

Save the Children UK

Submission to the
World Development
Report 2004:

“Making Services Work
for Poor People”



Save the Children

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Executive Summary

Save the Children UK (SC UK) welcomes the opportunity to provide feedback on the Outline of the World Development Report 2004, “Making Services Work for Poor People” (“the Outline”). SC UK is a member of the International Save the Children Alliance, the world's leading non-governmental children's rights organisation, with members in 30 countries, and operational programmes in more than 100. In 2001/2002, SC UK worked in 69 countries tackling poverty and supporting improvements in nutrition, food security, child welfare, water and sanitation services and emergency response from national to community level.

We welcome the attention being shown by the World Bank to key services for poor people. SC UK bears tragic witness to the failure of services in many contexts – in terms of mothers' and children's lives lost unnecessarily and children denied the kind of education that will enable them to fulfil their potential. Basic services are of vital importance to the well-being of children and young people throughout the world.

In particular we welcome and fully support the following:

- The recognition in the Outline that economic growth will not be enough on its own to meet the Millennium Development Goals. We agree that more than growth is required to achieve improvements in welfare outcomes. A UNICEF and UNDP report on high-achieving countries in terms of education and health outcomes found that they did not pursue economic growth first, before attending to social development; rather they addressed economic and social development simultaneously.¹
- The references to the role of donors, especially the recommendations at the end of the Health chapter, and the emphasis on donor accountability. The focus on donor support meeting recurrent expenditure for services for the poor is positive and should be further emphasised and broadened to include infrastructural costs.
- The view that broad expenditure programmes are more progressive than project support. Budget support is also welcomed as a step forward.
- The acknowledgement of the risks of thematic global funds, especially in relation to national priorities.
- The very important recognition that conditionality undermines national ownership of policies.
- The statement in the Introduction to the Outline that the biggest payoffs in health, “will come when the accountability of policy makers, providers and households shifts to improving outcomes; greater use of pro-poor contractual arrangements, better information to households and enhanced civil society oversight will help.”² We agree strongly with this statement. The way that health outcomes are analysed should also be reassessed and spending priorities need to change.

¹ Mehrotra and Delamonica, (forthcoming)

² Introduction to the Outline

However, we have a number of concerns, both with regard to the overall analysis and in relation to specific policy areas. Some of the shortcomings in the Outline are a result of the constraints imposed by the analytical framework it adopts. The 3 (or 4) actor framework adopted by the Outline has value as a tool to help analyse the relationships between key actors in service provision, but strengthening relationships should not be the primary focus of interventions to improve basic services for poor people.

The issue of power relations, while touched upon, is not adequately addressed. An adequate analysis must ask where the power lies in each of the relationships being discussed, and how strategies can be implemented to address this. The Outline also fails to elaborate mechanisms to strengthen the voices of the poor, and the particular difficulties faced by weak states are insufficiently dealt with. The 3 actor framework is discussed in Section I.

SC UK's main criticism of the Outline in its present form is its failure to fully acknowledge the importance of adequate resources to ensure basic service provision. While this issue is mentioned, it is not given the prominence it deserves. In SC UK's analysis, lack of resources is the primary reason for the failure of public systems in some countries to provide adequate services to their citizens. Conversely, those countries that have been able to provide relatively good public services are those that have persistently allocated resources to them. This issue is discussed at length in Section II.

It is in a context of a severe lack of funds that the private sector is being mooted by many decision-makers as a key player in basic service provision in developing countries. The second of SC UK's main concerns is the equivalence implied in the Outline between private service provision and public systems. There is evidence of private sector involvement achieving results in some areas. However, this is mitigated by concerns that very often the poor are excluded from any gains made, and that they often become worse off because of the inequity which frequently results from opening up basic services to market forces.

Some of the problems associated with private sector involvement are discussed in Section III. While we acknowledge a role in the provision basic services for private actors in some contexts, we hold the strong assumption that policy makers should work towards a situation where good quality health and education services are delivered free at the point of use to vulnerable and low income households through state provision.

Section IV deals with the related topic of User Fees. SC UK research supports a wide body of evidence that demonstrates the dangers associated with charging clients at the point of use for health and education services. Almost invariably cost recovery mechanisms of this type have the effect of dissuading the poor from accessing these services. Where the poor to pay for services, they are often forced to make hard choices about what essential good (such as other services or household commodities) they will do without. Exemption mechanisms attempting to mitigate this impact have not tended to work.

On top of these concerns, we draw attention to the lack of evidence to demonstrate any revenue collected from user fees is significant. SC UK believes that the WDR should strongly discourage policy-makers in poor countries from adopting user fees and urge them to find other ways to finance health and education services.

Sections V, VI and VII deal with other specific policy areas. Joint Public Private Initiatives are growing in importance in development strategies. In this submission, SC UK makes a number of recommendations about how and when they can be used effectively, and some of the problems associated with them.

Nutrition and Social Protection are both areas of vital importance to the well-being of children, but are only briefly touched on by the Outline. SC UK's research shows that the current approach adopted by the World Bank in its nutrition programming is not working, because it is based on a series of false assumptions. Social welfare is a vital basic service area for poor people and warrants similar discussion as given to health, education and water and sanitation.

Recommendations

On the basis of our analysis of the Outline and our experience of delivering basic services to poor people in developing countries SC UK makes the following recommendations to the authors of the World development Report 2004. These recommendations can also be found in the body of the submission.

Power relations

- The Outline fails to adequately address the issue of power in its discussion of the relationships between actors. Questions about where power lies, the consequences of such power, and strategies to empower the powerless, should be central to the WDR's critique and recommendations.
- The Outline should answer how, in practice, the poorest and most excluded can be enabled to hold providers and policy makers to account.

Public resources

- While the relationships between different actors are of vital importance in effective basic service provision, and the allocation of scarce resources is also critical, inadequate investments may be as or more critical. A growing body of evidence shows that sustained high-levels of investment in social sectors can lead to good educational and health services and outcomes. The WDR should reflect this evidence in its analysis, and call for urgently needed increases of resources to fund basic services.
- The WDR should acknowledge public expenditure trends that show significant reductions in health and education spending in many countries, especially in Latin America, the Caribbean and Sub-Saharan Africa, during the 1980s and 1990s. According a low fiscal priority to social services partly accounts for poor health and education outcomes. This fact should be central to solutions recommended by the WDR to improve the current situation.
- Donors should be encouraged to increase their funding of publicly provided basic services such as health, education and water. Donations should not be conditional on private sector involvement.

Private sector

- The public and private sectors should not be treated as equivalents in the health, education and water sectors. Private sector participation in basic service provision can involve a number of inherent dangers for poor clients. The WDR should reflect these clearly.
- Private sector involvement in basic service provision can undermine the long-term viability of an efficient and equitable public sector. The WDR should state that all such private sector involvement should be with a view to strengthening, rather than undermining, public systems.

- The WDR should warn policy makers about the dangers inherent in encouraging or allowing the development of a two-tier system of service provision, with lower income households accessing a poorer quality of services. Such a system is likely to result from increased private sector participation.
- Without adequate regulatory capacity, private sector participation in service provision is a matter of concern, because the needs of the poor are unlikely to be met. The WDR should recommend what regulatory mechanisms must be in place before private sector involvement should be contemplated as a possible policy option.

User fees

- SC UK endorses the need for a sector-by-sector and case-by-case approach to cost recovery mechanisms. However, we urge the World Bank to take a firm stance against user fees for basic health and primary education services except where there is overwhelming and uncontested evidence in their support.

Joint Public Private Initiatives

- The WDR should discuss which criteria are required to ensure that Joint Public Private Initiatives deliver broad and sustainable benefits to all.
- The financial sustainability of Joint Public Private Initiatives is vital. While stressing the need for greater co-ordination between donors and recipients, the Outline focuses on short-term forms of co-ordination e.g. agreeing funding priorities and joint supervision. The WDR should recognise the imperative that the process of co-ordination include open discussion between donor and recipient about the sustainability of any initiative beyond the initial implementation phase.

Nutrition

- Nutrition is one of the vital components of successful health outcomes. The WDR should include a substantially increased section on nutrition.
- SC UK research and operational experience show that growth monitoring and promotion is an inappropriate service for poor people in many contexts. The WDR should scrutinise this policy and suggest alternatives, in the light of SC UK's evidence.

Social Welfare

- Social welfare services and social workers are often vital in enabling vulnerable children to achieve their right to education, health and social development. The WDR outline should include a chapter on social welfare services.

I The 3 actor framework

The framework proposed by the Outline has the potential to become a useful analytical tool to identify effective responses to different kinds of failure in basic service systems. But SC UK does not agree with the proposition that strengthening the three-way relationships should be the overriding aim of interventions to improve basic services for poor people. The proposals for reform in the Outline are insufficient because:

- the analysis of why services have failed poor people is incomplete,
- power relations are inadequately addressed,
- mechanisms for strengthening the voices of the poorest are not elaborated, and
- the Outline fails to provide solutions that will work in the weakest states, particularly in those countries affected by conflict.

Why have services failed poor people?

The framework does not provide a basis for designing interventions in response to a broader analysis of why services have failed poor people in each country context. Very different approaches may be needed to respond to failures of governance, for example, or of financing, or of political will, or of administrative capacity. Subsuming these different responses under “strengthening the relationships” obscures the context-driven analysis needed to make services work in very different situations.

For instance, the Outline takes as its starting point the observation that most states have failed to provide good quality services for poor people without any analysis of the international pressures on southern governments. It ignores the financing crisis, often exacerbated by structural adjustment, which has led to dramatic reductions in service provision in some countries. It ignores the EU and US-imposed tariff barriers that have undermined governments’ ability to fund better services. It lacks an analysis of the conditions under which poor states have succeeded in rapidly expanding service provision. If these various factors are not properly considered, the policy responses recommended in the WDR may not be the most effective at reaching the poor. We explore this further in Sections II and III.

Power relations

The framework requires a much stronger disaggregated analysis of who benefits and who loses out within the relationships between citizen, service provider and policy-makers. Too often it treats a category such as ‘citizens’ or ‘providers’ as a uniform group with common interests.

Simply strengthening the different relationships may have no effect on service provision for the most marginalised children and communities. A high proportion of those excluded from good quality services are the powerless in society. Strengthening the relationship between “clients and providers” or “clients and policy-makers” – without asking which groups of clients have greatest power within these relationships – has the potential to further marginalise those adults, children and entire communities in each society who are seen as politically unimportant, who have least resources, or who are the targets of direct discrimination.

The task of reaching those most excluded from service provision is a key challenge ignored in the current Outline. Equally, it is not only the poorest of the poor who are

ignored in many of the prescriptions suggested in this framework. The idea of improving basic education by offering a choice of providers is so far from the reality faced by the poorest half of the population in many countries of the Sahel, for example, that it suggests a textbook response completely cut off from any context-driven analysis. Even if there were the resources to offer sufficient incentives to multiple service-providers in these circumstances, the effect of power relations in determining who succeeds in choosing the best options is ignored.

The statement that, “citizens . . . ultimately control the policymaker”³ exemplifies this lack of analysis. A more rigorous consideration of which citizens control or most strongly influence which policy decisions in each country would lead to quite different policy prescriptions. Strengthening the power of the poorest over policy decisions is an altogether different task from strengthening generic links between citizens and policymakers. It is unlikely to be initiated by those policymakers, and is equally a difficult political intervention for donors to make. So a further dimension of power relations missing from this analysis is: who are these recommendations *for*, and what is the political feasibility of different kinds of reforming interventions in different contexts?

Similarly, the discussion of the relationship between policymakers and providers lacks a clear understanding of the power dynamics between different policymakers and a multitude of possible providers, each with competing interests. There is a theoretical set of rules devised by policymakers under which providers operate⁴, but the way in which regulation actually influences the behaviour of providers is crucially determined by power relations between them. Again, simply strengthening the relationship may miss the point that states with weak capacity to deliver services are equally unable to regulate the non-state provision of services, resulting in further exclusion of the least powerful citizens in situations where private providers may have little incentive to meet their needs other than through the exercise of regulation.

Voices of the poor

The framework does not provide answers to the question of how, in practice, it is possible to strengthen the voice of the poorest and most excluded in holding providers and policy-makers to account. Strong experience from NGOs and rights groups in this area needs to be reflected in the final report.

In Nepal, for example, SC UK has supported the development of a community-based Education Management Information System.⁵ Community members (e.g. School Committees) are trained to do their own research and analysis of who is not in school, and the reasons behind this. They then work with local government to develop solutions that respond to their own analysis. The information is used locally for planning, but not taken over by central government in a traditional monitoring approach, which would introduce incentives to distort the data. But central government has been closely involved in the pilots, looking at how the approach could be replicated more widely. Power relations have been turned on their head: communities collect, own and analyse the data, they use them to influence and support local government, and this in turn informs central government policy.

³ Outline p8

⁴ Outline p8-9

⁵ Save the Children UK (a)

In Kasur, Pakistan, the NGO Sudhaar worked with communities to develop their own indicators for what makes a good teacher.⁶ Sudhaar then persuaded the district authorities to adopt these indicators as the basis for teacher promotion. The earlier corrupt appointments of head teachers has been replaced with a merit-based system, leading to a measurable improvement in school leadership and the effectiveness of schools in the area.

Low Income Countries Under Stress

The World Bank's task force report on Low Income Countries Under Stress sets out an approach for improving the provision of basic services as one of two top priority objectives that will be applicable across these diverse contexts. Yet the Outline does not reflect the detailed analysis contained in this task force report. For countries where governance, financing and capacity are all very weak, the question of how to respond (and crucially, in what sequence) is hardly addressed.

Key propositions in the LICUS report show a clearer understanding of the reform process than the Outline's generic "strengthen the relationships" approach. For example, the LICUS report suggests, "Choose reforms that meet the least resistance and that offer quick pay-offs to groups that are potential constituencies for further reform."⁷ A proposition such as this needs testing against likely consequences for equity, but is potentially a more useful idea than the one the Outline proposes: "Where the whole service-delivery chain is so weak, the only solution is for outsiders, e.g. donors, to intervene by setting up parallel structures to the public service delivery system."⁸

NGOs also have useful experience to offer in these contexts, which needs to be reflected in the final WDR. For instance, in rural Douentza, Mali, SC UK has supported the training of local parent-teachers for community-managed schools.⁹ Because the teachers are locally recruited, their ability to teach in the children's mother tongue has enabled the children to achieve results comparable with those in state-run schools. It is an interim solution as communities cannot meet the costs of paying teachers' salaries, but the lessons learned are strengthening the capacity of the state system. For example, the training for teachers to make a transition from teaching in mother tongue to French has influenced government teacher-trainers. And the example of successful mother-tongue-to-French transition was important in strengthening the hand of those in the Ministry of Education who sought to broaden this approach throughout the country's formal education system.

Another example of NGOs helping to strengthen the public system is in Mtwara District of southern Tanzania where SC UK has worked with the district education authorities and the schools inspectorate to enable Ward Education Co-ordinators to provide ongoing support to teachers and school committees.¹⁰ Ward Education Co-ordinators are local government employees, supporting a cluster of schools. Previously they had neither transport nor skills to reach schools with the support needed; now a low-cost combination of bicycles and training has enabled them to provide planning training to school committees, enabling schools to take a systematic approach to improving

⁶ Save the Children UK (b)

⁷ Key LICUS proposition 11

⁸ Outline p12

⁹ Save the Children UK (2000a)

¹⁰ Save the Children UK (2002a)

education for poor children. Some Ward Education Co-ordinators provide ongoing coaching to teachers, overcoming the failures of one-off, exam-based teacher training. The Ward Education Co-ordinators provide a bridge between communities and local authorities, enabling school committees to inform district-level decisions through the priorities outlined in their school plans. The local government system could easily replicate this model at minimal cost.

The WDR must represent NGOs and other non-state providers as playing a potentially key role in strengthening the capacity of government service systems, not as mere alternative providers where states are weak. For further discussion of this see Section III on private sector involvement.

Recommendations

- The present WDR outline fails to adequately address the issue of power in its discussion of the relationships between actors. Questions about where power lies, the consequences of such power, and strategies to empower the powerless, should be central to the WDR's critique and recommendations.
- The Outline should answer how, in practice, the poorest and most excluded can be enabled to hold providers and policy makers to account.

II Resources and the public sector

The overall approach of the Outline is that the status quo, and particularly a model of public services provided by a centralised agency, is failing to deliver quality services. It locates the reasons for the failure of the public sector to deliver principally in the relationships between three different sets of actors. This point of departure underplays the key constraint of inadequate financial resources and the extent to which it underpins poor quality services. It also fails to acknowledge both the very substantial welfare achievements made by a number of developing countries through public provision and financing of health, education and water services, and the reasons for erosion of delivery capacity in some countries over the last 20 years.

The WDR's recommendations for how to improve health, education, water and sanitation services for the poor will depend heavily on the analysis it makes of the present situation. A serious and comprehensive analysis of the reasons behind poor quality public services in many countries must take into account public expenditure trends in those countries, since much research shows that where countries have sustained public spending on basic services, outcomes have steadily improved.¹¹

While the Outline briefly recognises in its introduction the importance of additional finance, it does so in the context of a general critique of the effectiveness of public services. The implication is that the 'strengthening' of the relationships between client, service provider and policy maker is much more important.

However, SC UK's experience of supporting service delivery suggests that the acute lack of resources is absolutely critical. This message needs to be sent much more strongly.

The Bank's own Health, Nutrition and Population Sector Strategy makes a more balanced summary analysis of the present situation, and may be helpful as a basis for a revised introduction to the WDR.

“As shown by broad international experience, the underlying threats to good health, nutrition, and population outcomes are well known, and affordable solutions are frequently available. But, because of weak government implementation capacity and market imperfections in the private sector, potentially effective policies and programs often fail.”¹²

The recognition of weak government implementation capacity and the clear acknowledgement of the 'market imperfections' of the private sector are welcome. The strategy goes on to highlight the need to secure 'adequate financing'.

Research carried out by UNDP and UNICEF in more than 30 countries across Africa, Asia and Latin America, found that average public expenditure on basic social services is, on average, between 12 and 14 per cent of government spending¹³. Many countries spend more on servicing external debt than they do on basic services.

¹¹ e.g. Mehrotra and Delamonica, forthcoming

¹² World Bank (a)

¹³ Mehrotra and Delamonica, forthcoming

In many low-income, highly indebted countries, the low level of spending is explained by the lack of fiscal space. For instance, Ethiopia spends 22% of its national budget on health and education, but this amounts to only US\$1.50 per capita on health. Even if Ethiopia were to spend its entire budget on healthcare, it would still not meet the WHO target of US\$30-40 per capita.¹⁴

Successes achieved via public financing and provision

The Outline does not sufficiently recognise the successes achieved through the public financing and provision of basic services where there was political will and sustained commitment. A UNICEF paper on achieving basic services for all draws the conclusion that,

“There is a clear link between human development indicators, such as infant mortality and primary school enrolment, and the fiscal priority given by governments to basic social services.”¹⁵

This is supported by evidence from Malawi. Between 1990 and 1994 Malawi increased its spending from 11% to 18% of its national budget, with the share for primary education rising from 42% to 60%. This increased fiscal priority for education was linked to a doubling of school enrolment over the same period. User fees were also abolished in this period, an issue discussed in Section IV.

In a UNDP and UNICEF study of education and health outcomes in ten high-achieving countries across Africa, Asia and Latin America – Barbados, Botswana, Costa Rica, Cuba, Kerala state (India), Malaysia, Mauritius, South Korea, Sri Lanka and Zimbabwe – educational expenditure as a proportion of GDP was higher for the high-achievers relative to the region to which they belong, without exception, for the period 1978-1993. The same was true for health expenditure for all but one of the ten countries (South Korea).¹⁶

While the rest of Sub-Saharan Africa spent an average of about 1% of its GDP on health care between 1978-93, the high-achievers identified by UNICEF and UNDP spent over 2%.¹⁷ As well as adequately funding basic social services during growth, public expenditure in these countries was protected during economic stagnation and recession, when other governments tended to cut their budgets.

A relatively high priority was assigned in high-achieving countries to allocative and technical efficiency – the Outline’s commitment to allocative efficiency is therefore welcome. Primary health care was emphasised in the organisation of the health care system, and efforts were made to offset the urban bias. There was a similar approach in education, with primary education receiving a share of public education expenditure well over that of other developing countries.

While there are many factors that affect positive health and education outcomes, the critical importance of resource allocation is demonstrated by the evidence from these high-spending countries. The selected ten countries significantly out-perform their

¹⁴ Russell and Abdella (2002)

¹⁵ Mehrotra, Vandermoortele and Delamonica (2000)

¹⁶ Mehrotra and Jolly (1997)

¹⁷ Mehrotra (2000) p7

regions in both health and education indicators. In health, for example, whereas the infant mortality rate in the rest of Sub-Saharan Africa was 109 in 1993, Botswana, Mauritius and Zimbabwe had rates of 43, 19 and 58 respectively. Maternal mortality in the East Asia and Pacific region between 1990-92 was 159 – in Korea and Malaysia it was 26 and 59 respectively. In South Asia maternal mortality registered at 492 for the same period, in Kerala State and Sri Lanka it was 87 and 80 respectively. Finally, life expectancy at birth in 1993 averaged 68 in Latin America and the Caribbean – in Barbados, Costa Rica and Cuba the figure was 76.¹⁸

In education, adult literacy is significantly better in all ten high-spending countries than the regional average for both men and women, except for Malaysia (there are no figures for Barbados). For instance, male literacy in Sub-Saharan Africa in 1990 was 61%, and female literacy was 40%. However, in Botswana the figures are 84% and 65%, in Mauritius they are 85% and 75% and in Zimbabwe 74% and 60%.¹⁹

A forthcoming UNICEF and UNDP review of successes in human development comes to similar conclusions. The state plays an important role in the provision of basic social services. High-achieving countries did not rely on the free play of the market, on 'trickle down', or on narrowly targeted programmes as the mainstay for achieving universal coverage.²⁰

Growth in spending on a social sector permits a steady and financially sustainable development of that sector, since the extra resources required to sustain new developments become available year on year. If there is stagnation in spending, such new developments are likely to atrophy. In practice, real growth in spending may be required simply to ensure the continued effectiveness of existing services since population growth places greater demands on facilities and programmes.²¹

Erosion of public service delivery capacity over the last 20 years and consequences for health and education

Over the last 20 years, public service delivery capacity has been substantially eroded in many countries undertaking adjustment reforms, particularly in Sub-Saharan Africa, Latin America and the Former Soviet Union. Both statistical and qualitative evidence bear witness both to the decline in resources dedicated to public services in many countries in these regions over the last two decades and to the effects this has had on the wellbeing of their citizens. One study suggests that the declining share of government expenditure and the poor economic performance of the 1980s combined to cause cuts in real social expenditure per capita in half of all developing countries.²²

A study of 21 Latin American and Caribbean countries found that 16 experienced a real decrease in government health spending during the early 1980s, while five showed no change or an increase.²³ A review of health spending trends in Sub-Saharan Africa from 1975-85 showed that average growth in real per capita spending slowed from 3.16% to 1.87% per annum and was reversed (i.e. spending declined in real terms) in 12 out of 22

¹⁸ Mehrotra and Jolly (1997)

¹⁹ Mehrotra and Jolly (1997)

²⁰ Mehrotra and Delamonica, forthcoming

²¹ Mehrotra and Jolly (1997)

²² Ebel (1991), cited in Smithson (1994)

²³ Musgrove (1987), cited in Smithson (1994)

countries.²⁴ The decline was particularly severe in Africa and Latin America – in Asia and the Middle East rising real government expenditure on health was the rule rather than the exception.

In Sub-Saharan Africa public spending on health and education declined in both per capita terms and as a ratio of GDP between 1980 and 1993 (however in ‘high-achieving’ countries such as Botswana, Zimbabwe and Mauritius it did not decline).²⁵ Health expenditure fell in real terms in Uganda by 90% between 1972 and 1987, and in Ghana by 80% from the mid 1970s to the early 1980s.²⁶ Public expenditure on health and education in Zimbabwe declined substantially since it embarked on a structural adjustment program in 1991

Countries in Sub-Saharan Africa saw an increase in primary school enrolment from 39% in 1960 to between 80-85% in the early 1980’s. Some countries (including Angola, Botswana, Cape Verde, Kenya, Mozambique, Nigeria and Tanzania) had almost achieved universal enrolment by that time.²⁷ However spending in the region declined sharply during the 1980s, from an average of 3.8% of GNP in 1980 to 3.1% in 1988.²⁸ Given the economic stagnation or recession being experienced by many countries in the region this fall translated into a steep decline in per capita spending on education. Gross primary education enrolment in Sub-Saharan Africa consequently fell to around 75% by 1990.

The World Bank’s own evidence indicates a recognition of the extent to which underfinancing has compromised public health service delivery in Sub-Saharan Africa. For example:

- **Zambia:** “The people have nowhere to turn for help. Those [rural] buildings which have been historically primary health care centres or district hospitals are often empty shells. Many institutions are losing qualified health personnel, are utterly devoid of basic health materials.”²⁹
- **Madagascar:** “In 1985, the government budget for drugs and supplies decreased to one fifth of its 1977 level and only 10 percent of programmed medical imports were realised. This low level of expenditure only allowed primary health care centres to cover barely 25 percent of patient drug requirements...as a result real value of overall drug consumption in Madagascar declined by 30 percent between 1976-85.”³⁰
- **Nigeria:** “...Not only were capital investments suspended, resulting in unfinished infrastructure, but recurrent expenditures were drastically reduced to levels that could not support such routine functions as the payment of salaries, supply of essential consumables (drugs and instructional materials), and maintenance of facilities. The result has been a significant decline in the quality of services.”³¹

²⁴ Vogel (1989) cited in Smithson (1994)

²⁵ World Bank figures cited in Mehrotra (2000)

²⁶ Sustainability and health sector development, Lafond (1994)

²⁷ World Bank (2000)

²⁸ Africa Recovery

²⁹ World Bank (1992)

³⁰ World Bank (1996a)

³¹ World Bank (1996b)

- **Niger:** “After 1980... Niger's adjustment to economic crisis may have worsened inequality and poverty – notably the protection of public sector wages and deep cuts in government expenditures on health, education, agriculture, and the infrastructure (especially in rural areas)...the poor have virtually no access to medical care, education, and other social services.”³²
- **Tanzania:** “Health system performance suffered because of a lack of training and poor motivation of doctors and health workers, shortage of supplies, breakdown of transportation and inadequate management over a dispersed rural health system. In urban areas the health situation was worse. The quality of hospital care declined dramatically and clinics became increasingly crowded. Some dispensaries in Dar Es Salaam, for example, were attempting to cater for over 300,000 people.”³³
- **Senegal:** “There is ample evidence that the adequacy and quality of Senegal health delivery services in the public sector have deteriorated significantly over the last decade: data from 1978-86 show decline in consultations, in clients seen and in hospitalisations, all against a background of increasing population and a reduction in health facilities generally (fixed investment was 27 percent higher in the period 1981-85 than 1986-90).”³⁴

More recently, similar impacts can be seen in transition countries. A 1998 UNICEF report examining education in 27 post-communist countries in Central and Eastern Europe and Central Asia, also links the scale of public expenditure to the quantity and quality of education services.³⁵ It identifies six areas of focus for a public policy that would both improve education in general, and increase opportunities for less-advantaged children, including *Parental and community participation*, *Content and methods of teaching and learning*, and *Control of methods and standards*. The first and vital issue was *Financial resources and their distribution*.

Quality is linked directly with levels of public expenditure:

“The quality of schooling has fallen. Huge reductions have taken place in many countries in real public expenditure on education – by almost three-quarters, for example, in Bulgaria. Teacher morale has often declined along with pay, with negative consequences for the quality of instruction. Buildings and equipment have suffered disproportionately from spending cuts, and there are schools in many countries that are in a dire state of disrepair. The heating of schools in winter has become a serious problem in a number of countries, for example, Kyrgyzstan, Moldova and FYR Macedonia.”

Along with this fall in quality have come rising costs for students (see below on User Fees). The report calls for an increase in the share of national income devoted to education arguing that more money needs to be spent on teacher pay, buildings and equipment. This reduction of expenditure and consequent reduction in quantity and quality of service has also impacted on other sectors including social support and health:

³² World Bank (1996c)

³³ World Bank (1991)

³⁴ World Bank (1993a)

³⁵ UNICEF (1998a)

“Social support provided by schools is down. The provision of meals and the supervision of children after school have fallen. Health and dental checks are less common; for example, 670,000 basic grade children in Georgia received a health check-up in 1989, but only 250,000 in 1996.”

According to the report over 30,000 pre-schools have closed between 1991 and 1995 in the countries of the Commonwealth of Independent States, as money has dried up.

Central Asia has experienced a particularly devastating period for education leading to fears that a whole generation’s education is in jeopardy. Prior to independence Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan had adult literacy rates of close to 100%. These high trends have seen a decline since 1991. Enrolment in secondary education has fallen by an average of over 23% in these countries.

A particularly serious concern is the almost 40% drop in pre-primary enrolment in these countries, with Kyrgyzstan experiencing a 70% fall and Kazakhstan a 55% fall. Kindergartens have historically played a key role in raising household welfare in Central Asia, both by freeing up parents to engage in economic activities, and by providing young children with educative, nutritional and general health interventions. Under-resourcing in remaining kindergartens undermines their capacity to provide these services to young children.³⁶

Although primary education, which is still compulsory, has dropped by only an average of 4% (10% in Kyrgyzstan) this does not take into account declining school attendance. 40% of children take extended absences from their schools in some regions, due to child labour and increased poverty. Increasingly families are paying the costs of education such as books, meals and transport.

Although there are a number of causes of this decline in education services and outcomes, a major factor must be public expenditure, which has declined dramatically. Education expenditure as a percentage of GDP has fallen dramatically in each country of the region between 1991 and 1996 (e.g. by over 80% in Tajikistan and over 50% in Kazakhstan). As GDP has also substantially decreased the real expenditure on education in 1996 was running at between a quarter and a third of pre-independence levels. Both Kyrgyzstan and Tajikistan make commitments to increase education and health spending in their I-PRSPs. However, economic decline has been so severe that these funds may not be sufficient to provide adequate services.

The Outline’s recommendation that, “donor funding for health services need to focus on recurrent expenditure, including support to human resource development and incentives to serve the poor,”³⁷ is definitely a step in the right direction and should also apply to other basic services.

Recommendations

- While the relationships between different actors are of vital importance in effective basic service provision, inadequate investments may be as or more critical. A growing

³⁶ Klugman et al (1997) quoted in Falkingham (1999)

³⁷ Outline p48

body of evidence shows that sustained high-levels of investment in social sectors can lead to good educational and health services and outcomes. The WDR should reflect this evidence in its analysis, and call for urgently needed increases of resources to fund basic services.

- The WDR should acknowledge public expenditure trends that show significant reductions in health and education spending in many countries, especially in Latin America, the Caribbean and Sub-Saharan Africa, during the 1980s and 1990s. According a low fiscal priority to social services partly accounts for poor health and education outcomes. This fact should be central to solutions recommended by the WDR to improve the current situation.
- Donors should be encouraged to increase their funding of publicly provided basic services such as health, education and water. Donations should not be conditional on private sector involvement.

III Private sector involvement

The failure to adequately discuss the resource constraints that are a major factor behind public service failure is directly linked to a tendency, apparent in the Outline and elsewhere in World Bank documents, to make assumptions about the ability of private sector actors to deliver affordable services of good quality. Such assumptions often do not take into account existing evidence concerning private sector participation in basic service provision.

The WDR 2004 is being written in the context of an increased drive in the World Bank to encourage the involvement of the private sector in basic service provision in the developing world (see below). The view that the private sector provides many of the answers to public service failure is shared by the International Development Association (IDA) and International Bank for Reconstruction and Development (IBRD) and the International Financial Corporation (IFC).

Both IDA and IBRD adjustment loans promote private participation in infrastructure services, including water. As outlined in the World Bank's Private Sector Development Strategy,

“Adjustment lending has become an important vehicle for promoting private participation in infrastructure, focusing on privatisation of infrastructure enterprises, sectoral reform to allow new entry and development of regulatory frameworks and institutions. To attract private investment, adjustment lending programs support the implementation of a number of key measures to strengthen the investment climate.”³⁸

“...the share of conditionalities related to private participation in infrastructure as a part of adjustment lending more than doubled between FY96 and FY99, involving the privatization of infrastructure enterprises, sectoral reforms to allow new private entry, and development of regulatory frameworks and institutions.”³⁹

Drawing on its experience in infrastructural reform, the IDA/IBRD is increasingly seeking to use similar mechanisms to support an enhanced role for the private sector in the provision of social services.

“Drawing on relevant experience in private participation in infrastructure, the Bank would focus on developing policies, institutions and capacity to support effective and useful private forms of participation in the health and education sectors. Typically, this would be operationalized in programmatic lending or technical assistance work.”⁴⁰

³⁸ World Bank (2002) Para 69

³⁹ World Bank (2002) Para 63

⁴⁰ World Bank (2002) Para 148

“...as the importance of the private sector has become more widely recognised, more and more World Bank loans have included components that support the private health sector.”⁴¹

This policy is being strategically supported by the IFC, who recently established a department focussing exclusively on direct support for private forms of participation in health and education projects:

“IFC is also moving aggressively to invest in sectors where we believe there is substantial scope for more private sector involvement. This ranges from water and transportation investments to healthcare, education, and the environment. Not that we believe the private sector should replace the public sector, but private education and healthcare can and must complement the public providers of these services. And a little bit of competition will create innovation in these areas, often desperately needed, and hopefully this will have a positive spill-over effect on badly run public service providers.”⁴²

It is unclear from the Outline what precise analysis and recommendations the WDR will adopt with regard to when and how to use private sector providers for health and education. However, given the brief introduction, the tone with which the public and private sectors are respectively referred to, and the context, explained above, within which the report is being produced, an overall picture emerges of strong support for increased private sector provision supplementing public provision.

While not opposed in principle to the private sector playing a role in enabling countries to provide basic services, SC UK has a number of serious concerns in relation to increased private sector provision of these services. They include equity issues, affordability for poor people, the danger of further undermining public delivery systems, the conflict between profit imperatives and delivery of services to poor people. There is no clear evidence of greater efficiency in the private sector and the capacity of poor country governments to regulate the private sector, a vital component of success, is limited. These issues are discussed below (user fees is the subject of the following section).

Equity

A frequent outcome of increased private sector participation in the provision of basic services is the emergence of two tiers of services provision – one for those who can pay, and one for those who rely on free services. Tiered system of this kind are a reality in a number of countries, explicitly anticipated in others, and supported in principle by the World Bank as practicable and equitable. For example, the World Bank’s Education Sector Strategy comments that,

“The more that better-off families pay for education (as they do when they choose private education), the more the government can use its resources for the poor.”⁴³

⁴¹ IFC (2002)

⁴² Woicke (1999)

⁴³ World Bank (b)

In Nicaragua's SGPRS (PRSP equivalent) health reforms are planned that,

“will permit the [Health] ministry to focus its direct programs on the poor – via public and private health providers – while increasingly leaving the provision of health services to more fortunate Nicaraguans to the private sector.”⁴⁴

This argument is a common one and demands serious consideration. However, SC UK is concerned that the poorest people in society generally suffer when two tiers of basic service emerge, or are actively encouraged. While the intention of “freeing up” public resources to focus on poor households is commendable, there is little evidence so far that the resources are redirected in reality. This lack of evidence is acknowledged by the IFC.

“By producing extra capacity in the sector as a whole, the public sector will be able to redirect its scarce resources to those most in need. This argument has traditionally been very compelling and therefore much used as a justification for private sector involvement. However it is undermined by a lack of any real evidence.”⁴⁵

In the health sector, for example, some argue that private health insurance is a mechanism that can allow such freeing up of resources.⁴⁶ However, reforms in Chile, and to a lesser degree Argentina, have allowed people with private insurance to opt out of primary financing mechanisms making less money available to subsidise health for the poor.⁴⁷ Incentives to encourage private insurance, such as the South African system of giving tax breaks on contributions, have the effect of subsidising those already purchasing insurance, again reducing money available for publicly-funded health services.⁴⁸

“Experience in the USA and more recently in Latin America is that the viability of public and voluntary hospitals and health services is threatened when they have to compete with commercial providers for per-person public funds, private insurance and copayments. Typically, the public sector has been left to bear the risk for more vulnerable populations but with diminished risk pools (or pooled funding) to finance care.”⁴⁹

Drawing on an SC UK study of health financing in Ghana, Nepal, Pakistan, Uganda and Vietnam, Smithson (1994) summarises these issues well. He stresses the difficulty of putting well-intentioned policies into practice. Commenting on the possibility of charging for services in urban hospitals and cross-subsidising primary services he comments:

“In practice such ‘distributive objectives’ are difficult to achieve, not only because of the theoretical and political difficulty in diverting the proceeds

⁴⁴ Government of Nicaragua (2001)

⁴⁵ IFC (2002)

⁴⁶ The World Bank advocated policies incentivising the purchase of private health insurance in World Bank (1993b).

⁴⁷ IFC (2002)

⁴⁸ Bennett and Gilson (2001)

⁴⁹ Price et al. (1999)

from the point of collection, but also because public budgeting mechanisms often preclude the retention and redirection of savings made in one part of the health system for use in another.⁵⁰

Clearly, a critical aspect of whether private or state services are available to poor people is how much they cost users – this will be discussed in the following section.

The experience of the water sector in many developing countries supports the view that private sector participation in vital services should be treated with extreme caution. Privatisation of water and sanitation services has been growing rapidly in the last decade. Private sector capital expenditures in water and sanitation services in developing countries rose from \$297 million between 1984 and 1990 to \$25 billion between 1990 and 1997.⁵¹ However the evidence is at best mixed on the benefits the poor have derived.

A recent international fact finding mission on water sector reform to Ghana concluded that the present proposal to increase private sector involvement is unlikely to improve access to clean and affordable water and sanitation services.⁵² This is mainly because affordability could deteriorate even further than it already has (water tariffs were increased by 95% in May 2001) and there is no specific plan for protecting low-income consumers. While the proposal to provide connections free or at a subsidised rate is welcomed, concerns are raised that the economic criteria upon which improvements will be based will lead to a prioritisation of wealthier areas over lower income communities.

A series of 14 case studies carried out by WaterAid provides a balanced overview of private sector participation in water and sanitation services.⁵³ While some benefits have accrued in a few cases, the general tenor of the analysis is that the poor have not benefited significantly. A report of a rural water project involving private sector participation in Uganda found that a 10% community cash contribution, managed in a 'poor-unfriendly' way, excluded the poorest, and the preference of contractors for 'quick-fix, easy-to-install technology options' had left those in difficult-to-reach areas unserved.

The stratification of education is becoming an increasing concern in countries in Central Asia, such as Azerbaijan and Kyrgyzstan. A huge decrease in public spending on education since independence has been accompanied by major decreases in enrolment in pre-primary, primary and secondary education, and declining school attendance. Costs at all levels of the system have steadily increased causing poor families to drop out.⁵⁴

At the same time there has been growth in the tertiary sector in Central Asia, almost all of it privately funded. Kyrgyzstan has seen the emergence of eight new universities and 24 new colleges. While one might expect growth in any sector of education to be welcomed, a recent UNDP report concludes that the education systems in Central Asia are beginning to reflect the increased inequality and stratification in the region. While there is increased access for some to courses on business studies, economics and law, illiteracy is on the increase for others.⁵⁵

⁵⁰ Smithson (1994)

⁵¹ Thompson J., 2001

⁵² Report of the International Fact-Finding Mission on Water Sector Reform to Ghana, 2000

⁵³ WaterAid (a)

⁵⁴ Falkingham (1999)

⁵⁵ Falkingham (1999)

In most other transition countries a similar stratification is taking place. A UNICEF report states that:

“There is greater selectivity and competition in education, including the development of élite, better-funded upper secondary schools, as well as private schools. This may help more able children and those from better off families, but does little for others (and may take resources away from provision for them).”⁵⁶

Undermining the public sector

There are a number of dangers associated with the possibility of private sector involvement undermining the public sector. One is the potentially damaging nature of a two-tier approach to health care provision. The private sector is likely to attract the best clinicians with better wages, higher standard equipment and the prospect of professional advancement,⁵⁷ as happened in Thailand’s health system in the 1980s and 1990s, for example.⁵⁸

Another concern is the political impact of a two tier system. If the middle and upper classes and political decision makers do not rely on the public system for their health care or education, political pressure to maintain high standards in the public sector may decrease. This is likely to be even more the case if people are allowed to opt out of the primary financing mechanism. Research in the UK suggests that people who have private medical insurance are less likely to support increases in public spending on health than those who rely on the public health system.⁵⁹

The potential of increased private sector participation in health undermining public delivery systems is summarised by a recent Working Paper for the Commission on Macroeconomics and Health (associated with the World Health Organisation),

“If a parallel private sector is truly able to provide superior access to essential services, then the governmental health care system will obviously become less attractive and less equitable and a slow but progressive dissolution will result... International health organisations should have serious concern that the emergence of international trade in health insurance, by encompassing the middle and upper social classes, could significantly reduce governmental and public interest in addressing WHO’s ‘10’ basic community diseases. The rise in private health insurance could also reduce governmental opposition to increases in pharmaceutical prices – increases that may occur as a result of TRIPS related patent protections.”⁶⁰

Rather than undermine the long term capacity of public systems, the use of non-state actors, if it is deemed necessary, should be with the intention of strengthening the public sector. When the Cambodian government contracted health services to private providers,

⁵⁶ UNICEF (1998a)

⁵⁷ Sbarbaro (2000)

⁵⁸ Sitthi-amorn et al (2001)

⁵⁹ Brook et al (1998)

⁶⁰ Sbarbaro (2000)

for instance, although an evaluation found that the contracting-out model had performed better than the contracting-in model the Cambodian government and the Asian Development Bank agreed to roll out the contracting-in model. This was considered to be the best way to ensure the long term sustainability and future growth and reform of the public health system.⁶¹ If this example is cited in the WDR (it is cited in the Outline on p45) this outcome should be reflected.

Profit motive and service delivery

The profit motive is a serious concern to many who wish to see services made better for poor people. The World Bank acknowledges this in its Poverty Reduction Strategy Sourcebook:

“New entrants may focus on the most profitable segments (‘cream-skimming’), such as urban areas, where the cost of service provision may be lower and incomes higher. Privatisation could mean the end of government support. The result is that... prices for low income households may actually increase and/or availability decline.”⁶²

The pressure to make a profit can affect practice. In Egypt, private practitioners have been found to be more likely to prescribe the more expensive antidiarrhoeal drugs than administer a cheaper oral rehydration solution.⁶³ In Malaysia many private clinics fail to assess new clients properly when providing family planning services – they only undertook cervical screening if requested.⁶⁴

Similar concerns arise in Joint Public Private Initiatives, even where the public sector is more involved than in the previous examples. The desire to improve service quality is not the only motivation for a private sector donor’s involvement. The existence of other motivations should be acknowledged as they have implications for the sustainability and inclusiveness of commercially-funded donor interventions in service provision.

SC UK’s analysis of JPPIs has shown that companies are frequently motivated to participate for commercial reasons other than immediate profit. Companies such as Pfizer have clearly stated that JPPI donations can ‘enhance shareholder value’.^{65 66} Such donations may arise out of a desire to enhance reputation, silence public criticism or to establish better links with the heads of international organisations such as WHO and the World Bank.^{67 68}

There may be inherent conflicts of interest between such motivations and public health goals. Commercial donors to the Global Alliance for Vaccines and Immunization (GAVI), for example, have neglected the strengthening of health systems. GAVI is increasing spending on strengthening immunisations systems, but this is not enough.

⁶¹ Asian Development Bank (2002)

⁶² World Bank (2001)

⁶³ Swan and Zwi (1997)

⁶⁴ Swan and Zwi (1997)

⁶⁵ The Pink Sheet (2001)

⁶⁶ Heaton (2001)

⁶⁷ E.g. announcement by American Home Products Corporation following a vaccine donation in 2001 cited in Heaton (2001)

⁶⁸ Heaton (2001)

International donors and national governments should also increase their expenditure on supporting national systems.

In 1998 supplies of the drug eflornithine, which had been very successful in treating children with sleeping sickness, ran out, and the producer Aventis was disinclined to continue production on the grounds it was no longer commercially viable. It took three years of negotiation with WHO before Aventis finally agreed to produce the drug for another five years, and to transfer technology to potential long-term manufacturers.⁶⁹

Whilst commercial objectives can coexist with a commitment to social development, they can distort the inclusionary aims of JPPIs, and lead companies to limit the quantity or duration of their donation. Insufficient donations can lead to greater discrimination within a health system, rather than greater inclusion, as limited availability of basic drugs or services requires health professionals to select who will be treated and who will not.

With regard to Joint Public Private Initiatives, it is unrealistic to expect recipient governments in many countries to be able to assess the potential impact of the problems associated with donations made by the commercial sector. Dealings with the commercial sector have, in some cases, been characterised by recipients being under pressure to make swift decisions regarding the acceptance or refusal of donations.⁷⁰

For example, in initial negotiations with pharmaceutical companies regarding the provision of antiretroviral drugs, the WHO and the UN accepted preferential pricing offers that were made on a limited basis, and at price levels that were seen later not to be preferential enough to be useful.⁷¹ Just as these two large international organisations accepted inadequate offers in the initial stages of preferential pricing on antiretroviral drugs because it was not clear how resilient the offers of the pharmaceutical companies were to negotiation, under GAVI, Ministry of Health personnel in Ghana, Mozambique, Tanzania and Lesotho all felt pressurised to make rapid decisions regarding the acceptance of different types of vaccines, decisions that had long-term implications for their health systems.⁷²

Regulatory framework

A strong regulatory framework is vital to ensure that private sector participation can succeed in providing services to the poor, as the World Bank states with regard to water provision in its PRSP source book,

“Private network services will likely have good technical efficiency for the level of inputs they use, but may provide inferior or no services to the poor if the regulatory regime does not provide the right incentives for good performance.”⁷³

The Outline recognises this.

⁶⁹ Heaton (2001) p9

⁷⁰ Heaton (2001)

⁷¹ Heaton (2001) p10

⁷² Starling et al (2002) p45

⁷³ World Bank (c), referring to water privatisation

“Contracting with the for-profit sector requires strong monitoring and regulation capacity from policy-makers.”⁷⁴

Countries with weak regulatory frameworks will be unable to ensure that private sector actors provide a service that is equitable and accessible to all. The World Bank itself acknowledges that regulatory capacity is indeed weak in many of its client countries.⁷⁵

A DFID workshop held in 2000 analysing the role of the private sector in health care provision raised serious doubts about the efficacy of many private sector health services, and the ability of governments to regulate them. One of its major concerns was that, “many of the services being provided by the private sector are high cost but of low technical quality. Some may even be harmful.”⁷⁶

Developed countries find it a significant challenge to successfully regulate the private sector and it is questionable whether developing countries will be able to adopt strong negotiating positions or regulate contractors effectively. Experience in a number of countries has shown that the regulatory capacity of developing country government is insufficient to deal with multinational companies. A recent case study of Private Sector Participation in Manila’s water sector characterises the situation as ‘street-smart’ companies making unrealistic bids to win the tender, gambling that the rules can be changed in their favour at a later date, “given the weakness of regulation in [the Philippines] and the state’s historical permeability to private interests.”⁷⁷

In Ghana, the Public Utilities Regulatory Commission (PURC) is planning to allow regulated water utilities to self-audit, believing them to be in the best position to provide information about their water quality and operations.⁷⁸ The inability to properly regulate private sector contractors could lead to an inability to ensure positive impacts on the poor.

Save the Children’s experience in Pakistan and India has shown that, while private sector schools are sometimes perceived by families to be better than those provided by the public sector, there is a wide variation of the quality of education provided. Private schools catering for poor communities commonly employ a high proportion of untrained teachers and offer a poor service.⁷⁹

In a survey of private health practitioners in Cambodia, half of all consultations were found to be ‘potentially hazardous’ according to national WHO -based treatment protocols.⁸⁰

In a rural project in Mozambique, private sector participation was supposed to speed up the process of expanding coverage. However, it did not result in improved outcomes for the poor, and the projects constructed by the “inexperienced” private contractors were “of such poor quality that most have broken down.”⁸¹

⁷⁴ Outline p45

⁷⁵ IFC (2002) p17

⁷⁶ DFID (2000)

⁷⁷ WaterAid (a)

⁷⁸ Report of the International Fact-Finding Mission on Water Sector Reform to Ghana, 2000

⁷⁹ Save the Children (2002)

⁸⁰ Rose et al (2002)

⁸¹ WaterAid (a)

These examples, and others, highlight the need for good regulation of both small and large businesses, and that regulation has proven extremely difficult to implement effectively to date. Rather than set out intentions to get it right in future, policy makers should now seriously question whether reforming the public system may be preferable to significant involvement of the private sector.

Recommendations

- The public and private sectors should not be treated as equivalents in the health, education and water sectors. Private sector participation in basic service provision can involve a number of inherent dangers for poor clients. The WDR should reflect these clearly.
- Private sector involvement in basic service provision can undermine the long-term viability of an efficient and equitable public sector. The WDR should state that all such private sector involvement should be with a view to strengthening, rather than undermining, public systems.
- The WDR should warn policy makers about the dangers inherent in encouraging or allowing the development of a two-tier system of service provision, with lower income households accessing a poorer quality of services. Such a system is likely to result from increased private sector participation.
- Without adequate regulatory capacity, private sector participation in service provision is a matter of concern, because the needs of the poor are unlikely to be met. The WDR should recommend what regulatory mechanisms must be in place before private sector involvement should be contemplated as a possible policy option.

IV User Fees

SC UK welcomes the recent World Bank statements revising its policy on user fees for basic healthcare and primary education⁸². The revision is an important step forward to the fulfilment of children basic rights to health and education as laid out in articles 24, 25, 28 and 29 (and others) of the UN Convention on the Rights of the Child.⁸³

User fees were seen as an important part of reforms that hoped to ensure sustainable health and education systems in developing countries. In fact, as the evidence below demonstrates, they have been ineffective at raising significant revenue, have led to significant reductions in service utilisation, especially among the poor, and have led to serious financial difficulties for many who have been able to pay.

Cost recovery policy is being reviewed in a number of countries with significant results. Uganda, Malawi and Tanzania, for example, have recently abolished primary education fees, leading to massive increases in enrolment. Uganda has also stopped user fees for health, which led to an increase in utilisation by the poor while resources lasted, although resources have proved insufficient to meet the growth in demand (as noted by the Outline⁸⁴). These policy changes are part of a continuing change in the climate which at one time saw 75% of World Bank Health, Nutrition and Population projects to Sub-Saharan Africa, for example, include the establishment or expansion of user fees.⁸⁵

However, a review of 23 PRSPs and I-PRSPs conducted by SC UK in 2001 found that most of the countries surveyed maintained their reliance on cost recovery at the point of use in some form, a reliance typical of many other recipient countries, especially in Sub-Saharan Africa.⁸⁶ References to fee exemptions for the poor are widespread, as are commitments to better enforce them,⁸⁷ and a number of countries plan reductions in school and health fees and subsidies for water use, according to their PRSP's.⁸⁸ It is noteworthy that the World Bank and IMF Joint Staff Assessment (JSA) of Lao PDR's PRSP urges the government to go further in developing a user fees exemption policy in health – this is a welcome move in the right direction, although SC UK is still concerned that there is, in general, a poor track record of implementing exemptions.

SC UK believes that most of the evidence available shows that user fees are ineffective at improving social service delivery to the poor for four main reasons: reduced utilisation, failure of exemption mechanisms to protect the poor, financial hardship and low revenues.

The Outline concludes its section on user fees by stating:

⁸² World Bank (2002b)

⁸³ See <http://www.unicef.org/crc/fulltext-frameset.htm>

⁸⁴ Outline p18

⁸⁵ Newbrander and Johnston (1998)

⁸⁶ E.g. Simms et al (2001)

⁸⁷ E.g. Kyrgyzstan, Kenya, Ghana, Cambodia, Burkina Faso and many others. Marcus and Wilkinson (2002)

⁸⁸ E.g. Cambodia, Rwanda, Lesotho. Marcus and Wilkinson (2002)

“Bottom line: Should not have a blanket policy on user fees. Sector-by-sector approach.”⁸⁹

SC UK is concerned that the above statement does not sufficiently emphasise the devastating consequences user fees have had on the poor and the poorest in the majority of cases, as set out in the discussion below. The position adopted in the Outline will stabilise the trend of regarding exemptions and reductions of user fees as a policy goal, rather than seeking their phasing out and abolition.

Reduced utilisation (Health)

The Outline states that, “User fees... can lead to increases in utilisation among the poor”.⁹⁰ While there is a small amount of evidence to back up this statement, the majority of the evidence shows the contrary, as illustrated in a paper written for DFID in 2001:

“In virtually all cases where user fees were increased or introduced there has been a concurrent decrease in service utilisation. The magnitude of this drop in utilisation is frequently larger, and the effect of a longer duration, amongst the poor part of the population.”⁹¹

This view concurs with a recent SC UK analysis that demonstrates that user fees in Sub-Saharan African countries, including Kenya, Zambia, Madagascar, Tanzania and Senegal, have led to a decline in the use of maternity and other health services in the poorest communities, contributing to a rise in infant deaths and putting women’s health at risk.⁹² In Tanzania, for example, the combination of travel costs and user fees in one clinic meant that poor mothers do not bring their children to a doctor until they are very ill meaning that 53% of children die within 48 hours of being seen. The poorest do not come at all.⁹³

The evidence showing reductions in health service utilisation following the introduction of user fees is copious. In Zimbabwe use of health facilities fell by 25% in three years following the introduction of user fees⁹⁴, while child mortality rose by 13% between 1992 and 1993.⁹⁵ The effect was similar in Ghana⁹⁶, Zaire⁹⁷ (as it was then called), Swaziland⁹⁸ and Lesotho⁹⁹.

One report estimated that in Central Asia in 1994 an inpatient stay would cost the average *total* monthly income of the household for all but the top income quintile.¹⁰⁰

⁸⁹ Outline p18

⁹⁰ Outline p17

⁹¹ Bennett and Gilson (2001)

⁹² Simms et al (2001)

⁹³ Kasese (1995) cited in Harper and Marcus (1999)

⁹⁴ Mwanza (1998)

⁹⁵ Iliffe (1995) cited in Mwanza (1998)

⁹⁶ Waddington and Enyimayew (1989) cited in Ahrin-Tenkorang (2000)

⁹⁷ de Bethune et al (1989) cited in Ahrin-Tenkorang (2000)

⁹⁸ Yoder (1989) cited in Ahrin-Tenkorang (2000)

⁹⁹ Bennett (1989) cited in Ahrin-Tenkorang (2000)

¹⁰⁰ Abel-Smith and Falkingham (1995) cited in Falkingham (1999)

Another reported that in 1993 in Uzbekistan costs for surgery in decent clinics were equivalent to a tenth of the average annual salary.¹⁰¹

Dyna Ahrin-Tenkorang's recent Working Paper for the Commission on Macroeconomics and Health explains why the theory that led to user fees being introduced was at fault.¹⁰² Rather than being price inelastic, as was initially thought by proponents of fees, demand for health services is sensitive to price increases, especially among poor households. Proponents of fees may have failed to take into account other household expenditures of poor households, and indirect costs of healthcare such as time and travel costs. Indeed, Ahrin-Tenkorang argues, there are many cases in developing countries where the economically sound response to service inefficiency would be an incentive payment, as opposed to a fee.¹⁰³ The World Bank has indeed adopted such incentive programs in education, for instance the Bolsa Escolar programme in Brazil. Use of such incentives seems more widespread in education than in health.

Reduced utilisation (Education)

In education the evidence is equally clear. When Malawi abolished primary school fees in 1994, enrolment increased by 68% and in Uganda enrolment doubled in 1997 when primary school was made free for four children per family.¹⁰⁴ In Mongolia, where school subsidies were abolished and fees introduced, school attendance dropped by 25% from 1990-1994.¹⁰⁵ Many other examples show how school enrolments have dropped when fees are introduced.¹⁰⁶ A new study by DFID confirms that in Bangladesh, Kenya, Nepal, Uganda, Sri Lanka and Zambia the withdrawal of children from school remains a common response to increased costs or reduced household income.¹⁰⁷

Poor families in Central Asia have suffered from the introduction of fees in education. A recent UNICEF report states:

“Families must now pay for many of the services that were formerly included in ‘free basic education’. The growing use of fees means that children from poorer households increasingly face problems in gaining access to pre-primary education, extra-curricular activities in primary and secondary education, as well as remedial and foreign language courses. Yet these are the very children who stand to benefit most from investment in their education and associated peer activities to enhance their social skills and to help avoid poverty in later life as a result of inadequate qualifications.”¹⁰⁸

Another report argues that:

“The costs to families of educating children have gone up, often sharply. Fees charged for kindergartens have risen; fees have been introduced in

¹⁰¹ Lubin (1995) cited in Falkingham (1999)

¹⁰² Ahrin-Tenkorang (2000)

¹⁰³ Ahrin-Tenkorang (2000)

¹⁰⁴ UNICEF (1998b)

¹⁰⁵ UNICEF (1998c)

¹⁰⁶ e.g. Mwanza (1998), Booth (1994), Narayan and Parker (1996) cited in Harper and Marcus (1999)

¹⁰⁷ DFID 2002

¹⁰⁸ UNICEF (1997a)

some countries for upper secondary schools, and they are becoming more common for tertiary education. Reports abound in some parts of the region of parents paying teachers in state schools for extra lessons, of having to bribe to secure good exam marks, and of having to make contributions to get their children into good schools. Textbooks are now frequently charged for, and they have often become enormously expensive in relation to family incomes. Clothing and shoes – necessary to attend school – are no longer subsidised in the same way as before. Grants for students living away from home have fallen sharply. All these increases in costs come during a period when family incomes have fallen and inequality has risen.”¹⁰⁹

It is clear from the empirical data that user fees have had a severe effect on the access of the poor to basic services such as health and education. It seems surprising that the WDR authors write that, with regard to health services, “User fees ... can lead to increases of utilization among the poor.”¹¹⁰ While technically correct, this remark seems to overlook the majority of the literature on this subject. Two studies are cited in the Outline as evidence for the potential of user fees to improve service quality: “Litvack on Cameroon, Diop on Niger.” SC UK cautions the WDR authors against relying on one or two studies that cite the benefits of user fees when the large majority of literature on the subject warns vociferously about their negative impact.

It is also important to note that studies that have registered a positive effect on quality have often been one-off pilot experiments, with special help such as donor funds and skilled personnel from other institutions. They are therefore not sustainable across the whole system.¹¹¹

Failure of exemption mechanisms to protect the poor

Donors such as DFID and the World Bank now accept much of the evidence set out above, which is only a small selection of the data that now exists – indeed some of this evidence is alluded to in the Outline.¹¹² However, rather than seeking to phase out and abolish user fees, mechanisms to mitigate the impact of user fees on the poor are increasingly commonplace, as set out above, and there is implied support for this policy in the Outline.¹¹³

This faith in the ability of exemptions to successfully protect poor people’s rights to basic services is not supported by the extensive literature on the subject, including the World Bank’s own assessments. A study of targeted exemptions in Ecuador, Guinea, Indonesia, Kenya and Tanzania carried out by Management Sciences for Health found that only a third of patients who were entitled to waivers actually received them.¹¹⁴

A similar study by the World Bank’s Operations Evaluation Department found that due to administrative and other problems only 20% of the eligible poor in Zimbabwe received waivers, while in Mali the OED team could find no examples of waivers having

¹⁰⁹ UNICEF (1998a)

¹¹⁰ Outline, p17

¹¹¹ Simms et al (2001)

¹¹² Outline, p17

¹¹³ Outline p17

¹¹⁴ Newbrander and Johnston (1998)

been granted.¹¹⁵ Moreover, one of the study's authors commented that, "Project documents typically assert that the poor would be protected from the impact of these fees, but include few if any details about how this is to be done."¹¹⁶ The present WDR is in danger of continuing this trend.

SC UK's most recent research on user fees took place in East Hararghe in Ethiopia where targeting of exemptions for health services is done using an income threshold. This mechanism has been found to be extremely difficult to implement, especially where incomes are highly seasonal, where livelihoods are of a semi-subsistence nature and where information on income levels is virtually non-existent.¹¹⁷

Examples abound of the failure of exemptions to relieve the poor of paying for basic services. In Zimbabwe, school headmasters often failed to pass on information to poorer students, and when they did the children were often too embarrassed to tell their parents, or their parents too embarrassed to apply.¹¹⁸ Only 12% of the target population in Zimbabwe (3% of the total school population) benefited from exemptions.¹¹⁹

In an international survey of 26 low-income countries, Russell and Gilson conclude that many countries do not have any policies to promote health services to disadvantaged groups, that exemptions were extremely difficult to implement and that exemption-monitoring systems were rare.¹²⁰

SC UK believes that our own evidence and the overwhelming evidence in the public domain shows that policies aimed at exempting poor people from user fees for health and education, where they have been in place, have generally failed.

While the Outline does make reference to the problems that have been associated with user charges, it does not reject as emphatically as it should the policy of introducing or maintaining them. It is disappointing that it is necessary again to repeat the case against user fees for basic health and education, and to reiterate the dangers of relying on exemptions for the poor, particularly when those exemptions are linked directly to income.

Financial hardship

It is vital that the WDR does not confuse 'willingness' to pay and 'ability' to pay. A great deal of evidence documents the hardship that paying for essential services has caused many households. A DFID workshop summed up the issue, referring in this instance to private sector provision:

"It is now well recognised that large amounts of money are spent on private health care in low and middle-income countries even by the poor. This expenditure – especially in the case of catastrophic ill health or chronic illness – is a key factor in pushing people into poverty or in keeping them in poverty."¹²¹

¹¹⁵ Newbrander and Johnston (1998)

¹¹⁶ Newbrander and Johnston (1998)

¹¹⁷ Russell and Abdella (2002)

¹¹⁸ Kasese (1995) cited in Harper and Marcus (1999)

¹¹⁹ Stewart (1995)

¹²⁰ Russell and Gilson (1997) cited in Simms et al (2000)

¹²¹ DFID (2000)

The previously cited SC UK study of health services in the East Hararghe region of Ethiopia, for example, shows that of those who sought treatment for a chronic illness, 43% had cash available but had to sacrifice other essential consumption or investment (e.g. education) to cover the financial costs, and that 23% did not have cash available so had to sell assets or borrow money.¹²²

Researchers in China found that 44.3% of rural households living in poverty in 1998 fell into poverty due to medical spending.¹²³ Around 3 million people were driven into poverty in Vietnam between 1993 and 1998 as a result of meeting healthcare payments¹²⁴ – while half of all urban families in financial crisis in Bangladesh cite medical costs of a family member as the cause of their problems.¹²⁵ In one survey in Cambodia, 45 per cent of rural families found to have lost their land had done so as a result of debts relating to medical expenses – the largest single category.¹²⁶

According to a Kenyan study,

“...poor parents placed a very high premium on keeping their children in school. In order to do so, they would sell their possessions, beg, steal, brew and sell beer, pray, go to church, hawk produce, join self-help groups, cajole teachers into letting the children stay in schools, pay in instalments, put their children to work and sometimes become destitute trying to keep their children in school...As a last resort, many parents sold their maize seed in the hope of putting together enough money. Some poor parents report marrying their daughters off early to receive a bride price, so as to enable the rest of the children to continue school”¹²⁷

Similar reports exist from urban Zimbabwe¹²⁸ and rural Swaziland¹²⁹. In Zimbabwe the introduction of school fees has led to increased numbers of children working to pay for their own, or a sibling’s education.¹³⁰

In order to fully reflect the impact of the overall burden of user fees on poor households, the WDR should acknowledge the full range of payments they are required to make. An assessment of the ability of the poor to pay user fees for a particular service in isolation (i.e. without regard to other fees that have to be paid) will lead to a faulty result. In many transition countries, for example, significant increases in user charges for utilities such as gas, electricity and water are forcing households to make serious and painful trade-offs.¹³¹

This evidence shows that in many areas, while some people have, or are able to raise, cash to pay user fees, they are jeopardising other vital living expenses in order to do so.

¹²² Russell and Abdella (2002)

¹²³ Liu and Hsiao (2001) cited in Commission on Macroeconomics and Health (2001)

¹²⁴ Wagstaff (2001)

¹²⁵ IFC 2002

¹²⁶ Biddulph (2000) cited in Hilary (2002)

¹²⁷ Narayan and Nyamwaya (1996)

¹²⁸ Kanji (1993)

¹²⁹ Mnisi (1998)

¹³⁰ Mwanza (1998)

¹³¹ Save the Children UK (2000b)

This suggests that the assumption that because people do pay, they are able to do so without inflicting serious hardship on themselves and their families, must be rethought.¹³²

Financial returns are low

Even if the revenues generated from user fees were significant, SC UK would still argue that they should be eliminated due to their negative impact on poor people. But user fees are generally ineffective at raising revenue. Early Bamako Initiative targets were clearly over-ambitious:

“The money recovered through the self-funding mechanism will be used for the replacement of drugs and supplies and other operational expenses...including the supply of vaccines, syringes and needles.”¹³³

Income from user fees contributes less than 5% of total government spending on health in most African countries¹³⁴ and 40-60% of revenue raised can be soaked up by administration¹³⁵.

In one cost recovery scheme in Uganda, for example, a salary supplementation for health workers was so low as to be insufficient to reduce absenteeism.¹³⁶ In a well-established Nepalese scheme user fees were insufficient to sustain drug-supplies without continued external assistance.¹³⁷

A recent DFID report estimates that in countries with low-household incomes user fees are unlikely to raise more than 10-20% of service delivery costs.¹³⁸ In effect, in many cases, the result of cost recovery has been to impose charges on a service with no improvement in quality, while reducing the uptake of the poorest.

Other issues

Fees for income-elastic goods

The Outline states that, “For income-elastic, private goods, user fees may improve welfare”.¹³⁹ SC UK agrees that for non-essential and luxury goods user fees may be an effective way of recovering some public expenditure. However, careful analysis and debate is required to reach consensus on what constitute non-essential services.

Quality improvements

The WDR contends that, “User fees usually improve quality of services.”¹⁴⁰ It is true that an increased level of expenditure will usually improve quality of services, whether that increase be facilitated by user fees or other means. Improvements in quality of healthcare, in terms of staff and service quality, will usually bring about increased utilisation among all income strata, including the poor.

¹³² This subject is further discussed in Raberg and Jeene (2002)

¹³³ UNICEF (1988) cited in Smithson (1994) p67

¹³⁴ Creese and Kutzin (1996)

¹³⁵ Van der Meer 98

¹³⁶ Wamai (1992) cited in Smithson (1994) p30

¹³⁷ British Nepal Medical Trust (1991) cited in Smithson (1994) p30

¹³⁸ Bennett and Gilson (2001)

¹³⁹ Outline p17

¹⁴⁰ Outline p17

To argue that quality improves when new resources are available, and that this also has an impact on utilisation rates, is hardly a point worth noting. However, for the reasons outlined above, SC UK's strong position is that governments, donors and other parties should not encourage user fees as a means to increase resources, as they have strongly negative effects on the poor.

Sudden abolition

The Outline states that there are, "some disturbing signs of quality declines in Uganda and Malawi."¹⁴¹ While there is no doubt that such declines have taken place, we should be clear on the reasons for this. In both countries user fees were abolished swiftly without sufficient funds being made available to meet the shortfall. This problem was compounded by the immense success of the abolition of user fees in terms of attendance which rose by between 50-80% in a short period in both countries. Quality will inevitably decline in any service when dollar per pupil ratio is so massively and suddenly altered.

Recommendations

- SC UK endorses the need for a sector-by-sector and case-by-case approach to cost recovery mechanisms. However, we urge the World Bank to take a firm stance against user fees for basic health and primary education services except where there is overwhelming and uncontested evidence in their support.

¹⁴¹ Outline p18

V Joint Public Private Initiatives

The main argument of Chapter 6 of the Outline is that by bypassing the policymaker and dealing directly with the client or provider, aid can weaken the policymaker's relationships with both. The chapter's recommendations focus on how to make aid work more effectively through these relationships.

Compatibility between Global Programmes and Country Policy

The Outline makes specific reference to thematic global funds¹⁴² and states that by dealing directly with a service provider, such initiatives can create incompatibility at a country level, especially with the recipient's macroeconomic and budget management. SC UK's work on Joint Public Private Initiatives (JPPIs) in the health sector has also identified this problem of incompatibility.

JPPIs in the health sector tend to be disease-selective and run the risk of distorting national health strategies. Donations being offered by the commercial sector may determine where governments focus their health budget, rather than the health needs of children and the population in general. The need to fulfil application criteria for global thematic funds, such as the Global Alliance for Vaccines and Immunisation (GAVI), can lead to a disjointed approach that overrides any country-level commitment to more integrated sector wide approaches (SWAPs) or priorities identified in the PRSP process.

Transaction and systems costs

The Outline points to the high transaction and compliance costs of having many donors dealing directly with providers, thus creating a series of separate sector-specific investment projects.¹⁴³ SC UK's own analysis of the implementation of immunisation programmes under GAVI has shown that GAVI creates such additional transaction costs and subsequent recurrent costs.¹⁴⁴

Although in the first year after the application process, most government officials and multilateral agency staff reported that the benefits seemed to outweigh the costs, there were those who argued that GAVI produced additional burden on health systems for very little money in return. The introduction of new combination vaccines required additional staff capacity, appropriate cold chain facilities, and adequate waste management and transport facilities. Without reducing transaction costs and increasing funding for systems support, realising the maximum benefits of this immunisation programme is unlikely. While some of this critique has been taken on board, a pressing concern is the cost of vaccines 'post-GAVI'.¹⁴⁵

Donor pooling and the integration of aid

The Outline argues that by circumventing a recipient's delivery system, donors undermine local capacity and ownership. It recommends that donors pool their support, work directly with governments to integrate aid into a country's development strategy and budget process, and ensure knowledge transfer and capacity building.

¹⁴² Outline p32

¹⁴³ Outline p32

¹⁴⁴ Starling et al (2002)

¹⁴⁵ Personal communication from SC UK's Uganda Programme

SC UK welcomes this recommendation as previous SC UK studies of African health systems¹⁴⁶ and JPPIs¹⁴⁷ have shown that donor-controlled vertical programmes have often hindered the development of effective health systems. However, it is not necessarily the case that “joint supervision of overall and sector programmes”¹⁴⁸ will result in greater government control over donor supported service provision.

For example, GAVI requires countries to have an Inter-Agency Co-ordinating Committee (ICC) to oversee the application and implementation process. These are made up of representatives from government departments and other relevant national organisations and from multilateral and bilateral organisations, and led by a leading government health professional. The aims of ICCs are listed in the Outline; ownership, knowledge transfer and capacity building. However, in four countries the committees were less effective due to irregular attendance; in two countries informants reported that poor working relationships between multilateral agencies had dogged the ICC; and in one country a multilateral took over the management of the application and submission process. Therefore, rather than promoting country ownership of the process and capacity-building, ICCs in some countries were simply focused on completing the paperwork for the application.

Vertical programmes

After a decade of vertical donor-funded programmes in Africa, in the 1990s the donor community attempted to integrate some of the vertical programmes. One key problem that has been identified by studies assessing integration is that of underfunding. Integration is a costly process. A SC UK study of African health systems shows that at least part of the problem is that integration of services has been seen purely in terms of increasing the cost effectiveness of programmes by merging them.¹⁴⁹ However, the short-term financial costs of integration are often high and the process may throw up administrative, logistical and political difficulties, which impede progress. One key donor in East Africa told SC UK:

“We made a critical error with integration. In terms of resources it has to be an additive cost ... Each program has to come with its own money. We say integration is a means to improve cost effectiveness [but] the approach was wrong; who was going to pay?”¹⁵⁰

In some countries, this process of integration ran parallel to an effort to decentralise health services in order to make them more responsive to local communities. This created additional resource, administrative and logistical burdens.

Another issue to consider in relation to integration is the willingness of donors to participate. Poor working relationships between multilateral agencies on GAVI ICCs has already been discussed. It is also necessary to consider the willingness of commercial donors to pool their resources.

¹⁴⁶ Simms et al (2001)

¹⁴⁷ Heaton (2001)

¹⁴⁸ Outline p33

¹⁴⁹ Simms et al (2001)

¹⁵⁰ Simms et al (2001)

Monitoring and evaluation

The Outline refers to the need for donors to work with recipient governments to carry out ‘joint analytic work including impact evaluation to ensure better feedback and quality’.¹⁵¹ SC UK also sees this as an important issue and one which will require technical assistance and capacity building to achieve.

However, SC UK’s report on the implementation of GAVI shows that countries may lack the infrastructure to collate even the most basic quantitative data to inform the targeting of services. In all the countries included in the SC UK GAVI study, Ministries of Health found it difficult to submit reliable data on immunisation coverage. Coverage rates were considered to be overestimated due to poor data collection, which in turn meant that GAVI donations could be inadequate to cover the target population. Unreliable data on coverage rates has implications for the monitoring system built into GAVI, as governments were unable to set realistic performance targets. This point has been accepted by GAVI and the Data Quality Analysis process is a step in the right direction.¹⁵²

GAVI cannot be blamed for the present weaknesses in health information systems, but should be urged to increase investment in improving them, alongside the WHO and civil society. Such programmes should avoid relying on national health information systems to take important funding decisions until such improvements are made.

This in turn has implications for the performance awards system, which aimed to reward governments for performance measured in term of coverage.¹⁵³ The existence of unreliable starting data on coverage rates combined with performance-related awards based on subsequent coverage, clearly creates both the motivation and opportunity for data manipulation. While this is partly taken care of by Data Quality Analysis process, another key concern is that the “hard-to-reach” will be deliberately abandoned in favour of a numerical increase in the “easy-to-reach.”¹⁵⁴

Can countries that lack reliable minimum data sets be expected to successfully take on responsibility for more complex impact and quality evaluations? The Outline recognises the need for capacity building to support this process. But what about the financing of such evaluations? If evaluation is seen as a crucial stage in the successful provision of services, the cost of evaluation should be built into initial financial planning and should receive donor support.

Donor commitment and sustainability

SC UK strongly endorses the recommendation in the Outline that, “donor funding for health services needs to focus on recurrent expenditures, including support to human resources development and incentives to serve the poor.”¹⁵⁵ This should also apply to other basic services such as education and social welfare.

However, the Outline fails to fully address the issue of the relationship between donor commitment and the sustainability of service provision initiatives. Donor agendas can

¹⁵¹ Outline p33

¹⁵² Personal communication from SC UK’s Uganda Programme

¹⁵³ Starling et al (2002)

¹⁵⁴ Personal communication from SC UK’s Uganda Programme

¹⁵⁵ Outline p48

divert priority expenditure and create phantom agendas in national health strategies, which collapse after the donation has been spent.

It is positive that the five-year timeframe for donor commitment under GAVI is longer than many recipient countries have experienced with other donor funding agreements. However, SC UK's analysis of GAVI revealed that a failure by donors and recipients to discuss and co-ordinate future funding not only threatens the sustainability of the immunisation programmes, but also potentially jeopardises future government expenditure on other services.¹⁵⁶ The active assistance from GAVI in creating Financial Sustainability Plans is a welcome advance.

In all four countries where the study was conducted, GAVI led to the introduction of more costly combination vaccinations, and thus substantially increased the future cost of immunisation coverage. For example, the annual cost of Ghana's immunisation programme will triple. At the same time, the lack of discussion between donors and recipients regarding future funding led to an assumption amongst Ministry of Health officials that donors would continue to fund the programme, whilst donors remained silent on the issue. If donor funding is not forthcoming at the end of the five-year period, there are two possible scenarios: levels of immunisation coverage may be severely reduced, or money is diverted from other priorities in order to continue to fund immunisation.

Recommendations

- The WDR should discuss which criteria are required to ensure that Joint Public Private Initiatives deliver broad and sustainable benefits to all.
- The financial sustainability of Joint Public Private Initiatives is vital. While stressing the need for greater co-ordination between donors and recipients, the Outline focuses on short-term forms of co-ordination e.g. agreeing funding priorities and joint supervision. The WDR should recognise the imperative that the process of co-ordination include open discussion between donor and recipient about the sustainability of any initiative beyond the initial implementation phase.

¹⁵⁶ Starling et al (2002)

Nutrition

According to the World Bank, malnutrition is linked to nearly half of child deaths in low-income countries.¹⁵⁷ However, there is currently very little reference to nutrition services in the Outline. This is a substantial omission given the large investment in these services, primarily as vertical projects, which has taken place in the last 20 years.

Are nutrition services effective for poor people?¹⁵⁸

One of the cornerstones of nutrition services in many countries is growth monitoring and promotion (GMP) which usually is implemented alongside nutrition education. According to UNICEF, the purpose of GMP is,

“To prevent malnutrition from occurring and to maintain and promote good growth... It is an *operational strategy* which enables mothers or other guardians to visualise growth or lack of growth and to receive specific, relevant, practical guidance in ways in which they can act to assure health and continued regular growth in the child”¹⁵⁹.

However, SC UK’s experience has shown that growth monitoring and promotion is not an appropriate service in many contexts for poor people because the assumptions upon which it is based are rarely valid. These assumptions are discussed in detail below.

Assumption 1: The caregiver has a knowledge gap

This is the conceptual cornerstone of GMP. In its crudest terms, “mothers lack knowledge and skills on appropriate foods, preparations and timing of weaning foods.”¹⁶⁰ However, cultures attach meanings to food and hygiene which may not be aligned with western scientific knowledge. Thus, while there may not be an actual gap in knowledge, there may be practices which are maintained even though they carry nutritional risks for children.

Assumption 2: The knowledge gap can be filled by one to one advice using a growth chart as a communication tool

In order for this assumption to be valid, the weighing equipment must be accurate, the growth chart must be understood by health workers and this understanding must be transmitted to the mothers who in some cases may not share the same concept of steady growth as being reflective of a child’s development. The child’s weight must be accurately plotted by the health worker or mother, the child’s growth curve must be interpreted correctly and appropriate and relevant advice must be given to the mother.

For GMP to be effective it needs to be carried out within a functioning primary healthcare system to ensure that supplies, training, supervision and information are all in place. The importance of training and supervision cannot be underestimated as poor use of measuring equipment, inaccurate plotting of growth and reading the chart can all lead to a misdiagnosis. A visit by SC UK staff to a West Bengal village where volunteers (mainly local teachers) were carrying out growth monitoring revealed a range of common

¹⁵⁷ World Bank (d)

¹⁵⁸ For more on this issue see Save the Children (2001)

¹⁵⁹ UNICEF (1992)

¹⁶⁰ World Bank (1997)

errors: scales were not set at zero; mothers still held children as they were weighed; inaccurate plotting without a ruler on a rough surface.

Inaccuracy in growth monitoring can obviously be damaging for the children who are misdiagnosed, but it also distorts data gathered nationally for policymaking. Furthermore, data from growth monitoring often fails to give a true picture of the nutritional situation as many mothers are unable to attend clinics regularly, if at all, and information is often out of date by the time it reaches policymakers at provincial or national level. Experience from Ethiopia shows that where health clinics are not easily accessible (in some regions they may be a three hour walk away), mothers will not be able to spare the time to take children to be measured.

There has been considerable criticism of the Road to Health Chart on the basis that it is not a simple tool to use with mothers - in reality a graph is a sophisticated concept which is not easily communicated to women with little or no formal schooling. SC UK experience in Ethiopia confirms that growth monitoring is difficult to achieve in communities with high levels of illiteracy.

As well as being trained to understand the chart and teach mothers how to use it, health workers must be familiar with the range of possibilities for potential advice which they can give to mothers for a range of different problems. Growth faltering is a consequence of an enormous range of factors including poor sanitation, low energy density of complementary foods, low household food availability, diarrhoea, TB, anorexia due to sickness or Zn deficiency, non-responsive feeding behaviour, and dilution among others. The health worker must have the time and resources to talk to the mother to try and identify possible action which the mother can take to improve the child's situation. In addition the health worker must follow-up children whose growth is faltering in order to see if improvements are being achieved.

The reality of GMP functioning as part of the primary health care system is that health workers may not have the time or motivation to individually talk to mothers and follow up faltering children, they may not have received adequate training, they may not receive adequate supervision, scales may be old and inaccurate and thus mothers may see little point in attending the weighing sessions.

While the imparting of knowledge to mothers using the growth chart is central to the GMP strategy there is some evidence to suggest that the chart itself is superfluous and that mothers can learn just as much from only receiving health and nutrition education. So while the success of GMP assumes that the chart is a useful component to individualise education messages, in reality it may be an unnecessary component.^{161 162} A parallel issue is that women may be equipped to know whether their children are likely to be faltering on the basis of loss of appetite, sickness or other problems, without needing a weighing session to point it out.¹⁶³ More research on this issue would be valuable.

Assumption 3: The acquired knowledge is translated into a desire to change behaviour

¹⁶¹ Behague (1993)

¹⁶² Ruel and Habicht (1992)

¹⁶³ Gerein and Ross (1991)

“Behaviour results from a complex interaction between knowledge, belief, habit, culture, circumstance and environment. Any attempt to change or prescribe behaviour through a didactic approach to health education and without comprehensive understanding of this interaction is bound to fail.”¹⁶⁴

There is a danger that, in a poorly resourced government programme, health and nutrition education messages to be communicated during growth monitoring are not developed following careful analysis of what people do and why they do it. It is only on the basis of this understanding that messages can be appropriately designed to have any chance of impacting on behaviour.

Assumption 4: There is capacity in the household to accommodate the behaviour change without incurring risks (long or short term)

“The potential for a re-allocation of available resources so as to more adequately nourish children who would otherwise become malnourished, in most situations, is greatest at household level. In other words, the potential to reach global nutrition goals lies mainly with changes in the use of resources at the household level.”¹⁶⁵

This statement begs some key questions. In poor communities where there are high levels of malnutrition, what are the costs of reallocating available resources at household level? Is there the degree of flexibility suggested by this assumption or will the reallocation of resources carry a high cost, for example withdrawal of another child from school or not purchasing necessary goods?

The causes of malnutrition are multisectoral, embracing food, health and caring practices. They are also classified as immediate, underlying, and basic, whereby factors at one level influence other levels. The conceptual framework developed by UNICEF’s Nutrition Section serves as a guide in assessing and analysing the causes of the nutrition problem and helps in identifying the most appropriate mixture of actions.¹⁶⁶

There are several projects which are cited as GMP success stories. The Tamil Nadu Integrated Nutrition Project (TINP) in India and the Iringa Child Survival Development Programme (CSDP) in Tanzania are two of these. Research conducted in Tanzania showed that the percentage of under fives who were underweight fell from 56% in 1984 to 38% in 1988. The key to interpreting the data, however, is that in both project areas there were a number of services (targeted and generally accessible) which gave access to resources to caregivers whose children were experiencing growth faltering. TINP had, among other services, a targeting feeding programme for children whose growth was faltering and CSDP had a whole range of services including household food security interventions, water and environmental sanitation and income generating activities (while these activities were undertaken by the community there was external support for them).

In spite of the positive impact on nutritional status of these programmes, it is impossible to conclude the results occurred as a direct consequence of GMP. There were many

¹⁶⁴ Save the Children UK (1995)

¹⁶⁵ UNICEF (1992)

¹⁶⁶ UNICEF (1997b)

other interventions and given that nutritional status is an outcome of complex layers of factors it is a pity that the individual effect of GMP has not been calculated.

However, these success stories only serve to fuel the suspicion that the assumption that households have the capacity to reallocate resources to children experiencing growth faltering is not valid. There are no published findings which have demonstrated that GMP alone, in the absence of other interventions, can have an impact on nutritional status. The only circumstances under which a sustainable impact can be seen are when households have the material means to respond to the advice and education which they are receiving.

Assumption 5: The person responsible for implementing the behaviour change has the power within the household to implement the change

Where there may be room for re-allocation, for example when household resources are being allocated to expenditure which does not benefit household members (e.g. expenditure on alcohol), does the child's caregiver have the power within the household to reallocate these resources? Given that in most circumstances women are the caregivers and in many contexts women have less control over resources than men it is unlikely that this assumption will be valid in all contexts.

This analysis shows that while one of the prerequisites for GMP to be implemented adequately is a functioning health system, there are also serious doubts as to whether it is a service which is useful to poor people and contributes to improved health outcomes. SC UK is committed to investigating interventions which address the primary causes of malnutrition identified in different contexts. We aim to use this experience to broaden the current thinking about nutrition interventions beyond behaviour change strategies to interventions which improve households and children's access to resources.

Recommendations

- Nutrition is one of the vital components of successful health outcomes. The WDR should include a substantially increased section on nutrition.
- SC UK research and operational experience show that growth monitoring and promotion is an inappropriate service for poor people in many contexts. The WDR should scrutinise this policy and suggest alternatives, in the light of SC UK's evidence.

NOTE: SC UK has conducted research on large scale investments in nutrition in three countries: The Food Security Project, Ethiopia, 2002-2009; The Nutrition and Early Childhood Development Project, Uganda, 1998-2003; Bangladesh Integrated Nutrition Project, 2000-2004. The purpose of the research is to try to improve nutrition policy and practice and specifically to try to work towards a situation where nutrition services are more appropriate for poor people. The findings of the research will be released in Spring 2003 and will be sent to the WDR team once released.

VII Social Welfare

The criteria which the WDR authors used to determine which basic services it focuses on were, “Those services that fall under public responsibility; that do not primarily work through income generation; and contribute directly or indirectly to health and education outcomes.”¹⁶⁷ This has led to a focus on health, education and water and sanitation service, “with some treatment of rural transport, public security and social protection.”¹⁶⁸ However, the treatment of social welfare, particularly child protection, is very minimal.

SC UK strongly believes that the basic service area of social welfare, incorporating social protection, fully meets the criteria specified in the outline for determining the types of basic services on which to focus. The AIDS pandemic demonstrates the need for social welfare interventions to support the care of the growing number of orphaned children living in communities.¹⁶⁹ In transition countries poor parents are turning to residential care homes, which have many negative outcomes, as the only means for providing for their children’s education and health.¹⁷⁰

Social welfare services and social workers help vulnerable children achieve their right to education and to grow up in a stable home environment which enhances their health and social development. Ministries of Social Welfare, many NGOs and social workers focus on vulnerable groups (like street children, the disabled, refugees) and support them to access health and education. The conceptual framework which the Outline uses – the relationships between clients, providers (public or private), and policymakers and donors – can be readily applied to the social welfare sector in examining how services can work better for poor people. Certainly social welfare is a vital basic service area for poor people.

Recommendation

- Social welfare services and social workers are often vital in enabling vulnerable children to achieve their right to education, health and social development. The WDR outline should include a chapter on social welfare services.

¹⁶⁷ Outline p2

¹⁶⁸ Outline p2

¹⁶⁹ UN Declaration of Commitment on HIV/AIDS (2001), Art. 65

¹⁷⁰ UNICEF (1997a)

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