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Population, Health, and Nutrition

Population and Human Resources
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Population, Health, and Nutrition

Fiscal 1990 Sector Review

Population, Health, and Nutrition Division
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The population, health, and nutrition (PHN) share of total Bank lending has grown rapidly in recent years, increasing from 0.3 percent of total lending in fiscal 1987 to 4.5 percent in fiscal 1990. In addition, PHN work focuses much more on policy than it did in the past.

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This paper — a product of the Population, Health, and Nutrition Division, Population and Human Resources Department — is part of a larger effort in PRE to increase awareness of the lessons learned from the Bank's operational work. Copies are available free from the World Bank, 1818 H Street NW, Washington, DC 20433. Please contact Otilia Nadora, room S6-065, extension 31091 (69 pages, with tables).

World Bank lending in the population, health, and nutrition (PHN) sectors increased significantly in fiscal 1990. Over the past five years, PHN lending has grown rapidly both in the number of projects and in the amounts of loans and credits. The future lending portfolio indicates continued growth. Bank support of nutrition activities, both within the PHN sectors and as components of projects outside the PHN sectors, has expanded significantly.

The content and focus of PHN lending and sector work during fiscal 1990 respond to the needs of borrowing countries and to the Bank's emphasis on human resources development and poverty, and reflects the pertinent issues that PHN sector development work poses today. PHN work now focuses much more on the policy level than it did in the past. Health financing issues continue to be rigorously addressed as a priority. The use of local consultants and the participation of beneficiaries in Bank work is on the rise. Increased attention has been focused on NGOs in recognition of the important role they play in the PHN sectors. Social sector development operations, a new feature of PHN lending, have presented challenges to the Bank because of the streamlining and coordinating of roles and responsibilities in the Bank and at the national level that they require. Efforts to raise cofinancing and coordinate aid are being intensified because of the acute shortages of resources for the sectors in many borrower countries.

The Bank still faces important challenges in its effort to improve the effectiveness of its interventions in the PHN sectors. First and most important, the Bank has not yet comprehensively addressed all facets of the population issue, which encompass full and rigorous consideration by country operations and senior management staff, as well as effective and efficient delivery of family planning services. Second, while most PHN staff appreciate the importance of addressing management and institutional development issues, the quality and depth of PHN interventions in this regard vary.

The review suggests a number of recommendations for further improving the Bank's performance in the PHN sectors. On the technical side, the Bank should (1) continue to focus and improve its interventions at the policy level; (2) address management and institutional development issues more rigorously and comprehensively through project, sector, and research work; (3) squarely address and encompass the role of the private sector and NGOs in the design and delivery of PHN interventions; and (4) continue efforts to address and resolve PHN financing issues, given its comparative advantage in this regard.

Internally the Bank should (1) address the need to expand staff to accommodate continued growth likely in Bank work in the PHN sectors and (2) encourage greater use of experts from developing countries and the participation of beneficiaries in Bank work.

Because a population strategy paper is at an advanced stage of preparation, this review withholds suggestions for improving the effectiveness of the Bank's work in the population sector.

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EXECUTIVE SUMMARY

1. The volume of lending in the PHN sectors showed continued and significant growth in FY90: 18 PHN operations were approved during the fiscal year, valued at US$933.4 million--a 64 percent increase in the number of projects approved over the FY89 level of 11, and a 70 percent increase over the FY89 lending volume of US$550 million. In fact, both in terms of number of projects and loan/credit amounts, the volume of PHN lending has grown rapidly over the past five years. The significant reduction in lending volume, which occurred in FY87, was a temporary phenomenon, largely attributable to slippage in the lending program caused by the reorganization. The growth since that year, however, permitted a rapid recovery: FY90 figures exceed those of FY86, the year prior to reorganization, by an overall increment of seven projects and by a virtual doubling in the value of lending program. Of the 18 operations approved in FY90, 12 are straight PHN projects and six are social development projects--multi-sectoral operations encompassing the PHN and education sectors, and, in some cases, other sectors, as well, such as water and sanitation, urban, agriculture, women in development. The distribution of FY90 operations by region reveals that almost one half of them (eight) were in the Africa region, six in LAC and two each in the Asia and EMENA regions. The volume of sector work is also on the rise. In FY90, 32 PHN sector reports were completed, three more than the FY89 level, of which 15 were for the Africa region, 8 for Asia, 5 for EMENA, and 4 for LAC.

2. The future lending portfolio indicates a continuation of the growth in lending. The FY91 program is comprised of 20 projects valued at US$940 million, reflecting a growth in numbers of operations of 11 percent and in loan/credit amounts of 1 percent over FY90. The FY92 program indicates further increase over the FY91 program by 45 percent in terms of projected numbers of operations and by 43 percent in terms of projected loan/credit amounts. Such anticipated growth, even when discounted by a pipeline factor, is significant. About one-half of operations planned for FY91-92 are in the Africa Region, with the balance being rather evenly distributed across the remaining three regions. The FY91-94 Sector Work Program also shows a continued, strong emphasis on the Africa region: of the 77 sector reports planned over the next four years, 52 (or 67 percent) will be focused on Africa.

3. There are a number of reasons for the momentum in actual and forecasted growth in PHN lending. First, while population has been accorded high priority by the Bank for many years, efforts are currently being intensified to stimulate a demand for and a consequent increase in operations in this sector. Second, the demand for family planning and other population interventions is expected to continue to grow, as more governments, particularly those in Africa, come to fully appreciate the negative impact of population growth on development prospects, as well as the health benefits of family planning services. Third, human resource development is accorded very high priority, in the context of overall economic reform and development objectives, by both the Bank and national policy makers, whose dialogues have culminated oftentimes in human resource development strategies. These strategies, in turn, seek the support of various types of Bank interventions, including PHN operations, and PHN components in social development, SAL/SAC and SECAL operations. Fourth, many countries' health sectors, in particular, are currently poorly organized and financed, and face both rapidly escalating service costs and expanding consumer demand. Fifth, the growth in nutrition activities, which began just after reorganization, has accelerated during FY90 and is expected to continue in terms of its presence in PHN lending (including free-standing and integrated projects), as well as its presence in other multi-sectoral and structural adjustment operations.

4. The content and focus of PHN lending and sector work undertaken during FY90 responds to the Bank's emphasis on human resources development and on poverty, and is reflective of

pertinent issues and challenges posed by PHN sector development work today. Salient features and some shortcomings in project and sector work undertaken during FY90 to address sector issues are highlighted below:

(a) The categorization of population as a sector and its grouping in the Bank with the health and nutrition sectors have clouded an important issue, which has constrained the Bank's potential for making urgently needed gains on the population front. Rapid population growth has a dramatic impact on the economic development prospects of many countries. As such, not only must the issue of population growth be fully appreciated by staff who carry the responsibility for macroeconomic and structural adjustment dialogue and operations, it must be rigorously addressed by them as a crucial and integral part of their responsibilities. Family planning, while an obvious and important intervention in support of abating population growth, is not the only intervention at hand. Levels of education, employment, urbanization, the status of women, to name a few, constitute some of the other factors, which determine actual and desired family size. These determinants of population growth, therefore, need to be more rigorously addressed by staff responsible for macroeconomic dialogue and operations, as well as by the sectoral staff, whose policy and operational interventions could have some impact on these factors.

(b) A second challenge, which the Bank -- PHN staff in particular -- is facing is to increase the volume and effectiveness of family planning programs in the face of their various stages of development (from well-established programs, whose gains are beginning to plateau, as in some Asian countries, to new or nascent programs, some of which are not yet effectively meeting demand, which are in need of basic organizational and design assistance, and which are emerging with, and sometimes without, officially pronounced population policies, as in most African countries.) The growing numbers of governments providing family planning services, and the growing number of women of reproductive age, taken together with USAID's warning that it cannot continue to underwrite contraceptive supply indefinitely, implies increased demand for Bank resources in this area. In fact, the larger question, within which the commodity issue lies, is that of the almost inevitable demand for increasing Bank support, given the stagnant level of funding from other sources.

(c) The Bank has made some strides in the population sector in FY90. In summary, the encouraging news in FY90 lies more in the number and geographical range of lending for population than in the amount of lending alone, though this too was up, and more projects showed substantial support to population than was evident last year. The stimulus to population activities given by cofinancing, particularly in social development projects, has also been very encouraging. The report's overview of the population sector has concentrated on themes that have run through the FY90 program -- increased donor coordination, increased use of NGOs, and increasing integration of population into country development strategies.

(d) PHN work is focussed much more now at the policy and program levels than in the past. Sector dialogue is increasingly carried out in the context of broader, oftentimes, multi-sectoral initiatives or dialogues between the Bank and national governments. Bank investments are more strategic and programmatic in nature, supporting a portion of broader and longer-term policies and programs, and provide for capacity building in policy reform, investment planning, program design, implementation and evaluation.

(e) Efforts to coordinate aid, whether through formal cofinancing arrangements, or less formal means, are being intensified, given acute shortages in resources for the sectors, and are being facilitated by the policy/program approach mentioned above.

(f) Key management/institutional development issues in the PHN sectors are numerous and complex and are crucial to achieving improvements in PHN sector performance. There is, however, some variance in the degree to which Bank interventions have attempted to address these issues. A number of interventions to strengthen the management of an institution or part of an institution are limited to the provision of training, technical assistance, additional staff and equipment, and have not addressed in depth more difficult and sensitive issues such as: the organizational structure of ministries and of the programs and service delivery systems; the extent to which such organizational structures respond to decentralization policies; problems of inter-agency coordination and territorial issues. There are, however notable examples of FY90 projects which have addressed these issues fully and squarely.

(g) The use of local consultants and the participation of beneficiaries in project design, development and implementation is on the rise.;

(h) Health financing issues continue to be rigorously addressed as a priority through lending, sector and research work;

(i) Multi-sectoral operations, in the form of social development operations, a new feature of PHN lending, have presented new challenges to Bank staff in streamlining and coordinating roles and responsibilities within the Bank and at the national level;

(j) In recognition of the important role NGOs play in the PHN sectors, increased attention has been focused on them both through project and sector work.

(k) The momentum in nutrition activities which began following Reorganization has continued, and in some ways accelerated, during FY90. Lending has increased and the pipeline for future nutrition operations is strong. Nutrition's linkages with sector operations outside of PHN including agriculture, education, women in development, and others, as well as with adjustment activities, have grown stronger during the year. Staff capacity has been strengthened through nutrition training courses and the recruitment and hiring of additional technical nutrition staff in three of the four Bank regions. Nevertheless, many departments still do not have staff experienced in nutrition operations. The Bank needs to develop more institutional capacity to respond to management's commitment to nutrition and the many emerging opportunities.

5. PHRHN's policy and research program focussed on a number of the salient issues outlined above. Two studies in process on fertility determinants and on family planning effectiveness will assist Bank staff and national policymakers alike in the design and targeting of appropriate family planning programs and policies. Six other studies focus on various health sector issues, including AIDS and adult mortality, safe motherhood, health policy in Africa, hospital resource use, disease control priorities and adult health. A micronutrient study is also in process, whose results should contribute to improvements in the effectiveness of nutrition interventions. PHRHN also manages a portfolio of eight Special Grants Programs, of which five target health sector issues, two population and one nutrition. During the year PHRHN produced 20 publications, including 2 books, 2 technical papers, 15 working papers and one other paper.

6. While the nature and focus of PHN work carried out during FY90 are well placed, in general, and show great potential for impacting on the three sectors, there is scope for improving its quality and impact. The report, therefore, makes several suggestions for improving the Bank's work on the PHN sectors which are summarized below. It does qualify, however, that it will withhold suggestions particular to the population sector, pending the completion by the Population Adviser, PHR, of a population strategy paper, currently in draft.

7. With respect to technical issues, which confront Bank staff working on PHN sectors, this report suggests that particular effort in future work be focussed on the following:

(a) The increased focus of Bank PHN interventions at the policy and program levels has proven an effective means of achieving PHN sector objectives. Future Bank work should intensify and improve the quality of efforts undertaken thus far in this area. Sector dialogue should provide comprehensive and rigorous policy analysis, which fully reflects the wisdom and experience of experts residing in the country/region, as well as the socio-political context of the country in question. Decentralization policies should be fully explored with regard to their practical application in the PHN sectors. Project design should provide for capacity building in policy formulation, planning and program development, and implementation. It should also provide for pilot testing and replication of innovative proposals for policy reform. Provision also should be made for the ongoing review and revision of health sector policies and priorities in the face of evolving epidemiological profiles.

(b) Management and institutional development issues need to be addressed more rigorously and comprehensively through project and sector work. Particular emphasis should be placed on: (i) organizational analysis; (ii) coordination between institutions and agencies which share responsibility for one or more of the PHN sectors; (iii) clear definition of roles and responsibilities of agencies and staff involved in the sectors; and (iv) management capacity-building at every level of programs and services through practical training, supervision, limited and carefully selected technical assistance, aimed at developing the capacity of a clearly designated counterpart, and monitoring and evaluation of targets and performance.

(c) The role of the private sector and NGOs in the design and delivery of PHN interventions is great and growing. Bank interventions in the PHN sectors must, therefore, encompass these vital resources as well as the public sector in order to maximize the individual strengths and contributions of all actors in the PHN sectors, as well as their collective efficiency and effectiveness. This strategy is essential and has great impact potential, given the increasing assistance and attention accorded by the Bank to the policy/program arena.

(d) PHN financing issues will continue to be crucial to the success and sustainability of any PHN intervention, whether financed by the Bank or not. Given its comparative advantage (in terms of expertise in economics and finance, as well as the leverage it possesses at the macroeconomic level), the Bank should continue its efforts to address and resolve PHN financing issues, which call for: (i) mobilization of resources for the sectors (through a number of activities such as co-financing and aid coordination; reallocation of public resources within and across sectors; cost recovery schemes...), and (ii) effective utilization of resources (through such activities as cost containment, investment and financial planning and management, decentralized budget decision-making and accountability). It is particularly important in addressing this issue to build national capacity in these disciplines. Aid coordination, while currently being undertaken in many instances by the Bank, should ultimately become the responsibility of governments, whose policies and

priorities should drive the content and focus of external assistance to the sectors, rather than the reverse.

8. A number of suggestions are also made with regard to internal Bank issues, some of which emanate from this report's findings (a - g) others of which were suggested by operational staff on the occasion of commenting on this report, in particular suggestion (h):

(a) PHR Technical Divisions have demonstrated their potential for undertaking sector work, which has provided a regional dimension to PHN issues and succeeded in enhancing dialogues with, and the involvement of, key staff in the Bank (e.g., CODs), as well as regional experts and policymakers, in the development and implementation of Bank and national policies. This contribution has assisted in the achievement of progress in the sectors and should be continued.

(b) With the growth in numbers and complexity of PHN work, the need to expand staff capacity is evident. Gains have already been made in FY90, both through training and recruitment, but these are unlikely to be sufficient, given continued growth in the sectors as reflected in the FY91-94 lending program. Budget decisions in the Bank should consider this issue carefully, particularly given the high priority accorded to PHN sectors. The upcoming Population Strategy Paper will address this issue for the population sector, where a shortage of senior population experts is felt to be critical.

(c) Efforts should be intensified to employ developing country experts in all aspects of the Bank's work in PHN and to involve beneficiaries in the design, development and implementation of PHN interventions. The idea of establishing a special fund for internships by the Bank, to provide opportunities for developing country experts to work with the Bank for the first time, should be vigorously pursued.

(d) Roles and responsibilities in all work related to Social Sector Development Projects should be clearly delegated and streamlined.

(e) Models and methods for co-financing and aid coordination should be further developed and improved, including a full consideration of the costs and benefits of Bank staff involvement.

(f) Examples of successful coordination with CODs on human resources development aspects of microeconomic dialogue and operations (SAL/SAC) should be built upon and expanded.

(g) Promotion and expansion of nutrition activity in a wide variety of Bank lending and sector work (SAL/SAC, agriculture, food security, PHN, education...) should be continued, given the success achieved thus far.

(h) PHRHN should intensify its efforts to improve: (i) communications and exchange of information among staff in the Bank involved in PHN work; and (ii) processes and systems for information collection and analysis.

CHAPTER I. INTRODUCTION: PURPOSE AND SCOPE OF REVIEW

1. The purpose of this PHN Annual Sector Review is to examine and evaluate lending and sector work undertaken during FY90, and the degree to which it contributed to the fulfillment of Bank objectives overall. The report: (a) provides relevant data on the volume and mix of lending and sector work accomplished during the year; (b) undertakes a qualitative assessment of strengths and weaknesses of the work; (c) identifies special features, trends and issues pertaining to such work which may have implication for future strategies and choices in the PHN sectors; and (d) makes suggestions for possible improvements and refinements, which would contribute to the relevance and effectiveness of Bank interventions in the PHN sectors The report also describes research and policy work undertaken by PHRHN and its relevance to issues and information gaps identified.

2. The scope of the report has its limits, which should be made explicit in order to qualify the observations and suggestions made. The report reviews and evaluates lending and sector work; its coverage of projects under implementation is limited, however, to an integration of the major conclusions of ARIS reports, prepared thus far by PHR technical divisions, into this report's analysis of PHN work, contained in Chapter III. Furthermore, this report's analysis of lending work draws heavily from the 12 PHN projects and six social development projects with important PHN components approved in FY90. While recognizing that lending work undertaken during FY90 actually encompasses a larger sampling of projects (i.e., those at the preparation, appraisal and negotiation stages at the end of FY90), time and staff available did not permit a complete and rigorous review of all projects being developed during the FY.

CHAPTER II. FY90 OPERATIONS: LENDING AND SECTOR WORK

OVERVIEW OF LENDING

Lending Statistics

3. In FY90 a total of 18 PHN projects were approved by the Board, valued at US$933.4 million. This reflects significant increase in lending volume over FY89 levels. As shown in Annex 1, the number of FY90 operations increased over those in FY89 (11) by 7, or 64 percent; and the value of FY90 lending increased over that of FY89 (US$550 million) by US$383 million or 70 percent. The PHN share of total Bank lending continues to grow. In FY87, PHN lending accounted for 0.3 percent of total Bank lending for that year. In FY88 and FY89, PHN's share of Bank's lending grew to 1.6 percent and 2.6 percent, respectively. In FY90, this level has reached a high of 4.5 percent, a 42 percent increase over that of FY89, and is targeted for continued growth over the next few years, as illustrated by an ever-expanding pipeline (paras. 158-159).

4. Of the 18 operations categorized under the PHN portfolio, 12 were straight PHN projects, valued at US$813.5 million, and another six were social development projects, valued at US$119.9 million. Statistics on the 12 straight PHN projects are presented in Tables 1 and 2 and discussed in the section immediately below, entitled "PHN Projects." Statistics on the six social development projects are presented in Table 3 and discussed in the section of this chapter, entitled "Social Development Projects."

PHN Projects

5. Table 1 shows the countries, project titles, and loan amounts for straight PHN projects, by region, with regional comparisons for FY89. Africa, with four projects again, doubled its loan volume. Asia went from four projects to two and was the only region with lower loan volume. EMENA, with a very large loan to Morocco, increased its lending by 50 percent with no increase in the number of projects. LAC went from one project to four, with a large increase in lending volume, attributable, in large part, to the Northeast Brazil Basic Health project. Of the 11 countries on the FY90 list, three were also on the FY89 list (Nigeria, India, and Brazil). Seven of the 12 projects were funded by IDA, four by IBRD, and one jointly.

6. In five of the 12 FY90 PHN projects Bank funds were supplemented by external funds of cofinanciers in the amount of US$32.9 million. Taking the five cofinanced projects in aggregate, cofinancing amounted to 16 percent of total project costs or an additionality to Bank's funds of 25 percent. Broken down by region, these levels amount to 18 and 29 percent, respectively, for Africa and 12 and 18 percent, respectively, for LAC.

7. A comparison of the approvals for FY90 with the FY90 lending program table included in the FY89 Review shows the fluidity of the lending program for straight PHN projects, even at the start of a fiscal year. At the start of FY90 the program called for 16 Board presentations. Seven of these were not in fact approved during FY90 (Ghana H/P II, Mali P/H, Senegal P/H II, Togo P/H, Jordan H, Argentina H and Morocco H/N). All of these are now programmed for FY91 with the exception of Argentina, which is included in the FY92 lending program. The nine remaining projects were supplemented by three that had not been included in the original program: two were advanced (India P VII and Morocco H) and the Kenya P IV was a quick-response operation (Annex 5, paras. 5-11).

Table 1. PHN PROJECTS APPROVED IN FY90
(in US$ millions)

COUNTRY	PROJECT	AMOUNT		FY90 REGION TOTAL $	FY90 REGION #	FY89 REGION TOTAL $	FY89 REGION #
AFRICA							
Kenya	Population IV	35.0	IDA				
Lesotho	Population, Health & Nutrition II	12.1	IDA				
Nigeria	National Essential Drugs	68.1	IBRD				
Tanzania	Health and Nutrition	47.6	IDA				
				162.8	4	81.3	4
ASIA							
India	Population VII	96.7	IDA/IBRD				
India	Tamil Nadu Nutrition II	95.8	IDA				
				192.5	2	290.2	4
EMENA							
Morocco	Health Sector Development	104.0	IBRD				
Yemen A. R.	Health II	15.0	IDA				
				119.0	2	79.5	2
LAC							
Bolivia	Integrated Health Development	20.0	IDA				
Brazil	Northeast Basic Health II	267.0	IBRD				
Colombia	Child Care and Nutrition	24.0	IBRD				
Haiti	Health and Population	28.2	IDA				
				35..2	4	99.0	1
	GRAND TOTAL			813.5	12	550.0	11

Table 2. COFINANCING IN PHN PROJECTS APPROVED IN FY90
(in US$ millions)

COUNTRY	PROJECT	LOAN/CREDIT AMOUNT	TOTAL PROJECT COST	CO-FINANCING AMOUNT	CO-FINANCING % OF TOTAL PROJ COST	CO-FINANCING % OF LOAN/CRED AMT (ADDITIONALITY)
AFRICA						
Kenya	Population IV	35.0	41.3	2.2	5.3	6.3
Lesotho	Population, Health & Nutrition II	12.1	22.1	7.1	32.1	58.7
Nigeria	National Essential Drugs	68.1	85.1	0.0	0.0	0.0
Tanzania	Health and Nutrition	47.6	70.0	15.0	21.4	31.5
		162.8	218.5	24.3	11.1	14.9
ASIA						
India	Population VII	96.7	141.5	0.0	0.0	0.0
India	Tamil Nadu Nutrition II	95.8	139.1	0.0	0.0	0.0
		192.5	280.6	0.0	0.0	0.0
EMENA						
Morocco	Health Sector Development	104.0	171.3	0.0	0.0	0.0
Yemen A. R.	Health II	15.0	19.1	0.0	0.0	0.0
		119.0	190.4	0.0	0.0	0.0
LAC						
Bolivia	Integrated Health Development	20.0	38.6	6.2	16.1	31.0
Brazil	Northeast Basic Health II	267.0	610.6	0.0	0.0	0.0
Colombia	Child Care and Nutrition	24.0	40.2	0.0	0.0	0.0
Haiti	Health and Population	28.2	33.7	2.4	7.1	8.5
		339.2	723.1	8.6	1.2	2.5
	GRAND TOTAL	813.5	1,412.6	32.9	2.3	4.0

Social Development Projects

8. In concert with the increased emphasis on human resource development as an essential part of the development process, subscribed to by national governments as well as by the Bank, and facilitated by the merger in 1987 of the PHN and education sectors into human resources divisions, six social development projects, all containing substantial PHN components, were approved during the year. Of these, four were from the Africa Region and two from LAC.

9. As Table 3 indicates, Bank funds approved for these PHN components increased the amount of Bank-approved funds for PHN in FY90 by US$31.6 million, or about 4 percent over the US$813.5 million in approved PHN projects, for a total of US$845.1 million or 4.1

Table 3: SOCIAL DEVELOPMENT PROJECTS WITH PHN COMPONENTS, FY90
(in US$ millions)

COUNTRY	PROJECT	TOT PROJECT COST	OF WHICH FINANCED BY BANK IBRD	OF WHICH FINANCED BY BANK IDA	AMOUNT PHN IN TOT PROJ	AMOUNT BANK PHN	PHN AS % OF TOT PROJ	COFINANCING AMT	COFINANCING % OF TOT PROJECT COST	COFINANCING % OF LOAN/CREDIT AMOUNT (ADDITIONALITY)
AFRICA										
Cameroon	Social Dimen. of Adj/Human Res.	85.7	21.5		23.8	0.0	27.8	53.4	62.3	248.4
Chad	Social Development Action	26.9		13.4	6.9	1.6	25.7	12.2	45.4	91.0
Gambia	Women in Development	15.1		7.0	1.6	0.5	10.6	7.3	48.3	104.3
Uganda	Poverty & Social Costs	37.0		28.0	7.8	5.5	21.1	2.2	5.9	7.9
		164.7	21.5	48.4	40.1	7.6	24.3	75.1	45.6	107.4
LAC										
Bolivia	Social Investment Fund	95.6		20.0	57.9	9.2	60.6	43.6	45.6	218.0
Jamaica	Social Sector Fund	67.0	30.0		25.7	14.8	38.4	0.0 *	0.0*	0.0*
		162.6	30.0	20.0	83.6	24.0	51.4	43.6	26.8	87.2
	GRAND TOTAL	327.3	51.5	68.4	123.7	31.6	37.8	118.7	36.3	99.0

* While this project has no cofinancing, it is attracting the parallel financing of the Human Resources Department Program which the Bank is supporting in part through this project (paras. 31-33).

percent of total Bank lending. The World Bank Annual Report 1990 categorizes social development projects under the PHN sectors and attributes the total value of Bank loans/credits for these projects (US$119.9 million) as commitments to the PHN sectors, rather than just the value of these operations' PHN components (US$31.6 million), as identified in Table 3. The World Bank Annual Report 1990, therefore, reflects a higher level of Bank-approved funds for FY90: US$933.4 million or 4.5 percent of total Bank lending for that year. Table 3 highlights the major contribution of cofinancing to the value of social development projects. Total cofinancing for social development projects amounts to US$119 million, virtually doubling the contribution of Bank loans/credits for the six, and constituting over one-third of total project costs. For those five social development projects which received cofinancing, such contribution constituted almost half (46 percent) of total project costs and adds 132 percent to the Bank's contribution. It is significant to note that the US$31.6 million of Bank funds in PHN components represents only one quarter of total costs of PHN components of social development projects implying substantial success in raising large amounts of cofinancing for Bank-supported PHN operations.

10. Of these six social development projects, four were managed by PHR divisions (Chad, Gambia, Bolivia and Jamaica) and two were managed outside of PHR divisions: by AF2CO, in the case of Uganda, and by the SDA division, in the case of Cameroon. Of the four PHR-managed projects, two (Bolivia and Jamaica) focussed on sectors for which PHR is formally responsible (health, nutrition and education) and two (Chad and Gambia) spanned sectors incremental to PHR responsibilities, including agriculture/rural development, the informal sector, women-in-development, water and sanitation and urban sector, which warranted coordination with other sector divisions. The two externally managed operations focussed on sectors inside and outside PHR's mandate. Annex 2 provides a breakdown of the major sectoral components of these operations. An assessment of the management and coordination challenges posed by such inter-sectoral operations is presented in Chapter III (paras. 21-22), which suggests ways of streamlining roles, responsibilities, processes and practices based on the lessons learned thus far in our experience in social sector lending.

SECTOR WORK STATISTICS

11. PHN sector work continues at a high level of activity. As Table 4 below and the Table in Annex 3 indicate, 32 white through grey cover reports were completed in the past year. The Africa region produced 15 sector reports, laying the foundation for continued expansion of lending in the region. Some of them provide the first overviews of one or more of the PHN sectors in the countries concerned, while others concentrate on subsectors and/or issues in countries, which have already received Bank attention and assistance. Still others have regional focus. In Asia, with several mature programs, most reports focus on issues emerging in the sectors -- NGOs, financing and poverty, to name a few. In EMENA, the work has concentrated on the development of human resource strategy and the integration of PHN in social development programs. In LAC, the main effort last year was in Brazil, with a study addressing issues related to the epidemiological transition, and another on women's reproductive health. Annex 3 contains descriptions of selected sector tasks in an effort to provide some insight on the range and nature of sector work undertaken during FY90.

Table 4. PHN SECTOR REPORTS COMPLETED BY REGION, FY81-90

Number of Reports

	FY81	FY82	FY83	FY84	FY85	FY86	FY87	FY88	FY89	FY90
AFRICA	1	5	6	8	8	6	4	7	9	15
ASIA	1	1	4	4	3	2	0	1	9	8
EMENA	0	0	0	5	1	1	1	2	5	5
LAC	0	0	3	3	2	4	2	6	6	4
TOTAL	2	6	13	20	14	13	7	16	29	32

CHAPTER III: A PERSPECTIVE ON PHN WORK ACCOMPLISHED IN FY90: SPECIAL FEATURES, ACCOMPLISHMENTS, TRENDS AND ISSUES

12. This chapter analyzes strengths and weaknesses of PHN work undertaken during FY90, and identifies special features, trends and issues pertaining to this work, which may have implication for future strategies and choices in the PHN sectors. Some of these are common to all three sectors, while others are particular to only one. Brief descriptions of: (i) selected sector work carried out during FY90; (ii) FY90-approved PHN operations; and (iii) other innovative lending work undertaken during FY90 are presented in Annexes 3, 4 and 5, respectively.

POPULATION, HEALTH AND NUTRITION

Policy/Program Approach

13. The marked emphasis at the macroeconomic level on human resources development and social sector reform, increasingly supported by the Bank and national governments alike, has set the stage for more prominent and promising Bank interventions in the PHN sectors. An increasing number of SAL/SAC discussions and operations have culminated in the development of human resource development programs and strategies, which are supported directly by SAL/SAC operations and/or by PHN or social development projects. SALs for Poland and Hungary, each include PHN sectoral conditionality -- a direct result of the PHN strategy for Eastern European countries in transition to incorporate the issues of the social safety net and PHN policy reform into SAL discussions. Cameroon Social Dimensions of Adjustment/Human Resources, Chad Social Development Action, Uganda Poverty and Social Costs, to name a few SAL/SAC operations, have significant PHN components based on comprehensive human resource development programs and priorities established under these operations. The response of some PHN and non-PHN staff to this relatively new enabling environment is evident in the evolution of the quality, scope and outcome of sector dialogue. Whether initiated by sector work or project identification, sector dialogue is increasingly carried out in the context of broader, oftentimes multi-sectoral initiatives or dialogues between the Bank and national governments. Bank investments emanating from such dialogue are more strategic and programmatic in nature than before and support a portion of broader and longer-term policies and programs, which are more reflective of and appropriate to national issues and needs in the PHN sectors. To cite a few examples, the India Population VII Project supports a sector strategy, which emanated from a joint review of the population sector undertaken in 1987 by the government and the Bank. The Nigeria Essential Drugs Project supports the implementation of the Essential Drugs Policy adopted in 1988 by all 21 states. The Jamaica Social Sector Development Project finances a portion of a multi-year Human Resources Development Program, which the Government of Jamaica developed with Bank assistance.

14. Many Bank investments provide for capacity building in policy reform, investment planning, program design, implementation, and evaluation. The Bolivia Integrated Health Development Project will support and guide the government in the rationalization of health sector planning, policy making and investment planning and in the development of a plan of action, which will permit an annual review of program performance using specific indicators and targets. Under the Lesotho Population Health and Nutrition II Project, the government will be supported in the development of a national population policy and in the development of policy reforms in health financing and the role of PVOs in service provision. The Tanzanian Government will strengthen its capacity in planning, policy formulation and implementation under the Health and Nutrition Project.

15. In addition to benefitting from direct project support, capacity building and policy reform also occurs as an outcome of the process of sector dialogue and project implementation. For example, the Morocco Health Sector Investment Project is building on studies of financing and hospital administration, which were financed under the first Health Development Project. Follow-up by the government includes a major decentralization of hospital administration, financial control and fee collection, and wide-ranging reforms of the entire sector. These will be discussed at the government's second annual National Conference on Health Financing, where the potential reforms to be discussed are expected to include greater use of private sector health insurance, changes in the role of the social security system and that of the public health services in the provision of care, and modification of the investment code (linked to the Bank's economic work) to facilitate investments in private sector practice. Successful policy reform, which may occur as a result of this process, will provide a useful model for other countries and regions in the world.

Management/Institutional Development

16. Recent Bank investments reflect an increasing appreciation of the unequivocal importance of developing institutional capacity and sound management skills and practices in achieving PHN sector objectives. Virtually all PHN projects approved in FY90 include some provision for improving efficiency of programs and services through management strengthening interventions. Accompanied by the program approach described above (paras. 13-15), there has been a further and much-needed evolution towards a program (vs. project) management approach in Bank investments in the PHN sectors. In other words, Bank-financed management interventions are less concentrated than in the past on ensuring the effective implementation of a Bank-financed project in isolation, and more concentrated on the effective and efficient implementation of major policies and programs, whether Bank-supported or not. Virtually all projects have taken great care to ensure that the overall responsibility for project management and implementation rests with the appropriate line Ministry. The Yemen Health II SAR emphasizes this point by noting the very difficult and problem-ridden implementation of the Yemen Health I Project, which was attributable in part to the isolation from the Health Ministry of that project's management unit. Responsibility for oversight and coordination of the Morocco Health Sector Development Project is placed under the Planning Division in the Ministry of Health.

17. Key management/institutional development issues in the PHN sectors are numerous and complex and are crucial to achieving improvements in PHN sector performance. Salient management topics which should be addressed through Bank's project and sector work include: policy implementation and management; implementation of decentralized policies within the health sector; management and organization of services of the MOH; use and maintenance of MIS; management capacity building; inter-ministerial/inter-agency coordination; cofinancing and aid coordination; budgeting and financial management; management and delivery of services at the periphery; supervision; management and coordination of private sector and NGO activities. The list is not exhaustive, but illustrates the complexity of needs analysis work and of the design and implementation of appropriate interventions in this area. There is some variance in the degree to which Bank interventions have attempted to address these issues. A number of interventions to strengthen the management of an institution or part of an institution are limited to the provision of training, technical assistance, additional staff and equipment, and have not rigorously addressed more difficult and sensitive issues such as: the organizational structure of ministries and of the programs and service delivery systems; the extent to which such organizational structures respond to decentralization policies; problems of inter-agency coordination and territorial issues. There are, however, notable examples of projects which have addressed these issues fully and squarely. The Nigeria Essential Drugs Project is supporting the restructuring and consolidation of institutions responsible for the pharmaceutical sector at the

federal and local levels. The institutional development component of the Haiti Health and Population Project makes provision for the restructuring of the Ministry of Health and Population for the effective implementation of decentralization policies. An organizational analysis and support for decentralization of the Colombia Institute for Family Welfare will be supported under the Colombia Child Care and Nutrition Project.

18. In order to encourage and guide a more comprehensive and successful intervention in the management/institutional development of PHN, efforts should be made by PHRHN to undertake an in-depth review of PHN projects with this focus in mind to document successes and failures, develop guidelines and provide for exchange of knowledge and experience in this area through seminars or workshops.

PHN Financing

19. Bank investments in the PHN sectors are supporting in general much larger proportions of recurrent cost components than they have in the past. This shift has most certainly been influenced by the nature and scope of recent PHN dialogues, which address economic austerity issues and acute budget constraints seriously jeopardizing the sustainability of new investments. The focus of Bank work has been on improving the effectiveness and efficiency of priority activities and services, while expanding them prudently when their financial sustainability could be reasonably assured. Consequently, the content of PHN operations approved in FY90 reveals the allocation of significant proportions of Bank funds to recurrent costs, particularly drugs, contraceptives, supplies and salaries, and relatively small proportions to investment costs (civil works and equipment). A sampling of such projects is documented below:

(a) Over one-half of the total cost of the Tanzania Health and Nutrition Project is for recurrent costs, of which 80 percent is for pharmaceuticals and medical supplies.

(b) Recurrent costs, comprised mainly of nutrition supplements, salaries and drugs, account for about two-thirds of the total cost of the Second Tamil Nadu Nutrition Project;

(c) For the Morocco Health Sector Investment Project, drugs and supplies constitute a larger cost item than civil works;

(d) As its name indicates, the Nigeria Essential Drugs Project is dedicated entirely to ensuring a constant and affordable supply of essential drugs in support of the government's newly pronounced Essential Drugs Policy. Sixty percent of the total project cost or US$39.7 million will provide for a drug seed stock.

20. A formidable challenge posed by Bank investments in the PHN sectors lies in ensuring their financial sustainability, i.e. (i) minimizing the PHN recurrent cost burden through efforts to rationalize services in order to achieve cost-effectiveness and promote cost containment; and (ii) mobilizing resources through new/improved cost recovery mechanisms and through co-financing and aid coordination activities channelled into national policies and programs. In addition to the recurrent cost financing issues raised above, rapidly escalating investment costs also present a major financing issue, especially with respect to the hospital subsector. The Bank continues to address these issues actively in a search for optimal solutions, as evidenced by the regional and national targeted sector work undertaken and ongoing in FY90 (paras. 11 and 44-45), and project components dedicated to such issues as cost-effectiveness of health investments, health financing, financial management, cost recovery, and the like. There are numerous examples of such project-supported efforts. Morocco Health II supports an increase in cost recovery for curative care; mobilization of additional resources; streamlined arrangements for

services funded by public and private insurance funds. The Haiti Population and Health Project provides for the rationalization of cost recovery mechanisms; containment of salary expenses; further study of cost recovery policies. Under the Tanzania Heath and Nutrition Project, a plan of action will be prepared on the long-term financing of the health sector and a reallocation of the public budget to health will be undertaken. The Lesotho Population, Health and Nutrition II Project will support policy reform to increase cost recovery activity and revenues and to improve expenditure efficiencies. Given the Bank's advantage in terms of expertise in economics and finance, scope and quality of dialogue with governments, and the leverage it possesses at the macroeconomic level, particularly with SAL/SAC operations, it should continue to take the lead in researching and resolving health financing issues, both through practical experience in operations and through research work at the national, regional and worldwide levels.

Roles and Responsibilities in the Management of Social Development Projects

21. The collective experiences of Bank staff involved in the six social development projects approved in FY90 (paras. 8-10) have provided useful insight on issues regarding task management and coordination of projects with a multi-sectoral focus, which are an emerging trend in addressing human resources development issues. Projects which integrate PHN and Education sectors often emanate from human resources development dialogues initiated at the macroeconomic level. The coordination of education and PHN inputs is easily managed by PHR divisions, according to experienced PHR staff, particularly if the Bank-Government dialogue has resulted in the elaboration of a human resources development strategy or program on which such a project is based. Staff do state, however, that, in order to sustain and streamline the necessary communication with several line ministries in the design and implementation of such a program, it is advisable to appoint an agency in the country (planning institute, for example), responsible for human resources development, to coordinate and facilitate the dialogue between the Bank and the various line ministries.

22. Social development projects, which focus on sectors both within and outside of PHR divisions' responsibilities, can be successfully managed and coordinated by PHR divisions and by non-PHR divisions, alike, based on FY90 experience. Staff involved in such operations insist that the key to successful project design, development and implementation lies not only in consulting and communicating with various sector divisions, but by intimately involving them in, and making them responsible for, the full range of tasks for the appropriate sector component(s) (i.e., policy dialogue, program and project design, and supervision). An example of such coordination which has proven to be particularly successful is the Uganda Poverty and Social Costs Project, which is managed overall by the COD (the resident representative, in fact) but sectoral components are fully and clearly delegated to the sector divisions. Anything less than such full involvement and clearly delegated responsibilities of key staff can result in conflicting and/or confusing dialogue; Bank investments which are not fully supportive of sector strategies; poorly designed projects; and suspicion or even cynicism among staff about future collaboration. It should be qualified that the observations above emanate from experience gained thus far in the processing of social development projects. Careful monitoring of the execution of these projects is in order to ensure that coordination among the various divisions remains optimal and effective.

Non-Governmental Organizations

23. Another welcomed feature of the FY90 projects is the considerable effort to involve NGOs and local institutions in the design and implementation of PHN operations. In the past, NGOs were typically involved in activities such as information, education and communication (IEC), and very often this component was financed by a grant from a cofinancier, e.g., Sri Lanka, FY88. In some regions their role has evolved further, and NGOs are now playing an

important role in service delivery. This is the case in Bank-financed projects in the Africa region, and in the India project. In Haiti, health NGOs were involved in the consultations leading to project preparation. While a number of NGOs have worked in the EMENA region for many years, particularly in the Levantine countries and the Yemen Arab Republic (where one was involved in the Bank's first health project), they have not, traditionally, been a common, or well-accepted, part of the political or social process. NGOs linked to the distribution of food aid did make a valued contribution until recently, but these programs have been much reduced or phased out in the last few years, partly because food aid is now handled primarily by the World Food Program. NGOs indigenous to the area are relatively new and small, and the Bank has not yet found ways to involve them in Bank-assisted projects.

24. In the Africa region, where government health services may reach less than half the population, NGOs have long played an important part in providing health, and more recently, family planning services. Recognition of this contribution has led the Bank to greater efforts to involve NGOs in Bank projects, efforts which have necessitated dialogue with governments to overcome some of the difficulties involved in this process. NGOs play an integral role in a number of FY90 approved projects in the Africa region, with substantial population components. In Tanzania, the Ministry of Health and UMATI, the family planning association of Tanzania, take joint responsibility for population and family planning activities. In Kenya, where the recent Demographic and Health Survey revealed that NGOs and other non-government providers account for almost 30 percent of family planning services delivered, government support for NGOs has been strong, and the project again finances improvements in service delivery and quality through NGOs. In Lesotho, two health and family planning NGOs are identified as beneficiaries of the project, together with the MOH. In The Gambia and Cameroon, too, NGOs are assisted through the project: in The Gambia to strengthen community-based distribution, and in Cameroon by way of cofinancing from USAID. In India, the government has for some time recognized the contribution of NGOs, and has put in place a system for grant assistance. The seventh project contains a very substantial component to strengthen NGO involvement (Annex 4, para. 5).

25. The Population NGO Special Grants Program (para. 38), administered by PHRDR, has complemented this process by its strategy of stimulating collaboration in Africa between governments and NGOs, and strengthening technical and administrative capacity in NGOs. Other questions regarding the increased use of NGOs are being addressed by research in the regions and in PHRHN. For example, a study of the sustainability of NGOs is being undertaken through the Third Kenya Population Project -- an important issue in Kenya, and in other African countries, since the major part of NGO funding is coming from external sources. The issue will also be addressed in the sector work on alternative channels for family planning being done in many of the Africa sector operating divisions. In India, a study of NGOs produced jointly by the National Institute for Health and Family Welfare, and the Bank[1], addresses questions of technical capacity in NGOs, the organizational arrangements for managing collaboration with NGOs at the government level, the administration of grants, and alternative mechanisms for channelling technical and financial support to NGOs. The policy paper now underway in PHRHN, addressing Family Planning Program Effectiveness, is also examining the role of NGOs, and the implications for national programs. (This study is described more fully in Annex 9, paras. 9-13).

[1] "Strengthening the Role of Non-Governmental Organizations in the Health and Family Welfare Program", produced in Green Cover, June 1990

Methods of Carrying Out Project Design and Implementation, and Sector Work

26. Experience has shown that the involvement of regional experts, practitioners and beneficiaries in needs assessment and in project design and implementation contributes to a significantly improved product, which is more responsive to needs and priorities and more appropriate to the political, cultural, traditional, logistical and economic context of the country in question. In addition, the success and sustainability of initiatives emanating from such a process are much more likely, with the commitment and sense of ownership such a strategy stimulates, which are otherwise difficult, if not impossible to elicit. Notwithstanding the often strongly country-specific nature of consumer preferences (and hence of appropriate programmatic and institutional solutions to PHN problems), the employment of experts coming from the same region but not the same country, can be extremely useful. Not only might they supplement a possible short supply of local expertise and/or strong community institutions, they also permit an exchange of regional expertise and experience, which has great potential for resolving country-specific issues which may be common to a region and for stimulating a regional dialogue from which all participants could benefit. The Africa region, in particular, should be cited for having fruitfully employed this strategy in the course of its work. AFTPN's success in establishing and effectively utilizing a Population Advisory Committee comprised of African experts is noteworthy, and has resulted in a commitment and partnership between the Bank and key Africans in the promotion and expansion of population activities in Africa. The initiative of AFTPN and PHRHN to elicit the input of African health experts in the African Health Policy Study, through a series of regional workshops, also deserves mention. The Lesotho Population, Health and Nutrition II Project is innovative in its successful efforts to involve service providers in the project design; and the efforts to strengthen community participation in the design and management of PHN interventions in Benin, Guinea, Cameroon and Togo are noteworthy and provide useful examples upon which other such efforts could be built.

27. Given tight schedules and constrained budgets, it is understandable that, while appreciating the benefits of such a strategy, staff might be inclined to avoid this approach, the costs and risks of which are perceived to be high. Wider employment of this strategy in PHN is recommended by such means as: the production of case studies and/or guidelines to facilitate its implementation; creation of rosters of developing country PHN experts; a change in incentive structures to reward this approach, such as the acknowledgement and reward of such efforts through the PPR process; the creation of special funds from the Bank's administrative budget to cover the costs of very well designed and defined, short- or medium-term internships for Third World experts who never have worked with the Bank, to name a few.

Cofinancing and Aid Coordination

28. In an effort to ensure full implementation of human resources development policies, strategies and programs, Bank staff are making greater efforts to attract, consolidate and rationalize the flow of external resources into the PHN sectors, in direct support of program implementation to maximize cost-effectiveness of such investments as well as to mobilize more resources for the sectors. Some efforts to this effect have resulted in formal, and sometimes expansive, cofinancing arrangements for projects/programs initiated by the Bank (e.g. Bangladesh Population I, II and III Projects), while others culminated in much less formal and looser (no guarantee) agreements with donors for parallel or complementary financing of strategies or programs. As discussed in paras. 6 and 9, the Bank has had some success in attracting the support of aid donors for the PHN sectors. This demonstrated potential for raising cofinancing should be exploited, given the great need for increased financial resources for PHN sectors, as well as the equally important need to ensure a rational allocation of resources flowing into the

sectors within the context of a sound policy framework and well-organized and targeted programs. On the other hand, the costs (in staff time, particularly) of coordinating such aid can be significant. The development of governments' capacity to assume cofinancing and aid coordination responsibilities has not always been given due emphasis in such sector/program investments. While it is beyond the scope of this report to assess cost and benefits of various approaches to cofinancing and aid coordination by the Bank, it is an issue which warrants further scrutiny, given the urgent need, at least for the medium-term, for an increased flow of external resources into the PHN sectors. In the meantime, cofinancing and aid coordination activity in the population sector, described immediately below, illustrate the benefits of such efforts.

29. The Bank, led by AFTPN, and other donor agencies are joining together to support the efforts of African countries in population. This initiative, the "Agenda for Action to Improve the Implementation of Population Programs in Sub-Saharan Africa in the 1990s" is now underway, and will produce a program for the 1990s and beyond. Cosponsors of the initiative are the Bank, UNFPA and IPPF, and it is also supported by WHO and the African Development Bank. The involvement of this last institution is especially encouraging. Since the Berelson Report of 1976 on the Bank's Population Activities, the suggestion has been made that the Bank might draw the regional development banks into the process of population policy development - their close ties with their own regions making their support potentially very influential - but these are probably the first steps in this direction. In addition, not only will the Bank be working with other agencies on this initiative, but every effort is being made to involve African experts, and government representatives. These developments at the regional level are reflected in the design and financing of projects. The FY90 projects in Africa all involve a high degree of coordination among donors in support of population and family planning activities. In some cases the Bank has taken the lead in mobilizing and coordinating support, e.g., in Lesotho; in others it plays a supportive role, e.g., Kerya, Tanzania and Cameroon. Several donors have come in as cofinanciers of the FY90 Bank projects. Indeed, in several cases, it is their grant assistance that has made a population component possible, or has increased the range of population activities financed under the project, particularly with respect to policy development -- in Cameroon, The Gambia and Tanzania, for example. In Chad, too, birth spacing will be supported as part of the strengthening of health services, partly under the Bank loan, and partly under a donor grant.

30. Considerable donor coordination on population matters is also evident in the FY90 projects in other regions, though there are fewer cofinanced projects. In India, several multilateral and bilateral donors have provided support for many years to the Family Welfare Program. The Bank supports some states, for example, and other donors provide support in other states. In EMENA, the Morocco project seeks to strengthen basic health services, including MCH and family planning, and, in order to ensure complementarity and reduce duplication, has been designed in close collaboration with USAID's US$30 million Family Planning and Child Survival Project, begun one year ago. It also seeks to complement UNFPA's annual expenditure of US$3 million on population activities. In the Yemen Arab Republic the government's population activities are primarily supported by UNFPA and USAID. In the LAC Region, the Haiti project seeks to strengthen family planning and MCH by equipping institutions, providing training and IEC. UNFPA provides the government program with contraceptives. Population policy development is being assisted by UNFPA and USAID.

31. In addition to facilitating donor coordination, cofinancing offers several other advantages, as described in Annex 5, paras. 17-22 in relation to the Bangladesh population program. The impact of Bank lending is increased by its association with other donors, most of which offer grant assistance to population, and some of which do not have the technical resources to

provide independent population support, but welcome the opportunity to contribute through a Bank-managed project. The project, too, often contains population modules that otherwise might be difficult to lend for -- especially the kind of consensus-building activities, workshops etc., and setting up of population units and coordination mechanisms -- that are so important in policy and program development, but which, in countries where there is little existing demand, must precede the expansion of family planning delivery services.

POPULATION

32. The categorization of population as a sector and its grouping in the Bank with the health and nutrition sectors have clouded an important issue, which has constrained somewhat the Bank's potential for making urgently needed gains on the population front. Rapid population growth has a dramatic impact on the economic development prospects of many countries. As such, not only must the issue of population growth be fully appreciated by staff, who carry the responsibility for macroeconomic and structural adjustment dialogue and operations, it must be rigorously addressed by them as a crucial and integral part of their responsibilities. Family planning, while an obvious and important intervention in support of abating population growth, is not the only intervention at hand. Levels of education, employment, urbanization, the status of women, to name a few, constitute some of the other factors, which determine actual and desired family size. These determinants of population growth, therefore, need to be more rigorously addressed at the macroeconomic levels, as well as by the sectoral staff, whose policy and operational interventions could have some impact on these factors. A second challenge, which the Bank -- PHN staff in particular -- is facing is to increase the volume and effectiveness of family planning programs in the face of their various stages of development (from well-established programs, whose gains are beginning to plateau, as in some Asian countries, to new or nascent programs, which are not yet effectively meeting demand, which are in need of basic organizational and design assistance, and which are emerging with, and sometimes without, officially pronounced population policies, as in most African countries). The Bank has not yet reached its full potential for effectively and comprehensively addressing all facets of the population issue. It has, however, made notable strides during the fiscal year to this effect, which are described below.

33. While most regions are moving towards the drawing up of regional strategies for population, the Africa region has progressed furthest, and last year produced its short-term program for FY90-92[2], and for the longer term is collaborating with other donors and governments on "The Population Agenda" mentioned above. The Task Force was established by the Africa Regional Management Team at the end of 1988. The Country Departments (CDs), in consultation with the Task Force, prepared Country Action Plans for discussion with the national governments. The CDs identified a group of countries for priority activities on the basis of selected criteria and pending further discussion with governments. The actions proposed and their objectives are determined by the demographic situation and status of the population and family planning program in each country. The Bank's future operations, within the Action Program, will be guided by "(i) a broad definition of a population program, which would include measures to change attitudes towards family size, such as through improved education, changing taxation and inheritance laws, and cost sharing for social services; raising age at marriage; reducing infant and child mortality; and regulating population distribution and migration: (ii) a distinction between a population and family planning program, the latter being

[2] Report of the Africa Region Task Force on Population FY90-92, Volumes I and II, November 1989

only one element of a population program; (iii) provision of high quality family planning services as widely as possible through well-developed health systems and other channels; and (iv) support for elements of a population program in countries which do not yet have an official population policy or program"[3]. The country action plans set out programs for policy dialogue, economic and sector work that include more rigorous treatment of population issues, integration of population activities into SALS and SACs, into social development projects and non-PHN projects, as well as for traditional investments in the PHN sector.

34. An interesting feature of the process of developing the Program of Action is the extensive discussions which took place among the Country and Sector Operating Divisions, a dialogue which has helped the integration of population issues into the development of country strategies. Another interesting feature of the Task Force's work is its liaison with outside agencies, many of which were represented at Task Force meetings -- USAID, the Population Council, and Family Health International, for example. Third, the Task Force took into account views on population issues expressed by the Population Advisory Committee at a meeting in mid-April 1989. This committee, comprised of a group of African population experts and senior policymakers, has been formed to advise on the development of "The Population Agenda", the multi-donor initiative mentioned above.

35. In Asia, a Population Sector Study will be produced in FY91. A preliminary note[4] has suggested that the Bank is maintaining its program in the region with its major borrowers -- India, Indonesia and Bangladesh -- but must prepare itself to meet the changing demands of those countries, and could be doing more to generate demand in countries where family planning programs are at an early stage of development. In these latter countries there is a need for more targeted economic and sector work, to explore the economic-demographic relationships in those countries, and the possibilities of donor coordination. In the well-established programs, budgets are not increasing fast enough to keep pace with demand for family planning; USAID's role in contraceptive supply is at best stable, and may be reduced, resulting in increased demand for Bank resources for contraceptive procurement. The note classifies countries in the region according to their demographic characteristics and program history and suggests a differentiated Bank strategy.

36. In EMENA, family planning in Bank projects has been carried out through the health system. In some parts of the Middle East this reflects traditional attitudes towards population and family planning issues. In the Maghreb countries, however, there is growing acceptance of the need to consider demographic variables in economic and human resource development. The Maghreb division produced two reports in FY90 which provide this movement with important theoretical underpinning.[5] In LAC, many countries remain very sensitive on population matters, but have accepted the importance of family planning as a health intervention. Sector work in the region does much to reinforce this importance, the FY90 Brazil study on Women's Reproductive Health being a case in point.

37. Research work currently underway in the PHRHN division will help to inform some of the issues that the operating divisions and TDs in the regions are grappling with in the

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[3] Ibid, Executive Summary, para. 3.

[4] "Asia Region: Discussion Note on the Population Sector" June 29, 1990

[5] "Morocco. Reaching the Disadvantaged: Social Expenditure Priorities in the 1990s", and for the Maghreb, "The Demographic Challenge to Sustainable Economic Development"

formulation of country strategies. Work on the Determinants of Fertility Decline and Contraceptive Prevalence will help evaluate the place of family planning programs in human resource development; the extent and nature of the social development that affects demand for family planning, and the interventions that would be mutually reinforcing. The research on Family Planning Effectiveness, already mentioned in connection with NGOs, will also address issues of what structures and implementation mechanisms are most appropriate at different stages of a country's program development and fertility transition.

38. In LAC, EMENA, and Asia, regional strategy is developing more slowly than in Africa. Mechanisms such as the Task Force are not emerging. One reason might be that Africa is the one region which has a separate PHN Technical Division, whereas the others do not. Unless there is a sufficient number of people experienced in population in the TDs to promote and monitor the development of regional strategies and priority action programs, with all that this involves for economic and sector work and policy dialogue, it is unlikely that this will happen - SOD PHN staff being too involved in their own country work. At present, population professionals in the TDs are all too often so much engaged in providing support in the appraisal and supervision of country projects, and in country ESW, that there is very little opportunity left to draw back and take a regional view.

39. Total Bank lending for population amounted to just under $170 million in FY90, an increase of 35 percent over the previous year (Annex 6). Two projects were "free-standing" population projects -- Kenya Population IV and India Population VII, and six others made substantial provision for family planning (Annex 7). The two "free-standing" projects accounted for 78 percent of population lending, indicating the heavy dependence of the program, in dollar terms, on this type of project. In FY89 and FY88 the proportions were 99 percent and 88 percent respectively. The lesser proportion in FY90 is due to the larger number of combined projects. Including the "free-standing" projects, eight out of 12 PHN projects contain a population component in FY90, compared with 4 of 11 in FY89 and 5 of 8 in FY88. While there has been an increase in lending for population, its share of PHN lending is slightly down, from 23 percent to 21 percent.

40. Lending in the Asia Region, where the Bank has long been supporting large-scale national family planning programs formed, as usual, the mainstay of the population lending program. Here, the convention by which such projects are considered 100 percent population tends to overstate somewhat lending in the sector. In India, for example, there has been a major effort to make maternal and child health services a more equal partner in the Family Welfare Program -- both as essential in their own right, and as an important contributor to reducing family size desires. In the Africa region, where, with the exception of Kenya, the Bank has been involved in PHN only since the early 1980s, the strength of effort being put in is beginning to be show results. The only project without a family planning component is the Nigeria Essential Drugs project, and population lending represents nearly one third of PHN lending in the region. The Fourth Kenya Population Project, which primarily supports contraceptive supply, entered the FY90 program as a quick Bank response to the dramatic, and unexpected, acceleration in demand for family planning. In the second PHN project in Lesotho, the family planning component is valued at 10 percent of the total credit as compared with 3 percent in the first project. In Tanzania, the Bank is making its first investment in the sector. In LAC and EMENA, the Bank approach continues to be to ensure the provision of family planning within health services, and is reflected in the solid showing of family planning lending in these regions' FY90 PHN programs.

41. While defining the India project as totally "population" inflates the estimates of population slightly, this tendency is more than offset by the fact that many other features of the

combined PHN projects support the provision and management of family planning services -- joint costs incurred in training, building management and information systems, supplying equipment and drugs, constructing and rehabilitating clinics, and so on -- features not fully accounted for in the estimates for population lending given here. In addition, social development projects in Cameroon, Chad and The Gambia include population components,. The assistance given by the Bank has, moreover, been greatly magnified by increasing coordination with other donors at many levels of aid -- from cooperation in the design of assistance to a region, to division of labor in support to country programs, to cofinancing of projects.

42. The encouraging news for the population sector in FY90 lies more in the number and geographical range of the projects than in the amount of lending alone, though this too was up, and more projects showed substantial support to population than was evident last year. The stimulus to population activities given by cofinancing, particularly in social development projects, has also been very encouraging. This overview of the population sector has concentrated on themes that have run through the FY90 program - increased donor coordination, increased use of NGOs, and increasing integration of population into country development strategies. As stated earlier in this section, the full and rigorous treatment of population as a macroeconomic issue remains a challenge for the Bank. Another emerging issue is that of meeting the increased demand for contraceptive supply. The growing numbers of governments providing family planning services, and the growing number of women of reproductive age, taken together with USAID's warning that it cannot continue to underwrite contraceptive supply indefinitely, implies increased demand for Bank resources in this area. In fact, the larger question, within which the commodity issue lies, is that of the almost inevitable demand for increasing Bank support, given the stagnant level of funding from other sources.

HEALTH

43. Sector work and PHRHN research make clear that the following factors, among others, present a formidable challenge to Bank staff responsible for health sector development work in the Bank in the 1990s:

(a) Demand for health projects is great and growing, stimulated by the high priority placed on human resources development objectives by national governments and the World Bank;

(b) Weak institutional capacity severely constrains the potential of governments to translate policy into appropriate programs and to effectively manage their financing and implementation.

(c) The epidemiological and demographic profiles of countries are evolving (albeit at various stages of evolution, depending on the country/region) towards a disease burden, whose composition is shifting away from infectious and parasitic diseases and undernutrition, whose main victims are children, to non-communicable disease (e.g. cardiovascular disease and cancer), which largely affect adult populations. The emergence of AIDS has also significantly affected national and regional epidemiological profiles and priorities. Thus the choice of target populations, as well as of priority interventions for Bank investments, is not an easy one.

(d) Constrained resources for the health sector render priority-setting crucial, and call for efforts to maximize sector efficiency and to mobilize additional resources for

health (through cost recovery schemes, aid coordination/cofinancing efforts, and rationalization of national health budget allocations and expenditures).

(e) The involvement of private sector and NGOs in the delivery of health care is increasing in many countries, calling for efforts on the part of national governments to coordinate and regulate this essential contribution to health sector development, with a view to maximizing its utility.

(f) Hospitals and lower-level urban health facilities are increasingly (and correctly) appreciated as an integral part of a viable primary health care (PHC) system, rather than being perceived as competitors for resources with rural PHC facilities, resulting in the devotion of some Bank time, effort and resources to improving the management and efficiency of hospitals and to the strengthening of urban PHC facilities. Over and above an appreciation of the role of hospitals in PHC, Bank involvement in the hospital sector has sought to increase their internal efficiency, contain costs and restrain unjustified growth, given that hospitals, in many settings, consume a large proportion of scarce resources.

(g) Increased interest and attention is being accorded to the poor state of maternal health and to the need for cost-effective Safe Motherhood initiatives, resulting in a growth in demand for assistance in this domain.

(h) Chronic shortages of essential affordable drugs continue to constrain the quality and credibility of public health services.

44. Project and sector work undertaken during FY90 made a noteworthy effort to meet these challenges. In addition to the growing numbers of reports and operations produced to effectively meet a growing demand for health operations (Chapter II), the content and focus of lending and sector work addressed these issues in a number of ways, as discussed below.

45. A significant proportion of sector work undertaken during the year (including tasks still in process as well as completed tasks) accorded some of these issues a single focus, in an effort to further understanding of these issues and an appreciation of how to address them effectively in operations. Seven sector tasks focus exclusively on AIDS, nine on financing issues, three on women issues/Safe Motherhood, one on long-term health issues, one on NGOs. In addition, these and other pertinent issues raised above were addressed in the 20-plus sector tasks, which were more broadly focused on population, health and/or nutrition sectors. The relatively recent creation of Technical Departments has encouraged and facilitated the production of sector work with a regional focus. Such work has provided valuable insight and perspective on current sectoral issues and challenges. Examples produced or initiated during FY90 include: (a) for Africa: AIDS Resource Allocation (Phase I); Africa Health Policy Paper; Health Financing; and Review of Pharmaceuticals; (b) for Asia: Financing of Social Services; and Poverty and Health Services; (c) for EMENA: Demographic Challenge to Sustained Economic Development; and (d) for LAC: Social Security in Latin America: Issues and Options for the World Bank.

46. Project work was equally responsive to many of these issues, including:

(a) special components on AIDS (e.g. Haiti Health and Population; Tanzania Health and Nutrition; Lesotho Population, Health and Nutrition II);

(b) explicit and widespread (across projects) focus on reproductive health interventions (most notably the MCH component in the Brazil Health Project which draws heavily

on the FY90 sector report on Women's Reproductive Health in Brazil, and also the Bolivia Integrated Health Development Project, India Population VII and Nutrition II, to name only a few);

(c) investments to improve hospital management and efficiency and strengthen urban services (Lesotho Population, Health and Nutrition II, Yemen Health II);

(d) significant investment in drug supplies (Nigeria Essential Drugs);

(e) emphasis on institution building (e.g., Haiti Population and Health, Nigeria Essential Drugs, India Population VII, and Morocco Health);

(f) important resource allocation and mobilization initiatives (e.g., Tanzania Health and Nutrition, Haiti Population and Health, and Morocco Health); and

(g) coordination with NGOs (e.g., Lesotho Population, Health and Nutrition II).

47. Research and policy work undertaken in PHRHN during FY90, as described in Chapter IV, also contributes to the exploration and resolution of salient health issues outlined above.

NUTRITION

48. Bank support of nutrition activities, both including and in addition to PHN operations, has expanded significantly. Lending in FY90 totaled approximately $150 million for four operations in which nutrition was the principal focus (India Tamil Nadu Nutrition II, Tanzania Health and Nutrition, Colombia Community Child Care and Nutrition, Jamaica Social Sector Development). This compares to $50 million and two operations during the ten year period FY80 to FY89. In addition to these four significant operations, seven of the other nine PHN and four of the other five Social Sector projects, approved in FY90, support nutrition components. Other FY90 approved Bank operations which provide for nutrition activities include: three agriculture sector adjustment operations (Malawi SAC, Mali Agriculture SECAL, Mauritania Agriculture SECAL); three education operations (Madagascar Education Sector Reinforcement, Bangladesh General Education, Pakistan Sind Primary Education Development); and five structural adjustment operations (Sao Tome & Principe SAC III, Senegal SAL IV, Sri Lanka Economic Restructuring Credit, Algeria Economic Reform Loan, Trinidad & Tobago SAL I). The pipeline for future operations is strong, as well. Nutrition lending is expected to approach $200 million for three major projects in FY91, and exceed $500 million for at least six major projects in FY92. When counting nutrition components in projects in other sectors and the nutrition portion of adjustment projects, lending for nutrition for the period FY90-92 is expected to exceed $1 billion.

49. India continues to account for the largest volume of free-standing nutrition lending. Tamil Nadu Nutrition II will extend the successful Tamil Nadu pioneer project from the original 9,000 villages to all of that State's 20,000 villages. A new project tied to India's Integrated Child Development Services (ICDS) program (approved in September, 1990, $106 million) will extend Bank nutrition assistance to two new states, Orissa and Andra Pradesh. Also in the region are free-standing nutrition projects (or projects in which nutrition will be a main theme) in various stages of preparation, for Bangladesh, Indonesia, the Philippines, Sri Lanka and, again, India.

50. LAC has the most broad-based nutrition program of the Bank's four regions. Most significant in FY90 are the innovative Colombia Child Care and Nutrition project and the

Jamaica Social Sector Development project. Smaller nutrition components are supported in the two Bolivia projects (Social Investment Fund and Integrated Health Development credits), Brazil Northeast Basic Health II, and Haiti Health I. An Argentine request for a $200 million Social Emergency and Adjustment project (85% nutrition) may result in the Bank's largest nutrition operation to date. The Venezuela Social Development and Nutrition project prepared in FY90 ($105 million) will support food and nutrient supplementation programs through health centers, and targeted nutrition programs for primary and preschools. Projects in which nutrition will play a major role also are being prepared for Brazil, Ecuador, Guatemala and Mexico.

51. In addition to the Tanzania Health and Nutrition project, FY90 lending in Africa supports nutrition components in Lesotho PHN II, Chad Social Development Action, Gambia Women in Development, and Uganda Poverty and Social Costs. One of the largest nutrition activities in Africa has been the Bank's food-security initiative. In FY90 food security studies were completed for Kenya, Mozambique, Malawi, Benin and the Sudan. The first of this group of studies was Kenya's Food and Nutrition Policy Sector Study. In addition to analyzing malnutrition and food insecurity at both the household and individual levels, this study proposes several options for direct nutrition interventions including targeted fortification in specific regions at high risk for micronutrient deficiencies. The first free-standing food security operation in the Bank will be undertaken in Cameroon in early FY91. Included is a nutrition education program linked to efforts to improve the purchasing power of high risk households. Also under preparation is a free-standing Food Security and Nutrition project for Madagascar.

52. The two PHN projects approved in EMENA in FY90 also address nutrition. A significant portion of the Morocco Health Sector Investment project will support nutrition activities including growth monitoring and food and micronutrient supplementation, while the Yemen Health II project will significantly increase human resource capacity in nutrition through training. In the pipeline, a large nutrition operation is under discussion as part of a forthcoming Social Costs of Adjustment credit in Egypt, and a proposed Safety Net Program for Morocco will emphasize improving food and nutrition programs. EMENA has taken an active role in the recent Bank effort to design ways to improve primary school performance through alleviating malnutrition and hunger in students. The FY90 Pakistan Sind Primary education project will test whether a school feeding program can improve nutrition status, increase enrollment and enhance student achievement. Nutrition components in primary education projects designed to address the "teachability" of children in an effort to improve education efficiency are also under preparation in Africa (Mozambique, Burkina Faso) and LAC (Brazil, and the Dominican Republic).

53. Nutrition was featured in several PHN sector studies and addressed in numerous other Bank documents published during the year. Refer to Annex 8 for the complete list of nutrition-related sector and research work. Below are some of the highlights from this broad range of work.

54. Both the Tanzania and Mozambique PHN sector reviews included detailed analyses of the nutrition situation in these countries. In Tanzania the call was to adopt a national nutrition policy to elevate nutrition considerations in agricultural policy and for interventions to change infant and child feeding practices taking into account women's domestic labor burden. For Mozambique, recommendations were for growth monitoring, well-targeted food distribution and nutrition education programs, as well as for improvements in the targeting of food aid to vulnerable groups. Subsequent, significant nutrition operations are currently underway in each of these countries. In China, a Bank study of that Government's general urban food subsidy program showed how costly it has been and how its basic objectives could be met, at far lower cost, through a revised program based on targeting. Also on targeting, the Morocco Poverty

Study devoted chapters to both nutrition and food subsidies, and concluded that the food subsidy program is not targeted to groups at high nutrition risk, and policy reforms will at best protect the income of some beneficiaries of current policies but will not do anything about structural nutrition problems. The Social Safety Net project is expected to flow from this analysis.

55. A Bank Discussion paper on nutrition published during the year, "Improving Nutrition in India," identifies that, despite substantial progress towards evolution of a nutrition policy in India, the distribution of nutrition expenditures has been insensitive to the observed regional variations in malnutrition. Adoption of a regional approach to nutrition planning is called for, as well as efforts to strengthen the nutrition data bases to encourage the design of interventions appropriately molded to accommodate regional variations. The report "Fighting Malnutrition -- An Evaluation of Brazilian Food and Nutrition Programs" reviews Brazil's long and varied experience with emergency nutrition programs, and suggests that many of the constraints to effective nutrition interventions are operational rather than conceptual. A Bank Technical Paper also published during the year, "Helping Women Improve Nutrition in the Developing World: Beating the Zero Sum Game," draws attention to the linkages and competition among women's life roles, and suggests that women's time constraints may partially explain poor participation rates in many development projects. The report offers suggestions for using an analysis of women's roles to address nutrition problems in developing countries. Another technical paper "A Case for Promoting Breastfeeding in Projects to Limit Fertility" points out that actions to promote breastfeeding have generally not been a significant part of Bank population projects even though more women are protected from pregnancy in many countries through breastfeeding than through all family planning contraceptive methods combined.

56. A major bottleneck in Bank nutrition work in earlier years has been a shortage of staff knowledgeable in the field. FY90 saw a change on this front. Africa has hired two new nutrition experts (and is recruiting a third), LAC two, and Asia one. Three of the four Technical Departments now have full-time nutrition experts and one, ASTPN, has recruited a second. In addition, PHRHN conducted a three-day workshop on "Nutrition for Non-nutritionists"; more than twice as many Bank staff applied than could be accommodated. PHR repeated the course in early July 1990 and a special course for agriculture staff is scheduled for April 1991. Increasingly, the Bank is taking advantage of other donor, particularly UNICEF, presence and knowledge in nutrition to compensate for limited staff capacity. For example, the Tanzania Health and Nutrition Project expands a program that UNICEF and WHO successfully mounted with Italian government resources in 1984. Similarly, the Colombia Community Child Care and Nutrition Project is based on a model developed and tested by UNICEF and other non-governmental organizations. Also, Bank missions are receiving more help from UNICEF in the preparation of projects. An identification mission for a nutrition project in Bangladesh and preparation of the Argentina Social Emergency and Adjustment project have been carried out in collaboration with UNICEF.

57. The momentum in nutrition activities which began following Reorganization has continued, and in some ways accelerated, during FY90. Lending has increased and the pipeline for future nutrition operations is strong. Nutrition's linkages with sector operations outside of PHN including agriculture, education, women and development, and others, as well as with adjustment activities, have grown stronger during the year. Staff capacity has been strengthened through nutrition training courses and the recruitment and hiring of additional technical nutrition staff in three of the four Bank regions.

58. Nevertheless, most departments still do not have staff experienced in nutrition operations. The Bank continues to need to develop more institutional capacity to respond to management's

commitment to nutrition and the many emerging opportunities. With this additional capacity the Bank will be in a position to:

(a) ensure that the quality of nutrition operations continues to improve;

(b) ensure that a comprehensive effort is undertaken to assess the effects of adjustment on nutrition, and that effective compensatory actions are put into place;

(c) ensure that sector work undertaken through the African food security initiative generates appropriate nutrition operations;

(d) expand efforts to include nutrition components in primary education projects;

(e) strengthen the now still weak links between agriculture sector work and operations in the Bank and nutrition issues;

(f) incorporate breastfeeding promotion components in projects with fertility control objectives;

(g) explore and act upon other potential links between Bank operations -- e.g. worker productivity issues in infrastructure projects, forestry projects -- and nutrition; and

(h) direct attention to nutrition issues of increasing visibility and importance, e.g. diet quality issues, especially micronutrient deficiencies.

CHAPTER IV. THE PHN RESEARCH AND SPECIAL GRANTS PROGRAMS: A FOCUS ON ISSUES AND CHALLENGES IN PHN SECTORS

59. During FY90 PHRHN dedicated its resources to the research and support of many PHN sector issues raised in Chapter III. While Chapter IV will limit itself to the assessment of PHRHN's FY90 accomplishments, a more detailed description of PHRHN's work is presented in Annex 9; and a list of publications produced by PHRHN during FY90 is contained in Annex 10.

POPULATION

60. Two population research tasks will provide direction both to staff within the Bank, and to government officials on the development of appropriate policy and programs to facilitate an efficient reduction of fertility. The task entitled "Impediments to Contraceptive Use and Fertility Decline" will build upon previous studies to explore both demand and supply impediments with a view to recommending more effective targetting and design of FP services. "Effective Family Planning Programs" seeks to: (a) demonstrate the effectiveness of properly managed family planning programs at increasing contraceptive use; (b) provide a concise synthesis of the major factors that contribute to program effectiveness; and (c) recommend appropriate national policies and donor policies for strengthening family planning programs. The Safe Motherhood Initiative activities described below under the Health section, and in more detail in Annex 9, paras. 17-22, have sought to promote demand for and availability of family planning services in support of maternal health. Special Grant Programs, managed by PHRHN, support research on Population NGOs and on Human Reproduction.

HEALTH

61. Three PHRHN research tasks aim at assisting in the establishment of national health sector priorities (target groups and cost-effective interventions) in the face of an evolving epidemiological profile and constrained resources: "Adult Health", "Disease Control Priorities in Developing Countries" and "Economic Impact of Adult Mortality in Sub-Saharan Africa". Safe Motherhood activities undertaken by the division have successfully promoted, inside and outside of the Bank, the importance of this issue and continue to explore and promote the most cost-effective interventions in this regard.

62. The Africa Health Policy Study, targetted at government officials, Bank staff, and the donor community, will facilitate the development of appropriate health policy for Africa by Africans, by identifying the need for capacity building in this regard, assessing strengths and weaknesses of existing health policies in Africa, and encouraging donors to support the refinement of policy with more resources and greater flexibility. The International Health Policy Program, an initiative supported by two private American foundations, and undertaken in cooperation with the Bank and WHO, also supports the development of local capacity in health policy analysis.

63. The "Hospital Resource Use" study addresses both financing and management issues, exploring ways to increase hospital efficiency and cost-recovery efforts, which would permit reallocation of a significant amount of scarce resources for health away from hospitals to lower level facilities, whose services are suffering from lack of recurrent financing.

64. Several health issues are being addressed through special grant programs dedicated to the following topics: Tropical Diseases, AIDs, Riverblindness, Child Survival and Safe Motherhood.

NUTRITION

65. A research project on micronutrients will seek to improve information on how dietary quality changes with increased income and on the most cost-effective interventions for improving nutritional status. A Special Grants Program supports the United Nations/Administrative Coordination Committee (UN/ACC) Subcommittee on Nutrition.

CHAPTER V. PROSPECTUS

FY91-94 LENDING AND SECTOR WORK PROGRAMS

Continued Growth

66. Both in terms of number of projects and loan/credit amounts, the volume of PHN lending has grown rapidly over the past five years, as indicated in Annex 1. The significant reduction in lending volume, which occurred in FY87, was a temporary phenomenon, largely attributable to slippage in the lending program caused by the reorganization. The growth since that year, however, permitted a rapid recovery: FY90 figures exceed those of FY86, the year prior to reorganization, by an overall increment of seven projects and by a virtual doubling in the value of the lending program. The future lending portfolio indicates a continuation of the growth in lending. The FY91 program is comprised of 20 projects valued at US$940 million, reflecting a growth in numbers of operations of 11 percent and in loan/credit amounts of 1 percent over FY90. The FY92 program indicates further increase over the FY91 program by 45 percent in terms of projected numbers of operations and by 43 percent in terms of projected loan/credit amounts. Such anticipated growth, even when discounted by a pipeline factor, is significant. About one-half of operations planned for FY91-92 are in the Africa Region, with the balance being rather evenly distributed across the remaining three regions. The FY91-94 Sector Work Program reflects, as well, a strong emphasis on the Africa region; of the 77 sector reports planned over the next four years, 52 (or 67 percent) will be focused on Africa.

67. There are a number of reasons for the momentum in actual and forecasted growth in PHN lending. First, while population has been accorded high priority by the Bank for many years, efforts are currently being intensified to stimulate a demand for and a consequent increase in operations in this sector. Second, the demand for family planning and other population interventions is expected to continue to grow, as more governments, particularly those in Africa, come to fully appreciate the negative impact of population growth on development prospects, as well as the health benefits of family planning services. Third, human resource development is accorded very high priority, in the context of overall economic reform and development objectives, by both the Bank and national policy makers, whose dialogues have culminated oftentimes in human resource development strategies. These strategies, in turn, seek the support of various types of Bank interventions, including PHN operations, and PHN components in Social Development, SAL/SAC and SECAL operations. Fourth, many countries' health sectors, in particular, are currently poorly organized and financed and face both rapidly escalating service costs and expanding consumer demand. Fifth, the growth in nutrition activities, which began just after reorganization, has accelerated during FY90 and is expected to continue in terms of its presence in PHN lending (including free-standing and integrated projects), as well as its presence in other multi-sectoral and structural adjustment operations.

Nature and Focus

68. In addition to the projected rapid growth in the volume of PHN lending, several emerging trends in the nature and focus of PHN operations will have implications for the Bank's future work in these sectors. First the high priority accorded to human resources development by both the Bank and national governments alike, coupled with the merger in the Bank of population, health and nutrition and education sectors into population and human resources divisions, will sustain the emergence of social sector development operations, which encompass sectors within and outside of the responsibilities of PHR divisions. Social sector development projects comprise one quarter of all operations in the FY91-94 program. Second, PHN sector

adjustment operations are another emerging feature of PHN activities. Rather than the design, development and supervision of a project, whose activities are well defined, these operations will focus on broader policies and strategies, and will accommodate the design and implementation by governments of programs and activities that fall within broad parameters and that fulfill conditions defined under the operation.

ISSUES AND SUGGESTIONS FOR FUTURE WORK

69. PHN work has contributed significantly to the achievement of the Bank's overall development objectives. First, PHN, as an integral part of human resource development and poverty alleviation activities, figures prominently among the Bank's priorities. Second, PHN objectives have been effectively advanced through a variety of Bank activities: PHN project and sector work; the development and implementation of social development operations, encompassing the integration of education, and often other sectors into a multi-sectoral operation, targeted at poor and vulnerable segments of national populations; and the integration of PHN dialogue and activities into the Bank's macroeconomic work, most particularly, SAL/SAC and SECAL operations. Third, while PHN continues to be a most challenging and difficult field, a positive change in the environment is emerging. The Bank and national governments, alike, are according PHN high priority and the impact of Bank interventions is much greater, now that it is increasingly focussed at the policy and program levels, and meeting with increasingly receptive governments, whose growing appreciation of the value of policy reform has culminated in ongoing development and implementation of policies and programs, reflective of and much more appropriate to national PHN sector needs. Declines in TFR and increase in contraceptive use are being observed, as well as significant improvements in health status.

70. This report offers the following suggestions for more effectively carrying out future work in the PHN sectors. While most of the suggestions below address issues common to all three sectors, specific suggestions for improving the Bank's work in population will not be put forward by this report. They will, rather, be withheld pending the production of a population strategy paper, which is currently under preparation by the Population Adviser in PHRDR.

Technical Issues

71. With respect to technical issues which confront Bank staff working on PHN sectors (discussed in Chapter III), this report suggests that particular effort in future work be focussed on the following:

(a) The increased focus of Bank PHN interventions at the policy and program levels has proven an effective means of achieving on PHN sector objectives. Future Bank work should intensify and improve the quality of our work undertaken thus far in this area. Sector dialogue should provide comprehensive and rigorous policy analysis which fully reflects the wisdom and experience of experts residing in the country/region, as well as the socio-political context of the country in question. Decentralization policies should be fully explored with regard to their practical application in the PHN sectors. Project design should provide for capacity building in policy formulation, planning and program development, and implementation. It should also provide for pilot testing and replication of innovative proposals for policy reform. Provision also should be made for the ongoing review and revision of health sector policies and priorities in the face of evolving epidemiological profiles.

(b) Management and institutional development issues need to be addressed more rigorously and comprehensively through project and sector work. Particular emphasis should be placed on: (i) organizational analysis; (ii) coordination between institutions and agencies which share responsibility for one or more of the PHN sectors; (iii) clear definition of roles and responsibilities of agencies and staff involved in the sectors; and (iv) management capacity-building at every level of programs and services through practical training, supervision, limited, carefully selected technical assistance, aimed at developing the capacity of a clearly designated counterpart, and monitoring and evaluation of targets and performance.

(c) The role of the private sector and NGOs in the design and delivery of PHN interventions is great and growing. Bank interventions in the PHN sectors must, therefore, encompass these vital resources as well as the public sector in order to maximize the individual strengths and contributions of all actors in the PHN sectors, as well as their collective efficiency and effectiveness. This strategy is essential and has great impact potential, given the increasing assistance and attention accorded by the Bank to the policy/program arena.

(d) PHN financing issues will continue to be crucial to the success and sustainability of any PHN intervention, whether financed by the Bank or not. Given its comparative advantage (in terms of expertise in economics and finance, as well as the leverage it possesses at the macroeconomic level), the Bank should continue its efforts to address and resolve PHN financing issues, which calls for: (i) mobilization of resources for the sectors (through a number of activities such as cofinancing and aid coordination; reallocation of public resources within and across sectors; cost recovery schemes...), and (ii) effective utilization of resources (through such activities as cost containment, investment and financial planning and management, decentralized budget decision-making and accountability). It is particularly important in addressing this issue to build national capacity in these disciplines. Aid coordination, while currently being undertaken in many instances by the Bank, should ultimately become the responsibility of governments, whose policies and priorities should drive the content and focus of external assistance to the sectors, rather than the reverse.

Internal Bank Issues

72. PHR Technical Divisions have demonstrated their potential for undertaking sector work, which has provided a regional dimension to PHN issues and succeeded in enhancing dialogues with, and the involvement of, key staff in the Bank (e.g., CODs), as well as regional experts and policymakers, in the development and implementation of Bank and national policies. This contribution has assisted in the achievement of progress in the sectors and should be continued.

73. With the growth in numbers and complexity of PHN work, the need to expand staff capacity is evident. Gains have already been made in FY90, both through training and recruitment, but these are unlikely to be sufficient, given continued growth in the sectors as reflected in the FY91-94 lending program. Budget decisions in the Bank should consider this issue very carefully, particularly given the high priority accorded to PHN sectors. The upcoming Population Strategy Paper will address this issue for the population sector, where a shortage of senior population experts is felt to be an issue.

74. Other suggestions for changing the Bank's internal working environment to improve the effectiveness of PHN operations are explored in Chapter III and summarized below:

(a) Efforts should be intensified to employ Third World experts in all aspects of the Bank's work in PHN and to involve beneficiaries in the design, development and implementation of PHN interventions. The idea of establishing a special fund for internships by the Bank, to provide opportunities for Third World experts to work with the Bank for the first time, should be vigorously pursued.

(b) Roles and responsibilities in all work related to Social Sector Development Projects should be clearly delegated and streamlined.

(c) Models and methods for co-financing and aid coordination should be further developed and improved, including a full consideration of the costs and benefits of Bank staff involvement.

(d) Examples of successful coordination with CODs on human resources development aspects of microeconomic dialogue and operations (SAL/SAC) should be built upon and expanded.

(e) Promotion and expansion of nutrition activity in a wide variety of Bank lending and sector work (SAL/SAC, agriculture, food security, PHN, education...) should be continued, given the success achieved thus far.

(f) PHRHN should intensify its efforts to improve: (i) communications and exchange of information among staff in the Bank involved in PHN work; and (ii) processes and systems for information collection and analysis.

ANNEXES

PHN Lending, FY86-90
Commitment in US$ Millions (Number of Projects)

Region	FY86			FY87			FY88			FY89			FY90		
	1*	2	3	1	2	3	1	2	3	1	2	3	1	2	3
AFRICA	82	20%	(5)	31	57%	(4)	121	40%	(5)	81	15%	(4)	232.7	25%	(8)
ASIA	242	58%	(4)	0	0%	(0)	74	24%	(2)	290	53%	(4)	192.5	21%	(2)
EMENA	0	0%	(0)	13	24%	(1)	0	0%	(0)	80	14%	(2)	119.0	13%	(2)
LAC	96	23%	(2)	10	19%	(1)	109	36%	(1)	99	18%	(1)	389.2	41%	(6)
TOTAL	420		(11)	54		(6)	304		(8)	550		(11)	933.4		(18)

*1 - Lending in US$ millions
2 - percent of PHN lending
3 - number of projects

MAJOR SECTORAL COMPONENTS OF SOCIAL DEVELOPMENT PROJECTS, FY90
(As % of Total Base Costs)

Country	PHN	Education	Employment Training Skills Dev.	Sanitation	Agriculture	Other[1]
Cameroon	28.0	12.0	38.0	---	---	22.0
Chad	31.0	---	18.0	34.0	---	17.0
The Gambia	10.0	---	22.0	---	26.0	42.0
Uganda	23.0	38.0	---	9.0	---	30.0
Bolivia	61.0	30.0	---	---	---	9.0
Jamaica	47.0	49.0	---	---	---	4.0

[1] "Other" = predominantly cross-sectoral activities such as institutional development; community development; women in development; infrastructure; IEC and project management.

ANNEX 3

DESCRIPTION OF SELECTED SECTOR TASKS UNDERTAKEN DURING FY90

1. MALAWI POPULATION: The Bank completed its second Population Sector Report on Malawi (the first report was issued in 1985). The FY90 review was conducted as a joint exercise with the government, UNFPA, USAID, UNICEF, and other donors. A major purpose of this unusual format was to use the exercise (a difficult one to manage) as the basis for future program planning and donor coordination."The process was an important part of the product", to quote the task manager.

2. Malawi is a classic case of an African country that has resisted adoption of an explicit population policy but which has developed quite rapidly, over the past five years, an effective if still limited network of family planning services (called "child spacing" services). The government had accepted the two main recommendations of the Bank's 1985 report, i.e. that it should establish a population planning unit high up in the government, and that the small child spacing program should be expanded and strengthened. Two Bank Family Health projects supported the latter objective, among others. The popular response was strong and, despite rapid increases in both services and FP acceptors, services are still unable to keep up with demand. A Bank-sponsored Workshop (October 1989) for Principal Secretaries from all major government departments showed strong support for strengthening the program: senior government officials are clearly aware of and alarmed by the country's demographic situation, even though national politics still dictates that the program march under a "child spacing" banner.

3. Despite the recent rapid program expansion, the CPR is still only about 3 percent; the population growth rate is a very high 3.5 percent; the TFR is around 7.5; and density per sq. km. of arable land averages a high 171. These unfavorable demographic factors will inevitably exert strong pressure on land, on education and health services, and on the labor market. There is no prospect of long-term relief unless the present very high fertility levels can be brought down. The report contains many recommendations for doing this. The Bank's Third Family Health project, now under preparation, is already reflecting some of the report's recommendations. The government, as well as some of the donors, have drawn from this report in the development of clear proposals for improving and coordinating their own programs.

4. HEALTH FINANCING IN ASIA: The Asia TD has taken a particular interest in the financing of social services in its Region. An Education paper was completed in FY89. FY90 saw completion of "Health Financing in Asia". The paper, likely to be published as a Bank book, presents a comprehensive overview of health status among countries within the Region (India on one end, Korea on the other) and between Asia and the other Bank Regions, tied to an analysis of how different kinds of health activities are financed (central and state governments, private, and insurance funding). One of the paper's main findings is that health outcomes cannot be explained by differences in income levels or proportions of public budgets spent on health; rather, it notes that policies, or the way in which governments decide to spend their health funds, seem to have significant impact. The study, however, makes no attempt to deal with normative questions of how governments ought to spend their health funds. A 15-page Executive Summary highlights the report's findings.

5. WOMEN'S REPRODUCTIVE HEALTH IN BRAZIL: This is the third in a series of reports on Brazil's health sector. The unusual focus of this report is justified by the fact that reproductive health indicators are unusually poor for a middle-income country. Women are a particularly vulnerable and important group "because of their additional health needs associated

with reproduction and because of the importance of women's health for the health and survival of their children." The government established a special Program of Women's Health in 1984, but implementation has been thus far weak.

6. The following are identified as the key reproductive health problems of Brazilian women:

(a) severely limited choices of contraceptive methods and information;

(b) high rates of unsafe abortions (legally very restricted);

(c) high rates of cervical cancer (the main cause of cancer-related mortality among Brazilian women);

(d) a high percentage (25 percent) of women who receive no prenatal care, leading to high rates of maternal mortality;

(e) the world's highest rate of caesarian section deliveries (half of which are believed unnecessary, and which have high health and financial costs); and

(f) a growing incidence of sexually transmitted diseases and other reproductive tract infections.

7. The report finds the public health system unresponsive to women's basic health needs, in part the result of a general problem of misallocating public health funds in favor of hospital-provided curative care. Six priorities are named that would breathe life into the government's 1984 Women's Health Program. Action will require a modest increment in financial resources.

8. NIGERIA: HEALTH CARE COST, FINANCING AND UTILIZATION: This large and relatively well-off Sub-Saharan country shows health indicators no better than many of its smaller, poorer neighbors -- despite past heavy investment in health facilities and in staff training. Ironically, despite these investments, there has been decreasing demand for public health services. This is due to the fact that the system has been starved for current resources since the decline in oil revenues in the early '80s. Lower public revenues have dried up drug supplies and led to under-maintenance of facilities, causing people to avoid PHC facilities where they know they are unlikely to find drugs. They go instead to the private sector (dominated by church facilities), or traditional healers, or to the hospitals, where they know they have better chances of finding drugs.

9. The report recommends higher cost recovery (which is not expected to discourage demand if the poor are exempt), retention of some fees at collecting sites to permit better maintenance, assuring adequate drug supplies, reducing the hospital bias in the referral system by assuring lower charges at PHC units, and recognizing the private sector (including traditional healers) as part of the national health delivery system. [The critical drug problem is being addressed through the FY90 Essential Drug Project noted in para. 20. The FY91 Health System Fund project will also help overcome the resource shortage in all 21 States].

10. There have been major developments in Nigeria's health and population policies during 1988 and 1989. The first of those years saw the adoption of "The National Health Policy and Strategy to Achieve Health for All Nigerians", a remarkably frank document which noted the many weaknesses of the present system. Primary health care is underlined as the key to the health-for-all objective; a Model PHC Program has been introduced with federal assistance to

the states (responsible for health provision) to help them move in this direction. The Federal MOH has been successful in persuading all States to endorse development of a National Essential Drugs Program along the lines of WHO's world-wide recommendations. In population, the Government adopted (in early 1988, with a launching in April 1989) a new National Population Policy. This is a strong, explicit document for which consensus was carefully developed over a period of three or four years. The Bank, together with UNFPA and USAID, provided technical and financial assistance for this effort. A large Bank population project is expected to be approved in FY91.

11. THE MAGHREB (MOROCCO, ALGERIA, TUNISIA): THE DEMOGRAPHIC CHALLENGE TO SUSTAINABLE ECONOMIC DEVELOPMENT: This report explores the long-run economic impacts of population growth and means of abating rapid population growth to curb the magnitude of these impacts. Combined population in the three countries has increased from about 20 million in 1950 to nearly 60 million today. All three have begun the classical demographic transition from high to low birth, death, and population growth rates. They nevertheless face a surge in population over the next quarter century, which is bound to threaten their political stability and living standards. Inevitable rapid growth of the labor force will make it doubly difficult to reduce unemployment (already 18-20 percent, with emigration no longer a safety valve). The capital stock will almost surely be diluted, lowering productivity and real wages. Increasing budget constraints will make it difficult to improve social services as population continues to grow rapidly.

12. Rapid population growth has duel consequences for economic growth and poverty. It can stimulate economic growth by enlarging demand; but it slows any increase in per capita incomes by diluting the benefits of growth. So there is a clear trade-off between population growth and rising living standards, and a direct relation between rapid population growth and rising poverty. The absolute number of poor increases; the incomes of the poor fall; and the per capita availability of social services for the poor also falls. The remedies are to target services to the poor, and reduce fertility.

13. The report gives estimates of the increases in contraceptive prevalence rate (CPR) needed to attain the fertility rates consistent with an acceptable population growth rate, and of the cost implications in each country. As the family planning programs in all three countries are overly dependent on a single contraceptive method (the pill in Morocco and Algeria, the IUD in Tunisia), the report recommends that the choice of contraceptive method be broadened within each program.

14. Raising the CPR is the strongest means of lowering fertility but it is not the only instrument available. A wide range of social interventions impact upon fertility, including raising the legal age at marriage, increasing economic opportunities for women and restructuring social security systems. The report concludes that increased investments in population and family planning programs would carry extremely high social returns in the medium- and long-term.

15. ZIMBABWE: POPULATION SECTOR REPORT: Zimbabwe provides another encouraging example of effort beginning to have effect in Sub-Saharan Africa. It has achieved considerable success in developing its family planning program and reducing fertility. The contraceptive prevalence rate of 36 percent is the highest in Sub-Saharan Africa, and close to levels found in many Asian and Latin American programs, and the total fertility rate has declined by over one-third from peak levels in the late 1960s. Population growth rates are, at last, beginning to fall as declines in fertility overtake those in mortality, and a population policy and accompanying implementation plan are being developed.

16. The report identifies three major issues in building upon this strong foundation. First is the need to sustain progress made to date in the delicate task of building consensus and cooperative relationships among all the agencies, which must play a part in the successful development and implementation of population policy and the family planning program. Second, if the contraceptive prevalence rate is not to plateau at current levels, is the need to move beyond use of family planning for child-spacing and toward its use for family size limitation, entailing both expansion of the program and accompanying effort to stimulate demand. Third is the need for the government to put together a comprehensive budget and financing plan to form the basis for both national and donor funding for the program. The report was well received by the Zimbabwe government, gaining the personal endorsement of the President, himself, and forms the basis for renewed effort in the country's family planning program, which will be supported by the second family health project, scheduled for Board approval in FY91.

FY90 SECTOR WORK [1]

REGION/COUNTRY	REPORT TITLE	NUMBER OF REPORTS
AFRICA		
Regional	AIDS Resource Allocation	
Regional	Fertility Study	
Regional	Population and Natural Resources	
Botswana	Population Sector Review	
Cameroon	Population Assessment	
Comoros	Health Financing and Manpower	
Ethiopia	Population Policy	
Kenya	Population Sector Review	
Madagascar	Population Strategy	
Malawi	Population Sector Study	
Mozambique	PHN Sector Report	
Nigeria	Health Care Cost, Financing & Utilization	
Nigeria	Population Sector Work	
Zimbabwe	Health Financing Study	
Zimbabwe	Population Sector Report	15
ASIA		
Regional	Financing Social Services	
Regional	Poverty and Health Services	
Bangladesh	Strategy for Women in Development	
China	Long Term Health Issues	
India	Role of NGOs in Family Welfare Program	
Laos	PHN Sector Review	
Nepal	Poverty and Incomes Study	
Sri Lanka	Nutrition Review	8
EMENA		
Egypt	Poverty Alleviation	
Maghreb	Demographic Challenge to Development	
Morocco	Social Expenditures Priorities	
Yemen Arab Rep.	Women in Development	
Turkey	Health Sector Financing Memorandum	5
LAC		
Regional	Social Security in Latin America: Issues & Options for the World Bank	
Brazil	Adult Health in Brazil	
Brazil	Women's Reproductive Health	
Mexico	Nutrition and Food Security	4
TOTAL NUMBER OF REPORTS		32

[1] Completed reports, white cover and higher

ANNEX 4

SUMMARY DESCRIPTIONS OF PHN PROJECTS APPROVED IN FY90

1. BOLIVIA ("Integrated Health Development Project"): This is the Bank's first health operation in Bolivia; it grew out of a 1987 PHN sector review. The main objectives are to improve maternal and child health (MCH) care in the most populated parts of the country, i.e. the urban/peri-urban areas of the four largest cities. Priority target groups are pregnant and lactating women, children under five, and women at reproductive risk. Family planning policy development and implementation is being coordinated through the model of district-level medical services, which provides for coordination with, and reinforcement of, the nutritional surveillance system. The training of health personnel, and the rationalization of health sector planning and policy-making and investment planning will also get attention. A Plan of Action will establish annual performance indicators and targets.

2. BRAZIL ("Second Northeast Basic Health Services Project"): This is the largest PHN project ever. It is the Bank's sixth health project in Brazil, three of which are in the Northeast, the country's poorest region. Within the region, the project is targeted on the rural poor, especially women and children. The basic MCH services to be offered will in fact include many of those recommended in the FY90 sector report on Women's Reproductive Health in Brazil (see Annex 3, paras. 5-7), as well as growth monitoring and nutrition education. A "wide range of contraceptive methods" is slated to be provided (many details of the basic health services to be offered were left to be worked out after appraisal). The project will provide a classic test to see if family planning does in fact receive major attention, or benign neglect, during project implementation.

3. COLOMBIA ("Community Child Care and Nutrition Project"): The focus of this project is the support of home day care centers for the poor through which children will benefit from improved nutrition, health care, and pre-school child-development activities. The use of community homes and community mothers instead of government-owned facilities run by government personnel reflects a search for a more cost-effective alternative to an earlier program based on government facilities and government personnel. The earlier program served middle-class families; this project specifically targets poor neighborhoods. A more detailed description of this project is provided in Annex 5 (paras. 12-16).

4. HAITI ("First Health and Population Project"): This is a classic investment project (physical expansion of PHC facilities) with familiar institution-building and pilot-project components -- all in an unusually difficult environment. Project activities are grouped under three components: institutional development (13 percent of project costs), implementation of a model program of basic health services in one health region (61 percent), and the prevention and control of epidemics (especially tuberculosis and AIDS). Strengthening family planning is an explicit part of the basic health services and will account for 40 of the project's 86 person-months of technical assistance. Nutrition activities, including growth monitoring and nutrition education, are modest. However, resources to test potential nutrition interventions and to prepare a future nutrition project are built into this project.

5. INDIA ("Seventh Population Project"): In January 1987, the Government and the Bank reviewed the country's population program and agreed on some lessons that would guide future sector strategy. A key lesson was that, instead of trying to put more family planning into the MCH program (an important focus in most national strategies), India needed to put more and better MCH services alongside its family planning program. The accessibility and quality of those "Family Welfare" services (as MCH care is called in India) are now felt to be an

important determinant of demand for family planning services. In addition, the 1987 review agreed on the need to build outreach services onto the present static, facility-based service sites, and to balance the family planning program's high reliance on sterilization with a greater emphasis on temporary methods more attractive to younger couples; the review also noted that backward high-fertility States and urban slums deserved higher priority. As the GOI moved along this path, the Bank would shift its lending away from a narrow project focus towards program support lending. This is the first operation since the 1987 understanding was reached. Fifty-two percent of project costs are for hardware, 48 percent for software. Among the latter costs are maternal nutrition interventions and micronutrient supplementation and US$13 million (almost 10 percent of the project's $137 million total) to strengthen private voluntary organization (PVO) participation in the program, a longstanding GOI policy that has so far failed to realize its potential.

6. INDIA ("Second Tamil Nadu Nutrition Project"): This is a scale-up of the successful, innovative Tamil Nadu I project. While nutrition is central to the project, it includes a much wider set of village-based maternal and child health (MCH) services delivered by trained village health workers (all women). Recurrent costs account for about two-thirds of project costs, with "therapeutic nutrition" (the provision of food as a health intervention) the largest cost item (30 percent). Civil works, furniture and equipment, and vehicles total only 15 percent of the total; salaries are 25 percent, drugs 10 percent. One of the more interesting features of the project is the attention given to the coordination of village activities by two sets of MCH workers (Community Nutrition Workers and Village Health Nurses). The nutrition workers constitute a vertical-program intrusion into the "territory" of an older, broader-purpose government service.

7. KENYA ("Fourth Population Project"): This project was not in the lending program when FY90 began. It is thus a "quick-response" operation. For more on this "highlighted" project, see Annex 5, paras. 5-11.

8. LESOTHO ("Second Population, Health and Nutrition Project"): An important feature of this project is its strong family planning objectives (part of the credit proceeds will go directly to the Lesotho Planned Parenthood Association). The project's six components are: (i) family planning, including the development of a national popuiation policy, staff training, and contraceptive supplies; (ii) disease control (only tuberculosis and sexually transmitted diseases are explicitly named); (iii) strengthening of rural health services; (iv) strengthening of urban health services, including both filter clinics and upgrading of facilities and management at the central hospital; (v) support for a pilot household food security scheme and a food consumption monitoring system; and (vi) institutional development for the MOH. Policy reforms will be supported in two areas: (i) health financing (higher cost recovery and improved expenditure efficiencies) and (ii) development of a more mutually supportive and performance-based relationship between the MOH and the Private Health Association of Lesotho (an MOH-subsidized association of church missions which provides about 45 percent of the country's health services).

9. MOROCCO ("Health Sector Investment Project"): This loan finances the first phase of a long-term plan to rehabilitate existing facilities in a deteriorating public health system. It builds on an earlier Bank project (Health Development Project) which financed the design, testing and implementation of an improved primary health care delivery system for rural areas. It will finance the repair, renovation and re-equipment of rural dispensaries, health centers, emergency and referral services at provincial and regional hospitals, and administrative and sector reforms designed to decentralize the health system and strengthen its financial base. Civil

works are limited to the renovation of existing facilities; therefore, equipment, drugs and supplies take the largest share of the project budget. The project also supports growth monitoring, food supplements for children and iron supplements for pregnant women.

10. NIGERIA ("Essential Drugs Project"): This is the Bank's first free-standing essential drugs project. It will help the GON implement its new Essential Drugs Policy (EDP), adopted in 1987 and endorsed by all 21 States in mid-1988. The project does not limit itself to massive procurement of drugs; it will also develop institutional and administrative practices surrounding procurement, quality-assurance, logistics, storage, prescribing, cost recovery, and use of revolving funds. Only four states, plus the major urban areas having federal hospitals, will participate; the project will, however, provide a model for later implementation of the EDP throughout the country.

11. TANZANIA ("Health and Nutrition Project"): This first Bank PHN operation in the country is supported by five cofinanciers. The overall objective is to raise the quality, coverage and effectiveness of family planning, nutrition and basic health services in urban and rural areas, through the provision of support to critical and strategic elements of the PHN sectors. Specific activities are planned to strengthen (i) institutional capacity for planning, policy formulation and implementation; (ii) manpower development and training; (iii) sustainable provision and financing of pharmaceuticals and medical supplies; (iv) micronutrient deficiency programs; (v) implementation of the national population policy; (vi) rural PHC, through the implementation of the revised strategy in selected districts; and (vii) urban PHC, through reform and rehabilitation. Of the $62.8 million investment costs, US$28 million are for pharmaceuticals (this compares to US$12.7 million for civil works and vehicles). The GOT's revised PHC strategy statement includes the provision of family planning and nutrition services as core objectives.

12. YEMEN ARAB REPUBLIC ("Health Sector Development Project"): The overall objective of the Bank's second health operation in Yemen is the promotion of regional equity, focusing on under-served areas of the country, and the provision of means to improve the quality of life. The project implements a strategy aimed at developing regional support mechanisms for health care delivery. It develops the regional supporting apparatus (human and hardware capital), without which further strengthening and development of the primary health care system cannot proceed, as well as administrative and support service capabilities including pharmaceutical supplies and bio-medical maintenance. Through the establishment of regional training institutes for nursing and midwifery, the project provides local women with the opportunity to study, to work and to follow careers in these fields close to their homes. The project will facilitate the assignment of women to serve their own communities, where they will provide maternal and child health and family planning services.

ANNEX 5

HIGHLIGHTS OF INNOVATIVE PROJECT WORK UNDERTAKEN DURING FY90

1. In recent years the Bank has moved rapidly to develop new lending instruments and new types of projects. The PHN sector is no exception. To facilitate exchange of information and experiences among PHN staff working in different regions, which has become more difficult since the reorganization, it seems useful to call attention to a number of recent PHN innovations that surfaced in FY90. Five examples are summarized in this section: a new lending instrument about to be tried in two Nigeria Health and Population projects; the use of a traditional project financing approach to broad reform of the social sectors in Jamaica; a quick response to a threatened population emergency in Kenya; the privatization of pre-school day-care in Colombia; and mechanisms of donor coordination and cofinancing in the complex Bangladesh population project.

JAMAICA: Social Sectors Development Project

2. Social sector development projects are a post-Reorganization innovation, facilitated by the existence of integrated Population and Human Resources SODs. This project covers both the health and education sectors. The lending modality is also innovative, although not a "first": it is a modified sector loan (with sector objectives, policy reforms and commitments) but tied to a traditional project-financing format (no time-slice financing of a sector investment program -- only the traditional tight show-us-how-you-spent-it financing of specific expenditures lubricated, like many projects these days, by use of a revolving fund). Other innovative aspects include an annual joint Government/Bank review (without any conditionality or loan tranching), a stated intention to involve NGOs in project implementation, and a willingness to go ahead with the Bank project before cofinancing has been lined up for the much larger program of which the project is just one part.

3. The main project objective is to help the government restore the flow of funds to the social sectors, which had declined over the preceding decade. To reverse this trend, and to improve specified social services, the Bank helped the GOJ develop a multi-year program of Human Resources Development (the HRDP) and committed itself to try to find financing for it. The HRDP is to serve a series of objectives involving policy commitments by the Government. Among these are:

(a) Increasing the relative share of primary health care in the MOH recurrent budget to 25 percent by April 1991;

(b) Increasing the relative share of pre-primary and primary education in the Ministry of Education's recurrent budget to 38 percent by April 1992;

(c) In the field of nutrition, the Government will (i) phase out general food subsidies within two years, (ii) improve the targeting of the food stamp program, and (iii) improve the targeting of the school feeding program on poorer children and on more pre-primary and primary children;

(d) More non-medical services in public hospitals will be contracted out to private suppliers;

(e) The Government will review its current fee structure at public health facilities;

(f) The supply of textbooks for primary and secondary students will be increased. Steps will be taken to reduce the cost of primary textbooks. A rental fee will be collected for secondary-level texts from all but the very poor;

(g) For the public works components of the HRDP, the Government will use normal standards of economic viability and sectoral priority;

(h) Efforts will be made to increase non-governmental organization (NGO) participation in the HRDP.

4. In support of these undertakings (contained in a Statement of Sectoral Policies and an accompanying Policy Matrix), the Bank project will finance selected health and education activities included in the HRDP (other donors are to take the lead in HRDP projects they choose to assist under parallel financing). The self-contained nature of the Bank project allows it to go forward before financing for the whole HRDP has been lined up. The Bank project is financing civil works, furniture, equipment (including vehicles), pharmaceuticals, books, training, consultants' services, and incremental HRDP staff. (Pharmaceuticals account for over half the Bank's health-sector financing: the Bank is becoming an important source of finance for this key health item). The above juxtaposition of the broad sector objectives and policy commitments towards the HRDP on the one hand, and what the Bank is financing on the other, is but another example of how misleading it is to try to infer the Bank's interests and impact from a quick review of cost categories of Bank loans or credits. The HRDP -- not just the Bank project -- will be reviewed annually with the Bank in conjunction with annual donor coordination meetings. This annual review (not traditional project supervision missions and reports) is to be the key monitoring tool for the project, basing itself on annual target-setting and progress assessments.

KENYA: Clear Evidence of Progress

5. Concerned Kenyans and the donor community have been trying to reduce Kenya's fertility for about 20 years. Kenya was the site of the Bank's first population operation in Sub-Saharan Africa (SSA), in 1974, and has since received two other Bank credits for population (in 1982 and 1989). Despite the large effort, program performance indicators appeared stuck at discouragingly low levels. Were the donors up against insurmountable problems they understood poorly? Were they, in effect, only throwing good money after bad? Was the news from SSA going to remain discouraging if not hopeless? The Fourth Population Project, approved only one year after Population III became effective, replaces past discouragement with solid grounds for optimism. Most of the good news reported below comes from the Kenya Demographic and Health Survey 1989, the second such survey by the National Council for Population and Development, the government's population agency. Rising hope for Kenya is bound to spill over into other countries whose prospects for reducing population growth are not encouraging.

6. The Bank's Kenya IV project has followed so closely on Kenya III precisely because of emerging evidence that Kenyan couples are beginning to practice family planning much more commonly than before. The contraceptive prevalence rate (CPR) has increased dramatically over the past five years, rising from about 18 percent to an estimated 27 percent today. A 50 percent rise in the CPR in five years is dramatic. So strong has this trend been that the Government began to worry that it might run out of contraceptive supplies, especially of the modern-method supplies that have found rapidly-increasing acceptance (e.g. pills, condoms, IUDs, and especially, injectables).

7. Population III (appraised in 1988, before the 1989 survey results were availab[illegible] had greatly underestimated the country's need for contraceptive supplies. When the threat of a major supply interruption became apparent in mid-1989, the Bank moved fast: within nine months it had developed, appraised, and secured Board approval for a project that was not even in the lending program when FY90 started. The provision of contraceptives on such a scale relative to other project components is a new and innovative feature of this Bank population project.

8. The first page of the Population IV appraisal reports that "all of the family planning targets set at the time of approval of the Third Population Project [in 1988] have been surpassed: "The demand for all types of contraceptives has increased dramatically: actual use of condoms in 1988 was nearly ten times the estimated target; demand for injectables, estimated to be 127,000 doses, was 800,000 doses; and use of pills was more than twice the target figure. Such growth in the use of contraception shows no immediate sign of slowing. After years of inactivity and little progress, Kenya's population program appears to have finally taken off."

9. The appraisal report cites four key contributing factors:

(a) strong, sustained commitment at the highest levels of Government;

(b) public and private (especially NGO) delivery systems have been greatly expanded over the past two decades;

(c) the responsible government agency has been substantially strengthened, both administratively and financially; and

(d) continuing strong donor support.

10. The strong rise in acceptance of family planning is a long way from reducing the population growth rate. But it has already begun to reduce the average number of children women bear over their lifetime: the total fertility rate has declined from 7.7 to 6.7 over the past five years. The growth in the number of women entering their reproductive years will prevent the falling TFR from slowing population growth for many years to come. But eventually growth will slow down.

11. Growing acceptance of family planning reflects many underlying causes. In addition to changing values and norms, there has been an increase in the age of marriage (the proportion of women who marry before age 15 has declined from 25 percent for women now 40-44 to only 4 percent of those aged 15-19). The educational levels of women has also been rising (the proportion of women 15-49 with no education has fallen from 44 percent in 1977/78 to 25 percent in 1989). And children are becoming more expensive to raise: school costs are significant, and the government has recently begun charging for health services. Despite these several contributing factors, there is still need for further research before we have a good understanding of the causes of the country's apparent fertility decline.

COLOMBIA: Community Child Care and Nutrition

12. This project, dedicated primarily to the support of pre-school day-care centers, is a reflection of the evolution of development thinking and new priorities. The activity serves two objectives that stand high on today's agenda: the profitability of investing in human resources at an early age, and targeting benefits to the poor.

13. The project will provide nutrition, health monitoring, and child development services for pre-school children (aged 2-5). It will do this, not in government facilities staffed by government employees, but in the private homes of selected "community mothers". This approach represents a radical departure from that originally developed by the government in the early 1970s, when a network of government-run child-care centers was started (today there are about 1100 of these centers, serving some 280,000 pre-schoolers). By about 1980 it became apparent that these government centers were expensive, and were serving mainly the children of middle-class parents. So a search began for cheaper alternatives that could reach the poor. With help from UNICEF and some NGOs the present model was developed and then tested in several locations. The Government adopted the model in 1987; since then some 32,000 Child Care Homes (CCH) have been designated, serving about 500,000 children of the urban poor. The project will about double these figures over the five-year period 1990-94. It will also strengthen the program by giving the "community mothers" more training, improving the links between government health services and the child-care homes, and by building up the child-development activities.

14. The CCH program is run by a government agency, the Colombian Institute for Family Welfare (ICBF). It is financed by an earmarked 3 percent employer payroll tax (parents are also asked to make a contribution). As one of its policy undertakings, the Government has agreed to phase down (to 30 percent by 1995) its financial support for the old Child Care Centers, thereby helping to finance the expansion of the new program. A study will investigate whether or not the old program should be abandoned altogether as a government program. Another policy study will investigate the possibility of privatizing the manufacture and distribution of bienestarina, the well-accepted supplemental food now made in three factories owned and run by ICBF.

15. The old program was run by ICBF as a top-down government service, without community participation or oversight. The new one is administered through a three-tiered community structure -- a parents' association, a local assembly, and a local board of directors. ICBF lays down certain standards and guidelines, and arranges loans so the "community mothers" can bring their homes up to the required physical standard (e.g. a secure roof, a floor, a toilet). Loan repayment is secured by deductions from the nominal monthly stipend (about US$50) which the "mothers" receive.

16. The government's survey institution will add on an annual component designed to measure the impact of the new program on both the children and their families. Monitoring of the program's general implementation will include, in addition to normal supervision, an annual program review to be conducted jointly by ICBF and the Bank; ICBF will then prepare, for Bank review, a detailed expenditure plan for the following year. The use of annual program reviews is found in an increasing number of social sector projects.

BANGLADESH: A High Point in Donor Coordination

17. There are over a dozen donors, bilateral and multilateral, who want to assist in addressing the very urgent and very severe population problems which Bangladesh is facing. Some of these donors were provided assistance to this end long before the Bank's arrival in 1972. Many of the problems associated with poorly coordinated donor relationships were present in the Bangladesh case, as well. It took over a decade to work out the present impressive mechanisms that now govern the workings of the Bangladesh Population and Health Consortium (a semi-formal grouping of the Bank, the cofinanciers shown in the table presented at the end of this annex, and several UN agencies). Developing and maintaining the Consortium's financial and administrative relationships is one reason the Bangladesh population projects have always had high coefficients.

18. The Bank's first project was able to mobilize more support from more donors than had previously been involved, and linked six of them in an initial cofinancing relationship. At that time, all but one of the cofinanciers preferred to have parallel financing agreements with the government, with separate financial and operational reports, and separate supervision missions. Thanks to the Bank's intervention on this front, donor competition and confusion was reduced, and external resources were increased; but it was to take years before the parties learned how to minimize the administrative burdens which multiple donors often mean for a government.

19. The initial cofinancing arrangements were converted into a more structured Population and Health Consortium in 1987. Membership is limited to the Bank and its cofinancing partners, with WHO, UNFPA and UNICEF as executing agencies for a number of activities. Today, most members continue to sign separate agreements with the government and cross-agreements with the Bank (i.e. parallel financing remains the dominant mode, but under a master co-financing agreement between the Bank and the government). In time, most Consortium members have agreed to turn over their funds to the Bank for centralized disbursement under a Trust Fund arrangement, using Bank disbursement rules. The government needs to submit reports only to the Bank, which then submits financial reports to each donor.

20. The Consortium members remain on good terms with each other, and with the other donors who remain outside (e.g. ADB and USAID; USAID has applied for membership, but has not yet been incorporated). Donor coordination does not stop at the borders of the financing Consortium: non-members often attend meetings of the Consortium as observers. Consortium members have agreed to share the costs of a project administrator and, since 1986/87, three additional professionals in the Bank's Dhaka office. After a few years, as noted above, most Consortium members agreed to turn over their funds to the Bank for centralized disbursement, using common disbursement rules, centralized accounting, and consolidated financial reporting. This imposes so much additional administrative work on Bank headquarters that a four-person Project Support Unit had to be set up, much the largest and most complex of the many Trust Funds for which the Bank acts as trustee. The Bank had to be persuaded to take on these special arrangements, and to shoulder the added costs (in effect, the interest earnings of the donors' trust funds are paying these administrative costs). Consortium members agree to limit their field supervision to participation in two Bank-led annual missions: one is a 50-60 person program-review-cum-field-visit mission in February/March, the other a smaller supervision mission in September/October. Relations with the government today are actually so good that in early 1990 the government asked Consortium members for advice on its health and family welfare program for the next Five Year Plan. The Bank arranged a three-day working meeting for this purpose in May 1990, at WHO's Geneva headquarters.

21. Instead of falling victim to rivalries and administrative complexities, donor coordination and co-financing continue to grow: a new population and health project is under preparation that looks to be twice the size of Population III; the Consortium is likely to expand from seven members to 10 or 12 during the next fiscal year. The Bangladesh Population and Health Consortium is probably the longest-lived, largest, most complex, and perhaps the most successful example of donor coordination and cofinancing in the history of Bank operations.

22. Slowing population growth takes years, of course; but donors now think they see light at the end of the tunnel. The contraceptive prevalence rate (CPR) has risen from 7.7 percent in 1975 to 33 percent in 1989. The total fertility rate (TFR) has fallen from over 7.0 in 1977 to between 4.6 and 4.9 today. With only a slight increase in the age of marriage, active population policies, family planning and MCH seems to deserve most of the credit for these hopeful trends. The government deserves high marks on these achievements, but it could never have made as much progress as it has without the remarkably effective system of donor coordination and cofinancing which has been built up in the sector over the past 17 years. Some other countries have noted the success of the arrangements worked out over the years in Bangladesh, and have expressed interest in Bank assistance in doing something similar to this arrangement.

COFINANCING FOR BANGLADESH POPULATION I, II, AND III (1973, 1979, AND 1986)
(amounts in US$ millions)

	Project size	IDA loan	Co-financiers	Amounts
POPULATION I				
	45.7	15.0		
	NORAD	8.5		
			FRG	6.1
			AUSTRALIA	2.6
			UK	3.2
			CIDA	2.0
			SIDA	3.0
		6 bilateral agencies		25.4
POPULATION II				
	110	32.1	NORAD	20.0
			FRG	18.2
			AUSTRALIA	4.0
			UK	4.0
			CIDA	5.0
			SIDA	8.0
			NETHERLANDS	7.9
		7 bilateral agencies		67.1
POPULATION III				
	233.3	97.5	NORAD	29.5
			KFW (FRG)	28.2
			GTZ (FRG)	16.9
			AUSTRALIA	9.0
			UK	13.7
			CIDA	28.1
			NETHERLANDS	10.0
		7 bilateral agencies		135.4

Table . LENDING FOR POPULATION IN FY90 PROJECTS [1]
Commitment in US$ Million

Fiscal Year	Region	No. of Projects	No. with Population	Total PHN Lending	Total Lending to Population	Lending to Population & & of Total PHN Lending
1988	AFRICA	5	3	121.4	19.9	16.0
	ASIA	2	2	-4.5	62.3	84.0
	EMEMA	0	--	--	--	--
	LAC	1	0	109.0	--	--
	SUBTOTAL	8	5	304.9	82.2	27.0
1989	AFRICA	4	2	81.3	0.4	5.0
	ASIA	4	1	290.2	124.6	43.0
	EMENA	2	1	79.5	0.4	3.0
	LAC	1	0	99.0	--	--
	SUBTOTAL	11	4	550.0	125.4	23.0
1990	AFRICA	4	3	162.8	45.7	28.0
	ASIA	2	1	192.5	96.7	50.0
	EMENA	2	2	119.0	11.9	10.0
	LAC	4	2	339.2	15.0	4.0
	SUBTOTAL	12	8	813.5	169.3	21.0
	TOTAL	31	17	1,668.4	376.9	23.0

[1] Free-standing population projects and projects with population components.

Annex Table: POPULATION LENDING IN PHN PROJECTS, FY90

Region or Country	Project	Population Component	Population as % of PHN Credit or loan
AFRICA			
Kenya	Pop IV	35.0	100.0
Lesotho	PHN II	1.2	10.0
Nigeria	Nat Ess Drugs	0	-
Tanzania	Health & Nut	9.5	20.0
ASIA			
India	Pop VII	96.7	100.0
India	Tamil Nadu Nut II	0	0
EMENA			
Morocco	Health Sec Dev	10.4	10.0
Yemen AR	Health II	1.5	10.0
LAC			
Bolivia	Integrated H Dev	0	0
Brazil	NE Basic H II	13.4	5.0
Colombia	Child Care & Nut	0	-
Haiti	Health & Pop	1.6	6.0
TOTAL		169.3	21.0

ANNEX 8

NUTRITION COMPONENTS IN PHN SECTOR, POPULATION, HEALTH AND WID OPERATIONS APPROVED FY89-90

REGION/COUNTRY/PROJECT	NUTRITION ACTIVITIES
AFRICA	
1. Gambia - WID	growth monitoring, nutrition education, maternal nutrition, micronutrient supplementation
2. Lesotho - PHN II	training, institutional dev, grain processing
ASIA	
3. India - Population VII	nutrition training, maternal nutrition, micronutrient supplementation, nutrition research
EMENA	
4. Morocco - Health Sector Support	nutrition training, growth monitoring, micronutrient supplementation
5. Yemen (YAR) - Health II	nutrition education, training
LAC	
6. Bolivia - Health Dev	micronutrient supplementation
7. Brazil - N.E. Basic Health II	growth monitoring, training, nutrition education
8. Haiti - Health I	growth monitoring, nutrition education, operational studies

6/30/90

LIKELY NEW NUTRITION LENDING OPERATIONS**
(FY90-93)

REGION/COUNTRY/PROJECT	Estimated Amount (US$ millions)	Status
ASIA		
1. Bangladesh - Nutrition	50	FY92; reconnaissance completed 11/89; preparation mission completed 2/90
*2. India - Tamil Nadu Integrated Nutrition II	95.8	Board approved 6/14/90
*3. India - Integrated Child Dev Service I	106	FY91; Board presentation 7/17/90
4. India - Integrated Child Dev Service II	150	FY92; appraisal mission 9/90
5. Indonesia - Nutrition & Community Health III	75	FY93; govt has requested a third nutrition project; Nutrition II still underway
6. Philippines - Urban Health & Nutrition	30	FY93; govt request; identification mission completed
7. Sri Lanka - Poverty Alleviation & Employment (emphasis on nutr)	64.9	FY92; sector work completed; pilot community nutrition operations underway in on-going Health and Family Planning project to be expanded nationally under this project
AFRICA		
8. Kenya - Health & Nutrition Sector Adjustment	50.4	concept paper currently being written
9. Madagascar - Food Security & Nutrition	28.7	FY92; preappraisal mission in the field
10. Malawi - Health & Nutrition Sector	30	FY91; Board presentation 9/90
11. Nigeria - Food Security/Nutrition	-	FY91; sector work in process
*12. Tanzania - Health and Nutrition	47.6	Board approved 3/90
13. Tanzania - Human Resources I (expanding nutrition from the above)	80	FY92S

REGION/COUNTRY/PROJECT	Estimated Amount (US$ millions)	Status
EMENA		
14. Morocco - Food and Nutrition	12	proposal submitted for technical assistance funding
15. Pakistan - Nutrition	-	FY93
LAC		
16. Argentina - Child Nutrition	200	FY91; appraisal 10/90
17. Brazil - Quality Assurance & Health Promotion	200	FY92; appraisal 11/90
*18. Colombia - Community Child Care & Nutrition	24	Board approved 5/22/90
19. Ecuador - Social Sector Development	69	FY93S; identification mission 7/90
20. Guatemala - Health and Nutrition	25	FY92; reconnaissance and preparation missions completed
*21. Jamaica - Social Sector Investment	30	approved 7/89
22. Mexico - Nutrition	150	FY92
23. Venezuela - Social Development & Nutrition	95	FY91; negotiations 9/90

* indicates that the project has been approved by the Board.

** self standing projects or projects in which nutrition has a major role.

10/1/90

NUTRITION ACTIVITIES IN EDUCATION PROJECTS APPROVED AND UNDER PREPARATION (FY90-92)

REGION/COUNTRY/PROJECT	FY	NUTRITION ACTIVITIES (Approved or Proposed)
AFRICA		
1. Madagascar - Education Sector Reinforcement	90	nutrition in primary school curriculum
*2. Burkina Faso - Education V	92	nutrition in curriculum, school feeding, micronutrient supplementation, deparatization measures
*3. Mozambique - Education III	92	school feeding, micronutrient fortification, deparatization measures
4. Zaire - Education III	91	nutrition studies
ASIA		
5. Bangladesh - General Education	90	school feeding, nutrition in curriculum, non-formal nutrition education
6. Philippines - Second Elementary Edu	91	school feeding
EMENA		
*7. Pakistan - Sind Primary Education Dev	90	school feeding
LAC		
*8. Brazil - Innovations in Basic Education	91	school feeding, micronutrient supplementation, nutrition in school curriculum
*9. Brazil - NE Basic Education II	92	expansion of successful nutrition activities in "Innovations" project
*10. Dominican Republic - Primary Education	91	school feeding, micronutrient supplementation, deparatization measures
11. Mexico - Basic Education	92	school feeding, micronutrient supplementation, deparatization measures

* Includes a substantial nutrition component addressing nutrition needs of primary school-aged children.

6/30/90

NUTRITION ACTIVITIES IN ADJUSTMENT-RELATED LENDING (FY90)

REGION/COUNTRY/TYPE OF LOAN	NUTRITION-RELATED ACTIVITIES
STRUCTURAL ADJUSTMENT	
AFRICA	
1. Sao Tome & Principe - SAC II	school feeding
2. Senegal - SAL IV	SDA-sponsored food consumption and expenditure surveys
ASIA	
3. Sri Lanka - Economic Restruct Credit	targeted food subsidies (school feeding, food stamps) and MCH nutrition programs
EMENA	
4. Algeria - Economic Reform Loan	preparation of strategy for targeted food subsidies
LAC	
5. Trinidad & Tobago - SAL I	studies for improved targeting of food subsidies and school feeding, LSMS food expenditure survey
SECTORAL ADJUSTMENT	
AFRICA	
6. Malawi - Ag SAC	national nutritional surveillance system, comparative studies of direct vs indirect subsidies.
7. Mali - Ag SECAL	targeted emergency food distribution program, SDA program
8. Mauritania - Ag SECAL	targeted food aid
COMPANION PROJECTS	
AFRICA	
9. Chad - Social Development Action	food distribution with nutrition education, development of food security policy
10. Uganda - PAMSCAD	NGO-initiated nutrition programs, health/nutrition modules in household surveys
LAC	
11. Bolivia - Social Investment Fund	day care and school feeding programs, meal distribution to working children
12. Jamaica - Social Sector Investment	targeted food stamps, MCH nutrition programs

NUTRITION-RELATED SECTOR AND RESEARCH WORK (FY90)

REGION/COUNTRY	REPORT TITLE	STATUS
AFRICA		
Benin	Food Security Strategy Paper	yellow 10/89
Cote d'Ivoire	Malnutrition in Cote d'Ivoire	SDA WP #4, 5/90
Cote d'Ivoire	Child Anthropometry in Cote d'Ivoire	LSMS WP #51
Ghana	Nutrition Status in Ghana	SDA WP #3, 5/90
Kenya	Women and Food Security in Kenya	PPR WPS #232, 6/89
Kenya	Food and Nutrition Policy	green 1/90
Madagascar	Food Security and Nutrition	white 1/90
Malawi	Human Resources Sector Study	grey 4/90
Malawi	Food Security Report	grey 6/90
Mozambique	Food Security Study	grey 10/89
Mozambique	PHN Sector Review	grey 1/90
Sudan	Food Security Study	green 5/90
Tanzania	PHN Sector Review	grey 10/89
Zaire	PHN Sector Review	grey 5/89
Region	Nutrition Strategy	yellow 6/89
Region	Household Food Security and the Role of Women	WBDP 8/90
ASIA		
China	Long Term Health Issues	yellow 6/89
India	WID Strategy Paper	white 8/89
India	Improving FP, Health & Nutrition Outreach	grey 8/89
India	Improving Nutrition in India	WBDP #49, 1989
Laos	PHN Sector Review	yellow 10/89
Sri Lanka	Nutrition Review	grey 7/89
EMENA		
Egypt	Poverty Alleviation and Adjustment	yellow 4/90
Morocco	Social Expenditure Priorities	yellow 10/89
Morocco	Ending Food Subsidies: Nutr'l Welfare	Ec Rpt, V3#3 9/89
Morocco	Food Subsidies: Case Study	LSMS WP #50, 7/89
Pakistan	An Economic and Social Strategy	green 8/89
Yemen AR	Utilizing Womanpower for National Development	yellow 2/90
LAC		
Bolivia	Poverty Report	green, 6/90
Brazil	Women's Reproductive Health	yellow 12/89
Brazil	Fighting Malnutrition: An Evaluation	WBDP #60, 8/89
Chile	Social Development Progress in Chile	green 4/90
Guatemala	Health and Nutrition Sector	white 10/89
Mexico	Nutrition Sector Memorandum x39039	white 6/89
Region	Feeding Latin America's Children	IDC #49, 10/89

NUTRITION AND EDUCABILITY RESEARCH COMPLETED OR ONGOING (FY90)

COMPLETED

o Lockheed, Marlaine and Adriaan Verspoor. "Teachability: Children's Learning Capacity," Section from Improving Primary Education in Developing Countries: A Review of Policy Options, World Bank review and related policy paper, "Policies for Improving the Effectiveness of Primary Education in Developing Countries," 1990.

o Galloway, Rae. "The Prevalence of Malnutrition and Parasites in School-Age Children: An Annotated Bibliography." Background paper for the review Improving Primary Education in Developing Countries: A Review of Policy Options, and related policy paper. PHREE Background Paper Series. Document No. PHREE/89/24

o Levinger, Beryl. "Effects of Child Health and Nutrition on School Performance." Background paper for the review Improving Primary Education in Developing Countries: A Review of Policy Options, and related policy paper.

o Harbison, Ralph and Eric Hanushek. Educational Performance of the Poor: Lessons from Rural Northeast Brazil. Submitted for publication as a World Bank book. (Work done before current initiative.)

ON-GOING

o "Trace Nutrient Deficiencies and Cognitive Function and School Performance among Kenyan Children." An analysis of Collaborative Research Support Program (CRSP) Kenya Project data to examine the effects of iron and iodine deficiency on cognitive function and school performance. Analysis underway; to be completed by October 1990.

o "Cognitive Function and School Performance: Impact of Severe Drought and Food Shortage upon Schoolers in Rural Kenya." An analysis of longitudinal CRSP Kenya Project data to examine the impact of drought and food shortage on food intake, nutrition status and morbidity, and to examine the effects on school attendance, child cognitive functions, school achievement and behavior. Analysis underway; to be completed by October 1990.

o "The Effects of School Feeding Programs on School Performance in Jamaica." Analysis of Living Standards Measurement Survey (LSMS) data collected in Jamaica. In progress.

ANNEX 9

DESCRIPTION OF WORK UNDERTAKEN BY PHRHN DURING FY90

1. During FY90 PHR's PHN Division has been active on eleven main research tasks, many of them involving outside consultants. Work on each is summarized below. PHN also administers a program of Special Grants (the SGP) in support of the Bank's PHN objectives. A list of publications produced by PHRHN during FY90 is attached as Annex 10.

POPULATION

Demographic Work in PHRHN

2. PHRHN produced its annual update of worldwide demographic estimates and projections, which appeared as four working papers. This update incorporated revised projection methodology. Two working papers on the revised methodology were issued, concerning estimates and projections of international migration and projections of mortality. A third working paper, on projections of fertility, was completed and is being issued this fiscal year. The revised methodology provides a clear rationale for country-by-country projections; variation across countries in response to recent historical experience; a standard progression, beyond the period from which future trends are predictable, toward eventual population stability; and specifications for alternative scenarios. The methodology was developed from a careful review and analysis of demographic trends across countries.

3. Subsidiary work derived from the main estimates and projections exercise covered a variety of different topics and contributed to a number of separate Bank products. Some examples are:

- estimates of the adult population and adult mortality for a review of adult health
- a presentation on demographic factors and issues in Asian populations, contributing to a sector strategy note
- projections of the school-age population across countries, for an encyclopedia
- detailed estimates and projections for a number of countries, as contributions to sector reviews or project documents.

4. Empirical work included a review of mortality trends in Sub-Saharan Africa, focusing on direct and indirect estimates from Demographic and Health Surveys. A paper is in draft form. Another task was an analysis of contraceptive use in Brazil, which was incorporated into a sector report.

Impediments to Contraceptive Use and Fertility Decline in Different Environments

5. This major study was approved by the Research Committee during the year. The study was prompted by concern that world population will be much larger than predicted until recently. Both the World Bank and UNFPA have revised their estimates of when world population will double from its 1987 size of five billion and now estimate that this will occur 50 years earlier than expected - in 2025 and 2050, respectively. Ninety percent of this increase will occur in the developing world.

6. One reason for these upward revisions is that, despite substantial progress in reducing fertility in a few countries, contraceptive prevalence has not been increasing as fast as expected in many areas. The study seeks to explore the nature of the impediments to increased contraceptive use, with a view to developing both social programs, and building family planning services that reduce these impediments. The study distinguishes between the two elements of demand for, and supply of, contraception that have been demonstrated to influence prevalence. The impediments to be studied are those that lead to a lack of desire to limit family size or to

space births - demand, and those that constrain access to clinical and non-clinical family planning services - supply. It builds upon previous studies that have sought to differentiate between these elements, but which have, to date, been insufficient to permit analysis and understanding of both exogenous and endogenous relationships in a manner that informs policy and program development. It will use a methodology that enables the tracing of policy interventions through effects on demand and supply. The study will focus on Colombia, Zimbabwe and Tunisia, three countries that have all achieved substantial fertility declines but in different family planning program structures.

7. The hypotheses to be tested in the research are of major importance in addressing the following policy and program questions:

(a) Is contraceptive use among the poor more limited by fertility intentions or access?

(b) Which programs are most effective in reaching the poor?

(c) Is access to family planning alone sufficient to encourage its use or must it be supported with other health services, especially in high mortality environments?

(d) What are the trade-offs in different environments between targeting family planning to those already motivated to limit or space births and providing it more broadly?

8. These questions are particularly important for developing policies and programs in Sub-Saharan Africa, where motivation to restrict fertility is low, mortality is high and access to health services is lower than in many parts of the developing world. A major programmatic decision within that context is whether family planning services should be targeted to areas that already have some established demand to limit fertility or whether a broader based program would be more cost-effective in the long run. The study will, therefore, provide direction both to project officers within the Bank, and to those with responsibility for policy decisions and program design in borrower countries.

Effective Family Planning Programs

9. Family planning programs continue to be the most direct means of moderating rapid population growth in developing countries. Family planning has shown notable successes in the past, as in Indonesia, and has even begun to produce inroads against high fertility in mainland Sub-Saharan Africa: witness the 13 percent fall in total fertility between 1984 and 1989 in Kenya. However, these successes are not universally appreciated and are occasionally discounted as inapplicable elsewhere. Proper lessons from them -- and from the two decades of Bank experience and similar experience of other development agencies in this sector -- need to be drawn, for the benefit of programs in other countries that show uneven performance or face special problems.

10. This policy paper seeks to: (a) demonstrate the effectiveness of properly managed family planning programs at increasing contraceptive use; (b) provide a concise synthesis of the major factors that contribute program effectiveness; and (c) recommend appropriate national policies and donor policies for strengthening family planning programs.

11. Within the Bank, the paper will be directed towards population and human resources sector specialists responsible for project design and toward economists and managers with some responsibility for or influence over policy dialogue involving population. Outside the Bank, the paper is meant to influence views and practice among a variety of groups, including

(a) policymakers and managers in public and private family planning programs; (b) ministries of health and other government ministries with some responsibility for, involvement in, or interest in some aspect of population work; (c) private agencies, universities, and other institutions that provide assistance to family planning programs; and (d) staff of other donor agencies.

12. The paper's scope is limited to major features of family planning programs at various stages of development and will not include: (a) rational for reducing population growth and controlling fertility, (b) the Bank's contribution to containing population growth other than family planning interventions, or (c) comprehensive Bank strategy in Population. The policy paper will focus on the following:

(a) Family planning programs can succeed at promoting contraceptive use even in adverse social settings, where levels of income, education, health, women's status, and general welfare are low.

(b) Family planning programs that ensure better quality services are more successful over time than programs with a narrow focus on distributing contraceptives.

(c) Central to service quality and program success are enforcing accountability within a program and managing it strategically, meaning responding flexibly to the program environment.

(d) Private family planning provision is an important supplement and often a spur to a government program, though not a replacement for it.

(e) Creative promotion of programs, both government and private, is essential to their success.

13. In developing these themes, recognition will be given to regional and cultural differences, as well as to other differences in program environments that dictate variations in approach. What policy options emerge for governments and donors will also be considered.

HEALTH

Economic Impact of Adult Mortality in Sub-Saharan Africa

14. In line with the Bank's growing concern for the AIDS epidemic in Africa, the Research Committee approved, in January 1990, a major three-year study of the economic impacts of adult mortality and how governments and NGOs might extend whatever forms of household and community help they can afford. The work is being done in collaboration with the Department of Behavioral Sciences in the Faculty of Medicine at the University of Dar es Salaam. The study area (Tanzania's Kagera region) was selected because of its high rate of HIV infection.

15. Hundreds of thousands of young, productive Africans are known to be infected with the AIDS virus. Some 5-10 percent of these will develop the disease each year and will die. Although adult death was already eight times more frequent in Africa than in industrial countries, the AIDS epidemic has already quadrupled that death rate in some African capitals. Because of its clustering, and its stigma, the impact of AIDS deaths is believed to be more severe than that of other causes of adult mortality. The study will describe and estimate the private and public costs of the impacts of illness and death from AIDS and other causes on both households and communities, including the coping mechanisms used (e.g. changes in labor allocation, sale of assets, inter-household transfers, and child fostering). Methodologically, the

work will involve repeated interviews of a sample of about 800 households and with community representatives and health facilities.

16. The project has been approved by the Government of Tanzania and data collection will start during the second half of 1990. A seven-person Senior Advisory Panel (two from the Bank, two U.S. academics, and three Tanzanians) will oversee the study. Cost of the project will be $1.3 million, of which half will be funded by the Bank's research budget and half by outside donors. The output will be a series of papers plus a book-size final report.

Safe Motherhood

17. The Safe Motherhood Initiative was launched at an international conference in Nairobi, Kenya in February 1987, where the World Bank and other multilateral, bilateral and non-governmental organizations as well as developing country governments affirmed their commitment to the reduction of maternal mortality and morbidity. At that conference, and at the Conference on Better Health for Women and Children Through Family Planning, also held that year in Nairobi, a target was set by all participants to reduce maternal mortality by 50 percent by the year 2000.

18. Since 1987, advocacy efforts have reached full maturity, and policy and operational guidelines are being developed to reach that target. Regional and national workshops have been held to strength policies and to stimulate program planning. The World Bank became the Executive Secretariat for the Inter-Agency Group (IAG) on Safe Motherhood and Better Health Through Family Planning in January 1990 for an 18-month term. This group is comprised of the co-sponsors of the two major Safe Motherhood Conferences held in 1987. Two major annual meetings (MIP and Children's Summit) and two semi-annual meetings (IAG) of multilateral, bilateral, governmental and non-governmental organizations have been held to discuss programming, and implementation of safe motherhood activities as an integral part of their regular operations. This ensures that safe motherhood (SM) matures from being a specialized concept consisting of discrete activities to being an integral part of multi-sectoral activities at the international, regional and local levels.

19. On the research side, the Bank has supported the WHO's Safe Motherhood Operational Research Programme, which was created in 1987 with a US$1.0 million Bank contribution over a three-year period. The overall objectives of this program are to stimulate and support the application of known technologies and innovative approaches for maternal care through research, to monitor experiences in operations research and to disseminate that information. Thirty-seven studies have been funded, with twelve already completed.

20. Another research study is the PHR/LATHR work on the utilization of maternal health services in Jamaica. This study involves a background review of maternal health in Jamaica, a household survey, a linked provider survey, and data analysis and documentation of the findings. The final report should provide useful information on the quality and costs of maternal and family planning services, as well as suggestions for applying similar methodology in other countries.

21. NGO activities are also being supported by the Special Grants Program as a complement to direct lending for PHR projects. This has included support for the SM regional and national workshops conducted and arranged by Family Care International. In FY90, small grants were made to the Center for Development and Population Activities (CEDPA) and to the International Association for Maternal and Neonatal Health (IAMANEH), to assist indigenous developing country NGOs deliver family planning and maternal health services.

22. At present, PHRHN is providing operational support to facilitate the inclusion of SM activities in Bank projects. A recent database of projects with SM components found that a significant majority of PHN projects in FY90 have included SM activities. Sector work, too, has been responding to the Initiative; a good example of this is the recent report on Brazil Women's Reproductive Health.

Africa Health Policy Study

23. FY90 was the third year of this four-year review and restatement of health policy for Sub-Saharan Africa (SSA). The major work of the year was the holding of four regional workshops for African health professionals to solicit their views on sector priorities and problems (over half the budget is for consultative processes to involve Africans in the study). Invited professionals from 29 countries met in two-and-one-half day "brainstorming" sessions held in October and November in Accra, Abidjan, Lilongwe, and Bujumbura. The Bank Study Team deems the sessions a great success, generating much material, and high consensus, to guide the writing of the final paper (initial drafting began during the second half of the year). A grant from the Finnish aid agency, FINNIDA, covered the costs of the four workshops.

24. Among the leading impressions emerging from the workshops were: the absence of strongly-felt ideological views about health care; a pragmatic acceptance of the present pluralistic system of care in which government, non-government, and private providers (including traditional healers) all play important roles; a strong commitment to building up primary health-care facilities and a desire to avoid over-emphasis on urban hospitals; some resentment against donor-defined special-purpose or vertical programs that do not accord with local priorities and which may slow the development of general-purpose care capacity; agreement that government support for health care is unlikely to expand strongly in the near future, giving high priority to increased efficiency and increased cost recovery; a desire to increase clinic-level efficiency to make clinics more "user-friendly"; a feeling that drug costs are so important that all governments should make use of essential drug lists to assure adequate supplies; a concern for the government's standards-setting function, provided it could be reconciled with the difficulties of regulation and monitoring; and some fear that the present concern for AIDS may distort priorities and divert resources from building general-purpose care systems.

25. Some of the topics to be covered in the policy paper are:

(a) How to strengthen the role which households (which provide 80-85 percent of care to sick persons) can play. Empowering them to play this role better seems mainly a matter of better health education and giving them easier access to cheaper, standardized drugs.

(b) How to organize community involvement in health education and service delivery, since such involvement seems to make service delivery agencies more responsive.

(c) Private health providers (churches, private practitioners, traditional doctors, private voluntary organizations) today supply more than half of all health services. In view of the bleak outlook for major expansion of government health services, continued expansion of private-sector services is to be welcomed, with such subventions as governments can afford. However, private providers must meet reasonable standards, specified in regulations. In most countries the regulatory regimes were laid down over 40 years ago: it is therefore time that they be re-evaluated and updated.

(d) Few Ministries of Health combine effectively their policy-making and regulatory functions on the one hand, and their service-providing function on the other. The best arrangement would seem to be a clear separation of these two broad functions.

(e) WHO has developed an Essential Drugs Programme which has been demonstrated to cut almost in half the cost of drug procurement. Logistics, storage, prescription, and re-ordering are all made easier. The great majority of SSA countries have yet to adopt this system, however. A push on this policy is therefore needed.

(f) Another important source of needed health sector economies is increased and more effective utilization of public health facilities. The paper will explore possible ways by which this might be accomplished.

(g) The above perspective carries implications for the Bank's operations in Africa. Financial transfers (i.e., the number and size of loans) should help in the development of sound policies, and strengthening of institutions should receive greater emphasis. Sector work should pay more attention to the formulation of sector policies and to institutional development and less to assessing the virtues and weaknesses of specific health plans.

26. The project plans to involve African professionals in a similar consultative process when a draft of the final report is available in 1991.

Hospital Resource Use

27. Health professionals have known for a long time that hospitals, and particularly urban hospitals, absorb a very large share of funds available for meeting health sector recurrent costs. Surprisingly little systematic research on the problem has been done, however, either within the Bank or elsewhere. A set of seven background papers was prepared in FY87 and formed part of an initial proposal for a Bank research study on hospital resource use. These were followed by related field research activities in a number of countries. The book-length draft report on hospital resource use, completed during FY90, pulls together information from the background papers and follow-up research activities, plus other relevant work from Bank and non-Bank sources.

28. The report analyzes the relative cost-effectiveness of hospital services and existing patterns of hospital resource use in developing countries, including the share of public sector health resources absorbed by hospitals, the mix of inputs within hospitals, location, sex, age, and disease/condition. The study also assesses the usefulness of accounting and statistical studies of hospital costs and of service statistics. Recommendations are made for alternative financing measures to reduce the burden of hospitals on public budgets. The recommended policies are based on both economic theory and a review of the experience of several developing countries with user fees and insurance financing of hospitals. The report concludes with suggested alternatives to existing patterns of hospital service delivery. The service alternatives focus on enhancing sectoral efficiency by improving referral patterns and by using lower cost non-hospital treatment settings for services currently provided in hospitals.

Disease Control Priorities in Developing Countries

29. For the past two years the Bank has been conducting, with several collaborators, a Disease Control Priorities Review. The core of the Review is a series of papers on the significance of major clusters of diseases in the developing world and on the cost and

effectiveness of current technologies for their prevention and case management. In addition, as part of the Review, a number of cross-cutting papers provide demographic background, discuss issues involved in setting priorities, and review illustrative areas of intervention.

30. The Review undertakes two tasks simultaneously: (i) it shows, by extended example, that cost-effectiveness measures (of a rough-and-ready sort) can be potent tools for guiding resource allocation in the health sector; and, (ii) it considers a much broader range of diseases (and associated interventions) than the communicable childhood diseases that have dominated analytical concern in public health in developing countries. By undertaking these tasks, it provides a first systematic analysis of the disease control priorities appropriate to the increasingly diverse epidemiological conditions that developing countries face as a result of declining fertility and child mortality rates.

31. A published volume is expected to emerge from the Review. By the end of FY90, 30 chapters had been received from over 60 authors, and a manuscript had been submitted to the Publications Committee for review.

Adult Health

32. A major study entitled The Health of Adults in the Developing World was completed during the year and will be published by the Bank in 1991. The book highlights the emerging problems of the ill-health of adults (those in the age group 15-59) in developing countries. Due to the combined effects of changing demographic structure and progress in reducing the burden of communicable diseases of childhood, many of our borrowers are or will be facing a considerably different set of health issues than has been true in the past. Adults will be a larger fraction of the population that will fall ill and, in some cases, die from different causes. In this book the authors address:

- the scope of the problem in terms of mortality and morbidity;
- the consequences of ill-health among this, the most economically active, portion of the population;
- the most salient risk factors contributing to adult ill-health; and
- the formulation of an agenda for research and policy analysis.

The analysis presented in this book will serve to broaden the discussion and prioritization of health problems in the developing countries.

33. A companion study on Disease and Mortality in Sub-Saharan Africa was completed during the year and is scheduled for publication by the Oxford University Press before the end of 1990.

Tropical Diseases

34. Last year's Sector Review contained a detailed account of the history of the WHO-sponsored Tropical Diseases Research program and its funding under PHN's Special Grants Program (SGP). The Bank's long participation in this inter-agency research work has been paralleled by operational initiatives to develop projects and components that address tropical diseases in addition to longstanding and newly emerging threats, such as tuberculosis and AIDS. Tropical disease components have figured prominently in many agriculture and hydro-electric projects, and a few SALs have included malaria-control components. There have been only a

small number of free-standing tropical disease control projects, and few new ones are in the pipeline. A large schistosomiasis and tuberculosis control project under preparation in China is a notable example.

35. During FY90 an earlier outside grant from the Edna McConnell Clark Foundation to examine the characteristics of successful tropical disease control programs and organizations was continued. The study, which is also supported by the Bank, is nearing completion and a draft final report will be ready by the end of the year. Case studies examining tropical diseases control programs have been undertaken in five countries, and the research process and preliminary findings have been subject to periodic assessment by both internal and external reviewers. The main conclusion emerging from the study is that effective management of endemic tropical diseases requires a specialized organization distinct from the main health network, with a focus on multiple diseases, a campaign orientation, and the technological focus, absence of bureaucracy and flexibility this implies.

NUTRITION

Micronutrients

36. The Bank co-sponsored a three-day meeting on iron supplementation in June 1990 which concluded that logistics, not non-compliance, is the major roadblock in supplementing anemic individuals. It also recommended that all pregnant women be covered by iron supplementation programs. Iron fortification and dietary modification were seen as long-run solutions to iron-deficiency, especially for children and men.

37. With the Bank Research Administrator's support, PHR has co-sponsored research on the relationship between income and micronutrients in rural Philippines. Surprisingly little is known about how dietary quality changes with increased income even though extensive research has been conducted on dietary quantity or calories. This research is part of the incipient PHR major work program in nutrition on micronutrients.

SPECIAL PROGRAMS

Special Grant Programs (SGP)

38. Support for Special Grant Programs (SGPs) complements our direct lending for PHN projects. All SGPs listed in Table 7 below are managed by PHRHN, except for the Onchocerciasis Control Programme (OCP), which is managed by AF5PH. As shown in Table 8, the Bank contributed to eight PHN programs during FY90, of which seven had been supported in previous years and one, the UN Administrative Committee on Coordination/Sub-Committee on Nutrition (ACC/SCN), is being supported with SGP funds.

39. There are three types of SGPs in the PHN sector: operational, research, and catalytic. SGPs support multi-country activities which would be inefficient if undertaken at national level. Usually, individual countries could not afford to mount one of these programs. In the OCP case, a multi-country approach and long time frame (20 years) is essential to disease control. TDR, HRP and research on AIDS take advantage of informational economies of scale; support to these programs also results in significant benefits to many countries.

Table 7. PHN SPECIAL GRANTS PROGRAMS, FY86-90
(in US$ million and percent of total SGP funds)

PROGRAM	FY86		FY87		FY88		FY89		FY90	
	$M	%	$M	%	$M	%	$M	%	$M	%
Tropical Diseases	3.25	7.2	3.08	6.3	3.25	6.3	3.50	5.9	3.80	6.1
Human Reproduction					2.00	3.9	2.00	3.4	2.00	3.2
Safe Motherhood					0.50	1.0	0.50	0.9	0.50	0.8
Task Force for Child Survival			0.15	0.3	0.15	0.3	0.08	0.1	0.08	0.1
Population NGOs			0.25	0.5	0.50	1.0	0.50	0.9	0.50	0.8
AIDS							1.00	1.7	1.00	1.6
UN ACC Sub-Committee on Nutrition									0.08	0.1
Riverblindness Program (OCP)	2.50	5.5	2.50	5.2	2.00	3.9	2.50	4.2	2.50	4.0
Administration	0.25	0.7	0.42	1.0	0.40	0.8	0.53	0.9	0.56	0.9
	6.00	13.4	6.40	13.3	8.80	17.2	10.61	18.0	11.02	17.6

40. There are important reasons for Bank support of the SGPs: First, these programs complement project lending. For example, much of the AIDS research supported by the Bank through WHO/GPA, as well as regional studies dealing with IEC, methodology, and patient management guidelines, are necessary for effective implementation of AIDS components in Bank projects. Second, the presence of the Bank is seen as an assurance of sound financial management and administration of these programs. This in turn generates significant donor support. An increase in contributions from the Bank often generates a comparable increase from other donors. Third, while these programs depend on variable contributions from many donors, the SGP grants provide a stable and consistent stream of funding to executing agencies. This contributes to better planning and management, and to more effective programs.

41. In the catalytic programs where the Bank's objective is policy advocacy, the programs have been able to use that support to leverage resources from, or encourage policy dialogue with, other donors. In the case of the Task Force for Child Survival, for example, Bank involvement was an important factor in attracting US$200 million in funding from Rotary International for polio eradication.

The International Health Policy Program

42. The International Health Policy Program (IHPP) is an initiative supported by two private American foundations (The Pew Charitable Trusts and the Carnegie Corporation of New York) which is undertaken in cooperation with the Bank and the World Health Organization. The aim of the program is to develop local capacity for analysis of health policy questions, especially those concerned with health care for the disadvantaged. Assistance is given in the form of both institutional grants and individual career-development fellowships. In the first three years of the program Policy Analysis and Development Groups have been established at six African and three Asian institutions. An initial outside review of the program in November of last year gave it high marks and made suggestions for putting it on a longer-run basis than the present two donors are likely to be able to afford.

43. The IHPP and the Bank are working toward the development of effective working relationships. These are particularly strong in Burundi and the Philippines, where IHPP-supported groups are making important contributions to Bank activities; and in the SADCC countries of Southern Africa, where five IHPP fellowships have been awarded in close consultation with Bank staff members. The IHPP's Africa members have also participated in the development of the Bank's Africa Health Policy study; and two IHPP participants have served as consultants to PHRHN. The Bank has two representatives on the IHPP's Advisory Committee; and it provides professional guidance and office accommodations to the IHPP's three-person secretariat.

PHRHN PUBLICATIONS DURING FY90

Books

Ascadi, G.T.F., R.A. Bulatao, and G. Johnson-Ascadi. *Population Growth and Reproduction in Sub-Saharan Africa*, June 1990, World Bank Symposium.

Feacham, R. (editor) *et al. The Health of Adults in the Developing World*, June, 1990.

Technical Papers

Berg, Alan and Susan Brems. "A Case for Promoting Breastfeeding in Projects to Limit Fertility." World Bank Technical Paper No. 102.

McGuire, Judith S. and Barry M. Popkin. "Helping Women Improve Nutrition in the Developing World." World Bank Technical Paper No. 114.

Working Papers

Frenk, Julio, Enrique Ruelas, and Avedis Donabedian. "Hospital Management Staffing and Training Issues." PPR Working Paper No. 173.

Hayes, Richard, Thierry Mertens, G. Lockett and L. Rodrigues. "Causes of Adult Deaths in Developing Countries: A Review of Data and Methods." PPR Working Paper No. 246.

Bitran-Dicowsky, Ricardo and David W. Dunlop. "The Determinants of Hospital Costs: An Analysis of Ethiopia." PPR Working Paper No. 249.

PHRHN. "Population, Health and Nutrition: FY88 Annual Sector Review." PPR Working Paper No. 273.

Arnold, Fred. "Revised Estimates and Projections of International Migration (1980-2000)." PPR Working Paper No. 275.

Sai, Fred T. and K. Newman. "Ethical Approaches to Family Planning in Africa." PPR Working Paper No. 324.

Bulatao, Rodolfo, Eduard Bos, Patience Stephens, and My T. Vu. "Europe, Middle East, and North Africa (EMN) Region--Population Projections (1989-90 Edition)." PPR Working Paper No. 328.

Bulatao, Rodolfo A., Eduard Bos, Patience W. Stephens, and My T. Vu. "Latin America and the Caribbean (LAC) Region--Population Projections (1989-90 Edition)." PPR Working Paper No. 329.

Bulatao, Rodolfo A., Eduard Bos, Patience W. Stephens, and My T. Vu. "Africa Region--Population Projections (1989-90 Edition)." PPR Working Paper No. 330.

Bulatao, Rodolfo A., Eduard Bos, Patience W. Stephens, and My T. Vu. "Asia Region--Population Projections (1989-90 Edition)." PPR Working Paper No. 331.

Bulatao, Rodolfo A. and Eduard Bos. "Projecting Mortality for All Countries." PPR Working Paper No. 337.

Howard, L.M. "Supporting Safe Motherhood: A Review of Financial Trends (Full Report)." PRE Working Paper No. 413.

Howard, L.M. "Supporting Safe Motherhood: A Review of Financial Trends (Summary)." PRE Working Paper No. 414.

Foster, S.D. "Improving the Supply and Use of Essential Drugs in Sub-Saharan Africa." PRE Working Paper No. 456.

Mwabu, Germano. "Financing Health Services in Africa: An Assessment of Alternative Approaches." PRE Working Paper No. 457.

Other Papers

Chester, Lauren. "Beyond the Pill." *Bank's World*.

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