Folder Title:	Lending Program - Correspondence
Folder ID:	1103416
Series:	Director and Front Office records
Dates:	10/10/1979 - 09/27/1982
Fonds:	Records of the Population, Health, and Nutrition Sector
ISAD Reference Code:	WB IBRD/IDA WB_IBRD/IDA_89-06
Digitized:	05/01/2023

LENDING PROGRAM

Record Removal Notice

The World Bank Group Archives & Records Management

File Title	Barcode No.
Lending Program - Correspondence	1103416

Document Date	Document Type
23 September, 1982	Board Record

Correspondents / Participants

Subject / Title

Yemen Arab Republic - Health Project - Board Presentation September 28, 1982
Theme : "Laying the Foundation for Health Care in Yemen"

Exception(s)

Additional Comments

Declassification review of this record may be initiated upon request.

The item(s) identified above has/have been removed in accordance with The World Bank Policy on Access to Information. This Policy can be found on the World Bank Access to Information website.

Withdrawn by	Date
Chandra Kumar	06-Feb-15

P-3496-DO

382-22

DECLASSIFIED
WBG Archives

International Development Association

FOR OFFICIAL USE ONLY

N 437 ✓

FOR EXECUTIVE DIRECTORS' MEETING

For Sept 28th

For consideration on September 28, 1982

IDA/R82-114

FROM: Vice President and Secretary

September 9, 1982

YEMEN ARAB REPUBLIC: Health Project

1. Attached is the President's Report and Recommendation (P-3384-YAR) on a proposed credit to the Yemen Arab Republic for a health project.

2. A report entitled "Yemen Arab Republic: Country Economic Memorandum (2856-YAR) was distributed on November 6, 1980.

3. A detailed report entitled "Staff Appraisal Report: Yemen Arab Republic - Health Project" (3874-YAR) is being distributed separately.

4. A draft Development Credit Agreement and the Statutory Committee Recommendation are being distributed as report IDA/R82-114-L.

5. Questions on these documents should be referred to Mr. Houston (extension 74746).

Distribution:

Executive Directors and Alternates
President
Senior Vice Presidents
Senior Management Council
Vice Presidents, IFC
Directors and Department Heads, Bank and IFC

Document of

The World Bank

FOR OFFICIAL USE ONLY

Report No. P-3384-YAR

REPORT AND RECOMMENDATION

OF THE

PRESIDENT OF THE

INTERNATIONAL DEVELOPMENT ASSOCIATION

TO THE

EXECUTIVE DIRECTORS

ON A

PROPOSED CREDIT

IN AN AMOUNT EQUIVALENT TO US$10.5 MILLION

TO THE

YEMEN ARAB REPUBLIC

FOR A

HEALTH PROJECT

September 8, 1982

CURRENCY EQUIVALENTS

Calendar 1981			December 1981
Currency Unit	=	Yemeni rial (YR1)	YR1
$1	=	YR1s 4.50 1/	4.50
YR1 1	=	$0.22	0.22

FISCAL YEAR

July 1 to June 30 (prior to 1980)
July 1 to December 31 (1980)
January 1 to December 31 (from 1981)

ABBREVIATIONS

BHS/PHC	Basic Health Services/Primary Health Care
CPO	Central Planning Organization
FFYP	First Five-Year Plan, 1977-81
HMI	Health Manpower Institute
IDA	International Development Association
LBA	Local Birth Attendant
LDA	Local Development Association
MAF	Ministry of Agriculture and Fisheries
MOH	Ministry of Health
PFU	Planning and Follow-Up Unit
PHCU	Primary Health Care Unit
PHCW	Primary Health Care Worker
PIU	Project Implementation Unit
RHTS	Rural Health Training School
SSF	Salary Supplement Fund
SFYP	Second Five-Year Plan, 1982-86
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
WHO	World Health Organization
YAR	Yemen Arab Republic

1/ No par value for the Yemeni rial has yet been declared to the IMF. All exchange transactions are effected at the Central Bank rate which has been pegged to the US dollar since February 1973.

YEMEN ARAB REPUBLIC

HEALTH PROJECT

CREDIT AND PROJECT SUMMARY

Borrower: Yemen Arab Republic (YAR)

Amount: Special Drawing Rights: 9.62 million
(approximately US$10.5 million equivalent)

Terms: Standard IDA terms

Project Description: The proposed project is designed to strengthen and expand the capability of the Ministry of Health (MOH) to plan, staff and manage the country's health care system. The project comprises: (a) technical assistance for key departments at MOH, including the Health Manpower Institute (HMI) which has the responsibility of training middle-level health workers; and (b) infrastructure development, particularly for manpower training, including civil works, equipment and supplies. The proposed project's main benefits would be (i) the strengthening of MOH's planning, management and implementation capacity, particularly for its basic health services/primary health care (BHS/PHC) program; and (ii) the development, through HMI, of health manpower to staff BHS/PHC services and facilities. Because of the project's emphasis on institution-building and manpower training, these benefits would be of a long-term nature. Project risks relate to (i) retention of MOH staff; (ii) timely recruitment of qualified experts; and (iii) possible continued underutilization of HMI facilities. These risks are minimized by the strong Government commitment to this project, evidenced by specific measures which the Government has taken. The proposed salary supplements are expected to assist MOH in attracting and retaining quality staff in the short-run. The Government is committed to take the necessary measures to ensure that MOH's staff salaries would remain competitive, and to improve personnel management practices to further career development at MOH. The Government has contracted with a US firm, Western Consortium for the Health Professions Inc., to assist MOH in recruiting experts. As for HMI enrollment, the throughput from the general preparatory schools may continue to be insufficient and HMI may not be able to enroll sufficient number of students to utilize its facilities fully. However, the measures that MOH has taken will enhance HMI's share from the available pool of graduates.

Estimated Cost: (Project costs are exempted from customs duties and taxes)	Local	Foreign	Total
	---$ million---		
A. Technical Assistance Costs			
Consultant Services	0.5	1.9	2.4
Training	0.3	0.4	0.7
Subtotal	0.8	2.3	3.1
B. Infrastructure Costs			
Civil Works 1/	1.6	2.5	4.1
Furniture and Equipment 1/	0.3	1.1	1.4
Educational Material and Supplies	0.2	0.5	0.7
Vehicles 1/	-	0.5	0.5
Subtotal	2.1	4.6	6.7
C. Incremental Operating Costs			
Salaries and Wages 1/	2.5	-	2.5
Other Operating Costs 1/	0.6	0.2	0.8
Subtotal	3.1	0.2	3.3
Project Base Cost	6.0	7.1	13.1
Physical contingencies	0.2	0.4	0.6
Price contingencies	1.0	1.1	2.1
Subtotal	1.2	1.5	2.7
Total Project Cost	7.2	8.6	15.8
Financing Plan:			
Government 2/	5.3	-	5.3
IDA Credit	1.9	8.6	10.5
Total	7.2	8.6	15.8

Estimated IDA Disbursements: IDA FY	1983	1984	1985	1986
	---$ million---			
Annual	0.2	2.6	5.8	1.9
Cumulative	0.2	2.8	8.6	10.5

Estimated Completion Date: December 31, 1985

Rate of Return: Not applicable.

Staff Appraisal Report: Report No. 3874-YAR, dated September 8, 1982.

1/ Partly financed under a Project Preparation Facility (PPF) advance totalling $140,000.

2/ UNICEF is expected to contribute about $2.4 million towards the Government's share of project costs.

INTERNATIONAL DEVELOPMENT ASSOCIATION

REPORT AND RECOMMENDATION OF THE PRESIDENT OF IDA TO THE EXECUTIVE DIRECTORS ON A PROPOSED CREDIT TO THE YEMEN ARAB REPUBLIC FOR A HEALTH PROJECT

1. I submit the following report and recommendation on a proposed development credit to the Yemen Arab Republic (YAR) for Special Drawing Rights (SDR) 9.62 million (approximately US$10.5 million equivalent), on standard IDA terms, to help finance a Health project. UNICEF has informed the YAR Government and IDA of its interest in providing a grant in the amount of $2.4 million equivalent, towards the financing of this project.

PART I - THE ECONOMY

2. A basic economic report entitled "Yemen Arab Republic: Development of a Traditional Economy," (No. 2057a-YAR), dated December 14, 1978; a Country Economic Memorandum (No. 2856-YAR), dated October 23, 1980; a report on manpower development (No. 3181a-YAR), dated March 27, 1981; and a report on domestic resource mobilization (No. 3554a-YAR), dated January 6, 1982, have been distributed to the Executive Directors. Country data are attached in Annex I.

Introduction

3. Over the last decade YAR has experienced far-reaching changes in its socioeconomic structure and the material welfare of its citizens. The republican government which came to power following the 1962 Revolution succeeded in establishing within a surprisingly short period of time the foundations of a modern state.

4. Political integration and the growing influence of central authorities have provided the basis for rapid development of the public and private sectors. Under the Three-Year Development Program (1974-76) and the First Five-Year Plan (1977-81), the foundations of the country's physical and social infrastructure were laid and expanded, and first attempts were made at lifting agriculture, the mainstay of the economy, out of its medieval setting; industrialization was also started, albeit on a small-scale.

5. Rapid domestic economic growth has been accompanied and enhanced by the large inflow of remittances and transfers by Yemenis abroad, particularly workers in Saudi Arabia and the Gulf States. These are estimated to have increased, on a net basis, from around $40 million in 1969/70 to a level that has fluctuated around $1 billion on an annual basis between 1978 and 1980. They have since dropped to close to $790 million in 1981 (on the basis of tentative estimates by the Central Bank). Largely as a result of these cash inflows, YAR's real per capita GNP has increased significantly over this period, reaching an estimated $430 in 1980.

Major Development Issues

6. Recent achievements in development, remarkable as they are, should not detract from the fact that YAR continues to be one of the world's least developed countries. Productivity levels are still extremely low, especially in agriculture. Over 90 percent of the population reside in rural areas, a large part in remote villages without access to modern transportation, schools, electricity or health services. Agricultural land and water are scarce and few mineral deposits have been discovered so far.

7. The shortage of skilled manpower is an overriding constraint to YAR's development and limits the capacity of the public administration to manage and implement a growing and increasingly complex development program. The most critical shortages are in the skilled and semi-skilled occupations.

8. A special effort is required to mobilize domestic resources for the financing of fast-growing government expenditures. Although government revenue rose rapidly during the 1970s, the tax base is still very small. Most budget revenue is derived from import duties, while other sources of taxation are still largely undeveloped. So far, budget deficits have been covered through generous foreign aid. But this assistance could diminish in relative terms over the longer run, a development which calls for measures to broaden the tax base, strengthen the tax administration, and devise new schemes to tap the savings of the private sector. A Bank mission, with IMF participation, addressed these and related issues, and its report was discussed with the Government in November 1981. The Government has already implemented some of the mission's recommendations, but the tougher measures are likely to take more time to implement.

Government Objectives

9. As of the early seventies, the country has been trying to develop human resources and build new institutions, to strengthen the physical and social infrastructure, to raise the productivity of the commodity-producing sectors, and to improve the standard of living of the people, giving priority to their basic needs. The First Plan's targets which were in line with these objectives have by and large been met except in the agriculture sector where output has stagnated and actual growth fell considerably below targeted levels primarily because of the abandonment of marginal rain-fed areas where income opportunities could not compete with the opportunities of migration. The production of qat (a mild stimulant) has been on the increase and has competed for agricultural land. Its production is only partially reflected in the national accounts.

10. A draft Second Five-Year Plan (1982-86) was presented to an International Development Conference in April 1982. The Bank assisted as an executing agency for a UNDP-financed project by overseeing some inputs used by the Central Planning Organization for the plan. The plan aims at a 7 percent GDP growth target calling for a total investment of around $6.5 billion (1981 prices) over the plan period. The sectoral distribution of

investment underlies a continued broad-fronted strategy with a relative emphasis on agriculture and manpower development. The plan's financing depends heavily on external sources with around 70 percent of investment expected to be covered by grants and loan disbursements and direct foreign private investment. The Bank has cautioned the Government against setting unrealistically ambitious targets and advised it to maintain flexibility in plan implementation should the level of expected external resources prove untenable.

Recent Economic Performance

11. Overall economic performance during the First Plan period (1977-81) has been satisfactory. Real GDP grew at around 6 percent p.a. Investment effort was impressive averaging around one-third of GNP. Since 1978, however, a noticeable deceleration in the growth of most economic aggregates has set in. This has been mainly due to the stabilization in the inflows of workers' remittances and private transfers. Since imports and consumption continued to grow, national savings, the balance of payments and the foreign exchange position deteriorated. Thus, the overall balance of payments which showed considerable surpluses before 1978, showed an estimated $330 million deficit in 1981. Reserves which were equivalent to around 20 months of imports in 1975 were down to around 7 months by end 1981.

12. The budgetary position has also deteriorated rapidly as of 1978. The overall deficit has more than quintupled from 1977/78 to 1978/79 and has remained around the same level (some $500 million) through 1981. The main reason is the very steep rise in capital expenditures at a time when revenue increases were moderate.

13. YAR's commodity exports are still extremely low, reflecting the country's limited resource endowment and the underdeveloped state of its economy. Imports, on the other hand, have risen sharply from $194 million in 1973/74 to $1748 million in 1981. This upsurge in import demand reflects the rapidly rising cash incomes, the convertibility of the Yemeni rial, and the absence of import restrictions.

14. Although there are no reliable data on income and consumption distribution in YAR, there are reasons to believe that the benefits from recent growth have been widely distributed; migration has led to little apparent unemployment so far, and strong family ties ensure that many people benefit from the increase in incomes. Public social expenditures, especially on education and health, increased substantially, and the associated benefits accrue directly to an increasing segment of the population.

Capital Flows and External Debt

15. Since independence, YAR has received large amounts of foreign assistance. Given the country's low per capita income and its UN classification as a "least-developed country," most of the aid was provided in the form of grants and concessionary loans. Cumulative aid disbursements,

including grants, came to around $2 billion by the end of 1981. The principal donors have been Saudi Arabia, Kuwait, United Arab Emirates, Iraq, USA and West Germany as well as IDA and the Arab development funds.

16. About one-half of the total assistance given so far was provided as grants, mostly for food aid, technical assistance and more recently, for budget support primarily from Saudi Arabia. Food aid has been provided through the World Food Program and by a number of bilateral donors. A significant part of official grants has been made available in the form of technical assistance. Given the extreme shortage of skilled manpower in YAR, this type of aid has high priority and will be needed by the country for many years to come. Besides the grants, YAR received sizeable amounts of official loans and credits. Drawings on these loans have increased in recent years, reaching $417 million in 1980 and $294 million in 1981. Most of the official loans and credits have been committed for the financing of specific projects, with the main emphasis on roads, agriculture, including irrigation, and utilities. The remaining funds were given for commodity assistance or as cash loans.

17. The terms on which YAR has obtained official loan assistance have been very favorable. Loans from the USSR and the People's Republic of China are, for the most part, free of interest. Western European countries have generally charged between 3/4 percent and 2-1/2 percent. Interest rates charged by Arab countries have varied from 0 to 4 percent. Loan maturities range from 5-50 years, with a median of 20-30 years.

18. YAR's external public debt outstanding on December 31, 1981 was estimated at $1747 million, of which $1094 million was disbursed. IDA credits accounted for $239 million or about 14 percent of the total debt reported. Because of their very favorable terms of borrowing, the debt service payments amounted to $59 million for 1981, equivalent to around 1.3 percent of gross foreign exchange earnings (including workers' remittances and private transfers). Service payments are expected to rise significantly over the next decade.

PART II - WORLD BANK OPERATIONS 1/

19. The proposed credit would be the thirty-second to YAR, bringing total IDA commitments to $294.8 million.2/ The World Bank strategy in YAR has been threefold: to concentrate on developing the basic institutions, skills and physical infrastructure which are prerequisites for development,

---

1/ Substantially the same as Part II of the President's Report for the Fourth Highway credit which was approved by the Executive Directors on June 17, 1982.

2/ This includes the supplementary credit of $10.3 million for the First Tihama project, No. 376-1 YAR, and excludes the $7.0 million credit for the Textile Rehabilitation project, No. 832-YAR of 1978, which was cancelled at the Government's request in October 1979 (see Annex II).

to develop production and income in the dominant productive sector, agriculture, and to support the Government in its programs to meet basic needs in rural and urban areas. To achieve these objectives, IDA has extended ten credits, totaling $112.4 million, for agriculture, fisheries and rural infrastructure; twelve credits totaling $114.6 million, for infrastructure including highways, ports, water supply and sewerage, power distribution, and urban development; four credits, totaling $41 million, for education and training; two credits, totaling $14.3 million, for industry; and a $2.0 million credit to promote the exploration of the petroleum and geothermal resources to private companies. In FY78, an investment of $2.4 million by the International Finance Corporation was approved to help finance a dairy and juice project.

20. The main constraint to YAR's social and economic development has been, and will remain for some time, the critical shortage of manpower, especially skilled and professional, and the newness and weakness of its institutions. World Bank strategy in YAR has placed emphasis on helping to strengthen Yemeni institutions and manpower capabilities, through increased training of local staff and continued technical assistance, as well as through direct financing for education. Thus all IDA projects in YAR contain substantial components for technical assistance towards institution building. Three particularly important examples of the World Bank's support for institution building have been in the Central Planning Organization (CPO) and the Ministry of Agriculture and Fisheries (MAF). In CPO, the World Bank (through three grants totaling $520,000) and the Kuwait Fund have financed a team of planning and economic advisers so as to create a planning machinery. The Bank has been the executing agency for a UNDP-financed project to assist the CPO in the preparation of the Second Five-Year Plan, 1982-86 (see paragraph 10). In MAF, the Bank supplies the services of seven advisers initially financed by UNDP with the Bank as executing agency, and now financed jointly by IDA, the EEC Special Action Fund (under the Second Tihama project) and UNDP. The Agricultural Research Service at Taiz, which has the responsibility for carrying out applied agricultural research for the country as a whole, is also financed as part of this institutional support.

21. YAR's disbursement performance (disbursements as a percentage of total commitments) lagged somewhat lately largely due to the delay in the recruitment of staff for project implementation and the shortage of counterpart funds arising from budgetary constraints. Following a number of implementation reviews of the whole portfolio, there are indications that performance started to improve and implementation of ongoing IDA-assisted projects is now progressing satisfactorily. YAR's performance now compares favorably with the regional average and is considerably above that of countries at a similar level of development. Annex II contains a summary statement of IDA credits, Bank grants, and IFC investments, as well as notes on the execution of the ongoing projects, as of March 31, 1982.

22. Future World Bank operations will concentrate on reinforcing the institutional progress made in infrastructure, agriculture, rural development and education and training, and will seek to spread the benefits of development more widely throughout YAR. Particular attention will be given to YAR's

ability to implement projects, by ensuring the availability of key staff and technical assistance needed for successful implementation. An agricultural credit project and a fifth education project have been appraised; a third power project, a fifth highway project and a rural development project are in the preparation stage. Future projects are expected to include water supply and sewerage, urban and housing, and agricultural development, and may also include health and energy.

23. YAR has contributed an increasing portion of local currency financing and is expected to continue to finance a rising portion of its development expenditures in the future. Nevertheless, it remains among the least-developed countries and requires special assistance through financing of a large part of project costs, including local expenditures when necessary. As in the past, the costs of future projects are expected to be substantially higher than the amounts that IDA can provide, and we shall continue to cooperate closely with other donors so as to maximize IDA's catalytic role in stimulating cofinancing. IDA-supported projects, including this project, have led to about $325 million equivalent of cofinancing from other aid donors.

PART III - THE HEALTH SECTOR

Background

24. Despite the impressive economic achievements in the Yemen Arab Republic (YAR) during the 1970s, the health status of the population remains at an extremely low level compared with other developing countries. The quality of life as indicated by social data leaves much to be desired. Life expectancy is at a low level of 42 years, while the average for countries in North Africa and the Middle East is 57 years; the infant mortality rate (190 per 1,000) is as high as in parts of Sub-Saharan Africa; and the crude death rate (23 per 1,000) is one of the highest in the world. This is not surprising considering that only 17 percent 1/ of the population has access to safe water, population per physician is about 11,700 and the rural population, which comprises about 90 percent of the total, has virtually no access to health services (paragraph 29).

25. Information on disease conditions in YAR is scarce. Available data indicate that probably the most widespread diseases in YAR are intestinal parasites and infectious diarrheal diseases. The very incidence of these diseases is indicative of the low standards of hygiene and sanitation which are prevalent in the country, aggravated by the unprotected nature of many water sources. The main causes of infant mortality are diarrheal and respiratory diseases, measles and whooping cough. In general, diseases of high endemicity are tuberculosis, malaria, bilharzia and enteritis.

1/ This is a recently updated figure which is not reflected in the attached Social Indicators Data Sheet (Annex 1).

26. The problem of malnutrition is greater in terms of both frequency and severity in YAR than in other countries of the region. About 12 percent of Yemeni children suffer from moderate to severe protein-calorie malnutrition, and around 50 percent of children under five are anemic. One-third of all rural mothers also suffer from anemia. One factor contributing to infant malnutrition is the large-scale migration of the male labor force, which increased labor force participation by women, particularly in the agricultural sector. This led to a rapid decline in the incidence and duration of breast-feeding, and an increase in bottle-feeding. Considering the lack of safe water in rural areas, this entails serious infant health hazards.

27. The average age at marriage is low, 14 years for women in rural areas. The average number of children per family is about 6.6 and the crude birth rate, at an estimated 47 births per 1,000 persons, is higher than the average for countries in North Africa and the Middle East (41 per 1,000). Only a minority of Yemeni women are attended by local midwives during childbirth. For women living in remote areas, childbirth is the most serious threat to their lives. Maternal mortality is estimated at 10 per 1,000, as compared to a rate of 1 per 1,000 in Egypt.

28. The Government recognizes that improved health is fundamental to overall social and economic development in YAR. Accordingly, one goal of YAR's First Five-Year Plan 1977-81 (FFYP) was to develop a program which would meet the basic health care needs of 20 percent of the population before the end of the plan period, and 90 percent by the year 2000. A basic health services/primary health care (BHS/PHC) national health program was adopted in 1976 as Ministry of Health (MOH) policy, and is seen as the most effective and efficient means to achieve these goals. The BHS/PHC program emphasizes the development of a village-based primary health care system, supported by higher level facilities/staff and central MOH management and planning personnel (paragraph 34).

29. While the Government has worked towards achieving the above goals, its capacity to provide the needed services is extremely limited. MOH, which is responsible for the provision of health care services and the formulation of health policy, is a relatively new institution with a weak planning and implementation capacity. Training of the middle-level health manpower (e.g., nurses and technicians) vital to health care delivery is the responsibility of MOH's Health Manpower Institute (HMI) which is also an infant institution, having been established in 1972 (paragraphs 40-44). Accordingly, the combined effects of weak planning and implementation capacity at MOH and the insufficient production and deployment of health manpower resulted in the Government being able to provide basic health services to only 5 percent of the population by 1981, compared to a target of 20 percent.

30. The Government is also committed to the development of basic infrastructure projects which have direct impact on the health standard of the YAR population. Although it has concentrated its efforts during the 1970s along the perimeter of the Sanaa-Taiz-Hodeidah triangle, its water, road and nutrition activities have also reached the rural areas, with the assistance of

local efforts through the Local Development Associations (LDA) and external donors. By 1980, in addition to Government-supported activities, the LDAs sponsored the construction of about 2,000 water schemes and about 15,000 km of feeder roads in the rural areas. The water schemes, though not completely safe, have helped reduce the incidence of waterborne diseases such as typhus and cholera, while the new road network has increased the rural population's access to the available health services. In addition, the Government's substantial investments in the agricultural sector have assisted the Yemeni farmers in improving the yield and introducing new varieties and crops with higher nutritional contents.

31. Nonetheless, a number of major problems affecting the delivery of health care services remain to be solved. These include:

(a) lack of adequate planning, implementation and management capacity in all areas at MOH, due to inadequately-trained staff and poor management;

(b) insufficient production of well-trained middle-level health manpower to staff health-care facilities;

(c) limited funds to finance the recurrent costs of health care which are expected to increase significantly during the SFYP period (paragraph 45); and

(d) lack of participation by women in the health care system, both as patients and as staff.

Government Objectives

32. YAR's Second Five-Year Plan (SFYP), 1982-1986, reaffirms the Government's commitment to the BHS/PHC program and sets as a target the extension of this program to 25 percent of the population by 1986. The Government's commitment to attaining this objective is evidenced by its allocating $148 million (2.3 percent of total public and private investment) for health investment expenditures in the SFYP, with $60 million of this being allocated to the category of basic health services. The Government has also adopted a clear and realistic health manpower training plan that calls for a substantial increase in HMI output, from about 200 in 1981/82 to 410 in 1984/85 and has allocated about $10 million for health manpower training under the SFYP. In addition, the Government has recently reorganized MOH to provide a suitable organizational structure as the groundwork for improving MOH's capacity in several key areas, including planning of all types, evaluation and research; an allocation of $16 million for institutional support to the Ministry of Health is included in the SFYP.

33. The Government's health development objectives and the strategy for achieving them appear sound. Its approach is similar to its strategy in other sectors, where the Government has already made a headstart. The Government expects that the set objectives for the health sector, of which the proposed project is a part, would render the Ministry of Health an effective entity and at par with other technical ministries in YAR.

Health Care Activities

34. In the rural areas, the BHS/PHC program is designed to comprise a network of facilities at three levels: the primary health care unit (PHCU) or health post (covering about 500 people), headed by a primary health care worker (PHCW) recruited from the locality and trained at a nearby health center; the health subcenter or dispensary (covering about 5,000 persons) which provides maternal and child health care and curative services and is headed by an assistant nurse or a nurse; and, at the third level, the health center (covering up to about 50,000 people) which supervises the PHCUs, provides a more comprehensive service, including treating referral cases, and is staffed by nurses and medical assistants or doctors. Some of the nurses/ medical assistants in the health centers act as trainers of PHCWs and Local Birth Attendants (LBAs) and have the added responsibility of supervising these cadres. The training courses for PHCWs and LBAs last 20 and 16 weeks respectively. To achieve full coverage of YAR's entire rural population would require the development and staffing of over 120 BHS/PHC networks. The 5 percent coverage achieved by 1981 was realized by constructing scattered facilities; no complete network has yet been built.

35. The Government and several multilateral and bilateral external donors are implementing a number of direct health care programs in YAR. Among the ongoing and planned MOH and donor programs are the following: (a) WHO/MOH programs for the control of endemic diseases including malaria, tuberculosis, smallpox, bilharzia and diarrheal diseases; (b) construction of health centers and PHCUs by MOH, Local Development Associations and the Saudi Arabia and Kuwaiti Governments; (c) joint projects by MOH and various donors (e.g. USAID, Germany, France, the Netherlands, Sweden, Norway and several voluntary organizations, such as the various Save the Children organizations) to train staff and provide equipment for PHCUs; (d) provision of drugs and coordination of immunization campaigns, mainly provided by UNICEF; (e) construction and equipping of hospitals by MOH, Saudi Arabia and Kuwait; (f) staffing of hospitals by France, the USSR, China, Kuwait and Saudi Arabia; (g) a maternal and child health program funded by the World Food Program to provide high protein food to pregnant and nursing women as well as pre-school children; and (h) the bilharzia monitoring and control program funded by IDA and WHO under the Second Southern Uplands Rural Development credit.

36. Unfortunately, most external assistance has been provided independently with insufficient regard to the benefits that would accrue from better coordination; the MOH capacity in monitoring the implementation of these activities remains very weak. The proposed project therefore provides for strengthening of MOH capability to implement the Government's BHS/PHC program, as well as to strengthen the impact of foreign aid and coordinate assistance provided by the numerous external donors.

37. In addition to the above direct health care activities, the Government and a number of donors, including IDA, continue to undertake projects outside the health sector which have had and will continue to have a beneficial impact on public health. These projects, which are aimed at attacking

the causes of endemic diseases by increasing access to clean water and sanitary sewage facilities and by improving nutrition, are in the following sectors: water supply and sewerage, agriculture and fisheries, education and rural development. All of these sectors are supported by IDA assistance.

The Ministry of Health - Organization and Management

38. The Ministry of Health is organized into four Directorates-General at headquarters (Health and Medical Services, Pharmacy and Medical Supplies, Health Department Affairs, and Finance and Administration) and eleven in the field--one for each governorate. The head of each Directorate-General reports to the Undersecretary. In addition, a ministerial directive for the establishment of a Planning and Follow-Up Unit (PFU) was recently issued in line with the reorganization of MOH to be implemented under the proposed project. The PFU, when staffed and operational, will be responsible for planning, budgeting, statistics and manpower development, and its head will report to the Undersecretary. Two other new units which form part of the proposed project would also be established in the Directorate-General of Health and Medical Services--the Nutrition Unit and the Evaluation and Research Unit.

39. The standard of planning and management at MOH is poor. The Health Council, a coordinating committee composed of senior managers, rarely meets and there is limited communication among the different parts of the Ministry. Planning and budgeting are presently undertaken, if at all, only by ad hoc committees. Many Directors lack management training. There is no clear health education strategy and MOH's health education unit has technical and administrative weaknesses. Systematic personnel policies and procedures, necessary to motivate and retain quality staff, have yet to be developed. Poor drug inventory management and unsatisfactory storage facilities have produced chronic shortages of drugs throughout the health care system, despite the availability of the drugs themselves.

The Health Manpower Institute

40. The shortage of trained Yemeni health manpower, particularly middle-level staff, severely constrains the effective delivery of health services. Population per nurse in YAR is 4,580 (versus an average of 1,800 in the Middle East and North Africa) and about one-third of the nurses are expatriates. A number of health facilities, some of them fully equipped, are non-operational because of lack of staff and the majority of facilities which are operational are understaffed. Population per physician is 11,700 versus an average of 4,000 in the region. There is no medical school in YAR, so all doctors are either expatriates (about 45 percent) or Yemenis trained abroad. However, the Government of Kuwait has agreed to finance the construction, equipping and staffing of a medical school at Sanaa University, which could open around 1985.

41. The HMI is responsible for training middle-level health staff, comprising para-medical staff (nurses, medical assistants and midwives) and

health auxiliaries (laboratory assistants, practical nurses, laboratory technicians, community health nurses, etc.). Currently HMI's links with MOH headquarters are rather weak but as part of the reorganization of MOH, HMI is to be placed under the coordination of the Manpower Development Directorate in the new PFU. HMI now consists of the headquarters in Sanaa and two branches at Hodeidah and Taiz, which offer seven 3-year courses for paramedical workers and four 1-year courses for health auxiliaries. The Government plans for health manpower training include the eventual establishment of five new Rural Health Training Schools (RHTS) for training health auxiliaries, subject to experience gained at the first RHTS, to be constructed at Hajjah under the proposed project.

42. Currently, there are no in-service training courses; HMI offers only pre-service training. A total of about 200 HMI students graduated in 1981/82. Enrollment in the HMI programs, which reached about 400 students in 1981/82, has averaged only 50 percent of HMI's teaching capacity; this combined with attrition after graduation has led to actual production and placement of trained health manpower falling short of planned levels by over 60 percent. There have been several reasons for these shortfalls in recruitment and placement: lack of boarding facilities at HMI campuses; competition from the private sector and other Government institutions for the pool of preparatory (junior high) school graduates; low stipends for students; lack of a recruitment program; cultural factors inhibiting the recruitment of female nurse-trainees; and the fact that health workers' salaries have not been competitive with those in the neighboring Arab countries or Yemen's private sector. These problems have, however, affected all types of technical and vocational training in YAR.

43. The Government is addressing some of the above problems. In January 1982 it increased the salaries of its employees, including MOH staff, by as much as 60-100 percent. Furthermore, HMI and RHTS students will henceforth be inducted into the civil service upon enrollment, and will be paid regular Government salaries, which are competitive with stipends paid to students at other technical training institutions in YAR. The prospects of increasing the output of health workers and specifically of achieving the Government's goal of 410 HMI graduates per annum by 1984/85, therefore, have been enhanced.

44. The curricula of HMI courses are not yet fully consistent with the needs of the BHS/PHC program, and so need to be improved. Furthermore, Yemeni instructors at HMI lack training and experience, partly because the expatriate experts at HMI (provided under the WHO/UNDP project which terminates at the end of 1982) have frequently been used for direct teaching of students rather than as trainers of Yemeni instructors.

Health Finance

45. Partly in response to the need to finance the implementation of the initial stages of the BHS/PHC program, the Government has in recent years significantly increased the health sector's share of capital and recurrent

Government expenditures from 2.6 percent in 1977 to 5.2 percent in 1981, which is still slightly below the average for countries in the region. In terms of total investments, public and private, the health sector's share is planned to grow from 1.3 percent under the FFYP to 2.3 percent under the SFYP (paragraph 32). Currently no user fees are levied--all recurrent costs are covered by the Government and donor contributions. The Government is conducting a study to determine the projected recurrent costs of health care during the SFYP period and how to finance these costs.

IDA Experience and Strategy in the Health Sector

46. The proposed project would be the first IDA-assisted health project in YAR. However, as noted above (paragraph 37), several IDA-assisted projects in other sectors have had beneficial impacts on public health. These include four urban water supply and sewerage projects, three agricultural/rural development projects with water supply components in the Southern Uplands and the Tihama, two projects with nutrition components and two rural develoment projects which finance molluscicides and other equipment to combat bilharzia and malaria in the Southern Uplands. The proposed project is intended to address two of the key problems facing the health sector in YAR: the poor planning, implementation and management capacity at MOH and the severe shortage of well-trained health manpower to staff health care facilities. The project would support the Government's well-designed BHS/PHC program for extending quality basic health services to the populace as rapidly as possible.

PART IV - THE PROJECT

Background

47. The proposed project continues IDA's lending strategy of supporting the institutional development of key Ministries in YAR, in this case the Ministry of Health (MOH). The project was prepared by the YAR Government with assistance of consultants and two IDA preparation assistance missions of January and April 1981. It was appraised in September/October 1981 with post-appraisal in February 1982. Negotiations were held in Washington from July 13 to 15 1982. The YAR delegation was headed by His Excellency Dr. Mohammed Al-Kabab, Minister of Health, and included representatives of MOH and the Central Planning Organization. A Staff Appraisal Report entitled "Yemen Arab Republic - Health Project" (No. 3874-YAR) dated September 8, 1982 is being distributed separately to the Executive Directors. The main features of the credit and the project are summarized in the Credit and Project Summary and in Annex III. A map of the project sites is attached.

Project Objectives and Description

48. The proposed project is primarily designed to strengthen and expand the capability of MOH to plan, staff and manage the country's health care system. The project would be implemented over the 1983-85 period and would comprise two components: (i) technical assistance for key departments at MOH, including the Health Manpower Institute (HMI) which has the responsibility for training middle level health workers (paragraphs 40-44); and (ii) infrastructure development, particularly at HMI.

49. The proposed project thus has a dual focus: middle-level health manpower training, and institution-building at MOH. The development of YAR's BHS/PHC program is constrained by the lack of qualified middle-level health workers. As detailed above (paragraphs 34-37), several external donors have been active in constructing health facilities (at all levels), of which a significant number remains unutilized or underutilized due to the lack of staff. A UNDP/WHO project which assisted in the establishment and operation of HMI terminates in late 1982; it provides the basis upon which the proposed IDA-assisted project would build. As for institution-building, this deserves priority because MOH,due to poor management practices and a lack of adequately trained staff, lacks the capacity to effectively plan and manage its own direct health care delivery activities and those of external donors (paragraphs 38-39). If the fivefold increase in the coverage of the BHS/PHC program (from 5 percent of the population in 1981 to 25 percent in 1986) envisaged in the Second Five-Year Plan is to be achieved, and if further extension of basic health services is to be undertaken after 1986, MOH urgently needs technical assistance in several key areas. This assistance needs to comprise both experts' services and training of Yemeni staff.

Technical Assistance

50. The proposed project provides for (i) 23 man-years of consultancy services to establish the Project Implementation Unit (PIU) and strengthen five key areas in MOH headquarters, namely planning, health education, nutrition, evaluation and research, and supplies management; and (ii) 3 man-years of consultancy services to assist HMI in developing curricula and training of Yemeni staff in project evaluation and management, and health/hospital management. Moreover, the project provides for 150 man-months and 252 man-months of overseas fellowships for the training of senior MOH and HMI staff respectively. The consultants will be responsible for on-the-job training of Yemeni staff and for assisting with executive functions while those staff are away on fellowship training.

Infrastructure Development

51. This component of the proposed project aims at (i) modestly expanding HMI facilities to allow for the training of the anticipated increase in enrollments (paragraph 43); and (ii) strengthening MOH operational capability by constructing and equipping a medical supplies warehouse and maintenance workshop at Hodeidah as well as the provision of vehicles, equipment and furniture for the newly established departments/units, including the PIU, at MOH. It is anticipated that HMI graduates would be about doubled by 1984/85 when they are estimated to reach about 400. To absorb the projected increasing enrollment, the project provides for the construction, equipping and furnishing of additional teaching and boarding facilities for HMI branches at Hodeidah and Taiz and the establishment of a Rural Health Training School (RHTS) at Hajjah. The RHTS would be the first of five schools the Government plans to establish in rural Yemen. About half of the additional enrollment that would benefit from the proposed project are females since the project provides for the construction of three boarding facilities for female students in Hodeidah, Hajjah and Taiz.

Project Implementation

52. The proposed project would be implemented over a period of three years and MOH would be the implementing agency for all components. MOH has established a Project Implementation Unit (PIU) to assist in implementing the project. The PIU will be responsible for the day-to-day work of all aspects of project implementation. It is headed by a Yemeni Project Manager, who will be assisted by an internationally recruited project advisor and a senior engineer. In executing its work, the PIU will liaise with the heads of the respective MOH departments and the Director of HMI. Technical assistance funds allocated for the preparation of a health project under the IDA-assisted Third Education Project (Cr. 915-YAR) and an advance of up to $140,000 from IDA's Project Preparation Facility (PPF) are financing start-up costs of the PIU so that it can carry out activities required prior to credit effectiveness. Such activities include the recruitment of required experts, and the preparation of final engineering designs and bidding documents for civil works. Moreover, to ensure that a qualified and experienced project manager and an architect/engineer are selected for the PIU, the project would provide funds ($145,000) to pay part of the salaries of these two Yemeni staff on a phased basis over three years. The Government has agreed to take by July 31, 1983 the necessary steps to incorporate its share of these salaries into the MOH recurrent budget for 1984 and 1985 (Development Credit Agreement, Section 3.05).

53. Despite the recent salary increases announced for all levels of YAR Government employees, the salaries are not yet sufficient to attract and/or retain experienced and qualified Yemeni staff necessary for a successful implementation of the proposed project, and consequently for the strengthening of MOH. In addition, since the project would finance about 17 internationally recruited technical advisors for MOH headquarters and HMI, it is important that the necessary number of qualified Yemeni staff be retained. Therefore, the proposed project would finance a Salary Supplement Fund (SSF) that would allow the MOH to grant each qualified key staff, a monthly salary supplement amounting to about 34 percent of the basic salary. The total amount, including contingencies, to be allocated to the SSF under the proposed credit is about $130,000 to be paid into the SSF on a phased basis over three years. A list of the 20 key Yemeni staff eligible for the salary supplement has been provided by the Government. An initial payment of $50,000 into an SSF account would be made by IDA upon credit effectiveness. Subsequent payments into the account would be made semi-annually on the basis of actual expenditures. The Government has agreed to take the necessary steps by July 31, 1983 to incorporate progressively the salary supplement expenditures into the recurrent expenditure budget of MOH, commencing fiscal year 1984 and leading to full budgetary provisions of such expenditures for fiscal year 1986 (Development Credit Agreement, Sections 3.04, 3.05 and 4.03).

Staffing, Training and Technical Assistance

54. A total of 33.5 man-years of overseas fellowships would be provided for senior MOH and HMI staff. Those chosen for fellowship support would be

required to work for at least six months with the appropriate expert upon the completion of their overseas training (Development Credit Agreement, Section 3.06) and would also be subject to MOH's policy of bonding staff members for five years following their return. Overseas fellowships will be of at most 12 months duration, allowing time for returnees to overlap with the appropriate expert for at least six months. In addition, the proposed project provides for in-service training to MOH and HMI staff in a number of areas. Training courses and seminars of two to four weeks' duration would be provided to about 1,850 field staff. The project also provides for the National Institute for Public Administration to design a series of one-month in-service courses in administration and management for MOH staff in charge of clinics, hospitals and district health offices. About 120 Yemeni staff would benefit from this program.

55. The MOH and HMI staff would be substantially strengthened through a technical assistance/training program encompassing about 26 man-years of consultancy services for key areas in the health sector (nutrition, health education, training, supply management and planning), or for specialized management assistance. Such consultancy assistance would be particularly important to MOH and HMI while Yemeni staff are being trained abroad. The Government has contracted on terms and conditions satisfactory to IDA, a US firm, Western Consortium, to assist in the recruitment of the individual consultants and experts. It is also in the process of appointing key staff important to project implementation in advance of credit effectiveness, in which case they would be financed during that period from the proceeds of funds allocated for health-related expenditures under the technical assistance component of IDA Credit 915-YAR (Third Education Project). The qualifications and terms and conditions of employment of all consultants and experts shall be satisfactory to IDA (Development Credit Agreement, Section 3.03).

Monitoring and Evaluation

56. An Evaluation and Research unit would be established at MOH under the project. This unit would develop an adequate system to help standardize the monitoring and evaluation reports. It would ensure that satisfactory reporting of activities, including detailed implementation arrangements, would be prepared by the PIU with copies forwarded to IDA. The PIU would prepare periodic reports on the activities under the project, and the Government will ensure that the PIU is maintained with organization and staffing satisfactory to IDA (Development Credit Agreement, Section 3.02).

Project Costs and Financing

57. The total cost of the project, including contingencies, is estimated at $15.8 million equivalent, of which about 54 percent, or $8.6 million equivalent, represents the foreign exchange component. These estimates, adjusted to reflect the second quarter of 1982 prices, are based on prices quoted in contracts of a similar nature. The project is exempt from taxes and duties. Physical contingencies of 10 percent for civil works, furniture and equipment were assumed in developing the cost estimates. Price contingencies for the period 1982-85 have been applied to civil works, equipment,

furniture and technical assistance, at rates varying between 7 and 11 percent per annum for items locally procured and between 7.5 and 8 percent per annum for items subject to foreign procurement. Price contingencies, of which 53 percent are in foreign exchange, amount to about 15 percent of the base cost plus physical contingencies. Total contingencies, of which 56 percent are in foreign exchange, amount to about 21 percent of the base cost. The base cost related to the project components are $6.7 million for development costs (civil works, equipment, vehicles, and material); $3.1 million for technical assistance; and $3.3 million for incremental operating costs (paragraph 60). Experts' services of about 26 manyears have been costed at about $7,100 and $9,000 per man-month for long- and short-term experts respectively, including travel, subsistence, and overhead. All experts would be hired by the Government with the assistance of a recruiting firm. The 33.5 man-years of overseas fellowships have been costed at an average of about $14,600 per man-year, including travel and subsistence.

58. The establishment of the PIU and of new units/departments at MOH implies an increase in the number of Yemenis employed by MOH and a rise in salaries to attract and retain qualified Yemeni staff. The incremental operating costs of about $3.8 million, including contingencies, provide for the salaries of the additional staff and operating costs for additional vehicles, equipment and facilities included in the project.

59. An advance from IDA's Project Preparation Facility (PPF), of $140,000, made to cover start-up expenditures of the PIU prior to the credit effectiveness, would be financed under this credit.

60. The proposed IDA credit of SDRs 9.62 million (approximately $10.5 million equivalent) would finance the full foreign exchange requirements of the project ($8.6 million), the local costs of the phased contribution to the SSF and two PIU staff members' salaries, the technical assistance component, and other minor supplies. The credit would represent about 66 percent of total project costs. The balance of project costs, $5.3 million, would be met by the Government, with UNICEF expected to contribute about $2.4 million towards the Government share.

Procurement

61. All civil works contracts, costing about $5.2 million in total, would be awarded on the basis of international competitive bidding (ICB) in accordance with IDA 'Guidelines for Procurement.' Contracts for equipment and furniture ($1.8 million), supplies and materials ($0.9 million), and vehicles ($0.7 million), would be grouped, whenever feasible, to attract international competitive bidding. Small goods contracts estimated at below $50,000 each which cannot be grouped appropriately, and not exceeding $200,000 in total, would be awarded on the basis of local competitive bidding following procedures which are satisfactory to IDA and do not exclude foreign bidders. Miscellaneous goods contracts which are estimated at less than $10,000 each and not exceeding $200,000 in total, would be procured under normal Government procedures which are satisfactory to IDA, and which include

solicitation of quotations from at least three manufacturers or suppliers. A 15 percent preference margin, or the prevailing custom duty, whichever is lower, would be extended to local manufacturers in evaluating bids under ICB.

Disbursement

62. The proceeds of the proposed credit, to be disbursed over a three and one-half year period, would finance (a) civil works, 60 percent of expenditures; (b) equipment, furniture, vehicles and materials, 100 percent of foreign expenditures, 100 percent of local expenditures (ex-factory) for locally manufactured items and 70 percent of local expenditures for items procured locally (off-the-shelf); (c) consultants' services, studies and training, 100 percent of expenditures; (d) salaries of two eligible PIU staff and SSF expenditures for key Yemeni project staff, 100 percent of payments made for the first, 50 percent for the second, and 30 percent for the third twelve-month periods following the Effective Date; and (e) project preparation advance, amount due.

Accounting and Audit

63. Separate project accounts and appropriate accounting procedures would be established within the PIU to record all project-related financial transactions. The Government has appointed a qualified and experienced accountant to the PIU. Moreover, independent auditors, acceptable to IDA, would audit these accounts and submit their reports to IDA through the PIU not later than six months after the close of each fiscal year (Development Credit Agreement, Section 4.01).

Project Benefits and Risks

64. The project has two main benefits. First, it would strengthen MOH's capacity in planning, management and program implementation, particularly for the BHS/PHC program. It would enhance MOH's ability to coordinate and monitor the Government's health policies and programs including those of local authorities and those financed by various multilateral and bilateral donors and thereby improve their effectiveness. Secondly, it would develop, through HMI, health manpower required to staff the long-term expansion of the BHS/PHC services and facilities. The project would help increase the annual output of graduates of HMI from 210 at present to 410 by 1985, and reorient HMI's training for nurses and midwives to the specific needs of the BHS/PHC program. As a consequence, MOH's health care delivery in general and its BHS/PHC program in particular, would be improved in the long term.

65. Project risks relate to (i) retention of MOH staff; (ii) timely recruitment of qualified experts; and (iii) possible continued underutilization of HMI facilities. These risks are minimized by the strong Government commitment to this project. The proposed salary supplements are expected to assist MOH in attracting and retaining quality staff in the short-run. The Government is committed to taking the necessary measures to ensure that MOH's staff salaries would remain competitive, and that personnel management practices would improve to further career development at MOH. With regard to the

recruitment of experts, the Government has contracted with a US firm, Western Consortium, to assist MOH in recruiting experts. As for HMI utilization, enrollment in preparatory schools (which feed HMI and other institutions) is projected to more than double between 1981 and 1986, with the number of graduates increasing accordingly. In addition, HMI's chances of obtaining enrollees from the pool of preparatory school graduates would be enhanced by the measures which MOH has taken (paragraph 43).

PART V - LEGAL INSTRUMENTS AND AUTHORITY

66. The draft Development Credit Agreement between the Yemen Arab Republic and the Association and the recommendation of the Committee provided for in Article V, Section 1(d) of the Association's Articles of Agreement are being distributed to the Executive Directors separately.

67. Features of the Development Credit Agreement of special interest are referred to in Section III of Annex III.

68. I am satisfied that the proposed credit would comply with the Articles of Agreement of the Association.

PART VI - RECOMMENDATION

69. I recommend that the Executive Directors approve the proposed credit.

A. W. Clausen
President
By Syed Kirmani

Attachments
September 8, 1982
Washington, D.C.

TABLE 3A
YEMEN, ARAB REPUBLIC OF - SOCIAL INDICATORS DATA SHEET

AREA (THOUSAND SQ. KM.)
TOTAL 195.0
AGRICULTURAL 97.9

	YEMEN, ARAB REPUBLIC OF			REFERENCE GROUPS (WEIGHTED AVERAGES - MOST RECENT ESTIMATE) /a	
	1960 /b	1970 /b	MOST RECENT ESTIMATE /b	MIDDLE INCOME NORTH AFRICA & MIDDLE EAST	MIDDLE INCOME LATIN AMERICA & CARIBBEAN
GNP PER CAPITA (US$)	..	..	430.0	1253.6	1902.0
ENERGY CONSUMPTION PER CAPITA (KILOGRAMS OF COAL EQUIVALENT)	6.7	15.3	57.6	713.5	1259.9
POPULATION AND VITAL STATISTICS					
POPULATION, MID-YEAR (THOUSANDS)	4163.0	5258.0	7039.0/c	.	.
URBAN POPULATION (PERCENT OF TOTAL)	3.4	6.0	10.3	47.3	65.7
POPULATION PROJECTIONS					
POPULATION IN YEAR 2000 (MILLIONS)			11.0	.	.
STATIONARY POPULATION (MILLIONS)			26.4	.	.
YEAR STATIONARY POPULATION IS REACHED			2130	.	.
POPULATION DENSITY					
PER SQ. KM.	21.3	27.0	35.0	35.8	35.2
PER SQ. KM. AGRICULTURAL LAND	43.1	54.0	69.8	420.9	92.5
POPULATION AGE STRUCTURE (PERCENT)					
0-14 YRS.	42.4	43.0	45.4	44.3	39.7
15-64 YRS.	54.4	53.9	51.5	52.4	56.1
65 YRS. AND ABOVE	3.2	3.1	3.2	3.3	4.2
POPULATION GROWTH RATE (PERCENT)					
TOTAL	2.3	2.3	2.9	2.8	2.4
URBAN	8.1	8.0	8.3	4.6	3.8
CRUDE BIRTH RATE (PER THOUSAND)	49.7	48.8	46.7	41.2	31.4
CRUDE DEATH RATE (PER THOUSAND)	28.9	26.4	22.8	12.2	8.4
GROSS REPRODUCTION RATE	3.4	3.3	3.2	2.9	2.1
FAMILY PLANNING					
ACCEPTORS, ANNUAL (THOUSANDS)	..	..	..	.	.
USERS (PERCENT OF MARRIED WOMEN)	..	..	..	..	..
FOOD AND NUTRITION					
INDEX OF FOOD PRODUCTION PER CAPITA (1969-71=100)	119.0	84.0	92.0	100.4	110.0
PER CAPITA SUPPLY OF					
CALORIES (PERCENT OF REQUIREMENTS)	90.3	75.9	81.8/d	108.5	108.4
PROTEINS (GRAMS PER DAY)	68.9	55.4	59.5/d	71.9	66.0
OF WHICH ANIMAL AND PULSE	17.6	13.7	19.0/d	18.0	34.0
CHILD (AGES 1-4) MORTALITY RATE	60.4	..	50.0	15.1	5.6
HEALTH					
LIFE EXPECTANCY AT BIRTH (YEARS)	35.8	38.5	42.2	56.9	64.2
INFANT MORTALITY RATE (PER THOUSAND)	211.6	..	190.0	104.3	64.2
ACCESS TO SAFE WATER (PERCENT OF POPULATION)					
TOTAL	..	4.0	4.0/e	59.1	65.6
URBAN	..	45.0	30.0/e	83.1	78.9
RURAL	..	2.0	2.0/e	39.8	43.9
ACCESS TO EXCRETA DISPOSAL (PERCENT OF POPULATION)					
TOTAL	..	..	..	..	59.3
URBAN	..	..	..	..	75.3
RURAL	..	..	..	..	30.0
POPULATION PER PHYSICIAN	130093.8	24373.9	11673.3	4015.5	1617.3
POPULATION PER NURSING PERSON	..	..	4582.7	1802.2	1063.5
POPULATION PER HOSPITAL BED					
TOTAL	2726.3	..	1699.8	641.7	477.4
URBAN	..	..	226.1	538.3	679.8
RURAL	..	..	6752.9	2403.3	1903.4
ADMISSIONS PER HOSPITAL BED	..	..	14.3	25.5	27.3
HOUSING					
AVERAGE SIZE OF HOUSEHOLD					
TOTAL	..	..	5.0/g	..	..
URBAN	..	..	4.2/f,g	..	..
RURAL	..	..	6.0/f	..	..
AVERAGE NUMBER OF PERSONS PER ROOM					
TOTAL	..	..	2.8/g	..	..
URBAN	..	..	1.8/f,g	..	..
RURAL	..	..	3.1/g	..	..
ACCESS TO ELECTRICITY (PERCENT OF DWELLINGS)					
TOTAL	..	..	..	..	..
URBAN	..	..	56.5/f.g	..	..
RURAL	..	..	..	..	..

TABLE 3A
YEMEN, ARAB REPUBLIC OF - SOCIAL INDICATORS DATA SHEET

	YEMEN, ARAB REPUBLIC			REFERENCE GROUPS (WEIGHTED AVERAGES - MOST RECENT ESTIMATE) /a	
	1960 /b	1970 /b	MOST RECENT ESTIMATE /b	MIDDLE INCOME NORTH AFRICA & NORTH EAST	MIDDLE INCOME LATIN AMERICA & CARIBBEAN
EDUCATION					
ADJUSTED ENROLLMENT RATIOS					
PRIMARY: TOTAL	8.0	12.0	34.1	88.7	104.3
MALE	14.0	23.0	59.4	104.5	106.4
FEMALE	0.4	2.0	8.6	72.0	103.3
SECONDARY: TOTAL	0.1	1.0	4.0	39.7	41.3
MALE	..	2.0	7.0	49.3	40.4
FEMALE	..	0.1	1.1	29.0	41.8
VOCATIONAL ENROL. (% OF SECONDARY)	2.7/h	2.0	4.6/g	10.1	33.7
PUPIL-TEACHER RATIO					
PRIMARY	44.7/h	51.1	38.7/g	34.1	29.9
SECONDARY	22.9/h	24.0	18.5/g	23.7	16.7
ADULT LITERACY RATE (PERCENT)	2/5/h	10.0/i	21.0	43.3	79.1
CONSUMPTION					
PASSENGER CARS PER THOUSAND POPULATION	..	..	..	17.8	42.8
RADIO RECEIVERS PER THOUSAND POPULATION	..	15.3/j	15.4	131.3	270.5
TV RECEIVERS PER THOUSAND POPULATION	..	..	0.1	44.1	107.7
NEWSPAPER ("DAILY GENERAL INTEREST") CIRCULATION PER THOUSAND POPULATION	..	10.7	..	31.5	63.7
CINEMA ANNUAL ATTENDANCE PER CAPITA	..	..	0.9/d	1.7	2.7
LABOR FORCE					
TOTAL LABOR FORCE (THOUSANDS)	1263.3	1481.0	1753.3	.	.
FEMALE (PERCENT)	3.7	4.5	5.4	10.6	24.4
AGRICULTURE (PERCENT)	83.0	79.0	75.0	42.4	31.3
INDUSTRY (PERCENT)	7.0	9.0	11.0	27.8	23.9
PARTICIPATION RATE (PERCENT)					
TOTAL	30.3	28.2	24.9	26.0	33.6
MALE	57.7	55.0	49.8	46.2	50.4
FEMALE	2.3	2.5	2.5	5.6	16.8
ECONOMIC DEPENDENCY RATIO	1.5	1.6	1.9	1.9	1.3
INCOME DISTRIBUTION					
PERCENT OF PRIVATE INCOME RECEIVED BY					
HIGHEST 5 PERCENT OF HOUSEHOLDS	..	..	..	..	..
HIGHEST 20 PERCENT OF HOUSEHOLDS	..	..	..	..	..
LOWEST 20 PERCENT OF HOUSEHOLDS	..	..	..	..	..
LOWEST 40 PERCENT OF HOUSEHOLDS	..	..	..	..	..
POVERTY TARGET GROUPS					
ESTIMATED ABSOLUTE POVERTY INCOME LEVEL (US$ PER CAPITA)					
URBAN	..	..	366.0	279.2	..
RURAL	..	..	..	178.6	184.1
ESTIMATED RELATIVE POVERTY INCOME LEVEL (US$ PER CAPITA)					
URBAN	..	..	..	403.6	518.0
RURAL	..	..	157.0	285.6	371.1
ESTIMATED POPULATION BELOW ABSOLUTE POVERTY INCOME LEVEL (PERCENT)					
URBAN	..	..	..	22.1	..
RURAL	..	..	..	30.9	..

.. Not available
. Not applicable.

NOTES

/a The group averages for each indicator are population-weighted arithmetic means. Coverage of countries among the indicators depends on availability of data and is not uniform.

/b Unless otherwise noted, data for 1960 refer to any year between 1959 and 1961; for 1970, between 1969 and 1971; and for Most Recent Estimate, between 1978 and 1980.

/c Resident population, includes migrant workers abroad for less than a year.

/d 1977; /e 1976; /f In the major cities of Sanaa, Taiz and Hodaidah; /g 1975; /h 1962; /i 1973; /j 1972.

DEFINITIONS OF SOCIAL INDICATORS

Notes: Although the data are drawn from sources generally judged the most authoritative and reliable, it should also be noted that they may not be internationally comparable because of the lack of standardized definitions and concepts used by different countries in collecting the data. The data are, nonetheless, useful to describe orders of magnitude, indicate trends, and characterize certain major differences between countries.

The reference groups are (1) the same country group of the subject country and (2) a country group with somewhat higher average incomes than the country group of the subject country (except for "High Income Oil Exporters" group where "Middle Income North Africa and Middle East" is chosen because of stronger socio-cultural affinities). In the reference group data the averages are population weighted arithmetic means for each indicator and shown only when majority of the countries in a group has data for that indicator. Since the coverage of countries among the indicators depends on the availability of data and is not uniform, caution must be exercised in relating averages of one indicator to another. These averages are only useful in comparing the value of one indicator at a time among the country and reference groups.

AREA (thousand sq.km.)

Total - Total surface area comprising land area and inland waters; 1979 data.

Agricultural - Estimate of agricultural area used temporarily or permanently for crops, pastures, market and kitchen gardens or to lie fallow; 1979 data.

GNP PER CAPITA (US$) - GNP per capita estimates at current market prices, calculated by same conversion method as World Bank Atlas (1978-80 basis); 1960, 1970, and 1980 data.

ENERGY CONSUMPTION PER CAPITA - Annual consumption of commercial energy (coal and lignite, petroleum, natural gas and hydro-, nuclear and geothermal electricity) in kilograms of coal equivalent per capita; 1960, 1970, and 1979 data.

POPULATION AND VITAL STATISTICS

Total Population, Mid-Year (thousands) - As of July 1; 1960, 1970, and 1980 data.

Urban Population (percent of total) - Ratio of urban to total population; different definitions of urban areas may affect comparability of data among countries; 1960, 1970, and 1980 data.

Population Projections

Population in year 2000 - Current population projections are based on 1980 total population by age and sex and their mortality and fertility rates. Projection parameters for mortality rates comprise of three levels assuming life expectancy at birth increasing with country's per capita income level, and female life expectancy stabilizing at 77.5 years. The parameters for fertility rate also have three levels assuming decline in fertility according to income level and past family planning performance. Each country is then assigned one of these nine combinations of mortality and fertility trends for projection purposes.

Stationary population - In a stationary population there is no growth since the birth rate is equal to the death rate, and also the age structure remains constant. This is achieved only after fertility rates decline to the replacement level of unit net reproduction rate, when each generation of women replaces itself exactly. The stationary population size was estimated on the basis of the projected characteristics of the population in the year 2000, and the rate of decline of fertility rate to replacement level.

Year stationary population is reached - The year when stationary population size will be reached.

Population Density

Per sq. km. - Mid-year population per square kilometer (100 hectares) of total area; 1960, 1970 and 1979 data.

Per sq. km. agricultural land - Computed as above for agricultural land only; 1960, 1970 and 1979 data.

Population Age Structure (percent) - Children (0-14 years), working-age (15-64 years), and retired (65 years and over) as percentages of mid-year population; 1960, 1970, and 1980 data.

Population Growth Rate (percent) - total - Annual growth rates of total mid-year population for 1950-60, 1960-70, and 1970-80.

Population Growth Rate (percent) - urban - Annual growth rates of urban populations for 1950-60, 1960-70, and 1970-80.

Crude Birth Rate (per thousand) - Annual live births per thousand of mid-year population; 1960, 1970, and 1980 data.

Crude Death Rate (per thousand) - Annual deaths per thousand of mid-year population; 1960, 1970, and 1980 data.

Gross Reproduction Rate - Average number of daughters a woman will bear in her normal reproductive period if she experiences present age-specific fertility rates; usually five-year averages ending in 1960, 1970, and 1980.

Family Planning - Acceptors, Annual (thousands) - Annual number of acceptors of birth-control devices under auspices of national family planning program.

Family Planning - Users (percent of married women) - Percentage of married women of child-bearing age (15-44 years) who use birth-control devices to all married women in same age group.

FOOD AND NUTRITION

Index of Food Production per Capita (1969-71=100) - Index of per capita annual production of all food commodities. Production excludes seed and feed and is on calendar year basis. Commodities cover primary goods (e.g. sugarcane instead of sugar) which are edible and contain nutrients (e.g. coffee and tea are excluded). Aggregate production of each country is based on national average producer price weights; 1961-65, 1970, and 1980 data.

Per capita supply of calories (percent of requirements) - Computed from energy equivalent of net food supplies available in country per capita per day. Available supplies comprise domestic production, imports less exports, and changes in stock. Net supplies exclude animal feed, seeds, quantities used in food processing, and losses in distribution. Requirements were estimated by FAO based on physiological needs for normal activity and health considering environmental temperature, body weights, age and sex distribution of population, and allowing 10 percent for waste at household level; 1961-65, 1970 and 1977 data.

Per capita supply of protein (grams per day) - Protein content of per capita net supply of food per day. Net supply of food is defined as above. Requirements for all countries established by USDA provide for minimum allowances of 60 grams of total protein per day and 20 grams of animal and pulse protein, of which 10 grams should be animal protein. These standards are lower than those of 75 grams of total protein and 23 grams of animal protein as an average for the world, proposed by FAO in the Third World Food Survey; 1961-65, 1970 and 1977 data.

Per capita protein supply from animal and pulse - Protein supply of food derived from animals and pulses in grams per day; 1961-65, 1970 and 1977 data.

Child (ages 1-4) Death Rate (per thousand) - Annual deaths per thousand in age group 1-4 years, to children in this age group, for most developing countries data derived from life tables; 1960, 1970 and 1980 data.

HEALTH

Life Expectancy at Birth (years) - Average number of years of life remaining at birth; 1960, 1970 and 1980 data.

Infant Mortality Rate (per thousand) - Annual deaths of infants under one year of age per thousand live births; 1960, 1970 and 1980 data.

Access to Safe Water (percent of population) - total, urban, and rural - Number of people (total, urban, and rural) with reasonable access to safe water supply (includes treated surface waters or untreated but uncontaminated water such as that from protected boreholes, springs, and sanitary wells) as percentages of their respective populations. In an urban area a public fountain or standpost located not more than 200 meters from a house may be considered as being within reasonable access of that house. In rural areas reasonable access would imply that the housewife or members of the household do not have to spend a disproportionate part of the day in fetching the family's water needs.

Access to Excreta Disposal (percent of population) - total, urban, and rural - Number of people (total, urban, and rural) served by excreta disposal as percentages of their respective populations. Excreta disposal may include the collection and disposal, with or without treatment, of human excreta and waste-water by water-borne systems or the use of pit privies and similar installations.

Population per Physician - Population divided by number of practising physicians qualified from a medical school at university level.

Population per Nursing Person - Population divided by number of practising male and female graduate nurses, assistant nurses, practical nurses and nursing auxiliaries.

Population per Hospital Bed - total, urban, and rural - Population (total, urban, and rural) divided by their respective number of hospital beds available in public and private general and specialized hospital and rehabilitation centers. Hospitals are establishments permanently staffed by at least one physician. Establishments providing principally custodial care are not included. Rural hospitals, however, include health and medical centers not permanently staffed by a physician (but by a medical assistant, nurse, midwife, etc.) which offer in-patient accommodation and provide a limited range of medical facilities. For statistical purposes urban hospitals include WHOs principal/general hospitals, and rural hospitals, local or rural hospitals and medical and maternity centers. Specialized hospitals are included only under total.

Admissions per Hospital Bed - Total number of admissions to or discharges from hospitals divided by the number of beds.

HOUSING

Average Size of Household (persons per household) - total, urban, and rural - A household consists of a group of individuals who share living quarters and their main meals. A boarder or lodger may or may not be included in the household for statistical purposes.

Average number of persons per room - total, urban, and rural - average number of persons per room in all urban, and rural occupied conventional dwellings, respectively. Dwellings exclude non-permanent structures and unoccupied parts.

Access to Electricity (percent of dwellings) - total, urban, and rural - Conventional dwellings with electricity in living quarters as percentage of total, urban, and rural dwellings respectively.

EDUCATION

Adjusted Enrollment Ratios

Primary school - total, male and female - Gross total, male and female enrollment of all ages at the primary level as percentages of respective primary school-age populations; normally includes children aged 6-11 years but adjusted for different lengths of primary education; for countries with universal education enrollment may exceed 100 percent since some pupils are below or above the official school age.

Secondary school - total, male and female - Computed as above; secondary education requires at least four years of approved primary instruction; provides general, vocational, or teacher training instructions for pupils usually of 12 to 17 years of age; correspondence courses are generally excluded.

Vocational enrollment (percent of secondary) - Vocational institutions include technical, industrial, or other programs which operate independently or as departments of secondary institutions.

Pupil-teacher ratio - primary, and secondary - Total students enrolled in primary and secondary levels divided by numbers of teachers in the corresponding levels.

Adult literacy rate (percent) - Literate adults (able to read and write) as a percentage of total adult population aged 15 years and over.

CONSUMPTION

Passenger Cars (per thousand population) - Passenger cars comprise motor cars seating less than eight persons; excludes ambulances, hearses and military vehicles.

Radio Receivers (per thousand population) - All types of receivers for radio broadcasts to general public per thousand of population; excludes unlicensed receivers in countries and in years when registration of radio sets was in effect; data for recent years may not be comparable since most countries abolished licensing.

TV Receivers (per thousand population) - TV receivers for broadcast to general public per thousand population; excludes unlicensed TV receivers in countries and in years when registration of TV sets was in effect.

Newspaper Circulation (per thousand population) - Shows the average circulation of "daily general interest newspaper", defined as a periodical publication devoted primarily to recording general news. It is considered to be "daily" if it appears at least four times a week.

Cinema Annual Attendance per Capita per Year - Based on the number of tickets sold during the year, including admissions to drive-in cinemas and mobile units.

LABOR FORCE

Total Labor Force (thousands) - Economically active persons, including armed forces and unemployed but excluding housewives, students, etc., covering population of all ages. Definitions in various countries are not comparable; 1960, 1970 and 1980 data.

Female (percent) - Female labor force as percentage of total labor force.

Agriculture (percent) - Labor force in farming, forestry, hunting and fishing as percentage of total labor force; 1960, 1970 and 1980 data.

Industry (percent) - Labor force in mining, construction, manufacturing and electricity, water and gas as percentage of total labor force; 1960, 1970 and 1980 data.

Participation Rate (percent) - total, male, and female - Participation or activity rates are computed as total, male, and female labor force as percentages of total, male and female population of all ages respectively; 1960, 1970, and 1980 data. These are based on ILO's participation rates reflecting age-sex structure of the population, and long time trend. A few estimates are from national sources.

Economic Dependency Ratio - Ratio of population under 15 and 65 and over to the total labor force.

INCOME DISTRIBUTION

Percentage of Private Income (both in cash and kind) - Received by richest 5 percent, richest 20 percent, poorest 20 percent, and poorest 40 percent of households.

POVERTY TARGET GROUPS

The following estimates are very approximate measures of poverty levels, and should be interpreted with considerable caution.

Estimated Absolute Poverty Income Level (US$ per capita) - urban and rural - Absolute poverty income level is that income level below which a minimal nutritionally adequate diet plus essential non-food requirements is not affordable.

Estimated Relative Poverty Income Level (US$ per capita) - urban and rural - Rural relative poverty income level is one-third of average per capita personal income of the country. Urban level is derived from the rural level with adjustment for higher cost of living in urban areas.

Estimated Population Below Absolute Poverty Income Level (percent) - urban and rural - Percent of population (urban and rural) who are "absolute poor".

Economic and Social Data Division
Economic Analysis and Projections Department
May 1982

ECONOMIC INDICATORS

NATIONAL ACCOUNTS (US$ Mln)	1981 1/ (Current Prices)	ANNUAL RATE OF GROWTH (Constant Price) FY1977-81	FY1981
GNP at Market Prices 2/	3228	6	1
GDP at Market Prices	2877	6	5
Gross Domestic Investments	1284	26	3
Gross National Savings	518	1	-23
Exports of GNFS	251	24	30
Imports of GNFS	2141	13	6

OUPUT, LABOR FORCE AND PRODUCTIVITY (1981)

	Value Added		Resident Labor Force		V.A. Per Worker	
	US$ Mln	%	Thousand	%	US$	%
Agriculture	820	32	830	69	988	47
Industry	206	8	54	5	3815	182
Services	1492	60	318	26	4691	224
TOTAL/AVERAGE	2518	100	1202	100	2095	100

GOVERNMENT FINANCE (YR1s Mln)

	1977/78	1978/79	1979/80	1981	% of GNP 1981
Current Receipts	1985	2161	2755	3277	22
Current Expenditure	1250	1847	2531	3253	22
Current Deficit/Surplus	735	314	224	24	-
Capital Expenditure	1167	2618	2492	3807	26
External Assistance, Net	691	1904	976	2437	17

MONEY CREDIT AND PRICES

	---YR1s Million Outstanding End Period---			
Money Supply	5081	6273	7350	7868
Bank Credit to Govt. Sector	-990	-609	1199	4039
Bank Credit to Non-Govt. Sector	1555	2199	2830	3234
	------Percentages or Index Numbers------			
Money Supply at % of GNP	53	53	52	54
Annual Percentage Increase in:				
Money Supply	45	23	17	7
Consumer Price Index	17	22	11	7

1/ Provisional. The fiscal year was from July 1 to June 30 through 1979/80, then it was changed to coincide with the calendar year as of January 1981.

2/ Not including private transfers by Yemeni migrants whose duration of stay abroad exceeds one year.

BALANCE OF PAYMENTS (US$ Mln)

	1977/78	1978/79	1979/80	1981
Exports of Goods, fob	7	3	7	10
Imports of Goods, cif	-801	-1250	-1546	-1748
Trade Balance	-794	-1247	-1543	-1738
Non Factor Services, net	-69	-36	--	-51
Transfers and Factor Income, net	1039	833	1098	788
Balance on Current Account	176	-450	-445	-1001
M & LT Capital, net	176	416	229	542
Official Grants	100	312	112	337
Official Loans, net 1/	76	104	117	205
Disbursements	(81)	(114)	(124)	(262)
Repayments	(-5)	(-10)	(-7)	(-57)
Other Capital (including errors and ommissions), net	73	162	184	128
Increase in Reserves (-)	-425	-128	32	331
Gross Reserves (end FY)	1085	1213	1180	850

EXTERNAL PUBLIC DEBT (1981)

Total Outstanding	1747
of which disbursed	1094

DEBT SERVICE RATIO (1981) 2/

	%
Total Outstanding and Disbursed	1.3

MERCHANDISE EXPORTS
(Average 1976/77-1979/80)

Cotton and Cotton Products	14
Coffee	9
Hides and Skins	12
Biscuits and Confectionary	15
All Other Commodities	50
	100

1/ Based on figures published in the Central Bank's financial statistical bulletins. These figures differ slightly from debt information compiled on a loan-by-loan basis.

2/ Workers' remittances and transfers included in denominator.

EM1DB
August 1982

THE STATUS OF BANK GROUP OPERATIONS IN THE YEMEN ARAB REPUBLIC
(As of March 31, 1982 - $ Million)

A. Statement of IDA Credits 1/

Credit Number	Year	Borrower	Purpose	Amount (less cancellations) IDA	Undisbursed
		Five credits fully disbursed 2/		55.2	
465	1975	Yemen Arab Republic	Industrial Estate	2.3	0.4
545	1975	Yemen Arab Republic	Rural Development	10.0	0.04
559	1975	Yemen Arab Republic	Hodeidah Water Supply	8.1	0.01
611	1976	Yemen Arab Republic	Education II	8.0	0.8
636	1976	Yemen Arab Republic	Grain Storage and Processing	5.2	1.5
662	1976	Yemen Arab Republic	Livestock Credit and Processing	5.0	0.8
670	1977	Yemen Arab Republic	Sanaa Water Supply II	10.0	3.1
714	1977	Yemen Arab Republic	Port Development	6.0	1.1
794	1978	Yemen Arab Republic	Highways III	11.5	5.4
805	1978	Yemen Arab Republic	Tihama Agriculture II	10.5	4.6
837	1978	Yemen Arab Republic	Power Distribution	10.0	4.8
880	1979	Yemen Arab Republic	Tihama Agriculture III	15.0	14.2
915	1979	Yemen Arab Republic	Education III	10.0	6.9
950	1979	Yemen Arab Republic	Ibb and Dhamar Water Supply	12.0	11.9
978	1980	Yemen Arab Republic	Tihama Agriculture IV	5.5	5.4
1025	1980	Yemen Arab Republic	Fisheries Development	17.0	16.5
1067	1980	Yemen Arab Republic	Rural Development	17.0 4/	16.6 5/
1102	1981	Yemen Arab Republic	Regional Elect.	12.0	12.0
1122	1981	Yemen Arab Republic	Industrial Dev.	12.0	12.0
1202	1982	Yemen Arab Republic	Sanaa Urban Development	15.0	15.0
1203	1982	Yemen Arab Republic	Education IV	12.0	12.0
1216	3/1982	Yemen Arab Republic	Petroleum and Geothermal Exp.	2.0	2.0
		Total		271.3 1/	147.1
		of which has been repaid			
		Total now held by IDA		271.3	
		Total undisbursed			147.1

1/ Excluding $7 million credit for textile rehabilitation project which was cancelled on October 31, 1979, and a $6 million credit for the Agricultural Research and Development project and a $7 million credit for the Fourth Highway project which were approved by the Executive Directors on June 8 and 17, 1982, respectively.

2/ Including supplementary credit of $10.3 million of April 9, 1976.

3/ Not yet effective.

4/ Beginning with Credit 1067-YAR, credits have been denominated in Special Drawing Rights. The dollar amounts shown in this column represent the dollar equivalents at the time of credit negotiations.

5/ Beginning with Credit 1067-YAR, the dollar amounts shown in this column represent the dollar equivalents as of the date of this status report (i.e., March 31, 1982).

B. Statement of IFC Investments

Year	Obligor	Type of Business	(Amount in US$ millions) Loan	Equity	Total
1978	Yemen Dairy and Juice Industries Co. Ltd.	Dairy Products	2.4	-	2.4
	Total Gross Commitments		2.4		2.4
	less cancellations, terminations, repayments, sales		-		-
	Total commitments now held by IFC		2.4		2.4

Fully disbursed

C. Other Bank Group Activities

Two Bank grants of $200,000 each, and one of $120,000 were approved in July 1971, September 1973 and January 1976 to help finance, jointly with the Kuwait Fund for Arab Economic Development, a team of planning and economic advisors and later a management/administrative expert. The Kuwait Fund provided grants of about $200,000, $300,000 and $425,000.

D. Projects in Execution 1/

Cr. No. 465-YAR - Industrial Estate Project; $2.3 million Credit of March 4, 1974; Effectiveness Date: November 17, 1974; Closing Date: December 31, 1982.

Key staff for the Industrial Estate Development Authority have been appointed and advisory services for operations and civil engineering are being secured. Feasibility studies for the planned industrial estates in Taiz and Hodeidah are underway.

1/ These notes are designed to inform the Executive Directors regarding the progress of projects in execution and in particular, to report any problems which are being encountered and the action being taken to remedy them. They should be read in this sense, and with understanding that they do not purport to present a balanced evaulation of strengths and weaknesses in project execution.

Cr. No. 545-YAR - Southern Uplands Rural Development Project; $10.0 million Credit of May 13, 1975; Effectiveness Date: January 17, 1976; Closing Date: March 31, 1982.

The project is completed and the final withdrawal application, which will exhaust the credit proceeds, is being processed. The problem of cost escalation of rural water scheme was largely solved by elimination of the rural roads component, which became possible as a result of its financing by the local communities.

Cr. No. 559-YAR - Hodeidah Water Supply and Sewerage Project; $8.1 million Credit of June 20, 1975; Effectiveness Date: December 29, 1975; Closing Date: June 30, 1982.

Construction has been substantially completed. Transfer of the existing water system assets from the Port Authority has been effected. Training of operational personnel for the sewerage collection and treatment element has not proceeded apace.

Cr. No. 611-YAR - Second Education Project; $8.0 million Credit of February 13, 1976; Effectiveness Date: May 10, 1976; Closing Date: June 30, 1982.

All construction and equipping of project institutions is complete and all twelve institutions are operational. Technical assistance and staffing needs have been met by the appointment of expatriates from Arab countries. Progress in the utilization of the Basic Training Scheme is relatively slow.

Cr. No. 636-YAR - Grain Storage and Processing Project; $5.2 million Credit of June 7, 1976; Effectiveness Date: October 26, 1976; Closing Date: December 31, 1982.

Construction of all project components has been completed; the grain silo at Hodeidah and the bakeries at Sana'a and Taiz are in operation. Cost overruns on construction are being met by the Saudi Fund for Development and the YAR Government. The training program is underway and technical assistance is also continuing.

Cr. No. 662-YAR - Livestock Credit and Processing Project; $5.0 million Credit of November 15, 1976; Effectiveness Date: August 22, 1977; Closing Date: June 30, 1984.

Following escalation in the costs of this project, and a number of other implementation problems, the project scope was reduced without changing the project concept. One dairy farm has been completed, but the livestock fattening farm is facing some problems in the supply of irrigation water. The other physical works, although progressing reasonably well at

present, are about one year behind schedule. The slaughterhouses, meat markets, and animal health components, in particular, are achieving their aims, and the livestock fattening, dairy production, and village development components will provide valuable research information and development experience for the livestock sector in YAR. The vacant positions in the project implementation unit have been or are being filled.

Cr. No. 670-YAR - Sana'a Second Water Supply and Sewerage Project; $10.0 million Credit of January 14, 1977; Effectiveness Date: May 16, 1977; Closing Date: December 31, 1982.

All contracts for supply of materials and construction of the water and sewerage systems have been awarded. Implementation of the sewerage component of the project is behind schedule because of the delayed award of the civil works contract and changed location of treatment plant site. The closing date has recently been extended to allow time for acquisition of the treatment plant site.

Cr. No. 714-YAR - Port Development Project; $6.0 million Credit of June 8, 1977; Effectiveness Date: March 17, 1978; Closing Date: March 31, 1983

Civil works construction was completed in December 1981, about eleven months behind appraisal schedule. Final estimation of the cost of the works is in progress to determine final project cost including contractors claims.

Cr. No. 794-YAR - Third Highway Project; $11.5 million Credit of May 31, 1978; Effectiveness Date: April 4, 1979; Closing Date: March 31, 1983

Implementation is about two years behind schedule due to initial delays in arranging cofinancing and subsequent difficulties in locating a suitable training organization. Most of the equipment provided under the project has arrived and construction contracts for three of the five weighing stations have been signed. Implementation of a comprehensive training program has started. Preparation studies for the overlay program have been completed or are underway.

Cr. No. 805-YAR - Second Tihama Development Project (Wadi Rima); $10.5 million Credit of May 31, 1978; Effectiveness Date: March 5, 1979; Closing Date: June 30, 1984

After an initial slow start, progress on all components relating to Wadi Rima has picked up with some of them nearing completion. The agricultural extension service is proceeding satisfactorily.

Cr. No. 837-YAR - Power Distribution Project; $10.0 million Credit of July 25, 1978; Effectiveness Date: August 20, 1979; Closing Date: June 30, 1984

Implementation is underway and major contracts for the supply of equipment and materials have been awarded. The rural electrification interim study has been completed. YGEC's training center is operating but experiencing some problems relating to lack of text books. Training abroad is proceeding but not at an adequate pace to meet YGEC's pressing need for trained staff.

Cr. No. 880-YAR - Third Tihama Development Project (Wadi Mawr); $15.0 million Credit and $3.0 million Special Action Credit of April 20, 1979; Effectiveness Date: February 29, 1980; Closing Date: September 30, 1985

After a delay in declaring the credit effective and selecting project consultants for engineering work, implementation is now underway and the engineering consultants' inception report is expected shortly. Farm management consultants have been selected and their contract is under consideration by Government. Training of extension agents has started and assignments in the project area are being made. TDA has not yet appointed a project manager. Procurement of equipment for agricultural services has been initiated.

Cr. No. 915-YAR - Third Education Project; $10.0 million Credit of June 27, 1979; Effectiveness Date: December 21, 1979; Closing Date: July 31, 1986

Civil works equipment procurement is proceeding satisfactorily. One project institution is already operational; the remaining three project institutions will be completed shortly. The implementation of technical assistance has been slow and the Ministry of Education has been requested to submit a training program to utilize the funds allocated for this component.

Cr. No. 950-YAR - Ibb and Dhamar Water Supply and Sewerage Project; $12.0 million Credit of November 15, 1979; Effectiveness Date: January 13, 1981; Closing Date: December 31, 1984

Tardy preparation of the hydrological study and tender documents together with slippage of the well drilling program have delayed the water component. Drilling is nearing completion in Ibb and will recommence in Dhamar in April 1982. Bids for civil works are being evaluated and contract awards are expected shortly.

Cr. No. 978-YAR - Fourth Tihama Development Project (Wadi Rima II); $5.5 million Credit of April 21, 1980; Effectiveness Date: April 14, 1981; Closing Date: June 30, 1985

Contracts for the construction of irrigation structures have been awarded and the work started. The forestry expert and the sand dune stabilization expert have been appointed and about 800 ha of dunes have been selected for afforestation. The staff required for the rural uplift program has been appointed.

Cr. No. 1025-YAR - Fisheries Development Project; $17.0 million Credit of June 6, 1980; Effectiveness Date: April 14, 1981; Closing Date: June 30, 1986

After initial delays, project implementation has somewhat improved. A fisheries advisor has been selected and contract negotiations for construction of fishing ports and shore facilities are underway. Vessels for trial fishing and shrimping have been ordered.

Cr. No. 1067-YAR - Second Southern Uplands Rural Development Project; $17.0 Million Credit of November 24, 1980; Effectiveness Date: June 16, 1981; Closing Date: December 31, 1985

Agricultural extension, rural water supply construction and provision of agricultural credit, started under the First Southern Uplands project, are expanded to cover most of the provinces of the region. Key staff have been appointed. Expansion of agricultural extension services and implementation of additional rural water schemes are progressing on schedule.

Cr. No. 1102-YAR - Regional Electrification Project; $12.0 million Credit of May 15, 1979; Effectiveness Date: December 15, 1981; Closing Date: December 31, 1984

Project implementation is underway. Procurement of materials is complete and contracts with consultants for detailed engineering and construction supervision have been signed. The construction and erection contract has been awarded.

Cr. No. 1122-YAR - Industrial Development Project; $12.0 million Credit of May 15, 1979; Effectiveness Date: November 13, 1981; Closing Date: December 31, 1985

Project implementation is underway. The director general and credit adviser have been appointed.

Cr. No. 1202-YAR Sanaa Urban Development Project; $15.0 million Credit of February 5, 1982; Effectiveness Date: May 7, 1982; Closing Date: December 31, 1987

Project implementation is underway. The chief engineer and the implementation engineer have been appointed.

Cr. No. 1203-YAR Fourth Education Project; $12.0 million Credit of February 5, 1982; Effectiveness Date: June 15, 1982; Closing Date: December 31, 1987

Project implementation is underway.

Cr. No. 1216-YAR Petroleum and Geothermal Exploration Promotion Project; $2.0 million Credit of April 9, 1982; Effectiveness Date: (Not yet effective); Closing Date: June 30, 1985

Action on effectiveness and project start-up is underway.

YEMEN ARAB REPUBLIC

HEALTH PROJECT

SUPPLEMENTARY PROJECT DATA SHEET

Section I: Timetable of Key Events

(a)	Time taken by country to prepare project:	Ten months (June 1980 to April 1981)
(b)	The agencies which prepared the project:	Government and Consultants, with IDA assistance
(c)	Date of first presentation to IDA:	June 1980
(d)	Date of Departure of appraisal mission:	September 18, 1981
(e)	Date of completion of negotiations:	July 15, 1982
(f)	Planned Date of Effectiveness:	January 1983

Section II: Special Implementation Action by IDA

None

Section III: Special Conditions

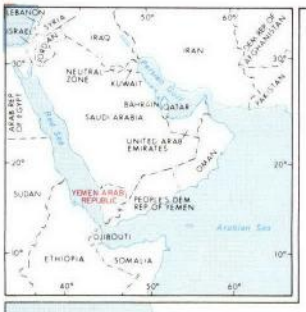
Measures to be Taken by the Government include:

(1) Incorporation of the salaries and salary supplements of eligible MOH staff into its budget (paragraphs 52-53).

(2) Establishment of a Salary Supplement Fund (paragraph 53); and

(3) Implementation of a staffing and training program (paragraphs 54-55).

IBRD 16317
MARCH 1982



YEMEN ARAB REPUBLIC

HEALTH PROJECT

Location of Physical Project Facilities

- Rural Health Training School
- Health Manpower Institutes
- Prototype Warehouse with Attached Equipment Maintenance Work Shop

- Paved Primary Roads
- Other Roads
- Airports
- Cities, Towns and Villages
- National Capitals
- Main Wadis
- Provincial Boundaries
- International Boundaries

N

0 20 40 60 80 100
KILOMETERS

0 20 40 60
MILES

PROJECTS:
- Agricultural
- Agricultural Research Centers
- Demonstration Farms
- Grain Storage
- Fisheries
- Fish Markets
- Industrial
- Education
- Highways
- Highway Maintenance
- Power Stations
- Transmission Lines
- Water Supply
- Port Development
- Urban Development

EXISTING FEATURES:
- Governorate Capitals
- National Capitals
- Primary Roads
- Secondary Roads
- Airports
- Ports
- Wadis
- Provincial Boundaries
- International Boundaries

ELEVATION (Meters):
- 0
- 300
- 1500

PROJECT:	FISCAL YEAR APPROVED:
HIGHWAYS I	1972
TIHAMA AGRICULTURE I	1973
EDUCATION I	1974
SANA'A WATER SUPPLY I	1974
SMALL INDUSTRY DEVELOPMENT	1974
SOUTHERN UPLANDS RURAL DEVELOPMENT I	1975
HIGHWAYS II	1975
HODEIDA WATER SUPPLY & SEWERAGE	1975
EDUCATION II	1976
GRAIN STORAGE & PROCESSING	1976
LIVESTOCK CREDIT & PROCESSING	1977
SANA'A WATER SUPPLY II & SEWERAGE	1977
PORT DEVELOPMENT I	1977
HIGHWAYS III	1978
TIHAMA AGRICULTURE II	1978
POWER DISTRIBUTION	1979
TIHAMA AGRICULTURE III	1979
EDUCATION III	1979
IBB & DHAMAR WATER SUPPLY & SEWERAGE	1980
TIHAMA AGRICULTURE IV	1980
ARTISANAL FISHERIES I	1980
SOUTHERN UPLANDS RURAL DEVELOPMENT II	1981
POWER II REGIONAL ELECTRIFICATION	1981
INDUSTRIAL DEVELOPMENT	1981
EDUCATION IV	1982
URBAN I	1982
AGRICULTURAL RESEARCH & DEVELOPMENT	1982
HIGHWAYS IV	1982
PETROLEUM & GEOTHERMAL	1982

IBRD 15174R1
JUNE 1982

Dr. Evans wants to speak on the phone to each of the Regional Vice Presidents -- and immediately afterward make appointments to meet with their Program Directors; Subject: Preparation of the Health Lending Program.

EASTERN AFRICA

Vice President:	Mr. Willi Wapenhans	x74037	
Director EA1 :	Mr. Jochen Kraske	x72491	Rm. A-1013
Director EA2 :	Mr. Andre Gue	x72607	Rm. C-1001

WESTERN AFRICA

Vice President:	Mr. Roger Chaufournier	x72063	
Director WA1 :	Mr. Bilsel Alisbah	x78051	Rm. E-324
Director WA2 :	Mr. X. de la Renaudiere	x72661	Rm. C-302

do LAST EAST ASIA & PACIFIC

Vice President:	Mr. Shahid Husain	x72283	
Director AEA :	*Mr. Stanley Please	x72103	
	(on Oct. 15 he goes to Indonesia - will be replaced by:		
	Mr. E.V.K. Jaycox	x73996	Rm. D-630

SOUTH ASIA

Vice President:	Mr. David Hopper	x72395	
Director ASA :	Mr. Michael Wiehen	x74945	Rm. C-502

EUROPE, MIDDLE EAST & NORTH AFRICA

Vice President:	Mr. Munir Benjenk	x74261	
Director EM1 :	Mr. A. Karaosmanoglu	x74503	Rm. C-702
Director EM2 :	Mr. Maurice Bart	x72383	Rm. F-718

LATIN AMERICA & THE CARIBBEAN

Vice President:	Mr. Nicolas Barletta	x75901	A-907
Director LC1 :	Mr. Eugenio Lari	x74621	Rm. B-906
Director LC2 :	Mr. Enrique Lerdau	x72333	Rm. A-837

TUES. OCT. 23 4 30 P.M.

Let Messenger know when appts. are made so he can coordinate with Kisa.

Thanks, Jean
Oct. 9/79

OFFICE MEMORANDUM

TO: Mr. J. Kisa; Mrs. A. Fonaroff; Dr. H. J. Park; and Mrs. L. Domingo

DATE: October 10, 1979

FROM: Harold W. Messenger

SUBJECT: Preparation of a Health Lending Program

1. With the Bank's FY81 budget cycle beginning in earnest it is important that a lending program for health be developed as quickly as feasible. Only projects firmly in regional lending programs provide justification for manpower resources for Projects' Departments. I would be grateful if the four of you could act as an ad hoc team under the guidance of Mr. Kisa to discuss with the Regions a program of health activities to be undertaken during the next five years. As you know, the outer years of a Five-Year lending program are necessarily tentative. Since the program is rolled over every year we will have additional opportunities to refine the program's outer years.

2. There are three kinds of activities which we need to discuss with the Regions. The first is sector studies. These would be most appropriate in countries where little is known about the health situation, and where there is a possibility of Bank involvement. Initially, I suggest that we attempt to limit sector studies to those countries that appear in the Five-Year lending program. Agreement on sector studies should be confirmed by the issuance of a Form 700.

3. We should also identify as firmly as possible the health projects that we would expect to send to the Board during the next five years. Attachment 1 is a summary by Region indicating health projects that we believe are already in Regional lending programs and other countries that have been mentioned as possible candidates for health projects. Also indicated on the attachment are estimates of the maximum numbers of projects by year that we can handle given the resources likely to be made available and the time required for project preparation.

4. One of the priorities of our new Department will be to prepare guidelines to help us select the countries to which we should devote our limited staff resources. For the time being, however, may I simply suggest that the following factors should be taken into account:

i. severity of health problems in the country concerned;

ii. the interest of the government in improving the health status of the poorest;

iii. the presence of at least some administrative capability in the government concerned to utilize the resources provided by a Bank health project;

iv. good experience with implementing Bank projects in other sectors;

v. the existence of extensive background work (a WHO Country Programming Exercise, for example);

vi. balance of projects among the Regions; and

vii. balance of projects between larger and smaller countries.

Attachment 2 for your information and use contains a compilation of three health indices by country, by region. The Physical Quality of Life Index (PQLI) is a composite of literacy, life expectancy and infant mortality rate. Life expectancy alone is also given in another column. The third column gives the per capita expenditure on health.

5. Third, we should obtain some indication of the Regions' interest in health components. These indications can be somewhat tentative at this time, but should form a basis for the completion of a firm health component lending program later.

6. Your principal contacts should be with the Programs Divisions.

7. Could we meet with Dr. Evans and Dr. Kanagaratnam on Wednesday, October 10 at 4 p.m. to discuss this task.

Cleared with and cc: Dr. Evans
Dr. Kanagaratnam
cc: Mr. Berg (o/r)
Dr. Liese (o/r)
Ms. Ueber Raymond (o/r)

HWMessenger:jb

WORLD BANK / INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

TO: Program Directors (see below)

DATE October 11, 1979

FROM: John R. Evans, Director, PHN

SUBJECT: Bank's Lending in the Health Sector

1. We are in the process of organizing the new Population, Health and Nutrition Department; within the next few weeks we expect to have two operating Divisions functioning consisting of staff of the former Population Projects Department, the Nutrition Division of the Agriculture and Rural Development Department and the health experts from the Office of Health and Environmental Affairs. An immediate task is to decide on a work program of health sector work, projects and components. A similar program for population exists and is being updated and a program for nutrition is being prepared. Once all three programs are available they will be integrated, with any necessary adjustments being made in consultation with the Regional Offices.

2. The Bank's activities in health will begin modestly, and because present resources available to the Department are limited, we feel it essential to reach agreement with the Regional Offices on items that can now be included firmly in the work program. I look forward to meeting you and to working together toward this goal.

3. During our meeting, I will be interested in hearing your views on health priorities in the countries for which you have Bank responsibility. For further information, following our discussion, I have asked a group of my staff, headed by Mr. J. Kisa, to contact your Division Chiefs to identify those countries in your Region most likely to need assistance in the health sector. While we would not expect this to produce a comprehensive overview of health problems in client countries, we believe this will greatly assist in the initial preparation of the FY81 budget and in preparing a five-year lending plan in the health sector. Over time our mutual understanding of health problems in client countries should improve as our operational activities increase.

4. I will be grateful for your assistance in this regard and look forward to arriving at agreements on items that can now be included firmly in the work program.

To: Mr. Kraske, EA1; Mr. Gue, EA2; Mr. Alisbah, WA1; Mr. de la Renaudiere, WA2; Mr. Please, AEA; Mr. Wiehen, ASA; Mr. Karaosmanoglu, EM1; Mr. Bart, EM2; Mr. Lari, LC1; Mr. Lerdau, LC2

TENTATIVE HEALTH LENDING PROGRAM, FY81-84

Region	FY81	FY82	FY83	FY84
East Africa				Sudan /3
West Africa			Mali /1 Nigeria /3	Ghana /1
EMENA			YAR /1	Afghanistan /1
LAC		Peru /2 El Salvador /2 Brazil /2		Mexico /3
East Asia		Indonesia /2		
South Asia				Sri Lanka /3

Probable max. for Dept.	FY81-82	FY83	FY84	FY85
	4	4	5	4

/1 In the lending program.
/2 Shown as reserve
/3 Initial discussion with the Region has been made by OEHA/

LVD
October 9, 1979

West Africa

Country	1977 [1] Population (mi)	1978 [2] PQLI Ranking	1975 [3] Per Capita Public Health Exp. ($US) Ranking	1977 [4] Life Expectancy at Birth Ranking
	(all rankings from group of 70 low and middle-income countries) 1= group lowest; 70= group highest [5]			
Nigeria	79.0	18/25	19	33/38
Ghana	10.6	39/41	58/59	33/38
Cameroon	7.9	18/25	45	18/29
Ivory Coast	7.5	28	70	52/54
Angola	6.6	3/4	54	2/3
Mali	6.1	1/2	20/21	4/10
Upper Volta	5.5	3/4	16	4/10
Senegal	5.2	11/12	58/59	4/10
Guinea	5.0	10	39/40	13/15
Niger	4.9	1/2	20/21	4/10
Chad	4.2	6/8	11	4/10
Benin	3.2	18/25	32/33	18/29
Togo	2.4	14	34	18/29
Central Africa Empire	1.9	6/8	36/37	18/29
Liberia	1.7	16/17	57	33/36
Mauritanie	1.5	6/8	41/42	4/10
Congo	1.4	18/25	67	18/29
Lesotho	1.3	51/52	36/37	39
Gambia	0.6	11/12	25/26	2/3

Sources:

1,4 World Development Report, 1979. The World Bank.

2,3 Joseph, Stephen C. and S. S. Russell, "Is Primary Care the Way of the Future." Prepared for presentation at the April 1979 Bellagio Conference on Population and Health.

5 A slash indicates a tie in rankings; e.g. 18/25= countries 18 through 25 have the same rankings.

Latin America and the Caribbean

Country	1977 [1] Population (mi)	1978 [2] PQLI Ranking	1975 Per Capita Health Expen. ($US) [3] Ranking	1977 Life Expectancy at Birth Ranking
		(all rankings from group of 70 low and middle-income countries) 1= group lowest; 70= group highest [5]		
Brazil	116.1	60	56	61/63
Colombia	24.6	65/66	61/62	61/63
Ecuador	7.3	61	51/53	57/58
Guatemala	6.4	56	49	55/56
Bolivia	5.2	39/41	48	45/47
Haiti	4.7	42/44	24	40/44
El Salvador	4.2	59	55	64/67
Hondurus	3.3	55	51/53	55/56
Paraguay	2.8	67	25/26	64/67

Sources:

1,4 World Development Report, 1979, The World Bank.
2,3 Joseph, Stephen C. and S. S. Russell, "Is Primary Care the Wave of the Future." prepared for presentation at the April 1979 Bellagio Conference on Population and Health.
5 A slash indicates a tie in rankings; e.g.18/25= countries 18 through 25 have the same rankings.

East Asia and the Pacific

Country	1977 [1] Population (mi)	1978 [2] PQLI Ranking	1975 [3] Per Capita Public Health Exp. ($US) Ranking	1977 [4] Life Expectancy at Birth Ranking
	(all rankings from group of 70 low and middle-income countries) 1= group lowest; 70= group highest [5]			
China, People's Rep.	885.6	62/64	39/40	68
Indonesia	133.5	48	1	33/38
Vietnam	50.6	54	17/18	61/63
Philippines	44.5	62/64	32/33	57/58
Thailand	43.8	62/64	24	59
Korea, Rep. of	36.0	69/70	15	64/67
Cambodia	8.4	37/38	2/3	33/38
Laos	3.2	16/17	2/3	4/10
Popua New Guinea	2.9	47	68	40/44

Sources:

1,4 World Development Report, 1979. The World Bank.
2,3 Joseph, Stephen C. and S. S. Russell, "Is Primary Care the Wave of the Future," Prepared for presentation at the April 1979 Bellagio Conference on Population and Health.
5 A slash indicates a tie in rankings; e.g. 18/25 = countries 18 through 25 have the same rankings.

East Africa

Country	1977 [1] Population (mi)	1978 [2] PQLI Ranking	1975 [3] Per Capita Public Health Exp. ($US) Ranking	1977 [4] Life Expectancy at Birth Ranking
	(all rankings from group of 70 low and middle-income countries) 1= group lowest; 70= group highest [5]			
Ethiopia	30.2	13	9	9
Zaire	25.7	31/33	22/23	18/29
Sudan	16.9	35	27/28	18/29
Tanzania	16.4	29/30	43	40/44
Kenya	14.6	39/41	44	48/49
Uganda	12.0	42/44	29/30	48/49
Mozembique	9.7	18/25	27/28	18/29
Madagascar	8.1	43/46	46	18/29
Rhodesia	6.7	49	65	45/47
Malawi	5.6	29/30	29/31	18/29
Zambia	5.1	37/38	63	33/38
Rwanda	4.4	18/25	12/13	18/29
Burundi	4.2	15	8	16/17
Somalia	3.7	9	35	11/12
Sierra Leone	3.2	26/27	41/42	18/19
Botswana	0.7	58	60	52/54
Swaziland	0.5	34	69	13/15
Equatorial Guinea	0.3	26/27	38	13/15

Sources:

1,4 World Development Report, 1979. The World Bank.

2,3 Joseph, Stephen C. and S. S. ssell, "Is Primary Care the W of the Future." Prepared for presentation at the April 1979 Bellagio Conference on Population and Health.

5 A slash indicates a tie in rankings; e.g. 18/25 = countries 18 through 25 have the same rankings.

South Asia

Country	1977 [1] Population (mi)	1978 [2] PQLI Ranking	1975 [3] Per Capita Public Health Exp, ($US) Ranking	1977 [4] Life Expectancy at Birth Ranking
	(all rankings from group of 70 low and middle-income countries) 1= group lowest; 70= group highest [5]			
India	631.7	45/46	22/23	40/44
Bangladesh	81.2	31/33	6	30/32
Pakistan	74.9	36	17/18	40/44
Burma	31.5	53	10	45/47
Sri Lanka	14.1	69/70	47	69
Nepal	13.3	18/25	5	16/17

Sources:

1,4 World Development Report, 1979. The World Bank.
2,3 Joseph, Stephen C. and S. S. Russell, "Is Primary Care the Wave of the Future." Prepared for presentation at the April 1979 Bellagio Conference on Population and Health.
5 A slash in the rankings indicates a tie; e.g. 18/25 means that countries 18 through 25 have the same ranking.

Europe, Middle East and North Africa

Country	1977 [1] Population (mi)	1978 [2] PQLI Ranking	1975 [3] Per Capita Public Health Exp. ($US) Ranking	1977 [4] Life Expectancy at Birth Ranking
	(all rankings from group of 70 low and middle-income countries) 1= group lowest; 70= group highest [5]			
Turkey	41.9	57	66	59/60
Egypt	37.8	48	61/62	50
Morocco	18.3	42.44	51/53	51
Afghanistan	14.3	5	12/13	4/10
Yeman A.R.	5.0	18/25	4	30/32
Jordan	2.9	50	50	52/54
Albania	2.3	68	64	70
Yeman P.R.	1.7	31/33	29/31	30/32

Sources:

1,4 World Development Report, 1979. The World Bank.
2,3 Joseph, Stephen C. and S. S. Russell, "Is Primary Care the Wave of the Future." Prepared for presentation at the April 1979 Bellagio Conference on Population and Health.
5 A slash in the rankings indicates a tie; e.g. 18/25 means that countries 18 through 25 have the same ranking.

and advice in dealing with crises (e.g., childbirth, family quarrels, crop failures, etc.). These persons and networks are then engaged as change agents; project staff focus their educational efforts on this small group; often the design of the new program is adapted to the capacities of these village mechanisms.

47. A second approach seeks to build commitment to the idea of local health care through a succession of meetings and small acts of assent by the community. For example, one program, supported by a private voluntary agency, first offers a presentation on health problems to a local church group. It then provides advice and instructions on organizing a local health committee, and setting goals for health promotion; finally, it requires that a building be provided for use as a health post. The person selected to become village health worker is then trained. The strategy is to obtain successively larger and broader acts of participation from the community over an indefinite period; those villages which fail to maintain the momentum are dropped from the program. In a Bank-financed rural development project in Brazil, information about the opportunity to obtain financial assistance to establish a local health post and to train a community health worker has been distributed to teachers and extension workers. Villagers have been required to establish a health committee, select a suitable candidate for training and make contributions to the cost of constructing a simple building. They have then been given matching support in the form of training, equipment and recurrent financing of salaries and supplies. The Government of the Republic of Korea has experimented with grants in aid to villages that meet broad requirements for standards and coverage of services.

48. A third approach to mobilizing community participation is to focus funding on activities that the communities prize enough to be willing to assume responsibility later for the operating costs. This implies that the health care program must address priority needs and that the community must not regard continued financing of health care as being exclusively a government responsibility.

IV. RECOMMENDED CHANGES IN BANK HEALTH POLICY

49. The Bank should begin lending for health projects in addition to continuing to finance health components of projects in such sectors as agriculture, education, family planning, urbanization and nutrition. Health projects should aim to strengthen the recipient countries' sectoral planning and budgeting capacity, and its primary health care system, and should include such elements as development of the basic health infrastructure, training of community health workers and paraprofessional staff, strengthening of logistics and supply of essential drugs, promotion of proper nutrition, provision of maternal and child health care including family planning, prevention and control of locally endemic and epidemic diseases, and development of management, supervision and evaluation systems. The components of a project would vary from country to country depending on existing programs, needs, resources,

institutional capacity, and national priorities. The projects might be located in either rural or urban areas or both. Generally, maternal and child health care, control of endemic diseases, immunization and development of management capabilities would be among the first elements to be provided. Projects would be designed to lead progressively to improvement of comprehensive health care, with priority being given to those in most need. Where proposals satisfy normal Bank criteria for lending, projects to manufacture drugs, health care equipment and other supplies would be considered.

50. Projects to be financed by the Bank would be expected to stress application of appropriate technologies. In particular, programs would be expected to: a) rely largely on mid-level health workers rather than physicians to provide care; b) employ simple, inexpensive buildings and equipment; c) place modest demands on the administrative and supervisory capacity of the ministry of health; d) produce reasonable standards of care and safety; and e) permit development of greater coverage and broader services over time.

51. Greater involvement by the Bank in the health sector is now justified for several reasons. First, the Bank's capacities in country programming and in sector analysis are needed to help to ensure the success of emerging national policies to expand the coverage of health care. The concept of primary health care and the goal of universal access to basic health services by the year 2000 have been widely embraced by governments. Major efforts are underway to mobilize resources and to devise plans of action to implement these objectives. The Bank already plays an important role in assisting governments in devising feasible, balanced overall programs of social and economic development. It now should provide essential technical assistance in formulating appropriate sector plans, detailed health project proposals and in developing appropriate institutions. Second, significant involvement in the health sector is an important element of the Bank's concern for alleviating poverty in the developing countries. An expanded policy for health operations is essential if the Bank wishes to deal effectively with the problems of poverty and low productivity among the poor. Third, a policy of lending for health projects is needed to complement and rationalize the Bank's activities in the health sector. The Bank has become a major source of development finance in health (see paragraph 21) through its components work, and its population, nutrition, and water and sanitation projects. It now needs to develop a consistent approach to operations in the sector. Its operations at present do not reflect a comprehensive policy for the sector, nor does it have sufficient specialized technical staff to provide advice to governments. Fourth, a policy of lending for health in countries which have not adopted formal family planning policies would strengthen the Bank's opportunities for dialogue on population issues and for provision of family planning services through primary health care. It is intended and expected that the Bank's lending for health will reinforce and enhance the effectiveness of its family planning work.

52. Project operations in health would also address several needs that cannot be met by components. The level of funding for projects could take into account the needs for reform or reorganization in the borrower's health sector; the components approach sometimes does not provide enough resources to allow desirable major changes to be implemented. An expanded program of health operations would increase the Bank's profile in the sector, provide a better basis for dialogue on national health policies and programs, and permit it to introduce discussion of the role of health in overall development. Furthermore, lending for projects would permit a more rational determination of health program boundaries. For example, the control of vector-borne diseases may require that pesticides be applied to an entire ecological zone, but the projects that might serve as vehicles for such health components frequently do not encompass such large areas. Finally, project lending would in some instances help to simplify otherwise complex, integrated development projects for which large investments in health are appropriate.

53. The policy of lending for components should also be continued. It has provided the Bank with opportunities to obtain diverse experiences in the sector, promoted contacts with governments and other agencies interested in health, and contributed to productive projects in other sectors. Components have permitted integration of development of health and other project activities and have focused health benefits on the target population of poverty-oriented development projects. Health components have also provided an attractive vehicle for exploring new approaches to health care and for assessing the likely performance of new institutional arrangements. Furthermore, components have dealt with health problems created by development projects.

A. Criteria for Bank Lending

54. The choice of countries and projects to be financed by the Bank should take into account the following factors. Sound sector work should ormally precede the identification of health projects. Understanding the roles of national and regional health authorities, and other ministries. agencies and professional organizations active in the sector is critical. Estimates of the long-term operational and financial implications of existing programs are needed before the feasibility of new programs can be assessed. An evaluation of the effectiveness of existing institutions and management procedures, and their capacity to support new activities is also important. In addition, sector work offers opportunities to consolidate support within governments for primary health care.

55. Countries should be willing to devise a strategy for providing access to basic health services to all citizens over a reasonable period of time. Development of health planning capacity and of a long-term plan for the health sector should be encouraged. Capacity to evaluate programs and to modify their design, management and assessment in response to information on their performance should be available or introduced as part of a health project. Willingness on the part of health officials and professional

medicine to seriously consider possible reforms in the organization, delivery and control of health care should also be a factor determining country priorities. Disease-specific health priorities should be established on the basis of mortality and morbidity attributable to diseases that can be controlled with simple, low-cost technologies.

56. A careful analysis of the sociocultural setting is critical. Since health care activities must be accepted by the client population, its preferences and beliefs should be ascertained. Field experimentation to test the appropriateness of specific approaches to health problems usually should be developed in parallel with general implementation of programs. Small-scale, first-phase projects or components may lead to savings in later implementation.

57. The priority of health in relation to other sectors in the borrower's economy should be assessed as part of the Bank's regular economic reporting and programming efforts. Particular attention should be paid to the influence on health of activities in other sectors and of health operations on population and population programs. Because health services will generally be financed from public funds rather than user charges, particular stress should be placed on the efficiency and equity with which resources are allocated.

58. The feasibility of governments' financing the recurrent costs of programs should be carefully examined. Since most countries are likely to continue to spend large amounts of domestic resources and foreign exchange on health care, an important objective of lending operations should be to assist in achieving cost-effectiveness throughout the sector. The Bank should be prepared, where necessary, to finance local and operating costs during project implementation, as is its practice in other sectors. The capacity of the government to meet recurrent costs (both foreign and local) following implementation should be carefully considered in establishing design standards.

59. Wherever feasible, programs should be targeted on highly vulnerable groups. Since the costs of particular health activities depend in part on the range of other activities being undertaken at the same time, the cost-effectiveness of groups of interventions should be examined. As in other sectors, trade-offs between efficiency and equity are expected. The risks attached to specific activities and to overall programs should be carefully balanced against their contributions to better health. The consequences of interruptions in lines of supply of essential materials, temporary failures to pay salaries and other obligations, serious and/or unusual side effects of control measures, and frustration of patients should be monitored. Projects should be designed to minimize the probability of inflicting harm on the population if their logistical arrangements are disrupted.

60. Lending to a country for health should take into consideration the absorptive capacity of health institutions. Initial operations in a country should generally stress the development of planning and management skills and the establishment of organizational structures and procedures for administration of the health care system.

61. The contents of health projects should normally be limited to activities under the control of the ministry of health. Although water supply, sanitation, food supply and education are recognized to be major determinants of health, the limited management and implementation capacity of most ministries of health argues against their being assigned responsibility for coordination of integrated, multisectoral projects. Integration with family planning should, however, be a part of most primary health care projects because of the important interactions between health and population.

62. The Bank should expand its collaboration with other external assistance agencies and professional organizations active in the health sector. It should continue to employ technical staff from WHO and its regional offices to assist in assessing health problems and devising programs to improve health. As noted above, the Bank's expanded activities in health would essentially complement the activities of WHO.

B. Proposed Lending Program

63. It is recommended that the initial program of lending for health start with one project in FY81 and expand to four or five projects by FY84. Sector work will be expanded concurrently with the lending program. In several countries existing commitments to components in rural health care and in control of tropical disease are large and could be consolidated into projects. The rate at which the program can be expanded will be reviewed in the context of the FY81 budget and operating program. In addition to lending for health projects, the Bank should continue to include health components in irrigation, rural development, urban and education projects; it is expected that there will be about 25 new components annually in FY80 and beyond.

C. Budgetary Implications

65. The proposed program of health projects lending has been translated into manpower and budgetary requirements using coefficients similar to those for the Bank's population projects. It has been assumed that about 2-1/2 years will be required for projects to reach the stage of Board presentation and that appraisal will usually be completed in the year prior to Board presentation. Total staff and consultant inputs required for health, including management and overhead, would amount to 21 manyears in FY80 and 25 manyears in FY81 compared with 9 manyears currently budgeted in FY80. The total direct costs of Bank health activities in FY80 would be approximately $1,310,000 (FY80 dollars) of which $967,000 would be the

WORLD BANK / INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

TO: Mr. Jochen Kraske, EA1

DATE: July 1, 1980

FROM: Huw M. Jones, PHN

SUBJECT: Coordination of Health, Nutrition and Population Lending Work

As discussed on the telephone today, I attach a copy of a memorandum drafted originally for distribution to the countries in Mr. Reese's division. It may well be more appropriate if it could be issued from you for EA1 as a whole. Mr. Sandberg told me that he would have no objection and it would certainly help this division in keeping up-to-date with and assisting in PHN activities.

Many thanks.

cc: Dr. Evans, Mr. North (o/r), Dr. Kanagaratnam, Mr. Berg, PHN
Mr. Messenger (o/r), Mr. Schebeck (o/r), Mr. Diaz, Ms. Derik, PHN
Mr. Reese, EA1, Mr. Sandberg, EA1, Mr. Hall, EA1; Files

PHN :EA1
HMJones:sr

DRAFT
PAHall:rs
June 25, 1980

To: See Distribution Below

From: David G. Reese, Division Chief, EA1DB

Subject: Coordination of Health, Nutrition and Population Lending Work

1. In , 1979, the Board of Executive Directors approved Bank lending directly for free standing health projects. In order to identify opportunities for direct Bank lending for health projects in southern African countries and ensure EAPDR and PHN coordination and supervision of health/ nutrition and population components, enhanced cooperation with the Population, Health and Nutrition (PHN) Projects Department is required. PHN is in the process of firming up its lending program and of defining its operational priorities in light of the newly adopted Health Policy Statement. It is our understanding that PHN has not, to date, received sufficient documentation from our region, to incorporate southern African countries, as appropriate, in their programming for discrete and component health project work. To facilitate the timely exchange of information on ongoing operations, I would appreciate it if copies of Terms of Reference, Back-to-Office reports and supervision summaries would be sent routinely to Mr. Harold Messenger, the Chief of Division I in PHN with particular attention to reports on ongoing and proposed projects with health components e.g., agriculture and rural development, urban, and water supply projects. Your cooperation in this matter is much appreciated.

+ education.

Cleared with and cc: Messrs. Hendry, Bronfman, Adler, Jones

cc: Messrs. Evans, North, Messenger, Schiebeck, Eccles, Gyamfi, Scearce, Erkmen and Nouvel

WORLD BANK / INTERNATIONAL FINANCE CORPORATION

Mr. Evans
N437

OFFICE MEMORANDUM

TO: COPD Directors and Regional Assistant Directors, Projects (all sectors)

DATE: June 10, 1980

FROM: Christopher R. Willoughby, Director, TWT CRW

Correlate to Dev Chiefs done 6/16/80

SUBJECT: Telecommunications Lending in Other Sectors

1. We are reviewing ways in which this Department's Telecommunications Adviser and Telecommunications Division can be more efficient and helpful in the preparation and execution of projects which include significant expenditures in telecommunications equipment.

2. In some instances we are contacted and do participate in some portion of the appraisal and supervision of projects with large telecommunication components. There are other instances, however, in which we do not become aware of the project until a major problem arises, sometimes several years after appraisal. This, of course, does not allow us to properly program or plan our work program, and we have found that the reliance on consultants is not always satisfactory.

3. Therefore, we are attempting to identify projects currently being prepared or which have been appraised over the last two or three years, which include expenditures for telecommunications equipment financed by the Bank/IDA. The importance of this exercise is underlined by our expectation that the total Bankwide telecommunications investments financed under other sectors is growing and may, in fact, be comparable to Bank lending directly through telecommunications loans and credits.

4. I would be grateful if you would indicate by c.o.b. June 18 to Mr. B. Wellenius, (room D 947, extension 75496), the name of a person in your Department who we could contact to assist us in the process of identifying recent or potential future projects in your sector which include the financing of some telecommunications investment.

BWellenius/RJSaunders:j

CONFIDENTIAL

OFFICE MEMORANDUM

TO: Dr. John R. Evans, Director, PHN

DATE: July 22, 1980

FROM: Ishrat Z. Husain, Chief, Opns. Div. II, PHN

SUBJECT: Project Pipeline for Division II

1. In response to your memo of May 5, 1980, we reviewed the countries in the three regions under Division II (East Asia and Pacific, West Africa and LAC) to identify countries that ostensibly would be of high priority for receiving Bank assistance in the population, health and nutrition sectors. We limited our review to the 27 Part II countries in our Regions with a population size of five million or over. These included eight countries from EAP, nine from West Africa, and ten from LAC. The countries were ranked by several indicators selected for each sector. For population, countries were ranked according to the following indicators: population size, CBR, CDR, RPG and GNP per capita. For health, countries were ranked by population size, life expectancy, and infant mortality rates. For nutrition, we used similar sets of indicators adopted by the Regions in preparing their proposed five-year operational program for nutrition: population size, infant mortality rate, life expectancy, GNP per capita, per capita supply of calories as percent of requirement, and per capita supply of protein (grams per day). Obviously, the composite ranking is only a crude indicator of priority, but nevertheless one that we believe will be useful for our purposes, pending the preparation of a more refined methodology by the Policy Unit. (The tables in the Annex show the ranking of the 27 countries for population, health and nutrition separately and suggested actions to be taken.)

Population

2. We have ten ongoing population projects in six out of the 27 countries included in the review. For obvious reasons, these are not the first six priority countries. As for the future, only one free-standing population project (Philippines III) is in the Lending Program for FY81-85 out of the 18 projects planned by the three Regions for PHN. About seven integrated projects are in the regional lending program during the next five years in six countries (Nigeria, Indonesia, Thailand, Dominican Republic, Vietnam and Peru) which would include population components or activities, the size and magnitude of which, however, are yet to be defined. Unless we are able to increase the number of free-standing population projects, the present situation might be interpreted by others (particularly by those who had expressed concerns in the past) as an erosion of Bank support to population in favor of health. More importantly, the seriousness of the population problem justifies as much focus and attention as can possibly be afforded. Consequently, we feel efforts should be made towards the development of more free-standing population projects than what is presently planned.

3. Of course, we cannot have population projects in all of the countries which we have identified as having serious population problems. In priority countries such as Niger, Mali, Guinea, Upper Volta, Cameroon and Mexico, we will be faced with innumerable difficulties. Although these

difficulties apply to health and nutrition areas as well, these are particularly serious in the case of population. These include (a) a country's reluctance to borrow for social sector rather than for developmental activities with a visible rate of return; (b) the availability of grant funds, particularly for population; (c) the sensitivity of the population sector in the country; (d) the constraints due to the shortage of funds to meet additional recurrent expenditures; and (e) administrative and managerial limitations and/or political problems which may make project preparation and execution difficult and time-consuming.

4. In countries where a separate population project could not possibly be prepared immediately for one reason or the other, an alternative strategy would be to start with a health project with some elements of family planning. Meanwhile, we should keep the issue alive among the persons who have the responsibility for making policy and project decisions both within the Bank and within the Ministries of Finance and Planning of the borrower countries and continuously update our assessment of possible government interest in Bank financing of a population program, considering the lead time required for project development.

5. Priority countries, where we could possibly develop free-standing population projects, in addition to the integrated projects planned during the next five years, include Ghana, Indonesia, Thailand and Nigeria. As you will note, two of them are repeater countries and the other two are new ones. The new ones involve extensive amounts of persuasion with many of our Regional colleagues and the recipient countries to borrow for population. We are planning a health/nutrition reconnaissance mission to Ghana in November, and if there is sufficient Government interest, we could initiate preparation activities soon after. At the same time, we will assess the status of a population program and Government interest in Bank assistance. As you know, the first population project in Indonesia is expected to be completed this year, and a third project has recently been signed. Except for an integrated project proposed in FY85, no separate population project is planned during the next five years. We feel there are a number of activities in the population sector which the Bank could assist, possibly in two to three years. An assessment of Thailand's interest in Bank assistance in the population sector should be made while developing a health project and if indications are favorable, project preparation could be initiated. Recent indications suggest that Nigeria is placing emphasis and priority to Bank assistance in the health-cum-maternal child care and family planning fields. Two projects are planned for Nigeria: a health/population project in FY84 and a food-nutrition project in FY85. A reconnaissance/identification mission found that "prospects for Bank operations in Nigeria's health sector, including eventually population and nutrition activities...are good." The possibility of a separate population project should be explored during the development of the proposed health project.

Health

6. Out of the 27 countries, a free-standing health or integrated project is planned in 19 countries during FY81-85 (including reserves). Specific preparation activities are being undertaken in six of them (Mali,

Nigeria, Peru, Senegal, Indonesia and Thailand), and discussions have been or are being initiated in another seven countries (Brazil, Ghana, Ecuador, Bolivia, Niger, Dominican Republic and Malaysia). There are indications that requests for a health project from two additional countries (the Philippines and Korea) will be forthcoming. As you will notice, all the 19 countries included in the Lending Program do not match the ranking as shown in Table 2. For example, no health project is planned for Upper Volta, Kampuchea or Bolivia, which have higher ranking than Ecuador, Korea or Malaysia. But the political problems in the former three countries will not permit project development in the near future.

7. While the number of projects planned for health activities is substantial, there are, however, several issues which we should focus our efforts on if we are to meet our lending targets, particularly in three major countries: Brazil, Indonesia and Mexico. Regarding Brazil, we would like to see an early resolution of the issue as to which of the two proposed health projects (Sao Paulo or Northeast) should be developed first. Based on positive indications from the Government concerning the development of a health project in Indonesia, we would like to see a health project programmed at least in FY82. In response to our representations, Programs has assured us of its willingness to advance the FY85 project in the Lending Program as soon as preparations are fairly advanced. To strengthen our position in this regard, we would appreciate it if you could please reiterate our stand with your counterpart in Programs whenever you get an opportunity. We would like to initiate discussions with Programs and with the Government of Mexico for a Bank-assisted health project. We anticipate some difficulties in pursuing this plan both with the Programs, and perhaps with the Government. We had asked one of our staff members (Mr. Cuca) to assess the Government's interest in a project during his participation in a rural development mission; the Government's reaction was not encouraging enough for us to start planning project preparation activities. This is a country where a lot of selling work is necessary.

JRtor

Nutrition

8. We have three ongoing projects in Brazil, Colombia and Indonesia. As shown in Table 3, Brazil's ranking in the nutrition status is very high. The approved FY81-85 Lending Program for nutrition is modest, consisting of four separate nutrition projects (Chile, Colombia, Nigeria and Senegal), and one integrated project with some elements of nutrition components (Indonesia, in FY85). We expect that our involvement in the development of the Food and Nutrition Plan for the Philippines will lead to the development of a Bank-assisted nutrition project. A nutrition project is planned for Chile, which has 26th ranking for nutrition--hence, clearly, a non-priority country. The ranking of countries for nutrition shows that almost all of the West African countries included in the review have serious nutritional problems (Mali, Nigeria, Upper Volta, Niger, Guinea and Ghana, Cameroon and Senegal), and a few from EAP and LAC regions (Indonesia, Vietnam, Bolivia, Colombia and the Philippines). For these countries, excluding the two in the Lending Program, we suggest, at least during the next two to three years, adding nutrition components, particularly in agriculture or health projects and conducting some sector work. Meanwhile, the possibilities of a free-standing nutrition project should be explored in countries where we have developed nutrition components or have organized sector work.

Overall Lending Program

9. Theoretically, our Division's FY81-85 Lending Program is fairly reasonable, albeit not a smooth one, with a bunching of projects in the two outer years and no project programmed for FY81. It shows 18 projects in 15 countries (regionally well-balanced with six projects in each region), and seven reserves in six countries. Out of the 27 countries reviewed, five are neither in our Lending Program nor in the reserve list (China, Upper Volta, Guatemala, Democratic Kampuchea, and Argentina). On the other hand, four other countries, which are either in the Lending Program or in the reserve list, do not appear in this list of priority countries owing to their population size (which is less than five million). These are Papua New Guinea, El Salvádor, Sierra Leone and Honduras.

10. We have doubts as to whether the above Lending Program can be met. We foresee that unavoidably, there will be several drop-outs from the countries now in the Lending Program owing to the constraints mentioned in paragraph 3 above. We expect that an enormous amount of preparation is needed to reach the right climate for Bank project involvement in these sectors, particularly in population, in several of the countries, and active follow-up by Programs and by our Department is necessary.

Attachments -

cc: Mr. North, PHN
Dr. Kanagaratnam, PHN
Mr. Berg, PHN
Mr. Messenger, PHN
Dr. Liese, PHN
Division Files

LVDOMINGO/IZHUSAIN:chb
LENDING PROGRAM/PHN

- POPULATION, HEALTH AND NUTRITION DEPARTMENT -

DIVISION II

RANKING OF PART II COUNTRIES WITH POPULATION OF 5 MILLION OR OVER FOR POPULATION PROJECTS a/

Ranking/Country	Population Size in millions	Status in Lending Program	Status of Project Preparation b/	Suggested Actions to Be Taken
1. Nigeria *	79	A health/population project in FY84.	A	Project should be advanced to at least FY82.
2. Niger *	5	A health project in FY85.	A	Project should be advanced to at least FY83 and should include FP components.
3. Mali *	6	A health project in FY83.	A	The health project should include FP components.
4. Guinea *	5	None. FY85 health/nutrition reserve.	C	A sector or reconnaissance mission may be planned in FY82.
5. Vietnam *	51	A social infrastructure project, including FP components, in FY85.	C	None.
6. Ghana *	11	A reserve health/nutrition project in FY83.	B	Efforts should be made to develop a free-standing population project.
7. Indonesia	134	An integrated project in FY85.	A	We should try to develop a free-standing population project.
8. Ivory Coast	7	A reserve health project in FY82.	C	The health project should include FP components.
9. Upper Volta *	5	None.	C	None.
10. Cameroon *	8	A health project in FY85.	C	The health project should include FP components.
11. Thailand	44	A population/health project in FY82.	A	The project is likely to slip to FY83 owing to Government's postponement of second project discussions.
12. Mexico	63	A reserve population/health project in FY83.	C	None. National program is progressing well.
13. Bolivia **	5	None.	B	A population project should be included in the lending program.
14. Philippines	44	A third population project in FY84.	B	None.
15. Senegal *	5	A nutrition/health project in FY83.	A	Decision should be reached soonest as to whether we should have one or two projects in FY81-85.
16. Ecuador	7	A reserve health/population project in FY82.	C	None. Project preparation was pursued actively in the past with not much success. Availability of IDA resources would greatly enhance the possibility of Bank involvement in population sector.
17. Brazil	116	A health project in Sao Paulo in FY82, and another in Northeast in FY85.	A	The projects should include FP components.
18. Peru	16	A health project in FY83.	A	The health project should include FP components.
19. China *	886	None.	C	A sector mission may be planned during the next 24 months.
20. Guatemala	6	None.	C	None. Government has considerable amounts of grant funds for social sector and has in the past been very conservative with respect to projects for which it would accept Bank loans.
21. Democratic Kampuchea *	6	None.	C,D	None.
22. Dominican Republic	5	A population/health project in FY83.	A	None.
23. Colombia	25	A nutrition project in FY84 and a health sector review in FY81.	C,D	None. Government has in the past refused to borrow from the Bank for population. National program is doing well.
24. Chile	11	A nutrition project in FY85.	C	None.
25. Korea	36	Except for ongoing project, no additional population project is planned for FY81-85.	C	None.
26. Malaysia	13	A third project was in the FY82 lending program earlier, but was subsequently dropped.	A	We should try to put back in the lending program a third population project.
27. Argentina	26	None.	C	None.

a/ Composite ranking of countries (with population of 5 million or over) based on the following indicators: population size, CBR, CDR, RPC and GNP/capita.

b/ Code Used: A = Project preparation being pursued actively; B = Discussions being initiated; C = To date no action is planned for the next six months; D = Population issue is politically sensitive in the country

* An IDA-eligible country
** A hard-blend country

July 19, 1980
LVDOMINGO:clh

— POPULATION, HEALTH AND NUTRITION DEPARTMENT —

DIVISION II

RANKING OF PART II COUNTRIES WITH POPULATION OF 5 MILLION OR OVER FOR HEALTH PROJECTS a/

Ranking/Country	Population Size in millions	Status in Lending Program	Status of Project Preparation b/	Suggested Actions to Be Taken
1. Nigeria *	79	A health/population project in FY84.	A	Project should be advanced to at least FY82.
2. Mali *	6	A health project in FY83.	A	None. Present timetable is reasonable.
3. Niger *	5	A health project in FY85.	A	Project should be advanced to at least FY83.
4. Indonesia	134	An integrated population/health/nutrition project in FY85.	A	We should push for an earlier health project, possibly for FY82.
5. Upper Volta *	5	None.	C	None. Program's view is that country has perhaps more foreign aid per capita for social sectors.
6. Brazil	116	A health project in Sao Paulo in FY82, and another in Northeast in FY85.	A	We should resolve within the Bank the priority between the two projects.
7. Senegal *	5	A nutrition/health project in FY83.	A	Decision should be reached soonest as to whether we should have 1 or 2 projects in FY81-85.
8. Guinea *	5	FY85 health/nutrition reserve.	C	A sector or reconnaissance mission may be planned in FY80.
Cameroon *	8	A health project in FY85.	C	None.
10. Vietnam *	51	A social infrastructure project, including health components in FY85.	C	None. IDA lending to Vietnam is presently politically sensitive.
11. Ghana *	11	A reserve health/nutrition project in FY83.	B	We should push for the inclusion of a health project in the Lending Program.
12. Ivory Coast	7	A reserve health project in FY82.	C	None. Preliminary discussions may be initiated next FY.
13. Democratic Kampuchea *	6	None.	C	None.
14. Bolivia **	5	None.	B	Availability of IDA funds would greatly enhance possibility of Bank involvement.
15. Peru	16	A health project in FY83.	A	None. The present timetable is reasonable.
16. Colombia	25	A health sector review in FY81; a nutrition project in FY84.	C	Health components should be included in the proposed FY84 nutrition project. Availability of IDA funds would greatly enhance possibility of Bank involvement.
17. China *	886	None.	C	A sector mission may be planned for the next 24 months.
18. Thailand	44	A population/health project in FY82.	A	We should try not to let this project slip to FY83 owing to Government's postponement of proposed project discussions.
Mexico	63	A reserve population/health project in FY83.	B	We should urge Regions to initiate active discussions on health project possibilities. Availability of IDA funds would greatly enhance possibility of Bank involvement.
20. Philippines	44	A population project in FY84.	C	We should initiate discussions on a health project, considering informal GOP interest for a health project.
21. Dominican Republic	5	A population/health project in FY83.	B	None. Proposed timetable is reasonable.
22. Guatemala	6	None.	C	None. Government has considerable amounts of grant funds for social sector and has in the past been very conservative with respect to projects for which it would accept loans.
23. Ecuador	7	A reserve health/population project in FY82.	A	Availability of IDA funds would greatly enhance the possibility of Bank involvement.
24. Chile	11	A nutrition project in FY85.	C	The proposed nutrition project should include some health components.
25. Korea	36	None.	C	We should follow up informal indications of interest by the Government for a health project.
26. Argentina	26	None.	C	None.
27. Malaysia	13	A primary health care project in CPP for FY83.	B	We should try to have a health project in the Lending Program for FY82 or FY83.

a/ Composite ranking of countries (with population 5 million or over) based on the following sets of criteria: population size, life expectancy, and infant mortality rate.

b/ Code Used: A = Project preparation being pursued actively; B = Discussions being initiated; C = To date no action is planned for the next six months

* An IDA-eligible country
** A hard-blend country

July 19, 1980
LVIBOHLNGO:ebb

– POPULATION, HEALTH AND NUTRITION DEPARTMENT –

DIVISION II

RANKING OF PART II COUNTRIES WITH POPULATION OF 5 MILLION OR OVER FOR NUTRITION PROJECTS a/

Ranking/Country	Population Size in millions	Status in Lending Program	Status of Project Preparation b/	Suggested Actions to Be Taken
1. Mali *	6	A health project in FY83.	A	The health project should include nutrition components. A free-standing nutrition project should be planned for at least FY85.
2. Nigeria *	79	A nutrition project in FY85.	C	We should try to advance it to FY83.
3. Democratic Kampuchea *	6	None.	C	None.
4. Indonesia	134	An integrated population/health/nutrition project in FY85.	C	We should respond favorably if Government requests a second nutrition project.
5. Upper Volta *	5	None.	C	None. Program's view is that country has perhaps more foreign aid per capita for nutrition: absorptive capacity is also a problem.
6. Niger *	5	A health project in FY85.	A	The health project should include nutrition components and should be advanced to FY83. A free-standing nutrition project may be planned for FY85.
7. Guinea *	5	FY85 health/nutrition reserve.	C	A sector review may be planned in FY82-83.
Vietnam *	51	A social infrastructure project in FY85 including nutrition.	C	None.
9. Bolivia **	5	None.	B	The reconnaissance mission planned this FY should also look into the possibility of including a nutrition component in the project.
10. Ghana *	11	A reserve health/nutrition project in FY83.	B	A project should be put in the FY83 Lending Program.
11. Colombia	25	A second nutrition project in FY84.	B	None. Present timetable is reasonable.
12. Cameroon *	8	A health project in FY85.	C	A nutrition component should be included in the health project.
13. Senegal *	5	A health/nutrition project in FY83.	A	Decision should be reached soon as to whether there will be 2 projects in FY81-85.
14. Philippines	44	None.	A	In view of ongoing activities in this sector involving Bank assistance, a separate nutrition project may be planned in the 5-year Lending Program.
15. China *	886	None.	C	None. A sector mission may be planned for the next 24 months.
16. Thailand	44	A population/health project in FY83.	A	Like the first project, the project should include nutrition components, if possible.
Ecuador	7	A health/population project in the reserve for FY82.	A	The project should include nutrition components.
18. Dominican Republic	5	A population/health project in FY84. No plans for a nutrition project.	B	None.
19. Guatemala	6	None.	C	None
20. Brazil	116	A health project in Sao Paulo in FY82, and another in Northeast in FY85.	A	The health projects should include nutrition components, if possible.
21. Peru	16	A health project in FY83.	A	None.
22. Ivory Coast	7	A reserve health project in FY82.	C	None.
23. Mexico	63	A reserve population/health project in FY83.	C	None.
24. Korea	36	None.	C	None.
25. Malaysia	13	A primary health care project is proposed for FY83.	B	None.
26. Chile	11	A nutrition project in FY85.	C	None.
27. Argentina	26	None.	C	None.

a/ Composite ranking of countries (with population 5 million or over) based on the following sets of criteria: population size, life expectancy, infant mortality rate, per capita supply of calories as percent of requirement, and per capita supply of proteins (grams per day).

b/ Code Used: A = Project preparation being pursued actively; B = Discussions being initiated; C = To date no action is planned for the next six months

* An IDA-eligible country
** A hard-blend country

July 10, 1980
LVOOMINGO:cbb

WORLD BANK / INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

Mr. Evans
1. Copies for SDN.
HWM
12 H.

TO: Operational Vice Presidents

DATE: ~~July~~ July 23, 1980

FROM: Ernest Stern, Vice President, Operations

SUBJECT: Fall 1980 Project Implementation Review.

In my memorandum of June 19, 1980, I indicated the special topics that will be covered as part of the Fall Project Implementation Review and the Regional responsibility for preparing papers on these topics. To assist in this process, I attach more detailed terms of reference for the special topics. If you have any questions regarding them, please call either Mr. Rajagopalan (Ext. 73041) or Mr. Israel (Ext. 76801).

Sectoral breakdown of topics?

Attachment

cc: Regional Projects Directors
CPS Directors
Mr. Israel

Fall 1980 Project Implementation Review

Terms of Reference for the Special Topics

The special topic for the Fall review is effectiveness of supervision, focussing on the following three subjects:

1. Experience with supervision during the early implementation stages.

2. Experience with country implementation reviews.

3. Supervision requirements of experienced countries which are large borrowers, including the use of local staff and institutions in supervision.

The work should concentrate on these subjects. However, other comments or information on the effectiveness of supervision more generally will also be welcome.

Since each subject will have to be adapted to the special circumstances of each Region, the terms of reference that follow are general and indicative.

A. Experience with supervision during the early implementation stages

Supervision has a special role to play during a project start-up period, say, during the first six to nine months after Board approval, particularly with new borrowers and innovative projects. This is the time when conditions of effectiveness are being complied with, staff and consultants hired, procurement initiated and some institutional changes implemented.

Issues to be considered in the review include:

(1) Type, frequency and composition of missions during this period. Staffyears alone may be an unsatisfactory indicator of the supervision effort for this period, since a short or small mission could be quite effective in helping to expedite matters. With regard to mission composition, what are the needs for specialized staff, such as procurement, disbursement and legal specialists?

(2) Effect of measures taken before Board approval on the conduct of the start-up operations and consequent need for Bank supervision. Influence of degree of project preparation: the trade-off between more complete project preparation and supervision in the early stages; impact of the Project Preparation Facility in expediting early implementation. Significance in this context of OMS 2.28 on the extent of project preparation expected prior to Board approval.

(3) Role of Resident Missions.

(4) Impact of start-up supervision: was implementation speeded up, and how?

(5) Relevance, if any, of implementation schedules and "targetting" during this period.

(6) Sectoral and country patterns. Experience with new borrowers and innovative projects compared to that with repeaters.

B. Experience with Country Implementation Reviews

The purpose of the exercise is to evaluate experience with these reviews and draw conclusions which could serve as a basis for designing a Bank policy. Main aspects to cover are:

(1) Type and modality of the review: did the agenda deal with projects, with countrywide issues, or both; length and frequency of the meetings; attendance (from the country and the Bank, and at what level; who was Chairman); extent and quality of borrower participation; quality and effectiveness of the background material prepared.

(2) Impact of the review (mainly through illustrations): implementation problems solved, general catalyst, speedier process, spread effects within government, etc. Was it possible to discuss sensitive issues (e.g. staffing, selection of consultants, contract awards)? Was country participation at a level that allowed decisions to be taken? Usefulness, or otherwise, for different types of problems.

(3) Costs (quantified to the extent possible, especially in terms of staffweeks). Negative effects, for example, on project-specific supervision, or in tying up high level country staff. In cases with a fairly long experience, what was the effectiveness of the reviews over time: did they become routinized, losing their impact? In which way could the process have been streamlined?

(4) Role of Regional Missions and Resident Representatives.

(5) Lessons for planning country implementation reviews. Prerequisites: country commitment; willingness to discuss problems in a public forum; minimum size of program; degree of preparation; etc.

C. Supervision Requirements of Experienced Countries which are Large Borrowers

One of the conclusions of the OED review of supervision is that "some of the borrowers [countries] with the biggest programs in terms of operations have some of the highest average supervision inputs, suggesting

both that supervision economies have not developed from borrower experience with Bank lending nor have economies been achieved in larger scale operations. ... This raises questions concerning possible differences in the characteristics of the projects, and also whether such borrowers are doing enough themselves towards supervising implementation." 1/

These questions have several facets. They could refer to the general level of institutional development in the country, or specifically of the borrowing entity; to the length of the relationship with the country, or the borrower; to the proportion of repeater projects; to the size of the Bank's portfolio or to the number of projects in the same sector or subsector that are being implemented simultaneously. Each of these characteristics could result in potential economies in the supervision function.

The review should examine the supervision experience in one or two countries in the Region which fall in this category, and compare it with that of other countries in the same Region, or with Regional or Bank averages, or both. The review should include the following aspects:

(1) A comparison of the intensity and type of supervision effort required. This should focus on a review of the nature and content of supervision; for example, the degree and type of implementation assistance provided, in addition to the standard indicators (staffweeks per project, number and composition of missions, costs).

(2) Reasons for the findings. The potential economies in supervision in experienced countries with large projects may have been wholly or partially offset by a variety of other factors. These may include: countrywide difficulties; more ambitious or innovative project objectives; the sector composition of the portfolio, for example, a larger proportion of new style projects; larger project size, especially in large countries; a large volume of procurement requiring processing by Bank staff; etc.

A related subject is the extent to which some of the tasks now performed by staff during supervision, such as problem solving and assistance in expediting, could be devolved to the borrower or to other institutions in the country. The greater the strength of the institutions involved, the less should be the need for implementation assistance; where institutional capacity to implement projects is weak, is Bank supervision substituting for other, preferable measures to strengthen that capacity? Aspects of this issue are:

1/ "Operational Policy Review - The Supervision of Bank Projects" (SecM80-129, February 22, 1980) para. 6.08.

(1) The accountability objective of supervision (to ensure that Bank funds are used for the purposes for which they were intended) cannot be relinquished. But could, for example, some local individuals or institutions (other than the borrowers) perform on behalf of the Bank certain pre-determined functions related to procurement or disbursement?

(2) Is Bank staff providing the amount of implementation assistance that is warranted under the circumstances? Could some of the implementation assistance better be provided by consultants or other institutions or groups in the country, and were the projects properly designed in this respect?

(3) How much and what kinds of supervision are necessary to learn lessons from project experience; could other arrangements be made, for example, greater reliance on evaluation by the country or the borrower?

July 1980

- small amts $
- small no of countries
- small concentration
- small impact.

} Criteria to assess PHN. determine

- large nos of people

DRAFT
JREvans/rb
September 25, 1980

Typology of Projects:

NEG: - science project slots - programs not sustained
- govt doesn't want middleman for small $ and no hardware

1. "ENTRY PROJECTS"

e.g. a. Get into the lending program for use of ~~IDA~~ funds by country and acceptance by region;

b. Initial work with Ministry of Health unfamiliar with World Bank;

c. Institution building and some element of PHC; implementation.

d. Experience for PHN staff working with the country. ~~implementation~~; TRUST

e. Bank commitment up to $3-~~10~~ m. lending.

f. Understood to be first step in 10-15 yr program but without obligation to country or region of Bank;

g. Simple design with high 'implementability'

Possible Sites: (Dates)

WA: Nigeria, ~~Gambia~~, Ivory Coast, Niger, Mali, Cameroons, Senegal.

EA: Malawi, Lesotho?

EMENA: PDRY, YAR. Sudan

LAC: Peru, Costa Rica

SA: ?Sri Lanka; ?Nepal; ?Pakistan

EAP: ?

2. PROJECTS IN DEPTH

e.g. a. Implementation of P.H.C. objectives in P, H and N;

b. Selective institutional strengthening;

c. Establishment of model for statewide implementation;

d. Moderately high expenditure $10-20 m.;

e. Technology transfer in priority areas

- training and supervision;
- drugs;
- communications, transport , IEC system.

f. Urban projects may be important area especially if no previous PHN experience in country;

g. Linkages with community development capability (local, UNICEF, etc.);

h. More complex projects but seek selectivity of interaction.

Sites: (Dates)

WA: ?Senegal Mali

?Nigeria (through Kaduna component project)

EA: Kenya

EMENA: Tunisia, Egypt, ?Morocco

LAC: Brazil NW Urban? - Colombia, ?Peru

SA: ?India; ?Pakistan

EAP: Indonesia (Health)

3. PROJECTS TO ACHIEVE STATEWIDE IMPACT

e.g. a. Previous experience working with jurisdiction to provide firsthand knowledge of implementation capability;

b. Large proportion of population not reached by basic PHN services;

c. Remediable (rectifiable) weaknesses in health system; e.g. transport;

d. Use of lending to encourage jurisdiction to convert resources on predictable basis to sector;

e. Provision of incremental recurrent costs on phasing basis - preferable in terms of 8-10 year plan;

f. Relatively large resource transfer;

g. At the end of proper lending spectrum closer to program loans.

Sites: (Dates)

W.A.:

EA: ?Kenya

EMENA:

SA: India: selected states (?Bangladesh)

LAC:

EAP:

4. EXPERIMENTAL PROJECTS

a. Uncertainty of effectiveness of interventions;

b. Clearly identified problem;

c. Strong interest of country in new approaches;

d. Simple project design, small cost;

e. Heavy investment - monitoring and evaluation.

Possible examples

1. Nutrition projects relating to marketing systems, supplementation and food technology; AG. credit +

2. Population beyond family planning;

3. Drug systems;

4. Community development in implementation of PHN services;

5. Parallel health/WS&S or health/education.

Discussion c John North

~~John Evans~~

Bank

~~(a) Discussion c Dr. Chiefs – Tuesday~~
~~(b) informal discussion c Bank – Tuesday~~
~~(c) ~~review~~ review with PHN staff to~~
~~(d) give sense of direction~~

Typology ~~types~~ of Projects:

[I] "ENTRY PROJECTS"

e.g. (a) get into the lending program for use of IDA funds by country and acceptance by region

(b) Initial work with M. of H. unfamiliar c W. Bank.

(c) Institution building and some element of PHC ~~[illegible]~~ implementation

(d) Experience for PHN staff working with the country

(e) Bank commitment up to $3–4 m.

* (f) Understood to be first step in 10–15 yr program but without obligation to country or region of Bank.

(g) Simple design with high "implementability"

Possible Sites: (Dates)

WA: Nigeria, Gambia, Ivory Coast, Niger, Mali, Cameroons, Senegal.

EA. Malawi, ? Lesotho

EMENA PDRY, YAR

LAC: ? ~~Haiti~~ Peru. Costa Rica.

A.S. ? Sri Lanka ? Nepal ? Pakistan.

EAP: ?

[2] PROJECTS IN DEPTH

e.g. (a) Implementation of P.H.C objectives in PHN

(b) Selective institutional strengthening

(c) Establishment of model for statewide implementation

(d) Moderately high expenditure @ 10-20 m

(e) Technology transfer in priority areas
- training + supervision
- drugs
- communications, transport, IEC systems

(f) Urban projects may be important area, especially if no previous PHN experience in country.

(g) Linkages with community development capability (local, UNICEF etc.)

(h) More complex projects but seek selectivity of intervention

Sites: (Dates)

WA: - ? Senegal
- ? Nigeria. (Kaduna component -> project)

EA. - Kenya.

EMENA - TUNISIA, EGYPT ? MOROCCO.

LAC - Brazil (URBAN NW.) ? Colombia ? Peru.

A.S. - ? India ? Pakistan

EAP - INDONESIA. (Health)

[3] Propts to achieve statewide impact

e.g. (a) ~~Substantial~~ Previous experience in working with jurisdiction to provide first hand knowledge of ~~and confidence in~~ implementation capability.

(b) Large proportion of population not reached by basic PHN services

(c) Remediable (rectifiable) weaknesses in health system; eg. - transport

(d) Use of lending to ~~permit~~ encourage jurisdiction to commit resources on predictable basis to sector.

(e) Provision of incremental recurrent costs on phasing basis - preferable in terms of 8-10 year plan.

(f) Relatively large resource transfer.

(g) At the end of ~~prop~~ lending spectrum closer to program loans

Sites (+ Dates)

W.A.

E.A. ? Kenya.

EMENA

S.A India: selected states. (? Bangladesh.)

~~LAC~~

~~EAP.~~

[4] EXPERIMENTAL PROJECTS

(a) ~~Area of~~ Uncertainty of effectiveness of interventions
(b) Clearly identified problem
(c) Strong interest of country ~~strong~~ in new approaches
(d) Simple project design, small cost
(e) Heavy investment monitoring + evaluation

Possible examples:

1. Nutrition projects relating to marketing systems, supplementation and food technology
2. Population beyond family planning
3. Drug systems
4. Community development in implementation of PHC services
5. Parallel health/WSDS or health/educ

WHAT

(1) M.CH / FP.

(2) EPI.

(3) SIMPLE REFERRAL CURATIVE ⟵ ART Pmmm Drugs

(4) HEALTH PROMOTION – WASH

(5)

HOW: i Personnel

ii Supervision/Referral

iii Training

iv Management

v

DRAFT
JREvans/rb
September 25, 1980

Typology of Projects:

1. "ENTRY PROJECTS"

e.g. a. Get into the lending program for use of IAA funds by country and acceptance by region;

b. Initial work with Ministry of Health unfamiliar with World Bank;

c. Institution building and some element of PHC;

d. Experience for PHN staff working with the country implementation;

e. Bank commitment up to $3-4 m.

f. Understood to be first step in 10-15 yr program but without obligation to country or region of Bank;

g. Simple design with high 'implementability'

Possible Sites: (Dates)

WA: Nigeria, Gambia, Ivory Coast, Niger, Mali, Cameroons, Senegal.

EA: Malawi, Lesotho?

EMENA: PDRY, YAR.

LAC: Peru, Costa Rica.

SA: ?Sri Lanka; ?Nepal; ?Pakistan

EAP: ?

2. PROJECTS IN DEPTH

e.g. a. Implementation of P.H.C. objectives in P, H and N;

b. Selective institutional strengthening;

c. Establishment of model for statewide implementation;

d. Moderately high expenditure $10-20 m.;

e. Technology transfer in priority areas

- training and supervision;
- drugs;
- communications, transport , IEC system.

f. Urban projects may be important area especially if no previous PHN experience in country;

g. Linkages with community development capability (local, UNICEF, etc.);

h. More complex projects but seek selectivity of interaction.

Sites: (Dates)

WA: ?Senegal

?Nigeria (through Kaduna component project)

EA: Kenya

EMENA: Tunisia, Egypt, ?Morocco

LAC: Brazil NW Urban? - Colombia, ?Peru

SA: ?India; ?Pakistan

EAP: Indonesia (Health)

3. PROJECTS TO ACHIEVE STATEWIDE IMPACT

e.g. a. Previous experience working with jurisdiction to provide firsthand knowledge of implementation capability;

b. Large proportion of population not reached by basic PHN services;

c. Remediable (rectifiable) weaknesses in health system; e.g. transport;

d. Use of lending to encourage jurisdiction to convert resources on predictable basis to sector;

e. Provision of incremental recurrent costs on phasing basis - preferable in terms of 8-10 year plan;

f. Relatively large resource transfer;

g. At the end of proper lending spectrum closer to program loans.

Sites: (Dates)

W.A.:

EA: ?Kenya

EMENA:

SA: India: selected states (?Bangladesh)

LAC:

EAP:

4. EXPERIMENTAL PROJECTS

a. Uncertainty of effectiveness of interventions;

b. Clearly identified problem;

c. Strong interest of country in new approaches;

d. Simple project design, small cost;

e. Heavy investment - monitoring and evaluation.

Possible examples

1. Nutrition projects relating to marketing systems, supplementation and food technology;
2. Population beyond family planning;
3. Drug systems;
4. Community development in implementation of PHN services;
5. Parallel health/WS&S or health/education.

Expenditure

Support to regions

* - greater support for regions to do economic and sector work

in

2 - costs of appraisal + supervision v. high
∴ do more in supervision

Hansen:

- Asst Director = focal point (Not task force)
- Subsidies - general subsidies
  - Women

Targetting: How to get out

Bracketta

- Political pressures - slum urban - rural

Hopper: - major investment in econ + sector work

Towards - micro - poverty.
meeting - macro - subsidies, supplementation

- Higher priority to Nutr in Pop + Health

Guidelines ①

Mid-pub

3.

Steen: ~~1.~~ 2. Sites are realistic. Poor been reader
Regions identify 3 countries in which they will make extensive econ + sector work. over next 2 years.

3. Food Strategy - link in to Sector work
- Philippines
- B'desh
- Egypt.

4. Feels econ + sector work can be done with the existing resources
Regions doubt

5. Regional focal point (not task force

6. Subsidy: more precision
under what circumstances is subsidy justified:
- delinked from food price impact
- replicable i.e sustainable after finance withdrawn
- only in context in overall nutrition program

WORLD BANK / INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

TO: Mr. Ernest Stern through Mr. Warren C. Baum DATE: October 28, 1980

FROM: John R. Evans, PHN

SUBJECT: Five Year Lending Program

1. With reference to Mr. Richardson's memorandum of September 22, 1980 I attach herewith a table showing the changes from the September 17 Lending Program printout which have been agreed with the Regions and those which are still under discussion.

2. The main changes are:

(i) India: At the Regional review of the CPP it was agreed that two Health projects should be included in the program. These have not yet appeared in the Lending Program. For the purpose of planning, FY82 and 84 are suggested.

(ii) PDRY: Both PHN and the Regional Programs Division believe that a Health project should be added for PDRY; FY83 has been suggested by PHN.

(iii) Nigeria: We have brought forward the FY84 Health project tentatively to FY83. This should be firmed up on the return of the upcoming identification mission.

(iv) Niger: We have tentatively brought forward the Health project from FY85 to FY83. It should be possible to firm this up on the return of the current identification mission.

(v) Indonesia: Regional Programs agrees that a Health project should be added to the program, but timing and amount are still open. PHN has suggested FY83.

(vi) Ivory Coast: Following a recent reconnaissance mission, and the agreement with Regional Programs a Health Project is proposed for FY83. (It is at present a reserve project for FY82.)

(vii) Peru: Presently shown in FY82 but is more likely for FY83. Timing will be reviewed by next preparation mission.

3. The foregoing do not constitute issues as such between PHN and the regional managements. All changes have received some regional support although in some cases the amount and/or timing cannot be firmed up at this point.

4. The attached table breaks the projects into Population, Health or Nutrition, but this in some cases merely reflects only the main focus since there may be substantial overlap over more than one field of activity - most population projects, for example, depend on health delivery systems and incorporate substantial health elements.

5. The timing of many of the projects is necessarily tentative, particularly in the outer years, although it represents the best assessment possible currently in each case. In the aggregate, however, the program indicates a substantial jump in PHN lending activity in FY83 whereas a slower build-up would seem more probable. This will be examined more closely in the course of FY82 budget preparation.

cc: Mr. Vergin
Program Coordinators
Mr. Messenger
Ms. Husain
Mr. Warford
Mr. Kang

LENDING PROGRAM/PHN

JDNorth/rb

	FY81	US$ million	FY82	US$ million	FY83	US$ million	FY84	US$ million	FY85	US$ million
POPULATION	Tunisia II	11	Kenya II	40	Thailand II	50	Kenya III	60	Rwanda I	10
			Egypt III	45			Dom.Rep. II	40 15	Egypt IV	50
							Philip. III	75	Thailand III	60
							Banglad. III	40		
HEALTH			YAR I	8	Mali I	13	YAR II	10	Cameroon I	10
			India I*	?	Senegal I	10	Brazil I***	20	Tunisia I	30
					Nigeria I***	50	Malaysia I	30	Brazil II	60 85
					PDRY I**	?	Papua I	25		
					Niger I	10	India II*	?	Indonesia II	90
					Indonesia I**	40				
					Ivory Coast I***	?			Viet Nam I	40
			Peru I	20	Brazil I	20			P	
					Morocco I	40	Malawi I***	15		
NUTRITION					Egypt I	30	Colombia II	40	Chile I	50
									Nigeria I	60
	1	11	5	113+	10	203+	11	355+	10	460

* India (82) & (84) proposed by Region for CPP - not yet shown in L.P.
** Additional projects under discussion with Regions.
*** Changes in timing.

PROPOSED HEALTH PROJECTS FY81-85

	Approved Lending Program	PHN Targets
FY 81	Kenya II Rural Health and Family Planning	✓
	Tunisia II Rural Health and Family Planning	✓
		Senegal H/N from FY 83
FY 82	Brazil Health	? ✓
	Yemen Arab Republic Health	? ✓
	Thailand Population/Health II	defer to FY 83
		Nigeria Health from FY 84
		Mali Health from FY 83
		Malawi Health from FY 83
		? Lesotho Health
		Morocco Health from FY 83
		Egypt III P/H from FY 85
FY 83	Peru Population/Health	✓
	Mali Health	FY 82
	Morocco Population/Health	FY 82
	Malawi Health/Nutrition	FY 82
	Senegal Health/Nutrition	FY 81
		India III P/H
		Sierra Leone Health
		Ivory Coast Health
		Thailand II P/H from FY 82
		? PDR Yemen H
		? Pakistan N/? H & P

FY84

Papua New Guinea Rural Health	?
Dominican Republic Pop/Rural Health	✓
Nigeria Health/Population	FY 82
YAR Health	✓

FY85

Indonesia Populatinn, Health & Nutrition	✓
Northeast Brazil Health	✓
Niger Health	✓
Cameroon Health	✓
Egypt Population/Health	FY 82
Tunisia Rural Health	✓

PROPOSED HEALTH PROJECTS IN THE APPROVED FY81-85
LENDING PROGRAM (As of May 15, 1980)

FY and Project	Amount of In/Cr. US$ million
FY81	
None	-
FY82	
Sao Paulo, Brazil Health	20
YAR Health	5
Thailand Population/Health *	50
FY83	
Peru Population/Health	20
Mali Health	13
Morocco Family Health	40
Malawi Health/Nutrition	15
Senegal Health Nutrition	10
FY84	
Papua New Guinea Rural Health	25
Dominican Republic Pop/Rural Health	15
Nigeria Health/Population	50
YAR Health	10
FY85	
Indonesia Population, Health & Nutrition	90
Northeast Brazil Health	60
Niger Health	10
Cameroon Health	10
Egypt Population/Health	50
Tunisia Rural Health	30

Total FY81-85 = 18

*Likely to slip to next FY.

LVDomingo
June 30, 1980

Proposed Health Projects FY 81-85

	Approved lending program	PHN Targets
FY 81	KENYA II Rural health + F.P.	✓
	TUNISIA II " " "	✓
		SENEGAL H/N from FY 83
FY 82	BRAZIL H	?✓
	YAR H.	?✓
	THAILAND P/H II	defer to FY83
		NIGERIA H. from FY 84
		MALI H from FY 83
		MALAWI H. from FY 83
		? LESOTHO ? H ?
		MOROCCO H. from FY 83
		EGYPT III P/H from FY 85
FY 83	PERU P/H.	
	MALI H ✓	→ FY 82
	MOROCCO P/H	→ FY 82
	MALAWI H/N	→ FY 82
	SENEGAL H/N	→ FY 81
		INDIA III P/H
		SIERRA LEONE H.
		IVORY COAST H.
		THAILAND II P/H from FY 82
		? PDR YEMEN ? H
		? PAKISTAN N/?H+P.
FY 84		

Division I. Other ~~foodulitzas~~ [ch] includes.

I

WORLD BANK / INTERNATIONAL FINANCE CORPORATION

June 3, 1980

Dr. Evans,

For your information, please.

I. Z. HUSAIN

Attachment (Lending Program)

— POPULATION, HEALTH AND NUTRITION DEPARTMENT —

DIVISION II

FY81-85 LENDING PROGRAMS, REGIONALLY-APPROVED AND DIVISION'S TARGETS

REGIONALLY-APPROVED	DIVISION'S TARGETS	REMARKS
FY81	**FY81**	
—	Senegal Health/Nutrition	Originally an FY82S project but recently slipped to FY83S. Given latest status of project preparation, and if appraisal will take place in October as planned by mission members, it is highly possible to advance the project from FY83S to FY81.
FY82	**FY82**	
Thailand POP/Health II 1/	Nigeria Health/POP	Recent I.D. mission found very encouraging evidence that a project could be developed within 18-month period.
Sao Paulo, Brazil Health	Sao Paulo, Brazil Health	
	Mali Health	Recent identification mission found ample evidence of official Government interest in a project. Preparation mission scheduled for July 1980.
FY83	**FY83**	
Peru POP/Health (S)	Peru POP/Health (S)	
Mali Health 2/	Thailand POP/Health II	RTG had asked for postponement of sector review and any intensive dialogue regarding a second project.
Senegal Health/Nutrition (S) 3/	S. Leone Health (FY83R) Ivory Coast Health (FY82R)	Both are reserve projects, but both are very good project possibilities for FY83.
FY84	**FY84**	
Papua N. Guinea Rural Health Philippines POP III Dominican Rep. POP/Rural Health II Colombia Nutrition II (S) Nigeria Health/POP 4/	The same as regionally approved.	
FY85	**FY85**	
Indonesia, PHN Thailand POP III Vietnam Social Infrastructure Brazil N.E. Health Chile Nutrition Nigeria Food/Nutrition Niger Health Cameroon Health	The same as regionally approved.	? Should be advanced.

1/ Likely to slip to FY83

2/ Could be advanced to FY82 given recent mission's findings

3/ See FY81 Remarks Column. We are still keeping a Population/Health project in the FY82 reserve list although Programs has dropped it from the list.

4/ Advanced to FY82. See FY82 Remarks Column.

June 2, 1980

PROPOSED HEALTH PROJECTS IN THE APPROVED FY81-85
LENDING PROGRAM (As of May 15, 1980)

FY and Project	Amount of In/Cr. US$ million
FY81	
None	
KENYA II: Rural health + F.P	
TUNISIA II " "	
SENEGAL H	-
NIGERIA H	20
MALI H	5
MALAWI	50
LESOTHO - ?	
MOROCCO	
EGYPT III - P/H	
FY82	
Sao Paulo, Brazil Health	
YAR Health	
Thailand Population/Health *	
PDR YEMEN - ??	20
EGYPT III - Pop/Health	13
FY83	
Peru Population/Health	40
Mali Health	15
Morocco Family Health	10
Malawi Health/Nutrition(s)	
Senegal Health Nutrition	
YAR - H	
PAKISTAN N/? Health + P.	
PDR YEMEN - doubtful	
INDIA III P/H	25
THAILAND II	15
S. Leone H	50
Ivory Coast H	10
FY 82 ✓	
	90
	60
	10
	10
→ FY 82 ✓	50
	30

Total FY81-85 = 18

*Likely to slip to next FY.

LVDomingo
June 30, 1980

International Bank for Reconstruction and Development
International Development Association

FOR EXECUTIVE DIRECTORS' MEETING

For consideration on March 10, 1981

R81-24
IDA/R81-16

FROM: Vice President and Secretary

February 12, 1981

BANK/IDA LENDING PROGRAMS - ALLOCATION AMONG INCOME GROUPS SECTORS AND REGIONS

Attached hereto is a copy of a memorandum from the President entitled "Bank/IDA Programs - Allocation Among Income Groups, Sectors and Regions" dated February 11, 1981.

Questions on this document may be referred to Mr. Robless (extension 75533).

Distribution:

Executive Directors and Alternates
President
Senior Vice Presidents
President's Council
Vice Presidents, IFC
Directors and Department Heads, Bank and IFC

THE WORLD BANK
Washington, D.C. 20433
U.S.A.

Office of the President

February 11, 1981

MEMORANDUM TO THE EXECUTIVE DIRECTORS

SUBJECT: BANK/IDA LENDING PROGRAMS - ALLOCATION AMONG INCOME GROUPS, SECTORS AND REGIONS

INTRODUCTION

1. At the meetings of the Committee of the Whole and the Board on the FY81 World Bank Group Financial and Operating Programs and Administrative Budgets,1/ it was agreed to prepare a retrospective review of the major policies underlying the allocation of the five-year lending program shown in the Budget Document. This Memorandum presents the results of such a review. It describes how the Bankwide lending program is put together and clarifies the programming processes which are being employed to implement policies. It reviews also how the distribution of lending among per capita income groups, regions and sectors has evolved since 1968 in reflection of the major policy decisions which have been taken by the Board during the period under review.

1/ Review of World Bank Group Financial and Operating Programs and FY81 Administrative Budgets (R80-129, IDA/R80-85, IFC/R80-47, May 16, 1980).

SECTION 1· PLANNING PROCESS

2. The Bankwide lending program is based on the Bank Group's individual country assistance strategies and country assistance plans which reflect the results of an on-going dialogue between the Bank and its respective borrowing member countries. In these country assistance strategies and plans, the Bank defines the direction of its activities (lending, technical assistance, economic work, sector work, aid coordination, etc.) in support of the development of each of its developing member countries. They take account of the country's development objectives and program, its past and prospective performance, the Bank's overall policies and priorities, the progress made and the difficulties encountered in pursuing the Bank's assistance strategy, and the country's requirements for financial and technical assistance with allowance for the assistance likely to become available from other donors.

3. The size of individual country lending programs, determined in the process of country assistance planning, is influenced by criteria which reflect policies set by the Board.2/ A number of these criteria are quantifiable. The planning process is, however, essentially judgmental in character. Among the factors which are taken into account, the following are given special attention. The per capita income of the country is used as one relative measure of levels of development. The general presumption is that the lower the per capita income of a country, the greater is its claim to Bank Group resources. Population size is taken into account by comparing country lending allocations per capita. The country's economic and social performance and the quality of its economic management are considered in the light of the particular stage of development reached by the respective country. The ability of the country to utilize Bank Group resources effectively for sound development projects is also assessed. Where assessments indicate poor performance, country allocations have been constrained. But, it has always been the policy of the Bank to ensure that, in such cases, its lending programs and technical assistance activities themselves focus on measures designed to improve performance and expand absorptive capacity.

4. In addition, for IBRD lending, the creditworthiness of the country is analyzed. This analysis serves the two-fold purpose of assessing creditworthiness limits as a guide to setting IBRD country lending policy, and identifying and promoting policy changes and structural adjustments that will enhance the borrower's economic and social development as well as its capacity to service external debt. The shares of individual borrowing

---

2/ For a full discussion, see "IDA Allocations Criteria" (IDA/R77-72 (Rev.), July 8, 1977): and "Country Criteria for Bank and IDA Lending," Operational Manual Statement No. 1.16 issued March 1978.

member countries in the Bank's loan portfolio are reviewed also to ensure that outstanding loans to any one country do not constitute too large a share of the total portfolio. The need to avoid undue concentration in the portfolio is one of the limits on lending to the largest borrowers.

5. Countries not considered creditworthy for IBRD lending are candidates for IDA lending. Given the severely limited supply of IDA resources, general income eligibility guidelines are set by the Board annually. In the 1973 review of IDA lending policies and practices, the Board agreed that there should be a strong presumption that countries with a per capita income of above $375 in 1970 prices ($625 in 1978 prices)3/ should not receive IDA assistance. For IDA eligible countries with some capacity to borrow on non-concessionary terms, IDA and IBRD lending are blended so as to provide the maximum feasible amount of Bank Group lending.

6. The sectoral composition of individual country lending programs is also determined in the context of the country assistance planning process. It is based on a detailed consideration of the development objectives and requirements of borrowing member countries in interaction with the sectoral policies and priorities which the Bank Group itself seeks to promote at the country level. The composition of individual country lending programs which is set in close consultation with the national authorities concerned also takes account of the level and composition of the programs of other multilateral and bilateral donors.

7. With the individual country lending programs as a basis, the formulation of the Bankwide lending program is a continuous, iterative process in which country considerations and Bankwide considerations interact. The five-year projections presented to the Board annually regarding amounts and patterns of lending provide a snapshot of this process and summarize the program as of the reference date. In effect, this five-year program is a rolling plan which is relatively firm as regards the lending volume and composition in the first two years of the planning period, but is subject to significant modifications in response to changes in country circumstances and policies in the outer years of the planning period.

3/ IDA Lending Policies (IDA/R73-7, February 7, 1973). See also GNP Per Capita Guidelines for Operational Purposes (Sec/M79-521, IDA/SecM79-251, July 3, 1979).

SECTION 2: PATTERNS OF LENDING

8. The major policies underlying the allocation of the lending program have grown out of discussions by the Board on this subject over the last decade. Apart from its annual review of the Bank Group's Financial and Operating Programs, the principal occasions for these discussions have included the Board's meetings on IDA lending policies in 1973, and 1977; the World Bank's financial policies and the FY74-78 IBRD/IDA program in 1972 and 1974; and the future role of the World Bank in 1977.4/ This Memorandum focusses on the Bank Group's plans for IBRD and IDA lending for the period FY81-85, as laid out in the Budget Document for FY81 5/ in the context of the policy framework which has shaped the Bank Group's lending patterns since FY68. The trends which have been established in the distribution of the Bankwide lending program by income group, region and sector show the extent to which the Bank Group has responded to the evolving views of its members on its role in the development process. The plans for the FY81-85 period will further reinforce these trends.

Distribution by Income Group

9. Table 1 below shows the distribution of IBRD and IDA funds to countries classified by their per capita GNP. For the purpose of this analysis, the table divides the Bank Group's borrowing member countries into five groups. Group I, the lowest income group, comprises countries whose per capita GNP measured in 1978 dollars does not exceed $360 and includes

---

4/ IDA Lending Policies (Feb. 1973); IDA Allocations Criteria, (July 8, 1977); The Scale of IBRD Financial Operations, FY74-78 (R71-276, December 15, 1971); Review of IBRD/IDA Program, FY74-78 (R73-295, IDA/R73-130, December 28, 1973); Revision of IBRD/IDA Program, FY74-78 (R74-115, IDA/R74-42, June 4, 1974); Review of IBRD/IDA Program and Financial Policies (R74-256, IDA/R74-106, December 12, 1974); Future Role of the World Bank and Its Associated Capital Requirements (R77-18, February 1, 1977).

5/ Review of World Bank Group Financial and Operating Programs and FY81 Administrative Budgets, (June 2, 1980, pp. 7 and 8). See also Sector Composition of Lending FY81-85 (R80-129/2, IDA/R80-85/2, IFC/R80-47/2, June 2, 1980).

those designated by the UN General Assembly as being the "least developed."6/ Groups II, III and IV comprise middle income countries with the upper limit of Group II being the IDA eligibility limit of $625 expressed in 1978 dollars. Group V covers the higher income countries with a per capita GNP of over $1745.

6/ As designated by the UN General Assembly on November 14, 1978, based on UN resolutions 32-92 and 32-99 of December 13, 1977, this group comprises: Afghanistan, Bangladesh, Benin, Bhutan (not a Bank Group member), Burundi, Central African Republic, Cape Verde, Chad, Comoros, Ethiopia, Gambia, Guinea, Haiti, Lao PDR, Lesotho, Malawi, Maldives, Mali, Nepal, Niger, Rwanda, Somalia, Sudan, Tanzania, Uganda, Upper Volta, and Western Samoa. Countries designated by the UN as least developed but which do not fall in Group I include Botswana, Yemen Arab Republic and Yemen P.D.R., all in Group II.

Table 1: DISTRIBUTION OF IBRD & IDA COMMITMENTS BY PER CAPITA INCOME LEVEL OF BORROWING COUNTRY a/

		Amount (FY80 commitment $m)					Percent of Total				
		Thru FY68	FY69-FY73	FY74-FY78	FY79-FY83	FY81-FY85	Thru FY68	FY69-FY73	FY74-FY78	FY79-FY83	FY81-FY85
Per Capita GNP b/											
Group I	IBRD	9655	2478	5609	5576	6391	19	11	16	14	15
(Up to $360)	IDA	6550	7792	9769	15361	16776	80	81	87	88	90
	Total	16205	10270	15378	20937	23167	27	32	34	36	37
Group II	IBRD	4862	2751	6251	8588	10240	9	12	18	21	23
($361-$625)	IDA	463	855	1288	2084	1806	6	9	11	12	10
	Total	5325	3606	7539	10672	12046	9	11	16	19	19
Group III	IBRD	4689	3214	4881	6891	7424	9	14	14	17	17
($626-$1075)	IDA	480	502	172	36	5	6	5	2	-	-
	Total	5169	3716	5053	6927	7429	9	11	11	12	12
Group IV	IBRD	12671	9934	12598	14111	15136	25	43	37	35	34
($1076-$1745)	IDA	655	456	-	-	-	8	5	-	-	-
	Total	13326	10390	12598	14111	15136	22	32	28	24	24
Group V	IBRD	19676	4616	4967	5222	4969	38	20	15	13	11
(Over $1745)	IDA	-	-	-	-	-	-	-	-	-	-
	Total	19676	4616	4967	5222	4969	33	14	11	9	8
Memo: Least Developed Countries											
	IBRD	1120	622	460	186	181	2	3	1	-	-
	IDA	1145	1653	3596	5314	5962	14	17	32	30	32
	Total	2265	2275	4056	5500	6143	4	7	9	10	10

a/ See Annex 1 for details of country classification.

b/ Per capita GNP in 1978 dollars according to the 1979 World Bank Atlas. No attempt has been made to allow for country movements from one income group to another over time. The per capita income grouping follows that adopted by the World Development Report, 1980.

10. In accordance with Bank policy as periodically reaffirmed by the Board, the extent of poverty in a member country has been an important determinant in the allocation of Bank Group resources.7/ Thus, the group of low income countries has received a steadily increasing proportion of IBRD/IDA lending and is projected to account for 37% of total commitments in FY81-85 compared with 27% through FY68. The major source of funds for this group will continue to be IDA. The group is programmed to account for 90% of total IDA commitments during FY81-85 compared with 80% in the period through FY68. The severe structural weaknesses of most of these economies, and thus their small debt servicing capacity, imply continued reliance on IDA for the bulk of their funds for the foreseeable future. The fall in the share of IBRD lending during FY69-73 resulted from reduced lending to India and Pakistan after the 1971 war. The sharp rise during FY74-78 reflects the start of large scale Bank lending to Indonesia whose balance of payments position was strengthened with the increase in oil prices. IDA lending to Indonesia was terminated in FY80.

11. Within the low income group, the attention given to the least developed countries has increased the most. Lending to these countries is projected to account for 10% of IBRD/IDA lending in FY81-85 compared with 4% through FY68. Accounting for 20% of the population in the low income group, excluding China, per capita lending to the least developed countries will amount to $24 during FY81-85 compared with $11 in the period prior to 1968.

12. In formulating the Bank Group's country assistance strategies for the low-income countries, a deliberate effort is made to promote better understanding of the aid requirements of these countries as well as to strengthen their development institutions and, through aid coordination and cofinancing, enhance their ability to better utilize the aid available to them. In the case of Sub-Sahara Africa, a special effort is now under way. A comprehensive study of the development strategy and prospects for Sub-Sahara Africa is examining options and strategies open to these countries in critical sectors and the associated external assistance requirements. The priority which has been assigned to the poorer countries is also seen in the emphasis which the Bank gives to the assistance which its staff provides through project identification, preparation, appraisal and supervision in order to alleviate some of the severe implementation constraints faced particularly by the least developed countries.

13. The principal considerations underlying the allocation of the lending program to countries in Groups II, III and IV were discussed by the Board in 1977 when it considered Management's memorandum on the future role

---

7/ See, for example, Revision of IBRD/IDA Program, FY74-78 (June 4, 1974) and Minutes of Meetings of the Executive Directors of the Bank and IDA and the Board of Directors of IFC on July 30 and August 1, 1974 (M74-36 (Rev), IDA/M 74-34 (Rev), IFC/M74-21 (Rev), August 16, 1974).

Board in 1977 when it considered Management's memorandum on the future role of the World Bank.8/ It was then noted that as regards improvements in a country's debt structure, the benefits arising from increased IBRD lending sometimes could be exaggerated. It was agreed, however, that there was strong justification for expanding IBRD lending to these countries based on the impact the Bank could have in helping them achieve a better allocation of their own resources, both through the careful selection of projects for IBRD financing and through the Bank's policy analysis and institution building advice. IBRD lending and policy advice would improve also their prospects of securing commercial bank loans and private investment on reasonable terms inter alia through cofinancing arrangements and, indirectly, by influencing the quality of economic management. Thus, IBRD lending has continued to grow strongly in all the middle income countries, with some differentiation between individual countries reflecting differences in access to alternative sources of capital.

14. Given the limited debt servicing capacity of most countries in Group II, IDA funds have continued to play an important though declining role for this Group. The particularly sharp increase in the share of IBRD lending in FY74-78 compared with the period before FY68 is mainly the result of IBRD lending to a number of large countries that had received little or none previously (including Cameroon, Egypt, and the Philippines).

15. With respect to Group III for which IDA lending has now been terminated, IBRD lending is programmed to grow at the Bankwide average. For Group IV, the share in IBRD lending has fallen reflecting their increased access to other sources of capital. Within this Group, lower-than-Bankwide average growth in IBRD lending is envisaged for such oil-exporting countries as Algeria, Malaysia and Mexico.

16. Taking account of the potential of countries in Group V to raise capital from alternative sources on reasonable terms, a continuing decline is projected in the share in total IBRD lending. The Bank's present graduation policy was established in 1974 when it was decided to examine the justification of continued IBRD lending to a given country when its per capita GNP reached $1000 in 1970 prices (equivalent to $2100 in 1978 prices).9/ Following such reviews, a number of countries were graduated: Iceland in FY74, Finland and Israel in FY75, Ireland in FY76, Spain in FY77, Singapore in FY78, and Greece in FY79. This general policy was again reviewed in 1977 when the Board considered Management's memorandum on the

---

8/ Future Role of the World Bank, Section 3 (February 1, 1977).

9/ Review of IBRD/IDA Programs and Financial Policies (paras. 77-80, December 12, 1974). In para. 78, a per capita income of $1000 was referred to as being in 1972 prices; reference was intended to the 1972 World Bank Atlas, which gave per capita income data in 1970 prices.

future role of the Bank.10/ It was emphasized that in the final analysis, the decision to reduce or phase out IBRD lending must be based on detailed scrutiny of the specific circumstances affecting individual countries.

Distribution by Region

17. The regional distribution is a by-product of country assistance planning adjusted to reflect overall Bank policies particularly as regards the deployment of Bank Group resources by country income level. The emphasis given to the lower income countries is seen in the share of both the total and the increment of concessional lending going to South Asia and Sub-Sahara Africa where the bulk of the world's poor are, as shown in Table 2.

18. The South Asia Region comprises three of the seven most populous developing member countries and 68% of the total population of countries in Group I (excluding China). Under present planning assumptions, the share of IDA resources going to the Region has been programmed to remain at about 60%, but this still allows only a per capita level of lending which is lower than that for all other Regions. Bank Group financial assistance to these countries will continue to be constrained by the availability of IDA funds and by the countries' limited creditworthiness for Bank lending.

10/ Future Role of the World Bank, Section 4 (February 1, 1977).

Table 2: DISTRIBUTION OF IBRD & IDA COMMITMENTS BY REGION

		Amount (FY80 commitment $m)					Percent of Total				
		Thru FY68	FY69-FY73	FY74-FY78	FY79-FY83	FY81-FY85	Thru FY68	FY69-FY73	FY74-FY78	FY79-FY83	FY81-FY85
E. Africa	IBRD	2386	1399	1825	1179	1308	5	6	5	3	3
	IDA	814	1268	1975	3173	3501	10	13	18	18	19
	Total	3200	2667	3800	4352	4809	5	8	8	8	8
W. Africa	IBRD	1864	1571	1878	2778	3440	4	7	5	7	8
	IDA	361	742	1047	1601	1650	4	8	9	9	9
	Total	2225	2313	2925	4379	5090	4	7	7	8	8
EMENA	IBRD	4892	5019	9657	10504	10541	9	22	28	26	24
	IDA	622	902	994	1308	1244	8	9	9	7	7
	Total	5514	5921	10651	11812	11785	9	18	23	20	19
LAC	IBRD	14776	8805	10266	13500	14648	29	38	30	33	33
	IDA	539	287	297	272	240	7	3	3	2	1
	Total	15315	9092	10563	13772	14888	25	28	23	24	24
East Asia and Pacific	IBRD	3749	3332	8441	11036	12614	7	15	25	27	28
	IDA	178	1576	378	811	668	2	17	3	5	4
	Total	3927	4908	8819	11847	13282	7	15	19	20	21
S. Asia	IBRD	7332	1259	1895	1391	1609	14	5	6	4	4
	IDA	5633	4830	6538	10316	11284	69	50	58	59	60
	Total	12965	6089	8433	11707	12893	22	19	19	20	20
Past Borrowers	IBRD	16555	1608	344	-	-	32	7	1	-	-
	Total	16555	1608	344	-	-	28	5	1	-	-

19. Although the shares of both Eastern and Western Africa have not changed much since FY68, important structural changes have occurred. In the case of Eastern Africa, IDA lending has increased substantially both in absolute and relative terms as the Bank Group expanded its country assistance programs in step with the expansion of development efforts in a number of countries in the Region (Kenya, Sudan, Tanzania) even while creditworthiness considerations made it necessary to substitute IBRD with IDA lending for a number of major borrowers. In the case of Western Africa, the Region's IBRD and IDA shares have remained stable during the decade. However, IBRD lending has increased for a number of important borrowers such as Cameroon, Ivory Coast, and Nigeria, and is expected to rise further in FY81-85.

20. The significant increase in the IBRD share of the EMENA Region during FY69-73 and FY74-78 was the result of a substantial expansion in lending to a number of middle income countries including Algeria, Morocco, Tunisia, and Turkey. Sizeable lending programs were also mounted in Romania, which joined the Bank only at the end of 1972, and in Portugal, which had not borrowed from the Bank for 10 years. The fall in the IBRD/IDA share of the EMENA Region since FY74-78 mainly reflects the decreasing shares of the oil-exporting countries which enjoy relatively strong balance of payments positions, and the southern European countries such as Portugal and Romania which are relatively high income borrowers, as shown in Table 3 below. The combined share of the remaining countries--mainly in Groups II and III--is constant in contrast to the steep fall for EMENA as a whole.

Table 3: DISTRIBUTION OF IBRD/IDA COMMITMENTS IN EMENA REGION

		FY80 $ Million					Percentage of Total Bank				
		Thru FY68	FY69-FY73	FY74-FY78	FY79-FY83	FY81-FY85	Thru FY68	FY69-FY73	FY74-FY78	FY79-FY83	FY81-FY85
European a/ Countries	IBRD	2223	2551	5195	6204	5984	4	11	15	15	14
	IDA	363	234	-	-	-	5	2	-	-	-
	Total	2586	2785	5195	6204	5984	4	8	11	11	10
Oil Exporters b/	IBRD	2274	1786	3556	2791	3087	4	8	10	7	7
	IDA	142	415	497	874	807	2	4	4	5	4
	Total	2416	2201	4053	3665	3894	4	7	9	6	6
Other c/ Countries	IBRD	395	682	906	1509	1470	1	3	3	4	3
	IDA	117	253	497	434	437	1	3	4	2	3
	Total	512	935	1403	1943	1907	1	3	3	3	3
EMENA	IBRD	4892	5019	9657	10504	10541	9	22	28	26	24
	IDA	622	902	994	1308	1244	8	9	9	7	7
	Total	5514	5921	10651	11812	11785	9	18	23	20	19

a/ Cyprus, Greece, Portugal, Romania, Turkey and Yugoslavia.
b/ Algeria, Egypt, Iran, Oman, Syria and Tunisia.
c/ Afghanistan, Jordan, Lebanon, Morocco, Yemen, A.R. and Yemen, P.D.R.

21. The Latin America and Caribbean Region also experienced a significant increase in its IBRD share in FY69-73 as the programs for several large borrowers such as Brazil, Colombia and Mexico were expanded. The sharp drop in the IBRD share in FY74-78 and its rebound in FY79-83 is the result mainly of the suspension and subsequent resumption of lending to Argentina in FY77. Argentina's share, however, will fall during FY81-85, as

will Mexico's, while the allocations for all major borrowers will grow at the Bankwide average. The decline in the IDA share reflects the phase-out of IDA lending to Ecuador, El Salvador and Paraguay.

22. Marked changes have taken place in the share of lending to countries in the East Asia and Pacific Region. The IBRD share increased dramatically in FY69-73 and FY74-78 as the Bank stepped up its lending to Korea and the Philippines in FY69 and FY70, respectively, and as large-scale IBRD lending to Indonesia commenced in FY75 and substituted for IDA funds in view of the country's substantially improved balance of payments following the oil price increases of the mid-1970s. Further increases in the Region's share of IBRD resources are envisaged during FY81-85. A forthcoming sizeable change which is not yet reflected in the distribution will, of course, follow from the start of lending to China.

Distribution by Sector

23. The Board has at various times over the last decade considered Sector Policy Papers which outlined how the Bank proposed to reorient its lending program to address issues of poverty, employment, basic needs and energy supply in its borrowing member countries. The policy dialogue which has ensued and the lending initiatives which have followed have had a profound impact on the Bank Group's relations with most of its borrowing member countries and on the sectoral composition of IBRD/IDA commitments.

24. The first notable change was initiated in the early 1970s as growing dissatisfaction with the distributional consequences of economic growth led to new perceptions of the development process involving a sharper focussing of development on the poorest of the poor in the developing countries. Thus, the Board formally accepted the Management's recommendation in 1974 that a major objective of the Bank Group's FY74-78 program would be to redirect an increasing part of its lending to raise the productivity of the poorest, and to address directly the qualitative dimensions of development.11/

25. With this new emphasis, a major shift occurred in IBRD/IDA lending for agriculture. It was not that agriculture had until then been neglected; in fact, lending for agriculture had increased from 7% of the total in FY60 to 16% in FY71-72 and 25% in FY73-74, when total lending had expanded at an annual rate of about 6.5% between FY60 and FY74. However, agricultural lending and analysis focussed increasingly on technologies and institutions relevant to the small farmer, and lending had as a specific major objective to expand agricultural production through increasing the productivity of the small farmer. To supplement this approach, new emphasis was placed on projects embodying an integrated approach to the development of an area to

---

11/ Revision of IBRD/IDA Program, FY74-78 (June 4, 1974). Minutes of Meetings of Executive Directors of the Bank and IDA and the Board of Directors of IFC, July 30 and August 1, 1974.

bring about improved productivity, increased employment and thus higher incomes for target groups and minimum acceptable levels of food, shelter, education and health.12/

26. Reflecting the emphasis which has been given to raise the productivity of the rural poor, the share of rural development and agriculture in IBRD/IDA commitments has grown progressively to 30% of total lending in FY74-78 and is projected to remain at that level for FY81-85. Lending for agricultural and rural development projects in which the majority of direct benefits is expected to accrue to the poverty target groups formed more than one-half of total rural development and agricultural lending during FY74-78, and is expected to continue to account for that proportion of lending in FY81-85.

27. Concurrent with these initiatives was the preparation of Bank projects aimed at alleviating urban poverty.13/ A program of urban development projects was initiated in 1972 specifically for improving the productive efficiency of urban centers and the living conditions and employment opportunities of low income groups. IBRD/IDA lending for such projects accounted for 2% of total commitments in FY74-78 and is expected to reach 5% in FY81-85. The aim of assisting with the alleviation of urban poverty also called for modifying the Bank's approach to lending to industry, transport and development finance companies as well as a special program for small-scale enterprise development to help member countries in their efforts to broaden employment and increase opportunities among the urban poor.14/

28. Lending for the social sectors--education, population, health, nutrition, water supply and sanitation--will continue to be an important part of the Bank's endeavors to help member countries meet the basic needs of the absolute poor. With respect to education, the FY81-85 share amounts to 4% compared with 1% before FY68. Lending for health began with experimental components in projects in other sectors. With the Board's

---

12/ Rural Development and Bank Policies: A Progress Report (R74-245, December 5, 1974).

13/ Urbanization: Sector Working Paper (R72-93 and R72-93/1, May 2 and 5, 1972).

14/ Employment Creation and Small-scale Enterprise Development (R77-76, March 28, 1977).

approval in FY80 of a full program of operations in the health sector,15/ a gradual increase in lending for health projects can be expected. Overall, there is a strong case for a significant volume of Bank lending for pioneering projects and programs in these social sectors. However, it will take time and additional experience to develop the programs and institutions to implement a significantly larger program and to ensure that Bank financed projects support the design and implementation of cost-effective and replicable programs.

29. A second major set of changes in the composition of the IBRD/IDA lending program has come from the recent initiatives of the Bank to play a more active role in helping its developing member countries adjust to the changed international economic environment of higher oil prices and sluggish world trade. Thus, structural adjustment lending was initiated in FY80 and a significant expansion in energy lending in particular for oil, gas and coal projects has begun. Currently planned commitments for both initiatives in the FY81-85 program, as presented with the Budget Document for FY81, 16/ however, by no means reflect the full scope of the role the Bank could play in the adjustment process.

30. In reviewing the Bank's proposals for structural adjustment lending, the Board noted that it would be difficult to predict the share and number of lending operations for structural adjustment with any precision.17/ The projections embodied in the FY81-85 lending program as presented to the Board in June were based on a preliminary estimate of the number of countries prepared to work with the Bank in initiating the difficult steps necessary for structural change and the speed with which programs which the Bank could support could be developed.18/ As the Bank's policy dialogue with its member countries proceeds, the required scale of lending for structural adjustment programs could well be larger.

15/ Bank Lending for Health (R79-175, June 25, 1979). See also Minutes of Meetings of Executive Directors of the Bank and IDA and the Board of Directors of IFC on July 24, 1979 (M79-39, IDA/M79-36, July 30, 1979).

16/ Sector Composition for Lending FY81-85.

17/ Lending for Structural Adjustment (R80-17, IDA/R80-22, February 5, 1980), Note on Program Lending (M80-150, February 29, 1980), Structural Adjustment Lending (R80-122, IDA/R80-83, May 9, 1980). See also Lending for Structural Adjustment (R80-17/2, IDA/R80-22/2, March 31, 1980).

18/ Review of World Bank Group Financial and Operating Programs and FY81 Administrative Budgets; Sector Composition of Lending FY81-85.

31. Likewise, as noted by the Board when it considered the Bank's proposals for expanding energy lending in August 1980, 19/ the currently planned lending program for the energy sector (coal and lignite, oil and gas, refineries, renewable energy, and electric power) of $11 billion in FY80 commitment $ ($13 billion in nominal $), amounting to 17% of total IBRD/IDA lending planned for FY81-85, is substantially below what is considered to be a feasible and desirable program. The latter based on a country-by-country review of investment needs and opportunities in the energy sector would amount to $20 billion in FY80 commitment $ ($25 billion in nominal $) or about 30% of the total IBRD/IDA five-year lending program.

32. It is clear that while the desirable energy program could be justified easily in terms of both need and likely returns, such an enlarged program, like that of an expanded program for structural adjustment lending, cannot be accommodated within the current Bankwide lending program without serious displacement of other high priority projects. The implementation of the enlarged programs for both energy and structural adjustment have therefore come to depend on an expansion of IBRD/IDA lending over presently planned levels.20/

33. Reflecting the combined impact of these various sectoral initiatives at the country program level, Table 4 shows marked shifts in the composition of the IBRD/IDA lending program.

19/ Energy in Developing Countries (R80-206, July 11, 1980, R80-206/1, July 29, 1980).

20/ Possible Expansion of IBRD/IDA Lending over Presently Planned Levels, (R80-325, IDA/R80-149, November 14, 1980).

Table 4: DISTRIBUTION OF IBRD & IDA COMMITMENTS BY SECTOR a/

Sector	Amounts (FY80 Commitment $m) Thru FY68	FY69-FY73	FY74-FY78	FY79-FY83	FY81-FY85	Percentages Thru FY68	FY69-FY73	FY74-FY78	FY79-FY83	FY81-FY85
Rural Development & Agriculture	4818	6465	13796	17685	19671	8	20	30	31	31
Urbanization	-	109	1098	2293	3314	-	-	2	4	5
Small-Scale Industry	30	17	650	831	1009	-	-	1	1	2
Population, Health and Nutrition	-	147	260	516	847	-	1	1	1	1
Water Supply & Sewerage	581	1386	1846	3510	3383	1	4	4	6	5
Education	699	1750	1873	2228	2290	1	5	4	4	4
Oil, Gas & Coal	353	249	391	2999	3962	1	1	1	5	6
Power	17988	5957	6098	7248	6081	30	18	14	13	10
Non-Fuel Minerals Mining	594	278	422	590	488	1	1	1	1	1
DFC	3161	3144	4258	3528	3814	5	10	10	6	6
Industry	3580	1357	3671	3680	4160	6	4	8	6	7
Transportation	19088	8172	7677	7434	6290	32	25	17	13	10
Telecommunications	867	1724	1041	931	1215	2	5	2	2	2
Program Lending & Structural Adjustment Lending	7942	1803	2325	4195	5934	13	6	5	7	10
Other	-	41	129	202	290	-	-	-	-	-
Total	59701	32599	45535	57870	62748	100	100	100	100	100

a/ See Annex 2 for sub-sector detail.

34. Prior to FY68, two-thirds of total lending went to the power and transportation sectors; agriculture, industry (including DFCs) and program lending accounted for the rest. The main focus of Bank activities then was to assist member countries in strengthening the basic infrastructure of their economies. Subsequently, the sectoral composition of lending has shifted markedly in response to new perceptions about the development needs of its member countries; lending operations have addressed broader development objectives, focussed on institution building, and aimed at programs designed to improve the productivity of the rural and urban poor. The trends established over the past ten years are projected to continue, the share of lending for traditional infrastructure development is programmed to decrease while that of sectors with a direct impact on the basic problems affecting the poor, including severe malnutrition, rising unemployment, and the growing inequality in the distribution of income are programmed to increase. For FY81-85, about one-third of IBRD/IDA lending is programmed to support projects aimed at the absolute poor (rural development, small-scale industry and basic needs); another one-quarter will

be for structural adjustment and energy lending--the latter will also include a reassessment of lending for power in the context of the energy development plans of the Bank's borrowing member countries. The share of lending for traditional infrastructure development is planned to continue to drop significantly to approximately 12% in FY81-85.

SECTION 3: CONCLUDING OBSERVATIONS

35. This review of the policies and processes which are shaping the Bank Group's IBRD and IDA lending patterns supports the following observations:

- Country assistance planning based on intensive and continuous dialogue with the Bank Group's borrowing member countries is the central element in the process which shapes the deployment of the Bank's resources.

- The distribution of lending by country income groups reflects policies set by the Board.

- Sectoral priorities established by the Board influence the content of the Bank's dialogue with borrowing member countries and help determine the basic thrust of the Bank's country assistance strategies. The impact of changes in the Bank's sectoral priorities is clearly demonstrated by the evolution of the Bank's sectoral lending patterns.

36. The agenda of development issues facing the Bank Group's member countries is long and demanding, and becoming increasingly complex. The scope and direction of lending as envisaged in the FY81-85 lending program has evolved to address priority needs in these countries within the context of our analysis of global developments and development priorities. But, while we are working on projects and programs which are designed to realize the projected lending patterns, changes in country conditions are inevitable. These changes will result in modifications of country allocations and in the country and sector distribution of Bank Group lending; new regional or global developments may also require modifications in the composition of the lending program.

Robert S. McNamara

Borrowing Member Countries a/
Grouped by Per Capita GNP in 1978 Dollars

Group I (Below $360)	Population b/ ('000)	GNP per capita b/ (US $)
* Afghanistan	14,616	240
Bangladesh	83,641	90
Benin	3,326	230
Burma	32,205	150
Burundi	4,271	140
Cape Verde	319	160
Central African Republic	1,909	250
Chad	4,320	140
Comoros	390	180
* East African Community	44,479	269
Equatorial Guinea	346	310 c/
Ethiopia	31,011	120
Gambia	570	230
Guinea	5,133	210
Guinea-Bissau	762	200
Haiti	4,831	260
India	643,896	180
Indonesia	135,993	360
Kenya	15,187	320
Lao, P.D.R.	3,300	90
Lesotho	1,279	280
Madagascar	8,298	250
Malawi	5,780	180
Maldives	145	150
Mali	6,297	120
Mauritania	1,545	270
Nepal	13,627	120
Niger	5,005	220
Pakistan	77,337	230
Rwanda	4,514	180
Senegal	5,377	340
Sierra Leone	3,296	210
Somalia	3,743	130
Sri Lanka	14,350	190
Sudan	17,390	320
Tanzania	16,871	230
Togo	2,418	320
Uganda	12,421	250 c/
Upper Volta	5,553	160
* Viet Nam	52,179	170
Western Samoa	157	350 c/
Zaire	26,410	210

Group II ($361-625):	Population b/	GNP per capita b/
Bolivia	5,290	510
Botswana	747	620
Cameroon	8,065	460
Caribbean Region	4,354	625
Congo	1,460	540
Djibouti	320	450
Egypt	38,686	400
El Salvador	4,382	600
Ghana	10,972	390
Guyana	836	550
Honduras	3,441	480
Liberia	1,742	460
Nigeria	81,039	560
Papua New Guinea	2,930	560
Philippines	45,639	510
Sao Tome & Principe	85	490
Solomon Islands	213	430
Swaziland	526	590
Thailand	44,345	490
Yemen Arab Republic	5,098	580
Yemen, P.D.R.	1,749	420
Zambia	5,295	480
Zimbabwe	6,913	480
Group III ($626-1075):		
Colombia	25,136	870
Dominican Republic	5,128	910
Ecuador	7,550	910
Guatemala	6,627	910
Ivory Coast	7,836	840
Jordan	2,985	1050
* Lebanon	3,011	1070 d/
Mauritius	918	830
Morocco	18,914	670
Nicaragua	2,490	840
Paraguay	2,893	850
Peru	16,820	740
Seychelles	63	1060
Syria	8,088	930
Tunisia	6,050	950

Group IV ($1076-1745):	Population b/	GNP per capita b/
Algeria	17,701	1260
Brazil	119,430	1570
Chile	10,734	1410
Costa Rica	2,110	1540
Fiji	599	1440
Jamaica	2,131	1110
Korea	36,616	1160
Malaysia	13,300	1090
Mexico	65,470	1290
Panama	1,826	1290
* South Africa	27,708	1480
Turkey	42,952	1210
Uruguay	2,892	1610
Group V (Over $1745):		
Argentina	26,371	1910
* Australia	14,366	7920
* Austria	7,498	7030
Bahamas	218	2620
Barbados	250	1940
* Belgium	9,870	9070
Cyprus	646	2110
* Denmark	5,084	9920
* Finland	4,745	6820
* France	53,182	8270
* Gabon	539	3580
* Greece	9,325	3270
* Iceland	226	8320
* Iran	35,849	2060 c/
* Iraq	12,216	1860
* Ireland	3,234	3470
* Israel	3,716	4120
* Italy	56,800	3840
* Japan	114,053	7330
* Luxembourg	358	10410
* Malta	335	2160
* Netherlands	13,971	8390
* New Zealand	3,187	4790
* Norway	4,048	9510
Oman	839	2570
Portugal	9,653	2020
Romania	21,853	1750
* Singapore	2,355	3260
* Spain	36,655	3520
Suriname	389	2110
Trinidad & Tobago	1,137	2910
* Venezuela	13,965	2910
Yugoslavia	21,933	2390

---

* Past borrowers and inactive borrowers.
a/ Excluding China.
b/ 1978 Population and GNP per capita figures according to the 1979 World Bank Atlas.
c/ 1976 $.
d/ 1975 $.

Sub-sector Detail of Sectoral Classification

Sector	Subsector
Agriculture and Rural Development	Agriculture Credit Area and Rural Development Crop Processing, Storage and Agro-Industry Fishing Forestry Irrigation, Flood Control and Drainage Land Reclamation Land Settlement and Transmigration Livestock Perennial Crops and Estates/Smallholdings Research and Extension
Urbanization	Sites and Services Urban Service Development Urban Transport
Small-Scale Industry	Small and Medium Scale Enterprise Development Industrial Estates Development
Population, Health and Nutrition	Health and Hygiene Nutrition Population
Water Supply and Sewerage	Pollution Control Sewerage Solid Waste Disposal Water Supply
Education	General Education Human Resource Management Vocational and Technical Training
Oil, Gas and Coal	Coal and Coal Gasification Exploration and Development Gas Oil Pipeline Development
Power	Distribution/Transmission Hydro-power and Dam Construction Nuclear Thermal
Non-Fuel Minerals Mining	Mining, Other Extractive
Development Finance Companies	DFC Industrial Credit

Sector	Subsector
Industry	Alcohol and Gasohol
	Engineering
	Fertilizer and Other Chemicals
	Iron and Steel
	Machinery and Electronics
	Pharmaceuticals
	Petrochemicals
	Pulp and Paper
	Refinery
	Textiles
	Tourism
	Other Industries
Transportation	Airlines and Airports
	Highways and Feeder Roads
	Highway Maintenance
	Ports, Harbors, Bridges and Waterways
	Railways
	Shipping
	Transport Sector lending
Telecommunications	Telecommunications
Program Lending and SAL	Industrial Imports
	Program Lending
	Structural Adjustment Lending
	Emergency Lending/Rehabilitation
Other	Free-standing projects providing finance for Technical Assistance in Project Preparation and Planning.

WORLD BANK / INTERNATIONAL FINANCE CORPORATION

JRE.
Ref. this morning's meeting.

OFFICE MEMORANDUM

TO: Mr. John D. North, Asst. Director, PHN

DATE: March 6, 1981

FROM: Ishrat Z. Husain, Chief, PHND2

SUBJECT: An Overview of Division 2's Lending Program: Prospects and Problems

1. Further to my memo of yesterday, I wish to bring to your attention the additional fact that even if we achieved our realistic lending program 100%, the coverage of population with health services would be very small. Almost all projects under preparation (Senegal, Peru, Mali, Indonesia, Nigeria and Brazil) will cover a few regions of the country and will have little national level support. Even the impact of regional activities in terms of improved health status will not be visible for at least five years. A substantial impact on country's population will be a matter of 10-15 years at the minimum unless we find ways to deal with key national level issues and strategies such as drug supply, logistics, supervision, low-cost health system and cost recovery, etc. Therefore, we should be cautious in our remarks with regard to the impact of our efforts on improving the health status in these countries.

cc: Mr. Messenger, PHND1; Dr. Liese (o/r), PHND2; Ms. Domingo, PHND2; Division Files

IZHUSAIN:gsr
LENDING PROGRAM/PHN

Population, Health and Nutrition
Projects and Sector Work Under Consideration for
East Africa Region

PROJECTS	FY82	FY83
	Kenya II (P)	Malawi (H)

SECTOR WORK

Botswana (P/H/N)
Burundi (P)
Malawi (N)
Sudan (P/H)
Swaziland (P/H/N)
Uganda (P/H/N)
Zimbabwe (P/H)

PHND1
4/2/81

Population, Health and Nutrition
Projects and Sector Work Under Consideration for
Europe, Middle East and North Africa Region

PROJECTS	FY82	FY83
	YAR (H)	PDRY (H) Morocco (H)
SECTOR WORK		
	Jordan (P/H) Morocco (N)	

PHND1
4/2/81

Population, Health and Nutrition
Projects and Sector Work Under Consideration for
South Asia Region

PROJECTS	FY82	FY83
	-	India (H) Pakistan (P)

SECTOR WORK

Bangladesh (N)
Pakistan (N)
Sri Lanka (H/N)
Nepal (P)

PHND1
4/2/81

WORLD BANK / INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

TO: Dr. John R. Evans, Director, PHN

DATE: April 1, 1981

FROM: I. Z. Husain, Chief, PHND2

SUBJECT: Division 2's Ongoing and Proposed Work Programs

The attached memorandum summarizes our Division's activities during the current fiscal year, our proposed work program in FY82, and the status of the projects in the pipeline. We hope that this will not only assist you in your letters to the WHO Regional offices in Asia and Africa, but will also be useful for your discussions with WHO (Geneva).

Attachment

cc: Mr. North, PHN
Dr. Kanagaratnam, PHN
Mr. Berg, PHN
Dr. Liese, PHND2
Division Files

HUSAIN/DOMINGO:chb
WORK PROGRAM/PHN

PHND2's WORK PROGRAM

Lending Operations

1. The following table reflects: (i) the FY82-83 lending program agreed with Mr. Stern on March 13, and (ii) the projects in our supervision portfolio.

Region	Lending Program FY82	Lending Program FY83	Supervision Portfolio
West Africa	Senegal (Health) (Standby)	Mali (Health) Nigeria (Health) (Standby)	—
East Asia	—	Indonesia (Health)	Indonesia I, II, III and Nutrition projects Malaysia I and II Korea Philippines I and II Thailand
LAC	—	Peru (Health)	Jamaica II Dominican Republic Trinidad and Tobago (PCR)

2. Lending. As you know, we are actively pursuing the preparation of the FY82-83 projects. Appraisal of the Senegal project is scheduled for June; preparation of the Peru project is fairly advanced and could be ready for appraisal in the Fall; and preparation missions are scheduled for Mali and Indonesia in June and July, respectively. Present indications seem to indicate that the above lending targets could be reasonably met.

3. In addition, preparation work is also underway in Nigeria and Niger. There is a possibility of advancing the Nigeria project if the agreed timetable is kept by the Government. The draft sector review for Niger has now been completed; a preparation mission is scheduled for June. Annex 1 lists the projects in the pipeline and summarizes their status.

4. Supervision. We do not have a problem project in our supervision portfolio. The non-availability of local funds, however, has caused major problems in the Philippines projects, which would, otherwise, have been problem-free. The project completion report for Trinidad and Tobago is expected to be released within two weeks.

Sector Work

5. We have a reasonably large sector work program in FY81 and FY82. We expect to complete six health sector reviews in FY81: Sierra Leone, Nigeria, Thailand, Niger, Peru, and Northeast Brazil. During FY82, we plan to undertake seven sector reviews: Brazil Health, Cameroon PHN, Colombia PHN, Haiti PH, Liberia PH, Peru N, and Philippines PH. In addition, one of our staff members

will participate in a Basic Needs Assessment mission to Nigeria which will focus on nutrition. With the exception of the Philippines, the proposed FY82 sector work program has not yet been discussed with the respective governments. No sector work program has as yet been proposed for FY83.

Health Component Work

6. We have a fairly large component program in FY81 involving the supervision of 14, appraisal of 7, and preparation of 4 health components in non-PHN projects. Over half of the projects are in LAC. There is a possibility that one of the components which we have appraised (the Rondonia health sub-project) will be converted into a free-standing health project under our responsibility enabling us to bring two projects to the Board in FY82. Annex 2 lists the projects wherein we have participated in either developing or supervising health components.

HUSAIN/DOMINGO:chb
4/1/81

FY82-85 LENDING PROGRAM BY REGION

Region	Projects	Loan Amount (US$ million)	FY	Status
West Africa:				
	Senegal Health	10	82-S	A one-man mission will visit Senegal next week to ensure that the June appraisal will be made possible.
	Mali Health	13	82	Preparation mission scheduled for June.
	Nigeria Health	60	84-S	Project preparation is continuing. If schedule agreed with the Government is kept, the project could be advanced to FY82.
	Niger Health	10	85	Draft of sector review completed. Preparation mission scheduled for June.
	Cameroon Health	10	86	Preliminary discussions with Government planned when new Resident Representative assumes his post in early July.
	Ivory Coast Health	NA	82-R	A reconnaissance mission is planned for May.
	Ghana Health and Nutrition	NA	83-R	The reconnaissance mission which visited Ghana in December 1980 found positive indications of Government interest in a Bank-financed project. Next mission will be sent as soon as Government clearance is received.
	Sierra Leone	NA	83-R	A one-man mission to discuss the recently completed sector memorandum will also look into Government interest in Bank assistance in the sector. Under an ongoing technical assistance project, a consultant is being provided to assist in strengthening the planning capability of the Ministry of Health.
	Guinea Health and Nutrition	NA	85-R	No discussions have taken place as yet.

FY82-85 LENDING PROGRAM BY REGION

Region	Projects	Loan Amount (US$ million)	FY	Status
East Asia:				
	Indonesia Health	60	83	A staff member was in the field last week to discuss with Government next steps in project preparation. Preparation mission planned for July.
	Malaysia Health	30	84	Preliminary discussions have taken place and will be pursued during next supervision mission of ongoing population projects.
	Philippines III	75	84	Problems in implementation of ongoing population problems are affecting the dialogue for a third project.
	Papua New Guinea	20	84	A staff member is now in the field to assess Government interest in Bank assistance in the sector.
	Thailand II	50	84	Problems in implementation of ongoing population project are delaying the preparation of a second project.
	Indonesia Population, Health, and Nutrition	100	85	Discussions will have to be deferred until the preparation of first project is fairly advanced.
LAC:				
	Peru	20	83	Preparation underway with assistance of Bank consultant.
	Brazil Health	20	84	Preliminary discussions had taken place and will be pursued actively during next three months.
	Chile Nutrition	57	85	Reconnaissance missions found positive signs of Government interest and have identified nutrition activities for Bank financing.
	Bolivia	NA	*	A reconnaissance mission is planned for May 1981.

* Not in the lending or reserve program

HUSAIN/DOMINGO:chb
4/1/81

PHND2's COMPONENT WORK PROGRAM, FY81

Activity	
SPN	Brazil Rural Devt. IV - Bahia I
SPN	Brazil Rural Devt. V - Pernambuco
SPN	Brazil Rural Devt. VI - Sergipe
SPN	Brazil Rural Devt. Minas Gerais II
SPN	Brazil Rural Devt. Minas Gerais I
SPN	Brazil Rural Devt. Ceara II
APR	Brazil Northwest Agric. Devt. I - Rondonia
PREID	Brazil Rural Devt. Bahia II
SPN	Bolivia Ulla Ulla Devt.
SPN	Bolivia Urban Devt.
APR	Cameroon Technical Assistance II
APR	Ecuador Puerto Ila-Chone Rural Devt. II
APR	Ecuador Esmeraldas Rural Devt. III
PREPN	Mali Rural Water
PPREID	Mexico Rural Devt./Pider IV
APR	Mexico Pider III R/D
PREPN	Nigeria Kano Water Sanitation
APR	Nigeria Second Urban Devt.
SPN	Philippines Urbanization I
SPN	Philippines Urbanization II
SPN	Philippines Rainfed Agric. Devt.
APR	Papua New Guinea Rural Devt. Enga
SPN	Thailand Northern Rural Devt.
SPN	Thailand Kasetsart Univ. (Education II)
SPN	Thailand Prov. Water Supply

For operational
review c̄ JDN · Jan 20th

For presentation to WCB

Duem: 17 + Ebdecbeins

Perception:

1. When Bank is only small % of resources, the advantages are tech. transfer + fixing of 5 years of plans + domestic resources to PH goals

2. When pressure on IDA; Pearce says lending IDA for oil + gas is nonsense; possible IBRD + cofinancing. Some priority for health sector. Some priority in ~~???~~ of IDA for PHN —

3. Priority in lending programs of region eg AS + EAP:
(a) Capability for implementation better (of Africa).
(b) Pop^n v. large.
(c) Ambivalence of DEA + Region to raise priority. No real backing because of conflict of resources
(d) Not part of the family of the region Bureau & Econ. mission gov't ++ for health.

Outline Years Memorandum

1. ~~Danger of~~ Being pushed back.

2. Waste of sector work.

3. ~~Smaller countries~~

eg.

Promise: when you have a project ready we will put in the program.

---

① Big projects / few slots: as pattern in region. Better to have smaller, regionally supplier projects

Indonesia 90%
Thailand 90%
Nigeria

Board / IDA Presentation for PHN

1. Egypt.
2. Thailand

How to get them interested.

Population

(a) Not yet a proper matter for PHN

(b) Why discussion
1. political unpopularity
2. slow start + long term for benefits
3. implementation difficulties

Need to make slots available

Agencies are floor funding encumbered funds to substitute for institutional commitment.

Preferred way = management commitment

Population, Health Nutrition Department
Division II

Summary

A review of the status of lending work in East Asia and West Africa regions show that reasonable progress has been made since the establishment of Division 2 in January 1980. Four projects are now in advanced stages of the project cycle : Senegal (field appraisal completed), Indonesia (field appraisal in February), Mali (advanced stage of preparation), and Nigeria (under preparation, appraisal in July). Three projects are in early stages of identification/ preparation (Niger, Upper Volta and Ivory Coast) and sector work is either ongoing or planned for four other countries which could possibly lead to project development (China, Cameroon, Thailand and the Philippines).

The pioneering efforts to start up PHN activities both in the Bank and in the countries were time-consuming, staff-intensive and difficult. Our Division has taken some internal steps it hopes will facilitate the generation and preparation of projects. However, there are a number of important factors that lie beyond the control of the Division. Generally, these include the following factors:

(i) reluctance of the countries to borrow on Bank terms for PHN sectors (Thailand and China);

(ii) uncertainty of availability of IDA funds (both EAP and WA regions); and

(iii) inadequate recognition by many Bank economists and Programs Departments of the importance of human resource in economic development.

Other factors specific to each of the regions are discussed below.

East Asia and Pacific

Of the 10 countries in EAP having a population of at least 1 million, four are in our lending program (Indonesia, Thailand, China, and Papua New Guinea) and sector work is ongoing in two other countries which would possibly generate projects (Malaysia and the Philippines). All these countries have serious problems either or in all PHN sectors based on selected demographic, health and nutrition indicators . (See attached tables.) No activities are either ongoing or planned during the next three years in the PHN sectors in three other countries in spite of their serious problems in either or all of the sectors because of difficult political situation (Laos, Vietnam and Kampuchea).

In addition to the factors mentioned above, there are two additional constraints faced by our staff in generating projects in EAP:

(i) availability of other sources of financing for health ~~the sector~~ (Malaysia and Papua New Guinea); and

(ii) implementation difficulties of ongoing PHN projects (Indonesia nutrition project and the Philippines population projects).

Internal steps are being taken to address the second constraint and progress is being made in this regard.

West Africa

There are 17 countries in WA having a population of at least 1 million. Of these, 6 are in our lending program (Senegal, Mali, Niger, Upper Volta, Sierra Leone, and Nigeria) and three are in the reserve list (Ivory Coast, Cameroon and Ghana). Sector dialogue has been initiated in Liberia through the participation of a staff member in the economic mission. These 10 countries face serious problems in either or all of the sectors. (See attached tables.) PHND2 has no ongoing activities in the remaining 7 countries for various reasons, some of which are as follows:

(i) difficult political situation in the country (Benin, CAR and Chad);

(ii) country fiscal constraints and limited Bank activities in the country (Guinea, Togo, Congo).

only 6 Mauretania

Because of the sensitivities surrounding population issues in the region, the focus of our projects under preparation is in health but covering as well nutrition concerns.

Attachment: Ranking of EAP and WA countries based on selected population, health and nutrition indicators

14 January 1982

Ranking of Division II Countries for PHN Projects by Sector[1]

WEST AFRICA

Region/Countries	Population	Health	Nutrition	Priority Sectors	Project in Lending Program	Status of Project Preparation	Problems Encountered in Project Generation/ Preparation
1. Benin	5	4	8	Population/Health	None	None	(i) sensitivity of population issues in country (ii) difficult political situation in the country (iii) limited Bank operations in the country.
2. Cameroon	4	5	6	All Sectors	An FY85 health project has been dropped recently.		(i) no major constraints so far
3. Central African Republic	12	8	10	Health	None	None	(i) Limited Bank operations
4. CHAD	11	4	2	Health/Nutrition	None	None	(i) No Bank activity in the country
5. Congo	13	12	13	Health	None	Initiated dialogue with Programs/Govt. through assistance in preparing CPP/ economic work	(i) Limited Bank operations in the country.
6. Ghana	2	9	7	Population/Nutr.	FY84 Health (Reserve Proj.)	Sector Reconnaissance	(i) political constraints
7. Guinea	6	11	8	Pop/Nutr.	None	None	(i) Bank's country strategy does not focus on these sectors
8. Ivory Coast	2	7	11	Population/Health	An FY86 health project was dropped from lending program	Sector REconnaissance Project identification ongoing.	(i) population a sensitive issue
9. Liberia	8	13	14	Population	none	None except participation in economic mission	(i) no political support from the government for population projects (ii) fiscal constraints
10. Mali	3	2	3	All sectors	FY83 health	Under preparation; APR, June 1982. Project preparation on schedule.	No major problems
11. Mauritania	10	10	8	Nutrition	none	Ongoing sector analysis	(i) no operational delivery system to attach project

12.	Niger	3	3	5	All Sectors	FY84 health	Sector work required for project work now completed; Recon/ID, March 1982	(i) population, a sensitive issue in the country. (ii) lack of constituency in government for nutrition issues (iii) changes of government delays project preparation.
13.	Nigeria	1	5	4	All Sectors	FY85S Health FY86 Nutrition	Health project under preparation; nutrition sector reconnaissance completed.	(i) population a sensitive issue. (ii) lack of constituency in government for nutrition sector (iii) limited institutional capacity
14.	Senegal	5	6	8	All Sectors	FY83 Health	Field appraisal for health project completed; board presentation, July 1982.	(i) no major problems for health projects except for difficulties in reaching agreement with Programs on project issues; (ii) nutrition project was prepared but subsequently dropped by Programs from lending program.
15.	Sierra Leone	5	13	12	Population	FY85 Health	Initial sector work completed	(i) population, a sensitive issue
16.	Togo	7	11	9	Population/Nutr.	None	None	(i) limited bank activity in the country
17.	Upper Volta	9	1	1	Health/Nutrition	FY84 Health	Ongoing sector work. ID Recon. planned early 1982.	(i) No major problems

Inclues only countries with population of at least 1 million.

/1 The ranking of the countries were based on the following indicators:
Population: population size, crude birth rate, and rate of population growth
Health: population size, life expectancy at birth, and infant mortality rate
Nutrition: Health indicators plus daily per capita calorie supply (% of total requirement).

RANKING OF COUNTRIES IN EAST ASIA AND PACIFIC
FOR PHN PROJECTS BY SECTOR /1

Countries	Population /2	Health	Nutrition	Priority Sector(s)	Project in Lending Program	Status of Project Preparation	Problems Encountered in Project Generation / Preparation
China	5	5	4	All Sectors	FY85 Health	Sector/reconnaissance mission planned early 1982.	No decision yet on size and blend of Bank lending operations in China.
Dem. Kampuchea	7	3	2	Health/Nutrition	None	None	No Bank lending operations in the country for the next 5 years.
Indonesia	2	1	1	All Sectors	FY83 Health FY86 Health	FY83 Health under preparation; APR planned in Feb. 1982. Initial discussions on Fourth Population Project.	(i) No major problems for Health and Population projects. (ii) Difficulties in implementing ongoing Nutrition project; a constraint in developing another free-standing Nutrition project. (iii) Absence of nutrition staff in Division.
Korea	4	6	7	Population/Health	None	None	Country fiscal constraints.
Malaysia	8	7	6	Population	An FY84 Health project was dropped from Lending Program by Programs.	Ongoing dialogue for a Health project and a Third Population project.	(i) Availability of other sources of financing for Health projects (ADB) (ii) According to Programs, preparation of another Population project hingers upon receipt of official request from Ministry of Finance.
ıpua New Guinea	6	4	3	Nutrition/Health	FY85 Health	None	(i) Availability of other external sources of financing for Health (ADB) (ii) No major problems for Nutrition.
Philippines	3	4	3	All Sectors	None	Ongoing sector review of PHN sectors which is expected to lead to dialogue for future projects in either or all of the sectors.	(i) Difficulties in implementation of two ongoing Population projects a constraint in developing another free-standing Population project. (ii) Institutional problems.
Thailand	3	5	5	All Sectors	FY85 Health	Ongoing sector review of Health and Nutrition which is expected to lead to future projects. Identification mission scheduled in Feb. 1982.	Government's relectance to borrow from the Bank for these sectors.
Viet Nam	1	3	4	All Sectors	None	None	Difficult political situation in the country.
Laos	6	2	2	Health/Nutrition	None	None	(i) Bank's lending strategy limited only to two sectors; agriculture and road transport (ii) Difficult political situation in the country (iii) Absorptive capacity of the country.

/1 Includes only countries with population of at least 1 million. The ranking of the countries was based on the following indicators:
Population: Population size, crude birth rate, and rate of population growth
Health: Population size, life expectancy at birth, and infant mortality rate
Nutrition: Health indicators plus daily per capita calorie supply (% of total requirement).

/2 The lower the composite ranking, the higher the priority.

1/13/82

LENDING PROGRAM FOR POPULATION AND HEALTH PROJECTS

	POPULATION [1]	HEALTH	
FY79			
	Egypt II ✓		
	Tunisia II 1982		
	Philippines II ✓		
	Bangladesh II ✓		
	(4)		
FY80			
	Kenya II - 1982		
	Korea I ✓		
	India II ✓		
	Dominican Republic II No		
Reserve:	El Salvador I No		
	(4)		
FY81			
	Ecuador I No	1 [2]	**Identified Projects** [3]
	Indonesia III ✓		
	Thailand II No		Peru
Reserve:	S. Leone I		Mali
	Pakistan II prep		Brazil
	(3)		Nigeria
FY82			Indonesia
	Malaysia III No	2	
	Korea II No		
	EMENA unidentified No		
Reserve:	Sudan I		
	Honduras		
	India III		
	(3)		
FY83			
	Kenya III No	3	
	Peru I OK		
	Indonesia IV ?		
	Philippines III ?		
	Bangladesh III ?		
	(5)		
FY84		4	
	(19)	(10)	

1/ Population Projects Department's FY79-83 Lending Program.
2/ Number of projects indicated in the Health sector policy paper presented to the Board.
3/ Information given by Dr. Liese.

LENDING PROGRAM FOR POPULATION AND HEALTH PROJECTS

	POPULATION [1]	HEALTH	
FY79	Egypt II Tunisia II Philippines II Bangladesh II (4)		
FY80	Kenya II Korea I India II Dominican Republic II Reserve: El Salvador I (4)		
FY81	Ecuador I Indonesia III Thailand II Reserve: S. Leone I Pakistan I (3)	1 [2]	Identified Projects [3] Peru Mali Brazil Nigeria Indonesia
FY82	Malaysia III Korea II EMENA unidentified Reserve: Sudan I Honduras India III (3)	2	
FY83	Kenya III Peru I Indonesia IV Philippines III Bangladesh III (5)	3	
FY84		4	
	(19)	(10)	

1/ Population Projects Department's FY79-83 Lending Program.
2/ Number of projects indicated in the Health sector policy paper presented to the Board.
3/ Information given by Dr. Liese.

WORLD BANK / INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

TO: Dr. John Evans, Director, PHN DATE: January 8, 1982

FROM: Cynthia Scherr, CPSVP

SUBJECT: Supplemental Loans/Credits

1. During Tuesday's PHN division chiefs' meeting, I discussed the origin and use of "supplemental" loans/credits in the Bank's programming system. To reiterate, the advantages to programming these "uncounted" operations relate to the budgeting of lending operations - not to the content or terms of the projects. If a Region cannot accommodate a PHN operation within its total numbers of projects, the use of a "supplement" is advantageous to you. However, if a Region is willing to include a small PHN operation as a project in its lending program, there is no advantage to PHN to propose it as a "supplement".

2. You asked me to follow-up on the programming of the "predevelopment" projects processed by EGY. These projects are generally small operations, focusing on promotional activities, technical assistance, institution-building, and in some cases, exploratory drilling. They are considered technical assistance/engineering projects with conditions and terms similar to those operations described in Operational Manual Statement 4.00. In forecasting a manpower budget for EGY, predevelopment projects which do not have an SAR are budgetted at 63 staffweeks as opposed to predevelopment projects which have an SAR and regular development projects which are budgetted at 125 staffweeks.

3. Again, if PHN and the Regions agree to program the proposed PHN technical assistance operations as "supplements", you should alert Mr. Tadvalkar to the timing (number per year) and manpower costs of them within the next week.

cc: Messrs. Richardson, North, Messenger
Ms. Husain

CMScherr:lic

Copy to Mr Pearce done

JAN. 13 2:00

RMF - For April 13 - 3:30 Pm meeting

1. State of Lending Portfolio

Number of projects are not ~~over~~ concern.

1

. Two concerns about Port folio.

(1). "Quality" in terms of potential impact on P, H + N.

The second ~~set~~ of problems concern

(2) Stability of Port folio ~~and~~ Support and Commitment of Regional Staff.

The second.

reaffirm by consistent support of these objectives in the lending program ~~the Bank program~~ and to raise the commitment level of the Bank to meet this policy

emphasizing

Key Messages.

Limited resources IDA, (IBRD) and ~~staff~~ less Bank staff. c. ~~Are the~~ Replenish of health projects looks very optimistic.
Three concerns about portfolio:

i Are the resources being applied in areas of greatest need.
- pop. influenced by proj.
- ~~health~~ qualitative impact in H.
- adequacy of attention to pop.

ii Stability of portfolio.
- Agreed country strategy.

iii Commitment + Support of Staff

iv /

FORM NO. 75
(9–78)

THE WORLD BANK

ROUTING SLIP	DATE: 15 / Jan / 82

NAME	ROOM NO.
Dr. Evans	

	APPROPRIATE DISPOSITION		NOTE AND RETURN
	APPROVAL		NOTE AND SEND ON
	CLEARANCE		PER OUR CONVERSATION
	COMMENT		PER YOUR REQUEST
	FOR ACTION		PREPARE REPLY
X	INFORMATION		RECOMMENDATION
	INITIAL		SIGNATURE
	NOTE AND FILE		URGENT

REMARKS: Re Constraints

John,
I should thought you would find this letter — para. 4, top of p. 2 — instructive.

Dave Radel

FROM:	ROOM NO.:	EXTENSION:

U.S. INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
USAID THAILAND
BANGKOK, THAILAND

CABLE: USAID THAILAND

TELEPHONE: 252-8191-9

December 30, 1981

Mr. David Radel
Project Officer
Population, Health and
Nutrition
The World Bank
1818 H Street, N.W.
Washington, D. C. 20433

Dear Dave:

Thanks for your November 25 letter and the copy of your semi-annual progress report. Your reports always provide an excellent summary of the status of the project and often contain useful information we would otherwise not be aware of.

As you may know, Tony Boni visited us again recently to assist in updating the estimates of current contraceptive supplies and probable future requirements. The situation is now somewhat confused with the simultaneous increase in RTG financing of contraceptives and the decentralization of the planning and budgeting process. I understand that Tony plans to share the current information about contraceptive supplies with you prior to your trip here in early February. Per your suggestion, I would be happy to join you in discussing with the Family Health Division the need to update the supply estimates on a regular basis.

I sense that there is considerable disappointment in the Department of Health over the decision to forego the further development of an AID-assisted nutrition project. We are trying to remain involved, however, through a couple of small-scale projects designed to follow-up on the nutrition surveillance study that Hank was involved in. We would be interested in collaborating with you in taking a broad look at the nutrition sector - particularly the area of food policy, which to date we have not assessed in detail. Even without a bilateral project, I believe that we could obtain centrally-funded technical assistance to participate in such a joint effort.

For meeting Feb 3 - O.V Ps.

Regarding the potential for a follow-on World Bank-assisted project, my reading is that unless additional IDA funds are available, the level of MOPH interest will be very low. Our proposed follow-on Population Project has not yet received final RTG approval, largely because of the issue of loan funds, even at our relatively soft terms.

We will look forward to seeing you and the other members of your group in late January and early February. In the meantime, if we can be of any assistance, please let me know.

With best regards.

Sincerely,

David

David A. Oot
Director
Health/Population/Nutrition

OFFICE MEMORANDUM

Cindy Sche

TO: Mr. Heinz Vergin, PAB

DATE: January 22, 1982

FROM: Giuseppe Pennisi, WAN

SUBJECT: Western Africa - Revised FY82-84 COPD Program

Please find attached, the COPD portion of our revised FY82-84 lending program.

Attachment

cc: Mr. Knox, WANVP
WAN Directors
COPD Directors
Ms. Scherr, CPSVP

CStover/fm

Changes in FY82-84
IDA COPD Projects
As Compared to October 30, 1981 Lending Program

	FY82	FY83	FY84	Changes
MLI Telecom. I	13.5			Original amount $11.0.
UPV Telecom III	17.0			Moved from FY83
MLI Gasohol		4.3		Original amount $5.0.
SEN Health		15.0		No change
MLI Rural Health			20.0	Original amount $19.5 and Moved from FY83
UPV Health			25.0	No change
NIG Health /1				Moved from FY84
MTA Petroleum	3.0			No change
GAM Energy	1.5			No change
(M) EQG Oil T. A.		2.3		Original amount $7.0 and Moved from FY82
(M) GHA Petroleum		9.5		Original amount $9.0 and Moved from FY82
(M) BEN Oil Expl.	8.0			No change Now 82 Regular however
(M) SEN Dome Flore		12.5		Moved from FY82
(M) NIG Petroleum			5.0	Moved from FY83
(M) MTA Oil		4.5		Original amount $10.0
(M) GUI Oil & Mineral			10.0	Moved from FY83
(M) GUB Oil Expl. II			5.0	Original amount $6.0
(M) GAM Oil II			5.0	No change
BEN Oil Expl. II			10.0	No change

M = Supplemental Project

WANPC
1/22/81

/1 No longer in FY82-84 program.

COB SILVER TRANSPORT	.0	17.0	GUB PORT BISSAU	.0	14.0 15.5						NIR ROADS VII	150.0	.0	CAM PORTS IV				
CAM ROADS V	100.0	.0	CAP PRAIA PORT	.0	7.0 6.0						CAP TRANSPORT SECTOR	.0	11.0					
			S CAP HIGHWAYS IV	.0	18.0						CAM ROADS VI	80.0	.0					
			CAM PORT III	15.7	.0													
INDUSTRIAL DEV & FIN DIVISION																			
NIG SMALL/MEDIUM SCALE	.0	16.0	WAN BOAD II	.0	5.0	S NIR DFC-IV	120.0	.0	S IVC IND. DEV.	50.0	.0	STP SME	.0	2.0					
NIR SME I	41.0	.0				GHA INDUSTRIAL DEVELOPM	.0	35.0 23.0	GUI IDF II	.0	21.0	SEN IDF III	15.0	.0					
GUI INDUSTRY REHAB (DFC	.0	17.0 19.0				CAM SME III	30.0	.0	S GAM DFC II	.0	5.0	S NIG SME III	.0	10.0					
												BEN BBD II	.0	15.0					
ENERGY DIVISION																			
TOG NANGBETO ENG. CREDI	.0	2.0	UPV POWER (KOMPIENGA)	.0	23.0 20.0	SIL POWER V (BUMBUNA)	.0	37.0	TOG NANGBETO II	.0	15.0	S SEN POWER	10.0	.0					
NIR POWER VI	100.0	.0	STP POWER & W/REHAB	.0	5.0 8.0				M BEN NANGBETO II	.0	15.0	S LIB POWER - ST. PAUL	42.0	.0					
MLI POWER/WATER	.0	26.0 24.0	IVC POWER II (SOUBRE)	35.0	.0							GUI POWER II	.0	25.0					
M BEN NANGBETO ENG. CREDI	.0	1.8 5.5	S GHA ECG POWER IV	.0	20.0 17.0							GHA POWER IV(BUI)	.0	60.0					
WATER SUPPLY DIVISION																			
NIR ANADUA WATER SUPPL	67.0	.0				S SEN WATER SUPPLY II	20.0	20.5 15.0	SIL WATER SUPPLY	.0	10.0	NIG WATER SUPPLY	.0	12.0					
GHA W/S ENG. & REHAB.	.0	10.0				S NIR KANO WATER SUPPLY	115.0	.0	S NIR BORNO WS	70.0	.0	IVC RURAL WATER SUPPLY	25.0	.0					
IVC WATER SUPPLY II	40.0	.0				S NIG WATER SUPPLY T.A.	.0	5.0	GHA WATER SUPPLY	.0	25.0	MLI POWER/WATER II	.0	25.0					
						MLI WATER SUPPLY I	.0	12.0	S CAM WATER SUPPLY III	40.0	.0								
URBAN PROJECTS DIVISION																			
IVC URBAN IMPT.II	51.0	.0	NIR URBAN III	70.0	.0	S GHA KUMA UPGRADING	.0	15.0	COB URBAN	.0	11.0	TOG URBAN WATER SUPPLY	.0	20.0					
LIB URBAN DEVELOPMENT	.0	10.0							S CAM URBAN II	40.0	.0	S SEN URBAN II	15.0	.0					
CAM URBAN DEVT	.0	40.0										S NIR URBAN IV	100.0	.0					
												IVC URBAN III	35.0	.0					
												BEN COTONOU URBAN/WATER	.0	24.0					

F482 83 84 85 86

IBRD IDA

COFD

TRANSP, WATER & TELECOMM DEPT																			
MLI TELECOMMUNICATION I	.0	13.5	S UPV TELECOM III	.0	17.0	S CAM TELECOM	40.0	.0											
CAM POST & TELECOM	7.5	.0																	
INDUSTRIAL PROJECTS DEPT																			
LIB NATIONAL IRON ORE C	20.0	.0	S TOG CIMAO REGIONAL CEME	15.0	.0	TOG PHOSPHORIC ACID	50.0	.0						S CAM INDUSTRY	25.0	.0			
			MLI GASOHOL	.0	4.3	S NIR FERTILIZER	100.0	.0											
						GUI MIFERGUI-NIMBA	50.0	.0											
SOCIAL HEALTH & NUTRITION DEPT																			
			SEN HEALTH	.0	15.0	UPV HEALTH I	.0	25.0	S SIL HEALTH	.0	10.0	NIR HEALTH II	75.0	.0					
			MLI RURAL HEALTH	.0	17.0 20.0	NIG HEALTH	.0	10.0	S NIR SOKOTO HEALTH PROJE	50.0	.0								
									IVC HEALTH II	10.0	.0								
									CAM HEALTH	10.0	.0								
ENERGY DEPARTMENT																			
NTA PETROLEUM EXPL.PROM	.0	3.0	M SEN DOME FLORE APPR DRI	.0	12.5	M GUB OIL EXPL. II	.0	5.0 6.0	SEN DOME FLORE II	35.0	.0	M NTA OIL	.0	11.0					
GHA ENERGY	.0	1.5	M NIG PETROLEUM	.0	5.0	M GAM OIL II	.0	5.0	CAM OIL I-BIBOUNDI	10.0	.0	IVC OIL EXPLORATION II	50.0	.0					
M ECG OIL TECH. ASSIST.	.0	2.3	M NTA OIL	.0	5.0 7.5	S BEN OIL EXPL. II	.0	10.0				S GHA PETROLEUM EXP. DEV.	.0	25.0					
M GHA PETROLEUM	.0	9.5	M GUI OIL & MINERALS EXPL	.0	10.0														
SEN OIL EXPLORATION	.0	8.0	S IVC OIL EXPLORATION	100.0	.0														
			M CAM OIL & GAS T.A.	7.5	.0														
AMOUNTS	844.5	223.6		611.2	355.7		983.0	339.5		944.0	640.0		967.0	509.0					
NUMBER OF PROJECTS	15	20		11	27		17	21		21	36		20	31					
TOTAL NUMBER OF PROJECTS	35			38			38			57			51						

M SUPPLEMENT PROJECT - NOT COUNTED AS PROJECT
S STANDBY PROJECT

TABLE LP-7

SOUTH ASIA REGION
FIVE YEAR LENDING PROGRAM
WORKING DRAFT - VERSION 3
BY MANAGER

(AS OF 01/25/02 10.48.34)

MANAGER: COPD

POPUL HEALTH & NUTRITION DEPT

	COUNTRY	BANK	IDA
FISCAL YEAR 03			
NN01 POPULATION	PAK	.0	15.0
		.0	15.0
		0	1

.0	40.0
0	1

WORLD BANK / INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

TO: See Distribution Below

DATE: January 21, 1982

FROM: John Ducker, EAHVP

SUBJECT: Reallocation of IDA Funds: FY83-FY84

As a consequence of the reduction in IDA funds, we have found it necessary to make some adjustments to the FY83-84 lending programs. I attach revised lists reflecting the adjustments in our lending program for FY83 and FY84 for the COPD sectors for your information.

Attachment

Messrs. Elejalde, Iskander, Kohli, Messenger, Saunders,
Ms. Haug

cc: Ms. Grammont, Peter, Wilson

JD/bw

EASTERN AFRICA REGION

COPD Managed Projects
FY83

Country/Project	FY	Bank US$	IDA US$	Board Date
Comoros				
Population	83	-	3.0	n.a.
Kenya				
Telecoms II	83*	44.0	-	6/82
Madagascar				
Petrol II	83*	-	15.0	6/82
Malawi				
Health-Nutrition	83	-	20.0	5/83
Somalia				
Petrol Expl.	83	-	5.0	6/83
Sudan				
Petrol	83	-	50.0	9/82
Zaire				
Gecamines II	83	-	40.0	3/83
Zambia				
Copper Mining	83	60.0	-	7/82
Refinery Eng.	83*	4.9	-	5/04/82
Petrol Expl. Prom.	83*	6.2	-	6/82

EASTERN AFRICA REGION

COPD Managed Projects
FY84

Country/Project	FY	Bank US$	IDA US$	Board Date
Ethiopia				
Petr. Expl. Prom.	84M	-	10.0	n.a.
Kenya				
Energy II/Refinery	84	50.0	-	n.a.
Lesotho				
Health/Nutrition	84	-	10.0	1/84
Rwanda				
Health/Population	84	-	15.0	n.a.

WORLD BANK / INTERNATIONAL FINANCE CORPORATION

Dr. Evans

OFFICE MEMORANDUM

TO: Messrs. Evans, Fuchs, Rovani, Willoughby DATE: January 26, 1982

FROM: Cynthia Scherr, CPSVP (Jnvt)

SUBJECT: FY83 Work Program - COPD Lending Programs

1. I am attaching the latest FY82-86 COPD lending programs proposed by the Regions. As you will note, EAN, WAN, AEN and ASN have submitted revised programs. LAC suggests we use their November program, and EMENA suggests we use their October program as attached.

2. The PAB guidelines note that you "should be guided by the number and types of centrally-managed lending operations under the revised regional programs...". If you find it necessary to marginally amend these regional programs (for example, due to bunching in one year, or known changes in the FY82 program), please note these changes in your cover memoranda to Mr. Baum forwarding your FY83 work programs.

Attachments

cc: Messrs. Baum, van der Tak, Richardson o/r
CPS Administrative Officers

CMScherr:lic

EAST ASIA & PACIFIC REGION
APPROVED FIVE-YEAR LENDING PROGRAM
AS OF 01/25/82

MANAGER: CPS-POPULATION

	COUNTRY	BANK	IDA
FISCAL YEAR 84			
NH01-*HEALTH I	INDONESIA	70.0	.0
		70.0	.0
		1	0
FISCAL YEAR 85			
HH01- HEALTH	CHINA	60.0	40.0
NH01- RURAL HEALTH	PAPUA NG	25.0	.0
NN03-*POPULATION II	THAILAND	75.0	.0
		160.0	40.0
		3	0
FISCAL YEAR 86			
NH02- HEALTH II	INDONESIA	60.0	.0
		60.0	.0
		1	0

EMENA

POPULATION PROJECTS BEST FY82-86 LENDING PROGRAM [illegible]

TABLE [illegible]
10/31/8[illegible]

	PROJECT	NAME		FY82 IBRD	FY82 IDA	FY83 IBRD	FY83 IDA	FY84 IBRD	FY84 IDA	FY85 IBRD	FY85 IDA	FY86 IBRD	FY86 IDA
	2KENNH02	POPULATION II	+		40.0								
	2KENNH03	POP. III	+								50.0		
*	2LESNH01	HEALTH/NUTR.	+						12.0				
	2MALNH01	HEALTH-NUTRITION	+				21.7						
	2MALNH02	HEALTH II	+										30.0
	2MAWNH01	HEALTH/POP.	+						15.0				
	3CAMNH01	HEALTH	+							10.0			
	3IVCNH02	HEALTH II	+							10.0			
	3MLINH01	RURAL HEALTH	+				19.5						
	3NIGNH01	HEALTH	+						10.0				
	3NIRNF01	HEALTH II	+									75.0	
	[illegible]	BONOTO HEALTH PROJECT	+							50.0			
*	3SENNH01	HEALTH	+				15.0						
*	3SILNH01	HEALTH	+								10.0		
	3UPVNH01	HEALTH I	+						25.0				
	5MORNH01	FAMILY HEALTH	+							20.0			
	5TUNNH01	RURAL HEALTH	+									15.0	
*	5YARNH01	HEALTH	+				12.0						
*	5YARNH02	HEALTH II	+								15.0		
*	5YDRNF01	HEALTH & NUTRITION I	+				4.0						
	5YDRNF02	HEALTH & NUTRITION	+										4.0
*	6BRANH01	SAO PAULO STATE HEALTH	+					50.0					
	6BRANH03	NE HEALTH - SECTOR	+									100.0	
	6BRANN04	NE DEVT I - HEALTH	+	13.0									
	6COLNF03	NUTRITION II	+							25.0			
	6CLMNH01	HEALTH	+									35.0	
*	6PERNH01	HEALTH	+					20.0					
	7CHANH01	HEALTH	+							60.0	40.0		
	7INSNH01	HEALTH I	+					70.0					
	7INSNH02	HEALTH II	+									60.0	
	7MAYNH01	PRIMARY HEALTH	+					45.0					
	7PAPNH01	RURAL HEALTH	+							25.0			
*	7THANH03	POPULATION II	+							75.0			
	8BANNH03	POPULATION III	+						30.0				
*	8INDNH03	POPULATION/HEALTH	+						30.0				
*	8INDNH04	POPULATION/HEALTH	+										75.0
	8PAKNH01	POPULATION	+				30.0						

POPULATION PROJECTS DEPT FY82-86 [illegible]

TABLE [illegible]
[illegible]

PROJECT	NAME	FY82 IBRD	FY82 IDA	FY83 IBRD	FY83 IDA	FY84 IBRD	FY84 IDA	FY85 IBRD	FY85 IDA	FY86 IBRD	FY86 IDA
	AMOUNT	17.0	40.0		102.2	185.0	122.0	275.0	115.0	285.0	109.0
	NUMBER	1	1		5	4	6	8	3	5	3

FIVE YEAR PROGRAMS	THRU 66 IBRD	THRU 66 IDA	FY67-71 IBRD	FY67-71 IDA	FY72-76 IBRD	FY72-76 IDA	FY77-81 IBRD	FY77-81 IDA	FY82-86 IBRD	FY82-86 IDA
AMOUNT			5.0	4.8	72.3	66.4	162.0	212.9	755.0	488.2
NUMBER			2	1	5	5	8	6	18	18

* STANDBY PROJECT
\# SUPPLEMENT
\+ [illegible] PROJECT

LAC

FIVE YEAR LENDING PROGRAM FOR POPULATION, HEALTH AND NUTRITION AS OF 10/31/91
REPORT PREPARED ON 11/09/91

CODE	FISCAL YEAR	PROJECT NAME	RESERVE PROJECTS BANK/IDA	FY 92	FY 93	FY 94	FY 95	FY 96	
		PERU							
NN01	84S	HEALTH		.	.	20.0	.	.	
		BRAZIL							
NN04	92	NW DEVT I - HEALTH		13.0	.	.	.	.	
NN01	84S	SAO PAULO STATE HEALTH SERVICE		.	.	50.0	.	.	
NN03	86	NE HEALTH - SECTOR		.	.	.	.	100.0	
		COLOMBIA							
NF01	95	NUTRITION II		.	.	.	25.0	.	
NH01	86	HEALTH		.	.	.	.	35.0	
TOTAL				13.0 1	.0 0	70.0 2	25.0 1	135.0 2	.0 0
		OF WHICH 'S'		.0 0	.0 0	70.0 2	.0 0	.0 0	.0 0

Munoz: Concentrate on Pop. for 2 reasons
1. Economic significance
2. Lending program is much weaker in P than H.
3. Further weakened by revision of FY 84 lending

Annex I:

(1.) Lending program 82-84.

[84] The significant change: - Malaysia P dropped
- India 84S-85S / or Bangladesh 84 / 85S dropped.
~~and 1 project 40 m~~
- Niger delayed to 85.

4 of 10 are out in '84 — 3 of 4 are Pop.

[83] less change - Mali slipped to '84 Comoros added.
Results in '83: 5H 1P = 6. '84: - 6H and 1 P = 7
South Asia program: 1 Pop project in Pakistan

(2.) ~~Population:~~

~~Totals~~ 1

Annex II → illustrate

need examples of what we are going to sell
Agreement c good on sector strategy.
= finance
= manpower
= financial
= target pop.

Q: (1.) Fear that approach is too careful, cautious. (Too heavy emphasis on sector work.) Danger. That govt. will ~~be persuaded~~ be uninfluenced except by project.
Point to successes..

(2) Ambitious. Coefficients ↓ / supervision.

(3) Small countries: - size of pop.

countries like India, Egypt. Limit by
& of IDA resources. Capital
available for other sectors - private.
concessional lending should give
special attention to fields like
Pop / Health which are high priority
but not attractive sources of
money

- India, Pakistan, Bangladesh
- Egypt + Algeria
- Indonesia + Thailand (not interested in USAID loan on soft terms)
- Nigeria

4. PHN pipeline much longer than appreciated. ~~Would~~ Will PHN have sufficient resources to achieve it? Coefficients need to be reduced because rewritten by staff unlikely to increase much if at all.

5. Egypt and Thailand warrant special attention to encourage borrowing on Bank terms for pop/health.

6. South Asia problematic. India ~~FY~~ + Bangladesh ~~IV~~ slipped to FY85; India ~~IV~~ remains in FY86; reserve projects for Nepal, FY87 and ~~Sri~~ Sri Lanka FY85 (govt keen) according to Hopper; Pakistan health project might be explored.

7. Stern Endorsed re summaries

Stern suggested State initiatives to put pressure on DEA.

WORLD BANK / INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

For Jan 27th meeting

TO: Mr. A. H. Shibusawa, Division Chief, ASADC DATE: January 21, 1982

FROM: Harold W. Messenger, Chief, PHND1

SUBJECT: Lending Strategy Papers: Burma/Nepal/Sri Lanka

1. Thank you for giving us the opportunity to comment on the draft lending strategy papers. We have focussed our attention on the treatment of population, health and nutrition. The draft strategy papers indicate that there are special considerations affecting the PHN sectors in these countries (financial constraints, other active donors, lack of data, etc.). Considering the importance of population, health and nutrition for the development programs of these countries and the special considerations, we are concerned that the PHN sectors are either not mentioned at all or receive low priority in terms of proposed Bank assistance. We believe it probable that there is a significant role for the Bank within the constraints which exist.

BURMA:

2. The December 1981 lending strategy paper for Burma draws attention to the Guidelines for the Fourth Four-Year Plan (1982/83-1985/86) which calls for higher investment in the social sectors, especially health. Of the 16 new projects proposed by Government, two are for health. The 1981 economic mission back-to-office report endorsed the Government's priority toward health. However, this is not reflected in the recent lending strategy: "...It is proposed to maintain our presence in the agricultural sector and to undertake projects in the transport/infrastructure, and industrial sectors." Although the lending strategy is stated to reflect the Government's priorities, it is not explained why the Bank does not consider operations in the case of health. PHN would propose that the lending strategy be amended to include for FY83 exploratory sector work as a preliminary step to identifying lending possibilities. This would also enable us to play a meaningful role within the Aid Group to guide the investments of other donors as well as possibly the Bank's.

NEPAL:

3. Presently, the Lending Strategy for Nepal shows no PHN projects nor does it include a reference to the conclusions of the discussion of population at the Aid Group Meeting or of the planned sector work. We recommend that paragraphs 1 and 9 refer to population growth as one of the highest priority problems and that a small population project be included in the revised five-year lending program to achieve a credible involvement in Nepal. To give population the emphasis it warrants in the strategy for Nepal we suggest the addition of the following.

> Population growth, health and nutrition are all major problems in Nepal. Life expectancy at birth is only 44 years, the lowest in South Asia. The crude birth rate of about 42 is at present partially offset by the high crude death rate, which together yield a

population growth of 2.2%. As health services improve in Nepal, the death rate will decline and the population rate will increase unless the crude birth rate also declines. Nepal has received during the past decade a considerable amount of financial assistance for its population program. Nonetheless, population activities in Nepal are neither well organized nor effective. The highest priority should be given to assistance to make more effective the population program in Nepal. The need to relieve intense population pressure on available arable land and on the economic and social infra-structure, should place population control high on the list of Government and Bank's development priorities in Nepal. At the December 1981 Aid Group Meeting, agreement was reached that the Bank would assist Nepal in developing a cohesive population strategy. A Bank sector mission is planned for April 1982 which will coordinate closely with other major donors and the Government officials concerned. Priority consideration must also be given to how to improve health and quality of health services. Declines in infant and child mortality rates are usually preconditions for reduction in the crude birth rate. The most likely outcome of the Nepal sector mission would be a proposal for a small project which would direct resources at the key constraints in the population program. The sector report could also provide a guide for other donor investments in the population field.

SRI LANKA:

5. The draft lending strategy paper proposes no population, health or nutrition projects in the five-year lending program and no reference is made to the FY82/FY83 sector mission which has been agreed by both the Government and the Region.

6. We would suggest the inclusion of the following paragraph in the strategy paper:

With a life expectancy at birth of 66 years, a population growth rate of 1.7% and an infant mortality rate of 49, Sri Lanka has achieved considerable progress with respect to social goals. While this is true in absolute terms and is even more striking when compared with other countries in South Asia, there appears to be some erosion recently of the earlier achievements, because of budgetary constraints and the consequent cutback on expenditures for the human resource sectors. To rectify an earlier imbalance in the use of scarce resources which had been biased against the productive sectors and in favor of the

human resource sectors, the Bank has encouraged Sri Lanka to focus on investments in the productive sectors, especially food production and exports. Large increases in expenditures for the human resource sectors would, of course, be inappropriate at this time, but the major issue is whether the limited funds available for population, health and nutrition are being utilized as effectively as possible. The Government, in some cases assisted by external donors, is planning substantial new investments in population, health and nutrition programs. For example, construction is to begin shortly on a 999-bed hospital donated by the Government of Japan. Although the capital costs will be fully met from abroad, the operating costs to run the hospital will have a marked impact on the health budget. (Full operation of the hospital could consume as much as one-third of the funds presently allocated in the current budget of the Ministry of Health.) A PHN sector mission will focus on health care financing and management in primary health care and suggest options for a more effective use of scarce resources. It is quite probable that a small but high priority Bank project could emerge from this sector review to finance improvements in health planning, strengthening of support systems (e.g., health information) and strengthening of out-reach services.

cc: Messrs. Wiehen, Geli, ASPDR; Evans, North, Hamilton, Clarkson, PHN

EMSchebeck:mw:jm

See Distribution Below

January 25, 1982

John R. Evans, Director, PHN JRE.

PHN Lending Program

Mr. Stern has placed this memorandum on the agenda of the Operational Vice President's meeting for Wednesday, January 27, 1982.

cc: Mr. Stern
Mr. Baum
Operational Vice Presidents

JREvans/rmf

WORLD BANK / INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

TO: Mr. Warren C. Baum, CPSVP DATE: January 25, 1982

FROM: John R. Evans, PHNDR JRE

SUBJECT: PHN Lending Program

1. At the meeting of operational vice presidents on January 6, I was asked to prepare for their consideration a paper on the PHN lending program, how it relates to expectations when this department was created and to present needs, and internal and external constraints to its development.

2. Annex 1 shows PHNs FY82-86 lending program as of October 31, 1981, and the modifications which were suggested by PHN to the Regions. Considered purely numerically, a lending program of 37 projects over the five years compares favorably with the two population projects annually which has been the historical average for that type of project taken together with the health lending which was envisaged in 1979 of one project in FY81 rising gradually to four in FY84.

3. In fact, the present approved lending program is fairly ambitious, given that health is a sector in which Bank experience is limited, in which the primary emphasis is on policy change, and in which software takes precedence to hardware. A comparison in terms of numbers alone however would be misleading and would not reveal how well the program responds to the priority needs of the member countries or to the policy directions preferred by the Bank. We see two sets of concerns in assessing the program; the first deals with its quality - does the program represent the optimum in terms of impact on world population and health problems in relation to the Bank resources mobilized for the purpose? - and, second, what obstacles exist to developing and achieving such a program?

4. Annex 2 shows by country and region the most important indicators in the PHN sectors. In the Annex are identified those 17 countries (excluding China) which the External Advisory Panel on Population, the Berelson Panel, listed in 1976 as key countries for special Bank attention on population. Population size was not used by the External Advisory Panel as the sole criterion by which to select priority countries --- but the underlying rationale was that the Bank should have as broad an impact on world population growth as possible. This is perhaps looking at priorities too simply, and even if one accepts population size as the key criterion, a nationwide project in a small country may have more impact than one of limited geographical scope in a larger country. Priority for health investment is set also by the nature and extent of the health problems, the coverage and effectiveness of the existing health network and the Government's health policies. In setting priority by country, one finds that high fertility rates and low health status usually go hand in hand. Delivery of family planning services is usually most efficiently handled in the public sector through the health network. Improved health

for mothers and children is expected to lower infant mortality which statistically has a long run correlation with lower fertility. To an important extent, therefore, the priorities for population and health overlap.

5. While it is possible to diagnose the nature and extent of nutrition problems, it is more difficult to sort out the intertwined causes - which may lie in another sector, perhaps agriculture - and even more difficult to devise affordable, feasible remedies. As agreed at the discussion of the 1980 paper, "Towards an Operational Work Program for Nutrition", we are first carrying out sector work in a few selected countries, before recommending any substantial lending work in nutrition. Only one free-standing nutrition project remains in the Lending Program at present. Health projects will include treatment of the manifestations of malnutrition as a part of health services.

6. In reviewing programs regionally, some patterns emerge. These may be summarized as follows:

a. South Asia: It is clear that South Asia with over 900 million people and deplorable health and nutrition status should be accorded our highest priority. Four of the 17 key countries identified by the Berelson Panel are in this region. The region's population is forecast to increase by 50% by the year 2000 and, except for Sri Lanka, life expectancy is low and the infant mortality rate is still high, and nutritional status has not improved significantly in spite of major gains in food production. There are substantial professional resources and established institutions, but they have had only marginal impact on the conditions of the rural population. The programs in population and health in Bangladesh and Pakistan should be geared to the limits of the absorptive capabilities of those countries. The biggest opportunity is in India; its integrated health and population program has reached the stage where substantial resources could be absorbed in further expansion, and a faster rhythm of lending - perhaps every year - ought to be achievable. For Nepal, the seriousness of the population problem is acknowledged, and sector work is planned; however, no lending is yet programmed for FY82-86. To provide the response that the situation in South Asia clearly warrants, the active support of the Programs Department is needed, both to impress on governments the implication of rapid population growth and to give appropriate priority to population/health in lending strategies.

b. Africa South of the Sahara: In these two regions there has been only one country, Kenya, with a population policy and program which the Bank has been able to support, but we are now actively preparing for health lending in several countries. Although only three African countries, Nigeria, Zaire, and Ethiopia, appear on the key country list, several more rate priority attention because of the high rates of population growth, poor vital statistics,

totally inadequate health systems and limited resources in relation to population. There is a clear need to help governments improve health delivery systems, not just to tackle the urgent health problems of these countries, but also to support population countrol programs as they are developed. As yet there is no acceptance in Africa of the small family norm. There is a need for the Bank actively to seek government support at the highest level on population matters; recent developments in some countries (e.g. the approval of national population councils in Senegal and Rwanda) suggest that the climate for such dialogue may become easier in many African countries over the next year or two.

The resource constraints of sub-Saharan Africa are particularly severe, and it is in these countries that we shall need to look closely and imaginatively at the problems of financing the recurrent costs of the health sector.

c. East Asia: Because the countries have relatively well-developed population programs and health systems, they could absorb substantial resources in improvement and expansion. In Indonesia, particularly, a larger pipeline of lending in population and in health would be well justified and feasible. For Thailand there are attractive prospects for additional lending if the Government's reluctance to borrow on Bank terms for social sectors could be overcome. Papua and New Guinea might be accorded some priority in this Region in the light of its extremely poor health indicators.

d. Europe, Middle East and North Africa: There are three key countries for population lending in this region, in one of which (Iran) the Bank is not active at all. In Egypt, the lending for population and nutrition has been deleted from the program because of the Government's reluctance to borrow for the social sectors on Bank terms. In Turkey, Bank strategy has not provided for health and population involvement despite its size and poor social indicators. In both Egypt and Turkey, population should be a main topic in dialogue with the governments. At the next level of concern, Algeria, Syria and Jordan might also be considered because of the high population growth rates.

Need Financing to achieve objectives in Egypt.

e. Latin America and the Caribbean: Population lending had earlier been confined to some of the Caribbean countries. A population project was appraised in Mexico, but no loan was made; elsewhere the sensitivity of population issues prevented earlier PHN involvement except through health components in other projects, and in two, largely experimental, nutrition projects. A pipeline of health projects is now building in Brazil and possibly in Colombia and Peru. High population growth rates in a number of LAC countries - Ecuador, Honduras, Nicaragua, for example - may justify joint PHN/Regional efforts to identify future possibilities for population and/or health involvement in the Region.

7. Thus, whilst the present approved lending program is a substantial one, the country composition still leaves a lot to be desired. A number of (large) countries have been omitted where population growth, poor health and malnutrition are most serious. The first problem facing PHN is therefore one of conscious refocussing of the program to improve its quality and impact. This will entail PHN and Regional offices agreeing on the countries on which to focus (we believe that the India sub-continent, Indonesia and sub-Saharan Africa stand out in this regard), developing a PHN strategy for each of those countries and adhering to such strategy during the constant process of lending program adjustment. Annex 3 shows the PHN lending program broken down regionally.

8. Agreement on PHN country strategy alone should help to counter the volatility of lending programs, but there are other problems affecting the stability of lending programs in the social sectors; these are:

a. Human Resource Development in Competition with Productive Sector Investment: The natural bias in allocating national resources to productive sectors may in times of economic crisis lead to sharp reductions in the support of human resources development and population control which do not produce results in the short term. High priority but long term goals are abandoned and the burden falls most heavily on the poorer segments of the population. An important component of the Bank's strategy for coping with economic crisis should be to influence social sector investments made by the country and by other development agencies to hold down recurrent costs while improving the impact on population, health and nutrition. This would be a major focus of health lending for example in Sri Lanka and Sudan.

b. Political Sensitivity of Population Lending: Population control is still a sensitive subject in many countries and tends to be avoided by governments and Bank staff. In Africa, the large family is still the norm. Population/health projects can improve the supply of family planning services but this must be matched by increased demand which is a function of national policy commitment and support in a variety of sectors such as education, rural development, and employment for women. Excessive population growth undermines development as a whole, but whilst its treatment as a development variable in economic reporting has been excellent in many cases, it has been relatively neglected in some important cases. As was recommended by the Berelson Panel, the Bank should not rely entirely on this Department's lending to promote fertility reduction, but should be prepared to use the weight of its total operations. It should use its dialogue at the macro level to initiate population policy discussions, to create project opportunities and to reinforce project implementation as has been done recently in Bangladesh, Nepal and Kenya.

c. Project size/resource transfer: The conflict between development and resource transfer objectives is highlighted by human resource

Health – in India – schools for hyg
in Pakistan – should do it as well
– in Sub-Saharan Africa – health needed
for women for W. Africa
E. Africa
S. Africa

Mr. Warren C. Baum | January 25, 1982

development projects. National planners resist population/health projects because they are slower to develop, more difficult to implement and less predictable in disbursement. Initial projects which emphasize software and institutional development are labour intensive in preparation (and supervision) and involve relatively small capital investments and amounts of foreign exchange. This pattern conflicts with Bank preference for large projects and country preference for rapid disbursement.

d. Resistance to "borrowing" for Social Sectors: Countries like Egypt and Thailand which welcomed IDA credits for population projects resist borrowing on Bank terms for social sectors.

9. For these reasons, PHN may be at greater risk in lending program revisions because the project impact appears in the longer term, a track record for delivering projects on schedule is not yet clearly established, substitution in the case of slippage is less readily achieved (as noted in Mr. Richardson's recent memorandum), and as a COPD it is not part of the regional "family" when decisions are made on program content. This underlines the critical need for commitment and support in the Regions, particularly from those Regional staff responsible for country programming and strategy development.

10. Recommendations: 2 goals: 1. Population: econ + soc ... 2. Human Resource Development - Health (+Nutr.) - goal in its own right - supports pop

(i) that Regions give special attention to PHN topics in selected key countries, in particular the Indian sub-continent and Indonesia. An operational strategy should be developed for PHN involvement in each such country;

(ii) the two African Regions and PHN promote health development as fast as possible in sub-Saharan Africa as a goal in its own right and use this as a framework within which to initiate dialogue on population issues; and

(iii) the Bank reaffirm its commitment to population using its dialogue at country level to initiate policy discussions, create projects in health and other relevant sectors and reinforce project implementation.

11. Bank statements over the past decade have underlined repeatedly the importance to development of reducing population growth rates in many countries. The results of efforts to date fall far short of expectations. Intensified competition for limited national resources and Bank/IDA funds in the 1980s will put even greater pressure on population lending. The key question is whether population is a sufficiently high priority for the Bank in the 1980s to warrant the special efforts across the Bank necessary to achieve a greater impact? If so, how can the thrust and consistency of program dialogue on population with key countries be strengthened? What signals from management might reinforce this? Should population receive greater attention in conditioning general lending and structural adjustment lending with key countries as has been done in Bangladesh and Kenya? Is a special incentive needed, for example, reserving some Bank/IDA funds to be used only for population?

Attachments
JDNorth/JREvans/rb

ANNEX 1

PHN
FY82-86 LENDING PROGRAM

PAB TABLE as of OCTOBER 31, 1981

	PAB PROGRAM 10/31/81	LOAN/CREDIT AMOUNT IDA	LOAN/CREDIT AMOUNT IBRD
FY82	✓ KENYA II (P)	40.0	
	✓ BRAZIL I (H)		13.0
	2	40.0	13.0
FY83	✓ MALAWI I (H)	21.7 → 20	
	S – MALI I (H) → 84	19.5 → 20	
	✓ SENEGAL I (H)*	15.0	
	✓ YAR I (H)*	12.0	
	✓ YDR I (H/N)	4.0	
	✓ PAKISTAN I (P) COMOROS 3m.	30.0 → 15	
	6	102.2	
	5H 1P		
FY84	✓ LESOTHO I (H/N)*	12.0 → 10	
	✓ RWANDA I (H/P)	15.0	
	✓ UPPER VOLTA I (H)	25.0	
	✓ BRAZIL II (H)*		50.0
	X MALAYSIA I (P) 1/ – OUT		45.0
	? – BANGLADESH III (P)	30.0	
	? – INDIA III (P/H)*	30.0 ? 40	
	S – NIGER I (H) → "out of 82-84" → 85	10.0	
	✓ PERU I (H)*		20.0
	✓ INDONESIA I (H)* + MAURITIUS		70.0
	10	122.0	185.0
	6H 2P/H 2P		
	[Revised 6H + 1HP]		
FY85	KENYA III (P)	50.0	
	✓ NIGERIA I (H) 2/		50.0
	✓ THAILAND II (H)*		75.0
	YAR II (H)*	15.0	
	✓ COLOMBIA II (N)		25.0
	✓ CHINA I (H)	40.0	60.0
	✓ SIERRA LEONE I (H)*	10.0	
	✓ CAMEROON I (H)		10.0
	✓ IVORY COAST I (H)		10.0
	✓ PAPUA N.G. I (H)		25.0
	MOROCCO I (H) 1/		20.0
	11	115.0	275.0
	9H 1P 1N		
FY86	MALAWI II (H)	30.0	
	INDONESIA II (H)		60.0
	YDR II (H)	4.0	
	TUNISIA III (P/H)		15.0
	✓ COLOMBIA I (H)		35.0
	✓ BRAZIL III (H)		100.0
	✓ NIGERIA II (H)		75.0
	✓ INDIA IV (P/H)*	75.0	
	8	109.0	285.0
	6H 2 P/H		

Uttar Pradesh – Nepal – ?

85 Sri Lanka (R)

86 Bangladesh (R)

1/ PHN recommended to change this project from Health to Population project.
2/ PHN recommended to advance these projects to FY84.
* Standby Project

January 20, 1982

POPULATION, HEALTH AND NUTRITION DEPARTMENT

SECTOR WORK, LENDING PROGRAM AND PHN-RELATED INDICATORS
(DIVISION I - SOUTH ASIA and EASTERN AFRICA)

Country	SECTOR WORK AND LENDING PROGRAM: Sector Work Completed/Started FY80-81	Sector Work Planned FY82-83	Approved Projects FY70-81	PAB Lending Program (as of 10/31/81) FY82-86	POPULATION, HEALTH AND NUTRITION-RELATED INDICATORS: Projected Population (millions) 1980	Projected Population (millions) 2000	Average Annual Population Growth(%) 1970-1979	CBR (per 1000) 1979	Life Expectancy at Birth (years) 1979	Infant Mortality Rate (aged 0-1) 1978	Child Death Rate (1-4) 1979	Population/ Physician 1977	Daily per Capita Calorie Supply as % of Reqmt. 1977
SOUTH ASIA													
India**		FY83	FY72(P);FY80(P) FY80(N)	FY84(P/H)[a]/;FY86(P/H)[a]/	673	975	2.1	34	52	125	15	3,620	91
Bangladesh**		FY83	FY75(P);FY79(P)	FY84(P)	92	148	3.0	44	49	130	19	8,780	91
Pakistan**	FY81	FY83		FY83(P)	82	141	3.1	44	52	142*	15	3,760	99
Burma**					34	50	2.2	37	54	140*	13	5,120	106
Sri Lanka**		FY82			15	21	1.7	28	66	49	3	6,750	96
Nepal**	FY81	FY82			14	21	2.2	42	44	133*	25	35,250	91
Maldives							Less than 1 Million		47*	121*	21*	15,884*	n.a.
EAST AFRICA													
Ethiopia**	FY83				31	53	2.1	50	40	162*	36	75,320	75
Zaire**					28	49	2.7	46	47	160*	25	15,530	104
Tanzania**					19	35	3.4	46	52	185*	18	17,550	89
Sudan**	FY81	FY83			18	31	2.6	46	47	141*	29	8,690	93
Kenya			FY74(P)	FY82(P);FY85(P)	16	34	3.4	51	55	91	15	11,630	88
Uganda**		FY83			13	24	3.0	45	54	120*	16	27,600	91
Madagascar**					9	15	2.5	46	47	102*	25	10,240	115
Zimbabwe		FY82		FY84R(H/P)	7	15	3.3	47	55	129*	15	7,030	87
Malawi**	FY81			FY83(H);FY86(H)	6	11	2.8	51	47	142*	25	40,680	90
Zambia		FY83			6	11	3.0	49	49	144*	22	10,190	87
Burundi**	FY81	FY83		FY85R(P/H)	4	7	2.0	45	42	140*	33	45,020	97
Rwanda**	FY81			FY84(H/P)	5	9	2.8	50	47	127*	25	38,920	96
Somalia**		FY83			4	6	2.3	46	44	177*	30	—	88
Lesotho**		FY82		FY84(H/N)[a]/	1	2	2.3	40	51	111*	20	18,640	99
Botswana	FY81	FY82					Less than 1 Million		48*	97*	23*	9,597*	n.a.
Comoros		FY83					Less than 1 Million		46*	148*	27*	—	n.a.
Djibouti		FY83					Less than 1 Million		45*	30*	10*	9,300	n.a.
Mauritius							Less than 1 Million		67*	40*	4*	2,410*	n.a.
Seychelles							Less than 1 Million		66*	32*	13*	2,760*	n.a.
Swaziland							Less than 1 Million		46*	156*	27*	7,400*	n.a.

Source: World Development Report 1981

a/ Standby Project
* Data from Sources other than the 1981 World Development Report
** Low-Income Countries
—— "17 Key Countries" Identified by the Berelson Panel on Population

January 20, 1982

POPULATION, HEALTH AND NUTRITION DEPARTMENT

SECTOR WORK, L G PROGRAM AND PHN-RELATED INDICATORS
(DIVISION II - EAP and WESTERN AFRICA)

Country	SECTOR WORK AND LENDING PROGRAM: Sector Work Completed/Staffed FY80-81	Sector Work Planned FY82-83	Approved Projects FY70-81	IBRD Lending Program (as of 10/31/81) FY82-86	POPULATION, HEALTH, AND NUTRITION-RELATED INDICATORS: Projected Population (millions) 1980	Projected Population (millions) 2000	Average Annual Population Growth(%) 1970-1979	CBR (per 1000) 1979	Life Expectancy at Birth (years) 1979	Infant Mortality Rate (aged 0-1) 1978	Child Death Rate (1-4) 1979	Population/ Physician 1977	Daily per Capita Calorie Supply as % of Requmt. 1977
EAP													
China**		FY82		FY85(H)	977	1,239	1.9	18	64	56	n.a.	1,160	104
Indonesia**			FY72(P),FY77(P) FY80(P),FY77(N)	FY84(H)[a/],FY86(H)	146	220	2.3	36	53	120	14	13,640	105
Vietnam**					54	88	2.9	36	63	62	5	5,620	83
Philippines		FY82	FY75(P),FY79(P)		48	75	2.6	34	62	65	6	2,760	108
Thailand	FY81		FY78(P)	FY85(H)[a/]	46	68	2.4	31	62	68	6	8,150	105
South Korea			FY80(P)		38	53	1.9	32	63	38	5	1,990	121
Malaysia			FY73(P),FY79(P)	FY84(P)	13	20	2.2	28	68	32	2	8,730	117
Dem. Kampchea**					n.a.[b/]	n.a.	1.8	33	44	150	n.a.	n.a.	85
Laos**					3	5	1.4	42	42	175	27	20,060	94
Papua N.G.				FY85(H)	3	4	2.3	37	51	159	16	14,040	85
WESTERN AFRICA													
Nigeria	FY81			FY85(H),FY86(H)	85	161	2.5	50	49	157	22	15,740	91
Ghana	FY81				12	21	3.0	48	49	141	22	9,920	86
Ivory Coast		FY83		FY85(H)	9	15	5.5 [c/]	47	47	154	25	15,220	105
Cameroon		FY82		FY85(H)	8	14	2.2	42	47	157	25	16,500	89
Mali**				FY83(H)	7	12	2.6	49	43	190	31	25,150	90
Upper Volta**		FY82		FY84(H)	6	10	1.6	48	43	183	31	49,810	79
Senegal				FY83(H)	6	10	2.6	48	43	160	31	15,710	95
Guinea**					5	9	2.9	46	44	141	28	16,630	84
Niger**		FY82		FY84(H)	5	10	2.8	52	43	200	31	42,720	91
Chad**					4	7	2.0	44	41	192	35	41,940	74
Benin**					4	6	2.9	49	47	206	25	26,880	98
Sierra Leone**				FY85(H)[a/]	3	6	2.5	46	47	136	25	n.a.	93
Togo**					2	4	2.4	48	47	163	25	17,980	90
Liberia	FY81				2	4	3.3	48	54	148	16	9,260	104
Central African Republic**					2	3	2.2	44	44	190	30	17,610	99
Mauritania**					2	3	2.7	50	43	186	29	15,160	86
Congo					2	3	2.5	45	47	180	27	7,290	103

Source: World Development Report 1981

[a/] Standby Project
[b/] Mid-1979 - 6 Million
[c/] The unusually large growth rate reflects large number of immigration.
* Data from Sources other than the 1981 World Development Report
** Low-Income Countries
—— "17 Key Countries" identified by the Berelson Panel on Population

January 20, 1982

SECTOR W LENDING PROGRAM AND PHN-RELATED INDICATORS
(DIVISION III - LAC and EMENA)

Country	SECTOR WORK AND LENDING PROGRAM: Sector Work Completed/Started FY80-81	Sector Work Planned FY82-83	Approved Projects FY70-81	PAB Lending Program (as of 10/31/81) FY82-86	POPULATION, HEALTH, AND NUTRITION-RELATED INDICATORS: Projected Population (millions) 1980	2000	Average Annual Population Growth(%) 1970-1979	CBR (per 1000) 1979	Life Expectancy at Birth (years) 1979	Infant Mortality Rate (aged 0-1) 1978	Child Death Rate (1-4) 1979	Population/ Physician 1977	Daily per Capita Calorie Supply as % of Requirements 1977
LAC													
Brazil	FY81	FY82	76(N)	FY82(H)[a]/FY84(H)/FY86(H)	119	177	2.2	36*	63	109*	8	1,700	107
Mexico					67	109	2.9	36	66	60*	5	1,820	114
Argentina					28	34	1.6	21	70	45*	3	530	126
Colombia		FY82	FY78(N)	FY85(N)/FY86(H)	27	40	2.3	30	63	77*	8	1,970	102
Peru	FY81	FY82		FY84(H)[a]/	18	28	2.7	38	58	86	14	1,550	97
Venezuela					15	24	3.3	35	67	45*	5	930	99
Chile					11	15	1.7	23	67	40*	6	1,620	109
Ecuador					8	14	3.3	40	61	70*	10	1,620	92
Guatemala					7	12	2.9	40	59	76*	13	2,490	98
Bolivia					6	9	2.5	43	50	168*	23	1,850	83
Dominican Republic			FY77(P)		5	9	2.9	36	61	37	10	n.a.	93
Haiti**		FY82			5	8	1.7	41	53	130*	21	5,940	93
El Salvador					5	8	2.9	39	63	60	8	3,600	90
Honduras					4	7	3.3	46	58	103*	14	3,290	89
Paraguay		FY82			3	5	2.9	38	64	64*	7	2,150	122
Uruguay					3	4	0.3	20	71	46*	3	540	114
Nicaragua					3	5	3.3	45	56	122*	16	1,670	109
Jamaica			FY70(P)/76(P)		2	3	1.6	29	71	16	3	3,520	119
Costa Rica					2	3	2.5	29	70	28	3	1,390	114
Panama					2	3	2.3	31	70	47	3	1,220	101
Trinidad & Tobago			FY71(P)		1	2	1.3	22	70	29	3	1,970	111
Guyana							Less than 1 Million	29	68	50*	4	7,660	n.a.
Suriname							Less than 1 Million	29	68	30*	4	1,927	n.a.
Barbados							Less than 1 Million	23	71	28	3	1,447	n.a.
Belize							Less than 1 Million	41	58*	45	n.a.	3,144	n.a.
St. Lucia							Less than 1 Million	33	67*	37	n.a.	2,950	n.a.
Grenada							Less than 1 Million	25	69	24	4	4,686	n.a.
Dominica							Less than 1 Million	21	58	20	n.a.	5,079	n.a.
EMENA													
Turkey					45	69	2.5	34	62	119*	9	1,770	115
Egypt			FY74(P)/79(P)		40	60	2.0	37	57	85	15	1,050	109
Iran			FY73(P)		38	64	2.9	43	54	n.a.	12	n.a.	130
Yugoslavia					22	26	0.9	18	70	34	2	760	136
Morocco	FY81	FY82			20	36	2.9	44	56	133*	16	11,040	105
Algeria					19	34	3.3	46	56	142*	16	5,330	99
Afghanistan**					16	25	2.6	47	41	226*	29	20,550	110
Iraq					13	23	3.3	45	56	104*	16	2,190	89
Portugal					10	11	1.4	18	71	39*	1	700	126
Syria					9	16	3.6	45	65	114*	7	2,570	108
Tunisia	FY81		71(P)/81(H)	FY86(H)	6	9	2.1	31	58	125*	13	4,800	112
YAR	FY81	FY82		FY83(H)[a]/FY85(H)[a]/	6	9	1.8	47	42	160*	41	12,460	91
Israel					4	5	2.7	26	72	15*	2	310	122
Jordan		FY82			3	6	3.4	45	61	97	10	1,960	62
Lebanon					3	4	0.8	30	66	65*	6	n.a.	101
PDRY		FY82		FY83(H/N)/FY86(H)	2	3	2.3	46	45	155*	34	7,760	81

Source: World Development Report 1981

[a]/ Includes only countries with 1 Million or more population.
* Data from sources other than the 1981 World Development Report.
** Low-Income Countries
—— "17 Key Countries" identified by the Berelson Panel on Population.

January 20, 1982

OVERVIEW: REGIONAL LENDING PROGRAM PHN F. _-86

	SA	EAP (Excl. China)	LAC	EMENA	EA	WA	TOTAL
FY82			BRAZIL I 13		KENYA 40		53
FY83	PAKISTAN I 30			YAR I 12 PDRY I 4	MALAWI 20	MALI 20 SENEGAL 15	101
FY84	INDIA III 30 BANGLADESH III 30	INDONESIA H I 70 MALAYSIA 45	BRAZIL II 50 PERU I 20		LESOTHO 12 RWANDA 15	U. VOLTA 25 NIGER 10	307
FY85		THAILAND 75 PNG 25	COLOMBIA H 25	YAR II 15 MOROCCO 20	KENYA 50	NIGERIA I 50 S. LEONE 10 CAMEROON 10 IVORY COAST 10	290
FY86	INDIA IV 75	INDONESIA H II 60	BRAZIL III 100 COLOMBIA H 35	TUNISIA 15 PDRY II 4	MALAWI 30	NIGERIA II 75	394
Number of Projects	(4)	(5)	(6)	(6)	(6)	(9)	(36)
US$ Million	165	275	243	70	167	225	1,145
Regional Population (Million)	910	351	341	256	167	164	2,189
Population Increase to 2000 (and %) (Million)	446 (49%)	182 (52%)	178 (52%)	144 (56%)	135 (81%)	134 (82%)	1,219 (56%)
PHN Lending US$/cap/year	0.04	0.16	0.14	0.07	0.20	0.2	0.10
Lending Program (all sectors) FY82-86 US$ Million	18,049	21,398	16,857	14,302	6,927	6,553	84,086
PHN lending as percent of total lending program	1.02%	1.28%	1.44%	0.48%	2.41%	3.43%	1.39%

Note: Excludes China throughout.
Lending program data based on PAB issue of 10.31.81

PHN
January 25, 1982

Mr. Ping Loh, EAP (through Mr. John North, Assistant Director, PHN)

January 28, 1982

Harold W. Messenger, Chief, PHNDI

PHN Strategies for Eastern Africa in the Context of the Report, "Accelerated Development in Sub-Saharan Africa."

I attach for your information a paper concerning PHN's strategies for Eastern Africa. An earlier version of this paper, distributed under cover of our memorandum of December 1, was discussed in December with Messrs. Adler, Gösten and you. It has been modified to incorporate as far as feasible the comments received. We would be very much interested in learning the reaction to the paper from you and your colleagues in the East Africa Region.

Attachment

cc: Dr. John Evans, Director, PHN; Dr. K. Kanagaratnam, PHN; Mr. A. Berg, PHN; Ms. I. Husain, PHNDII; Mr. J. Warford, PHNFRU; Mr. E. M. Schebeck, PHNDI; Mr. H. Diaz, PHNDI

HMessenger/kll

PHN STRATEGIES FOR EASTERN AFRICA

Introduction

1. The present paper outlines strategic considerations deemed important by the PHN Department in the Eastern African context. It does not constitute, however, a complete, formal statement of the policies and strategies that PHN plans to adopt in the region. PHN strategies for Sub-Saharan Africa are still at an early stage of formation, since our experience in this region has been very limited.

2. General (i.e., non-regionalized) considerations regarding PHN's policies and strategies can be found in several documents issued by PHN over the past several years (e.g., the 1980 Health Sector Policy Paper, the 1980 Five-Year Nutrition Lending Program, the 1977 O.M.S. No. 3.74 on lending operations in the population sector, etc.). In addition, current work being conducted by PHN's Policy and Research Unit (on pharmaceuticals policies, health sector financing, and on general guidelines for PHN sector work) is expected to have a major impact in shaping PHN's policies and strategies in the near future.

3. While this paper discusses population, health and nutrition separately, it is important to bear in mind that there are important linkages among these three areas. Improvements in health tend to raise the rate of population growth, both by reducing mortality and by increasing couples' biological ability to bear children. Under certain conditions, however, reductions in infant and child mortality, by increasing the expected return to parents on investments in the quality of children, can reduce desired family size, thus assisting in lowering population growth. Conversely, reductions in fertility through reduced average family size allow for better care by households of the smaller number of children, thus resulting in lower rates of infant and child mortality.

4. Similarly, strong linkages exist between population and nutrition, and between health and nutrition. Rapid population growth has turned a number of countries once self-sufficient or net exporters of food, into net importers. To the extent that these countries may not always be able to develop efficient non-food export production to pay for all the imported food that would be needed to maintain adequate nutrition standards, the incidence of malnutrition rises. The synergistic linkages between health and nutrition are also well known. People who do not get enough nutrients are more vulnerable to the effects of disease; conversely, certain types of disease reduce the body's ability to absorb nutrients, thus aggravating malnutrition. Hence health and nutrition interventions are mutually reinforcing in their effects.

5. Because of the importance of rapid population growth as an impediment to overall socioeconomic development, and in view of the rapid acceleration in the rate of population growth which is occurring throughout Eastern Africa, population will have to be given the highest priority among the three areas of PHN's concern for the foreseeable future. However, in the initial stages family planning services in the region will have to be closely integrated with other health services because of cultural factors which encourage high human fertility. Thus it will not be possible to make high-quality family planning services widely available to the public without a certain degree of strengthening of basic health services generally. The second level of priority for PHN will be those health programs the strengthening of which is not required to ensure the availability of family planning services, but which address important causes of

disease and mortality, and for which existing medical technologies permit low-cost effective treatment of large segments of the population. Nutrition programs will have to take third priority due in large part to the difficulty of identifying cost-effective interventions.

Population

6. The combination of falling death rates and high non-declining birth rates is creating an explosive situation throughout Sub-Saharan Africa. PHN strongly supports expanded Bank involvement in strengthening programs addressed to reducing fertility in the region. The Bank's approach, however, must take into consideration the political climate towards population control programs in Eastern Africa, which is generally unreceptive and occasionally hostile. In pursuing a dialogue with Governments on this matter, it might be helpful to think in terms of a "phased" strategy, approximately as follows:

7. Phase One: Development of Infrastructure for the Provision of Family Planning (FP) Services. In this phase, efforts would be directed at building a capability within the public health services (and NGOs, if they wished to participate) for provision of advice on modern FP methods, and for provision of the services themselves. This would mainly be a matter of training and of establishing contraceptive logistics. FP service statistics should also be developed. FP activities would be closely integrated with maternal and child health (MCH) activities, both in the actual provision of services and at headquarters (planning and evaluation functions). Information, education and communications (IEC) activities would be limited to MOH channels, and would stress the health benefits from adequate spacing, thus "latching on" to traditional attitudes. Contraceptive methods to be offered would mainly be orals, IUDs and sterilization. Catholic NGOs, if they chose to participate, could teach the ovulation method. The programs would have to be largely pill-based, because IUDs require relatively sophisticated back-up medical services which the countries will not be able to afford on a national basis for many years to come. Sterilization, on the other hand, would presumably be acceptable to only a small proportion of women (male sterilization is widely believed to be culturally unacceptable). This phase could be completed in about five years.

8. Phase Two: Intensive IEC Effort. In this phase, while continuing to consolidate the service capability developed in Phase One, governments would shift emphasis to the development of broadbased, intensive IEC efforts aimed at reducing desired family size. This phase is likely to be politically more controversial than the first. It also poses a fundamental question of organization in passing from a population program that is essentially MOH-based to a broad-based program. In this phase, governments would strongly encourage participation of NGOs and of all government agencies whose activities are directly or indirectly affected by rapid population growth. Duration of Phase Two is difficult to estimate, as the technological basis for successful IEC programs is not nearly as well developed as for the establishment of service capability, which is a relatively simple matter (technologically speaking).

9. Phase Three: Use of Innovative Approaches. This phase would see the development of non-conventional approaches such as the use of incentives and disincentives, use of commercial channels for distribution of contraceptives, and community-based distribution of contraceptives. The introduction of such programs presupposes widespread political support for fertility reduction. Their premature introduction could cause a serious backlash.

10. It is possible, of course, that in some countries in the region the above phases could be collapsed into an accelerated timetable of program development. Much will depend on the speed of the build-up of political support for population programs. This build-up should be assisted by the Bank through the utilization of every suitable opportunity at the operational and policy levels to highlight the gravity of the problems and the options available. What is needed is the instillation of a sense of urgency in the governments of the region in facing up the mounting problem of high population growth. At the present rates of growth, the population of most Eastern Africa countries would double about every 20-30 years, and those rates are moving upwards rather than falling. There is no feasible developoment strategy that could bring about increases in real incomes at an equivalent rate in this area of the world. Moreover, given the dynamics of population growth, the total population of a country which has been experiencing rapid population growth would continue to increase for about 70 years or more even after fertility rates have fallen to replacement levels. The time to start building up strong family planning programs in Eastern Africa is now.

11. It is understandable that, under the present conditions of tight financial constraints under which most governments in the region are operating, there will be a reluctance to launch new non-revenue producing programs such as family planning. However, if family planning services are integrated with existing health services, their marginal cost need not be high. Moreover, if the existence of a strong commitment on the part of Eastern African governments became clear, it is likely that substantial external aid in the form of grants and concessionary loans would be forthcoming. Thus it is doubtful that provision of family planning services in the region would have to be delayed because of financial constraints.

12. Other Factors Affecting Fertility. Outside the area of PHN assistance there are other factors at work in Eastern Africa which will tend to reduce desired family size and thus raise the demand for FP services. Urbanization is one such factor; education, and especially education of women, is another. As women become better educated and given opportunities to work in non-traditional jobs outside the household, their aspirations and preferences shift to activities other than the traditional maternal and domestic roles. Education also affects attitudes towards birth control by making the information about contraception more accessible, and may increase the efficiency with which contraceptive methods are used. In assisting governments in the region to design suitable educational investment plans, Bank education projects staff should stress the importance of the goal of providing fair educational opportunities for women. In the African context this should, initially at least, be more through non-formal education programs than through the formal school system. (The Program for Better Family Living of the FAO, a home economics/family planning program, has been successful in Africa on a small scale.) The economic benefits from the reduction in fertility induced by education of women, although difficult to quantify, are likely to be substantial and would strengthen the justification of the education projects concerned.

13. Prioritization of Countries for Bank Population Assistance. Except for several island states (Mauritius, Seychelles, Reunion), which have crude birth rates (CBRs) in the 20s, all Eastern African countries have CBRs above 40 per thousand, and several of them (Kenya, Ethiopia, Rwanda, Botswana, Malawi) have reached or surpassed 50 per thousand. Moreover, CBRs in the region seem to

be on the increase. In principle, Bank assistance to the development of population programs should be provided to any country in the region requesting such assistance. (Thus far, the only country in the region to have requested and received this kind of assistance is Kenya.) From the point of view of the demographic prospects of the region as a whole, of course, it would be very important that those countries with largest concentrations of population be reached by Bank population assistance. Out of 20 countries in the region where the Bank is active, six (Ethiopia, Sudan, Uganda, Kenya, Zaire and Tanzania) account for almost 75% of the region's population.

14. Rapid population growth generally has the effect of slowing down the growth of the capital stock per worker and hence it hampers economic growth, even if present population density is low. However, it can be expected that countries with the highest population densities will be more receptive to Bank offers of assistance in the development of population programs. Four countries in the region already have very high population densities: Burundi (143 persons per km^2), Comoros (150), Mauritius (450), and Rwanda (188). Except for Mauritius, they all have high birth rates of between 40 and 50 per thousand. Thus it would seem that it should be relatively easy for Bank staff to make a convincing case with government officials about the desirability of requesting Bank population assistance.[1/] These are small countries and together account for only 6% of the region's population. However, it is possible that a sort of demonstration effect exists in the population field, so that the more Eastern African countries request and receive Bank population assistance, the higher the likelihood that other countries in the region will follow suit.

Health

15. In discussing the elements of a health lending strategy for Eastern Africa, it is useful to focus on three basic elements:
(i) "Targeting", i.e. the selection of health problems and population groups to be emphasized in PHN financed projects; (ii) Cost-Effectiveness, i.e. the determination and implementation of least-cost technologies to achieve the desired reduction in the incidence of the health problems targeted; and (iii) Resource Mobilization, i.e. the mobilization of additional resources to implement the least-cost technologies.

16. Targeting. Targeting necessitates distinction among population groups. The most significant of such distinctions is between (i) children under five and pregnant women, and (ii) the rest of the population. (Other distinctions will also be relevant in particular countries, e.g. by region, but those are below the level of generality of the present discussion.) The significance of this distinction lies in the fact that for the bulk of the health problems of the first group, effective control technologies are already available and would seem to be affordable by even the poorest countries. Assistance in the tackling of these MCH problems should be a top priority for PHN. For the second group,

---

1/ Two other countries, Uganda and Malawi, have "medium" population densities of about 50 persons per km^2, and population growth rates of over 3%. If population growth does not decline, these countries would have population densities of about 200 persons per km^2 in 40 to 45 years' time. It may also be possible in due course to make a case with their governments regarding the desirability of initiating fertility reduction activities, perhaps with Bank assistance.

it would seem useful to distinguish between three types of health problems: (a) "tropical" diseases; (b) metabolic, vascular, degenerative and malignant diseases, and (c) traumatic injuries. For (a), existing technologies are effective but expensive. Widespread control may thus be out of reach for most Eastern African countries in the foreseeable future, in the absence of technological breakthroughs yielding new, low cost technologies. This highlights the importance of research on tropical disease control, an area where the Bank is already providing assistance through its contribution to the TDR program. Existing technologies for (b) are also expensive, and many are not very effective. Treatment of traumatic injuries is also expensive, usually involving surgery, and its effectiveness depends on the existence of adequate transport facilities for rapid movement of patients. Thus, as far as the second population group is concerned, PHN should encourage great selectivity of interventions on the part of Eastern African health services--and in some cases symptomatic treatment of illness.

17. Cost Effectiveness. In assisting in the design of projects to strengthen the provision of health services along the lines indicated in the previous paragraph, a foremost consideration for PHN would be that the services be provided at the lowest cost possible, subject to constraints of technical and cultural feasibility.

18. A realization of the paucity of resources relative to the immensity of health needs in poor countries has led to emphasis on primary health care systems--that is, community-based approaches stressing prevention, self-funding, and the use of community health workers. This approach is supported by PHN in the Eastern African context. An important consideration is that primary health care programs in rural areas will have to be developed pari passu with the expansion of the formal public health services (i.e. expansion of the network of rural health facilities and their outreach activities), which would be the vehicle for providing essential support services to community-based health workers (supervision, in-service training, provision of drugs and supplies). However, the pace of any planned expansion has to take into account resource constraints and administrative capacity. Almost certainly, a necessary condition for success of these programs will be the strengthening of planning capabilities at the district level. The resource constraint to expansion of primary health care is determined in part by the general growth of the economy (which is the main determinant of the growth of the public health budget) and in part by the planned rate of expansion of the public hospital sector.

19. Also related to the question of cost-effectiveness, is the need for Eastern African countries to strike an adequate balance between consolidation of existing service capacity and expansion (i.e., addition of new service delivery points and programs). In most countries in the region, there is ample scope to increase the "productivity" of the existing network of health facilities through the adoption of consolidation measures such as stepped-up refresher training, improved supervision, improved support systems (drug logistics, transport, maintenance), rationalized staffing patterns, and making up staff shortfalls. In PHN's view, consolidation measures of the types mentioned above should be given top priority by the region's governments; and these are, of course, all areas to which PHN normally devotes a great deal of attention in its operational work. However, it must be kept in mind that large segments of the population, especially in rural areas of Eastern Africa, do not now have regular access to

modern medical care because of distance to health facilities, and avail themselves of services only in cases of medical emergencies. Moreover, with rapid rates of population growth, it can be expected that during the 1980s vast new areas will be settled in the region. Provision of primary health care in all these areas (those now unserved, and those of new settlement) can be largely accomplished by deployment of CHWs, but this deployment has to be accompanied by a parallel extension of rural health facilities with "professional" paramedical personnel (nurses, public health technicians, etc.), as indicated in paragraph (18) above. Exclusive emphasis on "consolidation" would lead to increasing inequity in the distribution of the benefits of public health services. Therefore a balance has to be achieved between "consolidation" and "expansion" of services.

20. Effective consolidation also presupposes an adequate planning capability and data systems at Ministries of Health. Provision of technical assistance in this area is viewed by PHN as a high priority in Eastern Africa. Other international assistance agencies (e.g. USAID) are also interested in lending assistance in this area, and our efforts would have to be closely coordinated with theirs.

21. A third important consideration concerning cost-effectiveness is the recognition that in some cases health services can be provided at a lower resource cost to the population concerned if the providing agent is the private rather than public sector. In considering the role of the private sector in health in the Eastern African context, it is necessary to distinguish betwen non-profit, usually Church-related Non-Governmental Organizations (NGOs), and commercial entities.

22. NGOs have a long history of providing health services in the region, and remain an essential component of overall health services. Because they are typically more decentralized than government services, they can often implement small development projects in a more expeditious way than government units. Their services are also often of higher quality than those rendered in government facilities, perhaps because of the normally higher motivation of NGO staff, and the managerial effectiveness derived from smaller organizational size and greater decentralization in decision-making. Usually the capital and operating costs of NGO health service providers are at least partially subsidized by funds from abroad. PHN intends to explore in full possibilities to channel assistance through NGOs in the region. A possible model may be provided by the NGO component in the proposed FY82 Second Kenya Health/Population Project, where funds will be channelled to individual NGOs through two umbrella organizations, the Kenya Catholic Secretariat and the Protestant Churches Medical Association. It must be recognized, however, that the strength of the existing NGO institutional infrastructure varies among countries in the region, so that the scope for the use of NGOs in health delivery would have to be carefully assessed on a country-by-country basis. Bank staff will also have to stress the need for better coordination between NGOs and government services, to prevent wasteful duplication--a common situation presently in some countries in the region.

23. With regard to the role of commercial entities, it is convenient to distinguish, for the purposes of the analysis, between (a) private, for profit providers of health services (from commercial hospitals to single private practitioners), and (b) commercial providers of goods and services that are inputs in the provision of health services. In Eastern Africa, entities in the first

category have a role to play mainly in catering to the health needs of affluent residents and tourists. As such they would have to be taken into account in any thorough health sector analysis, but they are unlikely to play a significant role in PHN-assisted programs, which would have to cater to the needs of the bulk of the population. If the definition of the category is extended to include traditional health practitioners, however, it then becomes important from PHN's point of view, as large segments of the population in the region make use of the services of these practitioners. Training programs to improve the quality of the services provided by traditional health practitioners will be included in PHN assisted projects in Eastern Africa whenever appropriate.

24. The main example of entities in category (b) above are commercial providers of drugs, since in developing countries drugs normally account for a large percentage of recurrent public health budgets and of private expenditures on health. The question of the respective roles of the public and private sectors in all stages of drug supply is a complex one, and PHN's policies in this area are at an early stage of development. The public sector should invariably play a regulatory role, establishing a system of incentives conducive to the achievement of social objectives. It is more difficult to generalize about the extent to which the public sector should play an active role in production or distribution; this is, however, susceptible to analysis on a country-by-country basis.

25. Also within category (b) in paragraph (23), there is likely to be considerable scope for private sector participation in maintenance of health buildings, equipment and vehicles, which is typically deficient throughout the region. The determination of the most cost-effective division of labor between the public and the private sector in maintenance work would have to be conducted on a country-by-country basis, and would have to take into account factors such as the geographical distribution of health facilities, the present capacities of private maintenance services and its likely growth, economies and diseconomies of scale, etc. The various options available will be explicitly identified and assessed in future PHN-assisted projects in the region. Coordination with other Bank project organizational units also concerned with maintenance of public assets (e.g. education, highways, etc.) will also be emphasized.

26. Resource Mobilization. On a per capita basis, public health budgets in real terms are unlikely to grow substantially for most Eastern African countries in the 1980s. For capital expenditures, and especially for capital expenditures related to expansion of tertiary, curative facilities, it is likely that substantial amounts of funds from external assistance agencies will be available, given the high priority attached by most agencies to supporting these programs. The bulk of these funds will consist of grants, thus not directly worsening the government's fiscal situation or the balance of payments prospects (although there may be an opportunity cost in that the funds would have gone to another sector if not to population, health and nutrition). However, every dollar of development expenditures has fiscal implications in the form of additional annual operational and maintenance (O&M) expenditures subsequent to project completion; in fact, the ratio of incremental annual O&M expenditures per dollar of development expenditures is particularly high in the health sector. These incremental annual O&M expenditures would have, for the most part, to be absorbed in the government's recurrent budget (the exception being those O&M expenditures associated with development projects involving self-financing private entities). Economic and political considerations set an upper

limit to the feasible rate of growth of public health recurrent budgets in real terms over any given period: in Eastern Africa in the coming years this constraint will be particularly tight. Hence, foreign-assisted health development projects will have to be carefully coordinated, because low-priority projects, even if financed by external grants, would have a high opportunity cost in terms of other priority health projects that would have to be postponed in view of the recurrent budget constraint.

27. The recurrent budget constraint to expansion of health programs in Eastern Africa in the present decade could be somewhat relaxed by policies that changed the characteristics of health sector financing. The traditional approach in most countries in the region has been to depend almost entirely upon central government revenues, obtained through general taxation. Decentralization of decision-making aimed at achieving primary health care goals, instilling a sense of community participation, and providing an indication of the value that beneficiaries place upon health services, all suggest that increasing reliance upon local financing, user charges, and/or private sector activity may be appropriate. The general framework for analysis of cost recovery mechanisms in health should draw on that already developed for revenue-earning entities, in which efficiency, fiscal, and equity objectives are balanced in deciding how to use the scarce available resources.

28. While encouraging governments to stress the utilization of drug charges and of user fees for certain types of curative services, Bank staff will have to bear in mind several caveats: (i) in some countries introduction of cost recovery measures may be politically feasible only after intensive educational efforts by government; (ii) administrative costs are bound to be high; (iii) in a situation of low growth or stagnation of public services generally, it is not at all certain that proceeds from drug charges and user fees would constitute a net addition to public health resources (but even if they do not help to mobilize resources, user fees could discourage unnecessary use of the services, thus leading to better use of available resources); and (iv) care should be taken not to price the poor out of essential services, thus working against the achievement of fundamental health goals. The latter point implies that pricing policies for essential health services should ideally be based on a knowledge of the price elasticities of the demand for these services by income class, and especially for the lowest income brackets. Available knowledge in this area is scant. The scope for cross-subsidization should also be considered.

29. The fact remains, however, that in most developing countries there are large private expenditures for health services and health-related goods provided through channels that fall outside the formal health sector, especially traditional practitioners of medicine and commercial outlets engaging in the unregulated sale of pharmaceuticals. It is often the case that these expenditures actually result in a worsening of the health status of the buyers. Hence, if it were possible to reallocate resources from this informal health sub-sector to the formal one (governmental and non-governmental), it might be possible in some cases to effect an improvement in the overall health status of the population without increasing the per capita amount of resources allocated to health. Policies to this effect would have to be based not only on an understanding of the economics involved, but also of the cultural factors that may explain the preference of many households for the services of the traditional practitioners. In other cases, good results may be obtained by the training and support of informal sector health workers.

30. Even if overall per capita budgets for public health do not grow, it is possible that per capita budgets for primary health care services could grow, provided that at the margin hospital services absorbed a share of the increases to overall public health budgets lower than their present shares. This will also be politically difficult because hospitals in the region are generally heavily utilized and even overcrowded. Nevertheless, in countries in which Bank-assisted health projects are planned, the distribution of public health expenditures between the hospital sector on the one hand, and preventive and primary health care services on the other hand, will have to be an important element in the dialogue leading to project identification and preparation. Efficiency in the allocation of scarce public health sector resources mandates that preventive and primary-level health services should be stressed in Eastern Africa. The extension and improvement in quality of preventive health services can reduce the prevalence of communicable diseases and of complications of pregnancy, with a corresponding reduction of pressure on hospitals. On the curative side, simple treatment at the local level can often reduce the severity and duration of illness (e.g., malaria, pneumonia and diarrhea). Ways need to be found to reduce the public's "felt need" for hospital care, or at least their effective demand for these services (e.g., if charges are levied for their use). Every health system should have some hospital facilities as the tertiary referral point of the system, otherwise it will be difficult to maintain credibility of primary care services in the communities concerned. The question is of appropriate balance given needs and resources.

31. There are no easy options for the mobilization of resources for public health in general and primary health care services in particular in Eastern Africa. PHN will need to devote considerable resources to study this subject before we can be in a position to make specific recommendations. Planned research efforts by PHN's Policy and Research Unit on aspects of health sector financing should provide insight into this difficult issue. Over the next year it is planned that about six case studies of health sector financing will be conducted, associated with sector work. A major product of the exercise would be a policy paper which would set out the criteria the Bank should require for financial management policies in the health sector, with special reference to cost recovery.

32. Research Needs. There are certain areas of priority health research relevant to the Eastern African region which may require stepped-up external support. Among these areas are improvements in health services, the efficacy of existing vaccines, development of new vaccines, vector control, chemotherapy of prevalent diseases, and oral rehydration techniques (for treatment of diarrhea). It is important, however, to distinguish between those types of research within these priorities that relate to health problems that are Africa-specific and hence should preferably be undertaken within African countries, and those which relate to health problems not geographically confined to Africa. The second category of research is likely to cost less if it were conducted in developed countries already possessing sophisticated research facilities. Therefore, emphasis of PHN's assistance should go to the first category and within that category to health services research which is a key tool of planning and management and which is seriously deficient.

33. Prioritization of Countries for Bank Health Assistance. Perhaps the best summary indicator of the health status of the population of a country is life expectancy at birth. According to this indicator, the health status of

countries in Eastern Africa range from very poor to poor. The average life expectancy at birth for the region as a whole (weighted average) is about 48 years, as opposed to 74 years for countries with industrial market economies as a whole, 61 years for middle-income countries as a whole, and 57 years for low-income countries as a whole. Out of 20 countries in the region where the Bank is active, four (Djibouti, Ethiopia, Somalia and Burundi) have life expectancies at birth ranging from 40 to 45 years; another 9 (Sudan, Comoros, Madagascar, Rwanda, Zaire, Botswana, Malawi, Swaziland and Zambia) have life expectancies at birth ranging from 46 to 50 years. With the only exception of Mauritius (life expectancy at birth, 65 years), all countries in the region are in dire need of Bank assistance in the health sector. However, other things equal (e.g., government interest in Bank assistance, commitment to primary health care concepts, etc.), PHN will attempt to give higher priority within the region to those countries with lowest life expectancies and the largest populations.

Nutrition

34. Nutrition and Health Lending. In those Eastern African countries where health lending is presently programmed (FY83 Malawi, FY84 Lesotho, FY84 Rwanda), the integration of nutrition with health services will be considered as an explicit objective. Because of their synergistic effect, health programs and nutrition interventions undertaken in the same area generally magnify the impact of both and increase cost-effectiveness. Access to primary health care for diagnosis of malnutrition in low-income groups (for example, regular weighing of children to identify those at risk, nutrition education, and serving as an entry point for nutritional supplementation), and vaccination against diseases such as measles (that in combination with malnutrition causes serious illness or death), are important to good nutrition. So are control of the sources of infection and the high worm load that increase nutrient requirements, and distribution of Vitamin A capsules, iron and folic acid through health delivery facilities.

35. Bank Nutrition Strategy in Eastern Africa. Interventions through health projects are but one of a broad range of possible Bank interventions for improving nutritional status in Eastern Africa. The Operational Work Program for Nutrition, approved by senior and regional management in September 1980, outlines the broad areas of a Bank nutrition strategy. The main elements of such a strategy, applicable to Eastern Africa, are:

- Firstly, through economic and sector work, a substantial effort to improve our understanding on a country-specific basis of the nature and extent of the problem, where in the chain of nutrition events the weakest links that need addressing are located, and identification of suitable actions. Detailed work on nutrition-oriented food production and consumption policies might be included as part of our involvement in food and nutrition sector surveys, or by broadening terms of reference of agricultural sector work.

Thus, for example, agricultural sector work should examine policies designed to stabilize supplies and prices of basic foods (with special attention to the relationship between producer prices adequate to stimulate increased food production and price levels needed by low-income consumers). Likewise, it should analyze existing direct governmental interventions in food distribution.[2/]

- Secondly, to incorporate nutrition concerns explicitly into agricultural and rural development project work by: (a) developing projects which respond to the nutrition findings of economic and sector work; (b) monitoring nutritional consequences of Bank projects; and (c) where appropriate, adding nutrition-related components.

- Thirdly, to include improvement of nutritional status as an objective and part of the design of appropriate health projects (paragraph 34 above); and

- Fourthly, when appropriate, to undertake free-standing nutrition projects. (Given the demands such projects make upon domestic resources and delivery systems, this approach is probably the least feasible option in Eastern Africa.

36. Our knowledge of Eastern Africa's nutrition problems, its causes, and especially possible remedial actions, is incomplete. PHN's main emphasis will, in the near future, have to be placed upon economic and sector work. For FY83, Malawi has been selected as the regional focus country for an indepth nutrition sector study. In addition, nutritional aspects are also to be addressed in PHN's FY82 sector work for Lesotho and Zimbabwe. This sector work will be intensified over the next years.

Intersectoral Issues

37. Manpower Development. A common theme in PHN's work in Eastern Africa in all three areas of its concern will be a strong emphasis on manpower development. This will involve not only support for basic and in-service training programs, but also technical assistance to help Ministries of Health and other relevant entities to improve their personnel management policies. Special

---

2/ Food ration systems should be examined in terms of populations served, contribution to nutrition status of the malnourished, subsidies involved, and the effect on market prices for those outside of the ration system. In rural areas, which are usually poorly served, if at all, by food ration systems, food for work programs (with possible involvement by the World Food Program) should be explored as a way to tide some low-income farmers and landless workers over lean periods.

attention will be paid to cost-effectiveness in training of health manpower, involving the explicit evaluation of choices such as expansion of training capacity versus adoption of measures to reduce student and staff attrition; short courses of training of paramedicals versus longer courses producing more highly qualified staff; etc.

38. Cofinancing. As pointed out in paragraph (26) above, support of public health care programs, including family planning, is a high priority for most of the external assistance agencies operating in the Eastern Africa region. And, for the reasons indicated in the same paragraph, it is very important that the efforts of these agencies including the Bank, should be carefully coordinated. Although formal cofinancing of projects is not a necessary condition for adequate coordination, the latter is more likely to develop if projects are jointly appraised and financed by all interested agencies. This has the added advantage, from the countries' point of view, of reducing the "foreign aid workload" of government staff. This approach is being presently adopted in the context of the second IDA-assisted health/population project in Kenya (to be submitted to the Board in the first half of calendar 1982); in this case, the Government requested that Bank staff take the lead in preparing and appraising a package for donor assistance. This approach is, of course, not without costs to the Bank, as it requires higher inputs of Bank staff than straightforward Bank/government operations. However, in the interest of better serving the countries in the region, it is PHN's view that cofinancing of health/population projects should continue to be stressed in Eastern Africa.

PHN Strategies for Eastern Africa and the Report on "Accelerated Development in Sub-Saharan Africa"

39. The Report does not emphasize PHN sectors, since its main concern is with directly productive activities; indeed, in the case of nutrition, it contains no explicit discussion. Nonetheless, the Report does contain several specific recommendations on Bank assistance in the areas of health and population, and its agricultural sections have implications for nutrition. In this section, the Report's recommendations relevant to PHN are briefly discussed in the light of the discussion contained in previous sections.

40. Population. The Report recognizes the gravity of the population situation in Sub-Saharan Africa, and it recommends that the Bank should provide, wherever possible, strong support for family planning programs, both for services and for information and education activities. It further recommends that family planning services should preferably be integrated with health services in general, and maternal and child health care services in particular; that these services should be provided free of charge, or at a very low charge; and that female education should be encouraged. PHN fully agrees with all these recommendations, which are entirely consistent with the strategies outlined in paragraph (6) to (12) above.

41. Health. The Report identifies four areas where action can be most conducive to improving the health situation: increasing access to low-cost health care; consolidating and upgrading health systems; research improvements; and improving access to safe water and adequate sanitation. The first area refers to the emphasis that needs to be placed on provision of primary health care in the public health sector, and to the utilization of the private sector as a vehicle for providing health services or the inputs necessary for providing

health services. These matters were discussed in paragraph (18) and (21) to (25) above, respectively. The Report seems overly cautious on the matter of expanding rural health systems and especially community-based approaches, but in general its recommendations are in line with PHN's views as expressed in this paper. Likewise, the Report's emphasis on consolidation of health systems, which stresses the importance of adequate staffing of existing facilities and the strengthening of health service support systems, closely parallels the discussion in paragraph (19) above. The importance of health research was highlighted in paragraph (32), and in PHN's view the specific research areas identified by the Report are indeed of the highest priority. Concerning water supply and sanitation, PHN agrees with the Report's assessment of the importance of these factors in relation to the health status of the Sub-Saharan population. They have not been explicitly discussed in this paper because from an organizational point of view they fall largely outside PHN's mandate (except for hygiene education, which would be normally included in health education programs).

42. Nutrition. The Report contains no explicit nutrition strategy. In a continent where nearly two-thirds of all children are affected by malnutrition, this is a serious ommission.[3]/ Among adults malnutrition affects productivity and earnings, as shown in a recent Bank-funded research study in Kenya.[4]/ For the Sub-Saharan region nutritional deficiencies are predominantly caused by a shortage of food, and not by an imbalance between calories and protein. Moreover, malnutrition is largely a reflection of poverty: incomes are not adequate to meet the basic food requirements. The problem is particularly serious among families of landless agricultural laborers, small-holder farmers, small-scale fishermen, and the urban unemployed, who together constitute more than half of the malnourished in most countries.

43. Although the Report does not address nutrition explicitly, some of its recommendations for agriculture have potentially important nutrition implications. For example, the Report recommends deemphasizing semi-arid food crop production, and that programs should be devised to encourage migration from those poor regions to those better endowed. However, in many instances redistribution of better endowed land may not be politically feasible. In those instances, a transitional strategy should be designed to increase food output (those areas are only suited for food production), supplemented by services to prevent or remedy serious health problems from malnutrition.

44. The Report also draws attention to the fact that official food prices have often been set too low, and that this has had negative effects on farmer incentives to produce basic foods. It then recommends raising the price for food imports through duties in order to encourage domestic production. While this policy is in accordance with economic efficiency, the resulting increase in consumer food prices would exacerbate the nutritional problems of the poor, unless it is balanced with production and marketing policies to increase the availability of basic, low-priced staples traditionally consumed by the poor (such as cassava).

45. The Report points out that food marketing is vested too much with public institutions and too little with private traders, and it recommends a gradual freeing of domestic food marketing in order to encourage greater competition between public and private sectors. PHN agrees with this view, the

---

3/ A memorandum from Dr. John Evans to Prof. Berg, dated July 13, 1981, brought this issue to the attention of the author.

4/ Kenya: Health and Nutrition Worker Productivity Studies, Dr. M. Latham and Dr. L. Stephenson, World Bank, January 1981.

implementation of which should lower distribution costs and reduce consumer food prices. For marginal areas, however, the government may have to retain a preponderant role.

46. The Report states that changes in food policy pose sensitive problems, yet donors can help by providing technical advice and bridge financing to smooth efforts to align domestic prices for foodgrains more closely with world market prices. While bridge financing may be controversial, donors could assume an active role in assisting governments in formulating a food and nutrition policy, including the establishment of clearer policy goals and alternative strategies to deal effectively with the food and nutrition problem. Such policy work should enable governments to place the interrelated policy objectives of food production/distribution/consumption in the context of an overall investment program.

WORLD BANK / INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

TO: Warren C. Baum

DATE: April 27, 1982

FROM: John R. Evans, Director, PHN JRE

SUBJECT: PHN Lending Program

Attached please find:

(i) PHN lending FY82-85 programs categorized in terms of emphasis on population,

(ii) the list of key countries and other priority countries from the Berelson Panel Report, and

(iii) comments on possibilities for population lending in the key countries and other priority countries.

Our present plan, discussed with the OVPs in February, is to intensify our activities in some of the large countries of South Asia and East Asia and to use health projects to initiate a dialogue on population and establish some services with maternal-child health in Africa. In Latin America there may be considerable opportunity to expand family planning services as part of health projects. Ethiopia and Turkey, two of the three key countries without any PHN involvement, will be explored again with the regions but no action is planned for Zaire.

Given the interest of some Executive Directors in the population program, an informal discussion with them might be useful.

Attachment

JREvans:am

	Major Focus on Population	Minor Focus on Population	Health without Population
FY 82	Kenya II		Brazil I
FY 83	Comoros I Pakistan I	Peru I Dom. Rep. II (R)	Malawi I Senegal I YAR I
FY 84	Rwanda I	Lesotho I Brazil II Ghana I (R) Burundi (R) Botswana (R) Zimbabwe (R)	Mali I YDR I Upper Volta I Indonesia I
FY 85	Kenya III Bangladesh III India III Thailand II Sri Lanka (R)	Nigeria I YAR II (R)	Niger I Ivory Coast I China I

(R) Reserve

PHND
4/9/82

THE 17 "KEY" COUNTRIES
AND OF THE OTHER PRIORITY COUNTRIES

Countries	Mid-1977 Population Estimate/ (millions)
A. Key countries	
1. India	622.7
2. Indonesia	136.9
3. Brazil	112.0
4. Bangladesh	83.3
5. Pakistan	74.5
6. Nigeria	66.6
7. Mexico	64.4
8. Thailand	44.4
9. Philippines	44.3
10. Turkey	41.9
11. Egypt	38.9
12. South Korea	35.9
13. Iran	34.8
14. Burma	31.8
15. Ethiopia	29.4
16. Zaire	26.3
17. Colombia	25.2

Countries	Mid-1977 Population Estimate/a (millions
B. Other priority countries/b	
18. Afghanistan	20.0
19. Morocco	18.3
20. Algeria	17.8
21. Peru	16.6
22. Sudan	16.3
23. Tanzania	16.0
24. Kenya	14.4
25. Sri Lanka	14.1
26. Nepal	13.2
27. Malaysia	12.6
28. Iraq	11.8
29. Ghana	10.4
30. Syria	7.8
31. Ecuador	7.5
32. Cameroon	6.7
33. Guatemala	6.4
34. Upper Volta	6.4
35. Tunisia	6.0

February 7, 1978

EMENA

Key countries:

Egypt: The Population Projects Department (PPD) developed two projects in Egypt. The possibility of a third is hindered both by slow implementation of the second project and by the reluctance of Egypt to borrow for population on Bank, rather than IDA, terms.

Iran: PPD had also financed a project in Iran but it was cancelled in 1977, and the possibility of a new project is remote given the political circumstances of the country.

Turkey: It is a priority country, given the social indicators and earlier expressions of interest on the part of the Government. PHN has had informal contacts with the Region and there is some interest to begin discussing a sector study which might pave the way for lending.

Afghanistan: There is no early prospect for initiation of discussions on population.

Other priority countries:

Morocco: Discussion of a project in Morocco was begun by the PPD and has continued recently, but more toward a project in health with some population elements.

Algeria: It has expressed informal interest and the division will follow up.

Iraq: Presents problems at present due to the political situation.

LAC

Key countries:

Brazil: Our initial mission to Brazil for the Sao Paulo project was aimed at population but our subsequent discussion has been limited to health (including, of course, maternal child health). There are still some reservations on the part of the country and the Region about Bank involvement in population project, but we will keep alert to possibilities.

Mexico: One attempt was made several years ago to have a population project, advancing to the state of green cover. Internal resistance to borrowing for population stopped the loan. Mexico is still reluctant to borrow for the social sectors.

Colombia: The Government still prefers to deal with population on its own.

Other priority countries:

Venezuela: Would be a good candidate for a population project but per capita income may make this difficult.

Chile: It is not a priority given its low birth rate.

EAST ASIA AND PACIFIC

Key countries:

Indonesia: There is an informal understanding between the Region and PHN that when a project is ready an attempt will be made to accommodate it in the lending program. There has been some problem due to the small size of PHN projects in relation to the desired average size. It would be desirable to explore a fourth population project in the near future once implementation problems of the third project have been overcome; one is tentatively listed for FY85.

Thailand: A second population project for Thailand is listed for FY85 although the Ministry of Health does not accept the idea of borrowing for this sector on IBRD terms.

South Korea: PHN has offered to undertake sector work as an entry into a possible health/population project in the outer years of the current country program; Programs have no objections and the mission now in Korea will assess the opportunities for further population work.

Philippines: The primacy of the population issues, the uncertain level of funding for the population program and the substantial unmet demands for services suggest that further population projects should be added to the lending program in FY84 or FY85. By then the first project would have been completed and substantial progress should have been made in the implementation of the second project. Despite the GOP's recognition of the danger of the fast-growing population, the plan for 1983-87 gives no particular attention to population work.

Other priority countries:

Malaysia: There has been some reluctance on the part of the Region to include a population project in the lending program because of the political sensitivities in Malaysia. PHN has been working closely with the GOM (and the Family Planning Board in particular) to deal with the sensitivities. It is our understanding that GOM recognizes the need for continued assistance for population programs and wishes to redesign strategies using as a model the Family Development and Specialized Fertility Service Program started on a small scale under the second population and family health project. The May 1982 mission will assess the chances for a third project.

SOUTH ASIA

India: The lukewarm support from the India Programs Division for an intensified population/health program probably reflects the Government's view that it would prefer to use IDA funds for large, quick-disbursing projects in hard sectors. Some difficulty has been experienced by PHN in getting down to cases with the Government on the planned FY85 project.

Pakistan: The population project in Pakistan is scheduled for appraisal in May 1982.

Bangladesh: Discussions are beginning on the possibility of a third Bangladesh project which is now listed for FY85.

Burma: The Region has taken the position that PHN should not approach the Government of Burma at this time to explore interest in Bank assistance for health/population although a recent economic mission reported that the Government had expressed some interest in Bank assistance in the health sector. Since the Government's population views are pro-natalist, only family planning services to the extent they support family health objectives would be possible within the context of a health project.

Other priority countries:

Sri Lanka: A FY85 (R) project is in the lending program for Sri Lanka. The Government has postponed three times a health sector mission which is now scheduled for the last quarter of 1982. The Programs Division has had reservations about a population, health or nutrition project because it feared that it might give the wrong signals to government concerning investment priorities.

Nepal: A population sector mission is now in the field in Nepal following up the agreement reached by the Aid Group Meeting in December 1981. There has been reluctance in the Programs Division to support lending because it was felt that the requirements of the Nepalese population program could be met fully by present donors. Regional management has indicated willingness to support a project if the sector mission identifies an important role for the Bank.

EAST AFRICA

Key countries:

Ethiopia: PHN will participate in the economic mission in September 1982 at which time it is hoped that the dialogue will be established which leads to a health/population project.

Zaire: Although Zaire has a rapid population growth rate, there is no indication of interest in population control nor serious prospect of Bank involvement.

Other priority countries:

Sudan: The Programs Division acknowledges a great need in the health and population sectors of Sudan but has argued against investments in the sectors because of the effect of the recurrent costs generated on the precarious financial situation.

Tanzania: The economic situation precludes serious consideraton of health/population lending at this time.

WEST AFRICA

Nigeria: The discussions to date have given little encouragement of willingness to address the population problem but this will be followed up by a representative of PHN in the forthcoming economic mission.

FORM NO. 75
(9-78)

THE WORLD BANK

ROUTING SLIP	DATE: 6.3.82.

NAME	ROOM NO.
JRE (O/R)	
RMF	JAR to check E van der Tak

	APPROPRIATE DISPOSITION		NOTE AND RETURN
	APPROVAL		NOTE AND SEND ON
	CLEARANCE		PER OUR CONVERSATION
	COMMENT		PER YOUR REQUEST
	FOR ACTION		PREPARE REPLY
	INFORMATION		RECOMMENDATION
	INITIAL		SIGNATURE
	NOTE AND FILE		**URGENT**

REMARKS:
I have advised van der Tak of lack mention of population (pp 7 & 9). He thinks you may have to attend but you should check with him in advance since he doesn't know what Ernie Stern wants re attendance.

FROM:	ROOM NO.:	EXTENSION:
[signature]		

6/2

Ms. North

- This is the paper
E. Schabeck was referring
to this morning

- See p. 7 & 9,

- Pl. return the document.

Am.

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT
INTERNATIONAL DEVELOPMENT ASSOCIATION

SecM82-468

FROM: The Deputy Secretary

May 20, 1982

NOTICE OF MEETING
THE COMMITTEE OF THE WHOLE

World Bank Lending Program - Allocations Among Income Groups, Regions and Sectors

A meeting of the Committee of the Whole on the above topic will be held under the chairmanship of Mr. Ernest Stern, Senior Vice President, Operations, on Wednesday, June 9 at 10:00 a.m. in the Board Room.

A memorandum on this subject is attached. Questions on this document may be referred to Mr. John A. Edelman (ext. 60119).

Distribution:

Executive Directors and Alternates
President
Senior Vice Presidents
Senior Management Council
Vice Presidents, IFC
Directors and Department Heads, Bank and IFC

May 20, 1982

MEMORANDUM TO THE EXECUTIVE DIRECTORS

SUBJECT: WORLD BANK LENDING PROGRAM - ALLOCATIONS AMONG INCOME GROUPS, REGIONS AND SECTORS

I. INTRODUCTION

1. This memorandum reviews past patterns of World Bank lending by income groups, regions and sectors, and those currently planned for FY82-86 as presented in the Budget Document for FY83. 1/ The memorandum also briefly reviews the planning process used to arrive at these allocations. 2/

2. The projected allocations for FY82-86 reflect several major developments. The shortfall in actual and expected IDA resources has reduced planned World Bank lending to the lower income countries; the increased emphasis on Sub-Saharan Africa has been reflected in the new regional allocations; the lending program for China, started in FY1981, will continue to expand; and lending for the development of energy resources has been increased.

II. THE PLANNING PROCESS

3. The patterns of World Bank lending reflect the borrowing countries' development objectives, their priorities and requirements, and Bank-wide policies and constraints. The level of Bank lending to a particular country is determined largely by the country's effective needs, its size, per capita income, access to other sources of capital, creditworthiness, the availability of sound high priority projects, and judgments about the effectiveness of

---

1/ Review of World Bank Group Financial and Operating Programs and FY83 Administrative Budgets, May 20, 1982. Total availabilities of resources at current prices are assumed for FY82-86 at $60.0 billion for IBRD and $18.6 billion of commitment authority for IDA. However, as emphasized in that document, the planning assumptions for IDA are highly uncertain.

2/ Last year's review, Bank/IDA Lending Program - Allocations among Income Group, Sector and Region was issued as R81-24 IDA/R81-16, February 1981.

economic management, including the efficiency of use of domestic and external resources. Such judgments require an assessment of a country's economic performance and the quality of its economic management, with due regard for the country's particular stage of development. When such performance is judged to be inadequate, allocations are constrained; but special efforts are made to help address the underlying problems through technical assistance and a reinforced country dialogue. Eligibility for Bank borrowing is determined by considerations of creditworthiness, per capita income levels and access to private capital markets. But the level of Bank lending also is influenced by the need to maintain a balanced IBRD portfolio which is regarded as sound by the markets in which the IBRD obtains its own funding. For IDA, lack of creditworthiness for IBRD borrowing and low per capita GNP are the main criteria for determining eligibility. Low income countries with only limited creditworthiness are eligible for a mix of IBRD and IDA lending.

4. Within the approximate levels of lending for a country determined by such considerations, the sectoral composition of the country lending program is a product of an assistance strategy developed jointly by the country and the Bank which reflects the country's policies and priorities, specific Bank objectives as determined by the Board, the Bank's comparative advantage in particular projects and sectors, and the lending activities of other institutions.

5. The aggregation of these country programs can be analyzed by country income group, region, and sector. This analysis provides a basis for assessing the implementation of Bank-wide strategies and policies. The rest of this memorandum is devoted to these issues.

III. PATTERNS OF LENDING

Distribution by Income Group

6. Table 1 shows the lending program divided into the five per capita GNP categories used in the 1981 Board paper with adjustments made for price increases: 3/

3/ These are the same groups used in last year's Budget Document. 1979 per capita income ranges have been adjusted to 1980 data, reflecting the pattern of increases derived from GNP deflators (expressed in dollars). The country composition of the five categories, and changes since 1979, are shown in Annex 1.

TABLE 1: DISTRIBUTION OF IBRD AND IDA COMMITMENTS BY INCOME GROUP

GNP Per Capita a/	FY	Millions $ at FY82 Prices					Percent of Total				
		67-71	72-76	77-81	82-86 Revised	82-86 Previous b/	67-71	72-76	77-81	82-86 Revised	82-86 Previous b/
Group I (up to $410)	IBRD	2457	1915	2343	7977	4171	11.9	6.7	5.6	15.1	7.9
	IDA	4403	8903	13379	15294	19839	68.7	75.2	81.3	90.7	91.2
	Total	6860	10818	15722	23271	24010	25.4	26.8	26.8	33.3	32.3
Group II ($411-730)	IBRD	2002	5804	10759	15140	15893	9.7	20.4	25.6	28.6	30.2
	IDA	1340	2208	2909	1559	1906	20.9	18.7	17.7	9.2	8.8
	Total	3342	8012	13668	16699	17799	12.4	19.9	23.3	23.9	23.9
Group III ($731-1275)	IBRD	3228	3810	7084	8813	9372	15.7	13.4	16.8	16.6	17.8
	IDA	155	240	141	2	-	2.4	2.0	0.9	-	-
	Total	3383	4050	7225	8815	9372	12.5	10.0	12.3	12.6	12.6
Group IV $1276-2200)	IBRD	7849	12795	15813	16363	18212	38.1	44.9	37.6	30.9	34.6
	IDA	506	488	30	-	-	7.9	4.1	.2	-	-
	Total	8355	13283	15843	16363	18212	31.0	32.9	27.1	23.4	24.5
Group V (over $2200)	IBRD	5050	4169	6100	4647	4980	24.5	14.6	14.5	8.8	9.5
	IDA	-	-	-	-	-	-	-	-	-	-
	Total	5050	4169	6100	4647	4980	18.7	10.3	10.4	6.7	6.7
Total	IBRD	20585	28494	42098	52940	52629	100.0	100.0	100.0	100.0	100.0
	IDA	6405	11839	16459	16855	21745	100.0	100.0	100.0	100.0	100.0
	Total	26990	40333	58557	69795	74374	100.0	100.0	100.0	100.0	100.0
Memo: Least Developed Countries	IBRD	799	264	402	258	231	3.9	.9	1.0	0.5	0.4
	IDA	1027	3106	4778	6386	7469	16.0	26.2	29.0	37.9	34.3
	Total	1826	3370	5180	6643	7700	6.8	8.4	8.8	9.5	10.4

Note: Amounts and percentages may not add to totals due to rounding.

a/ Per capita GNP figures in 1980 dollars according to the 1981 World Bank Atlas and subsequent revisions. No allowance has been made for country movements from one income group to another over time.

b/ Program shown in the FY82 Program and Budget Memorandum of May 1981, adjusted to FY82 prices and for changes in country composition of these income categories since that Memorandum was issued.

Group I comprises countries with GNP of less than $410 per capita, including most of those defined by the UN General Assembly as "least developed." Group II includes lower middle-income countries with GNP per capita less than $730, the limit of IDA eligibility, while Groups III and IV include the remaining middle income countries. Group V comprises higher income countries with per capita GNP over $2200.

7. Because of constraints on creditworthiness and on the availability of IDA funds, the share of total IBRD/IDA lending to countries now included in Group I rose only slowly over the past decade - from 25.4 percent of total commitments in FY67-71 to 27 percent in FY77-81. In FY82-86 the share of total World Bank lending to this group is expected to rise sharply - to 33 percent. This is principally due to the inclusion of China in the World Bank lending program. It also assumes that the total level of IDA funding for FY85 and FY86 will be restored in real terms to that originally envisaged for the IDA VI period. This assumption is subject to a high degree of uncertainty.

Despite the higher share of Group I countries in the total, total lending in real terms is 3 percent below that projected last year, while the real level of IDA is now projected at 23 percent below that envisaged last year. The relatively small reduction in total lending is possible only because of a substantial hardening of the IBRD-IDA blend for the relatively few low income countries which have a sufficient measure of creditworthiness to service the increased debt. For the Least Developed Countries 4/, most of which are not creditworthy for IBRD lending, World Bank lending in real terms is projected at 14 percent below the volume foreseen last year, although the share of these countries in the reduced IDA total is now projected to rise from 29 percent in FY77-81 to 38 percent in FY82-86. The real increase in total commitments for FY82-86 now projected for the LLDCs is 28 percent higher than in the previous five year period FY77-81, while the comparable increase for all Group I countries is 48 percent.

8. The share of Group II countries has risen in the past primarily because of increases in IBRD lending; their share of IDA has declined steadily as scarce IDA resources were increasingly concentrated on the poorest countries. For FY82-86, a further sharp decline in IDA commitments is foreseen for this Group because of the especially severe constraints on IDA which means that a number of countries in the group whose creditworthiness has improved will have to rely exclusively on the Bank. This shift also accounts for the further increase in the share of Group II in total Bank lending in 1982-86. The projected IDA allocations for Group II countries are primarily for blend countries in Sub-Saharan Africa.

9. Group III countries are now solely IBRD borrowers. Lending to them has amounted to about 12 percent of total World Bank lending in the recent past and the same share is projected for FY82-86. This implies an increase, in real terms, of 22 percent over lending in FY77-81. Lending to Group IV countries will remain nearly constant in real terms, with a consequent drop in their share from 27 percent of the World Bank total to about 23 percent. This reflects restraints on allocations for several of the large borrowers in this group, mainly to accommodate increases to lower income countries.

10. The share to Group V countries (GNP per capita of over $2200) is expected to decline from 10 percent in FY77-81 to about 7 percent in FY82-86, representing a drop of 24 percent in real terms from the FY77-81 lending level. This, again, is to accommodate increases to lower income countries.

4/ As designated by the UN General Assembly as of 1981, the LLDCs in Group I are: Afghanistan, Bangladesh, Benin, Bhutan, Burundi, Central African Republic, Cape Verde, Chad, Comoros, Ethiopia, Gambia, Guinea, Guinea-Bissau, Haiti, Laos PDR, Lesotho, Malawi, Maldives, Mali, Nepal, Niger, Rwanda, Somalia, Sudan, Tanzania, Uganda, Upper Volta, and Western Samoa. Countries designated by the UN as least developed but which fall in Group II are: Botswana, Yemen Arab Republic and Yemen PDR.

Distribution by Region

11. The country specific lending programs developed on the basis of considerations discussed earlier can be aggregated into regional totals for analytical purposes although individual countries rather than regions are the primary focus of the Bank's planning process. This is true even in Sub-Saharan Africa where the Bank, in its recent study 5/, identified a number of issues that need to be addressed by the countries concerned. If the strategy suggested in that study can be implemented, this would justify an increase in levels of concessional assistance to that region. On the assumption that the governments in Africa will formulate appropriate programs of policy change, and investment programs consistent with those changes, IDA lending for Western Africa and Eastern Africa combined is planned to rise from about 25 percent of total IDA in the last decade to 34 percent for FY82-86.

TABLE 2: DISTRIBUTION OF IBRD AND IDA COMMITMENTS BY REGION

	Million $ at FY82 Prices					Percent of Total				
Fiscal Years	67-71	72-76	77-81	82-86		67-71	72-76	77-81	82-86	
Region				Revised	Previous a/				Revised	Previous a/
Eastern Africa										
IBRD	1296	1651	1444	1591	1699	6.3	5.8	3.4	3.0	3.2
IDA	910	1942	2684	3986	4377	14.2	16.4	16.3	23.7	20.1
Total	2206	3593	4128	5577	6076	8.2	8.9	7.1	8.0	8.2
Western Africa										
IBRD	1225	1674	2213	3683	3800	6.0	5.9	5.3	7.0	7.2
IDA	536	998	1474	1665	2031	8.4	8.4	9.0	9.9	9.3
Total	1761	2672	3687	5348	5831	6.5	6.6	6.3	7.7	7.8
EMENA										
IBRD	2272	6443	11089	11940	12768	11.0	22.6	26.3	22.6	24.3
IDA	474	1215	1277	236	414	7.4	10.3	7.8	1.4	1.9
Total	2746	7658	12366	12175	13182	10.2	19.0	21.1	17.4	17.7
Latin America and Caribbean										
IBRD	7556	8804	14124	14210	15589	36.7	30.9	33.5	26.8	29.6
IDA	209	319	281	163	242	3.3	2.7	1.7	1.0	1.1
Total	7765	9123	14405	14373	15831	28.8	22.6	24.6	20.6	21.3
East Asia and Pacific										
IBRD	2161	5707	10987	16435	15944	10.5	20.0	26.1	31.0	30.3
IDA	851	926	994	1796	881	13.3	7.8	6.0	10.7	4.1
Total	3012	6633	11981	18231	16825	11.2	16.4	20.5	26.1	22.6
South Asia										
IBRD	1475	1291	1914	5082	2830	7.2	4.5	4.5	9.6	5.4
IDA	3425	6438	9749	9010	13800	53.5	54.4	59.2	53.5	63.5
Total	4900	7729	11663	14091	16630	18.2	19.2	19.9	20.2	22.4
Past Borrowers										
IBRD	4599	2924	327	-	-	22.3	10.3	0.8	-	-
IDA	-	-	-	-	-	-	-	-	-	-
Total	4599	2924	327	-	-	17.0	7.3	0.6	-	-
All Countries										
IBRD	20585	28494	42098	52940	52629	100.0	100.0	100.0	100.0	100.0
IDA	6405	11839	16459	16855	21745	100.0	100.0	100.0	100.0	100.0
Total	26990	40333	58557	69795	74374	100.0	100.0	100.0	100.0	100.0

Note: Amounts and percentages may not add to totals due to rounding.

a/ Program Shown in the FY82 Program and Budget Memorandum of May 1981, adjusted to FY82 prices.

5/ Accelerated Development in Sub-Saharan Africa: An Agenda for Action, World Bank, 1981.

12. Even though creditworthiness considerations in the two African regions constrain their IBRD allocations, total lending for Sub-Saharan Africa would increase from 13 percent of the Bank total in FY77-81 to nearly 16 percent in FY82-86. This represents a real increase of 40 percent over FY77-81. The increase in IDA for FY82-86 is larger for Eastern Africa than for Western Africa. This reflects in part the graduation of Cameroon in Western Africa from blend status to an all-IBRD borrower, and the increase in IDA lending to several Eastern African countries from very low levels in FY77-81 in response to anticipated improvements in economic performance. On the other hand, the main increase in IBRD lending is expected in Western Africa where several borrowers appear creditworthy for expanded programs. The strategy in both Western and Eastern Africa is to focus resources on countries which are implementing major policy improvements in support of structural changes, whether or not this involves structural adjustment lending.

13. About 54 percent of IDA lending in FY82-86, compared with 59 percent in the previous five years, would go to countries in the South Asia Region, which has about 42 percent of the population of all Group I countries. On the basis of present assumptions about IDA availability, this would represent a decline in real terms from the FY77-81 level of 8 percent, compared with a 40 percent increase for this region envisaged last year. This drastic drop in expected IDA allocations has been partially offset by increased IBRD lending to India and Pakistan whose creditworthiness appears adequate to support at least a moderate increase in such borrowing. This shift to a harder blend is forced by the reduction in IDA availabilities, and is not a sustainable response to the needs of the low income countries of this region.

14. In East Asia, the continuing evolution of the lending program for China is the most important development. While increases are envisaged for a few other borrowers in this region because of improvements in performance, there are some offsetting reductions for countries with continued good export prospects and relatively good access to capital markets. On balance, the Regional share of total World Bank resources is projected to rise to around 26 percent in FY82-86 compared with 21 percent in FY77-81. The same type of offsets affect projected lending in EMENA, except that a sharp drop is projected in IDA lending in FY82-86, due to the graduation of Egypt to all IBRD status in FY81. However the planned increase in IBRD lending to that country and several others is largely offset by reduced shares for the higher income borrowers. As a result, overall lending to the region is projected to rise only slightly in real terms.

15. In LAC, IBRD lending is projected as constant in real terms. Since there are only a few small IDA recipients in the region, the share in World Bank lending declines - from 25 percent of the total to 21 percent. The constant level of IBRD lending in real terms reflects a combination of country-specific circumstances, e.g. uncertainties about performance and creditworthiness which constrain lending to several borrowers, an expected real decline in lending to several higher income borrowers, and increased lending to a few countries whose performance and creditworthiness are improving.

Distribution by Sector

16. The sectoral distribution of World Bank lending derives from development of country specific lending programs by the World Bank in consultation with its borrowers. The World Bank's main criterion is to provide its assistance in areas where it can be most effective, so these programs do not necessarily reflect the relative importance of sectoral investment shares within the country. The pursuit of Bank objectives has important sector implications - e.g. increasing the productivity of the poor which involves an emphasis on agriculture since most of the poor are in rural areas, or assisting members to reduce their dependence on imported energy in response to higher world energy prices. Although there are no independent targets by sector, implementation of such World Bank policies has led to major changes in the sectoral distribution of World Bank lending over the years. These changes are reflected in Table 3. In the program proposed for FY82-86, the shares of energy and structural adjustment lending are expected to increase significantly over FY77-81; that of the social sectors would rise moderately; transport and telecommunication would remain stable, while the share of agriculture is expected to decline moderately although lending for this sector, in real terms, would remain constant. Since the lending programs are firmer for the immediate years, a separate column shows the sectoral distribution for FY82-84. In this period, the rise in non-project lending is more pronounced than for FY82-86 as a whole, while the drop in agriculture is greater.

TABLE 3: DISTRIBUTION OF IBRD AND IDA COMMITMENTS BY SECTOR

	--------Million $ at FY82 Prices--------					----------Percent of Total----------				
Fiscal Years	67-71	72-76	77-81	82-86	82-84	67-71	72-76	77-81	82-86	82-84
Sector										
Agric. & Rural Devt. a/	4558	9935	18925	18637	10119	16.9	24.6	32.3	26.7	25.3
Energy b/	6538	5767	10585	15055	8875	24.2	14.3	18.1	21.6	22.2
Transportation & Telecommunications c/	8359	9299	8345	9666	6091	31.0	23.1	14.3	13.8	15.2
Non-Project Lending	1883	2763	2660	5326	3675	7.0	6.9	4.5	7.6	9.2
Social Sectors	1880	4569	8570	11083	5277	7.0	11.3	14.6	15.9	13.2
Water Supply	754	1707	3404	3025	1672	2.8	4.2	5.8	4.3	4.2
Education	1086	2046	2724	3852	1934	4.0	5.1	4.7	5.5	4.8
Health	26	252	452	911	273	0.1	0.6	0.8	1.3	0.7
Urban	14	564	1989	3294	1398	0.1	1.4	3.4	4.7	3.5
Industry & Mining d/	909	3862	3508	3822	2176	3.4	9.6	6.0	5.5	5.4
DFC, SSI, and Other	2863	4138	5964	6207	3729	10.6	10.3	10.2	8.9	9.3
Total	26990	40333	58557	69795	39942	100.0	100.0	100.0	100.0	100.0

Note: Amounts and percentages may not add to totals due to rounding.

Size of Projects

a/ Includes feeder and rural road projects for the periods after FY76. These account for $643 million (1.1 percent) in FY77-81, $1114 million (1.6 percent) in FY82-86 and $609 million (1.5 percent) in FY82-84.
b/ Includes oil, gas, coal, power, and energy-related industry.
c/ Excludes feeder and rural road projects for the periods after FY76.
d/ Includes non-fuel minerals only; excludes energy related industry.

17. The changes in the sectoral patterns of lending are the result of a variety of factors. There have been important modifications in country-specific circumstances; for example, the introduction of a substantial lending program for China has had a significant effect on sectoral allocations because, compared to Bank-wide averages, China has relatively large percentage allocations for energy and transport and a somewhat smaller allocation for agriculture. The reduction in expected IDA availability has had its major impact on lower income countries where agricultural lending has been of greatest importance. The lending programs of other multilateral institutions in agriculture have expanded, particularly those of IFAD and the African Development Bank. On top of this, the Bank's structural adjustment lending has been directed largely at improving the policy framework for agriculture and industry; in some countries this has led to a postponement in plans for direct project lending for these sectors. It needs to be stressed that the drop in the share of agricultural lending projected for the next few years does not mean that the Bank is now assigning lower priority than in the past to its objective of improving the productivity of the rural poor. In a number of countries, however, it does reflect modifications in the means for achieving this objective.

18. Lending for agriculture and rural development increased four fold in real terms between FY67-71 and FY77-81, and its share of total lending nearly doubled in that period. For FY82-86 the level of lending in real terms is expected to remain approximately the same as in the previous five years with a consequent decline in its share. Nevertheless, at 27 percent of the total, agriculture remains the most important single sector in the Bank program for the coming five years. Some of the factors responsible for the expected decline in the share of this sector have been touched on above. In a number of countries there has been an increase in the priority for transport, either to open up new land for agricultural development, as in Brazil, or to help achieve cost savings in that sector as well as others. A more general explanation may lie in the very rapid rise of lending in this sector during the past decade. This increase was the result of a broad approach to expanding agricultural investments in relatively capital intensive projects such as irrigation and drainage, as well as in the promotion of rural development projects. In a number of countries, the most obvious possibilities for economic investments in large scale irrigation have now been largely funded. This is particularly true in East Asia and North Africa. In South Asia, where there is still a large potential, work on some major projects in the Gangetic Plain is inhibited by lack of agreement on riparian rights.

19. The dramatic expansion of agricultural investment during the 1970s has also resulted in pressing the implementation and institutional capacities of some countries close to their limits. This appears to be true not only among the lower income countries of Africa and Asia, but also in some of the middle income countries in EMENA and LAC. Efforts to strengthen this capacity are underway, but this will take time. A closely related problem is the emergence of agriculture sector policy issues in areas such as producer pricing and interest rates which need to be addressed before a renewed expansion of direct lending for agriculture can be justified in some countries. Programs of institutional and policy change in agriculture are being developed under structural adjustment loans for a number of borrowers, particularly in Africa. Finally, there are a few countries where World Bank lending for agriculture now has lower priority than other sectors. In Korea, for example, substantial progress has been made in the development of its agricultural potential, so that the World Bank is now concentrating on agricultural policy issues through SAL lending and on other sectors such as urban development, education, and industry which are more crucial to employment generation and economic growth in that country.

20. An analysis of current lending programs for agriculture indicates that the poverty content in this sector is expected to remain high. 6/ Moreover, lending for the social sectors where the benefits are primarily directed at poverty alleviation and employment generation is expected to rise to 16 percent of the total in FY82-86 compared with less than 15 percent in FY77-81 and 11 percent in FY72-76. Within this group the main growth is expected to be for education, urban development and health, while lending for water supply is expected to drop significantly.

21. As noted in the recent Board Paper on energy, 7/ total lending for this sector is expected to reach 25 percent of the Bank program in FY82 compared with about 18 percent in FY77-81 Within this total, the main increases are for hydrocarbon development (oil, gas and coal) and for energy related industry (e.g. refinery conversions). Lending for those purposes increased from only one percent of the total in mid-1970s to 5 percent in FY79-81 and is projected at 10 percent for FY82-86 as a whole.

22. The share of transportation and communications fell substantially in the previous decade, from 31 percent in FY67-71 to 14 percent in FY77-81. A temporary rise is now foreseen for FY82-84, but for FY82-86 as a

---

6/ In over half the projects in the pipeline for the next two years, most of the direct benefits are expected to accrue to the poverty groups. This is the same share as for the past few years.

7/ World Bank Energy Program: A Status Report, R82-81, March 24, 1982.

whole the share is expected to be slightly lower than it was in the previous five years. The importance of transport in the China program and of major road investments to open up new land in Brazil have already been mentioned. Another important country case is in India where the need to address the severe railway bottleneck has led to a large increase in planned lending for that purpose. More generally, the relative priority of transport investment has gone up in a number of countries because higher energy prices have increased potential economic returns from projects that will reduce fuel and handling costs, not only in land transport but also in coastal shipping, inland water ways and containerization.

23. Commitments for non project lending (SALs and other program lending) are projected at just over 9 percent for the three year period FY82-84. Because lending of this type is difficult to forecast with any assurance beyond the next three years, the current program includes allowance for SALs amounting to only 5.5 percent of the lending program for FY85 and FY86. The total of 7.6 percent for the five year period FY82-86 compares with 9.5 percent projected in last year's Budget Memorandum. However, the latter included a notional allowance for emergency program lending equal to 2 percent of the program. While no such allowance is made this year, it is likely that there will be a need for some lending of this type. Moreover, it is quite possible that adjustment requirements of member countries in FY85-86 will remain acute, leading to larger SAL lending than now projected. Thus, lending of this type could well average between 9 and 10 percent of the total program over the next five years.

IV. CONCLUDING OBSERVATIONS

24. The modifications that have taken place in the FY82-86 lending program since last year's FY82 Budget Memorandum illustrate the continuous nature of the Bank's planning process, reflecting changes in the level and mix of resources available to the World Bank, the evolution of Bank policies and its perception of priorities, and change in country circumstances and preferences. The assumptions underlying the FY82 Budget Memorandum have been changed in several key respects. Current plans for IDA lending for FY82-86 have been reduced by 22 percent in real terms. Our expectation of structural and policy changes in Africa has changed as a result of the study carried out last year on Sub-Saharan Africa and this implies additional resources to support such changes. The addition of China to the lending program has added substantial new claims. The idea of creating a separate Energy Affiliate, which influenced last year's sectoral lending estimates for FY82-86, has been set aside for now. Finally, priorities have changed in a number of countries due to various factors and these changes have had a significant impact on the projected levels and patterns of lending in these countries. These modifications are reflected in the Bank-wide aggregates - particularly in the distribution by region and by sector.

25. The adoption of specific World Bank policy objectives one at a time may sometimes give the impression that these objectives imply [illegible] of lending which add up to more than the total of available resources. But since total resources are determined by the Board and the governments they represent, the Bank's multiple objectives clearly have to be reconciled to fit within the lending ceilings that are so authorized. The reconciliation process takes place largely within the framework of developing individual country lending programs which reflect the combined judgment of borrowers and the World Bank, bearing in mind considerations of Bank equity and overall policy objectives. This may lead to significant changes in the aggregate sectoral composition of the lending program. But when examined in the context of the circumstances of individual countries, these changes in sectoral content appear to be an appropriate response to [illegible] constraints and to new opportunities for economic investments, as well as to the policies and preferences of the countries concerned.

Stern:

FOR FORTHCOMING OVPs MEETING – IN ABOUT 2 WEEKS

6/2/82

A. Conclusions:-

(1.) Seemed satisfied with ~~stability~~ increase in lending volume + stability for '83 + '84. Soft in '85

(2.) Does the lending reflect real sectoral analysis to permit leverage on policy change ~~of causes of problems?~~

Based on disease analysis, service process analysis, cost analysis

(3) Agree to follow up with OVPs at meeting.

(B) Proposals:

i. Not blow all our leverage on getting projects to road left to effect policy change e.g. Egypt.

ii. Population/Health in larger countries project should get out of single/large project, 5 yr cycles – ~~Indian~~, B, one completed before next started

~~Popn~~ The rhythm method is not ~~safe~~ sure approach to pop control. Nor is progestins interruptions.

iii Small projects with major element of T.A & inst. building useful as initial projects: Approach to financial analysis

iv South Asia region requires most encouragement to change pattern of Pop/Health lending.

V Health valid: MCH - Key factors - Infant, child survival. Population particularly important. Are we going to make it.

a/vi Co-financing for health unlikely u / a pop. desirable for coord. of lenders

RMF — for Staff Meeting June 17th/82.

Meeting re Estern. June 14th/82

Management Implications of FY83 budget.

- already in '83 – carryovers from 82 in overcommitment
- estimates for 83 + 5yr lending program ↓ for IDA
- Bank lending more constrained than expected by reflation, Claims etc.

Extern projects – ↓ pipeline.

Reduction staff need – ↓ 40 staff as approved ~~need less~~

Period of uncertainty for staff.

Actions: (1) Reassignment:

- Aim to cut 40 positions + place 25 YPs + retrenchy staff. Offset by retirements + 75 resn T.A. posts to IDA
- limit recruitment from outside Bank except where not technically suited
- Possible that small no. of staff will not be able to be accomodated.
- Pendleton may help
- Necessary not to ~~use the~~ play games with Mgrs re choosing post to get rid of specific person.

Does not expect to continue in future years but cannot be certain.

Coor Note — Recommendations:
Table: — Projects — stage of prepn —
— ~~relative~~ emphasis on P. H. + dev.

Key Issues

Modest lending program reasonably stable for FY 83 7 projects / 6 projects FY 84.
Would welcome some ↑ in FY 84.

(1)
- India III + Bangladesh III slipped to FY 85 at regions request
- Some FY 85 $ might come forward
India, Bangladesh Ivory Coast Nigeria
- Of the Reserve Projects in 84
Botswana — Health / Pop
Burundi
Zimbabwe.

(2)
FY 85 needs strengthening — Indonesia slipped to FY 87
If going to ↑ lending explicitly for Popn
then need to ↑ rhythm of lending in large South Asian countries + Indonesia + Nigeria
- pattern to date has been single project to completion before starting a second.
- doesn't recognize different regions
- temptation to include too much
Favour (1) ~~Overlapping timing of~~ projects in different regions which overlap in timing.
(2) less comprehensive in scope + less taxing on management capability

In Africa, — small first projects best entry route for reasons listed. — financial analysis key role for lend

(3) Review of importance of Pop to overall development

FILE

Mr. Warren C. Baum June 16, 1982

John R. Evans, Director, PHN

PHN Lending Program - FY83-86

1. At the meeting with Mr. Stern on June 1, it was suggested that the detailed analysis of the PHN lending program for FY83-86 should be prepared for submission to the Regional Vice Presidents. Attached please find the updated lending program (Annex I) and a list of the changes since the lending program was presented to the Operational Vice Presidents at their meeting of January 27, 1982 (Annex II). The Minutes of the January 27 meeting are also attached.

2. At the meeting with Mr. Stern, there was concern expressed about the softness of the projects for FY85. The lending program for FY83 and FY84 appeared reasonably stable.

3. We discussed the need for a "different rhythm of lending" for population in Indonesia and the Asian subcontinent. Less comprehensive projects in different regions of these countries which overlap in timing may achieve better results and be less taxing on limited management capability.

4. PHN also hopes to begin lending in larger number of countries using small first projects as a vehicle for initiating policy dialogues and institution building related to population and health for carrying out financial analysis of the health sector.

5. If there is additional information which you require, please let me know.

cc: Mr. van der Tak
Mr. North

Attachment

JREvans/rmf

Meeting with O.P.S

J.K. comments:

1. Slaberbly Fy83 + 84.
2. Need to add to Fy84 from 4 Fy85 S and 3 Fy84R + other
3. The Fy85 is much too soft.. If major impact on pop. — ↑ selectivity of lending in key countries & explicit pop policies
4. Use of relatively small projects in health as entry point to sector. Compensation adv. of Bank in financial, economic aspects of sector.
5. Need for reinforcement of pop. policy issues in general country dialogue eg. Philippines, Sudan, Dakia, Nigeria
6. Noted importance of MCH centered health projects in countries unwilling to address pop°.

Stevens ~~was~~ was v. supportive

1. Health lending had had to buck the bureaucracy of Bank lending and should receive more regional support

2. Increased rhythm of lending in large countries with explicit pop. prems should be encouraged.

3. Willing to consider exemptions to 35% limit on local costs (in response to question from Ltc) but did not see this as the key issue

Hopper: noted absence of Nepal project!

Implications

a. Should press for changes in selected priority countries with reforms

b. i.e. develop a country strategy as approved. Baum feels this should begin with the regional VPs.

East Asian/Pacific: Indonesia: Other Islands Pop/Health
Slipped to FY/87 last region agrees to FY 85 if ready.
Thailand — relucbance of MOH to borrow
Korea — health pop — explored.
Philippines — needs feasture Pop projects in FY 84, 85
GOP plan for 1983-87 gives no attention to pop. work. MAAA
Need reinforcement — Sectoral dialogue

EMENA — Opening for Turkey due to recent retirement of Population dept
— Sept. meetings with MOH (Egypt) IBRD team
— Algeria + Morocco.
Since all IBRD team — explore co-financing with Arab Dev. banks.

LAC — pondering for pipeline in Brazil + Colombia
— Peru underway
Others: Dominican Republic
Jamaica
Panama.
Guatemala
Ecuador
Haiti

South Asia

India —

Pakistan — Health / Pop

Bangladesh — Health / Pop

Burma — recent economic mission reports
GOT interest in Bank assistance in
health sector.

Sri Lanka — sector mission Nov 82
Resume Project FY 85

Nepal — pop sector mission April 82

E. Africa

Ethiopia — Pkg participate in economic
mission Sept / 82

Sudan — concern about pop / health
investments because of the costs.
— $15m Schisto control components
on identification.

1/12

Joe.

Is this what you would like copied for the EDS mgs program.

Ron

Would para 2 do it?

Mr. Warren C. Baum

June 17, 1982

John R. Evans, Director, PHN

PHN Lending Program -- FY83-86

1. At the meeting of Operational Vice Presidents on January 27, 1982, the status of the PHN lending program was reviewed. Key issues in discussion were the importance of not losing sight of the population objective in health projects, the need to concentrate efforts in countries with a sense of direction in these sectors and the advantage of getting on with projects in order to have working models as examples to encourage governments.

2. The meeting agreed with the recommendations presented:

(i) that the Regions give special attention to PHN topics in selected key countries, in particular the Indian subcontinent and Indonesia. An operational strategy should be developed for PHN involvement in each such country;

(ii) the two African Regions and PHN promote health development as fast as possible in Sub-Saharan Africa as a goal in its own right and use this as a framework within which to initiate dialogue on population issues; and

(iii) the Bank reaffirm its commitment to population using its dialogue at country level to initiate policy discussions, create projects in health and other relevant sectors and reinforce project implementation.

3. An analysis of the updated PHN lending program is attached (Annex I). Changes since the lending program was reviewed with the Operational Vice Presidents in January are listed in Annex II.

4. The lending program for FY83 and FY84 appears reasonably stable but FY85 is much less certain. Strengthening of population lending in the Indian sub-continent and Indonesia will require a different rhythm of lending comprising projects in different regions of these countries which overlap in timing, are less comprehensive in scope and less taxing on management capability. In Africa, and perhaps elsewhere, small first projects may be the best route of entry into the sector to initiate dialogue on population and health policies, to strengthen planning, management and training institutions and to explore methods of financing the health sector.

5. Considering the reluctance of most governments to give priority to population and its importance to overall development, more attention is needed in dialogues at country level as noted above in recommendation (iii).

- Philippines, India
- Africa — Ivory Coast
— Nigeria
— Kenya
— Sudan

cc: Messrs. van der Tak
North

JREvans/rmf

POPULATION, HEALTH AND NUTRITION DEPARTMENT
LENDING PROGRAM FY 83-86

FY	COUNTRY	PROJECT	AMOUNT $M IBRD	AMOUNT $M IDA	NEXT STEPS AND DATE	MAIN OBJECTIVES	COMMENTS
83	Senegal	Rural Health		15.0	Yellow cover 6/82	Health w. MCH & FP	Board Presentation 2Qr FY83
	Indonesia	Health I	30.0		Yellow cover 7/82	Health (inc. FP)	Advanced to FY83
	Peru	Health I	26.0		Yellow cover 6/82	Health w. MCH & FP	Board Presentation 2Qr FY83
	YAR	Health I		11.0	Loan Comm. 6/82	Health	
	Malawi	Health I		10.0	Appraisal 7/82	Health/Nutrition	High Probability. Mainly technical assistance.
	Comoros	Population/Health		3.0	Appraisal 10/82	Population/Health	Mainly technical assistance.
	Pakistan	Population		15.0	Yellow cover 8/82	Population	High Probability.
		7N°	56.0	54.0			
84	Brazil	Sao Paulo Health*	50.0		Preparation 7/82	Health	Appraisal 10/82
	PDRY	Health I*		6.0	Appraisal 10/82	Health	Slowness of Preparation. May delay appraisal.
	Mali	Rural Health		17.0	Preparation 6/82	Health (inc. MCH)	Slowness of preparation caused slip to FY84. Appraisal 9/82.
	Upper Volta	Health I		25.0	Preparation ongoing	Health/Nutrition + Possible FP	Appraisal scheduled 4/83. PPF being processed.
	Lesotho	Health/Nutrition		10.0	Identification 6/82	Health & Nutrition	Builds on earlier sector review.
	Rwanda	Population		15.0	Project Brief 10/82	Population & Health	Probable follow up of Population component of BGM II.
		6N°	50.0	73.0			
85	Colombia	Nutrition II	25.0		Not scheduled.	Integ. Nutrition & Health	Scheduling dependent on progress of Nutrition I.
	Morocco	Health	30.0		Preparation 11/82	Health	PPF - Consultant being selected.
	Nigeria	Sokoto Health*	50.0		Appraisal 9/82	Health (inc. MCH), possibly population element	State Project
	Niger	Health	10.0		Preparation 6/82	Health (inc. MCH & possibly FP)	
?	Thailand	Population II	85.0		Identification Infield	Population, Health/ Nutrition	Doubtful due attitude of Health Minister to borrowing
?	China	Health I		100.0	Identification 9/82	Health	Health Sector/Identification Mission Sept. 82
	Ivory Coast	Health I*		10.0	Preparation Ongoing	Health	Presently shown in FY86 but being advanced again to FY85s.
	Bangladesh	Population III*		40.0	Preparation 9/82	Population	Slipped from 84 at request of Region.
	India	Population III*		30.0	Preparation 9/82	Population & Health	Slipped from 84 at Region's request.
?	Kenya	Population III		50.0	Identification 3/83	Population & Health	Depends on progress of Kenya II.
		10N°	200.0	230.0			
86	Brazil	Health II	100.0		Not scheduled	Health	
	Colombia	Health I	35.0		Identification 1/83	Health	Sector review discussions 10/82.
	Tunisia	Population II	25.0		Not scheduled	Health & Population	Timing subject progress Tunisia II.
	Sierra Leone	Health		10.0	Not scheduled	Not decided	May be identified late 1982.
	Cameroon	Health	10.0		Not scheduled	Health	Sector being reviewed by Economic Mission.
	Papua New Guinea	Health	?	?	Not scheduled	Health and Nutrition	Sector memo completed.
	India	Population IV		75.0	Not scheduled	Population & Health	Depends on timing of India III.
	Malawi	Health II		30.0	Not scheduled	Health	Depends on progress Malawi I.
		8N°	170.0+	115.0+			

RESERVE PROJECTS

84	Ghana	Family Health		22.0	Not scheduled	Population, Health and Nutrition	Sector Memo completed. Kept in reserve due country problems.
	Botswana	Health	11.0		Preparation 9/82	Health/Population	Sector review being discussed with Government.
	Burundi	Health		10.0	Project Brief 2/83	Health	
	Zimbabwe	Health	15.0		Project Brief 2/83	Health/Nutrition	Sector mission just returned
85	YAR	Health II		?	Not scheduled	Health and Nutrition	Subject progress YAR I.
	Sri Lanka	Health I		?	Not scheduled	Health/Population	Sector Review 11/82.
86	PDRY	Health II		?	Not scheduled	Health	Subject progress PDRY I.
	Dominican Rep.	Population II		?	Identification 9/82	Population and Health	Dom. Rep. I completed 6/82.
	Bangladesh	Population IV		?	Not scheduled	Population	Subject progress Bangladesh II.

PROJECTS IN MEMO TO OVP'S JANUARY 25, 1982 BUT NOT IN RECENT LENDING PROGRAM

84	Malaysia	Population II	Dropped due lack of Gov't interest, but this now being retested.
86	Indonesia	Health II	Slipped by Region to FY87 but Region agrees it will be accommodated in Lending Program when ready, probably FY85.
	Nigeria	Health II	Slipped by Region to FY87s, but might be brought forward if Nigeria I advanced.

*Standby

WORLD BANK / INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

TO: Files

DATE: June 29, 1982

FROM: Office of the Senior Vice President, Operations

SUBJECT: Minutes of Operational Vice Presidents' Meeting of June 23, 1982

Present:

Members: Messrs. Stern (Chairman), Baum, Chaufournier, Hopper, Husain, Knox, Wapenhans, Lerdau

Others: Messrs. Evans, Fuchs, Kaji, Richardson, van der Tak, Vergin, Horsley, Kopp, Wright, Fish, North, Ms. Pratt

Perspective Planning Model

1. Messrs. Kaji and Vergin described a joint PMD/PAB project to develop better tools for the analysis of the Bank's longer-term budget and staffing requirements. A consultant has been retained to assist in the design and development of an appropriate perspective planning model. A computer simulation model has been chosen and employed to capture the dynamics of the Bank's project cycle and other aspects of the operational work programs and processes. In order to overcome the limitations of a coefficient-based input/output model, the simulation model also attempts to capture the impact of selected qualitative aspects of operational inputs and outputs on productivity, speed of response to changing operating objectives, budget requirements, staffing patterns, etc. To calibrate such a model requires inputs of a judgmental nature and it was important that these inputs be developed in consultation with operational managers. PMD and PAB therefore suggested that it would be desirable to work on the further elaboration and testing of the model with a small advisory panel of operational managers. PMD and PAB would look to this panel to enhance the realism of the model, to check sensitive data inputs and also to brief the Operational Vice Presidents, when needed, about the model's strengths and weaknesses. It was agreed that Mr. Vergin would be in contact with the Regional Vice Presidents separately regarding appointment of individuals to this advisory panel.

OPS Role in the Project Cycle

2. The meeting discussed a memorandum on OPN 1.01, "OPS Role in the Project Cycle". Mr. Baum pointed out that OPN 1.01 had been prepared partly to clarify the manner in which OPS and EIS would work together in providing review comments to Regions. Specifically, the lead adviser would speak for both Vice Presidencies with respect to Regionally-managed projects. Those present observed that the OPN clearly and accurately reflected current practice. The meeting went on to discuss perennial problems in the project review process, particularly at the Loan Committee stage. To help avoid these problems, it was agreed that the Regions would ensure tht Parts III and IV of the President's Report (the principal object of OPSVP's review) would be provided to OPS at the Yellow Cover stage. Also, advisers conveying comments on behalf of the Loan Committee members would be asked to distinguish clearly among comments that were

substantive, presentational but mandatory (i.e., reflecting "house rules" on presentation), and purely advisory. Loan Committee members would instruct their staff to avoid making stylistic comments. Memoranda to files regarding such comments, which would routinely be cleared by the advisers transmitting the comments, should include only substantive points. Loan Officers receiving comments should be instructed to record presentational points for their own use separately, and these should not be cleared or made a part of the official file record. The Regions retain primary responsibility for quality control, however, and therefore would undertake to improve their own quality control with respect to clarity and conformity with Bank policies, standards and guidelines. These improvements would be initiated immediately and progress would be reviewed in six months' time.

3. During the discussion it was suggested that OPS staff should become more involved in providing advice with regard to supervision reports. OPS would review these suggestions and circulate a memorandum on the results of this review for discussion at a subsequent OVP meeting.

Industrial Sector Review

4. Mr. Stern called attention to recent memoranda on the subject of industrial sector reviews, circulated by himself and Mr. Fuchs on June 16 and 17, respectively. A number of those present, welcoming the increased attention to sector analysis, suggested that it would be useful to discuss relationships between Bank and the IFC on sector policy and it was agreed that this topic would be scheduled for discussion upon Mr. Stern's return at the beginning of August, and that Mr. Wuttke would be invited to attend.

PHN Lending Program

5. The meeting discussed a memorandum on PHN Lending Program - FY83-86 (Evans to Baum, dated June 17), which summarized the recommendations previously agreed that:

(i) the Regions give special attention to PHN topics in selected key countries, in particular, the Indian sub-continent and Indonesia. An operational strategy should be developed for PHN involvement in each country;

(ii) the two African Regions and PHN promote health development as fast as possible in Sub-Saharan Africa as a goal in its own right and use this as a framework within which to initiate dialogue on population issues; and

(iii) the Bank reaffirm its commitment to population, using its dialogue at counry level to initiate policy discussions, create projects in health and other relevant sectors and reinforce project implementation.

In discussing the PHN Lending Program, Dr. Evans pointed out that the FY83 program appeared stable but that further strengthening in FY84 would be welcome. The FY85 program appeared quite weak. He emphasized that achieving significant progress in family planning would require an intensified program of lending in those countries with explicit population policies. Less ambitious projects, overlapping in timing in different regions of the large countries in Asia should be more effectively implemented than very large-scale, less frequent projects, and at the same time would help maintain the continuity of dialogue in this critical area. In health, small initial projects were planned to strengthen institutions and to establish credibility for policy dialogue. The Bank's emphasis on financial analysis is a distinctive contribution among agencies active in health.

6. The meeting agreed on the importance of pursuing a dialogue on population, health and nutrition, even though it was recognized that constraints existed in many borrowing countries. The addition of lending for health had been aimed at increasing the Bank's impact on population and family planning but population lending remained too low and needs to be increased. In order to emphasize the importance attached to this sector, Mr. Stern agreed to consider excepting the 35% financing limit in richer countries in the cases of population projects.

Country Economic and Sector Work

7. A series of changes in the economic and sector work program and its management had been introduced during the past year, in particular, assigning Programs Division Chiefs' responsibility for managing CESW and the establishment of the Country Policy Department. It was felt to be useful to appoint a small working group to review what has been done, whether the changes that have been introduced are working and useful, and to prepare a brief paper, systematically examining our approach to CESW, and presenting any further recommendations for improvement. Mr. Christopher Hermans had been asked to chair the group and would contact the OVPs regarding appointment of other members. When a draft report was ready in two to three months, it would be reviewed by an advisory panel composed of operational managers.

Cleared with: Messrs. Stern, Evans, van der Tak, Vergin

JPratt:ml J. Pratt

DRAFT/(0675G)
JHouston:djd
9/27/82

YEMEN ARAB REPUBLIC

Health Project

Board Presentation September 28, 1982

Theme: "Laying the Foundation for Health Care in Yemen"

Mr. Chairman, Members of the Board:

As you will have read in the report "IDA in Retrospect," when the Yemen Arab Republic became a member of IDA in 1970, it had been completely isolated from the rest of the world for many centuries and it had virtually none of the basic social or economic infrastructure needed for the development process to begin. The country had no national budget or development plan, no agricultural services of any kind, and no modern health facilities.

Yemen realized impressive achievements in economic and social development during the 1970s: real GNP per capita and adult literacy more than doubled, the primary school enrollment ratio increased from 12 percent to 34 percent, and the proportion of the population with access to safe water increased from 4 percent to what is still a modest 17 percent. In the past decade external donors participated with the Government in activities in many of the other sectors and progress has been rapid. The health sector, however, has not received as much attention. The health status of the population remains very poor. The average life expectancy is 42 years, the fifth lowest in the world. A principal cause of poor health in Yemen is the almost total lack of basic health services in the rural areas, where

90 percent of the population lives. To date, IDA has supported a number of projects in Yemen outside the health sector with components intended to attack the causes of endemic diseases. Several projects have increased access to clean water; others, mainly in urban areas, have provided sanitary sewage facilities; and finally, others have improved nutrition and supported bilharzia control programs. This project will be the first to be supported by IDA in the health sector itself. Work with UNICEF

Under this project, the Ministry of Health will be assisted to develop its capacity to plan, implement and manage a national health care system.

In 1976 the Ministry of Health adopted a design for a health services program which emphasizes the development of a village-based primary health care system. It was to be supported by higher level facilities and centralized management and planning services. Effective implementation of this program has been greatly constrained by weaknesses at the Ministry of Health, and by a lack of trained health care workers, especially middle-level personnel such as nurses. As a consequence, the available assistance for health care could not be effectively utilized; the Government's goal was to meet the basic health care needs of 20 percent of the population by 1981. In fact, it was able to reach only 5 percent. This health project will provide technical assistance, training, infrastructure and equipment to help overcome the main constraints. Specifically, key departments at the Ministry will be strengthened, and the annual ouput of trained middle-level health care workers will be doubled by 1985. The aim is to establish a strong foundation for more effective utilization of direct health care activities and their

long-term expansion. Thus the project will continue our strategy of supporting institution-building in Yemen. UNICEF has agreed to participate in this project, the first time they would be working directly with the World Bank.

(0675G)

DRAFT/(0675G)
JHouston:djd
9/24/82

YAR - HEALTH PROJECT

Board Presentation - September 28, 1982

Possible Questions and Answers

1. Question: Since health conditions in YAR are so bad, why does this project emphasize institution-building at MOH and training of health workers rather than direct health care activities?

Answer: The Government and several multilateral and bilateral donors are implementing a number of direct health care activities, including immunization campaigns and construction of health centers and health posts (para. 35). Unfortunately, these efforts have not been well coordinated, due to weaknesses in the Ministry of Health's planning and management capacity (para. 36). In addition, most of the facilities which have been constructed are understaffed, even though many are fully equipped, and so their effectiveness is greatly reduced (para. 49). This project therefore aims at laying a foundation for the long-term improvement and expansion of Yemen's rural health care system.

It could also be pointed out that IDA-assisted projects in other sectors are having a beneficial impact on public health by attacking the causes of endemic diseases in YAR. These projects have increased access to safe water supplies and sanitary sewage facilities, improved nutrition and controlled bilharzia (para. 37).

2. Question: Why is it necessary for IDA to assist with supplementing the salaries of some project staff?

Answer: Despite the recent (January 1982) increases in Government salaries, these salaries are not yet sufficient to attract and retain Yemeni staff with the qualifications and experience necessary for successful implementation of the project. It is particularly important that the 17 internationally recruited technical advisors for MOH headquarters and HMI have capable Yemeni counterparts with whom to work (para. 53).

The IDA contribution to the salary supplements will be phased out over the life of the project and the Government has agreed to progressively incorporate the supplements into the MOH recurrent budget, leading to budgetary provision for the full supplement by 1986 (Credit Agreement, Sections 3.05 and 4.03).

POPULATION, HEALTH AND NUTRITION DEPARTMENT
LENDING PROGRAM FY 83-86

FY	COUNTRY	PROJECT	AMOUNT $M IBRD	AMOUNT $M IDA	NEXT STEPS AND DATE	MAIN OBJECTIVES	COMMENTS
83	Senegal	Rural Health		15.0	Yellow cover 6/82	Health w. MCH & FP	Board Presentation 2Qr FY83
	Indonesia	Health I	80.0		Appraisal Return 6/1/82	Health inc. FP Delivery	Advanced to FY83
	Peru	Health I	25.0		Yellow cover 6/82	Health w. MCH & FP	Board Presentation 2Qr FY83
	YAR	Health I		11.0	Loan Comm. 6/82	Health	
	Malawi	Health I		10.0	Appraisal 7/82	Health/Nutrition	High Probability. Mainly technical assistance.
	Comoros	Population/Health		3.0	Appraisal 10/82	Population/Health	High Probability. Mainly technical assistance.
	Pakistan	Population		15.0	Appraisal Return 6/1/82	Population	High Probability.
		7N°	105.0	54.0			
84	Brazil	*Sao Paulo Health	50.0		Preparation 7/82	Health	Appraisal 10/82
	PDRY	*Health I		6.0	Appraisal 10/82	Health	Slowness of Preparation. May delay appraisal.
	Mali	Rural Health		17.0	Preparation 6/82	Health inc. MCH	Slowness of preparation caused slip to FY84. Appraisal 9/82.
	Upper Volta	Health I		25.0	Preparation ongoing	Health + Possible FP	Appraisal scheduled 4/83. PPF being processed.
	Lesotho	Health/Nutrition		10.0	Identification 6/82	Health & Nutrition	Builds on earlier sector review.
	Rwanda	Population		15.0	First Brief 10/82	Population & Health	Probable follow up of Population component of BGM II.
		6N°	50.0	93.0			

*Standby

POPULATION, HEALTH AND NUTRITION DEPARTMENT
LENDING PROGRAM FY 83-86

FY	COUNTRY	PROJECT	AMOUNT $M IBRD	AMOUNT $M IDA	NEXT STEPS AND DATE		MAIN OBJECTIVES	COMMENTS
85	Colombia	Nutrition II	25.0		Not scheduled.		Integ. Nutrition & Health	Scheduling dependent on progress of Nutrition I.
	Morocco	Health	30.0		Preparation	11/82	Health	PPF - Consultant being selected.
	Nigeria	Sokoto Health*	50.0		Appraisal	9/82	Health (inc. MCH), possibly population element	State Project
	Niger	Health	10.0		Preparation	6/82	Health (inc. MCP & possibly FP)	
	Thailand	Population II	85.0		Identification	Infield	Population & Health	Doubtful due attitude of Health Minister to borrowing
	China	Health I		100.0	Identification	9/82	Health	Health Sector/Identification Mission Sept. 82
	Ivory Coast	Health I		10.0	Preparation	Ongoing	Health, No FP	May be advanceable to FY84.
	Bangladesh	Population III*		40.0	Preparation	9/82	Population	Slipped from 84 at request of Region.
	India	Population III*		30.0	Preparation	9/82	Population & Health	Slipped from 84 at Region's request.
	Kenya	Population III		50.0	Not scheduled		Population & Health	Depends on progress of Kenya II.
		10N°	200.0	230.0				

*Standby

POPULATION, HEALTH AND NUTRITION DEPARTMENT
LENDING PROGRAM FY 83-86

FY	COUNTRY	PROJECT	AMOUNT $M IBRD	AMOUNT $M IDA	NEXT STEPS AND DATE	MAIN OBJECTIVES	COMMENTS
86	Brazil	Health II	100.0		Not scheduled	Health	
	Colombia	Health I	35.0		Identification 1/83	Health	Sector review discussions 10/82.
	Tunisia	Population II	25.0		Not scheduled	Health & Population	Timing subject progress Tunisia II.
	Sierra Leone	Health		10.0	Not scheduled	Not decided	May be identified late 1982.
	Cameroon	Health	10.0		Not scheduled	Health	Sector being reviewed by Economic Mission.
	Papua New Guinea	Health	?	?	Not scheduled	Health	Sector memo completed.
	India	Population IV		75.0	Not scheduled	Population & Health	Probably depends on timing of India III.
	Malawi	Health II		30.0	Not scheduled	Health	Depends on progress Malawi I.
		8N°	170.0+	115.0+			

RESERVE PROJECTS

FY	COUNTRY	PROJECT	AMOUNT $M IBRD	AMOUNT $M IDA	NEXT STEPS AND DATE	MAIN OBJECTIVES	COMMENTS
84	Ghana	Family Health		22.0	Not scheduled	Population, Health and Nutrition	Sector Memo completed. Kept in reserve due country problems.
	Botswana	Health	11.0		Not scheduled	Health/Population	Sector review being discussed with Government.
	Burundi	Health		10.0	Not scheduled	Health	
	Zimbabwe	Health	15.0		Not scheduled	Health	Sector mission just returned
85	YAR	Health II		?	Not scheduled	Health	Subject progress YAR I.
	Sri Lanka	Health I		?	Not scheduled	Health/Population	Sector Review 11/82.
86	PDRY	Health II		?	Not scheduled	Health	Subject progress PDRY I. Standby for 87.
	Dominican Rep.	Population II		?	Identification 9/82	Population and Health	Dom. Rep. I completed 6/82.
	Bangladesh	Population IV		?	Not scheduled	Population	Subject progress Bangladesh II.

PROJECTS IN MEMO TO OVP'S JANUARY 25, 1982 BUT NOT IN RECENT LENDING PROGRAM

84	Malaysia	Population II	Dropped due lack of Gov't interest, but this now being retested.
86	Indonesia	Health II	Slipped by Region to FY87s but might be brought back to FY86 or 85.
86	Nigeria	Health II	Slipped by Region to FY87s, but might be brought forward if Nigeria I advanced.

PHN FY83-86 PROGRAM BY MAIN OBJECTIVES

FY	COUNTRY	PROJECT	P	H	N
83	Senegal	Rural Health	P	H	
	Indonesia	Health I	p	H	
	Peru	Health I	P	H	
	YAR	Health I		H	
	Malawi	Health I		H	
	Comoros	Population/Health	P	H	
	Pakistan	Population I	P		
84	Brazil	S. P. Health		H	
	PDRY	Health I		H	
	Mali	Rural Health	p	H	
	Upper Volta	Health I	p	H	
	Lesotho	Health/Nutrition		H	N
	Rwanda	Population	P		
85	Colombia	Nutrition II		h	N
	Morocco	Health		H	
	Nigeria	Sokoto Health	p	H	
	Niger	Health	p	H	
	Thailand	Population II	P	H	
	China	Health		H	
	Ivory Coast	Health		H	
	Bangladesh	Population III	P	h	
	India	Population III	P	H	
	Kenya	Population III	P	H	
86	Brazil	Health II		H	
	Colombia	Health I		H	
	Tunisia	Population III	P	H	
	India	Population IV	P	H	
	Malawi	Health II		H	N

	Program Presented to OVPs		Present Status	
FY83	Malawi I)		Same	Comoros
	Mali I)		Slipped to 84	added since
	Senegal I*)	6	Same	OVP meeting.
	PDRY I*)		Slipped to 84	
	YAR I)		Same	
	Pakistan I)		Same	
FY84	Lesotho I*)		Same	
	Rwanda I)		Same	
	Upper Volta I)		Same	
	Brazil (S. Paulo)*)		Same	
	Malaysia I)	10	Dropped	
	Bangladesh III)		Slipped to 85	
	India III*)		Slipped to 85	
	Niger I)		Slipped to 85	
	Peru I*)		Advanced to 83	
	Indonesia I*)		Advanced to 83	
FY85	Kenya III)		Same	
	Nigeria I)		Same	
	Thailand II)		Same	
	YAR II*)		Put in 85 Reserve	
	Colombia N II)	11	Same	
	China I)		Same	
	Sierra Leone I*)		Slipped to 86	
	Cameroon I)		Slipped to 86	
	Ivory Coast I)		Same	
	Papua New Guinea)		Slipped to 86	
	Morocco)		Advanced to 85	
FY86	Malawi II)		Same	
	Indonesia II)		Slipped to 87s	
	PDRY II)		Put in 86 Reserve	
	Tunisia III)	8	Same	
	Colombia I)		Same	
	Brazil III)		Same	
	Nigeria II)		Slipped to 87s	
	India IV*)		Same	

PHN Lending

Prospects not shown in program

1. Egypt - population - If IBRD terms acceptable.

2. Sudan - health - $15 m earmarked for schisto work in rehab. project, but we should start dialogue on population. (Deny us opportunity to look at more appropriate way of investing in health).

3. Ethiopia - health - Economic mission will review possibilities.

4. Indonesia - population - Possible follow-up on population, say about FY84.

5. Nepal - population - Sector mission, led by Bank, just completed. Project follow-up possible. In any case, a major t.a. role for PHN.

6. Bangladesh - drug manufacture - Possibility of project jointly with A.D.B.

7. India - Accelerated program to take advantage of implementation capacity.

8. Brazil - Possible wider involvement in health - pulling together component activity into regional health program.

9. Pakistan - May be desirable to look at health sector as soon as Pop. I is launched, with view to eventual better coordination of H&P programs.

June 1, 1982
JDN/rb