Policy, Planning, and Research

WORKING PAPERS

Population, Health, and Nutrition

Population and Human Resources
Department
The World Bank
September 1988
WPS 81

Reaching People at the Periphery

Can the World Bank's Population, Health, and Nutrition Operations Do Better?

Richard Heaver

How can field workers be expected to serve their most needy clients when program designers seldom try to identify and target these clients, understand their feelings and behavior, or monitor whether they are being reached?

Policy, Planning, and Research

WORKING PAPERS

Population, Health, and Nutrition

Many population, health, and nutrition (PHN) programs are designed to elicit behavior changes in poor people living at the geographic and social peripheries.

Few programs specifically target the disadvantaged, however, and research about clients focuses mainly on routine statistics rather than on whether education and services do or will meet clients' needs.

The health sector, in particular, has little understanding of what clients feel and why they behave as they do. Yet this is precisely what PHN program designers must know to increase acceptance of public health services among clients most inclined toward early mortality and least likely to accept family planning.

PHN program design should be reoriented to:

- Learn about clients' perceptions and behavior.
- Target the clients most in need of services.
- Give public sector providers of service stronger financial and nonfinancial incentives to understand and reach out to clients.
- Make more use of private or community-based delivery systems that are responsive to client needs.
- Carry out more studies that evaluate program responsiveness to clients.

This paper is a product of the Population, Health, and Nutrition Division, Population and Human Resources Department. Copies are available free from the World Bank, 1818 H Street NW, Washington DC 20433. Please contact Sonia Ainsworth, room S6-065, extension 31091.

CONTENTS

ACKNOWLEDGEMENTS

This paper would not have been possible without the painstaking research assistance provided by Lisa Collis, who did the quantitative analysis of project content; or the encouragement and guidance provided by Tony Measham and Randy Bulatao in both formulating the task and reviewing the result. In addition to my gratitude to them, thanks also to Alan Berg, Nancy Birdsall, Susan Cochrane, Willy De Geyndt, Steven Denning, Arturo Israel, Vulimiri Jagdish, Dean Jamison, Nydia Maraviglia, Sam Paul, Larry Salmen, Stan Scheyer, and others who provided helpful comments on the draft.

REACHING PEOPLE AT THE PERIPHERY: CAN THE WORLD BANK'S POPULATION, HEALTH, AND NUTRITION OPERATIONS DO BETTER?

by

Richard Heaver

1. INTRODUCTION

Poor people in third world countries tend to live at the geographic or social periphery. They are often poor <u>because</u> they live at the periphery--for example, in rural areas far from markets, job opportunities, and social services. They also often live at the periphery <u>because</u> they are poor--because the better off have squeezed them onto marginally productive rural land or into urban slums at the geographic center but social periphery of their societies. The poor at the periphery tend to be those with the highest rates of mortality and morbidity and the lowest rates of family planning acceptance; they are therefore the most important client group for population, health, and nutritic N) programs.

At the same time, because spending on PHN services in most developing countries is biased toward urban and elite groups, the poor at the periphery get less than average from their governments. The poor are also the hardest group to reach, not only because they are often physically distant, but also because they are culturally and socioeconomically distant from third world bureaucrats or doctors (not to mention Bank staff members). Finally, because they are poor and distant, these clients are often also politically peripheral, and hence the clients that public health services may have least incentive to reach. For all these reasons, the Bank is concerned that its PHN operations should do everything possible to reach out to this group.

This paper looks at the Bank's past and present PHN work to see whether the approaches being used are likely to be effective in reaching clients at the periphery, and to suggest some directions for the future. The focus is on design and management of direct efforts to deliver services and education aimed at behavioral change, and hence on the interface between worker and client. Excluded from the scope of the paper are PHN projects and project components aimed at strengthening referral and support systems--for example hospital services, vaccine production or drug supply logistics--even though these are important to the success of service delivery efforts at the periphery. Also excluded from the scope of the paper are Bank-financed efforts to assist the poor through changes in pricing and production policies--for example, in the areas of drug production and pricing or food subsidies--which can also be important complements to direct outreach to the poor.

Unfortunately, the state of the art in the PHN sectors is such that there are no established criteria for judging whether the Bank's PHN projects are sufficiently responsive to client needs. The best way of establishing such criteria might be to look closely at the characteristics of those projects which show the highest levels of contraceptive prevalence

and improvements in health and nutrition, and see what they have in common; these projects must be doing something right. But most of the Bank's PHN portfolio is too new for quantitative evaluations to be available, even where these were designed into the projects; we don't have a sure sense of what is working. At the same time, the Bank cannot wait, while high population growth rates continue and lives are lost due to poor health and malnutrition, for formal evaluation results to be available before attempting improvements in project designs. Under these circumstances, a desk evaluation of ongoing projects has limited value, but should at least be able to:

a) look at the special nature of the task to be done by PHN programs and infer from this the kinds of design and management approaches likely to be needed to maximize their responsiveness to client needs;

b) review the content of the Bank's PHN portfolio, and related sector and policy and research work, to see how far it reflects "best practice" as defined above, paying particular attention to projects and components which seem so far to be relatively successful; and

c) suggest improvements in PHN project designs, and related work programs and Bank practices.

These three objectives are the aims of the current paper.

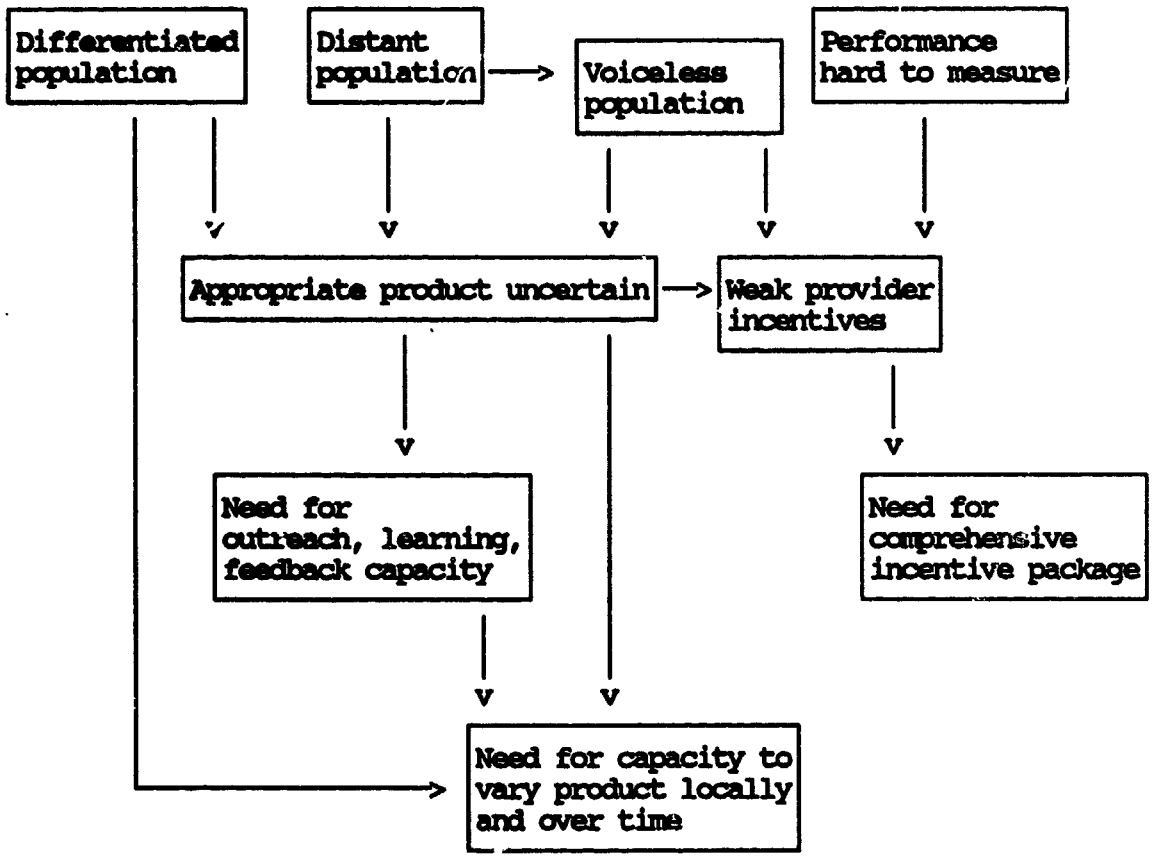
2. THE PHN PROGRAM TASK AND ITS CONTEXT: DESIGN AND MANAGEMENT IMPLICATIONS

One premise of this paper is that it is difficult to generalize about good management practice across tasks, organizations, and cultures, because what works and what doesn't will depend critically on the context. For example, in a corporate context, the theory that a manager's span of control should be between 12 and 20 subordinates may hold good. But in a nuclear research facility, a physicist may be able to manage a team of only two or three, given the complexity of the task and the close interaction needed between team members, while in the concert hall, a conductor can be expected to manage a 40-player orchestra as effectively as a 20-player one. Similarly, generalizations about good management based on studies by western academics of American corporations and public bureaucracies--where the bulk of management research has been done, and its lessons applied--may break down in third world environments.

Given this premise that management approaches should be task- and context-dependent, what then is distinct about PHN service delivery at the periphery? What makes this, as experience suggests, a particularly difficult task? And what special managerial approaches might best respond to this particular managerial challenge? The first section below looks at the characteristics of PHN program clients and the PHN program task, and some of the managerial implications. The subsequent sections look at the organizational and cultural contexts in which PHN program development must take place, and their implications for management.

The Task: Managerial Implications

The task of PHN programs at the periphery is to (a) deliver services and (b) provide information, education and communication which will induce the adoption of desired behavior, including the use of services. Some special characteristics of this task and of the client group, which have significant implications for the design of appropriate management systems, are summarized in this diagram, which is elaborated below.



Client populations at the periphery are highly differentiated. Peoples' behavior, priorities, and beliefs related to family planning, health, and nutrition vary, among other factors, according to their age, sex, level of education, size of family, income level, social status, ethnic group, and religion. This implies that PHN programs must be managed in such a way that the product or service provided to the client can be varied locally in the light of local priorities, beliefs, and behaviors which affect the likelihood of adoption. This runs counter to some conventional wisdom, derived from an epidemiological rather than sociological approach to health care, that a limited, standardized product (for example the GOBIFF package) is appropriate on the grounds that a small number of interventions

can address the small number of diseases which cause the majority of mortality and morbidity. In reality, the product line may need to be varied because:

a) There may be little initial demand for the epidemiologically appropriate interventions. In such cases, services outside the epidemiological package need to be offered first to gain clients' interest and confidence.

b) Adoption of some services in the epidemiologically appropriate package may be more in conflict with local cultural norms than others. In this case, a phased introduction would be appropriate.

c) A given intervention may need to be presented differently depending on local beliefs and practices. The key point here is that the task to be performed is not simply PHN service delivery but PHN extension; the product is not simply the intervention, e.g., immunization or family planning, but the intervention presented in such a way that it is likely to be adopted.

Two other factors, in addition to the differentiated nature of the client population, combine to increase uncertainties about what product is appropriate in a given situation. The physical and social distance of clients at the periphery, and secondly their powerlessness, mean that bureaucrats and service providers have little exposure to them, and hence little knowledge of their beliefs, priorities, and needs. This means that PHN management systems must incorporate a process for reaching out into the client population, learning about clients in a qualitative way, and feeding back what is learned into changes in the product. This implies a process of trial and error, and hence a management system which has the capacity to change and develop its product in an iterative way over time, as well as to vary it according to local conditions.

A further particular characteristic of the PHN program task at the periphery is that, for at least three reasons, it provides few in-built performance incentives for service providers. First, in a situation of low knowledge and high uncertainty, tasks are often not clearly defined and hence are not easily monitored. Second, performance in several PHN tasks is intrinsically hard to measure, especially for some preventive care which leads to lower mortality and fewer morbidity episodes--i.e., non-events which are difficult to monitor. Third, the physical and social distance and lack of influence of clients at the periphery together provide a strong disincentive for service providers to spend substantial time and effort understanding and assisting them. This is particularly so in the case of the poorest clients. In a situation of low demand from non-influential clients plus lack of accountability for performance, PHN management systems need to put a premium on the development of an effective incentive package for service providers. Such incentives might include financial rewards for performance but could also include non-financial incentives such as (a) defining target clients and measuring contact with them, (b) defining quantitative output targets and measuring progress, (c) providing recognition or prestige, (d) providing regular, problem-oriented training,

(e) providing supportive supervision, or (f) increasing providers' accountability to clients.

The Organizational Context: Managerial Implications

Task implementation can be helped or hindered by the organizational environment. IBM, for example, has found its existing corporate bureaucracy to be a suitable organizational environment for managing the manufacturing and sales of its computer equipment, but not for developing new products. Smaller companies with less bureaucratic structures and procedures have done better at this, and eaten into IBM's market share. One of IBM's responses has been to develop separate organizational units, freed from traditional corporate practices, to try and duplicate the entrepreneurial success of the competition. Does the organizational context of PHN program implementation facilitate or hinder the development of the managerial characteristics, outlined above, needed for the task?

Public health systems bear striking organizational similarities across developing countries. Such systems tend to be:

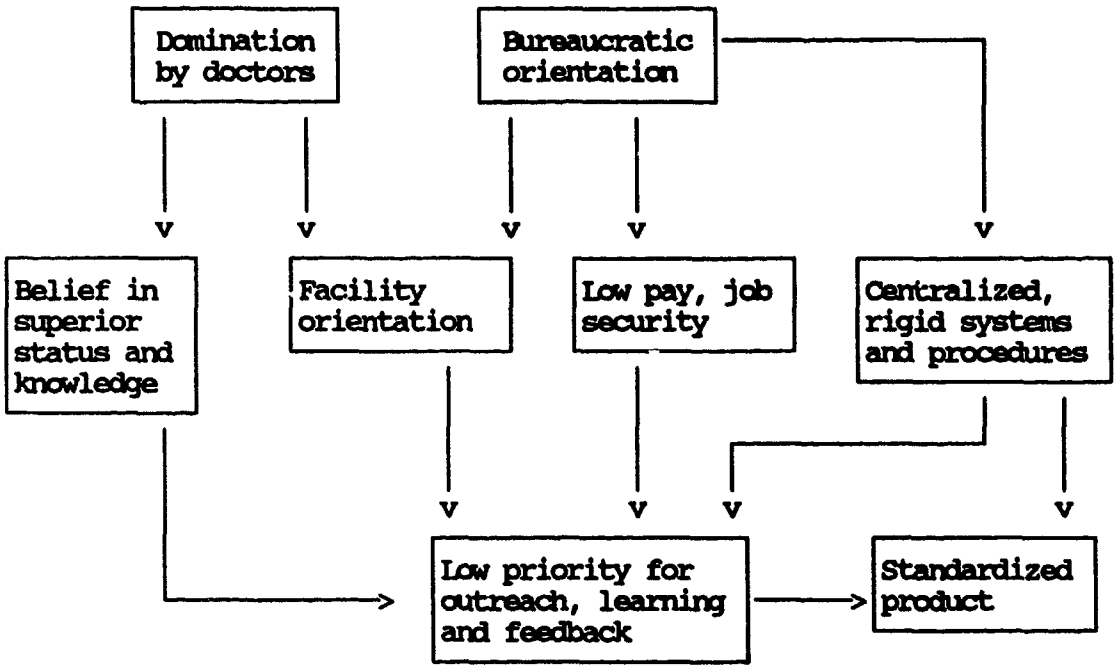
a) Public sector oriented. With some notable exceptions--for example, the development of the NGO sector in certain African countries--the assumption is that government should provide as well as finance public health care activities.

b) Bureaucratic. Planning tends to be centralized, the range of services standardized, and procedures rigid. Staff are promoted on seniority rather than merit and compensated partially for low wages by job security irrespective of performance.

c) Dominated by doctors. Doctors manage preventive care programs, although much of their training is in how to dispense curative care. They have little incentive to specialize in management, in communication/extension, or, within the medical field, in community health. Medical staff are trained to believe in the superiority of their technical knowledge, rather than to treat clients as important sources of knowledge and information.

d) Facility-oriented. Both the bureaucrat/client and the doctor/patient relationship traditionally rest on the applicant/patient coming to the provider when in need of services. This orientation toward the service provision facility rather than outreach is reinforced by the facts that clients have lower status than providers, and that it is more comfortable to provide services sitting in an office than on foot in a village.

The above characteristics might be summarized in a diagram corresponding to the previous one as follows:



This kind of organizational environment actively discourages development of the management approaches best suited to the PHN service task. Public sector health workers have little incentive for performance; are biased toward facility-based care rather than outreach; undervalue the importance of communication and extension skills; and have little incentive to learn from clients with less education and status than themselves. This suggests that, to have a significant impact on clients, the Bank's PHN projects would need to place special emphasis on countering the above incentives and beliefs in public health systems; or else seek alternative delivery systems, with more favorable organizational environments, outside the public sector.

At least three characteristics of not-for-profit NGOs differentiate them sharply from public sector health institutions. First, because of their philosophies, they have a high degree of commitment to community service and to results; though wages may be low, the incentive to perform is high. This is reinforced, secondly, by the dependence of most NGOs on fees from user charges; if service quality falls, the NGO's existence may be threatened. Third, NGOs tend to be small and operate on a local scale, with the result that they are (a) knowledgeable about and integrated into local communities; and (b) managed in a non-hierarchical and flexible way, both characteristics which facilitate organizational learning. NGOs therefore present promising alternative mechanisms for the channeling of Bank funds.

For-profit health care providers, whether village drug vendors,

traditional healers or traditional birth attendants, tend to share the second and third of the above characteristics of not-for-profit NGOs. However, they are usually less technically knowledgeable than not-for-profit providers, and have little interest in the provision of preventive health care or family planning, since these low-demand activities are seldom profitable. Despite these disadvantages, private sector providers are numerous and, because they are physically and socially less distant from clients than the government PHN system, strongly influence clients' PHN behavior. Their outreach and communication system is already in place, even if they are not communicating the "right" messages. This suggests that, in this organizational context, the Bank should have a role in encouraging governments to provide technical training for private providers, and to experiment with incentives which could make the provision of preventive health care and family planning profitable for them.

The Cultural Context

As noted above, the differentiated nature of client populations at the local level means that PHN programs should have a capacity to learn about clients' cultural differences and respond flexibly and appropriately. The cultural and political context at the country level will also help to determine what type of management system will be appropriate for PHN service delivery. For example, the possibilities for using NGOs for service delivery will be affected by a government's overall posture toward the private sector. The potential for using community participation techniques will depend on the level of development and representativeness of community organizations. In cultures with a tradition of social cohesiveness and self-help, a management system emphasizing community involvement can increase the demand for services and act as a performance incentive for health workers through increased accountability. But in cultures where communities are highly stratified by class or caste, community organizations and community participation may only allow local elites to capture PHN service benefits. The soundness of a given managerial approach will therefore depend on the cultural context, as well as the nature of the organizational context and the task to be done. This suggests that Bank projects should take a flexible, non-doctrinaire approach to the choice of service delivery system designs.

Summary

Taking into account the nature of the task and its environment, Bank-assisted PHN programs are more likely to be successful at reaching clients at the periphery if they:

i) emphasize outreach into the client community;

ii) segment the client population and target at-risk clients;

iii) acquire qualitative information about clients and service providers during program design;

iv) develop regular quantitative and qualitative feedback about performance;

v) have the capacity to vary their delivery strategies, package of interventions, and IEC strategies for the needs of particular client groups;

vi) develop a package of financial and/or non-financial performance incentives for field staff; and

vii) make use of NGO, private sector, or community-based service delivery channels as complements or alternatives to the public sector.

3. REVIEW OF BANK WORK IN PHN

This section reviews Bank work in the PHN sector from the perspectives developed in the previous section. The main focus is on the content of the Bank's PHN projects, with briefer discussions of the PHN sector work program and policy and research work program, and of institutional factors in the Bank which shape the content and emphasis of the overall PHN work program. Generalizations about the Bank's PHN projects are based on a desk review of 47 projects appraised between 1981, the year after the Bank's PHN department was founded, and mid-1987, the time that the PHN department was disbanded and dispersed among the regional departments of the Bank. A list of the projects by year is given in Annex A together with the results of the quantitative analysis of project content on the basis of which much of this section is written.

It should be noted that quantitative generalizations about the portfolio are based on features that were or were not included in the original project designs. This study therefore does not take account of changes in design made during implementation. In addition to generalizations about the portfolio, particular features, components or projects are described in the text or the case studies which follow it, where these seem to be useful for replication. But it should also be noted that in most cases, judgments about effectiveness can only be made on an interim basis, since most projects are not yet completed and evaluated.

A. Lending

Outreach

The vast majority of the Bank's PHN projects (about 95%) have included as one of their objectives extension of the coverage and/or quality of population, health, or nutrition services to poorly served populations. The main exceptions are a small number of projects focusing narrowly on manpower training and/or the institutional development of a Ministry of Health at the central level. Several indicators show that there is a consistent effort to include outreach activities in the Bank's PHN projects. No less than 69% of the projects involve the use of community health workers

to deliver services and provide education. No less than 85% of the projects include IEC components or substantial IEC activities, and over half (54%) involve the mobilization of community support groups to encourage the acceptance of IEC and/or services. The issues are therefore not whether outreach activities are being attempted, but how well these are targeted and how effectively IEC and delivery activities are designed.

Targeting

It is hard to see how progress toward PHN objectives can be monitored, or adequate incentives to field staff be provided, without some form of quantitative targets to measure against. Despite the fact that almost all PHN projects include the potentially quantifiable objectives of increasing the coverage and quality of PHN services, only 58% of the PHN projects sampled have numerical targets. An annual breakdown of the projects reviewed indicates that there has been no trend toward increasing quantification of targets in the last five years. In addition, as the Bank's 1986 Review of Health Lending also noted, where there are targets, types of targets are inconsistent between projects, with some focusing on input and output targets; others including hard-to-measure impact targets; and few including process targets and indicators. Case 1, the Zimbabwe Family Health Project (1986), is a good example of a project with clearly quantified output and process targets, and carefully chosen indicators to measure progress.

Broad quantitative targets and indicators allow monitoring of progress across populations, but may or may not be adequate to track progress in reaching specific client groups, or to give outreach workers an incentive to provide services to them. To the degree that client communities are stratified by class and income groups, rather than being homogeneously poor, targeting of particular clients becomes more important. The Bank's PHN projects have made some effort to target their resources to particular groups, in that in 40% of the sample the projects were concentrated on districts with relatively low PHN status or access to services. Much less has been done to target project resources to the particularly disadvantaged within given communities. This is of concern, since in the typical PHN program, workers are too busy to provide services to all clients, and will concentrate on those who come to the clinic for care, or whose homes are easiest to visit for outreach. The poorest and most at risk may not belong to these groups; it is quite possible for high or rapidly increasing levels of service utilization to be coupled with low levels of care for the most disadvantaged. Only one outreach project, the Tamil Nadu Nutrition Project (1980, Case 2) appears to have made a systematic effort to identify and assist the most disadvantaged (as opposed to the broader group of pregnant and lactating mothers and children who are the general beneficiaries of MCH services, and of fertile women who are the main targets of FP services, in the typical project). In the Tamil Nadu case, the use of growth monitoring to target supplementary feeding and other project measures on those children failing to thrive, and on their families, has proved highly cost-effective. A recent evaluation indicates that the project has had twice as much impact on malnutrition, for similar or less cost compared to less targeted programs operating in the same state.

Learning During Project Design

Information about clients. The Bank's PHN projects have been designed on the basis of substantial quantitative knowledge about clients, but very little qualitative knowledge, especially in the health subsector. The situation is summarized in the following table, showing percentages of projects with given types of information.

	Project Type		
Information Type	Population	Nutrition	Health
Basic demographic	88%	81%	83%
KAP	58%	38%	19%
Determinants of behavior	15%	10%	6%

In the above table, basic demographic information includes data on family size, age, fertility, etc.; on nutrition status; and on epidemiological status. The great majority of all project design teams had this kind of information. KAP information refers to the knowledge, attitudes, and practice of clients, i.e., their PHN-related beliefs and behaviors, on which there was information for many population projects, but much less often for nutrition and health projects. Project designers were by far the least well informed in all subsectors about the determinants of behavior--why clients believe and behave as they do, as opposed to what they practice. The data show no trend over the past six years toward improvement in the amount of qualitative information available, except in the case of the health sector. The fact that population has the most qualitative information and health the least, probably reflects the worldwide fertility survey effort during the 1970s and early 1980s in population and the fact that the Bank has been active longest in the population sector, whereas data are far weaker and the Bank's activities only six years old in the health sector.

The unavailability of qualitative information about clients during project design is of serious concern in sectors where extension is the heart of the task; how is IEC--which is included in almost all the projects--to be effectively planned in the absence of such information? Other sectors in the Bank have been experimenting in recent years with anthropological techniques (mainly structured interviewing and participant observation) for rapid collection of information about project clients. This began in the urban and rural development sectors as a joint effort with the Project Policy Department's Public Sector Management Unit. The original idea was to collect qualitative information from clients during implementation about their reactions to projects, so that mid-course corrections could be made to make designs more responsive to local needs. More recently, these techniques have been applied further upstream during project preparation, so

as to incorporate clients' views into the initial project design. A book by Larry Salmen, Listen to the People (IBRD/Oxford University Press), summarizing the Bank's experience in this area, was published in early 1987.

These techniques were applied during preparation of Ethiopia Family Health (1986, Case 3). This study, which took less than six months and cost less than US$15,000, excluding the cost of Bank staff assistance, yielded information which appears critical for project planning purposes, and which could not easily have been obtained from a standard KAP survey. This appears to have been the first effort since some of the early nutrition projects (e.g., Brazil Nutrition 1976 and Indonesia Nutrition Project 1977, Case 6) in which the Bank has funded systematic collection of anthropological information about PHN program clients.

Information about service providers. The pattern of information availability is the same with regard to service providers. Of the appraisal reports, 42% contain a basic description of provider practices, or refer to the existence of information about these. Only a small minority of reports discuss the determinants of provider behavior. Once again, the information gap is cause for concern. It is unclear how appropriate training and incentive systems can be designed for service providers without an understanding of the inappropriate perceptions and practices which need to be corrected.

Two recent projects attempted a systematic study of provider practices prior to appraisal, with very different approaches. Focus group techniques were used during preparation of the Nigeria Imo Health Project (1987, Case 4). They yielded useful qualitative information about both service provider and client attitudes and practices, took less than two months to implement, and involved about five (already trained) borrower staff for a month each, plus the time of one consultant. The project preparation facility for the Ethiopia Family Health Project (1986, Case 5) funded a functional task analysis of service providers, developing somewhat further a methodology last applied in a Bank PHN project in the first Pakistan Population Project (1983) but not subsequently used. This time-and-motion study yielded detailed information about the divergence between providers' job descriptions and actual practices for a cost of less than US$40,000 and took about five months.

Learning During Implementation

Information was collected during this review about three types of learning which have been built into the implementation phase of Bank PHN projects. First, learning about the effectiveness of IEC; second, learning about the effectiveness of service delivery; third, learning about performance from routine service statistics collected through the program's management information system. In addition, a number of projects have funded surveys to collect basic demographic, health, and nutrition data during implementation, to fill gaps in knowledge and to provide baseline information against which to evaluate project progress later. The number and type of these surveys were not quantified in this review.

Only about half of the 85% of projects that included an IEC component made provision for systematic feedback from clients about its effectiveness. Where this occurred, this was most commonly (44% of projects) through surveys or studies aimed at establishing changes in awareness and practice. In a minority of projects (about 8%), an effort was made to obtain feedback from service providers on a regular basis about the effectiveness of IEC. A particularly thorough effort to obtain feedback about the appropriateness of IEC messages was made in the Indonesia Nutrition and Community Health Project (1977, Case 6). This represents the Bank's only systematic attempt to date to apply social marketing techniques in the PHN sectors. Given the differentiated nature and distance of client populations and corresponding uncertainty about what IEC strategies and messages are appropriate, the fact that systematic qualitative feedback about IEC is not more widespread is cause for concern.

The same applies to feedback about the appropriateness of service delivery strategies, where only 36% of the projects had made provision for systematic qualitative feedback. This was accomplished in 23% of the projects through one-off surveys of client demand for, utilization of, and attitudes to services. Only 19% of the projects planned to do this through the development of regular feedback from clients, principally through the formation of local health committees to liaise with local service providers as for example in India Population 4 (1985) and the Guinea project (1987). Bank thinking about the development of qualitative feedback from clients in the PHN sectors appears to have lagged behind that in the agriculture sector. Feedback from clients is the driving force of the training and visit system of agricultural extension (Case 7), now being implemented in more than 40 countries.

By far the most important form of learning in the Bank's PHN projects has been through the development of management information systems for the collection, analysis and use of routine quantitative performance data. No less than 79% of the projects in the sample included efforts to strengthen management information sytems (MIS), the most systematic of which took place in the second, third and fourth India population projects (1980, 1983, and 1985; the early experience with this is documented in PHN Technical Note 85-3, "Managing Health and Family Planning Delivery Through Management Information System"). To the extent that these MIS development efforts are successful, they will yield useful information on whether projects and interventions are progressing as planned. They will not, however, be a substitute for qualitative feedback from clients as a key source of information on <u>why</u> (as opposed to whether) implementation problems are occurring.

<u>Flexibility During Implementation</u>

The inflexibility of their management procedures predisposes bureaucracies toward a "blueprint" approach to planning and implementation, whereas it is recognized that a "learning process" approach is more appropriate to the uncertainties of people-oriented development activities (<u>World Development Report</u> No. 6, 1983, p. 92). A small minority (about 10% of the Bank's PHN projects have included specific institutional changes to

encourage learning, problem-solving, innovation, and flexibility in implementation. The Indonesia Nutrition Project's social marketing approach is an example in the case of IEC (Case 6). In the case of both IEC and services, Bangladesh Population III (1985) is financing a Management Development Unit staffed by consultants external to the Ministry of Health to work in the districts where the project will be initially implemented in order to (a) provide on-the-spot advice with implementation problems, (b) identify systemic problems which cannot be solved in the field, and seek appropriate solutions in consultation with senior management; and (c) feed back the lessons from experience in the pilot districts into the nation-wide management strategy for service delivery. In this case, a learning process has been established through a centralized unit in direct touch with the field.

By contrast, the successful Tamil Nadu Nutrition Project (1980) was designed on the basis of a detailed blueprint, elaborated in the project implementation volume and not changed very significantly during implementation. This approach probably fits the rather special nature of the project--food supplementation--which is characterized by (a) limited, clear goals (closer to a vertical program than an integrated, multipurpose MCH program), (b) a product (food) for which there is existing demand, and (c) the relative ease of measuring progress in quantitative terms through weighing. Such an approach may be less suited to activities where demand has to be generated, and little is known about how to generate it. Comparisons have often been drawn between the Tamil Nadu project and the training and visit (T&V) extension management system, but these are only partially valid. The systems are alike in the rigid structure of their routines, specified in detail for each level of staff; but the Tamil Nadu system is geared to delivering a standardized project, whereas the T&V system is designed to constantly vary the product both over time and in different locations (Case 7). In the T&V case (in contrast, for example, to the Bangladesh project cited above), the learning process has been established in a decentralized way, through each and every field unit, so maximizing the potential responsiveness to local conditions.

The absence from most PHN project designs of specific managerial arrangements to foster innovation and flexibility during implementation does not mean that these do not occur in the majority of projects--although the inertia of bureaucratic management systems will tend to discourage their emergence. The limitations of a desk study leave unanswered the following important questions. (a) How often (and how) are performance problems identified through the MIS corrected? (b) Are project-financed KAP studies of client responses to IEC used to develop alternative strategies or shelved? (c) Is the feedback gained directly from clients through their participation in health committees, etc., listened to and acted on?

Incentives

The Bank has not systematically studied the issue of field worker (as opposed to client) incentives in the PHN sectors, and has no generally accepted vocabulary or conceptual framework for approaching the subject. But for practical purposes, three broad types of action to increase

performance incentives can be distinguished. First, efforts to increase accountability, which can take the form of clarifying worker responsibilities, setting targets and developing performance measures, providing feedback, and involving clients in assessing workers' effectiveness. Second, efforts to increase workers' rewards, which can take the form of increased pay or per diems, linking pay with performance, providing improved housing, providing career development opportunities, awarding places on training courses, or conferring prestige and recognition on outstanding performers. Third, efforts to support and involve workers, which can take the form of providing supportive supervision and regular on-the-job training; development of communications, such as newsletters, between center and periphery; and encouragement of joint problem-solving and peer review at group meetings of field workers in the same locality. It should be stressed that there may be very limited scope to change incentives in public sector bureaucracies. But to some degree, action in one of the above areas can substitute for action in another. For example, where civil-service-wide pay restrictions prevent increases in financial rewards, efforts to better support workers and measure and compare performance can nevertheless increase motivation.

The appraisal reports for the sample of projects studied contain little explicit discussion of incentives problems and few explicit proposals for strengthening performance incentives. This is not to say that the projects as designed will have no consequences for performance incentives, since many common project activities potentially affect incentives--for example, the targeting which is a feature of 58% of projects; the MIS development in 79% of projects; the management training in more than 50% of projects; and the development of supervision systems funded in 83% of projects. However, it is not possible to determine in a desk study how far these interventions are in practice designed to affect incentives. For example, where targets are a project feature, will they be solely aggregate project or program targets, or will they be broken down during implementation in the form of individual targets for workers. Or where an MIS is developed, will this be primarily for aggregate feedback to management on project performance, or will it be used to provide individual feedback to workers. But at least two general conclusions can be drawn from the review in this area. First, that the project activities which could potentially influence incentives are clustered in the areas of increasing accountability and support rather than increasing rewards (no more than 2% of the projects attempted to improve financial performance incentives). Second, that projects do not appear to have taken a planned approach to strengthening incentives, for example by combining different types of incentive measures into a comprehensive package for a given worker cadre, as has been done in the T&V extension system (Case 7).

Using Resources Outside the Public Sector

The Bank's PHN projects have made significant use of resources outside the public sector for program implementation. This has taken three main forms: use of community health workers; mobilization of community support groups; and financing of not-for-profit NGOs for service delivery. In the 69% of projects which feature community health workers (CHWs),

support has been mainly for training of CHWs and traditional birth attendants in the provision of basic preventive and curative care and in IEC and for improving their supervision. It is not known how cost-effective these workers have been.

Community support groups have been used in a variety of ways. Most commonly (59% of the projects), they have been mobilized to serve as channels for IEC or service acceptance. But in 29% of the projects, community groups, usually women's organizations and groups of community leaders, were trained in how to provide IEC. And in 27% of the projects, community groups were used to provide services; for example, women's groups in Malawi (1987) were to be trained in health surveillance and in the provision of simple care, and in Ghana (1985) the project was to finance grinding mills for women's groups to produce weaning food. In the Tamil Nadu Nutrition Project (1980), women's groups played an important role in nutrition IEC, in assisting with the monthly weighing of children for growth monitoring purposes, and in the local production of supplementary foods.

In at least three projects, communities were intended to have a major management and implementation role in the health system. In Morocco (1985), health management committees were set up to participate in health program planning with the Government and to manage health resources at the local level; in both Peru (1982) and Nigeria Imo (1987), funds were included in the project to finance small-scale health projects proposed and implemented by local communities; and in Nigeria Imo, the Village Health Development Committees were also to undertake health surveillance and identify individuals at high risk of disease. Finally, in 23% of the projects, communities were mobilized to provide in-kind or financial support for the government health system; in Indonesia Population 4 (1985), for example, village volunteers assisted in local health centers, and in the Niger project (1986), the project beneficiaries were expected to finance the maintenance of their health centers.

A somewhat smaller proportion of projects (21%) provided finance for activities carried out by NGOs, while it appears that only one project has made use of the commercial sector--the Colombia Nutrition project (1981), where shopkeepers sold subsidized food to the holders of food coupons. Three types of assistance have been provided to NGOs: provision of training and materials to assist NGOs to carry out IEC activities, as in Lesotho (1985) and Sierra Leone (1986); the provision of small amounts of money (US$0.1-0.5 million) for innovative activities to be carried out by NGOs, as in Botswana (1984) and Zimbabwe (1986); and assistance for NGOs to take over and run health centers, as in the Kenya Integrated Rural Health (1982) and Pakistan (1983) projects. Only in Bangladesh (1979 and 1985), have substantial funds (over US$4 million) been allocated to finance FP/MCH activities undertaken by NGOs, and no report on this experience is as yet available.

Over the period covered by this review, no increasing or diminishing trend is apparent in the use made by the Bank's PHN projects of non-government resources of any of the above types.

Lending: Summary of Findings

Positive: Most of the Bank's PHN projects incorporate efforts to develop outreach activities both for service delivery and for information, education, and communication.

Most of these outreach efforts take place through government health bureaucracies, but there is also a substantial effort to enlist the help of communities and NGOs (although not the commercial sector) in these efforts.

Negative: Many projects have no quantitative, aggregate performance targets, and only a small minority of projects aims to specifically target the most disadvantaged people in the communities served.

Information acquired about clients during project preparation is mainly quantitative; there is little understanding of the determinants of client behavior, especially in the health sector. The gap in qualitative information is generally not filled during project implementation, when the focus is on collecting routine service statistics, rather than inquiring into whether IEC and services appropriately meet client needs.

These two findings raise serious concerns about the effectiveness of the outreach efforts built into the projects. Are project services and IEC efforts likely to increase existing low levels of utilization and acceptance if they are designed in substantial ignorance of what clients feel and why they behave as they do? Can field workers be expected to be providing services to the most needy in their communities, when there is seldom a special effort to identify these clients and to monitor whether workers are reaching them?

Inconclusive but probably negative: A desk study of project plans cannot throw light on the degree to which project interventions are in practice changed during implementation to better meet client needs. However, very few project designs feature special institutional arrangements to encourage learning and adaptation during implementation. (It should also be noted that for the majority of projects where qualitative knowledge of clients is weak, there may be no valid basis on which to redesign interventions anyway.)

Many project interventions--such as targeting, MIS development and improvement of supervision systems--potentially affect worker performance incentives, but it is not known how they have actually done so in practice. In general, however, projects appear not to have taken a systematic approach to designing comprehensive incentive packages for particular worker cadres (and again, in most projects there may be insufficient qualitative knowledge about both clients and service providers to know what such packages should incorporate).

B. Sector Work

During the period reviewed, the Bank's PHN sector work consisted mainly of a series of rather broad surveys at the country level. Their purpose was to familiarize the Bank with PHN conditions, the structure and organization of health services, and the main problems and issues in the sectors, preparatory to identifying first lending operations in each country. Now that projects are under preparation or implementation in most countries interested in borrowing in the PHN sectors, attention is being turned to the design of a new generation of narrower and deeper subsector studies, which may in turn lead to a new generation of more focused subsector projects.

The intentionally broad scope of the first generation of sector work meant that no deep analysis of service provider/client relations could be attempted. This section is therefore correspondingly brief, merely noting that, insofar as the first generation studies dealt with management issues, they tended to focus on the structure of services; the staffing situation and manpower gaps; and the role and duties of different health cadres, mainly as all of these pertained to government services. Less attention was given to issues of service efficiency and effectiveness; processes and incentives, as opposed to structures; or to commercial, traditional and private not-for-profit PHN services. Insofar as these studies addressed client-related issues, they focused more on variation in PHN status by region and over time; and less on PHN status by income group, client perceptions of PHN problems, or client attitudes to PHN services from different types of provider.

One exception to this broad picture was the Ecuador Population, Health and Nutrition Sector Review (1986) which for the first time presented a systematic framework for analyzing the sector's institutional strengths and weaknesses. This included a "management audit" covering organizational designs (including issues of structure, centralization, autonomy, and coordination); organizational culture; planning systems; client population; provision of services; logistics of materials and maintenance; financing and budgeting; personnel; leadership; and control systems. However the breadth of this review--as indicated by the subject matter of the audit--prevented a detailed analysis of the particular design and management issues which are the concern of this paper.

C. Policy and Research Work

Completed Work

Three broad reviews covering respectively population, health, and nutrition sector work and lending were undertaken by the former PHN departmental front office. In addition, the PHN Policy and Research Division's Technical Note (TN) Series includes about 15 studies (out of a published total of about 135 titles) relevant to the management of PHN services at the periphery, and a few other relevant studies have been issued in the now-discontinued Bank-wide Staff Working Paper (SWP) Series. This section summarizes the general scope of these studies through FY87. It

does not attempt a critical analysis of each report. Complete titles for each paper referred to below by its series number can be found in Annex B.

Six papers looked at the effectiveness of entire population, health, or nutrition delivery systems in different country settings. Three are cross-country studies--one (SWP 345, 1979) reviewing the early experience with family planning programs in seven countries, one (TN 85-7) reviewing family planning pilot projects in Africa, the third (TN 86-30) organization and management issues in parasitic disease control programs. The other three papers looked at projects in particular countries. One (SWP 507, 1982) reviewed experience with 14 research and pilot PHN projects in India, another (SWP 515, 1982) focused solely on the Narangwal (India) project experience and the advantages and disadvantages of integrating family planning and health services. The third focused mainly on an analysis of latent and effective demand for family planning in Bangladesh, but contained a discussion of the service delivery system developed under the Matlab project and its extension areas.

Four papers looked at techniques for gathering information for managerial purposes. Three were about monitoring and evaluation--one (TN 85-2) reviewing monitoring and evaluation in completed Bank population projects, one (TN 85-1) looking at monitoring and evaluation experience in Bank projects in other sectors, and the third (TN 85-3) examining how management information systems could be used as a tool for managing population and health service delivery. The fourth paper (TN 86-1) reviewed the experience with focus group interviewing in the Nigeria Imo project summarized in Case 4.

Two papers looked at alternative physical facilities for service delivery, one (TN 86-4) reviewing the cost-effectiveness of health posts, the other (TN 86-5) the cost-effectiveness of mobile health units.

Three papers reviewed non-government channels for service delivery. One (TN 86-6) examined different countries' experience with the promotion and sale of contraceptives through commercial channels (though entitled social marketing of contraceptives, it does not explore social marketing in its broader definition). The other two review experience with community health workers--one (TN 86-3) a cross-country study, the other (TN GEN 19, 1984) an examination of the role and future of the barefoot doctor in China.

Two studies looked particularly at IEC--one (TN 85-10) focusing on communication support for population activities in sub-Saharan Africa, the other (TN RES 12, 1984) on the state of the art in nutrition education.

Finally, three papers commissioned by departments other than the former PHN department are directly relevant to the subject. Two dealt with the question of community participation. One (Discussion Paper No. 6, 1987), commissioned by the former Project Policy Department, was a cross-sectoral review of the Bank's experience with community participation; the other, commissioned by EDI and not circulated among operational staff, was a cross-agency review of the concept of community participation and

experience with it in the PHN projects of the major donors. The third paper (SWP 662, 1984), also commissioned by the former Project Policy Department, looked at the potential for adapting the Bank's training and visit system of agricultural extension to the PHN sector.

Current Work

Five relevant studies were under way in mid-1987 in the Population and Human Resources Policy and Research Division. Three of these dealt with the issue of financial incentives. One (Chomitz and Birdsall) was a broad review of the experience to date with both client and provider incentives, and of related conceptual, economic and ethical issues; one (Allison) looked at the potential for using incentives to increase client and provider involvement in IEC activities; and the third (Stevens) was a review of experience in the Ammanpettai program, India, with the payment of incentives to unsterilized, married women for remaining non-pregnant. Of the remaining two studies, one (Chernichovsky and de Leeuw) was a study of the cost-effectiveness of the Indonesian family planning programme, including the relative cost-effectiveness of different service delivery models. The other (Lewis and Kenney) planned to review the role, achievements, and potential of the private sector in family planning.

Conclusions

A study-by-study analysis would be required to assess the value of the above work to the Bank. But the following broad conclusions can be drawn from the overall scope of the subject matter. First, though the range of the studies is impressive, two areas--targeting and qualitative learning--which this paper argues have been given insufficient emphasis in project lending have also received little emphasis in the Bank's policy and research work. Second, that nearly all the studies are desk reviews, reflecting the fact that the Bank has not been engaged in operational research in the field, with the recent exception of the cost-effectiveness study of the Indonesian family planning program. Third, that most of the studies focus on rather broad strategic issues (for example, the pros and cons of community-based distribution of contraceptives) rather than detailed organization and management issues (for example, the kinds of incentives, supervision and training which make outreach workers effective at community-based distribution). The last two conclusions are related, in that the PHN literature, on which most of the studies are based, is deficient in analysis of process issues during implementation.

Specific suggestions for the focus of future studies in the subject area of this paper are made in Section 4 below (Conclusions and Recommendations).

D. Institutional Issues in the Bank

The focus of Bank work in the PHN sectors is the product not only of the intellectual state of the art in the sectors and of Bank assistance policy, but also of the Bank's institutional context. This partially determines whether and how know-how and policies are disseminated and

applied in the design and implementation of project and sector work tasks. This section briefly reviews some of the institutional factors which may have influenced how the Bank has gone about the task of assisting Borrowers with the development of their PHN services at the periphery.

Staffing

Professionals working on PHN operations in the Bank have tended to be of two types: population and public health specialists, and economists. The three operational divisions of the former PHN department contained between them only one sociologist, one management specialist, and one communications specialist. This staffing pattern helps to explain why the Bank has focused more on the collection of epidemiological and quantitative information about clients than on behavioral and qualitative information; and why more attention has been paid to the choice of PHN interventions to be emphasized in the programs the Bank supports, than to the detailed design of outreach systems to deliver them. The policy and research division of the former PHN department was heavily dominated by economists, and was not an effective constituency for advancing sociological, management, and institutional concerns in the work of the operating divisions.

Beliefs

There is uncertainty among at least some PHN project officers whether the Bank should concern itself with the details of outreach system design and implementation. On the one hand, there is the argument that the Bank is a bank, and that its job is therefore to agree on broad project designs and conditionality, leaving the Borrower, as implementor, to concern itself with the detailed planning of implementation in the field. On the other hand, there is an alternative argument that, while the Bank should concern itself with these issues because of their importance to program success, the Bank is not suited for this task because of its centralized nature, compared, say, to UNICEF.

This paper suggests that the first of these arguments confuses the Bank's role in institutional development with the Borrower's role in implementation. While it is never the role of the Bank, as financial intermediary, to implement projects, it is the Bank's role, as development agency, to assist with the Borrower's institutional development to ensure that projects are effective and loan funds safeguarded. This role in institutional development should include assistance with any Borrower systems and processes which are critical for success--whether they are accounting systems for tracking disbursements, or learning processes for improving services to clients. The second argument--that the Bank cannot operate effectively at the periphery--is contradicted both by PHN sector successes like the Tamil Nadu nutrition project, and by the Bank's heavy existing involvement with client/provider issues in agricultural extension and irrigation water management. More fundamentally, it can be argued that if the Bank does attach priority to its projects effectively reaching people at the periphery and is indeed not suited for the task, then it would be the Bank's job to rearrange itself institutionally so as to do better.

Incentives

Several aspects of the way the Bank does business have tended to discourage PHN staff from involvement with issues of provider/client relations and outreach system design--or at least failed to encourage such involvement. First, with regard to project preparation, the management review process has tended to focus on project briefs and appraisal reports, with their rather broad summary of project content; project officers have not in general been subjected to much scrutiny of the detail of how the project will improve services at the periphery. Similarly, management review has tended to focus more on project content, than on the process used to develop that project content--for example, the amount and kind of knowledge of service providers and clients on which the design was based, and the amount and kind of consultation involved in putting the project together.

Second, with regard to supervision, the Bank's centralized structure and its six-monthly "blitz" approach to supervision have made it difficult for project staff to build up a deep knowledge of processes in Borrower institutions and of performance in the field. Despite the PHN sectors' higher than average supervision coefficients, staff have felt that the time that they spend in the field is inadequate, and that the time that can be devoted to management issues at the periphery is squeezed by the need to attend to disbursement and procurement issues of relatively high visibility to Bank management.

Third, project staff have not been sent strong signals by management that project designs should make a particular effort to reach the disadvantaged. This may be partly a reflection of the Bank's greater preoccupation with macro-adjustment issues and reduced focus on poverty alleviation during the 1980s. It is also perhaps the product of a mistaken belief that the share of Bank lending devoted to the social sectors is in some way automatically money spent on poverty alleviation. Reinforced by the general recognition that the PHN sectors are not amenable to cost-benefit analysis, this belief may have encouraged a lack of rigor in ensuring that project-funded services go to those who most need them.

The Diffusion of Ideas

As striking as the innovations themselves which are noted in the cases annexed to this review, is the degree to which innovative projects in the PHN sectors appear to have been developed at the initiative of individual project officers working in isolation, with little dissemination of new ideas and approaches to other staff. A case in point is the Indonesia Nutrition Project's innovative and successful work in social marketing, which has not been replicated despite the fact that it was documented as far back as 1980. Indeed, it was apparent that in the operating divisions of the former PHN department, project staff were often unaware of innovative work being carried out by other staff even in their own division. And while innovation by individual project officers was officially encouraged by departmental management, there was no complementary effort by the policy and research division to consciously and strategically

foster innovation in this particular field in the operating divisions.

The slow dissemination of ideas was the result partly of inadequate communications between and within PHN divisions, but also, and more fundamentally, of a low priority given to staff training and to learning from experience within and outside the Bank. With regard to training, the operational work pressures which in all Bank sectors discourage staff from seeking training were not counteracted by management insistence that a certain number of weeks per year be devoted to this activity. With regard to learning from experience, a systematic review of experience outside the Bank with service delivery at the periphery was only commissioned in 1986, and no systematic effort was made by the PHN department to learn from the experience of other sectors within the Bank. Valuable (but very broad) internal reviews of operational work were carried out for each of the population, health, and nutrition sectors, but the latter two, like this review, were desk studies only. Primary reliance for learning from field experience--other than from routine supervision reporting--continues to be placed on the Bank's ex-post evaluation system, which, however, tends to produce its results 10-12 years after project appraisal. As of mid-1987, the two most recent PHN project performance audit reports dealt with Bangladesh Population 1 (1975) and Indonesia Population 2 (1977).

4. CONCLUSIONS AND RECOMMENDATIONS

The Bank's work in the PHN sectors has put considerable emphasis on the development of IEC services and outreach delivery systems. Because formal evaluations of most projects have not yet been carried out, we do not yet know for certain what impact these activities are having. However, it appears that the Bank's knowledge of the determinants of both client and service provider behavior is in most operations too scanty for it to be sure whether the design of these IEC services and outreach systems is appropriate to clients' needs and circumstances. It also appears that the Bank has not done enough to target project-financed services to priority clients, particularly the most disadvantaged clients at the periphery. These findings are worrying, in a situation where most Bank-supported PHN services are managed by public sector agencies with little incentive to reach the poor. Whereas, in the private sector, the firm that fails to be sufficiently responsive to its customers goes bankrupt and is replaced by a more effective company, in public health care the clinic which fails to meet its clients' needs will survive indefinitely with low levels of utilization.

This review concludes that the Bank can and should do more to ensure that the PHN services it supports are responsive to clients' needs, that they are more driven by the market. In general terms, Borrowers and the Bank could move in this direction by

- learning more about clients' perceptions and behavior;
- doing more to target the clients most in need of services;

- o involving clients more in designing, monitoring and implementing programs;

- o giving public sector service providers stronger incentives to understand and reach out to clients;

- o making more use of client-responsive service delivery systems outside the public sector; and

- o carrying out more evaluation studies to determine the responsiveness of programs to clients.

The remainder of this section suggests a number of specific changes in the way the Bank does business in the PHN sectors, which, taken together, might add up to a strategy for achieving the general reorientation outlined above.

Sector Work

Just as the kind of question asked determines the kind of answer received, the kind of sector work which the Bank undertakes strongly determines the nature of the lending which follows. As the Bank moves into the new generation of narrower and deeper subsector studies, it is recommended that the Country Departments (CDs), Technical Departments (TDs) and the central Population, Health and Nutrition Division (PHRHN) should jointly select countries where the institutional context and the level of commitment are favorable and should

- o undertake at least two pieces of sector work focusing specifically on the management of PHN service delivery at the periphery, and analyzing inter alia

  a) the state of qualitative knowledge about clients and service providers,

  b) who should benefit and who actually benefits from the programs,

  c) the incentive framework which determines the priorities and activities of service providers, and

  d) the present and potential contribution of the not-for-profit, traditional and commercial private PHN sector in as great detail as the public sector.

Lending

Identification/preparation. It is recommended that managers in the CDs should, for all future PHN projects with a service delivery/IEC orientation, ensure that

- o qualitative learning about the determinants of behavior of clients and service providers is used in project design (ready models can be found in the existing experience with beneficiary assessment, focus group interviewing and functional task analysis, and funding could often be arranged through the Project Preparation Facility);

- o quantitative output and process targets are developed;

- o particularly disadvantaged groups are identified and targeted where feasible (in this connection, special consideration should be given to the wider use of growth monitoring along the lines practiced in the Tamil Nadu nutrition project, not solely as a way of targeting supplementary feeding, but as a way of identifying the particularly disadvantaged for targeting of the whole available range of PHN and other services); and

- o MIS systems are developed which feed back performance data to field workers as well as upwards to managers.

In addition, it is recommended that PHRHN, the TDs and the CDs should jointly

- o identify several countries and projects for systematic experimentation with outreach systems which promote learning from clients and the adaptation of project interventions during implementation on a decentralized basis (ready models are available in the existing experience with social marketing and T&V); and

- o identify one or two countries and projects where a special effort would be made to develop private sector provision of services and/or IEC.

Supervision. The appropriateness of learning processes as opposed to blueprints in PHN service development at the periphery suggests a more important role for supervision, as compared to preparation and appraisal, than has been the de facto case in the Bank in the past. Yet, in a period of budgetary stringency and reduced supervision coefficients, it is clear that the time staff can put into field supervision will be strictly limited, and will, in many countries, decline. Under these circumstances, it is recommended that

- o project staff encourage more emphasis in project designs on strengthening the Borrower's own supervision process, with technical assistance as necessary, thus minimizing Bank staff's own technical assistance role during implementation;

- o project staff work with Borrowers to develop a routine reporting format, to be completed by the Borrower before the supervision mission, which would be tailored to the individual project, but would cover at least civil works progress, procurement and

disbursements, so that during the mission staff can spend more time in the field on selected outreach management issues; and

- o regional managements consider building on recent efforts (Kenya, India) to decentralize the supervision function together with one or more PHR staff to resident missions in countries with larger portfolios. While field postings of headquarters staff are expensive, if these staff are leveraged with locally hired staff, then substantially more time could be put into supervision for the same or less cost than at present (assuming that the Bank is prepared to move to dollar rather than staff week budgeting for supervision).

Policy and research work

The former PHN Policy and Research Division provided little leadership in the area of outreach management either intellectually, or in terms of learning from successful project experience and acting as a dissemination channel to the operating divisions. Given the central importance of this subject area for the impact of the Bank's work, it is recommended that

- o PHRHN and the TDs jointly initiate a series of formative evaluations in the field of five or six ongoing Bank projects and two or three non-Bank projects. These should be rapid and focused on processes in the areas of outreach and IEC program management, rather than on overall impact, which cannot be determined during implementation. The aim would be to feed back lessons learned to project staff in operations faster than can be achieved through the Bank's formal evaluation process.

- o PHRHN should initiate a small operational research program focusing on outreach and IEC program management. The purpose would be to systematically test alternative program management systems at the periphery in the context of Bank projects. This operational research could take place, among others, in one or more of the projects testing learning process approaches (see above), but should involve a more rigorous effort to document processes and determine cost-effectiveness than would be possible with the formative evaluations and routine in-project experimentation proposed above.

- o PHRHN should initiate papers in the Technical Note Series to give project staff operational guidance and ideas in several neglected areas. These might include

  a) a paper discussing, with case examples, the advantages and disadvantages of different qualitative learning methodologies,

  b) a paper on targeting, which would review the possibilities and limitations of process, output and impact targeting,

develop guidelines for "minimum standards" for targeting in Bank PHN projects; and examine alternative methods for targeting the most disadvantaged within client communities,

c) an operational summary of EDI's paper on community participation in health, which contained a useful conceptual framework for thinking about the appropriateness of different degrees and types of community participation for different tasks and cultural environments, and

d) a paper developing a conceptual framework and providing case examples of different approaches to providing incentives for service providers, including both financial and non-financial incentives.

- In view of the shortage of budget resources, PHRHN should seek outside grant funding for some or all of the above activities, possibly along the lines of the substantial United Nations-funded operational research program initiated and executed by the Bank's Urban Department.

Institutional

A greater focus on issues of management at the periphery will only be possible if PHR managers send project staff the appropriate signals. It is therefore recommended that

- CD managers should, in their reviews of project briefs, give as much attention to the processes used to prepare projects, and to management process and incentive interventions within projects, as to their broad investment content.

In view of the recent dispersal of the former PHN department in many scattered units across the Bank, and the fact that communications between former PHN divisions were already weak before the reorganization, special attention will be needed to providing a central focus and coordination arrangements for further work on management issues at the periphery. It is therefore recommended that

- PHRHN appoint a staff member, possibly with outside funding, to work full time to (a) provide intellectual leadership in this subject area, (b) coordinate the interchange of ideas between the various PHR divisions of the Bank and with the outside world, and (c) manage (and if necessary, seek funding for) the policy and research program outlined above. Such a person should ideally be a management specialist with sociological/anthropological skills or the reverse, and should have substantial field experience with PHN programs.

- Each TD should identify a staff member who, on a part time basis, would work with his PHRHN counterpart to assist with the above activities as they relate to that Bank Region.

- While individual initiative by project officers should in no way be discouraged, PHR managers should take a more planned, strategic approach to the development and dissemination of experience in management at the periphery by lending their support to an informal working group of interested PHR operational staff who would work with the PHRHN and TD specialists to refine, revise, and follow up on the various initiatives proposed above.

ANNEX A

SUMMARY OF QUANTITATIVE ANALYSIS OF PROJECT CONTENT

The percentages of projects with given elements in their designs, by year and by region, are shown in this table. In the following table, the presence or absence of an element in a given project is indicated by a 1 or a 0.

ELEMENTS IN PROJECT DESIGN	All projects	Year approved							Region					
		Pre-1982	1982	1983	1984	1985	1986	1987	Lat.Am. &Carib.	South Asia	East Asia	M.E.& N.Afr.	East Africa	West Africa
PROJECT CHARACTERISTICS														
Type														
A. basic health services	88	83	75	86	100	92	75	100	88	80	71	83	100	92
B. manpower	90	83	100	100	100	92	75	86	75	100	100	100	100	75
C. institutional development	100	100	100	100	100	100	100	100	100	100	100	100	100	100
D. urban health	6	0	0	0	33	0	13	14	0	0	0	0	22	8
E. disease control	13	17	0	14	0	15	13	14	13	0	29	0	11	17
F. population	58	17	25	57	33	62	88	86	25	80	43	17	100	83
G. nutrition	27	67	0	0	0	15	25	71	25	20	29	0	11	50
Targets, numerical	58	100	75	57	33	62	50	29	88	80	57	83	67	8
Management capacity														
A. weak	96	100	100	100	100	92	88	100	100	100	71	100	100	100
B. good	6	17	0	0	0	8	13	0	13	0	29	0	0	0
INFORMATION FOR PROJECT DESIGN														
Client fertility, family planning														
A. basic information	88	33	75	100	100	92	100	100	75	80	86	100	100	83
B. KAP & fertility practices	58	33	50	86	67	54	88	29	75	80	43	67	78	25
C. determinants of behavior	15	17	25	14	0	8	25	14	25	20	0	0	33	8
Client health status, behavior														
A. basic information	83	33	100	71	100	85	100	100	88	20	86	83	100	92
B. KAP	19	17	0	14	33	8	25	43	0	0	14	33	44	8
C. determinants of behavior	6	0	0	14	0	0	0	29	0	0	0	17	22	0
Client nutrition status, behavior														
A. basic information	81	83	100	29	67	92	88	100	88	40	71	83	100	92
B. KAP/consumption	38	67	75	14	33	31	25	43	50	20	43	67	33	25
C. determinants of behavior	10	50	0	0	33	0	0	14	25	20	14	0	11	0
Provider practices														
A. basic description	42	67	25	43	0	46	50	29	38	80	29	50	22	33
B. determinants	6	0	0	14	0	8	0	14	0	20	0	17	11	0
TRAINING & SUPERVISION														
Management training														
A. senior & middle managers	69	33	100	57	100	85	50	71	50	80	86	67	100	58
B. supervisors of field staff	52	50	25	43	33	54	50	86	38	80	43	33	56	67
C. salaried field staff	29	17	25	14	33	38	38	29	25	40	43	33	22	25
IEC training for field staff	58	50	75	71	33	46	63	71	50	60	14	67	89	50
Estab/improve field supervision														
A. general	83	83	75	86	67	77	88	100	75	80	100	50	89	92
B. provide transport, allowance	63	33	50	86	0	46	88	100	50	80	29	33	89	67

ELEMENTS IN PROJECT DESIGN	All projects	Year approved 1981	1982	1983	1984	1985	1986	1987	Region Lat.Am. &Carib.	South Asia	East Asia	M.E.& N.Afr.	East Africa	West Africa
C. guidelines on routines	27	33	0	14	0	23	38	57	25	60	0	17	11	42
Salaried field staff: job clarity														
A. revise/clarify job desc.	27	33	25	29	33	8	38	43	38	40	14	0	44	25
B. task programming	17	17	25	14	33	0	13	43	0	40	0	33	22	17
Salaried field staff: incentives														
A. nonfinancial	6	33	0	0	0	8	0	0	0	40	14	0	0	0
B. financial	2	0	0	0	0	8	0	0	0	20	0	0	0	0
Community volunteers: job clarity														
A. revise/clarify job desc.	13	17	0	14	0	15	13	14	0	0	14	0	33	8
B. task programming	2	0	0	0	0	8	0	0	0	0	0	0	0	8
Community volunteers: incentives														
A. nonfinancial	4	17	0	0	0	0	0	14	0	0	14	0	11	0
B. financial	2	0	0	14	0	0	0	0	0	20	0	0	0	0
COMMUNICATIONS														
Establish/improve MIS	79	50	100	86	100	69	75	100	75	100	43	100	89	75
Feedback from field staff	13	33	25	14	0	15	0	0	13	60	14	0	0	0
Client feedback re IEC														
A. obtained by staff	8	17	0	0	0	0	13	29	0	0	14	0	11	17
B. obtained thru surveys	44	83	50	43	0	23	50	57	38	60	14	67	56	42
Client feedback re services														
A. obtained by staff	19	0	0	14	33	38	13	14	13	40	0	17	0	33
B. obtained thru surveys	23	50	0	14	0	23	13	43	13	60	0	50	22	
Channels to field staff	23	17	0	29	33	15	38	29	38	40	0	17	33	1
COMMUNITY RELATIONS														
Choice of beneficiaries														
A. no targeting	50	17	50	57	33	77	25	57	13	60	57	50	67	5
B. targeted areas	40	67	50	43	33	15	63	29	75	20	29	50	22	33
C. targeted groups	19	50	0	0	33	15	13	29	25	40	14	17	11	1
Use of CHWs	69	67	75	71	67	69	63	71	75	100	71	33	56	83
Mobilize community support group														
A. for IEC/service acceptnce	54	50	25	71	67	62	25	71	25	100	29	50	67	67
B. for IEC provision	29	17	25	57	33	15	25	43	25	80	0	33	44	1
C. for service provision	27	33	25	0	33	31	25	43	50	20	29	0	11	42
D. for $ or in-kind support	23	50	0	43	0	8	13	43	25	40	0	17	22	25
Provide IEC														
A. general	85	83	100	86	100	85	75	86	88	100	57	100	89	83
B. Market segments, tailoring	25	33	50	57	33	8	13	14	25	40	14	17	44	
ORGANIZATION														
Finance NGO participation	23	17	25	14	33	23	38	14	13	40	14	0	44	25
Problem solving mngmt unit	8	17	0	0	0	15	0	14	13	20	14	0	11	
MEAN elements per project (excluding "Type")	17.2	17.8	16.3	17.0	15.3	16.1	17.0	20.6	16.1	22.2	13.3	16.5	19.9	15.9

ELEMENTS IN PROJECT DESIGN	Pre 1982						1982				1983							1984				1985		
	Brazil	Colombia	Jamaica	India	Indonesia	Tunisia	Kenya	Peru	Senegal	Yemen AR	Comoros	India	Indonesia	Malawi	Mali	Pakistan	Yemen PDR	Brazil	Botswana	China	Bangladesh	Burkina Faso	Colombia	Ghana
PROJECT CHARACTERISTICS																								
Type																								
A. basic health services	1	1	1	1	0	1	1	1	1	0	1	1	1	1	1	0	1	1	1	1	1	1	1	1
B. manpower	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0
C. institutional development	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
D. urban health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
E. disease control	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0
F. population	0	0	1	0	0	0	1	0	0	0	1	1	0	1	0	1	0	0	1	0	1	1	0	1
G. nutrition	0	1	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Targets, numerical	1	1	1	1	1	1	1	1	0	1	0	1	1	0	1	0	1	1	0	0	1	0	1	0
Management capacity																								
A. weak	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
B. good	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
INFORMATION FOR PROJECT DESIGN																								
Client fertility, family planning																								
A. basic information	0	0	1	0	0	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0
B. KAP & fertility practices	0	0	1	0	0	1	1	1	0	0	1	1	1	0	1	1	1	1	1	0	1	0	1	0
C. determinants of behavior	0	0	1	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0
Client health status, behavior																								
A. basic information	1	0	1	0	0	0	1	1	1	1	1	0	1	1	1	0	1	1	1	1	1	1	1	0
B. KAP	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0
C. determinants of behavior	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
Client nutrition status, behavior																								
A. basic information	0	1	1	1	1	1	1	1	1	1	1	0	0	1	0	0	0	1	1	0	1	1	1	1
B. KAP/consumption	0	1	0	1	1	1	0	1	1	1	1	0	0	0	0	0	0	1	0	0	0	0	0	0
C. determinants of behavior	0	0	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
Provider practices																								
A. basic description	0	1	1	1	0	1	1	0	0	0	0	1	0	0	1	0	1	0	0	0	1	0	0	0
B. determinants	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0
TRAINING & SUPERVISION																								
Management training																								
A. senior & middle managers	0	0	0	1	0	1	1	1	1	1	1	1	1	1	0	0	0	1	1	1	1	1	1	1
B. supervisors of field staff	0	0	1	1	0	1	0	0	0	1	0	1	0	1	1	0	0	0	0	1	1	1	1	0
C. salaried field staff	0	0	1	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	1	1	1	0	0
IEC train, salaried field staff	0	1	1	0	0	1	1	1	1	0	0	1	0	1	1	1	1	0	1	0	0	0	0	0
Establish/improve field supervision																								
A. general	1	0	1	1	1	1	1	1	1	0	1	1	1	1	1	0	1	0	1	1	1	1	1	1
B. provide transport, allowance	1	0	0	1	0	0	1	1	0	0	1	1	1	1	1	0	1	0	0	0	1	0	0	0
C. guidelines on routines & methods	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0
Salaried field staff: job clarity																								
A. revise/clarify job descriptions	0	0	1	0	1	0	0	1	0	0	0	1	0	0	0	1	0	0	1	0	0	0	0	0

ELEMENTS IN PROJECT DESIGN	Pre 1982						1982				1983								1984			1985			
	Brazil	Colombia	Jamaica	India	Indonesia	Tunisia	Kenya	Peru	Senegal	Yemen AR	Comoros	India	Indonesia	Malawi	Mali	Pakistan	Yemen PDR	Brazil	Botswana	China	Bangladesh	Burkina Faso	Colombia	Ghana
B. task programming	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	1	0	0	1	0	0	0	0	0
Salaried field staff: incentives																								
A. nonfinancial	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
B. financial	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Community volunteers: job clarity																								
A. revise/clarify job descriptions	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
B. task programming	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Community volunteers: incentives																								
A. nonfinancial	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
B. financial	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
COMMUNICATIONS																								
Establish/improve MIS	0	0	1	1	0	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	0	1	0
Feedback from field staff	0	0	0	1	1	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0
Client feedback re IEC																								
A. obtained by staff	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
B. obtained thru surveys	0	1	1	1	1	1	1	0	1	0	0	1	0	1	0	1	0	0	0	0	0	0	0	0
Client feedback re services																								
A. obtained by staff	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	1	0	0
B. obtained thru surveys	0	1	0	1	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0
Channels to field staff	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	1	1	0	0	0	0	0	0
COMMUNITY RELATIONS																								
Choice of beneficiaries																								
A. no targeting	0	0	1	0	0	0	0	0	1	1	1	1	0	1	0	1	0	0	0	1	1	1	0	1
B. targeted areas	1	1	0	1	0	1	1	1	0	0	0	0	1	0	1	0	1	1	0	0	0	0	1	0
C. targeted groups	0	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Use of CHWs	1	0	1	1	1	0	1	1	1	0	0	1	0	1	1	1	1	1	0	1	1	1	1	1
Mobilize community support group																								
A. for IEC/service acceptance	0	0	1	1	0	1	1	0	0	0	0	1	0	1	1	1	1	1	1	0	1	1	0	1
B. for IEC provision	0	1	0	0	0	0	1	0	0	0	1	1	0	0	0	1	1	0	1	0	1	0	0	0
C. for service provision	0	0	0	1	1	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	1	1	1
D. for financial or in-kind support	1	1	0	1	0	0	0	0	0	0	0	0	0	1	1	1	0	0	0	0	0	0	0	0
Provide IEC																								
A. general	0	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	0	1	1
B. market segments, tailoring	0	0	1	0	1	0	1	1	0	0	0	1	0	1	1	1	0	0	1	0	0	0	0	0
ORGANIZATION																								
Finance NGO participation	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	1	0	1	0	0	0
Problem solving management unit	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
TOTAL elements (excluding "Type")	10	14	22	25	18	18	21	19	12	13	13	21	9	22	19	18	17	17	18	11	27	13	14	9

ELEMENTS IN PROJECT DESIGN	1985									1986								1987							
	India	Indonesia-Mpowr	Indonesia	Indonesia-Nutri	Cote d'Ivoire	Jordan	Lesotho	Morocco	Nigeria-Sokoto	Brazil	China	Jamaica	Liberia	Niger	Rwanda	Sierra Leone	Zimbabwe	Ethiopia	Gambia	Guinea	Guinea-Bissau	Malawi	Nigeria-Imo	Oman
PROJECT CHARACTERISTICS																								
Type																								
A. Basic health services	1	0	1	1	1	1	1	1	1	1	1	0	0	1	1	1	1	1	1	1	1	1	1	1
B. manpower	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	0	1	1	1	1	1	1	0	1
C. institutional development	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
D. urban health	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0
E. disease control	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0
F. population	1	0	1	0	1	0	1	1	0	0	1	1	1	1	1	1	1	1	1	1	1	1	1	0
G. nutrition	0	0	0	1	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1	1	1	1	1	0
Targets, numerical	1	1	1	0	0	1	1	1	0	0	0	1	1	0	1	0	1	1	0	0	0	1	0	0
Management capacity																								
A. weak	1	1	0	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1
B. good	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
INFORMATION FOR PROJECT DESIGN																								
Client fertility, family planning																								
A. basic information	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
B. KAP & fertility practices	1	0	1	0	0	1	1	1	0	1	1	1	1	1	1	0	1	1	1	0	0	0	0	0
C. determinants of behavior	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	1	0	0	0	0	0	0
Client health status, behavior																								
A. basic information	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
B. KAP	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	1	1	1	0	0	0	0	1
C. determinants of behavior	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
Client nutrition status, behavior																								
A. basic information	0	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1
B. KAP/consumption	0	0	0	1	1	1	0	1	0	1	1	0	0	0	0	0	0	1	0	0	1	1	0	0
C. determinants of behavior	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
Provider practices																								
A. basic description	1	1	0	1	0	1	0	0	1	1	1	0	0	1	0	1	0	1	0	1	0	0	0	0
B. determinants	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
TRAINING & SUPERVISION																								
Management training																								
A. senior & middle managers	1	1	1	0	1	1	1	1	0	1	1	0	0	0	1	0	1	1	1	1	1	1	0	0
B. supervisors of field staff	1	0	0	0	1	0	1	0	1	1	1	0	0	1	0	0	1	1	1	1	1	1	1	0
C. salaried field staff	1	0	0	0	1	0	1	0	0	1	1	0	0	1	0	0	0	1	0	0	0	0	0	1
IEC train, salaried field staff	1	0	1	1	0	1	1	0	1	0	0	1	0	1	1	1	1	1	0	1	0	1	1	1
Establish/improve field supervision																								
A. general	1	1	1	1	1	0	0	0	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1
B. provide transport, allowance	1	0	1	1	0	0	1	0	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1
C. guidelines on routines & methods	0	0	0	1	0	0	0	0	1	1	0	0	0	1	1	0	0	0	1	0	1	0	1	1
Salaried field staff: job clarity																								
A. revise/clarify job descriptions	0	0	0	0	0	0	1	0	0	1	0	0	0	1	0	1	0	1	1	0	0	1	0	0

ELEMENTS IN PROJECT DESIGN	1985									1986								1987							
	India	Indonesia-Mpowr	Indonesia	Indonesia-Nutri	Cote d'Ivoire	Jordan	Lesotho	Morocco	Nigeria-Sokoto	Brazil	China	Jamaica	Liberia	Niger	Rwanda	Sierra Leone	Zimbabwe	Ethiopia	Gambia	Guinea	Guinea-Bissau	Malawi	Nigeria-Imo	Oman
B. task programming	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	1	0	0	0	0	1
Salaried field staff: incentives																								
A. nonfinancial	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
B. financial	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Community volunteers: job clarity																								
A. revise/clarify job descriptions	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0
B. task programming	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Community volunteers: incentives																								
A. nonfinancial	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
B. financial	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
COMMUNICATIONS																								
Establish/improve MIS	1	0	0	1	1	1	1	1	1	1	1	1	0	1	1	1	0	1	1	1	1	1	1	1
Feedback from field staff	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Client feedback re IEC																								
A. obtained by staff	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0	0	0	0
B. obtained thru surveys	0	0	0	0	0	1	1	1	0	0	0	1	0	1	0	1	1	1	1	1	0	0	0	1
Client feedback re services																								
A. obtained by staff	1	0	0	1	0	0	0	1	1	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0
B. obtained thru surveys	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	1	1	0	0	1	0	0	1
Channels to field staff	1	0	0	0	0	0	1	0	0	1	0	1	0	1	0	0	0	1	0	0	1	0	0	0
COMMUNITY RELATIONS																								
Choice of beneficiaries																								
A. no targeting	0	1	1	1	1	1	1	1	0	0	0	0	1	0	1	0	0	1	0	1	1	1	0	0
B. targeted areas	0	0	0	0	0	0	0	0	1	1	1	0	0	1	0	1	1	0	1	0	0	0	0	1
C. targeted groups	1	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	1	1
Use of CHWs	1	0	1	0	1	0	1	0	1	0	1	1	1	0	0	1	1	1	1	1	0	0	1	1
Mobilize community support group																								
A. for IEC/service acceptance	1	0	1	0	1	0	1	0	1	0	0	0	1	0	0	0	1	1	1	1	0	0	1	1
B. for IEC provision	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	1	1	1
C. for service provision	0	0	1	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	1	0	1	1	0
D. for financial or in-kind support	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	1	1	0	0	0	1	0
Provide IEC																								
A. general	1	0	1	1	1	1	1	1	1	1	0	1	1	1	0	1	1	1	1	1	0	1	1	1
B. market segments, tailoring	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0
ORGANIZATION																								
Finance NGO participation	0	0	1	0	0	0	1	0	0	0	0	0	1	0	0	1	1	0	0	1	0	0	0	0
Problem solving management unit	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
TOTAL elements (excluding "Type")	20	9	16	17	15	15	20	15	19	18	15	18	13	24	13	15	20	35	20	20	14	17	17	21

ANNEX B

WORKING PAPERS CITED IN THE TEXT

SWP 345 (79)	Family Planning Programs: An Evaluation of Experience
SWP 507 (82)	Health, Nutrition and Family Planning in India: A Survey of Experiments and Special Projects
SWP 515 (82)	Integrating Family Planning with Health Services: Does It Help?
SWP 662 (84)	Adapting the Training and Visit System of Extension to Population, Health and Nutrition Programs
TN RES 12 (84)	Nutrition Education--A State of the Art Review
TN GEN 19 (84)	The Barefoot Doctor: Training, Role and Future
TN 85-1	Monitoring and Evaluation: Policy and Practice in Other Bank Sectors
TN 85-2	Monitoring and Evaluation Components in Completed Population Projects
TN 85-3	Managing Health and Family Planning Delivery Through a Management Information System
TN 85-7	Family Planning Pilot Projects in Africa: Review and Synthesis
TN 85-10	Communication Support for Population Activities in Sub-Saharan Africa
DP 6 (86)	Community Participation in Development Projects--The World Bank Experience
EDI (86)	Community Participation in Health and Population Projects, by Patricia Martin, background paper for workshop on community participation, September 22-25, 1986.
TN 86-1	Underutilization of Public Sector Health Facilities in Imo State, Nigeria: A Study With Focus Groups
TN 86-3	Community-Based Health Workers: Head Start or False Start Towards Health For All?
TN 86-4	Health Posts: Are They Contributing to Better Health?
TN 86-5	Mobile Health Units: How Promising Are They?
TN 86-6	Contraceptive Social Marketing
TN 86-28	Adding Demand-Side Variables to Study the Intersection Between Demand and Supply in Bangladesh
TN 86-30	Organization and Management Issues in the Control of Parasitic Diseases.

Abbreviations:

DP	World Bank Discussion Paper
EDI	Economic Development Institute
SWP	World Bank Staff Working Paper
TN	Population, Health and Nutrition Technical Note

ANNEX C

CASE STUDIES

Case 1: ZIMBABWE FAMILY HEALTH PROJECT: TARGETS AND INDICATORS

Target Levels for Key District Indicators

	Percent to be Achieved by District							
Key Indicator	Beitbridge	Gokwe	Karoi	Pfura	Mutoko	Nderga	Nyanga	Tsholotsho
Contraceptive prevalence 1/	50	50	50	50	40	50	50	65
Immunization coverage 2/	80	70	80	70	85	85	85	80
Antenatal care 3/	85	95	90	70	90	90	90	85
Supervised deliveries 4/	75	60	80	80	90	90	60	75
Growth monitoring 5/	50	70	80	60	70	100	80	60
Oral rehydration use 6/	30	45	60	60	50	100	100	30
Nurses trained in family planning	100	100	100	100	100	100	100	100
Supervision of village health workers 7/	80	70	80	50	100	50	80	80
Rural health center supervision by community sister 8/	90	100	100	100	100	100	100	90

Definitions

1/ Proportion of married women in the reproductive ages using a modern method of contraception.
2/ Proportion of children aged 0-12 months immunized against all six of the target diseases of the expanded program of immunization.
3/ Proportion of pregnant women who receive antenatal care at least twice during their pregnancy.
4/ Proportion of deliveries carried out by trained health personnel (including trained traditional birth attendants).
5/ Proportion of children aged 12-36 months who receive at least four weighings annually.
6/ Proportion of mothers using oral rehydration therapy in the last diarrheal episode of a child under five years old.
7/ Proportion of VHWs who are supervised at least twice a month by a SCN/SCHN or HA in the community.
8/ Proportion of rural health centers visited by a community sister at least once a month.

Case 2: THE TAMIL NADU NUTRITION PROJECT: THE USE OF GROWTH MONITORING FOR TARGETING SERVICES TO THE DISADVANTAGED

Appraised in 1980, the Tamil Nadu Nutrition Project (TINP) had expanded by the end of 1987 to about 9,000 villages, each served by a Community Nutrition Worker (CNW), a newly created paraprofessional. CNWs were women from the village in which they were to work, selected for training as far as possible from those who were poor but had well-nourished children--i.e., women already well placed to teach others about how to make the most of limited income and food resources. Their main responsibilities were to weigh children monthly to see if they were growing adequately; provide short-term food supplements to those who were not; deworm children every four months; distribute vitamin A supplements twice yearly; educate mothers about proper nutrition and about diarrhea management; and provide supplementary feeding to pregnant women who needed it.

Targeting was a central feature of the project design. First, the project services were limited to children in the 6-36 month age group and to pregnant women, since it appeared that these were the most nutritionally at risk (although during implementation it was recognized that 0-6 month children were equally important beneficiaries). Second, each child in the target age group was weighed by the CNW once each month, and only those failing to grow adequately were included in the supplementary feeding program. Third, children who were severely malnourished received special medical examinations and referral care while their families received intensive nutrition education. Two alternative criteria were used to decide whether a child was eligible for supplementary feeding and special attention. If the child's growth chart showed it to be less than 70% of the median weight for its age, it was admitted to the program immediately. But in addition, children who had lost weight since the last month's weighing, or who did not gain enough weight for two consecutive months, were also eligible for feeding. On average 28% of the children weighed were eligible for the program.

A built-in danger of targeted programs is that not all clients receive program benefits, and that those who do not may lose the incentive to participate. At the start of the TINP project, it took considerable education to convince mothers whose children did not meet the criteria for supplementary feeding to nevertheless continue to bring their children for monthly weighing. Project managers believe that this educational effort was successful only because of the high degree of community involvement which the project encouraged. The first task of the newly trained CNW, before the delivery of any project services, was to recruit and train about 25 women volunteers (known as a Women's Working Group) to assist in the education and involvement of other villagers. Each volunteer was responsible for familiarizing a given group of families with the goals of the project, for giving them nutrition education, and for assisting the CNW in gathering and weighing the children in the three days each month allocated to that task. This community involvement led to the achievement of weighing rates averaging 90% of the children each month, minimizing the risk of excluding deserving clients--the main danger of targeted projects.

Targeting services through growth monitoring is often seen as essential to the cost-effectiveness of nutrition projects, including supplementary feeding projects. Besides making most productive use of the field worker's time, it minimizes the consumption of food, which is normally the most expensive recurrent budget item in such projects. Growth monitoring is also generally recognized as an important educational aid for parents. But growth monitoring should in addition be seen from a broader perspective, as an effective way of identifying the most disadvantaged children and families for the purposes of any poverty-oriented program, in the common situation where the poor are either not visible (because they may live farthest from the village center) or if visible not easily identifiable (because child malnutrition, when not in its most extreme forms, is seldom obvious to the naked eye). Its potential has been underexploited, for example, as a means of identifying those in need of health and other social services as opposed to just nutrition services. The complexity and costs of establishing large-scale growth monitoring systems (TINP's measures the weight of 800,000 children a month) need therefore to be set against such a system's potential benefits to a number of sectoral programs, not simply nutrition.

Case 3: ETHIOPIA FAMILY HEALTH: THE USE OF RAPID ANTHROPOLOGICAL APPROACHES IN PROJECT PREPARATION

Background

What is now known in the Bank as "beneficiary assessment" began in 1982 when a consultant anthropologist lived among the beneficiaries of an urban slum improvement project with the aim of feeding back their perspective to project management. As of mid-1987, assessments had been completed in 11 other projects, were ongoing in 3, and were proposed in 4 others. The main methods employed are participant observation, in which the observer gains an understanding of clients' social situation by living among them, and structured interviewing, conversations conducted around a set of previously chosen topics. The purpose is to understand the point of view of the clients, in the belief that if the project is planned in the knowledge of peoples' values and perceptions, is responsive to their needs, and is adapted to their behavior, it is more likely to be successfully implemented and bring about sustained development. A major difference between this and traditional sociological/anthropological approaches is speed. Where anthropologists have often studied communities for years before drawing conclusions, the Bank's assessments have taken from three to six months and hence are of almost immediate use to planners and communities.

The assessments have had a number of different types of benefits for project planners. In several projects, they showed that clients had little knowledge of the project and its services, and led to improved communication. In others, they revealed that so-called participative projects had little real community participation, or that client groups were more divided into different strata than had been previously thought; these insights led to the design of new arrangements for incorporating communities

in planning, and the provision of different services for different client groups. In yet other projects (as in the Ethiopian case below), they gave insights into clients' beliefs and perceptions which were previously unavailable and yet critical for the design of efforts to promote the use of project services.

The design of these assessments evolved in three main ways between 1982 and 1987. First, after the initial projects in which the methodology was developed, the assessments were carried out by locals rather than foreign consultants. Second, the approach was extended from the urban sector (10 projects) into rural development (5 projects); energy and education (1 project each); and the PHN sector (1 assessment completed in Ethiopia, another planned for India Population 5). Third, the approach has begun to be used further upstream in the project cycle. The original projects used client assessments during implementation for purposes of formative evaluation and mid-course correction; now several projects, including Ethiopia Family Health, have used the approach before appraisal, with the aim of influencing the initial design of services. For the 10 projects implemented by locals, the cost has been cheap: six months or less in time; an average of US$12,000 for the local costs, and US$14,700 for technical assistance from an expatriate consultant.

Ethiopia

Methodology. The project aims to promote the use of PHN services among people living in the rural areas of two major administrative regions of the country. The assessment was conducted in 25 villages, consisting of five villages chosen randomly from the villages of each of the five main ethnic groups in the area. From each group of villages, one was selected for participant observation and four for structured interviewing; in the 20 villages where interviewing took place, a total of 300 women and 200 men were randomly chosen to participate. The fieldwork was carried out by five teams of social researchers, one for each group of villages, and each consisting of one participant observer and two interviewers. The fieldworkers were chosen from different ministries of government, were qualified in sociology or a related discipline, and had had experience of qualitative field survey work. Ten were men and five were women--the reverse ratio was originally intended, but proved impossible owing to the shortage of qualified women. The fieldworkers were supervised by two experienced sociologists working for the Ministry of Health, and a consultant anthropologist funded by the Bank visited Ethiopia twice to help in the initial design of the assessment and in the drafting of the final report. The fieldworkers were trained for a week by the supervisors; a month was spent in the field during the assessment; manual data processing took one month; and data analysis and report writing, two months. The local cost of the assessment (i.e., excluding the fees and travel of the consultant) was about US$14,000.

Findings. The assessment uncovered a wide range of beliefs and practices relating to health and nutrition which helped to explain high levels of mortality and morbidity and low levels of service use, and which were unknown not only to the Bank project staff, but to the Ethiopian

Ministry of Health officials. For example, throughout the project area, measles, malaria, and infant malnutrition--all epidemiologically major causes of death and disease--were not viewed as serious; and tapeworms were often viewed as beneficial, since they were believed to inhibit or kill other intestinal parasites. Beliefs about the causes of many diseases were also often mistaken. For example, malaria was widely viewed as caused by vapors from the ground or by spirits; measles by spirits; venereal diseases by exposure to crowds of people (and, in the case of one ethnic group, by overwork!); and infant diarrhea during teething by worms infecting the gums (for which the local treatment is unhygienic extraction of the milk teeth, often leading to severe mouth infections).

Important information was obtained about the determinants of behavior as well as actual practices. It was discovered that a strong belief was held among all the ethnic groups that it was shameful and a sign of unfitness to be a wife for a woman to show any sign of weakness or sickness during pregnancy--a critically important explanation for the low utilization of antenatal services in the area. It was also generally believed that the consumption of white foods during pregnancy can cause shameful stains on the baby at birth; these foods were therefore carefully avoided, depriving both mother and baby of important sources of protein during this key period. Other beliefs and behaviors were particular to one ethnic group. The Amhara tribe, for example, delay the beginning of breastfeeding for several days after birth because they believe that colostrum (the highly nutritious, thick milk produced by mothers in the first days after birth, which also passes on the mother's immunity to diseases to the child) is bad for the baby.

Such findings represent critical qualitative information for project planners. With this kind of knowledge, it should be possible for MOH officials to design IEC strategies and messages to combat specific mistaken beliefs; to differentiate IEC strategies for a given ethnic group where their beliefs and behavior differ importantly from others; and hence increase the practice of preventive health care and the use of modern health services. Without such knowledge, it would be easy for the belief to be perpetuated that the main cause of Ethiopia's high levels of mortality and disease is the low coverage of rural health facilities.

Lessons for the future. In an informal evaluation of the assessment, the Bank staff involved drew a number of conclusions for the future:

Specific to Ethiopia

- The information was valuable, was obtained in a quick and cost-effective way, and could not have been gained from a traditional KAP survey--because, given existing levels of ignorance about the determinants of behavior, no one would have known the relevant questions to ask in a questionnaire survey.

- A number of quantitative questions had been asked about numbers of children, etc., to which the answers were not statistically

significant and could be better obtained from traditional surveys. These should be dropped in future efforts, so that the assessment could concentrate on qualitative information-gathering.

- The assessment had concentrated too much on clients' PHN beliefs and practices. It should have focused also on clients' perceptions and use of modern PHN services in the project area vis-a-vis the traditional healers in the area. Service providers and traditional healers would have been useful interviewees as well as clients.

- Such assessments should be repeated during implementation, both to fill the above gaps, and to see how clients' and providers' perceptions and use of services change as the project progresses, so as to facilitate rapid mid-course correction.

General

- A broad assessment of this type is likely to be useful during project preparation. It will open areas of inquiry and allow the formulation of questions to be pursued in narrower and deeper assessments carried out during implementation.

- Although in Ethiopia the client group was diverse, it was quite homogeneous in terms of class and income strata. In other countries, it might be important to stratify interviewees and the presentation of findings by strata within communities, as well as or instead of by ethnic groupings.

Case 4: THE NIGERIA IMO STATE HEALTH PROJECT: THE USE OF FOCUS GROUP INTERVIEWING IN PROJECT PREPARATION

Background

Focus groups bring together a small group of participants (usually six to twelve) for an informal group discussion on particular topics, led by a moderator working from a prepared discussion guide. Participants should feel comfortable and secure and at ease to express their views frankly, even when they differ from prevailing norms. The session works best when participants respond one to another, leading to deeper probing of issues than would be possible in a formalized interview. Experience shows this to be most feasible when the participants are of more or less equal status and have similar perspectives on the subject under discussion. It requires skill to lead the discussions properly--to dispel inhibitions and draw out the participants without letting anyone dominate, and to be flexible and let the discussion flow freely while regulating it so that important topics are covered adequately. Someone is assigned to take notes, and the session can be recorded on tape as well. The basic data to analyze consist of the statements recorded in the session.

Unlike the sample survey, this approach yields qualitative information that is inappropriate for statistical generalization. Rather, the purpose is to develop insights into the structure of social relations, of norms and values and of individual attitudes and behavior. The focus group approach produces results quickly, and each study can encompass a multiplicity of settings. In market research, this technique has been applied to test consumer reactions to new products. It has only recently been introduced into social science, with particular application to demographic research on fertility and family planning. It should be noted that the conclusions which are drawn from the group discussions depend entirely on the analyst's judgment and interpretation. Therefore, to control bias, the use of multiple analysts is recommended.

Nigeria

Ten focus group sessions were held--seven with rural groups (six of health care consumers and one of traditional medical practitioners) and three with urban groups (two of consumers and one of orthodox health care providers). Sites were selected to provide some representation of the major subcultural zones of the state. The groups consisted of: village women (3 groups); village men (2 groups); elementary schoolteachers (male and female); traditional medical practitioners (male and female); male civil servants of junior grades; female civil servants of junior grades; and nurses and midwives at a general hospital.

Discussion topics. With the groups of health care consumers, the discussion ranged over the following topics: general knowledge, attitudes and practices regarding childbearing and its impact on the health of mothers and children; basic health values; prenatal, postnatal, and preventive care; perception of infant and childhood morbidity and mortality and of their impact on fertility; steps taken when illness occurred; cost of health care; access to government health facilities and perception of utilization of services; and problems encountered with government health facilities, and recommendations for government action.

With providers of health care, the discussions centered on: perceptions of recent trends in the utilization of government health services; explanations for these trends, for example, problems that providers knew patients had encountered, or that providers had themselves observed in the course of working inside the public sector health care system; and providers' sense of the public perception of government health services. For health care providers in private practice (traditional medical practitioners), the balance of the session dealt with six questions relating to what diseases clients came to see them about; whether clients had previously gone to government health facilities, or came directly to them; how far clients travelled; what fees were charged, and how flexible they were concerning payment; recent trends in their client flow, for example, related to general economic conditions, or to fee increases at government facilities; and the problems their clients reported having with the government health services.

Findings: Reasons for Underutilization of Government Facilities

a) Consumer's views

Members of the public across the state were acutely aware of several problems inhibiting utilization of existing government health facilities.

i) Limited access and high cost of care. Rural residents felt they had been disadvantaged by the concentration of public sector health facilities in and around urban centers. The cost of health care at public sector facilities had become prohibitive for many, especially in view of the unsatisfactory service they reported. In addition to travel expenses, all respondents reported that going to government health institutions entailed considerable costs in time--waiting in line to register, to be seen by a doctor, for laboratory tests, to fill prescriptions at the pharmacy, etc.

ii) Lack of supplies and equipment. Chronic shortages of drugs at government health institutions were so notorious that the expression "O/S" (out of stock) had become standard in everyday speech. Many participants reported having had to go out and buy prescribed drugs from private pharmacists and then bring them back to be administered to patients admitted into general hospitals.

iii) Attitudes of health care providers. There was a widespread perception of uncaring attitudes on the part of health service personnel. Nurses in particular were universally perceived as harsh, rude, and uncaring, even to maternity patients. Doctors were similarly criticized, and also for making hasty prescriptions without listening appropriately to the patients.

iv) Nepotism and corruption. Nepotism was widespread. There were frequent complaints about relatives and friends being allowed to skip registration lines at government health facilities, and of previously "O/S" drugs suddenly becoming available at the hospital pharmacy when such personal connections arrived. Respondents also reported that they had purchased drugs from the open stalls in the marketplace, with the government stamp on the packages. Such drugs had obviously been diverted from the government health facilities. It was also learned in every group session that doctors frequently referred patients to their private clinics where they would give them the solicitous care not available at the public facility. Alternatively, a way to assure adequate care was to arrive at a personal arrangement with the attending physician. For example, a pregnant woman would pay a "surcharge" during her antenatal period as "insurance" for adequate care during labor. Surgeons were especially notorious for corrupt practices.

b) Provider's views

i) Private sector providers. In sharp contrast to the problems of the state health institutions, a private dispenser pointed out that his thriving practice owed much to the fact that he had low fees with

installment payment options, drugs were always in stock, patients did not have to wait long before he saw them and his attitude and manner reassured them. As a result, they would recommend his dispensary to other people. His patients frequently passed by several other facilities, both in the private and public sectors, in order to come to his dispensary. Similarly, the rural midwife in private practice reported charging low fees with instalment payment options, and offering solicitous service that gratified her patients.

ii) Public sector providers. The government health workers substantially confirmed public perceptions of the problems of the state health service. First, all agreed that fee increases had hurt. But on the other hand, nurses and midwives reported that even before recent fee increases, patients had been leaving the general hospitals. All government health workers also recognized the shortage of drugs and hospital supplies and the lack of equipment as serious problems. Concerning the attitudes of health care providers, the nurses and midwives conceded that nurses, attendants and ward orderlies used to be seen as rude, but maintained that they had begun to change since the Commissioner for Health assembled them to discuss this problem. Evidence of professional conflict in the hospital between doctors and nurses also emerged, with each side stating a case for controls on the autonomy or authority of the other. On the question of private practice and diversion of patients from the general hospitals, the resident doctor confirmed that several government doctors also had private practices. As for informal surcharges, the nurses and midwives reported that when they asked patients for the formally stipulated fees, often the patients would protest that they had already paid the doctors.

Conclusions

Questionnaire surveys might have revealed the problems of access to care, high cost of services, and lack of supplies and equipment in this case. But they would not have elicited adequate information about health provider attitudes, nepotism, diversion of services and supplies, and unofficial surcharges for care. A project design which was targeted at resolving the problems uncovered by a questionnaire survey might have focused on construction of additional health facilities and supply of drugs and equipment--and would almost certainly have had little impact on community health. The value of the focus group method of interviewing was that it uncovered critical information from service users about the attitudes and behavior of health care providers, which in this case was a more important determinant of program performance than technical or financial constraints.

Case 5: ETHIOPIA FAMILY HEALTH PROJECT: FUNCTIONAL TASK ANALYSIS OF SERVICE PROVIDERS

Background

The aims of a functional task analysis are straightforward: to identify exactly which tasks are undertaken by which cadres of workers in the health services, and what proportion of their time is taken up by which activities. To do this, health workers are observed on the job throughout the working day, with observations recorded, usually every ten minutes, on pre-designed forms listing the various possible types of activity. An obvious source of bias with this method is that the observer may influence the behavior of the worker, however unobtrusive the former may take care to be. But experience has shown that while workers may initially be affected, they get used to the presence of the observer and revert to normal patterns of activity within a couple of days. A task analysis lasting about six days, with the results obtained during the last four days being used as the basis of the analysis, might therefore be appropriate.

Task analyses of this type turn up important information for planners and implementors, principally about the discrepancies between what workers are supposed to be doing according to their job descriptions, and what they are actually doing in practice. These differences are often very significant. Sometimes, health service managers and foreign donors can be completely unaware of them, either because their visits to the field are infrequent, or because their visits are short and planned in advance, giving workers the opportunity to present an atypical front. More often, managers, especially at the middle level, will have impressions of what is common practice in the field, but insufficient hard evidence to make these impressions the basis for changes in staff training or the management and organization of services. In these cases, functional task analyses provide hard quantitative information about problems and practices, which is a sound basis for corrective action, and which, by its very existence, creates an incentive for such action.

Ethiopia

Method. The task analysis was carried out by a team of 21 workers from the Ministry of Health, assisted by two foreign consultants who designed the study, helped with field supervision and data analysis, and wrote the final report. The survey covered 10 health institutions: 1 rural hospital, 3 health centers and 6 health stations, in the two regions of the country to be assisted by the IDA project. The health centers were chosen to represent different geographical areas, the health stations randomly, subject to the constraint of being within two hours drive of a health center included in the study. All staff in each facility were observed for six consecutive days. (It should be noted that community health workers were excluded from the analysis, since it is difficult or impossible to observe, without disruption, health service activities whose provision is integrated with the workers' daily lives.) The training of the field workers took one week, the fieldwork itself five weeks, and data analysis and report preparation six weeks. The total cost of the survey and consultants (one

senior consultant for 18 weeks and one assistant for 16 weeks) was less than US$40,000.

Findings.

Productive versus non-productive time. A major finding of the analysis was that, despite extreme staffing shortages, almost 40% of working hours were used non-productively. As well as pointing to a major time and human resource management problem, this finding tends to confirm that workers do not in fact significantly change their patterns of activity because they are being observed.

Availability of services. Because of staffing shortages, many health stations were manned by only one health assistant instead of the planned complement of three, and the most remote health stations had the least staff (already known before survey). The survey indicated that large amounts of staff time were spent on fetching drugs and supplies from supervising facilities (no delivery system was in use), with the result that a remote health station with only one health worker might close for one week a month while the worker was absent seeking supplies.

Preventive versus curative care.

- The percentage of productively used time which went on curative as opposed to preventive care was 76% in the rural hospital, 56% in the health centers, and no less than 92% in the health stations.

- Health education was especially neglected. Potentially important community groups, such as schools, youth groups, and women's associations, were seldom visited, and then generally on request rather than at the initiative of the health worker. Health education given to patients waiting at health facilities emphasized nutrition and hygiene; oral rehydration therapy and family planning seemed to be overlooked altogether.

- Preventive child care was seen in practice as synonymous with the expanded program of immunization. Other forms of preventive care were seldom provided.

- Antenatal services were ineffective because of the lack of a system for tracking referred cases. Health workers had no means of knowing the treatment provided to a referred case by a superior facility, and hence no basis on which to provide follow-up care.

Family planning

- The policy that nurses and not health assistants should prescribe (as opposed to resupply) contraceptives was seriously hindering adoption. Family planning services at health stations were provided only at monthly visits by nurses, who saw 20 clients at most each visit. Additional clients (these sessions were always well attended) were told to return for the next monthly sessions,

even if they had travelled considerable distances, and were provided with no form of interim protection such as condoms or spermicides.

- Yet in practice at health centers (the next superior level of health facility), health assistants accounted for almost one third of the time spent on family planning, and it was health assistants who were observed checking the blood pressure and weight of family planning clients during consultations, while nurses appeared to do little in the way of routine checks before issuing oral contraceptives. This finding suggested that in fact health assistants could play a more active role in family planning at the health station level.

Case 6: INDONESIA NUTRITION DEVELOPMENT PROJECT: AN APPLICATION OF SOCIAL MARKETING

Background

In 1977, the Indonesian Ministry of Health's Health Education Directorate established a Nutrition Communication and Behavior Change Component, with Bank assistance, in five subdistricts of three provinces. The aim was to test communications techniques that would lead to improved nutritional status without involving food supplements or other costly schemes. The techniques used were those of social marketing--the adaptation of commercial marketing techniques to social sector programs. For some reason, the concept of social marketing among PHN specialists in the Bank seems to have become synonymous with the subsidized sale of contraceptives through commercial channels. The Indonesia Nutrition Project and its USAID successor demonstrate that social marketing is a broader approach, whose processes can be applied in any subsector. The assessment techniques and project interventions summarized below have since been further developed with USAID assistance, as described in a report, "The Weaning Project--New Strategies to Improve Infant Feeding Practices," prepared by the Directorate of Nutrition, MOH, Indonesia and Manoff International, Inc., Washington, D.C. (December 1986).

Qualitative learning

Community involvement. The communities in 10 villages to be assisted under the project were helped to conduct a "community survey" which consisted of weighing all children and charting their weights on a large community graph. A community meeting was then held to discuss the survey and to ask for solutions to problems it identified.

Guided interviewing. Central-level staff developed open-ended question guides around the problems identified. These were administered by investigators trained in qualitative research and participant observation techniques to a sample of 330 households intentionally biased toward those with malnourished children and limited resources--the hypothesis being that

if the most disadvantaged could change a practice, so could others. In each interview, infants were weighed and a 24-hour dietary recall was taken in order to calculate dietary deficiencies. An informal, leisurely conversation then followed, around specific nutritional topics, recorded on tape for later transcription. Then, in a significant departure from conventional practice, the investigator and mother jointly worked out particular dietary changes which were appropriate for that family's situation.

Product testing. Recipes for enriched weaning foods were developed and prepared on the spot during the interview, using materials available in the house. The foods were fed to the children and their advantages and disadvantages were discussed. Then the mother was asked to persist trying whatever recipe or activity had been agreed on until the investigator's return after three or four days. When the investigator returned, invariably the women had modified the recipe or activity to suit their needs, and had comments or questions. This phase of "product development" was seen as one of the most important elements of the methodology--social marketing's adaptation of commercial product testing.

Tailored products. The conversational interviewing led to the development of a segmented range of products, some applicable only in particular areas, some only for particular infant or child age groups. An example of the need for local adaptation was in recommendations for house-prepared weaning foods. It was found that despite cultural differences and physical distance between communities, the basic weaning food ingredients were the same everywhere. But the method of food preparation changed--notably the way fat was added to make the food calorically dense. Fat, as a weaning food ingredient, was new to most mothers and highly suspect; local adaptations made it palatable. Products/messages were also segmented according to the demographic characteristics of families. For example, messages were varied according to the specific nutritional concerns of mothers before and after childbirth, and for the different dietary requirements for infants and children of different ages between zero and three. By designing specifically tailored messages for each segment of the target audience, the project ensured that only immediately useful information would be directed to mothers in each category--an approach very similar to that behind message variation in the training and visit system of agricultural extension (Case 7).

Other project messages were applicable across broader client populations. It was found, for example, that mothers in East Java believed that one breast contained "food," the other "water"--a belief which favored suckling with the breast containing "food." This led to the drying up of milk in the less-used breast, and potential undernutrition. It is interesting that this behavior had not been identified by health workers before the systematic conversational interviewing used in the project. It was known that mothers in this part of Indonesia continued breastfeeding well into the second year of the child's life, and it had been assumed that breastfeeding conformed to medical guidelines and did not require special attention in the educational campaign.

Impact

The project was evaluated one-and-a-half years after the intensive communications program had begun, by comparing socioeconomically matched households inside and outside the project. It was found that project children ate more of the recommended foods, had higher protein and calorie intakes, and grew better than non-project children. The weight of project children never fell below the normal zone, while comparison children dropped below after the thirteenth month of life; and at 23 months of age, project children weighed an average 1.5 kilos more than non-project children. Project mothers had higher scores on knowledge of nutrition than non-project mothers. Moreover, those mothers with less formal schooling, who normally have less well-nourished children, had a score equal to the mothers with more education, indicating that the project met its objective of reaching the most at-risk client population.

Case 7: THE TRAINING AND VISIT (T&V) SYSTEM OF AGRICULTURAL EXTENSION

Background

The T&V system of extension was first implemented on a large scale in India in the 1970s, and has been adopted since in about 40 countries. Although it originated in the agriculture sector, it is a method for managing education and behavioral change which could be adapted to any sector where outreach to scattered populations or institutions is required. The system has been changed in various ways to adapt to different country conditions, but its main principles have remained the same. This is one of T&V's advantages; it is a clearly specified system, whose main elements can be explained to a minister or a fieldworker in less than half an hour.

Learning from Clients

The system is premised on the idea that appropriate guidance cannot be given to clients unless there is also a sustained effort to learn about clients' priorities and needs, and about the effectiveness of previous extension recommendations. T&V therefore centers on regular face-to-face meetings between the extension agent and the same group of clients. Normally, one extension agent supports eight groups of about ten "contact farmers," and will meet each group on the same day every fortnight in their fields. At these meetings, as well as giving advice to the farmers for the next fortnight, the agents will jointly, with each farmer, inspect the progress of the crops in the field, hear the farmers' comments about the usefulness of previous advice, and learn from them about the problems and areas where they feel they need guidance. Then, once a fortnight, all the extension agents in the local area meet together for half a day with their supervisor to report on progress and problems, and to swap ideas on improving their advice to farmers. Once a month, all the extension supervisors in the district meet together with specialists from the local agricultural research station to pool their feedback from fieldworkers.

The design of T&V's field supervision system also assists this learning process. Each first-line supervisor is responsible for no more than eight fieldworkers, each of whom he spends an entire day with in the field once a fortnight. Supervision is carried out not by questioning of fieldworkers, but through the supervisor's presence in the background during the fieldworker's meetings with farmers. Management's advice and action is therefore based directly on farmers' reactions, and the kind of relationship with is observed between fieldworker and client. Managers' first-hand knowledge of clients reinforces the feedback coming up through the routine fortnightly and monthly group meetings. More senior managers at district and head office levels also spend a portion of their time in the field, not inspecting their subordinates, but listening to farmers with them.

Varying the Product

The same set of meetings for feedback serves in reverse for the dissemination of extension advice which is appropriate to local conditions. At the monthly meeting, based on the feedback from the clients, and the type of seasonal farming activity that will predominate in the local area during the next month, district-level extension managers and research workers develop a set of recommendations appropriate for that particular area and time period. These recommendations are disseminated to fieldworkers at the regular fortnightly meetings with their supervisors and a subject-matter specialist. Both at these meetings and at the discretion of the worker in the field, messages will be further adapted to particular needs--for example, special emphasis may be given to a particular crop suffering a pest infestation in the local area; or workers will be guided how to vary specific recommendations, such as fertilizer dosages, to fit the individual farmer's ability to pay for cash inputs. Extension messages thus vary constantly, both through the year, and between different localities and individual farmers at any given time. Recommendations are disseminated by each fieldworker to his group of contact farmers, who are chosen to be representative of local farmers, and who also must be willing to pass on the advice they get to the local farming community.

Incentives

The T&V system gives no special financial incentive to fieldworkers. In fact, because of its insistence that workers must devote their entire time to education and motivation, rather than also working on the provision of credit or other inputs, T&V has often deprived workers of sources of illicit profits which were previously available to them. Financial incentives are replaced by a carefully planned mixture of prestige, professional and personal support, and accountability. Workers are motivated partly by the satisfaction gained by providing a useful service to farmers; the prestige and respect they receive within their villages have proved a very real, if intangible, incentive. Workers are also motivated by the group meetings they attend. The training that is provided at these meetings makes fieldworkers feel technically competent and up-to-date, while joint review of progress and joint problem-solving with their co-workers build a form of team spirit. Finally, the fact that

supervision takes place with farmers in the field--and that top managers regularly participate--constantly reminds fieldworkers and supervisors not just that they are accountable for their performance, but that they are primarily accountable downwards to their clients, rather than upwards to "the system."

Sustaining Performance

Senior extension managers have tended to react enthusiastically when they hear of T&V, perhaps because it is a clear, graspable system for dealing with the all too familiar constraints of weak technical knowledge and poor worker motivation. At the same time, the clear structure and rigid procedures which make T&V understandable and implementable within traditional development bureaucracies also open it to the danger of being taken over by the rigid, top-down nature of traditional bureaucracy and becoming only a purveyor of advice--that is, a training and visit system only, rather than a "learning and visit" system also. Experience has shown that constant reorientation by senior management (and, given the frequent turnover of management, reorientation of senior management by Bank staff) is needed throughout the implementation period, in order to ensure that the system's bottom-up, learning process receives as much emphasis as its top-down, teaching process.

PPR Working Paper Series

	Title	Author	Date	Contact
WPS63	Does Japan Import Less Than It Should?	Kenji Takeuchi	July 1988	J. Epps 33710
WPS64	Cocoa and Coffee Pricing Policies in Cote d'Ivoire	Takamasa Akiyama	August 1988	D. Gustafson 33714
WPS65	Interaction of Infant Mortality and Fertility and the Effectiveness of Health and Family Planning Programs	Howard Barnum	July 1988	S. Ainsworth 31091
WPS66	Slowing the Stork: Better Health for Women through Family Planning	Anthony R. Measham Roger W. Rochat	July 1988	A. Manciano 33226
WPS67	Price and Tax Policy for Semi-Subsistence Agriculture in Ethiopia	Robert D. Weaver Saad Ali Shire	August 1988	D. Gustafson 33714
WPS68	A Comparison of Lamps for Domestic Lighting in Developing Countries	Robert van der Plas		
WPS69	Does Local Financing Make Public Primary Schools More Efficient? The Philippine Case	Emmanual Jimenez Vicente Paqueo Ma. Lourdes de Vera	August 1988	T. Hawkins 33678
WPS70	Vocational Education and Economic Environments: Conflict or Convergence?	Arvil V. Adams Antoine Schwartz	August 1988	T. Hawkins 33678
WPS71	School Effects on Student Achievement in Nigeria and Swaziland	Marlaine Lockheed Andre Komenan	August 1988	T. Hawkins 33678
WPS72	The Relative Efficiency of Public Schools in Developing Countries	Emmanuel Jimenez Marlaine Lockheed Vicente Paqueo	August 1988	T. Hawkins 33678
WPS73	Taxation and Output Growth in Africa	Jonathan Skinner	August 1988	A. Bhalla 60359

PPR Working Paper Series

	Title	Author	Date	Contact
WPS74	Fiscal Stabilization and Exchange Rate Instability: A Theoretical Approach and Some Policy Conclusions Using Mexican Data	Andrew Feltenstein Stephen Morris	August 1988	A. Bhalla 60359
WPS75	Welfare Dominance and the Design of Excise Taxation in the Cote d'Ivoire	Shlomo Yitzhaki Wayne Thirsk	August 1988	A. Bhalla 60359
WPS76	On the Shadow Price of a Tax Inspector	Shlomo Yitzhaki Yitzhak Vakneen		
WPS77	Incentive Policies and Agricultural Performance in Sub-Saharan Africa	Bela Balassa	August 1988	N. Campbell 33769
WPS78	Economists, Institutions and Trade Restrictions: A Review Article	J. Michael Finger		
WPS79	Quantitative Appraisal of Adjustment Lending	Bela Balassa	August 1988	N. Campbell 33769
WPS80	Emerging Issues of Privatization and the Public Sector	Samuel Paul	September 1988	E. Madrona 61711
WPS81	Reaching People at the Periphery: Can the World Bank's Population, Health, and Nutrition Operations Do Better?	Richard Heaver	September 1988	S. Ainsworth 31091
WPS82	Microeconomic Theory of the Household and Nutrition Programs	Dov Chernichovsky Linda Zangwill	September 1988	S. Ainsworth 31091
WPS83	Welfare Costs of U.S. Quotas in Textiles, Steel, and Autos	Jaime de Melo David Tarr	September 1988	C. Cabana 61539
WPS84	Black Markets for Foreign Exchange, Real Exchange Rates and Inflation: Overnight vs. Gradual Reform in Sub-Saharan Africa	Brian Pinto	September 1988	R. Blade-Charest 33754