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INTERNATIONAL FINANCIAL INSTITUTIONS AND POPULATIONS PROGRAMS: A SURVEY OF CURRENT ACTIVITY

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Abstract. This report examines the population or family planning activities financed by the international financial institutions (IFIs), based on a survey of their activities. Only the World Bank and the Asian Development Bank current fund family planning projects. Reference is made to the international framework for family planning activity approved by the International Conference on Population and Development, held in Cairo in 1994. Tables are included listing all family planning programs funded by the World Bank and the Asian Development Bank between 1993 and 1997.

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ABSTRACT

This report examines the population or family planning activities financed by the international financial institutions (IFIs), based on a survey of their activities. Only the World Bank and the Asian Development Bank currently fund family planning projects. The regional multilateral development banks do not fund projects in this area. The International Monetary Fund also does not finance projects. Brief reference is made to the international framework for family planning activity approved by the International Conference on Population and Development, held in Cairo in 1994. Tables are included listing all family planning programs funded by the World Bank and ADB between 1993 and 1997. The report will be updated if the IFIs should institute significant policy changes in this area.

International Financial Institutions and Population Programs

Summary

Congress has been considering legislation to approve U.S. participation in an expansion of the financial resources of the International Monetary Fund (IMF) and to appropriate annual funding for the multilateral development banks (MDBs). In that context, Members of Congress have raised questions whether the international financial institutions (that is, the IMF and MDBs) finance population or family planning programs and whether their programs in this area finance abortion. This paper describes the policies and the activities of the IMF and the multilateral banks in this regard.

The International Monetary Fund does not finance projects in its borrower countries. In particular, it does not finance projects aimed at helping countries provide family planning services or other activities aimed at limiting the growth of their population. The United Nations Conference on Population and Development, held in Cairo in September 1994, identified a number of important issues and highlighted roles that bilateral and multilateral agencies could play regarding this issue. It did not specify any role for the IMF in this issue. The IMF Managing Director, in his address to the Conference, emphasized that rapid economic growth was a principal means for cutting the link between poverty and rapid population growth and for creating the domestic environment in which countries could "complete the transition to appropriate fertility levels."

The World Bank and Asian Development Bank (ADB) regularly lend to help countries undertake family planning and population programs. Between 1993 and 1997, the World Bank lent an estimated $870 million and the ADB allocated $65 million for family planning activities. This was approximately 1% of total World Bank lending and two tenths of 1% of ADB total lending for this period. In recent years, the World Bank and ADB have moved from funding free-standing family planning programs towards programs that treat family planning as one element in a more comprehensive health program. The ADB does not finance abortion and it normally allows other foreign aid providers to fund the purchase of contraceptive materials. The World Bank finances the purchase of contraceptives. In recent years, the World Bank has begun to shift its focus in the health sector from one of supporting specific autonomous projects to one of supporting comprehensive multi-donor programs to strengthen national health care systems. In the process, in countries where abortion is legal and abortion services are supplied by government health providers, Bank loans may help support institutions that provide that service, notwithstanding a general understanding that the Bank does not fund abortion programs. One instance has been identified where the World Bank has financed the purchase of suction equipment with the explicit understanding that it will be used for the medical termination of pregnancy.

The Inter-American Development Bank, European Bank for Reconstruction and Development, and African Development Bank do not finance family planning or population projects.

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In 1997 and 1998, Congress has been considering legislation to approve U.S. participation in an expansion of the financial resources of the International Monetary Fund (IMF) and to authorize annual funding for the multilateral development banks (MDBs). In that context, some Members of Congress have raised questions about whether the international financial institutions (IFIs) -- that is, the IMF and MDBs -- finance population or family planning programs and whether their programs in this area finance abortion. This paper describes the policies and the activities of the IMF and the MDBs in this regard. In particular, it analyzes several projects that the multilateral banks have said are exemplars of their activity and their approach to population or family planning issues.

Development is, by its very nature, a process entailing fundamental change. Development agencies often act as catalysts, urging or pushing countries to consider changes in their perceptions, policies, procedures, and priorities. Along this line, the international financial institutions (IFIs) often make a significant effort to encourage countries to consider new ideas and new ways of dealing with their problems.

Even so, the international financial institutions (IFIs) are hesitant about imposing social or cultural values on countries. Governments may be unwilling to accept the imposition of values that contradict their countries' basic cultural norms, and the backlash against pressure of this sort can have a far-reaching negative effect on the an IFI's relationship with that country.

Additionally, borrower countries have considerable influence within the IFIs themselves. In the Asian Development Bank (ADB), Inter-American Development Bank (IDB), and African Development Bank (AFDB), regional countries own a majority of the voting stock and have substantial influence. In the European Bank for Reconstruction and Development (EBRD), the borrower countries (or non-regional countries that are borrowers from other MDBs) control only 12.7% of the voting stock. However, Western European countries that share close cultural similarities with the borrower countries in Eastern and Central Europe own an additional 65% of EBRD voting stock. Industrial countries own a majority of the voting stock in the IMF and all the loans windows of the World Bank. But developing countries have a significant share of the vote -- 39% in the IMF, 43% in the International Bank for Reconstruction and Development (IBRD), World Bank's market-rate loan window, and 38% in the International Development Association (IDA), the World Bank's concessional loan facility. This gives the borrower countries considerable influence, as well as a sense of participation and ownership that encourages cooperation and helps diminish potential donor-recipient tensions within the multilateral bodies.

The IFIs do not implement projects or programs directly. Rather, they help finance programs or projects implemented by their borrower country governments or the governments' subsidiaries or designees. The IFIs may have a substantial role in the project design process. They may require, in connection with structural adjustment loans, that borrower countries adopt economic policy reforms the latter find painful. For project loans, the IFIs may require borrowers take financial, technical, organizational, or legal steps deemed necessary for the success of proposed project. These conditions are generally related to the goal of project effectiveness and normally consistent with the principle set forth in their charters,[1] that "only economic considerations shall be relevant to [IFI] decisions."

In general, the international financial institutions are sensitive to the cultural values and religious belief systems of their borrower countries. Considering the influence that borrower countries have in the banks and the stipulation that only economic considerations should be relevant, the IFIs tend to be circumspect about issues likely to offend the cultural or moral sensitivities of their borrower countries. This is particularly true as regards issues such as family planning. Developing countries vary considerably in their attitudes and cultural norms. Activities and policies that are deemed acceptable or appropriate in some developing countries are not acceptable in others. It is in this context that the multilateral agencies finance their social sector lending.

International Monetary Fund

The IMF does not make projects loans and, in particular, it does not make loans to finance population or family planning programs. IMF loans are intended to help the borrower countries stabilize their economic situation and cover (and ultimately reverse) chronic deficits in their balance of payments. Generally, a country's central bank is the borrower and recipient of the IMF funds. It uses the proceeds to help cover the country's international payment obligations (debts, imports, etc.). To receive an IMF loan, the borrower country must file a letter of intent with the IMF, describing the steps it will take to rectify its economic situation. When the IMF approves a loan, it opens up a line of credit for the borrower country and it disburses money against that line of credit when the country shows that it has met the targets and schedule specified in its letter of intent.

In April 1994, the joint IMF-World Bank ministerial committee on the transfer of resources to developing countries (Development Committee) discussed issues relating to the upcoming United Nations Conference on Population and Development, held in Cairo that September. The participants on the Development Committee are high ranking financial officials (Minister of Finance or equivalent) in their home countries. The press communique issued following the Development Committee meeting reported that the participants agreed that the world's population was likely to double in the next fifty years, if it continued growing at its present rate, and they said the "massive economic, social, political, and environmental

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[1]See, for example: Articles of Agreement of the International Bank for Reconstruction and Development. Article IV, Section 10. TIAS 1503; TIAS 5929.

consequences of these changes cannot be ignored." The ministers agreed that people should have the right to decide freely and responsibly on the number and spacing of their children. They also said that "family planning is only one of the available instruments and needs to be seen in the broader context of changing social patterns and the increased awareness of women's role." The ministers agreed that more emphasis should be given to improve the primary school enrollment rate, improve access to family planning and related health services, and to reduce maternal and child mortality in developing countries.[2]

No functions for the implementation of these goals were specified for the IMF. The Ministers approved of the fact that the World Bank had increased its lending for population, health, nutrition, and education programs and they welcomed the Bank's willingness to respond to further requests in those areas. They said they recognized "that the Bank is not the principal organization concerned with population, but that its policy dialog and wider operations give it a unique opportunity to promote population policies." They called on the Bank, donors, other multilaterals such as UNFPA and borrower country governments "to collaborate fully in operations and in mobilizing the institutional and financial resources needed...."[3]

The press communique issued following the Development Committee's October 1994 meeting reports that the ministers "welcomed the outcome of the recent United Nations Conference on Population and Development" and they "called on the World Bank and conference participants to play an active role in implementing the Program of Action approved by the Conference.[4]" No role was specified for the IMF. The IMF annual reports for 1994 and 1995 reprinted the press communiques issued by the Development Committee as well as copies of resolutions adopted by the IMF Interim Committee and the IMF executive board during those years.

The IMF has made no official statements regarding family planning or population policy. The closest thing to this may be the address [5] to the 1994 population conference in Cairo by IMF Managing Director Michel Camdessus, in which he noted that rapid population growth in the context of poverty was the source of many serious problems. The central concern, he said, is the need for more economic growth. This will raise living standards and "create the domestic environment needed to complete the transition to appropriate fertility levels...." To achieve high-quality growth, he maintained, countries need sound macroeconomic policies, appropriate structural policies, a trade and exchange regime open to international trade and investment, good governance, and effective social policies

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[2]Joint Ministerial Committee of the Boards of Governors of the Bank and the Fund on the Transfer of Real Resources to Developing Countries (Development Committee). Press Communique. Forty-eighth Meeting, Washington, April 26, 1994. Reprinted in the IMF *Annual Report, 1994*, pp. 204-5.

[3]*Ibid*., p. 205.

[4]Development Committee. Press Communique. Forty-ninth Meeting, Madrid, October 3, 1994. Reprinted in the IMF *Annual Report, 1995*, p. 214.

[5]Address by Michel Camdessus to the UN International Conference on Population and Development, Cairo, September 5, 1994. Photocopy supplied by IMF External Relations.

that militate against poverty, provide education for girls and women, and enable people "to exercise freely and responsibly their rights of parenthood, including the number and spacing of their children." The principal focus of his remarks addressed the need for improved economic policies in developing countries and international cooperation to create a more open world economic system.

Except for the above references to action by the Development Committee, the IMF does not mention population or family planning in its recent annual reports. No action by the executive board on this subject is mentioned and no publications or studies on this topic are listed in the back of its annual reports.

The World Bank

World Bank Policy

The World Bank regularly lends to help countries undertake family planning programs. It has made loans for this purpose from its market-rate loan window, the International Bank for Reconstruction and Development (IBRD), and from its concessional loan facility, the International Development Association (IDA). The International Finance Corporation (IFC) and Multilateral Investment Guarantee Agency (MIGA), the Bank's affiliates oriented towards private sector activity, have not been active in this area.

The World Bank published a book in 1994,[6] in connection with the population conference in Cairo, outlining its position regarding population programs. It makes five basic points: (1) slowing population growth is still a high priority in the poorest countries; (2) population policy should be integrated with social policies that address a range of poverty reduction and human development objectives; (3) population programs should provide the poor with access to high-quality, user-oriented services that offer a range of choices for fertility regulation and other reproductive health needs; (4) country specific strategies are required; and (5) other demographic issues such as urbanization, migration and aging must also be addressed. The book says there is a growing consensus "that population policy objectives should be integrated with broader social development goals and that population program strategies should build on the linkages between demographic behavior and social and economic progress." In particular, it says, "interventions which are responsive to individual needs and aspirations are not only better from a humanitarian and social development perspective but also more effective in lowering fertility than are programs driven by top-down demographic targets."

For the most part, the book treats the prevalence of resort to abortion as an issue of concern, especially the use of abortion as a means of fertility control in some countries (Ukraine, for example) with moderate rates of population growth. It also notes that women in poor countries may resort to abortion when the inadequacies in available methods leads to contraceptive failure. The book argues that the level of

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[6]World Bank. *Population and Development: Implications for the World Bank. Washington, D.C., August 1994.*

contraceptive use will go up, the health of women will be improved, and rates of abortion will go down if women and girls are educated, if family planning becomes an aspect of basic health programs and if patients are able to select (from a range of modern methods) the birth control methods most appropriate for themselves. The book notes, in box 1-1, that the idea of offering project staff or prospective recipients financial inducements in order to achieve numerical targets for the use of specific birth control techniques is controversial and dubious. It says that targets, if needed, "should be stated in terms of the proportion of individuals who are provided with quality services" rather than specific reductions in the fertility rate or adoption of particular methods. The book also argues, in box 6-2, that services for the management of unwanted pregnancy, including "medical termination of pregnancy (where permitted)" is part of the "essential women's health package" it recommends. It says in the text that the "components of the package will vary on a country-by-country basis, depending on local needs and institutional and financial capacity."

In his introduction to the volume, Armeane Choki, then-vice president for human resource development and operations policy at the Bank, emphasized the need for action to reduce maternal and child mortality in developing countries, to increase women's education, and to raise their economic and social status. "Such investments are beneficial in their own right,' he said, "and will also help slow rapid population growth." Likewise, he said, sustainable economic growth is a "prerequisite for human development and for completion of the demographic transition."

Current Practice

In its 1997 annual report, the World Bank indicated that it is trying "to more closely link population policies with reproductive health policies, thus integrating them into poverty reduction effort and the overall development agenda." It said that two projects approved that year, a $100 million loan to Argentina and a $248 million loan to India, illustrate this approach.

The Argentine loan helps fund the second phase of the country's maternal health and child welfare program. All provinces that elect to participate in the Argentina government program must provide the same package of services. The program aims to reduce the rates of childhood and maternal mortality in Argentina through immunization, improved nutrition, and better prenatal, neonatal, and post-partum maternal care. It also provides family planning services. The World Bank estimates that approximately 31% of the money from the loan will be used to fund reproductive health activities. It has no separate figure for family planning alone. Spokesmen for the potential beneficiaries and for relevant non-governmental organization (NGOs) are supposed to participate in the design and implementation of the program. There is no indication in the project documents[7] whether particular birth control methods will be emphasized or whether project staff will receive incentives to encourage increased utilization of this aspect of the program. The documents seem to suggest, however, that women's participation in the family planning aspect of the program

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[7]World Bank. *Project Appraisal Document for a Proposed Loan in the Amount of US$100.0 million to the Argentine Republic for a Second Maternal and Child Health and Nutrition Project*. April 24, 1997. Report 16419-AR.

will be voluntary. The private sector provides most of the medical care in Argentina. Government programs are basically supplemental and directed at specific needs. Abortion is not legal in Argentina.

The loan to India helps finance an expansion of the government's Family Welfare Program in 19 rural or tribal areas and 7 urban slums. The combined population of the areas to be served is about 36 million persons. According to the World Bank project appraisal document,[8] the project aims at "reducing maternal and infant mortality and morbidity, and unwanted fertility, thereby eventually contributing to stabilization of population growth." It focuses on helping women and children below five years of age by improving health during reproductive years and early childhood and by enabling couples to space or limit births.

The total cost of expanding the Family Welfare Program through this project is about $309 million over five years, of which $284 million will be provided by IDA. The World Bank says the Family Welfare Program is a component of the Indian government health care system. When all other costs are included and allowance is made for the input by the national and state governments and other donors, the World Bank estimates that it is financing about 15% of the cost of the health care system.

The Indian project will reportedly use a "participatory management approach" to family planning. The project appraisal document says this model, previously called the "target free" approach, "removes management incentives that have placed excessive focus on achieving annual method-specific contraceptive acceptor targets." The removal of all such targets or incentives by the Government of India is a specified condition the World Bank required for execution of the loan. The World Bank document says that different types of contraception will be available, depending on the preference of the user, to meet the needs of people at different stages of their life cycle. "It is the central hypothesis of the project that a more client-oriented service which offers greater contraceptive choice and the ability to give attention to reproductive health needs will, together with reductions in infant and child mortality, increase the utilization of family planning services." In effect, it says, this means a shift away from permanent methods (sterilization) to temporary methods, which allow control over the spacing of births.

The India loan document provides a comprehensive description of the Family Welfare Program's "package of essential RCH [reproductive and child health] services" that will be provided by the project. In the section outlining procedures for the prevention and management of unwanted pregnancy (p. 105), it mentions oral contraceptives, condoms, tubal ligations and vasectomies, IUDs (with required screening for contraindications), and counseling and medical termination of pregnancy within first trimester or referral to a district health center for termination of pregnancy in the second trimester.[9] NGO and private sector services will be involved in the delivery of services, though the public sector will continue to play the

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[8]World Bank. *Project Appraisal Document, India Reproductive and Child Health Project*. April 29, 1997. Report 16393-IN.

[9] Among the items to purchased in conjunction with the project are "suction apparatus (equipment) for the medical termination of pregnancy" (p. 36).

central role. NGOs and beneficiaries will be involved in monitoring implementation of the program. The World Bank estimates that half the proceeds from the $248 million loan will be used for reproductive health activities. No separate figure for family planning is available. Because of the high levels of poverty, government-run programs account for a substantial share of the medical care available in India. Abortion is legal in India and is regularly available through the health care system administered by the national government or by individual Indian states.

The Indian loan underscores what seems to be an emerging trend in foreign aid funding in the health sector -- consolidated multi-donor funding for general health care systems rather than targeted single-donor funding for specific activities. According to the World Bank, foreign aid donors often have focused in the past on particular diseases or on specific issues, such as immunization, family planning, nutrition, maternal and child health, or family planning. Separate administrative structures needed to be created to administer each program, in order to assure that project funds were used for only the designated purposes and to guarantee that the policy or procedural requirements for each donor were met. The result could be a hodgepodge of fiefdoms, where programs addressing the same problem could have different requirements, depending on the source of funding, and the recipient country's ability to fund its overall health care system could be limited by the requirement that it provide local currency counterpart funds to match the foreign aid money provided for the special programs. Because the overall composition of the health care system was often beyond the scope of their individual projects, foreign aid donors sometimes lacked opportunities to address general issues of priority and emphasis. Countries could use their own money to finance high-tech medical treatment facilities for elites, for example, while expecting foreign aid agencies to help cover the cost of basic care for the general public.

The move towards consolidated funding is reportedly an effort to remedy this situation. The recipient country government includes the issues of special concern in its national health care system and the donor agencies each agree to underwrite a specific share of the system's cost. As long as items are on the approved list of goods and services that will be financed and they meet the procedural requirements for procurement (international competitive bidding), for example, the World Bank will disburse funds to support its agreed percentage share of a particular aspect of the Indian care system.

From an operational or administrative perspective, the many development specialists view this new approach as an improvement. It is more efficient, it involves less micro-management, and it gives the World Bank and other foreign aid providers opportunities to influence the overall composition of the countries' health care systems. From a policy perspective, however, the new approach limits a foreign aid donor's scope of policy choice. In the past, there was a general understanding that the World Bank did not finance abortion in its family planning or population programs. If a developing country wanted to include abortion on its menu of possible services, it could seek bilateral funding from countries that offered such assistance. Under the new approach, however, the World Bank and other donors all finance a share of all the medical services provided by the national health regime. If abortion is one of the medical services the system offers, then in effect the foreign aid donors will finance a share of that service along with the other system costs.

In the case of the India loan, the World Bank seems to have accepted the idea that the Indian government should make the basic policy decisions in this area, even though it will be paying roughly 90% of the costs for the particular functions covered by the loan, and it stated in the project document that the suction equipment financed by the loan (equipment that can have non-abortion related medical uses) would be provided for the purpose of medical termination of pregnancy. World Bank staff argue that they do not advocate abortion or believe that it is an appropriate birth control technique. They say the Bank-funded family planning programs such as the one in India are likely to reduce the incidence of abortion because they assure women access to adequate contraception. They also say that other Bank programs, such as education for girls, have an intended effect over time in reducing the incidence of abortion. They say the Bank will not allow its funds to be used for sex-selection activities or to fund population programs in countries where such practices are likely to be supported.

World Bank Funding for Family Planning Programs, 1993-1997

The World Bank reports that, between 1993 and 1997, all but 14 of its 106 loans in the Population, Health and Nutrition Sector and 2 of the loans in its Social Sector involved reproductive health. (Population and family planning activities are included in the total for reproductive health activities. Since 1995, the World Bank has not regularly reported figures for population programs alone.) Table 1 (at the end of this report) shows all the loans since 1993 that reportedly help fund reproductive health activities. The total amount for the 94 loans was $7.08 billion; the Bank says that $1.96 billion of this funded reproductive health activities.

Analysis of the data suggests, however, that the World Bank's emphasis on family planning and reproductive health is probably less than these figures would suggest. Four of the projects on Table 1 dealt only with the prevention and treatment of sexually-transmitted disease (AIDS, etc.), clearly an important issue but a different one from the subject addressed in this report. Several other projects (some of them very large) had no reported outlays for reproductive health. These are shown as NA ("not available") on the table. It is not evident why the World Bank included them on its list. Furthermore, of the 70 projects designed to finance the delivery of health services, only 33 allocated a third or more of their resources for reproductive health. Many devoted only a small fraction for this purpose.

In 1993 and 1994, the World Bank channeled into population or family planning programs some 75% of the $446 million it lent to fund reproductive health activities other than those targeting sexually transmitted disease. If this trend continued during the period 1995 through 1997,[10] then one can estimate that $870 million of the $1.18 billion the World Bank lent for reproductive health programs other than the suppression of sexually transmitted disease during those years went to fund family planning. For the period 1993 through 1997, the total would be about $1.21 billion.

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[10]This assumption may not be sound, however, as the model used for family planning after 1994 involved a considerably larger outlay for medical care than did the model used before that date.

This is 17% of the total the World Bank lent (committed) in the Population, Health and Nutrition Sector and 1% of the total it lent for all purposes during this period.

The Asian Development Bank

ADB Policy

The Asian Development also lends to help support population or family planning programs in borrower countries. Most of its loans for this purpose have been funded by its concessional loan window, the Asian Development Fund (ADF), though projects in the more economically advanced regional countries such as Indonesia have funded by the ADB's regular market-rate loan program.

The ADB's policy in this area is set forth in a policy paper[11] published in 1994, in preparation for the Cairo population conference that year. The study said that "Integration of family planning with health and community development efforts as fully as possible is the preferred route to sustaining fertility decline in the context of general improvement in human welfare." This replaced an earlier strategy, described in a 1991 ADB publication, which said that population and health issues could be dealt with separately.[12] The 1994 study said that particular emphasis should be given to programs that reduce maternal and child mortality, improve prenatal, neonatal, reproductive health and child welfare, and expand female education. The approach stresses the availability of service, wide choice of methods, and reliable follow-up activity to monitor results. The sector study said "The crucial variable is the educated and healthy Asian woman able to manage her productive and reproductive life in the best interest of family and society." The report also specified that "future health projects should consider integrating population components unless there is a prohibitive reason for not doing so."

The policy statement said there should be a clear distinction between public polices that encourage couples to have fewer children and policies that coerce couples in this respect. "Protection of this most intimate right (planning one's family) is the *sine qua non* of humane population policy," it concluded. It also said that evidence regarding effectiveness does not provide "a convincing rationale for fertility policies involving client-targeted financial incentives or various forms of coercion." The document does not address the issue of abortion. It indicated, though, that provision of a wider and more appropriate choice of birth control methods appropriate to prospective users should encourage use of contraception and lessen the incidence of unwanted pregnancy.

The ADB study found that there are four types of developing countries in the region: those with little or no concern, some concern, moderate concern, or high

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[11]Asian Development Bank. *Population Policy: Framework for Assistance in the Population Sector*. Manila, 1994. Approved by the ADB Board of Directors July 12, 1994.

[12]Asian Development Bank. *Health, Population and Development in Asia and the Pacific.* Manila, 1991. Approved by the President of the ADB April 11, 1991.

concern about population planning and population issues. The approach that the Bank takes for each type of country will vary. In countries with little or only some concern, the report said the Bank should gather information, consult with officials, and provide technical assistance. Population activities might be a component of ADB education or health loans in these countries. On the other hand, in countries where there is greater concern about population issues, the report said the ADB should undertake detailed studies, it should help the country strengthen the relevant institutions and policies and it should finance integrated population and family planning projects or even stand-alone population projects when appropriate.

The study said that "resources for population activities need to be concentrated in DMCs [developing member countries] that face acute population-resource problems and have not been able to bring down population growth rates sufficiently in the past." It identified Afghanistan, Bangladesh, Bhutan, Cambodia, India, Laos, Nepal, Pakistan, Philippines, and Vietnam as being of particular concern.

Current Practice

The ADB said, in its 1996 annual report (the most recent report available) that its "main objective for the health and population subsector is to improve the quality of services, increase efficiency, and widen access, particularly for women and children, to primary health care and family planning services." The annual report emphasized in particular health projects the ADB had agreed to fund in Cambodia, Indonesia, and Vietnam. The ADB also approved another project involving family planning that year, not mentioned in the health section of the annual report, in Pakistan. The ADB has also made public its country economic reviews for Cambodia, Vietnam, and Pakistan. Consequently, it is possible to see how the population projects approved in 1996 fit into the ADB's analysis and policy framework for those countries.

Funded jointly by the ADB, the World Bank/IDA, and the German export finance agency, the ADB's $43 million loan to Vietnam in 1996 for a population and family health project emphasizes safe motherhood and family health in order to improve population services in 15 provinces having a population of 20 million persons. The ADB estimates that about $8.6 million of the total will be used specifically to fund family planning activities. IDA is financing the purchase of all contraceptive supplies and the family planning health delivery services in 5 provinces. The ADB will fund the delivery of these services in 10 other provinces. The project will involve the private sector and NGOs in the provision of services. It will offer a broader variety of modern contraceptive methods; the ADB believes this will help reduce reliance on IUDs and sterilization, with their attendant problems of infection, overuse, and non-use by younger women. It also believes this will also reduce the number of abortions. Abortion is legal in Vietnam. The project emphasizes health care for mothers and children and education on family health. There is no indication in the project proposal[13] how Vietnam's current policies

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[13]Asian Development Bank. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Socialist Republic of Viet Nam for the Population and*

(continued...)

limiting family size will be related to the program or if program staff will have incentives to encourage public participation in the program. The project document says population growth is a major problem in Vietnam.

The ADB country economic review for Vietnam[14] mentions the population issue only in passing. It focuses instead on the flow of people from rural to urban areas that are unprepared to receive so many new residents. One sentences says a reduction in the population growth rate would lessen the pressure in that regard.

The ADB's $200 million loan to Pakistan for its Social Action Program Project in 1996 funds part of the $1.5 billion foreign exchange cost of the $7 billion program. Bilateral foreign aid agencies and the World Bank will fund the other foreign exchange costs and the Government of Pakistan will pay the remaining $5.5 billion cost. The project has four components: primary health, primary education, population welfare, and rural water supply and sanitation. The ADB estimates that, of the $200 million provided by the loan, $32.6 million will be used to fund health programs, including $7.3 million for family planning or population activities.

In the population area, the Pakistan loan aims to expand coverage by family planning outlets from 40% to 85% of the population by the year 2000. Operations will be integrated with the health, education, and water and sewerage components of the program and decentralized. Beneficiaries and NGOs will be involved in its preparation and implementation. There is no discussion in the project document[15] whether project staff will have targets, quotas or incentives to encourage public participation or what types of family planning methods will be available to patients. Abortion is not legal in Pakistan.

The Bank's country economic review for Pakistan notes that high population growth and low rates of economic growth are major barriers to the elimination of poverty. It attributes the country's high levels of unemployment and underemployment to these problems. The primary focus of the country economic review[16] centers on ways for promoting economic growth. It stresses, in particular, the need for sound economic policy, more investment and saving, more foreign investment, and judicial and legal reform to facilitate private sector growth. Discussion of population issues is limited to a few early sentences in the study.

The ADB's $20 million loan to Cambodia in 1996 funds all the foreign exchange costs and 80% of the total costs for the country's new basic health services

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[13](...continued)
Family Health Project. August 1996. Doc. RRP:VIE 26378

[14]Asian Development Bank. *Country Economic Review, Socialist Republic of Viet Nam*. October 1997. Doc. CER:VIE 97021.

[15]Asian Development Bank. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Islamic Republic of Pakistan for the Social Action Program (Sector) Project II*. November 1996. Doc. RRP:PAK 28330.

[16]Asian Development Bank. *Country Economic Review: Islamic Republic of Pakistan.* September 1997. Doc. CER:PAK 97013.

project. The objective is to reduce preventable mortality and morbidity, particularly for poor women and children in rural communities, in five provinces that previously lacked basic health care service. There is no separate emphasis on family planning. The ADB reported, when queried, that none of the funds for the project will be used for family planning activities. However, depo-provera and progesterone are listed among the medications to be purchased and one of the 18 objectively verifiable indicators is the goal that at least half the married women aged 15 to 45 will know at least three modern methods of birth spacing and a source of supply for each. The ADB country economic review[17] lists health and education as areas of major concern but does not mention population growth as a factor inhibiting Cambodian development. Improvements in economic policy and performance are the main focus of the review.

The ADB's fourth action in 1996 to help fund family planning was a $45 million market-rate loan to Indonesia for a family health and nutrition project. It will provide basic health services to poor villages in five provinces. It aims to help families identify their health needs and make informed decisions to address them via public health facilities. Some 122,000 families are potential beneficiaries. According to the project document[18] each family's health needs will be identified and listed on a family health card and families will be responsible for updating the card and taking appropriate action, after consulting with health workers. "Capacity building...and empowerment of the beneficiaries to become responsible for their health are key objectives of the Project," the document reports. The ADB reported, when queried, that no funds from the loan are being be used to finance family planning activity. The design summary for the project (p. 41) indicates, however, that "family partnership for health, nutrition and family planning" is one of the project components and a 20% increase in the contraceptive prevalence rate and a 20% increase in new family planning users are specified output indicators. The project seeks to strengthen the capacity of village-level health centers and provide needed resources. It will provide resources to community organizations to better support their health initiatives and help them serve as a village health committee. Each village committee will analyze each family's priorities and actions and maintain a village health map. The project will also support mini-campaigns at the local level. There is no indication in the project document how the family planning aspects of the project will be implemented or what methods will be available to potential users, how the privacy of patients will be maintained, how patients will be protected from pressure for services they do not desire, and whether community mobilizers or project staff will be given incentives or targets to encourage participation. No country economic review for Indonesia is currently available.

ADB staff report that the Bank usually looks to the World Health Organization (WHO) or the U.N. Population Program (UNFPA) regarding the contraceptives and procedures that may be supported through ADB projects. The ADB only finances

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[17]Asian Development Bank. *Country Economic Review: Cambodia.* October 1996. Doc. CER:CAM 96022.

[18]Asian Development Bank. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Republic of Indonesia for the Family Health and Nutrition Project.* September 1996. Doc. RRP:INO 28074.

the purchase of contraceptive supplies when other funding sources are unavailable. The U.N. agencies are the preferred source of supply. ADB staff say a few ADB projects have provided supplies of condoms, birth control pills, IUDs, and injectable forms of contraception when a funding gap existed. None directly financed the provision of vasectomy or tubal ligation. ADB staff emphasize that the Bank does not provide funding for abortion. It is unclear whether other international or bilateral aid providers are financing surgical forms of contraception or abortion in connection with national programs the ADB is also supporting with its projects.

The ADB stressed, when asked, that its policy specifically prohibits any use of coercion or inappropriate incentives to influence clients to participate in population programs against their personal wishes or best interests. ADB staff report that "A careful review of the projects approved since 1993 reveals that all comply with the letter and the spirit of the Bank's policy." In particular, as regards the four projects discussed above, ADB staff state emphatically that "there are no cases where coercion or inappropriate incentives have been sanctioned or tolerated in these Projects." ADB staff did not indicate, however, if specific directives to this effect have been issued to project staff in the four countries or if disciplinary procedures have been specified or used to assure compliance with the policy.

ADB Funding for Family Planning Programs, 1993-1997

Between 1993 and 1997, the ADB made 18 loans to finance health programs. The two projects approved in 1995 and the six projects approved in 1997 seem not to have had a population component. The other health projects approved during these years had some family planning components, though the cost of those components in some cases (the Cambodian and Indonesian loans discussed above, for instance) may have been small. The combined total for these 10 loans was $494 million. The ADB says that, of this amount, about $65 million was to be used to support family planning activities. This was approximately 11% of total ADB lending in the health sector and about two tenths of 1% of total ADB lending for the 1993 to 1997 period.

Other Multilateral Banks

The Inter-American Development Bank (IDB) has a policy on population but it makes no loans for population programs. The European Bank for Reconstruction and Development (EBRD) and the African Development Bank (AFDB) have no policies on population and they make no loans in that area.

The IDB indicates, in its population policy statement,[19] that it wants "to avoid an oversimplification of the population problem which would lead to the conclusion that a reduction in the rate of population growth will in itself bring about social and

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[19]Inter-American Development Bank. *OP [*Operations Policy*]-741 Population*. IDB home page: http://www.iadb,org/poli/OP-741E.htm.

economic development." The IDB says it will focus on development and it will continue to emphasize the need for investment in the social fields as a concomitant to economic growth. The IDB may do demographic analyses as appropriate. It will also finance health projects to address maternal-child health concerns through improvements in modern health institutions and more integrated health systems aimed at meeting the needs of campesinos and marginal urban groups. The IDB's policy statement regarding public health[20] reiterates these concerns but makes no mention of any support for family planning activities.

The EBRD has made no loans in the health sector. The Inter-American Development Bank approved nine projects between 1993 and 1996 (the last year for which complete information is available) that address health services in a direct way. Several (in Brazil, Guatemala, Panama, Peru, and Venezuela) focused on health sector policy reform, though they also planned to provide increased services in low-income areas. Loans to strengthen the social investment funds in El Salvador, Guatemala, and Honduras aimed at improving facilities for local health care in poor villages, among other things (such as schools, water and sewerage, etc.) Improved health care for low-income people was also a goal of the social impact amelioration loan to Guyana. Maternal health and child welfare were sometimes mentioned as issues of special concern for all these projects but there was no indication in the IDB annual reports that family planning or population issues would be addressed. The combined total for the nine loans that dealt with health care issues was $788 million, about 3% of the IDB's total lending during this four year period.

The African Development Bank made two loans in 1994 through its regular market rate loan window to strengthen health care services in Gabon and Mauritius. It also made a private sector loan in 1995 to help investors build a state-of-the-art diagnostic health center in Nigeria. The combined total for these loans was $67 million, a little over 1% of the AFDB's market-rate lending for the 1993-1996 period. The AFDB's concessional loan affiliate, the African Development Fund (AFDF) made several additional loans in 1993 and 1996 for health projects. (The AFDF suspended operations in 1994 and 1995 due to disagreements between the Bank and donor countries.) Loans to Benin, Chad, Niger, and Uganda in 1993 sought to improve basic health care service in rural areas and strengthen the countries' health policies and their national health institutions. The four loans totaled $39 million, about 4% of AFDF lending that year. In 1996, the AFDF approved loans to Mozambique and Rwanda to reestablish basic health service in areas damaged by conflict and experiencing heavy inflows of returnees. The two loans totaled $18 million, about 3% of AFDF lending in 1996. There was no mention of family planning or population issues in any of the loans approved by the AFDB and AFDF. A 1993 loan to Senegal funded a demographic study of population movements and residency patterns in that country, in order to help improve development and economic policy. Though titled a "population" study, it was not a family planning project.

[20]Inter-American Development Bank. *OP [Operations Policy]-742 Public Health.* IDB home page: http://www/iadb.org/poli/OP-742E.htm.

Table 1. World Bank Lending for Population and Reproductive Health Activities (RHA), 1993-1997 (millions of U.S. dollars)

Year	*Country*	*Project Name*	*Loan Total*	*Amount for Pop*	*Amount for Pop & RHA*
1993	Angola	First Health	19.9	-.-	1.20
	Burundi	Social Action	10.4	.50	.50
	Guinea-Bissau	Social Action	8.8	.90	.90
	Zimbabwe	STD Prevent/Care	64.5	-.-	64.50
	Philippines	Urban Health & Nutrition	70.0	17.50	35.00
	Honduras	Nutrition & Health	25.0	.01	1.00
	Yemen	Family Health	26.6	10.70	13.30
	India	Integrated Child Dev Services	194.0	-.-	19.40
	India	Social Safety Net	500.0	40.00	40.00
	Pakistan	Second Family Health	48.0	12.00	18.20
	Indonesia	Third Com Health & Nutrition	93.5	9.40	37.40
	Papua New Guinea	Population & Family Planning	6.9	5.90	6.90
	Chile	Health Sector Reform	90.0	-.-	.80
	Colombia	Municipal Health	50.0	5.00	10.00
	Ecuador	Second Social Development	70.0	15.40	23.10
	Guatemala	Social Investment	20.0	.60	.60
	Iran	Health & Family Planning	141.4	59.50	59.50
	Jordan	Health Management	20.0	2.00	6.60
1994	Burkina Faso	Health & Nutrition	29.2	7.50	7.50
	Burkina Faso	Population/AIDS Control	26.3	14.10	26.30
	Chad	Health & Safe Motherhood	18.5	4.60	6.10
	Comoros	Pop & Human Resources	13.0	2.80	4.30
	Guinea	Health/Nutrition Sector	24.6	2.50	2.50
	Uganda	Sexually Transmitted	50.0	-.-	50.00
	China	Rural Health Manpower Dev	110.0	8.90	8.90
	Nicaragua	Health Sector	15.0	.60	.60
	India	Ninth Population	88.6	70.90	70.90

Year	*Country*	*Project Name*	*Loan Total*	*Amount for Pop*	*Amount for Pop & RHA*
	Nepal	Population & Health	26.7	21.40	21.40
	Malaysia	Health	50.0	.50	.50
	Argentina	Maternal/Child Health/Nutri	100.0	12.00	12.00
	Brazil	AIDS Control	160.0	-.-	160.00
	Peru	Basic Health/Nutrition	34.0	10.50	10.50
1995	Benin	Population & Health	27.8	NA	13.80
	Burundi	Health/Population	21.3	NA	6.00
	Cameroon	Health/Fertility/Nutrition	43.0	NA	21.50
	Chad	Population/AIDS Control	20.4	NA	20.40
	Kenya	Sexually Transmitted	40.0	NA	40.00
	Senegal	Community Nutrition	18.2	NA	1.82
	Uganda	District Health	45.0	NA	11.35
	Zambia	Health Sector	56.0	NA	26.00
	Zambia	Second Social Recovery	30.0	NA	0.90
	China	Iodine Deficiency Disorder	27.0	NA	2.70
	China	Maternal & Child Health	80.0	NA	45.00
	Indonesia	Basic Health on Five Islands	88.0	NA	22.00
	Laos	Health Services	19.2	NA	4.80
	Philippines	Women’s Health/Safe Mother	18.0	NA	18.00
	Lebanon	Health	35.7	NA	8.99
	Panama	Rural Health	25.0	NA	4.00
	Croatia	Health	40.0	NA	1.60
	Estonia	Health	18.0	NA	0.18
	Turkey	Second Health	150.0	NA	37.50
	Bangladesh	Nutrition	59.8	NA	14.95
	India	AP District Health Service	133.0	NA	28.60
	Pakistan	Population Welfare Program	65.1	NA	65.10
	Cambodia	Social Development Fund	20.0	NA	1.00
	Mexico	Essential Social Services	500.0	NA	50.00
1996	Vietnam	Population & Family Health	50.0	50.00	50.00
	Pakistan	Northern Health Program Proj	26.7	NA	26.70

Year	*Country*	*Project Name*	*Loan Total*	*Amount for Pop*	*Amount for Pop & RHA*
	Cote d'Ivoire	Integrated Health Services	40.0	NA	13.50
	Vietnam	National Health Support Proj	101.2	7.50	89.60
	Georgia	Health Project	14.0	.22	8.12
	Bulgaria	Health Sector Restructuring	26.0	NA	9.50
	India	State Health System Dev Proj	350.0	NA	56.00
	China	Disease Prevention Project	100.0	NA	NA
	Mozambique	Health Sector Recovery	98.7	6.00	35.90
	Indonesia	HIV/AIDS/STD Prevention	24.8	NA	24.80
	Sierra Leone	Integrated Health Sector	20.0	NA	1.30
	Argentina	Provincial Health Dev Project	101.4	NA	NA
	Mexico	Second Basic Health	310.0	NA	111.80
	Egypt	Population	17.2	NA	17.20
	Argentina	Health Insurance Reform	350.0	NA	NA
	Kyrgyz Rep	Health	18.5	NA	4.20
	Morocco	Improved Primary Health	68.0	NA	20.30
	Russia	Medical Equipment	270.0	NA	90.00
	Indonesia	Social Sector Reform	20.0	NA	NA
	Brazil	Health Sector Reform	300.0	NA	NA
	Macedonia	Health Sector Transition	16.9	NA	NA
	Argentina	Health Insurance TA	25.0	NA	NA
	Bosnia	War Victims Rehabilitation	5.0	NA	NA
1997	Niger	Second Health	40.0	NA	1.70
	Senegal	Endemic Diseases	14.9	NA	NA
	Cambodia	Disease Control & Health	30.4	NA	8.10
	Indonesia	Iodine Deficiency Control	28.5	NA	1.90
	Bosnia	Essential Hospital Services	15.0	NA	2.00
	Russia	Health Reform Pilot Project	66.0	NA	19.70
	Turkey	Primary Health Care Service	14.5	NA	4.40
	Argentina	AIDS Prevention/STD	15.0	NA	15.00
	Argentina	Maternal & Child Health	100.0	NA	31.30
	Paraguay	Rural Health	21.8	1.96	16.25

Year	*Country*	*Project Name*	*Loan Total*	*Amount for Pop*	*Amount for Pop & RHA*
	India	Malaria Control	164.8	NA	NA
	India	Reproductive Health	248.3	NA	124.15
	India	Rural Women's Development	19.5	NA	NA
	India	Tuberculosis Control	142.4	NA	NA
	Sri Lanka	Health Services Development	18.8	NA	7.64
Source: World Bank					

Table 2. Asian Development Bank Lending for Population Programs, 1993-1996
(millions of US dollars)

Year	*Country*	*Program Name*	*Loan Amount*	*Family Planning*
1993	Pakistan	Population	25.0	25.0
	Papua New Guinea	Population & Family Planning	7.1	7.1
1994	Indonesia	Rural Health and Population	40.0	5.0
	Marshall Is	Health and Population	5.7	.3
	Pakistan	Social Action Program (health only)	38.5	12.0
	Philippines	Women's Health & Safe Motherhood	54.0	* 0.0
1995		No family planning projects		
1996	Indonesia	Family Health	45.0	0.0
	Vietnam	Population & Family Health	43.0	8.6
	Pakistan	Social Action Program (health only)	32.6	7.3
	Cambodia	Basic Health Services Project	20.0	0.0
1997		No family planning projects		
Source: ADB				

* ADB says USAID funded the family planning components of this project.