Appendix B. Field- and Desk-Based Case Studies

Summaries of Field-Based Case Studies

BANGLADESH

Maternal and child health (MCH) has been a longstanding priority of the government and is the core of its health investment. Likewise, the government has long focused on increasing the coverage of basic education, which now includes preprimary through five-year old kindergarten. While immunization rates are high and the prevalence of traditional childhood diseases has decreased, children suffer from significant rates of malnutrition—with stunting at 41 percent in 2011 for children under the age of five. Mortality rates have declined from 88 per 1,000 live births in 2003 to 53 in 2011, and Bangladesh appears to be well on track to meeting most or all of the Millennium Development Goals related to early childhood development (ECD) by 2015.

The government’s multisectoral strategies, such as the National Children Policy (2011), typically summarize existing objectives and ongoing programs rather than provide a framework for developing new policy or approaches. In practice, the focus on children is addressed on a sector-by-sector basis with little coordination across ministries. As a result, initiatives that should involve more than one sector are often located within a single ministry. Given difficulties in trying to coordinate across ministries, neither the Bank nor other development partners have worked toward breaking down these silos.

The Bank’s main instrument to support to ECD is through two large sectorwide approaches (SWAPs), one for health, nutrition, and population and the other for primary education. These SWAPs are large, multi-donor programs that support a sizable percentage of investments in a given sector. Development partners typically agree that most or all of their financing and support will operate through these programs. As a result, coordination among development partners within a specific sector is high, and there few areas of overlap.

In generally, both SWAPs and other Bank-supported interventions tend to rely on geographic targeting. This follows the government’s long-standing focus on rural areas. While Bank support is generally for a national program, rural areas generally receive investment first, such as the community clinics and the expansion of preprimary education.

The first SWAP, which covers the health, nutrition, and population sector, was established in 1998 and is now implementing its third program, the Health Sector Development Program (2011-2016). It provides financing to most aspects of the sector...
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FIELD- AND DESK-BASED CASE STUDIES

and is supported by 16 development partners. Virtually all donor support to the health sector is organized through the SWAP.

Under the current model, the World Bank coordinates most of the SWAP’s development financing and plays a significant role in most knowledge work in the health sector and MCH. A recent Project Performance Evaluation Report by the Independent Evaluation Group (IEG 2014a) of the SWAP from 2005 to 2011 shows that the program, with substantial Bank support, made an important contribution to reducing both the child mortality and the maternal mortality rates. Among other interventions, the SWAP promoted the use of maternal vouchers to increase access to antenatal care and deliveries attended by health care workers. More recently, the SWAP has increased support for community clinics, which aim to increase the access to basic health services at the local level.

While the Bank has provided substantial support to address nutrition since the 1990s, its approach has changed over the past two decades. While successive country assistance strategies (CASs) have identified childhood nutrition as a challenge, the sector ownership has gradually changed. Earlier CASs have made references to nutrition as a health issue (with the domain of the health sector) that requires support from other sectors. The current CAS views it more as a multisectoral issue requiring a broader approach. Most support to improve child nutrition has been channeled through the Ministry of Health and Family Welfare, and the ministry is attempting to end self-standing nutrition programs and to mainstream nutrition interventions through the public health system. There has been little improvement in the nutritional status during this period, and IEG evaluations of both stand-alone projects and the health sector SWAP (2004–2011) argue that the World Bank has made little or no contribution to reducing child malnutrition (IEG 2014b). Recent analysis has suggested that the high rates of malnutrition in Bangladesh and other South Asian countries are associated with factors that are outside the traditional purview of the health sector, such as limited access to clean water, poor introduction of complementary foods to infants, and a lack of dietary diversity.

While the Bank has supported a good deal of analytical work in the health sector, most of it has focused on health system issues with little directly focusing on child health and nutrition issues. More recently, the social protection and labor sector has carried out pilots and evaluation of cash transfer systems that improved the nutritional status of children (World Bank 2012a).

The CAS does not make any explicit mention of early childhood education, either as an issue or as part of the program. Overall, Bangladesh has had a strong focus on improving access to primary education sector, which includes preschool education. As
the primary enrollment rate has increased to a point where virtually all children enter primary school, the government has increased its focus on expanding preprimary school. Prior to this initiative, the government, nongovernmental organizations (NGOs), and the private sector offered a patchwork of preprimary education with coverage that was believed to be low.

Both on its own and through the SWAP, the World Bank played a major role in supporting the expansion of preprimary education. The primary education SWAP is providing financing to support the production of material and teacher training; it is also supporting the construction of new preprimary classrooms. Development partners have agreed with the government that priority should be given to poorer areas with the greatest deficit in coverage. In addition to its role within the SWAP, the Bank has been quite active as an advocate for early childhood education. This includes working with the government and NGOs to develop a common approach to preprimary school that incorporates lessons from both types of providers. The Bank produced a number of policy notes discussing options for preprimary education and has remained quite active in the implementation of the preprimary expansion.

The government’s ownership of a particular policy initiative is the main determinant of sustainability and scaling up pilot initiatives. This happened both with preprimary education and the expansion of community clinics, which have strong government support. Since most development support is provided through SWAPs focusing on large government programs, development partners tend to facilitate this and generally put the government in the driver’s seat.

Ghana

Despite substantial progress over the last 10 years, children in Ghana face considerable threats and perform poorly across a number of indicators. In 2008 under-five and infant mortality stood at 87.4 per 1,000 live births and 61.7 per 1,000, respectively, with inequities persisting across income quintiles. Though under-five mortality in Ghana is below the regional average, this gap has been narrowing due to below average progress in recent years according to the results of the Demographic and Health Surveys (DHSs) of 2003 and 2008. The predominant cause of death for children under five is malaria (19 percent), followed by prematurity (14 percent) and birth asphyxia (13 percent). Mosquito net use has increased markedly by the poorest quintile of the population. Use of insecticide-treated bed nets by children and pregnant women of the poorest quintile has increased from 6.9 percent and 5.2 percent in 2003 to 30.6 and 37.6 percent in 2008, respectively. Mosquito net use tends to be higher among the poorer quintiles, reflecting a targeted push to underserved regions by development partners (World Bank 2012b. There remains a large gap in the use of skilled birth attendants (SBAs) across income quintiles. In 2003 only 20 percent of the poorest quintiles were assisted by a SBA
compared to 86 percent of the wealthiest quintile. In 2008 the poorest quintile has stayed much the same at 24 percent while the richest quintile has improved significantly to 95 percent according to the 2003 and 2008 DHSs.

Given Ghana’s level of economic development the percentage of stunted and underweight children is very high. Inroads of the bottom quintile have been made from 45 percent and 26 percent in 2003 to 33 percent and 18 percent in 2008, respectively. Though the wealthiest quintile performs better at 16 percent and 8 percent in 2003 to 16 percent and 10 percent in 2008, figures remain quite high indicating that malnutrition continues to be a concern even for the wealthiest share of the population.

Enrollment in preschools and kindergartens has increased significantly since the government included it as part of its mandatory basic education program. Gross enrollment has increased from 49 percent in 2003 to 99 percent in 2012. The net enrollment rate increased from 19 percent to 64 percent in 2012. These results, however, are not supported by an increase in the budget for preprimary education. The preprimary share of the budget preprimary was reduced by almost a full percentage point from 3.8 percent in 2008 to 2.9 percent in 2011. Anecdotal evidence suggests that quality has suffered due to lagging capacity and supplies. In 2008 when kindergarten was introduced into basic education, 75 percent of the 37,700 kindergarten teachers found themselves as unqualified. This has improved marginally to 65 percent of 42,417 teachers in 2013, according to sector performance reports from the Ministry of Education.

Registration at birth has increased substantially from 44 percent to 71 percent between 2003 and 2008. In 30 other sub-Saharan African countries with survey data for a similar period, progress in the registration of children younger than five years was slow. In these countries, the average registration rate was 53 percent in 1999–2003 and 49 percent in 2004–2010, with only a few countries making notable progress. In comparison Ghana stands out positively, according to the 2003 and 2008 DHSs.

The government of Ghana was the first to ratify the United Nations convention on the rights of the child and has since developed a comprehensive Early Childhood Care and Development (ECCD) policy and interministerial coordinating committee based on an understanding of internal obligations to ensure the survival, growth, development, and protection of children as envisaged in Ghana’s constitution of 1992 and the children’s act of 1998. An ECCD coordination body was initially set up under the Office of the President and had very high level support. However, after a change in administration, a Ministry for Children and Women’s Affairs was set up, and ECCD was placed therein as a separate department and later migrated to the Ministry of Gender, Children, and Social Protection. This has diminished the visibility and priority given to ECCD. The
World Bank was absent during this transition period. The coordination body appears alienated without access to finance or sufficient political capital to provide stewardship across stakeholders.

The World Bank has supported young children in Ghana through a variety of avenues over the last 10 years. Its recurring health and nutrition portfolio was supplemented by a series of Poverty Reduction Support Credits (PRSCs). The Education sector supported preprimary education since this was incorporated into the government’s basic education agenda in 2008.

Bank support in the health sector in the early 2000s was in the form of national budget support where the World Bank channeled its financing through the Ministry of Finance, which transferred it into an earmarked health account that was pooled with funds from other donors to support the Ministry’s Program of Work. Though the package of priority health interventions was not targeted explicitly to children, they were intended to be substantial beneficiaries of the program. In addition to the sector budget support operation, the World Bank supported the health sector through a series of PRSCs that contained triggers on child health, immunization, facility deliveries, health insurance enrollment (access to basic health package), and under-five malaria mortality rates. Since 2008 the Bank’s support shifted from budget support in health to more direct project investment lending, giving it greater control over project implementation. The two operations approved in 2008 and 2014 finance a community model with community health workers and volunteers providing a platform where essential services are delivered. This includes growth monitoring and promotion; promotion of breastfeeding and complimentary feeding; management of acute malnutrition; promotion of child spacing and contraception; hygiene promotion; promotion of postnatal care; and iron supplementation. Health workers and volunteers provide essential services at the communities where possible. Other donors were able to use this platform to increase reach of malaria nets, immunization, and treatment of severe and acute malnutrition.

Since 2012 the World Bank manages a Global Program for Education Project which has a component on district and school grants for basic education, which includes preprimary facilities. Activities include, the provision of instructional materials and learning inputs, school furniture, mentoring and coaching opportunities for teachers, training based on need, guidance and counseling system for girls, child-centered activities, library materials, equipment or tools (e.g., information and communications technology) to improve teaching and learning, minor works to refurbish classrooms or build latrines, and school-level reading competitions. As support is for the government’s Program of Work in general, it was not possible to separate out preprimary from general basic education.
World Bank support in these fields is aligned with the associated country partnership and assistance strategies. Child survival is a common theme across the partnership strategies, which appears to be driven by a focus on the Millennium Development Goals (MDGs). In 2000 child survival indicators such as under-five and neonatal morality rates were included as progress indicators in health. The CAS 2008 has a human development and basic services pillar, with a focus on the health PRSC series that includes prior actions on child survival and health system performance. Access to health services is part of the pillar on “protecting the poor and vulnerable” in the 2014 CAS. Nutrition is discussed alongside child survival and health. In 2000 for example child malnutrition is taken as a performance indicator in health while in 2008 a key health intervention proposed is vitamin A supplementation. The 2013 country partnership strategy (CPS) discusses community health and nutrition interventions to be delivered jointly. Though support to basic education is discussed across the documents, support to early childhood or pre-preprimary primary programs is not. None of the three country partnership strategies discuss or conceptualize the development of the child, and support to young children is treated sectorally and reach different aims. In the 2013 CPS for example basic education and agriculture are mentioned within the context of improved competitiveness and job creation. Nutrition and health on the other hand are part of the pillar focusing on protecting the poor and vulnerable.

The design of projects is largely based on technical, operational, and institutional lessons derived from similar previous projects (e.g., health), projects operating in a similar setting (other community-based projects in Ghana), evidence generated in the Region, and best practice notes. No evidence on ECD was generated in the country, and no regional or international evidence on ECD was drawn on to inform project design. Consequently none of the interventions focus on the process to develop the child. In the early 2000s the Bank provided sector budget support coupled with a series of PRSCs measuring progress against child survival indicators. The 2008 health project is titled “child survival,” which is an adequate reflection of the projects objectives. The follow-up project from this, though integrating health and nutrition activities, also focuses in essence on the survival of the child while district and school grants were made available for preprimary education. The World Bank had an active and versatile program to support young children but did not integrate it as was originally envisaged by the country’s ECCD policy.

The World Bank’s engagement in health and nutrition was well integrated and interventions were delivered to the same child. A community health officer and community volunteers undertake home visits to counsel pregnant women on health and nutrition during pregnancy; teach them to recognize danger signs; encourage them to seek timely antenatal care; adhere to iron and folic acid supplementation and malaria
prophylaxis schemes; ensure enrolment into national health insurance system; prepare the expecting mother for the immediate post-partum issues, including early initiation of breastfeeding, colostrum feeding, and exclusive breastfeeding for the first six months; facilitate facility delivery; and ensure a post-natal visit within seven days of delivery. As part of improved delivery care, community health officers will ensure that new mothers receive a high-dose vitamin A supplement soon after birth, start breastfeeding within the first hour after birth, and facilitate birth registration.

The nature of engagement of Bank staff across sectors was communicative, rather than collaborative. There were no institutional or managerial incentives for task team leaders (TTLs) to work across sectors, and TTLs were already overstretched, which discouraged active engagement with another sector. Additionally, data and most indicators are organized sectorally and are the measure of project success.

The Bank’s engagement with other development partners was collaborative, which was achieved through frequent donor group meetings. The Bank’s support was seen as highly complementary through its support to community platforms via the health and nutrition projects, which acted as a delivery vehicle through which other donors could provide their services. Vaccines supported by the GAVI Alliance, for example, were delivered at the community level. Similarly the Global Fund to Fight AIDS, Tuberculosis, and Malaria, together with the World Bank, the U.K. Department for International Development (DFID), and the U.S. Agency for International Development (USAID), purchased bed-nets and used the community platform to reach out to the underserved populations.

JAMAICA

The priority given to the development of the young child in Jamaica has been reflected in the Bank’s CASs since 2000. The priority relies on robust Jamaican data combined with international evidence linking weak developmental outcomes for children in the poorest quintiles during early childhood to low achievement in primary school, high rates of school attrition and noncompletion, poor psychosocial outcomes, and low labor market participation. The focus on ECD in the 2005 CAS was on the development of innovative programs to support children’s development from birth to three years of age (particularly for children at risk), expand access to day care for children from poor families, and improve the quality of and access to preprimary education for children four- to five-years old. This focus shifts in the 2010–2013 CPS reflecting the design of two projects approved in 2008: the Social Protection Project (SPP) which builds on the 2002 Social Safety Net Project 2002 and targets children in poor and vulnerable families for cash assistance conditional on compliance with health surveillance; and the Early Childhood Development Project (ECDP) which is creating monitoring and early intervention systems to support child development, enhance quality in education and
care settings, and strengthen early childhood institutions. The synergies between the two projects provide a framework for the development of integrated ECD interventions: health surveillance of the young child in the SPP provides the opportunity for monitoring of development and screening for risks utilizing the measures and systems being developed in the ECDP. The quality assurance mechanisms being developed for care and education settings will ensure all domains of child development are supported in improved learning environments. The focus of the new CPS 2014–2017 continues that of CPS 2010–2013, noting highly satisfactory results for the ECDP to date.

The government has put in place a national, cross-sectoral coordinating body for support to early childhood development. The Early Childhood Commission (ECC), established by act of parliament in 2003, advises the minister of education on ECD policy, convenes consultations with stakeholders, coordinates and monitors programs, identifies sources of funding for the early childhood sector, regulates care and education settings (which are predominantly in the private sector), conducts research, and provides public information. The board of the ECC is representative of the ministries of finance, education, health, labor and social security, the planning agency, and community and private sector umbrella groups, and draws on specialist areas of expertise in child development such as mental health, nutrition, and special needs. Although an early childhood policy has yet to be developed, the ECC led the development of the first National Strategic Plan (NSP) for ECD 2008–2013 with support from the Bank through a grant (2006–2008) from the Japan Policy and Human Resources Development Fund (PHRD). The plan sets out five processes for effectiveness in the areas of: parenting; preventive health care; early intervention for those at risk; safe, learner-centered, well-maintained care and education settings; and curriculum delivery—all underpinned by processes for collaborative work across sectors and the use of data in decision making. The Bank provides about one-fifth ($15 million) of the funding estimated as required for implementation of the NSP; the recent Bank approval of additional financing in 2014 provides another $12 million. Selected targets in the NSP are linked to loan disbursements 2009–2013, and new targets have been set for the period 2014–2018 to be supported by the additional financing.

The NSP serves as a coordinating framework for support from donors, international development partners, and national organizations ensuring that (since 2009) the support available is focused on the priority processes identified. The plan’s targets linked to the Bank’s support address the development of tools, systems, and structures. The Bank is the key donor in ECD for both breadth of work supported and quantity of funds committed. This engagement has been built on over two decades of dialogue with the government, support to social policy analysis that included a focus on the conditions affecting young child development, and technical assistance through the Caribbean Early Childhood Education and Development grant of 1996–1999 for
institutional strengthening in ECD led by the University of the West Indies. The outcomes of these areas of engagement have helped raise the profile of ECD in the country. The government undertook a strategic operational review in 2004 (funded by the United Nation’s Children Fund [UNICEF]) of the sectors providing support to young child development that generated the recommendation for a single coordinating body for policy and regulation in ECD. In the same period, the Inter-American Development Bank supported longitudinal research on the status of the preschool child in Jamaica and capacity building in ECD in Jamaica together with six countries of the Caribbean, and supports research interventions in Jamaica in parenting of children from birth to three years of age and tracking the status of a cohort of children from birth. UNICEF continues to provide long-term support to training, maternal and child health, development of parenting policy, and the Parenting Support Commission. The Caribbean Development Bank and national funding agencies have supported construction of care and education settings and practitioner training.

The Bank has long experience in working with Jamaica’s multisectoral planning agency, the Planning Institute of Jamaica (PIOJ), the body that ensures that all relevant sectors are represented in project planning and that work with the Bank is coordinated. All loans to the government of Jamaica are managed by the PIOJ through the External Cooperation Management Division. The role of the PIOJ in supporting the implementation of multisectoral projects constrains any reinforcement of sector silos or potential sector silos. Where there are areas of common interest within projects, for example, the child support component in the SPP requiring compliance visits to health centers, and the monitoring of child development and screening for risks components in the ECDP also operationalized in health centers, the relevant implementing agencies are brought together by PIOJ to coordinate efforts. The Social Safety Net Planning Committee chaired by the PIOJ is a joint committee of the Ministry of Health, Ministry of Education, and Ministry of Labor and Social Security. The committee ensures attention to all vulnerable groups, including children, and the equitable spending of resources including those from the Bank’s support to the SPP (2008–2018).

Despite the significant level of external support, and the coordinated and collaborative effort within the country, there are obstacles to the development of quality interventions for supporting child development. Public health services, free at the point of access, are overwhelmed and have not been able to sustain child development research interventions despite the robust evidence within the country of the effectiveness of parenting support and child stimulation approaches in the first three years of life. Lack of trained, skilled practitioners and stimulating learning environments in day-care centers and community-operated preschools remain obstacles to quality in over 90 percent of settings. The problem of addressing equitable access to quality services and supports to child development in Jamaica is not an issue of
coverage (estimated to be 97 percent); it is an issue of the lack of practitioner skills, specific interventions to support development and resources to establish remuneration levels, and terms and conditions for practitioners to retain them in the services. Direct public financial investment in young child development through supports to public health and education remains disproportionately low relative to investment in the development of older children and young people.

Targeting available assistance is a strategy that has been successfully deployed in the SPP in cash assistance for poor and vulnerable children. The evaluation found there was 38 percent more visits to health care centers for children from birth to six years old directly targeted by the program. The Bank’s support to the ECDP is enabling the functional capability to target to be created. An example of one of the innovations supported by the NSP is the Child Health and Development Passport, a parent-held tool with information and basic screening measures for parents to understand, support, and monitor their children’s development. Other examples include the school readiness tool to assist practitioners to identify learning and development needs of four-year olds, and the screening system for high-risk households that has the potential for assisting the targeting of interventions in health, protection, and education on an integrated and streamlined basis. The process of the inspection of all care and education settings has provided the community operators with a reality check on their standards in health, safety, care, and learning support, assisting them to prioritize improvements on a phased basis and enabling the ECC and partner training agencies to target future training interventions on an actual needs basis.

The Bank completed a report on the System’s Approach to Better Results in Education (SABER) in Jamaica in 2013, noting the considerable strengths in systems building and coverage of services. However, it identified weaknesses in the lack of specific program interventions to support the development of young children from birth to three years old, particularly the poor and vulnerable, and the persistent low quality of care and education programs for children ages three to six. None of the care and education settings had met the standards for registration under the Early Childhood Act of 2005.

The perception of Bank engagement in the design and implementation of the SPP is very positive. The project benefitted historically from Bank support to the social policy analysis project and the social safety net reform process. The step-by-step approach taken to piloting, review, and evaluation generated a confident level of ownership on the ground in the systems and processes being built by the project. Persons involved speak of benefits accrued from capacity built through training, study tours, and high-level engagement with Bank personnel. The perception of Bank engagement in the design and implementation of the ECDP is mixed. The project objective is widely supported, but the design though much admired for its breadth of vision is generally
thought to be not well understood either by the Bank or the country and to be too ambitious for the current resources, capabilities, and capacities of the ECC to implement. A prior assessment of what would work and how it would work was not undertaken for any of the systems and structures being created with project support. Lack of piloting of system components, lack of evaluation of systems during implementation, and lack of capacity of the ECC to manage and coordinate the scale of the project’s operations are cited as the main concerns by persons involved in both design and implementation processes for the project. The project has been restructured twice to ensure more realistic end of program targets. Joint management arrangements with the Ministry of Education for the remainder of the project are planned to strengthen operational capacity. The project’s design relied on the government maintaining the agreed “protected” level of spending on ECD to trigger loan payments; given challenges in the economy, this has not been possible.

KYRGYZ REPUBLIC

There has been considerable political turmoil in the Kyrgyz Republic during this time period. The political situation deteriorated seriously in 2004, and in March 2005 President Akaev’s regime was overthrown. This stemmed from the lack of impact from economic reforms, poor governance, corruption and nepotism, as well as a disputed re-election. In April 2010, President Bakiev was ousted because of authoritarian tendencies, as he had centralized power within the presidency. Protests were fueled by the belief that corruption, nepotism, and misuse of public assets had risen markedly. There was an outbreak of ethnically motivated violence in June 2010. An interim government kept a fragile peace in place and began a process of constitutional reforms. A presidential election was held in October 2011, but then the government was dissolved in August 2012, a new one was formed in September 2012, and political stability began.

Since the country gained its independence, the attention to the health sector and preschool subsector declined because of the general socioeconomic crisis in the country, unemployment, and resource loss from the former Soviet system. The preschool education system shrunk drastically due to the closure of kindergartens owned by collective enterprises and state farms. As a result, there are low preschool enrollment rates in the country. In 2009 enrollment among three- to six-year olds was 12 percent, but this was mainly for the urban population. Only 5.4 percent of the rural population is enrolled in preschool.

Progress has been made in maternal and child health. The rate of infant mortality and under-five mortality have decreased dramatically since 1997. According to the results of the 2012 DHS, the infant mortality rate is 27 deaths per 1,000 live births, while the rate in the past survey were more than twice as high (61 in 1997). Under-five mortality is 31
per 1,000 down from 72 in the last survey period. Nearly all women receive at least four check-ups during pregnancy with institutional deliveries. The main causes of maternal mortality are postpartum hemorrhage, hypertensive disorders, and septic complications. Thus, the main causes of maternal and infant mortality are related to health care quality during pregnancy, childbirth, and post-partum periods.

Water and wastewater service coverage in the Kyrgyz Republic are low by international standards. Only about one-third of the national population of 4.6 million had household connections. Another 40 percent received water from stand posts or water tanks, while the remaining had no organized water service. Because of the poor state of repair of facilities, lack of maintenance, and insufficient resources available for operations, concerns about the reliability and safety of the service are a source of discontent among the population, particularly in secondary and smaller cities and villages. Declining health indicators in the Kyrgyz Republic were linked to deteriorating water supply systems. The incidence of hepatitis A, typhoid, diarrheal diseases, and intestinal infections had significantly increased, particularly in the southern regions of Osh and Jalal-Abad.

The government’s development strategies emphasize well-being for the population and social sector measures to build human capital. While the government has focused across the years on reducing poverty, it has not actively linked ECD into this agenda. The country’s medium-term development strategy notes the deterioration in the health sector and emphasizes that the government will focus its efforts on fair and equal access for everyone, including the most vulnerable, as well as a minimal list of free-of-charge medical services. The National Sustainable Development Strategy presents a vision of improved governance and reduced corruption as a unifying theme and foundation for social development. There is no early childhood development strategy. There is no vision from the government to integrate its work across sectors.

Similar to the government, the Bank has not emphasized early childhood development as a focal area in all of its CPSs. The strategies focused on governance, as cronyism and political corruption stem from inadequate management of public expenditures and services, which have led to political instability since 2005. The strategic goal in the current partnership strategy is to reduce extreme poverty and promote shared prosperity through support for improved governance. No link between early child development and shared prosperity is made in the Bank’s partnership strategy.

The Bank has provided both lending and nonlending support toward MCH, hygiene promotion, and preschool education. In addition, the Bank has conducted country specific analytical work related to family allowances and preschool education, and jointly conducted a study on children’s nutrition with UNICEF. However, with the
exception of the preschool work, which has been financed by grants from the Fast Track Initiative (FTI) and the Global Partnership for Education (GPE), the Bank has not been the implementer or technical leader in areas of hygiene promotion, which is financed and implemented by DFID, and MCH, which is led by UNICEF and the World Health Organization (WHO). The Bank has focused on fiduciary management of the health SWAP and only recently participated in the MCH donor subtable, as its results-based financing impact evaluation has begun.

Through the Health Sector SWAP, the Bank has supported MCH through the State Guaranteed Benefit Package. This package includes prenatal care, antenatal visits, attended delivery, well-child check-ups, breastfeeding promotion and counseling, complementary feeding, growth monitoring and promotion, timely diagnosis of anemia and prescription of iron-containing drugs and folic acid, early detection of hypertensive disorders and timely referral to the delivery, proper monitoring of the fetus, prevention of HIV transmission from mother to child, standard package of recommended preventive services for children under five (i.e., assessment of development, immunization, routine micronutrient, diagnosis and treatment of anemia, oral rehydration therapy, therapeutic zinc supplementation for diarrhea, and growth monitoring and promotion).

The Bank is supporting a pilot to assess the impact that performance-based payments and enhanced supervision have on hospital quality and particular aspects of maternal and neonatal care in randomly selected Rayon hospitals. The evaluation is at the baseline data collection stage, and final results will be several years from now.

Representatives from the Ministry of Education noted their increased focus on preschool education, even though there is no constitutional requirement. Two factors that were reported to “push” to the government were: analytical studies and parental pressure. An institute in the Kyrgyz Republic did analysis of its recent participation in the Program for International Student Assessment (PISA). The country fared poorly on the test, which opened a debate on the quality of education in the country. Analysis of PISA results showed that children enter school much older and fewer of them have preschool experience, in comparison to other participating countries. Lack of school readiness was viewed as a contributing factor to the low PISA scores and “opened up the eyes” of the Ministry of Education. One analytic that the Bank provided to stimulate policy dialogue was a costing exercise of various models and implications to preschool coverage. The Bank also conducted a Benefit Incidence Analysis Study of Preprimary, showing that the wealthy predominantly benefitted. Respondents reported that parents are becoming more vocal about the lack of “free” preschool programs and are making demands on politicians and the minister of education.
Within the Bank’s work there has been more emphasis on child survival and health interventions than child development. “When there are no strategies in place for early intervention, it is recommended to provide families whose children may be at risk of not developing their full potential with information about interacting with their children to support optimal child development” (Engle 2011). Parental education programs or materials were not part of Bank-supported interventions. The data point to low percentages of parents who read to their children (29 percent) or have books in their homes (58 percent) (Engle 2011). Survey data indicated that television is the most influential communication mode in the country, but the Bank has not tapped into this avenue for programming to increase parental knowledge to stimulate their children, change behavior, or increase knowledge. Aga Khan, UNICEF, and the Asian Development Bank (ADB) have done pilot education programs (similar to Sesame Street).

Getting health workers to focus on child development has been piloted by WHO and UNICEF. These agencies have supported “Care for Child Development,” a training module for health care workers to learn how to provide age-appropriate guidance to the caregiver to foster cognitive, language, and socioemotional skills. It stresses cognitive stimulation, caregiver sensitivity and responsiveness to the child, and caregiver affect.

Content related to Care for Child Development has been put into physicians’ guidebook and a pilot training project was done with some health care workers. A process evaluation was done of the pilot, and it found training helped health care workers feel more competent in providing advice on child development. Family members reported doing more stimulation activities with their children, and children had higher scores in communication, gross-motor, and personal-social skills. WHO and UNICEF are working with the Ministry of Health to integrate Care for Development into the Health 2020 Strategy.

The Bank’s main basis of selecting interventions has been government programs (pre-existing or newly established in the case of preparatory program). In 2006 the Ministry of Education introduced a 100-hour school preparation program, which was changed to a 240-hour school preparation program in 2011 with support from the FTI. The coverage of this program increased to 60 percent of children in 2012. In 2014 this program will provide 480 hours (or a full year of school).

Another important part of the Bank’s work has been effectively coordinating and catalyzing the work of other donors. For example, the National Center for Health Promotion conducted health and nutrition work to promote behavior changes, and the Republican Centers were utilized by the DFID to promote hygiene promotion work.
The GPE project has also been informed by the work of the ADB and UNICEF’s community-ECD programs (as well as work done by other NGOs such as Aga Khan), which were influential in showing that community-based models were more financially sustainable, than the government’s state-run kindergarten.

The first FTI project can be characterized as supporting inputs such as books and furniture while the current GPE project has a more comprehensive focus on quality by working on curriculum, design of in-service training program for new kindergarten teachers, pilot inclusive education program (e.g., classes with children with special needs and those without), assessment of children’s readiness to learn, and evaluation of teachers’ pedagogical practices. As well, the Bank’s support through GPE focuses on those without access to state kindergartens.

All planned interventions were implemented, and nothing was dropped. Interventions were not designed to be integrated, except for the Bank’s support to state-run kindergartens as it is an integrated program of learning, nutrition, and health services. The Bank has predominantly operated sectorally in its ECD work. Bank staff from specific sectors support the respective line ministry and sectoral interventions, with limited cross-sectoral collaboration.

Donor alignment and coordination is a strong feature in the Kyrgyz Republic with each ministry effectively leading donor harmonization. There are sector tables and a subtable for maternal and child health, but none for early childhood development. The ministry ensures each donor is supporting the government program and assigns specific oblasts to particular bilateral agencies to avoid duplication.

While MCH has been sustained, there is a serious funding gap in the State Guaranteed Benefit Package, which presents a serious challenge to the financial sustainability in the health sector. The health sector depends on the resources from the SWAP, and donors will continue to fund the sector as the country has limited resources. State-run kindergartens and the preparation program have been sustained by the government, partly through a reduction in secondary teachers’ hours.

**MOZAMBIQUE**

Children in Mozambique are exposed to considerable risks. The most recent data from a Multiple Indicator Cluster Survey (MICS), conducted in 2008, estimates under-five mortality at 157, which compares to 113 for low-income countries (World Development Indicators). Deliveries were assisted by SBAs in only 20 percent of the cases, with a large divide by income quintile (i.e., lowest income quintile were 8 percent and highest 50 percent). Malnutrition is prevalent. A 2010 population survey estimates malnutrition at 45 percent, with a low of 25 percent in the Maputo region and 56 percent in Cabo.
Delgado. Sixteen percent of children are born with low birth weight, and breastfeeding rates are poor with only 37 percent of children being breastfed from birth to five months of age, which is the official WHO recommendation. Though registration at birth is mandated by law, only 31 percent of children under five are estimated to be so, with a rural–urban divide of 39 percent and 28 percent, respectively. While 50 percent in the wealthiest quintile are registered, this only holds for 20 percent of the poorest quintile, according to the 2008 MICS. Data on enrollment in preprimary schooling is not available, but based on limited public provision, can be projected to be low. Despite relatively high primary school enrollment rates estimated at 80 percent, only 48 percent of those complete primary school, which suggests poor school readiness.2

The World Bank started supporting activities directly relating to children under the age of five in 2009 following the 2007 CPS, which emphasized support to MCH through facility-based services, outreach, and community-based care. To date the health project trained 1,100 community health workers, distributed malaria bed nets in three target provinces, and procured over 8 million rapid diagnostic tests and 5 million doses of artemisinin-based combined therapy.

An effective presentation of dismal child development indicators that surfaced from a baseline survey of a World Bank supported impact evaluation of a Save the Children program was sufficient to generate interest in comprehensive, multisectoral ECD engagement by the government, which subsequently requested support from the Bank for this purpose. After the government had made its commitment clear, the Bank provided technical assistance for the setup of a multisectoral ECD commission, an ECD strategy, and a detailed operational implementation plan outlining the roles and responsibilities of stakeholders across sectors and all levels of decentralization.

In addition the Bank supported the government through lending. Two additional finance operations were approved providing support for nutrition in the above-mentioned health project and an ECD service package through an additional ECD component for a pre-existing education project. Through the nutrition subcomponent the Bank supports growth monitoring; various promotion activities (breastfeeding, appropriate complementary feeding, use of micronutrient powder); mobilization of pregnant women for antenatal care services (iron folic acid, deworming); provision of zinc tablets and oral rehydration salts solution to children with diarrhea; education on water, hygiene, and sanitation; and immunization. The delivery of nutrition services are contracted out to a third-party NGO, with the government playing a supervisory and quality assurance role. Through additional financing in the education project, the Bank provides financing for a basic ECD services package, which is delivered by an NGO through a community based delivery model, similar in design to the nutrition additional financing. NGOs are responsible for activities including community
mobilization and technical assistance to the community in setting up ECD centers as well as upfront and ongoing teacher training, monitoring of the quality of ECD services, and parenting education. The ECD program contains a curriculum that promotes the development of social, emotional, physical, language, and cognitive areas; seeks connections with health services; and involves work with parents, families, the community, and local government. Payment for NGOs follows a results-based model. Disbursement indicators include number of participating communities, number of preschools operating continuously with at least 80 percent attendance and parenting meetings, and number of preschools with a satisfactory quality rating. In addition technical and institutional capacity building support at the central, provincial, and district level is provided, and there is support to assist the Ministry of Education with oversight over the results-based disbursement framework.

Many design features of the small-scale Save the Children program were incorporated into the Bank’s ECD program. Adjustments were made to incorporate the stipends of teacher, as requiring communities to contribute toward stipends proved unsustainable after the Save the Children funding ended. Other design aspects were innovative in the context of Mozambique such as contracting out services to third-party providers and using a results-based disbursement mechanism, which bears close resemblance to results-based financing projects from the health sector in the Region.

Bank analytic work was considered critical to the policy dialogue and project design. The health study of 2005 largely informed the 2007 partnership strategy and the design of the associated health project. In addition to the presentation of the baseline survey of evaluation of the Save the Children program, the findings of the actual impact evaluation (with strong internal validity) were important for maintaining the political momentum after a change in leadership in the Ministry of Education. Furthermore the Bank is preparing additional analytical work including an impact evaluation of the nutrition and ECD package looking at both programs separately and in combination, a follow-up study on the long term effects of the Save the Children program, and a study on the provision of ECD services in urban areas. The value of these was widely acknowledged by all stakeholders.

Interventions are closely aligned with area of need as reflected by child development data. The health and nutrition interventions are implemented in the poorest provinces with among the worst health and nutritional outcome indicators. In nutrition a donor mapping exercise allocates different partners to different provinces to avoid overlap. For the ECD additional financing, need is a basic criteria for the selection of intervention districts. ECD activities are also implemented in urban areas like the Maputo district, which does not correspond to the highest areas of need. It is a government priority to
include urban settings to cover various demographics and be more representative of the population to better inform a potential national rollout.

The design of operations has gradually increased emphasis on ECD. While the Bank had a disease specific orientation (i.e., malaria and HIV/AIDS) in the earlier part of the 2000s, this has shifted to health sector support in 2007. It has some focus on the health of children under five and eventually complex ECD program that contains a curriculum to promote the development of social, emotional, physical, language, and cognitive areas; seeks connections with health services and the community; and involves pedagogical training for parents emphasizing behavioral change. While activities are now designed to be integrated, they do not yet reach the same child. Nutrition activities focus on the first 24 months, while the preprimary activities reach children of ages three to five. In the medium term this will converge, and children that benefited from improved nutrition will also receive preprimary education. A planned impact evaluation is looking to capture development outcomes of children that received either the nutrition alone, preprimary education alone, nutrition in combination with preprimary, or none of these. The necessitated that the nutrition and preprimary work be designed together.

While it is too early to judge on the sustainability of the Bank’s ECD program, several lessons can be drawn from the experience so far. Requiring communities to contribute toward the stipend of the preprimary teacher proved unsustainable. Stakeholders stressed the importance of the recent approval of an ECD budget for the sustainability of the Bank program. It provides a financing avenue for the government and an opportunity to be strategic about the allocation of funds, and involves the parliament on an annual basis as they approve the budget, which significantly elevates the status of ECD from a donor program to a real national priority.

Mozambique has strengthened interministerial coordination through setting up an ECD commission, committing to an intersectoral ECD strategy, and acknowledging the lead and coordinating role the Ministry of Education is taking as well as managing an ECD specific budget line. Throughout this process, the Bank has played an active role thereby strengthening the government’s effort in all of these areas and helping it to break down sector silos. Examples of the Bank’s work across silos are: preprimary education and nutrition additional financing components were jointly designed to strengthen ECD outcomes across a number of domains; Bank staff from various sectors contributed to the multisectoral ECD strategy; and an impact evaluation involved both the nutrition and the preprimary education interventions (the choice of treatment and control groups required coordination at the design stage as the evaluation aspires to assess the impact of one intervention in the absence of the other). The coordination across sectors was due to the initiative taken by TTLs, rather than institutional incentives.
Bank support was complimentary to that by other partners, and the Bank is part of all major sectorwide and cross-sector coordination mechanism. While the education financing mechanism focuses predominantly on issues beyond the preprimary level, it served as a coordination and communication platform. In nutrition, donor mapping has been conducted, and there is no duplication of activities, though concerns were raised with implementation arrangements where some partners felt they were insufficiently consulted. The health sector is highly populated, and numerous donors provide assistance in the area of MCH. Even though the Bank does not provide its financing through the joint financing mechanism, it is well aligned with the principles of the International Health Partnership. Donor support for children under five is operating in general through sector silos as they either provide vertical program support or finance sectorally oriented basket funds.

**Nepal**

Nepal is a poor country with rugged and remote regions and ethnic and linguistic diversity. Most of the population is concentrated in the Terai (combined 93 percent). The remaining population lives in the remote mountain region. As of 2011, there were 125 castes and 123 mother tongue languages spoken among Nepal’s 26.5 million people. Cultural norms and extreme weather (e.g., monsoons) contribute to malnutrition and food insecurity.

Nepal is one of a few fragile and conflict-affected states that are on track to achieve one or more of the MDGs. It is likely to meet the goals of eradicating poverty and extreme hunger, improving maternal health, reducing child mortality, and achieving universal primary education.³

These gains were made despite civil conflict between 1996 and 2006 and the enduring political instability in its aftermath. Nepal has experienced more than 25 different governments since the change to a constitutional monarchy (multiparty democracy) in 1990.

Health and education have long been priority concerns for successive governments of Nepal. The government’s strategy for 2002–2007 development (the Tenth Plan) emphasized improving basic social services (e.g., education, health, rural drinking water, and sanitation) to reduce poverty and to improve the living conditions in rural areas, as well as to address the root causes of the conflict. These goals have continued into the following three year interim plans.

The Interim Constitution (2007) is based on the vision of an inclusive society and gives all Nepali citizens—regardless of ethnicity, caste, religion, political persuasion, social and economic status, or gender—the right to free basic health services and free
education. Special emphasis was given to mothers and children. Targeting of programs was based on either a high concentration of disadvantaged ethnic minorities or geography. More recently, targeting based on multidimensional poverty, human development, and food security indices was reported.

The People’s Movement reinforced the government’s commitment to social inclusion and the view that basic health and education service is a fundamental human right as well as a precondition for economic growth. The government has committed to improving children’s welfare. It ratified the United Nations Convention on the Right of the Child in 1990 and has put in place policies that should help prioritize and facilitate implementation of early childhood development in the country. The Bank’s Early Childhood Development SABER found varied implementation, poor monitoring, and low quality.

Nepal’s CASs have been based on client demand, generally to leverage results for global initiatives to which it has committed itself; for example, the MDGs. Early strategies (1999 and 2003) reflected Nepal’s understanding that human development was integral for economic development. Health and education goals targeted essential health services and basic education, especially for the poor and disadvantaged. In the CAS for FY14, the Bank broadened its discussion of nutrition activities to those outside the health sector while it narrowed its focus from general education to skills development with no mention of the early childhood education and childcare centers.

The Bank’s support for ECD in the country has been sector driven. Given the government’s preference for the SWAP mechanism, the Bank’s support for early childhood development interventions has largely been on a sector-by-sector basis with limited coordination between sectors. Health and nutrition have been addressed by the health sector and preprimary by the Education sector. An advantage of the SWAP mechanism is that it has helped coordinate donor support in health and education.

The Bank has actively supported government-led reforms in health and education (e.g., Nepal’s National Health Strategy Program I and II and Education for All [EFA] Action Plan) through successive health and education SWAPs. The SWAPs represent the lion’s share of development assistance in health and education (although only a fraction of the government’s total program). The SWAP arrangements have helped build government capacity and harmonize donor support. The major donors participating in the SWAPs include the ADB, Australian Agency for International Development (AusAID), DFID, European Union (EU), the GAVI Alliance, GPE, Japan International Cooperation Agency, United Nations Educational, Scientific, and Cultural Organization (UNESCO), UNICEF, USAID, World Food Programme (WFP), and WHO.
Much of the Bank’s support for early childhood development is in the areas of maternal and child health and nutrition. The Bank supported the national health strategy and its implementation through two health sector SWAPs. The Bank supported the government in developing its Second Long-Term Health Plan (1997–2017) and closely collaborated with the government in preparing the action plans for Nepal’s Health Sector Programs. Analytical work conducted by the Bank identified maternal and child health and nutrition as an unfinished agenda. Under the National Health Sector Program, the government established a package of essential health care services which focused, in large part, on improving maternal and child health and the nutritional status of children and pregnant women. Health and survival were targeted through government programs such as the Expanded Program on Immunization, the Community-Based Integrated Management of Childhood Illnesses Program, the Community-Based Newborn Care Program, the Infant and Young Child Feeding Program, a micronutrients supplementation program, vitamin A and deworming campaign, and the Community-Based Management of Acute Malnutrition Program.

Trends in child health are improving. Sixty-four percent of Nepalese children under the age of five are fully immunized, but 81 percent of one- to two-year olds are fully immunized.

Nepal committed itself to attaining education for all as a signatory of the Jomtien Declaration on Education for All (1990) and recommitted itself to achieving its goal of universal access to basic and primary education by adopting the six goals that EFA introduced in the Dakar Framework for Action (2000). In 2003, the Ministry of Education in collaboration with UNESCO designed an action plan to achieve each of the EFA goals by 2015. As part of the EFA Action Plan, the Ministry of Education (with the support of UNESCO) issued a strategy paper for early childhood development, which recommended a holistic approach to child development including sensory-motor and social-emotional domains of child development, which are areas not being addressed by the government or donors.

In the Education sector, the Bank has supported the government of Nepal implement its Education for All Action Plan (2004). The expansion early childhood development (ages three to five) was a means to achieve the project’s development objective of enhancing the quality and relevance of primary education. In 2010, a follow-on project continued to target the expansion of early childhood education and development centers for children age four. The number of students entering first grade with “early childhood development experience” has reached 60 percent. However, there are weaknesses in the conceptualization, design, and implementation of ECD centers, and government support to ECD centers is minimal. Implementation plans envisioned community-driven partnerships with NGOs, with limited support from the Ministry of Education.
for one to two ECD facilitator stipends. As such, the quality of ECD centers is low (on average) and has not focused on child development as envisioned in the EFA’s core document.

More recent projects are designed as integrated with activities to support nutrition by taking a life-cycle approach to improving nutritional status. Specifically, Sunaula Hazar Din is a community-driven project that provides a set of goals out of which a community can choose the most relevant. The project targets children during the first 1,000 days of life. It also addresses anemia, delayed pregnancy, girls’ school attendance, protein intake, iron and micronutrient supplementation, complementary feeding practices, hygiene, safe drinking water, and sanitation.

The government of Nepal has long recognized the multisector nature of nutrition in its strategic documents. In 2004, the Ministry of Health and Population approved the National Nutrition Policy and Strategy, which recognized the significant role of nutrition sensitive ministries and the benefits of inter- and interministerial coordination in helping to improve nutrition. Yet, little movement toward a multisector solution was made, and health services remained targeted to maternal and child health and survival partly because of the large pockets of poor and under-served mothers and children.

Nepal has been less successful in combating chronic malnutrition. Stunting rates are high—42 percent of the population is stunted with higher rates among children below the age of five and significantly higher rates in remote regions. The largest number of stunted children live in the heavily populated Terai. Food insecurity, poor nutritional diversity, and poor sanitation and hygiene contribute to high wasting rates, especially in the Terai where open defecation is customary.

The World Bank has been heavily involved in country dialogue on nutrition. The donor community is driving the new agenda on nutrition, and the Bank was one of the main donor advocates of a multisectoral approach to nutrition (along with UNICEF, WFP, DFID, and AusAid). Bank analytical work focuses heavily on nutrition. The Bank collaborated in the Nutrition Assessment Gap Analysis (2009), which evaluated the government’s 2004 strategy, identified weaknesses in current efforts, and recommended a stronger commitment to attacking malnutrition multisectorally. The government of Nepal has approved the Multi-Sector Nutrition Plan (MSNP), involving the Ministry of Health and Population, the Ministry of Education, the Ministry of Federal Affairs and Local Development, the Ministry of Agricultural Development, and the Ministry of Physical Planning and Works. It created a high level steering committee on food security and nutrition and an interministerial coordinating committee located in the National Planning Commission to help coordinate ministry activities. It is too early to evaluate the MSNP’s effectiveness.
NICARAGUA

The government’s conceptualization and priority toward ECD has changed over the time period of review (FY00–14), and this has influenced the Bank’s partnerships strategies and the priority the Bank has given to ECD. Prior to 2008 the rationale for investing in ECD was boosting human capital to enhance productivity and income. Attaining the MDGs was also a motivating force for investment in young children. As infant mortality has improved, the CPSs have shifted their focus to child and maternal health. The current partnership strategy (FY13–15) has made an even more dramatic shift, as it strongly emphasizes early childhood development as a means to reduce the intergenerational cycle of poverty, reflecting the current government’s focus on improving social equity and opportunity. While an integrated concept of child development is noted in the Bank’s current CPS, the Bank’s support is described sectorally.

In 2010, the government established an ECD Commission to better integrate and coordinate ECD activities among the Social Security Institute, the president’s office, and the Ministries of Education, Health, and Family. This commission led the preparation of ECD policy, and since this time, the government has placed great importance on early childhood development. The government’s ECD strategy is grounded on the rights of the child as well as a social contract between the state and its citizens for the state to provide health, nutrition, education, child protection and the parents and family to stimulate, nurture, and respect their children. This strategy also emphasizes a coordinated delivery of interventions around the needs of the child and family by the Ministries of Health, Family, and Education and the community. Each ministry has respective responsibilities, but coordination exists at each level (central, department, municipal, and community).

Prior to the government’s ECD policy, a wide-range of ECD interventions such as maternal and child health, nutrition, childcare, and preschool were provided and financed by the Bank and other donors in the country. However, coverage for some interventions were low, and they were not coordinated. Programa Amor para los más Chiquitos was launched in 2011 to implement the ECD policy across the country but permitting regional adaptation. One condition that facilitated the rapid implementation was the centralized political structure within the government.

Programa Amor para los más Chiquitos uses existing programs or services implemented by the Ministries of Health, Family, and Education as well as volunteer brigades of women and youth in every community to provide information about the program; deliver messages to the family so that parents stimulate, care, and protect their children; and develop a registry of pregnant women and young children. Families are provided additional support from the municipal cabinet, social workers, health care
workers, or teachers, depending on the particular needs of the family. The goal of the program is to raise early childhood enrollments and improve health, nutrition, and development of the child through the provision of information to change parental behavior to ensure parents send their children for regular health check-ups and attend school and care and nurture their children. The use of community volunteers is part of the Nicaraguan culture and history, as similar efforts were successfully deployed in the 1980s for the literacy campaigns. Thus, the program capitalizes on volunteer efforts to change parental behavior and raise community consciousness around childhood development. This permits multiple entry points to deliver messages to parents, not just health care workers, as well as provide additional support to pregnant women and children.

Sector loans in health, social protection, and education support the Programa Amor para los más Chiquitos. The Bank assisted the government with development of the model for the program. These single sector projects have become integrated in their delivery because of the implementation arrangements in the country. Thus, projects designed to support one sector can in practice become multisectoral.

With funding from the GPE, the Bank is working to improve education quality in both formal and community preschools. A model, curriculum, and training program have been developed, which is a more systematic approach to building preschool quality, but quality assurance mechanism have not been developed. A consistent weakness at the preschool level has been teachers’ lack of knowledge and training in early learning and child development. Past Bank support focused on scaling up access through low-cost community preschools and provision of inputs. Difficulties were encountered with community preschool teachers, given their low pay (e.g., one-third of a formal teacher’s), which created the need for further recruitment and training of preschool teachers and their replacements, resulting in additional costs.

The Bank’s support to the Community Health Model and Maternity Houses has established a package of MCH services, with access improving over the years. For example immunization rates for tuberculosis and hepatitis B have increased from 80 percent in the early 1990s and now are nearly universal. Over the time period, more attention has been devoted to nutrition and its monitoring. Clear protocols for treating undernourished children are established and implemented, but stunting has only modestly declined from 30.5 percent in 1998 to 23 percent in 2006. Health workers understand the importance of focusing not only on child health and survival, but also on the monitoring of child development, screening for development delays, and the provision of information to parents.
Several Bank loans have supported the school feeding program, which provides a hearty, nutritious meal each day to preschoolers. A transfer program helps at-risk families in 26 municipalities in six departments by connecting them to social workers and a small stipend ($20 month), if they participate in Values School. The curriculum for this program incorporates child development but focuses on topics such as violence reduction and financial literacy, and is aimed at families with children from babies to teenagers.

There are limited data related to ECD. Under the current GPE, an ECD monitoring and evaluation system will be created, measuring the development of Nicaraguan children and assessing mastery of children within its curriculum to support the Ministries of Health, Family, and Education.

All of the projects have targeted poor mothers and children and focused on select municipalities and departments by applying geographical criteria and an explicit measure of poverty. Afro descendants and indigenous populations are the poorest groups in the country and heavily concentrated in particular areas. These groups are exposed to more poverty and have worse access to basic social services, which can be partly explained by the large concentration of them in the two Atlantic coast areas, which are geographically isolated. Thus, Bank projects have focused on these areas as well as others.

Country specific analytics (e.g., impact evaluation, economic and sector work [ESW], technical assistance) informed design elements and specific activities included in projects as well as policy dialogue. Analytics, such as a study of constraints to preschool enrollment, identified parental attitudes as a barrier to enrollment. Information from the SABER pilot was used during preparation to design the current project funded by GPE. A study of the maternity houses identified factors that influenced utilization. Analytics did not have a role in selecting the mix of interventions considered or supported as pre-existing government programs were the basis. Analytics have not examined integrated service delivery or interventions.

The interventions have been sustained and scaled up by the government. This seems to be related to the fact that the Bank has supported pre-existing government programs, and the government has had a great commitment toward maternal and child health and child development. Evaluations did not appear to be a motivating factor for scaling-up or sustaining interventions. Donors are likely to sustain their financing of MCH as long as the government can show progress in health indicators, as Nicaragua is a low-income country. Resources constrain scaling-up of preschool, which in 2010 was 55 percent. Preschool access is predominantly focused on urban rather than rural regions, according to Bank analysis.
Before the government’s ECD strategy emphasized interministerial coordination, each ministry worked separately. Bank staff within the human development sectors have begun to connect their ECD work, but sector support is predominantly provided by the Bank. Factors that have facilitated Bank staff working across sectors are:

- the sector leader and country manager advocate and push for staff to work together;
- country office staff are expected to work across all sectors of the Human Development Network;
- time is put within the staff work plan for cross sector knowledge sharing and work;
- work plans are formalized between staff in different sectors and networks and a budget code is provided for staff in each sector to bill time (not to the project code)
- natural synergies, such as impact evaluation work, public expenditure review, or social sector analysis, are catalyzed.

Cross-sectoral work can only be emphasized to the extent it fits within the project work scope, as the demands of the project are what fill the time of Bank TTLs. Collaborative work opportunities were limited, even if possible synergies could be beneficial. For example, connecting hygiene activities with health and education sector work has not been pursued.

Nicaragua receives about 30 percent of its budget from overseas development assistance; however, foreign aid in the social sectors has declined from $280 million in 2007 to $30 million in 2011. The country has been spending more on social services by limiting resources devoted to security and justice, and is improving its revenue flows. Even with effective macroeconomic management, the country will need external financial support to fully implement the Programa Amor para los más Chiquitos, as it is a low-income country. The government is currently developing an operational plan and budget to implement the ECD policy. Thus far, the Bank has not had a role in providing technical assistance to develop a medium-term operational plan and budget, identifying financial shortfalls.

The government has recently established an Intersectoral Donor Table related to early childhood development where all three line ministries participate as well as other donors. However, this subtable is not yet functioning, and coordination relies on the sectoral tables. While the government has made strong efforts to align the work of donors to focus on its priorities, it has emphasized bilateral coordination. Even though few donor organizations are present, coordination relates to sharing of information rather than harmonizing and establishing synergistic relationships. In previous years,
common work programs had been established. Global partnership programs such as the GAVI Alliance and GPE focused on funding specific sectoral interventions. Thus, conditions limiting the effectiveness of coordination related to both the government and institutional cultures of each donor organization.

**VIETNAM**

Vietnam has performed well in raising the living standards of children and is on its way to achieving the MDGs. Specifically the child mortality rate decline from 58 per 1,000 in 1990 to 27 in 2005 and to 23 in 2012. The maternal mortality rate declined from 233 per 100,000 in 1990 to 80 in 2005 and to 64 in 2011. Likewise, child malnutrition (wasting, under age five) declined from 41 percent in 1990 to 24 percent in 2005 and to 17 percent in 2011.

Vietnam has a strong and long-term commitment to children and early childhood development as demonstrated by its long-term focus on MCH interventions. While there is a broad understanding of ECD as an integrated concept, there is little cooperation among ministries. Sector silos are strong in Vietnam, which each ministry and program working on its own. The government has high level strategies, such as the Socioeconomic Development Plan of 2011, that include a focus on children as part of its overall goals (for example, the MDGs). While these goals require intervention from different sectors, there is no attempt at integration. The Bank has not played any role in strengthening interministerial coordination. While the Bank does not presently have any projects that focus specifically on ECD as an integrated concept, several have included child-related themes.

Vietnam is increasingly sophisticated and is in the driver’s seat in making policy. The most recent CPS (2012–2016) made no mention of children’s issues in the diagnosis of development challenges. The CPS included improving access to ECD as part of its social protection subpillar (“3.1. increased opportunities for the poor and household resilience to shocks”). There was no direct mention of ECD or childhood issues in the pillar related to health and education (“3.2. improved basic infrastructure and public sector delivery issues and access”).

Although the Bank is active in the education and health sectors, its support for ECD is primarily in the Education sector through a new project that supports the expansion of the preprimary education system. The Bank’s support for health focuses on secondary hospitals, which do not explicitly target children. However the Bank did finance pediatric and maternal units as well as training related to children’s health. The Bank is beginning to support nutrition through a rural development program in one of the poorest regions in the country—the Northern Uplands. The Northern Uplands has a high proportion of ethnic minority groups as well as a low level of human
development, including a high level of malnutrition. In social protection, the Bank has focused on improvement of targeting and the poor. The Bank is piloting cash transfers in poor provinces that will support parents with young children among other groups.

The World Bank developed and administered a holistic ECD project (financed by a trust fund from 2005 to 2008) that was implemented by an NGO in several provinces. This project was administered in coordination with local governments. After the trust fund project closed, its lessons proved important for the Ministry of Education and Training. The government proposed a follow-on program to expand the coverage and quality of preprimary education.

However most ECD activity is carried out on a sectoral basis, and the Bank’s support in ECD is quite focused. The Bank has generally worked within the context of these sector boundaries and has made no attempt to break down these boundaries. Within the Bank, there is little cross-sectoral collaboration. This largely reflects the government’s structure, which leads to little opportunities for cross-sectoral collaboration.

The government’s policy, which is supported by the Bank’s project, focuses on preparing children for school and developing capabilities (for example, improving nutrition and fine motor skills as well as other capabilities). The government policy has led to near universal coverage at age five and a high level of coverage in earlier years. The Bank reports that coverage for children at five years of age was 99 percent in 2014, with 80 percent enrolled in full-time preschools. Estimates suggest that the overall enrollment for ages three to five was around 90 percent in 2008. The Bank provides budget support to the preprimary program by reimbursing certain budget lines. The government program focuses on improving pedagogy and the quality of facilities and equipment. It uses a revised curriculum that is designed to be child centered.

Because of government policy, there is little or no collaboration among development partners in financing projects in most sectors. Donor support is fractured with little coordination or collaboration among donors. Only the World Bank, UNICEF, and NZAid are involved in preprimary education, along with some international NGOs (notably Save the Children and World Concerns for preschool children with hearing impairments). In the health sector, most donors have a similar program as the Bank’s, with a focus on hospital and higher level training (for example, the ADB) or on specific diseases (e.g., USAID with HIV/AIDS). Several NGOs directly support efforts to promote child nutrition.

The Bank has not carried out any analytical work focusing exclusively on ECD. Some analytic and advisory activities have included aspects of it. The Bank has worked closely with different partners on analytical work. This included several technical
documents that included some discussion on child development, including the poverty assessment (supported by the United Kingdom, Ireland, the European Commission, and several UN agencies) and the education report (financed by Belgium and the United Kingdom).

**Summaries of Desk-Based Case Studies**

**BULGARIA**

Bulgaria is an upper middle-income country in southeastern Europe. It has a population of 7.3 million and a gross domestic product (GDP) per capita of $7,283 (2011). Bulgaria is ranked 57 in the United Nations Human Development Index (2012), with an infant mortality rate of 8.5 deaths per 1,000 live births and a child mortality rate of 10 deaths per 1,000 live births—both of which are more than double the rates of Western European countries but lower than similar Eastern European such as Romania. Despite steady economic growth in the last decade, persistent pockets of poverty and uneven living standards remain particularly for disadvantaged groups.

Poverty and social exclusion have been associated with low levels of education and large household size, and is heavily concentrated among ethnic minorities, particularly the Roma. Although a wide range of early childhood development services are available in the education, health, nutrition, and social protection sectors for pregnant mothers and children from birth to seven years of age, there are significant disparities in access. Data indicate a poverty rate of 47.5 percent for Roma households compared to 4.9 percent for ethnic Bulgarian households (2007); 55 percent of Roma have completed eight years of schooling compared to 95 percent of ethnic Bulgarians (2007); 20 percent of Roma children under seven attend preschool compared to 60 percent of ethnic Bulgarians (2003). The Roma population is estimated at 800,000, which is about 10 percent of the total population.

The public childcare and child protection system in Bulgaria was dominated by the practice of institutionalization with the highest rate in all of Europe in 2001. This has been partly due to lack of early interventions (for children with special needs or families in crisis) and inadequate diagnosis of needs. The institutions themselves have been marked by poor conditions, leaving children unable to integrate effectively in society upon reaching the age of 18.

As part of its preparation for European Union (EU) membership (achieved in 2007), Bulgaria undertook concerted efforts to reform the child welfare system and address social inclusion challenges for the poor and Roma populations. These efforts focused on policy and legislative reforms as well as delivery of social services that aim to equalize
starting conditions for all children. The government took steps to establish a solid legal framework for the protection of children’s rights and the continued provision of early childhood development services.

It is against this backdrop that the World Bank partnered with the government to implement a Child Welfare Reform Project (CWP) in 2001. The project’s objective was to improve child welfare and protect children’s rights. The intent was to change the existing practice of institutionalizing children by developing community-based alternatives including day-care and preschool programs. The project also helped to establish the government institutions responsible for implementing the new child welfare reform strategy. The project design drew heavily from background reports, including a social assessment in which over 1,000 children, 1,000 mothers or caregivers from disadvantaged families, and 500 institution staff were interviewed. The project design reflected the need for a targeted approach to ensure disadvantaged populations could access social services. There was extensive collaboration with development partners including the United Nations Development Programme, UNICEF, and the EU. The EU, in particular, was a key partner in co-financing the policy development and capacity building aspects of the project. The overall approach was marked by the promotion of human capital development among disadvantaged children so that they could become future productive members of society.

The project activities were mostly implemented, including the establishment of the State Agency for Child Protection and the operations of community support centers (which provided basic services and counseling). However, there were significant implementation delays from political changes in the government and shortfalls in the provision of counterpart funding. The project period was extended by two years and closed in 2006. Although project data showed a 27 percent decrease in the number of new children being institutionalized and an 18.2 percent decrease in the total number of institutionalized children in project areas, outcomes with regards to actual improvements in child welfare and protection were not reported.

Following on the Child Welfare Project, the Bank partnered with the government to implement a Social Inclusion Project (SIP). The objective of this project was to promote social inclusion through increasing the school readiness of children below the age of seven. The project aimed to develop integrated preschool programs in targeted communities in order to provide poor and minority children with an opportunity to have an “equal” start in primary school. The project design was highly consistent with government strategies for social inclusion of the Roma. It again reflected extensive collaboration with the EU, this time directly leveraging EU financing for subsequent phases of the program. The overall approach was marked by the improvement of school
readiness among disadvantaged children so that they could overcome social exclusion challenges and become fully integrated into society.

However, similar to the CWP, the project experienced significant implementation delays and was restructured and extended for two years until 2015. To date, the project has completed civil works for the service facilities, but service delivery has not yet been initiated. The results framework was significantly revised partly due to methodological constraints in collecting data on “cognitive development,” “malnutrition,” and “quality of parent-child interactions.” Instead of comprehensive surveys measuring these indicators, a simplified school readiness diagnostic test was given to a sample of the project population as the baseline evaluation in 2012.

Bank support has been highly consistent with the government reform policies, and the lending activities have provided important short-term support to the government in solidifying its child welfare reform and social inclusion agendas. This is noted as an institutional outcome for the CWP at the local level, as “the municipalities’ willingness to effectively collaborate has increased significantly during the project implementation (as acknowledged also by representatives of the NGO sector) which made possible the completion of the community support centers.” The Bank’s country partnership strategies over the review period and ESW have addressed ECD only to a limited extent; however they have provided consistent messages on the importance of investing in early childhood interventions for targeted disadvantaged groups as a means of social protection. Overall, the Bank’s support to the government has been narrowly focused on a social protection approach, but it has been consistently delivered through both lending and analytic and advisory activities as well as in the country partnership strategies. There have been strong collaborative relationships developed with donor partners, namely the EU.

The project interventions have incorporated integrated approaches to a limited extent, primarily through preschool education programs that provide basic health screening, supplemental meals, and targeted income support to poor families (i.e., kindergarten fee reduction, free transportation). As noted in the SABER-ECD report for Bulgaria, “the relevant government institutions engaged in policy making do not yet fully recognize the concept or the need for a comprehensive and integrated ECD system” and thereby, the government has no explicit ECD strategy or intersectoral collaboration mechanism.

A notable shortcoming is the limited data on the effectiveness of the Bank’s early childhood interventions for Bulgaria’s disadvantaged populations. Although the Bank project designs have drawn heavily from background assessments and reports (both Bank and non-Bank) as well as from international evidence on the effectiveness of early childhood interventions on lifelong outcomes, there has been no comprehensive, formal
analytic work produced by the Bank with country-specific ECD data or evidence. The one completed CWP project did not provide adequate outcome data. The ongoing SIP project had initial shortcomings in the results framework, the indicators of which were revised in a project restructuring; meanwhile, the service delivery component of the project is scheduled to begin in September 2014 and will provide only one year of services before the project closes. Attention to ensuring service quality is also inadequate; while the Bank has helped to develop training and service delivery standards, there have been a lack of indicators to monitor quality assurance or project interventions to enforce adherence to standards.

**Ethiopia**

Ethiopia has shown significant progress in human development indicators since the late 1990s. Child mortality declined in half, the number of people with access to clean water has doubled, and primary school enrollment has quadrupled. The poverty headcount has declined from 46 in 1995–1996 to 29.6 in 2010–2011. Overall, Ethiopia has attained high economic growth at 10.7 percent per year and is projected to reach middle income status by 2025 (World Bank 2013). Its overall economic growth is dominated by agriculture, but only 10,556 hectares are under cultivation, and about 45 percent of its landmass is arable. Ethiopia continues to depend on external donor funds to sustain progress and stabilize imbalances.

Ethiopia achieved decentralization of its governance system by delegating authority and responsibilities to regional state, woreda (district), and kebele (village) governments. Politically, since the aftermath of the 2005 election, Ethiopia has stabilized. However, border tension with Eritrea, the continuing political instability between Sudan and South Sudan, and Islamic fundamentalists in Somalia make Ethiopia prone to outbreaks of conflict. The regional political instabilities contribute to localized conflicts and affect delivery of basic services in the most vulnerable parts of the country. As well, Ethiopia’s public health expenditure has fluctuated throughout the last decade; from 8.9 percent in 2000 to 13.1 percent in 2007 to 11.1 percent in 2012, coming short of the target set during the 2001 Abuja declaration to allocate at least 15 percent of the government’s annual budget to the health sector.

Three CASs and CPSs have been produced during the period under review. The Bank’s support for early childhood development is in close alignment with government’s Health Service Development Plan (HSDP I–IV). Some of the ECD interventions that are noted in partnership strategies are counseling on adequate diet during pregnancy, micronutrients and fortification, parent support programs, antenatal visits, malaria prevention, immunization, supplemental feeding, growth monitoring and promotion, and training for service providers. The Bank’s support is sectorally based with the intent of attaining the MDGs. In the early 2000s, the Bank mainly supported HIV/AIDS
and nutrition interventions. Recently, the Bank has shifted its focus to MCH. A similar pattern is also observed in the Bank’s analytical work.

Project interventions focused on maternal and child survival rather than child development; beneficiaries included mothers and children under the age of 16. Given Ethiopia’s severe vulnerability to chronic food insecurity, high food price inflation rates, prevalence of HIV/AIDS, and high maternal and child mortality rates, interventions are relevant. The Multisectoral HIV/AIDS Project (MAP) Project used the Strategic Framework for the National Response to HIV/AIDS in Ethiopia (2000–2004), developed by the Ministry of Health to draw lessons and highlight priority areas of action. Prevention, care, and support were emphasized in the strategy and were expected to benefit mothers and children through the Prevention of Mother-to-Child Transmission (PMTCT) Program intervention. The Protection of Basic Services operation included activities to promote the MDGs that aim to accelerate and sustain malaria control, reduce infant mortality through vaccines, and improve the delivery of primary health services.

In the early 2000s, nutrition-related projects, such as the Food Security Program (FSP) and drought recovery, were developed. An IEG Project Performance Audit Report and lessons from previous Bank emergency operations were used in designing the Emergency Drought Recovery Project. The report emphasized that projects aimed at reducing chronic malnutrition required a combined approach of production, income generation, and education of childcare providers.

Since the inception of the Health Extension Program in the late 1990s, health and nutrition related interventions were designed to be delivered at a community level through health extension workers. Thus, these workers provide not only primary health care services to the local community, but also integrated nutrition-related interventions to pregnant and lactating women.

In terms of the preprimary education, the government of Ethiopia is focused on achieving universal primary education (MDG 2), as is the Bank’s support. It has not been until the Third Education Sector Development Plan (2005-2006 to 2010–2011) where challenges in quality of preprimary education development were noted. In recent years, the government has shown increased interest in preprimary education, and it has recognized early learning is an essential step toward achieving educational goals. The government’s current educational strategy, Education Sector Development Program IV (2010–2015), includes plans for at least one preprimary class in all rural and urban primary schools. Thus far, the Bank has not supported preprimary since other donor partners, such as UNICEF, government of Canada, Czech Republic, Germany, and Finland, have been implementing preprimary and early childhood care related projects.
Targeting techniques are geographical and projects are designed mainly to benefit women and children in the most vulnerable woredas. As for the nutritional projects, regional districts were selected based on their proneness to drought and chronic food insecurity. For example, woredas in four regions were selected in accordance with the federal government’s relative vulnerability criteria. The Health MDG Support Project targeted children between the ages of 12 and 23 months and pregnant women, nationally supporting subnational activities under the MDG Performance Fund. As well, the rationale for the target area in the drought recovery project was to fill the gap in recovery efforts.

Analysis from Aide Memoire and Interim Status Reports revealed a mixed picture on implementation performance, where weaknesses were related to lack of institutional and procurement capacity and regular supervision. All planned interventions were implemented. Nevertheless, in the FSP case, a vital entry point criteria—weighing of children—was dropped. Measures taken to ensure service quality were not noted in project documents, except in one project where supervision of service providers was conducted to monitor the number of kebeles reached and whether children were gaining weight.

**Indonesia**

Indonesia is a lower-middle-income country that has experienced steady economic growth since undergoing an economic crisis in 1997. Although it has made progress in reducing poverty overall, significant inequality persists, with half of all households clustered around the poverty line. These households have seen only modest gains in health and education in the past two decades. Nutrition outcomes among children under five-years old have remained poor, as prevalence rates for stunting and wasting have improved little over time because of suboptimal breastfeeding, poor complementary feeding practices in children under two, high levels of diarrhea, and, to some extent, food insecurity. Health indicators provide a more mixed picture. Child and infant mortality rates have decreased steadily, as antenatal care coverage and skilled birth attendance rates have improved. However, the maternal mortality rate remains one of the highest in the Region, as the majority of women in rural areas have limited access to emergency obstetric services. In education, Indonesia has achieved nearly universal primary school enrollment for both boys and girls at all income levels. However, education performance remains poor, and moreover, children from poorer households and from rural areas have more difficulty progressing from primary to secondary levels and have poorer learning outcomes. Participation in preprimary education for children up to age six is growing and stands at about 50 percent, although there are significant disparities between the richest and poorest segments of the population.
Since 2000, the government has increased its focus on providing early childhood education. According to the Bank’s analytic work, the government of Indonesia has been influenced by the condition of poor children within its own country and by the pattern of international evidence about the value of early childhood education and development. In 2001, a new directorate dedicated to early childhood education was established within the Ministry of Education and key education policy documents have included early childhood education programs. In 2008, a more comprehensive National Policy and Strategy Design on Holistic and Integrated Early Childhood Development were developed. This strategy conceptualizes early childhood development as an integrated system to meet the needs of children in the areas of health, nutrition, education, and social protection.

The Bank’s country partnership strategies have reflected the emphasis on early childhood development through Education sector interventions. Although there is recognition that ECD overlaps across other sectors such as health as well as water and sanitation, the Bank’s approach to ECD is primarily sectoral and not integrated across the different sectors.

The Bank has provided significant support to the government’s expanding early childhood education program, through lending, analytic work, and policy dialogue. The Bank has supported lending for ECD interventions in multiple sectors. Three of the four Bank projects in the review period included ECD subcomponents in each of the sectors of water and sanitation, health, and social protection. The fourth project, the Early Childhood Education and Development Project, was a full stand-alone ECD project. Its objective was to improve poor children’s overall development and readiness for further education within a sustainable quality system. Activities included: training of management staff and teachers and child development workers; provision of block grants to communities to establish early childhood education centers in local communities (which provided playgroup and preschool programs for families with children from birth to six years of age); development of service standards; and development of a monitoring and evaluation (M&E) system and an impact evaluation. This project clearly articulates a comprehensive development process for the child as the primary rationale for the project, while the other three projects are more focused on child survival objectives. However, the project design is focused primarily on interventions in the Education sector, although these interventions may include learning activities on the promotion of breastfeeding, clean water, hygiene promotion, and child raising.

All four projects had geographically defined target populations, the selection of which was based criteria of high incidence of poverty and low coverage of services. None of the projects had explicit mechanisms to target poor households or individuals, namely
poor mothers and children. Instead, interventions were targeted to poor communities and villages. Three of the four projects utilized a community-driven development (CDD) approach. These three projects targeted provinces based on poverty-related criteria.

The stand-alone ECD project was mostly implemented as planned. The component on service delivery was largely implemented, establishing early childhood education programs in poor communities. An impact evaluation, included in the project design as a subcomponent, was carried out, with data from the first two rounds of the impact evaluation reported and analyzed in the Bank’s recent analytic work (Hasan, Hyson, and Chang 2013). The final round was completed as part of project completion and results showed improvements in the physical development, language, and cognitive development of children who participated in the programs at one year old (2009) and completed it four years later (2013). However, the component on quality assurance was only partially implemented, as national standards for early childhood education were issued through ministerial decree but are yet to be enforced, and therefore the project’s impact on quality is unknown.

The Bank has also produced a major report on early childhood education and development, based on its experience with the recently closed Early Childhood Education and Development Project (2006–2013) (Hasan, Hyson, and Chang 2013; Jung and Hasan 2014). This report provides rigorous data analysis of child development measures and educational outcomes among poor children based on baseline assessment of two cohorts of children and families that participated in the project. It provides a well-articulated argument on the importance of investing in ECD for holistic child development and overall poverty reduction efforts, covering multiple sectors such as nutrition and health. However, this approach has not yet translated into lending activities, where there is limited engagement of sectors beyond education. As noted in project documents, early childhood education was a new priority for the government and thus the Bank’s support—in lending, analytic work, and policy dialogue—was timely and effective in helping the government establish its early childhood education priorities.

JORDAN

The government’s conceptualization and priority toward ECD has been well articulated throughout the time period under this review (FY00–14). As a middle-income country with near-universal achievement on most of the key maternal and child health indicators, the focus within ECD has been more prominent within the Education sector, namely early childhood education which entails access to kindergartens and quality of preprimary education institutions and services. There is very little inequality for access to maternal and child health services regardless of circumstances, but a substantial gap
remains in the area of school readiness between the lowest and highest quintiles as well as lowest and highest levels of maternal education. Therefore, Jordan’s ECD interventions are not necessarily driven by focus on MDGs, but rather on selected EFA goals.

The main focus of Jordan’s national development agenda is growth with equity, which runs through all of CASs within the period under review. The focus on ECD increases more in recent CASs as well with number of policy instruments and projects developed and implemented by the donor community, including the World Bank. The first CAS in this review (FY00–02) highlights the importance of human development in general and quality education services in particular, but there is no mention of children below the ages of primary grades. During the implementation of the subsequent CAS (FY03–05), the government developed the Accelerated Social and Economic Development Plan, which recognized the importance of investing in children’s early years and placed human resource development at the center of the plan. As a result, the government asked the Bank to undertake a situation analysis of ECD in Jordan to inform the design of the Education Reform for Knowledge Economy Project, which placed a high priority on public provision of early childhood education. The following CAS (FY06–10) explicitly states that one of the government’s objectives is to expand access to preprimary education and to improve quality and regulatory framework to ensure performance level of the service providers and the governance of the education system as a whole. Having established substantive framework under the previous CASs, the early childhood education (ECE) interventions highlighted in the current CAS (FY12–15) focus on equity, quality, and relevance.

At the policy level specific to ECD, the government has had a comprehensive vision of early childhood years. The National ECD Strategy (2000) was developed under the leadership of the National Council for Family Affairs (NCFA) with support from UNICEF (later revised in 2009). It defined early childhood to include the period extending from pregnancy up to nine years of age. The strategy is comprehensive, taking into account health, nutrition, education, child protection, social welfare, and the role of media in promoting holistic development of the child. On the administrative and institutional issues, it sets out roles and responsibilities of the government in establishing effective systems for human resource development and performance management, planning and supervision, and monitoring and assessing the ECD outcomes. Jordan has a national council that is the coordinating body for ECD programs to promote collaboration and cooperation between national and local levels to create synergies between sectors. Additionally, the Vision Forum for the Future Education and Jordan Vision 2020 contributed to the policy directions for education reform, which placed a significant emphasis on kindergartens and its foundational role in lifelong
learning and Jordan’s economic prosperity, which was necessary to increase Jordan’s competitiveness in the knowledge-based economy.

The Bank-supported ECD interventions are found in the two education projects, namely, Education Reform for Knowledge Economy (ERfKE) I/II, with implementation spanning over a period of 10 years. The first project has a component dedicated to kindergarten and preschool education, which sets a strong foundation in policy reform and capacity building. Specific interventions included developing ECE curricula for both pedagogical training as well as classroom instruction; establishing a minimum standard of operation for ECE classrooms; revising licensing requirements for kindergartens; and classroom construction as well as provision of equipment and learning materials. The second phase has a subcomponent dedicated to ECE, which built on the work implemented under the first one, and critically reviewed established policies and guidelines in order to improve and modernize the preprimary education system in Jordan while expanding its reach.

There has been a strong evidence base for the design of ERfKE I/II, drawn from various sources. Combined with available evidence on the high returns on investment during the early years of life, the project established a mandate for the Ministry of Education to be directly involved in ECE by developing publicly-funded kindergartens and regulatory frameworks for ECE in general. Subsequently, the analytic work titled “Support to Jordan Early Childhood Development” undertook a situation analysis of ECE in Jordan and produced the Project Operational Manual for ECE in Jordan for ERfKE I, which was reviewed and refined before the designing of ERfKE II. It contained an extensive list of criteria to provide ECE with optimal quality: institutional development (licensing, curriculum, and professional development and staff accreditation); learning materials; physical facility (classroom size, amenities, safety standards); performance monitoring standards (quality standards, instruments); use of mass media; and parent education. For every criteria, a wide range successful programs were drawn from the United States, Europe, and Central America and adapted to Jordan’s context.

Based on the findings from these analytic works on ECD as well as several others in regional scope, both ERfKE I/II reflects the recommendations, which were translated into some of the strengths of the project design. For example, the situation analysis found that the access rate was low with high inequality among the wealth quintiles and 99 percent of ECE services were provided by the private sector in urban areas. The private sector was already using curricula for both teacher training and classroom pedagogy that was in line with the current global theory and practice. Therefore, instead of investing heavily in developing the in-house capacity of the Ministry of Education and reinventing the wheel in developing pre- and in-service teacher training and didactic curriculums, the ministry adopted the curriculum used by the private
sector providers. This public-private partnership also set the ground for streamlining licensing requirements and facilitating collaboration from the private sector. Also, the decision to target remote and rural areas where no private entity would invest was informed by the findings of the cost-effectiveness study.

Another intervention that was implemented with thorough consultations with donors and leading scientific evidence is the parenting program. The pilot program called Better Parenting Program (BPP) was already in place supported by UNICEF since 1996, and supported under ERfKE I. The main objective of BPP is to reach out to the majority of young children who have no access to organized group care during the day within their homes and informal community settings. It is designed to utilize existing community structures, covering topics of health, nutrition, early stimulation, and social welfare. The content of BPP was aimed at empowering parents and caregivers to provide a stimulating, loving and protective environment at home through increasing knowledge and parenting skills in the areas of health, nutrition, and the cognitive and social development patterns of their children from birth to age eight. Particularly, BPP is recognized for its strong M&E framework with effective enforcement. One of the documented successes of BPP is that parents, especially fathers—who traditionally delegate most of the child-rearing duties to mothers—have learned about the importance of play and quality leisure time with their children. The design of BPP was evaluated at the time of designing ERfKE II as having an impact on parental involvement, including fathers, on household knowledge and understanding of the importance and key principles of early childhood care in home and the community.

The two ERfKE projects also consider the importance of the process of child development. For example, the training of ECE service provider is accompanied by a rigorous performance monitoring and assessment systems to ensure quality and relevance, while drawing lessons from successful international examples. Within the design of BPP, three Integrated ECD committees were established at each pilot governorate to closely monitor parent education and outreach activities. Efforts to ensure quality of services was evident in the rigorous pre-service and in-service training programs for ECE service providers, which was linked to and eventually institutionalized within national universities to ensure sustainability.

Monitoring and tracking of ECE interventions and outcomes are also priorities, especially evident in ERfKE II, where Bank’s resources have been supporting the expansion and piloting of quality kindergartens and alternative childcare throughout the country, with gross enrolment rate slightly increasing from 52.3 percent in 2009-2010 to 58.9 percent in 2014. Jordan has established an overall M&E framework within the Education Information Management System, where preprimary indicators are systematically collected. There has not been an impact evaluation or a tracer study.
Given the region’s volatile political context and the influx of refugees from neighboring countries into Jordan, the government’s ECE services are considered to be one of the most egalitarian and inclusive model. The country has been affected significantly by the ongoing conflicts in the Region, some spanning over five decades. Refugees from Iraq, Palestine, and most recently Syria have put a strain on the government’s ability to provide comprehensive quality social services to all that are eligible. Yet, the government decided to extend the public ECE services (where available) to refugee children at no cost. Although many refugees are being supported by the United Nations Relief and Works Agency for Palestine Refugees in the Near East (for Palestinians) and UNICEF and other organizations for basic services, the Jordanian government also bears the brunt for providing for them with its own resources.

One of the continuing struggles for Jordan is the development of a workforce for the knowledge-based economy would be to keep the relevance of skills that young people acquire throughout the process of life-long learning, as the market needs constantly evolves with time. However, the government has demonstrated its commitment to preparing young children at a very early age starting in their homes to foster a favorable environment for such a workforce. The government’s commitment is also demonstrated by its financial contribution toward the Bank-supported projects. For ERfKE II, the government pledged as much as the Bank’s contribution toward the project, ensuring ownership and sustainability.

**Malawi**

The Malawi government’s conceptualization and prioritization of ECD has evolved over the time period under this review (FY00–14), and consequently the shift has also influenced the Bank’s CASs and its emphasis placed on ECD. General observations from the CAS analysis indicate that ECD interventions are not necessarily driven by focus on MDGs, as the visibility of ECD was rather low throughout the review period except in the two most recent CASs where selective human development issues began to emerge.

The first CAS in this review (FY98–00) contained the main priorities of democratic and macroeconomic reforms and did not mention human development issues. In the subsequent CAS (FY04–06), the devastating effects of HIV/AIDS on economic and social issues necessitated the shift in priorities to address the epidemic, as Malawi had one of the highest prevalence in the Region in 2000, which remained the same for the next several years (15.8 percent of adult population), but it did not have an explicit strategy to reach HIV-positive pregnant women or young children living with HIV/AIDS. The subsequent CAS (FY04–06) signified the beginning of priority shift in the government’s development strategy. For example, the Malawi Growth and Development Strategy (2006–2011) is the first national development strategy that
included child health indicators as a mid-term outcome. For the CAS (FY07–12), the Bank also addressed the ECD issues with relevant projects and ESW, while clearly recognizing that mitigating HIV/AIDS leads to better economic prosperity. The current CAS (FY13–16) addressed the ECD issues affecting the country recognizing that reduction in malnutrition and new HIV infection are the key actions to managing the stunting and the HIV/AIDS epidemic. In 2011, almost half (47 percent) of the children under age five in Malawi were short for their age from the long-term effects of malnutrition, and 20 percent were severely stunted.

The CAS discusses the need for an integrated approach to nutrition, which appears clearly in its results framework, and it is supported by the ongoing projects and the Bank’s Africa Regional Strategy.

At the policy level, the government has made strides in conceptualizing ECD in a holistic manner, taking into account various sectors (health, nutrition, education, and social and child protection) that play a role in child development. Integrated ECD Policy (2008, revised from the National ECD policy of 2003) recognizes the multisectoral nature of ECD while emphasizing the importance of providing a protective environment for a child to grow holistically. Building on this momentum, the government developed an ECD Strategic Plan (2009–2014) with four key criteria across all involved sectors: access, quality, governance, and relevance. The strategic plan had a costed implementation plan as well as a resource mobilization plan. In 2012, the government developed early learning and development standards in consultation with major donors, including the Bank. The strategies outline a comprehensive program for all relevant sectors to work together by adopting an integrated approach to ECD, whether through integrated or sectoral interventions. The ECD Strategic Plan identifies policies and programs relevant to ECD from each sector, and brings them together to illustrate the importance of cross-sectoral coordination and knowledge sharing. This is intended to facilitate a better understanding of how nutrition and feeding policy affects preschool attendance, or the effects of breastfeeding promotion on child health outcomes, and so on. Although scaling up effective interventions remains a constant challenge due to limited resources and capacities, the government has a clear vision of how to reach young children and those who care for them.

Of the areas of ECD interventions the Bank supports, the largest investments are made in nutrition and HIV/AIDS. Considering the prevalence of malnutrition and HIV/AIDS for all people in Malawi, but especially for women and children, the Bank strategically allocates its resources to important areas. In 2003, at the time when the Multisectoral HIV/AIDS Project (P073821) had commenced, the PMTCT Program was a new small-scale intervention. However, by the end of the project, the number of antenatal care clinics providing the minimum treatment package for PMTCT increased from 60 in 2006
to 573 in 2011. The subsequent Nutrition and HIV/AIDS Project (P125237) took the PMTCT component to scale, combined with various awareness raising activities, and the Bank remains committed to support this area. Although often it is difficult to isolate one donor’s contribution because of the nature of pooled funding, the Bank’s contribution was reserved for PMTCT and voluntary male medical circumcision which included circumcision of 140,000 newborn males in the five years of the project cycle. By 2013, 92 percent of infants born to HIV-infected women were provided with antiretroviral (ARV) prophylaxis to reduce the risk of early mother-to-child transmission in the first six weeks after birth.

The Nutrition and HIV/AIDS Project was the only project that the effort to integrate interventions was evident. For the nutrition component, the maternal and child nutrition service delivery at the community level is designed to fully utilize the primary health care facilities and clinics to reach and educate the pregnant and lactating mothers with information on care for their newborns and young children. Early infant diagnosis is also done in collaboration with the primary health facilities, making the referrals to labs and essential services more efficient (e.g., therapeutic feeding programs, access to ARVs, counseling). The Directorate of Nutrition is positioned within the Office of the President and Cabinet and not with the Ministry of Health. Coordination is facilitated through Technical Working Groups (TWGs) on Accelerated Child Survival and Development, HIV/AIDS, Family Planning, and Reproductive Health. Each TWG has subcommittees to address specific issues, such as PMTCT and Child Nutrition. Therefore, two disparate ministries and governing structures working to reach the same target population require conscious effort to integrate service delivery.

Early childcare and preschool interventions also received support from the Bank during this review period. The project was designed with an impact evaluation to investigate the cost-effectiveness of community-based childcare interventions, in the form of a randomized control trial. A total of 199 community-based childcare centers were randomly selected from four districts, each district representing a different region of Malawi. The interventions consisted of varied combinations of: provision of play and learning materials, nominal cash incentives for caregivers, caregiver training, and parenting education. The evaluation measures the incremental effects of different interventions on children’s cognitive, linguistic, physical, and socioemotional development. In designing the impact evaluation, significant efforts were made in consultation and coordination with the Ministry of Gender, Children and Social Welfare, UNICEF, and the implementing NGO while ensuring the project’s contribution to the overall outcomes of the ECD Strategic Plan (2009–2014) and the National Action Plan for Orphans and other Vulnerable Children (2009–2012).
Considering Malawi’s poverty level ($320 per capita) and the poor ranking on the Gender Inequality Index (124 out of 182 countries), targeting techniques of the projects in this review are mainly based on geography and climate issues (prone to drought and floods) rather than poverty rate. Although a handful of districts are more developed with better access to services and infrastructure, most districts are rural and have high poverty rates for all people including women and children. For the ECD impact evaluation, one district from each of four regions was selected to ensure regional, cultural, and linguistic representation. To analyze the scalability of the interventions, it was important to sample from different geographical, cultural, and linguistic backgrounds. Also, the nutrition component of the Nutrition and HIV/AIDS Project was strategic in its targeting method. The government had expressed its full commitment to support the Scaling Up Nutrition initiative, and the Bank supported the remaining 15 districts that were not financed by other donors. By doing so, the government provided the minimum nutrition package to all 28 districts, which was designed after taking into account findings and recommendations from relevant ESW.

Country-specific analytics (e.g., impact evaluation, ESW, and TAs) were used to inform project designs. For example, the infant and young child feeding study (P107544) shed light on the causes of persistent malnutrition in Malawi, and the subsequent Nutrition and HIV/AIDS Project incorporated advocacy and behavior change activities in the project design. The impact evaluation of the Protecting Early Childhood Development Project can be considered particularly relevant to the context of Malawi. It measures changes in child development, taking a close look at interventions’ effects on child development with specific indicators and internationally recognized assessment tools adapted to the Malawian context.5

One of the major challenges in tracking ECD outcomes in a regular and systematic fashion is the lack of mainstreamed M&E system across the relevant sectors. For example, individual ministries collect indicators that they are responsible for, but yet there is no established system to regularly share and update indicators in collaboration with other sectors. The ECD Strategic Plan envisages such a M&E system under the leadership of the Ministry of Gender, Children, and Social Welfare. However, because the strategic plan involves different sectors, each with competing priorities other than ECD issues, there is reluctance to invest in a shared M&E system in addition to the sectoral ECD priorities. The Protecting Early Childhood Development Project had a component dedicated to establishing a foundation for such a M&E system, but the activity was not completed by the close of the project.

Another key challenge of the Bank’s projects in Malawi generally is the issue of sustainability. With the training and capacity building, the Bank is cognizant of potential effects on sustainability with such interventions in addition to provision of
material inputs and technical assistance. However, considering the level of poverty Malawi is faced with, the Bank commits to sustain its support in the areas of health, nutrition, and preprimary education, as the government would not be able to continue the implementation without Bank or other donors’ financial support.

**MEXICO**

Mexico has one of the highest preschool enrollment rates in Latin America, with mandatory preschool starting at the age of three years. While the preschool coverage among four-year olds is almost universal, it is still below 70 percent among three-year olds. The government’s support for ECD interventions is based on international evidence that investing early in children’s development, particularly among the economically disadvantaged, constitutes one of the most effective and cost-effective means of improving student learning and mitigating inequality of opportunity through improved labor productivity. ECD is also supported under the Mexican constitution. Access to early care and preschool is still lower in rural and indigenous communities, and the country’s quality of education is inadequate. This may explain the low readiness for learning among children, especially the poor as reflected in later grades by high dropout rates in addition to low achievement as shown in the 2012 PISA results in math, reading, and science.

The Bank’s technical and financial support for ECD programs in Mexico started over two decades ago. In 1992, Mexico’s Ministry of Education launched a five-year Initial Education Project to improve parents’ child rearing practices, focusing on the poorest children under the age of three. It became the first time a comprehensive and free-standing ECD project was proposed for Bank’s assistance. In the project, community educators were expected to instruct parents about child development; positive parenting practices including stimulation, nutrition, basic health and hygiene; and family planning (Young 1996). At the same time, the Bank produced an Initial Education Strategy for Mexico that highlighted the issues of the country’s Initial Education Program and included recommendations to address them, which were incorporated into the Initial Education Project (World Bank 1992).

Several knowledge products were produced by the Bank that contributed to improve access to ECD services such as a comparative analysis of the childcare program under the Secretariat of Social Development to support working mothers in terms of the quality of similar international programs, and an impact evaluation to measure the impact of empowering parental participation in the Quality Schools Program (Programa Escuelas de Calidad, or PEC). Further, extensive technical support was provided under the programmatic Social Protection Technical Assistance, which included a strategic review of the Oportunidades program, the nutrition program, and the state coordination model.
In terms of ECD related policies, the Mexican government has implemented three important ECD initiatives between 2000 and 2006: preschool expansion, quality improvement, and curricula reform. The preschool expansion included a mandate for all parents in Mexico to send their preschool-aged children (three-, four-, and five-years old) to preschool, with target dates of 2004, 2005, and 2008 for 100 percent coverage of five-year olds, four-year olds, and three-year olds, respectively. The quality improvement initiative was part of a larger program providing supplemental funds to select preschools and schools in Mexico’s public education system. Finally, the curricula reform instituted a new preschool curriculum to be implemented nationwide for all programs across the three- to five-year-old age range (Yoshikawa and others 2007).

ECD activities supported by the Bank have been aligned with all CPS priorities to improve the quality of basic education aiming at major improvements in equity, service quality, and institutional capacity for efficient delivery of education services. The Bank has supported the government’s education reform to provide high quality preschool as well as fulfill its mandate that children complete three years of mandatory preschool education. For the time of the review (FY00–14), the majority of Bank supported ECD interventions were designed and implemented within established government compensatory educational programs under Consejo Nacional de Fomento Educativo (CONAFE)\(^7\) and fell under the Education sector, with the exception of the Support to Oportunidades Project. Selected ECD interventions in the Basic Education and School Management projects are under one of CONAFE’s administered programs—the PEC program—which was intended to empower school communities (including teachers, parents, and principals) and promote school autonomy by providing school improvement grants. School communities, including preschools, are expected to establish participatory school management practices by designing and overseeing a Strategic School Transformation Plan (Plan Estrategico de Transformacion Escolar) that responded to the needs of the school and its students. The inclusion of school-based management in project design drew on extensive sector work and a comprehensive social assessment as well as lessons from similar school-based management programs in Latin America and in other Regions.

CONAFE’s Initial Education Program (Programa Educación Inicial, or PEI) provides out-of-school training for parents, relatives, and caregivers of children from birth to age four to improve their competencies and practices in caring for children and contribute to their comprehensive development and school readiness. It is a community-based program providing important services to poor children in remote communities throughout Mexico.

ECD interventions supported under the Oportunidades program are integrated within Education and Health, Nutrition, and Population sectors and reach across several age
groups, benefiting young children and their parents as well as pregnant women. Prenatal and postpartum care visits, growth monitoring, immunization, and management of diarrhea and antiparasitic treatments are provided to mothers and young children. The bimonthly delivery of food supplements to vulnerable groups and food-nutrition education aims to reinforce infant and pregnant and lactating women’s nutrition. Coordinating efforts to link families and their young children to PEI have been piloted and further coordination between both programs may be included in the design of future Bank support in this area.

All projects under this review included in their components or subcomponents behavior change activities for parents, caretakers, or service providers in the form of training, home visits, and parent and caregivers support programs, including parents’ participation in school management (preschool) and or awareness campaigns. Training of parents in the preschool component of the Basic Education II project was reported to produce important modifications in practices of rural families benefiting young children.

The ECD interventions that supported physical and other aspects of child development were implemented under the parents’ support programs and included stimulation. The rationale for these interventions in projects from the Education sector is to prepare children for preschool and primary. The Support to Oportunidades Project included ECD interventions in the area of health and nutrition focusing on physical development. Project activities aimed not only at increasing program coverage but also improving service quality via training, beneficiary surveys, impact evaluations, and technical assistance. The Compensatory Education Project addressed inclusion of culturally appropriate ECD interventions in the areas of training, with materials developed in local languages.

The reviewed Bank projects target beneficiaries geographically from the poorest communities across the country. The World Bank is also working closely with the government of Oaxaca, one of the poorest states in Mexico, through a memorandum of understanding that includes financial, knowledge, and coordination services in multiple sectors, tailored to the specific needs of Oaxaca.

**Peru**

From the time period of this review (FY00–14), the government of Peru has emphasized early childhood development through interventions aimed to reduce chronic malnutrition and improve MCH. The rationale for the country to support ECD was within the CAS objective of poverty reduction and human capital development as well as to attain the MDGs by guaranteeing access of the poor to a wide range of health, education, and basic services. Aligned with priorities outlined by the government and
country partnerships, the bulk of the World Bank supported ECD interventions focused on mechanisms to increase access to maternal and child health services by the poorest populations, define standards that families could expect from social services, develop monitoring systems, and provide individualized data for parents on the learning, health, and nutrition status of their children. In the longer term, the government is committed to reducing the country’s social gaps through a vision of ensuring continuous growth but with greater emphasis on social inclusion. This commitment is reflected in the government’s social targets established for the end of 2016 which include the elimination of chronic malnutrition and the implementation of universal access to preschool education. Over the period of this review (FY00–14), the Bank’s support for ECD has been under four investment loans, development policy operations, technical assistance loans, and nonlending technical assistance.

While indicators related to maternal health have been steadily improving since 2000, with an increase in institutional births and prenatal visits from improved access to health care services, chronic malnutrition rates continue to be high, especially in rural areas and among indigenous communities. Cognizant of the problem, in 2007 the new government committed to decrease chronic malnutrition by 5 percentage points in five years. In 2007 the government introduced the Programa de Crecimiento y Desarrollo (CRED), a child growth and development protocol that helps mothers to understand their children’s growth and identify practices that could improve it. CRED is under the government’s subsidized health insurance (Seguro Integral de Salud) norms.

Aligned with the country’s strategy, the Bank provided technical and analytical support for the reforms of the government’s social programs to increase demand and improve quality and coverage of the health and nutrition services for pregnant women and young children living in rural areas. Prior to 2009, Bank operations supported the majority of ECD interventions under the health sector; however, as improving children’s nutrition status has been prioritized, most of the Bank ECD interventions are within the nutrition sector, in some cases integrated with health and transfer. One of the Bank’s strengths in project design in Peru to lower the barriers for the most disadvantaged to use the health, nutrition, education, and social services was the inclusion in most projects of culturally appropriated ECD interventions adapted to the indigenous population and to people living in remote areas as well as to multilingual context following recommendations from the Indigenous People’s Plan and other consultations.

Important gains have been achieved for MCH in the last decade in Peru. Access to prenatal care is almost universal: 96 percent of pregnant women had at least four prenatal visits in 2012 and over 86 percent of births were attended by a skilled staff, a stark increase from 59.3 percent in 2002. Immunization coverage for measles and
diphtheria, pertussis, and tetanus of children ages 12–23 months has remained above 90 percent since 2007 and was at 94 percent in 2012. The Bank has supported the government to increase quality in the provision of health services by improving family care practices for women (during pregnancy, delivery, and breastfeeding) and children under the age of three; strengthen health services networks with capacity to solve obstetric, neonatal, and infant emergencies and to provide comprehensive health services; and support the Ministry of Health’s governance functions of regulation, quality, efficiency, and equity for improving the new health delivery model of maternal and child health care in a decentralized environment.

The inclusion of behavior change activities in project design was based on the Bank’s analytical work in the Andean region that showed the lack of awareness of many mothers about their child’s nutritional failure—the lack of easily understood standards was an important obstacle to changing outcomes. Behavior change activities were targeted to mothers and other caregivers with respect to child health, hygiene, care, and feeding practices through campaigns and parent support programs that helped change families’ knowledge and practices. Chronic malnutrition has been sharply reduced from 31.3 percent in 2000 to 18.1 percent in 2012. However, chronic malnutrition rates persist in rural areas and among indigenous communities. In 2010, for example, in regions where more than 25 percent of the population is indigenous, the child chronic malnutrition rate was above 20 percent, and in remote communities (Huancavelica) it reached 43 percent.

The Bank’s support to improve maternal and child health and nutrition also comes from the Results and Accountability Development Policy Loan series (FY07–11) and through the Juntos for Nutrition Nonlending Technical Assistance (FY10–present) by assisting the government to put in place more comprehensive health registration systems, the dissemination of nutritional indicators through social marketing, support for nutrition counseling by health workers, stronger integration of nutrition initiatives through the Contabilidad y Responsabilidad para el Crecimiento Económico Regional strategy (child growth monitoring combined with nutrition counseling to parents), and the creation of the Articulated Nutrition Program, a strategic program of result-based budgeting which aims at concentrating efforts (budgetary, logistical, and organizational) in those regions with the highest malnutrition rates.

The Bank’s analytical work and technical assistance have supported reforms of the government’s previously inefficient food-based programs and efforts are now directed to the new school feeding Qali Warma (serving preschool students ages three and over in participating public schools, starting in school year 2013). The program aims to provide the children with quality nutrition throughout the school year based on their living situation and other factors, improve their attention spans in class, encourage
children’s attendance and retention, and promote better eating habits among them. The program introduced new elements such as implementation through Comités de Alimentación Escolar (School Feeding Committees), a decentralized procurement system at the school level, and alternative modalities of service provision depending on school size, cultural or geographical characteristics, local food availability, and a clear monitoring and evaluation system, among others. These strategies are supposed to improve program efficiency, avoid leakages, and help expand program benefits to areas with higher levels of poverty, therefore reaching the children with the most need.

In support to the government’s social inclusion strategy, ECD interventions in the areas of health and nutrition continue to be prioritized under the latest CPS (FY12-16) and supported by Bank’s operations in a more integrated approach under social protection frameworks—more specifically through the expansion of Juntos, a conditional cash transfer program—to improve the coverage and quality of the provision of basic preventive health and nutrition services in the 14 poorest regions of the country where Juntos operates. The intervention foresees increasing the number of children under the age of three who receive comprehensive health check-ups in a timely manner. At the same time, the Social Inclusion Development Policy Loan Series and the Technical Assistance Loan for example have exploited important synergies with a number of existing operations and instruments that enhance both the access and the quality of social services in Peru, especially in rural areas. The vision for the upgraded system is to cover the whole life-cycle, from prenatal and early child development to old-age and retirement.

There has been progress also in the area of preschool education services. Over the period of 2007–2012, net preprimary school enrollment increased from 65 percent to 78 percent. Despite high overall participation rates, 29 percent of children from the poorest quintile had no early education experience, while only 4 percent of children from the highest quintile did not participate in preschool (Woodhead and others 2009). Banks’ operations in early care and preschool have been limited in the country. Early interventions supported by the Rural Education Project to increase preschool and childcare coverage for those under the age of five who are living in rural areas have fallen short of the intended goals. Validated pedagogical models for preschool in a pilot were not scaled up and original coverage targets were not met. Currently, the Bank is supporting preschool assessment to measure preschool learning and the quality of preschool services in four dimensions: adult-child interaction, quality of facilities, stimulation, and child development and needs.

The Juntos program supported by the Bank also played an important role in unveiling coverage gaps in the provision of health and nutrition services. One of the main strengths of the program is its capacity to encourage the demand for services together
with efficient targeting mechanisms that prioritize attention to poor and extremely poor rural households. One of the implementation challenges of the Juntos is its weak beneficiaries’ affiliation capacities with respect to young children because of the limited incentive that families have to “declare” the birth of a new child, given that the amount of the cash transfer is independent of the number of children. This limitation is expected to be overcome as part of the restructuring of the program to include differentiated transfers. In addition, it was found that more information is needed by mothers to understand the objectives of the program and the health and nutrition co-responsibilities.

**REPUBLIC OF YEMEN**

The Republic of Yemen is a low-income country with a population of about 25 million people. It has one of the lowest GDP per capita rates in the world as well as the highest poverty rates in the Middle East and North Africa Region—54 percent of the population lives on less than $2 per day, and half the population is considered food-insecure (2012). Yemen ranks low on the United Nations’ Human Development Index (number 154 out of 187) and is unlikely to meet any of the MDGs. The country has been undergoing a political and social transition, which has been accompanied by a volatile security situation. The government is largely unable to provide adequate basic services, particularly for children and youth, which represent the majority of the population. In addition, three-quarters of the population is highly dispersed in rural areas in small, isolated settlements, which adds to the difficulty in providing services, either by the government or the private sector.

Key indicators of MCH reflect overall poor outcomes. Despite a declining trend since 1990, maternal, infant, and child mortality rates remain high. Childhood immunization coverage has improved to around 80 percent and, while coverage of antenatal care and skilled birth attendance have also improved, these rates still remain inadequate. Yemen also has one of the highest rates of chronic malnutrition among children in the world—58 percent of children under five-years old are stunted, and 15 percent suffer from moderate or severe wasting, based on 2012 data. Primary school enrollment is far from universal (76.4 percent in 2008–2011), and preprimary school enrollment is extremely low at less than 2 percent (2012). Although government legislation provides for free preprimary education starting at age three, the existence of preschool programs or early childhood care (public or private), particularly outside of urban areas, is extremely rare.

Since 2000, the Bank has provided support to the government on early childhood development through lending, analytic work, and policy development. The Bank’s analytic work has emphasized an integrated approach to ECD, whereby multiple sectors are engaged in addressing ECD as well as a child development process whereby early interventions aim not just for child survival, but also for cognitive, social, and
emotional development. In particular, the impact of the Bank’s technical assistance and policy dialogue is reflected in the government’s 2006 National Children and Youth Strategy. Similarly, the Bank’s integrated ECD approach is more often than not reflected in the various country partnership strategies over the review period.

The Bank’s project design has been highly relevant to and consistent with the poor ECD outcomes in the country. The project designs are also highlighted by realistic targeting approaches to ensure services reach poor mothers and children. Interventions are designed according to widely accepted evidence of the most cost-effective interventions for improving MCH; however, there is limited data on the use integrated approaches in Yemen, and Bank projects using integrated ECD approaches are rarely based on rigorous analytic work or clear evidence of the effectiveness of those integrated approaches.

Despite the broader strategic approach articulated in national and Bank strategies, actual Bank lending has shifted over time from the integrated ECD approach to a more sector-specific one. This likely reflects the Bank’s project implementation experience, in which local capacity was overestimated and thus implementation fell significantly short of the planned design. In particular, the capacity of sector ministries to coordinate interventions with other sector ministries was very limited. Also, the government had recently adopted a decentralized health system approach, but the capacity to deliver services at the decentralized level was extremely low.

Project designs in the latter part of the review period emphasized sector-specific approaches with more narrowly focused interventions (i.e., disease-specific). Most projects include health and nutrition interventions only. There are no projects with preprimary education interventions. The most recent projects have incorporated social protection interventions. This has led to more effective project implementation and some successes in improving ECD outcomes (i.e., increased coverage of childhood immunizations). Bank project design is also primarily focused on a short-term child survival approach, given the reality of high mortality and morbidity rates in the country. There has also been limited emphasis on quality of service provision or longer-term financial sustainability. Although M&E frameworks feature relevant and measurable ECD-related intermediate outcome indicators (i.e., proportion of births attended by skilled health workers), there is still a lack of measures for changes in the development of the child.

The Bank’s work has been relevant to and consistent with country needs, according to ECD-related indicators. Although, at a country level, the Bank has helped to conceptualize ECD as an integrated approach with a focus on child development, it has been less effective translating this approach into project design that reflects reality on
the ground. However, the Bank has gained a better understanding of underlying constraints (i.e., country conditions, weak capacity) over time and has adjusted its engagement in the country accordingly.

References


1 As defined by Grantham-McGregor and others (2007).
Data are dated and have likely improved since 2008 because of intensified efforts by the
government and development partners. Data for the 2013 Demographic and Health Survey
have already been collected but were not available at the time of writing.

For more information, visit
http://www.np.undp.org/content/nepal/en/home/mdgoverview;

The percentage is based on community and formal preschools.

The project interventions were a mix of provision of inputs as well as capacity building. The
control group received the play and learning materials only; the three treatment groups were
designed to test the effects of combining caregivers training, parenting education and cash
incentives for caregivers. This impact evaluation examines the incremental effects of positive
parenting, physical learning environment, and teacher-child interactions on child development.
Child development outcome areas include: receptive vocabulary, executive function (sustained
attention or persistence), fine motor and language skills, morbidity, and nutritional status.

The Mexican government’s policy on initial education stems from its constitution and is
spelled out in several official documents. Article 4 of the constitution establishes priority to
meet children’s “physical and mental needs” and provides them with support through parents
and public institutions. The main objective of the policy is “to provide children under four,
especially in the rural, indigenous and marginal urban areas, with equal opportunities of
educational services” and “to foster the development of young children’s physical, cognitive,
affectional and social capacities, stimulating their active participation in the educational process

The Bank has been supporting the Consejo Nacional de Fomento Educativo for over 20 years
in the design and implementation of education programs for Mexico’s most disadvantaged
communities. Early childhood development interventions have been designed and
implemented under two compensatory programs: the Quality Schools Program (Programa
Escuelas de Calidad) and the Initial Education Program (Programa Educación Inicial).