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Africa Region Human Development
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Enhancing Human Development in the HIPC/PRSP Context

Progress in the Africa Region during 2000

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Africa Region
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Foreword

Poverty reduction is the central focus of the World Bank's development assistance strategy. In recent years the institution has, together with its partners, evolved new concepts, processes, and operational instruments in an effort to enhance the effectiveness of its support to governments in the fight against poverty. The most notable of these new approaches include (a) debt relief through the Highly Indebted Poor Countries (HIPC) Initiative, (b) country leadership in articulating poverty reduction strategies through Poverty Reduction Strategy Papers (PRSPs), and (c) World Bank financial support through Poverty Reduction Support Credits (PRSC) to implement these strategies. Because human development (HD) is central to any poverty reduction effort, these new approaches typically place heavy emphasis on improving performance in the social sectors.

Given the newness of these developments, it is still too early to evaluate their impact on human development and poverty reduction. Yet, they have proceeded far enough in a large number of African countries to make an initial stock-taking exercise worthwhile. This paper is intended to serve that modest purpose. It offers readers an account of the progress during 2000 in the eighteen African countries that passed their Decision Points in the debt relief process during that year. The report includes basic facts on the countries involved, the pipeline of possible newcomers in coming years, the amounts of debt relief offered in relation to the current size of social sector spending in the eighteen countries, the content of HD policy measures included in the debt relief agreement, and countries' progress in preparing PRSPs. Readers will also learn about the World Bank's efforts to engage country counterparts in the HD sectors in a more effective dialogue on sector development, particularly in the health and education sectors. A key aspect of these efforts involve collaborative work between the World Bank and national teams in sector analysis that consolidate and deepen sector knowledge, the aim being to strengthen the basis for preparing sector inputs into PRSPs.

A stock-taking exercise of a still evolving process inevitably runs the risk of telling at best an incomplete story. It is thus my hope that, as we make progress in implementing the new concepts, processes, and instruments associated with debt relief and poverty reduction strategies, subsequent updates to this report will document the emerging lessons that can help to enhance the effectiveness of the World Bank's support for poverty reduction.

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This paper reports on the current status of an evolving process, and is circulated mainly to inform readers about what has happened so far. The authors wish to thank Fay Chetnakarnkul for help in consolidating the information, Tony Gaeta for sharing valuable information on debt relief, Birger Fredriksen for providing feedback on an earlier draft, and Lawrence Mastri for editorial assistance. While these colleagues have helped to improve the report, the authors alone are responsible for any errors that remain. The views expressed in the report are those of the authors and do not necessarily reflect the opinions or policies of the World Bank or any of its affiliated organizations.

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Introduction

In 1996 the World Bank and the IMF — supported by governments around the world — proposed the Highly Indebted Poor Countries (HIPC) Debt Initiative as a coordinated approach among official creditors to bring down debtor countries' external debt to sustainable levels. An enhanced version of the initiative was put in place in September 1999 to simplify and accelerate the process, as well as deepen the amount of debt relief and tighten the link to poverty reduction. The expectation was that, in return for debt relief, beneficiary countries would commit themselves to policies that advanced sound economic management and poverty reduction. The initiative emphasized structural and social policy reforms, particularly in delivering basic health care and education services, facilitated where needed by additional financing under the HIPC Initiative. In addition, governments benefiting from the debt relief would be expected to articulate their plans for poverty reduction in a Poverty Reduction Strategy Paper (PRSP).

Given the focus on health and education within the context of debt relief, the Africa Region formed a HD HIPC/PRSP Team in November 1999 to help task team leaders in the Human Development (HD) family provide sectoral inputs for the various HIPC/PRSP documents.* This report is intended to update World Bank colleagues and others on the team's work. It has three parts: the first summarizes key aspects of HIPC/PRSP processing and how the team has organized itself to provide sectoral inputs into the process; the second part uses examples to elaborate on the analytical work that the team is developing to strengthen capacity — both within the Bank's HD family and in counterpart national teams — to work with macroeconomists and ministries of finance officials in designing sector policy measures included in the HIPC/PRSP documents; the third part of the report concludes with some thoughts on lessons learned thus far.

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The HIPC/PRSP Process and HD Engagement in It

This section identifies the HIPCs and their current status vis-à-vis debt relief, and highlights selected aspects of the processing of the initiative, including the windows of opportunity for policy intervention to tighten the link between debt relief and poverty reduction. It reports on the progress to date in leveraging the process to advance social sector development, and elaborates on the team's efforts at capacity building.

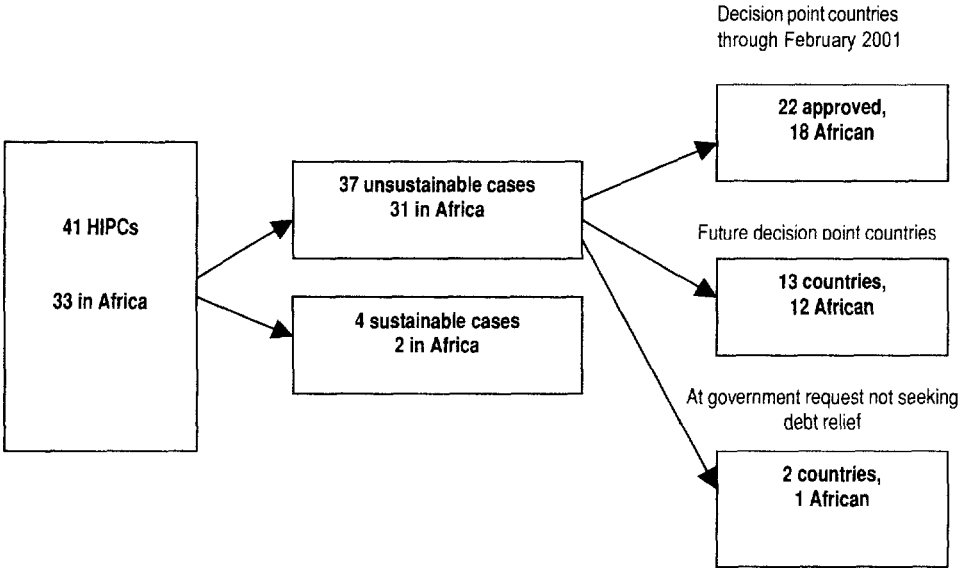
The countries involved and amount of debt relief

As of February 2001, there were forty-one highly indebted poor countries, thirty-three of them in Africa (Figure 1). Of these, thirty-seven countries (thirty-one in Africa) have unsustainable external debts (defined in most cases as a situation where the net present value of the country's debt relative to exports exceeds 150 percent), even after the full use of traditional mechanisms of debt rescheduling and debt reduction (e.g., under Naples terms, where low-income countries can receive a reduction of eligible external debt of 67 percent in net present value terms).[1] As of February 2001, twenty-two of these countries (eighteen in Africa) have passed the decision point under the Enhanced HIPC Initiative, having been formally approved for debt relief by the Executive Boards of the IMF and the World Bank. Two countries, Ghana and Laos, have opted not to seek debt relief under the HIPC Initiative. Decision points could be envisaged in the future for thirteen countries, twelve of which are in Africa.

The financial impact of the HIPC Initiative can be assessed in various ways.[2] First, it unambiguously reduces beneficiary countries' stock of external debt. For the twenty-two countries that have reached their decision points thus far, the stock of debt declines from an estimated US$44 billion in net present value terms after traditional debt relief, to $24 billion after HIPC debt relief, a reduction of 45 percent.[3] Second, these countries' debt service obligations also shrink. For the eighteen African countries in the sample, the reduction relative to the actual debt payments made in 1998–1999 will amount to a total of $0.6 billion a year averaged over 2000–03; and the reduction relative to the debt service payment due will amount to a total of $1.8 billion a year averaged over 2000–03. The financial impact of the initiative can also be appreciated in terms of other indicators: the debt service obligations of the eighteen African countries relative to their exports is projected to fall from the 1998–99 average of 17.0 percent to an average of 8.1 percent during 2001–03; correspondingly, debt servicing relative to the GDP is expected to drop from 3.3 percent to 1.8 percent, while debt servicing relative to government revenue is expected to decline from 26.0 to 11.8 percent.

Taking the calculations over a longer time span, Table 1 shows the average annual difference in debt service obligations with and without the HIPC Initiative during 2000–09 for the eighteen African countries concerned; for contextual purposes, the table also includes data on the current levels of public spending on education and health in these countries. For most countries, the reduction in debt service obligation is large relative to current public spending on education and health; leaving aside the outliers (i.e., Benin, Guinea-

Figure 1
Grouping of the Heavily Indebted Poor Countries
Status as of February 2001



Source: World Bank website at http://www1.worldbank.org/prsp/PRSP__Related_Documents/hipc_groupings.pdf; for a detailed listing of countries see Appendix Figure A1.

Bissau, and Zambia), the reduction ranges from nearly as much as total health and education spending in Guinea and Mozambique, to around a fifth of the total in Uganda, Burkina Faso, and Senegal, with the other countries positioned in between.

The sizable reduction in debt service obligations provides an important context for the debate on social sector development and poverty reduction. Many poor countries have explicitly identified high debt service as an obstacle to providing basic education and health services, and have argued that debt relief would help them expand and improve the provision of such services. Conversely, as debt relief is provided, many constituencies in creditor countries would like to ensure that the money thus freed would actually advance social development and reduce poverty. Thus, for both sides of the transaction, it is important to take advantage of the specific opportunities presented by the HIPC Initiative to strengthen the link between debt relief and improvements in social services and eventually, progress in poverty reduction.

A good start has been made by having countries benefiting from the HIPC Initiative commit to increasing their public spending on health, education, and other services targeted to disadvantaged populations. Based on plans reported in the HIPC documents, public spending on social services in the eighteen African countries is expected to rise from an estimated $2.5 billion in 1999, to an average of $3.4 billion annually during 2001–02, corresponding to an increase in spending from 4.4 percent of GDP to 5.1 percent, or an increase in spending from 29.6 percent of government revenue to 32.4 percent (World Bank 2001 cited above).[4] How much the increase in spending would produce tangible progress in social outcomes clearly depends on how effectively the countries use not just HIPC relief but all public resources. Policy reforms to remove constraints on service delivery are therefore critical. In the sections below we elaborate on some key aspects of the debt relief process under the HIPC Initiative, and the instruments associated with it, in order to clarify the opportunities for initiating and supporting the policy reforms needed to improve health and education outcomes.

Table 1
Debt relief relative to social sector spending in eighteen African countries [a/]

Country	Annual reduction in debt service obligations (2000-09) (millions of US$)	Public spending, 1998 (millions of US$)		Debt relief as % of social sector spending
		Education	Health	
Benin	2	68	30	2.0
Burkina Faso	33	97	66	20.2
Cameroon	86	225	48	31.5
Guinea	50[b/]	45	10	90.9
Guinea-Bissau	34[b/]	2	1	1133.3
Madagascar	52	77	30	47.7
Malawi	52[b/]	90	46	38.2
Mali	44	83	60	30.8
Mauritania	48	49	17	72.7
Mozambique	117	87	35	95.9
Niger	47[b/]	45	27	65.3
Rwanda	31	57[c/]		54.4[d/]
São Tomé & Principe	6[b/]	1.8	-	-
Senegal	44	182	29	20.9
Tanzania	115	150	74	51.3
The Gambia	9[b/]	9	6	60.0
Uganda	45	170	43	21.1
Zambia	176	54	36	195.6

Source: HIPC decision point document for each country, for data on the annual amount of debt relief. HIPC decision point document for Malawi, Niger, The Gambia, Madagascar, for data on these countries' public spending on education and health; World Bank Africa Live Database for Guinea, Guinea Bissau, Zambia, Mozambique, Mauritania, Benin, Burkina Faso, for public spending on education and health; and World Bank Africa Live Database for Senegal for public spending on education and Mali for public spending on health. Various health and education sector studies for Cameroon and Tanzania's public spending on education and health; and Mali's public spending on education; and Senegal's public spending on health (for Tanzania, the figure for education refers to the budgeted spending).

a/ These are the eighteen countries that have already passed their decision points as of end-December 2000.

b/ Annual reduction in debt services (2001–10).

c/ The figure refers to overall social sector spending in 1998.

d/ Debt relief as % of overall social sector spending in 1998.

The debt relief process and policy levers

The process involves two key phases, the first culminating in the decision point, and the second in the completion point. To reach the decision point a debtor country must have achieved a three-year period of satisfactory performance on the macroeconomic adjustment and reform programs supported by the IMF and the World Bank. At the decision point, the Executive Boards of the IMF and the World Bank formally decide on a country's eligibility for debt relief, and the international community commits to providing sufficient assistance by completion point for the country to achieve debt sustainability as assessed at the decision point.

After passing the decision point, a country enters the second phase and progresses toward the completion point when the bulk of assistance under the Enhanced HIPC Initiative is delivered. During this phase,

the IMF and World Bank provide "interim relief" while other creditors are generally expected to reschedule obligations coming due. The time it takes to reach the completion point is not pre-specified (hence it is called a "floating" completion point), but depends on the country being on track for macroeconomic performance under IMF/World Bank-supported programs, and how soon it achieves various structural policy reforms. At completion point creditors are free to choose the modality for delivering their debt relief assistance, including up-front debt reduction or debt-service reduction (e.g., Paris Club), debt-service reduction (World Bank), or grants made available to service debt as it falls due (IMF).

For each country eligible for the HIPC Initiative, two key documents formalize the process. The first is the HIPC decision point document, a joint paper prepared by the staffs of the World Bank and IMF for consideration by the Boards of the two institutions. It contains three types of information: (a) the country's record of macroeconomic adjustment and structural and social reforms; (b) the medium-term policy outlook; and (c) debt sustainability analysis and assistance.[5] The specific conditions agreed upon with the country for reaching the completion point are a key feature, typically arranged under three headings, "macroeconomic," "structural," and "social." Under the "social" heading is invariably the condition that the country prepare a Poverty Reduction Strategy Paper (PRSP) and implement it for at least one year; in addition, specific actions are often specified for policies in health, education, and HIV/AIDS control.

The PRSP is the second key document that formalizes the processing of the HIPC Initiative in each country. It describes the country's rolling three-year macroeconomic, structural, and social policies and programs to promote growth and reduce poverty, as well as associated external financing needs and major sources of financing. As such, it is expected to be updated regularly, with progress reports in the years between updates. The government is expected to take responsibility for managing the document's preparation (with technical inputs from Bank and IMF staff as needed) as well as its dissemination to obtain feedback through a participatory process involving civil society and other partners in the fight against poverty. Having the government take the lead is not only logical but also essential to create national ownership for the government's plan for poverty reduction. Because a full PRSP inevitably takes time to prepare, countries often start with an interim PRSP, which sets out the government's commitment and plans for developing a full PRSP) at the time they reach the decision point, and expands it into the full version in the subsequent months.

The HIPC decision point document and the PRSP are two instruments with a potentially powerful influence on the poverty focus of health and education policies. In order to accelerate countries' progress toward debt relief, the completion point triggers specified in the HIPC decision point document typically concern policy targets that can be achieved in a relatively short time-frame, say between twelve to eighteen months. In contrast, the government's poverty reduction strategy is expected to stretch over a longer time frame and cover a broader reform agenda. The difference in timing implies that the HIPC document is best used as an instrument for nudging forward immediate short-term strategic reforms — reforms on which the government's poverty reduction strategy can then build.

The promise of the HIPC/PRSP process lies in the fact that it brings together various perspectives that are essential to any poverty reduction strategy but which have not been sufficiently integrated in the past. In particular, the articulation of the policy priorities involves collaboration — on both the IMF/World Bank side, as well as on the government side — among macroeconomists and others working on broad structural issues on one hand, and sectoral staff on the other. In addition, an explicit role is reserved for other partners in the fight against poverty, including representatives of civil society, non-governmental organizations, and the donor community. The interactions should help enhance the link between sectoral reforms and broader actions on the macroeconomic front, as well as create mutual accountability for results.

These processes are still new and as such remain imperfectly structured for systematic and consistent contribution from sectoral staff, both at the World Bank and (even more so) in the health and education ministries in the HIPCs. Acceleration in the debt relief processing schedule adds to the difficulty because it inevitably reduces opportunities for meaningful interaction and consultation in the process. Within the HD family, the implications of the HIPC/PRSP process for the Bank's country assistance strategy needs to be

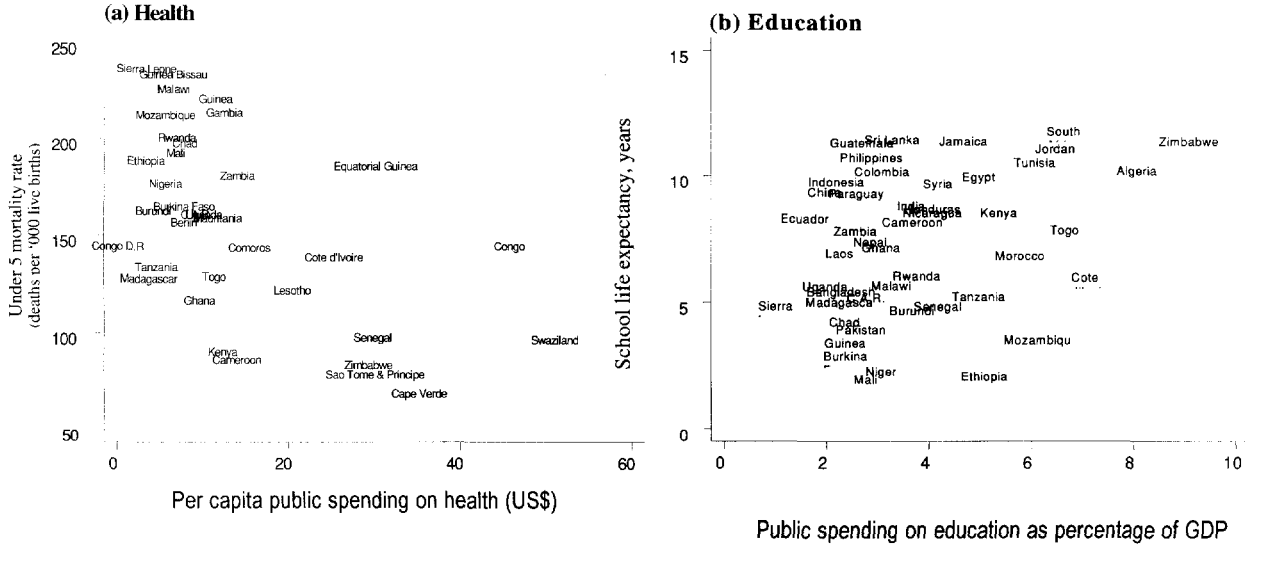
more fully recognized and acted on, specifically in terms of the provision of timely and pertinent sectoral inputs to inform the process. A start has been made with the creation of the HD HIPC/PRSP team, with some progress so far for the work on health and education.[6] The integration of social protection issues into the process has proved to be much more elusive, however, reflecting the spread of such issues across many sectors within the Bank, and across government ministries. As the teething pains are overcome with experience in the health and education sectors, the hope is that the work would expand to embrace social protection issues much more systematically than has been possible to date.

Advancing Human Development in the context of HIPC/PRSPs

There are two specific avenues for action to advance the HD agenda in the context of HIPC/PRSPs: (a) specifying appropriate short-term policy interventions as conditions for a country to reach its completion under the HIPC Initiative; and (b) providing technical inputs to support the design of the poverty reduction strategy paper by each country's government. To perform both tasks effectively requires a reasonably solid understanding of the health and education sectors — their current performance, the sources of inefficiencies and inequities in each sector, and potential options for improvement. That understanding must also be one that is shared by the government, and must go beyond simply looking at aggregate spending on education and health to examine how resources are in fact used and managed.

The challenge can be visualized in Figure 2, which shows the relation between indices of health and education outcomes relative to public spending. While the indices may not reflect all aspects of sector outcomes, the graphs nonetheless highlight the tenuous link between inputs of resources and outcomes, thus raising questions about underlying differences in policies that have produced such widely different outcomes across countries.[7] The graphs in effect suggest that, in some countries, substantial risk exists that the extra resources freed up under the HIPC Initiative would produce weak results at best if simply poured into the health and education systems as they currently operate. To improve outcomes would require significant efficiency improvements, so that the same resources can finance services that reach more people, with better targeting to the disadvantaged. In the inherently short processing time frame of the HIPC Initiative, the completion point triggers are best understood as a means for orienting the health and education systems toward improved delivery. As for the PRSPs, they are best understood as picking up where the HICP document leaves off, in that they articulate a more comprehensive medium-term reform agenda and the corresponding expenditure framework, as well as specific progress and outcome indicators to guide implementation and assess results.

Figure 2
Relation between public spending on health and education and sectoral outcomes, circa 1993



Enhancing HD inputs for the design of completion point triggers and PRSP follow-up

In light of the above challenge, the work of the HD HIPC/PRSP team is organized on two parallel tracks: (a) helping task team leaders to mobilize readily available data and information to provide immediate inputs, as needed, for the preparation of HIPC documents; and (b) guiding the preparation of Country Status Reports on health and education to consolidate existing sector knowledge.[8] The goal of this work is to lay the groundwork for engagement — both within the World Bank among macroeconomists and sectoral staff, as well as between the Bank and country counterparts — in the process of preparing and discussing the HIPC/PRSP documents.

The ideal sequencing is first to prepare the status report, discuss it with government counterparts, and collaborate with them on designing a broad agenda for policy reform and implementation — an agenda from which the key measures could be extracted for inclusion as conditions for reaching the completion point in the HIPC Initiative. In practice, the sequence typically unfolds in a less than ideal order because, while the preparation and discussion of a Country Status Report would inevitably take time, there are pressures to accelerate the debt relief process. Nonetheless, the preparation of a Country Status Report remains important, both to institutionalize sector knowledge within the Bank as well as to provide an objective benchmark for tracking subsequent policy development and dialogue. Thus, while the HD HIPC/PRSP team continues to support task team leaders in meeting the short-term needs of HIPC processing, it also directs its activities toward the long-term task of guiding the preparation of CSRs as the opportunity arises. The focus on long-term needs is inescapable because the Bank has on-going relations with governments. As such the HIPC process is only an initial step, albeit an important one, in the broader task of engaging countries in sector reform for poverty reduction, a task that includes follow-up on the PRSP and preparation of possible lending programs for public expenditure reform and poverty reduction.

Table 2
Topics addressed in health and education Country Status Reports

Health	Education
1. Macroeconomic and socio-economic context	1. Macroeconomic and socio-economic context
2. Trends and equity in outcomes	2. Trends in enrollment and coverage of the education system
3. Household caring practices	3. Education finance
4. Health seeking behavior	4. Functioning the education system
5. Out-of-pocket expenditures	5. Education and labor market links
6. Health sector performance: efficiency and equity	6. Equity issues in education
7. Public financing of health	7. Management issues in education
8. Policy implications for sector development	8. Policy implications for sector development

Content of Country Status Reports on health and education

Given the policy-intensive nature of the HIPC/PRSP process the most relevant contribution from sectoral staff is to identify key policy measures to improve health and education services, especially for the poor. Thus, the Country Status Reports are essentially diagnostic documents to identify the sources of inefficiency and inequity in the way health and education services are financed, managed, and delivered. Based on the materials developed for the PRSP Sourcebook for health and education, the HD HIPC/PRSP team has taken the work one step further by developing analytical templates as a practical approach to implementing the analysis. To illustrate the scope of the Country Status Reports, Table 2 lists the main topics they cover.

Four key features characterize the CSRs: (a) they are structured around a standard core of issues related to equity and efficiency in the management of public spending in health and education; (b) they rely on existing sources of information and data; (c) they are policy-oriented documents underpinned by solid analysis, rather than research papers; and (d) they are intended as living documents, both in the sense that they will need regular updating to keep the information fresh, and in the sense that they are open to incorporating new sector knowledge as it becomes available. The living-document approach is especially appropriate in the context of tight budgets because it allows the task of sector-wide analytical work to be separated into smaller, more feasible pieces of work.

The preparation of the status reports follows an ad hoc process adapted to country conditions, but typically goes through three phases, with a changing composition of the actors involved at each stage (Table 3). In the first phase, the focus is on getting as accurate and comprehensive a view of the sector as possible. The work does not usually involve new data collection, but relies instead on the data already on hand, whether through recently completed surveys or administrative data collected by the Ministries of Health and Education. Experience in many countries suggest that these data are often available but are under-utilized for lack of coordination and effort to pool together the various data sets. Given the nature of the work during this phase, the main actors will be World Bank staff and technical personnel from the relevant government ministries.

Table 3
Phases in preparing and discussing Country Status Reports on health and education

Phase	Activities and focus of the work	Main actors involved
Phase 1	a) Data collection, cleaning and analysis b) Drafting of the country status report (CSR)	a) World Bank team (HD HIPC/PRSP team + task team leaders for health and education) b) National team (mostly technical ministry staff) c) Technical consultants
Phase 2	a) Validation & dissemination of technical aspects of the CSR b) Discussion of policy options and drafting of policy chapter of the CSR	a) World Bank team (including macro colleagues) b) National team (mainly senior Ministry staff) c) IMF, donors and other partners
Phase 3	a) Broad discussion among government and civil society on policy directions for the sector b) Government commitment to specific policies, along with plan for implementation and monitoring of agreed actions.	a) World Bank team (including macro colleagues) b) National team (senior ministry staff + political leadership) c) IMF, donors + other partners

Organizing the work to build capacity

The approach is to engage appropriate counterparts — including Bank and IMF staff, government officials, donors, and other partners — at all stages of the work, and to collaborate in ways that help to build local capacity and ownership for the final product. The process is labor-intensive, and works best when managed to include relatively frequent field visits to interact with national counterparts involved in the work, as well as close coordination within the Bank and between the Bretton Woods Institutions. Although complex, this web of interactions is perhaps the only way to create a shared vision of sector development, to ensure continuity in the dialogue on policy reform, and, most importantly, to implement the concept of "putting governments in the driver's seat."

In the second phase, the focus shifts toward the policy dialogue and development, based on the diagnostic results. At this juncture, the composition of the actors on the country team shifts from technical personnel to policy staff, with some overlap between the two groups. The time will also be ripe at this point to bring donors and other partners into the picture, so as to agree on the accuracy of the diagnostic results as well as to brainstorm about possible policy options.

Finally, in the third phase, the dialogue shifts into even higher gear to involve the political leadership. In weighing the likely options, the government focusses on those with three key characteristics: (a)

potential for large positive impact on sector development; (b) feasibility of implementation; and (c) political acceptability. During this phase, the dialogue will widen even further to involve civil society in general. The idea is to develop broad ownership for the government's policy choices as well as to identify specific goals for implementation and benchmarks for monitoring progress.

Progress to date

Eighteen African countries have passed their decision points as of February 2001. How has the process been leveraged to reduce poverty and advance sector development, especially in health and education? What progress is being made to prepare health and education Country Status Reports to facilitate the Bank's engagement in the PRSP process?

Design of HIPC completion point triggers

A standard trigger is the completion of the PRSP and a one-year period of satisfactory implementation of the strategy. In addition, a few specific social sector triggers are typically included. These triggers vary across countries, with some focus on child immunization for health (Table 4), and teacher recruitment and pay policy for education (Table 5). Uganda had a poverty reduction strategy in place before the PRSP process was formalized, and reached its completion point in April 2000 based on satisfactory implementation of the strategy (as well as satisfaction of two other conditions pertaining to macroeconomic performance and assurances of other donors' participation in debt relief). Burkina Faso had a full PRSP by the time the country reached its decision point under the Enhanced HIPC Initiative in June 2000.

Completion point triggers can be thought of as structural reforms that need to be put in place in the short term to advance long-term sector development. Accepting this view raises an obvious question: how well does the choice of triggers shown in Tables 4 and 5 fulfill this role?

For the *health sector*, the triggers typically fall into three categories: (a) increase coverage of public health programs; (b) health sector reforms; and (c) health financing measures. The triggers in the first category focus on areas where considerable progress can be achieved in a short time with additional resources (both financial and human) and strong government commitment, and they target "best buys" in public health interventions — i.e., interventions that are both cost effective and especially responsive to the needs of the poor. These include increased immunization coverage and utilization of bed nets, expanded awareness of HIV, greater use of condoms in vulnerable groups, and better essential health coverage, such as increased utilization of antenatal care and primary health care (Senegal) and reduction of iodine and iron deficiency related illnesses (Mauritania). For some better performing countries, the reduction in inequality of outputs between regions was also introduced as a trigger (e.g., Benin and Mozambique). Most included HIV/AIDS-related triggers with the notable exception of Zambia, despite the fact that the HIV prevalence is 20 percent among adults in this country. In other countries, such as Burkina Faso, similar triggers were proposed but not retained in the final document to limit the number of triggers imposed. HIV/AIDS triggers were often worded in general terms and often did not include specific targets in terms of outputs with the exception of Malawi, which included an indicator on availability of condoms and test kits to the users, Cameroon and Guinea Bissau, which included population base behavior change indicators, and Mauritania, which committed to keeping HIV prevalence at its current low level.

The second type of triggers relates to health sector reforms needed to overcome obstacles that hamper the performance of the health sector in most Sub-Saharan African countries — such as, inadequate staffing of rural health centers and district hospitals; poor incentives for health personnel to accept posting to remote areas (Burkina Faso, Cameroon, Mali, Niger, Uganda); and dysfunctional arrangements for drug procurement and supply (Mauritania, Cameroon, Burkina-Faso, Madagascar, Niger). Some of the triggers also encourage greater community involvement in co-managing and co-financing health service delivery (Mauritania, Cameroon, Burkina Faso, Tanzania); stronger partnership with the private sector in service delivery (Cameroon); and progressive implementation of performance-based budgeting (Cameroon and Burkina Faso).

With regard to the third category of triggers, it is important to note that in all the countries that have been processed for debt relief so far, except perhaps Uganda, public spending on health is modest; and

Table 4
Health sector measures to reach the floating completion point under the HIPC Initiative [a/]
(Countries approved for the decision point as of February 2000)

		Increase coverage with essential interventions				Reform health systems		Increase financing		
Timing of D.P. document during 2000	Country	Raise child immunization rate	Address HIV/AIDS	Address Malaria	Address reproductive health	Address health personnel issues	Improve drug procurement/ availability	Increase public spending on health	Reallocate spending to essential services and/or rural areas	Other
Q1	Uganda [b/]									
	Mauritania	X	X		X		X			
	Mozambique	X	X			X	X	X	X	Develop health sector strategic plan
	Tanzania	X	X							
Q2	Benin	X	X		X			X	X	Adopt monitoring & evaluation system
	Burkina Faso	X				X	X		X	Prepare decentralization action plan
	Senegal	X			X					Increase primary health care utilization
Q3	Cameroon	X	X	X						
	Mali					X		X		
Q4	The Gambia					X			X	
	Guinea	X			X					
	Guinea-Bissau	X	X	X						
	Madagascar						X			Prepare bi-annual report on budget allocation and execution
	Malawi		X		X	X	X	X		
	Niger	X	X			X	X			
	Rwanda	X	X			X				Improve infrastructures; adopt and implement national health plans; and establish public, private, and NGO health providers cooperation.
	São Tomé and Principe	X								Construct health care centers
	Zambia			X			X		X	Improve quality of health expenditure data

Source: Summary based on the decision point documents for each country.
a/ At the floating completion point the bulk of assistance for debt relief under the enhanced HIPC Initiative is delivered.
b/ For Uganda (which reached its completion point in April 2000) no sector-specific conditions were specified for reaching its completion point.

donors, households and communities make significant contributions to health financing. Despite these extra budgetary sources of funding, the health systems of these countries suffer from inadequate funding for salaries and non-salary recurrent costs, and the adverse effects are exacerbated by inefficiencies in disbursement mechanisms. Indeed, many health systems appear to be over-funded in terms of external investment while being under-funded in terms of recurrent costs financing. Increasing the health

Table 5
Education sector measures to reach the floating completion point under the HIPC Initiative [a/]
(Countries approved for the decision point as of February 2000)

Timing of D.P. document during 2000	Country	Improve education finance			Address teacher issues			Enhance coverage & student flow			Other
		Increase/reallocate public spending	Reduce/eliminate school fees	Provide scholarships to target populations	Expand/modify recruitment; improve deployment	Strengthen incentives for rural postings	Increase intake/output of training colleges; expand in-service training	Improve coverage indicators [c/]	Reduce grade repetition	Raise survival rates	
Q1	Uganda [b/]										
	Mauritania							X		X	
	Mozambique	X						X	X		
	Tanzania										Complete school mapping in 50% of local authorities
Q2	Benin		X		X				X		
	Burkina Faso				X				X		Prepare decentralization action plan
	Senegal	X			X						
Q3	Cameroon				X		X				Construct classrooms
	Mali	X									Achieve satisfactory implementation of PRODEC, govt.'s 10 year dev. program
Q4	Gambia			X			X				
	Guinea				X			X			
	Guinea-Bissau		X					X			
	Madagascar				X	X					Prepare biannual report on budget allocation & execution
	Malawi	X					X				Improve handling of textbook distribution
	Niger				X				X		Construct classrooms; complete school mapping
	Rwanda						X	X			Establish framework for community participation; design/implement capacity-building program
	São Tomé and Principe				X						Construct classrooms; complete costing of sector strategy
	Zambia	X				X					Prepare action plan to raise survival rates in lagging provinces

Source: Based on the decision point documents for each country.
a/ At the floating completion point in the bulk of assistance for debt relief under the enhanced HIPC Initiative is delivered.
b/ No sector specific triggers were specified for reaching the completion point.
c/ Gross enrollment ratios, share of girls' in total enrollments, transition rate from primary to secondary school, and so on.

sector's share of the government's budget has therefore been included as a completion point trigger for some HIPCs. Increasing the share of funding going to services that serve the poor has also been included in some countries. In the Gambia, the trigger included increased financing for primary and secondary care services, and in Zambia increased cash release for health activities to the districts In Benin, the triggers specify budget allocation targets for HIV/AIDS and reproductive health activities. Such specificity was not possible in other countries, however, because the available information was insufficient to identify areas where increased funding would be a clear priority.

For the education sector, the triggers tend to focus on three areas across countries: education finance, teacher issues and coverage, and student flow. With regard to education finance, the triggers concentrate on public spending and its allocation. In Mozambique, Mali, Malawi, and Zambia, a trigger is included to increase the share of current spending allocated to education, while in Senegal the trigger pertains specifically to increases in the allocation for primary education only. In Malawi, a trigger is also included specifying a reallocation of spending in secondary schools from boarding services to pedagogical materials. Surprisingly, in only two countries, Benin and Guinea-Bissau, do the triggers seek to reduce or eliminate school fees or other school-related spending borne by families, and in only one country, the Gambia, is a trigger included to provide scholarships to target populations.

With regard to triggers addressing teacher issues, the most common ones relate to teacher recruitment and deployment. These triggers respond to the well known problems in many of the eighteen countries, especially in Francophone Africa, associated with the high cost of teachers and their uneven availability across schools, particularly in rural areas. New arrangements for teacher recruitment — such as contracting with local communities outside the civil service — have been under experimentation with successful results. Thus, in four countries — Benin, Burkina Faso, Senegal, and Mali — a trigger is included to facilitate the transition from experimentation toward institutionalization of the new arrangements. In Madagascar, where teacher shortages in primary education and their deployment across schools pose special difficulties, the completion point triggers focus on increases in numbers of teachers recruited and the criteria for their allocation across schools. In Guinea, where enrollments are projected to expand rapidly, the trigger aims mainly to ensure an adequate pace of teacher recruitment. Although teacher availability in rural areas is a problem in most of the countries, the completion point triggers specify the provision of incentives for rural postings in only two countries, Madagascar and Zambia. Finally, under the broad rubric of addressing teacher issues, a trigger is included in four countries — Cameroon, Gambia, Malawi and Rwanda — on the volume of teacher training activities.

The third set of triggers relates to coverage of the education system and student flow indicators. In Francophone Africa especially, many of the education systems suffer from inordinately high rates of repetition and dropping out. Where the background analysis is clear, such as in Mozambique, Benin, Burkina Faso and Niger, the completion point trigger is tied to specific action for improvement, often including the elimination of grade repetition within sub-cycles of schooling accompanied by measures to equip teachers with tools to improve the management of pupils' progression within the sub-cycle. Although low rates of student survival affects most of the countries, in only Mauritania was a trigger included that focused specifically on this issue. In five countries, the triggers relate to more aggregate indicators of coverage, such as the gross enrollment ratio, girls' share of enrollments, and the transition rate from primary to secondary education.

To summarize, the quality of policy triggers is uneven across countries, reflecting a corresponding unevenness in sector knowledge at the time the HIPC decision point documents were prepared. In education, for example, it is unclear that an increase in public spending on education in three of the countries in the sample — Mozambique, Mali, and Malawi — would enhance outcomes, given that in all three countries, there is evidence that the education system functions with a high degree of inefficiency (see Figure 1), implying that any additional spending is likely, in the absence of significant improvements in system management, to produce waste instead of the expected results. Tanzania is another example where the trigger for completion point — implementation of a school mapping exercise in some districts of the country — seems dubious as a way to advance sector development. Fortunately, as sector knowledge is built up in the meantime, possible shortcomings in policy design

Table 6
Completed and planned interim and full PRSPs for African countries

Interim PRSPs		Full PRSPs	
Completed (as of February 2001)	Planned in 2001	Completed (as of February 2001)	Planned in 2001
Benin	Congo (Rep. Of)	Burkina Faso	Benin
Cameroon	Côte d'Ivoire	Mauritania	Chad
Central African Rep.	Eritrea	Tanzania	The Gambia
Chad	Ethiopia	Uganda	Ghana
The Gambia	Lesotho		Guinea
Ghana	Nigeria		Guinea-Bissau
Guinea	Sierra Leone		Kenya
Guinea-Bissau			Malawi
Kenya			Mali
Madagascar			Mauritania
Malawi			Mozambique
Mali			Rwanda
Mauritania			Senegal
Mozambique			Zambia
Niger			
Rwanda			
São Tomé and Principe			
Senegal			
Tanzania			
Uganda			
Zambia			
21	7	4	14

Source: http://www.worldbank.org/prsp

can be corrected as the PRSP process unfolds. Such knowledge would also facilitate expansion of the reforms that the government undertakes beyond those that fit within the inherently narrow and short-term framework of debt relief processing.

Preparation of Poverty Reduction Strategy Papers

These papers are a natural follow-up to the HIPC decision point document, but unlike the latter, the governments themselves — with technical inputs, as needed, from Bank/IMF staff and whomever else the government wishes to involve — prepare them. Recognizing that the authorities may need time to prepare a full PRSP and to organize the process of participatory consultation, the Bretton Woods Institutions have agreed to accept interim documents at the time of the decision point, in the expectation that the full PRSP would be completed and the strategy articulated in it would be implemented for at least one year before a country can reach the completion point in the debt relief process.

Besides being a completion point trigger, PRSPs serve a broader purpose for Bank operations —namely, they are the logical basis on which to build country assistance strategies (CASs, which are the equivalent of business plans) and are treated as such in the Region. Thus, even countries like Kenya and Ghana, which do not currently expect to benefit from debt relief under the HIPC Initiative, have prepared interim PRSPs.

As of February 2001, a total of twenty-one African countries have prepared an interim PRSPs, with seven more planning to prepare one in 2001 (Table 6). Four countries — Burkina Faso, Mauritania, Tanzania, and Uganda — have completed a full PRSP, while fourteen plan to do so during 2001. Uganda is the furthest along in the process, and has already prepared a first-year progress report since its full PRSP was completed a year ago. Given the typically compressed time frame for preparing the interim PRSPs, the content and completeness of the documents vary widely across countries, with those for some countries focusing mainly on setting out specific plans and timetables for preparing the full PRSPs, using a participatory approach. In contrast, the full PRSPs are expected to be more comprehensive, typically including a documentation of the profile of poverty, as well as the government's long-term vision for poverty reduction, specific measures over the next three years to implement it, and the corresponding budget provision and monitoring indicators.

Table 7
Preparation of health and education Country Status Reports in the Africa Region
(Status as of February 2001)

Status of the work	Health	Education
Completed	Burkina Faso, Madagascar, Tanzania	Benin, Burkina Faso, Madagascar, Mauritania, Mozambique, Niger
Advanced stage	Guinea, Mozambique, Mauritania	Cameroon, Zambia, Guinea-Bissau, São Tomé & Principe
Underway	Benin, Cameroon, Chad, Guinea-Bissau, Malawi, Mali, Niger, Zambia, Uganda	Gabon, Guinea, Gambia, Togo
Possible starts in the next 6 months	Côte d'Ivoire, CAR, Ethiopia, Gambia, Senegal	Chad, Mali, Rwanda, Ethiopia, Senegal

While it is beyond the scope of this paper to delve into the details of the four full PRSPs completed so far, a few key features are noteworthy (see appendix tables A1-A12). As expected, interventions in education and health typically figure in the overall framework for poverty reduction under such rubrics as improving human capacities, social well-being, quality of life, and access to basic social services. But in some countries, investments in education also figure under other rubrics of the governments' poverty reduction strategy. In Uganda, for example, interventions in higher education appear under the economic growth rubric, while in both Uganda and Mauritania, interventions in vocational education and training appear under rubrics having to do with enlarging poor people's capacity to raise their own income. In all four countries, HIV/AIDS is treated as a health issue rather than as a constraint on economic growth.

With regard to content, the PRSPs of the four countries invariably focus on outcomes. In health, common outcomes include the mortality of children and women, the burden of communicable diseases (especially HIV/AIDS and malaria), while in education they include various indicators of enrollments, and schooling conditions (e.g., ratios of pupils to teachers, textbooks, and classrooms). The strategies of Mauritania and Burkina also include an explicit objective to protect the poor from overly burdensome health spending. The focus on outcomes marks a salutary change from past approaches to development efforts. Even though most of the PRSPs share an understandable tendency to set highly ambitious outcome targets, the iterative nature of the process implies that plans can be adjusted as unforeseen constraints are discovered during implementation. The experience of Uganda, the country with the most mature process so far, is instructive in this regard. The first-year progress report on its PRSP noted that most of the outcome targets in health and education were not met, explained why the targets were not met, and identified specific areas for attention in the coming year. An interactive process informed by candid annual assessments of achievements and constraints on progress could indeed help countries to move toward realizing their long-term outcome targets.

Progress in preparing HD Country Status Reports

Since PRSPs are country-prepared documents, the most effective way for the Bank to contribute is by providing high value-added technical inputs that can help deepen the dialogue — between donors and the government, as well as between the government and its in-country partners in development — on policy priorities for poverty reduction. HD Country Status Reports (CSRs) are a practical mechanism for providing such inputs. They essentially aim at creating, consolidating, and organizing sector knowledge in a policy-oriented framework. As such, they serve not only as a basis for informing the design of completion triggers in the decision point document but, more importantly, also as a basis for assessing governments' poverty reduction strategies and for engaging in the subsequent policy dialogue as it unfolds in the context of the annual progress reports.

As a mature international development agency, the Bank should in theory have the intellectual resources needed to prepare HD CSRs on short notice. Yet, our knowledge base has been eroded because of inadequate past investment in analytical work. In addition, the institution is poorly positioned to take advantage of available knowledge residing in country sector reports completed by the countries themselves, or by other donor agencies and academics. Part of the problem is that the information is typically fragmented or hard to access,

and sometimes dated, but the broader problem relates to issues of funding and incentives to get the work done. Building up the stock of CSRs was initially motivated by the demand for sector inputs in HIPC processing; but they also serve as a modest start in redressing the Bank's past neglect of sector work in health and education.

Table 7 reports on the current status of CSR preparation supported by the HD HIPC/PRSPS Team in various African countries. The choice of countries is driven in part by the debt relief processing schedule, but it is often also the result of several facilitating factors coming together: timing, availability of funding, readiness of national counterparts to participate in the preparation of the report, as well as interest and commitment on the part of the relevant Bank country team in having it prepared. Because CSRs take time to prepare, they should ideally be started well ahead of HIPC/PRSP processing. But the realities of budget constraints and logistical obstacles are such that the reports are in fact being prepared as conditions permit.

Table 7 indicates that some CSRs have already been completed. It is important to note that completed documents may not necessarily address all aspects of the topics for which documentation would be desirable; rather they represent the first round of work to amass and structure the available information in a policy-oriented framework. Where the information is plentiful, and the work has had time to mature, the CSRs are more comprehensive, such as those for education in Burkina Faso, Mauritania, Mozambique, and Madagascar. In contrast, most of the work on health started later, and the completed CSRs represent the results of a first generation effort based on data that were possible to gather in a brief period. As living documents, CSRs are a repository for sector knowledge, whose core content should ideally be updated periodically to incorporate new country data or information. In the time-sensitive context of the HIPC/PRSP processes, the value of the CSR depends as much on its availability on demand as on the comprehensiveness of its coverage. Thus, in this initial phase of creating a systematic knowledge base, the emphasis is on producing relatively simple CSRs that address basic issues of efficiency and equity in the management of public spending on health and education.

Progress in capacity building

The HIPC/PRSP process has created significant opportunities for building capacity through joint learning-by-doing. At the country level, the formation of working groups on health and education is the first step in the government's work of elaborating the PRSP. While their composition vary, these groups typically consist of senior managers of the line ministries as well as budget and policy analysts from the ministries of planning and finance. They sometimes include observers from donor agencies, and even representatives of NGOs and other civil groups. In Cameroon, for example, NGOs were consulted in the preparation of the AIDS strategy, opening the way for future collaboration between the government and NGOs, including the involvement of NGOs in specific activities under subcontracting arrangements. The Bank supports the work of these working groups by sharing technical resources (such as the PRSP Sourcebook, which is now widely available via the internet, as are related templates for structuring the work in education and health), and by collaboratiing with members of the group in preparing the CSRs where this has been chosen as the mechanism to consolidate sector knowledge.

Opportunities also exist for closer collaboration among the Bank's development partners, including bilateral donors and international organizations, such as WHO, UNICEF, UNAIDS, UNFPA, AfDB. This collaboration has meant increased support for the working groups, as well as dialogue on (a) a common understanding of the underlying analytical frameworks for assessing the link between education and health and poverty reduction; (b) lessons from various efforts to improve service delivery (e.g., efforts to reform and reorganize the health sector in Sub-Saharan African following the Bamako Initiative, and to accelerate public health programs such as EPI, Family Planning and Safe Motherhood, Polio Eradication, etc.); and (c) the design of sound pro-poor strategies in the health and education sectors that take advantage of debt relief to reinforce the donor community's efforts to ensure increased funding for the social sectors in Africa (through such initiatives as Roll Back Malaria, Stop TB, GAVI, Massive Attack, Education for All).

Within the Bank, the HD HIPC/PRSP Team has also initiated capacity building activities, beginning with a two-day training workshop in October 2000 on Health, Nutrition, and Population (HNP) issues in the HIPC/PRSP context. Plans are underway to organize, in collaboration with the HD Network, similar training for education sector staff in the Bank. The idea of replicating the training in regional workshops in Africa has been explored but is being deferred at present because of the prohibitive costs involved, especially in terms of Bank staff time.[9]

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1 The Executive Boards of the IMF and World Bank had already formally considered nine (seven in Africa) of the thirty-seven countries for debt relief before the Enhanced HIPC Initiative was put in place.

2 One perspective is the cost of debt relief to the creditor nations. The most recent estimates, made in September 2000 for the thirty-two HIPCs for which the relevant data are available, put the Initiative's total cost at US$28.6 billion (in end-1999 dollars).

3 For more details, see World Bank 2001. "Financial Impact of the HIPC Initiative. First 22 Country Cases." Mimeo, also available at http://www.worldbank.org/hipc/

4 While social services invariably include health and education, the data's coverage beyond these sectors may differ across countries. Thus, social sector spending includes spending on new programs to be financed partly with HIPC assistance in Benin, rural development and water supply in Burkina Faso, poverty-related activities, such as demining and rural development in Guinea-Bissau, poverty reduction programs in Mauritania, promotion of women in Senegal, water supply in both Tanzania and Uganda, and social safety nets, water and sanitation, and disaster relief in Zambia. These broader definitions explain the difference between the estimated $2.5 billion indicated here, compared to the total of $2.0 billion for education and health shown in Table 1.

5 A preliminary HIPC document is typically prepared before the decision point document, but for some countries this step has been eliminated in order to expedite processing of the initiative.

6 To be emphasized is that the health and education task team leaders for each country are the primary sectoral contacts for matters relating to HIPC/PRSP processing for the country. The HD HIPC/PRSP team was formed to support the task team leaders in this regard, as well as to enhance regional consistency in the quality of the HD inputs.

7 See Appendix Table A13 for examples of other health indicators that may be relevant for cross-country comparisons.

8 A Country Status Report of reasonable depth may take six months or more of real time to prepare.

9 Following the HNP training session, the UNICEF and WHO representatives who attended the training expressed their institutions' interest in co-organizing similar training in regional workshops for country teams (comprised of key policy analysts and decision-makers from the ministries of health and finance/budget in various countries) from target countries. Recognizing the potential of the workshops for sharing knowledge and building the capacity of country teams to analyze health and poverty issues using available data for their country, UNICEF and WHO are prepared to help organize and finance the workshops, provided that the Bank is willing to fund Bank staff to prepare the training materials and participate in the workshops.

2

Strengthening the Content of HD Inputs to the HIPC/PRSP Process

In both the health and education sectors, a basic assumption is that the resources freed from debt relief would be used to enhance and improve the delivery of basic services, especially to the poor. What policy measures can advance this agenda, and how can progress be tracked? Diagnosing the current status of sector performance and sources of poor outcomes is a first step toward answering these questions. The work forms the substance of the Country Status Reports discussed above. This section provides examples of the kinds of analysis undertaken in this regard.

Policy-relevant analytical work in health[1]

The examples relate to the following topics, all of which can be analyzed using data commonly available in most African countries: (a) interactions between health and poverty; (b) household behavior and the health of vulnerable populations; and (c) evaluating health system performance.

Assessing health outcomes among the poor

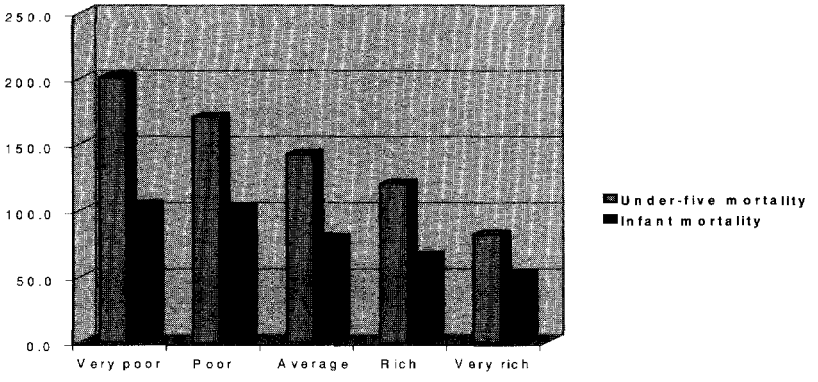
The purpose here is simply to document the extent to which the health, nutrition, and family welfare outcomes among the poor differ from those among the better-off. Data are increasingly available for this purpose, disaggregated not only by socioeconomic characteristics, but also by relative income or wealth level. In many African countries Demographic and Health Surveys (DHSs), for example, have been completed (with repeat surveys in some cases), which permit documentation of the gaps in outcomes between the rich and the poor, thus giving policy makers information to evaluate the targeting of health resources to reach the poor.[2]

In Cameroon, this type of analysis shows that infant and under-five mortality rates are highly correlated with income (Figure 3), with under-five mortality among the poorest groups more than twice as high as among the very rich. Health indicators also vary substantially across regions and across urban and rural areas. In the context of preparing the health budget for 2000–01, the information is being used to justify the following decisions: (a) setting a reduction in regional inequities in under-five mortality rates as a key policy objective; and (b) concentrating the bulk of additional spending on health to improve primary health care services and nutrition activities in the poorest rural areas.

In some countries, analysis of data from demographic and health surveys can reveal the importance of factors other than household wealth in affecting the health of the poor. In Burkina Faso, for example, health indicators are not correlated with income in an incremental way (Figure 4). The pattern shows a large gap between the richest 20 percent and the remaining 80 percent of the population. Other determinants beyond income, including environmental and household behaviors, probably also influence the health of the population. These factors will have to be further explored and taken into account if the government is to make a difference to child health outcomes.

Data from Mali provides another example of the impact of environmental factors on the health of the poor (Figure 5). The rate of diarrhea and respiratory infections among children — ailments linked to the quality of water supply, sanitation, and air — is com-

Figure 3
Infant and under-five mortality by income group, Cameroon 1998



Source: Government of Cameroon, based on the 1998 Demographic and Health Survey (DHS).

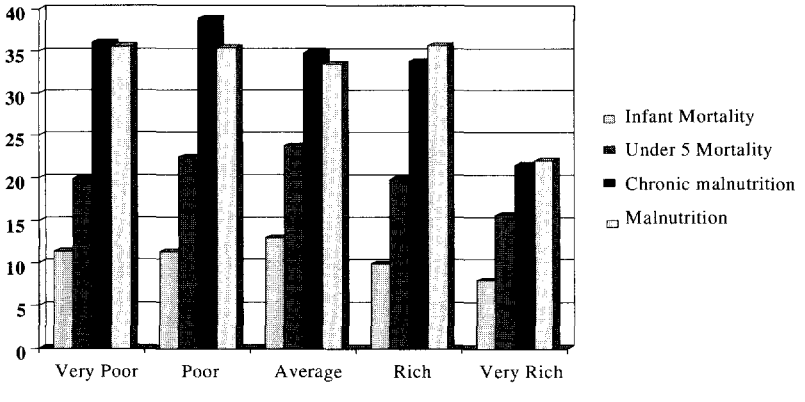
pared across socioeconomic groups. The results show that children in the richest 20 percent of households are less often sick with infectious diseases, especially diarrhea, probably because they live in cleaner environments. In such cases, it may be appropriate to explore the need for specific interventions to improve the environmental conditions in which children from poorer families live.

Household behavior and the health of vulnerable populations

The use of essential services and household expenditures can help in evaluating households' health-seeking behaviors. While dedicated surveys with specific questions on health-seeking behavior and household spending on health have been used to generate information (in Mauritania and Mali), many existing surveys also contain the desired information. Information on households' caring practices and health-caring behavior and willingness to pay for essential services are particularly useful in identifying ways that the government can channel out-of-pocket spending toward cost-effective health interventions.

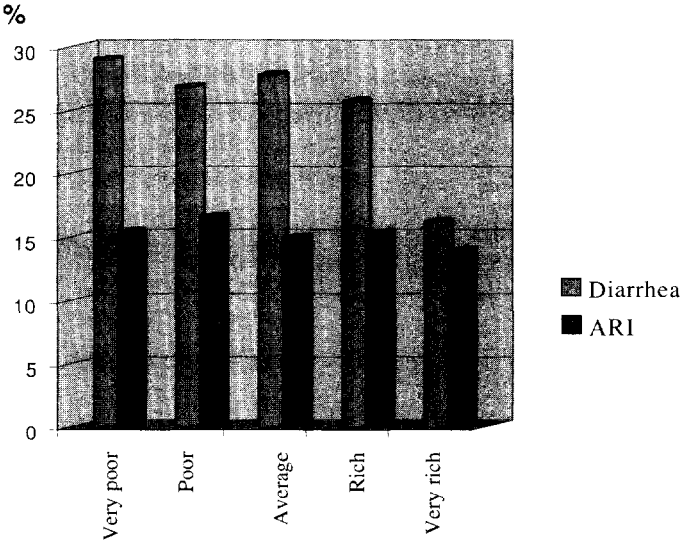
HEALTH CARE PRACTICES AT THE HOUSEHOLD LEVEL. DHSs and UNICEF's multi-indicator surveys are good sources of information on households' caring practices. Rates of exclusive breastfeeding, and utilization of oral rehydration therapy (ORT), for example, are good predictors of households' inclination to adopt health-promoting behaviors. That such behaviors are not necessarily correlated with socioeconomic class is evident in the data for Guinea, for example, where better educated

Figure 4
Health indicators by income group, Burkina Faso 1996



Source: Government of Burkina Faso, based on the 1996 Demographic and Health Survey (DHS).

Figure 5
Prevalence of diarrhea and acute respiratory infection by wealth group, Mali 1995/6
(Among children less than three years of age)



Source: Government of Mali, based on "Health and Poverty in Mali" (background document for the PRSP), draft 2000.

mothers and urban residents have poorer breastfeeding practices than those in lower socioeconomic groups; their care of children with diarrhea also does not appear to be superior to that offered by mothers in the latter groups (Table 7). In contrast, better educated men and those who live in urban areas are much more likely to have used condoms than other men. This kind of analysis can help to identify areas of health care practices that may need specific emphasis in public health policy design.

IMPACT OF HEALTH SPENDING ON INCOMES OF THE POOR. Living on small incomes, poor people may decide to accept the pain and discomfort of sickness rather than incur the out-of-pocket expenses of health care that may bring economic ruin. Thus, even though poor households are generally less healthy than rich households, they may spend less on health services, in both absolute and relative terms. This is the pattern in Burkina Faso (Table 8) — a result that is consistent with the observation in Sub-Saharan Africa that the poor often do not use modern health care services at all, whether public or private. The implication is that, in formulating health interventions to reach the poor, it needs to be recognized that adverse self-selection in health-seeking behavior — because of poverty or other factors — may constitute as much of an obstacle to better health as supply-side constraints in the health system. Evidence from household surveys are increasingly making it possible to examine the role of self-selection, thereby permitting ministries of health to take more systematic account of them in health planning and policy formulation.

Evaluating the performance of the health system

One approach to assessing the extent to which health services serve the poor is to evaluate the health system's performance on a matrix of indicators — including access to basic services, availability of human resources, availability of drugs, vaccines and other essential consumables, production of services, and continuity of care and quality of services. The discussion below focuses on access to a core package of health services, the availability of human resources, and evaluation of service delivery bottlenecks.

ACCESS TO A CORE PACKAGE OF HEALTH SERVICES BY THE POOR. Most countries define a core package of services based on the burden of diseases affecting the overall

Table 8
Household health care practices, Guinea 1999

Health care behavior	Educational attainment of respondent			Locality	
	None	Primary	Secondary	Rural	Urban
Average duration of breastfeeding with water only (in months)	6.4	3.7	0.6	6.4	3.8
% treating diarrhea by increased intake of fluids	51.7	61.4	55.4	51.4	57.9
% of men having ever used a condom	17.4	44.9	64.5	22.8	56

Source: Government of Guinea, based on "Health and Poverty in Guinea" (background document for the PRSP), draft 2000.

population and the demand for health care. This package needs to be revisited in light of the specific burden of disease among the poor as well as evidence on the best buys in health care. The review can help identify the need to add new interventions (e.g., micronutrient supplementation), while at the same raising questions about interventions included previously (e.g., cardiologic services). In most low-income countries the best buys listed in appendix table A14 would have to be part of the core services targeted to the poor.

Once there is clear agreement on the components of the core package of services, it is important to examine the pattern of accessibility and use by the poor. In Burkina Faso the utilization of essential services — including vaccination, ANC, and assisted delivery — varies widely across socioeconomic groups, a pattern that does not mirror the pattern of mortality but appears to reflect gaps in the supply of services to the poor. Closer examination of the problem reveals that about a quarter of the nonusers had been discouraged from using basic health services because prices were too high (Figure 6). Other reasons included distance and a perception that the diseases were not serious enough to justify a visit to a health center. This type of analysis is important for understanding the key factors that limit the demand for essential services and, therefore, in formulating interventions that remove the impediments to better health among the poor.

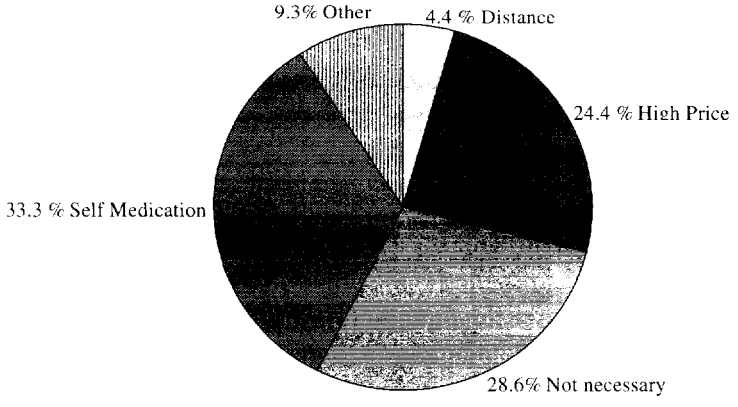
AVAILABILITY OF HEALTH PERSONNEL. In many Sub-Saharan African countries, essential health staff, such as multipurpose obstetric nurses and surgeons, are in critically short supply — a problem that particularly impedes delivering services to rural areas. The situation in Niger is common: there is currently one medically trained staff for 400 people in Niamey, the capital city, compared with a ratio of more than 4,000 in the most deprived provinces of the country (Figure 7). The poor distribution of staff reflects in part the effects of a civil service pay structure that pays health personnel the same pay and benefits regardless of where the person serves. But the pay structure is not the only problem; the difficulty of attracting staff to rural areas has also been exacerbated by the recent

Table 9
Out-of-pocket health spending in Burkina Faso 1998

	Nationwide	Urban areas	Rural areas		
			Average	North	Other rural
Per capita spending					
In Fcfa	4,900	9,490	3,000	1,300	2,250 to 3,700
In US $	8	15.8	5	2	3.8 to 6.2
% of income spent on health	10	14	9	-	-

Source: Government of Burkina Faso, based on "Health and Poverty in Burkina Faso" (background document for the PRSP), draft 2000.

Figure 6
Reasons for non-utilization of basic health services in Burkina Faso 1998



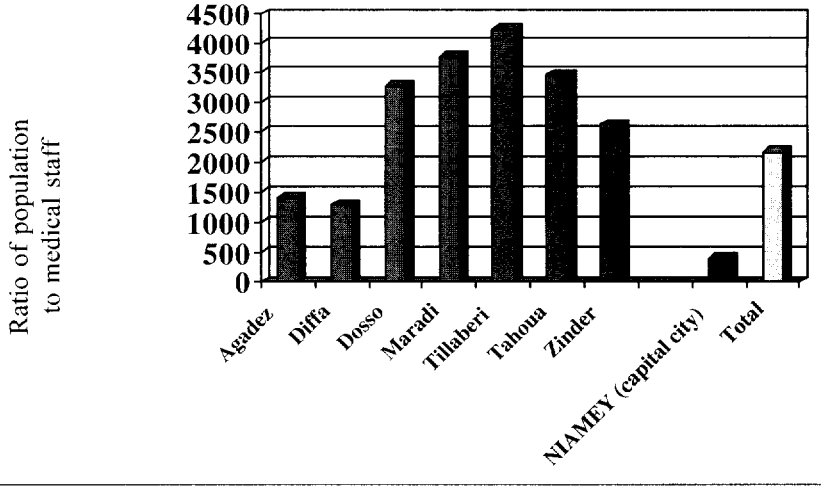
Source: Government of Burkina Faso, based on "Health and Poverty in Burkina Faso" (background document for the PRSP), draft 2000.

explosion of private services, a development that has expanded the opportunities for public health staff to supplement their income in private clinics in the cities. As a result, it has become harder and harder to attract staff to rural areas where this source of extra income is nonexistent. In Benin, a study shows that the privatization of health services had led to a widening urban–rural gap in staffing patterns, with health staff crowding into the capital city and into wealthy localities where the population is more able to pay for services.

The shortage of qualified staff is a problem that plagues almost all health systems in Sub-Saharan Africa. While hardly any system has yet found a comprehensive solution to address it, governments have experimented with innovative approaches, including using staff with different technical profiles (e.g., auxiliary midwives), decentralizing recruitment, offering financial incentives to staff who accept postings to remote and difficult areas, remunerating staff according to performance, and even implementing civil service reform. Consolidating the lessons from these experiments and mainstreaming the promising approaches is critical to successful implementation of public health programs, particularly in terms of their reach to target populations. Without progress on this front, it is hard to see how increased funding for health — funding which is expected to become available in the HIPC/PRSP context — can be effectively absorbed to produce genuine progress in health service delivery and ultimately in the health of the poor.

EVALUATING BOTTLENECKS IN SERVICE DELIVERY. The health system can be evaluated for bottlenecks by tracking the delivery of specific pro-poor outputs —for example, immunization visits, vitamin A supplementation,

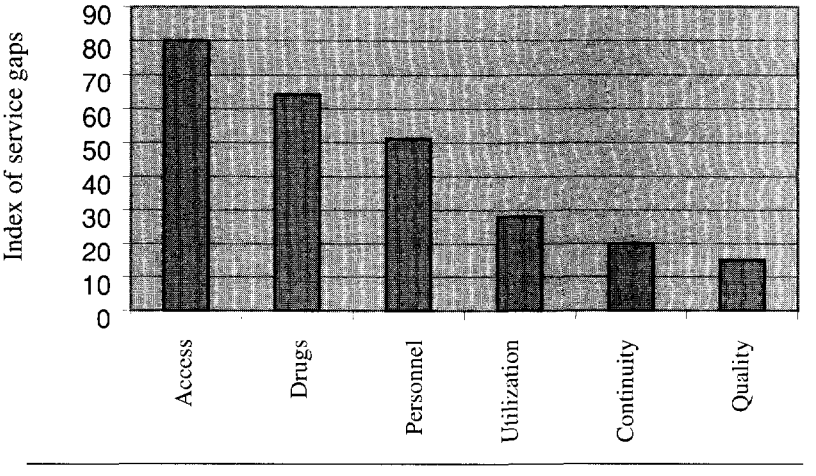
Figure 7
Population per medically trained personnel by region, Niger 1997



Source: Government of Niger, based on "Health and Poverty in Niger"(background document for the PRSP), draft 2000.

visits for treatment of ARI, IMCI, full treatment of TB, access to impregnated bed-nets, and treatment for malaria. Beyond aggregate patterns, it is also revealing to examine the extent to which poor people benefit from continuity in health care (e.g., TB treatment courses finished, children fully immunized). For example, simple indicators for immunization would be disparities by socioeconomic group in the dropout rate for immunization between DPT1 and DPT3. Especially revealing are analyses to examine the gaps across different aspects of service delivery. In Mauritania, this type of analysis for IMCI suggests that the largest bottleneck is located at the level of access (Figure 8), closely followed by constraints in the availability of drugs and health personnel. This kind of structural analysis can be conducted across localities and socioeconomic groups to identify bottlenecks and possible options in targeting actions for improving service delivery.

Figure 8
Comparing service provision gaps for IMCI, Mauritania 2000



Source: Government of Mauritania, based on "Health and Poverty in Mauritania" (background document for the PRSP), draft 2000.

Policy-relevant analytical work in education

The examples below illustrate selected analytical approaches to document education sector outcomes, and evaluate potential sources of inefficiencies in the management of public spending on education.

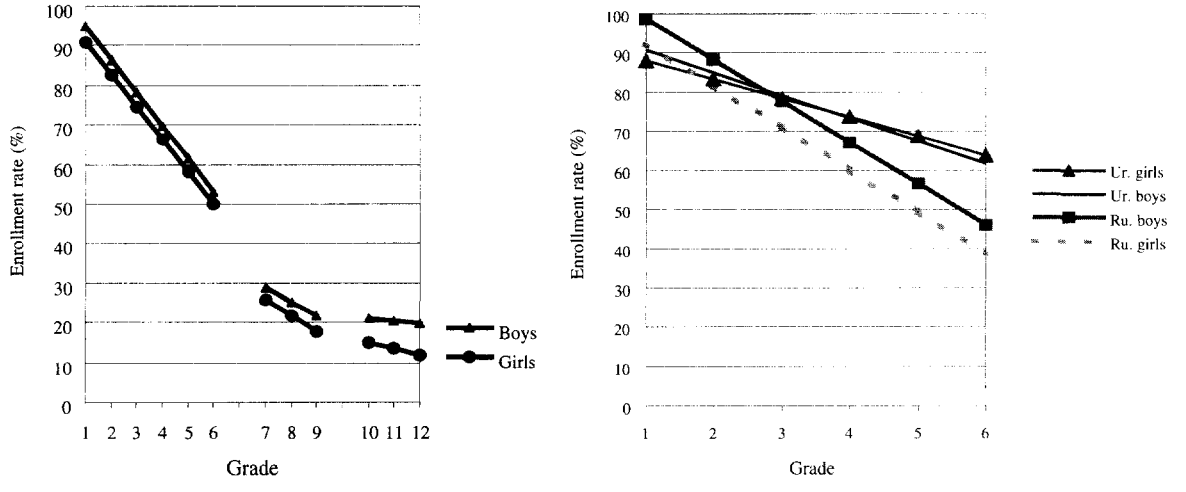
Grade-specific student flow profiles

Gross or net enrollment ratios by level of education are a common measure of coverage. The former is defined as the ratio between total enrollments in a given cycle of schooling and the population in the official age range for that cycle; the latter ratio is computed the same way, except that the numerator includes only students in the official age range. Despite their popularity as indicators of coverage, they tend to obscure the nature of the problem, largely because they refer to averages across all grades in a cycle of schooling when what is needed is a more disaggregated pattern of coverage. For this reason the World Bank's PRSP Sourcebook recommends focusing on the enrollment rate in the final year of the primary cycle as the starting point for evaluating options to enhance the poverty-reducing impact of education policies. By implication, this means documenting the grade-to-grade pattern of student flow.

To see the advantage of using grade-specific profiles, compare two countries, Senegal and Chad, whose gross enrollment ratios in 1998 were 62 and 65 respectively. The similarity in the ratios hide wide differences in the underlying pattern of student flow; however, in Senegal 65 percent of each age cohort enter grade one, and 40 percent of the entrants reach the end of the cycle, whereas in Chad the corresponding figures were 83 and 19 percent. These differences call for quite different approaches to expanding coverage: in Chad there is a clear need to improve survival rates within primary schooling, while in Senegal, improving entry rates to grade one deserve as much emphasis as improving the survival rate.

Documenting student profiles across population groups within a single country can provide even more useful insights for policy development. In Mauritania, for example, the conditions for reaching completion point specified in the HIPC decision point document refer to targets in the gross enrollment rate and share of girls in total enrollments. In aggregate terms, the gross enrollment ratio is relatively high at 86 percent, and girls already account for nearly half of total enrollments. Subsequent analyses completed after HIPC processing reveal that a high rate of repetition (aver-

Figure 9
Disparities in student flow profiles in Mauritania 1998



Source: World Bank & Mauritania Education National Team, *Le système éducatif mauritanien: Eléments d'analyse pour instruire des politiques nouvelles* (forthcoming).

aging 16 percent) is partly responsible for the high gross enrollment rate, and that much work remains to be done to boost effective coverage. Raising the cohort survival rate is indeed the most important policy thrust needed to expand primary school coverage, and efforts are especially needed to lift up the rate among rural boys and girls (see Figure 9).

Computing the student flow profiles requires a blend of two types of data: (a) survey information on enrollment status by single years of age for primary school age children, to fix the rate of entry to grade one; and (b) the number of students and repeaters in each grade, to compute the grade-to-grade transition rates. The former can typically be found in household surveys, many of which are now available — sometimes in repeated surveys — for African countries; the latter type of data is even more common, since most education ministries collect and publish such data annually. In combination, the two items provide a complete documentation of student flow throughout primary and secondary school. While the result does not represent a truly longitudinal cohort pattern, it has the advantage of being current. Given the relative ease of documenting the student flow profiles and the pertinence of these profiles in policy dialogue and design, they have now become a standard feature in all education Country Status Reports.

Demand-side and supply-side constraints on enrollments

Student flow profiles alone are not sufficient to determine appropriate interventions for improvement. Additional analysis is needed to examine the relative roles of demand-side and supply-side constraints. Some simple approaches can be applied to existing data to shed light on the issue. In Mauritania, for example, of the 45 percent of pupils who drop out before reaching the end of the cycle, fully two-thirds are estimated to do so because they attend schools in which the full cycle of schooling is not offered. A major factor in the poor survival rates is therefore on the supply side. Simulation analysis suggests that removing this impediment would raise the enrollment rate at the end of the primary cycle from its current level of about 50 percent to 85 percent.

Niger is another country where the survival rate to the end of the primary cycle is relatively poor (about 60 percent in 1998). Yet, unlike the situation in Mauritania, supply-side interventions may not be appropriate in most parts of the country. To illustrate, consider the results in Table 10 showing the gross enrollment ratios in three regions of the country. In Diffa and Mirriah, about 70 percent of the children live in villages with no school, while in Dosso 42 percent are in such villages. Would building more schools in Mirriah, the region with the lowest gross enrollment

Table 10
Gross enrollment ratios in villages with and without schools in three regions, Niger 1998

Type of village	Population group	Region			All three regions
		Dosso	Diffa	Mirriah	
All villages	Overall	28	20	12	23
	Girls	21	18	9	17
	Boys	34	22	15	28
Villages with a school	Overall	47	65	40	47
	Girls	35	59	30	36
	Boys	59	71	48	58
% of school-age population in villages without a school		42	70	70	52

Source: Niger Country Status Report (forthcoming).

ratio, help? The answer can be assessed by comparing schooling only in villages with schools: the gross enrollment rate in such villages is 65 percent in Diffa, whereas it is only 40 percent in Mirriah. In Dossa, where the supply of schools is much more plentiful, the gross enrollment rate in such villages rises to only 47 percent. This suggests that even with a massive school building program in Mirriah, progress in extending coverage is likely to be limited unless demand-side impediments are also removed.

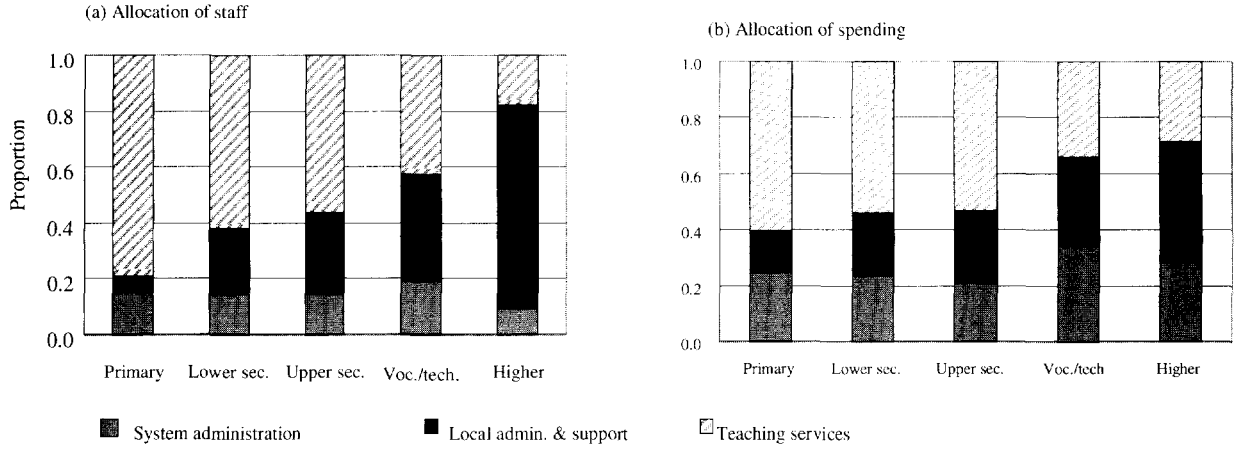
The functional allocation of aggregate spending on education

In the debate on debt relief and poverty reduction, there is a tacit assumption that public spending on education should increase as extra resources from debt relief become available. In countries where public spending is modest, such an increase would seem quite justified. Yet even in such countries, it is useful to examine the efficiency with which current resources are allocated across functions.

The typical approach is to extract from budget documents the relevant information on the allocation of the education budget: distribution by current and capital spending, distribution across levels of education, distribution by categories of spending (such as salaries, materials). While useful, the exercise is often frustrating because budget documents seldom contain sufficient detail to examine the allocation across sub-sectors — for example, when sub-sectors such as primary and lower and upper secondary education are grouped within a single ministry. Moreover, budgeted amounts may not correspond to actual spending, and even if they do, the information can rarely be arranged to document the extent to which spending is allocated for administration and teaching activities at the school level.

Yet these aspects of public expenditure management are both desirable and feasible to document by combining two sources of information: budget data and information on personnel allocation and civil service pay. Consider the results for Madagascar shown in Figure 10. The first panel shows the allocation of public employees by level of education and function. Combining the data on staff allocation, and that of the distribution of staff by salary grade, as well as information on the salary structure, it is possible to compute the aggregate spending on salaries by level of education. When the result is added to information on the non-salary spending, we obtain a picture of the overall allocation of spending, both across levels of education and by function within each level. The approach — building up the picture of spending from the composite components — serves two purposes: (a) it offers an independent check on the correspondence between aggregate budget amounts and actual spending; and (b) it makes it possible to document the distribution of spending between overheads, school-level administration, and teaching services.

Figure 10
Functional allocation of staff and public spending on education in Madagascar 1998



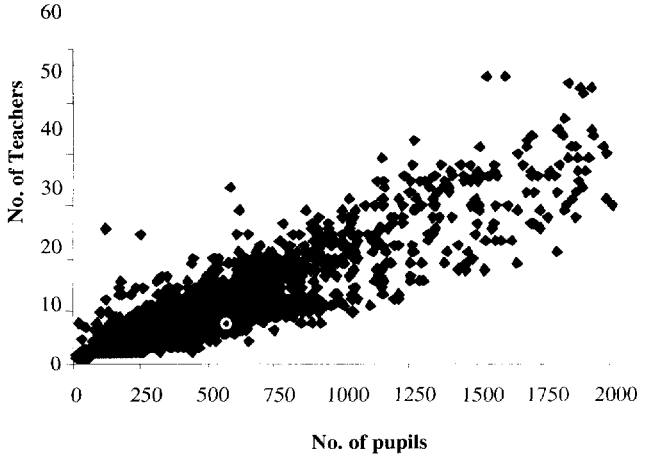
Source: World Bank, "Education and Training in Madagascar: Towards a Policy Agenda for Growth and Poverty Reduction" (forthcoming).

For Madagascar, the approach suggests that budgeted amounts correspond to actual spending. In other countries, this approach sometimes uncovers discrepancies caused by staff attributed to the education vote actually working elsewhere in government jobs unrelated to education. In addition, in Madagascar the pattern of staff and expenditure allocation is striking in highlighting the preponderance of spending on overheads and institutional-level administration. While the results may not be conclusive by themselves, they signal a potential problem in the efficiency of public expenditure management that warrants further attention.

School-level patterns in teacher deployment

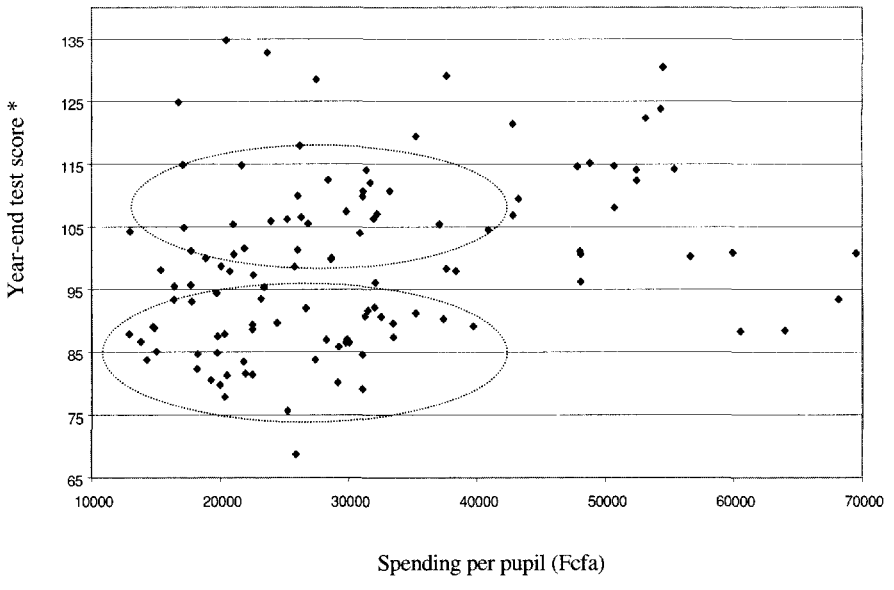
Beyond looking at patterns of allocation in the aggregate budget, it is also useful to examine the allocation of spending across schools as another possible source of inefficient expenditure management. Such analysis is possible with data that are routinely collected through annual school censuses in almost all countries. Figure 11 shows the results for Mozambique; each point in the graphs represents a school with the indicated school size on the x-axis and the number of teachers at the school indicated on the y-axis. The relation between the two variables is relatively weak, with a R^2 of 0.86, which implies that 14 percent of the variation in teacher deployment is unrelated to school size. In contrast,

Figure 11
Relation between number of pupils and teachers at the school-level, Mozambique 1998



Source: World Bank, "Cost and Financing of Education. Opportunities and Obstacles for expanding and improving education in Mozambique" (forthcoming).

Figure 12
Relation between spending and student learning among fifth graders, Burkina Faso 1996



* Adjusted for pupils' initial test scores and socio-economic backgrounds

Source: World Bank, *Coûts, financement et fonctionnement du système éducatif du Burkina Faso; contraintes et espaces pour la politique éducative* (forthcoming).

a similar analysis for Guinea shows a much tighter relation between the two variables, with a R^2 of 0.92.

Similar work in Benin, Burkina Faso, Madagascar, and Zambia suggests that poor teacher deployment is often a significant issue in the sector, and the effects are particularly adverse in rural areas. Because teacher salaries represent the bulk of spending by the state, the randomness in teacher deployment effectively implies a high degree of inequity in resource allocation, and by implication wide disparities in the conditions of schooling across schools. The outcome points either to the absence or lax application of appropriate criteria for teacher placement, or to inadequate incentives for teachers to accept posting to rural areas. In some countries, it has therefore been appropriate to include measures to restructure teacher pay and incentives for rural postings as a completion point trigger under the HIPC Initiative.

The link between resources and student learning

How efficiently are resources used to produce learning outcomes across schools? This question is at the heart of public expenditure management, not least because in the final analysis schools are accountable for student learning. More data are becoming available to permit a good analysis of the issue. Consider the results for Burkina Faso in Figure 12, which shows on the x-axis public spending per pupil, and on the y-axis fifth graders' year-end test scores adjusted for differences across schools in pupils' initial test score and their socioeconomic characteristics. Three features of the graph warrant comment: (a) schools vary substantially in resource endowment, ranging from a low of only 12,000 Fcfa, to nearly 70,000 Fcfa; and (b) schools also vary in the effectiveness with which resources are transformed into student learning, with the year-end test score ranging from around 65 to 135; and (c) the relation between resource endowment and test score is very weak, so that among schools with a spending level of 20,000 Fcfa per pupil, average year-end test scores can range from 77 to 135.

The results for Burkina Faso highlight a need for much better management of teaching and learning processes within the classroom. This calls for interventions, not only to equip teachers more effectively for their tasks (e.g., through more intensive in-service training) but also to strengthen the incentives for improvement, including tighter supervision of the

lagging schools. To see the importance of better management, note that the schools in the top bubble in the graph are on average twenty-five points ahead in test scores of the schools in the bottom bubble, even though the two sets of schools have similar spending per pupil. A difference of this magnitude is large because a decrease in the pupil-teacher ratio from 50 to 30 (which implies a 67 percent rise in spending per pupil) would produce a gain of only 1.5 points in year-end test scores in the same sample of pupils.

This type of analysis has been applied in an increasing number of African countries (e.g., Senegal, Cameroon, and Madagascar), where recent surveys on student learning have been implemented. In countries where such data are unavailable, the approach can also be applied using examination results as a second best measure of learning outcomes. In most settings, the typical finding is that pedagogical processes could be much better managed. While the results do not give guidance on what to do to improve outcomes, they motivate greater attention to the problem, and help to focus scarce management resources on the lagging performers.

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1 The examples reported here rely on a paper prepared by Agnes Soucat and Abdo Yazbek on "Rapid Guidelines for Integrating Health, Nutrition, and Population Issues in Interim Poverty Reduction Strategy Papers on Low-Income Countries," draft of October 2000.

2 Based on data from demographic and health surveys, the HNP Department in the HD Network has prepared Poverty and Health Fact Sheets for more than forty countries.

3

Emerging Lessons

In many ways the HIPC Initiative has created a new dynamic in international development. By reducing the burden of external debt service, it ameliorates what debtor countries have long contended is a significant impediment to better access to basic health and education services, especially among the poor. At the same time, it opens the way for creditor countries to shift the focus toward increased accountability for results. The process has just been launched, and it is still too early to judge its effectiveness in bringing about progress in poverty reduction and human development.

Yet some lessons can be drawn regarding the process itself. The building blocks for effective HD engagement include the following:

- on-demand availability of country-specific sector knowledge focused especially on issues relating to better management of public (and private) resources to deliver basic health and education services to the poor;
- collaboration on analytical work with counterpart country teams as a mechanism to build in-country capacity to prepare sectoral inputs to the PRSPs and subsequent monitoring of program implementation and outcomes; and
- active partnership with key non-sectoral partners (such as macroeconomists within the Bank and ministries of finance and planning) to address impediments to sector development and to increase accountability for results.

With regard to the work at the Bank, the HIPC/PRSP process calls for changes in business practices and staff behavior. Much greater investment in building sector knowledge will obviously be needed as a long-term strategy — but perhaps not so much in the lumpy model of standard economic sector work as in the model of initiating and maintaining a living knowledge base around a core set of issues. Budget realities may indeed make the latter approach more feasible, since a living knowledge base can be built up in modular increments around a core structure as budgets permit. Taking the long view is important to minimize our lack of readiness in future rounds of policy dialogue on the progress of poverty reduction and human development. The demand for current, off-the-shelf sector knowledge will intensify in a future where the Bank's business environment is increasingly characterized by the HIPC/PRSP process as a key feature.

Changes in staff attitudes will also be important. In particular, HD sector development must be viewed as an integral part of broader efforts to reduce poverty, and our work needs to pay explicit attention to the sector policy context for enhancing basic social services for the poor — of which the delivery may sometimes be supported as part of the Bank's lending operations. Given that governments are expected to play the leading role in defining their own poverty reduction strategies, the Bank's sectoral staff are perhaps most effective when making technical contributions to help articulate these strategies in collaboration with the relevant country counterparts and staff from other external partners, drawing on the Bank's intellectual resources and comparative experience to inform the policy debates. While attitudes will no doubt take time to change and the change may not always be easy, the shift in orientation is essential to making the Bank a more effective development partner for its clients.

A1

Appendix tables and figures

Table A1
The role of health and education in Uganda's Poverty Eradication Action Plan (PEAP) 2000

Pillar of the PEAP	Health	Education				
		Prim.	Sec.	Voc/tech	Higher	Adult literacy
Creating a framework for economic growth and transformation					X	
Ensuring good governance and security						
Directly increasing the ability of the poor to raise their incomes				X		
Directly increasing the quality of the life of the poor.	X	X	X			X

Source: Government of Uganda 2000. "Poverty Reduction Strategy Paper. Uganda's Poverty Eradication Action Plan. Summary and Main Objectives," Ministry of Finance (Planning and Economic Development), Kampala, March 24.

Table A2
Uganda's 2000 PRSP: Health and education sector measures & monitoring indicators

Sub-sector	Strategy/Targets	Monitoring indicators
	By 2004/5 achieve the following:	
Health	▪ Reduce child mortality from 147 to 103 per thousand ▪ Reduce maternal mortality from 506 to 354 per 100,000 ▪ Reduce HIV prevalence by 35% ▪ Reduce total fertility rate to 5.4 ▪ Reduce stunting to 28%	▪ Immunization rates ▪ %of health centers with trained staff ▪ % of health centers without stockouts ▪ Utilization of health services ▪ Perceptions of service delivery ▪ Prevalence for HIV and malaria
Primary	▪ Approach net enrolment close to 100% by 2003 ▪ Reduce pupil-teacher ratio to 50 by 2000 and 41 ▪ by 2009 ▪ Stabilize teacher-classroom ratio at 1.6: 1 by 2003/4.	▪ Net and gross primary enrolment ▪ Pupil-textbook and teacher ratios ▪ Public perceptions of quality ▪ Estimates of quality from the National Assessment of Progress in Education (NAPE).
Secondary	▪ Raise transition rate from primary to sec/voc to 65% by 2003 ▪ Set pupil-teacher ratio at 30 by 2003	▪ Net and gross enrolment ▪ Indicators of quality ▪ Incidence of benefits, including access of poorest 20%.
Vocational education	▪ Increase number of trainees to 100,000 by 2003	▪ Enrolments and completion ▪ Employment of graduates
Tertiary education	▪ Expand enrolment from 25,000 to 50,000 by 2003 ▪ Ensure women make up 40% of enrollments ▪ Eliminate disparities by district & increase access among lower socio-economic groups ▪ Provide places for 8,000 government students at Makerere University	▪ Total enrolment in tertiary education, and gender breakdown ▪ Enrolment by socio-economic group, and district of origin
Adult literacy	▪ Implement 5-year program to achieve 85% literacy rate	▪ Literacy rates, by sex

Source: Based on Government of Uganda 2000 (Annex Table 1).

Table A3
Uganda's PEAP/PRSP First Year Progress Report 2001 [a/]

Sector/sub-sector	Assessment of progress and challenges
Health	▪ The PEAP/PRSP interim targets for child immunization and trained staff not met in 1999/2000 ▪ Child malnutrition has declined, but HIV/AIDS and malaria continue to pose serious threats ▪ Significant increase in the demand for health services, met mostly by private providers ▪ Access to safe water has increased, but problems with maintenance remain. PEAP/PRSP interim targets for the number of springs and shallow wells not achieved ▪ Challenges: Recruiting health personnel in districts and getting them onto the government payroll Finalizing the national policy on user fees for health services Providing adequate drugs and medical supplies to health facilities Expanding coverage of and access to minimum health care package services; this has been limited (for example, only 25 percent of deliveries take place in health facilities; contraceptive prevalence rate is only 15 percent; only 30 percent of malaria patients have access to treatment within 24 hours of the onset of symptoms)
HIV/AIDS	▪ Progress achieved in creating awareness about transmission of HIV/AIDS ▪ Progress achieved in enhancing treatment of sexually transmitted diseases (STDs) ▪ Challenges: Making health care affordable for a large proportion for people living with AIDS Limited integration of HIV/AIDS activities in all sectoral programs
Primary education	▪ Primary enrollments remain high (6.1 million pupils), with net enrollment ratio at 77% in 2000 ▪ Student achievement appears to be declining with recent massive increase in enrollments ▪ PEAP/PRSP indicators not met for ratio of pupils to teachers, to classrooms, and to textbooks ▪ Challenges: Making access to primary education universal, while raising the quality of standards Recruiting adequate numbers of qualified teachers Ensuring that newly recruited teachers access the payroll Improving the availability of textbooks
Secondary education	▪ Strategic plan completed ▪ Initial activities to expand access and improve quality started, including: 4 sites identified for first pilot secondary schools 73 secondary schools given grants for construction and rehabilitation 16 secondary schools identified to serve as centers for Comprehensive Secondary Education 36 functional Teacher Resource Centers established to offer in-service teacher training Guidelines and incentives developed to enhance community contribution for secondary education
Vocational education	▪ Policy has been developed ▪ Funds secured from the German Government to support private Vocational Training providers all over the country ▪ Standardization of the curriculum requires further attention
Higher education	▪ Excellent progress as university level education expanded without overburdening state budget; public spending on education doubled between 1995 and 2000, but allocation for Makerere University rose by only 7% ▪ Increase in enrollment and its composition at Makerere University especially noteworthy: number of students rose from 9,369 in 1995/1996 to 20,368 in 1999/2000 & share of privately-sponsored students exceeds 70 percent in 1999/2000
Adult literacy	▪ Slow progress a problem ▪ Funding increased to implement nationwide adult literacy program ▪ Training of literacy instructors begun and resources pay them secured

Source: Government of Uganda. 2001. "Uganda Poverty Reduction Strategy Paper. Progress Report 2001. Summary of Poverty Status Report," Ministry of Finance, Planning and Economic Development, February, Kampala.
a/ Shows information relating directly to the health and education sectors only.

Table A4
The role of health and education in Burkina Faso's 2000 Poverty Reduction Strategy (PRSP)

Pillar of the PRSP	Health	Education		
		Primary	Post-primary	Literacy
Accelerate equity based growth				
Guarantee that the poor have access to basic social services	X	X	X	X
Expand opportunities for employment and income-generating activities for the poor				
Promote good governance				

Source: Government of Burkina Faso, Ministry of Economy and Finance, May 25, 2000. Poverty Reduction Strategy Paper. Based on text discussion and annexes.

Table A5
Health sector strategy/objectives and monitoring indicators in Burkina Faso's 2000 PRSP

Strategy/objectives	Monitoring indicators (2000-2003)
Improve life expectancy by at least 10 years by 2010	▪ Vaccination coverage ratio (in %) by 2003: BCG increases to 85% DTCP3 increases to 70% Measles increases to 70% Yellow fever increases to 70%
▪ Prioritize interventions addressing health problems of the poorest segments of the population	▪ Rate of use of health facilities : number of new contacts per person and per year in first level health centers (CSPS, CMA) increases to 0.27
▪ Decrease infant mortality from 105 to 50 per thousand by 2009, and IMR in rural areas from 113 to 75 per thousand and IMR in urban areas from 113 to 45 per thousand	▪ CSPS meeting the standards in terms of staffing 100% by 2003
▪ Protect underprivileged groups through policies designed to make essential health care affordable	▪ Essential drugs breakdown rate (%) <8
▪ Supports participation of users and communities in the development and management of health care activities	▪ Cost of medical interventions in first level health centers

Source: Government of Burkina Faso, Ministry of Economy and Finance, May 25,2000. Poverty Reduction Strategy Paper. Based on text discussion and annexes.

Table A6
Education sector strategy/objectives and monitoring indicators in Burkina Faso's 2000 PRSP

Strategy/objectives	Monitoring Indicators 2000-03
Enhance public spending on education	Gross enrollment rate:
Raise education share from 21.6 % currently to 26.0 % in 2010	--Overall
Maintain share of basic education at 60% of education spending	-- among girls
Allocate 7% of basic education spending to literacy programs	-- in least privileged rural areas
Improve management of teacher recruitment	Enrollment rate in grade 1:
Decentralize hiring over the next 10 years	-- among girls
Set salaries of new hires at 3.5 to 5.0 times per capita GDP	-- in rural areas
Reform organizational structure of the ministry of education	-- in the 20 poorest provinces
Improve service delivery to the poor and to disadvantaged groups	Literacy rate:
Stimulate demand for education through comprehensive approach	-- among women
Target school construction to rural areas	-- among women in the 20 poorest provinces
Construct toilet facilities in all new schools	Average cost per child in primary school
Construct of water supply points in schools	
Support for school canteens	
Fee exemption for girls in 20 provinces with lowest enrollments	
Continue distribution of textbooks free-of-charge	
Improve student flow	
Raise survival rate from grade 1 to grade 5 from 60% to 75% by 2010	
Reduce repetition rate in primary education from 18 to 10 % by 2010	
Expand literacy programs	
Target services to women	
Establish permanent literacy and training centers	
Incorporate literacy activities as part of other social services	

Source: Government of Burkina Faso, Ministry of Economy and Finance, May 25, 2000. Poverty Reduction Strategy Paper.
Based on text discussion and annexes.

Table A7
The role of health and education in Mauritania's 2000 PRSP

Pillar of the PRSP	Health [a/]	Education [b/]	Vocational training
Accelerated and redistributive growth			
Growth anchored in the economic environment of the poor			X
Developing human resources and ensuring universal access to basic infrastructure and service	X	X	
Strengthening institutional capacities and governance			

Source: Islamic Republic of Mauritania December 13, 2000. Poverty Reduction Strategy Paper.
a/ Includes nutrition.
b/ Includes all levels from pre-school to higher education, as well as literacy programs; excludes vocational education and training.

Table A8
Health and nutrition strategy/measures and monitoring indicators in Mauritania's 2000 PRSP

Objectives/strategies	Actions (to be monitored during 2001–04)
Improve health services provided to population groups, particularly the poorest Reduce morbidity and mortality associated with major diseases	▪ Develop and provide a minimum care package of health care services at all levels of health system to improve maternal and child health and address major health problems (e.g., AIDS, malaria, TB, diarrhea, ARI, shistosomiasis, Guinea worm, micronutrient deficiencies) through: o construction and equipping of health centers and health posts o hiring of medical and paramedical personnel o establishment of specific payment systems for health post personnel in disadvantaged areas o establishment of a sustainable system of supplying good quality drugs based on recommendations emerging from studies in progress and consultations with donors.
Strengthen the equity, quality, efficiency of and sustainable access to essential care	▪ Solidify and extend system of cost-recovery at all levels within the system ▪ Study and establish a system to care for the indigents in collaboration with the departments concerned ▪ Involve the poorest users and communities in health decisions
Improve HIV/AIDS prevention	▪ Strengthen and equip outlying health care facilities to provide services to prevent and care for opportunistic infections ▪ Develop AIDS detection and counseling in category A health centers ▪ Provide psychological-medical-social counseling for people living with HIV
Improve sectoral guidance, planning & management	▪ Complete study on health sector costs and performance and implement its recommendations ▪ Establish budget-program and system to monitor performance
Improve nutritional status of population groups	▪ Implement the Taghdiya community nutrition program ▪ Extend recovery centers for malnourished children

Source: Islamic Republic of Mauritania December 13, 2000. Poverty Reduction Strategy Paper.

Table A9
Education sector strategy/measures and monitoring indicators in Mauritania's 2000 PRSP

Sub-sector	Objective/Strategy	Actions (monitored during 2001–04)
Basic education	Raise enrollment rate to 100% by 2004	▪ Ensure schools have facilities to offer full-cycle instruction (construct 1,533 new classrooms; rehabilitate 564 classrooms) ▪ Hire 409 new teachers ▪ Institute bonuses for teachers posted to disadvantaged areas
	Reduce regional/gender disparities in access	
	Improve quality and reduce disparities in schooling outcomes	▪ Provide all schools with pedagogical materials ▪ Equip all schools with desks
	Improve caliber of teachers	▪ Maintain ongoing teacher training
Secondary education	Expand lower secondary cycle & ensure adequate access for girls	▪ Construct and rehabilitate classrooms ▪ Hire 600 new lower secondary teachers
	Improve quality esp. in rural areas & exam results	▪ Equip all schools with desks ▪ Install computers and provide teaching materials ▪ Maintain ongoing teacher training
Technical/ vocational education	Improve labor force qualification Enhance inclusion of rural populations' inclusion in the economic fabric	▪ Construct & rehabilitate training centers ▪ Purchase specialized equipment ▪ Train trainers
Higher education	Tighten fit with the labor market	▪ Purchase of pedagogical materials ▪ Complete study of the supply, quality and relevance of higher education ▪ Introduce measures to enhance quality
Central management	Improve management the system	▪ Introduce school mapping ▪ Create a good staff management system ▪ Modernize & decentralize administration ▪ Strengthen institutional capacity
Literacy	Develop adapted literacy program	▪ Develop & distribute literacy manuals ▪ Establish incentive system for literacy personnel ▪ Strengthen "mahadras" contribution to the literacy effort

Source: Islamic Republic of Mauritania December 13, 2000. Poverty Reduction Strategy Paper.

Table A10
Role of health and education in Tanzania's 2000 PRS

Pillar of the PRSP	Health	Education
Reduce income poverty		
Improve human capabilities, survival and social well being	X	X

Source: Government of Tanzania. 2000. Poverty Reduction Strategy Paper, Ministry of Finance, October.

Table A11
Health sector strategy/measures and monitoring indicators in Tanzania's 2000 PRSP

Poverty reduction strategy Indicators	Intermediate indicators (2000–2003)	Actions
Long Term Raise Life Expectancy to 52 years by the year 2010 **Medium Term** Lower Infant mortality rate from 99 per 1000 to 85 per 1000 by 2003 Reduce under-five mortality from 158 to 127 per 1000 by 2003 Lower maternal mortality from 529 per 1000 to 450 per 100,000 by 2003; *(NB: this is a non measurable target)* Reduce malaria related fatality for under 5 children from 12.8% to 10% by 2003	Raise % of the rural populaion with access to safe and clean water from 48.5% in 2000 to 55% in 2003 Raise % of immunized children under 2 years old from 71% in 2000 to 85% in 2003 Increase coverage of births attended by trained personnel from 50% to 80% Raise % of districts with active HIV/AIDS awareness campaigns to 75% by 2003	Provide quality health services through essential health package delivery Strengthen and reorient the delivery of secondary and tertiary health services, to ensure more effective support of primary health care Train health personnel Promote and coordinate private sector and civil society activities in health Rehabilitate malfunctioning water supply schemes, protection of water sources Promote nutrition education especially to mothers and reinforce reproductive health and family planning Raise % of the rural population with access to safe and clean water Promote HIV/AIDS and public health awareness, including through peer education in schools Strengthen the program of integrated management of Childhood illness

Source: Government of Tanzania. 2000. Poverty Reduction Strategy Paper, Ministry of Finance, October. Based on text discussions and annexes.

Table A12
Education sector strategy/measures and monitoring indicators in Tanzania's 2000 PRSP

Poverty reduction strategy	Intermediate indicators (2000–2003)	Actions
Long Term Reduce illiteracy by 100% by 2010		
Medium Term Achieve gender equality in primary and secondary education by 2005.		
Increase share of school age children successfully completing primary education.	Gross primary enrolment ratio rises to 85%	Abolish primary school fees starting 2001/02
	Net primary school enrolment ratio rises from 57% to 70%	Strengthen the management capacity of districts, schools, TTCs and adult education centres
	Transition rate from primary to secondary level rises from 15% to 21%	Complete school mapping and improvement plans
	Primary dropout rate falls from 6.6% to 3%	Increase capacity & improve inspection services coverage
Increase share of students passing Standard 7 examination at a specified score	No. of students passing at specified mark in standard 7 examination rises from 20% to 50%	Improve quality and distribution of primary school teachers through in-service training at annual rate of 10% up to the year 2003
		Improve learning environment at all levels (textbooks, materials, furniture, sanitation, classrooms, teachers houses, etc.)
Expand demand-driven skills development	Secondary gross enrollment ratio rises from 5% to 7%	Promote private and community based secondary education
		Improve & protect basic education spending share
		Provide/construct additional classrooms and rehabilitate existing ones

Source: Government of Tanzania. 2000. Poverty Reduction Strategy Paper, Ministry of Finance, October. Based on text discussion on pages 19 & 26, and Annex II.

Table A13
Examples of health indicators for cross-country comparisons

Countries	Life Expectancy at Birth	Infant Mortality (per 1000 live births)	Under Five Mortality (deaths per 1000 live births)	Maternal Mortality (deaths per 100,000 live births)	Fertility Rate (number of children per woman)	HIV Prevalence rate	Child Malnutrition (weight per age)
Africa [a/]	**52**	**91**	**151**	**822**	**5.6**	**8%**	**32**
Mauritania	53	92	140	930	5.5	0.5%	23
Burkina Faso	46	105	219	484	6.8	7%	33
Guinea	46	122	220	880	5.7	2%	24
Madagascar	58	96	162	596	6.0	0.5%	36
Mali	50	120	192	577	6.7	1.5%	31
Côte d'Ivoire	55	88	138	597	5.6	10%	24
Ghana	60	71	110	740	5.0	3.6%	27
Uganda	40	99	141	506	6.7	8.3%	26

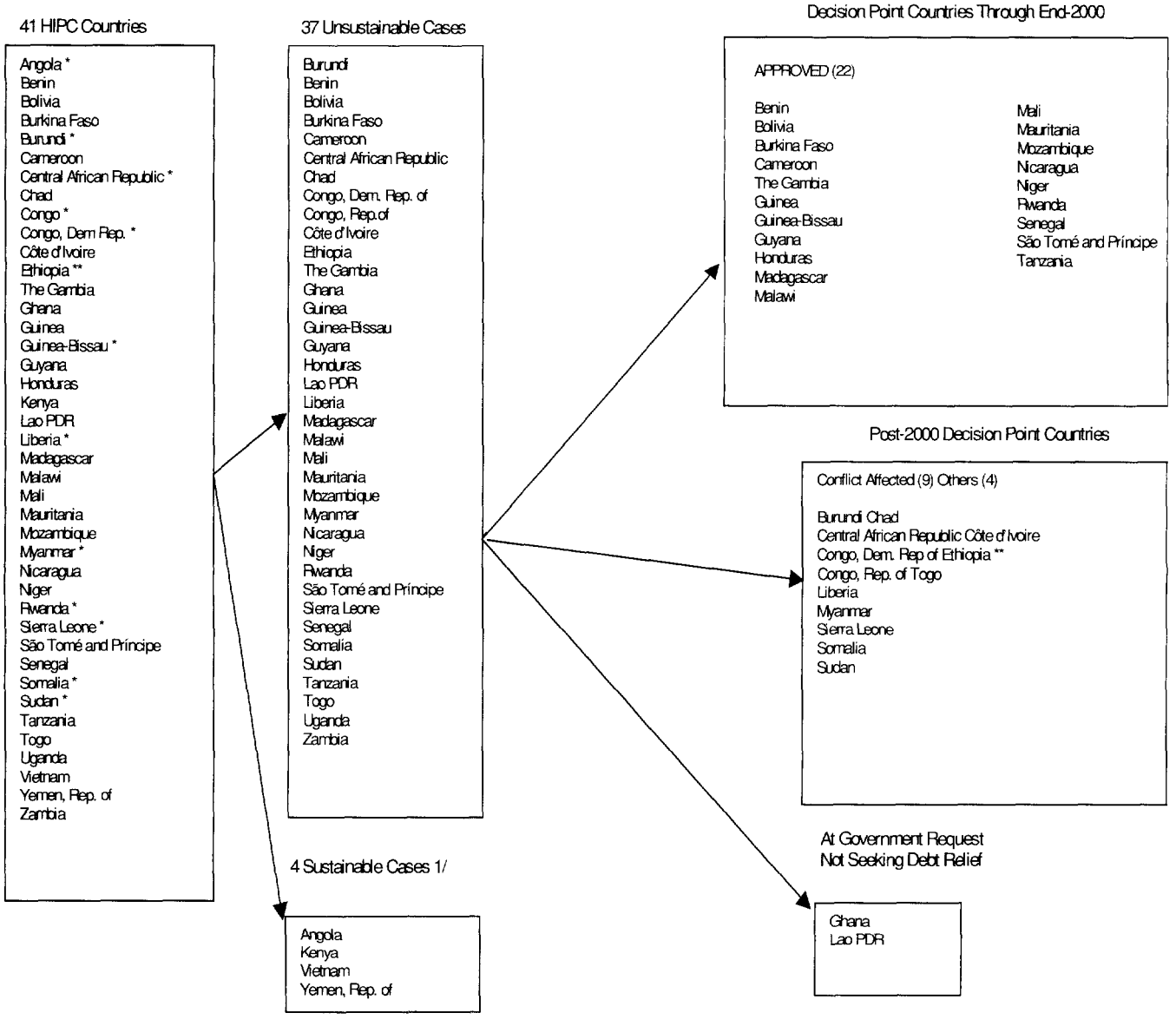
a/ Averages for 1990–96.

Table A14
Selected best buys in health [a/]

Outcome	Conditions and Services	Interventions
Reduction of IMR and U5MR	Integrated Management of Childhood Illness	Case management of ARI, diarrhea, malaria, measles and malnutrition; immunization, feeding/breastfeeding counseling, micronutrient & iron supplementation, antihelminthic treatment, and referral
	Immunization (EPI Plus)	BCG at birth; OPV at birth, 6,10, 14 weeks, DPT at 6, 10, 14 weeks, HepB birth, 6 and 9 months (optional), Measles at 9 months TT for women of child bearing age
Improve nutrition	Child Protein Energy Malnutrition	Promotion of Breast feeding with appropriate complementary feeding, IEC (communications for behavior change) [b/]
	Vitamin A Deficiency	Vitamin A supplementation: for women, within 60 days post-partum; for children 6 – 59 months, twice-yearly; fortification of staples with vitamin A, IEC (communications for behavior change)
	Anemia	Iron and folic acid supplementation for women of reproductive age, iron supplementation of infants 6 to 24 months; fortification of staples with iron, IEC (communications for behavior change)
	Iodine Deficiency	Salt iodization, IEC (communications for behavior change)
	School health and nutrition	Health and nutrition education, de-worming, iron supplementation
Reduce maternal mortality and fertility	Reproductive health/ Safe motherhood	Family planning, prenatal delivery care, clean/safe delivery by trained birth attendant, post-partum care, and essential emergency obstetric care for high risk pregnancies and complications
	Family Planning	Information & education and availability and correct use of contraceptives
Control communicable diseases	Sexually Transmitted Diseases (STD)	Case management using syndromic diagnosis and standard treatment algorithm
	HIV/AIDS prevention program	Education on safe behavior, condom promotion, STD treatment, safe blood supply, prevention of Mother To Child Transmission 'including counseling on infant feeding options for HIV+ mothers
	Malaria	Case management (early assessment and prompt treatment), and selected preventive measures (e.g. impregnated bed-nets, presumptive treatment)
	Tuberculosis	Direct Observed Treatment Short-course; Case detection by sputum smear microscopy among symptomatic patients. Standardized treatment regimen of 6-8 months. Directly observed treatment for at least initial 2 months.

a/The list is based on the work of technical group at the World Bank and WHO documentation.
b/ Supplementary feeding can be considered *in addition to* but not as a substitute for, the above nutrition interventions, where inadequate access to food by vulnerable groups [pregnant and lactating women, children under 2] in food insecure households, is a cause of malnutrition. Food supplementation can serve as an incentive to attend health clinics and as an 'educational tool' to improve capacity to care for children and women in the household. Given the costs and risks involved in food supplementation programs, other means to increase attendance or improve caring practices should first be considered. Food supplementation of vulnerable people cannot substitute for measures to address household food insecurity, and should therefore be accompanied by safety net measures, such as food stamps, income transfers, income generation for women, asset generation, etc. Similar considerations apply to school feeding: School feeding can have educational benefits, because it can improve learning, enrollment and attendance. Integrated programs that combine school feeding with nutrition and health education, deworming, and micronutrient supplementation are more likely to have nutritional benefits than school feeding alone.

Figure A 1
Grouping of the Heavily Indebted Poor Countries
Status as of end-December 2000



* Conflict affected. ** Cessation of hostilities signed on June 18, 2000. A peace agreement was signed with Eritrea on December 12, 2000.
1/ These countries are expected to achieve debt sustainability after receiving debt relief provided under traditional mechanisms.
2/ Countries which reached their decision points under the original HIPC framework (i.e. prior to the endorsement of the enhanced HIPC framework during the Annual Meetings of the World Bank and IMF in September 1999).

Bibliography

Government of Burkina Faso. 2000. "Health and Poverty in Burkina Faso," background document for the draft PRSP, Ministry of Health.

Government of Burkina Faso. 2000. Poverty Reduction Strategy Paper, Ministry of Economy and Finance, Ouagadougou, May 25.

Government of Cameroon. 2000. "Health and Poverty in Cameroon," background document for the draft PRSP, Ministry of Health.

Government of Guinea. 2000. "Health and Poverty in Guinea," background document for the draft PRSP, Ministry of Health.

Government of Islamic Republic of Mauritania. 2000. Poverty Reduction Strategy Paper, December 13.

Government of Mali. 2000. "Health and Poverty in Mali," background document for the draft PRPS, Ministry of Health.

Government of Mauritania. 2000. "Health and Poverty in Mauritania," background document for the draft PRSP, Ministry of Health.

Government of Niger. 2000. "Health and Poverty in Niger," background document for the draft PRSP, Ministry of Health.

Government of Tanzania. 2000. Poverty Reduction Strategy Paper, Ministry of Finance, October.

Government of Uganda 2001. "Uganda Poverty Reduction Strategy Paper. Progress Report 2001. Summary of Poverty Status Report," Ministry of Finance, Planning and Economic Development, Kampala, February.

Government of Uganda. 2000. Poverty Reduction Strategy Paper. "Uganda's Poverty Eradication Action Plan. Summary and Main Objectives," Ministry of Finance, Planning and Development, Kampala, March 24.

The World Bank. 2000. Grouping of the Heavily Indebted Poor Countries posted at website: http://www1.worldbank.org/prsp/PRSP_Related_Documents/hipcs_groupings.pdf.

The World Bank. "Education and Training in Madagascar: Towards a Policy Agenda for Growth and Poverty Reduction." Human Development Department, Africa Region. Washington D.C.: World Bank (forthcoming).

World Bank & Benin Education National Team. "Le système éducatif béninois Performance et espaces d'amélioration pour la politique éducative." Washington, D.C.: World Bank (forthcoming).

World Bank & Mauritania Education National Team. 2000. "Le système éducatif mauritanien: Eléments d'analyse pour instruire des politiques nouvelles. "Washington D.C.: World Bank (forthcoming).

World Bank & Niger Education National Team. "Contraintes et espaces de liberté pour le développement en quantité et en qualité de l'éducation au Niger." Washington, D.C.: World Bank (forthcoming).

World Bank (various years). Africa Live Data Base for Government social expenditure statistics. Washington, D.C.: World Bank.

World Bank. 2000. "Benin. Decision Point Document under the Enhanced Heavily Indebted Poor Countries (HIPC) Initiative." Washington, D.C.: World Bank.

World Bank. 2000. "Burkina Faso. HIPC Debt Initiative: President's Memorandum and Recommendation and Completion Point/ Second Decision Point Document." Washington, D.C.: World Bank.

World Bank. 2000. "Cameroon. HIPC Debt Initiative: President's Memorandum and Recommendation and Decision Point Document." Washington, D.C.: World Bank.

World Bank. "Cost and Financing of Education. Opportunities and Obstacles for expanding and improving education in Mozambique." Washington, D.C.: World Bank (forthcoming).

World Bank. "Coûts, financement et fonctionnement du système éducatif du Burkina Faso; contraintes et espaces pour la politique éducative." Washington, D.C.: World Bank (forthcoming).

World Bank. 2000. Financial Impact of the HIPC Initiative posted at website: http:// www.worldbank.org/ hipc/ Financial_Impact.pdf

World Bank. 2000. "Guinea. Enhanced HIPC Debt Initiative: President's Memorandum and Recommendation and Decision Point Document." Washington, D.C.: World Bank.

World Bank. 2000. "Guinea-Bissau. Enhanced HIPC Debt Initiative: President's Memorandum and Recommendation and Decision Point Document." Washington, D.C.: World Bank.

World Bank. 2000. "Madagascar. Enhanced HIPC Debt Initiative: President's Memorandum and Recommendation and Decision Point Document." Washington, D.C.: World Bank.

World Bank. 2000. "Malawi. Enhanced HIPC Debt Initiative: President's Memorandum and Recommendation and Decision Point Document. Washington," D.C.: World Bank.

World Bank. 2000. "Mali. Initiative for Heavily Indebted Poor Countries (HIPC). Document for the Completion Point Under the Original Framework and Decision Point Document under the Enhanced Framework." Washington, D.C.: World Bank.

World Bank. 2000. "Mauritania. HIPC Debt Initiative: President's Memorandum and Recommendation and Decision Point Document, Corrigendum."Washington, D.C.: World Bank.

World Bank. 2000. "Niger. Enhanced HIPC Debt Initiative: President's Memorandum and Recommendation and Decision Point Document." Washington, D.C.: World Bank.

World Bank. 2000. "Republic of Mozambique. Decision Point Document for the Enhanced Heavily Indebted Poor Countries (HIPC) Initiative." Washington, D.C.: World Bank.

World Bank. 2000. "Rwanda. Enhanced HIPC Debt Initiative: President's Memorandum and Recommendation and Decision Point Document." Washington, D.C.: World Bank.

World Bank. 2000. "São Tomé and Principe. Enhanced HIPC Debt Initiative: President's Memorandum and Recommendation and Decision Point Document." Washington, D.C.: World Bank.

World Bank. 2000. "Senegal. HIPC Debt Initiative: President's Memorandum and Recommendation and Decision Point Document. Washington," D.C.: World Bank.

World Bank. 2000. "Tanzania. HIPC Debt Initiative: President's Memorandum and Recommendation and Decision Point Document" Washington, D.C.: World Bank.

World Bank. 2000. "The Gambia. Enhanced HIPC Debt Initiative: President's Memorandum and Recommendation and Decision Point Document." Washington, D.C.: World Bank.

World Bank. 2000. "Uganda. HIPC Debt Initiative: Second Decision Point Document." Washington, D.C.: World Bank.

World Bank. 2000. "Zambia Enhanced HIPC Debt Initiative: President's Report and Recommendation and Decision Point Document." Washington, D.C.: World Bank.

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In recent years, the World Bank, in collaboration with its partners, has developed new concepts and operational instruments to support governments in their fight against poverty. Among the most notable of these new approaches are (a) debt relief through the Highly Indebted Poor Countries (HIPC) Initiative, (b) country-led plans for reducing poverty through Poverty Reduction Strategy Papers (PRSPs), and (c) World Bank financial support for these strategies through Poverty Reduction Support Credits (PRSCs).

During the year 2000, eighteen countries passed their "decision points" in the debt relief process — that is, the Executive Boards of the IMF and the World Bank had formally approved the countries for debt relief. This study presents basic facts on the countries involved, foresees the possibility of newcomers in the process, and analyzes the content of HD policy measures included in the debt relief agreements. Readers will also learn of the Bank's efforts to engage country counterparts in the HD sectors in an effective dialogue about sector development, particularly in health and education.

The report is divided into three parts: the first summarizes HIPC/PRSP processing; the second part examines the analytical work that the team is developing to strengthen capacity for designing sector policy measures in the HIPC/PRSP documents; and, finally, the report reflects on the lessons learned so far.