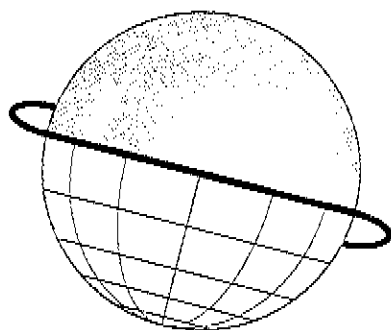


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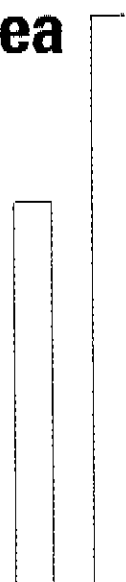
Macroeconomic Evolution and the Health Sector

Guinea

Country Paper



**World Health Organization
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Macroeconomic Evolution and the Health Sector

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Preamble

The objective of this country report is to assess the availability of resources for the Guinean health sector and to discuss the impact of macroeconomic developments in Guinea on health expenditure and the health status of the Guinean population. Although important, the focus of this report is not on the resource needs of the health sector, as reported by the Government, neither on the efficient allocation of resources within the health sector.

As basic data with respect to GDP, prices, and investment as well as health status indicators are either completely lacking or of very poor quality, an assessment of recent economic developments in Guinea and their impact on the health sector must be regarded as very tentative.

Executive Summary

Guinea is reported to have a per capita income of US\$ 400 (1988), which lies above the average per capita income of Sub-Sahara Africa of US\$ 320, and its agricultural and mineral resources make it to one of Africa's more richly endowed countries. Social indicators, however, indicate an extremely low level of living standard which is comparable to that of the poorest countries in Sub-Saharan Africa: life expectancy is 42 years, infant mortality is about 146, the under five mortality rate is about 248, and only about 13 per cent of the population is estimated to have access to local health care.

The present leaders in Guinea which came to power in April 1984 started the implementation of a comprehensive economic and financial reform programme in late 1985. The reform programme has been supported from its outset by the World Bank, the IMF and several industrial countries. The principal objective of the reform programme was to improve the structure of incentives, and efficiency in the Guinean economy. The main measures in the first phase of the economic reform programme included the decontrol of prices (except the prices for rice and petrol), the devaluation of the Guinean currency, the liberalization of internal and external trade, and administrative reforms which centered on staff reduction, improvements of the efficiency of the civil service and the privatization or liquidation of public enterprises. The second phase of the reform programme which started late 1988 focused at strengthening the management of public finances through improved budgeting, resource mobilization and expenditure control, and the design of compensatory measures to improve the conditions of life of the poor.

The reform measures have yielded growth of per capita income of 1.6 per cent per annum in the period 1987-1989. One of the key results of the economic reform programme has been a shift in relative prices in favor of the private sector, and the rural sector in particular, and at the expense of the public sector. Accordingly, agricultural production especially the production of coffee increased in recent years. Agricultural growth is projected to average 3.6 per cent per annum in the coming years. Domestic rice production increased as a result of the discontinuation of the distribution of rice at highly subsidized prices and favorable weather conditions.

The shift in relative prices brought about by the economic reform programme tends to raise employment and purchasing power in the private sector, and particularly in the agricultural sector, and to lower them in the public sector. The purchasing power of civil servants has been estimated to have declined importantly although salaries have been adjusted over the last years. Staff reduction in the civil service have been substantial. A reduction of about 13,000 staff has been planned for 1989 in ministries with the exception of the administrative staff in the Ministries of Education and Health. Whereas in the period 1984-1986 jobs have been created, more recently a deterioration of the employment market has been reported. In the second quarter of 1989 only 6 per cent of those seeking positions found employment compared to a reported 24 per cent in the previous year. In the rural areas segments of the population and regions without direct access to rising agricultural output will most likely face losses in their purchasing power as their nominal income is fixed while prices rise.

In manufacturing and commerce, small-scale enterprises and services showed an important increase in their activities. Commerce is the most important sector of the Guinean economy in terms of its contribution to GDP (38 per cent). The average growth rate in the secondary and tertiary sectors is projected to be about 4 per cent in the medium term.

The mining sector, which is almost completely separated from the other sectors of the Guinean economy, is critical for Guinea's economy as it contributes about 77 per cent of export earnings and about 60 per cent of the Government's fiscal receipts in the period 1986-1988.

Other major developments in the Guinean economy have been: The inflation rate has been reduced from about 70 per cent per annum in 1986 to about 28 per cent in 1989. Externally, the current account deficit which reached a peak in 1988 with US\$ 210 million is projected to reach US\$ 83.3 in 1990. External debt roughly doubled during the eighties from US\$ 1,143 million in 1980 to US\$ 2,176 million in 1989. Debt service payments were equivalent to 6 per cent of GDP or 14 per cent of exports in 1989. The debt service-export ratio was slightly lower than the average rate for Sub-Saharan Africa of 15 per cent. Official aid per capita doubled from US\$ 21 in 1984 to US\$ 42 in 1988.

The Government budget deficit, which as share of GDP increased to 5 per cent in 1989, has been almost exclusively externally financed in recent years. A main objective of the Government's budget policy in the early nineties will be to reduce the budget deficit as share of GDP to about 3.5 per cent and to keep real expenditure roughly constant. This budgetary policy implies for public health expenditure that it can only expand in real terms when other components of government expenditure are reduced, i.e. the share of health expenditure in total expenditure is increased. As budget resources will be severely limited for the foreseeable future, it will be essential to make more cost effective use of existing resources in the health sector.

The effect of the economic reform programme on the nutrition and health status is likely to vary between segments of the population and between regions. Increasing per capita income can be in general expected for the private and rural sector. Therefore, the nutrition status of people who receive their income from activities in these sectors will tend to stabilize or even improve. Adverse effects of the reform programme include: lay-offs of civil servants and public enterprise employees, and losses in purchasing power as a result of price increases of primary food products, rents, water, electricity, and health services. The most vulnerable groups in the urban areas are urban poor, unemployed civil servants, unemployed former employees in public enterprises and unemployed graduates. In the rural area the nutrition status and the health status of groups that suffer losses in their purchasing power must be expected to be affected negatively by the economic developments.

Whether and to which degree the nutrition and health status of the most vulnerable groups will be affected by the reform programme and the economic development will also depend importantly on the efficacy of the Government's social policy and the extent to which unemployed will find employment in the private sector. The Government's social policy which has been part of the reform programme is specially designed to cushion the adverse effects of the economic reform on vulnerable groups. One measure of the social policy package are transitory severance payments for civil servants who are not reemployed in the newly organized public administration. NGOs are considered to have a particularly important role to play in meeting the immediate needs of vulnerable groups during the adjustment period.

As the efficacy of the Government's social policy programme is of key importance to the health sector an adequate participation of the MSPP in the formulation, implementation and monitoring of social policy measure should be ensured.

Public health expenditure increased in real terms on average by 24 per cent per annum between 1986 and 1989. The trend of rising real health expenditure is likely to have been broken in 1990. In this year budgeted health expenditure decreased in real terms even assuming an inflation rate as low as 16 per cent. As real overall government spending, in contrast, is projected to increase by about 7 per cent the share of health expenditure to GDP will decrease. This Government policy appears to be in contradiction with its stated objectives to give a high priority to social expenditures including health expenditure. Given also the relatively low share of current health expenditure in current government expenditures, discussions are needed about the reallocation of funds from other sectors, such as defense, to health. However, even if a larger share would be attributed to health, government health expenditure per capita will remain modest in the coming years. Thus, it is imperative that

resources are used as efficiently as possible. The proper mix of inputs financed by the health budget needs also to be examined. Capital health expenditure is to about 90 per cent externally financed and therefore relatively independent from government revenues.

In its national plan the Guinean health ministry (MSPP) proposes a programme whose overall cost amounts to US\$ 76.2 million for the period 1990-92. About 10.8 per cent of the expenditures are planned to be financed domestically, and 10.9 per cent externally. Financing for about 78 per cent of the costs still needs to be found. As there is no guarantee that the Central Government will be forthcoming with the necessary funds and a substantial financial gap exists for which financing has still to be sought a realistic reassessment of the plan may be required.

I. Macroeconomic Developments

1. Background

During the presidency of Sekou Toure (1958-84) Guinea's private sector was largely replaced by a network of state enterprises and controls in all sectors of the economy. Guinea, having been a major exporter of agricultural products at independence (1958), was transformed by the mid-seventies into an important bauxite exporter and a net food importer. The separation of the economy in an official and non-official sector became increasingly important. While the official sector depended on the exports of minerals for its income and functioned through a system of administered prices the non-official sector derived its income from clandestine exports and private transfers from abroad and was supplied largely by smuggled imports. At the beginning of the eighties, the non-official sector satisfied almost all demand for marketed consumer goods in rural areas and about 80 per cent of urban consumer demand.

Severe financial difficulties in the early eighties indicated a serious deterioration of Guinea's economy. Its external position was characterized by mounting debt service obligations, private capital flights and a massive accumulation of payments arrears which amounted to over US\$ 300 million at the end of 1985. The exchange rate was seriously overvalued with an official rate of 23 Sylls per U.S. dollar compared to 400 Sylls on the parallel market. Domestically, the budget deficit expanded mainly as a result of declining tax receipts and rising subsidies to public enterprises.

In April 1984 a new regime came to power by a military coup and Colonel Lansana Conte was named President. The new Government designed an economic and financial reform programme whose main objective has been to put in place a policy framework supporting a market-oriented economic system.¹ The implementation of the economic reform started in late 1985 and since then the economic development in Guinea has been primarily determined by these reforms efforts. The economic reform was from the outset supported by a first Structural Adjustment Credit, two consecutive IMF standby arrangements and a first annual arrangement under the Structural Adjustment Facility. The second phase of the structural adjustment programme started in the second half of 1988.

One of the major results of the reform programme has been a shift in relative prices in favor of the private sector and in particular agricultural production at the expense of the public sector.

2. Recent economic developments: Domestic sector.

a. Production

(i) Aggregate production

Guinea, with a per capita GNP of US\$ 400 in 1988 according to the official statistics, would be one of the richer countries of the least developed countries. However, given the poor quality of the national accounts it may be questioned whether Guinea's per capita GNP lies significantly above the average per capita income of Sub-Saharan Africa (US\$ 320). In terms of natural resources Guinea is richly endowed with agricultural, mineral, and energy resources.

¹ For details on the economic and financial reform programme see section I.3.

Throughout the 1958-1984 period, economic growth remained below the growth rate of the population of slightly less than 3 per cent per annum. An exception was the period 1973-76 when expanding bauxite operations led to an economic expansion.

In the reform period 1987-89 the economy grew by about 4.4 per cent per annum in real terms which represents an increase of about 1.6 per cent of per capita income.

In the years till 1993 the Guinean economy is expected to grow by about 4 per cent per annum according to recent estimates of the Ministry of Planning, the IMF and the World Bank. Under the assumption that the population grows by 2.8 per cent this would represent an average increase of per capita income by 1.2 per cent per annum.

(ii) Structure of production:

Agriculture, livestock, manufacturing and commerce, water and energy, and transportation. The three principal sectors of the economy contributed roughly equally to the gross domestic product in 1986-87. The most important activities are services (38.4 per cent of GDP) followed by industry (31.6 per cent of GDP) and agriculture (30 per cent of GDP). Output in the primary sector is estimated to have provided a livelihood for some 80 per cent of Guinea's population in 1980.

Agriculture

Agricultural production comprises mainly food crops (rice, maize, and cassava) and bananas, pineapples, palm oil and coffee.

According to FAO estimates average food production per head was in 1985-87 about 5 per cent lower than in 1974-76 and this despite the country's substantial agricultural potential.² The exports of agricultural products which accounted for 60 per cent of export in 1958 practically stopped following independence. Guinea having been a net exporter of food grains at independence is now a net importer of cereals. In 1986, Guinea imported 100,000 tons of cereals, 30 per cent of which was provided by donor food aid.

In recent years agricultural production increased as relative prices shifted in favor of agricultural production due to the economic reforms. Domestic rice production increased due to favorable weather conditions and because prices rose strongly as a result of price liberalization³. Similarly, coffee production and exports rose significantly in past years as producer prices rose. Since the state coffee company has been replaced by private enterprises producers have received as much as 80 per cent of the Conakry fob price for their coffee. Currently, the diversification of agricultural production is emphasized to strengthen food self-sufficiency by developing food crops and because cash crops face a difficult international market. Given the pursuit of the economic reform agricultural growth is projected to average 3.6 per cent per annum over the period till 1993.

Livestock and Fishing

The importance of livestock decreased drastically over the last fifteen years. Livestock accounted for only 4 per cent of Guinea's total output in 1987 compared to about 11 per cent in 1973.

Three quarters of Guinea's livestock population is located in Middle and Upper Guinea. The population consists mainly of N'Dama cattle, sheep, goats and pigs.

² As official figures for crop production are not available estimates computed by international organizations are the only source for data.

³ The official rice price functions only as reference price.

The fishing industry is in an early stage of development contributing only 0.1 per cent to Guinea's gross domestic product in 1987. As Guinea's maritime resources are plentiful fishing could contribute to Guinea's food self-sufficiency and its trade account. In recent years projects have started to exploit Guinea's maritime and onshore potentials.

Mining

Since the early seventies when mining accounted for only about 3 per cent of national output mining became an important source of income contributing 21.1 per cent to GDP in 1987. Presently, the external account and government revenue is largely dependent on mining. The mining sector contributed about 77 per cent of export earnings and about 60 per cent of the Government's fiscal receipts in the period 1986-88. This dependence makes the Guinean economy highly vulnerable to adverse trends in international bauxite and alumina markets.

Whereas government income is highly dependent on the mining sector only about 7,000 people are employed in the mining industry. The mining sector functions very much as an enclave in Guinea's economy.

Mining consists of the production of bauxite, alumina and diamond. Since 1979 volume output has stagnated with the exception of the diamond production which rose sharply as a new mining company entered production.

Manufacturing and Commerce

Manufacturing contributes only about 5 per cent of total value added in 1987. Plants are set up for processing agricultural products and producing low value products for the domestic markets. Commercial activities constitute the largest subsector of the economy before industry and agriculture.

As part of the Government's reform programme state enterprises have been privatized or reorganized. Thirty-one public enterprises have been privatized since the beginning of 1986 and an additional seventy are in various stages of liquidation. Small-scale enterprises and services are showing an important increase in their activities, reflecting the shift in the terms of trade away from the public sector towards the rural and private industry and service sectors. The main activities are construction, agro industry, transport and trade. Further privatization of enterprises and commercial activities is expected to stimulate growth in the secondary and tertiary sector to an average rate of about 4 per cent per annum over the period till 1993.

Water and energy

Guinea has one of the least developed urban water supply networks in West Africa, with only nine urban centers out of 35 equipped with pipe systems. The majority of the urban population of about 1.5 million, of which 0.7 million live in the capital city of Conakry, have to rely on unsafe sources for their water needs, while only a minority has access to piped water. In the rural areas, water supply is a quantitative problem in the north of Middle and Upper Guinea, and a qualitative problem throughout the country where many villages do not have potable drinking water.

In recent years several water supply projects have been started which include a major expansion of the water supply network in Conakry and a reorganization of the water supply sector and of its finances.

Transportation

The transport infrastructure is considered by the World Bank to be the single most severe impediment to output recovery. In order to restore links between the capital and the interior the transport system has to be improved considerably.

Projects to improve the road system which are financed by the World Bank and by other sources have started.

b. Income, wages, and employment

A main characteristics of the structural adjustment programme (SAP) has been a shift in relative prices in favor of the rural and service sector and private industry, at the expense of the public sector. The result has been a reduction in the number of civil servants and the creation of jobs in the private sector. At the same time, the purchasing power in the private sector in general and in the rural sector in particular has improved whereas some segments of the urban population, in particular civil servants have suffered a decline in their purchasing power. According to estimates purchasing power of civil servants has gone down by 16 per cent in the period 1984-87.

The average monthly salaries of a civil servant was less than US\$ 50 (GF 20250) per month in 1985 using the parallel market exchange rate for conversion. By comparison, in Mali, whose per capita GDP is of the same order of magnitude as Guinea's, civil servants earn about three times as much. The official salary is considered to have represented only about one quarter of total income, with the remainder coming from second jobs or other sources of income. Although salaries have been adjusted over the past years to take account of price rises in the basic commodities, civil servants' real income is estimated to have declined substantially mainly due to the loss resulting from the elimination of the distribution of rice and other commodities to civil servants at highly subsidized prices. In 1986, more than 40 per cent of the households in Conakry had expenditure levels below the basket of basic goods which has been evaluated by the MPCII to cost GF 68,500.

By the end of 1988 public sector employees on active duty had been reduced by about 15,000, or 17 per cent. Transitional arrangements are in place to facilitate their absorption into the private sector. A reduction of about 13,000 staff has been planned for 1989 from all ministries except the administrative staff of the Ministries of Education and Health and the custom and security service.

In the period 1984 to 1986 about 21,000 jobs have been created in the small enterprise sector in Conakry alone according to a survey undertaken by the Ministry of Plan and International Cooperation. According to statement made by the President of Guinea in his recent independence day address the employment market recently deteriorated. In the second quarter of 1989 only 6 per cent of those seeking jobs found employment compared with a claimed 24 per cent in the previous year.

In order to mitigate the adverse impact of the economic reform programme on the vulnerable groups, the Government has adopted a social policy programme details of which are reported in section I.4.

c. Prices

Prices with the exception of prices for rice, petroleum products, public transportation, and public utilities have been deregulated since 1985. The official price of rice and petroleum products was raised to pass the effects of devaluation through to domestic prices. Measures were also undertaken in 1989 to ensure that food aid rice is sold at full cost.

Inflation which has been a serious problem in Guinea appears to have been under better control in recent years. The inflation rate in Conakry which peaked at 72 per cent in 1986 was reduced to 28.2 per cent in 1989 which was about 3 per cent above the target rate. Food prices rose by about 38 per cent on average per annum in recent years. Food prices are importantly determined by the depreciation of the Guinean franc as Guinea is a net importer of food.

One of the highest price increases can be found for health services. In 1986 inflation in the health sector amounted to 131 per cent which in the following year decreased to 45 per cent.

Prices of housing and electricity increased by even more than that of health services in 1986. The inflation rate in Conakry of this subcomponent of the general price index was 233 per cent in 1986.

3. Recent economic developments: External sector

a. Overview of balance of payments⁴

The structure of Guinea's current account has been characterized by a trade account surplus that was outweighed by a service account leading to an overall current account deficit. The current account deficit increased strongly in the eighties from US\$ 7.5 million in 1983 to US\$ 210.3 million in 1988 which represented 18.3 per cent of GDP. In 1989, the deficit was reduced to US\$ 125.5 million or 7.7 per cent of GDP (Table 3).

The substantial increase in the current account deficit is explained by a decreasing trade account surplus and an rising deficit in the services and private transfer account. The trade account surplus decreased due to stagnating exports of bauxite and alumina which represent 80 per cent of all recorded exports, and expanding imports. The increase in the deficit on the services and private transfers account has been due mainly to increased interest payments on external debt and increased payments for services and transfers related to the public investment programme (PIP). These unfavorable external payments performance resulted in an accumulation of arrears on external debt and a depletion of foreign reserves in 1988.

In the first half of the nineties Guinea is expected to face a difficult external environment with high current account deficits and resulting external financing problems. The projected current account deficits are the result of deteriorating mining earnings after 1990, together with the growth in private sector and public investment-related imports and scheduled interest payments on public debt. To bridge the expected financing gap a combination of resources of the third-year arrangement under SAF, debt relief, balance of payment assistance including an enhanced SAF program, IDA adjustment lending and additional SPA financing are required.

b. External debt

Guinea's total stock of debt roughly doubled from US\$ 1,143 million in 1980 to US\$ 2,176 million in 1989 which is equivalent to 134 per cent of GDP. About 64 per cent of Guinea's external debt was contracted on concessional terms in 1989 compared to about 59 per cent in 1980. The share of multilateral debt in total long-term debt was 28.6 per cent in 1989 and that of official bilateral debt was close to 66.7 per cent. The remainder of the debt was supplied by private creditors.

Debt service payments on long-term debt amounted to US\$ 98 million in 1989 which is equivalent to 6 per cent of GDP or 13.6 per cent of exports. The debt service-export ratio is slightly below the average rate for Sub-Saharan Africa of 15 per cent in 1989.

During recent years Guinea took a series of steps to reschedule or refinance its external debt. With the official creditors presented in the Paris Club several agreements were reached in the period April 1986 to April 1989. As a result of the rescheduling actual debt service payments were substantially below the scheduled level.

⁴ As with most of Guinea's statistics the balance of payments data is rudimentary. Smuggling has been widely spread and according to some estimates exports smuggled amounted to up to US\$ 100 million per year.

Several industrialized countries wrote off recently parts of Guinea's external debt. In November 1989 US\$ 33 million of Guinea's public debt to West Germany was written off. Similarly, France announced that it had decided to write off debts of US\$ 259 million. In December the USA wrote off an amount of approximately US\$ 5.4 million.

c. Exchange rate

The currency of Guinea is the Guinean Franc (GF). As part of the reform programme launched in January 1986 the Guinean franc replaced the Guinean syli and in several steps a flexible exchange rate system was introduced. Guinea maintains now a flexible exchange rate system under which the exchange rate against the U.S. dollar is set in weekly auctions. Apart from the official exchange market a parallel currency market still exists on a significant scale due to the existence of distortions in the economy and de facto restrictions in the exchange and trade system.

At introduction in January 1986, the GF was changed from GF 24.3 per U.S. dollar to 300 GF per U.S. dollar. Since then the Guinean franc has devalued gradually. At October 1, 1990 the GF was quoted with GF 680 per U.S. dollar.

4. Macroeconomic policies

a. The Government's economic and financial reform program⁵

The prime objective of the first phase of the reform programme which started late 1985 was to put in place a policy framework supporting a market-oriented economic system. Specific measures that were undertaken included corrections of the seriously overvalued currency, the establishment of a new banking system, decontrol of prices, liberalization of internal and external trade, improvement of the efficiency of the public sector by cutting employment levels and by withdrawing from commercial and industrial activity and the reorientation of public investment towards directly productive sectors.

In the course of 1986-87 progress was made towards implementing these measures. The new Guinean franc (GF) was introduced in January 1986, replacing the syli as Guinea's currency. All prices were decontrolled with the exception of prices for rice and petroleum products. Of the 128 state enterprises in existence in 1984, 69 had been liquidated by mid 1988, 20 had been transferred to private ownership, another 20 were in the process of privatization or liquidation, and only 19 were to be retained as public enterprises. Administrative reforms centered on staff reduction, improvement of the efficiency of the civil service and decentralization.

Measures during the second phase of the reform programme which started in late 1988 focused at strengthening the management of public finances through improved budgeting, resource mobilization and expenditure control, improving the legal and institutional framework to enhance efficient resource allocation, establishing complementary measure in support of growth, and the design of compensatory measures to improve the conditions of life of the poor, concentrating on the most vulnerable groups and those directly affected by the transitional costs of adjustment.

Whereas the reform process slowed down in the first three quarters of 1988 it regained momentum in the last quarter of 1988 and the first quarter of 1989. New organizational frameworks for key ministries were adopted, progress was made in the selection of civil servants to be retained, the liquidation of the national petroleum distribution company and

⁵ The reform programme is presented in the 'Declaration of the Government of Guinea's Development Policy', Annex V, World Bank (1988)

its replacement by private operators was started, the structure of interest rates was revised including the deregulation of short-term lending rates, food aid rice was sold at full cost, the 1989 budget was adopted more timeously, electricity tariffs were increased by 100 per cent and the petroleum pump price was raised by about 50 per cent.

These improvements in performance made possible the approval of a second annual arrangement under the IMF's Structural Adjustment Facility, SAL II being declared effective on March 2, 1989, and the conclusion of a Paris Club rescheduling on favorable terms in April 1989.

An important component of Government policy are measures to cushion the adverse effects of adjustment on vulnerable groups. During the first phase of the adjustment programme transitional measures were concentrated on assistance to public employees who have left or will leave their government or state enterprise jobs as part of the adjustment process. Measures included compensating civil servants for the increase in the cost of living, continued payment on a temporary basis of salaries to laid-off civil servants, voluntary departure bonuses with access to loans at favorable rates for civil servants with bankable projects.

During the second phase⁶ the emphasis of the social policy component will be on transitory measures to protect vulnerable groups and the development of a comprehensive social policy reform concerned with increasing the participation of the poor in the growth process. The specific measures include the maintenance of a safety net to protect vulnerable groups against expenditure cuts, particularly in the health and education sectors, the continuation of severance packages to civil servants leaving the public administration, the implementation of a comprehensive social policy to upgrade the living conditions of poor and disadvantaged groups, and the improvement of the Government's capacity to monitor living standards of the population during the adjustment process. As part of the second phase the Government also created a National Commission on Social Policy (CNPS) at ministerial level (Figure 1). The Commission is designed to supervise the development of social policy to be implemented during the second phase. The CNPS and its official-level sub-committee replaces the National Poverty Task Force (NPTF).⁷ The senior socio-economic adviser to the Minister of Planning and International Cooperation will also be the Secretary of the CNPS, and Chairman of the official level subcommittee supporting the CNPS.

As a complement to the growth-promoting objectives of the Structural Adjustment Programme a Socio-economic Development Support Project (SEDSP) of SDR 6.9 million has been designed.⁸ The main objectives of the project are to support actions for improving access to employment and basic services for particularly vulnerable groups including those adversely affected by the structural adjustment programme and to enable the Government

⁶ The social policy component of the structural adjustment programme is outlined in the 'Declaration of the Government of Guinea's Development Policy' reproduced in Annex V of World Bank (1988).

⁷ The NPTF was established in September 1987, in the Ministry of Planning and International Cooperation (MPCI), with special assistance from the representatives of UNICEF in Conakry. It was composed of representatives of the departments concerned with planning, finance, housing, health, social affairs, rural developments, transport and decentralization, as well as representatives of international organizations such as World Bank, UNDP, and UNICEF. The NPTF completed a report, entitled "Composante Social du Deuxième Prêt d'Adjustement Structurel, Rapport du Group de Travail Interministériel", on the poverty profile of Guinea, the identification of vulnerable groups in rural and urban sectors, the identification of a first series of projects in the areas of basic education, primary health care, nutrition, employment generation.

⁸ See the World Bank (1989a). Figure 1 shows how the project is institutional integrated into the MPCI.

to develop a long-term programme for alleviating poverty in Guinea. The core of the project consists of three main components: social policy planning, monitoring living standards which includes the implementation of permanent household surveys to track the evolution of living conditions of households during the adjustment period, and the establishment of a pilot programme of sub-projects for socio-economic development. The aim of the pilot programme is to channel funds to small, grass roots sub-projects assisting vulnerable groups in the low-income segment of the population.

An example of a sub-project in the health sector that could be financed by the pilot programme is a project initiated by Medecins Sans Frontière (MSF) in 1986 to rehabilitate health services in the area of Kouroussa, in Upper Guinea.

b. Structural adjustment program

The economic reform programme has been supported by loans from the IMF and the World Bank. The first phase of the programme (1985-1988) was supported by an IMF Stand-by Arrangement of SDR 33 million, by an IDA structural adjustment credit and a Special Facility for Africa of SDR 38.5 million. In addition extensive Special Joint Financing from Germany and Japan, and cofinancing from Switzerland, France and the United States, and the IDA-financed Technical Assistance Project for Economic Management (SDR 9.7 million) was provided.

The second phase of the adjustment programme (1988-93) has been supported by a second IDA Structural Adjustment Credit of SDR 47 million, with additional financing from France, the European Community, the African Development Bank, Japan and the United States. The second phase will also be supported by a Second Economic Management Credit of SDR 11.3 million with cofinancing from several other donors.

c. Official development assistance

Official development assistance to Guinea increased from US\$ 123.2 million in 1984 to US\$ 278.1 million in 1988. Aid per capita increased from US\$ 20.8 to US\$ 41.9.

The main bilateral donors have been France, which supplied in 1988 alone about 31 per cent of aid, Italy and Japan. The main multilateral donors have been the IDA, UNDP, and the EEC.

d. Administration and state of planning procedure

Public Administration

The public administration has been judged overstuffed and unproductive. Government operations have been mainly handicapped by problems associated with an underpaid, underemployed, and less-than-adequately motivated civil service. A major priority of the economic reform has therefore been to implement administrative reform measures to rationalize and decentralize public administration.

To improve the efficiency of the public service the Government has implemented measures to cut the number of civil servants, to upgrade qualifications, to introduce a more adequate rate of remuneration and to withdraw from commercial and industrial activities. Specific measures are qualification tests for the personnel of all ministries. When the tests and evaluations are completed new organizational structures as well as salary adjustments conforming to a new salary scale are to be implemented progressively. The new organizational structure was planned to be completed in March 1988. Employees who fail to qualify for the newly organized civil service will receive a severance pay to the equivalent of 6 month of salary. Employees that choose departure from the civil service instead of participating in the qualification tests receive a resignation premia. In this way the civil service of the

Central Government is planned to be reduced to about 45,000 employees compared to 60,000 employees at the outset of the program.

An important objective of the Government's reform policy has been the decentralization of public administration meaning that local branches of government and community organizations take increasing responsibility for the development initiatives in their immediate community. Within this process the Government encourages the entry of international, community-oriented NGOs and the development of national organizations of the same type. The NGOs are considered to have a particularly important role to play within the framework of the Government's social policy in meeting the needs of vulnerable groups during the adjustment process. The international donor community has given special support to the work of NGOs to ensure that the development projects that they finance are reaching the most vulnerable groups of the population. Responsibility for supporting the decentralization process and the participation of NGO's is entrusted to a Secretariat of State for Decentralization (SED).⁹

For improving the management of public finances particular emphasis is given to the establishment of a comprehensive annual investment budget, which includes all foreign-financed projects, so as to impose budgetary discipline and to take account of associated recurrent expenditures. More specifically the Government will ensure that ministries are notified about their expenditure ceilings, a monthly ceiling is placed on operating expenditure commitments, directors of administration and financial affairs (DAAF) are appointed in ministries, and a permanent mechanism is established for monitoring and controlling staff levels and the wage bill on the basis of the census of civil servants.

The Government has also approved the second economic management support programme (PAGEN II) in agreement with IDA and other donors. This project provides resident technical assistants and short-term consultancy services to help the principal ministries to improve their management of public finances.

To improve the coordination of economic policy the Economic and Financial Coordination Committee (EFCC) has created a technical support unit. This unit is responsible for systematically monitoring the economy and the recovery program.

Public investment programming

The Government adopted its first three-year rolling Public Investment Programme totaling US\$ 592 million for the period 1987-89 in March 1987. The main share of investment (45 per cent) was directed towards rebuilding the country's infrastructure such as transport, telecommunication, and energy. Other important shares of public investment resources were devoted to rural development (25 per cent), education (6.7 per cent) and health (6.2 per cent).

For the period 1989-93 the external financing requirements for the PIP are projected to total US\$ 1,290 million. The Government is expected to fund an additional US\$ 283 million or 18 per cent.

e. Public finance

The Central Government budget has been characterized by a rising overall deficit in recent years from GF 12.1 billion (1.8 per cent of GDP) in 1985 to an estimated GF 85.2 billion (5.2 per cent of GDP) in 1989. This development has been the result of increasing expenditures while revenues stagnated in some years. A principle objective of the Government is to reduce the budget deficit to reach a share of GDP per annum between 3.0

⁹ The resident missions of UNICEF and the World Bank have compiled a directory of NGOs working in Guinea.

and 3.5 per cent in the period 1989-1992. The budget deficits in recent years have been almost exclusively externally financed. In 1989, about 80.7 per cent of the deficit on cash basis was foreign financed.

Total expenditure increased more than tenfold since 1985 and amounted to GF 322.9 billion in 1989. The share of capital expenditure in total expenditure rose substantially from 6.5 per cent in 1985 to 51.4 per cent in 1989. Most of capital expenditure has been foreign financed. The rise in current expenditure, from GF 85.2 billion in 1986 to GF 156.8 billion in 1989 was mainly the result of rising wages and salaries, increases in defence spending which accounted for a significant part of the increase in the goods and service subcomponent, and growing debt servicing.

Total expenditure is projected to increase in the medium term in accordance with the inflation rate implying constant expenditures in real terms. The composition of total expenditures is planned to change. The trend of a growing share of capital expenditure is projected to continue. Salaries are one subcomponent of current expenditure which are expected to grow even in real terms.

Total revenues including grants almost tripled since 1986 and amounted to GF 236.8 billion or 14.6 per cent of GDP in 1989. The tax base is rather narrow and highly dependent on tax revenues from the mining sector which accounted for 68 per cent of total tax revenues in 1989.

Real revenues are expected to grow in the coming years. This increase is thought to be brought about by a more efficient tax collection in other sectors than the mining sector in which the tax collection is already tightly controlled. Whether the planned cuts in the budget deficits can be achieved will therefore depend primarily on the feasibility of the increase in non-mineral revenues. Even if revenues can be raised external financing will remain crucial for balancing the Central Government budget.

II. The Health Sector

1. Population and Urbanization

The population of Guinea has grown by 2.1 per cent during the period 1960-1988. In 1988, the population reached 6.6 million. The fertility rate in 1988 is 6.2. Assuming an annual population growth rate of 2.6 per cent (UNDP, 1990) over the period 1988-2000, the Guinean population will amount to almost 9 million in the year 2000 (see table 6). Note that this projected population growth rate is somewhat lower than that for Sub-Saharan Africa (3.1 per cent) and for the group of least developed countries (2.8 per cent).

Currently, about one quarter of the population lives in urban areas and about 12 per cent in Conakry. In view of the growth rate of the urban population, viz. 5.2 per cent over the period 1988-2000, the share of the urban population in total population is projected to be 33 per cent by the year 2000.

Lower Guinea has with 32.1 per cent the highest number of inhabitants, followed by Middle Guinea with 27.6 per cent of the population, Upper Guinea with 20.6 per cent and the Forest Region with 19.7 per cent.

2. Health Status and its Determinants

The health status of the Guinean population is very poor even compared to that of other Sub-Saharan countries and low-income countries. The health status indicators presented in table 7 are life expectancy at birth (LE), the infant mortality rate (IMR) and the under-five mortality rate (U5MR). Life expectancy at birth is reported to be 42 in 1988. Infant mortality rate and the under-five mortality rate are 146 per 1000 and 248 per 1000 in 1988. As can be seen in table 7, these figures are considerably higher than the rates in comparable countries. Still it can be observed that to some extent modest improvements in health status were realized over the past two decades.

The main influences on health status are nutrition, safe water and adequate sanitation and housing, education and health services including family planning and immunization services. Selected indicators of these determinants are discussed next. First, it is generally acknowledged that malnutrition is a major health problem in Guinea although data on the extent and prevalence of nutritional deficiencies are not collected on a systematic basis. Malnutrition is reported to be widespread among women, lactating mothers and young children. The regions most affected by malnutrition are Upper and Middle Guinea due to drought and recurrent pre-harvest food shortages. From table 7, one sees that the daily calorie supply is around 1,777 in 1986 and 1988. Note that the daily calorie supply as a percentage of requirements is 77 per cent in 1984-1986 (UNDP, 1990). The latter percentage is less than the one reported for 1964-1966, viz. 81 per cent. It is also less than the percentages recorded for Sub-Saharan Africa and the least developed countries in 1984-1986, viz. 91 and 89 per cent, respectively. The precarious domestic situation thus explains the importance of food imports. In 1984-1986, 14.4 per cent of the food available was imported. The food aid in cereals in 1987-1988 amounted to 26,200 metric tons. The latter is about 9 times as much as the average food aid per Sub-Saharan country.

Secondly, the population's poor health status is influenced largely by the lack of safe water and poor environmental and personal hygiene, particularly in rural areas. In 1985-1987, only 19 per cent of the population had access to safe water. The discrepancy between the rural and urban areas is illustrated by the fact that 12 per cent and 41 per cent of the rural and urban

population, respectively, had access to safe water. Also note that progress in safe water supply has been very slow since 1975; in that year 14 per cent of the population had access.

Thirdly, the adult literacy rate is 29 per cent in 1985. Literacy among women is lower than that among men: the literacy rate among females as a percentage of the literacy rate among males is 43 per cent. It stands to reason that this inadequate degree of literacy hampers advances in health status. The fact that especially women are subject to a high degree of illiteracy hinders the necessary improvement in the health and hygienic habits of households.

The health services are an essential determinant of health status, of course. In view of its importance, the health services structure in Guinea is discussed separately in the next section.

3. The Health Care System

a. Organization

The Ministry of Public Health and Population (Ministère de la Santé Publique et de la Population, MSPP) is responsible for the formulation and implementation of national health policy and for overall administration, coordination and management of the country's health system. The MSPP was created in January 1988 replacing the previous Ministry of Health and Social Affairs. A chart depicting the organization of the MSPP is given in figure 2.

The regional management of health care services is decentralized along the lines of Guinea's administrative structure (figure 3). In each region, there is a medical officer (Inspection Régionale de la Santé, IRS) who is responsible for inspection and coordination of health services and other activities such as financial and administrative planning, in-service training of staff and drug distribution.

In each of the 34 prefectures a director of health (Direction Préfectorale de la Santé) has the task to support the primary health care programs in the subprefectoral health centers. For instance, he receives orders for essential drugs from health centers and communicates them to the National Primary Health Care Programme (Programme PEV/SPP/ME). In addition he coordinates all health activities. The director is assisted by the head of the prefectural hospital. At the sub-prefectoral level, the chief of the health center is also in charge of supervising the health personnel in the sub-prefecture.

b. Types of Services

Publicly provided services

Public health services in Guinea are provided through a pyramid of facilities comprising 2 university hospitals, belonging to the Centre Hospitalier Universitaire (CHU), 6 regional hospitals, 29 prefectural hospitals and 344 subprefectoral health centers (MSPP, 1990a).

The first formal entry point into the public health system is the subprefectoral health center. The latter is designed to provide a variety of curative and preventive services, including maternity and maternal and child health services, limited inpatient services, health and nutrition education and outreach services. Health problems that cannot be dealt with at the health center level are in principle referred to the prefectural hospital. The six regional hospitals and the two university hospitals provide tertiary care.

In one third of the subdistricts (sous-préfectures), health centers were linked up with the National Primary Health Care (PHC) Programme (Programme National PEV/SPP/ME) in 1989. The target for 1990 is that half of all health centers are covered by this Program. The latter ensures that these health centers are supplied with essential drugs. The participating health centers have also adopted a uniform cost-recovery scheme, whereby fees are collected for the different health services provided, in particular the prescription and direct provision of drugs to patients.

A salient feature of the current cost-recovery system is that, at present, fee revenues are only used in part for the financing of incentive payments to personnel and a limited amount of operating costs. The bulk of revenues is accumulated in bank accounts. Certainly, health centers have acquired the capability of budgeting health services and collecting and administering fee revenues. However, as yet they have not reached the stage of effectively utilizing the fee revenues in an autonomous way. Note, for instance, that important expenditures items such as the cost of pharmaceuticals are in effect financed via the National PHC Program.

The granting of further autonomy to health centers would have to be prepared cautiously, however. In fact, one of the outcomes of the study by Waty and Brudhon-Jakobowicz (1990) on the budgets of health centers in Upper-Guinea, is that a large degree of financial autonomy (including the financial responsibility for the purchasing of drugs) would entail serious financial problems: half of the health centers would face bankruptcy or have a budget deficit. Health centers would encounter such problems mainly because of excessive costs for personnel (i.e. incentive payments) and other specific services in comparison to inadequate fee revenues. In turn, the low level of revenues from fees can be explained by substandard utilization of health services.

Whereas the health centers participating in the National PHC programme have acquired a certain degree of autonomy so far, this is not the case of the university, regional and prefectural hospitals. They are directly administered by the MSPP. Also note that hospitals charge a fee per consultation and per admission. However, in contrast to health centers, all revenues have to be transferred to the treasury.

For drug supplies hospitals also depend entirely upon Pharmaguinee. The latter state-run company is in charge of distribution of drugs to public health care institutions, especially hospitals. Hospitals receive a budget allocation (crédit) from the Central Government. The latter allows them to buy pharmaceuticals at Pharmaguinee. In 1990, the value of drugs distributed by Pharmaguinee amounted to 0.5 billion GF.

Non-publicly provided health services

The new Government has made continuous efforts to promote the participating of the private sector, including non-profit organizations, in the development of the health system. For instance, since 1985, 2 private clinics, 53 medical and dental practices, 5 laboratories for biomedical analysis, 58 nursing practices, 128 private pharmacies and 28 private sales outlets have been established. Private pharmacies and sales outlets are supplied by 6 wholesale traders. In addition, two private hospitals are run by bauxite companies in the secondary towns of Kamsar and Boké. The services provided at these hospitals are available to the entire population living within their respective catchment areas, however. Also note that some 6,000 traditional healers provide health services and several traditional birth attendants attend deliveries in each village.

It is important to notice that some prefectural hospitals are managed jointly with non-government organizations such as Médecins-sans-Frontières, Médecins du Monde and the Association Française des Volontaires du Progrès. In contrast to the health centers, these hospitals have obtained a large degree of autonomy in that they are able to utilize fee revenues independently from the MSPP.

c. Levels of Services

Health Personnel

In 1984, the population per physician and per nurse were reported to be 57,400 and 6,400, respectively. These ratios are among the highest in the world. Figures for 1988 are presented in table 9. It can be seen that the number of physicians and nurses has increased drastically

since 1984. Indeed, 9,700 inhabitants per physician and 4,300 inhabitants per nurse have been recorded. How this considerable increase in the number of health personnel has come about is not entirely clear. Likely explanations are that the health personnel statistics reported for 1984 were underestimated and/or that Guinean health personnel that worked in neighbouring countries returned to Guinea. Although the size of health personnel may have expanded significantly, questions may be raised about the quality of medical education and the competence of graduates. However, an assessment of the issue of quality can not be made in view of the lack of information.

As can be seen from table 9, substantial differences exist in the distribution of health personnel between the various regions. The region of Lower Guinea (Basse Guinée) is endowed with the highest number of health personnel per population. Within the region of Lower Guinea, the capital city of Conakry attracts major numbers of health personnel. In fact in 1986, Conakry accounted for 12 per cent of the population and had 45 per cent of the nation's physicians, 58 per cent of pharmacists and midwives, and 39 per cent of nurses.

Health Care

Despite the involvement of many health centers in the National PHC Programme and the policy of prescribing low cost essential drugs, the utilization of health services is relatively low. We repeat that in their study about the functioning and financing situation of participating health centers in Upper Guinea, Waty and Brudon-Jakobowicz (1990) point at the rather low level of health services utilization. The ratio of consultations per person per year is below 1 in 15 out of the 18 health centers. In only one health center does this ratio exceed 2. Health centers also vary substantially in the total volume of health services. For instance, the number of consultations per month varies between a minimum of 106 and a maximum of 1122.

The health centers are also largely responsible for the administration of vaccines. The percentage of infants under one year that was immunized against tuberculosis, polio, DPT and measles in 1987 amounts to 23 percent only. The latter compares rather unfavorably with the average for Sub-Saharan Africa, viz. 52 per cent (UNDP, 1990). Note also that significant differences in vaccination coverage across the country's regions have been reported (UNICEF, 1989).

A socio-economic evaluation of the National PHC Programme was started in November 1990. The results should contribute to a better understanding of the determinants of utilization patterns and to the subsequent adjustment of health policies.

Hospitals are especially characterized by excess supply of personnel. The two university hospitals in Conakry have almost one member of health personnel per hospital bed. In the regional hospital of Kindia, the size of health personnel amounts to 119 (of which 22 are physicians) whereas the number of beds is 100. There is also excess supply of personnel in prefectural hospitals. For instance in the prefectural hospitals of Fria and Mamou, there are 13 and 11 physicians relative to 60 and 54 beds, respectively. Despite the relative abundance of personnel, patients' utilization of services is low. Indeed, the average occupancy rate in the prefectural hospitals of Lower Guinea, Middle Guinea, Upper Guinea and the Forest Region amount to 19.4, 28.1, 22.76 and 22.74 per cent, respectively. In the other hospitals, the average occupancy rate is 32.1 per cent (MSPP, 1990). One of the major causes of low utilization of services is the poor quality of services. Especially the shortage of pharmaceuticals and the lack of hygiene in hospital buildings contribute to this substandard quality.

4. Health Financing

Four main sources of financing health care exist in Guinea: the MSPP budget and local government budgets, external assistance and household budgets.

a. Central Government Health Expenditures

Level of Expenditures

Health expenditures in current GF rose by a factor of eight from GF .957 billion in 1985 to GF7.412 billion in 1990 (table 10). Real health expenditures, using the consumer price index for deflating the expenditures, increased on average by 24 per cent per annum between 1986 and 1989. This trend of rising health expenditures stopped in 1990. In this year real health expenditures as budgeted will decrease by 5 per cent, assuming the inflation rate will equal the targeted inflation rate of 16 per cent. However, it seems that due to the rise in fuel costs last August and pressures on public and private sector wages, the chances of holding the inflation rate below 20 per cent in 1990 are jeopardized (EIU, 1990). In other words, the decrease in real health expenditures risks to be larger than 5 per cent.

An alternative price deflator for health expenditures worth considering is the subcomponent of the consumer price index for health and hygiene. Unfortunately, it is only available for 1986 and 1987. When using this deflator, the real increase (decrease) in health expenditures is smaller (greater) than the one calculated using the consumer price index: real spending decreased by about 6 per cent in 1986 (instead of an increase of 53 per cent) whereas an increase of 6.3 per cent is computed for 1987 (instead of an increase of 14 per cent).

Note from table 10 that the ratio of health expenditures to government expenditures has been about 5 per cent in 1989 and 1990. The ratio of health expenditure to GDP, which is a measure of the domestic resources allocated to publicly provided health care is less than half a per cent.

Structure of Expenditures

The largest part of government health budget is allocated to current expenditures: the latter amount to 68.3 and 72.8 per cent of health expenditures in 1989 and 1990, respectively. The salary component accounts for about 60 per cent of current expenditures in 1989 and 1990. The share of the expenditures for pharmaceuticals in the latter years is about 19 per cent.

Basic salaries of health personnel are quite modest. The basic salary of a nurse and a physician amount to 30,000 GF (US\$ 44) and 60,000 GF (US\$ 88), respectively. However, a general increase in salaries can only be envisaged when the government is committed to increasing the overall health sector budget. A fortiori, without an upward adjustment of this budget, a salary increase would provoke a decrease in the budget for pharmaceuticals, supplies and other operating costs. In particular as drugs and supplies are already very often unavailable in hospitals, such a policy would lead to serious shortages of medicines and a further decrease in the quality of care.

b. Local Government Health Expenditure

Local governments allocate part of their own budgets to the health sector to finance salaries of selected categories of personnel (in particular maintenance workers) and to defray other operating costs. The largest part of these expenditures is financed through local tax revenues (ristournes) and a smaller part through direct contributions by the Central Government. In principle, local governments such as those of prefectures allocate 30 per cent of their tax revenues to health and education.

The annual health expenditures at local government level are estimated at about GF 225 million. This represents only a modest contribution compared to the current expenditures budgeted by the Central Government, viz. 4,433 and 5,396 billion GF in 1989 and 1990, respectively.

c. External Aid

Guinea did not, until about 1983, receive external aid for health care. However, in recent years external financing rose considerably. According to the World Bank (1987), external assistance amounted to US\$ 7.8 million or US\$ 1.3 per capita during the period 1983 to 1986.

As can be seen in table 10, external aid finances the bulk of capital expenditure in the health sector. In fact, external aid finances 82.4 and 85.9 per cent of total capital expenditures in 1989 and 1990, respectively. Most of the external funding is provided by multilateral institutions such as the European Community's Fonds Européen de Développement (FED), the World Bank, UNICEF and WHO. Note especially that the drug distribution component in the National PHC Programme is financed almost exclusively via grants from UNICEF and the Italian Government. These grants are included in total capital expenditures; they amounted to approximately US\$ 1.8 million over the period 1986-1990. The World Bank has also extended an IDA credit of US\$ 19.7 million (covering the period 1986-1991) to the Guinean Government in order to develop health services in health centers and prefectural hospitals, especially in rural areas.

d. Households

Households take part in the cost-recovery of publicly provided health services. At the subprefectural health centers that are part of the National PHC Program, patients contribute to cost-recovery via fees. The fees cover the costs of essential drugs provided at the health center. Fee levels depend upon the type of treatment. For instance, treatment against malaria in children and adults costs GF 50 and GF 100, respectively; treatment against sexually transmitted diseases such as gonorrhea and syphilis by means of penicillin-procaine costs GF 2,000. It is estimated that in 1989 household expenditures on essential drugs amount to US\$ 823,194 or 0.494 billion GF; in 1990, these expenditures amount to US \$ 1,527,372 or 1.039 billion GF. It is projected that these expenditures will rise to US\$ 2,172,042 or 1.477 billion GF in 1991 (UNICEF, 1989).

Despite the participation in the National PHC Program, whose management of drug supplies is quite adequate, health centers may lack specific drugs from time to time. Health centers may run out of stock due to inadequate stock management; they may also underestimate the time that elapses between the ordering of drugs and their arrival at the health center. Shortage of drugs at health center levels may thus enhance the purchasing of pharmaceuticals at private pharmacies or outlets.

Households contribute in a limited way to the financing of publicly provided health services at hospital level. Flat fees are charged per consultation (GF 100) and per week of hospitalization (GF 3,000). Drug availability at hospital level is very limited. Hence, many times patients receive prescriptions and have to buy the necessary drugs outside the public sector. The low drug availability is likely to be one of the causes of the low utilization rates of hospital services. In view of the low occupancy rates mentioned above, revenues from hospital fees are rather limited. For instance, revenues collected by the two university hospitals in Conakry amounted to GF 117,600,000 in 1990. The latter amount represents a mere 2 per cent of that year's current government health expenditures.

We reiterate that in view of the problems with drug availability at state-run hospitals and health centers, patients may have to acquire pharmaceuticals at private pharmacies. The country's imports of pharmaceuticals are supplied to private pharmacies and outlets via the

six wholesale traders. The value of sales of imported drugs amounted to 1.32 billion GF in 1989. Guinea also has a number of pharmaceutical companies, such as Soguipharm and Eniphargui, that manufacture a selected number of essential drugs for private sale. Note that Soguipharm also sells part of its production, viz. 10 per cent of its total sales amount, to Pharmaguinee. It is interesting to observe that Soguipharm's sales volume is about identical to the value of drugs distributed by Pharmaguinee to public hospitals.

As said above, a number of hospitals are managed jointly by NGOs and the state. These have acquired an important degree of autonomy. Apart from having established their own cost-recovery schemes, these hospitals would also have their own channels of drug distribution. Most often the purchase of essential drugs is organized by the NGOs via international tenders. The availability of drugs at these hospitals is usually very adequate. This explains in part the high utilization rates observed. In turn the latter explains why the amount of costs recovered by such hospitals is quite important. For instance, the fee revenues collected at the hospital of Nzérékoré (which is co-managed by MSF-Belgium) amount to 165,000,000 GF.

It is thus apparent that households' health expenditures are highly significant vis-à-vis those of the government. For instance, in 1989, the sum of the sales of drugs at health centers participating in the National PHC Programme and the value of imported drugs amounted to 1.814 billion GF. The latter already represents 41 per cent of current government health expenditures. Other evidence of the importance of households' health expenditures comes from an expenditure survey held among 300 households in Conakry in the period 1986-1988 (Fandre, 1990). It was found that the shares of health expenditures in total expenditures amounted to 16 and 9 per cent in 1986 and 1988, respectively.

5. Sector Policy and Strategy

The current inadequacy of the public health system is emphasized in the "Declaration of the Government of Guinea's Development Policy" (World Bank, 1988, Annex V). The Government considers it unacceptable to allow the health and education sectors to deteriorate further given the very low levels of the social indicators and the scant resources allocated to these sectors. Therefore the Government expects to assign high priority to these sectors when preparing the budget of current and capital expenditures and to increase their allocation. The Government is implementing a plan of action for the health sector that emphasizes primary health care: protection of mothers and children, vaccination programs and hygiene.

The Government's specific objectives till the year 2000 are:

- (i) to ensure the coverage of 80 per cent of the population by health centers;*
- (ii) to renovate the sub-prefectoral health centers;*
- (iii) to renovate and reequip 22 prefectoral hospitals, and the 4 regional hospitals;*
- (iv) to ensure the supply of essential drugs;*
- (v) to extend and improve cost recovery;*
- (vi) to integrate traditional medicine into the health system;*
- (vii) to ensure the training of personnel in view of primary health care.*

For specifying the financial requirements of its action plan, the Government has prepared a budget plan for the years 1990 to 1992 to be presented in section III.3.

III. Implications of Macroeconomic Developments for the Health Sector

1. Effects on Nutrition Status and Health Outcome

Guinea was shown to have low levels of social indicators (Section II). They are as low or even lower than the indicators for the poorest countries in Sub-Saharan Africa. Therefore, any further deterioration of the nutrition and health status is declared inadmissible by the Government.

One of the main characteristics of the economic and financial reform in Guinea has been a shift in relative prices at the expense of the public sector but in favor of the rural and private industry and service sector. A result of this shift has been an increase in agricultural production and a substantial expansion of the activity of small-scale enterprises and services. Accordingly, the increase in per capita income of about 1.6 per cent per annum in recent years was concentrated in the private and rural sectors. Similarly, employment has expanded in the private sector while it has decreased in the public sector. Given this basic economic evolution, the nutrition status and therefore the health status can be expected to stabilize or even improve for the groups employed in these sectors of the Guinean economy.

Apart from these positive effects the economic and financial reform is likely to have adverse impacts on the health status of specific segments of the Guinean population. The negative effects of the economic reform include: lay-offs of civil servants and public enterprise employees, and losses in purchasing power as a result of price increases of food products, rents, water, electricity and health services. The most vulnerable groups in the urban areas, and specifically in Conakry, include unemployed civil servants, unemployed former employees in public enterprises and unemployed graduates. Note that the purchasing power of civil servants has been reported to have decreased substantially and unemployment appears to have increased in urban areas in 1989 (Section I.2.b). The rural area groups and regions that do not share in the rise of agricultural output are most likely negatively affected by the economic changes. These groups face losses in their purchasing power due to rising expenses that are not compensated by rising income.

To mitigate the adverse effects of the economic reform the Guinean Government has incorporated a social policy component into its reform programme (Section I.3.a). Whether the nutrition and health status of the most vulnerable groups will deteriorate depends importantly on the efficacy of the social policy measures and on the extent to which unemployed are absorbed by the private sector. For civil servants, for example, who are not taken over by the newly organized public administration the Government has instituted severance packages. The severance payments are transitory and will stop in 1991, however. Discontinuing these severance payments would constitute an important hardship for civil servants who are still unemployed. That this is a relevant issue seems to be indicated by the recent increase in unemployment.

NGOs are considered to have a particularly important role in meeting the needs of vulnerable groups during the economic adjustment process. In this way they complement the social policy measures of the Government.

2. Effects on Health Service Delivery

a. Central Government Health Expenditures

An important objective of the economic reform is the control of government expenditures. Accordingly, the Government plans to have a budget deficit not larger than 3 to 3.5 per cent of GDP per annum in the coming years. It also plans to keep real Central Government expenditures constant. The latter implies that real health expenditures would only be able to increase as soon as other components of government expenditure are reduced. Note, however, that capital expenditures in the health sector would be less sensitive to the government's budgetary policy, as 80 per cent of all capital health expenditures is externally financed.

It has in fact been the declared objective of the Government to attribute a high priority to the health sector and to increase the share of health in the overall budget. However, while this policy has been followed in the years 1986 to 1989, less importance appears to have been given to the health sector in 1990. Notice in table 10 that the share of health expenditure in overall government expenditures will decrease in 1990. Assuming an inflation rate of 16 per cent, real health expenditures in GF will drop by about 1.8 per cent. As the inflation rate will most likely be closer to 25 per cent, real health expenditures could be reduced by up to 11 per cent. In other words, these findings are at variance with the Government's official objective of safeguarding the health sector.

As the real health budget has come to be severely limited, it is all the more important that one makes a cost-effective use of the available resources. In other words, it is imperative to strive for an optimal combination and size of inputs into the health sector. Let us cite especially that human resource planning is needed in view of containing health personnel costs and leaving room for financing other necessary inputs. For instance, assuming the size of health personnel remains constant, a decrease in real health expenditures will have an adverse effect on the budget for complementary inputs such as pharmaceuticals. Given the current lack of medicine in public hospitals, the present allocation decision will only exacerbate the serious problems in delivering adequate health services.

Note that the present shortage of medicine is a consequence of the decision to allocate a relatively low share of the government budget to health. However, it is also a result of a recent exchange rate policy. In fact, an important component of economic policy has been the devaluation of the Guinean Franc by about 107 per cent in the period 1986-1989. As drugs (and other equipment) are in general imported and as the devaluation has been passed through to domestic prices, the expenses for medicines increased substantially. The latter is reflected in the strong increase of the subcomponent of the consumer price index for health and hygiene. It follows that this devaluation reduced the purchasing power of the government budget for pharmaceuticals. Note that the decline in the real budget for drugs concerns especially the hospital sector, as drugs in the National PHC programme are financed by outside sources.

b. Household Expenditures and Cost-recovery

The relative economic improvement of some segments of the population may create a greater potential for cost-recovery among households for publicly provided health services. For instance, the rural population that benefits from the boost in agricultural production should be able to have greater access to the health centers participating in the National PHC Programme. However, groups that face adverse economic effects may be in a difficult position to pay user fees.

Discussions are underway at the MSPP about introducing a cost-recovery scheme at the level of public hospitals. It will be very important to determine patients' contributions such that access to health services can be insured. In view of safeguarding the utilization of health services by the most vulnerable groups, exempting them from payment of contributions or fees may well become necessary.

c. Resource Needs and Financing

In its National Plan for the Development of the Health Care System, the MSPP proposes a series of projects whose overall cost for the period 1990-1992 amounts to US\$ 76.241 million or GF 51.844 billion (Table 11). Of the latter amount, 10.8 and 10.9 per cent would be financed by domestic and external sources, respectively. Financing for about 78 per cent of the cost still needs to be found.

The Guinean Government would finance GF 4.245 billion of the domestically financed part, or GF 1.415 billion on an annual basis. Under the assumption that these expenditures would occur in addition to the regular government budget, the budget for health expenditures in 1990 would have to be at least 7.9 billion GF (= 6.489 billion GF + 1.415 billion GF). The amount budgeted for 1990 is 7.412 billion, however. In other words, the health expenditures budgeted for 1990 are 6.2 per cent below the theoretically required amount. Also notice that total health expenditures (including externally financed expenditures) as a share of total government expenditures drops from 5.0 per cent in 1989 to 4.7 per cent in 1990. The share of current health expenditures in current government expenditures reduces from 2.8 per cent in 1989 to 2.6 per cent in 1990. It thus seems that the Government takes decisions with respect to the health budget that are in contradiction with the announced policy.

It is important to note that, apart from the shortfall in government resources, there is a further need to find additional funds to finance US\$ 60.553 million or 41.156 billion GF over the period 1990-1992. Under the assumption that it is possible to cover this financing gap (US\$ 20.174 million on a yearly basis) by external resources, this aid amount would represent an increase of 11.4 per cent of total ODA to Guinea in 1986. As a matter of comparison, the increase in ODA from 1986 to 1987 amounted to about 22.4 per cent. It follows that about half of this increase in total ODA would be needed to finance the financing gap in the National Plan.

IV. Implications for Actions

A first important issue in health policy for Guinea will be to ensure the financing of the plan for the development of the health care system for the period 1990-1992. It appears that there is no guarantee that the Central Government will be forthcoming with the necessary funds. In addition, a substantial financial gap exists for which financing has still to be sought. Given the present state of commitment from the national government and the limitation on external resources, it is doubtful whether funding for the 'principal' and 'additional' proposals can be ensured in the short run. Therefore, a realistic reassessment of the plan may be required.

Secondly, the overall role of health within the central government budget needs to be carefully scrutinized. Note that the share of current health expenditures in total current government expenditures is relatively low. Discussions are needed about the possibility of reallocating funds from other sectors, such as defense, to health. However, even if a larger share would be attributed to health, government health expenditures per capita will remain modest in the coming years. Thus, it is imperative that resources are used as efficiently as possible. The proper mix of inputs financed by the health budget needs also to be examined. For instance, a suitable balance between expenditures on health personnel and complementary inputs such as drugs and equipment is required.

Thirdly, a challenge for the coming years is to identify to what extent recovery of costs of health services among households can be instituted. A strategy of cost-recovery is advisable, but only if it can contribute to a better provision of quality health care and to a more equitable pattern of utilisation of health services. It is hoped that the results of the evaluation of the National PHC Programme would facilitate the formulation and/or adjustment of cost-recovery policies at the primary health care level. As the MSPP also considers the implementation of cost-recovery at the hospital level, much attention will have to be paid to the way fees or other forms of patient contributions are established as the latter have an impact on the utilisation pattern of health care services across socio-economic groups.

Fourthly, the specific measures of the social policy component in the second phase of the economic reform include the protection of vulnerable groups against expenditure cuts, particularly in the health and education sectors, the continuation of severance packages to civil servants leaving the public administration, and the improvement of the Government's capacity to monitor living standards of the population during the adjustment process. The commission that supervises the implementation of the social policy at the ministerial level is the National Commission on Social Policy (CNPS). As the social policy programme is of key relevance to the health sector the institutional development of the CNPS should be closely observed and an adequate participation of the MSPP in the formulation and implementation of the social policy should be ensured.

The monitoring of the impact of the structural adjustment programme on the living standards of households is of specific concern to the MSPP as it helps to identify vulnerable groups who are mostly in need of health services. The results of households surveys that are to be organized on a regular basis should be considered as an important input into the formulation of health policies.

V. Acronyms and Abbreviations

AfDF	- African Development Fund
CNPS	- Commission Nationale de Politique Sociale
DAAF	- Directors of Administration and Financial Affairs
DPS	- Directeur Préfectoral de la Santé
EFCC	- Economic and Financial Coordination Committee
IRS	- Inspecteur Régional de la Santé
MEF	- Ministère d'Economie et de la Finance
MPCI	- Ministère du Plan et de la Coopération Internationale
MSP	- Ministère de la Santé Publique et de la Population
NPTF	- National Poverty Task Force
ODA	- Official Development Assistance
PAGEN II	- Second Economic Management Support Project
PHC	- Primary Health Care
PIP	- Public Investment Program
SAF	- Structural Adjustment Facility
SAL	- Structural Adjustment Credit
SAP	- Structural Adjustment Programme
SPA	- Special Programme of Assistance
SED	- Secrétariat d'Etat à la Décentralisation
SEDS	- Socio-Economic Development Support Project
WFP	- World Food Program

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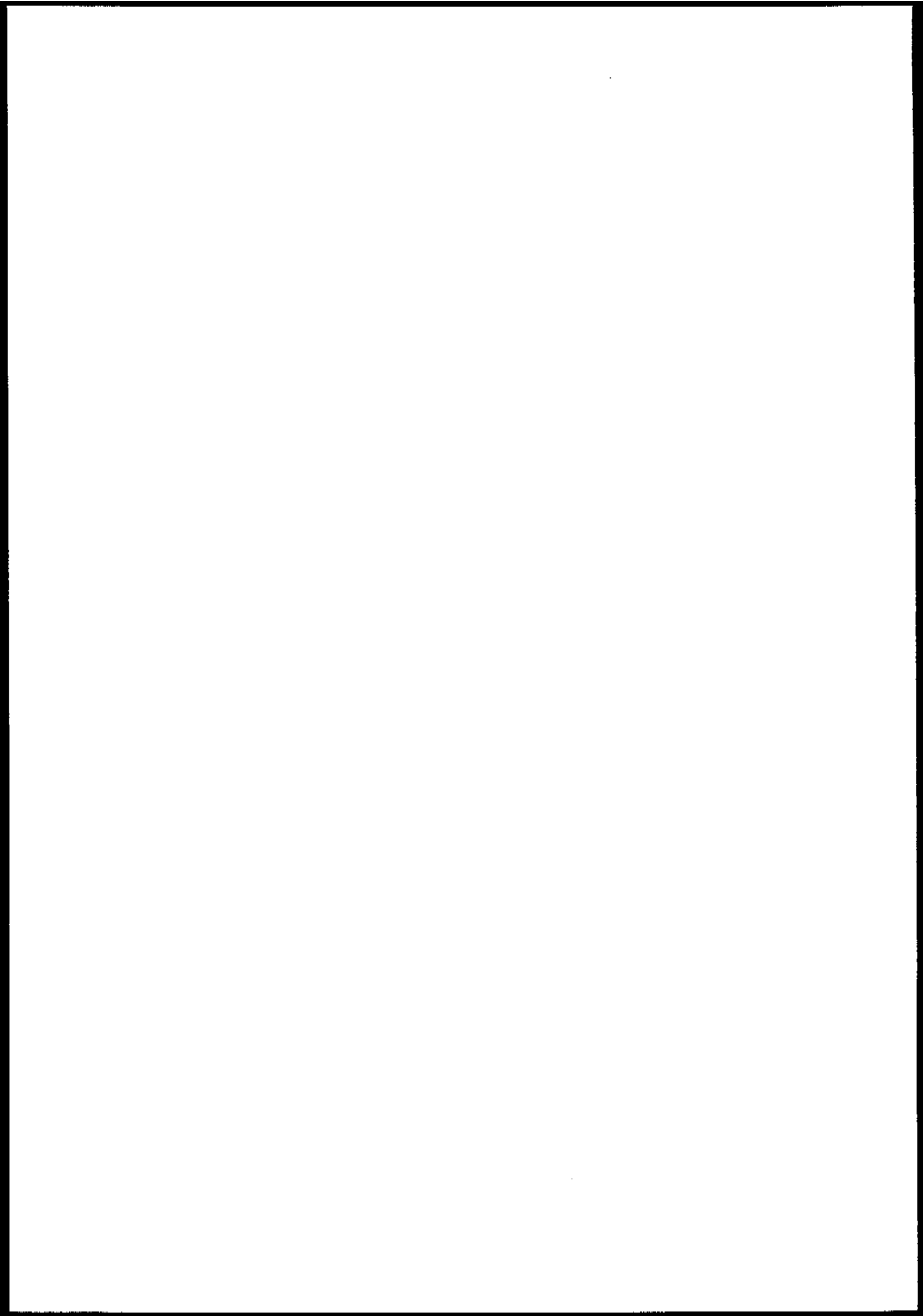
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VII. Annexes

Table 1

Gross Domestic Product by Sector of Origin, 1986-88					
<i>(%, in billions of GF)</i>					
	1986	1987	1988	1989	1990 Proj.
Growth Rates (% per annum) <i>(from constant price data)</i>					
GDP		6	5.9	4.3	
Agriculture		4.2	4.8	5.7	
Industry		7.5	6.8	2.1	
of which manufacturing		3.8	5.8	1.6	
Services		4.9	5.9	5.1	
Shares of Gross Domestic Product (%) <i>(from current price data)</i>					
GDP	100	100	100	100	
Net Indirect Taxes	1.3	1.6	1.6	1.6	
Agriculture	30.7	29.4	29.1	29.5	
Industry	31.3	33	33.3	32.6	
of which manufacturing	5.5	3.5	3.5	3.4	
Services	38	37.6	37.6	37.9	
Memorandum item:					
GDP, current prices	671	902	1151	1430	1760

Source: World Bank (1989b)

Table 2

Consumer Price Index, 1985-89					
(Dec. 1986 = 100)					
	Dec. 1985	Dec. 1986	Dec. 1987	Dec. 1988	Dec. 1989
Total	58.2	100.0	133.7	169.0	
Rate of change (%)		71.8	33.7	26.4	
Food	74.7	100.0	143.0		
Rate of change (%)		33.9	43.0		
Health & hygiene	43.3	100.0	144.7		
Rate of change (%)		130.9	44.7		
Housing	30.9	100.0	131.8		
Rate of change (%)		223.6	31.8		
Electricity & Water		100.0	95.4		
Rate of change (%)			-4.6		
Memorandum item:					
Consumer Price Index (period average)		100.0	136.7	174.2	223.3
Rate of change (%)			36.7	27.4	28.2
Implicite GDP Deflator		76.7	100.0	120.7	163.4
Rate of change (%)				20.7	35.4

Source: IMF (1987, 1988); World Bank (1989b)

Table 3

Balance of Payments, 1986-90					
(in millions of US\$)					
	1986	1987	1988	1989	1990
				Estimat	Proj.
CURRENT ACCOUNT BALANCE	-54.0	-74.5	-210.3	-125.5	-83.3
Excl. official transfers	-96.3	-157.3	-293.8	-223.3	-199.9
Trade Balance	141.5	137.8	11.6	144.0	188.7
Exports, f.o.b.	603.5	628.4	603.3	721.0	799.6
Of which: Bauxite & alumina	467.2	484.8	454.5	530.6	613.4
Imports	-462.0	-490.6	-591.7	-577.0	-610.9
Of which: Public sector	-204.3	-176.9	-191.1	-180.3	-209.5
Service & Priv. Transfer	-237.8	-295.1	-305.4	-367.3	-388.5
Non-factor services, net	-79.6	-121.0	-110.0	-129.0	-110.7
Factor services, net	-144.1	-136.1	-168.6	-200.9	-242.1
Private transfers, net	-14.1	-38.0	-26.8	-47.4	-35.8
Official transfers	42.3	82.8	83.5	97.8	116.6
CAPITAL MOVEMENTS	36.9	71.6	73.7	89.5	114.1
Public capital, long term	49.8	50.4	38.0	70.9	96.6
Public capital, short term	-15.2	0.0	0.0	0.0	0.0
Mixed mining comp.	-2.7	16.0	29.3	8.6	6.6
Other priv. cap.l incl. direct invest.	5.0	5.2	6.5	10.0	10.9
Errors and omissions	-34.9	-8.2	13.6	-1.5	0.0
OVERALL BALANCE	-52.0	-10.7	-123.1	-37.2	30.9
FINANCING	52.0	10.7	123.1	37.2	-30.9
IMF credit	10.9	14.6	0.0	17.2	2.4
Disbursement & Purchase	17.6	21.9	0.0	22.5	14.9
Of which: SAF	0.0	14.6	0.0	22.5	14.9
Repayment & repurchase	-6.7	-7.3	0.0	-5.3	-12.5
Gold		-9.2	-19.6	-18.4	-24.0
Other reserve movements	-23.3	-34.0	42.0	-20.5	-8.7
Changes in arrears	-274.8	7.5	57.0	-88.5	-13.8
Reduction of arrears	-285.3	-16.5	-19.0	-104.7	-19.8
Accumulation of arrears	10.5	24.0	76.0	16.2	6.1
Other liabilities	-13.5	0.0	0.0	0.0	0.0
1986 Paris Club resch.	219.2	6.3	0.0	0.0	0.0
Other debt resch.	133.5	25.5	43.7	30.9	13.2
1989 Paris Club resch.	0.0	0.0	0.0	116.5	0.0

Source: World Bank (1989b)

Table 4

Government Budget, 1986-90					
<i>(in billions of GF, %)</i>					
	1986	1987	1988	1989 Est.	1990 Proj.
Revenue and grants	94.9	161.1	188.8	237.7	327.4
Tax revenues	73.4	111.4	127.3	179.4	251.7
Mining sector	62.2	90.4	89.1	109.9	140.8
Non-mining sector	11.2	21.1	38.2	69.5	110.9
of which: on income & profits	1.1	1.6	2.9	4.6	56.9
of which: on goods & service	4.1	10.4	23.7	40.5	56.9
of which: on intern. trade	6.0	9.0	11.7	13.5	21.5
Non-tax revenue	8.3	14.9	23.3	10.2	21.0
Grants	12.8	34.8	38.1	58.3	58.0
Total expenditure	136.2	192.2	271.3	322.9	418.5
Current expenditure	85.2	107.3	147.9	156.8	205.5
Wages & salaries	18.2	21.3	45.5	55.7	77.1
Goods & services	45.0	51.8	48.0	52.9	70.5
Subsidies & transfer	9.5	16.0	22.9	15.9	22.7
of which: severance payments	0.0	3.5	5.0	0.7	2.5
interest paymentst due	12.5	18.2	31.4	32.3	35.2
Capital expenditure	51.0	84.9	123.5	166.1	208.0
Deficit, commitment basis	-41.8	-31.1	-82.5	-85.2	-86.1
Changes in ext. arrears	3.2	-5.3	12.2	-16.9	-6.8
Changes in dom. arrears	0.0	3.7	1.0	-9.2	-2.5
Deficit, cash basis	-38.6	-32.7	-69.4	-111.3	-95.4
Financing	38.6	32.8	69.4	111.3	99.4
Foreign financing, net	36.7	38.3	65.4	89.8	71.3
Domestic financing, net	1.8	-5.5	4.0	-3.0	-10.8
Memorandum item:					
Changes in expenditure		41.1	41.2	19.0	29.6
Inflation rate (period average)		36.7	27.4	28.2	16.0
Deficit (commitment) as % of GDP	-6.2	-3.5	-7.2	-5.2	-4.9

Source: World Bank (1989b); Ministère de l'Economie et des Finances (1989)

Table 5

Official Development Assistance, Net, 1984-88					
(in millions of US\$)					
	1984	1985	1986	1987	1988
Bilateral Aid	42.2	52.5	95.2	142.4	184.5
Canada	9.8	11.2	2.8	4.8	6.6
Denmark	3.4	0.7	3.6	2.9	1.1
France	9.4	20.0	35.9	51.0	86.8
Germany, F.R.	8.5	6.7	11.6	24.8	11.4
Italy	3.3	3.2	7.0	7.6	31.4
Japan	2.7	5.0	3.2	22.5	26.6
United States	4.0	8.0	12.0	23.0	13.0
Others	1.1	-2.3	19.1	5.8	7.6
Multilateral Aid	51.3	57.5	67.1	70.6	80.0
Af.D.F.	1.1	7.6	12.0	13.6	9.5
E.E.C.	13.9	10.4	15.0	13.3	10.7
IBRD		-5.0	-7.8	-10.0	-12.0
IDA	19.8	21.5	35.5	38.2	43.0
IFAD	0.3	3.3	4.4	2.8	
UNDP	5.2	4.4	5.8	6.9	10.9
UNICEF	1.0	0.9	1.0	1.6	1.5
WFP	2.1	0.9	1.4	2.0	2.5
Arab Agencies	4.8	5.5	-2.6	0.5	7.1
Others	3.2	8.0	2.4	1.7	6.8
Arab Countries	29.7	2.1	4.4	12.0	13.6
Total	123.2	112.1	166.6	225.0	278.1

Source: OECD (1990)

Table 6

Population, 1985-2000			
(millions, %)			
	Urban	Rural	Total(1)
1985			6.201
1986			6.331
1987			6.464
1988	1.587 (24%)	5.053 (76%)	6.600
1989			6.772
1990			6.947
1991			7.128
1992			7.314
1993			7.504
1994			7.699
1995			7.899
1996			8.104
1997			8.315
1998			8.531
1999			8.753
2000			8.989

1 Population figures starting in 1990 are medium projections.

Source: MSPP (1989)

Table 7

Nutrition and Health Status					
(Sub-Saharan Africa/Low-income countries)					
	1965	1982	1985	1986	1988
Nutrition Status					
daily calory supply (cal. p. person)	1923 (./1993)			1777	1776 (2095/2392)
daily protein supply (grams p. person)	40				40 (52/57)
Health Status					
life expectancy at birth	35.1				42.2 (50.6/61.4)
IMR (p. 1000 live b.)	196				146 (113.6/72.6)
U5MR	346 (1960)				248 (173.4/174.8)

Source: World Bank (1989c); UNICEF (1989).

Table 8

Access Indicators					
(Sub-Saharan Africa/low-income countries)					
	1981	1984	1985	1987	1988
Safe Water					
(% of population)					
Total			19.0 (36.5/...)		
Urban			41.0 (75.5/73.4)		
Rural			12.0 (24.2/...)		
Medical Care					
Population per					
- physician	54,430 (1965)	57,390 (../5410)			9.700(1)
- nurse	4,750 (1965)	6,380 (../2150)			4,300(1)
Infants immunized					
(%)					
- DPT				16.0 (45.7/41.3)	
- Measles	15			27.0 (52.9/43.4)	
- Polio				16.0 (../...)	
- BCG				31.0 (../...)	
- TB				31.0 (../...)	
Access to local health care (%)					13

1 Figures reported in MSPP (1989a);

Source: World Bank (1989c); UNICEF (1989).

Table 9

Regional Distribution of Medical Personnel in 1988					
(Population per Medical Personell)					
Categories	National Level	Lower Guinea	Middle Guinea	Upper Guinea	Forest Region
Physician	9700	4700	21500	17800	19200
Chemist	50300	31300	112800	61400	51600
Dentist	384700	161200		450000	1290000
Midwife	18600	7800	106000	61400	28600
Nurse	4300	2500	12100	7400	3700

Source: MSPP (1989a)

Table 10

Central Government Health Expenditure, 1985-90

(in billions of GF, %)

	1985	1986	1987	1988	1989 Estimat.	1990 Proj.
Expenditure	0.957	2.151	3.247	4.872	6.489	7.412
Current exp.					4.433	5.396
Of which: Salaries					2.700	3.227
Of which: Pharmaceutic.					0.850	1.000
Of which: Others					0.883	1.169
Capital exp.					2.056	2.016
Capital expenditure (financed externally)					9.603	12.306
Changes in						
nom. expenditure		124.8	51.0	50.1	33.2	14.2
real expenditure		53.0	14.3	23.7	5.2	-1.8
H.exp./Gov. exp.1					5.0	4.7
Cur.hlth exp./cur. exp.2					2.8	2.6
Cap. hlth exp.3 /cap. exp.					7.02	7.83
Health exp. /GDP4		0.32	0.36	0.42	0.40	0.37
Health. exp. per capita (US\$)				733.8 (1.55)	958 (1.55)	1067 (1.57)

1 Health expenditure as percentage of total government expenditure (including externally financed capital expenditures);

2 Current health expenditure as as percentage of current government expenditure;

3 Capital health expenditures including externally financed expenditures

4 Domestically financed health expenditure.

Source: MSPP (1989a); Lacrolique and Mrejen (1990); own calculations

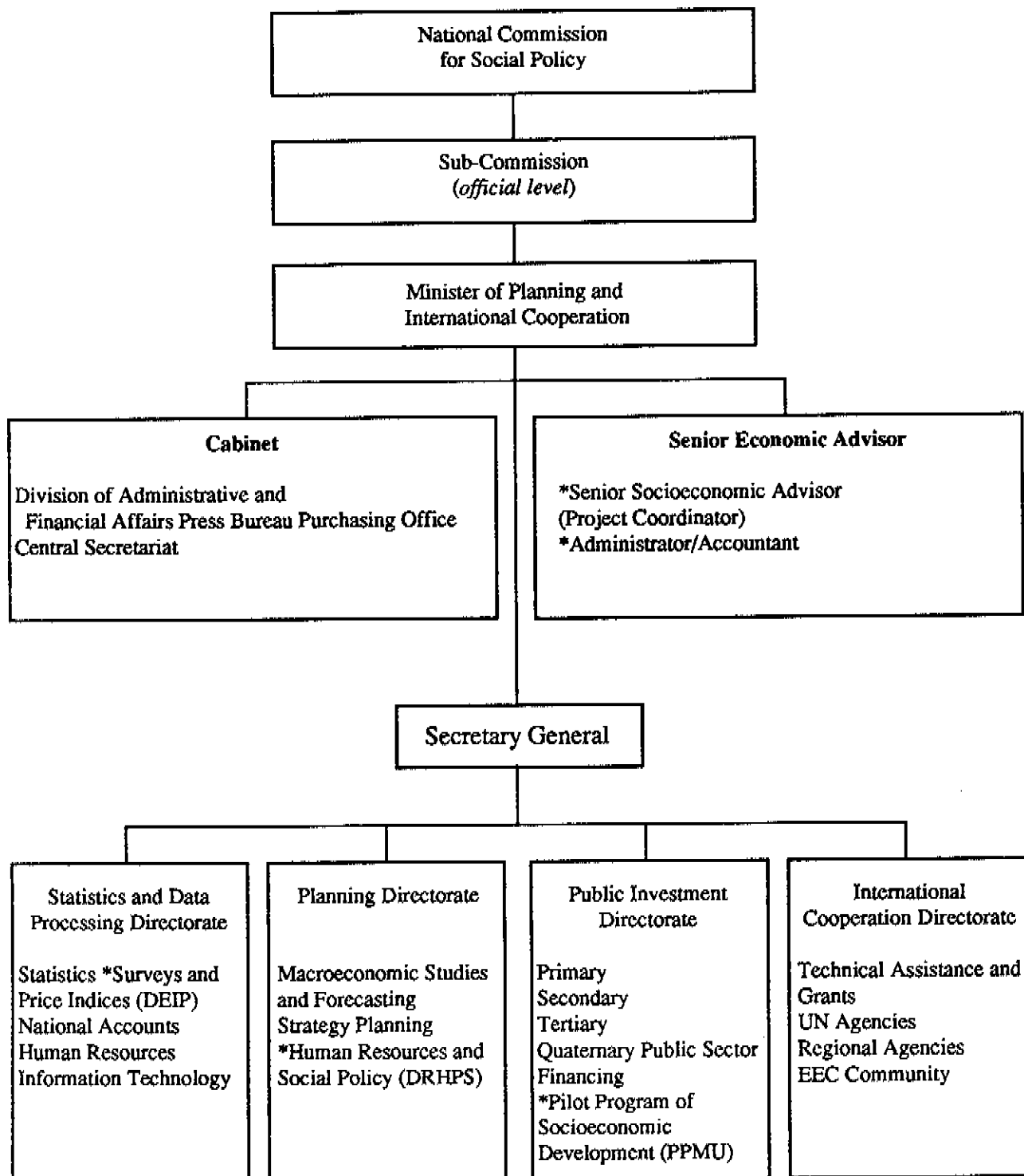
Table 11

Financial Plan, 1990-92					
(in millions of US\$, GF)					
	1990	1991	1992	Total \$	Total GF
I. Principal Proposition					
Expenditure	16.141	17.955	15.378	49.473	
<i>Current expenditure</i>					
Salaries	0.211	0.378	0.452	1.041	
Drugs etc.	0.100	0.429	0.839	1.368	
Others	0.327	0.594	0.878	1.799	
<i>Capital expenditure</i>					
Construction/renovation	8.125	10.64	8.79	27.555	
Equipment/cars	7.377	5.913	4.418	17.71	
Financing	5.951	5.571	3.807	15.33	
Central Government	1.467	1.613	1.775	4.855	
Collectivity	0.5	0.58	0.75	1.83	
Cost recovery	0.05	0.083	0.108	0.242	
External assistance	3.934	3.294	1.174	8.403	
Financing Gap	10.19	12.384	11.571	34.144	
II. Additional Propositions					
Expenditure				27.767	
Current expenditure				12.341	
Capital expenditure				15.426	
Financing				1.388	
Central Government				1.388	
External assistance					
Financing Gap				26.379	
III. Propositions I and II					
Expenditure				77.241	52.524
Current expenditure				16.55	11.254
Capital expenditure				60.691	41.27
Financing				16.718	11.368
Central Government				6.243	4.245
Other domestic financing				2.072	4.409
External assistance				8.403	5.714
Financing Gap				60.523	41.155

Source: MSPP (1989a); 1\$ = 680 GF (1 October 1990)

Figure 1

Organizational Chart of the SEDSP

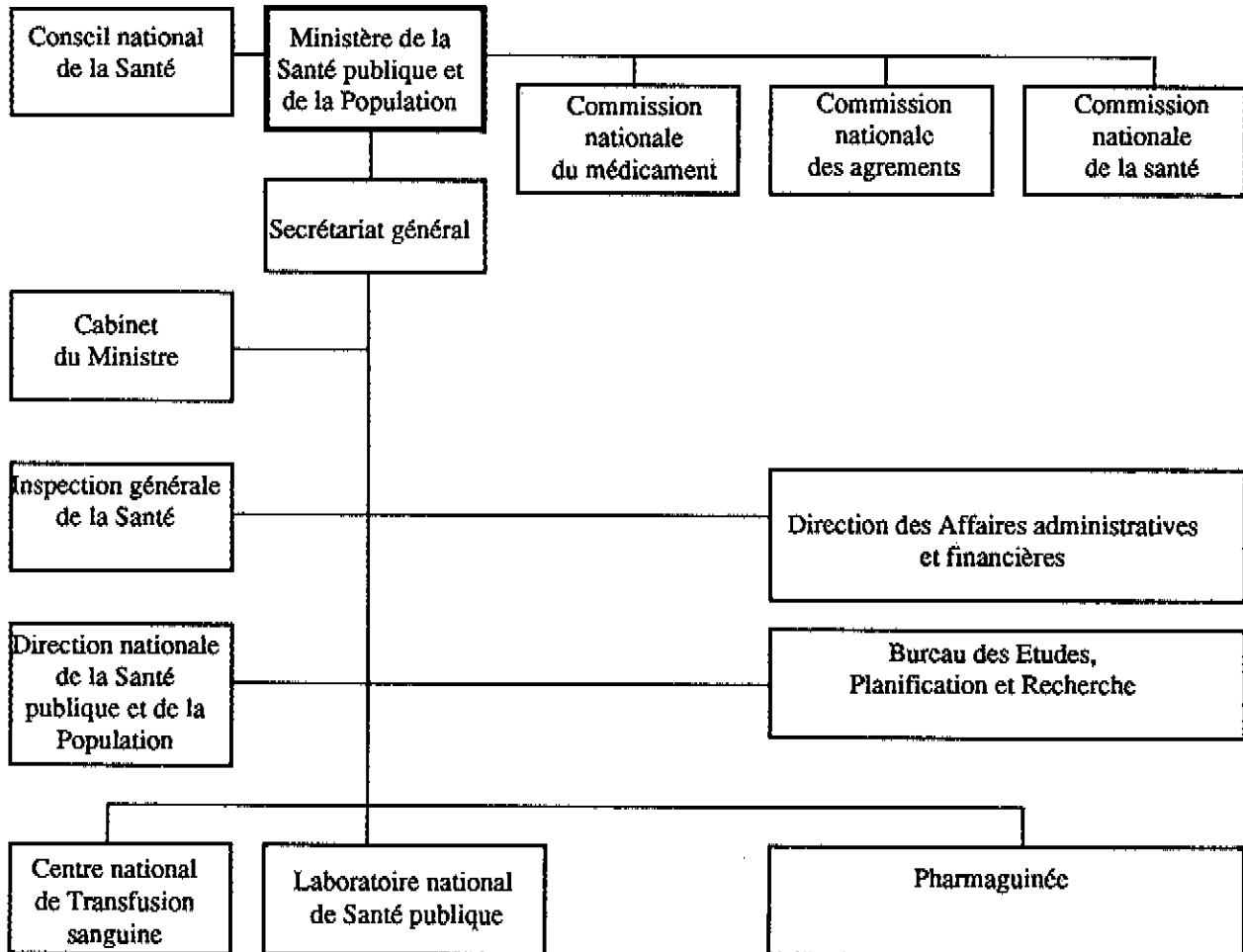


* Special responsibility under proposed Project

Source: World Bank (1989a)

Figure 2

Organizational Chart of the MSPP



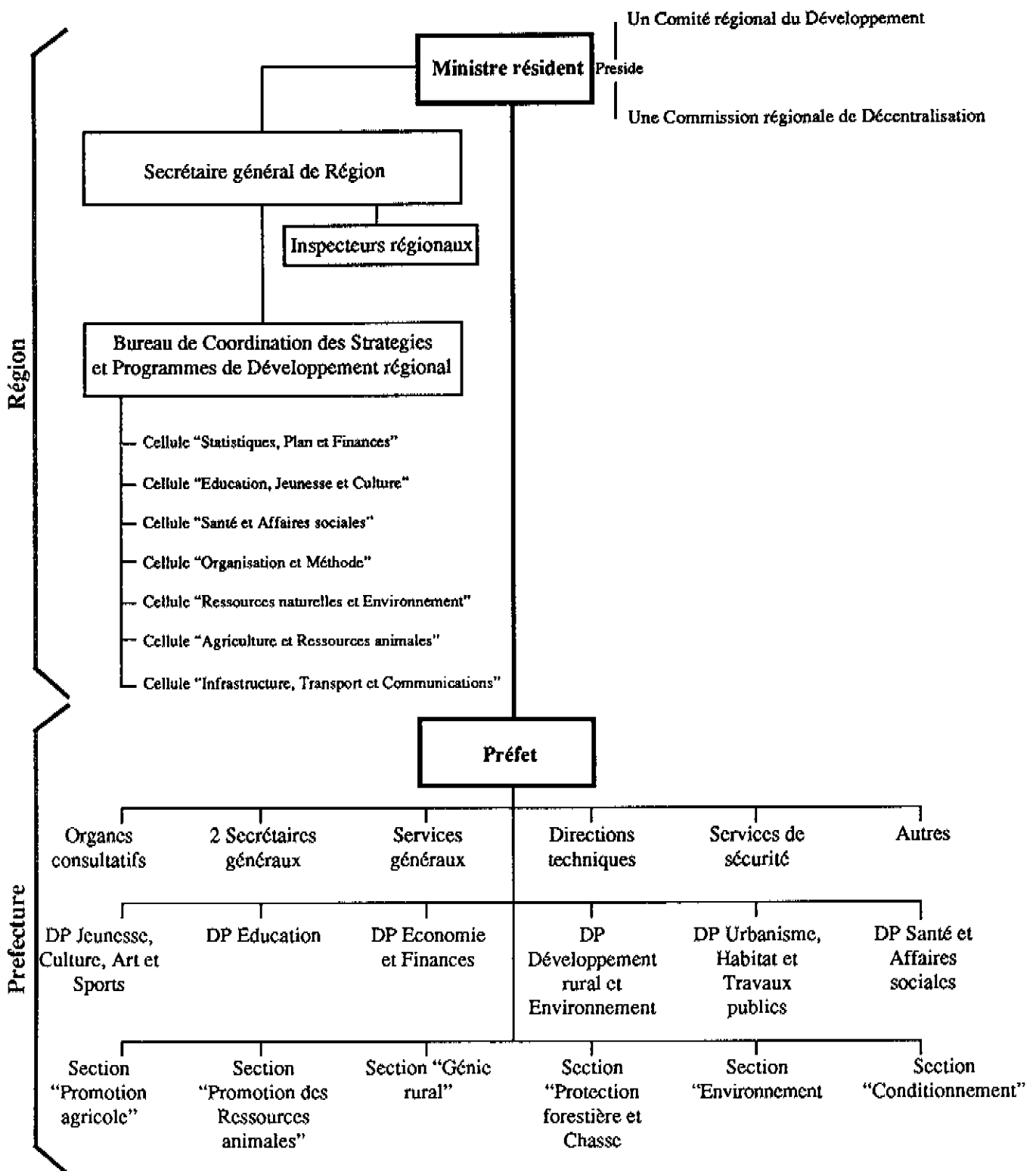
Source: MSPP (1989a)

Figure 3

Structure administrative régionale

prévue par les décrets

003/PRG/SGG/89; 004/PRG/SGG/88 et 008/PRG/SGG/89



Source: FAO (1989)