Standing Committee
for Economic and Commercial Cooperation
of the Organization of Islamic Cooperation (COMCEC)

COMCEC

Improving Basic Services Delivery for the Poor in the OIC Member Countries

COMCEC COORDINATION OFFICE
September 2015

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Conceptual Framework

A lack of access to basic services is closely linked to poverty. Poverty is generally defined as being income poor. However, poverty actually has many dimensions. Apart from being income poor, a lack of access to basic services like education, health care services, safe drinking water, sanitation facilities and electricity put people at a disadvantage and prevent them from living a decent life. A lack of access to basic services exacerbates income poverty by generating a poverty trap where people cannot improve their living conditions due to being uneducated, sick and time poor. When a lack of access to basic services is also a consequence of being income poor, this creates a vicious cycle. In this respect, governments have a responsibility in providing these basic services. If the provision is left solely to the private sector, inequalities in access would likely occur.

Services fail to reach the poor because of failures in the accountability relationships between actors. Accountability can be defined as holding actors responsible for their actions. The World Development Report 2004 sets out an accountability framework that is adopted in this report to illustrate the actors in the service delivery chain and the relationships that link them together. According to this framework, there are three sets of actors in the delivery chain: the citizens, the State (the policymakers and the politicians) and the service providers. These actors are linked to one another through accountability relationships. Services can be delivered to citizens via two routes, the long route and short route of accountability. The long route of accountability occurs when the State takes part in delivering the services. Citizens hold the State accountable for the delivery of the services while the State holds the service providers accountable. In contrast, in the short route of accountability, citizens hold service providers directly accountable for service delivery. Given this framework, services can be delivered via a number of models. These are central service provision, decentralized service provision, contracting out service delivery to private companies, community participation, and private sector service provision. Each of these models have their own advantages and disadvantages and different impacts on the accountability relationships.

Overview of OIC member countries

Voice and compact, which are key to accountability relationships in service delivery, are generally weak in OIC member countries. Voice is the accountability relationship between citizens and the State while compact is the accountability relationship between the State and the service providers. The Voice and Accountability index, constructed by the World Bank, measures the first link in the accountability framework between citizens and the state. OIC countries do not score well in the index with an average score of -0.86 compared to the World average of 0.00 in 2013. Similarly, the Government Effectiveness index, constructed by the World Bank, can be used as a proxy to represent the strength of the relationship between the state and the service providers. The average Government Effectiveness index for OIC countries was low at -0.62 compared to the World average of 0.00 in 2013.

Education

Overall, OIC member states have high primary school enrolment rates but disparities exist between and within countries. Various models are employed for the delivery of education services. While central provision of services and decentralization are almost equally common, contracting out services is also observed in a small number of member countries. Community participation is common in many of the member countries (in the form of Parent-

Teacher Associations) and private provision exists in every member country in varying degrees. On average, government spending on education is high but significant disparities exist across countries. The OIC average for government spending on education as a share of total government budget is at 14.7 percent, which is slightly higher than the world average of 13.5 percent. Aid constitutes an important and common source of financing for education in OIC member countries. Common sector challenges observed in OIC countries include a failure to reach the poor, gender disparities in access, low quality of education, absenteeism of the teachers, informal payments and private tutoring. These challenges are in fact symptoms of failures in the accountability framework.

Health Care

Health outcomes have improved over the last two decades, but significant disparities exist within and between OIC member countries. Different types of service delivery models for health care can be observed across OIC member countries. Central government provision is somewhat more common among upper middle income member countries while decentralization is observed commonly among all income groups. Contracting out services is observed in a number of countries as a method to mitigate problems in publicly provided services or to increase efficiency and quality of delivery. Community participation in health care is often implemented through management committees, which have a varying degree of responsibility depending on the country. Private provision in health care service delivery is observed in varying degrees, as well. Government spending for health is low in member countries compared to the World. Member countries, on average, allocate 8.9 percent of total government expenditure to health in 2012, compared to the World average of 15.7 percent. In contrast, OIC member countries have a high dependence on out-of-pocket expenditures and external resources for health care financing. In addition to access problems for the poor and high out of pocket expenditures, low quality of public hospitals and staff shortages are additional challenges for the sector.

Water and Sanitation

Lower middle income and low income member countries, as well as rural areas within the countries, are at a significant disadvantage with regards to access to an improved water source and sanitation facility. The location of a household is an important determinant for access to drinking water or sanitation, especially across Sub-Saharan African countries. Several types of service delivery models can be observed among OIC member countries in water and sanitation including provision by the local government, a national utility company, user groups, contracted private providers or independent private providers like pit emptiers or water tankers. Delivery models typically differ depending on rural/urban location. In OIC member countries, government subsidies are commonly used to finance operations and maintenance costs. Additionally, in most of the OIC member countries, except for those in the high income group, financing through donor funds is common. Total aid received by the OIC member countries made up 37.1 percent of the total aid disbursed in year 2013 for developing countries. Challenges in the water and sanitation sector can be summarized as: low access in rural areas, clientelism in service delivery, low quality of services with intermittent hours of service delivery, and the lack of a central authority to oversee the sanitation sector.

Electricity

Access to electricity is lowest among lower middle income and low income OIC member countries with more pronounced disparities between urban-rural localities within these countries. People living in rural areas in OIC countries are at a significant disadvantage with an average 59.6 percent of the population having access to electricity compared to an average 82.1 percent in urban areas. Among OIC member countries, several types of service delivery models can be observed. Two common models are vertically integrated national utility company and unbundled companies. Public-private partnerships are observed in almost all of the countries either in generation or in the distribution of electricity. Community participation in the electricity sector is observed through user cooperatives in a small number of member countries. Government subsidies are a common type of financing in the electricity sector among the member countries. Majority of the member countries across all income groups subsidize electricity utilities to a certain extent. Challenges in the sector include low rural connection rates, especially among the countries in Sub-Saharan Africa, low quality with intermittent supply, and financial instability necessitating continuous government subsidies.

Recommendations

Delivery of services can be improved by strengthening the accountability relationships between actors in the delivery chain. While increasing financing to services can lead to improvements, in order to obtain better value for money - without increasing budgetary requirements- it is necessary to improve the accountability relationships presented in the accountability framework. In order to achieve this, the long route or short route of accountability will need to be improved.

In the long route of accountability, voice and compact should be strengthened in order to deliver better quality and more equitable services to citizens. Voice can be improved by strengthening civil society engagement and democratization, which is a rather long-term process. Compact can also be improved by establishing a program to monitor and evaluate the performance of service providers, allowing the state to hold providers accountable by using the results. Contracting out services to private providers can also improve the compact by giving flexibility to the State on who to contract with and select the best performing agents.

The short route of accountability or client power can be strengthened by increasing the citizens' choice, participation and/or level of information. Improving the short route of accountability is easier to do in the short-to-medium term and can yield quicker results. First, improving a citizen's choice strengthens client power by giving citizens greater enforceability power over service providers. Citizens' choice can be improved by increasing competition between service providers or by linking their revenues to the number of citizens they serve. This way, citizens have greater enforcement power over the service providers and can "punish" them by walking away. Choice may also be improved by increasing citizens' purchasing power enabling them to choose among multiple competing private providers. Secondly, citizen participation improves client power by aligning the incentives of the providers with that of the citizens. Participating in service delivery through Parent-Teacher Associations or utility cooperatives can lead to better outcomes because the citizens are serving *themselves,* which is highly likely to improve the quality of the services. Lastly, information is key for the client to hold service providers accountable. Information can be improved via mechanisms like information campaigns or report cards.

Introduction

Poverty is a challenge for most of the OIC member states. It is estimated that approximately 350 million people in OIC countries live in extreme poverty, using the $1.25 a day poverty line.[1] An estimated 1.2 billion people live in extreme poverty worldwide, which means more than one-fourth of the World's poor are living in the OIC countries. The percentage of the people living below $1.25 a day in upper middle income countries is, on average, 1.3 percent, but is as high as 43.4 percent in low income member countries.[2]

The Standing Committee for Economic and Commercial Cooperation of the Organization of Islamic Cooperation adopted poverty alleviation as a cooperation area in 2012. In this regard, the Working Group on Poverty Alleviation publishes studies on various topics around the theme of poverty across OIC countries, identifying challenges and developing recommendations. In this respect, this study focuses on basic service delivery in OIC member countries, covering education, health care, water, sanitation and electricity sectors. The study presents the situation in the member countries drawing on data collected from various sources and a literature review with regards to the access to the services, service delivery models employed and financing of the services along with common challenges that were observed in member countries in the delivery of basic services.

A lack of access to basic services is closely linked to poverty and problems with service delivery can be found, to some degree, across all OIC countries. Poverty is multi-dimensional. Being poor is not only having a low level of income but is also a lack of access to education, health care, safe drinking water and sanitation facilities along with electricity. A lack of access to basic services further exacerbates income poverty and, when basic services are not provided equally to all citizens, it creates a vicious cycle where income poor individuals do not have access to basic services and those who do not have access remain income poor. The poor lack access to basic services across many member countries independent of the country's income level, though problems are definitely more pronounced among the low income countries**.**

Basic services often fail to reach the poor because of failures in the accountability relationships between citizens, the State and the service providers. The World Development Report (WDR) 2004 sets out a framework illustrating how these three key relationships affect service delivery. This report uses the WDR's framework to give an overview of service delivery models across five sectors in member countries including the current levels of access, financing methods, and commonly observed challenges.

The report focuses on education, health care, water, sanitation and electricity sectors in the OIC countries. OIC countries generally lag behind World averages in the indicators showing access to basic services. On average, primary school enrolment rate is lower, under-5 child mortality rate is higher, access to improved drinking water source and access to electricity are both lower than the World averages. Only access to an improved sanitation facility is on par with the World average, yet World average is already low. Access issues are generally more pronounced in lower-middle income and low income countries, for the poor and for the people living in rural areas. All kinds of service delivery models are implemented in the member countries in different sectors without necessarily following a regional or income level trend. Common challenges are observed in many countries. These challenges are

[1] COMCEC Poverty Outlook 2014

[2] Authors' calculations using World Bank, World Development Indicators.

sometimes due to the financing problems while at other times they are signs of failures in the accountability framework.

In-depth case studies for four of the member countries further highlight the situation in more detail. Case countries are Turkey, Bangladesh, Lebanon and Indonesia. The case countries were selected in order to represent different service delivery models in different sectors to the extent possible. In addition, they were selected to represent different income groups and regions of the OIC. For in-depth case studies, in addition to literature reviews, expert interviews were also conducted.

For the analysis, first, publicly available data was gathered to document access to basic services in the member countries. Secondly, to identify the service delivery models, financing mechanisms and challenges observed in the sectors, a vast literature review was conducted. The literature review was based on a web-based search of reports and papers that are as up to date as possible and representing the countries' situation. Official OIC income groups were used to organize the discussion and the analysis. However since the challenges of the countries are generally common and the challenges resulting from accountability framework failures are independent of income, common challenges and related recommendations are presented without the income group division.

To the extent of our knowledge, the analysis presented in the report is unique in identifying and presenting access to basic services, service delivery models, financing schemes and challenges for five sectors for a large number of countries. For this reason, the report is an important contribution to the literature expanding knowledge on basic service delivery in the OIC countries.

This report is structured in five chapters to provide a comprehensive overview of service delivery across OIC countries. The report begins with a conceptual framework and methodology chapter that describes the relationship between poverty and basic services. Following, the report introduces the accountability framework. Highlighting best practices, this section provides an overview of different types of service delivery models and an assessment of their advantages, disadvantages, and their impact on accountability relationships. The chapter ends with the methodology used to prepare the analysis. Chapter 2 presents an overview of member countries' education, health, and water, sanitation, and electricity sectors. For each sector, the report provides a general overview with regards to basic services, service delivery models, methods of financing, and common challenges. In Chapter 3, service delivery models are explored in more detail in case studies for four selected countries. For each country, three sectors are outlined including access to and quality of the services, the service delivery models, and their financing schemes. Each sector is assessed in accordance with the accountability framework with recommendations on how relationships can be improved to result in better service delivery. Chapter 4 presents the recommendations that could be adopted by the countries to improve service delivery. Chapter 5 concludes the report.

1. Conceptual Framework and Methodology

1.1 Basic Services and Their Link with Poverty

Multiple Dimensions of Poverty

Extreme poverty is defined as living with less than $1.25 a day and affects an estimated 1.2 billion people worldwide.[3] Eradicating extreme poverty is the number one goal in the Millennium Development Goals (MDGs) of UN and it is the primary goal in the agenda of international organizations such as World Bank. Yet, unfortunately, income poverty is not the only aspect of being poor.

In fact, poverty has many dimensions. It is not only a lack of material well-being but also a lack of opportunities to live a tolerable life.[4] A person who earns more than $1.25 a day may still be deprived of healthcare, an opportunity for education, safe drinking water, sanitation facilities, or electricity. Qualitative research shows that this is indeed the situation faced by the poor. The global poor define extreme poverty as a lack of food, a lack of access to infrastructure, being in poor health, being illiterate, and being without a voice.[5] These deprivations, together, put people at a severe disadvantage and, therefore, constitute the multiple dimensions of poverty.

The concept of multi-dimensional poverty is gaining momentum in the development community. UNDP's Multi-Dimensional Poverty Index (MPI) which accounts for deprivations in health, education, and living standards[6] was developed in 2010. It estimates that the number of people living in multi-dimensional poverty is actually higher than the number of people estimated using the income threshold. MPI estimates that 1.5 billion people in 91 developing countries live in multidimensional poverty as opposed to 1.2 billion people estimated by the $1.25 poverty line.[7]

What are Basic Services?

The deprivation of several basic services can constitute poverty. For the scope of this report, we selected five basic services based on the multi-dimensional poverty index and World Development Report 2004, both of which are considered to be important and influential in terms of understanding the relationship between poverty and service delivery. These basic services can be defined as follows:

Basic education services: UNESCO defines basic education as:

> "Whole range of educational activities, taking place in various settings, that aim to meet basic learning needs …, basic education comprises primary education (first stage of basic education) and lower secondary education (second stage). It also covers a wide variety of non-formal and informal public and private activities intended to meet the basic learning needs of people of all ages.[8]"

[3] UNDP (2014). $1.25 poverty line is widely used by international organizations such as World Bank and UN. This poverty threshold used to be $1 in the past which was first used in the World Development Report 1990 of World Bank. Later, the threshold was revisited and increased to $1.25 a day (See Ravallion, Chen and Sangraula, 2009).
4 Anand and Sen (1997)
5 Narayan et al. (2000)
6 Among the living standards, the indicators that are included are cooking fuel, sanitation, water, electricity, floor material and assets.
7 UNDP (2014)
[8] UNESCO (2015)

Hence basic education should meet basic learning needs of every individual which "comprise both essential learning tools (such as literacy, oral expression, numeracy, and problem solving) and the basic learning content (such as knowledge, skills, values, and attitudes) required by human beings to be able to survive, to develop their full capacities, to live and work in dignity, to participate fully in development, to improve the quality of their lives, to make informed decisions, and to continue learning."[9]

While UNSECO's definition also includes lower secondary education, in line with MDG goal of achieving universal primary education, we focus on access to primary education services in the report. Primary education activities usually begin at age 5, 6 or 7 depending on the country and lasts for 4 to 6 years.[10] Systematic studies of reading, writing and mathematics begin at this level of education.[11]

Basic health care services: The World Health Organization (WHO) states in its constitution that having access to the highest attainable standard of health is a fundamental human right.[12] In this respect, health services are provided to achieve this goal and are defined as approaches for prevention, promotion, treatment, rehabilitation and palliative care that must be sufficient to meet health needs in quality and quantity.[13]

Basic health care services can be defined as the primary health care services that are essential for individuals at a minimum level. The importance of primary health care services was set forth in the international agenda by the Alma-Ata Declaration of 1978 and this declaration mobilized the movement on primary health care.[14] Primary health care services are defined by the Declaration as the first level of contact of the individuals with the national health system.[15] As stated in the declaration, these services at minimum must include maternal and child care services, immunization, provision of essential drugs, prevention and control of locally endemic diseases and appropriate treatment of common diseases and injuries.

Drinking water services: Households collect or purchase drinking water using a number of different methods and sources. A water source is recognized as "improved" by WHO/UNICEF Joint Programme for Water Supply and Sanitation when "by nature of its construction or through active intervention, the source is protected from outside contamination"[16] In this respect, improved sources of drinking water are listed as: (i) Piped water into dwelling, (ii) Piped water to yard/plot, (iii) Public tap or standpipe, (iv) Tube well or borehole, (v) Protected dug well, (vi) Protected spring and (vii) Rainwater. Drinking water services are defined as providing access to the above improved water sources, either by private or public sector.

It must be noted, however, that access to an improved water source does not necessarily mean access to safe drinking water. Studies in Sub-Saharan Africa show that 67 percent of the population has access to an improved water source, but 28 percent of this "improved" water sources is actually contaminated with bacteria.[17] Not surprisingly, the best way to mitigate this problem seems to be to increase the population covered with piped water.[18]

9 UNESCO (1990)
10 OECD (2015)
11 OECD (2015)
12 WHO (2013)
13 WHO (2013)
14 WHO (2008)
15 Declaration of Alma-Ata (1978)
16 WHO and UNICEF (2014)
17 WHO and UNICEF (2014)
18 WHO and UNICEF (2014)

Sanitation services: Like drinking water, sanitation facilities are also defined as improved or unimproved. The WHO/UNICEF Joint Programme for Water Supply and Sanitation defines "Improved" sanitation facilities as "a facility that hygienically separates human excreta from human contact".[19] In this respect, types of facilities that are accepted as improved are: (i) Flush toilet, (ii) Piped sewer system, (iii) Septic tank, (iv) Flush/pour flush to pit latrine, (v) Ventilated improved pit latrine (VIP), (vi) Pit latrine with slab, (vii) Composting toilet. Hence, provision of sanitation services includes providing any type of the improved sanitation facilities listed above. This might include connecting households to sewer systems or selling households pit latrines.

Electricity services: Electricity is delivered to end users around the world, by using mainly three types of systems: (i) grid systems, (ii) mini-grid systems, and (iii) off-grid systems.[20] Grid systems are a network system that are usually operated as a monopoly and typically cover both main urban centres and rural areas, to the extent possible. Service delivery via a national grid system includes generation, transmission and distribution of the electricity, managed by the same or separated companies.

Mini-grid systems are localized with a much smaller capacity and are generally operated in small towns or communities. Different from mini-grid systems, off-grid systems are used by the individual households/businesses typically for generating electricity only for their own use.[21] For instance, home-based solar systems are an example of off-grid electricity system. Both, mini-grid and off-grid systems are generally used in the areas where the national grid does not reach.

What is the role of the Government?

Improving education and health outcomes is a government responsibility. There are both economic and social reasons behind the government's responsibility and needed intervention in the provision of education, health care, water, sanitation, and electricity. Leaving provision solely to the private market can have a negative impact. Two reasons might be listed behind this negative effect[22]: First, markets generally fail to absorb externalities, hence for instance the positive externality generated by immunizing a child would be disregarded by the market and second, markets fail to provide equitable services since only the people who can afford their services could have access. In line with these economic and social aspects, a governments' responsibility on health and education is usually further bound by their constitutions.

Governments' responsibility in protecting citizens' rights to health, education and an adequate standard of living is also backed by international treaties signed by the governments. In this the International Covenant on Economic Social and Cultural Rights binds the states signing the covenant that they will protect the rights of their citizens such as "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", "the right of everyone to education" and "the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions".[23] The covenant, which was signed by

19 WHO and UNICEF (2014)
20 Scott and Seth (2013)
21 Scott and Seth (2013)
22 World Bank (2003)
23 UN General Assembly (1966)

169 states from around the World[24], was adopted in United Nations General Assembly in 1966 and entered into force in 1976[25].

Governments allocate a significant share of their budget to finance basic services. Public expenditures on education and health made up 14.4 and 15.7 percent, respectively, of total public expenditures worldwide in 2009[26]. In many countries, basic education is constitutionally mandated to be free of charge and is entirely financed by the public budget.[27] Governments also take part in financing and providing infrastructure services. Estimates show that 0.64 percent of government revenue worldwide is allocated to subsidies that finance electricity services.[28] It also seems to be the norm to provide subsidies for operations & maintenance or capital costs of water utilities around the World with only 30 percent of water utilities being able to cover both types of these costs without government intervention.[29] This rate goes as low as 3 percent in the low income countries.[30]

Higher public spending alone does not necessarily result in better provision of services. Higher public spending is associated with lower child mortality rates for children living on less than one dollar a day.[31] However, for instance per capita income, inequality and female education are found to explain cross-country differences in health outcomes to a wider extent while the impact of public spending on health is found to be small and insignificant.[32] Furthermore, there is evidence showing that higher government spending on health does not reduce average child mortality rates in countries with "bad" governance.[33] Governance affects education outcomes as well. For instance, in Uganda, in the 1990s, government spending on education increased over time, but the enrollments remained stagnant. Trying to understand the reasons behind this failure, a Public Expenditure Survey conducted in 1996, revealed that only 13 percent of the grants intended for public schools actually reached the schools.[34] This is not only the case in developing countries but also in developed countries. For instance, in the US, per student spending on education doubled in real terms in between 1970 and 2000 while a similar increase in student performance was not observed on the benchmarked tests.[35]

Public spending might not reach the poor. As mentioned before, one reason that government intervention in public service provision is necessary is to improve equity in access to services. Government spending on public goods is aimed at restoring equity for citizens, but often end up reaching the wealthy instead of the poor.[36] Often, the poor cannot access the service to benefit from the subsidies that are provided to finance it.[37] In some cases, poor households cannot afford user fees to access the service and, in other cases, they are not connected to the infrastructure network that provides the service, particularly in rural areas and urban slums. For example, in Asia, public health care spending is found to be pro-rich in Bangladesh, Nepal, India, Indonesia and China.[38] The reason behind this could be the

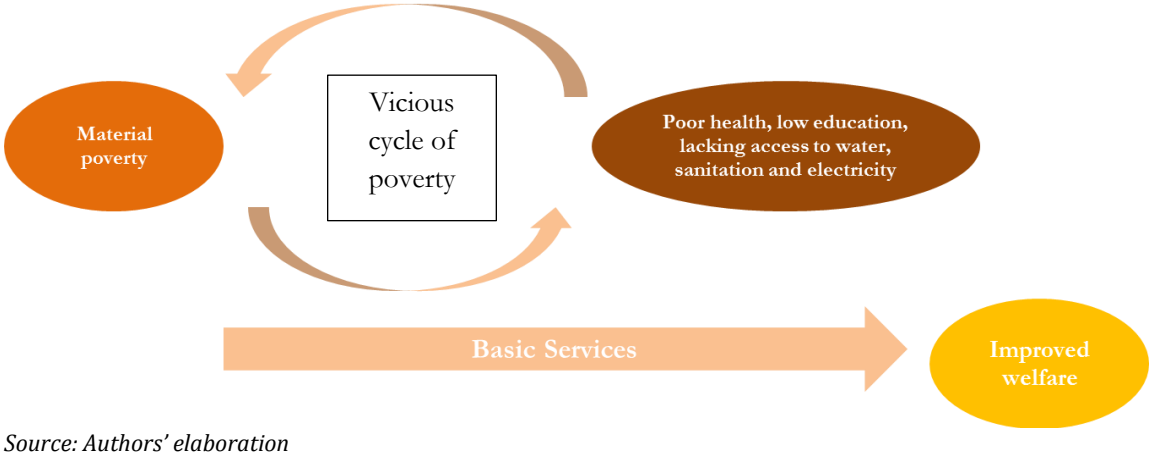
24 Out of 57 OIC member countries, 50 of them signed the Covenant and among them only 1 country has not ratified yet (United Nations Treaty Collection, 2015).
25 UN General Assembly (1966)
26 World Bank, World Development Indicators.
27 UNESCO (2009)
28 Clements et al (2013)
29 Komives et al (2005)
30 Komives et al (2005)
31 Wagstaff (2003)
32 Filmer and Pritchett (1999)
33 Rajkumar and Swaroop (2008), Wagstaff and Claeson (2004)
34 Reinikka & Svensson (2001)
35 Bruns et al (2011)
36 Castro-Leal et al (2000), Wagstaff et al (2014)
37 Komives et al (2005)
38 O'Donnel et al (2007)

distribution of the hospital network which does not have a good coverage in the rural areas in these countries.[39] Similarly, in Africa, public spending on curative care is found to be pro-rich in countries including Cote d'Ivoire, Ghana, Guinea, Kenya, Tanzania and Madagascar.[40]

Access to basic services and material poverty

Different aspects of multi-dimensional poverty reinforce each other and trap people into a vicious cycle of poverty. In this respect, low levels of access to basic services are both a cause and consequence of material poverty. Having limited access to affordable basic services can push non-poor households into material deprivation and push poor households into deeper material deprivation. People in poor health are unable to work, children without electricity cannot study after dark, and households without access to potable water or sanitation are at greater risk for disease. At the same time, due to the governments' failure to provide or ensure the equity in access to basic services, people with low levels of income or wealth are generally less likely to have access to these services. Children in the poorest income quintile in developing countries are less likely to attend primary school, are three times less likely to be delivered by a skilled attendant at birth, nearly twice as likely to not receive measles immunization, and more than twice as likely to die before their fifth birthday compared to children in the richest income quintile.[41] Provision of basic services is important in maintaining equality of opportunity, in the absence of which a vicious cycle of poverty is created (See Figure 1). Examples below show how this vicious cycle is created leading to a poverty trap.

Figure 1: The vicious cycle of poverty in the absence of lack of access to basic services



Source: Authors' elaboration

Material poverty results from low levels of access to basic services

- **Poor health, as a result of inadequate health care services, prevents people from participating in their regular income generating activities.** This is particularly devastating for those whose livelihood heavily depends on physical strength.[42] Poor health also leads to poverty through high out-of-pocket health expenditures, which can have grave consequences for the poor and near-poor people. It is estimated that each year 150 million people are pushed into poverty due to catastrophic out of pocket health

39 O'Donnel et al (2007)
40 Castro-Leal et al (2000)
41 UNICEF (2010)
42 Banerjee and Duflo (2011), Sala-i Martin (2005)

expenditures.[43] Poor health has a negative impact at the macro level as well. Prevalence of malaria in Africa and life expectancy at birth are found to be robust determinants of economic growth.[44] Hence while good health is essential for every individual, it is also central to national poverty reduction strategies.[45]

- **Low levels of education and illiteracy exacerbate difficult living conditions for the poor and prevent people from getting out of poverty.** Beyond its value as a basic human right, education is a form of human capital with an important value as a means to income generating activities. It is a widely known and proved fact that higher levels of education are associated with higher levels of income.[46] Moreover education is linked with poverty through its relation with health. For instance, illiteracy of mothers and fathers is found to be one of the key determinants of child mortality.[47]
- **Not having an access to safe drinking water and improved sanitation leads to poverty through poor health.** Increasing people's access to water and sanitation have direct impact on reducing poverty through improving people's health, reducing health costs, increasing their productivity and time savings.[48] Inadequate access to improved water and sanitation leads to adverse health outcomes.[49] For instance, diarrhea, which is caused by unsafe, pathogen contaminated food or water, is the second leading cause of child mortality.[50] It is estimated that in 2012, 622,000 under-five deaths were due to diarrhea and 322,000 of these deaths were estimated to be associated with poor levels of access to safe drinking water or improved sanitation.[51] Hence improving access to safe drinking water and improved sanitation is associated with decreases in child mortality by preventing diseases like diarrhea. As a matter of fact, in the United States, nearly 75 percent of the decline in infant mortality between 1900 and 1946 is estimated to be due to piped water and better sanitation.[52]
- **Not having access to electricity puts people at a disadvantage in terms of income generating activities and education.** Electricity access lets households extend their activities beyond day-light hours and provide power to the machines that would result in time savings for the individuals which might be used in other productive activities like education or employment.[53] Moreover access to electricity is also linked with health outcomes. In some parts of the World, health facilities lack access to electricity and, as a result, cannot provide adequate services. For instance, it is estimated that more than 40 percent of health centers in Ghana, Rwanda and Kenya do not have electricity access.[54]

Material poverty leads to low levels of access to basic services - when services fail to reach the poor

- **The chances of surviving beyond one's 5th birthday depend on his/her household's level of wealth.** In many developing countries, it is more likely to die before turning 5 for the poorest children compared to the richest. Despite the fact that under 5 mortality has

43 WHO (2013)
44 Artadi and Sala-i Martin (2005), Sala-i Martin et al (2004)
45 OECD (2003)
46 OECD (2013)
47 Kiros and Hogan (2001)
48 WWAP (2015)
49 WHO (2014)
50 Wagstaff and Claeson (2004)
51 WHO (2014)
52 Cutler and Miller (2005)
53 UNDP (2005)
54 World Bank (2010a)

declined in many countries, the divide between the rich and the poor remained.[55] The ratio of under 5 mortality rates of the poorest 20 percent to the richest 20 percent is on average 2.2 in developing countries, meaning that on average it is twice as likely that a child would die if he was born into a poorer household compared to a child born into a richer household.[56]

- **Poor children cannot reach basic education services.** Primary school enrolment rate, on average, is estimated to be 64 percent among the poorest compared to 90 percent among the richest in year 2008.[57] In many developing countries there are large disparities in access among children due to their wealth status.
- **Poor people lack access to improved water source and sanitation facilities.** For instance, in Sub-Saharan Africa the coverage for the improved water sources of the richest is estimated as 86 percent while it is only 36 percent for the poorest in year 2008.[58] In a number of countries in Africa disparities go almost as far as full coverage for the richest and no coverage for the poorest.[59]
- **Inequalities in access to improved sanitation facilities are worse than inequalities in access to improved water sources.** For instance, in Sub-Saharan Africa access to improved or shared sanitation facilities is estimated as 75 percent among the richest while it is only 15 percent among the poorest, while in South Asia, the disparity is even wider with 92 percent coverage for the richest 20 percent, compared to only 4 percent coverage for the poorest 20 percent of the population.[60]
- **People living in rural areas are at a disadvantage in access to electricity.** While 95.3 percent of the population living in urban areas have access to electricity, this rate drops to 70.2 percent for the population living in rural areas[61]. Differences are wider in the developing regions of the World like Sub-Saharan Africa. In Sub-Saharan Africa, rural coverage is as low as 14.1 percent compared to the urban coverage of 67.9 percent.[62]

The Way Forward

Doing more of the same will not be enough to overcome inequalities in access to basic services. Some progress has been made towards achieving universal access to basic services, however it will take generations to reach people from all levels of income, genders, and geographies. For instance, in Sub-Saharan Africa, males in the richest quintile are expected to reach universal primary school completion by 2021 while females in the poorest quintile are expected to reach this target by 2086, which is 67 years later.[63] Similarly, many countries in Sub-Saharan Africa are not expected to reach universal coverage of drinking water and sanitation until 2100.[64]

In this respect, delivery of basic services remains a priority among the international development community. Over the past two decades, members of the international development community implemented several programs and campaigns to promote and expand access to basic services. The largest and perhaps most notable of these is the

55 UNICEF (2010)
56 UNICEF (2010)
57 UNCIEF (2010)
58 UNICEF(2010)
59 UNICEF (2010)
60 UNICEF (2010)
61 World Bank, World Development Indicators
62 World Bank, World Development Indicators
63 UNESCO (2014)
64 ODI (2015)

Millennium Development Goals (MDGs) established in 2000 by the United Nations in partnership with their member states and the world's leading development institutions. The MDGs set targets for countries to achieve by 2015 and include several goals related to the delivery of basic services such as achieving universal primary education, reducing child mortality, improving maternal health, combating HIV/AIDS, malaria and other diseases, and expanding access to improved water and sanitation sources. In July 2014, the UN adopted the Sustainable Development Goals, which are intended to complement the original eight MDGs. The goals and targets will be finalized at the special summit on sustainable development in September, 2015. Not surprisingly, of the seventeen Sustainable Development Goals that were proposed, several are related to basic service delivery. These goals are:

- End poverty *in all its forms* everywhere
- Ensure healthy lives and promote well-being for all at all ages
- Ensuring inclusive and equitable quality education and promote lifelong learning opportunities for all
- Ensure availability and sustainable management of water and sanitation for all
- Ensure access to affordable, reliable, sustainable and modern energy for all
- Make cities and human settlements inclusive, safe, resilient and sustainable

The Sustainable Development Goals place greater emphasis on the multiple dimensions of poverty. The MDG target to eradicate poverty was to halve the population living on less than $1.25 a day. The SDGs expands on the MDG's target for poverty in its proposed goal of *ending poverty in all its forms* by setting targets "to reduce at least by half the proportion of men, women and children of all ages living in poverty in all its dimensions according to national definitions" and, "By 2030, ensure that all men and women, in particular the poor and the vulnerable, have equal rights to economic resources, as well as access to basic services, ownership and control over land and other forms of property, inheritance, natural resources, appropriate new technology and financial services, including microfinance".

1.2 Models of Basic Service Delivery and Best Practices from Around the World

Services are delivered to citizens by public providers, private providers, citizens, themselves, or a combination of all three. Government involvement in service delivery varies across countries, but no matter the role, they are responsible for allocating sufficient resources and delegating tasks to service providers. When a government provides services, the service providers act as agents of the State and hence are "employed" by the State. On the other hand when private providers provide services without government intervention, they act as agents of the citizens and hence are "employed" by the citizens directly. This nuance may create differences in the quality and the quantity of services provided by the State and the services provided by private parties.

The delivery of services includes three types of actors: the state, the citizens and the service providers. These actors are linked together through accountability relationships. In this report, the accountability framework set out by the World Development Report (WDR) 2004 of the World Bank is used to understand the service delivery mechanisms and how they might fail to reach the poor. WDR 2004 is regarded as a ground-breaking document in the development community with its depiction of service delivery and how it might fail. It could be

the only report, the 10th anniversary of which is celebrated by a conference to discuss its influence.[65]

In this section, we will firstly describe accountability, and the accountability framework as set out by WDR 2004. Then we will discuss how the accountability relationships between the actors can be strengthened in order to improve service delivery. Lastly, we will look at different service delivery models and how they affect accountability relationships and highlight global best practices.

1.2.1 General Framework: Actors and Accountability

What is accountability?

Accountability is to hold actors responsible for their actions.[66] In other words, to hold someone accountable for an action or outcome means that the accountable person will face the consequences that result from the delivered outcome. In this respect, the provider of a service is accountable to the client and hence responsible for the outcome. For example, a water vendor is accountable to the customer for the water he sells, a doctor is accountable to the patient for the surgery he performs and an electricity distribution company is accountable to the citizens for the electricity it provides. Hence when something goes wrong with these goods or services, the people or entities providing the service will face the consequences and they have to provide an explanation to the clients that they are accountable to.

Accountability has five main features, which are delegation, financing, performing, information and enforcing, as defined by the WDR 2004. In this respect, in any accountability relationship the client must first delegate a task to the provider. Secondly the client provides adequate resources for the services to come through by financing them. Afterwards the services are delivered by the provider and hence a level of performance is observed by the client. This performance is assessed by the client to understand if the service is provided at the desired quality level. If the client is not happy with the result he may walk away from the provider and thus punish him through causing a financial loss or through legal action. Hence this possibility of punishment empowers the client and enforces the provider to act in a certain way.

Who are the actors?

The WDR 2004 sets out a framework to illustrate the service delivery chain. According to this framework, three sets of actors and the accountability relationships in between these actors make up the delivery chain (See Figure 2).

Citizens: The citizens receive the services. Citizens are a heterogeneous group composed of many other sub groups and individuals. Yet, basic needs of the citizens are common since every individual needs basic services.

The state (Politicians and policymakers): The state is responsible for collecting and allocating public funds and setting rules and regulations related to service delivery. This group is composed of elected politicians and bureaucrats who are not elected but appointed. The strength and capacity of the state is important for the service delivery chain to work.

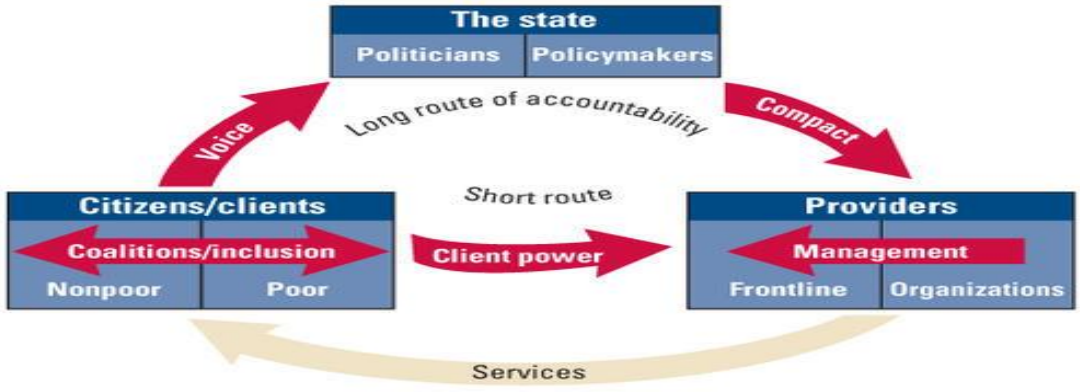
Service providers: This group includes the organizations and the frontline services providers that interface directly with citizens. Service providers can take many different forms

[65] The impact of 2004 WDR was discussed in a conference on January 2014, hosted together by Overseas Development Institute and World Bank. Available at http://www.odi.org/events/wdr-conference-making-services-work-for-poor-people
66 McGee and Gaventa (2010)

depending on the sector and the country. A service provider might be a Ministry, a public utility company, NGO, or a private company.

These groups of actors are connected to each other via a set of accountability relationships as depicted below:

Figure 2: The Accountability Framework in Service Delivery



Source: World Bank, World Development Report 2004 "Making Services Work for the Poor"

How are the actors linked with each other?

The actors are linked through principal-agent relationships.

1. **Citizens and the state (*Voice*):** Citizens are the principal actors in their relationship with the state. The State is accountable to the citizens for delivering adequate services. The state manages this task through the service providers.

   Citizens hold the state accountable for their actions through voice. In the accountability relationship between citizens and the state, the state is delegated the job of delivering services and is financed through taxes collected from the citizens. If service delivery is mismanaged or poor, the state must justify its actions to the citizens. Citizens have the power to hold the state accountable through public elections and can vote against the poorly performing government actors. Beyond the ballot box, citizen voice can also be exerted through the courts, in particular, via right-based laws, as well as through media and civil society.

2. **The State and the service providers (*Compact*):** In the relationship between the state and the service providers, the state is the principal while service providers are the agents responsible for the delivery of the services. In the relationship between the State and the service providers, the service providers *serve* the State and are accountable to it.

   The State (politicians and policymakers) exert power on providers through compact. Compact is a set of rules and regulations put forth by the state for the provider organization to follow in order to deliver services. This generally includes rewards, sanctions, and monitoring methods.

   For example, If the Ministry of Education, as the service provider, is delegated the job of delivering education services to the public and is financed by the government budget. The performance of the Ministry might be monitored via national or international exams, collected statistics on access of the population and quality of the

schools. The Ministry is held accountable to the State (central governments) for its performance. However, the compact relationship can be weak if policymakers lack the established mechanisms to collect information on the quality of the services, such as not having staff capacity to monitor quality of education facilities in rural areas. Without information, it becomes hard to enforce power over the service providers. While compacts are generally vague, it can be made clearer by developing a contract with the provider that outlines rewards and sanctions in greater detail. Having a contract with the provider allows the State to exercise greater enforcement because it gives them the ability to terminate the contract and "fire" the provider if the provisions outlined in the contract are not met.

3. **Citizens and the service providers (*Client power*):** Lastly, there is the principal-agent relationship between the service providers and the clients (citizens). While the public service providers are "employed" to serve the citizens, they are "employed" by the State. Hence public providers may or may not be accountable to the citizens depending on the client power that the citizens have over the providers. In contrast, private service providers are directly accountable to the citizens since they serve the citizens directly and not the State.

   In the accountability relationship between the citizens and private providers, private providers are directly accountable to the clients, since citizens delegate the job to the private providers, finance them and have the power of enforceability by walking away from them. While, in contrast, public service providers are accountable to citizens indirectly because they are actually "employed" by the State to "serve" the citizens. Yet, through established mechanisms citizens might exert direct client power on public providers as well. For instance, when the public providers' budget is linked to the number of citizens it serves and the citizens have the option of choosing from a number of public service providers citizens have the client power over the public service providers as well. This is actually exactly the enforceability mechanism that citizens use over private providers to make them deliver good quality services. Mechanisms to issue complaints are another way for citizens to make the providers directly accountable to them. Client power can also be exerted when citizens are part of the governance structure, hence directly contributing to the service provision.

Long and short route of accountability

Given the three relationships outlined above, citizens have two routes to enforce accountability (i) the short route, which occurs between citizens and providers or (ii) the long route, which occurs between citizens and providers via the State. The short route is *the* relationship between private sector service providers and clients while between public service providers and the clients it may exist as well depending on established mechanisms to empower the clients. In the short route, the citizens have a direct relationship with the service provider and can hold them accountable for their actions. In comparison, in the long route, the service provider is indirectly accountable to the citizens and directly accountable to the State. Because there are multiple accountability relationships in the long route, the delivery chain may fail to address the needs of the citizens when there are weaknesses in voice or compact relationships.

In the long route of accountability, voice and compact should be strong to make services work for the poor. Citizens are linked with service providers through the state in the long route of accountability. As a result, citizens need a strong voice to enforce accountability over the State. If the state is not properly monitoring or sanctioning service providers, it is

important for citizens to exert power over the government to make changes. In some cases, citizens may not have a strong voice. For example, political power may not represent poorer households, marginalized citizens may not understand their rights, independent media may not exist, or the judiciary system may be slow or dysfunctional. Hence citizens need the tools and mechanisms for monitoring and sanctioning to hold the service providers directly accountable to them.

Beyond the accountability framework, current discussion in the development community on making services work for poor people adds social norms and individual behaviour as important elements. Recent studies indicate that despite an absence of incentives, like rewards or sanctions, the frontline service providers might still deliver adequate services. In one study, it is found that although public prenatal clinics in Uganda, Kenya and Ghana were weak on sanctioning for misbehaviour along with low user expectations for the quality of the services, they received high performance ratings.[67] One possible explanation was that the individuals who choose careers in public health care are self-selected and already have a pro-social outlook. In a similar vein, the World Development Report 2015 emphasizes the role of social norms for better policy making. Social norms or "what we think that the others are doing" may be used or at least may be taken into account for better service delivery. For instance, in the UK, it was found that tax payers paid more when they receive letters noting that other citizens in their neighbourhood paid their taxes.[68] A similar approach could easily be used to increase fee collection rates for water and electricity services. In another example, the community led total sanitation approach has had great success in changing the social norm around open defecation by increasing the shame and disgust around it in the communities. It was found that this approach was useful in decreasing open defecation in some communities in Indonesia, Bangladesh, and India.[69]

1.2.2 Models of Basic Service Delivery

There are no bad or good models of service delivery per se but some models are more appropriate than others in certain circumstances. The models that we will describe here are central service provision, decentralized service provision, public-private partnerships, community participation, and private sector service provision. We will describe each model and explain how it fits into the accountability framework, which relationships can be improved, the advantages, and the challenges. Each model is also accompanied by a best practice case from one of the five focus sectors: education, health, water, sanitation and electricity.

Central provision

Central government provision can be thought of as the traditional model of service delivery. For education and health sectors, central provision of services means that there is a ministry responsible for service delivery and holds all the decision making power for resource allocation, financing and staff employment. Both the financing and delivery of services is under the responsibility of the central government and decision making power is not shared with lower tiers of the government or local governments. Private participation through public-private partnerships does not exist in this model.

In case of the infrastructure sector, governance structure is somewhat different. As we will see in Section 2.2 of the report, a ministry is rarely directly responsible for the delivery of

67 Dizon-Ross et al (2014)
68 World Bank (2015)
69 World Bank (2015)

water and electricity services. In the case of water and electricity, service delivery is delegated to a public utility company. This public utility company is accountable to the central government and may or may not be autonomous in decision-making in areas such as staff hiring, investment decisions, or setting tariffs.

Voice and compact must be strong for central government provision to work well. According to the WDR 2004, if central government already uses pro-poor politics and if the clients have homogenous needs in terms of the service, then central government provision could work well. This might be the case in the provision of immunization services for instance since clients have homogenous needs regarding this service. In addition, if the service quality is difficult to monitor, it will be difficult to enforce a contract, making central government a better choice for providing this kind of a service.

Advantages

Economies of scale: Especially with water, sanitation, and electricity, centralizing provision has significant economies of scale. In other words, it is cheaper to provide these services by a single agency to a large group of people. This is the reason why in many countries a national utility company naturally takes over the responsibility for these services. Even if the delivery of water services are decentralized to local governments, services are aggregated under a smaller number of administrations in countries like France, Netherlands, England, Philippines and Brazil in order to benefit from economies of scale.[70]

Better management and control over homogenous services: Central government provision of services works well in cases where local governments are weak in capacity or it is difficult to monitor the quality of the services. Central governments almost always have better human capital than local governments. A central implementing agency generally leads to better outcomes when managing large-scale provision of services, like rural electrification projects.[71]

Possible challenges

Failure in the long route of accountability: Everything that was discussed as posing a challenge in the long route of accountability is a challenge for central provision of services. The service providers are only accountable to the central government and, unless they are monitored effectively, may provide low quality services to citizens.

Clientelism: A clientelist approach in the delivery of services can be seen in every type of basic services. Politicians may show preferential treatment to a particular group of citizens or a particular region at the expense of others. The problem of clientelism is not specific to central government provision and can also be observed in local government provision of services. It is especially apparent in the infrastructure sector where semi-autonomous national utilities provide service and there is political control over tariff structure.[72]

Box 1 Best practice: Rural electrification in Thailand through a single public agency

More than 99 percent of Thailand's rural villages have access to electricity currently. In comparison, in the 1970s, only 10 percent of the population outside of the Bangkok Metropolitan Area had access to electricity. The significant increase in access is largely attributed to strong government support for rural electrification and solely dedicated public agency (Barnes, 2005).

70 World Bank (2008)
71 Mostert (2008)
72 World Bank (2003)

Thailand delegated rural electrification to the Provincial Electricity Authority (PEA), an autonomous government agency created to distribute electricity to areas outside of the Bangkok Metropolitan Area. The government prepared the National Rural Electrification Plan, which aimed to cover all villages with electricity in 25 years, a time period which was later shortened to 15 years.

During the initial phase, PEA opened a separate office to oversee the expansion of the electricity grid network. After the grid expansion was completed, PEA dissolved this office and continued to manage electricity distribution to urban and rural areas outside of Bangkok. PEA had full-autonomy over its budget and was able to complete the project without a deficit. PEA established an urban-to-rural cross subsidy to improve financial viability (World Bank, 2012). Participation of local communities was encouraged during the expansion process through cash or in-kind contributions obtained from communities (World Bank, 2012). In many cases, villagers supported the construction by providing free labour (Barnes, 2005).

Rural electrification did not suffer from a clientelist agenda. Citizens understood in advance of the project that some villages could not be reached via grid extension and villages were selected through an objective process that accounted for factors like proximity to the grid, to roads, and population of the village (World Bank, 2012). Therefore, village selection was not affected by politics and investment decisions were made using objective criteria.

Thailand's success in rural electrification can be attributed to (i) government will and support in rural electrification, (ii) managing the process centrally through an autonomous agency, and (iii) widespread community participation.

Sources: Barnes, Douglas F. ed. 2005. The Challenge of Rural Electrification: Strategies for Developing Countries. Washington, DC. World Bank.

World Bank. 2012. Addressing the Electricity Access Gap. Washington, DC

Decentralization in service delivery

Decentralization can be defined as transferring roles and responsibilities from the central government to lower tiers of the government.[73] Decentralization adds another level to the accountability framework by establishing a new compact relationship between the central government and a lower tier public agency (elected or not elected local government or public authority). In terms of the accountability framework, decentralization of services can improve the compact and the voice. If implemented with a clear division of responsibilities and established monitoring mechanisms, decentralization can improve service delivery.

There are many forms of decentralization that give varying degrees of authority to local governments. In terms of service delivery, the WDR 2004 uses the following classification for decentralization: (i) deconcentration (ii) delegation and (iii) devolution.

Deconcentration occurs when the central government allocates some, but not all, of its responsibilities to a lower-tier government. In this model, agents are generally appointed by the central government and can be regional or provincial directorates, governors or mayors. The central government still maintains authority over the lower-tier government and is involved in most decision-making. Service delivery is implemented at the local level, but

73 World Bank (2003)

reports directly to and is accountable to the central government. Financing and budgetary control are usually managed by the central government.

Delegation is one step closer to full decentralization. In delegation, the central government allocates more responsibilities to the local government. Local leaders may be elected but the central government controls the budget and spending priorities. Service delivery is managed locally, but finances are transferred from the central government and may also maintain control over human resources. The local service provider is closer to the client geographically, but is fully or partially accountable to the central government.[74]

Devolution is full decentralization. The central government transfers full responsibility of local matters to the local government. Local leaders are elected by the public and the local government generates its own finances. The local government maintains a relationship with the central government and is mandated to follow national policies and regulations.[75] The local government is responsible for managing and financing service delivery. Unlike deconcentration and delegation, the local government is accountable to its citizens, which may improve service delivery through improving voice.

Advantages

Better management at the local level: Decentralized models typically use resources more efficiently because they are managed in closer proximity to service delivery. In Bolivia, decentralization had a positive impact. Finances were better matched to the needs of the localities and access to services became more equitable. They were able to shift investment to areas that needed it the most. Municipalities that had lower access to education received more funding for education services and municipalities with lower water and sanitation coverage received greater investments.[76]

Improving voice: In case of deconcentration and delegation, lower-tier agencies are still accountable to the central government and generally are not expected to affect the voice relationship with citizens. However, when the responsibilities are devolved to an elected local government, citizen voice increases and they can more easily affect policies. Through elections, citizens have the ability to hold local governments accountable for service delivery.

Possible challenges

Inequalities between localities: Devolution of responsibilities to local governments might result in severe inequalities. This might be due to low revenue generating capacity of different local governments. In China, Shanghai municipality has the largest revenue generating capacity in the country. As a result, its per capita spending is 8 times more than the neighbouring province Henan.[77] Another problem that can occur is that local governments may not place a high priority on health care or education services. This was the case in Uganda. During the decentralization process, districts significantly decreased their budget share for primary health care services from 33 percent to 16 percent between 1995 and 1998.[78]

Lack of capacity in local governments: Local governments may not have adequate capacity in terms of human resources or financial resources to deliver services. In some cases, local governments do not have enough revenue generating mechanisms, which hinders their

[74] World Bank (2003)
75 Ahamad et al (2014)
76 Mansuri and Rao (2012)
[77] ADB (2013)
[78] Akin, Hutchinson, and Strumpf (2001)

operating capability. In Nigeria, education and health services were decentralized to municipalities, but the municipalities could not pay the salaries of teachers and doctors. As a result, the central government had to take back the responsibility.[79]

Box 2 Two different ways of decentralization in the delivery of education services, the cases of Netherlands and Finland

The Netherlands and Finland are two examples of countries with different kinds of decentralization methods but have had good results in their education system. In the Netherlands, school autonomy is established via School Boards while in Finland municipalities are responsible for allocating budgets and personnel management in schools.

The education system of the Netherlands is one of the most decentralized education systems in the World (World Bank, 2012). The Ministry of Education has an overall responsibility in policymaking while the School Boards are responsible for the delivery of the education services by owning and operating the schools. A total of 1,200 School Boards oversee primary education. While half of these boards oversee only one school, the remaining boards oversee 30 to 50 schools each. School Boards control the school budget and have the autonomy to hire and fire teachers as well as principals. They report to a Board of Governors and the Board of Governors report to the Government. Parents are also represented in School Boards or they take part in the Participation Council each school has which has the right to give advice or consent to the School Board (World Bank, 2012).

Apart from a high level of decentralization, the education system of the Netherlands is well known for high level of choice it provides to the citizens by funding all public and private schools. Hence a parent may choose to enrol her child to any school which increases competition between schools and possibly increasing their performance as well. 70 percent of the schools in the country are private and subsidized by the government (World Bank, 2012). As a result, the Netherlands has one of the most successful education systems in the World, which is confirmed in their high performance in international assessment results (Patronas et al, 2009).

In Finland, a different from of decentralization is implemented with a very low level of private participation. The Ministry of Education is in charge of overall policymaking, curriculum, and central funding. Municipal governments, through their Municipal School Boards, are responsible for implementation at the school level including financing and human resource decisions. Schools have a certain level of autonomy including the freedom to use the teaching methods they prefer as long as they comply with certain national standards.

Similar to the Netherlands, parents are free to choose public or private schools since all public and private schools are funded by the government. Yet, private schools only constitute 1.5 percent of all the schools in the country (World Bank, 2012). Finland is also one of the top performers in international assessment tests (World Bank, 2012). The high success of Finland is in part attributed to the high quality of its workforce in the education sector.

Sources: World Bank. 2012. Netherlands: School Autonomy and Accountability. SABER Country Report. World Bank: Washington, DC.

World Bank. 2012. Finland: School Autonomy and Accountability. SABER Country Report. World Bank: Washington, DC.

[79] Ahmad and Brosio (2009)

Contracting out

Contracting out is an arrangement between the public sector and private entities, where the private entity provides a public service. Typically, the private entity will have management responsibility and remuneration linked to performance. Contracted out entities may have the responsibilities for designing, building or rehabilitating, financing, maintaining and operating. Contracted out entities can be financed through user fees or government funding or a combination of the two.

In the accountability framework, contracting out services, affect the compact relationship between the policymakers and the service providers. By introducing an explicit contract instead of a compact, policymakers can delegate the responsibilities, rewards and sanctions, all of which are stated and enforced through legal means. Contracts should include items regarding the quality of the services and standards to be followed, making the operator legally obliged to follow a set of standards. Apart from legally binding the provider, the fact that other companies might be hired by the state to do the same job could increase the enforceability of the state via increased competition.

Advantages

Increase in access to services: The government can use contracting out to increase access to services. Contracting out services may increase access where the private entity or NGO has a greater presence or easier access in hard to reach areas. In this respect, the government may consider partnering with NGOs because they generally have a wider reach in rural or poorer communities. One example is Fe y Alegria, an NGO that partner with central governments to operate schools for the poorest communities in Latin America and Spain.[80] Under this model, the salaries of the teachers and the principals are paid by the government while construction and maintenance of the schools are funded through donors, voluntary fees and participation from local communities. In 2005 there were 1.2 million students in schools operated by the NGO.

Contracts may increase access through including coverage obligations and penalties for not reaching a certain population. Many countries, including Columbia, Honduras, Gabon, and Senegal, write coverage obligations into their contracts with private providers for water service delivery.[81] Focusing on Gabon, the 20 year concession contract that was signed with the company had specific water service coverage targets including a list of new towns to be served, 5 year moving targets to be reached and penalties to be paid in case the targets are not met.

Increase in quality and efficiency of services: Private companies may increase the quality and efficiency of the services provided. An econometric analysis of the effect of private sector participation in 1200 water and electricity utilities across multiple developing countries found that private participation was associated with increases in coverage, daily hours of service and a reduction in water losses.[82] Another study also found consistent results, using data from urban water utilities in developing countries worldwide.[83] Overall it was found that private participation in service delivery improved operational efficiency and service quality. Quality improvements are observed in the education sector in case of private participation as well.

[80] ADB and UNICEF (2011)
[81] World Bank (2006)
[82] Gassner et al (2009)
[83] Marin (2009)

Publicly funded privately operated schools are found to be more likely to have higher levels of academic achievement compared to publicly operated institutions.[84]

Possible challenges

Weak government capacity: Contracting out services requires a high level of monitoring and supervision from the side of the purchaser.[85] Since the government is already weak to provide services itself it may also be the case that the government is weak as well to monitor and enforce the contracts on the private providers or NGOs. For instance, for the Basic Package of Health Services Program private providers were contracted out to provide health services to ten states in South Sudan. As a result of a combination of weak government capacity and an over-ambitious program design, the project took an additional three years to be implemented and only reached four out of the ten targeted states at the end.[86]

Box 3 Contracting with NGOs for better health service delivery in developing countries

Contracting out NGOs to deliver primary health care or nutrition services led to improved results in a number of countries including Bolivia, India, Cambodia, Guatemala, Madagascar, Senegal, Pakistan and Bangladesh. In these countries, different types of contracting schemes were used and these schemes were compared with each other and with the traditional way of public provision of services where possible. In these countries, in some cases NGOs were contracted to manage existing government services through management contracts while in other cases NGOs were contracted to both manage and supply infrastructure, personnel or equipment through service contracts.

These arrangements were usually large scale reaching millions of people in many of these countries. For instance, in Guatemala, contracting out primary health care services reached a population of 3 million beneficiaries in the mountainous areas of the country. Similarly in Cambodia, 1.5 million beneficiaries were reached through services contracted out to NGOs. These programs which started as pilot projects were further scaled up in most cases. For instance, the project in Guatemala covers 27 percent of the population now (Loevinsohn and Harding, 2005)

Results generally show improvements in service delivery through contracted services. For instance in Guatemala after the government had signed 160 contracts with 88 NGOs for the provision of a basic package of health services including maternal and child health, the mixed model where a management contract was signed with NGOs improved the coverage rates around 5-16 percentage points higher than the traditional model of service delivery (Wagstaff, 2004). Similarly in Cambodia for instance, health indicators like immunization coverage and antenatal care improved more for the villages served by NGOs under management and service contracts (Wagstaff, 2004).

Sources: Loevinsohn, Benjamin, and April Harding. "Buying results? Contracting for health service delivery in developing countries." The Lancet 366.9486 (2005): 676-681.

La Forgia, G., P. Mintz, and C. Cerezo. 2005. “Is the Perfect the Enemy of the Good? A Case Study of Large-Scale Contracting for Basic Health Services in Rural Guatemala.” in ed. Gerard M. La Forgia “Health System Innovations in Central America Lessons and Impact of New Approaches”. World Bank, Washington, DC.

Wagstaff A, Claeson M. The Millennium Development Goals for health: rising to the challenges. Washington, DC: World Bank, 2004.

[84] Schütz, West, and Woessmann (2007)
[85] OECD (2009)
[86] OECD (2009)

Community participation

Community participation occurs when community members are involved directly in service delivery. There are varying degrees of community participation in service delivery. In some cases, communities directly manage, finance and deliver services. Some examples include water or electricity cooperatives and schools managed by community-led school boards. Community participation can also take the form of financial contributions, sweat equity such as building a school or sanitation facility, or advisory services, such as parent-teacher associations. Citizens who participate in service delivery are better informed and have a stronger voice.

Advantages

Increasing access: Community provision of services can lead to increased access, especially in areas where other methods of service delivery have difficulty in reaching. El Salvador's EDUCO program, as an example, saw substantial increases in enrolment and attendance in schools managed by parent only school boards.[87]

Increasing quality: Quality of services can improve when the community is involved in the delivery. A well-known example is the citizen report card programme to monitor health service delivery in Uganda. This intervention led to a decrease in staff absenteeism, decrease in waiting times at health centres, increase in access and satisfaction from the side of the patients.[88] In the infrastructure sector, community participation can lead to better maintenance of the equipment. In Pakistan, a study comparing infrastructure projects implemented by the government and infrastructure projects implemented by the communities through support of government funds or NGOs found that the maintenance of equipment improved in projects implemented by the communities themselves.[89]

Possible challenges

Capture: Community participation may not adequately represent the entire community, excluding residents based on income, gender, or cultural identity. In fact, studies find that participants in civic activities are more likely to be wealthier, more educated and male.[90] Decision making power or access to the funds may be controlled by one group resulting in bias towards other population groups.

Low capacity of communities: Communities might not be well equipped to run services, especially when technical knowledge is necessary. For community involvement to provide positive results, the production must be small scale and require little technical knowledge.[91] In this respect, community-based infrastructure projects might work better when the communities are trained in the technical aspects of the projects.[92]

Fairness issue: Citizens directly providing the services themselves, especially by providing free labour or high financial costs, is debatable. While better off people living in urban areas have access to basic services without any specific effort, the citizens who are already income and time poor might be asked to participate in the provision of services by providing these scarce resources. This raises a question of fairness and if the central government is trying to escape from its responsibilities.

87 Fiszbein (2005)
88 Mansuri and Rao (2012)
89 Mansuri and Rao (2012)
90 Mansuri and Rao (2012)
91 Fiszbein (2005)
92 Mansuri and Rao (2012)

Private provision

Private sector might take a part in the provision of public services. Private service providers are active in the provision of many types of basic services such as private schools, private sanitation trucks, and water vendors. However, it is rare for basic services to be provided purely in a private market.

Private provision of services increases accountability between service providers and citizens. In fact, this kind of service provision is the short route of accountability. Answerability and enforceability is strong due to increased choice. Revenues of private providers are directly bound to the number of customers they have and losing a customer is equal to losing revenue. As a result, private providers have a direct incentive to provide good services to their customers.

Box 4 A Water Cooperative Serving 750,000 people in the city of Santa Cruz in Bolivia

Cooperatives are autonomous associations, composed of individuals participating voluntarily to meet their common economic, social and cultural needs through a jointly-owned and democratically controlled enterprise (Ruiz-Mier and Ginneken, 2005). In provision of services, cooperatives might act better than both private providers and public providers since members are both users and providers of the services. Hence cooperatives do not seek profit and they have a goal to provide and receive good services. Water and sanitation cooperatives are a form of utility cooperatives which usually serve customers in rural areas.

In this respect SAGUAPAC of Bolivia is different since it operates in one of the cities of Bolivia, hence in an urban area. Starting its operations in 1979, SAGUAPAC is responsible for provision of water and sanitation services in the city of Santa Cruz, Bolivia (Ruiz-Mier and Ginneken, 2005). It is the largest water cooperative in the World serving 750,000 citizens with good performance in international standards such as availability of water 99.9 percent of the time and 97 percent of metered connections (Ruiz-Mier and Ginneken, 2008, 2005).

Customers own and control SAGUAPAC. While the cooperative is primarily accountable to its customers, it is also accountable to the regulator agency and external financing institutions (Ruiz-Mier and Ginneken, 2005). The regulator agency approves tariffs and sets targets for the cooperative to expand its water and sewerage connections. Yet, expanding its reach beyond its territory remains a challenge for SAGUAPAC. A reluctance to increase tariffs that would be the result of such an expansion is likely to be a reason behind this problem (Ruiz-Mier and Ginneken, 2008).

Sources: Ruiz-Mier, Fernando; Ginneken, Meike van. 2008. Consumer Cooperatives for Delivery of Urban Water and Sanitation Services. World Bank, Washington, DC.

Ruiz-Mier, Fernando; Ginneken, Meike van. 2005. Consumer Cooperatives: An Alternative Institutional Model For Delivery Of Urban Water Supply And Sanitation Services?. World Bank, Washington, DC.

Advantages

Increase in quality: Since private providers want to keep and possibly increase the number of customers they serve, the quality of the services they provide is expected to be high. This is why in private hospitals waiting times are lower and the behavior of the staff is generally better compared to public hospitals. Private schools are also found to achieve better results compared to public schools.[93]

93 Patrinos et al (2009)

Increase in access: Private sector participation can increase access to basic services. The WSP's Domestic Private Sector Participation Initiative expanded access to water and sanitation to over 950,000 people across 14 countries this year. In addition, 42 percent of the beneficiaries are low income.[94] For governments that do not have resources to deliver services themselves, encouraging private market participation can be a good solution to improving access.[95]

Possible Challenges

Inequality in access: Relying too much on the private market can result in inequity in access to services. Poor residents can be excluded because they cannot afford services. Because the focus is on profit, private companies cannot recognize positive externalities that could be generated outside of the market. For example, providing education free of charge can increase access to education, which can lead to several positive social outcomes which cannot be a goal for private sector but only for the government.

Box 5 Domestic Private Sector Participation in the Provision of on-site sanitation in Peru

Creating Sanitation Markets initiative has been promoting private market solutions to overcome the challenge of low access to improved sanitation in the poor areas of Peru. Between years 2007-2010, Creating Sanitation Markets initiative began in four pilot areas which have high levels of poverty and low levels of access to sanitation. In order to build an effective link between supply and demand four key actions were focused on: demand motivation, local supply, product design and household financing options. Trainings were held in order to improve local private sector capacity targeting local plumbers, artisans and hardware store owners. Different financing mechanisms were tried with the consumers including subsidies. Private sector provision was employed as the main model to provide services.

At the end of the pilot phase, households without access to sanitation decreased by 35 percent from 31.7 percent to 21.1 percent of the households. In addition, 18 percent of the households improved their existing sanitation facilities. The majority of the clients of Creating Sanitations Markets Initiative was below the poverty line and while 86 percent of these clients bought the sanitation facilities through their own resources, 8 percent used credit and 6 percent used a mixture of these two. Satisfaction of the citizens with the local supply of sanitation services turned out to be very high with 83 percent general satisfaction rate. Trying to solve the sanitation problem through a market mechanism increased employment in the project areas and in addition sales of the local hardware stores increased as well.

Source: Baskovitch. 2011. Markets at the Bottom of the Pyramid: A Win-Win Scenario for Government, the Private Sector, and Communities. Washington DC: Water and Sanitation Programme

1.3 Data & Methodology

The study is composed of two main sections with regards to basic service delivery in the OIC member countries. Firstly, the general situation of basic services in the member countries was mapped out with regards to (i) access (ii) models of service delivery and financing, and (iii) common challenges. Secondly, in-depth case studies were carried out to

94 WSP (2014)
95 Sy et al (2014)

understand the basic service delivery and access of the poor in selected member countries in more detail.

In this respect, to map out the general situation with regards to basic services in member countries data was collected from several resources. This includes data collected from (i) publicly available data sources and (ii) a literature review carried out to identify service delivery models in the member countries.

First, publicly available data on education, health, water, sanitation and electricity outcomes were collected from a number of data sources. These data sources are:

1. World Bank, World Development Indicators
2. World Bank, Worldwide Governance Indicators
3. World Bank, Health Nutrition and Population Statistics by Wealth Quintile Database
4. UNESCO Institute for Statistics, Education Statistics
5. UNESCO, EFA Reports 2009 and 2015, Statistical Tables
6. UNESCO, WIDE Database
7. OECD, Aid Activities Database (Creditor Reporting System)
8. WHO, Global Health Observatory Data Repository

Data collected from these databases were used in several graphs that will be seen throughout the report.

Secondly, a comprehensive literature review and meta-analysis of existing academic literature was carried out to identify the service delivery models employed in 4 different sectors in the OIC member countries. The purpose of the literature review was to find published resources related with or mentioning the governance structure in the sectors in the member countries. The service delivery models presented in the Conceptual Framework have been searched for each country and each sector. To achieve this purpose a systematic internet search was conducted. This search included:

1. Comprehensive web-based search using key words (e.g. education system in Lebanon, health care in Lebanon, contracting out in health in Lebanon, etc.)
2. Searching document libraries of organizations such as World Bank, Asian Development Bank, OECD, Water and Sanitation Program of World Bank
3. Scanning of reference sections of key reports for further references

As a result of the literature review tables were constructed for each of the 4 sectors that the report focuses on, mapping out the service delivery models employed in the member countries. The existence of the following service delivery models was tracked for each country: (i) central government provision, (ii) decentralization, (iii) contracting out, (iv) community participation and (v) private provision and the meta-data for **36** (of 57 member) countries was compiled from a total of **185** sources. The meta-analysis included data from countries for which background literature existed in the education, health, water, sanitation and electricity sectors. Table 1 provides the number of countries and the number of references per sector that were used for the meta-analysis in the report.

The majority of the papers found in the review were published by international organizations such as World Bank, UNESCO or WHO. In addition, journal papers, reports by other agencies or private companies and government documents as well as websites of service provider organizations/government bodies were used as resources to map out the service delivery models in the member countries. A significant effort was made to reach resources that were

as relevant and as up to date as possible for the literature review and the majority of the resources collected were from 2010-2015. The full list of documents utilized for the background meta-analysis can be found in the references section of this report.

Table 1: Number of countries included in the literature review for each sector and number of references used

	Education	Health	Water	Sanitation	Electricity
Number of countries included in the literature review	35	36	33	33	35
Number of references	43	49	47	47	46

2. Overview of OIC Member Countries

Poverty is a challenge for a significant share of lower middle income and low income OIC member countries. OIC member countries[96] span all income levels and, using the World Bank's income level division, are classified among high income (7 countries), upper middle income (16 countries), lower middle income (17 countries) and low income (17 countries) countries. It is estimated that approximately 350 million people in OIC countries live in extreme poverty, using the $1.25 a day poverty line.[97] An estimated 1.2 billion people live in extreme poverty worldwide, which means more than one-fourth of the World's poor are living in the OIC countries. The percentage of the people living below $1.25 a day in upper middle income countries is, on average, 1.3 percent, but is as high as 43.4 percent in low income member countries. A lack of access to basic services exacerbates income poverty by generating a poverty trap where people cannot improve their living conditions due to being uneducated, sick and time poor.

In this section, we will discuss firstly the strength of voice and compact in OIC member countries which strongly affect basic service delivery and secondly service delivery in education, health, water, sanitation and electricity sectors in the member countries. Strength of voice and compact are added in order to give a general understanding of the relationship between citizens and the state and the service providers in member countries. In the service delivery part, indicators related to access to services followed by service delivery models and common challenges observed in member countries will be presented.

Throughout the report, the division of income groupings was used to organize the discussion. While there are some similarities between the countries in each income group, there are also dissimilarities. Especially in terms of access, grouping with regards to income level gives a clearer picture. However in terms of service models, income division does not directly lead to similarities. Similarly, a division with respect to regions does not give clear differences, either. Hence, for better organization of the report we use grouping with regards to the income level.

2.1 Voice and Compact in OIC Member Countries

As outlined in the previous chapter, weaknesses in the accountability relationships between the citizens, the state and the service providers result in service delivery failures. Citizens' voice in service delivery needs to be strong so that the state is accountable to them. Otherwise, when voice is weak, governments may more frequently and easily allocate resources as they wish without a threat of penalty. Hence, clientelism may arise and the poor is at risk of being neglected. Similarly compact between the state and the service providers must be strong so that the service providers are accountable to the state. Otherwise, service providers may fail to deliver services in adequate quantity and quality. Hence services may fail to reach the poor.

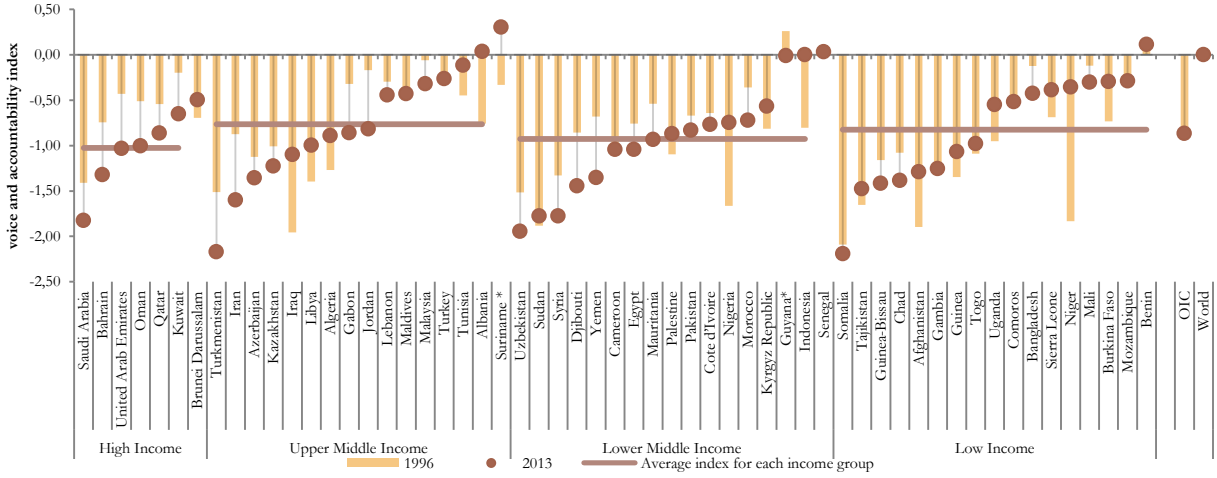
The voice and accountability index, constructed by the World Bank, measures the first link in the accountability framework which is between the citizens and the state. The index tries to reflect the strength of voice in countries by "capturing perceptions of the extent to which a country's citizens are able to participate in selecting their government, as well as

[96] The Organization of Islamic Cooperation (OIC) is composed of 57 member countries spread around the World. There are three official regional groups of the cooperation. These are the Asian Group (18 countries), the African Group (17 countries) and the Arab Group (22 countries). Asian Group includes the two member countries from South America as well.
97 COMCEC Poverty Outlook 2014

freedom of expression, freedom of association, and a free media.[98]" Unfortunately, OIC countries do not score well in the index[99] (See Figure 3). On average, the voice index was -0.86 in OIC compared to the World average of 0.00 in 2013. While high income countries seem to score lower on average, wide disparities are observed across all income groups. Among all OIC member countries, voice was found to be strongest in Suriname and weakest in Somalia. Other OIC countries with comparatively strong voice are Albania, Benin, Senegal and Indonesia, all scoring at or higher than 0.

Voice and accountability deteriorated in the last two decades for many of the member countries. This was especially the case in a number of MENA countries including all the high income countries in the region. Countries like Tajikistan and Uzbekistan also deteriorated in terms of the strength of voice. In comparison to other MENA countries, in Tunisia, Algeria and Libya, voice improved compared to 20 years ago. This is also the case in some of the lower income member countries like Niger, Nigeria and Uganda.

Figure 3: Voice and accountability index for the OIC member countries (1996 and 2013)



Source: World Bank, Worldwide Governance Indicators

Yet, it must be remembered that voice is only one piece towards the long route of accountability, and strong voice does not directly lead to improved outcomes. In addition to voice, the state and its compact relationship with the service providers need to be strong for the delivery chain to work. However, it is safe to assume that when voice is weak, service delivery will more likely to fail than not given the logic of the theoretical framework.

Government effectiveness index, constructed by World Bank, can be used as a proxy to represent the strength of the relationship between the state and the service providers. This index reflects the compact relationship by "capturing perceptions of the quality of public services, the quality of the civil service and the degree of its independence from political pressures, the quality of policy formulation and implementation, and the credibility of the government's commitment to such policies." On average OIC countries do not score well in this index[100] (See Figure 4). Government effectiveness index was -0.62 on average in the OIC countries compared to the World average of 0.00 in 2013. As opposed to the voice index which

98 World Bank. World Governance Indicators
99 The score ranges between 2.5 and -2.5, being closer to -2.5 means that the voice is weaker.
100 The score ranges between 2.5 and -2.5, being closer to -2.5 means that government effectiveness is weaker.

was lower in high income member countries, government effectiveness is highest on average for this group. In addition, government effectiveness gets lower on average with decreasing levels of income. Among all OIC member countries, compact was found to be the strongest in the United Arab Emirates and the weakest in Somalia. Other OIC countries with comparatively strong compact are Malaysia, Turkey Suriname, Tunisia and all high income member countries except Kuwait, all scoring at or higher than 0.

Figure 4: Government effectiveness index for the OIC member countries (1996 and 2013)

Source: World Bank, Worldwide Governance Indicators

Over the last two decades, a number of the member countries strengthened the compact relationship while in some others it deteriorated. High income member countries either improved their government effectiveness or they stayed the same. Regarding other income groups it is hard to come up with a generalization. Countries like Niger, Iraq, Afghanistan, Suriname and Turkey are among the ones that improved their government effectiveness over time. In comparison in countries including Cote d'Ivoire, Egypt and Libya government effectiveness deteriorated.

Strong compact coupled up with strong voice are necessary for the long route of accountability to work. Unfortunately, weak voice and weak compact are observed together in most of the OIC member countries. This is expected to result in failures in the service delivery, especially in the service delivery to the poor.

2.2 Service Delivery in OIC Member Countries

This section provides an overview of services in the education, health, water and sanitation and electricity sectors in OIC member states considering data available from international sources on access and financing. In terms of the description of each sector and provision of services by country type, the section relies on the literature review meta-data analysis carried out for this report.

2.2.1 Overview of Education Services in OIC Member Countries

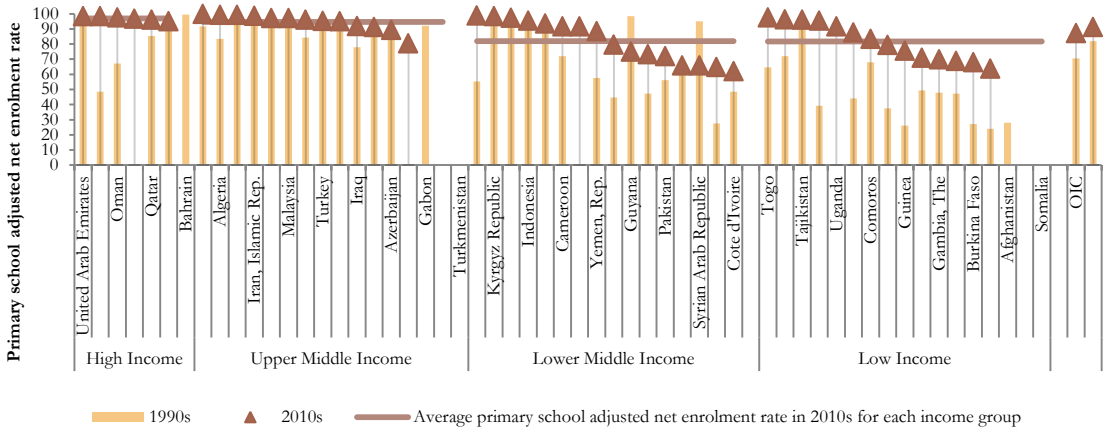
Access to Education

Achieving universal primary education around the World was established as one of the eight millennium development goals. Although this target has not been met yet, significant improvements have been made worldwide in the rates of children attending primary school. The adjusted primary school net enrolment rate reached 91.1 percent as of 2012, up from 82

percent in 1990.[101] This achievement can be attributed to factors such as abolishing school fees, increasing demand for education through cash transfers, school food programs and increasing the supply of schools.[102]

School enrolment rate of primary school age children is greater than 90 percent for more than half of the OIC member states. Countries with high enrolment rates can be found across all regions and income levels. For instance, among the low income member countries Togo, Benin and Uganda from Sub-Saharan Africa and Tajikistan and Bangladesh from Asia all have enrolment rates higher than 90 percent. Yet, several other member countries significantly lag behind. The lowest levels of enrolment rates are found in Gambia, Mali, Burkina Faso, Niger, Nigeria, Cote D'Ivoire, along with Djibouti and Syria, all of which have enrolment rates lower than 70 percent.

Figure 5: Primary School adjusted net enrolment rate in the OIC Member Countries (1990s and 2010s)



Source: UNESCO Institute for Statistics, Education Statistics. The figure here presents the earliest data available in 1990s and the latest data available in the 2010s. In some cases the earliest data from 1990s is actually from early 2000s. And in some cases data for 2010s, is actually from late 2000s. Some countries do not have data available in the indicated time periods.

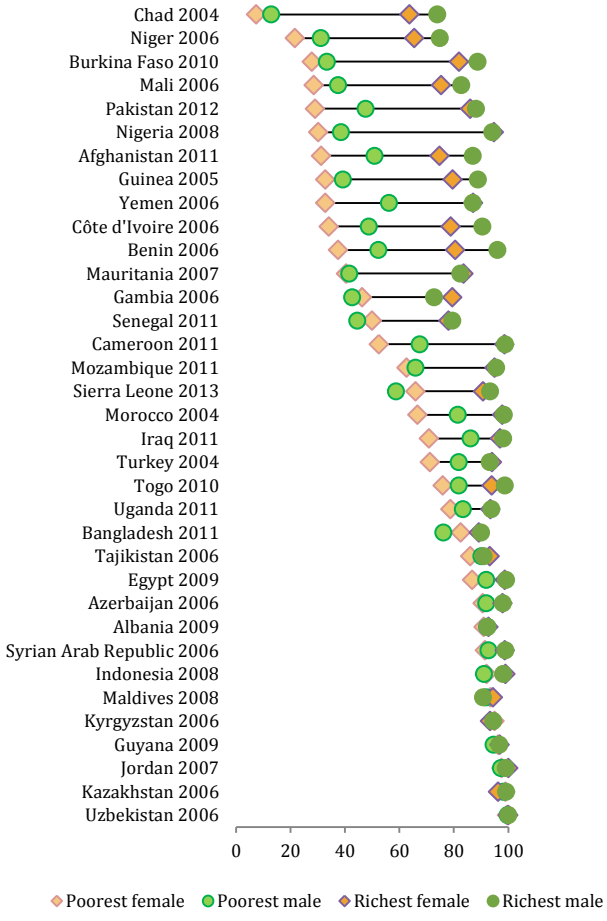
The average enrolment rate for primary school in OIC member states is slightly lower than the World average in the 2010s. Average adjusted net enrolment rate was 87.1 percent in OIC countries compared to the World average of 91.1 percent (See Figure 5). High and upper middle income member states exceeded the world average at 96.9 percent and 94.6 percent, respectively. In comparison, averages for lower middle income and low income member countries are lower than the World average with 82.0 and 81.7 percent, respectively.

Access to basic education improved or remained high over the past decade for most of the member states (See Figure 5). Most of the high and upper middle income member states already had high levels of enrolment rates in 1990s. As of 2010s almost all high income and upper middle income member states reached enrolment rates higher than 90 percent. In addition to high income countries Oman and Kuwait which increased their primary school enrolment rates significantly over time, a number of countries from the lower income groups improved their primary school enrolment rates dramatically as well. Countries like Morocco, Bangladesh, Togo and Benin reached enrolment rates higher than 95 percent in 2010s, coming

101 UNESCO Institute for Statistics, Education Statistics.
102 UNESCO (2014b)

up from rates lower than 75 percent in 1990s, and in the case of Benin, coming up from only 39.3 percent in year 1990.

Figure 6: Primary school adjusted net attendance rate, by gender and wealth quintile in the OIC Member Countries



Despite these high achievements, wide variations are still observed among the lower middle income and low income countries. The net enrolment rate for school-age children is 98.8 percent in Morocco but 61.9 percent in Cote d'Ivoire which are both lower middle income countries. Similarly, among low income member countries, Bangladesh has the highest enrolment rate at 96.2 percent and Niger has the lowest enrolment rate at 63.6 percent.

Country averages mask wide disparities between the poor and the rich children in terms of access to education. In countries with high enrolment rates, like the abovementioned Morocco, Benin, or Togo, poorer children are less likely to attend school. The disparity between rich and poor children is 42.5 percentage points in Benin and 17.3 percentage points in Togo.

Source: UNESCO Institute for Statistics, Education Statistics.
Only the member countries with available data are presented in the graph.

Disparity in education access between rich and poor tends to increase in poorer countries. Average difference in attendance rates of primary school age rich and poor children is 6.4 percentage points for upper middle income countries while it is 33.5 percentage points for low income countries. However, there are wide differences in inequality among some countries in the same income groups. For instance, both Maldives and Iraq are upper middle income countries, but, Maldives has no difference in primary school net enrolment between the poorest and wealthiest quintiles, while, in Iraq, the difference is 19 percent. Similar disparities are also present in lower middle income and low income groups. The highest level of disparity among OIC countries is in Nigeria, a lower middle income country, where only 34.5 percent of the primary school age children from the lowest wealth quintile attend school compared to 94.4 percent of children from the wealthiest quintile.

Gender exacerbates disparities between poor and rich children (See Figure 6). While some countries, like Indonesia, Jordan, Guyana, Kazakhstan and Uzbekistan, do not have any disparities in enrolment rates for poor girls versus rich boys, other countries, like Pakistan, Afghanistan and Burkina Faso, exhibit tremendous differences. Sometimes, differences exist in countries in the same region with similar income-levels. Indonesia and Pakistan, both lower income countries in Southeast Asia, have stark differences. The adjusted net attendance rate of girls from the poorest quintile in Pakistan is 28.9 percent compared to 88.1 percent for boys from the richest quintile while these rates are 92.1 and 98.1 percent respectively in Indonesia. Given that both of these countries have the same predominant religion and similar income levels, it is curious to see such wide differences (See Figure 6).

Models of Education Service Delivery and Financing of Education in OIC Member Countries

Table 2 highlights the different service models in the education sector employed in each country, based on the meta-data analysis carried out for this report. It is common among member countries for the Ministry to share the decision-making power. For most countries, a degree of decentralization is present where responsibilities are allocated to regional directorates or to local governments. Central government provision is common, particularly in upper middle income countries where the Ministry of Education is typically responsible for financial allocations and human resources. Contracting education services to the private sector or to NGOs is not very common among OIC member states. Qatar, UAE, Maldives and Pakistan were all found to implement contracting out in education in changing scales.

Table 2: Models of service delivery in the OIC countries for education services

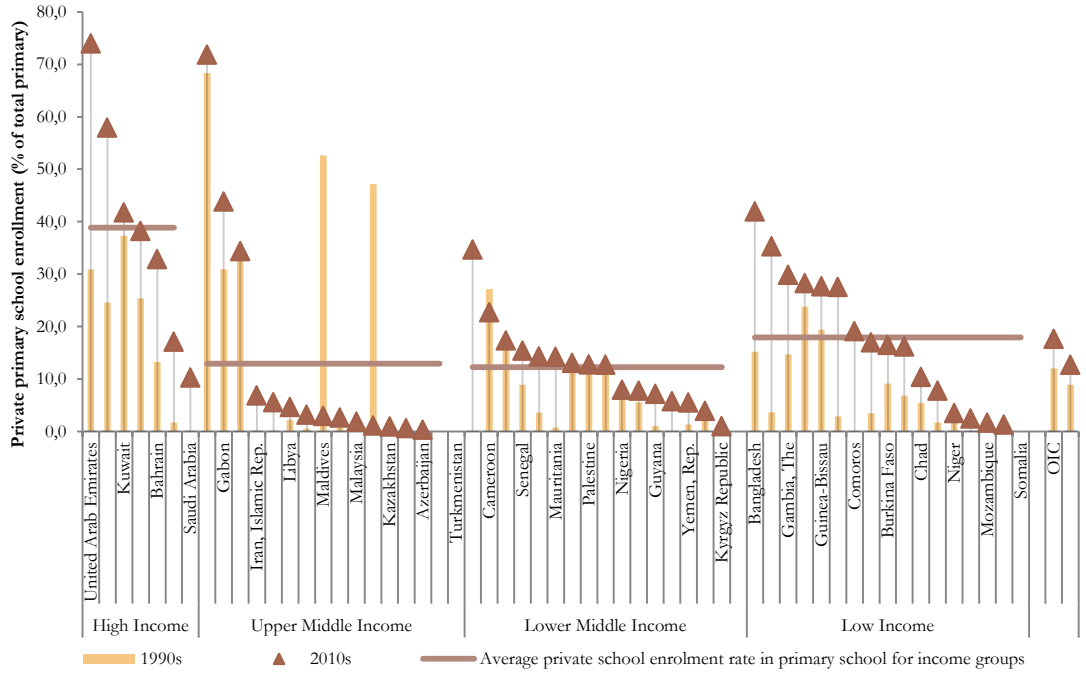
		Central government provision	Decentralization	Contracting out	Community participation	Private provision
High Income	Kuwait		x			x
	Qatar			x	x	x
	Saudi Arabia		x			x
	United Arab Emirates		x	x		x
Upper-Middle Income	Albania		x			x
	Algeria	x				x
	Azerbaijan		x			x
	Iran		x		x	x
	Iraq		x			x
	Jordan	x				x
	Kazakhstan		x			x
	Lebanon	x			x	x
	Libya		x			x
	Malaysia		x		x	x
	Maldives		x	x	x	x
	Tunisia	x				x

	Turkey	x			x	x
	Turkmenistan		x			x
Lower-Middle Income	Cameroon		x		x	x
	Egypt		x			x
	Indonesia		x		x	x
	Kyrgyz Republic		x			x
	Morocco		x		x	x
	Nigeria		x		x	x
	Pakistan		x	x		x
	Senegal		x		x	x
	Uzbekistan		x		x	x
Low Income	Bangladesh	x				x
	Benin	x			x	x
	Burkina Faso		x		x	x
	Mali		x		x	x
	Mozambique		x		x	x
	Sierra Leone		x		x	x
	Tajikistan		x			x
	Uganda		x		x	x

Source: Meta-data compiled from literature review by the authors.

Community participation through Parent-Teacher associations and school boards are found in a number of countries. These associations have varying degrees of power and are found to be more common in countries among the lower income groups. For instance, in Mozambique, Mali, Sierra Leone and Uganda, school committees are responsible for running the schools. In contrast, in Indonesia, school committees only have an advisory role in decision making and responsibility for financial support for the school.

Figure 7: Private school enrolment as a percent of total primary school enrolment among the OIC Member Countries (1990s and 2010s)



Source: World Bank, World Development Indicators. The figure here presents the earliest data available in 1990s and latest data available in the 2000s. In some cases the earliest data from 1990s is actually from early 2000s, and the data from 2010s might be from late 2000s.

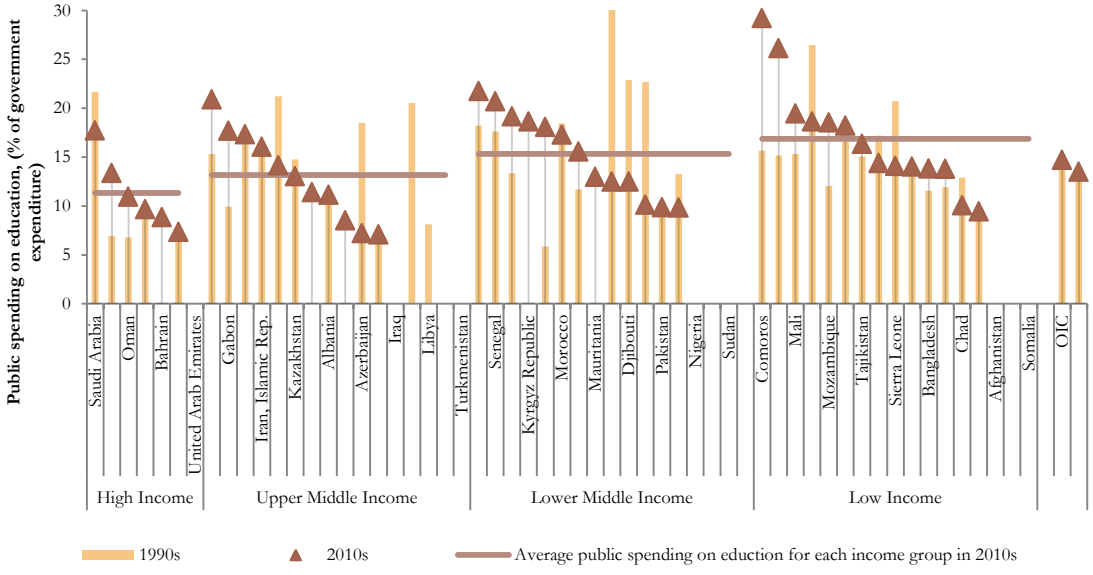
Private provision of education services is common in all OIC member countries. In fact, the average private primary school enrolment rate for member countries is higher than the World average (See Figure 7). In the 2010s, an average of 17.7 percent of children that were enrolled in primary school attended private institutions in the member countries as opposed to 12.7 percent in the World as of 2012. However, wide variations exist among member countries with regards to private school enrolment rates. The highest rate is found in the UAE with 74 percent of primary school children attending private schools while the lowest rate is found in Azerbaijan at only 0.3 percent (See Figure 7).

OIC countries allocate a lower share of their GDP but a higher share of their government budget as public spending on education compared to the World averages. In 2011, average government spending on education as a share of GDP was 4.8 percent worldwide compared to the OIC average of 4 percent. Although public spending on education as a share of GDP is lower than the World average, the OIC average for government spending on education as a share of total government budget is slightly higher than the world average, at 14.7 percent and 13.5 percent, respectively.

On average high income member countries allocate a lower share of their government budget on education compared to other income groups (See Figure 8). Governments are

recommended to spend 15 to 20 percent of their budget on education.[103] Around the World, generally, high income countries tend to spend lower shares of their budget on education compared to low income countries. In 2012, high income countries across the world spent an average 12.3 percent of their government budget on education whereas low income countries spent 14.9 percent.[104] A similar trend is apparent among the OIC member countries. The high income group on average spent 11.3 percent of their budget on education, while the low income group spent 16.9 percent of their budget in 2010s.

Figure 8: Public spending on education as a percent of total government expenditure (1990s and 2010s)



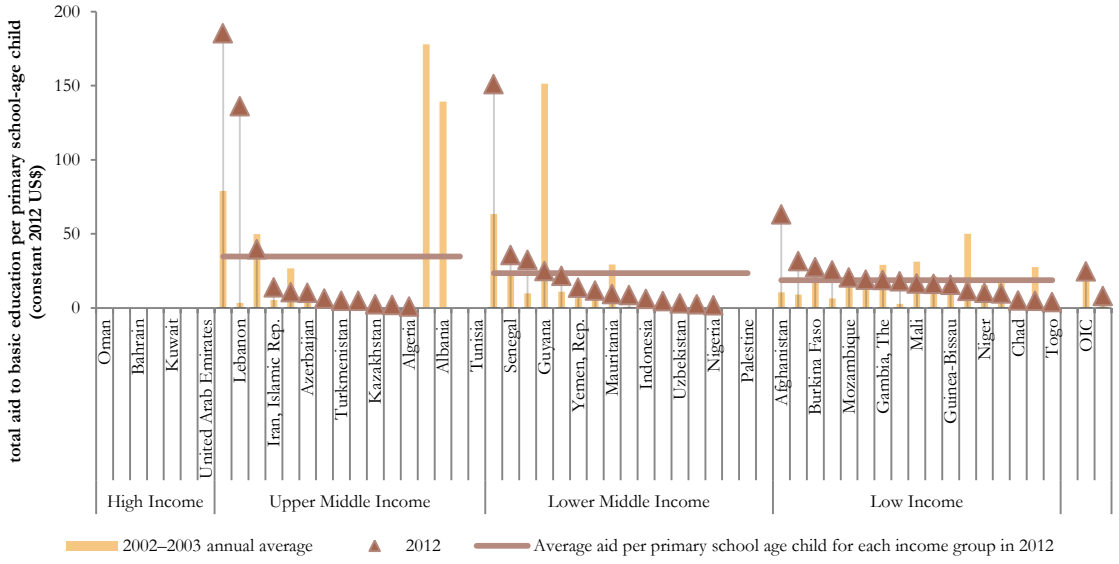
Source: World Bank, World Development Indicators. The figure here presents the earliest data available in 1990s and the latest data available in the 2010s. In some cases the earliest data from 1990s is actually from early 2000s, and for 2010s, it might actually be from late 2000s. Some countries do not have data available in the indicated time periods.

In the majority of the high income and upper middle income member countries, education is constitutionally free. The number of countries providing education for free due to their constitution is lower among lower middle income and low income states. In addition, in some countries, despite education being constitutionally free, in practice, there are fees associated with education.

103 UNESCO (2014b)
104 UNESCO (2014b)

Aid constitutes an important source of financing for education in the OIC member countries. Per child aid received on basic education is three times higher in the OIC member countries than the World average (See Figure 9). In 2012, OIC average was $24.7 compared to $8 in the World. In fact, almost half of the total aid received on education in the World was received by OIC member countries at a total of $5,553 million in 2012.

Figure 9: Total aid to basic education per primary school-age child (2002-2003 average and 2012)



Source: UNESCO, EFA Report 2015, Statistical Tables for Aid. For some countries no data was available for one of the years or both years.

High Income Countries

Certain degrees of decentralization in decision making power are observed across high income member countries. In Kuwait, Saudi Arabia and United Arab Emirates, the decision-making power is decentralized to regional directorates or emirates[105]. For example, in the UAE, schools in education zones are licensed by the emirate in which they operate while the Ministry of Education oversees the education sector in general.

Contracting out education services via independent schools is an innovative education reform in the Middle East that is spearheaded by Qatar[106]. In Qatar, public schools are composed of independent schools that are publicly funded but privately run and semi-independent schools that will all be transitioned into independent schools[107]. The program is expected to improve quality of service delivery by strengthening the compact between policymaker and the provider and increasing accountability. Yet, in Qatar, private schools still seem to be preferred over independent schools by the parents[108]. In addition to Qatar, UAE is another member state where a pilot project has been undertaken by the Abu Dhabi Emirate that enables private providers to operate public schools[109].

105 See UNESCO-IBE (2011f) for UAE, UNESCO-IBE (2011e) for Saudi Arabia and UNESCO-IBE (2011c) for Kuwait
106 Brewer et al. (2007)
107 UNESCO-IBE (2011d)
108 Financial Times (2012)
109 Embassy of the United Arab Emirates (2015)

Community participation in the decision making processes in schools is not common practice among high income member states. This type of model has only been observed in Qatar, where establishing a Board of Trustees is a legal requirement for the independent schools. These boards take part in directing the school and they represent the parents and the society. There are also parent councils in these schools in Qatar[110].

On average high income countries have the largest share of private school attendance among other income groups. The rate is currently the highest in the United Arab Emirates at 74 percent. In fact, the UAE has the highest private school enrolment rate among all other OIC member states. In contrast, the lowest rate of private primary school enrolment in the group is seen in Saudi Arabia at 10.3 percent as of 2013. (See Figure 7).

Average government spending on education as a share of GDP in high income member countries is slightly lower than the World average. On average this group spends 3.7 percent of their GDP on education. However, variations can be observed among different countries. Saudi Arabia spends the highest share of its GDP at 5.1 percent and Qatar spends the lowest share of its GDP at 2.4 percent. Government spending on education as a share of GDP has been pretty much stagnant over the years in high income member countries. The average share in the 1990s was similar to the level in the 2010s at 3.9 percent. Oman is the only country in the group that increased government spending on education as a share of GDP, between 1990 and 2009. Education is not a high budget priority for most high income member countries. On average, high income countries spend 11.3 percent of their budgets on education. Saudi Arabia is the only outlier, spending 17.7 percent of its budget on education.

Education is provided free of charge in public schools to all citizens in the high income countries. In fact, there is a legal guarantee of free education in these countries[111]. Yet, in Qatar and Saudi Arabia there is evidence that some primary school fees are charged to students despite the legal guarantee[112].

Upper-Middle Income Countries

Governance mechanism of the public education system is highly centralized in upper middle income countries. Jordan, Lebanon, Turkey and Algeria have highly centralized education systems[113]. In Algeria and Turkey, only primary school headmasters are appointed at the regional level while decisions related to budget allocation and recruitment of teachers are made by the Ministry of Education. Similarly, in Tunisia, budget allocation and teacher recruitment is under the responsibility of the central government and regional directorates have very little responsibility. The directorates only participate in decision-making related to the opening of new schools, provision of trainings and supervision of teachers together with the Ministry of Education[114]

Several countries decentralized decision-making on budget allocation and teacher recruitment to lower levels of the government. In Turkmenistan, Kazakhstan and Iran, regional directorates have the responsibility of financing the schools through allocated budget[115]. In Iran, the responsibility of teacher recruitment was also transferred to regional authorities giving an even higher degree of autonomy for regional directorates. In Albania, Regional Education Directorates are responsible for teacher recruitment and have the

110 UNESCO-IBE (2011d)
111 UNESCO (2014b) and Tomasevski (2006)
112 UNESCO (2008b)
113 See World Bank (2008a) for Jordan, Lebanon and Algeria; OECD (2013) for Turkey
114 See World Bank (2008a)
115 See UNESCO-IBE (2007b) for Turkmenistan, UNESCO-IBE (2011i) for Kazakhstan and World Bank (2008a) for Iran

authority to plan investments including construction of new facilities and provision of in-service trainings. [116].

School-based management is observed in only one country in this group. In Azerbaijan, schools are given autonomy to hire and fire teachers in the country.[117] According to the Education Law, implemented in the country in 1992, schools were given more autonomy in decision making. This kind of a school-based management model was not observed in any other member countries in this group.

Maldives is the only country in the group that has a public-private partnership in the education sector[118]. Schools in Maldives are supported by the government but privately managed or managed by the communities. Government provides support to these schools including salaries for some of their teachers and financial subsidies.

Enrolments in private primary schools usually constitute a share of less than 10 percent in the overall enrolments (See Figure7). In countries such as Algeria, Azerbaijan and Kazakhstan this rate is lower than 1 percent. Some countries in this income group rely heavily on private provision of basic education services, namely Lebanon, with 71.8 percent of enrolment in private schools, followed by Gabon with 43.9 percent of primary school enrolments in private schools.

Community participation in decision-making in the education system via school councils and parent-teacher associations is observed in a number of countries. In Malaysia, Iran, Turkey and Azerbaijan, parent-teacher associations provide assistance in the management of schools and occasionally contribute financially[119]. Yet, the decision making power of these entities is limited especially when school autonomy is not present.

Upper middle income member countries, on average, spend slightly more on education as a percent of their GDP compared to high income member countries, at 4 percent. Yet, there are differences observed between countries in the group. As of 2012, Maldives and Tunisia spent the highest share of their GDP on education at 6.2 percent each, while, in 2011, Azerbaijan spent the lowest share at 2.4 percent.

The average share of government budget spent on education is 13.2 percent among upper-middle income member countries. High expenditure on education among a number of countries in this income group indicates that education is a high priority. Malaysia, Tunisia, Gabon and Iran allocate the greatest share of their government budgets to education at over 15 percent of their budgets. In fact, in Malaysia, as of 2011, 20.9 percent of the total government budget was allocated to education.

All upper-middle income member countries receive aid to fund their education sector. Among the member states in this income group, the amount of aid received in 2012 for education ranges from $289 million, in the case of Jordan, to $2 million, in the case of Maldives and Suriname. Yet, in most cases, the share of aid for basic education is lower than half of the total amount of aid received for education sector as a whole. For instance, in Tunisia, only 12 percent of the total aid received for education is allocated to primary education. In comparison, in Jordan, 55 percent of the total aid for education is allocated to primary education. Jordan also stands out among other member countries because total aid per

116 See UNESCO-IBE (2011a)
117 See Hörner et al. (2007)
118 See UNESCO-IBE (2011k)
119 See UNESCO-IBE (2011j) for Malaysia, UNESCO-IBE (2011b) for Iran, UNESCO-IBE (2011l) for Turkey and Hörner et al. (2007) for Azerbaijan

primary school age child is the highest in the group with $185 as of 2012. In other countries like Algeria, Turkey and Kazakhstan, this amount is as low as $1 or $2 per child.

A legal guarantee for free education is common practice for the countries in this income group. Except for Malaysia and Maldives, there is a legal guarantee for free education in all of the upper-middle income OIC countries[120]. Yet, in practice, there are still some charges applied for primary education in most of the countries[121]. Only Algeria, Gabon, Iraq, Jordan, Kazakhstan, Libya and Tunisia are all legally free with no extra charges applied[122].

Lower-Middle Income Countries

Decentralization is common among lower-middle income countries. Out of 9 lower middle income countries, each had evidence of a decentralized education system. Regional or local authorities are empowered on a number of issues in these countries. For instance, Egypt, Morocco, Cameroon and Uzbekistan[123] all decentralized a number of the Ministry's responsibilities and operations to regional directorates. These responsibilities mainly include staff recruitment and supervision and developing regional plans.

In Kyrgyz Republic, Senegal, Nigeria, Indonesia and Pakistan, the degree of decentralization is higher[124]. In Kyrgyz Republic, local authorities are responsible for managing finances and staff recruitment and deployment. Devolution of responsibilities to local governments is observed in Senegal, Nigeria and Pakistan. After a similar decentralization reform in Indonesia, responsibilities including the overall management of the education system, the licensing of schools and the planning and supervision of the teaching force and providing the bulk of public financing for primary and junior secondary schools were transferred to districts. In Indonesia, schools were also given autonomy on most of the school operations except hiring and firing of the staff which remained in the authority of central government[125].

Contracting out services as a form of basic service delivery has only been observed in Pakistan[126]. This was done in a certain locality of the country in Punjab where an NGO took over the management of approximately 140 schools. Although education services are mandated to be financed by the local government, the funding for this project was largely from a combination of donors and the central government.

Private provision in primary education is common among lower middle income member states. However, there are differences between countries with the share of total enrolments in private primary schools varying between 1 percent in Kyrgyz Republic and 22.7 percent in Cameroon. On average, lower middle income countries have the lowest share of private school enrolment rate in primary schools with 12.3 percent, which is at the end very similar to upper-middle income countries with 12.9 percent.

Community participation in decision-making in the education system is common among member countries in this group. In Indonesia, Cameroon, Nigeria and Senegal, parent-teacher associations (PTA) or school councils are involved in providing education services[127].

120 UNESCO (2008b) and Tomasevski (2006)
121 UNESCO (2008b)
122 UNESCO (2008b)
123 See UNESCO-IBE (2011g) for Egypt, World Bank (2009) for Morocco, World Bank (2012b) for Cameroon and ADB (2010) for Uzbekistan
124 See World Bank (2014a) for Kyrgyz Republic, Aziz et al. (2014) for Pakistan, Gueye et al. (2010) for Senegal, Samer (2013) for Indonesia and World Bank (2008b) for Nigeria
125 Vernez, Karam and Marshall (2012)
126 Batley et al. (2004)
127 See Vernez, Karam and Marshall (2012) for Indonesia, World Bank (2012b) for Cameroon, Gueye et al. (2010) for Senegal and World Bank (2008b) for Nigeria.

These associations usually have the responsibility to support the operations of the schools financially. In Senegal, PTAs pay for the school's water, electricity and telephone bills and, in Cameroon, PTAs pay for teacher salaries in addition to other school expenses. In Indonesia, in addition to providing financial support, school committees have advisory roles.

Member countries in the lower-middle income group have the highest share of government spending on education as a share of GDP, equal to 4.3 percent on average. However, variations exist among the group with government spending on education as a share of GDP ranging between 6.8 percent, as of 2011, in Kyrgyz Republic and 2.2 percent in 2009 in Sudan. Average government spending on education as a share of total government budget is high in lower middle income countries. In this income group, on average, countries spend 15.3 percent of their government budget on education. The majority of the countries allocate a share higher than 10 percent. Only Pakistan and Egypt spend less than 10 percent of their budget on education. Countries like Senegal and Cote d'Ivoire allocate the greatest share by spending more than 20 percent of their government budgets on education.

Some countries in the group made significant cuts to their budget share on education over the past decade. Djibouti, Guyana and Yemen decreased their budget share on education by more than 10 percentage points between the end of 1990s and the beginning of 2010s, from above 20 percent. On the contrary, in a similar time frame, Indonesia increased the government budget share on education from 5.9 to 18.1 percent between 1994 and 2012 making education a priority area for the government.

Aid is an important source of funding in the education sector for this group of countries. In 2012, total aid received on education ranged between $421 million in Pakistan and $3 million in Guyana. However, the size of the population has to be considered. Although Pakistan receives the highest amount of aid on education, it receives the fourth largest amount of aid per primary school age child. Djibouti, in 2012, had the highest amount of aid per capita at $151 per primary school age child. As a comparison, countries like Cameroon and Nigeria received $2 per child. In addition, it must be noted that total aid received on education increased for most of the countries in the group over the last decade.

Primary school is not free of charge in most of the lower-middle income member countries. Schools in this income group are not free due to an absence of a legal guarantee or it is legally free but in practice there are fees charged at the schools[128]. Syria and Morocco are the only two countries in this income group where primary schools are both legally free and there are no additional fees charged. Although education is not legally free, Indonesia is trying to make education more accessible to the poor. Recently, a new program was launched to guarantee free education for the poor[129].

Low Income Countries

Only two low income countries have a centralized education systems. Out of the 8 low income countries, Bangladesh and Benin have the most centralized education systems. In Bangladesh, the public education system is centralized fiscally and administratively[130]. In Benin, the education system remains centralized despite a recent decentralization effort that provided schools with grants in an attempt to increase their autonomy[131].

[128] UNESCO (2008b) and Tomasevski (2006)
129 Economist (2014)
130 World Bank (2013a)
131 DANIDA and AFD (2012)

Devolution of responsibilities to local governments is observed in a number of countries in Sub-Saharan Africa. In Burkina Faso, Sierra Leone, Mali and Uganda, responsibilities for education have been devolved to local authorities[132]. In this respect, for instance in Uganda, District Education Departments are not extensions of the Ministry, but are instead accountable to the district administration.

Share of primary school enrolments in private school differs significantly among the countries in this income group (See Figure 7). More than 20 percent of enrolment in Bangladesh, Guinea, Guinea-Bissau, Mali and Togo are in private schools. In contrast, Afghanistan, Mozambique and Tajikistan have less than 5 percent of their primary school enrolment in private schools. Over the past two decades, private school enrolments increased in all the countries in this group.

Community participation is common in the education sector in low income member counties. Community participation in decision making is observed in Uganda, Mali, Sierra Leone, Mozambique, Benin and Burkina Faso[133]. In most cases, the responsibilities of the committees extend beyond an advisory role and they are actually running the schools. For instance, in Mozambique, Mali, Sierra Leone and Uganda, school management committees are responsible for running the schools. In Uganda, school committees are the statutory body governing the schools on behalf of the government and they receive grants directly from the central government. In Benin, community participation occurs via parent teacher associations and, due to the low level of funding from the government, parents hire teachers and finance as much as a quarter of total expenditures despite the abolition of school fees. In Burkina Faso there are efforts to establish school committees as well.

Average government expenditure on education as a percent of GDP for low income countries is similar to lower middle income countries. On average, government expenditure on education is 4 percent of the GDP for countries in this group. This share goes as high as 7.6 percent in Comoros and as low as 2.2 percent in Bangladesh. Over time, trends are very much mixed for the countries in this income group. For half of the countries in this income group, government spending on education as a share of GDP decreased or remained stagnant over time, while the other half increased. The share had the highest increase in Comoros with 3.8 percentage points. In comparison, Tajikistan decreased its share by 4.2 percentage points between 1990s and 2000s. Low income countries allocate a large share of their government budgets on education. On average low income countries, spend the highest share of their budget on education at 16.9 percent, compared to other income groups. For the majority of the countries in this income group, government spending on education as a percent of total government spending is higher than 10 percent. Comoros spends the highest share of total government spending in this group and also among the rest of the OIC countries at 29.2 percent as of 2008.

Aid is an important source of funding for the education sector among all low income member countries. In 2012, low income member countries received an average of $108 million in aid on education, ranging from $504 million to Bangladesh and $8 million to Guinea-Bissau. However, average aid for basic education per primary school age child is the lowest for the countries in this group compared to other income groups. Different time trends exist among the countries in this group with regards to aid for education. For instance in Comoros

[132] World Bank (2012a) for Burkina Faso, World Bank (2007) for Sierra Leone, Pearce, Fourmy and Kovach (2009) for Mali and De Grauwe et al . (2011) for Uganda

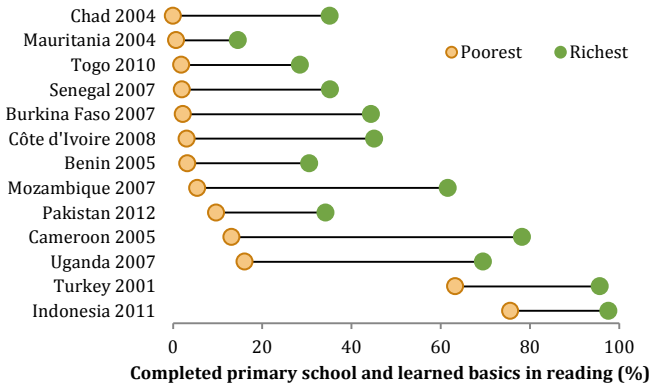
133 Open Society Foundations (2012) for Mozambique, Pearce, Fourmy, and Kovach (2009) for Mali, World Bank (2012a) for Burkina Faso, Engel and Cossou (2011) for Benin and De Grauwe et al. (2011) for Uganda

and Uganda, aid per primary school age child substantially declined from $39 to $11 per child in Comoros and from $23 to $5 per child in Uganda. In contrast, aid in Afghanistan increased from $10 to $63 per child and, in Bangladesh, from $9 to $32 per child. Afghanistan and Bangladesh are also the highest recipients of education aid among all other OIC member countries.

In low income member countries, primary education is either not constitutionally free or is legally free but still charges fees. Some countries in the group, like Uganda, Mozambique, Sierra Leone and Benin, abolished the school fees in the last decades[134]. Abolishing school fees in Uganda resulted in an improvements in outcomes and especially for disadvantaged groups.[135]

Common Challenges

Figure 10: Percent of children who completed primary school and learned basics in reading, by wealth quintile



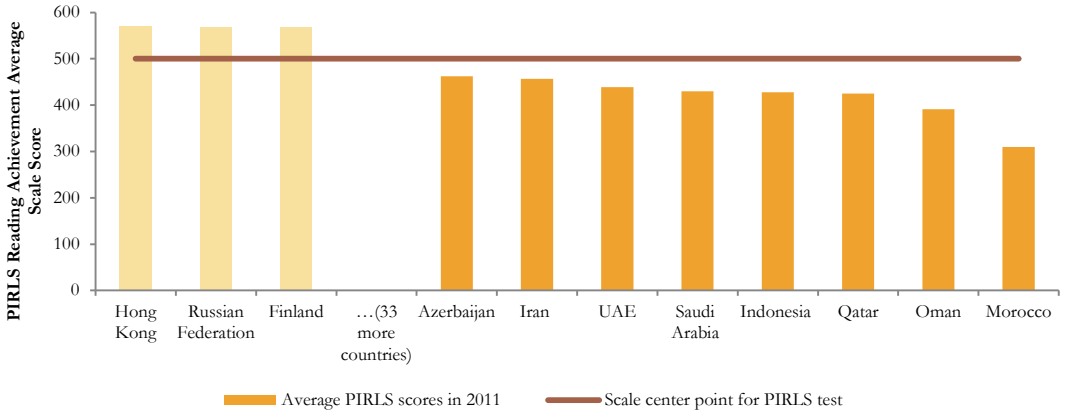
Source: UNESCO WIDE Database

Similar challenges can be observed across member states in all income groups. The challenges of not being able to reach the poor and gender disparities in access to education are discussed in the first part of the chapter. Apart from these serious challenges, quality of education, absenteeism of the teachers, informal payments and private tutoring are other common challenges observed across the member states. These challenges are in fact symptoms of a failure in the accountability framework.

A common problem is the poor quality of the education sector. In several countries, public schools are failing to offer good quality education, which can be seen from extremely low levels of learning depicted in Figure 10. In Chad, almost none of the poor children who complete primary school are able to read. Similarly, in Mauritania, Togo, Senegal, Burkina Faso, Cote d'Ivoire, Benin, Mozambique and Pakistan less than 10 percent of students that complete primary school can read. The share increases slightly above 10 percent in Cameroon and Uganda and above 60 percent in Turkey and Indonesia.

134 See Engel and Cossou (2011) for Benin, Essama-Nssah (2011) for Uganda, World Bank (2007) for Sierra Leone and Fox et al. (2012) for Mozambique
135 UNESCO (2014b)

Figure 11: Average PIRLS reading achievement test scores (2011)



Source: PIRLS 2011[136]. (The range is 1-1000, but the highest score is Hong Kong with 571.)

Low levels of achievement, which is a sign of low quality of education, is not only a problem of low income member countries. Results of the reading achievement test PIRLS taken by the 4th graders across a number of countries show that all the participating OIC member countries, regardless of their income level, have an average score below the PIRLS scale center point of 500 (See Figure 11). Furthermore, member countries are at the bottom of the list of 45 countries.

Lack of human resources is more of a challenge for low income countries (See Figure 12). Among high income member states, the pupil-teacher ratio is generally quite low, ranging between 8.6 pupils per one teacher in Kuwait and 18 pupils per one teacher in the UAE. In comparison, the number of pupils per one teacher is significantly higher in low income member states ranging between 23 in Tajikistan and 61.3 in Chad. Yet, quality of teachers is a problem for countries in all income levels. In Qatar, where there is one teacher for every 9 primary school children, the percent of trained teachers in primary education is only 48.9 percent. Not surprisingly, low quality of teachers is more of a problem in low income member states again. The percentage of trained teachers is the lowest in Guinea-Bissau among member states at 38.9 percent.

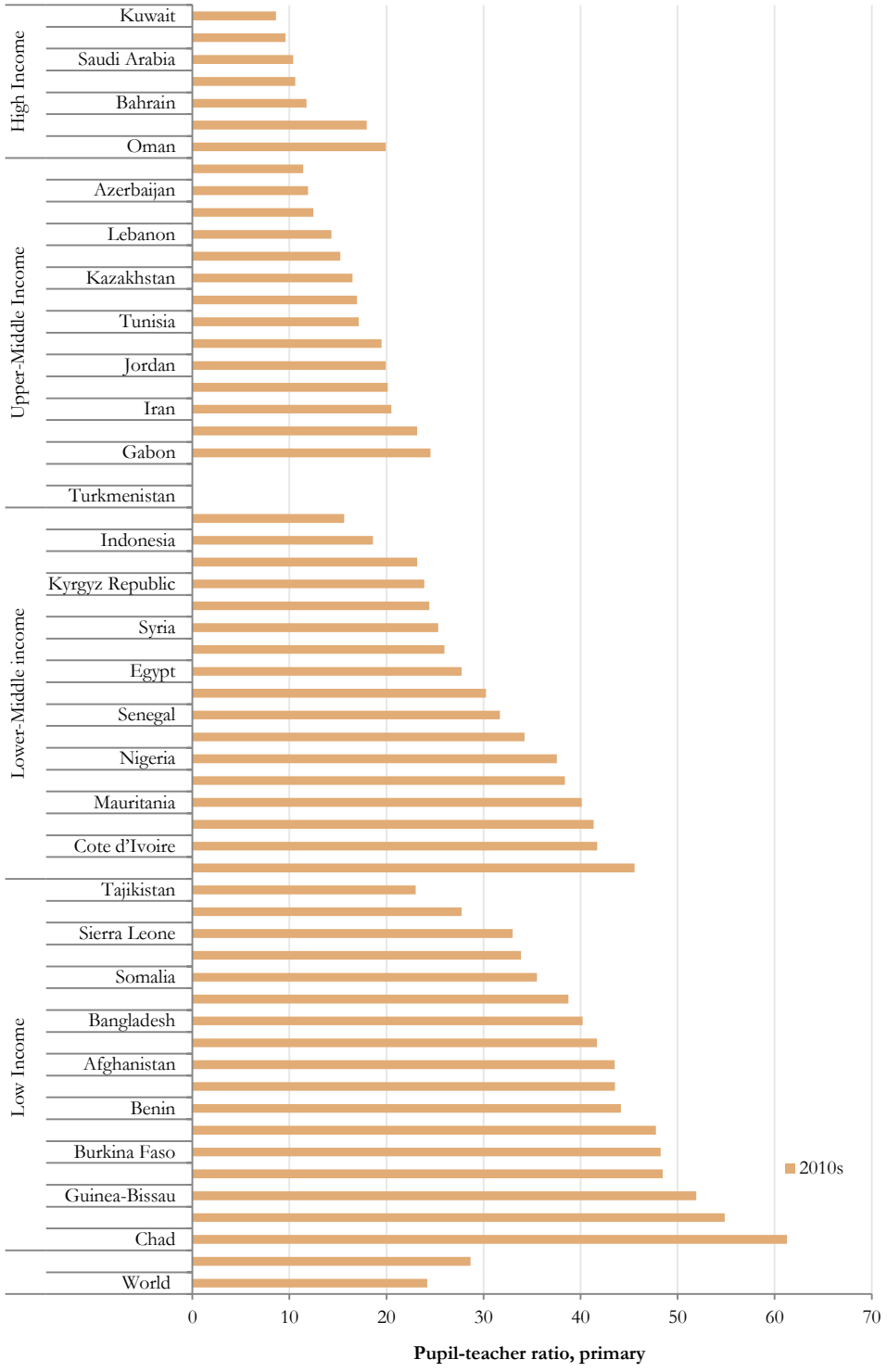
The problem of absenteeism of the teachers is another issue among the member countries. In Uganda, an average 53 percent of teachers were not found in the classroom teaching while the rate reaches 60 percent in rural public schools.[137] The situation is somewhat better but similar in Senegal with 29 percent of teachers on average being absent from the classroom.[138] Similarly, in countries in the MENA region, teacher absenteeism is reported to be a serious problem at a 22 percent average across the region.[139]

136 Mullis et al. (2012)
137 Wane and Martin (2013)
138 World Bank (2012c)
139 Brixi, Lust and Woolcock (2015)

Informal payments and private tutoring is a problem among member countries. This kind of a practice would result in inequities between the children who can afford these payments and who cannot. In a setting where the teacher salaries are low and there is no mechanism to hold teachers accountable of their actions, these kinds of problems might surface. For instance, in Egypt, private tutoring became one of the primary aspects of education system rather than being an assistance when need arises.[140] Reasons behind this anomaly could be stated as low payments of teachers and the national one-time exams.[141] In some member countries, informal payments are observed in the education sector. In Azerbaijan and Tajikistan, a study found that almost 40 percent of parents reported that teachers expect parental contributions to increase their salaries.[142] The situation seems to be better in Kazakhstan with only 10.6 percent of the parents stating that schools ask for contribution in exchange for better grades.[143] Informal payments in the education sector are a common problem in MENA countries as well where, on average, one third of the citizens in MENA countries paid informal fees in education sector.[144]

140 World Bank (2008a)
141 World Bank (2008a)
142 ESP/NEPC (2010)
143 ESP/NEPC (2010)
144 Brixi, Lust and Woolcock (2015)

Figure 12 Pupil-teacher ratio in the OIC member countries in primary education (2010s)



Source: World Bank, World Development Indicators. The World average is for year 2012. Graph represents rates for OIC Member Countries for the latest year available in 2010s. In some cases, latest year available might be an earlier year.

Quality problems such as low levels of achievement in the schools, absenteeism and informal payments observed in the member countries are signs of failures in the accountability framework. Quality might be low because of a number of reasons including a low level of financing, low level of teacher qualifications, as well as due to the failures in the accountability framework such as weak voice, compact and/or client power. A weak voice could result in the government not to prioritize the education sector which would lead to a low level of financing. In return, low levels of financing might cause quality problems. A weak compact between the State and the service providers could also easily result in quality problems. A lack of monitoring and evaluation mechanism for the schools and absence of incentives for the teachers to provide better quality services make the service providers less accountable to the State. Schools and teachers are more likely to fall short of meeting the standards when these mechanisms are missing. Hence it is difficult to tackle quality problems like absenteeism or informal payments without addressing accountability problems. Moreover, when voice and compact are already weak the absence of client power will add to the quality problems in the sector, making them likely to persist. When parents cannot hold the schools or teachers directly accountable of the results, and service providers are neither punished nor being rewarded for the results, quality problems like low achievements or absenteeism may easily occur. To strengthen client power, parents might be given responsibility for monitoring the quality of the schools, which is likely to improve the outcomes.

Service models might have their own problems. For instance, decentralized systems could lead to inequalities in spending among localities. This is the case in Nigeria where most of the states in the North spend lower than 20 percent of their budget in primary education while others spend one-third of their budget.[145] In the context of decentralization, the absence of supervision and monitoring by a central authority can cause problems like in the case of Kyrgyz Republic where a high degree of decentralization in education leads to a high degree of inequality in financing education.[146] This in turn causes accountability problems among the local authorities in terms of using funds and achieving results.

Centralized government provision generally lacks the necessary accountability mechanisms in the education sector. This actually creates a problem due to the opacity of these systems. Information on school performance is generally not shared within these systems and participation of local governments or the community is weak. For instance, with regards to information sharing on performance of schools there is wide range among the countries in the MENA region in terms of sharing information on school performance. In Qatar and Saudi Arabia nearly half of the students attend schools which post their achievement data as opposed to less than 20 percent in Jordan and Tunisia.[147] In return, this affects the quality of the system since the parents lack information to hold the service providers accountable.

145 World Bank (2008b)
146 World Bank (2014a)
147 Brixi, Lust and Woolcock (2015)

2.2.2 Overview of Health Services in OIC Countries

Access to Health Care Services

Major improvements were achieved in health outcomes worldwide over the past decade. Between 1990 and 2013, under-five child mortality almost halved reaching 45.6 deaths per 1000 live births down from 90.2 deaths, while maternal mortality ratio also dropped from 380 to 210 deaths per 100,000 live births between 1990 and 2013[148]. Although there is a general positive trend, there are significant differences between regions, and between urban-rural locations and rich-poor households in the countries. The under-five mortality rate is highest in Sub-Saharan Africa with 98 deaths per 1,000 live births while it is the lowest in Eastern Asia with 14 deaths per 1,000 live births. Similarly, maternal mortality ratio is 510 per 100,000 live births in Sub-Saharan Africa as of 2013, while it is the lowest in Eastern Asia among the developing regions with 33 deaths[149].

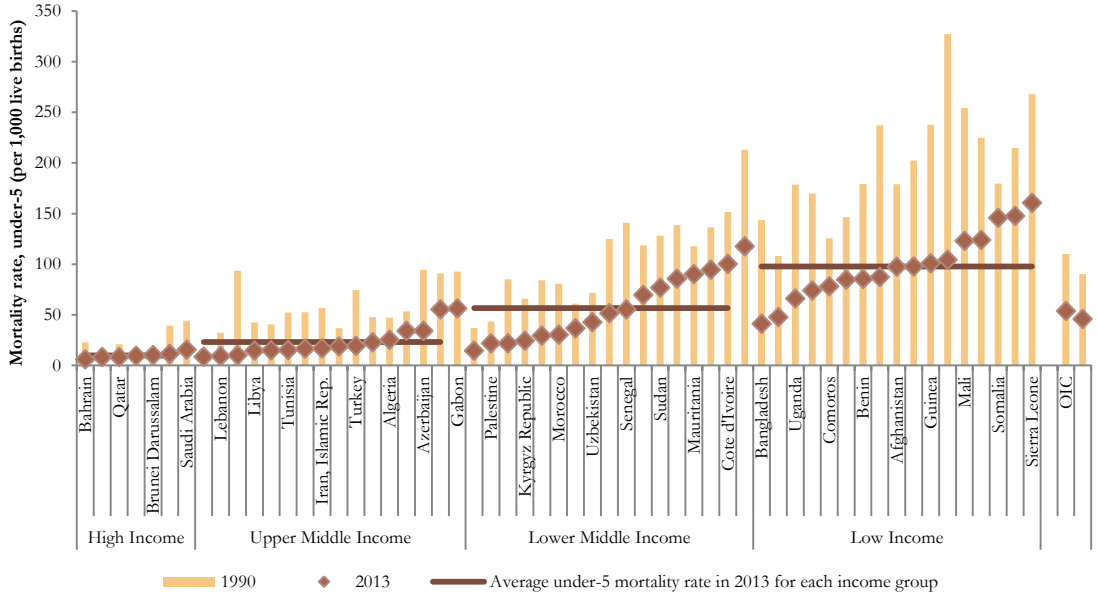
On average OIC countries have a slightly higher child mortality rate compared to the World average. Under-five mortality rate is 53.8 per 1,000 live births in OIC member states as opposed to the World average of 48 deaths per 1,000 live births. However, wide variations between member countries can be observed. Member states in Sub-Saharan Africa, Afghanistan and Pakistan all have high child mortality rates compared to other member countries. The average child mortality rate is inversely related to a country's GDP (See Figure 13). The likelihood of a child dying before reaching age 5 in low income member states is 10 times higher compared to a child in high income member states. The highest child mortality rate among member states is observed in Sierra Leone, which has an under-5 mortality rate of 160.6 deaths per 1,000 live births. In comparison, the lowest under-5 mortality rate is seen in Bahrain with 6.1 deaths per 1,000 live births.

OIC member countries have a higher maternal mortality ratio on average compared to the World. The maternal mortality ratio is still significantly higher in OIC member countries with 247.2 deaths per 100,000 live births compared to the World average of 210[150]. Maternal mortality ratio increases tremendously as the income of the country decreases. In high income member states, the ratio is 14.9 deaths per 100,000 live births while this ratio is 55.6, 256 and 514.4 on average in upper middle income, lower middle income and low income member countries, respectively.

However, similar to worldwide trends, mortality rates declined in all OIC member countries. The average under-five mortality rate declined from 110.0 to 53.8 per 1,000 live births in member countries between 1990 and 2013. Over time many countries achieved significant advances (See Figure 13). Similar to under-5 mortality rates, maternal mortality ratio has also declined in OIC Member Countries. On average, maternal mortality ratio dropped down to 247.2 per 100,000 live births in 2013, from 456.0 in 1990.

148 World Bank, World Development Indicators
149 UN (2014)
150 World Bank, World Development Indicators

Figure 13: Under-5 Mortality rate -per 1,000 live births- (1990 and 2013)

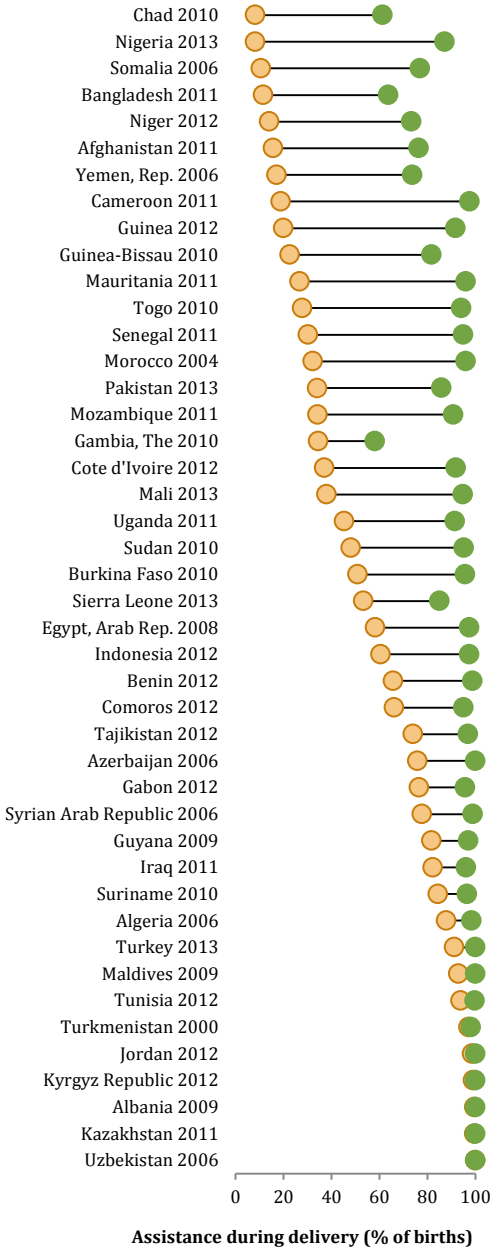


Source: World Development Indicators

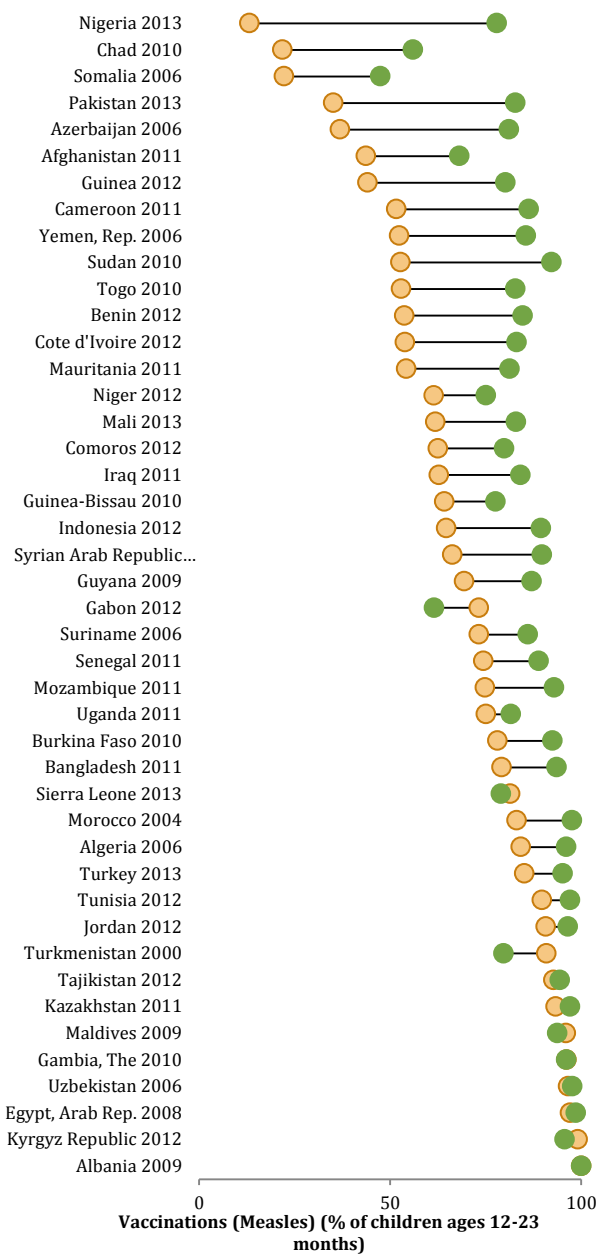
In line with the improvements in maternal and child mortality rates, births attendant by skilled health staff and measles immunization rates for children generally improved among the member states. Not surprisingly, large disparities exist between and within countries in immunization rates and the ratio of births attended by skilled staff. For instance, the lowest immunization rate for measles is seen in Somalia with only 46 percent of children aged 12-23 months being vaccinated against the disease. The highest rate, which is 99 percent, is observed in a number of countries from varying income levels. None of the low income countries reach 99 percent coverage, but Bangladesh, the Gambia and Tajikistan were successful in attaining an immunization rate of 90 percent of the children against measles. One hundred percent of births are attended by skilled health staff in Kuwait, Qatar, the UAE and Kazakhstan. On the other hand, only 22.7 percent of births are attended by skilled health staff in Chad, the lowest rate among member countries.

Figure 14: Assistance during delivery and measles vaccination rate, by wealth quintile

Panel A. Assistance during delivery (any skilled personnel), by wealth quintile



Panel B. Vaccinations (Measles), by wealth quintile (% of children ages 12-23 months)



Source: World Bank, Health, Nutrition and Population Statistics by Wealth Quintile

Despite improvements over time in health outcomes, basic health care services continue failing to reach the poor in many of the member countries (See Figure 14). As of 2013, less than 1 in 10 women in the poorest income quintile in Nigeria had a birth attended by a skilled healthcare worker. In contrast, almost 9 out of 10 women in the richest quintile in Nigeria had access to this service. On the other hand, in some of the member countries, disparities are non-existent or very close to zero. In Uzbekistan, for instance, an individual's income does not determine whether or not she receives skilled assistance during child birth because they have 100 percent coverage for both the rich and the poor. Additionally, in Kazakhstan, Albania, Jordan, Kyrgyz Republic and Turkmenistan, disparities are at most 2 percentage points with high levels of access for women from all levels of wealth groups.

Wealthier children have a better chance of being vaccinated against measles in many of the member countries. For instance, in Pakistan and Azerbaijan, it is more than twice as likely for children in the richest quintile to be vaccinated compared to children in the poorest quintile. However, a number of countries managed to close this gap. Albania, Kyrgyz Republic, Egypt, Uzbekistan, the Gambia and Maldives all have good coverage rates and equality in access to measles immunization.

Models of Health Care Service Delivery and Financing of Health Care Services in OIC countries

Different types of service delivery models can be observed across OIC member countries for the delivery of health care services. Table 3 compiles the different service models in the health sector employed in each country in the literature review, based on the meta-data analysis carried out for this report. It is difficult to come up with generalizations by income groups or regions. Central government provision is seen among upper middle income countries as well as lower income countries. Yet, this type of provision is somewhat more common among upper middle income member countries. It must be noted that there is a decentralization process in all the member countries studied in Sub-Saharan Africa. However, several of these countries are unable to implement the decentralization in practice. A somewhat similar situation is found in Albania, Azerbaijan and Morocco where there are decentralization efforts or certain responsibilities are allocated to regional authorities or service providers, but the central government still retains control over service provision.

Table 3: Models of service delivery in the OIC Member Countries for health care services

		Central government provision	Decentralization	Contracting out	Community participation	Private provision
High Income	Kuwait		x			x
	Qatar			x		x
	Saudi Arabia	x	x			x
	United Arab Emirates		x	x		x
Upper-Middle Income	Albania	x				x
	Algeria		x			x
	Azerbaijan	x				x
	Iran		x	x		x
	Iraq	x				x
	Jordan	x		x		x
	Kazakhstan		x			x
	Lebanon		x	x		x
	Libya		x			x
	Malaysia	x				x
	Maldives	x				x
	Tunisia	x		x		x
	Turkey	x				x
	Turkmenistan		x			
Lower-Middle Income	Cameroon	x			x	x
	Egypt	x		x		x
	Indonesia		x		x	x
	Kyrgyz Republic		x		x	x
	Mauritania		x		x	
	Morocco	x				x
	Nigeria		x	x	x	x
	Pakistan		x	x		x
	Senegal		x		x	x
	Uzbekistan		x			x
Low Income	Bangladesh	x		x		x
	Benin		x		x	x
	Burkina Faso		x		x	x
	Mali		x		x	x
	Mozambique	x				x
	Sierra Leone	x				
	Tajikistan		x			x
	Uganda		x	x	x	x

Source: Meta-data compiled from literature review by the authors.

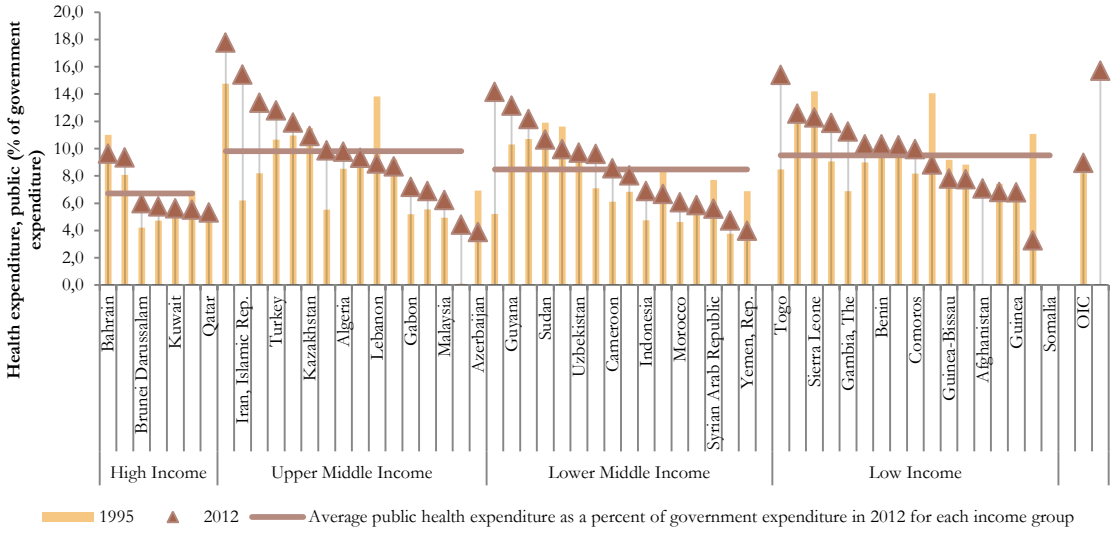
Contracting out is used in a number of countries to mitigate problems in publicly providing services or to increase efficiency and quality of delivery. This type of service delivery model is found in a number of lower income countries as well as higher income countries. In Pakistan, primary health care services are contracted out to a semi-government body. Iran also implemented a similar program as a pilot.

A number of lower middle income and low income member states have community participation in health care services delivery. Community participation in health care is implemented through management committees, which have a varying degree of responsibility depending on the country. In Mali, communities directly run the community health care centres with autonomy over their budget and personnel. In comparison, in Uganda committees have monitoring responsibility but without any sanctioning power.

Member countries use private provision in health care service delivery but in varying degrees. For instance, in Lebanon, private provision of services is the main type of service delivery model in health care while, in Iran, private sector provision is limited and is not growing compared to the public sector.

On average, OIC countries allocate a lower amount of their government budget to health compared to the World. In OIC member countries on average 8.9 percent of total government expenditure was allocated to health in 2012, while this share was 15.7 percent for the World (in 2009). Furthermore, this share has remained constant for OIC member countries since 1995. In 1995, average share of total government spending allocated as public health expenditures was 8.2 percent, increasing only 0.7 percentage points in 17 years.

Figure 15: Public health expenditure as a percent of total government expenditure (1995 and 2012)

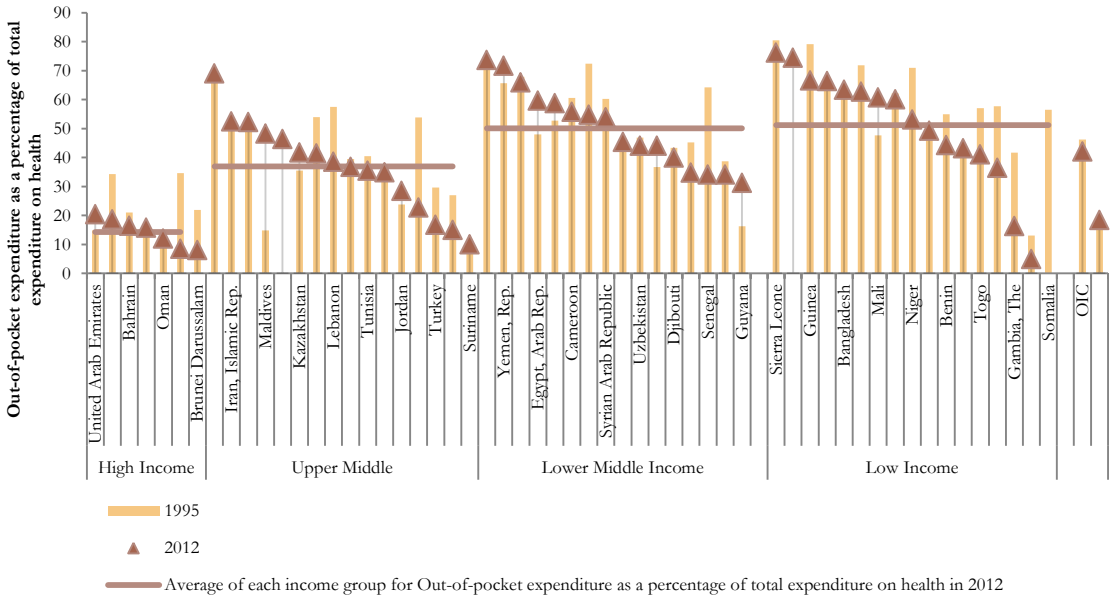


Source: World Bank, World Development Indicators. (Note that the World average is for year 2009).

The share of public health expenditures in total government spending does not increase as a country's income level increases for OIC member countries (See Figure 15). In general around the World, high income countries spend larger shares of their budget on health while low income countries depend more on out-of-pocket spending and external aid to finance health care. In high income countries globally, average government expenditure on

health as a percentage of total government expenditures was 17 percent compared to 9.5 percent in the low income countries in 2011[151]. In comparison, high income OIC member countries spend the lowest shares of their budgets as public health expenditure. On average high income member countries spend 6.7 percent of their budget on health while this share is higher for other income groupings, all of which are still lower than the World average.

Figure 16: Out-of-pocket expenditure as a percent of total expenditure on health (1995 and 2012)

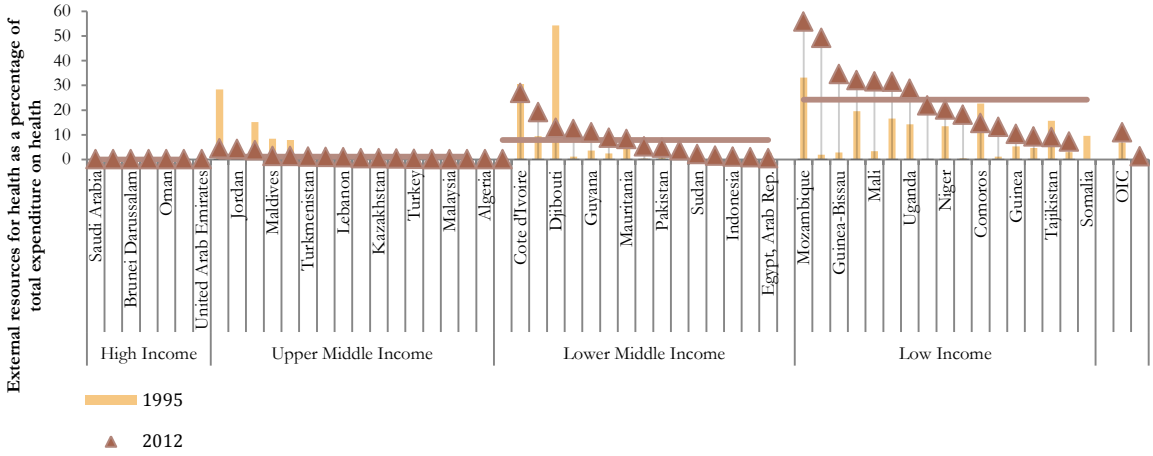


Source: WHO, Global Health Observatory Data Repository. (Note that the data for World average is obtained from World Bank, World Development Indicators).

OIC member countries have high dependence on out-of-pocket expenditures and external resources for health care financing compared to the World (See Figure 16 and Figure 17). Out-of-pocket spending as a share of total health spending is 42.0 percent in OIC member countries and share of external resources in total health spending is 10.9 percent as opposed to the World averages of 18.4 and 1.2 percent respectively. Regarding out-of-pocket expenditures, there is little improvement among OIC member countries while aid dependence for health care financing has increased. In 1995, the share of out-of-pocket spending in total health expenditures was 46.3 percent on average, decreasing by only 4.2 percentage points in 17 years. Meanwhile, share of external resources in total health spending increased by 4.1 percentage points from 6.8 percent in 1995. Average income level of the group seems to have an effect on these shares. The share of out-of-pocket spending and external resources in total health care expenditures increase with decreasing income levels of the groups.

151 World Bank, World Development Indicators

Figure 17: External resources for health as a percent of total expenditure on health (1995 and 2012)



Source: WHO, Global Health Observatory Data Repository. (Note that the data for World average is obtained from World Bank, World Development Indicators).

High Income Countries

The most centralized service delivery model among the 4 countries in this income group is observed in Saudi Arabia. Although there are regional health directorates in Saudi Arabia, majority of their activities require approval from the Ministry of Health. Hence their autonomy is very limited. Yet, Saudi Arabia is making efforts to increase decentralization through increased hospital autonomy. The country recently started implementing this model in a number of Ministry of Health hospitals[152].

There is a certain degree of decentralization observed among other high income member countries. Compared to Saudi Arabia, the United Arab Emirates is more decentralized largely due to the administrative structure of the country since the entities responsible for health care provision are the Emirates Health Authorities[153]. Similarly, a decentralization of authority is also present in Kuwait where there are established health regions working with considerable level of autonomy[154].

Contracting out to private agencies is observed in high income member states. In the United Arab Emirates, partnering with foreign companies to run the daily operations is common practice[155]. In Qatar, the primary health care service provider is a Medical Corporation which has a network of primary health care centres and hospitals that work as a non-profit entity[156]. Private provision of health care services is observed in varying degrees in the countries in this group. For instance, in Kuwait, health care services are mainly provided by public facilities whereas in Qatar, more than 65 percent of the health care providers in the country are private[157].

[152] See Almalki, Fitzgerald and Clark (2011)
153 See US-UAE Business Council (2014)
154 See WHO (2014e)
155 See US-UAE Business Council (2014)
156 Goodman (2015)
157 See WHO (2014e) for Kuwait and Fenton (2015) for Qatar

Public spending on health care as a share of GDP and as a share of total government spending is the lowest on average in high income member countries compared to other income groups. High income member countries spent an average of 2.1 percent of their GDP on public spending in health in 2012. This share was slightly higher in 1995 with 2.5 percent. Similarly, the share of public spending on health in total government expenditures was lower for high income member countries compared to other income groups at 6.7 percent in 2012. This rate has pretty much stagnated over the years among high income member countries with an average of 6.5 percent of public spending allocated to health in 1995.

Average out-of-pocket spending as a share of total health expenditure is lowest in high income member states compared to other income groups. On average, the share of out-of-pocket spending in total health expenditures in high income member states was 14.3 percent in 2012. Over time, this share decreased from 22.0 percent in 1995, which points to an overall improvement for the citizens. The reduction is largely due to improvements in Qatar, Saudi Arabia and Brunei, as can be seen in Figure 16. In addition, in Qatar, Kuwait, Saudi Arabia and the United Arab Emirates, health care services are found to be provided free of charge to the citizens[158].

Apart from government spending and out of pocket spending, external resources are not used in financing health care in the high income member states. In fact, these countries are themselves the sources of external assistance in poorer countries; for example Kuwait provides external assistance through the Kuwait Fund[159] and Saudi Arabia was the largest funder for humanitarian aid in 2009[160].

Upper-Middle Income Countries

Central government provision is commonly observed among upper middle income member states. In Iraq, Jordan, Tunisia, Malaysia, Maldives and Turkey, decision-making related to health care service delivery is largely centralized[161]. In all of these countries, the Ministry of Health is the main public service provider owning and operating a network of primary health care facilities and hospitals.

Local authorities have varying degrees of autonomy over the management of health care services delivery. In Kazakhstan, Azerbaijan and Albania, local governments own and operate some or all of the health care units in their jurisdictions. Yet, the degree of decentralization of decision making power is different among each of these countries. In Azerbaijan and Albania, the allocation of funds at the local level is controlled centrally[162] while in Kazakhstan, regional health departments have greater autonomy to allocate budget, contract and pay workers[163].

Decentralization of authority is at the level of the provider in some of the member states. Public hospitals were given autonomy in Lebanon and Libya[164]. In Libya, hospitals have their own budgets and recruit their personnel. Similarly, public hospitals in Lebanon were granted with flexibility in running their operations since 1997, in order to increase their efficiency.

158 See HMC (2015) for Qatar, Oxford Bussiness Group (2013) for Kuwait, Almalki, Fitzgerald and Clark (2011) for Saudi Arabia, WHO (2012) for UAE
159 WHO (2014d)
160 WHO (2013e)
161 See WHO (2013c) for Iraq, WHO (2009b) for Jordan, AfDB (2014) for Tunisia, WHO (2010b) for Malaysia, WHO (2014b) for Maldives, Aran and Ozceli (2014) for Turkey
162 See Ibrahimov et al (2010) for Azerbaijan and World Bank (2011) for Albania
163 See Katsaga et al (2012)
164 See IGSPS (2012) for Lebanon and WHO (2010a) for Libya

Private provision of health care services is common in all of the countries. Although there are no statistics at hand representing the situation in each country, some countries, like Maldives, Iran or Tunisia, have limited private sector provision. For instance, in Tunisia, 14 percent of the hospital beds are provided by the private sector[165]. In comparison, Lebanon is an outlier, where private health sector constitutes the backbone of the health care service provision with 82 percent of the country's capacity in hospital beds provided by the private sector[166].

Contractual agreements with private companies or NGOs for the provision of health care services is observed in a number of member countries in this income group. In Lebanon, in a number of primary health care centres are contracted out by the government to NGOs[167]. Tunisia and Jordan are reported to have experience with contracting out hospital services[168]. Iran is experimenting with contracting out health care service by piloting contracting out primary health care services in several provinces[169].

Upper middle income countries allocate the largest share of their GDP and their government spending to public health expenditures compared to other income groups. On average, upper middle income countries allocated 3.1 percent of their GDP and 9.8 percent of their total government spending to public health expenditures in 2012. Upper-middle income countries increased public spending on health care both as a share of GDP and as a share of total government expenditures between 1995 and 2012. Yet, there are significant differences across member countries. Azerbaijan has the lowest share of government budget allocated to health among all other member states, at 3.9 percent. In contrast, Jordan dedicates almost one-fifth of its budget on health spending, which is the highest share of total budget spent on health care among all other OIC Member Countries.

There is a wide range in out-of-pocket spending rates among the countries in this income group (See Figure 16). On average, 36.9 percent of total health spending in upper middle income countries comes directly out-of-pocket which is lower than it was in 1995at 39.5 percent. Despite a small overall decline in the share of out-of-pocket health expenditures, the situation is still grim for the citizens. In Azerbaijan out-of-pocket spending as a share of total health spending was 69 percent. For comparison, out-of-pocket expenditure is 10.1 percent in Suriname and 15 percent in Algeria, as of 2012. Furthermore, the majority of the countries have out-of-pocket spending higher than 25 percent and some, like Albania and Kazakhstan, have rates higher than 40 percent. In fact, in a number of upper-middle income countries, primary health care or at least a basic package of health care services are provided free of charge to citizens. Algeria, Iraq, Libya, Azerbaijan, Kazakhstan, Maldives, Malaysia and Turkey offer primary health care services free of charge, but, in practice, under the table payments may be required[170].

Health care financing from external resources is limited among upper-middle income member countries (See Figure 17). Among the countries in this income group, mainly the government or the health care users are financing health expenditures. On average, external resources as a share of total expenditure on health was 1.2 percent among the countries in this group, which is the lowest average rate compared to lower-middle income and low income

165 See AfDB (2014)
166 See IGSPS (2012)
167 See IGSPS (2012)
168 Siddiqi, Masud and Sabri (2006)
169 Siddiqi, Masud and Sabri (2006)
170 See World Bank (2006) for Algeria, WHO (2013c) for Iraq, WHO (2010a) for Libya, Ibrahimov et al (2010) for Azerbaijan, Katsaga et al (2012) for Kazakhstan, WHO (2010b) for Malaysia, Maldives Ministry of Health and Gender (2014) for Maldives, Aran and Ozceli (2014) for Turkey.

group averages. There is little variation among countries with the share of external resources ranging between 4.5 percent in Suriname and 0 percent in Algeria, Iran and Malaysia[171]. In addition, there is a general decline in the share of external resources in total health expenditures with the average rate declining to 1.2 percent from 4.6 percent in 1995.

Lower-Middle Income Countries

Central government provision is observed in only a small number of member states in this income group. In Egypt, Morocco and Cameroon, the Ministry of Health is the main provider of the health care services[172]. In Morocco, however, there is an ongoing effort to decentralize the service delivery model where they created health regions. A similar effort is also ongoing in Cameroon where health districts were established in 1996, however they still do not have autonomy.

Decentralization of health care service delivery is common among the remaining lower-middle income states. In Indonesia, Pakistan, Nigeria and Senegal, regional or local governments are mainly responsible for delivery of health care services as a result of decentralization reforms[173]. Apart from delegating the service delivery responsibilities to local governments, hospitals were given substantial autonomy in Senegal, with control over managing their finances and human resources. This hospital reform increased utilization of services while it also led to deteriorations in equity in access to services[174].

In addition to varying degrees of private provision in all the countries contracting out health care, provision is experimented in a small number of member states. For instance, in Nigeria, contracting out in health care provision is limited to preventive services for AIDS where services are contracted out to NGOs. In comparison, in Pakistan, a common practice is to contract primary health care services to a semi-government body[175]. Service quality is found to be higher in the primary health care units in Pakistan in which the service provision is contracted out[176]. Egypt has pilot programs where, similar to Pakistan, primary health services are contracted out to accredited private providers and NGOs[177].

In a number of countries, community participation in the provision of health care services exists. Nigeria, Cameroon, Mauritania and Kyrgyz Republic have health committees in communities in urban or rural areas with varying degrees of responsibility[178]. In Cameroon, health committees are held responsible for the drug funds of health care centres while in Nigeria they have limited involvement in the management of health facilities by requesting vaccines or taking a role in the maintenance of the facilities. In Senegal, health committees are reported to participate in primary health care activities as well as in the construction of new facilities, latrines and participation in health financing[179].

Lower-middle income countries allocate a similar share of their government spending as public health expenditures as upper middle income and low income member countries. Average public spending on health as a share of total government spending is 8.5

171 As stated in WHO (2014f) -World Health Statistics Report-, the share might not actually be 0, but if it is lower than 0.05 percent, due to rounding, it is reported as 0.
172 See WHO (2013a) for Egypt, Prah Ruger and Kress (2007) for Morocco and Nzima Nzima (2014) for Cameroon
173 See WHO (2008a) for Indonesia, WHO (2013b) for Pakistan, Tine, et al. (2014) for Senegal and World Bank. (2010c) for Nigeria
174 Lemière, Turbat and Puret (2012)
175 See World Bank (2010c) for Nigeria and Tanzil et al (2014) for Pakistan
176 Tanzil et al (2014)
177 See Siddiqi, Masud and Sabri (2006)
178 See World Bank (2010c) for Nigeria, CORE Group (2009) for Cameroon, WHO (2008c) for Mauritania and Ibraimova et al (2011) for Kıyrgyz Republic
179 WHO (2008c)

percent in 2012 for this income group. The share of GDP allocated to public health expenditures is 2.5 percent. Lower-middle income countries allocate more of their resources and budget for public health expenditures than they did in the past. Yet, there are disparities between spending rates in member states. Djibouti allocates the highest share of the government budget for public health expenditures at 14.1 percent, compared to Yemen, which allocates only 4 percent of total government spending on health as of 2012.

High levels of out-of-pocket spending pose a problem for countries in this income group. As of 2012, the average out-of-pocket expenditure as a share of total health expenditures was 50.1 percent for lower-middle income countries. This rate decreased slightly from 52.5 percent in 1995. Overall, the countries in this group have high out-of-pocket spending rates but the rate differs among countries (See Figure 16). The rate ranges from 31.3 percent in Guyana to 73.7 percent in Sudan in 2012. Moreover, all the countries in the group have out-of-pocket spending rates higher than the World average of 18.4 percent. More than half of total health expenditure was paid out-of-pocket by health care users in many lower-middle income countries including Cameroon, Egypt and Morocco. In fact, several countries in this income group provide primary health care services free of charge, at least on paper. In Egypt, health care fees are negligible per visit. In Pakistan, public health care services are free of charge. In Uzbekistan and Kyrgyz Republic, there is a guaranteed basic health care package that covers some basic services[180]. Yet, evidence suggests, particularly in Pakistan, that free services are not actually free[181].

Health financing from external resources is common among lower-middle income countries and constitutes an important share of total spending on health in a number of them (See Figure 17). On average, 7.9 percent of total health spending in lower-middle income countries was financed via external resources in 2012. This share remains almost constant at 7.8 percent in 1995. Similar to other income groups, there is a wide disparity between countries. In 2012, 26.9 percent of expenditure was from external resources in Cote d'Ivoire while it was only 0.4 percent in Egypt. While the average share of external resources in health care spending changed little over time, dependence on external resources for health care financing decreased for a number of countries in the group including Cote D'Ivoire and Egypt. In comparison, in Senegal, the share of external resources in total health spending significantly increased. This share reached 19.1 percent in 2012 from 9.4 percent in 1995.

Low Income Countries

In a small number of member countries in this income group central government provision is the main model of service provision. Bangladesh, Mozambique and Sierra Leone are the only countries in this income group that use a model of central government provision for health services[182]. In fact, in Sierra Leone and Mozambique, there are efforts for decentralization. However, in practice, the situation is different. For instance, in Mozambique, budget execution is mostly centralized with only 25 per cent of the total public expenditure controlled at the local level by the provincial, district and municipal governments[183]. The situation is similar for Sierra Leone with both financial and human resources managed at the central level despite the decentralization of these services at the district level[184].

180 See World Bank (2010a) for Egypt, World Bank (2010) for Pakistan, Ahmedov et al (2007) for Uzbekistan and (World Bank (2014) for Kyrgyz Republic.
181 World Bank (2010b)
182 See World Bank, Independent Evaluation Group (2014) for Bangladesh and Visser-Valfrey and Umarji (2010) for Mozambique and Simson (2013) for Sierra Leone
183 Visser-Valfrey and Umarji (2010)
184 Simson (2013)

In a large number of the member countries in this income group, decentralization of responsibilities regarding health care service delivery is common. In Tajikistan, Burkina Faso, Benin, Mali and Uganda, health care delivery is decentralized to local governments[185]. In Tajikistan, regional governments are allowed to develop their health policies and allocate resources accordingly. In addition, regional governments have the authority to decide on the wage levels for health workers in their region.

A small number of countries in the sample contract out service delivery. Contracting out health care services is experimented in Bangladesh and Uganda[186]. In both of these countries, the central or the local governments partner with NGOs to deliver services. In Bangladesh, this model is implemented in large cities where primary health care service delivery is contracted out to NGOs. This type of model had positive outcomes. Results suggest improved service delivery in the areas covered with contracted out NGOs. In Uganda, NGOs were already providing 60 percent of hospital services when government initiated a scheme to fund them in order to decrease the user fees and improve service delivery. Limited results suggest increased utilization, reduction in user fees and improvement in staff salaries.

Community participation or community provision is observed in a number of countries in this income group. The countries where community participation is found are all in Sub-Saharan Africa. Benin, Burkina Faso, Mali and Uganda promote community participation in health care service delivery through established health management committees[187]. The committees do not all have the same power and responsibilities across countries. For instance, in Uganda, health management committees have only monitoring responsibility without any imposing power. In comparison, in Mali, community health associations own and manage community health centres with the authority to hire and fire personnel as well as managing their own resources. The associations are also recognized legally by the state.

On average low income countries spend similar shares of their budget and GDP as public health care expenditures compared to other country income groups. Low income countries allocated 2.3 percent of their GDP to public health expenditures in 2012. This share is similar to that allocated by lower middle income and high income countries, at 2.5 percent and 2.1 percent respectively. Government budget allocated to health spending is also similar to other income groupings. Public health spending as a share of total government expenditures is on average 9.5 percent for this income group. Average public spending on health as a share of GDP increased from 1.9 percent in 1995 to 2.3 percent in 2012. In comparison, the average share of public spending on health as a share of total government expenditures was almost stagnant at 9.7 percent in 1995 and 9.5 percent in 2012. The most dramatic changes in the allocated spending to health as a share of total government spending was observed in Chad, which decreased from 11.1 percent in 1995 to 3.3 percent in 2012, the lowest share of government spending in health among all other OIC countries. In comparison, positive changes are observed among several countries in this income group. The most dramatic positive changes were observed in Togo and The Gambia, which increased the share of budget allocated to health by 81.3 percent and 63 percent respectively. In fact, Togo is the only country among the group spending more than 15 percent of its government budget on health, as of 2012.

185 See Khodjamurodov and Rechel (2010) for Tajikistan, Wal et al (2007) for Burkina Faso, WHO (2014a) for Benin, Lamiaux, Rouzaud and Woods (2011) for Mali , WHO (2008b) for Sierra Leone and Uganda Ministry of Health and Makerere University School of Public Health (2012) for Uganda

186 See Heard, Nath and Loevinsohn (2013) for Bangladesh and England (2004) for Uganda

187 See WHO (2008c) for Benin, Wal et al (2007) for Burkina Faso, KIT (2005) for Mali and Bjorkman and Svensson (2009) for Uganda

Out-of-pocket spending as a share of total health spending in low income countries is the highest level among the income groups (See Figure 16). The average share of out-of-pocket spending in total health expenditures was 51.2 percent in 2012. In the majority of the countries, health care users are still the main financers of health care with out-of-pocket spending at more than half of all health expenditure. However, over time, the average rate actually decreased from 57 percent signaling a slight improvement in low income member states. The most dramatic improvements regarding out-of-pocket spending was in Mozambique where there was a 61.8 percent decline in the share of out-of-pocket spending. In fact, Mozambique now has the lowest share of out-of-pocket spending among all member states with only 5 percent in 2012. User fees are a common source of health financing among low income member countries. Yet, according to the results of our literature review, in a number of the member countries in the group such as Bangladesh, Tajikistan and Uganda primary health care services are actually provided free of charge for users[188].

External resources are an important part of health care financing in low income member countries (See Figure 17). Low income member countries had the highest share of external resource financing in total health expenditures with 24.2 percent in 2012. In the last two decades, the average share of total health spending financed by external resources more than doubled from its previous level of 10.5 percent in 1995. Some differences exist across low income countries with regards to dependence on external resources for health financing. External support in health financing in Bangladesh, Chad and Tajikistan are less than 10 percent of total health expenditures, whereas in Mozambique and Gambia, external sources make up more than 40 percent of total health expenditures.

Common Challenges

As was seen in the first part of this section, access to health care by the poor lags severely behind the rich and constitutes a major challenge for many of the OIC countries. High levels of out-of-pocket spending in many of the member states exacerbates this challenge by creating a barrier to access. Apart from the problems that are already presented in the previous parts of this section, other challenges include low levels of quality at the public hospitals, staff shortages and issues related with the delivery model of the services.

Low levels of quality in public hospitals is a common problem among OIC member states. Low quality is apparent in a number of ways such as the deterioration of materials and facilities in Algeria, Tajikistan and Nigeria or the long waiting times in public hospitals, as in Iraq and Kuwait, or staff shortages seen across many of the member states (See Figure 18)189. In some instances, health facilities work under conditions where there is no clean water or electricity. For instance. In Senegal only 39 percent of primary health care facilities in the country have available clean water, sanitation and electricity at the same time190. While this

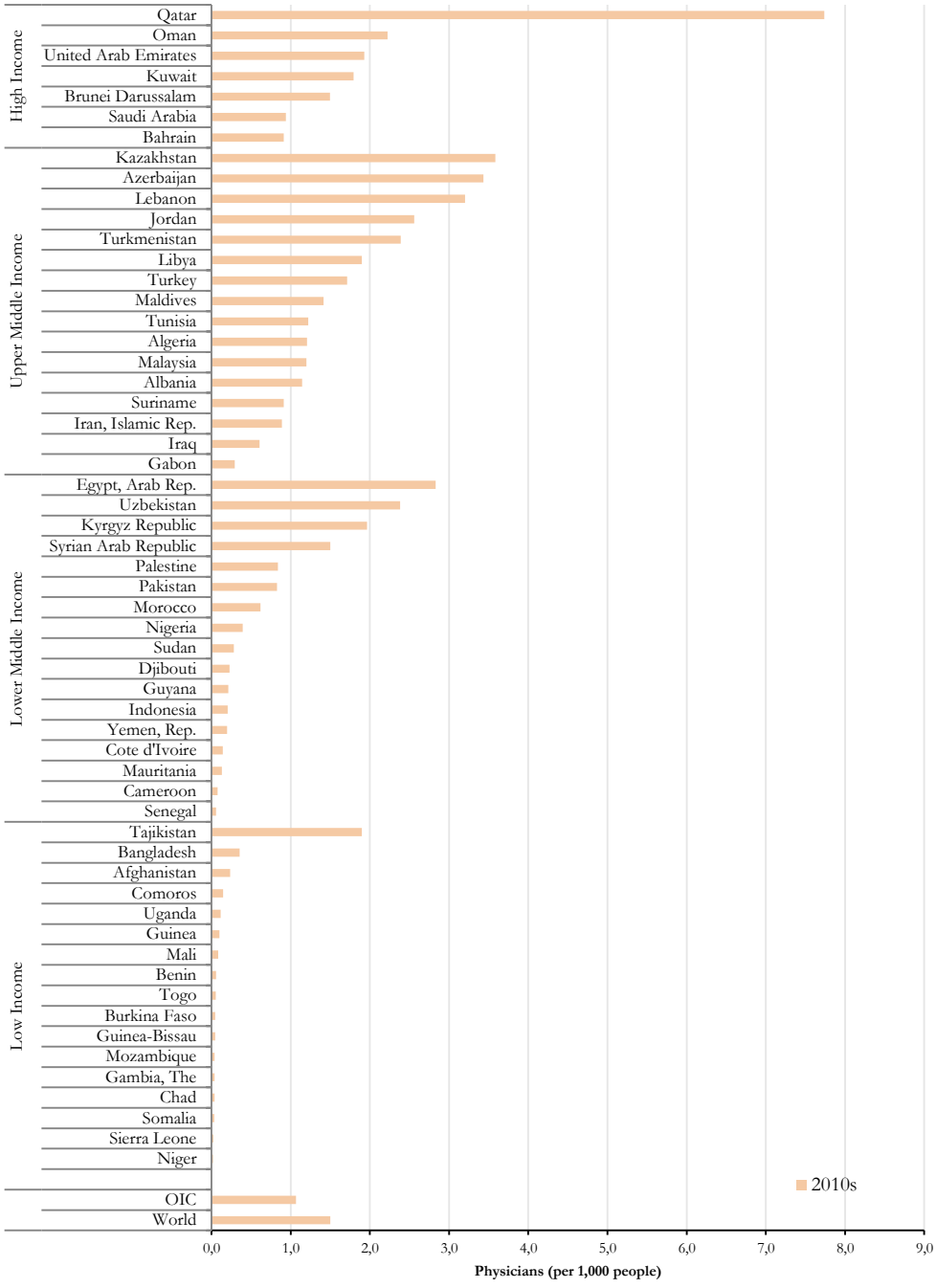
188 See Chowdhury et al. (2011) for Bangladesh, Khodjamurodov and Rechel (2010) for Tajikistan, Uganda Ministry of Health and Makerere University School of Public Health (2012) for Uganda.
189 See World Bank (2006) for Algeria, Khodjamurodov and Rechel for Tajikistan, WHO (2009c) for Nigeria, WHO (2013c) for Iraq and WHO (2014e) for Kuwait
190 See World Bank (2012)

rate is higher in Uganda at 64 percent, it is still far below a level of universal availability of basic necessities in all health facilities[191].

Staff shortages constitute a major challenge for member countries. Part of the reason behind low quality of services is inadequate numbers of health personnel available in the member countries. The world average for number of physicians per 1,000 people was 1.5 in 2011. Across the world, the number of physicians per 1,000 people increases as the income group of the countries increase. In high income countries, the number of physicians per 1000 people is 3.1 while it is as low as 0.2 for low income countries[192]. However, it must be noted that even in a lower income country like China, it is 1.9 physicians per 1,000 people[193]. In comparison, number of physicians per 1000 people is 1.1 on average for OIC member countries and, for more than half of the member countries including members from the high income group such as Bahrain and Saudi Arabia, this rate is lower than 1 (See Figure 18).

191 See Wane and Martin (2013)
192 World Bank, World Development Indicators
193 World Bank, World Development Indicators

Figure 18: Number of physicians per 1,000 people in 2010s



Source: World Bank, World Development Indicators. The World average is for year 2011. Graph represents rates for OIC members for the latest year available in 2010s. In some cases, latest year available might be an earlier year.

Apart from having a low level of health workforce, absenteeism is another issue for member countries. Absenteeism is a problem among member countries including Bangladesh, Senegal and Uganda[194]. In Senegal, 20 percent of the personnel were found absent in the health facilities during random spot checks. In Uganda, this number is worryingly higher, with 46 percent of staff being absent from the workplace.

Quality problems observed in the health care sector are signs of failures in the accountability framework. Apart from low levels of financing, failures in the accountability framework may result in problems observed in the health care services delivery. A stronger voice between the citizens and the State would be more likely to ensure that an adequate level of financing is allocated by the government for financing health care services. A weak compact between the State and the service providers could easily result in quality problems in the health care service delivery such as absenteeism. Absence of rewards for better performance or sanctions for not meeting the standards leads to low quality services. Apart from failures in voice and compact, weak client power could also lead to quality problems. In contrast, when the community itself can monitor the health care centres or take part in their decision making processes, quality is likely to improve. As a matter of fact, in Uganda a community-based monitoring program led to significantly improved health outcomes through improving information of the community about the providers. To achieve this, report cards showing the performance of health facilities were prepared and meetings between the community members and health care providers were facilitated. Results show that health care utilization increased while child mortality declined in the treatment villages.[195]

Service delivery models are associated with a number of problems. For instance, centralized management structure of health care delivery systems may lead to problems in communication due to delays in the chain of command or the existence of more than one channel of communication leading to confusion. For instance, in Turkey, communication between the provincial health directorates and the Ministry of Health occurs through the provincial governor's office, but sometimes the general directorates in the Ministry directly communicate with province directorates bypassing the governor's office and creating confusion[196]. Despite delays in communication, keeping the decision making at the central level might lead to unrealistic policies compared to realities on the ground, like in Tunisia, where the distribution of resources and certain strategic choices made by the central government are inadequate[197].

Decentralization of management can also lead to problems. In Indonesia, health was not considered a priority for district governments and, as a result, adequate funds were not allocated, resulting in a collapse of the surveillance system. In Tajikistan, there are significant wage differences between regions for health personnel depending on budgetary resources and the priority given to health by local authorities[198]. Another problem resulting from decentralization is the management of health services like immunization, which might be better managed centrally. In Pakistan, EPI (Expanded Program on Immunization) significantly deteriorated after the devolution of services to local governments[199].

194 See World Bank, Independent Evaluation Group (2014) for Bangladesh, World Bank (2012) for Senegal, Wane and Martin (2013)for Uganda
195 J-PAL (2015)
196 See Savas, Karahan and Saka (2002)
197 WHO (2010c)
198 See WHO (2008a) for Indonesia and Khodjamurodov and Rechel (2010) for Tajikistan
199 WHO (2013b)

Greater hospital autonomy does not directly lead to improved results. As in the case of Senegal, equity in access to health care deteriorated due to the lack of an accountability mechanism for hospitals. At the time of the hospital reform, the proposed mechanisms to ensure hospital effectiveness and efficiency were not put in place. The hospitals were given the authority to recruit personnel, collect fees and run their own budget, but the access to services by the poor declined with only 3 percent using health care services[200].

Although health committees are important in carrying citizens' voice to the managers of facilities, they are not always as effective nor as participatory. In Mali, for instance, community health associations usually do not have any women participants or participants from remote rural villages[201]. The health committees in Burkina Faso are reported to be weak and demotivated[202]. In Uganda, health committees are responsible only for monitoring and do not actually have any power to sanction the heath personnel[203].

2.2.3 Overview of Water and Sanitation Services in OIC Countries

Access to Water and Sanitation

Water

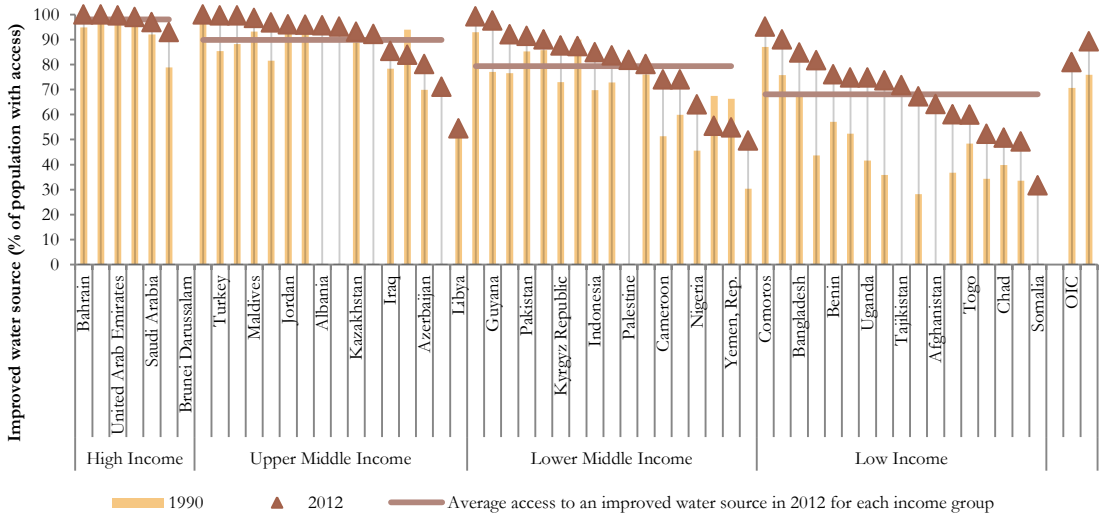
Access to an improved water source increased globally over the past two decades. In 1990, 76 percent of the global population had access to an improved water source, while in 2012 this rate reached 89 percent[204]. Yet, significant disparities remain between regions. For instance, in Northern Africa, 92 percent of the population had access to an improved drinking water source while in Sub-Saharan Africa, this rate was at 64 percent in 2012. In addition to regional disparities, urban-rural differences persist. As of 2012, more than 90 percent of the population who do not have access to an improved water source lived in rural areas[205].

Access to an improved water source is slightly lower in OIC member countries compared to the World. 80.9 percent of the population living in OIC member countries had access to an improved water source in 2012 compared to the World average of 89.3 percent. In addition, there are wide disparities in access in between member countries (See Figure 19). As of 2012, the lowest level of access was in Somalia with only 31.7 percent of the population covered, while the highest level of access was seen in Qatar and Lebanon with 100 percent access. Access seems to be associated with the income group of the country as well as the region. Countries in Sub-Saharan Africa have lower access rates in general and high income countries have high access rates (See Figure 19). However, there are countries in lower income groups with good access rates as well such as Comoros and countries in higher income groups with low access rates such as Libya.

In OIC member countries, similar to the average trend in the World, access to an improved water source increased over the past two decades. The average rate of access to improved water sources among OIC countries was 80.9 percent in 2012 and 70.2 percent in 1990. For the majority of the members, coverage increased (See Figure 19). Especially low income member countries all showed a considerable increase in access to an improved water source between 1990 and 2012 (See Figure 19).

200 Lemière, Turbat and Puret (2012)
201 See KIT (2005)
202 Wal et al (2007)
203 .Björkman and Svensson (2009)
204 WHO and UNICEF (2014)
205 WHO and UNICEF (2014)

Figure 19: Percent of the population with access to an improved drinking water source (1990 and 2012)

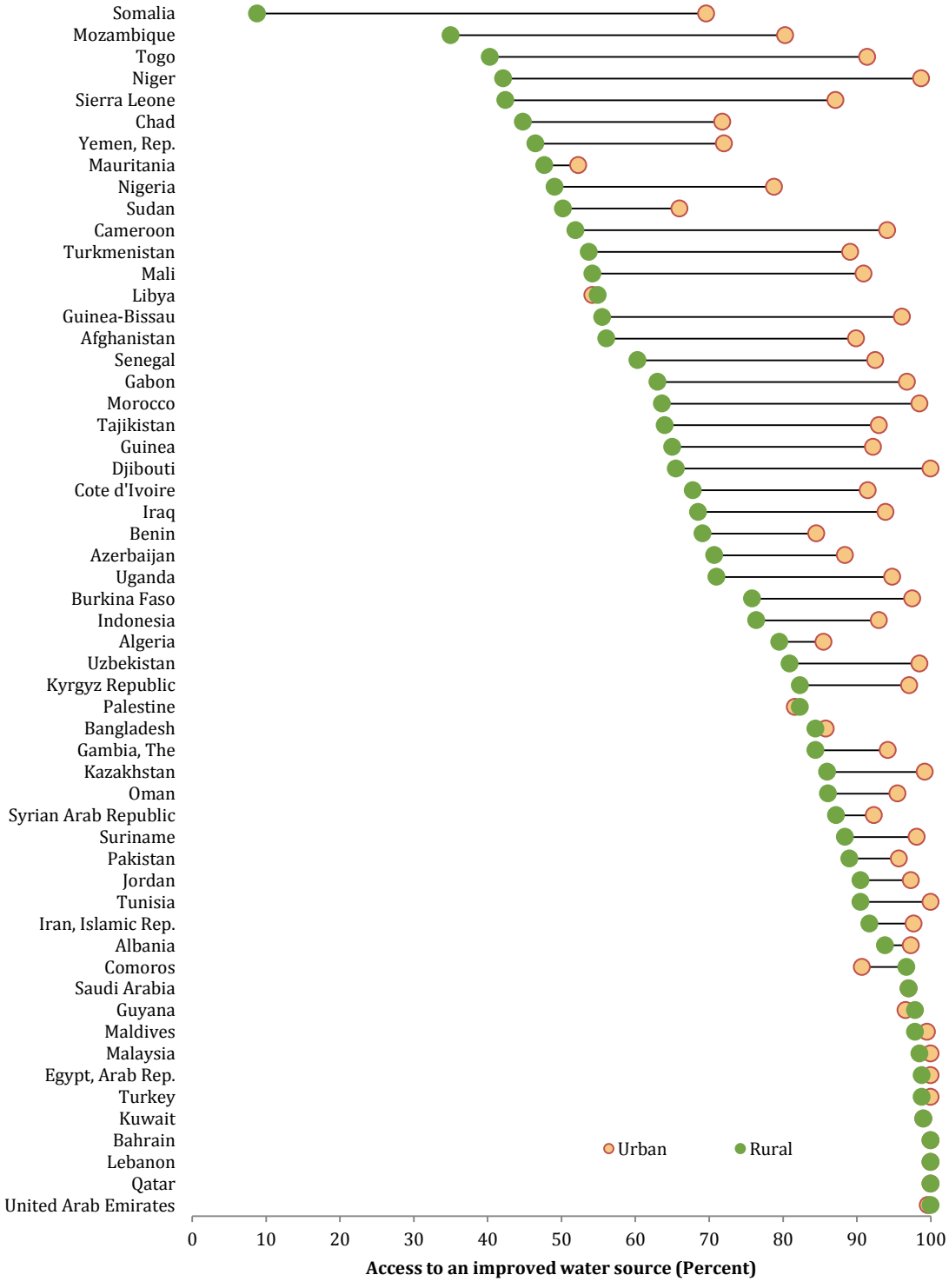


Source: World Bank, World Development Indicators

While most member countries increased their access to an improved water source, urban-rural disparities remained. As can be seen in Figure 20, many of the member countries exhibit urban-rural disparities in access to an improved water source as of 2012. The location of a household is an important determinant for access to drinking water across Sub-Saharan African countries, Turkmenistan and Afghanistan. For instance, in Turkmenistan, 89.1 percent of the urban population is covered while access is at 53.7 percent for the population living in rural areas.

In contrast, a number of countries from different income groups have low levels of inequality in access to an improved water source. For instance Qatar, Turkey, Egypt and Comoros, each of which are countries from different income groups, all have more than 90 percent of their population covered in both urban and rural areas. In addition, the low income countries Gambia and Bangladesh have notably good levels of coverage in both urban and rural areas, with more than 80 percent of the population having access to an improved water source.

Figure 20 Percent of the population with access to an improved drinking water source, by location (2012)



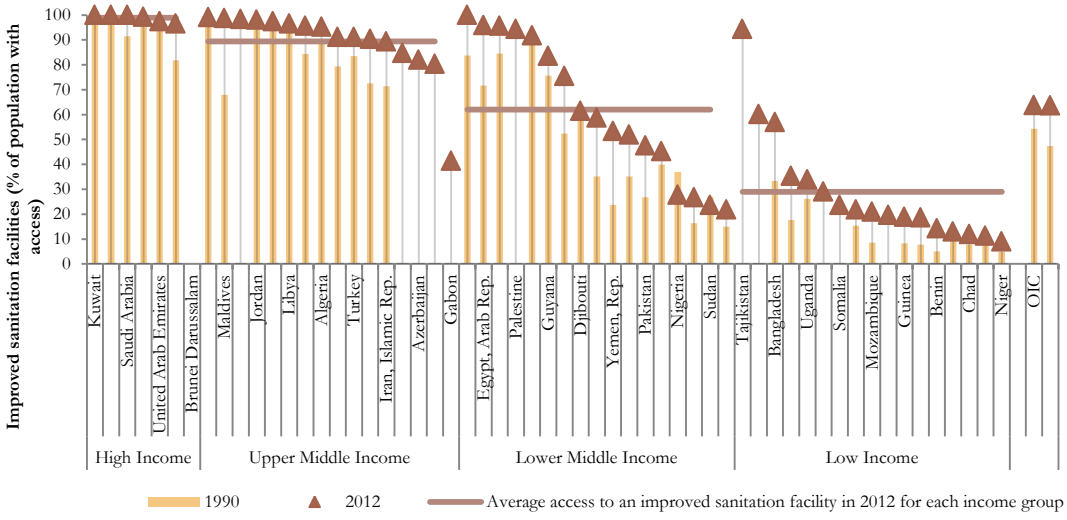
Source: World Bank, World Development Indicators

Sanitation

Like access to an improved water source, access to an improved sanitation facility increased over time around the World. However, coverage in sanitation significantly lags behind coverage in water. In 1990, access to an improved sanitation facility was 49 percent, reaching 64 percent in 2012[206]. Similar to access to an improved water source, populations living in particular regions of the World and rural areas have lower levels of access. Especially in Sub-Saharan Africa, coverage is very low at 30 percent compared to coverage in Northern Africa at 91 percent as of 2012[207]. Urban and rural disparity in sanitation coverage is also significant. In 2012, 80 percent of the urban population had access to an improved sanitation facility compared to only 47 percent in rural areas.

Access to an improved sanitation facility in OIC member countries is on par with the World average in 2012, which is already low. OIC member states had an average 63.8 percent coverage in 2012 compared to the World average of 63.6 percent. However, access remains low in many of the member countries (See Figure 21). In a number of member countries in Asia like Bangladesh, Indonesia, Afghanistan and Pakistan and in all of the member countries in Sub-Saharan Africa, access to an improved sanitation facility was lower than 60 percent in 2012. Difference between the country with the lowest level of access and the highest level of access is extremely high with 91 percent, between Niger and the countries with 100 percent access, namely Kuwait, Qatar, Saudi Arabia and Uzbekistan. Among the low income member countries, only Tajikistan had a high level of access where only 5.4 percent of the population lacked access to an improved sanitation facility in 2012.

Figure 21: Percent of the population with access to an improved sanitation facility (1990 and 2012)



Source: World Bank, World Development Indicators.

[206] WHO and UNICEF (2014)
[207] WHO and UNICEF (2014)

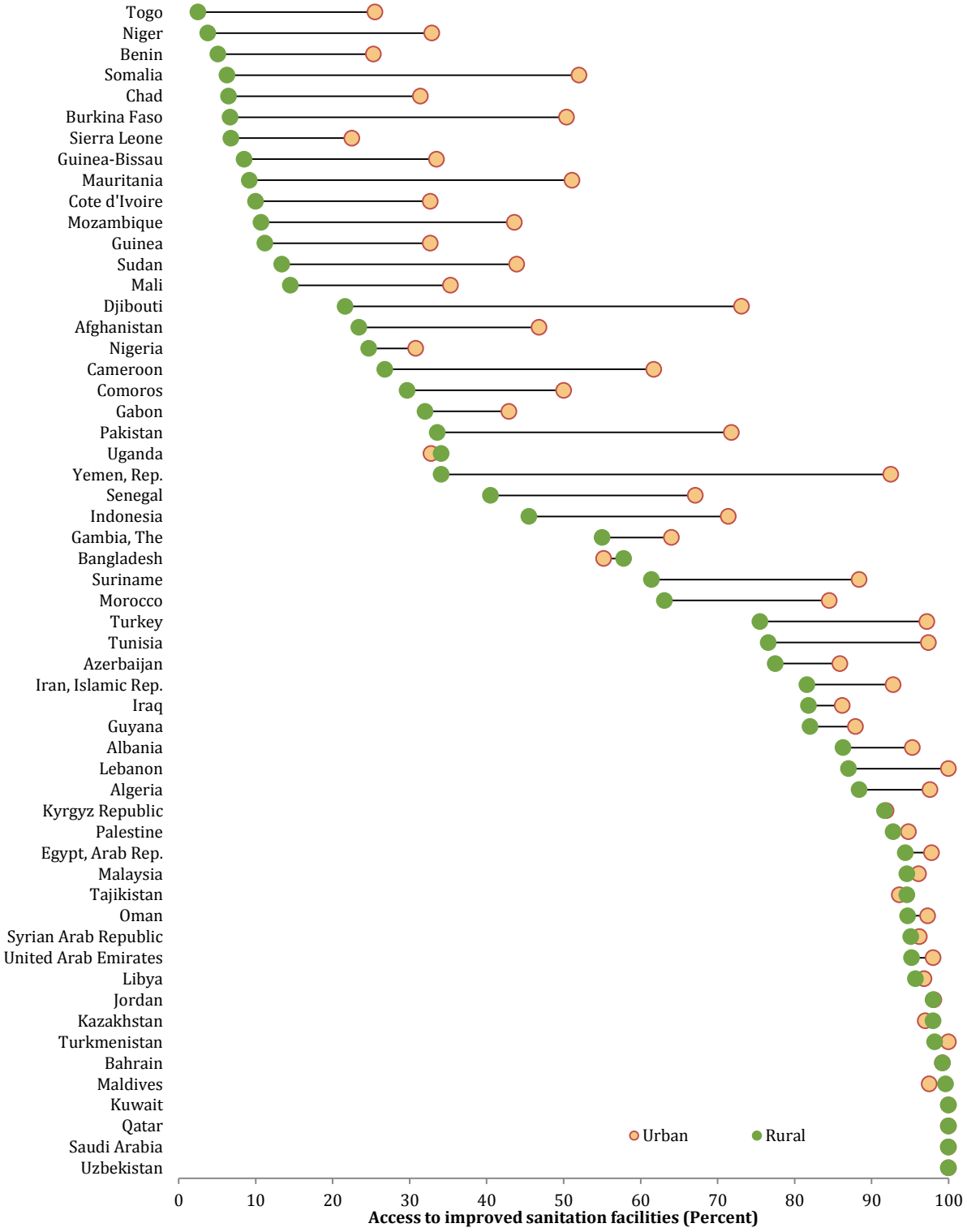
Average level of access to an improved sanitation facility increased slower in OIC member countries over time compared to the World (See Figure 21). In 1990, in OIC member countries, access was 54.3 percent on average while it reached 63.8 percent in 2012. In the same time frame, access in the World reached a similar level with 63.6 percent in 2012 up from 47.3 percent in 1990. The level of improvements are especially limited in most of the low income member states. Hence, although access increased more or less in every member state, countries in Sub-Saharan Africa all lag behind (See Figure 21).

People living in rural areas are at a substantial disadvantage regarding access to sanitation facilities in the member countries (See Figure 22). While in many of the low income countries access rates are low both in urban and rural areas, in 25 of the 56 countries[208], more than 50 percent of the population living in rural areas lack access to improved sanitation facilities. Moreover, in one-sixth of the member countries, the situation is grimmer with more than 90 percent of the rural population not having access to an improved sanitation facility.

Yet, there are countries with high coverage rates across both urban and rural areas. Saudi Arabia, Maldives, Uzbekistan and Tajikistan, each of which are from a different income group, all have coverage rates higher than 90 percent in both urban and rural areas. However, among the low income member countries Tajikistan is the only one with coverage rate as high as 90 percent in rural areas and the rest of the countries in the group have low levels of access in rural areas.

[208] 56 countries since Brunei does not have data on sanitation

Figure 22: Percent of the population with access to an improved sanitation facility, by location (2012)



Source: World Bank, World Development Indicators

Models of Water and Sanitation Service Delivery and Financing Water and Sanitation Services in OIC countries

Several types of service delivery models can be found among OIC member countries for water and sanitation (See Table 4). Different from health and education services, central provision is more commonly delivered through a national utility company rather than a ministry. In some cases, ministries are the responsible authorities for the provision of sanitation services while this is very rare for water provision. Overall, central provision of water and sanitation services is seen in countries across all income groups and in regions. For instance, Kuwait, Jordan, Bangladesh and Uganda have central provision in all or some part of service delivery for water and sanitation. Delivery models also typically differ depending on remoteness and rural/urban location. For instance, in Benin and Burkina Faso, rural areas are under the governance of local governments who can contract out services to private providers or user groups whereas, in the urban areas, there is a national utility company responsible for service delivery.

Table 4: Models of service delivery in the OIC countries for water and sanitation services

		Water					Sanitation				
		Centralized provision/ National utility	Decentralization (Local governments/ Regional utilities etc.)	Contracting out	Community participation	Private provision	Centralized provision/ National utility	Decentralization (Local governments/ Regional utilities etc.)	Contracting out	Community participation	Private provision
High Income	Kuwait	x					x		x		
	Qatar	x		x			x		x		
	Saudi Arabia			x					x		
	United Arab Emirates		x	x			x		x		
Upper-Middle Income	Albania		x					x			
	Algeria	x		x			x		x		
	Azerbaijan	x				x	x				
	Iran		x					x			
	Jordan	x					x		x		
	Kazakhstan		x			x		x			x
	Lebanon		x			x	x	x			x
	Malaysia		x	x			x				
	Maldives	x			x	x	x			x	x
	Tunisia	x			x		x				
	Turkey		x					x			
	Turkmenistan		x			x		x			
Lower-Middle Income	Cameroon	x		x			x		x		
	Egypt		x					x	x		
	Indonesia		x		x	x		x		x	
	Kyrgyz Republic		x		x			x			
	Mauritania	x		x		x	x				x
	Morocco		x	x				x	x		
	Nigeria		x			x		x			x
	Pakistan	x	x		x	x	x	x		x	
	Senegal			x	x		x				
Low Income	Bangladesh	x	x			x	x	x		x	x
	Benin	x		x	x		x				
	Burkina Faso	x		x	x		x				
	Mali	x	x	x	x			x			x
	Mozambique		x	x	x	x		x		x	x
	Sierra Leone		x			x		x			x
	Tajikistan		x					x			
	Uganda	x	x	x	x		x	x	x		x

Source: Meta-data compiled from literature review by the authors.

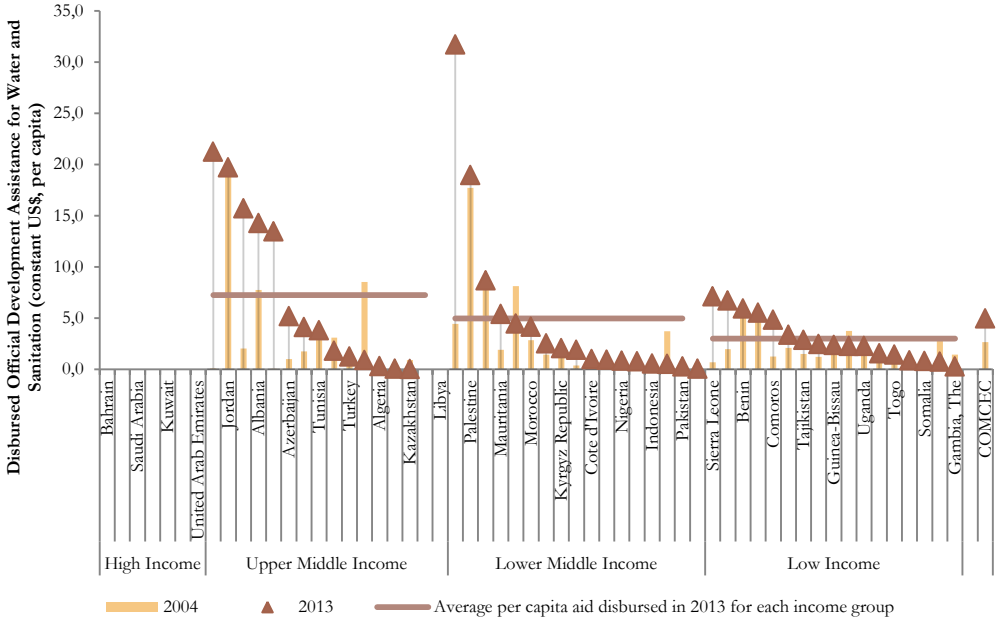
In some cases, service delivery is decentralized via regional authorities/utilities or local governments. Local governments might deliver services themselves, establish a water board to oversee delivery, or contract out services to private providers or to users associations. In fact, contracting out water and sanitation service delivery to private providers is a common service delivery model among member states. Contracts are implemented for the operations in large cities for instance in Algeria and for the majority of the urban areas in Mozambique.

User groups are active in a number of countries in the delivery of water services. Local governments commonly contract user associations to manage service delivery in Sub-Saharan African member countries including Mali, Benin, Burkina Faso and Mozambique. Also, in Tunisia, almost half of the water service delivery in rural areas are under the responsibility of user associations.

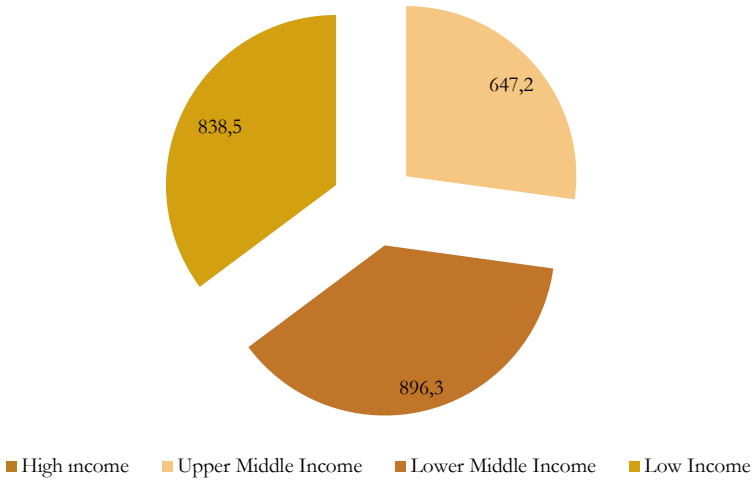
In the delivery of sanitation services, community participation is seen through demand-driven approaches. In Pakistan and Bangladesh, community-led total sanitation is implemented in villages with success and the approach was incorporated into national policies. Another similar approach was implemented in Indonesia where communities were encouraged to participate in the implementation of sanitation facilities through choosing from a menu of options and participating in the construction.

Figure 23: Disbursed Official Development Assistance for Water and Sanitation

Panel A. Per capita Disbursed Official Development Assistance for Water and Sanitation (2004 and 2013)



Panel B. Total Disbursed Official Development Assistance for Water and Sanitation for the countries in OIC income groups -constant US$, millions- (2013)



Source: Author's calculations. Data source for disbursed ODA is OECD, Aid Activities Database (Creditor Reporting System). Data source for population is World Bank World Development Indicators.

Private participation in service provision is found in the manufacturing and distribution of facilities, in cleaning pits and provision of drinking water. This type of service delivery might actually exist in all countries, yet we only report here the ones that were found in the literature review.

In the OIC member countries, government subsidies are common, especially in the high income, upper middle income and lower middle income member countries. It is recommended that an appropriate mix of these resources should be achieved to reach a level of sustainable cost recovery[209]. Even in the most developed countries public budgets continue to play a role in financing these services[210]. Yet, for instance in OECD countries, the public budget is generally used to cover capital expenditures rather than operations and maintenance costs, which are covered by the tariffs[211]. For the OIC member countries, literature review results show that a number of the low income member countries along with some of the countries from other income groups achieve cost recovery in operations and maintenance. In most of the OIC member countries, except the ones in the high income group, financing through donor funds is common, in addition to financing through tariffs and the public budget (See Figure 23). Total aid received by the OIC member countries made up 37.1 percent of the total aid disbursed in year 2013 for developing countries. Total amount of aid disbursed in water and sanitation sector reached as high as $2,382 million in 2013, up from $1,419 million in 2004.

209 OECD (2009)
210 OECD (2009)
211 OECD (2011)

High Income Countries

Central management of services, decentralization to local governments, and contracting out services are all present as delivery models in the 4 high income member states. In the provision of sanitation services, it is common to have a central responsible authority while this is not necessarily the case for water services. Contracting out services is seen in all of these member states, though in different forms.

Water and sanitation services are generally managed by separate central government bodies. In Kuwait, Qatar and UAE, sanitation is managed by a separate central authority. Delivery of water is also managed centrally in Kuwait and Qatar but not in the UAE[212]. Due to its federal governing structure, the UAE is the only country where there are separate authorities in each emirate responsible for water service delivery. The emirates Abu Dhabi, Dubai and Sharjah each have their own electricity and water authorities delivering potable water while, in the rest of the northern emirates, water is delivered by one separate authority[213].

Private sector participation in delivering water and sanitation services can be observed in varying degrees among high income member countries. Private companies are responsible for running the wastewater treatment plants in Kuwait, producing water in wastewater treatment plants or in desalination plants in Qatar, desalinating water in Dubai, UAE and running the operators through contracts with the government as in Saudi Arabia[214]. Saudi Arabia is the only country where there are public-private partnerships in the operation and maintenance of services and, hence, directly in contact with the customers.

In high income member countries, the operation costs of water are covered by the government and, to a large extent, through subsidies. Hence, tariff rates are very low or non-existent for the end users. There is no record of donor funding for high income member countries for water and sanitation sector. All the investments are financed through the public budget.

Water and sanitation service are generally heavily subsidized in high income member countries. In Kuwait, the government's electricity and water subsidies are as high as 93 percent of the total costs[215]. Similarly, in Saudi Arabia, Qatar and United Arab Emirates cost recovery for water is lower than 40 percent due to the very low tariffs that are charged[216]. In Qatar, water consumption is actually free of charge for citizens while expatriates, who constitute 80% of the population, pay a flat rate, which makes up 35% of the total operational costs[217]. Wastewater collection and treatment is generally subsidized without any tariffs charged for the services. In Saudi Arabia, there is actually no cost recovery for wastewater collection and treatment[218] and similarly, in Qatar, there is no wastewater tariff charged for consumers[219].

All investments for water and sanitation in Gulf countries are financed by the central government, and not through any donor funds[220]. Gulf countries must rely heavily on

212 See UNDP (2013) for Kuwait, UNDP (2013) and The ICE (2011) for UAE and Kahramaa (2015) and Ashgal (2015) for Qatar
213 UNDP (2013), The ICE (2011)
214 See MEED Insight (2012) for Kuwait, Oxford Business Group (2014) for Qatar, NWC (2015) for UAE
215 Capital Standards (2013)
216 UNDP (2013)
217 GWI(2011)
218 UNDP (2013)
219 GWI (2011)
220 UNDP (2013)

desalination, which is a costly way of producing water. In this respect, governments of Gulf countries have plans to invest large amounts of money in water production over the coming years. Saudi Arabia and the United Arab Emirates are planning to invest $53 billion and $10 billion until 2020 respectively, while Kuwait is planning to invest $7 billion until 2025[221]. All these large investments are financed by the central governments.

Upper-Middle Income Countries

Water and sanitation services are managed via central authorities with limited private participation in several upper middle income countries. In Jordan, Tunisia, Azerbaijan, and Maldives (for the main island), water and sanitation services are provided via the same national utility company[222]. In some cases, the utility companies are corporatized like in Jordan, where some of the utilities serving the cities are corporatized. Similarly, in Azerbaijan, the water utility is a joint-stock company. However, ownership of these utilities lies with the state in both Azerbaijan and Jordan. Malaysia is another country where a national company is responsible for the delivery of sanitation services[223]. This company was taken over by the state from a private holding company.

Local governments with responsibility of providing water and sanitation services is another common model for the countries in this income group. Albania, Kazakhstan, Turkey and Turkmenistan decentralized service provision for water and sanitation to local governments[224]. In some other member countries, services are decentralized at the regional level. For instance, in Iran, there are provincial water and wastewater companies to provide water and sanitation services and, in Lebanon, regional utilities provide water and sanitation services[225].

Contracting out services is not common among the member states in this group. In a few cases, contracted operators run the utility or they run the wastewater treatment plants through build-operate-transfer agreements. For the provision of sanitation services, public-private partnerships are seen in Jordan and Tunisia. In Jordan, private contractors exist in the sanitation sector for the operations of wastewater treatment plants and in Tunisia private operators are running a small part of the national utility company's network[226]. There are also cases where the entire operational responsibility in large cities is delegated to private operators. In major cities in Algeria, public utility companies for water and sanitation services have management contracts with private firms. This model is found to have positive results with improvements in service delivery[227].

Community participation in water and sanitation service delivery is not widely implemented among the countries in this group. Yet, in some countries it is an important service delivery model. For instance, in Tunisia, user associations (Agricultural Development Cooperatives) have a large presence in the rural areas, providing water for 43.7 percent of the rural population[228]. These cooperatives manage a total of 1,000 water points, 950 pumping stations and 80,000 distribution points (public fountains, standpipes and individual

221 UNDP (2013)
222 See OECD (2014a) for Jordan, OECD (2014b) for Tunisia, OECD (2011) and World Bank and AWM OJSC (2011) for Azerbaijan, and GWP Consultants (2006) for Maldives
223 See Japan Sanitation Consortium (2011)
224 See World Bank (2011h) and Bakllamaja (2013) for Albania, UCLG (2014) for Kazakhstan and for Turkey and UNDP (2010b) for Turkmenistan
225 See World Bank (2010b) for Lebanon and NWW (2015) and UCLG (2014) for Iran
226 See OECD (2014a) for Jordan and OECD (2014b) for Tunisia
227 OECD (2010)
228 OECD (2014b)

connections)[229]. The cooperatives are delegated by the Ministry of Agriculture for the maintenance and operations of the facilities that are constructed by the government[230].

Independent private provision is observed in a number of member countries in different forms. Lebanon, Azerbaijan, Kazakhstan, Turkmenistan and Maldives are the countries where this type of provision is found to exist. For instance, in Lebanon, due to the low levels of continuity in the public water provision, a significant number of unregulated private providers exist in the country with almost all of the households receiving services from both public and private providers[231]. While not as widespread as Lebanon, in Azerbaijan small scale water providers serve a part of the population as well. Approximately 10 percent of the population has connection to small scale water providers in the country[232]. Different than these countries, in Kazakhstan private providers own and operate the utility companies in a number of cities[233].

Among the upper-middle income countries, it is common to subsidize the water and sanitation sector. Yet, there are examples where cost recovery in operations and maintenance is achieved without subsidies, like in Azerbaijan and Maldives. Apart from the public budget and the tariffs charged, donor funding is an important source of financing for upper middle income countries for water and sanitation services. In 2013 total ODA received reached $647 million for upper middle income countries. Although the total amount received is lower than other country groups, average per capita aid to the sector is highest.

Cost recovery is hard to achieve in a number of countries and public budget is allocated to cover the remaining financing gap. Algeria, Jordan, Lebanon, Albania, Kazakhstan and Turkmenistan use government subsidies because tariffs are not enough to achieve cost recovery[234]. In comparison to other member countries in the group countries, in Turkmenistan, water is provided for free to consumers.[235] Turkmenistan does not receive external assistance and, therefore, all the capital and operational costs of water and sanitation services are financed through the public budget. Cost recovery could be expected to be achieved better when the regional authorities set the tariffs themselves. Yet, in Turkey for instance, although municipalities can charge their own tariffs, they receive aid from the Ministry of Development, Ministry of Environment and Urban Planning, the Provincial Bank and the Treasury when they need financial assistance[236].

Some countries in this group achieve cost recovery by increasing the level of user tariffs. In countries like Malaysia, Tunisia, Azerbaijan and Maldives, water utility companies generally are reported to work at cost recovery levels[237]. Azerbaijan manages to collect revenues from users that exceed operational costs with a ratio of collected water tariffs to operating costs of 1.2 in 2009[238]. In comparison, in Malaysia, the revenues collected from users are usually not

229 AfDB (2009)
230 OECD (2014b)
231 World Bank (2010b)
232 OECD (2011)
233 Vodokanal-Invest Consulting (2004)
234 See Maliki, Benhabib and Charmes (2009) for Algeria, OECD (2014a) for Jordan, World Bank (2010b) for Lebanon, World Bank (2011h) for Albania, OECD (2011) for Kazakhstan and UNDP (2010b) for Turkmenistan
235 UNDP (2010b)
236 UCLG (2014)
237 See Japan Sanitation Consortium (2011) for Malaysia, OECD (2014b) for Tunisia, OECD (2011) for Azerbaijan and GWP Consultants (2006) for Maldives
238 OECD (2011)

enough to cover expansion of services or construction of new facilities; hence state operators generally borrow funds from the government[239].

Regarding financing of wastewater collection and treatment, there are different practices observed among the countries ranging from introducing taxes, to charging tariffs, to subsidizing operations. In Algeria, private contractors run the services in five cities where prices are set by the state for each city according to the cost of providing these services in that particular city[240]. In comparison, Jordan has a wastewater tax that is equivalent to 3 percent of the property's rental value and in Iran sewerage tariffs are collected alongside the water bill[241]. In Tunisia, the public water utility operates with cost recovery, but, 39 percent of the operating expenses of the public company responsible for sanitation is subsidized by the state[242]. Similarly, in Malaysia, the public company responsible for sanitation is subsidized by the government because it cannot cover its costs due to low tariffs and low collection rates[243].

A high amount of donor funding is received by the upper middle income member countries for financing water and sanitation. In 2013, $647.2 million was disbursed to upper middle income OIC member countries from donors, an increase from $366.2 million in 2004. While total aid received is lower for this country group compared to the lower and lower-middle income country groups, several countries of this group are receiving a larger amount of per capita aid than lower income member countries (See Figure 23 Panel A and B). For instance, Maldives received $21.2 per capita in aid for water and sanitation in 2013 and, in Jordan, it was $19.7 per person. However, not all countries in the group receive ODA. Libya and Turkmenistan does not have any record of official development assistance for the sector in 2013.

Lower-Middle Income Countries

In general, among the member states in the group, a central utility company delivers the services through public-private partnerships. Mauritania is the only country in the sample where a central authority is responsible for the delivery of water and sanitation services without any private participation. In Mauritania, two separate public companies operate the water and sanitation services in urban centres[244]. However at the rural level, Mauritania also makes use of public-private partnerships. The separate government authority responsible for rural service delivery gives contracts to private providers.

Decentralization of water and sanitation services to local governments is commonly observed in this group. In Morocco, Indonesia, Nigeria, Pakistan and Kyrgyz Republic, water and sanitation services are provided via local governments to a large extent[245]. State or subnational governments provide the services via separate agencies in most of these countries. However, it is also possible for local governments to contact out the services, as is the case in Morocco.

Public-private partnerships exist in different forms in all of the member countries in this income group. In Cameroon and Senegal, a contracted private operator is responsible for service delivery in urban areas and manages the operations of the national utility company[246].

239 Japan Sanitation Consortium (2011)

241 UCLG (2014)
242 OECD (2014b)
243 Japan Sanitation Consortium (2011)
244 World Bank (2011e)
245 See OECD (2010) for Morocco, ADB (2012) for Indonesia, World Bank (2011b) for Nigeria, ADB (2009) and WSP (2007) for Pakistan and UNDP (2014) for Kyrgyz Republic
246 See World Bnak (2010a) for Cameroon and World Bank (2011i) for Senegal

Different from these countries, in Morocco, as mentioned earlier, these services are entrusted to local governments and they, in turn, can contract out to private providers. In 2009, Morocco had 13 public independent operators and 4 private operators working under concession agreements with local governments[247]. In other countries, like Egypt and Mauritania, private participation exists but it is more limited. In Egypt, private companies are given concessions to build and operate wastewater treatment plants[248] while in Mauritania, the public entity responsible for the delivery of services in rural areas gives contracts to private operators[249].

Community participation is common in lower-middle income countries, especially for the delivery of water in the rural areas. In Pakistan, the Kyrgyz Republic and Senegal, user associations have the responsibility for operations and maintenance of the water supply systems in rural areas[250]. In the Kyrgyz Republic, user associations are formed by the community members and are registered as legal bodies. The user associations own the water supply and sanitation systems and deliver services in their jurisdiction. Similarly, in Senegal, two-thirds of the management of boreholes are delegated to user associations. Delegating rural water supply schemes is found to be successful in Senegal in terms of financial viability, condition of infrastructure, and the number of connected people. Community participation is also seen as a service delivery model in sanitation services. In Indonesia, a demand-driven approach has been implemented to improve sanitation in villages[251]. Community members are given a choice in the type of sanitation facility that they want and are asked to participate in the construction of the facilities. Central and local governments participated in funding of the operations.

Private sector is also active in these countries, usually making up for the low quality of service delivery. In Mauritania, Pakistan, Indonesia and Nigeria, private water vendors or small-scale water service providers are common[252]. Water vendors are generally more expensive than public connections, as is the case of Indonesia, which adversely affects the poor[253]. In addition to water delivery, private companies work in operations related to sanitation services such as in pit emptying in Mauritania and in excreta management in Nigeria[254].

Most of the member countries in this income group cannot cover operations and maintenance costs through the tariffs. The reasons behind this might include rates that are set too low as well as low billing and collection rates. Public budget remains an important source for financing the sector. In addition, official development assistance is also an important source of financing for the countries in this income group. Lower middle income countries receive the largest share of aid on water and sanitation among other groups.

Except in Mauritania, Morocco and Senegal where water tariffs cover a large share of the operations and maintenance costs, most countries among the lower-middle income group fall short of covering their operations and management costs in water and sanitation services[255]. For instance, in Egypt, Cairo's water tariffs are among the lowest in

247 OECD (2010)
248 Embassy of Denmark in Cairo (2014)
249 World Bank (2011e)
250 See WSP (2007) for Pakistan, UNDP (2014) for Kyrgyz Republic and World Bank (2010a) for Senegal
251 ADB (2012)
252 See World Bank (2011e) for Mauritania, WSP (2007) for Pakistan, ADB (2012) for Indonesia and World Bank (2011b) for Nigeria
253 ADB (2012)
254 See World Bank (2011e) for Mauritania and World Bank (2011b) for Nigeria
255 See World Bank (2011e) for Mauritania, AFD (2013) for Morocco and Mehta (2004) for Senegal

developing country megacities covering only 25 percent of the total costs[256]. Other countries, like Indonesia, Pakistan, Nigeria, Cameroon and Kyrgyz Republic, also have water tariff rates that are insufficient to cover O&M costs[257]. In Cameroon, the operation cost recovery was 80 percent in 2005 while it was 100 percent in Senegal[258]. An operational cost recovery at 100 percent is still not a recommended rate for developing countries because it does not allow for future investments.

The situation with regards to sanitation is similar, if not worse, in terms of cost recovery. Again, in Cairo, Egypt, cost recovery in sanitation is as low as 10 percent. In Mauritania, where the water utility is financially more stable, the utility responsible for sanitation is subsidized by the government[259]. In Kyrgyz Republic, the maintenance costs of sanitation services are not covered by user charges.

Total aid for water and sanitation increases for the countries in this group from $639 million in 2004 to $896.3 million in 2013. As of 2013, Djibouti received the highest amount of per capita aid in water and sanitation at $31.7 (See Figure 23 Panel A). Between 2004 and 2013, per capita aid received for water and sanitation decreased only for Egypt, Guyana, Senegal and Syria among the countries in this group. In fact, in 2004, Egypt received the highest amount of aid for water and sanitation among all other OIC member countries at a total of $264.4 million while in 2013, this amount decreased substantially to $41.9 million.

Low Income Countries

Urban water is usually delivered centrally through a public utility company in urban areas. In Benin, Burkina Faso, Mali and Uganda, urban water services are managed and delivered by a national utility[260]. In Burkina Faso and Uganda, the same public company is also responsible for sanitation services in urban areas.

While this is the case in urban areas or large cities, the service provision model is different in these countries in the rural areas and small towns. In these areas, local governments have the responsibility to deliver services and they act as contracting authorities delegating responsibility for operations and maintenance to user associations or private providers. This is the case in Burkina Faso, Benin, Mozambique and in Mali[261]. Community Water Committees also participate in the management and delivery of water and sanitation services in Sierra Leone and Uganda in rural areas[262]. Similarly, in Bangladesh water and sanitation service delivery is decentralized to local authorities but for the large cities as well[263]. In Bangladesh, Water Supply and Sewerage Authorities (WASA) are responsible for water supply and sanitation services in large urban areas, while in other urban areas there are municipalities running these services.

Community-led total sanitation approach is observed in Bangladesh[264]. Community-led total sanitation approach which was also implemented in Pakistan as mentioned above was actually implemented for the first time in Bangladesh in the World. In this approach

256 World Bank (2005)
257 See ADB (2012) for Indonesia, World Bank (2011b) for Nigeria, UNDP (2014) for Kyrgyz Republic and WSP (2007) for Pakistan and Banerjee and Morella (2011) for Cameroon
258 Banerjee and Morella (2011)
259 See World Bank (2005) for Egypt and World Bank (2011e) for Mauritania
260 See World Bank (2011c) for Benin, World Bank (2011d) for Burkina Faso, UNDP (2009) for Mali and World Bank (2011g) for Uganda
261 See World Bank (2010a) for Burkina Faso and Benin, UNDP (2009) for Mali and World Bank (2012) for Mozambique
262 See Bennett, Thompson and van Ginneken (2011)for Sierra Leone and Government of Uganda Ministry of Water and Environement (2012) for Uganda
263 ADB (2013)
264 Hanchett et al (2011)

communities are informed by NGOs about better sanitation approaches and are motivated to build their own sanitation facilities.

Private provision of services, while limited, is observed among the countries. In urban areas in Mozambique, small scale private providers play an important role in providing water supply and in pit emptying services[265]. In the capital city, Maputo, services obtained from small scale private providers are found to be preferred by the public because they are more reliable, more efficient in travel and waiting times, and payments are easier. In Bangladesh, although limited, private sector sells hand pumps and cleans pit latrines[266].

In a number of countries in the group, especially in those with larger cities, cost recovery is economically feasible. Yet, they often do not achieve cost recovery because their tariffs are artificially low due to political reasons or low collection rates. As a result, it is common to subsidize the utilities. Official development assistance is also an important funding source with low income countries receiving a total of $838.5 million in 2013.

In low income member countries, cost recovery through user tariffs is achieved in a number of the countries for water and sanitation services. In Benin and Burkina Faso, the state water companies are able to finance their operations and maintenance costs through the tariffs[267]. In a number of countries in this group, cost recovery depends on where the utility is located. In countries like Mozambique, Uganda and Bangladesh, when the utility company is located in a big city, cost recovery could be achieved. However, in small towns, operating costs need to be subsidized by the government[268]

In a number of other countries, cost recovery cannot be achieved due to reasons like clientelism and low collection rates. In Mali, Sierra Leone and Tajikistan, cost recovery for operations cannot be achieved through user charges. In Mali, maintaining tariffs at heavily subsidized levels are highly politicized and constitute a constraint on the public utility company to recover costs and increase its investments[269]. Similarly, in Tajikistan, local water service providers are managed by local authorities and are commonly obliged to charge tariffs at low levels[270]. In Sierra Leone, in addition to the low tariff rates, low collection and billing rates also contribute to low levels of generated revenues[271].

Total aid received by low income member states for water and sanitation doubled for the countries in this income group from $414.2 million in 2004 to $838.5 million in 2013. With the exception of Gambia, Guinea and Niger, total aid received in water and sanitation increased for all the countries. The highest amount of per capita aid is received in Mozambique with $6.7 while it is lowest in Gambia with only $0.3 per person.

Common Challenges

Water

As discussed in the first part of this section, access to improved water sources in rural areas remains lower than access in urban areas for many member countries. Piped network systems do not usually reach rural areas. As a result, rural populations depend on wells, boreholes, standposts or surface water. A similar situation also exists in peri-urban

265 World Bank (2012)
266 ADB (2013)
267 See World Bank (2011c) for Benin and Marin, Fall and Ouibiga (2010) for Burkina Faso
268 See World Bank (2012) for Mozambique, World Bank (2011g) for Uganda and WSP (2009) for Bangladesh
269 UNDP (2009)
270 UNDP (2010a)
271 Bennett, Thompson and van Ginneken (2011)

areas or informal settlements inside the cities. Reaching these areas is a challenge, especially for lower income member countries.

Clientelism is a general problem in the delivery of water services. When utilities that provide water are heavily dependent on government financing and their management staff are appointed by the politicians, they lose their autonomous functioning and politicians can exert excess control over the company. This usually results in artificially low tariffs and low quality services. For instance, in Mali, maintaining tariffs at heavily subsidized levels is a political decision that constrains the utility company from expanding investments in urban areas[272]. Similarly, in Tajikistan, local water service providers are under the control of local authorities who appoint directors, direct subsidies, and make decisions on capital investments[273]. This, in turn, leads to low levels of service quality with 70 percent of infrastructure requiring rehabilitation and an average leakage rate of 50-60 percent in public water[274].

Low quality of services is common in water service delivery. Being connected to the piped water network does not equate to 24-hours of uninterrupted service delivery. In Lebanon, although the connection rates are high, continuity of supply ranges from 3 to 22 hours during the summer season[275] with significant regional differences in water supply quality across the country. In the capital city, Beirut, water is supplied for only 3 hours per day at summer time while it is supplied for 24-hours in neighboring Tripoli, which can be attributed to a 5-year management contract with a private company that was implemented in 2004-2007 and led to a long-lasting efficiency improvement[276]. Similarly, in Albania and Azerbaijan, water service availability is low with an average of 11 hours and 7 hours per day, respectively[277]. Low quality of service delivery increases citizens' demand for private water services. For instance, in the capital city Maputo in Mozambique, citizens prefer to pay higher fees for private water services over using low quality pubic services[278].

Poor citizens are generally not connected to the public network and being unconnected to the water network could be more expensive. Water obtained privately from vendors or private connections is generally more expensive, which can severely impact the poor. In Indonesia, only 10-15 percent of the poor living in urban areas are connected to the piped water network. The unconnected population obtain water from individual wells, small-scale providers, or water vendors[279]. Yet, the price of water obtained from the vendors can be as high as five times of the price of water obtained from connection to a piped network[280]. Similar trends in prices can be observed in Sub-Saharan Africa. A report shows that in 15 largest cities in Sub-Saharan Africa, the price of 1 cubic meter of water sold by private water tankers and water vendors could be as high as 8 to 10 times that of water sold through house connections[281]. For instance, in Nigeria, water provided through household connection is $0.17 for 1 cubic meter of water while it is sold at $5.71 for the same amount by private vendors, similarly in Cote D'Ivoire, household connection costs only $0.04 for cubic meter as opposed to $3.35 charged by private vendors for the same amount.[282]

272 UNDP (2009)
273 UNDP (2010a)
274 UNDP (2010a)
275 World Bank (2010b)
276 World Bank (2010b)
277 See World Bank (2011h) for Albania and OECD (2011) for Azerbaijan
278 World Bank (2012)
279 ADB (2012)
280 ADB (2012)
281 Banerjee and Morella (2011)
282 Banerjee and Morella (2011)

Failures in the accountability framework are associated with the challenges like clientelism and intermittent water supply. When the line between the policymakers and the service providers is hard to draw, policymakers usually do not have the incentives to hold themselves accountable. In return, service providers generally end up holding tariffs at below cost recovery levels, which is a political decision rather than an economic one. Low tariffs results in low quality services and low quality services may further lead to low collection rates since the customers may not want to pay for low quality services, hence a continuous loop is created. In a setting like this, service providers generally lack accountability to the citizens ending up having no incentive to improve service delivery.

The community participation model may have its own shortcomings. In operations and management of water delivery services, community participation is commonly seen. Although this model increases voice and client power, it may not capture all voices in the community. In Uganda, users' associations have low levels of trust among community members. A survey among rural households showed that 90 percent of respondents thought that the fee collected for maintenance by their water user committee was used incorrectly[283]. In addition, in countries where an urban piped water network already cover larger areas, rural populations demand to be connected to the network instead of using water points managed by users' associations. This is the case in Tunisia[284]. Piped network connection reaching every household is desired by the citizens instead of hand pumps or standpoints.

Sanitation

Several member countries do not have a specific authority responsible for sanitation services or lack national plans and guidelines to improve its delivery. Because responsibilities regarding sanitation are not delegated effectively, disruptions in service can occur. In Sierra Leone, there is confusion related to which institute has the responsibility on promotion and implementation of sanitation[285]. Similarly, in Mali, due to the high prevalence of on-site sanitation, there are no adequate institutional arrangements for sanitation services where the responsibilities are shared between households, NGOs, communes and private providers[286]. In Cameroon, since there are no plans targeting to improve rural sanitation, the directorate under the Ministry of Energy and Water that is responsible for rural areas only implements activities to improve the situation in water[287].

On-site sanitation is generally neither regulated nor subsidized. On-site sanitation services are common among member countries, particularly in lower income groups. In Benin, Uganda and Mozambique, the government does not take part in financing latrines or regulating on-site sanitation facilities, which leads to concerns around groundwater contamination[288]. Government subsidies targeting on-site sanitation may have a positive effect. In Bangladesh, Mozambique and Senegal, projects with government support in financing on-site sanitation led to improved results in increasing access[289].

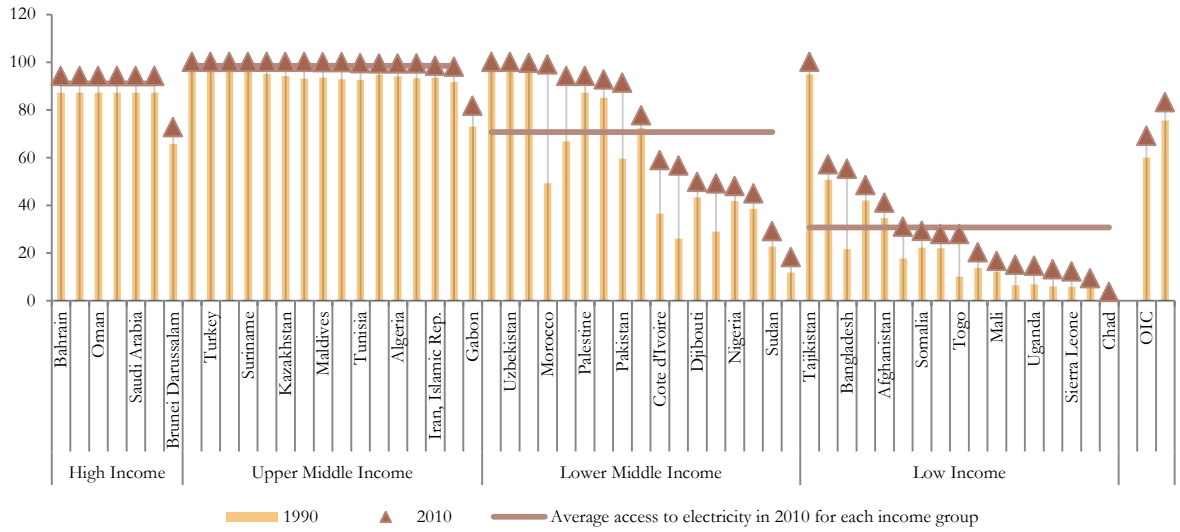
283 Jacobson et al (2010)
284 OECD. (2014b)
285 World Bank (2011f)
286 UNDP (2009)
287 World Bank (2011a)
288 Banerjee and Morella (2011)
289 Trémolet, Kolsky and Perez (2010)

2.2.4 Overview of Electricity Services in OIC Member Countries

Access to Electricity

Over the years, the rate of access to electricity has increased worldwide. In 2010, 83.1 percent of the World's population had access to electricity, up from 75.6 percent in 1990. Despite the overall improvement in access, regional and urban-rural disparities remain. To illustrate regional disparities, the access rate to electricity was 31.8 percent in Sub-Saharan Africa compared to 94.7 percent in the MENA region in year 2010. Within countries, while the urban-rural gap in access decreased slightly over time, rural areas still lag behind. In 2010, the average worldwide access rate to electricity was 95.3 percent in urban areas as opposed to 70.2 percent coverage for the rural areas. This is a slight improvement from 1990 rates, when the access rate was 93.7 percent in urban areas and 60.7 percent in rural areas.

Figure 24: Percent of the population with access to electricity (1990 and 2010)



Source: World Bank, World Development Indicators

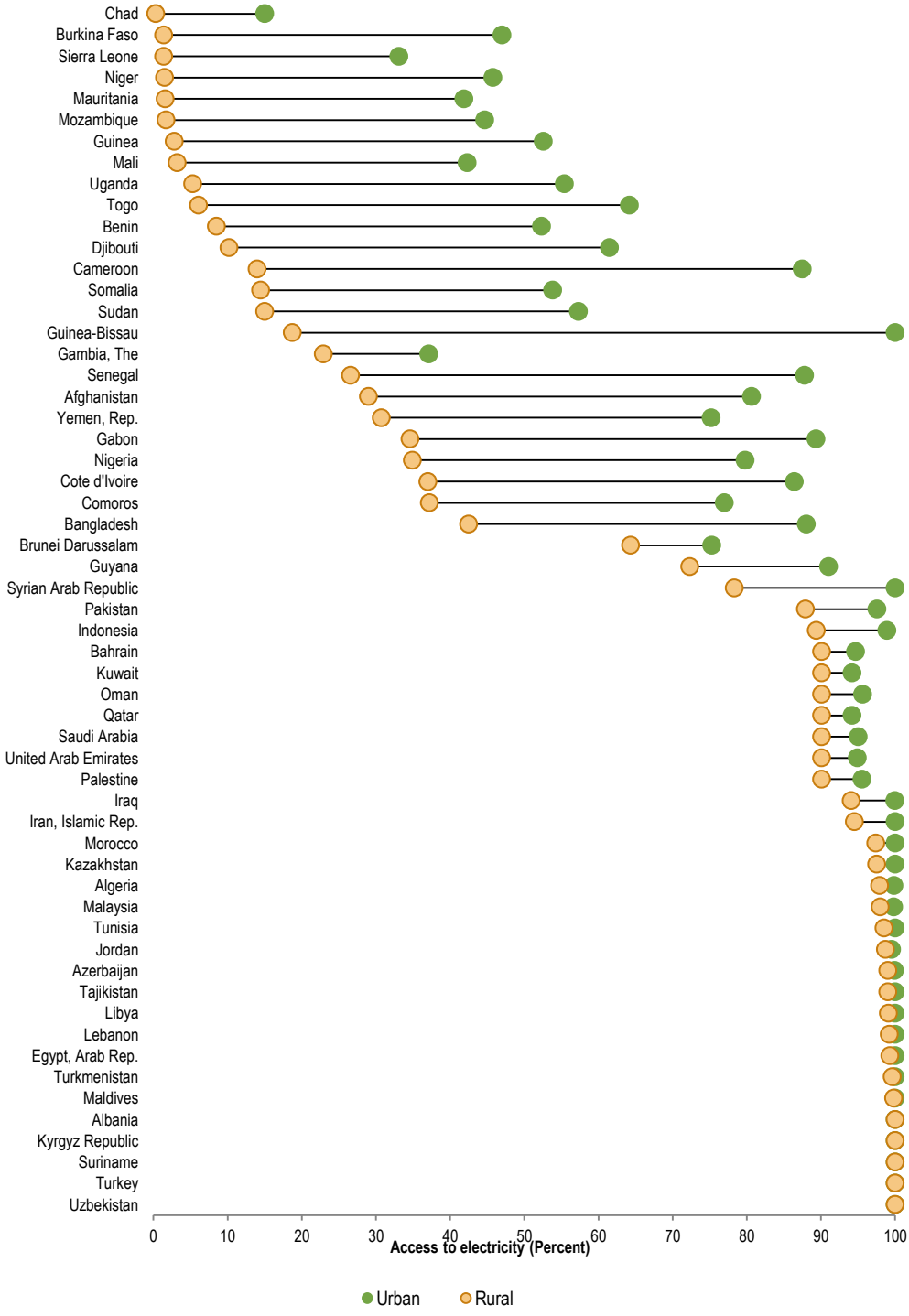
Average access to electricity is lower in OIC Member Countries, compared to the World. In 2010, 69.1 percent of the population in OIC countries had access to electricity compared to 83.1 percent in the World. Coverage rates are especially low among member countries in Sub-Saharan Africa along with Afghanistan and Bangladesh. High income and upper middle income countries have almost uniformly high coverage rates, while wide disparities exists in lower middle income and low income countries (See Figure 24). Among the lower middle income member countries, the highest access rates are seen in Kyrgyz Republic and Uzbekistan with 100 percent coverage while the lowest rate is seen in Mauritania with only 18.6 percent access. Similarly difference in access rates are evident in low income member states where there is a 96.5 percentage point spread between the coverage rates in Tajikistan and Chad where population connected to electricity is as low as 3.5 percent. On average, low income member countries severely lag behind other country groups. Excluding Tajikistan, which has 100 percent access rate, average access for the low income countries was only 26.4 percent in 2010.

The average electrification rate increased over the past two decades in OIC member countries (See Figure 24). Average access to electricity in member countries increased to 69.1 percent in 2010 from 59.9 percent in 1990. Some member countries achieved major improvements during this time period. Morocco, for example, achieved almost full coverage in access in 2010 from a level of 49.2 percent in 1990. Bangladesh is another successful case, where the access rate increased from 21.6 percent in 1990 to 55.2 percent in 2010.

Despite improvements, electricity access remains low in almost half of the member countries. More than 50 percent of the population lack access to electricity in all of the countries in the low income group excluding Tajikistan, Bangladesh and Guinea-Bissau. The situation is more extreme in Niger and Chad where higher than 90 percent of the population is without access to electricity. Low electrification rate is a severe regional problem in Sub-Saharan Africa. Except Gabon, Senegal and Guinea-Bissau, all member countries from the region have electricity access rates lower than 50 percent.

In addition to the national and regional differences, there are significant disparities regarding urban and rural access among the member states (See Figure 25). On average, 59.6 percent of the rural population in member countries have access to electricity compared to 82.1 percent in urban areas. In general, the gap between urban and rural is larger among low income member countries. Except Tajikistan, Chad and Gambia, the gap between urban and rural access in low income member countries is greater than 30 percentage points. Cameroon has the highest level of urban-rural disparity in electricity coverage where, in 2010, the access rate to electricity was 87.5 percent in urban areas and 14 percent in rural areas. In comparison, Turkey, Uzbekistan, Suriname, Kyrgyz Republic and Albania achieved 100 percent access in both urban and rural areas.

Figure 25: Percent of the population with access to electricity, by location (2010)



Source: World Bank, World Development Indicators

Models of Electricity Service Delivery and Financing Electricity Services in OIC countries

Among OIC member countries, several types of service delivery models can be observed as highlighted in Table 5. Two common models are vertically integrated national utility company and unbundled companies. Trends are not observed based on income group or region with regards to unbundling the utility. For instance, in the same income and regional group: Uganda unbundled the national electricity company and privatized some functions while Mozambique has a national utility company which is vertically integrated with no private participation.

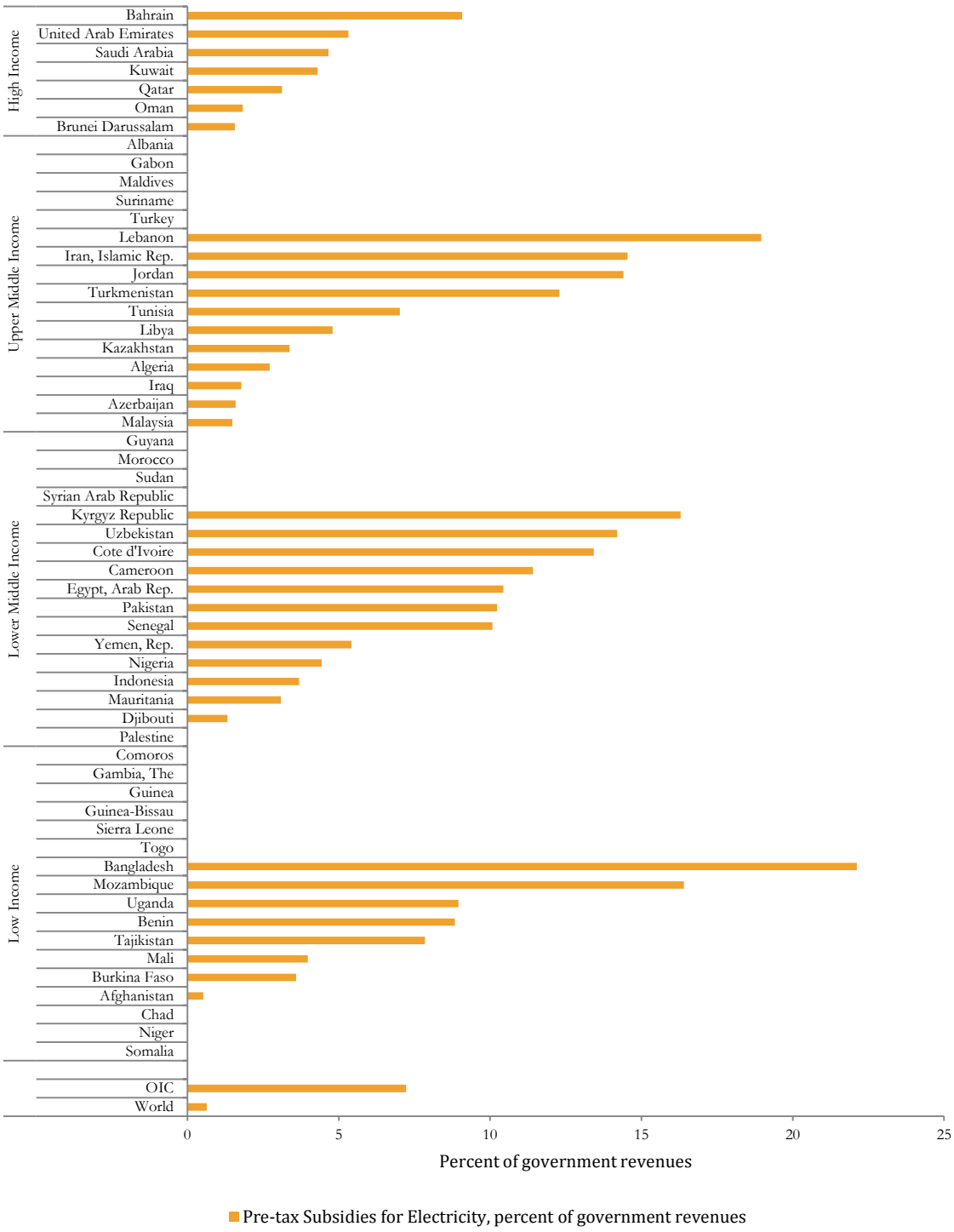
Table 5: Models of service delivery in the OIC countries for electricity services

		Central provision (Vertically integrated national utility company)	Decentralization (Unbundled national company/ Regional utilities)	Contracting out (includes: Management contracts, concessions, IPPs in generation/distribution, privatization of unbundled companies)	Community participation (cooperatives)	Private provision (Off grid private provision)
High Income	Kuwait	x		x		
	Qatar	x		x		
	Saudi Arabia	x		x		
	United Arab Emirates		x	x		
Upper-Middle Income	Albania		x			
	Algeria		x	x		
	Azerbaijan	x				
	Iran		x			
	Iraq		x			x
	Jordan		x	x		
	Kazakhstan		x	x		
	Lebanon	x		x		x
	Libya	x				
	Malaysia		x	x		
	Maldives		x			x
	Tunisia	x		x		
	Turkey		x	x		
	Turkmenistan	x				
Lower-Middle Income	Cameroon			x		
	Egypt		x	x		
	Indonesia	x		x		
	Kyrgyz Republic		x	x		
	Mauritania	x				
	Morocco	x		x		
	Nigeria			x		
	Pakistan		x	x		
	Senegal	x		x		
	Uzbekistan		x			
Low Income	Bangladesh		x	x	x	x
	Burkina Faso	x	x	x	x	
	Mali	x			x	x
	Mozambique	x		x		
	Sierra Leone		x	x		
	Tajikistan	x		x		
	Uganda		x	x		

Source: Meta-data compiled from literature review by the authors.

Public-private partnerships are observed in almost all of the countries either in generation or in the distribution of electricity. In many countries, private participation is observed in the generation of the electricity. In Malaysia, IPPs generate half of the electricity in the country. In other countries, parts of unbundled companies are privatized, such as in Turkey or Nigeria.

Figure 26: Pre-Tax Subsidies for Electricity as a percent of government revenue (2011)



Source: Clements et al 2013. Countries at the top of each income group with no data are classified as "n.a." by the authors.

Community participation in the electricity sector is observed through user cooperatives in a small number of member countries. This type of service provision is observed among a number of low income member countries across different regions. Bangladesh, Mali and Burkina Faso make use of consumer cooperatives in electricity distribution in rural areas. In Bangladesh, cooperatives are registered with the country's Rural Electrification Board and each own and operate a rural distribution system under their jurisdiction. Their customers are also their members.

Among the OIC member countries, subsidies are common in the electricity sector (See Figure 26). Pre-tax electricity subsidies are estimated to make up 0.64 percent of global government revenues compared to an average 7.2 percent in the OIC member countries.[290] Around the World, utilities generally charge enough to cover their O&M costs. Only 15 percent of electricity utilities around the world are charging too little to cover their O&M costs.[291] The prevalence of low electricity tariffs is more common among lower middle income and low income countries with 27 and 31 percent, respectively, being unable to recover their O&M costs.[292] In the OIC, majority of the member countries across all income groups subsidize electricity utilities to a certain extent. These subsidies might reach very high levels, as in the case of Bangladesh where subsidies make up 22.2 percent of the government revenues. In comparison, some of the member countries do not have subsidies, such as Turkey, where costs are directly reflected in tariff prices.

High Income Countries

Most high income member states use a model of central provision for transmission and distribution but privatize generation. Usually there is a central government agency responsible for transmitting and distributing electricity while privately owned generation plants are becoming more common for purposes of increasing efficiency and to meet the increasing demand. In Kuwait, Qatar and Saudi Arabia there is a single public agency responsible for transmission and distribution of electricity[293] but generation of electricity is privately provided[294].

Decentralization of electricity provision is not common in high income member states. Only in the United Arab Emirates, instead of one agency responsible for the electricity transmission and distribution, there are five state-led entities, four of which are owned by the governments of the emirates and one federally controlled authority for the smaller northern emirates[295]. Similar to other high income countries, UAE also has private participation in electricity generation.

All high income member countries spend part of their budget on electricity subsidies. The share of subsidies for electricity in government revenues range from 1.6 percent in Brunei to 9.1 percent in Bahrain (See Figure 26).

290 Clements et al. (2013).
291 Komives et al (2005)
292 Komives et al (2005)
293 See Capital Standards (2013) for Kuwait, KAHRAMAA (2015) for Qatar and Alawaji (2012) for Saudi Arabia
294 See KAHRAMAA (2015) for Qatar, Saudi Electric Company (2013) for Saudi Arabia, (US. Energy Information Administration (2014d) for Kuwait
295 Afridi and Baryalay (2014)

Upper Middle Income Countries

In several upper middle income countries, a vertically integrated national utility company has a monopoly over the sector. Azerbaijan, Lebanon, Libya, Tunisia and Turkmenistan have an integrated national utility company responsible for generating, transmitting and distributing electricity to consumers that has a monopoly in the power sector.[296]

Different from the previous group of countries, decentralization of electricity supply is seen in a number of the member countries in two different ways: (i) decentralization via regional utilities or (ii) decentralization of operations via unbundling the national utility companies into separate companies responsible for each leg of the electricity supply chain. In Iraq, Maldives and Malaysia, utility companies are responsible for different states or islands[297], which is in part due to the political and geographical conditions of these countries. Algeria, Jordan, Albania, Iran, Kazakhstan and Turkey unbundled their national utility companies and maintain some or all of the newly formed companies under state ownership[298]. In Kazakhstan, Turkey and Jordan, transmission companies are state owned while generation and distribution is privatized. In comparison, unbundled companies are owned by the state in Algeria, Albania and Iran.

Private participation in the electricity sector is evident in varying degrees among different parts of the supply chain. Many of the member countries use power generated by IPPs, which are not in direct contact with customers and usually sell the generated power to a single purchaser. For instance, in Malaysia, IPPs generate half of the electricity of the country.[299] While IPPs are common in this income group, Kazakhstan stands out as a special case because most of its generation plants are privately owned and they have a competitive market for electricity generation[300]. Apart from this kind of partnership with private companies, privatization of unbundled national utilities is evident among member countries as well. In Jordan, Turkey and Kazakhstan, some or all of the distribution companies are privatized while transmission companies are kept state owned.[301]

In a number of counties informal private power generators sell electricity directly to the customers in several countries. This is the case in Iraq and Lebanon where power shortages create space for a separate informal market to meet the needs of customers.[302] In Lebanon, this is an expanding informal business where majority of the households use back-up generation through a subscription with a private generator.

In several upper middle income countries, high percentages of government budget are allocated to electricity subsidies. In Lebanon, Iran, Jordan and Turkmenistan, the share of electricity subsidies in government revenues are higher than 10 percent. Turkmenistan spends a high share of its government revenue on electricity subsidies because electricity is supplied

296 See UNECE and IEA (2013) for Azerbaijan, Fardoun et al (2012) for Lebanon, Reegle (2012a) for Libya, Barnes (2005) for Tunisia, Reegle (2012b) for Turkmenistan
297 See Al-Khatteeb and Istepanian (2015) for Iraq, Ministry of environment and Energy, Republic of Maldives (2012) for Maldives and US. Energy Information Administration (2014e) for Malaysia
298 See IMF (2015) and Reuters (2014) for Albania, World Bank (2007) for Iran, US. Energy Information Administration (2014c) for Kazakhstan and US. Energy Information Administration (2014f) and Vagliasindi (2013) for Turkey.
299 US. Energy Information Administration (2014e)
300 US. Energy Information Administration (2014c)
301 See Vagliasindi and Jones (2013) for Jordan, US. Energy Information Administration (2014f) and Vagliasindi (2013) for Turkey and US. Energy Information Administration 2014c for Kazakhstan
302 See Al-Khatteeb and Istepanian (2015) for Iraq and World Bank (2009) for Lebanon

free of charge to the consumers.[303] In Jordan and Lebanon, electricity tariffs are reported to be much lower than the actual costs.[304]

There are also cases where electricity tariffs are not subsidized, like in the case of Turkey[305]. Electricity prices were changed in Turkey to reflect the costs of generation, transmission and distribution.

Lower Middle Income Countries

An integrated national utility company is responsible for the sector in a number of member countries in the group. Senegal, Indonesia, Morocco and Mauritania have an integrated national utility company that is responsible for the generation, transmission and distribution of electricity.[306]

In comparison, some countries unbundled these utility companies into separate parts. In Egypt, Pakistan, Kyrgyz Republic and Uzbekistan, public electricity companies are unbundled and majority of their parts are kept in state ownership.[307] For instance, in Egypt, there are six generation, one transmission and nine distribution companies under the governance of an umbrella holding company. Similarly, in Pakistan, the power sector was restructured and the power utility that serves areas outside of Karachi was unbundled to create 4 generation, 1 transmission and 10 distribution companies.

Public-private partnerships are observed in electricity generation in several countries in this income group. In Egypt, Morocco, Indonesia, Senegal, Kyrgyz Republic and Kazakhstan, privately owned power plants sell energy to national companies for distribution.[308] For instance, in Indonesia, these power plants produce 14 percent of the country's electricity. In comparison, in Morocco, 68 percent of the electricity generated in the country is privately generated.[309]

A higher degree of private participation is observed in two of the member countries in Sub-Saharan Africa region. There is a high degree of public-private participation in the sector in Cameroon and Nigeria. Nigeria's electricity sector is one of the most liberalized in Africa. Electricity generation and distribution is fully privatized in the country while transmission assets are held by the federal government.[310] In Cameroon government has gone under a 20 year concession agreement with a private company to run the integrated national utility company.[311] Similar to this kind of service provision model, the case of Karachi in Pakistan could also be mentioned here. While the rest of the companies are state owned in Pakistan, the integrated utility serving Karachi was privatized in 2005 with government retaining 26 percent of its shares and selling the rest to a private company.[312]

303 UNECE (2013)
304 See Fardoun et al (2012) for Lebanon and World Bank (2013b) for Jordan
305 US. Energy Information Administration (2014f)
306 See GIZ (2013) for Senegal, Vagliasindi and Jones (2013) for Indonesia, Amegroud (2015) for Morocco and (World Bank (2014) for Mauritania
307 See World Bank (2015) for Egypt, Trimble, Yoshida and Saqib (2011) for Pakistan, Abdyrasulova and Kravsov (2009) for Kyrgyz Republic and Kochnakyan et al (2013) for Uzbekistan
308 See World Bank (2015) for Egypt, Amegroud (2015) for Morocco, Vagliasindi and Jones (2013) for Indonesia, World Bank (2013c) for Senegal, Abdyrasulova and Kravsov (2009) for Kyrgyz Republic
309 Vagliasindi (2013)
310 KPMG (2013)
311 Vesey (2011)
312 K-Electric (2015)

Among lower middle income countries, it is again common to subsidize electricity. In 7 of the countries from this group, subsidies are higher than 10 percent of government revenue. These countries are Kyrgyz Republic, Uzbekistan, Cote d'Ivoire, Cameroon, Egypt, Pakistan and Senegal.

Low Income Countries

Vertically integrated state-owned utilities are responsible for the delivery of electricity services to the public in Mozambique, Mali and Tajikistan.[313] In comparison, decentralization of operations to varying degrees is observed in other countries. In Bangladesh and Sierra Leone, there are separate state-owned utilities responsible for providing services while in Uganda, a national utility is unbundled with the transmission company remaining state owned while the rest is privatized.[314]

Private participation in the form of public private partnerships is evident in electricity generation or distribution in almost all of the countries. Uganda, after unbundling their national utility, established 20 year concession agreements with private companies for generation and distribution.[315] In Burkina Faso, the institutional structure is somewhat different. The national utility company of the country has a monopoly over the import and export of electricity but it does not have a monopoly over generation and distribution, hence private companies are allowed to operate in these areas of operation.[316]

Electricity cooperatives are a common way of distributing electricity in rural areas in Bangladesh, Burkina Faso and Mali.[317] Cooperatives are made up of electricity customers and are supported by Rural Electrification Funds/Boards in both countries. In Bangladesh, cooperatives are registered with the country's Rural Electrification Board and they own and operate a rural distribution system under their jurisdiction.

Private operators are also found in Mali and Bangladesh. In Mali, in addition to the cooperatives, private local energy companies also receive support from the Rural Electrification Fund. These small private companies usually operate mini-grid systems and are effective in rural electrification. In Bangladesh, private local grids are widespread.[318]

Among low income member countries, there is a wide range between the levels of subsidies as a share of government revenues. In Bangladesh, subsidies are estimated to be as high as 22.1 percent of the government revenue while in Chad and Niger they are almost non-existent.

Common Challenges

Low connection rates in rural areas is a major challenges, especially among lower income countries (See Figure 27). A number of reasons could be listed for the incidence of low electrification rates. These may include (i) High costs of supplying rural and peri-urban areas (ii) weak implementation capacity of the governments and (iii) electricity generation

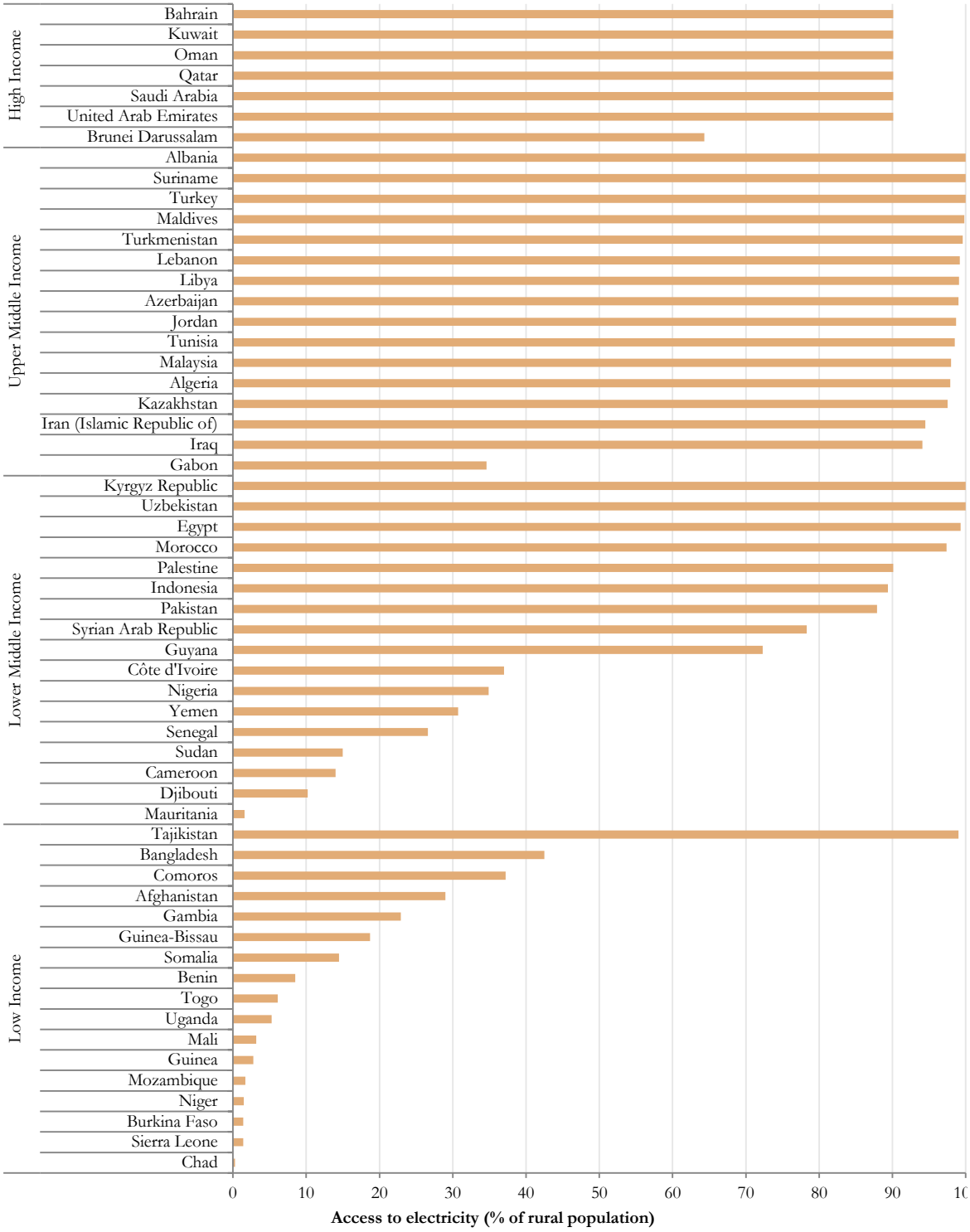
313 See Chambal (2010) for Mozambique, Ministry of Energy and Water Resources, Republic of Mali (2012) for Mali and EBRD (2010a) for Tajikistan
314 See World Bank (2013d) for Bangladesh, Economic Commission for Africa Southern Africa Office (2004) for Sierra Leone and Clements et al (2013) for Uganda
315 Clements et al (2013)
316 World Bank (2013a)
317 See Khandker, Barnes and Samad (2009) for Bangladesh, World Bank (2013a) for Burkina Faso and Ministry of Energy and Water Resources, Republic of Mali (2012) for Mali
318 Baker (2009)

shortages.[319] In rural areas, fewer people are dispersed over a large area, which leads to a small number of people sharing a high amount of cost. Hence, low cost recovery for the utility and unaffordable tariffs are a common challenge in rural areas. Apart from issues related to costs, governments may not have enough resources or managerial skills to address rural electrification issues. In some cases, there might not be enough electricity generated to distribute to the population. For instance, total generation capacity in Sub-Saharan Africa with 68 gigawatts is no more than that of one country, Spain, while per capita electricity generation in the region is less than one third of South Asia.[320]

Governments use different approaches to tackle the problem of low rural electrification. While in some countries, like Mali, off-grid approaches are implemented via supporting local rivate providers or communities, in other countries, like Mozambique, a more centralized approach is employed by the national utility implementing a rural roll-out programme.[321] The Moroccan government and national utility implemented a successful rural electrification program[322]. The program started in 1996, and between 1990 and 2010 Morocco increased its rural electricity access rate from 15.6 percent to 97.4 percent. Evidence shows that having a separate Rural Electrification Fund or Agency and having a centralized approach where a single utility is responsible for implementation is a more effective way in increasing rural connections in Africa.[323] Yet, off grid solutions have been successful as well, for instance in Bangladesh. In 2003, the country initiated a solar home system program which led to electrification of three million households in 10 years.[324] In addition to this off-grid solution, access to the main grid increased in the rural areas as well. Rural electricity cooperatives extended access to an additional 1.3 million households in the same time period.[325]

319 World Bank (2012)
320 Eberhard et al (2011)
321 See Chambal (2010) for Mozambique and Ministry of Energy and Water Resources, Republic of Mali (2012) for Mali
322 ISDB (2013)
323 Eberhard et al (2011)
324 Sadeque et al (2014)
325 Sadeque et al (2014)

Figure 27 Percent of the rural population with access to electricity (2010)



Source: World Bank, World Development Indicators

While it is a success to achieve high connection rates, this does not directly lead to having access to continuous electricity. Low quality of services, frequent blackouts and power shortages are common among the member countries. For instance, in Tajikistan, Lebanon and Iraq, there are power shortages especially during times of heavy usage.[326] Power shortages force customers to turn to the informal private market or to household generators for electricity. Electricity obtained from private sources is generally more expensive than publicly provided services. For instance, in Lebanon, the average bill for electricity provided by private generators was $47 compared to average bill of the national utility of $26, in 2008. In addition, although the electricity provided by private unregulated providers is more expensive, it also only provided for half the number of hours in a day.[327] In Iraq, many families have their own generators costing as much as $1,000 a month, which is equivalent to one sixth of the average annual income in the country.[328]

Low financial viability in the electricity sector is a common problem along with regressive subsidies. In Jordan, the National Electric Power Company generated losses equal to 5 percent of GDP in 2011 and 2012 largely due to not being able to reflect its increasing costs in consumer tariffs.[329] Similarly, in Mauritania, rising costs of fuel are not reflected in tariffs and, as a result, residential and commercial tariffs are more than 30 percent below cost recovery levels.[330] In fact, electricity subsidies usually benefit the rich more instead of the poor because poor households are not heavy users of electricity or are not connected to the grid. In many Sub-Saharan African countries, including Uganda, Chad, Burkina Faso, Guinea, Mozambique, Cameroon and Senegal, electricity subsidies are very regressive, meaning the share of the benefits allocated to the rich is larger than their population share.[331] Similarly, in Pakistan, benefit incidence analysis indicates that the poorest 20 percent of the households only receive 10 percent of the electricity subsidies.[332]

Challenges observed in the delivery of electricity services are associated with the failures in the accountability framework. National utilities which cannot act autonomously end up being used for political purposes. Keeping the tariffs at below cost recovery levels is an example to such political decisions. Since tariff raises are generally associated with public discontent, for short term political gain they are being kept low which leads to the low financial viability of the utilities. Low financial viability in return leads to quality problems in service delivery like intermittent electricity supply. A weak voice exacerbates these problems, leaving the State to handle the situation as it wishes without facing any negative consequence.

326 See Fields et al (2013) for Tajikistan, Al-Khatteeb and Istepanian (2015) for Iraq and World Bank (2009) for Lebanon
327 World Bank (2009)
328 Economist (2014)
329 World Bank (2013b)
330 Clements et al (2013)
331 Foster and Briceno-Garmendia (2010)
332 Trimble, Yoshida and Saqib (2011)

3. Case Studies

In order to illustrate the service delivery models and challenges of delivering services to the poor in OIC Countries, a sub-set of four member countries were selected as case studies for the report. The case countries were selected mainly on the basis of income and regional diversity, but they also embodied diverse models of service delivery which significantly contributed to the illustrative ability of the report. Table 6 below provides an overview of service delivery models in the case countries selected for Section 3 of the report where one can observe the wide variety of models employed across sectors.

Table 6: Service models employed in selected case countries

		Central government provision	Decentralized/ Local government	Contracting out	Community participation	Private provision
Education	Turkey	x			x	x
	Lebanon	x				x
	Indonesia		x		x	x
	Bangladesh	x				x
Health	Turkey	x				x
	Lebanon		x	x		x
	Indonesia		x		x	x
	Bangladesh	x		x		x
Water	Turkey		x			
	Lebanon		x			x
	Indonesia		x		x	x
	Bangladesh	x	x			x
Sanitation	Turkey		x			
	Lebanon	x	x			x
	Indonesia		x		x	
	Bangladesh	x	x	x		x
Electricity	Turkey		x	x		
	Lebanon	x		x		x
	Indonesia	x		x		
	Bangladesh		x	x	x	x

3.1 Turkey

3.1.1 Country Background

Turkey is a member of G-20 with a GDP of 822.1 billion USD and GDP per capita of 18,660 USD as of 2013[333]. Despite being one of the largest economies in the World, Turkey ranks low in human development measures. In 2013, the country was ranked 69th in the Human Development Index, out of 187 countries. One reason for low human development outcomes is the high levels of regional disparity that persists in Turkey. According to a socio-

333 World Bank, World Development Indicators.

economic development index constructed by the Ministry of Development of Turkey, out of the 26 regions in the country, the least developed 5 are located in the Eastern and South-eastern regions of Turkey.[334]

Electorally, Turkey has a parliamentary system with proportional representation. The Turkish state is centralized, and thus the services like education and health are provided centrally. Turkey is divided into 81 provinces and 919 districts[335]. Each province has a governor and a municipality. Districts also have municipalities. The governors are appointed to the provinces by the central government; while elections take place for the municipalities. Overall, the municipalities have the responsibility of providing potable water, sewage systems, storm drains, solid waste management and public transportation.[336]

	Indicator	Value	Year
Population	Population, total	74,932,641	2013
	Population growth (annual percent)	1.3	2013
	Urban population (percent of total)	72.4	2013
	Population ages 0-14 (percent of total)	25.7	2013
GDP	GDP growth (annual percent)	4.1	2013
	GDP per capita, PPP (constant 2011 international $)	18,660	2013
Poverty	Poverty headcount ratio at $1.25 a day (PPP) (percent of population)	0.08	2011
	Urban poverty headcount ratio at national poverty lines (percent of urban population)	0.6	2012
	Rural poverty headcount ratio at national poverty lines (percent of rural population)	5.9	2012
Inequality	GINI index (World Bank estimate)	40.0	2011
	Income share held by highest 20 percent	46.5	2011
	Income share held by lowest 20 percent	5.8	2011

Source: World Bank, World Development Indicators

Basic services delivery in Turkey is affected by the strength of the accountability relationships between the citizens, the State and the service providers. Voice is weaker in the country (compared to the World average) while compact is relatively stronger. While the country has a higher voice and accountability in that score compared to the OIC average it ranks low compared to the the World average. Turkey ranks better in the Government Effectiveness index, compared to both the OIC average and the World average. On government effectiveness, the country's score of 0.37 (the index varies between -2.5 and 2.5) indicates that the quality of the public services is perceived as good and come with good policy formulation and implementation[337]. (See also Figure 3 and 4 in Section 2.1 Voice and Compact in OIC Member Countries).

334 Ministry of Development of Turkey Socio-economic development index (2011)
335 Ministry of Interior Relations of Turkey (2015)
336 UCLG (2014)
337 World Bank, Worldwide Governance Indicators.

3.1.2 Education Sector

Access to and Quality of Education

Enrolment in primary education in Turkey is high and has slightly improved over the last two decades. In 2012, primary school adjusted net enrolment rate was 95.1 percent, an increase from 94.4 percent in 1990.[338] While the enrolment rate actually made a peak in 2008 at 98.9 percent, it dropped down slightly in the last 5 years.

The levels of enrolment in primary education vary little by region or by income group in Turkey. Net schooling ratio for primary education is higher than 90 percent in all of the provinces of Turkey and is higher than 95 percent even in the least developed provinces.[339] Differences in primary school attendance used to be more apparent across income groups. In 2004 the net attendance rate was 76.8 percent for the children in the poorest income quintile and was 98.5 percent for children in the richest income quintile. [340] Yet, more recent data shows that the disparity is actually much smaller. Demographic and Health Survey (DHS) for Turkey for the year 2013 indicates that net schooling ratio for basic education –including both primary and lower secondary education- is 90.8 percent for the children in the lowest wealth quintile as opposed to 95.5 percent for the children in the highest wealth quintile.[341]

Gender parity in primary school enrolment improved over the last two decades. Gender parity in basic education –including both primary and lower secondary education- improved especially after 1997, with the implementation of Basic Education Reform Law (No. 4306) which made lower secondary education mandatory. In 1994, gender parity index (GPI) in primary school was already high with 0.930 while it further reached 0.988 in 2013. However, the actual increase was observed in the gender parity index for lower secondary education which became mandatory in 1997. In 1997, GPI was 0.778 while it reached 0.986 by 2013.[342]

While enrolment rates are high in Turkey, the ratio of children that finish primary school is comparatively lower. The survival rate to the last grade of primary school is 90.0 percent and it actually declined over the past two decades. In 1993, the rate was higher with 94.9 percent of the students completing primary school education.[343]

The quality of education in basic and secondary schooling in Turkey remains a challenge. The Trends in International Mathematics and Science Study (TIMSS) is an internationally comparable test that assesses the basic mathematics and science skills of 4th and 8th graders around the World. Turkey participated in the test for the first time in 2011 for 4th graders. The country ranked 35th in the mathematics test and 36th in the science test among 50 countries[344]. The results show that 23 percent of the 4th grade students do not have basic mathematics knowledge in Turkey compared to an average of 10 percent for the rest of the countries. The ratio of students who do not have basic science knowledge is even higher in the country with 30 percent. In comparison, in the rest of the countries participating in the test, this ratio is much lower at 8 percent. Since Turkey participated in TIMMS for 4th graders for the first time in 2011, there is no benchmarking evidence for the quality of primary education for previous years. However, Turkey participated in TIMMS for the 8th graders in the previous

338 The Ministry of Development of Turkey (2014a)
339 Ministry of National Education of Turkey (2014)
340 UNESCO Institute for Statistics, Education Statistics. 2004 is the latest year the data is provided for attendance rates by wealth quintile for Turkey by UNSECO Institute for Statistics.
341 Hacettepe University Institute for Population and Health (2014). According to the same source, overall, the net schooling ratio is 94.4 percent in 2013.
342 UNESCO Institute for Statistics, Education Statistics
343 World Bank, World Development Indicators, 2013.
344 Oral and McGivney (2013)

rounds of the test. Comparing the results of 2007 with the results of 2011 shows that there is an improvement in the ratio of students who have a basic knowledge of mathematics and science. In 2007, the ratio of 8th grade students with basic mathematics knowledge was 59 percent and reached 67 percent in 2011. Similarly, the ratio of 8th grade students with basic science knowledge increased from 71 percent in 2007, reaching 79 percent in 2011.

The education and training required for teachers is inadequate in Turkey. In successful education systems around the world, the selection and the employment of the teachers are carried out by multi-level and multi-criterion assessment methods, which evaluate a candidate's pedagogical knowledge, proficiency in a specific area, and communication skills.[345] However, in Turkey, a teacher's candidacy is evaluated by a centralized exam called the Public Personnel Selection Examination (KPSS), which is a general exam used for 15 different government branches and is not specifically tailored to or appropriate for the education field.[346]

Modality of Service Delivery

Primary education policy in Turkey is managed by the Ministry of National Education (MONE). The central level of MONE includes the Minister's office; The Board of Education (with responsibility over the curriculum), the Board of Inspection and the Strategy Development Presidency. In each of the 81 provinces and 919 districts, there are Provincial and District National Education Directorates.[347] The external supervision and evaluation of preschools and primary schools are carried out by primary education inspectors. According to a directive of MONE issued in November 1999, provinces and districts (within the borders of the municipalities) with a population less than 30,000 are considered Education Zones.[348]

Basic education is free and obligatory in Turkey. In 1997, the government extended compulsory education to 8 years; this policy played a role in overcoming gender disparity in enrolment for basic education (8 years of schooling), especially for the enrolment of girls in lower secondary education.

The education sector is highly centralized in Turkey. In terms of school autonomy in financial resources or education policies, Turkey is more centralized than the OECD average. According to calculations by OECD, in Turkey, 92 percent of the decisions in personnel management, 60 percent of the decisions in planning and structures, and 58 percent of the decisions in resource management are taken at the central level of government in public lower secondary education. In comparison, these rates are 24, 43 and 19 percent respectively, on average, in the OECD countries. Moreover, the content of education is decided at the central level without leaving any space for the individual schools to make their own choices. The authority of the central government in the selection of courses and the textbooks, and in planning of the curricula (68 percent, 76 percent and 65 percent, respectively) is much higher than the authority of the school in these areas (14 percent, 9 percent, and 14 percent, respectively).[349]

School autonomy in budget management is limited. The central government has significant control over financing and budget management even at the school level. While in Turkey, the average ratio of inclusiveness of the teachers and the school administration in school budget planning is 34 percent and their authority in "allocation" of this budget within the school is 56

345 Darling-Hammond (2010), Mourshed ve Barber (2007)
346 The Ministry of Development of Turkey (2014a)
347 UNESCO (2012)
348 UNESCO (2012)
349 OECD (2012), OECD (2013)

percent, these average ratios are 46 percent and 81 percent for OECD, respectively[350]. Moreover, it is illegal to collect money for registration in public schools. However, cases have been reported that donations are demanded for the "Parent Teacher Association" in the process of registration[351]. The Parent Teacher Association is a legal organization that is comprised of parents of the students and was founded to ameliorate school facilities and improve educational outlook. There are three possible sources of income for the Parent Teacher Association: Donations, catering in school areas/parking lots, and the organization of social and cultural activities for profit.

The expenses of schools are covered primarily by the central government. First, the staff wage bill is paid through the Ministry of Finance. Secondly, the schools' utility bills are covered by the Special Provincial Administrations. Thirdly, on *ad hoc* basis, municipalities sometimes provide funding -at will- for small-scale construction projects on a school's campus[352]. For other school expenses, the governor either applies for funding from the Special Provincial Administration or seeks help through civil society or Parent Teacher Associations.

Government spending on education as a share of GDP has increased in the last two decades but it remains low compared to developed countries. Turkey allocated 3.99 percent of its GDP to education in 2013[353] while this share was 3.4 percent in 1993[354]. Current ratios remain low when compared to OECD and EU countries, where an average of 6.3 percent and 5.9 percent of GDP is spent on education, respectively.[355] The expenditure allocated for education is expected to increase as Turkey has passed a regulation extending compulsory education to 12 years, a regulation which will increase the need for both infrastructure and the teaching staff.

Various programs were launched to encourage financial support to the education sector. The Campaign, 100 percent Support for Education, is intended to increase financial support for education from private and non-governmental organizations through tax exemptions on educational spending. To date, $1 billion USD in private contributions were collected. Under the Income Tax Law numbered 193 (September 2003)[356], a 100 percent tax deduction can be provided in exchange for contributions to education. [357]

Over the recent years, Turkey has made efforts to increase the number of accredited private schools. Engaging private sector in service delivery is likely to improve the choice, by increasing the choice of providers. In the "MONE Strategic Plan" (2010-2014), Article 24 of the Plan aims at increasing the proportion of private schools from 5.21 percent to 9 percent and the proportion of students receiving education at a private institution from 2.76 percent to 5 percent. It also seeks to transform after-school support centres into private schools.[358] During the period of 2012-2013, the number of private secondary schools in Turkey was 1033, and the number of students registered to these schools was 156,665. There appears to be a regional difference in the number of the private schools, as Istanbul (373), West Anatolia (131) and Aegean (105) are the regions with the highest numbers of the private schools. Private schools do not exist in 23 provinces in Turkey.

350 OECD (2012) Check
351 Köse and Şaşmaz (2014)
352 Köse and Şaşmaz (2014)
353 Ministry of National Education of Turkey (2013)
354 World Bank, World Development Indicators.
355 Ministry of National Education of Turkey (2013)
356 See http://www.gib.gov.tr/fileadmin/mevzuatek/gerekceler/GVK/cilt_1_193_sayili_kanun.pdf
357 OECD (2013)
358 Ministry of National Education of Turkey (2009)

There are various mechanisms to target the poor in the education sector. MONE develops and distributes textbooks for free to all students for all types of primary and secondary schools. Furthermore, for students who commute certain distance, lunches are provided by Provincial National Education Directorates. In addition, through a conditional cash transfer program under the aegis of the Social Cooperation Solidarity Foundation, cash is provided to families conditional on students' attendance. The expenditure on this fund constitutes 4.5-5 percent of all public expenditure in education[359]. It is also obligatory for private schools to admit a certain percentage of students with a scholarship. Increasing the purchasing power of citizens can improve choice in the accountability framework, hence targeting the poor via these mechanisms is crucial.

Applying the Accountability Framework to Turkey's Education Sector

The low level of school autonomy is identified as one of the most striking issues that cause a failure in the accountability framework in Turkey's education sector. Increasing citizen participation in governance can strengthen their voice. One mechanism available to address this problem is Turkey's "Parent Teacher Associations". The role of Parent Teacher Associations (PTA) is quite limited in the current setting, and involve mainly fundraising through activities for the school.

Currently, participation in PTA activities is low. Parents from low socioeconomic background are also -reportedly- not willing to participate in the activities of PTAs. Parent Teacher Associations are envisaged to improve the accountability of the school system by facilitating communication between school management and families as well as incorporating the families into the decision-making processes. However, parents try to avoid this kind of responsibilities because the activities of the PTA can be seen as a burden[360].

Low school autonomy has implications for investments at the school level. Due to low school autonomy, even financing small-scale repairs in school facilities poses a challenge for school directors. According to one qualitative interview in the field, "in the best-case scenario, to make such repairs, it takes at least one year to complete necessary procedures" including an application to the Special Provincial Administrations. Hence, school infrastructure suffers from underinvestment.

In order to improve participation, the roles of the PTAs need to be more defined and more capacity building can be provided to school management bodies. Cooperative school models can also be encouraged and facilitated as in some developed countries.

3.1.3 Health Care Sector

Access to and Quality of Health Care

The health of Turkey's population has improved substantially over the last decade. A series of reforms were implemented in the beginning of 2003, under the Health Transformation Program (HTP) that has led to the achievement of Universal Health Coverage (UHC)[361]. Before the reforms, less than 70 percent of the population was covered with insurance, and even those with insurance did not have adequate access to timely health services[362].

359 Köse and Şaşmaz (2009)
360 Köse and Şaşmaz (2009).
361 WHO (2011)
362 Akdağ (2011)

In this time period, the average life expectancy in Turkey reached 72.0 for men and 77.0 for women in 2009[363]. The infant mortality rate decreased to 7.7 per 1000 live births in 2011 from 31.5 per 1000 live births in 2002. The maternal mortality rate similarly decreased to 15.5 per 100,000 live births in 2011, from 64.0 in 2002. The rate of full vaccination coverage increased from 78 percent in 2002 to 97 percent in 2011. These improvements are also reflected in a survey of citizens' satisfaction with health care, in which the percent of the citizens satisfied with the health care services increased from 39.5 to 75.9 percent between 2003 and 2011[364]

Healthcare provision and utilization has increased over time for all regions. According to the 2013 Health Statistics Report provided by the Ministry of Health, a total of 133,775 medical doctors and 735,159 healthcare staff are employed. In 2013, there were 1,517 hospitals in Turkey, of which 854 were owned by the Ministry of Health, 550 were private facilities, 69 were academic hospitals, and 44 were owned by the other healthcare facilities.[365]

The number of per capita visits to health care facilities was 3.2 in 2002; it rose to 8.2 in 2011. Similarly, per capita hospital visits increased from 2.0 in 2002 to 4.9 in 2011. The number of acute care hospital beds per 100,000 increased from 216 in 2002 to 243 in 2011. During the same period, the number of doctors (per 100.000 population) increased by more than 20 percent, from 139 in 2002 to 169 in 2011. The number of general practitioners also increased although to a smaller extent, rising from 47 per 100,000 in 2002 to 53 per 100,000 in 2011. The implementation of Health Care Services at Home, aimed at providing medical care for bedridden patients in their homes has recently started[366].

Regional distribution of healthcare facilities creates inequality. Despite improvements in hospital capacity, performance, and high satisfaction rates among patients; regional disparities persist. According to the socio-economic development index of cities in Turkey, apart from the number of beds in the intensive care units, the bed capacity per 10,000 citizens is 24.9 in the most developed part of the country, while this number is 15.4 in the least developed parts of the country. The difference in the bed capacities per 10,000 between the most developed and least developed was 2.9 times in 2002 and this ratio dropped to 1.62 times in 2008.[367]

Despite recent improvement, regional disparities in healthcare staff is still a persistent issue. The Ministry of Health has made various policy changes aimed at diminishing the gap in the number of health personnel among provinces. These policy changes have succeeded, to some extent, as the personnel gap between the highest and lowest provinces fell between 2001 and 2011 as follows: "for specialists from 1:14 to 1:2.7; for general practitioners from 1:9 to 1:2.3; and for nurses and midwives from 1:8 to 1:4"[368]. However, regional disparities are still evident. As of 2011, while Western Anatolia had 2.6 physicians per 1,000 population, South-eastern Anatolia's ratio was 1.16 physicians becoming the lowest ratio in the country.

Modality of Service Delivery

Turkey's public health sector is centralized. Under the new healthcare system, Health Transformation Program that Turkey initiated in 2003, the Ministry of Health became the main provider of health care services, and the Social Security Institution (SSI) became the main purchaser of health care services in both the public and private sectors.[369] The Ministry of

363 WHO (2011)
364 Akdağ (2011); Atun, et al. (2013)
365 Akdağ (2013)
366 Aran, and Rokx (2013)
367 Güngör (2012)
368 Güngör (2012)
369 Aran and Rokx (2014)

Health manages public health care facilities, as well as directs the country's public health policy. It serves as a policy-making and supervisory body. The Ministry has two important autonomous directorates; Public Hospitals Institution, which serves the function of organizing new publıc hospitals, and the Turkish Pharmaceutical and Medical Device Agency, whose function is to regulate the pharmaceutical market. The Ministry of Health not only serves in the city centres but also in the villages.[370]

The Health Transformation Program aimed at strengthening primary health care services through the use of a family medicine system. At the end of 2010, the Family Medicine Programme (FMP), with the aim of assigning each patient to a specific doctor, was established throughout the country. Community Health Centres (CHC), which provide free-of-charge logistical support to family physicians for priority services such as vaccination campaigns, maternal and child health and family planning services, were established.[371] Both Family Health Centres and CHCs are under the supervision of Provincial Health Directorates (81 provinces), which are responsible for the planning and provision of health services at the provincial level and are accountable to the Ministry of Health[372].

A "district based healthcare" system was adopted by the Ministry of Health, dividing Turkey into 29 healthcare regions according to their need and accessibility of healthcare, flow of patients, and socio-economic conditions. Since 2009, regulation 2010/50 ensures that patients' healthcare needs and treatments are first met in their healthcare region.[373]

There are three types of hospitals in Turkey; public hospitals that are owned by the Ministry of Health, hospitals owned by the private sector, and the academic hospitals affiliated with teaching universities. The Ministry of Health's public hospitals have 68.1 percent of the total bed capacity and 67.2 percent of the medical doctors in the country, while 59.9 percent of all patient operations are conducted by public hospitals. In contrast, private hospitals have a smaller bed and human resources capacity. The private sector has 13.9 percent of the total bed capacity and 20.3 percent of medical doctors. 26 percent of the patient operations are conducted by private hospitals whereas 14.4 percent of operations are conducted by academic hospitals.[374] In light of this data, it could be argued that the public hospitals owned by the Ministry of Health are the largest providers in the healthcare system in terms of infrastructure, human resources, and the quantity of the service provided.

Health spending as a percent of GDP increased substantially over the past decade. As of 2012, public health expenditures as a percent of GDP was 4.7 percent, increasing from 2.4 percent in 1995. Similarly public health spending as a share of total government expenditures increased from 10.7 percent to 12.8 percent between 1995 and 2012. While this rate is higher than the OIC average of 8.9 percent it is still lower than the World average of 15.7 percent.[375]

Public sector health facilities are primarily funded by the central government. In 2008, 43.9 percent of funds for health spending came from the SSI and 27.6 percent from other government sources, while the rest comes from out-of-pocket payments, and other private sources.[376] All citizens except the following are covered by the UHI program: "conscripts undertaking military service, foreigners with their own social insurance coverage in their

370 WHO (2011)
371 Aran and Rokx (2013)
372 WHO (2011)
373 Güngör (2012)
374 Güngör (2012)
375 World Bank, World Development Indicators.
376 Menon et al. (2013)

home country, people working in country representative offices abroad with social security coverage in the host country, tourists or short-term visitors, illegal immigrants, and prisoners"[377]. Since 2008, all health care services for the population under 18 years old has been free regardless of the social security status of parents.

Out-of-pocket payments are relatively low and decreased over the past two decades. In 2012, out-of-pocket expenditure was 16.9 percent of healthcare expenditure and, in 1995, it was 29.7 percent.[378] Furthermore health care system is generally progressive. Households in the top quintile in 2008 paid 1.97 percent of total expenditure on health care and households in the lowest quintile paid 1.43 percent.[379]

During the period of 2004-2010, the program of "family medicine providers" was introduced and co-payments are waived for outpatient visits to family medicine providers. As of 2015, co-payments are US$ 2,95 per visit to academic and Ministry of Health hospitals, and US$ 5,54 for visits to private hospitals. The copayment for pharmaceutical related expenditure is 20 percent of purchase cost and is further subsidized to 10 percent of purchase cost for retired persons. Privately owned hospitals are allowed to apply extra cost to patients, up to an additional 70 percent of the SSI tariff.[380]

The Green Card (Yeşil Kart) Program was initiated in 1992 and is a noncontributory health insurance program funded through the national budget. The Green Card is a landmark social protection program for Turkey and the number of beneficiaries more than tripled, from 2.5 million in 2003 to 9.1 million in 2011, due to expansion of the Program's benefits[381]. As of 2006, all primary care services have become free regardless of social security status. Green Card beneficiaries were prioritized and progressive steps were taken through the benefits packages so that Green Card beneficiaries could access the same facilities. It has now been turned into the Universal Health Program. That was one effort to extend services to the poor. This resulted in the Ministry of Health's increased number of contracting relationships with private providers. This program initiated the coverage of outpatient services in 2004 and for prescription drugs in 2005. No co-payment for prescription drugs was intended in the program, a 20 percent co-payment was introduced as a result of the unforeseen increase in pharmaceutical expenditures.[382]

Applying the Accountability Framework to Turkey's Health Care Sector

In the health sector, various mechanisms have been introduced to improve the accountability framework and empower clients through the Health Transformation Program.

Firstly, patients were allowed to choose their family doctors at the primary health care clinics and hospitals and this in return translated into higher payments for doctors, thus aligning incentives of the service providers with the patients. In addition to their base salaries, physicians in the healthcare system started to receive monthly payments determined on the quantity of patients that they treated through the **performance-based supplementary payment system,** which was introduced in ten Ministry of Health hospitals in 2004.

Secondly, performance-based payment system, a financial incentive aimed at increasing the productivity of the medical doctors and increasing the numbers of medical doctors in public

377 Aran and Rokx (2013)
378 World Bank, World Development Indicators.
379 Aran and Hentschel (2012)
380 Aran and Rokx (2014)
381 Menon et al. (2013)
382 Aran and Rokx (2014)

hospitals, was introduced. About 89 percent of hospital specialists engaged in private practice to boost their incomes, however performance-based payments which increase the monthly overall wage of the medical doctors would eventually attract more healthcare staff to the public hospitals instead of their private practice.[383] Since its implementation in 2004, a voluntary transition of the medical doctors from dual practicing between public hospitals and private clinics to full time work in the public hospitals was observed in 2005.

Thirdly, by initiating contracts with the private sector, universal health coverage was expanded allowing clients to choose among public providers or, for an additional fee, private providers. According to the accountability framework, this is expected to increase the choice of providers and, in turn, increases accountability.

Fourthly, the reform improved compact between the State and the service providers, as well. Its success is particularly evident in more remote regions of the country; the salaries that were increased through this system resulted in a decrease in absenteeism and moonlighting. The full-day law passed in the later stages of the reform (in 2011-2012) also contributed to the reduction in moonlighting – but this law was passed only after the levels of moonlighting had already been significantly reduced.

Lastly, new mechanisms were introduced for the patients to express their suggestions and complaints. These include a telephone hotline in the Ministry of Health and Prime Ministry, and patient rights units in public hospitals.[384] Complaints received were directed to patient rights units at the hospitals and are taken to a provincial board for further advice or if any action should be taken.[385] These mechanisms improve the accountability relationship between the citizens and the service providers.

The health transformation program primarily aimed to improve the client power between the providers and the citizens. The accountability of the service providers to patients was strengthened mainly by linking the revenues of the providers to the number of patients served. Thus an incentive is introduced for the service providers to serve patients better (or the patient could walk away and "punish" the provider resulting in a revenue loss). It is important to note, however, that this "quantity-based" pay-for-performance system has been criticized for decreasing the quality of the healthcare service in exchange for increasing the quantity of patients. Patient consultations per physician were 2,272 in 2002, 3,176 in 2006 and 4,850 in 2011[386]. This could have been the crude measure of the productivity of the physicians, however, the numbers solely show the increase of the quantity of the patients, and do not necessarily indicate sustained healthcare service quality.

3.1.4 Electricity Sector

Access to and Quality of Electricity Services

One hundred percent of the population has access to electricity in Turkey. [387] This rate has already been high for Turkey with 100 percent access in 1990. Moreover no disparity exists between urban and rural access. Per capita electricity consumption is 2760 Kwh in Turkey, similar to the world average of 2970 KWh.[388] The total volume of load shed during

383 Akdağ (2013)
384 Atun et al (2013)
385 Atun et al (2013)
386 Aran and Rokx (2014)
387 World Bank, World Development Indicators
388 International Energy Agency Statistics.

unplanned outages has steadily decreased over time[389]. Only 0.02 percent of electricity is lost due to system faults.

The Turkey Electricity Distribution Company (TEDAS) and distribution companies set guidelines and limitations on power outages. Power outages cannot exceed 72 hours in rural areas and 48 hours in urban areas per year without a 48 hour advance notice and outages cannot exceed 32 hours for rural areas and 24 hours for urban areas per year without any notice. If outages exceed these amounts, the customers are entitled to apply for compensation. This regulation aims to empower the client because it holds the service provider accountable. However, voltage fluctuations resulting in blackouts can be frequent particularly in areas where informal connections put stress on the electricity infrastructure.[390]

Electricity generation is primarily based on natural gas, but Turkey has plans to diversify sources. The share of natural gas in electricity generation was 43.8 percent in 2013[391] and the share of renewable resources in was 25.2 percent in 2011[392]. The law titled "Electricity Market and Supply Security Strategy Document"[393] states that until 2023, the share of natural gas in electricity generation should decrease to 30 percent. The government has plans to diversify resources for electricity generation in order to ensure greater security in supply. In 2010, Turkish and Russian governments signed an agreement for the construction of a nuclear plant in Akkuyu, Mersin. To that aim, a company titled "Akkuyu Nuclear Power Plant Electricity Production" was founded[394].

Modality of Service Delivery

The electricity sector in Turkey is primarily managed by the central government but is implemented by both the public and private sector. Electricity is regulated by the Ministry of Energy and Natural Resources. In line with the European Union's Energy Acquis, in 2001, a new Electricity Market Law[395] was enacted that resulted in the establishment of the Energy Market Regulatory Authority (EPDK) as the main regulatory body and led to restructuring the state-owned enterprise electricity production/transmission company (TEAŞ)[396].

As an independent and financially autonomous regulator of power, gas, petroleum, and liquefied petroleum gas, EPDK is responsible for preparing and implementing secondary legislation; authorizing market participants; approving and publishing tariffs; monitoring and supervising market participants; conducting technical, legal, and financial audits; settling disputes; approving, amending, and enforcing performance standards; and, where necessary, applying sanctions.

TEAŞ was unbundled to form three State-owned Public Enterprises: the Turkish Electricity Transmission Company ("TEIAŞ") for the transmission, the Electricity Generation Company ("EUAS") for the generation, and the Turkish Electricity Trading and Contracting Company ("TETAS") for wholesale activities.

The distribution of electricity is privatized in Turkey through the transfer of operating rights. In 2006, the electricity grid, under the aegis of the Turkish Electricity Distribution

389 Vagliasindi and Jones (2013)
390 "Monitoring the Social Impacts of Electricity Privatization in Turkey: Understanding Social Impacts and Improving Acceptability". World Bank, 2015.
391 EPDK (2014)
392 Ministry of Development of Turkey (2014b)
393 Ministry of Development of Turkey (2009)
394 Ministry of Development of Turkey (2014b)
395 Law Nr. 4628 "Elektrik Piyasası Kanunu"
396 Nyman (2015)

Company (TEDAS), was divided into 21 regional distribution companies, 20 of which have operating rights for their franchise zones and one, KCETAS in Kayseri, is privately owned[397]. In this system, all existing and future assets belong to TEDAS and the private company receives the license for the sales and takes the responsibility for investing in the infrastructure.

The role of the private sector for the electricity generation has steadily increased over the years. The share of the private sector in the electricity generation increased from 52 percent in 2006 to 62 percent in 2012[398]. The specific share of private production companies (other than existing agreements) has been improving over the years and constituted 35 percent of total electricity production in 2013[399].

A new automatic pricing mechanism was set in 2008 that aims for cost recovery. A uniform national selling price to the customers is set by EPDK that account for loss and non-payment rates in different regions. A price equalization mechanism was implemented to achieve cross-subsidy between regions[400]. In the current national tariff structure, the losses in the sector are reflected equally in consumers' electricity bills irrespective of the distribution region. In other words, consumers in regions with lower loss and non-payment rates subsidize consumers in regions with higher loss and non-payment rates. EPDK covers financial losses for distribution companies based on pre-determined targets for the amount of unbilled households and predicted electricity loss.

Due to the new pricing system, the residential tariff has increased. The residential tariff in electricity prices has nearly doubled between June 2008 and May 2014. Between 2006 and 2012, average electricity expenditures increased from 12.9$ per month to 27.3$ per month, according to the Household Budget Survey. As of mid-2014, households paid 0.13$ per kWh for electricity[401].

The Electricity Market Law enacted in 2013 led to the establishment of the Energy Market Operations Company (EPIAS). A joint venture between the electricity transmission system operator TEIAŞ (30 percent equity share), Turkey's stock exchange Borsa Istanbul (30 percent) and electricity and gas market participants (40 percent)[402], EPIAS oversees fiscal reconciliation of market disequilibrium in the electricity sector. Before EPIAS the Market Fiscal Reconciliation Centre, under the aegis of TEIAS,[403] operated with Day-Ahead Market and Balancing Power Market to ensure short-term security of supply and market equilibrium between supply and demand[404] (Mains frequency 50 Hz). Balancing Power Market provides the real-time market adjustment in 15 minutes through disposable electricity capacity of energy providers available in the market.

Applying the Accountability Framework to Turkey's Electricity Sector

Electricity generation in Turkey is primarily reliant on natural gas and supply outages can cause high prices. For instance, between February 2012 and December 2013, the high electricity prices were a result of outages in natural gas supply[405]. Hence, the electricity generation resources need to be diversified.

397 Öztürk (2014)
398 Ministry of Development of Turkey (2013)
399 EPDK (2014)
400 Nyman (2015)
401 World Bank (forthcoming).
402 Nyman (2015)
403 See https://www.pmum.gov.tr/pmumportal/xhtml/hakkimizda.xhtml
404 Ministry of Development of Turkey (2014)
405 EPDK (2013)

Systematic social protection systems do not exist for those who cannot afford energy price increases. High electricity prices as a result of the cost-based national tariff pose great challenges especially for farmers who rely on electric water pumps for irrigation and informal/seasonal workers without guaranteed monthly salaries. When they cannot pay their electricity bills regularly and on time, they are charged late payment fees. This exacerbates their fiscal burden. The purchasing power of the client is directly linked to the accountability framework through choice. The payment options should be flexible and adjusted to different income patterns to facilitate the collection of bills and alleviate the fiscal burden over poor households.

The greatest problem in the sector is a high level of loss and non-payment, which translates into inefficiencies in the sector and a significant free-rider problem – thus loosening the accountability relationship between the client and service provider. Loss and non-payment issues are prevalent especially in two distribution regions: Dicle EDAS and Van Golu. In 2013, the percent of loss and non-payment was 75.41 percent in Dicle EDAS and 65.84 percent in Van Golu[406]. By the end of 2014, EPDK set a target for distribution companies to reduce the loss and non-payment rate to 59 percent; however, distribution companies could not meet the target.

The current system that divides the distribution of electricity into different regions does not necessarily enhance the client power, since the client currently does not have the option to choose the provider it wishes. However, it increases the compact, since the government has the authority to choose among different service providers. In addition, in the current system of cross-subsidy, the non-paying consumers are subsidized at the expense of paying consumers in other distribution regions. The regime neither targets the poor nor incentivizes the non-paying consumers for paying their bills. The government aims to reform this system by implementing regional tariffs in electricity prices; however the deadline of this reform was extended to 2020 because it would entail skyrocketed prices for the two distribution regions mentioned above.

The composition of the electricity bill is not perceived as fair in the eyes of the customers. Firstly, only 59 percent of the electricity bill reflects actual electricity consumption. The electricity distribution companies should inform the public about the necessity for cost recovery and employ a more effective communication strategy to address grievances. Better informed clients might reduce the non-payment rates in the long run and this might lead to an improvement in the accountability of the sector. All in all, the communication and information exchange between electricity distribution companies and customers need to be enhanced to improve the accountability of the system, create fairness in distribution and payments and empower clients.

3.2 Bangladesh

3.2.1 Country Background

Rapid population growth remains Bangladesh's biggest challenge in regards to service delivery. Bangladesh is the 8th most populous country in the world with 156 million people in 2013, adding 7 million people since 2005.[407] Despite three quarters of the population living in rural areas, Bangladesh is one of the most densely populated countries in the world with more

406 EPDK (2013)
407 World Bank. World Development Indicators

than 1,000 people per square kilometre.[408] The combination of high density and rapid population growth make it challenging for basic services to remain adequate.

The Bangladesh economy has seen substantial improvement over the last decade, but the country is still facing widespread poverty. Bangladesh is a low income country with a per capita GDP of $2,853 in 2013. The GDP per capita more than doubled since 1990 from $1,239.[409] Bangladesh achieved this with strong private-sector led growth with substantial employment generation, particularly in the garment manufacturing sector.[410] Some contributing factors are a greater number of women entering the workforce and higher remittances being sent to the rural poor. [411] In 2014, Bangladesh experienced a dip in the economy due to political unrest but growth is expected to rebound.[412] Despite the past decade's economic growth, Bangladesh is ranked the world's 6th poorest country and has an estimated 65 million people living below the national poverty line.[413] Almost 7 million people in Bangladesh are living in urban slums.[414] As a result of widespread poverty, delivery of basic services is polarized among those who can afford private sector interventions and those who cannot.

	Indicator	Value	Year
Population	Population, total	156,594,962	2013
	Population growth (annual %)	1.22	2013
	Urban population (% of total)	32.75	2013
	Population ages 0-14 (% of total)	30.00	2013
GDP	GDP growth (annual %)	6.01	2013
	GDP per capita, PPP (constant 2011 international $)	2,853.45	2013
Poverty	Poverty headcount ratio at $1.25 a day (PPP) (% of population)	43.25	2010
	Urban poverty headcount ratio at national poverty lines (% of urban population)	21.28	2010
	Rural poverty headcount ratio at national poverty lines (% of rural population)	35.16	2010
Inequality	GINI index (World Bank estimate)	32.12	2010
	Income share held by highest 20%	41.41	2010
	Income share held by lowest 20%	8.88	2010

Source: World Bank, World Development Indicators

Contributing to its economic growth, Bangladesh has had relative political and economic stability since 1991. Prior to this, Bangladesh faced two decades of political unrest. The Bangladesh Liberation War led Bangladesh to its independence from Pakistan in 1971. From its independence, Bangladesh faced severe poverty, famine, and a string of military coups. Democracy was restored in 1991 and was followed by economic progress. In 2014, a widespread boycott and protest of elections by major opposition parties called for the

408 UNICEF (2012)
409 World Bank.. World Development Indicators. PPP (constant 2011 international $)
410 World Bank (2014b)
411 UNICEF (2012)
412 World Bank (2014b)
413 World Bank, World Development Indicators. Calculated by the author using poverty headcount ratio at $1.25 a day (PPP) x total population
414 UNICEF (2012)

resignation of the Prime Minister, Sheikh Hasina of the socialist-leaning Awami League. More than half of parliament seats were left unfilled and the Awami League maintains control of the government.

Bangladesh's government authority is mostly centralized. In 1977, an ordinance was passed to extend greater power to local government and municipalities through elected councils and an ability to raise revenue. In 2008, the ordinance was amended to extend responsibilities of town planning, development, public health and sanitation, water supply, sewage disposal, and maintenance of public infrastructure. At the district level, government officials are appointed but municipalities have an elected mayor and, since 2008, increased community participation.[415] However, despite these decentralization efforts, the central government still exerts a high level of control over municipalities and the delivery of basic services.

Bangladesh is geographically organized into seven administrative divisions and 64 districts, which are further divided into sub-districts or upazilas. Officials at smaller geographical levels are appointed, not elected. Larger cities, such as Dhaka, Khulna, and Chittagong, are run by city corporations with an elected mayor and ward commissioners.

The World Bank's Voice and Accountability index and Government Effectiveness index both rank the country low. On voice and accountability, Bangladesh has a score of -0.42.[416] While this is better than the OIC average of -0.86. On government effectiveness, the country also scores low with -0.82, which is lower than the OIC average of -0.62. A low level of government effectiveness indicates that the quality of the public services is perceived as low and not independent from political pressures along with weak policy formulation and implementation.

3.2.2 Education Sector

Access to and Quality of Education

Access to education in Bangladesh has improved over the past decade. Like most OIC member states, net enrolment for primary school in Bangladesh saw an increase over the past decade. In 2010, net enrolment was 96 percent of the population and in 1990, was 72 percent.[417] Illiteracy was a widespread problem in Bangladesh, but saw substantial improvement over the past decade. In 2001, 63 percent of the youth population (age 15 to 24) were literate and, by 2015, 83 percent were literate.[418]

Despite improvements, completion of primary school is a continual challenge. In 2010, 79 percent of students enrolled in grade 1 continued to complete grade 5. Although this reflects a 19 percent increase from 2010, it is still low. [419] The dropout rate also saw an improvement at 12.4 percent in 2013 from 50 percent in 2008.[420] Repetition rates declined but are still high at an average of 6.9 percent for all grades. [421] Despite these improvements, the rates are still problematic. An estimated 5.5 million children between the ages of 6 and 14 were out-of-school in 2010, which represents 16 percent of the reference population.[422] Fifty-

415 Bangladesh is geographically organized into seven administrative divisions and 64 districts, which are further divided into sub-districts or upazilas. Larger cities, such as Dhaka, Khulna, and Chittagong, are municipalities and are run by city corporations with an elected mayor and ward commissioners.
416 World Bank, Worldwide Governance Indicators. Voice and accountability index, 1996 and 2013.
417 World Bank.. World Development Indicators
418 UNESCO Institute for Statistics, Education Statistics
419Government of the People's Republic of Bangladesh (2014)
420Government of the People's Republic of Bangladesh (2014)
421Government of the People's Republic of Bangladesh (2014)
422 World Bank Human Development Sector (2013)

nine percent of the out-of-school children never enrolled in school or never completed the first grade level.[423]

Enrolment and completion rates are lowest among poor households. Fewer students in the poorest quintile of the population are enrolled in primary school. In 2011, 79.2 percent of children in the poorest income quintile attended primary school whereas 89.6 percent of children in the richest quintile[424]. Bangladesh is performing better than many OIC member states in this respect. The average gap between the poorest and the wealthiest quintile for OIC member states was 24.8 percent compared to 10.4 percent in Bangladesh in 2011. However, poor households represent 54 percent of out-of-school children in Bangladesh.[425]

Educational achievement is low, particularly among poor households. The National Student Assessment survey is conducted every two years since 2006 and measures achievement of grade 3 and grade 5 students in Bangla and Mathematics. The 2013 assessment revealed that only a quarter of grade 5 students are learning language skills and three-quarters are learning mathematics at their grade level. Poorer students perform significantly lower than wealthier students. It is estimated that children from poor families are at least 3/4th a year behind rich counterparts in Bangla and half a school year behind in Mathematics.[426] Furthermore, regional disparities exist in performance with students in Dhaka and Chittagong, more populated cities, performing better than the national average whereas students in the more rural Rajshahi and Sylhet lagging significantly.

Gender equality in primary education has improved substantially. No more than two decades ago, female enrolment in primary school lagged behind male enrolment. Eleven percent fewer females were enrolled in primary school than males in 1990. More recently (2010), the reverse has occurred with 4.4 percent more females than males enrolled in primary school.[427] Also, improved gender equality can be seen in youth literacy rates. In 2001, 7 percent more male youths were literate than female youths. Now, 4 percent more females are literate than males.

Modality of Service Delivery

The management of primary education in Bangladesh is highly centralized. The central government acts as both the state regulator and provider of basic education. Several NGOs also operate in Bangladesh to fill in gaps in the education system such as reaching the out of school population. Overall, citizens in Bangladesh have limited voice in primary education delivery. While Bangladesh has made improvements in access, the quality of education still suffers in poor rural areas.

Primary education policy in Bangladesh is directed by the Ministry of Primary and Mass Education (MoPME) and implementation and management responsibilities lie with the Directorate of Primary Education (DPE). The National Curriculum and Textbook Board develops curriculum and text book for primary, secondary, and higher secondary levels of school. The Bangladesh Bureau of Education Information and Statistics (BANBEIS) is responsible for collecting information and data related to primary education.

DPE appointed officers to each upazila and developed community-based School Management Committees (SMC) in an effort to decentralize the management structure and increase

423 World Bank Human Development Sector (2013)
424 UNESCO Institute for Statistics, Education Statistics
425 World Bank Human Development Sector (2013)
426 World Bank Human Development Sector (2013)
427 UNESCO Institute for Statistics, Education Statistics

accountability through community participation.[428] While some more active SMCs are able to influence decision-making, the central government still controls the recruitment of teachers, financial decisions, and general management.[429] Visits to schools by DPE usually only occur once a year and there is a general lack of accountability in the management structure. A head teacher is appointed to each school to manage day-to-day operations and report to DPE.[430]

Like management, all financial decisions pertaining to government operated schools in Bangladesh are made by the central government. Tuition for primary schools is publicly funded, but students are responsible for examination and scholarship fees. All government registered schools, both secular and religious, are funded with public resources in the form of an annual block allocation from the Ministry of Finance. The allocation is then distributed to respective agencies.[431] Ninety percent of the public spending is allocated to teacher salaries. The remaining ten percent is allocated to operating expenses and funds a program that provides stipends to girls in rural areas. The National Curriculum and Textbook Board (NCTB) develops and distributes textbooks for free to all students for all 13 types of primary schools. NCTB is managed by MoE but also receives a block allocation from the Ministry of Finance. There are some examples of SMCs raising contributions from the local community for school operating expenses, but schools are largely dependent on government support.[432]

Government spending on education as a share of GDP has increased but still remains low. This share increased form 1.6 percent in 1990 to 2.2 percent in 2009. Similarly, public spending in education, as a percent of all government expenditure, increased from 11.6 percent in 1990 to 13.8 percent in 2009.[433]

Government expenditure favours regions with poorer populations in an effort to reduce the gap in attainment between wealthier and poorer children, Upazilas (sub-districts) with higher incidence of poverty receive a larger share of recurrent public funding and tend to have teachers with higher qualifications. [434] The government spends an average $23 per primary students per year, but this figure varies by upazila. Expenditure averages $27 per student in the poorest quintile of upazilas and $18 per student in the wealthiest quintile of upazilas.[435]

The education sector is strongly supported by the donor community. Development partners provided Bangladesh with $504 million in aid to education in 2012, which is the highest among other low-income OIC countries and three times the amount in 2003.[436] The recent Primary Education Development Policy created a Joint Financing Agreement with development partners allowing for sector support to be paid directly to the Ministry of Finance.[437] Multilateral institutions like ADB, WB, and UNICEF help fund and have heavily influenced the development of the education sector programs, particularly in increasing access to female students.[438]

A successful conditional cash transfer program, called the Primary Education Stipends Program (PESP), is funded by several development organizations including the World Bank,

428 Steer, Rabbani, and Parker (2014)
429 Steer, Rabbani, and Parker (2014)
430 World Bank Human Development Sector (2013)
431 World Bank Human Development Sector (2013)
432 Steer, Rabbani, and Parker (2014)
433 World Bank, World Development Indicators
434 Steer, Rabbani, and Parker (2014)
435 Steer, Rabbani, and Parker (2014)
436 UNESCO, EFA Report 2015, Statistical Tables for Aid.
437 Steer, Rabbani, and Parker (2014)
438 Japan Bank for International Cooperation (2002)

UNESCO, and UNICEF. The program provides grants to 40 percent of primary school age children in rural schools on the condition that students meet a minimum criteria for attendance, achieve a score of 45 percent or higher on annual examinations, and (for girls) remain unmarried.[439] The program was initiated in 2002 and is modeled after a similar program that targets the secondary education level. In 2010, the program was revised to expand coverage to more economically disadvantaged upazilas using geographic targeting mechanisms.[440] The program is credited with attributing to the increased in primary school enrolment in the country.

Over recent years, Bangladesh has made efforts to nationalize non-governmental schools including religious schools. MoPME and DPE oversee 68,373 primary schools, which accounts for 79.9 percent of the student population. It includes 22,632 registered non-government primary schools that were recently nationalized in 2013 a part of an effort to improve quality and make education more accessible. [441] Before they were nationalized, registered non-government schools were privately operated schools but received basic teacher pay, a limited allowance, and stipends for some rural students, and free textbooks from government funds. Now, the recently nationalized schools receive a full allowance from government funding. The impetus to nationalizing the non-governmental schools was that many were underperforming compared to the government public schools. While it is too early to assess, it is hoped that the increased government funds will improve quality.

Religious education institutions are prominent among primary schools. Bangladesh has 8,206 madrasahs[442]. Like private schools, Bangladesh led a large effort to register religious-affiliated schools over the past decade to ensure their curriculum includes modern subjects such as mathematics and language skills. Policy directives for madrasahs are led by the Ministry of Education (MoE) and the Madrasah Managing Committee (MMC) is responsible for all administrative duties including hiring of teachers and staff, controlling expenditure and budgets, and mobilizing resources.[443] The Ministry provides madrasahs with basic teacher pay and a limited allowance, as well as free textbooks.

There is a significant share of NGOs involved in education provision. NGOs are credited with expanding access to education to hard-to-reach groups in Bangladesh including children from disadvantaged background and out of school children.[444] NGO schools are supervised by an appointed NGO Bureau, using a similar structure to the SMCs. Conditions in NGO schools tend to be better than government public schools including smaller classroom sizes, strong parent-teacher associations, and teachers with higher levels of training and less absenteeism.

Several non-formal education programs reach populations traditionally excluded from formal education. Non-formal programs include the MoPME led Reaching Out-of-School Children Program (ROSC) and the Shishu Kollyan (Each Child Learns) program, which educate around 95,000 students.[445] The ROSC program was started in 2005 and is an inexpensive, yet successful program that delivers education to students who were never enrolled or dropped out of primary school.[446]

439 UNICEF (2012)
440 World Bank Human Development Sector (2013)
441 Government of the People's Republic of Bangladesh (2014)
442 Government of the People's Republic of Bangladesh (2014)
443 World Bank Human Development Sector (2013)
444 World Bank Human Development Sector (2013)
445 Government of the People's Republic of Bangladesh (2014)
446 World Bank Human Development Sector (2013)

The Bangladesh Rural Advancement Committee (BRAC) is a well-known NGO-led program that aims to make education available for out-of-school children. It was started in 1972 to relocate refugees after the Bangladesh independence and has since achieved great success in reaching disadvantaged populations. BRAC is the largest Non-Formal Primary Education Program and include more than 50,000 schools aimed at promoting literacy. Several prominent global NGOs operate schools that follow the BRAC model.[447]

Applying the Accountability Framework to the Education Sector in Bangladesh

Weak voice of citizens inhibits better service delivery when combined with the state's low financial capability. As a result public schools are overcrowded, operate for an inadequate number of hours in unmaintained buildings. The challenges in quality are much more apparent among poorer rural communities.

- Ninety percent of primary schools in Bangladesh practice double-shifting where teachers divide their day among two different groups of students. As a result, students in double-shift schools have 595 contact hours per year with teachers versus 861 contact hours per year in single-shift schools.[448] The international standard is 900 to 1,000 hours per year.
- Teacher quality and absenteeism needs improvement. In 2008, a survey found that 14 percent of Government public school teachers were absent on the day of the survey visit.[449] In addition, 47 percent of teachers arrived late with an average delay of 30 minutes.[450]
- Overcrowding is a continual issue in schools. Bangladesh has an average standard of 40 students per teacher, 19 percent of the schools had more than the standard.
- The condition of the facilities need improvement. A survey of teachers reveal that 40 percent of classrooms were in poor condition and 19 percent were unusable. Bangladesh had plans to build 1,500 new schools between 2011 and 2014, it is not clear how many were completed. But, even with new schools, population growth and increases in enrolment continue to place demands on facilities.

Weak compact between public schools and the Ministry can be improved by increasing monitoring and oversight. The Monitoring and Evaluation Division of the Central Government has produced an annual sector performance report since 2009, which improves accountability by providing publicly available data on school performance and quality. However, adequate oversight in the school system is still lacking. The regional directorates, appointed by the central government, seldom visit or observe schools in rural areas resulting in a lack of accountability and inability to enforce the service delivery compact. Furthermore, given that the schools do not have any decision making power or any incentive to provide better services, even a higher number of visits may not result in better outcomes.

Community participation can lead to improvements in education quality. The SMCs are designed to engage the community in education service delivery. However, they have little authority over decision making in schools which limits the client power. With a centrally provided service delivery model, citizens are required to take the long route of accountability and, as a result, a stronger voice from citizens and a stronger compact between the state and the schools are needed for the services to work well. Since these two are not well established

447 World Bank Human Development Sector (2013)
448 World Bank Human Development Sector (2013)
449 Government of the People's Republic of Bangladesh (2014)
450 Government of the People's Republic of Bangladesh (2014)

in the country, increasing community participation in the decision-making process for service delivery and hence the client power can result in greater improvement.

3.2.3 Health Care Sector

Access to and Quality of Health Care

The health of Bangladesh's population has improved substantially over the last decade. Like many of the low income OIC member states, life expectancy in Bangladesh increased by 10 years from 1990 to 2013.[451] The under-five child mortality rate reduced substantially from 144 deaths per 1,000 live births in 1990 to 41 deaths per 1,000 live births in 2013. [452] Maternal mortality similarly improved from 550 deaths per 100,000 live births in 1990 to 170 deaths per 100,000 live births in 2013. [453]

A disparity still exists between poorest and wealthiest populations. Under-five mortality for the poorest quintile was 78 deaths per 1,000 births compared to 38 deaths per 1,000 live births for the richest quintile, in 2011[454]. Only 11 percent of the births in the poorest quintile were delivered with skilled assistance, compared to 64 percent for the wealthiest.[455] Children in the poorest quintile are 14 percent less likely to be vaccinated against measles than those in the wealthiest quintile.

The supply of hospitals are well-represented geographically. The public sector manages community clinics, which are designed to serve up to 10,000 residents with three health care staff. They provide in-patient and out-patient care including emergency services.[456] Upazila Health Facility Complexes are larger health care facilities at the sub-district level that provide more specialized services. There are 413 Upazila Health Facility Complexes with 14,557 beds.[457]

Bangladesh has 59 district hospitals and nine general hospitals with bed capacities ranging from 50 to 200 patients, which provide secondary care. Tertiary level care is provided by 17 academic hospitals (affiliated with a medical school) with a total of 8,900 beds and are located at the regional level.[458]

The private sector is large and provides 2,600 hospitals and clinics and 4,500 diagnostic laboratories across the country. [459] NGOs also play a large role in health care at the community level. NGOs in Bangladesh are leading several program specific projects. One such program is provision of health services at the community level through micro health insurance (MHI). Some NGOs also provide staff support to community clinics.

Despite widespread coverage of health care facilities, Bangladesh has a severe shortage of skilled health care workers. Bangladesh has an estimated 0.4 physicians for every 1,000 people compared to the world average of 1.5 physicians per 1,000 in 2011. [460] While the number of physicians in Bangladesh doubled since 1990, it is not nearly enough to adequately serve the population. Specialists represent less than a quarter of all doctors.[461] Furthermore,

451 World Bank, World Development Indicators
452 World Bank, World Development Indicators.
453 World Bank, World Development Indicators.
454 World Bank, Health Nutrition and Population Statistics by Wealth Quintile Database
455 World Bank, Health Nutrition and Population Statistics by Wealth Quintile Database.
456 World Bank (2014a)
457 World Bank (2014a)
458 World Bank (2014a)
459 World Bank (2014a)
460 World Bank, World Development Indicators
461 El-Saharty et al. (2015)

the skill mix of medical professionals in imbalanced. Bangladesh has 2.5 times more doctors than nurses while the World Health Organization recommends the opposite, 3 nurses to 1 doctor.[462] Another indicator of availability, an estimated 31 percent of all births are attended by a skilled health professional, which is half the amount of most low-income OIC countries. The shortage of medical personnel is amplified in rural or more remote parts of the country.[463]

Unskilled health care professionals are prevalent in the private sector. Particularly in rural areas, people seek medical advice from traditional healers, pharmacists, and village doctors. The number of unskilled health providers is significantly higher than the number of trained physicians. Bangladesh has approximately 12 village doctors per 10,000 people and 31 traditional healers per 10,000.[464] Village doctors are given a short training from a few weeks to a few months in common illnesses from unregulated, unregistered private institutions. [465] Traditional healers are spiritual doctors and have no formal medical training. Most pharmacies have a medical representative on staff, 98 percent of which have a bachelor degree but no formal medical training.[466]

Modality of Service Delivery

Bangladesh's public health sector is highly centralized. The Ministry of Health and Family Welfare (MoHFW) manages public health care facilities, as well as directs the country's public health policy. [467] In urban areas, delivery of health care services is provided through the Ministry of Local Government, Rural Development, and Cooperatives.[468] In non-urban areas, the Directorate General of Health Services, under the MoHFW, oversees health care delivery with many service provides reporting directly to the ministry, bypassing local authorities.[469] The private sector is largely unregulated. Bangladesh does not have any system to license private health care providers or monitor their activities.

Bangladesh has three levels of publicly available health care providers: community clinics, district hospitals, and academic hospitals. Community clinics, called Community Health Care Services, are designed to provide day-to-day health care services to rural communities with greater community involvement. They are funded by MoHFW but are managed by a Clinic Management Group, which includes local public leaders and community representatives. The largest hospitals in Bangladesh are academic hospitals and are affiliated with teaching universities. Despite being associated with teaching colleges, these hospitals are still primarily managed by MoHFW. District hospitals are also managed directly by MoHFW.

Health spending as percent of GDP increased substantially over the past decade. Per capita health expenditure tripled from $23.40 in 1995 to $67.80 in 2012 but is still significantly lower than the average per capita expenditure for low income OIC countries, at $89. The private sector spends more in health care than the public sector. Despite widespread government provision, private health care providers account for 2.4 percent of the GDP while public health care accounts for 1.2 percent of the GDP.[470] The private sector plays a large role in health provision, but is largely unregulated by the government.

462 El-Saharty et al. (2015)
463 WHO (2010)
464 Ahmed et. al. (2011)
465 Ahmed et. al. (2011)
466 Rahman et al. (2014)
467 World Bank (2014a)
468 WHO (2010)
469 World Bank (2014a)
470 World Bank. World Development Indicators

Public sector health facilities are primarily funded by the central government but out-of-pocket expenditure is high. The MoHFW provides an estimated 97 percent of funding for public health care services and local governments provides about 1 percent.[471] Funding is allocated to hospitals based on the number of staff and the number of beds in the hospitals, which has led to some inequality in areas that face greater disease risk. However, patients primarily finance services through user fees, both formally and informally.

NGOs and development assistance plays an important role in the health care sector. External resources as a percentage of GDP increased from 3.0 percent in 1990 to 7.2 percent in 2012. While this figure more than doubled in two decades, it is still small compared to other OIC low income countries. NGO-led programs in health care are mostly active at the grassroots level or in a few rural communities. NGO expenditure on health care is 1 to 2 percent of national health expenditure.[472]

Out-of-pocket spending is high. Most public health services are provided to Bangladesh citizens without charge. However, informal service fees are common at all levels of health care and can sometimes be as high as ten times the official cost of the service.[473] The 2003 Bangladesh Service Delivery Survey indicated that 80 percent of respondents paid for services in "free" sub-district hospitals.[474] Out-of-pocket expenditure for both public and private health care services is high at 63 percent of total health care expenditure.[475] The largest category of household expenditure in health care is on medical goods and pharmaceuticals.[476] The high cost of health care is enough to deter residents from using services, particularly among the country's poorest households.

Bangladesh has 44 insurance companies focusing on general, life, and accidents and are usually offered through employers.[477] However, the market is not very big. In an effort to reduce out-of-pocket expenditure, several NGOs are providing health services through provision of micro health insurance or at a reduced cost. The BRAC program that provides education services is also involved in health care provision, providing health care at lower cost through community health care providers. Another NGO, Maria Stopes, provides services at a flat rate or through a card-based MHI to certain vulnerable groups.[478] While NGOs attempt to improve service delivery to poorer households, it is not enough to make a countrywide impact.

Applying the Accountability Framework to the Health Care Sector in Bangladesh

Bangladesh's greatest challenge in the health care sector is staff capacity - and therefore low compact - in the delivery of public health services. The sector faces an overall shortage of medical personnel but also an imbalance in skills mix across geographies. In addition, absenteeism is high among public sector health providers because many also participate in the private sector.[479] Physicians in the public sector lack a defined career mobility, are sometimes not provided the infrastructure or supplied that they need to do their job, and, overall, are not incentivized to perform well.[480] MoHFW has developed several policies to address human

471 World Bank (2014a)
472 Bangladesh Health Watch (2012)
473 Vaughn, Karim, and Buse (2000)
474 Bangladesh Health Watch (2012)
475 World Bank. World Development Indicators
476 World Bank (2014a)
477 Bangladesh Health Watch (2012)
478 Bangladesh Health Watch (2012)
479 El-Saharty et al. (2015)
480 El-Saharty et al. (2015)

resources challenges, particularly to reduce absenteeism in rural areas, but it has failed to effectively monitor or enforce the policies.[481]

The compact between the Ministry, stakeholders, and the providers in Bangladesh's health care system is weak. Decision-making power is ill-defined and spread across a number of stakeholders including the central government bureaucrats, politicians, development partners, and physicians through the Bangladesh Medical Association. For example, the process to fill a vacancy at a local hospital involves 9 steps including approvals with the MoHFW, Public Service Commission, and the Ministry of Public Administration and can take up to 3 years.[482]

To improve the accountability of health care providers, Bangladesh must strengthen the compact between the state and the provider. One way to do this would be for the central government to allow health care providers more decision-making power in terms of budgets, human resource decisions, and policy. Secondly, client power might be improved. Mechanisms for patients to monitor the services and report their grievances could be established which would increase citizens' voice and, therefore, ability to hold the service providers accountable for their actions.

In one example of strengthening compact, Bangladesh, with financing from the Asian Development Bank and other partners, improved health care provision to the urban poor by contracting out services to NGOs. In response to poor health outcomes among the urban poor, facilities with a comprehensive reproductive healthcare centre (CRHCC) to provide obstetrical care and a primary healthcare centre (PHCC) to provide curative and preventive services, and public health outreach were built for every 500,000 people in Dhaka, Chittagong, Khulna, and Rajshahi. Management for the facilities in Dhaka, Khulna, and Rajshahi were contracted out to 11 NGOs and in Chittagong to the Chittagong City Corporation.[483] The NGOs were selected via a competitive bidding process and are given the power to recruit or fire their own staff and manage operational costs. Funding for the centres is provided by the Ministry on a reimbursement basis rather than through an up-front budget allocation. It was found that the centres run by NGOs provided more services per capita and better overall care, and that health standards improved in the areas that they covered.[484]

3.2.4 Water and Sanitation Sector

Access to and Quality of Water & Sanitation Services

Because access to treated piped water supply is limited, ground water is the primary source of drinking water in Bangladesh.[485] While Bangladesh is located on a river-delta, a rich source of surface water, it is too turbid, salty, and polluted to be used as drinking water when it is not treated. The surface water also fluctuates significantly in level of quality between monsoon and dry seasons.[486] Bangladesh has only one operating water treatment plant, which extends piped water supply to an estimated 31 percent of the country's households.[487,488]

Most households in Bangladesh use tube wells with hand pumps to withdraw groundwater, which are installed by the water utility company, local government, or privately by the

481 El-Saharty et al. (2015)
482 El-Saharty et al. (2015)
483 Heard, Nath, and Loevinsohn (2013)
484 Heard, Nath, and Loevinsohn (2013)
485 Ministry of Foreign Affairs of Denmark (2010)
486 ADB (2009)
487 Ministry of Foreign Affairs of Denmark (2010)
488 Ministry of Foreign Affairs of Denmark (2010)

household.[489] Bangladesh has 7 million such tube wells with hand pumps, 5.5 million constructed by private sector for private owners, 1.2 million by government, and 300,000 by NGOs.[490] One tube well can serve roughly 20 people, but most poor households do not have access to one close to home.[491]

Access to sanitation is limited but is improving. A result of a Government-led sanitation campaign in 2005, an estimated 57 percent of households now have access to improved sanitation facilities in Bangladesh, an increase of 24 percent from 1990.[492] Compared to other low income OIC countries, Bangladesh is making progress towards better sanitation. However, the system is still inadequate and cannot keep pace with Bangladesh's rapid population growth.

A quarter of the population has access to the sewer network.[493] The remaining 75 percent of the population use on-site sanitation solutions such as septic tanks or pit latrines.[494] However, many do not have any installed sanitation solutions. Dhaka, a city of 14 million people, has one sewerage treatment plant. The plant is capable of handling 10 percent of domestic sewage, but is only running at one third of its capacity.[495] The country has no sanitary landfills and only a small portion of garbage is collected.[496]

Access to water varies across geographies, but is similar among rural and urban areas. Access to improved water sources and sanitation facilities is fairly equal among urban areas and rural areas. In urban areas, 85.8 percent of households have access to improved water and 55.2 percent have access to improved sanitation compared to rural households at 84.4 percent and 57.8 percent, respectively. However, water supply in rural areas is almost entirely hand pumps or well extraction whereas some urban areas have piped water supply.

Stark differences in water access exist among cities. In Bangladesh's capital, Dhaka, 83.3 percent of the 14.4 million residents have access to water for 23 hours per day but, in Chittagong, 34.2 percent of the 6.5 million residents have access for an average of 8 hours per day. In the smaller Bagerghat, 42.4 percent of its 1.5 million residents have access to water for an average 2 hours a day.[497]

The operation and maintenance of piped water and sanitation systems in Bangladesh is inadequate. Leakage and deterioration of pipes, wells, and machinery related to water delivery is prevalent. Dhaka loses 30 percent of the water supply due to leaking pipes.[498] As a result of poor maintenance, access to piped water is limited to an average of 11.5 hours per day across the country.[499] In terms of sanitation, many households do not have the resources needed to purchase and install a hygienic latrine or other solution.[500] In a survey conducted by the Bangladesh government, 73 percent of households without a latrine lack financial resources to purchase one.[501]

489 ADB (2009)
490 ADB (2009)
491 ADB (2009)
492 World Bank, World Development Indicators. Access to improved sanitation includes access to piped sewer system, septic tank, pit latrines, ventilated pit latrine, pit latrine with slab, and composting toilet.
493 ADB (2013)
494 ADB (2013)
495 Ministry of Foreign Affairs of Denmark (2010)
496 ADB (2009)
497 WSP (2009)
498 ADB (2013)
499 WSP (2009)
500 Ministry of Local Government, Rural Development and Cooperatives of People's Republic of Bangladesh (2005)
501 Ministry of Local Government, Rural Development and Cooperatives of People's Republic of Bangladesh (2005)

Water pollution is a serious problem in Bangladesh, especially in Dhaka. Untreated waste is continually discharged into Dhaka's surface water. With more than 7,000 industrial corporations, about 1.3 million cubic meters of untreated or partially treated waste water is discharged into surface water each day. Households discharge an additional 500,000 cubic meters of untreated wastewater into surface water per day. As a result, surface water in Dhaka is highly contaminated. Ammonia concentration is 46 percent, biological oxygen demand and presence of heavy metals exceed allowable limits for open water. An estimated 50 percent of families lost a full week per year due to water borne disease.[502]

Wide-spread arsenic contamination affects most privately installed tube wells. More than half the 160 million people living in Bangladesh are exposed to arsenic and 20 million are said to be exposed to excessive levels of arsenic.[503] At least 53 out of 64 districts of Bangladesh are affected by arsenic pollution. It is estimated that 15 to 25 percent of all existing tube wells in Bangladesh are contaminated by arsenic.[504]

Diseases related to poor sanitation practices are also prevalent. Diarrhea disease causes 110,000 children under five years of age to die each year. The average child suffers from diarrheal disease three to four times a year.[505]

Modality of Service Delivery

The water and sanitation sector is primarily managed by the central government but service delivery is provided through locally-based semi-autonomous authorities or by municipalities. The Ministry of Local Government, Rural Development, and Cooperatives oversees the water and sanitation sector. The sector is guided by a sector development plan, last updated in 2011. Policy formation, strategic planning, and monitoring are implemented by the Ministry's Local Government Division (LGD). Water and Sanitation Authorities (WASA), which are semi-autonomous agencies, supply water and sanitation services to Bangladesh's larger cities including Dhaka, Chittagong, Khulna, and Rajshahi. WASAs provide treated water, sewerage services, and storm-water drainage to six cities. In smaller municipalities, the water and sanitation services are provided by the municipality or city corporations. Communal water and sanitation systems, such as a well or latrine servicing multiple households, are implemented and maintained by the local government institutions and are found mostly in rural areas.

Capital improvement projects and infrastructure improvements are financed and managed by the central government. The Department of Health Engineers (DPHE) delivers water and sanitation services to areas not served by a WASA or a municipal body. DPHE also install infrastructure across the country and provides technical assistance to city corporations and municipal bodies responsible for service delivery. DPHE constructs new projects, but the municipality manages it.

The water and sanitation operations and maintenance are financed by revenue from customers, but capital improvements are financed by the central government. While it does not have a specific budget, water and sanitation improvements are subsumed under physical planning, water supply, and housing.[506] The Government invested an average of US$259.30 million annually from 2007 to 2011 on water-related infrastructure and programs.

502 Ministry of Foreign Affairs of Denmark (2010)
503 Ministry of Foreign Affairs of Denmark (2010)
504 ADB (2009)
505 Ministry of Local Government, Rural Development and Cooperatives of People's Republic of Bangladesh (2005)
506 ADB (2013)

Portions of this funding were allocated to flood preparedness and water resource management and detailed budget items for potable water supply and basic sanitation are not itemized.[507]

The service providers (WASAs, municipalities or city corporations) set and collect their own tariffs and connection fees. Four of the 11 providers surveyed collected enough in fees to cover their operation and maintenance costs. Some of providers receive subsidies from the local government or the local government covers labour or electricity costs.[508] However, others simply do not maintain or drop important components of their operations.

Three providers have more than a year's worth of client's outstanding bills including the country's two largest cities Dhaka and Chittagong. This is, in part, due to customer's inability to pay for services. In some cases, residents cannot afford connection fees. At this time, none of the providers allow payment plans by installment.[509]

The private sector is encouraged to invest in the water and sanitation sector, but large-scale involvement is minimal. The private sector supplies 84 percent of the structured water supply and the remainder is provided by the government. [510] The structured water supply is small, but most households use private vendors to install hand pumps or tube wells for water and septic tanks or latrines for sanitation. Small-scale provision of water at "water kiosks" is common, particularly in urban slums, where water vendors sell water sourced from the public supply to residents who are not connected to the grid, do not have access to wells, or who cannot afford monthly water tariffs. Often, the water is sold at high prices and is illegally acquired from the public supply.[511]

Significant resources for the water and sanitation sector are provided by development organizations. The average annual overseas development assistance for water-related infrastructure and programs was $177.69 from 2007 to 2011.[512] The Bangladesh Municipal Development Fund (BMDF) and the Hygiene, Sanitation, and Water Services (HYSAWA) Fund are registered as government-owned companies and act as a vehicle to receive financing from international agencies.

Applying the Accountability Framework to the Water and Sanitation Sector in Bangladesh

Bangladesh has taken several steps to increase community participation in an effort to improve the sanitation sector. While they still face challenges, Bangladesh has made significant improvements in sanitation through policies and NGO support. Open defecation was common across Bangladesh but levels have reduced from 34 percent in 1990 to two percent in 2012.[513] Bangladesh along with NGOs worked closely with community members and local governments to improve conditions and install pit latrines.

Community Led Total Sanitation, a project led by the NGO WaterAid to stop open defecation in Bangladesh, empowered community members to improve their sanitation situation. Community members worked closely with the NGO to encourage their neighbors to stop open defecation and purchase low-cost latrines supplied by the WaterAid. It is estimated that more than 5,000 communities achieved total sanitation by 2006 as a result of the project.

507 UN Water (2013)
508WSP (2009)
509 WSP (2009)
510 Ministry of Foreign Affairs of Denmark (2010)
511 Baker (2009)
512 UN Water (2013)
513 WHO and UNICEF (2014)

Building on the success of this campaign, from 2003 to 2006, the Government of Bangladesh embarked on a countrywide effort to reach 100 percent sanitation coverage and an end of open defecation by 2010. [514] The government allocated 20 percent of its Annual Development Programme (ADP) to fund districts for improving sanitation. 90 percent of the allocation was to be used to procure and distribute sanitary latrines to the poor. The remaining 10 percent was used for a public health campaign for sanitation, each locality was transferred funds.[515] Led by the central government, the campaign relied on local governments to implement, who in turn partnered with NGOs and international donor organizations.

The campaign has had enormous success, not only in reducing open defecation but also with the installation of sanitary latrines. A recent study found that 89.5 percent of households in a sample now own or share a latrine that safely confined faeces.[516] Bangladesh's improvements in the sanitation sector is an example of how decentralizing decision-making power to local governments and engaging the community can lead to improvements.

Weak government capacity and ineffective management has led to inadequacies in the provision of water. In theory, WASAs and municipalities have the authority to manage installation of and operations and maintenance, manage billing, and set and adjust water tariffs. But, in practice, decision-making power is spread across central government, local government, and water utilities leading to a general lack of accountability. Revenue collection is low among most WASAs or municipalities, who, in turn, rely on subsidies from central or local government. However, because the system is not formalized and funds are not always available, it leads to deteriorations in operations and maintenance.

In an effort to encourage improvements, the Government of Bangladesh began an initiative called Benchmarking and Performance Improvement Programming (BM&PIP) funded by several development organizations through the Water and Sanitation Program. They worked with stakeholders from related ministries, water authorities, and selected local governments to develop the Bangladesh Water Utilities Data Book in 2009. The idea is that benchmarking progress and providing evidence-based research will lead to improvements in the sector by increasing accountability. The report compares data across 11 water providers assessing their coverage, revenue, and identifying inefficiencies. It is hoped that efforts like this will continue leading to improved accountability among service providers. However, to achieve improvements, Bangladesh should also better define compacts between service providers, local government, central governments, and citizens.

3.3 Lebanon

3.3.1 Country Background

Lebanon is an upper-middle income country with an estimated population of 3.8 million Lebanese citizens.[517] Additionally, 260,000 Palestinian refugees and 1.2 million Syrian refugees reside in the country.[518]

Poverty constitutes a problem in Lebanon. It is estimated that 28.6 percent of the population lived under $4 a day poverty line in 2004.[519] When a multidimensional poverty approach is adopted, poverty was found to be somewhat higher with 30.9 percent of the

514 WSP (2009)
515 Ministry of Local Government, Rural Development and Cooperatives of People's Republic of Bangladesh (2005)
516 Kullman, and Ahmed (2011)
517 UNDP (2014)
518 UNDP (2014) for the number of Palestinian refugees and UNHCR (2014a) for the number of Syrian refugees
519 UNDP (2014)

population having unsatisfied basic needs.[520] Major regional disparities in poverty levels exist in the country. The population with unsatisfied basic needs increases as high as 47 percent in the North while it is only 9 percent in the capital city, Beirut.[521]

	Indicator	Value	Year
Population	Population, total	4,467,390	2013
	Population growth (annual %)	0.96	2013
	Urban population (% of total)	87.55	2013
	Population ages 0-14 (% of total)	20.82	2013
GDP	GDP growth (annual %)	0.90	2013
	GDP per capita, PPP (constant 2011 international $)	16,622.9	2013
Poverty	Poverty headcount ratio at $4 a day (% of population)	28.6*	
	Urban poverty headcount ratio at national poverty lines (% of urban population)	-	
	Rural poverty headcount ratio at national poverty lines (% of rural population)	-	
Inequality	GINI index (World Bank estimate)	-	
	Income share held by highest 20%	-	
	Income share held by lowest 20%	-	

Source: World Bank, World Development Indicators. (*) Poverty estimate is obtained from UNDP (2014).

Syrian refugee crisis is currently a major challenge for the country. The number of registered Syrian refugees was 1.2 million as of December, 2014[522] and the total number of refugees is estimated to be even higher when unregistered refugees are also taken into account. Given the country's small population, Lebanon has the highest number of refugees per capita in the World with 232 per 1,000 inhabitants.[523] Due to the refugee influx, between 2010 and 2014, economic growth slowed in the country and the unemployment rate increased.[524] In addition, the refugee influx creates enormous pressure on the delivery of basic services and will continue to do so given that the number of refugees is estimated to further reach 1.5 million by the end of 2015.[525] The Syrian refugee crisis exacerbates the poverty issue in Lebanon. It is estimated that the crisis will further push 170,000 Lebanese under the $4 a day poverty line – in addition to the current 1 million already below the line.[526] Apart from the Lebanese poor, Syrian refugees are living in dire conditions as well. A 2014 assessment showed that half of the Syrians were living below a $3.84 poverty line and 71 percent of Syrians cannot meet their basic needs without engaging in negative coping strategies.[527]

In Lebanon, decentralization is limited and waits to be further defined with a bill waiting in the Parliament to be approved since 2014. The country is divided into 6 governorates that are further divided into 26 districts including Beirut, which is a district on its own.[528] Each governorate is head by an appointed governor and the districts are head by an

520 UNDP (2014)
521 UNDP (2014)
522 UNHCR (2014a)
523 UNHCR (2014b)
524 UNHCR and UNDP (2014)
525 UNHCR and UNDP (2014)
526 World Bank (2013)
527 UNHCR and UNDP (2014)
528 UCLG (2015)

appointed District Administrator (*qa'imaqam*). There are 1,108 municipalities, which are an administrative level found within districts.[529] Municipalities have elected municipal councils and are legally responsible for all activities related to public interest.[530] In 2014, a decentralization bill was introduced in the Parliament with the aim of improving "transparency, accountability and monitoring, bringing the citizen closer to holding accountable those he has elected."[531] With the new law, which is still waiting to be approved, the districts will be head by an elected council instead of the District Administrator.[532] The elected councils will be responsible for development projects in the districts.

Accountability relationships are not sufficiently strong in the Lebanon, which impacts service delivery. The World Bank's Voice and Accountability index and Government Effectiveness index both rank the country lower than the World average, though above the OIC average. On voice and accountability, Lebanon has a score of -0.44[533] which is better than the OIC average of -0.86. Lebanese people find it difficult to hold public officials accountable. According to the results of the Arab Barometer 2010-11 survey, 60.8 percent of the citizens stated that it is very difficult to gain "*access to the concerned official to file a complaint when you feel that your rights have been violated*". In accordance with this finding, the results of the Gallup Poll 2013 suggest that only around 10 percent of the surveyed citizens voiced opinion to public officials in the last month in Lebanon.[534] On government effectiveness, the country also scores low in the World Bank government effectiveness index with -0.39, which is higher than the OIC average of -0.62 but lower than the World average of 0.00.[535] A low level of government effectiveness indicates that the quality of the public services is perceived as low with weak policy formulation and implementation. This is also evident from the fact that, according to Gallup World Poll 2013, Lebanon is one of the countries with the lowest public satisfaction on "*the efforts to deal with the poor*" with less than 30 percent satisfaction rate as opposed to the satisfaction rates higher than 50 percent in countries like Libya, Tunisia and Jordan.[536]

3.3.2 Education Sector

Access to and Quality of Education

Lebanon has almost achieved universal primary education. In 2013, the primary school adjusted net enrolment rate was 95.9 percent in the country.[537] In the last two decades, enrolment rates increased substantially. In 1997, primary school adjusted net enrolment rate was more than 10 percentage points lower at 84.2 percent.[538]

While no regional disparity exists in primary school net enrolment rates, regional disparities exist in the ages children enter primary school and the primary school completion rate. In Lebanon, the Beirut governorate has the highest percentage of children attending primary/secondary school at 99.2 percent. The lowest enrolment rate is among the North Lebanon districts at 96.2 percent in 2009.[539] Despite having little variation in enrolment

529 CAS (2015)
530 UCLG (2008)
531 Daily Star (2014)
532 Atallah (2014)
533 World Bank,World wide Governance Indicators
534 Brixi, Lust and Woolcock (2015)
535 World Bank, Worldwide Governance Index
536 Brixi, Lust and Woolcock (2015)
537 UNESCO, Education Statistics
538 UNESCO, Education Statistics
539 CAS (2009). Note that according to the statistics of the national agency CAS, in year 2009 percentage of children of primary school age attending primary or secondary school was 98.3. UNESCO statistics is different for this year with 90.7

rates between regions, a closer look indicates inequalities in other education outcomes. All children who are at the primary school entry age were enrolled in grade 1 in the Beirut governorate, compared to only 83.5 percent in North Lebanon districts (excluding Akkar and Minieh-Danniyeh).[540] Net primary school completion rates are overall significantly lower in the country compared to primary school enrolment rates. 72.4 percent of the children in Lebanon were completing their final year of primary education at the correct graduation age in 2009. Moreover, this rate differs across regions. The lowest rate was observed in the North Lebanon districts with 65 percent as opposed to the highest rate in the Mount Lebanon governorate (excluding Beirut suburbs) with 78.9 percent.[541]

Low quality of education is a challenge for Lebanon. Lebanon participated in the international assessment test TIMSS since 2003 for the assessment of 8th graders in mathematics and science. Results show that, in 2011, 27 percent of children taking the test did not have basic mathematics knowledge. Only a slight improvement was observed over the last decade in the achievement of the 8th graders with the share of low achievers decreasing 5 percentage points from 32 percent in 2003.

Public and private schools differ in quality, which affects poor children adversely. In Lebanon, children from lower socio-economic backgrounds are generally concentrated in public schools.[542] More affluent parents prefer to send their children to private schools, which are perceived to offer better quality of education. Indeed, TIMSS results show that, on average, students in public schools have lower achievement compared to students in private schools.[543] This further exacerbates the inequality of opportunity that children from disadvantaged background face. Factors like place of residence or the father's educational attainment strongly affect student achievement, which illustrates the existence of long-term inequalities embedded in the system.[544] Public schools also have infrastructure problems, which are worse in more disadvantaged regions in the North. Overall, 22 percent of schools lack access to piped water in the country. This rate rises to more than 50 percent in parts of the country in the North.[545]

Pupil to teacher ratio is low in Lebanon with an over-supply of teachers. Lebanon has a very low pupil to teacher ratio of 14.3 in primary schools in 2012. Comparatively, the World average was 24.2 and countries in the same region also had higher ratios like Jordan with 19.9 or Algeria with 23.2.[546] In addition, public schools have a lower pupil-to teacher ratio of less than 8 while, for private schools, it changes from 11 to 19.[547] In the last three decades, the number of students increased by 25 percent while number of teachers increased by 111 percent.[548] Although in terms of quality of education a low pupil to teacher ratio in public schools is a good quality indicator, too low a ratio may also indicate an inefficient use of resources. Given that 87 percent[549] of government expenditures on education are allocated to pay teacher salaries, employing a higher than necessary number of teachers may put a burden on the budget. While the number of teachers far exceeds the need, the number of teachers

percent. According to the statistics of UNESCO, enrolment rate rises to 95.9 percent in 2013. CAS does not have updated data for the years later than 2009.
540 CAS (2009)
541 CAS (2009)
542 UNDP (2014)
543 UNDP (2014)
544 World Bank (2015b)
545 Ministry of Education and Higher Education of Lebanon (2014)
546 World Bank, World Development Indicators
547 UNDP (2014)
548 World Bank (2010a)
549 Ministry of Social Affairs of Lebanon (2011)

with a university degree is actually low in the country. In public schools, 54.5 percent of the teachers do not hold a university degree.[550]

Teacher absenteeism is only a minor problem for Lebanon compared to the region. Teacher absenteeism which is a common problem in the MENA region does not seem to constitute a major issue for Lebanon. According to the results of TIMMS 2011, only 7 percent of the students attended schools whose principals reported that teacher absenteeism is a serious problem as opposed to the MENA average of 22 percent.[551]

Gender parity in primary school enrolments has been achieved in Lebanon. Lebanon has a gender parity index of 1 for the primary school net enrolment rate. However, it must be noted that this is not the case for secondary education. In Lebanon, the unequal enrolment rate in secondary education is in favour of the girls with a gender parity index of 1.15.[552] This is largely due to the fact that boys are expected to contribute to the household income at an early age.

The Syrian refugee crisis constitutes a major challenge for the education sector in the country. The capacity need is enormous with the total number of school age Syrian children far exceeding the total number of enrolled children in the Lebanese public schools. In Lebanon, 482,000 Syrian children are of school age as opposed to the 300,000 Lebanese children the public schools are serving.[553] Despite major efforts, only 90,000 refugee children were enrolled in public schools during the 2013/14 school year. Hence, there is a significant problem of out of school children in the country. In order to address this challenge, in October 2013, a second shift in the afternoons was introduced in public schools to increase the capacity.[554]

Modality of Service Delivery

In Lebanon, there are four types of schools, public schools, semi-private schools, private schools and schools operated by UNRWA serving only in Palestinian refugee camps.[555] Semi-private schools-also known as free private confessional schools- are generally religiously affiliated schools. Despite their name, they are generally not free.[556] Public and private schools (including semi-private) are almost equal in number with 1,365 public and 1,442 private and semi-private schools.[557] However the majority of the students attend private schools in the country. In 2013, 71.8 percent of the primary school children were enrolled in private schools.[558] UNRWA schools are free and teach the Lebanese curriculum to Palestinian children.

Governance of public education is centralized in Lebanon. Responsibilities with regards to policy, planning, resource allocation, teacher recruitment and definition of curriculum all lie with the central government.[559] The Ministry of Education and Higher Education is responsible for public education from pre-primary to secondary school and also regulates the private sector. Regional education bureaus link schools to the Ministry. These bureaus are responsible for the monitoring of the schools and circulating Ministry decisions to the schools.[560]

550 World Bank (2010a)
551 Brixi, Lust and Woolcock (2015)
552 CAS (2009)
553 Government of Lebanon and UN (2014)
554 UNDP (2014)
555 Ministry of Education and Higher Education of Lebanon (2014)
556 Hamdan (2013)
557 Ministry of Education and Higher Education of Lebanon (2014)
558 World Bank, World Development Indicators
559 Brixi, Lust and Woolcock (2015)
560 Skaf and Habib (2012)

Financing of education differs across school types. Public schools are financed through a School Fund and a Parent Council Fund. Except for a yearly contribution of $60 that is collected from parents for the Parent Council Fund, public schools are free of charge.[561] The level of contribution to the Parent Council Fund is decided by the Ministry and it is fixed for all public schools. In addition to the Parent Council Fund, public schools receive $100 per child from the Government to the School Fund to finance the school's operational costs. The types of expenses that these funds can be allocated to is outlined in regulations. Semi-private schools are also subsidized by the State but they are not free of charge for the children. These schools charge parents between $450 and $533 a year.[562] Private schools are solely financed by the parents and their yearly prices range from $1,500 to $15,000 a year.[563]

Public spending on education as a percent of total government expenditures in Lebanon is well below the UNESCO's recommended 15-20 percent share. For Lebanon, this rate was 7.1 percent in 2012. While total expenditures on education constitute 13 percent of the GDP, only 2 percent of the GDP is estimated as expenditure by the government. The remainder is private expenditures.[564]

After the Syrian crisis, donor support for the education sector has been a crucial element in financing education services. Total aid received for the education sector increased for the country in the last decade from $39.3 million in 2003 to $148.8 million in 2012.[565] Donor funding is key to accommodate a large number of refugee children. In 2012, 40,000 refugee children were accommodated in public schools at a total cost of $53 million, $24 million of which was financed by donor agencies through UN.[566] However, the total number of children in need of education increased significantly with the influx of refugees entering the country over the last three years. Hence, for the year 2016, it is estimated that $255 million is required as additional funding to meet the needs of the sector.[567]

Applying the Accountability Framework to Lebanon's Education Sector

In Lebanon, where voice and compact are weak as evidenced by Worldwide Governance Indicators, strengthening client power might improve outcomes of the education sector. Client power is weak in public schools. Although Parent Councils are present, they do not have any decision making power even though the main responsibility of the Council is to collect additional funds for the schools' expenses. Implementation of plans and programs issued in the last 5 years by the government might serve well in strengthening the accountability relationships in the education sector.

The latest Sector Development Plan of the Ministry of Education and Higher Education includes measures that would improve the accountability relationships between the sector's actors. Lebanon's Education Sector Development Plan for 2010-2015 prioritizes a number of issues for improvement of quality education. These priority areas include (i) education available on the basis of equal opportunity, (ii) quality education that contributes to a knowledge society, (iii) education that contributes to social integration, (iv) education that contributes to economic development and (v) governance of education. More specifically, under the second priority area, the plan includes objectives that would improve the client power if implemented, such as *"Enhancing the interaction between the school and the*

561 World Bank (2015a), Ministry of Education and Higher Education of Lebanon (2014)
562 Hamdan (2013)
563 Hamdan (2013)
564 Ministry of Social Affairs of Lebanon (2011)
565 UNESCO EFA Report 2015, Aid Tables
566 World Bank (2015b)
567 Government of Lebanon and UN (2014)

community", and *"Piloting the School Based Management Model."*[568] These objectives are likely to improve the client power of the parents by increasing their participation in service delivery and in decision making processes.

A recent program aiming to improve access to education of Lebanese and Syrian children has features that are likely to improve the accountability relationships. "Reaching All Children in Lebanon with Education" (RACE) program was initiated in 2014 by the Ministry of Education and Higher Education with support from international donor agencies. The program aims to improve the access of vulnerable Syrian and Lebanese children (3-18 years) to quality education by 2016.[569] The program targets an average number of 413,000 Syrian and Lebanese children per year.[570] In addition to providing financial support to the government to extend access to vulnerable children in public schools, the program has components that will enhance the governance of the sector and the accountability relationships between the actors. One of the subcomponents in this aim is "Learning outcomes assessment and M&E strengthening". This component will focus on strengthening the school-based monitoring system of the Ministry in 200 public schools.[571] The system will collect information on access, learning, retention and psycho-social situation of the students. This mechanism strengthens the compact relationship between the State and the service providers. The schools are expected to become more accountable of their performance since they will be monitored by the State. As an additional step, policymakers might introduce rewards or sanctions for better enforcement. Another subcomponent that will have an impact on the governance structure is "School-based management and monitoring and school grants". The school-based management programme by the World Bank is in its design stage and will distribute grants based on school improvement plans for the implementation of projects.[572] This is a type of decentralization and may strengthen the compact by introducing an incentive for service providers to improve school quality in order to receive increased funding.

3.3.3 Water and Sanitation Sector

Access to and Quality of Water and Sanitation Services

In Lebanon, although water resources are abundant, water supply does not meet demand due to a number of inefficiencies in service delivery. In an average year, the yield of water is about 2,700 million m^3 while average demand ranges between 1,473 and 1,530 m^3 per year.[573] Even though water supply far exceeds the demand, water shortages are a common due to problems with the distribution and delivery. Although the country is well endowed with water sources, with the current depletion rate, severe water shortages are expected to occur by 2020.[574]

Access to water is high but the quality of access is a major challenge. Access to an improved water source is at 100 percent in Lebanon and access to a piped network is also quite high with 78 percent coverage.[575] However, despite the high coverage rates, the quality of the water is low with intermittent access. The hours of water supplied from the piped network ranges from an average of 7.6 to 13 hours a day in the country depending on the season. In addition, the quality of the drinking water supplied through the network is

568 Ministry of Education and Higher Education of Lebanon (2010)
569 Ministry of Education and Higher Education of Lebanon (2014)
570 Ministry of Education and Higher Education of Lebanon (2014)
571 Ministry of Education and Higher Education of Lebanon (2014)
572 Ministry of Education and Higher Education of Lebanon (2014)
573 Farajalla et al. (2015)
574 World Bank (2010b)
575 UNDP (2014)

perceived to be low by the consumers. Survey results indicate that only 53 percent of the households connected to the network use it for drinking and around one-fifth of the consumers in every region, except Beka'a, rate the quality of public water as "poor or very poor."[576]

Access to water and the continuity of the water supply depends on the region. Access to piped water is as low as 65 percent in the North and as high as 93 percent in Beirut and Mount Lebanon (BML). While the connection rates are lower in the North, the continuity of supply is the highest at a continuous 22 hours in both the high and low seasons as opposed to only 3 hours of continuous supply in Beirut in the high season and 13 hours in the low season. In contrast, in other countries in the region like Morocco and Tunisia, 24-hour water supply in the major cities is already established.[577]

The low quality of water supply is associated with a high rate of leakages, a low storage capacity and inefficiencies in the governance of the sector. It is estimated that 40 percent of water is lost to leakages in the piped network. This rate is very high compared to other countries in the region like Tunisia with 20 percent water loss or Morocco with 32 percent.[578] Storage capacity is also very low in the country which adds to the imbalance of water supply between seasons. In Lebanon, only 6 percent of total resources can be stored as opposed to the 85 percent MENA average.[579] Furthermore, water consumption is not metered in Lebanon giving no incentive to the consumers to control their water use. Flat fees also do not give any incentive to the providers to increase the efficiency of the network.

Access to an improved sanitation facility is 100 percent in Lebanon with two thirds of the population connected to the piped sewerage network. It is estimated that 66.9 percent of the population is connected to the sewerage network while the remaining use open air sewers or sanitary pits.[580] Wastewater treatment is insufficient in the country with 92 percent of the wastewater disposed to the environment without treatment.[581] In contrast, an average 32 percent of total water consumed is treated in the MENA region.[582]

The Syrian refugee influx further exacerbates problems in the sector. Water demand was estimated to increase by 7 percent of its pre-crisis demand level in 2013.[583] Given that the number of refugees increased significantly since this estimate was calculated, the demand is expected to increase further in 2015. Most of the Syrian refugees reside in the regions where there is already low connection to the water network, which puts the refugees and the host communities at a further disadvantage.[584] It is estimated that a third of Syrian refugees lack access to safe drinking water.[585] The influx of refugees has contributed to wastewater pollution as well. Wastewater pollution is estimated to have been increased by a third since 2011.[586]

Modality of Service Delivery

In Lebanon, the water sector is primarily managed by the Ministry of Energy and Water while four Regional Water Establishments (RWEs) are responsible for operations and

576 World Bank (2009)
577 World Bank (2010b)
578 World Bank (2010b)
579 World Bank (2012)
580 UNDP (2014)
581 Bassil (2010a)
582 Bassil (2010a)
583 World Bank (2013)
584 World Bank (2013)
585 Government of Lebanon and UN (2014)
586 Government of Lebanon and UN (2014)

maintenance of drinking water, wastewater and irrigation.[587] In addition to the four RWEs, there is one River Basin Agency responsible for managing country's rivers. The RWEs are legally autonomous and deliver services to the population in their territory. Apart from these entities, the Council of Reconstruction and Development, which is a planning ministry, is an important actor in the sector responsible for managing and executing investments through donor financing.[588]

Box 6. Contracting out private companies for water service delivery

In Lebanon, there is a legal framework that allows Regional Water Establishments (RWEs) to deliver the services themselves or contract out private companies. However, such an arrangement must be approved by the Parliament in order to be operationalized. Hence, RWEs cannot act autonomously and contract out services to private parties.

The only time such a management contract was actually implemented in the country was in Tripoli between 2003 and 2007. The contracted private company achieved an improvement in the water quality and provided a 24 hour continuous supply in 18 months while increasing the collection rate from 30 percent to 50 percent.[589] However, at the end of the contracting period, the private company did not want to proceed with a second contract due to high costs of operation and the Northern Water Establishment did not seek to renegotiate terms. Yet, currently, Tripoli is the only city in Lebanon with 24 hour of continuity in water supply and this is attributed to the success of the contracted out company in increasing the network's efficiency.[590]

The sector is regulated mainly by Law 221 which was enacted in 2000, although exceptions exist in actual delivery of services. Prior to the law, there were 22 water boards and 209 local committees in the country responsible for the operations.[591] With the new law, four RWEs were established and the tasks of water and wastewater operations were delegated to them. Although operations and maintenance are legally the responsibility of the four RWEs, *de facto* municipalities still operate the network in some areas.[592] Municipalities and local committees continue to play a role in small irrigation schemes, collecting wastewater and operating and maintaining water networks.[593]

Due to the intermittency of the water supply, many households rely on private providers, even when they are connected to the piped network. Households purchase water from a number of sources like water trucks, mineral water gallons or bottles and artesian wells. The private sector is unregulated, which brings concerns about the quality of the water provided and it is also very costly for the households compared to the public network. The cost for the same amount of water obtained from the private providers is significantly higher than the cost of water provided from the public network: 1 m3 of water costs from $100 to $220 when purchased in water gallons from private providers while the same amount is only $0.29 to $0.42 when obtained from the public network.[594] However, due to the low quality of water supply from the public network, reliance on the private sector is

587 Farajalla et al. (2015)
588 World Bank (2010b)
589 World Bank (2012)
590 World Bank (2010b)
591 World Bank (2010b)
592 World Bank (2010b)
593 Farajalla et al. (2015)
594 World Bank (2009)

very high in Lebanon with over 70 percent of the expenditures on water by the households going to the private sector.[595]

RWEs are in charge of financing their operations and maintenance expenses, but they have not yet achieved financial autonomy. Out of the four Regional Water Establishments only the one in Beirut is able to cover its operations and maintenance costs using the tariffs collected from the households. The North and South water establishments can recover their operations and maintenance costs excluding electricity bills while the Beka'a Water Establishment falls short of covering its operation and maintenance costs, excluding the electricity bill. The Beka'a Water Establishment can only recover 13 percent of its O&M costs with the revenues it collects.[596] The Water Establishments, which cannot collect enough revenues to cover their electricity costs, are implicitly subsidized because the government does not collect these expenses.

External funding is a major source for water and wastewater sector for the capital expenditures in the country. Council of Development and Reconstruction manages the majority of the investments in the sector and the majority of its budget is financed through donor funding.[597] Major contributors include the World Bank, European Investment Bank, Kuwait and France. With the Syrian refugee influx, the funding need of the sector increased tremendously in recent years. Disbursed Official Development Assistance for the sector already increased by ten-fold between 2004 and 2013 reaching $70.7 million.[598] Yet, for 2016, the estimated funding need of the sector far exceeds the disbursed amount in 2013. To ensure access to safe drinking water and improved sanitation facilities, the sector will need an additional funding of $190 million for the upcoming year.[599]

Applying the Accountability Framework to Lebanon's Water and Sanitation Sector

Fully implementing Law 221, which regulates the sector, could improve the accountability relationships in the sector. The law established autonomous RWEs creating a clear difference between the policymakers and the service providers, which is a priority for a strong compact relationship. However, water establishments have not taken their responsibilities in full yet due to financial or institutional constraints.

Roles and responsibilities of the institutions in the sector sometimes overlap and weak coordination between institutions results in inefficiencies. Law 221 does not establish an ultimate responsible institution for the sector. Instead, it places the Ministry of Environment and Water in a role to advice the current government in policymaking.[600] The coordination between the Ministry of Environment and Water and the Council for Reconstruction and Development is less than optimal. MoEW is not involved in the planning of donor financed wastewater investments, which are under the responsibility of CDR, yet the completed plants are then handed over to the MoEW to operate and maintain. This kind of weak coordination results in underutilized infrastructure and misguided investments, like the wastewater treatment plant financed by the World Bank and completed in 2000 in Ba'albeck that could not be operational for years because households were not connected to it by the sewerage network.[601]

595 UNDP (2014)
596 World Bank (2010b)
597 World Bank (2010b)
598 OECD DAC Database
599 Government of Lebanon and UN (2014)
600 Farajalla et al. (2015)
601 World Bank (2010b)

The National Water and Sanitation Strategy (NWSS) that was approved by the Council of Ministers in 2012 includes measures to improve governance and accountability in the sector. Achieving full autonomy and financial sustainability of RWEs is one of the priorities of NWSS, which will improve governance of the sector. To achieve financial sustainability of the RWEs, tariffs reflecting the level of water consumed will be introduced and the number of metered customers will be increased. According to the plan, the metered connections are targeted to reach 75 percent of total connections by 2015. Making the water establishments fully autonomous is important in improving the compact between the policymakers and the service providers. An autonomous organization with clearly delegated tasks that is adequately financed can be held accountable by the policymakers for the service it delivers. In addition, the Strategy also identifies strengthening the central capacity and oversight mechanism of the Ministry of Energy and Water as a priority. This includes developing monitoring and evaluation of water establishments by using a monitoring body and performance targets. Monitoring and evaluation mechanisms strengthen the compact relationship and make the service providers more accountable to the central government by making the State better informed. The strategy also puts an emphasis on the importance of introducing more public private partnerships in the sector starting with management contracts like the one implemented in Tripoli a decade ago. This is planned to be developed by putting the necessary legal and institutional changes in place.

In Lebanon, ways to exercise or enhance voice and client power through Laws that will improve information and participation of the consumers exist for the water sector. The 6th Principle of the Environment Law 444\2002 ensures free access to information and public disclosure while the 7th principle is on the cooperation between central government, municipalities and citizens.[602] When implemented, the 6th and 7th principles can improve the voice and client power of the citizen by ensuring access to information hence arming them with the tools to demand better services and lobby.

3.3.4 Electricity Sector

Access to and Quality of Electricity Services

In Lebanon, while electricity coverage is universal, quality constitutes a major challenge with daily blackouts being the norm. Electricity coverage is high in Lebanon at a rate of 100 percent.[603] Yet, on average, blackouts last 6 hours a day.[604] The system operates with high levels of technical and non-technical losses compared to the international standards. Of the total electricity produced, only 60 percent is billed to the consumers, with 15 percent technical loss (losses of power generated due to infrastructure problems), 20 percent non-technical losses (unbilled and stolen electricity) and 5 percent uncollected bills.[605] In comparison, countries in the same region, such as Egypt or Jordan, incur losses at a significantly lower rate with 15 percent and 13.1 percent, respectively. Due to the inefficiencies in the supply of electricity, Lebanon was ranked as the second to worst in the quality of electricity supply in World Economic Forum's Global Competitiveness Index in 2014 out of 144 countries.[606]

Electricity rationing in Lebanon is pro-rich since it favours the richest area of the country, Beirut. The hours of electricity rationing is set by Electricite du Liban (EdL), however, the schedule of blackouts is not publicly available.[607] The number of hours of

602 Farajalla et al. (2015)
603 World Bank, World Development Indicators
604 World Bank (2013)
605 Bassil (2010b)
606 World Bank (2015b)
607 Hasbani (2011)

electricity supply differs across regions with the lowest number of blackout hours observed in Beirut and the highest in the North. In Beirut, blackout hours are, on average, 3 hours per day while, in other parts of the country, it reaches as high as 13 hours.[608] Daily blackouts lead households to rely on private generators, which are more expensive than the public connection. Rationing of electricity exacerbates the already existing inequalities between Beirut and other regions by supplying more electricity to the citizens who can more easily afford alternative energy sources.

A shortage in the electricity supply is one of the primary causes behind the frequent blackouts. The installed capacity of Electricite du Liban (EdL) is 2,019 MW and falls far short of meeting a demand of 3,195 MW at peak hours.[609] New power generation capacity was last added in the 1990s and, since then, the country relies on the existing capacity. Lebanon has made use of unsustainable solutions to meet demand, such as by using ships that arrived from Turkey in 2013 to generate electricity off the coast and distribute it to Beirut.[610]

Syrian refugee influx increased the already unmet demand in the country. It is estimated that demand for electricity will increase between 251 MW and 362 MW by the end of 2014.[611] Increased demand will result increased costs incurred by both the government and Lebanese households. It is estimated that capital costs to meet the rising demand will reach $310 million by the end of 2014.[612] In addition, increased demand has a cost to Lebanese consumers due to the diversion of the already limited power capacity to refugees. It was estimated that the average number of hours of electricity supply would drop by 10 percent by the end of 2013, leading consumers to rely more on private power generators.[613] In effect, cost directly born by the Lebanese consumers is estimated to be $206 million in 2013 as a result of a rise in reliance to private generators.[614]

Modality of Service Delivery

Electricite du Liban (EdL), the vertically integrated national utility, is the main actor for the electricity sector in Lebanon. The Ministry of Energy and Water is responsible for planning and policy-making in the electricity sector while EdL has a monopoly over the generation, transmission and distribution of electricity. EdL is currently a public institution with civil servants as employees.[615] It is led by a Director General and a Board of Directors, who are all appointed by the Council of Ministers. EdL lacks an adequate amount of qualified human resource capacity with 63 percent of the full-time positions vacant. Instead, EdL hires around 2,000 contractual employees, many of whom are "unqualified political appointees" as described by the Ministry of Energy and Water's Policy Paper.[616]

EdL was formed to unify the electricity sector in Lebanon and to achieve universal access in the country. In 1954, the electricity concessions in the country were merged under one entity, the Electricity and Public Transport Authority.[617] The authority was later split into two in 1961.[618] The establishment of a unified authority proved successful in increasing the electricity coverage in the country. While in 1962, less than one-third of the villages were

608 World Bank (2009)
609 World Bank (2013)
610 Economist (2013)
611 World Bank (2013)
612 World Bank (2013)
613 World Bank (2013)
614 World Bank (2013)
615 World Bank (2013)
616 Bassil (2010b)
617 Hasbani (2011)
618 Hasbani (2011)

connected to the network, but by 1974 only 50 villages lacked access.[619] However, the civil war in 1975-1990 not only damaged the infrastructure but also the governance of the sector and EdL. Most notably, the displacement of customers due to the war, the inability to formalize their connections in their new locations, and the negligence of customers to pay the bills contributed to EdL's decline.[620]

Apart from EdL's monopoly in the sector, a number of small concessions exist in the distribution of electricity. These distribution companies cover a very small part of the overall network. The number of customers connected to the concessionary distribution companies is 82,000, which is only 6.4 percent of the total number of connections in the country.[621] Concession companies buy electricity at reduced prices around 50 to 75 LBP/kWh compared to a cost of 225 LBP/kWh, resulting in losses for the EdL.[622]

Unregulated private generators and self-generation constitute a significant part of the total electricity generated in Lebanon. Due to the frequent power outages in Lebanon, customers heavily rely on private generators or their own power outlets as a back-up source. Only 61 percent of the total demand is estimated to be supplied by EdL while 34 percent was supplied by self-generation with the rest of the demand being suppressed (unmet).[623] With 92 percent of households relying on this informal market, revenues of the sector were estimated to be $1.7 billion or 3.7 percent of 2014 GDP.[624]

Electricity subsidies place a heavy financial burden on the government's budget, feeding a system of inefficiencies. In Lebanon, budget transfers to EdL constitute one of the government's largest expenditures, along with personnel costs and interest payments.[625] Between 1992 and 2013, an average 2.3 percent of GDP was spent as transfers to EdL, however, in recent years, transfers increased significantly reaching an average of 4.4 percent of GDP per year[626]. The amount transferred exceeded $2 billion per year in 2012.[627] Lebanon is heavily dependent on oil for electricity production, hence the size of transfers to EdL generally reflect the changes in global oil prices. With a recent drop in oil prices, transfers to EdL are expected to be lower in 2015, but electricity subsidies will continue to constitute a significant share of the public debt of the country.[628] According to an estimate by the World Bank, Lebanon's public debt-to-GDP ratio would have been 87.8 instead of 143.1 if EdL operated without making losses.[629]

The low level of current tariffs undermine the financial stability of EdL. A nominal tariff freeze has been in place since 1996, which does not reflect the rising costs of oil and remains far below cost recovery levels.[630] Although it uses an inverted tariff system, the current tariff structure is not equitable due to high fixed costs. In addition, since all users are subsidized by the government whether small or large, poor or rich, the tariff structure is not progressive. The tariff structure could be revised substantially to improve service delivery without hurting households since households actually have a high willingness to pay for better services.

619 Hasbani (2011)
620 Hasbani (2011)
621 Bassil (2010b). The share is calculated by the author.
622 Bassil (2010b)
623 World Bank (2008)
624 World Bank (2015c)
625 World Bank (2015b)
626 World Bank (2015b)
627 World Bank (2015b)
628 World Bank (2015c)
629 World Bank (2015b)
630 World Bank (2015c)

Results of a survey by the World Bank showed that an average household would pay 56 percent more than their current bill in exchange for a 24-hour continuous electricity supply.[631] Tariff increases as large as 100 percent were estimated to still be within the affordability range for households in all income levels.[632]

Applying the Accountability Framework to Lebanon's Electricity Sector

In Lebanon, the legal framework for unbundling and privatizing the utility company already exists since 2002. The Electricity Law (Law 462/2002) sets out an outline for restructuring the sector. The law calls for (i) establishing an independent regulator for the sector, (ii) separating generation, transmission and distribution activities and establishing commercial public corporations responsible for production and distribution, (iii) transferring up to 40 percent of the shares of the initially government owned public corporations to private companies and (iv) retaining the transmission company in public ownership and engaging private companies only through management contracts.[633] A number of key steps to implement the law were not taken until July 2006. A committee was later formed to implement the Decree and for the restructuring of the sector.[634] However, the war with Israel in 2006 destroyed some parts of the infrastructure and caused a political stalemate, inhibiting the country from implementing the law.[635] As of today, the law has still not been implemented.

With the new government, in 2010, a policy paper was prepared by the Ministry of Energy and Water and accepted by the Council of Minister in an effort to reform the sector. The policy paper puts forward a set of measures to be implemented in order to reach 24 hour service delivery by 2014. With regards to the governance of the sector, the policy paper calls for the corporatization of EdL. This process was supposed to be completed in 2013 and includes relieving EdL of some of its responsibilities by engaging independent power producers and operations and maintenance contracts. In addition, the Policy Paper calls for initiating a process to revise the Electricity Law (Law 462).

In fact, implementing the Electricity Law would likely improve the accountability relationship between the state and the service provider in the delivery of electricity services. Corporatization is "the act of reorganizing a State Owned Enterprise into a legal entity with corporate structures similar to other companies, including a board of directors, management, and shareholders."[636] This shift in the legal identity of utilities aims to "allow the government to retain ownership but still enable it to run SOEs efficiently and on a more commercial basis like other companies."[637] Hence, unbundling and privatization aside, only the corporatization of the public utility as envisaged in the Policy document would improve "compact" by separating the service provider from the policymakers more clearly. Corporatization of the utility could help in terms of increasing the autonomy of service provision, increasing the focus on profitability, and reducing the interference of the government.

631 World Bank (2009)
632 World Bank (2009)
633 Law 462, Higher Council for Privatization. http://www.hcp.gov.lb/pages.asp?pageid=4&subid=17
634 World Bank (2008)
635 Hasbani (2011)
636 World Bank (2014)
637 World Bank (2014)

3.4 Indonesia

3.4.1 Country Background

The Republic of Indonesia is made up of approximately 17,000 islands across the Indian Ocean with over 80 percent of the population living in Java and Sumatra islands. The world's 4th most populated country, Indonesia is rapidly urbanizing with more than half of its population living in urban areas. The urban population has more than doubled from 56 million in 1990 to 131 million in 2013. As a nation of islands, Indonesia also has many remote rural areas with concentrations of the country's poor population. The geographic disparities and rapid increase in urban population has made service delivery challenging for Indonesia.[638]

	Indicator	Value	Year
Population	Population, total	249,865,631	2013
	Population growth (annual %)	1.21	2013
	Urban population (% of total)	52.25	2013
	Population ages 0-14 (% of total)	28.89	2013
GDP	GDP growth (annual %)	5.78	2013
	GDP per capita, PPP (constant 2011 international $)	9,254.42	2013
Poverty	Poverty headcount ratio at $1.25 a day (PPP) (% of population)	16.2	2011
	Urban poverty headcount ratio at national poverty lines (% of urban population)	9.2	2011
	Rural poverty headcount ratio at national poverty lines (% of rural population)	15.7	2011
Inequality	GINI index (World Bank estimate)	38.14	2011
	Income share held by highest 20%	43.65	2010
	Income share held by lowest 20%	7.63	2010

Source: World Bank, World Development Indicators

Indonesia, a lower-middle income country, had strong annual GDP growth of 5.78 in 2013. In 1997, Indonesia was greatly impacted by the Asian financial crisis pushing the country into low income status for several years. Despite the crisis, income per capita has more than doubled over two past decade to US$9,254 in 2013 from US$4,295 in 1990. However, the country still faces widespread poverty with 16.2 percent of the population falling under the US$1.25 a day poverty line.[639] Vulnerability to poverty is also high in Indonesia with 43.3 percent of the population falling under the 2 USD per day poverty line, and with a large percentage of the population hovering just above the poverty line, which means small shocks to households through income or prices can have drastic effects on the national poverty rate.

Indonesia is made up of 34 provinces that are subdivided into 416 districts and 98 municipalities.[640] Districts are further sub-divided into 7.024 sub-districts and 1.626 villages.[641] In 2004, Indonesia passed a Law 32/2004 transferring service delivery from the central government to the district, sub-district and village governments allowing greater authority and responsibility in planning, financing, implementing, and managing regional and

638 World Bank (2015)
639 World Bank, World Development Indicators
640 Permendagri No.39 (2015)
641 BPS (2015)

local infrastructure services.[642] As per this law, the education sector, health care sector, and water and sanitation sector underwent a decentralization process over the past decade.

3.4.2 Education Sector

Access to and Quality of Education

Overall access to primary education did not improve over the past two decades, but it did improve for the poor. The adjusted net enrolment rate for primary school was 95.3 percent in 2012, which decreased from 97.9 percent in 1990.[643] Enrolment in Indonesia is better than the average enrolment rate for OIC lower middle income countries, which is 80.9 percent.[644] The enrolment rates across income levels are better for wealthier children but indicate an improvement from 1990 for the poor. For children in the poorest income quintile, net enrolment was 91.6 percent in 2012, up from 89.1 percent in 1990 and, in the wealthiest quintile, net enrolment was 98.5 percent in 2012, up from 98.4 percent in 1990.[645]

Indonesian student outcomes are low. Indonesian students are assessed using the Progress in International Reading Literacy Study (PIRLS) and the Trends in International Mathematics and Science Study (TIMSS). PIRLS results indicate an improvement with 4th grade students at or above the low international benchmark in reading increased from 54 percent in 2006 to 66 percent in 2011. [646] But, TIMSS results for mathematics and science do not indicate an improvement. For maths, TIMSS indicates that the percentage of students at or above the low international benchmark fell from 48 percent in 2006 to 43 percent in 2011.[647] Scores for science had no change between the two years.

Differences exist in primary school enrolment and student outcomes across geographical regions. A gap in enrolment exists across districts, but is narrower than it was in 2001. As an example, enrolment rates in the remote region of West Papua are 46 percent for junior secondary school.[648] Student outcomes also vary across provinces and districts, with poorer or more remote districts achieving less than wealthier districts. Scores on a national examination, the Ujian Nasional (UN) examination, indicate spread of 23 percentage points across average scores by province.[649]

Drop-out rates among primary school students are already low, but there is room for improvement. The survival rate for primary education was 89 percent in 2011 compared to 79.9 percent in 1990.[650] The drop-out rate is higher in rural areas suggesting that distance to school is a barrier.[651] Students in Yogyakarta are three times more likely to attend an early education centre (ages 4 to 6) than children in the more rural Papua.[652] Poorer households are more likely to drop out, children age 18 to 20 in the poorest districts complete on average 6 years of education compared to children from the wealthiest districts who complete 8 years of education.[653] However, while dropouts in urban areas tend to occur among poorer children, they occur at all income levels in rural areas.

642 Asian Development Bank (2012)

644 World Bank, World Development Indicators
645 World Bank, World Development Indicators
646 World Bank (2013a)
647 World Bank (2013a)

649 World Bank (2013a)
650 World Bank, World Development Indicators
651 World Bank (2013b)
652 World Bank (2013b)
653 World Bank (2013b)

The quality and quantity of teachers in Indonesia are low. Studies indicate that a teacher's subject matter expertise has a direct link to student outcomes. A recent teacher competency assessment indicated that only 20 percent of teachers obtained a score above the benchmark for base level competency in subject matter and pedagogy.[654] A certification program was introduced but has not shown tangible results in terms of student outcomes.[655] The ratio of pupils to teachers is 18.6 in Indonesia, which is significantly lower than the average for OIC countries at 28.6. Like all other indicators of education quality, this too varies across districts.

Modality of Service Delivery

Indonesia recently transitioned to a school-based management system. Starting in 2001, Indonesia devolved several responsibilities associated with the provision of education to district governments and, in 2003, to schools themselves through district-level education boards and school committees.[656] A 2005 law introduced certification and training programs for teachers and provided guidelines for school-based management. Increased school and community involvement in management strengthens the accountability of the education sector by improving community participation in decision-making through school committees and bringing management closer to local communities.[657]

The central government maintains a role in the education sector by formulating education policy, establishing curriculum, and setting national standards.[658] Provincial governments play a role in human resource recruitment and helping schools achieve international standards in education.[659] The District governments shoulder the largest responsibility by overseeing the organization of education, hiring and managing school staff, and the establishment and registration of schools.[660]

An education board, chaired by the principal and composed of teachers, manages the school. The school advisory committees include parents, community members, education experts and/or practitioners and provide input on education policy and programs, budget plans, and teacher training. They also raise money to support education and supervise education policy and program implementation.[661] The members are elected and are broadly representative of the community, though there are some reports that this is not occurring as instructed.[662]

Each school develops an annual and four-year plan that includes their vision, mission, and goals based on input from all stakeholders, chaired by principal and approved by the education board. The plans are incorporated into the District's education sector planning process. The principal, along with the District government, manage the school's day-to-day activities. A teacher is assigned to responding to complaints and requests from the public. [663]

Financing for education increased substantially as part of recent reforms. Indonesia approved a constitutional mandate in 2002 to allocate at least 20 percent of the government's budget to education. In 2009, they achieved this but, in 2012, the level was 18 percent. Government expenditure in education in 2012 was 3.6 percent of the GDP, which is slightly lower than the OIC average of 4.0 percent. International aid to primary education increased

654 Indonesian Ministry of Education, Ujian Kompetensi Guru exams, 2012
655 World Bank (2013b)
656 World Bank (2013a)
657 World Bank (2013a)
658 World Bank (2013a)
659 World Bank (2013a)
660 World Bank (2013a)
661 Vernez, Karam, Marshall (2012)
662 Vernez, Karam, Marshall (2012)
663 World Bank (2014a)

from $50 million in 2003 to $172 million in 2012, which is $2 per child to $6 per child. The implementation of school-based management was supported by several development organizations including the World Bank, UNICEF, UNESCO, ADB, USAID, JICO, and AusAID.

Like management, education financing is shared among all levels of government. The district governments provided 61 percent of public education spending in 2009, the central government provided 38 percent, and the province governments provided only 1 percent. District government funding is mostly allocated towards operations and maintenance including teacher salaries and supplies. Central government funding is allocated for non-salary expenditures such as technology provision, student scholarships, school rehabilitation, or other improvement programs. [664]

Out-of-pocket expenditure can inhibit poor households from accessing basic education services. Primary schools, since 2009, are prohibited from charging monthly tuition fees, but they do collect "voluntary fees" and contributions. A household's out-of-pocket expenses related to education remain high with transportation, meals, supplies and uniforms. The average per-capita expenditure on primary school education for a student in the poorest quintile is $26, which is approximately 15 percent of per capita household expenditure.[665]

The private sector plays an important role in education in Indonesia. In 2012, 17.3 percent of primary school age children are enrolled in private primary schools.

Applying the Accountability Framework to Indonesia's Education Sector

Alongside the transition to school-based management, Indonesia introduced several complementary programs that increased the financial decision-making power of schools and communities. In 2005, Indonesia introduced Bantuan Operasional Sekolah (BOS), a national school grant program that aimed at offsetting household vulnerability to fuel price hikes.[666] As per the program design, school management committees and school advisory committees decide how to spend the grant based on a menu of options. The amount of funding through BOS is allocated on a per student basis as an incentive for schools to increase enrolment.

BOS played a significant role in paving the way to school-based management in Indonesia because it provided a regular stream of funding to schools to implement at their own discretion. Schools generally have little discretion over education funding and need to communicate funding needs to government officials, which can sometimes lead to a breakdown in the route to accountability. The lack of funding affects poorer districts more than wealthier districts because wealthier districts are more self-sufficient with the ability to generate funds for school improvements.

By 2012, the BOS program provided block grants to 228,000 schools at an estimated US$1.7 million cost.[667] Some schools used the funds to purchase supplies, some provided food for students, did maintenance or repairs to the school, contributed to poor students for transport or uniforms, or provided professional development for staff. BOS funds could also be used to hire teachers or personnel, as long as the amount allocated to such activities did not exceed 20 percent of the school's staff costs.

For many districts, it succeeded in providing a vehicle for the transition to school-based management by increasing school and community participation in the decision-making

664 World Bank (2013a)
665 World Bank (2013b)
666 World Bank (2007)
667 World Bank (2014a)

process, although the program is also widely criticized for having little impact on lowering household costs. More than 60 percent of the schools that received BOS funding reported that school committees were involved in the final decision-making process for financial matters, which illustrates the importance of the program for building capacity for school-based management.[668]

One flaw in the program design was the level of outreach to communities. It was found that districts with less prior experience with community participation were less likely to engage households, particularly poor or marginalized households. Better outreach to poor households on how BOS operated and on the value of their input could potentially lead to lowering education costs, which was the goal of the program.

Another important subsidy program that engaged the community was PNPM Generasi, also known as the national Community Empowerment Program. PNPM Generasi was introduced in 2007 and provided block grants to rural communities to make improvements in education and maternal health. Provided by the central government, by 2009, the program covered 2000 villages in 5 provinces with an annual budget of $40 million.[669] Community members and district governments work with a trained program facilitator in a participatory planning exercise to determine how to use the funds. The size of the annual block grant is based on the village's previous year's performance against targeted indicators. The program has been linked to several positive impacts including a decrease in malnutrition, increase in maternal health, and an increase in primary school enrolment. [670]

In 2007, Government of Indonesia launched a nationwide programme of the so-called Program Keluarga Harapan (PKH, Family Hope Programme), a conditional cash transfer programme which provides direct cash benefits with conditionality to ultra-poor households if they access health and education facilities. This programme was designed for extremely poor families (10% of the bottom of the official number of the poor) where the pregnant mothers and infants must regularly check their health, and school aged children must go to school with monthly 85% of class presense.

A study by World Bank (2011) showed PKH led to a more intensive participation in class for those students who were already attending school. The hours spent in the classroom for students aged 13-15 years old increased by approximately 0.7 hours per week. Further a research by Smeru (2011) found PKH had a role in lowering the level of student absences, especially the beneficiaries in rural areas in NTT.

In 2014, the government launched Indonesia Smart Card (Kartu Indonesia Pintar/KIP), which guarantees and ensures that all school aged children from disadvantaged families receive financial assistance for education up to the completion of high school/vocational school.

Indonesia's school-based management system is designed to encourage a bottom-up approach to education service delivery but, for many districts, the system is not working at its full potential. The transition to a school based management system is intended to improve accountability by incorporating parents into the delivery of education services. While enrolment rates increased, the quality of education has had little improvement. Programs like BOS and PNPM Generasi helped schools through the transition by providing financial incentives, but many schools and communities, particularly in remote areas where capacity is

668 World Bank (2014a)
669 Olken, Onishi, Wong (2011)
670 Olken, Onishi, Wong (2011)

low, do not indicate a full understanding of the school-based management system and are not taking advantage of its possibilities.[671]

A national survey found that school advisory committees were involved in about 40 percent of decisions made by the school.[672] Furthermore, few district governments recognize and utilize school planning processes. For schools that did involve the community in their school development plans, only 12 percent of district governments incorporated the plans into their education planning process.[673] In many Districts, communication between district governments, schools, and the advisory committees was insufficient.[674]

The participation in the school advisory committees was found to sometimes be subjected to clientelism. The committee members, who are to be elected and representative of the community, were instead appointed by government officials. Less than 15 percent committee chairs and less than 25 percent committee members were elected.[675] As a result, they may not be representative of the community at large. The presence of clientelism undermines the process of community participation because it leads to favouritism among certain populations and potential marginalization of other segments of the population.

The transition to school-based management as well as pay-for-performance schemes through community block grants can -in theory- improve accountability and lead to better education outcomes, by increasing both compact and client power. However, it is important to take steps to fully implement the system by better clarifying roles and improving local capacity for implementation. When district governments, schools, and communities are better informed on the system and their roles and when school administrators have the resources and capacity necessary to implement school-based management, such innovative service delivery models are likely to deliver better results for Indonesia.

3.4.3 Health Care Sector

Access to and Quality of Health Care

The health of Indonesians has improved substantially over the past two decades. The under-five mortality rate improved substantially from 29.3 deaths per 1,000 live births in 2013 from 84.3 deaths per 1,000 live births in 1990, putting Indonesia closer to achieving the Millennium Development Goal.[676] Immunizations for measles improved to 84 percent of children age 12-23 months in 2013 from 58 percent in 1990. Maternal mortality rate improved to 190 deaths per 100,000 live births in 2013 from 430 deaths in 1990.[677] 83.1 percent of women were attended by skilled health staff during childbirth in 2012, up from 40.7 percent in 1990.[678]

However, the quality of health care varies substantially across geographies and income groups. For example, the rate of under-five mortality is 70 percent of 1,000 live births among the poorest income quintile compared to 23 percent in the richest quintile in 2011.[679] While the gap between the richest quintile and poorest quintile has narrowed since 1990, from 79.8 to 47.0 percentage points in 2011, the under-five mortality rate in more remote provinces is

671 Vernez, Karam, Marshall (2012)
672 World Bank (2014a)
673 World Bank (2013a)
674 Vernez, Karam, Marshall (2012)
675 World Bank (2014a)
676 World Bank, World Development Indicators
677 World Bank, World Development Indicators
678 World Bank, World Development Indicators)
679 World Bank, World Development Indicators

two to three times higher than other provinces.[680] In terms of maternal health, 97.4 percent of the wealthiest quintile had skilled assistance during birth – an indicator closely linked to reducing maternal mortality - compared to only 60.4 percent of the poorest quintile in 2011.[681] Also, 89.5 percent of the wealthiest quintile was immunized for measles compared to 64.7 percent of poorest quintile in 2011.[682]

The Indonesian health care system suffers from severe supply side constraints. Countrywide, Indonesia has a network of over 9,000 primary health centres (*puskesmas*) at the sub-district level. Each puskesmas is intended to serve approximately 25,000 to 30,000 people and functions as a gateway provider that refers to secondary or tertiary providers. Indonesia has 1,632 secondary-care hospitals with 163,000 beds and 376 tertiary hospitals. Tertiary hospitals are primarily public, whereas half of the secondary hospitals are private. Indonesia also has a shortage of 13,875 hospital beds based on their population. [683] Health care facilities are not equally distributed across the country. In 2010, there were an average 3.79 puskesmas per 100,000 people nationwide, some provinces have fewer than 2 puskesmas per 100,000 people while others, particularly in the eastern part of Indonesia, have up to 12 per 100,000 people.[684] This is also driven by differences in population density across the provinces. Some areas have a more severe shortage of hospital beds with less than 50 percent of beds required to serve the population.[685]

Skilled staff is not equally distributed across all provinces. Indonesia has an average of 2 doctors per 1000 people in 2012, an improvement from 1 doctor per 1000 people in 1990. The WHO benchmark is 2.3 doctors per 1000.[686] However, approximately 65 percent of all doctors are concentrated in the Java-Bali region, leaving a gap in more remote parts of the country.[687] Approximately 25 percent of puskesmas do not have any doctors on staff.[688] Between 20 to 30 percent are without one of four basic medical specialities[689].

Facilities suffer from a lack of supplies and basic services. Only 72 percent of puskesmas had water access, 74 percent have adequate toilet facilities, 84 percent had access to basic communication systems such as telephones.[690] Regional differences in conditions vary widely. In Papua, only 40 percent of puskesmas had water and sanitation facilities compared to 80 percent or more in provinces in Java.[691] Additionally, there are fewer services offered at rural puskesmas. For example, 53.4 percent of rural puskesmas have basic emergency obstetric services compared to 73.3 percent urban puskesmas.[692]

High instances of leakages or gaps exist in access to health care. The right to universal health coverage was mandated by an amendment to Indonesia's 1999 constitution[693], but the country is still working towards provision. In 2005, Indonesia introduced *Jamkesmas*, a government-financed health insurance program for the poor and near poor. The program

680 Harimurti et al. (2013)
681 World Bank, World Development Indicators
682 World Bank, World Development Indicators
683 Harimurti et al. (2013)
684 Harimurti et al. (2013)
685 Harimurti et al. (2013)
686 World Bank, World Development Indicators
687 Harimurti et al. (2013)
688 Harimurti et al. (2013)
689 Four basic specialties are general surgery, internal medicine, obstetrics/gynecology, and pediatrics as outlined by Harimurtu et al. (2013).
690 World Bank and Indonesia National Institute of Research and Development. (2014)
691 World Bank and Indonesia National Institute of Research and Development. (2014)
692 Harimurti et al. (2013)
693 World Bank and Indonesia National Institute of Research and Development. (2014)

provides coverage to more than 76 million people, which is one-third of Indonesia's population.[694] However, a 2011 survey found that only 33 percent of the participants are poor or near poor meaning the program has considerable leakage to non-poor.[695] *Jamkesmas* replaced the former *Kartu Sehat* program, which was introduced in 1998 and provided health insurance cards to the poor. *Kartu Sehat* reached only 20 percent of the population but almost 80 percent had difficulties using it for access to health care.[696]

Other publicly provided insurance programs are *Jamsostek Health,* for those employed in the formal sector, was established in 1992 and serves 5 million people, and *Askes,* for civil servants, was established in 1960 and serves 16.6 million people.[697] Firms with more than 10 employees are required to participate in *Jamsostek* but firms can opt-out of provision if they provide private voluntary health insurance. As a result, only 15 percent of formal sector employees are insured through *Jamsostek*. As of 2013, almost 60 percent of the population remains uncovered by any insurance, many of which are employed in the informal sector.[698] The Universal Health Insurance Coverage program outlined below changed this reality, though the program is currently not yet fully funded and operationalized.

Modality of Service Delivery

Indonesia's health care sector is currently undergoing reforms aimed at universal health coverage by 2019.[699] Starting in 2014, per the 2011 *Badan Penyelenggara Jaminan Sosial Law,* Indonesia merged *Jamkesmas*, *Jamostek Health*, and *Askes*, along with other existing social health insurance schemes to streamline uniform benefits under a single umbrella insurance administrator. Referred to as *BPJS Kesehatan,* the umbrella insurance administration is expected to contract with public and private providers to deliver a standard benefits package to all citizens.[700] Starting on January 1, 2014, 121.6 million people were enrolled in the *BPJS* program, 96.4 million of which are poor or near poor.[701] The program is expected to be fully operatized by 2019.

Health care provision is decentralized but the Ministry of Health retains considerable control. As per the 2001 decentralization laws, health care provision was decentralized and district and municipal governments are now the key administrative units for health care provision.[702] The Ministry of Health maintains policymaking, financial, and managerial responsibilities.[703] The Ministry develops sector objectives, minimum performance standards, human resources planning, and preparation of annual planning exercises. District and municipal governments are responsible for day-to-day management of health facilities, human resources, and salaries. The central government retains control over staff allocations and planning, which limits the district government's authority in hiring staff.[704] The universal health insurance program (*BPJS Kesehatan*) is managed by the central government, but supervision and monitoring activities occur at the local level. Targeting for the program is determined through quotas set at the central government but district governments are involved in selecting, registering, and interfacing with recipients.

694 Harimurti et al. (2013)
695 Marzoeki et al. (2014)
696 Soors et al. (2010)
697 Marzoeki et al. (2014)
698 Harimurti et al. (2013)
699 Global Health Workforce Alliance (2012)
700 World Bank and Indonesia National Institute of Research and Development (2014)
701 Marzoeki et al. (2014)
702 Global Health Workforce Alliance (2012)
703 Gobal Health Workforce Alliance (2012)
704 Global Health Workforce Alliance (2012)

Although the public sector generally plays the dominant role in health care, private providers play a dominant role among wealthier households. As per recent health care reforms, Indonesia encourages the participation of the private sector as both insurers and providers. In terms of providers, about 62 percent of all hospitals are private. Among the top three income deciles, 69.5 percent use private facilities over public facilities for outpatient care, compared to 51.6 percent of the bottom three deciles.[705] Approximately 60 percent of all outpatient visits occur at private facilities, mostly at the primary care level.[706] Also, 70 percent of public sector doctors also practice privately.

While central government is the primary source of financing for health care provision, district governments have some discretion over expenditure.[707] District governments are responsible for managing operation budgets for puskesmas and secondary care facilities including supply-side investments such as equipment or drugs. The Central government manages operational budgets for tertiary hospitals and contributes towards special programs at all levels including immunizations, contraception, or communicable disease prevention.[708]

Public health expenditure is low in Indonesia - compared to other OIC countries - at 1.2 percent of GDP in 2012, which represents an increase from 0.7 percent in 1995. The average public expenditure on health care for OIC countries is 2.6 percent of GDP. Health expenditure was 6.9 percent of all government expenditure in 2012, up from 4.8 percent in 1995.[709] External assistance is low, at 1.1 percent of total health expenditure in 2012. [710]

Out-of-pocket expenditure is high for both insured and uninsured. The out-of-pocket expenditure in Indonesia was 45.5 percent of total expenditure on health in 2012.[711] This is, in part, because more than half the population are not covered by insurance and use private health care facilities. About 50 percent of out-of-pocket expenditure is from the top three wealthiest decile and 15 percent from the bottom three deciles.[712]

The financing system for universal health insurance for the poor is complex and is not always fully funded. In the case of *BPJS Kesehatan*, the cost of health care services incurred by a patient is reimbursed as a fixed fee to the health care provider by the Ministry of Finance.[713] However, the reimbursed cost does not directly cover the full cost of services. The Ministry also provides supply side subsidies to health care providers in the form of staff salaries, capital improvements, or operational costs. Furthermore, the district sets the reimbursement amount for services, but the central government provides the financing, which results in some mismatch between requirements and actual funding.[714]

Applying the Accountability Framework to Indonesia's Health Care Sector

The partial decentralization of health care has led to a lack of accountability among health care providers in Indonesia. The central government still retains budgetary control over many aspects of health care provision. This is particularly evident in the allocation of human resources. The central government develops an annual plan for each district including minimum staffing needs based on demographic changes, health status, and existing health

705 Marzoeki et al. (2014)
706 Marzoeki et al. (2014)
707 Harimurti et al (2013)
708 World Bank and Indonesia National Institute of Research and Development (2014)
709 World Health Organization Global Health Observatory Repository
710 World Health Organization Global Health Observatory Repository
711 World Health Organization Global Health Observatory Repository
712 Harimurti et al (2013)
713 Harimurti et al. (2013)
714 Harimurti et al. (2013)

programs. The district government and health centres provide little input into their staffing needs, which often results in a mismatch in skills or a shortage in human resources.[715] Districts can petition for additional staff, but many resort to the central government's staff plan. Furthermore, decentralization has made it difficult for staff to be reassigned to different levels or different locations.[716]

Public health care providers have little incentive to provide quality care and compact is low. Doctors in Indonesia do not have performance-based incentives to improve quality of service. Up to 70 percent of physicians are also practicing privately, and there are reports that they refer public sector patients to their affiliated private practices. In addition, Indonesia's accreditation and licensing procedures are weak.[717]

Indonesia recently re-established a policy to incentivize doctors to work in remote and rural locations, but it is not as strong as its predecessor program. Before the financial crisis of 1997, Indonesia had a mandatory policy of civil service for medical school graduates for up to 5 years. Incentives were in place for remote areas that included additional benefits, shorter terms of 2 to 3 years and a more priority for preferred future civil service postings. [718] Following the financial crisis, the government could not afford to offer incentives and civil service was no longer an attractive career track. As a result, skilled staff declined in remote areas. More recently, Indonesia implemented a policy offering recent graduates shorter contracts (up to 6 months) and an additional 250 percent on top of their base salary. Other policies such as internship programs and recruitment and outreach were also implemented.[719] While there is still a heavy bias towards urban locations, the number of graduates taking rural or remote posts has improved.[720]

Another challenge that Indonesia faces is a lack of financial support to make improvements in facilities or supplies, particularly in remote geographies. Indonesia's public expenditure on health care as a percent of GDP is among the lowest of OIC countries.[721] Achieving universal health care will be more effective with increased funding. Quality of health care facilities is low and there is a high instance of health care employees moonlighting in private practice, indicating that salaries are not competitive. Increasing overall funding to the sector, while providing clear guidelines on expenditure, may result in improvement.

Improved targeting of the poor can improve coverage and make better use of government funds. Because the distribution of income in Indonesia is narrow, with a large percentage of the population just above the US$ 1.25 poverty line and being vulnerable to poverty, identifying poor households for targeting of social assistance programs can be difficult. Given the dynamic nature of households around the poverty line, having a static data base of the poor households (which Indonesia has adopted for several of its social protection programs), can be especially hard and lead to problems in targeting when the lists are not regularly updated. A 2011 survey indicated that the *Jamkesmas* program, which is now rolled into *BPJS Kesehatan*, had a considerable amount of leakage to non-poor households, with one-fifth of the participants belonging to the top three income deciles.[722] By improving targeting mechanisms, through the implementation of a mix of community and household level targeting, Indonesia can increase coverage among those who need it most.

715 Global Workforce Alliance (2012)
716 WHO (2008)
717 WHO (2008)
718 Global Health Workforce Alliance (2012)
719 Marzoeki et al. (2014)
720 Global Health Workforce Alliance (2012)
721 World Health Organization Global Health Observatory Repository
722 Harimurti et al (2013)

The conditional cash program PKH aimed to reduce poverty and improve social welfare by providing cash transfer to vulnerable household that comply with a set of health and education conditions. The health condition include the utilization of services including antenatal and postnatal care, growth monitoring, immunizations and vitamin A supplementation. The study found PKH had positive impact on a range of health indicators, i.e. visits to Posyandu (local voluntary health services) increased by 3 percent, child growth monitoring increased by 5 percent and immunisation activities increased by 0,3 percent (TNP2K, 2013). While the study by World Bank (2010) showed the increase number of pre natal care by 9-13 percent, post natal care by 21 percent, growth monitoring by 22% and utilization of skilled birth attendants by 5 percent. A study by World Bank (2010) found that PKH had positive spill over impact to non PKH member, such as prenatal check increased by 4 percent, growth monitoring increased by 7 percent and utilization of skilled birth attendant by 8 percent.

3.4.4 Water and Sanitation Sector

Access to and Quality of Water & Sanitation Services

Almost three quarters of Indonesians obtain water through self-provision by accessing ground water or collecting surface water. Access to an improved water source increased to 84.9 percent in 2012 from 69.7 percent in 1990.[723] Half of Indonesian residents use groundwater for drinking water obtained from wells or hand pumps. The other half of the population uses surface water from lakes, streams or rain (18 percent), piped water supply (15 percent), or bottled water (13 percent).[724]

In rural areas, access to an improved water source increased from 61.0 percent in 1990 to 76.4 percent in 2012, which can be attributed to both advances in rural water supply and a declining rural population[725]. Approximately 15 percent of rural households purchase water from small-scale community-based supply organizations while the remainder collect or access water on their own.[726]

In urban areas, 93 percent of the population had access to an improved water supply in 2012, compared to 89.6 percent in 1990.[727] While the government has made an effort to increase piped water supply, half of all urban residents use groundwater through shallow or deep wells.[728] The other half of urban residents are using piped water supply or purchasing bottled water.[729]

Sources of water used varies across income groups with poor households often unable to access the piped water supply. More than half of the wealthiest quintile use bottled water as their primary source of drinking water.[730] In the poorest quintile, 80 percent of households use a groundwater pump or well, followed by 7 percent using piped water and 7 percent using bottled water.[731] Although the public piped water supply is lower in cost than water from private providers, the poor face several barriers to accessing it including high up-front connection fees and a -rather prohibitive- home ownership requirement to establish connection to the piped water supply.[732]

723 World Bank, World Development Indicators
724 WIRA Study Team (2012)
725 World Bank. World Development Indicators.
726 WIRA Study Team (2012)
727 World Bank, World Development Indicators
728 WIRA Study Team (2012)
729 WIRA Study Team (2012)
730 World Bank (2015)
731 World Bank (2015)
732 WIRA Study Team (2012)

The quality of water is poor. The quality of water extracted from ground wells is unregulated and has the risk of being highly contaminated. Indonesia has the highest instance of typhoid in South Asia, which is a waterborne disease[733] and there are reports that the water supply carries E.coli. Each year, more than 33,000 children die from diarrhoea and 11,000 from typhoid, likely contracted from drinking water or sanitation practices.[734] The piped water system in Jakarta is treated, but the pipe networks are often poorly maintained and can result in contamination.

Access to sanitation is improving but continues to be a problem in Indonesia. Access to improved sanitation services increased to 58.8 percent in 2012 from 35.2 percent in 1990.[735] While this is a substantial improvement, it is still very low and is particularly low in rural areas where only 37.4 percent of the population had access to improved sanitation in 2012, up from 23.7 percent in 1990.[736] In urban areas, 71.4 percent of the population had access to improved sanitation in 2012 and 61.1 percent in 1990.

Communal and on-site wastewater systems were constructed in 591 districts across the country. However, utilization of the facilities remains low or totally unused.[737] A quarter of households in rural areas and 7 percent of households in urban areas rely on open defecation.[738] Less than 1 percent of urban households have access to a piped sewer systems, most use on-site septic tanks or communal systems. Septic tanks are generally of poor quality, not properly sealed, or have a single chamber. Less than 5 percent of household wastewater from septic tanks is disposed of safely.[739]

Disparities in access to sanitation exist across income levels and regions. In urban areas, 90 percent of households in the wealthiest income quintile had access to improved sanitation compared to 56 percent of the poorest quintile. In rural areas, 71 percent of the wealthiest households had access to improved sanitation compared to 31 percent of the poorest quintile.[740] In rural areas, open defecation occurs across all income segments.[741] Access to improved sanitation varies substantially across regions. In Jakarta, 87 percent of households use an improved toilet connected to a septic tank or sewerage system compared to 28 percent of the population in Papua, where open defecation is the primary sanitation solution.[742]

Modality of Service Delivery

Provision of water services in Indonesia is decentralized, but central government still exerts considerable control. Local governments provide piped water services through Performance Monitoring of Water Supply Companies (PDAMs). Indonesia has 341 PDAMs that manage roughly 8 million water connections.[743] The role of PDAMs has evolved considerably since their creation in the early 20th Century, but it is complex and involves many actors. Following the economic crisis in 1997, PDAMs were unable to adequately deliver services and, except for 21, were in close to critical condition with outstanding debts. Over the following decade, laws were enacted by the central government to restructure PDAMs, devolve oversight

733 WIRA Study Team (2012)
734 World Bank (2014b)
735 World Bank, World Development Indicators
736 World Bank, World Development Indicators
737 World Bank (2015)
738 World Bank (2015)
739 World Bank (2015)
740 World Bank (2015)
741 World Bank (2015)
742 World Bank (2015)
743 ADB (2012)

and management to local governments, and allow involvement of the private sector, community groups, and cooperatives in the delivery of drinking water.

While the management of PDAMs are effectively decentralized to local governments, various ministries in the central government exert considerable control through public works projects, policies, regulations, and financial matters.[744]

- The Ministry of Public Works oversees capital improvement projects in water and sanitation. MoPW also determines policies and standards for surface water supply and sanitation including technical regulations for the construction and operation of water or sewerage treatment facilities.
- Ministry of Home Affairs (MoHA) establishes guidelines for water tariffs, PDAM management, loan management, and accounting. MoHA is also responsible for monitoring performance of local governments and providing support where needed.
- Ministry of Health is responsible for issuing quality standards to ensure clean and potable water quality.
- The Ministry of Energy and Mineral Resources is responsible for regulating groundwater.
- Ministry of Environment establishes policies and implements programs on water pollution and environmental issues.
- Ministry of Mines and Energy are responsible for groundwater exploration.
- National Development Planning Agency (BAPPENAS) is responsible for long and medium term national program planning and the evaluation of program effectiveness.
- The Ministry of Finance (MoF) is the owner of all water and sanitation assets that are state-owned. Also, central government funding is allocated to and managed by the line Ministry and the projects are generally implemented by the provincial or sub-regional government.[745]

Community-based water groups are gaining popularity in Indonesia as service providers since the 2004 Water Resources Law codified their existence. Several villages in Indonesia are simply out of the reach from formal channels of utility provision. One CBO typically provide services to 1,200 low income people. While there is no formal census of CBOs, it is thought that they service up to 800,000 people with piped water throughout the country.[746] Compared to PDAMs, CBOs have performed considerably better in both service provision and water quality. More than 60 percent of CBOs are able to earn more than their expenditures, making it possible to maintain and, in some cases, expand their networks.[747]

The private sector plays a large role in the supply of drinking water. One-third of households purchase drinking water from private entities. Some residents purchase water from private vendors because they do not have access and others do because they do not trust the quality of piped or groundwater, both of which should be boiled before consumption. The market for refilled bottled water has increased substantially in recent years, particularly in urban areas. Between 2000 and 2004, piped water access increased on average by 1 percent annually while bottled water increased by 25 percent.[748] Both water kiosks selling refillable bottled water and small-scale water providers selling groundwater proliferated in an effort to

744 Hadipuro (2010)
745 World Bank (2015)
746 World Bank (2011)
747 World Bank (2011)
748 Hadipuro (2010)

fill in PDAMs gaps.[749] Regulations on the private water market are not stringent and are infrequently monitored, leading to variability in quality and potentially hazardous for consumption.[750]

Sanitation systems are mostly self-provided by households. On-site systems, such as septic tanks, are the primary method of wastewater treatment and disposal. Few areas have sewerage systems. In some regions, the PDAMs manage sewerage services but, in others, they are managed by specially constituted public enterprises (PD-PAL) or public service agencies (BLU-D).

The Sanitation by Communities (SANIMAS) program is a demand-driven program that engages community in the provision of sanitation facilities. Residents choose and install communal septic tanks, communal bathing, washing, and toilet facilities, or small wastewater treatment plants with a sewerage system. Funding for the improvements is provided by the local and central governments, but the community provides labour. SANIMAS operates in more than 100 cities and 22 provinces.[751] The Indonesia Sanitation Sector Development Program (ISSDP) incorporates the principles from SANIMAS and established a framework for extending sanitation services to poor urban areas in 12 cities between 2006 and 2010.[752]

Funding allocated to the water and sanitation sector is very low. Expenditure on the water and sanitation sector almost tripled between 2005 and 2013 from US$615 million to US$1.7 billion, but accounts for less than 1 percent of country's infrastructure expenditure and 0.2 percent of the GDP. [753] Indonesia's allocation is among the lowest in the world; the United Nations suggests that at least 1 percent of GDP is allocated to water and sanitation. [754] Half of all water and sanitation expenditure is from the central government level, whereas 39 percent is at the provincial level and 10 percent by local governments.[755]

Households account for almost one-third of spending in the water and sanitation sector. The average out-of-pocket spending per capita on water supply was US$1.42 in 2013 and accounts for 1.5 percent of total household spending. Households are either paying tariffs for connection to piped water or sewerage system or they paying private water providers and/or services to empty septic tanks. The cost of bottled water is 500 times the price of publicly piped water.[756]

Piped water service is financed through user tariffs, but it is not sufficient to support the sector. Local governments are expected to manage and finance the water and sanitation sector through their local budgets and PDAMs, as part of a 2006 Ministry of Home Affairs regulation, are expected to achieve full cost recovery through collection of user tariffs plus a 10 percent return on investments.[757] PDAMs, in theory, are meant to be the primary source of revenue generation for local governments but this has not occurred at all. To satisfy this regulation, many PDAMs increased tariffs but, even with the increase, few are able to achieve full cost recovery. Local governments mostly lack the financial resources to support PDAMs, which has led to the deterioration of services.

749 Hadipuro (2010)
750 World Bank (2015)
751 ADB (2012)
752 ADB (2012)
753 World Bank (2015), Figures are in 2011 US$
754 World Bank (2015)
755 World Bank (2015)
756 World Bank (2015)
757 Hadipuro (2010)

Applying the Accountability Framework to Indonesia's Water and Sanitation Sector

Weak compact between the central government and PDAMs leads to poor service delivery in water provision. The compacts between PDAMs and the government are very complex with several different government entities responsible for regulating or funding various parts of the delivery chain. No single government entity is fully accountable for managing PDAMs and, as a result, they have little incentive to improve access to services or extend services to poor households. In order to strengthen performance of PDAMs, Indonesia could consider revising its compact to clearly delineate responsibilities and providing performance-based incentives.

Increasing voice can lead to better targeted investments. Because PDAMs are continually operating at a loss, the central government steps in to provide funding. However, the Ministry's focus is on capital improvement spending to increase access to piped water and sanitation systems in mostly urban areas. PDAMs do not have the capacity to connect households to the facilities provided by the Ministry, often leaving them underutilized and unmaintained. Furthermore, households, for multiple reasons, are not taking steps to connect to existing piped infrastructure. In terms of water, the number of households connected is larger than the number that uses it as a primary water source, despite it being much cheaper than purchasing water from private vendors.[758] By taking a more bottom-up, household-oriented approach and allowing for community input, Indonesia can make better use of the funding by addressing issues such as reducing connection fees, improving water quality, increasing safe collection and disposal of waste from septic tanks, or changing attitudes towards open defecation. Legally registered community water forums already exist in several cities and can be the platform for this engagement.[759]

Indonesia has had success involving the community in water and sanitation provision, which, through increased voice and accountability, improves service delivery. It was found that services provided by CBOs are better maintained, more efficient, and most are financially sustainable. A survey conducted by the World Bank in 2011 found that households were willing to pay from 30 percent to 300 percent higher than existing average tariffs for better water service.[760] Replicating or expanding this model or promoting community involvement in service provision can lead to great improvements in Indonesia.

Working with the community to change attitudes towards open defecation or usage of unsanitary unconfined latrines can lead to improvements. Education campaigns can help improve people's attitudes towards public piped water supply or piped sanitation systems. A Water and Sanitation program was implemented by the government of Indonesia, the World Bank and other donors in 29 rural districts in East Java aimed at discouraging open defecation, increasing toilet usage, and generally raising awareness of clean sanitation practices. After the program came to a close, 16 percent of the households built toilets and reported rates of childhood diarrhoea declined by 1.4 percent.[761] While such programs are implemented at a small scale, they illustrate that taking a community-based approach to changing behaviour can result in significantly better outcomes.

758 World Bank (2015)
759 World Bank (2006)
760 Sy (2011)
761 World Bank (2014b)

4. Recommendations

Delivery of services can be improved by strengthening the accountability relationships between actors in the delivery chain. As described in this report and in the framework provided by the WRD 2004, there are two routes of accountability that can be used to improve service delivery to the poor. While increasing financing of services might lead to improvements as well, in order to obtain better value for money - without increasing budgetary requirements- it is necessary to improve the accountability relationships presented in the accountability framework (See Figure 2). This can be done in a number of ways:

4.1. Improving the long route of accountability

1. **Improving Voice**: As indicated in Section 2.1 of the report, the OIC countries analyzed for the study have relatively low levels of voice when compared globally, hence start out at a disadvantage when compared with other countries/regions. Improving "voice" of citizens is generally a long process requiring increased civil society engagement and democratization. Several ways of increasing voice of citizens to make government more accountable can be carried out through information campaigns that inform citizens of their rights. Historically, these processes involve civic engagement and are bottom-up processes that result from citizens' increased awareness of their rights. Where the voices of the poor and the citizens in general are weak, the long route of accountability often fails. While some policies that increase voice of the client through complaints mechanisms or improved monitoring and evaluation of projects are welcome, the recommendations of this report focus instead on improving the short route of accountability in the short to medium term.
2. **Improving Compact:** Governments can strive to improve compact through improved governance and capacity building for civil servants as well as public providers. Compact can be improved via better capacity building as well as pay-for-performance type schemes. All interventions would need to be monitored and evaluated for results to ensure that they have the desired impact. As an example, the Health Transformation Program in Turkey sought to deliver a more equitable distribution of health personnel across regions by implementing a pay-for-performance system coupled with mandatory service as well as incentives linked to the region of services performed. The system has improved in the short term the distribution of doctors and nurses across the country[762]. Any such intervention that seeks to align the incentives of the service providers to provide better services to the poor (or in regions where the poor need the services) needs to be evaluated in the medium term for results.

   Instead of civil servants, private companies or NGOs might be contracted by the central government or local governments to deliver services. This is likely to improve the compact relationship by giving the public sector a choice in who to contract with and hence a power to enforce higher standards of service delivery. In several African countries, private providers and sometimes user groups are responsible for operating small piped water delivery systems through contracts with local governments resulting in service improvements and efficiency gains.[763] Engaging contracted NGOs in public-private partnerships in the health care sector in a number of developing countries was also found to improve health outcomes.

762 Atun et al (2013)
763 World Bank (2010b)

4.2. Improving the short route of accountability

In the short-medium term, policies that improve the short route of accountability can be more effective in situations where the long route of accountability fail the poor. Improving choice for clients, increasing community participation, improving information for the clients of services are three ways in which the short route of accountability can be strengthened.

1. **Improving Choice:** Increasing choice of providers leads to greater accountability. If citizens can choose among several providers to deliver services, they are given the ability to end a relationship with a poor service provider. By increasing competition, providers are expected to be more accountable for the quality of their services. Increasing choice can occur by incentivizing private provision in the service delivery field. However public providers should have an incentive to attract more clients in order for this approach to work. In this respect for instance capitation based payment schemes for public schools and health care centres might be useful to improve service delivery. In Indonesia, the BOS school grant program has provided grants to schools on the basis of the number of students enrolled at the school. This has provided an incentive for school principals to increase enrolments and therefore reach out to students who may have been out of school (who would disproportionately be the poor children in the neighbourhood). The parents were given choice in the program for enrolling at a school of their choice, and since this choice was linked to the budget that the school would receive from the program, the incentives of the service provider were aligned with the poor citizens. Although a rigorous controlled impact evaluation is not available for the program, time trends show that enrolment in junior secondary school has increased particularly for poorest households following the introduction of the BOS program.[764]

   Increasing the purchasing power of citizens can also improve choice. When there are already multiple providers in the sector, giving citizens more purchasing power can empower them to hold their provider accountable by increasing competition among providers. Conditional cash transfer programs in education and other demand-side targeted programs such as voucher schemes enable households to have more choice in selecting providers. Voucher schemes, if designed well, can also allow households to select private providers for services with public financing and allow citizens "to vote with their feet" and move public funding around between public and private providers. Turkey is currently experimenting with a voucher scheme in the education sector through scholarships for students enrolled at private secondary schools. The program in Turkey is fairly recent – introduced in 2014 - and requires a rigorous impact evaluation before results can be discussed. In Colombia, a similar program was implemented in the late 1990's with positive impact on education outcomes.[765]

2. **Improving participation:** Increasing citizen participation in governance can strengthen the short route of accountability. Direct citizen involvement in service provision can increase the quality of the service delivery because citizens are both providers and beneficiaries of the services. Hence, the incentives of the service provider will be directly aligned with the incentives of the citizens. Parent Teacher Associations (PTA)'s that are directly involved in running the school can have an impact on improving outcomes. Some Latin American countries have experimented with such community-participation models in education service delivery: In Nicaragua, an elected council composed of parents, teachers and the director runs the schools[766] and this community-based model was found

764 Al-Samarrai et al. (2014)
765 Angrist et al (2002)
766 Fiszbein (2005)

to improve enrolment, attendance rates, and test scores. In most countries in the OIC region, there are PTAs that exist primarily to raise funds for the school but most do not have a role in school management. Uganda is the only country in the OIC sample where we observed decision making powers provided to parent teacher associations. Increasing the involvement of communities in school decision making on allocation of funds as well as teacher management could improve client power and potentially result in better outcomes

Similarly, in the water and sanitation sector, we have observed the cooperatives model in Bangladesh, Tunisia and Indonesia where the incentives of the service provider (the cooperative) and the beneficiaries are aligned. In the United States and Mexico, user groups, which are cooperatives of providers and clients, are responsible for operation and maintenance of water and electricity delivery.[767] The cooperatives, composed of citizens, provide these services to the citizens themselves. While this increases the burden of effort on the part of the citizens, it becomes one way to ensure accountability in service delivery.

Citizen participation can also be enhanced via establishing complaint mechanisms. Complaint mechanisms like the one introduced in public hospitals in Turkey improves the client power. These mechanisms increase the enforceability of the clients since the clients can give feedback on the services and the state/policymakers can take the necessary actions to enforce quality service delivery.

3. **Improving information:** Information works in a number of ways to improve the accountability relationships. Better informed clients can make better choices and demand better services. Information interventions can improve client power and voice at the same time. Information campaigns, which are a kind of information intervention, improve citizens' knowledge on their rights, service expectations, and performance standards. A public expenditure survey in Uganda indicated that only 13 percent of the grants allocated to schools actually reach the schools[768]. In response, the government initiated a newspaper campaign publishing monthly grant amounts for each school. Equipped with this information, school directors as well as parents were able to identify any discrepancies in the grant amounts the school received.

   Report cards are another form of information campaign where performance and quality of schools or hospitals are published for the citizens to see and compare service providers. In OECD countries, report cards are used to publish publicly the performance of health facilities[769]. Apart from interventions like this, participating in international student assessment tests for instance in education sector improves citizens' knowledge regarding where the country stands and the quality of services provided. In return the citizens can demand better services.

   Improved monitoring and evaluation of existing programs is key to providing information to both policy makers as well as citizens on the effectiveness of programs. A culture of evaluating policy and program impact is developed in some of the Sub-Saharan Africa region and Asia region OIC countries, while in the MENA region, the collection, analysis and interpretation of data for evaluation purposes is deeply missing. Services can be improved by providing better information on budgets and performance of programs to both decision-makers and citizens in OIC countries. Increased transparency and improved information can be a tool for learning from past experience, and can also be used to hold policy makers and service providers accountable for quality service delivery.

767 Ruiz-Mier and Ginneken (2005)
768 Reinikka and Svensson (2011).
769 Ringold et al. (2011)

5. Conclusions

A lack of access to basic services is closely linked with poverty. Apart from being income poor, being uneducated, ill or having a lack of access to safe drinking water, sanitation facility or electricity constitute additional dimensions of poverty, further exacerbating income poverty. If basic services are not delivered to citizens equally, poor citizens can end up in a poverty trap where they are continuously deprived of the means necessary to lead a tolerable life.

For successful service delivery to the poor; the accountability relationships between citizens, state and the service providers must be strong. Given the importance of basic services and their link with poverty, this study uses the accountability framework from the World Development Report 2004 to explain the reasons behind service delivery failure to the poor. According to this framework, services might be delivered to citizens via the long or short route of accountability. Service delivery fails when, in the long route of accountability, the state does not act in an accountable way to the citizens and/or service providers are not accountable to the State. Service delivery can be enhanced by improving these relationships. It can also be enhanced by improving the short route of accountability through increasing client power, which can make service providers more accountable to citizens.

The outcomes in access to basic services in several member countries indicate failures in the delivery chain. The poor are at a disadvantage in access to education, health, water, sanitation and electricity in many of the member countries. Furthermore, other challenges observed in the member countries, such as teacher and health worker absenteeism, intermittent water and electricity service delivery and other quality problems, are all associated with the failures in the accountability relationships between citizens, state and the service providers.

Among OIC countries, there are various levels of access to services, several different service delivery models and financing methods, and common challenges found in the delivery of education, health, water & sanitation and electricity sectors. These findings can be summarized as follows:

Education

Overall, OIC member states have high primary school enrolment rates but disparities exist children is greater than 90 percent for more than half of the OIC member states. In addition, access to basic education improved, if not remained high, over the past decade for most of the member states. Yet, high average enrolment rates mask wide disparities in access to education between poor and rich children. The average difference in attendance rates for primary school age rich and poor children is 6.4 percent for upper middle income countries while it is 33.5 percentage points for low income countries.

OIC countries employ various models to deliver education services. Central government provision is common, particularly in upper middle income countries where the Ministry between and within countries. The school enrolment rate for primary school age of Education is typically solely responsible for the decisions regarding financial allocations and human resources. However, it is also common among member countries for the Ministry to share the decision-making power with regional directorates or local governments. Contracting out education services to the private sector or to NGOs is not commonly found among OIC member states. Only Qatar, UAE, Maldives and Pakistan were found to contract out education services to varying degrees. Community participation is observed via the usage of Parent-Teacher Associations, the responsibilities of which change from country to country. Private provision of services is common among member countries. An average 17.7 percent of all children enrolled

in primary school attend private institutions as opposed to the World average of 12.7 percent. Yet, the average private school enrolment rate masks disparities between member countries. The highest rate is found in the UAE with 74 percent of primary school children attending private schools while the lowest rate is found in Azerbaijan at only 0.3 percent.

On average, government spending on education is high but significant disparities exist between countries. The OIC average for government spending on education as a share of total government budget is at 14.7 percent and it is slightly higher than the world average of 13.5 percent. In fact, in the majority of the high income and upper middle income member countries, education is constitutionally free while this is less common among the lower income member countries. However, significant disparities are observed between member countries in terms of budget allocated for education. A lower middle income country, Comoros, allocates the highest share of its budget to education at 29.2 percent and the lowest share is allocated by an upper middle income country, Lebanon, at 7.1 percent.

Aid constitutes an important and common source of financing for education in OIC member countries. Almost half of the total aid received for education worldwide was received by the OIC member countries at a total of $5,553 million in 2012. In addition, per child aid received for basic education is three times higher in the OIC countries with $24.7, compared to the World average of $8. Per child aid received is higher on average in upper middle income member countries with $34.8 compared to low income member countries with $18.7.

Common challenges observed across member countries include a failure to reach the poor, gender disparities in access, low quality of education, teacher absenteeism, informal payments and private tutoring. These challenges are, in fact, symptoms of failures in the accountability framework.

Health Care

While health outcomes improved over the last two decades, significant disparities exist within and between OIC member countries. The average under-five mortality rate declined from 110.0 to 53.8 per 1,000 live births in member countries between 1990 and 2013. However, the likelihood of a child dying before reaching age 5 in low income member states is 10 times higher compared to a child in high income member states. Within countries, statistics reveal that poor children are at a disadvantage in being vaccinated against measles or being delivered by skilled health staff in many of the member countries.

Different types of service delivery models can be observed across OIC member countries for health care. Central government provision is seen among upper middle income countries as well as lower income countries. Yet, this type of provision is somewhat more common among upper middle income member countries. Decentralization is also common among member countries. Contracting out is used in a number of countries to mitigate problems in publicly provided services or to increase efficiency and quality of delivery such as in Pakistan and Iran. Community participation in health care is implemented through management committees, which have a varying degree of responsibility depending on the country. Private provision in health care service delivery is observed in varying degrees as well.

In OIC member countries, reliance on out-of-pocket spending and external resources is high for health care financing. Member countries on average allocate 8.9 percent of total government expenditure to health in 2012, while this share was 15.7 percent for the World. In contrast, OIC member countries have a high dependence on out-of-pocket expenditures and external resources for health care financing compared to World averages. Out-of-pocket spending as a share of total health spending is 42.0 percent in OIC member countries and share of external resources in total health spending is 10.9 percent as opposed to the World averages of 18.4 and 1.2 percent, respectively.

Common challenges are observed across member countries also in the health sector. The poor lag severely behind the rich in terms of access and, in many of the member states, high levels of out-of-pocket spending exacerbate this challenge. In addition, low quality at public hospitals and staff shortages constitute other important problems.

Water and Sanitation

Lower middle income and low income member countries, as well as rural areas within the countries, are at a significant disadvantage with regards to access to an improved water source and sanitation facility. On average, access to an improved source of water is slightly lower in OIC member countries compared to the World while access to an improved sanitation facility is on par with the World average, in 2012. An average of 80.9 percent of the population has access to an improved drinking water source in OIC countries while access to an improved sanitation facility is an average 63.8 percent of the population. Yet, significant disparities are observed in access between countries and between urban and rural locations within countries. Access to an improved water source is as low as 31.7 percent in Somalia and access to an improved sanitation facility is only 9 percent in Niger. The location of a household is an important determinant for access to drinking water or sanitation especially across Sub-Saharan African countries, and in countries like Afghanistan, Pakistan and Indonesia.

Several types of service delivery models can be observed among OIC member countries for water and sanitation. Unlike health and education services, central provision of water and sanitation services are more commonly delivered through a national utility company rather than a ministry. In some cases, ministries are the responsible authorities for the provision of sanitation services while this is very rare for water provision. Overall, central provision of water and sanitation services is observed in countries across all income groups. For instance, Kuwait, Jordan and Uganda have central provision in all or some part of service delivery for water and sanitation. Delivery models also typically differ depending on remoteness and rural/urban location. For instance, in Benin and Burkina Faso, rural areas are under the governance of local governments who can contract out services to private providers or user groups whereas, in the urban areas, there is a national utility company responsible for service delivery. Contracting out water and sanitation service delivery to private providers is a common service delivery model among member states. In addition, user groups are active in a number of countries in the delivery of water services like Mali, Benin, Burkina Faso, Mozambique and Tunisia. Private participation in service provision is most commonly found in manufacturing or distribution of facilities, in cleaning sanitation pits, or in the provision of drinking water by water vendors.

In OIC member countries, government subsidies are common, especially in the high income, upper middle income and lower middle income member countries. A number of the low income member countries along with some from other income groups achieve cost recovery in operations and maintenance. In addition to financing through tariffs and the public budget, most OIC member countries, except those in the high income group, use financing through donor funds. Aid received by OIC member countries made up 37.1 percent of the total aid disbursed in year 2013 for developing countries. 72.8 percent of the disbursed aid goes to lower middle income and low income OIC member countries. The total amount of aid disbursed to the water and sanitation sector reached as high as US$2,4 billion in 2013, up from US$1,4 billion in 2004.

Common challenges observed among member countries are low access in rural areas, clientelism in service delivery, low quality of services with intermittent hours of service, and the lack of a central authority to oversee the sanitation sector.

Electricity

Access to electricity is the lowest among lower middle income and low income OIC member countries with more pronounced disparities among localities within these countries. Overall, OIC member countries have a lower electrification rate compared to the World. In 2010, 69.1 percent of the population in OIC countries had access to electricity compared to 83.1 percent in the World. While, on average, high and upper middle income countries have high access rates, more than 50 percent of the population lacks access to electricity in all of the countries in the low income group excluding Tajikistan, Bangladesh and Guinea-Bissau. People living in rural areas are at a significant disadvantage where only 59.6 percent of the population have access to electricity compared to 82.1 percent in urban areas, on average.

Among OIC member countries, several types of service delivery models can be observed. Two common models are a vertically integrated national utility company or unbundled companies. Trends are not observed based on income group or region with regards to unbundling the utility. For instance, in the same income and regional group: Uganda unbundled the national electricity company and privatized some of its newly formed companies while Mozambique has a national utility company which is vertically integrated with no private participation. Public-private partnerships are observed in almost all of the countries either in generation or in the distribution of electricity. Community participation in the electricity sector is observed through user cooperatives in a small number of member countries, all in the low income group, such as Bangladesh, Mali and Burkina Faso.

Government subsidies are commonly used to finance the electricity sector in member countries. Pre-tax electricity subsidies are estimated to make up 0.64[770] percent of government revenues on average globally compared to an average of 7.2 percent in the OIC member countries. Most member countries, across all income groups, subsidize electricity utilities to a certain extent. These subsidies might reach very high levels, as in the case of Bangladesh where electricity subsidies are estimated to make up 22.1 percent of the government's total revenue.

Challenges observed in the sector include low rural connection rates, which are especially observed among the countries in Sub-Saharan Africa, low quality of electricity with intermittent supply, and financial instability of the system requiring government subsidies. The subsidies are generally pro-rich because the poor are often not connected to the system at all, and the population is subsidized without prioritizing.

The key to providing services adequate in quantity and quality is strengthening the accountability relationships between actors. While it is important to strengthen voice in the long term, the compact and client power can both be strengthened in the short to medium term to improve accountability and, therefore, service delivery. To strengthen compact, monitoring and evaluation mechanisms can be established to improve central oversight. Contracting with private providers can also generally lead to improvements in accountability. While improving compact strengthens the long route of accountability, the short route of accountability can be improved by empowering citizens so that they can hold service providers directly accountable for their performance. Such strategies that target the short route of accountability may give quicker results in countries where voice and compact are weak and weak changes in the long route of accountability may be difficult to bring about in the short term.

770 This is calculated by dividing identified subsidies by global government revenues as reported in Clements et al (2013)

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