Folder Title:	President Wolfensohn - Briefing Book for President's Meetings and Events - World Bank Background Information - Public Health Issues for Donna Shalala's Visit to India and Vietnam - November 14, 1997
Folder ID:	30489174
Series:	Meeting and event briefing materials
Dates:	11/05/1997 – 11/14/1997
Subfonds:	Records of President James D. Wolfensohn
Fonds:	Records of the Office of the President
ISAD Reference Code:	WB IBRD/IDA EXC-13-10
Digitized:	09/09/2025

World Bank Background Information
(Public Health Issues)
for Ms. Donna Shalala's
Visit to India and Vietnam

IDW Copy

Archive Management for the President's Office

Document Log

Reference # : Archive-01938

IRGS

Edit Print

A. CLASSIFICATION

- [ ] Meeting Material
- [ ] Trips
- [ ] Speeches
- [ ] Annual Meetings
- [ ] Corporate Management
- [ ] Communications with Staff
- [ ] Phone Logs
- [ ] Calendar
- [ ] Press Clippings/Photos
- [ ] JDW Transcripts
- [ ] Social Events
- [x] Other

B. SUBJECT: Background Briefing Information (Public Health Issues) prepared by the World Bank for Ms. Donna Shalala's Visit to India and Vietnam, Nov. 1997
Brief includes:
--- Note from JDW to Secretary Shalala
--- Table of Contents
--- Brief: The World Bank Group and Infectious Disease Control in India
--- South Asia Sector Brief: WB and Health Sector Development and Disease Control in India
--- Brief: The World Bank Group and and Maternal and Child Care and Women's Health in India
--- South Asia Sector Brief: WB and Population and Reproductive and Child Health in India
--- India Basic Facts & Figures
--- Briefing Note: Public Health Issues in Vietnam
--- Brief: Vietnam - Incidence and Treatment of Infectious Diseases
--- Brief: Women's, Maternal & Child Care
--- Vietnam Basic Facts & Figures

DATE: 11/14/97

C. VPU

Corporate
- [ ] CTR
- [ ] EXT
- [ ] LEG
- [ ] MPS
- [ ] OED
- [ ] SEC/Board
- [ ] TRE

Regional
- [ ] AFR
- [x] EAP
- [ ] ECA
- [ ] LAC
- [ ] MNA
- [x] SAS

Central
- [ ] CFS
- [ ] DEC
- [ ] ESD
- [ ] FPD
- [ ] FPR
- [ ] HRO

Affilliates
- [ ] GEF
- [ ] ICSID
- [ ] IFC
- [ ] Inspection Panel
- [ ] Kennedy Center
- [ ] MIGA

D. EXTERNAL PARTNER
- [ ] IMF
- [ ] UN
- [ ] MDB/Other IO
- [ ] NGO
- [ ] Private Sector

- [x] Part I
- [ ] Part II
- [ ] Other

Donna
Have a great trip —
Hope to see you soon —

JAMES D. WOLFENSOHN
PRESIDENT

THE WORLD BANK
1818 H STREET, N.W.
WASHINGTON, D.C. 20433 U.S.A.

TEL.: (202) 458-5120
FAX: (202) 522-3031
TELEX: MCI 248423

Background Briefing Information
(Public Health Issues)
prepared by the World Bank
for Ms. Donna Shalala's Visit to India and Vietnam

November 1997

At Mr. Wolfensohn's request, World Bank staff prepared the enclosed briefing information on the Bank's efforts in the public health area in India and Vietnam.

Table of Contents

No general information provided for India.

Incidence and Treatment
of Infectious Diseases

The World Bank Group and Infectious Disease Control in India

1. India has made significant progress in the past several decades in improving the health and well-being of its people: life expectancy has risen to 61 years, and infant mortality has fallen to 74 deaths per 1,000 live births. Despite this, India continues to bear a heavy and disproportionate burden of both communicable and non-communicable diseases, and emerging diseases such as AIDS have begun to affect national and regional epidemiological profiles and priorities. Two million cases of malaria are "recorded" every year. Current estimates indicate that about 2.5 million people are infected with HIV. About 330,000 deaths occur every year due to TB.

2. In addressing these issues, the government has used World Bank assistance to make high-return investments to reduce the burden of the most significant infectious diseases: leprosy, AIDS, tuberculosis and malaria. These have been developed in close partnership with bilateral aid programs, WHO and centers of excellence such as the US Centers for Disease Control. A brief description of IDA-assisted programs follows:

- The National AIDS Control Project, approved in 1992, supports the government's National AIDS Control Program with an IDA credit of US$84 million. The project focuses on metropolitan cities and aims to: promote public awareness and community support; improve blood safety and its use; build capacity for surveillance and clinical management; strengthen control of the transmission of sexually transmitted diseases; and strengthen the management capacity for HIV/AIDS control. The results of the project to date have been mixed, but quite good in Bombay and Madras.

- The National Leprosy Elimination Project, approved in 1993, is financed with an IDA credit of US$85 million. The project aims to eliminate leprosy as a public health problem by the year 2000 by reducing the disease prevalence to 1 per 10,000. The project is reaching out to underprivileged communities and is expected to benefit directly an estimated 4 million people, of which 1.6 million are women. The project is progressing well, and has helped reduce the all-India prevalence rate for leprosy from 19.5 per 10,000 in 1992 to 5.9 per 10,000 in 1996.

- The Tuberculosis (TB) Control Project, financed by an IDA credit of US$142.4 million, was approved in early 1997. The goal of the project is to reduce preventable TB-related illness and deaths by preventing the increase of infectious TB, and the development of drug resistance. The revised approach to be adopted under the project focuses on improved diagnostic methods, cures that reduce the risk of infection, administration of short-course treatment to prevent development of drug resistance, a rigorous system of patient registration and follow-up, and decentralized service delivery to facilitate access for the poor. Project implementation is just beginning.

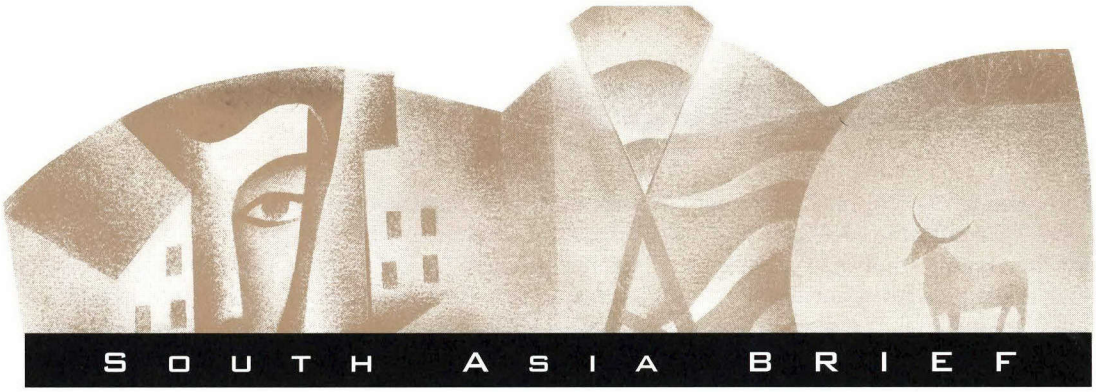
- The Malaria Control Project, for which IDA has provided a credit of US$164 million, aims to improve activities of the national program for more effective malaria control through a more balanced and appropriate package of interventions. These include better-integrated early detection and treatment; more selective and appropriate use of insecticides; personal protection measures; and epidemic planning and rapid response. Overall, the project would directly benefit approximately 210 million people at risk of malaria. This project, too, is just beginning.

3. The control of communicable diseases will continue to be an important priority for IDA. The immediate pipeline includes a second AIDS control project and a disease surveillance project.

SECTOR

BRIEF

India



The World Bank Group and Health Sector Development and Disease Control in India

India has made significant progress in the past several decades in improving the health and well-being of its people. Over the past 40 years, life expectancy has risen by 17 years to 61 years, and infant mortality has fallen by more than two-thirds to 74 deaths per 1,000 live births.

Despite these significant strides, the country continues to bear a heavy burden of both communicable and non-communicable diseases. Furthermore, India is experiencing a slow epidemiological evolution from infectious and parasitic diseases to non-communicable diseases. Also, the emergence of AIDS has begun to affect national and regional epidemiological profiles and priorities.

India's health sector faces several key issues: respective roles of the public and private sectors, budget and resource allocation, management of health services, quality of care, and work force. The Union and state governments are addressing these issues, and the country has embarked on a series of programs to adjust its health strategies, technical paradigins, and appropriate technology, and to improve the performance of its health programs.

Since 1991, the World Bank Group has significantly increased its emphasis on health sector development in India. The Bank has been working to help India reduce the level of mortality, morbidity, and disability through a three-pronged approach. The first is to reduce the burden of the most significant diseases by supporting priority programs with positive externalities. The second is to strengthen the performance of state health systems to deal with the evolving burden of disease by providing more efficient and effective health care. The third is to strengthen essential functions such as food and drug administration capacities.

The Bank has also collaborated with the World Health Organization (WHO) and other centers of excellence such as the United States Centers for Disease Control and Prevention, the United States National Institutes of Health, and bilateral agencies in strategy development, technical matters, peer review, project design, and program monitoring.

Through projects to control the spread of AIDS, leprosy, cataract blindness and tuberculosis—and a future project to control malaria—the Government of India is seeking to reduce the burden of the most significant endemic diseases with World Bank Group assistance focusing on high-return investments.

Through two Bank Group-assisted projects to support state health systems, the government has also sought to help states improve their health policy environment and access to and quality of services, with particular attention to building institutional capacity, the first-referral level, and services for the poor. This will help establish sustainable health systems that focus on cost-effective programs, and also make sufficient use of the private sector.

In the future, the priority will continue to be developing effective and sustainable health systems that can meet the dual demands posed by the growth in non-communicable diseases and peoples' needs for better quality and higher levels of health care.

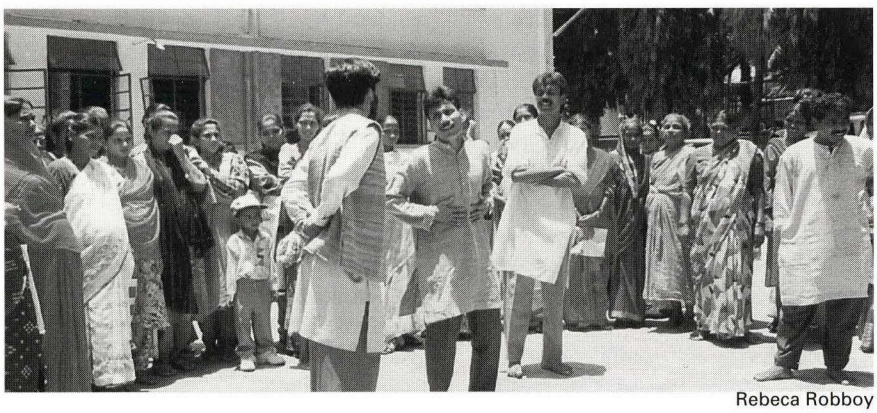
ONGOING WORLD BANK-ASSISTED HEALTH OPERATIONS

There are five ongoing projects with the Union and state Ministries of Health and Family Welfare. Three are aimed at critical diseases that constitute current and future burdens on India's health care system, and two are aimed at strengthening the health care system at the state level.

The **National AIDS Control Project**, approved in 1992, supports the government's strategy to initiate a National AIDS Control Program with an IDA credit of US$84 million. The project is a start-up investment intended to launch expanded preventive

activities to control HIV transmission. This initial investment will set the stage to mobilize support and assistance from various internal and external sources.

The project focuses on metropolitan cities and aims to: promote public awareness and community support; improve blood safety and its use; build capacity for surveillance and clinical management; strengthen control of sexually transmitted diseases; and strengthen the management capacity for HIV/AIDS control. Under the project, regulations have been promulgated to upgrade condom specifications,



Rebeca Robboy

Healthcare workers use traditional street plays to communicate health messages.

and policies calling for humane treatment of people with HIV/AIDS were developed.

The **National Leprosy Elimination Project**, approved in 1993, is financed with an IDA credit of US$85 million. The aim of the project is to expand the coverage of the National Leprosy Eradication Program and enhance its effectiveness in preventing disability. Ultimately, the project aims to enable India to eliminate leprosy as a public health problem by the year 2000 by reducing the disease prevalence to 1 per 10,000.

The project is reaching out to underprivileged communities and is expected to benefit directly an estimated 4 million people, of which 2.4 million live below the Government of India's poverty line and of which 1.6 million are women. The project is progressing well and has helped reduce the all-India prevalence rate for leprosy from 19.5 per 10,000 in 1992 to 5.9 per 10,000 in 1996.

The **Blindness Control Project**, financed with an IDA credit of US$117.8 million, was approved in 1994. The project's key objectives are to: improve the quality of cataract surgery; expand service delivery to underserved populations; and reduce the backlog of cataracts by more than 50 percent and incidence by 30 percent in seven selected states: Uttar Pradesh, Madhya Pradesh, Andhra Pradesh, Rajasthan, Maharashtra, Tamil Nadu, and Orissa.

The project, which involves both NGOs and the private sector, is working to enhance the quality of service and expand service delivery through new strategies, increased use of modern surgical techniques, and expanded coverage to rural and isolated people. It is also developing skills for eye care by strengthening selected training institutions, upgrading skills of ophthalmic and health personnel, and providing management training to project managers. The project also promotes outreach activities and public awareness through NGOs and community organizations, and is strengthening key institutions at the central, state, and district levels.

In the first two years of the project, the number of surgeries increased by 23 percent. Between July 1995 and June 1996 alone, 1.49 million surgeries were financed under the project; about 60 percent of these operations were performed by or with inputs from NGOs.

The **Andhra Pradesh First-Referral Health Systems Project** was also approved in 1994, and is financed with an IDA credit of US$133 million. The project aims to help the Government of Andhra Pradesh improve efficiency in allocation and use of health resources through policy and institutional development, and improve the quality, effectiveness, and coverage of secondary-level health care to serve better the neediest people.

Ultimately, the aim is to improve the health status of the people of Andhra Pradesh, especially the poor and underserved, by reducing mortality, morbidity and disability. The project has also served as a model that can be replicated to reorient the health system in other states in India.

The project in Andhra Pradesh set the stage for the **State Health Systems II Project**, approved in 1996 and financed by an IDA credit of US$350 million. The project aims to help the Governments of Karnataka, Punjab, and West Bengal put in place a coherent approach to integrating a basic package of preventive and curative health care services.

The project has three main activities. First, it will strengthen health care institutions and their ability to deliver services, develop health care policy, and develop surveillance

capacity for major communicable diseases and response capabilities.

Second, it will improve service quality, access, and effectiveness at the first-referral level by upgrading community, subdivisional, and district hospitals. It will also upgrade the effectiveness of clinical and support services, improve the referral mechanism, and strengthen linkages with the primary and tertiary health care levels.

Third, the project will improve access to primary health care in remote and underdeveloped areas.

In addition to benefiting indirectly the states' populations as a whole through the provision of better quality health services, the project will benefit directly approximately 10 million out-patients and 700,000 in-patients currently using existing hospital services. By expanding access to health care, the project will benefit an estimated additional 5.2 million new out-patients and 800,000 new in-patients. Broader sectoral reforms envisaged by the project will increase the efficiency and lead to substantial cost savings in each state.

A large proportion of project beneficiaries are from poor and vulnerable segments of the states' populations. The project also targets tribal populations and promotes a life-cycle approach to women's health.

The **Tuberculosis (TB) Control Project**, financed by an IDA credit of US$142.4 million, was approved in early 1997. The project represents a significant step for India—a country that carries 30 percent of the world's tuberculosis burden—as it introduces a new technical approach, customized to meet India's unique situation.

The revised approach focuses on improved diagnostic methods, cures that reduce the risk of infection, administration of short-course treatment to prevent development of drug resistance, a rigorous system of patient registration and follow-up, and decentralized service delivery to facilitate access for the poor.

The Indian Ministry of Health and Family Welfare first tested this revised approach through pilot projects financed by the Bank in 15 rural and urban sites, curing more than 15,000 patients over a period of 16 months, for a very successful 80 percent cure rate.

Drug manufacturers were also given the opportunity from the beginning of project preparation to gear up to meet future demands based on new, widely accepted technical requirements, and special provisions were introduced in the project to encourage private physicians in India to adopt the new standards for TB control.

The project finances the National TB Control Program over five years to strengthen the program nation-wide and set up the institutional and managerial infrastructure needed to expand the government's revised strategy for TB control to the entire country within 8-12 years.

The goal of the project is to reduce preventable TB-related illness and deaths due to TB by preventing the increase of infectious TB, the annual risk of infection, and the development of drug resistance. It is expected that at least 1.9 million TB cases will be diagnosed and treated, that at least 85 percent of the cases covered under the revised strategy will be cured, and that 850,000 TB patients will be treated with short-course chemotherapy and 230,000 with conventional drugs.

Future Operations

The government is now preparing a project for **Malaria Control** for which IDA will provide a credit of about US$164 million. The proposed project aims to improve activities of the national program for more effective malaria control through a more balanced and appropriate enhanced package of interventions such as: better-integrated early detection and treatment; more selective and appropriate use of insecticides; personal protection measures; and epidemic planning and rapid response.

Overall, the project would directly benefit approximately 210 million people at risk of malaria.

The government is also preparing a project for **Capacity Building for Food and Drug Quality Control**, which would be financed by an IDA credit of about US$150 million. The main purpose of the project is to strengthen essential public health functions with a focus on promoting consumer protection and quality control in food and drugs.

The proposed project would consist of incremental investments to strengthen:

- quality control of drugs, including augmenting drug and pharmaceutical testing facilities, providing additional inspection and technical staff, and strengthening the information flow;
- food quality control and safety, including augmenting food-quality testing facilities, establishing a national food control information system, promoting consumer awareness, developing advisory services, enhancing field operations, and training and developing personnel to analyze, inspect, and manage food quality control; and
- management and storage of pharmaceutical supplies, research institutions, disease surveillance pilot operations, and sectoral policy development.

The Bank Group and the Government of India are also in the initial stages of discussion for a third **State Health Systems Project**, which would be carried out in two or three states and financed by an IDA credit of about $300 million. The project would be similar to State Health Systems II in the sense that it would target investments at the first-referral and primary level of health care and address key policy issues at that level. The project would emphasize:

- enhancing efficiency in the allocation and use of health resources through policy and institutional development; and
- improving the performance of the health care system in the specific states through improvements in quality, effectiveness, and coverage at the primary and secondary levels of health care.

Research and Analysis

India: Policy and Finance Strategies for Strengthening Primary Health Care Services was published in May 1995. It reviews some of the key constraints to the efficient provision of health care and offers several key recommendations:

- The roles of the public and private sectors in financing and providing primary health care services need to be rethought, and a strategy needs to be developed that takes into consideration the existing levels of private provision of services.
- Financing priorities for public expenditures on health need to be reevaluated, expenditures on primary health care and supplementary central funding to needy states need to be increased, and resources need to be mobilized through innovative financing.

India: New Directions in Health Sector Development at the State Level: An Operational Perspective covers the recent experience of Andhra Pradesh, Karnataka, Punjab, and West Bengal in health sector development. The report makes several specific recommendations for health sector policy and institutional development needed to increase the effectiveness of health systems and to harness the private sector, which accounts for 78 percent of overall health spending in India:

- Reorient health care strategy to integrate a need-based approach with the population-size-based approach, rationalize service norms based on demand for services to address problems of duplication in service delivery, and update technical approaches to strengthen program effectiveness.
- Improve coordination of public and private sectors by increasing private participation, strengthening linkages between the government and NGOs, and expanding the government's capacity to monitor and regulate private health care provision.
- Strengthen state financing of health care by developing budgeting and fiscal tools, and by providing supplementary finance.
- Increase and prioritize state expenditures on health.
- Implement cost-recovery mechanisms.
- Improve the analytical basis for decision-making, including developing an institutional capacity for health sector planning.
- Strengthen public sector management of health care by strengthening overall management authority, and by enhancing the capacity of and increasing coordination among administrative agencies and public health care providers.

Plans are beginning to be implemented in several states with the support of the Bank through high-level policy dialogue, extensive sector work, lending, and strategic workshops to harness the private health sector. These include:

- expanding the scope of the private sector where it has a comparative advantage, such as tertiary health care, and superspeciality and support services;
- increasing the contracting-out of specific publicly provided services to the private sector where economically attractive and administratively feasible, such as support services and limited mainstream diagnostic and clinical services;
- promoting the private and NGO sectors to participate in preventive and promotive services and in underserved areas;
- encouraging the private sector to adopt appropriate therapeutic norms and regimens recommended by the national programs for specific diseases; and
- expanding the government's capacity to monitor, register and certify private health care with regard to resources, provision and practices.

For more information, please contact:

In Washington: Rebeca Robboy: (1-202) 473-0669 e-mail: Rrobboy@worldbank.org
In New Delhi: Geetanjali Chopra: (91-11) 461-7241 e-mail: Gchopra@worldbank.org

The World Bank Group and Maternal and Child Care and Women's Health in India

1. India was among the first developing nations to recognize the threat rapid population growth poses to national development and to adopt policies to address the problem. Its Family Welfare Program, launched in 1951, has contributed significantly to improving the health of mothers and children and to providing family planning services. In addition, improved household food security and an expanding primary health care system have brought about impressive gains in women's health status. However, women in India continue to be relatively disadvantaged in matters of survival, health, nutrition, literacy and productivity. India is one of the few countries where males significantly outnumber females: the sex ratio was 929 females for every 1,000 males in 1991. Maternal deaths remain high at 437 per 100,000 live births, and the total fertility rate is as high as four or more per woman in the poorer northern states of the Hindi-speaking belt.

2. The government provides a variety of services to address the needs of women, and the Bank Group has supported these initiatives, particularly in the areas of reproductive and child health (RCH) and nutrition. Between 1972 and 1986, four population projects totaling about US$188 million were approved. Since then, the volume of lending has been stepped up to about US$900 million, with the approval of five population projects, a Child Survival and Safe Motherhood project, and an RCH project, with four projects and about US$350 million still outstanding. The aim of the earlier projects was to strengthen the capacity of the government's family welfare program to deliver better quality population control services more equitably. Over the last few years IDA has assisted the government to move toward an RCH approach. This approach provides an essential package of services that facilitates people in regulating their own fertility, women in undergoing pregnancy and childbirth safely, successful outcomes of pregnancy in terms of maternal and infant survival and well-being, and couples having sexual relations without the fear of pregnancy or disease.

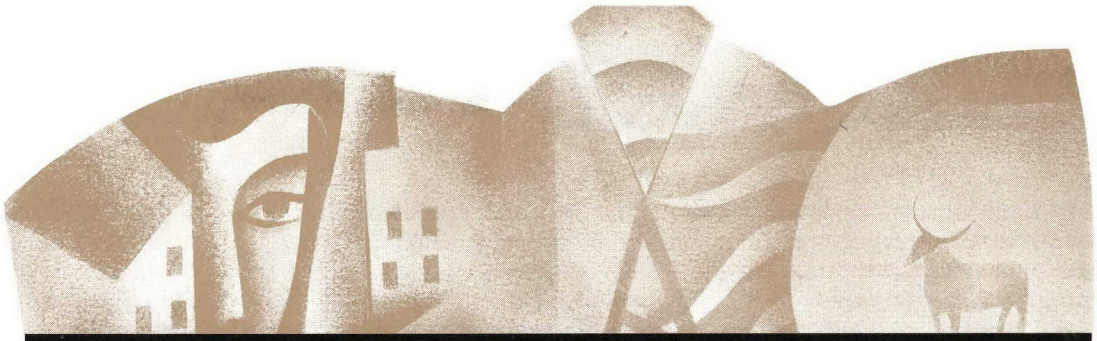
3. Working with Indian nutrition and early childhood development programs, the Bank has helped India to better target its nutrition efforts, improve family nutrition and health practices, and strengthen maternal and child health services. The Tamil Nadu Integrated Nutrition Project I (TINP I) provided an IDA credit of US$32 million to improve the nutritional status of pre-school children and pregnant and nursing women. It was successfully completed in 1989, and evaluations indicate that the project cut severe malnutrition in half and prevented many at-risk children from becoming malnourished. A second Tamil Nadu nutrition project (TINP II), approved in 1990, provides an IDA credit of US67.5 million to extend the project to the entire state. The Integrated Child Development Services (ICDS) Project, approved in 1991, is financed with an IDA credit of US$74.3 million. The project has succeeded in increasing the outreach of nutrition, health and education services to pregnant women and children under 3 years old. An IDA credit of US$194 million was approved in 1993 for the ICDS II project. A new project, the Women and Child Development Project, is now being appraised, which seeks to improve the health and nutrition of children 0-6 years old and pregnant and nursing women.

4. IDA will continue to support India's need to prevent and manage unwanted fertility, improve women and children's health and raise the nutritional levels of its population. A second Reproductive and Child Health project is planned to help the government to consolidate its move to a client-oriented, needs-based approach. A Nutrition Program Review has been initiated, which will provide a valuable basis for taking forward the dialogue between IDA and GOI on the issue of food security and nutrition and their links to education and health.

SECTOR

BRIEF

India



SOUTH ASIA BRIEF

The World Bank Group and Population and Reproductive and Child Health in India

India was among the first developing nations to recognize the threat rapid population growth poses to national development and to adopt policies to address the problem. Its Family Welfare Program, launched in 1951, has contributed significantly to improving the health of mothers and children and to providing family planning services.

Forty-six percent of eligible couples now use some form of contraception, fertility has declined by about two-fifths, and immunization coverage of children is approaching 80 percent. However, maternal deaths remain high at 437 per 100,000 live births, and the total fertility rate, while below replacement level in the states of Kerala and Goa, is as high as four or more children per woman in the poorer northern states of the Hindi-speaking belt.

India's continued high fertility rate, combined with a two-thirds drop in the death rate and a doubled life expectancy, have resulted in substantial population increases, from 342 million in 1947, to 684 million in 1981, to 931 million people today. Each year, 16 million people are added to the population and by 2050, India's population is projected to reach 1.5 billion.

Slow progress in the 1980s made it essential for India to devise innovative strategies to achieve greater dynamism in its Family Welfare Program. In the early 1990s, the Government of India began a paradigm shift from a system based on contraceptive method-specific and fertility reduction targets and monetary incentives to a broader system of performance goals and measures designed to encourage a wider range of reproductive and child health services. The Ministry of Health and Family Welfare developed an action plan to strengthen the program and made several recommendations consistent with the reproductive and child health approach.

This approach, which was adopted by the Government of India when it initiated the Child Survival and Safe Motherhood Program in 1992, is also central to the new vision of population policy that emerged from the 1994 Cairo International Conference on Population and Development. Reproductive health refers to a state in which people can reproduce and regulate their fertility, women go through pregnancy and childbirth safely, the outcome of pregnancy is successful in terms of maternal and infant survival and well-being, and couples are able to have sexual relations free of the fear of pregnancy and disease.

In its transition to this approach, India is taking careful account of the links between family welfare and other health services. More emphasis is now placed on the private and voluntary sectors as they develop in the increasingly dynamic Indian economy.

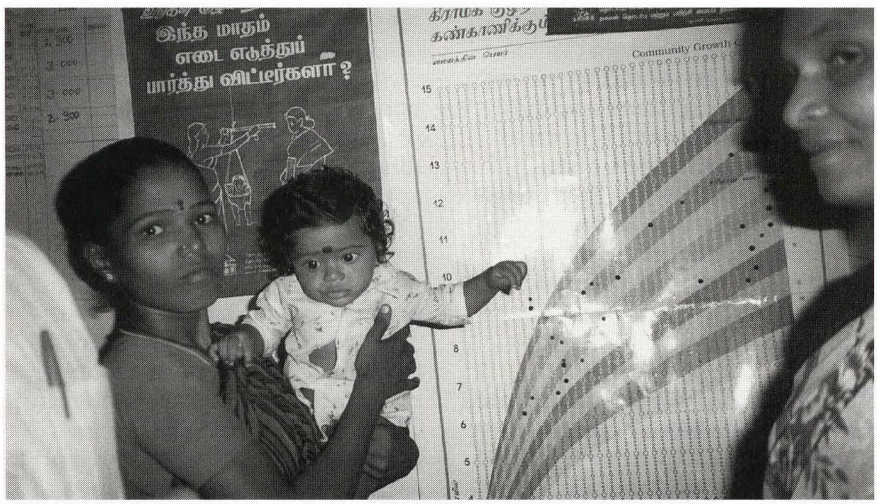
World Bank Group assistance to India's efforts in population and reproductive and child health (RCH) dates back to the earliest days of Bank involvement in the population sector. Between 1972 and 1986, four population projects totaling about US$188 million were approved. Since then, Bank Group-Government of India collaboration has been stepped up, with approval of five more population projects and a Child Survival and Safe Motherhood (CSSM) Project totaling about US$645 million, and preparation of a Reproductive and Child Health Project for some US$248 million. The objective of each of these projects has been to strengthen the capacity of the family welfare and health systems to deliver better quality services more equitably.

The development of this lending program has been based on a number of analytical efforts and on a continuous dialogue between the Bank Group and the Government of India, which has allowed the Bank to support India's transition to a reproductive and child health approach. The Bank has focused an increasing share of its attention on those features of the Family Welfare Program that constrain it from being more effective, including reorienting management focus from contraceptive targets to client-responsive quality service.

The Bank Group also continues to emphasize assistance to the national immunization program, programs in safe motherhood, and the control of acute respiratory infections and diarrheal disease.

Completed World-Bank Assisted Operations

The **First Population Project** (1972-80) was financed by an IDA credit of US$21.2 million and a grant from the Swedish International Development Authority. The project supported the Family Welfare Program in five districts in the state of Karnataka and six districts in the state of Uttar Pradesh. The project was essentially an experimental demonstration project intended to test the efficacy of various program activities, and to develop ways for attaining better performance of the national program.



Rebeca Robboy

Monitoring child health.

The project experience indicated ways subsequent World Bank support of the Family Welfare Program could be improved, and was the foundation for the government's subsequent accelerated program of family planning and maternal and child health. Also, the two population centers established under this project have carried out a variety of research.

The **Second Population Project** (1980-88) was supported by an IDA credit of US$46 million. The project assisted the Family Welfare Program in six districts of eastern Uttar Pradesh and three districts in the state of Andhra Pradesh. The project was part of a government effort to obtain external assistance to strengthen the Family Welfare Program in underprivileged districts of selected states.

The project gave further support for the integration of family planning and mother and child health care services, emphasized the importance of generating demand for services and, as in all subsequent projects, stressed the increased use of temporary contraceptive methods and gave substantial support for the construction of basic health facilities. An estimated 22.7 million women and children benefited from strengthened family welfare services provided under the project.

The **Third Population Project** (1984-91) was financed by an IDA credit of US$70 million. It too was implemented in underprivileged districts–six districts of northern Karnataka and four districts of the state of Kerala. Project impact was particularly notable in Kerala, where project support helped bring program implementation in the underprivileged project districts up to the much higher standard already achieved in the rest of the state. In Kerala project districts, contraceptive use has increased and, on average, immunization of children has risen from about 28 percent to about 78 percent. Overall, approximately 18 million women and children in the 10 project districts were reached by the project-assisted family welfare program.

The **Fourth Population Project** (1986-94) was supported by an IDA credit of US$51 million and was implemented in West Bengal. In the four districts where facility construction was supported by the project, program implementation benefited more than 12 million women and children. The project emphasized maternal and child health. A comparison of fertility, mortality, and infant mortality rates between the pre-project year of 1984 and 1992 indicates substantial progress in these three vital indicators.

During the course of the project, the birth rate in West Bengal declined from 30.4 to 24.6 per 1,000, the death rate from 10.7 to 8.3 per 1,000, and the infant mortality rate from 82 to 64 per 1,000 live births. There was also very good progress in the share of couples using modern contraception, which improved from 33 to 52 percent. State-wide support for program management information, communications, and training components had a positive effect on the implementation and impact of West Bengal's family welfare program in general.

The **Fifth Population Project** (1988-96), financed by an IDA credit of US$57 million, supported the National Family Welfare Program in the municipalities of Bombay and Madras, and was

extended to other urban areas in the states of Maharashtra and Tamil Nadu. The main goal was to improve the service delivery and outreach systems of family welfare services in urban slums. Innovative features included support for involvement of non-governmental organizations (NGOs) and private medical practitioners in carrying out the Family Welfare Program. The project met its service delivery objectives and benefited some 2.5 million poor women and children in slum areas.

The **Child Survival and Safe Motherhood Project** (1991-96), financed by an IDA credit of US$214.5 million, supported the enhancement and expansion of the Maternal and Child Health (MCH) component of the National Family Welfare Program. It was national in scope, with emphasis on districts where maternal and infant mortality rates were higher than the national average.

The project's specific objectives were to enhance child survival, reduce maternal mortality and morbidity rates, and increase the effectiveness of service delivery by supporting:

- child survival programs including the Universal Immunization Program, diarrhea control programs, and the control of acute respiratory infections;
- a Safe Motherhood Initiative to improve ante-natal and delivery care for all pregnant women and to identify high-risk pregnancies; and
- institutional systems development, including improving and expanding training programs for family welfare workers, education and communication, and management information.

More than 42 million women and children benefited annually from the services provided.

Ongoing World Bank-Assisted Operations

The **Sixth Population Project**, approved in 1989, provides assistance through an IDA credit of US$124.6 million. The project supports improvements in the efficiency and effectiveness of the delivery of family welfare services in the rural areas of the states of Andhra Pradesh, Madhya Pradesh, and Uttar Pradesh. The project has established a well-regarded and systematic program of in-service training and a training culture focused on improving performance of workers and an increased awareness of how to monitor and improve the quality and effectiveness of training.

Three state institutes of health and family welfare, 18 regional training centers, 91 district centers/teams, and 23 field practice demonstration areas have been established and are conducting regular in-service training; 23 basic auxiliary nurse midwife (ANM) training schools have also been strengthened. In addition, 1,620 sub-centers with ANM residence have been constructed, equipment and furniture have been provided to sub-centers, and primary health centers and delivery kits have been provided to traditional birth attendants.

Overall, it is estimated that up to 40 million rural households in the three project states are benefiting from program improvements achieved with project support.

The **Seventh Population Project**, which supports the National Family Welfare Program in the states of Bihar, Gujarat, Haryana, Jammu & Kashmir, and Punjab, through an IDA credit of US$81.6 million, was approved in 1990. This project, which also has a special training focus, is similar to the Sixth Population Project. At least 22 million families in the rural areas of the project states will ultimately benefit from project-assisted improvements in the quality and coverage of program services.

Since the project began in 1991, rates of sterilization and use of IUDs, oral pills, and conventional contraceptives have been steadily rising. Systematic and regular in-service training for family welfare workers has also been established.

The **Eighth Population Project**, financed through an IDA credit of US$79 million, became effective in May 1994. The project supports the improvement of family welfare services in the slum areas of Bangalore, Calcutta, Delhi, and Hyderabad. It focuses on the reduction of fertility as well as maternal and infant mortality rates among people living in urban slums by improving the outreach of family welfare services, upgrading the quality of family welfare services, expanding the demand for health services through expanded information, education and communication activities, and improving the administration and management of municipal health departments.

The Ninth Population Project, which became effective in September 1994, is being implemented in three states–Assam, Karnataka, and Rajasthan–and is financed through an IDA credit of US$88.6 million. The project supports improved access to, demand for, and quality of family welfare services, particularly among poor, remote, and tribal peoples.

The project aims to:

- strengthen family welfare service delivery, including establishment of first-referral units;
- improve the quality of family welfare service;
- strengthen demand-generation activities through improved information, education, and communications planning and activities;

- strengthen program management and implementation capacity; and
- provide funds for innovative schemes to improve service delivery.

Future Operations

Building on a major analysis done collaboratively by the World Bank and Government of India, and recent Indian program developments, the Indian government is preparing a **Reproductive and Child Health (RCH) Project**, which would support the National Family Welfare Program in improving the health status of women and children, especially the poor and underserved. An essential package of reproductive and child health services is integral to the project approach.

The project would include two major components:

- a nation-wide policy reform package, covering monitoring and evaluation, institutional strengthening, and service delivery; and
- a local capacity enhancement component that would fund district and city sub-projects aimed at meeting specific needs of local priority groups.

The project is expected to be approved in mid-1997, and would be financed with an IDA credit of about US$248 million.

Research and Analysis

Two major studies, ***Improving Women's Health in India*** (1996) and ***India's Family Welfare Program: Moving to a Reproductive and Child Health Approach*** (1995), provide background for the Bank Group's discussions with the Indian government on further developing public, voluntary, and private sector capacity to address needs of the Family Welfare Program and health problems of India's women. The former was published as part of the Bank's *Directions in Development* series and the latter was published as part of the Bank's *Development in Practice* series.

Both studies build on an earlier study entitled ***Family Welfare Strategy in India: Changing the Signals*** (1990). Taken together, these studies provide support for the important steps the government has taken in moving away from a target-driven, demographic approach emphasizing female sterilization, toward a client-centered approach that helps people meet their broader health and family planning goals.

Improving Women's Health in India provides a comprehensive overview both of women's health issues and the government's programs to improve them. Despite considerable progress, the report argues that India still has a large, unfinished agenda in the areas of reproductive and child health. The report emphasizes women's reproductive health and the factors underlying excess female mortality at early ages, especially in the northern "Hindi belt" states of Bihar, Rajasthan, Madhya Pradesh, and Uttar Pradesh. These states account for almost 40 percent of India's population and exhibit well-documented unfavorable demographic trends compared with the rest of India.

The book also points out the needs of women in rural areas where mortality levels are substantially higher than in urban areas and access to care is limited. Its focus is on the measures necessary to address existing policy and implementation constraints and improve the quality, acceptability, and use of services essential to women's health. Further progress and more resources are needed.

In 1994, the Cairo Conference formalized a growing international consensus that improving reproductive health, including family planning, is essential to human welfare: reducing unwanted pregnancies safely and providing high-quality health services both satisfies the needs of individuals and stabilizes the population.

This perspective, strongly supported by the Government of India in its Program of Action in the India Country Report prepared for the Cairo Conference, led to a major piece of collaborative analytical work with the World Bank Group entitled ***India's Family Welfare Program: Moving to a Reproductive and Child Health Approach***. The report identifies the major constraints on India's Family Welfare Program and recommends ways in which these constraints might be overcome. In addition, it discusses an "Essential Reproductive Health Package" designed to provide a cluster of recommended reproductive health services directed primarily at the needs of actual and potential patients. The Reproductive and Child Health Project was based partly on this work.

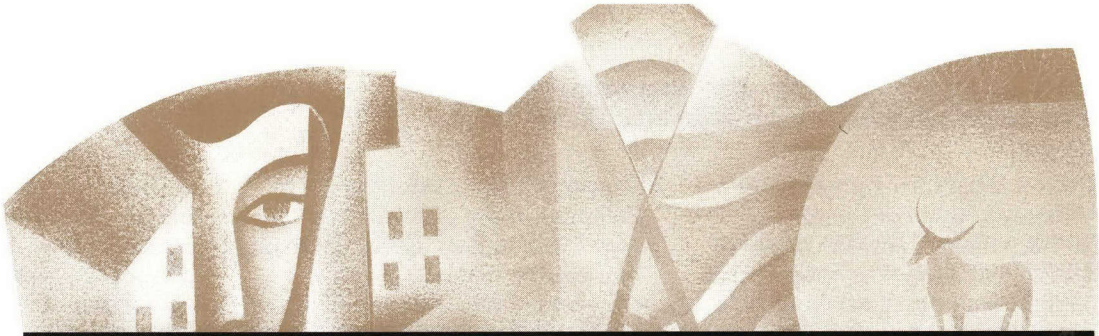
For more information, please contact:

In Washington: Rebeca Robboy: (1-202) 473-0669 e-mail: Rrobboy@worldbank.org
In New Delhi: Geetanjali Chopra: (91-11) 461-7241 e-mail: Gchopra@worldbank.org

SECTOR

BRIEF

India



SOUTH ASIA BRIEF

The World Bank Group and Nutrition in India

The World Bank Group has supported nutrition efforts in India through two Tamil Nadu Integrated Nutrition (TINP) projects and two Integrated Child Development Services (ICDS) projects.

In conjunction with the TINP projects, the Bank Group has helped India to better target its nutrition programs, improve family nutrition and health practices, and strengthen maternal and child health services.

Through the ICDS projects, the Bank Group has helped the government address malnutrition, health, and pre-school education among India's poorest children and pregnant and nursing women. And, the Bank Group has worked closely with UNICEF to help address specific micronutrient deficiencies through the recently completed Child Survival and Safe Motherhood Project. Today, India accounts for the largest volume of Bank Group lending devoted specifically to nutrition programs.

Despite India's substantial progress in raising the nutritional status of its people, the challenge of malnutrition will be with India for many years to come. Malnutrition consists of deficiencies in both proteins and micronutrients; in India, it is highest among scheduled castes and scheduled tribes.

According to India's National Family Health Survey (1992-93), the proportion of children under 4 years old with moderate and severe malnutrition was close to 60 percent in a number of states, including Bihar, Uttar Pradesh, Madhya Pradesh, and West Bengal. In 1992-93, it was estimated that slightly more than half of children under 4 years old are undernourished according to weight and height for age. The consequence of such malnutrition is lowered potential for physical and mental development and greater susceptibility to disease.

The Bank's main objective in assisting the Government of India in nutrition is to help the central and selected state governments adopt policies, strategies, and cost-effective programs to deal with the nutrition problems of pre-school children (particularly those under 3 years old) and pregnant and nursing women.

In the future, the principal challenge will continue to be developing and putting in place an effective, efficient, and sustainable approach to reducing malnutrition and fostering early childhood development.

Completed World Bank-Assisted Nutrition Operations

An IDA credit of US$32 million for the first **Tamil Nadu Integrated Nutrition Project (TINP)** was approved in 1980 and the project was successfully completed in 1989. Its overall goal was to improve the nutritional and health status of pre-school children, primarily those 6-36 months old, and pregnant and nursing women. The project provided a package of services: nutrition education, primary health care, supplementary on-site feeding of children who were severely malnourished or whose growth was faltering, education for diarrhea management, administration of vitamin A, periodic deworming, and supplementary feeding of a limited number of women.

This project marked the first large-scale use of growth monitoring in India, through monthly weighing of all children 6-36 months old, to target delivery of these nutrition and health services to needy children, and to educate mothers.

Under this project, some 9,000 community nutrition centers and 2,000 new health sub-centers in 173 of Tamil Nadu's 373 rural blocks were established. Local participation in the project and project coverage were high, and an effective program of mass and interpersonal communications, particularly at the village level, was established.

The project cut severe malnutrition in half and prevented many at-risk children from becoming malnourished. The key to TINP's success was the great care taken in planning and executing process elements, including careful selection and training of community nutrition workers, heavy emphasis on intensive and supportive supervision, and efforts to gain community support. TINP today provides perhaps the largest longitudinal data base on child growth and health in the developing world, and lessons learned from this project were incorporated into the design of TINP II.

Ongoing World Bank-Assisted Nutrition Operations

The **Tamil Nadu Nutrition II (TINP II) Project** extends the successful Tamil Nadu pioneer

project from the original 9,000 villages to most of the state's 20,000 villages. An IDA credit of US$95.8 million was approved in 1990 in support of this project; the credit amount has since been revised to US$67.5 million.

The project aims to:

- increase the range, coverage, and quality of nutrition and health services;
- improve child feeding and care practices;
- promote community involvement, including support for formation of women's groups and community education; and
- upgrade project management and evaluation.

More than 5 million children under 6 years old and 2 million pregnant and nursing women benefit directly from the project's services.

The **Integrated Child Development Services (ICDS) Project,** approved in 1991, is financed with an IDA credit of US$74.3 million–revised from US$96 million. The project supports India's ongoing ICDS Program and focuses on improving the nutrition, health, and pre-school education status of tribal, drought-prone, and otherwise disadvantaged people in Andhra Pradesh and Orissa.

About 5 million pre-school children and about 3 million pregnant and nursing women directly benefit from the project's nutrition and health services. The project has succeeded in increasing the emphasis on reaching pregnant women and children under 3 years old, especially in Andhra Pradesh.

An IDA credit of US$194 million for the **ICDS II Project** was approved in 1993. This project supports India's ongoing ICDS Program in the states of Bihar and Madhya Pradesh. The project seeks to meet the needs of India's poorest people, many of whom are tribal, by improving the nutrition, health, and pre-school education status of children under 6 years old (with special emphasis on children 0-3 years old), and the nutrition and health status of pregnant and nursing women.

Rebeca Robboy

Future Operations

A new project, **Woman and Child Development,** is now being prepared which aims to help the Indian government develop a more effective, efficient, and sustainable approach to reducing malnutrition and fostering early childhood development. The project seeks to:

- improve the health, nutrition, and psychosocial status of children 0-6 years old, with particular emphasis on preventing malnutrition in those under 3 years old; and
- improve the health and nutrition of women, particularly pregnant and nursing mothers.

In addition, the project seeks to improve child care practices and would include efforts to enhance women's development and their ability to address issues of malnutrition at the household level. Finally, the project would strengthen the capacity at central, state, and block levels to provide high-quality training and support to functionaries of India's ICDS program. It is expected that five states will participate in the project. The project approach would vary substantially among states, depending on their needs, the status of their existing programs, and their preferences.

Research and Analysis

Several analytical studies provide the basis for the Bank Group's involvement in nutrition in India. Among the most important is ***Improving Nutrition in India*** (1990), which identifies the priority target populations and geographical areas for nutrition interventions, analyzes effectiveness of various responses to the nutrition problem, and discusses outstanding nutritional issues. The study concludes that:

- There are wide variations in malnutrition across regions, age, and social groups, and by gender;
- Direct nutrition expenditures have been modest and not always sensitive to variations in malnutrition; and
- There is scope to improve the productivity of expenditures by strengthening and reorienting existing programs and by reducing mismatches between expenditures and distribution of need.

Overall, the study argues for the need to strike a proper balance among needs, potential demand, and available resources.

May 1997

For more information, please contact:

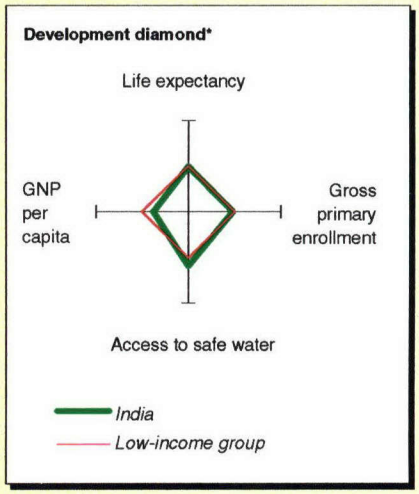
In Washington: Rebeca Robboy: (1-202) 473-0699 e-mail: Rrobboy@worldbank.org
In New Delhi: Geetanjali Chopra: (91-11) 461-7241 e-mail: Gchopra@worldbank.org

Basic Socio-Economic
Indicators

India at a glance

11/7/97

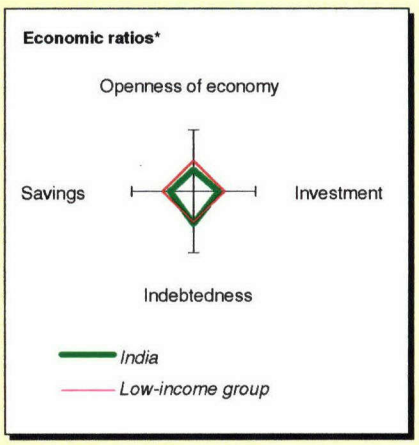
POVERTY and SOCIAL	India	South Asia	Low-income
Population mid-1996 *(millions)*	943.2	1,264	3,229
GNP per capita 1996 *(US$)*	380	380	500
GNP 1996 *(billions US$)*	358.4	481	1,601
Average annual growth, 1990-96			
Population *(%)*	1.7	1.9	1.7
Labor force *(%)*	2.0	2.1	1.7
Most recent estimate *(latest year available since 1989)*			
Poverty: headcount index *(% of population)*	35	..	..
Urban population *(% of total population)*	27	26	29
Life expectancy at birth *(years)*	62	61	63
Infant mortality *(per 1,000 live births)*	68	75	69
Child malnutrition *(% of children under 5)*	63	..	..
Access to safe water *(% of population)*	63	63	53
Illiteracy *(% of population age 15+)*	48	50	34
Gross primary enrollment *(% of school-age population)*	102	98	105
Male	113	110	112
Female	91	87	98



KEY ECONOMIC RATIOS and LONG-TERM TRENDS

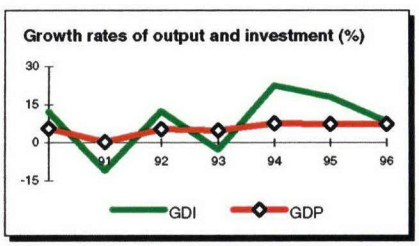
	1975	1985	1995	1996
GDP *(billions US$)*	91.0	214.3	328.3	355.8
Gross domestic investment/GDP	20.8	24.2	26.2	26.5
Exports of goods and services/GDP	6.2	6.0	12.1	12.0
Gross domestic savings/GDP	20.4	21.1	22.7	23.1
Gross national savings/GDP	20.6	21.6	24.2	25.3
Current account balance/GDP	0.0	-2.8	-2.1	-1.2
Interest payments/GDP	0.3	0.6	1.4	1.3
Total debt/GDP	15.1	19.1	28.9	25.2
Total debt service/exports	13.1	22.7	26.9	22.6
Present value of debt/GDP	..	..	22.8	..
Present value of debt/exports	..	..	161.4	..

	1975-85	1986-96	1995	1996	1997-05
(average annual growth)					
GDP	4.2	5.6	7.3	7.5	6.5
GNP per capita	1.9	3.5	5.4	5.2	..
Exports of goods and services	3.9	11.5	31.6	7.5	10.3

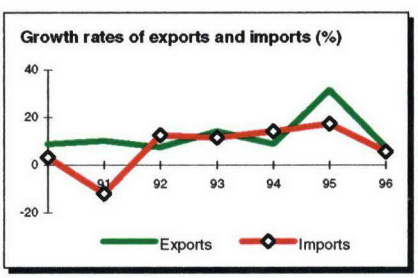


STRUCTURE of the ECONOMY

	1975	1985	1995	1996
(% of GDP)				
Agriculture	40.5	33.0	27.9	27.8
Industry	23.7	28.1	30.1	29.2
Manufacturing	16.7	17.9	19.7	20.1
Services	35.8	38.8	42.1	43.0
Private consumption	70.2	67.8	66.8	66.4
General government consumption	9.4	11.1	10.5	10.5
Imports of goods and services	6.6	9.1	15.6	15.3



	1975-85	1986-96	1995	1996
(average annual growth)				
Agriculture	2.5	3.6	-0.1	5.7
Industry	5.3	6.6	11.6	7.0
Manufacturing	5.5	6.7	13.6	8.1
Services	5.1	6.7	8.8	7.4
Private consumption	4.5	4.8	2.6	6.8
General government consumption	6.5	3.9	5.1	7.2
Gross domestic investment	4.1	7.1	17.9	8.5
Imports of goods and services	9.1	6.0	17.3	5.7
Gross national product	4.1	5.4	7.2	6.7

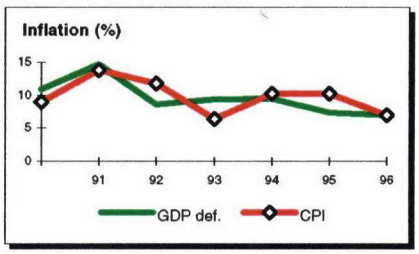


Note: 1996 data are preliminary estimates. All GDP data other than sectoral value-added are in market prices.

* The diamonds show four key indicators in the country (in bold) compared with its income-group average. If data are missing, the diamond will be incomplete.

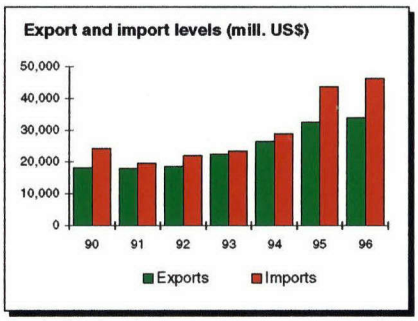
PRICES and GOVERNMENT FINANCE

	1975	1985	1995	1996
Domestic prices				
(% change)				
Consumer prices	..	5.6	10.2	7.0
Implicit GDP deflator	-1.5	7.5	7.3	7.0
Government finance				
(% of GDP)				
Current revenue	..	23.8	24.7	25.2
Current budget balance	..	2.2	1.0	1.3
Overall surplus/deficit	..	-11.0	-10.1	-10.4



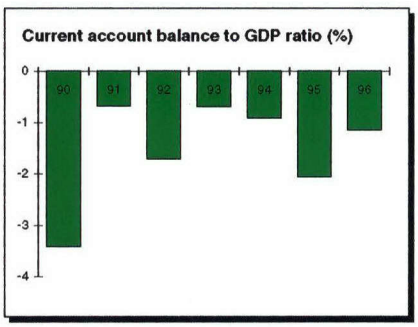
TRADE

	1975	1985	1995	1996
(millions US$)				
Total exports (fob)	..	8,793	32,311	33,638
Tea	..	512	352	290
Iron	..	473	515	484
Manufactures	..	5,640	24,540	24,749
Total imports (cif)	..	15,957	43,670	46,121
Food	..	1,321	1,293	1,359
Fuel and energy	..	4,054	7,526	9,679
Capital goods	..	3,502	4,560	4,513
Export price index *(1980=100)*	..	98	104	103
Import price index *(1980=100)*	..	84	115	116
Terms of trade *(1987=100)*	..	118	90	89



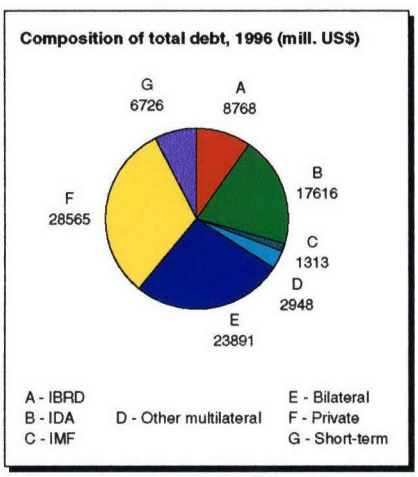
BALANCE of PAYMENTS

	1975	1985	1995	1996
(millions US$)				
Exports of goods and services	5,650	12,773	39,668	42,556
Imports of goods and services	5,990	19,422	51,213	54,431
Resource balance	-340	-6,649	-11,545	-11,875
Net income	-150	-1,552	-3,735	-4,118
Net current transfers	470	2,207	8,506	11,888
Current account balance, before official capital transfers	-20	-5,994	-6,774	-4,105
Financing items (net)	20	6,542	3,050	10,095
Changes in net reserves	0	-548	3,724	-5,990
Memo:				
Reserves including gold *(mill. US$)*	2,065	9,493	21,246	26,160
Conversion rate *(local/US$)*	8.7	12.2	33.5	35.5



EXTERNAL DEBT and RESOURCE FLOWS

	1975	1985	1995	1996
(millions US$)				
Total debt outstanding and disbursed	13,708	40,960	94,858	89,827
IBRD	436	2,396	9,849	8,768
IDA	2,809	9,750	17,499	17,616
Total debt service	822	3,532	13,346	12,667
IBRD	89	313	1,713	1,514
IDA	24	124	357	364
Composition of net resource flows				
Official grants	511	450	345	408
Official creditors	1,260	1,424	-1,048	-163
Private creditors	83	2,277	589	-1,102
Foreign direct investment	85	106	2,133	2,359
Portfolio equity	0	0	2,471	2,775
World Bank program				
Commitments	917	2,882	1,697	1,725
Disbursements	531	1,375	1,318	1,628
Principal repayments	63	157	1,169	1,074
Net flows	467	1,218	149	554
Interest payments	50	280	901	804
Net transfers	417	938	-752	-250



Vietnam

Briefing Note:

PUBLIC HEALTH ISSUES IN VIETNAM

A. SECTORAL CONTEXT

- Vietnam's once extensive rural health delivery infrastructure and performance deteriorated badly during the 1980s as a result of reduced Eastern Block aid and macroeconomic instability. This led to sharp reductions in health service utilization, which persist to this day--2/3s of all patients resort to self-medication.

- Previous health status gains (e.g., communicable disease reduction) declined during this period--malaria deaths reached 4,600 in 1991, the highest ever recorded--and only began to be reversed in the early 1990s.

- Government's 1996 health budget was approximately US$225 million or about US$3 per capita. For the period 1990-1995, public health expenditures amounted to 1.1% of GDP compared to 1.8% for China and 0.7% for Indonesia. Less than 20% of the health budget is spent on preventive health care. Vietnam has one of the highest hospital bed ratios per person in East Asia--higher than China, Thailand and Indonesia. But average occupancy rates in district hospitals are only 50%.

- Over the past decade, at a time when resources for public services were being dramatically reduced, a new set of market-oriented principles was promulgated. However, little analysis was undertaken of how to make their implementation effective. The sector today reflects a blend of overlapping approaches--socialist principles of equity and state responsibility, a market-oriented view of user contributions, and international paradigms for improving health care in developing countries. As a result, there is a lack of clear strategy for the sector and resource use is often inefficient.

- Vietnam's health service personnel, once proud and highly motivated, are demoralized. Public facilities are underutilized. Articles in the media suggest the public views many hospital and clinic staff as uncaring and providing poor quality service. Service usage confirms this perception. Despite the existence of a large public health service, it is estimated that as much as 80% of current health care is privately purchased and is not provided by the formal government health system. Few mechanisms exist to ensure that these private services are of adequate quality.

Incidence and Treatment
of Infectious Diseases

B. INFECTIOUS DISEASES

Major Diseases

Diarrhea, malaria and respiratory infections account for the majority of reported illnesses, and respiratory infections, tuberculosis, viral encephalitis, malaria and dengue fever are the leading infectious disease causes of mortality (firm numbers are not available and existing statistics need to be viewed as providing orders of magnitude only).

Malaria

- Mortality dropped to around 300 in 1995 from a high of about 4,600 deaths from malaria in 1991 (nonetheless, about half the Vietnamese population is still at risk of falling ill from malaria). This drop was due primarily to increased financing for the National Malaria Control Program (NMCP), which had previously been grossly underfunded.

- The Bank's National Health Support Project provides about US$24 million in support to the NMCP for locally effective anti-vector measures, particularly treated bednets, improved program management, training, supervision, communications, and program-related applied research.

Tuberculosis

- TB is a major public health problem and the second most important infectious disease killer after acute respiratory infections. More than 50,000 new cases occur annually.

- The Bank provides about US$23 million to support the National Tuberculosis Program with drugs, equipment, means of transport, training and operations support. The Bank collaborates closely with the Royal Netherlands Tuberculosis Association, which has been providing high quality technical assistance to the Program since 1986.

HIV/AIDS

- In comparison to many of its neighbors in the region, Vietnam has so far been less affected by the HIV/AIDS epidemic. However, since the first case of HIV infection was reported in December 1990, the number of reported cases has risen to more than 7,000. UNAIDS-Hanoi estimates that as many as 263,000 people could carry the virus by 2000. The epidemic is therefore emerging as a serious threat.

- At the request of the Ministry of Health and its partners in UNAIDS-Hanoi, the Bank will soon begin work on a project that will seek to minimize the risk of blood-borne disease transmission (HIV/AIDS, hepatitis, malaria) throughout the country.

C. WOMEN'S, MATERNAL AND CHILD HEALTH

- The Infant Mortality Rate (IMR) is relatively low at 41 per 1,000 births.
- Immunization rates are very high, at over 85% of young children.
- Malnutrition rates are among the highest in Asia; half of all children under 5 years are stunted as a result of chronic malnutrition and 42% are underweight.
- Despite relatively high life expectancy of 68 years (higher for women than for men), the Maternal Mortality Ratio (MMR) is still high, ranging from 110-200 per 100,000 births depending on the area of the country.
- Fertility has fallen by at least 25% since the late 1970s to a total fertility rate (TFR) of around 3 children per woman, and the contraceptive prevalence rate (CPR) now stands at 44 % for modern methods.
- However, the total abortion rate (TAR) (including very early pregnancy termination, known as Menstrual Regulation, or MR) is extremely high, at an average of 2.7 abortions per woman during her reproductive years.
- Rates of sexually-transmitted diseases (STDs) and reproductive tract infections (RTIs) are thought by health providers to be high, but accurate data are only now being collected.
- 40-50% of pregnant women and 35% of young children are anemic.

Key Issues

- Contraceptive options need to be diversified from a primary emphasis on IUDs and pregnancy termination, in order to attract more users from high-failure traditional methods to modern methods and to lower the abortion rate.
- Malnutrition rates among children need to be reduced.
- Rates of anemia among pregnant women and children need to be reduced.
- The decline in primary health services needs to be reversed as it has particularly affected the availability and quality of maternal, reproductive and child health care for poor and rural populations.

Bank Response

- Two sister projects addressing primary health care and reproductive health became effective in 1996. These are the National Health Support Project (NHSP) and the Population and Family Health (PFH) Project. Together they cover upgrading of primary health care services in 34 provinces, with a focus on maternal, child and reproductive health care. These provinces hold more than half the country's population. All are poor provinces not previously covered by other donors. The PFH project also covers upgrading of the national family planning program, with an emphasis on diversification of methods and service quality improvement, data collection, operational research and pilot interventions for STDs and RTIs.

- Discussions have been underway with the government for some time about potential Bank support for a child development and nutrition project. It has been difficult to

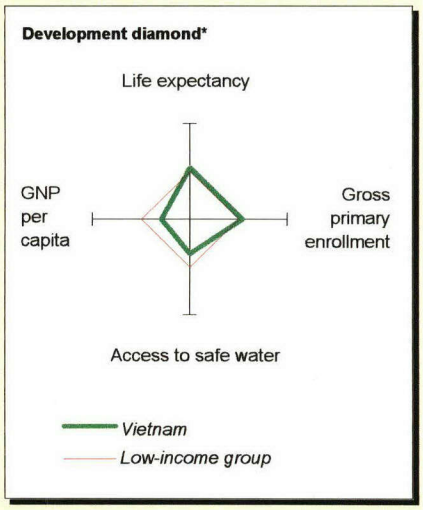
achieve consensus over key sector policies for addressing Vietnam's substantial nutrition problems. The relevant government agencies have also not been inclined to commit to the kind of technical interventions that the Bank believes would lead to a quality project. In light of the importance of this issue, the Bank continues to pursue this dialogue in collaboration with UNICEF and others.

Basic Socio-Economic
Indicators

Vietnam at a glance

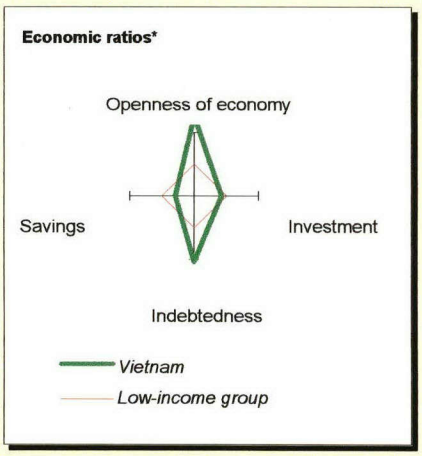
11/5/97

POVERTY and SOCIAL	Vietnam	East Asia	Low-income
Population mid-1996 *(millions)*	75.3	1,726	3,229
GNP per capita 1996 *(US$)*	290	890	500
GNP 1996 *(billions US$)*	23.3	1,542	1,601
Average annual growth, 1990-96			
Population *(%)*	2.0	1.3	1.7
Labor force *(%)*	1.9	1.3	1.7
Most recent estimate *(latest year available since 1989)*			
Poverty: headcount index *(% of population)*	51	..	..
Urban population *(% of total population)*	21	31	29
Life expectancy at birth *(years)*	68	68	63
Infant mortality *(per 1,000 live births)*	41	40	69
Child malnutrition *(% of children under 5)*	45	..	..
Access to safe water *(% of population)*	38	49	53
Illiteracy *(% of population age 15+)*	6	17	34
Gross primary enrollment *(% of school-age population)*	114	117	105
Male	..	120	112
Female	..	116	98

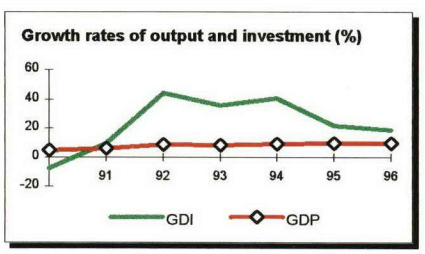


KEY ECONOMIC RATIOS and LONG-TERM TRENDS	1975	1985	1995	1996
GDP *(billions US$)*	..	17.0	20.2	23.3
Gross domestic investment/GDP	..	..	27.1	27.8
Exports of goods and services/GDP	..	..	36.0	41.0
Gross domestic savings/GDP	..	..	..	..
Gross national savings/GDP	..	..	16.8	16.6
Current account balance/GDP	..	-3.1	-10.2	-11.3
Interest payments/GDP	..	..	0.5	..
Total debt/GDP	..	..	109.1	97.8
Total debt service/exports	..	..	14.8	9.3
Present value of debt/GDP	..	..	115.2	..
Present value of debt/exports	..	..	316.5	..

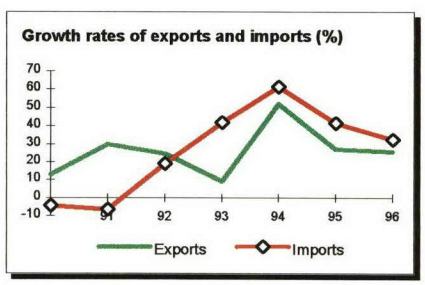
	1975-85	1986-96	1995	1996	1997-05
(average annual growth)					
GDP	..	*6.9*	9.5	9.3	9.3
GNP per capita	..	4.9	7.4	7.4	6.3
Exports of goods and services	..	*25.4*	27.1	25.6	13.6



STRUCTURE of the ECONOMY	1975	1985	1995	1996
(% of GDP)				
Agriculture	..	..	27.5	27.2
Industry	..	..	30.1	30.7
Manufacturing	..	..	..	..
Services	..	..	42.4	42.1
Private consumption	..	..	76.8	..
General government consumption	..	..	..	..
Imports of goods and services	..	..	46.8	54.7



	1975-85	1986-96	1995	1996
(average annual growth)				
Agriculture	..	*5.2*	4.7	4.8
Industry	..	*11.7*	13.9	15.6
Manufacturing	..	..	..	..
Services	..	*8.2*	10.9	8.9
Private consumption	..	..	..	..
General government consumption	..	..	..	..
Gross domestic investment	..	*26.4*	21.7	18.9
Imports of goods and services	..	*24.3*	41.3	32.3
Gross national product	..	7.2	9.5	9.3

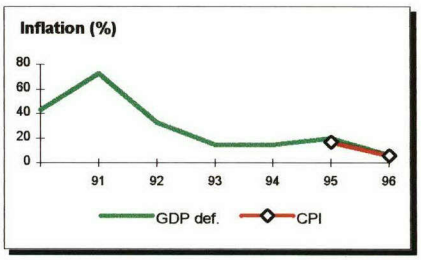


Note: 1996 data are preliminary estimates. Figures in italics are for years other than those specified.

* The diamonds show four key indicators in the country (in bold) compared with its income-group average. If data are missing, the diamond will be incomplete.

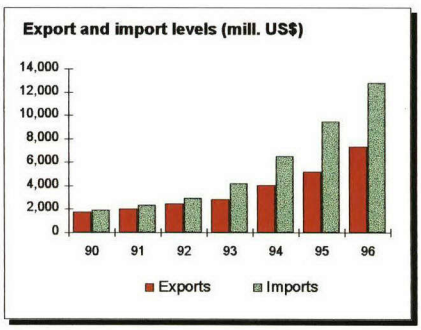
PRICES and GOVERNMENT FINANCE

	1975	1985	1995	1996
Domestic prices				
(% change)				
Consumer prices	..	..	16.8	5.6
Implicit GDP deflator	..	94.2	19.5	6.1
Government finance				
(% of GDP)				
Current revenue	..	..	23.9	23.6
Current budget balance	..	..	5.2	6.1
Overall surplus/deficit	..	..	-0.1	-0.1



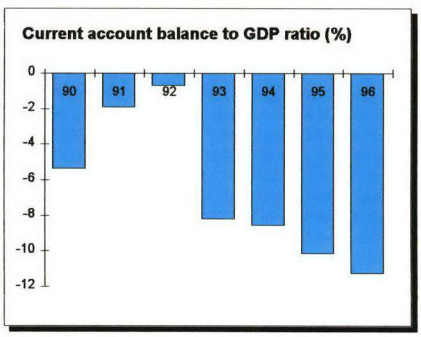
TRADE

	1975	1985	1995	1996
(millions US$)				
Total exports (fob)	..	507	5,198	7,330
Rice	..	..	547	855
Fuel	..	..	1,063	1,346
Manufactures	..	..	..	..
Total imports (cif)	..	930	9,457	12,779
Food	..	..	..	..
Fuel and energy	..	..	..	..
Capital goods	..	..	..	..
Export price index *(1987=100)*	..	..	..	..
Import price index *(1987=100)*	..	..	..	..
Terms of trade *(1987=100)*	..	..	..	..



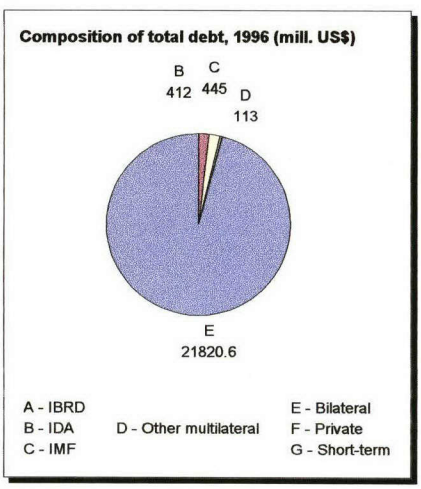
BALANCE of PAYMENTS

	1975	1985	1995	1996
(millions US$)				
Exports of goods and services	..	..	7,272	9,573
Imports of goods and services	..	..	9,457	12,779
Resource balance	..	..	-2,185	-3,206
Net income	..	-90	-362	-487
Net current transfers	..	52	474	1,050
Current account balance, before official capital transfers	..	-534	-2,073	-2,642
Financing items (net)	..	265	1,894	2,171
Changes in net reserves	..	269	179	471
Memo:				
Reserves including gold *(mill. US$)*	..	..	1,320	..
Conversion rate *(local/US$)*	..	8.3	11,010.0	11,080.0



EXTERNAL DEBT and RESOURCE FLOWS

	1975	1985	1995	1996
(millions US$)				
Total debt outstanding and disbursed	..	..	22,041	22,791
IBRD	..	..	0	0
IDA	..	..	231	412
Total debt service	..	..	309	..
IBRD	..	..	0	0
IDA	..	..	2	3
Composition of net resource flows				
Official grants	249	38	150	150
Official creditors	..	..	298	466
Private creditors	..	..	-67	..
Foreign direct investment	..	..	2,236	1,838
Portfolio equity	..	..	..	..
World Bank program				
Commitments	..	..	265	502
Disbursements	..	..	47	189
Principal repayments	..	..	1	1
Net flows	..	..	46	188
Interest payments	..	..	2	2
Net transfers	..	..	45	186



Note: Debt includes non-convertible currency debt.

E. COMMENTS:

File Location	Cleared By	Date:
☒ EXC ☐ IISC ☒ Archives	Marisela Montoliu Munoz	01/16/98

View Update History