INTERGOVERNMENTAL HEALTH ASSISTANCE IN FRANCOPHONE WEST AFRICA

by

Elliot J. Berg*

CENTER FOR RESEARCH ON ECONOMIC DEVELOPMENT
The University of Michigan
Ann Arbor, Michigan 48109

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Elliot J. Berg*

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*An especially important part has been played in this study by Mr. Christian Chabboud of the University of Clermont-Ferrend and Ms. Martha Ayneswort of John Hopkins University.

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ABSTRACT

This paper introduces the shift in thinking about the importance and type of development aid for health projects and programs in relation to West Africa. It describes the volume and nature of health programs financed by major donors and recent changes in donor attitudes and priorities in the health area. The donors covered are the World Bank, WHO, the European Development Fund, France, and USA. Annexes give summaries of OECD spending on health assistance; a recent French budgetary statement on health assistance; and a recent OECD/DAC statement on recurrent-cost financing.

RESUME

Ce document présente le changement qui s'est produit dans la façon dont l'importance et le type l'aide au développement pour les programmes et les projets de santé relatifs à l'Afrique occidentale sont considérés. Il décrit le volume et la nature des programmes sanitaires financés par les principaux donateurs ainsi que les modifications récentes des attitudes et intérêts prioritaires de ces derniers dans le domaine de la santé. Les donneurs étudiés sont les suivants: la Banque mondiale, l'OMS, le Fonds européen de développement, la France et les Etats-Unis. Les appendices offrent le résumé des dépenses de l'OCDE concernant l'aide à la santé, un rapport budgétaire français récent sur le même sujet ainsi qu'un rapport de fraîche date de l'OCDE/CAD sur le financement des coûts périodiques.

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INTRODUCTION

Foreign assistance has always been an important element in the modern health care system of the less developed countries and this is particularly true in West Africa. The health care institutions which were transferred in the colonial period were staffed and supported by public and private agencies for many decades, and after colonial rule ended, foreign assistance remained a principal source of finance for hospitals, medical schools and disease control programs, as well as a major source of high level health manpower.

About the time that the West African states became independent, there occurred a shift in thinking about the role of health in economic development. Until the mid-50s or early 1960s health received small but generally benign attention in the development literature; reduction in human misery through better health care is obviously positive from the humanitarian point of view. During these years, economic analysis of health programs underlined two effects, one good, the other bad. Better health would increase the quality of labor; healthier people work harder, longer and better. But better health also increases the rate of population growth, with negative effects on economic growth: resources which might have been used for investment must go to support the consumption of larger numbers of people. After 1960, concern over these negative economic effects of population growth became dominant, lowering the priority of health aid among donors.

In West Africa--unlike perhaps other poor regions--this shift in thought appears to have been overridden by the general post-independence rise in foreign aid flows. Hospitals were built and equipped, medical schools were started, programs of disease control expanded, such as those organized by the Joint Organization Against Major Endemic Diseases in West Africa (OCCGE). Despite the erosion of intellectual support for health programs in development, therefore, donors continued and even expanded their involvement in the health sector in West Africa.

In the 1970s strong new challenges emerged on the intellectual front, which re-established and even elevated the priority of health for development.[1]

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[1]The following section draws heavily from F. Golladay and B. Liese, "Health Problems and Policies in the Developing Countries", World Bank Staff Working Paper No. 412, August 1980, pp. i-ii.

(1) The proposition that better health inevitably means faster population growth was challenged. An alternative argument has been put forward - the "child survival hypothesis" that if parents see more of their children survive, they will lower their fertility rate. This hypothesis has received some empirical support.[1]

(2) Development theory became heavily focussed on the distribution of the benefits of economic growth. Bad health among the very poor lowers their capacity to learn and adapt, and their ability to work. It reduces the quality and quantity of labor the poor can provide.

(3) The idea has spread that the prime purpose of aid, as of development strategies generally, should be to meet basic human needs. Better health is certainly one of these basic needs.

All of these ideas have given a new attraction to health as a program area for donors. But another notion has emerged which narrows this new attraction: the distinction between "good" and "bad" health aid. The distinction is rarely made explicitly.[2] But it is implicit in almost all contemporary statements on health policies, official or unofficial.

"Bad" health aid is easy to identity: big hospitals and sophisticated medical equipment, specialist physicians imported via technical assistance, medical training in industrial countries. This is "bad" aid because it is usually urban, it is costly, it does not improve the health of most of the local people and it imposes an inappropriate technology on local health care systems.

"Good" aid, naturally, is the opposite of "bad" aid: it is rural; it is heavily preventive; it is addressed to the problems of the poor majority; it emphasizes training and support of paramedicals for community health-oriented efforts. In summary fashion, "good" health aid sustains "primary health care" efforts, and those aimed at control of communicable disease, while "bad" aid is that which supports hospitals (mainly urban) and inappropriate medical technology.

This distinction between "good" and "bad" health aid is very recent; not long ago, what we call "bad" health aid was the only model of health care availa-

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[1] It also received resounding political ratification, notably at the Bucharest Conference on Population in 1974.

[2] See, however, Alistair White, "British Official Aid in the Health Sector," Discussion Paper No. 107, Institute for Development Studies, Sussex, England, April 1977.

ble. Nor is the distinction always clear-cut. It is perhaps over-drawn here, and in any case, it is not present as such in statements of donor policies. But as we will see below, there now exists a strong and virtually universal concensus among donors that primary health care has the highest priority, and aid for urban hospitals the lowest. In reality, however, West African governments, like LDCs generally, continue to allocate resources along traditional lives--i.e., heavily urban, curative, physician-based. At the same time, and related to this, successful primary health care experiments are few, and a great many operational problems remain resolved.

These observations provide background for the description of donor programs and policies which follows. We will describe the volume and nature of health programs financed by major donors and recent changes in donor attitudes and priorities in the health area. We will treat in turn the World Bank, the WHO, the European Development Fund of the European Community, and two bilateral donors active in the Onchocerciasis Control Program (OCP) area: France and the U.S.A. Three annexes provide summary data on spending on health assistance by OECD countries, a recent French government budget statement regarding health assistance and a recent OECD/DAC statement regarding recurrent cost financing.

The main purpose of this paper is to help inform policy-makers and others in the OCP countries about general aid donor policies in the health field. As shown in the text of the paper, ideas and approaches have evolved rapidly in recent years, and sources of assistance which were only a few years ago closed to less developed countries have become much more approachable. While not a "how-to-do-it," the paper can clarify recent changes and thereby increase access of OCP governments to new resources.

I. THE WORLD BANK

A. Evolution of World Bank Activities in Health

The World Bank has financed health components of development projects in other sectors such as agriculture and rural development for many years, but its first formal statement on lending policy with respect to the health sector was not issued until 1975. The 1975 Health Sector Policy Paper established improved access to basic health services and alleviation of the health problems caused by development projects as priorities for World Bank lending. From July 1975 to June 1978, the World Bank provided $188 million to health components of 70 projects in 44 countries, making it a major lender in the health sector. Table 1[1] presents the breakdown of these loans by the type of health component financed.

In 1980 the World Bank adopted a new policy of direct lending to health sector projects, discussed below. The Bank intends to continue financing health components of non-health projects, however, in recognition of their contribution to the development of multisectoral health strategies and their importance in alleviating health problems arising from development projects in other sectors.

B. Lessons of Past Experience in Health Lending

The accumulated experience of the World Bank is financing health components of development projects in other sectors has confirmed the feasibility of providing quality, low-cost basic health care through the use of trained village health workers. Several programmatic aspects of basic health care have been found to be of critical importance:

- achievement of a minimal level of quality in service delivery;
- simplification and standardization of diagnostic and treatment procedures;
- local recruitment of village health workers and their assignment to home communities;
- community participation through the selection of village health workers, local provision of some health infrastructure, and local financing of health services;
- periodic in-service and on-the-job training programs to strengthen and upgrade the skills of village health wrokers;

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[1] Source: World Bank, Health Sector Policy Paper, February 1980, p. 56.

TABLE 1

World Bank Lending for Health Components, Fiscal Years 1976-78[1]
(in million US dollars)

	Total Cost of Parent Project	Health Component Cost	World Bank Contribution to Health Component
1976			
Health services			
Rural	227.73	8.56	6.29
Urban	383.50	6.80	3.05
Vector control	455.20	7.88	7.18
Health education/manpower training	94.98	5.27	2.27
Population	13.20	9.24	4.36
Nutrition	71.96	4.22	1.56
Rural water supply	663.00	21.60	10.58
TOTAL		63.57	35.58
1977			
Health services			
Rural	676.29	26.04	11.48
Urban	260.00	4.61	2.50
Vector control	436.60	32.50	18.30
Health education/manpower training	81.65	1.35	1.34
Population	67.50	47.25	20.65
Nutrition	94.95	22.71	2.79
Rural water supply	1,569.50	64.35	31.53
TOTAL		198.81	88.59
1978			
Health services			
Rural	518.33	11.47	4.97
Urban	185.48	4.17	2.07
Vector control	140.00	5.58	....
Health education/manpower training	7.00	.80	.63
Population	68.60	48.02	21.23
Nutrition	0.00	0.00	0.00
Rural water supply	1,398.10	72.62	35.58
TOTAL		142.76	64.48
Total health components, excluding rural water supply, 1976-78		246.76	110.67
Total health components, 1976-78		405.14	188.36

Symbol: ... for "not available."

[1]Fiscal years ending June 30.

- establishment of a pyramidal network of referral facilities to community health workers can send patients who need more specialized care;
- adequate logistical support for community health workers; insuring availability of basic drugs and supplies; and
- improved management of the health sector at the national level.

In addition, the Bank's health activities have demonstrated the necessity of providing visibly effective health services, such as basic treatments and maternal care at the outset of health projects, in order to build the credibility of health workers in the community. Only after this credibility has been established can health workers hope to launch effective preventive campaigns which involve changing the habits of individuals.

C. Priorities

According to the 1980 Health Sector Policy Paper, World Bank lending in the health sector aims at strengthening primary health care systems and expanding local capacity for health planning and budgeting. Priority programs include: maternal and child health care, endemic disease control, immunization programs, and improving health management capability. Projects which promote local manufacture of drugs, equipment, or other health supplies are also a high priority. World Bank financing favors projects utilizing appropriate health technologies, such as the utilization of mid-level auxiliary personnel for service delivery, application of low cost and simplified technology, minimum reliance on supervision or administration by the Ministry of Health; maintenance of adequate standards for performance and safety, and the ability of the project to expand coverage and service over time.[1]

The World Bank utilizes the following guidelines in determining the countries and projects which will receive assistance:

- previous basic analysis and evaluation of the health sector and long-term financial implications of existing programs;
- existence of a country strategy for achieving universal access to health care;
- analysis of socio-cultural characteristics of the target population;
- sufficient pilot-testing of health interventions prior to their

[1] Ibid, p. 63.

application on a wide-scale;
- consideration to the influence of activities in other sectors on health, and of health on activities in other sectors, particularly the population sector;
- the capacity of Governments to finance recurrent costs after project implementation;
- the absorptive capacity of existing health institutions; and
- efficient and equitable allocation of resources.

Priority is given to those countries in greatest need of assistance. The World Bank finances both urban and rural health projects provided that whenever possible project beneficiaries are those groups at greatest risk.

II. THE WORLD HEALTH ORGANIZATION

A. Types of Assistance and Areas of Involvement of WHO

The World Health Organization (WHO), a specialized agency of the United Nations , facilitates the international coordination of health and medical related activities. It specifically provides assistance in:

1. the isolation and control of contagious diseases;
2. the international standardization of the nomenclature of drugs; collection of data on drugs;
3. the assessment of the medical and health concerns of member nations and the provision of the necessary technical assistance to deal with these problems;
4. the vocational training of individuals and the dissemination of technical literature and information;
5. the coordination and promotion of research.

The programs subsidized by WHO involve
- the strengthening and reinforcing of medical service, training of personnel, and health care planning;
- family health care including improvement in health care for mothers and children, research on human reproduction, and raising nutritional standards;
- the prevention of transmittable tropical diseases such as malaria, schistosomiasis, onchocerciasis, and smallpox.
- the immunization of children against diptheria, measles, polio, and tuberculosis;

- the provision of water and sanitation; and
- the improvement of systems for collection and handling of medical statistics.

The total budget of WHO for 1978-79 exceeded $US 300 million. Two-thirds of these funds were devoted to improving and strengthening medical services, family health care programs, vocational training, control of transmittable diseases and better sanitation.

B. Observations Drawn from the Experiences of WHO

According to WHO studies, it is clear that vector-borne diseases of the gastro-intestinal tract and respiratory infections are the principal causes of morbidity in developing countries.

Improvement of medical and health care in these countries is prevented by the following obstacles:

First, governmental health care strategies are not integrated into other policies aimed at social and economic development. The separation of health and medical policies and projects from policies in related sectors is deleterious to their implementation.

Second, there is an absence of an effective planning mechanism in the health area. Objectives are often poorly defined because no criteria have been devised upon which to base necessary decisions. With no clear objective or policy orientation, it is hardly possible to develop comprehensive health care strategies.[1]

Further, at times the medical community or even the government oppose the improvement of the health care system, especially when decentralized decision-making is attempted and applied to programs which involve community-wide participation. Moreover, medical training is inadequate and not well-suited to the needs of the population. Not only are the funds allocated to the health sector insufficient, but there are problems with the distribution of these resources. One can attribute this to the inefficiencies and ineffectiveness of the medical infrastructure and the attitude of health care personnel toward traditional medicine. Too often basic medical services are poorly conceived (lack of good management, proper resources, and logistical support).

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[1]Djukanovic et Mach, "Comment répondre aux besoins sanitaires fondamentaux des populations dans les pays en voie de développement," OMS, Genève 1975.

C. WHO Priorities

The priorities articulated by WHO at the time of its first involvement in developing countries focused essentially on the prevention of the most serious and prevalent contagious diseases. The immunization compaigns against tuberculosis and the eradication of smallpox and malaria were priorities. This policy has achieved some success (smallpox) but has met with disappointment (notably in the prevention of malaria).

Subsequently a philosophical reorientation took place giving a higher priority to the satistaction of the basic needs of the population. The 1978 Alma Ata Conference on primary health care marks the official adoption of this new focus. This conference led member countries of WHO to adopt a new set of priorities for health planning and to strive for the following goal: health for all by the year 2000. The resolutions passed during this conference provided the framework for future WHO policies.

According to the definition which was drawn up at the Conference of Alma Ata, "Primary Health Care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford."[1]

Primary health care has the following dimensions:

- promotion of proper nutrition;
- provision of drinkable water;
- care for mothers and children;
- inoculations against the major infectious diseases; and
- the prevention of endemic diseases.

Primary health care strategies should seek to develop a higher degree of self sufficiency for these countries; the use of sophisticated technology which is imported should be reduced to the bare minimum while at the same time more appropriate technology should be substituted. Appropriate technology means "a technology which is less costly, more efficient in technical terms, and better adapted to the physical and social environments of developing countries and to their medical services."[2]

Primary health care policy, as it was defined at the conference of Alma Ata, also implies community-wide participation, as much for the articulation of prio-

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[1] W.H.O./UNICEF, Primary Health Care, Alma Ata, 1978.

[2] O.M.S. "Rapport de la consultation sur la technologie appropriée pour la santé, Genève, 1977, Annexe 3.

rities and objectives on a local level, as for the evaluation of its performance.

According to WHO, a national primary health care strategy will be successful only if there is political support for it. Only that will effect an allocation of resources which favors primary health care and a delegation of power to local communities.

III. THE EUROPEAN COMMUNITY: EUROPEAN DEVELOPMENT FUND (FED)

The European Community has maintained a high profile in Africa for many years. An evaluation of the volume and structure of aid from FED will indicate some general tendencies.

A. The Volume and Evolution of the Aid Flow to the Health Sectors of the Associate States from the European Community

Between 1959 and 1978 the European Community granted about $300 million through FED for health projects in the Associated States -- mainly African nations until recent years.[1] Health as defined here includes water provision (to rural villages and wells) and sanitation.

The evolution of FED's commitments over the years is traced in Table 2, which reveals that the volume of assistance to the health sector has sharply declined from the first period to the second and third periods of its existence.

It is clear from Table 3, which depicts the structure of the flow of aid, that projects related to medical infrastructure and personnel training absorbed 45 percent of the funds: water provision in towns, 30 percent; water provision in rural areas, 18 percent; and sanitation, 9 percent.

Shortly after 1960, FED financed the establishment of large-scale medical facilities (general hospitals), of which the hospitals of Mogadishu and Nouakchott are two examples. Thereafter, many projects were financed in rural areas (dispensaries) or in medium-sized cities (hospitals, maternity hospitals). Therefore, contrary to that which is often argued, FED did not give priorities solely to large-scale hospitals, except perhaps in the case of Somalia, where a large portion of the assistance from the Community was extended upon the hospital at Mogadishu. It is true, all the same, that until recently the aid de-

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[1] La Commission des Communautés Européennes, Projets financés par le Fonds Européen de Développement dans le domaine de la santé (1959-1978), Bruxelles 1978.

TABLE 2

EUROPEAN DEVELOPMENT FUND (FED):
AID TO THE HEALTH SECTORS IN ASSOCIATED STATES (1959-78)
(commitments)

Units: 1000 European Accounting Units[1]

Year	1st FED	2nd FED	3rd Fed	4th FED
1959	15 894			
1960	11 608			
1961	29 604			
1962	6 787			
1963	2 026			
1964	11 139	6 259		
1965	943	33 572		
1966		4 200		
1967		14 920		
1968	228	4 130		
1969		7 866		
1970	65	273	275	
1971		2 202	7 937	
1972		4 995	1 521	
1973	100	13 283	20 841	
1974			22 470	
1975		3 565	4 684	
1976			2 300	4 564
1977			280	34 577
1978				17 934
TOTAL	78 404	95 265	60 308	57 075

[1]The European Accounting Unit was worth the same as a U.S. dollar through 1971, and somewhat more than a dollar subsequently.

SOURCE: E.E.C. internal document.

voted to the health sector mainly reached urban populations, as indicated in Table 3.

B. Conclusions Drawn from the Experience of FED in the Health Sector

In 1979 a committee reviewed 24 health-related projects which FED had financed in Africa.[1] Several findings emerged from this study on the effectiveness and functioning of institutions and operations which had been financed since 1958.

One critical problem revealed by this study was the poor maintenance of hospitals and other medical facilities -- lack of adequate supplies of water and electricity and lack of proper upkeep on and spare parts for medical equipment.

The occupancy rate of large-scale hospitals is clearly higher than that of smaller hospitals; this is due to the difference in the quality of care available, both in terms of facilities and personnel, at the two levels.

It is also apparent that most of the hospitals which are financed by FED are staffed by expatriate doctors. With the exception of Somalia and Madagascar, the level of FED involvement could not be maintained without the use of doctors who are associated with technical assistance programs. Aside from what this implies in connection with recurrent costs, the assignment of medical and paramedical personnel to hospitals favors curative medicine at the expense of preventive medicine.

A budgetary study reveals that general hospitals have more funds at their disposal than the intermediate hospital units (provincial and regional hospitals). For instance, the yearly operating cost per bed reaches as high as 320,000 CFA for certain general hospitals (Mogadishu) against 100,000 CFA for smaller centers like those of Zinder and Maradi in Niger.

It appears that foreign aid contributed key functions to the precarious budgets of health services. The salaries of the medical and paramedical personnel and those of the local employees charged with maintenance duties are generally paid by the Ministries of Health. Local organizations finance the purchase of medications and the operation of rural dispensaries. Foreign aid is allocated to operating and repairing medical and health-related facilities. A system of charging patients for hospital services, which has begun in large hospitals, could alleviate some of the budgetary problems, but this is less likely to help since hospitals lack budgetary autonomy, that is, hospital revenues are paid into the general treasury.

[1] Ibid.

TABLE 3

STRUCTURE OF AID FLOW FROM F.E.D. TO THE HEALTH SECTORS IN ASSOCIATED STATES (1959-1978)

(in percentages)

	Medical infrastructure and training	Potable Water Supply		Sanitation
		Urban Areas	Rural Areas	
1st FED	51.0	16.7	20.3	12.0
2nd FED	41.6	32.8	21.2	4.4
3rd FED	37.9	46.6	14.1	1.4
4th FED	48.6	18.3	13.2	19.9
Period 1959-78	44.8	28.7	17.5	9.0

SOURCE: Calculations made from EEC internal documents.

According to this evaluation, the large hospitals financed by FED principally serve the urban population. The hospital at Mogadishu is almost exclusively used by the population of the capital. But this is not the case at Nouakchott where the hospital serves the whole population -- so the usual generalization is not always valid. Clearly there exists one problem which if often ignored; if Mauritania lacked a general hospital, the seriously ill could receive care only in neighboring countries.

An ex-post evaluation of large scale FED projects in Upper Volta and Niger highlights the need for the projects to be integrated into a coherent national health plan. In both instances, attempts were made to improve already-existing medical facilities by the development of mobile medical units (in Niger), and by the prevention of endemic diseases (in Upper Volta).

In choosing "mass medicine" (mobile and preventive) in Niger, the integration of curative and preventive medicine has been facilitated. This was more difficult to achieve in Upper Volta because the medical and health care infrastructure centers around services which are administered through hospitals. One should note that the hierarchical structure of the "medical care pyramid" is seldom respected in Upper Volta. This is shown by the low occupancy rate of the smaller, regional hospitals in Gaoua and Fada N'Gourma. In contrast, due to the stricter regulations in Niger, the infirm are obliged to pass through regional hospital units where it is determined if the case warrants a transfer to a higher level.

On the whole, the medical staff is sufficient to ensure the smooth functioning of most projects financed by FED. It is, however, necessary to note that a disparity exists between the urban centers and the rural areas. (In Upper Volta, there is a ratio of 138,000 inhabitants to one doctor in rural areas, while the ratio is 8,000 tol in the capital.) Attention is also called to the number of expatriate doctors -- 85 percent in Niger. Often, African doctors choose to practice in the capital while expatriate doctors are assigned to rural areas. The training of medical and paramedical personnel must take place in programs which are adapted to the specific medical needs of each country if these problems are to be alleviated. Furthermore, steps to improve working conditions and increase renumeration must be taken in order to induce African doctors to practice medicine in rural areas.

C. FED Priorities in Health Sector Aid

Experts from the ACP states (African, Caribbean, and Pacific) and the

European Community examined aid objectives in the health sector and determined which priorities should be retained at a conference held in Freetown in December of 1978. Their conclusions were based upon evaluations of past medical projects.[1] They agreed upon the following principles:

(1) Advancement in the health sector goes hand in hand with social and economic development. A strategy for better health care and more efficient medical facilities cannot be isolated from policies which ultimately determine its success. It is in this manner that rural development and infrastructure improvement must go along with any improvement in the medical and health care of a country.

(2) Aid to the health sector must also encourage services which are affordable and accessible to all, regardless of geographical location.[2] Efforts to reach the most underprivileged (i.e. those who do not enjoy access to medical services or whose access is rather limited, especially those who reside in rural areas or in urban centers which are undergoing rapid population surges[3]) must take priority. These needs can be met by improving the structure of the basic health services network and through mass education programs in preventive health.

FED chose these criteria for selecting projects: they must answer the real needs and aspirations of the population. They must also be both integrated into a national hierarchical medical system and distributed fairly to the various regions of the country in question. Local financial resources and personnel must be employed to deal with recurrent costs and assure the smooth functioning of FED projects. In most instances, medical projects should seek to increase the efficiency of existing facilities rather than create new ones.

IV. UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (U.S.A.I.D.)

A. Evolution of U.S.A.I.D. Health Assistance

U.S.A.I.D. is the principal agency for U.S. bilateral development assistance with missions or representatives in over 70 developing countries. During the 1960s, health was a low priority of A.I.D., with the exception of fairly high

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[1] Réunion d'experts CEE/ACP, Principes de base se dégageant de l'évaluation ex-post de projets d'investissement financés par le FED dans le secteur de santé, Freetown, décembre 1978.

[2] Ibid., p. 2.

[3] Ibid., p. 6.

outlays for population and family planning programs at the end of the decade. A.I.D. assistance during this period consisted primarily of capital transfers, allocated in part on the basis of the economic potential of recipient countries.

In the early 1970s, as it became clear that capital transfers alone were not sufficient to accelerate development, emphasis came to be placed on improving the human contribution to development through programs of educational and social development. In 1973 the U.S. Congress issued a mandate to A.I.D. to channel development assistance to programs addressing the basic human needs of the neediest people in the poorest countries. Under this directive, the proportion of A.I.D. bilateral development assistance allocated to the poorest countries has risen from 68% in 1975 to 84% in 1981.[1]

Since the 1973 Congressional Mandate, increased emphasis has been placed on three basic needs sectors: (1) food production and nutrition; (2) population planning and health; and (3) education and human resources. Between 1973 and 1979 the share of programs for "food production and nutrition" and for "population planning and health" rose from 26% and 18% to 47% and 24%, respectively, of the total A.I.D. assistance for functional programs (see Table 4). The total volume of A.I.D. development assistance for health to Africa was $34 million in 1978 and $56 million in 1979. In both 1978 and 1979 about half of all development assistance for health to Africa was allocated for health delivery services, and about one-fifth for population programs. Other areas of health assistance for Africa were health planning, environmental sanitation, disease control, and nutrition (see Table 5).

B. Priorities in the Health Sector

According to A.I.D.'s 1980 Health Sector Policy Paper,[2] four areas of the health sector have been identified as priorities: (1) primary health care, including basic maternal and child health, nutrition, and family planning services; (2) water and sanitation; (3) control of selected diseases; and (4) health planning.

1). Primary Health Care

Provision of low-cost and universally accessible primary health care to the poorest people in developing countries is A.I.D.'s highest priority in the health sector. The most important elements of primary health care insofar

[1] A.I.D. Congressional Presentation, FY 81, p. 124

[2] U.S.A.I.D., Health Sector Policy Paper, March 1980.

TABLE 4

A.I.D. Development Assistance for Functional Programs

Fiscal Years 1973 and 1979[1]

(US$/millions)

	1973[2]		1979[3]	
	Amount	Percent	Amount	Percent
Food Production and Nutrition	225.4	26	614.2	47
Population Planning and Health	154.1	18	317.9	24
Education and Human Resources	88.4	10	97.7	8
Selected Development Problems	229.2	26	117.4	9
Selected Countries and Organizations	177.8	20	152.8	12
TOTAL	874.9	100	1,299.9	100

[1]Operating expenses are not included.

[2]Source: A.I.D., Implementation of "New Directions" in Development Assistance, Report to the Committee on International Relations, July 22, 1975, p. 5.

[3]Source: A.I.D. Congressional Presentation, FY 1981, Main Volume, p. 116.

as A.I.D. funding is concerned are:

- basic maternal and child health services;
- family planning information and services;
- immunization of children;
- availability of basic medicines;
- health education on nutrition, hygiene and sanitation; and
- improved data collection, planning, and evaluation systems.

In the past, A.I.D. has funded the following elements of primary health care systems:

- basic and in-service training for primary health care workers;
- development of health education materials;
- research, planning, and evaluation of primary health care activities;
- data collection and analysis;
- temporary procurement of essential commodities; and
- administrative logistic support.

A.I.D. has also supported efforts at developing local capacity for production of medicines, contraceptives, and other supplies and equipment for the provision of primary health care.

2). Water and Sanitation

A.I.D.'s second priority reflects its commitment to the goal of the International Safe Drinking Water and Sanitation Decade of "safe water and adequate sanitation" by 1990. The greatest obstacles to this goal, according to A.I.D., are operation and maintenance problems and the need for developing low-cost appropriate technology for water and sanitation systems which can be constructed, operated, and maintained locally. Water and sanitation components eligible for A.I.D. assistance include:

- construction or rehabilitation of water systems;
- hygiene and health education;
- training of local personnel in management, maintenance, and administration of water and sanitation systems; and
- local manufacture of hardware, spare parts, and equipment necessary for water and sanitation projects, and their standardization.

3). Disease Control

In addition to supporting immunization of children as an integral part of primary health care, A.I.D. is placing special emphasis on assisting

TABLE 5

A.I.D. Development Assistance for Health to Africa[1]

(US$'000)

	Development Assistance		
FY78	Grant	Loan	Total
Health Delivery Services	15,731	592	16,323
Health Planning	1,511		1,511
Environmental Sanitation		2,500	2,500
Disease Control	5,888		5,888
Population	7,404		7,404
Nutrition	200		200
TOTAL	30,734	3,092	33,826
FY79			
Health Delivery Services	21,718	9,500	31,218
Health Planning	365		365
Environmental Sanitation	3,200		3,200
Disease Control	5,810		5,810
Population	10,440		10,440
Nutrition	3,123	2,000	5,123
TOTAL	44,656	11,500	56,156

[1]Source: Inter-Agency Working Group on African Health Strategy, Developing U.S. Health Strategy for Sub-Saharan Africa, Vol. 1, July 31, 1979, Table 6-I.

projects for the control of malaria, schistosomiasis, and onchocerciasis. Malaria control projects supported by the Agency include the training of personnel, temporary provision of commodities, health education, and applied field research. Because of the high cost and limited effectiveness of existing technologies for prevention and treatment of schistosomiasis, A.I.D. primarily supports research and development of cost-effective control measures, technical assistance for project design, training of personnel, and environmental (engineering) modification components of schistosomiasis control programs. The Agency also assesses development projects in other sectors with respect to their possible effect on the spread of schistosomiasis. A.I.D. participation in onchocerciasis control is achieved multilaterally in collaboration with other aid donors.

4). Health Planning

Priorities for A.I.D. assistance in health planning are:

- training of personnel for health planning, especially in the form of direct support of health planning training programs in host country institutions;
- technical assistance for the design and implementation of improved health data collection systems; and
- special studies to identity and assess positive and negative health implications of activities in other development sectors.

C. Types of Health Assistance

Approximately two-thirds of A.I.D. assistance is in grant form, the remaining third consisting of low-interest concessionary loans. A.I.D. funds are increasingly provided for training of host country personnel, technical assistance, and temporary provision of essential equipment and supplies. Capital construction is currently de-emphasized, and is considered only in cases where such investments "are clearly an integral part of a larger health sector activity, and where other sources of funding are unavailable."[1] A.I.D.'s philosophy is that recipient countries should provide for the recurrent costs of health programs, and that program proposals must explicitly set out plans for local absorption of recurrent costs. However, "when resources are scarce, A.I.D. is prepared to help finance some of the recurrent costs of primary health care programs."[2]

[1] Ibid, p. 20.

[2] Ibid, p. 21.

V. FRENCH ASSISTANCE TO THE HEALTH SECTOR

A. Volume and Trends in French Aid to the Health Sector

French assistance to the health sector is channelled through the Fund for Assistance and Cooperation (FAC).

As indicated in Table 6, the level of aid allocated to health remained low throughout the period from 1960 to 1976 in comparison with all bilateral aid commitments from France (and not just the commitments of FAC). With a few exceptions (Mali, Central African Republic, Mauritania, and Chad) French assistance barely rose in real terms during that period. In come instances (Senegal, Upper Volta, Benin, and Ivory Coast) the share of health-sector aid appeared to shrink.

B. French Aid to the Health Sector: Areas of Involvement; Recent Trends and Developments

There are seven major areas of involvement: technical assistance, training programs for medical and paramedical personnel, development programs, support programs, emergency medical care, medical research, and social programs.

1) Technical Assistance

Since 1970, French technical assistance programs furnished trained personnel who are essential to the functioning of current health care networks and medical facilities in francophone Africa. Between 1961 and 1976, specialized medical personnel have grown from 20 percent to 40 percent of the entire technical assistance program. However, technical cooperation encounters obstacles both in recruiting and in fully utlizing the available manpower. The operating and personnel costs of expatriate medical staff have grown considerably over the years (30 to 50 million CFA per expatriate doctor in 1976).

2) Training of Medical and Paramedical Personnel

Newly trained medical and paramedical personnel will replace expatriates in the future. French activities in this area provide instructors and grant scholarships. In 1979, 77 instructors offered their services to 12 university hospitals and medical schools to train local personnel. Between 1961 and 1976, 2,646 scholarships were awarded for medical and paramedical training. More and more of this instruction is taking place in Africa. Basic instruction and training is often given in Africa while scholarships for study in France focus upon specialized and advanced training. During the 1978-79 academic year

Table 6: French Commitments to the Health Sector in West and Central Africa in Thousands of French Francs and in Percent

A--commitments to health B--total commitments C--health as a percent of all commitments D--technical assistance (health)

		1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976
BENIN	A	6032	3314	1048	400	-	-	925	-	250	-	3840	2639	2517	2140	2423	6710	2081
	B	16555	27625	18456	37264	23868	19002	27594	26352	20186	15690	31498	40195	52923	47741	51813	53987	56841
	C	36.4	12.0	5.68	1.07	-	-	3.35	-	1.24	-	10.6	6.6	4.7	4.4	4.7	12.4	3.7
	D												1451	1535	1741	2300	3031	1581
CAMEROON	A	-	3730	3980	1834	-	-	1640	1310	400	50	1800	7265	9577	6062		N/A	9199
	B	4644	55721	52516	47293	45083	59839	52679	50528	41683	29690	36273	121216	146452	181489		226694	433634
	C	-	6.7	7.6	3.9	-	-	3.1	2.6	1.0	0.2	5.0	6.0	6.5	13.3		5.1	2.1
	D												6056	6968	5783		N/A	8809
CONGO	A	3230	2168	600	2840	1472	-	784	1156	3609	1610	-	5990	6015	11117	8298	8205	8801
	B	29303	29588	17057	37019	34865		8080	6582	29731	11557	18125	57441	77286	85796	102291	142393	234313
	C	11.0	7.3	3.5	7.7	4.2		9.7	11.6	12.1	13.9		10.4	7.8	13.0	8.1	5.8	3.8
	D												5212	5800	6097	7600	5889	8421
IVORY COAST	A	3720	5790	2420	2434	820	25800	-	1000	41	63	-	2676	4101	5480	5431	5147	4254
	B	43790	45877	53760	69805	36946	53332	41290	46386	48640	22133	31757	173446	176365	277523	319448	347149	529967
	C	8.5	12.6	4.5	3.5	2.2	48.4	-	2.2	0.08	0.3	-	1.5	2.3	2.0	1.7	1.5	0.8
	D												2338	3741	4053	5200	4666	4088
C.A.R.	A	2910	3396	65	27	774	-	920	560	1572	1113	2303	5947	7373	7520		10298	12868
	B	29119	19682	9382	21204	39675	17912	20025	13980	12262	15483	7120	53255	47541	71388		133854	104594
	C	10.0	17.2	6.9	1.3	1.9	-	4.6	4.0	12.8	7.2	3.2	11.2	15.5	10.5		7.7	12.3
	D												4793	6100	6020		6669	9228
GABON	A												3661	4517	5264	6879	6956	8093
	B												52725	84447	131060	123694	221550	226023
	C												6.9	5.3	4.0	5.6	3.1	3.6
	D												3661	4051	5240	6850	6935	8093
UPPER VOLTA	A	4900	850	552	1600	680	2020	790	2275	2100	1800	2670	6188	7456	7407	10931	7631	9408
	B	25218	21675	23196	25530	22401	32206	24686	33961	30401	18887	30757	86187	117115	111999	135843	116798	164227
	C	19.4	3.9	2.4	6.3	3.0	6.3	3.2	6.7	6.9	9.5	8.7	7.2	6.4	6.6	8.2	6.5	5.7
	D												4015	5116	5362	8900	7189	7253

TABLE 6: Share of French Commitments to the Health Sector in Thousands of French Francs and in Percent (CONTINUED)

MALI	A	1377	-	-	-	-	1400	-	2046	3450	1040	2160	5352	3290	2532	4926	4515	11959
	B	37054	17561	27887	9801	13185	6537	4242	21283	18125	13597	25675	63989	76392	100390	92858	114132	169269
	C	3.7	-	-	-	-	21.4	-	9.6	19.0	7.6	8.4	8.4	4.3	2.5	5.3	4.0	7.1
	D												1416	1841	1816	3000	2945	4890
MAURITANIA	A	420	-	-	100	706	360	640	1580	630	100	600	2952	4720	5002	4100	4551	5821
	B	45301			17465	28561	22108	11994	11867	13306	11722	7863	22108	50122	57321	36750	66551	46582
	C	0.9	-	-	0.6	2.5	1.6	5.3	13.3	4.7	0.8	7.6	13.4	9.4	8.7	11.1	6.8	12.5
	D												2352	3180	3557	4100	3551	3991
SENEGAL	A	4712	7758	1335	2163	953	-	3550	1654	2189	1541	2423	2638	1713	7426	12257	10200	11328
	B	42998	38565	34747	39650	69115	19003	39587	22758	28220	15518	32841	18280	33580	189934	271898	319361	312968
	C	11.0	20.1	3.8	5.4	1.4	-	9.0	7.3	7.8	9.9	7.4	14.7	5.1	3.9	4.5	3.2	3.6
	D														5107	6510	8060	9218
NIGER	A	1296	50	80	9080	-	320	-	580	-	680	1674	4980	3903	3704	6375	5653	4860
	B	27781	4737	35175	39809	40136	24843	28428	36403	35759	27896	38459	66869	108407	85504	130401	151121	247664
	C	4.7	1.1	2.3	22.8	-	1.29	-	1.6	-	2.4	4.3	7.4	3.6	4.3	4.9	3.7	1.9
	D												2604	2173	2644	4700	4244	3690
CHAD	A	1010	2126	1200	2220	500	-	4142	6012	3000	608	2640	8205	5023	4784	8111	7809	11351
	B	28863	18846	12859	37740	39423	26858	20941	23866	22884	12034	46083	98912	101151	91001	95267	110232	215457
	C	3.5	11.3	9.3	5.9	1.3	-	20.0	25.2	13.1	5.0	5.7	8.3	5.0	5.3	8.5	7.1	5.3
	D												7005	3503	3884	5375	6159	7826
TOGO	A	-	340	-	-	412	920	2400	-	1308	3540	600	701	2006	1168	1920	8625	10054
	B	4668	16661	2109	18019	16712	10883	10147	13066	19035	12718	16473	42160	40488	58009	63523	55680	168271
	C	-	2.0	-	-	2.5	8.4	12.5	-	6.0	27.8	3.6	1.7	5.0	2.0	3.0	15.6	6.7
	D												586	756	1068	1700	1299	919

SOURCES: Secretariat of the FAC, External Financing and Expenditures in the Health Sector in Africa, 1971.

NOTES: From 1960 until 1970 - 72 for Senegal only the commitments for operations (Title III and for investment Title VI are counted. Data for technical assistance is available only for the years after 1971.

Military aid, food aid, or special assistance because of the drought not included after 1971.

397 scholarships were awarded to students who were pursuing their studies at African universities, while 267 scholarships were granted to students who were acquiring specialized training in France.

(3) Development Programs

France is involved in updating and servicing medical infrastructure by renovating capital equipment, by creating new units, or through rehabilitating existing hospitals. All medical and health related projects undertaken must not involve costs which are beyond the financial means of a country. "These programs are formulated so as not to thrust recurring costs upon the recipient states which cannot be sustained by the budgets of the Ministries of Health."[1]

In 1979, these programs consisted of: construction, expansion and equipping of hospitals (18,400,000 F.-- 64 percent); training (1,200,000 F.-- 4 percent); onchocerciasis (5,000,000 F.-- 17 percent); Joint Organization Against Major Endemic Diseases in West Africa (OCCGE) (3,300,000 F.-- 12 percent); Organization Against Major Endemic Diseases in Central Africa (OCEAC) (700,000 F.-- 2 percent); a total of 28,630,000 F.

4) Support Programs

These programs provide assistance to certain hospitals, health centers and mobile units by furnishing basic medications, both curative and preventative, vaccines, laboratory equipment, and all-terrain vehicles. Often, these programs are linked with French medical technical assistance and enhance the effectiveness of expatriate doctors.

In 1979, the support programs for Africa were allocated 20,670,000 F. which were apportioned in the following way:

- Rural medical services and (prevention of) widespread endemic diseases	5,470,000	26%
- Assistance to medical clinics	3,700,000	18%
- Curative medicine and medical services provided in hospitals	10,000,000	48%
- Innoculations (enlarged programs)	600,000	3%
- Prevention of tuberculosis	900,000	4%
TOTAL	20,670,000	100%

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[1] OCDE, "La cooperation française dans le domaine de la Santé," 1976, p. 15.

5) Emergency Medical Care

Emergency medical assistance is provided to African nations during epidemic outbreaks (cholera, meningitis). In 1979, France provided emergency services and medical facilities to Chad, Zaire and Djibouti. These commitments rose to 1,228,000 F. in 1978.

6) Medical Research

Assistance in this area seeks to stimulate research into important public health problems in Black Africa (contagious and parasitic diseases, nutrition). To this end, France has financed a portion of the personnel costs of the Overseas Pasteur Institutes at Dakar, Bangui, and Tananarive and has funded other research centers (IRAT, ORSTOM). In 1979, the three Pasteur institutes received 3,400,000 F. for operating costs and 500,000 F. for offices and their furnishings.

7) Social Programs

French bilateral aid in this area is apportioned according to the priorities defined by recipient states, be it for training of social workers, medical coverage of vulnerable groups, advancement of women, or rural and urban community development.

8) Aid to International Organizations

France participates in several specialized international medical and health programs, notably in the international program for the prevention of onchocerciasis (26 million F. spent from 1974 - 1979; 30 million anticipated for the second phase of the program, 1980 - 1985) France gives funds to international development programs such as the OCCGE and the OCEAC.

C. Current Priorities

The current priorities for French assistance to the health sector are:

- Preventive medicine (early detection and inoculation against major endemic and epidemic diseases);
- Improvement in nutrition and the environment to induce a reduction in overall morbidity;
- Development of medical and health care services in rural areas
- Improvement of the quality of care and in the efficiency of existing medical facilities.
- The general and specialized training of medical and paramedical personnel; and
- The orientation of research toward major diseases as well as toward food production (notably proteins).

VI. CONCLUSIONS

General donor policy regarding health care has neared unanimous agreement during the past five years. Following the international community's support of the objective called "health for everyone by the year 2000", primary health needs now stand high on the list of funding priorities of financing sources. Donor agencies have also reached a consensus relating to primary health care and the type of assistance required by this approach.

Nonetheless, it would be wise not to take these new health policies for granted, for a least two reasons. First, even if important funds are available for primary health projects, industrialized countries still lack experience in this particular field. In the past, they have experienced a comparative advantage by dispensing curative care with the best techniques and hospitals, using a highly qualified staff more often affiliated with private rather than public institutions. Therefore, financing agencies could only mildly contribute, on the basis of solid experience, to national health planning and the preparation of appropriate techniques and cheap preventive care at the community level. In the meantime, financial aid to highly technical health projects has decreased despite the fact that it is the field where industrialized countries excell and where beneficiaries may profit most from their competence.

Second, due to the importance given to primary health care by the donor policies, the receiving countries might feel overly encouraged to stick to a health strategy whose results have not been completely tested. To our knowledge, the only case where that kind of care has been successfully applied on a large scale has been in China. However, the happy results are solely restricted to pilot projects or regional programs. Indeed, the technical and bureaucratic conditions required to carry out a primary health care system on a national level have not been met yet within most of the developing countries and have rarely been found in western Africa. Logistics, staff, guidance towards appropriate services, administration, financing, and evaluation are some areas where improvement is needed. Consequently, by emphasizing assistance to primary health, donors prevent recipients from developing more diversified (and less risky) health strategies. On the one hand, it would seem wise and appropriate for the OCP countries, as well as western African countries, to progressively organize their own primary health system. On the other hand, it would be equally helpful, and for the same reasons, if the donor

countries broadened primary health care means and programs according to local capacities. By the same token, financing sources should not neglect the maintenance of the existing health infrastructure in which lies the durability of the primary health care system.

In fact, the composition of the financial aid shows that foreign donors are aware of the delicate issues having to be faced and also that they will continue to finance equipment, training and basic curative needs.

Reinforcing the health ministries' planning, general policies and budgeting capacities and carryout basic sectoral studies, are domains where important foreign donors are now ready to contribute more financially than in the past. These aspects should be taken into consideration by OCP members while searching for new resources.

APPENDICES

APPENDIX I

OECD PRESS RELEASE

ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT

PRESS/A(79)21

Paris, 3rd May, 1979

O.E.C.D. DEVELOPMENT ASSISTANCE COMMITTEE
DAC GUIDELINES ON LOCAL AND
RECURRENT COST FINANCING

The Development Assistance Committee (DAC) of the OECD has agreed to introduce an important new element of flexibility in development co-operation financing policy by approving guidelines for recurrent cost financing to be included in the existing DAC Guidelines on Local Cost Financing, which were adopted at the 1977 DAC High-Level Meeting [see PRESS/A(77)47, Annex II].

The term "recurrent cost financing" refers to the use of official development assistance for procuring goods and services (for example local personnel) required for maintaining and operating a given project or program.

According to the new guidelines, DAC Members recognize that adequate external financing of recurrent costs may be necessary to ensure the successful completion, maintenance and operation of specified development projects/programs; to encourage the selection of projects and techniques which make full economic use of available local human and material resources; and in this way, to contribute to productive employment and the satisfaction of basic human needs. With this in mind, DAC Members undertake to respond constructively to requests for recurrent cost financing assistance from developing countries, where this is essential to maintain and operate effectively particular development programs and projects.

The full text of the DAC Guidelines on Local and Recurrent Cost Financing is attached.

DAC GUIDELINES ON LOCAL AND RECURRENT COST FINANCING

I. INTRODUCTION

1. DAC Members agree upon the importance of the positive contribution which local cost financing [1] can make to the furtherance of several important objectives of development co-operation including the satisfaction of basic human needs. Agreement to engage in local cost financing:

- can assist in building up local productive capacity;
- can provide employment and a direct and immediate increase in the income of local populations as projects and programs are implemented;
- can relieve one of the absorptive capacity problems encountered frequently with the neediest countries by broadening the range of programs/projects eligible for aid.

Furthermore, donors recognize that it could be detrimental to the development efforts of recipient countries if good projects are not implemented as a result of the inability of the recipient to provide or obtain the funds required to cover local costs. For the above reasons donors undertake to provide adequate levels of local cost financing since the need for this type of assistance is likely to increase with emphasis on basic needs projects.

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[1] For the purposes of these Guidelines "Local Cost Financing"

(a) refers only to financing through official development assistance;

(b) refers to expenditures by means of transfers of freely-convertible foreign exchange for purchases of local goods and services needed for the implementation of projects or programs.

(c) may form part of the capital assistance or technical assistance components of projects or programs or may be in the form of general budgetary support;

(d) does not refer only to funds specifically earmarked for local cost financing but would include funds eventually used to finance local costs in those cases where the donor has expressed no preference as between local currency and foreign exchange components;

(e) includes the financing of local costs through the use of counterpart funds generated by commodity import schemes when the primary intent of such financing is to generate local currency for development projects and programs.

2. Increased levels of local cost financing are most effectively accorded on a case by case basis after consideration of the development objectives of both the recipient and the donor country. It is therefore necessary for donors to maintain a flexible attitude towards local cost financing in order to avoid a situation where projects are automatically considered ineligible. In general, donors agree to take measures to meet shortfalls for developing countries which desire to promote programs/projects with large local cost components but which, in spite of determined efforts, are unable to mobilize all the required resources internally.

3. In the process of fixing appropriate levels of local cost financing, DAC Members believe that the overall development objectives of the recipient country, its economic and social conditions, and the specific nature of the project or program are important. A list of some of the important considerations appears below. The purpose of the list is to outline major points which could argue in favor of a decision to finance local costs. The points are not intended to provide a rigid framework for donor action nor are all of them likely to be applicable to every proposal which may be considered. Furthermore the guidelines set out in this document are not designed to define limits to the flexibility with which DAC Members are willing to consider local cost financing. Individual donor countries are encouraged to liberalize their policies as much as possible.

II. CONDITIONS WITHIN THE RECIPIENT COUNTRY WHICH MAY MAKE IT PARTICULARLY APPROPRIATE FOR LOCAL COST FINANCING

4. The following points concerning the economic situation within the recipient are to be given close attention. Although each point does not have the same relevance for the final decision to finance local costs, donors agree that each of them is indicative of the country's potential need for external local cost financing:

i. the degree of scarcity of resources in terms of the savings potential;

ii. the degree of scarcity of resources in terms of fiscal base;

iii. the level of under or unemployment;

iv. the nature of the general development program (especially the degree to which it is oriented to the satisfaction of basic human needs);

v. the strain on the economy of the recipient which could be caused by increased demand for imports and inflation generated as a result of development programs whose local costs are met from internal resources.

III. TYPES OF INVESTMENT PROGRAMS/PROJECTS MOST SUITABLE FOR LOCAL COST FINANCING

5. The particular characteristics of the project/program under appraisal are also an important element in the decision of when to finance local costs, and Members agree to pay particular attention to the considerations listed below when fixing levels of local cost financing. (It is understood that the characteristics listed are of varying significance and may not all be relevant to each project/program that is proposed and that it may not be possible in every case to obtain accurate information.)

i. General

- the priority given to the project/program by both recipient and donor;
- the degree to which the project/program is geared to the satisfaction of basic human needs and is consistent with the objective of self-reliance;
- the assurance on the part of the recipient that if it obtains the desired local cost financing it will be able to provide the required goods and services locally.

ii. Uses of output

- the extent to which goods and services produced by the project/program flow to the poorest sectors of the population and are directed to the satisfaction of basic human needs.

iii. Suppliers of local goods and services

- the impact of purchases of local goods and services on employment and income distribution.

iv. Technical characteristics of the project/program

- the degree to which production techniques are consistent with the local/regional factor and resource endowment;
- the extent to which the social and economic costs of production are consistent with the recipient country's objectives;
- the degree to which the project/program meets appropriate technical standards.

v. Economic

- the degree to which the project when completed will be independent of external assistance within a reasonable period of time in cases where the project itself may not be revenue generating (e.g. educational investment);

- the extent to which the secondary demand generated by the local expenditure can be met within a reasonable period of time.
- the degree to which the project/program meets appropriate tests for viability.

6. For general budgetary support DAC Members may consider the overall composition of the budget to be financed by the recipient government, in the light of similar considerations to those outlined in the previous paragraph.

IV. THE FINANCING OF RECURRENT COSTS

7. DAC Members acknowledge that all development projects give rise to expenditures related to maintenance costs which normally are the responsibility of the country where the project is situated. DAC Members recognize that adequate external financing of recurrent costs[1] may be necessary:

(a) to ensure the successful completion, maintenance and operation of specified development projects/programs;

(b) to encourage or, in any case, not to discourage, the selection of projects and techniques which make full economic use of available local human and material resources; and in this way,

(c) to contribute to productive employment and the satisfaction of basic human needs.

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[1] For the purposes of these Guidelines, "recurrent cost financing":
(a) refers only to financing through official development assistance;
(b) refers to financing needs arising from specified development projects/programs.
(c) refers to transfers of freely-convertible foreign exchange, or counterpart funds, generated from commodity aid, for procurement of goods and services (including salaries of local personnel) required for maintaining and operating a given project/program during and after completion of the initial financing;
(d) does not refer to general budgetary support.

8. With this in mind, DAC Members undertake to respond constructively to requests for recurrent cost financing assistance from developing countries, where this is essential to maintain and operate effectively particular development programs and projects.

9. DAC Members will provide recurrent cost financing according to the merits of individual cases, taking into account such factors as:

(a) the overall domestic financing capacity of the country, giving especially favorable consideration to requests from least developed and other countries with low domestic financing capacity;

(b) the nature and degree of the constraints faced by the recipient country in meeting recurrent costs from domestic resources for the project/program under consideration; the financing of recurrent costs should, in particular, be used to support projects of real social or economic worth which normally, at least at the outset, do not generate sufficient receipts to cover these costs;

(c) the contribution of the project/program under consideration to the effective use of local human and material resources and to the recipient's economic and social development;

(d) the jointly-assessed ability of the recipient to take on increasing shares of the recurrent costs of the projects/programs under consideration over time, recognizing that it is not appropriate for either recipients or donors to prolong external recurrent cost financing over too long a period.

10. In accordance with the basic principle of long term self-reliance and in order to preserve the recipient's commitment to particular aid projects/programs, DAC Members, in cases where they decide to participate in recurrent cost financing, will provide such financing for specified time periods with agreements for gradual takeover by the recipient. They recognize that the precise sharing of recurrent cost financing over time depends on various factors, including those set out in paragraph 9, and will endeavor to suit the phasing-out of recurrent cost financing to the needs of individual cases.

11. DAC Members will ensure that the recurrent costs of proposed projects and programs, as well as the local and offshore investment costs, are jointly assessed and taken into account prior to the commitment of aid funds; that in determining the design of projects and programs and the appropriate contributions of external and domestic resources, full account is taken of the scope for economic use of domestic resources including existing infrastructure; and that the projects and techniques chosen are consistent with the overall development objectives of the recipient country.

12. DAC Members agree to take any necessary steps to adapt their procedures and policies of recurrent cost financing as required by the preceding paragraphs.

V. REVIEW OF IMPLEMENTATION

13. Review of implementation of these guidelines will be undertaken as part of the DAC Aid Reviews.

APPENDIX II

Bilateral Commitments of Official Development Assistance (ODA) for Health by DAC Members, 1974-1978

$ m

	1974	1975	1976	1977	1978[3]
Australia	9.8	20.6	3.3	1.5	4.8
Austria	0.1	1.0	0.1	*	0.1
Belgium	(20.2)	(27.0)	3.4[1]	6.4[1]	10.0[1]
Canada	8.1[1]	11.5[1]	8.6[1]	11.2[1]	17.1[1]
Denmark	2.7	5.3	7.2	17.1	4.2
Finland	0.8	2.0	0.2	0.2	0.4
France[2]	147.8	233.5	261.6	266.3	409.2
Germany	26.7	25.4	13.8	27.7	32.8
Italy	-	2.0	-	3.7	4.5
Japan	6.2	9.7	7.7	22.4	75.4
Netherlands	18.3	25.6	129.6	57.9	72.9
New Zealand	4.7	1.9	0.3	2.6	2.9
Norway	12.5	21.9	8.7	3.1	43.5
Sweden	28.3	22.4	26.8	47.2	16.6
Switzerland	0.8	0.1	0.3	2.1	2.2
United Kingdom	10.7[1]	7.6[1]	1.8[1]	19.1	17.8
United States	180.5	190.0	167.1	198.4	294.0
TOTAL	478.2	607.5	640.5	686.9	1008.4
CEC	21.9	9.2	..	18.0	21.5

N.B. Health aid expenditures refer to health services and health care at all levels, also include population programs and nutrition but exclude aid for drinking water supplies and sanitation.

[1] Capital assistance only, excluding expenditures on technical cooperation.

[2] Includes health aid and social security (illness) transfers to overseas departments and territories ($86.4 m or 58.5 p.c. of total in 1974).

[3] Data available as of end-January 1980.

* Less than $0.1 m

.. Not available at time of writing

Source: Members reporting to DAC 5 except for data in round brackets which are country submissions specially prepared for health aid meetings at the DAC.

APPENDIX III

French Aid to the Health Sector

An Outline of the 1980 Budget for Cooperation and Assistance

Section no. 33

- A note on French involvement in the area of health and social assistance.
- Measures taken for health care and social assistance for overseas officials and their families.

I. Involvement in medical and social programs.

In 1979, France primarily assisted in the implementation of public health programs which had been formulated by recipient countries with the following objectives in mind:

1) The protection of the population's reproductive and productive capacity by a qualitative and quantitative reduction in overall morbidity;

2) The advancement of health care and social programs in rural areas;

3) Heightened development of preventive and "social" medicine, principally through mass campaigns to detect and prevent the major epidemic and endemic diseases through inoculations and medications;

4) Modernization of the health care system and improvement of the efficiency of existing facilities without a concurrent burdensome growth in costs;

5) General and specialized training of African medical and para-medical personnel;

6) Increasing applied medical research toward the appropriate cures and therapy for and the detection and prevention of the major endemic diseases.

7) Satisfactory health care for our overseas officials — for all expatriate personnel who are involved in tropical regions.

Achievement of these goals requires involvement in six principal sectors:

- technical assistance in the form of personnel
- financial assistance for development and support programs
- general and specialized training programs for the local personnel
- applied medical research endeavors
- sound medical care for French advisors and officials working overseas.

- The Number of Doctors and Paramedical Technicians Furnished through Technical Assistance Programs

There is a direct correlation between the reduction in our manpower and the availability of "nationals" for these positions. Envisioned are

- the removal of paramedical personnel whose positions will be assumed by nationals while increasing the number of specialized technicians

- the replacement of general practitioners with recent graduates of local medical schools.

However, the need for medical officials is as high as it was in 1978. To deal with these imposed personnel reductions, some countries are adopting a policy of directly paying the salaries of the personnel who exceed the quota allotted to each country. This enables them to develop their medical and social infrastructure.

In the qualitative realm, there has been a growth in the demand for specialized and highly skilled doctors. This poses recruitment problems which threaten to become serious as this tendency is reinforced.

The department strives to maintain a balance in the number of specialists who are stationed in the capitals and larger cities and the number of practitioners who are assigned to the interior. Therefore, the construction of full regional hospitals should be assisted in countries which possess the resources to operate them (Ivory Coast, Cameroon, Senegal, Madagascar ...).

The sources of medical and health personnel recruits remain unchanged: 55 percent come from the Army's Health Services Division, 35 percent are recruited through contractual arrangements, and 10 percent belong to the V.S.N., who have adapted better and better to their task. However, the shortness of their stay is viewed as a handicap by certain countries which tend to limit, indeed abolish, these positions (Ivory Coast, Cameroon).

The recruitment of specialized doctors remains difficult because the pay is low, the working conditions poor, and the resources inadequate.

- Training of Medical and Paramedical Personnel

Students on scholarship in France from countries which do not have a medical school encounter problems when attempting to gain acceptance at French medical schools because of selection processes based on discriminatory quota systems.

The department considers training an essential activity and thus awards scholarships for general training in Africa and specialized training in France.

The efforts of our 77 instructors in the 12 Centres Hospitaliers Universitaires (CHU) and medical schools as well as the efforts of our practitioners, who give courses at CHUs and at nursing and public health schools, enlarge the opportunities for training within Africa.

The basic training of medical personnel and social workers will henceforth take place, in most cases, in Africa.

As a result, scholarships for study in France are generally intended for advanced and specialized training.

For the 1978-79 academic year 397 scholarships were awarded to students enrolled in African medical schools, 261 scholarships were awarded to individuals who were either enrolled in French universities or who were acquiring practical experience in various French universities and clinics. The French efforts in the area of training are complementary to those of other bilateral donors, viz. FED and WHO. There has been steady growth in the number of local medical personnel, but young practitioners confront readjustment problems which are pecuniary and social in nature. These problems are difficult to resolve and seem, in large part, to be due to the limited opportunities facing medical personnel returning to their home country, where public office and employment is their sole option.

II. Development and Support Programs

- Development Programs

A strategy of modernization, indeed an expansion, of medical infrastructure, involves either renovating capital equipment and medical facilities or readapting existing hospitals. The guiding principle is always to be careful to initiate projects and plans which will not subsequently overburden health budgets.

We participate in large-scale multilateral sanitation and health improvement operations which have social and economic impacts. In particular, we are supportive of the international campaign against onchocerciasis in the Volta River Basin in West Africa (26,000,000 F.given between 1974 and 1979 and 30,000,000 allocated for the second phase of the campaign (1980-1985)).

Our aid to regional organizations, working toward the prevention of major endemic diseases which are acute in Africa, continued: 3,330,000 F. to the Joint Organization Against Major Endemic Diseases in West Africa (OCCGE) and 700,000 F. to the Joint Organization Against Major Endemic Diseases in Central Africa (OCEAC).

In 1979, several projects were initiated, continued or completed:

Rwanda	: hospital at Ruhengeri (5th stage of modernization) - expansion and equipment	7,500,000 F.
Congo	: hospital at Brazzaville (2nd stage) - radiological equipment	900,000 F.
	: hospitals at Pointe Noire and Mossendjo technical equipment	600,000 F.
C.A.R.	: hospital at Bangui (5th stage)	1,700,000 F.
Senegal	: hospital at Ziguinchor (2nd stage) - expansion	3,000,000 F.
	equipment for the Dantec hospital at Dakar	500,000 F.
Burundi	: University hospital at Bujumbura - equipment	2,000,000 F.
Djibouti	: Peltier hospital at Djibouti - technical equipment	600,000 F.
Gabon	: Franceville nursing school - teaching and laboratory equipment	1,200,000 F.
Chad	: hospital at N'Djamena	1,600,000 F.

- Medium-term Support Programs

Once again, the Department emphasized support programs such as provision of basic, preventive and curative services, vaccines, laboratory and x-ray equipment, small medical and surgical instruments, and all-terrain vehicles; all in an effort to prevent the major endemic diseases. Priority was given to the problems of the most underprivileged countries.

These funds were crucial in ensuring the smooth operation of certain hospitals, rural health clinics, and mobile medical units. In some instances (Mauritania, Upper Volta, Chad, Rwanda and Burundi) these programs were integrated into the official health plan and were coordinated with our other medical projects. These support programs uniformly improved the working conditions of our practitioners.

In 1979, the following programs were anticipated:

Djibouti	: prevention of tuberculosis	900,000 F.
Upper Volta	: rural medical care and prevention of major endemic diseases	2,500,000 F.
	hospital and urban medical services	10,000,000 F.
C.A.R.	: prevention of major endemic diseases	700,000 F.
Mali	: prevention of major endemic diseases	350,000 F.
Mauritania	: medical support teams	800,000 F.
Senegal	: enlarged inoculation campaigns	600,000 F.
Niger	: rural medical care	400,000 F.
Chad	: prevention of major endemic diseases	1,520,000 F.
Rwanda	: basic medical support	1,700,000 F.
Burundi	: basic medical support	1,100,000 F.
Zaire	: basic medical support	100,000 F.

In addition, aid was allocated to the Centres d'Appareillage (producers of medical equipment) formerly under the Secretariat of the A.C.V.G. A total of 500,000 F. was given to the centers at Dakar, N'Djamena and Ouagadougou to help meet operating costs.

- Emergency Medical Relief

The funds made available to the Department allow it to help many African nations during epidemic outbreaks of cholera and cerebro-spinal meningitis (Rwanda, Senegal, Chad, Burundi and Congo). The department intervened in Chad, Zaire, and Djibouti as well to furnish basic medical assistance; 1,288,000 francs were allocated. The effectiveness of these activities is greatly appreciated by the receiving countries and they undeniably enhance the reputation of our permanent medical aid.

- Aid to Medical Research

The programs which encourage and support medical research at African research institutes have actively been pursued. Besides personnel support, financial assistance was given to:

- the Pasteur Institutes at Dakar, Bangui and Tananarive. These specialized centers which are authorized by WHO received 3,400,000 F. for operating expenses and 500,000 F. for offices and their furnishings.

- international organizations working for the prevention of the major endemic diseases:

OCCGE for West Africa	3,121,000 F.
OCEAC for Central Africa	700,000 F.

- Support and Assistance for Social Programs

Priorities drawn up by individual countries which govern the selection of social programs:

- training of health personnel and social workers at all levels
- medical care and social assistance for mothers, children, and adolescents
- economic and social advancement of women
- rural and urban community-wide development
- elimination of illiteracy
- special social programs for the physically handicapped (in particular for the blind)

In the area of social work 56 specialists have been hired thus far and it is expected that more will be needed in the future, since they are in demand by the receiving countries (by Gabon in particular). Excellent results have been obtained by our social programs through scholarships and internship awards in France, by our travelling teaching units which train permanent social workers, by the provision of audio-visual materials, and by the outfitting of libraries as well as through the 100,000 F. devoted to logistical support programs.

III. Measures Taken to Provide Medical Protection for Our Overseas Officials and Their Families

Medical care for our technical assistants is assured by the Cooperation accords which require that 80 percent of the hospital fees are paid by the E.A.M. and ongoing medical treatment is administered by our doctors at the medical/social centers.

In fact, although these officials contribute to social security, they must often purchase their own medications and join a mutual insurance plan. This situation has been only slightly modified and improved by the recent extension of social security benefits to those individuals who are stationed abroad as a part of cooperation.

The medical/social centers which are reserved for our officials and their families provided services which are particularly appreciated; they ensure adequate medical supplies and perform medical check ups. The number of centers grew from 21 to 22 this year. Some are stocked with a small supply of medication which can alleviate local shortfalls. Patients requiring routine treatment are sent to local hospitals while the more critically ill are sent either to hospitals in Africa (Dakar, Abidjan and Tananarive) or to France.

The outlays of these medical/social centers reached 2,300,000 F. in 1979 excluding personnel expenditures. Because of growing operating costs, expenditures are expected to rise.

IV. Outlook for 1980

The policy of cooperation in the health and social-service areas is currently formulated in the context of the experiences of the last ten years and is adjusted to the needs of each country.

It seems unlikely that the number of expatriate personnel will decline because the demand for specialists and highly skilled technicians is growing. It continues to be difficult to find the necessary specialists, though the primary source of recruits is still the Army Department's Health Services Division. An agreement on this subject between the two Departments was recently reached.

Our efforts in training and specialization for doctors and paramedics must continue. Success is dependent upon the careful selection of applicants, the proper choice of both the areas of study and the host institutions for students in France. It is also important that students trained abroad be assisted in their efforts to assimilate back into their society upon the completion of their internships.

The recruitment of medical professors to teach in Africa continues to pose tough problems. Plans have been drawn up to separate the duties of chairmen from those of experienced clinical assistants, from military doctors, or specialists.

The length and continuity of their stay overseas are among the factors which determine the teaching effectiveness of these instructors.

The training of African instructors under conditions which resemble the training environment of their French counterparts can be conducted at various French schools, notably at the Houphouet-Boigny hospital which was recently opened in Marseille.

Our investment projects seek to improve the regional and national hospitals and to stimulate the construction of new facilities which will be fully integrated with overall development schemes.

The logistical support programs are key links in many countries, appearing most effective in poorer countries where our officials depend on this logistical assistance. These programs are also responsible for raising the standard of health care and reaching more individuals in the outlying areas. We anticipate that these programs will be expanded in 1980 due to the pressing needs of many countries (Mauritania, Chad, Zaire, C.A.R., Congo . . .).

The involvement of our technical assistance programs in managing the hospitals of Dakar, Girard, and Rotic in Tananarive allow them to guarantee high quality care while serving as models of health and medical care to the military establishments of Senegal and Madagascar and helping them in the training of their military doctors and nurses.

The inefficiency prevalent in some countries, economic and financial matters, and the progressive Africanization of some sectors may all cause an increase in our technical assistance especially to hospitals, to child-health services, to endemic disease control, and to research efforts. We will also attempt to furnish our medical personnel with direct logistical support.

This scheme has already been implemented in some former Belgian colonies. It entails analyzing each situation separately and thus determining the commitments which each party should make in terms of financing and personnel, etc. This will greatly improve the effectiveness of our efforts.

One should guard against the following dangers:

- inciting jealousy within local personnel of the efficiency of our efforts compared to national endeavors;

- an overburdening of existing structures due to the success of our operations and raising unrealistic expectations in the population;

- on a national level it sometimes happens that increased efficiency is gained at the expense of humanitarianism or regional favoritism.

To counter these negative elements we should retain our specialists in hospitals and continue to assist the endemic diseases prevention campaigns on a national level and, above all, in rural areas. We must also encourage social and economic progress in all impoverished countries.

The rural areas possess valuable national resources and must benefit as much as is possible from the social and medical programs.

After 1980, all economic development projects will be systematically accompanied by medical and social programs which incorporate the active participation of the concerned populations.

TABLE SUMMARIZING PERSONNEL PROVISION BY THE FRENCH GOVERNMENT IN AFRICAN AND MALAGASY COUNTRIES

COUNTRY	DOCTORS PHARMACISTS DENTISTS	PARAMEDICAL TECHNICIANS	SOCIAL WORKERS	TOTAL
BENIN	15	1		16
BURUNDI	6	6		12
CAMEROON	52	10	1	63
C.A.R.	41	26	5	72
CONGO	35	19	7	61
IVORY COAST	183	87	15	285
DJIBOUTI	23	16		39
GABON	58	30	12	100
GUINEA BISSAU	1			1
UPPER VOLTA	36	3	6	45
MADAGASCAR	52	33		85
MALI	16	5	1	22
MAURITIUS	3			3
MAURITANIA	32	12		44
NIGER	30	7	1	38
RWANDA	7	5		12
SENEGAL	69	21	4	94
HAITI	1	1		2
SAO TOME	1	1		2
CHAD	39	17	6	62
TOGO	12	2		14
ZAIRE	5	3		8
OCCGE	24	9		33
OCEAC	5	1		6
GENERAL OPERATIONS				
TOTAL 1979	746	315	58	1119
TOTAL 1978	731	293	71	1095

DISCUSSION PAPERS

CRED normally publishes 6-8 discussion papers annually, which provide preliminary reports on the research (institutional or personal) of its senior staff. In many cases, revised versions of these papers are later published in academic journals or elsewhere. Individual discussion papers can be purchased for $3.00 each; an annual subscription (based on a July 1-June 30 subscription year) is available for $15.00. Subscriptions are also available on an exchange basis for publications from other institutions.

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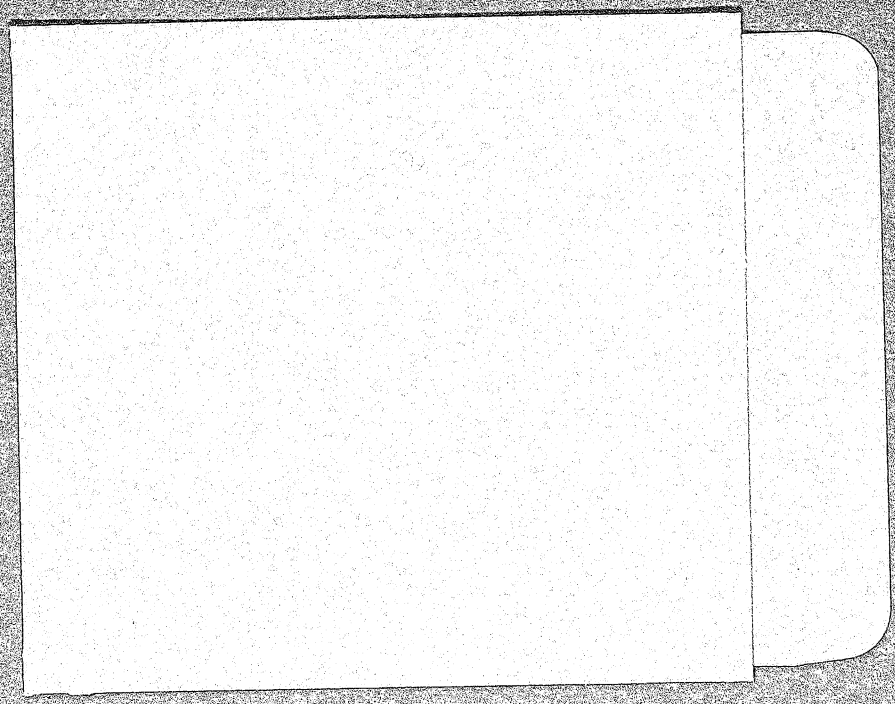

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