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Population, Health, and Nutrition

Annual Operational Review for Fiscal 1992

Denise Vaillancourt
Stacye Brown
and Others

Growth in the population, health, and nutrition sector has been significant in the past five years, stimulated by the World Bank's renewed commitment to reduce poverty and its rapidly growing emphasis on human resource development.

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Population, health, and nutrition (PHN) lending decreased in fiscal 1992 from the record levels of fiscal 1991, in both the amount and the number of operations. Lending amounted to $961.6 million for 16 projects, compared with $1,567.6 million for 28 projects in fiscal 1991.

This temporary dip in PHN lending is attributable largely to pipeline factors. Fiscal 1993 lending is projected to recapture if not exceed the fiscal 1991 level, and projections for fiscal 1994 and fiscal 1995 are for a continued increase in lending volume.

PHN projects approved in fiscal 1992 have been responsive to the World Bank's objective of poverty alleviation. Collectively, fiscal 1992 projects cover the essential features of good poverty work but the depth and quality of poverty work varies across projects. Drawing from the good practices observed and lessons recorded in this year's portfolio, the review offers the following suggestions, among others, for strengthening PHN interventions to alleviate poverty:

- Poverty information and monitoring must be accompanied by dissemination and sensitization activities to strengthen national understanding of poverty-related issues and national commitment to resolving them through the proper policy.

- Community involvement in project design and development requires clearly defined and carefully designed institutional and procedural mechanisms, and a concerted effort to make them work.

- It is essential that PHN sector work identify poor and vulnerable groups and assess their needs and demands for basic health, family planning, and nutrition services.

- Even the most demand-driven project designs targeted to clearly identified poverty groups require promotional activities to ensure that these groups participate in and benefit from project initiatives.

Health lending is now a decade old, and many innovations in PHN lending have emerged only in the past four or five years. This review demonstrates that good practices and new and promising ideas — well worth emulating — are scattered across PHN work.

Overall, PHN work is moving in the right direction and the quality of work is generally seen to be improving. Welcome trends (which should be encouraged and reinforced) include serious attention to the poorest, most vulnerable populations, growing consideration of the demand of target groups, and increased attention to monitoring and evaluation of sector performance.

Produced by the Policy Research Dissemination Center

Population, Health, and Nutrition

Annual Operational Review for Fiscal 1992

by
Denise Vaillancourt
Stacye Brown
and Others

Population, Health, and Nutrition Department

ABBREVIATIONS AND ACRONYMS

AFTPN	Africa Technical Department, Population, Health and Nutrition Division
AIDS	Acquired Immuno-deficiency Syndrome
ARIS	Annual Review of Implementation and Supervision
ASR	Annual Sector Review
ECA	Europe an ' Central Asia Region
EDI	Economic Development Institute
FY	Fiscal Year (July 1 - June 30)
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
IEC	Information, Education and Communication
IES	Income and Expenditure Survey
KNH	Kenyatta National Hospital
LAC	Latin America and the Caribbean Region
LATHR	Latin America and the Caribbean Technical Department, Human Resources Division
LSMS	Living Standards Measurement Survey
MCH	Maternal and Child Health
MENA	Middle East and North Africa Region
MIS	Management Information System
MOHFW	Ministry of Health and Family Welfare
MOPH	Ministry of Public Health
MPND	Ministry of Planning and National Development
NGO	Non-governmental Organization
OED	Operations Evaluation Department
PCR	Project Completion Report
PHN	Population, Health and Nutrition
PHRHN	Population, Health and Nutrition Division of the Population and Human Resources Department (As of January 1, 1993, this division has become the PHN Department)
PMP	Private Medical Practitioners
PVO	Private Voluntary Organization
SAR	Staff Appraisal Report
SIMAP	Social Impact Amelioration Program and Agency
STD	Sexually-Transmitted Disease
UNDP	United Nations Development Programme
WDR	World Development Report
WHO	World Health Organization
WID	Women in Development
WPS	Working Paper Series

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This report was prepared by PHRHN, which has recently become the new PHN Department.

The task manager and main author is Denise Vaillancourt, who also researched and analyzed the special topics on poverty and quality. Other team members and their respective contributions include: Stacye Brown (review and analysis of operational statistics and trends), Rae Galloway (review of sector work and of policy, research and dissemination activities), Jane Nassim and Chantal Worzala (Population), and Leslie Elder (Nutrition). Chantal Worzala also prepared the Annex on Lessons Learned. Hoai Hong provided the team with ongoing secretarial and organizational assistance; and Christopher Wilson also provided graphics and word processing assistance in the preparation of this document for publication.

EXECUTIVE SUMMARY

Lending

1. The volume of Population, Health and Nutrition (PHN) lending decreased during FY92 from the record levels achieved in FY91, both in terms of lending amount and in terms of number of operations. Lending amounted to $961.6 million for 16 projects, compared with $1567.6 million for 28 projects in FY91. This dip in PHN lending is largely attributable to pipeline factors and is temporary. FY93 lending is projected to recapture if not exceed the record level achieved in FY91, and projections for the following two fiscal years indicate a continued increase in lending volume. Growth in the PHN sector has been significant during the past five years, stimulated by the Bank's renewed commitment to the reduction of poverty and its rapidly growing emphasis on human resource development.

2. Among the 16 operations included in this year's PHN portfolio are four social sector projects, with lending amounting to $51.0 million, or 5.3 percent of overall lending to the PHN sector. These operations, aimed at poverty alleviation, support activity in a variety of sectors. The PHN components of these projects amounted to $19.6 million or 38 percent of lending for that type of project. "Pure" PHN lending -- consisting of the 12 "pure" PHN projects and the PHN components of the four social sector projects -- amounted to $926.3 million in FY92, or 96 percent of officially reported lending to the PHN sector.

3. Since FY90, annual lending in the sector has remained above $900 million exceeding the target set by President Conable in November 1989 to increase PHN lending to $800 million annually during the period FY90-92. However, FY92 lending for PHN falls short of another goal set by Mr. Conable in September 1990 at the World Summit for Children: to increase lending for primary health care from three to five percent of overall Bank lending. In FY92 lending for primary health care accounted for 3.4 percent of the Bank's lending, largely a reflection of the overall temporary decrease in PHN lending this year. Nevertheless, the proportion of PHN lending for primary health care remains at roughly the same level as last year (78 percent) and the goal set by Mr. Conable will most likely be achieved again next year, as it was in FY91.

4. During FY92, the proportion of total Bank lending to the PHN sector decreased from 6.9 percent in FY91 to 4.4 percent, or from 5.7 percent to 4.3 percent if lending to non-PHN components is excluded. However, based on three-year moving averages, lending volume in the sector has been steadily increasing and is expected to continue to increase on average by 25 percent each year for the next three years.

5. The South Asia region accounted for the greatest proportion of lending volume ($377.5 million or 39 percent of total FY92 lending for the sector), while the Africa region processed the largest number of PHN operations (six projects or 38 percent of the FY92 portfolio). The proportion of PHN projects that receive IDA funds is larger than the Bank-wide average. Since 1990, IDA has accounted for a minimum of 43 percent of PHN lending, while accounting for a maximum of 30 percent of overall Bank lending during the same period. In FY92, IDA represented 68 percent of PHN lending and 30 percent of overall Bank lending. All lending to social sector projects was IDA-financed during FY92, as befits the important role of these projects in poverty alleviation.

6. During FY92, the number of cofinanced projects remained proportionally the same as in FY91. Every region except East Asia had at least one cofinanced project. However, the Bank leveraged fewer additional funds for its PHN and social sector projects in FY92 than in FY91. Social sector projects received more donor contributions than "pure" PHN projects.

7. Investment costs represented a smaller share of project costs in FY92 than in FY91 -- 59 percent versus 70 percent. The increase in the recurrent cost proportion of total project costs may reflect a growing appreciation of the high ratio of recurrent to investment costs characteristic of the human resources sectors and an increasing willingness on the part of the Bank to finance assistance of this type. Financial

sustainability of PHN operations is ensured through sector reform and project conditionality aimed at mobilization of increased resources for the sector and at their more efficient allocation.

Sector Work

8. Twenty-five sector reports were completed in the PHN sector during FY92, a decline from the 33 reports produced in FY91. Five country-specific health sector reports, which reached grey cover in FY92, were reviewed to assess their usefulness for devising policies and programs to address poverty alleviation and the quality of PHN services. Collectively the reports cover the essential aspects of these issues: identification of poor and vulnerable groups, allocation of resources for health; mobilization of additional resources through increased public resources and/or greater role for private sector; decentralization of sector activity; and assessment of the demand for services. However, not all reports adequately covered all of these aspects. While financing issues were generally well addressed, the identification of poor groups and assessment of their demand and needs were not always carried out in sufficient depth. The review stresses that this element of sector work is necessary to influence and inform the design and targeting of Bank investments in the sector and makes suggestions for improved performance in these important areas.

Supervision

9. During FY92, the PHN sector had 107 projects under supervision, representing commitments of $5.3 billion. Nineteen percent of PHN operations under supervision this year were categorized as problem projects. While this represents an increase in the proportion of problem projects over the FY91 level for PHN (13 percent), it approximates the overall FY92 Bank average of 18 percent, indicating that the overall "health" of PHN projects under supervision is in line with the Bank average. The average supervision coefficient for PHN in FY92 was 17.0, exceeding the overall Bank average of 13 by 30 percent. At 20.9, the PHN supervision coefficient including local staff input exceeds the Bank average of 14.1 by almost half, but does reflect a greater use of local staff for supervision than the Bank average. This divergence from the Bank average is probably a reflection of the relative newness of the health sector and the consequent inexperience of weak health ministries in managing Bank projects, and also of the increasing attention to software components in PHN projects, which, while appropriate, tends to add to the complexity of operations.

10. Given the paucity of project completion reports (PCRs) completed during the year and the growing importance and interest attached to the lessons of implementation experience, this review provides: a brief overview of lessons learned from various sources; examples of good practices in Staff Appraisal Reports (SARs) for analyzing lessons and incorporating them into new project designs; a summary of PCR findings, and a compilation of lessons derived from the Seventeenth Annual Review of Implementation and Supervision (ARIS).

Policy, Research and Dissemination

11. The PHN Department [1] maintains a diverse work portfolio that includes: the carrying out of policy and program-relevant research; the dissemination of research findings drawing from work undertaken both inside and outside of the Bank; and the provision of direct support to operations. Specific operationally relevant research ongoing or completed in FY92 include: a Best Practices paper on Micronutrient Deficiency Disorders, a Best Practices paper on Women's Health and Nutrition; a paper on Effective Family Planning Programs, Guidelines on Safe Motherhood, and a study of the Economic Impact of Adult Mortality in Africa, focusing specifically on how households cope with illness and death of victims of Acquired Immunodeficiency Syndrome (AIDS).

12. Dissemination activities include the organization of 19 seminars attended by 363 Bank staff, on a variety of PHN topics; the publication of 19 Working Papers and a series of two-page "PHN Notes"; and the publication of three technical papers. PHRHN and the technical

departments conducted training programs that aimed to inform Bank management and staff about key sector issues. Notable among FY92 training activities was a half-day seminar for senior Bank management, including the President of the World Bank, to discuss the implications of rapid population growth for economic development and poverty alleviation objectives of the Bank, followed by region-specific seminars for regional management teams. Other staff training included a successful five-day program on effective work in the health sector and a five half-day nutrition "best practices" seminar. In addition, the Population Working Group, Health Financing Working Group and AIDS Working Group each met regularly to facilitate discussion and dissemination of relevant technical issues and innovations. Finally, the startup of preparation for the 1993 World Development Report (WDR) on health generated a series of excellent technical seminars, which many Bank staff attended.

13. A major part of the work program of the PHN Department is to provide support to operations. In FY92 PHRHN provided 112 weeks of direct operational support to assist in sector analysis, lending and supervision. This was approximately 20 weeks in excess of planned support.

Population, Health and Nutrition Content of Projects

14. *Population*. Ten projects in the FY92 PHN lending program provide assistance to family planning, two of which (Niger and Mauritania) also contain components that support the development of population policy and analytical capacity. One interesting aspect of the FY92 portfolio is its contribution to the geographical expansion of the Bank's population portfolio. The Niger Population project represents the Bank's first freestanding population project in the Sahel. Five other projects (Mauritania, Equatorial Guinea, Chile, Poland and Romania) are the first Bank lending operations in the PHN sector in those countries, with all but one providing direct support to family planning. (While not addressing family planning directly, the Chile project will support the design of a women's health program.)

15. The volume of lending for population, at $103.2 million, represents a substantial drop from last year's total of $351 million, a drop that was forecast, but not expected to be quite so steep. The number of projects with a population component is also down from FY91's record level of 18, reflecting, in part, the drop in the number of PHN projects overall.

16. PHN sector work completed and ongoing in FY92 gave substantial attention to population issues. These studies also dealt with the themes of integration and decentralization of PHN projects, under the headings of improving the effectiveness of services delivered, the efficiency of resource allocation and utilization, and the equity of access. In addition, sector work examined the effect of population growth on other development activities -- in the provision of social services, and its impact on labor markets, in particular.

17. *Health*. The main thrust of health projects approved during the year is the provision of primary health care services to those most in need: largely the poor, women of child-bearing age and children under the age of five. Considerable emphasis is thus given to maternal and child health services. A fundamental objective of these interventions is to improve the quality, efficiency, and equity of basic services. As a complement to interventions at the service level, FY92-approved health operations also provide considerable support to building national capacity for policy formulation and sector management and to the field testing and eventual country-wide application of policy reforms, which aim for increased sector efficiency and equity.

18. Notable features of this year's portfolio reveal two emerging trends in health sector lending: increasing attention to urban primary health care and to the hospital sector. FY92 health operations also targeted a number of priority diseases, notably AIDS, schistosomiasis, tuberculosis and malaria. A brief overview of projects' coverage of these aspects of health lending is provided in this review. Finally, two FY92 projects addressed the issue of an evolving epidemiological profile characterized by the

emergence of an aging population and chronic disease.

19. *Nutrition*. Nutrition lending in the Bank continues to grow. While the number of PHN projects with nutrition components decreased between FY91 and FY92 from 22 to 10 (reflecting the overall drop in the *total* number of PHN projects in FY92), the allocation of total project resources for nutrition has continued to grow, rising from $49.3 million for FY87-89 to $893 million for FY90-92 to an estimated $1257 million for FY93-95. Attention to micronutrient deficiencies and long-term strategies for food fortification remain areas of emphasis in PHN projects.

20. Resources allocated for nutrition-related activities outside the PHN portfolio increased significantly in agriculture, education and emergency relief operations. In addition, FY92 adjustment projects continue the trend of including nutrition conditionality, with 10 structural and sector adjustment operations addressing nutrition, including two that contain specific nutrition actions required for tranche release. In what is largely a new area of Bank lending, four adjustment operations contain sizable credits to address the impending starvation and food insecurity resulting from an unprecedented drought throughout southern Africa in FY92.

Poverty Content of PHN Operations

21. PHN projects approved during FY92 have been responsive to the Bank's poverty alleviation objective, in terms of both content and focus. Every operation approved during the fiscal year addressed poverty issues in a significant way: twenty percent of the portfolio comprised multisectoral operations, whose major objective is the alleviation of poverty. The primary objective of thirty-five percent of operations is the provision of basic social services to the poor, responding to an important component of the poverty strategy recommended by WDR 90. And the balance of operations (seven projects or forty-five percent of the portfolio), while not addressing poverty alleviation as the primary objective, include interventions from which the poor should derive significant benefits. All operations addressed both short- and medium-/long-term interventions, combining support for improving quickly and directly the wellbeing of the poorest and most vulnerable of the groups with efforts to develop and strengthen national commitment and capacity to improve the economic and social wellbeing of the population.

22. Collectively, FY92 projects cover the essential features of good poverty work: poverty information and monitoring; understanding and responding to the needs of the poor; targeting assistance to those most in need; and reforms in policy, financing and organization. Although the coverage of these features is quite extensive, the depth and quality of each of these aspects of poverty work varies across projects. Drawing from the good practices observed and lessons recorded in this year's portfolio, the review offers suggestions for further strengthening of PHN interventions aimed at poverty alleviation.

Quality Issues

23. Overall, the PHN projects approved during the fiscal year cover fully the selected indicators of quality reviewed in this document (Chapter IV). The great majority of these projects provide in some way for: flexibility and learning throughout implementation; project management arrangements that will serve to build capacities of existing structures and institutions; and monitoring and evaluation activities that will permit assessment of impact as well as process indicators. The ways in which these activities are carried out, however, vary from project to project and the review suggests ways to improve work in this regard, drawing from particularly good project designs and documented lessons of experience.

24. Low quality of services is consistently raised and addressed in PHN operations across the board. However, for the most part, analyses and interventions focus on issues of technical quality and the need for strengthening outreach activities for promotional and preventive activities. Relatively little is done, however, to assess or address the more subjective and culturally charged

dimensions of quality. Again, lessons of experience and innovative features of the FY92 portfolio are reviewed and offer some guidance in this regard.

Conclusion

25. Health lending is now a decade old; and many innovations in PHN lending have emerged only recently -- over the past four or five years. Notable among these are multisectoral operations aimed at poverty alleviation objectives, and sector funds, which accommodate a decentralized, demand-driven approach to the provision of social services and social safety net assistance. Furthermore, fully one half of PHN projects approved since 1980 (or over the past 13 years) were approved only during the last *three* years (FY92 included). Thus PHN experience in the Bank is very short and project designs are still somewhat experimental. PHN staff are, therefore, challenged to exploit lessons of experience and to develop innovative approaches to still new and emerging sector issues. This review has shown that there are indeed good practices and new and promising ideas scattered across PHN work, which are well worth noting and emulating.

26. Overall, the thrust of PHN work is moving in the right direction and the quality of work is generally seen to be improving. Noteworthy and welcome trends include serious attention to the poorest and most vulnerable populations, growing consideration of the demand of target groups/beneficiaries and increased attention to monitoring and evaluation of sector performance. These trends should be encouraged and reinforced.

[1] Prior to January 1, 1993, the PHN Department was known as the Population, Health and Nutrition Division of the Population and Human Resources Department (PHRHN).

CHAPTER I. INTRODUCTION: PURPOSE AND SCOPE OF REVIEW

1.1 The objectives of this Population, Health and Nutrition (PHN) Annual Sector Review (ASR) are: (a) to provide an overview of the FY92 work portfolio, including statistics on the volume and mix of lending and sector work and a brief discussion of salient features and trends; and (b) to address in some depth, as the special topic of this year's review, the contribution of PHN lending to the Bank's poverty alleviation objective.

1.2 This report covers three components of the PHN work portfolio. First, the portfolio of FY92-approved *lending* operations considered in this review comprises the sixteen projects officially categorized as PHN sector, including a number of multisectoral operations, aimed at poverty alleviation objectives that support, in some cases, relatively small PHN components. Second, the review provides statistics on *sector work* and some analysis of sector reports' treatment of poverty and quality issues. Third, the coverage of the projects under *supervision*, now numbering more than one hundred, is limited to some basic statistics on the size and composition of the supervision portfolio, on the proportion of problem projects, and on Bank staff resources devoted to supervision. The Eighteenth Annual Review of Implementation and Supervision (ARIS), provides a thorough review of supervision work.

This report did, however, take great care to review the lessons learned through implementation experience, as documented in the Seventeenth ARIS and in the Staff Appraisal Reports (SARs) and Projection Completion Reports (PCRs) produced for the PHN sector during the year. These lessons are compiled and discussed in a specially prepared annex to this report, and served to inform and inspire the approach to this review's special topic.

CHAPTER II. OVERVIEW

A. Lending

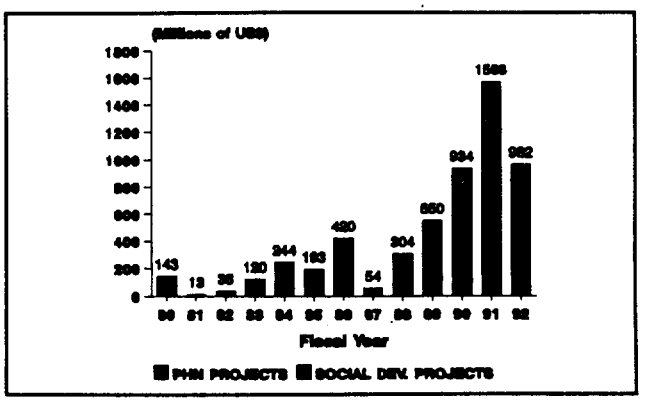
1. *Trends in the Lending Portfolio*

2.1 The volume of PHN activities decreased during FY92 from the record levels achieved in FY91, both in terms of lending amount and in terms of number of operations. Lending amounted to $961.6 million for sixteen projects, compared with $1567.6 million for twenty-eight projects in FY91 (Figure 1). This dip in PHN lending is largely attributable to pipeline factors (both advancement of projects from FY92 to FY91 and slippage of others from FY92 to FY93) and poses no cause for concern. FY93 lending is projected at least to recapture and in all likelihood to exceed the record level achieved in FY91; and projections for FY94 and FY95, respectively, indicate a continued increase in lending volume. Growth in the PHN sector has been significant during the past five years, stimulated by the Bank's renewed commitment to the reduction of poverty and its rapidly growing emphasis on human resource development.

2.2 Since FY90, social sector projects (multi-sectoral operations aimed at poverty alleviation) have been a common feature of PHN work. In FY92 there were four, with lending amounting to $51.0 million, or 5.3 percent of overall lending to the PHN sector. PHN components of these four social sector projects amounted to $19.6 million or 38 percent of lending for that type of project. "Pure" PHN lending--consisting of "pure" PHN projects and PHN components of social development projects--amounted to $926.3 million, or 96 percent of officially reported lending to the sector (Annex 1, Table 1).

2.3 In addition, in FY92 three social sector projects included in other categories of the Bank's lending provide substantial support to PHN sector activity. As shown in Table 1, PHN components of these projects are estimated at $81.6 million, which brings total lending for "pure" PHN in FY92 to just over $1 billion.

Figure 1: Lending for the Population, Health and Nutrition Sector, FY80-92



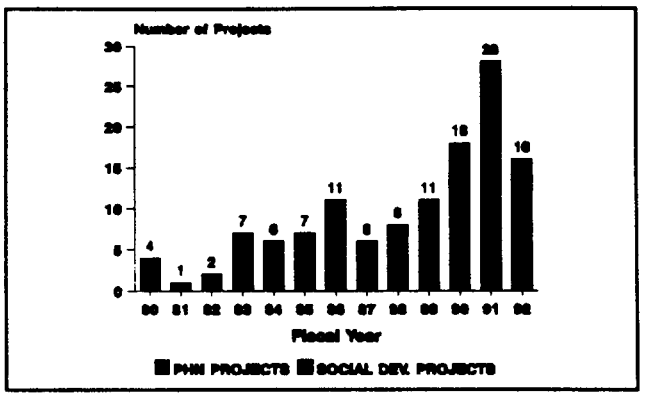


Table 1: Non-PHN Projects with PHN Components
(US$ Millions)

Country	Project	Total IBRD/IDA	Of Which for PHN
Côte d'Ivoire	Human Resource Development Program	150.0	75.0
Guinea-Bissau	Social Relief (Supplemental Credit)	2.9	00.6
Sudan	Drought Recovery	16.0	06.0
	Total	**168.9**	**81.6**

2.4 Many FY92-approved operations are multisectoral in nature. This reflects the poverty alleviation objectives of these operations, and efforts in some projects to stimulate demand for family planning services. Table 2 provides a breakdown of support to the various sectors under PHN projects for FY91 and FY92. For further reference, Annex 2 presents a summary description of each of the 16 PHN operations approved in FY92.

Table 2: Composition of PHN Projects Approved in FY91 and FY92 (US $ million)

Sector	FY91		FY92	
	$	%	$	%
PHN	1300.20	82.9	926.27	96.3
Infrastructure	110.20	7.0	16.40	1.7
Income Generation	89.30	5.7	6.80	0.7
Education	58.70	3.8	2.23	0.3
Water	6.30	0.4	3.30	0.3
Agriculture	2.90	0.2	6.70	0.7
Total	1567.60	100.0	961.70	100.0

2.5 One lending target for the PHN sector was exceeded in FY92, while another was not reached this year. In November 1989, President Conable pledged to increase PHN lending to $800 million annually during the period FY90-92. Since FY90, annual lending in the sector has remained above $900 million. In September 1990, Mr. Conable set a goal at the World Summit for Children of increasing lending for primary health care from three to five percent of overall Bank lending. In FY92, lending for primary health care accounted for 3.4 percent of the Bank's lending (Annex 1, Table 2). Lending falls short of this goal because of the overall, temporary decrease in PHN lending this year. The proportion of PHN lending for primary health care remains high, at 78 percent or roughly the same level as last year. And the goal will most likely be achieved again next year, as it was in FY91.

2.6 During FY92, the proportion of total Bank lending to the PHN sector decreased from 6.9 percent in FY91 to 4.4 percent, or from 5.7 percent to 4.3 percent if lending to non-PHN components is excluded (Table 3). As explained in

Table 3: Trends in Lending to the PHN Sector by Region, FY90-92

1a. PHN Lending Amounts (in US $ millions) and Number of Projects

Region	FY90		FY91		FY92	
	Amount	No.	Amount	No.	Amount	No.
Africa	232.7	(8)	432.8	(12)	100.3	(6)
E. Asia	0.0	(0)	164.0	(2)	129.6	(1)
S. Asia	192.5	(2)	388.5	(4)	377.5	(3)
ECA	0.0	(0)	0.0	(0)	280.0	(2)
LAC	379.2	(6)	337.3	(5)	47.5	(3)
MENA	119.0	(2)	245.0	(5)	26.8	(1)
Total	923.4	(18)	1567.6	(28)	961.7	(16)

1b. PHN Lending as a Percent of Total Bank Lending

Region	FY90		FY91		FY92	
	Pure PHN	Total PHN	Pure PHN	Total PHN	Pure PHN	Total PHN
Africa	4.3	5.9	12.3	12.8	1.9	2.5
E. Asia	n.a.	n.a.	3.4	3.4	2.3	2.3
S. Asia	5.5	5.5	9.5	10.8	12.6	12.6
ECA	n.a.	n.a.	n.a.	n.a.	13.1	13.1
LAC	5.8	6.4	5.6	6.4	0.6	0.9
MENA	3.4	3.4	4.0	12.1	1.8	1.8
Total	4.1	4.5	5.7	6.9	4.3	4.4

Note: "Pure PHN" refers to PHN only projects and PHN components of Social Development Projects.

"Total PHN" encompasses lending for entire PHN sector, including non-PHN components.

para. 2.1, the lower lending levels achieved during FY92 represent a temporary glitch in PHN activity. Based on three year moving averages, lending volume in the sector has been steadily increasing and is expected to continue to increase on average by 25 percent each year for the next three years. (More detailed information on PHN lending is given in Annex 1, Table 3.)

2.7 Specific investment loans (SILs) were the major lending instrument utilized in the sector in FY92, accounting for 12 (or 75 percent) of the 16 approved projects (Table 4). The portfolio also includes one sector investment loan (SECIL) and three social investment funds (SIFs), the latter in support of sub-projects prepared in-country by communities, local governments, and NGOs, among others. These funds are managed by the borrower, which has responsibility for the solicitation, review, appraisal, approval and supervision of sub-projects. Moreover, some SILs/SECILs provide for sector funds to support innovative activities as a complement to other components. A list of all sector funds is provided in Annex 1, Table 4.

Table 4: Sectoral Composition and Funding Characteristics of PHN Portfolio, FY92

	SIL (12)	SECIL (1)	SIF (3)
PHN Only (12)	Equatorial Guinea Kenya Mauritania Niger China Poland Romania Egypt India (AIDS) India (MCH) India (Family Welfare)	Chile	
PHN and Education (1)	Sao Tome and Principe		
PHR and other sectors (3)			Rwanda Honduras Guyana

Note: Figures in parenthesis represent the number of projects.

SIL - Specific Investment Loan

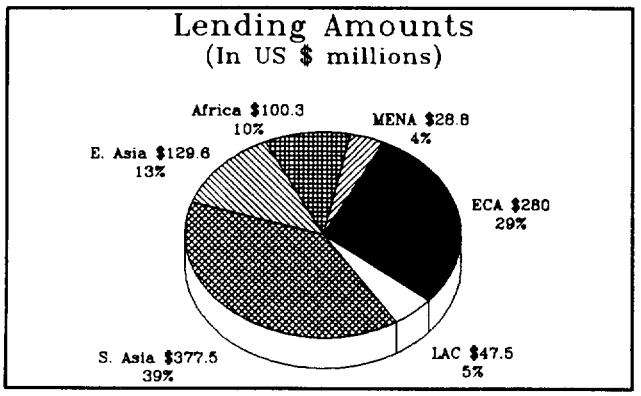
2. *Regional Distribution and IBRD/IDA Commitments*

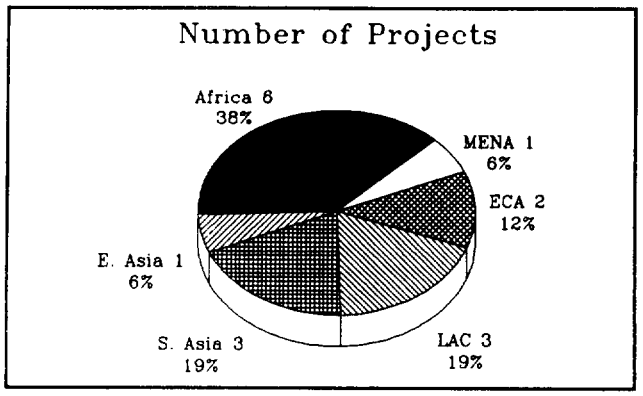
2.8 The South Asia region accounted for the greatest proportion of lending volume, while the Africa region processed the largest number of PHN operations in FY92. Six projects supported PHN and social sector activities in Africa; and three projects were approved each in the Latin America and the Caribeen region (LAC) and in South Asia, two projects in Europe and Central Asia (ECA), and one each in Middle East and North Africa (MENA) and East Asia. Thirty-nine percent of loan and credit amounts were for projects in South Asia, 29 percent for ECA, 13 percent for East Asia, 10 percent for Africa, 5 percent for LAC and 3 percent for MENA (Figure 2). The average size of IBRD/IDA allocations for PHN operations in FY92 was $60 million. Lending amounts for projects in the Africa, LAC and MENA regions were lower than average. Loans/credits for projects in the Asia regions were larger than the average. The average size of loans/credits for PHN operations for each of the six regions was: $140 million for ECA, $129.6 million for East Asia, $125.8 million for South Asia, $26.8 million for MENA, $16.7 million for Africa, and $15.8 million for LAC.

2.9 The proportion of PHN projects that receive IDA funds is larger than the Bank-wide average. Since 1990, IDA has accounted for a minimum of 43 percent of PHN lending, while accounting for a maximum of 30 percent of overall Bank lending during the same period. In FY92, IDA represented 68 percent of PHN lending and 30 percent of overall Bank lending (see Annex 1, Table 5). IDA accounted for all lending to social sector projects during FY92, as

befits the important role of these projects in poverty alleviation.

Figure 2: Regional Distribution of PHN Lending, FY92





3. *Cofinancing*

2.10 During FY92, the number of cofinanced projects remained proportionally the same as in FY91. Every region except East Asia had at least one cofinanced project. All of the projects in the LAC and MENA regions were cofinanced, while half of the projects in the Africa region were cofinanced (Table 5). The Bank leveraged fewer additional funds for its PHN and social sector projects in FY92 than in FY91 according to both measures of additionality--the amount donor cofinancing (not recipient governments) adds to the Bank lending for all PHN projects (overall additionality), and the amount cofinancing adds only to those projects that are cofinanced.

2.11 Social sector projects received more donor contributions than "pure" PHN projects representing 54 percent of overall additionality, compared to 13 percent for PHN-only projects. In the cofinanced social sector projects, additionality was 60 percent; in the PHN-only projects it was 22 percent. Social sector projects offer an attractive means of combining assistance from donors, since they support a broad range of social investments. Most social sector projects support a portion of a larger country social program.

2.12 In-country cofinancers (excluding government counterpart funds) continue to remain a feature of PHN lending. In the East Asia and the ECA regions, one project included cofinancing from state governments and public agencies. Beneficiaries are contributing in one Africa project and two LAC projects. Amounts committed by in-country cofinancers tend to be small, since they are, in most cases, the municipalities, NGOs, and local groups that will be presenting proposals for project funding. In two projects, the beneficiaries' contribution matched at least half of the government's contribution. In the Guyana SIMAP/Health, Nutrition, Water and Sanitation project, the beneficiaries fully matched the amount committed by the government.

2.13 The Bank financed on average 62 percent of total project costs in the PHN sector during FY92. Average total projects costs in the "pure" PHN projects were higher than in the social sector projects--$117 million versus $34 million. Bank loans/credits on average were lower in social sector projects than in PHN-only projects--$13 million versus $79 million--due to the additional leverage gained in cofinancing from external sources in social sector projects.

4. *Project Funds by Expenditure Category*

Table 5: Cofinancing from Official Sources in PHN Projects, FY91 and FY92

3a. Cofinanced Projects

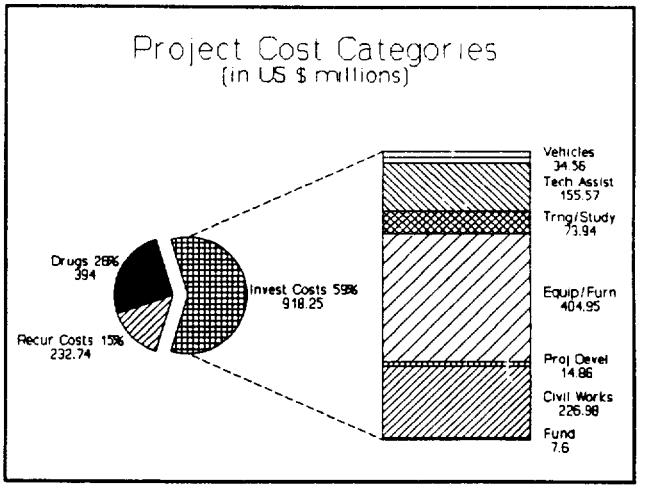
Region	FY91 No. of Cofinanced Projects	FY91 Total No. of PHN Projects	FY92 No. of Cofinanced Projects	FY92 Total No. of PHN Projects
Africa	8	12	3	6
E. Asia	1	2	0	1
S. Asia	3	4	2	3
ECA	0	0	1	2
LAC	3	5	3	3
MENA	2	5	1	1
All Regions	17	28	10	16

3b. Additionality (%)

Region	Overall Additionality FY91	Overall Additionality FY92	Additionality in Cofinanced Projects FY91	Additionality in Cofinanced Projects FY92
Africa	26.2	30.2	41.4	57.8
E. Asia	12.9	n.a.	35.3	0.0
S. Asia	69.5	18.4	95.6	23.2
ECA	n.a.	10.0	n.a.	19.2
LAC	13.6	40.6	79.9	40.6
MENA	105.0	38.8	148.6	38.8
All Regions	56.0	19.3	110.2	29.4

2.14 Investment costs represented a smaller share of project costs in FY92 than in FY91--59 percent versus 70 percent (Figure 3). The greatest share of investment costs financed in FY92 projects was for equipment, furniture, supplies and civil works--70 percent. Recurrent costs, including drugs, contraceptives and nutrition supplements, accounted on average for 41 percent of total project cost, an increase over the 30 percent share in FY91. This increase in recurrent costs may reflect a growing appreciation of the high ratio of recurrent to investment costs characteristic of the human resources sectors and an increasing willingness to finance assistance of this type. Financial sustainability of FY92 operations is addressed through a combination of the following: Bank financing of recurrent costs on a gradually declining basis; and financial reforms to mobilize additional resources for PHN, including increased allocation of public funds for PHN, cost recovery schemes, and increased role for the private sector and non-governmental organizations (NGOs).

Figure 3: Breakdown of Total Project Costs by Expenditure Category



2.15 Project costs allocated to drugs (including contraceptives and nutrition supplements) increased significantly from 6 percent in FY91 to 26 percent in FY92. The "drugs" cost category is shown separately in the figure, since it has been categorized both as an investment and as a recurrent cost by different projects within and across regions. While drug costs are recurrent in nature, in that supplies need to be replenished on an ongoing basis, the purchase of an initial stock of drugs through a project, which will be replenished ultimately through cost recovery and/or by other means, is sometimes categorized by task managers as an investment cost.

B. Sector Work

2.16 Twenty-five sector reports were completed in the PHN sector during FY92, a decline from the 33 reports produced in FY91 (see Annex 1, Tables 6 and 7). Of these, five reports were published in grey cover, eleven in green cover, and nine in yellow cover. Three reports focused mainly on population, 10 on health, and three on nutrition. One report covered

population, health and nutrition and eight focused on the social sectors or poverty alleviation, but paid specific attention to the PHN sector.

2.17 In FY92, five country-specific health sector reports were published in grey cover (Nigeria: Health Care Cost, Financing and Utilization; Poland: Health System Reforms - Meeting the Challenge; Romania: Accelerating the Transition - Human Resource Strategies for the 1990s; Brazil: Women's Reproductive Health; and Yemen: Human Development - Societal Needs and Human Capital Response). In this section, these reports are examined to assess their usefulness for devising policies and programs to address poverty alleviation and the quality of PHN services in developing countries (A review of population sector work is provided in paras. 2.41-2.42).

2.18 A first step in making use of limited resources to alleviate poverty is to identify the poor and vulnerable groups. The strongest reports classified the poor by gender, geographic area, income, nutritional level, and educational level, among other indicators. However, several reports did not provide data on who the poor are and where they reside. The Romania Human Resources Strategies Report did make the case that the country should conduct an assessment of the needs of poor and vulnerable groups in the country. The identification of poor and vulnerable groups and the assessment of their needs and demand for basic health services is an essential component of general health sector work. Chapter V of this report stresses this message and offers guidance in this regard.

2.19 A key barrier to poverty alleviation mentioned in most reports is the misallocation of health resources. Many countries spend the majority of their health resources on costly curative care, and, consequently, most reports stressed the importance of redirecting funds from curative care to primary health care activities for the general population. The Brazil Women's Reproductive Health Report goes a step further by recommending that women, in particular, be targeted to benefit from basic health services, since they currently benefit from a disproportionately smaller share of available health resources. However, several reports also make the point that in order to reach the poor and vulnerable groups, reallocation of public health expenditures will not be enough; actual spending must increase if needs are to be met.

2.20 While increasing resources for public health services is important for poverty alleviation, the best reports stressed that countries need to find a way to pay for this increase. The Poland Health Systems Reform Report emphasizes the need to diversify sources of funding. Several reports recommend giving greater support and encouragement to the private sector (including NGOs) to deliver health services. Increased government recognition of the private sector is important since private sector providers offer a complement of services to those provided by the government thus expanding service availability overall; and the quality of private services is often relatively high. The Nigeria Health Care Cost, Financing and Utilization Report emphasizes the need to encourage the "complementary role" of the private sector to provide services, especially to higher income groups. This report suggests that in order to ensure that access and quality are maintained or improved, the government may need to provide incentives to the health sector and regulate it through education programs targeted to providers. The Romania Human Resource Strategies Report suggests that granting more autonomy to private sector providers may be an effective incentive for encouraging their growth.

2.21 A number of reports recommend decentralization as a way to increase access to and quality of health services; however, several reports warn that there should be simultaneous efforts to improve management and financing at decentralized levels. In the Republic of Yemen Human Development Report, training of female health workers in rural areas is recommended as a means to improve the access to and quality of health care, especially for women.

2.22 In order for improved quality and access to have an impact on health, these services must be utilized. The Romania Human Resource Strategies Report acknowledges the problem of underutilization and suggests that the government remain responsive to consumer demand and find innovative ways to increase demand for social services. In Nigeria, the demand for health services is actually decreasing as the population increases. This decline in utilization has serious ramifications for the poor: while they use the public health services the most, they are also the group that relies most heavily on self-treatment. Assessing the demand for services is generally neglected in these reports, probably because of a lack of data. Only in the Poland report was demand given sufficient attention. Demand analysis should also be related to knowledge of the poor. While a few reports did estimate the overall demand for health services, much more detail than was generally included is needed for adequate project design. Again, Chapter V takes up this issue.

C. Supervision and Project Evaluation: Lessons Learned

2.23 During FY92, the PHN sector had 107 projects under supervision, representing commitments of $5.3 billion. Africa has the highest number of projects under supervision (45 projects or 42 percent of the entire portfolio), amounting to $1.1 billion (Annex 1, Figure 1 provides more details).

2.24 During FY92, 19 percent of PHN operations under supervision were categorized as problem projects (with ratings of 3 or 4). While this represents an increase in the proportion of problem projects over the FY91 level for PHN (13 percent), it approximates the overall FY92 Bank average of 18 percent, indicating that the overall "health" of PHN projects under supervision is in line with the Bank average. The average supervision coefficient for PHN in FY92 was 17.0, exceeding the overall Bank average of 13 by 30 percent. At 20.9, the PHN supervision coefficient including local staff input exceeds the Bank average of 14.1 by almost half, but does reflect a greater use of local staff for supervision than the Bank average. This divergence from the Bank average is probably a reflection of the relative newness of the health sector and the consequent inexperience of weak health ministries in managing Bank projects, and also the increased attention to software components in PHN projects, which, while appropriate, tends to add to the complexity of operations.

2.25 Two project completion reports (PCRs) were produced in FY92 (Annex 1, Table 8): the Yemen Health Development Project and the Mexico Water, Women and Development Project, which was canceled even before becoming effective due to the sudden availability of grant funds for activities initially slated for project support. The small number of PCRs produced during the year is a reflection of the small size of the PHN lending portfolio in the recent past. (Figure 1)

2.26 To compensate for the paucity of PCRs produced this year and to accommodate the growing importance and interest attached to the lessons of implementation experience, this ASR reviewed lessons learned as documented during the year in three sources: (1) Staff Appraisal Reports (SARs) for FY92 projects; (2) the PCR on Yemen Health; and (3) the Seventeenth Annual Report on Implementation and Supervision (ARIS) - Fiscal Year 1991.

2.27 Annex 3 provides a brief overview of lessons learned from these various sources, examples of good practices in SARs for analyzing lessons and incorporating them into new projectdesigns, a summary of PCR findings, and a compilation of lessons derived from the ARIS.

D. Policy, Research and Dissemination

2.28 The PHN Department[1] maintains a diverse work portfolio that includes: awareness raising on pertinent PHN topics; conducting policy and program-relevant research; the preparation and publishing of technical papers; staff training; and the provision of direct program support to operations. Areas of focus of the division's work

program include women's health, micronutrient malnutrition, health economics, AIDS, hospital financing and costing, worldwide demographic estimates and projections, family planning, and health management.

2.29 Awareness raising involves meeting with other donor agencies and development organizations to discuss and promote salient topics in the PHN sector. In FY92 PHRHN continued its involvement in several inter-agency task forces, including the Task Force for Child Survival and the Inter-Agency Group on Safe Motherhood and Better Health Through Family Planning, and participated in preliminary meetings for the International Conference on Nutrition that was held in Rome in December 1992. PHRHN was also involved in inter-agency discussions on micronutrient malnutrition and co-sponsored an international conference in Montreal on the subject.

2.30 To raise awareness and share information within the Bank, the PHN Department sponsors seminars; publishes a Working Paper Series and PHN notes on current topics; organizes and conducts training courses; and prepares a series of best practices and other papers aimed at helping Bank staff in operations develop and implement more effective Bank projects. During FY92, PHRHN provided new information to Bank staff working in operations by sponsoring 19 seminars, attended by a total of 363 Bank staff, on a variety of PHN topics. PHRHN also published 19 Working Papers and a series of two-page PHN notes, and assisted with the publication of three technical papers.

2.31 PHRHN and the technical departments conducted training programs that aimed to inform Bank management and staff about key sector issues. The most significant of these programs was a half-day seminar for senior Bank management including the President of the World Bank, managing directors, several vice presidents, and about thirty department directors. Its purpose was to consider the implications of rapid population growth for economic development and poverty-alleviation objectives of the Bank. Outside experts reviewed the current state of our knowledge about the consequences of population growth and the efficacy of family planning services as a means to improve reproductive health and help families achieve their fertility and family-size goals. The seminar was followed by region-specific seminars for regional management teams and the task managers of population projects; that series will be ongoing throughout FY93.

2.32 Other staff training included a successful five-day program on effective work in the health sector; a five half-day nutrition seminar that disseminated best practice among nutrition specialists; a monthly series of technical seminars for the Population Working Group; a brown-bag luncheon series that focused on current issues in health-care financing; and periodic meetings of an AIDS Working Group, all these organized by PHRHN. The technical departments offered a number of region-specific programs, including migration issues in the Middle East and North Africa; nutrition, decentralization and AIDS, in the Asia region; and poverty analyses, including the impact of targeted nutrition assistance, in the LAC region. In addition, the startup of preparation for the 1993 World Development Report (WDR) on health generated a series of excellent technical seminars, which many Bank staff attended.

2.33 The Bank's Economic Development Institute (EDI) organized seminars in the LAC region on public budgeting for PHN, including the issues of public finance for social security and health care; in Eastern Europe on health care and public social spending; and in Asia on health. In all these seminars, Bank staff played significant roles in the dissemination of experience with Bank projects and ongoing research.

2.34 Staff in the PHN sector grew from about 310 to about 360 during the course of FY92, as a result of some new hires and transfers from other sectors. PHRHN found, through two questionnaires sent to staff, that training on health insurance and health-care financing, as well as best practice exchange-of-information in all areas of population, health, and nutrition project

formulation, have highest priority among Bank staff for their immediate training needs. There is also considerable interest in the use of study tours to learn about current practice in the more successful OECD countries that have been able to moderate the high costs of health care services while assuring quality and broad coverage. Maintaining and enhancing staff skills through training will continue to be a major sector challenge.

2.35 Specific, operations-relevant research undertaken by PHRHN included preliminary research on Best Practices papers on Micronutrient Deficiency Disorders and on Women's Health and Nutrition; publication of a paper on Effective Family Planning Programs and Guidelines on Safe Motherhood; an ongoing study of the Economic Impact of Adult Mortality in Africa, specifically focusing on how households cope with illness and death of AIDS victims; and continuing work on costing and financing issues for hospitals. This work synthesizes lessons learned from the experience of countries and donors, and explores cost-effective strategies for combatting major health problems in the world.

2.36 A major part of the work program of the PHN Department is to provide support to operations. In FY92 PHRHN provided 112 weeks of direct operational support to help staff in operations conduct sector work and identify, prepare, appraise, supervise and evaluate Bank projects. This was approximately 20 weeks in excess of planned support.

E. Population, Health and Nutrition Content of Projects.

1. *Population*

2.37 Ten projects in the FY92 PHN lending program provide assistance to family planning, two of which (Niger and Mauritania) also contain components that support the development of population policy and analytical capacity. One interesting aspect of the FY92 population lending program is its contribution to the geographical expansion of the Bank's population portfolio. The Niger Population project, for example, represents the Bank's first freestanding population project in the Sahel. Five other projects (Mauritania, Equatorial Guinea, Chile, Poland, and Romania) are the first Bank lending operations in the PHN sector in those countries; all but one of these provide direct support to family planning (the Chile Technical Assistance and Hospital Rehabilitation project does not address family planning directly, although it does have a subcomponent that will fund the design of a women's health program).

2.38 The volume of lending for population, at $103.2 million, represents a substantial drop from last year's total of $351 million, a drop that was forecast, but not expected to be quite so steep (Annex 1, Tables 9 and 10 provide more detail). The number of projects with a population component is also down from FY91's record level of 18, reflecting, in part, the drop in the number of PHN projects overall. Slippage from FY92 to FY93 provides additional explanation. Two projects committing substantial resources to population - Ethiopia Population and Nepal Population and Health, together amounting to $76.0 million - are now expected to go to the Board in FY93. Both the volume of population lending and the number of projects are expected to increase next year, and be maintained in FY94. (Annex 1, Figure 2 provides more detail). Bank support for population projects benefitted substantially from IDA funding, as it has in the past. Eight of the 10 population projects are IDA-supported, to the value of $80.8 million, or 80 percent of population lending. In comparison (as noted above in para. 2.9), 68 percent of PHN lending in FY92 is IDA-financed. For Bank lending as a whole, the proportion financed by IDA is 30 percent.

2.39 One relatively minor reason for FY92's low population lending figure is an accounting change, which allocates the reinforcing subcomponents of a population project to the relevant subsector in recognition of the increasingly integrated nature of population and PHN projects. (Based on the definition previously

used, FY92's total would have been $125 million.) This change has been introduced as part of the effort to track the subsectoral thrust of human resource lending, which increasingly integrates activities in several sectors into one project. Thus, the loan amount for a population project with maternal and child health (MCH) or women in development (WID) components is no longer quantified as 100 percent population. The increasingly diverse nature of Bank population projects reflects the effort to address not only the unmet need for contraception that exists in most countries, but to stimulate the demand for family planning that derives from better infant, child and maternal health, and from improved women's status. Programs that used primarily to provide family planning services are moving to provide maternal and child health, including nutrition interventions (India Family Welfare) and WID components (Mauritania and Niger projects). Often projects involve local communities or NGOs in these activities. Indeed, moves towards including NGOs and the private sector in general, and towards decentralizing control in public programs, are frequently features of current population and PHN projects, reflecting the search for ways to improve access of vulnerable groups.

2.40 The Niger Population project, for example, establishes a Population Fund to finance private sector, NGO, and community involvement in service delivery and information, education and communication (IEC) activities. In addition, the India Family Welfare project will put forth "concerted effort" to include private voluntary organizations (PVOs) and private medical practitioners (PMPs) in the delivery of services and IEC. The Innovative Schemes component of this project establishes a revolving fund used to finance PVOs and PMPs. They will compete for the funds, proposing new interventions that involve the community directly. Suggested projects include creche programs, nutrition and environmental sanitation projects, and female education and training activities. This project targets involvement of PVOs because "PVOs generally take up innovative programs by adopting strategies and methodologies which are aimed at fostering social transformations, thereby generating attitudinal changes and improving quality of life of women in particular (SAR, p. 21)."

2.41 PHN sector work completed and ongoing in FY92 gave substantial attention to population issues. These studies also dealt with the themes of integration and decentralization of PHN projects, under the headings of improving the effectiveness of services delivered, the efficiency of resource allocation, and the equity of access. In addition, sector work examined the effect of population growth on other development activities - in the provision of social services, and its impact on labor markets in particular. The FY92 reports for IDA countries focussed on countries with rapid rates of population growth - in the majority of cases over 3 percent per annum, or only reduced below this level by high mortality (e.g. Guinea Bissau). Four PHN reports reached grey cover for countries in eastern Europe and the former Soviet Union, but only one, Romania, deals with population and family planning issues in any detail, although the Poland study takes up the issue of family planning's role in improving maternal and child health.

2.42 A sector report on *New Directions in the Philippines Family Planning Program* quantified the health benefits of family planning to women and children, and its message is being increasingly noted and quoted in the Philippines. The report's key finding is that "...preliminary analyses of available data indicate that if pregnancy were avoided by women under the age of 20, over 35, with four or more children, and less than 15 months post-partum, both the infant and child mortality rates would decline by almost 25 percent and the number of infant and child deaths would decline by 35 to 50 percent.

2. *Health*

2.43 The main thrust of health projects approved during the year is the provision of primary health care services to those most in need: largely the poor, women of child-bearing

age and children under the age of five. Considerable emphasis is thus given to maternal and child health services. A fundamental objective of these interventions is to improve the quality, efficiency, and equity of basic services. Quality issues are primarily addressed through interventions to: upgrade physical facilities, upgrade the technical and outreach skills of personnel, ensure the availability and affordability of essential drugs and adequate recurrent financing, and involve communities in the design and management of sector activity. (See Chapter IV for a fuller discussion of quality issues).

2.44 As a complement to interventions at the service level, FY92-approved health operations provide considerable support to building national capacity for policy formulation and sector management and to the field testing and eventual country-wide application of policy reforms, which aim for increased sector efficiency and equity. These objectives are largely realized through financing and institutional reforms such as: the mobilization of additional resources through cost recovery and increasing health's share of the public budget; reallocation of the public budget for health in favor of basic services for the poor and underserved; more financial autonomy for hospitals and increased private sector activity thus liberating public funds for basic services for the poor; decentralization; and increased involvement of NGOs and communities in health sector activity. Section E of Chapter III provides a more detailed analysis of project support in this regard.

2.45 Notable features of this year's portfolio reveal two emerging trends in health sector lending: increasing attention to urban primary health care and to the hospital sector. In support of urban health services, the Kenya Health Rehabilitation project will support the development and initial implementation of a strategic plan for health services in the Nairobi areas; the Mauritania Health and Population project will strengthen basic health services in three regions including Nouakchott; and the India Family Welfare project will improve the supply and management of family welfare services for poor urban populations.

2.46 Assistance to the hospital sector will be provided through a number of health operations. The Chile Technical Assistance and Hospital Rehabilitation project will initiate improvement in the quality of hospital services in Santiago through the support of subprojects to rehabilitate hospitals to be designed and implemented by hospital staff and local health authorities. The Equatorial Guinea Health Improvement project will support key reforms in the management of two national hospitals, in Malabo and Bata, including progressive management and financial autonomy, the selective application of the fee-for-service policy, and the strengthening of accounting and administrative controls. Under the Kenya Health Rehabilitation project, the Kenyatta National Hospital will be rehabilitated and its organization and management strengthened.

2.47 Health operations also targeted a number of priority diseases. This year the Bank's second ever freestanding AIDS project was approved for India (the first being for Zaire in FY89). AIDS is also addressed through projects in Romania (safer blood products and AIDS testing), China (surveillance of STDs and AIDS), Kenya (HIV/AIDS-related supplies for hospital workers to avoid inadvertent transmission), and Rwanda (targeting of emergency assistance to AIDS-afflicted families and orphans). In addition, the Equatorial Guinea project will help establish a sexually transmitted diseases (STD) program in the Ministry of Health. Malaria is a primary target of both the Equatorial Guinea and Sao Tome and Principe projects. Schistomiaisis is the sole target of a project in Egypt and one of two targets in the China project, the other being tuberculosis.

3. *Nutrition*

2.48 Nutrition lending in the Bank continues to grow. While the number of PHN projects with nutrition components decreased between FY91 and FY92 from 22 to 10 (reflecting the overall drop in the total number of PHN projects in FY92), the estimated allocation of total project resources for nutrition in the three-year period

FY93-95 continues the strong climb upwards, rising from $49.3 million for FY87-89 to $893.9 million for FY90-92 to $1257 million for FY93-95 (Annex 1, Table 11 and Figure 3).

2.49 In addition to PHN activity, resources allocated for nutrition-related activity outside the PHN portfolio increased significantly in agriculture, education and emergency relief, among others. The Emergency Drought Recovery and Mitigation Project in Zimbabwe includes nearly $21 million for a child supplementary feeding program. Within agriculture projects, both the Ghana National Agriculture Extension Services project and the Chile Small Farmer Services project finance expanded extension services to women with a strong emphasis on nutrition. A $15.3 million school feeding component in Chile's Primary Education Improvement project also adds to the total project resources for nutrition represented in Bank projects for FY92 (Annex 1, Table 12).

2.50 Attention to micronutrient deficiencies and long-term strategies for food fortification remain areas of emphasis in PHN projects with nutrition components. Several projects under preparation, including the FY94 Pakistan Nutrition project, are exploring potential vehicles such as sugar, for the iron fortification necessary to make a sustained impact on the widespread iron deficiency anemia found in so many lower income countries. Under the Bank's Special Grant program on micronutrients, financial support for the development of a ten-year action plan to combat global iron deficiency anemia has gone to the International Nutrition Foundation for Developing Countries and work continues on a best practices paper on micronutrients.

2.51 The nutrition component in Poland's Health Services Development project represents a shift away from the traditional attention to undernutrition found in most Bank projects. Its focus on preventive counseling and education is aimed at addressing unhealthy dietary practices leading to high levels of mortality due to cardiovascular disease and cancers found in Poland. This new direction in nutrition programming will be repeated in upcoming PHN projects in several of the countries of eastern Europe and central Asia.

2.52 FY92 adjustment projects continue the trend toward inclusion of nutrition conditionality, with 10 structural and sector adjustment operations addressing nutrition, including two that contain specific nutrition actions required for tranche release (Annex 1, Table 13). In what is largely a new area of Bank lending, four adjustment operations contain sizable credits to address the impending starvation and food insecurity resulting from an unprecedented drought throughout southern Africa in 1992. The Malawi Entrepreneurship Development and Drought Recovery Program disbursed $50 million of the $120 million Credit in the first tranche for the purchase of maize imports, while $10 million under Mozambique's Economic Recovery credit will assist with emergency import of seeds, farming equipment and food. Zambia and Zimbabwe's FY92 adjustment operations also include IDA credit for drought-relief importation of agriculture inputs and food grain.

2.53 In spite of the addition of several technical nutrition specialists to the Bank's staff this year, the rapid escalation of nutrition operations in the Bank's pipeline and the increased demand for direct operational support from the PHN Department, forces the continued reliance on outside consultants. Further augmentation of the Bank's technical nutrition capacity is necessary to support adequately the growth in this sector.

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[1] Prior to January 1, 1993, the PHN Department was known as the Population, Health and Nutrition Division of the Population and Human Resources Department (PHRHN).

CHAPTER III: SPECIAL TOPIC: PHN'S CONTRIBUTION TO THE BANK'S POVERTY ALLEVIATION OBJECTIVE

A. Background

3.1 The 1990 World Development Report (WDR) documents the extent and impact of poverty around the world, and, drawing on the Bank's own experience of the last three decades, emphasizes that economic growth alone is not a sufficient development objective or adequate measure of success. It argues convincingly that investments in human resources contribute to increasing incomes and to the reduction of poverty. As time goes by, the real success of this WDR lies less in the documentation, dissemination and reanimation of this very important message and more in the significant way it has influenced and continues to influence both the content and approach of the Bank's work.

3.2 The 1990 WDR reaffirmed the Bank's commitment to poverty reduction as its fundamental objective, and was followed by a series of operational documents, which provide practical guidance in strengthening the focus on poverty reduction in Bank operations. The policy paper, *Assistance Strategies to Reduce Poverty*, articulates a two-pronged strategy for sustainable poverty reduction: (1) the generation of income-earning opportunities for the poor; and (2) the provision of basic social services to the poor to enable them to seize those opportunities. The strategy also calls for providing a social safety net for vulnerable groups during periods of adjustment. The *Poverty Reduction Handbook* demonstrates good-practice analytical and operational work. Operational Directive 4.15 on *Poverty Reduction* summarizes Bank procedures and guidelines for operational work on poverty reduction, emphasizing the importance of assessing country policies, reviewing public expenditures, and strengthening institutions in achieving that objective. This chapter will demonstrate just how well and to what extent PHN operations respond to the Bank's poverty alleviation objective, by analyzing the design and content of the sixteen operations approved in FY92.

B. Context

3.3 The Bank's contribution to poverty alleviation efforts through its PHN sector must be evaluated in the proper context. The following section thus sketches out in a country setting: *what* are the essential activities for successful and sustainable poverty alleviation, *who* should be responsible for carrying out these activities, and *how* these activities should be carried out. Only when these three elements are clearly laid out does the optimal role for the Bank begin to emerge.

1. *What*.

3.4 In order to address and resolve poverty issues, a country needs to carry out four crucial and complementary activities. First, *information collection and analysis* permits the identification of poor and vulnerable groups and provides essential information on their location(s), needs, constraints, demands and on why their needs and demand for basic social services are not being met. Second, a country's *policies, strategies and reform measures* can be instrumental in reaching the poor and are a reflection of political commitment to poverty alleviation. Well-articulated macro- economic and multisectoral policies that are oriented toward growth with poverty reduction will provide the framework needed to carry out poverty alleviation activity both within and outside of the PHN sector. The impact on the poor of PHN policies and priorities needs to be well understood by planners and policy makers. A re-examination and reform of PHN policies, financing and institutions in light of their impact on poor and vulnerable groups will permit improvements in access, quality, affordability, efficiency and effectiveness of PHN services, which will benefit poor and vulnerable groups.

3.5 The *translation of policy into practice* is a third essential ingredient for successful and sustainable poverty reduction. It involves the planning and programming of resources and design of activities for the optimal benefit of the poor. Particularly challenging in this regard (both technically and politically) are: (1) the review and reallocation of public investment and recurrent budgets for PHN away from the development of more sophisticated services and the support of an excessively curative orientation, characteristic of many current allocative patterns, towards more basic curative, preventive and promotional activities; and (2) the targeting of groups most in need, both to ensure the availability of basic services and to ensure their affordability. Finally, *implementation* of poverty alleviation activities requires good organization and sound management of human, financial and physical resources, a reliable monitoring and evaluation system for early detection of implementation issues, and the flexibility to fine-tune design and objectives to overcome these issues rapidly. In addition to tracking the implementation process, monitoring and evaluation should assess the impact on the poor of program or project interventions, and should inform policy analysis and formulation.

2. *Who.*

3.6 Both L. Salmen's *Institutional Dimensions of Poverty Reduction* (WPS No. 411) and the FY91 Annual PHN Sector Review (WPS No. 890) stress the importance of using optimally the numerous and various potential actors and institutions in the sector -- both public and private -- according to their comparative advantages. Salmen argues that the understanding, development and use of local and informal institutions in the design, promotion and delivery of basic services for the poor is likely to result in an intervention which is highly cognizant of and responsive to demand and, therefore, more likely to result in the success and sustainability of such interventions. The FY91 ASR, which addressed "Institutional Development in Support of a Poverty Focus for the PHN Sectors", argues that significant gains in quality and efficiency could be realized if the private commercial sector, NGOs, community organizations, universities, national and regional institutions specializing in training, consulting and research and other groups outside the public sector, were encouraged to work in partnership with government -- both centralized and decentralized -- to address and resolve sector issues.

3. *How.*

3.7 How best to address the poverty problem is a question which has not been fully answered. This is due in part to the need to tailor interventions to a particular country context, thus indicating an "it depends" answer. It is also due in part to the fact that lessons from experience have not been sufficiently analyzed, exploited or widely disseminated and that much more pilot testing, operational research, and monitoring, and evaluation of poverty initiatives need to be carried out in order to fine-tune efforts to alleviate poverty and provide basic social services to the poor.

3.8 There does exist, however, some guidance in this regard. The operational guidelines emanating from the 1990 WDR, the FY91 PHN ASR and L. Salmen's *Institutional Dimensions of Poverty Reduction* all stress the importance of the following three conditions for successful and sustainable poverty alleviation interventions:

(a) A full *understanding* of the extent of the poverty issue at all levels of government (particularly the highest), which would provide the basis for a firm *commitment* to address the issue and more *transparency* in policy formulation.

(b) The reorientation of poverty interventions (including basic social services) to be more

knowledgeable and accommodating of the locations, problems, needs and perspectives of poor clients. According to Salmen, experience suggests that poverty reduction efforts would be more successful if they were energized more by *demand* than supply.

(c) *National capacity* to carry out the four essential activities outlined above (i.e., information collection and analysis; policy analysis and formulation; planning, programming, budgeting and targeting; and management, monitoring and evaluation of implementation), and to mobilize and coordinate the optimal contributions of partners in carrying out those four activities, including clients or target groups, NGOs, private sector, community groups, government (centralized and decentralized, across sectors).

C. The Bank's Role

3.9 In varying degrees and patterns, the three above-mentioned conditions for successful and sustainable poverty alleviation are not at present being effectively met in most of the Bank's client countries. These will take time to be fulfilled, and yet the needs of the poor and vulnerable are urgent in many of these countries and must be addressed immediately. Appropriate Bank intervention should ideally address both the short and medium-term issues. In order to prevent poor and vulnerable groups from slipping through the social safety net, particularly during periods of economic hardship and adjustment, the Bank should invest in activities to improve quickly and directly the food security and social welfare of the poorest and most vulnerable population groups. However, short-term, emergency-type investments aimed at reducing poverty do not constitute by themselves a sufficient response to the Bank's poverty alleviation objective. The Bank needs also to focus on a crucial medium-term objective: that of stimulating and encouraging the three above-mentioned conditions for success and sustainability of poverty interventions over the medium- to long-term. It should assist in developing and strengthening, where needed and appropriate, a country's commitment and capacity to address and resolve its own poverty-related issues and problems, with the full involvement of those who have much to gain from and contribute to the process: the poor.

D. Evaluation of FY92 Portfolio of PHN Projects: An Overview

3.10 PHN projects approved during FY92 have been responsive to the Bank's poverty alleviation objective and have addressed both short- and medium-term issues. The following sections of this chapter will provide an overview of the poverty content of these projects and analyze special features of these interventions. For reference, the Credit and Project Summaries for each of the sixteen projects, as presented in the respective SARs, are reproduced in Annex 2.

3.11 All sixteen PHN projects approved this year will, in various ways, benefit poor and vulnerable segments of national populations. This portfolio of projects can be subdivided into three categories in terms of how their design and objectives are geared towards poverty alleviation. The classification of the sixteen projects is presented in Table 6 and discussed below.

3.12 *Category 1: Multisectoral Interventions for Poverty Alleviation (Poverty Projects).* The primary objective of these projects is the provision of short-term emergency assistance to address the basic needs of groups most affected by a country's economic adjustment process, while also building national capacity to monitor and alleviate poverty in the medium- and long-term. Three of the sixteen PHN projects (or about 20 percent of the FY92 portfolio) fall into this category: Rwanda Food Security and Social Action, Guyana SIMAP/Health, Nutrition, Water and Sanitation, and Honduras Second Social Investment Fund. Short-term assistance provided through these projects is channeled to target groups in a

decentralized and demand-driven manner, and includes: credits to small business/entrepreneurs, provision of basic social services (food aid, primary health care, day care centers), and income generation opportunities/temporary employment on public works activities to develop social and economic infrastructure at the local level. Medium-term components of these projects include efforts to increase national capacity to monitor living standards and basic needs of populations and to reform policies and develop and implement strategies (both inter- and intra-sectoral) to eliminate poverty.

3.13 *Category 2: Provision of Basic Social Services to the Poor as Primary Objective.* As an important complement to broadly-based economic growth to generate income earning opportunities for the poor, the WDR 1990 emphasized the direct improvement of the welfare of the poor through the provision of basic social services. This category of projects, of which there are six (or about 35 percent of the FY92 portfolio) focuses on that aspect of the Bank's poverty reduction strategy as the primary objective. These projects target poor populations, and within those populations, particularly disadvantaged and vulnerable groups (mostly mothers and children). All of these projects include both short-term assistance, aimed at improving the quality and accessibility of basic social services, and medium-/long-term assistance aimed at developing national commitment and capacity to reform, implement and monitor sector policy with a view to improving the social welfare of poor and vulnerable groups. Of the six projects included in this category, four are in the Africa region (Equatorial Guinea Health Improvement, Mauritania Health and Population, Niger Population, and Sao Tome and Principe Health and Educaton), and two are in India (Child Survival and Safe Motherhood, and Family Welfare [Urban Slums]).

3.14 *Category 3: PHN Interventions Whose Benefits to Poor Are Important But Not the Primary Objective.* Projects in this third category (totaling seven, or about 45 percent of the FY92 protfolio) do not set poverty alleviation as their primary objective, but support strategic sectoral interventions, which will in fact benefit poor and vulnerable groups both directly and indirectly. Four of these projects (Kenya Health Rehabilitation, Poland Health Services Development, Romania Health Rehabilitation, and Chile Technical Assistance and Hospital Rehabilitation) are supporting policy, institutional and operational reforms from which the poor should derive significant benefits. Such reforms include: (a) increased attention and resources for prevention and promotional activities (vs. curative); (b) increased financial and managerial autonomy for higher levels of health care and greater private sector involvement, both of which should liberate public funds for basic services; (c) regulation of drug production, procurement, distribution and prescription for better quality and greater affordability of health services; (d) development and expansion of the institutional framework for health (private sector involvement, decentralization of authority and responsibility, community involvement), which should provide the poor with "exit" and "voice" options; and (e) mobilization of resources through cost recovery with a social safety net for the poor.

3.15 In addition to medium-term interventions focussed on sector reforms, these projects also include components which are more clearly and directly focussed on poverty issues -- both short- and medium-term. The Chile project will improve health service provision to a majority of the poor population of metropolitan Santiago by upgrading the dilapidated capital stock of seventeen hospitals that cater to the ambulatory and tertiary care needs of the city's semi-rural and marginal peri-urban areas. The Kenya Health Rehabilitation project will support the establishment of a National Household Welfare Monitoring and Evaluation System to monitor trends in poverty and evaluate impact of policies on household welfare. The Poland and Romania projects provide for more effective targeting of poor and vulnerable populations.

Table 6: Classification of FY92 PHN Projects by Poverty Objectives and Content

REGION	Category 1 Multisectoral Interventions for Poverty Alleviation	Category 2 Provision of Basic Social Services to Poor and Vulnerable Groups as Primary Objective	Category 3 PHN Sector Interventions Whose Benefits to Poor Are Important, But Not Primary Objective
AFRICA	Rwanda	Equatorial Guinea Mauritania Niger Sao Tome	Kenya
EAST ASIA			China
ECA			Poland Romania
LAC	Guyana Honduras		Chile
MENA			Egypt
SOUTH ASIA		India Safe Motherhood and Child Survival India Family Welfare (Urban Slums)	India AIDS Prevention Control

3.16 The three remaining projects in this category target diseases which afflict the poor. The Egypt and China projects are supporting major programs for the control of schistosomiasis, targeting mainly rural and lower income and less educated segments of the population. The China project will also support a major reform in that country's approach to tuberculosis. The new control strategy emphasizes treatment of *all* detected cases to reduce infection rates rapidly, rather than searching for new cases and treating only these who can afford to pay, which had been the practice. This will lead to increased effectiveness, accountability and *equity* in the control of that disease, and will help alleviate the immediate, often financially devastating impact of the disease on the patients and their families.

3.17 The India AIDS project will benefit poor segments of the population and migrant labor. As a part of project preparation the impact of HIV/AIDS at the household level in India was assessed and found to have devastating effects on the social and economic welfare of the victims and their families, such as loss of economic security, potential loss of land and other assets, reduced remittances to family and friends, reduced capacity to finance education, orphans (young and old), not to mention the high costs of medical care and funerals. This project's success in reducing the incidence of HIV/AIDS will thus contribute to poverty alleviation in an important way.

E. Special Features of Poverty Interventions in the FY92 Portfolio

3.18 This section selectively highlights design features of poverty interventions included in PHN's FY92 portfolio of projects. While it is premature to call them "best practices", these components of poverty work in the Bank generally reflect careful consideration and incorporation of lessons of experience and as such hold promise for success and sustainability of investments. This section is by no means an exhaustive inventory or comprehensive analysis of the coverage and treatment of each of these special features. Rather, it provides an overview of the poverty content and a flavor of the design and approaches of this year's crop of PHN projects. The special features reviewed in this section are: (1) poverty information and monitoring; (2) understanding and responding to the needs and demand of the poor; (3) targeting; and (4) reforms in policy, financing and management/organization of activities. The last category covers the three key areas of Bank intervention in poverty alleviation as set out in the recently distributed OD 4.15 on *Poverty Reduction*: assessment of country policies; review of public expenditure; and reform of institutions.

1. *Poverty Information and Monitoring*

3.19 A general objective of the Rwanda Food Security and Social Action Project is to increase government capacity to monitor the living standards of the population. This project will thus support the development of a system to trace the evolution of selected determinants of welfare and welfare outcomes at the levels of the household and the individual, in the context of the country's adjustment process. This system is comprised of a combination of integrated surveys (which observe the income generation and expenditure processes and basic needs achievements) and priority surveys (which provide for the rapid identification and monitoring of a wide range of welfare indicators of policy target groups). The design of this welfare monitoring system will integrate data collection and processing, on the one hand, with policy relevant analysis, on the other.

3.20 The Kenya Health Rehabilitation Project is supporting a component to develop within the Ministry of Planning and National Development (MPND), the establishment of a National Household Welfare Monitoring and Evaluation System for monitoring trends in poverty and evaluating the impact of policies on household welfare. The project will develop permanent capacity to carry out national household surveys on an annual basis and to analyze data collected as a basis for providing advice to MPND and social sector ministries in policy design.

3.21 In order to improve knowledge about the extent of poverty and the determinants of living standards, the Guyana SIMAP/Health, Nutrition, Water and Sanitation Project includes a component to strengthen that country's data collection capacity. It will support the development of a methodology for a Living Standards Measurement Survey (LSMS), the execution of field work, and the analysis of results. The LSMS will be implemented in conjunction with UNDP's Income and Expenditure Survey (IES). Selected LSMS modules with particular focus on social sectors data will be added to the IES in its second survey round. Survey rounds for the LSMS will be undertaken on three separate occasions, the last of which is expected to be completed in mid-FY93.

2. *Understanding and Responding to the Needs and Demands of the Poor*

3.22 A review of PHN projects over the past five years reveals a notable trend of increased importance attached to the demand and perspectives of beneficiaries in project design and development. This is reflected in increased involvement of NGOs, other local organizations, and beneficiaries in the assessment of needs and in the design, implementation and evaluation of

interventions. It is also reflected in the emergence of a number of more carefully conceived, culturally appropriate and better targeted programs aimed at encouraging the poor to seize opportunities to participate in their own development and at stimulating among this group latent demand for basic social services. The following paragraphs give examples of how some projects have done this.

3.23 *Involvement of Beneficiaries, NGOs and Other Grassroots Organizations in Program Design and Implementation.* By design, two Sector Funds approved during the year (Honduras and Guyana) are largely demand-driven interventions. These funds, intended to address the basic needs of the poor, finance subprojects which are designed, developed and implemented by NGOs, community groups, and/or local government agencies. A national agency is given responsibility to manage the funds, to solicit proposals for subprojects, and to appraise, approve, supervise and evaluate them. The labor-based public works component of the Rwanda Food Security and Social Action project has a similar design, whereby communes (local administrative units) are invited to submit proposals for small public works subprojects, which would provide temporary income-earning opportunities for the poor.

3.24 Over and above the special demand-driven design of social funds, virtually all FY92 projects provide for the participation of the poor in some form. One particularly good example of thoughtful, well-designed and extensive participation is the India Family Welfare (Urban Slums) project. A major activity of this project is to increase the participation of urban slum communities in the design, implementation and supervision of the family welfare services being provided to these communities. Under this project community groups will undertake and/or participate extensively in beneficiary/needs assessments initiated by each municipality targeted for project assistance. In order to elicit and encourage community inputs to project design, as a part of project preparation each municipality undertook a series of workshops during which participants, drawn directly from the targeted slum communities, commented on and recommended changes to project design.

3.25 Four methods for community participation will be employed under this project: (a) the establishment of neighborhood communities; (b) the promotion of PVO partnerships; (c) the organization of supplementary health support schemes such as sanitation and nutrition awareness; and (d) the support of community-initiated ideas with financial, material and staff resources. And six community involvement strategies have been identified: persuasion, education, information feedback, consultation, joint planning of design, and delegated authority.

3.26 A plan for operationalizing community participation was prepared by each municipality. The plan itemizes for each of the six strategies: implementation methods; government inputs; community inputs; joint management structures; associated problems/issues risks; requirements to increase demand; expected benefits; evaluation indicators; and additional funding required. This project may provide a good model for other PHN operations striving to initiate and institutionalize community participation in the design and implementation of basic social services, particularly in an urban setting.

3.27 The following are yet other examples of community participation initiatives included in FY92 projects. Promoting regular consultations with beneficiaries is a general objective of the Equatorial Guinea Health Improvement project; management of a new pilot drug system, supported under this project, will involve community participation through facility-level management committees comprising representatives of the beneficiaries. The Sao Tome and Principe Health and Education project will finance a study on community involvement in the social sectors as well as an IEC campaign to stimulate community participation in malaria

control activities. A portion of the Population Fund under the Niger Population project will be allocated to subprojects designed by beneficiaries, which would support activities in the promotion and provision of family planning services and basic primary health care. To minimize the risk of inefficient management of the Rwanda Food Security and Social Action Project, beneficiaries will be involved in the monitoring process.

3.28 Agreement was reached during negotiation of the Romania Health Rehabilitation Project that the Government would prepare for Bank review a development plan for health promotion and public participation for the period 1992-94, which would include training of district health education workers and involvement of NGOs. The India Child Survival and Safe Motherhood Project will support the design and development of a number of community participation strategies and the implementation of district planning including community participation based on Ministry of Health and Family Welfare (MOHFW) guidelines.

3.29 *Raising Awareness and Stimulating Demand.* In addition to eliciting and responding to the perspectives and demands of communities/ beneficiaries, FY92 projects also devote significant resources and effort to the stimulation of latent demand for basic social services and to raising awareness about the value of preventive activities. As for the provision of services supported by FY92 projects, the preponderance of IEC activities are targeted to poor and vulnerable segments of the population as a complementary means of improving their social welfare. This activity poses a significant challenge, given that poor groups are the most difficult to reach and influence. Not only will such activity encourage these groups to adopt behaviors to improve their own health, it will better equip them to fulfill their role as participants in the design, monitoring and evaluation of basic social services for the communities. Both the Poland Health Services Development Project and the Romania Health Rehabilitation project will support health promotion and preventive activities as an important part of the health reform to be implemented under those projects. The Niger Population project will develop a nationwide IEC program to promote family welfare and women's status. Major activities of the program include: (a) expanding mass media communication; (b) strengthening inter-personal communication; (c) organizing listeners' groups at the village level; and (d) expanding IEC activities of voluntary associations such as woman's associations and youth groups, and other community action groups including NGOs and the private sector.

3.30 All three India projects approved during FY92 include well designed and targeted IEC programs. Notable among them is the India National AIDS Control Project, which is supporting an extensive program to raise public awareness and increase community involvement. The program's strategy has two main components: (1) mass media for creating a favorable environment for prevention across the whole social fabric; and (2) focused, inter-personal communication and interventions targeted at four risk groups: commercial sex workers; intravenous drug users and sexually transmitted disease patients; persons who engage in high risk behavior such as migrant workers, truck drivers, and adolescents; and persons who cannot control their high risk (e.g., mothers and patients needing blood or blood products). An important and innovative feature of this component is the sensitization and mobilization of political and social leaders in addressing this issue.

3. *Targeting*

3.31 Targeting methodologies employed in FY92 projects tend to vary by type of project and objective. The three operations which aim to alleviate poverty through multisectoral interventions (identified as Category 1 projects in Table 6) appear to use the most elaborate methodologies. The Guyana project targets the urban and rural poor, in particular women of child-bearing age and children under five years of

age. The project employs a poverty targeting methodology developed with UNDP support, which permits the assessment of poverty through the analysis of key indicators: health, education, housing, and employment. Prior to appraisal each subproject will be screened two times: first its geographical location will be evaluated against regional level poverty maps, and second its specific location will be considered and evaluated against indicators available at the village level, tailored, where possible, to the type of subproject proposed. During the subproject appraisal visit, SIMAP staff will verify the level of need of the population as well as the fit between SIMAP's targeting criteria and intended beneficiaries. The Guyana SAR notes a lesson of experience which calls for a modification of the demand-driven format of social fund projects and greater care in targeting investments to those in greatest need. Guided by regional and village level indicators, SIMAP's promotional strategy to stimulate demand and determine priorities will accommodate that lesson.

3.32 That same lesson is also emphasized and reflected in the Honduras Second Social Investment Fund project. Sixty percent of the funds of the first project, which targeted its subprojects based on a poverty map, went to poor regions, falling short of its initial target of 73 percent. Experience has shown that, for a number of reasons, it is difficult to ensure that a sufficient proportion of social funds are allocated to the poorest. Where targeting is not used, larger proportions of funds will in all likelihood be absorbed by wealthier municipalities with larger demand for projects and greater capacity to prepare proposals. NGO-sponsored projects tend to be developed in more advantageous municipalities. Furthermore, promotional activities have been insufficient in poorer municipalities and subprojects are usually smaller in poorer areas. To ensure that subprojects would be more accurately targeted, therefore, the second project will: increase promotional activity; pay subproject-related wages aligned with the market rate for unskilled labor to ensure participation of the lowest deciles of the income scale; allocate funds on the basis of a poverty map and a departmental/ municipal index of poverty; ensure that social services subprojects receive at least 20 percent of overall program funds; make more funds available to finance projects most demanded by the poor; and give priority to high social returns projects.

3.33 The Rwanda Food Security and Social Action project has clearly defined but varied target groups reflecting the diversity of interventions supported by that project. Target groups include: (a) individuals with insufficient earning capability (landless farmers, poor female-headed households, AIDS-afflicted families, orphans); (b) farmers faced with acute food insecurity; (c) farmers with land less than 0.2 hectare needing off-farm employment to survive; and (d) micro-entrepreneurs. For the labor-based works component, the forty-three poorest communes were selected using an index of vulnerability, which ranks communes on the basis of indicators/needs in terms of poverty alleviation and which will be reviewed at the project's mid-point.

3.34 Category 2 projects, aimed at the provision of basic services to poor and vulnerable segments of national populations, target the poor using geographic criteria. A number of these projects target particularly vulnerable groups within those populations, notably women of child-bearing age and children under five years of age. They reach these groups through well-targeted IEC programs to stimulate demand and by strengthening the services tailored to the specific needs of those groups.

4. *Reforms in Policy, Financing and Organization*

3.35 A number of projects will develop capacity and support initiatives to monitor social poverty indicators and the impact on those indicators of policies and strategies of a *macroeconomic* or *multisectoral* nature. The social

survey component of the Rwanda Food Security and Social Action project will strengthen government capacity to monitor the living standards of the population through socio-economic surveys and studies, which will provide the foundation for the development of a long-term poverty alleviation strategy and for the development of a national food policy, both of which are important objectives of the project. The development of a National Household Welfare Monitoring and Evaluation System supported under the Kenya project will provide a better information base for the design of social policies.

3.36 Significant reform of *PHN* policies and strategies are encouraged and supported through the great majority of PHN projects approved during the fiscal year. These reforms largely support a reorientation of priorities and refinement in strategies, the aim of which is to increase the quality, efficiency and equity of health care services and thus benefit the poor and vulnerable both directly and indirectly. New or reaffirmed priorities support, *inter alia*, an increased emphasis on primary health care (prevention and health promotion, in particular) on selected diseases (e.g., malaria, schistosomiasis, tuberculosis, and AIDS) and health problems (e.g., high infant, child and maternal mortality), and on selected groups with acute needs (e.g. poor, underserved populations, women of child-bearing age and children under five).

3.37 In order to address these priorities more effectively and efficiently, Ministries of Health with project support are testing and implementing institutional and financial reforms. While not always done exclusively for reasons of poverty alleviation, these reforms should facilitate achievement of that objective.

4.a *Institutional Reforms.*

3.38 Institutional reforms supported by FY92 projects include efforts to embrace and use more rationally the potential of various actors in sector activity. Under these projects, decentralization policies will be implemented, the role and responsibilities of central ministries will be redefined and strengthened, private sector and NGO activity will be encouraged and supported, and community participation will be institutionalized. These reforms are likely to give the poor increased opportunity to participate in sector activity, and to have their concerns and problems addressed at the local level, where they would most likely be better understood. They could also improve the availability and affordability of basic social services. A number of community participation initiatives have already been described in section E. 2 above. The following paragraphs will describe selectively project support of decentralization and private sector development.

3.39 *Decentralization.* Virtually all FY92-approved projects support decentralization of health sector activity. The Mauritania Health and Population Project supports the governments' strategy to decentralize service delivery. The government has already defined structural, administrative and staffing norms for regional services. The project will assist in strengthening regions' capacity to assume newly decentralized responsibilities by (1) developing training programs for regional personnel; (2) developing a maintenance system for vehicles, equipment and infrastructure; (3) strengthening financial management; and (4) strengthening health service delivery in three regions. The Chile Technical Assistance and Hospital Rehabilitation project will facilitate decentralization of decision-making and resource management, by delegating needs analysis and the design and implementation of hospital rehabilitation subprojects to Health Service Areas and hospital managers and staff. With assistance from the Equatorial Guinea project, decentralization of decision-making would be achieved though greater delegation of authority to the district level on use of approved budgets, personnel management, drug distribution, and management of revenues for drug supply and

maintenance. The Niger Population project will strengthen departmental and district capacity in sector management, planning, monitoring and evaluation.

3.40 Both Poland and Romania will pilot test, with project assistance, decentralization of health sector policy making, planning, management and evaluation in three to four subregions in each of these countries, with the intention of eventually decentralizing on a country-wide basis. An interesting and innovative feature of both of these projects is that pilot subregions were chosen to participate in the projects based on a nation-wide competition initiated by those governments inviting proposals from regions/districts. All three India projects support decentralization activities: the AIDS project will strengthen central and state management capabilities; the Safe Motherhood and Child Survival project will improve management information systems, supervision, planning, logistics management and maintenance at the central, state and district levels. The Family Welfare (Urban Slums) project will improve management and administration of municipal health departments and support municipalities in the preparation and implementation of City Health Plans.

3.41 There is conventional, but unproven wisdom on the topic of decentralization. It should not be seen as a panacea. While it is likely to make services more responsive to clients, it may be, in some instances, less efficient and cost-effective than more centralized services, and may also invite central governments to decentralize too rapidly financial and organizational responsibilities to state and local governments, which are at present incapable of assuming them.

3.42 *Private Sector Development.* An important objective of the Kenya Health Rehabilitation project is to rehabilitate the Kenyatta National Hospital (KNH) to reduce its burden on the overall public budget and permit an increase in expenditures on preventive and primary health care. In support of the KNH Private Practice Plan, the Kenya project will support the rehabilitation and expansion of a private wing of that hospital and the construction of high quality office space for rental by KNH doctors for their private practices. The four objectives of this plan are to: provide KNH doctors with the opportunity to see and treat private patients on the hospital premises and thus ensure their continuous presence; run the private wing as a model institution to inspire and motivate the public sector; elevate KNH's image and reputation; and increase profit and augment KNH revenues. Over and above this initiative, KNH has become a parastatal and is thus expected to cover an increasing share of expenditures from its direct revenues. The Chile Technical Assistance and Hospital Rehabilitation project is financing a feasibility study for a private hospital project in Santiago.

4.b *Financial Reforms*

3.43 Financial reforms encouraged and supported under FY92 projects comprise a number of initiatives and activities that should significantly improve the quality and access of health services for the poor. They include: the mobilization of additional financial resources through cost recovery (fees for service and health insurance); increasing the social sectors' share of the public budget; reallocation of resources within social sector budgets in favor of basic services for the poor and underserved; more financial autonomy for hospitals and increased private sector activity, thus releasing public funds for basic services for the poor.

3.44 Most FY92 projects are supporting the implementation of a combination of these reforms to achieve greater efficiency and equity in the delivery of PHN services. Because of its leverage and comparative advantage in financial issues, the Bank is monitoring scrupulously project performance in this regard. Some examples of Bank involvement of this type are provided below. The government of Mauritania has developed a financing plan which provides for a gradual

increase in the Ministry of Public Health's (MOPH's) share of the general recurrent budget during the course of project implementation. MOPH share will grow to 5.5 percent in 1992 and by additional increments of 0.5 percent annually until it reaches a level of 7.5 percent in 1996. The plan also ensures that budget allocations for the 13 regions combined will total at least UM60 million for drugs and UM90 million for other operating costs and that allocations will be maintained in real terms at 1991 prices up to the end of 1996. The Bank will review annually during the course of project implementation the draft recurrent budget for health for the following fiscal year and the draft three-year investment budget for health. This project will also support the introduction of cost recovery activity in three regions, which will be organized and managed through local health communities, and which will raise revenues principally through the sale of drugs. Because of its pilot nature, this cost recovery system will be introduced gradually over the first three years of the project. All health centers and one-third of the health posts will implement the initiative in the project's first year; all regional hospitals and another third of the health posts will join the initiative during the second year of the project, and in the project's third year the balance of health posts will be brought into the experiment.

3.45 The Rwanda Food Security and Social Action Project was prepared and is being implemented in close coordination with the ongoing Structural Adjustment Program. During the course of the design and development of both of these operations, the government, with Bank assistance, prepared a social action program which aims to (a) establish a social safety net including core social sector programs and a national social action program targeted to the poor; (b) mobilize resources to ensure adequate funding of this core social expenditure program; and (c) monitor closely the financial and physical implementation of the social expenditure program. The programming process for social sector public expenditures has been integrated into the Structural Adjustment Program as part of the component aimed at improving public sector resource management. This process has two main elements: (a) a review of the public investment program to eliminate all investments inconsistent with sectoral policies and/or that are economically or financially inefficient; and (b) adequate budgetary allocations to cover the operational costs of essential development programs such as the social safety net. In order to avoid under-funding of social programs, the annual review of social sector public expenditure programs is a covenant of the Food Security and Social Action Operation.

3.46 Both the Poland Health Services Development project and the Romania Health Rehabilitation project will assist efforts on the part of those governments to diversify sources of health care financing and thus lessen total dependence on the public budget, which is under pressure from rising costs and demand for health care. The Poland project will finance feasibility studies on (a) the introduction of contributory health insurance; (b) cost recovery; (c) private sector health services; and (d) preparation of draft legislation on health financing. The decentralization pilot supported under the Romania project will allow field testing and experimentation with financial decentralization and autonomy, and new financing schemes. The Poland project will also support efforts to develop a more efficient and equitable basis for budget preparation, based on criteria such as demography, morbidity, socioeconomic factors, and existing resources.

3.47 The Equatorial Guinea Health Improvement project will support the implementation of key financial reforms in the hospital sector. These include financial and managerial autonomy for the country's two major hospitals; stricter enforcement of the fee collection policy by targeting exemptions more narrowly; elimination of transfer to the Public Treasury of funds collected by hospitals; and the strengthening of financial management and

control systems. The hospital fee policy will be reviewed one year into the project's implementation with a view to refining and expanding it to other facilities.

3.48 Municipalities participating in the India Family Welfare (Urban Slums) project must generate resources from direct beneficiaries of the facilities and programs being developed under the project, in order to support a portion of operating and maintenance costs of those activities. City Health Plans, to be developed by those municipalities, will thus set out financing plans, a regime of fees, and plans for insurance and subsidization. During the course of the design and development of the India AIDS project, the Bank and MOHFW initiated a collaborative study on health financing to identify gaps in financing of sectoral interventions and how they can be effectively met in light of the escalating costs of caring for AIDS patients. Under the India Safe Motherhood and Child Survival project, the government has committed itself to maintain levels of planned budgetary allocations for the national MCH program for fiscal years 91-95, as agreed with the Bank.

3.49 Currently available data, which are sparse and somewhat unreliable, indicate a drastic reduction in social sector public expenditure in Sao Tome and Principe over the past decade or so. As a part of the Health and Education project, the government will prepare a report, based on more reliable data, on social sector allocation and expenditures from 1987 to the present. For each of the subsequent fiscal years, the government will present to IDA and discuss the adequacy of future budgets. The government, having recently adopted an essential drugs policy, will also initiate with project assistance cost recovery from the sale of drugs, which should also assist in generating increased resources for health.

3.50 This chapter shows that the Bank's PHN sector operations have been responsive to the Bank's restated emphasis on poverty alleviation as a fundamental development objective. Chapter V reflects on this achievement, notes some areas of relative weakness in poverty-related work of the PHN sector, and suggests ways of further strengthening this aspect of PHN work, based on some of the better designs of this year's projects and on implementation experience and lessons learned, documented during the year.

CHAPTER IV: A BRIEF LOOK AT QUALITY

4.1 Quality in PHN projects can be analyzed from two perspectives: the quality of the projects, themselves, and the quality of PHN services delivered through those projects. This chapter will provide a brief assessment of the FY92 portfolio of projects from both of these perspectives.

A. Quality of PHN Projects

4.2 What are the characteristics of a high quality PHN project? Drawing from lessons of experience documented during the year (see Annex 3), a sound and appropriate Bank investment in the PHN sector should address both short-term needs (the provision of basic services and other emergency assistance to poor and vulnerable groups) and medium- /long-term needs (the development of national commitment and capacity to identify, address, and resolve sector issues and problems). Interventions should be cost effective, strategic, and flexible to accommodate learning during implementation and to incorporate lessons of experience. The impact of operations should be closely monitored and evaluated, calling for a good information base and carefully selected indicators of success. Project management arrangements should provide for efficient execution of activities while contributing to long-term capacity building objectives. This section selectively reviews the following features of FY92-approved PHN lending, which provide some indication of the quality of these operations: strategic nature of operations; flexibility/opportunities for learning and fine-tuning; project management arrangements; and monitoring and evaluation.

1. *Strategy: Addressing Both Short-and Long-term Needs*

4.3 This year's projects address both short-term and medium- /long-term needs (see Chapter III). The strategic nature of these projects go well beyond that one feature of their design, however. Most projects are conceived as one in a series of interventions aimed at sector reform. Sector work sets the stage for project assistance and each operation builds on the previous one and prepares for the next. A few illustrations of the strategic nature of FY92 operations are provided below.

4.4 The Chile project was designed as a preparation phase for a subsequent health sector reform project. As such, one of its intermediate objectives is to create a receptive environment for the implementation of some of the difficult policy and institutional reforms envisaged under a planned second operation. The Kenya project is also being used as an opportunity to prepare for future policy and managerial reform to be supported under a health sector adjustment operation planned for FY94. The recently completed sector report, *Poland: Health System Reform,* provided an important input into the formulation by that government of a strategic framework for fundamental systemic reform in the health sector. The introduction and testing of this reform program is now being supported by an FY92 operation in that country. The Romania project is designed to provide immediate assistance for critically neglected parts of the health sector (primary health care) while at the same time building the institutional base for meaningful reform. It will thus support the introduction of reform while ensuring maintenance and improvement of basic services. The India AIDS project is seen as the first critical step in dealing with HIV. Under this project, the government will prepare a strategic plan for the next phase of the program. The India Family Welfare project will support detailed preparation and project launch activities for another fifteen designated cities to be financed under a future project. It will also assist the government to refine further its Urban Revamping Scheme to

develop operational models for nation-wide replication.

2. *Flexibility/Opportunities for Learning and Fine-tuning*

4.5 As an extension of their strategic nature and long-term vision, FY92 projects for the most part demonstrate considerable flexibility to accommodate learning during implementation and consequent refinement of project activities and sector strategy. The Chile project will assist in the development, pilot testing and initiation of key reform measures through the undertaking of twelve policy/institutional reform studies and the pilot testing and start-up of recommendations for implementation. The project features built-in flexibility to adapt, as appropriate, recommendations of the reform studies: a $1.4 million fund under the project will finance their pilot testing. The Equatorial Guinea project will support the development and pilot-testing of efficient procedures for the procurement, distribution and management of essential drugs in public facilities. Under the Rwanda project, the component to develop micro-enterprise activity is experimental in nature. Operational research on this component will provide feedback and guidance to government and development agencies on ways off-farm employment can be developed in that country.

4.6 An essential drugs program pilot-tested under a first project in Sao Tome and Principe in FY90 introduced policy reform measures including: (a) preparation of a national essential drugs list; (b) preparation of guidelines for distribution and prescription; (c) improvements in drug procurement; and (d) introduction of cost recovery measures. The second (FY92-approved) project would help institutionalize and implement policy reforms initiated under the first project. The China project will research, develop and disseminate cost-effective methods and materials for further improving disease control strategies and programs and sustaining progress made. Operational research planned under the India AIDS project will assess and allow for adaptations in control interventions before replicating them in other areas. Under the India Family Welfare (Urban Slums) project, small-scale process and impact evaluation activities would be conducted to help adjust and shift the IEC program as needed. The findings of such research and feedback would be incorporated into program plans, which would be developed on an annual basis.

3. *Project Management*

4.7 Project management arrangements for all FY92-approved projects are intended to strengthen the capacity of concerned ministries and institutions to manage sector activity over the medium- to long-term. In fact the great majority of projects are designed so that the implementation responsibility rests with appropriate, responsible units within government, both at the center and the periphery. Projects which work with a number of line ministries (e.g., Rwanda, Niger, and India AIDS) have placed project management responsibilities in Plan ministries and established inter-ministerial technical coordination committees. The two sector funds (Guyana and Honduras) are managed by agencies specially set up to handle these emergency operations. These agencies are largely autonomous, although they do coordinate with line ministries and are viewed as temporary institutions, whose purpose is to complement line ministries during a period of adjustment. The project management unit under the Rwanda operation was also set up to have as much operational autonomy as possible, separating program and financial management from technical management.

4.8 How the responsibilities of these more autonomous agencies will be gradually phased out and permanently integrated into concerned line ministries is not yet clearly set out, though this is a stated intention of those projects. A pattern of project management arrangements is detected in

the FY92 portfolio that favors a more autonomous agency for multisectoral and/or emergency-type operations. Those multisectoral projects that rely on line ministries and other already existing agencies to implement them make for rather complex operations. The various arrangements for project management and implementation included in FY92 projects reveal somewhat of a tension between smooth and successful project implementation (assured by a more autonomous project management and implementation entity), on the one hand, and institutional development (which occurs when existing, but weak, units within government are responsible for project management and implementation), on the other. An increasing number of project management entities are largely independent from central administrations. This autonomy has many positive aspects with regard to project performance but its institutional implications in the long run should be assessed.

4. *Monitoring and Evaluation*

4.9 Considerable attention has been paid by the majority of FY92-approved operations to the development of a good information base and to monitoring and evaluation. And that attention has been, in some cases, thoughtful and thorough, focussing not only on tracking the project's success, but also on developing national capacity for improved information collection, analysis and management and for monitoring and evaluation of sector activity more broadly. All of the FY92 projects support improvements in the collection, analysis and management of sector information. And all FY92 operations provide for a mid-term review in order to take a thorough look at project progress and impact and to adjust and refine the operation accordingly. In addition, significant provision has been made in many projects to monitor progress and evaluate impact on an ongoing basis. Examples follow.

4.10 Under the Chile project a study will be undertaken to develop methods for monitoring each project component and for evaluating costs and benefits of the investment. The study will recommend appropriate methodologies for monitoring and evaluating for efficiency, equity and quality of care and for financial effectiveness. Technical assistance will be used under the Guyana project to carry out an external evaluation of SIMAP's impact and to improve the internal monitoring of the project cycle and evaluate the implementation of food supplementation activities. Indicators are process-oriented, but will be complemented by a series of studies to assess the quality and impact of various categories of subprojects. The mid-term review for the Honduras project will focus on targeting, quality, impact, administrative efficiency and financial soundness, prospects for the future of the Honduras Social Investment Fund, and how to strengthen line ministries based on lessons of experience from this project. The Rwanda project has compiled a list of project indicators to evaluate each component, which are process oriented. As a necessary complement to these indicators, the project's impact at the family and community level will be assessed through the LSMS component as well as other social studies.

4.11 Malaria targets established under the Sao Tome and Principe project are very explicit: decrease the parasite index by 50 percent from 410 cases/10,000 to 200; decrease malaria mortality in children under five by 80 percent from 65/10,000 to 13; and decrease malaria mortality in the general population by 85 percent from 20/10,000 to 3. These indicators will permit effective project monitoring and evaluation. The project will support the maintenance of efficient epidemiological surveillance and regular evaluation of the malaria control program. Key indicators to measure program performance, agreed with the government, will provide for simple, practical and timely information; they include both operational indicators and epidemiological indicators. The China project will support operational research on management, economic, social and epidemiological factors to

improve tuberculosis control in different settings in China. It will improve the disease surveillance system to adjust and target control activities appropriately and will improve monitoring and evaluation systems at all levels. In addition, this project will finance research into alternatives for improving surveillance and control of other key infectious diseases. Indicators will permit the tracking of project inputs, process steps, and epidemiological and output measures. Process indicators will clearly show whether and where project objectives are being achieved and will be sufficiently specific to highlight non-performing subregions, permitting quick intervention on the part of MOPH and IDA.

4.12 Indicators for the Romania project will provide for very extensive review of both process and output. An important objective of the India AIDS project is to monitor the development of the HIV/AIDS epidemic in the country. It will, in this regard, finance operational research and social/behavioral studies and epidemiological and intervention studies to fine-tune the program approach. It will also support the collection of baseline information for planning and programming, measuring changes in behavior and in process and outcome indicators, assessing mass awareness campaigns, and providing quality control. Process indicators have been established and agreed with the Government; impact indicators include World Health Organization (WHO) indicators for evaluating the AIDS strategy world-wide. Other impact indicators have been established to complement those of WHO and will be tracked through operational research supported under the project.

4.13 The India Safe Motherhood and Child Survival project is supporting the development of an enhanced management information system (MIS) designed to upgrade the monitoring and evaluation function. Key performance indicators have been discussed with the government and are process-oriented, focussing on quantity of services delivered and coverage level achieved. Impact being more difficult to evaluate, studies and operational research will be undertaken to determine whether objectives are being achieved. The India Family Welfare project has compiled a set of indicators of progress and targets that will facilitate close tracking of that project. It itemizes by city: the objectives and components; indicators of project progress (number and proportion of couples effectively protected due to family planning methods; mortality figures in different age groups); and project targets and process indicators.

B. Quality of PHN Services

4.14 Virtually all SARs for FY92 operations discuss the issue of low quality of services. Low quality is attributed to some combination of the following factors: state of disrepair of infrastructure and equipment; unreliable supply of essential drugs; poor performance of personnel, due to insufficient technical and outreach skills and low motivation; unresponsiveness of services to client demand; and inadequate financing of essential operating costs. Project efforts to address the issue of low service quality, consequently, aim to upgrade physical facilities and equipment; ensure an adequate and affordable supply of essential drugs; upgrade the skills and motivation of personnel; elicit and consider the demand of the client in service design and delivery; and ensure adequate recurrent financing through cost recovery, mobilization of more public funds for the social sectors, and/or reallocation of the public budget for social sectors in favor of basic services. All of these interventions are, without question, essential to improving the quality of services; and they are provided for in virtually all FY92-approved operations.

4.15 However, more can and should be done to improve the quality of services. While greater attention is being paid to demand, it is addressed in terms of the type and mix of services desired and not in terms of the compassion, care and

empathy with which those services are delivered. Two initiatives undertaken during FY92 address the issue of quality in much more depth than the typical PHN activity and are highlighted here for the consideration others.

1. *India AIDS Project*

4.16 The government of India has stated its unequivocal support for the policy of humane treatment of persons affected by HIV/AIDS, as articulated in Resolution WHA41.24 of the World Health Assembly. This decision is in recognition that programs for the prevention and control of AIDS should be planned and implemented in a manner that ensures the humane treatment of affected persons, which is an essential pre-requisite for an effective long-term policy for the prevention and control of AIDS. Accordingly, the India AIDS project would assist the government in creating a framework for the provision of health, psychological and social support to HIV-infected persons and AIDS patients. The aim would be to: foster the spirit of understanding and compassion for HIV-infected persons; protect the rights and dignity of HIV-infected persons; avoid discriminatory action against and stigmatization of HIV-infected persons; ensure the confidentiality of HIV test results and case reports; and promote the availability of social services including confidential counseling.

4.17 Counseling services would be available to the affected individuals and their families on their request and would not be imposed on them. The purpose of counseling support for persons with HIV and AIDS would be to : offer explanation and help get the individual to understand the significance of having HIV or AIDS, motivate the infected individual to minimize the risk of transmitting the infection through the use of condoms, and assist in meeting the psychosocial needs of the individual and his/her family, including guidance on lifestyle, adjustment and maintenance of good health for as long as possible. The government has established a Technical Advisory Subcommittee on Social, Ethical and Legal Issues, which will put in place and monitor the operation of effective procedures through which affected persons can express grievances and seek resolution of concerns.

4.18 This concept could be applied in other PHN programs as they impinge so intimately on the personal choices, values and lives of individuals, households and communities. Evaluating and addressing quality of services on technical grounds alone will not ensure that services will be valued by clients.

2. *Sector Report on Quality of Health Care in Côte d'Ivoire*

4.19 Both the approach to the subject matter as well as the subject matter, itself, are unique features of this piece of sector work. Rather than the Bank taking the lead in addressing this topic, some aspects of which are subjective and culturally charged, a national team was assembled to assess quality of services in Cote d'Ivoire. This team visited a large number of facilities throughout the country and observed and assessed the quality of care provided at every level of service. The findings of this study are thought-provoking and highly attuned to the cultural context, revealing important and pervasive deficiencies in the quality of health services in that country. The exercise so motivated this national team to address the issue of low quality of services that they compiled its findings and produced a well conceived, feasible (both technically and financially) and comprehensive plan of action in the space of a few months, on which they received strong national consensus. While it had initially been envisaged that a project would be developed to finance recommendations emanating from that sector work, in actual fact, the plan of action was developed and approved so rapidly and government commitment to address the issue was so high that funds from the ongoing Human Resources Development project were earmarked

to permit immediate implementation of recommendations.

4.20 With the exception of the two tasks highlighted here, PHN project and sector work have addressed quality largely from the technical perspective. Chapter V offers a number of suggestions on how to address, as well, the human dimension of quality issues.

CHAPTER V. PROSPECTUS

A. Future Work Portfolio

5.1 The future lending program looks quite strong. Both the number of projects and lending amount projected for FY93 are nearly double the levels achieved in FY92 and, even when discounting for the pipeline factor, are estimated to equal, if not exceed, record levels attained in FY91. Lending volume is expected to continue to grow and to remain above $2 billion over the next three years.

5.2 Sector work output is projected to increase to about forty reports in FY93. Over half of the sector work scheduled for the next two years will focus on countries in the Africa region.

B. Conclusions and Recommendations

1. Poverty

5.3 PHN operations approved during the fiscal year have been responsive to the Bank's poverty alleviation objective, in terms of both content and focus. Every operation approved during the fiscal year addressed poverty issues in a significant way: twenty percent of the portfolio comprised multisectoral operations, whose major objective is the alleviation of poverty. The primary objective of thirty-five percent of operations is the provision of basic social services to the poor, responding to an important component of the poverty strategy recommended by WDR 90. And the balance of operations (seven projects or forty-five percent of the portfolio), while not addressing poverty alleviation as the primary objective, include interventions from which the poor should derive significant benefits. All operations provide for both short- and long-term interventions, combining support for the basic PHN and other social needs of the poorest and most vulnerable of national populations with efforts to develop and strengthen national commitment and capacity to improve the economic and social well-being of the population.

5.4 Collectively, FY92 projects cover the essential features of good poverty work: poverty information and monitoring; understanding and responding to the needs of the poor; targeting assistance to those most in need; and reforms in policy, financing and organization. Although the coverage of these features is quite extensive, the depth and quality of each of these aspects of poverty work varies across projects. Drawing from the good practices observed and lessons recorded in this year's portfolio, the ASR offers the following suggestions for further strengthening of PHN interventions aimed at poverty alleviation:

- Poverty information and monitoring must be accompanied by dissemination and sensitization activities to strengthen national understanding of poverty-related issues, and commitment to resolving them, and deliberately linked to the policy process.

- Involvement of communities in project design and development will significantly improve prospects for success and sustainability but require clearly defined and carefully designed institutional and procedural mechanisms and a concerted effort to make them work.

- Targeting beneficiaries is essential to the fulfillment of poverty alleviation objectives but must be done with great care and flexibility. Even the most demand-driven project designs aimed explicitly at clearly and accurately identified poverty groups must be accompanied by promotional activities to ensure that these groups both participate in and benefit from project initiatives.

- The identification of poor and vulnerable groups and the assessment

of their needs and demands for basic health, family planning and nutrition services is an essential component of PHN sector work as it influences and informs policy dialogue and the design and targeting of Bank investments in PHN. Household-based social surveys (already found in several social sector projects) can contribute to analysis of demand.

- Reforms in policy, financing and organization must be decided at the national level, based on felt needs of a variety of actors, and should be pilot tested and further researched before implementing nationwide.

2. Quality of Projects

5.5 Overall, the PHN projects approved during the fiscal year cover the selected indicators of quality reviewed in Chapter IV. The great majority of these projects provide in some way for: flexibility and learning throughout implementation; project management arrangements that will serve to build capacities of existing structures and institutions; and monitoring and evaluation activities that will permit assessment of impact as well as process indicators. The ways in which these activities are carried out, however, vary from project to project and the following suggestions for improving work in this regard, drawn from particularly good project designs and documented lessons of experience, are offered here.

- Providing built-in flexibility in initial project design allows for the redirection of projects that are not going well. Operational research and pilot testing are extremely useful, both in facilitating information flow and in encouraging learning-by-doing, and provide an effective vehicle for introducing flexibility into projects.

- Involving implementing agencies and beneficiaries in project design will ensure that plans are feasible and understood by those who will manage the project and that services will be utilized by intended beneficiaries.

- Ensuring that project complexity, as indicated by the number of components, the extent of conditionalities and the number of donors and implementing agencies, does not exceed national or Bank capacity for project management should contribute to smooth and timely implementation.

- In order to monitor project performance effectively, both process and impact indicators should be established in sufficient detail and numbers and agreed with project implementors at the outset. While process indicators are amenable to routine monitoring, impact indicators may best be tracked through special studies or operational research.

3. Quality of PHN Services

5.6 Low quality of services is consistently raised and addressed in PHN operations across the board. However, for the most part, analysis and interventions focus on issues of technical quality and the need for strengthening outreach activities for promotional and preventive activities. Relatively little is done to assess or address the more subjective and culturally charged dimensions of quality. Again, lessons of experience and innovative features of the FY92 portfolio offer the following guidance in this regard:

- When assessing and addressing issues of low quality of services in project and sector work, PHN staff should consider not only issues of technical

quality, which are generally adequately covered, but the human factor as well. A more holistic approach to health care should be evident not only in the empathy and bedside manner of the technical staff, but should also be a fundamental objective of policies and programs.

- Cultural sensitivity enhances project success. Interventions should be designed with a view to the likelihood of beneficiary acceptance.

4. Overview

5.7 Health lending is now a decade old; and many innovations in PHN lending have emerged over the past four or five years. Notable among these are multisectoral operations aimed at poverty alleviation objectives, and sector funds, which accommodate a decentralized, demand-driven approach to the provision of social services and social safety net assistance. Furthermore, fully one half of PHN projects approved since 1980 (or over the past 13 years) were approved during the last *three* years (FY92 included). Thus PHN experience in the Bank is very short and project designs are still somewhat experimental. PHN staff are, therefore, challenged to exploit lessons of experience and to develop innovative approaches to still new and emerging sector issues. This ASR has shown that there are indeed good practices and new and promising ideas scattered across PHN work, which are well worth noting and emulating. The Chile Technical Assistance and Hospital Rehabilitation project devoted considerable time to analyzing lessons of experience, reviewing 34 Bank-financed health operations, as well as lessons learned by other development organizations and empirical studies inside and outside the Bank. This effort has resulted in a very well-designed project.

5.8 The focus of this review has been on poverty and quality issues. However, the recommendations emanating from the analysis, while directly addressing those issues in particular, should serve more broadly to improve the impact of Bank PHN interventions on the general health and well-being of a country's population. The evaluation of the impact and effectiveness of PHN sector activity, be it from the Bank or a country's perspective, is difficult and could benefit from a clearly defined and common framework for analysis. This need is being addressed through a number of ongoing efforts including the WDR 93 on health; AFTPN's draft paper "Better Health in Africa"; and LATHR's initiative to develop a set of mutually agreed PHN performance indicators. In the meantime, it can be said that the overall thrust of the Bank's PHN work is moving in the right direction and that the quality of this work is generally seen to be improving. Noteworthy and welcome trends include serious attention to the poorest and most vulnerable populations, and growing consideration of the demand and perspectives of those groups. These trends should be encouraged and reinforced.

ANNEX 1

Statistical Annex

Table 1: FY97 Projection: Health and Nutrition Portfolio
(US$ Million)

Country	Project	IBRD	IDA	PHN		Education		Water		Income Gen.		Infrastructure		Agriculture	
				$	%	$	%	$	%	$	%	$	%	$	%
AFRICA															
Equatorial Guinea	Health Improvement		5.5	5.5	100.0										
Kenya	Health Rehabilitation	31.0		31.0	100.0										
Mauritania	Health and Population		15.7	13.2	84.0					2.5	16.0				
Niger	Population		17.6	16.1	91.5					1.5	8.5				
Rwanda	Food Security and Social Action		19.1	1.0	5.2					1.7	8.9	9.7	50.8	6.7	35.1
Sao Tome & Principe	Health & Education		11.4	9.73	85.4	1.67	14.6								
EAST ASIA															
China	Infectious & Endemic Disease Control		129.6	129.6	100.0										
SOUTH ASIA															
India	National AIDS Control		84.0	84.0	100.0										
India	Child Survival and Safe Motherhood		214.5	214.5	100.0										
India	Family Welfare (Urban Slum)		79.0	79.0	100.0										
EUROPE & CENTRAL ASIA															
Poland	Health Services Development	130.0		130.0	100.0										
Romania	Health Rehabilitation	150.0		150.0	100.0										
LAC															
Chile	Technical Assistance & Hospital Rehabilitation	27.0		27.0	100.0										
Guyana	SIMAP/Health, Nutrition, Water and Sanitation		10.3	7.0	68.0			3.3	32.0						
Honduras	Second Social Investment Fund		10.2	1.84	18.0	1.40	13.7			1.1	10.8	5.86	57.5		
MENA															
Egypt	National Schistosomiasis Control		26.8	26.8	100.0										
TOTAL		338.0	623.7	926.27	96.3	3.07	0.3	3.3	0.4	6.8	0.7	15.56	1.6	6.7	0.7

Total Lending for PHN was 961.7

Table 2: Primary Health Care (PHC) Component of PHN Lending, FY92
(US$ million)

COUNTRY	PROJECT	Official Total PHN Lending $	1 Total "Pure" PHN $	Of Which: Non-PHC $	%	Description	2 Balance PHC Components $	%
AFRICA								
Equatorial Guinea	Health Improvement	5.5	5.5	0.0	0.0%		5.5	100.0%
Kenya	Health Rehabilitation	31.0	31.0	31.0	100.0%	5	0.0	0.0%
Mauritania	Health and Population	15.7	15.7	2.5	15.9%	3	13.2	84.1%
Niger	Population	17.6	17.6	2.9	16.5%	3&4	14.7	83.5%
Rwanda	Food Security & Social Action	19.1	18.9	17.9	94.7%	6	1.0	5.3%
Sao Tome & Principe	Health and Education	11.4	9.7	0.0	0.0%		9.7	100.0%
Total for Africa		100.3	98.4	54.3	55.2%		44.1	44.8%
EAST ASIA								
China	Infectious & Endemic Disease Control	129.6	129.6	0.0	0.0%		129.6	100.0%
Total for East Asia		129.6	129.6	0.0	0.0%		129.6	100.0%
SOUTH ASIA								
India	Nat. AIDS Control	84.0	84.0	30.3	36.1%	6	53.7	63.9%
India	Child Survival and Safe Motherhood	214.5	214.5	0.0	0.0%		214.5	100.0%
India	Family Welfare/Population VIII	79.0	79.0	1.6	2.0%	6	77.4	98.0%
Total for South Asia		377.5	377.5	31.9	8.4%		345.6	91.5%
EUROPE AND CENTRAL ASIA								
Poland	Health Services Development	130.0	130.0	86.2	66.3%	5	43.8	33.7%
Romania	Health Rehabilitation	150.0	150.0	7.5	5.0%	4	142.5	95.0%
Total for Europe and Central Asia		280.0	280.0	93.7	33.5%		186.3	66.5%
LATIN AMERICA AND THE CARIBBEAN								
Chile	Technical Assistance & Hospital Rehabilitation	27.0	27.0	27.0	100.0%	5	0.0	0.0%
Guyana	SIMAP/Health, Nut.,Water & Sanitation	10.3	7.1	0.0	0.0%	6	7.1	100.0%
Honduras	Social Investment Fund II	10.2	5.7	0.0	0.0%		5.7	100.0%
Total for Latin America and the Caribbean		47.5	39.8	27.0	67.8%		12.8	32.2%
MIDDLE EAST AND NORTH AFRICA								
Egypt	National Schistosimiasis Control	26.8	26.8	0.0	0.0%		26.8	100.0%
Total for Middle East and North Africa		26.8	26.8	0.0	0.0%		26.8	100.0%
	Total	961.7	952.1	206.9	21.7%		745.2	78.3%

Total PHC	745.2
Total Bank Lending for FY92	21707.4
PHC as % of Total Bank Lending	3.4%
PHN as % of Total Bank Lending	4.4%

1. Net of non-PHN components (e.g. in education, infrastructure, agriculture/rural development...)
2. Bank's support to the PHC component is broadly defined as any support to facilitate the implementation of national PHC policies. This would include institution and capacity building; support of nutrition activities; support of family planning service delivery and IEC; and strengthening of referral hospitals in support of PHC.
3. Non-health related WID.
4. Non-FP related Population.
5. Assistance to Hospital Sector not directly supportive of PHC strategy.
6. Other.

Table 3: Population, Health and Nutrition Lending Volume, FY 80-92
Amount and Share of Total PHN Sector Lending by Region

	FY80			FY81			FY82		
	$	%	No. of Projects	$	%	No. of Projects	$	%	No. of Projects
Africa	0.0	0.0	(0)	0.0	0.0	(0)	23.0	63.9	(1)
East Asia	65.0	45.5	(2)	0.0	0.0	(0)	0.0	0.0	(0)
South Asia	78.0	54.5	(2)	0.0	0.0	(0)	0.0	0.0	(0)
ECA	0.0	0.0	(0)	0.0	0.0	(0)	0.0	0.0	(0)
LAC	0.0	0.0	(0)	0.0	0.0	(0)	13.0	36.1	(1)
MENA	0.0	0.0	(0)	12.5	100.0	(1)	0.0	0.0	(0)
TOTAL	143.0	100.0	(4)	12.5	100.0	(1)	36.0	100.0	(2)

	FY83			FY84			FY85		
	$	%	No. of Projects	$	%	No. of Projects	$	%	No. of Projects
Africa	21.8	18.4	(2)	30.5	12.6	(3)	64.1	33.6	(3)
East Asia	27.0	22.8	(1)	85.0	35.0	(1)	85.0	44.5	(2)
South Asia	18.0	15.2	(1)	70.0	28.8	(1)	0.0	0.0	(0)
ECA	0.0	0.0	(0)	0.0	0.0	(0)	0.0	0.0	(0)
LAC	33.5	28.3	(1)	57.5	23.7	(1)	0.0	0.0	(0)
MENA	18.1	15.3	(2)	0.0	0.0	(0)	41.9	21.9	(2)
TOTAL	118.4	100.0	(7)	243.0	100.0	(6)	191.0	100.0	(7)

	FY86			FY87			FY88		
	$	%	No. of Projects	$	%	No. of Projects	$	%	No. of Projects
Africa	81.1	19.3	(5)	30.8	56.9	(4)	121.4	39.8	(5)
East Asia	113.4	27.0	(2)	0.0	0.0	(0)	0.0	0.0	(0)
South Asia	129.0	30.8	(2)	0.0	0.0	(0)	74.5	24.4	(2)
ECA	0.0	0.0	(0)	0.0	0.0	(0)	0.0	0.0	(0)
LAC	96.0	22.9	(2)	10.0	18.5	(1)	109.0	35.7	(1)
MENA	0.0	0.0	(0)	13.3	24.6	(1)	0.0	0.0	(0)
TOTAL	419.5	100.0	(11)	54.1	100.0	(6)	304.9	100.0	(8)

	FY89			FY90		
	$	%	No. of Projects	$	%	No. of Projects
Africa	71.3	12.1	(4)	232.7	25.2	(8)
East Asia	165.6	28.0	(3)	0.0	0.0	(0)
South Asia	124.6	21.2	(1)	192.5	20.8	(2)
ECA	75.0	12.7	(1)	0.0	0.0	(0)
LAC	150.0	25.4	(1)	379.2	41.1	(6)
MENA	4.5	0.8	(1)	119.0	12.9	(6)
TOTAL	591.0	100.0	(11)	923.4	100.0	(18)

	FY91			FY92		
	$	%	No. of Projects	$	%	No. of Projects
Africa	432.8	27.6	(12)	100.3	10.4	(6)
East Asia	164.0	10.5	(2)	129.6	13.5	(1)
South Asia	388.5	24.8	(4)	377.5	39.3	(3)
ECA	0.0	0.0	(0)	280.0	29.1	(2)
LAC	337.3	21.5	(5)	47.5	4.9	(3)
MENA	245.0	15.6	(5)	26.8	2.8	(1)
TOTAL	1567.6	100.0	(28)	961.7	100.0	(16)

Table 4: FY92-Approved PHN Projects: Funds Components
(US$ million)

Regional/ Country	Project	Fund	Amount	Total Project Cost	Percent of Project Costs	Regional Share of Total Fund Amount (%)
AFRICA						
Niger	Population	Population Fund	0.5	24.1	2.1	
Rwanda	Food Security & Social Action	Micro-enterprises	1.8	46.1	3.9	
		Subtotal	2.3			2.60
S. ASIA						
India	Family Welfare	Innovative Schemes	9.5	96.6	9.8	
		Subtotal	9.5			10.76
LATIN AMERICA AND CARIBBEAN						
Guyana	SIMAP/Health, Nutrition, Water & Sanitation	Primary Health Care and Nutrition	9.2	11.7	78.6	
Honduras	Second Social Investment Fund	Social Investment	67.3	67.5	99.7	
		Subtotal	76.5			86.64
		Grant Total	88.3	246.0	35.9	100.0

Table 5: IBRD/IDA Financing of PHN Projects, FY 1980-92
(US$ Million)

	FY80-FY84	FY85-FY89	FY87	FY88	FY89	FY90	FY91	FY92
IBRD for PHN	219.5	847.3	33.3	109.0	377.5	524.6	647.0	307.0
IDA for PHN	333.4	769.4	20.8	195.9	213.5	398.8	920.6	654.7
IBRD Share of All IBRD/IDA Lending (%)	75.0	79.0	80.0	77.0	77.0	73.0	72.0	70.0
IDA Share of All IBRD/IDA Lending (%)	25.0	21.0	20.0	23.0	23.0	27.0	28.0	30.0
IBRD Share of All PHN Lending (%)	40.0	52.0	62.0	36.0	64.0	57.0	41.0	32.0
IDA Share of All PHN Lending (%)	60.0	48.0	38.0	64.0	36.0	43.0	59.0	68.0
PHN Share of All IBRD (%)	0.4	1.2	0.2	0.7	2.3	3.5	3.9	2.0
PHN Share of All IDA (%)	2.0	4.0	0.6	4.4	4.3	7.2	14.6	10.0
Avg. IBRD PHN Loan	27.4	42.4	11.1	109.0	63.0	74.9	58.8	102.3
Avg. IBRD Loan All Sectors	71.0	78.0	112.0	125.0	94.0	125.0	130.0	135.0
Avg. IDA PHN Loan	27.8	30.8	7.0	28.0	35.6	33.2	54.2	50.4
Avg. IDA Loan All Sectors	33.0	27.0	32.0	45.0	30.0	45.0	61.0	59.0

Table 6: Population, Health & Nutrition Sector Reports Completed by Region, FY83-92

Region	FY83	FY84	FY85	FY86	FY87	FY88	FY89	FY90	FY91	FY92	TOTAL
Africa	6	8	8	6	4	7	9	15	12	8	83
E.Asia	1	2	1	1	2	0	4	5	4	4	24
S.Asia	3	2	2	0	0	1	5	3	0	1	17
ECA	0	0	0	0	1	0	0	0	3	4	8
LAC	3	3	2	4	3	6	6	4	8	7	46
MENA	0	5	1	2	0	2	5	5	6	1	28
Total	13	20	14	13	10	16	29	32	33	25	206

Table 7: Population, Health & Nutrition Sector Reports Completed in FY92

Region/ Country	Project	Report Date	Report Color
AFRICA			
Regional	AIDS Resource Allocation	12/10/91	
	Primary Health Care	06/29/91	
	Natural Resource	03/30/92	
	SAP & SSNA	06/29/92	
	Malnutrition	07/30/91	
	Macroeconomic	06/29/92	
	Pharmaceutical Financing	06/20/92	
	Tanzania Survey	06/30/92	
	Improving Service Quality	06/30/92	
	Improving Women Human	06/30/92	
	Cost Recovery	06/30/92	
Angola	PHN Survey	06/18/92	
Cameroon*	Population and Family Planning Review	06/91	Yellow
Comoros*	Health Financing & Development	01/23/92	
Cote d'Ivoire	Health Patient	06/26/92	
Ethiopia	Health Study		
Guinea-Bussau*	Social Sectors Strategy Review: Breaking Poverty's Stranglehold on Development	09/91	Yellow
Mauritania	WID	06/26/92	
Nigeria*	Health Care Cost and Financing Study	10/91	Grey
Senegal*	Women in Development	02/21/92	
Sudan	Health Sector		
Tanzania	Local Government Study	05/16/92	
Tanzania*	Women and Development	06/91	Green
Tanzania*	AIDS Assessment and Planning Study	10/04/91	Green
Uganda	Village Health		
Uganda	Human Resources	06/22/92	
Zimbabwe*	Nutrition Review	06/30/92	Yellow
EAST ASIA			
Regional	Asia Population Issues	02/14/92	
China	Environment	04/30/92	
Indonesia*	Health Insurance Issues in the 1990s	01/09/92	Green
Philippines*	New Directions in the Family Planning Program	10/91	Grey
Pakistan*	Health Sector Study: Key Concerns and Solutions	02/92	Yellow
Vietnam	Population & Health	01/23/92	
Vietnam*	Health, Population & Nutrition Sector Review	06/92	Green

Table 7 (cont'd): Population Health & Nutrition Sector Reports Completed in FY92

Region/ Country	Project	Report Date	Report Color
SOUTH ASIA			
India	Health Sector	06/30/92	
Pakistan*	Health Sector Study: Key Concerns and Solutions	02/92	Yellow
ECA			
Albania*	Health Sector Reform during the Transition	03/23/92	Green
Poland*	Health Sector Reform	01/09/92	
Poland*	Social Sectors Expenditure Review	01/92	Green
Romania*	Accelerating the Transition: Human Resource Strategies for the 1990s	10/92	Grey
LAC			
Regional*	Feeding Latin America's Children: An Analytical Survey	11/91	Grey
*	From Platitudes to Practice: Targeting Social Programs in Latin America	06/92	Yellow
*	Poverty Alleviation in Central America and Panama: Proposal for a Regional Unit for Technical Assistance in the Social Sectors	09/26/91	Yellow
Brazil*	Women's Reproductive Health	06/91	Grey
Brazil*	Private Sector and Social Services in Brazil, Who Delivers, Who Pays, Who Regulates	03/92	Green
Dominican* Republic	Prospects for Social Sectors Development During the Nineties	08/91	Yellow
Honduras	SIF Evaluation	06/10/92	
Honduras	Food Coupon Evaluation	05/19/92	
Nicaragua*	Social Sector: Issues and Recommendations	05/92	Yellow
MENA			
Yemen*	Human Development: Societal Needs & Human Capital Response	01/92	Green

*Source: Internal Documents Unit.

Table 8: Operations Evaluation Department Reports on PHN Sector, FY92

Region/ Country	Project	Date
	Project Completion Reports	
LAC Mexico 6/30/92	Water and Women in Development Project	
MENA Yemen 9/30/91	Health Development Project	
	Other	
Multi-country	The World Bank's Role in Human Resouce Development: A Statistical Overview with Special Reference to Sub-Saharan Africa	6/92

Table 9: Lending for Population[1] in the FY92 PHN Lending Program

	Project	Total Bank	Total Population	% Population	
		($000)	($000)		
AFRICA					
Equatorial Guinea	Health Implementation	5.5	0.2	4.0	IDA
Kenya	Health Rehabilitation	31.0	0	-	IDA
Mauritania	Population & Health	15.7	6.9	43.9	IDA
Niger	Population	17.6	11.6	66.0	IDA
Rwanda	Food Security	19.1	0	-	IDA
Sao Tome & Principe	Health & Education	11.4	~ ~	~ ~	IDA
TOTAL		100.3	18.7	18.6	
EAST ASIA					
China	Infectious Disease	129.6	0	-	IDA
TOTAL		129.6	0	-	
EAST ASIA					
Poland	Health	130.0	6.5	5.0	IBRD
Romania	Health Services	150.0	14.4	10.0	IBRD
TOTAL		280.0	20.9	7.5	
LAC					
Chile	T.A.& Hospitals	27.0	0	-	IBRD
Guyana	H/N/Water	10.3	0.2	1.9	IDA
Honduras	Social Investment II	10.2	0.1	1.0	IDA
TOTAL		47.5	0.3	0.6	
MENA					
Egypt	Schistosomiasis Control	26.8	0	-	IDA
TOTAL		26.8	0	-	
SOUTH ASIA					
India	AIDS	84.0	0	-	IDA
India	Health 1 (MCH)	214.5	0.1	~ ~	IDA
India	Population VIII	79.0	63.2	80.0	IDA
TOTAL		377.5	63.3	16.8	
GRANT TOTAL (16 Projects)		961.7	103.2	10.7	

~ ~ Very small population amount.

1. Please note a definitional change. Predominantly population projects are no longer counted as 100% population, as in the past, but reinforcing components are allocated to the relevant subsector. FY92 population lending would be $124.9 under the previous system.

Table 10: Lending for Population Projects and Components by Region, FY87 – FY92

FY	Region	Number of PHN Projects	Number with Population Component/a	Total PHN Lending ($ million)	Population Lending ($ million)	Population Lending as % of PHN
1987	Africa	4	4	30.8	7.9	25.6
	East Asia	–	–	–	–	–
	South Asia	–	–	–	–	–
	ECA	–	–	–	–	–
	LAC	1	1	10.0	6.8	68.0
	MENA	1	–	13.3	–	–
	Total	6	5	54.1	14.7	27.2
1988	Africa	5	3	121.4	29.9	24.6
	East Asia	–	–	–	–	–
	South Asia	2	2	74.5	62.3	83.6
	ECA	–	–	–	–	–
	LAC	–	–	–	–	–
	MENA	1	–	109.0	–	–
	Total	8	5	304.9	92.2	30.2
1989	Africa	4	2	71.3	0.4	0.6
	East Asia	3	–	165.6	–	–
	South Asia	1	1	124.6	124.6	100.0
	ECA	1	–	75.0	–	–
	LAC	1	–	150.0	–	–
	MENA	1	1	4.5	0.4	8.9
	Total	11	4	591.0	125.4	21.2
1990	Africa	8	3	232.7	45.7	19.6
	East Asia	–	–	–	–	–
	South Asia	2	1	192.5	96.7	50.2
	ECA	–	–	–	–	–
	LAC	6	2	379.3	15.0	4.0
	MENA	2	2	119.0	11.9	10.0
	Total	18	8	923.5	169.3	18.3
1991	Africa	12	9	432.8	135.3	31.3
	East Asia	2	1	164.0	104.0	63.4
	South Asia	4	2	388.5	75.0	19.3
	ECA	–	–	–	–	–
	LAC	5	5	337.3	10.7	3.2
	MENA	5	1	245.0	26.0	10.6
	Total	28	18	1567.6	351.0	22.4
1992	Africa	6	4	100.3	18.7	18.6
	East Asia	1	–	129.6	–	–
	South Asia	3	2	377.5	63.3	16.8
	ECA	2	2	280.0	20.9	7.5
	LAC	3	2	47.5	0.3	0.6
	MENA	1	–	26.8	–	–
	Total	16	10	961.7	103.2	10.7

(a) "Free–standing" population projects and PHN projects with population components.

Table 11: PHN Projects with Nutrition Components, FY92

Region/Country	Project Title	Total Project Cost	Total Project Nutrition[a]	Total Loan or Credit	Amount Loan/ Credit for Nutrition
		(US$ Million)			
AFRICA					
Mauritania	Health & Population	24.4	1.4	15.7	.7
Niger	Population	24.0	2.8	17.6	2.4
Rwanda	Food Security & Social Action	46.1	18.9	19.1	1.0
ST&P	Health & Education	12.0	<.1[b]	11.4	.1[b]
TOTAL			23.1		4.1
SAS					
India	Child Survival and Safe Motherhood	329.6	60.3	214.5	39.3
India	Family Welfare (Urban Slums)	96.5	2.6	78.5	2.3
TOTAL			62.9		41.6
ECA					
Poland	Health Services	227.0	11.4	130.0	6.5
TOTAL			11.4		6.5
LAC					
Chile	Technical Assistance & Rehabilitation	45.3	.3	27.0	.3
Guyana	SIMAP/Health, Nutrition Water & Sanitation	11.7	3.6	10.3	3.2
Honduras	Second Social Investment Fund	67.5	7.4	6.7	.7
TOTAL			11.3		4.2
FY92 Total for Nutrition			108.7		56.4

[a] Indicates total resources for nutrition components by all donors (e.g. IDA/IBRD, Government, other co-financiers).

[b] Includes nutrition study.

Table 12: Nutrition in FY92 Bank Projects[1]

Region/Country	Project Title	Total Project Cost	Total Nutrition[2] (US$ Million)	Nutrition Activities[3]
AFRICA				
Ghana	National Agricultural Extension Services	41.1	.5	NE,NT,LS
Mauritania	Health & Population	24.4	1.4	NID,NR,NT
Niger	Population	24.0	2.8	IG,LS,MN,NE,NT
Rwanda	Food Security and Social Action	46.1	18.9	DW,FD,GM,MN, NE,NID,NT
ST&P	Health & Education	12.0	<.1	NR
ST&P	Agricultural Privatization & Smallholder Development	17.2	2.2	FD
Zimbabwe	Emergency Drought Recovery & Mitigation	1044.0	21.0	FD
TOTAL			46.8	
SAS				
India	Child Survival and Safe Motherhood	329.6	60.3	MN,NE,NID NR,NT
India	Family Welfare (Urban Slums)	96.5	2.6	FE,NE
TOTAL			62.9	
ECA				
Poland	Health Services	227.0	11.4	NE
TOTAL			11.4	
LAC				
Chile	Technical Assistance & Hospital Rehabilitation	45.3	.3	NR
Chile	Primary Education	243.0	15.3	SF
Chile	Small Farmer Services	236.0	15.0	NE

Table 12 (cont'd): Nutrition in FY92 Bank Projects[1]

Region/Country	Project Title	Total Project Cost	Total Nutrition[2]	Nutrition Activities[3]
		(US$ Million)		
Guyana	SIMAP/Health, Nutrition, Water & Sanitation	11.7	3.6	FD,NE,NS
Honduras	Second Social Investment Fund	67.5	7.4	CG,FD,GM,NE,NS
TOTAL			41.6	
FY92 Total			162.7	

1. Includes nutrition projects and nutrition components in projects categorized as PHN, Education and Agriculture projects. Not included are nutrition components in Structural or Sectoral Adjustment projects or financing for Food-for-Work operations.

2. Indicates total resources for nutrition components by all donors (e.g. IDA/IBRD, Government, other co-financiers).

3. Nutrition Activities:
CG - Community Gardens
DW - Deworming
FD - Food Distribution
FE - Feeding Programs (on-site)
GM - Growth Monitoring
IG - Income Generation (e.g. market gardens)
LS - Development of Labor Saving Devices
MN - Micronutrient Programs
NE - Nutrition Education
NID - Nutrition Institutional Development
NR - Nutrition Research/Studies
NS - Nutrition Surveillance
NT - Nutrition Training
SF - School Feeding

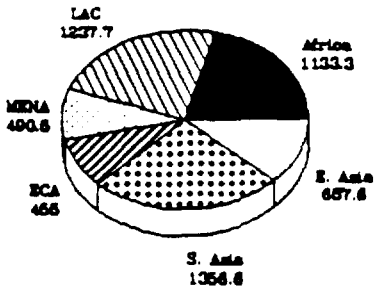
Table 13: Nutrition in Structural and Sector Adjustment Operations, FY92

Region/Country	Operations	Nutrition Actions
AFRICA		
Burkina Faso	Agricultural SECAL	Strengthen food security strategy; develop early warning system.
Malawi	Entrepreneurship Development and Drought Recovery Program	$50 million credit for importation of maize and strengthening of food distribution network.
Mozambique	Economic Recovery Credit	$10 million credit for drought relief including emergency imports of seeds, farming equipment and food.
Zambia	Privatization/Industrial Reform Credit	$100 million credit for importation of food grains to avert drought-related malnutrition.
Zimbabwe	SAP	$35 million credit for provision of targeted, subsidized commodity for low income groups affected by drought.
ECA		
Romania	SAL I	Expand eligibility for locally-administered social assistance (predominantly free meals) and vouchers for in-kind assistance (food coupons).
MENA		
Morocco	SAL II	Prepare study of effect of public transfer measures, including feeding programs, designed to protect poor from shocks of decreased income.
Tunisia	Economic and Financial Reforms Support Loan	Improve targeting of consumer food subsidies to more efficiently channel benefits to the poor.
LAC		
Panama	Economic Recovery Loan	*Develop, implement and evaluate pilot program to address nutrition needs of lactating mothers, and children through school-age in poorest regions; formulate national program following completion of pilot.
Peru	SAL	*Develop profiles for priority projects in nutrition. Prepare national nutrition policy based on review of existing food assistance programs.

*Condition of loan or tranche release.

Figure 1:
PHN Projects under Supervision
(US $ millions)

Lending in
US $ millions



Number of
Projects

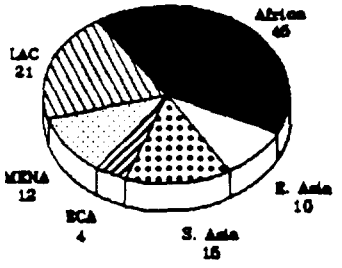
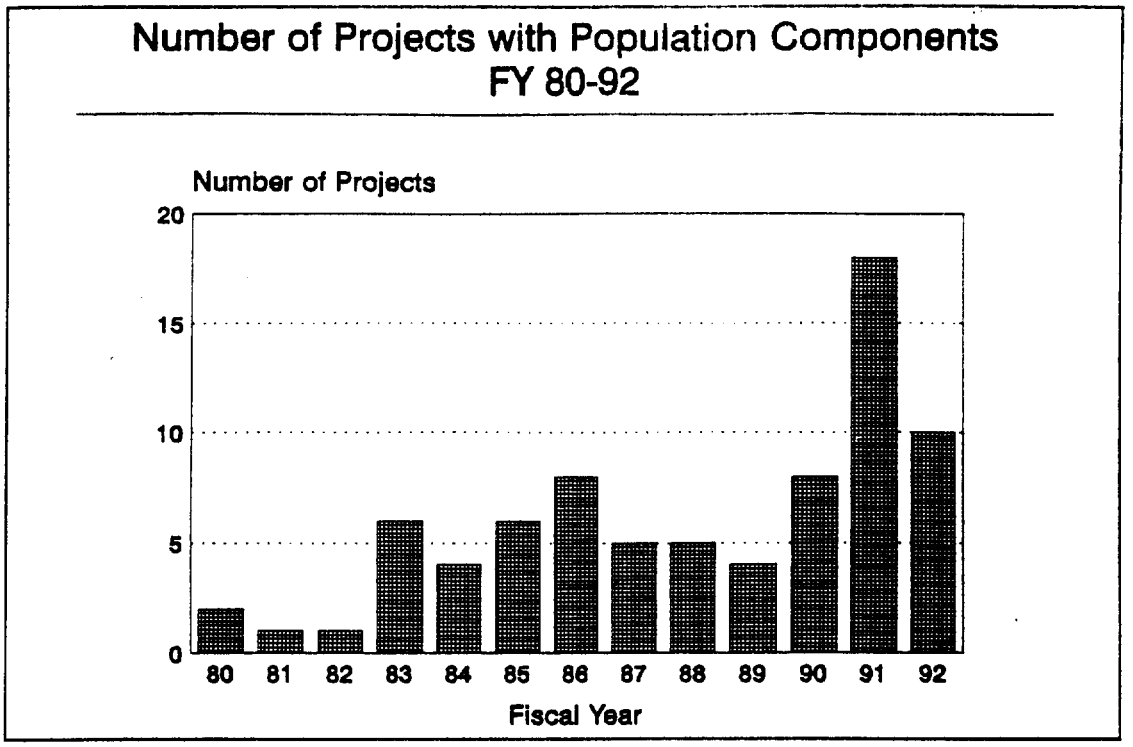


Figure 2


Number of Projects with Population Components
FY 80-92
Number of Projects
20
15
10
5
0
80
81
82
83
84
85
86
87
88
89
90
91
92
Fiscal Year

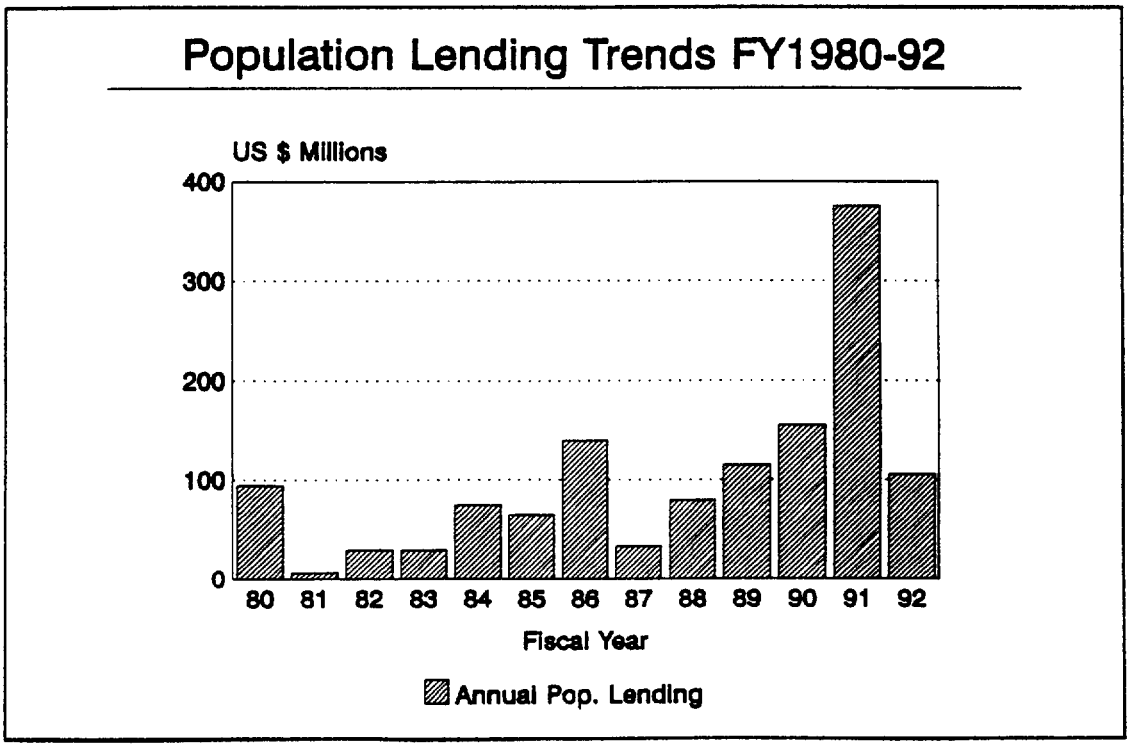
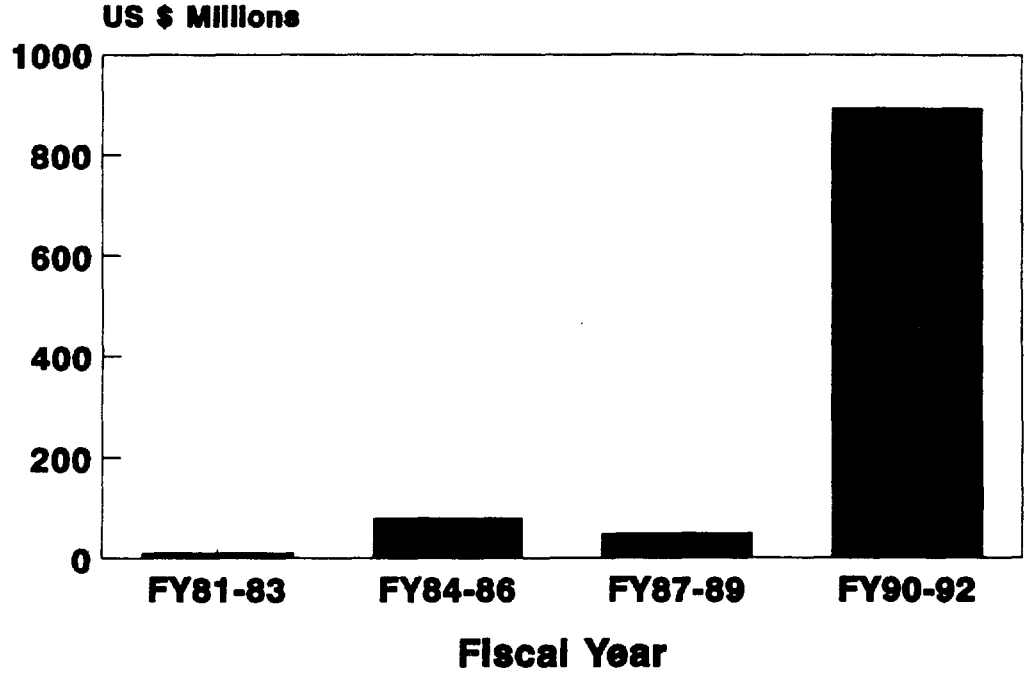

Population Lending Trends FY1980-92
US $ Millions
400
300
200
100
0
80
81
82
83
84
85
86
87
88
89
90
91
92
Fiscal Year
Annual Pop. Lending

Figure 3: Total Project Resources for Nutrition, FY81-92



*These data are based on an assessment of the total resources allocated to nutrition in nutrition projects and nutrition components of projects categorised as PHN, Education, Agriculture and WID projects. They do not, because of difficulties of quantification include Structural or Sectroral Adjustment projects. FY93-95 data are based on estimates of project budjets.

ANNEX 2

Loan and Credit Summaries of FY92-Approved PHN Operations

Loan and Credit Summaries of FY92-Approved PHN Operations[1]

Africa Region

Equatorial Guinea - Health Improvement Project

The objective of the project is to strengthen the capacity of the Ministry of Health to plan, coordinate and monitor Equatorial Guinea's health sector activities by establishing a coherent sector policy and strategy; gradually building up a credible MOH management system and team, strengthening MOH's organization and staff capabilities, and promoting regular consultations with the donors active in health and the beneficiaries of health care. The project would also help the Government improve the quality of its field services and increase its capacity for service delivery in the critical areas of primary health care, mother and child health and family planning, major diseases control and essential drug supply to ensure continuity of vital health services.

Specifically the project would:

(a) institute at the central level a core management team (a Managing Committee, MC) of MOH Senior Managers, strengthen MOH's organization and decentralize functions; and improve sector management through training, provision of material support and technical assistance;

(b) establish a management information system and a planning unit in MOH to carry out health investment screening, analysis and programming, and to support the implementation and subsequent annual revisions of the Government health strategy;

(c) develop human resources for carrying out health activities through technical and management training of staff at all levels of the health system; and

(d) strengthen priority health programs targeted on vulnerable groups, including malaria control, mother and child health and family planning, and sexually transmitted diseases through rehabilitation of facilities and provision of medical equipment and essential drugs.

Kenya - Health Rehabilitation Project

Support the government's reform of the health sector by (a) rehabilitation Kenyatta National Hospital (KNH) to reduce its burden on the overall budget and permit an increase in expenditure on preventive and primary health; (b) improving delivery of health services in the Nairobi area; and (c) preparing for future policy and managerial reform. Support the development of a National Household Welfare Monitoring and Evaluation system.

Four main components correspond to the four objectives: (a) the physical rehabilitation and institutional development of KNH; (b) a strategic plan for health services in the Nairobi area and its initial implementation; (c) strengthening the Division of Planning and Development in the

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[1] These summaries are taken directly from the Staff Appraisal Reports.

Ministry of Health and conducting analyses to lead to a future sector reform program and a public investment program for health; and (d) the design and implementation of a system of household surveys and the analysis of their results.

Mauritania - Health and Population Project

The objectives of the proposed project are to: (a) improve the quality and accessibility of basic health and family planning services following a strategy of decentralization of service delivery; (b) assist the Government to articulate a national population policy and define a corresponding program of actions; and (c) enhance women's ability to participate in and contribute to the country's social and economic development. A heavy emphasis is placed on policy reforms related to the proposed investments which are secured by specific project conditions. To achieve these objective the project would finance investments to: (a) develop the regional health service system through (i) development of training programs for regional personnel; (ii) development of a maintenance system for programs for regional personnel; (ii) development of maintenance system for vehicles, equipment and infrastructure; (iii) strengthening of financial management at the regional level; and (iv) assistance for health services in the regions of Brakna, Hodh el Gharbi, and Nouakchott; (b) strengthen capacity at the central level to support regional health services through (i) strengthening of technical capacity in three programs of special emphasis - family planning, health education, and nutrition; and (ii) improvement of management systems for personnel, finance and health information; (c) define a national population policy and its action plan and assist in its implementation; and (d) promote the status of women through (i) institutional support for the Executive Secretariat for the Promotion of Women, including the development of a national WID strategy and action plan; (ii) micro-projects for women's cooperatives; and (iii) functional literacy training for women's cooperatives.

Niger - Population Project

The project would assist the Government in implementing an effective national population program, with the primary objective of accelerating the onset of fertility decline by increasing the contraceptive prevalence rate was rapidly as possible, reducing maternal mortality, promoting attitudes favoring a reduction in family size norms, and enhancing the capacity of women to effectively participate in socioeconomic development. To this end, the project supports policies and investments designed to:

(a) Strengthen the delivery of maternal health and family planning (MCH/FP) services by: (i) supporting policy reform in the areas of essential drugs and cost recovery, and strengthening departmental and district capacities in sector management, planning, monitoring and evaluation; and (ii) increasing access to and improving the quality of MCH/FP services at all levels of service delivery (village, canton, district and department), and providing support for the participation of NGOs, including community groups and other private sector agencies, in MCH/FP service delivery and information, education and communication (IEC) activities;

(b) Promote family welfare and women's status by encouraging behavior favoring a reduction in family size norms, and by enhancing the capacity of women to effectively participate in socioeconomic development, through support for: (i) a nationwide IEC program; (ii) promoting the status of women; and (iii) nutrition interventions; and

(c) Reinforce the capacity for population policy analysis, research, monitoring and coordination by: (i) improving the capacity for sociodemographic data collection, analysis, research and evaluation; (ii) strengthening the institutional capacity for the promotion and coordination of the national population program; and (iii) establishing a Population Fund to encourage active private sector and NGO involvement in the population program.

Rwanda *- Food Security and Social Action Project*

The objectives of this project are: (a) to improve the food security and social welfare of the poorest population groups; (b) to improve the government's capability to monitor living standards of the population; and (c) to initiate a long-term poverty alleviation strategy. Target groups include: (a) individuals with insufficient income-earning capabilities, such as landless farmers, poor female-headed households, AIDS-afflicted families, orphans and others (annual target: 75,000 people); (b) farmers faced with acute food insecurity (annual target can vary from 0 to 300,000 people); and (c) farmers with land smaller than 0.2 hectare which will need off-farm employment to survive (annual target: 25,000 workers and 125,000 dependents). In addition, potential micro-entrepreneurs will be the target of a micro-enterprise development component.

Sao Tome & Principe *- Health and Education Project*

The project would assist the Government of STP to reverse the recent declines in the health and educational status of the population. In health, the project would support: a comprehensive program to control malaria; the provision of essential drugs; and the strengthening of health planning. In education, the project would support: the provision of school textbooks and educational materials; strengthening of schools inspection at the primary level; and the improvements in education planning. In both sectors, the main institutional reform goals would be to improve efficiency in service delivery and to improve the utilization of existing resources and mobilization of additional resources. These goals would be achieved through the improvements in planning, management information and external assistance coordination and through the program of cost recovery from the distribution of essential drugs and school textbooks. The project would also include a limited number of studies in very high priority areas, including nutrition, family planning and community involvement in social sector. These studies would be aimed at improving the understanding of the issues and constraints and recommending suitable interventions.

East Asia Region

China *- Infectious and Endemic Disease Control Project*

The project would support the Borrower's national tuberculosis control program in selected provinces and the main parts of the national schistosomiasis control program. A Support to the tuberculosis control program will consist of the following sub-components in 12 provinces during the period 1992-1998: 1. Tuberculosis Control through a) expansion, improvement and free provision of tuberculosis diagnostic services; b) free provision of anti-tuberculosis chemotherapy to reduce the sources of infection; (c) improvement of case management by adoption of a revised standard tuberculosis registry, reporting forms and supervisory protocol; and 2. Institutional Strengthening through d) strengthening infectious disease control capacity by establishing a national Tuberculosis Project Office and Tuberculosis Control Center; e) reorganizing and upgrading

provincial tuberculosis programs; f) implementing a Tuberculosis Policy Package of administrative, technical and financial reforms to improve the systems by which the tuberculosis dispensaries in participating provincial programs are financed and managed; and g) operational research on management, economic, social and epidemiological factors to improve tuberculosis control and preparation of future health programs.

B. Support to the national schistosomiasis control program (1992-1996) would consist of the following sub-components in eight provinces, constituting the main elements of the Borrower's Eighth Five-Year Plan for schistosomiasis control to be carried out in accordance with an agreed Schistosomiasis Policy Statement: 1. Schistosomiasis Control through a) case identification and treatment of infected individuals by mass- and selective-chemotherapy; b) identification and treatment of infected animals; and, c) snail control by molluscicide and environmental control; and, 2) Institutional Strengthening through d) strengthening schistosomiasis control program offices and institutes; e) improvement of the surveillance system; f) improvement of the monitoring and evaluation systems; and g) undertaking studies, through a Joint Research Management Committee, of management, economic, social and epidemiological factors to improve schistosomiasis control in different settings in China and preparation of future health programs.

C. The project would also support a program of research into alternatives for improving surveillance and control of other key infectious diseases, including (i) sexually transmitted diseases and human immune deficiency virus and (ii) epidemiological studies of all types of hepatitis and operational research on effective control of hepatitis B virus through immunization.

ECA Region

***Poland** - Health Services Development Project*

The project would support the Government's economic reform program by improving health, strengthening the health sector's contribution to the social safety net, and containing upward pressure from the health sector on the state budget. To achieve these goals, the project would: (a) improve health status by strengthening health promotion and prevention programs; (b) support the first steps in restructuring the health sector by shifting the focus from institutional care to effective primary care through better trained primary care doctors and nurses; (c) strengthen institutional capacity in policy making, planning, management and evaluation by providing managers access to improved information systems and management education; and (d) ensure sustainability of services and control costs in the health sector in the medium-term by improving effectiveness, efficiency and quality of service delivery in three project regions.

The project would comprise four components: (a) Health Promotion; (b) Primary Health Care; (c) Health Management; and (d) Regional Health Services. For each, it would provide for technical assistance, training, equipment and civil works (US$182.6 million equivalent base cost; and US$227.0 million total cost including contingencies). The project would be implemented over a period of seven years and completed by December 31, 1998. A special feature of the project design is the targeting of components (a), (b) and (c) in three project regions under component (d) to minimize impact. Health services in the three regions would be reorganized as "health consortia" of participating voivodships. Concurrently, the project would also contribute to

progressive strengthening of the entire health sector through aspects of components (a), (b), and (c) that would be implemented in a phased manner at the national level.

Romania *- Health Rehabilitation Project*

The project would have two principal objectives: (a) to rehabilitate and upgrade the primary health care delivery system which is collapsing through want of equipment, spare parts, drugs and medical supplies; and (b) to support the first steps of a major restructuring of health sector financing and management to ensure a sustainable, cost-effective health care system in the medium term.

Rehabilitation and upgrading primary health care would be achieved by: (a) upgrading rural dispensaries according to criteria of demographic coverage, local needs, community support and availability of medical staff; (b) improving reproductive health care services, focussing on maternal and child health and increasing access and choice in family planning services; (c) strengthening training for nurses and physicians in key aspects of primary health care; (d) introducing a health promotion program to provide a greater focus on preventive medicine; (e) ensuring the supply of essential drugs, consumable, vaccines and blood products (including preparing a restructuring plan for the Romanian pharmaceutical industry); and (f) upgrading the communication/transport system for emergencies.

Restructuring of health sector financing and management would be facilitated by: (a) preparing and implementing the first phase of a major reform of: health finance; the roles of the public and private sector; the legal framework; organization and management of health care; and institutional development. In addition, a pilot project to decentralize health care management and improve resource allocation would be supported; (b) developing a Health Information System to assist Ministry, district and local managers set objectives, allocate resources, anticipate needs and monitor performance; and (c) developing the Health Services Management Institute as an institution able to provide the health system with well trained health care managers and policy analysts.

The project's major policy actions would include: support for the restructuring of health care finance and management; supporting the restructuring of the Romanian pharmaceutical industry; shifting some of the patient load from the tertiary hospitals to the primary care structuring, thereby lowering unit costs of health care; shifting the emphasis of contraception from abortion to modern methods of family planning; reviewing emphasis on continuing education for medical staff; and increasing attention to preventive, rather than curative medicine to address the country's high morbidity and mortality rates.

LAC Region

Chile *- Technical Assistance & Hospital Rehabilitation Project*

The primary project objectives are: (a) to assist the Government in developing and launching critical policy, institutional, and operational reforms that will increase the efficiency and effectiveness of health care delivery; and (b) to initiate the improvement in the quality of hospital services in Metropolitan Santiago by upgrading selected physical facilities and medical technology,

which have seriously deteriorated after a decade of almost no investment. Specifically, the project would:

(i) Assist in the development, pilot-testing, and/or initiation of key reform measures in health service delivery reorientation, health financing, health, health labor incentives, strategic planning and management improvement, and procurement and quality assurance of pharmaceuticals and food supplements;

(ii) assist the Ministry of Health, under a sector development scheme, to respond systematically to urgent requests for reconstruction, rehabilitation, and upgrading of selected hospitals in Metropolitan Santiago that pose health and safety hazards to their patients, staff, and surrounding environs, and/or are providing inadequate health care partly because of severely deteriorating facilities and medical equipment;

(iii) facilitate the decentralization of decision-making and resource management by delegating to the HSAs and hospital managers/staff in the project area the needs analysis, as well as execution of hospital rehabilitation subprojects in their respective areas.

The project represents the first stage in the Bank's planned assistance to the health sector. In this regard, it would comprise the preparation stage for a possible sector operation (the proposed Health Sector Reform Project). This first operation would support the project objectives by financing the following components:

(a) Technical Assistance (14 percent of total project cost): This component consists of (i) about 12 policy/institutional reform and infrastructure investment studies, covering diagnostic and implementation design stages; and (ii) pilot-testing of key reforms (the Pilot Implementation Program), as well as the start-up phase of the information system, and training and information workshops. While the technical assistance component accounts for less than 20 percent of total project cost, it is the centerpiece of the proposed operation. The studies, pilot tests, and start-up operations address the core of the sector's major efficiency problems. The project features built-in flexibility to adapt, as appropriate, the recommendations of the reform studies.

(b) Hospital Rehabilitation Program (80 percent of total project cost): This component would finance urgent rehabilitation needs of 17 hospitals (Type 1 and 2) in six Health Service Areas (HSAs) in the poor urban and semi-rural areas of Metropolitan Santiago. Financing of the hospital rehabilitation subprojects would be allocated using a demand-driven mechanism, i.e., subprojects would be proposed by the hospital through their respective HSAs; these would be reviewed and approved by the Project Coordination Unit (PCU in conjunction with the Ministry of Planning, using selection criteria agreed with the Bank. The subprojects would be implemented by the HSAs; periodic monitoring and review of implementation progress would be exercised by the PCU.

(c) Project Administration (6 percent of total project cost): This component would support the operation of a PCU which would coordinate project implementation, provide assistance to the HSAs, and continue preparation of a possible follow-up operation.

Guyana - SIMAP/Health, Nutrition, and Water and Sanitation Project

The main objective of the proposed project will be to assist the GOG in cushioning the social costs of the adjustment process through the establishment of an effective mechanism aimed at addressing the basic needs of the population in a decentralized manner, such as through NGOs, community groups, and local government agencies. The project will aim to: (a) improve health and nutrition status over the short-term, in particular of pregnant and lactating women and children under five, through the financing of food supplementation programs, the rehabilitation and equipping of health care centers and day-care centers, and the rehabilitation of the water supply, sanitation and stormwater drainage structures; and (b) assist the GOG in the formulation of sustainable policies and programs in the social sectors over the medium-term. The proposed project will consist of four components: (a) institutional development; (b) sub-project implementation; (c) establishment of a living standards measurement survey (LSMS); and (d) development of a policy framework in the health sector.

The institutional development component (16 percent of total costs) will complement the efforts by the Inter-American Development Bank (IDB) to assist the GOG in the development of administrative, management and operational procedures for the Social Impact Amelioration Program (SIMAP) Agency. Financing will be provided for technical assistance, administrative costs, vehicles and office technology. A dated plan of action to phase-out SIMAP and gradually integrate its activities into existing government agencies has been developed and will be implemented. SIMAP will be vested with administrative, technical and financial autonomy and will be responsible for appraising, approving, financing and monitoring sub-projects. The sub-project implementation component (78.5 percent of total costs) will primarily address the basic health, nutrition and water and sanitation needs of the groups most affected by the country's economic decline, and in particular of pregnant and lactating women and children under five years of age. Eligibility criteria developed during project preparation define the nature and scope of sub-projects to be implemented in this component. Financing will be provided for: (a) rehabilitation and equipping of primary health care facilities; (b) nutrition surveillance and education, and food distribution programs targeted at children and pregnant and lactating women; (c) construction, rehabilitation and equipping of day-care centers; (d) installation and rehabilitation of basic water supply facilities and sanitation systems; and extension rehabilitation of small drainage systems; and (e) technical assistance to sponsoring agencies. Based on proposals received over the past twelve months, SIMAP has identified a portfolio of solid sub-projects to be financed during the first year of implementation of the proposed project. The LSMS component (2.5 percent of total costs) will entail the development of a household survey to assist the GOG in the evaluation of policies and programs, with a particular focus on the social sectors. The LSMS will be implemented in conjunction with an income and expenditure survey financed by the United Nations Development Program (UNDP) and will draw data from a third of its 7,000 household sample. Financing will be provided for technical assistance, operating expenditures, and equipment. The health sector policy development component (3 percent of total costs) will include the financing of national and international technical assistance to help the GOG define medium-term policies and strategies for the health and nutrition sectors and, on that basis, design a portfolio of programs and projects for external financing.

Honduras - Second Social Investment Fund Project

Building on the achievements of FHIS-I, the Project would help the Government sustain its poverty alleviation efforts and maintain social cohesion during the period of economic adjustment until line ministries strengthen their institutional capacities and complete policy reform programs. The credit would finance a range of small-scale subprojects (91% of the total project cost of US$67.5 million) sponsored by municipalities, community organizations, and NGOs, in four broad categories: (i) social infrastructure (54% of total subproject cost); (ii) economic infrastructure (13%); (iii) social services (22%); and (iv) credit to small informal sector services (22%); and (iv) credit to small informal sector entrepreneurs (11%). wherever feasible, the subprojects would be carried out by 7small private contractors using labor-intensive methods. The credit would also provide institutional support through technical assistance to the NLO, so that NGOs improve their ability to plan, prepare, and implement subprojects for poorer communities (0.3%). The credit would not finance the operating costs of the executing agencies (9% of total costs).

MENA Region

Egypt - National Schistosomiasis Control Project

The proposed project would support the development of a sustainable national program to control schistosomiasis, Egypt's most important parasitic disease. The proposed project has three specific objectives: (i) to extend the National Schistosomiasis Control Programme (NSCP) to five governorates in the Eastern and Western regions of the Nile Delta; (ii) to modernize and rehabilitate the existing program in Middle and Upper Egypt, and the Suez Canal area in order to increase its efficiency and effectiveness; and (iii) to support operational research and strengthen management of the Ministry of Health's Endemic Diseases Control Department (EDCD) in order to further increase operating efficiency and to control operating costs. The credit would finance three categories of expenditure: (i) laboratory equipment, vehicles, drugs, molluscicides, consulting services and training for the governorates being added to the national program; (ii) replacement of obsolete and depreciated laboratory equipment and vehicles; retraining of staff; and purchase of drugs and pesticides for governorates included earlier in the national program; and (iii) consultancy services, computers, vehicles and research funds to strengthen the central agency charged with planning and executing the program.

South Asia Region

India - National AIDS Control Project

The project would support the Government's efforts in controlling the HIV/AIDS epidemic in order to preserve human capital development and to minimize the reversal of health improvements. The project would constitute a start-up investment to launch expanded preventive activities in the control of HIV transmission. The ultimate objective of the project would be to slow the spread of HIV in India so as to reduce future morbidity, mortality and impact of AIDS.

The project would have a multi-pronged strategy and would comprise the following components: (a) promoting public awareness and community support with a primary focus on sexual

transmission, behavioral change and condom promotion through mass media communications nationally; private advertising agencies; NGOs to reach risk behavior groups in 12 States and Union Territories; and the existing health system countrywide; (b) improving blood safety from a current 30 percent to 90 percent of the blood supply, and enhancing the rational use of blood and the share of voluntary donations; (c) building surveillance and clinical management capacity to monitor the spread of the epidemic and to strengthen the skills of health staff and social workers in managing and counselling HIV/AIDS persons; (d) controlling sexually transmitted diseases by improving clinical services and case management in the country's STD centers and training private practitioners in metropolitan areas; and (e) strengthening the management capacity for HIV/AIDS control through the formation and support of organizational structures at the national and State level

India - Child Survival and Safe Motherhood Project

The project would support enhancement and expansion of GOI's Maternal and Child Health (MCH) Program for the 1991-1995 period. It would cover the incremental costs associated with the program. It would be national in scope, but with an emphasis on specific districts where maternal and infant mortality rates are higher than the national average. It would be co-financed by UNICEF and take into account its experience in assisting the GOI in implementing the Universal Immunization Program (UIP) during the Seventh Five-Year Plan (1985-90). Its specific objectives would be to enhance child survival, prevent maternal mortality and morbidity, and increase the effectiveness of service delivery. These objectives would be achieved through supporting: (a) Child Survival Programs including: sustaining UIP as well as strengthening diarrhoea control programs, the control of acute respiratory infections (ARI), prophylaxis against blindness and eye lesions due to Vitamin A deficiency, enhanced newborn care and the active promotion of breast feeding. These interventions will be called "UIP Plus;" (b) a Safe Motherhood Initiative which would improve maternity care and preventive programs for all women, giving enhanced emphasis to pregnant women with high-risk factors, strengthening essential obstetric care and capabilities to treat obstetric complications, while concurrently promoting birth spacing, timing, post pactum counselling, and prophylaxis and control of nutritional anemia; and (c) Institutional Systems Development which would include improving and expanding training programs for family welfare workers, expanding information, education and communications dissemination, and strengthening existing center and state/district management information, supervision, planning, procurement, logistics, and maintenance systems.

India - Family Welfare (Urban Slums) Project

The project would include the following components: Increasing the Supply of Family Welfare Services to slum populations through improvements in outreach services using volunteer female health workers recruited from the slum communities, and the upgrading of existing and construction of new health facilities; Improving the Quality of Family Welfare Services provided to slum populations, by upgrading the supervisory, managerial, technical and interpersonal skills of all levels of new and existing medical and para-medical workers through pre-service, institutional in-service, and on-the-job recurrent training; and increasing the availability of drugs, medicines and other appropriate health supplies; Increasing the Demand for Family Welfare Services through expanded information, education and communication activities, increased participation of the

community in the preparation and implementation of various project activities and increased participation of Private Voluntary Organizations (PVOs) and Private Medical Practitioners (PMPs) in the delivery of health and family welfare services to the slum communities; Improving the Management and Administration of the municipal Health Departments through appropriate upgrading of project supervision, management information systems (MIS), information, education, and communication (IEC) functions, as well as integrating and/or strengthening co-ordination of health services with the provision of environmental sanitation, water supply, education and other critical services; Innovative Schemes which cover a range of additional services including supplementary nutrition, creche programs, environmental sanitation drives, female (particularly adolescent girls) education and skill training; and Preparation of Future Projects which would support the detailed preparation and project launch activities in another fifteen designated cities.

ANNEX 3

A Summary and Assessment of Lessons Learned

The Consideration of Lessons Learned: A Summary and Assessment

This Annex summarizes and assesses the treatment of lessons learned in the Staff Appraisal Reports (SARs) of PHN projects approved in FY92, in the Yemen Health Project Completion Report (PCR), and in the Seventeenth Annual Report on Implementation and Supervision (ARIS) - Fiscal Year 1991. A brief overview is followed by examples of "good practice" SAR reports, a summary of PCR findings, and a compilation of lessons arising from the ARIS.

The PHN projects approved in FY92 have, in the aggregate, benefitted from close attention to lessons learned from past projects, including those of both Bank and other organizations. The SARs for the new projects fall into three categories: those that have clearly culled lessons from past experience and used them in the present design (6 of 16 projects); those that have taken time to review past lessons, but have been less successful in drawing clear ties between lessons learned and the new project -- at least as reflected in the SARs (5 projects); and those with no distinct reference to lessons learned (5 projects).

LESSONS LEARNED: AN OVERVIEW.

Similar themes echo through the lessons cited in the various documents. Two broad categories can be identified, design and implementation issues, and technical issues. Within these, smaller sub-categories emerge, dealing with specifics of procurement, community involvement, or social investment funds.

Design and Implementation Issues

♦ **Targeting of beneficiaries** is important to the fulfillment of project objectives. Targeting is equally important for general poverty alleviation goals, where poorer groups must be targeted, and specific interventions such as AIDs projects, where high risk groups are the target. Unique situations that might facilitate interventions must be incorporated into the project approach, such as targeting of specific occupational or migrant groups.

♦ **Government commitment is crucial, and can be achieved through better planning and coordination with the government.** All parties must agree on project objectives and implementation strategies. When local governments will be involved in implementation, they must also be part of project planning, and their support for the project ascertained.

♦ **Involving implementing agencies in project design** will ensure that plans are feasible, and understood by those who will manage the project.

♦ **Ensuring sustainability involves attention to recurrent cost provision.** Projects need to budget for recurrent costs, and ascertain government (national and local) willingness and ability to cover them in the future.

♦ **Community involvement in design and implementation** will increase the chances that project objectives are met. Once a project starts, community mobilization will enhance project impact.

♦ **Cultural sensitivity enhances project success.** Interventions should be designed with a view to the likelihood of beneficiary acceptance. For example, a women-to-women approach increases acceptance of MCH and family planning services in restrictive societies. In a similar vein, health facilities need to be open at hours that are convenient for clients.

♦ **Donor coordination is necessary** to avoid overburdening country governments' administrative capacity.

♦ **Information needs for solid projects** include (1) good demographic and sociological data about project beneficiaries (in order to design project to meet their needs); and (2) good baseline and follow-up data for planning impact assessment.

♦ **Decreasing the complexity of projects**, in the number of components, the extent of conditionalities, and the number of donors and implementing agencies increases project viability.

♦ **Providing built-in flexibility** allows for the redirection of projects that are not going well.

♦ **Operational research** provides one vehicle for introducing flexibility into projects, and for collecting necessary information.

♦ **Lessons on project supervision** were numerous, ranging from the need to increase resource allocation and Bank and local staff training for supervision (especially for Social Development Funds), to the delegation of some supervision tasks to local Resident Mission or Consultants, and the provision of more supervision in the start-up phase, a time when projects can be more easily redirected (see Box 1 for a distillation of lessons on supervision from the ARIS).

♦ **Simplified procurement procedures** lessen the likelihood of project delay and decrease administrative burdens. However, some procurements, such as construction and equipment purchases, require extra attention and supervision.

♦ **Technical assistance** is an important part of most projects, but to be effective TA must be timely and well supervised.

♦ **Social Investment Funds will be more successful if:**
- The funding agency is semi-autonomous, and free from political pressures.
- A standardized menu of sub-projects is adopted as a guide for grant proposal design and evaluation.
- Informal sector credit operations: (1) are turned over to specialized NGOs; (2) use market rates; (3) adopt cost sharing mechanisms; and (4) lend to "solidarity groups".
- Transparency and accountability are maintained.

♦ **Frequent in-service training** will increase clinical and administrative skills, especially if linkages are created between training and practice. This is especially true with training on MIS and evaluation systems. All training programs should be carefully examined to make sure that they are truly appropriate and well-designed.

♦ **Field workers' tasks must be clearly defined and manageable.**

Technical Issues

♦ **Lessons specific to MCH and Family Planning projects include:**
- Provision of emergency obstetrical care in case of complications is an essential component of basic maternity services.
- The provision of family planning services can be effectively delivered by non-family planning organizations.
- Increasing the opportunities for women to participate in the economy leverages the impact of population projects.

- **AIDS projects will benefit from the following lessons:**
  - Speed of project start-up, given the nature and the seriousness of the epidemic.
  - Many types of interventions should be followed and numerous groups targeted, but the project must prioritize among them and work to benefit from synergies between them.
  - Controlling STDs other than AIDS is important, as this can help diminish spread of AIDS itself.
  - The media is an effective tool for changing social norms, and complements direct contacts aimed at changing behavior.
  - AIDS is not solely a health problem. Therefore, a multi-sector approach is called for.

BEST PRACTICE: THE INCORPORATION OF LESSONS INTO SARS.

Among the projects approved in FY92, several stand out as exemplary in their treatment of lessons learned. Projects such as India Family Welfare (Urban Slums) Project, or the India Child Survival and Safe Motherhood Project benefit from a long history of similar projects. They incorporate this accumulated wisdom well, outlining explicitly how the lessons will be translated into the project design. The India AIDS Prevention and Control Project, on the other hand, is the first AIDS project in the country, and only the second Bank-supported AIDS project approved. Consequently, it does not benefit from the same depth of experience as the other two India projects, but it does incorporate the experience of other types of health interventions in the country, as well as the experience of the Bank's first AIDS project (Zaire, FY89), into its design.

The Honduras Social Investment Fund II is a follow-on project, which seems to have taken to heart the lessons learned in the first cycle. The SAR acknowledges both the successes and failures of the first project, and states, with page references to the project design section of the SAR, exactly how the new project will build on successful design features, and work to change weaker ones.

The Chile Technical Assistance and Hospital Rehabilitation Project is the first World Bank health project in that country, and one of only a few Bank operations to date to focus on the hospital sector. To ensure a well-designed and successful intervention, the Chile team reviewed the designs and/or evaluations of 34 other Bank health projects, a number of relevant projects of other development organizations, and empirical studies from both inside and outside the Bank. While many of these projects did not involve hospital rehabilitation directly, the relevant lessons about issues such as simplicity of design, importance of government commitment, recurrent costs, ease of implementation, speed of decision-making, and health facility construction were incorporated into the design.

AFTER THE FACT: LESSONS LEARNED FROM PROJECT COMPLETION REPORTS (PCRS)

Only two PCRs were published in the PHN sector during FY92. One evaluated the Yemen Health Development Project. The report summarized "findings and lessons learned," separating them into four categories: the simplicity of project design; the need for more, appropriate information; sensitivity to culture; and financial sustainability. These lessons have been incorporated into the summary above. The other PCR covered a project, the Mexico Water, Women and Development Project, which was canceled before becoming effective. In this case, the Bank was proposing to provide loan funds for a water and sanitation project, with a WID focus. Shortly after the loan was signed, the GOM implemented a poverty alleviation program providing grants, making a loan unattractive. After 16 months of discussions about changing the project, it was canceled. The GOM is, however, interested in discussing a different WID project with the Bank.

FOCUS ON SUPERVISION: THE ARIS.

As in years past, the FY91 Annual Review of Implementation and Supervision has drawn on the collective experience of the Bank to evaluate processes and progress. The summary of lessons learned presented above addresses most of the constraints to good project performance that appear in the ARIS. We have, however, reproduced below a summary of supervision issues taken from the ARIS. While the summary is based on an analysis of the implementation experience of all projects in all sectors, the issues and lessons included in this summary are all highly relevant to the PHN sector, and are well worth repeating here.

Box 1: Focus on Supervision: A Summary of the Issue as Addressed in the ARIS*.

Factors affecting the effectiveness of supervision reported in the FY91 ARIS include:

Staffing Issues and Supervision Management:

- Insufficient training of Bank staff on institutional and macroeconomic issues, procurement, auditing, and disbursement.
- Frequent turnover of Bank staff, discontinuity of staff between appraisal and supervision.
- Insufficient training of local staff to Bank procedures.
- Insufficient supervision in start-up phase.
- Inadequate skill mix availability, in particular, for human resources and environment projects.

Design Issues:

- Complexity of project designs, including multiplicity of donors, components, conditionalities, and implementation agencies.
- Lack of flexibility at implementation.

Communication Issues:

- Complexity of procedures and documentation, in particular with respect to procurement.
- Insufficient communication to borrowers of their responsibility for effective implementation.

Lessons:

- Increase supervision resource allocation selectively.
- Intensify Bank headquarter and resident mission staff training.
- Improve supervision planning and intensify supervision during the start-up phase.
- Revisit and simplify complex projects.
- Build flexibility into initial project design through mid-term reviews.
- Manage short-term risks, possibly be increasing cost sharing in times of unforeseeable fiscal constraints within the country limits and without the Bank's leverage in the latter years of project implementation.
- Standardize (and simplify) bidding documents.

To enhance the effectiveness of supervision, the following measures were taken in FY91:

- Staff training was intensified, in particular on procurement, auditing, and disbursements.
- Supervision plans are increasingly included systematically in all SARs.
- Most Regions issued guidelines to staff for mid-term reviews and for revisiting project designs.
- Cost-sharing arrangements were revisited on a case-by-case basis, and the Bank's share increased.
- Major efforts to simplify and standardize bidding documents were undertaken by the Regions with assistance from COD.

* As presented in the ARIS as **Box 6: Effectiveness of Supervision***.

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