6 Implementing human development programs: some practical lessons

This chapter concentrates on four key questions that invariably affect the way human development programs are organized, and how effective they are.

- Political support. This has been critical to the considerable success of human development programs in reaching the poor. Its absence also helps to explain some of the failures.
- Finance. Money alone will not produce human development. But a shortage of funds is a common, often binding constraint. So methods that reduce unit costs or raise new revenues have a considerable role to play in expanding services.
- Administration. For many programs, administrative and institutional capacities may be even scarcer than finance. Yet project experience shows that their importance is frequently overlooked.
- Demand. The way families and individuals respond to services is crucial to improving health, hygiene and nutrition; to whether children from poor families go to school or have to work instead; and to reducing fertility.

These four factors—like education, health, nutrition and fertility—are closely interlinked. For instance, financial and administrative constraints can be eased by political support, which in turn will be stronger if programs can be made less costly or administered more readily, or if there is a heavy demand for them. The links, though, are not all complementary: for example, paramedical workers have lower salaries than doctors, but they need more supervision.

Human development needs political support

Political support for human development cannot be taken for granted. The poor frequently are politically weak. They are often too sick, uneducated, geographically dispersed and busy to be politically active. Influential elites, particularly large landowners, may oppose human development programs if they feel that their power and status might be undermined. They might feel, for example, that educated children are less likely to settle for working in serf-like conditions on haciendas or plantations.

Even if there is no direct opposition, the extent and form of human development programs will generally be influenced by keen political competition for limited tax revenues. Because policymakers generally live in urban areas, as do the most politically active of the people who benefit from public services, these programs tend to suffer from urban bias (though reductions in urban social expenditures do not necessarily lead to increases in rural expenditures). But the health and education facilities available even to urban elites in poor countries are generally inferior to those available to the middle class in rich countries. A major political challenge of the 1980s will be to adapt and extend programs to the poor, particularly those in rural areas.

Despite the difficulties, it has usually been easier to obtain political support for health and education programs that benefit the poor—witness the large increases in school enrollment and life expectancy—than for policies of, say, land or tax reform. Why? Largely because, unlike land reform or increased taxation, more knowledge, health and vitality for the poor are not obtained by reducing them for someone else. Of course, such programs must be financed. The rich may have to pay more in taxes than they get in direct benefits. But they are often prepared to support human development, in part because it has a legitimacy that transcends culture, religion, ideology and class. This is particularly true if poor children are involved. The idea that all children should have a fair start—without the handicaps of disease, illiteracy and malnutrition—is widespread.

In some circumstances, moreover, everyone gains. Those who are not poor will benefit if endemic diseases are eradicated—prevention usually being cheaper than cure. Malaria control is an obvious example: the main beneficiaries are the rural poor, who are most likely to be infected. But mosquitoes that bite the infected poor may
fly on to bite the rich as well. In Brazil in 1974, an epidemic of spinal meningitis aroused public concern—in response, 80 million people were vaccinated within 10 months, stopping the epidemic.

Human development programs are also seen almost everywhere as contributing to national unity. Universal primary education in particular can provide all citizens with a common intellectual heritage and help overcome the potentially divisive effects of regionalism, tribalism, race and caste and class distinctions. In addition, governments often see human development as helping to build broad-based political support among potentially antagonistic groups.

The appeal of and political commitment to human development cut across ideological boundaries: China, Cuba and North Korea have placed great emphasis on such programs, but so have South Korea and Costa Rica. Their appeal is reinforced by international and ethical support. The Universal Declaration of Human Rights of 1948 included the rights to food, health and education. The United Nations and its specialized agencies have played an important role in focusing international attention on human development and population issues. All the major religions also provide strong backing for efforts to improve the health, nutrition and education of the poor.

**Easing the financial constraint**

Finance ministers everywhere (with the exception of some mineral-rich countries) find that available funds cannot meet the many competing demands placed on them. In the poorer countries, public revenue (taxes, other domestic revenue and foreign assistance) usually is less than 20 percent of GNP, while expenditures other than on social programs (agriculture, infrastruct-

ture, debt service, defense and so on) commonly exceed 12 percent of GNP. Yet governments that have assured virtually everyone primary education, health care, family planning services, adequate food, pure water and sanitation have generally spent more than 10 percent of GNP (and often a good deal more) on doing so.

The costs involved depend on many factors (see box), among the most important of which are the range and standard of services. Thus governments in some poor countries—notably Sri Lanka and

---

### How much would it cost?

Take an illustrative list of human development needs: five years at school; adequate nutrition; primary health care no more than an hour away; family planning services; at least 20 liters a day of pure water within 100 yards of home; and a pit latrine. How much would it cost a government in a developing country to provide this for everyone?

The answer varies from country to country, depending first (and most importantly) on the standard of service; second on such factors as climate, communications and population dispersion; and third on the balance between capital and operating costs (most budgets do not provide enough for the operating costs that an effective service would need). But there are also two general rules that affect cost: one, for any given standard the proportion of GNP required falls as GNP rises, partly because higher-income countries have more educated people—whose wages are therefore relatively lower—to implement the programs, and partly because nonlabor costs rise more slowly than GNP. And two, marginal unit costs usually fall as coverage rises, but only up to a point: the costs of reaching the last 10-20 percent of the population may be several times the average costs for the first 80-90 percent because of physical inaccessibility or inadequate demand.

Some examples from different countries:

- **Education.** The average gross enrollment ratio for primary school in developing countries in the early 1970s was about 70 percent; central governments were then spending an average of 1.7 percent of GNP on primary education. Few governments have provided universal elementary education for less than 3 percent of GNP. Peninsular Malaysia spent 2.7 percent in the mid-1970s and had a gross enrollment rate of 93 percent.

- **Nutrition.** In 1979, when subsidized rations were restricted to the poorer half of the population in Sri Lanka, they still cost 4 percent of GNP. Eliminating food deficits in Brazil—with its much higher income—could cost from 1 to 2 percent of GNP in 1980, depending on the type of food provided.

- **Health and family planning.** Malaysia's system of public health care covered more than 75 percent of the population in 1974. It relied heavily on low-cost paramedical staff—and its operating costs were nearly 2 percent of GNP. Sri Lanka's government spent about 1.7 percent in the mid-1970s. China's central government spent less than 1 percent on health in 1978, but much of the primary care system was financed locally; Brazil's spent about 2.5 percent of GNP in 1975, but public health insurance was biased toward hospitals and urban areas—covering almost 80 percent of urban dwellers but much less of the 40 percent of people in rural areas.

- **Water.** A recent World Bank estimate suggests that it would cost the Tanzanian government about 1.8 percent of GNP a year over a 10-year period to supply every village with pure and reliable water, plus 0.8 percent for operating costs once the system is fully established. In Brazil the investment needed to cover the whole population by 2000 has been estimated at less than 0.1 percent a year of a much larger and faster-growing GNP in rural areas (allowing for higher costs to reach the last 10 percent of the rural population) and perhaps 0.1 to 0.2 percent a year in urban areas depending on GNP growth. Coverage of the rural and urban populations was 62 and 14 percent, respectively, in 1976. Operating costs are borne by the users.

- **Sanitation.** In Brazil, where 37 percent of urban houses had sewers or septic tanks in 1976, extending the sewer network to cover them all by 2000 would require annual investments of about 0.2 to 0.3 percent of GNP. Providing latrines in rural areas would cost only between 0.01 and 0.02 percent of GNP.
probably China—have managed to provide the essential services (primary education, food supplements and basic health and family planning facilities) to almost everyone for less than 10 percent of GNP. Typically, though, governments are spending from 3 to 10 percent of GNP for human development programs that are far from comprehensive—and whose effectiveness is often reduced by lack of money for operating costs (wages for health workers and teachers, maintenance of water supply systems, gasoline for transportation of doctors in rural areas, textbooks in schools).

How can financial constraints on human development programs be eased? There are four ways: increasing taxes, reallocating revenues, reducing costs and using resources other than those obtained from national taxes and duties.

**Increasing tax revenues**

Many developing countries have already made impressive progress in improving their tax-gathering (see Table 6.1). Since 1975, however, tax ratios in developing countries have not increased; although some obvious steps can be taken (making taxes more progressive and reducing evasion and arrears), the scope for raising taxation is less now than it was 20 years ago.

This is especially true of the poorer countries—even where foreign trade is a substantial share of output. Their tax administration is generally weaker, there is usually substantial unmarketed output, and their taxable surplus accounts for a smaller share of their GNP. Even a tax-to-GNP ratio of 15 percent in such countries implies a heavy tax burden. Take India as an example: its taxable surplus may be defined as all income beyond the poverty line (defined there as the income of the fortieth percentile in the distribution of income). On this basis, India’s taxable surplus in 1975 was 41 percent of aggregate income; the ratio of taxes to taxable surplus therefore was 34 percent—comparable with the tax-to-GNP ratios of industrialized nations.

Earmarking taxes for programs with strong ethical or political appeal can raise extra money when further general taxation is not feasible. In Colombia a share of the beer tax is reserved for public hospitals. Many Latin American countries finance their health and social security budgets by a payroll tax. (But payroll taxes cover only formal employment, and they tend to reduce growth in jobs by raising the cost of labor relative to capital.) Motor fuel taxes are good for earmarking, for several reasons. They are easy to collect, are progressive, help curb oil consumption, and have high revenue potential—in some cases exceeding 1 percent of GNP. But like all earmarked taxes, they should be used only sparingly, because they increase the rigidity of the way government revenues are spent.

**Reallocating existing revenues**

Public spending on human development can be increased by reallocating government revenue from less productive uses, including wasteful showcase projects, subsidizing inefficient enterprises and, so far as security considerations permit, military spending (which on average in East Asia, South Asia and the Middle East exceeds public outlays on education and health combined). And within human development programs there is often room to reallocate budget shares away from high-cost and less-urgent projects (such as urban hospitals and universities largely serving the relatively well-off) and toward more basic programs (such as primary health care and education).

**Keeping costs down**

By modesty in standards and efficient choice of technology, governments can provide services relatively cheaply—and without precluding future improvement. (For example, public standpipes can supply safe water at some sacrifice in convenience but at less than half the cost of individual house connections.) This general approach will often be opposed by teachers, doctors, architects, engineers and other professionals who insist on high standards—and correspondingly high costs. Not surprisingly, the financial constraint is then said to prevent the extension of services to poor rural areas. Political leaders have sometimes felt that it was better to accept unaffordably expensive standards than to risk the charge that they were backing "second rate" projects. But the World Bank's experience in health, education and urban development projects suggests that many governments now see political as well as economic benefits from being able to reach the poor by accepting lower standards initially.

Chapter 5 discussed a number of specific ways of economizing in health, education and nutrition programs. China's barefoot doctors (see box overleaf) are an excel-

---

**Table 6.1 Taxes as a percentage of GNP**

<table>
<thead>
<tr>
<th>Group of countries</th>
<th>1953-55</th>
<th>1972-76</th>
<th>Percentage increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 low-income developing countries</td>
<td>11.2</td>
<td>16.0</td>
<td>43</td>
</tr>
<tr>
<td>17 middle-income developing countries</td>
<td>12.1</td>
<td>16.4</td>
<td>36</td>
</tr>
<tr>
<td>Total (24 developing countries)</td>
<td>11.8</td>
<td>16.3</td>
<td>38</td>
</tr>
<tr>
<td>15 developed countries</td>
<td>26.2</td>
<td>36.2</td>
<td>38</td>
</tr>
</tbody>
</table>

Note: Taxes include social security taxes.
China's barefoot doctors

Best known for its use of “barefoot doctors” at the grass roots, China's rural health care system has several other faces—specialized urban hospitals serving the surrounding areas, well-equipped county hospitals, and health clinics at commune centers. These facilities provide indispensible support for the extensive coverage provided at the “brigade” level—catering to a large village or several small ones. Each brigade sets up a program with financial support from the government; but once established, it must be self-financing (though the government may help in exceptional circumstances). A majority decision of the brigade members is enough to start or end a program; individuals can choose to join—and leave—it.

China’s 1.6 million barefoot doctors (roughly one per 600 people) operate at the brigade level in rural areas. Many are women, selected by the brigade members for training, and supported by them during training (which usually takes place in the slack agricultural season). After completing training, the barefoot doctors return to their brigade, continuing to devote part of their time to farm work.

Barefoot doctors are trained to use both modern techniques and traditional Chinese medicine—acupuncture and herbal cures, for example. By combining the two, they increase acceptance of modern treatment and reduce costs—since they prepare herbal medicines from locally grown ingredients.

As a rule, the brigade program is financed from four sources: an annual premium paid by members; charges for the service; appropriations from the brigade’s social welfare fund (collected through a tax on each production team’s income); and, sometimes, subsidies from the county government.

The annual premium, 1-2 yuan ($0.60-1.20) per person or 5-10 yuan ($3-6) per family, depending on the locality, is a considerable sum for peasants whose incomes average only about 100 yuan ($60) a year (only a small proportion of which is cash income). The brigade’s social welfare fund is a fixed percentage of its total income, so the contribution from the fund to the health program depends on the brigade’s income. Members pay for each visit to the brigade health station. In complicated cases, they may have to go to the commune health center or the county hospital. Charges at the commune health center are normally paid out of the brigade’s health fund; but patients attending the county or specialized hospitals must pay at least part of the fees themselves.

Like other primary health care systems relying on community health workers, China’s has faced problems of credibility and training, and of uneven levels of service. Steps are now being taken to address these problems, including more emphasis on initial and in-service training of barefoot doctors. The intention is to upgrade the services as funding and staff skills permit.

lent example both of keeping costs down and of upgrading services as the economy grows—the Chinese are now providing their primary health workers with additional training and better support. Restricting subsidies to those who cannot afford to pay for services can also help keep costs down (see pages 62-63 for examples of how this can be done in nutrition programs). But overly narrow targeting may sacrifice some political support from middle- and upper-income groups—support that may be critical in establishing a program to reach the poor, too. Various ways of cutting unit costs in higher education—by far the most expensive part of the educational system—were also discussed earlier (see page 50).

Using resources other than national tax revenue

The state invariably plays a central role in education, health and nutrition programs. But it is by no means the only source of finance for human development. With the proper incentives, individuals, private firms and other nongovernmental organizations can play an important role.

Most food consumption, of course, is privately financed. Moreover, the relatively well-off are often willing to pay for private education and medical treatment. Where the expansion of private education and health care is not inconsistent with national policy, this would allow scarce government funds to be concentrated on the poor. But if the middle classes invariably send their children to private schools, much of the necessary political support for high-quality public education may be lost.

One way of mobilizing private funds for education is by restricting the number of places in public universities, maintaining high standards there, and then allowing the private sector to cater to those who can afford it but do not succeed in the stiff competition for the places in public universities. Scholarships to public universities can be provided for those who cannot afford tuition fees. This has been done in South Korea, where 72 percent of higher education enrollments are in private institutions, while in primary education (which is virtually universal) 99 percent of the enrollments are in public schools.

In some cases it is even possible to charge the better-off enough to subsidize services for the poor. In many countries, for example, fees for private and semiprivate hospital rooms are set well above costs and the surplus used to subsidize poorer ward patients. There are even better opportunities for this type of cross-subsidy in urban water and sanitation systems, where the subsidy can be virtually automatic. The well-off are generally willing to pay more than the actual cost of the service because the alternative to being connected to the public system is a private well or septic tank, at much higher cost.

Local resources can also reduce the financial burden on the center. In Tanzania in the mid-1970s, self-help labor was equal to about 10
Self-help in Sri Lanka

From small beginnings in 1958, the Sarvodaya Shramadana Movement now employs some 6,000 full-time workers and reaches more than 10 percent of the country's rural population. It has full-scale programs in some 300 villages, but is active in another 2,300. It has organized education, health, nutrition, sanitation and housing; set up agricultural and handicraft programs; and is starting to promote other small-scale rural industries.

The village of Panakura, in the poor hilly district of Kegalle, provides a good example of the Movement's work. Simon Jayawickrama had graduated from Panakura's primary school and was doing well in the secondary school two miles away; then he had to drop out in the tenth grade to help support his family. Through his former teacher and the local Buddhist monk, he made contact with the Movement; with the help of the local Sarvodaya workers in nearby Atulugama, Simon began working amongst Panakura's 81 families. After intermittent visits over a two-week period, a first Shramadana workcamp was organized—to build a road to the village. A second camp began building a community center—both projects chosen by the villagers themselves.

The Sarvodaya Movement provided cement, reinforcing rods and skilled labor. For 15 weekends, 80 percent of the villagers put in 6-8 hours of manual labor a day. With the help of 100 young workers from Sarvodaya groups in other villages, they established a community kitchen where everyone pooled and prepared their food; took part in community meditation, singing, dancing and other cultural activities; and held two daily community meetings (called "family gatherings") where everyone, young and old, had an opportunity to discuss their problems and ways of solving them.

Following the workcamps, Simon and 10 others went to the Sarvodaya regional training institute at Kegalle for a two-week leadership training course. On their return they began forming what Sarvodaya calls the "social infrastructure"—groups for mothers, farmers and so on. Representatives from each group made up the Village Reawakening Council, which has initiated various productive activities, such as growing bananas and passion fruit as cash and food crops, and set up a cooperative store.

In the community center built during the Shramadana camp, one of the Sarvodaya trainees has helped the mothers organize a community kitchen and daycare center. Here young children are taught about health and hygiene, and are vaccinated by a visiting government health worker (who received part of her training from Sarvodaya). The school-age children's group is responsible for a garden that helps to supply the community kitchen, and for keeping the community center clean. The local Buddhist monk took a four-month course on village development at the special Sarvodaya training school for monks.

As well as extending its coverage, the Movement is improving the follow up to the initial Shramadana workcamp phase, to prevent backsliding. Although the long-term effect of Sarvodaya's work remains to be properly evaluated, most observers have been strongly impressed by the way it has involved people in development. It has attracted widespread international support.

How much has all this cost? The Sarvodaya budget for 1979-80 was $2.3 million, an average of less than $1,000 per village assisted. Voluntary labor and other payments in kind contributed many times that amount. Of the cash budget, some 80 percent came from international assistance (both private and official), 10 percent from Sri Lankan donations and 10 percent from the sale of commodities produced in Sarvodaya's training farms and schools.

As people become more mobile and the cash economy more widespread, the strength of traditional self-help efforts may wane. But instead of providing resources in kind, local communities can raise money (through local taxes or charges) to support their efforts. Like other forms of self-help, this can be stimulated by matching grants from the central government in support of locally initiated and managed activities. In Kenya, for example, the government assists *harambee* (self-help) projects that meet official guidelines. But sluggish administration in central agencies can suffocate local participation and self-help—enthusiasm and initiative may wane if decisions take too long or promised assistance does not arrive on time.

Self-help is not always the right answer. In education, for example, local financing can lead to such an uneven distribution of qualified teachers, books and equipment as to intensify the inequities the country is trying to reduce. Northeastern Brazil and northern Nigeria provide two cases in point. In both regions, low incomes partly explain why the wages and quality of teachers fall below the national average; they also partly explain the low enrollment rates in these regions. If local economic and social progress lags well behind the national average, financial and technical assistance from the central government will be crucial.

Developing administrative strengths

Institutional constraints are in many cases at least as serious a barrier to human development as shortage of funds or lack of political support. Effective administration usually requires more than the efficient working of official bureaucracies; it depends on such factors as the availability of middle-level
manpower, the complementary activities of local governments and voluntary agencies, the receptivity of intended beneficiaries to public services, and the persistence of effort.

Unlike many aspects of agricultural, industrial and infrastructural development, human development programs can rarely be put out to contract. Improvements cannot be effected by changes in policy or legislation alone. Funds, equipment and advanced technologies can seldom substitute for trained field personnel or administrators.

Administration is a vital ingredient in primary health care: without adequate training, supervision and supplies, locally recruited paramedical staff cannot be effective. This is one of the important lessons of Brazil's early experience with rural primary health care in its poor northeast region, one confirmed in countries as diverse as China, Jamaica and Botswana.

In education, too, there are obvious administrative difficulties, because of the number and geographic spread of primary schools. But most countries have wide experience of operating an educational system, although major changes in curricula or teaching methods may be administratively demanding. For nutrition, general food subsidies are simpler to organize than targeted programs—but subsidizing food consumed mainly by poor people (see pages 62-63) is a form of targeting that eases administrative problems.

Improving administration at the periphery is far more complex and difficult than administrative reform at the center, a task that has itself often proved intractable. Many of the poor are hard to reach through conventional public programs, and the end-of-the-line workers may not be motivated to break the social, linguistic and physical barriers that separate them from the poor. Supply lines for textbooks or medicine may be continually breaking down, and the necessary technical support may be lacking. But these and similar difficulties must be overcome to reach the poor; that usually means improving organization at the grass roots.

**Strengthening government machinery**

No matter how resourceful individuals or local communities may be, sustained progress in human development inevitably requires national governments to mobilize and apply the much greater resources, both domestic and international, at their disposal.

Reviews of World Bank projects reveal a number of common institutional problems—among them, weak planning agencies and an inability (or failure) to relate annual budgets to long-term development priorities. Some of the existing deficiencies are due to inappropriate administrative structures and procedures, which still tend to reflect the metropolitan models on which they were patterned. They place undue emphasis on central control and take inadequate account of prevailing cultural or social attitudes.

Other weaknesses arise because the administration is not properly geared to identifying the people to be served, increasing their access to services, adapting services until they are appropriate, delivering them efficiently and observing (and reacting to) the public's response. This sequence requires people who can learn from the intended beneficiaries and gain their confidence (see box). This is critically important when the poor are cautious (or even hostile)—as they often are in their reactions to preventive medicine, family planning and nutrition education.

Most developing country governments are well aware of the need to improve administrative performance, and have undertaken some form of public sector reorganization. A common objective is to decentralize; planning units are being created at the state or provincial level in the Philippines and Sudan, for example, as a first step toward greater devolution of power (though premature decentralization, as in Tanzania, can complicate program implementation).

With the help of multilateral and bilateral agencies, many countries are trying to improve the performance and skills of public sector employees through training; through better job classification, which facilitates recruitment, training and evaluation; and through changes in civil service regulations—for example, to specify promotion requirements more clearly and to tighten discipline. Thailand is introducing special procurement procedures to prevent slippage in project implementation. Malaysia is implementing a more systematic approach to the preparation and appraisal of agricultural projects. Several Asian and African countries have begun to streamline cumbersome budgetary practices.

These and other efforts to make government machinery more efficient will take many years to produce discernible results. The continuous expansion of public sector activities in most developing countries has produced its own set of constraints: many bureaucracies have become large, powerful and protective of their own interests. Frequent changes of political leadership have insulated some bureaucracies from pressures for reform; in other countries radical attempts to restructure or purge public services have greatly
Rural poverty unperceived

Poor people are often the most difficult to reach. Many live on the edges of villages, far from main roads. They are illiterate, have no radios and know little about events beyond their neighborhood. They rarely go to public meetings and travel little except in search of work. Those whose legal position is weak (such as refugees or squatters) may even try to hide, to be invisible to the official eye. Out of sight, they hope to be out of mind.

As for the professionals who work in rural development programs, many of them are caught in an urban trap. Young, unmarried officials are sent to remote rural areas; but age, marriage and their careers draw them back to the towns and cities. And those who do live in the countryside often direct their attention toward people they have in common with—the not-so-poor.

What can be done to correct this bias? Changing career patterns and incentives to reward rural work is fundamental; training can also play a role.

Without the need for complicated research, in-service training can help people to understand more about poverty. For example:

- Family case studies: a day in the life of a landless household, or how a poor family survives the hungry season.
- Getting poor people to talk about significant incidents in their life and work, particularly about those they see as being responsible for their poverty.
- Exploring practices and attitudes that affect, for instance, diets and fertility.
- Seeking out those who do not use services or adopt new practices, and trying to understand the reasons for this.

Relatively simple but systematic surveys can sometimes help those who carry them out. To take one example: in a densely populated part of western Kenya, junior agricultural extension staff and home economics workers were each given a random sample of 100 households to survey, in the area where they worked. After the survey, many at first thought that the sample had been biased heavily against the better educated households. One of the agricultural staff complained that only one of his 100 households had an improved breed of cow: he was surprised to learn that he had, without recognizing it, been concentrating on better-off households; in fact the area average was only one of these cows for more than 200 households. A home economics worker was appalled at the poverty she had found. “These people do not come to my meetings,” she said. Perceiving reality is the first step to changing it.

Reduced the ability of governments to maintain essential human development programs.

Choosing appropriate administrative strategies

To help make programs fully effective, administrators may need to use a variety of institutions—national bureaucracies, public enterprises, private businesses, voluntary agencies, local governments and organizations of intended beneficiaries—and strike the right balance between them.

In family planning, for example, traditional channels of private marketing, which reach even remote villages, have proved effective in many countries (including India, Indonesia, Jamaica and Sri Lanka). These private distributors supplement rather than supplant the services available through health ministries or other official family planning agencies. The cost to users has been kept low by providing the private distributors with free or highly subsidized contraceptives and controlling the retail price. And in Singapore, contraceptive information was at one time distributed with public utility bills.

Organizations of intended beneficiaries are not conventionally regarded as administrative agencies, but they can play a valuable role. Farmers’ organizations, rotating credit associations, women’s clubs, religious groups and marketing cooperatives are in principle accountable to, and can reflect the interests of, their members. They can involve their members, too, as no bureaucratic agency can. When local health centers in northern Senegal were unable to reach the people directly in a child-feeding program, the religious leaders took over part of the food distribution: recent research indicates that this is an effective way of getting food to poor families. Local groups can also provide reliable feedback on project experiments, and can influence bureaucracies to improve services in ways that unorganized, poor individuals could not.

Research in both developed and developing countries shows that when the beneficiaries are involved through their own organizations, they respond more effectively to services. That has happened, for example, in 4,500 village cooperatives organized by the Indian National Dairy Development Board; in 200 local development associations in the Yemen Arab Republic; in more than 9,000 Mothers’ Clubs in South Korea, where family planning and other community functions have been assumed by traditional credit associations (called kaes); and in special radio listening and discussion groups in which about 2 million rural Tanzanians participated during the “Man is Health” campaign in Tanzania in 1973.

There is of course a danger that poor people’s organizations may come to be dominated by local elites, with an associated risk of corruption. One of the main problems of agricultural cooperatives, for instance, has been to resist this type of domination. Unlike subsidized agricultural credit or fertilizer, however, primary education cannot be stolen, hoarded or resold. And though medicines can be, even the richest person would not want a hundred vaccinations. Another problem is infighting between rival local groups. But the suspicions that established
bureaucracies may have about organized beneficiaries or local governments should not blind them to their potential for effective action.

When administrative abilities are weak, it is sensible to concentrate on projects that do not need much organization. Food fortification (see page 63) involves minimal administrative effort. And in Cameroon a state corporation has effectively distributed low-cost pharmaceuticals through commercial channels. But this approach does not work for every kind of service, and it often fails to reach the most deprived people.

Where countries have a relatively strong administrative system but the poor are badly organized (a fairly common combination), governments can provide services that do not require joint action—such as primary education, basic health services, mass vaccination campaigns and subsidized food. Sri Lanka and the Indian state of Kerala, for example, have managed to achieve striking progress without relying much on local development groups. But even there, programs tend to be more active and effective if the intended beneficiaries are involved through local organizations.

Demand: ensuring that services are used

As has been shown, the poor sometimes fail to take advantage of services even if they are available (see page 52). The reasons for this "reluctant demand" vary across countries and sectors; but the more accurately they can be identified in particular cases, the better they can be tackled. Sometimes this can be done by changing the way a service is provided or reducing the costs of using it. Often it means changing the perceptions of intended beneficiaries. This may be simply a matter of providing information; but it commonly requires changes in long-standing attitudes and habits.

Changing the way services are delivered

A school calendar may compete unnecessarily with the crop cycle, with important exams held at times when students are most needed by their parents in the fields. The staff of a health center may not keep a regular schedule, forcing people who have traveled for several hours to return home without treatment. The local clinic may be short of drugs or so inconveniently located that a patient with a minor complaint may prefer to go straight to an urban hospital—or to the traditional healer, who may live in the village. Often the changes required to make a service more attractive to potential users are self-evident, such as providing them in a language that the beneficiaries understand. This does not mean that they are necessarily easy to implement.

Reducing costs to users

The benefits of services for health, education, nutrition and family planning often may be (or at least appear to people to be) less than their direct and indirect costs (see box). The latter can sometimes be reduced. For example, providing free textbooks (and uniforms, if required) and locating schools within walking distance will reduce the direct costs of school attendance. Providing free transport to health clinics is another possibility.

Providing information

The reason people do not take up a service may simply be that they lack information about it, or they may not know what to do: people may claim to be "aware" that family planning services exist, but have little idea what their use entails. They may assume that a newly established clinic will charge fees or require membership. Education and organization of beneficiaries can help. So can direct information campaigns, making use not only of mass media like radio or billboards, but also entertainers. Research on the diffusion of new ideas suggests that direct contact between people is the most effective form of communication. It has also been found that mass media are more influential if they are heard (or read) in a group. Radio forums, for example, in which a radio program is followed by a discussion, are a promising way of changing social attitudes and behavior. Since it is difficult to form such groups on an ad hoc basis, religious and other social groups may be useful.

Overcoming sociocultural obstacles

Deciding to use a service may require a more fundamental change in attitudes and practices. The idea may be controversial; for example, women may have heard unfavorable rumors about modern medicine or family planning methods. The poor may not appreciate the benefits, say, of different hygiene and sanitation arrangements because they do not understand how diseases are caused. Or the lack of demand may have roots deep in traditional taboos, beliefs or preferences. In many countries, men often refuse to allow women and girls to go to male doctors or community health workers. The same beliefs mean that girls are frequently not sent to school and girls to go to male doctors or community health workers. The same beliefs mean that girls are frequently not sent to school and hence there are few female medical workers. In Africa and Southeast Asia certain types of food rich in vitamin A (such as dark green, leafy vegetables) are cheap and abundant. Yet many cases of blindness among children are caused by vitamin A deficiency—because eating these
Private costs of using public services

Data on the private costs of using public human development services are scarce. A recent study of Peninsular Malaysia, however, estimated them for education, water and health care.

- Education. Malaysian families had to cover—in addition to examination fees and purchases of texts and supplies—the costs of shoes, uniforms, snacks, transport and special fees. In 1974 these averaged $47 a year for a student in primary school, $123 for a student in secondary school.

The table shows that families in the lowest income quintile spent about a fifth of their incomes on out-of-pocket school costs. Even allowing for some bending of the truth by respondents, this is impressive—and it understates the burden. A fifth of the income of a poor family represents a far greater sacrifice than a fifth of the income of a wealthy family. And the cost of forgone earnings—what students could earn by working if they were not in school—is excluded.

- Health care. The Malaysian study showed a strong relation between household income and expenditure on private health care—but almost no relation between income and consumption of public health care. Most patients paid no fees for public inpatient or outpatient treatment. Nor were expenditures on transport to the place of treatment related to income, although there was a weak inverse association between travel time and frequency of treatment. Thus the need for medical care of the poor and most of the rest of the population was met through the public system at little private cost.

<table>
<thead>
<tr>
<th>Family income quintile</th>
<th>Percentage of households with students</th>
<th>Percentage of their income spent on out-of-pocket school costs</th>
<th>Percentage of households with piped and treated water</th>
<th>Percentage of their income spent on water</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest</td>
<td>73</td>
<td>18</td>
<td>20</td>
<td>4.1</td>
</tr>
<tr>
<td>Second</td>
<td>67</td>
<td>10</td>
<td>37</td>
<td>2.6</td>
</tr>
<tr>
<td>Third</td>
<td>71</td>
<td>10</td>
<td>43</td>
<td>2.0</td>
</tr>
<tr>
<td>Fourth</td>
<td>66</td>
<td>8</td>
<td>62</td>
<td>1.5</td>
</tr>
<tr>
<td>Highest</td>
<td>50</td>
<td>6</td>
<td>76</td>
<td>0.8</td>
</tr>
</tbody>
</table>


...foods is regarded as a sign of low social status.

Higher incomes and better education will clearly help to overcome many of these obstacles. Traditional social and cultural structures can sometimes also be adapted to new uses rather than ignored or swept aside. The Indonesian family planning program has been notably successful in this respect, as well as in decentralized responsibility for implementation (see box overleaf).

The more that programs require people to change their behavior (the pattern of distributing food within families), threaten established norms (family planning), challenge vested interests (professional associations) or offer few immediately obvious benefits (sanitation), the more patiently they must be introduced. Public education and persuasion are needed, and it will take a long time to reap the economic and political benefits.

Coercion

In attempting to spread human development, many countries have gone beyond information and persuasion to use various forms of coercion. Laws establishing compulsory primary education are perhaps the most widespread example. Using laws is sometimes regarded as more unfairly coercive than, say, manipulating costs, since it allows no parental choice at all. But because children usually suffer more than their parents, such measures as compulsory schooling should be seen more as protecting the rights of children than as restricting those of parents.

Just how much coercion is considered to be acceptable will vary according to a country's culture and political values. In some places, traditional social structures have been enlisted to exert pressure on their members. This has been a characteristic of the Indonesian family planning program. Among the Hausa in northern Nigeria, a program to eradicate sleeping sickness has been successfully sustained through strong leadership. Every year the villagers clear the undergrowth along the banks of rivers and streams. They do not fully understand the reasons, but they are willing to do what their traditional leaders ask. Nevertheless, programs of education, health, nutrition and family planning have more chance of success if the beneficiaries come to see the programs as serving their interests.

Affecting behavior within the family

Especially in poor households, the interests of parents, children and old people can diverge, causing maldistribution of food, education and medical care within the family (see pages 61–62). Raising family incomes can reduce or eliminate the economic reasons for unfair shares; more education of parents, especially of mothers, can mitigate the cultural reasons (see box on page 50). In addition,
The banjars of Bali

Indonesia’s family planning program combines central direction with decentralized implementation. The program has strong political support from the president, to whom its chairman reports directly. Family planning is an integral part of national and provincial development plans—ministers and provincial governors are responsible to the president for their execution. And the program maintains a central data system to monitor performance and ensure that no region or even village runs short of contraceptives. But the task of implementing specific goals rests largely with provincial and local staff, and political and community leaders in the villages.

The program offers strong (but non-monetary) incentives for managers and staff at all levels, because it was designed to give credit for success to local managers. Most of the contact with families is by village volunteers. The program rewards them, too—outer-island midwives can earn trips to Bali for training, while Balinese chiefs whose villages have made the most progress in family planning are taken to see the successful East Java program.

The approach is tailored to specific local needs; it fosters local initiative and experiments with unconventional projects. People at provincial and village levels submit ideas for new campaigns, and funds are quickly provided for the ones approved. The program has also made use of the private sector—traditional traveling herb vendors (called luaks jamus) have been enlisted to supply contraceptives to remote villages as well as urban areas. In the province of Bali, the traditional community council (called banjar) has been harnessed to promote family planning. For centuries banjars have been the hub of village life. There are more than 3,700 of them today; adult men in Bali belong to their village banjar and attend monthly meetings. In 1974 the government in Bali started to work through banjar leaders to create an awareness of family planning, to identify people who might be keen on planning their families, and to help them do so. Typically, the monthly banjar meeting now begins with a roll call; each man responds by saying whether he and his wife are using contraceptives. Replies are plotted on a village map—prominently displayed.

The results have been striking. An estimated 49 percent of eligible couples have adopted family planning in Bali, compared with 29 percent for the country as a whole. The World Fertility Survey showed that the average number of children a Balinese woman could expect to have had fallen from 5.8 in mid-1969 to 3.8 in 1976.

Improved earning opportunities for educated women, lower infant mortality rates and a rising age at marriage will help parents to provide more for all their children and to have fewer of them.

Without these sorts of change, it is difficult to affect the way food, education and medical care are shared within families. But it is not impossible. Door-to-door inoculation campaigns can reach all children. This has been done recently in Mozambique and Sierra Leone. And the way work is organized will also affect inequalities within families. For example, the Anand Dairy Cooperative in India increased the income received directly by Indian women—since they have traditionally been responsible for looking after cows and goats, selling the milk and controlling the proceeds themselves. By selling cooperatively, the members get higher profits than they otherwise would. Families are fed better. More of the children are now attending school. And as the younger educated women are seen to be taking a greater part in running the cooperative, education for girls is becoming more highly valued. In dairy development projects in three other Indian states—all based on this model—similar results are being obtained.

**International assistance**

International aid for human development programs has been provided for decades and has contributed to several notable successes. It has played a major role, for instance, in helping to spread education; in eradicating smallpox and sharply reducing several major diseases (including yaws, malaria, leprosy and African sleeping sickness); and, perhaps most significantly, in increasing the production of basic foods.

On the other hand, some aid programs have failed—or have succeeded while indirectly contributing to inappropriate policies. Until the early 1970s, there was an emphasis on showcase universities, large urban hospitals and large-scale agriculture—consistent with development thinking at that time. Not surprisingly, such international assistance involved transferring some technologies or institutions from developed countries without adequate recognition of how the circumstances of developing countries differed.

Since the benefits of human development are received partly by today’s children but even more by their children and grandchildren, governments that are hard pressed financially may find it difficult to justify spending as much on human development as is desirable for long-run economic growth, let alone for alleviating poverty. This dilemma—which will be acute during the next few years of financial stringency—is one for which external assistance can be particularly helpful. Many other measures—from small-farmer programs to power generation and industrialization—are also needed to reduce poverty and raise average incomes; these merit strong international support as well.

If donors providing assistance to a country are unwilling to finance human development programs, these programs in most cases will be smaller than they otherwise would have been. Similarly, if donors are willing to finance only “bricks and mortar”
but not teachers or health workers, the net effect will be excessive capital intensity—showing up in overly expensive and underused buildings and insufficient staff. Yet in developing countries a high proportion of spending on primary education and health care, for example, is—and should be—for operating (recurrent) costs. In many countries, such as Tanzania and Upper Volta, money for operating costs is already very short—with the result that schools without books or even paper, health posts without medicines or supervision (due to inadequate travel budgets or gasoline shortages) are increasingly common. These shortages will get worse as growth slows and countries struggle to keep up their physical investment rates.

Most aid agencies have preferred to limit their funding to physical investment, being reluctant to finance operating costs partly because of concern that projects in which a developing country lacked a substantial financial stake might not develop enduring roots, but also from fear of encouraging consumption at the expense of investment. As this Report stresses, however, human development increases productivity, reduces fertility and thus promotes long-term growth in average incomes. A significant part of spending—operating as well as capital—on human development therefore is investment. This is most evident in primary education, which in many countries has economic returns well above average; the salaries of teachers should no more be regarded as consumption than the wages of workers on irrigation projects. There is a large element of investment in family planning programs as well (indeed the estimated returns often are even higher) and to a lesser extent in health and nutrition programs.

With increasing recognition of the importance of antipoverty programs, and of the investment component of many of these programs, practices have begun to change. Several donors, including the World Bank, have been financing the salaries of agricultural extension workers, and in some cases the operating costs required to carry out education and training projects—teachers’ salaries and teaching materials, for example. In May 1979 the OECD’s Development Assistance Committee adopted new guidelines on the financing of local and recurrent costs, which recognized that basic human development programs were particularly suitable for these kinds of financing.

Donors should of course be concerned to avoid waste in operating costs, just as in construction costs. And they need to ensure that programs develop adequate financial support for operating costs from national and local governments—lest they wither away when international aid is withdrawn. Thus the share of operating costs covered by external assistance should be reduced gradually, which will encourage steady increases rather than quantum jumps in the amounts to be financed from local funds.

Donors should also consider providing sectoral or subsectoral, as well as project, financing. This enables governments to focus on the institutional, planning and policy issues that have a strong influence on the success of individual projects; it also provides a useful framework for striking the appropriate balance between capital and operating costs. In practice, subsectoral financing—limited by activity or region—is often preferable to sectorwide financing. Through subsectoral financing, donors can assist a continuing series of activities, while ensuring that no one project or program relies for long periods on outside aid and that implementation difficulties in one project or region do not interfere with continued financing for others.

The importance of persistence

Programs that cost the least often require the most organization. Moreover, whether in state bureaucracies at one extreme or among the intended poor beneficiaries at the other, an organization’s strength generally depends on the education and resourcefulness of its members. That cannot be developed overnight.

One key lesson from 30 years of development experience is that it takes a long time to build up effective institutions. Neither governments nor donors should expect quick results, or give up too easily. For example, evaluation of family planning programs shows a close relation between their effectiveness and the number of years they have been in existence.

As Chapter 5 explained, and as Figure 6.1 confirms with respect

Figure 6.1 Literacy rates, selected developing countries, 1950 & 1970

Lit the rates are for the 20–24 age group and determined by data availability. Dates are close to 1950 and 1970.
to education, the level of human development at one time is strongly influenced by its level decades earlier. Thus, human development is not something that can be deferred: what is done now—or not done—will have an influence for a long time to come. When austerity programs are necessary (as will be the case for a number of countries over the next few years), attention should be given to the need for investment in the human development of the next generation. When economic difficulties originating in the workings of the world economy or economic mismanagement cause cutbacks in human development programs, children pay heavily—in loss of future income or health, and in some cases with their lives.