Initial Project Description:
Survey of Education and Health Providers

Background Study for the
World Development Report 2003/04 on Basic Service Delivery

World Bank Research Group on

Public Service Delivery

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Introduction

The Millennium Development Goals call for major improvements in education and health in developing countries by 2015: universal primary education; reductions in under-5 mortality and child mortality, by two-thirds and three-quarters, respectively; and a halt to the spread of HIV/AIDS, malaria, tuberculosis, and other major diseases. If these goals are to be met, considerable progress will need to be made outside the education and health sectors — for example, through increased availability of clean water and sanitation, as well as investments in technological development at the global level. But success will also depend heavily on adopting the right policies and institutions within these sectors, and in particular creating appropriate incentives for teachers and health care workers.

There is relatively little systematic evidence on the extent of absences from health and education facilities; what evidence is available suggests that current incentives for professionals in these sectors are far from adequate, especially in South Asia.[1] A multi-country study of education and health providers can document the extent of absence from schools and clinics by teachers and health care workers. It can also determine the correlates of absenteeism — not only the characteristics of an individual worker, but also the institutional features and policies in the education and health systems of a particular jurisdiction (whether that is a country or, in decentralized systems, a subnational jurisdiction). Thus it can help assess the efficacy of different institutional or policy innovations, such as those accompanying decentralization. Such a survey can alert national and international policy makers to the problem; provide guidance on how to address it; and energize civil society. The rest of this document discusses the objectives and modalities for undertaking an in-depth multi-country survey of education and health providers.

Objectives

This study has three objectives

1. Document the extent of the problem of provider absence in a range of jurisdictions (districts, states, countries) at different levels of development and with different institutional structures.

2. Characterize provider absence: How much is the problem concentrated among particular individuals, facilities (e.g., clinics and primary schools), regions (e.g., rural areas) or sectors (health vs. education).

[1] The term "absenteeism" is sometimes used to refer to the problem of high levels of absence among teachers and health care workers. We will generally use the term "absence" instead, because absenteeism typically implies that providers are irresponsible or derelict in their duties. While this implication is sometimes correct, we recognize that absence is often caused by exogenous circumstances, such as illness, or by official duties that take the provider out of the facility. What we are interested in investigating is the extent and causes of excessive absence, at least some of which seem likely to involve incentive structures.

3. Examine institutional correlates of provider absence across countries, with a special focus on the effects of decentralization, community involvement, salaries, labor institutions, and recruitment and retention policies.

Modalities

1. Surveys in each country will be conducted by teams led by local researchers, affiliated with the Global Development Network, in collaboration with the core implementation team based in Washington.

2. Templates for the education and health facility surveys have been developed, circulated for comment, piloted in India, Kenya, and Uganda, and revised for broader application. These efforts are being coordinated by an implementation team based in Washington. The template includes all the information to be collected at the facility level and at the level of individual providers. In each jurisdiction being studied (country or, in the case of India, state), this facility-level information will be supplemented with a survey aimed at collecting information on variations in institutions and policies across jurisdictions. In addition, guidance on training and survey practices to ensure consistent application across countries will be developed. Country teams will add to the template as appropriate for their countries, in consultation with the implementation team.

Literature Review

The problem of high levels of absence among teachers and health care workers — extent, causes, and effects — does not appear to have been widely studied in a development context. Even in OECD countries, the literature on provider absence is relatively small and has failed to produce many robust conclusions.

For the case of **developing countries**, there are some limited findings on the *extent* of absence. Glewwe, Kremer, and Moulin (1999) found that teachers in one area of Kenya were absent from school 28.4 percent of the time, and in school but absent from their class an additional 12.4 percent of the time. The 1999 Public Report on Basic Education for India found that one-third of head teachers were absent when PROBE investigators visited, sparking considerable public debate on the issue in India (PROBE Team 1999). While neither of these analyses was based on a nationally representative sample, Chaudhury and Hammer did draw on a nationally representative sample of primary health centers in Bangladesh and found high absence rates among doctors: in certain types of health facilities, 80 percent of doctors were absent when the survey was taken (Chaudhury and Hammer 2002).

In addition to those studies, a recent survey of primary schools in the states of Uttar Pradesh and Madhya Pradesh found that 17 percent of teachers were absent from school, and another 20 percent were at the schools but absent from their classrooms (Rao 1999; World Bank 2001). In a sample of schools in West Bengal, Amartya Sen found absence rates of 20 percent among primary school teachers (Sen 2002). In a large sample of public and private

schools in the North West Frontier Province of Pakistan, the rate of teacher absence averaged 18 percent (Ali and Reed 1994; King, Orazem, and Paterno 1999). Another survey of primary schools in Pakistan found absence rates of about 10 percent in the surveyed schools (Reimers 1993). And a World Bank report on Bangladesh in the mid-1990s cited school surveys showing that "often 50 percent of teachers are absent, and cases where schools are functioning with only one teacher present for over a hundred children at different grade levels are not uncommon" (World Bank 1995). Overall, the problem appears to be particularly serious in South Asia.

On the *causes* of provider absence, a recent study on Nicaraguan schools (King and Ozler 2001) suggested that *a lack of local control* over schools may sometimes be responsible. Specifically, it concluded that Nicaragua's program expanding school-level administrative autonomy and parental involvement had led to sharp increases in attendance by teachers, with the largest improvements coming in schools in poor rural areas. *Illness* appears to be another major cause of teacher absence, with research indicating that teachers with HIV/AIDS are often repeatedly absent even before they reach the terminal stage of the disease (World Bank 2002). A DFID study on teacher resource centers (Fairhurst et al. 1999) notes that *teacher training* can itself be a cause of absence, when it removes teachers from the classroom for up to a month of training at a time, with no substitutes to cover for the teachers. In some cases, *gender* may play a role, as when competing demands of home and workplace contribute to high rates of absence among female teachers (El-Sanabiy 1989).

The *effects* of absenteeism in developing countries have not been well studied either. The analysis of NWFP schools finds that higher rates of teacher absence increase *student promotion rates* for a given level of test scores but reduces *student continuation rates*. The authors hypothesize that this is because teachers that are absent more often are less able to make accurate assessments of student progress (King, Orazem, and Paterno 1999). This study does not appear to test for the effects of teacher absenteeism on improvements in test scores. The other cited survey of primary schools in Pakistan did test for such an association, but failed to find any correlation between teacher absence and achievement levels (Reimers 1993). However, as the study looked at simple correlations without any control variables, the finding remains open to question. Clearly, there is a need for more research in this area, but the presumption should be that while merely having a teacher in place is not *sufficient* for students to learn, it is probably *necessary*.

The problem of teacher absence has received somewhat greater attention in **developed countries** – paradoxically, given that absent teachers are usually replaced by substitutes in rich-country schools, and thus the instructional costs of absence may be lower than in poorer countries. Nevertheless, even here the literature is sparse. On the causes of absence, one study found that more generous school district leave policies led to higher rates of absence, while more generous leave buyback provisions reduced absence (Ehrenberg, Rees, and Ehrenberg 1991). A study of teacher absence in one large school district suggests that there is persistence over time in absence — that is, the teachers who have been absent most often in the past are those who account for the most absences today — and that school employees with poorer performance ratings were absent significantly more often than

average (Pitkoff 1993). A recent survey of the available studies on teacher absence concludes that there are few robust findings on its causes (Norton 1998).

Similarly, the same survey is unable to draw any robust conclusions regarding the *effects* of provider absence. For example, the study by Ehrenberg et al. found no direct effect of teacher absence on student performance on standardized tests. Note, however, that their study (like most studies on rich countries) investigates only reported absences — meaning that substitute teachers would generally have filled in for all of the absent teachers. Norton notes that although having good teachers in place may be preferable to having substitute teachers, if it is the least effective teachers who are most frequently absent (as evidence from Pitkoff's study suggests), then the educational costs of their absence may be small. Nevertheless, there remains considerable disagreement on this point. Pitkoff notes that absence rates were highest in schools where students were "poorest and failing the most," suggesting that absence is likely to exacerbate inequalities of student achievement. This finding may well carry over to most developing countries, if, as the current evidence suggests, absence is most severe in poor and rural areas.

What our review of the literature shows is that there are very few systematic studies based on nationally representative data that give insight even into the *extent* of provider absence in health and education, let alone its *causes*. This conclusion applies to both OECD and developing countries. While there have been a number of research studies and examples of sector work that have touched on the extent of teacher and health care worker absences in various countries, few have explored rigorously the correlates and causes of these absences. And to our knowledge, almost none of the existing studies has based its analysis on a *nationally representative* facility- and individual-level survey such as the one who are proposing. Moreover, because we will be using the same survey instruments and sampling methodologies across countries, we will be able to construct an *internationally comparable* dataset on provider absences; again, this is a contribution to the existing literature.

To be more specific, there is relatively little hard evidence from nationally representative samples now available on the quantitative extent of the correlation between provider absences and possible determinants such as salaries, inspections, community participation, staff autonomy, health conditions, contract form (permanent vs. temporary), unionization, and whether service providers are from the same ethnic/linguistic background and geographic area as clients. More information is also needed on the degree of heterogeneity among facilities in provider absences, and on the extent to which the problem is due to very high rates of absence among a subset of staff, as opposed to frequent absences among a majority of employees. If ensuring that teachers and health-care workers are present on the job is at least necessary for making progress in these sectors — even if it is not sufficient — then gaining a better understanding why so many are absent seems essential to meeting multilateral development goals in these sectors.

Selection of Survey Areas

Support from the UK Department for International Development, combined with other sources of support, will allow us to survey schools and health centers in more than 70 states/provinces in seven countries. Based on this work, we will seek additional support to extend the analysis to additional countries.

South Asia focus: This initial survey will include an intensive focus on South Asia. Two countries from the region are included — *Bangladesh* and *India* — and these countries together include 85 percent of South Asia's population. Moreover, Indian states will receive by far the most thorough coverage, with each being sampled more intensively than other whole *countries* in the survey; the India survey will also take up over half of the DFID-financed portion of the direct survey budget. There are four reasons for this heavy weighting toward the region:

- The problem of absence appears to be more severe in South Asia than elsewhere. Beyond the limited quantitative evidence cited above, there is considerable anecdotal evidence supporting this point. For example, in many areas even very poor parents try to withdraw their children from the state schools in parts of India and pay for them to attend private schools, in large part because of better teacher attendance in the private schools (and despite facilities that are often worse).
- The costs of absence in terms of human development are likely to be great in South Asia. These three countries account not only for almost a quarter of the developing world's population, but also nearly half of the world's poorest people (those living under $1/day) and a large share of the primary school-age children who are not in school
- The level of experimentation and diversity of approaches in health and education is high. Responsibility for service delivery lies at the state level in India, and there are significant institutional variations in the way states have attempted to improve the efficiency of service delivery. This will allow for an assessment of the effect of different approaches on absence. For this reason, we are proposing to survey nearly all the Indian states, with each one surveyed with the same intensity as the other countries outside India: 20 states are currently planned, with 100 schools and 100 health centers surveyed in each. Three examples of the kinds of institutional variations in education that we will investigate are:
    - The state of Madhya Pradesh has for several years implemented a program for community accountability of schools, the *Educational Guarantee Scheme*, in remote and deprived areas of the state. The program provides teachers to poor communities that take the initiative to set up their own schools and places these schools under the authority of the local village government (*panchayat*). There are strong reasons to believe that this higher level of local accountability has reduced teacher absence. Indeed, the government has just decided to apply the EGS philosophy throughout the state educational system, by making parent-teacher associations compulsory, giving parents

more powers to hold teachers accountable, and giving them financial autonomy over state funds.

- ❖ Some states are experimenting with *non-formal education* (NFE) centers, many operated by local NGOs, as another approach to devolved management in education. One motivation of this program was to reduce absence, but Banerjee, Jacob and Kremer (2002) find absence rates are high among NFE teachers as well in at least one area of Rajasthan. This study will attempt to explore whether this is true more generally.
- ❖ Gujarat has experimented with giving teachers initial three-year contracts, rather than permanent employment, as a kind of *probationary period*. Anecdotal results suggest that absence has fallen as a result, and the Ministry of Education now considers this a best-practice approach. We will examine how this approach correlates with absence at the state and individual level.

- From a logistical perspective, there are experienced survey teams in place in these countries, and costs of data collection are low, which should make it possible to carry out a high-quality survey in each country even in the relatively short time available before the publication of the WDR.

Global comparators: In addition, the project aims to carry out comparable surveys in at least six countries representing other regions. Eventually, we hope to get a global perspective on the problem of absence and its interaction with different institutional structures and policies. To the extent possible — given resource constraints and the need for quality surveys — this project will make a start on that global coverage. Beyond India and Bangladesh in South Asia, we plan to carry out surveys in several other developing regions: in Sub-Saharan Africa, *Uganda* and *Ethiopia,* as well as a related survey in *Kenya*; in East Asia, *Indonesia*; and in Latin America, *Peru* and *Ecuador*.

These countries have been selected for several reasons:

- They are all low- or lower middle-income countries facing significant health and education challenges.
- Like India, two of the larger countries in the sample — Ethiopia and Indonesia — have substantially decentralized government structures. We will be able to explore whether the different approaches that are evolving have had an effect on provider absence.
- As in South Asia, there are experienced survey teams in place in these five countries.

Once the templates are set and as additional resources became available, it should be possible to extend the surveys into additional countries. In the meantime, however, we expect that there will be enough variation across states and districts that it will be possible to statistically examine the relationship between institutions, service provider incentives, and absence at the state or district level by pooling data from the eight countries.

Sampling Procedure

Permissions, stratification, and sample selection

Each country team leader will be responsible for determining what procedures, if any, are needed to obtain permission to collect this data in their country. Team leaders will contact the Ministries of Education and of Health in order to develop a sampling frame (i.e., obtain a list of schools and clinics in each district, or else a list of villages and towns, as appropriate) and obtain any permission necessary to make random, unannounced visits to facilities.

Sampling of districts and facilities within districts will be done centrally to make sure it is done on a largely consistent basis across the entire study, along the following lines. First, the larger jurisdiction (country or Indian state) will be stratified geographically. Within each region, districts will then be selected randomly on a population-weighted basis, for a total of ten districts per country or state. Primary schools and primary health centers (PHCs) within each district will be chosen one of two ways, depending on availability of information.

For schools, we plan to use a population-based random sampling. We will choose randomly ten villages or towns (urban blocks) within each district, after stratifying by rural/urban location. Enumerators will then proceed to the village or town and find out from villagers where the closest government and private schools are. They will then visit up to a total of three schools and carry out the facility survey in each one. (Where there are more than three schools, enumerators will choose schools on a randomized basis, in a way that ensures that both government and private schools are included in the sample.)

For the health sector, we plan to sample using a facility-based rather than population-based approach. Where it is available, we will acquire a list of all the Primary Health Centers (PHCs) within each district. (With the schools, this may not be possible, because there may be no central lists of private schools.) Facilities will then be chosen randomly for visits, after stratification by rural/urban location. Lists would ideally be obtained from both central government and district authorities.

To reduce travel and transportation costs, it may sometimes be necessary to cluster villages/towns or facilities. Under the facility-based selection approach, for example, five areas may be randomly chosen within each district, and two schools in that area will be selected, rather than choosing a random sample of ten areas. During data analysis, we will adjust standard errors to account for clustered sampling.

At the facility level, we will also obtain a roster of teachers in the school or health care workers assigned to the clinic. If the facility is large (for example, if there are more than 25 teachers in a school), we will interview a random sample of the teachers to keep the size of the survey manageable

Types of facilities to be surveyed

This survey is focused on basic education and health care. Given time and personnel constraints, it will therefore focus only on primary schools and primary health care clinics, and not secondary schools or hospitals.

From a sectoral perspective, this study aims primarily to understand provision of health and education services in the public sector. Private schools and clinics will not necessarily be sampled in every country, but they will be included in the survey as appropriate — that is, wherever the private sector is a significant provider of health and education and it is possible to obtain the lists of private institutions needed to generate a sampling frame or to find the private institutions during visits at the village/town level.

Data Collection

Data collection through questionnaires will take place at three levels: the facility level, the level of the individual teacher or health care worker; and the national

Facility level

At the facility level, we will collect the following information:

- size of facility and number and names of workers (teachers, doctors, nurses, etc.) assigned to it
- the hours that facilities are supposed to be in operation and the time of the visit
- presence or absence of each provider on the roster *(which workers are present at the time of the visit, and which are absent)*
- reasons for absence of each worker *(for those not present, we will determine the reason for the absence, since teachers/health care workers may be absent on official business, such as in-service training or supply pick-up)*
- provider activity *(what each provider is doing at the time of the visit)*
- types of services offered *(for clinics)*
- the remoteness of the facility *(for example, distance to the nearest paved road and the nearest large town)*
- distance to the nearest bank *(because in some countries, workers must travel a significant distance to a bank to cash their checks, causing them to be absent from work)*
- primary languages of students/patients *(to see if a language gap between providers and clients is associated with absence)*
- community involvement *(such as existence of parent associations, number of parents attending meetings, parent financing of schools, community involvement in health facility management)*
- educational attainment of patients and of students' parents

- monitoring and supervision *(method of monitoring staff, if any, and frequency of visits by health or education ministry officials)*
- discipline *(number of staff fired/disciplined and the reason for firing of disciplinary action)*
- procedures for filling in for absent teachers or health care workers *(in schools, for example, are there substitute teachers, or are classes combined, or are children sent home?)*
- date and time of the visit *(to confirm that there is no time trend as information on our visits spreads[2], and to check whether rates of absence are highest at a particular time of day)*
- usage of the facility *(for schools, data on the number of pupils attending, and comparisons with official enrollment data and school attendance statistics; for clinics, the number of patients who visited previous day)*
- school finances *(source of each worker's official salary, such as government, parents' fees, or NGO; fees paid by parents)*
- educational background of each worker
- characteristics of the facility *(for example, in the case of schools, whether it has a library or blackboard)*

Individual level

By surveying all teachers or doctors present at each of the surveyed facilities, we will collect information at the individual level to investigate how teacher and health care worker absence varies with important correlates. In addition to collecting information on each worker's absence at the time of the visit, this requires collecting the following information:

- commuting logistics *(how long the individual's commute is, and by what means of transport)*
- ties to the local community *(whether the individual was born in the area where they work, and where their family lives)*
- rank of the employee *(e.g., whether he is a teacher or headmaster, in the case of schools)*
- demographic characteristics of the individual *(such as age and sex)*
- ethnic group and mother language of the individual *(and comparison with the community)*
- training and preparation for the job *(the educational level of the teacher or health care worker)*
- marital status and number of children *(as well as number of own children in the school in the case of teachers)*
- outside income-earning opportunities *(whether other jobs are held by the teacher or health care worker)*
- job tenure and work history
- pay information *(how the worker receives his/her pay, whether it is in arrears)*
- motivations for career choice and current level of job satisfaction

[2] Evidence from earlier work suggests this is not a problem.

We will also obtain as much of this individual-level information as possible for absent teachers and health care workers, by asking the headmaster or clinic director about absent employees. We will also confirm the information with the teacher or health care worker on the second visit.

Both the facility- and individual-level educational surveys have now been piloted in three countries: Kenya, Uganda, and India, and the health surveys are now also being piloted. We are modifying the surveys to reflect the results of those investigations, but preliminary results are quite promising.

National/state institutions survey

To complement this data collected through questionnaires at the facility and individual level, we will ask the country team leader to prepare a report on the national- (or state-) level institutional environment for the education and health sectors. (In India, it will be important to collect this information at the level of the state, because of the variation across states in institutional structures and incentive policies.) We have prepared a detailed survey instrument for this purpose, covering the following topics:

- provider types, numbers, and qualifications (including for non-regular providers)
- provider work hours and excused absences (including a module on extent of AIDS among providers)
- provider salaries and benefits, including procedures for bonuses and promotions and extent of wage arrears
- recruitment, assignment, and transfer policies
- provider participation in facility management
- private providers and the institutional environment
- discipline and dismissal procedures
- local (parent/client) involvement in personnel decisions
- cash and non-cash incentive schemes for attendance
- institutional environment and political competition
- unionization among providers

Using this institutions survey, we will collect both information about the formal institutions and subjective assessments of how these institutions work in practice. The country survey director will collect this information both by drawing on existing sources and by surveying higher-level education and health officials, non-government experts, and a subsample of providers during facility-level survey work.

Proposed Survey Size

Number of facilities per jurisdiction

In each jurisdiction (nation or Indian state), we will survey 10 districts, with at least two visits each to a representative sample of at least 10 health facilities and 10 or more primary schools within each; if the average village has 1.5 schools, the sample will actually be 15 schools per district. This means detailed and representative provider- and facility-level results from perhaps 150 schools and some 100 health centers for each jurisdiction. In addition, there will be a third visit to some smaller sub-sample of the schools and to all of the health centers, as a check and to provide additional data on long-term absence. With these repeated visits, we expect to carry out some 300 school visits and 300 health center visits in each jurisdiction, which should provide several thousand observations of presence/absence for individual providers and all of the necessary facility-level correlates.

Our power calculations suggest that this number of observations should give us estimates of the absence rate that are sufficiently precise. Based on a sample of data from the Kenyan pilot, we have looked into the correlations at the school and geographic division level. We found that given these correlations, the number of observations should be sufficient to investigate cross-jurisdiction variation in approaches and results. Standard errors at the teacher level were below 1 percent, and at the school level they were below 1.5%. Even with the smaller sample size at the district level, the teacher-level standard errors were below 3 percent. There is obviously a trade-off between additional observations per country and additional countries; we believe that the balance of this level of precision and the number of states/districts is the appropriate one, given resource constraints. This is especially so given that many Indian states are the size of countries, so that India alone will add twenty country-size jurisdictions to our study.

Rationale for repeat visits

Having multiple observations over time for each facility will help us determine whether absences are concentrated among a few teachers and health care workers, or are more spread out among a broader set of workers. This information could help shape policies. For example, a 10 percent absence rate could arise because all workers are absent 10 percent of the time, or because 5 percent of workers are ghost workers who never show up while the majority are rarely absent. In this case, policies targeted at the ghost workers would not make the majority of teachers feel threatened. On the other hand, if all workers are absent 10 percent of the time, the policy implications will differ. Repeat visits will help us understand which approach to solving the problem will be most promising.

The study will yield information on the extent to which the problem is concentrated in particular facilities. If it turns out that some schools account for much of the excessive absence problem, while others have relatively minor problems, then programs targeting problem schools could go a long way towards addressing absence.

Because much basic information on teachers and health care workers will have been collected on the first visit, we will not need to collect as much information on the second and third visits. Nevertheless, the second visit will not only improve the accuracy of the estimates of the absence rate, but also allow collection of detailed individual-level data from teachers who were absent at the time of the first visit. With this data, we will be able to obtain much richer insights into the question of who is absent and why — detail that would be lacking if we surveyed only teachers who were never absent. By combining this information on individual- and facility-level correlates with institutional information collected at the level of the jurisdiction as a whole, we will be also able to assess which policies and institutions have the greatest effects on absence rates.

Products

This project will yield several products:

- A final global paper on absence and its correlates, with a focus on institutional structures and policies that seem to promote higher attendance levels, to be written by the core team
- A section in the World Development Report, also written by the core team
- Country-specific reports on absence for a number of the sample countries, written in collaboration with local researchers
- Papers suitable for dissemination through academic journals

Dissemination Strategy

Wide dissemination is essential to the success of this project, probably even more so than with many other research projects. One objective of the project is to provide data that will raise the salience of the issue in key low- and lower middle-income countries, to increase public awareness and build a constituency for change. Clearly, this will not happen if the findings are known only to a small group of education or health experts.

Dissemination of the findings of this report will proceed along two tracks:

1. Dissemination as part of the WDR: The World Development Report obviously offers a great opportunity for broader public awareness-raising about the problem of absence and possible solutions. Assuming that the surveys reveal interesting results, the findings will figure prominently in the WDR, and will be disseminated along with the rest of the report through various vehicles:

- The WDR team will share the draft WDR in a broad *Web-based consultation* in February and March 2003, by which point some early findings should already be in the report. This should raise awareness of the findings among interested groups.

- *WDR team members* — especially the co-directors, Shanta Devarajan and Ritva Reinikka — will travel to various parts of the developed and developing world to disseminate the findings of the WDR in the months after its release.
- *Senior Bank officials*, including chief economist Nick Stern, will publicize the findings of the WDR and this study in their speeches and policy dialogue.
- Past experience suggests that the WDR will get *wide media coverage*. Indeed, the coverage may be even heavier this year, because this WDR covers well-defined, concrete topics (including health and education) that figure prominently in the everyday lives of newspaper readers and radio and TV audiences.

2. Stand-alone dissemination of this study: In addition to this WDR dissemination, which will likely be a very effective way to get broad-brush results out into the public view, we will carry out more in-depth dissemination efforts aimed at policymakers and experts in this field. This will take several forms:

- *Policy dialogue in the survey countries:* Carrying out this survey requires the approval of health and education ministries, so ministry officials will be involved in the process even before any data is collected. In many cases, they are eagerly anticipating the results; for example, Indian officials expressly requested that Gujarat be included in the survey, so that they can gauge the effectiveness of the experiment with 3-year--term teachers. In Ethiopia, the results will inform the public expenditure review scheduled for next summer, and in Uganda, the extensive contacts of one of the WDR co-directors will help to ensure that the findings affect policy. In each country, we will report back to ministry officials on the findings through an individual country report.
- *Dissemination through Bank country teams and networks:* In each of the survey countries, we will be coordinating with the Bank country team, as we have already done in the pilot countries. As participants in the process, country team members will feel ownership of the results even before the study is released, and will be well positioned to disseminate results through their own policy dialogue and program/project work. Because one of the WDR co-directors is also chief economist for the Human Development Network, there is a natural link with HD and a vehicle for ensuring that results inform Bankwide HD approaches.
- *Global conference:* We plan to hold a one-day global conference aimed at senior policymakers in health and education from the nine survey countries, as well as researchers, NGOs, and donor representatives. The conference would highlight the provider absence results, but would also focus on working through the possible solutions suggested by the research. Given the South Asia focus of the study, we propose to hold it in Delhi in August 2003; we would consult with DFID and other Bank staff on the participants for the conference.
- *Other dissemination efforts:* In addition, members of the core team will present their findings through seminars at universities and research institutes in both developed and developing countries. Findings will be disseminated through the heavily visited

World Bank research website, as well as the e-mail research newsletter that goes out to thousands of subscribers.

Implementation Team

The Washington-based team will be comprised of Nazmul Chaudhury, Economist, World Bank; Jeff Hammer, Lead Economist, World Bank; Michael Kremer, Professor of Economics, Harvard University and Consultant, World Bank; and Halsey Rogers, Senior Economist, World Bank.

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