}

**Overall Impact of Bank-Financed Projects, 1981–91: Results from a Statistical Analysis**

3.23 This study used 1981 and 1991 census materials in an attempt to explain observed differences between districts in health and demographic status of the population. The data were also used to determine whether the presence or absence of a Bank-financed project in a district had a significant explanatory effect. The district is a particularly good unit of analysis for this purpose since most projects during this period were implemented in selected districts rather than over entire states or the whole country. The results are subject to a number of qualifications, including the fact that the Bank financed only a few population and nutrition projects, and none of the health projects, during this period. The most important determinants of child mortality, fertility, and contraceptive prevalence are income, female education, and a dummy variable representing the state. Compared to these variables, the presence or absence of a Bank project in a district, while positive, is small. The most satisfactory results arising from the presence of a Bank-financed project occur in states which themselves have a strong positive effect on the outcome variables. These findings do not undercut the real progress India has made in all districts during this decade, but they do suggest that there was only a little differential effect of having the Bank support the government's program in a particular district. The most likely explanation for these weak findings is fungibility, the likelihood that Bank inputs nominally provided to a district tend to substitute for other resources provided to the district so that the net effect is some improvement in the resource position of all districts.

3.24 Table 3.1 shows the results of a simultaneous structural model, including the effects of the outcome variables on one another. Bank projects are assumed to have a direct impact only on contraceptive prevalence. The effect looks significant, but quite small: on average, prevalence would be one percentage point higher in districts with Bank projects. Since CPR rose during the decade by 22 points in Bank districts and 18 points in non-Bank districts in the same states, that suggests that about a quarter of the better performance in Bank districts could be attributed to the Bank's presence. That is not trivial, but it is swamped by the influence of many other factors. The strong connections between fertility and child mortality, and from mortality to contraceptive prevalence, suggest that more should have been done to emphasize child health as a way to induce demand for contraception and thereby reduce fertility, which would have a further, dramatic effect on children's survival.

\textsuperscript{22} With the advent of the systems projects, this may be changing.
Table 3.1. Simultaneous structural estimation of effects on demographic variables, 1991: regression coefficients and total direct and indirect impacts

<table>
<thead>
<tr>
<th>Predictive Variables</th>
<th>Child Mortality</th>
<th>Contraceptive Prevalence</th>
<th>Total Fertility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Mortality</td>
<td>0.006</td>
<td>0.011</td>
<td></td>
</tr>
<tr>
<td>CPR</td>
<td></td>
<td>(0.009)</td>
<td></td>
</tr>
<tr>
<td>Total Fertility</td>
<td></td>
<td>9.403</td>
<td></td>
</tr>
<tr>
<td>World Bank Project</td>
<td></td>
<td>0.990</td>
<td></td>
</tr>
<tr>
<td>Total Impact</td>
<td></td>
<td></td>
<td>0.09342</td>
</tr>
<tr>
<td>World Bank Project</td>
<td>(0.09342)</td>
<td>0.98975</td>
<td>(0.00983)</td>
</tr>
</tbody>
</table>

Source: Srinivasan et al., 1998, Tables 9 and 10

3.25 The regression coefficients can be converted into estimates of the total (direct and indirect) effect of each determinant on the outcome variables. On average, the one-point increase in the CPR would imply a decline in child mortality of about 0.1 per thousand, which is extremely small compared to the average Indian level of around 100 per thousand. Direct emphasis on saving children from dying is doubtless more productive. Finally, the combined effect of greater contraceptive acceptance and lower child mortality due to Bank projects would be to reduce the TFR by only about 0.01, which is minuscule compared to the level of 4.5 in 1991. That a one percentage point increase in contraceptive prevalence leads to so small a decline in total fertility reflects the numerous other determinants of fertility, but in particular it shows the relative ineffectiveness of emphasizing sterilization, independently of the age and number of children already reached. The finding that income, education, and cultural variables are more important than density of service centers in explaining health outcomes is consistent with other studies. It suggests that the Bank and the GOI should look outside the health sector for policy options that may have been overlooked. Some possibilities are included in para. 4.6.

4. Conclusions and Policy Implications

4.1 What overall assessment of the Bank's contribution to the Indian HNP sector can be drawn from the materials presented in this study? As noted in Chapter 1, this assessment cannot be completely separated from an assessment of the Indian program, but it focuses on those factors for which the Bank might reasonably be held responsible.

4.2 Progress since 1970 in reducing fertility, mortality, and morbidity has been substantial but not extraordinary given what has been achieved elsewhere and very disappointing given India's goals; it also has been very uneven. The Bank's contributions to this progress are of three kinds. First, it has provided financial resources that resulted in a more rapid expansion of the health system. This contribution cannot be very large because it supports the public program which itself is responsible for only a small fraction of the results. Within that limited domain, however, the Bank provides a substantial portion of the discretionary resources available to the

23. This unevenness is clearly evident in geographic disparities. It is undoubtedly also present amongst population groups—for example, women compared to men, poor compared to non-poor, and scheduled castes and tribes compared to the rest of the population—but evidence here is weak. The fact that India's national programs, and the Bank-supported projects, have tried preferentially to improve the situation of women, the poor and the disadvantaged, is not enough to guarantee that those groups have benefited more than average.
MOHFW and through it to a number of states. The share of Bank financing in total project costs has risen from 50–75% in the early population projects to 80–90% in the recent health projects. Of course, the sector would have received some of these resources anyway, which means that part of the Bank's contribution helped ease budget pressures in other sectors. But the presence of the Bank funds for this sector must have significantly strengthened the ability of the MOHFW to compete for budgetary resources and induced more of those funds to be used in the primary health subsector.24 The second contribution, through policy dialogue and sector work, has varied greatly over time. During the first half of the period under study, this contribution was minimal: there was no sector work and projects did not seek significant policy adjustments. Since about 1989, however, the volume of sector work has been substantial and projects have become more innovative. Our judgment is that the quality of the sector work is generally excellent and that it is appreciated within the MOHFW and the donor community. How much circulation it gets outside this community is unknown, but the conscious efforts being made in recent years to consult with stakeholders during project design should be having a positive effect. The third contribution is more subtle, consisting of the discipline and transparency that is imposed by having to follow Bank procedures in preparing project documents, to respect Bank procurement and accounting practices, and to contribute to midterm reviews, completion reports, seminars, and workshops. While impossible to quantify, the cumulative effect of completing 10 projects and having 13 others under way must be substantial.

4.3 The Bank's program in India has had four emphases:

- Extending the government's primary health care system in poor and under-served areas and improving the quality of that program
- Concentrating on children and mothers
- Supporting interventions to reduce fertility and attack specific diseases or nutrition problems that have especially high cost-benefit (or cost-effectiveness) ratios for the society
- Developing first-referral services and dealing with systemic policy issues at the state level.

The materials presented in the previous chapters lead us to believe that these are the correct foci.

4.4 The evolution of the Bank's contribution is also roughly correct; that is, it has been approximately in line with the evolution of needs and problems. In the early days, the focus was on building infrastructure, providing equipment, and training new staff to expand and extend the delivery system for simple, family welfare interventions. As that expansion proceeded, the focus began to shift to emphasize quality, a broader range of services, including secondary and referral services, and system reform. Other features of this evolution include shifts from a narrow focus on supply to at least some concern with demand-side issues, from concern strictly with the public sector to greater concern with private providers, and from preparation of projects in isolation to consultations with stakeholders.

4.5 Our main criticism of this experience is that it has taken much longer than it should have to get to this point. Consequently, the development effectiveness of the overall program—of what the Bank has done for the past 25 years—is less than it might have been. One of the most egregious examples is the dropping of targets for sterilizations. As long ago as 1970, in the SAR...
for the first population project, the Bank complained that there was too much emphasis on sterilization and that this was hurting the program; but apart from such expressions of concern, the Bank took no actions on the matter for almost 20 years, and even then, the action was limited to a sector study that was not submitted to the Board and made public. Similarly, the focus on expansion of the primary health system continued with Bank support well into the 1990s, despite evidence during the past two decades of excess capacity, caused in part by potential clients bypassing the public primary system because of poor service quality, and no evidence that more densely spaced facilities improve outcomes, especially for the poor (Srinivasan 1998 and World Bank 1998a).

Why Has Progress Not Been Faster?

4.6 Shortage of resources and ineffective management have undoubtedly been important factors. In addition, however, this report emphasizes four other factors with significant policy implications. (1) Both the government and the Bank have focused on the public health system, even though about 80% of health spending is private, largely from out-of-pocket sources (profit and non-profit), thereby severely limiting the scope of coverage and resources that might have been mobilized. (2) Until recently, a single model or blueprint was applied to the whole country despite its diversity, with the result that there was seldom a good fit with local conditions. (3) This blueprint was excessively concerned with physical expansion of the health system and inadequately concerned with establishing the conditions for an effective health system on the one side and changing individual's health-related behavior on the other. (4) Important determinants of health and demographic status lying outside the traditional confines of the sector have been neglected. Examples include neglect of policies to reduce road and traffic accidents, smoking, environmental pollution, education of mothers, and transport and communication systems that take health needs into account. Recent projects are beginning to change this picture, which should result in more rapid progress in the future.

Why Has the Bank Taken So Long to Develop an Effective Program?

4.7 Many factors can be called upon to explain why the Bank has taken so long to develop an effective program: lack of adequate information on which to act, an early image of itself as a provider of hardware and infrastructure and resistance by Indian counterparts to involvement in other areas are good examples. But what explains why these factors were permitted to stand in the Bank's way? We believe there are two reasons that are more fundamental. First, the Bank has not been very forceful in resisting weak performance by project and program authorities, thereby allowing problems to continue from one project to another. As noted in Chapter 2, until the early

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25. The latter report notes that the study undertaken "could not find any significant correlation between child survival and the availability of public health facilities" (paragraph 13).

26. These conditions include payment for services related to service provided (rather than establishing budgets independent of output); input combinations determined by the service provider (not by rigid line-item budgets or central administrators); proper sharing of risks between payers, providers, and patients (rather than patients bearing the bulk of the risks); and competition among providers.

27. For example, habits and customs with respect to nutrition, personal hygiene and disposal of wastes, and treatment of and care of the ill,

28. According to Brandon and Hommann (1995), the health problems associated with water pollution alone are responsible for 15% of the DALYs recorded for India.
1990s, the Bank largely went along with government policy and mode of operation in the health sector and avoided contentious issues. This posture has its roots in the historic relationship between the Bank and India. Second, there has been a tendency to focus more on the big picture of program and project development than on the details of implementation. For example, while the Bank repeatedly called for more attention to non-permanent contraceptive methods and greater involvement of NGOs and the private sector, it did not undertake the kind of analysis required to suggest how these changes might be accomplished. Here again, the situation has changed markedly during the past decade.

Implications for the Future

4.8 Most of our critical comments about the Bank’s program pertain to its first 20 years; the program as it is now constituted is essentially on the right track. Nevertheless, there are several areas where we see room for additional improvements. A number of lessons have been suggested in conjunction with individual topics and project components throughout this study. Here we focus on several cross-cutting issues.

Toward an Effective Referral System

4.9 Referral is arguably the crucial feature of a well-functioning health system. How can an effective system be established between primary and secondary institutions in rural India? The approach that has been taken so far is to develop programs to improve the functioning and skills of health workers at secondary and primary levels. The state system projects are attempting to do this mainly at the secondary level, the RCH project at the primary level. Undoubtedly, other projects outside the HNP sectors are helping by improving transport and communications, a third necessary element for an effective system. But these three systems have to function together. Currently, they each report to different administrative units, and the incentives to work together are weak or non-existent.

4.10 Within the public sector, at least in rural areas, some degree of vertical integration, combined with performance-based budgeting, is the only satisfactory way to deal with this problem. Ultimately, a hospital has to take responsibility for providing health services to all individuals in its catchment area, decide what kind of outreach and logistic services are required for this purpose, and manage the operation of those services. The Apollo hospital in Chennai performs in this fashion and receives a payment from local government authorities for doing so according to jointly agreed performance criteria. The same principles should be applied to public hospitals, public health centers, and subcenters within the hospital’s catchment area.

4.11 Within the private sector and between the public and private sector, less formal means must be found. One possibility is to allow private doctors access to public facilities provided they meet certain qualifications and are willing to abide by specified protocols in referring their patients. The first step in developing ideas about what can be done here is to study what transpires now between institutions at different levels in the public and private spheres. Such a study may discover opportunities to develop and apply approaches that do not require radical institutional change.

Personnel Problems, Performance Incentives, and Accountability

4.12 Ministry officials acknowledge that this cluster of problems is the most difficult one they face in attempting to improve quality of service delivery. Unfortunately, the Bank has virtually no basis on which to make practical recommendations; it has never studied these issues in a way that would generate such recommendations. Nor can we make any recommendations, other than to suggest the kind of studies that are needed.

4.13 The raw material for doing anything about this problem is detailed information about the incentive structure within which health personnel operate as a consequence of the way they are recruited, compensated, promoted, disciplined, terminated, and transferred. The Bank has not done much work in this area, and sometimes sees these problems as matters to be solved by managerial and technical training. But training will not be applied if there are no incentives to use what is being taught and, indeed, may be unnecessary if the incentives are present. Sector staff argue, with some justification, that many of these problems are general civil service issues, or relate to the way doctors are trained and recruited for public service, issues they can do nothing about. The result is that no effective action is taken and the problem remains. This phenomenon needs careful, detailed study even if most of the determinants lie outside the sector; it is too important for sector performance to be ignored or simply complained about.

4.14 The goal of such studies should be to look for ways around constraints that cannot realistically be changed, not simply to identify these constraints. In the process, the studies should consider the pros and cons of existing adaptations to these constraints. Consider, for example, two adaptations of this sort, the common one of public doctors compensating for their poor salaries by charging fees (and providing better service) to patients after hours, and the less common, but perhaps growing practice of trying to fill vacancies by contracting with private doctors to work in public clinics (while they undoubtedly carry on with their private practice after hours). While the first practice typically is deplored and the second looked upon favorably, from a welfare point of view, they are very similar. Both provide lower-quality services for those who cannot pay and somewhat higher quality for those who can pay, thereby reducing the likelihood that those who can pay will take undue advantage of the free services; both require good supervision and regulation to work well. Studies to determine how these mechanisms work, their likely welfare impacts compared to alternatives and how they might better be regulated and supervised, and pilot projects to determine how variations might work in the field, could be very productive. Because of India’s diversity, such studies would have to be undertaken in each new context where the Bank considers working.

Getting the Private Sector Involved

4.15 Mobilizing the private (profit and non-profit) sector to serve public health goals raises issues of contracting, accreditation, regulation, referral, and appropriate division of labor between the public and private sectors. Above all, it means using public funds to purchase private medical services. It has been hard for the government to accept the idea of splitting funding from provision of services. Efforts within Bank-funded projects have been limited to contracting out

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30. A case in point (although not an example of a personnel problem) is the observation that many doctors reuse needles without adequate sterilization. This happens not so much because the doctors do not know better but because of shortage of funds or unavailability of disposable needles, difficulties in using sterilization equipment in the field, and similar problems.
secondary activities such as IEC, patient recruitment, and outreach. But an increasing number of incidents of states or municipalities contracting with individual doctors or institutions are coming to light. The Bank can help by continuing to encourage such experiments, perhaps building them into projects, evaluating how they work, and bringing to bear information on how this mechanism works and is regulated in other countries.

4.16 It is probably impossible right now to develop an accreditation and regulatory system for the medical profession throughout the whole country. But a good, effective start in this direction can be made through the contracting system by clearly specifying and widely publicizing the criteria by which private service providers are selected. This would automatically create two classes of service providers and should induce clients to gravitate to those who have or are eligible to receive such contracts and give other service providers a strong incentive to obtain the background required to meet these criteria.

4.17 The key to developing a referral system that includes private doctors is to give them incentives to collaborate with referral hospitals. That is the basis for the suggestion made above in discussing referral. Here again, the initiative could usefully begin with contract doctors.

4.18 No existing policy establishes a clear division of labor between public and private health services in India; both systems seem to have grown independently. The absence of such a policy results in serious inequities if not also inefficiencies—the rich being provided with tertiary services at nominal prices, insurance companies offering inexpensive policies on the assumption that these tertiary services are available to their clients, and the poor, when adequate public services are not available, paying private sector fees or going without services. Cost recovery in public facilities can help, depending on how the poor are treated and how the funds collected are used within the system, but should be applied as part of a broader policy establishing the division of labor. A starting point to establish such a policy would be clear acceptance that the public sector must take responsibility for funding (not necessarily providing) preventive services, health education, the mitigation of environmental health problems, and the provision of at least basic health services for the very poor. Of course, it must also take responsibility for setting standards, regulating the sector, and adjudicating conflicts. Beyond this, another useful criterion is comparative advantage. Since the government seems to do a better job at interventions that can be done in the style of a campaign (cataract blindness camps, immunization campaigns) and the private sector seems to do better providing ongoing recurring services, perhaps there is a basis for a division of labor along these lines. But it should be recognized that since comparative advantage changes over time, policy decisions need to be revisited periodically. Thus, for example, it made sense for the public sector to provide tertiary services after independence when few high-quality private services were available, but the case for doing so today is much weaker.

4.19 Considerations such as these must go into any policy discussion about how to organize the health sector in India. The issues are complex and contentious, as any minister or secretary of health in Europe or North America will attest. The one thing that is clear from Western experience, however, is that making adjustments as issues arise without having thought through these more fundamental questions can lead to serious inefficiencies and inequities. The Bank can help by marshaling experience from other countries, studying how these experiences might be adapted to India, and refraining, in the projects it finances, from doing anything that would
encourage expansion of public services (not necessarily finance) into areas that could as easily be provided by the private sector. This is the focus of recently initiated sector work.

Performance-based Budgeting in Bank-Financed Projects

4.20 While the Bank cannot do anything directly about lack of accountability, it could link project performance with disbursements to give project authorities an incentive to hold others down the line more accountable. One way to do this within a project is to establish periodic—perhaps annual—agreements with the principal implementing agency about how much progress needs to be made and what performance standards maintained before the next allotment of project funds is released. To apply this mechanism, both parties would have to agree on an operational definition of “progress” and “performance,” how much progress is realistic to expect during a period, and how to measure and verify the extent of progress. Implementing agencies would find themselves with a strong incentive to establish a baseline and monitor progress since the next allotment of funds would depend on it. Funding agencies would have to undertake their own independent assessments to determine whether reports on progress were accurate. They would also have to be prepared to provide technical assistance or other inputs to help solve problems as they arise.

4.21 There should be four major benefits from using such a mechanism. First, it places more of the risks of failure on the implementing agency and thereby gives it a strong incentive to overcome constraints to progress. This agency would have to fight for complementary inputs and a certain degree of autonomy in using them if it is to succeed. Eventually the agency would find it useful to develop similar understandings with key staff and agencies on which it depends for critical inputs so that it is not held responsible for the mistakes of others. Second, this mechanism would force both financiers and implementing agencies to be more realistic about how complex and sophisticated a project is feasible and how much time and resources are required to implement it. Third, funding agencies would have to stop trying to apply the same model everywhere. The agreement that is signed in a district of Uttar Pradesh will have to look very different from the one signed in a district of Kerala. Fourth, if both parties are flexible about how the agreed targets are to be reached and how problems that arise along the way are to be solved, this mechanism would set in motion an evolutionary, trial-and-error process that should result in real, even if slow, progress over time. The one inflexible rule would have to be that funds actually stop flowing until the agreed amount of progress is accomplished. If that rule is compromised, the stimulus for the evolutionary process will dissipate.

4.22 The rigorous application of this mechanism would also have some costs. The design of projects is likely to take more time and be more staff-intensive. Disbursements are likely to be slower than under the present system. Indeed, funding agencies would be seen as being responsible for slowing disbursement when agreed progress is not achieved. At least initially, the process is likely to be disorderly and lead to some misunderstandings and conflict. Most

31. This is not to suggest a strictly laissez-faire policy. Government involvement is needed to ensure quality and accountability in the provision of services, no matter who provides these services.

32. It should help obviate the kinds of problems that arose with contraceptive targeting, though on a different level. For example, this mechanism should provide incentives for targets and indicators of progress to be selected by negotiation rather than being imposed from the top; for the establishment of rules for moving to the next step in the project that are tied to indicators that capture the spirit and underlying purpose of the project; and for the use, where appropriate, of multiple and qualitative indicators.
important and difficult, the uniform application of this approach could lead to better-off states receiving more assistance than poorer states because, typically, the poorer states are the ones least capable of effective program implementation. The Bank has been faced with this problem since the early 1990s when the government encouraged it to develop state reform projects, but this mechanism would intensify the problem. If the poorer states are not to fall farther behind, the only solutions to this problem is to lower standards for acceptable performance or to develop and use alternative delivery channels. Serious thought needs to be given to this last possibility if progress in providing health services to the poor in these backward states is to be made in a reasonable period.

4.23 USAID is applying such a system in its Innovations in Family Planning Services Project in Uttar Pradesh. The midterm review of this project presents a very positive picture of results so far but (along with interviews) also confirms the chaotic, time-consuming and staff-intensive nature of the process (USAID 1997). The Bank, through its new Adjustable Program Lending instrument, is now encouraging a similar approach and steps in this direction have been included in the RCH project and the second AIDS project, following the introduction, halfway through the first project, of such a mechanism for allocation among the states. Other donors are experimenting with similar mechanisms. These initiatives are among the most innovative and promising to come along in the foreign assistance field in a long time. They should be carefully studied, other variants tried, and the results widely disseminated and applied.

Coping with Size and Diversity

4.24 Most Indian states are larger than the nations of Africa and the differences between them are at least as great. But because these states have been pulled together into a single nation, these facts have not been allowed to influence foreign assistance programs to the extent that they should. No state in India receives as much attention or resources on a per capita basis as does any nation in Africa and its special problems have tended to be ignored or minimized.

4.25 As noted above, until the early 1990s, the government reinforced this tendency by attempting to apply a single blueprint in the health field to the whole country. Diversity was not allowed to influence project design or execution. After the passage of the decentralization amendments to the constitution, this picture began to change and the government began to encourage the Bank and other donors to think about the special needs of individual states. This created an enabling environment that has resulted in projects of significantly greater quality. The state systems projects are emblematic of this change.

4.26 But this is only a modest step in the direction of taking India's enormous size and diversity fully into account. To go further, all of the issues raised above must be considered in relation to the circumstances of individual states, rather than solely in terms of the nation as a whole. If this were done systematically, it is likely to have far-reaching implications for staffing, resource allocation, the channels through which the Bank does business in India, and relations with the central government—implications we can only vaguely imagine at the present time. The work required to derive these implications should be an important part of the Bank's agenda in India.
Appendix: Workshop Papers and Participants

As part of this project, OED commissioned a series of papers that were presented at a workshop in New Delhi on April 2 and 3, 1998. This appendix consists of a list of the topics, papers, authors, and discussants and a list of the workshop participants.

The papers are available from OED on request, by contacting Marcia Bailey (202-473-9617, mbailey@worldbank.org, or c/o OED, World Bank, Washington, D.C., 20433).

Topics and Papers

Overview of Progress (Discussant: Pravin Visaria, Institute of Economic Growth, Delhi)


Determinants of Progress (Discussant: Pravin Visaria, Institute of Economic Growth, Delhi)


Utilization and Service Quality (Discussant: Leela Visaria)

“Quality of the Family Welfare Services under the National Programme, An Overview of ICMR Studies,” Badri N. Saxena, Indian Council of Medical Research, New Delhi.

Training (Discussant: Rameshwar Sharma)


Information, Education, and Communication Programs (Discussant: Ashok Chatterjee)


Changing Signals in the Family Welfare Program (Discussant: Nirmala Murhy)


“Assessing the Impact of Target Free Approach on India’s Family Welfare Programme,” Rashid A. Ansari, et al., Center for Operations Research and Training, Baroda.

NGOs (Discussant: Vimla Ramachandran)
“The Contribution of NGOs to the Effectiveness of the Fifth and Eight Indian Population Projects,” David Mansfield, consultant (presented by Ronald Ridker).

Private Sector Involvement (Discussant: R. S. Shukla)


Decentralization (Discussant: Ravi Duggal)


List of Participants

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