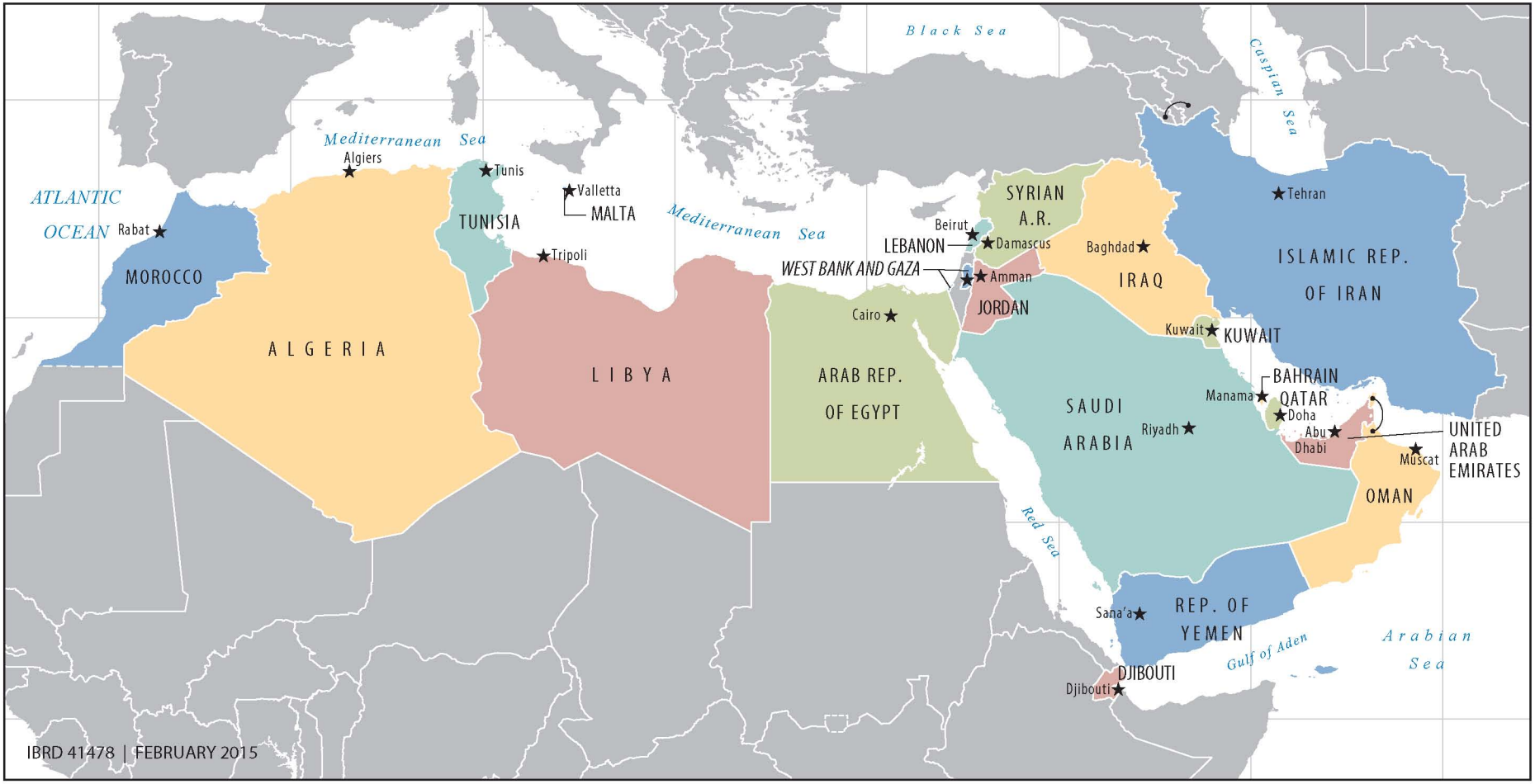
Trust, Voice, and Incentives

Learning from Local Success Stories in Service Delivery in the Middle East and North Africa

Hana Brixi, Ellen Lust, and Michael Woolcock

WORLD BANK GROUP



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"We are often forced to pay bribes and give out gifts to get our paperwork done at various governmental departments, especially the traffic and real estate departments, where corruption is rampant."

"There is simply no point in expressing your opinion. No one listens."

"Public services are not good. For instance, we have an obvious problem in sectors. If you go to the hospital, you may just find one doctor, lots of sick people, and not enough medications. Same problems occur in the education sector."

"Engagement with the community is different. It is regular now. Parents are involved in decision making; they oversee and support the school. They provide support to the teachers and school by their active participation."

"Teachers are often unable to teach because of crowded classrooms, low salaries, and unresponsive school management."

"The problem is that public servants are not employed based on their qualifications, but because they belong to specific parties."

"Citizens have a role to play in changing the current reality of institutions by fighting all forms of corruption and bribery. This can only happen with unity and popular consciousness. Such problems will not be resolved when citizens keep encouraging and giving bribes to public officials."

"In the clinic, we are all one team. We work together and help each other to care for our patients. But if a staff member does not care, he or she is out."

Sources: Comments received on the World Bank Middle East and North Africa Facebook page (https://www.facebook.com/WorldBankMiddleEastNorthAfrica) during online consultations for this report (quotes 1–6); comments received during local success case studies (quotes 7–8).

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Foreword

The Middle East and North Africa (MENA) is in a state of volatile change. This period of change is imposing hardships on the people of the region, and the outbreaks of conflict and violence represent a clear danger not only regionally, but globally as well.

Under the circumstances, it is essential to focus on the welfare of the region's youth and its economic and institutional health in order to build the foundation for lasting stability and shared prosperity. Public institutions and services are central to this effort. In particular, it is crucial to harness the ability of public institutions to align their incentives with the needs of the people; the ability of education systems to help the region's children and youth develop the competencies and skills that will serve them well for their future lives and livelihoods; and the ability of health systems to address the rapidly growing burden of chronic diseases, as well as the remaining pockets of high maternal and child mortality and malnutrition.

In the aftermath of independence, leaders of MENA countries promised their citizens industrialization and better standards of living through state intervention. That intervention included the expansion of education and health services, which generated unprecedented improvements in basic human development outcomes, as well as food and fuel subsidies and employment in the public sector. It gave rise to a social contract binding governments and citizens, establishing political legitimacy and strong nationhood and instilling citizens' support for government, as well as the expectation that the state would assume responsibility for economic and social welfare.

The post-independence social contract became unsustainable because it hampered the creation of the inclusive institutions and accountability mechanisms at the political, administrative, and social levels that would motivate providers, public servants, and policy makers to deliver quality services to the poor and other non-privileged populations. As a consequence, the majority of Arab children are not learning well enough while at school, and many mothers with young children find health clinics closed, doctors absent, or essential medicines out of stock when they need medical help.

This report focuses specifically on the public institutions underpinning service delivery. In the right institutional environment, the interactions between these various stakeholders create a virtuous cycle of performance. In such a cycle, citizens have the means to inform

policies and comment on the quality of services, and both public servants and providers are attuned to those opinions by a system of incentives that reward their effectiveness in responding to them. As services improve, citizens' trust in government increases, which serves to consolidate social cohesion.

However, this report documents that in the Middle East and North Africa this virtuous cycle has not been achieved. Many of the public institutions that deliver basic social services are not responsive to citizens' needs. As a result, services have suffered, leaving citizens with little recourse but to abandon the system and seek alternate means of meeting their needs. This negative cycle will have to be broken in order for investments in education and health to begin delivering meaningful outcomes for the Arab people. The evidence clearly indicates that the poor—lacking the needed personal connections, the means to pay informal fees, or the luxury of opting out from the public service system—are the ones suffering the most from ineffective service delivery.

In its search for solutions, the Bank team has identified local examples of effective service delivery and shared the lessons learned. For instance, at a girls' school in rural West Bank, a school principal has managed to build a culture of inclusion and commitment among community members, parents, and teachers. The success of the school has become a shared responsibility, and the results are impressive. The students excel in national tests despite the poverty and instability that surround them. There are equally powerful examples in schools and health clinics in Jordan and Morocco of citizens finding better ways to provide services to their communities.

There is no blueprint for creating the right accountability mechanisms to monitor and motivate public servants and service providers. Every environment has its own distinct social and political characteristics, and solutions have to be either drawn from or adapted to them. In this respect, we hope that the report will prove useful to policy makers, service providers, and citizens alike. While mapping out the key drivers of effective service delivery, it aims to launch a regional discussion on local strengths as the source of potential solutions.

The World Bank Group stands ready to contribute and help the governments and people of the region promote inclusive institutions and create efficient service delivery in order to better respond to citizens' needs and boost shared prosperity.

Hafez Ghanem
Vice President
Middle East and North Africa Region
The World Bank

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Moving forward, the Governance Global Practice, Education Global Practice, and Health, Nutrition and Population Global Practice of the World Bank Group have agreed to use the framework and conclusions presented in this report as a prism in their effort to enhance education and health services in the MENA region (see *Maximizing the World Bank's Impact in the Middle East and North Africa: Global Practices—Middle East and North Africa Region Partnership Report*, published by the World Bank in 2014).

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Abbreviations

AFR	Africa
EAP	East Asia and Pacific
ECA	Europe and Central Asia
EHGS	Egypt Health and Governance Study
ESSB	*établissement de soins de santé de base*
GAC	Governance and Anti-Corruption
GCC	Gulf Cooperation Council
GDP	gross domestic product
HCAC	Health Care Accreditation Council
HIV/AIDS	human immunodeficiency virus/acquired immune deficiency syndrome
HNP	Health, Nutrition and Population
ICR	Implementation Completion Report
IEG	Independent Evaluation Group
ISCED	International Standard Classification of Education
ISIS	Islamic State of Iraq and Syria
LAC	Latin America and the Caribbean
MENA	Middle East and North Africa
MP	member of parliament
OECD	Organisation for Economic Co-operation and Development
PETS	Public Expenditure Tracking Survey
PFM	public financial management
PHC	primary health care
PHCC	primary health care clinic
PISA	Programme for International Student Assessment
PPP	purchasing power parity
PTA	parent-teacher association
SABER	System Approach for Better Education Results
SAR	South Asia
SEDGAP	Secondary Education Development and Girls Access Project

SIAAP	*Service d'Infrastructures d'Action Ambulatoires Provincial* (Provincial Service of Infrastructure and Ambulatory Care)
TIMSS	Trends in International Mathematics and Science Study
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNHCR	United Nations High Commissioner for Refugees
UNRWA	United Nations Relief and Works Agency

Overview

The Middle East and North Africa (MENA) is a rising middle-income region, and its citizens rightly expect quality public services. Yet too often they experience disappointment: students attending local schools are insufficiently prepared for the 21st century economy, and those needing health care too often find that public clinics have no doctors or medicines. Few in positions of authority are held accountable for such shortcomings. This situation both undermines the potential for improvement and heightens people's unhappiness with the delivery system.

Although dissatisfaction with education and health services is widespread in the MENA region, local successes do exist and offer inspiration. At the Kufor Quod Girls' Secondary School in the rural West Bank, for example, Ms. Abla Habayeb, the school's principal, provides her teachers with daily encouragement and support, and she involves community members, parents, and teachers in decisions about improving the school. Teachers, students, and the community then reciprocate that commitment. Thus, amid the surrounding poverty and instability, Kufor Quod girls excel in national tests. Similarly, in some poor villages in Jordan and Morocco, the leaders of schools and clinics are reaching out to the community, inspiring citizens' trust and engagement through transparent and inclusive decision making and the delivery of excellent services.

Learning from such local successes is vital because there are no blueprints for solving service quality problems. Countries around the world are striving to improve education and health care quality. But simply modernizing school and hospital facilities and training staff are no longer sufficient. Delivering quality services requires motivated staff. And staff motivation arises in turn from values and accountability, which are grounded in the wider political, administrative, and social rules, practices, and relationships. Providing high-quality services is hard; the World Bank itself has struggled to ensure that its projects enhance incentives in country systems to achieve better learning and health outcomes.

Finding solutions is especially difficult in the institutional and sociocultural contexts in the MENA region. Its citizens not only demand better services but also expect their government to provide them, reflecting the promises made by Arab leaders at the outset of independence five decades ago that the state would provide better living conditions. Since then, MENA citizens have gained nearly universal access to education and

health care, which is a commendable achievement. Now they expect these services to be of high quality and create greater opportunities for all.

Although they have excelled at building schools, constructing hospitals, and training staff, the region's societies have fallen short in fostering the *accountability* and values needed to motivate public servants and service providers to deliver quality services. Whether and how teachers teach, doctors treat the sick, and bureaucrats react to citizens' demands do not seem to matter in the selection of leaders (and their promotions and salary increases) or in the social acceptance of public servants. Rather than *performance*, what seems to matter most for political and professional careers are personal relationships and social ties. This limits citizens' *trust* in and formal *engagement* with public institutions. To fulfill their needs, citizens rely on their own relationships or informal fees. Thus a cycle of poor performance has emerged, perpetuating a culture of privilege and cronyism.

Improving the quality of public services will require breaking this cycle of poor performance: making politicians, public servants, and providers accountable to citizens and promoting citizens' trust in and engagement with state institutions. At the local level, leaders and communities can inspire the needed changes by demonstrating possible local solutions and identifying the remaining systemwide constraints. Communities, states, and donors that succeed in improving service quality and accountability will go a long way toward earning and retaining citizens' trust.

Citizens' expectations

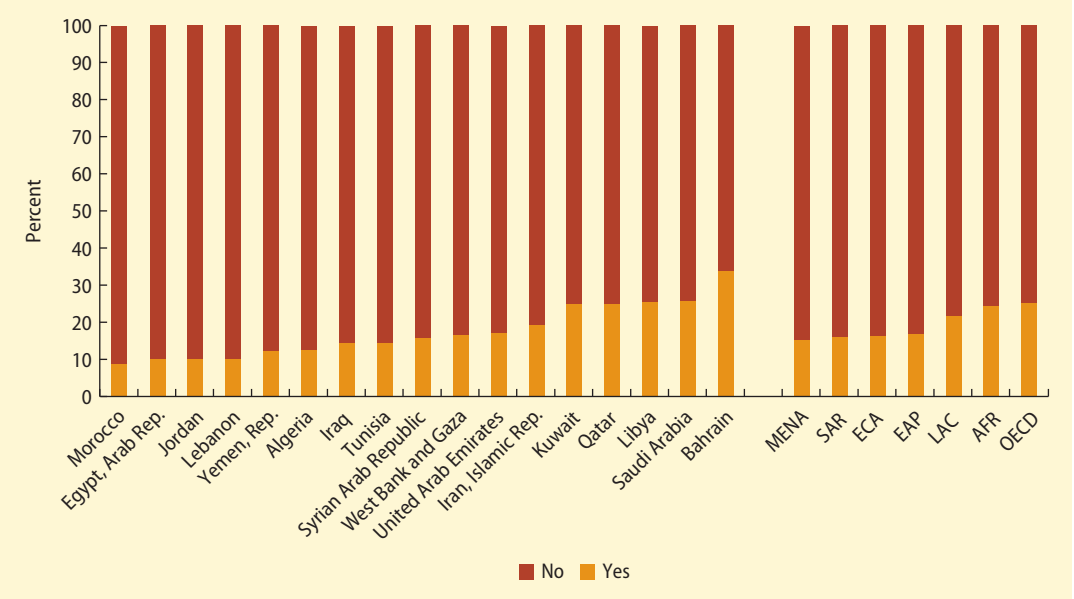
The quality of social services provided in the Arab world lags surprisingly behind its potential. Historically, its citizens have cared deeply about education, health, and other services; indeed, universal access to education and health is a constitutional right in most countries in the Middle East and North Africa. The region is predominantly composed of middle-income countries, with adequate human and material resources, and its governments are perpetually engaged in reform efforts aimed at better service provision. And yet dissatisfaction among the public runs so deep that failure to receive adequate services underpinned the calls for *karama* (dignity) that echoed throughout the Arab Uprisings in 2010–11. Today, as the region continues to reel from deep dissatisfaction—struggling with ongoing transitions, conflicts, and fragility—it is ever more critical to assess the status of service delivery, recognize the underlying causes of problems, and look for effective solutions.

The dissatisfaction with services is widespread. In the 2013 Gallup World Poll, on average about half of respondents in the MENA region, compared with about 30 percent in Asia and Latin America and the Caribbean, expressed their dissatisfaction with education services and health care in their country. The 2010–11 Arab Barometer found that about two-thirds of MENA respondents perceived the performance of their government in improving basic health services as "bad" or "very bad." More broadly, citizens of the MENA countries tell pollsters that their government should do better in ensuring service delivery and fighting corruption. And yet they also express little trust in their government's involvement in the social sectors. Moreover, they are less likely than citizens of other regions to seek accountability and tell public officials what they think (figure O.1).

Local successes: Autonomy, accountability, and participation

The average levels of citizens' dissatisfaction, however, mask significant variation within countries and possible excellence in some localities. As we document here, some communities have managed, often despite difficult circumstances, to attain extraordinary outcomes using innovative local solutions to the prevailing problems. These local successes can provide useful insights and inspiration for practitioners, policy makers, and donors.

FIGURE O.1 Voiced opinion to public officials in the last month: MENA and other regions, 2013



Source: Gallup World Poll, 2013.
Note: AFR = Africa; EAP = East Asia and Pacific; ECA = Europe and Central Asia; LAC = Latin America and the Caribbean; MENA = Middle East and North Africa; OECD= Organisation for Economic Co-operation and Development; SAR = South Asia.

Examples of local successes in service delivery highlight the importance of autonomy, accountability relationships, and participation at the local level. Although central management systems (such as the School and District Development Program and the Health Care Accreditation Council in Jordan or the Concours Qualité in Morocco) create environments conducive to providing quality services, the impacts of such systems are not uniform. Our case studies uncover key drivers of change at the local level. They highlight the importance of accountability relationships—and the role of local leadership in sparking and institutionalizing such relationships—to trust and effective citizen engagement.

As noted earlier, the Kufor Quod Girls' Secondary School in a small village near the city of Jenin in the West Bank traces its success to parental and community engagement and the ability of the school's principal to build and maintain a motivating, encouraging work environment for teachers. The principal has partnered with the Jenin school district to secure support, such as the pedagogical support of the district supervisors for Kufor Quod's teachers, and some autonomy in implementing school improvement plans.

Similarly, deep in Jordan the Zeid Bin Haritha Secondary School in the village of Yarqa has been achieving excellent results amid poverty and low capacity. Jordan's national School and District Development Program, launched in 2009, encourages schools and directorates to collaborate with parents and communities, and it provides small school grants allowing some autonomy. Involving parents and citizens as partners, however, has not come naturally in traditional communities such as in Yarqa, with its deeply embedded lines of authority. It meant changing the leadership style of the school principal and teachers, creating a sense of common purpose around the school in the community, and establishing new relations through a parent-teacher association and Education Council and making these new structures effective. Significantly, the Education Council in Yarqa has reached out to parents and the wider community and gained their trust for its transparency

and inclusive decision making. Furthermore, friendly competition and rivalry among local schools and communities have helped to improve student outcomes. Student performance in national tests has become a source of community prestige and pride. Supporting student learning—and addressing obstacles such as the school's supply of electricity and some students' vision impairments—has become a shared responsibility.

In the health sector, top clinics across Jordan benefit from partnering with local social institutions and health committees and from formalizing health management procedures at the local level. These steps have been facilitated by Jordan's accreditation process, which supports improvements in facility administration by establishing clear rules and regulations and supporting monitoring and transparency. Local leadership and engagement enhance the impact of such administrative reforms. In the locations we visited, health committees have reached out to both citizens and health workers in gathering and addressing community needs, sometimes uncovering—and resolving—hidden challenges such as previously undetected high levels of diabetes and hypertension in the Zay community. In some communities, social ties have facilitated the process of establishing priorities, extending public health outreach, and mobilizing resources to support health clinic activities and development.

Finally, the best-performing rural health clinics in Morocco draw effectively on their strong partnerships with local communities, on positive competition devised by the Ministry of Health, as well as on support from the provincial and regional offices of the Ministry of Health available to reform-oriented local leaders. Launched in 2007, Morocco's Concours Qualité program of competition among health facilities, involving self-assessment and audit by peers, recognizes good work and motivates improvement. It has been especially effective in the presence of dynamic and visionary leadership at the local, provincial, and regional levels. The excellent clinics we visited have translated such effective leadership into a culture of quality and innovative performance improvements among health workers. These clinics exhibited a sense of a shared mission and a collaborative ethic, supported by good record keeping, transparency, participatory training workshops, and attention to interpersonal relations. The clinic staff regularly communicates with the provincial and regional officials of the Ministry of Health to ensure adequate supplies of medications and to solve related implementation problems. Moreover, clinic health workers actively engage with nearby social organizations and individuals—such as youth groups, the *murshidat* (women serving as religious guides), and women working in the local *hammams* (public baths)—to build awareness of health issues such as family planning, HIV/AIDS testing, breast cancer, and chronic diseases.

The cycle of poor performance

Notwithstanding such examples of local successes, a majority of MENA citizens routinely experience a cycle of poor performance in their daily lives: political, administrative, and social institutions fail to instill adequate accountability and motivation in policy makers, public servants, and service providers to meet citizens' needs. As citizens experience poor service quality, they increasingly regard the government as corrupt and ineffective. Thus their trust in public institutions suffers, leaving them with few options other than turning to informal social networks and paying informal fees to tackle their individual needs. As illustrated by our case studies, the cycle of performance (figure O.2) may be virtuous at the local level—with local formal and informal accountability relationships filling the institutional gaps, motivating better performance, and inspiring citizens' trust and formal participation—but it appears to be stuck in a low equilibrium at the national level in most MENA countries. The MENA region's historical development explains the initial factors underlying this cycle. As noted, that development led citizens to place a high value on education, health, and other services and created expectations—stronger

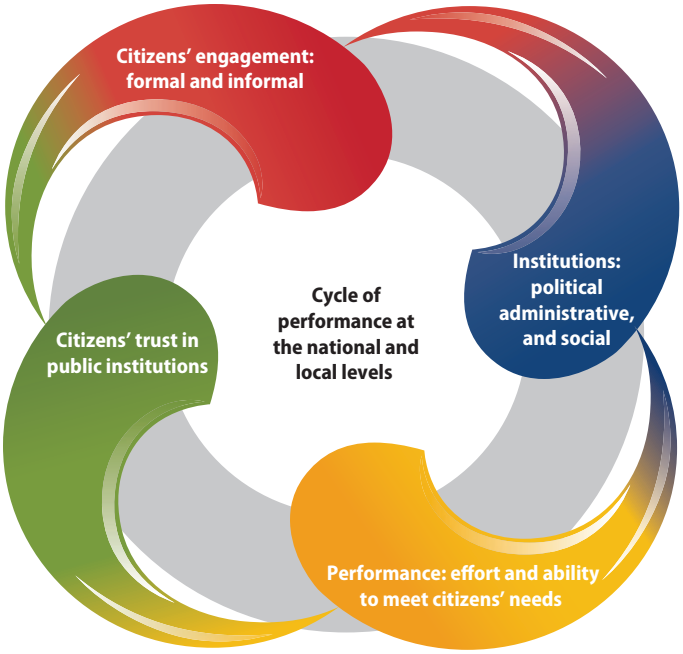
than in other regions—that the state would provide these services, but the region largely eschewed the establishment of institutions geared toward meeting these expectations. Without dependable institutions and citizens' trust in public institutions, there is little formal citizen engagement, institutions remain stagnant, and service delivery is poor. A central concern is thus how can this cycle of poor performance be overcome? Below, we examine how the prevailing cycle is structured and reinforced.

Political, administrative, and social institutions: Lack of formal accountability

Political institutions in most MENA countries lack accountability mechanisms, with citizens unable to obtain adequate information, voice demands, or incentivize policy makers and public servants through formal channels. Authoritarian regimes—which have the least constrained executives, the weakest parliaments, and the lowest levels of judicial independence in the world—dominate the MENA region. The region lags behind other regions in its transparency, objectivity, and professionalism in civil service appointments and management. Directly elected local governments are found in only a small minority of countries in the region, and where they do exist, councils have limited budgets and responsibilities. With the exception of the Arab Republic of Egypt, Morocco, and the West Bank and Gaza, local council budgets are less than 5 percent of total public expenditures, far behind the world average of 38 percent for federal systems and 22 percent for unitary ones.

Opacity further undermines accountability. Freedom of information and public disclosure laws and practices that would allow citizens and intermediaries to monitor government activities are either lacking or are not implemented. On the Global Integrity Index, the region ranks the lowest on the public access to information indicator, the legal right to access information, and whether the right of access to information is effective.

FIGURE O.2 The cycle of performance



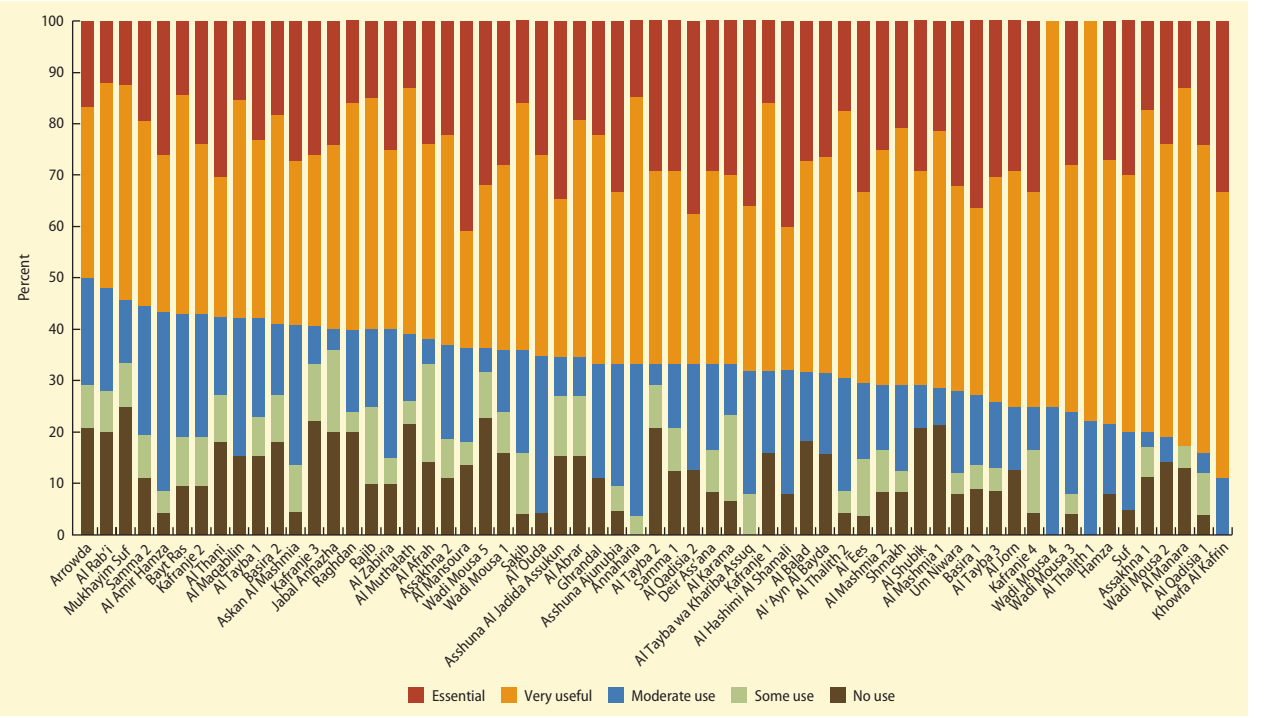
Citizens have few opportunities to provide feedback on performance quality and to seek accountability. Accountability institutions such as justice sector services, independent audit agencies, and ombudsmen are underdeveloped in the region, making it difficult for citizens to submit complaints, hold public servants and service providers accountable, and obtain their rights. Executive authorities tend to exercise influence over the judicial branch and over agencies designed to address corruption. Independent audit agencies, inspectors general, and ombudsmen tend to lack resources, authority, and autonomy. Political capture has promoted a system that lacks the information needed to monitor and evaluate performances. As a result, there are few consequences when violations occur and very few performance-oriented incentives and norms for providers and administrators.

Weak, politically captured regimes are coupled with—and compound—ineffective administrative systems and accountability mechanisms. Administrative institutions suffer from highly centralized and opaque bureaucracies and weak management

systems, and service providers and public servants are rarely held accountable. Local administrators and service providers have little influence on policy formulation and implementation, and they lack autonomy to manage human resources, make financial decisions, enforce rules, or bring about change on their own without the blessing of the central authority. At the same time, they face little oversight of and pressure on their own performance. Information on the performance of frontline service providers, such as schools and health facilities and their staffs, is generally not collected, evaluated, or followed up on. For example, surveys in Egypt and Morocco suggest that teachers appear to be minimally assessed, and school inspections generate little action. With some exceptions (such as the United Arab Emirates) government agencies do not regularly produce or disclose criteria against which their performance could be independently monitored. This is in part because of capacity weaknesses—that is, a lack of facility-level information and weak monitoring and internal controls—and little enforcement and performance management. It also reflects political capture at the national and subnational levels that subverts incentives toward establishing accountability.

Because state institutions lack both internal and external accountability, social norms and regulations within society and communities can play a vital role in motivating policy makers, public servants, and service providers. Social institutions emphasize obligations to members of social networks over national welfare. The result is the widespread practice of *wasta* (figure O.3), a form of clientelism, as well as a willingness to treat

FIGURE O.3 Importance of *wasta* in obtaining a government job, by municipality: Jordan, 2014



Source: Governance and Local Development survey, 2014.
Note: The numbers next to some localities (municipalities) indicate that they are sublocalities or areas within them. The numbers were added for survey purposes; they are not official administrative boundaries.

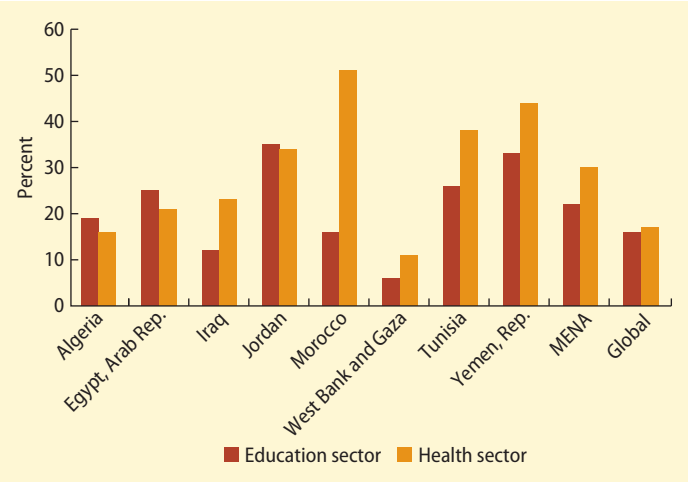
informal payments as a necessary practice. *Wasta* allows individuals to obtain public services, jobs, and other economic opportunities, and preferential treatment when dealing with administrative procedures. In this way, *wasta* can undermine fairness and equality of opportunity as well as erode administrative systems and overall state performance (as, for example, when the recruitment and advancement of administrators and service providers are based on *wasta* rather than merit). The strength of social institutions at the local level varies and is likely to explain some of the variation in performance, including education and health services delivery, as well as some of the elements of success in the local case studies described in this report.

Performance in education and health: The quality challenge and subnational variation

Education and health outcomes have improved in recent decades, but they have not kept up with demands. In most MENA countries, outcomes such as school enrollments or child mortality have converged to their expected levels based on economic development. The quality of services has not, however, kept pace with the broader socioeconomic transitions. MENA students score low on international competency tests, and graduates struggle to find jobs while employers report vacancies unfilled due to skill gaps. Health inequities based on income, gender, degree of urbanization, and age persist. The out-of-pocket health expenditure is high by international standards, leading to impoverishment and to forgoing health care because of its cost. Citizens typically find little information publicly available about the performance of schools and health facilities or about fees at health facilities. The lack of transparency can give rise to informal user fees, which about one-third of citizens of MENA countries have reportedly paid in the education sector and especially in the health sector (figure O.4).

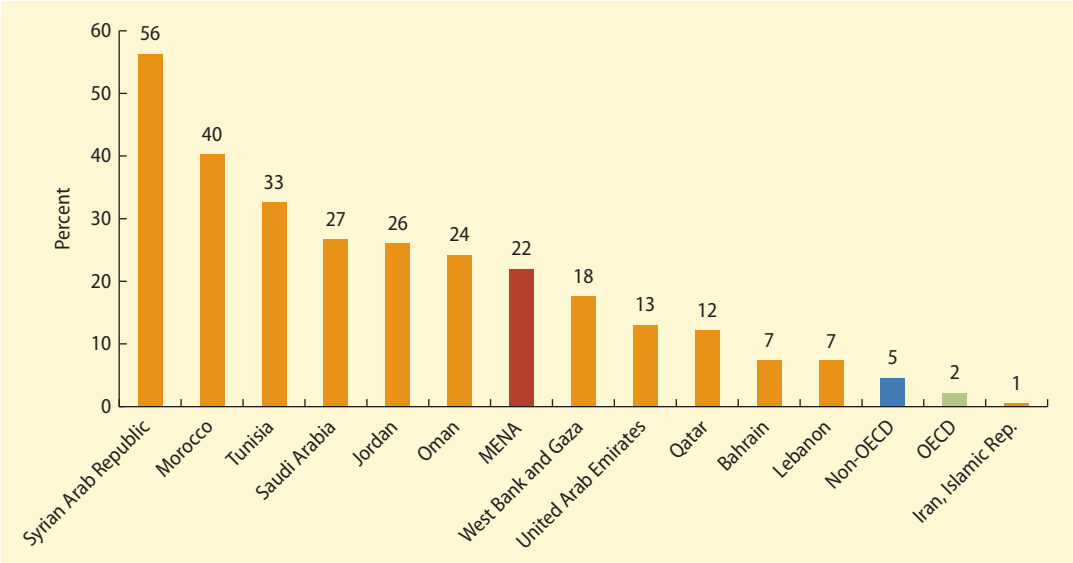
Service delivery is characterized by the weak efforts and capacity of providers at the local level. Surveys suggest that providers may not possess the qualifications and professional autonomy, among other things, needed to deliver quality services, particularly in rural localities. They also often lack key resources such as teaching materials and medicines. Meanwhile, their efforts appear to be lagging: 30 percent of students in MENA countries attend schools in which principals reported that teacher absenteeism is a serious problem (figure O.5). Similarly, health professionals exhibit high levels of dissatisfaction, and absenteeism surpasses 30 percent in countries for which data exist: Egypt, Morocco, and the Republic of Yemen. Where observations exist, the adherence to curricula in schools and to clinical care protocols in health facilities appears low (figure O.6). Public sector teachers and health workers tend to offer some services as private efforts for a fee, which can create a conflict of interest. In Egypt, for example, 89 percent of private physicians also work in public facilities where they may be absent or extend little effort during official hours while giving their best performance at their private practice.

FIGURE O.4 Percentage of respondents reporting payment of informal fees, education and health care sectors: MENA region and globally, 2013



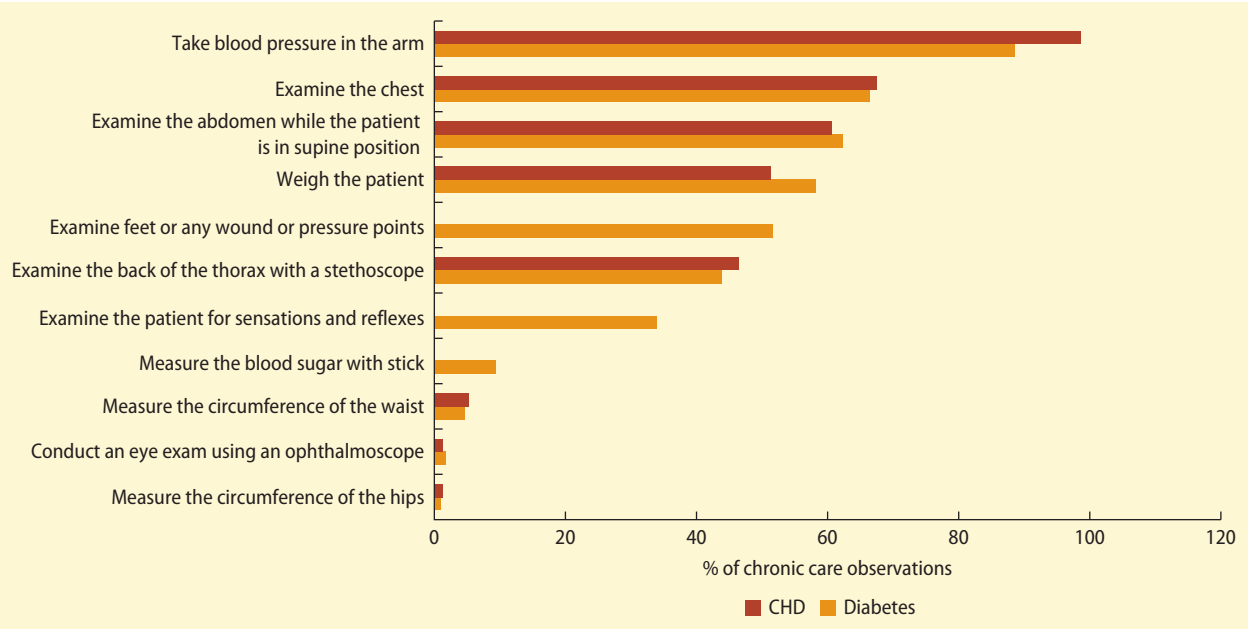
Source: Global Corruption Barometer, 2013.
Note: MENA = Middle East and North Africa.

FIGURE O.5 Percentage of students whose principals report that teacher absenteeism is a serious problem in their school: MENA region and globally, 2011



Source: TIMSS, 2011.
Note: MENA = Middle East and North Africa; OECD = Organisation for Economic Co-operation and Development.

FIGURE O.6 Adherence to care protocols for diabetes and coronary heart disease in health facilities: Arab Republic of Egypt, 2010



Source: EHGS, 2010.
Note: CHD = coronary heart disease.

The quality of service provision varies significantly within countries, in part because of the weak national political and administrative institutions and the resulting influence of social institutions and local governance practices. Indeed, the results in education (such as student test scores) and the quality indicators in health (such as the adherence to care protocols) exhibit significant subnational variation.

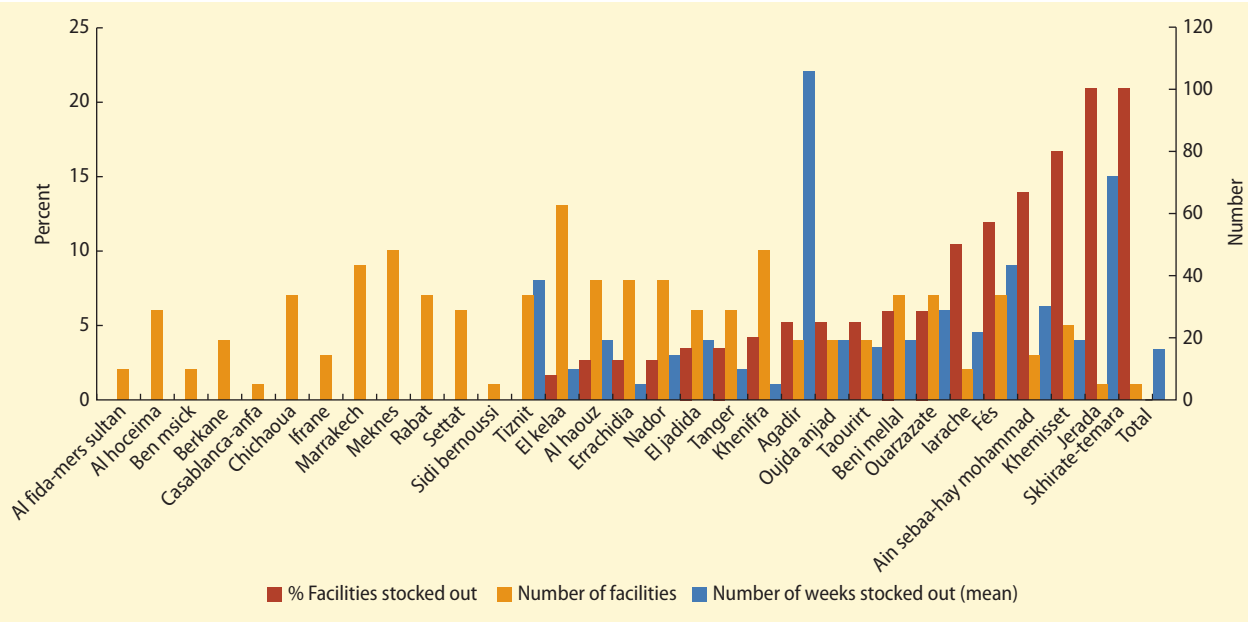
Service delivery process indicators vary as well within countries. Examples are staff absenteeism and qualifications and the availability of instructional materials, essential medicines, and other key inputs (figure O.7). The patterns across service delivery indicators also vary, showing little correlation, for example, between staff effort and the availability of key inputs. This may indicate that staff, materials, and other inputs in service delivery are managed in an insular manner, along the vertical administrative lines in the generally heavily centralized service delivery systems in the MENA countries.

The poor quality of education and health care as perceived by the majority of MENA citizens and demonstrated by the available evidence can be traced to the weaknesses in the effort and capacity of providers. Such weaknesses in turn reflect the characteristics of the prevailing political, administrative, and social institutions, especially the weak accountability mechanisms facing policy makers, public servants, and service providers. The lack of simple monitoring and internal controls undermines the distribution of textbooks to schools and medicines to health facilities. The interplay of formal and informal pressures and norms at the national and local levels influences the efforts of providers.

Citizens' trust and engagement: Shaped by service delivery and state performance

Citizens' experiences when they visit a health facility or observe their child's learning, when they seek a job or deal with administrative procedures, affect not only their view of performance but also their attitude toward the state. The low satisfaction with

FIGURE O.7 Availability of aspirin, by province: Morocco, 2011



Source: PETS (health), Morocco, 2011.

public services, perceived corruption and nepotism, and, indirectly, unresponsive institutions appears to erode citizens' trust in public institutions in many MENA countries. Across countries, findings from the Gallup World Poll, Arab Barometer, and Worldwide Governance Indicators reveal a high correlation between citizens' satisfaction with service provision and indicators based on underlying measures of state institutional quality and performance such as government effectiveness, rule of law, and control of corruption. Furthermore, the data suggest that trust in national government is highly associated with citizens' satisfaction with education and health services and with their perceptions of the pervasiveness of corruption. For those MENA countries for which data are available, our analysis suggests that the probability of trusting the national government increases by 13 percentage points when respondents are satisfied with education and by 11 percentage points when they are satisfied with health care. On the other hand, citizens' trust in public institutions declines by 35 percentage points when respondents believe that corruption is widespread within their governments. These results also hold across MENA countries when measuring trust in the judiciary. With respect to nepotism, respondents are 10 percentage points likelier to trust their national government when they believe that qualifications are more important than connections. Interestingly, though, we found that the influence of tribal affinities has only a small impact on citizens' trust in national government.

Low trust in public institutions—and perceived powerlessness over the decision-making processes—undermines citizen-driven, bottom-up approaches and social accountability tools (such as public hearings, community scorecards, public opinion polls, and civil society oversight committees) that could be used to improve service delivery. Institutions in most MENA countries offer their citizens few opportunities to encourage better service delivery through choice (selecting better providers), voice (giving feedback to providers and public servants and holding them accountable), and voting (choosing political leaders committed to ensuring better services). In the face of weak institutions, poor performance, and low trust in public institutions, citizens tend to disengage. In much of the region, people believe they have little chance of succeeding by simply following the rules. In surveys in Algeria and Morocco, for example, only a quarter of respondents considered it effective to seek services or file complaints directly through the relevant government agency; higher numbers of respondents believed it was more effective to go through family, friends, and other social ties. In the Republic of Yemen, only 10 percent of citizens who believed they had a valid reason to make a complaint actually did. Furthermore, civil society organizations are subjected to state intervention and crackdowns in most MENA countries, which limit their effectiveness and may explain why citizens rarely join such organizations.

When citizens need services from the state, try to resolve complaints and grievances, or have to deal with administrative procedures, they often do so through informal channels, resorting to survival mechanisms such as *wasta* or informal payments or, more rarely, demonstrations or rebellions. Unfortunately, in doing so they exacerbate the existing problems, eroding formal accountability and norms of public service, undermining public welfare, and widening the inequality of opportunities. In more extreme cases, such as the Houthis' rebellion in the Republic of Yemen, stemming in part from the Houthis' unresolved grievances related to poor public services, they may unravel postconflict institutions and trust building. There are, however, instances—as our examples of local successes illustrate—in which citizens' trust and engagement can be inspired by local leaders and can support improvements in service quality. Finally, the rising popularity of social media and their use by citizens to share their experience and demands, partly facilitated by successful e-governance initiatives in several MENA countries, are opening potentially effective engagement avenues for the future.

Bases for improvement

Because of the complex circumstances facing MENA countries, it is necessary to build on evidence of local successes and positive trends that show where and how the cycle of generally poor performance can be challenged. We seek to identify the bases for improvement and encouragement so that citizens, civil servants, policy makers, and donors can act on them. Many policy makers across the MENA countries want to deliver visible results and, in doing so, bolster their authority and public support. Conflicts, crises, and political transitions in the region may give national and local leaders a unique opportunity to reform institutions and accountability mechanisms and tackle service delivery challenges, as well as boost citizens' trust in public institutions and constructive engagement. Donors, including the World Bank Group, as well as governments and civil service organizations, need to learn from their own (often failed) efforts to support quality in education and health services. In moving forward, the MENA countries can explore possible incremental approaches to systemic reforms, the options for empowering communities and local leaders to find local solutions, and possible quick wins.

Extraordinary shocks

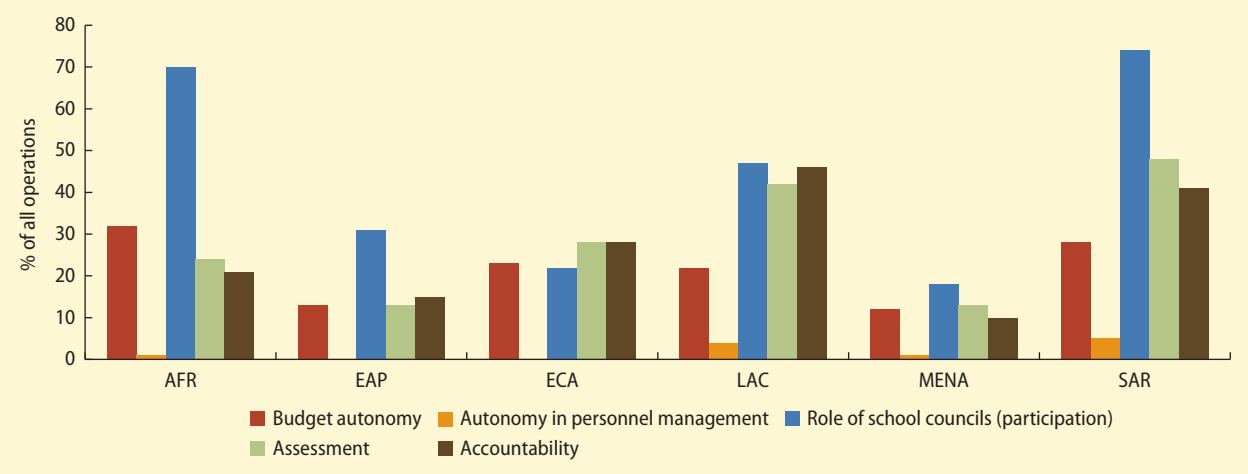
The extraordinary shocks spreading from North Africa to the Arabian Peninsula—as unsettling, costly, and risky as they are—can open possibilities for reform. Conflicts, refugee crises, and regime changes can make national and local leaders more likely to take risks, disrupt existing institutional arrangements, and alter elite coalitions. Costly events today may prompt changes in institutions, trust, and engagement that result in better performance. For example, transitions triggered by dramatic ruptures can potentially, at least in the short run, increase trust, engagement, and the possibilities of institutional reforms. Elites often experience a brief honeymoon period with much of the population, during which they can gain citizens' acquiescence to reform despite poor performance. Such opportunities may be short-lived, however, and the extent to which they can be exploited is likely to depend on a number of factors such as the strength of state institutions, the degree of polarization within society, and levels of regional or international intervention. But if citizens see improvements, they may remain engaged, thereby positively motivating service providers and public servants and supporting statewide reforms and institution building.

It is therefore critical to seize the opportunities offered in crises to buoy service provision, press for institutional reforms, and foster citizens' trust and positive engagement. Even in the midst of enormous difficulties that citizens and states face, there is an opportunity to escape the cycle of poor performance. Preparing to face these challenges and seeking ways to open new opportunities for breaking the cycle of poor performance require a clear understanding of how the international community, local policy makers, civil society, and citizens can work together to improve the quality of public services provision.

Donor intervention

Regardless of such extraordinary shocks, donors have been only partly effective in supporting education and health care quality in the MENA countries. Over the last 10 years, the World Bank Group has been increasingly highlighting the role of incentives and citizen engagement in achieving equitable and high-quality services. In the MENA region, this emphasis has figured prominently in the Bank's analytical and reimbursable advisory activities but has been less pronounced in operations. Only about 10 percent of the Bank's projects in the MENA countries (compared with about 30 percent on average in other regions) have promoted autonomy and accountability in education (figure O.8) or transparency and accountability in health services delivery. This low rate—along with a relatively modest success rate of Bank

FIGURE O.8 SABER analysis of World Bank School Autonomy and Accountability Interventions, by region, FY03–13



Source: World Bank forthcoming.
Note: SABER = Systems Approach for Better Education Results; AFR = Africa; EAP = East Asia and Pacific; ECA = Europe and Central Asia; LAC = Latin America and the Caribbean; MENA = Middle East and North Africa; SAR = South Asia.

operations supporting education and health services delivery in MENA countries—partly reflects the difficulty in developing interventions to address the cycle of performance beyond capital investments and capacity building and to motivate better performance by policy makers, public servants, and service providers and inspire citizens' trust and constructive engagement.

If programs, systems, and civil service organizations supported by donors are to be trusted by citizens, donors may need to reach out to citizens directly to build trust. Simple measures such as providing them with detailed information on donor support, objectives, interventions, and cost, disaggregated to the village level, would be a step forward and a possible model for promoting transparency domestically.

Experience suggests that the usual focus on identifying policy reform needs must be matched by a corresponding focus on how any given policy will actually be implemented, by whom, and why. One might hope that the new "science of delivery" approach provides a space within which such issues can be explored by looking at the nature of a problem and developing a hypothesis while being agnostic about the solution; by using evidence to inform the implementation of solutions; by taking an adaptable, creative, and context-driven approach; and by being able to capture cumulative knowledge when finding and fitting local solutions. Furthermore, the World Bank's initiative on social accountability in the MENA region appears to be a promising approach, even if its implementation requires time, money, and expertise in order to appropriately engage with local contexts. Examples of positive deviance—such as the Secondary Education Development and Girls Access Project (SEDGAP) in the Republic of Yemen, which is seeking to engage community leaders, parents, girls, and female teachers—offer valuable lessons on how donors can help. Investing in the high-quality collection of local data can pay handsome dividends in terms of enhancing the efficiency and effectiveness of everyday decision making, providing an evidence base for promoting organizational learning, and helping to identify where, when, and how such positive deviance occurs.

An incremental approach to systemic changes, local initiatives, and quick wins

Improvements in education and health services will not come simply through policy reforms, through modernization of schools and health facilities, or through training of educators and health professionals. Our analysis indicates that, to foster better performance, policy reforms and investments need the backing of institutions—especially incentives and norms embedded in both formal and informal accountability relationships—and citizens' trust and engagement. Experience suggests that performance improves when political institutions are the primary drivers of outcomes, or—as our case studies illustrate—when skillful leaders use them to tap into and exploit social institutions for better outcomes. Decentralization, incorporated in a broad package of reforms aimed at putting more power into the hands of local officials, can help strengthen incentives for better performance if supported by adequate accountability mechanisms and resources. The evidence on citizen engagement shows that information is necessary but not sufficient to motivate collective action, to make local or central officials accountable, and to influence public sector performance. More promising results emerge from multipronged strategies that encourage enabling environments for collective action and bolster a state's capacity to actually respond to the voices of its citizens. An ability to respond to citizens' feedback on the quality of service delivery is crucial to sustaining trust and participation.

Meanwhile, to have an impact, institutional and policy reforms must emerge from problem-led learning processes, facilitate the "finding and fitting" of context-specific solutions, and seek the participation of broad groups to ensure that new institutions are shared, legitimate, and contextually appropriate. Reforms also need to recognize the actual incentives that prevail for stakeholders associated with a specific problem in a specific setting. Within the existing constraints, an incremental, problem-driven approach to institutional and policy reforms can combine considerations about feasibility and political support with considerations about possible solutions. Such an approach also can result in design reforms that align more closely with the existing reform space and thereby gradually expand the space for reform.

Drawing on the available evidence, we set forth two broad sets of recommendations. First, we argue for a stronger social contract among public servants, citizens, and providers. To that end, we propose an approach of strategic incrementalism toward improving institutional quality and accountability mechanisms and motivating public servants and providers to serve the poor and other nonprivileged populations. In particular, we explore options to

- Develop effective external accountability institutions such as courts, independent auditors, and ombudsmen to monitor—and subject to public scrutiny—the performance of service providers and public servants and provide tools for the resolution of citizens' complaints and grievances.
- Strengthen monitoring, internal controls, and performance management in the public sector as well as within the education and health systems, including mechanisms to share and act on performance information, exposing service providers and public servants to internal accountability for performance.
- Modify mechanisms for selecting, encouraging, and rewarding leaders, public servants, and service providers so as to internalize norms of personal responsibility, professional accountability, and public service.
- Learn from intracountry variations to design solutions that fit local contexts, evaluate and strengthen policy implementation, inform citizens, energize local leaders, and scale up local successes.

Second, we call for empowering communities and local leaders to find "best-fit" solutions in motivating educators and health professionals and in harnessing social accountability to inspire trust and empower

citizens to act. Possible options for governments include measures to

- Build coalitions among champions of reforms in government, civil society, and the private sector to improve service delivery, giving local actors space to engage in piloting possible solutions.
- Systematically collect feedback on public services from users, benchmark service delivery and local governance performance, and disseminate information on performance to provide a rigorous basis for citizen action.
- Close the feedback loop among citizens, service providers, civil society organizations, and the private sector in order to strengthen the coherence of policy development; provide a foundation for prioritizing problems and possible solutions (with an emphasis on the most disadvantaged, poor, and vulnerable); more equitably allocate finite public resources across the local and national levels; and improve implementation effectiveness by enhancing mutual accountability and the dissemination of useful information on performance standards.

In addition, quick wins are needed—especially in countries in transition or emerging from a conflict and fragility—to gain and retain trust and make the cycle of performance virtuous. Quick wins could come in any form of improvements observable by citizens. The state, for example, could reach out to identify and popularize local successes through the media; hold public awareness campaigns on citizens' rights, service delivery standards, and anticorruption; conduct solution-focused public meetings to address problems such as absenteeism and material shortages in service delivery; expand opportunities for citizens' engagement; and demand a response to citizens' feedback. Citizens' experience with the state and with service delivery can improve more rapidly with the appropriate use of information communication technology.

We argue that because of the complex circumstances found in MENA countries, it is necessary to build on evidence of local successes and positive trends at the level of institutions, performance, and citizens' trust and engagement. We hope that this report and its recommendations will help citizens, civil servants, policy makers, and donors alike jointly identify and build on the present foundation to improve the delivery of social services, shifting the cycle of performance into a virtuous gear. An improved cycle of performance is what those living in the MENA countries deserve and what would enable them to fulfill their hopes and dreams for the future.

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Introduction

The Middle East and North Africa (MENA) region is at a critical juncture, with complicated transitions and tragic conflicts on one side and a tremendous potential based on rich human and natural resources on the other. The majority of the population in the region is lacking economic opportunities, facing inequalities, demanding social injustice, and expressing frustration and mistrust. In parts of the region, children, women, and other vulnerable population groups are suffering from extreme insecurity or even open conflict, struggling for survival and in need of essential services. Meanwhile, political uncertainties and poor state performance are exacerbating tensions in the society, deepening mistrust, and discouraging citizens from engaging with the state. With visionary leadership, the right policies, and inclusive institutions, this vicious cycle can be broken and a renewed social contract can be established allowing citizens to receive better services. A renewed social contract and better service delivery would also empower young women and men to realize their aspirations and potential and build a brighter future for the next generation.

This report examines the role of trust, incentives, and enagement as critical determinants of service delivery performance in the MENA countries. It expands the *World Development Report 2004* approach to "making services work" by exploring how political, administrative, and social institutions affect provider responsiveness. It also explores how a state's performance shapes citizens' trust and the nature of their engagement at the national and local levels, which in turn further influence institutional development and performance (World Bank 2004).

Focusing on education and health, this report illustrates how the weak external and internal accountability relationships prevalent in the MENA political and administrative spheres undermine incentives toward policy implementation and performance, and how such a cycle of poor performance can be counteracted. According to the evidence, weak accountability as well as low satisfaction with public services negatively affects citizens' trust in the state. Low trust in public institutions explains in part why citizens seldom engage with the state and service providers through formal channels, relying instead on *wasta* (personal relationships), informal payments, and other survival mechanisms. Case studies of local successes reveal the importance of both formal and informal accountability relationships and the role of local leadership in inspiring and institutionalizing incentives toward better service delivery.

Even more broadly, enhancing the services received by MENA citizens requires forging a stronger social contract among public servants, citizens, and service providers, as well as empowering communities and local leaders to find "best-fit" solutions. Lessons learned from the variations within countries, especially the outstanding local successes, can serve as a solid basis for new ideas and inspiration for improving service delivery. Such lessons may help the World Bank Group and other donors, as well as national and local leaders and civil society, develop ways to enhance the trust, voice, and incentives for service delivery to meet citizens' needs and expectations.

Organization of this report

This report explores the perceptions, realities, governance determinants, and possible solutions for education and health services delivery in the MENA region.[1] The report is divided into five parts.

In part I, we describe citizens' perceptions and expectations as well as the realities and local successes in social services delivery in the MENA region. First, we summarize insights from surveys about citizens' attitudes toward education and health services, their expectations about the government's role in providing those services, and how citizens try to fulfill their needs. Second, drawing on the literature and databases, we briefly review the impressive achievements of the MENA countries in expanding access to basic education and health services and improving core human development outcomes over the last five decades. We then highlight the remaining challenge of poor service quality and citizens' dissatisfaction. Finally, we examine cases of local success in which schools and health facilities are performing far beyond expectations under very difficult circumstances.

Overall, we find that the MENA countries are not meeting their potential in providing citizens with education and health services. Citizens demand quality services and believe the state is responsible for delivering such services, but states fail to meet citizens' expectations and overcome the service quality challenge, particularly in the public sector. That said, examples of local successes can be found, demonstrating that better realities are possible. Why is this? Why does service delivery fall short of potential in the MENA region?

We argue that the answer to this question lies in the cycle of poor performance that has emerged in much of the region (figure I.1). Institutions are a useful starting point for understanding this cycle. In the MENA region, state institutions lack both internal and external accountability, in part because of the shortage of information on performance that is needed to guide centralized decisions and in part because of the lack of incentives toward establishing accountability mechanisms for performance in public sector services delivery. When institutions are weak, service delivery policies are not successfully implemented. As Acemoglu and Robinson (2012, 78) argue, "The low education level of poor countries is caused by economic institutions that fail to create incentives for parents to educate their children and by political institutions that fail to induce the government to build, finance, and support schools and the wishes of parents and children."

Based on their experiences with poor-quality service delivery, as outlined in chapters 1 and 2, citizens perceive governments as corrupt and ineffective. Not only do public services seem captured by public servants and local elites with limited accountability to citizens, but a large share of private services also appear captured by the same public servants as part of their employment in both the public and private sectors. This problem is not evident in many of the Gulf states because an abundance of resources allows these states to provide high-quality services. But even there, service provision falls short of the promise these resources should provide.

Low trust in institutions undermines bottom-up pressures for improving service delivery. Citizens can provide incentives for public service delivery through choice (using public services), voice (giving feedback to

providers), and voting (choosing political leaders who support service delivery systems). However, in the face of weak institutions, poor performance, and low trust people often disengage. They turn instead to local nonstate actors and institutions for services. When they do demand services from the state, citizens tend to do so through informal channels and seek piecemeal, selective solutions to their individual problems.

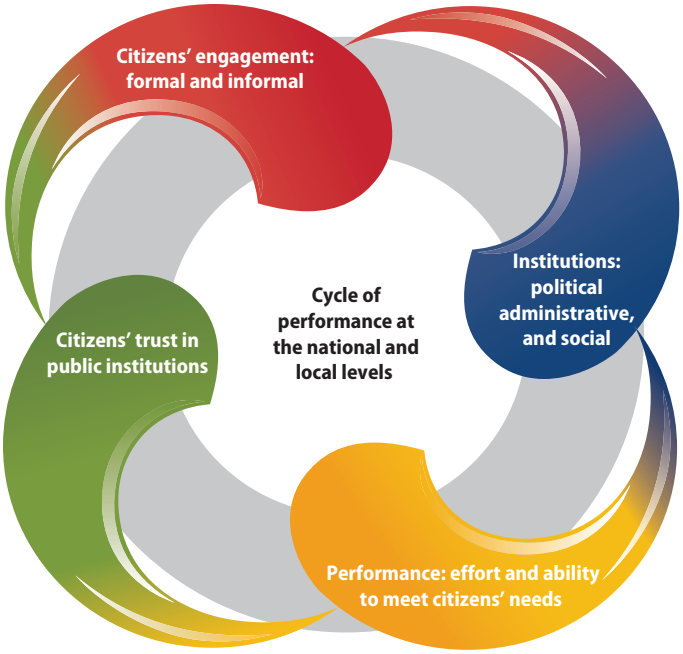
Circumventing the state perpetuates institutional weakness. When citizens walk away from public services or fail to give feedback, state actors lack the information they need to improve institutions. When political competition is weak, there is little pressure to develop better state solutions. Indeed, the importance of political engagement to developing institutions was clear in postcommunist eastern Europe. There, formal administrative institutions and rules were established and enforced in countries that had the vibrant political competition needed to pressure governments for reform (Grzymala-Busse 2010).

Cycles vary, of course, driven by differences in the available resources, societal composition, and the agency/leadership of key actors. And they are alterable. As shown in chapter 3, a virtuous cycle can develop at the local level (even in context of a poor performance at the national level) when local stakeholders are driven by individual will or social obligations to take initiatives.

In part II, chapter 4 explains how historical experience has led citizens to value health and education, fostered their dependence on the state, and has limited state responsiveness. Chapter 5 provides a detailed picture of the political, administrative, and social institutions that affect service delivery.

In part III, we turn our attention to performance at the point of service delivery: we explore the efforts and abilities of teachers and health professionals and the availability of key inputs such as instructional materials in schools and medicines in health facilities. We also discuss how these efforts and availability are affected by institutions. Drawing on surveys, we focus first on the national level (chapter 6) and then explore the nature

FIGURE I.1 The cycle of performance



and extent of subnational variation in service delivery performance (chapter 7). The subnational variation analysis underscores the message of chapter 3 that local successes can be found and that much about service delivery challenges and possible solutions can be learned in local contexts.

Completing the cycle of performance, in part IV we discuss how institutions and performance affect citizens' perceptions of the state and the nature of citizen action vis-à-vis the state. In particular, we seek to reveal how performance influences citizens' trust in the state (chapter 8), and how this trust in turn shapes the nature of citizens' engagement at both the local and national levels (chapter 9).

Because of the complex circumstances facing MENA countries, it is necessary to build on evidence of local successes and on positive trends that buck the cycle of generally poor performance. In this respect, in part V, chapters 10, 11, and 12 identify the bases for improvement and encouragement so that citizens, civil servants, policy makers, and donors can act on them. We acknowledge that many policy makers

across the MENA countries want to deliver visible results and, in doing so, bolster their authority and public support. As we discuss in chapter 10, conflicts, crises, and political transitions give rise to a new dynamic, which may present national and local leaders with a unique opportunity to reform institutions and accountability mechanisms and to tackle service delivery challenges as well as boost citizens' trust and constructive engagement. The cycle of poor performance can also be altered by reforms in the absence of such major disruptions. That depends on appropriate learning by and incentives from international donors (discussed in chapter 11), or incremental institutional reforms and local reform coalitions in society and government (chapter 12), or a combination of these factors. Thus by arguing that much of the MENA region is stuck in a low-equilibrium cycle of performance, we are not suggesting that citizens are doomed to weak institutions, poor service delivery, dissatisfaction, and suboptimal engagement. Rather, we are suggesting that efforts to reform service provision in the region should foster citizens' trust and engagement as well as enhance the political, administrative, and social institutions that affect state performance. To devise effective solutions, these efforts can build on the local success stories found in MENA countries.

Note

1. Because of differences in the transliteration of Arabic, place-names often differ slightly from one source to another. The versions of place-names appearing in this report are largely those used in the various surveys cited or those used by the World Bank's country offices.

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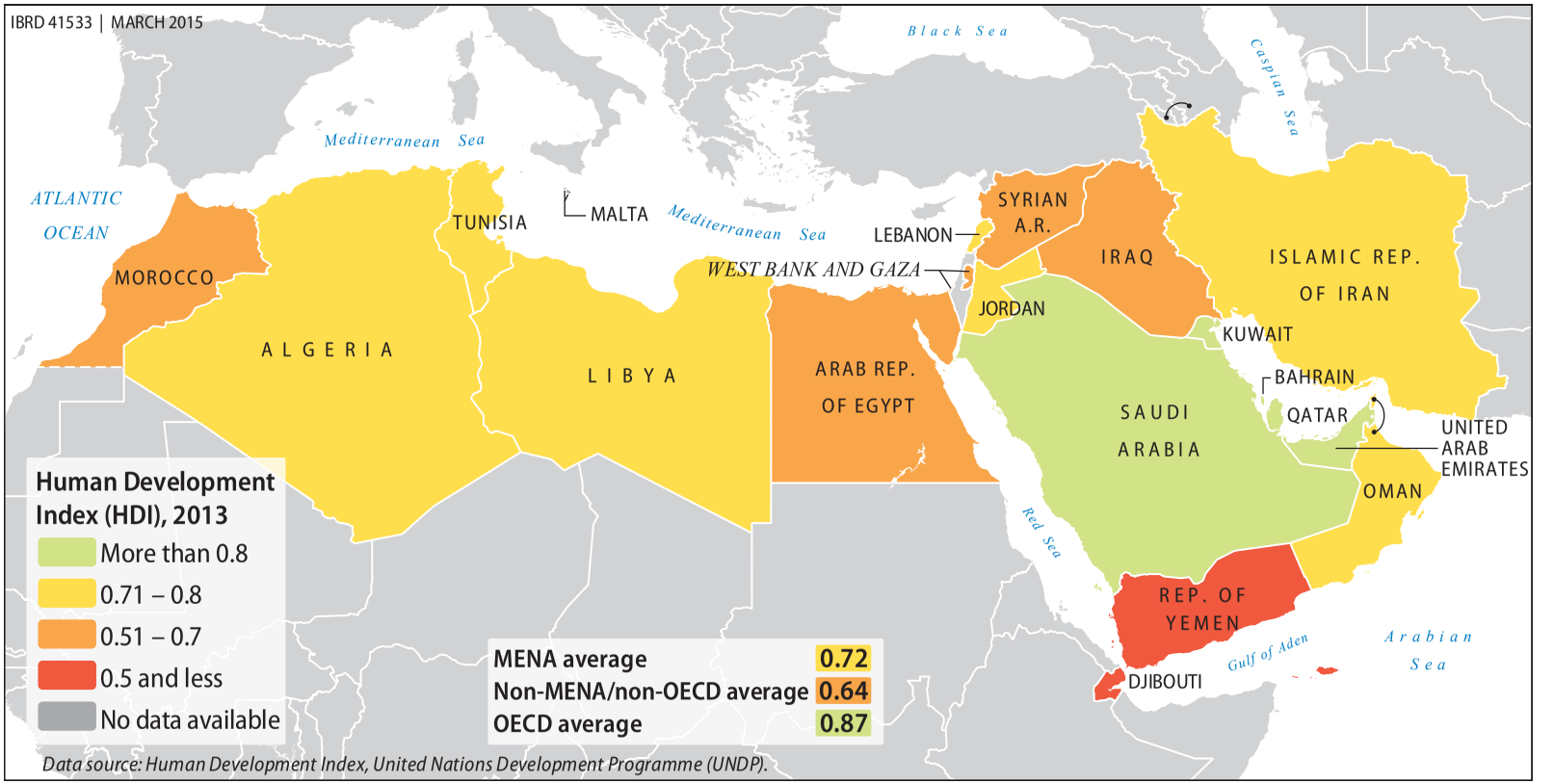
Expectations, Reality, and Inspiration in Education and Health Services Delivery

PART I

In part I, we explore citizens' perceptions and expectations of social services delivery in the Middle East and North Africa (MENA) as well as the realities and local successes. In chapter 1, we summarize insights from the available polls and surveys about citizens' attitudes toward education and health services, their expectations about the government's role in providing those services, and their attempts to pursue their needs. Then, drawing on the available literature and databases, in chapter 2 we briefly review the impressive achievements of MENA countries in expanding access to basic education and health services and improving core human development outcomes over the last five decades. We also highlight the remaining challenge of poor service quality and citizen dissatisfaction. Finally, in chapter 3 we examine cases of "positive deviance" and offer four case studies of schools and health facilities performing far above expectations in very difficult circumstances.

MAP I.1 Human Development Index (HDI) values for MENA, 2013



Source: World Bank (IBRD 41533, March 2015).

A Demand for Better Services but Not Formal Accountability

1

- Universal access to education and health is a constitutional right in most countries in the Middle East and North Africa (MENA), and their citizens place a high value on education and health care.
- Citizens of the MENA region are not satisfied with the existing services and with their government's efforts to improve service delivery.
- Citizens expect their government to play a strong role in providing welfare, but they rely mainly on informal mechanisms in pursuing their individual needs.

Social services typically constitute a critical interface between citizens and their state, shaping in turn citizens' expectations of the state, the level of trust they place in it, and the manner in which they engage with it. These relationships are explored in detail in this report. In this chapter, we mainly approach education and health services through the eyes of the citizens of the Middle East and North Africa (MENA) region, recognizing that citizens' perceptions and expectations reflect not only their current experiences and realities but also the promises and hopes of the past.

This chapter especially highlights the great emphasis placed by MENA citizens on education and health and on the government's role in ensuring the provision and quality of these services. By contrast, citizens are generally dissatisfied with the available education and health services and their government's efforts to improve these services, and they tend to rely on informal mechanisms in demanding accountability for service delivery.

The right to education and health services in the MENA region

Many countries in the Middle East and North Africa consider the delivery of social services—education and health—to be the state's responsibility and the right of all

citizens to universal access to be enshrined in their country's constitution and law. Since the Arab Uprisings in 2010–11, the revised constitutions in countries such as the Arab Republic of Egypt, Morocco, and Tunisia have further strengthened these rights and the state's obligation to ensure their protection and fulfillment. The constitutions of all MENA countries set education as a right for all citizens and, with the exception of Morocco, mandate that basic education is compulsory and free for youth. Similarly, the right of all citizens to health care is to some extent enshrined in the constitutions of all MENA countries except for Djibouti, Jordan, and Lebanon. Furthermore, as part of the global movement to ensure that all people obtain the health services they need without suffering financial hardship when paying for them (so-called universal health coverage), Egypt, Morocco, Tunisia, and the Gulf Cooperation Council (GCC) countries[1] are striving to increase health coverage as a right for all citizens.

The pronounced right of citizens to education and health services and the state's responsibility in delivering them are rooted in the political economy of Arab independence following World War II. With independence, Arab leaders sought to break away from the earlier elitist policies and promised their people industrialization and better living standards through state intervention. That intervention included massive expansion of education and health services as well as food and fuel subsidies and employment in the public sector. It gave rise to a social contract binding government and citizens to establish political legitimacy and strong nationhood and instilling in citizens support for government as well as the expectation that the state would assume responsibility for economic and social welfare. In the region's oil-rich countries, oil revenues further augmented citizens' expectations that the state would play a big role in the provision of services and welfare. Although the arrival of liberalization and marketization in the region during the 1980s partly undermined the state's provision of these services, the expansion in education and health has continued and so have expectations of a strong role for government in these sectors and in providing for citizens' welfare. Paradoxically, many countries in the region have implemented the postindependence social contract by drawing on administrative institutions established under colonization, which has limited the effectiveness of policy implementation and of state action (Cammett 2013; Issawi 2013).[2] The historical underpinnings of the current service delivery challenges are described in more detail in chapter 4.

The Arab people place a high value on education and health services along with employment opportunities in the context of economic prosperity. Much like the rest of the world, for them economic growth is a top priority. In the World Values Survey, 2010–14, the majority of respondents in Egypt, Iraq, Jordan, Kuwait, Libya, Morocco, Qatar, the Republic of Yemen, Tunisia, and the West Bank and Gaza identified a high level of economic growth as the current top priority of their economies. In Algeria and Lebanon, citizens gave priority in part to economic growth and in part to defense and citizen engagement (figure 1.1).

Against this backdrop, citizens give priority to education and health care, together with job opportunities. As a 16-year-old Palestinian boy from Hebron put it, "Of course if someone wants to find a respectable job, he has to get educated," or as an adolescent girl from Rafah said, "Education is a girl's best weapon to face the world" (Krishnan et al. 2012). In the My World survey organized by the United Nations, MENA citizens—much like citizens elsewhere—reported that education and health care were among their top priorities (figure 1.2).[3] A recent opinion poll in Egypt found similar results (figure 1.3). These results were consistent with those of earlier surveys, such as the poll conducted by Zogby International in 2005 (Attitudes of Arabs, 2005).

Moreover, MENA citizens expect education and health services to be delivered well. They view the ability of governments to

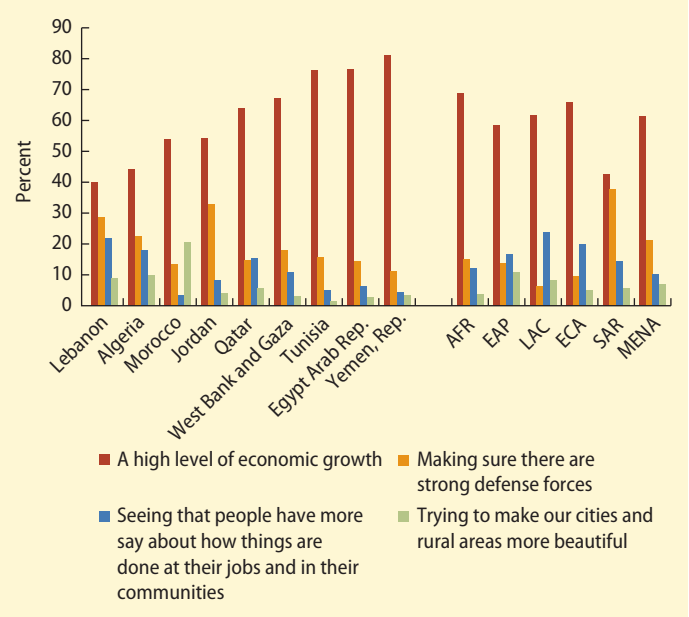
"deliver goods" as a key aspect of governance. In this respect, they are no different from other people (Bratton 2010; Leavy and Howard 2013; Bergh, Menocal, and Takeuchi 2014). This is also illustrated by the political economy of the recent uprisings in the region. These uprisings pushed to the forefront the embedded economic and social grievances, driven largely by deep dissatisfaction with the provision of public services and the lack of employment opportunities, as well as with the signs of political capture and crony capitalism (Walker and Tucker 2011; Cammett and Diwan 2013).[4]

Citizens' satisfaction and demands on government

On average, a large share of MENA citizens indicate in surveys that they are not satisfied with education and health services. For example, the 2013 Gallup World Poll, which covers citizens and Arab-speaking residents across countries, found on average nearly 40 percent of respondents dissatisfied with the education services in their country (figure 1.4) and 45 percent dissatisfied with the availability of quality health care (figure 1.5). On the positive end, respondents in Bahrain, Oman, Qatar, and the United Arab Emirates reported relatively high levels of satisfaction with both education and health services. By contrast, the majority of citizens in Egypt, Iraq, Morocco, and the Republic of Yemen were dissatisfied. Overall in the MENA region, levels of satisfaction with services across sectors appear lower than those of other regions, except for Africa (figure 1.6).

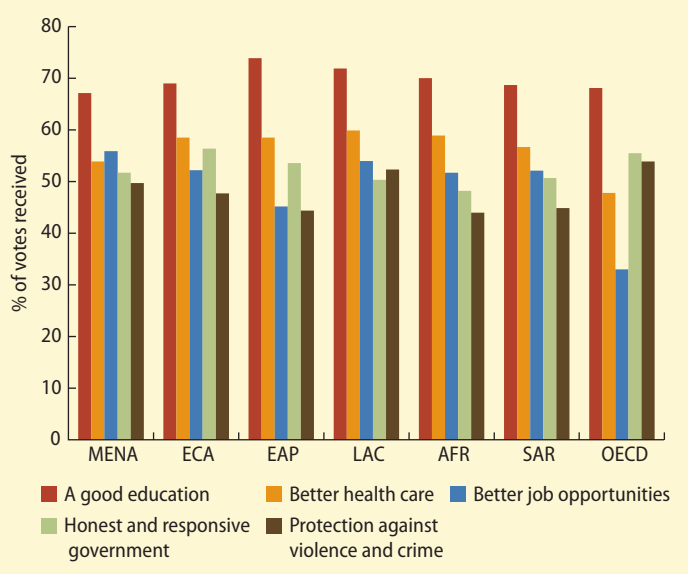
In some MENA countries, citizens are concerned about corruption in education and health care. According to the Global Corruption Barometer, the majority of citizens in Algeria, Egypt, Lebanon, Morocco, and the Republic of Yemen perceive the education and health systems in their countries to be corrupt or extremely corrupt (figure 1.7). In some countries, respondents complained about being "constantly exposed to corruption, favoritism, poor customer service, and deficient information" when

FIGURE 1.1 Prioritizing values: MENA and other regions, 2010–14



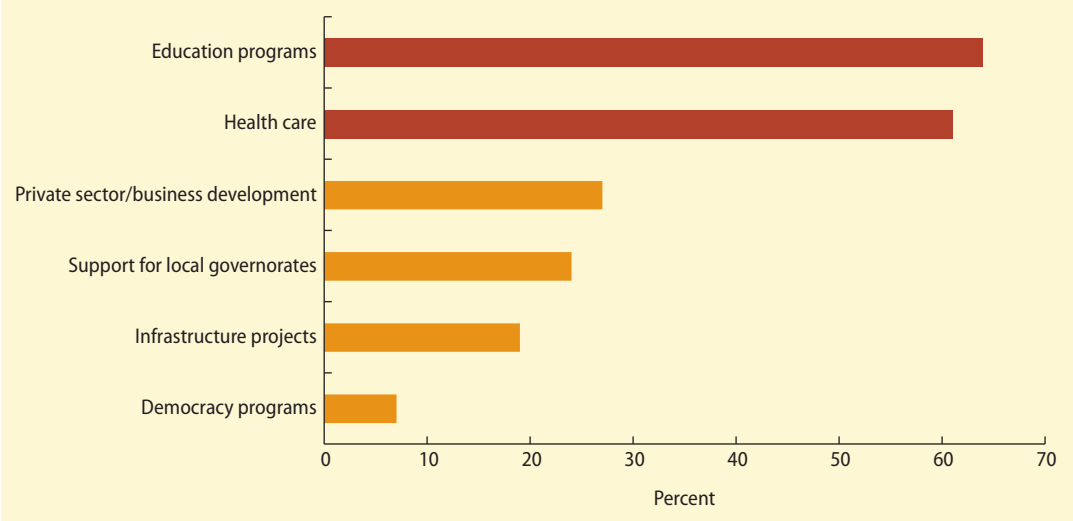
Source: World Values Survey, 2010–14 (Wave 6).
Note: Algeria, 2014; Arab Republic of Egypt, 2012; Iraq, 2013; Jordan, 2014; Kuwait, 2013; Lebanon, 2013; Libya, 2013; Morocco, 2011; Qatar, 2010; Republic of Yemen, 2013; Tunisia, 2013; West Bank and Gaza, 2013. AFR = Africa; EAP = East Asia and Pacific; ECA = Europe and Central Asia; LAC = Latin America and the Caribbean; MENA = Middle East and North Africa; SAR = South Asia.

FIGURE 1.2 Citizens' priorities among services: Various regions, 2014



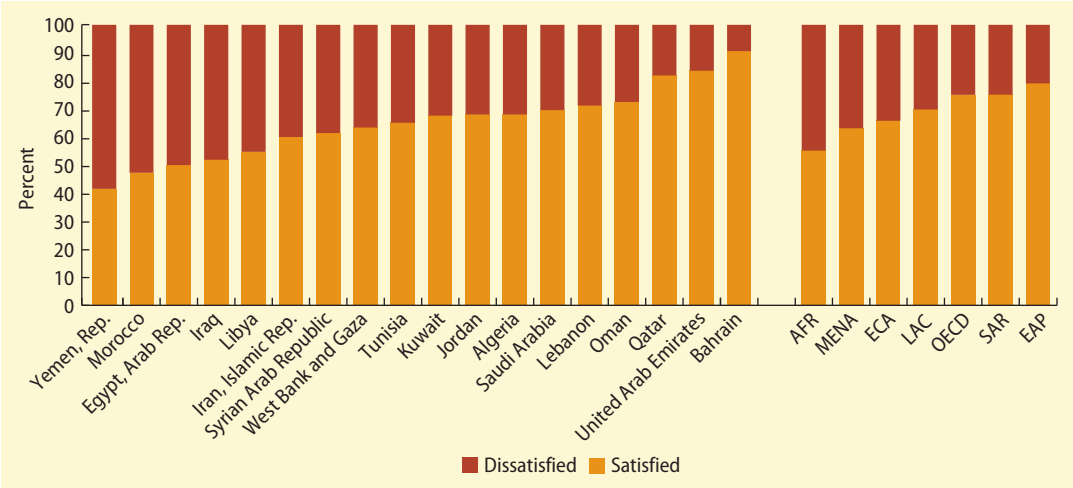
Source: My World Survey, 2014.
Note: AFR = Africa; EAP = East Asia and Pacific; ECA = Europe and Central Asia; LAC = Latin America and the Caribbean; MENA = Middle East and North Africa; OECD = Organisation for Economic Co-operation and Development; SAR = South Asia.

FIGURE 1.3 Top two issues in need of the greatest investment: Arab Republic of Egypt, 2011



Source: Egypt Public Opinion Survey, April 14–27, 2011.

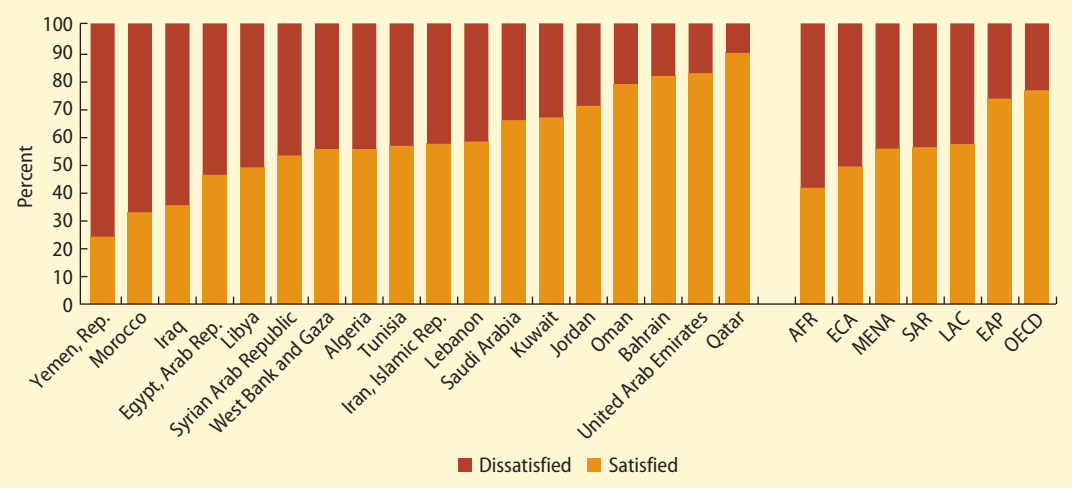
FIGURE 1.4 Satisfaction with education services: MENA and other regions, 2013



Source: Gallup World Poll, 2013.
Note: AFR = Africa; EAP = East Asia and Pacific; ECA = Europe and Central Asia; LAC = Latin America and the Caribbean; MENA = Middle East and North Africa; OECD = Organisation for Economic Co-operation and Development; SAR = South Asia.

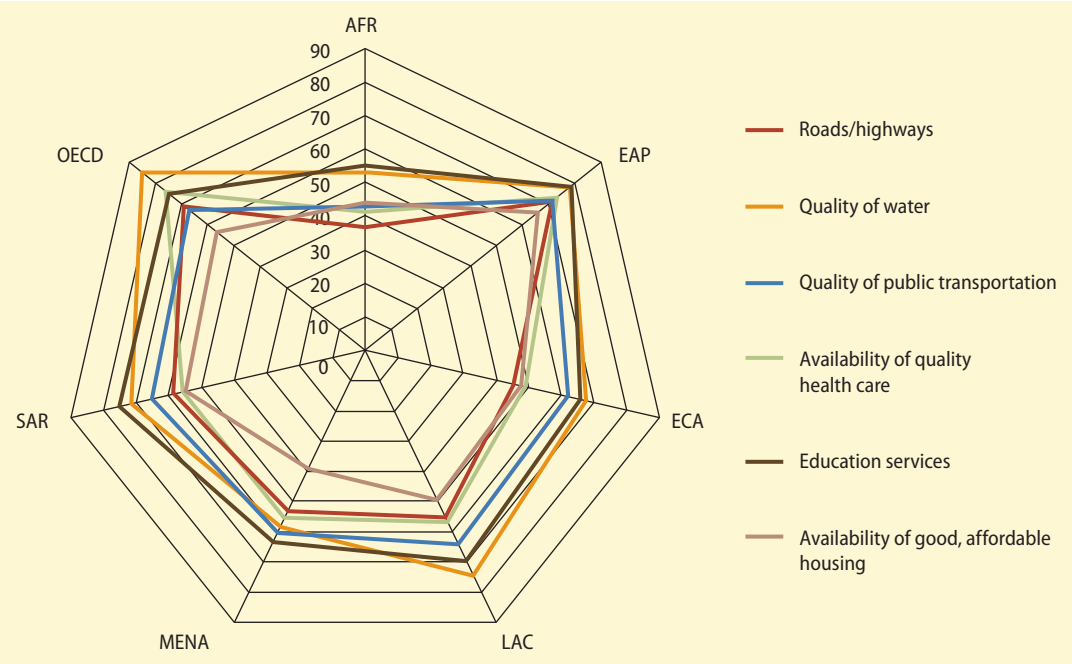
dealing with public services and the bureaucracy (World Bank 2007). The perceived prevalence of corruption varies across MENA countries. Scores on public sector corruption indicate low prevalence in the GCC countries when compared with Iraq, Libya, the Republic of Yemen, and Syria (Corruption Perceptions Index, 2014)—see figure 1.8. In addition, figure 1.9 reveals that MENA GCC respondents were on average more satisfied with their government's effort to fight corruption than those in other regions and non-GCC MENA countries (Gallup World Poll, 2013). A majority of respondents in Lebanon

FIGURE 1.5 Satisfaction with the availability of quality health care: MENA and other regions, 2013



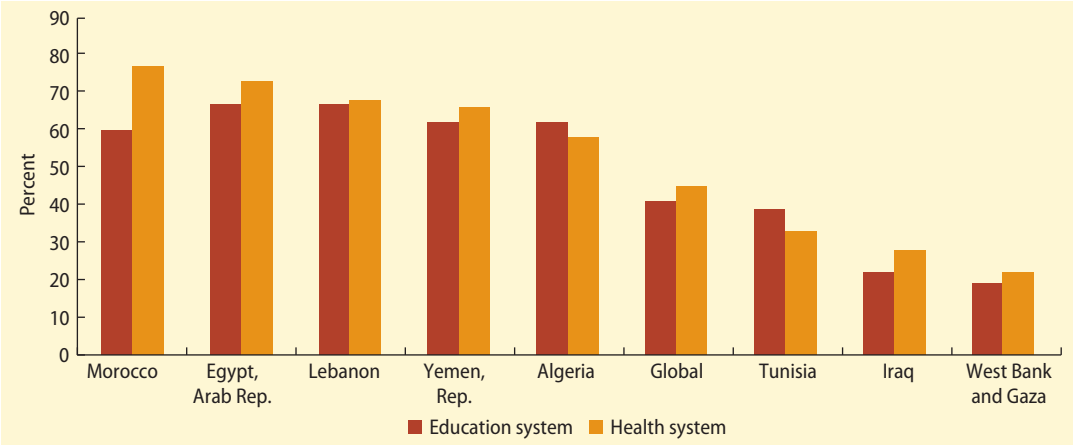
Source: Gallup World Poll, 2013.
Note: AFR = Africa; EAP = East Asia and Pacific; ECA = Europe and Central Asia; LAC = Latin America and the Caribbean; MENA = Middle East and North Africa; OECD = Organisation for Economic Co-operation and Development; SAR = South Asia.

FIGURE 1.6 Satisfaction with services across sectors: MENA and other regions, 2013



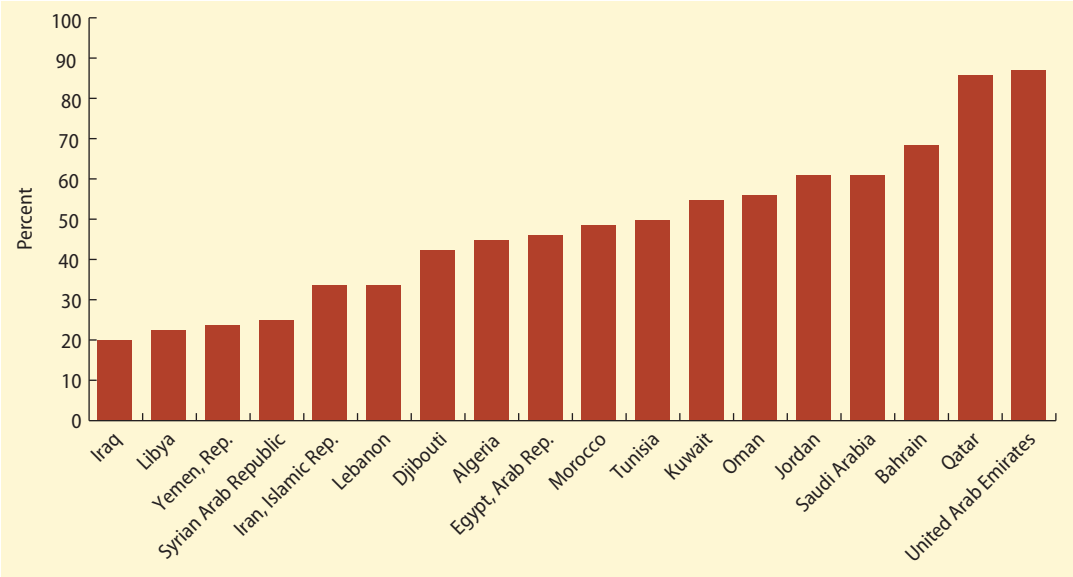
Source: Gallup World Poll, 2013.
Note: The figure shows percentages. AFR = Africa; EAP = East Asia and Pacific; ECA = Europe and Central Asia; LAC = Latin America and the Caribbean; MENA = Middle East and North Africa; OECD = Organisation for Economic Co-operation and Development; SAR = South Asia.

FIGURE 1.7 Education and health systems—corrupt or extremely corrupt: Selected MENA economies, 2013



Source: Global Corruption Barometer, 2013.
Note: MENA = Middle East and North Africa.

FIGURE 1.8 Public sector corruption score: Selected MENA economies, 2014

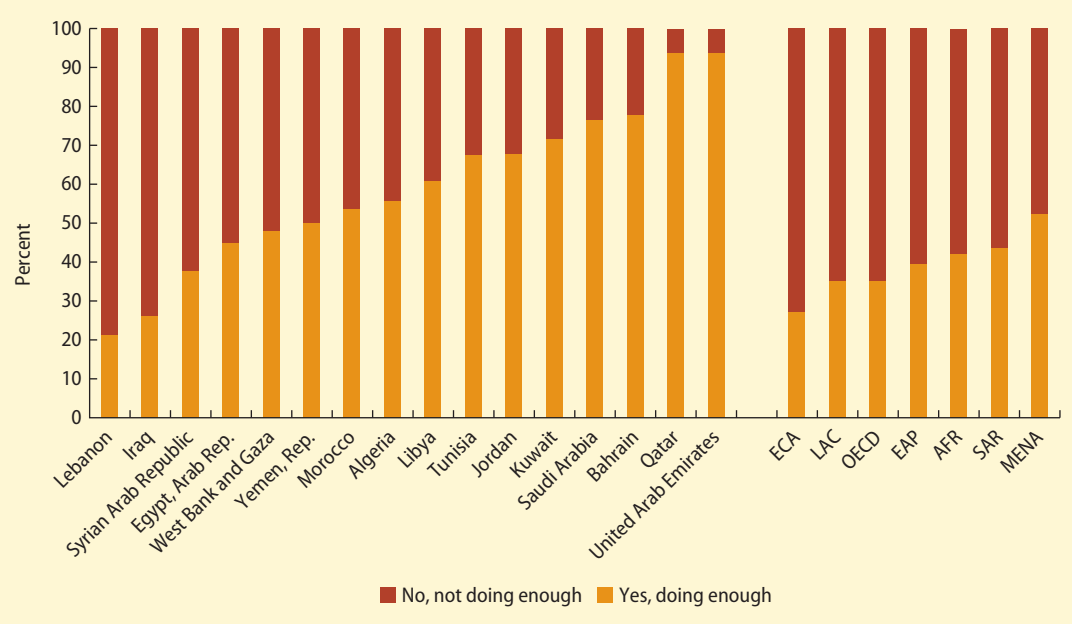


Source: Corruption Perceptions Index, 2014.
Note: Score: 0 (highly corrupt) to 100 (very clean). MENA = Middle East and North Africa.

(80 percent), Iraq (74 percent), Syria (62 percent), Egypt (55 percent), and the West Bank and Gaza (52 percent), however, responded that government was not doing enough to fight corruption.

Within countries, satisfaction with services appears associated with levels of income and education in households. In most MENA countries, higher-income respondents and females tend to be more satisfied with education and health services than lower-income respondents. More educated respondents tend to be more satisfied with health care but less satisfied with education (Gallup World

FIGURE 1.9 Perceptions of government's efforts to fight corruption: MENA and other regions, 2013



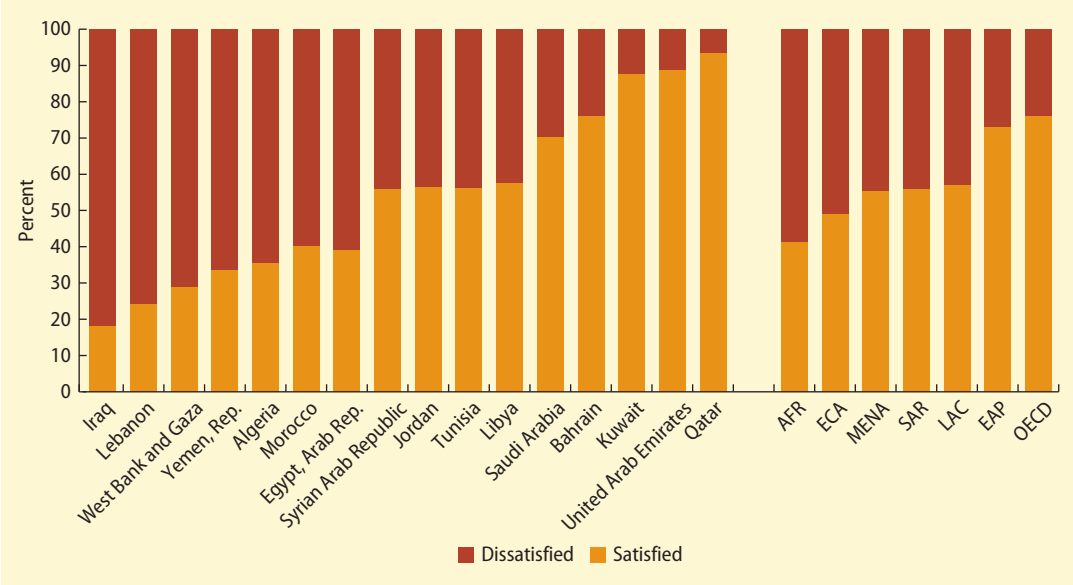
Source: Gallup World Poll, 2013.
Note: AFR = Africa; EAP = East Asia and Pacific; ECA = Europe and Central Asia; LAC = Latin America and the Caribbean; MENA = Middle East and North Africa; OECD = Organisation for Economic Co-operation and Development; SAR = South Asia.

Poll, 2013).[5] These differences in part reflect differences in access (such as in the ability to pay formal or informal fees) and information (including knowledge of objective performance measures and evidence). "You need to pay the staff to get good service," said some citizens in recent surveys (World Bank 2013), which may imply that, as one Moroccan health professional stated, those able to pay benefit from services more (Allin, Davaki, and Mossialos 2006).

In the broader socioeconomic context, MENA citizens tend to express concern about exclusion and clientelism. Especially in the developing MENA countries, respondents emphasized the need for pro-poor policies and expressed dissatisfaction with efforts to deal with the poor (figure 1.10). By contrast, respondents in the GCC countries, especially in Kuwait, Qatar, and the United Arab Emirates, were largely satisfied with their government's effort to address poverty.

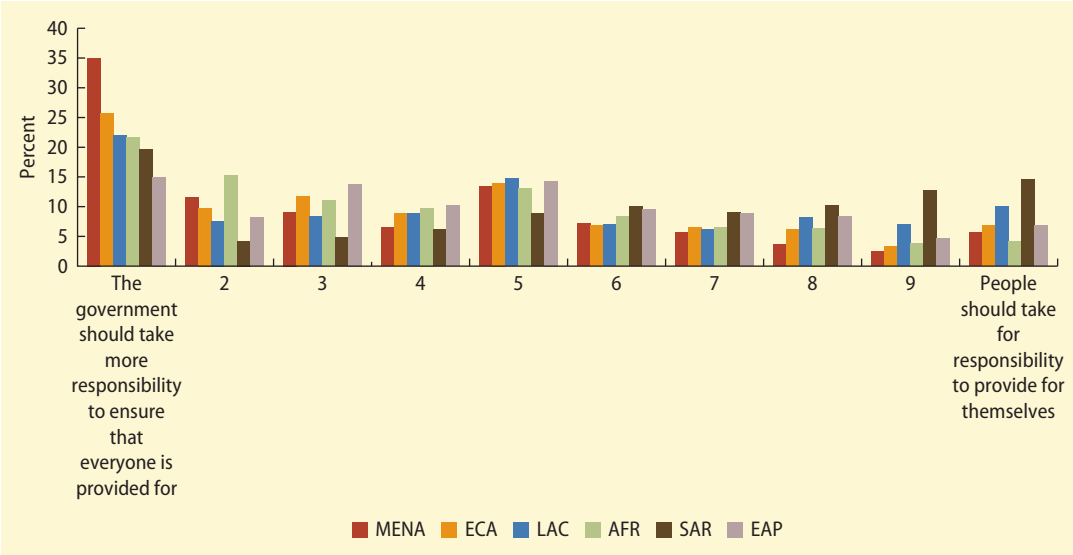
Reflecting the postindependence social contract, the Arab people expect their governments to take more responsibility for their overall welfare and engage more effectively in improving services. Nearly half of respondents in the selected MENA countries believed their governments should take more responsibility to ensure that everyone is provided for, whereas less than 10 percent believed that people should instead provide for themselves (as seen in figure 1.11 by contrasting those responding 1 or 2 with those responding 9 or 10 in the given range). As figure 1.11 shows, the Arab people expect significantly more government action on behalf of citizens' welfare than do citizens of other regions. Furthermore, an overwhelming majority of respondents in Lebanon (90 percent), Iraq (79 percent), Algeria (77 percent), the Republic of Yemen (76 percent), Egypt (67 percent), Tunisia (65 percent), Jordan (60 percent), and the West Bank and Gaza (57 percent) evaluated

FIGURE 1.10 Satisfaction with efforts to deal with the poor: MENA and other regions, 2013



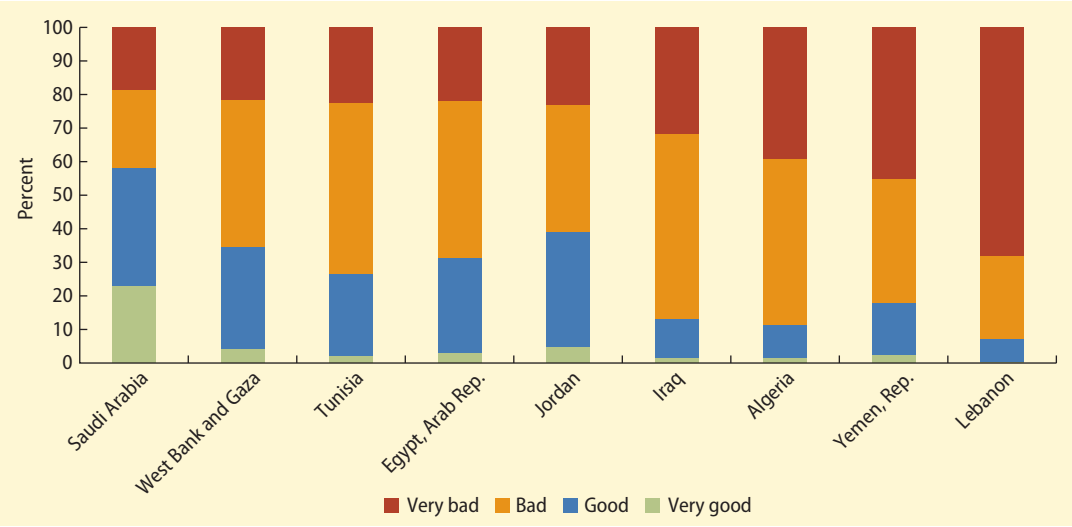
Source: Gallup World Poll, 2013.
Note: AFR = Africa; EAP = East Asia and Pacific; ECA = Europe and Central Asia; LAC = Latin America and the Caribbean; MENA = Middle East and North Africa; OECD = Organisation for Economic Co-operation and Development; SAR = South Asia.

FIGURE 1.11 On a continuum of 1 to 10, citizens' expectations of their government: MENA and other regions, 2010–14



Source: World Values Survey, 2010-14 (Wave 6).
Note: AFR = Africa; EAP = East Asia and Pacific; ECA = Europe and Central Asia; LAC = Latin America and the Caribbean; MENA = Middle East and North Africa; SAR = South Asia.

FIGURE 1.12 Perceptions of performance of current government in improving basic health services: Selected MENA economies, 2010–11



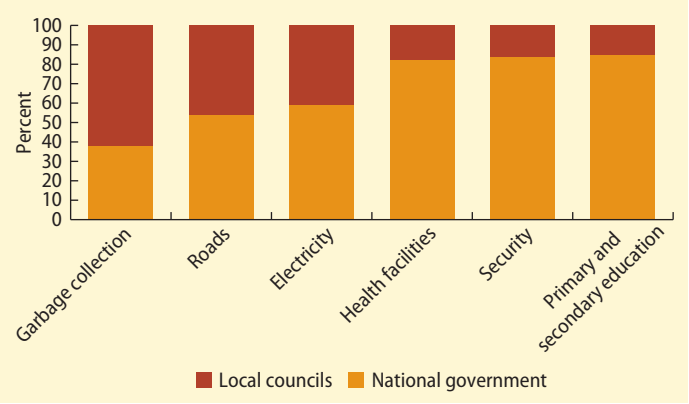
Source: Arab Barometer, 2010–11 (Wave II).
Note: Survey includes only citizens. MENA - Middle East and North Africa.

their government's performance in improving basic health services as either bad or very bad (figure 1.12).

For education and health as well as security, citizens' perceptions of government responsibility mainly pertain to the central government. These perceptions largely reflect the high extent of the centralization of authority in the education and health systems (as discussed in chapter 5). However, the division of responsibilities is often not transparent. In a survey in Tunisia, for example, many citizens believed the local government to be responsible for services that were under the purview of the central government, and almost 25 percent of respondents in the survey were unable or unwilling to answer (figure 1.13).

The next chapter discusses in more detail the realities of and the elements of citizens' satisfaction with education and health services. Chapters 8 and 9 explore how citizens' perceptions of service delivery and state performance affect their trust in public institutions and its different levels of government and the nature of their engagement with the state.

FIGURE 1.13 Citizens' perceptions of service delivery responsibility: Tunisia, 2014



Source: Transitional Governance Project, 2014.

Citizens' trust and engagement

In view of the high value that MENA citizens place on education and health services and their perceptions of state responsibility in ensuring the provision and quality of these services, it is not surprising that citizens exhibit higher trust in public institutions in countries—and, at the subnational level, in

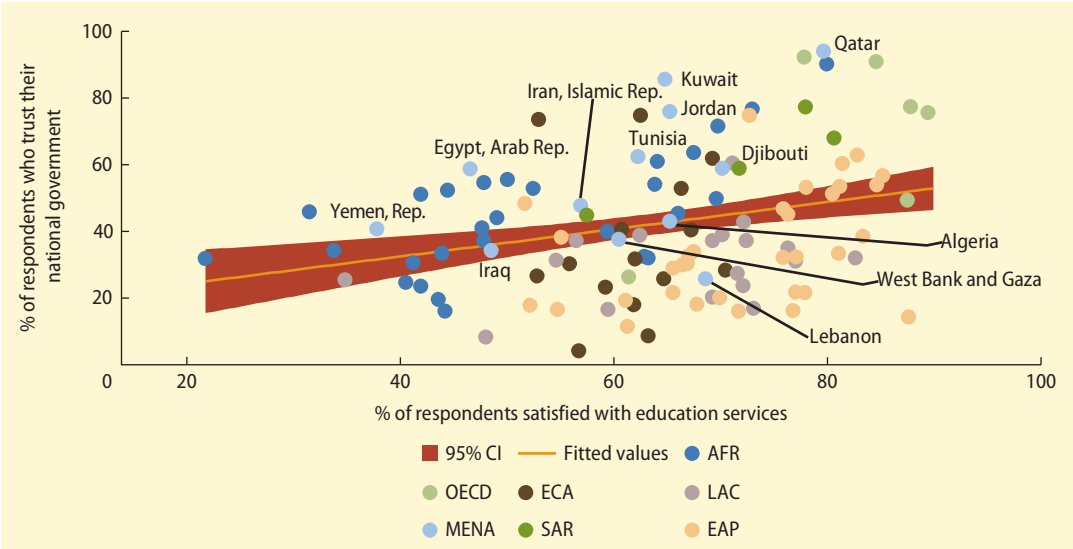
localities—where they are more satisfied with education or health care. Among those surveyed, a large share of respondents in Jordan, Kuwait, and Qatar expressed trust in their national government (with rates above 80 percent), whereas less than half of respondents in Iraq, Lebanon, and the West Bank and Gaza expressed trust in their governments (Gallup World Poll, 2013).

Globally, there seems to be a positive correlation between trust in government and satisfaction with services (see figures 1.14 and 1.15). This relationship seems stronger across MENA countries, which may reflect the high demand that MENA citizens place on their governments to ensure service provision (Gallup World Poll, 2013).

Qualitative analyses indicate that apart from the citizens' experience with service delivery, it is often the observed accountability relationships that influence their views of the state and their trust in government. Fieldwork on local governance and service delivery in the Republic of Yemen (conducted in 2014 as part of the Yemeni local governance program) illustrated the importance of the perceived informal and formal accountability relationships in government and service delivery and the significant role of the local customary institutions in constructing accountability relationships between citizens and the state, acting in essence as intermediaries between them.

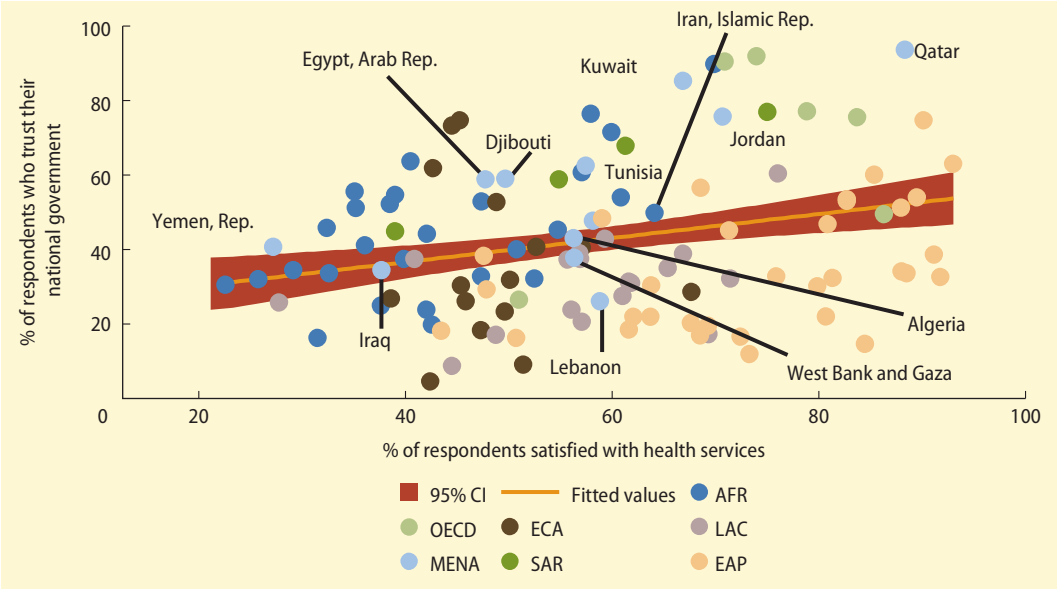
Finally, in contrast to their high expectations of state action, MENA citizens tend to forgo formal engagement with the state, including administrators and service providers. Compared with the citizens of other regions, those of the MENA region are the least likely to voice their opinions to public officials (figure 1.16). As chapter 9 explains, the citizens of MENA countries are not likely to seek accountability for service delivery through formal channels. Instead, anecdotal evidence suggests that it is not uncommon for citizens to use their social networks to reach out to ministry officials or members of parliament to voice a complaint or request state intervention such as capital investments in a given school or health facility.

FIGURE 1.14 Satisfaction with education services and trust in government: MENA and other regions, 2013



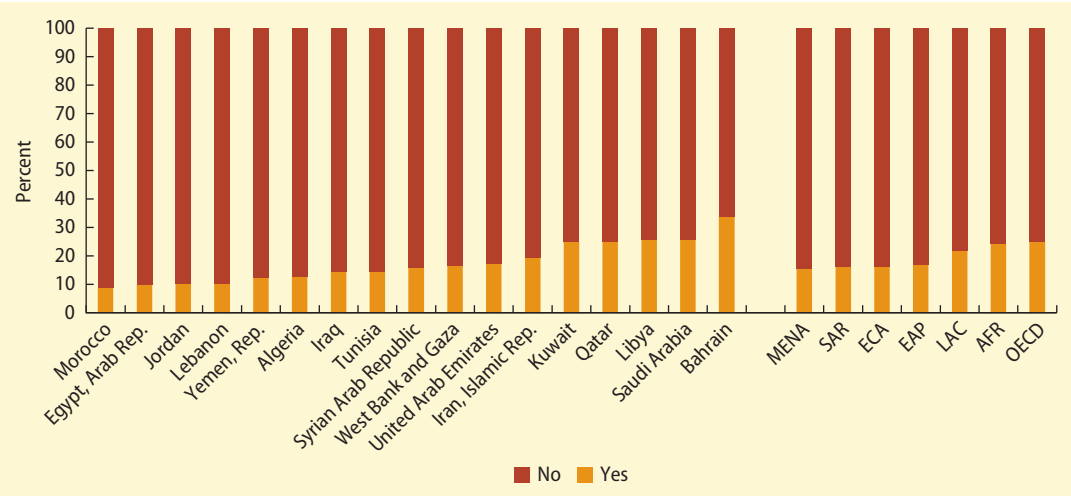
Source: Gallup World Poll, 2013.
Note: CI = confidence interval; AFR = Africa; EAP = East Asia and Pacific; ECA = Europe and Central Asia; LAC = Latin America and the Caribbean; MENA = Middle East and North Africa; OECD = Organisation for Economic Co-operation and Development; SAR = South Asia.

FIGURE 1.15 Satisfaction with health services and trust in government: MENA and other regions, 2013



Source: Gallup World Poll, 2013.
Note: CI = confidence interval; AFR = Africa; EAP = East Asia and Pacific; ECA = Europe and Central Asia; LAC = Latin America and the Caribbean; MENA = Middle East and North Africa; OECD = Organisation for Economic Co-operation and Development; SAR = South Asia.

FIGURE 1.16 Voiced an opinion to a public official in the last month: MENA and other regions, 2013



Source: Gallup World Poll, 2013.
Note: AFR = Africa; EAP = East Asia and Pacific; ECA = Europe and Central Asia; LAC = Latin America and the Caribbean; MENA = Middle East and North Africa; OECD= Organisation for Economic Co-operation and Development; SAR = South Asia.

This chapter has looked briefly at citizens' perspectives on education and health services in the MENA region. This report seeks to explain why MENA citizens approach education and health services, and the state, in the way they do and what the service delivery realities and challenges are. In the next chapter, we present evidence on the state of education and health services delivery in the MENA region.

Notes

1. The GCC countries are Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates.
2. Arab states emerged from the era of colonization with varied administrative capacities and competence. Egypt and Tunisia, for example, entered independence with strong functioning national administrations, while other countries such as Libya and Lebanon had weak administrative penetration and bureaucracies with little experience, making full territorial control difficult. Other states were still struggling with the formation of social structures and economies within the arbitrary territorial lines drawn by the Europeans. This was an acute problem for the nomadic tribal families in Jordan, Iraq, and the Gulf.
3. My World, an anonymous online survey, asks respondents around the world to identify what is most important to their families. Among the MENA economies, the sample includes Algeria, Bahrain, Egypt, Jordan, Lebanon, Morocco, Oman, Qatar, the Republic of Yemen, Saudi Arabia, Sudan, the Syrian Arab Republic, Tunisia, the United Arab Emirates, and the West Bank and Gaza. Online voting was open until 2015. Figure 1.2 reflects the votes received until July 3, 2014.
4. In "After the Arab Spring: The Uphill Struggle for Democracy," Walker and Tucker (2011) offer a comprehensive review of the grim and deteriorating conditions in the run-up to the Arab Spring. In their book *The Political Economy of the Arab Uprisings*, Cammett and Diwan (2013) provide an overview of the important developments across the Arab world prior to the Arab Uprisings. They argue that it was the interaction of political factors and real and perceived economic developments that brought about the protests. In particular, the perceived inequality of opportunity, underscored by the crony capitalism and political connections shaping economic opportunities in the region, was a central concern.
5. The reported results are based on two logistic regressions performed using the 2013 Gallup World Poll data. The first equation lists satisfaction with education as a dependent variable (binary variable coded as 1 = satisfied, 0 = dissatisfied) with the following explanatory variables: age, education, employment status, gender, and income quintile. The second equation lists satisfaction with the availability of quality health care as a dependent variable (binary variable coded as 1 = satisfied, 0 = dissatisfied) with the following explanatory variables: age, education, employment status, gender, and income quintile.

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The State of Education and Health Services Delivery: The Quality Challenge amid Impressive Advances

2

- Education and health outcomes have improved over the decades, gradually approaching the levels expected based on economic development.
- Although citizens have gained access to services, their needs have shifted with the economic, demographic, and epidemiological transitions. Conflicts and refugee crises have added extra pressure.
- The private provision of services has grown, expanding the choices for some citizens.
- Service quality has become the main challenge.

As discussed in chapter 1, the citizens of the Middle East and North Africa (MENA) region value education and health services and expect the government to ensure their delivery and quality. This chapter briefly summarizes the region's impressive advances in education and health outcomes and in promoting access to essential services. The analysis highlights service quality as the key challenge facing MENA countries, in part reflecting the shifting needs driven by the region's economic, demographic, and epidemiological transitions.

Outcomes

Although education and health outcomes differ significantly across and within countries in the MENA region, the advancements achieved over the past decades have been applied almost uniformly, except for the unfortunate local reversals due to conflicts.

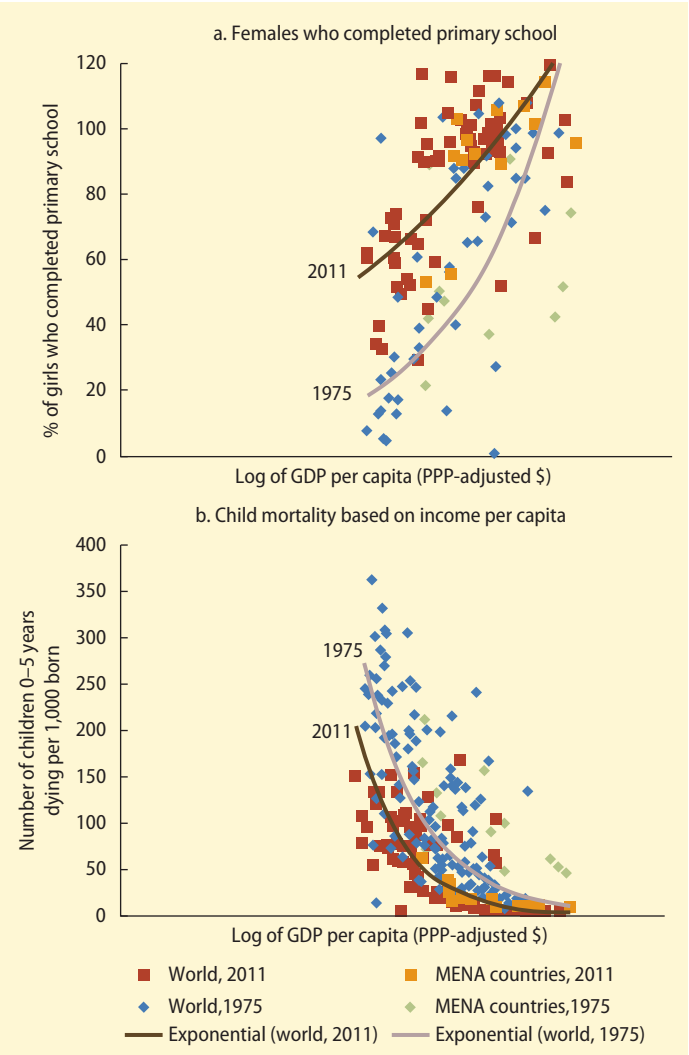
Historical advancement

Over the last five decades, the citizens of MENA countries have seen their education and health improve rapidly. As governments across the MENA region have invested in building a wide network of schools, hospitals, and clinics and in training teachers and health professionals, citizens have rapidly gained access to essential services. Indeed, on several fronts they have seen their education and health rapidly improving in absolute terms and relative to other countries at a comparable

stage of economic development. Although significant differences exist within as well as across countries in the region, education and health indicators in MENA countries have largely converged to the levels expected based on income per capita (figure 2.1).

Education and health outcomes look encouraging on several fronts. Life expectancy at birth increased from 64 to 72 years between 1990 and 2011, compared with an increase from 65 to 70 years during the same time period worldwide. Premature death and disability from most communicable, newborn, nutritional, and maternal causes with the exception of HIV/AIDS have decreased significantly and faster than expected based on the growth in income per capita (Mokdad et al. 2014). These improvements have been driven in part by successes in selected areas of public health such as immunization (figure 2.2). In education, primary, secondary, and tertiary enrollment and completion rates have risen rapidly and achieved parity for girls and boys. Net enrollment rates for primary education have approached levels seen in member countries of the Organisation for Economic Co-operation and Development (OECD)—see figure 2.3. And the average returns to primary education in the MENA region have been estimated as the highest in the world, especially for females (Montenegro and Patrinos 2014).

FIGURE 2.1 Performance of MENA countries in education and health: Females who completed primary school and child mortality based on income per capita, 1975 and 2011



Source: World Development Indicators (database).
Note: MENA = Middle East and North Africa; GDP = gross domestic product; PPP = purchasing power parity.

Recent shifts in needs

The economic, demographic, and epidemiological transitions experienced during recent decades have shifted the demands on service delivery. The region's economies and labor markets are increasingly dependent on the creation of private sector jobs amid rapid population growth. This situation has altered the skills needed and the demands on the region's education and training systems. As for health, the MENA region's middle- and high-income countries are experiencing rapid changes in lifestyles, bringing about major shifts in the disease burden.

Education and training systems in the MENA region are finding it difficult to meet the shifting labor market needs. These systems emerged as part of the postindependence social contract, which included an emphasis on public sector employment and on the role of education and training systems in preparing youth for public sector jobs. In recent decades, however, public sector jobs have become costly to generate for an expanding pool of applicants, driven by high

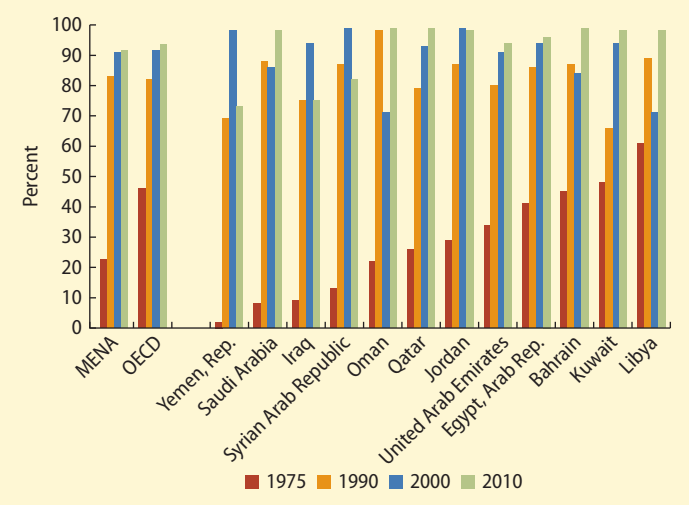
population growth, the increasing participation of females in the labor force, and rising labor force qualifications. Moreover, the formal private sector has been curtailed in some MENA countries by crony capitalism and a poor business climate (Diwan, Keeefer, and Schiffbauer 2014; Rijkers, Freund, and Nucifora 2014). The result is that there are few "desirable" jobs—too few, in fact, to motivate the education and training systems to adopt reforms that would produce skills applicable to the private sector.

These trends have contributed to an erosion in the value of the skills currently produced by the region's education and training systems. In contrast to primary education, the average returns to secondary and tertiary education, especially for males in the MENA region, are currently estimated to be the lowest among all regions (Montenegro and Patrinos 2014). Moreover, the MENA region has the world's highest unemployment rate among youth, and particularly among educated youth and young females. For young men and especially women, the transition from education to work is longer in the MENA region than in any other region (ILO 2004).

Although private sector job creation is a key problem, MENA's employment challenge also stems in part from the skill gaps and mismatches generated through the education and training system. On average, one-third of unemployed youth are university graduates, even though enterprises report being unable to fill vacancies. About 40 percent of employers in the MENA region identify skill mismatches as a major constraint to doing business and growth (Gatti et al. 2013). Although further economic development and employment in MENA countries increasingly rely on job creation in the private sector, the education systems have a legacy of preparing youth for public sector jobs.

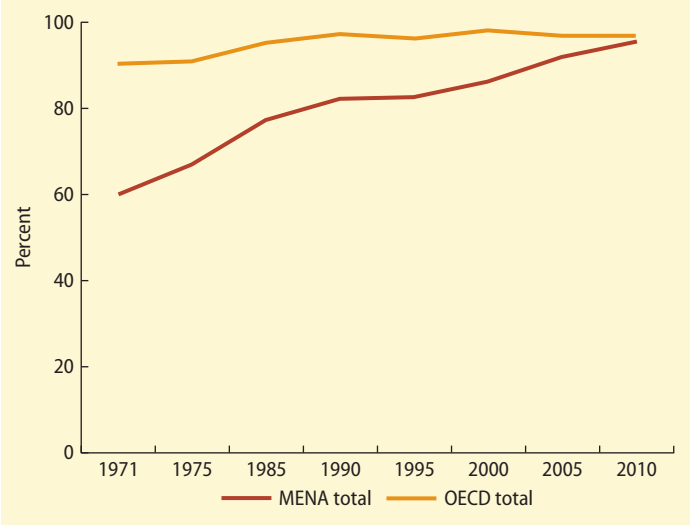
In health, the region is experiencing a rapidly growing burden of noncommunicable diseases, posing new demands on the health system. According to Mokdad et al. (2014), between 1990 and 2010 the disease burden from many noncommunicable causes increased, especially ischemic heart disease, stroke, mental disorders, musculoskeletal disorders, and chronic kidney disease (figure 2.4). The epidemiological profile of many high-income and some middle-income

FIGURE 2.2 Percentage of children aged 12–23 months immunized for measles: MENA and OECD countries, selected years, 1975–2010



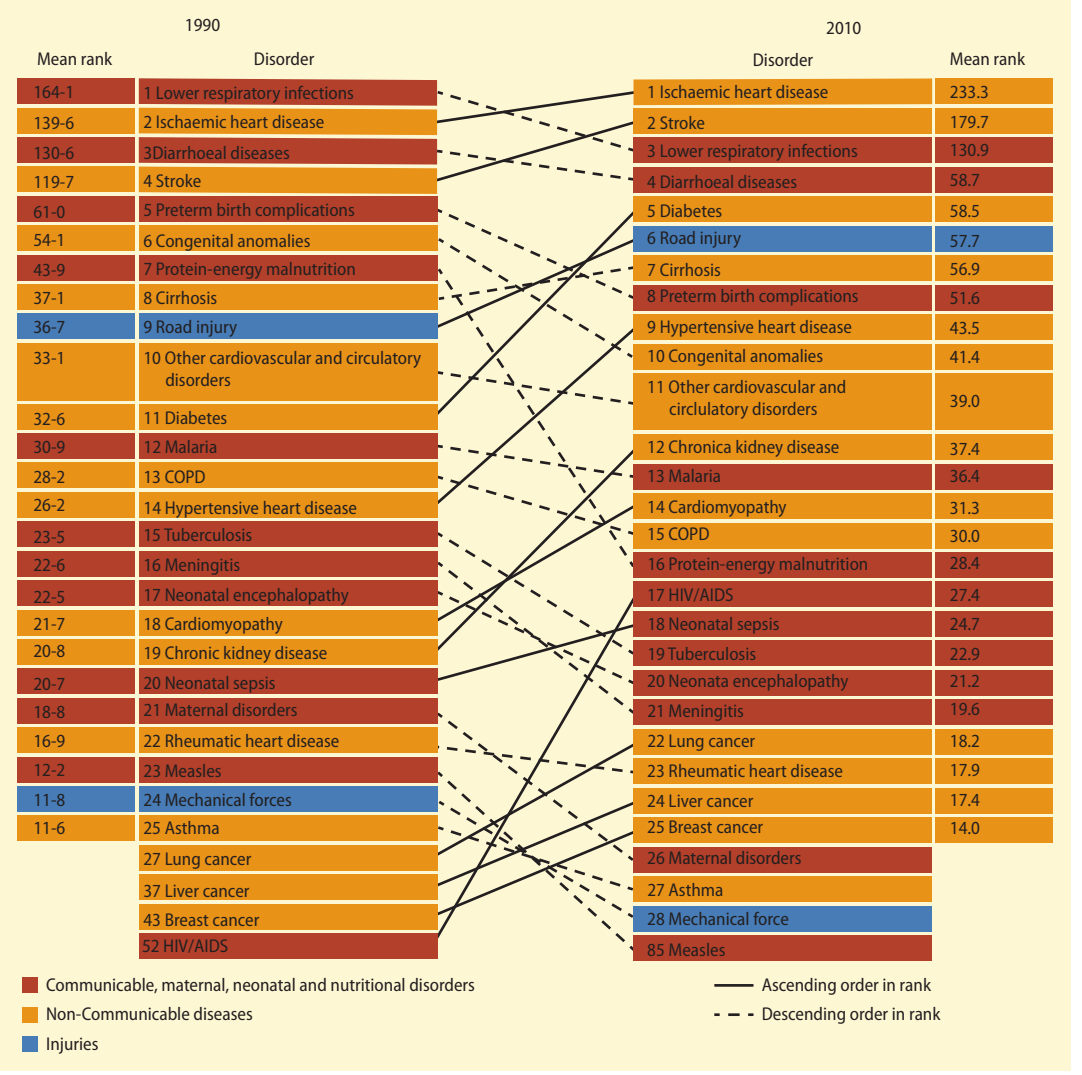
Source: World Development Indicators (database).
Note: MENA = Middle East and North Africa; OECD = Organisation for Economic Co-operation and Development.

FIGURE 2.3 Net enrollment rates (adjusted) for primary education: MENA and OECD countries, selected years, 1971–2010



Source: World Development Indicators (database).
Note: MENA = Middle East and North Africa; OECD = Organisation for Economic Co-operation and Development.

FIGURE 2.4 Ranking of top 25 causes of death in the Arab world, 1990 and 2010



Source: Mokdad et al. 2014.

Arab countries resembles that of countries in Europe, the United States, and Canada, with health losses from most noncommunicable diseases increasing over the last 20 years. The exceptions are Djibouti and the Republic of Yemen, where lower respiratory infections and diarrheal diseases continued to be the main causes of death during 1990 and 2010. In Algeria, the Arab Republic of Egypt, Iraq, Jordan, Lebanon, Libya, Morocco, the Syrian Arab Republic, Tunisia, and the West Bank and Gaza, ischemic heart disease and stroke became the leading causes of death in 2010. In Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates, the leading causes of death included road injuries as well as noncommunicable diseases.

The rapid increase in noncommunicable diseases in the Arab world suggests that the

change in the disease burden is a result of a change in behaviors, including lower levels of physical activity, a less healthy diet, and rising health risks such as smoking. Its obesity rates are among the highest in the world, especially among preschool children and women in the Gulf countries (de Onis and Blössner 2000; Kelishadi 2007; Mirmiran et al. 2010), and tobacco consumption is very high among men (Rahim et al. 2014).

Health systems in the region are ill-prepared to tackle the shifting disease burden and the underlying behavioral drivers. Overall, the health system stewardship of the national health ministries is underdeveloped. Health information systems are weak, which undermines the design and limits the effectiveness of health policies and prevention programs. Meanwhile, public health functions such as the promotion of healthy lifestyles and preventive care are relatively underdeveloped; health systems in the region have focused instead on curative care (Veillard et al. 2011; Mokdad et al. 2014; Rahim et al. 2014).

The effects of conflicts

Conflicts and refugee crises have generated education and health challenges across MENA countries. As we discuss in chapter 10, refugee populations have elevated the demand for public services in their host communities. In 2014 in Jordan, for example, over 120,000 refugee children enrolled in schools throughout the country (some 100,000 in host communities and 20,000 in camps), and over 35,000 refugee children received remedial, nonformal, or informal education as well as basic life skills interventions (UNHCR 2013). The refugee influx has severely strained the health systems of host countries, most recently in Jordan and Lebanon, because of (1) the sharp rise in communicable diseases; (2) the emergence of new diseases not present earlier in host communities; and (3) the increasing risk of epidemics such as water-borne diseases, measles, and tuberculosis. Among noncamp Syrian refugees in Lebanon and Jordan, nearly three-quarters of the needed health care is related to acute illnesses (UNHCR 2013). Meanwhile, many localities in Iraq, Syria, and the West Bank and Gaza have seen their service delivery capacity partly or largely destroyed, and the deficits in service delivery are deepening.

Conflict and the limitation of available resources, particularly when public infrastructure is targeted, force citizens and governments to severely stretch what resources they have available. In cases of displacement, many refugees experience trauma as a result of their journey or the forced substandard living conditions. Most refugees also arrive in the host communities with health conditions that require immediate attention. For example, the common health care needs of Syrian refugees entering Lebanon include reproductive health care and family planning, child health care such as vaccinations, and treatment for acute illnesses such as respiratory infections and gastrointestinal diseases, chronic diseases such as hypertension and diabetes, and mental health problems. Yet refugees such as those in Lebanon often cannot access the limited resources available because they do not have the ability to pay the public fees when applicable (UNHCR 2014). Some innovative resources such as mobile medical units are available, but these units are scarce and providing coverage is still a challenge.

In terms of education, most refugee families value education and would like to register their children in schools, but they cannot in part because of no space in nearby schools, the distance of schools that do have space from the place of residence, and the costs of registration, books, and other fees. In certain circumstances, lack of adequate water, sanitation, and hygiene facilities in schools is a barrier to attendance for Syrian children, especially for girls.

Conflicts and refugee crises in the MENA region have reversed decades of educational achievement and may create a "lost generation." Because of the collapse in Syria, for example, more than 3 million children have left school, and thousands of young

school-age children have never been enrolled (Chahine et al. 2014). Among Syrian refugee children living in urban centers in Jordan, school enrollment rates range from 31 to 61 percent, depending on the governorate, and refugee students have a 5 percent dropout rate (UNHCR 2013). In Lebanon, only 6 percent of the surveyed Syrian refugees aged 15–24 years were enrolled in formal education even though more than a third of the youth sample had been enrolled in Syria before displacement (Chahine et al. 2014). The gravity of the situation is even starker when comparing the estimated 72 percent of Syrian refugees aged 15–18 years enrolled in formal education in Syria in 2010 (reflecting a high 95 percent transition from primary to secondary education in Syria in 2010) with the mere 8 percent of 15–18-year-old Syrian refugees enrolled in schools in Lebanon (Chahine et al. 2014).

Access

Access to essential services remains a problem in the MENA region's low-income countries, Djibouti and the Republic of Yemen. Their residents face widespread constraints in obtaining basic services, including clean water—a challenge exacerbated by the effects of climate change and population growth in the region[1]—and sanitation, as well as essential health care. Partly as a consequence, their life expectancy is 10 years less than the regional average.

Other countries in the region face narrower access challenges related to education and health. For example, 52 percent of households in the MENA countries (the highest rate among all regions), compared with about 29 percent globally, are without adequately iodized salt, which is critical for healthy brain development in children (UNICEF MICS).

In education, the key remaining access challenge relates to preprimary education. Gross enrollment in preprimary education stands at 27 percent in the region, compared with the international average of 48 percent and the OECD average of 86 percent (figure 2.5). In fact, on average, MENA countries pay relatively little attention to early childhood learning, despite strong evidence of its immense benefits (El Kogali and Krafft 2015).

Equity in access

Access disparities remain of concern, especially in health in the MENA region. MENA countries have broadly achieved equity in access to basic education and selected public health services such as immunization. Access to other essential services, however, is unequal in some countries, driving a high variation in health outcomes such as child malnutrition in Morocco (figure 2.6) and child mortality in Egypt (figure 2.7).

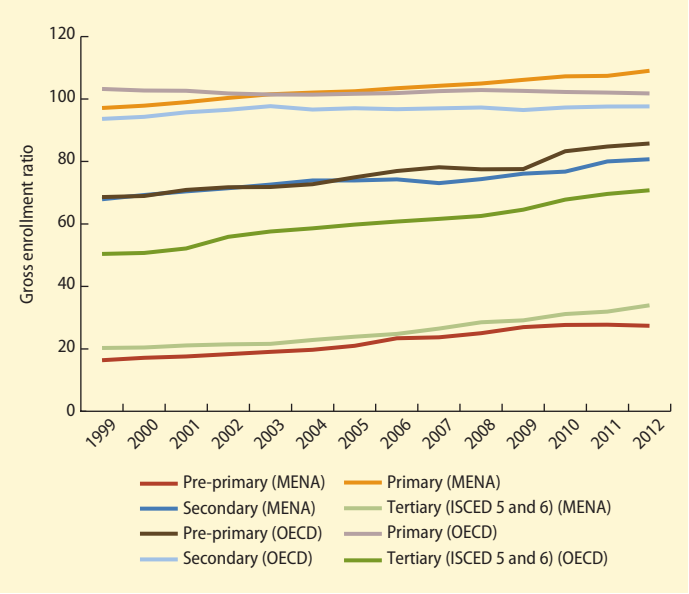
Poor water quality and poor sanitation facilities are largely found in rural areas, and the related deaths and illnesses are concentrated among the children there. In Djibouti, nearly all those who reside in urban areas have clean drinking water compared with just over half of those in rural areas. Similar differences in access to clean water are found between urban and rural communities in Morocco (37 percentage point gap) and Iraq (35 percentage point gap). In the Republic of Yemen, just three-quarters of those in urban areas enjoy clean water compared with less than half in rural areas (47 percent). Consequently, child mortality, especially due to diarrhea, tends to be higher in less developed rural areas.

Similarly, disparities in access to critical goods and services, such as prenatal care, skilled delivery care, iodized salt, child development activities, and early childhood education, remain large, giving rise to unequal opportunities for the healthy development of children and their prosperity later in life. The most advantaged child has, for example, a 16–69 percent chance of receiving early childhood care and education, depending on the country, but the least advantaged child has a 0–13 percent chance. Among the MENA economies for which data exist, the

gap is the narrowest, fourfold, in the West Bank and Gaza and sixfold in Djibouti and Egypt. It is the widest—17-fold—in Iraq and Libya (El-Kogali and Krafft 2015). Such disparities have been found closely related to a mother's education as well as household income and location.

Many women in rural areas and in low-income populations lack access to essential maternal health services. Rural women in Djibouti, Morocco, and the Republic of Yemen and low-income women in Egypt, Morocco, and the Republic of Yemen are significantly less likely to have their child delivery attended (figures 2.8 and 2.9). Similarly, women in rural areas and in low-income populations—such as in Egypt, Morocco, and the Republic of Yemen—are less likely to receive antenatal care during pregnancy (figures 2.10 and 2.11).

FIGURE 2.5 Gross enrollment ratios by education level: MENA and OECD countries, 1999–2012



Source: EdStats.
Note: MENA = Middle East and North Africa; OECD = Organisation for Economic Co-operation and Development; ISCED = International Standard Classification of Education.

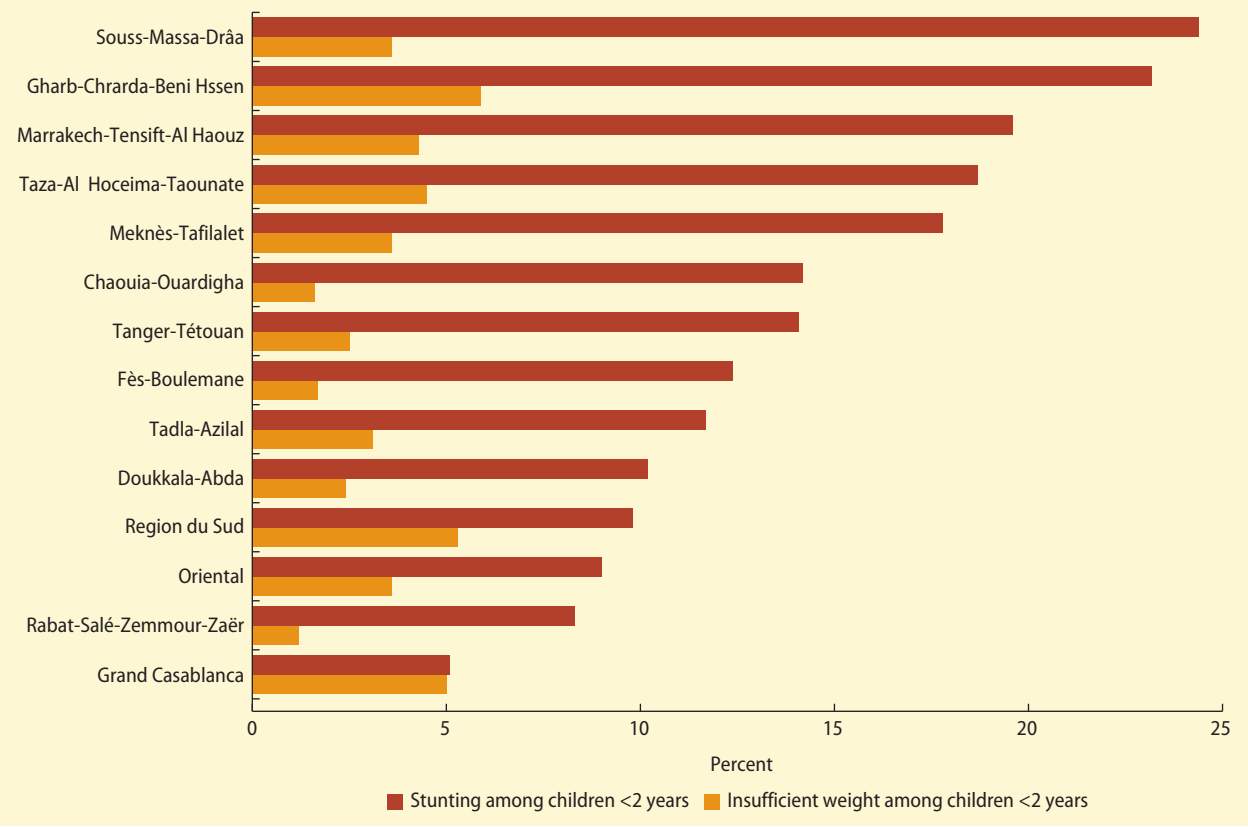
Access barriers

In some MENA countries, citizens report physical barriers to access to services. In the Republic of Yemen, the majority of schools do not have a paved road within their catchment area (Public Expenditure Tracking Survey, PETS, Republic of Yemen, 2006). In Egypt, citizens reported in 2010 needing almost an hour to reach a health facility (Egypt Health and Governance Study, EHGS). Morocco's citizens said they traveled an average 14 kilometers to a health facility (Quantitative Service Delivery Survey [QSDS], Morocco, 2009). By contrast, in Jordan and Lebanon, health facilities are available within a 30-minute walking distance to more than 90 percent of refugees as well as citizens.

Finding a public health facility closed during opening hours appears to be a common barrier. Patients in the Republic of Yemen reported in 2010 traveling on average a half-hour to a health facility, but one in 20 patients who came to a health facility over the last six months found it closed during opening hours (QSDS, Republic of Yemen 2010). Fifteen percent of survey respondents in Morocco's rural areas and 8 percent in urban areas reported finding their facility closed during opening hours at least once during the six months prior to the survey (QSDS, Morocco, 2009). This seems consistent with the PETS survey's finding that because of staff shortages about 20 percent of health facilities had to close on the day survey staff conducted mobile visits.

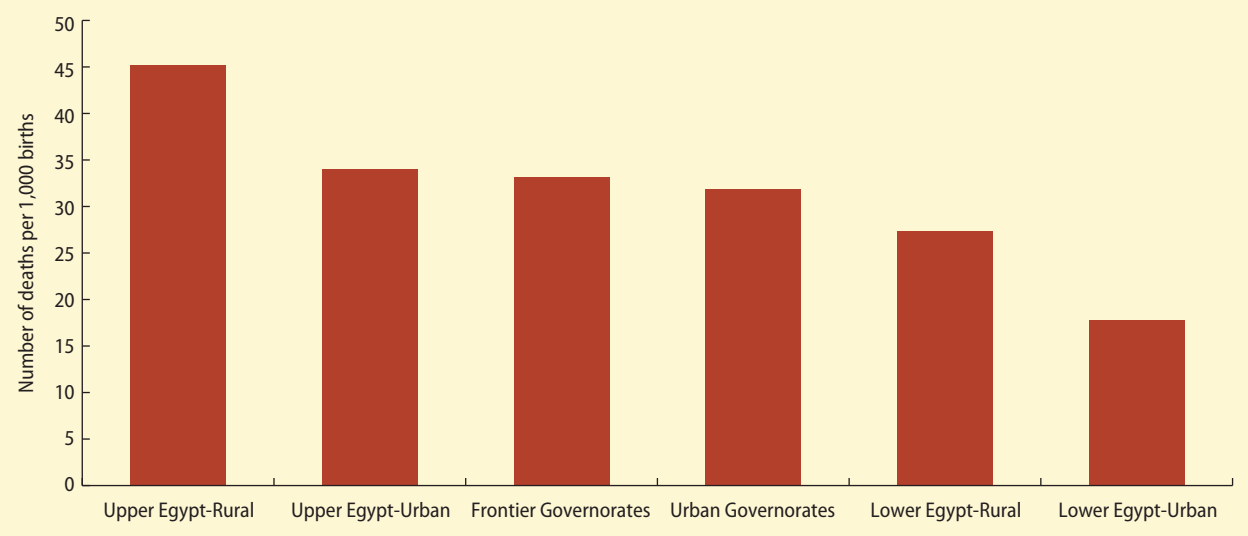
Financial barriers are more significant in health care than education. Out-of-pocket payments are relatively high in several developing MENA countries, accounting for more than half of total health expenditures in Egypt, Morocco, the Republic of Yemen, and Syria (World Health Statistics, 2010). In Egypt, 37 percent of survey respondents reported that the cost of medicines and fees were the main deterrent in seeking care (EHGS, 2010). In Morocco, out-of-pocket payments seem to accrue disproportionately to lower-income population groups, who are less likely to access the free services offered

FIGURE 2.6 Regional variation in child malnutrition: Morocco, 2010–11



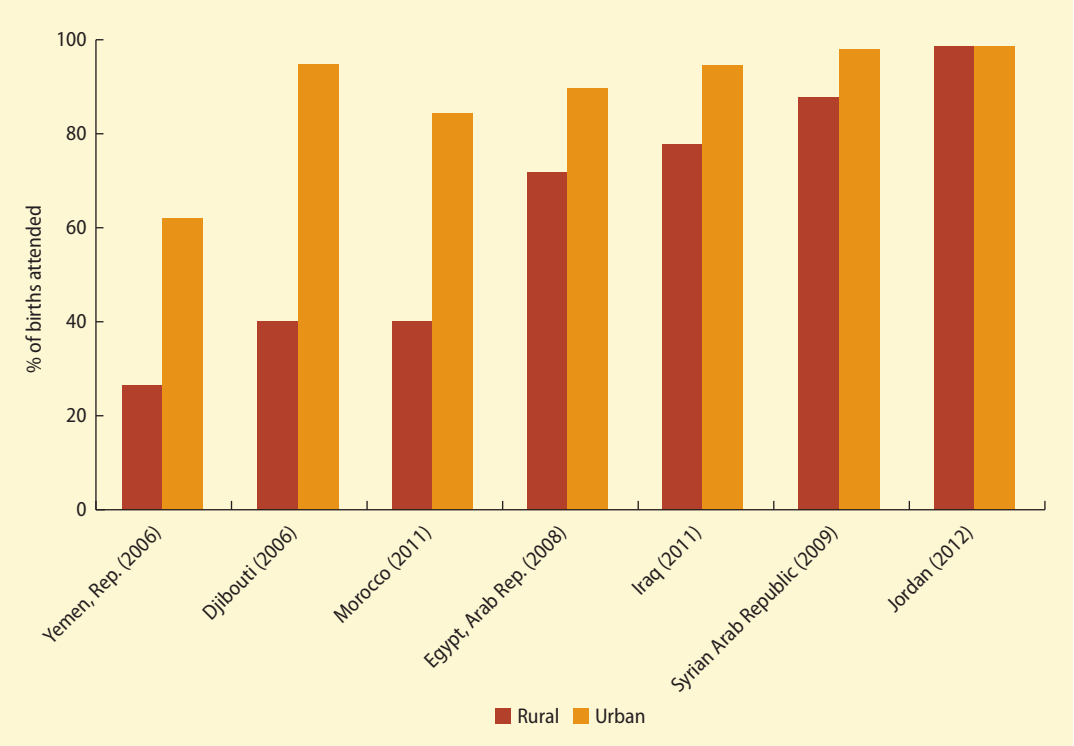
Source: Demographic and Health Survey, Morocco, 2010–11.

FIGURE 2.7 Child mortality (under 5 years): Arab Republic of Egypt, 2008



Source: Demographic and Health Survey, Arab Republic of Egypt, 2008.

FIGURE 2.8 Geographic inequities in access to health services: Selected MENA countries, 2010



Source: World Health Statistics, 2010.

FIGURE 2.9 Income inequities in access to health services: Selected MENA countries, 2010

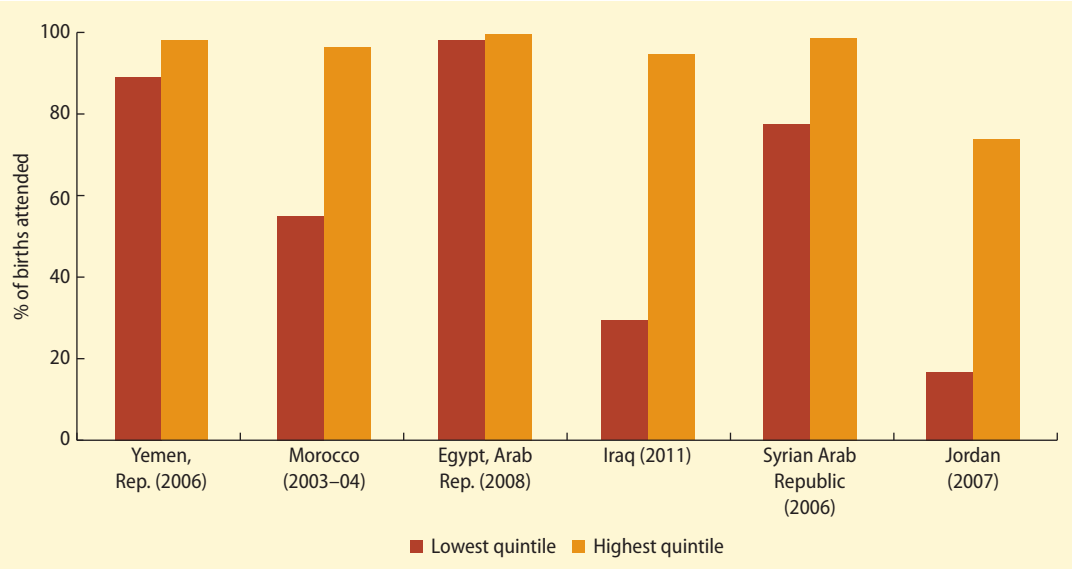
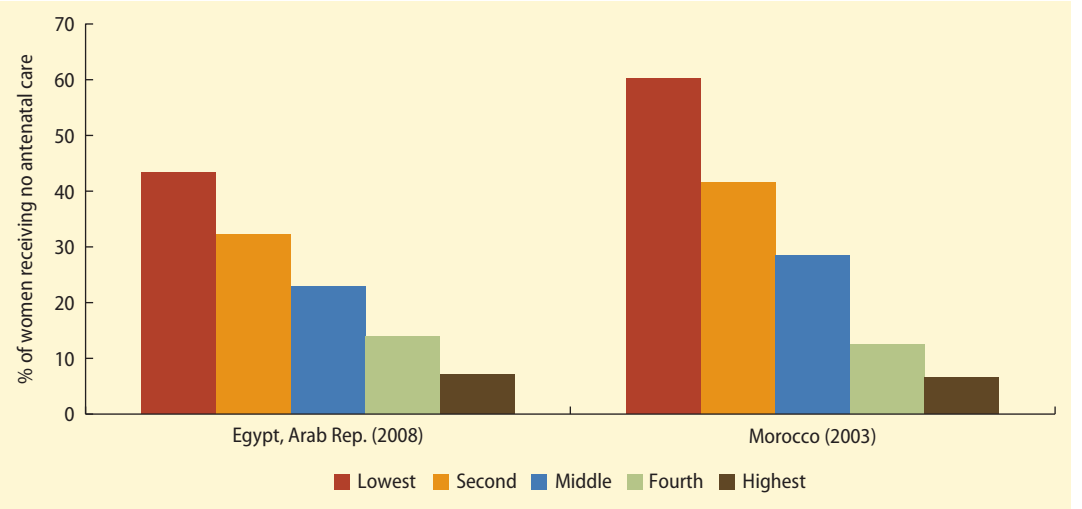
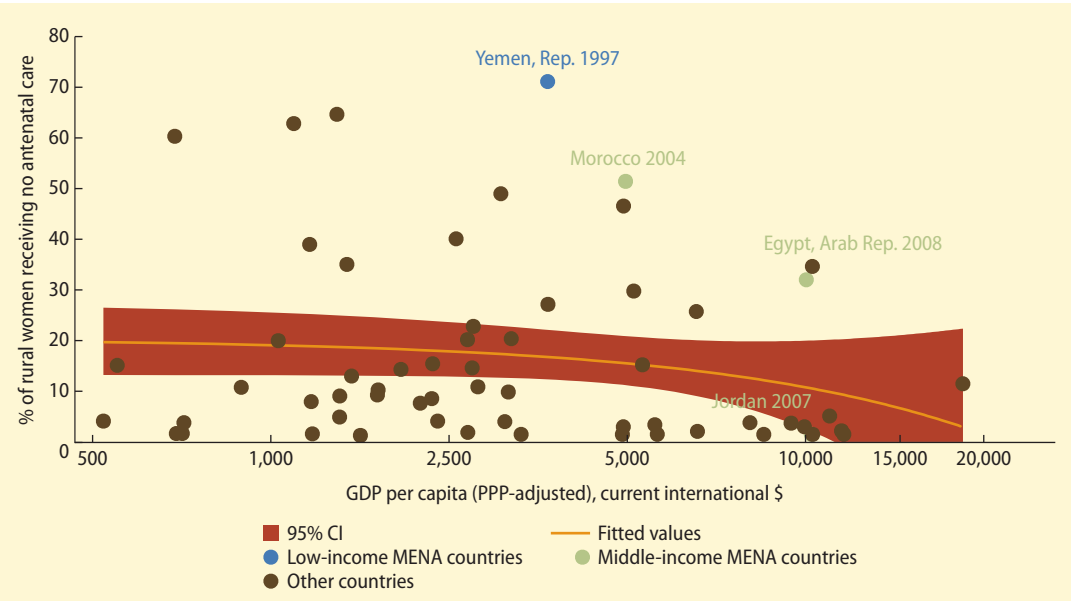


FIGURE 2.10 Differentials in the receipt of antenatal care by wealth quintile: Arab Republic of Egypt (2008) and Morocco (2003)



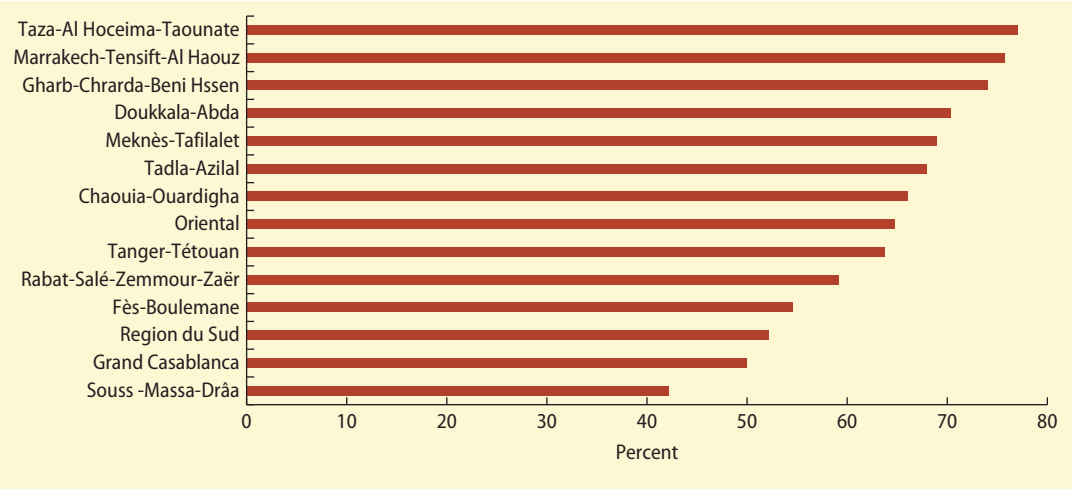
Sources: Demographic and Health Survey, Arab Republic of Egypt, 2008; Morocco, 2003.
Note: Percentages shown are for births over last three years.

FIGURE 2.11 Limitations in access to antenatal care in rural areas: MENA and other countries, various years



Sources: Demographic and Health Surveys, ICF International; World Bank.
Note: GDP = gross domestic product; PPP = purchasing power parity; CI = confidence interval; MENA = Middle East and North Africa.

FIGURE 2.12 Percentage of married women mentioning lack of money as a barrier to health care, by region: Morocco, 2010–11



Source: Demographic and Health Survey, Morocco, 2010–11.

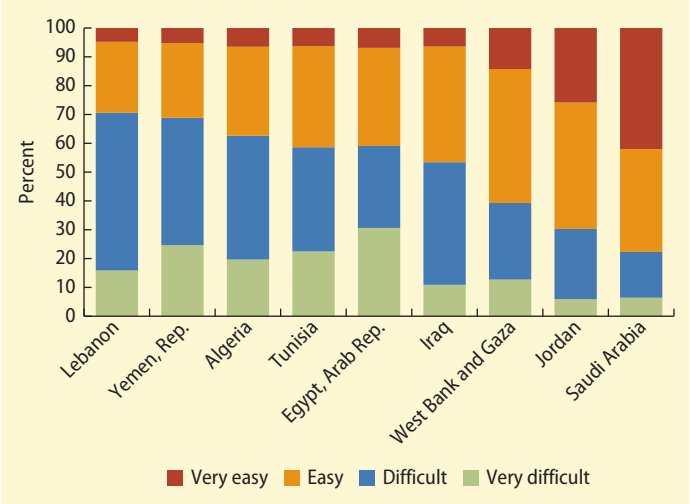
by public hospitals. This reflects in part the fact that among the 58 percent of respondents unaware of their entitlement to certain health services and medicines for free, a large proportion are poor (World Bank 2013a; QSDS, Morocco, 2009).

Financial constraints are more pronounced in rural and less developed regions because accessing care often requires relatively high transport costs. Reportedly, lack of money is a factor limiting the majority of married women in Morocco from accessing health care, especially in Morocco's less developed regions (figure 2.12).

Other barriers can make it difficult to access services. In Algeria, Egypt, Iraq, Lebanon, Tunisia, and the Republic of Yemen, a majority of citizens reported difficulty in seeking treatment in the nearby clinic or hospital (figure 2.13). As we discuss in chapters 6 and 7, these difficulties may relate to staff absenteeism, qualifications, or availability of medicine.

In some countries, cultural norms may aggravate access to services. In the MENA region, conservative cultural norms place women and girls at a disadvantage in accessing services. Norms restricting the movement of women have real consequences for their education and health, particularly in rural areas where they face the obstacles of geography and the limited availability of female teachers and female health professionals. In richer countries, such norms coupled with outdated health beliefs contribute to the high levels of obesity found among women

FIGURE 2.13 Difficulty or ease in obtaining medical treatment in a nearby clinic or public hospital: MENA region, 2010–11



Source: Arab Barometer, 2010–11 (Wave II).

(El Zein et al. 2014). Apart from women, older people, internally displaced persons, migrants, and refugees, as well as the poor, also find themselves disadvantaged in accessing services, in part because of cultural, social, and other barriers (Kronfol 2012).

Yet other barriers may emerge as a consequence of conflicts and refugee crises. Even as host communities in Jordan and Lebanon, for example, contract additional teachers and introduce multiple shifts in schools to accommodate refugee children, many children remain out of school, reporting reasons such as violence and intimidation at school, challenges in adjusting to a new curriculum, inability to catch up after missing months or even years of schooling, and working in order to earn money for their families (United Nations 2014).

Choice

Access to both private education and health services is becoming increasingly common in MENA countries. The situation, however, differs widely not only across countries but also within countries, especially between rural and urban areas.

In health, the demand for private care is particularly high in the more specialized services such as mental health and dental care, where often long wait times and quality limitations in public provision push users into the private realm (Kronfol 2012). In Egypt, nearly half of respondents in the 2010 Egypt Health and Governance Study used a private service in the last six months, reporting the following main concerns about public facilities: lack of specialized doctors, unavailability of doctors, and overcrowding. Choice seems to be limited. For example, in Morocco 93 percent of rural citizens and 72 percent of urban citizens reported having only one provider, reflecting in part the financial barriers to accessing private services (QSDS, Morocco, 2009). In Jordan and Lebanon, the demand for private provision in both education and health has sharply increased in communities affected by conflict and refugee crises as citizens cite overcrowding in public facilities as a concern.

In education, private providers have played a strong role, especially in the expansion of technical and higher education and in preprimary education, where the majority of enrolled children attend private facilities in most MENA countries. Private primary and secondary education are particularly common in Lebanon, Qatar, and the United Arab Emirates, where the majority of students are estimated to be enrolled in private schools. In other countries, private schools generally cater to students from more affluent backgrounds, and in some Gulf countries to immigrant children.

Although the growth of formal private services has improved choices in education and health care, it has also contributed to inequalities because the private sector is concentrated in urban areas, compounding the disparities between urban and rural and rich and poor (Phillimore et al. 2013). Among citizens in the MENA countries, private schools tend to have significantly higher proportions of affluent children than public schools (Trends in International Mathematics and Science Study, TIMSS).

Overall, few private schools serve rural areas. In Egypt, for example, the 2010 System Approach for Better Education Results (SABER) survey identified in rural areas only 285 private primary schools and 76 private secondary schools, compared with 16,097 public primary schools and 1,254 public secondary schools. By contrast, in urban areas nearly 20 percent of primary and secondary schools were private. The SABER survey in Egypt also found that public primary and secondary schools had on average about 450 students, whereas private primary and secondary schools tended to be smaller, with about 350 and 150 students, respectively. Meanwhile, the Republic of Yemen had 294 private and 944 public primary schools in urban areas, but only 9 private primary schools, compared with 10,569 public primary schools, in rural areas (SABER, 2010). Similarly, in Jordan and the West Bank and Gaza, private school teachers accounted for

nearly a third of all primary and secondary school teachers in urban areas, but for less than 5 percent of teachers in rural areas (SABER, 2010).

Beyond formal private health facilities and schools, private service provision in both education and health in the MENA region includes a shadow market driven in part by citizen choice and in part by distortions in provider incentives in the absence of any viable regulatory mechanisms. This shadow market includes public sector teachers who engage in tutoring and health professionals who operate dual practices, thereby facing potential conflicts of interest (as we discuss in chapter 6).

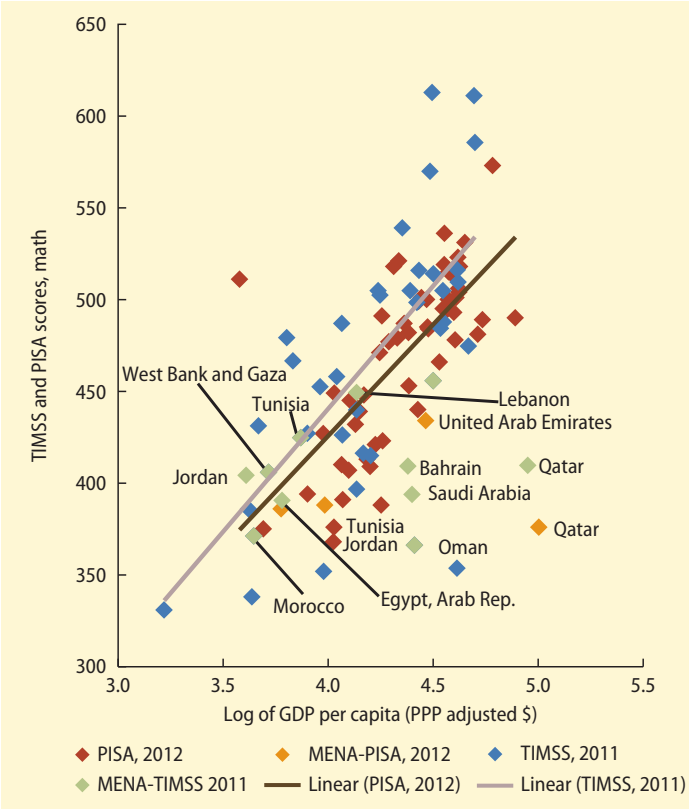
The quality challenge

Service quality is a major challenge throughout the MENA region. Increasingly, this challenge is taking center stage in the public debate across MENA countries as well as in country development strategies and government education and health policy documents. The quality challenge pertains to the entire education and health systems and to public providers specifically. Service quality appears somewhat higher in private education and health care. In Bahrain, Lebanon, Oman, and preconflict Syria (but not in Tunisia), students in private schools outperformed their peers in public schools on TIMSS tests. In the health sector, private facilities outperformed public facilities in some elements of quality such as waiting times and the availability of medicines and advanced equipment. As discussed shortly, MENA citizens on average perceive the quality of education and health care to be higher from private providers, especially in education.

Student performance

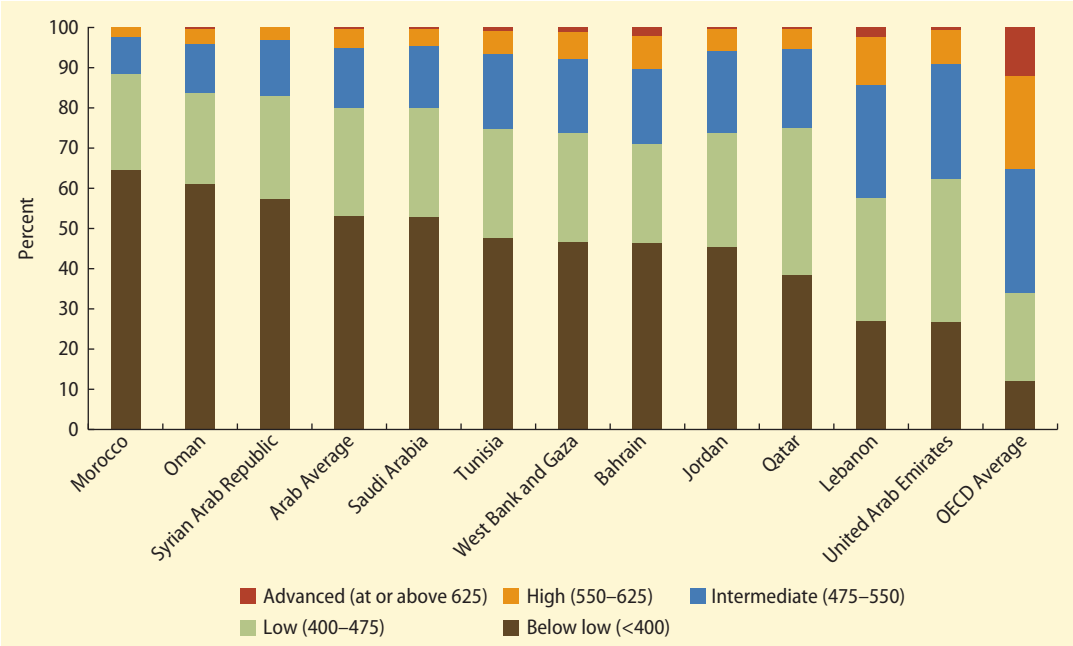
The challenge of attaining quality is immense from preprimary education to higher education. Among young children, only 33 percent in the Republic of Yemen, 36 percent in Djibouti, and 48 percent in Morocco engage in developmental activities—and these are among the lowest estimated rates in the world. Meanwhile, violent child discipline involving psychological aggression or physical punishment is widespread in the MENA region, negatively affecting children's physical, psychological, and social development (El-Kogali and Krafft 2015). In the classroom, the results from early grade reading and math assessments reveal that MENA children are lacking the required foundational reading and math skills. Likewise, students in MENA countries fall behind those in most other countries in basic reading, math, and science as measured by TIMSS and the 2011 and 2012 Programme for International Student Assessment (PISA) test scores (figure 2.14). The majority of

FIGURE 2.14 Benchmarking student math scores against levels of GDP per capita: MENA economies, 2011 and 2012



Sources: TIMSS, 2011; PISA, 2012.
Note: PISA = Programme for International Student Assessment; TIMSS = Trends in International Mathematics and Science Study; MENA = Middle East and North Africa; PPP = purchasing power parity; GDP = gross domestic product.

FIGURE 2.15 Student performance on TIMSS mathematics benchmarks (grade 8): MENA and OECD economies, 2011



Source: TIMSS, 2011.
Note: TIMSS = Trends in International Mathematics and Science Study; MENA = Middle East and North Africa; OECD = Organisation for Economic Co-operation and Development.

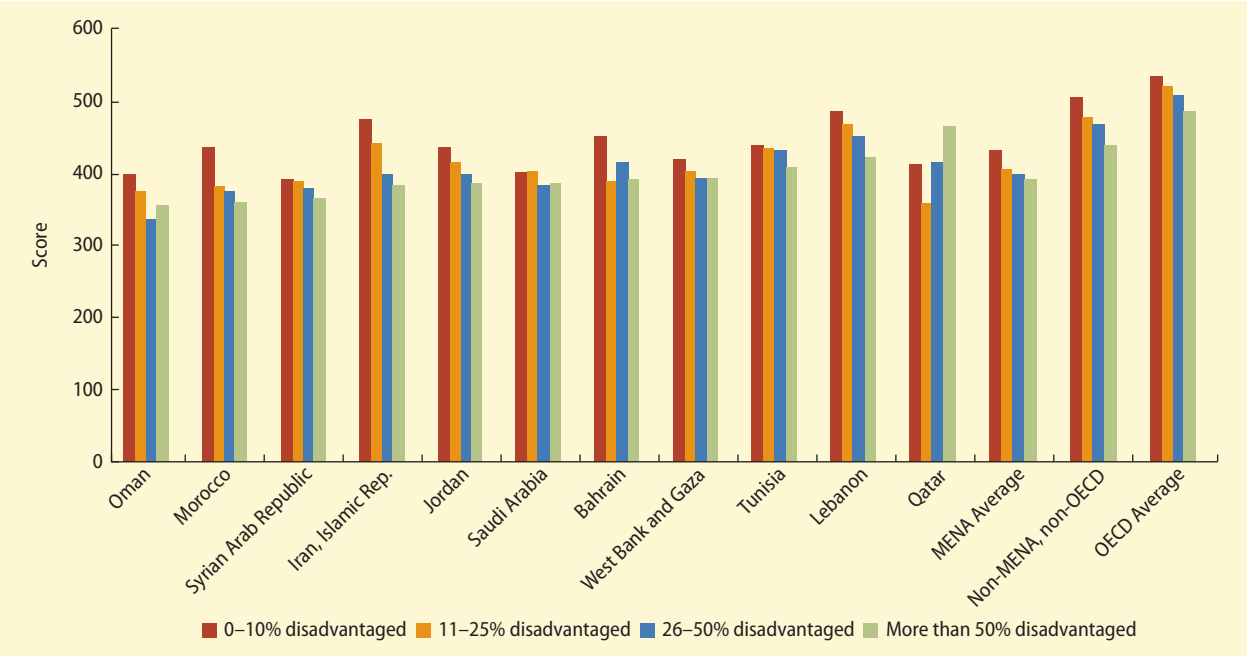
fourth- and eighth-grade students in MENA countries participating in these tests scored "below low" in math and science (figure 2.15). In higher education, the rapid quantitative expansion in both public and private provision has raised significant quality concerns (El Hassan 2013; Baporikar 2014).

Interestingly, girls on average outperform boys across MENA countries. Not only do girls typically achieve better scores in math, reading, and science in international tests such as the Progress in International Reading Literacy Study (PIRLS), TIMSS, and PISA, but they also tend to have lower repetition rates across urban and rural areas, in private as well as public schools, as measured by the national education statistics in, for example, Morocco. The gap is especially high in the Gulf Cooperation Council (GCC) countries, perhaps reflecting in part the social contract offering most boys an implicit public sector job guarantee based on their citizenship.

The variation in educational attainment suggests gaps in achieving equality of opportunity. Students' school performance relates more closely to their socioeconomic backgrounds in MENA countries than internationally. In the 2011 math TIMSS scores, MENA students in schools with a high share of disadvantaged students fell behind their peers in the more affluent schools by 41 points (and by over 77 points in Morocco), compared with the 49-point difference in OECD countries (figure 2.16).

In part as a reflection of the extensive inequality in the quality of primary and secondary education, the recent expansion in access to higher education in MENA developing countries has applied less to children in rural areas and those whose parents have low levels of education and are engaged in basic occupations than to children from urban and stronger socioeconomic backgrounds. In Egypt, children from the top

FIGURE 2.16 Student performance on TIMSS mathematics (grade 8), by socioeconomic background of schools: MENA economies and internationally, 2011



Source: TIMSS, 2011.
Note: TIMSS = Trends in International Mathematics and Science Study; MENA = Middle East and North Africa; OECD = Organisation for Economic Co-operation and Development.

wealth quintile are over twice as likely to complete a secondary education and four times as likely to complete a college education than those from the bottom quintile, and children from urban governorates are more likely to complete a secondary or higher education than those from rural Upper Egypt or Frontier governorates. Consequently, between 1998 and 2006 the share of college graduates among the least advantaged youth increased by only 1 percentage point, compared with a 17 percentage point increase among the most advantaged youth (Ersado and Gignoux 2014).

Although conflicts and refugee crises generally have a negative impact on education quality, exceptions exist. Most notably, children in schools operated by the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA)[2] are achieving higher than average learning outcomes despite their adverse circumstances. The UNRWA advantage in learning outcomes—despite apparent commonalities with public school—is 25 points, a quarter of a standard deviation, or about a year's worth of learning. Moreover, more UNRWA students achieve the international benchmarks in math and science. UNRWA students in Jordan and the West Bank and Gaza achieve on average scores that are 23–80 points higher than their peers in public schools, even after controlling for student characteristics and for urban or rural contexts (Patrinos et al. 2013).

Health services quality and the problem of opacity

Health care in the MENA region does not measure up to international standards and people's expectations, as chapter 1 illustrated. The actual practice of health care often differs from evidence-based practices

because of poor oversight and lack of accountability. The literature suggests that long waiting lines, absent providers, lack of privacy and confidentiality, medication errors, and informal payments erode the quality of health care across the MENA region (Zaky, Khattab, and Galal 2007; Jabbour and Yamout 2012). The difficulty in obtaining appointments, long waiting times, overcrowding, and poor infrastructure and hygiene have been also reported in surveys in Morocco, the Republic of Yemen, and, following the Syrian refugee crisis, in host communities in Jordan and Lebanon trying to extend services to refugees.

Facility surveys in Egypt revealed deficiencies in practices. The 2010 Egypt Health and Governance Study, which surveyed facilities across Alexandria and Menoufia, used direct observations of clinical practices to measure whether protocols were followed and to calculate a "quality index"[3] for the care provided. According to this quality index, the average provider performed 63 percent of standard procedures that constitute a routine antenatal examination, 59 percent of the standard procedures for examination of a sick child, and only about 38 percent of the standard procedures for diabetes or coronary heart disease (CHD)/hypertension patients. Much like the results of other studies, the analysis suggests relatively good standards for perceived priority interventions such as immunization, maternal health, and epidemic control, but poor care for chronic disease management, prescribing patterns, health education, and referral patterns (World Bank 2013b). We will discuss some of these results in more detail at the national level in chapter 6 and the subnational level in chapter 7.

Information about service quality and standards—rarely available

Overall, little information on service quality is reported and collected within the education and health systems, and even less is available to citizens. Key aspects of performance such as continuity, comprehensiveness, and appropriateness in health care provision are generally not measured in MENA countries.[4] Service quality standards tend to be poorly defined and, where defined, not publicly available.

As discussed in chapter 5, although schools and health facilities are inspected regularly in most MENA countries, information on performance is typically not shared throughout the centralized education and health systems, receives no follow-up, and is not made available publicly. According to the TIMSS, significant variation in the transparency of information on performance exists in the MENA region. Nearly half of students in Qatar and the United Arab Emirates attend schools in which achievement data are posted publicly, compared with 20 percent and less students in such schools in Jordan and Tunisia.

Opacity on performance exacerbates information asymmetries that bar citizens from making informed choices and demanding accountability, and it intensifies market inefficiencies (Keefer and Khemani 2005). Meanwhile, the lack of information on the quality of services provided by individual schools and health facilities, and by the education and health systems at large, is one of the institutional roots of the quality challenge in MENA countries.

Implications for efficiency

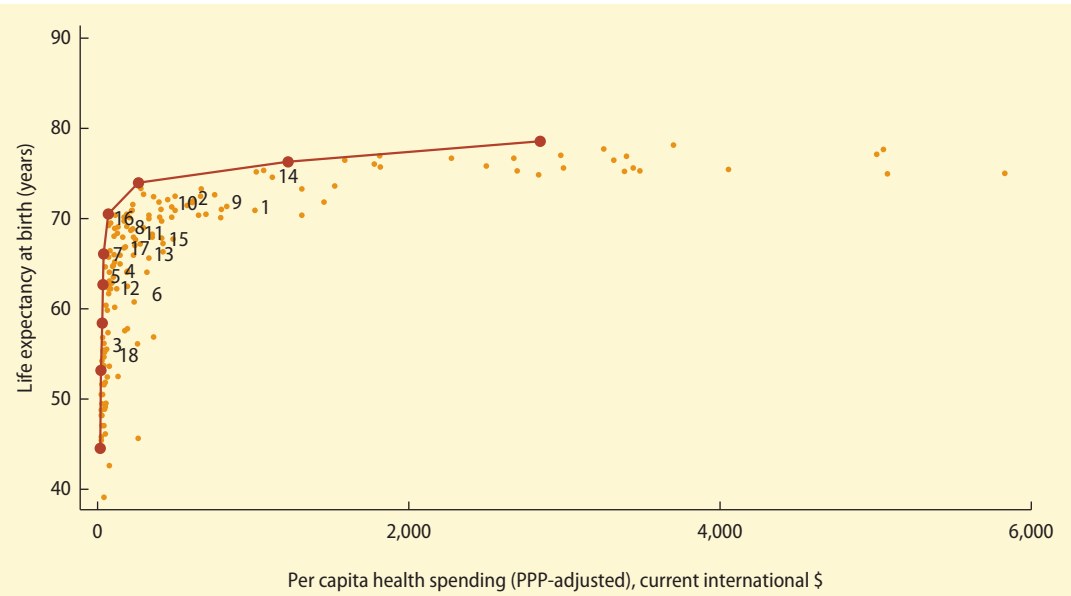
The quality challenge in the MENA region colors analysis of the efficiency of public expenditure on education and health services in MENA countries.[5] The efficiency of the education and health systems of these countries varies widely, depending on the specific result under consideration. For example, in primary education enrollments and life expectancy at birth, many MENA countries appear to be achieving high efficiency in public spending on education and health. In fact, the MENA region ranks second globally in efficiency of spending on education as measured by net primary enrollment and seventh globally in health as measured by life expectancy at birth (Mottaghi forthcoming). Compared with those of other regions,

MENA's efficiency scores are strong for both developing MENA countries and for the Gulf countries. Lebanon and preconflict Syria appeared to be on the efficiency frontier in their public spending on health (figure 2.17), and several MENA countries were near the efficiency frontier on education during 2000–10 (figure 2.18). Considering education enrollment but using a different methodology, Grigoli (2014) estimates that efficiency of public spending on education varies significantly in the MENA region, with Bahrain, Kuwait, and Qatar achieving the highest efficiency scores and Djibouti and Morocco the lowest.

If efficiency is measured in relation to service quality or equity, MENA countries appear to exhibit lower levels of efficiency in public spending on education and health. In student performance on international tests, only Lebanon—among the MENA countries for which TIMSS data exist—appears on the efficiency frontier in its public spending on education and seems to have an efficient education system. The GCC countries achieve an efficiency score of 0.678 in their public spending on education, which is relatively lower than OECD countries' score of 0.879 (table 2.1). The Republic of Yemen and Morocco appear to have relatively inefficient education and health systems because they are both far off the efficiency frontier in their public spending when considering student performance and rural women's access to antenatal care as the metric (figures 2.19 and 2.20).

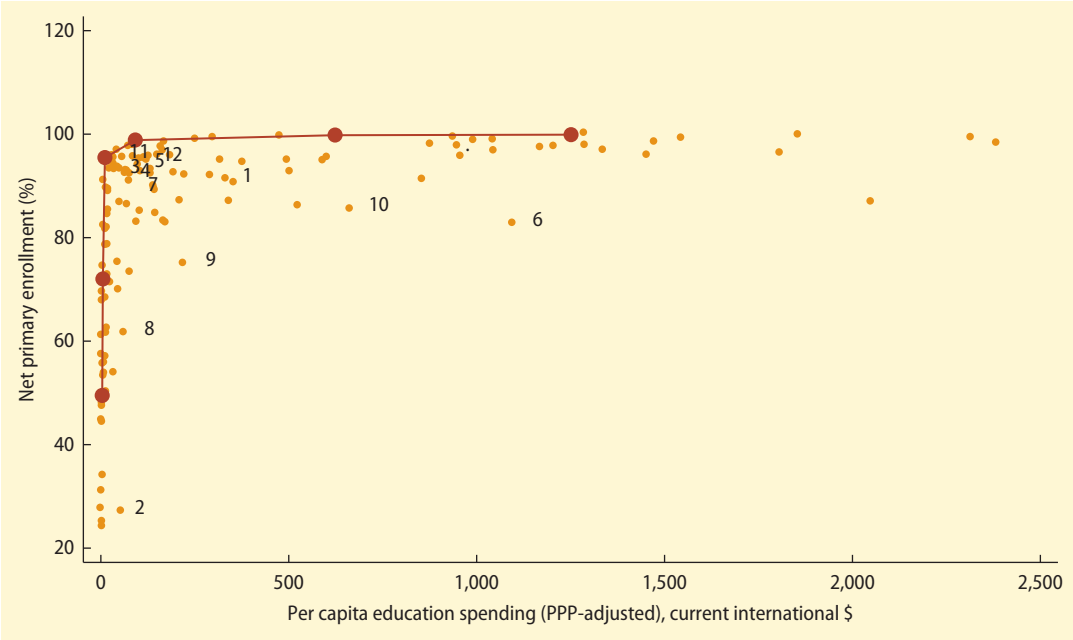
Another perspective on the efficiency of education systems is grade repetition and dropout rates. According to the World Bank's World Development Indicators, the repetition rates in MENA countries exceeded 6.4 percent (7.6 percent among boys) at the primary level in 2012, which was higher than the international average of 4.6 percent (4.4 percent among boys). The rate was particularly high in Lebanon and Morocco (above 8 percent in total and close to 10 percent among boys). National education

FIGURE 2.17 Preliminary estimates of efficiency frontier, life expectancy at birth: Selected MENA countries, 2000–10



Source: Mottaghi forthcoming.
Note: 1 = United Arab Emirates, 2 = Bahrain, 3 = Djibouti, 4 = Algeria, 5 = Arab Republic of Egypt, 6 = Islamic Republic of Iran, 7 = Iraq, 8 = Jordan, 9 = Kuwait, 10 = Lebanon, 11 =Libya, 12 = Morocco, 13 = Oman, 14 = Qatar, 15 = Saudi Arabia, 16 = Syrian Arab Republic, 17 = Tunisia, 18 = Republic of Yemen; MENA = Middle East and North Africa; PPP = purchasing power parity.

FIGURE 2.18 Preliminary estimates of efficiency frontier, net primary enrollment: Selected MENA countries, 2000–10



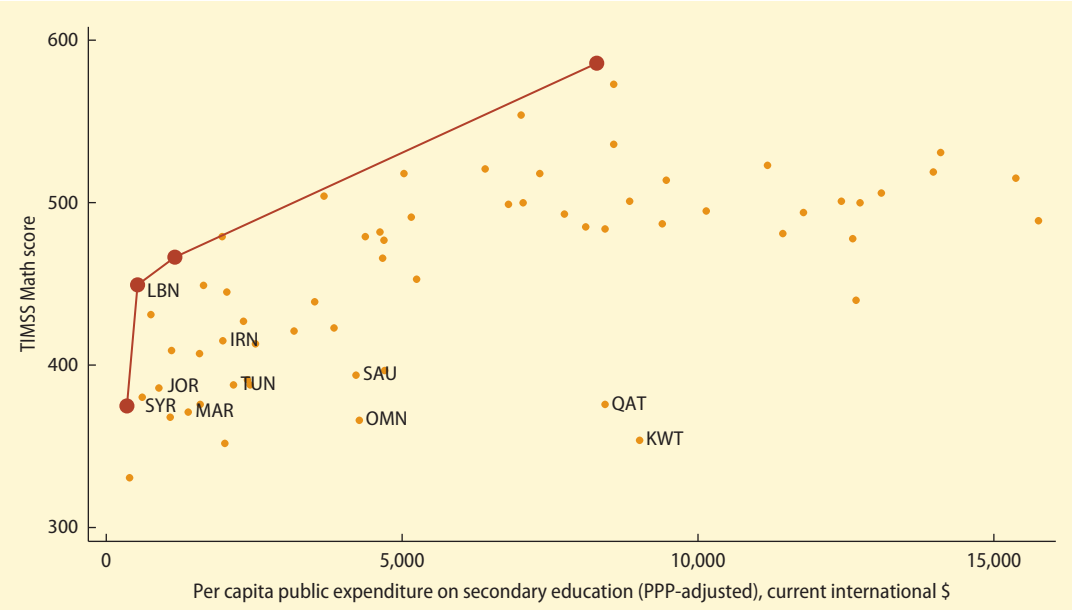
Source: Mottaghi forthcoming.
Note: 1 = United Arab Emirates, 2 = Djibouti, 3 = Arab Republic of Egypt, 4 = Islamic Republic of Iran, 5 = Jordan, 6 = Kuwait, 7 = Lebanon, 8 = Morocco, 9 = Oman, 10 = Qatar, 11 = Syrian Arab Republic, 12 = Tunisia; MENA = Middle East and North Africa; PPP = purchasing power parity.

TABLE 2.1 Preliminary estimates of efficiency scores, by region, 2010–11

	Education	Health
	Eighth-grade math scores (PISA, 2012; TIMSS, 2011)	Percentage of women receiving antenatal care in rural areas
MENA	0.785	0.611
GCC	0.678	—
MENA dev oil export	0.853	0.290
MENA dev oil import	0.858	0.717
EAP	0.906	0.909
ECA	0.947	0.901
LAC	0.814	0.929
SA	—	0.779
SSA	0.774	0.834
HIC	0.860	—
HIC: non-GCC	0.882	—
HIC: OECD	0.879	—
HIC: non-OECD and non-GCC	0.909	—
Lower MIC	0.903	0.826
Upper MIC	0.853	0.916

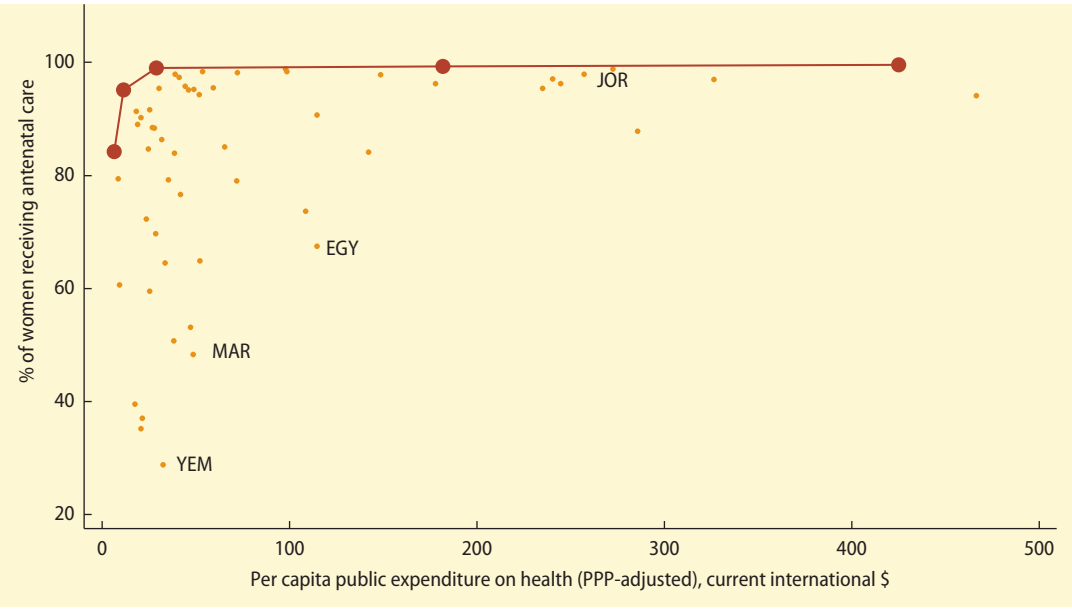
Source: Mottaghi forthcoming.
Note: — = not available; PISA = Programme for International Student Assessment; TIMSS = Trends in International Mathematics and Science Study; MENA = Middle East and North Africa; GCC = Gulf Cooperation Countries; EAP = East Asia and Pacific; ECA = Europe and Central Asia; LAC = Latin America and the Caribbean; SA = South America; SSA = Sub-Saharan Africa; HIC = high-income country; OECD = Organisation for Economic Co-operation and Development; MIC = middle-income country.

FIGURE 2.19 Preliminary estimates of efficiency frontier, 2012 PISA math scores and 2011 TIMSS math scores for eighth-grade students: Selected MENA countries



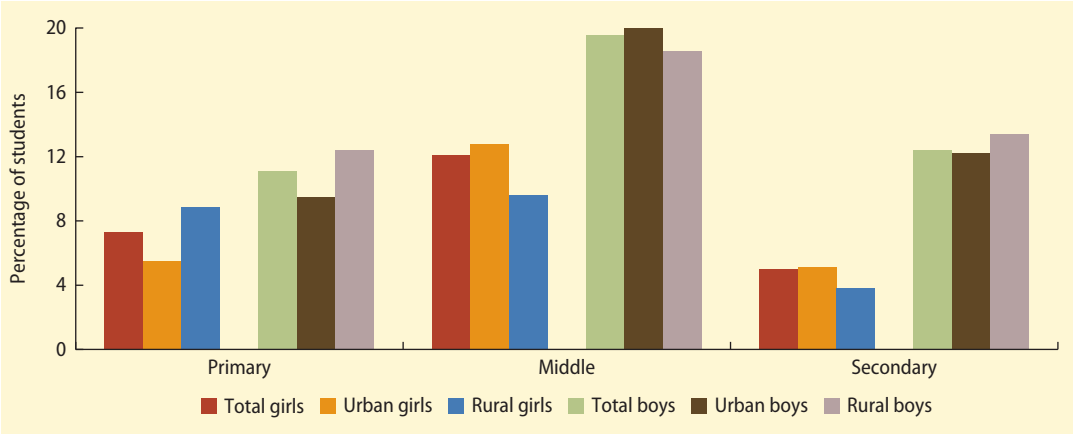
Source: Mottaghi forthcoming.
Note: TIMSS = Trends in International Mathematics and Science Study; PISA = Programme for International Student Assessment; MENA = Middle East and North Africa; IRN = Islamic Republic of Iran; JOR = Jordan; KWT = Kuwait; LBN = Lebanon; MAR = Morocco; OMN = Oman; QAT = Qatar; SAU = Saudi Arabia; SYR = Syrian Arab Republic; TUN = Tunisia; PPP = purchasing power parity.

FIGURE 2.20 Preliminary estimates of efficiency frontier, percentage of women receiving antenatal care: Selected MENA countries, available years from 1997 to 2013



Source: Mottaghi forthcoming.
Note: EGY = Arab Republic of Egypt; JOR = Jordan; MAR = Morocco; MENA = Middle East and North Africa; YEM = Republic of Yemen. PPP = purchasing power parity.

FIGURE 2.21 Repetition rates, by education level and geographic coverage/gender in public schools: Morocco, 2010–11



Source: Education statistics, government of Morocco.
Note: Definition of repetition rate from United Nations Educational, Scientific and Cultural Organization, http://www.uis.unesco.org/Library/Documents/eiguide09-en.pdf.

statistics—for example, in Morocco—indicate that in repetition rates, the gender gap is significantly wider than the rural-urban divide (figure 2.21). The primary completion rate surpasses 90 percent in most MENA countries (compared with the international average of 86 percent). Dropout rates are reported to be a greater problem in middle and secondary schools across MENA countries. In the Gulf countries, which have opened higher education opportunities to all citizens, the dropout rates have reached relatively high levels in universities.

Citizens' satisfaction

Evidence on citizens' satisfaction with services is mixed across and within MENA countries. As shown in chapter 1, the satisfaction rates with education and health services are relatively low among citizens in the MENA region, particularly in its developing countries, compared with the averages in other regions. Citizens' satisfaction with education services and with the availability of quality health care is relatively high in Bahrain, Kuwait, Oman, Qatar, and the United Arab Emirates (Gallup World Poll, 2013). Surveys suggest that in societies and countries with lower illiteracy rates and a higher per capita gross domestic product (GDP), education quality is perceived more positively—regardless of actual quality—than in countries with higher poverty and illiteracy rates.

Public sector versus private sector

Satisfaction is higher with both education and health care provided by the private sector than by the public sector. Generally, citizens perceive public schools and health facilities to be of lower quality than private establishments and cite overcrowding, inadequate infrastructure, and nonmotivated staff (World Bank 2007 and surveys cited in this report). This perception is consistent with the available data showing on average better service delivery results—in terms of quality and service delivery indicators (see chapter 6)—for private schools and facilities compared with public ones.

Generally, satisfaction with public services tends to be low; users cite having few alternatives, giving them little ability to use "choice" in holding providers accountable. Proximity is a key determinant in choosing a provider. When asked about the most

important factor for them in choosing a health provider, 42 percent of patients in Morocco referred to proximity, whereas only about a quarter referred to the cost of consultation and 16 percent to the unavailability of the specific type of care sought at another facility (QSDS, Morocco, 2009).[6] In the Republic of Yemen, 34 percent of respondents in the 2010 QSDS reported choosing a particular facility because of its proximity to their home. Unfortunately, many have limited choice in service providers, having to make do with those that exist. In Morocco, the vast majority of both rural (93 percent) and urban (72 percent) patients reported in the 2009 QSDS that they did not have multiple providers from which to choose and that proximity was the main reason for their choice of provider. Although the lack of choice declared by patients may mean they cannot afford the cost of private providers as an alternative to, for example, a basic health care facility or *établissement de soins de santé de base* (ESSB), the availability of options per se, regardless of cost, is also likely to be an issue, particularly in rural areas (World Bank 2013a).

In the Republic of Yemen, according to the 2009 Governance and Anti-Corruption (GAC) Country Diagnostic Survey, among those using the services over the last six months, less than half of respondents in both urban and rural areas reported satisfaction with public health care (particularly the availability and cost of medications), and less than 40 percent expressed satisfaction with public education. The survey identified the quality of public education as a serious social problem—indeed, more serious than inflation, public sector corruption, and health care quality.

Satisfaction with education and health in Egypt, Morocco, and the Republic of Yemen

Citizens tend to be more satisfied with the timely availability of education and health services than with their quality. On average, across Egypt, Morocco, and the Republic of Yemen in recent years, residents reported satisfaction with the timeliness and cost of services. The main areas of dissatisfaction were the availability and cost of medications, the exchange of information about health and medications with health providers, and the quality of education. Apart from these similarities, the reported levels of satisfaction with education and health differ within as well as across countries, in part reflecting the subnational variation in service delivery performance, a topic explored in chapter 7.

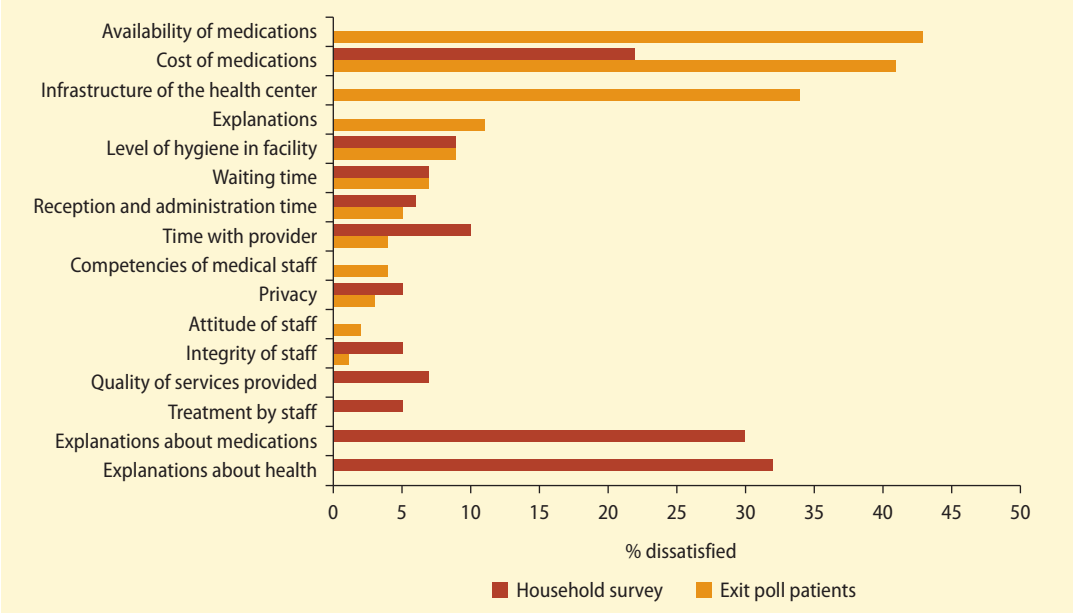
In Egypt, respondents to the 2009 GAC survey placed education services among the top 3 of the 13 government services, with three-quarters of respondents indicating they had received education services in a timely fashion, and nearly two-thirds saying they had been treated "decently" by education providers and charged a reasonable amount in fees.

The Community Scorecard initiative launched by the World Bank in 2010 surveyed parents in Egypt's Ismailia governorate and found significantly lower levels of satisfaction with education, even though 93 percent reported that they were satisfied or very satisfied with the headmaster's performance (Bold and Svensson 2010). Among the parents sending their children for tutoring, 76 percent reported the need for extra academic help, and 21 percent reported that inadequate instruction at their children's school was the main reason.

For health services, over 60 percent of respondents to the 2009 GAC survey in Egypt reported receiving services in a timely fashion and at an acceptable cost, and half reported they felt they were treated decently. Similarly, the 2010 Egypt Health and Governance Study household survey and in-depth interviews indicated general satisfaction with health facilities and services, including their availability, timeliness, and cost. Patients mainly complained about shortages of specialists, medications, and laboratory tests.

In Morocco, the 2009 QSDS revealed general satisfaction with most elements of health care (on average more than half of

FIGURE 2.22 Patients' dissatisfaction with aspects of health care: Republic of Yemen, 2010



Source: QSDS (health), Republic of Yemen, 2010.

respondents were at least somewhat satisfied). The main source of dissatisfaction was the cost of prescription drugs, with nearly two-thirds of respondents saying they were somewhat or very dissatisfied with these costs, and only 3 percent thought the costs of prescription drugs were very good.

In the Republic of Yemen, the 2009 GAC survey found that on average less than 30 percent of respondents in both urban and rural areas rated the quality of public education that their child received during the last school year as "good," even as the majority expressed satisfaction with the teachers, syllabi, and school access and infrastructure. But significant variation emerged within regions, with the majority of respondents from Al-Mahwit (80 percent), the capital (59 percent), and Mareb (54 percent) satisfied, but few from Amran (7 percent) and Lahj (4 percent). In health care, much like Egypt and Morocco, the 2010 QSDS, using both exit interviews and a household survey, identified availability and the cost of medications as the main sources of dissatisfaction in the Republic of Yemen across both survey samples. Twenty-nine percent of household survey respondents and 43 percent of exit poll patients were dissatisfied with the availability of medications, and 22 percent and 41 percent, respectively, were dissatisfied with the cost (figure 2.22).

Variation in service satisfaction in Tunisia

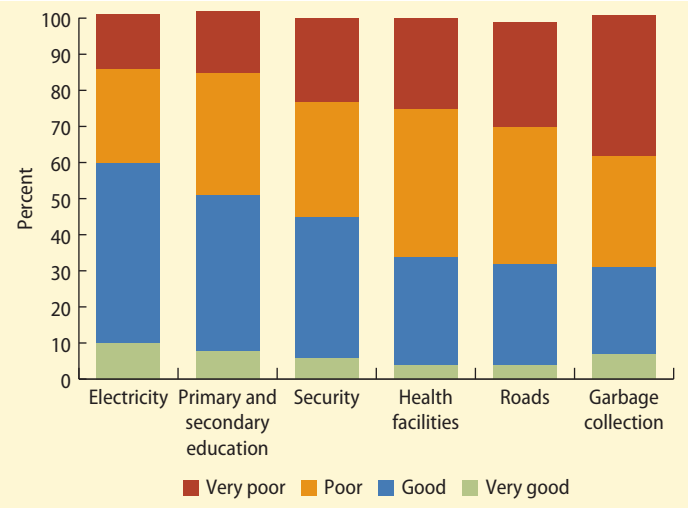
Citizens' satisfaction with services can vary significantly within countries. Surveys from Tunisia, for example, indicate a considerable variation in the perceptions of service quality across sectors (figure 2.23) and localities (figures 2.24 and 2.25). Satisfaction levels across sectors are most closely correlated between education and health services (table 2.2). The correlation in satisfaction between education and health services appears relatively strong compared with other sectors, and also when comparing results across countries using the 2013 Gallup World Poll data (tables 2.3 and 2.4).

Similar variation is found in the Republic of Yemen. There, the 2013 Yemen Polling Center survey found variations in the attitudes toward service provision among elites in Sana'a, Aden, and Taiz, with respondents in Aden viewing education and health most negatively. By contrast, respondents in Sana'a found social security and electricity to be the most problematic areas, whereas those in Taiz viewed sanitation and water most negatively. We further discuss subnational variation in service delivery in chapter 7.

Corruption

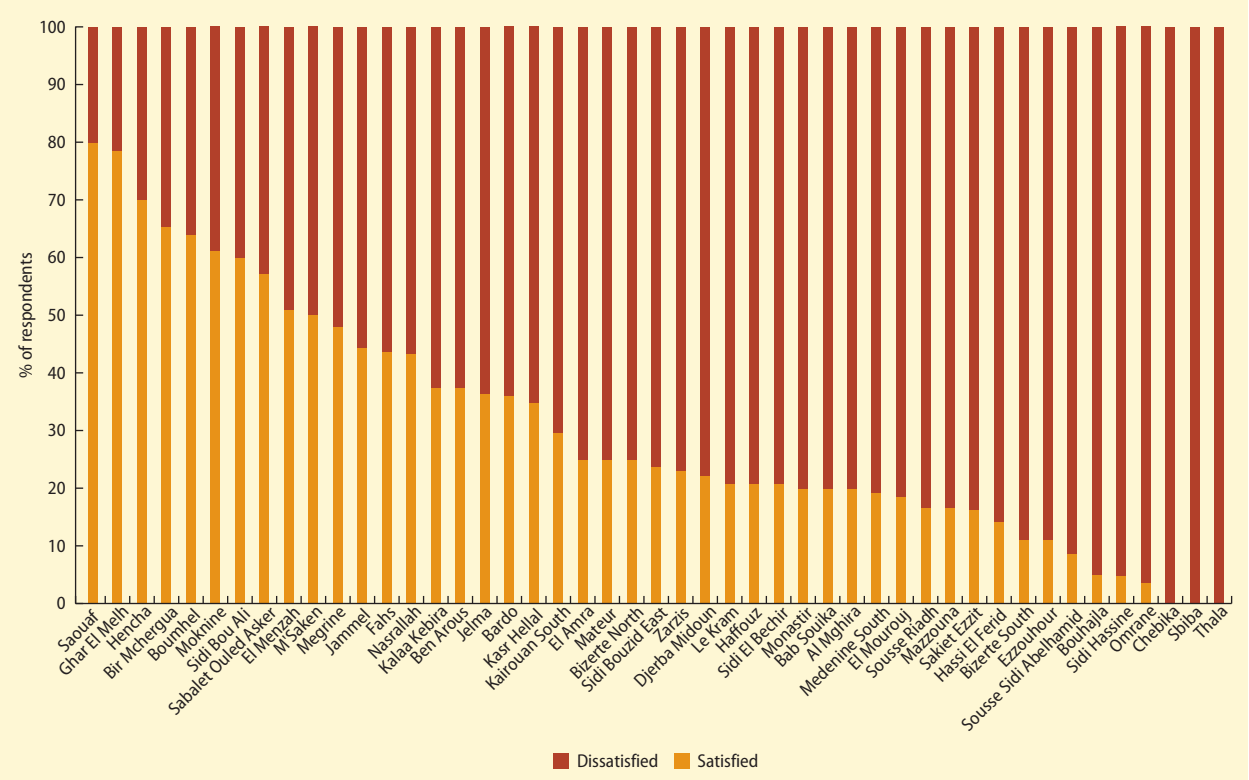
Although citizens' perceptions of overall corruption in MENA countries are comparable with those in other regions, MENA citizens are more likely to refer to corruption when reporting on their experience with

FIGURE 2.23 Variations in perceptions of service quality: Tunisia, 2014



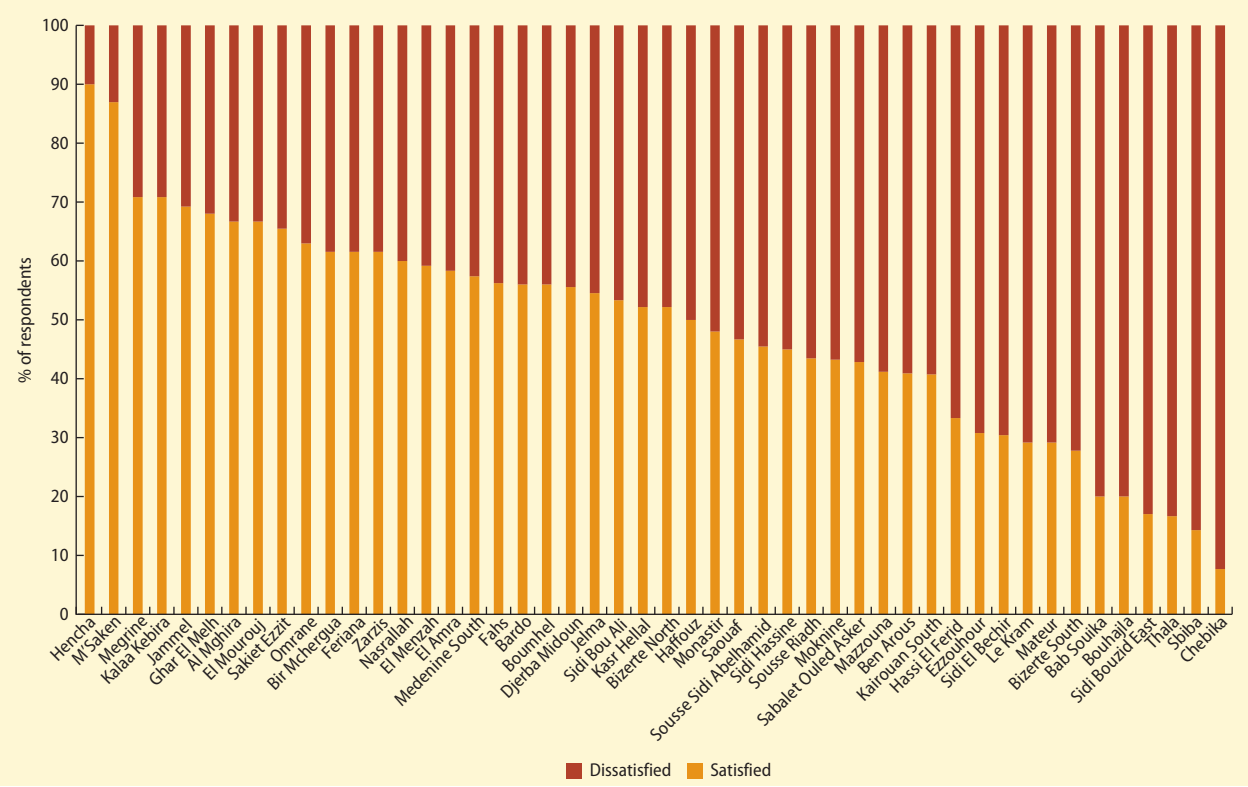
Source: Transitional Governance Project, 2014.

FIGURE 2.24 Satisfaction with quality of garbage collection, by region: Tunisia, 2014



Source: Transitional Governance Project, 2014.

FIGURE 2.25 Satisfaction with quality of education, by region: Tunisia, 2014



Source: Transitional Governance Project, 2014.

TABLE 2.2 Correlation between individuals' evaluations of different services (Spearman's Rho): Tunisia, 2014

	Education	Health	Roads	Electricity	Security	Garbage
Education	1					
Health	0.5946	1				
Roads	0.3947	0.5233	1			
Electricity	0.4306	0.4297	0.4566	1		
Security	0.4046	0.4002	0.2716	0.4148	1	
Garbage	0.2957	0.3857	0.4568	0.3642	0.3073	1

Source: Transitional Governance Project, 2014.

education and health services. According to Transparency International's 2013 Global Corruption Barometer, more than half of respondents in MENA countries believe their education and health systems are corrupt or extremely corrupt. The proportion of MENA citizens who have paid informal fees related to education or health is higher than the global average, reaching 51 percent of respondents in Morocco who reported paying informal fees in the health sector and 38 percent of respondents in Jordan who reported paying informal fees in the education sector (figure 2.26).

TABLE 2.3 Correlation between individuals' satisfaction with different services: Globally, 2013

	Telephone	Internet	Cellular	Transport	Road	Water	Education	Health
Telephone	1							
Internet	0.8093	1						
Cellular	0.4529	0.5552	1					
Transport	0.3886	0.4238	0.3681	1				
Road	0.4713	0.4973	0.3979	0.7378	1			
Water	0.4659	0.6002	0.3668	0.6421	0.7045	1		
Education	0.1413	0.2154	0.1661	0.6258	0.6582	0.7141	1	
Health	0.4396	0.5299	0.2835	0.6455	0.797	0.8014	0.7948	1

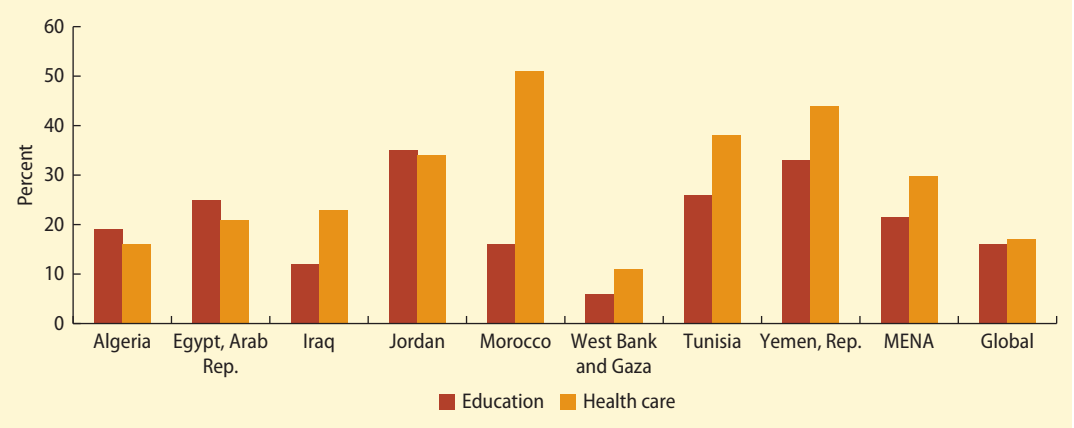
Source: Gallup World Poll, 2013.

TABLE 2.4 Correlation between individuals' satisfaction with different services: MENA region, 2013

	Telephone	Internet	Cellular	Transport	Road	Water	Education	Health
Telephone	1							
Internet	0.6762	1						
Cellular	0.2974	0.5624	1					
Transport	0.2309	0.5729	0.3562	1				
Road	0.3507	0.6821	0.3454	0.9369	1			
Water	0.4618	0.7296	0.2588	0.741	0.8225	1		
Education	0.2542	0.6397	0.3168	0.8237	0.8543	0.6623	1	
Health	0.428	0.7952	0.4345	0.7279	0.858	0.7633	0.8181	1

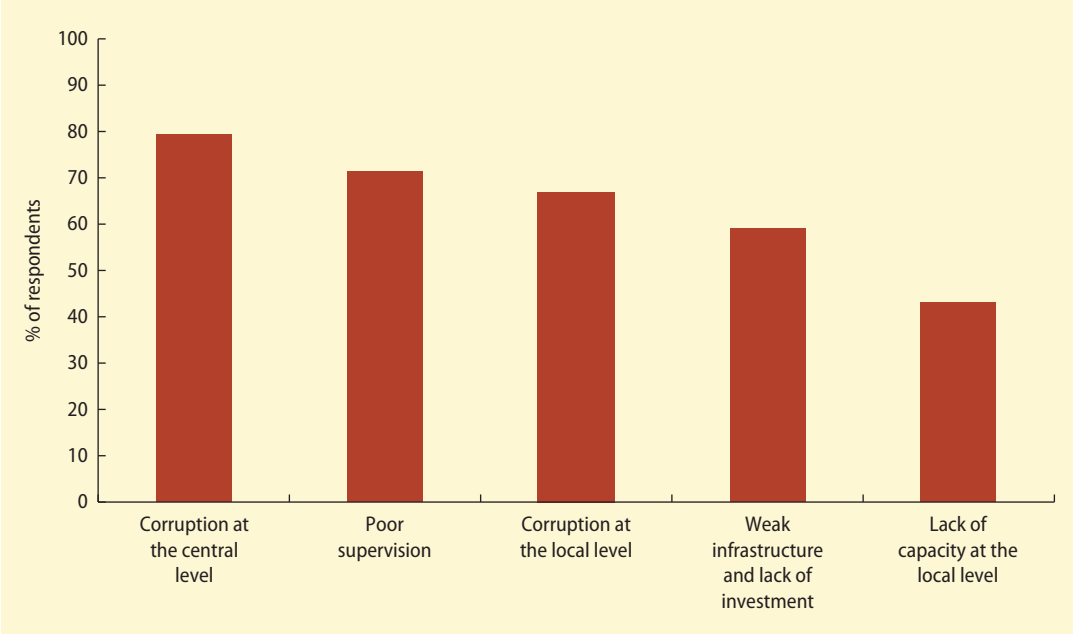
Source: Gallup World Poll, 2013.

FIGURE 2.26 Percentage of respondents reporting payment of informal fees, education and health care sectors: MENA region and globally, 2013



Source: Global Corruption Barometer, 2013.
Note: MENA: Middle East and North Africa.

FIGURE 2.27 Perceptions of role of corruption in services: Republic of Yemen, 2013

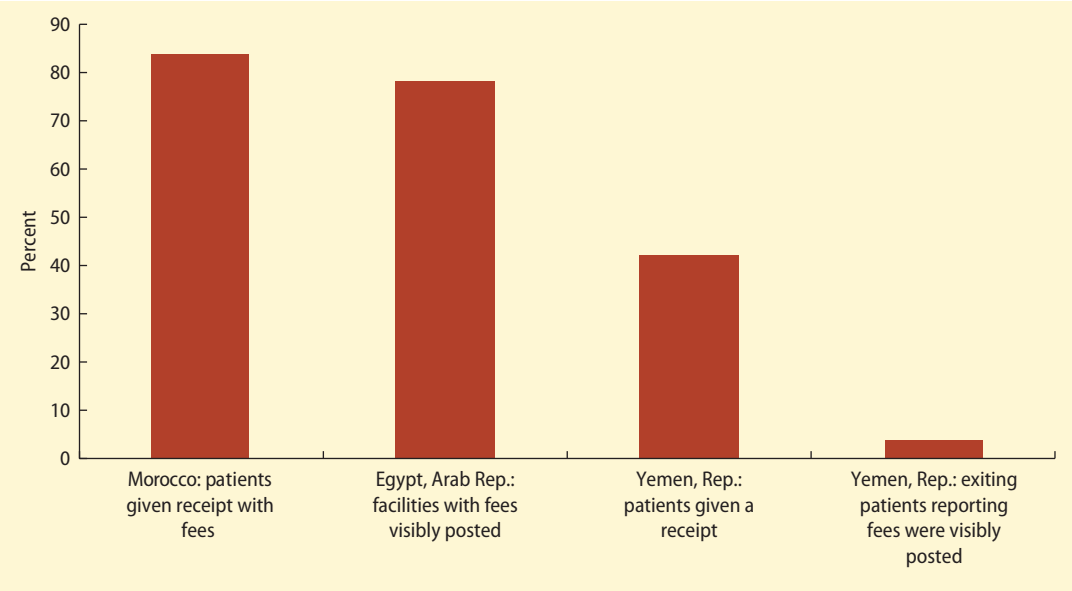


Source: Local Governance Survey, Republic of Yemen, 2013.

In the Republic of Yemen, an inventory of corruption complaints over a three-year period revealed that 240 cases of corruption were reported in 2005, 358 in 2006, and 558 in 2007. Indeed, acts of corruption related to education are some of the more commonly reported incidences of corruption in the Republic of Yemen, reaching 22 percent of cases filed in 2005.[7] Health care was the second most frequent source of corruption cases filed. In 2005, 10 percent were associated with the Ministry of Health; in 2006, 8 percent; and in 2007, 11 percent.[8] Against this backdrop, it may not be surprising that the 2013 Local Governance Survey in the Republic of Yemen suggested that citizens often blame service delivery problems on corruption at both the local and central levels (figure 2.27).

In many cases, the lack of transparency in the cost of services, outcomes, and citizens' rights creates conditions ripe for corruption and the selective provision of services. In medical facilities, for example, citizens are not fully aware of the official costs of care, which creates opportunities for service providers to demand additional payments. Surveys on health services delivery and mechanisms that promote transparency in the payment of health services fees, including receipts for services and posting of fees, have found some important variations across the region. Facility-based surveys in Egypt show that just fewer than 8 in 10 facilities had their fees visibly posted (EHGS, 2010). Among health service users in Morocco, 84 percent reported being given a receipt with itemized fees at their last visit (QSDS, Morocco, 2009—see figure 2.28). In the Republic of Yemen, the lack of transparency is even starker; just 4 percent of patients exiting a facility reported that fees were visibly posted, and only 42 percent of patients reported they had been given a receipt (QSDS, Republic Yemen, 2012). Partly as a consequence, different citizens may end up paying different fees for the same service (see figure 2.29 based on the EHGS).

FIGURE 2.28 Transparency in fees at health facilities: Morocco (2009), Arab Republic of Egypt (2010), and Republic of Yemen (2010)

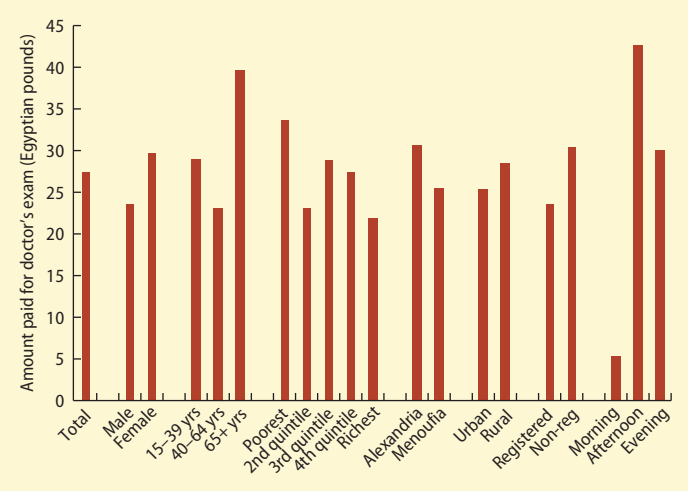


Sources: Morocco: QSDS (health), 2009; Arab Republic of Egypt: EHGS, 2010; Republic of Yemen: QSDS (health), 2010.

Reflections in the wider historical and institutional contexts

The remarkable advancement of MENA countries in expanding access to basic education and health services and the remaining challenge of service quality and citizens' satisfaction have common roots in the unique institutional and sociocultural contexts for service delivery in the MENA region. As we discussed in chapter 1, citizens of the MENA region not only demand better services, but also expect their governments to provide them, reflecting the promises made by Arab leaders at the outset of independence and the subsequent social contract outlined in chapter 1 and discussed in more detail in chapter 4. The postindependence social contract, however, has eschewed the creation of institutions and accountability mechanisms at the political, administrative, and social levels that would motivate providers, public servants, and policy makers to deliver quality services to the poor and other nonprivileged populations. Chapters 4 and 5 will examine these historical and institutional underpinnings of the current realities in service delivery performance in MENA countries.

FIGURE 2.29 Fees for examination by doctor, by background characteristics: Arab Republic of Egypt, 2010



Source: EHGS, 2010.

As we discuss in chapters 4–9, the citizens of the MENA region are facing a cycle of

performance stuck in a low equilibrium: institutions and accountability mechanisms are failing to promote adequate performance. This situation undermines citizen trust, prompting them to adopt forms of engagement that further erode institutions, accountability mechanisms, and norms. In this low equilibrium, the poor find it especially difficult to have their voice heard and needs addressed. The observed subnational variation in performance, satisfaction, and trust further confirms the existing system-wide weaknesses and suggests that they can be partly counteracted at the local level.

Indeed, some localities in MENA countries have successfully counteracted the national cycle of poor performance and developed local solutions—schools and health facilities that motivate their staffs, deliver excellent results in low-capacity settings without any special advantages, and inspire citizens' satisfaction, trust, and constructive engagement in the community. The next chapter will describe four examples of such local successes.

Notes

1. Evaluations by the Joint Monitoring Programme conducted by the World Health Organization and UNICEF reveal that the MENA region is on track to meet the United Nations' Millennium Development Goals for clean water and sanitation. Independent analyses, however, indicate that these assessments failed to take into account water quality, affordability, and sustainability, resulting in overstated coverage rates for clean water and sanitation (Zawahri, Sowers, and Weinthal 2011). Moreover, population pressure, increased levels of use, and declining supplies place many Arab countries in danger of falling under the absolute water-poverty level by 2050 (El Zein et al. 2014).
2. UNRWA operates one of the largest nongovernmental school systems in the Middle East. Operating in five areas (the West Bank, Gaza, Jordan, Lebanon, and Syria), it manages nearly 700 schools, hires 17,000 staff, and educates more than 500,000 refugee students a year.
3. To measure differences in adherence to protocols between different types of consultations, the EHGS normalized all structural observations to a quality index. The index compiles all components of the observation checklist into a score between 0 and 1, in which 0 means that none of the elements of a checklist was observed and 1 means that the provider conducted every single aspect of the consultation according to the checklist.
4. Few dimensions of health care performance are measured in MENA countries, whereas in Canada, for example, performance dimensions such as acceptability, accessibility, appropriateness, competence, continuity, effectiveness, efficiency, equity, responsiveness, and safety are measured.
5. Empirical and theoretical measures of efficiency are based on ratios of observed output levels to the maximum that could have been obtained given the level of input utilization. This maximum constitutes the efficient frontier, which is generally used as a benchmark for measuring the relative efficiency of the observations (http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTDEBTDEPT/0,,contentMDK:20297571~menuPK:64166739~pagePK:64166689~piPK:64166646~theSitePK:469043~isCURL:Y,00.html). The measurement of efficiency generally requires an estimation of costs, an estimation of output, and a comparison of the two. The larger the output is in relation to a given input, the more efficient is the activity (Afonso, Schuknecht, and Tanzi 2010).
6. Quality of care offered by the health provider at a basic health care facility in Morocco was reported by only 9 percent of patients as the most important factor influencing choice, whereas quality of care was a bigger factor in choosing among hospitals, in particular university hospitals: 51 percent of the respondents at university hospitals reported choosing that facility because of the quality of the care provided, compared with 31 percent for other types of hospitals (QSDS, Morocco, 2009).
7. Among the corruption cases processed in 2005, nearly 20 percent involved education agencies or services, and an additional 2 percent were related to higher education ministries. When combined, education-related reports of corruption are more prevalent than corruption cases related to any

other services (health, public works, water, etc.). In 2006, education-related corruption complaints contributed 9 percent of all reported corruption complaints, in third place after finance and agricultural irrigation as the specific domains reporting corruption. However, when corruption cases related to higher education (4 percent) are added to the general education prevalence, education is once again more prevalent than any other specified sector. In 2007, higher education itself constituted approximately 11 percent of all reported corruption cases, with general education contributing about 8 percent of all reported corruption cases.

8. These data should be interpreted with caution and not taken as definitive evidence that corruption is highest in education and health care. Because of the salience of education and health care to people's daily lives, it may be that acts of corruption in these areas are more frequently cited than cases of corruption in other areas.

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Local Successes: Satisfaction, Accountability, and Quality at the Local Level

3

- To understand service delivery, one must conduct an in-depth examination. The positive deviance approach can reveal how the elements of local solutions have emerged.
- A top-performing rural school in the northern West Bank traces its success to active parental engagement, effective coordination with the school district, and the ability of the school principal to build a motivating and encouraging work environment for its teachers.
- In Jordan, an excellent school in a tribal community benefits from a vibrant Education Council trusted by the community for its transparency and inclusive decision making and from school grants allowing some autonomy.
- Top health care clinics in Jordan benefit from their partnership with local social institutions and health committees and from formalizing health management procedures at the local level.
- The best-performing rural health clinics in Morocco effectively draw on their strong partnerships with local communities as well as positive competition and support devised by the Ministry of Health.
- These case studies reveal the importance of building trust, engagement, and accountability in service delivery at the local level. Lessons from these experiences can be part of (though not a substitute for) a broader strategy for promoting systemwide institutional reform.

As described in chapter 2, countries in the Middle East and North Africa (MENA) face a challenge in improving the quality of education and health services delivery; citizens are not satisfied with the services they are receiving. If the average quality of services is poor, however, that situation does not prevail always and everywhere. In some places, the standard of education and health care that citizens receive is remarkably high. In chapter 7, we draw on household surveys to document the nature and extent of subnational variation in service provision indicators across selected MENA countries. In this chapter, we seek depth rather than breadth, using case studies of four instances of highly effective service delivery to explain how regional and local factors can align to yield positive outcomes.

Data drawn from household surveys can provide an abundance of useful information on where, why, and for whom the quality of service delivery varies. But many factors that cannot be adequately captured in household surveys, such as the effectiveness of local leaders, also matter. To more fully appreciate the significance of the social processes by which specific combinations of factors and choices shape outcome variation, we need to drill deeper, using different research tools. This is especially so if we wish to explain and replicate unusually successful cases, because some of the key factors driving these outcomes will only be discernible (observable) through qualitative methods, and not all of these factors (or combinations of factors) will be reproducible elsewhere. Some communities may do well merely because of political connections that yield a steady flow of material resources—a factor that cannot be readily assessed via a household survey, nor one that would be invoked as a policy recommendation for improved performance elsewhere. Similarly, it may turn out that an idiosyncratic combination of factors drives both positive and negative deviance[1] in each setting, making it difficult to identify general implications for development policy, which necessarily must be articulated at broad levels of societal aggregation.

Even so, examining cases in which communities have managed, often despite difficult circumstances, to attain extraordinary outcomes using innovative local solutions to prevailing problems can provide many useful insights for practitioners and policy makers. Crucially, such insights can also be a source of hope and inspiration, showing citizens and fellow professionals alike that someone, somewhere, somehow has found a better way to do things even though they faced similar obstacles and problems. Building service delivery systems that recognize and reward improvement in implementation quality is a central challenge for development in the 21st century. This is true everywhere, but especially in the MENA region, where the consequences of success and failure often feed so immediately into sensitive social tensions, and where citizens' expectations of their government increases along with rising wealth, education, and political openness.

To demonstrate the nature and significance of these local factors in shaping service delivery performance, we present in this chapter four case studies of success: education services in the West Bank and Jordan and health services in Jordan and Morocco. Each case was selected on the basis of a broader analysis of variation in service delivery within each economy and because it demonstrates a particularly instructive array of strategies that have been deployed in response to local (but not atypical) problems.

Case study 1: Education services in Jenin, West Bank

Beyond its intrinsic value, education is an important investment in human capital that offers people a sense of hope and optimism for a better life in a world characterized by seemingly insurmountable barriers, soaring rates of youth joblessness, and deep uncertainty about what the future may hold for them. In recent years, the education system in the West Bank and Gaza has achieved considerable gains and performed well on major education outcomes, attaining levels comparable with those of middle-income countries. In 2011 the literacy rate in the West Bank and Gaza for adults aged 15 and over reached 95 percent, which is much higher than the rate in countries with similar per capita incomes such as India and the Arab Republic of Egypt and similar to that in much richer neighbors in the region such as Turkey, whose per capita income is seven times that of the West Bank and Gaza, and Jordan, whose per capita income is three times greater (Krishnan et al. 2012). Enrollment in basic education is universal. In 2012 the enrollment rate for secondary education was 81 percent, and, equally important, the enrollment rate in tertiary education was above 40 percent for the 18–24 age group the same year (Krishnan et al. 2012), which is high when compared with the rate for middle-income countries. In addition,

access to basic and secondary education is highly equitable with respect to gender, location, refugee status, and household income.

High enrollment rates and educational expenditures of 4.9 percent of the gross domestic product (GDP) are all the more noteworthy considering the difficult economic and political situation facing the West Bank and Gaza (Claussen, Kiernan, and Gramshaug 2013).[2] In contrast to other countries in the developing world, teacher absenteeism is not a major problem. Teachers do show up to teach and seem relatively accountable to their clients.[3] In addition, parents seem to be heavily invested in their children's education, as demonstrated by their high levels of in-kind and financial contributions to schools, particularly in rural areas. Nevertheless, achieving universal enrollment access is only one step toward ensuring an educated and productive population able to compete on the world stage and, more immediately, to survive the many uncertainties it confronts. Indeed, the focus of education policy has recently shifted toward quality of learning because major weaknesses continue to prevail in the classroom (as highlighted by the average student's modest performance in national and international assessments). Students' outcomes in the 2011 Trends in International Mathematics and Science Study (TIMSS) were low when compared with those of other countries with similar GDP per capita or per student expenditure, and they fall below the international average. For example, the share of eighth-grade students scoring at least 475 on the science assessment (classified as an intermediate international benchmark) was only 33 percent, whereas the share for the mathematics assessment was 25 percent (EdStats).

The perennial difficulties experienced by residents of the West Bank and Gaza in improving the quality of education stem largely from the highly complicated political climate to which they have been subjected for over a decade. The region's economy is highly dependent on Israel, and its capacity to support schools is highly strained. Schools in many rural areas suffer from small classrooms and insufficient financial resources to provide the basic educational materials. In addition, mobility restrictions on students and their continual exposure to the psychological trauma arising from the ongoing conflict have taken a toll on students' abilities to experience an ordinary learning environment in which they can thrive, personally and intellectually.

Beyond the political instability, which arguably is the main constraint in improving education services, the education system in the West Bank and Gaza has long relied on obsolete and outdated pedagogical methods, characterized by teacher-centered learning with an emphasis on rote memorization and basic numeracy. Consequently, students are not fully engaged, perform poorly, and lack the essential critical thinking and problem-solving skills needed for survival in today's highly competitive global economy. The costs to the society emerging from such a system seem enormously high because high-productivity skills such as innovation and entrepreneurship are lacking and yet are urgently needed by an economy with high youth unemployment rates,[4] a saturated public sector, and high population growth of 2.3 percent (Krishnan et al. 2012). These costs are particularly high for boys, who tend to withdraw from education sooner than girls. Their enrollment rates are more susceptible to a weak socioeconomic status, amid social norms that focus on supporting education for girls and preparation for adulthood. Boys are also under pressure to resume the breadwinner role when family resources are constrained.

Kufor Quod Girls' Secondary School

The weak overall learning outcomes for students in the West Bank mask a high level of variation across the performance spectrum, with a few schools scoring well above the national average in the TIMSS and Tawjihi national assessments. This result suggests that in these schools, which face constraints similar to those faced by their peers, potentially innovative approaches and local

practices are contributing to education quality in ways that could be generalized and thereby serve as a potential source of inspiration to schools at the lower end of the spectrum. To this end, we visited one of the top-performing schools on the 2011 TIMSS, Kufor Quod Girls' Secondary School in Jenin, to try to identify some of the innovative in-school practices and governance mechanisms underpinning its performance.[5] In doing so, we sought to document some of the ways in which the different stakeholders—school directorate, principal, teachers, students, and parents—were working together to address particular challenges and, in the process, enhance the quality of learning.

The Kufor Quod Girls' Secondary School is in the small village of Kufor Quod, located a few kilometers from the city of Jenin in the north of the West Bank. The school has almost 300 students and about 25 full-time teachers, as well as a principal and a counselor. The school's performance in the 2011 TIMSS was relatively high. The average score for eighth-grade students in science was 529 and in mathematics 500, placing them in the first rank for the highest science average score and in the second rank for the highest mathematics average score among all public schools in the West Bank and Gaza. Both scores placed the school above the intermediate international benchmark.

The school, compared with its peers and especially boys' schools, enjoys a relatively favorable environment that provides a comforting space for learning. Violence and discipline problems in the classroom are rare. The number of students in each classroom is relatively small, enabling teachers to dedicate more time to each student's individual learning needs. This also enables teachers to move vertically across grades (as opposed to teaching horizontally all sections within one grade), which could in some ways be advantageous to students who might benefit from having a teacher who is already familiar with their needs and challenges. In addition, the school enjoys a high level of parental involvement and commitment to education—a factor common to all schools in Jenin, as noted during our visit to Jenin's education directorate, one of the 16 field directorates spread throughout the West Bank. The Ministry of Education and Higher Education (MOEHE), through the directorates, provides schools with classrooms, textbooks, and other materials, in addition to managerial and technical supervision.[6] In addition, during its preparation for the 2011 TIMSS, the school, similar to other schools in Jenin, received rigorous support from the directorate.[7] The comprehensive, structured planning process for the TIMSS focused on two efforts. The first was forming at the directorate level a committee whose sections had different roles and responsibilities—for example, the supervisors' section designed and developed capacity-building programs and conducted field visits to provide pedagogical and content support to the science and math teachers, and the external relations section enhanced the engagement of parents and the local community by conducting awareness campaigns about the importance of the TIMSS. The second area was encouraging the implementation of several activities believed to play an important role in increasing students' TIMSS results, such as developing simulation exercises based on questions similar to those in the TIMSS, conducting frequent competitions at the directorate level (including all 144 schools), and investing in social platforms (such as creating a Facebook page) to support ongoing discussions between students and provide supporting materials.

Such thorough planning and preparation played an important role in raising students' TIMSS performances at the directorate level in general and at Kufor Quod in particular. A sense of genuine pride and accomplishment was felt by all involved—staff at the directorate level, principal, teachers, students, parents, and the local community—as a result of having achieved relatively high scores at the national level and enjoying the acclaim of being able to represent their country internationally. The deputy director at the directorate and his staff, who were the key actors in the major TIMSS preparations, were even nicknamed "the TIMSS Men." In all of this,

the truly remarkable and innovative part was that the directorate did not lose track of the goal—enhancing the education outcomes of students without restricting them to achieving only high TIMSS scores—while also harnessing the energy and pride gained from achieving high TIMSS scores to push for even higher educational attainment, including in those subjects not formally part of the TIMSS process.

The directorate's effort was particularly successful and most visible in Kufor Quod because of the outstanding leadership exhibited by the school's principal, Ms. Abla Habayeb (see photo 3.1). Over a long career, she has forged remarkably productive and robust relationships with all the parties involved based on reciprocal trust and respect, thereby benefiting from informal networks and tight intercommunity relations. These relationships ensure that accountability mechanisms work in the right direction and are further harnessed in the pursuit of higher-quality education. In terms of her upward relationship with the directorate, the principal's years of service (29 of them as a principal) have earned her an excellent reputation, which she uses in her relationship with the directorate to gain its trust. In turn, she has earned the right to receive considerable autonomy to pursue initiatives on her own and seek the directorate's ongoing support. Her seemingly boundless energy and motivation of teachers, students, and parents, in addition to her regular consultations with them, further increase their commitment and ensure their sustained cooperation as part of a collective quest to improve the school's learning outcomes and physical environment.

In short, Kufor Quod's impressive academic performance and dedication to education are largely attributed to the school's principal, who has made it her personal mission to aim high and deliver the best education possible to her students, especially in view of the many constraints they encounter on a daily basis. From a policy perspective, the challenge remains of setting up a *system* that ensures that her local practices and innovations are not personality-driven but instead are incorporated into an institutionalized process that offers other schools guidance, inspiration, and accountability. To this end, we now explore some of the broader institutional processes enabling Ms. Abla to oversee an effective learning environment.

PHOTO 3.1 Abla Habayeb, principal of Kufor Quod Girls' Secondary School

Source: © Jumana Alaref and Michael Woolcock / World Bank. Further permission required for reuse.

Accountability mechanisms at work

Between the school and Jenin's education directorate. The midlevel relationships between the service providers (schools within the directorate) and Jenin's directorate are characterized by seemingly effortless direct communications. In establishing an accountability relationship with school principals, the directorate has been able to strike the right balance in ensuring that principals are accountable for their work and expected to deliver results according to a predefined set of clear guidelines, while giving them autonomy and space during implementation to find context-specific solutions. Principals are

entrusted to do their work and duties in innovative ways they themselves deem fit, while the directorate supports them consistently, enhances healthy competition between them, and monitors and evaluates them as reflected in students' overall performance, teachers' feedback, and the level of local community engagement. During preparation for the TIMSS, the sense of partnership and collaboration between the two was reinforced by the participatory approach the directorate took through workshops that sought the principals' input on the directorate's plan and their suggestions for improving and enhancing cooperation. In her efforts to internally push her staff and students toward exerting more effort, Ms. Abla capitalized on this partnership with the directorate by working hard to earn the trust of both staff (such as by offering professional development) and students (by actively involving them in numerous decisions[8]) in return for their ongoing support.

One way in which the directorate is able to support schools is through teacher supervisors. Supervisors (1) assess teachers' performances and provide content and pedagogical support; (2) design, develop, and implement training programs for teachers on methods of teaching, classroom management, and measurement and evaluation; and (3) provide feedback to the Palestinian Curricula Center on the newly developed textbooks. The supervisors' role has recently evolved from a purely authority-based relationship with teachers (based on a rigid focus on progress through the official curriculum) toward a more flexible one that concentrates on mentorship, support, and cooperative learning.[9] Within Jenin's directorate, supervisors have begun using new criteria in assessing teachers' performance. These criteria are centered on evaluating the gradual shift in teachers' pedagogical practices from purely lecturing to student-centered learning based on discussions and debates. In addition, supervisors serve as a conduit for transferring effective and innovative approaches between classrooms and schools, inviting well-performing teachers to provide training for other teachers and helping to formulate a comprehensive plan that outlines issues and solutions. For example, the science teacher at Kufor Quod Girls' Secondary School who helped prepare students for the 2011 TIMSS talked about her experience and participated in training sessions with other teachers. In this way, supervisors are an important accountability channel for teacher monitoring and the provision of support in updating teachers' pedagogical practices, bearing in mind that the supervisors themselves still largely adhere to the traditional way of evaluating teachers—that is, their ability to cover all the material on time—leaving little room and few incentives for teachers to innovate or venture into different models of teaching.

Although this collaborative framework does not yet set the stage for complete school-based management, it is a refreshing departure from a rigid centralized system to one in which the directorate works with the schools and their communities to help prioritize school needs and determine how best to support students. This vision was adopted by the director as a result of her personal conviction and was not implemented at the level of all directorates by the Ministry of Education. This suggests that the success of this framework in supporting all schools in Jenin, and its particular benefits for Kufor Quod Girls' Secondary School (mainly because of the principal's ability to fully capitalize on it), is of high potential value for other directorates in the West Bank and Gaza seeking to learn from and implement new ideas in their own schools.

Between the school and its teachers. The directorate's philosophy in dealing with its own schools has been echoed by the principal in her internal accountability mechanism with teachers. The nature of the relationship between the principal and teachers is centered on continual support, which in turn is translated positively into the level of effort exerted by teachers and reflected in students' academic performances. The principal supports teachers in the following ways:

- *Continual process of systematic encouragement and nonmonetary*

incentive schemes. Despite her limited autonomy and lack of ability to reward high-performing and exceptional teachers with monetary bonuses and rewards, the principal ensures that her staff members are constantly appreciated and receive the incentives they need to sustain high-quality work. Teachers reported that such appreciation takes the form of fair and equal treatment of all teachers and verbal and public encouragement of exceptional teachers in front of the entire school when test scores are publicized. The result is a relaxing environment in which teachers are able to perform their job properly, with little rivalry or tension between them.

- *Professional development and in-service training*. As part of their professional development, teachers in Kufor Quod receive regular training by the Ministry of Education and external entities, mainly nongovernmental organizations and international donors. The school's lack of material resources has not diverted the principal from the importance of focusing on the factors inside the classroom that have an impact on learning, mainly improving teaching pedagogy. Therefore, based on her assessment of teachers' needs, the principal nominates her teachers for training courses and releases the time for them to participate, taking into consideration the availability of training, its location, and a teacher's workload. However, as argued by teachers during our interviews, the training offered may not necessarily translate into updated pedagogy or more effective teaching, highlighting the need for a more structured system that is in line with international standards and that helps teachers upgrade their skills and venture into innovative models of teaching. Thus rather than asking for financial contributions or better technological and material resources for her school (which is clearly a need), the principal requests training courses for her teachers that acquaint them with the successful education modules implemented elsewhere that could be adopted in her school.

  Meanwhile, teachers' commitments to constantly improving have fostered an environment of cooperation aimed at enhancing student learning. Teachers often fill in for each other in cases of unforeseen absenteeism. In addition, they exchange knowledge by attending each other's classes and adopting creative teaching techniques such as pairing low-performing students with high-performing ones in group homework.
- *Participatory approach to the decision-making processes at the school level*. The principal frequently consults the teachers when she must make decisions that affect them and the students. For example, the school improvement plan is developed collaboratively by the principal, counselor, and the math, science, technology, and Arabic teachers in order to reflect students' needs (such as any particular weaknesses among students requiring more support) or staff needs (such as any necessary training) before the plan is shared with the directorate. Teachers are also consulted on the budget allocation process before it is sent to the directorate so that the budget reflects their needs.
- *Teachers in turn reciprocate the commitment*. The framework of partnership and trust that the principal has established with teachers has allowed her to retain the best and most dedicated of them and provide incentives for everyone to work harder and be more committed. She has extended those incentives to, for example, the math and science teachers who prepared students for the 2011 TIMSS and have a reputation (according to supervisors) for exhibiting special in-class practices, openness to recommendations and feedback, knowledge of the TIMSS, and a desire to create a student-centered environment. In another example of exceptional dedication by teachers to their students, those at the school did not take part in the frequent strikes called by teachers and unions across the country

> to demand higher wages. They asserted on paper that they were on strike, but in reality—and despite being subject to pressures from the unions—they continued to teach classes in order to better prepare students for their exams. When asked why they would do such a thing, one of the teachers shrugged and said, "Oh, but my conscience would not allow me to not teach to the best of my capabilities." We then asked, "But imagine you were working in a different school where you did not feel quite as appreciated, would you still do the same thing?" The teacher replied, "No, I would not. It is only natural to give back what you receive in the first place."

Between the school and its students, parents, and the local community. In a community characterized by tight intercommunity relations, complex political dynamics, and a highly constrained government, the support provided by parents and the local community is essential to the principal in sustaining the quality of her school and pushing forward. To the principal's advantage, the local community consists of highly engaged parents committed to providing education for their children, often against all odds. Therefore, parents' involvement reflects a very high level of awareness of their children's academic performance and behavior in the classroom. The principal has formalized such engagement through many channels. For example, parents provide their own feedback and signature on every item of homework to ensure that they monitor their children's performance. And parents participate in activities in the classroom. Furthermore, the principal has established a more formal structure through the school's parent-teacher association, which she has used as an avenue to discuss students' performance with their parents before scheduled midterm and final exams and afterward. The Education Career Council she has established is an attempt to stimulate discussions among parents about the need to give their children the freedom to choose the academic track they would like to pursue in their last two years of high school—scientific, literary, or commercial.[10] The principal also uses innovative strategies to reach out to parents who are not as actively involved in their child's education, such as inviting illiterate parents to attend first-grade classes to learn how to read and write.

Engagement by parents and the local community extends to issues beyond the classroom and includes their participation in the decision-making process. Parents, who are viewed as partners, become heavily invested in their children's school. In many instances, they contribute to the school by providing material resources in response to the often-heard plaint by the Ministry of Education that its financial capabilities are limited. Examples of parent involvement include constructing the second floor of the school building and helping to provide a computer lab.

The collaborative environment in the school has created a safe learning environment for students—one that provides an appropriate platform for students to exert more effort in the classroom. Students regard their teachers as their "friends" and the principal "as a mother-like figure." They feel their voices and concerns are heard, and they are treated equally, without discrimination, based on their level of academic performance. Moreover, students with special needs (such as those with visual or learning difficulties) receive ongoing support from the administration and students alike, mirroring the broader cultivated attitude that everyone in the school has an equal role to play in the learning process.

Remaining challenges

Kufor Quod Girls' Secondary School is an exceptional case of what can happen when a school's leadership works with its directorate, teachers, parents, and students as one collaborative unit to optimize the education offered by the school. The question of whether the model Ms. Abla (with the support of her superiors) has been able to implement within the boundaries of her school is sustainable remains, nevertheless, an open-ended one.

There continues to be room for improvement in having her local best practices "routinized" into an approach that ensures its continuity after someone else takes over and slowly integrating this approach into a structured governance system that is not personality-dependent. Such a step would enhance the likelihood that other schools in the West Bank and Gaza would also benefit from her innovations and in turn would be accountable for generating improvements of their own.

Meanwhile, the potential and dedication offered by teachers and students demonstrate that Kufor Quod has the potential to improve even further. The TIMSS results achieved by the school are above the intermediate international benchmark, but they still fall short of reaching the advanced and high international benchmarks. Although the system established by Ms. Abla may well safeguard her students' relatively high achievements and prevent them from deteriorating, a lingering question does remain: how does one help a school such as Kufor Quod improve even further and leapfrog to the standards of modern education systems that fully prepare their students for the global economy? The answer to that question is not necessarily found in having the administration or teachers undertake some new techniques but rather in the broader context of the current rigid education system in the West Bank and Gaza that provides very little room for flexibility, innovation, or change. It is evident when listening to students' and teachers' needs that students do not have a sufficiently firm grasp of some relevant subject areas and, most important, an ability to deconstruct and reconstruct knowledge and apply it in varying contexts and to real-world situations. Unfortunately, students' abilities to develop critical thinking, problem solving, and broader skills sets are somewhat lagging.

Understanding these limitations requires examining the factors that seem to keep the system locked in place without sufficient room for flexibility. These factors include (1) the use of textbooks that are usually loaded with information with the expectation that teachers will cover all the material before the end of the academic year, leaving little room for other types of learning activities; (2) the criteria used by supervisors to evaluate teachers, which largely rest on teachers' abilities to teach all the material "on time" and their ability to recite the information accurately to students, leaving no incentives for teachers to innovate or venture into different models of teaching that rely more on active engagement between students and teachers; and (3) a reliance on exams that tend to merely measure students' abilities to learn the information by heart, leaving little room for creative thinking, problem solving, and innovation. Limited by the system's boundaries, any professional development practices developed for teachers are thus tailored to what the system demands that students learn, leaving no chance for promoting new learning paradigms and innovative practices.[11] Such a system is particularly costly to those living in the West Bank and Gaza because their political reality and nearly crippled labor market necessitate more than ever finding innovative practices and unconventional methods to break out of the box in which they find themselves and thinking of alternative routes to mitigate the effects of the economic and political hardships they face.

Conclusions and implications

When asked by our team about their dreams and aspirations for the future, students at Kufor Quod did not hold back on giving impressive answers that revealed their desires to achieve much more than what the world seems to expect from them.[12] Ensuring that their dreams are not crushed by their harsh circumstances requires a collective commitment from policy makers and donors alike to students acquiring the skills that would enable them to achieve what they are capable of and never give up on their dreams. Not just Kufor Quod students but all students in the West Bank and Gaza have the right to dream and deserve a real chance to translate these dreams into reality.

The various lessons and implications for policy and practice arising from Kufor Quod

Girls' Secondary School could be extended to other schools to reduce the gap between aspiration and reality, between the best schools and the rest. Any options for scaling up these successful local practices require a full-fledged collaboration plan that moves in three directions: upward with the directorate's relationship with the school, downward to the teachers, and then outward to the local community as part of a binding social compact to prioritize school needs and determine how best to support student learning of increasingly complex issues. Specifically, several micro-level steps were taken by Kufor Quod that other schools and directorates could consider implementing. These include:

- *Adopting the plan devised by the director of Jenin's directorate that set up strong accountability mechanisms with school principals by giving them sufficient autonomy in making decisions and launching innovative initiatives at the school level.* Such a plan creates a culture of partnership and aligns incentives by cultivating a broader attitude that all stakeholders have roles and responsibilities to fulfill in return for support, with the ultimate goal of serving students' learning needs and supporting them as much as possible.
- *Within schools, building effective interaction between principals and teachers.* Providing teachers with encouragement and support and ensuring that they are qualified and regularly participating in opportunities for professional development are essential to motivating teachers and to cultivating and sustaining successful accountability mechanisms, not only with other educators but also with broader professional norms.
- *Externally, forging mutually supportive interaction among teaching staff, parents, and the local community.* Establishing transparent and genuinely collaborative partnerships ensures not only ongoing involvement in students' learning environment in the classroom (which is essential in raising academic performance), but also ongoing support for the principal by participation in the decisions that affect the future of students and their school.
- *Receiving the surrounding environment's trust and support so that the principal can perform his or her duties more smoothly and efficiently.* For example, Kufor Quod's development plan—which consists of ongoing monitoring and evaluation, regular assessments at early stages to detect inefficiencies, and the development of remedy plans—requires the collaborative involvement of all stakeholders (by incorporating their input and various assessments) to realize its effective implementation.

Beyond these specific insights, however, perhaps the most important lesson learned is to create space at the local level for schools to find and implement their own solutions to their own particular problems. Learning collectively how to optimize, within the constraints the school and its community face, is the first step to expanding the frontier across the education system itself.

Case study 2: Education services in Yarqa, Jordan

Jordan is fortunate to have a long-standing commitment to education. Unlike many of its neighbors, Jordan does not depend on oil exports to sustain its national economy, and thus since its inception as an independent state in 1946 it has recognized that "investing in people" is the key to sustaining its social cohesion, political stability, and economic prosperity.[13] In a region that scores below international averages on educational performance, we found Jordan to be a positive outlier. Even so, there is considerable variability between schools and between genders in the quality of the education that students receive. In the case we describe here, community members of the villages of Ira and Yarqa were able to work together, through formal and informal networks, to identify and constructively address

common educational challenges related to service delivery. Through this success, their school cluster was able to (1) strengthen the citizen provider route for accountability; (2) institutionalize a culture of inclusiveness, transparency, and collaboration in decision making; and (3) institutionalize a process of self-review, continual improvement, and enhanced services.

Zeid Bin Haritha Secondary School

Past the winding roads leading out of Amman and deep into the municipality of Al Salt is the village of Yarqa, a typical tribal community that sits amid the hills of serene rural Jordan. Zeid Bin Haritha Secondary School, a modest-sized school located off of a main street, serves 192 students from grades 5 to 12. Zeid Bin Haritha is one school in a cluster of 11 schools in Ira and Yarqa, two small villages with a combined population of 9,400. Like some other schools across Al Salt and other municipalities in Jordan, Zeid Bin Haritha's buildings and facilities are outdated and in need of renovation, classes are overcrowded and poorly heated in winter, and teacher shortages are a common problem. At the helm of the school is principal Hatim Zaydoun, a tall, commanding figure, who projects an aura of authority even to members of the parent-teacher association (PTA), a difficult feat that has clearly consolidated Hatim's position within the community.

The PTA of Zeid Bin Haritha (and others across Jordan) is not a typical parent-teacher association. Its members are retired teachers, parents whose children graduated long ago from school, and practicing teachers. Here, the PTA is one player in the new approach to promoting school autonomy and community engagement. Despite the unconventional formulation of this PTA, there is no mistaking that education outcomes and quality are at the top of the agenda of this association and school. This PTA, like many others recently established in Al Salt, is the result of joint efforts by the local community and school to attain better education outcomes.

Jordan's education system has long been hailed as a star performer in a region that consistently performs below the international averages.[14] With its advanced education system regionally, Jordan has an 8 percent illiteracy rate, the third lowest rate in the Arab world. Its primary gross enrollment ratio increased from 71 percent in 1994 to 99 percent in 2010, and its transition rate to secondary school increased from 63 percent to 98 percent over the same period (EdStats). Jordan also ensures a high level of gender parity in access to basic services. As a result, it has achieved 95 percent parity in literacy, full parity in primary and secondary enrollment, and increased life expectancy for both sexes. In terms of student learning outcomes, on the 2003 and 2007 TIMSS, Jordan's students outperformed many of their peers. However, most recently, in 2011, student outcomes dipped considerably, especially among boys.[15]

Although the dip in student performance came as a surprise to Jordan's Ministry of Education and outside observers, the ministry has been actively undertaking new and innovative projects that could maintain improved student performance levels and curb the recent declines. In doing so, the ministry, as part of the second phase of the education development plan that began in 2009, embarked on a path toward greater school autonomy and enhanced community engagement as one of its initiatives to improve student learning outcomes. This process includes implementation of the School and District Development Program (SDDP), a donor-funded national program that aims to develop schools and directorates by promoting greater collaboration between schools and communities to systematically determine and address school and local needs. These efforts seek to foster (1) increased participation by local stakeholders in decision making and priority setting; (2) greater efficiency and transparency in the use of resources; (3) increased engagement by parents and support through financial or in-kind donations; (4) improved student learning and school environment; and (5) improved provision of

education services that result in higher student learning outcomes.

Under the SDDP, the objectives of increased school autonomy and community engagement are being achieved by a school self-review process that involves input from parents, teachers, and students[16] in four key areas: teaching and learning, leadership and management, community engagement, and student environment. Each school appoints a domain leader for the four key areas, who then collects and analyzes the inputs of stakeholders against standardized quality indicators to identify a set of priorities. The domain leaders form part of the School Development Team, led by the school principal, and together they draft a School Improvement Plan (SIP). The SIP is shared with the Education Council,[17] which is responsible for a number of schools within one area, together forming a cluster of about 10 schools. The hope is that the school and district improvement plans will allow better insight into how communities in which the government provision of social services is lacking and the lines of accountability are broken or blurred because of factors beyond individual control can improve basic services in an equitable manner.

In Jordan's rural villages such as Ira and Yarqa, families depend on agriculture and the local administrative public sector for their income. Community members have maintained their roots in these villages for generations and enjoy a relatively calm and simple life that is family-centered. But they find it difficult to accept change. With the introduction of the SDDP and the push toward community engagement in schools through joint school and community training, community members and school principals were hesitant and uncertain of the benefits to be reaped from changing the current processes of managing schools. "We take our role very seriously, and realize that it's up to us to determine what the school needs are for the upcoming year," explained Hatim. "This is not the way we used to do it in the past. When we were told there needs to be more community involvement in school practices we weren't sure about that."

This case study examines the ways in which different groups involved in the day-to-day operation of schools—teachers, students, parents, communities, and broader associational groups—work together (or not) to identify and constructively address common educational challenges related to service delivery.

Challenge: A culture of disengagement

Ira and Yarqa are close-knit villages that have defined community structures based on tribal lineages and intracommunity relations rooted in Jordan's Bedouin and Islamic traditions. "We live in a rural small village. It's like a large family. We hold evening events all the time, family gatherings and the *majlis*, where issues are discussed and we hear from each other and the children about what's happening at school," explained the father of a student. Villagers describe their community as "rural," "tribal," and "closed." Here, tribal and community practices of authority prevail; individuals with predetermined characteristics are given the authority, albeit in a tacit manner, to engage and advocate for the village. The close community relations and high levels of acquaintance lead to frequent interactions, both formal and informal. Through these interactions, citizens share stories and news from the community, build ties, and establish a sense of belonging to the village. The interwoven relations within the villages have made citizens comfortable with the pace of rural life in Jordan. Any changes to this situation are easily detected and are at first viewed with cynicism and concern.

Because of the interconnectedness and ease of information flow in these villages, formal means of communication at the school level are overlooked. After all, teachers and principals regularly see the parents of students outside of school. And yet despite this informal mode of communication, parents and other members of the community shy away from reaching out to teachers or school principals on matters beyond those of student behavior or performance. The lines of authority between the school and community are

drawn so that teachers and the school principal hold all the decision-making power internally, with little input and involvement from parents—a relationship with which both parents and the principal have been comfortable. However, recognizing the positive effects that can be reaped from school and community cooperation, educators in Jordan have explored options for improved student outcomes that harness this approach to improved student outcomes.[18]

They must begin, however, by addressing two challenges: first, how to involve parents and citizens in the school planning process when many of them are unsure of how to do so, and possibly have no interest in participating, and, second, how to convince principals and schools to accept a shared decision-making process. As one teacher from the PTA put it, "Our problem in Jordan is that parents used to be neglectful about their children's education. This is something we used to suffer from. . . . The problem was not with the teacher or student, but it was the environment and the lack of cooperation between parents and school." With the move toward increased school autonomy, parents and community members are expected to participate and make their voices heard in issues beyond their children's learning outcomes and behavior in school—the traditional reasons for a school to communicate with a parent. However, the barriers to engaging with schools that stem from socioeconomic factors such as the parent's level of education, employment status, occupation, social standing, and gender still prevail today. "I'm not afraid of bringing issues up to a school principal or a teacher," said Um Amira. "My house is very close to the local girls' school and I can see a lot of what is happening from my window. If anything is not to my liking or I see misconduct, from a teacher or student, I have no problems reporting it to the principal right away. I am comfortable doing so because I used to be a school principal. Of course, there are other mothers who don't have this level of comfort and would not bring issues up because of fears or insecurities. This is common."

Students are also expected to participate in school decisions (photo 3.2). The intention in including students in the decision-making process is evident, but in practice it sometimes contradicts existing notions of the role and expectations of youth in the community. A recent assessment[19] found that 44 percent of teachers believed that school managers do not include students in decision making, resulting in the exclusion of students from discussions and leaving principals and teachers misinformed about everyday problems in the school environment.

PHOTO 3.2 Jordanian youth in an after-school setting at an elementary school

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As a result of implementation of the School and District Development Program and related measures, at the school level, principals have had to reconceptualize their role as school leader from one that is solitary and autocratic[20] to one that is inclusive, transparent, and consensus-based, essentially adopting a form of distributed leadership. "The principal is constantly in contact with the parents. He has all our numbers and he's the center of contact as he is aware of all the school problems," explained one parent. Hasan, a teacher who used to be a student at the same school, recounted, "In the past, the way we used to engage with families was at the end of the school year, there was a school celebration that parents were invited to, in order to learn about the past school year and student performance. Other than that there was no communication with parents unless there was a problem with their child." These comments illustrate the difficulty encountered in enforcing new behavior and attitudes toward engagement and community involvement in which principals are being asked to give up their absolute authority in all school-related matters, but they are given relatively few incentives to do so and have little understanding of the expected results. These difficulties intensify in contexts that are otherwise tolerant of autocratic leadership styles in schools and suspicious of external challenges to authority.

Partnerships working toward change

Abu Muhanad evokes the classical image of a tribal leader. His traditional headdress, the *hatta*, a white and black fabric, is draped over his gray hair, and it frames his face to reveal the deep lines etched by years of experience and wisdom. His knowledge of Jordan's history and its education system is quite comprehensive, and he can recount it with great accuracy and detail. No matter the occasion, he wears the traditional *thoub* over which he adds a wool sweater and a sports coat to protect against the winter chill. When he enters a room, all welcome him and make space for him at the head of the table, regardless of whether he was invited to the meeting, indicating respect and admiration for a man who is not only an elder but also the elected chairman of the Education Council for the cluster of schools.

Activating community engagement with schools requires a tactical ability to harness and create a sense of cohesion and purpose. Parents have to think beyond their children, and teachers and principals have to think beyond their own schools, because under the SDDP, schools are placed into a cluster that in theory establishes a network of support and collaboration if those relations function as designed. Although many schools across Jordan are still struggling with regulating their cooperation under the school clusters, Ira and Yarqa are happily showcasing the benefits of their experiences. The strategic maneuvering of the villages could be attributed to the training received through the project, as well as having identified a strong Education Council chairman, who in that capacity represents the local traditions and cultures of the community, while having a forward-looking vision of what the schools and citizens together can accomplish as he was an educator himself for over 20 years.[21] His knowledge of the education sector and the trust local members have in him have made it possible for him to mobilize and influence local representatives and leaders and convince them of the benefits of functioning under a cluster of schools with increased parental and community engagement. "We work as one team: the local community and the school," said Abu Muhanad as he described the new attitudes toward increased school autonomy.

However, realizing a common vision and commitment to the effective delivery of education entails in every country forging a sustained complementarity between informal and formal systems. Communities everywhere have a prevailing approach to educating and socializing their young members; it is only relatively recently that this approach was supplemented by a more structured and

uniform institution called schooling that is overseen (if not necessarily provided) by the state.[22] Whether and how the prevailing informal system accommodates and supports the formal system play a large role in shaping the overall quality of education that children receive.[23]

Managing power relations

As implementation of the SDDP began, community members organized themselves in a manner that institutionalized and legitimized the informal instantiations of community and tribal leadership through school PTAs and local Education Councils (LECs). "At the meeting yesterday, three community representatives attended who were not invited," said a school principal about a PTA meeting. "We cannot stop them from attending and sometimes their presence steers the conversation away from the original topics of discussion." In principle, educational reformers advocating increased community engagement at the school level seek school cooperation with a community council comprising a broad cross section of society. In Ira and Yarqa, the reality is that the prevailing norms of tribal authority largely determine who does and does not sit on such councils, thereby ensuring that tribal and community control over how schools educate and ultimately socialize their students is maintained. The villages of Ira and Yarqa, under Abu Muhanad's leadership, were able to reconcile some of those effects by respecting and accommodating the informal social structures throughout the process of change. To that end, larger community buy-in to the vision of how their schools should be operating was achieved, and community gains became plausible.

Indeed, the remaining challenge is managing the negative aspects of these informal mechanisms, which tend to appear in the form of capture by one or more groups who share the same vested interests over the interests of the majority. Although he symbolizes the traditional culture and as an elder is likely an influential member in the prevailing informal system, Abu Muhanad is also progressive in his views of and vision for education. "You always have to keep reading and staying up to date with what is happening in America, Canada, Russia, or Korea. Otherwise you are left behind in this constantly changing world," explained Abu Muhanad. With a genuine commitment to education and improving student outcomes, he has, with the support of school principals, been able to build a process of democratic decision making that includes the voices of teachers, parents, and, to a small extent, students—a difficult accomplishment considering that it has required changes in the attitude, behavior, and beliefs of community members. "The decisions we make here are done collaboratively," said a teacher in reference to the Education Council. "We used to run on a dictatorial system . . . [and] now that has changed. We have consensus and we work as one school cluster." This reconceptualization, largely a response to the SDDP, has created a sense of internal accountability that extends beyond that of school to parents; it is now one of parents and community to school.

Of course, some impediments to progress still exist. Describing the current impediments to community cohesion, one principal observed, "Once we passed the first obstacle of convincing citizens to engage with the schools we faced another challenge. There are some people who created obstacles on purpose, for personal reasons. . . . Essentially they don't want to see a principal who has been leading successfully to progress. If a certain school principal is doing good work and has a strong reputation, some people might worry that that school principal can be a competitor for a school council position that they want."

To address some of these challenges, educators have devised innovative solutions to mitigate the undue influence of powerful community members. For example, Hatim, a principal, created the Friends of the School Council, an informal but diverse group of parents to provide independent input into key decisions.[24] He took this step out of concern that an elected body such as the PTA would

mainly represent local elites who received votes because of their influence and family affiliation. Although the PTA is an important body, it cannot address some of the tribal issues that arise. By creating a separate body with no formal leadership structure and with a representative from every family in the community, the principal was able to elicit the information he needed and secure more equitable community buy-in to reform processes without letting the formal PTA meetings become a venue at which select community leaders felt challenged or only advocated for their own interests. This type of maneuvering was possible because the principal has been in this community for several years, making him adept at managing local politics. Establishment of the informal Friends of the School Council thus achieved similar programmatic ends without it being perceived as a rival of the existing power brokers. The school development plan was therefore created through a joint meeting with the PTA, students, community members, and the Friends of the School Council. Nevertheless, passive forms of resistance can still be exerted on a daily basis against anyone perceived as receiving too much attention.

Working together and holding all accountable

Thus in the villages of Ira and Yarqa, based on a belief in the benefits of community and school engagement, the daily process of education was transformed into one that was responsive, agile, and relevant to the local context. Greater engagement among the schools, community, Education Council, field directorate, and Ministry of Education resulted in stronger accountability among schools, parents, and students. Establishing PTAs, student councils, and a student suggestion box[25] allowed groups to identify their interest in education, and, through participation in the school self-review process, they realized their right to contribute to the school assessment, question school operations and management, and not limit their interventions to exam scores and behavioral matters. These demonstrated efforts to improve the quality, diversity, and frequency of interaction between the school and community stand in stark contrast to the old ways of communication and are now bearing fruit—for example, attendance at previous PTA meetings had averaged 5 persons, but it was now attracting more than 37. As one teacher remarked, "The school used to be closed; now it is open for the community. We as teachers and a school can work with parents to address the needs of students. We have a common understanding now between the school and parents."

Soliciting feedback from parents via a questionnaire as part of the input to the SIP was at first regarded by parents as a "test."[26] The result was low initial response rates, but over time (and with further encouragement from teachers, principals, and leaders such as Abu Muhanad), parents realized that such information provided a useful and rational basis on which difficult decisions could be made. "Now the engagement with the community is different: it's regular, they are involved in decision making, they oversee and support the school," observed Hasan, the teacher and former student at Zeid Bin Haritha School. "They provide support to the teachers and school by their active participation."

The increased interaction was then translated into higher parent expectations, leading them to seek stronger school initiatives, activities, and standards of teaching. These expectations were in turn reciprocated by the schools, which—having seen and, for some, having harnessed the positive outcomes of community involvement—were happy to cooperate with the local community to address challenges to service delivery. "I stopped solving school problems on my own," explained the principal of a girls' school. "I now wait for the LEC meeting, and share my problems and there I find multiple solutions. Principals now offer support to each other, and we come up with ideas that I would have never thought of." An example is the responses to the electrical issues facing her school: "The school was built in two

stages; when they built the second phase of the school they didn't install enough fuse boxes and with the operation of the other part of the school our electricity would constantly be cut off. Computers in the lab were burnt as a result of this. When I brought this up, I found lots of help. Community members spoke to the electrical company; others came to the school to see what they could offer in terms of solutions until they installed new boxes."

With clear, positive outcomes from community engagement, friendly competition and rivalry began among local schools, and even parents, to provide better student outcomes and better school activities that would boost pride and prestige for the community. It also helped parents and the community rally around common issues that their children might be facing but that had not been addressed by the education system such as student learning difficulties and services for students with special needs. For example, the local community together with the administration organized doctor's visits to schools to identify students with vision impairments. After the visit, parents pooled their funds to print textbooks in larger font sizes for students with severe visual issues. And the school worked with mothers of students with learning difficulties to organize a workshop on the special teaching practices and methods needed for preparing diagnostic plans to assess the learning challenges such students face.

This direct citizen-provider interaction, called the short route to accountability in the *World Development Report 2004: Making Services Work for Poor People* (World Bank 2004), is also a response to the realization of schools, parents, and community members that their direct engagement with the Ministry of Education has largely proven to be ineffective. School leaders and community members in Ira and Yarqa are convinced that the Ministry of Education is not capable of supporting the day-to-day needs and unpredictable occurrences that deter the provision of quality services in their villages.

Functioning as a cluster

One of the incentives for principals to relinquish some of their singular authority and support this new process of community engagement was the recognition bestowed on them as leaders in the local Education Council and the creation of a dependable support system. The LEC facilitated and formalized interaction between school principals that had not taken place previously (or had occurred much less frequently). It also became a platform for cooperation and problem solving for the cluster, thereby alleviating the burden of a sole operator, the principal, to address school challenges. As one principal pointed out, "When the schools were placed in a cluster and we began to meet and follow up on student scores, we realized there was a joint problem with students' writing skills in Arabic in the early grades, second, third, and fourth. The teachers decided to study and analyze student results, after which they put together a plan for development and met with the cluster where it was agreed to implement the plan across the schools. Now in the second year of implementation we see improved student learning." As a cluster, the communities and the schools they encompass have become a unit that has a vested interest in seeing that all schools succeed because one school's success can be shared with the neighboring school or community.

Beyond the immediate community-to-provider relations, midlevel accountability within the cluster between the field directorate and the schools is largely mediated by the LEC. At the directorate level, every cluster is represented by the head of its LEC at the Educational Development Council.[27] This representation enables the field directorate to stay informed about all the local developments and challenges that the schools are facing within each cluster under the directorate. In turn, the directorate reviews the School Improvement Plans and sets priorities and plans based on the common needs, which in turn are based on the actual realities faced by all schools in the directorate. Thus the field directorate has to ensure that schools in Ira

and Yarqa have updated SIPs and are communicating their progress.

In addition to the LEC acting as an intermediary entity between the schools and field directorate, school advisers (formally known as inspectors) have been able to provide schools with guidance and support on issues related to curriculum, instructional matters, and school resources. The school advisers are, to the extent possible, members of the local community or neighboring communities, and so they are familiar with the context and social structures in which these schools must operate. School advisers also have, at some point in their careers, been principals and have faced many of the same difficulties current principals have to address. In the villages of Ira and Yarqa, the community, which welcomes the advisers, has placed great confidence in the advisers' abilities to solve problems related to student behavioral issues and to matters of teacher shortages. The close cooperation among school, adviser, and community has resulted in some instances in advisers circumventing the long route through the Ministry of Education in favor of finding local solutions to educational challenges. For example, the shortage of a biology teacher in one school was remedied by sharing a biology teacher from a neighboring school. This solution was organized by the adviser, who, with the schools, recognized that the process followed by the Ministry of Education to appoint a teacher was too slow to solve the shortage.

The pursuit of change

Acquiring and retaining good teachers are a central preoccupation of both parents and principals in Ira and Yarqa, and across Jordan. One key challenge arising from the structure of the labor market is the availability of high-quality male teachers. Whereas teaching is a relatively desirable family-friendly, high-status profession for women, thereby attracting a steady stream of the brightest graduates,[28] teaching is a path taken by men only when other more prestigious, more lucrative options are not available. In an education system that is segregated by gender after the fourth grade, the net result is that boys often receive instruction from less talented and less committed male teachers, creating a negatively reinforcing cycle in which the educational experience of boys only further diminishes the likelihood that the best of them will later seek a career as a teacher. Even if young men were to start their career as teachers, they probably would not remain in that profession should other employment opportunities come along.

Moreover, because of the familiar discipline issues associated with managing all-male classrooms, the pedagogical styles in boys' schools tend to be autocratic (even quasi-militaristic), in stark contrast to the more interactive, engaging teaching styles characterizing most girls' schools, with their more extensive exchange of knowledge, more critical thinking, and more advanced teaching methods. Historically, most trainee teachers in Jordan have been given no opportunity to gain practical experience in classroom management, and once placed in a school they receive little in the way of in-service training by the Ministry of Education to upgrade and refine their skills. This is now steadily changing, but it has yet to be incorporated into standard professional practice.

School and community problem solving

Parents, teachers, and students are aware of these challenges and make no attempts to hide or deny the effects they have on the teaching and learning process. But the members of the community and schools in Ira and Yarqa together devised local solutions to these problems. Problem solving became a community activity in which everyone was given an opportunity to pitch in, make a suggestion, or lend his or her voice to the ongoing conversation. Schools resorted internally to their teachers for support and externally to parents, community members, and the school cluster. Community and school problems could range from how to utilize the school grounds to how to address a student's

learning disability or to identify the in-kind services a parent can provide.

By leveraging social and community relations, the schools in Ira and Yarqa solved local problems through transparent procedures that were accepted locally. Some of the outcomes of the collective decision-making process included parents volunteering to read stories to students (a parent fluent in written Arabic read to first- and second-grade students, another provided a similar service in English); pairing high-performing students with low-performing ones; planting a citrus garden on the school grounds and giving the harvested fruits to students as a snack; and printing textbooks in a larger font size for students with visual disabilities.

Empowering teachers to focus on student learning outcomes

"The role of the teacher has changed," explained Um Sumaya, a teacher at a girls' school. The surrounding group of peers from her school nodded in agreement with her statement. "In the beginning I used to just write on the board all class while students copied the work. Now I just lecture for five minutes and let the students participate in practical learning activities." The consensus among the teachers demonstrated the change not only in the style of cooperation between the school and community, but also in the internal processes of a school from the development of a SIP to the pedagogical styles used in the classroom.

Um Sumaya and her peers readily admitted that although their teaching practices were changing, there was still room for improvement. In fact, they would eagerly accept any opportunity for further professional development. As one teacher said, "When we started implementing the SDDP, our school created a plan based on outcomes of the surveys of the teachers, parents, and students. From the survey we saw that teacher training is a priority. So we sent a letter to the directorate of education informing them of this need. And from there we received training opportunities." Although those opportunities are appreciated, further efforts toward comprehensive teacher development are needed. Teachers and supervisors agree that even though they do get a degree of support from their field directorate, more can be done to improve teaching and learning practices. To address deficiencies, teachers have been working together within the school cluster to address their needs. "If a new teacher is appointed, as teachers we give our time and tell him or her to sit in on our classes so that they can learn," explained one teacher.

The shift to focusing additional resources on teachers continues to evolve. Teachers and principals in Ira and Yarqa clearly understand that quality education is established through quality teaching, but there is still a desire to demonstrate quality through material resources at the school. Initially, cooperation through community engagement and the LEC were centered on bridging the shortages in materials by securing in-kind and financial donations for materials such as smart boards, white boards, and computers. This is not unlike many other communities and regions in Jordan and elsewhere that equate quality with physical and material resources—after all, without basic infrastructure, quality education cannot be delivered. However, research and practice have demonstrated that the greatest determinant of improved education services is the relationship between teacher and student (photo 3.3). Thus investing in teacher training and quality is an important step toward providing better education services.

Because of the persistent constraints in investing in teacher quality, it is not surprising that some parents hire tutors to work with their children after school hours, and that teachers themselves often become these tutors as a way of supplementing their modest incomes. However, this practice creates a negative cycle in which the basic incentives for teachers (and students) to do their job in class time are reduced, with the children from families least able to afford tutoring fees suffering the most.[29]

PHOTO 3.3 Young Jordanian practicing her arithmetic at an elementary school

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Responding to large- and medium-scale interruptions in service delivery

Perhaps the most well-known example of intercommunity cooperation was the response to a fire at the Yarqa Secondary School for Boys that had rendered the school unsafe. Several classrooms were severely damaged, and the school's archives were destroyed.[30] The school happened to be quite near Zeid Bin Haritha. Principal Hatim described his school's response: "In the summer, the PTA held an urgent meeting, and we brainstormed on how to help in this situation so that the school could be operational by the start of the academic year. We raised funds, and the PTA cooperated with families and the student council to restore the neighboring school." Cooperation even extended to sharing teachers because the damaged school had a shortage of teachers; temporarily accepting some students to lighten the burden; and restoring the damaged archives. "The documents in the school were totally burned; we had to bring specialists in to recover some of those documents. We even sent teachers from our school to help in that effort. The two schools kept cooperating together throughout the process, along with the other schools in the cluster." Because of this support, the damaged school was indeed able to open on time.

Other (less dramatic) examples of community cooperation include parents offering to fix a water tank, plant a garden, construct a fence, and donate a stove and ladder, and the provision of workshops and lectures on civil defense, technology, medicine, and teaching in collaboration among the local community, schools, and local universities. "The Ministry of Education is too slow," said a teacher. "We know we can't depend on them for all our problems. Now we know when we need support we turn to the cluster and we ask students' parents and other community members for help. Together we are able to get the resources we need." Perceptions such as these and the poor or failed responses from the Ministry of Education have pushed schools and community members closer together because they recognize that efforts to involve the ministry in every interruption of

education services are not effective, even though at times it is necessary.

Enduring challenges

These encouraging examples of community cooperation demonstrate the ways in which collective action can be harnessed in pursuit of the common good.[31] As many observers have noted, however, close communities also have a downside in that they can exert undue influence over decisions that, with broader input, might have yielded superior outcomes. In addition, powerful community leaders can sometimes feel threatened by external initiatives that they perceive as a potential (or actual) challenge to their authority and status. But even the most functional of communities can only do so much; without adequate public resources the quality of school buildings and resources will inevitably decline. The schools we visited showed visible signs of aging, and classrooms were very small for the number of students they were expected to hold. School facilities were also lacking—for example, the bathrooms had to be changed to accommodate students. The old teachers' bathroom was destroyed, and a larger shared student-teacher bathroom was created. However, the bathroom is far from the main school structure, making it hard to monitor what happens there.

It is unreasonable to expect positive community relations, as important as they are, to plug resource gaps of this magnitude. (In this sense, all our case studies are instances of optimizing within otherwise suboptimal structural circumstances.) A lack of proper facilities such as a sports center can create problems, especially for boys who feel constrained because they have no space to express themselves and expend youthful energy. Following the fire, the disconnect with the Ministry of Education in terms of financial support was partially filled by the local community, who care deeply about their students attending the school—indeed, they fixed the fire-damaged school by themselves in two months. But such "social solutions" cannot be the basis on which such problems are regularly addressed. The Ministry of Education's statements that it had no financial resources to spare and asking that students be transferred to the neighboring schools suggest that much remains to be done to enhance the resources of the ministry as well as strengthen its own relationships with the communities it serves.

Another challenge is to ensure that stakeholders are aware of their level of agency and their ability to engage with leadership teams. The more educated and economically better positioned parents in Ira and Yarqa were giving their feedback and engaging with the schools, but this relationship was not as apparent for illiterate community members or those with lower incomes. The general consensus among the local Education Council and PTA was that these community members were represented by either their children (students at the schools) or by acknowledgment of their hardships. However, this could not be determined.

A final enduring challenge, at least from an assessment point of view, is discerning when and how the "words" of stakeholders about local education reform (deftly using familiar development phrases) and their "actions" (incorporating new behaviors into everyday practice) actually begin to align. For example, although the PTA recognizes that there should be greater involvement between the school and community and that it represents a difference in the past relationship, the tone and terms of discussion still seem to fall along the same lines: how to fix low scores and address behavioral problems. PTA members can be very good about voicing their concerns in "development-speak" and calling for the school and community to "work hand in hand." In practice, however, when it comes to establishing the structured means for ongoing contact, there is clearly room for improvement. Because the SDDP is still something relatively new to the villages of Ira and Yarqa, stakeholders refer to the changes they have experienced as processes that happened within that project. Internalization of actions is still forming, presenting the risk that should the project end, community

engagement might end as well. And yet there is also reason to be optimistic that further improvements can build on what has been attained thus far.

Reflections and implications

The villages of Ira and Yarqa have successfully used an external program to mobilize social relations, which are a defining feature of everyday life in Jordan. Communities are structured around close family ties and singular tribal affiliations (a key basis of identity, informal authority, and dispute resolution), which means there was already a social platform on which to build. Discerning ways in which to harness the many positive aspects of these relationships—and, where necessary, to curb their undue influence—became the central task of school principals seeking to implement the SDDP in ways beneficial to students, teachers, parents, and the wider community. National education reforms are successful to the extent they are coherently and legitimately mapped onto prevailing local norms and governance mechanisms and, when necessary, incrementally curb the undue influence of powerful local elites. Realizing these types of reforms is a collective social task that, like any such task anywhere, requires persistence, learning, and a tolerance for occasional setbacks. Building the capability for such tasks and ensuring the legitimacy of the reform process itself entail ensuring that the details informing such strategies primarily emanate from citizens themselves (as opposed to external development "experts"').

Although commitment to the LEC seems high in Ira and Yarqa, as well as awareness and appreciation of the possibilities for collaboration it offers, there is some room for improvement in formalizing avenues such as PTAs and translating everyone's willingness to work hand in hand into actual actions that guarantee participatory approaches in reaching decisions. A more structured system of offering incentives and support (professional development, rewards), whether for teachers, students, or principals, is needed to enhance the learning environment and ensure that accountability works. Moreover, the LEC was established as part of compliance with program guidelines, and formal regulations for its mandate were only recently passed.

Meanwhile, community engagement and accountability relationships may be improving in "successful" cases such as Ira and Yarqa, but other communities have not been as responsive to the program. Fourteen out of 42 field directorates do not have an Education Council thus far, but implementation is slowly moving forward, and so there is much for everyone to learn from successful cases as the rollout of the program continues.

Case study 3: Health care services in Jordan

The quality of health care in Jordan is notably uneven. On the one hand, Jordan has a reputation in the MENA region for high-quality specialty care, prompting some 200,000 patients to travel to Jordan from other countries each year seeking treatment. On the other hand, anecdotes point to the lower quality of primary health care (PHC), leaving many Jordanians—particularly the poor, the vulnerable, and those living in rural areas—without access to high-quality essential health services. The problem facing Jordan is not a dearth of knowledge or limited public spending on health care, but rather inefficiency coupled with inequity in financing and the provision of services to meet citizens' needs. This said, the availability of quality services depends not only on providing material and human resources, but also on establishing good governance procedures and practices to use these resources effectively. Thus governments, development partners, and scholars have increasingly emphasized the role that voice and participation, transparency, accountability, monitoring and enforcement, and rules and regulations play in determining good governance with downstream impacts on the quality of service delivery. Collectively, these facets of governance interact to shape how efficient, effective, and responsive the health system is to citizens' needs (photo 3.4).

PHOTO 3.4 Sign greeting patients at a health center in Jordan: "Welcome to our center. We promise to present you with the highest quality of health services."

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Six clinics in four governorates

To identify governance factors that may affect the quality of service delivery in public primary health care clinics (PHCCs) and comprehensive health care clinics (CHCCs) in Jordan, we visited six clinics in 4 of Jordan's 12 governorates ('Amman, Al Balqa', Jarash, and 'Ajlun). The clinics were selected in collaboration with the Ministry of Health and from referrals by the Health Care Accreditation Council (HCAC) based on the clinics' notable improvements in the quality of their services over the preceding three to five years and based on their positive performances compared with clinics in the surrounding areas and in regions with similar socioeconomic profiles.

During the site visits, open-ended qualitative interviews were conducted with chief medical officers, medical and administrative staff, patients, and members of local health committees. Questions focused on the quality of services delivered, management and administrative systems, and governance procedures and relations. Visual inspection of the facilities and administrative records was also conducted to assess the condition of the existing infrastructure and equipment, the availability and control of pharmaceutical stocks, and the management of patient health records and other health and administrative information.

The results of this exploratory study are not readily generalizable to all PHCCs and CHCCs in Jordan, but they point to structural constraints that limit the ability of health facilities to provide equitable access to high-quality essential services. At the central level, the Ministry of Health plays an important and dominant role in supporting PHCCs and CHCCs, but the current system lacks incentives to promote sufficient staffing, particularly of female doctors and staff in less desirable posts such as in rural and remote areas. In addition, although the system of using PHCCs as an entry point for doctors trained abroad helps provide PHCCs with a steady stream of newly minted doctors, most leave the clinics after a short period to return to specialized medical training. Indeed, the majority of doctors employed in the clinics visited had taken their degrees outside of Jordan and had been employed in their clinic for a very short period. Resource limitations thus create a system dominated by less-experienced staff and foster a high turnover, which in turn hinders communication and the formation of trust between communities and health clinic staff, as well as among staff within facilities and with the Ministry of Health.

Other important structural constraints that result in inefficiencies and preclude more proactive clinic management and effective service provision are mainly related to the lack of transparency and systematic monitoring. Both Ministry of Health and clinic staff suggested a lack of transparency in staff placement, promotion, and training opportunities and in budget processes. The lack of transparency prompts communities to make

extensive requests, and it undermines facilities' resourcefulness and their abilities to set and achieve long-term goals, ultimately forgoing midrange changes that could improve facilities, programs, and staff quality. This situation hinders planning, and particularly the ability of facilities to make informed choices that increase the quality and efficiency of health care services. Furthermore, inadequate resources for effective monitoring appear to compound the problem because facility-level issues often go undetected. This, coupled with the fact that facilities have little or no control over their own budget and its execution, limits the ability of clinics to improve overall service quality based on perceived community needs.

Despite these constraints, the site visits uncovered drivers that appear to promote good service delivery. These drivers are related to facility management and quality assurance. They are also related to the relationships between facilities and their communities, as well as the social institutions and ties that shape positive engagement between the community and providers, among facility staff, and between the facility and community and the broader regional and national levels. These drivers are discussed in the sections that follow.

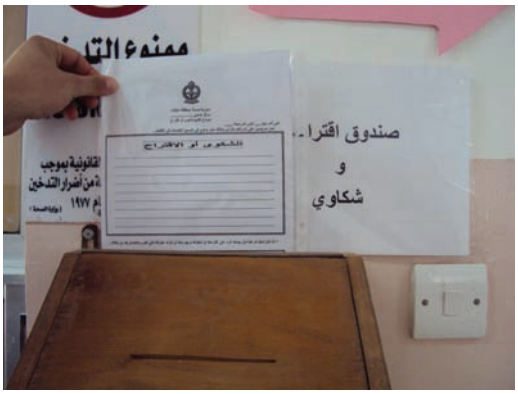
Facility management and quality assurance

Effective administrative procedures can improve the quality of service delivery through more transparency and greater voice and participation. Based on the findings from this case study, an accreditation process provides one mechanism for improving facility administration and the attendant quality of health care. The Jordanian accreditation process, which is administered by the HCAC,[32] sets rigorous standards to be met every three years. The procedures and requirements help establish clear rules and regulations, increase transparency for clients and staff, develop more effective staff monitoring, and give the staff in facilities as well as communities a greater voice and higher level of participation.

Formalized decision-making and management procedures foster better health care. The accreditation process requires establishing and adhering to clear administrative and clinical procedures, including patient file systems, personnel files, committees for clinic management, and guidelines for access to pharmacy stocks. Such procedures set clear expectations and facilitate information sharing and problem solving between patients and staff and among staff. Moreover, as a staff member in one of the PHCCs visited (Al Mastaba) explained, such guidelines, along with engagement in the accreditation process, help to establish a "culture of quality" and encourage staff to do their best.

Efforts to improve transparency were clearly visible in many of the clinics visited. Prices and patients' rights were visibly posted in every clinic, and in some, such as the Sakhra CHCC, the results of patient surveys as well as responses to patient suggestions and complaints were prominently displayed on a bulletin board. Such transparency creates and reinforces a culture of respectful patient-centered care. Practices instigated by the accreditation process also created and formalized opportunities for patients' and staff members' voices to be heard. Posting of hotline numbers for patient complaints, the provision of suggestion boxes (photo 3.5), and periodic patient surveys were practices

PHOTO 3.5 Suggestion and complaint box at a health care center in Jordan



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instigated by the accreditation process. Accreditation standards also support voice and participation among staff members through regularly held staff meetings and committee participation to address issues such as infection control, quality improvement, patient safety, and security.

Local health committees provide a venue for aggregating and expressing community needs and preferences and mobilizing resources to address them. The terms of reference established by the Ministry of Health for local health committees, combined with the role of the coordinator, provide an organized approach to assessing and communicating community needs. An annual survey of committee members determines priorities for action, and motivated committee members, chosen from key community leaders, leverage their talents and networks to mobilize resources to address community health concerns. The health committees act primarily as a "board of directors," helping to identify key issues and mobilize their resources and networks to enhance outreach and implementation. For example, a community health screening organized by the Zay CHCC health committee uncovered previously unrecognized high levels of diabetes (32 percent) and hypertension (25 percent), thereby facilitating patients' turn to the clinic for chronic care.

Although the nature of blood ties and other informal networks were unchanged before and after the establishment of the committees, interviewees in clinics and on the health committees agreed that the formalization of the process generated through the accreditation process made the health committees more effective. Factors contributing to this included members' pride in being given a formally recognized role, enhanced financial and administrative support, requirements regarding regular meetings and established procedures (such as voting for priority public health issues that the health council would address in the community), and requirements for broad participation.

Leadership enhances the impact of administrative reforms associated with the accreditation process. Strong, proactive leaders can multiply the positive outcomes of these reforms. The chief medical officer (CMO) of the Sakhra CHCC recognized the value of procedures and extended them beyond the minimum requirements. For example, as part of personnel management, the CMO established a training manual for new staff members, reviewed it with them, and required them to sign a paper agreeing to its conditions. In addition, the CMO searched for and distributed standard procedures on diseases beyond Jordanian guidelines and worked with the health committee to establish a Facebook page where clinic activities and discussion of clinic performance would be posted online. However, administrative reforms are less effective under weak leaders. For example, a CMO in one clinic noted that staff meetings were not held because people worked on different days and the assumption was that "everyone knows their job."

Social ties

Social networks play an important role in facilitating voice and participation, and potentially in improving the extent and quality of services. Personal ties, whether among family or friends and neighbors, are particularly valuable for establishing priorities, extending public health outreach in the community, and mobilizing resources to support clinic activities and development. Interviews with the staff and members of local committees at the health care facilities visited indicated that shared identity, especially a common tribal affiliation, was particularly valuable in rural areas but somewhat less relevant in urban centers, where people from diverse regions and backgrounds intermingle and many residents do not come from the major Trans-Jordanian tribal families. Indeed, when members of the local health committees in rural facilities and local residents hail from the same tribes, the staff and governing board of a facility have a built-in channel through which to reach the community with vaccination and other health campaigns and to encourage greater compliance with medical instructions. For example,

in the Zay CHCC, located in a village near Al Salt, members of the health committee felt that their personal and professional connections helped to mobilize the community to participate in health care campaigns such as screening for noncommunicable diseases and family planning initiatives.

Among the key factors driving the perceived increased participation in these events were shared blood ties; committee members claimed that their center's health initiatives were relatively successful because the members came from the same families as the targeted beneficiaries. In their estimation, this enhanced their positive contributions to the work of the local health committee. Similarly, at the Sakhra CHCC in 'Ajlun governorate, staff members noted that local tribal relations facilitated their work in the community. The Al-Moumani family, a prominent Trans-Jordanian family, is the dominant group in the village, cementing its presence in the community through high rates of intermarriage. Of the 24 members of the center's local health committee, 17 hailed from this tribe. These family ties enable the staff and committee members to reach local residents relatively easily and to encourage them to visit the center and to comply with medical advice.

Beyond family ties, social networks and linkages to important local social institutions help health workers to accomplish their tasks. Mosque and religious leaders play an important role in both urban and rural areas, particularly for issues that can be understood within religious teachings such as contraceptives, vaccinations, drugs, and smoking. Directors of youth centers, school principals and teachers, and other established community members were cited as lending similar weight to initiatives. Staff members emphasized that the support of the local religious authorities was vital for their health campaigns. For example, the cooperation of the local mosque and the inclusion of the imam on the health committee helped to boost the success of family planning initiatives among local residents in Sakhra. Before the establishment of this working relationship with local religious institutions, women were reluctant to undergo exams. Ties with other local actors such as school officials also facilitate the work of health centers. At the Alyazedyah Health Center in Al Balqa' governorate, the school principal offered to ask students to help the staff with refurbishment of the center. The head of the local health center gratefully accepted, and a group of students painted and cleaned the facility.

Strong social ties may facilitate health care improvements in some instances, but the tight-knit nature of the community can also complicate the work of the health center. For example, it may make sensitive issues such as domestic violence more difficult to address. Indeed, one clinician explained that domestic violence was not "seen" in the clinic, noting that because everyone in the village is related, no one would talk and the providers thus do not ask. Where strong social ties are driven by blood ties and where they promote intermarriage and consanguinity, they can also increase health risks.

Conclusions

The Jordanian health system stands out within the MENA region for its relatively comprehensive coverage of the population in basic health services. Furthermore, some of the staff members at the facilities visited had distinguished themselves by their dedication and commitment to their work, which clearly has tangible effects on the quality of care delivered. The comparative success of the health system in Jordan appears to continue even now in the face of the serious strains imposed on the system by the Syrian refugee crisis.

However, the challenges to sustaining the gains are numerous. For one thing, although administrative reforms and the accreditation process can generate multidimensional improvements in the quality of care, only a small percentage of health centers in the public health system have been accredited, and many are not even eligible because of deficiencies in their infrastructure. Furthermore, the future of the HCAC is uncertain because the U.S. Agency for International Development

(USAID) program that funded its activities and fully subsidized the accreditation process for participating public facilities ended in 2013. Unless the facilities seeking accreditation are willing and able to share the financial burden of the process, sustainability of the HCAC is uncertain. Moreover, the administrative reforms at the facility level can result in significant improvements, but until upstream problems are solved, thereby reducing the high turnover, inexperienced staff, number of weak budgets, and other problems, the improvements in health care will be limited. Similarly, although social institutions can facilitate better health outcomes, these are facilitators of, not replacements for, effective governance.

There is much to be learned in order to develop governance mechanisms that facilitate quality service delivery. The evidence linking governance to service delivery quality is still sparse and focused on clinic operations and not on health outcomes. It is essential to identify the key governance levers that will improve quality throughout the system, especially among facilities that are unaccredited and unlikely to undergo accreditation in the near future, which currently is the vast majority of facilities. It is also essential to explore the linkages between blood ties (especially tribal diversity), social institutions more broadly, and the delivery of social services. These need to be more systematically examined through rigorous research based on comparisons of subnational units. To the extent that political and social institutions are associated with improvements in services delivery, it is important to explore why and how they are linked in order to identify areas in which reform is more likely to be effective.

Case study 4: Health care services in Morocco

Located in one of the poorest provinces in Morocco, the public health center we visited on a hot morning in May was packed with patients. The day of our visit was reserved for patients suffering from chronic diseases such as diabetes and hypertension, which have high prevalence rates in the area and throughout the country. Thus an especially high volume of patients were waiting to be seen by the one of the center's two full-time doctors. On average, about 90 patients visit the center each day, almost all of whom come in the morning. The center's catchment area is home to more than 18,500 people. The center has an attractive garden, which was created and is tended to by the center's employees, and a ramp from the parking lot to the entrance of the center provides handicapped patients with access. This health center is one of the more than 2,600 public primary health care centers that mainly serve the urban and rural poor in Morocco.[33]

Over the last decade, the Moroccan government has made a concerted effort to improve public health as part of a larger strategy to boost human development and reduce poverty. Despite decreases in mortality rates during earlier decades, Morocco's maternal, child, and infant mortality rates—especially in rural areas—are among the highest in the MENA region. According to the national statistics, in 2011 about 10 percent of Morocco's 13.4 million rural residents and 3.5 percent of its urban residents fell below the national poverty rate. Meanwhile, several important institutional reforms were adopted during the 2000s. In particular, the government focused on expanding health care coverage through the development of medical insurance schemes. In 2002 the government enacted a law that precipitated the creation of two insurance programs: a compulsory public health insurance system (Assurance Maladie Obligatoire or AMO), which covers public sector and formal private sector employees, and a medical assistance scheme targeting the poor (Regime d'Assistance Maladie aux Economiquement Démunis or RAMED), which was extended across the country in 2012.

The government bodies closest to primary health centers, the provincial delegations, manage the budgets of the primary care facilities, which have on average about 15,000 people in their catchment areas. Each of the

83 delegations has a head doctor, who is in charge of ambulatory care at the provincial level, or a medecin chef du SIAAP (Service d'Infrastructures d'Action Ambulatoires Provincial), who oversees all of the primary care facilities in a province. In 2011, as part of the national administrative decentralization process, 16 regional directorates were established. These directorates work closely with the provincial delegations to manage local health priorities and issues in their respective regions.

In 2007 the Ministry of Health launched the first round of the Concours Qualité (CQ) to improve the quality care at public hospitals and primary care facilities.[34] The CQ consists of competitions between health facilities to achieve the highest level of care within their respective provinces. The process entails a self-assessment in which staff at participating centers complete standardized questionnaires that measure a range of quality indicators, as well as an audit by peers. Based on the logic that competition and recognition of good work motivate people to seek improvement, the CQ is designed to encourage the participating facilities to upgrade care. The heads of provincial delegations select centers to participate based on the motivation of the team, their openness to change and willingness to adopt new procedures, and their prospects for winning.

PHOTO 3.6 A well-managed and well-stocked pharmacy in one of Morocco's primary health care centers

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In return for enrolling in the CQ, employees have greater access to supplemental training programs, and centers may become eligible to receive new equipment or even to receive funds for renovation. The CQ and other reforms in the health system have made important advances in improving access to and the quality of primary health care in Morocco.

The track record of the CQ and a spate of research in health policy and management suggest that governance at multiple levels—at the facility itself as well as at all administrative levels—has an important effect on the quality of health care. To explore these linkages, we visited six different public health centers outside of major urban areas of Morocco. About half of the selected facilities had participated in the CQ at least once. Because of the limited size of the sample and the fact that it does not represent the full range of variation in health centers in the country, it is impossible to make generalizations based on our findings. Nevertheless, our visits yielded some compelling observations that deserve further investigation using more systematic research methods.

Our visits to urban and semiurban primary care centers revealed substantial variation in the quality of care, even in this limited sample. A consistent array of factors were observed at facilities that performed well, including larger patient loads, reasonable wait times despite high demand, good management and good availability of stocks, consumables, and equipment (photo 3.6), and detailed and regular maintenance of patient medical records. For example, at a center in a small provincial town we noted that the vaccines and other medications were stored properly and carefully, the pharmacy was well managed and stocked, and all personnel were following the proper protocols for disposal of medical waste. Medical staff members kept consistent medical records and followed clear procedures for storing and restocking medications and consumables and maintaining careful records on the upkeep, repair, and replacement of equipment. Staff members claimed that the adoption of these

procedures was leading to shorter wait times and improving the monitoring of patients' health status. The center's management had also devised clever ways to ensure that patients formed lines when waiting for services to avoid crowding. For example, through a small window near the exit of the facility, the pharmacy staff dispensed the medications prescribed to patients. To access the window, patients had to pass through a corridor created by a half-wall designed to accommodate one wheelchair and no more than one person at a time. The center is in the process of constructing a similar structure so that patients line up single file outside the facility while waiting to enter during the morning rush. At a center in another provincial city, a nurse stationed at the entrance greets patients and issues them colored tickets that correspond with color-coded signs indicating the different departments in the facility. The system ensures that illiterate patients know where to go even if they cannot read the signs posted in the center.

Interviews with doctors and other medical staff as well as observations during the site visits suggested that at least five factors are associated with improvements in the quality of health care at Moroccan PHCCs: (1) leadership; (2) team spirit and a shared mission; (3) participation in the Concours Qualité; (4) effective coordination with local and regional officials from the Ministry of Health; and (5) partnerships and community relations. These factors are described in the sections that follow.

Leadership

The presence of dynamic, energetic, and visionary leadership at multiple levels is a sine qua non for the establishment of well-managed, high-performing PHCCs. Effective leaders can motivate staff members to carry out their duties competently and thoroughly, introduce new procedures and management systems, institute a "culture of quality" among staff members, inspire confidence in the community and local government officials, and attract additional resources for the facility. This is especially important in the context of tight budget constraints and the consequent chronic understaffing of facilities. The head doctors at the high-performing centers we visited spoke with evident pride of their accomplishments and placed great value on their roles as stewards of the quality improvement process.

Ultimately, a successful facility requires far more than strong leadership, particularly to maintain its good practices over time. The innovations and procedures introduced by visionary and energetic leaders must be institutionalized and routinized so they can outlive the tenure of a single person. Furthermore, in rural areas it is all the more challenging to attract competent physicians with good leadership skills. In a facility in a semirural area, the head doctor was often not present at the facility, in part because chronic understaffing obliged him to rotate among several different centers in the province.

Team spirit and shared mission

A sense of a shared mission and a collaborative ethic help to motivate staff and ensure that they all know and fulfill their responsibilities. These principles may even encourage personnel to propose ways to improve the delivery of services. Like leadership, team spirit and a relatively flat organizational culture are especially important in the context of resource scarcity in which staff members are required to make do with less. As the delegate from the Ministry of Health in one province noted, "It is vital to have a team ethic. If a center has problems in interpersonal relations, then it does not work. . . . Motivation among the personnel is vital, especially given the lack of human resources in the health sector." Doctors at high-performing centers have internalized the importance of team spirit. The head doctor of a busy health center in a provincial city emphasized that a strong ethic of teamwork and will (*volonté*) is shared by all the staff.

To promote a team-based approach and to facilitate the effective functioning of the center, the head doctors of health centers

convene monthly staff meetings. At these and other supplemental meetings, the employees discuss the problems they encounter while carrying out their jobs and report on their activities. Some facilities also hold monthly training workshops for the staff. For example, in one center a nurse showed us a document describing a recent training workshop on quality improvement that was conducted by the head doctor of the provincial SIAAP. An earlier training workshop in this center focused on increasing and reinforcing transparency and good record keeping (*tracabilité*) in the facility. In a semirural facility, the head doctor discussed the lack of sense of teamwork in the center and the importance of overcoming obstacles to better interpersonal relations among the staff members.

Participation in the Concours Qualité

Meetings with staff members from facilities that had and had not competed in the national CQ revealed that the program clearly has a positive effect on the management and administration of the participating PHCCs. The mere act of enrolling in the program generates a significant transfer of knowledge and procedures to the managers of health centers. The head doctors and nurses of all participating PHCCs unanimously agreed that systematic procedures for maintaining medical records, monitoring stocks of medications, consumables, and equipment, and tracking vaccinations and other health campaigns in the community were developed in preparation for the CQ competition and maintained thereafter. As a result, participating centers instituted better systems of record keeping, managing stocks and equipment, and disposal of medical waste. Staff members also agreed that these changes resulted in better tracking of patient health status and shorter wait times. The senior staff members of facilities participating in the program now subscribe to a set of management principles based on teamwork, openness to innovation, and ongoing quality improvement, and are more open to pursuing partnerships to improve access to medical care in their communities.

When asked what changed in her health center after participation in the CQ, the head doctor of a center in a semiurban area claimed that wait times plunged, regular staff meetings were institutionalized, more management and administrative protocols were introduced, posters informing patients of the center's policies and providing important health information were displayed around the facility, and sanitary procedures were greatly enhanced, potentially reducing infection rates. The head doctor at another semiurban center noted that participation in the CQ greatly improved relations among staff members, who now share team spirit. The competition inherent in the CQ process also encouraged her staff members to adopt and adhere to many administrative changes. In particular, she noted that the stocking and storage procedures for medications improved substantially after participating in the CQ. At another health center in a provincial town, the head doctor said that since her center enrolled in the CQ it has been far more structured and organized and staff members feel more valued. She noted that staff members already possessed dynamism and will, but they subsequently learned about specific procedures and systems that would improve the operation of the center. "We wanted to work but didn't know how," said the head doctor.

These observations from centers that participated in the CQ contrast sharply with those by staff at facilities that did not enroll in the program. For example, in a semirural facility, staff reported that basic sanitary practices were deficient, and the examination rooms did not have separate medical waste containers. At another nonparticipating facility in a small provincial town, the medical staff could not report on the system for managing drug stocks, and they were bewildered when asked to report on the basic management and administrative procedures used in the facility.

The clearly positive impact of the CQ is testament to the value of the program. The greatest challenge for the program, however, is its sustainability. When asked whether she intends to enroll the facility in the upcoming

competition, a doctor at a high-performing center that had won a prize in a recent round of the program replied that she would not participate in future rounds because she could not commit the time to prepare for the competition while meeting the needs of a heavy patient load. In fact, she highlighted an irony of participation in the CQ: participating centers attract more and more patients, even from beyond their catchment areas, as news of their improved quality of care spreads. As a result, high-performing centers may face heavier strains on their material and human capital than other centers or heavier strains than they experienced prior to enrollment in the program. Furthermore, a lack of personnel may hamper the ability of some facilities to implement or maintain the systems they instituted after participation in the CQ, particularly in understaffed rural centers.

Effective coordination with local and regional officials from the ministry of health

For PHCCs, effective coordination between the head doctor and local health officials is critical to meeting the needs of the populations in their catchment areas. Regular exchanges between the administrators of facilities and officials from the provincial delegation helps to ensure that stock-outs of medications and equipment do not occur, that facilities receive resources when available, and that local solutions are developed for local problems. In addition, open channels of communication aid in the dissemination of good administrative and management practices, usually emanating from the local delegations and regional directorates down to the administrators of PHCCs. For example, a provincial health official noted, "When provincial delegates are close to the staff and work closely with them, they are more motivated." Furthermore, the outlooks of local officials affect the possibilities for innovation. In some provincial delegations, officials actively encourage partnerships with other local actors, granting more freedom to doctors to be entrepreneurial in establishing local partnerships.

Partnerships and community relations

Partnerships with nearby groups, organizations, and prominent individuals help PHCCs to meet the needs of their surrounding communities more effectively. Staff members described initiatives with local mosques, the women with religious educations who serve as religious guides (*murshidat*), the women who work in the local *hammams* (public baths), and the local civil society organizations working on the environment, women's issues, youth, and in other areas. Collaborative projects focus on a range of topics such as family planning, HIV/AIDS testing, breast cancer, and chronic diseases. Partnerships with these local actors help PHCCs to target populations with health awareness campaigns, motivate patients to follow medical protocols, and encourage openness in the community to health-promoting practices that might otherwise be viewed as violations of culturally conservative norms. For example, with the support of the *murshidat*, women in some communities began to use intrauterine devices at a higher rate and agreed to undergo HIV/AIDS testing.

Formal and informal partnerships with local groups are all the more important in the context of low resources. Health officials in one province emphasized that the lack of financial resources leads to chronic understaffing, in part because doctors who retire are not replaced. In this context, the delegation of the Ministry of Health in one province we visited is now trying to promote partnerships. For example, the head doctor at one facility negotiated lower prices for women at various private providers in the area. Zakat funds[35] were mobilized to support the medical needs of these women, offer home visits by doctors, and provide clothing for local children. The local delegation also approached local private institutions, asking them to sponsor material aid programs within hospitals in the province.

In one center in a provincial town, the resourcefulness of the staff coupled with strong community engagement led to tangible improvements in the facility. The center's benches, outdoor fencing, garden, and interior painting and décor were all obtained or carried out with the help of local formal and informal groups and community members. Local community-based groups also helped by advertising the center's vaccination campaigns.

Case studies to share ideas and inspire change

Many interesting and important findings emerge from these four case studies. At one level, these findings may not seem surprising. After all, good leadership, effective management systems, close engagement with the local community, mutual accountability mechanisms, high expectations, aligned incentives, and strong support from middle tiers of the civil service (that is, not just "policy makers" at the top and frontline staff at the bottom) all combine to enable teams to provide services that meet high professional standards and satisfy citizens' demands, often in the face of very difficult circumstances. The cases examined are veritable islands of success in seas that all too often cannot or will not deliver. As we discuss in more detail in later chapters, these cases reveal how cycles of performance that positively reinforce one another have been created and sustained at the local level.

The primary point of presenting such success stories, however, is not to elicit an itemized list of factors or practices that should be adopted elsewhere. It may be that some can indeed be replicated elsewhere, but at the level at which actual solutions need to be discerned, the combination of factors required is likely to be highly idiosyncratic—lots of devils lurk in lots of details. Above all, these cases demonstrate that in spite of deep and pervasive challenges confronting service delivery providers in the MENA region, someone somewhere has figured out how to make things work. There is always variation (see chapter 7), and a key basis for searching for locally legitimate solutions to these challenges is to map, explore, and explain this variation, to share the strategies and (especially) the ideas driving positive outcomes, and to encourage those elsewhere to do the same.

Such an approach alone, however, cannot bring about broader systemic reform, and it cannot compensate for the absence of the basic levels of financial, human, and material resources needed to make even a minimally effective system function. It must be part of, not a substitute for, institutional change. But this will take a long time, and waiting for such change to happen means consigning the present generation to a bleak future. Change has to begin somewhere, and one place to start is to recognize and reward those featured in the cases described here—that is, those who are already making it happen.

If there are transferable lessons, they lie in reiterating the important aspirations (no matter how attained) of structuring meaningful incentive schemes, diligently managing human resources, and fostering both motivated leadership and genuinely engaged staff. In order to realize these goals, however, domestic policy analysts can conduct analytic case studies along the lines provided here, identifying local instances of where, how, and by whom effective responses to these organizational bottlenecks in everyday services provision have been found and implemented.

Notes

1. The concept of (and methodology underpinning) positive deviance as a learning tool for frontline service delivery reform was formulated by Pascale, Sternin, and Sternin (2010). Methodologists might instinctively be concerned that such an approach commits the error of "selecting on the dependent variable"— that is, of failing to recognize that the same factors seemingly driving success may elsewhere have no (or even the opposite) effect. Ordinarily, this is a legitimate concern, but the positive deviance approach (1) presumes some prior professional knowledge of

the extent of the variation characterizing the outcome variable of interest (such as quality of education) and the main (or expected) factors responsible for it (such as wealth, teacher quality); (2) seeks to explore the forms and sources of variation within settings that are geographically proximate and demographically similar, thus "controlling" for broad factors that might otherwise be responsible for observed variation such as proximity to roads and public transport; and (3) makes only mild causal claims regarding the formal identification of factors shaping local outcome variation and instead strives to inspire those working elsewhere by showcasing specific instances of how local innovators have crafted effective solutions to difficult problems. The classic case is nutrition among the poor in the slums of Vietnam, where a positive deviance approach discovered wide variation in stunting among infants, but learned that some children living in exactly the same desperate circumstances were nonetheless doing relatively well because their mothers defied the prevailing community norms, opting to feed their infants small amounts several times a day (rather than larger amounts twice a day) and to supplement their diets where possible with nutrients. These simple but nonobvious differences were social innovations by the mothers themselves, and thus enjoyed considerable local legitimacy when shared with others. Importantly, such discoveries are complements to, not substitutes for, broader changes in health policy (and expansions in health policy infrastructure and resources) that might be required to bring about society-wide improvements in child nutrition.

2. Claussen, Kiernan, and Gramshaug (2013) also report that education accounted for 15.7 percent of the total public expenditure in 2012, at approximately US$680 per student per year. All dollar amounts are U.S. dollars unless otherwise indicated.
3. As we note shortly, however, strikes can cause teachers to miss many days of instruction over the course of a school year.
4. In 2000 youth unemployment was 4 percentage points over the already high rates of overall unemployment. By 2009 this gap had increased to 10 percentage points (World Bank 2011).
5. Field visits to Jenin were conducted March 23 and March 24, 2014. Semistructured interviews and focus group discussions were held with the director of Jenin's education directorate, math and science supervisors, the principal of Kufor Quod Girls' Secondary School, teachers, students, parents, and the local community. The case study was inspired in part by an earlier study carried out by the Assessment and Evaluation Department (AED) of the Ministry of Education and Higher Education (MOEHE), which compared high-performing schools with low-performing schools to uncover differences in school- and classroom-level factors influencing student learning.
6. The city of Jenin is an agricultural center for the surrounding towns. Because the city has no major industry, its citizens have shifted their attention to education as their only option to elevate their financial standing. This fact is indeed mirrored in the city's yearly performance in the state exams, Tawjihi. In 2013, 7 high schools from Jenin alone were among the 10 highest-performing schools across the West Bank and Gaza.
7. All schools in Jenin underwent this rigorous preparation, but Ms. Abla was particularly able to capitalize on it and use it to her advantage, as we explain shortly.
8. For example, students selected the dates for their exams and even the colors of the curtains in the classroom.
9. Supervisors were previously known as "inspectors," but the title was recently abolished in the spirit of this new concept.
10. This initiative is of particular importance because girls tend to choose the literary stream in order to later enter careers that conform to the traditional definition of what constitutes an acceptable profession for a girl.
11. On the broader importance of and challenges associated with forging such education systems in the 21st century, see Pritchett (2013).
12. The students' stated career aspirations included dentist, lawyer, aeronautical engineer, and teacher.
13. Interview with the chairman of the local Education Council, March 20, 2014. Even so, Jordan remains heavily dependent on donations from the Gulf countries and donors.
14. As assessed by international assessments such as the TIMSS and the Programme for International Student Assessment (PISA).
15. TIMSS, 2003, 2007, and 2011.

16. A preset questionnaire is developed for all four key areas and distributed to the stakeholders based on a random sample of the school's database.
17. The Education Council (EC) is composed of all school principals within the cluster, student representatives, community representatives, and the head of the EC, who is an elected community member. The EC approves the SIP and shares it with the Field Directorate. The directorate is responsible for monitoring progress and reporting to the Ministry of Education.
18. The integration of decision making and improved cooperation between school and community is one approach detailed in newly adopted Act 6/L of Ministry of Education Law Number 3 (1994) and its amendments.
19. The most recent SDDP assessment was conducted under the Monitoring and Evaluation Partnership (MEP) project and published in May 2013. MEP is a four-year (2010–15) project funded by the U.S. Agency for International Development and implemented by World Education with the aim of strengthening the technical capacity of the National Centre for Human Resources Development (NCHRD) and providing financial support for a series of program quality evaluations of Jordan's Education Reform for Knowledge Economy (ERfKE II) program.
20. "As a school principal all the authority and decision making power was with me," explained one principal. "Community members and parents didn't get involved in the planning process."
21. The chair of the local Education Council is elected by the community and receives training for the role through the SDDP project.
22. Most countries, of course, have both private and public schools, but even if some students are receiving education in private schools, that sector itself is still regulated (and in some cases actively funded) by the state.
23. The importance of the complementary relations between informal and formal systems has a long history in social science, but in recent years it has been articulated most prominently by Nobel Laureate Douglass North (1990).
24. The Friends of the School Council is composed of one influential member of every family who sends their child to the school at hand.
25. Students did seem to actually use the suggestion box, but even if they did so only infrequently, the box's very existence conveyed an important symbolic signal that student input to decision making was desirable and useful.
26. Completing a questionnaire obviously requires literacy, and it seems the database of parents only included those who were literate, leaving it unclear (to us) how the views of illiterate parents were obtained.
27. The Educational Development Council at the directorate level consists of a president, a deputy, and three members: the head of the LEC within the school cluster, members of the field directorate development team, and a student team consisting of two members. Its main responsibilities include (1) participating in activities and competitions; (2) strengthening the mutual understanding of the community partnership by encouraging schools and others to share their experiences and success stories; and (3) discussing challenges during implementation of the SIPs of school clusters.
28. As measured by student scores (specifically Tawjihi).
29. Certain reforms were recently implemented by the Ministry of Education in which teachers receive higher salaries for teaching students for longer hours to deter them from resorting to private tutors. Other parental perspectives on this were that (1) many teachers are simply not qualified or trained to teach properly (which forces parents to seek tutors); (2) teachers are not paid or given the incentives to teach well, and so they do not; and (3) the situation has perpetuated students' belief that they must take private classes to receive higher grades, regardless of how good the teacher is.
30. The perpetrators of the fire remain at large, although it is suspected that youths were responsible. That "no one knows" who committed the crime seems implausible in a small community, not least because certain aspects of how the fire was spread appear quite strategic, but for now we take it as given.
31. Technically, we cannot formally verify that these positive examples of school-community interaction would not have happened anyway (that is, we do not have a "counterfactual"). One could argue that local culture and Bedouin traditions dictate that one cares for one's neighbor and community, and thus that

these examples cannot be attributed to the reforms. Even so, we are not trying to make a causal empirical claim. Because of the region's reputation as a place where positive collective action is relatively rare, we are using these examples as illustrative evidence of what did take place within the auspices of a developed education council and of what positive collective action can achieve in the sphere of enhancing public education.

32. The Health Care Accreditation Council (HCAC) was established in 2007 as a private, not-for-profit organization that oversees and implements the accreditation of health care facilities in Jordan (see http://www.hcac.jo).
33. In 2010 Morocco had 2,689 primary health care centers (World Bank 2013, 7).
34. The sixth edition of the CQ was completed in 2014.
35. Zakat is form of obligatory alms giving paid by Muslims to other poor Muslims. It is one of the five pillars of Islam, and all practicing Muslims who have the financial means are expected to pay the alms.

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Data source

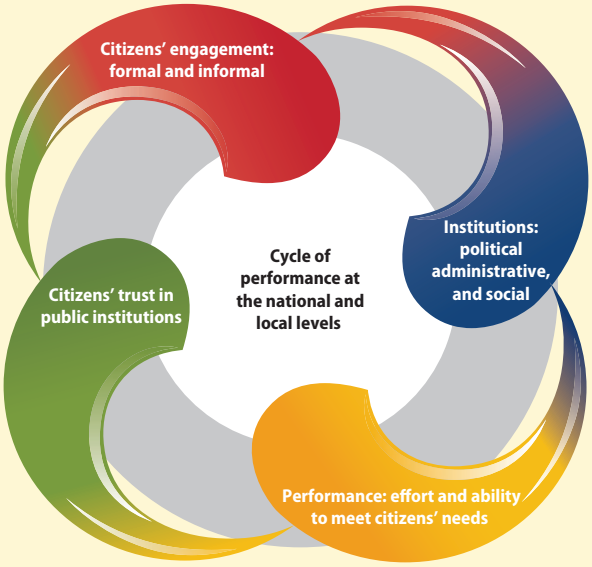
EdStats, World Bank, http://datatopics.worldbank.org/education/

The Historical and Institutional Drivers of Performance

PART II

Part I revealed that although local successes exist, the economies in the Middle East and North Africa (MENA) are not meeting their potential in providing their citizens with the education and health services they believe the state should deliver. Why does service delivery fall short of potential in the MENA region?

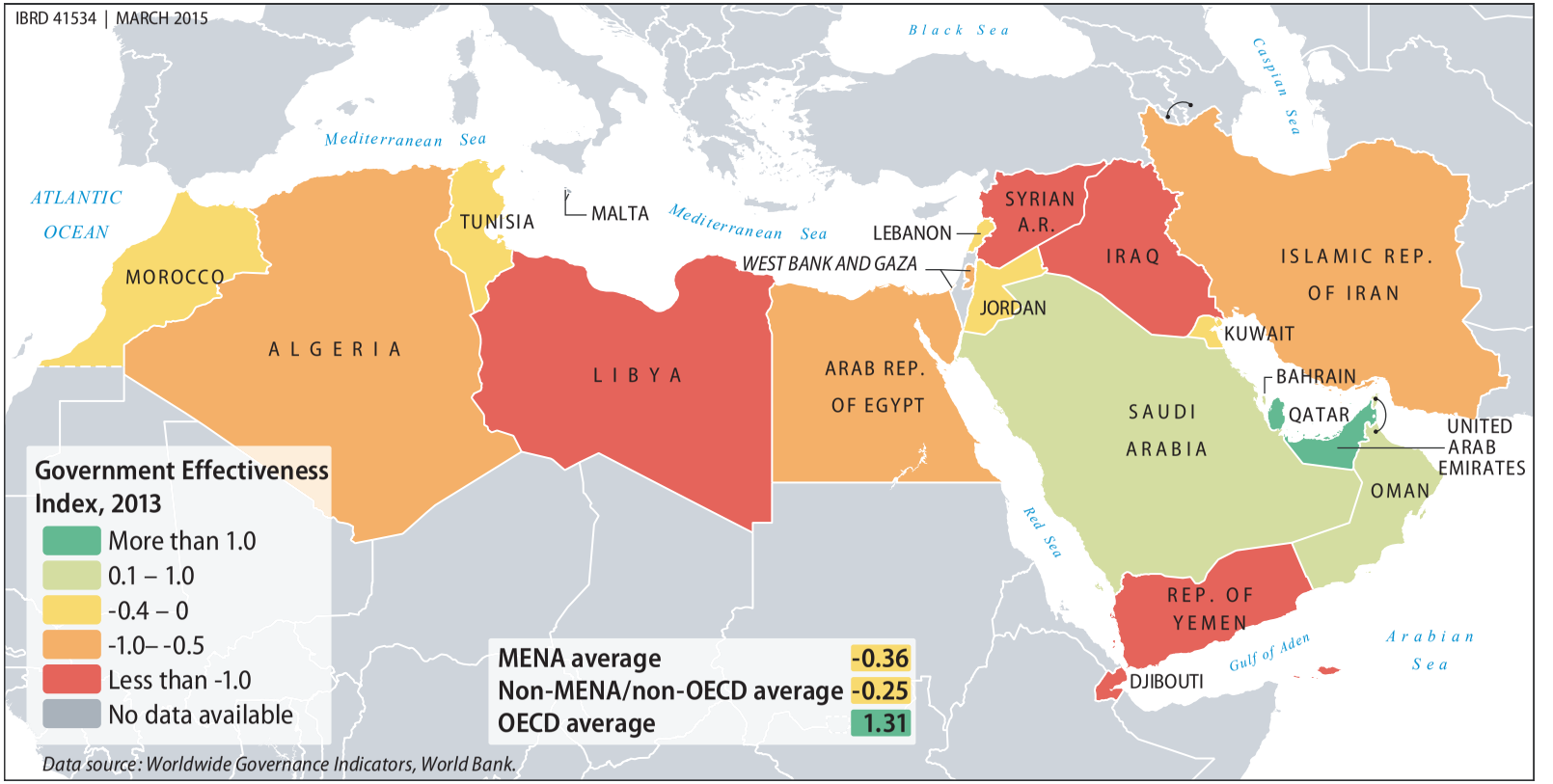
The answer to this question lies in the "cycle of poor performance" that has emerged in much of the region. State institutions lack both internal and external accountability, in part because of the shortage of information on performance that could guide centralized decisions and in part because of the lack of incentives toward establishing accountability mechanisms for performance in the delivery of public sector services. When institutions are weak, service delivery policies are not implemented successfully.



Low trust in institutions undermines bottom-up pressures for improving service delivery. Citizens can provide incentives for public services delivery through choice (using public services), voice (giving feedback to providers), and voting (choosing political leaders who support service delivery systems). However, in the face of weak institutions, poor performance, and low trust, people often disengage. They turn instead to local nonstate actors and institutions for services. When they do demand services from the state, citizens tend to do so through informal channels and seek piecemeal, selective solutions to their individual problems.

Chapter 4 explains how historical experience has led citizens to value education and health, has fostered their dependence on the state, and has limited the state's responsiveness. Chapter 5 provides a detailed picture of the political, administrative, and social institutions that affect service delivery, setting the scene for a more detailed look at service delivery performance in chapters 6–9.

MAP II.1 Government Effectiveness Index values for MENA, 2013



Source: World Bank (IBRD 41534, March 2015).

Historical and Cultural Roots of Citizens' Attitudes and State Performance

4

- **Drawing on their historical and cultural roots, citizens of the countries in the Middle East and North Africa value education and health services and expect the state to provide them.**
- **Colonial and postcolonial rules have reinforced the political salience of subnational identity groups, including tribes and large families, regions, and ethnic and sectarian divisions.**
- **The political economy of the region has brought about weak institutions, often incapable of meeting citizens' demands.**

As we saw in chapter 1, the citizens of the Middle East and North Africa (MENA) place a high value on education, health, and other services, and they expect the state to provide such services. But this has not always been true. In earlier years, providing these services was the responsibility of religious communities and private households. Later, the state began to provide services, seeking to protect its own military and commercial interests. Even as public education systems emerged, however, the provision of education was primarily elite-driven.[1]

Only in the postindependence period did the widespread provision of public services become part of a new social compact. It arose in many cases from the political battle raging between the newly emerging elites and entrenched interests. The agreement that was finally struck called for the states to provide citizens with education, health care, and employment in return for acceptance and little resistance. At first, this arrangement resulted in more state-provided services, including a significant expansion of student enrollment, the establishment of new hospitals, and other improvements in public service delivery. And yet the political compact thwarted the creation of the mechanisms that would ensure voice and accountability, ultimately contributing to heightened popular expectations, social divisions, and the atrophy of political institutions. As revealed in the coming chapters, the result has been a huge demand for services, widespread disappointment in their provision (particularly in

nonoil states), diminishing trust in public institutions, and disengagement.

Education and health as elite privilege

The three monotheistic religions that have shaped the MENA region hold education and health in high regard. For example, in the Islamic Hadith, as narrated by Al-Tarabni, the Prophet Muhammed encourages education, saying, "Seeking knowledge is obligatory on every Muslim." The Qur'an (5:32) states that "if anyone saved a life, it would be as if he saved the life of the whole people, thereby placing great importance on the role of doctors."[2] So, too, in Judaism one finds in the Talmud that "whoever saves a life from Israel, the Scripture considers it as if he saved an entire world" (Babylonian Talmud, Sanhedrin 37a). Christianity highly values the extension of education and progressive medicine to local communities. Thus in the 18th and 19th centuries, Christian missionaries were among the pioneers in establishing local schools, universities, and clinics.[3]

Because Arab societies initially viewed education and health as private affairs, families and communities took responsibility for providing these services. In education, for example, parents chose whether and how to educate their children. Often, both boys and girls[4] were taught how to read and were inaugurated into the fields of Arabic poetry and the art of oration. There were also close ties between religion and education. In Saudi Arabia, for example, "the child's education began at home. As soon as he could speak it was the father's duty to teach him 'the word,' La ilah illa Allah (no God but Allah). When six years old, the child was responsible for the ritual prayer. It was then that his formal education (consisting of religious studies, literacy and light mathematics) began. The elementary school (*kuttab*) was an adjunct of the mosque, if not the mosque itself" (Trial, Winder, and Bayly 1950, quoting Hitti).

The elites began to recognize the value of education and health care, particularly during the Golden Age of Islam in the seventh and eighth centuries, but access to services was largely restricted to the elites. The Abbasid Caliphate (750–1258 A.D.) became a seat of knowledge and advancement, with the Abbasids establishing the House of Wisdom (Bayt al-Hikma) that brought together scholars from across the world to translate and expand on research and teachings from Europe to China. Scholars made important advances in science, technology, and medicine. The first hospital was established in Baghdad in 805 A.D., and at one time as many as 60 hospitals are said to have existed in the capital city (Nagamia 2003; National Library of Medicine 2011). However, access to hospitals in the region's major cities was limited primarily to elites. For the first 500 years of the Ottoman Empire's long rule (1299–1922), successive caliphates believed health services, hospitals, and clinics were the responsibility of charitable organizations, and education was the responsibility of the family, who could teach children at home or seek the help of scholars in the *kuttab*.

In the 19th century, however, Ottoman rulers turned to Western education in the wake of rising security threats from the recently modernized European powers. As Gasper explains, in the 1820s, Mohammed Ali, the Turkish commander who ruled Egypt, at first under Ottoman command, "established modern schools, sent promising students abroad to complete their studies, and brought in foreign advisers and experts to train military officers and teach at new scientific and technical institutes" (Gasper 2013, 13). Reforms focused on education, but access to education was initially limited to a small segment of the population. Similarly, Moroccan rulers and the Ottoman Empire introduced a "New Order" (Nizam Al-Jadid) and the "Auspicious Reordering" (Tanzimat, 1839–1909) in the hope of matching the development of their European neighbors and conveying the appearance of European-style statehood (Anderson 1987). These reforms began to change the nature of citizen-state relations in which the state interacted more closely with its citizens and

became involved in new domains. And yet Moroccan rulers and the Ottoman Empire focused primarily on expanding the army, economy, and state bureaucracies that would support the creation of a middle class that could compete in the areas of commerce and foreign trade. The military and provincial administration were restructured, standing armies were established, and a new administrative staff with greater technical skills was fostered, all accompanied by higher taxes (Anderson 1987).

Ottoman rulers wanted to import Western education models because they perceived such an education to be a means to acquiring military power and improving economic productivity. During the late Ottoman period, Sultan Abdul Hamid II encouraged the development of education by aspiring not only to Western attitudes toward education, but also to Western structures of schooling that separated children by age and placed them within a single institution. These changes in education began with the introduction of military schools in 1834 (Provence 2011). By 1845 the government had decreed that a military preparatory school should be built in all provincial capitals with an army corps headquarters. In addition to military schools, missionaries established and operated schools across the empire in cities such as Beirut, Istanbul, and Damascus, including a missionary college that was founded in the mid-1860s (Provence 2011). However, recognizing that the notion of sending Muslim children to missionary schools did not appeal to elite families, the sultan issued an act that introduced public education.

The new Education Act of 1869 established a multitiered civil education system with two options, military (*askariyye*) school or civil (*mulkiyye*) school. The law dictated that elementary schools (*ibtidaiyye*) were to be built in each village, middle schools (*rusdiyye*) in each town, and an Imperial Sultani Lycee (*idadiyye*) preparatory school in every provincial capital. This was an ambitious endeavor, and so implementation was slow. Military schools were given priority. They were constructed first, were placed in better locations, and were better financed than the civil schools. In addition, military schools were free of charge, whereas civil schools charged high tuition fees, which undoubtedly had an effect on student enrollment (for example, by 1900 the civil preparatory school in Baghdad had attracted 96 students, whereas the military school had enrolled 256 students). Children from elite families dominated the civil schools, and the families continually lobbied for more. The sultan hoped education would bind the people of the empire together, and so the expansion continued—from 1893 to 1894 more than 50 military middle and preparatory schools were constructed across the empire. Yet even as the empire ended in 1922, public education was far from universal.

This was even truer outside the Ottoman Empire. The Arabian Peninsula and the current Gulf countries persisted in their nomadic and tribal traditions. In Saudi Arabia, for example, Bedouins were mainly illiterate, although they had deep knowledge of their country's geography and history. Poetry and the Qur'an were of utmost importance; Bedouins could easily recite pages of folk poetry and knew the Qur'an by heart (Trial, Winder, and Bayly 1950). Public education, however, was unknown.

Similarly, only a minority of the population enjoyed modern health care. The role of missionaries in the health industry was less contentious than it was in education, and so they were allowed to operate and contributed significantly to expanding health care, particularly in the Levant (Bourmand 2008; Chiffoleau forthcoming). And yet most state efforts to expand health care focused on security, and especially the military. Sanitation reforms and quarantines were implemented to protect the army from the epidemics that were widespread at that time. Municipal hospitals were built in the provinces, and the posts of civilian sanitary doctors were multiplied to contain the spread of infectious diseases. However, graduates of the medical schools in Cairo and Istanbul, the most prestigious institutions at the time, were quickly absorbed into the army in an

effort to keep the military strong and able to protect its territory. Before the reforms, Ottoman rulers paid little attention to health care. The sale of food and medicine was regulated as part of general commercial regulations in order to prevent economic fraud and ensure the adequacy of provisions for the capital city.

From privilege to state building

The decline of the Ottoman Empire altered the process of state formation and administrative development and consequently the provision of education, health, and other services. The impact was felt at different times for different countries. For example, Algeria moved from Ottoman to French control in 1830 and would remain so until 1962, and Tunisia became a French protectorate in 1881. But Lebanon, Syria, and other countries in the Levant remained under Ottoman rule until the end of World War I. Imperial powers also exercised power differently across territories (Owen 1992), ranging from direct colonies to mandates, protectorates, condominiums, and direct treaties. There were also differences based on the degree of rule (direct or indirect), type of government (monarchy or republic), and the political importance of the European settler community. All these factors determined how power was exercised within the newly created states, and they would ultimately influence the extent to which populist welfare regimes would emerge in the independence period, mobilizing support on the promise of public services.

In general, colonizers concentrated public services in capitals and large urban areas, thereby limiting access to a small elite group. Education, in particular, was used as a tool to win favors, control segments of the population, and staff colonial administrations. Control was achieved by limiting access to secondary education to elite families in order to win their loyalty. Cairo University and American University of Beirut were the only two functioning universities in the region, and just a small segment of the Middle Eastern population gained access. Those who had the means traveled abroad to Europe and the United States. For the most part, however, the majority did not pursue a higher education. Illustrative of the limited access to education was Algeria, which in the 1950s had an indigenous population of 10 million. Only 7,000 were in secondary school, and only 600 attended a university (Richards and Waterbury 1996).

Those elites who gained access to education were given positions in colonial bureaucracies, thereby expanding the manpower used to modernize the state. This new civil service was needed to manage roads, railroads, ports, and power; to run the mail and telegraph services; to identify and tax the population; to staff all echelons of the local administration; and to assume all the intermediate positions between the colonial authorities and the population. Thus by essentially creating a new upper class of managers and officers, middle class of technicians, and lower class of workers (Polk 1965), the colonizers were able to sustain their control and enforce policies that increased services and finances for their own benefit.

Similarly, the colonial interests determined health care policies. Sanitation policies, for example, were used to protect colonizers' military and economic interests—and in some cases as a tool to "civilize" populations that the colonizers considered backward, ignorant, and dangerous (Camau, Zaiem, and Bahri 1990; Arnold 1993; Rivet 1995; Mitchell 2002). The outbreak of smallpox in Palestine in 1921 proved to be such a case (Davidovitch and Greenberg 2007). The health reforms under the Tanzimat largely missed Palestine, and thus disease was widespread; malaria and trachoma were common ailments. The British rulers exerted much effort to rid Palestine of infectious diseases, installing new sewage systems, creating swamp drainage projects, and conducting hygiene education campaigns. They also introduced new regulations and policies for licensing health care professionals, pharmaceutical and food regulations, and quarantine measures.

Such programs had limited results, however. Many of them were only partially implemented because the British investments were limited. And local populations often feared modern medicine. For example, when vaccinations were introduced, many locals resisted the injections by hiding in caves and remote areas when physicians visited their villages. Overall, the colonial powers did not pay much attention to the health needs of the locals except when the health of the local populations was impeding colonial economic production or enterprises.

The colonial powers not only left vast segments of the population without adequate education and health care, but also reinforced social divisions and thwarted development of effective administrative institutions. According to Owen (1992), three policies underlay colonial rule: (1) to favor certain ethnicities (such as Arab over Berber), regions, and tribes; (2) to create alliances with large landowners, who for their loyalty received tax exemptions and the legal authority to rule over their peasants; and (3) to manage economies in such a manner that left the Middle Eastern economies open and subject to influence from the colonial rulers and other markets (for example, states were not allowed to have their own central bank and remained relatively constrained in their ability to raise revenue). As a result, tribes, families, and other groups gained political salience; wide chasms in society fostered populist demands; and state institutions remained underdeveloped (Tibi 1990; Shryock and Howell 2001; Hourani 2010).

Independence and the new social compact: Services, a right for all

Arab countries shifted their provision of public services after they gained independence (for most of them, after World War II). Leaders wanted to break away from the policies set by the European colonizers and focus instead on industrialization, better living standards, higher incomes, and the expansion of services that would improve social and economic development across populations (Abu-Laban and Abu-Laban 1976). They also sought to mobilize populations that were hugely frustrated with the socioeconomic gaps between the colonial elite and the rest of the people. In the heady days of the post–World War II period when state-led development and populism were gaining strength globally, nationalist leaders throughout much of the region used the promise of services to gain support of the masses. Countries whose militaries were oriented toward the lower classes in order to overthrow the incumbent elites as well as socialist-oriented republics with large welfare states began to emerge. Examples were the Arab Republic of Egypt, Iraq, and the Syrian Arab Republic. In other countries such as Jordan and Morocco, which managed to hold off such threats, conservative forces remained in power, often in monarchies. Yet they too needed to respond to popular pressures, in part by promising public services (Waterbury 1970; Yoav 2007; Lust-Okar 2008, 2009a, 2009b). Finally, in the Gulf states, where independence came later and oil rents were available, the ruling families founded their regimes on a promise of services for loyalty (Anderson 1987; Beblawi and Luciani 1987; Crystal 1990; Herb 2005).

Eventually, a social compact emerged to bind governments to their citizens. The new leaders promised to improve living standards and equality and to introduce mass access to public services such as education and health. Postindependence constitutions echoed the role of the state as the institution responsible for social, political, and economic policies; in essence, the new constitutions introduced the state as an agent of public welfare. Policies fortifying the social compact included reliance on state planning in setting economic priorities, nationalization of private and foreign assets, food and fuel subsidies, and the overall centralization and control of political parties, unions, and other associations in an effort to limit the political sphere to one that conformed to the unity of the state (Yousef 2004). These policies instilled

in citizens the expectation that the state would provide services.

In addition, the discovery of oil and expansion of the oil industry in some countries made it possible to offer generous welfare, leaving citizens to anticipate that services would be their slice of the oil booty. In the Gulf states, education, health, and other social services were introduced in the 1950s as part of a welfare state in which local populations would receive services free of charge or pay a small fee to gain access (Bahgat 1999). In Kuwait, the discovery of oil in 1946 led to the establishment of the first public hospital. The number of medical professionals grew from 3,840 in 1970 to 13,616 in 1986 (Salid 1991). In the United Arab Emirates, primary health facilities increased from 45 clinics in 1977 to 105 health centers by the end of 1999.

Public education was also introduced to create a skilled workforce to support the modernization process. To promote and encourage families to send their children to school, education was offered free of charge, and some enrolled students received books, uniforms, and monthly allowances (Bahgat 1999). In Saudi Arabia, development of the oil industry was accompanied by Western influences, which also seeped into the field of education. An American boys' school opened in Saudi Arabia's Eastern Province, teaching English, basic mathematics, and other courses in vocational education. Those who graduated with these skills were able to enter the oil industry and earn salaries that were three times higher than those of their untrained peers. Following the discovery of oil in Kuwait, it expanded its public schools, and enrollments grew from 51,090 in 1961 to 364,412 in 1986 (Salid 1991). Countries across the MENA region thus saw major changes in the education sector. The expansion of public education translated into the secularization of schools and the formalization of education by standardization and setting a curriculum. The number of primary school teachers in 13 Arab states combined more than tripled between 1950 and 1971, rising from 103,004 to 382,477, which represents a 13 percent annual growth rate (Abu-Laban and Abu-Laban 1976). By 1970 six Arab states (Jordan, Kuwait, Lebanon, Libya, Syria, and Tunisia) had nearly universal educational systems at the primary level (Abu-Laban and Abu-Laban 1976). The expansion of schools was accompanied by efforts to improve student access and enrollment. In 1971 the average net enrollment rates in the MENA region were 59 percent, compared with 90 percent in member countries of the Organisation for Economic Co-operation and Development (OECD). By 1975 the MENA average had jumped to 66 percent, and in 1990 it reached 82 percent. By 2010 MENA countries had a net enrollment rate (95 percent) that was comparable to that of the OECD countries (96 percent). The female enrollment rate, which in 1971 was only at 44 percent of primary school–aged girls, had by 2010 reached 93 percent in the MENA countries. The number of university students rose from 20,000 in 1945 to about 400,000 in 1971 (Issawi 1982).

During the early period of independence, health facilities still reflected the era of elitism that preceded that period. They were situated only in large cities, were ill-equipped, and were under the administration of religious missions. Meanwhile, the medical workforce was limited—for example, in 1952 Egypt had one physician per 2,700 persons (Chiffoleau 1997), and in 1955 Syria had one physician per 4,000 persons (Camau, Zaiem, and Bahri 1990). However, some strides were being made in curbing disease and raising health indicators. For example, the spread of vaccination centers across the region helped reduce the incidence of childhood diseases as well as infant mortality rates.

Institution building in newly independent states

The expansion of public services was important in building national support for the newly established regimes and promoting social and economic development in the former colonies, but it also emerged in the context of, and contributed to, weak political

and administrative institutions. The administrative institutions that emerged were intended to implement redistributive policies, but most Arab states emerging from the era of colonization had weak administrative capacities and competence. Countries such as Egypt and Tunisia, which had gained early autonomy from the Ottoman Empire and were subjected to less direct colonial rule, had functioning national administrations by the early 20th century, while countries such as Libya and Lebanon had weak administrative penetration and ill-fitted bureaucracies with no experience, making full territorial control difficult. Other states were still struggling with the social structures and economies that were bunched together via the arbitrary territorial lines drawn by the Europeans. This was an acute problem for the nomadic tribal families in Iraq, Jordan, and the Gulf states.

In addition, most newly independent states lacked the funding needed to support extensive social services (Polk 1965). The rich oil-producing countries, particularly the Gulf states, were an exception. They generally had the economic resources to support an expansive public services program, although they were affected by the instability in oil prices. They were also able to develop positive relations with their citizens, who increasingly came to see themselves as minorities in largely expatriate communities, thereby further deepening support for their leaders. Often, however, countries that promised their citizens free public services, such as Egypt, Libya, the Republic of Yemen, and Syria, struggled to finance those efforts. Minor alarms were raised early on about the sustainability of this route, and in some instances, budget deficits occurred, resulting in inadequately supplied facilities (Saleh et al. 2014).

Despite these challenges, and in the face of the initial stages of instability that included military coups, the Arab states continued to expand services. They promised universal health care, public education, and even jobs to all graduates. Governing elites saw such policies as crucial for development, as well as a key component of efforts to strengthen and stabilize political regimes. However, the political logic that drove policies and implementation resulted in bloated bureaucracies, inefficient state-owned enterprises, and higher deficits (Nabli 2007; Cammett and Diwan 2013).

Incumbents also used access to choice positions in large bureaucracies and state resources to reward political allies. Often, they favored members of certain tribes, sects, regions, or other social groups, exploiting identities that had been reinforced during the colonial era. In countries such as Saddam Hussein's Iraq, Jordan, the Republic of Yemen, and Saudi Arabia, state elites used tribes as the "building blocks of the modern state" (Alon 2007, 7—also see Ayubi 1995; Jabar 2001; Sakai 2001). As Shryock and Howell (2001, 266) explain about Jordan, the Hashemites "built a political system that corresponds to, addresses, and depends on these houses [Jordanian tribes] in fundamental ways: as targets of incentive, punishment, and reward; as sites and methods of recruitment to public office; and as a means of exclusion from power." Elsewhere, most notably in Lebanon, sectarian divisions were the basis of the political order. However, the use of social identities in establishing political order did not translate into political inclusion; pacts often remained at the elite level, with few benefits trickling down to constituents (Cammett 2009; Corstange 2010). Nor did this strategy foster political compromise. Indeed, as Waterbury (1970) argued about Morocco, managing conflict across groups served to both help ruling elites maintain power and reinforce these identity groups.

Economic crises, neoliberal policies, and the failure to reconstruct the social compact

By the early 1980s, the situation in much of the region had become unsustainable, but it was difficult to reverse. Populist politics, combined with falling oil revenues, increasingly large young populations, and inefficient bureaucracies, strained economies.

In particular, those regimes that did not have oil revenues were forced to implement austerity programs. Consumer subsidies were reduced, and agricultural and industrial prices were liberalized. This led to a sharp increase in food and kerosene prices. For example, the price of flour and flour products increased by 50–67 percent in Egypt in 1977, by 40 percent in Morocco in 1981 and another 34 percent in 1984, and more than doubled in Tunisia the same year. In 1989 the Egyptian government waived state subsidies for flour a second time, and the Jordanian government reduced subsidies for fuel and cigarettes. Meanwhile, Algeria and Egypt reduced state expenditures on welfare programs, especially health care (Bienen and Gersovitz 1986; Seddon 1989; Sadiki 2000; Rivlin and Even 2004; Devlin 2010).

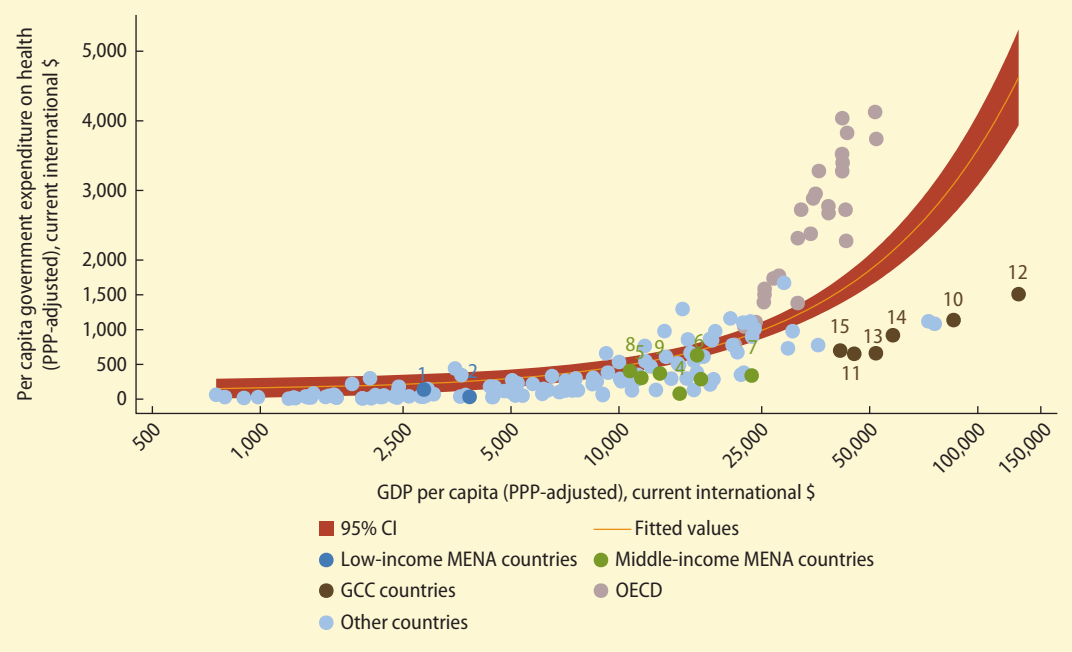
Citizens vehemently resisted cuts in these areas (Prasad 2014, 15–18). The urban middle and lower classes took to the streets protesting austerity programs. Subsidy cuts and higher prices led to demonstrations and riots in Morocco in late 1983, Tunisia in 1984, Sudan in 1982 and 1985, Algeria in 1988, and Jordan in 1989 (Richards and Waterbury 1996, 268). Governments responded in many cases by restoring subsidies. They also opened up opportunities in the private sector, called elections, (re)convened parliaments, allowed the establishment of new political parties and civil society organizations, and attempted to reform public services.

And yet despite budgetary pressures, the MENA countries generally did not reduce spending on education and health. According to data from the United Nations Educational, Scientific and Cultural Organization (UNESCO) Institute for Statistics, these countries increased their per capita spending on primary and secondary education throughout the 2000s; only Jordan and the Islamic Republic of Iran saw a slight decrease in spending in 2011. Similarly, according to data from the Global Health Observatory Data Repository at the World Health Organization (WHO), the per capita expenditures on health by the MENA countries varied greatly over the period 1995–2012, but there was no significant decrease.

The levels of spending in low- and middle-income MENA countries on both education and health care are similar to those in countries with similar levels of gross domestic product (GDP) per capita, although the Gulf countries tend to spend less when compared with OECD member countries (see figures 4.1 and 4.2). For example, in terms of the primary education expenditure per student as a percentage of GDP per capita, in 2012 Jordan spent 12 percent and the Islamic Republic of Iran 16 percent, whereas Kuwait spent 17 percent and Oman 14 percent (slightly lower percentages than countries with similar GDPs per capita). Figure 4.3 shows that in 2011 Jordan, the Islamic Republic of Iran, Kuwait, and Oman had similar spending levels on secondary education, whereas the Republic of Yemen was spending only 11 percent of its GDP on secondary education per student—a percentage that is low when compared with those of countries with similar GDPs per capita.

However, citizens have also seen their out-of-pocket expenditures for education and health care increase, even as governments have failed to reduce their fiscal burdens. Weak and captured institutions, as discussed in the next chapter, have led to inefficient use of funding and the poor-quality services outlined in chapter 2. The result is that citizens who can increase their spending receive the services they need. Trends in primary school enrollment indicate that households are spending more out of pocket for private schooling, particularly in the Gulf countries where families are more likely to have disposable income (figure 4.4). On the other hand, citizens of the Gulf countries tend to spend less out of pocket on health than their peers in the MENA countries. In the Republic of Yemen, for example, out-of-pocket expenditures make up 72 percent of total health expenditures, whereas they make up only 9 percent of total health expenditures in Qatar (World Development Indicators, 2012). Today, households in MENA countries pay on average 6 percent of their total

FIGURE 4.1 Per capita government expenditure on health: MENA and other countries, 2012



Sources: World Development Indicators, 2012; Global Health Observatory Data Repository, 2012.
Note: PPP = purchasing power parity; GDP = gross domestic product; CI = confidence interval; MENA = Middle East and North Africa; GCC = Gulf Cooperation Council; OECD = Organisation for Economic Co-operation and Development. Low-income MENA countries: 1 = Djibouti, 2 = Republic of Yemen; middle-income MENA countries: 3 = Islamic Republic of Iran, 4 = Iraq, 5 = Jordan, 6 = Lebanon, 7 = Libya, 8 = Tunisia, 9 = Algeria; GCC countries: 10 = Kuwait, 11 = Oman, 12 = Qatar, 13 = Saudi Arabia, 14 = United Arab Emirates, 15 = Bahrain.

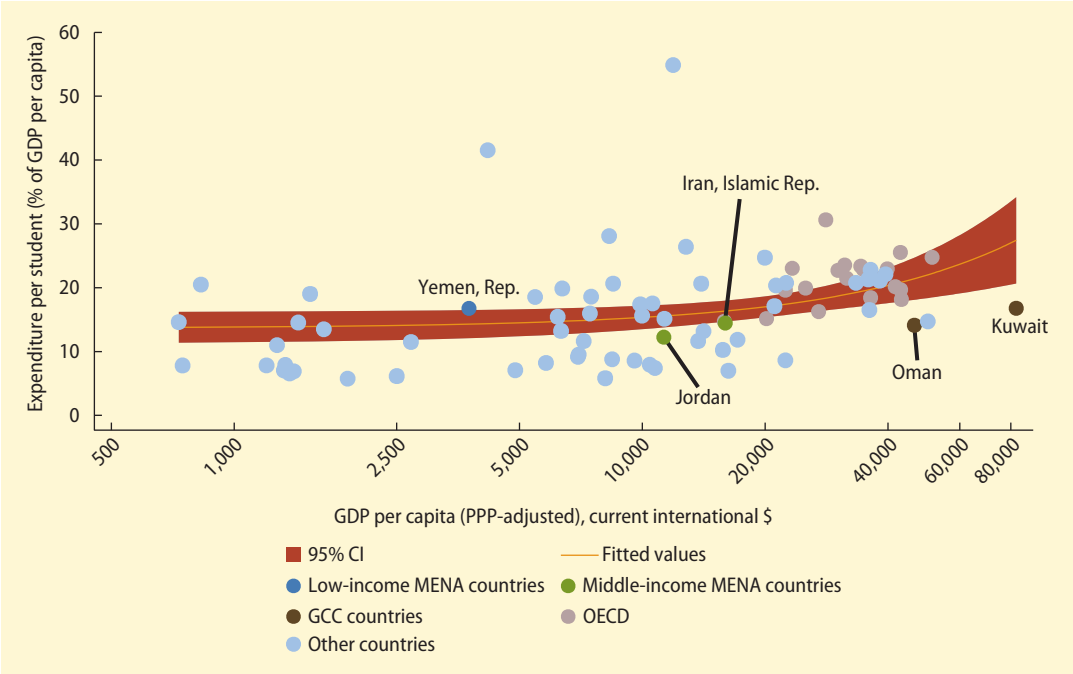
household expenditure on health care, with most of this spending used on medications, physician visits, and diagnostic services (Elgazzar et al. 2010). Lower-income countries such as Egypt, Morocco, the Republic of Yemen, and Syria have higher out-of-pocket spending, placing the poor at a disadvantage that could push them deeper into poverty or force them to forgo health care.

Moreover, after the fall in 2011 of Egyptian president Hosni Mubarak and Tunisian president Zine El Abidine Ben Ali, evidence emerged that the small minority of politically connected benefited disproportionately from the political reforms established in the wake of the economic crises of the 1980s. As a result, the gap between the rich and poor widened.[5] Meanwhile, as Cammett and Diwan (2013) argue, the alliance between the middle classes and the state that had emerged in the 1990s eroded during the following decade (Diwan 2013). At the same time, promises of democracy never materialized. Parliaments, political parties, and civil societies remained weak, and state institutions lacked the accountability, transparency, and enforcement mechanisms needed to translate citizens' demands into effective policies.

High expectations, weak institutions, and low performance

Despite weak institutions and broken promises, citizens' expectations that the state would play a major role in providing education, health, jobs, and other services did not dissipate.[6] However, populations lost trust in the ability of governments to provide quality services that addressed their needs, and they saw corruption and lack of freedom

FIGURE 4.2 Per capita government expenditure on primary education (percentage of GDP per capita): MENA and other countries, 2011



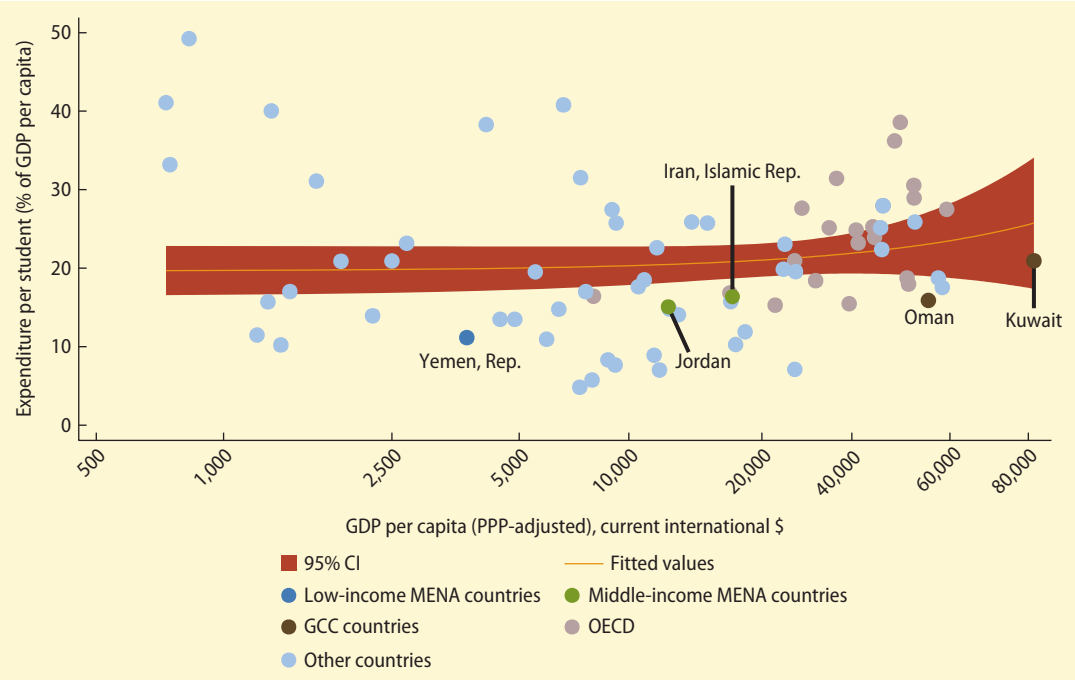
Source: World Development Indicators, 2011.
Note: GDP = gross domestic product; PPP = purchasing power parity; CI = confidence interval; MENA = Middle East and North Africa; GCC = Gulf Cooperation Council; OECD = Organisation for Economic Co-operation and Development.

and opportunities as the major reasons for failure. Better education, health, and other services were among the demands of people during the Arab Uprisings that began to spread across the Middle East in late 2010 and early 2011.

Most governments found it difficult to reduce subsidies or to limit the public sector wage bill, especially in the face of the Arab Uprisings. Under mounting economic burdens, governments seeking to reduce subsidies and limit the public sector wage bill to ease budget deficits saw their efforts often pushed back. The governments of Egypt, Jordan, the Republic of Yemen, and Tunisia attempted to cut subsidies in 2011, 2012, and 2014, but reversed those measures in the face of mounting opposition (Al-Khalidi 2012; Buck 2012; BBC 2014; IRIN 2014). Indeed, from 2010 to 2013 the Tunisian government responded to public demands by *increasing* subsidies to the point that the 2013 expenditures were 300 percent higher than those in 2010 (*Africa Report* 2014). Influenced by developments in the MENA region, in Sudan, opposition to a cut in fuel subsidies led to unrest, leaving more than 50 dead (Zaid et al. 2014). This is not to say that subsidies are never drawn back: The Islamic Republic of Iran replaced subsidies to energy products with targeted cash transfers to the population in 2010, and Egypt managed to do so in 2014, with President Abdel el-Sisi exploiting his honeymoon period in office to make an unpopular decision. In general, however, such cuts are politically difficult because the public continues to expect that the state *will* provide such support.

Revised constitutions in Egypt and Tunisia have further strengthened citizens' rights and the state's obligation to ensure appropriate funding for education. Governments across

FIGURE 4.3 Per capita government expenditure on secondary education (percentage of GDP per capita): MENA and other countries, 2011

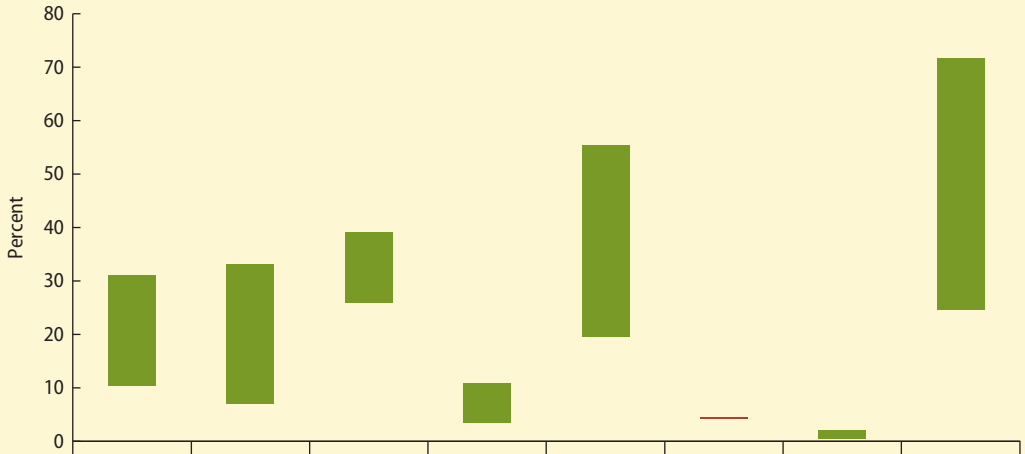


Source: World Development Indicators, 2011.
Note: GDP = gross domestic product; PPP = purchasing power parity; CI = confidence interval; MENA = Middle East and North Africa; GCC = Gulf Cooperation Council; OECD = Organisation for Economic Co-operation and Development.

the region have developed new strategies, policies, and reforms in the education and health sectors that demonstrate a commitment to improving services. Education reforms include improvements in curricula, in teacher policies (as demonstrated by the Systems Approach for Better Education Results, SABER),[7] and teacher training. Similarly, in the health sector, governments have introduced policies and reforms for universal coverage and quality in health care. As part of the global movement toward universal health coverage, Egypt, Morocco, Tunisia, and the Gulf Cooperation Council countries are striving to increase health care coverage, and countries have aligned with the World Bank around its regional health strategy with fairness and accountability at its core. Whether such strategies, policies, and reforms can succeed and whether promises can be kept will largely depend on the ability of countries to orient the incentives of public servants, providers, and communities toward their implementation.

Successfully improving service delivery depends on more than simply announcing rights and policies. The ability of institutions to perform, citizens' evaluations of such performances and trust in public institutions, and their willingness to engage are essential. And yet achieving a positive cycle of performance requires overcoming some of the problems that emerged through the postcolonial period: citizens' high expectations, deep social divisions, and weak institutions. As we shall see in the coming chapters, these problems diminished performance, fostered frustration, and shaped engagement in ways that often undermined the development of stronger, more effective systems.

FIGURE 4.4 Private primary school enrollment as a percentage of total primary enrollment: MENA region, selected years, 1985–2010



	Bahrain	Jordan	Kuwait	Morocco	Qatar	Syrian Arab Republic	Tunisia	United Arab Emirates
1985	10.5	6.9	25.9	3.4	19.6	4.5	0.5	24.6
1995	17.9	27.3	31.1	3.7	34.1	3.9	0.6	41.2
2005	23.6	30.4	33.0	6.6	45.3	4.4	1.1	61.1
2010	31.1	33.1	39.1	10.8	55.5	4.2	2.1	71.7

Source: EdStats.
Note: The bars represent the difference in private primary school enrollment as a percentage of total primary enrollment between 1985 and 2010.

Notes

1. In general, elites are those in a society who enjoy a disproportionate amount of social, political, or economic power. In the MENA region, there has been some variation in the nature of elites over time. During the Ottoman rule, elites were those individuals who served the sultan (usually through the collection of taxes), who embraced Islam, and who assimilated into Ottoman social practices, including speaking the Ottoman language. As the central power of the sultan began to weaken in the reform and modernization periods, the nature of the elites also shifted as local households within the ruling classes began to gain political and economic control, soon becoming provincial notables who secured military and administrative functions. Under the Tanzimat reforms, state formation solidified, and thus administrative positions increased and were soon handed over to a new generation of well-educated bureaucrats who performed like their Western counterparts. As the Arab states gained independence, state administration and state-society relations developed and so did the nature of the state's beneficiaries, the elites. Across the region, elites were formulated across sects, class, tribes, and landowners, leading to variation, for example, among the landowner elites of Morocco, the elitist tribesmen of the Republic of Yemen, and the Ba'ath party members of Iraq.
2. So, too, a Hadith, as narrated by Usamah Sbin Shareek, established the legitimacy of medicine: "I was with the Prophet, and some Arabs came to him asking, 'O Messenger of Allah, should we take medicines for any disease?'

He said, 'Yes, O You servants of Allah take medicine as Allah has not created a disease without creating a cure except for one.' They asked which one. He replied 'old age.'"

3. This had complex implications for development as well as West-East relations. See Makdisi (2008) and Doğan and Sharkey (2011).
4. Girls usually joined young boys during the early years of education, but once they reached puberty their education was discontinued.
5. For a discussion of the disproportionate gains by crony capitalists, see Diwan, Keefer, and Schiffbauer (2014) and Rijkers, Freund, and Nucifora (2014).
6. Evidence of this can be found in public opinion polls. When asked about whether the state should play a large role in the economy, respondents in Egypt and Tunisia were nearly united in demanding that it do so. When asked what the most important components of democracy are, in Egypt, nearly 70 percent of respondents saw democracy in economic terms—either narrowing the gap between rich and poor or providing basic necessities (Transitional Governance Project, 2012). More than 32 percent in Tunisia agreed (Transitional Governance Project, 2012, 2014) and 12 percent in Libya (Transitional Governance Project, 2013). Of the three countries in transition, only in Libya was there support for a limited state role in the economy (or capitalist economy) and was democracy viewed in terms of civil liberties and turnover of government through elections (Transitional Governance Project, 2013).
7. SABER is an initiative to produce comparative data and knowledge on education policies and institutions, with the aim of helping countries systematically strengthen their education systems.

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Institutions Influencing the Cycle of Performance

5

- In most countries in the Middle East and North Africa, political institutions are highly centralized and not inclusive, and citizens and frontline service providers have little influence on policy formation and implementation.
- Political institutions lack accountability mechanisms, with citizens unable to obtain information, to voice demands, or to give policy makers and public servants the incentives through formal channels to improve services.
- Administrative institutions suffer from highly centralized bureaucracies and weak management systems, and so they are unable to allocate human and material resources efficiently and manage performance.
- Social institutions emphasize obligations to members of social networks over national welfare, resulting in the widespread practice of *wasta*, a form of clientelism, as well as informal payments in return for services.
- Weak political institutions and the lack of accountability contribute to a cycle of poor performance.

Why have decades of capacity building contributed little to service quality in the Middle East and North Africa (MENA) region? Why is information not properly collected throughout the delivery chain and followed up on later? For many political economists and country experts, the answers to such questions lie in understanding the incentives that political institutions in the MENA countries generate. *World Development Report 2004: Making Services Work for Poor People* made the compelling argument that better public services depend on better governance (World Bank 2004). Indeed, the World Bank (2003) has reported that enhancing governance in the MENA region rests on two core values: inclusive laws and regulations that treat all members of society indiscriminately[1] and mechanisms of internal and external accountability that ensure that those laws and regulations are respected. When these institutions are weak and accountability is lacking, providers lack incentives to perform well and citizens are more likely to suffer poor-quality services—that is, the cycle of performance for service delivery is stuck in a low-level equilibrium.

This chapter explores the institutions that shape service provision in the MENA region, focusing on three interrelated arenas: political, administrative, and social (see figure 5.1).[2] Institutions include both the formal (legislated rules) and informal (norms) rules and procedures that outline the responsibilities of actors, the costs and benefits associated with alternative choices, and the legitimacy of actions. Political institutions are the norms and rules in the state sphere; social institutions encompass the formal institutions within society (such as tribal councils and formal religious institutions) as well as social norms; and administrative institutions are the rules and regulations that structure bureaucratic processes.

Institutions exist and influence actors at different levels, from national policy makers to frontline service providers. In a public health clinic, for example, providers' efforts are shaped by the nature and strength of the administrative and social institutions within the clinic. Examples of factors that affect services are whether there is a well-implemented human resources policy that sets clear performance standards, calls for annual reviews, ensures that results are transparently recorded and reviewed with the clinician, and lists sanctions for those who fail to perform, and whether there are social norms that create clear expectations of providers' efforts and sanctions for those who fall short. National-level institutions also affect the clinic's services by means of transparent, responsive policy making, rationalized budgetary support, and effective enforcement of rules and mechanisms playing important roles.

These institutions shape accountability mechanisms, helping to create incentives for actors across the service delivery chain to accept and respond to their responsibilities. Accountability generally requires that those who hold providers and policy makers responsible are informed about providers' and policy makers' roles and responsibilities as well as performance (transparency), and they are able to punish low performers (enforcement). These mechanisms can be based on political institutions (such as information acts, elections), social institutions (such as norms of transparency, social sanctions), or administrative institutions (such as clear information-sharing procedures, effective enforcement). Institutions may be less directly related to soft accountability—the internalized norms of responsibility. And yet even here institutions may play a role in helping form professional associations that foster professional norms, or they may reduce corruption and create norms of responsibility.

FIGURE 5.1 Political, administrative, and social institutions affecting service delivery

Political, administrative, and social institutions are interrelated. As shown in chapter 4, strong social institutions—that is, the social norms and tribal, sectarian, and other institutions that reinforce identity groups—have affected the development of political institutions. Indeed, at times they have even incorporated tribal or sectarian norms and mechanisms formally into political systems (Shryock and Howell 2001; Weir 2006; Maktabi 2013). State institutions also can create or reify identity categories and social groups, thereby influencing social divisions (Lieberman and Singh 2009; Lieberman and Singh n.d.). Similarly, captured political regimes can undermine the development of rational administrative systems.

This chapter examines institutions in the MENA region with an eye toward their impact within the cycle of poor performance on accountability and, subsequently, performance in service delivery. The first section examines how political institutions hinder policy development and implementation. The second looks at how administrative institutions in the public sector hamper accountability mechanisms in the compact among policy makers, administrators, and service providers by, for example, limiting the flow of information and possessing limited authority to impose sanctions or reward good effort. The third section then explores how social institutions at both the national and local levels shape service delivery. Unfortunately, in much of the region today, interlinked political, administrative, and social institutions across the service delivery chain impede the provision of education, health, and other services.

Political institutions

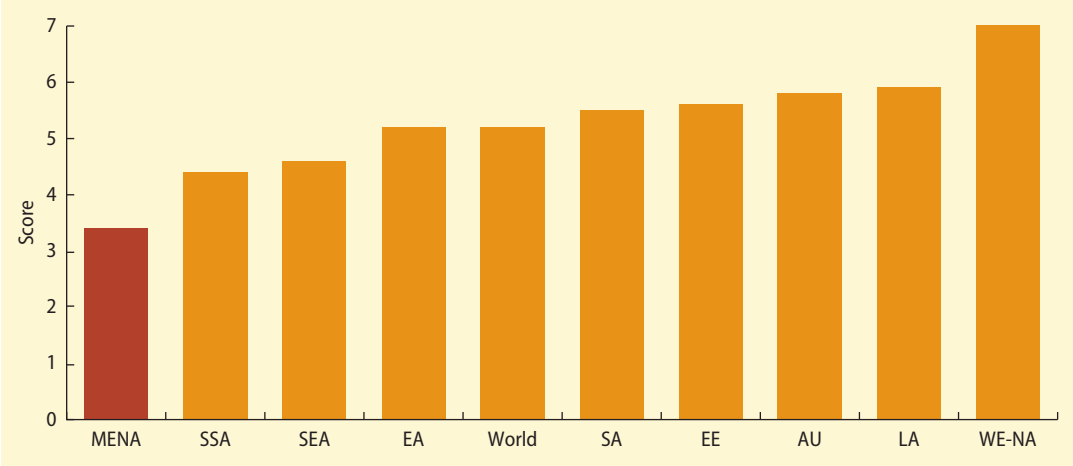
Political systems affect service delivery. The 2004 *World Development Report* characterized the "long route of accountability" as that by which citizens hold providers accountable indirectly through exercising pressure on politicians (World Bank 2004). Political actors also can engage directly in administrative reform, initiating changes that have a direct effect on service delivery. Unfortunately, as discussed in chapter 4, most MENA countries have developed regimes in which state institutions are politically captured, highly centralized, and weak. State institutions thus limit the ability of citizens and political actors to demand change, implement policies, or hold those in the service delivery chain accountable.

Influence of authoritarian regimes

Authoritarian regimes dominate the MENA region. Polity measures find that, as a region, the MENA countries have the least constrained executives, the weakest parliaments, and among the least independent judiciaries in the world (see figures 5.2, 5.3, and 5.4).[3] Certainly, one can debate whether authoritarianism always undermines development and the provision of services,[4] but at least in the MENA region it has skewed the distribution of resources away from those in need and has led to a leakage of resources. As discussed in chapter 4, both monarchs and presidents have increasingly relied on their ability to reward key constituencies—such as the military, the intelligence services *(mukhabarat)*, key party loyalists, and tribal leaders—in order to stay in power. But this is not unique to the MENA region; elsewhere, authoritarian regimes also maintain power by granting privileged access to services based on political connections and loyalty (Olivier de Sardan 1999; Desai, Olofsgard, and Yousef 2009). In the MENA countries, this practice has been reflected at times in the establishment of institutions (for example, military health systems, elite educational facilities) that funnel a disproportionate amount of resources to key constituents and provide them with better services. In general, the success of long-standing authoritarian regimes in the region has relied on and contributed to weak accountability.

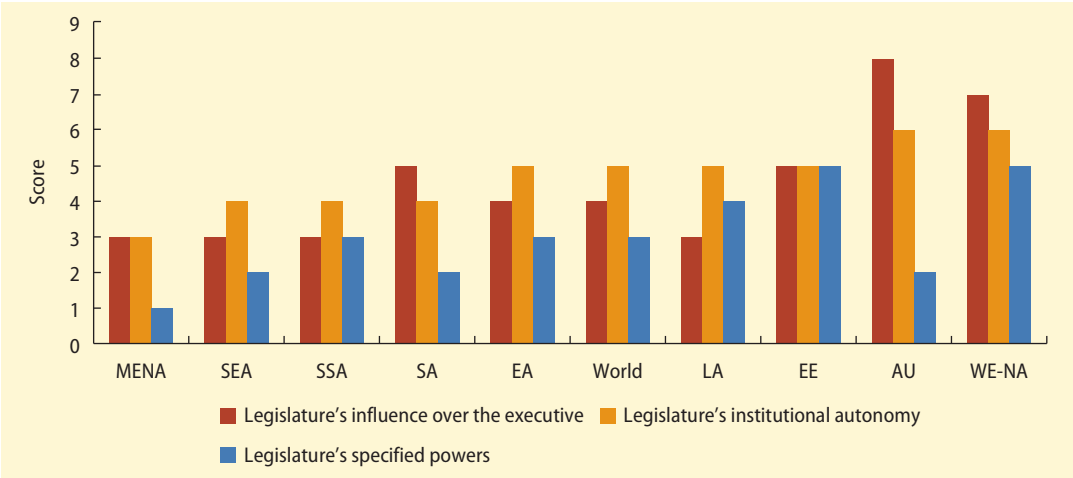
Political capture extends across the service delivery chain. As demonstrated by the Global Integrity Index (2009), the MENA region lags behind other regions in terms of civil servant appointments and evaluations

FIGURE 5.2 Institutional constraints on the decision-making power of the executive: All regions, 2014



Source: Polity IV Annual Time-Series 1800–2013.
Note: Score: 1 (unlimited executive authority) to 7 (executive parity or subordination). AU = Australia and Pacific; EA = East Asia; EE = Eastern Europe; LA = Latin America; MENA = Middle East and North Africa; SA = South Asia; SEA = Southeast Asia; SSA = Sub-Saharan Africa; WE-NA = Western Europe and North America.

FIGURE 5.3 Degree of legislative autonomy: All regions, 2014

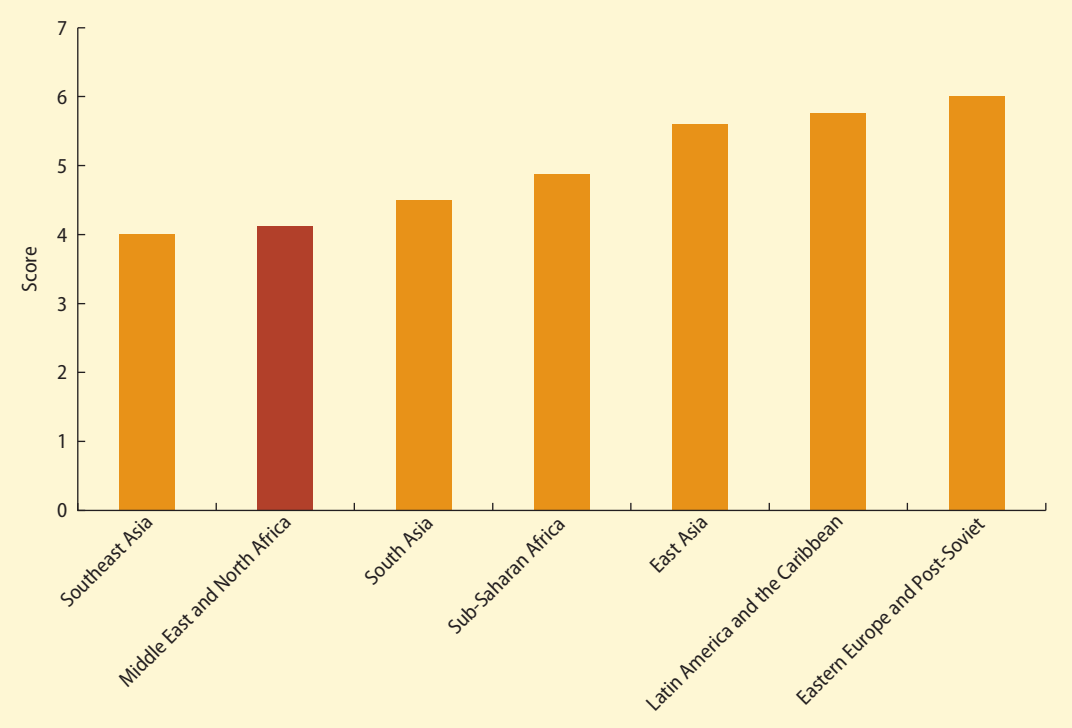


Source: Fish and Kroenig 2009.
Note: Legislative influence, autonomy, and power are measured as the number of powers of the legislature over the executive, the extent of institutional autonomy of the legislature vis-à-vis the executive, and the number of specified powers held by the legislature. Score: 0 (least powerful) to 9 (most powerful). AU = Australia and Pacific; EA = East Asia; EE = Eastern Europe; LA = Latin America; MENA = Middle East and North Africa; SA = South Asia; SEA = Southeast Asia; SSA = Sub-Saharan Africa; WE-NA = Western Europe and North America.

based on professional criteria, the actions (hiring, firing, etc.) of civil service management, and publication of the number of authorized civil service positions along with the number of positions actually filled (figure 5.5). The result of weak procedures is that they distort the incentives that public sector employees have to work efficiently and honestly and impair the ability of citizens and management to hold them accountable.

Political capture is particularly problematic because the MENA regimes are

FIGURE 5.4 Regional averages of judicial independence: All regions, 2014



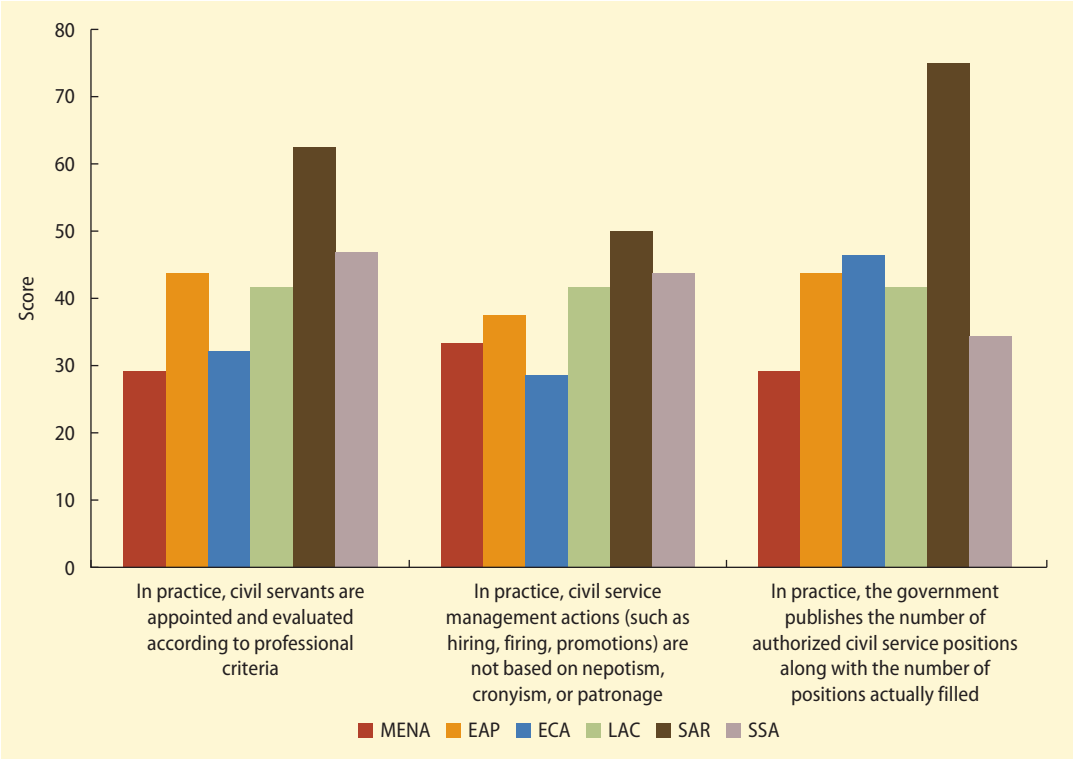
Source: Bertelsmann Transformation Index, 2014.
Note: The y-axis reflects an expert-coded index on a 7-point scale, regarding the question, "To what extent does an independent judiciary exist?" An independent judiciary is defined as one that has the ability and autonomy to interpret and review existing laws, legislation, and policies, both public and civil; pursue its own reasoning, free from the influence of political decision makers or powerful groups and individuals and from corruption; and develop a differentiated organization, including legal education, jurisprudence, regulated appointment of the judiciary, rational proceedings, professionalism, channels of appeal, and court administration.

highly centralized. As a 2007 World Bank report noted, "With few exceptions, MENA countries still feature remnants of their inherited colonial past where the sharing of power between the central and local levels of government is still heavily skewed toward the former" (World Bank 2007, 1). Directly elected local governments are found in only a small minority of countries in the region, and where they do exist, councils have limited budgets and responsibilities. With the exception of the Arab Republic of Egypt, Morocco, and the West Bank and Gaza, local council budgets account for less than 5 percent of total public expenditures, far behind the world average of 38 percent for federal systems and 22 percent for unitary ones (World Bank 2007, iii). Most local councils have some control over solid waste management, zoning, and other local issues, but they have no influence over education, health, or other services.

Lack of information and transparency

Lack of information further undermines accountability. Freedom of information and public disclosure laws and practices that would allow citizens and intermediaries to monitor government activities and pressure state actors for better performance are scarce. In some countries, Access to Information (ATI) laws are on the books, but their provisions are vague. Limited institutional capacity and resources constrain their implementation, and governments prohibit the public disclosure of a wide range of information. For example, Jordan passed an ATI

FIGURE 5.5 Performance of MENA region compared with other regions in effectiveness of laws governing civil service administration, 2009

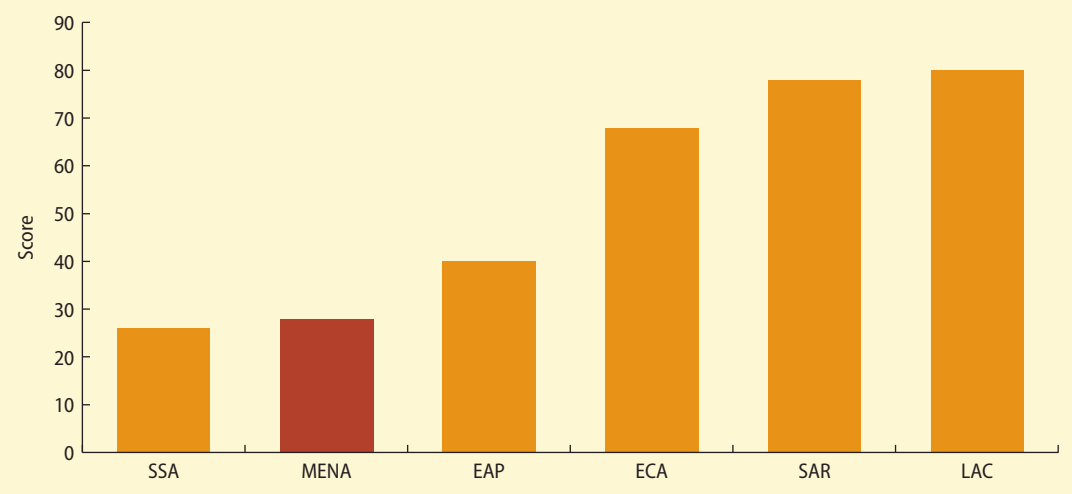


Source: Global Integrity Index, 2009.
Note: Score: very strong (90–100); strong (80–89); moderate (70–79); weak (60–69); very weak (below 60). EAP = East Asia and Pacific; ECA = Europe and Central Asia; LAC = Latin America and the Caribbean; MENA = Middle East and North Africa; SAR = South Asia; SSA = Sub-Saharan Africa.

law in 2007, but the information council responsible for the implementation and promotion of access to information never received funding from the state budget; the scope of information designated as "classified" remained broad; the personal data required to request information appeared excessive; and a large swath of the population, including officers in 50 percent of Ministries and 40 percent of journalists, had no knowledge of the law as late as 2010.[5] Lebanon, Morocco, and Qatar lack the relevant legislation. In Lebanon, a law proposed in 2009 remains stalled. In Morocco's 2011 constitution, Article 27 states that citizens cannot be denied access to public information except when access threatens national security or private life, but no legislation further defines or guarantees public access to information (Almadhoun 2012). Civil servants who provide the general public with information can be sanctioned under vague legislation governing the treatment of official data and information, as in Egypt. Further undermining the use of information are legal provisions on libel and slander that too often are used against citizens who criticize government officials. Such treatment is a strong disincentive to filing complaints related to the poor delivery of services.

Indeed, the MENA region lags notably behind the rest of the world in transparency. On the 2009 Global Integrity Index, the region ranked among the lowest on the public access to information indicator (figure 5.6), the legal right to access information, and whether the right of access to information is effective. So, too, the Open Budget Index

FIGURE 5.6 Public access to information: All regions, 2009



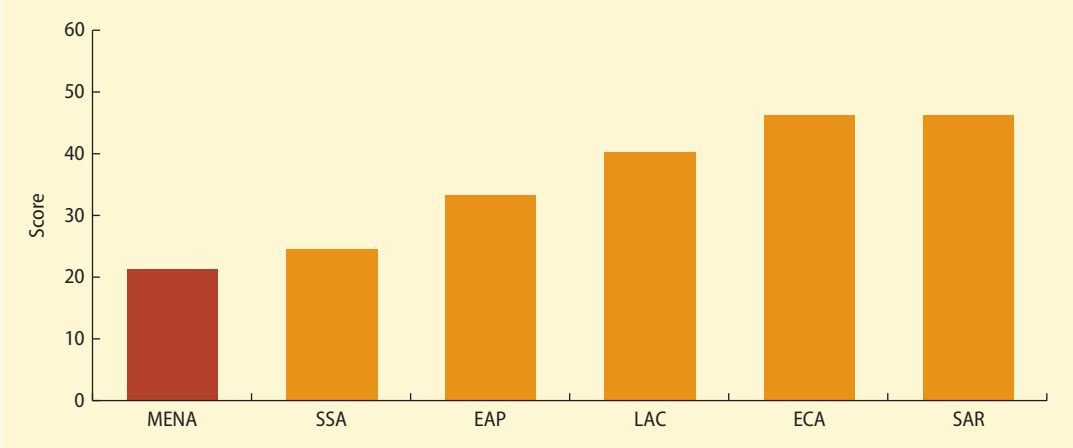
Source: Global Integrity Index, 2009.
Note: Score: very strong (90–100); strong (80–89); moderate (70–79); weak (60–69); very weak (below 60). EAP = East Asia and Pacific; ECA = Europe and Central Asia; LAC = Latin America and the Caribbean; MENA = Middle East and North Africa; SAR = South Asia; SSA = Sub-Saharan Africa.

ranks the MENA region acutely low on participatory budget indicators and does not rank the region at all on the citizens' budget indicator, which reflects the existence of a publicly available, simplified budget document that uses nontechnical language and accessible formulas to facilitate citizens' understanding and engagement (figure 5.7). The Open Data Barometer (2013) found that most MENA countries ranked below the world average on their readiness to implement reforms (figure 5.8) and give citizens the rights and freedoms to use data to hold governments accountable. It also found an absence of strong rights to information for citizens (figure 5.9). Meanwhile, the region also falls behind the world average on the availability of data on the performance of health and primary and secondary education services (Davies 2013).

The MENA governments have made positive strides toward recognizing that connectivity and digital development can facilitate faster and more direct access to services and information, but their levels of digital development vary widely across and within MENA countries. High-income countries have achieved high levels of connectivity and penetration rates, whereas the other MENA countries are struggling with building these connections. The challenges to digital development vary across the region. Lebanon, for example, has the human capital and capacity to implement digitized government services, but it lacks the financial capability and political stability needed to adopt and implement digitization initiatives. Elsewhere, human capital is in short supply. The MENA countries also face issues such as the human and resource capacity of their Ministries, their information and communications technology infrastructure, data protection, consumer rights, and information technology security standards in order to build greater trust between users and service providers.[6]

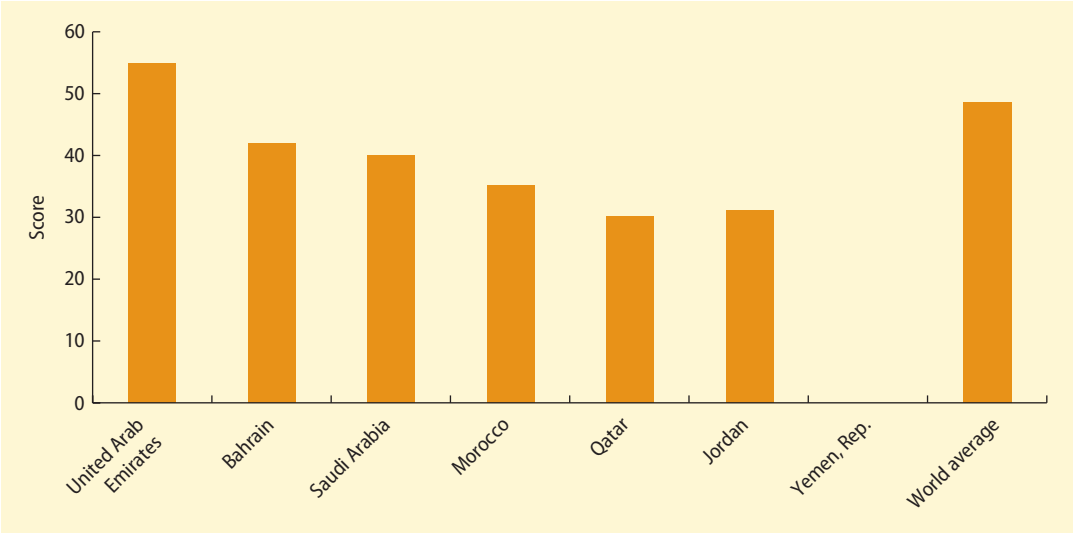
The MENA countries thus vary significantly in their e-governance readiness and implementation. The United Nations' e-government development index (EGDI) is a composite measure of three important dimensions of e-government: provision of online services, telecommunication connectivity, and human capacity. According to the EGDI, Bahrain is among the top 25 EGDI world leaders, ranking 18th out of 144. Bahrain is

FIGURE 5.7 Open budget index: All regions, 2013



Source: Open Budget Index, 2013.
Note: EAP = East Asia and Pacific; ECA = Europe and Central Asia; LAC = Latin America and the Caribbean; MENA = Middle East and North Africa; SAR = South Asia; SSA = Sub-Saharan Africa.

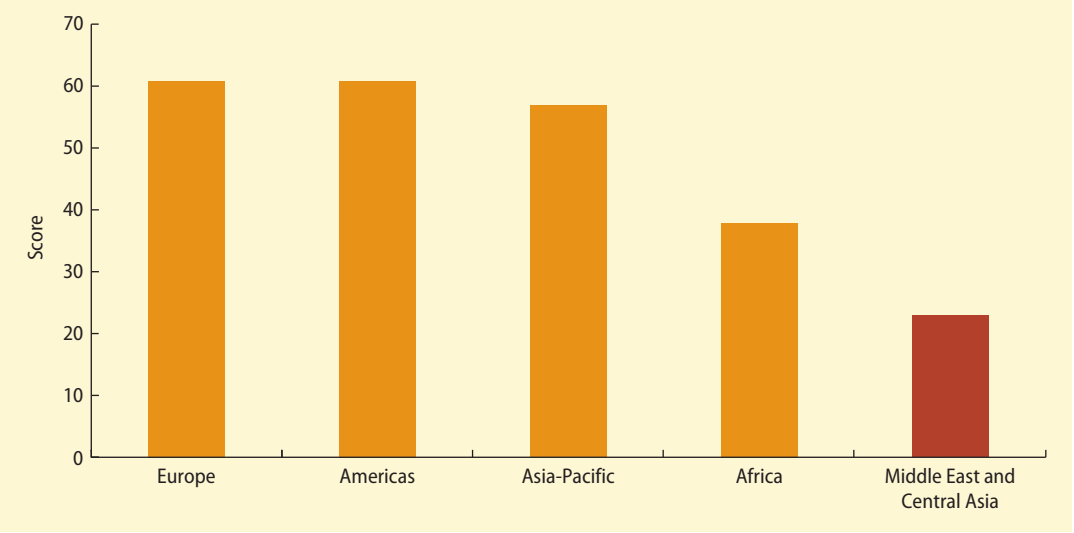
FIGURE 5.8 Readiness subindex: Selected MENA countries and world average, 2013



Source: Open Data Barometer, 2013.
Note: The value for the Republic of Yemen is zero. The readiness subindex has three main components: (1) government capacity and the presence of government commitments to open data; (2) citizen and civil society freedoms and engagement with the open data agenda; and (3) available resources for entrepreneurs and businesses to support economic reuse of open data and to catalyze intermediary actions (Davies 2013).

followed by other member countries of the Gulf Cooperation Council (GCC): the United Arab Emirates, 32nd; Saudi Arabia, 36th; Qatar, 44th; Oman, 48th; and Kuwait, 49th. The other MENA countries are ranked closer to the center: Tunisia, Egypt, and Morocco are 75th, 80th, and 82nd, respectively, and toward the bottom are Libya, ranked 121st, and Algeria, 136th. All countries in the region, with the exception of the United Arab Emirates and Algeria, have moved up in the rankings, demonstrating

FIGURE 5.9 Right to information law index: All regions, 2013



Source: Open Data Barometer, 2013.

their commitment to improving e-government services across the region. In other assessments of digitized government[7] services, the United Arab Emirates ranked third and Saudi Arabia ranked fifth among the top 10 leading countries providing digitized services. The high ranking of the United Arab Emirates is attributed to initiatives such as the Emirates Government Service Excellence Program, which was established to standardize service quality, ensure consistency in customer experience across service centers, and promote cost efficiency. Based on citizen satisfaction surveys conducted by Accenture (2014), the United Arab Emirates also ranked as the top leader in citizen satisfaction and engagement. The citizens of the United Arab Emirates are aware of the importance of digital channels in improving service quality and outcomes, and, as a result, they have become confident of their government's ability to meet the challenges that may arise in the process. In Saudi Arabia, a number of public services are available through digital channels. For example, the Ministry of Labor and the Human Resources Development Fund developed a Virtual Labor Market ecosystem that serves all stakeholders in the labor market. Another example of digitalizing government services in the region is Morocco's development of an e-consultation platform through the website of the Secrétariat Général du Gouvernement. Citizens can access legislative texts online, read and download them, and post their comments and concerns.

Although some e-government services are provided in the MENA region, the lack of information needed to assess and monitor local service provision remains a problem, hindering the ability of civil society organizations and the media to play watchdog and advocacy roles. Indeed, in the MENA region, civil society organizations and the media do not enjoy the freedom and the ability to exercise real pressure on the state. Citizens' rights to protest and demonstrate, and to voice demands through the media, are restricted by law and in practice. Despite the exponential increase in civil society organizations in the Middle East following liberalization over the last two decades, the ability of associations to mobilize and voice critical demands remains limited. They continue to operate under highly restrictive legal frameworks that allow considerable scope for government entities to

interfere in their activities. Egypt is an example of severe restrictions, and even in Qatar, which enjoys a particularly positive rating on corruption indexes, Law 12 (2004) prohibits civil society organizations from focusing on corruption (Business Anti-Corruption Portal 2014). There are important exceptions, of course, such as Al-Bawsala in Tunisia and the Leaders of Tomorrow in Jordan, but, in general, civil society is weak and disconnected. As Jordan's director of civil society organizations at the Ministry of Political Development explained in 2010, "apart from having some scattered operations and state sponsored clubs, they pretty much have nothing else."[8]

Lack of external accountability mechanisms

Justice sector services, when implemented properly, provide accountability tools for citizens to hold service providers accountable for poor or undelivered services. These tools can be used in three primary ways: (1) for citizens filing complaints for poor or nondelivery of services; (2) for individual or group complaints from service providers (such as doctors, nurses, or teachers) about the poor working conditions under which services are provided; and (3) for public interest litigation to force governments to enforce constitutional and other rights to education and health care. Public interest litigation—bringing cases against government that affect a high number of beneficiaries "for the public good"—could be used to force governments to improve service delivery frameworks when constitutional rights are involved. But such actions in the MENA region remain rare because citizens have not yet benefited from litigation, unlike those of other countries such as India and South Africa (Brinks and Gauri 2014). Indeed, in the MENA countries, the justice system fares poorly in terms of cost, ease of access, speed proceedings, and corruption.

Comprehensive data on complaints from citizens about the delivery of education and health services are scarce, but the limited official data and anecdotal evidence suggest that both sectors are considerable sources of complaints for both service users and service providers. A household survey conducted in Jordan in 2012, the Statistical Survey on the Volume of Demand of Legal Aid Services, found that 6 percent of civil legal problems involve access to health care, primarily related to medical negligence. Those respondents in the lowest two expenditure quartiles, which represent the poor and much of the near-poor, were more likely to report legal problems related to health care.

Citizens do file complaints in attempts to hold service providers accountable. For example, in Jordan in 2010, the Ombudsmen Bureau reported that the Ministry of Education received the second highest number of complaints for maladministration of any public sector entity, just behind the Civil Service Bureau. The Ministry of Health received the sixth highest number of complaints. More than 44 percent of complaints about the Ministry of Education were related to the hiring, promotion, and assignment of teachers and administrative staff. In 2010 the Ministry of Education also received 31 complaints, including through its complaints hotline, related to the physical and verbal abuse of students. However, according to the National Centre for Human Rights, no effective actions were taken against the education staff alleged to have committed abuses. The National Centre for Human Rights received only 41 complaints in 2010 and 44 in 2009 related to access to health care services—a relatively small number in view of the magnitude of health care services. Meanwhile, complainants are subjected to some risk. In 2010, 38 teachers protesting for better working conditions were temporarily suspended by the Ministry of Education.

Executive authorities also have a tradition of appointing politically dependent judges and continually meddling in the jurisdictions of courts (World Bank 2003). As a result, the judicial branch is an instrument the executive can use to legitimize its political ambitions (Jabbour and Yamout 2012). Independent audit agencies, inspectors-general, anticorruption commissions, and ombudsmen lack sufficient resources,

authority, and autonomy, and their assessments are not always disclosed to the public or followed up by the state (World Bank 2003). Even when decisions are issued in favor of citizens, they remain difficult to enforce. Thus external audits emerge as ineffective and incapable of detecting corruption practices, further contributing to weak policy implementation.

An ombudsman office, *waseet eljumhuria*, is normally set up by the state to investigate individual citizens' complaints of maladministration, especially that of public authorities. The offices established in Jordan, Lebanon, Morocco, and Tunisia illustrate the lack of sturdiness of such offices in the context of weak, politically captured institutions. In Jordan, the ombudsman was established to examine complaints from individuals relating to any decree, procedure, practice, or act of refusal by the public administration and to help citizens access information withheld by government agencies (Almadhoun 2012). But the ombudsman's bureau has been annulled and merged with the Anti-Corruption Commission (ACC), and its staff has been transferred to the ACC after little more than four years in existence, according to an article in the June 2013 *Jordan Times* (Abu Nimah 2013). In Lebanon, evidence on the ground points to the limited effectiveness of the ombudsman, bound by vague legal frameworks. For example, Law 664 (2005), which established the office, is still lacking the implementing ordinances (Almadhoun 2012). In Morocco, the Office of the Ombudsman is relatively effective and releases its information publicly. However, it still lacks the authority to initiate investigations and impose penalties (Global Integrity 2010). In Tunisia, the National Ombudsman Service was loyal to the ruling party under the regime of President Zine El Abidine Ben Ali. The new ombudsman is emphasizing the principle of establishing a dialogue between the public administration and society.

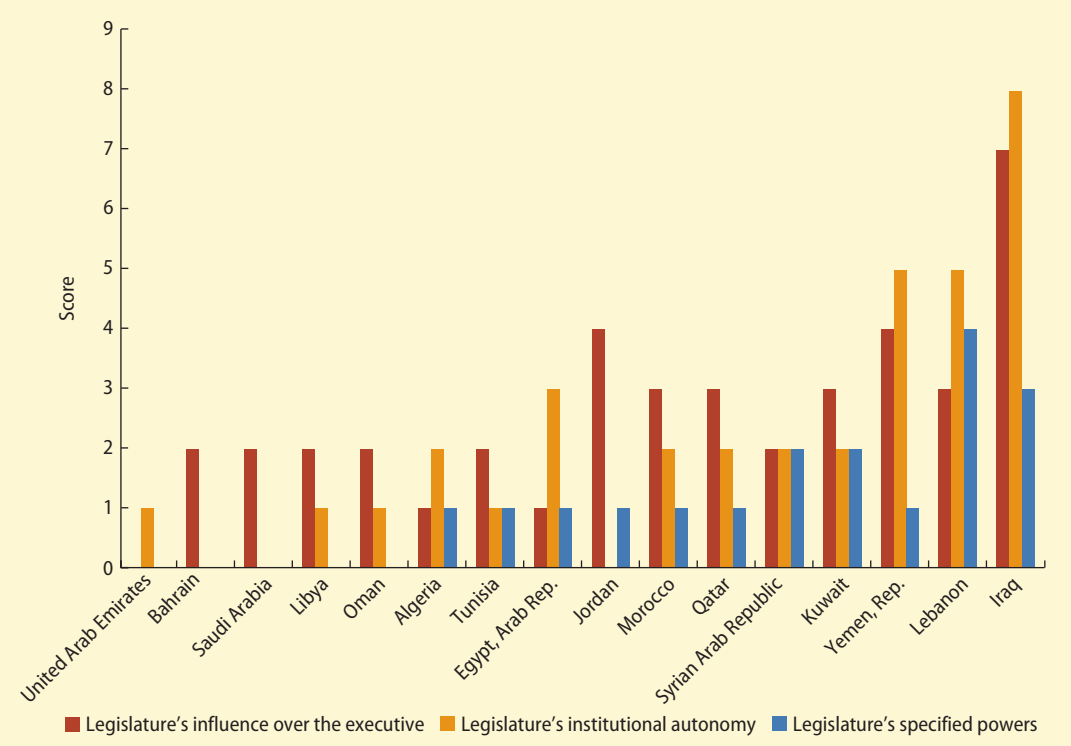
The agencies designed to address corruption are rarely independent. Egypt has four anticorruption agencies: the Transparency and Integrity Committee, Administrative Control Authority, Administrative Prosecution Authority, and Illegal Profiting Apparatus (Business Anti-Corruption Portal 2014). However, they are all closely linked to the president, prime minister, or minister of justice. Furthermore, their annual reports are not made public; they are presented only to the president, minister of justice, or minister of interior (Business Anti-Corruption Portal 2014). In Jordan, the law stipulates that the Anti-Corruption Commission must be financially and administratively independent of executive interference. Nevertheless, Global Integrity (2011) has reported that the commission is not entirely free from political interference and that appointments can be based on loyalties, nepotism, and favoritism.

The poor, who are perhaps the most dependent on state-run education and health services, face considerable obstacles in accessing justice institutions because of a combination of lack of financial resources and poorly targeted services intended to benefit them. Not all MENA governments provide legal aid services to the poor for civil cases, which include education and health care. For those that do, services exist primarily on paper but are rarely implemented in practice (Prettitore 2012). In countries such as Jordan, where court fees are relatively high, the process of waiving fees based on poverty involves vague criteria on establishing poverty status and cumbersome procedures that involve gathering multiple documents from various government entities. The Statistical Survey on the Volume of Demand for Legal Aid Services conducted by the Department of Statistics and the Justice Center for Legal Aid in Jordan in 2012 found that over 90 percent of respondents were unaware of available legal aid services (Prettitore 2013). Administrative courts are often present only in the capital city, requiring those in other areas to travel long distances with the associated costs for travel. They also often have higher fees and require specialized legal representation, thereby prompting citizens to attempt instead to resolve problems through *wasta*, a form of clientelism described later

in this chapter. Other vulnerable groups such as refugees often face additional legal and practical obstacles that are not fully addressed by the existing services. Comprehensive data on the extent of legal aid and the court deferment services provided through the courts are lacking. Anecdotal evidence suggests that the provision of services is not widespread, at least in relation to demand (Prettitore 2012).

Finally, legislatures in the MENA region are heavily constrained and thus limited in their abilities to initiate reform (Fish and Kroenig 2009). At the national level, parliaments have little legislative power—many are unable to draft legislation and are easily dismissed by more powerful executives (see figure 5.10). Parliaments also experience frequent turnover and have weak legislative support systems. For example, although some parliaments in the MENA region have the authority to approve the state budget, they must review it over a short period, and it is often drafted in vague language and requires intensive work to ascertain its details. Parliamentarians therefore have only limited influence over the outcome (World Bank 2003). The external audit process, carried out to provide a parliament with reassurances on the adherence to financial laws, is often weak and ineffective as well, in part reflecting the restricted role that parliaments play in providing oversight. Because of the ineffective checks and controls at every step of the budget cycle,[9] parliaments are unable to detect corrupt practices associated with government expenditure, further contributing to weak policy implementation.

FIGURE 5.10 Legislative influence, autonomy, and power: MENA region, 2009



Source: Fish and Kroenig 2009.
Note: Legislative influence, autonomy, and power are measured as the number of powers of the legislature over the executive, the extent of institutional autonomy of the legislature vis-à-vis the executive, and the number of specified powers held by the legislature. Score: 0 (least powerful) to 9 (most powerful).

The role that parliaments, or more precisely parliamentarians, play in providing services is one that reflects the weakness of political institutions, not the importance of parliament. Because of the state's opacity and lack of accountability, citizens seek intermediaries who can help them access services. Parliamentarians use their positions to pressure ministers and bureaucrats to dispense jobs, licenses, and other state resources to their constituents, becoming service providers to certain groups rather than providing legislative or executive oversight. They may not be able to legislate more effective public services administration, but parliamentarians can use their position to help provide such services.[10] In Jordan, for example, many citizens call members of parliament *na'ib khadmat*, or service parliamentarians, "signaling the perception that their primary role is to help their constituents obtain employment, access to health care, education, and other services, or necessary permits and licenses from the government bureaucracy" (Lust, Hourani, and Al-Momani 2011).

Candidates typically compete in terms of their ability to offer patronage and public employment to their supporters or to intervene in the bureaucracy to solve individual constituency problems or deliver club goods rather than in their ability to deliver public goods and services more efficiently and effectively to the citizenry at large (Sakai 2001; Lust 2009; Cammett 2009; Kao 2012). As Corstange (2011) has argued about Lebanon and the Republic of Yemen, "politicians spend most of their time jockeying on behalf of constituencies based on sect, tribe, extended family, and region over who gets hired into the civil service, where the roads get paved, and who keeps their electricity longest." In doing so, they not only undermine the role that parliaments could play in developing policies that ensure better transparency, oversight, and enforcement of service provision, but also reinforce social institutions that, at least in the MENA context of clientelism, undermine development of strong administrative and political institutions and equal access to services.

In short, the MENA region suffers from weak, captured political institutions that undermine voice and accountability. Indeed, the World Bank's Voice and Accountability measures in its 2012 Worldwide Governance Indicators (figure 5.11) continue to find the MENA region the most restrictive in the world. On a scale ranging from –2.5 (most restrictive) to 2.5 (most permissive), no MENA country received a positive rating, and the region had the lowest average rating. There is some variation across the region, as demonstrated in figure 5.10, and certainly Tunisia (after 2011) stands as an exception. In general, however, citizens in the MENA find it difficult to hold policy makers and service providers accountable.

Administrative institutions

Weak, politically captured regimes are coupled with—and compound—ineffective administrative systems and accountability mechanisms. Accountability mechanisms within bureaucracies, the command and control elements of public administration, encompass Weberian notions of hierarchy, rules, and regulations, in addition to market-driven concepts and practices such as personnel management, performance evaluation, auditing, and monitoring (Blind 2011). In the MENA region, the highly centralized system just described leaves both administrators and providers with little autonomy to enforce rules, manage human and financial resources, or develop solutions. Moreover, political capture has promoted a system in which there is a general lack of clear information on performance that can be used for monitoring and evaluation, few consequences when violations occur, and a general absence of incentives for providers and administrators.

Lack of coordination and insufficient capacity for performance management

Within the public sector, policy and cabinet coordinating mechanisms are generally weak. In many countries, Ministries at the central level are responsible for formulating and

FIGURE 5.11 Index of extent to which citizens can participate in government selection and freedoms of expression, association, and media: MENA and other regions and selected MENA economies, 2012

Source: Worldwide Governance Indicators, 2012.
Note: Score: −2.5 (most restrictive) to 2.5 (most permissive). AU = Australia and Pacific; EA = East Asia; EE = Eastern Europe; LA = Latin America; MENA = Middle East and North Africa; SA = South Asia; SEA = Southeast Asia; SSA = Sub-Saharan Africa; WE-NA = Western Europe and North America.

implementing national policies and monitoring and evaluation. However, this distribution of operational activities often comes at the expense of coordinated strategic actions and vision. Initiatives that require developing common policies and shared vision and coordination across Ministries, agencies, and departments often struggle. For example, El-Jardali et al. (2012) found, using a purposive sample across 11 eastern Mediterranean countries, that the majority of policy makers cited lack of coordination among government entities and lack of coordination between government and service providers as a

primary hindrance to the use of evidence in health policy making.

The lack of coordination often results in the overlap of responsibilities for policy implementation across the Ministries of Health, Education, Finance, and Planning (Jabbour and Yamout 2012). For example, poorly functioning communication lines between the Ministries of Education and Health might result in the latter building medical and nursing schools without any needs assessment. The lines of communication between the Ministry of Health and the Ministry of Finance are not straightforward and may not connect the budget allocation process with health care priorities. In many countries, the final decision-making authority on health lies not within the Ministry of Health but within the Ministries of Finance and Planning, adding another layer to the decision-making process. In addition, many Ministries struggle with the legal aspects of hiring, such as the scope of practice, job description, performance evaluation, and licensing, without a clear understanding of the criteria used.

Services also suffer from the lack of coordination within Ministries. For example, in Morocco the lack of integration and communication within the Ministry of Health and across different levels of care has led to a structural resource misallocation in the health system, contributing to the overuse of hospitalization and emergency services. According to a 2009 survey in Morocco (World Bank 2013), 54 percent of patients were referred to a hospital for the same care they could have received at an outpatient clinic at a lower cost, resulting in a loss of efficiency.

Moreover, the system for policy implementation and service delivery has an insufficient capacity for performance management. With some exceptions (such as the United Arab Emirates), government agencies do not regularly produce clear performance criteria against which their efforts could be independently monitored and benchmarked. Nor do government offices at the cabinet level typically monitor performance data on a regular basis. The same is true of Ministries of Public Administration and Administrative Reform.

A World Bank review of performance management policies along the entire employment cycle of a civil servant at Tunisian's Ministry of Industry reveals that the country's legal framework for public sector performance management is in principle well designed and set up for recruiting the most qualified candidates and promoting high-performing employees. However, in reality the system suffers from structural weaknesses on four main fronts: (1) recruitment—although competitive recruitment remains the main recruiting method, the significant recent increase in other methods such as direct recruitments and regularizations indicates a deterioration in the quality of competencies recruited and in the supervision rate; (2) evaluation—the evaluation method, which consists of an annual professional rating and a quarterly performance rating, suffers from lack of transparency and objectivity and from grade inflation; (3) compensation—the system remains complex, and the link between performance rating and compensation remains weak, rendering professional evaluation criteria irrelevant; and (4) promotions—application-based promotions are subjective and emphasize seniority over performance (Brockmeyer, Khatrouch, and Raballand 2014).

Although such challenges have been identified in past reforms, attempts to address them have been largely unsuccessful, requiring a better understanding of the broader political economy environment governing reforms.

Centralization of service delivery

According to Tosun and Yilmaz (2008, 8), "In all [MENA] countries, the deconcentrated units of the central government provide a big chunk of public services, including education and health, under strict guidance of the central government." As shown in tables 5.1 and 5.2, with a few exceptions such as Lebanon, the Ministry of Education assumes all the key responsibilities: policy making, financing, and service delivery. The health system in the MENA

Table 5.1 Division of responsibility among central ministries, provincial and regional administrations, and schools on policy setting, planning, finance, human resource management, and pedagogy: Selected MENA countries, 2014

	Algeria[a]	Djibouti	Egypt, Arab Rep.	Iran, Islamic Rep.[b]	Jordan	Lebanon	Morocco	Tunisia	Yemen, Rep.
Policy									
National strategy	CMs	CMs	CMs	CMs	CMs	CMs	CMs	CMs	CMs
Action plan	CMs	CMs	CMs	CMs	CMs	CMs	CMs	CMs	CMs
Planning									
Creation and closure of primary schools	CMs, PRAs	—	CMs, PRAs	CMs	—	CMs	CMs, PRAs	CMs, PRAs	CMs, PRAs
Establishment of input and infrastructure norms	CMs	CMs	CMs	CMs	—	CMs	CMs	CMs	CMs
Finance									
Resource allocation		CMs	CMs	CMs, PRAs[c]	CMs	CMs	CMs, PRAs[d]	CMs	CMs
Human resource management									
Selection of primary and secondary school directors	PRAs[e]	CMs	CMs	Schools	CMs	CMs	CMs	CMs	CMs, PRAs
Recruitment of teachers	CMs	—	CMs	PRAs	CMs	CMs	CMs	CMs	CMs, PRAs, schools[f]
Management of in- and preservice training	CMs, PRAs	CMs	CMs	PRAs	—	—	CMs	CMs, PRAs[g]	CMs, PRAs
Establishment of teacher responsibility	CMs, PRAs	—	CMs	PRAs	CMs, schools	CMs	CMs	—	CMs
Supervision of teachers	PRAs, schools	PRAs	PRAs	Schools	CMs, PRAs	CMs, schools	PRAs	PRAs	CMs, PRAs
Pedagogy									
Definition of curriculum and textbook context	CMs	CMs	CMs	CMs[h]	CMs	CMs	CMs	CMs	CMs
Setting standards and exam management	CMs	PRAs	PRAs	CMs	CMs	CMs	CMs, PRAs	CMs	CMs, PRAs

Source: Framework adapted from World Bank (2008).
Note: Information was updated to 2014 when possible. CMs = central Ministries; MENA = Middle East and North Africa; PRAs = provincial and regional administrations; — = not available.
a. Information dates back to 2005.
b. Information dates back to 2005.
c. In the Islamic Republic of Iran, resources are determined by the central Ministry, but the allocation to schools is determined at the regional level.
d. In Morocco, regional levels (academies) have a say in some resource allocations, including school improvement plans.
e. In Algeria, primary school directors are appointed at the regional level, but secondary school directors are appointed by the Ministry of Education.
f. In the Republic of Yemen, according to the SABER Teacher Policies (http://saber.worldbank.org/index.cfm?indx=8&tb=1), statutory law suggests that schools are entitled to hire and fire teachers, and yet this is rarely practiced.
g. In Tunisia, preservice training for teachers is administered by the Ministry of Education, but in-service training is administered regionally.
h. In the Islamic Republic of Iran, the curriculum is determined by the Ministry of Education, but the curriculum for preprimary education is determined regionally.

Table 5.2 Division of responsibility among the central ministries, provincial and regional administrations, and health facilities on policy setting, planning, finance, and human resource management: Selected MENA countries, 2014

	Djibouti	Egypt, Arab Rep.	Jordan	Lebanon[a]	Morocco	Tunisia	Yemen, Rep.
Policy							
National strategy	CMs	CMs	CMs	CMs	CMs	CMs	CMs
Action plan	CMs	CMs	CMs	CMs	CMs	CMs	CMs
Planning							
Creation and closure of health facilities	CMs	CMs	CMs	CMs	CMs	CMs	CMs
Establishment of input and infrastructure norms	CMs	CMs	CMs	CMs	CMs	CMs, PRAs	CMs
Finance							
Resource allocation	CMs	CMs, PRAs[b]	CMs	HFs	CMs, PRAs	CMs	CMs
Human resource management							
Selection of health facilities' directors	CMs	PRAs	CMs, PRAs	HFs[c]	CMs	CMs	PRAs
Recruitment of health personnel	CMs	CMs	CMs	HFs	CMs	CMs, PRAs	PRAs
Firing of staff	CMs	CMs	CMs	HFs	CMs	CMs, PRAs	PRAs
Management of staff training and professional development	CMs	CMs, PRAs	CMs, PRAs	HFs	CMs	CMs	CMs, PRAs
Standard setting and performance criteria	CMs	CMs	CMs	HFs	CMs	—	CMs
Supervision of staff	CMs	CMs, PRAs[d]	CMs, PRAs	HFs	PRAs	CMs, PRAs	CMs, PRAs

Source: Framework adapted from World Bank (2008).
Note: Information was updated to 2014 when possible. CMs = central Ministries; MENA = Middle East and North Africa; PRAs = provincial and regional administrations; HFs = health facilities; — = not available.
a. In Lebanon, the 1996 Law No. 544/96, Public Hospital Autonomy, was aimed at enhancing the performance of public hospitals by granting them financial and managerial autonomy and the flexibility for better procurement and recruitment of qualified personnel, thereby also giving them an opportunity to be competitive with the private sector. Currently, appointments of administration board members for public hospitals are issued by government decrees. The appointed board is autonomous, meaning the financial risk is shifted from the central administration down to the level of hospital management, with financial autonomy (control over budget) and administrative autonomy (control over staff management and hiring and firing decisions) at the hospital level, with the exception of one hospital (Ammar 2009).
b. In Egypt, most resources are allocated at the regional level, and yet a considerable amount is allocated centrally through the Ministry of Health such as for capital expenditures.
c. Although the 1996 decree states that a hospital manager is to be appointed by the hospital board, "the practice has ranged from the board making recommendations that the MOH may or may not accept, to a local political leader submitting one name to the Minister of Health, who then recommends the appointment without consulting with Ministry cadres nor with the hospital board, nor with the MOH division in charge of public hospitals" (Eid 2001).
d. In Egypt, medical staff members are monitored technically by means of the central Ministry and the relevant professional syndicate (union) through its local branches. Administrative and financial reporting are carried out by the regional administration.

region is organized in a similar fashion. The Ministry of Health is considered the principal governing body of the health system and has the mandate for health policy making, planning, regulation, monitoring, and evaluation and for ensuring access to essential health services (Jabbour and Yamout 2012).

Administrators and providers have little control over the management of financial resources. According to data gathered in the 2010 Egypt Health and Governance Study (EHGS), few health facilities have the flexibility of their own budget and line item allocations: only 3 percent of surveyed facilities reported they had their own budget, and 33 percent of facilities were receiving their budget from the Ministry of Health. Among the few (n = 11) facilities that had their own budget, just over half were able to freely allocate between budget items. The budgets of these facilities were mostly allocated for nonmedical supplies, and few contained line items for medications, personnel, payroll, contract service, or general expenditures. School financing is also highly centralized in the Republic of Yemen, where budget decisions are made through a collaborative process involving central, governorate, and

district-level education, administration, and finance entities, and individual schools have no role in their own budgeting process.

Local administrators also have little decision-making authority over the hiring, firing, and training of staff. In Egypt, for example, the distribution of teachers across governorates is controlled centrally, based on the number of registered pupils, and the governorate distributes teachers to schools under its jurisdiction (UNESCO 2010/11). Teachers hired on an open-ended contract can be fired only by the Educational Directorates, but teachers who are hired on a fixed-term contract can be fired by the local educational authorities as well (Systems Approach for Better Education Results, SABER). No facility surveyed in the EHGS sample could dismiss a person for bad performance. In Egypt, the district also decides if and what training staff receives, with mandated Ministry and governorate approval for certain levels of training and grades of staff. Similarly, in the Republic of Yemen, school principals have little or no authority over hiring and firing decisions or teacher assessments.

The development of curricula and pedagogy is also highly centralized. In Egypt, the Ministry of Education is responsible not only for educational policy and its implementation, but also for determining curricula and textbooks and approving teacher qualifications. Curriculum development is carried out with the participation of teachers and other school-level stakeholders, but they do not exercise final decision-making power. In the Republic of Yemen, according to SABER, no curriculum setting occurs at the subnational, governorate, or local levels. Teachers cannot design the curriculum, and their autonomy in choosing teaching methods is limited, but they do have full autonomy in grading students and deciding whether a student should repeat or fail a grade.

Tables 5.1 and 5.2 expand more thoroughly on the level of decentralization in the public education and health systems in selected MENA countries. They do so by providing a clear picture of the division of responsibilities on five indicators (policy setting, planning, finance, human resource management, and pedagogy) among the central Ministries, provincial and regional administrations, and health facilities/schools. The tables also illustrate the degree of financial and managerial autonomy for each. As explained earlier and shown in both tables, the public education and health systems remain heavily centralized in the MENA region.

Weak budgeting practices and information management systems

The lack of an explicit performance orientation in the internal budget processes of all MENA countries further weakens internal accountability. The traditional input-based budget common in many countries throughout the region does not provide policy makers with information on what goods, services, or policies are being financed by government expenditures. In the absence of this information, attempting to ensure the efficiency and effectiveness of expenditures is a challenging task. Consistent with the broader global trends in the member countries of the Organisation for Economic Co-operation and Development (OECD) and elsewhere, many MENA countries have sought to restructure incentives for performance through their budgeting process in the hope of aggregating the inputs used to deliver a particular group of activities.[11] To date, however, limited progress has been achieved across MENA countries.

The slow progress in introducing a performance-based approach stems in large part from the fact that many of the basic elements of the public financial management (PFM) system must be put in place before it can work effectively. Often these weaknesses are fully recognized only when work begins on a pilot. In Syria in 2008, for example, work with pilot Ministries revealed that, in addition to the standard dual budgeting problem, a large portion of the sectoral expenditure in education and in agriculture was fragmented between the relevant sector Ministry and the Ministry of Local Administration. In the West

Bank and Gaza, it is recognized that the accounting systems need to be modified to allow programs to be monitored during execution of the budget. Although charts of account changes[12] are manageable, the accounting system would not be able to manage complex cost allocations.

Another challenge is to avoid a situation in which a reform becomes an information collation exercise, thereby losing sight of the objectives. When fully developed, a program structure can involve a range of subprograms and activities. Combined with the associated performance indicators, the information demands can be extensive. This approach might make sense in a well-developed budget system in which skilled staff can use the information effectively. However, in an environment in which the capacity to prepare and use the information is constrained, the data collation process can become an end in itself. This was a criticism of the initial work on the results-oriented budgeting in Jordan carried out from 1998 to 2004. In Morocco, the initial budget documents included hundreds of input or output indicators, but little attention was paid to them.

As a result of these challenges, in spite of the considerable interest in MENA countries in introducing a performance-focused approach to budgeting, success has been limited to date, and the time frame for effective implementation has been consistently extended. Performance budgeting reforms are complicated and difficult, in part because they rely on having many other elements of the PFM system functioning at the level of a reasonable standard and in part because a broader demand for the data being produced is needed. It is possible that such reforms will produce higher returns in the future, particularly in countries such as Jordan or Morocco that have been working to implement them for some time. However, to date these reforms have still not proven to be a simple or direct route to pressuring line departments to improve their performance.

In addition, weak information systems hinder the ability of policy makers to make evidence-based decisions and constantly monitor the performance of administrators and providers. For example, Morocco's health information system suffers from uncoordinated and duplicated parallel systems, lack of standardized terminology, lack of skills for managing databases and data processing, underutilization of the available information, inadequacy of data production for the needs of decision makers, and lack of regular updates and rigorous data (World Bank 2013). This weak system hinders policy makers' routine access to reliable information on the health status of the population, risk factors, utilization of services, resource flows, and provider performance.

Administrators—Limited in their ability to hold service providers accountable

Evaluation of education and health services at the point of delivery largely fails to lead to improvements in service. In many places, evaluation simply does not take place or is not captured in the data available. In others, where evaluation systems reportedly exist, there are generally few consequences, either positive or negative, in response to such reviews.

In education, despite clearly stipulated minimum scores for both internal and external evaluations and well-articulated consequences for poor assessments, teachers appear to be minimally assessed. For example, according to SABER, at the national level in Egypt, the last round of external teacher evaluations was conducted in 2010. However, Egypt Education Community Scorecard (ECSC) data from schools in the Ismailia governorate of Egypt suggest that teachers in that governorate are evaluated even less frequently (Bold and Svensson 2010). Almost three-quarters (71 percent) of surveyed teachers reported that a quality assurance officer (QAO) had never assessed them. When assessments occurred, they were sporadic and infrequent: 19 percent of teachers reported they were visited once a year, 6 percent once a term, 7 percent once or more a term, and 12 percent less than once a year. Among those teachers who had been

assessed, only 21 percent reported that the QAO taught them any useful practices.

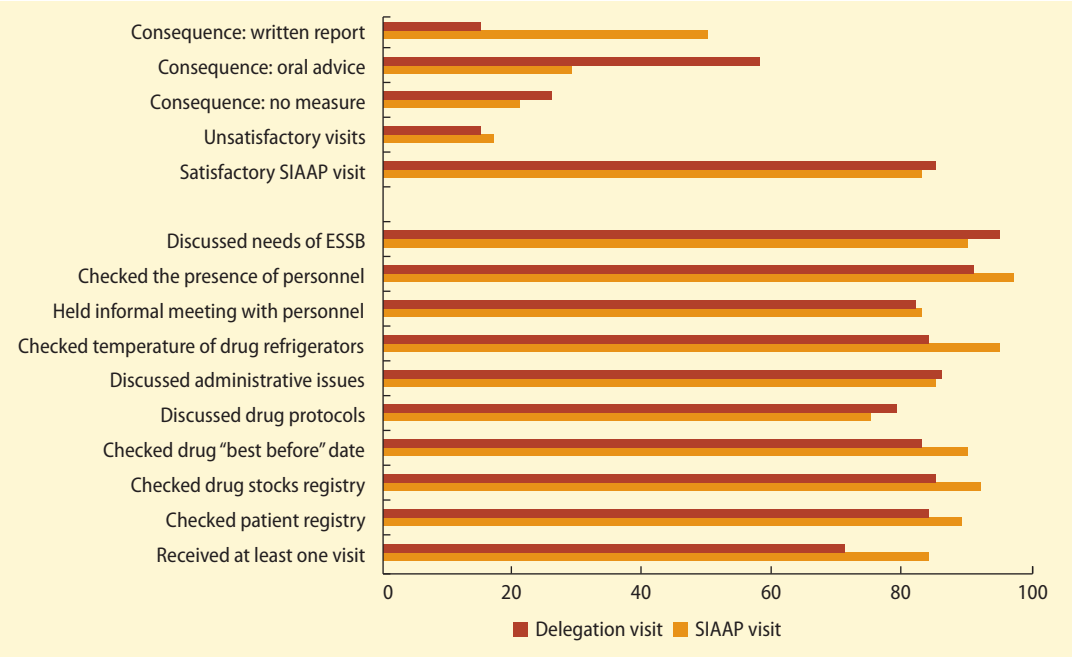
The Republic of Yemen is another example of weak oversight and incentives for education providers. Civil service regulations stipulated that a public school teacher's compensation package must be reduced in cases of absenteeism without valid cause or without previous notification. Absenteeism is to be reported to the Governorate Office of Education, an implementing agency within the Ministry of Education. However, the 2006 Public Expenditure Tracking Survey (PETS) found that of the schools surveyed in which an incident was reported, only 37 percent took any action, and most teachers were given only verbal or written warnings.

In health, the 2010 Egypt Health and Governance Study provides some clues about how health services delivery is evaluated. About half (57 percent) of facilities reported using a supervisory checklist for health system components and the provision of health services. However, the interviewer was able to see actual documentation in only about two-thirds of these cases. About half (46 percent) of facilities also reported conducting a facility-wide review of mortality, but documentation was available for only 70 percent of these facilities. Seventy percent of surveyed facilities reported a periodic audit of medical records or service registers, but documentation was unavailable for one-third of these audits. About three-quarters (76 percent) of facilities reported they had a quality assurance committee or team or a quality improvement program (75 percent) in place, but about one-fifth of each group (17 percent and 23 percent, respectively) were unavailable for observation by the interviewer. Only half (57 percent) of facilities could show the interviewer any financial data on the facility's expenses. These gaps could indicate lapses in the reporting, organization, or existence of mechanisms of quality management.

The 2011 Morocco PETS and 2011 Quantitative Service Delivery Survey (QSDS) provide details on supervisory visits conducted in one cadre of primary health facilities, *établissements de soins de santé de base*, or ESSBs (figure 5.12). These facilities receive two types of external supervisory visits that cover similar topics, yield similar results, and have similar geographic coverage, indicating significant duplication of efforts. ESSBs are visited by health program managers, allocated in every province, to supervise program drugs in terms of program implementation and material supplies to ESSBs. Health program drugs tend to be part of specific national health programs such as those for diarrhea, family planning, maternity, and acute respiratory infection. These programs are funded, allocated, and supervised by a division in the central administration of the Ministry of Health, as shown in figure 5.13. The visit is generally led by the head of the Provincial Service of Infrastructure and Ambulatory Care (SIAAP), who supervises program managers in the health delegation and is in charge of supervising ESSBs for medical matters. ESSBs also receive visits from the provincial health delegation, which supervises and manages administering other vital and essential drugs to ESSBs and other administrative matters (figure 5.13). Unsatisfactory SIAAP visits are more likely to be followed by a written report than are the provincial health delegation visits. However, because these visits are not typically surprise ones, the ESSBs have time to present their best (but not necessarily representative) face.

Procurement rules and processes are often not standardized, and procedures remain opaque to those managing procurement. For example, in Egypt the EHGS found that only about one-third (35 percent) of facilities reported standardizing their purchases. There is also little experience in using tenders or calls for bids on procurement, and only a minority of facility respondents were able to correctly describe the official procurement processes their facilities followed for all types of supplies, whether nonmedical supplies, medical supplies, or heavy equipment, most of which are managed on a monthly basis. Similarly, in Morocco the 2011 PETS indicated that drug management lacked standardization and clarity. There are

FIGURE 5.12 Percentage of duplication in supervisory visits to primary health facilities (ESSBs): Morocco, 2011

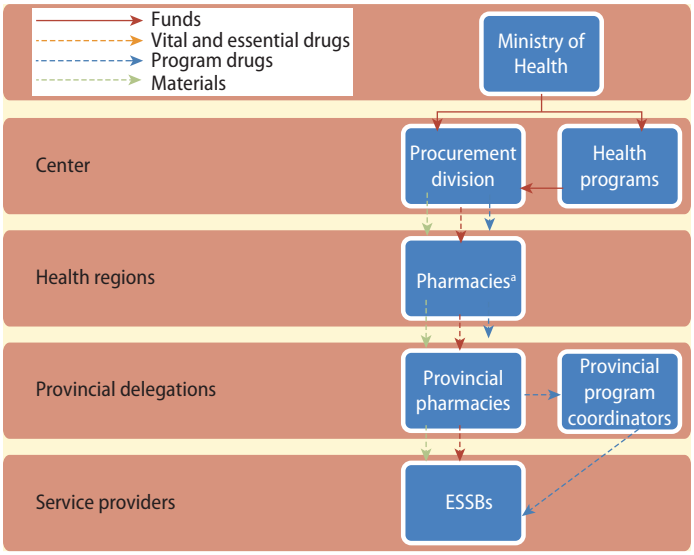


Sources: PETS (health), Morocco, 2011; QSDS (health), Morocco, 2011.
Note: ESSB = primary health facility (*établissement de soins de santé de base*); SIAAP = Provincial Service of Infrastructure and Ambulatory Care (Service d'Infrastructures d'Action Ambulatoires Provincial).

two management systems for drugs: one system addresses essential drugs and the second covers program drugs. The two systems have different budgets and allocation systems, and they have a different manager in each province who is in charge of supervising program implementation, including the drug and material supplies for the ESSBs. These varying systems of drug management complicate the supply chains and likely sow confusion and disorganization about a facility's stock.

The monitoring mechanisms for drug reception are also weak. For example, the 2011 PETS found that in Morocco, only half of the surveyed ESSBs were using a registry book for essential drugs compared with 83 percent for program drugs. The remainder kept drug reception slips. The process of monitoring materials received by the ESSBs was even less rigorous than that of drugs. For example, for the first delivery in the year 2010, 50 percent of ESSBs that

FIGURE 5.13 In-kind transfer flows to primary health facilities (ESSBs) in the Moroccan public health system



Source: Data from the Government of Morocco.
Note: ESSB = primary health facility (*établissement de soins de santé de base*).
a. Only eight regional pharmacies had been created at the end of 2011. If no regional pharmacy exists, in-kind transfers flow directly to provincial pharmacies.

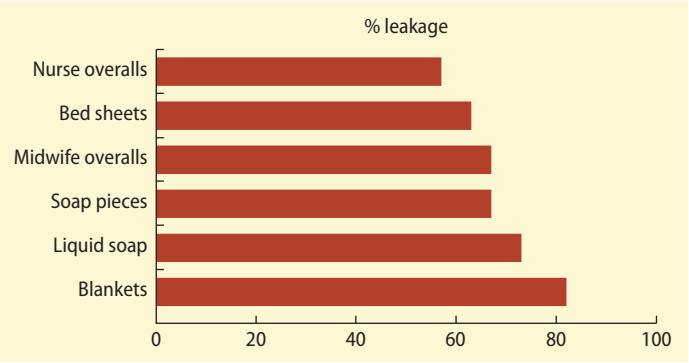
received materials did not have any paper record documenting and monitoring the process of receiving and distributing materials but rather responded "by memory" when asked.

Such lapses lead to leakages of supplies. In Morocco, the 2011 PETS and the 2011 QSDS found that almost two-thirds of drugs (61 percent) shipped from provincial delegations to the ESSBs were not reaching the designated ESSBs. The leakage of drugs from the Ministry of Health to the delegations was much smaller, though still non-negligible at 24 percent. Program drugs were more likely to go missing than essential drugs. Leakage was even greater with other supplies: 50–80 percent of six other medical supplies were not reaching the ESSBs from the delegations. From nurse overalls (57 percent leakage) to blankets (82 percent), the 2011 PETS and QSDS reported substantial capture between what delegations sent out and what ESSBs received (figure 5.14).

In short, the MENA region suffers from a relatively wide gap between legal and policy frameworks and their actual implementation (figure 5.15). In most cases, as chapters 6 and 7 elaborate, regulations and protocols are not always followed in schools and health facilities. Certainly, there are high-performing countries, most notably the United Arab Emirates, which has devoted an extraordinary effort to improving accountability mechanisms and service delivery performance. The reasons for this are not readily apparent, but possibly may be traced to the country's high-income, relatively homogeneous population and the vision of the political leadership.

Taken together, implementation problems result in a system largely lacking controls and accountability mechanisms. Monitoring, enforcement, and support mechanisms from the top are not available to encourage providers across the service delivery chain to engage effectively. Nor are there incentives and professional opportunities to foster internal accountability. The result, as described in chapters 6 and 7 and illustrated in box 5.1, is inadequate supplies, shabby infrastructure, providers who are absent or show up for limited periods, and citizens with unmet needs.

FIGURE 5.14 Percentage of leakage in medical supplies in shipments from provincial delegations to ESSBs: Morocco, 2011



Source: PETS (health), Morocco, 2011.

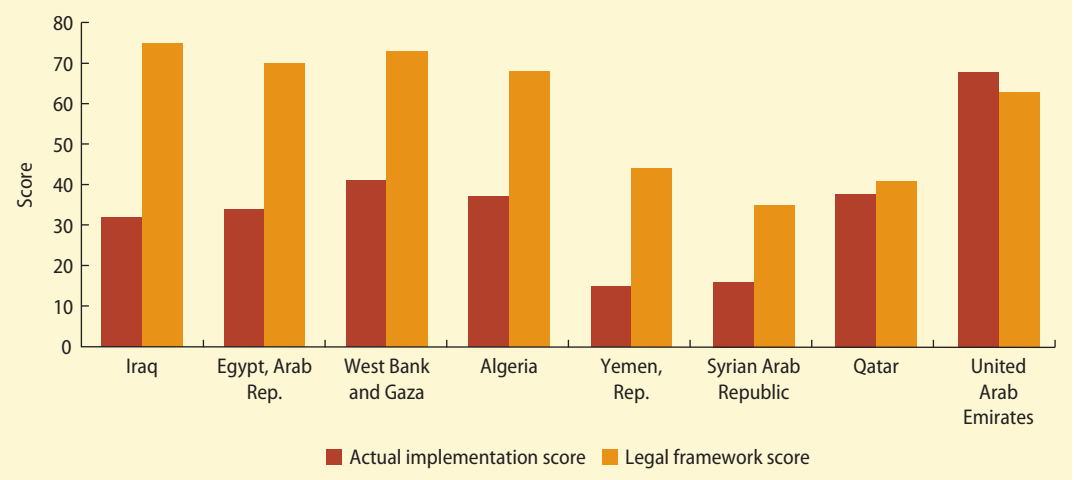
Social institutions

As Weir (2003) has argued, often "in the Arab World, political boundaries and government policies are surface phenomena compared to the deeper infrastructures of belief, family, kin, and obligation." Social institutions, most broadly conceived to include norms and regulations within society, affect both soft and formal accountability. These institutions vary both within and across countries. They include social capital and professional norms that, at least ideally, are nurtured by civil society, as well as norms for communal obligations that are often formed along the lines of blood ties, ethnolinguistic divisions, religion, and other social identity markers.

Social capital, professional norms, and soft accountability

Social trust and norms of reciprocity can increase individuals' willingness and ability to exchange resources and engage in cooperative activities across segments of society, as well as strengthen professional norms that ultimately can boost service provision. Proponents of civil society argue that civil society organizations can facilitate not only democracy but

FIGURE 5.15 Global integrity scores, MENA region



Source: World Bank 2014a, 23.
Note: The rule of law indicator comprises four subcategories: (1) anticorruption law; (2) anticorruption agency; (3) rule of law; and (4) law enforcement. The difference between actual implementation scores and legal framework scores represent "implementation gaps." Actual implementation scores are based on indicators that start with "in practice," whereas legal framework scores are based on indicators that start with "in law." Score: very strong (90–100), strong (80–89), moderate (70–79), weak (60–69), very weak (below 60).

also service provision. Putnam argued in *Making Democracy Work* (1993), for example, that the formation of civil society organizations could bring together citizens on a noncompulsory basis for any number of reasons, from forming a bowling league to launching a charitable association. Such organizations can sometimes act as interest groups, putting pressure on the state or providers for better services, or they can be an integral part of nonstate service provision.

And yet political institutions have affected the development of social trust. Authoritarian regimes have constrained the development of civil society in much of the MENA region. In countries such as Egypt, for example, professional associations of health workers and teachers were organized in a corporatist system that channeled, and constrained, associational activities (Bianchi 1989). Elsewhere, a study by El-Jardali et al. (2012) found that physicians, nurses, and other medical associations in the Republic of Yemen were having little influence on the policy-making process. The same study concluded that the Jordanian nurses' association was having a greater impact on policy making than its counterpart in the Republic of Yemen. Moreover, as Rothstein (2011) has noted, political institutions that fail to control corruption reduce social trust, further undermining the development of rule of law, as discussed in chapter 8.

Even where professional associations are given greater leeway, political constraints on voice often undermine the space for policy-making influence and professional development (Gregg 2013). For example, the Tunisian General Labor Union and the Jordanian Medical Association have both long been allowed to play a more assertive role in engaging in politics than Egyptian trade unions, and they have challenged incumbent policies. But even in these cases, the Tunisian and Jordanian governments at times took steps to repress them (see also Toensing 2011).

At times, professional associations become more politicized and end up playing a greater role in political competition than in professionalization. For example, under President Ben Ali, being a syndicalist in Tunisia was associated with being outside the central leadership, and even in opposition to Ben Ali.

Box 5.1 Examples of underperforming health centers in the MENA region

Consistently low performance characterizes two provincial health clinics in one MENA country today.

Health center 1

The first health center, which appeared rundown, had two full-time doctors, one pediatrician who attends regularly, and seven nurses. But very few staff members, including the head doctor, were present when the research team arrived at about 2 p.m., even though the facility is officially open from 8:30 a.m. to 4:30 p.m. Staff members said the center receives an average of 80 patients a day, most of whom visit the facility before 1 p.m.

The administrative procedures and systems for maintaining equipment appeared to be lacking. Even though the center rarely experiences stock-outs of medications or other problems related to its supply of drugs, the pharmacy did not appear to be well stocked, at least one medication on the shelves had already expired, and the refrigerator used to store vaccines in the pharmacy did not contain a thermometer, threatening the quality of the existing supply.

There were also noticeable shortcomings in the system for ensuring compliance with basic professional standards of hygiene. For example, the sink in the examination room had no soap (a problem routinely observed elsewhere), and the individual examination rooms did not have separate medical waste containers. Instead, a centrally located garbage can was devoted to medical waste. Furthermore, the nurse staffing the tuberculosis laboratory and treatment did not herself follow good hygiene practices; she was wearing a large number of gold bracelets on her arms, which is not recommended for staff members treating infectious patients.

Health center 2

At this rural clinic, services were provided by seven staff members—a doctor, an ambulance driver, a hygienic technician, and four nurses, only three of whom lived locally. When the research team visited the center during the afternoon, no patients were present. The center lacked a sense of dynamism and exhibited low standards of governance and health care.

As for its low standards of governance, when asked about staff meetings, the head doctor and acting head nurse (the actual head nurse was out that day) replied that meetings are held periodically as needed rather than regularly. Generally, the head doctor calls a meeting only when problems arise or after she meets with the chief medical officer. The clinic also had a decided lack of established procedures for handling administrative records and managing the operations of the facility. Apparently, the head nurse handles these tasks, but she had not communicated her procedures to other staff members. Furthermore, the head doctor was unable to answer basic questions about the facility's system for managing drug stocks and had no knowledge of the facility's budget for medications.

Completing the picture, the health center had not adopted measures to improve the accountability of providers to patients and their families. No suggestion box was visible in the facility, and few notices regarding procedures were posted on the walls, apart from two signs indicating the location of the office for treating chronic diseases and instructing patients not to request medications for which they lack prescriptions. No effort had been made to organize outreach activities in the community. The head doctor repeatedly referred to the center's relationship with the municipality, which periodically sends workers to clean the facility's garden and coordinates the maintenance of the local ambulance, but she seemed entirely unmotivated to participate in a national program for improving service delivery, stating that she and the other staff members were not up to the task of taking part. Indeed, the Ministry official accompanying the research team emphasized that the major difference between this center and higher-performing facilities boiled down to the quality of the management. In fact, the governance concerns were particularly stark in this facility because the center had recently been renovated and had relatively good equipment.

The same situation affected professional associations in Jordan under King Hussein. Such organizations acted more as a bellwether of political sentiment than as groups that could act as an interest group to promote workers' rights or inculcate professional norms.

Not only has the role of the professional association in developing a collective sense of identity and promoting professional norms and pride in a job well done been stifled, but so, too, have civil society and the development of social trust more generally. As scholars have noted, civil society organizations can have perverse consequences for social trust, particularly when they are politicized or constrained by closed political regimes (see Berman 1997; Jamal 2007; Makuwira 2011). Thus in much of the MENA region, there is little reason to believe that the dramatic increase in civil society organizations witnessed in the 1990s raised social capital or advanced professional norms that would serve as the foundation for soft accountability.

Social diversity and communal obligations

Although civil society has remained relatively weak throughout the MENA region, identity-based groups have tended to thrive. The form varies—from predominantly tribe-based identities in Jordan, Libya, and the Republic of Yemen, to sectarian groups in Iraq and Lebanon, to prominent families and clans in Morocco, Syria, and Tunisia—but the role of communal identities has remained strong. Indeed, states have developed and maintained political institutions by taking into account communal and collective identities: a state's local administrative boundaries are sometimes drawn along tribal or sectarian lines; local sheikhs serve as the local administrative officials; legal regulations are designed to incorporate tribal or religious law; and projects are implemented in close cooperation with the local social elites (Weir 2006; Fattah 2011; Aslam 2014).

There is important variation within as well as across the MENA economies in the extent to which these social groups are present and powerful, as well as in the extent to which individual group members identify with their communal group, share its interests, or abide by its norms. Considerable variation also emerges when citizens are asked whether local clans or families influence local politics. For example, as shown in figure 5.16, the citizens of Tunisia are generally much less likely than those of Jordan to tell survey researchers that there are influential families or clans present in their location and they are much more likely to view these actors as influential in some locations than others. This finding likely reflects very real differences in the constellation and strength of social groups present in various locations.

As a World Bank (2003) report noted, tribes historically behaved much like state actors: they regulated power, ensured the rights of individuals, and defined relationships in society. They provided, "in their own way, values now called participation, accountability, predictability, justice, the rule of law, and transparency." Today, however, there is a great deal of variation in the nature of tribes, large families, and other social groups in the region. Some have relatively formal, regulated mechanisms for choosing electoral candidates, resolving disputes, and maintaining community coherence, while others are internally divided and weak. Nevertheless, in much of the region, tribes and other social groups continue to play some of these roles, at times to the chagrin of citizens, who see them (much like state elites) as providing unjust decisions or exploiting their position (Corstange 2008; Aslam 2014).

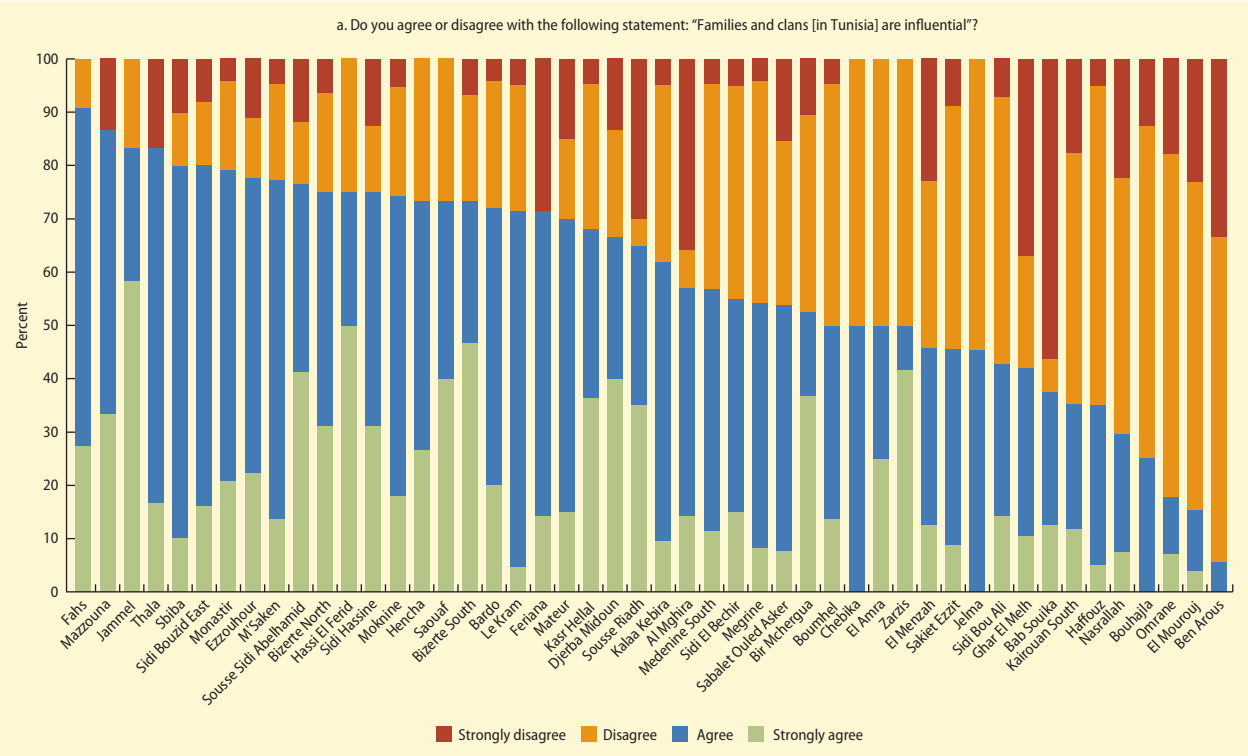
The extent to which tribes or other social groups provide a mechanism to hold service providers and their superiors accountable depends on a number of factors. First, it depends on the extent to which social identities are linked to strong norms of obligation. As described in chapter 4 and as shown in evidence from other regions as well, the strength of social identities and importance of social obligations can vary, depending in part on state policies and incentives (Jabar

2001; Sakai 2001; Morris MacLean 2002; Baylouni 2010). Moreover, the role that social groups play can depend in part on their relationship with society. For example, Tsai's 2007 study of service provision in China suggests that social organizations are better at fostering good services when they are embedded within the community, giving local authorities a reason to cooperate with them. More formally organized social groups are also likely to have a greater capacity for gathering resources, monitoring services, and enforcing compliance.

The diversity of social groups is also likely to affect service provision. Some observers believe more heterogeneous areas provide incentives for political elites to compete for support and thus yield better services. In her study of the relationship between tribal diversity and the provision of public goods in Jordan, Gao (2012) found that heterogeneous areas where either multiple tribes existed or tribes were internally divided were able to obtain more resources from the state and enjoyed higher levels of service provision. Similarly, a study conducted in the Republic of Yemen concluded that more resource investment in education was correlated with more tribally heterogeneous areas (Egel 2011). Unfortunately, it appears that in both cases more heterogeneous areas are associated with greater levels of migration, which makes it difficult to determine whether greater levels of development stem from competition or from the demands of a more mobile, and potentially more resourceful, population.

Indeed, the relationship between social diversity and service provision remains

FIGURE 5.16 Influence of families and clans: Tunisia and Jordan, 2014



Source: Transitional Governance Project, 2014.

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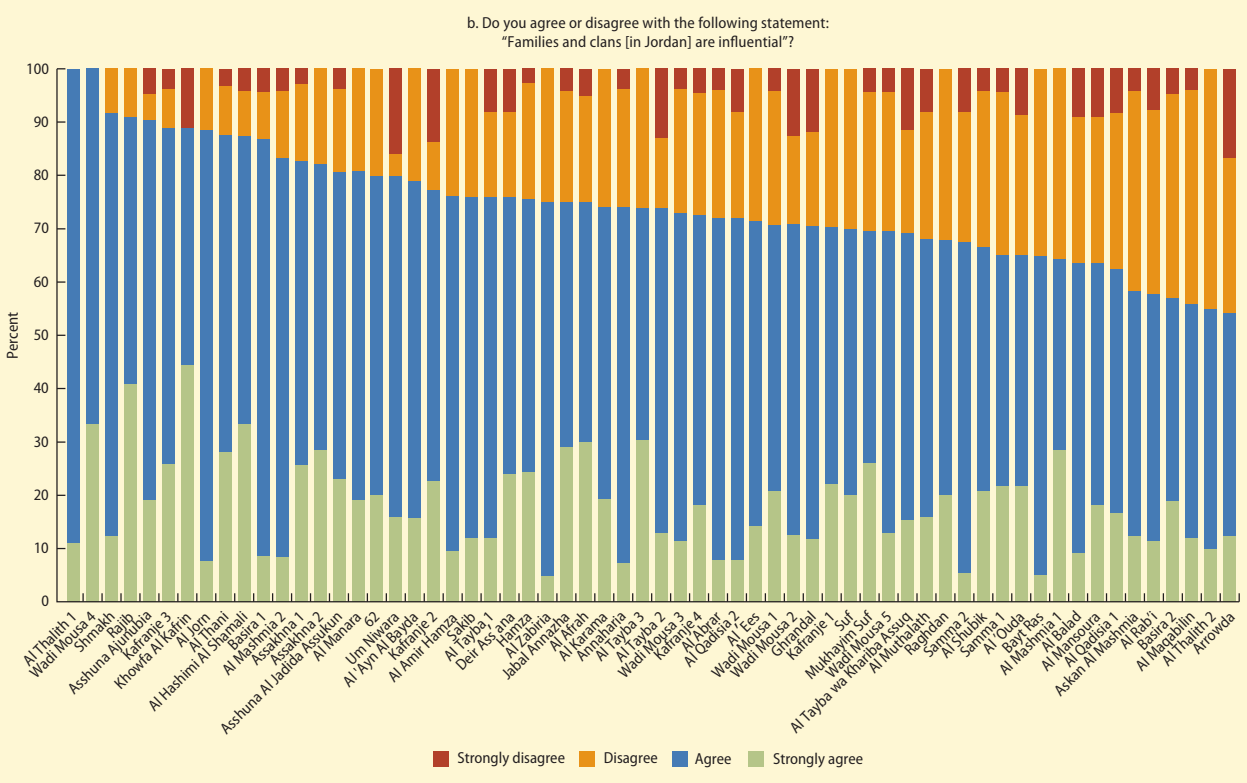
FIGURE 5.16 Influence of families and clans: Tunisia and Jordan, 2014 *(continued)*



Source: Governance and Local Development survey, 2014.

opaque (vom Hau and Singh 2014). Some scholars have argued that members of one social group are less likely to cooperate with members of other social groups, and so diverse societies are less likely to invest in public goods (Easterly and Levine 1997; Alesina et al. 2003; Costa and Kahn 2003). Others have argued that social diversity depresses investment in public goods only inasmuch as it serves as a proxy for competing interests. They argue that it is the level of between-group inequality or polarization (Baldwin and Huber 2010) or a history of state building (Miguel 2004; Singh 2010) and not social fragmentation per se that depresses service provision. A longitudinal study in India found that the relationship varies across services, with a negative relationship between fragmentation and the provision of health care, electricity, and education in middle schools (Banerjee and Somanathan 2007).

Other scholars have turned from the impact of social groups on intragroup relations and toward their ability to sanction their own members. Behavioral games have found that co-ethnics are more likely to cooperate for fear of being sanctioned and in recognition that by being more closely linked through social networks they face a higher possibility of sanction (Habyarimana et al. 2007). Similarly, an experiment in community-based monitoring in Uganda found that more homogeneous areas were able to push for better health service delivery and overcome the free-rider problems inherent in community monitoring after an information intervention, apparently because the community in homogeneous areas could

impose more sanctions on health care providers areas where social norms and institutions apply to everyone (Bjorkman and Svensson 2010). In addition, a study in Kenya found that school committees in ethnically diverse areas were associated with lower local public goods provision. The study showed that school committees in ethnically diverse areas were more likely to suffer from local collective action failures because of imposing fewer community social sanctions and using less verbal pressure against parents who do not contribute to public fund-raising or pay school fees, resulting in lower funding of local schools and worse facilities in 84 primary schools (Miguel and Gugerty 2005).

Questions remain about the impact of social diversity on service provision, but considerable evidence suggests that this factor has a significant impact on the quality of services in the MENA region. Indeed, not only are savvy administrators constrained by social ties, but they also can activate them to mobilize community support and incentivize their staff. These dynamics are discussed in the case studies presented in chapter 3, and are nicely illustrated in box 5.2 by the Sakhra Comprehensive Health Center, where exploiting close ties in the community and good governance practices resulted in exceptional service.

The role of social norms, *wasta*, and informal payments

The impact of social institutions on public organizations, service provision outcomes, and citizen engagement extends far beyond the presence of tribes, or even ethnic, sectarian, or other social groups. Underlying norms that extend across society also affect the provision of services, and they are particularly influential in much of the MENA region because of the weak state and administrative institutions. Two social norms are particularly widespread and influential: first, individuals are more obligated to respond to friends, family, and others in their social networks than they are to strangers, and, second, individuals place importance on maintaining the social status of their own network.

In general, these norms underpin a practice called *wasta,* which is Arabic for both "intermediary" (referring to the person) and "intercession" (the act). *Wasta* is based on an implicit social contract in which typically relatives or members of social or tribal groups who are in positions of power are obligated to provide assistance (favorable treatment) to others within the same group (Barnett, Yandle, Naufal 2013). A form of clientelism, "wasta involves social networks of interpersonal connections rooted in family and kinship [as well as other personal] ties and implicating the exercise of power, influence, and information sharing through social and politico-business networks. It is intrinsic to the operation of many valuable social processes, central to the transmission of knowledge and the creation of opportunity" (Hutchins and Weir 2006, 143–44).

Wasta provides people with solutions to a set of social problems and resource allocation issues. It allows individuals to obtain public services and receive preferential treatment when dealing with administrative procedures. Those who have *wasta* can gain university admission, obtain a business license, and manage a wide array of other daily tasks. Those seeking to change their children's schools or to find a hospital bed for a sick parent, for example, often require someone in the right place willing to pave the way.[13] *Wasta* is also often instrumental in gaining privileged access to economic opportunities, including employment. As Meles (2007) notes, "Wasta has now become a right and an expectation" in Arab societies.

Yet *wasta* also undermines equality. Many view *wasta* as a source of nepotism, cronyism, and corruption, with historical roots in a tribal system of social organization (Al-Ramahi 2008).[14] It is a form of social informal networks in a job search, but the poor and other disadvantaged residents remain unlikely to be able to penetrate such networks. In the economic sphere, *wasta* is considered a form of "crony capitalism" in which success in business depends on a close

Box 5.2 Improving quality of care against all odds: Mobilizing social ties in Jordan

The Sakhra Comprehensive Health Center is small and slightly disheveled, with evident resource constraints. Nevertheless, it is teeming with activity and resourcefulness. A sheet on the wall is the "screen" from the previous night's presentation on the safe use of certain medications. A blue curtain cordons off a corner in the maternal and child unit, providing privacy for nursing mothers. Staff members promptly respond to calls placed over a public address system that they proudly explained they purchased using staff donations. Nestled in one of the poorest regions of Jordan (Ajloun governorate) and with a catchment area of a little over 15,000 inhabitants (and recently an additional 1,500–2,000 Syrian refugees), the Sakhra Comprehensive Health Center is a bustling hub. A dedicated chief medical officer at the Sakhra center has been able to nurture and draw on close social ties—with the directorate, among the staff, and with the close-knit community—in order to raise the standards of care at this rural Jordanian clinic.

Strong facility management, complemented by innovative and decisive leadership, has created a clinic environment that fosters staff motivation, encourages feedback, and is responsive to community needs. Staff members are visibly energized, patient-centeredness is omnipresent, and patients, community members, and staff have a voice—a combination of governance drivers that helps explain the clinic's success. Staff members are encouraged to express their grievances and suggestions and to participate in determining and implementing solutions to problems encountered at the clinic. During our visit, the staff repeatedly noted, "We are one hand," and they showed pride in the center's accomplishments.

The clinic also emphasizes engagement with the community, which is socially homogeneous and dominated by a relatively influential tribe. Engagement occurs via multiple means such as outreach programs, informational lectures held at the center and the local mosque, home visits for medical testing and consultations, and health fairs. Like other clinics participating in Jordan's accreditation program, the Sakhra center also has a local health committee, which serves as a channel for aggregating and addressing community demands and ideas. Based on its formalized structure and diverse membership, the committee supports the clinic by identifying and mobilizing resources to address leading issues of concern to the community. Closeness to the community is also visible in the patient-centered approach, with a billboard posting responses to patient comments and signs emphasizing patients' rights and safety, as well as statements about the goals and principles of the center.

The professional goals of the center are transparent as well. Each year, the center produces an operational plan that identifies the activities it will carry out, with clear targets such as reducing hypertension by a given percentage and launching a minimal number of outreach programs.

Is good management of the center responsible for its apparent good governance in delivering quality services? In part it seems to be, but good management can only do so much. The active engagement of community leaders and their capacity to motivate local residents to communicate their demands and to act as their own health advocates are also vital, especially because these factors strengthen accountability. In this regard, the local health committee plays a crucial role in facilitating communication between the center and the community, so that expectations and responsibilities become clear, rendering providers accountable to their patients. Thus the Sakhra center benefits from good governance both within the facility itself and in the community where it is located.

Note: The research team applied systematic measures of the relevant aspects of quality to all the facilities visited. The team was unable to be as systematic in its observations as it could be using close-ended survey questionnaires. Moreover, the sampling was not random but based on the Ministry of Health accreditation process. Indicators considered included the presence and condition of basic infrastructure; medical records and how they are kept; the system of maintaining drugs; the credentials of health personnel; the continuous training of health personnel; the presence of protocols for treating specific health conditions; and staff absenteeism. Based on the team's observations, the Sakhra center was providing quality services relative to its constraining environment.

relationship between business owners and government officials. It may take the form of favoritism, tax breaks, legal permits, or other forms of state intervention (World Bank 2014b). Meanwhile, services may be delivered adequately to members of groups that are politically connected, but poorly to the rest of the citizenry as a whole. In the absence of weak internal and external checks, such affiliations often come at the expense of meritocracy and fairness and become the basis for awarding employment, obtaining services, and solving disputes, circumventing states' formal rules and further undermining them.

Wasta perpetuates the problems associated with weak administrative systems as well. It contributes to the lack of accountability, oversight, and internal checks and balances within public sector administration. Staffing of bureaucracies and Ministries is often based on *wasta* rather than on merit or performance. Indeed, both the 2013 Gallup World Poll and the Arab Barometer 2010–11 (Wave II) poll found that the vast majority of citizens believe that knowing people in high places is important in obtaining a government job.[15] In 6 out of 10 countries surveyed by the Arab Barometer, the majority of citizens felt that political affiliations were more or as important as qualifications and experience in obtaining government employment,[16] and more than half of respondents in all countries believed that family and tribal identities were as or more important than qualifications in obtaining a government job. The results did not differ significantly across income, employment, or education.

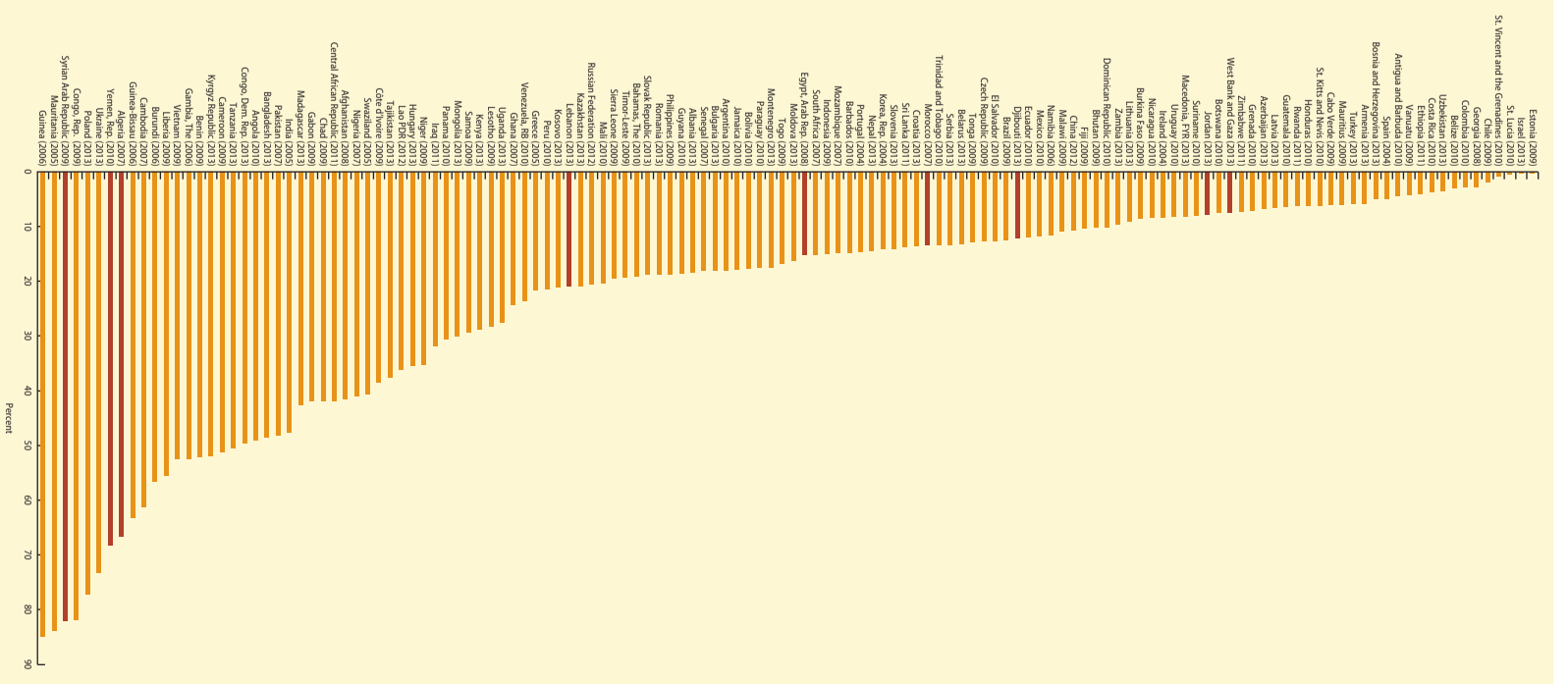
Hiring based on networks and personal relationships not only helps those in administrations simplify their search (as it often does outside the MENA region as well), but also allows those in positions of power to fulfill social obligations and to demand greater loyalty (Fernandez and Weinberg 1997; Al-Ramahi 2008; Pankani 2014). This situation can create perverse incentives for providing loyalty at the expense of effort, and it shuts out well-qualified job seekers. The resultant lack of meritocracy in hiring could have grave consequences for effort and performance.

Social norms, combined with weak administrative accountability mechanisms, are also a basis for informal payments. These under-the-table fees are charges for services and supplies that are supposed to be free of charge in the public system (Balázs 1996; Gaal et al. 2006). In addition to monetary payments, informal payments can take the form of tangible gifts or other favors.

Informal payments are thought to be substantial within bureaucratic units and public sector jobs where there is an excess supply of capital and human resources, weak incentive schemes, lack of accountability and government oversight, and an overall lack of transparency. Figure 5.17 shows the percentage of firms in selected countries that make informal payments to public officials to "get things done" in the areas of customs, taxes, licenses, regulations, services, etc. The estimates of informal payments tend to be high in developing and transitioning countries, which include among them some MENA countries for which data are available such as Iraq, the Republic of Yemen, and Syria. Attempts to understand the scope of informal payments and the motivations underlying their existence are often empirically inconclusive and contradictory (Gaal et al. 2006).

However, there is evidence that informal payments are not always viewed as morally reprehensible (Allin, Davaki, and Mossialos 2006). And yet even if they are viewed as socially acceptable or expected, informal fees are detrimental to citizens' welfare in terms of equal access to services and the quality received. In the health sector, it has been argued that informal fees can encourage unprofessional behavior among physicians, motivating them to provide good care for only those who make extra payments and rendering their services unaffordable for the poor and most disadvantaged. In addition, informal payments could undermine the efficiency of the health system as a whole; governments may turn a blind eye to problems of poor resources and underpayment, and in turn physicians may resist attempts at reform

FIGURE 5.17 **Percentage of firms making informal payments to public officials: Selected economies, 2005–13**



Source: World Bank Enterprise Survey, 2005–13.

and formalizing informal payments if their profits from their practice are substantial and are not subject to state taxation (Mossialos and Karokis 1992).

Moreover, evidence from Morocco demonstrates that side payments can be a serious obstacle to poor patients who are trying to access medical care. A survey of 1,000 households conducted by Transparency International in 2002 in Morocco found that 40 percent of respondents admitted making an illicit payment for a service that was supposed to be free, and 81 percent of those who made the payment thought that the bribe was effectual and led to the desired result (Allin, Davaki, and Mossialos 2006). As the health minister summed up the problem in 2002: "56 percent of those that have the means to pay are benefiting from public hospitals, while 15 percent of the country's poorest are paying out of their pockets" (*La Vie Economique* 2005). Finally, even when informal payments are seen as gifts, it is hard to determine how much regulation and oversight are exercised over such payments or whether children whose parents donated receive any preferential treatment by the school administration, for example.

The form and relative influence of social and state institutions vary across states, subnational regions, and individuals. In Lebanon, Libya, and the Republic of Yemen, for example, the near absence of effective political and administrative institutions gives social forces free reign, while in Egypt and Tunisia state institutions are more effective (Lust 2013). Social norms differ as well. Although we find high correlations between the extent to which *wasta* is seen as necessary for obtaining various goods and services (such as government jobs, health care, and education), the expectation that *wasta* is essential in such situations varies considerably across localities (see figure 5.18 for a demonstration of the importance of *wasta* and bribes in Tunisia; similar results have been reported for Jordan as well). The same variation is found for informal payments. Such variation in the strength of social institutions at the local level is likely to explain some of the subnational variations in service delivery found in chapter 7. The weak administrative and political institutions leave much space for social ties and institutions to play an important role in shaping service delivery.

Potential for reform?

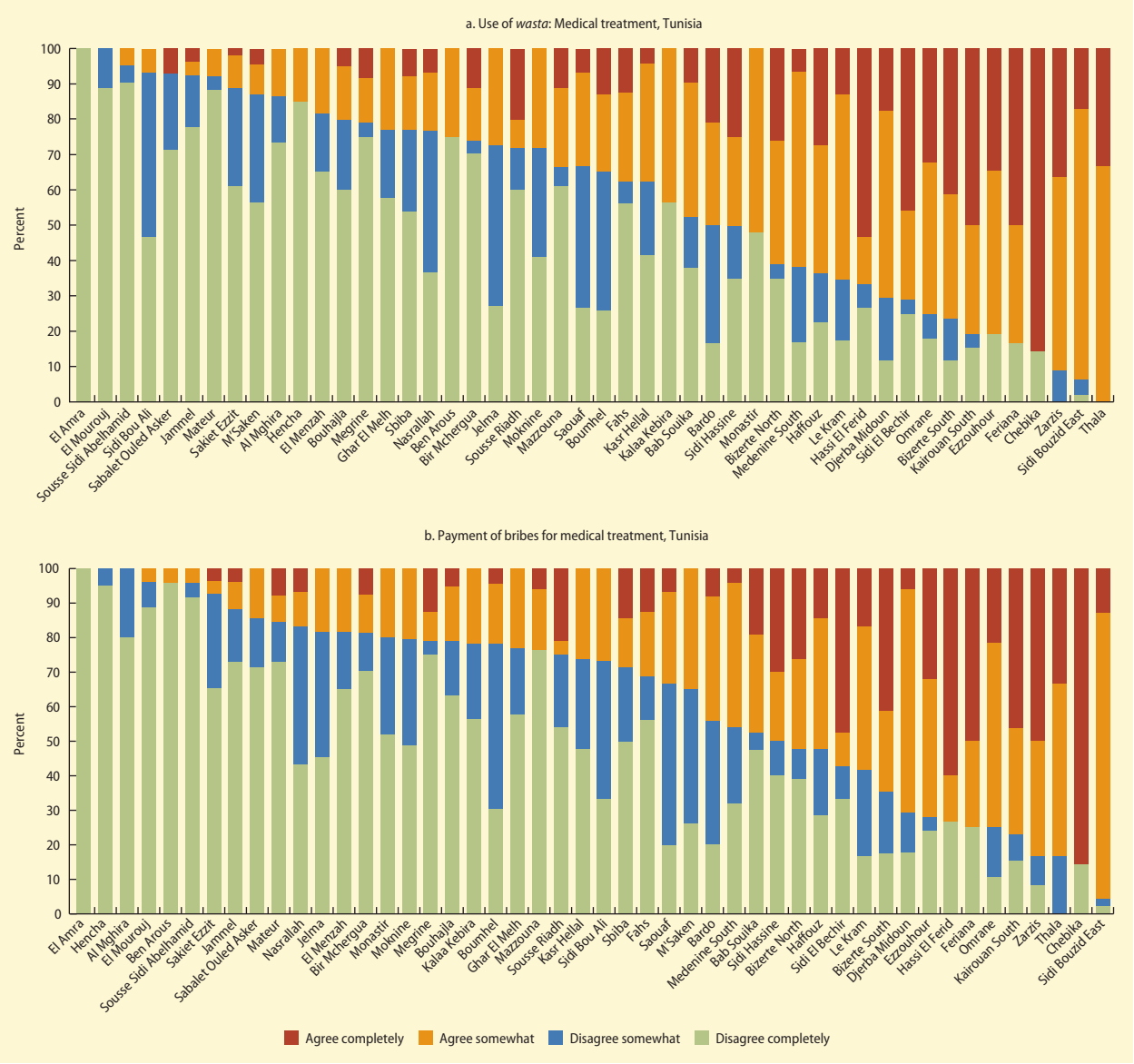
This chapter has described how in much of the MENA region both formal and informal institutions undermine accountability.

Political institutions are characterized by centralized power in highly authoritarian, politically captured institutions, limited voice, scarce information, and largely absent enforcement. Each of these factors breaks down the chain of accountability, thereby leading to a gap between how service provision is intended to work and the poor quality that users encounter at the point of delivery.

Administrative institutions are hampered by lack of management capacity in the public sector, which may take the form of a limited flow and monitoring of inputs and outputs, limited performance-related information, and a limited authority to impose sanctions or reward good effort. The result is the inability of one level along the chain to hold another level accountable. This limited capacity appears to be a symptom rather than a root cause of the problem in administrative institutions. The cause appears to be embedded in political and social institutions, which orient the incentives of public servants away from performance and toward clientelism and patronage. The by-products are lax rules and regulations, a limited emphasis on monitoring and results such as the quality of services provided to the poor and nonprivileged populations, and weak management practices—all of which further shape the incentives of government employees within the bureaucracy.

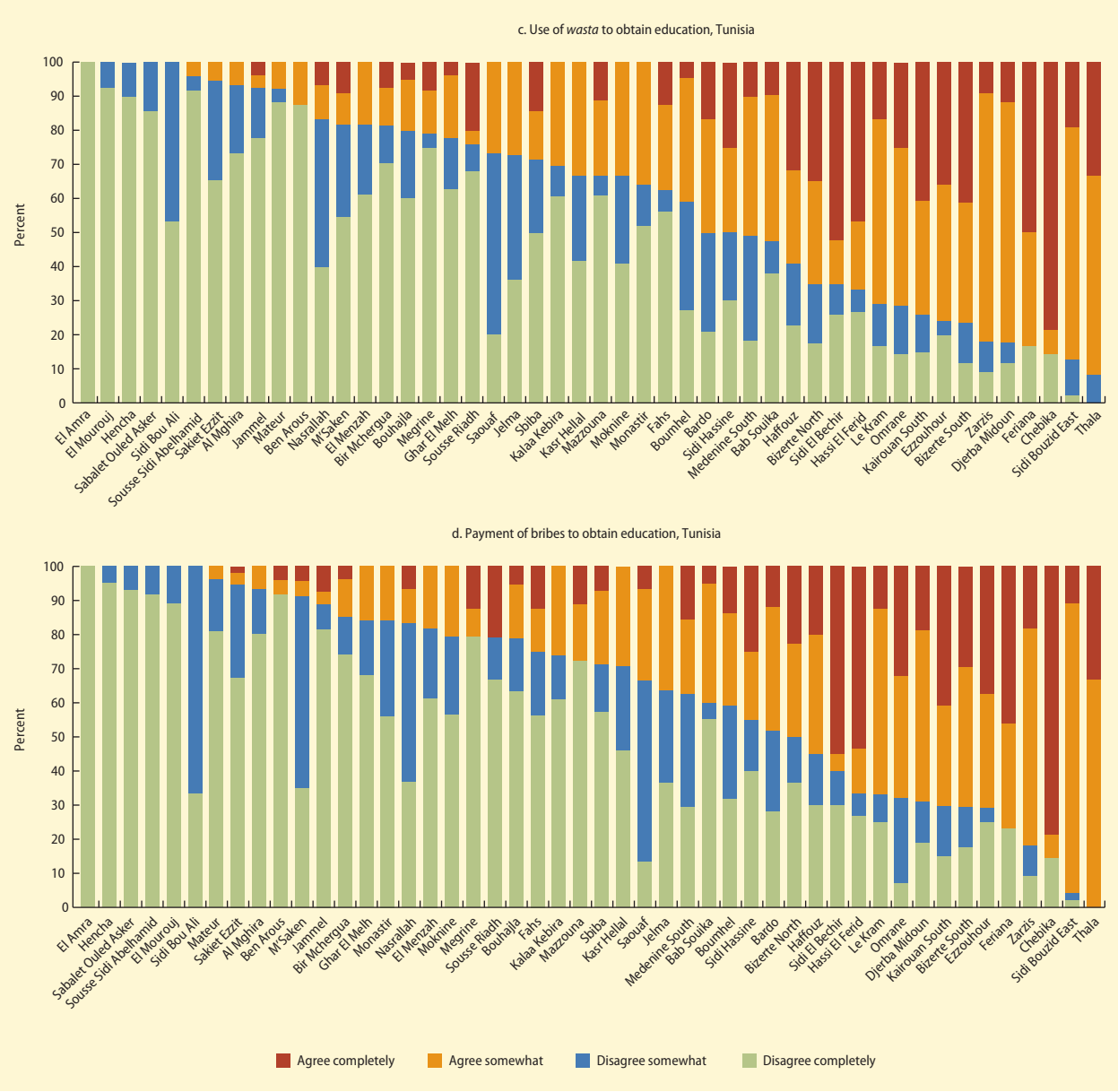
Finally, *social institutions* shape the incentives of service providers across the chain. Strong social norms that emphasize obligations to the members of one's tribe, ethnic group, or other social network (often at the expense of the greater good) produce an

FIGURE 5.18 Importance of *wasta* and bribes in obtaining medical treatment and education: Tunisia, 2014



(continued next page)

FIGURE 5.18 Importance of wasta and bribes in obtaining medical treatment and education: Tunisia, 2014 *(continued)*



Source: Transitional Governance Project, 2014.

environment conducive to corruption and one that legitimizes the usage of connections to solve individual problems or obtain services without creating pressures for improving service delivery systems.

Overall, this chapter paints a bleak picture. Most MENA countries have a web of weak and captured political institutions, ineffective administrative systems, and social norms that place personal connections above the public interest. The result undermines accountability and service delivery, which is discussed at greater length in chapters 6 and 7. It also makes effective reform difficult because weak institutions and poor performance undermine citizens' trust and shape engagement, which will be the subject of chapters 8 and 9.

Notes

1. The World Bank (2003, 39) has defined inclusiveness as follows: "the rights and interests of all groups—particularly women, ethnic and religious minorities, and any vulnerable group—are guaranteed and their concerns are addressed by the government."
2. According to North (1990, 3), institutions "are the rules of the game in a society, or more formally, are the humanly devised constraints that shape human interaction." Institutions include "formal" rules such as constitutions and laws enforced by the state and "informal" constraints such as "codes of conduct, norms or conventions," both of which are generally enforced by society's members. Similar understandings of institutions underpin the literature on domestic politics and international relations. See, for example, North and Weingast (1989); Khalil (1995); Greif (1998); Simmons and Martin (2001); Hodgson (2006); and Greif and Kingston (2011). Our view of institutions has much in common with the trifold classification adopted by the World Bank (2014a). Whereas the classification set forth by the Bank distinguishes among political, economic, and social and cultural institutions, equating social and cultural institutions with informal institutions, we distinguish between political and administrative institutions and, more important, recognize that social and cultural institutions can be both formal and informal and, similarly, that informal political and administrative mechanisms can operate as well.
3. Expert-coded measures of judicial independence, compiled by the Bertelsmann Transformation Index (Bertelsmann Foundation 2014) and by the CIRI Human Rights Dataset (Cingranelli et al. 2014) find the MENA region to be among the regions with the least independent judiciaries. It is worth noting that surveys of business leaders conducted by the World Economic Forum (2014) find that judiciaries in the MENA region are similar to those throughout much of the world, although considerably less independent than those in Western Europe, North America, Australia, and the Pacific.
4. For more on this subject, see Huntington (1968); Drèze and Sen (1989); Wade (1990); Maravall (1994); Diamond and Plattner (1995); Ross (2006); Hasnain (2008); Herb (2009); Fukuyama (2012); Gerring, Thacker, and Alfaro (2012); and McGuire (2013).
5. The public knowledge percentages were taken from a 2010 survey implemented by the Al-Urdun Al-Jadid Research Center, cited in Almadhoun (2012). Jordan's 2007 law scored 52 out of 150 points on the ATI rating developed by the Center for Law and Democracy and Access Info.
6. These insights are derived from a regional online survey administered by the Mohammed Bin Rashid School of Government (MBRSG) Governance and Innovation Program in collaboration with Bayt.com (http://www.mbrsg.ae/getattachment/ff70c2c5-0fce-405d-b23f-93c198d4ca44/The-Arab-World-Online-2014-Trends-in-Internet-and.aspx). The survey targeted almost 3,000 respondents in 22 Arab economies (Algeria, Bahrain, Comoros, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Mauritania, Morocco, Oman, Qatar, the Republic of Yemen, Saudi Arabia, Somalia, Sudan, the Syrian Arab Republic, Tunisia, the United Arab Emirates, and the West Bank and Gaza). Seventy-five percent of the sample was male; 14 percent of the sample was between the ages of 15 and 24; and 44 percent was between the ages of 25 and 34. The countries most represented in the sample size were (from the largest to the smallest) Egypt, Saudi Arabia, the United Arab Emirates, Algeria, Jordan, and Morocco.
7. Accenture Report January 2014, which defines digital government as "the optimal

use of electronic channels of communication and engagement to improve citizen satisfaction in service delivery, enhance economic competitiveness, forge new levels of engagement and trust, and increase productivity of public services. A digital government encompasses the full range of digitalization—from the core digitalization of public services to the digital infrastructure, governance and processes, including both front- and back-office transformation needed to deliver the new service paradigm."

8. Interview with Ali Ibrahim Al-Khawaldeh, director, Civil Society Organizations Department, Ministry of Political Development, Jordan, by Aida A. Essaid, October 18, 2010, Amman, Jordan, and cited in Saif (2012).
9. For a thorough review of the six elements of the budget cycle and the reforms that the MENA countries have pursued to date to further strengthen these elements, see World Bank (2012).
10. According to the Arab Barometer, 2010–11 (Wave II), the following believe that the parliament has little or no role in the formation of policies: 63 percent, Republic of Yemen; 61 percent, Algeria; 61 percent, Lebanon; 50 percent, Iraq; 46 percent, the West Bank and Gaza; and 31 percent, Jordan.
11. This discussion draws on Beschel and Ahern (2012). More updated information on the experiences of various MENA countries' with public sector reforms can be found in Beschel and Yousef (2014).
12. A chart of accounts (COA) is a financial tool for classifying, recording, and reporting information on financial plans, transactions, and events in a systematic and consistent way. In particular, it specifies how financial transactions are recorded in a series of accounts by defining the scope and content to capture the relevant financial information, and provides a coding structure for the classification and recording of relevant financial information (both flows and stocks) within the financial management and reporting system (Cooper and Pattanayak 2011).
13. For a discussion of *wasta,* see Kilani and Sakija (2002).
14. For a full review of the historical roots and evolution of *wasta*, see Barnett, Yandle, and Naufal (2013).
15. In the Gallup World Poll (2013), the percentage of respondents who disagreed with the question "In general, do you agree that knowing people in high positions is critical to getting a job?" (*wasta*) was as follows: 10 percent, Lebanon (n = 99); 12 percent, Jordan (n = 97); 19 percent, Kuwait (n = 98); 20 percent, Morocco (n = 98); 20 percent, Republic of Yemen (n = 98); 22 percent, Tunisia (n = 97); 23 percent, Libya (n = 80); 24 percent, Egypt (n = 99); 25 percent, Saudi Arabia (n = 88); 27 percent, Algeria (n = 99); 29 percent, Qatar (n = 82); 31 percent, West Bank and Gaza (n = 96); and 32 percent, Iraq (n = 94).
16. In Lebanon, 2 percent of respondents said employment is obtained without connections; 24 percent, sometimes through connections; and 75 percent, always through connections; Republic of Yemen: 5 percent, without connections; 25 percent, sometimes through connections, and 70 percent, always through connections; West Bank and Gaza; 3 percent, without connections; 30 percent, sometimes through connections; 67 percent, always through connections; Iraq: 4 percent, without connections; 30 percent, sometimes through connections; 66 percent, always through connections; Jordan: 4 percent, without connections; 31 percent, sometimes through connections; and 65 percent, always through connections; Tunisia: 6 percent, without connections; 33 percent, connections are sometimes important; 61 percent, connections are always important; Algeria: 10 percent, connections are not important; 35 percent, connections are sometimes important; 55 percent, connections are always important; Egypt: 10 percent, connections are not important; 35 percent, connections are somewhat important; 55 percent, connections are very important; Saudi Arabia: 13 percent, connections are not important; 45 percent, connections are somewhat important; 42 percent, connections are always important.

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Polity IV Annual Time-Series 1800–2013, Center for Systemic Peace, http://www.systemicpeace.org/

QSDS (Quantitative Service Delivery Survey), World Bank, http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPOVERTY/EXTPSIA/0,,contentMDK:20467190~isCURL:Y~menuPK:1108016~pagePK:148956~piPK:216618~theSitePK:490130,00.html

SABER (Systems Approach for Better Education Results), World Bank, http://saber.worldbank.org/index.cfm

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World Bank Enterprise Survey, http://www.enterprisesurveys.org/

Worldwide Governance Indicators, World Bank, http://data.worldbank.org/data-catalog/worldwide-governance-indicators

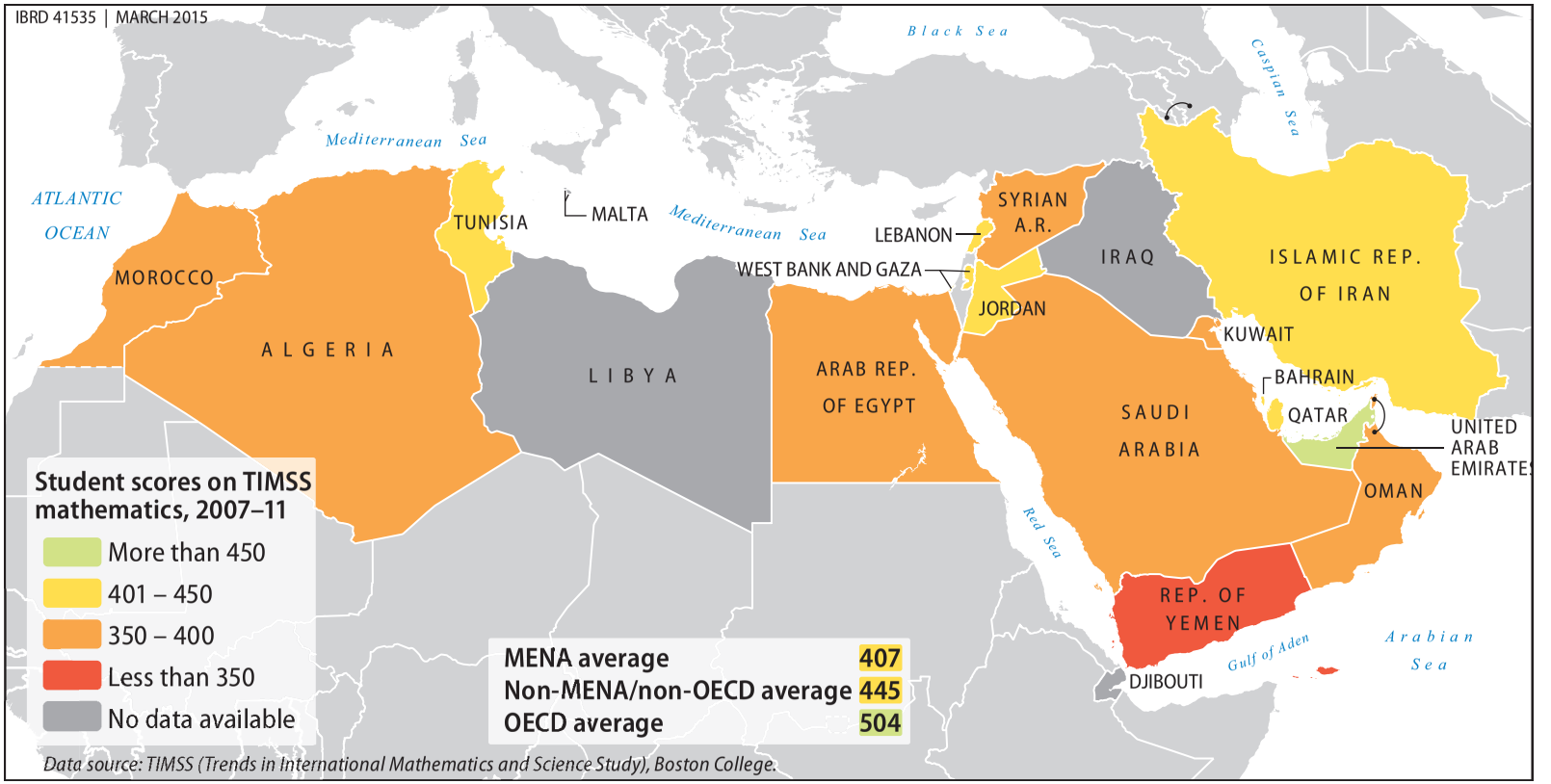
Service Delivery Performance

PART III

In part II, we introduced the cycle of performance framework, explaining that the weaknesses in education and health services delivery are rooted in institutions. We also described how state institutions in the Middle East and North Africa often lack both internal and external accountability, which undermines policy implementation.

In this part, we turn our attention to performance at the point of service delivery. We explore the efforts and abilities of teachers and health professionals and the availability of key inputs such as instructional materials in schools and medicines in health facilities. We then look at how such performance is affected by institutions. Drawing on surveys, we focus first on the national level (chapter 6) and then explore the nature and extent of subnational variation in service delivery performance (chapter 7).

MAP III.1 **Student scores on TIMSS mathematics in MENA, 2007–11**



Source: World Bank (IBRD 41535, March 2015).

Service Delivery: Gaps in Providers' Efforts and Abilities and in Inputs

6

- Performance indicators at the point of service delivery in the Middle East and North Africa (MENA) reveal weaknesses in providers' efforts and abilities and in the availability of key inputs such as instructional materials and medicines.
- Absenteeism seems widespread, particularly in public schools and health clinics.
- Adherence to curriculum and health care protocols is limited, in part driven by limited abilities.
- Schools in the MENA region are short on instructional materials, and health facilities are short on medications.

Captured political institutions and weak administrative structures, as described in the preceding chapter, often undercut incentives for providers, administrators, and policy makers to ensure the provision of quality services for the poor and other disadvantaged populations. There is variation across the Middle East and North Africa (MENA) region and within countries, but close study of the service delivery process in education and health reveals overall weaknesses in providers' efforts and abilities, as well as in the distribution of key inputs into service delivery by administrators and policy makers.

In this chapter, we draw broadly on the World Bank Group's Service Delivery Indicators (SDI) approach[1] in examining the efforts and abilities of staff and the

Table 6.1 Key service delivery indicators

Education	Health
What providers do (providers' efforts)	
Absence from school	Caseload
Absence from classroom	Absence from facility
Time spent teaching	
What providers know (providers' abilities)	
Minimum knowledge	Diagnostic accuracy
Test scores on English, mathematics, pedagogy	Adherence to clinical guidelines
	Management of maternal/neonatal complications
What providers have to work with (availability of resources)	
Students per textbook	Drug availability
Equipment availability	Equipment availability
Infrastructure availability	Infrastructure

Source: http://www.sdindicators.org/.

availability of the key inputs and resources that contribute to a functioning school or health facility. The full set of these indicators is shown in table 6.1. Because focused Service Delivery Indicators surveys have not been conducted in MENA countries, this chapter and the next, which analyzes subnational variation in service delivery performance, cover a subset of indicators determined by the available data.

Providers' efforts

The efforts of teachers and health workers, as well as of administrators and policy makers, broadly represent a manifestation of the existing institutions and accountability mechanisms. Weak political and administrative accountability mechanisms leave space open for social institutions seeking to motivate providers. These institutions fill the void effectively by motivating teachers and health workers in some local contexts, as our examples of local successes in chapter 3 illustrate. But, more commonly, the weaknesses in formal accountability hurt or distort providers' efforts.

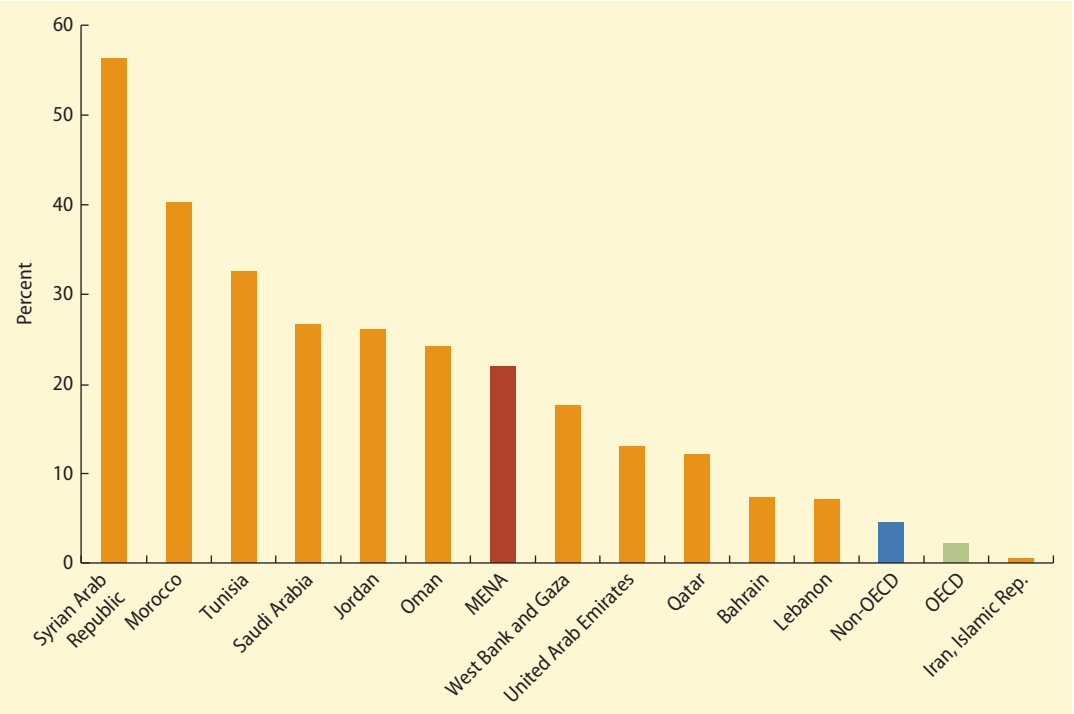
Absenteeism and lack of motivation

The available data suggest weaknesses in providers' efforts in both education and health, particularly in terms of relatively high rates of absenteeism. According to the Trends in International Mathematics and Science Study (TIMSS), on average, 22 percent of students in MENA countries attended schools whose principals reported that teacher absenteeism was a serious problem (figure 6.1), and 25 percent of students attended schools where late arrival of teachers was a serious problem (TIMSS, 2011). Furthermore, 14 percent of school principals in Jordan and Tunisia and 9 percent in the United Arab Emirates reported in the Programme for International Student Assessment (PISA) that teacher absenteeism seriously hindered student learning (PISA, 2012). Absenteeism in both schools and health facilities has also surfaced as a problem in the available country surveys (figure 6.2), which allow analysis at the subnational level and in relation to other service delivery indicators (see chapter 7). In the Republic of Yemen, for example, one-third of surveyed public health facilities had at least two employees absent at a time, and in all hospitals at least one staff member was absent, with an average of about nine employees absent. In Morocco, the World Bank's 2011 Quantitative Service Delivery Survey (QSDS) and 2011 Public Expenditure Tracking Survey (PETS) found that 27 percent of staff members were absent across basic health care facilities (*établissements de soins de santé de base,* ESSBs).

According to TIMSS and survey data, absenteeism is somewhat lower in private schools than in public schools. Analysis of the 2010 Egypt Health and Governance Study (EHGS) data has suggested that 40 percent of female staff members were absent at least once a month as opposed to 52 percent of male staff members. Similarly, staff on term contracts had lower absentee rates than staff on open-ended contracts, and staff in facilities where the local media were reportedly critical had lower absentee rates than those in localities where the media were positive or did not play a role.

While at school, teachers may not be teaching in the classroom. As the World Bank's Systems Approach for Better Education Results (SABER) and the available surveys document, in some MENA countries,

FIGURE 6.1 Percentage of students whose principals report that teacher absenteeism is a serious problem in their schools: OECD, non-OECD, and MENA economies, 2011

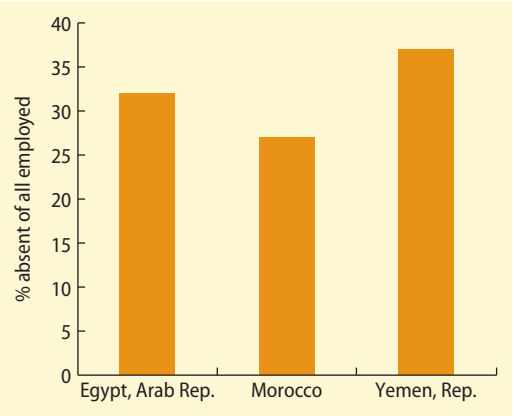


Source: TIMSS, 2011.
Note: MENA = Middle East and North Africa; OECD = Organisation for Economic Co-operation and Development.

teachers' working time is defined only as the time spent at school, and their hours of instruction are not given (Arab Republic of Egypt) or are not recorded (Republic of Yemen). During the PETS visits in the Republic of Yemen in 2006, only 42 percent of teachers were in the classroom teaching. Nineteen percent were absent; 8 percent were reported as "idle"; and the rest were carrying out authorized nonteaching tasks.

The efforts of providers are only partly associated with their workload and satisfaction. By international standards, provider workloads appear to be lower in schools and higher in health facilities. Provider satisfaction is relatively low in the MENA region, especially in public schools (TIMSS). In Egypt, Morocco, and the Republic of Yemen (for which the relevant surveys are available), satisfaction among health professionals is on

FIGURE 6.2 Percentage absent of total employed in health facility: Arab Republic of Egypt, Morocco, and Republic of Yemen, 2010 and 2011



Sources: Egypt: EHGS, 2010; Morocco: PETS (health), 2011; QSDS (health), 2011; Republic of Yemen, QSDS (health), 2010.

average very low, while their workload, particularly in Morocco, is relatively high by international standards. Among the surveyed staff at Morocco's ESSBs, only 20 percent of doctors reported job satisfaction, whereas 58 percent expressed their desire to leave the ESSB they served (PETS, Morocco, 2011; QSDS, Morocco, 2011).

Staff motivation is reportedly a problem. The EHGS (2010) found in Egypt that nearly half of health facility managers reported lack of staff motivation as the main constraint to service delivery, followed by lack of supplies (39 percent), shortage of qualified staff (38 percent), lack of equipment (33 percent), and lack of medications (29 percent).

Tutoring and dual practice

Weaknesses in providers' efforts in public schools generate a demand for (and are exacerbated by) the supplementary services available in the private sector. Schoolchildren in many MENA countries rely heavily on tutoring to gain basic skills. For example, the Survey of Young People in Egypt (SYPE) conducted by the Population Council found that about 58 percent of students in primary education and 64 percent in secondary education were being tutored privately, often by their own public school teachers outside the classroom (SYPE, 2009).

For teachers, tutoring (even if banned for public school teachers such as in Egypt) often becomes an important source of income, possibly compromising their efforts in the classroom (Hartmann 2008; Sobhy 2012). Teachers in the five Egyptian governorates surveyed by PETS tended to hold multiple jobs simultaneously; 90 percent in Fayoum, 85 percent in Dhakalia, 79 percent in Cairo, 67 percent in Luxor, and 65 percent in Minea reported multiple jobs. Poorer governorates reported a lower proportion of such arrangements, but this may stem from fewer job opportunities.[2] Focus group discussions in Egypt and Tunisia indicated that teachers received significantly higher income from tutoring than from their salary. Although systematic, quantitative evidence is not available on the costs of such dual employment—for example, higher absenteeism and deterioration of the quality of teaching or health care—it is clear that, in principle, it presents a conflict of interest and potentially perverts incentives (that is, teachers might not teach well during school hours in order to increase the demand for their private lessons afterward).

Private tutors are also attractive to parents because their children do better in school, especially if tutored by their own teachers. For this reason, the surveyed parents spoke against any ban on tutoring by public school teachers.

Similarly, patients in public health facilities often find their physicians—as public sector employees who may simultaneously hold jobs in the private sector[3]—available only in their private practice. As some users of public facilities noted, "There isn't anything in the evening except the private examination of the unit doctor." In the private sector, by contrast, qualitative analysis from the EHGS shows that opening times are significantly more reflective of patient needs. Although the exact magnitude of this phenomenon in the MENA region is not fully understood, anecdotally it appears that as much as 100 percent of doctors may be engaged in dual practice in some MENA countries.

The theoretical and empirical literature indicate that dual practice may shift physicians' attention toward generating income in their private practice, thereby raising absenteeism in public hospitals and further complicating staffing in rural facilities. Ferrinho et al. (2004) found that in República Bolivariana de Venezuela, doctors missed about 37 percent of their contracted service hours, while in Costa Rica, a majority of doctors and nurses felt physicians were unjustifiably absent from work or, even when present, often saw private patients in public hospitals during public sector hours. And because urban centers offer more opportunities for dual or private practice, the recruitment and retention of physicians in rural areas become even more challenging, widening health inequity.

Where dual practice occurs, particularly in low-income countries, physicians have been known to give their best performance at their private practice while exerting a minimal effort at public hospitals. According to a study by Das et al. (2013), public sector doctors in Madhya Pradesh, India, are more likely to give the correct treatment for angina in their private practice than in their public practice. Physicians also reportedly refer public facility patients to their private practice or engage in "cream skimming" of profitable patients by intentionally altering the quality of treatment, increasing waiting times, and reducing communication with patients in the public hospitals to divert patients to their private practice (Jan et al. 2005). Meanwhile, patients with poorer education and health may be more vulnerable to such inducements (Eggleston and Bir 2006). The result is the capture of clients and often efforts to push patients from the low-cost public services to the more expensive private ones, further increasing the financial burden on them.

If appropriately regulated, dual practice can have positive effects. These include the ability of the public sector to hire qualified doctors at a reduced cost; a reduced reliance on informal payments; mobilization of private participation in health care and transfer of skills and knowledge between private and public practices; and reductions in waiting times for patients (Araújo, Mahat, and Lemiere 2014). Whether these possible positive effects outweigh the potentially negative effects mainly depends on the strength of the existing accountability mechanisms, including the norms of professional conduct and public service.

The regulatory approaches to dual practice vary widely, ranging from allowing dual practice without restrictions to a complete ban (such as in Canada and Turkey). Other countries fall within that range—for example, offering exclusive contracts and supplementary payments for full-time public sector employees (Spain and Portugal), restricting private sector income (France and the United Kingdom), or allowing private practice in public facilities (France). Many MENA countries have attempted to regulate dual practice to minimize its negative impacts on social welfare. At one extreme, economies such as Egypt permit dual practice without restrictions, while at the other extreme West Bank and Gaza and Tunisia have tried to establish a complete ban on dual practice. Other countries such as Saudi Arabia have imposed a complete ban on all public sector physicians with the exception of those working in university hospitals. And yet most MENA countries continue to grapple with dual practice, whatever the instituted policy, to mitigate its potentially adverse effects on health service quality, efficiency, and equity.

To succeed, MENA policy makers need to recognize that dual practice in developing countries is a symptom of a deeper problem of weak standards, motivation, and accountability. In MENA countries, as in many other countries, service standards typically do not exist or are not monitored and enforced; professional bodies play a limited role in regulating and monitoring performance; and civil society is not empowered to exert peer pressure or consumer pressure on physicians to adhere to ethical and professional norms. The poor organizational and management practices in public hospitals, the poor monitoring systems, and the high levels of impunity in the health sector result in the underperformance of health workers in many developing countries. As illustrated by the recent experience in Greece,[4] dual practice policies have little effect unless issues of standards, motivation, and accountability are addressed (Araújo, Mahat, and Lemiere 2014). By contrast, strong monitoring and enforcement capacity, transparency, and well-established health financing systems facilitated a successful regulation of dual practice in Canada, France, and the United Kingdom (Araújo, Mahat, and Lemiere 2014).

A systematic review of international experience identified the presence of the following factors as key to success in addressing dual practice: (1) a well-organized health

financing system; (2) strong regulatory and monitoring systems covering prices, services, and quality in both the public and private sectors, including strong professional boards to monitor and regulate providers; (3) well-established civil society groups to provide feedback and to curtail loss of quality in private and public services; and (4) a political commitment to action as well as a professional commitment to ethics (Kiwanuka et al. 2010).

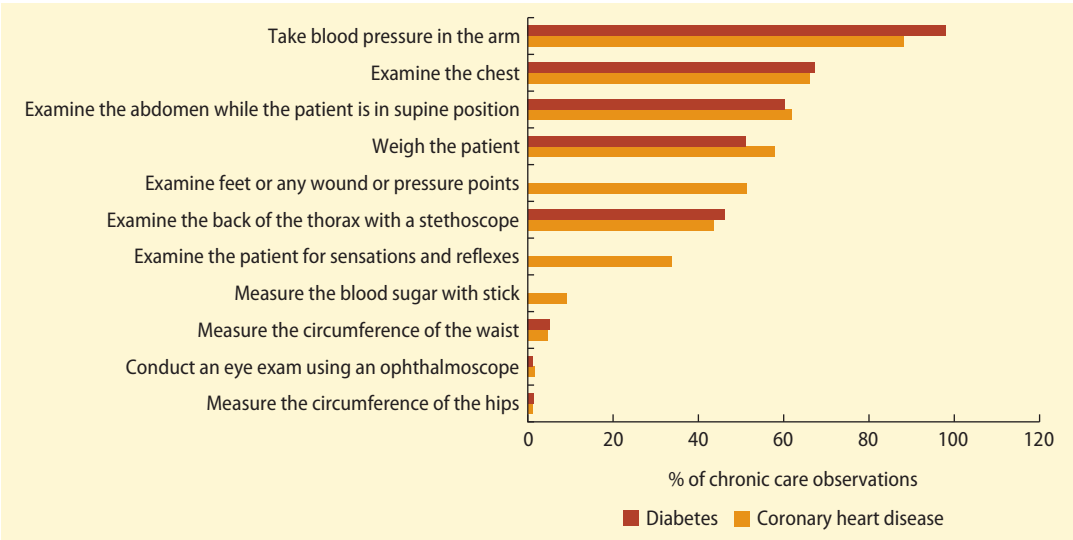
Providers' abilities

What providers know and what approaches they apply to the existing policies and standards are to a significant degree a function of institutions. In this context, our observations of the abilities of teachers and health workers largely relate to the gap between the rules and policies, on one hand, and the reality, on the other—that is, the challenge of policy implementation and enforcement documented in the preceding chapter.

In the empirical research, provider compliance with policies and standards has been predictive of health care quality (Das and Hammer 2014). And considering the influence of institutions on performance, provider compliance has been found related in a statistically significant way to accountability.

As a proxy for providers' abilities, adherence to policies, curricula, and clinical care protocols appears relatively low in the MENA countries where observations have been made. In Egypt, for example, as measured by the 2010 Egypt Health and Governance Study, the majority of doctors did not follow the standard protocols of clinical care. Only about half of patients with diabetes or coronary heart disease (figure 6.3) and two-thirds of children patients (figure 6.4) were weighed as part of an outpatient visit. In schools, according to the limited evidence available, curricula and teaching policies are not adequately implemented. The 2010 Egypt Education Community Scorecard project found that what teachers actually do in the classroom—in terms of practice, content, and pedagogy—may differ widely from the existing policies and regulations (Bold and Svensson 2010). Although many MENA countries have developed robust strategic frameworks and policies for education,

FIGURE 6.3 Percentage of chronic care observations conducted: Arab Republic of Egypt, 2010

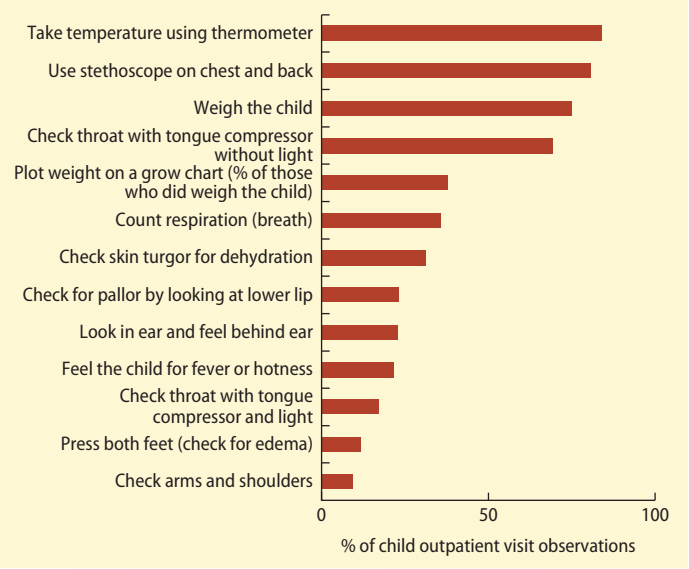


Source: EHGS, 2010.

as demonstrated by the World Bank's SABER project (2010–11), which targeted the technical and vocational education systems, student assessment systems and teacher policies in those countries perform less well on system oversight and service delivery. For example, although curricula reforms across the MENA countries seek to reduce rote learning, 70 percent of students in those countries reported memorizing formulas or procedures in at least half of the math classes they attended. These weaknesses are particularly pertinent as MENA countries seek further reforms to match the supply of skills with demand. The reliance on memorizing lessons in math seems on average higher in MENA countries than elsewhere (figure 6.5).

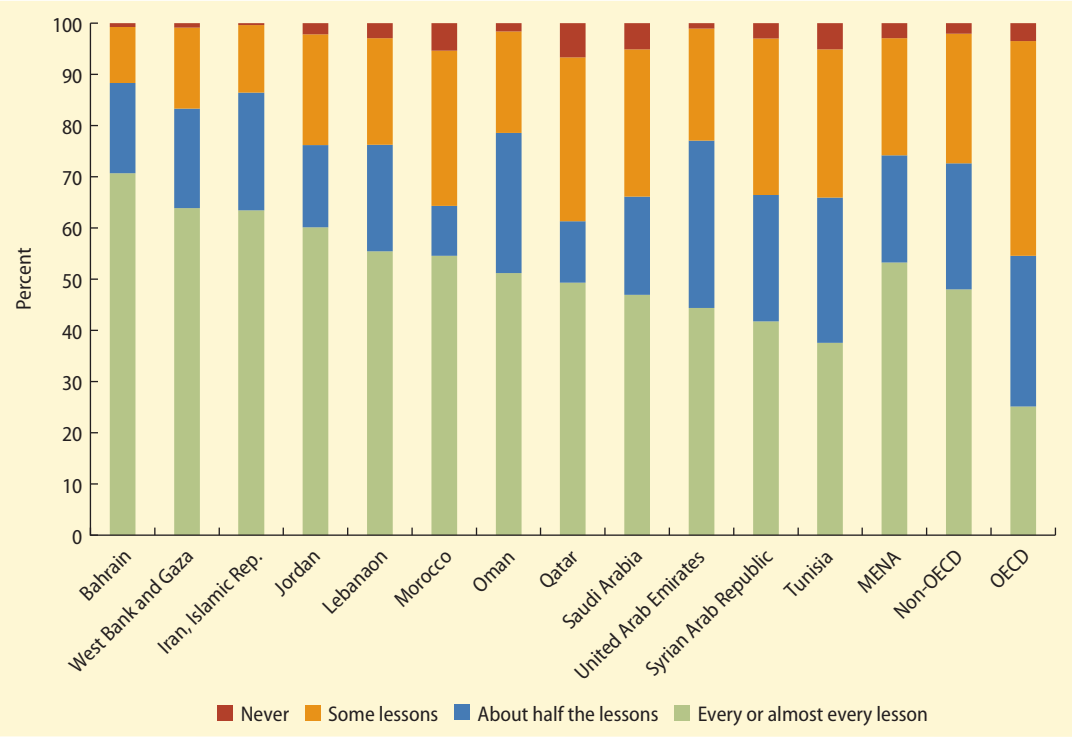
Among teachers, skills in math and pedagogy may be more limited, particularly in rural areas. As reported by principals in the

FIGURE 6.4 Percentage of child outpatient visit observations conducted: Arab Republic of Egypt, 2010



Source: EHGS, 2010.

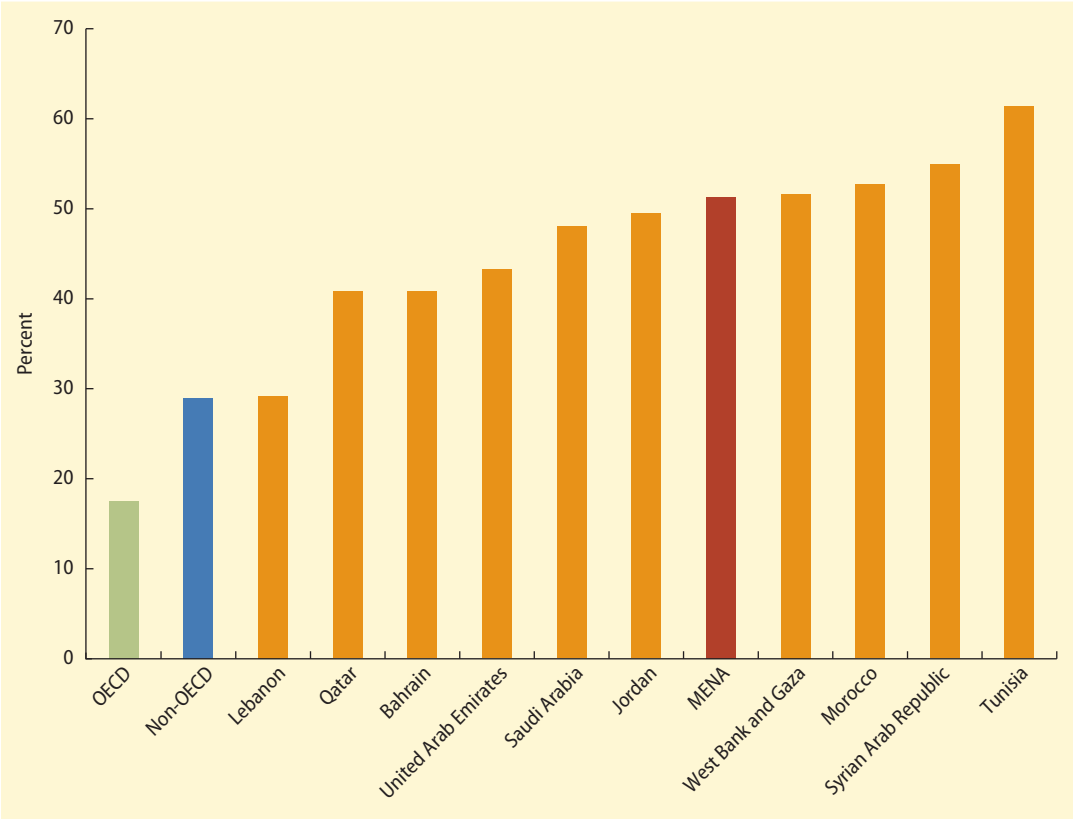
FIGURE 6.5 Percentage of students (grade 8) who report reliance on memorizing lessons in math: OECD, non-OECD, and MENA economies, 2011



Source: TIMSS, 2011.
Note: MENA = Middle East and North Africa; OECD = Organisation for Economic Co-operation and Development.

TIMSS, over half of MENA students attend schools that have a shortage of qualified math teachers (figure 6.6). Although most teachers in the MENA region have relatively high levels of education and report feeling prepared to teach (TIMSS, 2011), the Early Grade Reading Assessment (EGRA) points to a lack of knowledge of the specific pedagogical techniques that lead to better reading skills and the Early Grade Mathematics Assessment (EGMA) to a focus on teaching procedural skills rather than a deep understanding of mathematical concepts. In Iraq, half of teachers reported that they had received no preservice training in how to teach reading and math (Iraq Education Surveys, 2012). In the Republic of Yemen, almost 40 percent of the pool of teachers lacked a postsecondary teaching diploma from a Teacher Training Institute, which is the minimum educational qualification required by the Ministry of Education to become a teacher. Most of these unqualified teachers were found in rural schools (76 percent) and were teaching basic education (91 percent). Only 35 percent of the teachers teaching grades 1–6 held postsecondary diplomas or higher qualifications (PETS, Republic of Yemen, 2006). Other evidence suggests that teachers often cannot identify weaknesses in foundational math and reading skills, and when they can they do

FIGURE 6.6 Percentage of students (grade 8) who attend schools with severe shortages of specialized math teachers: OECD, non-OECD, and MENA countries, 2011



Source: TIMSS, 2011.
Note: MENA = Middle East and North Africa; OECD = Organisation for Economic Co-operation and Development.

not address them adequately so they can cover the necessary material as prescribed by the national curricula (EGRA, EGMA).

Recognizing the challenges associated with acquiring the necessary skills, especially in the context of conflict, aid organizations and ministries of education sometimes work together to launch teacher training programs. Kurdish Iraq, which has a concentration of Syrian and Iraqi refugees, saw the launch of an advanced training program for all teachers working in primary schools across the camps within the Erbil governorate (UNHCR 2014). The training covers psychosocial support, education methodologies, project management, as well as monitoring and evaluation. And yet many teachers in classrooms filled with refugees or displaced children do not have the skills or experience needed to teach large class sizes and students with differentiated needs and from different backgrounds. Students with special needs are at a particular disadvantage in this instance.

In the health sector, across the MENA region, rural areas are especially prone to experiencing shortages of qualified professionals, and openings are partly filled by expatriate staff in the Gulf countries. Surveys in Egypt, Morocco, and the Republic of Yemen have documented serious staff shortages in most rural localities. In the Republic of Yemen, for example, during the 2010 QSDS survey, only 27 percent of public health units had physicians on the roster, and only 40 percent had a nurse. In health centers, 59 percent had a physician on staff and 62 percent had a nurse. Among hospitals, 13 percent had no doctor, and 25 percent had no nurse.

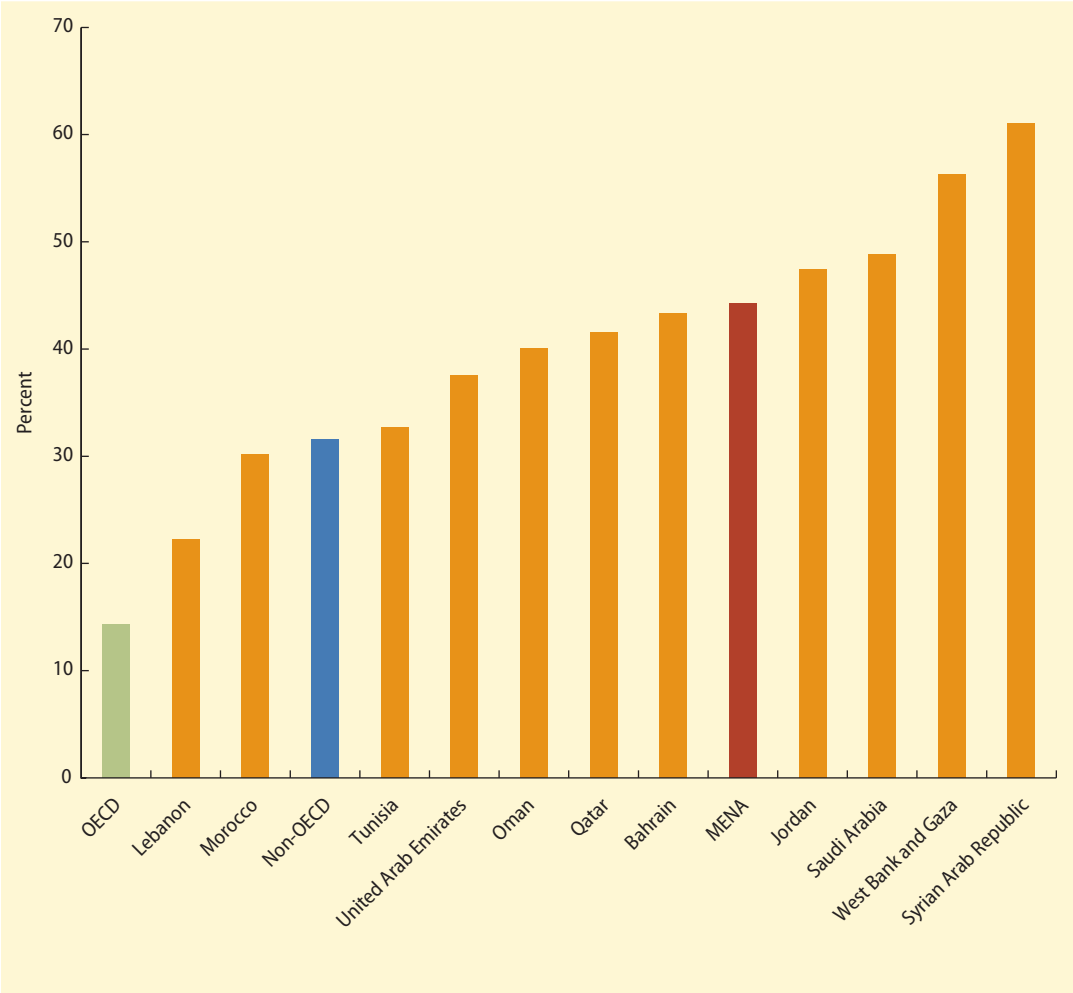
Availability of key inputs

Revealing the weaknesses in internal controls and other basic administrative institutions, MENA countries experience shortages of key inputs in services such as instructional materials in schools and medicines in health facilities. According to the 2011 TIMSS data, on average about 45 percent of students in the MENA region—in both richer and poorer countries—attend schools that have severe shortages of instructional materials (figure 6.7). The reported shortages of materials were especially high in Saudi Arabia, the Syrian Arab Republic (preconflict), and West Bank and Gaza.

Serious shortages have been reported by both public and private schools and are particularly high in rural areas. In Morocco, for example, 63 percent of surveyed rural schools compared with 19 percent of surveyed urban schools reported serious shortages of instructional materials in 2011 (TIMSS). Some shortages may arise because of leakage. The PETS in Egypt revealed that schools in the Luxor and Ismailia governorates received only 0.3 and 1.7 textbooks per student, respectively, whereas the records of the Ministry of Education reported textbook procurement for these governorates of over 22 textbooks per student (PETS, Egypt, 2008). Some computers were available in most schools covered by TIMSS in the MENA region, but nearly half of schools in the Islamic Republic of Iran, one-third in Saudi Arabia, and 12 percent in Morocco reported having no computers at all (TIMSS, 2011). On a more basic level, overcrowding and lack of electricity, water, and toilets (particularly separate toilets for female teachers and girls) appear to be an acute problem in the Republic of Yemen and Djibouti. Overcrowding and reliance on multiple shifts have become a challenge more recently in the communities in Lebanon and Jordan hosting Syrian refugees.

In health, shortages of medications are widespread. The surveyed facilities typically lacked essential medications such as oral penicillin (Egypt) and metformin (Morocco)—see figure 6.8. In Morocco, in three-quarters of ESSBs, at least one drug was out of stock; almost a third of the sampled drugs were out of stock; and replenishment of out-of-stock drugs took two months on average (QSDS, Morocco, 2011). Furthermore, rural ESSBs with maternity wards lacked the basic equipment for pregnancy monitoring and baby delivery. In the Republic of Yemen, facilities of all types across governorates were found

FIGURE 6.7 Percentage of students (grade 8) who attend schools with severe shortages of instructional materials: OECD, non-OECD, and MENA economies, 2011



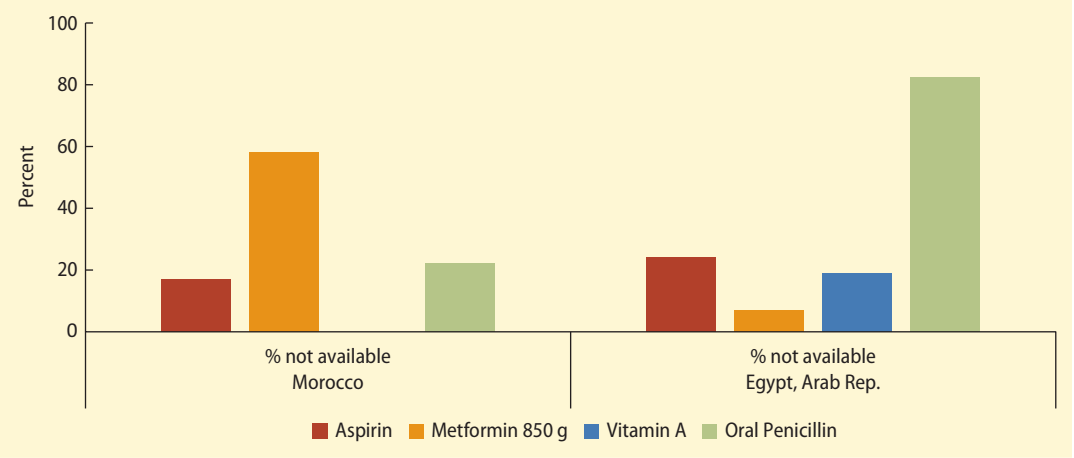
Source: TIMSS, 2011.
Note: MENA = Middle East and North Africa; OECD = Organisation for Economic Co-operation and Development.

poorly resourced and short of standard utilities as well as medications. Similarly in Egypt and Tunisia, facilities, especially in rural areas, have been found underequipped (Saleh et al. 2014).

Shortages in key inputs appear to negatively affect service quality and citizen satisfaction. With the exception of Oman and Saudi Arabia, the reported lack of instructional materials is associated with lower student test scores on the TIMSS. Surveys have reported that shortages of medications as well as their relatively high cost are the main source of citizen dissatisfaction.

The prevalence of gaps in the availability of key inputs such as instructional materials and essential medicines can be traced back to systemic weaknesses in the public procurement systems in the MENA countries. These weaknesses range from a lack of transparency and procurement planning to excessive centralization, poor quality of bidding documents and technical specifications, repetitive rejection of bids, and the limited

FIGURE 6.8 Medication availability: Morocco (2011) and the Arab Republic of Egypt (2010)



Sources: Morocco: PETS (health), 2011; QSDS (health), 2011; Egypt: EGHS, 2010.

participation of suppliers in both the education and health sectors. These bottlenecks, coupled with political interference and corruption, also add cost. The prices of essential medicines, for example, are high in the MENA countries compared with the internationally referenced prices.

Interpreting service delivery performance

This chapter has documented the selected performance weaknesses at the point of service delivery. In doing so, it has highlighted a mix of gaps in providers' efforts and abilities and the availability of key inputs. Although simple internal control mechanisms can ensure an adequate distribution of textbooks to schools and medicines to health facilities, much more complex institutions and accountability mechanisms—informal and well as formal—are at play in driving the behavior of teachers and health workers.

In chapter 5, we outlined the key political, administrative, and social institutions that shape the incentives of providers. We argued that the roots of service delivery performance problems, such as provider absenteeism, poor quality of teaching or care, and shortages of textbooks and medicines, can often be traced to the wider political, administrative, and social institutions and accountability mechanisms. However, more research is needed to pinpoint which institutions and types of formal and informal incentives influence provider behavior in which way. In this respect, the case studies presented in chapter 3 offer a useful illustration of the possible positive institutional influences at the local level.

It is important as well to recognize the demand-side constraints that affect service delivery performance and results. In the MENA region, these constraints stem mainly from the labor market distortions flowing from the existing social contract, as noted in chapter 2 and further discussed in chapter 5. These distortions mainly affect the performance of the education and training systems. They are especially pronounced in the Gulf Cooperation Council (GCC) countries, and they are connected to the established welfare-sharing mechanism at the core of the social contract (box 6.1).

Chapter 7 describes the extent and nature of performance variation at the point of service delivery within countries and illustrates the importance of looking beyond averages in examining service delivery challenges and their institutional drivers.

BOX 6.1 The demand-side story in the quality of service provision

Development specialists now recognize the supply-side "good governance" mechanisms that drive the quality of service provision: transparency, high-quality public sector management, monitoring and regulatory mechanisms, and independent accountability institutions. The demand-side story, however, has received less attention. The general assumption is that citizens demand and value high-quality services across all sectors. And yet citizens' demands for services differ across countries and sectors, and the quality of services is associated with the level of demand citizens exhibit.

This finding is clearly demonstrated by examining the impact of natural resource rents on the quality of education and health services. Rents may impede the development of institutions that give providers incentives to use resources efficiently. But they also shape citizens' demands for different services. Although the demand for high-quality health services is high across both rentier and nonrentier countries, citizens in rentier economies are less likely to demand high-quality education, leading to a lower supply of high-quality education even if institutional quality is taken into account.

The explanation for this is simple: citizens in rentier economies are less concerned about attaining a high-quality education because students and their parents do not see education as critical to a career. In the rentier system, they are able to obtain good jobs and a high standard of living regardless of the quality of education they attain. For example, when college graduates are guaranteed public sector employment—as in Qatar—their incentives to attain a high-quality education decline. By contrast, although unearned foreign income may free citizens from the need to attain a high-quality education, it does not free them from concerns about their health. Thus rents have no effect on health status, and so the demand for high-quality health care is high in both rentier and nonrentier countries.

Rents therefore affect education and health in different ways. They do not have a statistically significant impact on health, but they negatively affect the quality of education. Analysis of the 2011 TIMSS math scores worldwide for fourth- and eighth-grade students as a measure of education quality reveals that the relation between rents and education is statistically significant and substantial. Controlling for institutions and other covariates, an increase in rents by about US$22,000 per capita decreases, other things being equal, the TIMSS scores by 70–90 points. By contrast, when one controls for institutions, in 2012 rents had no statistically discernible effect on health outcomes, as measured by standardized mortality rates and per capita disability-adjusted life years (DALY) for noncommunicable diseases only (Global Health Observatory, 2012).

Moreover, analysis of the 2011 TIMSS student surveys in eight MENA GCC and non-GCC countries finds that the differences in education provision are driven by a lower concern about education. With few exceptions, students in nonrentier countries report that their parents talk more about school with them, they feel more like they belong in school, they believe it is important to do well at school, and they discern a closer connection between success at school and their future career than students in rentier countries.

These findings offer new insights that are worth considering. For one thing, they highlight the importance of taking citizens' demand for service delivery more seriously. Moreover, because the demand for different services can vary significantly between rentier and nonrentier countries and across different sectors such as education and health, they suggest that policy makers and practitioners must consider much more carefully both supply- and demand-side forces.

Source: Alaref, Lueders, and Lust (2014).

Notes

1. http://www.sdindicators.org/.
2. By law in Egypt, teachers employed in a public school are allowed to simultaneously hold other teaching positions in other schools. However, teachers on open contracts are not legally allowed to hold another job (SABER).
3. This phenomenon in the health care setting is known as dual practice or "moonlighting." It has been documented as a common practice in both developed and developing countries.
4. Greece's attempt to ban dual practice (1983–2002) is an example of an attempt to regulate the phenomenon without addressing the deep underlying issues that led to it in the first place; it backfired. Because of the weak accountability and monitoring system in the Greek health sector, the ban did not result in a reduction of informal payments, nor did it eliminate dual practice, which continued outside the regulatory jurisdiction of government.

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Subnational Variation in Service Delivery Performance

7

- Service delivery performance varies widely within countries, even as service delivery systems are centralized in countries in the Middle East and North Africa.
- Even where the political and administrative accountability mechanisms are weak, some communities are able to motivate providers to adhere to standards and deliver quality services.
- Apart from the familiar local factors such as wealth, it matters how local leaders and local institutions fill the institutional gaps penetrating service delivery systems from the national level.
- The existing forms and sources of variation allow identification of where an effective response to the existing institutional constraints already exists.

As earlier chapters have described, many challenges are associated with the delivery of social services in the Middle East and North Africa (MENA). The array of complex challenges range from a lack of basic resources and limited accountability to outdated practices and perverse incentives. Levels of performance are on average below where they should be, but there is great variation within them, all the way down to the individual villages and even within specific schools and health clinics. No matter what unit of analysis is selected, one can identify some areas in which the quality of performance is truly awful, a majority in which most providers are struggling to do the best they can, and a few that are extraordinary (as we saw in the case studies in chapter 3), somehow managing to overcome the same difficulties confronting everyone else and consistently deliver outstanding services.

This chapter seeks to identify the nature and extent of this variation in performance, to explain where and why it occurs, and to draw on these explanations as a basis for promoting systemic improvement. The analysis draws on a combination of secondary and (some) primary data, and so does not always reach the level of precision we might desire, not least because most of the data were not designed to answer the specific questions we are asking. For present purposes,

however, the goal is aspirational, and our evidence is indicative: to bring about the reforms required, MENA countries must acquire a more comprehensive and accurate sense of how they are performing and, on this basis, gain insights into what improvements might be sought and what could be done to bring them about. Lessons can be learned from outside sources, to be sure, but they mostly are found first at home, from those who have already figured out how to make things work.

In this chapter, we document the nature and extent of the subnational variation in service delivery quality primarily in the area of health services and (to a lesser extent) education. Although these services are typically administered in a highly centralized manner, as described in chapter 5, this chapter aims to detect better-performing entities at the facility, district, or regional level in order to identify more proximate and tangible factors associated with their relative success. In the opening sections on health services in the Republic of Yemen and Morocco, we draw on both quantitative survey data and qualitative material from interviews with country experts about how they perceive and understand variation in service delivery. Where possible and appropriate, we integrate the results of the quantitative and qualitative analyses into a single account. Subsequently, we present summary evidence of a more indicative nature, based on surveys in a range of countries: education and health services in the Arab Republic of Egypt and education in the Republic of Yemen, Morocco, Saudi Arabia, Oman, Qatar, the United Arab Emirates, Bahrain, and Tunisia.

Subnational variation in health services delivery in the Republic of Yemen

In the Republic of Yemen, subnational variation in health services delivery was examined using the 2010 Quantitative Service Delivery Survey (QSDS) for that country.[1] Because of the nature and coverage of the data, the analysis was conducted at both the governorate and district levels. The priority indicators of interest in analyzing both data sets were those best reflecting the process of service delivery. They included the availability of specific forms of infrastructure and medical equipment, the rates of absenteeism among medical and other staff, and the availability of essential medications. Annex A briefly describes the QSDS data set for the Republic of Yemen.

Variation in infrastructure and equipment availability

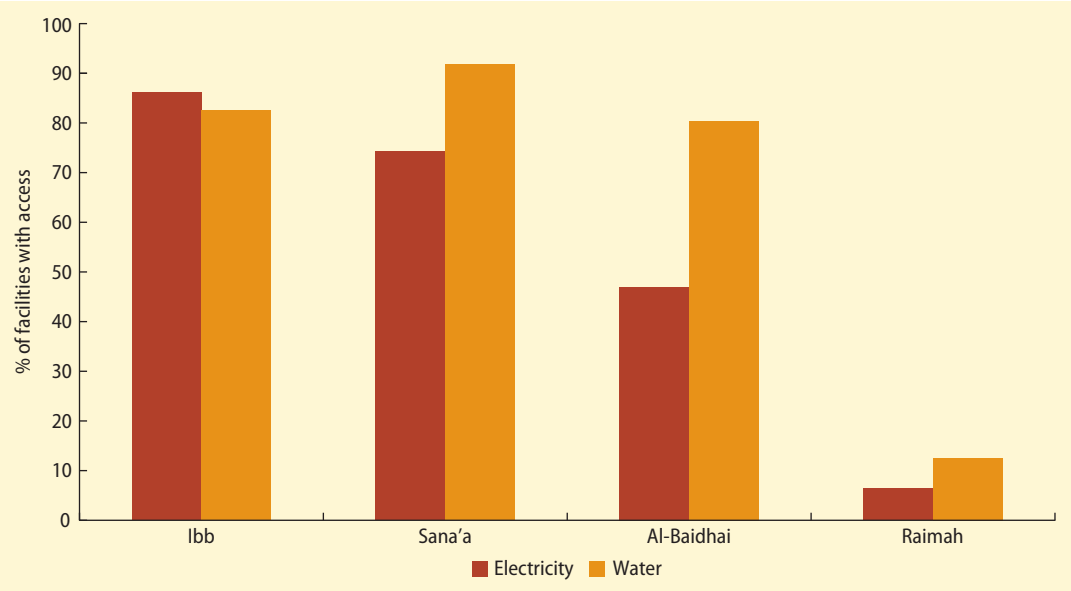
In the Republic of Yemen, there is considerable subnational variation in the provision of infrastructure such as electricity, beds, and water (figures 7.1 and 7.2). At the governorate level, Ibb had the highest percentage of health care facilities with electricity (86 percent) and also the highest number of beds (an average of 8.4 per facility). Sana'a had the highest percentage of health care facilities with water (91 percent), while at the other end of the spectrum Raimah had the lowest access to both electricity (only 6.3 percent of facilities) and water (12.5 percent). Very few facilities had access to telephones, wireless, heating, and vehicles or ambulances, preventing subnational analysis.

Even wider variation is evident at lower units of analysis. At the district level, Alshaar had the highest mean number of beds across facilities, with an average of 8.4. The five districts with the highest number of beds (10 or more) and their respective governorates were in ascending order: Alshaar (Ibb), Alsawadiah (Al-Baidha), Mothikerah (Ibb), Mokairas (Al-Baidha), and Arhab (Sana'a).

Variation in absenteeism

At the governorate level, Raimah had the lowest level of absent health facility employees, 27 percent, compared with 29 percent in Al-Baidha, 31 percent in Ibb, and 40 percent in Sana'a. Raimah, however, was by far the weakest performer in terms of access to water and electricity, suggesting that problems in one

FIGURE 7.1 Availability of electricity and water in health care facilities, by governorate: Republic of Yemen, 2010



Source: QSDS (health), Republic of Yemen, 2010.

domain (logistics, access) are not necessarily associated with problems in another (relational challenges such as attendance). There also was considerable variation within Raimah itself; at the district level, the level of absent health facility employees varied between 0 and 90 percent (figure 7.3).

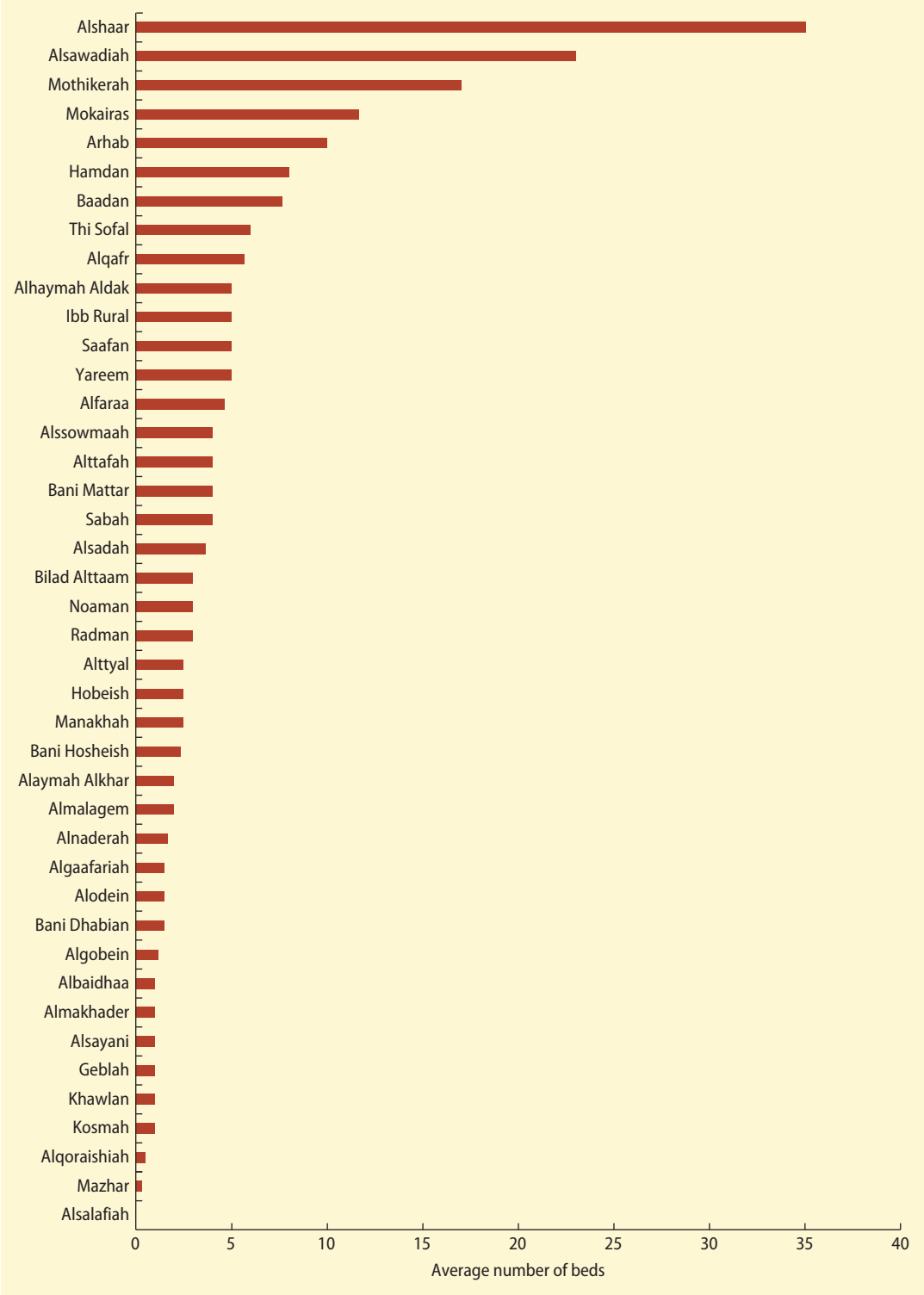
From an analysis of the relationship between measures at the district and governorate levels emerge strong positive correlations (0.85 or above) between the availability of amenities (electricity, water, heat, telephone), but just moderate correlations for the availability of beds (table 7.1). Staff absenteeism, however, correlates only very weakly with both equipment and amenities (less than 0.10) at the district level; more moderate correlation appears between absenteeism and the availability of beds, electricity, and water at the governorate level. At the facility level, there is less overall correlation in general, with weak correlations among all investigated measures.

These important findings suggest that the mechanisms for managing staff may be very different than the mechanisms for maintaining equipment and improving amenities—in other words, strategies for successful reforms will have to be tailored to the specific characteristics of the problems and contexts involved.

Explaining variation in health services in the Republic of Yemen

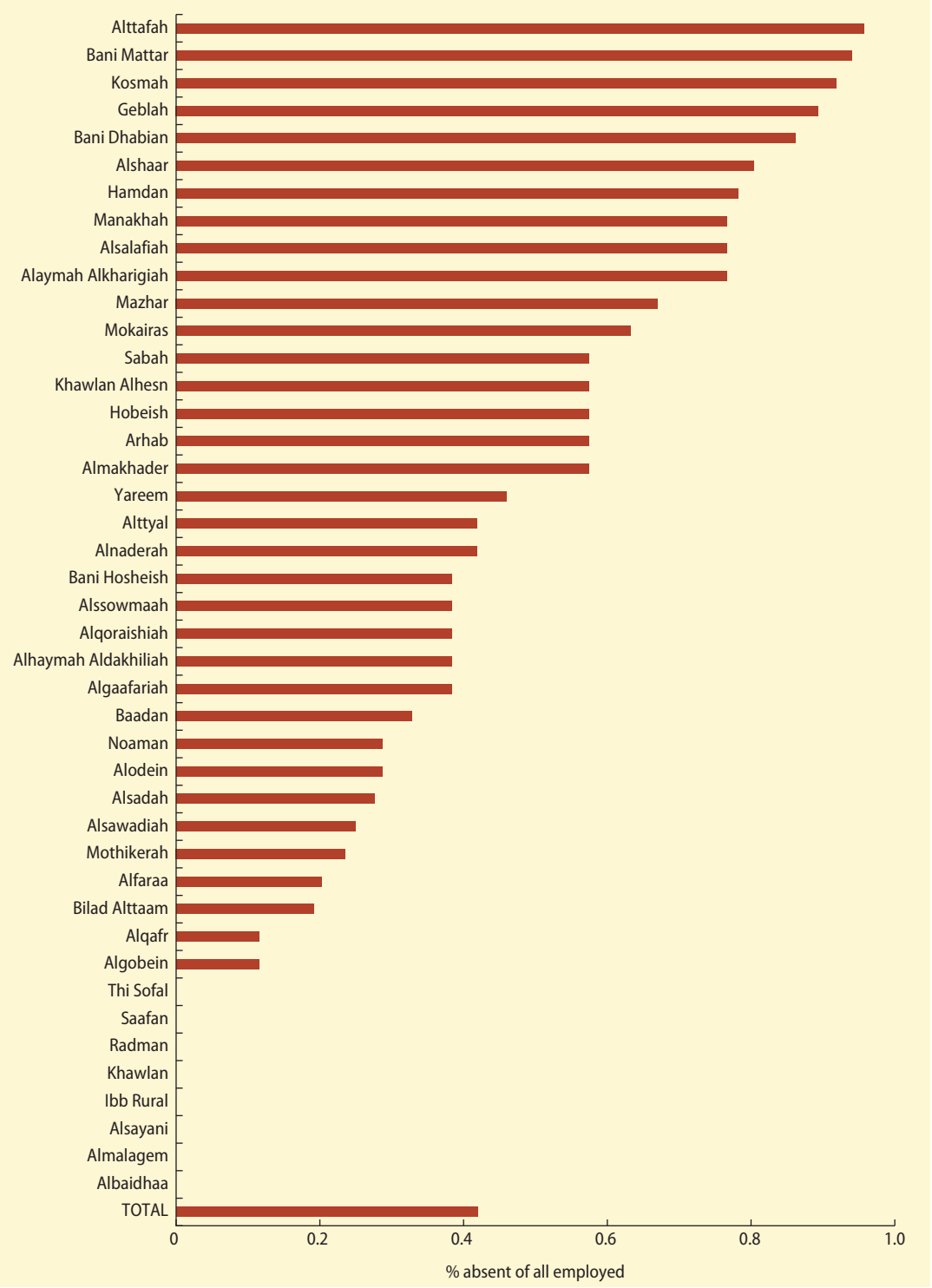
What is the explanation for why and where such variation occurs in the Republic of Yemen? There is no straightforward answer. The variables one might ordinarily expect to account for these differences, such as wealth or location (for example, remote rural), seem to be far from consistent predictors. Of the 4 governorates (of 21) covered in the QSDS survey, Raimah tends to be consistently the most poorly resourced and underperforming governorate, and yet compared with the other governorates it had the fewest (though not significantly) number and percentage of absentee workers and the lowest percentage (22 percent) of patients who reported having

FIGURE 7.2 Average number of beds per health care facility, by district: Republic of Yemen, 2010



Source: QSDS (health), Republic of Yemen, 2010.

FIGURE 7.3 Absenteeism in health care facilities, by district: Republic of Yemen, 2010



Source: QSDS (health), Republic of Yemen, 2010.

Table 7.1 Correlation of absenteeism in health care facilities and other measures at the governorate and district levels, Republic of Yemen

	Absenteeism	No. of beds	Electricity	Heat	Water	Telephone
Governorate						
Absenteeism	1					
No. of beds	−0.246	1				
Electricity	−0.192	−0.160	1			
Heat	−0.015	0.578	0.647	1		
Water	−0.392	−0.064	0.977	0.636	1	
Telephone	−0.001	0.552	0.664	0.999	0.649	1
District						
Absenteeism	1					
No. of beds	0.017	1				
Electricity	−0.013	0.164	1			
Heat	0.051	0.388	0.861	1		
Water	−0.003	0.116	0.930	0.882	1	
Telephone	0.055	0.293	0.882	0.942	0.901	1

Source: QSDS (health), Republic of Yemen, 2010.

to pay for the care they received. And yet in Raimah only 11 percent of patients reported receiving a receipt listing all their fees, compared with 37–68 percent among those accessing facilities in other governorates. For mobile health units, Raimah residents reported the shortest visits and the highest percentage noted that the amount of time was not appropriate.

In this study, interviews with country experts revealed that two key factors were thought to shape the delivery of health services: geographic accessibility and culture. These factors interact in important ways in the Republic of Yemen, particularly in the behavior of women seeking health care. In the north, there are fewer facilities, and although on paper the coverage rate for fixed unit facilities is about 67 percent, in reality it is probably closer to 35 percent because of the greater density of facilities in urban areas. In addition, cultural factors in the north limit the movements of women without a chaperone, and so women are unlikely to travel far for health care when alone. If facilities were closer to women's homes, access might not be as limited, but cultural issues exacerbate the problem of health care utilization. Because of the country's low population density (it has some 133,000 population sites), the use of stationary health facilities is not an effective strategy. The use of mobile outreach teams has helped address differential utilization rates, primarily through mobile vaccination programs, and this approach should be continued to bridge the gap between less remote and more remote areas. In addition, cultural differences, particularly the mobility of women, lead to differential patterns of seeking birthing facilities. Meanwhile, the home care delivery system is addressing these problems of distance between facilities and the communities they are intended to serve.

The absence of any clear-cut explanation for the variation in facilities, resources, and staff diligence in the Republic of Yemen suggests that distinct dynamics are associated with each type of problem and that would-be solutions to these problems must be tailored to these idiosyncrasies. Because these problems are likely to be highly context-specific, the best source of solutions is likely to be those professionals and others who have already managed to work within the prevailing constraints to find a better way of doing things.

Subnational variation in health services delivery in Morocco

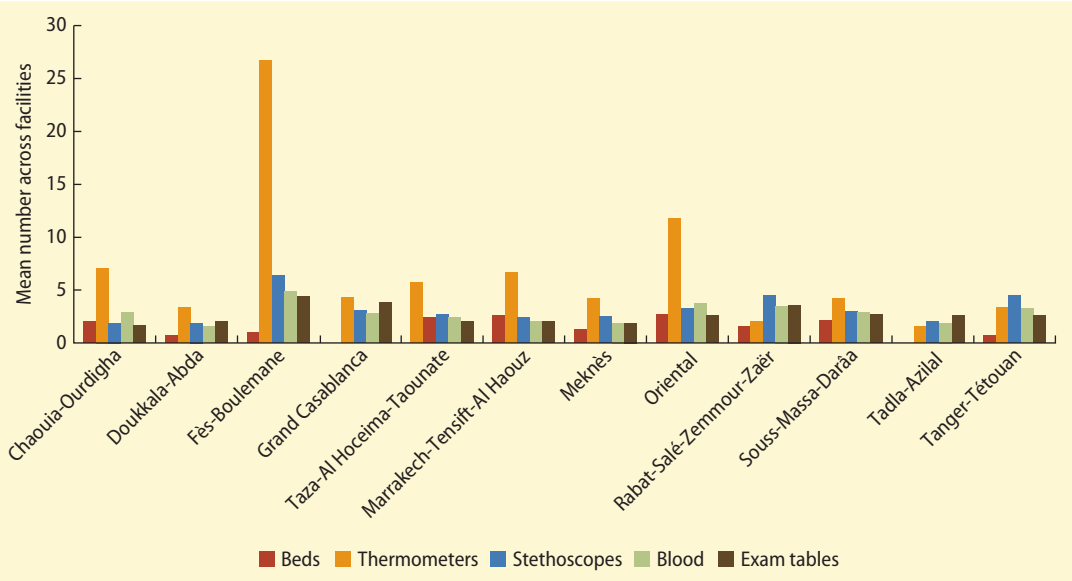
This analysis uses two World Bank surveys of the health care sector in Morocco: the Public Expenditure Tracking Survey (PETS) and the QSDS. These surveys covered 180 health centers (*établissements de soins de santé de base*, ESSBs) across 12 of Morocco's 16 regions and 31 provinces/prefectures, thereby limiting the ability to generalize to all of Morocco. In addition, only a specific cadre of health facilities was sampled in Morocco, which limits the ability to extrapolate the findings to all health care facilities. Furthermore, because these facilities were purposively sampled to be in the vicinity of a hospital, they likely show better performance than those not as closely located to a higher-tier health care setting. Annex B describes the Morocco PETS and data sets.

Variation in medical equipment availability

At the regional level, Taza-Al Hoceima-Taounate had the highest average number of beds across facilities (mean = 7.0), whereas two other regions barely had one (figure 7.4). Similar variation is found at the provincial level (figure 7.5), with Skhirate-Témara having the highest average number of beds across facilities (mean = 8.0), whereas several other provinces had only one bed per facility. At the regional level, Fès-Boulemane had the highest mean number of thermometers (mean = 26.7), stethoscopes (6.4), (units of) blood[2] (4.9), and exam tables (4.4) across facilities, suggesting that the capacity to provide basic resources (medical equipment) extends across the component elements—that is, being able to provide one resource (or not) correlates strongly with being able to provide others. Using these items as measures of equipment availability, at the provincial level facilities in Fès (n = 7) were the best equipped, followed (in no particular order) by Berkane, Agadir, Al Fida-Mers Sultan, and Skhirate-Témara.

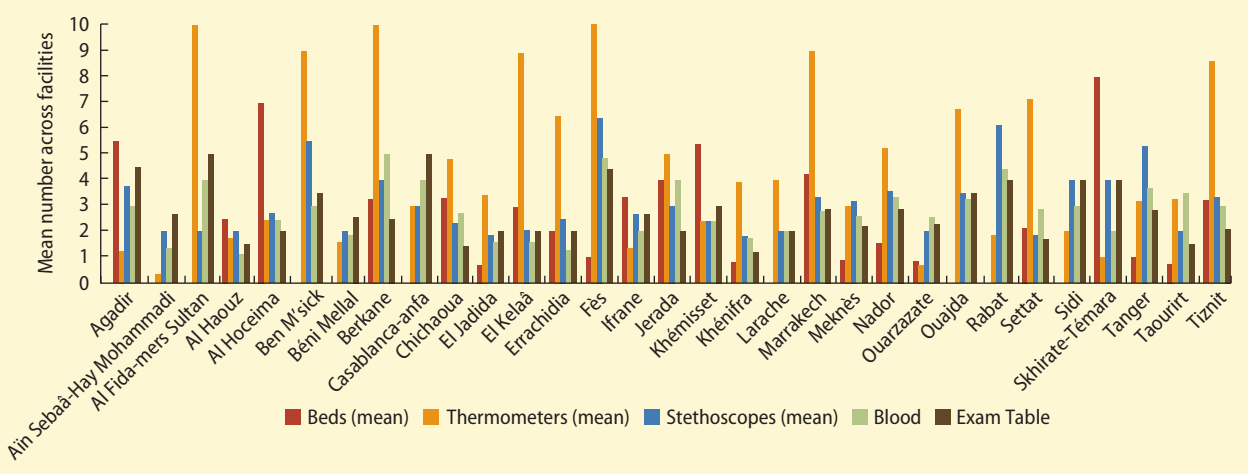
In addition to basic physical infrastructure, health facilities must have a reliable and adequate stock of essential medical supplies such as aspirin. At the regional level, aspirin was available at all facilities in Chaouia-Ouardigha and

FIGURE 7.4 Availability of medical equipment at health facilities, by region: Morocco, 2011



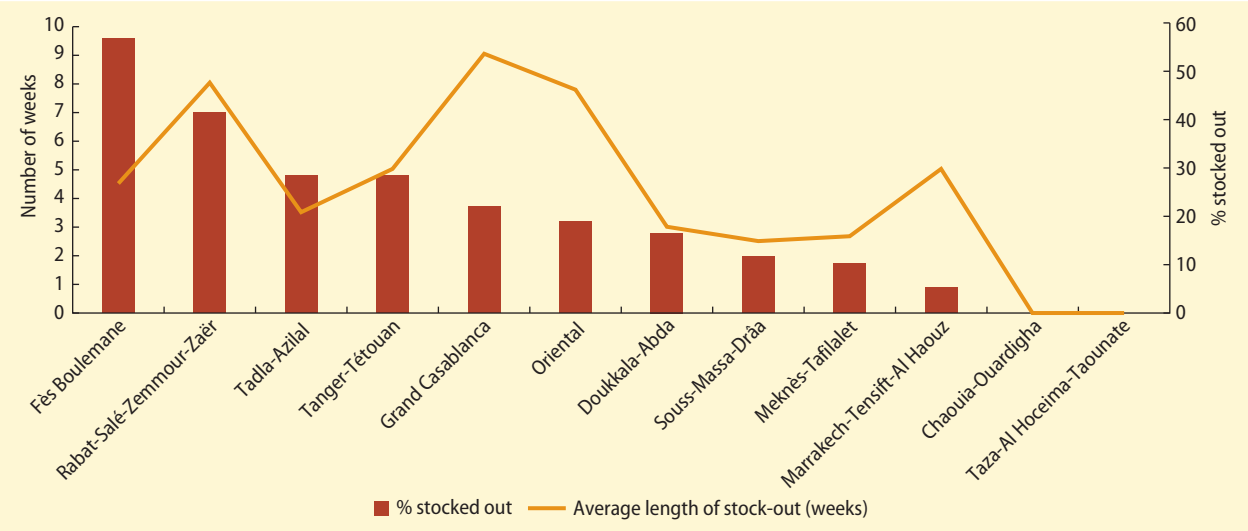
Sources: PETS (health), Morocco, 2011; QSDS (health), Morocco, 2011.

FIGURE 7.5 Availability of medical equipment at health facilities, by province/prefecture: Morocco, 2011



Sources: PETS (health), Morocco, 2011; QSDS (health), Morocco, 2011.
Note: The mean number of thermometers exceeds the axis range.

FIGURE 7.6 Availability of aspirin, by region: Morocco, 2011

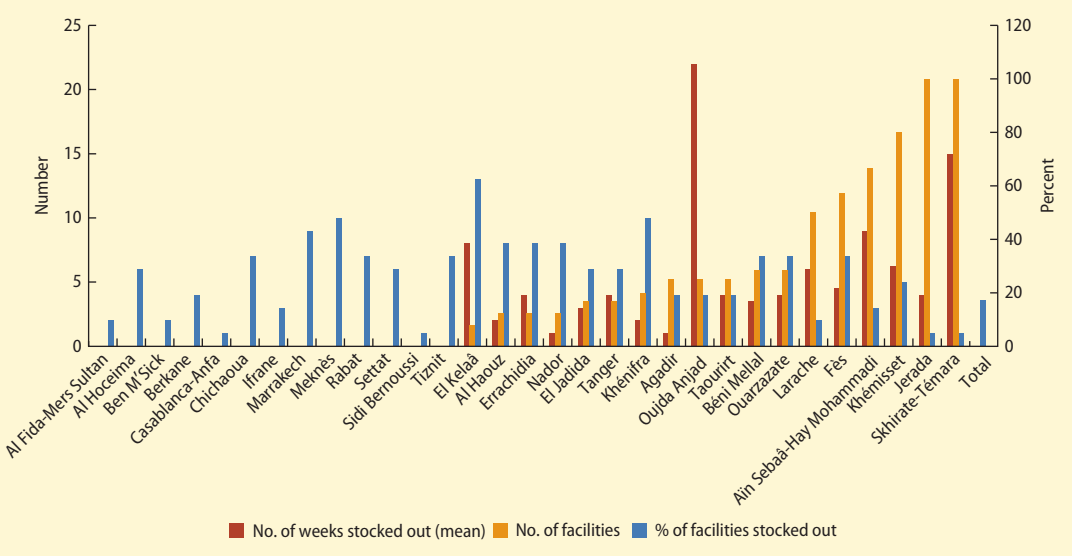


Sources: PETS (health), Morocco, 2011; QSDS (health), Morocco, 2011.

Taza-Al Hoceima-Taounate. At the provincial level, aspirin was available in all facilities in 12 different provinces (see figure 7.6). Among provinces where more than five facilities were surveyed, Meknès, Marrakech, Rabat, Chichaoua, Settat, and Al Hoceima had perfect records of aspirin availability.

The availability of metformin (used to treat type 2 diabetes), however, was less uniform. At the regional level, many facilities were stocked out. Although the percentage of facilities without stock was lowest in Rabat-Salé-Zemmour-Zaër and Taza-Al Hoceima-Taounate (33 percent of facilities had no

FIGURE 7.7 Availability of aspirin, by province/prefecture: Morocco, 2011



Sources: PETS (health), Morocco, 2011; QSDS (health), Morocco, 2011.

stock), the average stock-out time was only six weeks in Rabat-Salé-Zemmour-Zaër, compared with 28 weeks in Taza-Al Hoceima-Taounate. At the provincial level, four provinces—Al Fida-Mers Sultan, Rabat, Sidi Bernoussi, and Skhirate-Témara—reported no stock-outs. However, few facilities in each of these provinces reported. Only in Rabat were more than five facilities surveyed (n = 7).

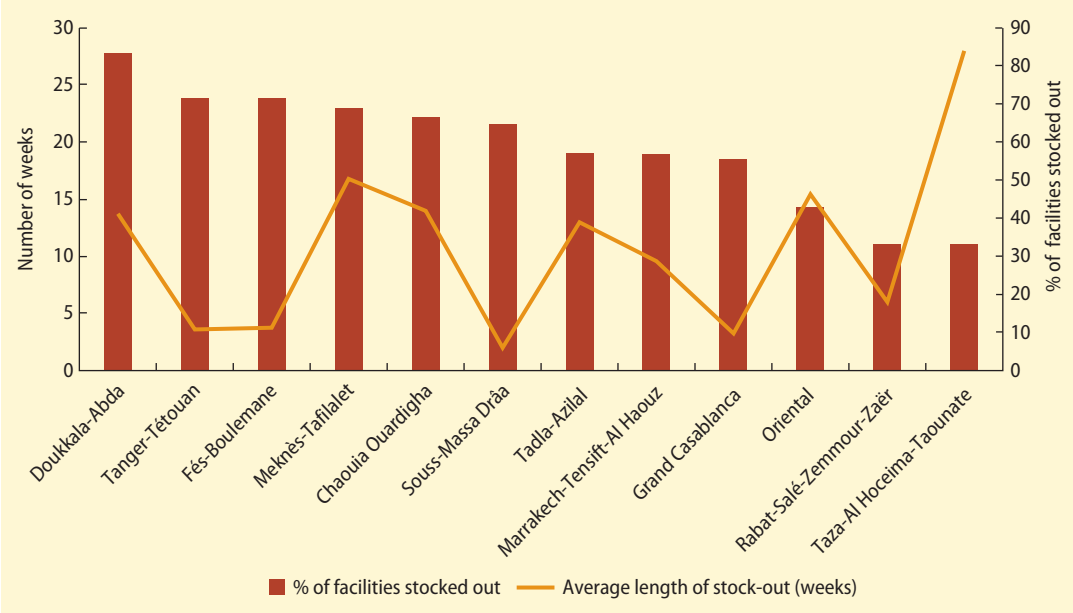
Using the stock-outs in aspirin and metformin as measures of essential drug availability, facilities in Rabat had the best records of aspirin and metformin availability at both the regional and provincial/prefectural levels (see figures 7.6, 7.7, 7.8, and 7.9).

Variation in absenteeism

Beyond material infrastructure and basic medical supplies, health clinics need trained and diligent staff. One measure of diligence is staff absenteeism, and in Morocco the average rate is 27 percent (figure 7.10). This average, however, masks wide variation. At the regional level (figure 7.10), both Oriental and Grand Casablanca had the lowest percentages of absences among employed staff (20 percent); absences in Tanger-Tétouan and Fès-Boulemane were more than double this level (44 percent). At the provincial level (figure 7.11), Jerada (located in Oriental) had the lowest percentage of all staff absenteeism, 0 percent. However, that province had only one facility, employing a total of nine staff. Using a cut-off criterion of five facilities surveyed, Marrakech (96 staff across nine facilities) had only 14 percent absenteeism, while Rabat (57 staff across seven facilities) had only 16 percent absenteeism.

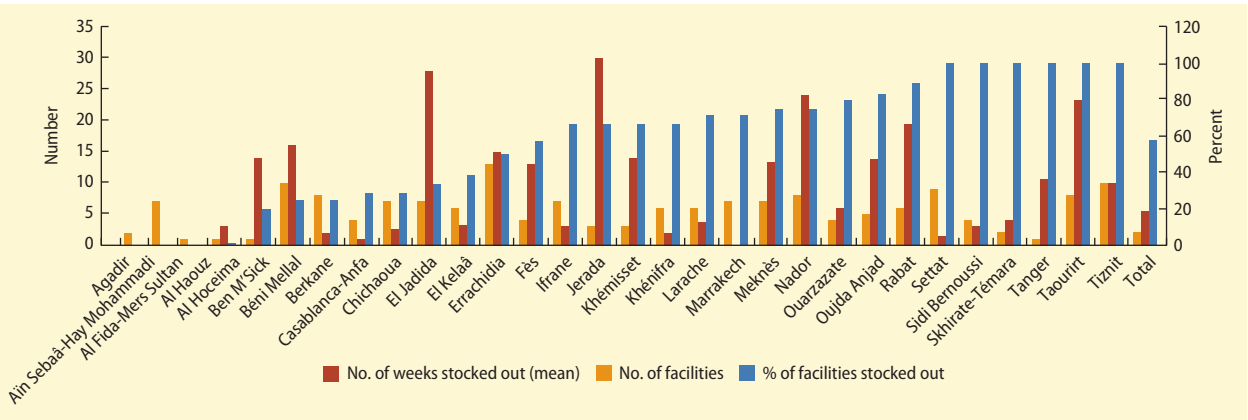
Absenteeism is a particular concern among doctors, the key providers of medical services, who are missing on average 42 percent of the time in Morocco. At the regional level (figure 7.12), absences among doctors were lowest in Rabat-Salé-Zemmour-Zaër (21 percent) and Grand Casablanca (23 percent) and highest in Tadla Azilal (73 percent) and Fès-Boulemane (an astounding 81 percent). At the provincial level (figure 7.13), Casablanca (four doctors in one facility), Jerada (two doctors in one facility), and Skhirate-Témara (four doctors in one

FIGURE 7.8 Availability of metformin, by region: Morocco, 2011



Sources: PETS (health), Morocco, 2011; QSDS (health), Morocco, 2011.

FIGURE 7.9 Availability of metformin by province: Morocco, 2011



Sources: PETS (health), Morocco, 2011; QSDS (health), Morocco, 2011.

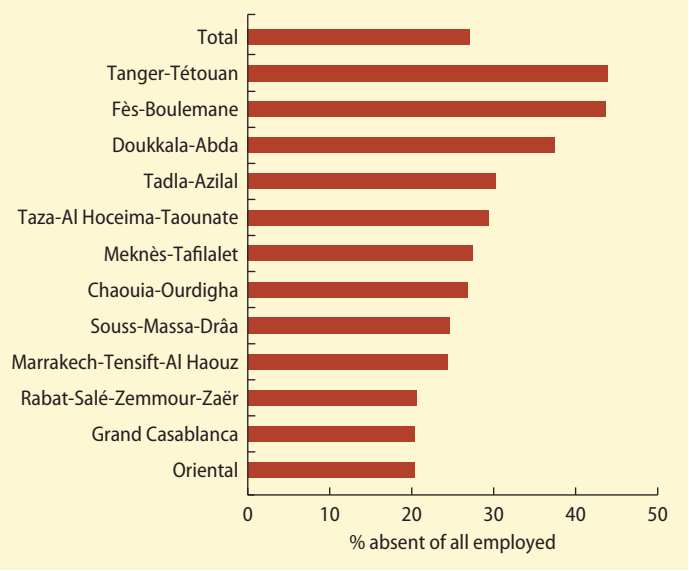
facility) each had 0 percent absenteeism among their employed doctors. Al Fida-Mers Sultan and Ben M'Sick each had only 14 percent of doctors absent (each had seven doctors across two facilities). In those provinces in which a minimum of four facilities were surveyed—Agadir (10 doctors across four facilities), Marrakech (25 doctors across nine facilities), and Rabat (30 doctors across seven facilities)—20 percent of employed doctors were absent, performing better than the national average of 42 percent of doctors absent.

Even in some of the "best" regions and provinces, however, it is clear that structural incentives (including lack of accountability)

conspire to enable doctors working in public facilities to routinely shirk their duties. It would be highly instructive to learn how and why some facilities (and not others) are able to overcome these constraints. Without further investigation, we can only speculate—based on our case study evidence presented in chapter 3 and the secondary literature—that the combination of strong midlevel leadership (which expects, requires, and encourages facility staff to do their jobs to the best of their ability) and social ties (exerting local pressures and motivation via community norms and reputation mechanisms) explains why and where absenteeism is low.

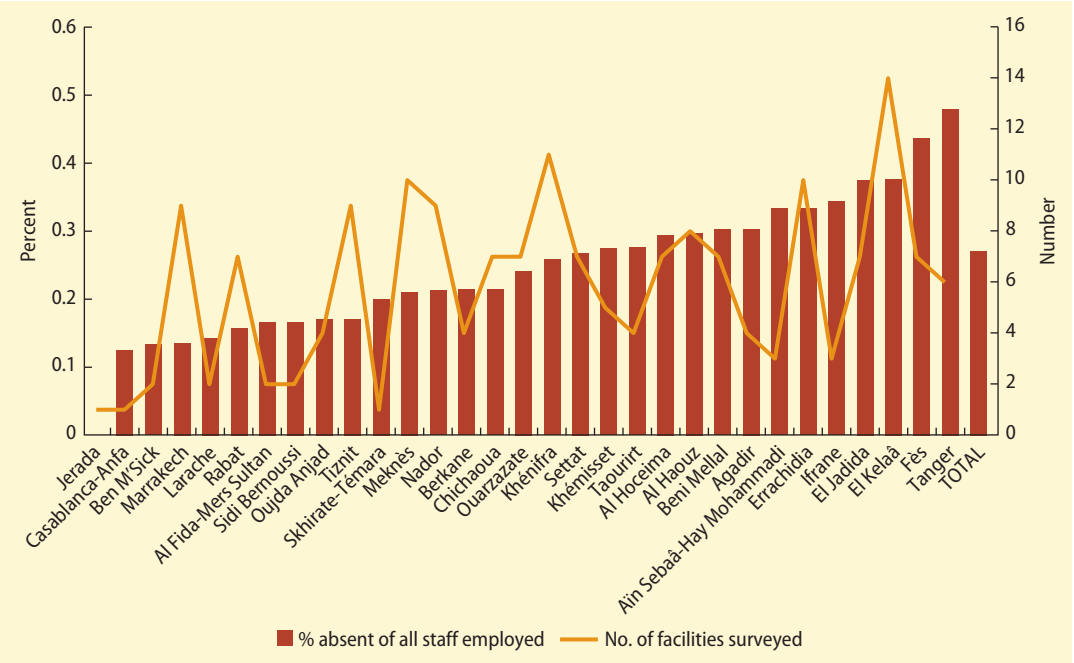
The correlation between absenteeism and the measure of equipment and availability was substantial but unusual, with geographic level affecting the direction of correlation (table 7.2). For example, at the regional level, staff and doctor absenteeism generally were correlated moderately negatively with other

FIGURE 7.10 Absenteeism among health facility staff, by region: Morocco, 2011



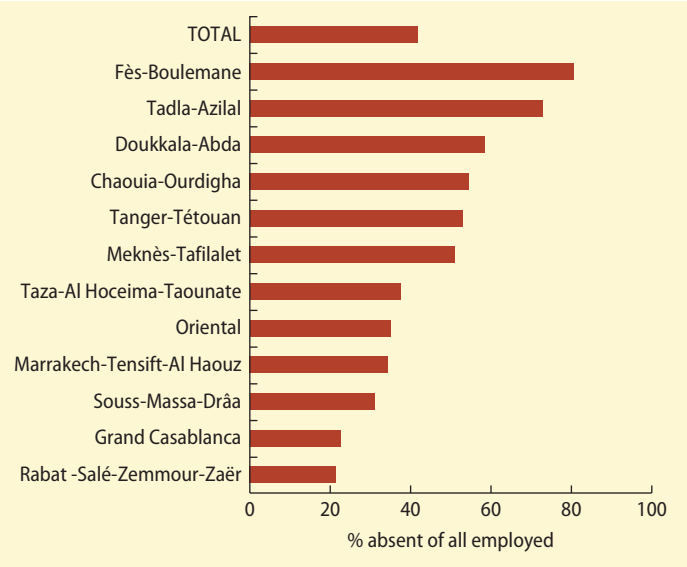
Sources: PETS (health), Morocco, 2011; QSDS (health), Morocco, 2011.

FIGURE 7.11 Absenteeism among health facility staff, by province/prefecture: Morocco, 2011



Sources: PETS (health), Morocco, 2011; QSDS (health), Morocco, 2011.

FIGURE 7.12 Absenteeism among doctors, by region: Morocco, 2011



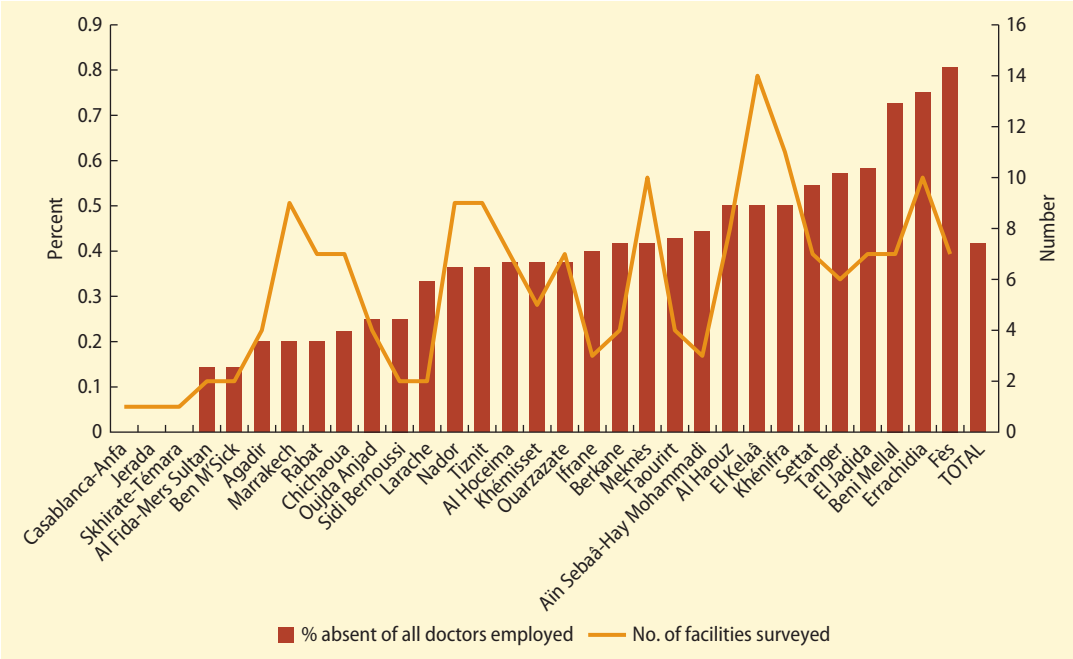
Sources: PETS (health), Morocco, 2011; QSDS (health), Morocco, 2011.

supplies (beds, thermometers, stethoscopes, exam tables, and blood supply). At the provincial level, however, this direction reversed, with a moderate positive correlation among the measures. In general, supplies were positively correlated with absenteeism (but only modestly so).[3] Box 7.1 describes some notable performers in health services delivery in Morocco.

Explaining variation in health services in Morocco

In Morocco, country experts cited the gap between urban and rural areas and the origin of health care facility staff as the major factors driving variation in service delivery performance in health. Because health care facilities in urban areas tend to be closer to hospitals than the primary health centers in more remote areas, the quality of care in urban areas tends to be higher. As for

FIGURE 7.13 Absenteeism among doctors, by province/prefecture: Morocco, 2011



Sources: PETS (health), Morocco, 2011; QSDS (health), Morocco, 2011.

Table 7.2 Correlation between absenteeism and other measures at regional and provincial/prefectural levels, Morocco

	Staff absenteeism	Doctor absenteeism	No. of beds	No. of thermometers	No. of stethoscopes	Blood supply	No. of exam tables
Region							
Staff absenteeism	1						
Doctor absenteeism	0.769	1					
Number of beds	−0.404	−0.440	1				
No. of thermometers	−0.193	−0.042	0.572	1			
No. of stethoscopes	−0.353	−0.360	0.707	0.784	1		
Blood supply	−0.419	−0.327	0.817	0.741	0.918	1	
No. of exam tables	−0.505	−0.458	0.739	0.761	0.968	0.926	1
Province/prefecture							
Staff absenteeism	1						
Doctor absenteeism	0.780	1					
No. of beds	0.180	0.105	1				
No. of thermometers	0.268	0.443	0.345	1			
No. of stethoscopes	0.346	0.439	0.316	0.560	1		
Blood supply	0.385	0.553	0.548	0.466	0.731	1	
No. of exam tables	0.382	0.459	0.393	0.531	0.915	0.770	1

Sources: PETS (health), Morocco, 2011; QSDS (health), Morocco, 2011.

BOX 7.1 Notable performers in health services delivery in Morocco

Taking various summary indicators into consideration, the following regions of Morocco were the best performers according to the 2011 PETS and QSDS:

- *Rabat-Salé-Zemmour-Zaire*. Thirteen facilities were surveyed in this region (population, 2.4 million). The region had low levels of doctor and all staff absenteeism and had lower than average percentages of facilities out of stocks of metformin. The region performed less well in terms of equipment and aspirin availability: it was frequently stocked out (42 percent of facilities) and for long periods of time (mean = 8 weeks).
- *Grand Casablanca*. Ten facilities were surveyed in this region (population, 3.6 million). The region had low levels of absenteeism among both doctors (23 percent) and all staff (20 percent). Stock-outs of metformin were around the national average of 58 percent of facilities, and 22 percent of Grand Casablanca's facilities were stocked out of aspirin. The region had about average levels of other medical equipment, although facilities in the region reported no beds, which may stem from their proximity to hospitals for inpatient care.
- *Oriental*. Twenty-two facilities were surveyed in this region (population, 2 million). The region had the lowest absenteeism among all staff (20 percent) and was lower than average in terms of doctor absenteeism (35 percent). Metformin was not available in 43 percent of its facilities, and aspirin was stocked out in 19 percent of Oriental's surveyed facilities (slightly above average). In terms of other medical equipment, facilities in the region had about average levels of equipment.

At the provincial/prefectural level, the following were the stand-out performers (where at least two facilities were surveyed):

- *Rabat*. Seven facilities were surveyed in Rabat (population, approximately 620,000). Rabat's facilities performed well on measures

(continued next page)

BOX 7.1 Notable performers in health services delivery in Morocco *(continued)*

of equipment and drug availability, as well as doctor (20 percent) and all staff (16 percent) absenteeism. Although no facilities reported having beds, facilities were relatively well supplied with blood, stethoscopes, and exam tables. Furthermore, all facilities reported the availability of both metformin and aspirin.

- *Berkane*. Four facilities were surveyed in Berkane (population of the town, approximately 80,000; population of the province, 270,328). It is unclear from the data and documentation whether the sampled facilities were all in the town or simply the province of Berkane. Facilities in the province appeared to be well stocked with thermometers and blood. Employing across its four facilities 42 staff, 12 of whom were doctors, it had average levels of doctor absenteeism and below average (21 percent versus 27 percent) levels of all staff absenteeism. Aspirin was available in all facilities, but half were stocked out of metformin, slightly below the national average of 58 percent.
- *Jerada*. Only two facilities were surveyed in the town of Jerada (population, approximately 30,000). Jerada province (population, 105,840) is home to smaller cities (populations ranging from 2,000 to 44,000). Despite the fact that only two facilities were surveyed, the levels of absenteeism were extremely low—0 percent among both all staff (n = 9) and doctors (n = 4). Despite these staffing successes, high percentages of facilities in Jerada were stocked out of both of the essential drugs investigated.
- *Al Fida-Mers Sultan*. Two facilities were surveyed in this prefecture (population, 332,682) of Grand Casablanca. The facilities employed 12 staff, 5 of whom were doctors. Al Fida-Mers Sultan was relatively well equipped, had both aspirin and metformin available, and had lower than average percentages of absenteeism among all employed staff (17 percent) and doctors (14 percent).
- *Ben M'Sick*. Two facilities were surveyed in this prefecture (population, 285,879) of Grand Casablanca. Absenteeism among both all staff (15 employed, 14 percent absenteeism) and doctors (7 employed, 13 percent absenteeism) was better than average in this prefecture. Aspirin was available in both facilities, but metformin was not available in either.

retaining more qualified and experienced staff, employing staff from the areas surrounding a health facility appears to be a more successful strategy for staff retention than looking farther afield. No single historical or institutional factor was cited as a driver of variation in health services delivery. The financial factors, however, are less clear: health financing is not based on volume or activity or catchment, and so it is difficult to establish what factors related to financing could be contributing to variation at the subnational level.

As for the factors shaping the effectiveness of organizational governance procedures, country experts cited the quality of information systems. Those facilities that have better information management also tend to have better drug management, both of which are usually facilitated by the human resources of that facility. In the Republic of Yemen, both the quantitative and qualitative data point to a diverse range of contingent factors shaping superior (and, for that matter, inferior) performance at any given location or for any unit of analysis: there is no obvious overlap or complementarity between problems in one domain and those in another. Even so, important implications are that each problem needs to be addressed on its own terms and that investments have to be made in data collection and management to enable practitioners to identify, track, and investigate outcome variations at the level at which supportable

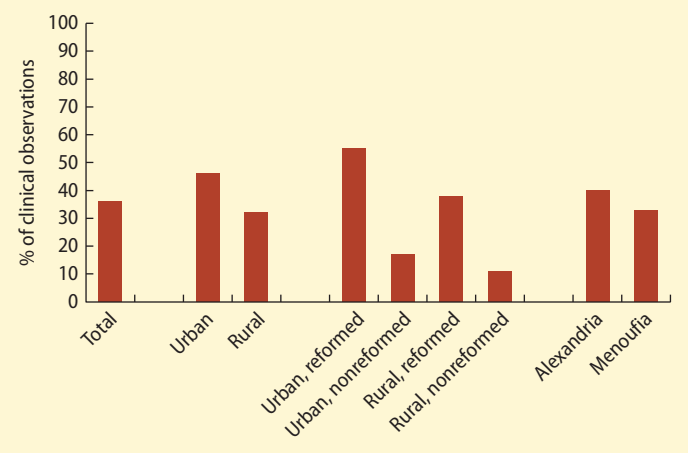
solutions can be implemented. Building a system that can deliver incrementally higher average (and lower variability) performance requires mechanisms that give priority to organizational learning over a quest for universal ("best practice") solutions. And precisely because there are limited resources for addressing all manner of service delivery problems in different communities, comprehensive data that are accessible to officials, providers, and citizens alike can aid the process of assigning priority to these challenging problems (and the potentially harsh tradeoffs associated with each) on an informed and participatory basis.

The next sections turn to less detailed—but equally instructive—examinations of variation in education and health services in Egypt and in education in the Republic of Yemen, Morocco, Saudi Arabia, Oman, Qatar, the United Arab Emirates, Bahrain, and Tunisia.

Education and health services in Egypt

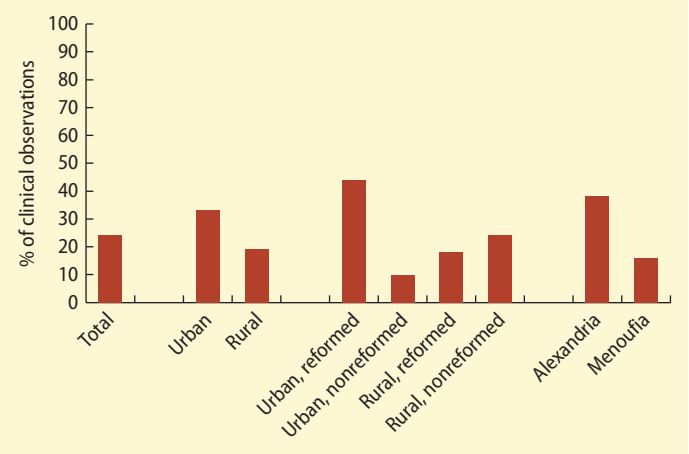
As a large and populous nation, Egypt is bound to display considerable variation in the effectiveness of its service delivery, all of which can be a basis for analysis and learning. In health care, variation can be seen in, among other areas, adherence to protocols. For example, as part of a routine examination of sick children, medical staff are required to check the child's breath count (figure 7.14); when examining diabetes patients, they should check the feet and legs for pulsation (see figure 7.15). But even these supposedly uniform and simple tasks are not always carried out and not everywhere. Some areas perform these standard tasks much more effectively than others. In nonreformed clinics in rural areas, for example, breath counts are checked only 11 percent of the time, whereas in reformed urban clinics (which are otherwise the best performers) the rate is still only marginally more than 50 percent. (The difference between reformed and nonreformed clinics is described in the note to figure 7.14.)

FIGURE 7.14 Adherence to sick child care protocol, counting breaths: Arab Republic of Egypt, 2010



Source: EHGS, 2010.
Note: "Reformed" and "nonreformed" are Egyptian classifications. Within the traditional Ministry of Health facilities, reformed facilities are those contracted by the Family Health Fund (FHF) and that operate according to distinctive procedures. Nonreformed facilities are those not contracted by the FHF or that do not operate in accordance with its procedures. Alexandria and Menoufia are the only two governorates included in the Egypt Health and Governance Study (EHGS).

FIGURE 7.15 Adherence to diabetes care protocol, examining feet and legs for pulsations: Arab Republic of Egypt, 2010



Source: EHGS, 2010.
Note: On the distinction between reformed and nonreformed facilities, see note, figure 7.14.

Explaining variation in health services in Egypt

Key informants cited weak administrative institutions, including organizational fragmentation (that is, systems with differing authority and operating procedures) as the primary source of variation in health

services delivery in Egypt. Even within state-owned facilities, different organizational authorities are charged with overseeing different regulations, implementing different requirements and guidelines, and operating in accordance with different systems of incentives. These entities, such as the Health Insurance Organization, the Family Health Fund, and the traditional Ministry of Health structures, have their own managerial processes and reporting relationships, which result in differences in service delivery. Although the average Egyptian would likely not know the difference between one facility and another, these differences are likely evident at the quality level. For the user, these differences may appear in the form of the availability of qualified staff, opening hours, drug availability, etc. The 2010 Egypt Health and Governance Study (EHGS) report and analyses did not account for this nuanced but crucial factor. Meanwhile, of the traditional Ministry of Health facilities, some are reformed and some are nonreformed (see note to figure 7.14 for an explanation of this distinction). Some yet not all reformed facilities are contracted by the Family Health Fund, leading to another layer of regulatory and administrative differences. As noted, these various systems of governance result in differing levels of quality and service delivery, and in turn in islands of well-performing facilities because there are not enough resources to apply improvements across the spectrum. There are no major cultural, historical, ethnic, or religious determinants of variation because Egypt is largely homogeneous in this regard. Rather, variation results mostly from the different systems of bureaucracy and quality of actual implementation.

Health facilities that are reformed or are operated under a number of different pilot programs become the objects of streamlined governance, with more resources, clearer reporting relationships, and often better supply and drug management. For example, reformed facilities tend to be better equipped with medicines because they use a revolving fund, selling drugs at a reduced rate and purchasing more with those funds, safeguarding against stock-outs.

Explaining variation in education services in Egypt

In Egypt, the differences in education outcomes at the subnational level follow similar lines—for example, socioeconomic status and the urban-rural divide. Aside from the composition of the population being served, key informants cited budgeting processes, training institutions, and cultural norms as the major factors distinguishing between poorly performing and well-performing education facilities and subnational entities. Although the budget and allocation process is in principle democratic and occurs from both the bottom up and the top down, in practice this process does not lead to an equitable distribution of resources. Rather, because schools and districts must negotiate their budgets, many resource allocations are the result of the negotiating power and ability of administrators, which lead to unequal outcomes in the distribution of resources and educational achievement. The imbalance may be further exacerbated by possible distribution problems as table 7.3 illustrates, drawing on the 2007/08 PETS (education).

Institutional factors also lead to variation in education services delivery at the subnational level. The Higher Teacher Training Institutions both drive and reinforce differences in teacher quality. Because some training facilities are better than others and they recruit teachers based on where the teachers live, those in poorer areas are recruited to teach in those same disadvantaged areas.

Another issue cited as a factor in the variation in education services delivery is the absence of a culture of accountability. This is manifested in a number of ways, but a primary example offered by a key informant was the examination guidelines provided by the National Center on Education and the Economy (NCEE). NCEE creates a template for examinations (essentially an outline) of what they should cover. The template is then

Table 7.3 Subnational variation in textbook distribution, by governorate: Arab Republic of Egypt, 2007 and 2008

	Cairo[a]	Dakhalya	Ismailia	Fayoum	Menia	Luxor	Total
Total textbooks, 2007/08 (PETS)	n.a.	21,344,855	351,485	14,283,899	15,853,034	27,000	
Total textbooks, 2007/08 (MoE, textbook sector)	48,527,809	21,079,493	4,914,197	12,490,819	19,944,434	2,136,125	109,092,877
Total students (MoE, EMIS)	1,527,520	990,189	202,340	538,975	963,533	96,439	4,318,996
Average number of textbooks per student (PETS)		21.6	1.7	26.5	16.5	0.3	
Average number of textbooks per student (MoE, textbook sector)	31.8	21.3	24.3	23.2	20.7	22.2	25.3

Source: PETS (education), Egypt, 2007/08.
Note: PETS = Public Expenditure Tracking Survey; MoE = Ministry of Education; EMIS = Education Management Information System; n.a. = not applicable.
a. In Cairo, textbooks are sent directly from the Ministry of Education to the districts of education.

adapted at the governorate level, leading to different examinations across the country. Without standardization, it is difficult to compare the situations in governorates in any meaningful way, and because the tests change on a yearly basis there is no way to observe any progress within or across governorates. This exemplifies the lack of mechanisms for accountability and enforcement in education services delivery. Without even basic common metrics, a policy maker has no ability to implement a culture of accountability.

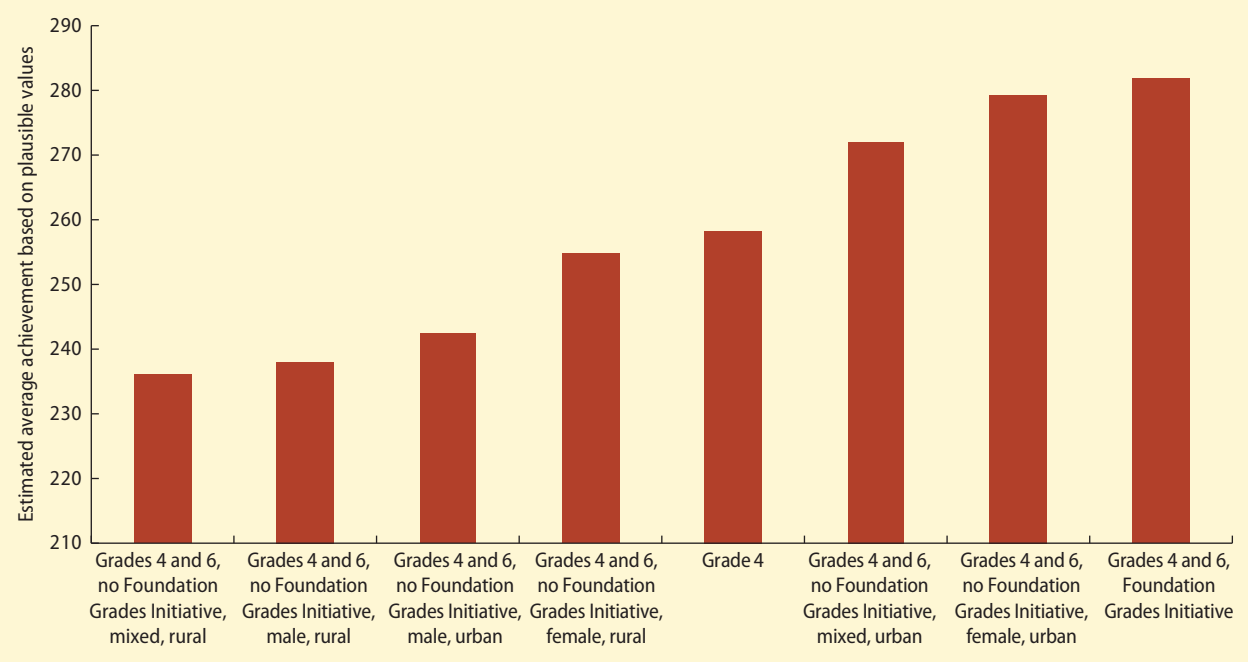
Managerial abilities and leadership—preventing elite capture at the local level—were also cited as a major driver of variation. According to one key informant, there are no managerial inputs in terms of training or monitoring, and thus management of education is not aimed at achieving results. Schools tend to be overstaffed with teachers but undermanaged. Absenteeism is therefore not a major problem because teachers are present in high numbers, but few are actually teaching. This is also related to the heavy reliance on tutoring in Egypt. In schools that perform well, it is often because of opportune leadership or a strong educational mission. The headmaster is engaged in the community and is able to engage parents in the school environment. This engagement tends to be especially fruitful in communities that include local entrepreneurs and benefactors.

Education services in the Republic of Yemen

The availability of data from the Trends in International Mathematics and Science Study (TIMSS) and PETS on subnational variation in education in the Republic of Yemen enables such comparisons. For example, the data reveal wide variation in overall test scores in grades 4 and 6, largely along an urban-rural continuum (figure 7.16), with students in mixed (male-female) rural schools scoring almost 20 percent lower than their urban counterparts. Some of this variation may be attributable to the quality of teachers (in urban settings there are twice as many teachers with the highest qualifications as in rural areas—see figure 7.17). But whatever their level of training, teachers must be present and active in the classroom for actual learning to occur, and here again considerable variation was found: at the governorate level, over a quarter of teachers were regularly absent in Shabwah, whereas in Hadramout this rate fell to 12 percent (figure 7.18).

This type of preliminary analysis of subnational variation could be conducted on all kinds of issues, but the following are some additional summary findings. At the governorate level, Hadramout is the best performer in terms of having low dropout rates (1.9 percent—it is over 10 percent elsewhere) and failure rates (14 percent—44 percent elsewhere), but Hadramout is only midrange in terms of grade repeat rates (15 percent—from 12.8 percent to 20.1 percent elsewhere). It pays its teachers on time at the most reliable levels (62 percent), but also, interestingly, it has the highest rate of teachers expressing dissatisfaction with their work environment (24 percent—13–16 percent elsewhere). The presence of parent-teacher associations

FIGURE 7.16 Student performance on TIMSS mathematics (grades 4 and 6), by sex and location (rural or urban): Republic of Yemen, 2011



Source: TIMSS, 2011.
Note: Categories are based on the Yemen Explicit Stratum definition in the Trends in International Mathematics and Science Study (TIMSS). Foundation Grades Initiative refers to the program developed by the Ministry of Education in the Republic of Yemen to help students perform better in the 2011 TIMSS exercise. The program was implemented in a sample of schools to determine whether schools subject to the program would outperform comparison schools. The program aimed at addressing the unfamiliarity of pupils with test items and testing procedures, any incompetence to read, and inadequate mathematics and science teaching (Duret, Abdulmalik, and Jones 2010).

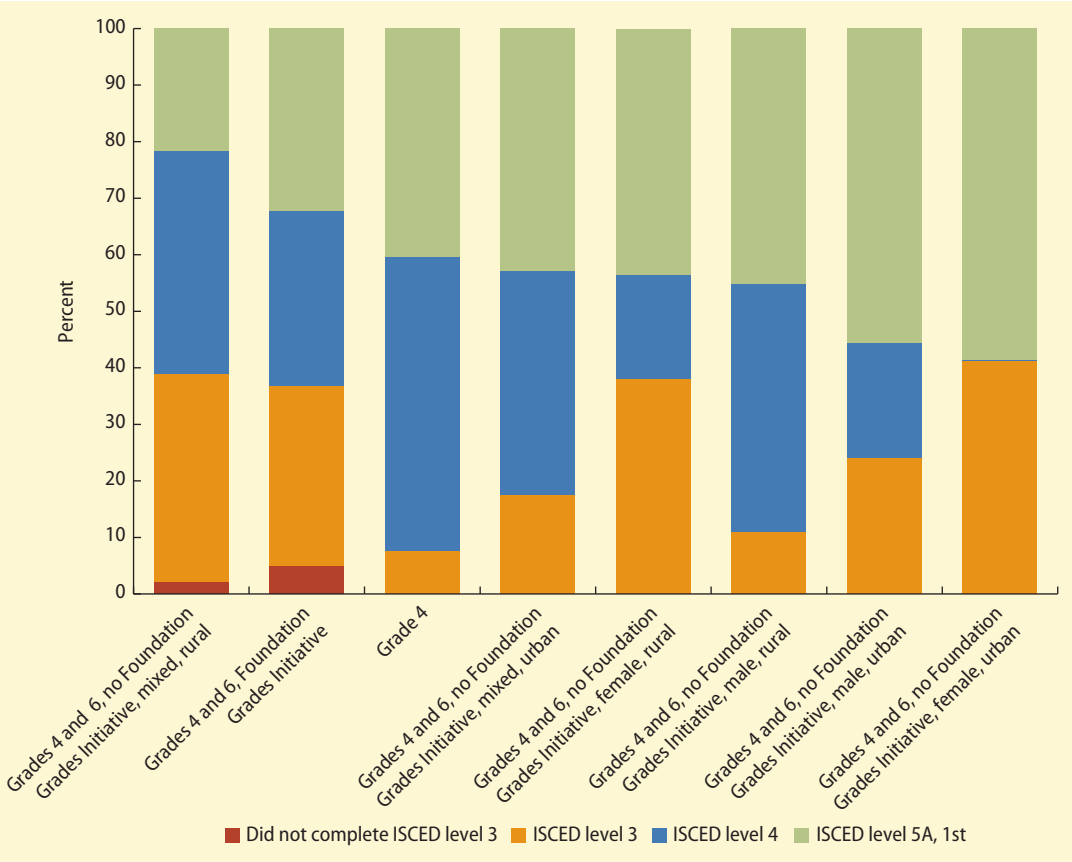
in the Republic of Yemen is also highest in Hadramout (all but one school in the governorate has one).

Explaining variation in education services in the Republic of Yemen

In the Republic of Yemen, key informants argued that the existence or nonexistence of a business community reinforced the quality of educational performance by shaping the culture and motivations of the individuals in that community. Areas with an active business community and stronger ties to the market economy have higher historical, cultural, and economic incentives for better-performing education systems. In areas in which this culture of entrepreneurship is not present, there is less of a commitment to the goals of education and therefore greater acceptance of service delivery failures. In addition, in many areas in the south of the Republic of Yemen, the lasting influence of the British occupation and its legacy of education remains, resulting in a stronger orientation toward education when compared with areas in the north. Taiz, for example, has more of a business culture and sense of social corporate responsibility in terms of building and supporting the university. Individuals who contribute to the workings of the university feel that when they invest in education they are investing in the well-being and future of the people in that region. This attitude trickles down to both primary and secondary education.

Clearly, further analysis is needed to identify more precisely where and why

FIGURE 7.17 Level of teacher education by ISCED level, grades 4 and 6 TIMSS math scores: Republic of Yemen, 2011



Source: TIMSS, 2011.
Note: TIMSS = Trends in International Mathematics and Science Study; ISCED = International Standard Classification of Education. Categories are based on the Yemen Explicit Stratum definition in the TIMSS. Foundation Grades Initiative refers to the program developed by the Ministry of Education in the Republic of Yemen to help students perform better in the 2011 TIMSS exercise. The program was implemented in a sample of schools to determine whether schools subject to the program would outperform comparison schools. The program aimed at addressing the unfamiliarity of pupils with test items and testing procedures, any incompetence to read, and inadequate mathematics and science teaching (Duret, Abdulmalik, and Jones 2010).

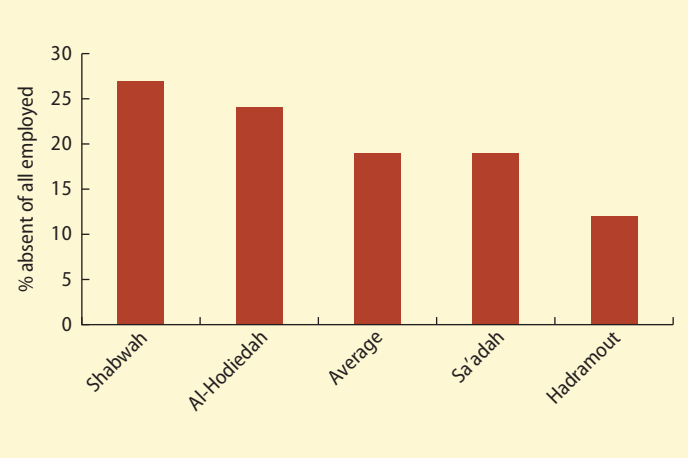
variation occurs, but for now the central point should be clear: variation is ubiquitous, and the usual factors that might account for it only go so far. For more accurate, more useful findings, local researchers and policy makers must themselves undertake such analyses.

Education services in Morocco

Variation in education indicators is also evident in Morocco, although the variation is accentuated (perhaps not surprisingly) in comparisons of public schools with the higher-performing private schools. Within public schools across the country, there is relatively little variation in mathematical performance (figure 7.19), which itself is an interesting analytical point of departure. This lack of wide variation is all the more noteworthy when one considers the wide variation in the provision of basic inputs (availability of instructional materials, figure 7.20) and teacher effort (absenteeism,

figure 7.21). How this diversity in upstream resource provision and its corresponding importance in each setting combine to yield relatively similar student performance is a topic for future study.

FIGURE 7.18 Teacher absenteeism, by governorate: Republic of Yemen, 2006



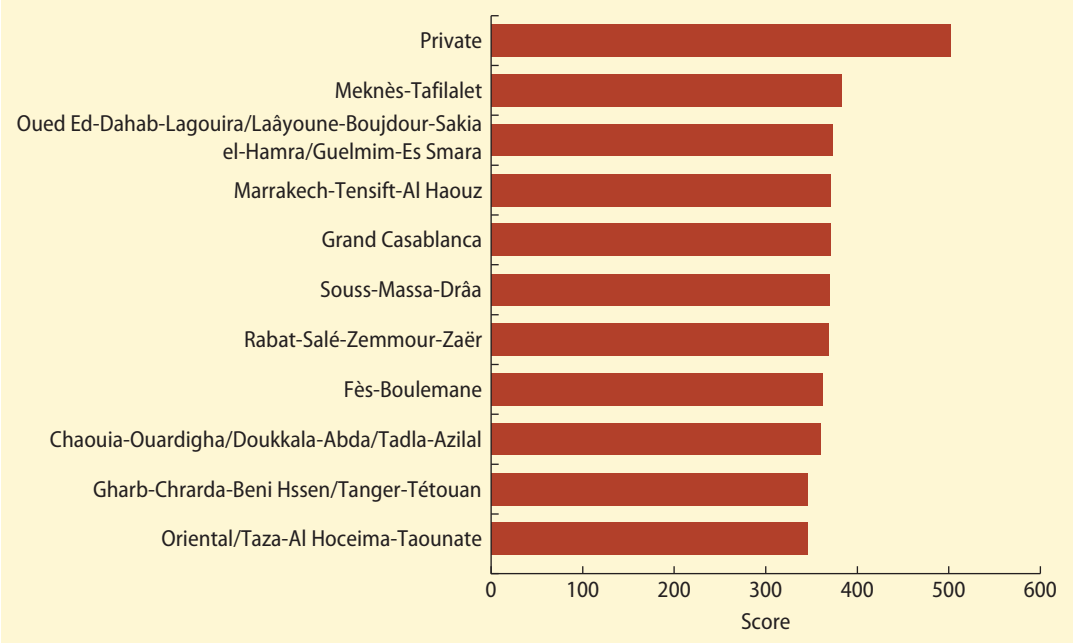
Source: PETS (education), Republic of Yemen, 2006.

Explaining variation in education services in Morocco

In Morocco, variation in service delivery is primarily attributed to the persistent divide between urban and rural areas. This divide is also correlated with and compounded by differences in socioeconomic status, with urban areas tending toward greater wealth and rural areas toward higher levels of poverty. Culture and tradition produce variation in education services delivery in Morocco as well because communities that are already more educated (usually urban) have a stronger tradition of education than less educated communities (usually rural). Another difference possibly driving variation in education services delivery at the subnational level is language. Children who speak Arabic have greater exposure to and engagement with the Arabic education system than children from Berber backgrounds.

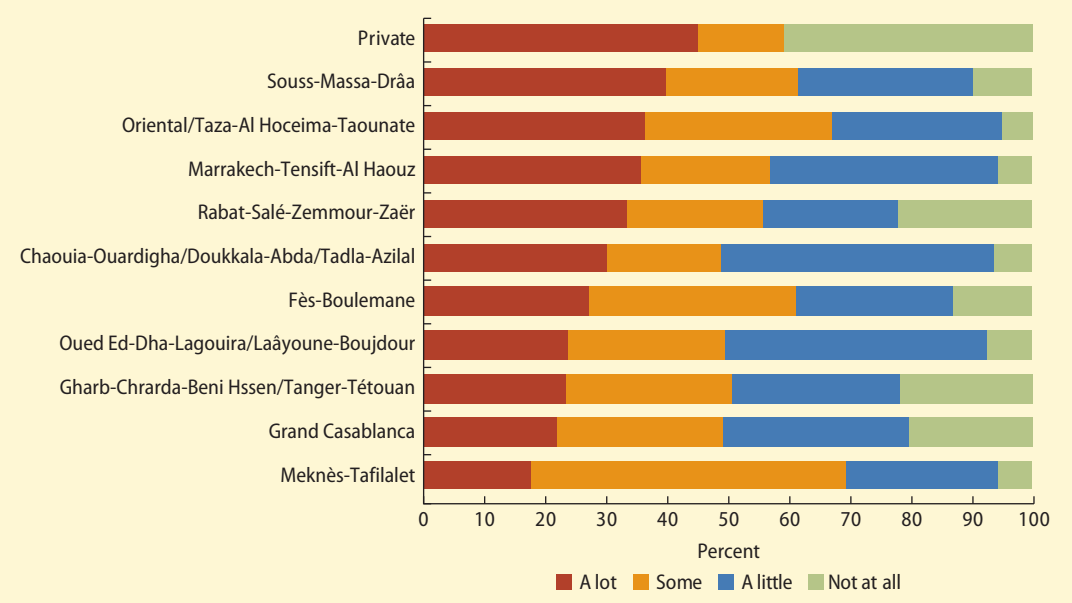
Setting aside the composition of the population, education services delivery is also affected by the ability or inability of

FIGURE 7.19 Student performance on TIMSS mathematics (grade 8), by region: Morocco, 2011



Source: TIMSS, 2011.
Note: TIMSS = Trends in International Mathematics and Science Study.

FIGURE 7.20 Availability of instructional materials, by region: Morocco, 2011



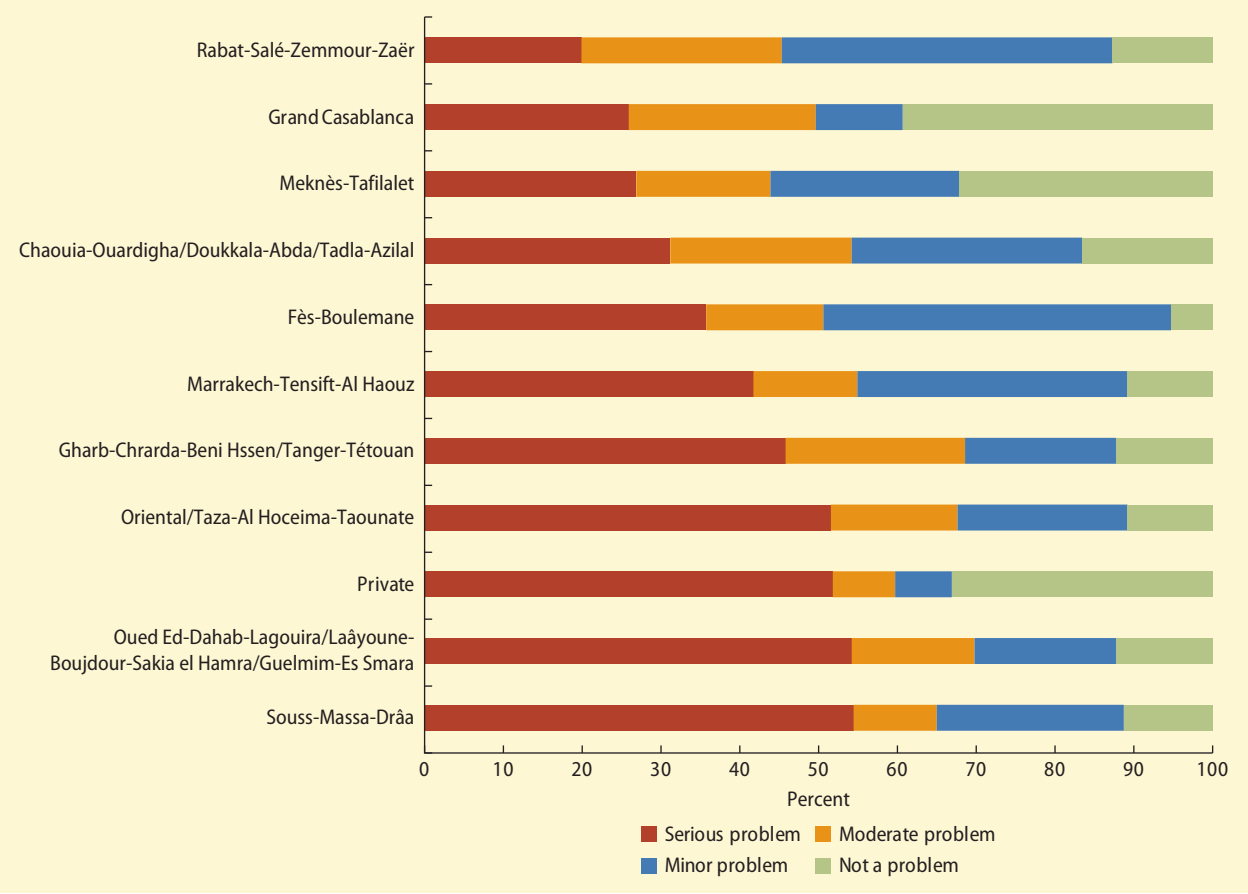
Source: TIMSS, 2011.

providers to adapt their service provision to the specific needs of a community and special groups. Variations in performance are also affected by differences in the types of people who are attracted to education and the types of people who are hired as teachers and administrators. Differences in who is attracted to the education sector and who is hired are affected as well by location. Because urban areas such as Casablanca, Rabat, and Fès are considered more desirable places to work and live, and places in which individuals have more educational options, there is more competitiveness among providers. This competitiveness results in a greater likelihood of competency among providers and greater experience among both teachers and administrators. Ultimately, it is hoped that the services they provide are of higher quality.

The civil service framework reinforces variation between urban and rural areas because younger, less experienced teachers are usually assigned to more rural and remote areas. Once they have gained more experience and have taught in a rural area for a number of years, they are entitled to request a transfer to a place of their choosing. This system therefore perpetuates the variation in teacher quality between rural and urban areas. Quality of infrastructure also leads to variation in both students and teachers because insufficient or lacking transportation and facilities acts as a barrier to accessing and providing education services. These structural barriers are compounded when teachers do not live near where they work. Finally, schools located in rural areas generally have weaker systems of accountability than those in urban areas, which allows greater variation in the services provided and poor quality. A key informant cited a better educated, more affluent, more empowered citizenry as a factor in greater accountability in the school system because this factor translates into more involved parents with greater expectations.

Across all three countries featured here—Egypt, Morocco, and the Republic of

FIGURE 7.21 Teacher absenteeism, by region: Morocco, 2011



Source: TIMSS, 2011.

Yemen—key informants argued that elite capture at the local level coupled with the diligence of local entrepreneurs and benefactors were driving sources of variation in the quality of education and health services delivery. They also cited the urban-rural divide, regional historical and cultural differences (some of which stem from colonialism), and the presence and strength of a business community as key components of subnational variation in service delivery related to education. In a number of examples, key informants pointed to one individual or family who had achieved financial success and decided to reinvest that in their community by building a school or health facility, but sometimes forcing the state to cover the operational costs once built. In other instances, interviewees cited examples of one headmaster, manager, or high-ranking Ministry of Health or Ministry of Education administrator at the directorate level who created and sustained his or her own microsystem of accountability and superior service delivery performance. These examples were often discussed in terms of chance or the personalities of the key people involved. Less was known about the specific processes used to achieve better results.

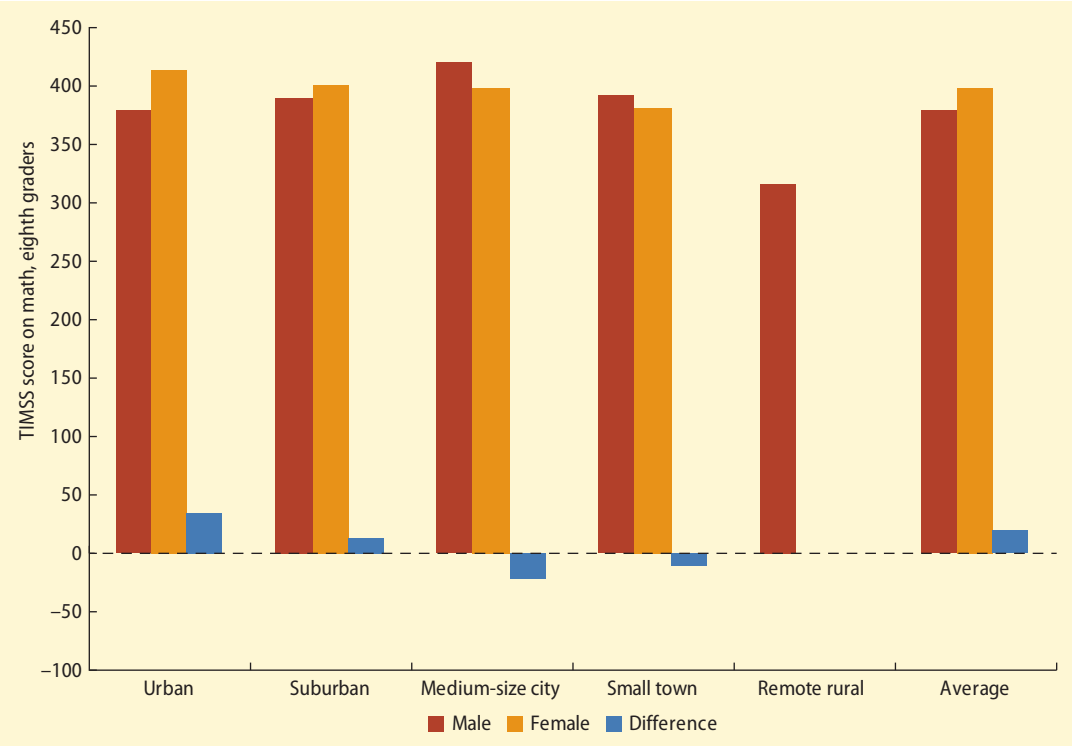
Education services in Saudi Arabia, Oman, Qatar, the United Arab Emirates, Bahrain, and Tunisia

This section provides brief examples of subnational variation in education services in Saudi Arabia, Oman, Qatar, the United Arab Emirates, Bahrain, and Tunisia. Analysis of the TIMSS data from Saudi Arabia enables exploration of the variations across the urban-rural divide and between genders (figure 7.22). On average, in Saudi Arabia female students outperform male students, but this difference is largely driven by location: girls do best in schools in cities and suburbs. The performance of boys declines markedly in remote rural areas, whereas it is highest in medium-size towns, suggesting that factors beyond town size per se are driving outcomes.

Gender differences in education outcomes between urban-rural settings are also seen in Oman (figure 7.23). Girls on average consistently outperform boys and see only modest absolute declines in more rural settings. Boys perform well in the most urban settings, but also perform relatively well in remote rural settings. In Qatar, the gender and location gap is less pronounced (figure 7.24), with boys in small towns outperforming boys elsewhere and girls everywhere.

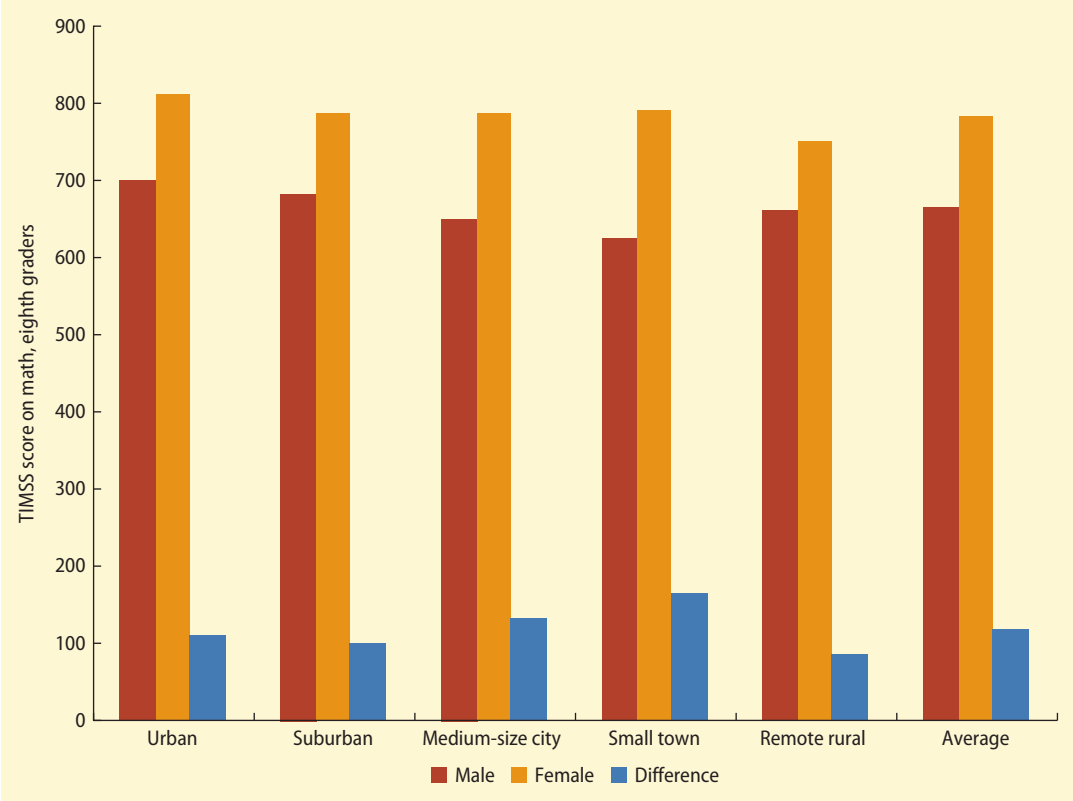
As in Morocco, student achievement in the United Arab Emirates is relatively uniform across subnational areas (figure 7.25), and yet

FIGURE 7.22 **School performance, by sex and location: Saudi Arabia, 2011**



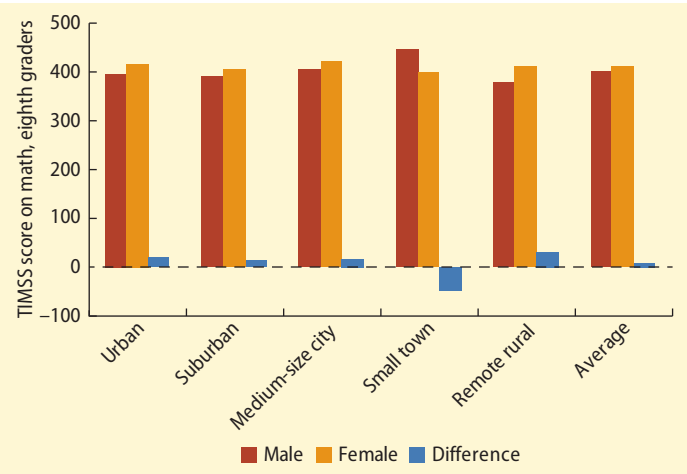
Source: TIMSS, 2011.
Note: TIMSS = Trends in International Mathematics and Science Study.

FIGURE 7.23 Education outcomes, by sex and location: Oman, 2011



Source: TIMSS, 2011.
Note: TIMSS = Trends in International Mathematics and Science Study.

FIGURE 7.24 Education outcomes, by sex and location: Qatar, 2011

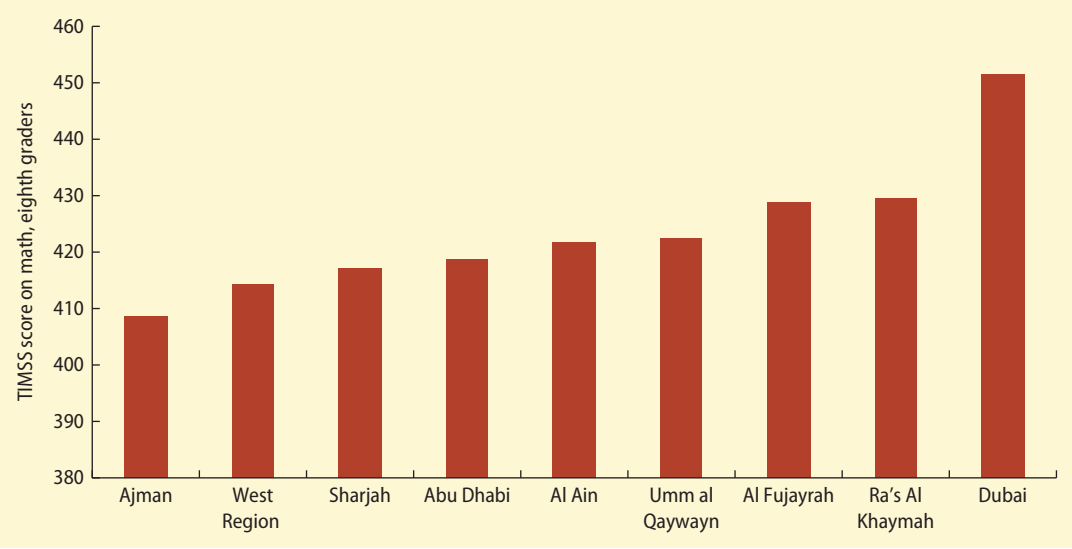


Source: TIMSS, 2011.
Note: TIMSS = Trends in International Mathematics and Science Study.

this is attained in the face of considerable variation in the availability of instructional materials (figure 7.26) and teacher absenteeism (figure 7.27). A similar pattern emerges in Bahrain: wide variation in instructional materials and teacher absenteeism (as broad proxies for, respectively, basic resource provision and provider efforts) nevertheless generates quite similar levels of student achievement, especially among those attending public schools (figures 7.28, 7.29, and 7.30).

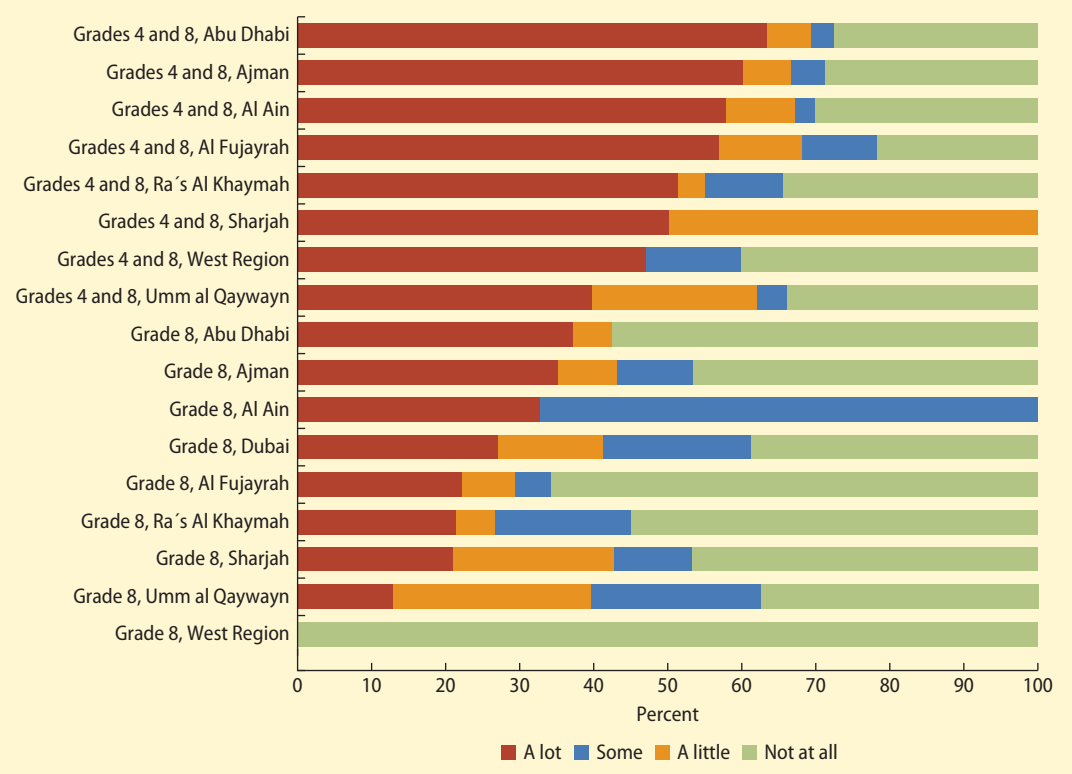
Finally, in the countries considered in this section, like those considered earlier, there often appears to be little relationship among variations in infrastructure, basic materials, and provider efforts. These inputs seem to be quite distinct realms of

FIGURE 7.25 Student achievement scores, by region: United Arab Emirates, 2011



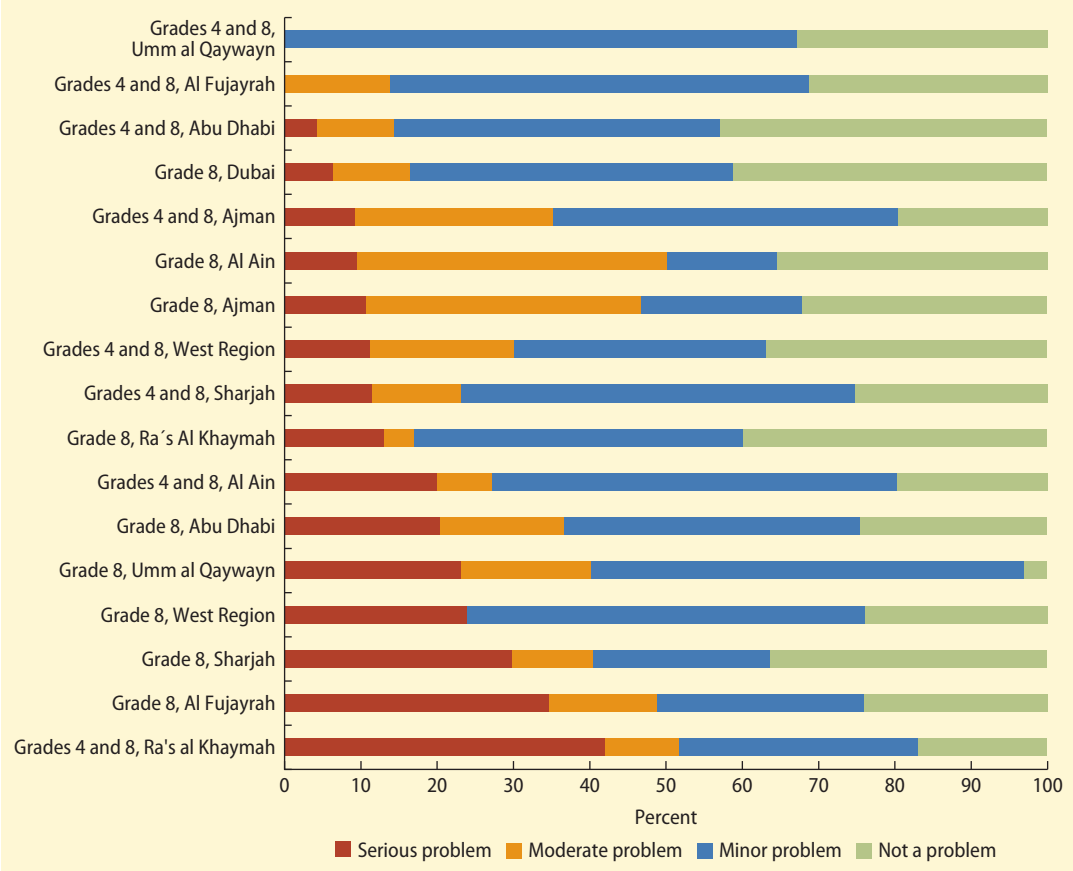
Source: TIMSS, 2011.
Note: TIMSS = Trends in International Mathematics and Science Study.

FIGURE 7.26 Availability of instructional materials, grades 4 and 8, by region: United Arab Emirates, 2011



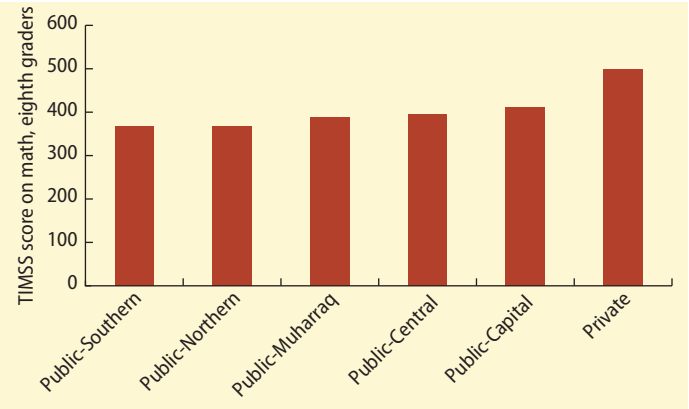
Source: TIMSS, 2011.

FIGURE 7.27 Teacher absenteeism, grades 4 and 8, by region: United Arab Emirates, 2011



Source: TIMSS, 2011.

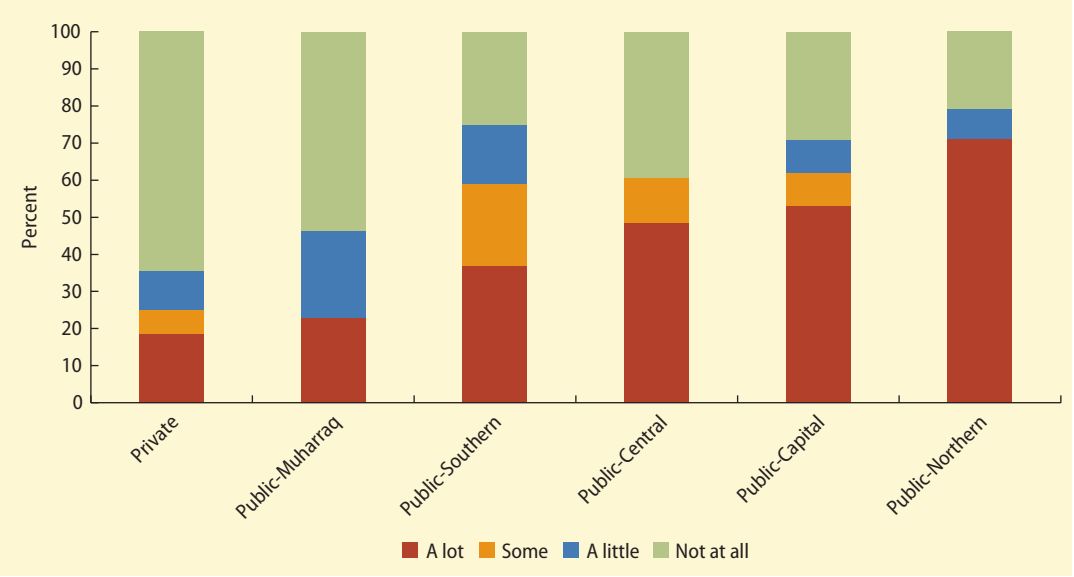
FIGURE 7.28 Student achievement scores, public and private schools, by region: Bahrain, 2011



Source: TIMSS, 2011.
Note: TIMSS = Trends in International Mathematics and Science Study.

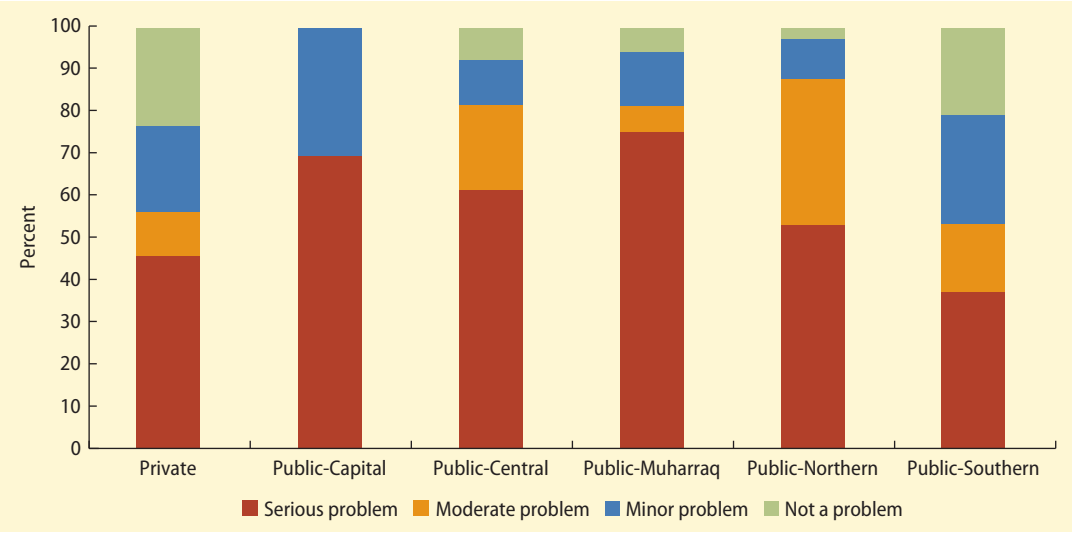
activity in the provision of education, with performance (success or failure) in one domain being largely uncorrelated with performance in another (see table 7.4, which summarizes the findings from Tunisia[4]). This finding reinforces the general conclusion that effective reform in the delivery of education services will require providing specific responses to each type of problem: one-size solutions will definitely not fit all. Put another way, if the core policy challenge is to increase the overall performance of the education sector in each MENA country in order to provide students with the skills and sensibilities required for the 21st century, there is no obvious or clear place to start—each binding

FIGURE 7.29 Availability of instructional materials, public and private schools, by region: Bahrain, 2011



Source: TIMSS, 2011.

FIGURE 7.30 Teacher absenteeism, public and private schools, by region: Bahrain, 2011



Source: TIMSS, 2011.

constraint problem is unique, seemingly unrelated to others. If there is an upside to this challenge, it is that the wide variation in key inputs is itself evidence that solutions lurk somewhere; the task going forward is to find, examine, and learn from them.

Concluding observations

The central message of this chapter is that service delivery performance varies widely within countries—and within provinces and districts—even where service delivery

Table 7.4 Correlation between inputs to education: Tunisia, 2011

	Instructional materials	General supplies	School buildings	Job satisfaction	Teacher late arrivals at school	Teacher absenteeism
Instructional materials	1					
General supplies	0.581*	1				
School buildings	0.435*	0.526*	1			
Job satisfaction	−0.034	0.021	0.017	1		
Teacher late arrivals at school	−0.106	0.016	0.016	0.223*	1	
Teacher absenteeism	−0.164	−0.066	−0.025	0.231*	0.553*	1

Source: TIMSS, 2011.

systems are centralized. This variation is to be expected, and it emerges for a host of reasons, some of them familiar (wealth) and laudable (high qualifications), others less obvious. We have also seen, within as well as across countries and sectors, that the performance characteristics of the three core components of service delivery—physical infrastructure, basic supplies, and qualified/diligent staff—are frequently out of sync with one another: problems and strengths in one domain do not necessarily correlate with problems and strengths in others. We have described several instances in this chapter of country contexts in which different *types* of implementation problems overlap little with each other. Even in communities with the lowest quality of service provision, problems pertaining to staff absenteeism frequently do not correlate with problems stemming from inadequate supplies, meaning that strategies for responding to the former cannot also be assumed to be responding to the latter.

Many of the processes driving subnational variation are deeply contingent on context-specific combinations of different local and systemwide factors. These can only be discerned through careful exploration of local circumstances and the particular structures shaping how large bureaucracies function.

In particular, subnational variation can manifest itself in how local leaders as well as local institutions and accountability mechanisms fill the gaps in the national political and administrative accountability mechanisms discussed in chapter 5. Even where the political and administrative accountability mechanisms are weak, some communities are able to achieve the high provider efforts and abilities needed to adhere to standards. The existing forms and sources of variation allow identification of where an effective response to the existing institutional constraints already exists.

All this means that much of the time it will be necessary to customize solutions to the prevailing problems because it cannot be assumed that what works to address a particular concern in a particular sector in a particular context will work elsewhere. Those seeking solutions to their specific problems, however, need not start from scratch; they can exploit the existing forms and sources of variation to identify where an effective response to the existing constraints is already available. And even if adopting and adapting such insights itself proves difficult, those desiring improvement can be assured that things are not fated to be the way they are: someone somewhere somehow has figured out a better way. It is hoped that those facing their own seemingly intractable challenges can learn from and be inspired by those challenges. We will come back to these issues when discussing possible solutions in chapter 11.

Returning now to the cycle of performance, part IV will explore how performance affects citizens' trust in institutions (chapter 8), and how this trust in turn influences the nature of citizen action (chapter 9).

Annex A

QSDS data set, Republic of Yemen

The Quantitative Service Delivery Survey (QSDS) data set is somewhat limited in its coverage of the Republic of Yemen. Because it covers only 4 of the country's 21 governorates, it is not possible to draw conclusions about health care performance in the country as a whole. These data, then, should be interpreted with caution; they provide only general insights into trends in the governorates, districts, and facilities surveyed and how the measures under investigation relate to each other. They also provide in-depth information about the performance of each of the sampled facilities.

The QSDS assessing health care in the Republic of Yemen comprised three modules, including a survey of 82 health facilities (units, centers, and hospitals) across four governorates: Al-Baidah, Ibb, Raimah, and Sana'a. These four governorates were selected because of the particular challenges they face in delivering public health services and because a pilot program of expanded outreach services was to be implemented in each. Thus the analysis based on this data set cannot be generalized to the Republic of Yemen in its entirety.

In the QSDS, the sampling frame for the facility survey sought a census of all 108 health facilities for which the Ministry of Health was able to provide location data—8 hospitals, 35 health centers, and 65 health units (*wuhdah*). The final sample, as noted, was composed of 82 facilities (8 hospitals, 29 health centers, and 45 health units)—see table 7A.1 for the number of facilities by governorate and district. In this chapter, the subnational variation is explored systematically by (1) briefly describing the data; (2) identifying for each indicator investigated the well-performing governorates (of the four) and districts within them; and (3) drawing conclusions for each indicator. The correlation analysis conducted at the governorate and district levels reveals

Table 7A.1 Number of health facilities, by region and province: Republic of Yemen, 2010

Region	District
Ibb (n = 29)	Alfara
	Almakhader
	Alnaderah
	Alodein
	Alqafr
	Alsadah
	Alsayani
	Alshaar
	Baadan
	Geblah
	Hobeish
	Ibb Rural
	Mothikerah
	Sabah
	Thi Sofal
	Yareem
Al-Baidha (n = 14)	Albaidhaa
	Almalagem
	Alqoraishiah
	Alsawadiah
	Alssowmaah
	Alttafah
	Mokairas
	Noaman
	Radman
Sana'a (n = 23)	Alaymah Alkharigiah
	Alhaymah Aldakhiliah
	Alttyal
	Arhab
	Bani Dhabian
	Bani Hosheish
	Bani Mattar
	Hamdan
	Khawlan
	Khawlan Alhesn
	Manakhah
	Saafan
Raimah (n = 16)	Algaafariah
	Algobein
	Alsalafiah
	Bilad Alttaam
	Kosmah
	Mazhar
Total	82

Source: QSDS (health), Republic of Yemen, 2010.

the relationship between equipment availability and staff absenteeism.

Annex B

PETS and QSDS data sets, Morocco

The 2011 Public Expenditure Tracking Survey (PETS) and Quantitative Service Delivery Survey (QSDS) in Morocco covered 180 health centers or *établissements de soins de santé de base* (ESSBs) across 12 regions of Morocco, spanning 31 provinces/prefectures. This facility survey built on a user survey conducted in 2009, in which users of both hospitals and health facilities were surveyed on their experience at those facilities. The number of facilities surveyed varied by region and province/prefecture in both surveys, but the number nevertheless remained the same from 2009 to 2011 because the latter survey was based on the former. The sample varied at both times (by region and province) but was the same across times (see table 7B.1). The 2009 sample was drawn using a two-stage design. First, hospitals were randomly sampled with the goal of covering most of Morocco and all categories of hospitals. Health centers in the vicinity of sampled hospitals were then selected randomly, stratified by urban and rural areas. The 2011 PETS surveyed only those ESSBs surveyed in 2009, not hospitals. Because the sampled ESSBs were in the vicinity of hospitals and urban areas, they were likely to provide a better picture of service delivery performance than ESSBs throughout Morocco in general.

Similar to the analysis of the Republic of Yemen, subnational variation was explored systematically by (1) briefly describing the data; (2) identifying for each indicator investigated the well-performing regions and provinces/prefectures; and (3) seeking explanations for the subnational variation uncovered. The correlation analysis conducted at the regional and provincial/prefecture levels revealed the relationship between equipment availability and staff absenteeism.

Table 7B.1 Health facilities surveyed by PETS, by region and province/prefecture: Morocco, 2011

Region	Province/ prefecture	No. of facilities
Chaouia-Ouardigha	Settat	7
Doukkala-Abda	El Jadida	7
Fès-Boulemane	Fès	7
Grand Casablanca	Aïn Sebaâ-Hay Mohammadi	3
	Al Fida-Mers Sultan	2
	Casablanca-Anfa	1
	Sidi Bernoussi	2
	Ben M'Sick	2
Taza-Al Hoceima-Taounate	Al Hoceima	7
Marrakech-Tensift-Al Haouz	Marrakech	9
	Al Haouz	8
	Chichaoua	7
	El Kelaâ	14
Meknès-Tafilalet	Meknès	10
	Errachidia	10
	Ifrane	3
	Khénifra	11
Oriental	Berkane	4
	Jerada	1
	Nador	9
	Oujda	4
	Taourirt	4
Rabat-Salé-Zemmour-Zaër	Rabat	7
	Khémisset	5
	Skhirate-Témara	1
Souss-Massa-Daràa	Agadir	4
	Ouarzazate	7
	Tiznit	9
Tadla-Azilal	Béni Mellal	7
Tanger-Tétouan	Tanger	6
	Larache	2
Total		180

Sources: PETS (health), Morocco, 2011; QSDS (health), Morocco, 2011.

Notes

1. Data sets focusing on health services delivery with enough geographic coverage were analyzed at the lowest level of reasonable confidence.
2. The precise measure of "units of blood" is unclear.

3. Beyond issues pertaining to variation in statistical "noise" and "power" at different units of analysis, one can speculate that a reason for this widely varying result—based on findings reported elsewhere in this chapter—is that informal social accountability measures are more accurately captured at the district and provincial levels, and that such measures are more effective in addressing relational issues (such as whether staff members show up for work) than logistical ones (such as overcoming inadequate supplies and basic infrastructure).
4. Additional tables documenting these interactions in other MENA countries (which are remarkably similar to those reported for Tunisia) are available upon request.

Reference

Duret, E., H. Abdulmalik, and S. Jones. 2010. "Country Case Study: Yemen: Mid-term Evaluation of the EFA Fast Track Initiative." http://www.camb-ed.com/fasttrackinitiative/download/FTI_Yemen_CR(Feb2010y).pdf.

Data sources

EHGS (Egypt Health and Governance Study), World Bank, http://documents.worldbank.org/curated/en/2010/06/16332545/egypt-management-service-quality-primary-health-care-facilities-alexandria-menoufia-governorates

PETS (Public Expenditure Tracking Survey), World Bank, http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTSOCIALDEVELOPMENT/EXTPCENG/0,,contentMDK:20507700~pagePK:148956~piPK:216618~theSitePK:410306,00.html

QSDS (Quantitative Service Delivery Survey), World Bank, http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPOVERTY/EXTPSIA/0,,contentMDK:20467190~isCURL:Y~menuPK:1108016~pagePK:148956~piPK:216618~theSitePK:490130,00.html

TIMSS (Trends in International Mathematics and Science Study), Boston College, http://timssandpirls.bc.edu/

Transitional Governance Project, http://transitionalgovernanceproject.org/

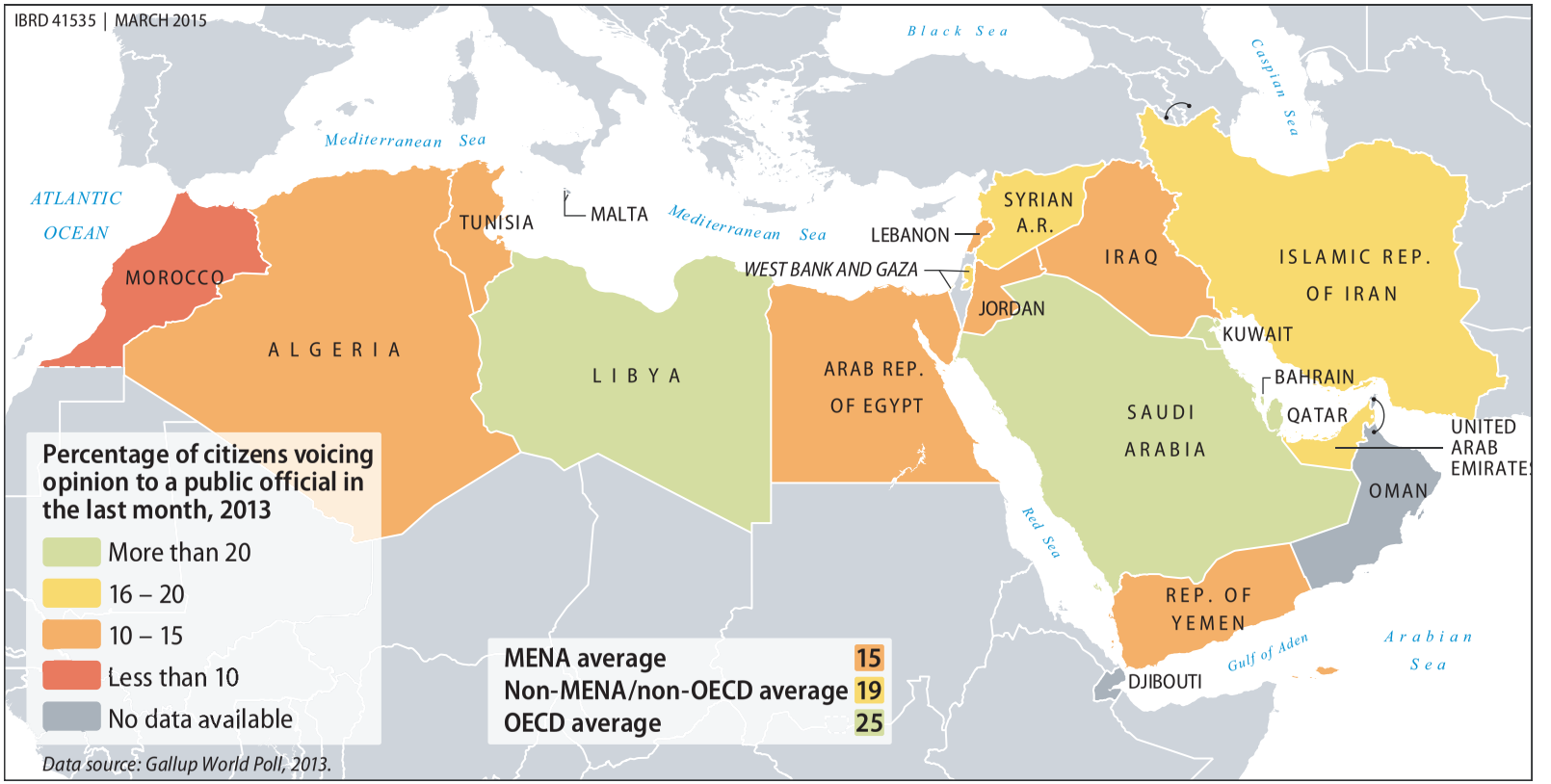
Citizens' Trust and Engagement

PART IV

In parts II and III, we covered the institutions and performance elements of the cycle of performance framework, explaining and further documenting the weaknesses in education and health services delivery in the Middle East and North Africa (MENA). We argued that these weaknesses are rooted in institutions, and we further explored how institutional, and especially accountability, weaknesses influence performance at the point of service delivery on average (chapter 6) and in specific local contexts (chapter 7).

In part IV, we study how performance affects citizens' perceptions of the state and citizens' actions in dealing with the state. In particular, we seek to uncover how performance influences citizens' trust in service providers (chapter 8), which in turn shapes the nature of citizens' engagement at both the local and national levels (chapter 9).

MAP IV.1 **Percentage of citizens voicing opinion to a public official in the last month in MENA, 2013**



Source: World Bank (IBRD 41535 | March 2015).

Citizens' Response to Poor Performance and Unresponsive Institutions? Lower Trust

8

- Citizens view the poor quality of services as an indication of the inability or unwillingness of state institutions to meet their needs.
- If citizens believe that the ruling elites are either incapable or uncaring, they may lose trust in public institutions.

As we saw in the preceding chapters, citizens are frequently dissatisfied with the quality of the education, health, and other services they receive. Schools are overcrowded and underperforming; doctors and nurses are frequently absent from clinics, and, when they are present, they often do not follow the standard protocols; garbage stays in the streets; and streets are unpaved. Because citizens expect the state to provide these services, they equate the failures in service provision with the failure of the state. The object of their blame varies to some extent, with some finding fault with service providers or local officials and others blaming the central government. Whatever the case, poor performance undermines trust in the state.

This chapter explores the link between performance and trust. It begins with a brief

discussion of the role of trust in the state. It then looks at how citizens place their blame on the state and the ways in which it undermines trust in state institutions and actors more generally.

Many studies have recognized the important role that political trust plays in effective government operations and regime stability. High levels of trust reduce government failures and enforcement and transaction costs; lack of trust is a breeding ground for opportunism, informality, and free-riding, seriously compromising the effectiveness of public policies. Trust is positively associated with the support of democratic values and political involvement (Inglehart 1990; Muller and Seligson 1994; Rothstein and Uslaner 2005). Trust can also encourage civic cooperation and the collective mobilization of citizens, freedom of expression and association, and the right to pursue economic opportunities, all of which are crucial for democratic sustainability and legitimacy. Authoritarian regimes also seek to induce trust among the populace as a way of asserting their legitimacy and regime survival. They employ clientelism and the distribution of patronage to increase vertical trust among narrow interest groups or nationalism to rally support from the masses (Jamal 2007; Jamal and Nooruddin 2010).

Trust is driven by individual-level judgments and perceptions of how the government and various political actors are performing (Hetherington 1998; Norris 1999; Levi and Stoker 2000; Jamal 2007; Hakhverdian and Mayne 2012). In general, however, citizens evaluate their governments based on two different sets of criteria: those related to "input" or procedural performance such as the implementation of laws and regulations that guide the functioning of institutions, and those related to "output" or policy performance and the provision of services responsive to citizens' preferences and needs. Whenever state institutions perform poorly on these two main fronts, citizens' trust in institutions is likely dampened (Hakhverdian and Mayne 2012). In their study of the origins of political trust in postcommunist societies, Mishler and Rose (2001) found that citizens' trust can be earned by the state responding efficiently to public priorities. Along similar lines, Yang (2013) has argued, after studying both authoritarian and democratic regimes, that trust is a function of citizens' perceptions of how capable their institutions are and how committed those institutions are to fulfilling their function.

In line with the literature, performance-based perceptions of how governments are responding to the needs of ordinary citizens also appear to drive trust in the Middle East and North Africa (MENA). Indeed, the linkage between performance and trust may be even more evident in the MENA region because its citizens, as discussed in chapter 1, have high expectations that the government will provide for them and yet seem to be deeply dissatisfied with the services they receive and in turn blame state institutions for failing them. Therefore, satisfaction with services and trust in state institutions appear to move in parallel in the MENA region.

Blaming the state for poor services

Citizens' experiences when they visit a health clinic, send their children to school, try to turn on their lights, or try to access clean water affect not only their view of performance but also their attitude toward the state. Even when they access these services through private providers, they may resent having to do so. Their confidence in the state may further decline if they have to turn to using *wasta* or informal payments to gain the services they believe they rightfully deserve. Recent data from Tunisia reveal that a strong, statistically significant correlation exists between citizens' unfavorable evaluations of how well their government is providing services and their deep belief in the importance of *wasta* and informal payments in obtaining services (table 8.1). The belief that the government is doing a bad job in providing health services is correlated with the belief that *wasta* matters in obtaining medical treatment (0.53), school-related services

Table 8.1 Correlation between evaluation of various services and belief in the importance of *wasta* and bribes: Tunisia, 2014

	Wasta: medical treatment	*Wasta*: schools	*Wasta*: construction	Bribes: medical treatment	Bribes: schools	Bribes: construction
Evaluation: health	0.53***	0.50***	0.48***	0.52**	0.51***	0.47***
Evaluation: education	0.57***	0.55***	0.54***	0.57***	0.56***	0.54***
Evaluation: roads	0.57***	0.55***	0.55***	0.53***	0.55***	0.53***

Source: Transitional Governance Project, 2014.
Note: The evaluation variables are categorical variables in which higher values imply worse evaluations. The *wasta* and bribes variables are also categorical variables in which higher values imply a stronger belief in their importance and influence in obtaining services.
$^{*}p < .10$ $^{**}p < .05$ $^{***}p < .01$

(0.50), and construction (0.48), and with the belief that bribes or informal payments matter in medical treatment (0.52), schools (0.51), and construction (0.47). Similarly strong, statistically significant correlations also exist between poor evaluations of the government's performance in education and construction and the belief in the importance of *wasta* and informal payments or bribes in obtaining services.

When the state seems uncaring about the welfare of ordinary citizens, notions of fairness and equity are heavily compromised. In some cases, the state simply excludes some users from accessing services—one example is the marginalized groups excluded by the state in the Republic of Yemen (Aslam 2014). At other times, those who are unable to gain privileged access or who lack information (often because fees and regulations are not posted) feel that they face higher costs than others. For example, in Sana'a in the Republic of Yemen a woman complained that "the I.D. card officially costs 300 riyals, but in reality it may cost 2,700 riyals."[1] For many women, for the poor, and for members of other marginalized groups, this situation puts services out of reach. As another young woman from the Republic of Yemen stated, voicing her frustration about the access to health care, "Basically there are no health services for the people." And in the Arab Republic of Egypt, a middle-aged woman wryly observed about the lack of real options, "A public hospital is where you lose your life, . . . a private one is where you lose your money" (World Bank 2013).

Nonstate actors can and do take on some of the responsibility for providing services. At times, the private sector, charities, or local social elites can help relieve the demand for state-provided services and increase citizens' trust in state institutions. However, even when private providers deliver services, the state is still responsible for ensuring that the provision of quality services is fair and equitable. When it fails to uphold this responsibility, allowing unqualified providers to deliver services based on political allegiance, ethnic or religious belonging, or other discriminatory criteria (Cammett 2014),[2] it undermines citizens' trust in the state as well. As one Yemeni man from Al-Hodeidah told his focus group, local elites "control people whenever they provide a simple service," while one from Mareb complained, "We are not satisfied [with the role of elders in dispute resolution] but there isn't a state" (Aslam 2014). This is not unique to the MENA region. Indeed, there is evidence from Europe that at-risk individuals in systems with higher reliance on private health provision have lower trust in their government (Cammett, Lynch, and Bilev 2014).

Lacking trust in institutions and actors

Citizens are not simply dissatisfied with the state's failure to provide services; for them, that failure reflects the nature of the institutions themselves. When they have to pay additional fees to put their children in the best schools, when they have to hire tutors to

ensure that their children receive good marks, when the clinic doctor asks them to visit his private clinic in order to undergo the medical tests needed, they do not believe such scenarios reflect only on the directorate, school, or clinic; rather, these experiences create or reinforce the notions that the state is corrupt, incompetent, or uncaring.

Citizens find the experience of dealing with the bureaucracy daunting and frustrating. They feel "constantly exposed to corruption, favoritism, poor customer service and deficient information" and complain about the "crazy machine of bureaucracy" (World Bank 2007, 10). As a Yemeni from the focus group in Mareb noted, "Government is very far from us." Indeed, even local council members echo that frustration. One council member from Al-Hodeidah complained, "I exhaust all efforts in serving and helping the citizens, but I am helpless when there is no response." Citizens agree; elected officials may be closer to the people, but "they are not the decision makers," as a man from Taiz explained (Aslam 2014).

Furthermore, surveys find that most people believe corruption flourishes in government institutions and agencies.[3] A 2009 survey found that 92 percent of Egyptians believed corruption had become an "undeniable part of life" (Al-Gharini, Al-Rashidi, and Al-Gamal 2009). One in four respondents believed that it was more widespread in the central ministries; nearly one in five believed it prevailed at the level of localities and directorates; and two in five felt it existed equally at both levels. When it came to allocating the blame for corruption, 61 percent of respondents stated that public servants were responsible for the spread and high prevalence of corruption, and 59 percent blamed senior officials.[4] Jordanians primarily blamed senior public officials, but also held politicians, lower-level public servants, and businessmen responsible.[5] As concluded in a 2007 World Bank report, "Tales abound of irresponsible behavior by local governments, such as keeping the street lights on all day, or of 'big shots' who are accumulating enormous water or electricity bills and not being prosecuted. These stories, true or false, contribute to a general sense of unfairness and cynicism about public life" (World Bank 2007, 18–19).

The relationship between perceptions of institutions and the context governing them on the one hand, and citizens' confidence and trust in the state on the other can be observed. It is evidenced, for example, by the high correlation between the percentage of respondents who trust their national government and the Worldwide Governance Indicators (WGI), which include underlying measures of state institutional quality and performance such as government effectiveness, rule of law, and control of corruption. Table 8.2 reports the correlations between WGI measures and trust. Trust is highly correlated with political stability (0.9, $p < .01$), government effectiveness (0.8, $p < .01$), regulatory quality (0.6, $p < .10$), rule of law (0.9, $p < .01$), and control of corruption (0.9, $p < .01$). MENA countries in the Gulf Cooperation Council (GCC) have very high levels of trust in government when compared with MENA non-GCC countries. Although the high levels of trust could be attributed to more than one factor, such as the nature of their political economies and composition of their populations, GCC countries score "very satisfactory" on the Corruption Perceptions Index (as illustrated

Table 8.2 Correlation between percentage of respondents who trust their national government and WGI measures: MENA region, 2013

	Voice and accountability	Political stability	Government effectiveness	Regulatory quality	Rule of law	Control of corruption
Percentage of respondents who trust their national government	0.1964	0.8844***	0.7685***	0.5721*	0.8928***	0.9071***

Sources: Gallup World Poll, 2013; Worldwide Governance Indicators (WGI), 2013.
Note: MENA = Middle East and North Africa. *$p < .10$ **$p < .05$ ***$p < .01$

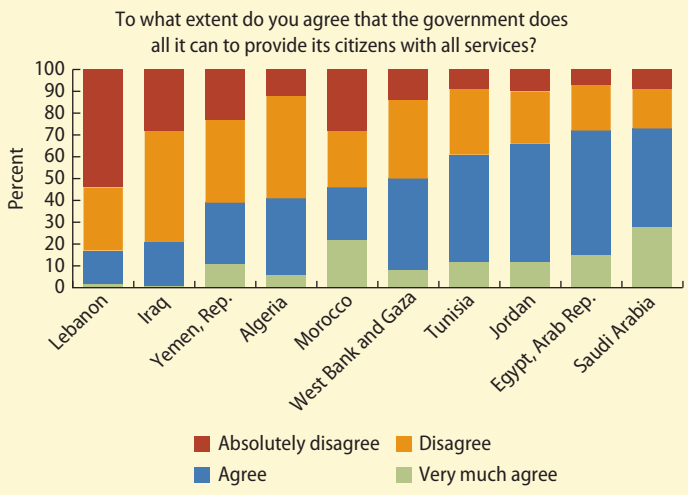
in chapter 1), have stronger institutions, and in general enjoy very favorable citizen evaluations of their governments' performance.

Citizens' trust can be directed toward a wide range of institutions, such as local government, the civil service administration, the legislature, political parties, civil society organizations (CSOs), or the judicial system. Public opinion polls reflect the low levels of trust and confidence among citizens in the willingness and ability of governments (national or local) and legislatures to solve citizens' problems. In 5 of the 10 countries surveyed by the Arab Barometer in 2010–11, nearly 50 percent of respondents disagreed with the statement "the government does all it can to provide its citizens with services" (figures 8.1 and 8.2). Moreover, people believe elected parliaments are not able to enact policies that improve service delivery. Indeed, majorities across the Arab world do not believe that their parliament is performing well.[6] Local governments are also seen as toothless and ineffective in carrying out their tasks and duties. For example, in the 2010–11 Arab Barometer, 42.3 percent of respondents in Iraq evaluated the performance of their local government as bad or very bad, while only 24.4 percent evaluated it as good or very good.

Similarly, citizens have little trust in the effectiveness of political parties and CSOs. According to the 2010–11 Arab Barometer surveys, only in Egypt and Morocco did a majority of citizens believe political parties cared about the needs of ordinary citizens, and political parties were generally seen as more concerned about their leaders' benefits than public welfare.[7] Citizens voiced higher trust in CSOs, but there were certainly differences in the extent to which citizens trusted different associations. Still, people were often unaware of the CSOs and charities in their own areas.[8] Moreover, citizens recognized the constraints that CSOs faced. For example, fewer than one in six citizens in Egypt believed civil society had an impact on local politics (Transitional Governance Project, 2012).

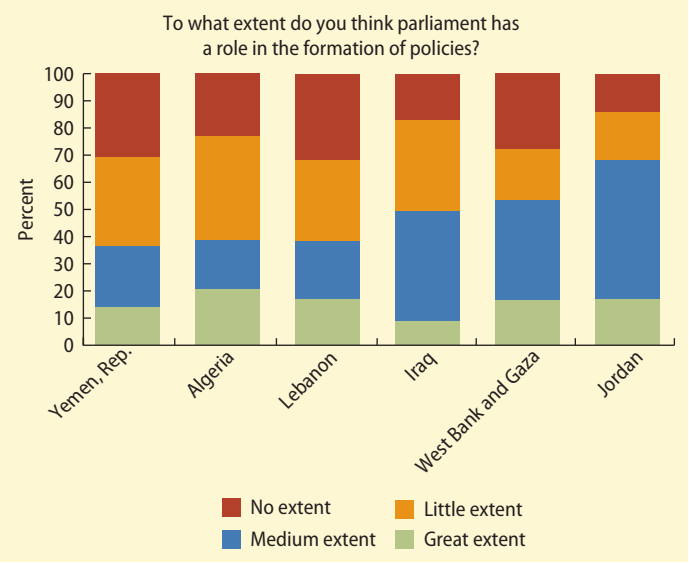
As noted earlier for service delivery performance, there is significant subnational variation in the levels of trust that citizens have in state institutions. For example, Tunisia's administrative divisions (*mu'atamadiya*) vary in the levels of trust they place in the Constituent Assembly and the local government (figures 8.3a and 8.3b). Although data

FIGURE 8.1 Perceptions of the effectiveness of governments: MENA region, 2006–08, 2010–11



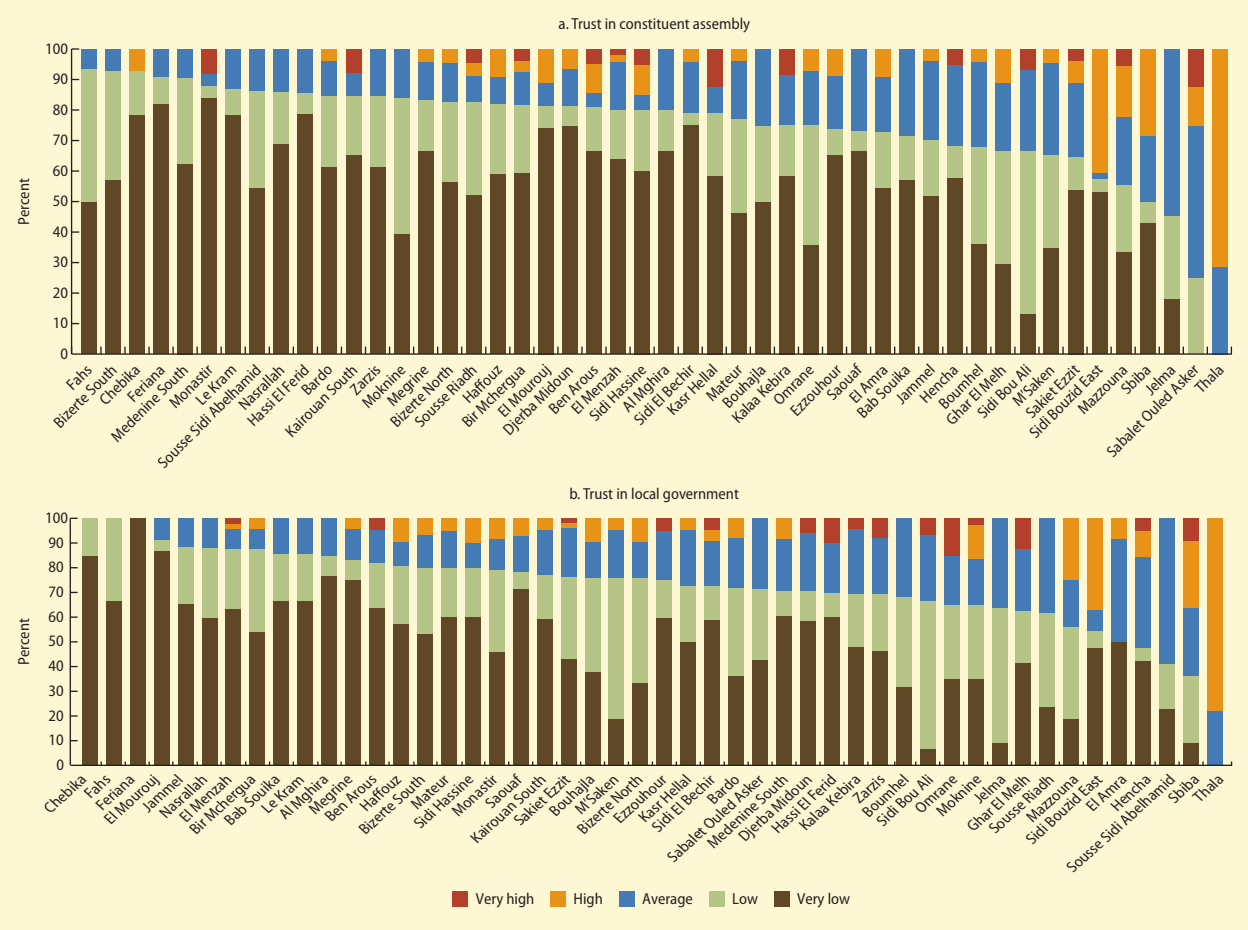
Sources: All countries except Morocco: Arab Barometer, 2010–11 (Wave II); Morocco: Arab Barometer, 2006–08 (Wave I).
Note: MENA = Middle East and North Africa.

FIGURE 8.2 Perceptions of the effectiveness of parliaments: MENA region, 2010–11



Source: Arab Barometer, 2010–11 (Wave II).
Note: MENA = Middle East and North Africa.

FIGURE 8.3 Subnational variation in trust in state institutions, by region: Tunisia, 2014



Source: Transitional Governance Project, 2014.

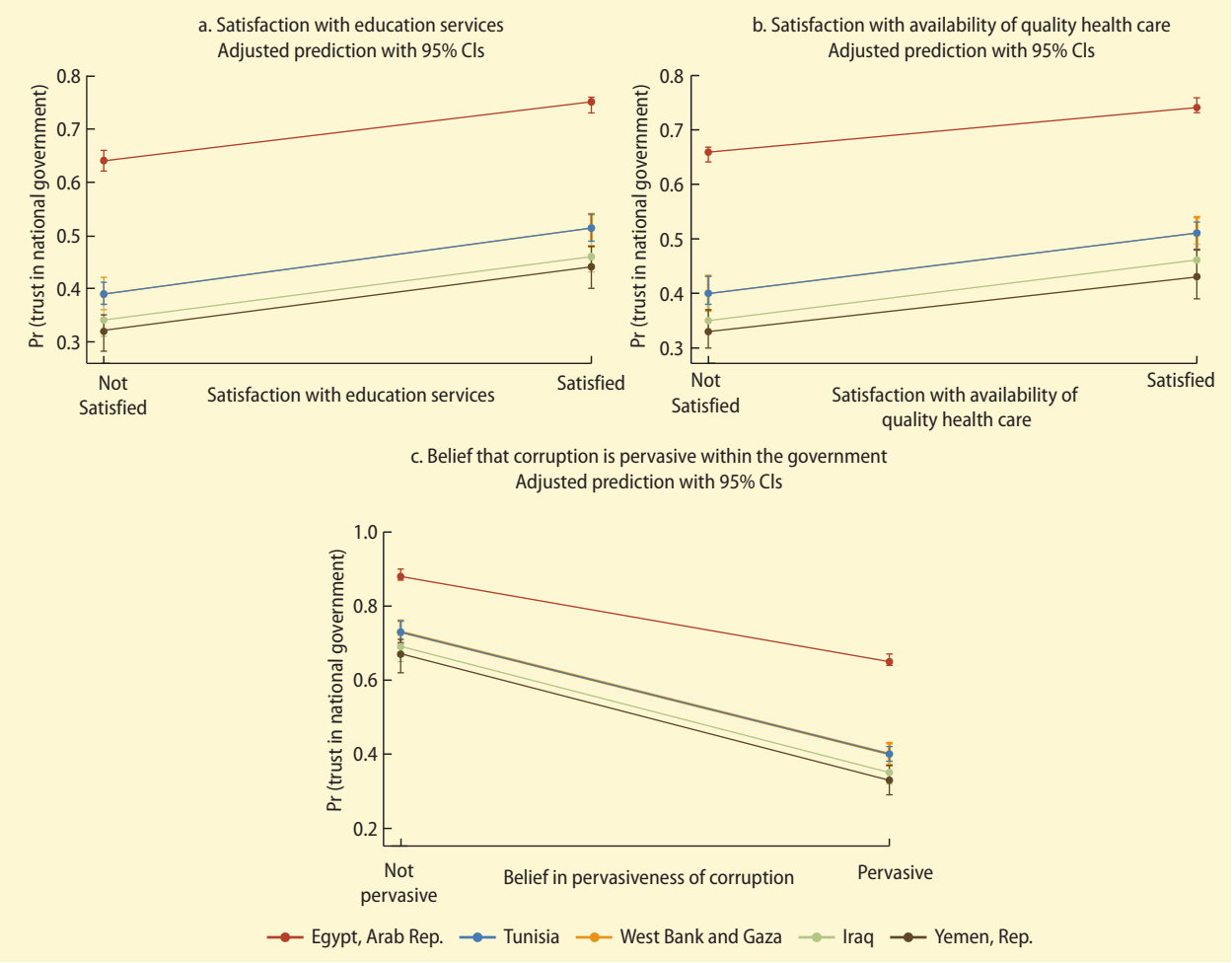
limitations do not allow us to attribute this wide variation in trust to service delivery performance by the state in each division, the evidence is complementary to our earlier analysis and suggests that state performance and subsequently trust in it are not uniform within countries.

Empirical analyses, relying on perceptions-based data from the Gallup World Poll (2013) and the Arab Barometer (2010–11), lend additional support to the notion that performance legitimacy in the eyes of citizens affects trust levels. Based on data from the 2013 Gallup World Poll, trust in national government seems to be highly associated with citizens' satisfaction with education and health services and their perceptions of the pervasiveness of corruption within their government and state institutions. Estimating a binary logit model[9] (which includes the demographic variables likely to affect trust) reveals that the probability of trusting the national government is significantly higher among respondents who are satisfied with education services and the availability of quality health care and who believe that corruption is not pervasive within their government. For example, in Egypt the predicted probability of trusting the national government is 77 percent among those who are satisfied with education services compared with 67 percent among those who are not satisfied. The results are

statistically significant for other MENA economies such as Iraq, the Republic of Yemen, Tunisia, and West Bank and Gaza. The results seem to be quite similar when respondents are satisfied with health services, where the probability of trusting the government is statistically significantly higher for those who are satisfied with health services in the five sampled MENA countries. There are similar results regarding belief in the pervasiveness of corruption, but with a larger magnitude. For example, the probability of trusting the national government is only 40 percent when respondents believe that corruption is widespread, whereas it is 73 percent among those who believe it is not widespread (see figure 8.4 and tables 8A.1, 8A.2, and 8A.3 in the annex).

Using trust in the judiciary as a second measure of trust in state institutions, the results hold and, as with the analysis using trust in national government as a measure for state institutions, the magnitude appears larger for belief in pervasiveness of corruption. For example, in Tunisia the probability of trusting the judiciary is 61 percent

FIGURE 8.4 Predicted probability of trusting the national government as a function of satisfaction with education and health services and believing that corruption is pervasive: Selected MENA economies, 2013

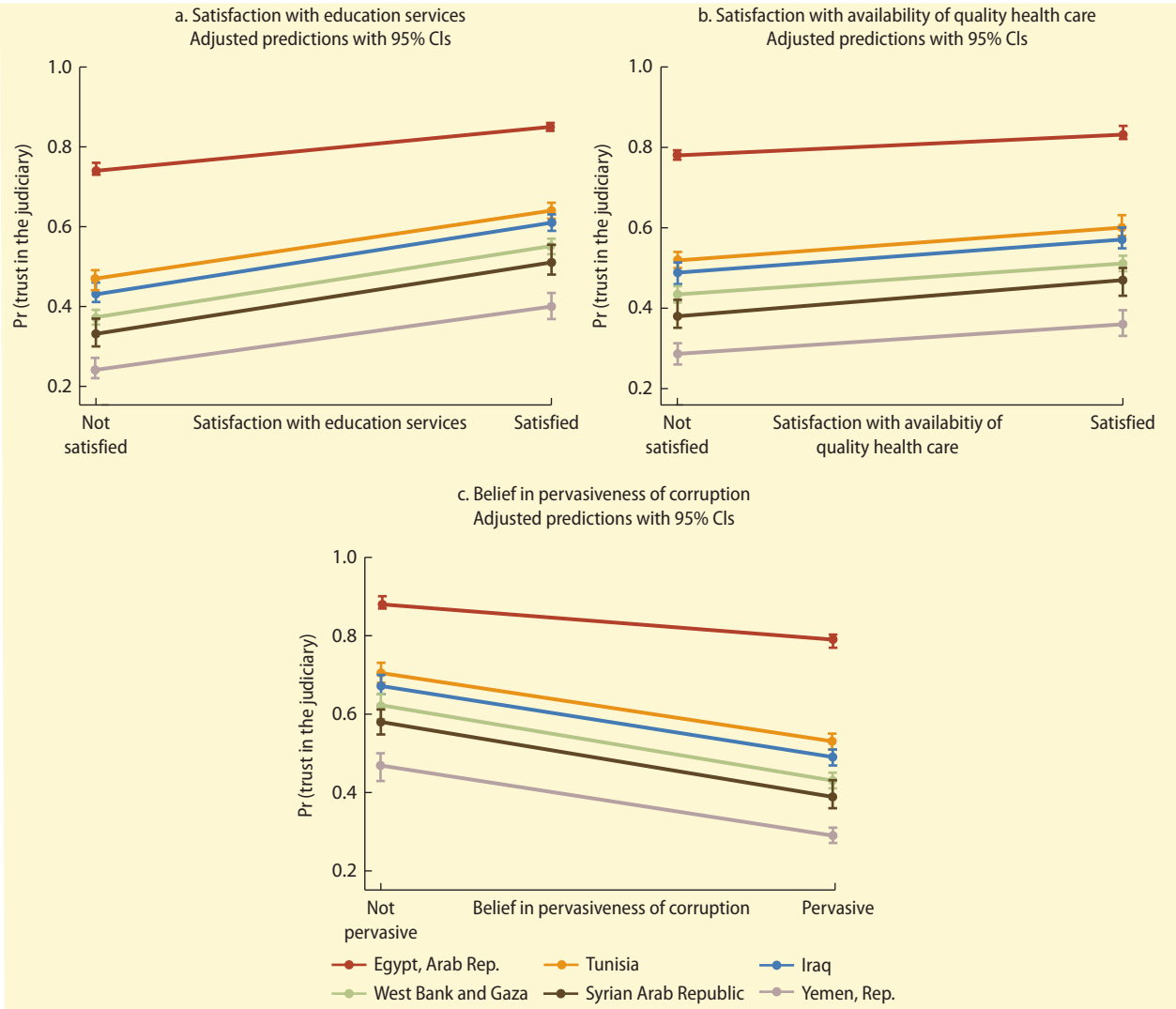


Source: Gallup World Poll, 2013.
Note: CI = confidence interval; MENA = Middle East and North Africa; Pr = probability.

when respondents are satisfied with health services, compared with 53 percent when they are not. The magnitude (that is, the difference in probabilities) seems higher for the belief in the pervasiveness of corruption, as the probability of trusting the judiciary is 71 percent when respondents do not believe that corruption is widespread, whereas it drops to 53 percent when they believe it is (see figure 8.5 and tables 8A.4, 8A.5, and 8A.6 in the annex).

As expected, perceptions of pervasiveness of corruption have a remarkably strong and significant association with trust in government. In probing more on the elements of corruption, the Arab Barometer asked in a categorical variable about whether respondents believed that qualifications were more important than connections in obtaining employment, as important as connections, or less important. Trust in government is a categorical variable that ranges from trusting

FIGURE 8.5 Predicted probability of trusting the judiciary as a function of satisfaction with education and health services and believing that corruption is widespread: Selected MENA economies, 2013



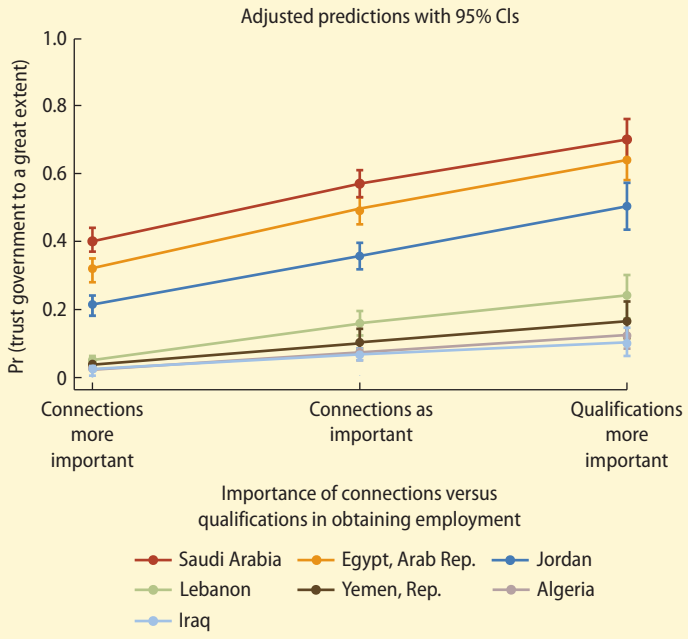
Source: Gallup World Poll, 2013.
Note: CI = confidence interval; MENA = Middle East and North Africa; Pr = probability.

the government to a great extent to absolutely not trusting it. Estimating a multinomial logit model[10] reveals that the probability of trusting the national government to "a great extent" compared with "absolutely not trusting it" increases significantly when respondents believe that qualifications are more important than connections and is higher than the probability when respondents believe that connections are more important than qualifications. This effect tends to be particularly strong for countries such as Egypt, Jordan, and Saudi Arabia (see figure 8.6 and table 8A.7 in the annex). For example, in Saudi Arabia, the probability of trusting the government is 41 percent when respondents think that connections are more important than qualifications. It then increases to 58 percent when they believe it is as important, and then jumps to 71 percent when they believe it is less important than qualifications. The impact of the importance of tribal affinities on trust in national government was found to be very modest, with little or no impact on trust, suggesting that in many cases citizens do not view tribal affinities in a negative light.

These results are similar to findings elsewhere that corruption and perceptions of government performance in service delivery in the MENA region are significantly associated with lower trust (Rothstein 2011). The impact of political corruption on erosion of the trust of citizens has been supported empirically by various regional barometers. Using data on perceptions of corruption and trust in state institutions from the Eurobarometer, Della Porta (2000) found an inverse relationship between corruption and trust. Similarly, Chang and Chu (2006) used the Asian Barometer to test whether trust was more likely to be eroded by corruption, and they found a strong significant impact across the five Asian countries in their sample.

Although this correlation between perceptions of service quality and trust in government may not appear to be an absolute indication that poor quality service delivery undermines trust, there are reasons to believe this relationship holds. Certainly,

FIGURE 8.6 Predicted probability of trusting the government to a great extent compared with absolutely not trusting it as a function of perceptions of the importance of connections in obtaining employment: Selected MENA countries, 2010–11



Source: Arab Barometer, 2010–11 (Wave II).
Note: Reference category for the dependent variable is "absolutely do not trust the national government." CI = confidence interval; MENA = Middle East and North Africa; Pr = probability.

there may be some endogeneity between citizens' evaluations and trust—that is, those who do not trust the government are more likely to view its performance negatively, and they also may be more likely to engage in corrupt practices, which in turn undermines trust in government and its institutions (Cleary and Stokes 2006; Morris and Klesner 2010). Furthermore, perceptions of corruption and service delivery are subjective and affected by many factors. For example, they may be picking up some of the effects of citizens' unhappiness with their country's broader economic situation and the overall political performance of the government such as perceived fairness, freedom, and satisfaction with the democratic process (Chang and Chu 2006). Measuring actual government performance in service delivery objectively rather than relying on perceptions to understand its actual impact on trust would be ideal, but it is empirically

difficult (Yang and Holzer 2006). Instead, we remind readers of the earlier findings that individuals' perceptions of service delivery vary to some extent across services, even when their evaluation of and engagement with the state remain the same. This suggests that citizens' perceptions do mirror reality to an extent and gives us confidence that the quality of service delivery contributes to citizens' low trust in the state.

Conclusion

The evidence largely suggests that citizens' trust in public institutions in the MENA countries is similar to what has been suggested in the literature and found in other regions. Their trust in the state is a function of their perceptions of the quality of the services offered, as well as their evaluations of government's efforts to provide services in a fair and equitable manner.

Citizens cite the need for connections and informal payments to access services, the widening inequities, and the fact that the most vulnerable segments have been left uncovered. Their trust levels are also heavily affected by their perceptions of the institutions governing them. They find dealing with the bureaucracy daunting, and they find the ministries crippled with corruption, staffed by unresponsive and undermotivated civil servants.

The strategies long deployed by the states with deep colonial legacies such as clientelism and patronage have gained the vertical trust of a narrow set of groups, but they have alienated the populace in general, resulting in inequitable social institutions and a largely dissatisfied population.

Annex Predicted probabilities tables on trusting the national government

Table 8A.1 Predicted probabilities of satisfaction with education services on trusting the national government: Selected MENA economies, 2013

Independent variable	Predicted probability on trusting the national government
0 = not satisfied, Arab Republic of Egypt	0.665***
	(0.00815)
0 = not satisfied, West Bank and Gaza	0.406***
	(0.0142)
0 = not satisfied, Iraq	0.361***
	(0.0136)
0 = not satisfied, Tunisia	0.412***
	(0.0114)
0 = not satisfied, Republic of Yemen	0.339***
	(0.0190)
1 = satisfied, Arab Republic of Egypt	0.771***
	(0.00708)
1 = satisfied, West Bank and Gaza	0.537***
	(0.0139)
1 = satisfied, Iraq	0.490***
	(0.0148)
1 = satisfied, Tunisia	0.543***
	(0.0114)
1 = satisfied, Republic of Yemen	0.465***
	(0.0209)
No. of observations	16,812

Source: Gallup World Poll, 2013.
Note: All predictors are at their mean value. Standard errors are in parentheses.
$^{*}p < .10$ $^{**}p < .05$ $^{***}p < .01$

Table 8A.2 Predicted probabilities of satisfaction with availability of quality health care on trusting the national government: Selected MENA economies, 2013

Independent variable	Predicted probability on trusting the national government
0 = not satisfied, Arab Republic of Egypt	0.661***
	(0.00840)
0 = not satisfied, West Bank and Gaza	0.408***
	(0.0143)
0 = not satisfied, Iraq	0.358***
	(0.0134)
0 = not satisfied, Tunisia	0.408***
	(0.0116)
0 = not satisfied, Republic of Yemen	0.337***
	(0.0184)

(continued next page)

Table 8A.2 Predicted probabilities of satisfaction with availability of quality health care on trusting the national government: Selected MENA economies, 2013 *(continued)*

Independent variable	Predicted probability on trusting the national government
1 = satisfied, Arab Republic of Egypt	0.749***
	(0.00842)
1 = satisfied, West Bank and Gaza	0.513***
	(0.0150)
1 = satisfied, Iraq	0.461***
	(0.0158)
1 = satisfied, Tunisia	0.514***
	(0.0125)
1 = satisfied, Republic of Yemen	0.438***
	(0.0219)
No. of observations	10,821

Source: Gallup World Poll, 2013.
Note: All predictors are at their mean value. Standard errors are in parentheses.
$^{*}p < .1$ $^{**}p < .05$ $^{***}p < .01$

Table 8A.3 Predicted probabilities of belief in pervasiveness of corruption within government on trusting the national government: Selected MENA economies, 2013

Independent variable	Predicted probability on trusting the national government
0 = not pervasive, Arab Republic of Egypt	0.887***
	−0.00758
0 = not pervasive, West Bank and Gaza	0.734***
	−0.0155
0 = not pervasive, Iraq	0.691***
	−0.0172
0 = not pervasive, Tunisia	0.735***
	−0.0154
0 = not pervasive, Republic of Yemen	0.671***
	−0.0226
1 = pervasive, Arab Republic of Egypt	0.658***
	−0.00743
1 = pervasive, West Bank and Gaza	0.404***
	−0.0136
1 = pervasive, Iraq	0.355***
	−0.0131
1 = pervasive, Tunisia	0.405***
	−0.0103
1 = pervasive, Republic of Yemen	0.334***
	−0.0184
No. of observations	10,821

Source: Gallup World Poll, 2013.
Note: All predictors are at their mean value. Standard errors are in parentheses.
$^{*}p < .1$ $^{**}p < .05$ $^{***}p < .01$

On trusting the judiciary

Table 8A.4 Predicted probabilities of satisfaction with education services on trusting the judiciary: Selected MENA economies, 2013

Independent variable	Predicted probability on trusting the judiciary
0 = not satisfied, Arab Republic of Egypt	0.748***
	(0.00730)
0 = not satisfied, Syrian Arab Republic	0.339***
	(0.0158)
0 = not satisfied, West Bank and Gaza	0.377***
	(0.0105)
0 = not satisfied, Iraq	0.437***
	(0.0120)
0 = not satisfied, Tunisia	0.471***
	(0.0117)
0 = not satisfied, Republic of Yemen	0.247***
	(0.00976)
1 = satisfied, Arab Republic of Egypt	0.859***
	(0.00543)
1 = satisfied, Syrian Arab Republic	0.514***
	(0.0172)
1 = satisfied, West Bank and Gaza	0.555***
	(0.0102)
1 = satisfied, Iraq	0.615***
	(0.0117)
1 = satisfied, Tunisia	0.648***
	(0.0108)
1 = satisfied, Republic of Yemen	0.403***
	(0.0125)
No. of observations	15,472

Source: Gallup World Poll, 2013.
Note: All predictors are at their mean value. Standard errors are in parentheses.
$^{*}p < .1$ $^{**}p < .05$ $^{***}p < .01$

Table 8A.5 Predicted probabilities of satisfaction with availability of quality health care on trusting the judiciary: Selected MENA economies, 2013

Independent variable	Predicted probability on trusting the judiciary
0 = not satisfied, Arab Republic of Egypt	0.786***
	(0.00666)
0 = not satisfied, Syrian Arab Republic	0.389***
	(0.0163)
0 = not satisfied, West Bank and Gaza	0.429***
	(0.0106)
0 = not satisfied, Iraq	0.490***
	(0.0117)
0 = not satisfied, Tunisia	0.525***
	(0.0116)
0 = not satisfied, Republic of Yemen	0.289***
	(0.0101)

(continued next page)

Table 8A.5 Predicted probabilities of satisfaction with availability of quality health care on trusting the judiciary: Selected MENA economies, 2013 *(continued)*

Independent variable	Predicted probability on trusting the judiciary
1 = satisfied, Arab Republic of Egypt	0.838***
	(0.00610)
1 = satisfied, Syrian Arab Republic	0.473***
	(0.0179)
1 = satisfied, West Bank and Gaza	0.514***
	(0.0107)
1 = satisfied, Iraq	0.575***
	(0.0127)
1 = satisfied, Tunisia	0.609***
	(0.0115)
1 = satisfied, Republic of Yemen	0.364***
	(0.0130)
No. of observations	15,472

Source: Gallup World Poll, 2013.
Note: All predictors are at their mean value. Standard errors are in parentheses.
*$p < .1$ **$p < .05$ ***$p < .01$

Table 8A.6 Predicted probabilities of belief in pervasiveness of corruption within government on trusting the judiciary: Selected MENA economies, 2013

Independent variable	Predicted probability on trusting the judiciary
0 = not pervasive, Arab Republic of Egypt	0.889***
	(0.00602)
0 = not pervasive, Syrian Arab Republic	0.582***
	(0.0187)
0 = not pervasive, West Bank and Gaza	0.621***
	(0.0132)
0 = not pervasive, Iraq	0.677***
	(0.0136)
0 = not pervasive, Tunisia	0.707***
	(0.0134)
0 = not pervasive, Republic of Yemen	0.470***
	(0.0163)
1 = pervasive, Arab Republic of Egypt	0.790***
	(0.00613)
1 = pervasive, Syrian Arab Republic	0.395***
	(0.0163)
1 = pervasive, West Bank and Gaza	0.434***
	(0.00983)
1 = pervasive, Iraq	0.496***
	(0.0115)
1 = pervasive, Tunisia	0.531***
	(0.0107)
1 = pervasive, Republic of Yemen	0.294***
	(0.0102)
No. of observations	15,472

Source: Gallup World Poll, 2013.
Note: All predictors are at their mean value. Standard errors are in parentheses.
*$p < .1$ **$p < .05$ ***$p < .01$

On trusting the government to a great extent

Table 8A.7 Predicted probabilities of perceptions of importance of connections in obtaining employment on trusting the government to a great extent compared with absolutely not trusting it: Selected MENA countries, 2010–11

Independent variable	Predicted probability on trusting the government to a great extent
1 = connections are more important than qualifications, Algeria	0.0289***
	(0.00428)
1 = connections are more important than qualifications, Arab Republic of Egypt	0.322***
	(0.0176)
1 = connections are more important than qualifications, Iraq	0.0266***
	(0.00392)
1 = connections are more important than qualifications, Jordan	0.215***
	(0.0136)
1 = connections are more important than qualifications, Lebanon	0.0517***
	(0.00613)
1 = connections are more important than qualifications, Saudi Arabia	0.409***
	(0.0195)
1 = connections are more important than qualifications, Republic of Yemen	0.0416***
	(0.00570)
2 = connections are as important as qualifications, Algeria	0.0841***
	(0.0116)
2 = connections are as important as qualifications, Arab Republic of Egypt	0.497***
	(0.0219)
2 = connections are as important as qualifications, Iraq	0.0695***
	(0.00975)
2 = connections are as important as qualifications, Jordan	0.357***
	(0.0199)
2 = connections are as important as qualifications, Lebanon	0.161***
	(0.0187)
2 = connections are as important as qualifications, Saudi Arabia	0.576***
	(0.0204)
2 = connections are as important as qualifications, Republic of Yemen	0.114***
	(0.0145)
3 = qualifications are more important than connections, Algeria	0.125***
	(0.0204)
3 = qualifications are more important than connections, Arab Republic of Egypt	0.647***
	(0.0318)
3 = qualifications are more important than connections, Iraq	0.110***
	(0.0188)
3 = qualifications are more important than connections, Jordan	0.504***
	(0.0351)
3 = qualifications are more important than connections, Lebanon	0.241***
	(0.0337)
3 = qualifications are more important than connections, Saudi Arabia	0.704***
	(0.0290)
3 = qualifications are more important than connections, Republic of Yemen	0.169***
	(0.0266)
No. of observations	7,311

Source: Arab Barometer, 2010–11 (Wave II).
Note: All predictors are at their mean value. Standard errors are in parentheses.
$^{*}p < .1$ $^{**}p < .05$ $^{***}p < .01$

Notes

1. Member of a focus group convened for the social development study conducted by the World Bank (2007).
2. Also see Cammett and MacClean (2014) for a more general discussion of how the characteristics of nonstate providers—including the degree of formalization, degree of embeddedness/locus of operation, profit orientation, and eligibility criteria—combine with the characteristics of private provider-state relations to affect the effects of nonstate provision on citizens' trust.
3. In the 2010–11 Arab Barometer, the percentages of respondents answering yes to the question "Do you think that there is corruption within the state's institutions and agencies?" were as follows: Algeria, 93 percent (n = 1,178, 2011); Egypt, 82 percent (n = 1,193, 2011); Iraq, 97 percent (n = 1,215, 2011); Jordan, 74 percent (n = 1,065, 2010); Lebanon, 97 percent, (n = 1,379, 2011); Republic of Yemen, 94 percent (n = 1,137, 2011); Tunisia, 79 percent (n = 1,047, 2011); and West Bank and Gaza, 77 percent (n = 1,054, 2010). In two-thirds of the countries surveyed by the Arab Barometer, less than 15 percent of respondents believed that the government did a great deal to eliminate corruption. In Algeria, Egypt, and Tunisia, more than two-thirds believed that corruption was widespread or very widespread within the government. Even in countries that are experiencing a transition—Egypt and Tunisia—citizens do not believe the government handles corruption well. Only in those two countries when surveyed in 2011 did a majority of respondents believe the government was working to eliminate corruption to a great or medium extent.
4. Another 26 percent blamed citizens themselves, 16 percent blamed municipalities, 15 percent blamed businessmen and the private sector, and 14 percent pointed to the police (see Al-Gharini, Al-Rashidi, and Al-Gamal 2009).
5. Results of a 2007 Jordanian public opinion poll from the Center for Strategic Studies at the University of Jordan, cited in Al-Gharini, Al-Rashidi, and Al-Gamal (2009).
6. Specifically, when asked by the Arab Barometer how they would evaluate the performance of their parliament in carrying out its tasks and duties, the percentage that answered "good" or "very good" was in Algeria, 6 percent (2011); Iraq, 23 percent (2011); Jordan, 49 percent (2010); Lebanon, 15 percent (2010); Libya, 30 percent (2013); Morocco, 9 percent (2007); Republic of Yemen, 21 percent (2011); Tunisia, 8 percent (2012); and West Bank and Gaza, 39 percent (2010). In Libya, only one in seven citizens believed their parliament had taken the right steps to fight corruption (Transitional Governance Project, 2013).
7. In probing citizens' trust of political parties, the Arab Barometer (2010–11) used a four-scale categorical variable: trust them to a great extent, trust them to medium extent, trust them to a limited extent, and absolutely do not trust them. The following responded that they absolutely do not trust political parties in their economies: Algeria, 53.4 percent; Egypt, 41.1 percent; Iraq, 52.4 percent; Jordan, 41.6 percent; Lebanon, 60 percent; Republic of Yemen, 46.2 percent; Tunisia, 48.8 percent; and West Bank and Gaza, 52.7 percent.
8. The Gallup World Poll (2013) reported that the following were unaware of social and nongovernmental organizations in their areas that offer people opportunities to serve the community by volunteering their time: Algeria, 55.8 percent; Bahrain, 19.8 percent; Egypt, 60 percent; Iraq, 67.6 percent; Jordan, 49.6 percent; Kuwait, 43 percent; Lebanon, 44.2 percent; Morocco, 56.8 percent; Oman, 43.7 percent; Qatar, 37 percent; Republic of Yemen, 81.6 percent; Saudi Arabia, 26.9 percent; Syrian Arab Republic, 68.6 percent; Tunisia, 66.9 percent; United Arab Emirates, 35.6 percent; and West Bank and Gaza, 62.2 percent.
9. The binary logit model included trust in national government (a binary variable coded 1 if yes and 0 if no) as a dependent variable and the following explanatory variables: (1) satisfaction with education (a binary variable coded 1 if yes and 0 if no); (2) satisfaction with the availability of quality health care (a binary variable coded 1 if yes and 0 if no); and (3) a belief in the pervasiveness of corruption within the government (a binary variable coded 1 if yes and 0 if no), in addition to age, gender, income quintile, and employment status.
10. The multinomial logit model included as a dependent variable trust in national government (a categorical variable coded as 1 = trust the government to a great extent; 2 = trust the government to a medium extent; 3 = trust the government to a limited extent; 4 = absolutely do not trust the government). It also included the following explanatory variables:

(1) the role of connections in gaining employment (a categorical variable coded as 1 = connections are more important than qualifications in gaining employment; 2 = connections are as important as qualifications in gaining employment; 3 = qualifications are more important than connections in gaining employment); (2) the role of tribal affinity in gaining employment (a categorical variable coded as 1 = tribal affinities are more important than qualifications in gaining employment; 2 = tribal affinities are as important as qualifications in gaining employment; 3 = qualifications are more important than tribal affinities in gaining employment); (3) age; (4) educational attainment; (5) gender; and (6) urban/rural status.

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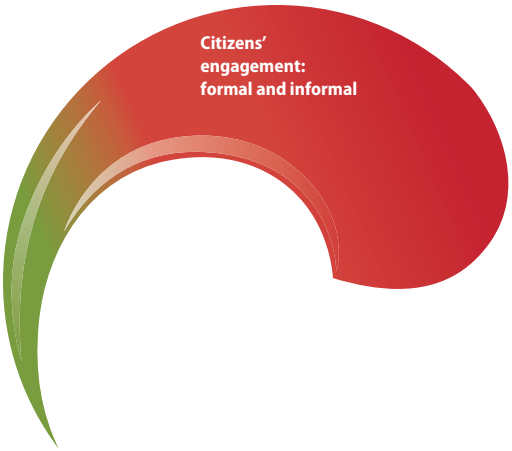
Effects of Lower Citizen Trust on Citizen Engagement: Circumventing the State, Relying on *Wasta*, and Pursuing Conflict

9

- Citizens' trust (and lack of trust) in public institutions shapes their behavior.
- Citizens of the Middle East and North Africa rarely engage formally with the state or use formal institutions to demand accountability.
- Instead, they circumvent the state when possible, turning to private providers, charitable organizations, and informal pathways (such as *wasta* or informal payments) to access state services, or they engage in head-on conflict with the state.

On the face of it, the Middle East and North Africa (MENA) region seems to suffer from a paradox: citizens have high expectations of their governments, and yet they do not pursue any formal means of demanding change through action. In this chapter, we provide one potential explanation for this paradox. We argue that the key element in understanding citizens' lack of formal engagement is low trust, in many ways driven by lack of an institutional capacity for accountability and voice empowerment even if citizens were to demand accountability through formal channels.

The challenge in the MENA region in reviving bottom-up approaches and social accountability tools to put more pressure on state institutions lies in the fact that citizens



do not trust that their formal institutions are capable of reforms or of making any tangible improvements on the ground. They also tend to generally feel that they have no power over the decision-making process. Therefore, they disengage because they believe there are no official formal processes or redress mechanisms where their voices can be heard, and indeed rightfully so. The preceding chapters illustrated how weak jurisdictions, inadequate financial support, and lack of independence from political pressure compromise the effectiveness of many political and administrative accountability mechanisms—a situation that is well known to most citizens, who, as we have noted, see state institutions as politically captured, toothless, and riddled with corruption. Thus rather than engage directly with the state, citizens often circumvent the state, resort to survival mechanisms such as *wasta* or informal payments, or at times confront the state. Unfortunately, in doing so they exacerbate the problem and widen the inequities in service provision.

This chapter explores these dynamics. It begins with a discussion of the failure of citizens to engage directly with the state. It then turns to a discussion of how citizens circumvent the state (primarily seeking individual solutions) or engage in conflict. It concludes by considering the impact that the expansion of social media can have on engagement.

Directly engaging the state and public services delivery institutions

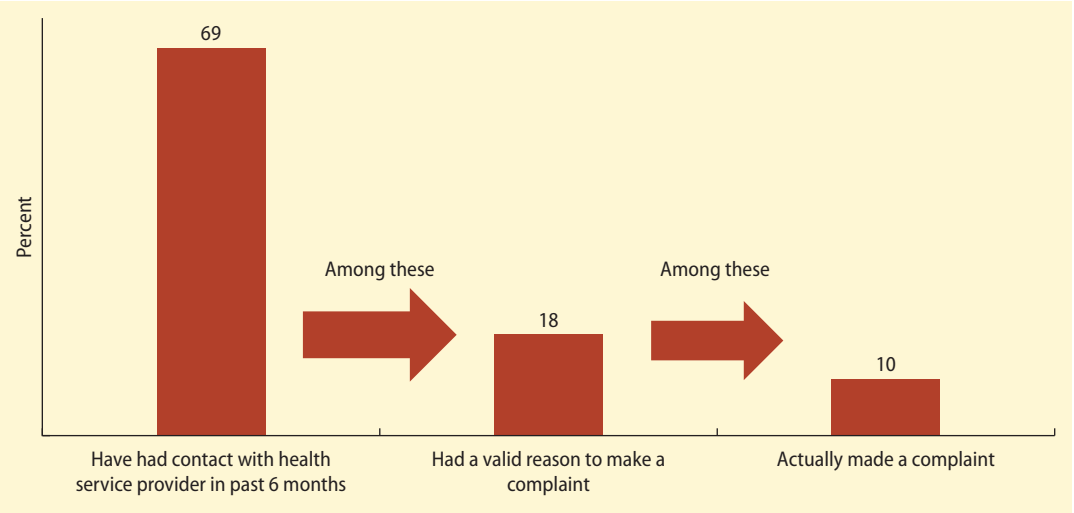
In much of the MENA region, people are unlikely to use official channels to obtain services because they believe they have little chance of succeeding by simply following the rules. For example, in surveys conducted in Morocco and Algeria in 2007, only about half of citizens said they would go directly to a government agency to obtain services, and only about a quarter thought it would be effective to do so. More citizens believed they stood a better chance if they went through friends or family.[1]

Citizens also tend not to file complaints or directly challenge authorities because of their feelings of disempowerment. Analyses at the individual level using Arab Barometer data found that those least satisfied with their government's efforts to provide services are also the ones least likely to file a complaint through formal means when their rights are violated.[2]

In the Governance and Anti-Corruption (GAC) survey conducted in 2009 in the Republic of Yemen, only 10 percent of respondents who answered that they had a valid reason to make a complaint actually did so (figure 9.1). This finding suggests that these citizens recognized grievances but felt unable to address them. A service provider in Ramallah in the West Bank reflected similar concerns in a focus group, saying, "We can see injustice and inefficiency, and understand what causes them; but that in itself does not lead to action. I actually mean, whatever we are discussing right now, it will not solve our problems. We are sitting here, and none of us has the power to make decisions" (World Bank 2007). As Ringold, Holla, and Koziol (2012, 12) note, such problems are "particularly salient in low-income countries [and subregions], where providers may come from more affluent backgrounds and citizens may not feel in a position to question them . . . because of their status, credentials, or knowledge, or they may be concerned about the repercussions of giving negative feedback"(also see World Bank 2010).[3]

Engagement with the state in the form of political action does not happen frequently, and citizens seldom see voting, signing petitions, and other actions as effective means of changing policies in ways that improve the lives of ordinary citizens. Thirty-four percent of all respondents in sampled MENA countries of the sixth wave of the World Values Survey answered that they had never participated in a local election and 32 percent responded the same about a national one. The percentage of respondents never voting in a local election was as high as 72 percent in Tunisia and as low as 20 percent in the Arab Republic of Egypt. However,

FIGURE 9.1 Rate of respondents who had and acted on a complaint about health services: Republic of Yemen, 2009



Source: GAC, Republic of Yemen, 2009.

as indicated earlier, the picture also varies within countries. For example, in Jordan, participation levels in parliamentary elections can range from 20 percent to more than 90 percent at the local level (figure 9.2a). In Tunisia, some degree of variation in voting is found as well at the level of administrative districts, although it is not as high as that found in Jordan (figure 9.2b).

Citizens rarely join political parties or civil society organizations (CSOs) in order to influence policy because they do not trust the efficacy of these groups.[4] For example, the World Values Survey found that in the 10 economies surveyed, only in Lebanon, the Republic of Yemen, and West Bank and Gaza were more than one in five citizens likely to be a party member, and only in the Republic of Yemen did party membership surpass 20 percent.[5] Citizen engagement in CSOs in MENA countries is also low. The Republic of Yemen again leads, with 28 percent of respondents claiming to be members of CSOs, but most of these associations are not aimed at pressuring policy makers.[6] Gengler et al. (2013) concluded in their analysis of the 2010 Qatar World Values Survey that the 20 percent of the resident population who do engage in civic associations "seem to engage in association life primarily in order to seek their private advantage and interact with like-minded individuals, ends that serve exactly to reinforce rather than challenge the established social and political system."

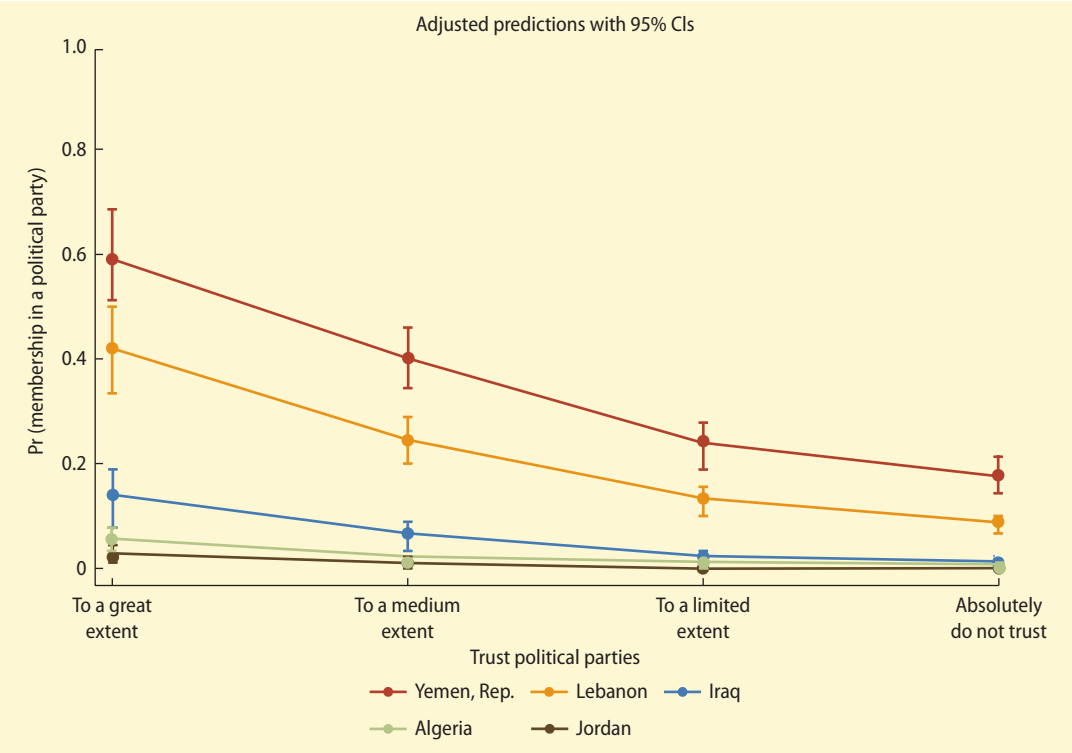
Evidence from the Arab Barometer indicates that in some countries, citizens' limited engagement stems from the little trust they have in the efficacy of organizations, including political parties (see figure 9.3 and table 9A.1 in the annex). Estimation of a binary logit model[7] reveals that the predicted probability of becoming a member of a political party is higher among respondents who trust political parties and their efficacy.

The effects are noticeably strong in Lebanon and the Republic of Yemen. In the latter, the probability of becoming a member of a political party is 60 percent when respondents trust parties "to a great extent," whereas it is only 18 percent when they "absolutely do not trust" parties. Similarly, in

FIGURE 9.2 **Percentage of respondents participating and voting in elections at the subnational level: Jordan and Tunisia, 2014**

Source: Governance and Local Development survey, 2014.
Note: In panel a, the numbers that appear next to some localities are sublocalities. Numbers were added for survey sampling purposes and do not represent official administrative boundaries.

FIGURE 9.3 Predicted probability of becoming a member of a political party as a function of trust in political parties: Selected MENA countries, 2010–11



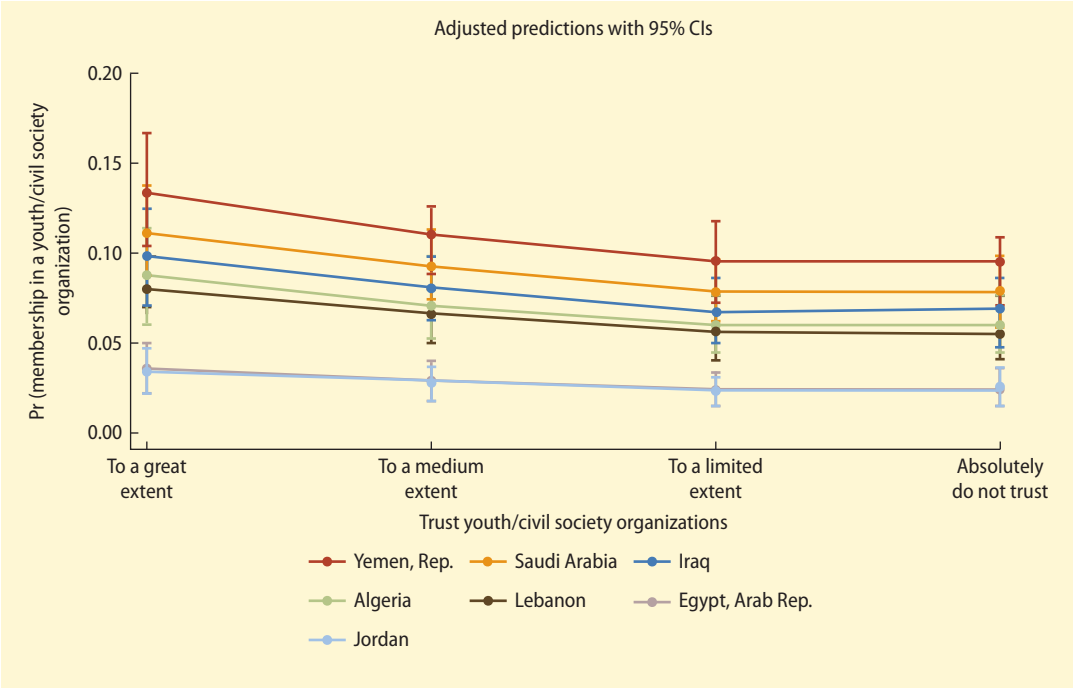
Source: Arab Barometer, 2010–11 (Wave II).
Note: MENA = Middle East and North Africa; CI = confidence interval; Pr = probability.

Lebanon the probability of becoming a member increases from 10 percent to 42 percent when respondents trust political parties "to a great extent." The results are also significant for Algeria, Iraq, and Jordan, although of a smaller magnitude.

Similar to the lack of engagement in political parties, the limited trust in CSOs or their capacity to implement changes is significantly related to lack of membership among citizens in such movements, although the effect is smaller in magnitude (see figure 9.4 and table 9A.2 in the annex). Estimation of a binary logit model[8] reveals that the probability of becoming a member of a CSO such as a youth or cultural group is lower among those who do not trust such organizations. In the Republic of Yemen, the probability of becoming a member is 14 percent among those who trust such organizations, where it is only 10 percent among those who do not.

Citizens' quests for accountability are further hampered by the institutional constraints (so-called supply-side accountability) that do not allow CSOs to function freely without state intervention and continual crackdowns. These in turn limit citizens' effectiveness in influencing policy and can explain why they do not trust and do not join such organizations. Indeed, the social accountability literature argues that citizens need to supplement their demands for accountability and their capacity for collective action with accessible and

FIGURE 9.4 Predicted probability of becoming a member of a youth/civil society organization (CSO) as a function of trusting CSOs: Selected MENA countries, 2010–11



Source: Arab Barometer, 2010–11 (Wave II).
Note: MENA = Middle East and North Africa; CI = confidence interval; Pr = probability.

responsive accountability institutions to move from the "'accountability trap" to improved public sector performance, or else, as Fox (2014) has written, "voice becomes toothless."

Even parent-teacher organizations and boards of trustees are often weak. Education is well suited to community action aimed at improving service quality because many parents view the education of children as extremely important. Schooling (unlike health care, for example) accommodates continual, frequent engagement among parents, teachers, and school administrators. Moreover, a 2007 World Bank report concluded that these parties do want more communication between parents and teachers. And yet in public schools such councils remain weak or absent (World Bank 2007). A report by the Carnegie Middle East Center, *The Arab World's Education Report Card: School Climate and Citizenship Skills*, concluded, "The effective school-family partnership that is present in many non-Arab countries is virtually absent in the Arab region. This has negative implications for the school climate as well as student achievement" (Faour 2012, 24).

Often, citizens contact local governments (and particularly mayors) for help in obtaining jobs and accessing education, health care, and other services, because they view such officials as important interlocutors with the state. However, as elaborated earlier, local governments are often weak in the MENA region and do not have significant autonomy over financial resources and decision-making power. And yet high volumes of requests are

still received even when the services sought are not under local officials' purview or the local government's resources are inadequate. For example, in the Republic of Yemen citizens petitioned local council members for services even though both council members and their constituents acknowledged the council members were "helpless" and "not the decision makers" (Aslam 2014). In Jordan, mayors and local council members bemoaned that even when they are overwhelmed with enormous challenges, limited time, and few material resources, they are inundated with requests for all types of services.[9]

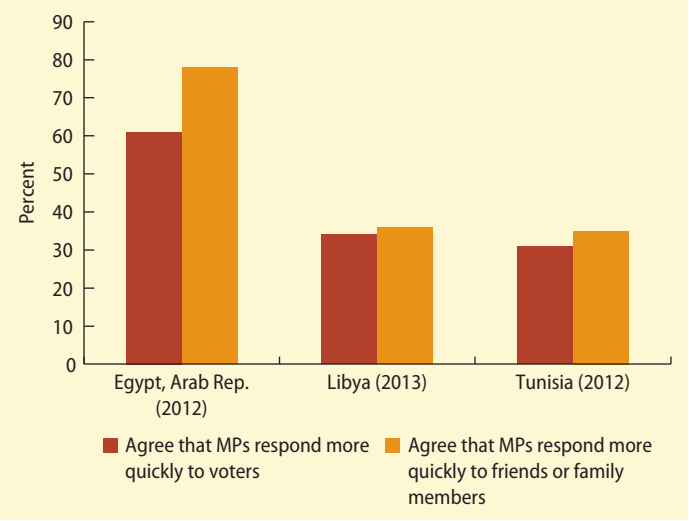
At times, however, engagement in local CSOs and collective action aimed at obtaining better services are occurring. The case studies in chapter 3 illustrate how in some instances citizens have been able to mobilize themselves and find ways to hold providers and their local representatives accountable, albeit their practices remain context-specific and have yet to be institutionalized. The 2000s saw an increase in strikes, primarily for better wages and working conditions (see Ortiz et al. 2013; Khatib and Lust 2014), and since 2011, from Bahrain to Oman, there have been protests over school fees, wages, better living standards, and government corruption.[10] There are also important national, regional, and local variations. For example, in the World Bank's 2008 Public Expenditure Tracking Survey (PETS) in Egypt, nearly two-thirds of eighth-grade students reported that their parents had been invited to participate in committees (far above the regional average), and one-third of the schools in the six governorates included in PETS received extra resources from community sources.[11] A governor in Qena, Egypt, Adel Labib, demonstrated how participation can be achieved. His firm belief that community participation is critical to development led him to form local expert and community councils to support school development, and his willingness to engage in the communities—walking through towns and holding meetings to get to know residents personally—helped to build the legitimacy and trust needed to mobilize community support. As a result, Qena saw considerable gains in the six years of Labib's tenure: his efforts generated local funds to improve hospitals, schools, and roads and created programs to lower illiteracy and unemployment rates (Bennet 2011).

Circumventing the state

In authoritarian states plagued with politically captured institutions that cater only to the interests of certain groups and constituents without any guarantees of equal protection or fair judicial proceedings, citizens are more likely to rely less on formal processes to obtain services and secure their rights (Hardin 1996). In the MENA region, as elsewhere, citizens turn to nonstate actors for services. Those who can afford to do so buy water from private sources, put their children in private schools, and see doctors in private clinics. The wealthy and poor alike also turn to each other (World Bank 2007). The 2013 Transitional Governance Project survey in Libya found that 62 percent of respondents helped out neighbors at least once a month, and in Egypt helping those in need is considered the most important citizenship norm. Local social elites, religious leaders, and charities also help citizens meet their needs. For example, in Egypt wealthy religious people sponsor a chain of religious Al-Azhar schools in Zagazig. These schools—which are free, provide a daily meal, and emphasize religious education—provide an alternative education for the rural poor. But such alternatives are not available everywhere (World Bank 2007).

As described in chapter 5, citizens of the MENA region tend to use personal connections, *wasta*, to get things done, even when turning to officials. Those seeking to change their children's school or find a hospital bed for a sick parent, for example, often need someone in the right place willing to pave the way.[12] Many turn to ministers of parliament (MPs, called "service parliamentarians,"

FIGURE 9.5 Responsiveness of members of parliament (MPs): Arab Republic of Egypt (2012), Libya (2013), and Tunisia (2012)



Source: Transitional Governance Project.

na'ib khadmat), school principals, clinic directors, or even ministry officials to appeal for a school transfer, a faster referral for clinic services, or other solutions to individual problems (figure 9.5). But they make such appeals on a personal basis. For example, MPs are likely to respond more readily to people they know and who voted for them than to the average citizen.[13] More generally, the Arab Barometer surveys found that, across countries, 16–40 percent of citizens, depending on the country, used *wasta* within during the last five years in filling a need. Exploiting personal connections to obtain services and resources is for many not a form of corruption but simply a way to do business (Khatib 2013).

At times, the practical path to obtaining services more quickly means engaging in corrupt activities such as giving out bribes or making payments under the table. In this case, the effect of corruption becomes self-reinforcing. It reduces trust in the regime's ability to respond to citizens' concerns (as demonstrated earlier), which in turn breeds corruption because it could drive citizens to offer bribes to secure their rights and public services within the bureaucracy (Morris and Klesner 2010).

According to the evidence in the MENA region, citizens use informal side payments (or bribes) to obtain services, although the prevalence of bribes varies across services as well as countries and subnational regions. For example, in the Republic of Yemen nearly two-thirds of respondents said that when the traffic police stopped them, they were asked to make a side payment to avoid fines (World Bank 2010). About one-third of respondents were asked for additional payments for their eldest child's schooling in the past year (33.5 percent in rural areas and 22.8 percent in urban areas), and the average fees were nearly one-third of the respondent's average monthly salary (World Bank 2010).[14] Similarly, in 2012, 48 percent of Egyptians completely agreed, and another 15 percent somewhat agreed, with the statement "A bribe should be paid to get access to health care" (Transitional Governance Project, 2012). The World Bank's 2009 Governance and Anti-Corruption Country Diagnostic Survey in the Republic of Yemen found that 39 percent of respondents believed that "families like theirs" needed to pay bribes in order to obtain education services (World Bank 2010). In Tunisia, informal payments are also deemed useful to obtain a government job or navigate the bureaucracy. By contrast, in Libya (and possibly in Gulf countries where rents help support services that are provided by expatriate communities), citizens believe informal payments are less necessary. A 2013 survey found that 87 percent of Libyans completely disagreed with the statement "People like me have to pay bribes for medical treatment in local hospitals" (Transitional Governance Project, 2013). Nevertheless, bribery is often so common that it is an expected part of the transaction.[15] It may foster additional disincentives to follow the written rule since the general perception is that "everyone is doing it," thereby lowering the risks associated with offering bribes.

Although side payments could be viewed as positive contributions from the local community to help financially struggling schools

and local clinics, the process through which contributions are made is suboptimal. Such payments are an inefficient way to obtain sufficient resources. They are opaque, they increase transaction costs, and they foster dissatisfaction. As one parent explained,

> *If you want to transfer your child from a school in one place to another place, you have to pay a lot of expenses, around 500–600 pounds without any reason, even if it is your right to transfer and it is in your residence district. If you refuse to pay, they would say the location is not suitable, and you have to pay donations to the school and gifts to the managers, and to pay for construction. My daughter was not transferred until I bought photocopying papers for 100 pounds, a carpet, and an electric fan, although it was her right to be transferred. I do not mind paying but with my own free will.* (World Bank 2007)

As this respondent suggests, even when side payments are requested for the "greater good," such payments appear to increase dissatisfaction. The Yemeni GAC survey found that those who were asked for a bribe were more likely to complain about the service (World Bank 2010).[16] Bribery deflates a citizen's satisfaction, which likely also further degrades his or her engagement in strengthening service delivery systems.

Citizens' coping strategies also include actions that undermine public welfare, circumvent the law, and quietly challenge the state (World Bank 2007; Bayat 2010). People find ways to divert electric lines, pull their children out of school, or exploit subsidized medications or foodstuffs. Often they justify such actions by pointing to the injustices of the system and the ruling elites. For example, one provider in the West Bank noted, "One of the main factors which contribute to the increasing rate of power line theft is that people consider us thieves, blood suckers and that it is OK to steal from us" (World Bank 2007).

Such actions address basic needs, and they are certainly reasonable responses to the existing circumstances. People have little reason to believe that if they try to obtain services through direct means they will succeed. Moreover, in the authoritarian regimes that prevail across the MENA region, demanding accountability and better services through more direct, confrontational appeals could have serious negative consequences. Finally, as Olson (1965) noted long ago, collective action is difficult to organize, particularly among large groups.

Individual solutions are reasonable, but they also can be problematic. First, they exacerbate social inequalities because some citizens (such as the less educated or urban migrants) have fewer economic resources and less access to the social and political networks that can provide access to services. Such actions also undermine citizen agency. People are able to get what they need not because they communicate with the state to demand better services, but because they accept the status quo and find ways to work around it. Finally, such actions quash collective action. It is not surprising, then, that there is a significant negative correlation between clientelistic practices (and particularly vote buying) and the provision of public services (Khemani 2013).

Clashing with the state

Finally, at times pent-up grievances provoke citizens to engage in head-on collisions with the state. In Tunisia and Egypt, for example, poor service provision provided an impetus for citizens to take to the streets in 2010–11, demanding change. The Arab Uprisings were remarkable moments of mass mobilization in opposition to the state that opened up a transition period offering citizens new reasons for hope. As we discuss in chapter 10, the uprisings led to (at least temporary) greater trust and engagement and opened up possibilities for positive institutional reform.

At other times, the mounting dissatisfaction leads to longer and more violent clashes

between citizens and the state. In the Republic of Yemen, for example, violence between the Houthis and the state has been growing. According to a 2013 survey in the Republic of Yemen, poor government services are viewed as a major reason for the Houthis' grievances.[17] Similar grievances, driven by poor governance and inequality, appear to underlie support for the Islamic State of Iraq and Syria (ISIS) and other movements that are challenging states across the region (Gerges 2014; Al Makhtoum 2014).

The use of social media

Social media are widely understood to be an effective means of catalyzing collective action, but they can also be a powerful tool for generating discussions of government services, local issues, and politics. A survey conducted by the Arab Social Media Report (2014) found that about 50 percent of respondents were using personal social media accounts such as Facebook, Twitter, and LinkedIn to talk about government services.[18] In 2012 the Pew Research Center compared social media usage internationally and found that those living in the MENA region were among the top users of social media to debate politics, religion, and local issues.[19] When asked, 64.5 percent of MENA social media users reported discussing politics, compared with 34 percent internationally, and 79.2 percent reported talking about local issues, compared with 46 percent internationally (Pew Research Center, 2012). This was most evident during the Arab Uprisings, when activists used social media for disseminating or sharing information and mobilizing groups. For example, when Tunisian and Egyptian Facebook users were asked about their main usage of Facebook during early 2011, 33 percent of Tunisian users and 24 percent of Egyptian users said it was to spread information to the world about the movement and related events; 31 percent of Tunisians and 31 percent of Egyptians said it was to raise awareness inside the country on the causes of the movement; and 22 percent of Tunisians and 30 percent of Egyptians said it was to organize actions and manage activists.

Users across the MENA region are optimistic about the use of new technology and social media to improve service delivery. Seventy-five percent of the Internet users surveyed for the Arab Social Media Report (2014) believed that one of the benefits of social media was better quality of service delivery because the flow of information between customer and government was improved; 78 percent believed it would lead to services that better meet citizens' needs; 79 percent agreed that social media would reduce service delivery costs; and 76 percent mentioned the increased inclusiveness of service delivery. In addition, 60 percent of respondents from high-income MENA countries believed social media made their government more accessible, compared with an average of 40 percent in middle-income countries.

And yet it appears that most of the conversations are limited to social groups and not between citizens and their government (Shediac et al. 2013). Thus citizens are skeptical about the impact social media will have on their government's responsiveness to their needs. If people do engage with their government, the majority of youth prefer to do so via blogs and social media, whereas those in the older generation (49 and above) prefer to communicate face to face and through gatherings such as *majalis*. Few citizens use their government's official social media page as a means of communicating feedback or suggestions. Instead, 73.8 percent of those who do so use such pages to gather information on services or entities (figure 9.6). And when given other options for seeking information about government services, citizens are less likely to first choose the government service website or social media platform, preferring instead to conduct a general online search—indeed, in one survey 30 percent of respondents preferred this option (figure 9.7). This is likely an indication of the low levels of trust citizens have in government responsiveness through social

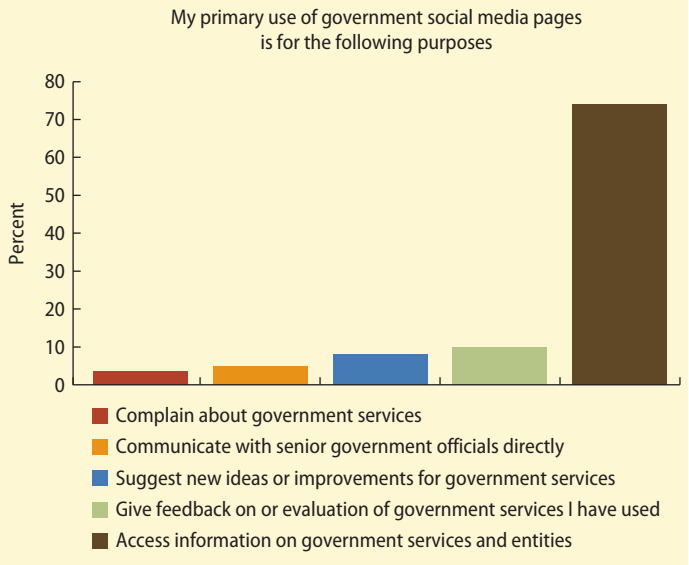
media channels or a reflection of their lack of interest in communicating with government (Shediac et al. 2013).

There is no denying that connectivity is having a bigger influence on citizen and government engagement. Promising efforts have been made in areas such as e-governance in some MENA countries, but it is still not clear whether other countries in the MENA region will follow this path and how governments and citizens in the region can harness these technologies to improve accountability and the quality of service delivery. In the absence of strong institutions and trust in government, even the impact of social media may be limited.

Conclusion

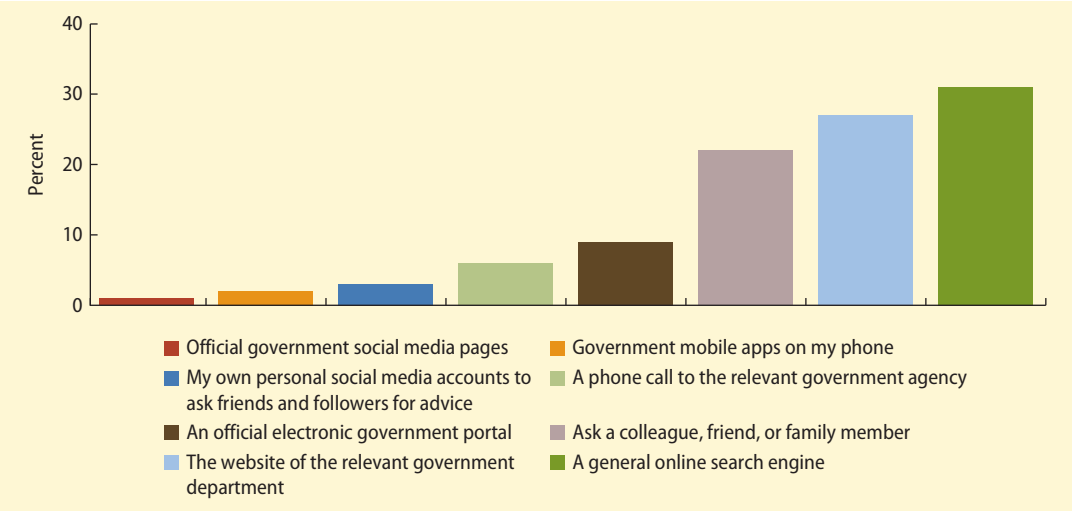
In the MENA region, poor-quality service provision is affecting citizens' distrust of the state, which in turn has shaped their engagement with the state. In most MENA countries, citizens do not formally engage with the state to demand accountability. This is in part because they do not believe their institutions are capable of implementing any credible improvements on the ground and in part because of their awareness of the lack of responsive and accessible mechanisms even if they were to voice their concerns. After the recent upheavals in the region, there were attempts to expand political mobilization through CSOs and more widespread use of social media, but such attempts mainly

FIGURE 9.6 Primary uses of government social media: MENA region, 2014



Source: Arab Social Media Report 2014.
Note: MENA = Middle East and North Africa.

FIGURE 9.7 Sources of information about government services: MENA region, 2014



Source: Arab Social Media Report 2014.
Note: MENA = Middle East and North Africa.

occurred on ad hoc basis, and it is still not clear how far activists can push for accountability and improvements in the quality of service delivery.

Overall, most citizens have turned away from any formal engagement with the state. Instead, they have sought services from private providers, used mechanisms that bypass formal state pathways in an attempt to benefit from public services, and, at times, confronted the state. In normal times, such survival mechanisms further reduce the effectiveness and credibility of public institutions. Meanwhile, the lack of collective action contributes to the problems of nepotism, cronyism, and capture.

In more extreme cases, confrontations, which spiked in 2011, can take various forms—from toppling autocrats in Egypt and Tunisia, to civil wars in Libya, Syria, and the Republic of Yemen, to state-led reforms in Morocco and much of the Gulf. These confrontations have an impact across the cycle of performance. They dislodge institutions, alter the demand for and supply of services, alter citizens' trust in institutions, and spur new engagement—that is, they can reshape the cycle of performance. How such major shocks, as well as more gradual reforms and donor incentives, can shift the cycle of performance out of a low-equilibrium state is the subject of chapters 10–12.

Annex Predicted probabilities tables

Table 9A.1 Predicted probability of trusting a political party on becoming a member of one: Selected MENA countries, 2010–11

Independent variable	Predicted probability
1 = trust a political party to a great extent, Algeria	0.0578***
	(0.0140)
1 = trust a political party to a great extent, Iraq	0.142***
	(0.0268)
1 = trust a political party to a great extent, Jordan	0.0300***
	(0.00997)
1 = trust a political party to a great extent, Lebanon	0.420***
	(0.0411)
1 = trust a political party to a great extent, Republic of Yemen	0.600***
	(0.0421)
2 = trust a political party to a medium extent, Algeria	0.0269***
	(0.00609)
2 = trust a political party to a medium extent, Iraq	0.0693***
	(0.0117)
2 = trust a political party to a medium extent, Jordan	0.0137***
	(0.00453)
2 = trust a political party to a medium extent, Lebanon	0.246***
	(0.0225)
2 = trust a political party to a medium extent, Republic of Yemen	0.403***
	(0.0301)
3 = trust a political party to a limited extent, Algeria	0.0129***
	(0.00298)
3 = trust a political party to a limited extent, Iraq	0.0340***
	(0.00595)

(continued next page)

Table 9A.1 Predicted probability of trusting a political party on becoming a member of one: Selected MENA countries, 2010–11 *(continued)*

Independent variable	Predicted probability
3 = trust a political party to a limited extent, Jordan	0.00654***
	(0.00221)
3 = trust a political party to a limited extent, Lebanon	0.134***
	(0.0151)
3 = trust a political party to a limited extent, Republic of Yemen	0.242***
	(0.0225)
4 = absolutely do not trust political parties, Algeria	0.00902***
	(0.00203)
4 = absolutely do not trust political parties, Iraq	0.0239***
	(0.00406)
4 = absolutely do not trust political parties, Jordan	0.00457***
	(0.00152)
4 = absolutely do not trust political parties, Lebanon	0.0971***
	(0.00904)
4 = absolutely do not trust political parties, Republic of Yemen	0.182***
	(0.0161)
No. of observations	5,793

Source: Arab Barometer, 2010–11 (Wave II).
Note: All controls are at their mean value. Standard errors are in parentheses. MENA = Middle East and North Africa.
$^{*}p < .10$ $^{**}p < .05$ $^{***}p < .01$

Table 9A.2 Predicted probability of trusting a youth/civil society organization on becoming a member of one: Selected MENA countries, 2010–11

Independent variable	Predicted probability
1 = trust a youth/civil society organization to a great extent, Algeria	0.0878***
	(0.0128)
1 = trust a youth/civil society organization to a great extent, Arab Republic of Egypt	0.0365***
	(0.00710)
1 = trust a youth/civil society organization to a great extent, Iraq	0.0980***
	(0.0134)
1 = trust a youth/civil society organization to a great extent, Jordan	0.0346***
	(0.00632)
1 = trust a youth/civil society organization to a great extent, Lebanon	0.0807***
	(0.00954)
1 = trust a youth/civil society organization to a great extent, Saudi Arabia	0.113***
	(0.0127)
1 = trust a youth/civil society organization to a great extent, Republic of Yemen	0.135***
	(0.0159)
2 = trust a youth/civil society organization to a medium extent, Algeria	0.0724***
	(0.00941)
2 = trust a youth/civil society organization to a medium extent, Arab Republic of Egypt	0.0298***
	(0.00553)
2 = trust a youth/civil society organization to a medium extent, Iraq	0.0810***
	(0.00948)
2 = trust a youth/civil society organization to a medium extent, Jordan	0.0283***
	(0.00491)

(continued next page)

Table 9A.2 Predicted probability of trusting a youth/civil society organization on becoming a member of one: Selected MENA countries, 2010–11 *(continued)*

Independent variable	Predicted probability
2 = trust a youth/civil society organization to a medium extent, Lebanon	0.0664***
	(0.00805)
2 = trust a youth/civil society organization to a medium extent, Saudi Arabia	0.0937***
	(0.0100)
2 = trust a youth/civil society organization to a medium extent, Republic of Yemen	0.112***
	(0.0117)
3 = trust a youth/civil society organization to a limited extent, Algeria	0.0611***
	(0.00838)
3 = trust a youth/civil society organization to a limited extent, Arab Republic of Egypt	0.0250***
	(0.00493)
3 = trust a youth/civil society organization to a limited extent, Iraq	0.0685***
	(0.00899)
3 = trust a youth/civil society organization to a limited extent, Jordan	0.0237***
	(0.00439)
3 = trust a youth/civil society organization to a limited extent, Lebanon	0.0560***
	(0.00750)
3 = trust a youth/civil society organization to a limited extent, Saudi Arabia	0.0793***
	(0.00875)
3 = trust a youth/civil society organization to a limited extent, Republic of Yemen	0.0953***
	(0.0112)
4 = absolutely do not trust youth/civil society organizations, Algeria	0.0610***
	(0.00856)
4 = absolutely do not trust youth/civil society organizations, Arab Republic of Egypt	0.0250***
	(0.00491)
4 = absolutely do not trust youth/civil society organizations, Iraq	0.0684***
	(0.00979)
4 = absolutely do not trust youth/civil society organizations, Jordan	0.0236***
	(0.00453)
4 = absolutely do not trust youth/civil society organizations, Lebanon	0.0559***
	(0.00747)
4 = absolutely do not trust youth/civil society organizations, Saudi Arabia	0.0792***
	(0.0101)
4 = absolutely do not trust youth/civil society organizations, Republic of Yemen	0.0951***
	(0.0122)
No. of observations	7,885

Source: Arab Barometer, 2010–11 (Wave II).
Note: All controls are at their mean value. Standard errors are in parentheses. MENA = Middle East and North Africa.
$^{*}p < .10$ $^{**}p < .05$ $^{***}p < .01$

Notes

1. These data are taken from a Transitional Governance Project survey conducted in 2007 on constituent approaches when dealing with government. In Algeria, the responses of constituents (n = 232) were as follows: "take issue directly to agency involved," 56 percent; "take issue to family and friends," 26 percent; "take issue to a religious person," 9 percent; "go to courts," 2 percent; "take issue to a minister," 3 percent; "take issue to local government," 3 percent; "ask the local MP [member of parliament]," 1 percent. No constituents responded "take issue to a political party" or "other." In Morocco, responses from constituents to the same survey (n = 768) were as follows: "take issue directly to agency involved," 49 percent; "take issue to family and friends," 31 percent;

"take issue to local government," 7 percent; "take issue to a religious person," 2 percent; "go to courts," 3 percent; "ask the local MP," 2 percent; "take issue to a minister," 2 percent; "take issue to a political party," 1 percent; "other," 4 percent.

2. Using the Arab Barometer data (2010–11), we ran a multinomial regression model that consisted of a categorical dependent variable labeled as "how easy is it to access services in case your rights have been violated" and coded as 1 = very easy, 2 = easy, 3 = difficult, 4 = very difficult, and 5 = never tried. The independent variables were the following: satisfaction with government's efforts to improve service delivery, income, age, gender, urban/rural, and income quintile. Holding everything constant, the relative log odds of not trying to file a complaint versus believing it is very easy decreases by 3.145 when people believe that a government's efforts are very good compared with believing it is very bad (the result is statistically significant at the .05 level). In other words, they are more likely to file a complaint when they are more satisfied with the government's efforts.
3. In the GAC report on the Republic of Yemen (World Bank 2010), regression results suggest that, in general, males, the wealthy, and the more educated are more likely to have had contact with public services providers than females, poor respondents, and less educated respondents. Similarly, urban respondents are more likely to have had contact with public services providers than rural respondents.
4. As demonstrated by the very low levels of citizen awareness of the existence of such institutions in areas close to their residence (Gallup World Poll, 2013).
5. According to data from the 2010–11 Arab Barometer and Transitional Governance Project, the following percentages of respondents declared themselves members of a political party: Algeria, 2 percent (n = 1,207, 2011); Egypt, 3 percent (n = 2,510, 2012); Iraq, 3 percent (n = 1,196, 2011); Jordan, 1 percent (n = 1,178, 2010); Lebanon, 12 percent (n = 1,383, 2011); Libya, 5 percent (n = 1,001, 2013); Republic of Yemen, 31 percent (n = 1,147, 2011); Tunisia, 2 percent (n = 1,185, 2011); and West Bank and Gaza, 14 percent (n = 1,190, 2010).
6. According to the 2006–08 Arab Barometer data, the following percentages of respondents declared themselves members of a CSO: Algeria, 21 percent (n = 1,283, 2006); Jordan, 6 percent (n = 1,130, 2006); Lebanon, 18 percent (n = 1,179, 2007); Morocco, 13 percent (n = 1,272, 2006); Republic of Yemen, 28 percent (n = 663, 2007); and West Bank and Gaza, 22 percent (n = 1,265, 2006).
7. The binary logit model included membership in a political party (a binary variable coded 1 if yes and 0 if no) as a dependent variable and the following explanatory variables: (1) trust in political parties (a categorical variable coded as follows: 1 = trust to a great extent; 2 = trust to a medium extent; 3 = trust to a limited extent; 4 = absolutely do not trust parties); (2) age; (3) gender; (4) income; (5) educational attainment; and (6) urban/rural status.
8. The binary logit model included membership in a youth organization (a binary variable coded as 1 if yes and 0 if no) as a dependent variable and the following explanatory variables: (1) trust in CSOs—associations, clubs, volunteer youth groups, etc. (a categorical variable coded as follows: 1 = trust to a great extent; 2 = trust to medium extent; 3 = trust to a limited extent; 4 = absolutely do not trust parties); (2) age; (3) gender; (4) income; (5) educational attainment; and (6) urban/rural status.
9. Interviews with local councils and mayors in northern areas of Jordan, October 22–24, 2014.
10. For example, see International Crisis Group (2012) and *Middle East Monitor* (2013).
11. Bold and Svensson (2010) noted that there was considerable variation, "ranging from all schools in Ismalia to none in Fayoum." There was also wide variation across schools. According to the PETS survey results, the schools that reported receiving funds from boards of trustees and communities recorded a total of LE 148,124 during the fiscal 2007–08. The mean amount received was LE 2,743 per school, but the median was much lower, LE 714 per school, reflecting the uneven distribution across schools.
12. For discussions of *wasta,* see Kilani and Sakija (2002).
13. MPs in Morocco and Algeria also appear more likely to be more responsive to men than to women. On average, 20–29 percent of requests for constituent services made to deputies in Morocco and Algeria are from females (see Benstead 2014).
14. There is also interesting regional variation in the Republic of Yemen. For example, over

50 percent of respondents from Taiz, Hajjah, and Sana'a reported making additional payments for their eldest child's education in the last school year, whereas 10 percent of respondents from Al Mahwit, Abyan, and Al-Baidha reported doing so.

15. For example, a survey conducted in Egypt in 2009 found that 41 percent of respondents believed a bribe is generally a "previously known thing that happens spontaneously between the civil servant and the citizen," 16 percent said that people offer the bribe unprompted, and 30 percent said a civil servant openly requests the payment (Al-Gharini, Al-Rashidi, and Al-Gamal 2009).
16. "There is also a strong correlation, 0.66, between the percentage of respondents who have been asked to pay a bribe for a service and the percentage of respondents who believe they have a valid reason to complain about the service" (World Bank 2010, 19).
17. In a survey conducted by the Yemen Polling Center (2013), almost two-thirds of respondents identified poor government services as a major reason for their grievances (on a four-scale answer, 42 percent identified poor government services as a very large reason, and 21 percent identified it as a somewhat large reason). Other factors were the insensitivity of the central government (47 percent, very large; 18 percent, somewhat large) and lack of local authority and autonomy (60 percent, very large; 15 percent, somewhat large).
18. Based on a regional online survey administered in 22 Arab economies (Algeria, Bahrain, Comoros, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Mauritania, Morocco, Oman, Qatar, the Republic of Yemen, Saudi Arabia, Sudan, the Syrian Arab Republic, Tunisia, the United Arab Emirates, and West Bank and Gaza). The survey sampled 3,654 respondents from February to May 2014.
19. Based on a Pew Research Center survey conducted in 2012 that included Egypt, Jordan, Lebanon, and Tunisia from the MENA region and 21 nations internationally. The results are based on those who already use social media sites.

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New Openings

PART V

In this report, we have analyzed the expectations and realities in the delivery of education and health services in the Middle East and North Africa (MENA), and we have explained these in the context of the cycle of performance. Chapter 1 revealed that citizens of the MENA region are not satisfied with services and expect their governments to improve them. Chapter 2 cautioned that, although citizens of the MENA countries largely enjoy access to education and health services, they face significant challenges in the quality of services. Chapter 3 then described some local communities that have overcome these quality challenges.

Building on chapter 4, which illustrated the historical and cultural context within which the cycle of performance operates in the MENA region, chapter 5 explored the influence of state and nonstate institutions on state performance and underlined the weaknesses in the existing accountability mechanisms facing policy makers, public servants, and service providers in most MENA countries. Chapters 6 and 7 illustrated how these institutional weaknesses affect the efforts of teachers and health workers to deliver services, and how the effects may differ in different local contexts. Finally, chapters 8 and 9 discussed how service delivery and state performance affect citizens' trust in public institutions, and how such trust translates into the nature of citizen engagement.

Because of the complex circumstances facing MENA countries, it is necessary to build on evidence of local successes and positive trends that buck the cycle of generally poor performance. In this part, chapters 10, 11, and 12 identify the bases for improvement and encouragement—for citizens, civil servants, policy makers, and donors alike—to act on those successes and trends. As we discuss in chapter 10, conflicts, crises, and political transitions may give national and local leaders a unique opportunity to tackle service delivery challenges as well as boost trust and constructive engagement. In chapter 11, we acknowledge that donors, including the World Bank Group, need to learn from their own (often failed) efforts to support education and health services. Finally, chapter 12 suggests possible incremental approaches to systemic reforms, options for empowering communities and local leaders to find local solutions, and possible quick wins.

Transitions, Conflicts, and Refugees: Both an Opportunity for and a Strain on the Cycle of Performance

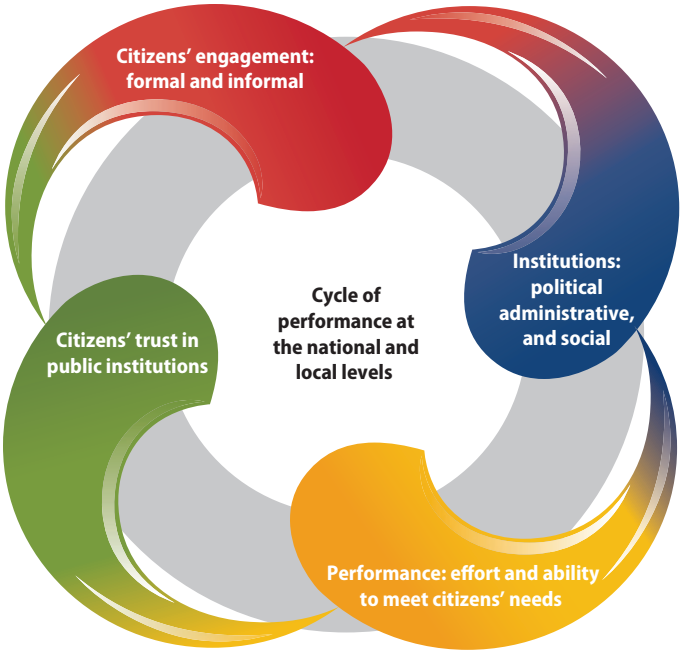
10

- Dramatic changes such as the regime transitions, conflicts, and refugee crises facing the Middle East and North Africa region today strain the cycle of performance, but they also can spark a needed change.
- Transitions in power and the uncertainty they bring initially undermine political and administrative institutions as well as performance, but they do offer opportunities for positive reforms. They also affect trust and engagement in a positive way—at least at first.
- A conflict destroys institutions while increasing the demand for services. At first, performance declines. And yet the conflict provides a rallying point for citizens, and ultimately trust, engagement, and institution building can be restored.
- An influx of refugees also places high demands on service delivery and opens the possibility of institutional reform. Incumbents may find it necessary to establish new institutional arrangements in response to the stress, and these institutions may prompt better performance.

This chapter explores how the dramatic challenges facing the Middle East today affect the possibilities for change in the cycle of performance (figure 10.1). We take as a starting point that crises can open possibilities for reform. They can disrupt existing institutions, alter elite coalitions, and place actors—citizens, policy makers, and elites alike—in a domain of losses,[1] making them more likely to take risks (Skocpol 1979; Keeler 1993; Weyland 2004; Hunter 2006). The performance cycle introduced in the previous chapters provides us with a framework through which we can consider how these changes impinge on service delivery. Political transitions, conflicts, and refugee crises have affected, and may be expected to affect, the cycle of performance at various points, altering engagement, institutions, performance, and trust. Moreover, political crises sometimes create countervailing pressures—for example, heightening engagement while diminishing trust.

In this chapter, we draw on diverse empirical and theoretical findings from within and beyond the Middle East and North Africa

FIGURE 10.1 The cycle of performance



(MENA) region. The evidence is too weak and the processes are too stochastic to argue that the impacts we point out are inevitable or exhaustive. Nor are we arguing that these are the only pressures that affect the cycle. Rather, the goal of this discussion is to stimulate thinking about opportunities for the future.

Such thinking is particularly important in the MENA region today as it witnesses the most intense regionwide transformations in at least a century. The Arab Uprisings in 2010–11 began a political rupture, the rumblings of which had been heard for a decade. The turmoil that started in Tunisia soon spread across the region, taking different forms in different places. The Arab Republic of Egypt, Libya, and Tunisia overthrew long-standing leaders, and the Republic of Yemen replaced President Ali Abdullah Salah, albeit with a handpicked successor in the hope of a carefully managed transition. The ruptures put these countries on transition courses that varied, from a reversion to authoritarianism in Egypt to relatively successful democratization in Tunisia to the breakdown into conflict in Libya and the Republic of Yemen. Elsewhere, uprisings led to conflicts that failed to overthrow regimes—a short-lived uprising in Bahrain and a much longer one in the Syrian Arab Republic that prompted regional intervention led to refugee crises and created stateless spaces that were fertile ground for militant organizations. A small set of countries, including Morocco, the Gulf states, and Jordan, largely avoided (at least until now) major changes, in part by undertaking reforms aimed at increasing public support for the regime in power. In short, the MENA region is currently in the midst of dramatic change.

Transitions

In Egypt, Libya, and Tunisia, the Arab Uprisings saw long-standing dictators fall from power, beginning transition processes driven from below. Activists took to the streets, old ruling parties were discredited, and party buildings were set ablaze. Since then, these countries have seen new political parties emerge and elections called. Their citizens are engaged—in the streets, through social media, and at the polls, and debates abound over a variety of issues, including election rules, constitutional changes, transitional justice, and decentralization. Transitions, then, impinge on all parts of the cycle: institutions, performance, trust, and engagement.

Institutions

The very essence of a transition is a struggle over the rules of the game, and thus transitions entail changes in both the strength and the form of institutions at all levels of the system. The extent and nature of institutional change during transitions are driven by various factors: the preexisting institutional strength and form, state resources and capacity, leadership, and heightened engagement.

In the short run, the uncertainty inherent in transition periods weakens institutions; rules and norms are uprooted and new ones are not yet established. And yet the extent to which a transition undermines the provision of public services may depend on the nature of the state's political institutions at the

outset of the transition. When a strong state was in place prior to the political rupture, a transition may be less likely to undermine the provision of services. For example, Tunisia enjoys a more developed bureaucracy and stronger state than Egypt and Libya. Even though strikes in Tunisia have crippled the economy and the government has not been able to pursue reforms as effectively as citizens have demanded, it does not appear that entrenched "deep state" forces have been able to sabotage services to achieve their own political gains.[2] By contrast, in Egypt the state is weaker, and the political forces determined to stymie the transition were able to sabotage service provision (especially electricity, water, and solid waste management) to achieve personal gain (Hubbard and Kirkpatrick 2013). At the extreme, in Libya the state was too weak to retain control over strategic resources and institutions, ultimately resulting in a civil war that, as we discuss shortly, is undermining education, health, and other services.

Transitions allow space for innovation as well as the possibility of decentralization and local solutions. When national and regional controls in what were previously highly centralized systems weaken, local leaders are able to implement innovative solutions. School principals, chief medical officers, municipal councils, and directorates previously constrained by inefficient arrangements can create new ones. For example, a study of Egypt's education system based on open-ended surveys of school administrators found that the early period of crisis in Egypt prompted administrators to make decisions, reformulating policies, procedures, and responsibilities within their schools. This freed savvy administrators from sometimes unnecessary, inefficient constraints, although it also left less adaptable ones without support. The crisis was thus "both a threat and an opportunity" for reform (Rissmann-Joyce 2014).

In the same vein, transitions open the way for nonstate actors to fill the vacuum left by the weakening state. Local governance, including dispute resolution, security, and service provision, can be captured by new social actors and institutions, which often come into conflict with the state and nonstate institutions in place before the transition. For example, in Egypt's Sinai the transition resulted in the spread of Islamic-based unofficial courts, which have come into conflict with both state and previously state-tolerated tribal courts (Revkin forthcoming). Observers argue that new groups (gangs or mafias) are emerging even in areas around Cairo because of the state's inability to meet citizens' needs.[3] Similarly, in Iraq the informal economy grew considerably after 2003, especially in the areas of small-scale urban services, and by 2006 an estimated 80 percent of the labor force was engaged in an informal economy (Looney 2006).

Finally, transitions provide an opportunity to debate and form new institutional arrangements, placing new items on the agenda. For example, in transitioning countries universal health care has been the subject of dialogues over new constitutions and policies, and it has appeared in party programs and in increasingly vocal advocacy campaigns (Saleh et al. 2014). Similarly, although decentralization has long been on the reform agenda, it is now debated with new interest. Moreover, countries in transition receive more attention and the resources and expertise needed to put in place such reforms (Institute for Integrated Transitions 2013). Not everyone welcomes such an intervention, but it may make it difficult for naysayers to avoid reform and strengthen the hands of reformers. At least in the short run, there are pressures for institutional reforms that promise greater service provision.

Performance

Unfortunately, transitions are likely to reduce a state's ability to provide services in the near term. Demands for education, health, and other services increase, but the MENA countries in transition have thus far seen a decline in performance.

In part, performance suffers due to the uncertainty surrounding transitions, the outflow of experienced personnel, and the

fewer resources. The extent to which these changes occur depends in part on choices made during the transition. The removal of personnel associated with the *ancien* regime (often in response to popular demands) and the appearance of new entrants as political appointments can leave ministries and state offices with inexperienced staffs. The unstable environment of transitions can also lead to a loss of resources. Tourism declines, which had a particularly high impact in Tunisia and Egypt. Seven percent of the gross domestic product (GDP) in Tunisia (UNWTO 2011), accounting for 450,000 jobs, is based on tourism; 5.6 percent in Egypt.[4] Moreover, an unprecedented freedom to strike and demonstrate cripples production. In Tunisia, for example, work stoppages in the state-owned Gafsa Phosphate Company caused output to plummet from 7.5 million tons before 2011 to 3.3 million tons in 2014 (Saleh 2014). Volunteerism alleviated some of these pressures in the early days of the transition. A sense of pride and nationalism can mobilize citizens to organize food drives for the poor, clean their neighborhoods, or otherwise contribute material and human resources.[5] But this mobilization diminished rapidly, leaving transitional governments strapped for resources.

At the same time, transitions create additional demand for education and health services. In part, heightened expectations drive the demand. The abrupt change has physical and mental repercussions as well. Indeed, as Mohamed Elmahdy, professor of psychiatry at Al-Azhar University, has noted, the uncertainty, insecurity, and feelings of loss that follow revolutionary change lead to a spike in depression, post-traumatic stress disorder (PTSD), and other psychological problems that require attention (Elmahdy 2012).[6] These issues manifest themselves both emotionally and physically.

Trust

Transitions also affect citizens' trust in public institutions. In general, trust derives from citizens' historical experience with the state, the state's performance, and leadership. In the early period of the transition, trust—or at least optimism—skyrockets. Not only have the leaders so closely associated with repression and exploitation been removed, but regime change that was unthinkable only a short time before has been achieved. People have high hopes for the future. It is a period that Leszek Balcerowicz, the Polish economist and former finance minister, has called the period of "extraordinary politics," in which people "are pretty euphoric" because of their "freshly regained freedom" (Balcerowicz and Gelb 1995; Balcerowicz 1997).

According to the polls, at least initially trust is restored. In 2013, citizens in the transitioning countries anticipated better prospects for good governance, less corruption, an improved economy, and better security in the future. This stood in sharp contrast to those in economies that did not undergo political rupture, where majorities of citizens expected these conditions to worsen (figure 10.2).

This period of heightened trust can be short-lived, however. In Egypt, distrust between elites who had, hand in hand, taken to the streets began to emerge within months of President Hosni Mubarak's downfall. By April, non-Islamist activists and party leaders were grumbling that the Muslim Brotherhood was colluding with the military, while Islamists were warning that non-Islamists would corrupt Egypt's society. Distrust between the Copts and Muslims also emerged. In Tunisia, similar distrust among citizens took shape. In response to repeal of the ban on headscarves and the appearance of displays of religiosity in the public sphere, Islamists' opponents often decried the social change. Overall, citizens' trust in institutions and actors has plummeted in transitional countries in the MENA region.[7]

Ultimately, people decide whether they trust state institutions and actors based on the ability of the latter to provide services, maintain stability, and stimulate economic growth. Indeed, in North Africa's transitional countries a majority of citizens believe they are worse off today than before

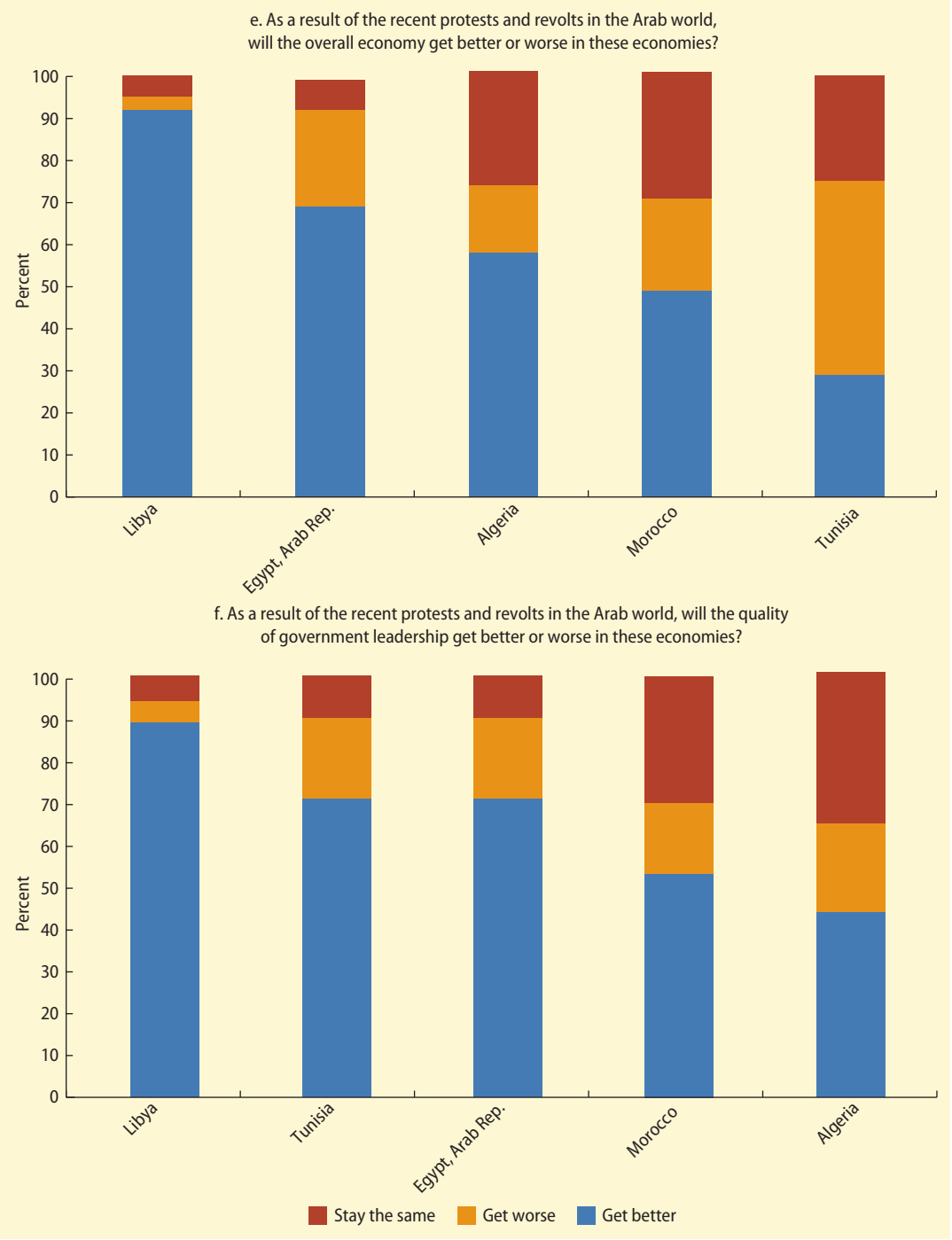
FIGURE 10.2 Survey of citizens of transitioning economies: Prospects for good governance, the economy, government corruption, security and safety, the overall economy, and quality of government leadership: MENA region, 2013

(continued next page)

FIGURE 10.2 Survey of citizens of transitioning economies: Prospects for good governance, the economy, government corruption, security and safety, the overall economy, and quality of government leadership: MENA region, 2013 *(continued)*

(continued next page)

FIGURE 10.2 Survey of citizens of transitioning economies: Prospects for good governance, the economy, government corruption, security and safety, the overall economy, and quality of government leadership: MENA region, 2013 *(continued)*



Source: Gallup World Poll, 2013.

2011 (Transitional Governance Project).[8] Moreover, since the transitions began, Tunisians and Egyptians have tended to rate economic concerns as the most important issues facing their country—64 percent[9] in Tunisia (Transitional Governance Project) and more than 50 percent in Egypt.[10] In Libya, the vast majority see security as the main issue.[11] All three countries believe their governments and political parties are not dealing with these problems effectively.

Engagement

Finally, transitions change citizen engagement with the state and offer an opportunity to break out of the low-efficiency equilibrium. Engagement was not entirely absent before the 2010–11 uprisings, but the forms that it took were often indirect and underground (Khatib and Lust 2014). Particularly in Egypt, Libya, and Tunisia, where incumbent regimes were pushed from power, new political parties were allowed to form, previously banned actors were allowed to engage, and new civil society organizations were established. For example, in Egypt the Muslim Brotherhood, which previously was officially prohibited from engaging in politics, came into power; political parties were established for the first time in Libya; and in all countries the previously strong grip of the ruling parties was eliminated. These events offered a chance for political participation to move from the informal to the formal sphere (Khatib 2013).

However, opportunities were not expanded for everyone. Today, those once close to the former regime often find themselves unable to participate because of either popular pressure or lustration laws. For many others, however, the previous constraints on voice and participation have faded, and, at least in the initial periods, they are eager to engage the state, often for the first time. They make demands in strikes and demonstrations, speak their mind through social and traditional media, run in elections, and flock to the polls. Information flows more easily, and there is high public engagement.

Indeed, in the MENA region as in transitions elsewhere[12] the fall of the regimes opened the floodgates, giving citizens a chance to mobilize and voice demands. Tunisian teachers went on strike within weeks of President Zine El Abidine Ben Ali's downfall, demanding improvements in the country's education system and the status of teachers (Education International 2011, 2012). Egyptian doctors staged sit-ins at hospitals, transit and dockworkers went on strike, students took to the streets, and mill workers called for better working conditions (Faiola 2011; Rollins 2014). After the fall of President Ali Abdullah Saleh's government, the Republic of Yemen saw strikes from port workers, employees at the Ministry of Youth and Sports, postal workers, bus drivers, health professionals, and, perhaps most visibly, garbage collectors, who organized a nationwide strike that lasted in some parts of the country up to three months, "filling the cities with the unbearable stench of filth and decay" (Alwazir 2012). These calls for better conditions and an end to corruption had severe repercussions for the education and health systems and often frightened away international investors.

Newfound freedoms of association led to the formation of new organizations and greater mobilization. For example, after the fall of Mubarak Egypt saw the formation of two new labor unions: the Egyptian Federation of Independent Trade Unions (EFITU), with 261 new trade unions and some 2.45 million members, and the Egyptian Democratic Labor Congress (EDLC), with 246 unions. The EFITU included the Independent Teachers Union of Egypt (ISTT), which sought to move teachers on temporary contracts to permanent status after they had been in a post for three years, to advocate for wage increases, and to provide teachers with greater leverage in the teaching process. As Ayman Albaili of the ISTT explained, "The previous regime considered education as a commodity which parents could afford or not. The role of teachers was marginalised in the decision making process on education. Our union wants to

reassert teachers in the education process and improve their status and rights" (Education International 2011). Labor strikes almost doubled in the year of the revolution (see table 10.1).

And yet over time citizens' enthusiasm for voicing demands begins to flag, placing constraints on these movements. People become tired of clogged streets, nonfunctioning industries, and disrupted services, and many even become willing to support the introduction of measures that would clamp down on mobilization. Thus Egypt's Presidential Decree 107 enacted in 2013 (the Protest Law) was subjected to less backlash than one might have predicted at the downfall of Mubarak. The law requires organizers of public gatherings to notify the police at least three days in advance of a campaign with specific information on the place of gathering or route of the procession, the start and end times of the event, the subject of the event, the demands and slogans featured at the event, and the names of the individuals or group organizing the event, with a place of residence and contact information (Article 8). Arguably, the enthusiasm for demonstrating also dies down because the results are minimal. Far from creating better economic conditions, mobilizations are blamed for contributing to the economic slowdown. Most citizens do not see their conditions improve, and so they lose faith that the government can solve their problems. Engagement slowly returns to pretransition levels.

Engagement in the formal political process also spikes but then diminishes over time. In both Egypt and Tunisia, for example, the transition saw an upsurge and then a decline in the enthusiasm for participation. At the national level, citizens are refraining from voting. In Egypt, only 47.14 percent of the voting-age population went to the polls in the 2014 presidential elections (International IDEA, 2015), even though the voting period was extended and citizens were pressured to turn out to the polls. By contrast, in 2012, 49.14 percent turned out to vote (International IDEA, 2015). In Tunisia, the parliamentary elections also saw diminished enthusiasm. In 2012, 82 percent of Tunisians surveyed said they planned to go to the polls for the next election, but as the election approached in 2014, this number dropped to 54 percent (Transitional Governance Project). Eventually, only 45.39 percent of the voting-age population turned out to vote (International IDEA, 2015).[13] In Libya, too, engagement in the political process has declined, with 48.72 percent voting in the first General National Congress elections of July 2012 and only 15.64 percent in the parliamentary elections of 2014 (International IDEA, 2015).

Perhaps most important, however, transitions allow the development of new efforts to monitor and hold providers accountable. Community monitoring and initiatives by citizens and civil society organizations emerge (such as client surveys, feedback mechanisms, score cards, polls, independent research) to highlight failures and hold administrative and political actors accountable. For example, in Tunisia Al-Bawsala, an independent nonprofit nongovernmental organization, provides citizens with daily updates on the workings of the Constituent Assembly, brings representatives and their constituents together in at times combative public meetings, and to a lesser extent engages in mobilizing communities to solve local issues.[14]

Such efforts are not entirely new, nor are they restricted to transitioning countries. For example, in Jordan and the Republic of Yemen providers instituted 24-hour service hotlines as early as 2007. And in Jordan, organizations such as Leaders of Tomorrow

Table 10.1 Labor strikes: Arab Republic of Egypt, 2006–12

Year	Number of labor strikes
2006	222
2007	614
2008	609
2009	700
2010	584
May 2011 – April 2012	1,137

Source: Abdalla 2012, 2.

used creative techniques and convened community meetings to foster information sharing and communication between citizens and policy makers. Yet these efforts often face obstacles and resistance from entrenched forces within established regimes. In transitioning countries, governments taking their seats for the first time are more likely to embrace such initiatives. Thus, for example, in Tunisia in 2011 the office of the prime minister launched its first national scorecard for 10 public services; 8,500 citizens participated, and the results were published online. A second national scorecard on services and benefits from the National Health Insurance Fund was launched in 2012.

Very different transition processes can unfold, however, affecting the opportunities for engagement. In Egypt, the rollback of institutional protections for freedom of speech, protest, and party participation—highlighted by the banning of the Muslim Brotherhood and April 6 movements, prohibition of the Freedom and Justice Party, mass arrests, and death sentences—sent a clear message to citizens that they have limited latitude to voice their demands. It is not surprising, then, that citizens and elites alike are choosing to step back from engaging the state. As one revolutionary activist and former member of parliament (MP) explained, now is the time to seek to address people's basic needs, not to put forth platforms or run in elections.[15] By contrast, in Tunisia citizens are frustrated with political parties and democracy, but they do not face the same institutional constraints as Egyptians in voicing demands. Elites of all political persuasions continue to engage in politics, mobilizing supporters in part by promises of public services and economic growth. Finally, in Libya it is the weakness of the state that ultimately prompted the disintegration of order, with many choosing bullets over ballots.

Conflict

The MENA region has also witnessed a horrific escalation of conflict since 2011. The Libyan transition has deteriorated into civil war, and the Republic of Yemen threatens to do the same. Calls for change were repressed brutally in Bahrain and the Syrian Arab Republic, with the Syrian civil war continuing in full force. Violence has escalated as well in Iraq. Ungoverned spaces in Syria and Iraq have given rise to the Islamic State of Iraq and Syria (ISIS), which is expanding with bloody vengeance. Moreover, the pressures in neighboring states, combined with unresolved domestic conflicts, have led to the outbreak of violence in Lebanon. And fighting between Israel and the West Bank and Gaza rose to devastating levels throughout the summer of 2014. In short, various forms of civil and interstate war are spreading across the region. Such wars entail a number of challenges: the diminished capacity of the state to control its population and administer services; an increase in the need for education, health, and other services in the face of declining resources; and the emergence of new actors and forms of engagement. Wars may also affect citizens' trust in public institutions and their engagement, although how they do so is less transparent.

Before turning to each of these issues, it is important to note that the impact of civil wars on the cycle of performance is likely to vary, depending on several factors. In general, as Stewart, Huang, and Want (2000) note, the costs of conflict are highest when conflict is geographically pervasive and a government is undermined to the point that it is unable to effectively collect taxes or provide services. The impacts of conflict also vary with a set of interconnected factors: the duration of the conflict, the level of international intervention and support, the nature of the economy (such as the extent of subsistence agriculture, reliance on international trade, dependence on few industries), institutions (for example, the strength of civil society organizations and quasi-governmental and governmental institutions), and the character of the society (such as the initial level of poverty and vulnerability, social support networks)—see Stewart and Humphreys (1997).

Institutions

Civil wars affect institutions primarily by diminishing the state's ability to control geographic areas and populations. The level of control may change over time, as the back and forth of government and rebel control over swaths of land and populations in Syria demonstrate. When and where the government is not in control, new and diverse institutions and governance arrangements emerge under nonstate actors. Indeed, as Watkins (2014) argues, "conflict zones are characterized by states that have lost this monopoly in reality or in the eyes of their people. Thus, what is 'legitimate' becomes unmoored from its Weberian foundation. In this context, alternative forms of power, control, and coercion develop to fill the void. Nowhere is this void more visible than at the margins of the state where warlords and nonstate armed groups principally operate" (see also Schneckener 2006).

Even where the state remains in control, central authority over outlying areas is diminished, with attention diverted to the war effort. This opens the way for local elites and providers—both from the state and from outside of it—to establish new rules and procedures.

Several studies of the long-term impacts of civil war suggest that some such wars promote stronger institutions that may even encourage accountability. Bellows and Miguel (2006), examining the community-level effects of the 11-year civil war in Sierra Leone, found no evidence of uniform, persistent adverse effects of the civil war violence on local institutions. Violence destroyed some of the existing institutions, but also led to the creation of new ones. In general, they found that areas that had experienced violence were associated with higher levels of mobilization and collective action, which could possibly lead to better postwar political accountability. This finding fits well with those of Levitsky and Way (2012) and Bermeo (2014), who have argued that revolutionary conflict makes regimes more resilient.[16] It may also help explain the finding by Collier (1999) that nations engaged in long civil wars actually experience an increase in economic activity after the cessation of conflict, whereas those engaged in short civil wars do not. Conflict, particularly long civil wars, may undermine old institutions but, as just noted, lead to the emergence of new ones. When new institutions are developed in a context in which mobilizing citizen support and resources is crucial, they may ultimately promote greater levels of voice and accountability. In the short run, however, the war is likely to undermine the provision of services.

Performance

The death and destruction of war increase the demand for services and simultaneously make it more difficult for the state to provide them. The need for health services escalates to treat injuries as well as the increased prevalence of distress. Indeed, the World Health Organization estimates that between one-third and one-half of the individuals who witness such political violence experience PTSD, depression, anxiety, and other mental disorders (Sausa 2013).

The demands for services are compounded by the need to repair the infrastructure for education, water, electricity, and transportation destroyed in the war. Education and health inputs are limited by the destruction of facilities, the loss of teachers and health care workers through death or migration, and the inability of families to contribute to education costs.[17] At the same time, the war forces the government to shift resources to military support. Meanwhile, the economy is stifled by the decline in tourist receipts, foreign direct investment, remittances, and industrial output, and, in some cases, by international sanctions (Stewart, Huang, and Want 2000).[18] Gupta et al. (2004) have argued that governments resolve economic problems by sacrificing macroeconomic stability rather than by cutting spending on social services (perhaps because of the incumbents' need to maintain public support), but it is nevertheless clear that conflict hinders performance

(see also Stewart, Huang, and Want 2000; Blomberg, Hess, and Orphanides 2004).

Conflict affects achievements in education and health in both the short and long run. Cross-national studies of health and conflict have found conflict associated with undernourishment, lower height, reduced life expectancy, and higher infant mortality rates (Stewart, Huang, and Want 2000; Ghobarah, Huth, and Russett 2004; Gates, Hegre, and Nygård 2012). Often, women suffer especially from lack of health services during pregnancy and childbirth (Stewart, Huang, and Want 2000). The extent to which the health system deteriorates appears to depend in part on the extent to which a government was committed to providing services before the war. In the past, some governments such as El Salvador, Mozambique, and Nicaragua remained committed to social objectives even during war, while others such as Liberia, Somalia, and Uganda invested little and realized particularly poor infant mortality rates relative to their GDP (Stewart, Huang, and Want 2000).

The negative impacts of conflict on health are readily apparent in the MENA region. For example, the sanctions placed on Syria since May 2011 have led to an increase in the costs of health care and pharmaceuticals and to a shortage of medical supplies not produced locally, including those for cancer, diabetes, and heart disease. Sanctions have also resulted in power shortages, which have exposed the vulnerable to extreme temperatures and interrupted vaccination programs (Sen 2013). In Iraq, sanctions led to a rise in infant mortality from 47 to 108 deaths per 1,000 births from 1994 to 1999, with the mortality rates of children under 5 increasing from 56 to 131 per 1,000 births (Batniji et al. 2014). In the West Bank and Gaza, the sanctions, occupation, and warfare related to the long-standing conflict with Israel have increased food insecurity: 33 percent of the residents of the West Bank and Gaza did not have enough food in 2013, compared with 27 percent in 2011 (UNRWA 2014).

Political tensions also undermine the ability of health care workers to provide services. For example, in Syria and Bahrain, doctors caring for opposition fighters reportedly have been targeted by the regimes in power or imprisoned, and in Syria, some hospitals have been taken over by the national army, leaving opposition forces unable to seek medical attention without facing arrest and torture (Batniji et al. 2014). There is good reason to believe that such lopsided access to health care is a problem in rebel-held areas as well. Indeed, such politically charged conflict environments place well-intentioned health care workers in precarious positions, making it even more difficult for them to provide services.

Where the infrastructure is weak at the outset, problems are likely to be particularly acute. For example, in the Republic of Yemen the health system comprised only 842 public health centers, which reached only 68 percent of the population, at the outset of the conflict in 2011. Not surprisingly, as the conflict continued, citizens' conditions deteriorated, particularly in the center and west of the country. The Joint Economic and Social Assessment for the Republic of Yemen explained:

> *All sectors of life in Yemen were affected during 2011, and as might be expected the nutrition situation deteriorated during that time. Given the weak starting point . . . , most vulnerable Yemeni families began 2011 ill-prepared to absorb the shocks induced by the crisis. As a result, conflict, general insecurity, and rising prices for essential commodities aggravated hunger and malnutrition. Vulnerable populations experienced a lack of access to food, reduced diversity in diets, changes in breastfeeding practices as a result of the crisis, and reduced access to clean water because of fuel prices, which led to catastrophic results. Compounding the above, the overall breakdown of social services as a result of the unrest created conditions whereby addressing the intensifying problem of children's health and nutrition became even more challenging.* (World Bank 2012, 81)

Meanwhile, long-standing conflicts and occupation can undermine good governance mechanisms, making the provision of public health care difficult, even when the conflict is not raging. Giacaman et al. (2009) aptly describe the situation in the West Bank and Gaza:

> *The absence of any control by the Palestinian National Authority over water, land, the environment, and movement within the occupied Palestinian territory has made a public-health approach to health-system development difficult, if not impossible. These issues have been exacerbated by the dysfunctional political and institutional systems of the authority; the damaging effects on ministries of using the authority resources for patronage to secure loyalty; marginalization of the Palestinian Legislative Council; and corruption and cronyism, all of which led to a rapid increase in the number of health-service employees of the Palestinian National Authority without evident improvement in the quality of health services.*

Conflict affects education as well. Schools are destroyed, and school calendars are disrupted. Parents often keep their children at home, fearing for their safety, and children who do make it to classrooms find it difficult to concentrate on their studies. As noted in *World Development Report 2011*, "when children are late coming home, a parent has good reason to fear for their lives and physical safety. Everyday experiences, such as going to school, to work, or to market, become occasions for fear" (World Bank 2011). The conflict in the summer of 2014 in the West Bank and Gaza destroyed 26 schools and partially destroyed 232 schools, forcing delay of the start of school (*The Guardian* 2014).[19] Longer wars, which lead to displacement of families, are likely to have even greater impacts. Often, as studies of Cambodia, Guatemala, and Rwanda have shown, the impacts of conflict on the education system are long felt.[20]

The costs of conflict affect segments of society unevenly. In some countries such as Syria and the Republic of Yemen, it is the most vulnerable who are unable to afford private medical services and whose situation deteriorates most precariously (Batniji et al. 2014). Often, impacts are also felt geographically. For example, in the West Bank and Gaza malnutrition is geographically clustered, determined more by access to food and road closures than by financial means. So, too, during the conflict in Iraq, childhood mortality was regionally determined because those living in areas under UN sanctions experienced greater increases in mortality rates than those in the autonomous northern regions.

Geographical concentrations of conflict are particularly evident when conflicts lead to widespread internal displacement. The problems mirror those of refugees. Put briefly, "the sudden and rapid movement of refugees and IDPs [internally displaced persons] into low- and middle-income cities can generate a host of negative shocks. When arriving in large numbers, new arrivals can generate stresses on already dilapidated water and sanitation services, exacerbate conflicts over tenure and access to land, and generate competition for resources with host populations" (Muggah 2012).

Trust and engagement

The existing evidence on the linkages between conflict and trust and engagement is less clear. The extent to which citizens continue to trust public institutions is likely to depend on their prior relationship with the regime, as well as the extent to which they believe the regime will prevail. On the one hand, political violence undermines trust between citizens and the state, between providers and ministry officials, and between citizens themselves (Sausa 2013). Conflict situations may thus strengthen citizens' reliance on their social kin, with the result that they feel and act less like citizens and more like family or tribal members.

At the same time, conflict may push citizens seeking protection to trust the state

more deeply. Indeed, García-Ponce and Pasquale (2014) have found that people exhibit more trust in their national government and head of state when they have suffered from political violence. They argue that citizens see the government as capable of imposing order and providing security. Yet they also note that people may fear government repression and thus *express* greater levels of trust even when they actually feel differently.

Civil war can also alter the ability of citizens to engage by changing constraints and their access to information. The change in constraints is twofold. First, the deterioration of order opens up new options and incentives for engagement, including financial incentives to join armed groups. Second, at the same time in both opposition- and government-controlled areas, the space for dissent is often limited because purported "traitors" are punished.

Finally, in addition to these constraints there is reason to question the extent to which citizens engage in contributing to or demanding improvements in health, education, or other services in the midst of ongoing conflicts. For example, rather than seek education boys in conflict zones often leave school to join the fighting or support their families. This may help explain why the ratio of girls' to boys' primary enrollment, as well as illiteracy ratios, improve during war years (Stewart, Huang, and Want 2000; Sausa 2013). However, it also suggests that engagement in education diminishes during war.

Refugees

Conflicts also push refugees to neighboring states, thereby affecting the education, health, and other systems there as well. According to *World Development Report 2011*, neighboring countries host nearly three-quarters of the world's refugees (World Bank 2011). And that is certainly the case in the MENA region, where countries bordering on conflicts bear the brunt of refugee crises (multiple times for Jordan). Refugees place particular strains on a state's ability to deliver services; they can provide catalysts for social conflict that can diminish trust in public institutions, and they face unique constraints and incentives that shape engagement.

Performance

We begin this discussion of refugees with performance because it is the step in the cycle of performance most clearly affected by refugee crises. Refugees place additional demands on a state, vying with nationals for education, health care, housing, and other goods and services. And the additional burden can be exceptionally high; refugees tend to be disproportionately women, children, and the elderly; the healthy younger men leave to fight (Lischer 2009).

Today, the MENA region is particularly affected by the conflicts in Iraq, Libya, and Syria. The Syrian conflict has led to a refugee crisis that heavily affects its neighbors. As of September 2014, 1,185,275 Syrian refugees were in Lebanon (24.58 percent of its population), 615,792 in Jordan (over 7.75 percent of its population), 843,625 in Turkey (1.1 percent of its population), and 215,303 in Iraq (0.60 percent of its population). These refugees were primarily located in northern Kurdish areas (2.58 percent of the population of Iraqi Kurdistan). Elsewhere, data from the United Nations High Commissioner for Refugees (UNHCR) for January 2014 indicated that about 3,300 refugees and 53,600 internally displaced persons were in Libya (UNHCR 2014). After the escalation of violence in Libya in the summer of 2014, reportedly up to one-third of the population (about 1.8 million Libyans) fled to Tunisia (Gall 2014). A similar spike in IDPs has been seen in Iraq and Syria as ISIS has expanded across the region.[21]

The extent to which the service delivery system is able to absorb refugees and perform well depends in part on the manner in which refugees are incorporated into society, the availability of additional resources from the international community, and the state's capacity to adjust to new demands. The Lebanese government allowed refugees but

did not place them in camps, a decision that was politically driven. However, refugees were then scattered across the country, primarily in hard-to-reach areas, making it difficult to provide health and other services because of the challenges of access and transportation (Naufal 2012). Even in Jordan, the high flow of refugees made it difficult for the state and UNHCR to keep up with demand. Thus, for example, refugees report that waiting for UNHCR registration, or having had it expire, is the main cause of being unable to access services in Jordanian health clinics (CARE Jordan 2013).

Service delivery systems in host countries may become overwhelmed. In Jordan, a 2013 CARE rapid community assessment of living conditions for refugees found that hospitals and health care clinics refused to treat refugees, often citing a lack of beds, medications, and other supplies. Over 50 percent of respondents in the CARE survey reported that they had paid for private health care services since entering Jordan as refugees, in some cases more than JD 1,000 (CARE Jordan 2013). (The majority of these were Syrians not registered with the UNHCR.) Even refugees who are registered and can access public health care find themselves in need of medications and specialty care that they are unable to afford (IFRCJRC 2012). Moreover, in focus group discussions Syrians living in Madaba noted that they were unable to access public clinics and hospitals in the city, and were instead referred to Amman, which was costly in terms of transportation (CARE Jordan 2013).

Similar issues are faced in education. The 2013 CARE survey conducted in four large Jordanian cities (Madaba, Mafraq, Irbid, and Zarqa) found that in three of the four cities Syrians had more school-age children out of school than enrolled in it. This finding may stem to some extent from families' need for child labor, particularly in female-headed households. However, even in Irbid, where 73 percent of children were not enrolled, only 10 percent of those out of school reported working (CARE Jordan 2013). Another explanation may be found in the difficulty that some Syrians report in enrolling their children. One man described his trials in enrolling his two children in school in Amman. He searched and searched, determined to enroll them, and finally went to one principal day after day. "She threw me out the door, and I came back in through the window," he explained, until at last she admitted his children.[22]

The additional burden on the service delivery system affects not only refugees but nationals as well. As the Migration Policy Centre notes about Lebanon, "The ever increasing number of refugees weighs on the capabilities of host communities, which are poor and lack the resources and adequate economic, educational and sanitary infrastructures. The host communities' economic situation is difficult and the refugees constitute a heavy burden" (Naufal 2012). Similar problems are found in Turkey. There, locals complain that they are unable to get immediate treatment in hospitals because the hospitals are overcrowded with Syrians. Although reportedly no central order has been issued to give Syrians priority, the wounded arriving on a daily basis may crowd out Turkish citizens (Özden 2013).

At times, the uneven cost of conflict can also have a reverse effect. For example, as noted in chapter 2, Palestinian student refugees served by the United Nations Relief and Works Agency (UNRWA) schools score better in international benchmarking tests in math and science than their public school peers. UNRWA operates one of the largest nongovernmental school systems in the Middle East. It manages nearly 700 schools, hires 17,000 staff, educates more than 500,000 refugee students a year, and operates in four areas (Jordan, Lebanon, Syria, and the West Bank and Gaza).

UNRWA students in Jordan and the West Bank and Gaza on average achieve scores that are 23–80 points higher (equivalent to about a year's worth of learning) than public school students, even after controlling for student characteristics and for urban or rural contexts (Patrinos et al. 2014). In part, this may be because Palestinian refugee students are very aware of the adversities they face and

view education as a path toward maintaining hope for the future. UNRWA schools offer relevant and equitable learning opportunities by ensuring that they recruit and maintain a strong teaching force that is able to manage the challenges their students face, by providing students with academic guidance and socioeconomic support, and by promoting a high level of school and community engagement (Patrinos et al. 2014). Together, with a great sense of community and commitment to a common goal, schools are able to provide a relevant education despite the challenges.

Trust, engagement, and institutions

The impact of refugee crises on trust, engagement, and institutions is also less than clear. The ability of the state to provide high levels of services to citizens affects trust in public institutions, and where refugees disrupt tenuous social balances, as they do in Lebanon, the state's strategies toward what are seen as more or less favorable social groups affect trust. As for engagement, refugees bring new actors into the system who, as just described, may have unique constraints and conditions that shape their demands on the state.

Moreover, the presence of refugees can spark citizen mobilization along ethnic, sectarian, or class lines, strengthening nonstate actors and institutions. Increased engagement may be particularly likely when animosities have traditionally existed between refugee ethnic groups and those of the host country (Puerto Gomez and Christensen 2010). Another catalyst for engagement is when refugees alter the balance between rival ethnic or sectarian groups in the host country, such as in Lebanon with the arrival of Palestinian refugees in the 1960s and Syrian refugees today. Economic inequalities may also spark engagement because the refugees may increase the stresses on the host economies, particularly when resources flow to refugee communities alone.

Other factors also may influence the extent to which refugees affect engagement. They may increase environmental stresses, particularly on land and water, prompting responses by citizens. For example, a 2013 assessment of the impacts of the Syrian refugees in Lebanon cited particular problems of solid waste management, water, and electricity, which has led to a deterioration in living conditions for both the refugee and host communities (World Bank 2013). When refugees are located near the border of a conflict, they can serve as the base of rebel social networks, facilitating the spread of weapons and violence, exacerbating bilateral tensions that can in turn increase tensions with the host communities (Puerto Gomez and Christensen 2010).

Finally, although refugee crises do not entail the same degree of institutional change experienced during transitions, they nevertheless require the creation or adaptation of rules and procedures governing access to education, health, and other services. In the short run, such institutional changes may be minimal, particularly when refugees are granted access to services under the auspices of UNHCR. However, in the long run, states are often forced to implement greater change. In some cases, this can lead to the creation of parallel systems, while in others it may lead to more systemic changes and investments. In Turkey, for example, the government passed a comprehensive migration law that established a legal system to protect and aid refugees. Such measures are particularly important because 65 percent of the Syrian refugees in Turkey live outside of the camps.

And yet these steps are also difficult, especially when the host communities resent the stresses of in-migration. For example, as Ibrahim Saif, Jordan's minister of planning and international cooperation, explained, at the same time that the Jordanian people are becoming tired of the strains of hosting Syrian refugees, it is becoming ever more apparent that the refugees will not be returning home any time soon. The government thus recognizes the need for institutional reforms that address long-term problems, and yet it is difficult to implement them in the current climate.[23] This form of compassion fatigue means that the impact of refugees on the cycle of performance is likely to change over time.

Conclusion

Today, the MENA region is inundated by major crises—regime change, wars, and refugees—spreading from North Africa to the Arabian Peninsula. The results of these ruptures remain to be seen, and no easy forecasts can be drawn. However, they do offer opportunities for changing the cycle of performance, and even open up the possibility that costly events today may prompt changes in institutions, trust, and engagement that result in better performance tomorrow. During transitions, elites often experience a brief honeymoon period with much of the population, during which they can gain citizens' acquiescence to reform. Such opportunities may be short-lived, and the extent to which they can be exploited is likely to depend on factors such as the strength of state institutions, the degree of polarization within society, and the levels of regional or international intervention. However, if citizens see improvements they may remain engaged and continue to support reform.

It is therefore critical to seize the opportunities offered in crises to buoy service provision, press for institutional reforms, and maintain citizens' trust and positive engagement. Even in the midst of the enormous difficulties faced by citizens and their states, there is an opportunity to escape the cycle of poor performance. Preparing to face these challenges and seeking ways to open new opportunities for breaking the cycle of poor performance require a clearer understanding of how the international community, local policy makers, civil society, and citizens can work together to build citizen trust and engagement, and to motivate public servants and service providers toward providing better services.

Notes

1. Weyland (2004) explains how situational conditions affect individual choices, and how grave, acute problems—crises—trigger bold reforms. People who face the danger of losses prefer risky choices. Severe problems that pose grave threats of further deterioration tend to induce people to take particularly bold countermeasures. This is in contrast to situations in which people can choose between gains; such a choice makes them exercise great, and often excessive, caution. According to the research, the intersection of two conditions—the assumption of power by a new leader and the eruption of severe problems that put this leader in the domain of losses—is crucial for the initiation of drastic adjustments. Because such problems often trigger elite renovation, the crisis appears to be the main factor in the adoption of drastic reforms.
2. On the difficulties faced in Tunisia's transition, see Bertelsmann Foundation (2014), Freedom House (2012, 2014), and World Bank (2014).
3. Interviews with Egyptian activists and observers, Cairo, August 2014. More generally, see Muggah (2012).
4. For Tunisia, a report from the World Travel and Tourism Council (2014a) claims the direct contributions were 7.3 percent, to total 15.2 percent of GDP. For Egypt, the direct contributions to GDP from tourism were 5.6 percent, and the total impact on GDP (direct and indirect contributions) was 12.6 percent (World Travel and Tourism Council 2014b).
5. On Egypt, see Rissmann-Joyce (2014). On Egypt, Libya, and Tunisia, see John D. Gerhart Center for Philanthropy and Civic Engagement (2013).
6. In addition, on the impact of China's Cultural Revolution, see Islam, Raschky, and Smyth (2011); on the negative effects of conflict on pregnant women's health and the long-term health prospects of their children, see Kaitz et al. (2009) and Zapata et al. (1992).
7. By December 2013, 68 percent of Libyans felt the General National Congress was performing poorly (Transitional Governance Project). On Egypt and Tunisia, see Benstead et al. (2013).
8. In September 2013, 41 percent of Libyans believed they were worse off than before 2011, and 27 percent felt they were the same. In 2014, 54 percent of Tunisians believed they were worse off than before 2011, and 24 percent said they were about the same.
9. From a 2014 Transitional Governance Project survey. This figure includes 34 percent who cited fighting unemployment; 13 percent,

restoring economic growth; 11 percent, fighting poverty and economic inequality; and 6 percent, fighting rising prices.

10. Four polls were conducted under the Transitional Governance Project in August, September, October, and November 2011. The polls found that the percentage of Egyptians rating an economic concern as the top issue facing Egypt ranged from 53 percent (in August) to 49 percent (in November.) Security was the second most frequently cited concern.
11. Surveys from May, September, and December 2013 conducted under the Transitional Governance Project.
12. The extent to which transitions foster mobilization, the duration and nature of this mobilization, and its political repercussions depend on the type of authoritarian regime, the level of prior organization by labor unions and other organizations, and the political role of unions and professional organizations—see Valenzuela (1988). For examples of the upsurge in labor strikes during the transitions in Brazil, Peru, and the Philippines, see Haggard and Kaufman (1995, 62), and on Brazil see Nervo Codato (2006, 15).
13. There were two rounds of presidential elections. The turnout reported is the average turnout over the two rounds of voting.
14. See http://www.albawsala.com for more information.
15. Interview with Egyptian activist in the revolutionary youth movement, Cairo, August 2014.
16. For a discussion of the impact of war and, more generally, of democratization, see Bermeo (2010).
17. On these issues in Rwanda, see Akresh and de Walque (2008), and in Guatemala, see Chamarbagwala and Morá (2011).
18. The World Bank's *World Development Report 2011* reported that it is difficult to return to prewar investment levels, even after conflict ends (World Bank 2011). For more on the impact on investment in Uganda, see Deininger (2003). Also see Collier (1999) and Stewart and Humphreys (1997).
19. Estimates vary slightly. Another source states that at least 280 schools and kindergartens were damaged or destroyed (Jalbout, Dryden-Peterson, and Watkins 2014), whereas a third source found that 25 government schools were completely destroyed and at least 207 others were damaged, including 75 run by UNRWA, the United Nations Relief and Works Agency for Palestine Refugees in the Near East (Maigua 2014).
20. On Cambodia, see Akresh and de Walque (2008) and de Walque (2006); on Guatemala, see Chamarbagwala and Morá (2011).
21. For more details, see the UNHCR Syrian Refugee Regional Response Information-Sharing Portal, http://data.unhcr.org/syrianrefugees/country.php?id=107.
22. Interview with Syrian baker from Damascus area living in Amman, Jordan, by Ellen Lust, March 28, 2014.
23. Skype interview with Ibrahim Saif, minister of planning and international cooperation, Amman, Jordan, and New Haven, Connecticut, February 4, 2014. On the tensions between Syrian refugees and Jordanians, see, for example, REACH (2014).

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Data sources

Gallup World Poll, http://www.gallup.com/services/170945/world-poll.aspx

International IDEA, http://www.idea.int/vt/index.cfm

Transitional Governance Project, http://transitionalgovernanceproject.org/

Donor Support 11

- Donors have been only partly effective in supporting education and health services delivery in countries in the Middle East and North Africa (MENA).
- World Bank nonlending activities have increasingly sought to address the weaknesses in institutions and citizen engagement that undermine service delivery performance; lending operations have done so to a lesser degree.
- The usual practice of identifying policy reforms must be matched by a corresponding focus on how any given policy reform will actually be implemented and by whom.
- Social accountability is a promising approach for the MENA countries, even if its implementation requires time, money, expertise, and fit in local contexts.
- Evaluation of donor activities is essential. Evidence is lacking, however, on the effectiveness of the responses to such evaluations of Bank activities.

The quality of education and health in the Middle East and North Africa (MENA) region remains low despite higher spending and policy reforms. As we have seen, school enrollment rates and access to basic health care facilities have steadily improved, but students perform below average in the classroom, and health care coverage and its use are highly inequitable. However, these low averages are accompanied by considerable variation between and (especially) within countries, and much can be learned from examining how it is that some settings—from governorates and provinces to individual villages and specific schools and clinics—perform so much better than others, despite facing similar challenges. In this report, we argue that such variation can be a major source of ideas and inspiration for policy makers seeking ways to improve the quality of service delivery. In the same way, it behooves donors, including the World Bank, to seek ways to enhance their own effectiveness by examining and learning from variation in the quality of their engagement with clients. Here, we examine the Bank's own record of operational and nonlending work (analytical, advisory, and

technical assistance activities) in the MENA region and how this assistance has changed over time. This examination will serve as a basis for identifying those areas in which strengthening may be required, where mutually beneficial partnerships have been the most fruitful, and where new opportunities may be found.

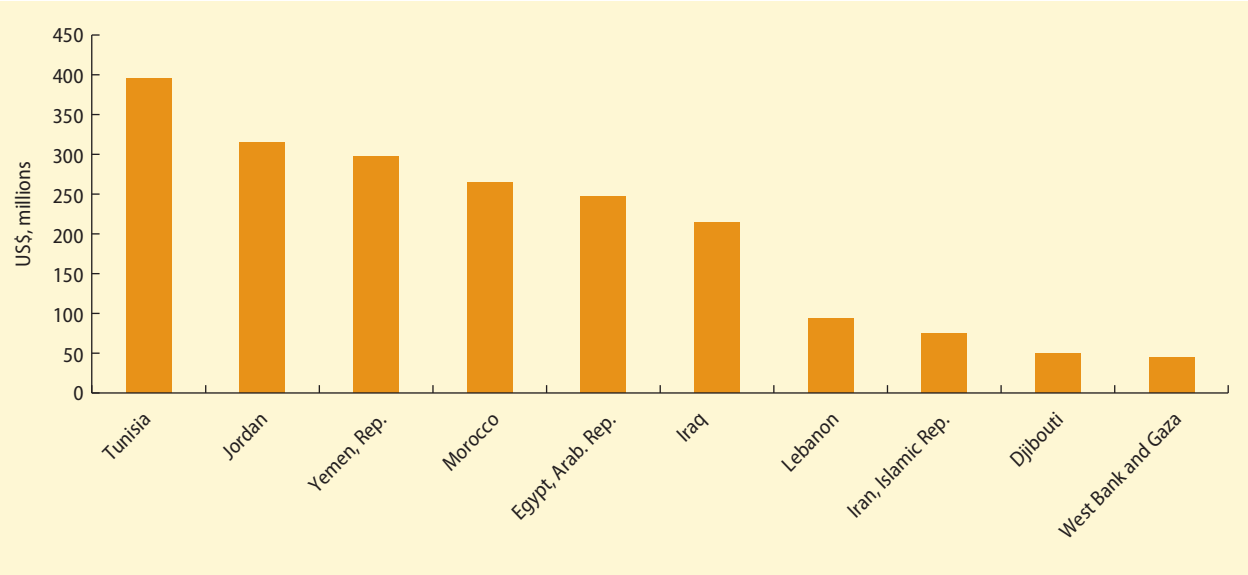
Quality of service delivery has always been a crucial area of attention for the World Bank and other donors in the MENA region. In looking at the Bank's role in supporting education and health services delivery in the region over the last 25 years, we consider the following questions: How have projects evolved? On what bases have deficiencies in service delivery been addressed? Which governance mechanisms were taken into consideration, and which were ignored? We start by looking at how World Bank projects in the MENA region have been designed through the years: what were the challenges in the MENA countries, and how did the Bank respond? The Bank's role is explored from a governance perspective, asking which governance mechanisms were considered at the project design stage and which governance drivers were promoted throughout implementation. Project performance is analyzed by looking at the main components of assessments of project success and failure. The chapter concludes by considering the outlook for the future of project design and implementation.

An overview of the World Bank's education and health activities in the MENA region

The Bank's involvement in the MENA region, as elsewhere in the world, takes various forms, but its efforts roughly fall into two categories: operational and nonlending (which mainly includes analytical, advisory, and technical assistance activities). The volume of operational activity across the MENA region from 1994 to 2014 is summarized in figure 11.1.

The primary purpose of the World Bank's operational engagement in education and health issues in the MENA countries has changed considerably over time, beginning

FIGURE 11.1 Education and health lending, World Bank: MENA region, 1994–2014



Source: World Bank.
Note: MENA = Middle East and North Africa.

as early as 1970. In health, for example, one can discern six phases: population lending, 1970–79; primary health care, 1980–86; health reform, 1987–96; health outcomes and health systems, 1997–2000; global targets and partnerships, 2001–06; and system strengthening for results, 2007–present (see IEG 2009b).[1] The Bank's first involvement in the health sector focused on improving access to family planning services as a response to the concern about the adverse effects of rapid population growth on economic growth and poverty reduction. Direct lending in the health sector formally began with the 1980 "Health Sector Policy Paper" (World Bank 1980). This effort enabled the Bank to better address the health needs of the poor by enhancing access to low-cost primary health care. The first loan to expand basic health services was made in 1981 to a MENA country, Tunisia. Two new objectives were added following the release of *Financing Health Services in Developing Countries* in 1987: making health financing more equitable and efficient and reforming health systems to overcome systemic constraints (World Bank 1987). Service delivery was linked to public sector efficiency and thus was subjected to the structural reforms of the 1980s and 1990s. A new strategy paper in 1997 shifted the focus from access to health outcomes, much like the shift in focus in the education sector (World Bank 1997). Nevertheless, improved health system performance in terms of equity, affordability, efficiency, quality, and responsiveness to clients continued to be a priority, with the addition of increased financing of single-disease or single-intervention programs that are often launched within weak health systems.

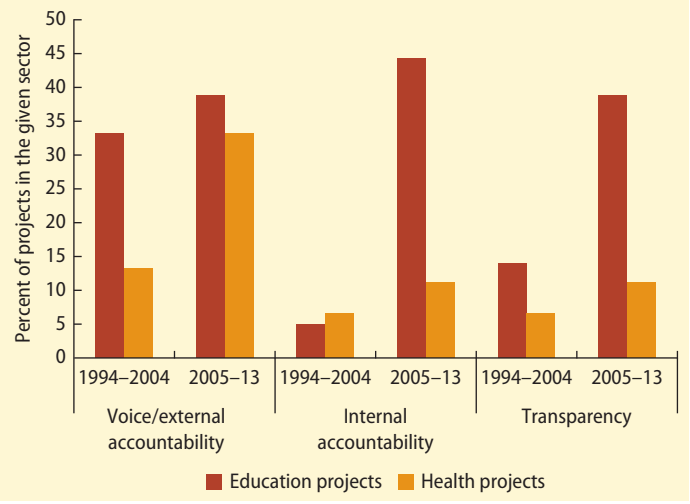
The emphasis on performance of the education and health systems continues today. The latest Bank health strategy continues to adhere closely to the objectives of the 1997 strategy, but introduces a stronger focus on governance and the importance of demonstrating results. Similarly, Bank strategies on education and social protection promote system development, including approaches to comprehensive institutional strengthening within the education and social protection sectors.

Because of the existing weaknesses in institutions and accountability mechanisms (chapter 5) and in formal citizen engagement (chapter 9), an even greater emphasis on governance and accountability in addressing service delivery is needed. The regional MENA Health, Nutrition, and Population Strategy, entitled *Fairness and Accountability: Engaging in Health Systems in the Middle East and North Africa* (World Bank 2013b), calls for fair and accountable health systems, thereby addressing the transformative sociopolitical changes that have shaken up the MENA region since December 2010. It addresses systemic disparities as well as a fair distribution of costs, dignified provider-patient interactions, and the obligation of client countries to ensure that health care services are timely, effective, safe, appropriate, cost-conscious, and patient-centered.

Meanwhile, increasingly Bank education and health operations have included components that address accountability, transparency, and citizen engagement. The proportion of education projects seeking to improve external and internal accountability and transparency rose to over one-third during the last decade (figure 11.2). The increase has been less pronounced in health projects, although projects designed since the adoption of the new regional health strategy in 2013 seek greater emphasis of these governance elements.

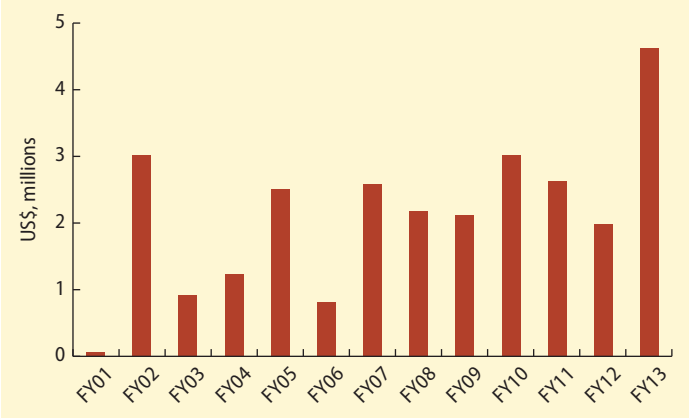
The challenges facing the World Bank in education have differed throughout the region—from increasing overall access to education to supporting higher education and, more recently, preprimary education and the education-to-job transition. In line with the Bank's 1995 "Education Sector Strategy Paper," basic education was supported as the highest priority in lending to countries without universal literacy and with low enrollment rates (World Bank 1995). Primary education was also nurtured because the social rates of return were found to be highest in most developing countries. In the MENA

FIGURE 11.2 The changing role of voice, accountability, and transparency in World Bank education and health projects: MENA region, 1994–2013



Source: World Bank.
Note: MENA = Middle East and North Africa.

FIGURE 11.3 Analytical and advisory activity commitments, education and health, World Bank: MENA region, FY01–13



Source: World Bank.
Note: Actual total cumulative cost = bank budget + trust funds. The fiscal 2000–04 data on coordinated analytical activities offered only one option, "Prepared jointly with other donor(s)." Thus considerable caution should be exercised in any comparison with post–fiscal 2005 data, except if restricted solely to donor participation. All estimates are based on the authors' calculations. MENA = Middle East and North Africa.

region, this was true of the Republic of Yemen, where the primary enrollment rate increased by 21.5 percent between 1999/2000 and 2010/11 (UNESCO Institute for Statistics, education, 2012), but also of countries such as Morocco in the 1990s, where primary enrollment was about 70 percent at that time. Countries with improved outcomes such as Tunisia and Jordan worked with the World Bank to enhance higher education and the education-to-job transition ("knowledge economy"). Gaps in urban and rural education as well as gender equality were recurring themes and continually considered in project design.

Analytical and advisory activities have undergone a remarkable expansion since 2001. Their monetary value peaked in fiscal 2013 (figure 11.3).

Although the World Bank's education lending portfolio is almost three times the size of its health lending portfolio, the health sector has dominated analytical work in the MENA region over the last 12 years. Especially in fiscal 2008 and 2009, analytical work in health was approved for loans at least twice as much as in education. When differentiating between analytical work and technical assistance, it becomes apparent that health activities in the MENA region have been especially strong in terms of technical assistance, particularly between fiscal 2008 and 2014. Analytical work has been less constant in the health sector; it has mostly consisted of Health Sector Reviews, disease-specific analyses (such as HIV/AIDS and schistosomiasis), Health Policy Notes, and Regional Health Studies. Specific governance issues addressed include governance of the pharmaceutical sector (Jordan), dual practice reform in medical practice (West Bank and Gaza), and assessment of hospital performance (Tunisia). Generally, analysis in the education and health sectors has included sector-specific analytical work, technical assistance, and the capacity-building programs of the World Bank Institute. Outside the education and health sectors per se, analytical work can refer to education and health services delivery in core diagnostics (public expenditure reviews, poverty assessments) and multisector analytical work.

When working toward improving service delivery in a client country, it is useful to look

at the client's budget flows and interactions through the delivery chain in order to detect inefficiencies or leakages—breaks in the chain. Analytical tools for conducting such core diagnostic work include the World Bank's Public Expenditure Tracking Survey (PETS) and Quantitative Service Delivery Survey (QSDS), which aggregate data on inputs, outputs, user charges, quality, and other characteristics directly from the service provider level so that more can be learned about "the linkages, leakage, and the way spending is transformed into services" (Dehn, Reinikka, and Svensson 2002).

Several PETS and QSDS activities have been conducted in the MENA region for education and health, and they form the basis for much of our analysis of performance at the point of service delivery in chapters 6 and 7. For example, in 2011 the PETS and QSDS surveys conducted in Morocco shed light on the flow and use of resources in the public health sector. Some of the PETS and QSDS tools have been funded by other donors such as the European Commission and used with other research methods to gain a comprehensive understanding of the health or education expenditure chain in a given MENA country. In the Republic of Yemen, for example, tracking education expenditures means analyzing public resource management and teacher absenteeism rather than undertaking a "pure" PETS in the education sector. The reason is that Yemeni schools receive few or no cash resources, rendering a PETS approach, which emphasizes estimating fiscal leakages from cash resources allocated at the school level, unsuitable. Thus the 2006 World Bank study of the education sector in the Republic of Yemen used an absenteeism survey to examine the leakages in wage and salary expenditures.

Other World Bank products of this kind include its Public Expenditure and Financial Accountability Country Assessment, which determines how to improve public financial management (PFM). Country Procurement Assessments have been carried out in the Arab Republic of Egypt, Iraq, Jordan, Morocco, and the Republic of Yemen, along with numerous Public Expenditure Reviews. Assessments like these underline the need to treat service delivery as a cross-cutting issue that must be analyzed and supported comprehensively, with clear links to public sector governance and public financial management. Finally, even though the World Bank has produced many comprehensive sector analyses, the gaps in the data in this field are still large, especially because most of the studies conducted have focused on three countries: Egypt, Morocco, and the Republic of Yemen.

Factors shaping variation in operational effectiveness

In placing the World Bank's activities in the MENA countries in context, it helps to have a broader sense of the "aid landscape" in the region, something that aidData enables us to do.[2] Of the more than 14,500 projects in the aidData database, 7 percent are in MENA countries, and of the 12 donors (including the World Bank) associated with these projects, 8 work in the MENA region. How well does the World Bank perform in the MENA region compared with its performance in other regions? And in turn how does that performance stack up against the performance of all other donors in the MENA region compared with their own performance in other regions? The preliminary answer is that, on average, donors perform worse in the MENA region than they do elsewhere. The World Bank, however, does slightly *better* than average (though likely it is not statistically significant). At the very least, the World Bank does not seem to perform worse than average, unlike other donors.[3]

Even so, the World Bank's involvement in the MENA region has faced several challenges in recent years. The regional political economy has played a distinct role, affecting the Bank's engagement, in particular through the nature and type of Bank-client relationships, which have recently changed because of the Arab Uprisings and transformations in the region. Before 2011, the Bank's relationship with clients was often not all it

appeared to be. During President Zine El Abidine Ben Ali's regime in Tunisia, for example, the country had the Bank's biggest lending portfolio in education and health, adding up to almost $395 million between fiscal 1994 and 2014 (see figure 11.1). Internationally, Tunisia was perceived as a strong, diligent client, and it was praised for its comparably good economic and social development. The latest Independent Evaluation Group (IEG) Country Program Evaluation for Tunisia, which analyzed the World Bank's engagement from fiscal 2005 to 2013, reveals a different picture, however, stating that the "relationship was broadly characterized by tight government control and relative passivity on the part of the Bank, in particular after 2007" (IEG forthcoming). The Tunisian government sometimes interfered in the Bank's work; it would inhibit the dissemination of some analytical work, prevent the pursuit of some key work (for example, Public Expenditure Reviews, Investment Climate Assessments), and intervene in the Bank's interaction with stakeholders. Even though the analysis that was actually produced was of high quality, the Bank's reputation as a provider of independent analysis was affected by the Tunisian case. Examples like this demonstrate that the Bank's engagement in the MENA region has often been welcomed, but only to a certain extent, even though many countries in the region have performed quite well compared with others in the developing world.

Beyond broad political economy considerations, internal assessments of Bank projects have lamented the challenge of moving from the provision of inputs (buildings, supplies, staff training) to ensuring the quality of outcomes (learning, public health functions, curative care). Concerns about the quality of education have been a focus of World Bank engagement since at least the early 1990s, but at that time the main priority in the MENA region was increasing the access to education for the burgeoning young populations. Thus country assistance in education was designed comprehensively, and the objectives of projects were dominated by construction components. Over time, it became apparent that quality was not necessarily the result of just delivering inputs, and yet the Bank struggled to move beyond these tasks. In Jordan, for example, where seven Bank-assisted education projects were initiated or fully delivered in the 1990s, the Operations Evaluation Department (OED) Country Assistance Evaluation reasoned that "despite the generally satisfactory outcome for each of the seven projects in terms of their objectives (dominated by construction) . . . the assistance strategy focusing on primary and secondary education, vocational training, and lately higher education during the nineties, has not yet made a significant contribution to improvements in the quality of education at any level" (Operations Evaluation Department 2004).

In the years that followed, teacher training combined with stronger parent-student involvement in schooling became a useful strategy for targeting enhanced education quality, frequently incorporating the concept of participation. For example, measures that were recommended in the early 2000s to improve the quality of education in Egypt included involvement of the community through school councils, enhancement of teacher capacity (as well as an emphasis on student learning evaluations), installation of new technology, and competition in private sector engagement (World Bank 2002).

In addition to teacher training, the contribution that parents and students could play in raising school quality emerged in concert with accountability frameworks and closer attention to concepts of incentive structures. The 2008 MENA education flagship report powerfully concluded that where "reforms in the past have tended to focus on the engineering of the education system (building schools, printing textbooks, hiring teachers) . . . today's reforms should rely more on the use of incentives and accountability measures" (World Bank 2008). Moreover, to further strengthen accountability from a demand-side perspective, social accountability tools incorporating the citizen's voice began to be introduced.

One of the most influential (if contested) concepts of the last 20 years in development has been "good governance." Under this broad umbrella has emerged a related set of ideas—for example, voice, participation, accountability, transparency—which are believed to be essential to shaping incentive structures that promote high-quality service delivery (Ringold et al. 2012). Supported by a combination of hard-won experience, newly gained insights, and academic research, these concepts now guide World Bank activities, from analytical work to outputs on the ground. An example is the stronger emphasis on participation and the role of "communities" as both a means and a target of development assistance (see World Bank 2001). More diverse areas of participation have been incorporated since the mid-2000s, when social accountability and other related concepts and corresponding tools were introduced. For the MENA region, the essential significance of social accountability became evident in 2010–11 because the revolutions in four countries were not only about the people's desire for change but, more important, their desire to be heard and be out of the shadow of their former omnipresent leaders.

The shift just described toward including "participation" in project design has been clearly visible in education, where community participation was strongly encouraged as of the early 2000s. Mothers' and fathers' councils were introduced or strengthened in schools throughout the MENA region, and local councils or community committees became involved through the development of community-based action plans or similar initiatives. Here, however, a distinction must be made between passively *addressing* the community and actively *involving* the community at the decision-making level, because many earlier projects had referred to involvement when elaborating on the concept of community participation.

Also in the early 2000s, student learning was becoming the main focal point in education, although it now depended mainly on teacher training and its quality. Education projects thus continued to be input-oriented, with an emphasis on provider ability and the availability of key inputs. In fact, this was the World Bank's overall education policy at that time and thus was not applied just to the MENA region. As the 2006 IEG evaluation of World Bank support to primary education noted, "Only about one in five projects had an explicit objective to improve student learning outcomes. This does not mean that projects were unconcerned about quality: almost all aimed for improvements in educational quality, but until recently this was mostly seen in terms of delivery of inputs and services" (IEG 2006). A look at education projects throughout the 2000s reveals that little has changed until recently for the MENA region.

More or less the same assessments can be made of the health sector. In the late 1990s and early 2000s, improvements in the quality of care were sought by providing training and medical equipment as well as rehabilitating facilities. Providers' efforts were targeted only indirectly through the implementation of quality and staffing norms, and monitoring mechanisms or incentives were seldom introduced into project design. The Jordan Operations Evaluation Department Country Assistance Evaluation of 2004 asserted that "while primary health care and health sector staffing have improved as a result of training and construction financed by these projects, the overall results in terms of long term policy reform in the health sector have not been impressive" (Operations Evaluation Department 2004).

In education (and to a lesser extent in health), upgrading management information systems was frequently invoked as a basis for improving education quality, as were other relevant governance drivers such as transparency and access to information. However, measures that were recommended or implemented in education, such as providing information on teaching practices and publicly available student learning outcomes, were aimed at enhancing education management mostly at the administrative level and not at the school level. This thesis is supported by an upcoming study on World Bank

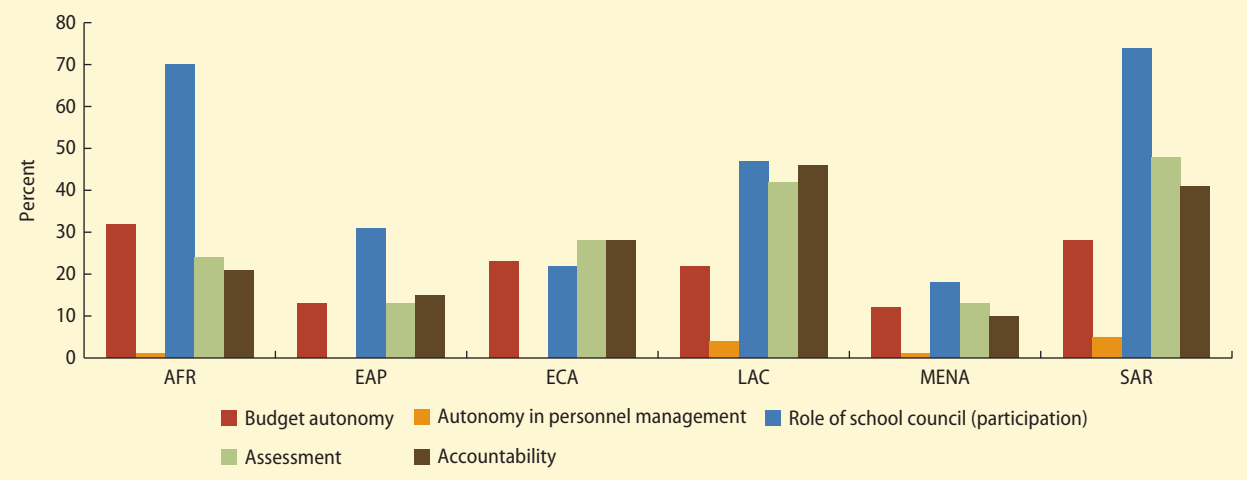
support for school autonomy and accountability for fiscal 2003–13 (World Bank forthcoming). It finds that the World Bank's program in the MENA region has been relatively less active in supporting school autonomy and accountability when compared with other regions. Although 14 projects are supporting school autonomy and accountability in the MENA region (slightly above average when compared with other regions), the vast majority of them include such support at the subcomponent level rather than the component level, and there is no stand-alone school autonomy and accountability project.

In the health sector, the organizational and management tools introduced by the World Bank from the 1990s on to enhance hospital performance were mostly directed at the level of the Ministry of Health rather than the hospital. The same could be said of the procedures and information systems deemed necessary for improving decision making and resource allocation, although the low level of support for autonomy/autonomous management is no doubt rooted in the centralized systems in the MENA countries, where virtually all the decision-making power resides in the line ministries. As for accountability, the governance concept was mostly supported as an "internal" process in service delivery—that is, monitoring mechanisms and information transparency within the service delivery chain. Even though participatory elements were increasingly introduced throughout the early and mid-2000s, (external) instruments to ensure that clients would be able to hold the provider accountable were rarely introduced or promoted by the Bank.

Thus in the area of governance in social services delivery, the World Bank's involvement in the MENA region in the early 2000s was primarily aimed at ensuring the availability of key inputs and improving provider ability, seemingly ignoring the role of provider effort and (external) accountability mechanisms in social services delivery. Since then, the role of incentives and accountability has increasingly been acknowledged, and the mechanisms for addressing them were sought throughout the mid-2000s by donors, including the World Bank. As the 2006 IEG evaluation of World Bank support to primary education argued, "past education reforms failed to focus on incentives and public accountability" and "few Bank-supported country programs directly addressed teacher recruitment and performance incentives; particularly lacking are performance incentives related to student learning outcomes." Rightly, it concluded that the "new road requires a new balance of engineering, incentives, and public accountability measures" (IEG 2006).

In recent years, things have changed. In education, analytical work in particular has begun to follow "the new road" in introducing new governance tools for education. The 2011 SABER[4] evaluation for Tunisia, for example, listed "Teacher Motivation" as one of eight goals and focused on formal mechanisms to hold teachers accountable as well as performance-related incentives (World Bank 2011b). Assessment tools such as SABER aim for a comprehensive analysis of factors that affect education services delivery, including early childhood development, education resilience, school autonomy and accountability, school finance, school health and school feeding programs, student assessment, and teacher and workforce development. During the first phase of an assessment, policy data are analyzed based on an analytical framework that uses global evidence to identify the policies and institutions that matter most for promoting learning for all. The second and third phases explore quality of service delivery, focusing on policy implementation and the quality of education services provided. When looking at how World Bank interventions are working toward the school autonomy and accountability policy goals, however, SABER analysis shows that little has been done so far in the MENA region compared with other regions (see figure 11.4). The highest proportion of World Bank activities lies in the area of the role of school councils in school governance or participation (policy goal 3); it accounts for a little more than 15 percent of interventions.

FIGURE 11.4 SABER analysis of World Bank school autonomy and accountability interventions, by region, FY03-13



Source: World Bank forthcoming.
Note: SABER = Systems Approach for Better Education Results; AFR = Africa; EAP = East Asia and Pacific; ECA = Europe and Central Asia; LAC = Latin America and the Caribbean; MENA = Middle East and North Africa; SAR = South Asia.

Relatively less emphasis has been on accountability in finance, school operations, and learning (policy goal 5).

Another notable example of an analytical tool is the new Benchmarking Governance as a Tool for Promoting Change initiative, which today includes 100 universities in the MENA region (World Bank 2013a). It focuses on governance in higher education, with an emphasis on management orientation, autonomy, accountability, participation, and public/private sector differentiation.

In health, the World Bank's perspective is also changing to include an increasingly bottom-up focus on engaging with client countries. In 2011 a Japan Social Development Fund (JSDF) project was approved, and its key objective was to "improve the quality and responsiveness of health service delivery for reproductive health through community involvement and empowerment in planning and delivering health services in underserved areas of the Recipient's peri-urban and rural governorates" (World Bank 2011a). Even though the frequency of community participation as a stated objective of development projects had been steadily increasing since the early 2000s, the inclusion in the JSDF project of direct *empowerment* as a goal of project recipients was novel.

Also in analytical work, the World Bank has pursued a stronger "citizen perspective"—most of all in the MENA sector strategy for 2013–18 (World Bank 2013b). The recently introduced governance mechanisms, which have to date mainly appeared in analytical work but also to an extent in lending, are the expression of a shift in perspective for World Bank support of social services in the MENA region. Social accountability tools, in particular, are being used more frequently in the human development sectors. Methodologies such as community scorecards have been piloted in the region, focusing on citizens as the ultimate stakeholders and thus adding to the Bank's work on the supply side of governance (Beddies et al. 2011).

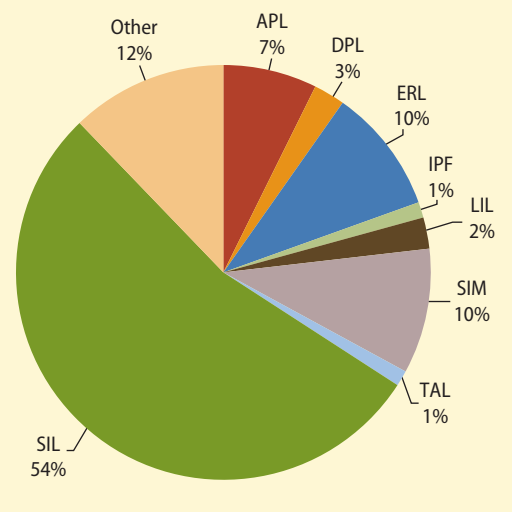
The challenge of project implementation in the MENA region

These promising advances still face considerable challenges when it comes to implementation via the World Bank's

lending instruments. In recent years, most Bank lending in the MENA region in education and health has taken the form of investment lending, and, of the array of instruments available for this purpose, two in particular—the Adaptable Program Loan (APL) and the Learning and Innovation Loan (LIL)—have been established for the express purpose of providing more flexibility and space for innovation during project implementation (see box 11.1). In principle, these instruments should be well placed to facilitate the discovery of country-specific strategies for enhancing the quality of service delivery in MENA countries.

Over the period 1994–2014, 7 percent of the Bank's lending instruments were APLs, which accounted for 6 projects out of 82 in the MENA education and health lending portfolio (figure 11.5). Two of these were education projects with two phases (and therefore four projects in total), and two were health projects, approved in 2001 and 2008, including one for additional financing for the Djibouti Health Sector Development program. All six projects were rated satisfactory or moderately satisfactory. The Djibouti Second School Access and Improvement project was rated moderately unsatisfactory by the Independent Evaluation Group Implementation Completion Report (IEG ICR) review, largely because "evidence was not provided on improvements in quality and system efficiency. The efficiency of investment of project resources was modest, as project activities were either not completed or were funded by other donors, some activities were implemented late, and there was instability in the implementing agency" (IEG 2013). APLs are designed specifically for strengthening

FIGURE 11.5 World Bank education and health lending instruments: MENA region, 1994–2014



Source: World Bank.
Note: MENA = Middle East and North Africa; SIL = Specific Investment Loan; SIM = Sector Investment and Maintenance Loan; TAL = Technical Assistance Loan; APL = Adaptable Program Loan; DPL = Development Policy Loan; ERL = Emergency Recovery Loan; IPF = Investment Project Financing; LIL = Learning and Innovation Loan.

BOX 11.1 World Bank's adaptable program loans and learning and innovation loans

Adaptable Program Loans (APL) provide phased support for long-term development programs. An APL is actually a series of loans in which each loan builds on the lessons learned from the previous loan(s) in the series. APLs are used when sustained changes in institutions, organizations, or behavior are deemed central to implementing a program successfully.

Learning and Innovation Loans (LIL) finance (at a level of $5 million or less) small, experimental, "risky," or time-sensitive projects in order to pilot promising initiatives and build a consensus around them or to experiment with an approach in order to develop locally based models prior to a larger-scale intervention. LILs are predominantly used in sectors or situations in which behavioral change and stakeholder attitudes are critical to progress and where "prescriptive" approaches may not work well.

BOX 11.2 The independent evaluation group's process for conducting implementation completion reports: How it works

Project outcomes and World Bank performance are assessed and rated in an Implementation Completion Report (ICR), a document written by the Bank project team and subsequently reviewed by the Independent Evaluation Group (IEG) team. As part of its ICR review, the IEG independently rates project performance. If the IEG rating differs from the ICR rating, the IEG explains the difference. On average, the IEG rating tends to be worse than the original ICR rating. In the case of MENA human development projects, if the IEG reported a different rating for Bank performance, it was either "moderately unsatisfactory" or "unsatisfactory." Such IEG ratings generally reflect significant weaknesses in project design and project implementation, while recognizing the often complex situations on the ground. The difference between the ratings reported by the project team in the ICR and by IEG in its ICR review often stems from the somewhat more subjective and insightful approach of the former and the highly objective and rigorous approach of the latter.

institutional capacity, but in the MENA region at least their performance does not stand out—they have not performed especially well or especially poorly (see box 11.2).

Assessments of two early LILs in the education sector (approved in 2001) reached less ambivalent conclusions: each was rated unsatisfactory in both the ICR and the ICRR (Implementation Completion and Results Report). "Based on the modest ratings for relevance, efficacy, and efficiency," the Morocco Adult Literacy (Alpha Maroc) program was rated unsatisfactory, whereas the relevance and efficacy of the Yemen Higher Education Learning and Innovation project were found to be modest at best (IEG 2009a; IEG 2011). Although its objectives generally addressed the Country Assistance Strategy priorities of transparent governance, efficient public administration, and creating social benefits and human capital through investment in education, the Yemen Higher Education project aimed to develop a sector strategy "without the benefit of essential technical and analytic work, and the design failed to put into place the prerequisites for piloting, the one highly relevant objective. . . . There is no evidence of efficiency; in fact, despite an attempt to significantly scale up project activities, less than two-thirds of the credit was disbursed" (IEG 2011). Based on its modest relevance, modest efficacy, and negligible efficiency, the project was rated unsatisfactory.

As for the Yemen Higher Education project, the ICRR asserted that the technical and analytical work ordinarily essential for designing a higher education sector strategy was not carried out. This could be a shortcoming of the LIL mechanism because its capacity is limited (it is small) and because doing genuinely innovative work requires a level of organizational capability that (by definition) ministries struggling to implement key services may lack. Even so, again no prerequisites for piloting were put into place, which would have been a central objective of a LIL. Thus weak project management could also be a reason for the unsatisfactory project performance.

A more recent Bank programmatic innovation—the Program for Results (PfoR)—seeks to shift the core incentives for development projects from the delivery of inputs to disbursements linked to tangible and verifiable outcomes.[5] Disbursement-linked indicators (DLIs) play a critical role in this process; they provide the participating government with incentives to achieve key program milestones and improve performance. DLIs can be outcomes, outputs,

intermediate outcomes, or process indicators. Of the PfoR portfolio and pipeline operations, 34 percent are mapped to the World Bank's Health, Nutrition, and Population (HNP) Global Practice, followed by the Governance Global Practice with 14 percent. The HNP sector of the Bank has prepared and implemented the most PfoR projects thus far. The Morocco Health Sector Support Program for Results project is currently under way in the MENA region, and three more PfoR projects are in the pipeline. One project was recently approved, and one is under implementation (National Initiative for Human Development Support, Phase II, Morocco)—see World Bank (2012). Taken together, MENA countries account for up to 25 percent of total PfoR project financing, second only to Africa with 37 percent. There is no indication yet of how PfoR projects are performing in the MENA region, but such a fundamental shift in how incentives and imperatives are structured in loan agreements will surely yield interesting findings when the assessments are eventually conducted.

More broadly, project performance remains critical in both the education and health sectors in MENA countries. The reasons for project weaknesses vary—whether in the concept review stage or implementation stage; however, the final assessment continues to be project failure. Regarding overall project design, Denizer, Kaufmann, and Kraay (2013) assert that "project size matters," meaning that large projects usually comprise several components and are thus more complex, which has a negative bearing on successful project completion. Project performance is therefore affected by project size and design. Denizer et al.'s quantitative analysis holds up in the MENA region, where a majority of ICRs relate project difficulties to overly ambitious project goals for too short a period of time.

Indeed, 56 of 72 closed projects in education and health had to revise their closing dates. One example is the Secondary Education Enhancement project in Egypt. It was implemented in 1999, but did not close until 2012, six years after its scheduled closing in 2006. According to the ICR, the project's specific goals for education programs and processes were overly ambitious—even with four closing date extensions and 13 years of project implementation, only 2 of 18 targets were confirmed as achieved. The problems with this project were related to incomplete social analysis and public awareness outreach, incomplete preparation of school grant activity, lack of a baseline for evaluation of development outcomes, and lack of satisfactory monitoring and evaluation designs. Surprisingly, more or less the same assessments were made in the IEG report on higher education development projects in Egypt, Jordan, and the Republic of Yemen, as well as in the ICR for the Moroccan National Initiative for Human Development Support project.

In education, projects in the MENA region seem to have focused on inputs or immediate conditions (sometimes successfully) but without reliable measurements of student learning. There was thus no indication of whether these inputs actually made a difference in terms of student outcomes. For several projects, the links among outputs, outcomes, and project development objectives were not clear, and the indicators did not capture the real results of the operation.

In health, assessments of programs in the MENA region also found that a focus on the availability of key inputs undermined project effectiveness because institutional aspects were neglected. In the Moroccan Social Priorities program (Basic Health Project), for example, an emphasis on infrastructure, drugs, and equipment resulted in timely procurement. However, little attention was paid to the actual quality of the services delivered. Despite efforts to avoid the outcome of an earlier project in which newly built and stocked facilities could not open because of lack of personnel, this outcome was repeated. But this weakness in project implementation was hardly acknowledged in the ICR, where the Bank's performance was rated as satisfactory because "identified unexpected problems were found to be primarily of an institutional nature with structural roots,

residing in domains beyond the scope of the current project" (World Bank 2004). The IEG review of the ICR review then reversed this rating, finding that although "most physical targets were met, several facilities were closed and those that remain open are not fully functional, service quality is low, and they are underutilized" (IEG 2004). Notably, the project ICR was prepared in 2004, and the project had been approved in 1996. Project thinking and expectations thus vary in the time between project design and its assessment. This was a key issue for most of the projects because their time frames were revised extensively and frequently.

During project implementation, the task team composes ISRs (Implementation Status and Results Reports) to record the project status. Often, however, the ISRs are not created with the due diligence needed to foresee or respond to project complications. For example, the ICR for the Yemen Higher Education Learning and Innovation project (which closed in 2008) noted that the "ISR for the mid-term review was recorded 11 months after the review took place" (World Bank 2009). Furthermore, it stated, "Ratings in ISRs were unrealistic, with PDO [project development objective] progress rated 'satisfactory' even though the disbursement and overall implementation was very slow, with missed deadlines repeatedly for planned activities, and the (legally required) six-monthly reports were not available to substantiate the progress." The activities of the project had changed without acknowledging that the agreed-on indicators had been modified. Until the last year of the project, the ISR did not highlight this disconnect, which in the end led to a "moderately unsatisfactory" rating in project outcome and an "unsatisfactory" rating for Bank performance.

The composition of the task team is important for project implementation. Denizer, Kaufmann, and Kraay (2013) found that "task manager characteristics are important and have quantitatively large and significant impacts on project performance." They argued that task manager fixed effects are at least as important as country fixed effects in accounting for variation in project outcomes. Accordingly, the ICR for the Yemen Higher Education Learning and Innovation project stated that the weak project delivery was also related to overloaded task team leaders (TTLs) and slowly responding sector management. The TTL and other team members changed four times during the project, and the "frequent turnover of the staff resulted in discontinuity and inconsistency in the quality of technical supervision" (World Bank 2009).

Another essential point for project design is highlighted in the IEG health financing evaluation (IEG forthcoming). Specifically, the evaluation asks for systematic country diagnostics that address health financing as a cross-cutting issue in country engagements and also relate it to questions of public finance and budget management, ensuring an analysis of equity in health services use and finance, financial protection, and financial sustainability. Thus there is an increasingly strong emphasis on approaching service delivery from a range of disciplinary perspectives, which is essential when working toward improving the governance of social services.

There are some strong early warning indicators of project outcome ratings. For example, higher preparation costs are often associated with eventual low project outcome ratings. These costs can stem from several factors that seemingly do not improve despite significant resources flowing into project preparation—factors such as undue initial project complexity or limited country ownership. It is statistically proven that early warning signals, including "problem project" flags and "monitoring and evaluation" flags often predict the project outcome rating. Based on this finding, Denizer, Kaufmann, and Kraay (2013) reasoned that the "overall rate of 'satisfactory' World Bank projects could be improved if incentives to significantly restructure or simply cancel problem projects at the implementation stage were strengthened, and by increased emphasis on monitoring and evaluation over the life of the project." This observation aligns with the earlier finding that weak monitoring and evaluation often

signal fatal problems in project implementation and evaluation.

And what is the role of project restructuring in improved project outcomes? The lack of incentives for restructuring in the Yemen Higher Education Learning and Innovation project possibly led the task team to resist formally restructuring the project despite fundamental changes that were proposed by the ministry and incorporated into the project during its implementation. The ICR, in rating the project outcome as moderately unsatisfactory, asserted that "if the team had focused fully on the implications of the changes proposed by the Ministry and considered a formal restructuring, the tradeoffs and the capacity requirements could have been better taken into account and the indicators revised to match agreed revised objectives" (World Bank 2009).

Finally, Denizer, Kaufmann, and Kraay (2013) found that the time between project completion and evaluation is important to project outcome ratings. True project outcomes only become apparent over time, highlighting the need for a longer time period between project completion and its evaluation. Thus it is important to establish incentives that reward the long-term impact of projects more than their satisfactory completion. This is especially true for the education and health sectors, where projects may generate positive student or health outcomes only years after project completion.

Lessons and opportunities going forward

Evaluations of sector and regional work offer a comprehensive understanding of the common approaches and challenges in World Bank operations across sectors and regions. Country Assistance Evaluations (CAEs), in particular, illustrate the bigger picture over time, reflecting on the Bank's work in the country context. This is especially important for the MENA countries. Bank sector work such as in education and health has often been less effective than it should have been because recommendations have required politically sensitive decisions and fundamental changes in the way technical ministries operate (OED 2001). The apparent objectivity of IEG reviews enables sensitive questions and critical assessments of Bank procedures. For example, the Jordan Country Assistance Evaluation of 2004 asks why, in view of the importance of education to the government of Jordan, did the Bank fail to undertake "a review of the whole education sector at any time during the eighties or nineties in order to determine priorities between the three levels of education and hence to ascertain the most important areas for Bank assistance to the sector" (OED 2004). A few paragraphs later, it becomes apparent that by the time an education sector review was planned for Jordan, the Bank had already financed 10 education projects without an assessment of the strategic objectives of the education sector as a whole. Examples like this are numerous, and yet many of the IEG assessments echo each other, calling out the same challenges year after year. Thus the Bank's responsiveness remains questionable: evidence is lacking on the effectiveness of the Bank's response to the evaluations.

When speaking frankly about the challenges confronting all donors in the MENA region, however, one should also look for, and look to, those places and spaces where more promising initiatives are under way. One such place might be the Republic of Yemen,[6] where the Second Basic Education Development project explicitly concedes that "input-based approaches" to improving education have been ineffective and "there is no evidence that teacher training and supervision . . . has resulted in better teaching," all while "quality indicators at the country level remain poor" (World Bank 2013c). As such, the project is adopting a competency-based approach in conjunction with a conditional cash transfer program to try to encourage both high attendance and a focus on learning outcomes. Adjustments have been made to accommodate the seemingly "overambitious design"[7] that initially characterized the project, and it is hoped that other necessary adjustments will be made along the way. It is

far too early, of course, to make summary judgment on the success of this project. The point is that an honest reckoning is being made with past approaches, a shift has been initiated to focus on outcomes (not just inputs), and midcourse adjustments are being undertaken as immediate feedback becomes available.

The Republic of Yemen is also home to the Secondary Education Development and Girls Access Project (SEDGAP)—see box 11.3. Here we see how a deep commitment to implementation dynamics in a country beset with conflict can begin to make a real difference in the lives of poor and marginalized groups.

Conclusion: Are there even more "lessons" to be learned?

This report and this chapter have sought to provide both a realistic sense of the immense development challenges facing the MENA region in service delivery—for donors and

BOX 11.3 Implementing education projects in the Republic of Yemen: The Secondary Education Development and Girls Access Project (SEDGAP)

Mouna's story

I got married when I was in seventh grade and gave birth to nine children because my father-in-law didn't allow me to use contraceptives. I insisted on continuing to study. I took my children with me to the school and walked almost 8 kilometers to school. After finishing my education I worked as a volunteer teacher. When I joined the school, only 10 girls studied there, but after I started teaching, the number of girls went up to 72.

I have benefited from the female teacher contracting scheme, which has a great impact on my life. My role now is not just teaching but also advocating for girls' education. I make the best use of every social gathering and speak about the importance of education and sending girls to schools.

Mouna lives in the Republic of Yemen, one of the poorest countries in the MENA region. Over the last 10 years, World Bank teams have worked to improve the living conditions and educational opportunities for women like Mouna and their families. Over the period 1994–2014, the lending portfolio for the education and health sectors of the Republic of Yemen totaled almost $300 million, making the country the third largest aid recipient in the MENA region for those respective sectors. Shaken by conflict and severe crises, the Republic of Yemen has proven to be a demanding work environment for the Bank. Project implementation and evaluation have been difficult and risky. However, it is in the personal stories like Mouna's that one can learn about the true impact and success of a project against all odds.

The context

In the Republic of Yemen, the poverty rate rose to 54.5 percent in 2012. The severe unrest since 2011 and the high population growth rate are placing growing pressures on the education system.

And yet the last decade has seen significant improvements. The basic education gross enrollment ratio (GER) rose from 68 percent in school year 1998–99 to 86 percent in 2011–12. Girls' enrollment has surged over the same time period, with the GER rising from 42 percent to 76 percent for basic education and from 16 percent to 23 percent for secondary education. Nevertheless, many children drop out of school early, particularly girls in rural areas. An estimated 2 million 6- to 15-year-olds were out of school in 2011. School survival rates are also low: only half of those who enter grade 1 reach the end of basic education. And there is the persistent gender inequality: the 2009/10 grade 6 completion rates were 51 percent for girls and 71 percent for boys (61 percent for all).

(continued next page)

BOX 11.3 Implementing education projects in the Republic of Yemen: The Secondary Education Development and Girls Access Project (SEDGAP) *(continued)*

The project

The Secondary Education Development and Girls Access Project (SEDGAP) was approved in 2008, and it closed in January 2015. The objective of SEDGAP was to improve the gender equity, quality, and efficiency of secondary education in targeted districts, with a particular focus on girls in rural areas. The project financed a set of supply- and demand-side interventions (civil works, provision of school materials, capacity-building activities, and teacher training), including incentive programs such as conditional cash transfers and transportation incentives. The project was initially cofinanced by five development partners for a total of $103.4 million. In 2010 the upheaval in the country resulted in a significant reduction in project funds, to $47.2 million, as some development partners withdrew from the project or reduced their contribution.

Results and experiences

In spite of the difficult context, the Ministry of Education strenuously pursued implementation of the project as planned, especially the incentive programs. These programs appear to have had positive, tangible impacts in the targeted districts—for example, transportation incentives led to the improved retention of boys and girls who had to travel long distances to attend school and contributed to reducing the dropout rate and increasing the enrollment rate of students. Also, based on recent data from the Ministry of Education, the conditional cash transfer schemes have proved highly effective in increasing the enrollment of boys and girls from disadvantaged areas. Stories like Mouna's show that every small step counts in improving the lives of the poor.

Source: World Bank staff.
Note: Names have been changed to protect identities.

domestic actors alike—as well as a vantage point from which opportunities for improvement might be apparent. As this report explains, enhancing service delivery—and especially addressing the quality challenges in education and health services—requires a thorough understanding of political, administrative, and social institutions; performance indicators; and citizen trust and engagement at the national level and in local contexts. It also requires devising solutions that would fit—and gradually enhance—the cycle of performance and would be embraced by local leaders and their communities.

The key challenge is building high-capability education and health systems as part of the whole cycle of performance. If they are embedded in functioning accountability mechanisms that are trusted by citizens and that benefit from citizens' feedback and action, education and health systems would be better able to build on the initial logistical successes of infrastructure provision to tackle the more complex but vexing tasks of ensuring quality learning that prepares students for the 21st century and ensuring health care for all. If citizens are to trust the programs and systems supported by donors, donors may need to reach out to citizens directly to build trust. Simple measures such as providing citizens with detailed information on donor support objectives, interventions, and cost, disaggregated to the village level, would be a step forward and a possible model for promoting transparency domestically.

An important factor in identifying opportunities is being able to locate and learn from those who have already made the system work and building on the insights gained from them. If governments, donors, and others are to engage in the type of analysis that yields such insights, it is important that the World Bank itself be self-critical and that it analyze the variations in its own operational performance, seeking opportunities for improvement. This chapter reveals how the Bank has changed its approach to (and rationale for) service delivery over the years. However, it has consistently struggled to actively

support more than the provision of basic inputs, even when deploying instruments expressly designed to facilitate more "adaptive" implementation. Perhaps the harder question, because of recent experiences in the MENA region, is whether the Bank, with its current procedures and incentive structures, can support an approach to project design and implementation more focused on solving locally prioritized problems and delivering the real results that citizens rightfully expect. Many of the concerns raised in the recent high-profile IEG review, *Learning and Results in World Bank Operations: How the Bank Learns* (IEG 2014), seem to apply to the MENA region. The question, then, is can the World Bank now be a leader in pioneering a different (and potentially more effective) approach?

A key lesson from this analysis is that *how* engagement is structured among donors, governments, and citizens matters. In other words, the usual focus on policy reforms in the abstract must be matched by a corresponding focus on how any given policy will actually be implemented, and how the prevailing system of political imperatives and incentives will shift in favor of learning and effective delivery (as opposed to just process compliance). One might hope that the new "science of delivery" approach provides a space within which such issues can be explored by looking at the nature of a problem and developing a hypothesis while being agnostic about the solution; by using evidence to inform the implementation of solutions; by taking an adaptable, creative, and context-driven approach; and by being able to capture cumulative knowledge when finding and fitting local solutions.

For now, social accountability is a promising approach for the MENA region, even if its implementation requires time, money, and expertise so that it can be appropriately adapted to local contexts.[8] At the 2014 spring meetings of the World Bank, mainstreaming citizen engagement officially became an imperative across the MENA portfolio. It remains to be seen exactly what form this imperative will take and how it will draw on the community participation approach pioneered in the mid-2000s after publication of *World Development Report 2000/2001* (World Bank 2001). And one can reasonably ask to what extent social accountability tools deployed by "communities" are likely to overcome powerful institutional pressures (or inertias). Even, or especially, on this point, however, there will be variation: the social compact binding citizens and state will be reimagined in different ways in different places in different sectors. Building the collective capability to be willing to try new things, to demand high standards from each other, and to share with and learn from each other is the challenge ahead.

Notes

1. The time horizons are broad and mostly mark the introduction of new concepts rather than the completion or even abandonment of the old ones.
2. See http://aiddata.org/.
3. Thanks to Dan Honig for conducting this analysis. As part of his PhD research, Honig extended the aidData database to enable analysis of the larger coverage of projects reported here.
4. The World Bank's Systems Approach for Better Education Results (SABER) is an initiative to provide comprehensive comparative data and knowledge on education systems around the world.
5. http://web.worldbank.org/WBSITE/EXTERNAL/PROJECTS/0,,contentMDK:23215867~pagePK:41367~piPK:51533~theSitePK:40941,00.html.
6. See also *Strengthening World Bank Portfolio Performance in the Republic of Yemen* (World Bank 2014) for a fuller accounting of how the Bank is actively seeking to improve the quality of its engagement in the Republic of Yemen.
7. See page 2 of http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/MNA/2014/08/23/090224b08266734b/1_0/Rendered/PDF/Yemen00Republi0Report000Sequence004.pdf.
8. http://siteresources.worldbank.org/EXTSOCIALDEVELOPMENT/Resources/244362-1193949504055/Scalingup.pdf.

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Incremental Changes in the Social Contract and Local Empowerment

12

- **Enhancing service quality requires building institutions and promoting citizens' trust and engagement.**
- **The social contract among policy makers, public servants, citizens, and providers can be improved through incremental changes to strengthen accountability mechanisms, internal control, and performance management as well as modify recruitment and promotion mechanisms.**
- **Empowering communities and local leaders and building coalitions of reformers inside and outside of government can help in the design and implementation of best-fit solutions.**

This concluding chapter is devoted to possible solutions to the social services delivery problems in the countries of the Middle East and North Africa (MENA). Clearly, many policy makers across the MENA countries want to deliver visible results and, in doing so, bolster their authority and public support within an atmosphere of political fragility. They may not have the will, the power, or the support to drastically shake up the entire system of service delivery institutions and accountability mechanisms, but they may be willing and able to make incremental systemic changes and allow local initiative in motivating and supporting teachers and health workers. As we explained in chapter 10, conflicts, crises, and transitions in the MENA region also may create opportunities for wide-ranging systemic reforms. Similarly, the atmosphere of instability and fragility may generate a desire for quick wins. With that in mind, in this chapter we explore possible approaches to incremental systemic reforms, options for empowering communities and local leaders to find local solutions, and possible quick wins to enhance citizens' experience with the state, especially in the areas of education and health care.

Instead of sector-specific reforms, such as teacher policies, school management, or provider payment mechanisms and quality management in hospitals, we focus on cross-cutting governance elements that critically affect service delivery performance. We argue that the roots of service delivery problems, such as provider absenteeism, poor quality of teaching or care, and shortages of medicines and textbooks, can often be traced to these

cross-cutting governance elements. Examples of these elements are transparency, public sector management including civil service, independent accountability institutions such as courts, and an enabling environment for citizen action. Efforts at the cross-cutting governance level need to accompany sector-specific solutions in education and health.

Lessons from experience

Experience has shown that policy reforms—and public spending—are typically necessary but not sufficient to improve the delivery of social services. Drawing on the literature and especially on evidence from the MENA region, our analysis indicates that without adequate political and administrative institutions, accountability mechanisms, and internalized norms of personal responsibility and public service, improvements in education and health services will not come simply through policy reforms, through modernization of schools and health facilities, or through training of educators and health professionals. To foster better performance, policy reforms and investments need the backing of institutions—especially incentives and norms embedded in both formal and informal accountability relationships—and citizens' trust and engagement.

Similarly, narrowly focused institutional reforms within the education and health sectors will have only a limited impact if they are not anchored in broader institutional changes. Experience suggests that performance in service delivery improves when political institutions are the primary drivers of outcomes, or—as our case studies in chapter 3 illustrate—when skillful leaders use them to tap into and exploit social institutions for better outcomes. Decentralization, incorporated in a broad package of reforms aimed at putting more power into the hands of local officials, can help strengthen incentives for better performance if supported by adequate accountability mechanisms and resources. Meanwhile, enabling environments for collective action are needed so that citizens can hold local and central public servants accountable.[1] However, only strong administrative institutions can enable the state and providers to actually respond to citizens' voices and their needs. Indeed, an ability to respond to citizens' feedback on the quality of service delivery is crucial to sustaining citizens' trust and participation. Likewise, policy reforms, and the mechanisms for their implementation, need to draw on evidence, including findings from monitoring, evaluation, and citizens' feedback in local contexts.

Experience also suggests that for institutional reforms to have an impact, they have to emerge from problem-led learning processes, facilitate the finding and fitting of context-specific solutions, and engage broad groups to ensure that new institutions are shared and embedded. Historically, institutional reforms that overlooked contextual realities often failed. The problem-driven iterative adaptation approach to institutional reforms that is showing more promise calls for reform interventions to focus on solving problems through purposive muddling that includes active, ongoing experiential learning, with engagement by broad sets of agents who together ensure that reforms are viable and relevant (Andrews 2013; Andrews, Pritchett, and Woolcock 2013).

The success of institutional and policy reforms depends on the actual incentives that prevail for stakeholders associated with a specific problem in a specific setting. Understanding the way in which political, economic, and social interests intersect can help in designing both institutional and policy reforms in a way that will strengthen pro-reform coalitions and encourage compromise. In this respect, political economy analysis can help connect data about decisions, the de jure design of institutions, and the de facto use of institutions, thereby identifying constraints and opportunities for progressive change. Within the existing constraints, an incremental, problem-driven approach to institutional and policy reforms can combine considerations about feasibility with considerations about finding solutions that are robust and meaningful. This approach can

adapt reform design to align with the existing reform space and gradually expand it (Fritz, Levy, and Ort 2014).

Recognizing that there is no magic bullet on these fronts, we do not try to provide a comprehensive set of solutions. Instead, we highlight examples of success in the region and elsewhere to inspire policy makers, public servants, citizens, and donors across the MENA countries. The MENA region is striving to overcome its complicated political transitions and tragic conflicts, and the key is to seek and learn from positive examples. As Ibish recently observed when reflecting on the challenges the region is facing, "Under such circumstances, it is an intellectual and political moral duty to look for (but not invent) real evidence that allows one to retain a sense of decency and openness to a better future. And such evidence genuinely does exist in the Arab world today, despite a 'big picture' that is, or at least currently seems, so unremittingly appalling" (Ibish 2014).

Strengthening accountability and incentives through incremental changes

Capacity is important, but it is not a promising area for improving the quality of service delivery in the MENA countries. Where capacity is very low, institutional incentives are not, of course, sufficient to improve performance. For example, incentives for nurses in clinics will have little impact on the quality of health care if the nurses lack the skills needed to serve patients, and those incentives that bring teachers to classrooms may still fail to provide a good education if the classrooms are overflowing with students. Overall, with the exception of low-income countries such as Djibouti and the Republic of Yemen and situations of conflict and refugee crises, low service delivery capacity does not appear to be the key binding constraint in the education and health sectors in the MENA countries.

Meanwhile, the evidence suggests that undertaking policy reforms, building schools and hospitals, and providing equipment and training are alone unlikely to yield better outcomes. Instead, greater improvements in service delivery can be achieved by aligning the incentives of policy makers, public servants, and service providers with the needs and rights of citizens. The way forward can involve strategic incrementalism to give public servants and providers incentives to improve their performance and promote citizens' trust and engagement. Incremental changes in incentives at the center of government, in sectors, and at the local level can transform the social contract in the MENA countries, sending them down the path to greater meritocracy in the public and private sectors alike. Such changes will elevate the value of education and skills in meeting the needs of the economy and society. Measures promoting transparency, accountability, and norms of personal responsibility and public service can play an important role in this effort, both at the center of government as well as at the level of service providers and their respective sectoral departments.

Develop effective accountability institutions to monitor the performance of service providers and provide tools for the resolution of complaints related to service delivery.

Independent oversight institutions such as supreme audit institutions, ombudsmen, and courts are critical components of national accountability systems. As auditing moves beyond fiduciary matters to questions of results and effectiveness, it can make government more transparent and more accountable for what has been accomplished with public money. Supreme audit institutions have increasingly recognized the importance of demonstrating relevance to citizens by being a credible source of independent and objective insight and guidance to support beneficial change in government and service delivery. An ombudsman, who deals with complaints from the public about decisions, actions, or omissions of public administration, serves to protect the people against violations of rights, abuses of power, errors, negligence, unfair decisions, and maladministration, and to improve public services

while making the government's actions more open and its administration more accountable to the public. Courts, particularly administrative courts, can help support citizens' exercise of their legal rights to health services and sanction service providers for failing to implement their mandates. Because accountability institutions disseminate their findings publicly, assist citizens, and interact with the state and service providers, they also help to strengthen citizens' trust and engagement in the state.

For their part, governments must ensure that accountability institutions are accessible to all citizens. Awareness and information campaigns should be conducted so that citizens know their rights and how to exercise them. Accountability institutions should receive adequate financial and personnel resources and operate under clear regulatory frameworks. Whistleblower legislation needs to be in place to protect citizens who file complaints, and laws on libel and slander should not be used against citizens as a means of protecting corrupt or incompetent officials. Information on complaints to and investigations by accountability institutions should be made public and easily accessible. Legal aid services should be made available to ensure that poor and vulnerable citizens have access to accountability mechanisms. In facilitating access for all, governments can effectively partner with civil society organizations. Governments should also experiment with the establishment of specialized accountability institutions geared toward the education and health sectors, such as medical-legal partnerships and health care ombudsmen.

Accountability institutions can create formal mechanisms to actively seek citizens' input and complaints and report back on the status of their requests, feedback, and input. The Superior Audit Office (SAO) of the Republic of Korea established a complaint hotline and whistle-blower mechanism through which citizens can report areas suspected of irregularities or corruption and request audits. The 188 hotline collects "reports on unjust handling of petitions by administrative agencies, complaints, and particularly behaviors such as unjustly refusing receipt and handling of petitions on the grounds that they may be later pinpointed by audit and inspection." The hotline also receives "reports of corruption and fraud of public officials, including bribery, idleness, embezzlement and the misappropriation of public funds." This mechanism has been widely disseminated in Korean society and has a dedicated page on the SAO's website. In addition, the SAO has established specialized channels for receiving audit requests from citizens about matters of public interest and corruption. A committee of auditor generals and civil society experts assesses these requests and responds to citizens within 30 days (Effective Institutions Platform 2014).

Accountability institutions have also proven effective at the subnational levels. In Pakistan's Khyber Pakhtunkhwa province, for example, the provincial ombudsman provided redress to about 1,800 citizens' grievances during 2012–13 and both carried out an awareness campaign and instituted a citizen report card for 10 basic services (including education, health, and sanitation) that targeted potential as well as actual service users.[2]

Strengthen internal controls and performance management, including mechanisms to share and act on information.

A government can improve its performance by focusing on results in policy advice, central and departmental management processes, and public accountability. The relative priority of these areas is different in each country. Countries worldwide have adopted performance-oriented approaches to management, budgeting, personnel, and institutional structures.

However, such approaches are effective only when they are built on an effective system of control. Combating absenteeism and gaps in the distribution of key inputs such as instructional materials in schools and medicines in health facilities depends on having internal management controls in place.

Service delivery in MENA countries would benefit from strengthening the basic recording, monitoring, and management of inputs and transactions in the service delivery chain and from greater transparency in the public finance management and procurement systems. Stronger ex post control and processes of internal control in the public sector would facilitate policy implementation and operation of the education and health systems.

Because of the complexity of the education and health services delivery chains, social institutions also play an important role in motivating behavior, especially if the internal controls are weak and public management moves from input controls to performance management. In accountability and control, as in all other dimensions of management, the informal systems—individuals' motivations, values, and attitudes—are as important as formal systems. Strategies to strengthen control and accountability must take this into account or fail. Performance-oriented management can effectively complement (and even partly replace) input and process controls when formal controls can be partly replaced by social controls as staff internalize the appropriate values and norms as well as organizational goals.

Supported by effective administrative and social accountability mechanisms, some performance-oriented approaches would be easy to implement in MENA countries. Information on results and the different elements of performance, for example, could be introduced into government reporting, subjected to independent verification and public debate, and used as part of public management. More advanced approaches include introducing performance measures into budgeting and management; delegating responsibility to line ministries and agencies; taking steps toward meritocracy in public employment; and privatizing and outsourcing services that could be effectively provided by the private sector and civil society. Performance-oriented financing of services could complement managerial accountability by providing financial incentives for performance (such as pay for performance). Finally, private service providers could operate under a uniform regulatory framework, in parallel with public service providers, and offer citizens choices grounded in the accessibility of information on performance such as standards-based school and hospital assessments and accreditations.

Greater transparency of government performance across departments and service delivery systems and providers can nurture formal and informal accountability for performance. Making information about the performance of schools, health facilities, and the overall education and health systems readily available to policy makers, public servants, providers, and the public can draw attention to the deficiencies and variations in results as well as in the service delivery process. Such a measure is likely to create both informal and formal pressure for improvement and can help in devising the appropriate corrective and support measures. Introducing greater transparency in the relevant information on performance can increase citizens' trust in the state's efforts to improve public services, as well as empower action by citizens at both the local and national levels.

In this context, the MENA countries would need to strengthen the system of school and health facility inspections in order to generate the relevant information on performance and then to adjust human resource management and institutional capacity building in the education and health sectors in response to such information. Furthermore, information on the different performance elements of schools, health facilities, and the education and health systems can be benchmarked across localities within countries to provide citizens with the relevant comparative framework geographically and over time. Such information would cover the key aspects of service provision such as continuity, comprehensiveness, and appropriateness in health care services and student learning and the education-to-work transition in education services.

Other performance-oriented reforms in the public sector would take time and

much effort. Constructing a true performance budget, for example, requires major changes in information, costing, and measurement systems. Reformatting budget documents to show workload or output data does not suffice; citizens also must receive accurate information on how spending options or choices affect the services they receive from the government (Schick 2011). Changing the attitudes of public servants and politicians toward performance requires creating specific incentives and controls as well as spreading an understanding of the education and health systems and how the actions of key actors influence each other (OECD 2005).

Although efforts to introduce performance management in a comprehensive, top-down fashion have been met with only partial and gradual success, many examples of success can be found at the agency or sector level. Such cases are particularly inspiring when succeeding against the odds in fragile, conflict-affected settings, as documented in the Ministry of Basic and Secondary Education and the Ministry of Finance and Economic Affairs in The Gambia; the Ministry of Public Works and Transport and Électricité du Laos in the Lao People's Democratic Republic; the Ministry of Finance and Economic Development and Local Councils in Sierra Leone; and the Ministry of Health, the Central Bank, and the Ministry of Social Solidarity in Timor-Leste (see Barma, Huybens, and Viñuela 2014).

Inspiring examples of promoting performance management in the public sector are also found in the MENA region. Morocco's experience in redesigning a public agency (Caisse Nationale de Sécurité Social) involved effective measures for enhancing accountability and efficiency as well as for streamlining and computerizing administrative procedures, building a skilled staff, and conducting transparent inspections and audits (Ferrali 2013). Jordan's approach to creating a "citizen-friendly" Civil Status and Passports Department consisted of overcoming a notorious lack of motivation and corruption by overhauling the department's highly centralized structure, eliminating unnecessary steps in service delivery, and evaluating employee performance, with consequences for promotions and a bonus structure (Iyer 2011).

Policy makers can encourage such agency-led initiatives through public recognition and awards (the importance of which is further discussed in the next section) at both the subnational and national levels. For example, Dubai's Executive Council introduced the Hamdan Bin Mohammed Award for Smart Government of Dubai in 2013. During 2013–14, 32 awards recognized specific programs and services, including best public service, best new government service, and best public-private partnership, as well as best efforts such as best improvement team or best service center manager. Citizens voted to select the winner from among the top three finalists; experts served as international judges in the preselection. The final awards were announced by the crown prince and, in addition to public recognition, involved a financial prize.[3]

Governments can also establish programs that provide incentives for monitoring the provision of quality services, apart from private-public partnerships and reliance on civil society. An Egyptian conditional cash transfer program piloted in Ain es-Sira (a suburb of Cairo) in 2009 helped poor women ensure that their children went to, stayed in, and excelled at school, and also led to obvious improvements in health. Such programs, when done well, can help repair relations between the poor and the state. Hania Sholkamy, the professor at the American University of Cairo who helped to design the program, explained: "Civil society can monitor programs, can organize social audits, can provide auxiliary benefits and projects, can even take on the responsibility of providing work opportunities or better markets so that families will find exits from poverty. But the state is the duty bearer in the case of social protection, and for these transfers to work, they must be entitlements, not handouts" (Sholkamy 2014). Civil society engagement at the point of service delivery may indeed be supported by government as well as international development partners without posing

any risk to the underlying clientelist political systems. Civil society organizations, however, do not stand above the clientelistic pressures that may be present in society, but some civil society organizations, like some political actors, eschew such practices.

Experimentation, even at the local service delivery level, is important to test how reforms fit local and national institutions. Some well-meant control and performance-oriented reforms can at times have limited or perverse impacts. For example, curriculum reforms implemented in the United Arab Emirates were geared toward improving education outcomes and creating an entrepreneurial sense of citizenship. But the students began to feel entitled (despite the fact that the curriculum was aimed at reducing their dependence on the state), perhaps because they were selected to attend a special school (Jones 2013). Even mechanisms as simple as time/date stamping machines were introduced to improve nurses' job attendance in India. But after significantly reducing absenteeism, the time-punch machines suffered from breakages (some of which were proven deliberate), and staff reverted to their old habits of poor job attendance without any disciplinary action (Banerjee, Glennerster, and Duflo 2008). In these cases, the reforms in state institutions were undermined by weak political accountability mechanisms, by social norms and institutions that remained unchanged, and by the time lag between reforms and their observable results.

Finally, effective implementation of policies and programs aimed at better provision of services must also take into account the gap between the central government and its ministries and the local service providers. Policy reforms by the national government and ministries are unlikely to be implemented successfully in the absence of mechanisms that bridge the gaps between them and local service providers and motivate implementation at the local level. Currently, the weak or distorted monitoring, control, accountability, and incentive mechanisms permeating the service delivery chain imply that well-meaning otherwise impressive policies at the national level are frequently not implemented successfully. Often, such gaps are only exacerbated by support of projects through "parallel" institutions and vertical programs. Using such channels may seem more efficient in the short run, but they actually weaken the state.

Modify the mechanisms for selecting, encouraging, and rewarding leaders, public servants, and service providers in order to internalize norms of personal responsibility and public service.

Meeting citizens' demands for education and health services delivery requires reorienting the incentives and attitudes of policy makers, public servants, and service providers not only through formal accountability mechanisms but also through internalized norms of personal responsibility and public service. Our case studies of local successes in chapter 3 reveal that such norms are often a powerful engine of good performance. Similarly, Al-Yahya (2009), drawing on a survey of administrators in public sector organizations in Saudi Arabia, suggested that norms and organizational culture, including participative practices, are significant predicators of motivation and the effective utilization of competence.

Norms of personal responsibility and public service must be nurtured through human resource management in the overall public sector and within the education and health sectors. Selection, promotion, and recognition mechanisms as well as training can help internalize values of collective purpose, public service, and individual responsibility for results, as well as specific professional values. This emphasis implies the need to nurture fundamental values such as fairness, equity, justice, and social cohesion as part of public administration and service delivery. When service providers, public servants, and policy makers demonstrate such values in their actions, they are likely to strengthen trust in the governmental and political system as a whole. Where needed, the effort to internalize these values can be accompanied by

deregulation of administrative controls that quash individual initiative and personal responsibility.

The traditional centrally controlled bureaucracy common in MENA countries is a workable, robust system for internalizing the norms needed to achieve quality service delivery for all. Internationally, such traditional bureaucracy models have been shown to be effective, especially where the constitutional institutions of society have been disrupted or discontinued; where the other institutions in society are not particularly well ordered; and where national culture attaches importance to the existence of a strong, all-embracing concept of the state and therefore a need for strong cultural consistency across the core public service (OECD 2005).

Standard competitive examinations and diplomas can promote fairness in the entry into public service and into service provider positions such as teachers and health workers. Pre-entry and on-the-job training for different categories of civil servants and service providers can foster the spirit of public service and collective values. And transparency in recruitment and promotion systems can help reduce patronage. Other measures can be taken to limit political capture and improve fairness and trust as well as employee motivation and performance. One measure is more advanced public employment approaches such as open and competitive processes for filling each position. Another is strong individual performance assessments, relying on job objectives and adherence to certain values and norms as defined in a performance agreement and linked to promotion and advancement. And yet another is transparent pay differentials (which can also be a step toward attracting qualified medical and teaching staff to posts in less desirable areas).

Teachers and health workers are the largest highly specialized groups of public servants. Their management, including attracting, grooming, and motivating them, requires a holistic approach.

With respect to teachers, Bruns and Luque (2015) have highlighted the need to, first, make teacher recruitment more selective by raising the standards for entry into teacher education; raising the quality of teacher education schools; and raising the hiring standards for new teachers. The second need is to make teachers more effective by supporting their development during their critical first five years of teaching and assessing teachers' strengths and weaknesses; by offering training to remedy teachers' identified weaknesses and leverage the skills of top performers; by matching teachers' assignments to the needs of schools and students; and by building a professional community of teachers both within schools and across the school system. Finally, to motivate teachers, experience suggests that no education system achieves high teacher quality without aligning professional rewards, accountability pressures, and financial rewards in a context-specific manner. For example, Finland, Singapore, and Ontario (Canada) have all established strong professional rewards for teaching, whereas Singapore relies on stronger accountability pressures.

Similarly for health workers, the World Health Organization (2006) has called for management of the national health workforce to move beyond salary and training in the public sector to approaches requiring upholding and strengthening the professional ethos of health workers, building trust among stakeholders, and linking people's expectations with health worker performance. Norms of shared purpose and nonfinancial incentives have been found to play an important role in motivating health professionals (Biller-Andorno and Lee 2013). This entails acknowledging their professionalism; addressing professional goals such as recognition, career development, and further qualification; and encouraging health workers to meet their personal and organizational goals as part of their working environment.

Finally, simple measures may go a long way in internalizing norms of personal responsibility and public service. *World Development Report 2015: Mind, Society, and Behavior* reports that simply reminding health workers, teachers, public servants, and

policy makers of the social expectations of their performance can improve it (World Bank 2015). In health facilities and schools, supportive supervision by peers, professional associations, and civil society organizations has been shown to contribute to sustaining norms of professional behavior, as have social cues in the form of recognition such as awards, token prizes (such as stars and plaques to display in the workplace), and small gifts (a book or pen). The case studies in chapter 3 suggest that such approaches are indeed accepted positively by teachers and health workers, providing them with greater satisfaction at work and the motivation to meet the expectations of their students and patients as well as supervisors and the community at large.

Learn from intracountry variation to design solutions that fit local contexts, to evaluate and strengthen policy implementation, and to scale up local successes.

Whether at the level of the individual, group, or organization, iterative learning is the pathway to mastering complex tasks. When we first learn to speak a language, to play a musical instrument, or to ride a bicycle, for example, we routinely make elementary errors; any objective measure of our initial "performance" would deem us failures. But we try again, making more mistakes, soliciting feedback from and observing those who are better than us, and trying again and again. Eventually, we can converse in full sentences, play a recognizable tune, and pedal along safely. Acquiring any professional skill, from songwriting to brain surgery, requires embarking on a long quest from awkward novice to seasoned practitioner; we learn such complex tasks primarily by doing and mentoring (as opposed to, say, listening to long lectures).

The same basic logic and processes apply to groups; they, too, must learn how to master complex tasks, but with the added difficulty of doing so collectively. In businesses and large organizations today, a process of experimentation, rapid feedback, iteration, and scale-up is standard practice (Manzi 2012). One can also discern elements of such practices in today's most effective public organizations in both developed and developing countries (Grindle 1997; Levy 2014; World Bank forthcoming). Such processes appeared as well in the early years of public agencies in now-developed countries, including those agencies that initially struggled to obtain political legitimacy and autonomy such as the post office in the United States (Carpenter 2001). Over time, such agencies and the services they delivered became seamlessly embedded in the fabric of everyday life, to the point that most citizens of developed countries took entirely for granted the daily arrival of the mail, electricity, and clean water, as well as education and health care. Such extraordinary service delivery systems were not born large, accountable, and effective; they became so over time as they incrementally acquired the capability to implement more complex and contentious tasks, at scale, in a political context that eventually gave them the support and legitimacy they needed (Lindert 2004).

Today's developing countries, however, and especially those in the MENA region, face additional challenges as they seek to deliver quality services. Unlike their counterparts in the private sector of today's developed countries, they cannot presume the presence of effective legal, financial, and regulatory systems that make rapid institutional innovation and iteration possible. Indeed, creating and sustaining such systems are themselves a major part of the development challenge. Moreover, many public administrative systems in developing countries are not being built from scratch; most have a long pre- and postcolonial history, which means that many decades of administrative practice have seen the consolidation of all manner of internal procedures, incentives, and expectations that are not always conducive to high performance. Indeed, there may be powerful forces committed to blocking the necessary reforms.

In such challenging contexts, there is no universal strategy or toolkit for promoting

change, but that does not mean nothing can be done. As this report has sought to demonstrate, there is widespread variation in the quality of service delivery within MENA countries, much of which cannot be accounted for by standard economic or geographic factors. Data on subnational variation in service delivery can assist policy makers in identifying possible effective responses to performance challenges. Some of the insights emerging from a detailed analysis of subnational variation may be generalizable to crafting national policy reforms—for example, they may reveal for human resource management lessons learned about the qualifications, experiences, and temperaments of those who are delivering innovative bureaucratic solutions and quality front-line services for citizens. However, other insights will not. In these instances, it is the process by which solutions are discovered rather than the solutions themselves that should be the focus of attention.

Data on subnational variation can also help citizens make informed choices and demand accountability. Documenting the actual change already being achieved by local actors somewhere can be a constructive basis for promoting that change more broadly. Further diagnostic work based on qualitative analysis of local successes can facilitate their possible scale-up and identify bottlenecks to address in the wider institutional framework for service delivery. Box 12.1 provides an example of local institutional reform geared toward transparency and the responsiveness of schools.

Meanwhile, low-cost, timely access to information on the performance of local schools and health facilities in nearby towns and elsewhere in the country can empower citizens to approach local officials and community leaders and seek action. Such information can energize local leaders to pursue improvements and help them make hard decisions about where and how finite resources—in the face of a wide array of vexing problems—should be optimally allocated. Ideally, both broad quantitative data and deep qualitative data would be available to local leaders and policy makers seeking service delivery improvements because each methodological approach has its own set of complementary strengths and weaknesses. Ideally, officials would draw on subnational variation data to regularly commission their own analytic case studies of unlikely successes in service delivery as part of a broader strategy for enhancing organizational learning.

Empowering communities and local leaders to find best-fit solutions

The government can create the authorization necessary to further empower communities and local leaders to find best-fit solutions. Despite similarities in the overarching dynamics of service provision, barriers and potential solutions to improving service delivery are linked to local conditions. Indeed, even when national-level policies are put in place, they are implemented to very different degrees and with diverse effects locally. It is critical, then, that local communities be authorized by the central government to find the appropriate solutions and to implement experimental programs that may at times be scaled up to the national level.

Such an arrangement would require trust and cooperation between the central and local governments and between the state and civil society. Central governments need to allow, or even demand, a degree of autonomy at the local level, and local elites need to trust that they have the freedom to innovate within limits. Civil society, citizens, and state actors also need to develop the mutual trust that allows engagement of all forces. The effective engagement of citizens, communities, and local leaders to actively seek solutions—including solutions to address the needs of poor, marginalized, and disadvantaged groups—also requires actionable information and an outreach to those excluded as well as strategic allies. It is not surprising that, according to the evidence, political relations among citizens, civil society, and state leadership are the most important domain for improving performance incentives and accountability (Devarajan, Khemani, and Walton 2011). From the community

BOX 12.1 How assessing schools and clearly informing the public promote learning in Dubai

As Dubai has grown over the last two decades, the demand for private education has grown with it. Today, 88 percent of all primary and secondary school students attend private schools, most of which cater to the various communities in this city and emirate in the United Arab Emirates. Fifteen curricula are available, including those for U.K., U.S., Indian, Pakistani, Iranian, French, German, Filipino, and Japanese students. Increasingly, Emirati nationals are also opting for private establishments.

The surge in demand led subnational authorities to recognize the need to establish an entity—the Knowledge and Human Development Authority (KHDA)—to oversee the private sector. The immediate challenge for this new public entity was to identify an appropriate approach for regulating a private education sector.

About that time, the World Bank published *The Road Not Traveled: Education Reform in the Middle East and North Africa* (World Bank 2008). The report argued for better interaction between government and constituents based on transparency, accountability, and participation as a way to foster improved national policies, programs, and services in education.

The KHDA adopted this approach in Dubai. The KHDA inspects all schools on a yearly basis and makes the results of inspections available online, in publications, and even via a mobile device application. It rates schools on eight criteria, resulting in an overall rating of unsatisfactory, acceptable, good, or outstanding. Ratings are given without regard to price. Indeed, the Indian High School, one of the least expensive secondary schools in Dubai, is rated "outstanding," whereas schools far more expensive are only rated "acceptable."

Information on all aspects of the private education system in Dubai is now available, and it has sparked public debate in the media. Moreover, the information is being used and so is useful. Parents are asking more questions when choosing schools and interacting with teachers and school heads, who, when given KHDA feedback, are striving to improve their teaching practices and school environment (World Bank 2014).

There is, however, one caveat: the stakeholders who do act are those in a position to take advantage of the information offered to them. Although the better schools are improving, the weaker schools are getting caught in a low-equilibrium trap from which they do not have the means, either material or technical, to escape. The KHDA, aware of this asymmetry, is taking steps to help stakeholders by producing guides for parents explaining what characterizes good schools, supporting weak schools to help them improve, and holding events called "What Works" to expose teachers and schools to best practices.

The KHDA's initiatives offer lessons for other countries in the region and indeed internationally:

- Adopt an approach that is entirely transparent, is openly accountable, and has strong stakeholder participation—all hallmarks of good governance.
- Disseminate information about all aspects of the system. School ratings, one of the key elements of the KHDA approach, not only stir public discussion about the importance of school quality but also, more significantly, create higher expectations among education consumers and providers. However, policy makers should not rely exclusively on these means alone because very real constraints, technical or material, may prevent certain schools from improving.
- Experiment with incentive mechanisms but remain flexible. The KHDA allows schools to increase their fees if they receive better ratings, but at the moment this only serves as an incentive to those schools near the cutoff for a higher rating. Other kinds of incentives should be explored.
- Leverage competition between schools but not exclusively. In Dubai, competition has promoted some school improvement, but it is not complete: schools that have failed to progress over several years are discouraged. Indeed, it may be that collaboration rather than competition could support change just as effectively. In the same way that teachers feel that collaboration with other teachers is one of the most effective ways to learn how to become a more effective teacher, collaboration with other schools helps them improve as well.

perspective, evidence on citizen engagement and social accountability efforts points to four important lessons (Mansuri and Rao 2013; Fox 2014):

1. Information must be actionable. Citizens can act on information only if an enabling environment is in place to reduce the fear of reprisals. Incentives for information-led action increase with the likelihood that the state will actually respond to citizens' voices. If citizens receive no response and observe no improvements in performance, trust and engagement are likely to decline, and participation—whether spontaneous or induced—will not be sustained. On the other hand, positive results observable by citizens can generate trust and legitimacy for the state as well as for agencies and concrete reforms.
2. Only those local governments that are pushed by citizens and civil society to be more accountable are likely to become more responsive when bolstered by the increased funding and authority that comes with autonomy or decentralization. Experience suggests, for example, that the localities with more critical local media tend to have more responsive local governments and service delivery.
3. Enabling environments are needed to actively encourage the voice and representation of those who normally would be excluded because of gender, ethnic, or class bias.
4. Local voices that challenge unaccountable authorities are by themselves likely to be either ignored or squelched. Citizen action that has the backing of government allies who are both willing and able to get involved, or that has forged links with other citizen counterparts to build countervailing power, has a much greater chance of addressing impunity.

Build coalitions among champions of service delivery reform in government, civil society, and the private sector, giving local actors space to develop possible solutions.

Reform champions in government, civil society, and the private sector can make more headway in improving service delivery by building coalitions. Charismatic leaders who engender trust, mobilize engagement, and find allies in government and society often form such coalitions. As described in earlier chapters, the principal of the Kufor Quod Girls' Secondary School in the West Bank, the leader of Jordan's Sakhra comprehensive health care clinic, and the governor of Qena, Egypt, established personal ties with like-minded officials, local civil society actors, and citizens to mobilize human and material resources for better schools, health care services, and municipal services.

Governments should provide political space and incentives for such initiatives. Many such efforts have emerged from civil society organizations. Led by energetic youth, they are aimed at bringing together policy makers, government officials, service providers, and citizens. For example, in Jordan the group Leaders of Tomorrow has established Diwanieh, a project that engages local and national officials in direct discussions with citizens before live audiences from across the country.[4] They address a number of critical issues such as the use (or misuse) of local revenue and inadequate local services. Governments should recognize and encourage such efforts because they may ultimately increase public trust and engagement, particularly if coupled with other initiatives aimed at enhancing performance.

More formal efforts could be encouraged as well. Local health committees and education councils that include local officials, service providers, citizens, and key members of civil society may operate under a broad umbrella of national initiatives (such as accreditation programs or national school improvement efforts) and could provide a forum for long-term efforts across multiple projects. The local progress on national initiatives can be tracked transparently through publicly displayed "thermometers," postings on Facebook and other social media, and

public announcements in mosques, schools, and other venues.

Moreover, coalitions can create new opportunities for joint reform efforts. For example, in Tunisia Al-Bawsala, a civil society organization initially formed as a watchdog of the Constituent Assembly, and reform-minded Assembly members worked together to organize meetings with citizens in public forums across the country. A meeting in Satour found the community with a severe water shortage because of the mismanagement of water funds by the local committee. In response, Al-Bawsala worked with citizens and officials at the local and governorate levels to identify the problem and find a solution—in this case, an elected water management body that incorporated representatives from all the local clans (Al-Bawsala 2014).

Similarly, at the national level coalitions engaging citizens can achieve tremendous success in making otherwise unlikely reforms possible, including the establishment of high-level political institutions such as a new constitution. Here, Tunisia's example is highly inspiring. The Tunisian electoral commission took advantage of relationships with political parties, government, and the public to overcome inexperience in volatile circumstances and organize elections for a National Constituent Assembly that would rewrite the Tunisian constitution while helping to restore the public's faith in elections (Tavana 2013).

Efforts to establish mechanisms for engaging citizens in policy development, implementation, and monitoring tend to be more effective if building on the existing networks of local authorities and social institutions. These networks and institutions can provide valuable assets for mobilizing resources and legitimizing policies. For example, public health clinic directors have found that the imams of local mosques can legitimize and mobilize support for programs—they can assure their congregants that family planning is consistent with God's will, that immunizations are not tainted, and that drugs and obesity defile God's temple. Speaking from positions of social or religious authority, local community leaders and networks can legitimize programs and mobilize communities and resources to engage in efforts that promote service delivery. As one customary leader in Sana'a in the Republic of Yemen put it in a focus group discussion for this study, customary authorities can serve as "a connecting link between the community and the traditional powers."

If projects are not embedded in communities, even the best-intentioned efforts can remain fruitless. In India, for example, the effort to establish Village Education Committees (VECs) to monitor the performance of public schools was launched, but it was not connected to local champions. As a result, although most villages had a VEC four years after their establishment very few parents knew of it or understood its purpose—even some parents who were ostensibly members (Banerjee et al. 2010). Attempts to circumvent local leaders can also generate resistance and undermine efforts. Such local leaders may see their roles as complementary with that of the state, but they also resist reforms that would leave them sidelined.

Circumventing or ignoring local social authorities, networks, and institutions can in fact be counterproductive. This may be particularly true in postconflict situations, when such institutions fill important roles left empty by the withdrawal of state authority. Where traditional leaders and organizations have stepped in to provide services, particularly in the context of the conflicts, refugee crises, and weak states found across the MENA countries today, it is especially important to build coalitions of reformists across state and society that take into account these local forces.

Systematically collect feedback on public services from users, benchmark service delivery and local governance performance, and disseminate information on performance to provide a rigorous basis for citizen action.

To benchmark performance and measure improvements, citizens, civil society organizations, state officials, and service providers

need information that has been systematically collected on the quality and adequacy of public services. The citizen report cards (CRCs) implemented in Tunisia, Tanzania, and elsewhere are a simple but powerful tool for use in both promoting transparency and providing public agencies with systematic feedback from the users of public services (Action Aid n.d.; Hakikazi Catalyst 2004). In Tunisia, citizens have welcomed the ability to provide feedback and monitor progress on public services delivery (see box 12.2).

BOX 12.2 Tunisia's experience in building citizen feedback loops on service delivery

Before the revolution of 2010–11, Tunisia had no performance targets that citizens could use to hold service providers accountable. Since 2011, the government and civil society organizations (CSOs) embarked on a program, facilitated by the World Bank, to develop qualitative and quantitative tools for citizen monitoring of service delivery appropriate for the Tunisian context. Participatory monitoring guidelines were prepared and used to train all the stakeholders involved.

In the first stage, communities were mobilized to participate, and their perceptions of health, education, employment, and social assistance were identified through qualitative tools, such as local community scorecards. This approach was applied through a pilot phase conducted in 6 of Tunisia's 24 governorates that are home to both urban and rural communities. Local CSO and community groups were brought together, and training was provided by the World Bank. The scorecards helped foster citizen empowerment and identified the key strengths and weaknesses of local services from the community's perspective. Action plans for improving services were then developed with local service providers.

In the second stage, a quantitative assessment using a household survey was conducted based on approaches such as citizen report cards and social audits, adapted to the Tunisian context. Using a participatory approach, the questionnaire was developed with the government, with support from CSOs, based on areas identified by communities in the first stage through a qualitative technique. The quantitative assessment served as a pilot exercise for instituting a mechanism for routinely monitoring key performance indicators of the quality of service delivery. In the future, the tool will help track whether services regularly meet citizens' expectations and the needs and gaps that need to be addressed over time.

Policy implications for raising accountability in Tunisia

Since the revolution, Tunisia has for the first time adopted policy reforms of accountability in the public sector, albeit gradually. For example,

- A new law was adopted in 2011 on access to information.
- The government implemented in 2012 the first participatory "barometer of public services."
- The government adopted policies on participatory outreach (2011) and accreditation in education and health (2012).
- A decree in 2013 institutionalized participatory monitoring in one of Tunisia's highest supreme audit institutions, the National Controller's Body for Public Services.

These measures created a framework for improving service delivery in areas in which provider behavior and incentives were lacking. And yet to fully sustain and improve accountability and service delivery performance, improving demand-side governance will be critical to meeting citizens' aspirations:

- To date, the demand for public administrative information by citizens remains low because citizens do not believe in their ability to act upon such information toward achieving a change.
- A greater effort to proactively encourage citizen access to information and participation is needed.
- Reforms to ensure freedom of information, freedom of association, and participatory accountability mechanisms for service delivery will help to align incentives for greater responsiveness.

Source: World Bank (forthcoming).

More complex instruments, similar to the Public Administration Performance Index (PAPI) developed in Vietnam, use citizen surveys to benchmark local governance across a range of issues, allowing the relevant parties to consider the relationship between service delivery outcomes and other governance issues.[5] Such efforts create incentives for government agencies to undertake reforms and provide the targeted information needed for those reforms. PAPI demonstrated how benchmarking can provide incentives. A poorly performing province from the 2010 pilot study requested input from the team and independently developed an action plan to improve its future performance. More generally, provinces included in the pilot study showed improvement when reassessed, suggesting that they acted on the information. Similarly, the ongoing University Governance Benchmarking exercise, which includes 100 universities in the MENA region, collected information useful for improving performance and measuring progress (World Bank and Marseille Centre for Mediterranean Integration 2013).

Providing citizens with information on performance and gathering citizen feedback can be done cheaply and highly effectively with the help of today's information communication technology. Citizens can receive on their mobile phones regular updates about the performance of the schools and hospitals in their locality and the ranking of schools and hospitals in their country. Government agencies or civil society organizations also can establish ways in which people can use their mobile devices to report provider absences and the unavailability of services or essential medicines. In Peru's southern province of Puno, for example, designated citizen-monitors oversee the quality of maternal and child health care and use information communication technology to report violations of users' rights and engage with service providers, the regional ombudsman's office, CARE Peru, and ForoSalud (a civil society health forum) on ways in which to improve maternal and neonatal health services.[6] Technology and information can help citizens find others who share a common cause, build common ground beyond a locality or group, and launch networks to enable strategic collective action that can influence the power relations and incentive structures that determine whether government actors really will respond (Gigler and Bailur 2014).

Information also provides a rigorous basis and a proactive agenda for communities, civil society organizations, or local governments to use in pursuing a dialogue with service providers to improve the delivery of public services. Extensive public campaigns using community meetings, websites, and social media can generate a constant stream of information that invites the public and public officials to recognize both obstacles and successes.

Closing the feedback loop, engage citizens and partners in civil society organizations and the private sector to strengthen policy development, prioritization (with emphasis on the most disadvantaged, poor, and vulnerable), public resource allocation, and policy implementation.

Information must be linked with mechanisms that allow citizens, service providers, and officials to share and act on the information they receive about performance (Hanushek and Raymond 2005). Engaging local residents and civil society is key. Such engagement can bring new solutions to the table, mobilize local resources, and help ensure that programs and policies have buy-in from local actors. It can also provide soft accountability incentives, making providers more willing and able to invest in offering good services and benchmarking performance.

The public can be brought in as partners to assess needs, establish priorities, and consider solutions. Sector-specific mechanisms such as health boards and education clusters can seek the participation of clients, providers, community stakeholders, and officials. Town hall meetings and consultations can be effective at establishing community priorities and also strengthening social cohesion.

Virtual consultations are also possible, such as that used in a "Government Asks" initiative in the Brazilian state of Rio Grande do Sul, where citizens are given an opportunity to give policy input, either choosing between pair-wise policy choices or suggesting solutions via mobile phone, Internet, or (in poor areas) face-to-face consultations. Such processes can have an enormous impact. The "Government Asks" initiative alone yielded more than 1,300 citizen policy proposals, with over 120,000 votes cast on prioritization. It led to higher budget allocations for primary health care, family health programs, and regional hospitals.

In all cases, transparent and inclusive processes of consultation are essential. Inclusion is particularly important in the current context in the MENA region, where the stresses of Syrian refugees, internally displaced persons, and conflict are reshaping communities, undermining states, and placing extraordinary pressures on local officials and service providers. The influx of Syrian refugees is exacerbating the problems encountered in delivering water, transportation, solid waste collection, education, health care, and other services. In this context, the very question of inclusionary processes raises objections. It is difficult for citizens and local officials to accept the inclusion of noncitizen refugees in governance processes. And yet excluding these residents, who sometimes outnumber local citizens, exacerbates tensions. Moreover, it shuts out people who are equally affected by local problems and may be able to contribute to solutions. It is particularly important, although difficult, to ensure that marginalized voices (whether refugees, women, the poor, or others) are represented and that the political capture of such processes is avoided.

Inclusion is also important in efforts to systematically gather representative information on needs and priorities. A community development project in Jordan found that when civil society organizations conducted citizen surveys of local needs, presented the results in a public meeting, and asked elected representatives to find solutions, communities were able to resolve long-standing problems.[7] The combination of information and engagement also appeared effective in designing and implementing solutions in Uganda, where an intriguing study found that public meetings in which information was distributed to citizens improved health outcomes significantly (Björkman and Svensson 2009).

Governments can also give third parties opportunities to monitor performance, engaging in quality assurance for both public and private providers. The MENA region has recently seen the emergence of civil society organizations aimed at monitoring public performance, from national parliaments to local officials and civil servants. In Tunisia, Al-Bawsala not only monitors the Constituent Assembly, providing citizens with information about representatives' attendance and voting, but also recently extended this oversight function by launching two new programs, Marsad Baladia and Marsad Budget, that will monitor municipal activities and their budgets and make them publicly available in an easily digestible form. Globally, the social auditors who check government records against on-the-ground project implementation can also raise citizens' awareness of their rights, shine a spotlight on officials' actions, provide a space for collective interaction between officials and the public, and create incentives for better services. Sector-specific monitoring is possible as well. For example, in the Philippines the Department of Education collaborated with G-Watch and civil society groups to establish Textbook Count, monitoring whether textbooks were delivered on time and in the promised quantities and were of good quality (Guerzovich and Rosenzweig n.d.).

Delivering quick wins

Especially in countries emerging from a shock such as conflict and transition, policy makers, service providers, and civil society should seek quick wins, investing in efforts that are clearly offering improvements in

service delivery, thereby inspiring citizens' trust and rendering the cycle of performance virtuous.

Popularize local successes; hold public awareness campaigns on citizens' rights, service delivery standards, and social norms; expand opportunities for citizen engagement; and demand a response to citizens' feedback.

States can identify and popularize local successes by using the media, awards, and other campaigns to draw attention to best practices and to the social norms of responsive and clean service delivery and government. Transparency in criteria and justification are critical in these efforts in order to avoid the real or perceived politicization or political capture of such rewards, which ultimately could undermine trust. Not only can school principals, chief medical officers, and other providers be honored at the national or district level, but the same practices can be applied within facilities. Properly implemented, such efforts not only honor those who model best practices, but also provide an opportunity to involve them in teaching and advising both peers and superiors.

Policy makers and communities can also participate in public meetings aimed at needs assessments, planning, and the implementation of projects directed at improving service delivery on a small scale. Such meetings can be solution-focused, such as addressing absenteeism and material shortages in service delivery.

The key is plugging into the existing awareness. For example, in Jordan a network of civil society organizations established to conduct legal information and awareness activities has expanded to include public awareness campaigns on drug abuse and other issues. Such interventions can be launched relatively quickly and provide citizens with actionable information on their rights and entitlements and on the existing support mechanisms toward their realization. Interventions should, however, be combined with sufficient efforts and resources to deliver on feedback because failure to do so could further undermine trust, engagement, and ultimately performance.

Moving forward

In this report, we have recognized that the MENA region is at a critical juncture, with complicated transitions and tragic conflicts on one side and a tremendous potential based on rich human and natural resources on the other. We have described how the majority of the population in the region lacks economic opportunities, faces inequalities, demands social justice, and expresses frustration and mistrust. Our analysis suggests that with visionary leadership and inclusive institutions, this vicious cycle of poor performance can be countered. A renewed social contract can allow citizens to receive better services, and empower young women and men to realize their aspirations and potential and build a brighter future for the next generation.

We argue that because of the complex circumstances found in MENA countries, it is necessary to build on evidence of local successes and positive trends at the level of institutions, performance, and citizens' trust and engagement. We hope that this report and its recommendations will help citizens, public servants, policy makers, and donors alike jointly identify and build on the present foundation to improve the delivery of social services, shifting the cycle of performance into a virtuous gear. An improved cycle of performance is what those living in the MENA countries deserve and what would enable them to fulfill their aspirations for the future.

Notes

1. The term *enabling environment* is rarely defined with precision. Fox (2014), for example, refers to actions by external allies that have two characteristics. First, they reduce the actual and perceived risks and costs often inherent in collective action. Second, they bolster the actual and perceived efficacy of collective action by increasing the likelihood or degree of a positive institutional response.

2. Alsam, Ghazia, ombudsman, Khyber Pakhtunkhwa, Pakistan, unpublished communication, based on "Aide Memoire (2014) Governance Support Project for Khyber Pakhtunkhwa, the Federally Administered Tribal Areas (FATA) and Baluchistan—P126425, Midterm review, Oct. 28–Nov. 15, 2013."
3. More information is available at http://www.dtmc.gov.ae and http://www.youtube.com/user/DTMCentre.
4. See http://leadersot.org/initiatives/diwanieh.
5. See http://www.papi.vn for more information.
6. See http://governance.care2share.wikispaces.net/Social+accountability+in+Latin+America and http://www.ciudadanosaldia.org/que-hacemos/realizamos-mediciones-y-analisis/rankincad.html.
7. Interview with U.S. Agency for Development staff, Jordan.

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This book examines the role of incentives, trust, and engagement as critical determinants of service delivery performance in the Middle East and North Africa (MENA) Region. Focusing on education and health, the report illustrates how weak external and internal accountability undermines policy implementation, service delivery performance, and citizens' trust and how such a cycle of poor performance can be counteracted. Case studies of local success reveal the importance of both formal and informal accountability relationships and the role of local leadership in inspiring and institutionalizing incentives toward better service delivery performance.

Enhancing services for MENA citizens requires forging a stronger social contract among public servants, citizens, and service providers while empowering communities and local leaders to find "best fit" solutions. Lessons learned from the variations within countries, especially the outstanding local successes, can serve as a solid basis for new ideas and inspiration for improving service delivery. Such lessons may help the World Bank Group and other donors, as well as national and local leaders and civil society, to develop ways to enhance the trust, voice, and incentives for service delivery to meet citizens' needs and expectations.

"This magnificent work is a model of multidisciplinary research and judicious harvesting of multiple sources of relevant data to assess why many MENA countries lag on vital education and health outcomes. In opening our eyes to the causes of failure, the book breaks new ground in pointing to how improvements in public services can uplift citizens and bolster the prospect for democratic governance."

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"This report highlights innovative social accountability as a crucial element in improving the quality, efficiency, and equity of educational and health provision services in the MENA Region. It looks at how innovative engagement of citizens as an entry point to monitor and evaluate education and health services can create pressure on leaders, government officials, and service providers to improve their performance."

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"This book makes valuable contributions by highlighting the importance of 'soft' inputs, notably multiple dimensions of governance, in driving the improvement of service delivery and by emphasizing the importance of the quality and not just the supply of social services. At the same time, the report delves into some of the deeper underlying social and political issues that stymie efforts to improve the quality of services in the 'cycle of performance.' The report homes in on the roots of service delivery problems, such as provider absenteeism, poor quality of teaching or medical care, and shortages of medicines and textbooks. Together, the theoretical and empirical chapters show that these problems require more than technical or financial solutions. Rather, these kinds of issues can often be addressed by devoting attention to cross-cutting components of governance such as transparency, public sector management and institutions such as the civil service or courts, and social environments that promote citizen action. Attending to bottlenecks in governance processes is necessary to solve a variety of service delivery problems."

— ***Melani Cammett, Professor of Government, Department of Government, Harvard University***

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