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Population, Health, and Nutrition

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FY88 Annual Sector Review

Population and Human Resources Department

PHN lending increased in FY88, despite a shortfall of PHN staff resources. Lending for health predominated, but population lending accounted for 27 percent of the total. Bank leaders should continue emphasizing population concerns. The Bank should also consider more population specialists and more training of senior economists and managers on the subject.

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PHN lending rebounded in FY88 to $304.9 million for eight projects, a 50 percent increase in volume over the previous five-year average.

Lending for health predominated, while population lending (featured in five of the eight projects) accounted for 27 percent of the total. Interest in nutrition increased, but nutrition lending received little emphasis (except in connection with structural adjustment).

Important trends included increased attention to project "software," continued support for decentralization of health systems, more efforts to involve the private sector in delivering PHN services, more emphasis on health costs and financing, development of new ways to reach clients at the periphery, and more emphasis on focused projects.

Supervision coefficients for PHN projects declined from 16.5 staffweeks in FY87 to 13 in FY88. Only seven of 40 projects had major problems — principally with technical assistance, lack of counterpart funds, and inadequate managerial capacity.

The recommendations of the review are that the Bank should use more specialized technical personnel (usually local consultants) on missions, and more local consultants in sector work; place more Bank personnel in the field or increase field office responsibility for supervision; build monitoring into the projects and provide training for it; and set project supervision coefficients at appropriate levels (perhaps 15 staffweeks).

Sector work for FY88 was twice that for FY87, half of it for the Africa region. Sector work focused mainly on internal efficiency, costs and financing, and management capacity.

Population lending has accounted for about one-third of PHN lending for three years, but more should be done. Bank work in population is hampered by relatively weak demand for population projects, the shortage of Bank specialists on the subject, and the ready availability of grant funds from other donors.

The Bank should capitalize on its comparative advantage in affecting population policy and programs.

If lending to PHN sectors is to increase from its current low level of 2 to 3 percent of Bank lending to 5 percent or more, current staff resources are inadequate. There is a shortfall in PHN staff resources of about 20 staffyears (1.3 staffyears per PHR division), to meet the targeted level of 12 to 14 projects and $500 million a year in PHN lending.

This paper is a product of the Population. Health, and Nutrition Division, Population and Human Resources Department. Copies are available free from the World Bank, 1818 H Street NW, Washington DC 20433. Please contact Sonia Ainsworth, room S6-065, extension 31091 (56 pages with tables).

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1. PHN lending rebounded in FY88 to $304.9 million for eight projects, a 50% increase in volume over the previous five-year average. A relatively strong lending pipeline should result in the achievement in FY89 of at least the dollar target, enunciated by Mr. Conable, of $500 million in PHN lending by 1990. Within the sector, lending for health again predominated in FY88. Nutrition lending received little emphasis in the fiscal year but renewed interest in free-standing projects and in relation to structural adjustment operations augurs well for the future. Population lending accounted for 27% of the PHN total for FY88 and featured prominently in five of the eight projects.

2. Several important trends emerged or continued in FY88 lending:

(a) increased attention to the "software" aspects of projects,

(b) continued support for the decentralization of the health system,

(c) increased efforts to involve the private sector in PHN service delivery,

(d) more emphasis on health costs and financing,

(e) development of new approaches to reaching clients at the geographic and social periphery, and

(f) greater emphasis on focused projects.

The changing composition of PHN projects and their more focused nature, puts upward pressure on the resources required to design and prepare projects. In order to sustain these improved lending practices, the Bank should:

(a) encourage the development of projects that meet the new demands for careful, detailed design of the "software" components,

(b) in the review process, check the details of project design to see that these new demands are being met,

(c) ensure that local personnel who will be responsible for implementing the project participate in project preparation. This may entail workshops to sensitize and train local personnel about important issues in the sector as well as the increasingly common project launch workshops, and

(d) continue to provide training in the appropriate design of projects for Bank personnel who do not have experience in the sectors but are responsible for PHN projects.

3. Supervision coefficients for PHN projects declined from 16.5 staff weeks in FY87 to 13 staff weeks in FY88. Seven of the forty projects in the portfolio had major problems in the fiscal year. Difficulties with technical

assistance, lack of counterpart funds, and inadequate managerial capacity were the principal problems encountered. To improve project implementation and the quality of services, the Bank should:

(a) use more specialized, technical personnel -- usually local consultants -- on missions, with specific responsibility for particular technical components,

(b) place more Bank personnel in the field or increasing the responsibility of field offices for supervision,

(c) build monitoring into the projects and providing requisite training to local personnel, and

(d) set project supervision coefficients at an appropriate level for PHN projects -- perhaps 15 staff weeks -- based on the need for intensive oversight.

4. PHN sector work arrested a decline in output evident since FY85, doubling the FY87 number of reports at 16 completed. The Africa region accounted for half of the FY88 output. Sector work focused mainly on internal efficiency, costs and financing, and management capacity. Reports completed in FY88 required an average of 54 staff weeks, a 20% increase over the average for FY81-85. To safeguard the crucial role of sector work in both dialogue and lending, the Bank should make every effort to increase the role of local consultants in sector work.

5. Population lending has accounted for approximately one-third of total PHN lending over the past three fiscal years. This review concludes that much more can and should be done. The Bank's work in population is hampered by the relatively weak demand for population projects, the substantial availability of grant funds from other donors, and the dearth of specialized Bank staff. On the other hand, the overall mission of the Bank in supporting development and alleviating poverty, and in policy dialogue, place the institution in an advantageous position to affect population policy and programs. To capitalize more effectively on these opportunities, the following actions are recommended:

(a) at least one major statement a year on population by the President, and more vigorous leadership by other senior managers in country dialogues,

(b) strong signals from top management to staff about the priority of population concerns,

(c) appointment of a population advisor in each region, and recruitment of additional population specialists,

(d) additional staff training, especially for senior economists and managers, and

(e) continued efforts to encourage other donors to emphasize population concerns and the involvement of international and local non-government organizations.

6. The Bank is at a turning point in its PHN operations as it seeks to expand lending at a time of constrained resources. Analysis of the lending program and availability of staff resources suggests a shortfall of about 20 staff years (1.3 staff year per PHR division) to deliver the targeted level of 12-14 projects and $500 million per year in PHN lending, while maintaining or improving the quality of projects, sector work, and supervision. This shortfall could be met by: (a) decreasing the time allocated to each task, (b) having fewer but larger operations, or (c) additional staff.

7. Decreasing coefficients would compromise quality, given the complex demands of PHN sector work and projects. Having fewer but larger operations would require greater emphasis on sector lending and less emphasis on small countries in Africa and elsewhere. But focused projects often are more appropriate and appear to be better implemented than broader-based operations. Additional staff resources therefore represent the best approach to increasing both the quantity and quality of PHN lending and sector dialogue.

8. If lending in these sectors, which are so critical to human resource development, is to increase over time from its current low level of 2-3% of Bank lending to 5% or more, current staff resources clearly will not be adequate to the task.

I. INTRODUCTION

1. Lending in the PHN sectors for FY88 was $304.9 million for eight operations -- 1.9% of total Bank lending -- marking a 50% increase over the previous five-year average. Although partly due to project slippage from FY87, this is a considerable achievement. The current $500 million target[1] for the PHN sectors -- which would represent 2.5% of total Bank lending of $20 billion -- should be attained this fiscal year.

2. In light of increasing poverty in a number of countries, current knowledge about the effect on economic growth of high fertility rates and poor health and nutrition, and the efforts of the countries themselves and of other donors, 2.5% of Bank lending may not fully reflect the Bank's commitment to these critical sectors. If more lending for PHN is desirable, is it feasible? What changes, if any, would increased lending require? This review attempts to answer these important questions.

3. In any case, as lending in the sectors increases, additional efforts must be made to maintain and improve the quality of operations. Quality may be slipping in the effort to produce more projects with limited resources. We therefore discuss the time and resources required to develop and supervise effective PHN projects.

4. In Section II we discuss the major changes that have occurred during FY88 in PHN lending and sector and research work, key issues in the sector, how the Bank has responded, and what we see in the future. In Section III we provide a more detailed look at Bank operations in population and suggest how to strengthen this high-priority component of PHN lending. Section IV draws together the conclusions and recommendations stemming from the analysis.

II. TRENDS

A. Overview of Lending Program

5. Lending volume. The Board approved eight new PHN projects totaling $304.9 million in FY88 (table 1). This is 50% higher than the average volume of lending for FY83-87 -- $207 million (table 2) -- and

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[1] President Conable stated in a speech to the Safe Motherhood Conference in Nairobi, February 1987, that annual lending to the population, health and nutrition sectors would double by 1990, to about $500 million.

slightly above the average number of projects (7.4). The FY88 program reflects efforts to increase lending activities in Sub-Saharan Africa: five of the projects were in Africa, two in Asia and one in Latin America. Five operations were in countries borrowing for the first time in the PHN sectors (Burundi, Ethiopia, Guinea, Uganda and Sri Lanka). Two population projects (in Kenya and India) included substantial support for non-government efforts in family planning, reflecting an increased effort to involve the private sector in PHN projects.

Table 1: PHN LENDING FOR FY88
Commitment in US$ millions

Country	Project	Amount	
AFRICA			
Burundi	Population & Health	14.0	(IDA)
Ethiopia	Family Health	33.0	(IDA)
Guinea	Health Services Development	19.7	(IDA)
Kenya	Third Population	12.2	(IDA)
Uganda	First Health	42.5	(IDA)
ASIA			
India	Fifth Population	57.0	(IDA)
Sri Lanka	Health & Family Planning	17.5	(IDA)
LAC			
Brazil	NE Endemic Disease Control	109.0	(IBRD)
TOTAL		304.9	

Table 2: PHN LENDING PROGRAM, FY83-87
Commitment in US$ millions (Number of projects approved)

Region	FY83		FY84		FY85		FY86		FY87		Average 83-87	
AFRICA	22	(2)	31	(3)	65	(3)	82	(5)	31	(4)	46	(3.4)
ASIA	27	(1)	155	(2)	85	(2)	242	(4)	0	(0)	102	(1.8)
EMENA	37	(3)	0	(0)	43	(2)	0	(0)	13	(1)	19	(1.2)
LAC	34	(1)	58	(1)	0	(0)	96	(2)	10	(1)	40	(1.0)
TOTAL	120	(7)	244	(6)	193	(7)	420	(11)	54	(6)	207	(7.4)

6. Lending constraints. One project (Uganda) was advanced from FY89 to FY88 status, but four projects for which approval was expected in FY88 were delayed. The reasons cited for delay included:

(a) changes in Bank personnel at Reorganization (Indonesia),

(b) slow administrative processes in the client country (Nigeria),

(c) additional time needed to redesign the project to tackle a new health problem (AIDS) with the collaboration of many cofinanciers (Zaire), and

(d) persistent delays in preparation in some countries getting PHN loans for the first time (Benin).

7. Other commonly cited obstacles to timely delivery of the lending program include:

(a) personnel changes within client-country ministries of health (MOH). New ministers often have different priorities and approaches to sector needs, so much so that some projects (e.g., Tunisia Health II) are dropped from the lending program;

(b) suspension of all Bank disbursements to a particular country, (e.g., Zambia); and

(c) a shortage of Bank staff with technical skills in population, health or nutrition. In AF1PH, for example, one public health specialist is responsible for eight countries where the demand for Bank-supported activities in the PHN sectors is high.

8. FY89 program status. The PHN lending program for FY89 is shown in Table 3. Some of the projects that slipped from FY88 are well advanced in preparation and Board presentations are scheduled for CY1988 or early 1989 (Zaire, Nigeria-Imo Health). Other projects in the FY89 program have advanced quickly or according to schedule and are currently expected to be approved as planned: Brazil (Malaria), China, Mozambique, Turkey and the People's Democratic Republic of Yemen. This suggests that lending volume will increase again in FY89 and should result in achievement of the $500 million target, but the number of projects approved may be about the same as in FY88.

Table 3: FY89 PHN LENDING PROGRAM[a]
Commitment in US$ millions

Country	Project	Objectives	Amount	Status[b]
AFRICA				
Benin	Health & Population	o Improve management of health system o Strengthen key health programs o Rehabilitate and revitalise rural health facilities	5.0 (IDA)	Appraised 6/88
Mozambique	Health & Nutrition	o Improve primary health care services	27.0 (IDA)	Appraised 7/88
Nigeria	Imo Health	o Help Imo State improve PHC services and initiate a population awareness and family planning service program	27.6 (IBRD)	Board presentation scheduled 11/88
Zaire	AIDS	o Support for medium-term National AIDS Control Program	6.2 (IDA)	Board approved 9/88
ASIA				
China	Health III	o Develop and implement regional health development programs for three medium-sized cities (improve efficiency, affordability and quality through sectoral policy reforms in management, financing and planning) o Develop emergency care systems in urban centers	110.0 (IDA)	Appraisal 12/88
Indonesia	Health III	o Improve health in certain provinces o Assist in design and implementation of policies to support decentralisation and resource mobilization	38.0 (IBRD)	Appraised 10/88
EMENA				
Turkey	Health I	o Improve health conditions in underprivileged provinces o Strengthen national health program o Support institutional development	80.0 (IBRD)	Appraised 6/88
Yemen PDR	Health II	o Extend PHC services o Develop FP services o Strengthen sector management	4.3 (IDA)	Appraised 3/89
LAC				
Brazil	NE Basic Health II	o Improve health services in six states o Strengthen MOH's state secretariats of health through technical assistance	275.0 (IBRD)	Negotiations 1/89
Brazil	Amazon Basin Malaria	o Control malaria through: a) civil works for sanitation and source control b) vector control chemotherapy c) institution building	150.0 (IBRD)	Appraisal 10/88
	TOTALS		723.1	

[a] As of 7/13/88

b As of 10/17/88

9. Emphasis on health in the five-year lending program. Table 4 and Annex I show the proposed five-year lending program. Plans call for an increasing number of PHN operations -- especially in Africa and to some degree in other low-income countries in Asia -- while sustaining the current effort in both LAC and EMENA. Table 5 shows the five-year lending program by type of project. Lending for health predominates, reflecting greater demand than exists for the population and nutrition sub-sectors. Nevertheless, the labels in table 5 provide only a general idea of project content. For example, while "health" projects account for about one-third of the projects in the five-year lending program, most of them will include some attention to both population and nutrition.

Table 4: FIVE-YEAR PHN LENDING PROGRAM, FY89-93[a]
Commitment in US$ million (Number of Projects)

Region	FY89		FY90		FY91		FY92		FY93	
AFRICA	65.8	(4)	293.6	(9)	279.4	(10)	232.5	(10)	208.0	(6)
ASIA	148.0	(2)	275.0	(4)	395.0	(6)	375.0	(6)	170.0	(3)
EMENA	84.3	(2)	90.0	(3)	130.0	(3)	50.0	(1)	50.0	(1)
LAC	425.0	(2)	120.0	(2)	365.0	(3)	541.0	(4)	435.0	(6)
TOTAL	723.1	(10)	778.6	(18)	1,169.4	(22)	1,198.5	(21)	863.0	(16)

[a] As of 7/13/88

Fifteen projects are labeled PHN; all but one are in Africa. These represent the more typical, broad-based project that addresses numerous problems in one operation. Many of the countries are small (Ghana, Lesotho, Mali, Rwanda, Burkina Faso, Burundi and Cape Verde) so it is unrealistic to design projects for single sectors or problems. Sixteen of the 87 projects in the lending program are more focused operations (e.g., AIDS, malaria, chronic diseases, national essential drugs, health financing), or enter into new areas for PHN operations (e.g., social sector adjustment). The emphasis on health lending again is apparent in these 31 operations, which account for another third of the five-year lending program.

10. Population. Seventeen of the 87 projects are labeled population and health. These will give more attention to population than the standard health project. In addition there are seven free-standing population projects. The population lending program is discussed in more detail in Section III.

Table 5: PHN FIVE-YEAR LENDING PROGRAM BY SUBSECTOR[a]
(Number of projects)

Fiscal year	Region	Total	Health[b]	Population	Nutrition	Health & Population[c]	Health & Nutrition	PHN	Focused[d]
1989	AFRICA	4	0	0	0	2	1	0	1
	ASIA	2	2	0	0	0	0	0	0
	EMENA	2	2	0	0	0	0	0	0
	LAC	2	1	0	0	0	0	0	1
1990	AFRICA	9	0	0	0	2	1	2	4
	ASIA	4	1	1	1	0	0	0	1
	EMENA	3	2	0	0	0	0	1	0
	LAC	2	2	0	0	0	0	0	0
1991	AFRICA	10	3	1	0	2	0	3	1
	ASIA	6	2	1	0	2	1	0	0
	EMENA	3	2	1	0	0	0	0	0
	LAC	3	0	0	0	1	0	1	1
1992	AFRICA	10	0	0	0	4	0	6	0
	ASIA	6	2	2	0	1	0	0	1
	EMENA	1	0	0	0	1	0	0	0
	LAC	4	2	0	0	1	0	0	1
1993	AFRICA	6	0	1	0	0	0	2	3
	ASIA	3	1	0	0	1	0	0	1
	EMENA	1	1	0	0	0	0	0	0
	LAC	6	5	0	0	0	0	0	1
TOTAL		87	28	7	1	17	3	15	16

a Categorization is based mainly on the name of the project, supplemented by project information when available. Reserve status projects are not included.
b Many of these projects may include small family planning and/or nutrition components.
c Includes family health.
d AIDS, malaria, social development, human resources, health financing, national essential drugs, poverty alleviation, health system fund, social sector adjustment, integrated health/education, chronic disease

11. Nutrition. Projects that focus on nutrition have been under-emphasized in PHN. Some of the reasons for this follow:

(a) Before Reorganization, nutrition was not given high priority in the PHN Department. The Department turned down certain unsolicited requests for nutrition projects (e.g., Pakistan).

(b) Nutrition is not a sector in the conventional sense. It cuts across disciplines -- health, agriculture, education and economics -- and across organizational charts, thus requiring more than the usual analysis and preparatory time for projects.

(c) Nutrition often gets passed over in favor of easier, "shorter" routes to human development.

(d) For political reasons, governments may not want to acknowledge a problem of malnutrition or, more commonly, have not focused on the problem or the possibility of Bank support in dealing with it.

12. This situation may change according to signs of renewed interest in nutrition in FY88. The following developments have been noted:

(a) A heightened awareness both in the Bank and in borrowing countries of the effects on nutrition of the debt crisis and adjustment.

(b) A better understanding (e.g., from evidence cited in the Africa Food Security paper[2]) that even successful projects in agricultural production, as important as they are, are not enough to address the problem of malnutrition. Their effect on nutrition depends on who grows the food and who gets the increased income.

(c) Increased realization (by the development community at large and Bank PHR staff, particularly in Asia and Africa) that increasing the income of small farmers will not by itself eliminate malnutrition among the farmers' children -- that behavioral factors (including how the increased income is used) and the health environment must also change.

(d) More appreciation (by the Bank and the development community at large) of how much time it will take to improve nutrition through economic and agricultural growth strategies alone. There is general agreement that in the long run improved nutrition depends largely on the pattern of national growth. For most of the world's malnourished, it will take more than a generation -- even assuming maximum economic growth -- to reach adequate nutrition levels.

(e) A new perspective within the Bank on the cost and effectiveness of nutrition programs. Nutrition programs have often been considered too costly, a perception arising from the cost of food associated with universal or poorly targeted feeding programs. Several country departments now recognize that the Bank is in a particularly good position to help governments spend wisely the limited resources available for nutrition.

13. Currently there are one nutrition project (India) and three health and nutrition projects (India, Mozambique, Tanzania) in the lending program. Nutrition projects have also been requested by the governments of Colombia, Sri Lanka, Zambia, Senegal and the Philippines. Nutrition is important in several upcoming multisectoral loans, such as those to Jamaica, Bolivia, Mali, Tanzania, Haiti and Lesotho. Nutrition sector work just completed in Ghana and scheduled soon for Bangladesh (and, on a smaller scale, in Kenya and Burkina Faso) might also lead to operations. In addition nutrition aims

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2 Report of the Task Force on Food Security in Africa, June 30, 1988.

and activities loom large in the new Africa Food Security Initiative. Were all of these activities to materialize, the investment in PHN projects could substantially increase.

B. FY88 Lending

14. Prior reviews[3] of Bank-supported PHN projects have noted a strong emphasis on health (over population and nutrition) and on investment in health infrastructure. The first generation of projects approved after the Bank began lending directly for health in 1979 usually were implemented through the ministry of health (MOH). They usually emphasized maternal and child health care (MCH), including family planning and nutrition services implemented through the formal health system. Objectives mainly included:

(a) increasing health service coverage, efficiency and effectiveness,

(b) strengthening management through institution building,

(c) improving training, especially of paramedical personnel,

(d) strengthening physical infrastructure through renovation and new construction, and

(e) broadening sector knowledge through studies.

15. Projects that focus on one or a few problems, as opposed to a broad-based health project, are now receiving greater emphasis in Bank-supported PHN efforts. In FY88, two projects (Kenya Population III, Brazil Endemic Disease Control) are much more focused than the typical PHN project. The FY89 program includes one project that will support, exclusively, activities to prevent and control AIDS in Zaire and another to control malaria in the Amazon Basin in Brazil. Other focused projects are in the five-year pipeline (see table 5). Although the evidence is not yet definitive, more focused PHN projects appear to be implemented more effectively.

16. Other planned projects are attempting to broaden links to other ministries (planning, social welfare, women's affairs, agriculture) and to the private sector, e.g., Tanzania Health and Nutrition. Links to the private sector and to selected key ministries appear to facilitate project implementation.

17. The major features of PHN projects approved in FY88 are summarized in Annex 2. Of the eight projects, three (Ethiopia, Guinea, Uganda) are called health projects; two (India, Kenya), population projects; one (Burundi),

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[3] Anthony R. Measham, "Review of PHN Sector Work and Lending in Health," World Bank PHN Technical Note 87-21, March 1986; George B. Simmons and Rushikesh Maru, "The World Bank's Population Lending and Sector Review," World Bank PPR Working Papers, September 1988; Alan Berg, "Nutrition Review," World Bank PHN Technical Note 86-14, December 1987.

a population and health project; one (Sri Lanka), a health and family planning project; and one (Brazil), an endemic disease control project. Names of PHN projects clearly cannot fully describe project content. Six of the eight FY88 projects (all except Brazil and Uganda) include family planning activities (Annex 3) and four include nutrition activities (Annex 3).

PHN Project Features in FY88

18. The following important trends in PHN lending in FY88 are discussed below:

(a) increased attention to the "software" aspects of projects -- for example, information, education and communication (IEC) and training,

(b) continued support for decentralization of the health system,

(c) increased efforts to involve the private sector in PHN service delivery,

(d) more emphasis on health financing and cost recovery, and

(e) development of new ways to reach people at the geographic and social periphery.

19. More attention to "software." While past PHN projects have committed from 40% to 80% of project resources to civil works, the range in FY88 projects is 10% to 40%. (An exception is the Uganda First Health Project, which is similar to the earlier prototypical basic health project, emphasizing physical rehabilitation and new construction.) While six of the eight FY88 projects seek to extend basic health services by developing physical infrastructure, most of these projects focus more attention than earlier PHN projects did on improving the quality of, and generating demand for, PHN services (table 6).

20. Information, education and communication (IEC) activities have been included in almost all PHN projects over the years. The commitment to IEC, as measured by its share of loan/credit proceeds, is substantial in several FY88 projects (Sri Lanka-21%; Uganda-16%; Burundi-9%; and Ethiopia-7%). New techniques for developing effective communications programs -- qualitative research, pre-testing of messages and establishing channels for communication between clients and project managers -- are planned in some FY88 projects (Burundi, Ethiopia, India). Other new strategies include population-related IEC activities for primary schools and adult literacy programs (Kenya) and training programs in communications skills for health personnel (Guinea).

Table 6: DISTRIBUTION OF FY88 PHN PROJECT COSTS[a]
(Component costs as % of total base costs)

Component	AFRICA					ASIA		LAC
	Burundi Pop & Health	Ethiopia Family Health	Guinea Health	Kenya Pop III	Uganda Health I	India Pop V	Sri Lanka Health & FP	Brasil Disease Control
Institutional development								
- National	13	7	14	8	5		11	
- Regional/district			5	10		20	4	12
Health and FP service delivery	72	39	61	35	72	64	35	
Manpower development (training)		31	1			5	2	
Pharmaceuticals		14					20	
IEC development	9	7		3	16		21	
Multisectoral program development				7				
Private sector participation				37	2	11		
Disease control								78
AIDS								3
Research							6	1
Community mobilization/participation					2			5
Project preparation facility	6	2		5	3		2	
Project mgmt. and administration				12				

a Component breakdown reflects the categorization of cost tables in project SARs. In some cases, the service delivery components may include IEC or manpower development, etc.; that has not been singled out as in other projects.

21. Institution building through training has always been important in Bank PHN activities. All FY88 projects provide for management training (usually within the MOH) at the senior, middle-management and field levels. Technical training for health personnel is included in five of the eight projects. Two support some form of training for doctors, five the training of paramedical personnel and half the training of community health workers. Six of the projects include training programs for traditional birth attendants, communications personnel, pharmacists, storekeepers or others. More resources are being committed to manpower development than in earlier PHN projects (more than 30% of project costs in Ethiopia).

22. IEC and training components in Bank-supported PHN projects have not been formally evaluated but staff perceptions are that in most cases governments have not successfully implemented effective IEC and training activities through Bank-supported projects. The following are some of the reasons cited for this.

(a) Bank projects are large and complicated, and IEC and training components -- usually allocated few project resources -- tend to be neglected.

(b) Only two Bank PHN staff members are communications specialists. This makes it difficult for Bank staff designing PHN projects to keep up with the rapidly changing state of the art of PHN communications.

(c) IEC and training activities require close supervision and may demand substantial technical assistance, both of which are difficult to provide consistently.

23. Improvements in health care quality through training and IEC activities are slower and more difficult to realize than expansion of physical infrastructure. Many efforts are experimental and require close supervision and monitoring. Re-training personnel -- an inherently difficult task -- will be necessary as we learn what does and does not work. Collaboration among and within many governmental and private organizations will be essential to take full advantage of the latest innovations in IEC and training. Managerial demands will continue to increase as personnel-intensive activities become the focus for improvements in the PHN sectors.

24. Fostering decentralization. A primary PHN goal is to encourage the decentralization of planning, delivery and supervision of basic health care services. Increasing recognition of the district level's critical role in the delivery of effective primary health care has shifted somewhat the Bank's approach to improving the management of health care, whether or not countries have developing (Ethiopia, Guinea) or well-developed (Sri Lanka) health systems. The FY88 PHN program fosters a "district approach" by supporting the following:

(a) greater attention to the analysis of MOH organizational problems (e.g., defining staff roles and responsibilities and identifying specific ways to improve management structures),

(b) continued emphasis on costs and financing (e.g., establishing a data base on costs, examining the impact of current financing arrangements on the level and distribution of services, and proposing options for revising health financing systems).

Future PHN projects (e.g., in China, Indonesia and Brazil) will emphasize the decentralization of health services.

25. Although challenges remain, progress in decentralization efforts has been made. In Brazil, project management at the federal level is being restructured to facilitate decentralization, a high government priority. Financial management of basic health services has been decentralized in Lesotho, and the modalities for decentralization have been spelled out in The Gambia. The dearth of counterpart funds in Morocco precludes the implementation of many activities, but provincial level planning has been carried out in the spirit of the district approach to health care delivery. Areas deserving priority attention in the future include:

(a) identifying ways to assure that decentralized decision-making power is matched by a transfer of resources,

(b) developing planning and management training that allows regional and lower-level personnel to effectively carry out new responsibilities,

(c) designing appropriate systems for improving logistical regional support, and

(d) developing appropriate health information systems responsive to the needs of a decentralized system.

26. Involving the private sector in service delivery. An important goal of the FY88 PHN lending program, particularly for population projects, was to involve more fully in service delivery both non-government and private sector organizations and ministries other than health. In the Kenya operation, more than one-third of project costs are intended to support activities that will increase the demand for and the supply of family planning services through non-government organizations (NGOs). The India project calls for the increasing involvement of private voluntary organizations (PVOs) in the delivery of services, involving the private sector in training activities and exploring opportunities for family planning services delivered by private medical practitioners.

27. In FY88 the Bank, working with the International Planned Parenthood Foundation (IPPF), continued through the Special Grant Program to support efforts to stimulate NGO involvement in health and family planning projects in Africa. The goal of this program is to encourage cooperation between governments and NGOs and to include the latter in Bank-financed projects. The response to a series of national and international workshops has been positive.

28. Continued emphasis on costs and financing. As a result of slow economic growth and record budget deficits in many developing countries in the 1980s, health spending has leveled off or even declined on a per capita basis. Reduced health budgets have led governments to consider alternative ways of organizing and financing services, including various forms of cost recovery and a larger role for the non-government sector (see para. 26). Among external assistance agencies, the Bank has taken the lead in the area of costs and financing of health care -- in its policy and research division (see para. 54) and in sector and project work.

29. Cost recovery and alternative approaches to health financing are integral to FY88 projects. Three projects (Guinea, Uganda and Ethiopia) include a specific health services cost recovery component. Others (Burundi, India and Sri Lanka) support research activities designed to:

(a) identify more efficient and effective resource allocation schemes,

(b) examine the implications of insurance models for health care delivery, and

(c) assess borrower-country capability in the management and financing of health.

30. Our borrowers have expressed a very high level of interest in new approaches to health care financing. Health financing subsector work has

been completed or is ongoing in 16 countries (Annex 4). Numerous projects in the pipeline are intended to build upon the results of this work. This response to the Bank's initiative in health care costs and financing demonstrates the need to continue this work. Three sets of action are now required: careful monitoring of the impacts of these approaches on equity and efficiency, continued emphasis on costs and financing in sector work, and further policy and research work in PPR.

31. Reaching the periphery. The poor at the geographic and social periphery tend to have the highest rates of mortality and morbidity and to exhibit the greatest resistance to accepting family planning services. They are therefore the most important clients for PHN projects. At the same time they are the hardest group to reach because they are physically, culturally and socioeconomically distant from health service personnel and government servants. Providing effective services at the periphery requires knowledge of the demand for, and use of, existing services -- as well as the needs and attitudes of individual clients and health personnel. With few exceptions (Tamil Nadu Nutrition, Indonesia Nutrition, Peru I, Bangladesh III and Ethiopia) this knowledge has not been acquired during either project preparation or implementation. Following are some of the reasons for this:

(a) few Bank personnel possess the skills necessary to design a project that will address the issue of reaching the periphery,

(b) the project approval process tends to focus on broad issues and pays relatively little attention to the detailed specification of client/provider interaction, and

(c) the Bank stresses efficiency in the preparation process, which militates against the relatively labor-intensive tasks involved in reaching clients at the periphery.

32. The FY88 Ethiopia Family Health Project is an example of a Bank-supported project specifically designed to reach the periphery, through studies that provided detailed knowledge before project appraisal of beneficiaries and health care providers, and specification of tasks for field workers and supervisors. It appears that the information was valuable, was obtained in a quick and cost-effective way, and could not have been gained from traditional surveys.

33. The trade-off between detailed project design and low lending coefficients is borne out by the Ethiopian project. More than 240 staff weeks were required for project preparation -- 50% more than the average number of staff weeks (about 160) expended per project since the Bank began direct lending for health (Annex 5). Clearly, if the Bank is to maximize the probability of success in health, nutrition and family planning projects, there is a limit to how much lending coefficients can be reduced. While we are not suggesting that the Bank invest over 200 staff weeks in PHN project preparation, many staff are concerned that coefficients lower than 150 staff weeks may be incompatible with good project design. A possible alternative would be to enter into agreement with another agency or agencies, such as UNICEF, to carry out much of this detailed project design work. Another

option would be to increase the size of the average PHN operation, possibly by greater emphasis on sector lending. (The five-year lending program suggests that a trend in this direction already may be underway.) We return to these questions in paras. 117-121.

C. The PHN Sectors and Structural Adjustment

34. The PHN sectors are involved in the Bank's structural adjustment lending operations and its sectoral adjustment lending (SECAL) program in two ways:

(a) The structural adjustment process offers an opportunity for the Bank to encourage the institution of needed changes in the PHN sectors by creating opportunities for dialogue with client-country governments that could lead to specific policy changes.

(b) The Bank has a responsibility to protect vulnerable groups from the negative social effects of the structural adjustment process -- including the deterioration of their health and nutrition -- by monitoring and, where necessary, helping to develop and implement programs.

35. FY88 structural adjustment lending (SAL). Eleven structural adjustment loan/credits were approved in FY88 (table 7). The extent to which these programs incorporate specific policy changes for the PHN sectors and/or activities to cushion the impact of adjustment on vulnerable groups varies considerably from country to country (see Annex 6). Three of the eleven operations (Burundi, Guinea, Chile) include sizable health and nutrition interventions for groups affected by adjustment.

36. In two cases (Mozambique, Uganda), the emphasis is on general measures to stabilize the economy (e.g., fiscal management and analysis of sectoral strategies). In another country (Tunisia), structural adjustment concentrates specifically on trade and producer prices, taxation and the financial system. In all three of these countries specific interventions to alleviate the negative effects of adjustment on the poor are not included, but complementary activities through the PHN sectors are being discussed. Where consumer food subsidies are to be reduced (Tunisia, Mozambique), they are to be reduced least on consumer items that most affect the poor.

Table 7: STRUCTURAL ADJUSTMENT LENDING PROGRAM, FY88
Commitment in US$ million

Country	Type of loan/credit	Amount	
AFRICA			
Burundi	SAL II	90	(IDA)
Central African Rep.	SAL II	40	(IDA)
Congo	SAL I	70	(IBRD)
Gabon	SAL I	50	(IBRD)
Guinea	SAL II	65	(IDA)
Madagascar	SAL	125	(IDA)
Mozambique	Rehab. II	70	(IDA)
Togo	SAL III	45	(IDA)
Uganda	Econ. Recovery	65	(IDA)
EMENA			
Tunisia	SAL I	150	(IBRD)
LAC			
Chile	SAL III	250	(IBRD)
TOTAL		1,020	

37. Four of the SALs approved in FY88 (Congo, Gabon, Togo, the Central African Republic) include a component to monitor the social impact of adjustment. This monitoring process includes:

(a) developing and maintaining adequate data bases on the social impact of structural adjustment,

(b) carrying out economic and social studies on the implications of adjustment, and

(c) strengthening institutional capacity to identify, appraise and evaluate additional programs for alleviating poverty.

Preparation of a PHN sector loan is underway in Togo to complement the structural adjustment process.

38. Two SALs (Burundi, Guinea) include specific social action programs that will be implemented once sectoral strategies have been developed. In addition, they will support the immediate implementation of nutrition and primary health care programs for groups affected by the adjustment process. PHN projects were also approved for both of these countries in FY88.

39. One SAL (Chile) has a comprehensive health component that includes primary health care services as well as measures to make the decentralized health system more efficient, to strengthen the private health insurance system, repair equipment and rehabilitate major health facilities.

40. A comprehensive initiative addressing the social costs of adjustment was developed in FY88 under the FY87 Ghana structural adjustment project. The Program of Actions to Mitigate the Social Costs of Adjustment (PAMSCAD) includes:

(a) community initiative projects designed to help communities identify and implement projects that will build and rehabilitate their social and economic infrastructure, generate employment and address the needs of vulnerable groups,

(b) projects targeted to generate jobs for the underemployed and unemployed,

(c) projects to meet the basic needs of vulnerable groups through interventions involving water and sanitation, health, nutrition and shelter, and

(d) projects to improve vulnerable groups' access to education.

41. Nutrition links to agricultural sector adjustment. The shift from global to targeted consumer food subsidies in both agricultural sector adjustment loans (Mexico, Morocco) approved in FY88 clearly have implications for the nutrition sector. In Mexico, efforts will be made to compensate the poor for the effects of the elimination of global food subsidies by:

(a) revising criteria for eligibility for subsidies in the urban areas,

(b) expanding targeted subsidies to rural areas on a pilot basis,

(a) studying the possibility of expanding other food programs, and

(b) expanding nutrition monitoring.

In Morocco also, the goal is to implement a targeted program to compensate the poor for eliminating the present system of food subsidies. The program combines the controlled marketing of inferior goods (those purchased by the poor) and larger and stronger food distribution programs.

42. Conclusion. The Reorganization has facilitated somewhat the coordination of PHN and structural adjustment operations. SALs now more frequently address the effects of adjustment on vulnerable groups either as part of the adjustment operation or through a parallel PHN project.

D. PHN Project Supervision in FY88

43. Supervision reports reflect the experience and background of individual project officers and vary substantially in quality and the amount of detail provided about specific PHN issues. Routine supervision reports (Form 590) focus mainly on disbursement and major problems in implementation. Other reports (such as aides memoire and back-to-office reports) supplement this routine information, at times addressing specific technical and managerial issues. To explore key implementation issues, we consulted these sources of information, circulated a questionnaire to all PHN project officers and held follow-up interviews with 25 of them.

44. Forty PHN projects were supervised during fiscal 1988. Twelve of the 40 projects had no major problems, 17 had moderate problems, seven had severe problems, and in two countries Bank disbursements were suspended (Annex 7). Problems were mainly in the areas of technical assistance, counterpart funding and the managerial ability of local staff.

45. Technical assistance. More than a third of PHN projects supervised encountered problems with technical assistance (TA). Some client countries, for example, often are unwilling to use expatriates for technical assistance (China, Burkina Faso, Brazil, Senegal). Others (Zimbabwe, Sierra Leone) have had difficulties recruiting technical assistance for certain components, such as health education. And several countries (Indonesia, Tunisia, Brazil, Cote d'Ivoire, Colombia, Comoros, Mali) have had poor results because of their limited ability to manage technical assistance. Efforts undertaken during FY88 to make technical assistance more effective in PHN projects included:

(a) providing specific training for client-country personnel in setting objectives for TA and establishing terms of reference that will require TA providers to make specific recommendations (China),

(b) making large TA components more flexible to permit more client-country autonomy in hiring (Brazil, China), and

(c) using the services of private organizations and the resources of parallel PHN programs to guide the use of TA (YAR, Lesotho, Senegal).

46. Counterpart funds. A second major problem for PHN activities is the frequent lack of counterpart funds. Inadequate government support for PHN projects has resulted in the elimination or ineffective implementation of several project components. For example, training centers and health posts constructed in some Bank projects have not been adequately staffed or supplied because of insufficient government funds (Indonesia, Morocco). In other cases moratoria on hiring, a result of budget constraints, have meant that personnel trained under Bank-supported PHN projects could not be assimilated into the health system (Colombia, Tunisia). In some cases, extensive government dialogue during project preparation has helped to prevent problems during implementation. In Indonesia, where government

budgetary constraints are particularly severe, efforts are being made to decrease the counterpart contribution from 40% to 30%.

47. Managerial capacity of local personnel. Many problems arise because of inadequate administrative and managerial capacity in ministries responsible for PHN projects. These include:

(a) delays in processing bids, claims and reimbursements,

(b) slow hiring of personnel for project components,

(c) poor adherence to Bank procurement practices, and

(d) inadequate supervision of construction and/or technical assistance activities.

To resolve these problems, training programs for project personnel have been initiated both to improve general management and to develop skills in, for example, Bank procurement practices.

E. Effectiveness of Bank Supervision

48. The PHN supervision coefficient for FY88 was 13. This is higher than the coefficients for other sectors, but well below earlier years of PHN lending (see table 8). Many of the emerging trends in PHN projects -- for example, the new emphasis on "software" components such as IEC and training, institution building and alternative financing options -- will demand more staff time and thus exert upward pressure on supervision coefficients. One question that needs answering is, what is the minimum time needed to adequately review and monitor complex processes of behavior change in multiple sites? This is unlikely to translate into less than 15 staff weeks on average, in the judgment of experienced PHN project officers.

Table 8: AVERAGE SUPERVISION STAFF WEEKS FOR AGRICULTURE, EDUCATION, PHN AND URBAN PROJECTS, FY85-88

Sector	FY85	FY86	FY87	FY88
Agriculture	11.1	11.5	12.1	11.3
Education	8.3	9.1	8.9	7.6
PHN	14.8	21.6	16.5	13.0
Urban	11.4	10.1	10.5	10.7

Source: Operations MIS

F. PHN Sector and Research Work

Sector work

49. Sixteen sector reports were completed in FY88 (see Annex 8), compared with eight in FY87 (table 9) and an average of 13 for the preceding five years. Performance in FY88 put a healthy stop to the decline in sector work from FY85 on. The Africa region, a major contributor to PHN sector work, accounted for half of FY88 output. Most sector work addressed issues within a specific sector, such as population (Botswana, Niger, Algeria) or health (Chile), or such subsectoral issues as family planning (Burkina Faso), financing and efficiency within the health sector (Nigeria, Indonesia), and considerations of the equity and economic viability of social programs, including social security (Argentina, Brazil, Jamaica). With few exceptions the issues covered were similar:

(a) internal efficiency and the rationalization of services within a sector,

(b) resource mobilization, particularly the potential for selective increases in cost recovery through user fees, and

(c) developing the institutional capability and administrative efficiency to formulate and implement programs.

Table 9: PHN SECTOR REPORTS COMPLETED BY REGION, FY81-88

Region	Number of Reports								Type of Report		
	FY81	FY82	FY83	FY84	FY85	FY86	FY87	FY88	Broad	Focused	Total
AFRICA	1	5	6	8	8	6	4	7	35	10	45
ASIA	1	1	4	4	3	2	0	1	8	9	17
EMENA	0	0	0	5	1	1	1	2	7	3	10
LAC	0	0	3	3	2	4	3	6	14	6	20
TOTAL	2	6	13	20	14	13	8	16	64	28	92

50. In countries where governments have launched stabilization and structural reform measures (Bolivia, Mozambique), where the Bank or Fund is supporting a SAL (Zaire, Madagascar) or where the condition of the poor has been deteriorating and SALs are planned (Jamaica, Argentina, Brazil), sector work has reviewed government social programs, identified their limitations and recommended how to make them more responsive to human resource development and other social needs. Five studies (Madagascar, Mozambique, Zaire, Pakistan, Bolivia) were general PHN sector reviews, outlining the principal issues and constraints within the sector and providing recommendations as a

basis for initiating a dialogue with the government and for identifying and designing projects. A recurring theme of all the reports -- and one in keeping with Bank priorities -- was the need to develop sectoral strategies involving the private sector and NGOs with a view to mitigating resource constraints and reaching more of the population. These reports -- and the the companion volume on population of the Pakistan CEM -- have also assessed the impact of rapid population growth on other sectors, thereby keeping population concerns visible in development discussions.

51. Sector work completed in FY88 paid off substantially for both the Bank and its borrowers. It helped initiate policy dialogue with governments, realign lending priorities, educate PHN staff in areas relatively new to them, such as social security and associated programs, and improve project design. Sector work also helped to identify the substantive issues to be addressed in lending operations. About 80% of the sector work completed in FY88 led to the identification of a project or the definition of population, health or nutrition components in related projects (see Annex 9).

52. In FY88, an average of 54 staff weeks per report[4] were spent in sector work, a 20% increase over the 45 staff weeks calculated for reports processed to green cover or beyond for the period FY81-85.[5] At the same time, fewer than half (seven) of the reports were processed to green cover or beyond, and reservations were expressed by staff about the speed with which white covers could move to yellow or whether they could be processed any further at all, given staff constraints and the demands of project work. While some of this increase in staff input may be attributable to the Reorganization and attendant staff shifts, the scope of sector work is expanding to incorporate analyses of social programs, even in baseline reports, and sector analysis is moving toward new and, for the Bank, relatively uncharted areas such as social security, health maintenance organizations, and health insurance. Moreover, government and non-government programs -- their efficiency, financing, delivery and management -- are likely to acquire added dimensions as they are expanded to include AIDS, chronic diseases, aging populations and rapidly evolving medical technologies. Sector work addressing these issues is desirable but inherently staff-intensive. We take up the resource implications of sector work in paras. 117-121.

Policy and research work

53. In FY88, the major concern in the Bank's policy and research work continued to be the internal efficiency of the population and health sectors, with a specific focus on the design of cost-effective programs for

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[4] Based on reports for which information on staff weeks was available.

[5] There are obvious limitations to comparing some pieces of sector work with others. Focused sector work may require fewer and different resources than broad sector reviews; and the same applies to countries. However, the "Review of PHN Sector Work and Lending," PHN Technical Note 86-14, suggests that a reasonable target is 30-40 staff weeks per report.

reducing fertility and improving health, and the development of better policies and measures to support such programs (Annex 10). This focus provided the framework within which several emerging issues likely to be critical in shaping PHN programs were addressed:

(a) the role of the private sector and NGOs in family planning and health delivery,

(b) the need for high-quality health data to assist in health research in Africa and elsewhere -- focusing on such issues as the burden of disease, high birth rates, and malnutrition, and

(c) what to do about AIDS.

In response to the AIDS epidemic, the Bank became involved in collaborative analysis with WHO's Global Programme on AIDS (GPA) on several subjects: the direct and indirect costs and attendant economic implications of AIDS, the demographic impact of AIDS, and its implications for family planning and health programs. In addition, the Africa Region produced a strategy paper for dealing with AIDS in that region which was well received.

54. Health costs and financing are critical policy areas for the Bank and its borrowers although the key issues vary substantially by region and level of development. Studies are underway to examine the efficient use of hospital resources and to evaluate alternatives to high-technology hospital care. This work includes an AFTPN study, "Cost Recovery in the Health Care Sector: A Synopsis of Selected Country Studies in West Africa" and an ASTPN study, "The Financing of Social Services in Asia," both of which began in FY88.

55. The main piece of nutrition research completed in FY88, Malnutrition: What Can Be Done? Lessons from World Bank Experience, shows that nutrition projects are feasible and effective and have produced important findings, a few of which refute conventional wisdom about nutrition and development. The successful Tamil Nadu nutrition project, for example, showed that targeting the program to 6-36 month old children in this case, is far more cost-effective than programs covering children of all ages. This lesson is transferable to other types of programs. The comprehensive and high-quality longitudinal data emanating from the Tamil Nadu project provide the basis for continued analysis.

56. Recent years have seen a weakening of the commitment of developing countries and donor agencies to endemic disease control and in many cases a resurgence of disease. Little empirical research has been done on the organization and management of major disease control programs. With the support of the Edna McConnell Clark Foundation, PHRHN initiated work on an "Inter-Country Comparative Study of the Organization and Management of Schistosomiasis and Other Tropical Disease Control Programs." This research project will help in the development of new approaches to the control of tropical diseases. Research will be carried out in Brazil, Egypt, Indonesia, Morocco, Zimbabwe, the Philippines and the Sudan.

57. Concern about rapid population growth has steadily increased in developing countries, but the ability and resources to mount effective family planning programs are limited in various regions. Research was conducted in FY88 on experience in and out of the Bank with service delivery to poorly served groups at the periphery. This PHR Department research indicates that Bank-financed population (and health and nutrition) projects are often not designed to target clients at the periphery. The research paper, "Costs, Payments and Incentives in Family Planning Programs: A Review for Developing Countries," reviewed different country approaches to (1) charging for, or providing free, different contraceptive methods and services in the public and private sectors and (2) incentives to encourage contraceptive use. In connection with its policy-related work, PHRHN prepared its annual demographic projections by region, country department and major economic groupings. World population projections and related demographic statistics were updated and published.

III. THE BANK'S COMMITMENT TO AND CAPACITY FOR POPULATION ACTIVITIES

58. Population is a subsector of PHN in terms of lending, but population issues are critical to many areas of development and thus to the overall mission of the Bank. In this section we review the history of Bank involvement in the population field and consider the strengths and weaknesses of the Bank's recent population activities.

A. The Demographic Context

59. The world's population doubled between 1950 and 1988 and nearly 90% of this increase occurred in developing countries. Although the rate of population growth has slowed -- to 1.7% per year -- annual growth rates remain high in several developing regions: about 2% in south Asia, over 2% in Latin America and over 3% in Africa. At an annual growth rate of 3%, a population doubles every 23 years. The reason for this rapid rate of growth is declining mortality rates -- as yet unmatched by declines in fertility.

60. Reduced rates of population growth could contribute to development and individual health, but an estimated 300 million couples who wish to control their fertility do not have the means to do so. If couples had only the number of children they say they want, the fertility rate in Pakistan would be four children per woman instead of six; in Egypt it would be three instead of five. In many Sub-Saharan African countries, few women wish to stop childbearing, but many wish to delay the birth of their next child. In Ghana, for example, 37% of the women who want another child want to wait at least two years. This desire to space children in part reflects women's recognition that the health of mother and child are improved by birth intervals of at least two years. Data from 34 countries show that neonatal mortality is 70% higher if the mother has a child under two when her next child is born; the mortality rate is 90% higher in the post-neonatal period. Children born to women under 20 and into large families also experience higher mortality.

B. The Bank's Involvement in Population

61. The World Bank entered the population field in 1969 out of growing concern that rapid population growth was a serious impediment to economic and social development in many countries. The Bank has maintained this position although it recognizes the complexity of the relationship. Indeed the 1984 World Development Report -- focused on population and timed to coincide with the International Conference on Population in Mexico -- was a major contribution in the field.

62. At that Conference, Bank President A.W. Clausen gave fresh impetus to Bank population activities. He pledged a doubling of Bank population and related health lending, to $500 million by 1990. Bank President Barber Conable endorsed this commitment in his speech to the Safe Motherhood Conference in Nairobi in 1986: "By 1990 we expect to have projects in about 50 countries with approximately 12 to 14 new operations a year. Lending for population, health and nutrition could reach $500 million a year, about twice our level in 1984-5."

63. In FY86, the total amount of PHN lending was $420 million. In terms of volume, lending in the sector was therefore already close to the target. An estimated $129 million (31%) of this was committed to population, according to an external review[6] of the Bank's lending in population. The review noted that this compared favorably to other donor funding -- about the same as the UNFPA budget and about half the size of the USAID budget for population activities at that time.

64. As the largest economic development agency, the Bank has the status and opportunities to discuss development policies across the board, and has often used its position to draw attention to population issues. "Perhaps the single most effective element in the Bank's work on population is the policy dialogue that links population issues with other aspects of development," says one review.[7] This policy dialogue has firm foundations in the Bank's economic and sector work which also paves the way for project identification and development. Since 1979, the Bank's ability to lend directly for health projects has greatly increased its opportunities to lend for population. And the Bank can complement assistance to family planning programs with activities in fields known to increase the demand for such services -- for example, female education.

65. On the other hand, the Bank faces certain difficulties in doing population work. For one thing, the political sensitivity of population issues limits governments' willingness to borrow for population. For another, the Bank provides assistance through loans, not grants as other population donors do, and some governments are reluctant to borrow for the social sectors (see para. 73).

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6 Simmons and Maru, "Population Lending and Sector Review".

7 Ibid., p. 73.

66. PHN structure. Internal factors also affect what the Bank can do. In the 1970s, population activities were the responsibility of the Population Projects Department. In 1979, the Department was reorganized and became the Population, Health and Nutrition Department, to take advantage of the many organizational and substantive links between the three sectors. The change allowed family planning to be introduced within a health framework in countries unwilling to address population issues openly, and it allowed small population projects to become components of health projects with savings in administrative time. As part of the recent restructuring of the Bank, the PHN Department has been disbanded and responsibilty for PHN operations placed within Country and Technical Departments. It is perhaps too early to tell whether the changes will further, or constrain, population activities. In the short term, however, there does seem to have been some down-turn in population lending.

C. The Population Lending Program

67. Table 10 provides an overview of population lending in the past three fiscal years. FY87, the year of the Reorganization, is not representative. Overall, lending to population projects and health projects with population components declined from 33% to 27% between FY86 and FY88. Total PHN lending in FY88 was 73% of its FY86 level; population lending, 59%.

68. In FY88, five projects contributed to lending in population, including two that were largely devoted to population, though with maternal and child health (MCH) components (India V and Kenya III); two that allocated 30-40% of resources to population (Burundi and Sri Lanka); and one largely health project (Ethiopia) that was designed to lead to a free-standing population project. Almost all health projects make some provision for family planning -- generally only a small part of the loan, but to that extent these estimates understate lending for population. And in many countries, these small beginnings are expected to be a springboard for greater population lending in the future.

69. Lending pipeline. No large population project is scheduled for FY89 and only two of the ten projects combine health and population operations (Benin, $5 million, and Nigeria-Imo Health, $38 million -- see table 3). Family planning will be incorporated with MCH in Brazil-NE Basic Health, Turkey and Yemen PDR. Total involvement will probably not exceed $30 million, although there is a FY90 standby project (India Population VI) of $75 million. In addition to one free-standing population project in FY90, there are two population/health loans (Lesotho, $8 million, and Togo, $10 million -- see Annex 1, page 1). Jordan, Morocco, Ghana, Ecuador, Madagascar and Djibouti may contain population components. For the most part, however, population lending in the next two years goes mainly to India VI. In FY91, there may be population operations in Nigeria, Indonesia, Algeria and perhaps another in India (see Annex 1, page 2).

Table 10: LENDING FOR POPULATION BY REGION[a]: FY86-88
Commitment in US$ million

Fiscal year	Region	No. of projects	No. with population component[b]	Total PHN lending	Total lending to population	Lending to population as % of total PHN lending
1986	AFRICA	5	5	81.1	9.7	12.0
	ASIA	4	2	242.4	129.0	53.0
	EMENA	0	-	-	-	-
	LAC	2	1	96.0	0.3	0
	Subtotal	11	8	419.5	139.0	33.0
1987	AFRICA	4	4	30.8	7.9	26.0
	ASIA	0	-	-	-	-
	EMENA	1	0	13.3	-	-
	LAC	1	1	10.0	6.8	68.0
	Subtotal	6	5	54.1	14.7	27.0
1988	AFRICA	5	3	121.4	19.9	16.0
	ASIA	2	2	74.5	62.3	84.0
	EMENA	0	-	-	-	-
	LAC	1	0	109.0	-	-
	Subtotal	8	5	304.9	82.2	27.0
	Total	25	18	713.5	235.9	33.0

Source: Annex 11

a Post-Reorganization country groupings
b "Free-standing" population projects and projects with population components.

Regional experience

70. Although the largest population loans are made to long-standing population/family planning programs in Asia, lending to Africa has been increasingly emphasized recently. In the last three years, 12 of the 18 population and population/health loans have been to African countries.

71. Africa. Population activities in Africa further the Bank's efforts to assist governments to improve economic development, health and individual well-being. The region's average annual rate of population growth of 3% is not expected to decline until around the year 2000, 20 to 30

years later than in other major world regions. The effects of high, relatively uncontrolled fertility on the health of mothers and children are increasingly well documented. The total fertility rate is over 6 for the region as a whole. A decline to 4 would not only slow the pace of population growth, but reduce maternal mortality by about one-third. The effect of reductions in family size on the health of children is not so easily quantified, but spacing children at least two years apart would reduce infant mortality in Africa by an estimated 5% to 20%.[8] In a region where one child in five does not live to see his or her fifth birthday, this would save many lives.

72. In this context, the lending pipeline for Africa is disappointing. A January 1988 memo from Mr. Jaycox to Mr. Conable on Bank population activities in Sub-Saharan Africa, mentioned seven PHN projects in FY89, four of which were to have population components. Only one of these projects (Benin) is still in the lending program. One (Tanzania) has now slipped to FY90, one (Zambia) has changed to reserve status, and one (Mali) has been dropped. On the other hand, one project with the population component (Nigeria -- Imo Health), has since been added to the Region's FY89 lending program. The situation is similar for FY90. Of the 12 projects with a population component, six have either slipped or been dropped.

73. Difficulties in the lending program arise from both external and internal constraints. In Botswana, for example, an IBRD country, project preparation in all human resource areas is not receiving priority as the government is unwilling to borrow at IBRD rates.

74. Many Bank staff are of the opinion that, despite external constraints, high-level Bank management could do more to initiate and support efforts in Africa -- particularly francophone Africa -- to impress upon (generally unwilling) governments, the importance of population. Policy dialogue takes a great deal of time and effort. In Ethiopia, for example, it was three years and over 240 staff weeks from project identification to approval. Initially, the authorities were extremely reluctant to discuss population, but in the end agreed to formulate a population policy.

75. Resource constraints affect our ability to develop substantial population components. Health projects usually do not require the prolonged and delicate policy dialogue that family planning-oriented projects require. Until this year, nearly all projects in Africa were joint health/population projects. In FY88, two of the five projects in Africa had no, or minimal, population components. Several of the projects in the five-year lending program are also special-purpose health projects -- e.g., national essential drugs (see para. 9). These health projects are vitally needed, but to the extent that projects are not "population-driven," the argument that we are

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[8] Senegal - 5%; Ghana - 17%; Kenya - 20%. World Fertility Survey data cited in "Family Planning Saves Lives," 1986, Washington, D.C., The Population Reference Bureau.

addressing population concerns through health lending needs qualification. The size of the component is less important than project objectives.

76. Most of the projects in Africa are typical of "first-generation" projects, with a heavy emphasis on health infrastructure and large population components planned for second-generation projects. Sustained vigilance is necessary to ensure that the population components are not downplayed, and to support policy dialogue and project development in other countries in the region. The needs are great and the opportunities are there. The 1980s have seen great changes in African government attitudes on population growth, family planning and the feasibility of intervention.[9] The Bank has assisted in many of these developments. It has contributed to policy breakthroughs in several countries that previously opposed or took a laissez-faire approach to intervention -- notably Burundi, Malawi, Nigeria and Senegal.

77. EMENA. Population problems in some EMENA countries are similar to those in many Sub-Saharan African countries: high population growth rates, high fertility rates, and high maternal mortality rates. As in Africa, religious and cultural reasons cause overt discussions of population and family planning issues to be sensitive, but the health benefits of spacing births are not. This, then, appears to be the avenue for introducing discussions of family planning. Projects in Jordan and The Yemen (both PDR and AR) are taking this approach.

78. The countries of the Maghreb are more open to discussions of population issues, although in the case of Algeria this represents a relatively recent shift in attitude. What happened in Algeria illustrates the Bank's comparative advantage in population work.

79. The Bank responded swiftly to Algeria's request for assistance in developing a population policy. A middle-income country that borrows on IBRD terms, Algeria turned to the Bank for support. (The government had first approached UNFPA, which was unable to provide assistance at the level requested.) The loan terms were less important than the Bank's expertise. The Bank's sector review provided a good analysis of Algeria's situation, concrete advice about the activities needed to meet objectives, and an estimate of the costs involved.

80. UNFPA was able to increase the level of its assistance. It will provide a grant of $10 million, $6 million of which will go to the Ministry of Social Affairs for IEC and related activities. The Bank's role will be to increase family planning delivery through the Ministry of Health. A family planning project is planned for FY91, but may become a component of the FY90 health project.

81. The other main focus of population activity in the region has been in Pakistan, where the first population project (1983) has encountered

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[9] "World Population Trends and Policies: 1987 Monitoring Report," Preliminary Version, United Nations, New York.

many difficulties -- lack of commitment from government, lack of management capacity, too great a concentration on family planning rather than more comprehensive population activities, and a failure to take into consideration the low status of women. Efforts are now being made to formulate new approaches to reducing population growth in Pakistan.

82. Asia. This region absorbs most Bank population lending. Large projects are underway in Bangladesh, India and Indonesia, where the governments have a firm commitment to population policies and the programs demonstrate the success of family planning interventions. In Indonesia, for example, fertility is considerably lower than would be expected on the basis of its level of economic development. In Bangladesh, use of contraceptives has increased from 5% to more than 25% in just over a decade. In India, crude birth rates have declined nearly 20% since the 1960s and the annual rate of population growth has slowed from 2.3% to 2.0%.

83. Because of the size and complexity of the projects, PHN staff have been placed in the Bangladesh and India resident missions. The Bangladesh program has many cofinanciers, and the resident advisor has played a key role in management. In-country representation also benefits operations in India. The three PHN staff working on India in Washington are supervising large projects at the same time that they develop others.

84. LAC. Fertility rates in this region are declining. The relatively advanced level of development in Latin America and the Caribbean results in strong demand for family planning in most countries of the region. NGOs have played a prominent role in the provision of services in many countries, notably in Colombia and Brazil. Government later took more responsibility in a number of countries, for example, Mexico. And the private sector has been important in all cases. Nevertheless, high fertility still persists in some population sub-groups and geographic regions, especially among the rural poor and indigenous groups, for whom family planning (and health) services tend to be less available and accessible.

85. Most countries in the area are reluctant to discuss population and family planning issues and Bank strategy has been low-key. Initiatives such as the recent Safe Motherhood Workshop in Brazil have focused on family planning as a way to improve maternal and child health. Family planning is a component of MCH in the Brazil projects but lending for population as a whole is limited in this region.

D. Population Sector, Research and Policy Work

86. Sector work. The largest amount of population sector work in FY88 was done in the Africa region (para. 49), where interest in family planning has grown somewhat and data are increasingly available. Asia region did no population sector work in FY88, but has undertaken a large sector review for FY89. LAC covered population slightly in a PHN sector review for Bolivia and in a population and health sector strategy paper for Mexico. Despite its small PHN staff, EMENA had two well-focused activities: a quick response to Algeria's policy shift and an evaluation of the unsuccessful program in Pakistan. Population strategy development was part

of Nepal's CEM. The drafting of the population portion of the Pakistan CEM was delayed until FY89 despite completion of background papers. The pressure of short-term fiscal crises deflected government attention away from Pakistan's long-term problems.

87. No population sector work is scheduled for FY89 in LAC or EMENA. Asia plans population sector work for the two biggest borrowers, India and Indonesia. The Africa region plans four population sector reviews, and three PHN sector reviews will include population. Also, strategy papers are planned for many countries, including India, Brazil and Nigeria.

88. Research and policy work.[10] The technical departments were established only in FY88, so most in-house research output in that fiscal year came from PPR. The major cross-national products were the annual population projections and reviews of the private sector's role and of costs, payment and incentives in family planning. Work was also done on attempts to reach people at the periphery, the role of family planning in safe motherhood, the links between poverty and fertility, and the cost-effectiveness of alternative ways of reducing fertility. All externally-funded research projects in population had been completed in FY87 and no new ones have yet been funded. The last major policy paper on population was the SSA population policy report in 1986. In a follow-up to that report, AFT is planning to produce a report on strategies for the 1990s in FY90. The next global population policy paper is planned for FY91. Research in progress should yield a policy paper focused on family planning at that time.

E. Key Issues for the Bank

89. The remainder of this section will address four key issues:

(a) What role should senior Bank management play in addressing the population problem?

(b) To what degree should population work be integrated into health projects?

(c) How should projects be designed to meet country-specific needs?

(d) How adequate are PHN resources for reaching specific lending goals?

90. The role of Bank management. In the past two decades we have learned that the success of family planning programs depends upon the desire of individual men and women to regulate their fertility and the commitment of national leaders to reducing national fertility. The Bank can only

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[10] It is beyond the scope of this review to cover such valuable research as the work on incentives in Bangladesh that was sponsored out of project funds.

indirectly affect the demand for family planning among individual couples, but it can play a major role in influencing government commitment. It can influence governments by providing information about the seriousness of the problem and by offering analytical, financial and moral support to countries that make serious efforts to address the problem. Mr. Conable's speech at the 1988 Annual Meeting in Berlin, which called for action on population as part of a five-point attack on poverty, was a valuable restatement of the Bank's commitment to population work.

91. Integration of population components in health projects. In many countries -- particularly in Africa and to some degree in EMENA -- population lending in recent years has been almost exclusively linked to health -- except in Kenya and Pakistan. This approach offers certain advantages:

(a) introducing population lending in countries that would be sensitive to free-standing family planning projects,

(b) focusing on the health sector where most service delivery takes place,

(c) providing services in areas where demand is low, and

(d) assuring attention to population in small countries where free-standing population projects are not possible.

Integrating population activities into health projects also poses disadvantages:

(e) operations tend to be restricted to ministries of health, where commitment may be low and skills in family planning limited (although this can be addressed by project components),

(f) the family planning component may not be implemented successfully unless it is large and well planned, and the supervising staff is well-trained, and

(g) ministries of health are almost always poorly equipped to carry out activities that generate demand for family planning.

92. It is essential that the population components of health projects be well-designed. They should stipulate targets, provide for staff training, support IEC activities to generate demand for family planning, and give information about the safety and efficacy of contraceptives and the contribution of family planning to better health. The Bank teams which develop and supervise these projects should include people with specialized population skills.

93. Well-designed population components in health projects can be very effective as, for example, in the Malawi I and Zimbabwe projects. They are most likely to succeed when other delivery systems, especially involving NGOs, are added to the ministry of health. Nevertheless, opportunities to develop free-standing projects should be sought wherever possible.

94. Country-specific needs. Different approaches to population lending should be taken depending on a region's attitudes and problems and how far along countries are in the demographic transition, in population policy formulation and implementation, and in family planning program capacity. We should consider ways to expand beyond reliance on the ministry of health; ways to involve other organizations; and increased coordination with other donor agencies in the support of national population programs.

95. Some start has already been made in these directions. Expanded use of NGOs has been emphasized for the past three years. In FY85, the Bank began a regional initiative in Africa, providing the International Planned Parenthood Federation with assistance to strengthen the management capabilities of local family planning associations and to encourage their use as executing agents in government-sponsored programs. In FY88, this assistance amounted to $300,000.

96. Many individual projects support NGO initiatives (for example, in Sri Lanka, Bangladesh, Kenya, Zimbabwe and The Gambia). The use of such intermediaries minimizes a problem frequently identified in Bank projects: that staff are not able to monitor provider-client relations at the periphery. Careful examination of NGO management capacity and some site visits will still be necessary, of course. But the Bank can take advantage of the grass-roots experience of these organizations which in many countries, fill important gaps in government services.

97. Similarly, the impact of Bank lending can be magnified by coordination with other donors, and cofinancing in some instances. In Sri Lanka, the relatively small ($5 million) population component of the Bank's FY88 project supports a major UNFPA undertaking. In Bangladesh, several donors are cofinancing aid to the national program.

98. Staff resources. As discussed in the FY87 annual Sector Review meeting, we have been concerned since Reorganization that we may have too few staff with sufficient experience and background in the population sector.

99. Before Reorganization there were just over 100 Bank higher-level staff members (not including consultants and advisers) in the three operating divisions and the research division of PHN. About 60 of these people are still working in the PHN sectors. In addition, five new individuals with relevant qualifications and/or experience outside the Bank are now working in the sector. Table 11 shows the number and distribution of people with PHN training and experience. To the extent that there are others working in PHN without such background or experience, this number of 65 underestimates the quantity of resources available.

100. We asked the operating divisions how many people devote 20% or more of their time to population activities. They indicated that about 40 people are so employed. Seven have no prior experience or qualifications. In fact fewer than one in three of those working on population have technical training in demography, public health or population planning.

Apparently there is some ground for concern about the number and the training of those working in the sector.

101. Under the new structure, staff working in PHN are widely dispersed in the Bank. Many PHN staff members express feelings of isolation and concern about "deprofessionalization." The opportunities for on-the-job training, advice and support that were available in the old centralized department no longer exist. It is not as easy as it used to be to keep up with developments in the field, or even in other parts of the Bank. Channels of professional communication are mainly informal, based on former contacts.

Table 11: HIGHER-LEVEL STAFF[a] IN PHR DIVISIONS BY PHN BACKGROUND AND EXPERIENCE

Division	Total in PHR operating and technical divisions	Total with PHN experience and/or qualifications	Total with experience in PHN in Bank before FY88	Total with experience in PHN before joining Bank	Total with PHN-related academic qualifications
AFRICA					
Human Resources Divisions (6)[c]	36	14	13	7	10
Technical Division (PHN only)	9	7	7	4	4
ASIA					
Human Resources Divisions (5)	39	10	9	5	4
Technical Division (PHR)	17	4	4	4	4
EMENA					
Human Resources Divisions (3)	18	8	7	2	4
Technical Division (PHR)	14	5	5	3	3
LAC					
Human Resources Divisions (2)	11	4	3	3	2
Technical Division (PHR)	19	3	3	2	1
PPR					
PHRHN	11	10	9	4	6
TOTAL	174	65	60	34	38

[a] Based on a review of staff profiles. Includes operations assistants and research assistants. Does not include support staff or consultants.

[b] Postgraduate training in public health, sociology, anthropology, medicine, demography, health economics.

[c] Numbers in parentheses indicate number of divisions.

102. It is important to train inexperienced PHN staff and to build consensus on the importance and role of population activities among other specialists. To overcome some of the constraints imposed by a shortage of technical skills, we suggest the need for population advisors for each Region to provide:

- a review of Bank operations in that area,
- a locus of specialist knowledge and advice,
- a focus for policy dialogue with governments (so they feel the advisor has the ear of high-level Bank management), and
- liaison with outside agencies (e.g., other donors) working in the region.

These advisors would complement the Senior Population Adviser in PPR.

F. Recommendations on Bank Population Work

103. We recommend that Mr. Conable make at least one major statement a year on population and development issues, such as the one he made in Berlin, and that other senior managers follow suit in their regions. Senior Bank management has made few strong public statements about the importance of population issues since 1984. The Bank must use its status and its pre-eminence in development to increase the momentum of all population efforts. We recommend that:

- management consider how to strengthen the incentives for staff members to emphasize population, so often a sensitive and difficult topic. Leadership from the President through all levels of management should send strong signals of the importance of population work;
- the Bank consider recruiting additional specialist population staff. At a minimum, there should be a population advisor in Operations to complement the Senior Population Advisor in PPR, but preferably also a population advisor for each of the Regions, to identify population issues that ought to be raised and to help decide how to include these in country strategies;
- additional training be provided -- internal seminars and workshops -- to strengthen the knowledge base of senior economists and managers who will be engaging in dialogue about population issues with ministers and other high-level leaders of countries seeking Bank assistance;
- the Bank continue to encourage other donors to be more active in, and allocate adequate funding for, population work, stimulate regional banks to do more in this field, and help coordinate the activities of international and local NGOs for

population work at all levels. The Bank should expand the promising work done with NGOs in Africa (helping them to improve their management, bringing them closer to their governments) and place greater emphasis on the use of NGOs in Bank projects.

IV. CONCLUSIONS AND RECOMMENDATIONS

104. The Bank is at a turning point in its PHN operations as it seeks to expand lending at a time when PHN resources are constrained. Commitment to sector goals -- improving health and nutrition and reducing fertility -- is strong in many countries and increasing in others, and demand for Bank lending is increasing. The Bank has pledged to increase lending to help reduce poverty and develop human resources -- two objectives in which PHN work figures critically. The question is: How should the Bank expand its PHN operations? And are additional resources necessary to improve or even to maintain the quality of the lending program while increasing the volume? We address these questions in the context of the project cycle.

A. Project Design and Supervision

105. The following emerging or continuing trends in sector operations have important implications for project design, preparation and supervision:

(a) Many countries are borrowing for the first time in the PHN sectors,

(b) PHN projects are now more focused -- some on a single area (e.g. essential drugs, malaria or AIDS), and

(c) PHN projects are putting more emphasis on:

(i) the "software" aspects of projects,

(ii) decentralizing health systems,

(iii) involving the private sector in PHN service delivery,

(iv) experimenting with different approaches to financing services, and

(v) designing projects to reach people at the social and geographic periphery.

106. The trends described above will tend to add to the resources required to bring projects to the Board. For example, additional time and staff are required when working with first-time PHN borrowers with little or no experience in preparing, and few specialists to help design, a project for Bank financing. In addition, other donors often want to join the Bank

in providing assistance in the PHN sector. This increases opportunities for cofinancing but complicates and often delays design and preparation.

107. Recent changes in PHN projects, including the move to more focused projects in some countries, increase the demand for specialized technical personnel, some of whom are not currently available in the Bank. Consultants can often meet this need, but there are too few nutrition and population specialists to carry out this work.

108. In countries that have already had at least one Bank-assisted PHN project, succeeding projects often focus on a particular aspect of the health system, such as health financing, that often requires a high level of specialized skills. Renewed interest in nutrition, for example, will require more technical staff resources than the two nutrition specialists currently available in the Bank.

109. Projects are increasingly concerned with improving "software" components, such as information, education and communication (IEC) activities and institution building through training. The Bank has emphasized these components, but some projects have not tapped state-of-the-art techniques or accomplished what they set out to do. For governments to realize improvements in the sector, they must find ways to improve the quality of service delivery and increase the demand for services, particularly among populations that are not currently well-served by the system.

110. The Bank should consider the following changes:

(a) encourage the development of projects that meet the new demands for careful, detailed design of the "software" components,

(b) in the review process, check the details of project design to see that these new demands are being met,

(c) ensure that local personnel who will be responsible for implementing the project participate in project preparation. This may entail workshops to sensitize and train local personnel about important issues in the sector as well as the increasingly common project launch workshops, and

(d) continue to provide training in the appropriate design of projects for Bank personnel who do not have experience in the sectors but are responsible for PHN projects.

111. Project supervision. Increased lending to countries inexperienced in Bank projects calls for more intensive supervision. Improving the quality of services means becoming more knowledgeable about the nuts and bolts of project implementation at the community level. This knowledge requires field visits by supervision missions as well as building into PHN projects mechanisms to assure that needed actions take place at the local level. Attending adequately to the quality of services requires that

supervision missions spend relatively less time in the capitol city and on "hardware" questions and more time in the field on "software" issues.

112. The need for intensive supervision and technical expertise might be met in one or a combination of the following ways:

(a) using more specialized, technical personnel -- usually local consultants -- on missions, with specific responsibility for particular technical components,

(b) placing more Bank personnel in the field or increasing the responsibility of field offices for supervision,

(c) building monitoring into the projects and providing requisite training to local personnel, and

(d) setting project supervision coefficients at an appropriate level for PHN projects -- perhaps 15 staff weeks -- based on the need for intensive oversight.

113. PHN and structural adjustment. Because of the health and nutrition consequences common to many adjustment efforts -- decreased spending for social services, for example, and the dismantling of consumer food subsidies -- the health and nutrition sectors should figure more prominently in policy-based lending operations to protect vulnerable groups affected by the adjustment process. This will require careful sector work. We must also encourage greater collaboration among personnel in the Country Departments responsible for structural adjustment projects, personnel responsible for PHN lending, and technical PHN personnel who can help develop components to address specific health and nutrition needs within the structural adjustment process.

B. Sector and Policy and Research Work

Sector work

114. PHN sector work remains critical to Bank dialogue with governments and to project identification and design. Paradoxically, although more staff time has been used in the preparation of reports, fewer are being processed to green cover and beyond -- reportedly because of inadequate staff time to devote to sector work and the demands of lending.

115. Clearly, sector work is crucial to sound lending operations. To safeguard its role, prevent a decline in the number of studies being completed and supplement some of the skills lacking in-house, the Bank should increase country contributions to sector work. This would increase the impact of sector work and reduce the burden on staff time but different staff skills and input may be needed to manage the collaboration. Our expérience with such efforts -- including two sector studies completed this year in Brazil (to which local consultants contributed substantially) and Chile (where the entire study was done by a local consultant) -- offers a possible model for future collaboration.

Policy and research work

116. Communication between the Bank's research complex and Operations presents new challenges in a more decentralized institution. PHR must strive to build a strong communications link with Operations. In designing its research program, it should constantly keep in mind the relevance of its activities to operations and involve the technical and country departments as fully as possible.

C. Future PHN Lending

117. Finally, we turn to the questions of how the Bank can expand its PHN operations and what, if any, additional resources are required to achieve this objective. We address these questions by analyzing the projected lending program in relation to a prototypical PHR country operating division.

118. Unless an unusually large number of projects drop and/or slip, the five-year lending program (table 5) suggests a significant expansion of PHN lending. The pipeline includes an average of 17 projects a year with an average annual volume of $900 million. Allowing a slippage factor of one-third yields 11 to 12 projects and $600 million of lending a year -- or 3% of total lending of $20 billion per year. This would meet the targets set by Mr. Conable, at least in terms of quantity.

119. The average (prototypical) PHR division has 6.5 higher level (HL) staff to cover education and PHN (table 11). Education lending is about triple PHN lending in volume and the supervision portfolio is twice the size of PHN. We assume, on the basis of work programs and the testimony of PHR division chiefs, that slightly less than half of their staff resources are devoted to PHN work and that they each receive roughly one staff year of support from the Technical Department. Available staff resources and work program in our prototypical division, then, would be as follows:

Staff Resources Devoted to PHN		
PHR SOD 3 HL staff years (at 40 staff weeks)	=	120 SW
PHR TD 1 HL staff year (at 40 staff weeks)	=	40 SW
TOTAL	=	160 SW
Work Program		
Lending (1-1/2 projects every 2 years at 150 SW plus 25% for "dry holes")	=	140 SW
Supervision (3 projects at 15 SW each)	=	45 SW
Economic and sector work	=	30 SW
TOTAL	=	215 SW

120. These rough estimates suggest that current PHN staff resources are insufficient by about fifty-five staff weeks (almost one and one-third staff years) per division to deliver the projected lending program. This resource shortfall could be met by (a) decreasing the amount of time devoted to each PHN sector work, lending, and/or supervision task, (b) having fewer but larger operations, or (c) adding additional staff. Decreasing coefficients much below 150 SW for lending and 15 SW for supervision would hurt quality, given the complex demands of PHN projects. Having fewer but larger operations -- in other words, more emphasis on sector lending -- might be seen as a way of dealing with the staffing shortage. But growing evidence that more focused projects tend to be implemented better and have a greater impact makes this undesirable as a wholesale approach. Decreasing coefficients for sector work would erode the quantity and quality of sector work, and thus the analytical underpinnings of PHN lending. Additional staff resources therefore represent the best approach to increasing both the quantity and quality of lending in the sectors. As we have argued in Section III, lending for population may be affected disproportionately in a resource-constrained environment.

121. We have discussed only how to manage the current lending program, which comprises about 3% of Bank lending. If lending in these sectors, which are so critical to human resource development, is to increase over time to 5% or more of Bank lending, current staff resources clearly will not be adequate to the task.

ANNEX 1

FY90 PHN LENDING PROGRAM[a]
Commitment in US$ millions

Country	Project	Amount		Status
AFRICA				
Chad	Social Development	10.0	(IDA)	Appraisal scheduled 5/89
Cote d'Ivoire	Human Resources I	100.0	(IBRD)	Appraisal scheduled 11/89
Djibouti	Health	NA		Reserve
Ghana	PHN II	25.0	(IDA)	Standby FY89, appraisal 1/89
Kenya	Health Financing	25.0	(IDA)	Appraisal scheduled 1/89
Lesotho	Health/Pop II	8.0	(IDA)	Appraisal scheduled 1/89
Madagascar	Pop/Health/Nut	40.0	(IDA)	Slipped to Reserve
Nigeria	Nat'l Essential Drugs	65.6	(IBRD)	Standby FY89, appraised 9/89
Tanzania	Health & Nutrition	20.0	(IDA)	Standby FY89
Togo	Pop/Health Sector	10.0	(IDA)	Appraisal scheduled 4/89
Zambia	Family Health	NA		Reserve
Zambia	Food Security/Nutrition	NA		Reserve
ASIA				
Bangladesh	Poverty Alleviation	60.0	(IDA)	Appraisal scheduled 2/89
India	Nutrition II	100.0	(IDA)	Appraisal scheduled 6/89
India	Population VI	75.0	(IDA)	Appraisal scheduled 1/89
Philippines	Health Development	40.0	(IBRD)	Appraisal scheduled 11/88
EMENA				
Algeria	Health Management	20.0	(IBRD)	Appraisal scheduled 8/89
Jordan	Health II	20.0	(IBRD)	Appraisal scheduled 4/89
Morocco	Health II	50.0	(IBRD)	Appraisal scheduled 5/89
LAC				
Ecuador	Health I	20.0	(IBRD)	Appraisal scheduled 11/89
Mexico	Health I	100.0	(IBRD)	Appraisal scheduled 8/89
TOTAL		778.6		

[a] As of 7/13/88

FY91 LENDING PROGRAM
Commitment in US$ millions

Country	Project	Amount	
AFRICA			
Botswana	Pop	NA	Reserve
Central African Republic	Health Sector	10.0	(IDA)
Equatorial Guinea	Health	4.0	(IDA)
Ethiopia	Pop	NA	Reserve
Kenya	Rural Health	45.0	(IDA)
Malawi	Health/Pop III	20.0	(IDA)
Mali	Pop/Health	5.0	(IDA)
Nigeria	Nat'l Pop	50.0	(IBRD)
Nigeria	Health System Fund	70.0	(IBRD)
Rwanda	PHN II	15.4	(IDA)
Somalia	Pop/Health	20.0	(IDA)
Sudan	PHN	40.0	(IDA)
Uganda	Health	NA	Reserve
Zambia	Pop	NA	Reserve
ASIA			
Bangladesh	Pop & Health	110.0	(IDA)
Burma	Health	NA	Reserve
India	Pop VII (Urban)	100.0	(IDA)
India	Health & Nut	60.0	(IDA)
India	Support to NGOs	NA	Reserve
Indonesia	Health Sector	75.0	(IBRD)
Korea	Health Sector	NA	Reserve
Malaysia	Health	20.0	(IBRD)
Pakistan	Family Health	30.0	(IDA)
EMENA			
Algeria	Family Planning	20.0	(IBRD)
Turkey	Health II	100.0	(IBRD)
Yemen Arab Republic	Health II	10.0	(IDA)
LAC			
Argentina	Soc Sec Adj & Invest	200.0	(IBRD)
Colombia	Health Sector	140.0	(IBRD)
Haiti	Health & Pop	25.0	(IDA)
TOTAL		1,169.4	

FY92 LENDING PROGRAM
Commitment in US$ millions

Country	Project	Amount	
AFRICA			
Angola	Health & Nut I	NA	Reserve
Burkina Faso	Pop/Health	20.0	(IDA)
Burundi	Health/Pop II	20.5	(IDA)
Cape Verde	Pop/Health/Womens Dev	5.0	(IDA)
Chad	Pop/Health	20.0	(IDA)
Ethiopia	PHN	70.0	(IDA)
Ghana	PHN III	40.0	(IDA)
Guinea	Health II	20.0	(IDA)
Lesotho	Human Resource I	NA	Reserve
Mauritania	Pop/Health	5.0	(IDA)
Mozambique	Health II	NA	Reserve
Niger	Pop/Health	20.0	(IDA)
Tanzania	Human Resource I	NA	Reserve
Zambia	Family Health II	NA	Reserve
Zimbabwe	Family Health II	12.0	(IBRD)
ASIA			
China	Rural Health IV	100.0	(IDA)
India	Pop VIII (NGOs)	100.0	(IDA)
Indonesia	Pop V	50.0	(IBRD)
Lao PDR	Health Dev	5.0	(IDA)
Nepal	Pop & Health	20.0	(IDA)
Philippines	Health Finance	100.0	(IBRD)
Philippines	Nutrition	NA	Reserve
Philippines	Health II	NA	Reserve
Sir Lanka	Poverty & Employment	NA	Reserve
Viet Nam	Health & Family Planning	NA	Reserve
EMENA			
Tunisia	Health & Pop II	50.0	(IBRD)
LAC			
Brazil	Metro Health II	200.0	(IBRD)
Brazil	Health Sector Prog	200.0	(IBRD)
Chile	Social Sector Adj	125.0	(IBRD)
Dominican Rep	Health & Pop	16.0	(IBRD)
TOTAL		1,198.5	

FY93 LENDING PROGRAM
Commitment in US$ millions

Country	Project	Amount	
AFRICA			
Angola	Human Resources I	25.0	(IDA)
Comoros	Pop & Human Resources	10.0	(IDA)
Guinea Bissau	Health/Education	13.0	(IDA)
Kenya	Pop IV	20.0	(IDA)
Nigeria	PHN IV	90.0	(IBRD)
Zaire	PHN	50.0	(IDA)
ASIA			
Bangladesh	Poverty Alleviation II	65.0	(IDA)
Bhutan	Pop & Health	NA	Reserve
India	Pop VI-Nat F Welfare Trg	NA	Reserve
Indonesia	Prov Health III	75.0	(IBRD)
Sri Lanka	Health & Pop II	30.0	(IDA)
EMENA			
Algeria	Health II	50.0	(IBRD)
LAC			
Argentina	Health Sector	100.0	(IBRD)
Brazil	AIDS & Chronic Disease	100.0	(IBRD)
Ecuador	Health II	40.0	(IBRD)
Guatemala	Health Proj	20.0	(IBRD)
Mexico	Health II	150.0	(IBRD)
Panama	Health/Soc Sec	25.0	(IBRD)
TOTAL		863.0	

FEATURES OF PHN PROJECTS - FY88

Country	Health facilities development			Human resources development						Institutional Building		Cost Recovery	Pharmaceutical Strengthening	Tropical Disease	AIDS	Safe Motherhood	Family Planning[b]	Nutrition[c]	IEC			
				Technical Training				Management														
	PHC Services	Regional level	Tertiary care	Para-Doctors	Medical	VHW	Other[a]	Senior Medical	Field	MOH	Private								Family Health	Planning	Nutrition	Other[d]
AFRICA																						
Burundi	X	X			X	X	X	X	X	X	X				X	X	X	X	X	X	X	
Ethiopia	X	X			X	X	X	X	X	X			X			X	X	X	X	X	X	
Guinea	X	X			X	X	X	X	X	X		X	X		X	X	X	X	X	X	X	X
Kenya								X	X	X	X						X	X		X		
Uganda	X	X	X					X	X	X	X	X	X		X		X			X	X	
ASIA																						
India	X	X	X	X	X	X	X	X	X	X	X					X	X		X	X		
Sri Lanka	X	X		X	X		X	X	X	X			X				X			X		
LAC																						
Brazil							X	X	X	X				X	X							X

a Includes traditional birth attendants, trainers, communications specialists, pharmacists, stores keepers, midwives.
b Family Planning/Population Characteristics FY88, Annex 3
c Nutrition in FY88 Projects, Annex 3
d Interpersonal communication skills, group techniques, use of IEC materials.

ANNEX 3

FAMILY PLANNING/POPULATION CHARACTERISTICS OF PHN PROJECTS APPROVED, FY88

	Guinea	Ethiopia	Kenya	Burundi	India	Sir Lanka
Provision of services						
- Government	X	X	X	X	X	X
- Community-based	X	X	X		X	
- NGO/PVO			X		X	
Training						
- Skills/technical	X	X	X	X	X	X
- Management			X		X	X
IEC	X	X	X	X	X	X
Research/studies			X	X	X	X

NUTRITION ACTIONS IN PHN PROJECTS APPROVED IN FY88

	Guinea	Ethiopia	Kenya	Burundi
Nutrition surveillance	X			
Growth monitoring				X
Nutrition education				
- General	X	X	X	
- Breastfeeding				X
- Weaning				X
- Oral rehydration therapy (ORT)		X		
Training - technical	X			
Development of weaning foods				X
Research/studies	X			X

PROJECTS ARISING FROM HEALTH FINANCING SECTOR WORK (COMPLETED, PROPOSED, OR INITIATED)

Country	Health Financing Sector Work	Project(s)	FY
Africa			
Central African Rep	Cost/Financing Health Care	Health Sector	91
Comoros	Health Financing		
Cote d'Ivoire	Cost and Financing in Health	Health II	90
Kenya	Health Financing	Health Financing	90
Kenya		Rural Health	91
Madagascar	Health Financing	Pop/Health/Soc	90
Malawi	Health Financing	Health III	91
Nigeria	Public Financing of Health	Imo Health	89
Nigeria		National Essential Drugs	89
Nigeria		Health System Fund	90
Rwanda	Health Financing	PHN II	91
Somalia	Health Financing	Pop/Health	91
Zimbabwe	Health Financing	Family Health II	92
ASIA			
Bangladesh	Health Financing	Poverty Alleviation	90
Bangladesh		Pop/Health	91
India	Health/Family Finance	Family Welfare	90
India		Nutrition	90
Indonesia	Issues in Health Planning and Budgeting	Health III	89
EMENA			
Tunisia	Health Sector Finance	Health/Pop II	91
Turkey	Health Sector Finance	Health I	89
LAC			
Brazil	Public Spending on Soc Programs	NE Basic	89
		Amazon Malaria	89
Mexico	Health Financing	Health Project	90

NOTE: Many broader pieces of sector work will include studies of health financing options, this table lists sector work focused specifically on health financing.

Annex 5

FHH PROJECTS APPROVED BY REGION AND FY, STAFF WEEKS (SW) EXPENDED AND CALENDAR MONTHS (FT) FROM IDENTIFICATION TO PROJECT APPROVAL

FY81		FY82		FY83		FY84		FY85		FY86		FY87		FY88	
Project	(SW) FT	Project	(SW) FT	Project	(SW) FT	Project	(SW) FT	Project	(SW) FT	Project	(SW) FT	Project	(SW) FT	Project	(SW) FT
AFRICA															
		Kenya	(328.6)	Senegal	(261.3)	Comoros	(86)	Nigeria	(153.9)	Cote d'Ivoire	(150.8)	Zimbabwe	(197.2)	Burundi	(168)
		Population I	NA	Rural Health	39	Pop Health	12	Sokoto Health	47	Health I	21	Family Health	28	Health Pop	26
				Malawi	(168.9)	Mali	(218.5)	Lesotho	(198.7)	Ghana	(110.4)	Gambia	(108.8)	Ethiopia	(243.2)
				Health I	30	Health Dev	44	Health Pop	34	Health Ed	26	Pop Health	29	Family Health	36
						Botswana	(101.6)	Burkina	(130.6)	Niger	(174.5)	Malawi	(154.6)	Guinea	(134.5)
						Family Health	24	Health I	40	Health	20	Health II	33	Health Pop	18
										Rwanda	(158.1)	Guinea Bissau	(93.0)	Kenya	(158.1)
										Family Health	24	PHN	48	Population	52
										Sierra Leone	(144.5)			Uganda	(147.9)
										Pop Health	16			Family Health	15
ASIA															
				Indonesia	(132)	China	(182.3)	Indonesia	(98.4)	India	(121.1)			Sri Lanka	(168.2)
				Prov Health	24	Rural Health	20	Health Manpower	16	Pop IV	NA			Family Health	15
						India	(108)	Indonesia	(138.5)	Indonesia	(91.5)			India	(236.9)
						Pop III	NA	Pop IV	NA	Nutr Comm	24			Pop V	41
										Bangladesh	(289.7)				
										Pop/Fam Health	NA				
										China	(156.9)				
										Health II	50				
EMENA															
Tunisia	(267.1)	Pakistan	(226.9)					Jordan	(111.9)			Oman	(202.2)		
Health Pop	47	Population	NA					Health	14			Health	26		
		YAR	(218.5)					Morocco	(194.4)						
		Health I	27					Health	68						
		PDRY	(141.6)												
		Health Dev I	30												
LAC															
		Brazil	(38.8)	Peru	(183.5)	Brazil	(266.5)			Colombia	(157.3)			Brazil	(117.1)
		New Health	26	Health	52	Sao Paulo Health	NA			Health	48			Endemic Disease	34
										Brazil	(172.0)				
										NE Basic H Serv	32				
Average SW per project per year[a]					190.4		160.5		146.6		157.0		151.2		171.7

[a] For years where more than two projects were approved.

Annex 6

PHN ACTIVITIES IN FY88 STRUCTURAL AND AGRICULTURE SECTOR ADJUSTMENT LOANS (SALs)

	Burundi SAL II	Central African Republic SAL II	Congo SAL I	Gabon SAL I	Guinea SAL II	Mozambique Rehab II	Togo SAL III	Uganda Economic Recovery	Tunisia SAL III	Chile SAL III	Morocco Ag. II	Mexico Ag
Monitor social dimensions of adjustment	X	X	X	X	X	-	X	-	-	-	-	-
- develop and maintain data bases	X	X	X	-	X	-	X	-	-	-	-	-
- carry out social studies	X	X	X	-	X	X	X	-	-	-	-	-
- strengthen institutional capacity	-	X	-	-	X	-	X	-	-	-	-	-
Complementary activities - PHN sector	X	-	-	-	X	X	X	X	X	-	-	-
Elaborate sectoral diagnosis and strategies	X	-	-	-	X	-	-	-	-	-	-	-
- PHC projects	-	X	-	-	X	-	-	-	-	X	-	-
- Nutrition projects	X	-	-	-	X	-	-	-	-	-	-	X
Targeted consumer subsidies	-	-	-	-	-	X	-	-	X	-	X	X
Preventive health care programs	-	-	-	-	-	-	-	-	-	X	-	-
Comprehensive health care system	-	-	-	-	-	-	-	-	-	X	-	-
Food security program	X	-	-	-	-	-	-	-	-	-	X	-

ANNEX 7

FEATURES OF PVH PROJECTS, FY81-87

PROJECT	FY	Basic Health Services	Health Facilities Dev. Level 1	Level 2	Level 3	Family Planning Serv.	Para-Medical Training	Strengthening Management	Tropical Disease Control	Strengthening Pharmaceuticals	Water Supply/ Sanitation	Nutrition	Cost Recovery	IEC	Location Urban	Location Rural	Research	No.of Beneficiaries (millions)	FY88 Status (Problems)
TUNISIA II HP	81	X	X	X		X	X	X			X	X		X	X	X	X	2.3	/2
BRAZIL I H	82	X	X	X			X	X	X					X		X	X	0.7	/2
KENYA II P	82	X	X	X		X	X	X		X		X	X	X		X	X	2.5	/2
PAKISTAN II P	83	X		X		X	X	X				X	X	X	X		X	20.0	/3
YAR I H	83						X	X		X		X		X			X		/2
PERU I PHC	83	X	X			X	X	X	X			X	X	X	X	X	X	3.5	/4
SENEGAL I Rural H	83	X	X			X	X	X		X		X		X		X	X	3.4	/2
INDONESIA prov. H	83	X	X	X			X	X	X	X			X			X	X		/2
MALAWI I H	83	X	X			X	X	X		X	X		X	X	X	X	X	0.8	/2
PDRY I H	83	X	X			X	X	X						X		X		1.3	/1
COMOROS I HP	84	X	X			X	X	X		X				X	X	X		0.5	/3
MALI I H	84	X	X			X	X	X		X	X	X	X	X	X	X	X	0.65	/1
BRAZIL II	84	X	X	X		X	X	X				X		X	X	X	X	2.0	/2
CHINA I Rural H	84	X	X	X			X	X								X	X	31.0	/1
INDIA III P	84	X	X	X		X	X	X				X	?	X		X	X	18.2	/2
BOTSWANA I Fam. H	84	X	X		X	X	X	X		X		X	X	X	X	X			/2
NIGERIA I Sokoto H	85	X	X			X	X	X			X	X		X		X	X	1.15	/2
LESOTHO I HP	85	X	X			X	X	X				X		X		X	X		/1
JORDON I H	85	X	X	X		X	X	X				X		X	X	X	X		/2
INDONES. II H Mpwr	85						X	X											/3
MOROCCO I H	85	X	X	X		X	X	X		X		X	X	X		X	X	2.1	/2
INDONESIA IV P	85	X				X	X	X	X			X		X		X	X	1.8	/1
BURKINA FASO H	85	X	X	X		X	X	X	X	X		X	X	X	X	X	X	4.0	/1
INDIA IV P	86	X	X	X		X	X	X				X	X	X	X	X	X	2.2	/3
COLOMBIA HS Integr	86	X	X	X		X	X	X			X	X	X		X	X	X	3.7	/2
IVORY COAST H Demo	86	X	X			X	X	X				X	X		X	X	X		/2
INDONESIA H&Comm H	86	X	X			X	X	X				X		X		X	X		/2
BANGLADESH P&Fam H	86	X	X	X		X	X	X	X	X		X	X	X	X	X	X	35.0	/2
GHANA H & Ed.	86	X	X			X	X	X						X		X			/3
NIGER H	86	X	X			X	X	X	X	X		X	X	X		X	X	3.4	/1
RWANDA Family H	86	X	X	X		X	X	X				X				X	X		/2
SIERRA LEONE HP	86	X	X	X		X	X	X		X		X	X	X		X	X	1.2	/4
BRAZIL NE Basic H	86	X	X	X		X	X	X		X		X	X			X	X	3.6	/2
CHINA II	86	X	X	X			X	X		X			X			X	X	30.0	/1
ZIMBABWE Family H	87	X	X	X		X	X	X				X		X	X	X	X	0.8	/1
GAMBIA I PH	87	X	X	X	X	X	X	X		X		X	X	X	X	X		0.7	/1
MALAWI II HP	87	X	X	X		X	X	X		X		X	X	X	X	X	X	2.0	/1
JAMAICA P/H	87	X	X	X		X	X	X					X	X	X	X		1.16	/2
OMAN H	87	X	X	X		X	X	X		X		X	X	X		X	X	0.3	/1
GUINEA BISSAU PHN	87	X	X			X	X			X		X	X			X	X	0.175	/1

/1 None
/2 Moderate
/3 Severe
/4 All disbursements suspended

ANNEX 8

PHN SECTOR WORK COMPLETED FY88

Country	Report Title	Cover	Staff Week
AFRICA			
Botswana	Population Sector Review	white	n/a
Burkina Faso	The National FP Program	white	23
Madagascar	Population and Health Sector Review	grey	73
Mozambique	Population and Health Sector Review	white	48
Niger	Population Sector Memorandum	white	20
Nigeria	Public Financing of Health	white	84
Zaire	PHN Sector Review	green	74
ASIA			
Indonesia	Issues in Health Planning and Budgeting	yellow	86
EMENA			
Algeria	Toward the Control of Population Growth: Questions and Strategies	white	n/a
Pakistan	Population and Health Sector Report	white	63
LAC			
Argentina	Social Sectors in Crisis	red	n/a
Bolivia	PHN Sector Review	green	31
Brazil	Public Spending on Social Programs	grey	34
	Policies for Reform of Health Care, Nutrition and Social Security in Brazil	green	n/a
Chile	Health Sector Analysis in Chile	white	n/a
Jamaica	Summary Review of the Social Well-Being Program	grey	n/a

ANNEX

PROPOSED LENDING OPERATIONS ARISING FROM SECTOR WORK

Region	Country	Sector Work	Proposed Projects
Africa	Burkina Faso	The National Family Planning Program	o Being used to define the FP component in the Health Services Development Project.
	Madagascar	Population and Health Sector Review	o Population and Health.
			o Economic Management and Social Action program (emergency program put together by co-financiers).
	Mozambique	Population and Health Sector Review	o Health and Nutrition.
	Niger	Population Sector Memoran.	o Population/Health Project.
	Nigeria	Public Financing of Health	o Health System Fund.
	Zaire	PHN Sector Review	o AIDS.
Asia	Indonesia	Issues in Health Planning and Budgeting	o Health III.
EMENA	Algeria	Towards the Control of Population Growth: Questions and Strategies	o Family Planning.
LAC	Argentina	Social Sectors in Crisis	o TA for Management of Social Sectors.
			o Investment Loan in Health and Education.
	Brazil	Policies for Reform of Health Care, Nutrition and Social Security	o Second NE Basic Health.
	Bolivia	PHN Sector Review	o First Integrated Health. Development Project
	Chile	Health Sector Analysis	o Provided health-related conditionalities for SAL III.
	Jamaica	Summary Review of the Social Well-Being Program	o Social Sectors Investment.

ANNEX 10

RESEARCH AND POLICY WORK COMPLETED FY88

SUBJECT/Region	Title of Report
HEALTH	
Africa	The Determination of Hospital Expenditures: An Analysis of Ethiopia.
	Research and Policy Analysis of Hospitals in Malawi.
	The Direct and Indirect Cost of HIV Infection in Developing Countries: The Case of Zaire and Tanzania.
	Data Needs for Health Sector Planning in Sub-Saharan Africa.
	A Campaign of Hope for Africa.
	Implications of Control Measures for the Spread of HIV Infection.
	Cost Recovery in the Health Care Sector: A Synopsis of Selected Country Studies in West Africa.
Asia	The Development, Growth, and Distribution of Public and Private Medical Resources in the Philippines. PHN Technical Note No. 87-24.
	Financing Health Services: Some Speculations and an Example from Indonesia. PHN Technical Note No. 87-22.
	Price and Income Elasticities of Demand for Modern Health Care: The Case of Infant Delivery in the Philippines. PHN Technical Note No. 87-23.
Inter-regional	The Financing and Economics of Hospitals in Developing Countries: Key Issues and Research Questions. PHN Technical Note No. 87-20.
	Guidelines for the Selection and Use of Pesticides in Public Health Programs.
	Safe Motherhood Initiative: Proposals for Action. World Bank Discussion Paper No. 9. French and Spanish Translation.
	Cost Effective Integration of Immunization and Basic Health Services in Developing Countries: The Problem of Government Costs.
	Objectives and Methodology of the World Health Survey.
	Interaction of Infant Mortality and Fertility and the Effectiveness of Health and Family Planning Programs.
	"Client-Provider Interaction at the Periphery: What's Worked in Large-Scale Population, Health, Nutrition Programs in the Third World."
	"Reaching People at the Periphery: Can the Bank's Population, Health and Nutrition Operations Do Better?"

ANNEX 10

SUBJECT/Region	Title of Report
POPULATION	
Africa	Africa Region: Population Projections 1987-88: Short and Long Term Estimates.
	Family Planning Services in Sub-Saharan Africa.
	The Development of Population and Family Planning Policies in Sub-Saharan Africa.
Asia	Asia Region: Population Projections 1987-88: Short and Long Term Estimates.
EMENA	Europe, Middle East and North Africa Region: Population Projections 1987-88: Short and Long Term Estimates.
	"A Causal Analysis of the Determinants of Desired Family Size among Husbands and Wives in Egypt: A Revised Examination."
LAC	Latin America and Caribbean Region Population: Population Projections 1987-88 Short and Long Term Estimates.
Inter-regional	Slowing the Stork: Better Health for Women through Family Planning.
	The Effects of Education, Health and Social Security on Fertility in Developing Countries: Their Implications of a Policy
	The Private Sector and Family Planning in Developing Countries: Its Role, Achievements and Potential
	Costs, Payments, and Incentives in Family Planning Programs: A Review of Developing Countries.
	Fertility and Poverty in Developing Countries.
	Family Planning Services at the Periphery.
	The Role of International Agencies, Governments and the Private Sector in the Diffusion of Modern Contraceptive Technology in Society.
NUTRITION	Malnutrition: What Can Be Done? Lessons from World Bank Experience.
Asia	"China's Food and Nutrition Planning."
Inter-regional	Nutrition Planning is Alive and Well, Thank You.
	Nutrition Review. PHN Technical Note No 87-21.
	A Rationale for Promoting Breastfeeding in World Bank Projects with Fertility Limitation Objectives.
	"Nutrition Policies and Programs: A Decade of Redirection."
INTERSECTORAL	Cost Recovery for Education and Health in Developing Countries.

Population Lending by Year and Region ANNEX 11

AFRICA

Year	Country	Project Type	Loan Size	Size of Population Component	Total
1974	Kenya I	P	12.00	12.00	12.00
1982	Kenya II	P	23.00	23.00	23.00
1983	Malawi I	H	6.80	0.60	
	Senegal I	H	15.00	1.40*}	2.00
1984	Botswana I	H	11.00	0.80 }	
	Comoros I	H	2.83	0.40 }	2.70
	Mali I	H	16.70	1.50*}	
1985	Burkina Faso I	H	26.60	0.50 }	
	Lesotho I	P/H	3.50	0.70 }	2.60
	Nigeria I	H	34.00	1.40*}	
1986	Ghana I	H	15.00	0.80 }	
	Côte d'Ivoire I	H	22.20	4.90 }	
	Niger I	H	27.80	1.70 }	9.70
	Rwanda I	H	10.80	1.20 }	
	Sierra Leone I	P/H	5.30	1.10 }	
1987	Zimbabwe I	H	10.00	2.00 }	
	Gambia I	H	5.60	0.60 }	
	Guinea-Bissau	H	4.20	0.50*}	7.90
	Malawi	P/H	11.00	4.80 }	
1988	Burundi	P/H	11.00	4.40 }	
	Ethiopia	FH	33.00	3.30 }	
	Guinea	H	19.70	0.00 }	29.90
	Kenya	P	22.20	22.20 }	
	Uganda	H	52.50	0.00 }	
				Total by Region	89.90

* Approximate total

Population Lending by Year and Region

LATIN AMERICA AND THE CARIBBEAN

Year	Country	Project Type	Loan Size	Size of Population Component	Total
1970	Jamaica I	P	2.00	2.00	2.00
1971	Trinidad & Tobago I	P	3.00	3.00	3.00
1976	Jamaica II	P	6.80	6.80	6.80
1977	Dominican Republic	P	5.00	5.00	5.00
1978	Colombia	N	25.00	0.00	0.00
1982	Brazil I	H	13.00	0.00	0.00
1983	Peru I	H	33.30	1.00	1.00
1984	Brazil II	H	55.50	0.00	0.00
1986	Colombia I	H	36.50	0.30*	0.30
1987	Jamaica	P/H	10.00	6.80	6.80
1988	Brazil III	H	109.00	0.00	0.00
				Total by Region	24.90

*Approximate total

Population Lending by Year and Region

ASIA

Year	Country	Project Type	Loan Size	Size of Population Component	Total
1972	India I	P	21.10	21.20	
	Indonesia I	P	13.20	13.20 }	34.30
1973	Malaysia I	P	5.00	5.00	5.00
1974	Bangladesh I	P	15.00	15.00	15.00
1976	Philippines I	P	25.00	25.00	
	Indonesia II	P	24.50	24.50 }	49.50
1978	Thailand I	P	30.00	30.00	30.00
1979	Bangladesh II	P	32.00	32.00 }	
	Malaysia II	P	17.00	17.00 }	
	Philippines II	P	40.00	40.00 }	119.00
	Korea, Rep. of	P	30.00	30.00 }	
1980	India II	P	46.00	46.00	
	Indonesia III	P	35.00	35.00}	81.00
1984	India III	P	70.00	70.00	70.00
1985	Indonesia IV	P	46.00	46.00	46.00
1986	Bangladesh III	P	78.00	78.00	
	India IV	P	51.00	51.00 }	129.00
1988	India V	P	50.50	50.50	
	Sri Lanka	H/FP	17.50	5.30 }	55.80
				Total by Region	634.70

Population Lending by Year and Region

EUROPE, MIDDLE EAST & NORTH AFRICA

Year	Country	Project Type	Loan Size	Size of Population Component	Total
1971	Tunisia I	P	4.80	4.80	4.80
1974	Egypt I	P	5.00	5.00	5.00
1979	Egypt II	P	25.00	25.00	25.00
1981	Tunisia II	P/H	12.50	1.10	1.10
1983	Pakistan I	P	18.00	18.00 }	
	Yemen, AR I	H	10.50	0.00 }	18.00
	Yemen, PDR	H	7.60	0.00 }	
1985	Jordan I	H	13.50	3.40	
	Morocco I	H	28.40	2.80 }	6.20
1987	Oman	H	13.30	0.00	0.00
				Total by Region	60.10

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