



WORLD BANK GROUP

HUMAN CAPITAL PROJECT

HCI COMPASS

(A Living Document)

© 2020 International Bank for Reconstruction and Development / The World Bank
1818 H Street NW
Washington DC 20433
Telephone: 202-473-1000
Internet: www.worldbank.org

This work is a product of the staff of The World Bank with external contributions. The findings, interpretations, and conclusions expressed in this work do not necessarily reflect the views of The World Bank, its Board of Executive Directors, or the governments they represent.

The World Bank does not guarantee the accuracy of the data included in this work. The boundaries, colors, denominations, and other information shown on any map in this work do not imply any judgment on the part of The World Bank concerning the legal status of any territory or the endorsement or acceptance of such boundaries.

Rights and Permissions

The material in this work is subject to copyright. Because The World Bank encourages dissemination of its knowledge, this work may be reproduced, in whole or in part, for noncommercial purposes as long as full attribution to this work is given.

Any queries on rights and licenses, including subsidiary rights, should be addressed to World Bank Publications, The World Bank Group, 1818 H Street NW, Washington, DC 20433, USA; fax: 202-522-2625; e-mail: pubrights@worldbank.org.

Disclaimer

The HCI Compass is a living document that will be updated as we learn from its implementation. If you have any comment or feedback to strengthen the usefulness of the product, please contact the Human Capital Project team at humancapital@worldbank.org.

HCI COMPASS

INTRODUCTION

Human capital is central to various aspects of the development process. First, it is an essential driver of labor productivity, which in turn drives economic growth. Second, human capital is key to ensuring growth is inclusive—(i.e. to ensure all parts of society can benefit from the fruits of growth). Third, human capital is a key building block of social cohesion and trust in institutions. Societies with high human capital and high equality of opportunity are more socially cohesive, more able to find solutions to complex challenges, and ultimately more prosperous.

The Human Capital Index (HCI) is a tool designed to measure how well a country is doing in terms of fulfilling its Human Capital potential. It converts core indicators on survival, schooling, and health into measures of future worker productivity. The HCI is a useful advocacy tool for policy makers in that it allows them to see spending in the social sectors as investments that reap

benefits in the long run. As an index that captures the distance to the frontier, it can also help countries set an explicit goal that policymakers can hope to meet.

However, as a tool for policymaking the HCI is limited. Although it identifies the broad areas in which a country is far from its potential, the HCI does not inform what to do to get there. And because it moves only very slowly, it does not provide timely feedback to policymakers on whether their policies are working. The objective of the Human Capital Index Compass is to serve as a guidance note that addresses these limitations.



The Human Capital Index Compass has two objectives:

A

First, it aims to help countries answer the question: **“What do we need to do to improve our HCI and its sub components (child survival, adult survival, stunting, years of schooling, test scores)?”** It does so by providing a checklist of key policies, legal framework and aspects of service delivery that characterize countries with good human capital outcomes and/or are proven to be important to improving the key components of the HCI. Pinpointing the set of policies and interventions that drive human capital outcomes is complicated by the fact that the underlying production function and how the different factors interact to produce outcomes is not straight forward. As such, some of the policies and service delivery indicators identified in this note could be mere correlates rather than determinants of human capital formation. The relative importance of the indicators would also vary based on where a country currently stands.

B

Second, it aims to help countries answer the linked questions: **“How well are these policies working? And how do we know we are on track?”** It does so by identifying intermediate outcome variables and benchmark variables that will help policymakers assess progress on the ground towards a better HCI. We can think of these variables both as the intermediate results of the policies recommended under point A above, and as “leading indicators” of what will happen to the HCI over time. For this, these variables need to meet at least two core criteria: they must be analytically linked to the policies recommended above and they must be good predictors for eventual changes in the HCI. These variables may be quantitative or qualitative depending on what they are trying to measure.

The HCI Compass does not intend to replace comprehensive diagnostics of constraints to human development in a country. That is something that is part of the regular dialogue on policy. What it seeks to do is to provide a checklist for policymakers to assess whether the key policies are in place; how mature and developed they are; whether they are being implemented properly on the ground; and whether they are yielding the expected intermediate results. It is, in essence, a guidance note rather than a diagnostic tool which aims to inform policy makers what data to collect and which indicators to consider in discussing policy options.

THE HCI IS COMPOSED OF THREE COMPONENTS:



SURVIVAL

Children who don't survive don't grow up to become future workers



SCHOOL

Contribution of quality-adjusted years of school to productivity of future workers



HEALTH

Contribution of health (average adult survival rate and stunting) to productivity of future workers)



PRODUCTIVITY

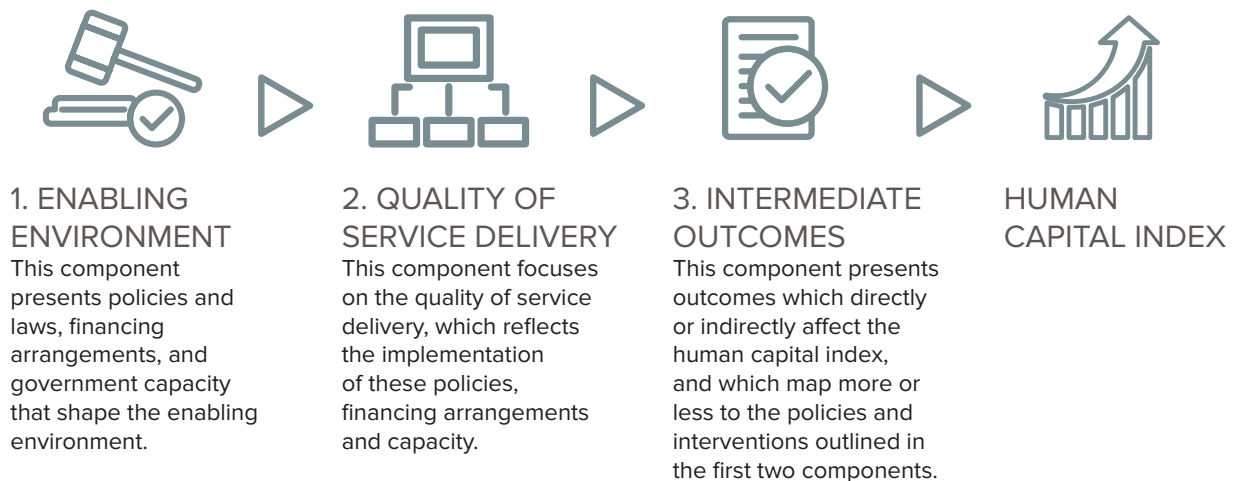
of a future worker (relative to benchmark of complete education and full health)

HUMAN CAPITAL INDEX COMPASS STRUCTURE

At its core, the guidance note assumes that households themselves produce human capital and are the ones making the decisions about investments in human capital.

But these decisions are in turn the result of their interactions with the overall policy and legal environment (the broader enabling environment in which both households and service providers operate), and with service delivery providers. So, for example, households will invest in the education of their children if quality schooling services are available and affordable and/or if the household has the resources and means to send their children to school or to educate them at home. How much they invest will also depend on what the returns are to those investments. These decisions may also be affected by social norms and culture, as well as by geography and broader infrastructure beyond the service delivery systems themselves. The same is roughly true for investments in health. Governments cannot directly impact household decisions, but they do influence the broader enabling environment and they greatly influence and shape service delivery systems. Even in the absence of service delivery, governments can nudge households to invest in their children's human capital.

With this background in mind, the HCI Compass has three distinct components. The first two align with those areas that governments can influence. The intermediate outcomes are, in a way, leading indicators of what we expect to see in the HCI, which can be thought of the final outcome of this chain.



Policymakers in a country would use the HCI Compass as a guide, adapting it to their particular needs and challenges. For example, a country that is lagging in stunting but doing well on test scores would naturally focus more on the policies that pertain to improving stunting outcomes. The guidance note can (and should) be tailored and adapted to country needs, circumstance and data availability. It is a self-assessment, carried out by countries' own policymakers with or without technical support from the World Bank or other development partners, depending on what a country wants or needs.

To capture equity, indicators need to be disaggregated along social, economic, demographic, or geographic lines, depending on the aspect of equity that is most pressing in the country.

1. ENABLING ENVIRONMENT

1.1 Policies and Legal Framework

Nurturing human capital requires a conducive policy environment as the latter affects household decisions and the quality of service delivery- two critical determinants of human capital outcomes. Households represent the key driver of demand, while providers shape supply. The behavior of both households and providers are influenced by policies, systems and legislation.

While not all demand side factors can be directly affected by actions taken by governments, certain legal and policy measures may create the space for improving utilization of services. Poor and vulnerable households often struggle to make rewarding investments in their children because they are financially constrained and find the alternative use of their kids' time (child labor) appealing in the short run. As these price considerations are critical determinants of utilization of services, it is important that policies are in place to remove user fees for basic education and essential healthcare. Even when these services are available for free, their utilization by the chronically poor cannot be guaranteed due to related expenses and the opportunity costs involved. The chronically poor may also have sub-optimal investments on their nutrition and other aspects that determine human capital outcomes. The quality of policies to identify and target the poor and the governments' readiness to protect the vulnerable from the ill-effects of disasters are key in this regard.

In addition to these measures that relax financial constraints to human capital investments, legal measures can be taken to alter parental preferences through compulsory basic education, forbidding child labor and creating a conducive environment to facilitate learning (educating kids in their mother tongue). As health

outcomes and cognitive skills are partly determined by what happens at the earliest stage of development, parental knowledge and awareness about optimal child development practices are critical. In this vein, the maturity of policies to prevent early pregnancy, promote healthy pregnancy, ensure safety and promote Early Child Development (ECD) and nutrition services are crucial; mothers that start child bearing later in life are more likely to be educated, have fewer children and invest better in their children. Policies and legal frameworks also affect the longevity and quality of life of the productive workforce through, for example, tax and non-tax policies that discourage the consumption of unhealthy products which are known to contribute to chronic diseases and premature death (including road traffic accidents).

Even when the demand for services is revealed, poor service delivery affects human capital outcomes. This is partly why we have the learning crisis. Although huge progress is made in terms of bringing kids to school, the low quality of schooling leaves children without the foundational skills they need to be productive. The quality of services people receive in both schools and health facilities is a function of the quality of providers, availability of infrastructure and other inputs. The maturity of policies that set these standards and the monitoring mechanisms to ensure them will determine the rate at which resources will be converted into human capital outcomes.

Table 1.1 provides a list of guiding questions to assess de jure policies and legal framework. De facto policy implementation will be assessed through the guiding questions in the quality of service delivery and intermediate outcomes sections.

TABLE 1.1. POLICIES AND LEGAL FRAMEWORK

GUIDING QUESTIONS TO ASSESS WHAT NEEDS TO BE IN PLACE	SCALE OF RESPONSE	REMARK
<p>P1. How adequate is the country’s policy and legal framework to ensure equitable human capital development?</p> <ul style="list-style-type: none"> Has the country established a framework for quality education and learning for all? Has it established Universal Health Coverage? Has it put in place a core national system of social protection to protect households from extreme poverty and shocks? 	Scale to be defined.	
<p>P2. Have user fees been removed for essential health care (childbirth, immunizations, nutrition services, emergencies, family planning) and basic education?</p>	Scale to be defined.	
<p>P3. How mature are the policies or strategies that establish early childhood development as a priority?</p>	Scale to be defined.	Refer to System Approach for Better Education Results (SABER) .
<p>P4. How adequate are policies/programs for prevention of early pregnancy?</p> <ul style="list-style-type: none"> Does the legal framework establish access to family planning (including for adolescents)? What is the legal age of marriage (<18 or >=18)? 	Scale to be defined.	
<p>P5. How adequate are policies/programs to guarantee safety in the provision of education and health services?</p>	Scale to be defined.	In the education sector, this refers to safety from physical, sexual and psychological abuse and in health it also refers to safety from infections. Refer to Global Program for Safer Schools and WHO’s Guide to Patient Safety Policy .
<p>P6. How developed is the country’s foundational identity system – civil register, population register, and/or national ID system?</p> <ul style="list-style-type: none"> Is there a clear legal framework? Are registration and documentation free? Are the systems accessible in terms of – time, distance, procedures? Is privacy protected and technology robust? Are the systems interoperable with other systems or programs? 	Scale to be defined.	Refer to Guidelines for ID4D Diagnostics .
<p>P7. How mature are policies to establish quality of standards for inputs and infrastructure and monitoring mechanisms in.....?</p> <p>a) education sector</p> <p>b) health sector</p>	Scale to be defined.	This will include a judgment as to whether or not standards for disability-friendliness of facilities exist. The monitoring mechanisms should consider presence of pre-service (upon graduation) and periodic assessment of providers’ competency (not only knowledge). Refer to Global Education Policy Dashboard (GEPD) and adapt it for the health sector.
<p>P8. How mature are the policies to attract, select, support, evaluate, and monitor.....?</p> <p>a) teachers</p> <p>b) healthcare workers</p>	Scale to be defined.	Refer to GEPD and adapt it to healthcare worker.
<p>P9. How mature are the policies that stipulate and allocate key management functions as well as policies to attract, select, support, and evaluate principals (school management)?</p>	Scale to be defined.	Refer to GEPD .

TABLE 1.1. POLICIES AND LEGAL FRAMEWORK (CONTINUATION)

GUIDING QUESTIONS TO ASSESS WHAT NEEDS TO BE IN PLACE	SCALE OF RESPONSE	REMARK
<p>P10. Is the legal framework conducive to school attendance, completion and learning?</p> <ul style="list-style-type: none"> a) Does the legal framework establish compulsory schooling through lower secondary level? b) Does the legal framework forbid child labor? c) Is the language of instruction in the early grades different from native tongue? 	<p>Scale to be defined.</p>	
<p>P11. How developed is the country's system to identify the poor and vulnerable to direct programs and benefits?</p> <ul style="list-style-type: none"> • Is there one or multiple social registry(ies)? • What is the legal, regulatory and policy framework? • Are the intake or registration processes accessible? • What is the periodicity of registration? • Is it interoperable with the ID system and social programs? • Are there established management standards, guidelines and processes for operating the Social Registry? 	<p>Scale to be defined.</p>	<p>Refer to Social Registries for Social Assistance and Beyond: a Guidance Note and Assessment Tool.</p>
<p>P12. Is the national disaster risk management framework adequate to protect human capital?</p> <ul style="list-style-type: none"> • Does the legal framework for disaster risk management include shock-responsive safety net programs? • Does it include a plan to ensure social infrastructure is resilient or included in reconstruction plans? • Does it have an early warning system to trigger social responses? • Does the country have a financing plan in place to fund emergencies? • Are there strong coordination mechanisms in place? 	<p>Scale to be defined.</p>	<p>Refer to framework presentation and in-depth presentations on various elements here and here.</p>
<p>P13. How adequate are policies to address malnutrition?</p> <ul style="list-style-type: none"> • Are nutrition services (preventive and treatment) included in UHC minimum package of services? • Are nutrition services linked to demand side interventions such as conditional cash transfers and behavioral change interventions? • Is there code for marketing of breast-milk substitutes? • Is there legislation on Universal Salt Iodization? 	<p>Scale to be defined.</p>	
<p>P14. How mature are policies to adequately discourage the consumption of goods such as tobacco, alcohol and sugary beverages through fiscal policy and non-price instruments?</p> <ul style="list-style-type: none"> • Is there complete ban on advertisement and promotion of tobacco products (direct and indirect) • Is there complete ban on smoking in all public spaces? • Is excise tax on cigarettes more than 70% of the retail price of the most popular brand? • Does the country have excise tax on sugar sweetened beverages? • What is the legal alcohol drinking age? • Are there restrictions to alcohol advertisement and promotion? 	<p>Scale to be defined.</p>	
<p>P15. How mature are policies to promote road safety?</p> <ul style="list-style-type: none"> • Do they allow for the management and monitoring of road safety performance based on a safe system through a dedicated agency which is responsible for road safety for the country? • Do they manage speeds down to safe system levels which provide appropriate to the road users present (30km/h where vulnerable road users – especially pedestrians and bicyclists are present; 50km/h where side impact crashes are possible, etc.)? • Do they ensure that vehicles sold meet minimum standards for safety (as set by UN conventions) and keep up to date on maximizing the introduction of new safety technologies? • Do they require safety of road design to the highest standard in the construction, expansion, and maintenance of roads? • Do they deliver strong general deterrence of risky road user behaviors through well publicized, uncorrupted effective enforcement with unavoidable penalties which effectively deter? • Do they deliver effective rapid post-crash care with well-resourced facilities and well-trained medical staff, available to all regardless of financial means to pay? 	<p>Scale to be defined.</p>	
<p>P16. How adequate are policies to promote women's labor force participation?</p> <ul style="list-style-type: none"> a) Is there mobility restriction for women? b) What is the country's score in the Women, Business and the Law Index?" 	<p>Scale to be defined.</p>	<p>Refer to Women, Business and the Law.</p>

TEXT COLOR KEY

- Cross Sectoral Indicators
- Education Sector Indicators
- Social Protection and Jobs indicators
- Health, Nutrition and Population Indicators

1.2 FINANCING

Public investment in the social sectors is critical to improve human capital outcomes. Health and education systems that mainly rely on out-of-pocket payments are likely to leave some section of the society behind. Since these sectors are grossly underfunded in most low-income and lower middle-income countries, policy measures that aim at increasing the per capita spending on health, education and social protection or their prioritization in the government budget are essential. Equally important as the volume of spending is a country's budgeting process- its reliability, predictability and execution- issues at the center of Public Expenditure and Financial Accountability assessment (PEFA). Human capital outcomes also depend on allocative decisions within a sector budget. Many of the most-cost effective interventions that augment human capital development happen at primary levels of

care, basic education and social assistance. The relative budget allocated to this level of care is, hence, an important consideration in creating a conducive enabling environment.

Table 1.2 presents a list of guiding indicators related to financing and public financial management. It is crucial to note that more spending is not necessarily the solution nor is there a magic level of spending countries should aspire to. Progress in these dimensions should be monitored in light of a country's context (coverage of critical interventions, room for efficiency gains, etc). Disaggregating these indicators at sub-national levels and looking at benefit incidence across socio-economic groups is also critical (please refer to [BOOST Public Expenditure Database](#) for disaggregated expenditure data)

TABLE 1.2 FINANCING

	GUIDING QUESTIONS TO ASSESS WHAT NEEDS TO BE IN PLACE	SCALE OF RESPONSE	REMARK
FINANCING	F1. Per capita health expenditure (public, private and total).	Continuous measure.	
	F2. Share of government health expenditure spent on primary health care.	Continuous measure.	
	F3. Nutrition spending as percentage of health expenditure.	Continuous measure	Where available, nutrition expenditure includes nutrition sensitive expenditures outside the health sector.
	F4. Government expenditure per student in pre-primary education as a percentage of GDP per capita.	Continuous measure.	This can also be per child spending, where the denominator is the age specific population size corresponding to preprimary and primary level.
	F5. Government expenditure per student in primary education as a percentage of GDP per capita.		
	F6. What is the status of the country's public financial management (using PEFA assessment).	Scale A to D.	
	F7. Spending on social assistance as % of GDP.	Continuous measure.	
	F8. Spending on social insurance as % of GDP.	Continuous measure.	
	F9. Spending on labor market interventions as % of GDP.	Continuous measure.	

TEXT COLOR KEY

- Cross Sectoral Indicators
- Education Sector Indicators
- Social Protection and Jobs Indicators
- Health, Nutrition and Population Indicators

1.3 GOVERNMENT CAPACITY TO MANAGE

The weak-link between social sector spending and outcomes that we often see in low income settings is a product of poor planning and management across the state machinery. Government capacity to manage, adopt a meritocratic system and inculcate accountability is critical to convert resources allocated to social sectors into human capital outcomes. High performing public systems rely on data and evidence to adjust service delivery, inform policy and operational decisions such as those that relate to procurement, personnel management, targeting etc. Where a country lies in continuum of a politicized-meritocratic system would determine how effective and efficient

service delivery will be; the closer to a purely meritocratic system a country is the higher the value for money. The partiality-impartiality of decision making will determine bureaucrats' capacity and motivation to deliver results. A government system that clearly defines mandates and shows transparency in accountability and instills mechanisms to enforce quality standards has a better chance of converting resources into better outcomes.

Table 1.3 presents a list of guiding questions to monitor government's capacity to manage and achieve value for money.

TABLE 1.3. GOVERNMENT CAPACITY TO MANAGE

	GUIDING QUESTIONS TO ASSESS WHAT NEEDS TO BE IN PLACE	SCALE OF RESPONSE	REMARK
GOVERNMENT CAPACITY TO MANAGE	G1. Is core decision-making impartial, as measured by extent of a) politicized personnel management, b) politicized policy-making, c) politicized procurement and d) politicized identification or targeting processes.	Scale to be defined.	Refer to GEPD .
	G2. What is the quality of bureaucracy, as measured by a) knowledge and skills, b) work environment, c) merit, and d) motivation?	Scale to be defined.	Refer to GEPD and Bureaucracy Lab .
	G3. To what extent does the system (health, education, social protection, other) collect and utilize data for planning and service delivery?	Scale to be defined.	
	G4. Is there monitoring and enforcement of quality standards in education and health sectors?	Scale to be defined.	
	G5. Is there clarity, coherence and transparency of accountability & mandates?	Scale to be defined.	

TEXT COLOR KEY

- Cross Sectoral Indicators
- Education Sector Indicators
- Social Protection and Jobs Indicators
- Health, Nutrition and Population Indicators

2. QUALITY OF SERVICE DELIVERY

Quality of service delivery is a critical driver of human capital outcomes as the latter is partly determined by different forms of services utilized. Service delivery is where the policies, legal frameworks, financing arrangements and overall government capacity manifest their effectiveness. This can be assessed in the following three ways:



AVAILABILITY OF PROTOCOLS, INPUTS AND INFRASTRUCTURE

These are ingredients that service providers have to work with. In the education sector, this refers to the percentage of schools with electricity, drinking water, functioning toilets, blackboard, chalk etc. The health sector is a little more complicated as input requirements vary across disease burden and life cycle of patients. In much of low-income and lower middle-income countries, a large part of the disease burden is communicable diseases. It is important to make sure that the sector is equipped to diagnose, treat and manage these diseases. In addition to the volume of health professionals and presence of condition specific protocols that are relevant for different age groups and diseases, inputs for quality childbirth experience are critical in most low-income countries where a significant share of under 5 mortality happens in the first 28 days.



COMPETENCE OF SERVICE PROVIDERS

Across both the education and health sector, competence of service providers is a critical constraint. In the education sector, content knowledge and pedagogical skills of teachers determine student learning. The effectiveness of the teacher-student interaction is a function of the competence of school principals. The same applies to the health sector, especially for conditions where provider training is thin. As the relative importance of non-communicable diseases among adults increases, the competence of primary care providers to provide drug therapy and counseling to individuals who have had a heart attack/stroke determines human capital outcomes (such as adult survival rate and productivity of work force). For the provision of social protection benefits and services, the quality of service providers is also essential to ensure they reach the poor and vulnerable with relevant messages and benefits.



SERVICE PROVIDER PRACTICE AND ADHERENCE TO PROTOCOLS

Various studies have shown that competence alone may not guarantee quality service delivery as motivation, provider effort and practice matter (this is what is often referred to as the know-do gap). Provider effort can be measured by the presence or absence rate of providers, especially those of teachers. For various reasons, health providers in most low-income settings are either unable or not motivated enough to practice what is stated in condition specific protocols. From the perspective of human capital outcomes (under five mortality), critical areas to monitor include the extent to which all dimensions of essential newborn care and integrated management of childhood illnesses are practiced. From the perspective of social protection schemes, quality of service delivery can be measured by the utilization of social registry for social assistance programs, the rates of inclusion and exclusion in safety net programs and the regularity of support, and the extent to which programs effectively implement accompanying measures such as information, counseling, and training activities.

TABLE 2.1 QUALITY OF SERVICE DELIVERY

Table 2.1 presents indicators to measure the adequacy of these inputs and infrastructure and monitor the competence and practice/adherence of providers.

GUIDING QUESTIONS TO ASSESS WHAT NEEDS TO BE IN PLACE	SCALE OF RESPONSE	REMARK
Q1. Number of active skilled health professionals (doctors, midwives, nurses) who are actively providing clinical care per 10,000 population.	Continuous measure.	Refer to Global Health Observatory (Inputs).
Q2. Proportion of facilities which had stock-outs of essential medicines in a specified period.	Continuous measure.	Refer to Service Delivery Indicators (SDI) (Inputs).
Q3. How endowed are childbirth facilities with inputs necessary to provide high quality childbirth care, including emergencies (this includes competent personnel)?	Scale to be defined.	(Inputs).
Q4. How widely are condition specific protocols for management of patients in place?	Continuous measure.	Pick a couple of conditions that are most relevant for a country. Refer to Service Availability and Readiness Assessment (SARA) .
Q5. Is the health sector equipped for adequate diagnosis, treatment and management of communicable conditions such as Tuberculosis, Malaria and HIV/AIDS?	Scale to be defined.	This is a proxy for quality of care for communicable diseases. (Inputs).
Q6. Can the health system diagnose, triage and treat malnutrition?	Scale to be defined.	(Inputs).
Q7. Percentage of primary care providers competent to provide drug therapy and counseling to individuals who have had a heart attack or stroke and to high risk individuals (using vignettes).	Continuous measure.	This is a proxy for quality of NCD care for adults (Competence).
Q8. Proportion of newborns who received all four elements of essential care: i) immediate and thorough drying ii) immediate skin-to-skin contact, iii) delayed cord clamping, iv) initiation of breastfeeding in the first hour.	Continuous measure.	The focus on newborns is justified because most U5M happens in the first 28 days. (Practice/adherence).
Q9. How widely is integrated management of childhood illness practiced?	Scale to be defined.	(Practice/adherence).
Q10. PHCPI quality index.	Continuous measure.	Please refer to Primary Health Care Performance Initiative (PHCPI) (comprehensive measure).
Q11. UHC Service Coverage Index.	Scale to be defined.	Refer to Tracking UHC .
Q12. Quality of inputs, measured by percentage of schools with (a) functioning blackboard and chalk, (b) pens, pencils, textbooks, and exercise books in 4th grade classrooms, (c) basic classroom furniture (tables/desks and chairs), and (d) information technologies.	Scale to be defined.	Refer to GEPD or SDI (Inputs).
Q13. Quality of infrastructure as measured by percentage of schools with (i) drinking water, (ii) functioning toilets (separate for girls), (iii) classroom visibility, (iv) electricity, (v) and accessibility for people with disabilities.	Scale to be defined.	Refer to GEPD and SDI (Infrastructure).
Q14. Quality of teaching as measured by percent of teachers with at least minimum content knowledge, b) percent of teachers with a given level of pedagogical skills, c) presence/absence rate [grade-specific as relevant].	Scale to be defined.	Refer to GEPD and SDI (competence + practice/adherence).
Q15. Quality of school management as measured by a) percent of schools where instructional leadership is present, b) percent of principals with a good understanding of their schools, c) percent of principals with a good command of management practices, d) percent of schools with operational functions covered.	Scale to be defined.	Refer to GEPD (competence).
Q16. Quality of the social registry (as measured by the extent to which the data is up-to-date, the number of programs using the registry to identify their beneficiaries, and/or the share of social assistance budget directed through it, etc.).	Continuous measure.	Refer to Social Registries for Social Assistance and Beyond: a Guidance Note and Assessment Tool .
Q17. Quality of targeting of safety net programs (measured by rates of inclusion or exclusion, by program type).	Continuous measure.	
Q18. Quality of content of safety net programs (measured by share of programs which provide information services or incentives for increased investments in human capital, or share of beneficiaries from these programs).	Continuous measure.	
Q19. Quality of services provided by safety nets (measured by the share of program staff who are qualified social workers).	Continuous measure.	
Q20. Quality of safety net transfers, measured by the adequacy of benefits, the regularity of payments, and the share of payments made through financially-inclusive accounts or electronic means.	Scale to be defined.	

*PHCPI quality index is a composite measure of quality based on comprehensiveness of services provided, continuity, person-centeredness, provider availability, provider competence and safety. This index can be used where data exist.

3. INTERMEDIATE OUTCOMES

One of the objectives of the HCI Compass is to help countries gauge if they are on the right track to improve their human capital outcomes. Putting in place the critical policies, laws, public financing, transparency and accountability mechanisms is meant to influence service delivery quality and its use by households. It is only if the enabling environment and its impact on service delivery translate to some household/individual level outcomes, would we find improvement in human capital outcomes. The pressing question, from the perspective of enabling course correction within a government’s political cycle, is “which types of intermediate outcomes to track on a frequent basis”.

These indicators need to be leading indicators to the HCI, analytically linked to the policies and amenable to change with some government action. While most of the indicators presented below fulfill the criteria of being relatively more amenable to change with some action (compared to the HCI), some do not. The latter are chosen with the objective of providing governments with a broader set of indicators to account for the complexity of the human capital production function.

The fact that human capital outcomes have

a complex production function makes it necessary to improve along a wide range of intermediate outcomes simultaneously. While a one-to-one positive association between these indicators and the HCI may not necessarily exist, improvements along these dimensions altogether would bring about improvements in the index.

The set of intermediate indicators chosen here either directly affect the index components (e.g enrollment rates), or are indirectly related to the components of the index (e.g. the relevance of early pregnancy and early marriage to infant mortality, the association of fertility rates with per capita human capital investment, the link between maternal and child health services with infant mortality and stunting, the link between road traffic accidents and hypertension with adult survival, etc.).

Table 3.1 presents a list of intermediate indicators and indicates how these indicators roughly map to the list of enabling environment and service delivery level indicators presented above.



TABLE 3.1. INTERMEDIATE OUTCOMES

ENABLING ENVIRONMENT LEVEL INDICATORS*	SERVICE DELIVERY LEVEL INDICATORS (IMPLEMENTATION)**	INTERMEDIATE OUTCOMES (AT HOUSEHOLD OR INDIVIDUAL LEVEL)
P1-3	Q1-8, Q10-15	1. PHCPI access index (summary index of perceived financial and geographic barriers to access) (Refer to PHCPI). 2. Proportion of women of reproductive age (15-49) who have their need for family planning satisfied with modern methods. (Refer to Demographic and Health Survey (DHS), Multiple Indicator Cluster Survey (MICS) or World Development Indicators (WDI)). 3. Percentage of pregnant women receiving all guideline-recommended actions during antenatal care visits (including iron-folic acid supplementation, immunizations, STI screening and advice on breastfeeding, complementary feeding and weight gain during pregnancy)). 4a. Proportion of births attended by skilled personnel (Refer to DHS) 4b. Proportion of women receiving oxytocin within 1 min of birth of infant (denominator includes out-of-facility births). 5. Share of target population covered with all vaccines included in national program (Refer to DHS or MICS). 6. Proportion of children under 5 receiving appropriate Vitamin A supplementation (Refer to DHS or MICS). 7. Percentage of women who receive appropriate routine cervical cancer screening 8. Prevalence of normal blood pressure, regardless of treatment status. (Refer to the World Health Organization's STEPS Instrument). 9. Enrollment rate at pre-primary level (Refer to UNESCO Institute for Statistics (UIS)). 10. Enrollment rate at primary level (Refer to UNESCO Institute for Statistics (UIS)). 11. Drop-out rates at end of primary (Refer to UNESCO Institute for Statistics (UIS)). 12. Enrollment rate at secondary level (Refer to UNESCO Institute for Statistics (UIS)). 13. Foundational skills for children upon entering schools (Refer to GEPD).
P4-5, 7-9	Q12-15	14. Prevalence of early marriage (Refer to DHS). 15. Prevalence of early pregnancy (Refer to DHS). 16. Prevalence of violence (GBV, including violence by teenagers) (Refer to WDI). 17. Perceptions/awareness of parents and children on value of education. 18. Percentage of children reading by age 10 (Refer to Learning Poverty). 19. Drop-out rates at end of secondary (Refer to UNESCO Institute for Statistics (UIS)). 20. Percentage of children with disabilities currently excluded from the schooling system (Refer to available census data).
P10	Q12-15	21. Percentage of children not attending school (Refer to UNESCO Institute for Statistics (UIS)). 22. Incidence of child labor (Refer to UNICEF Data Warehouse). 23. Learning gaps between majority and minority/indigenous children and between the bottom and top quintile I (Refer to UNESCO Institute for Statistics (UIS)).
P11-12, F7-8	Q16-20	24. Coverage of the social registry, as measured by the share of the country's population covered, share of the bottom quintile covered, or share of the poor registered. (Refer to Social Registries for Social Assistance and Beyond: a Guidance Note and Assessment Tool). 25. Coverage of safety net programs, measured as share of population which benefits (or number of beneficiaries) and share of poor households (or households in the bottom quintile or bottom 2 quintiles) who are beneficiaries of programs). 26. Poverty impact of social safety nets, measured by the difference in pre- and post-transfer poverty incidence, poverty gap, and consumption of the poor. 27. Coverage of labor market programs, measured by the number of beneficiaries of programs that foster the labor force participation or earnings of women and/or youth. 28. Coverage of shock-responsive social protection programs measured by the share of shock-affected poor and vulnerable households supported by programs during the most recent large-scale covariant shock

TEXT COLOR KEY

- Cross Sectoral Indicators
- Education Sector Indicators
- Social Protection and Jobs indicators
- Health, Nutrition and Population Indicators

*Corresponds to “Enabling Environment” indicators in Table 1.1, 1.2 and 1.3. (P=policies; F=financing; G=government capacity)

**Corresponds to “Service Delivery” level indicators in Table 2.1. (Q=quality of services)

TABLE 3.1. INTERMEDIATE OUTCOMES: (CONTINUATION)

ENABLING ENVIRONMENT LEVEL INDICATORS*	SERVICE DELIVERY LEVEL INDICATORS (IMPLEMENTATION)**	INTERMEDIATE OUTCOMES (AT HOUSEHOLD OR INDIVIDUAL LEVEL)
P3-4, P13	Q9	29. Proportion of infants 0–5 months of age who are fed exclusively with breast milk (Refer to DHS) 30. Proportion of children 6–24 months of age who are fed breast milk (Refer to DHS) 31. “Proportion of children 6-24 months with Minimum Acceptable Diet. (Refer to DHS)”
P6, P15	Q16	32. Percentage of adults with a national ID number (or percentage of adults with an ID card). (Refer to ID4D) 33. Percentage of children under age 5 whose births are registered (Refer to UNICEF data) 34. Number of road traffic deaths per year (Refer to Global Health Observatory)
F1-2		35. Percentage of households at risk of catastrophic and impoverishing health expenditures (different thresholds) (Refer to Health Equity and Financial Protection Indicators (HEFPI)) 36. Out of pocket health expenditures as a percentage of total health expenditure (Refer to Health Equity and Financial Protection Indicators (HEFPI))
F8		37a. Female labor force participation (%) 37b. Youth employment (%) (age 15-29) (Refer to International Labor Organization Statistics (ILOSTAT))”

TEXT COLOR KEY

- Cross Sectoral Indicators
- Education Sector Indicators
- Social Protection and Jobs indicators
- Health, Nutrition and Population Indicators

*Corresponds to “Enabling Environment” indicators in Table 1.1, 1.2 and 1.3. (P=policies; F=financing; G=government capacity)

**Corresponds to “Service Delivery” level indicators in Table 2.1. (Q=quality of services)

HUMAN CAPITAL PROJECT

The Human Capital Project is a global effort to accelerate the quantity and quality of investments in people to promote sustained and shared economic growth. The project aims to create the political space for national leaders to prioritize transformational investments in health, education and social protection. The objective is rapid progress toward a world in which all children are well nourished and ready to learn, can attain real learning in the classroom, and can enter the job market as healthy, skilled, and productive adults.

The HCI Compass is a product of the Human Capital Project prepared in close collaboration with the Education Global Practice, the Health, Nutrition and Population Global Practice, and the Social Protection and Jobs Global Practice of the World Bank.

www.worldbank.org/humancapital

