GAMBIA-National Health Development Project
ICR (C1760-GM)

SecM96-747

FROM: Vice President and Secretary

July 5, 1996

IMPLEMENTATION COMPLETION REPORT

THE GAMBIA

NATIONAL HEALTH DEVELOPMENT PROJECT
(Credit 1760-GM)

Attached is a report entitled: "Implementation Completion Report: The Gambia National Health Development Project (Credit 1760-GM), dated June 14, 1996, (Report No. 15738) prepared by the Africa Region.

Distribution:

Executive Directors and Alternates
President's Executive Committee
Senior Management, Bank, IFC and MIGA

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Report No. 15738

IMPLEMENTATION COMPLETION REPORT

THE GAMBIA

NATIONAL HEALTH DEVELOPMENT PROJECT
(CR. 1760-GM)

June 14, 1996

Population and Human Development Division
Western Africa Department
Africa Region

CURRENCY EQUIVALENTS

US$1	=	D 9.77
D 1	=	US$0.1
D 1 million	=	US$102,354

MEASURES

1 m	=	1.09 yd
1 m²	=	10.76 sq ft
1 km²	=	0.38 sq mi

ABBREVIATIONS AND ACRONYMS

DRF	Drug Revolving Fund
EDF	European Development Fund
GNP	Gross National Product
ICR	Implementation Completion Report
IDA	International Development Association
MoH	Ministry of Health and Social Affairs
NGO	Non-Governmental Organization
NHDP	National Health Development Project
ODA	Overseas Development Association
PHC	Primary Health Care
PIC	Project Implementation Committee
PMU	Project Management Unit
PPF	Project Preparation Facility
SCFHN	Sub-Committee on Family Health and Nutrition
SDR	Special Drawing Rights
UNCDF	United Nations Capital Development Fund
UNFPA	United National Population Fund
UNICEF	United Nations Children Fund
VDC	Village Development Committee
WHO	World Health Organization

Fiscal Year
July 1 to June 30

IMPLEMENTATION COMPLETION REPORT
THE GAMBIA
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(CR. 1760-GM)

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PREFACE

This is the Implementation Completion Report (ICR) for the National Health Development Project in The Gambia, for which Credit 1760-GM in the amount of SDR 4.7 million was approved on February 17, 1987, and made effective on November 2, 1987.

The Credit was closed on June 30, 1995, compared with the original closing date of December 31, 1992. 97.1% of the credit was disbursed, and the last disbursement took place on October 11, 1995. Cofinancing for the project in the amount of US$1.0 million was provided by the Netherlands. Parallel financing in the amount of US$20.4 million was provided by China, Italy, the Netherlands, the United Kingdom, UNCDF and the EDF.

The ICR Part I was prepared by Edward Brown, former Task Manger; Part II (the statistical annexes) was prepared by Angelika Pradel and Myrina McCullough (AF5PH); the entire ICR was reviewed by Richard Seifman (Nutritionist) and Ok Pannenborg, (Division Chief), AF5PH, and by Emmerich Schebeck, Project Advisor, AF5DR. The Borrower provided comments which are incorporated in the ICR.

Preparation of this ICR was begun during the Bank's final supervision mission in March 1995. It is based on the Staff Appraisal Report, the Development Credit Agreement, the WHO evaluation report, supervision reports, correspondence between the Borrower and the Bank and other relevant material in the project file. The Borrower, and in particular, the Project Manager Yaya Sanyang, contributed to the preparation of the ICR by submitting his own evaluation report which is attached as an annex. All pertinent comments from the Government have also been taken into account to the extent possible.

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IMPLEMENTATION COMPLETION REPORT
THE GAMBIA
NATIONAL HEALTH DEVELOPMENT PROJECT
(CR. 1760-GM)

EVALUATION SUMMARY

Credit Number:	Cr. 1760
Credit Amount:	SDR 4.7 million (US$ 5.6 million equivalent)
Beneficiaries:	Ministry of Health
Date effective:	November 2, 1987
Date closed:	June 30, 1995
Cofinancing:	(see Table 8b)

Introduction

1. The National Health Development Project (Credit 1760-GM) was the first Bank operation in the health sector in The Gambia. It was developed in response to the National Health Development Program (NHDP) which sought to address acute national health problems by strengthening institutional, management and financial capacity at all levels of service delivery and extending health services to underserved areas.

Project Objectives and Description

2. The objectives of the Project, as stated in the Development Credit Agreement, were (i) strengthening and expansion of Gambia's national health program; (ii) the decentralization of health sector management; (iii) the improvement of health sector planning; and (iv) the introduction of a more effective cost recovery system. The components were structured around two main Parts: **Part A** was a series of **sectoral reforms** aimed at strengthening sector management, finance and support services and **Part B** was a series of **investments** aimed at strengthening primary health care (PHC) and extending services to underserved areas.

Evaluation of Objectives

3. The Project's objectives were consistent with The Gambia's strategy for economic recovery and development and were in accordance with the Bank's Country Assistance Strategy. The objectives and corresponding project components responded adequately to the pressing needs of the sector at the time; however, they were ambitious, covering a wide range of sector issues at different levels at a time and in a country with limited management and institutional capacity. Moreover, the Bank had no experience in this sector in the country. Given this complexity, preparation of the project could have benefited from better assessment of relative risk and alternative project design, more specific performance criteria for monitoring project objectives, and baseline data for setting realistic indicators. Flexibility in project design, however, permitted changes where technical soundness in the original design became questionable. In addition, the Project's multi-donor effort permitted substantial resource mobilization and provided the basis for extensive donor coordination. As a result, the Project

was constructively more complex than it would have been as a straightforward investment activity, and can be viewed as a predecessor of the current sector investment credit approach.

Implementation Experience and Results

4. **Part A**. The objectives of assisting the Government to restructure health management and administration at the central level and to strengthen institutional capacities through decentralized management and financial resource mobilization were substantially achieved. However, *Support Services* which was a subcomponent of the sectoral reform objective was only partially achieved.

5. **Part B.** Project investments to upgrade technical skills of service providers (including traditional community-based health providers), rehabilitate, upgrade, construct and equip health facilities, and coordinate reproductive health activities were substantially achieved. Contributions to improvements in the quality and coverage of basic health services include: (a) the establishment of an "at risk nurse" management training program and a nurse anesthetics training program; (b) establishment of a ferry boat system to ensure timely referral of complicated medical cases from the north bank of the River Gambia to Banjul; (c) expansion of PHC to the underserved Western Region; (d) the expansion of communicable disease prevention and treatment programs, including the provision of drugs, laboratory supplies, and in-service training to nurses; and (e) the establishment at Bansang hospital of a nursing school with teaching equipment and materials. This led to the development of a cadre of local nurse instructors and senior nursing staff, and promoted the integration of primary health care courses into the curricula of the Community Health Nurses training program.

6. Not all Part B investment objectives were fully met or met in the anticipated time frame, however. The expansion of PHC to the peri-urban areas of Banjul and the training of selected Village Development Committee members in financial management were not achieved. Furthermore, very little of the operational research under the nutrition subcomponent was carried out. Moreover, the civil works element was slow to begin and, due to inadequate physical specifications and an underestimation of contingencies, considerable cost overruns were experienced. However, reprogramming of project funds, re-prioritization of the rehabilitation needs and complementary funding provided by other donors, permitted the completion of about 95% of the required civil works.

Project Sustainability

7. The prospects for sustainability of project interventions are good. The sectoral reform elements of the Project, in particular the central reorganization of health management and administration, the decentralized management of health services at the district level, and the introduction of a nationwide cost recovery program have laid a good foundation for effective health service delivery in The Gambia. While more needs to be done to improve the amount and composition of health manpower, the strengthening of the nurses training program has laid the foundation for a more enduring improvement in health manpower. It is anticipated that the current weaknesses in the PHC program and support services would be addressed under the proposed health population and nutrition project. However, the July 1994 coup d'état has slowed the preparation process considerably, and this may lead to significant loss and reversal of some of the Project's achievements and their sustainability, unless the follow up project is initiated without further delay.

Key Factors Affecting Achievement of Major Objectives

8. Four categories of factors adversely affected the Government's capacity to implement the Project: limited management and organizational capacity, manpower constraints, weak systems-wide budgetary processes, and limited Government commitment to the implementation of certain policy decisions (see paras 3.15-3.18).

IDA and Borrower Performance

9. Project identification was consistent with The Gambia's health policy and the economic recovery program. The original components of the Project as defined at identification were mainly investments (Part B). However, reform elements were included only during appraisal which explains, in part, delays in implementing some of the reform elements. A post-appraisal mission to further advance the dialogue and strengthen stakeholders commitment to the reform elements would have been essential. In this regard, appraisal of the project could be considered as less than satisfactory. The Government was actively involved in the preparation of the project and demonstrated a strong commitment to the investment part of the Project.

10. Project supervision was satisfactory. Implementation problems were identified in a timely fashion and sufficient advice was given to address the problems to the extent possible. The cooperation with the Borrower and the cofinanciers was excellent. During the first two years of project implementation, the performance of the PMU was deficient due primarily to the lack of familiarity with IDA rules and regulations. As experience improved, so did performance. Performance of contractors, consultants, and technical assistants was generally good. Few breaches of covenants did take place (see para 3.23), yet overall compliance with the legal covenants was acceptable.

Key Lessons Learned

11. Implementation of this Project has provided valuable experience in highlighting areas where work is needed to improve quality, access, and coverage of public health service delivery. The key lessons are: (a) the need to provide adequate lead-time for implementation of targeted interventions; (b) the need for up-front agreement/ownership/implementation of key policy objectives to improve quality at entry; (c) the need for caution in establishing Inter-ministerial coordination committees; (d) the importance of physical integration of project coordination unit into the parent ministry; (e); the need for simpler project design and development; and (f) the need for improvements in project management through training and establishment of effective accounting and financial management systems prior to project effectiveness.

12. The incorporation of the lessons learned in future operations in the sector has been an ongoing process of dialogue with the Government. The completion, immediately following the coup d'état of July 22, 1994, of a National Health Policy Document and the preparation of the second phase of the National Health Development Program 1994-2000, drew extensively from the lessons learned under this Project and the Bank's Sector Investment Program approach. The new operation would build on the experience of this Project in addressing family health, family planning and nutritionally-related issues. It would rely heavily on community participation and capitalize on potential partnerships with NGOs, the private sector, and research institutions operating in The Gambia.

IMPLEMENTATION COMPLETION REPORT
THE GAMBIA
NATIONAL HEALTH DEVELOPMENT PROJECT
(CR. 1760-GM)

PART I: PROJECT IMPLEMENTATION ASSESSMENT

I. INTRODUCTION

Economic Situation and Health Sector Policies

1.1 In 1984, The Gambia was one of the poorest countries in the world, suffering from a scarcity of natural and human resources, decreasing Government revenues and foreign exchange reserves. The GNP per capita was US$260 and the economic growth was far below the population rate of 3.5%. Health indicators were equally poor, with a life expectancy at birth of 42 years, and infant mortality rate of 125 per 1,000 live births and a maternal mortality rate of 1,000 per 100,000 live births. Malnutrition, infections, a high fertility rate of 6.5, complications at pregnancy and childbirth, malaria, anemia, diarrhea and respiratory tract infections were the major causes of high mortality and morbidity rates. Since 1975 The Gambia has sought to address these health problems by placing more emphasis on extending health services to rural areas. In 1979, a Primary Health Care (PHC) policy was adopted an major resource shifts were announced: From urban to rural and from curative to preventive. This was evidenced by the reduction of allocations to hospitals in the health recurrent budget from 70% during the period 1966/77, to 47% in 1982/83, and to 35% in 1986/87. The health project (Credit 1760-GAM) marked the beginning of the Bank's involvement in the health sector in The Gambia and it was designed as the main thrust of the Government's National Health Development Program (NHDP).

II. PROJECT OBJECTIVES

A. Original Project Objectives

2.1 The objectives of the Project were: (i) the strengthening and expansion of The Gambia's health program; (ii) the decentralization of health sector management, (iii) the improvement of health sector planning; and (iv) the introduction of a more effective cost recovery system.

B. Project Description and Components

2.2 Project components were structured around two main Parts: **Part A** was a series of **sectoral reforms** aimed at *strengthening health sector management, finance and support systems*, through: (a) central reorganization, including reorganization of the Ministry of Health (MoH), and granting of semi-autonomy to the two Government hospitals (the Royal Victoria and Bansang Hospitals); (b) decentralization of health administration at the district level; (c) establishment of a cost recovery system; and (d) strengthening of support systems, including transportation and communications. **Part B** was a series of **investments** aimed at *strengthening national health services* through: (a) the expansion of primary health care (PHC) to the Western

Region and the peri-urban areas of Banjul; (b) training of health service providers; (c) rehabilitation, upgrading and new construction of health facilities; (d) coordination of family health, nutrition and family planning activities; and (e) monitoring and evaluation.

C. Credit Covenants and Special Agreements

2.3 All conditions of effectiveness were met as expected. In addition, *special covenants or agreements* were included in the DCA to promote achievement of the project objectives: the Borrower was expected to: (i) prepare and thereafter review annually, with the Association a three-year rolling plan satisfactory to the Association for investment and recurrent *expenditures* in the health sector, with the annual development and recurrent *budgets* for the fiscal year immediately following; (ii) establish and thereafter maintain a Project Implementation Committee (PIC) with oversight functions in the management of the Project, and a Sub-committee on Family Health and Nutrition (SCFHN); and (iii) carry out and furnish the Association for its review and comments, the results of a mid-term evaluation on December 31, 1989 and a final evaluation by December 1992. These agreements were all complied with. However, the PIC and its Sub-committee (SCFHN) met regularly only during the first two years of the Project, after which the meetings became sporadic and eventually ceased.

D. Evaluation of Project Objectives

2.4 The Project's objectives were consistent with The Gambia's strategy for economic recovery and development, and were in accordance with the Bank's Country Assistance Strategy. The objectives and corresponding project components responded adequately to the pressing needs of the sector at the time; however, they were ambitious, covering a wide range of sector issues at different levels, and at a time and in a country with limited management and institutional capacity. Moreover, the Bank had no experience in this sector in the country. Given that this was the first Bank-funded investment in the health sector in The Gambia, preparation, especially objective setting, could have benefited from: (a) a better assessment of relative risks and alternative project design; (b) more specific performance criteria/indicators for monitoring achievements of project objectives; and (c) baseline data for setting realistic indicators. However, the flexibility of the project design permitted changes where technical soundness in the original design became questionable. In addition, the Project's multi-donor effort permitted substantial resource mobilization and provided the basis for extensive donor coordination. As a result, the Project was constructively more complex than it would have been as a straightforward investment activity, and can be viewed as a predecessor of the current sector investment credit approach.

III. IMPLEMENTATION EXPERIENCE AND RESULTS

A. Achievements of Project Objectives

3.1 ***Sectoral Reform Objectives (Part A)***. The objectives of assisting the Government to restructure health management and administration at the central level, and to strengthen institutional capacities through decentralized management and financial resource mobilization were substantially achieved. The granting of semi-autonomous status to the two Government hospitals (Royal Victoria and Bansang hospitals) through the establishment of hospital management boards and the devolution of financial management authority through direct

budgetary allocation, substantially improved the availability and quality of tertiary health services in the country. It not only enabled them to improve their daily management but also have access to private funding, and have greater assurance of drugs and supplies. Personnel management autonomy allowed hospitals to offer incentives outside the civil service structure, leading to improved recruitment and retention of staff, a problem that continues to plague the rest of The Gambia civil service.

3.2 *Decentralization of health management* to the districts was substantially achieved. Health Teams now, largely control their training programs and deployment of staff, elaborate work plans and budgets, and these form the basis for national health sector planning. They also now have limited discretionary spending authority for stationary and other supplies. At the community level, however, more needs to done to strengthen Village Development Committees, an element of the project which has yet to be achieved.

3.3 The objective of establishing an effective *cost recovery system* was substantially achieved. Although the level of revenue generated by the system was below expectations (35% compared to expected 100%), the then existing fee collection system was considerably improved, availability of drugs and medical supplies, staff moral, and quality of service delivery were dramatically improved. The additional resources generated by the cost recovery system complemented Government budgetary allocations and helped increase the total resources available to the health sector. Given the less than full recovery of the cost of drugs and medical supplies, the Government lived up to its commitment at credit negotiations of assuring at all times, sufficient funds in the health budget to meet the costs of drugs and medical supplies. The low level of revenue collected was principally due to three factors: (a) high exemptions--over 60% of beneficiaries were exempted from fees--and the reluctance of the Government to change this policy for political reasons; (b) weak management--inadequate personnel to manage a system which required a skill mix different from that traditionally available in the health sector; and (c) lack of effective accounting mechanism--the initial reluctance of the Government to permit revenue retention at the point of collection, as all revenue must go into the consolidated budget for redistribution. These constraints are now being addressed through a restructuring exercise being undertaken under the Bamako Initiative.

3.4 A key element of the sectoral reform objective, which was only partially achieved was *Support Services.* Both the *transport services* and the *communication network* subcomponents functioned poorly. With regard to *transport services,* after the initial good start, during which all the key activities were implemented (Table 5), changes in the management and withdrawal of ODA technical assistance, led to decline in the maintenance capacity and consequent decline in the level of fleet availability. The latter, however, is due more to the high costs of replacement vehicles which the Government has had difficulties funding without external aid. Worth noting, nevertheless, are some of the structural/institutional changes introduced under this component: the establishment of routine maintenance facilities in each Region; the construction of a central maintenance workshop in Banjul; and the rationalization of fuel distribution, including regional storage facilities. Poor management of the overall transport services has led, however, to a less than satisfactory achievement of the underlying objectives of the support services subcomponent.

3.5 The *communication network* designed to improve the quality of supervision of PHC and patient referrals between the different levels of health facilities was scaled down by a third due to

funding difficulties. In addition, technical difficulties, lack of training and capacity to supervise the maintenance of the equipment led to rapid deterioration. The Italian Government and the United Nations Capital Development Fund financed and supported the installation of the network. Although not completely superseded by the recent extension of the telephone network in the country (all the major health facilities are now within reach of telephone communication), except for very remote areas, this type of radio technology, given the maintenance cost, has become increasingly a less appropriate communication technology in health service delivery in The Gambia.

3.6 ***Strengthening National Health Services (Part B).*** Project investments to upgrade technical skills of service providers (including traditional community-based health providers), rehabilitate, upgrade, construct and equip health facilities were substantially achieved. Contributions to improvements in the quality and coverage of basic health services include: (a) the establishment of an "at risk nurse" management training program and a nurse anesthetics training program to address the high level of maternal and child mortality. These innovative technical redesign efforts were undertaken in response to the human resource constraints which had become more apparent immediately after credit effectiveness. Both training programs were highly commended by the Western Africa College of Surgeons and WHO for their effective and appropriate response to the local situation; (b) establishment of a ferry boat system to ensure timely referral of complicated medical cases from the north bank of the River Gambia to Banjul; (c) expansion of PHC to the underserved Western Region; (d) the expansion of communicable disease prevention and treatment programs, including the provision of drugs, laboratory supplies and in-service training to nurses; and (e) the establishment at Bansang hospital of a school for training nurses, including the provision of teaching equipment, materials and development of a cadre of local nurse instructors and senior nursing staff at the school, and the integration of primary health care subjects into the curricula of the Community Health Nurses training program.

3.7 *Physical Objectives.* A major achievement of the project was the establishment of secondary level health delivery facilities through the upgrading/construction, equipping and staffing of 8 major health centers to relieve the burden on the two tertiary level hospitals and bring basic health services closer to the population. Four of these secondary level health facilities are now able to deal with minor surgical operations and medical complications and only refer major medical complications to the two tertiary level hospitals, thus completing the three-tier health delivery pyramid for The Gambia, as envisaged in its national health plan. Furthermore, essential services (water and electricity) of many health facilities were rehabilitated, rendering them more functional and thus providing greater access to the population. In addition, the construction of several staff housing units (about 32 units) has helped to partially alleviate one of the perennial problems the MoH has faced in redeployment of health personnel to remote and underserved areas.

3.8 Not all Part B investment objectives were fully met or met in the anticipated time frame, however. The expansion of PHC to the peri-urban areas of Banjul was not achieved, due to delays in the completion of the study expected to inform and guide the implementation of the program. The training of selected Village Development Committee members in basic principles of accounting and financial management was also not implemented. Very little of the operational research envisaged under the nutrition subcomponent of the project was carried out. The coordination role of the SCFHN was never achieved. The civil works element was slow to begin,

and due to inadequate physical specifications and an underestimation of contingencies, considerable cost overruns were experienced. However, the reprogramming of project funds, re-prioritization of the rehabilitation needs and complementary funding provided by other donors (such as the UK/ODA, the Dutch Government, the EU, and UNFPA), permitted completion of about 95% of the proposed civil works under the Project.

B. Summary of Project Costs, Financing Arrangements and Implementation Timetable.

3.9 *Project Costs.* The total project cost at appraisal was estimated at US$20.8 million equivalent (net of taxes) with a foreign exchange component of US$17.8 million (86%). Base cost estimates were in November 1986 prices. The breakdown of project cost in local and foreign currencies is given in Table 8A.

3.10 *Financial Arrangements.* IDA's contribution at appraisal was estimated at US$5.6 million equivalent (November 1986 exchange rate with SDR) and the Government participation at US$1.3 million equivalent. Total credit amount disbursed at ICR preparation (US$6.1 million equivalent) was higher than anticipated at appraisal due to changes in the US$/SDR exchange rate (Table 4). Government's actual contribution of $5.73 million equivalent was higher than anticipated at appraisal. In addition to the operating costs of the project unit (US$0.30), the Government funded the Drug revolving fund ($4.22 m.) and 32 staff housing units ($1.2 m.). Furthermore, even this figure excludes incremental staff costs covered by the Government. Detailed breakdown of donor contributions is shown in Table 8B.

3.11 *Implementation schedule.* Project preparation took about 14 months (September 1985 to January 1987), which was within the norm for the sector. Project effectiveness was delayed from May to November 1987, due to delays in meeting the conditions of effectiveness, in particular that relating to the recruitment of the project manager. The original closing date was June 1992, however, the project was extended for an additional three years to June 1995, to enable the completion of civil works activities, which had been delayed for reasons mentioned above.

C. Analysis of Key Factors Affecting Achievement of Major Objectives

3.12 Four categories of factors adversely affected the Government's capacity to implement the Project: limited management and organization capacity, manpower constraints, weak systems-wide budgetary process, and limited Government commitment in the implementation of selected policy decisions.

3.13 *Management and organizational capacity* to execute a multi-donor project of this magnitude and complexity was inadequate. From the beginning, the PMU was not provided with the full complement of staff needed to carry out its functions. The project management unit was run for the most part by only two persons--the project manager and an accounts clerk. In addition, lack of experience in Bank procedures, in particular procurement and disbursements, led to delays in achieving targets. However, the situation soon improved with the recruitment of a procurement officer and a more dynamic project manager. The Project had three project managers, four project coordinators (i.e. the Permanent Secretaries of MoH) and four Ministers of Health and three task managers during its lifetime. There was, however, a steady five-year

period (1989-94) when the principal actors remained the same except for the Ministers, and this was the period during which implementation was most successful. With regard to the PIC, while there was great hope for its role at the beginning, with frequent changes in the memberships, and infrequent meetings, it became increasingly ineffective and ceased to function by the end of the second year. Moreover, the SCFHN due the lack of effective leadership functioned very poorly at the beginning and eventually its functions were de facto taken over by the two national NGOs (the Gambia Family Planning Association and the Gambia Food and Nutrition Association).

3.14 *Manpower constraints* constituted a major bottleneck in the implementation of the Project. Limited high and intermediate level technical, medical and administrative staff, and the high personnel turnover were major obstacles. While considerable efforts continue to be made to train Gambian physicians and attract private practitioners, the number is inadequate to meet the minimum level of staff complement needed to effectively operate the major health facilities. Over 60% of physicians in the public sector in The Gambia are expatriates of short-term duration (two years), making it costly to invest in training and upgrading of skills. The situation is equally desperate among the other levels of health personnel: nurses, paramedics, and the new cadre of administrative staff (management and accounting) to support and sustain the reform efforts in decentralization and cost recovery. A considerable effort was made to address these issues under the Project, however, the underlying problems are systemic rather than sector specific, and are thus beyond the control of MoH. High attrition rates are not unique to the health sector and are principally a reflection of the overall scarcity of well trained technical manpower in the country. Moreover, the rigid conditions of recruitment into the civil service, the poor remuneration and less than stringent rules on staff retention after training contributed to the high turnover. (This issue would have to be considered under the Country Assistance Strategy for The Gambia when donor agencies, including the Bank, resume active development.) assistance.

3.15 Other *systems-wide* issues also affect health sector performance, in particular a cumbersome budgetary process. The inadequate monitoring of budget allocation against expenditures by the Ministry of Finance and Economic Affairs, led in the early stages of the project to overspending by some sectors to the detriment of others, in particular the health sector. This created funding difficulties, with consequent delays in the implementation of some project components.

3.16 *Lack of initial Government commitment* contributed to delays in project implementation--rather than non-implementation--of certain elements of the Project. The hospital reform effort took much longer than had been anticipated due to resistance from MoH management. Resistance from the Treasury to permit retention of user chargers at the points of collection, rendered full cost recovery impossible. Moreover, delays in restructuring the of the cost recovery fee system to reduce exemptions was due to initial resistance from some stakeholders since it was proposed during the election year.

D. Project Sustainability

3.17 The prospects for sustainability of project interventions are good. The sectoral reform elements of the Project, in particular central reorganization of health management and administration, the decentralized management of health services at the district level and the introduction of a nationwide cost recovery program have laid a good foundation for effective

health service delivery in The Gambia. The integration of the technical and administrative wings of the MoH has led to greater cohesion in planning and coordination of public health services at the central level. However, further work needs to be done to clearly define the institutional loci and role of some of the sub units (namely the epidemiology and statistics unit, and the directorate of support services) which were the subject of considerable controversy during the implementation of the reorganization program.

3.18 While more needs to done to improve the number and composition of health manpower, the establishment in Bansang of the nurses training program and the integration of PHC subjects into the nurses curricula have helped strengthen the program and provided a good basis for further expansion. With regard to the PHC program, it is anticipated that the proposed health, population and nutrition project will help strengthen community participation and thereby improve sustainability. The considerable decline in the transport fleet, renders the current transportation arrangement unsustainable. Moreover, while the ferry ambulances perform a critical function, they have been poorly maintained and most have fallen into disrepair. Here again, it is envisaged that the follow-up project would examine the support services issues more broadly. With regard to the low level of cost recovery, the Government had already initiated under the Project, through the Bamako Initiative, mechanisms to ensure increased revenue levels, through retention of revenues at the centers of collection and through greater community participation in planning and resource management. To consolidate and further scale-up initiatives started under this Project, it was anticipated that the proposed follow-up project would have by now become effective. However, the July 1994 *coup d'état*, slowed down considerably the preparation process, due to the suspension of new external aid from the Bank and other donors. Moreover, major changes in the administration of the MoH (with new actors with limited experience and knowledge of sector issues), have led to a slow down in the reform efforts. These recent external shocks may lead to significant loss and reversal of some of the Project's achievements unless the follow-up project is initiated without further delay.

E. Bank Performance

3.19 The Bank's overall performance was satisfactory. Project identification was consistent with The Gambia's health policy and the economic recovery program. The original components of the Project as defined at identification were mainly investments (Part B). However, during preparation, further diagnosis and analysis of sector issues and policies revealed the importance of introducing sectoral reforms to buttress the proposed investments. Thus reform elements were including during appraisal. This addition, however, left open the possibility that certain sectoral issues were inadequately fleshed-out or did not receive adequate review by key stakeholders. This explains, in part, the delays experienced in implementing some of the reform elements. In addition, two key elements which constituted the main thrust of the project at identification (nutrition and family health), were considerably marginalized at appraisal and thus did not received adequate funding. Although time and resources devoted to project preparation and appraisal seemed adequate, the Project could have benefited from a post-appraisal mission to further advance the dialogue and firm-up the details on the reform elements and streamline the investment component. These had to be dealt with during supervision. In this regard, the appraisal could be considered as less than satisfactory.

3.20 Project supervision was satisfactory. Implementation problems were identified in a timely fashion and sufficient advice was given to address the problems to the extent possible. Follow up on advice and the decisions taken during missions were adequate. Bank staff flexibly dealt with necessary modifications. The cooperation with the Borrower and the cofinanciers was excellent. Implementation followed Bank policies and procedures. With 14 supervision missions in seven years of project implementation, sufficient time was spent in the field. However, reporting on the Project became less detailed with the beginning of discussions on the follow-up project at the end of 1992, when the project was extended to permit the completion of outstanding civil works.

F. Borrower's Performance

3.21 The Government was actively involved in the preparation of the project. For this purpose, support was provided by the inter-ministerial Health Planning Committee. Throughout project preparation, Government demonstrated a strong commitment to the Project. Performance during preparation was, thus, satisfactory. However, performance during implementation faulted as new actors revisited the objectives of some the reform efforts vested interested

3.22 During the first two years of project implementation, the performance of the PMU was deficient, mainly due to the lack of familiarity with IDA rules and regulations and the lack of effectiveness of the PIC. As experience improved, so did performance. Performance of contractors, consultants and technical assistants was generally good. In cases of less than satisfactory performance, the Project could have benefited from timely replacement. In addition, financial management was less than satisfactory throughout project implementation, reflecting the weak capacity of MoH in this area. The performance of the Auditor General in auditing the project accounts was also less than satisfactory. However, the auditor was changed getting to the end of the project with objective of introducing a new accounting system for the follow up project. Apart from a few breaches of covenants, such as the failure to maintain the SCFHN and the PIC during the Project's life-time, compliance with the legal covenants was satisfactory.

E. Assessment of Project Outcomes

3.23 Despite the many difficulties encountered in implementation, the Project resulted in a number of achievements, many of which are of an enduring and sustainable nature. At the sectoral reform level, major accomplishments are the institutional restructuring and management strengthening. Central reorganization, has led to better streamlining of technical and management responsibilities. An important indicator of enhanced capacity at the MoH is the quality of the recently produced national health policy document and the strategy for the second phase of the national health development program. These documents were developed with little intervention from external partners; both the diagnosis of health sector issues and proposals to address them were well done, reflecting lessons learned through the implementation of this and other projects and provided, prior to the coup, the basis for a coordinated sector interventions. The semi-autonomy of the hospitals, decentralized health management and cost recovery have set the stage for a more effective and efficient delivery of public health services. Despite the financial limitations of the cost recovery system, the introduction of a nation-wide fee-for-service system has become generally accepted by the population and with continuing improvements in the quality of services, the impact on health would be significant.

3.24 At the level of specific investments, the development of secondary (intermediate) level health service delivery facilities fills a major gap in the public health delivery pyramid. These are infrastructure investments which the Government is committed to sustaining. Expansion of PHC to the Western Region has considerably increased coverage of basic health services in the country. However, quality of health services remains a major problem. This is reflected in the fact that national health indicators for The Gambia remain very low, posing an enormous challenge for the Government and its partners to intensity efforts to improve health status.

H. Future Operations

3.25 The incorporation of the lessons learned in future operations in the sector has been an ongoing process of dialogue with the Government. The completion, immediately following the coup d'état of July 22, 1994, of a National Health Policy Document, and the preparation of the second phase of the National Health Development Program 1994-2000, drew extensively from the lessons learned under this Project, and the Bank's Sector Investment Program approach. The long hiatus (two years) in the preparation of the follow-up project due to the 1994 coup, has led to some modifications in the proposed project, which is not to be a sector investment operation. Notwithstanding, however, the new operation would build on the lessons of this Project, principally address family health, family planning and nutrition and related critical support. It would rely heavily on community participation and capitalize on potential partnerships with NGOs, the private sector and research institutions operating in The Gambia.

IV. KEY LESSONS LEARNED

4.1 Implementation of this Project has provided valuable experience in highlighting a number of weaknesses and challenges to improve quality, access and coverage by a public health service delivery system. This knowledge will be reflected in the design and development of the next Bank operation in the health sector, currently under preparation.

4.2 *Provision of adequate lead-time*. The relative lack of experience of the Bank in the sector in the country led to a more ambitious setting of goals and deadlines. Experience with the Project suggests that, particularly in a democratic setting where parliamentary approval is required for many policy decisions, adequate consideration must be given to the time required to obtain approval through the various levels of decision making.

4.3 *Up-front agreement/implementation of key policy objectives*. The painstaking effort and considerable amount of time needed to obtain approval for the implementation of agreed policy reforms, underscores the importance of initiating implementation of critical policy decisions prior to project effectiveness. The evidence suggest that after project effectiveness, loss of leverage leads to delays, as manifested in the delays in creating the semi-autonomy for the hospitals, implementation of the cost recovery system, and devolution of budgetary authority to the district health teams.

4.4 *The ineffectiveness of Interministerial coordination committees.* Experience under this Project has shown that coordination committees are generally ineffective, and make little or no contribution to effective project implementation. Due, principally to frequent changes in

membership, commitment of PIC members was weak. Attendance at meeting was infrequent and most seemed to have been attracted by the perks provided. Future operations in the sector should be circumspect in proposing such an arrangement.

4.5 *The importance of physical integration of project coordination unit into the parent ministry*. The success of this project as being the thrust of the public health development program in The Gambia during the last eight years was due principally to it being fully owned by MoH. The location of the PMU within the Ministry contributed a great deal to this ownership. The project manager was regarded as full member of the MoH management team. Donors channeled their resources through the PMU, and this has helped strengthen the Government's aid coordination.

4.6 *Project design and development*. Project objectives should be sufficiently modest and based on sound knowledge of the sectoral issues and constraints. Efforts should be made to compile reliable baseline data in order to set realistic and clear targets and to define easily measurable indicators. Complexity should take into account the capacity of implementing agencies to effectively monitor and implement each element of the project. Early implication of the stakeholders, including beneficiaries, service providers. local authorities, NGOs and key donors involved in the sector would enhance ownership and commitment to implementation. Key policy issues should be implemented up-front as much as possible.

4.7 With regard to *project management*, the most important lessons are: (a) the importance of providing the management unit with the full complement of staff. In addition to the manager/coordinator, accounting, and procurement staff are essential; (b) the need to provide project staff with sufficient training in procurement and other Bank procedures and requirements; (c) the importance of integrating project management into the core functions of the Ministry in order build management capacity and ownership; and (d) the need to define and establish during project preparation, the accounting and financial management systems and to have them in place at effectiveness. This would ensure effective start-up and avoid delays.

PART II: STATISTICAL TABLES

TABLE 1: SUMMARY OF ASSESSMENTS

A. Achievement of Objectives	Substantial	Partial	Negligible	Not Applicable
Macro policies	[ ]	[ ]	[ ]	[X]
Sector policies	[X]	[ ]	[ ]	[ ]
Financial objectives	[ ]	[X]	[ ]	[ ]
Institutional development	[X]	[ ]	[ ]	[ ]
Physical objectives	[X]	[ ]	[ ]	[ ]
Poverty reduction	[ ]	[ ]	[ ]	[X]
Gender issues	[ ]	[ ]	[ ]	[X]
Other social objectives	[ ]	[ ]	[ ]	[X]
Environmental objectives	[ ]	[ ]	[ ]	[X]
Public sector management	[X]	[ ]	[ ]	[ ]
Private sector development	[ ]	[ ]	[ ]	[X]
Other (specify)	[X]	[ ]	[ ]	[ ]

M&E was an obj as was coord PHNoChiv (PIC) & strengthen VDCs

B. Project Sustainability	Likely	Unlikely	Uncertain
Program of Reforms	[X]	[ ]	[ ]
Program of Investments	[X]	[ ]	[ ]

loss of revenues due to foclown proj (?)

C. Bank Performance	Highly satisfactory	Satisfactory	Deficient
Identification	[ ]	[X]	[ ]
Preparation Assistance	[ ]	[X]	[ ]
Appraisal	[ ]	[ ]	[X]
Supervision	[ ]	[X]	[ ]

D. Borrower Performance	Highly satisfactory	Satisfactory	Deficient
Preparation	[ ]	[X]	[ ]
Implementation	[ ]	[X]	[ ]
Covenant Compliance	[ ]	[X]	[ ]
Operation	[ ]	[ ]	[ ]

E. Assessment of Outcome	Highly satisfactory	Satisfactory	Deficient
	[ ]	[X]	[ ]

M&E?

TABLE 2: RELATED BANK CREDITS

Credit Title	Purpose	Year of Approval	Status
Preceding Operations			
NONE IN HEALTH			
SAL	The Structural Adjustment Program brought about significant changes in many sectors (financial, public enterprises, fisheries, and agriculture). Inasmuch as the SAL brought the country out of a severe financial crisis and the economy back into a positive growth path--all during the years of the health project--its impact was of importance for the NHDP.	1986	Completed
Following Operations			
Women in Development	Containing a PHC element to complement the effort of the health project in extending PHC services to larger areas of the country.	5/1990	Ongoing

Source: Bank MOP, MIS

TABLE 3: PROJECT TIMETABLE

Steps in Project Cycle	Date Planned	Date Actual/ Latest Estimate
Identification (Executive Project Summary)	February 1985	September 1985
Preparation	February '85-December '85	September '85-January '87
Appraisal	December 1985	January 1986
Negotiations	July 1986	November 1986
Board Presentation	October 1986	February 1987
Signing	March 1987	June 1987
Effectiveness	May 1987	November 1987
Mid-term Review	December 1989	September 1993
Credit Closing Date	June 31, 1992	June 30, 1995
Project Completion Closing Date	December 31, 1992	December 31, 1995

Sources: Bank Project Brief, SAR, Supervision reports.

TABLE 4: CREDIT DISBURSEMENTS: CUMULATIVE ESTIMATED AND ACTUAL (IN US$ THOUSAND)

Calendar Year	1987	1988	1989	1990	1991	1992	1993	1994	1995
Appraisal Estimate	0.90	1.90	2.90	4.10	5.10	5.18			
Actual	0.00	1.10	1.46	2.56	3.43	3.79	4.48	5.62	6.18
Actual as % of estimate	0	58%	50%	62%	67%	73%			
Date of Final Disbursement:	**October 11, 1995**								

Source: SAR, Annex 11.2; MIS Portfolio Report PFDBR29

TABLE 5: KEY INDICATORS FOR PROJECT IMPLEMENTATION

Information put in [brackets] signifies that these indicators were not contained in the SAR or in the earlier monitoring checklists but were added at later stages of supervision. Blanks in column "Estimated" signify that no estimates were given.

Key Implementation Indicators	*Estimated*	*Actual*
Part A: Reforms		
1. Central Reorganization		
1.1 Reorganization of MoH		
- Construct and renovate additional space in MoH	from 11/86	10/89
- Relocate key staff to single office complex		6-9/90
[- Execution of ODA support package, including provision of TA on health economics and management]		[9/89-7/92]
- Development of management system and management training	10/88	1989
- Development and implementation of new organizational structure:		
[* ODA report to suggest new organizational structure]	[1/90]	[1/91]
[* Cabinet approval of new structure		[8/92]
[* Implementation of new structure]		[11/92]
[- Training of staff of the Health Planning Unit]		[10/89]
[- ODA report on new health planning and information system]	[1/91]	[1/91]
1.2 Hospital Semi-Autonomy		
- Legislative Enactment of Hospital Management Board (HMB) through Passing of Medical Services Act	4/87	4/88
- Inauguration of the HMB as semi-autonomous institution under the MoH	4/87	4/89 RVH 7/91 Bansang
[- Appointment of HMB members]	[7/88]	[7/89]
[- Recruit Chief Executive Officer for RVH]	[5/89]	[1991]
[- Elaborate work plan for decentralization of financial management; also for RHTs]	[11/89]	[7/90]
- Devolution of financial, personnel and administrative responsibility from PS to HMB	1988	7/91
- Recruit personnel officer and two finance officers for hospitals	5/88	Not done.
[- Recruit financial management consultant; to work also on RHTs, DRF and project finance]	[5/88]	[6/89]
- Hospitals to establish separate accounting systems, keep cost accounts, plan and administer the annual budget and manage allocated manpower		7/91
2. Decentralization		
- Review roles of members of the Regional Health Teams (RHTs)	2-3/87	1991/92
- Provision of one finance officer, one finance clerk and one administrative officer to each of the 3 RHTs	1988	Not done.
[Later on replaced by:		
- SCF/UK to provide two health administrators	[1990]	[1990]
- Appointment of three local health administrators]		[1992]
- Transfer of increased budget and personnel authority to RHTs and health center staff	4/87	1991/92
[- Establish financial and personnel management systems and elaborate accounting and procedures manual]		[1994]
[- Train RHT staff in financial and personnel management]		[1994]
- Assistance to Village Development Committees (VDCs) to be more active in supervision of Village Health Workers (VHWs)		Not done.

3. Cost Recovery Program		
- Prepare fee schedule		1/88
- Approval of new fee structure by Cabinet	Condition for Board presentation	4/88
- Launching of CRP, including drug revolving fund		8/88
- Appointment of management accountant to establish accounting system	2/87	6/89
[- Establishment of regional storage facilities]	[12/87]	[6/89]
- Staff training in drug supply management	3/88	4-12/88
[- Training of accounting staff]	[5/88]	[7/88]
[- Recruit 8 cashiers and 3 accountants]	[7/88]	[7/88]
- Upgrading of Central Medical Store (CMS)	11/88	1989-90
[- Procure drugs: first order; second order]	[6/88]	[12/88-3/89] [8/89]
[- Procure other medical supplies]	[11/88]	[1988-90]
[- Procure quality control lab]	[8/88]	[1991]
[- Procure packaging equipment]	[11/88]	[1990]
[- Computerize inventory control systems)]	[10/88]	[1988]
[- Appointment of fund management accountant]	[2/88]	[6/88]
[- Evaluation of DRF]	[5-89/3-92]	[10-89/7-92]
[- In-depth analysis of cost and pricing mechanism]	[1/90]	[7/90]
[- Economic analysis of fee system and of impact on utilization and quality of service	[from 12/89]	[7/90]
[- Introduction of revised fee structure]	[7/92]	[1994]
4. Transport Services		
- Provision of 30 new vehicles	1/89	1/91
- Rehabilitation of 30 vehicles	1989	1990
- Provision of spare parts	9/88	3/92
- Provision of fuel	from 7/88	1989-95
- Provision of a tanker truck	9/88	1/91
- Appointment of an expatriate transport manager (ODA)	1988-90	1988-1992
- Appointment of a local counterpart to the transport manager	6/88	8/91
[- Appointment of local counterpart to external mechanical supervisor and engineer]	[6/89]	[8/91]
- Establishment of a transport policy to streamline transport management, incl. standardization of vehicle types, rational allocation and use of transport fleet		1989
- Establishment of a transport management system with clear procedures for requisitions, stock and inventory control, and guidelines for preventive maintenance		1/88
- Establishment of maintenance workshops at central and at regional levels	12/86	7/89
- Establishment of regional storage facilities for bulk purchases of fuel	12/87	7/89
[- Proposal to improve transport management]	[3/93]	[3/93]
5. Communications Network	8/88	
- Procurement and installation of 30 small, solar-powered VHF transceivers, and of slightly smaller units for the DMS, the RHTs and the hospitals		6/88 (only 20 units installed)
- Training of a local service vendor		Not done.
- Preparation of a simple operating handbook		Not done.

Part B: Investments		
6. Expansion of PHC		
- Expand PHC services to 53 villages in the Western Region, incl. 11 key villages		1/89 (coverage of 80 villages)
- Training of 11 Community Health Nurses (CHNs)		1987/89
- Initial and in-service training for VHWs and TBAs		1/89 - 7/90
- Provision of 11 CHNs with motorcycles	9/88	1990
- Provision of VHWs and TBAs with bicycles	9/88	2/88
- Improve integration of Village Health Services (VHS) with Basic Health Services (BHS) and the referral system (RHTs to conduct outreach clinics in all key villages)		Mid-1994
- Training of selected VDC members in basic principles of management and simple financial accounting and control		Not done.
- Expansion of communicable disease program by in-service training for about 330 nurses, and by provision of drugs and lab supplies		1992-94
- Study to prepare PHC for peri-urban areas of Banjul	1988	first one: 7/90 second: 1993
- Extension of PHC to peri-urban areas of Banjul	1988	Not done.
7. Improvement of Health Facilities	5/90	
- Rehabilitation and upgrading of:		
* Royal Victoria Hospital (RVH)	5/90	
- improvement of water, drainage, electricity systems (ODA)		6/92
[- general rehabilitation of RVH (ODA)]		[6/93]
- upgrading of facilities, esp. pediatric ward and lab. (Italy)		10/89
* Bansang hospital:	5/90	
- from old wards: create pediatric and obstetric ward, new outpatient department (Italy)		10/89
- remodeling of existing wards, operating rooms, lab, X-ray		Not done.
* 5 (7) dispensaries	5/90	Not done.
- Minor upgrading of	5/90	
* 7 health centers		Not done.
* 7 dispensaries		6/95 (only 1 of 7)
- Construction of:	5/90	
* 50 staff houses (The Gambia)		1990-1994
* New health center for Banjul peri-urban area		12/88
* New polyclinic in Banjul (Italy)		2/89
- Provision of essential services at each of the facilities:	5/90	
* refrigeration (solar; Italy, UNICEF)		2/89
* emergency lighting (solar; Italy, UNICEF)		Mid-1990
* water heating (solar; Italy, UNICEF)		Mid-1990
* upgrading of standby power and water supplies where necessary		11/94
- Provision of furniture and simple medical and surgical equipment	5/90	6/90
- renovation of CMS; IDA	11/88	1989-90
[- additional correction work on CMS; IDA]		[6/91]
[- extension of SEN school, Bansang (Netherlands)]		[6/96]

8. Strengthen Family Health and Nutrition		
- Upgrading of 5[6] Health Centers:	5/90	
- upgrade and equip as special MCH centers, and		
- build maternity waiting homes in:		
[Fajikunda (Italy)]		2/89
Brikama (Italy)		2/89
Kuntaur (Italy)		2/89
Essau (ODA/IDA)		7/90
Basse (EDF)		1993
Farafenni (China)		8/89
		Only Essau, Basse, Farafenni obtained maternity homes (by mid-1993).
- Overseas in-service training for 5 (6) doctors and 10 (12) nurse-midwives in MCH risk management; to be deployed to the special MCH centers		Replaced
[Component replaced by country training:		
- nurse-anesthetist program		[1989-92]
- at-risk pregnancies program]		[1989-92]
- 24 [72] p/m of expatriate doctor/nurse-midwife TA to provide assistance during the first year of the MCH centers	1990	1989-94
- Provision of 3 small emergency ferries to cross the river to the nearest health center	10/88	7/89
9. Nurses' Training		completed by 11/92
[- Launching of Nurses' Training Program]		[5/89]
- Incorporation of PHC into CHN and SEN curricula	1989/90	1990
- 24 p/m of foreign fellowships for 2 CHN instructors to strengthen their clinical and teaching skills		1992/93
- Transfer of SEN training from RVH to Bansang		1989
- 5 p/y of overseas fellowships for nursing instructors and senior nursing staff		completed in 7/90
- In-service training for CHN and SEN in midwifery and nutrition, and 12 p/m of TA (physician) to support training	1989	1994/95
[- Recruit counterpart training coordinator for in-service training]		[6/90]
10. Health Education, Nutrition and FP		
- Establishment of a sub-committee on family, health and nutrition (SCFHN - under the Project Implementation Committee) to coordinate, review and approve detailed plans for the three programs	6/87	3/87 (with a short life time)
- Appointment of an Executive Secretary for the SCFHN to develop and maintain an inventory of all relevant programs in The Gambia		2/90 (resigned in 12/90; no replacement)
- Integration of various nutrition programs through the Development of a Nutrition Action Program (NAP)		Draft before 4/89
- Among other things, NAP to establish guidelines for those responsible for macro-economic policies which heavily influence nutrition conditions (such as price policies for agriculture and for food) in order for them to take nutrition/consumption issues into account		Not done.
- Operational research on nutrition intervention by Nutrition Unit		1991/92
- Health Education Unit (HEU) to develop rolling 2-year plans for FP, health and nutrition	1988	5/91
- HEU to develop and test FP, health and nutrition messages		Not done.
- In-service training for 10 doctors and 40 nurse-midwives in FP and MCH	1989	12/92
-Study tour for MoH and GFPA to a successful program in another country		Not done.

11. Monitoring and Evaluation		
- ESU to review and improve the health information system, esp. in relation to FP, health and nutrition needs		1-6/90
- ESU to develop a 5-year action plan for its work		6/89
- Mid-term project evaluation	12/89	10/89
- Final project evaluation	12/92	9/93
12. Project Management		
- Establishment of a Project Implementation Committee (PIC)		at effectiveness (short life time)
- Establishment of a Project Management Unit (PMU); to be appointed:		at effectiveness
- Project Manager		1/88
- Deputy Project Manager		4/88
- Project Accountant		7/88
[- Procurement Officer]		[3/88]

TABLE 6: KEY INDICATORS FOR PROJECT OPERATION

Key indicators for project operation were neither contained in the SAR or the DCA, nor were they elaborated during project life.

TABLE 7: STUDIES INCLUDED IN PROJECT

Study	Purpose as defined at appraisal/redefined	Status	Impact of the study
1. Organization, Staffing and Efficiency Study	To guide institutional reform and decentralization.	Completed during preparation stage.	Used extensively in reform work.
2. ODA Report on new MoH structure	To recommend improved organizational structure to MoH.	Completed by 1/91.	Provided platform for elaboration of actual MoH structure.
3. First Evaluation of Drug Revolving Fund (DRF)	To assess the functioning of the DRF.	Completed by 10/89.	Evaluation was used during mid-term review to undertake course corrections.
4. Economic Analysis of the DRF	To assess the validity of the existing fee structure and the impact of fees on the utilization and the quality of services.	Completed by 7/90.	No impact.
5. Second Evaluation of the DRF	To prepare the ground for a new fee structure.	Completed by 7/92.	New fee structure was introduced in 1994.
6. Transport Study	To improve transport management.	Completed by 3/93	Basis for later studies.
7. Studies on Primary Health Care (PHC) for the peri-urban areas of Banjul	To give the socio-economic information needed to design PHC for urban areas.	First study completed by 7/90; second study by 1993.	Basis for later studies.
8. Greenwood Report	To analyze the role and function of the HMB and to guide the future development of the RVH and the Bansang Hospital.	Completed by 5/93.	Major impact on management of both hospitals, with improvements in financial management, resource mobilization and retaining of staff.
9. Mid-Term Review	To assess progress made in the reforms and investments components of the project.	Completed by 10/89.	Enabled decisions on project modifications to increase effectiveness.
10. WHO Final Project Evaluation	To assess overall performance of the project.	Completed by 9/93.	Guides preparation of future health policy and projects.

Source: SAR; Bank Supervision Reports.

no mention in ICR

TABLE 8A: PROJECT COSTS

Item	Appraisal Estimate (US$,000)			Of which: IDA Credit		
	Local Costs	Foreign Costs	Total	Appraisal Estimate (US$,000)	Appraisal Estimate (SDR,000)	Actual (SDR,000)
1. Civil works	1,948	7,797	9,745	963	810	690
2. Equipment and vehicles	543	3,350	3,893	978	822	1,305
3. Drugs and medical supplies	0	2,106	2,106	611	513	597
4. Materials and fuel	27	457	484	484	407	321
5. Consultants, operations	385	3,749	4,134	2,156	1,812	1,372
6. PPF Refund	40	360	400	400	336	265
7. Unallocated/Special Account						13
TOTAL	2,943	17,819	20,762	5,592	4,700	4,563

The details on the IDA credit rather than the latest estimate for the total costs are given, because it was not possible to give an actual cost breakdown for other donors by expenditure category or by local/foreign costs. The appraisal estimates are from the SAR, p. 21. The actual for the IDA credit is taken from the Disbursement Information as of 3/17/96. The actual is given in SDR rather than in US$ because the credit is denominated in SDR. Due to constant exchange rate fluctuations between the SDR and the US$ a comparison between the appraisal estimates and the actual in US$ would not be possible.

TABLE 8B: PROJECT FINANCING

Source	Appraisal Estimate (US$M)*			Actual/Latest Estimate (US$M)**		
	Local Costs	Foreign Costs	Total	Local Costs	Foreign Costs	Total
IDA	0.4	5.2	5.6			6.2[1]
United Kingdom	0.0	0.9	0.9			6.4
Netherlands ½ CO, ½ parallel	0.0	2.0	2.0			3.5
Italy	1.9	7.7	9.6			9.6
UNCDF UNFPA?, p 5	0.0	0.4	0.4			0.4
China	0.2	0.8	1.0			1.0
European Development Fund	0.0	0.0	0.0			0.5
Government of The Gambia	0.5	0.8	1.3			5.7
Total	3.0	17.8	20.8			33.3

* Financing Plan, SAR, p. iii

** From Project Unit's Evaluation Report. A breakdown in local and foreign costs is not possible.

20.4 G22 21.4 3.10

TABLE 9: ECONOMIC COSTS AND BENEFITS

Cost-benefit analyses were not undertaken, and a net present value or an economic rate of return were not calculated.

[1] Due to the facts that IDA credits are denominated in SDR, and that the SDR was devaluated during the course of the project, the US$ equivalent of the actual IDA credit disbursements are higher than the appraisal estimate.

TABLE 10: STATUS OF LEGAL COVENANTS

Agreement	Section	Covenant Type	Present Status	Original Fulfillment date	Revised Fulfillment date	Description of Covenant	Comments
Article III	3.01 (a)	5	C	Throughout Project	Throughout Project	The Borrower declares its commitment to the objectives of the Project as set forth in Schedule 2, it shall carry out the Project with due diligence and efficiency and in conformity with appropriate adm., financial, and public health management practices, and shall provide the funds, facilities, services, and other resources required.	Complied with.
Article III	3.01 (b)	4	C	Throughout Project	Throughout Project	The Borrower shall (i) open and maintain a project account (the Project Account) to be used to meet expenditures for the project; (ii) pay into the project account an initial deposit in the Borrower's currency equivalent to $20,000; (iii) ensure that there shall be at the beginning of every quarter amounts equivalent in Borrower's currency not less than $20,000.	Complied with.
Article III	3.01 (c)	2	C	Through-out Project	Throughout Project	The Borrower shall establish and thereafter maintain in a form and with functions satisfactory to the Association the revolving fund described in Part A (3) (iii) of the Project. Further provisions relating to the Revolving Fund are set out in Part D of Schedule 5 to this Agreement.	Revolving Fund was maintained throughout the project. Recovery level was lower than expected.
Article III	3.02	10	C	Through-out Project	Throughout Project	Except as the Association shall otherwise agree, procurement of the goods, works and consultants' services required for the project and to be financed out of the proceeds of the Credit shall be governed by the provisions of Schedule 3 of the Agreement.	Complied with.
Article III,	3.03	9	C	(i) Dec., 1989 (ii) Dec., 1992	(i) Oct. 23-Nov. 3, 1989 (ii) September 1993	The Borrower and IDA shall, (i) no later than December 31, 1989, carry out and furnish to the Association for review and comment, the result of the mid-term evaluation of the Project; and (ii) no later than December 31, 1992, carry out and furnish to the Association for its review and comments the result of the final evaluation of the project.	(i) Mid-term review was held Oct. 23 - Nov. 3, 1993. ٤٥١ (ii) The final evaluation was conducted by WHO in Sept. 1993. (Closing of project extended to June, 1995.)

Agreement	Section	Covenant Type	Present Status	Original Fulfillment date	Revised Fulfillment date	Description of Covenant	Comments
Article III	3.04 (a)	9	C	Annually	Annually	The Borrower shall, no later than May 1 every year through 1992 prepare and furnish to, and thereafter review with, the Association: (i) plans satisfactory to the Association for investment and recurrent expenditures in the health sector (including family planning and nutrition expenditures) for the three fiscal years immediately following; and (ii) the Borrower's annual development and recurrent budgets for the health sector for the fiscal year immediately following. The said plans shall be consistent with the Borrower's economic recovery programs and shall be used by the Borrower as a framework in seeking financing from other donors for the health sector.	Complied with.
Article III	3.04 (b)	2	C			The Borrower undertakes in seeking financing for the health sector to do so on the basis of the health sector expenditures set out in the plans required under paragraph (a) of this section.	Complied with.
Article III	3.05 (a)	5	CP	Throughout Project	Established: 11/02/87	The Borrower shall establish, and thereafter maintain, in a form and with functions satisfactory to the Association a Project Implementation Committee (PIC) which shall have responsibility for overseeing the carrying out of the Project. Further provisions relating to PIC are set out in par A of Schedule 5 to this Agreement.	PIC was established at effectiveness. It continued sporadically in the beginning of the project, then terminated.
Article III	3.05 (b)	5	C	Throughout Project	Throughout Project	The Borrower shall establish, and thereafter maintain, in a form and with functions satisfactory to the Association a Project Management Unit (PMU) which shall have responsibility for coordinating the day-to-day Project execution activities of line units of MoH. Further provisions relating to PMU are set out in part B of Schedule 5 to this Agreement.	Complied with.

Agreement	Section	Covenant Type	Present Status	Original Fulfillment date	Revised Fulfillment date	Description of Covenant	Comments
Article III	3.05 (c)	5	CP	Throughout Project	Established: 11/02/87	The Borrower shall establish, and thereafter maintain, in a form and with functions satisfactory to the Association, a Sub-Committee of the Project Implementation Committee referred to in Part B (4) of the Project. Further provisions relating to SCFHN are set out in Part C of Schedule 5 to this Agreement.	SCFHN established at effectiveness. Since the departure of secretary of the committee, SCFHN became dormant and terminated.
Article III	3.06	1	C			The Borrower undertakes that its recurrent budget expenditures on health, as a percentage of the Borrower's total recurrent budget expenditures (exclusive of debt service), shall be maintained at not less than the 1985/86 recurrent budget expenditure levels.	Relative budget expenditure on health even increased: 1986/87 7.3% 1987/88 8.3% 1988/89 9.1% 1989/90 9.8% 1990/91 14.1% 1991/92 10.1% 1992/93 11.9% 1993/94 12.3% 1994/95 11.1%
Article IV	4.01 (a)	1	C	Throughout Project	Throughout Project	The Borrower shall maintain or cause to be maintained records and accounts adequate to reflect in accordance with sound accounting practices the operations, resources & expenditures in respect of the departments or agencies of the Borrower responsible for carrying out the project or any part thereof.	Complied with.

Agreement	Section	Covenant Type	Present Status	Original Fulfillment date	Revised Fulfillment date	Description of Covenant	Comments
Article IV	4.01 (b)	1	CP	12/31/87 12/31/88 12/31/89 12/31/90 12/31/91 12/31/92 12/31/93 12/31/94 12/31/95	04/19/89 08/07/89 12/28/90 10/19/90 01/14/92 11/30/92 03/25/94 05/01/95 01/30/96	The Borrower shall: (i) have the Revolving Fund, the Special Account and the accounts referred to in para (a) above audited for each fiscal year in accordance with appropriate auditing principles consistently applied, by independent auditors acceptable to the Association; (ii) furnish to IDA, as soon as available, but not later than 6 months after the end of such year, a certified copy of the audit report; (iii) furnish to the Association such other information concerning the Revolving Fund, the Special Account and the said accounts and the audit thereof and said records as the Association may reasonably request.	The first three audit report were received 16, 8 and 12 months late, respectively.
Article IV	4.01 (c)	1	C	Throughout Project	Throughout Project	For all expenditures with respect to which withdrawals from the Credit Account was made on the basis of SOEs, the Borrower shall: (i) maintain separate records of accounts reflecting such expenditures; (ii) retain, until at least one year after completion of the audit for the FY in which the last withdrawal from the Credit Account was made, all records evidencing such expenditures; (iii) enable the Association's representatives to examine such records; (iv) ensure that such separate accounts are included in the annual audit referred to in para (b) of this section and that the report thereof contains, in respect of such separate accounts, separate opinion by said auditors as to whether the proceeds of the Credit withdrawn in respect of such expenditures were used for the purposes for which they were provided.	Complied with.

Source: Development Credit Agreement, MIS Covenant Compliance Report, Supervision reports for dates of fulfillment

Covenant types:

1. = Accounts/audits
2. = Financial performance/revenue generation from beneficiaries
3. = Flow and utilization of project funds
4. = Counterpart funding
5. = Management aspects of the project or executing agency
6. = Environmental covenant
7. = Involuntary resettlement
8. = Indigenous people
9. = Monitoring, review, and reporting
10. = Project implementation not covered by categories 1-9
11. = Sectoral or cross-sectoral budgetary or other resource allocation
12. = Sectoral or cross-sectoral policy/ regulatory/institutional action
13. = Other

8. Present Status

C = covenant complied with
CD = complied with after delay
CP = complied with partially
NC = not complied with

TABLE 11: COMPLIANCE WITH OPERATIONAL MANUAL STATEMENTS.

BORROWER COMPLIED WITH ALL OPERATIONAL MANUAL STATEMENTS.

TABLE 12: BANK RESOURCES: STAFF INPUTS

Stage of project cycle	Planned*		Revised*		Actual	
	Weeks	US$	Weeks	US$	Weeks	US$
To Appraisal					65.20	52,700
Appraisal to Board Approval					45.30	77,500
Board Approval to Effectiveness					6.00	16,660
Supervision					85.30	183,800
Completion					13.00	14,900
Grand Total					214.80	345,560

Source: Cost Accounting Menu (COSR51: lending and supervision)

* Planned and revised work programs were not computerized until 1994. Therefore, even those recorded since 1994 for supervision could not provide a comprehensive estimate and are not included in this ICR.

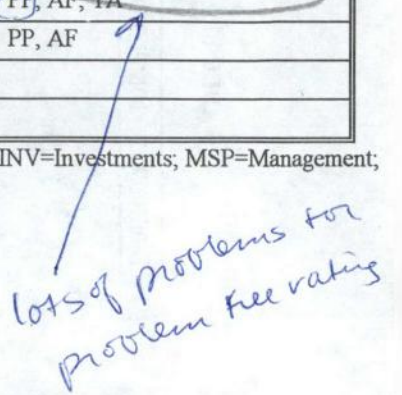
TABLE 13: BANK RESOURCES: MISSIONS

STAGE OF PROJECT CYCLE	MONTH/ YEAR	NO. OF PERSONS	DAYS IN FIELD	SPECIALIZED STAFF SKILLS REPRESENTED	PERFORMANCE RATING		TYPES OF PROBLEMS
					IMPLEMENT STATUS	DEVELOP. IMPACT	
TO APPRAISAL	09/84	3	5	HPE,ECN,IEC	N/A	N/A	N/A
	12/84	4	4	HPE,ECN, FNA			
	05/85	5	10	HPE,ECN,PPN,			
	07/85	4	14	FNA,IEC HPE,NTR,FNA, EGR			
APPRAISAL THROUGH BOARD APPROVAL	01/86	6	11	HPE,PRO,MSP, FNA,IEC,EGR	N/A	N/A	COF (ADB, Italian, Dutch, and UK ODA)
	01/87	2	5	HPE			
BOARD APPROVAL - EFFECTIVENESS	0	0	0				
SUPERVISIONS	12/87	1	6	PPN	1	1	
	03/88	2	11	PPN,PRO	1	1	
	06/88	0	14.5	PPN,PRO	1	1	
	02/89	1	4	PPN	2	1	PMP
	11/89	2	22	PPN,ARC	2	1	PMP, PP,TP,TA,SP
	06/90	2	7	PPN,HPE,INV	2	2	PMP, PP, SP
	11/90	3	9	PPN,HPE,INV, ARC	2	2	PMP, PP, SP, CLC
	12/91	4	18.5	PPN, HPEs, SOC	2	2	PMP+, PP, SP+, CLC, AF, TA+
	06/92	5	10	PPN.HPE, SOC, HPE	2	2	PMP, PP, SP+, CLC, TA+
	11/92	1	1	PPN	2	2	PMP, PP, SP+, CLC, TA+
	07/93	1	11.5	PPN	1	1	PMP, PP, SP+, CLC, TA+
	11/93	4	20	PPN, HPE, FNA, PRO	1	1	PP, AF, TA
	03/94	3	2.5	PPN,NGO,SOC	1	1	PP, AF
	04/95	1		NTR	1	1	
COMPLETION	03/96	1	3	HPE			

Specializations: ARC = Architect, ECN=Economist, EGR=Engineer, FNA=Financial Analyst; HPE= Health and Medical; IEC= Info/Educ/Commun; INV=Investments; MSP=Management; NGO=NGO Specialist; NTR= Nutrition. PPN=Population/Demography PRO=Procurement; SOC=Sociology;

Performance Ratings: 1=Problem Free; 2= Moderate Problems; 3= Major Problems; 4= Major Problems

Key to problems: AF = Availability of funds; FP = Financial performance; PP = Procurement progress; CLC = Compliance with legal covenants; PMP = Project management performance; SP = Studies progress; TA = Technical Assistance; TP = Training Progress; + = particularly problematic



THE GAMBIA

Aide Memoire

World Bank Project Mission: Health, Population and Nutrition
March 4-16, 1996

Introduction

1. A World Bank mission comprised of Richard Seifman, Task Manager (AF5PH), Debrework Zewdie, Reproductive Health Specialist (HDD), Lynnda Kiess, Nutrition Specialist, (HDD) and Yaya Sanyang, Project Manager for the National Health Development Project (NHDP) visited The Gambia from March 4-16 to carry out the following objectives: a) to prepare the Implementation Completion Report of the NHDP (Credit GM-1760), b) to address any outstanding audit issues under this project, and c) to discuss a new World Bank Health Participatory, Population and Nutrition project.

Mission Work Program

2. The mission met with the Ministry of Health, Social Welfare, and Women's Affairs, Mrs. Nyimasata Sanneh-Bojang, Senior Ministry of Health officials, and officials from other Ministries, including the Ministry of Finance, the Ministry of Local Government, the National Population Secretariat, United Nations agencies, bilateral and multilateral donors, non-governmental organizations and the Medical Research Council. The mission visited several health centers, dispensaries, hospitals and community health workers during a field visit. Cooperation was excellent throughout the visit, and the mission greatly appreciates the time and assistance given to the team during the visit.

Main Areas of Discussion and Agreed Next Steps

3. The draft Implementation Completion Report (ICR) for the NHDP project was completed. The Ministry of Finance agreed to a procedure for repayment of overclaims to the Bank, in light of the final audit report for NHDP. In addition, the Government intends to request an extension of the Project Preparation Facility (PPF 823-GM), which ends in June 1996.

4. At the time of the Bank's visit the Government was revising the National Health Policy and developing National Health Action Plans. Simultaneously, African Development Bank consultants were in The Gambia to finalize a health sector requirements study, with their final report expected by June, 1996. In addition, UNDP is facilitating Government efforts to prepare for a Social Sector Roundtable tentatively scheduled for the second half of 1996. The Government has established a National Consultative Committee to prepare for this Social Sector Roundtable. During its meeting on March 14, 1996, this Committee decided to revise the existing National Health Policy (1995-2001), develop a National

Health Plan to support the Health Policy, and Health Action Plans, and to review and revise the National Population Policy, for the Roundtable discussions.

5. Given this situation and the mission's discussions with the Government, it was agreed to wait until the Government's priorities were further clarified to design specific interventions for a new Bank supported Participatory Population, Health, and Nutrition Project. The Bank and the Government, would however, actively engage in a project preparatory process that would: a) build on the strengths and lessons learned during the National Health Development Project, b) concentrate principally on primary health care/family health, family planning and related critical support services up to the Divisional level; and c) be responsive to evolving Gambian national health policies and plans.

6. Funds from a Japanese Grant are available for project preparation. Based on the process described above, it was agreed that the Government would identify proposals to use these funds. (Funds will be provided for initiatives which already have commenced and are time-sensitive, i.e. the Local Initiative Fund.) Furthermore, a rough timetable for reaching agreement and beginning Grant-funded activities was agreed to, namely, that the Government would submit proposals to the Bank that will lead to project preparation by early April 1, 1996. A draft Grant Agreement including the Technical Description Schedule, would be negotiated and costed, and Terms of Reference prepared during May-June, with funds then available by July 1996. Taking into account the process of intensive appraisal and negotiations, this would allow for the possibility of an IDA Credit in mid-1997.

7. The mission was assured of the Government's concurrence with the approach and its full cooperation.

NATIONAL HEALTH DEVELOPMENT PROJECT

IDA CREDIT 1760 GM

(1987 to 1995)

END OF PROJECT REPORT

PROJECT MANAGER
NATIONAL HEALTH DEVELOPMENT PROJECT
MINISTRY OF HEALTH, BANJUL, THE GAMBIA
AUGUST 1995

NATIONAL HEALTH DEVELOPMENT PROJECT
END OF PROJECT REPORT

1. PREAMBLE

The National Health Development Project (NHDP) was conceived during the preparation and implementation of The Gambia's Structural Adjustment Programme (SAP) in the early 1990s. This period also coincided With the end of the implementation of the Primary Health Care (PHC) Action Plan. The major underpinnings influencing the design of the project and strategies developed have their basis in these seemingly two conflicting ideologies. The sectoral reform of the health administrative system and the implementation of a user charges could both be considered as paroxysms of the SAP. In addition the strengthening of the health infrastructure and enhancing the effectiveness of the Major Health Centres and the Village Health services are necessary outcomes of the PHC development.

The Gambia in the early 1980s had all the attributes of a least developed sub-Saharan African country with limited natural and human resources, rapid population expansion, poor health indicators, high level of morbidity and mortality from preventable causes and dwindling government resources; less and less of which is actually filtering to the people most in need. The system was exacerbated by poor performance of the economy. Rapid population growth negated any modest growth in the economy. These were coupled with dwindling foreign exchange reserves, balance of payment difficulties and an overblown and inefficiency public sector. The effect of these has been severe shortages of drugs and other medical supplies, low staff moral and deteriorating physical environment at the point of service delivery.

In 1985 the Gambia evaluated its PHC programme. This confirmed that the basic attributes of the programme are sound. The VHS has improved access to services for the majority of rural inhabitants, the TBA and VHW are effective in delivery basic care at the **community** level and more important the communities themselves have began to take active roles in health promotional activities.

A major constraint is the weak supervision mechanism and inadequate referral/evacuation system. In addition the health system was laden with a centralised management and administrative structure which relegates less priority to planning and budgeting. The health services were plagued by three major constraints:

- Inadequate resources to finance the extended PHC system particular the non salary recurrent cost.
- The burden of over centralized administrative and management system leading to inefficiencies, stifling of initiative and lack of priority identification.
- Inadequate human resources and lack of specific skills.

The NHDP was envisaged and launched with this background.

2. PROJECT DESCRIPTION

The NHDP was designed as a health sector management project geared towards improving access and quality of basic health care for a Gambians. This is to be accomplished through a combination of administrative and management reforms and a program of investment to improve infrastructure and enhance programme development.

The project had the following specific objectives as outlined in the staff appraisal report:

a) A programme of reforms to strengthen health sector management, financing and support systems through decentralisation, reorganisation, mobilisation of financial resources and strengthening of logistic support.
b) Extension of the PHC programme to achieve geographic coverage
c) Strengthening and expansion of the communicable disease control programme nation-wide
d) Improve health infrastructure at all levels
e) Improve the quality and training of nurses with specific orientation towards PHC.
f) Enhance family health and nutrition services.

These are to reinforce the government's overall PHC strategy with the aim of making basic health care accessible to all Gambian. a number of the strategies were targeted to specifically reduce maternal and infant mortality.

2.1 IMPLEMENTATION STRATEGY

The project was implemented under the overall direction of a multisectoral Project Implementation Committee (PIC) chaired by the Permanent Secretary of Health who also acted as Project Coordinator. The day to day execution of project activities was vested in the Project Management Unit (PMU) consisting of a Project Manager, Deputy Project Manager, and an Accountant. In addition, a sub-committee was established to coordinate project activities concerning Family Health and Nutrition (SCFHN).

The PMU had its locus within the Ministry of Health. Different components of the projects were implemented as discrete constituents according to sources of funding. The project will be reviewed according to those constituents for the rest of this report.

a) Administrative and central management reform
b) Hospital autonomy
c) Establishment of a cost recovery programme
d) Nurse Training Programme (NTP)
e) Health Infrastructure development
f) strengthening PHC services
g) Overall project co-ordination.

At the end of implementation, the NHDP had received the following financial contributions:

DONOR	COMPONENT	CONTRIBUTION AMOUNT	GMD EQUIV.
IDA	PM/CONSUL/DRF CONSTR/TRG/VEH.	USD 5.1 million	D 48.45 m
British ODA	HMSP	GBP 0.3 million	D 4.62 m
	Essua MHC		D 4.5 m
	RVH Rehab	GBP 3.335 m	d 51.35 m
Dutch Govt.	NTP	USD 1.5 m	D 14.25 m
	CRP	USD 1.0 M	D 9.5 m
	SEN school		D 10.0 m
Italian Govt.	Three MHCs, Lab Paed. Unit Rehab. Polyclinic, Mater. Ward and OPD Bansang	USD 9.1 M	d 86.45 M
	CRP	USD 0.5 m	D 4.75 m
EDF under URDIP	Basse MHC		D15.0 m

The Project originally expected to be completed in June 1992 was finally closed in June 1995 after three extensions. An end of project evaluation was independently conducted by WHO in September 1993. This evaluation conducted an overall assessment of the impact of the NHDP as gauged by the objectives set out in the Staff Appraisal report. In addition specific intervention strategies were assessed in terms of the design, appropriateness and impact on health status of Gambians. The end of project evaluation was to assist government to make a valid judgment on the impact of the investment programme implemented during the project with a view to forming a basis for the formulation of a successor programme of investment.

The evaluation indicated that the overall objectives of the project were to a large extent realized albeit at a slower implementation rate than planned. A major shortcoming was the relative lack of effective integration of the different components of the project. The evaluation assessed the project achievements as compared with the objectives set out in the appraisal. This report will focus on reviewing the implementation strategy and lessons learnt with a view to assisting government and donors in the design of a successor health/population/nutrition project.

3. PROJECT CO-ORDINATION

3.1 PROJECT IMPLEMENTATION COMMITTEE

The Project Implementation Committee had the responsibility of overseeing the execution of the project. It was chaired by the Permanent Secretary of the Ministry of Health (also project coordinator) and draws its membership from the government ministries responsible for Finance , Planning, Office of the President and Rural development. The Director of Health Services, the Project Manager and representative of the Gambia Family Planning Association were also members. The membership was later increased to include

representatives of the WHO office, Banjul and the Medical Research Council (MRC). The PIC was to meet regularly at least twice a month during the initial phase of the project.

The composition of PIC is more a reflection of the desire to implement a multi-sectoral comprehensive health package. It was designed to involve the key development players in giving guidance and direction during project implementation. Through the PIC significant consideration would be given to health in the setting of national priorities and development strategies.

The PIC did not live up to expectations. It met less often after the first year with poor attendance. As the PW and the MOH took more decisions without prior consultation of the PIC, the critical function of the body became defunct.

A number of reasons could be advanced for lack of effective performance of the PIC. Whereas project design requires intensive multi-sectoral consultation as a prerequisite for a sound and coherent project, day to day management and implementation calls for precise and firm action often requiring time-limited decision making which is unsuitable as a function for a committee. The PMU and MOH were ultimately accountable for the action and resources, not the PIC. The effectiveness of the PIC in setting implementation guidelines and monitoring guidelines was also limited by the lack of crucial information to members which the PMU never shared. The infrequent PIC meetings became more confrontational, concerned less with monitoring the project than probing the PMU.

The lack of optimal performance of the PIC did deprive the project of a critical tool, but by centralising decision-making within the PMU and MOH particularly in the last four years of the project Government was able to implement major sectoral reforms policies. It is doubtful that the PIC would have helped facilitate the reorganisation of the MOH and the setting up of Hospital Management Boards.

3.2 PROJECT MANAGEMENT UNIT

The PMU was established within the MOH. The first set of staff were appointed more for the positions they held prior to the project. The Director of Health Services retired to become the Project Manager and the Principal Health Planner retained his job but also functioned as Deputy Project Manager. The attributes for complacency and conflict were already in place.

The functions of the PMU were never clearly defined particularly in relationship the Director of Health Services (DHS). The DHS is not only the chief governmental adviser of all health matters but the day to day management of the services is within his purview. Yet his only role in the day to day implementation of the project is as a member of the PIC. The NHDP is by de-factor an health project in toto with the objective of making major sectoral reforms. Unlike WID, the role of the DHS in the implementation of the NHDP is key if not the most important, Once the PIC became default, the only medium of consultations and influence on project direction has been through the office of the PS. The continues difficulty of the PMU in dealing with the DHS can be viewed from this perspective. Project Components like the Nurse Training Program (NTP) which were implemented jointly with the DHS (as co-signatory to the accounts) proceeded at a faster rate than the Health Management Strengthening Project (HMSP) implemented directly within the auspices of the PMU and PS.

The project had three Project Managers, four Project Coordinators (PS), three DHS, four Ministers of Health, and three IDA task managers during its lifetime. As of June 1990 there was no Deputy Project Manager. The most stable period was the last five years when management stabilised .with the same PM, PS, DHS and IDA Task Manager. This was the period when most administrative reforms were implemented. Despite the constraints of functional roles and staff changes the PMU was able to execute the different components of the project successfully, albeit with delay. A lost opportunity is that the

experience of the PMU should have inherently strengthened the donor coordination and planning skills of the MOH.

3.3 SUB-COMMITTEE ON FAMILY HEALTH AND NUTRITION

This component got slightly sidelined during appraisal and almost totally relegated during implementation. Not withstanding, significant policy changes have been made in the area of family health and nutrition albeit not under the auspices of the NHDP. Prior to NHDP Family Planning (FP) services in the country were offered from government health facilities, Gambia Family Planning Association (GFPA) run clinics and a host of other NHDP also operate limited FP services. Each of these operated separately and independently from each other. The overlapping of programme areas, non complementary strategies and competition for scarce resources between the agencies resources were further exacerbated by the lack of any mandated government focal point for policy direction of FP. Any FP policy that existed was ill defined under the Five year Development Plan of 1975/76 to 1979/80. Rather aim for policy formulation and sectoral reform to reflect the importance of Family Health in national development, the appraisal stopped short by emphasising co-ordination and information sharing.

The development of the Nutrition services mirrors what transpired under FP. Four government agencies established nutrition units (Health, Agriculture, Community Development and Economic Planning) and a number of international and local NGOs became involved with food supplements, nutritional education, research, agricultural production, or food preservation and storage. The objective under the project was to institutionalize a system of information sharing and programme co-ordination.

As defined under the credit agreement the SCFHN is to draw membership from all the major agencies involved in Family Health and nutrition activities in the country. The Deputy Permanent Secretary was originally assigned the functions of Executive Secretary. This was discontinued after a year. A full time Executive Secretary was appointed in February 1990. He resigned from the post within 10 months and was never replaced. Records indicate that the SCFHN met for a total of less than 10 sittings.

4. ADMINISTRATIVE AND CENTRAL MANAGEMENT REFORM

This component of the project was financed by the Overseas Development Administration (ODA) of the British Government which sub-contracted to the Nuffield Institute for Health Services Studies under the Leeds University (NI). This component of the project started late. A project proposal was presented to the Gambia Government and the ODA in September 1988, but only a year later was a management adviser seconded to the Ministry of Health by the Nuffield Institute.

The Health Management Strengthening Project (HMSP), financed by the ODA and implemented through the NI was to focus on three main areas of sector reform:

- Central level administrative structure for the MOH
- Strengthening the Health Information System
- Developing a comprehensive health planning system.

The HMSP was designed to have a management consultant/adviser to be based in the MOH for a prolonged period (12-18 months) to provide guidance and support to the process of administrative reform. The Management adviser, envisaged to be senior and with fair experience in health system management is to be supported by regular short-term (<4 weeks) Consultancies from the NI. These would be further reinforced through training of planners and epidemiologists (non clinical) at NI. An ODA TA was already in place at the ESU. This would be supported and enhanced with short term consultancies and training.

The MA was in place in October 1989. The first short-term consultant arrived in November 1989 to recommend an Organisational Structure for the MOH. This was followed by 16 short-term consultancies on planning, decentralisation, health information and development of operational policies for transport, personnel and supplies services. A total of 10 training fellowships were awarded for planning, information technology and health information. A number of senior officers also visited NI for exchange programmes. The HMSP was effective for just over two years. The management adviser was withdrawn in December 1991 not to be replaced.

The HMSP tended to be judged by the high expectations generated by the IDA staff appraisal report and consequent ODA/NI consultancy reports. Adequate recognition was not given to the need for consensus-building in the design of a reorganized structure. The implementation of the planning and budgetary system, decentralisation. and support for DHTs and the development of operational policies for the support services all depended on progress on the implementation of the organisational structure (OS).

4.1 ORGANISATIONAL STRUCTURE

The verdict on the OS is still far from conclusive. Tremendous progress has been made in realigning the administrative/management structure of the MOH. The three directorates envisaged under the report have now been set up and reflected in the government budget. The symbolic transfer of the DHS to the Ministry premises has been effected since 1991. The mailing and filing system have been fully integrated. The directors and the PS form a core management team responsible for all policy decisions. A number of gray areas continue to create concern. This include the responsibility for donor co-ordination, the locus of ESU/Health Information and the merging of the NHDP/PMU and the DPI. The role of the DSS, hereto the DPS, is still less define and seem to change depending on the post holder. Four DPS have been posted to the post in four years. The DHS still continues to manifest the seeming conflicting roles of chief adviser to the MOH (members of both HMBs) and implementation of the health services.

It was a weakness in the design of the project to have left an inherently contentious issue as central as MOH reorganisation to separate bilateral agreement negotiations. This component of the sector reform had been identified as one of the major impediments to efficient use of health resources and effective delivery of services. An issue for such importance should have been a conditionality of credit effectiveness at best or funded under parallel financing arrangement to ensure effective use of IDA leverage in influencing speedy government decision making. The scars from the controversy surrounding the OS are still apparent. The central planning committee, a key requirement of the OS now meet at most twice a year. The sensitization of the MOH staff on the OS and lines of responsibility now seem irrelevant.

4.2 SUPPORT FOR DPI

The support for the Directorate of Planning and Information was concluded prior to the establishment of the DPI in July 1992. Four Health Planners were trained at the Masters level and all but one are still within the DPL a Planning Cycle relying on the DHT to develop their own operation yearly plans is still effective. The DPI has yet to evolve into a focal point for donor co-ordination. This is more a reflection of the separation of the NHDP/PMU, the strong influent of the DHS and the need to bolster the image of the DPL.

4.2 SUPPORT FOR ESU

The support for ESU was largely a continuation of existing ODA support for the health information system. Since 1986 an ODA TA statistician was based at the ESU to strengthen the collation and analysis of data from health returns and special surveys. A couple of desk-top computers were provided and local training provided for the data entry clerks. The HMSP gave initial support through the revision of the

health information system (reporting system from health facilities), developing potential for operational research at the field level and training.

NI, in collaboration with the ODA TA, assisted government in designing the reporting format for a levels of the service. Data collected was based on relevance at the point of collection. Staff at the facility level were trained in the use of the new forms and basic analysis to enable them to extract relevant information for their own use. Feedback mechanisms and cross checking of data also improved the level of reporting.

A major deficiency of this sub-component was the restriction of health information and morbidity data to ESU. Six out of the eight staff who benefited from long term overseas training left the services without ever reporting for work. This desperate staff situation, the departure of the ODA TA in 1991, and the completion of the HMSP in 1992 made sustaining any gains difficult.

5. HOSPITAL AUTONOMY

The Medical Services Act establishing the legal framework for the operational separation of the he hospitals from the rest of the health services was passed into law by mid 1988. At first a single Management Board was responsible for both Hospitals but in 1992 separate board were appointed by the Minister one each for RVH and Bansang. The operations of the Medical Services Act, the roles and functions of the ENS inter-alliance the relationship with the MOH have been the subject of two major reviews. The- Greenwood report looked at the future development of the RVH and Bansang Hospitals and the WHO end of project evaluation of the NHDP devoted a substantial portion to the HMB.

The HMBs currently have a significant level of operational autonomy in terms of budgeting and financial management, personnel administration and day to day management of services.

These administrative and financial autonomy has allowed the HMB to develop the level of services offered and response to the changes needs of these institution, Clinical staff have been offered remuneration packages to reduce attrition and were necessary expatriate staff have been contracted from the sub-region to urgement staffing levels. Both hospitals have now appointed nationals as executive managers.

Whereas the autonomy of the HMB accrued significant advantages for both institutions, a number of concerns have persisted. The meaning and degree of autonomy to be granted to the HMB is still less clearly defined. The National Health Policy defined the government stance towards hospitals but it may be necessary to take this a step further and define a hospital development programme. This would not only clarify the roles of the HMBs in the development PHC but also define the relationship between the HMBs and other government agencies including the MOH.

The hospital share of the health budget has declined from 47% in 1982/83 to just under 35% in 1986/87. This proportion has now risen to 45% in 1993/94. As the HMBs increase their efficiency in utilising allocated resources and boost their lobbying power for additional extra-budgetary health resources, this trend could continue to grow.

In the establishment of the HMBs the magnitude of changes envisaged at the beginning was more than the system was capable of absorbing. The development of account and administrative systems, personnel management, procurement and supply management all had to be established and tested over a period of time. The provision of TA by the project at the level of Chief Executive for a period of four years may have provided the necessary leadership necessary for the implementation of these changes but delayed the process of allowing the HMB to tackle these issues in their own way earlier on.

6. COST RECOVERY PROGRAM

The conceptual frame work for the system of cost recovery in the health sector was less clearly defined prior to the implementation of the user charges. This was further complicated by inadequate preparation in ensuring that all the essential administrative attributes were in place prior to the launching of the programme.

The expected level of cost to be recovered was never ascertained. The government never accepted a basic concept of CRP that payment at the point of use should be the main determinant to access in the health services. The CRP was therefore laden with exemptions and other strategies to minimise the effect on charges on utilisation's. Members of the armed forces were exempt from payment. Anti-natal attendants (over 50% of all attendants) pay a one shot fee of D10 for five years of service. Average anti-natal visits for the first year of life is five visits. Children 5-8 years are exempt from fees and children 9-14 years pay one dalasi per visit. Chronic illness patients pay an annual registration fee of D30 for a year of treatment. The charges were pledged at a flat fee rate D5.00 per visit.

A WHO-financed drug needs assessment in 1986 was handicapped by lack of adequate health utilisation data. The CIPHA consultant who designed the operational procedures for the CRP were not in place at the commence of the implementation of the programme. Contrary to expectations, government did not second all the required administrative and financial staff required for the full implementation of the CRP. These were further compounded by the lack for training of health staff and an almost negligible public sensitisation campaign.

The CRP has had two major reviews of its performance since its inception in 1988. In 1993, within the auspices of the Bamako Initiative, the charges for non-hospital services were revised.

The percentage recovery for the cost of drugs and medical supplies for the first three years of the life of the CRP averaged 35%. All indications are that this trend has been maintained, particularly with the new fee structures introduced in August 1994.

The CRP has instituted within the national health service the notion of paying for a service that had been free. It has continued to contribute significantly to the cost of drugs and medical supplies. Whereas its financial performance has been below the high expectations envisaged at the launch of the program, the concurrent negative impact of the introduction of the CRP was also less than expected. Despite evidence of indigent patients being exempt from fees by prescribers, there was a notable drop in OPD attendance during the first two years (1988/89) of the CRP. By 1990 the level of total ODP attendance was still 20% below that of 1987, the year preceding the introduction of the CRP. There is evidence that the reduction in the utilisation of health services was more severe in rural areas.

Taken as a whole the implementation of the CRP was a qualified success. The Drug Revolving Fund had stayed viable and functional for seven years. The population has by default accepted paying for services and there have been no major shortages of drugs and supplies since 1988. The fall in utilization though significant it has not been drastic and should improve with sustained improvement in quality of services (availability of drugs, better infrastructure and transport services).

Nonethesless, the CRP is beset with operational and management constraints. Even with the revised charges introduced in 1994, there is a direct link between resources used and fees paid. This makes the monitoring of the financial performance of the CRP difficult. The-two most important assets of the CRP--stock of drugs and other supplies and cash collected--continue to be managed as separate entities. For operational efficiency and necessary financial control there is need to streamline the management of the Central Medical Stores and the CRP.

A number of lessons can be drawn from the implementation of the CRP. It is essential to clearly put into focus the conceptual framework for the implementation of the CRP. The levels of recovery, the exemptions to be imposed and the effect of these exemptions should be policy decision entered into by government prior to commencement of the CRP. A number of the exemptions are political decisions rather than based on any empirical evidence. Given alternative options than flat rate user charges and financial impact of each of the exemption, government could consider alternative policies.

To expect government to deploy a sizable amount of administrative and accounting staff to manage the CRP amidst staffing constraints was unrealistic.

7. NURSE TRAINING PROGRAM

The Gambia health manpower had a number of outstanding features. The demand for the extended PHC was compelling a orientation towards PHC, creating demand for additional trained staff. This was at a time when the attrition rate for senior staff particularly of SRN/SCM was at an all time high and increasing. This is compounded by the fact that over 60% of trained health personnel were based in the two hospitals. Two main strategies were adopted which were to imbue components of the NHDP.

A situational analysis of the status of the health manpower was carried out in 1987. This clarified the quality, variety and locus of the trained health personnel. The reports ambition of predicting the future demand for such trained staff was less satisfactory. In addition an assessment of nurse training in the Gambia was conducted with a view to streamlining the training and deployment of nursing staff in the health services. This report recommended the restructuring of the curriculum of all nurse training schools (SRN/SCM, SEN and CHN) and the merging of SEN and CHN into a graduate school for health service workers.

In the event that what was appraised under NHDP and implemented was a watered down version of a comprehensive health manpower training programme, the project centered on improving the skill of the graduates from the two schools for SEN and CHN as separate entities.

The Gambia draws its non-clinical health manpower from four training schools. The school for the training of State Registered Nurses/State Certified Midwives and the school for Public Health Superintendent are amalgamated with the Gambia College within the auspices of the Ministry of Education.

Within the Ministry of Health there are two health schools--State Enrolled Nurses and Community Health Nurses. Prior to the NHDP, two-year SEN graduates were expected to provide competent bedside nursing, relieving the acute shortage of the more senior SRNs. The SRN contingent not only provides most of the managers of the PHC system but also tutors of all four training schools. In time and with the development of PHC, the SEN were slowly absorbed into management roles in health centres and dispensaries becoming involved in the supervision of PHC and community health services. A major focus of the NTP was to reorient the training to reflect the emphasis on PHC.

The CHN started in 1976 as community health motivators. With the advent of PHC their role changed into supervision of VHW and TBA at the community level. Because of the shortage of trained staff, a significant number of CHN were deployed at health centres to support MCH clinics. These two new roles were never reflected in their curriculum or training.

The NTP had a more focused role in strengthening the two training schools for SEN and CHN with a view to support their enhanced roles in the development of PHC. The project implemented a separate entity within the NHDP PMU. An expatriate public health physician was in charge of day-to-day management

with the DHS and PM, NHDP as co-signatories to the accounts. This arrangement ensured complementary activities with other project components and also provided the backup support of the PMU in carrying out policy decisions.

A total of 12 tutors were trained for both Schools. Expatriate tutors were provided while the Gambians were on training. The physical locus of the SEN school was moved from Banjul to Bansang. The curriculum of both schools was revised and updated. A revolving fund for books was set up in both schools. An in-service training unit was established within the MOH and training centres set up in all district health team. Support was also given to the development of the Nurses and midwives Council which regulates nursing practice in the Gambia.

Considering the limited scope of the NTP and the co-management within the NHDP PMU it could be considered an qualified success. Project sub-components were all executed successfully. But barely two years after the completion of the project all but three of the trained tutors for the SEN school in Bansang have left the school. The book revolving fund is in difficulty. The NTP missed in resolving two major policy issues concerned within the two schools. Combining the two training schools to produce a graduate for the Gambia PHC system was never resolved. This would save cost, reduce duplication provide a single career structure with promotional opportunities. Despite all the inputs of the project, the midwifery course for the SEN school introduced under the NTP is still based in Banjul mainly due to inadequate accommodation for students and tutors. The NHDP was a lost opportunity to assist government in addressing the overall health manpower situation.

8. HEALTH INFRASTRUCTURE DEVELOPMENT

The health infrastructure at the beginning of the NHDP was antiquated and clearly unable to support the expanded PHC services. The expansion of the community based Village Health Services and increasing coverage of MCH/EPI had over a period of barely 6 years brought over 70% of Gambians within the remit of health services. The few health centres and dispensaries did not have the infrastructure to accommodate either the increasing number of referrals coming from the VHS or the actual demand for higher level curative care.

The civil works component of the project was to address these constrains through selective rehabilitation of existing infrastructure and cautions expansion of the maternal and pediatric services at both major hospital. The series of seven major health centres were to be built to support the referral system from VHSs, dispensaries and minor health centres. Government was expected to complement this with the construction of staff accommodation at all rural health facilities to facilitate deployment of experience and qualified staff. In addition two new ventures were to be initiated; the construction of maternal waiting homes to reduced maternal mortality and design and construction of a model health centre.

In budgetary terms of the civil works accounted for about 70% of the funds disbursed within the auspices of the NHDP. Despite delays at the beginning, almost all the works identified were successfully completed. It took two and half years of project extension to accomplish this.

ODA (UK): The British Government (ODA) financed the renewal of the essential services and rehabilitation of the RVH at a total cost of about $5.0 million. This is in addition to the construction of a major health centre at Essua. The ODA also financed the UK Project Office which provided the TA Architectural and Consulting Services for all NHDP civil works.

ITALIAN GOVERNMENT: Under a turn-key project the Italian Government constructed and equipped three-more health centres; a polyclinic in Banjul; the central laboratory and pediatric unit at the

RVH and a new maternity wing and ODP at Bansang Hospital. All the Italian construction projects were handed over to government by early 1990.

EUROPEAN UNION: The European Union (EU)) through the European Development Fund (EDF) agreed to finance the construction of one major health centre at Basse and six MCH/EPI outreach clinic sites around Upper River Division. Despite cost over-runs and construction delays, the project was completed and handed over to government in 1993.

DUTCH GOVERNMENT: The Dutch Government contribution to the civil works was largely due to the availability of counterpart funds accruing from the sale a heavy duty power generation fuel donated to the government. This funds were used for the strengthening of the State Enrolled Nursing School and Bansang Hospital. A total of just under DI 0 million was available under this fuel grant. Ten units of fully furnished senior staff houses were provided for use by the HMB and the SEN School. Additional class rooms, administrative block, library, wardens house, an all purpose centre and renewal of the essential services are now been provided for the SEN school.

IDA: The use of IDA funds in the civil works has been in three main areas. Essential equipment (midwifery and anesthetic/surgical) and furniture necessary for the operation of constructed facilities were provided. The essential services (reliable water supplies and backup/emergency power supply) were provided at existing health facilities not covered by the rehabilitation work. A model health centre was designed and built at Kuntair and a model maternity waiting home was completed at Essua.

To support the CRP the central medical stores was rehabilitated and adequate and proper storage facilities provided for drugs and other supplies.

GAMBIA GOVERNMENT: Within its yearly recurrent budgetary provision, 24 units of senior staff houses and 10 units of junior staff houses were constructed at different health facilities throughout the country. All the houses were fully completed. These houses have not only "owed the deployment of senior staff to these facilities but also enabled better of duty coverage for emergencies.

An overriding concern during the implementation of the civil works is the balance between cost and quality of the cost (specifications). The PMU had insisted on higher specifications to guaranty value for money. This has in many instances put the costs of facilities prohibitively high. The cost of a model maternity home (D. 5m) of a rural health centre (D2.5m) makes the replication of these beyond the means of government. The implementation of civil works is time consuming. The completion cycle for a major health centre (design to defects and liabilities) is a minimum of four years. Standardising designs and specifications could reduce this significantly.

9. STRENGTHENING PRIMARY HEALTH CARE SERVICES

The strengthening of existing PHC was one of the fundamental underpinnings of the NHDP. These had two major objectives. To extend existing viable Village Health Services to achieve geographic coverage of the country. Secondly to implement a number of additional strategies to increase the effectiveness of the existing PHC.

EXTENSION OF VILLAGE HEALTH SERVICES

At the beginning of the project resources were provided to establish 80 village health services in the Western Administrative Division. This is the last geographic area of the country to be covered. For the first time village based services were introduced in communities within commuting distance from Banjul and with fairly large urban population.. In these urban periurban areas no VI)Cs were created or village

health workers trained. Depending on the size of population TBA were selected form different wards, trained and redeployed back to their wards performing with better skills and equipment what they been doing previously.

The development of the PHC in the periurban area under the guise of extending VHS was on ad-hoc basis and the strategy was not well thought through. The demand for services with the fast growing urban/periurban areas of Greater Banjul goes far beyond providing home based delivery by trained TBAs. All indicators are that these TBAs conduct a significant number of safe deliveries and refer difficult cases they cannot handle. Urban housing is precarious, overcrowded and with poor sanitary conditions, 0 these conditions getting worst with increase population. Most urban mothers would deliver at home if they don't have access to a health facility. This is compounded by the fact that TBAs do not address the increase demand for MCH/EPI/FP services and general OPD. Urban trained TBA became 'isolated' units on their own without regular supervision, recognition or any links with the formal health services.

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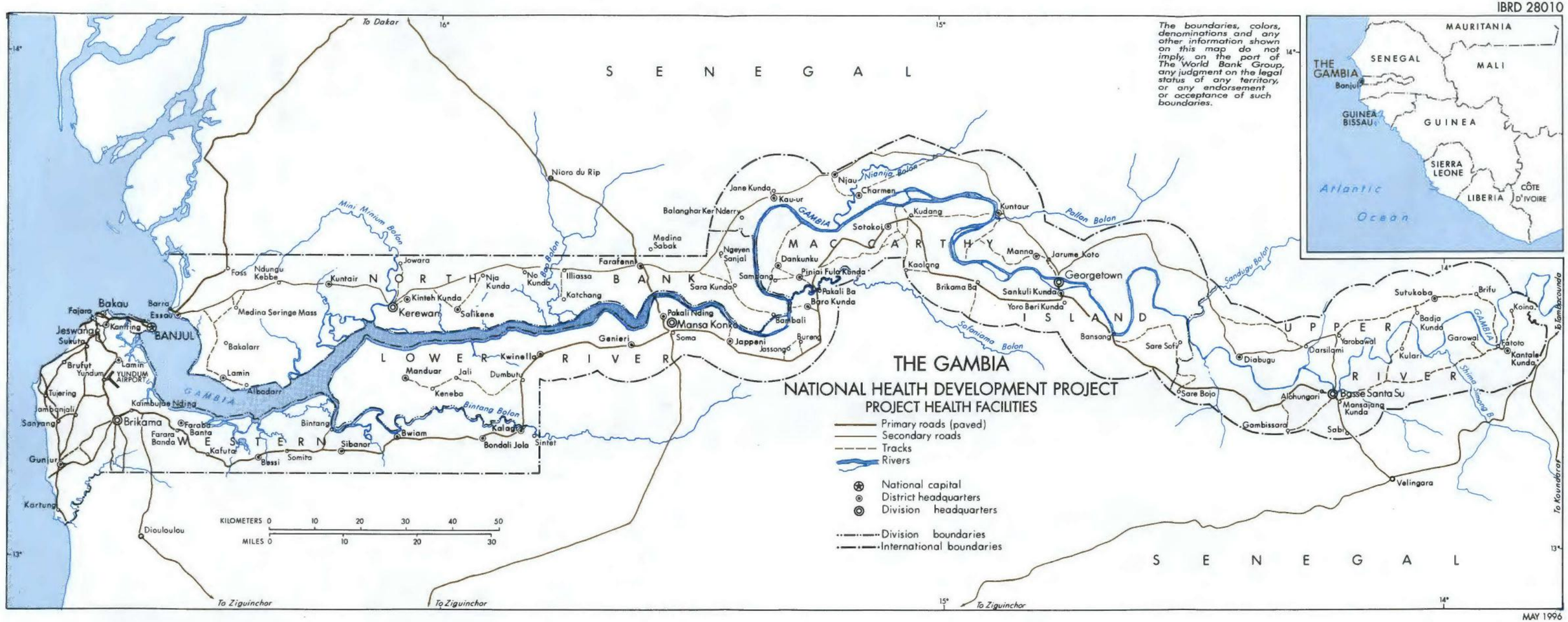

MAY 1996

This PIF was posted on July 8, 1997

OED ID :	C1760
Type :	EVM
Country :	Gambia
Project Description :	National Health Dev.
Sector :	HH /
Subsector :	HE /
Lending Instrument :	Specific Investment
L/C :	C1760

Operations Evaluation Department
PROJECT INFORMATION FORM

Table of Contents

A1. General Project Information

OED ID :	C1760
Type :	EVM
Country :	Gambia
Project Description :	National Health Dev.
Sector :	HH /
Subsector :	HE /
Lending Instrument :	Specific Investment
L/C :	C1760

3. Key Dates

	Original	Latest
Departure of Appraisal Mission		01/01/86
Approval		02/17/87
Signing/Agreement		06/05/87
Effectiveness	11/02/87	11/02/87
Physical completion	12/31/92	12/31/95
Closing	12/31/92	06/30/95
ICR receipt in OED		07/11/96
Review date		03/28/97
EVM/PAR approval		06/30/97

1. Reviewer: Laura Raney

2. Do you agree with the assigned primary Sector and Subsector? (●) Yes ( ) No

Sugg. Sector:
Sugg. Subsector:

4. Key Amounts ($US million)

Original Commitment	5.6
Total Cancellation	0
Total project cost	
Original	20.8
Latest	33.3

5. Cofinanciers

	First	Second	Third
Name	Netherlands		
Original Commitment ($US million)	1		
Total Cancellation ($US million)	0		

6. Distribution of latest cost among component types ($US million):

Physical	2,592
Technical assistance	1,372
Balance of payments	0
Line of credit	0
Other	0

7. Applicable disbursement profile (no. of years): 7

8. Number of supervision missions: 15

9. Name(s) of primary author(s) of ICR (indicate if not known): Edward Brown

11. Names of managers

	At entry	At exit
Task manager	N. Birdsall	E. Brown
Division chief	I. Hussain	O. Pannenborg
Department director	J. North	M. Ayub

A2. Project Objectives Evaluation

1. Were the project objectives revised during implementation? **Yes**

   If Yes, did the Board approve the revised objectives as part of a formal restructuring? **No**

   Date of Board approval

Note: If objectives were revised, base the ratings in subsequent sections on the revised objectives.

2. Taking into account the country's level of development and the competence of the implementing agency, to what extent did the project design have the following characteristics:

Demanding on Borrower / Implementing Agency	High
Complexity	High
Riskiness	Substantial

3. Did the project include a monitoring and evaluation system for the implementation phase? **Yes**

If Yes, rate the extent to which the system met each of the following five criteria for a good M&E system:

Clear project and component objectives verifiable by indicators	Negligible
A structured set of indicators	Negligible
Requirements for data collection and management	Negligible
Institutional arrangements for capacity building	Negligible
Feedback from M&E	Negligible

4. For this particular project, rate the importance of the project's objectives:

Physical	High	Institutional	High
Financial (interest rates; pricing / tariff policies; cost recovery	High	Social	Not Applicable
Economic		Environmental	Not Applicable
Macro-economic policies (fiscal; monetary; trade)	Not Applicable	Private sector development	Not Applicable
Sector policies	Not Applicable	Other (specify):	
		Human Development	Substantial

B1a. Outcomes — Relevance

1. Indicate the extent to which each of the project's objectives was relevant in terms of the Bank's / Borrower's current country or sectoral objectives:

Physical	Substantial
Financial (interest rates; pricing / tariff policies; cost recovery	High
Economic	
Macro-economic policies (fiscal; monetary; trade)	Not Applicable
Sector policies	Not Applicable
Institutional	High
Social	Not Applicable
Environmental	Not Applicable
Private sector development	Not Applicable
Other (specify):	
Human Development	Substantial

2. Summary Rating of Relevance

Rate the extent to which, as a whole, the project's goals were consistent with the Bank's strategies, taking account of the relevance and importance of each of the project's objectives: High

Average rating: Substantial

If your overall rating differs from the average rating, please comment on reasons for this difference:

Institutional development and cost recovery are weighted more than physical and training.

B1b. Outcomes — Efficacy

1. Indicate the extent to which each of the following objectives was in fact accomplished:

Physical	Substantial
Financial (interest rates; pricing / tariff policies; cost recovery	Modest
Economic	
Macro-economic policies (fiscal; monetary; trade)	Not Applicable
Sector policies	Not Applicable
Institutional	Modest
Social	Not Applicable
Environmental	Not Applicable
Private sector development	Not Applicable
Other (specify):	
Human Development	Substantial

2. Summary Rating of Efficacy

Rate the efficacy of the project, taking account of the importance of the objectives and the extent to which they were accomplished: Modest

Average rating: Substantial

If your overall rating differs from the average rating, please comment on reasons for this difference:

Institutional development and cost recovery are weighted more than physical and training.

B1b. Outcomes — Efficacy (cont'd)

3. Rate the extent to which each of the following factors affected the achievement of this project's objectives:

World markets / prices	Not Applicable	Performance of contractors / consultants	No Effect
Natural events	Not Applicable	War / civil disturbance	Not Applicable
Cofinancier(s) performance	No Effect	Other (specify):	

B1c. Outcomes — Efficiency

1. Is an **Economic Rate of Return** (ERR) available for this project? ○ Yes ◉ No

If No, is a **Financial Rate of Return** (FRR) available? ○ Yes ◉ No

If a rate of return is available, provide the following information (in percent):

		Point Value	Range	Weighted Average	Coverage / Scope
At Appraisal	◉ Not Available ○ Not Applicable		From : To :		
At Completion	◉ Not Available ○ Not Applicable		From : To :		

2. Was another measure of efficiency provided? ○ Yes ◉ No

If Yes, then answer the following:

Measure used

Coverage / scope of measure

Comparison to appraisal estimate

3. If no measure of efficiency was provided for this project, would it have been reasonable to expect one? ○ Yes ◉ No

If Yes, explain:

4. Rate the quality of the economic analysis according to the following criteria:

Soundness of analysis

Conduct of sensitivity / risk analysis

Consideration of institutional constraints to achieving results

Extent to which benefits accrue to target population

Consideration of environmental externalities

Consideration of fiscal impact

Consideration of alternatives to meeting objectives

Overall rating of quality of analysis

Average rating

If your overall rating differs from the average rating, please comment on reasons for this difference:

B1c. Outcomes — Efficiency (cont'd)

5. Summary Rating of Efficiency

Rate overall to what extent the project accomplished its goals efficiently:	Not Applicable	If your overall rating differs from the average rating, please comment on reasons for this difference:
Average rating		

B1d. Outcomes — Summary

1. SUMMARY OUTCOME RATING

Rate the project's outcome (i.e., the extent to which it achieved relevant objectives), taking account of its relevance, efficacy, and efficiency:	Marginally Unsatisfactory
Average rating	Satisfactory
If your overall rating differs from the average rating, please comment on reasons for this difference:	Half of investment components were not achieved: health education, nutrition and family planning component; monitoring and evaluation; expansion of PHC to peri-urban areas; and training of Village Development Committee members in financial mgmt.

B2. Sustainability

1. Rate the extent to which each of the following conditions is expected to influence this project's sustainability :

Technical viability	Negative	Policy environment	No Effect
Financial viability	Negative	Institution / management effectiveness	Positive
Economic viability	Not Applicable		
Social conditions	Not Applicable	Local participation	Not Applicable
Environmental concerns	Not Applicable	Other (specify):	
Government commitment	Negative		

2. SUMMARY SUSTAINABILITY RATING

Rate the probability of maintaining the project's relevant development achievements generated or expected to be generated:	Uncertain
Average rating	Unlikely
If your overall rating differs from the average rating, please comment on reasons for this difference:	Institutional changes are sustainable, but physical changes are questionable in their sustainability. It is known that at least two sub-components are unlikely to be sustained: emergency ferries for transport to referal clinics, communications syst

B3. Institutional Development

1. Was this project directed primarily toward Institutional Development? ◉ Yes ○ No

2. If not, did the project contain components with significant Institutional Development objectives? ○ Yes ○ No

3. Did the project's Institutional Development activities include each of the following:

Establishment of a new organization	No
Elimination of an existing organization	No
Restructuring / privatizing of an organization	Yes

4. For this particular project, rate the relevance of the following Institutional Development objectives:

National capacity	
Economic management	High
Civil service reform	Not Applicable
Financial intermediation	Not Applicable
Legal / regulatory system	Not Applicable
Sectoral capacity	High
Other (specify):	
Agency capacity	
Planning / policy analysis	High
Management	Substantial
Skills upgrading	Substantial
MIS	Substantial
Other (specify):	
NGO Capacity	Not Applicable

5. For this particular project, rate its efficacy in achieving the following Institutional Development objectives:

National capacity	
Economic management	Modest
Civil service reform	Not Applicable
Financial intermediation	Not Applicable
Legal / regulatory system	Not Applicable
Sectoral capacity	Modest
Other (specify):	
Agency capacity	
Planning / policy analysis	Modest
Management	Modest
Skills upgrading	Substantial
MIS	Negligible
Other (specify):	
NGO Capacity	Not Applicable
Overall ID Efficacy	Modest

6. SUMMARY INSTITUTIONAL DEVELOPMENT IMPACT RATING

Rate the extent to which, as a whole, the project resulted in improvement of the country's/sector's ability to effectively use its human, organizational, and financial resources: Modest

Average rating: Modest

If your overall rating differs from the average rating, please comment on reasons for this difference:

C1. Bank Performance

1. To what extent did each of the following apply during project identification / preparation:

Involvement of government	Substantial
Involvement of beneficiaries	Negligible
Project consistency with Bank strategy for country	Substantial
Grounding in economic and sector work (ESW)	Not Available
Other (specify):	

Overall rating on identification / preparation: Unsatisfactory

Average rating: Unsatisfactory

If your overall rating differs from the average rating, please comment on reasons for this difference:

2. Indicate the extent to which the Bank took account of the following during project appraisal:

Technical analysis (inc. alternatives)	Negligible
Financial analysis (inc. funding provisions, fiscal impact)	Modest
ERR/FRR cost-benefit analysis	Not Applicable
Institutional capacity analysis	Modest
Social and stakeholder analysis	Negligible
Environmental analysis	Not Applicable
Risk assessment (inc. adequacy of conditionalities)	Modest
Incorporation of M&E indicators	Negligible
Incorporation of lessons learned	Not Applicable
Readiness for implementation	Modest
Suitability of lending instrument	Modest

Overall rating on appraisal: Unsatisfactory

Average rating: Unsatisfactory

If your overall rating differs from the average rating, please comment on reasons for this difference:

3. Considering the identification / preparation and appraisal processes discussed above, rate the overall quality of the project at the time of Board approval (Quality at Entry): Unsatisfactory

4. Indicate the extent of Bank project supervision in the following areas:

Reporting on project implementation progress	Modest
Identification / assessment of implementation problems	Modest
Use of performance indicators	Negligible
Enforcement of Borrower provision of M&E data	Negligible
Advice to implementing agency	Modest
Enforcement of loan covenants / exercise of remedies	Modest
Flexibility in suggesting / approving modifications	Modest
Other (specify):	

Overall rating on supervision: Unsatisfactory

Average rating: Unsatisfactory

If your overall rating differs from the average rating, please comment on reasons for this difference:

C1. Bank Performance (cont'd)

5. SUMMARY RATING OF BANK PERFORMANCE

Rate the Bank's overall performance, taking account of identification / preparation, appraisal, and supervision activities:	Unsatisfactory
Average rating	Unsatisfactory
If your overall rating differs from the average rating, please comment on reasons for this difference:	

C2. Borrower Performance

1. Rate the Borrower / Implementing Agency performance on the preparation of this project: Satisfactory

2. Rate the extent to which government / implementing agency performance on the following dimensions supported project implementation:

Factors generally subject to government control

Macro policies / conditions	Not Applicable	Administrative procedures	Negligible
Sector policies / conditions	Not Applicable	Cost changes	Modest
Government commitment	Substantial	Implementation delays	Negligible
Appointment of key staff	Negligible	Other (specify):	
Counterpart funding	Modest		

Factors generally subject to implementing agency control

Management	Modest	Use of technical assistance	Modest
Staffing	Negligible	Beneficiary participation	Not Applicable
Cost changes	Modest	Other (specify):	
Implementation delays	Negligible		

C2. Borrower Performance (cont'd)

3. Summary Rating of Borrower Performance on Project Implementation

Overall rating: Unsatisfactory

Average rating: Unsatisfactory

If your overall rating differs from the average rating, please comment on reasons for this difference:

4. Rate Borrower compliance with loan covenants / commitments:

Satisfactory

5. SUMMARY RATING OF BORROWER PERFORMANCE

Overall rating: Unsatisfactory

Average rating: Satisfactory

If your overall rating differs from the average rating, please comment on reasons for this difference:

Implementation is weighted more than preparation.

D. Special Themes

1. Indicate whether each of the following social concerns was a major project emphasis:

Gender related issues	No
Settlement / resettlement	Not Applicable
Beneficiary participation	No
Community development	Yes
Skills development	Yes
Nutrition and food security	No
Health improvement	Yes
Other (specify):	

2. Did the project have an unintended or unexpected effect on social concerns, regardless of the project's objectives?

No

If Yes, was the effect positive or negative?

3. Did the project place a major emphasis on poverty alleviation? ○ Yes ◉ No

If Yes:

Was this a Poverty Targeted Intervention?	○ Yes ◉ No
Did it emphasize broad-based growth with labor absorption?	○ Yes ○ No
Did it emphasize human development (education, health, or nutrition)?	○ Yes ○ No
Did it emphasize the provision of a social safety net?	○ Yes ○ No

4. Indicate whether each of the following environmental concerns was a major project emphasis:

Natural resource management	Not Applicable
Air / water / soil quality	Not Applicable
Urban environmental quality	Not Applicable
Other (specify):	

D. Special Themes (cont'd)

5. Did the project have an unintended or unexpected effect on environmental concerns, regardless of the project's objectives?

No

If Yes, was the effect positive or negative?

7. Rate the priority of the project for audit

High

8. Rate the priority of the project for impact evaluation

Medium

6. Indicate whether each of the following private sector development (PSD) concerns was a major project emphasis:

Improvement in legal or incentive framework designed to foster PSD (e.g., trade, pricing)	Not Applicable
Restructuring / privatization of public enterprises	Not Applicable
Financial sector development	Not Applicable
Direct government financial and / or technical assistance to the private sector	Not Applicable
Other (specify):	

E. Rating of ICR

1. Rate the quality of the ICR by the following characteristics:

Analysis	
Coverage of important subjects	Unsatisfactory
Recalcualtion of ERR or FRR	Not Applicable
Soundness of analysis	
Internal consistencies	Unsatisfactory
Evidence complete / convincing	Unsatisfactory
Adequacy of lessons learned	Satisfactory
Aide-memoire of the ICR mission	Unsatisfactory

Future orientation	
Plan for future project operation	Not Available
Performance indicators for the project's operations phase	Not Available
Plan for monitoring and evaluation of future operations	Not Available
Borrower / cofinancier inputs	
Borrower input to ICR	Satisfactory
Borrower plan for future project operation	Not Available
Borrower comments on ICR	Satisfactory
Cofinancier comments on ICR	Not Available

2. SUMMARY RATING OF ICR

Rate the quality of the ICR:	Unsatisfactory
Average rating	Unsatisfactory

If your overall rating differs from the average rating, please comment on reasons for this difference:

E. Rating of ICR (cont'd)

3. Rate the quality of borrower participation in the project completion process on the following:

Analysis	Satisfactory	Focus on lessons learned	Satisfactory
Concern with development impact	Unsatisfactory	Self-evaluation	Satisfactory
Internal consistency	Satisfactory	Evaluation of Bank	Satisfactory
Evidence to justify views	Satisfactory		

F. Summary of Ratings

1. SUMMARY OF RATINGS

	ICR	EVM
Outcome	Satisfactory	Marginally Unsatisfactory
Sustainability	Likely	Uncertain
Institutional Development efficacy / impact	Substantial	Modest
Bank performance	Satisfactory	Unsatisfactory
Borrower performance	Satisfactory	Unsatisfactory
ICR quality		Unsatisfactory

2. Explain any differences between OED ratings and those in the ICR:

Project outcome is rated marginally unsatisfactory as not all project components were achieved. Sustainability is rated as uncertain due to the lack of evidence of maintenance of the investmesnts and the stated dependence on the follow-up Bank-assisted project whose preparation has been delayed since the 1994 coup d'etat. Institutional Development is rated as modes given that the reorganization of the MOH was delayed, contentious, and is still the subject of concern as several key roles remain undefined. Bank performance is rated as unsatisfactory because of poor project supervision, as evidenced by the disconnect between the reporting of problems encountered during implementation and the status ratings. Borrower performance is rated as unsatisfactory due to the inconsistent levels of commitment and the persistent financial and administrative difficultues experienced during the project.

G. Overall Judgements / Miscellaneous Comments

1. Enter any overall judgements or rationales and miscellaneous comments below.

Comments on Section A1:
question 5. amount not cancelled (as written) rather amounts were in excess of planned.
question 6. the actuals are given in SDR rather than in US$ in the ICR for the stated reason that the credit was denominated in SDR, and due to constant exchange rate fluctuations between the SDR and the US$, a comparison between the appraisal estimates and the actual in US$ would not be possible.

Comments on the ICR:
There appears to be a major disconnect between the reporting of problems encountered during implementation (many) and the status ratings (good).

The M&E subcomponent was not reported on, nor were the findings of the m-t and final evaluations mentioned in the ICR.

The expansion of PHC to the underserved Western region, the main component, is under-reported.

The enhanced health education, nutrition, and family planning programs sub-component was not reported on.

Despite the multi-donor effort, there is no discussion of donor coordination, nor is there evidence that donors were involved in evaluation (ICR mission or comments on ICR).

There is no plan for future operation of the project.

THE WORLD BANK GROUP

ROUTING SLIP	DATE: July 2, 1997

NAME	ROOM. NO.
Mr. Robert Picciotto, DGO	G7-121
THRU: Mr. Ulrich Thumm, Adviser, OED	G7-005

	URGENT		PER YOUR REQUEST
	FOR COMMENT		PER OUR CONVERSATION
	FOR ACTION		NOTE AND FILE
✓	FOR APPROVAL/CLEARANCE		FOR INFORMATION
✓	FOR SIGNATURE		PREPARE REPLY
	NOTE AND CIRCULATE		NOTE AND RETURN

RE: THE GAMBIA—National Health Development Project (Cr. 1760-GM)
Implementation Completion Report

REMARKS:

The Region disagreed with some of OED's ratings but, after discussion with OED, agreed that OED's ratings should stand. Please sign the attached EM.

This ICR was reviewed by Laura Raney.

FROM	ROOM NO.	EXTENSION
Christopher Gibbs	G7-029	3-1735

The World Bank
Washington, D.C. 20433
U.S.A.

Office of the Director-General
Operations Evaluation

June 30, 1997

OED EVALUATIVE MEMORANDUM ON IMPLEMENTATION COMPLETION REPORT

The Gambia: National Health Development Project (Credit 1760-GM)

The Gambia National Health Development project, supported by Credit 1760-GM for SDR 4.7 million (US$5.6 million), was approved in FY87. It was the first Bank operation in the health sector in The Gambia. Following three one-year extensions, the credit was closed in June 1995. The dollar value of the credit amount disbursed (US$6.1 million) was higher than anticipated at appraisal due to changes in the US$/SDR exchange rate. The project was co-financed by the Government of the Netherlands (US$1.0 million), and six donors provided parallel financing. The Implementation Completion Report (ICR) was prepared by the Africa Regional Office. Annex B contains the borrower's contribution to the ICR. All the partners were provided with copies of the draft ICR, but no comments were received.

The objectives of the project were to (i) strengthen and expand The Gambia's national health program, including essential family planning and nutrition activities; (ii) decentralize health sector management; (iii) improve planning; and (iv) enhance cost recovery. The objectives were to be achieved through two parts: Part A was a program of reforms to strengthen health sector management, financing and support systems through decentralization, reorganization, mobilization of financial resources, and strengthening of logistical support; and Part B was a program of investments to strengthen national health care through (i) extension of primary health care to the Western Region and the Banjul peri-urban area and expansion of the communicable disease program nationwide; (ii) improvement of health facilities; (iii) improvement of nursing skills; (iv) enhancement of health education, nutrition and family planning programs; and (v) monitoring and evaluation.

Despite some delays in implementation, the program of reforms was achieved, with the exception of strengthened support services which was only partially achieved. Restructuring of health management and administration took place at the central level, and the two government hospitals (Royal Victoria and Bansang) were granted semi-autonomous status through the establishment of hospital management boards. Institutional capacities of the health sector were strengthened through decentralized management at the district level, and a cost recovery system was established with improvements in the fee collection system, availability of drugs and medical supplies. Half of the program of investments was achieved. The civil works component experienced severe delays and considerable cost overruns. Primary health care was extended to the Western Region, and health facilities were improved through the rehabilitation of essential services (water and electricity). Secondary level health delivery facilities were

established through the upgrading/construction, equipping and staffing of eight major health centers to relieve the burden on the two tertiary level hospitals and bring basic health services closer to the population. Project investments to upgrade the technical skills of service providers including traditional community-based health providers were also achieved. Other subcomponents, however, were not achieved, namely, the expansion of primary health care to the peri-urban areas of Banjul; the training of selected Village Development Committee members in financial management; improvement of health, education, nutrition, and family planning services; and monitoring and evaluation. The ICR did not evaluate the family health and nutrition component or the monitoring and evaluation component.

The Operations Evaluation Department (OED) disagrees with the ICR ratings. The ICR rates project outcome as satisfactory, sustainability as likely, institutional development as substantial, and Bank performance as satisfactory. OED rates project outcome as marginally unsatisfactory because there were significant shortcomings in the achievement of project objectives. Sustainability is rated as uncertain because of lack of evidence of maintenance of project components and acknowledged dependence on a follow-on project where preparation has been delayed since 1994. Institutional development is rated as modest because the reorganization of the Ministry of Health was delayed, contentious, and is still the subject of concern as several key roles remain undefined. Bank performance is rated as unsatisfactory because project supervision did not recognize the degree to which implementation difficulties were hampering the achievement of project objectives.

The lessons identified by the ICR suggest (i) the need for simpler project design and development; (ii) the need for early agreement and ownership of key policy objectives to improve quality at entry; (iii) the need to improve project management through training and establishment of effective accounting and financial management systems prior to project effectiveness; (iv) the importance of physical integration of project coordination unit into the parent ministry; and (v) the need to define monitoring and evaluation indicators by project appraisal to enable the borrower and the Bank to objectively assess project achievements and their impact.

The ICR is unsatisfactory as the documentation of implementation and the project's achievements are neither detailed nor convincing. The ICR does not discuss donor coordination, despite the project's multi-donor effort, nor does it contain a plan for future operation of the project. An audit is planned.

THE WORLD BANK/IFC/M.I.G.A.

OFFICE MEMORANDUM

DATE: June 4, 1997

TO: Mr. Mahmood A. Ayub, Director, AFC14

FROM: Roger Slade, Division Chief, OEDD1

EXTENSION: 8-1293

SUBJECT: **THE GAMBIA—National Health Development Project (Cr. 1760-GM)**
Implementation Completion Report

1. Thank you for your response to our request for comments on the draft Evaluation Memorandum (EVM) and ratings of the project. This responds to the issues raised in your note and that of Mr. Seifman. Our conclusion is that although the issues and information presented in Mr. Seifman's note are pertinent to the evaluation of the project, they do not provide a sufficiently strong basis for the Operations Evaluation Department (OED) to change OED's ratings for the project, except in the case of the rating of Borrower performance.

Outcome Rating

2. Your department suggests that the project be rated as *satisfactory*, while OED concludes that the project's overall outcome is *marginally unsatisfactory*. Mr. Seifman notes that the Gambian Government formulated a National Health Policy and increased the health sector's share of the budget from 7.3 percent to 11.1 percent[1] during the period of project implementation. These are both important accomplishments on the policy front, although the degree to which these changes can be attributed to the project is not clear in either the ICR or Mr. Seifman's comments. A discussion of trends in sectoral budget allocations and how they were influenced by the project would have been an important addition to the ICR, but the current version does not include this information, and, therefore, was not considered in our assessment of project outcome. Moreover, it is not clear how these accomplishments relate to the stated project objectives, nor do they, in our assessment, outweigh the observation that only about half of the planned investments to strengthen health services were completed. And, as noted in the draft EVM, the fact that the plans for the operation of the project did not include performance indicators and that no indicators of change in service coverage are provided in the ICR makes it difficult to assess the claim that coverage of basic health services significantly increased. Overall, we believe that the balance of accomplishments is less than would merit a satisfactory rating.

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1. It is not clear from Mr. Seifman's note if this refers to real or nominal change.

Bank Performance

3. Mr. Seifman suggests that OED has placed inappropriate weight on the quality of supervision in rating the Bank's performance. He suggests that the gap between the problems noted in supervision reports and routine rating of project implementation status as satisfactory may reflect decisions taken by Task Managers during the supervision process and should not be second-guessed by OED. Our perspective is that supervision efforts should minimize the disconnect between observations about project performance on the ground and as reported to Bank management. The apparent problems that occurred during the course of implementation (as reflected in an extension of three years, which is significantly above the average for HNP) might have responded to more timely and responsive supervision, although this observation is based on hindsight. Moreover, we find the reporting on project completion, in particular the absence of data to back claims that the project contributed to the expansion of health services (e.g., how many more people gained access to services through the upgrading and construction of eight health centers, what data are available to indicate whether these facilities are in fact being used, etc.) and to attribute changes in policy to the project, are less than satisfactory, as reflected in our comments on the quality of the ICR. There is no disagreement between the ICR and OED's assessment that project preparation and appraisal were "less than satisfactory" (ICR, para. 3.19). These observations lead us to the assessment of Bank performance as unsatisfactory.

Borrower Performance

4. We have reconsidered our assessment of the Borrower's performance in light of Mr. Seifman's comments. The policy changes noted in para. 1 are indeed positive accomplishments, although they do not bear directly on the implementation of the project. The Borrower's completion report is clear and thorough, presenting a frank discussion of the strengths and weaknesses of the project. In view of the apparent improvement in project management in the last five years of the project and the quality of the completion reporting, we agree that Borrower performance should be rated as satisfactory rather than unsatisfactory.

Quality of ICR

5. Mr. Seifman's comments on OED's rating of the quality of the ICR (OED rates the ICR quality as unsatisfactory) include some interesting thoughts about how best to measure outcomes in the health sector and notes that expectations of what can be measured must be realistic. OED would agree with this point and would in fact not have objections to a report that based its assessment of performance on changes in "process indicators such as access to and use of facilities and services," rather than the more difficult outcome measures. This distinction, however, is not relevant in this case since neither type of indicator is reported. The report's documentation of implementation and the project's achievements are insufficient. For example, the ICR provides no discussion of the factors that constrained accomplishment of the project's family planning and

nutrition service delivery goals. Guidelines on ICR preparation seek discussion of the future operations of the project itself, rather than on future trends in the sector, as reported in this ICR. Lastly, it is evident that the length restrictions on the ICR encourage those preparing completion reports to reach judgments about what is and is not included in the short space available. OED's assessment is that, in this case, these decisions placed inadequate weight on the need for data to back up claims for project accomplishments and to cover the entirety of the project in the report.

6. I hope this clarifies the analytic base for our assessment of this project's performance and the quality of the ICR.

cc: Thumm (OEDDR); Gibbs, Raney (OEDD1), Pannenborg, Pradel, Seifman, Theunynck (AFTH2); Mba-Kalu (AFT14); Jonas (HDDHE)

THE WORLD BANK GROUP

ROUTING SLIP	DATE: May 30, 1997

NAME	ROOM. NO.
Mr. Roger Slade, Chief, OEDD1	G7-035

	URGENT		PER YOUR REQUEST
	FOR COMMENT		PER OUR CONVERSATION
	FOR ACTION		NOTE AND FILE
✓	FOR APPROVAL/CLEARANCE		FOR INFORMATION
✓	FOR SIGNATURE		PREPARE REPLY
	NOTE AND CIRCULATE		NOTE AND RETURN

RE: THE GAMBIA—National Health Development Project (Cr. 1760-GM)
Implementation Completion Report

REMARKS:

Attached for your clearance and signature is OED's response to the Region regarding objections to the ratings given the above referenced ICR.

The ICR was prepared by Laura Raney.

good reply. Thanks.

FROM	ROOM NO.	EXTENSION
Susan A. Stout Susan	G7-051	8-2537

~~Sent~~

The Region disagreed with some of OED's ratings, but, ~~following~~ after discussion with OED, agreed that OED's ratings should stand. PI

THE WORLD BANK/IFC/M.I.G.A.

OFFICE MEMORANDUM

DATE: May 30, 1997

TO: Mr. Mahmood A. Ayub, Director, AFC14

FROM: Roger Slade, Division Chief, OEDD1

EXTENSION: 8-1293

SUBJECT: **THE GAMBIA—National Health Development Project (Cr. 1760-GM) Implementation Completion Report**

1. Thank you for your response to our request for comments on the draft Evaluation Memorandum (EVM) and ratings of the project. This responds to the issues raised in your note and that of Mr. Seifman. Our conclusion is that although the issues and information presented in Mr. Seifman's note are pertinent to the evaluation of the project, they do not provide a sufficiently strong basis for the Operations Evaluation Department (OED) to ~~agree to the proposed~~ change ~~in~~ OED's ratings for the project, except in the case of the rating of Borrower performance.

Outcome Rating

2. Your department suggests that the project should be rated as *satisfactory*, while OED concludes that the project's overall outcome is *marginally unsatisfactory*. Mr. Seifman notes that the Gambian Government formulated a National Health Policy and increased the health sector's share of the budget from 7.3 percent to 11.1 percent[1] during the period of project implementation. These are both important accomplishments on the policy front, although the degree to which these changes can be attributed to the project is not clear in either the ICR or Mr. Seifman's comments. A discussion of trends in sectoral budget allocations and how they were influenced by the project would have been an important addition to the ICR, but the current version does not include this information, and, therefore, was not considered in our assessment of project outcome. Moreover, it is not clear how these accomplishments relate to the stated project objectives, nor do they, in our assessment, outweigh the observation that only about half of the planned investments to strengthen health services were completed. And, as noted in the draft EVM, the fact that the plans for the operation of the project did not include performance indicators and that no indicators of change in service coverage are provided in the ICR makes it difficult to assess the claim that coverage of basic health services significantly increased. Overall, we believe that the balance of accomplishments is less than would merit a satisfactory rating.

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1. It is not clear from Mr. Seifman's note if these are real or nominal changes.

Bank Performance

3. Mr. Seifman suggests that OED has placed inappropriate weight on the quality of supervision in rating the Bank's performance. He suggests that the gap between the problems noted in supervision reports and routine rating of project implementation status as satisfactory may reflect decisions taken by Task Managers during the supervision process and should not be second-guessed by OED. Our perspective is that supervision efforts should minimize the disconnect between observations about project performance on the ground and as reported to Bank management. The apparent problems that occurred during the course of implementation (as reflected in an extension of three years, which is significantly above the average for HNP) might have responded to more timely and responsive supervision, although this observation is based on hindsight. Moreover, we find the reporting on project completion, in particular the absence of data to back claims that the project contributed to the expansion of health services (e.g., how many more people gained access to services through the upgrading and construction of eight health centers, what data are available to indicate whether these facilities are in fact being used, etc.) and to attribute changes in policy to the project, are less than satisfactory, as reflected in our comments on the quality of the ICR. There is no disagreement between the ICR and OED's assessment that project preparation and appraisal were "less than satisfactory" (ICR, para. 3.19). These observations lead us to the assessment of Bank performance as unsatisfactory.

Borrower Performance

4. We have reconsidered our assessment of the Borrower's performance in light of Mr. Seifman's comments. The policy changes noted in para. 1 are indeed positive accomplishments, although they do not bear directly on the implementation of the project. The Borrower's completion report is clear and thorough, presenting a frank discussion of the strengths and weaknesses of the project. In view of the apparent improvement in project management in the last five years of the project and the quality of the completion reporting, we agree that Borrower performance should be rated as satisfactory rather than unsatisfactory.

Quality of ICR

5. Mr. Seifman's comments on OED's rating of the quality of the ICR (OED rates the ICR quality as unsatisfactory) include some interesting thoughts about how best to measure outcomes in the health sector and notes that expectations of what can be measured must be realistic. OED would agree with this point and would in fact not have objections to a report that based its assessment of performance on changes in "process indicators such as access to and use of facilities and services," rather than the more difficult outcome measures. This distinction, however, is not relevant in this case since neither type of indicator is reported. The report's documentation of implementation and the project's achievements are insufficient. For example, the ICR provides no discussion of the factors that constrained accomplishment of the project's family planning and

nutrition service delivery goals. Guidelines on ICR preparation seek discussion of the future operations of the project itself, rather than on future trends in the sector, as reported in this ICR. Lastly, it is evident that the length restrictions on the ICR encourage those preparing completion reports to reach judgments about what is and is not included in the short space available. OED's assessment is that, in this case, these decisions placed inadequate weight on the need for data to back up claims for project accomplishments and to cover the entirety of the project in the report.

6. I hope this clarifies the analytic base for our assessment of this project's performance and the quality of the ICR.

cc: Thumm (OEDDR); Gibbs, Raney (OEDD1), Pannenborg, Pradel, Seifman, Theunynck (AFTH2); Mba-Kalu (AFT14); Jonas (HDDHE)

THE WORLD BANK/IFC/M.I.G.A.

OFFICE MEMORANDUM

Bell — Please make changes (RANEY/ICRS/REPLY#2) and give to Laura. Roger let me know what you for clearance think. I'm a little uncomfortable about SPN Susan and Bank performance — Susan

DATE: May 29, 1997

TO: Mr. Mahmood A. Ayub, Director, AFC14

FROM: Roger Slade, Division Chief, OEDD1

EXTENSION: 8-1293

SUBJECT: **THE GAMBIA—National Health Development Project (Cr. 1760-GM)**
Implementation Completion Report

1. Thank you for your response to our request for comments on the draft Evaluation Memorandum (EVM) and ratings of the project. This responds to the issues raised in your note and that of Mr. Seifman. Our conclusion is that though the issues and information presented in Mr. Seifman's note are pertinent to the evaluation of the project, they do not provide a sufficiently strong basis for OED to agree to the proposed change in OED's ratings for the project, except in the case of the rating of Borrower performance.

Outcome Rating

2. Your department suggests that the project should be rated as *satisfactory*, while OED concludes that the project's overall outcome is *marginally unsatisfactory*. Mr. Seifman notes that the Gambian Government formulated a National Health Policy and increased the health sector's share of the budget from 7.3% to 11.1% [1] during the period of project implementation. These are both important accomplishments on the policy front, although the degree to which these changes can be attributed to the project is not clear in either the ICR or Mr. Seifman's comments. A discussion of trends in sectoral budget allocations and how they were influenced by the project would have been an important addition to the ICR, but the current version does not include this information, and therefore was not considered in our assessment of project outcome. Moreover, it is not clear how these accomplishments relate to the stated project objectives, nor do they, in our assessment, outweigh the observation that only about half of the planned investments to strengthen health services were completed. And, as noted in the draft EVM, the fact that the plans for the operation of the project did not include performance indicators and that no indicators of change in service coverage of are provided makes it difficult to assess the ~~ICR's~~ claim that coverage of basic health services significantly increased ~~due to the project~~. Overall, we believe that the balance of accomplishments is less than would merit a satisfactory rating.

it's

in the ICR

[1] It is not clear from Mr. Seifman's note if these are real or nominal changes.

Bank Performance

3. Mr. Seifman suggests that OED has placed inappropriate weight on the quality of supervision in rating the Bank's performance. He suggests that the gap between the problems noted in supervision reports and routine rating of project implementation status as satisfactory may reflect decisions taken by Task Managers during the supervision process and should not be second-guessed by OED. Our perspective is that supervision efforts should minimize the disconnect between observations about project performance on the ground and as reported to Bank management. The apparent problems that occurred during the course of implementation (as reflected in an extension of three years, significantly above the average for HNP) might have responded to more timely and responsive supervision -- although this observation is based on hindsight. Moreover, we find the reporting on project completion, in particular the absence of data to back claims that the project contributed to the expansion of health services (e.g. how many more people gained access to services through the upgrading and construction of 8 health centers, what data are available to indicate whether these facilities are in fact being used, etc.) and to attribute changes in policy to the project are less than satisfactory, as reflected in our comments on the quality of the ICR. There is no disagreement between the ICR and OED's assessment that project preparation and appraisal were "less than satisfactory" (ICR, para 3.19). These observations lead us to the assessment of Bank performance as unsatisfactory.

Borrower Performance

4. We have reconsidered our assessment of the Borrower's performance in light of Mr. Seifman's comments. The policy changes noted in para. 1 are indeed positive accomplishments, although they do not bear directly on the implementation of the project. The Borrower's completion report is clear and thorough, presenting a frank discussion of the strengths and weaknesses of the project. In view of the apparent improvement in project management in the last five years of the project, and the quality of the completion reporting, we agree that Borrower performance should be rated as satisfactory rather than unsatisfactory ~~as originally proposed~~. suggested

Quality of ICR

5. Mr. Seifman's comments on OED's rating of the quality of the ICR (OED rates the ICR quality as unsatisfactory) include some interesting thoughts about how best to measure outcomes in the health sector, and notes that expectations of what can be measured must be realistic. OED would agree with this point, and would in fact not have objections to a report that based its assessment of performance on changes in "process indicators such as access to and use of facilities and services", rather than the more difficult outcome measures. This distinction, however, is not relevant in this case, since neither type of indicator is reported. The report's documentation of implementation and the project's achievements are insufficient. For instance, the ICR provides no discussion of the factors that constrained accomplishment of the project's family planning and

nutrition service delivery goals. Guidelines on ICR preparation seek discussion of the future operations of the project itself, rather than on future trends in the sector, as reported in this ICR. Last, it is evident that the length restrictions on the ICR encourage those preparing completion reports to reach judgments about what is and is not included in the short space available. OED's assessment is that, in this case, these decisions placed inadequate weight on the need for data to back up claims for project accomplishments, and to cover the entirety of the project in the report.

6. I hope this clarifies the analytic base for our assessment of this project's performance and the quality of the ICR.

cc: Thumm (OEDDR), Gibbs (OEDD1), Richard Seifman ( ), Ok Pannenborg ( ), Angelika Pradel ( ), Edna Jonas ( ), Serge Theunynck ( ), Roseleen Mba-Kalu ( ),

The Gambia -OED recap: significant shortcomings in the achievement of project objectives thus outcome rated as marginally satisfactory (vs. satisfactory).
1. Program of reforms was achieved: hospitals semi-autonomous, restructuring of health management and admin at central level. establishment of cr, decentralized mgmt at district level.
2. Half of program of investments not completed
Severe delays and considerable cost overruns in civil works component
Upgrading/construction of secondary health facilities, upgrade technical skills of providers
Not achieved: expansion of PHC to peri-urban area, training of VDC members in financial mgmt, improvement of health, ed, nut and fp services, M&E. Family health and nutrition component outcome unknown.

Mahmood Ayub
The Gambia

We have reviewed OED's evaluation noting the points you put forth. They are addressed in turn below.

Evaluators review outcome to determine whether the operation has achieved most of its major goals efficiently and has achieve, or is expected to achieve, satisfactory development results with only a few shortcomings.

The performance rating criteria focus on how good a job each partner - the Bank as the chief advisor and the borrower as the owner- has done during the different stages of the project cycle: from project identification in the context of broader strategy, preparation, and appraisal to implementation, with the ultimate objective of securing satisfactory results on the ground.

1. Outcome Rating

Outcome argument:
1. formulated and promulgated a National Health Policy -(ICR does say that an indictor of enhanced capacity at the MOH is the quality of the recently produced national health policy document , para 3.23)
2. Increased the Relative Budget Share - not mentioned in ICR
3. Reorganized the hospital sector - noted

Response: OED bases its ratings upon the evidence presented in the ICR and compares the outcome with the stated project objectives as found in the SAR. OED rates the project as marginally unsatisfactory because there were significant shortcomings in the achievement of project objectives. [To recap: While the program of reforms was achieved, half of the program of investments was not completed, and the civil works component experienced severe delays and considerable cost overruns. The subcomponents not achieved included expansion of PHC to peri-urban area of Banjul; training of VDC members in financial management; improvement of health, education, nutrition and family planning services, and monitoring and evaluation. The family health and nutrition subcomponent could not be evaluated based on the ICR.] It does seem odd that the end of project evaluation which was independently conducted by WHO in September 1993 which conducted an overall assessment of the impact of the project as gauged by the objectives set out in the SAR was not mentioned. (Se Borrower's contribution, p. 3) The project was ambitious, as noted in the ICR (appraisal was less than satisfactory, para 3.19).

2. Bank Performance

OED rates Bank performance as unsatisfactory because project supervision did not recognize the degree to which implementation difficulties were hampering the achievement of project objective; weak appraisal (noted in the ICR) and poor project supervision, as evidenced by the disconnect between the reporting of problems encountered during implementation and status ratings.

Argument: The OED evaluation superimposes its judgment over the person on the spot. The degree to which these were considered de minimus by the task manager was a decision made in a context at a particular time and place.

Response: Valid point. OED bases its judgment on the information provided in the ICR. On the basis of evidence provided, it appears contradictory that, given the number of sub-components which did not take place, that, as stated in para 3.20, "Implementation problems were identified in a timely fashion and sufficient advice was given to address the problems to the extent possible. Follow up on advice and the decision taken during missions were adequate." OED also based its judgment on the discrepancy between the number and types of problems listed, of which two were cited as an example, from Table 13 which shows consistent problems with Project management performance (first 8 missions); procurement progress (in 9 supervision reports); studies progress (in 7, and particularly problematic in 4); compliance with legal covenants in 5; technical assistance (in 6 and particularly problematic in 4); and availability of funds (in 3).

3. Borrower Performance

OED rates Borrower performance as unsatisfactory because of the inconsistent level of commitment and the persistent financial and administrative difficulties experienced during the project.

Argument: Gauge of Government commitment: level of recurrent resources to the health sector, relative to other sectors. Counterpart commitments were not a problem. With respect to financial management, work began on a new accounting system.

ICR states that financial management was less than satisfactory throughout project implementation, reflecting the weak capacity of MOH in this area. The performance of the Auditor General in auditing the project accounts was also less than satisfactory (para 3.22) From the beginning the PMU was not provided with the full complement of staff needed to carry out its functions. (para 3.13) Limited high and intermediate level technical, medical and administrative staff, and the high personnel turnover were major obstacles (3.14) Systems wide issues: civil service and cumbersome budgetary process. Supervision ratings: problems noted with availability of funds in 3 instances. Perhaps we are missing some information at para 3.21 and 3.22 contain incomplete sentences. The project had three project managers, four project coordinators and four MOH during its lifetime (ICR para 3.13).

4. ICR Quality

OED rates the ICR as unsatisfactory:
Documentation of implementation and the project's achievements are neither detailed nor convincing.
Important aspects of the project are underreported.
The ICR fails to explain why monitoring and evaluation failed.
There is no discussion of donor coordination in the text, despite the considerable multi-donor effort.
There is no plan for future operation of the project.

Argument: Limited to 10 pages, thus more details not provided. Selection of what is included was a judgment call. Absence of health outcome indicators is more a reflection of realistic result expectations than oversight. The extent of coverage of BHS is reflected in the very high rates of immunization and frequency of antenatal care, even if not explicitly stated in the ICR. Future operations discussed in future operations section which dealt with the situation in a changing political environment and the Bank's future intended follow-up actions. (Modification and build on lessons.)

No monitoring and evaluation data given or discussed in ICR. Future operations should report the understanding with the borrower on the measures to maximize project benefits, the indicators for monitoring and evaluation the future operation of the project, and the Bank's intended follow-up actions.

THE WORLD BANK/IFC/M.I.G.A.

OFFICE MEMORANDUM

DATE: May 29, 1997

TO: Mr. Mahmood A. Ayub, Director, AFC14

FROM: Roger Slade, Division Chief, OEDD1

EXTENSION: 8-1293

SUBJECT: **THE GAMBIA—National Health Development Project (Cr. 1760-GM) Implementation Completion Report**

1. Thank you for your rapid response to our request for comments on the draft Evaluation Memorandum (EVM) and ratings of the project. This memo clarifies the basis for the judgements reached in the draft, and responds to the issues raised in your note and that of Mr. Seifman. Our conclusion is that though the additional information provided in Mr. Seifman's note is pertinent to the evaluation of the project, it does not provide a sufficiently strong basis for OED to agree to the change in the outcome rating for the project.

2. Regarding the outcome rating, OED reviews outcome to determine whether the operation has achieved most of its major goals efficiently and has achieved, or is expected to achieve, satisfactory development results with only a few shortcomings. OED rates the project as marginally unsatisfactory because there were significant shortcomings in the achievement of project objectives. The additional information regarding the government's increase in the relative budget share allocated to health over the time period of the project underscores the importance of the project in helping to attain key policy reforms. While the program of reforms was achieved, as noted in the Evaluative Memorandum, half of the program of investments to strengthen health services was achieved. The outcomes of the project components aimed at maternal care and family planning initiatives, strengthening nutrition services, health education, and monitoring and evaluation are not discussed in the ICR. This lack of information led to the presumption, perhaps false, that these components were unsuccessful. The project's accomplishments in policy reform, training, and civil works are laudable. Our review of previous experience in the sector, however, suggests that these key "software" components—health education and the coordination of MCH, family planning, and nutrition programs—are necessary for lasting impact in strengthening health services. As noted, without data from a monitoring and evaluation system, it is impossible to assess the ICR claims that the expansion of primary health care to the Western Region has considerably increased coverage of basic health services to the country. The text of the ICR does not discuss the achievements of this component, i.e., improved quality of care, increased utilization, nor the number of villages to which PHC was expanded.

The World Bank/IFC/MIGA
O F F I C E M E M O R A N D U M

DATE: May 27, 1997 04:49pm EDT

TO: See Distribution Below

FROM: Richard Seifman, AFTH2 (RICHARD SEIFMAN@A1@WBWASH)

EXT.: 82897

SUBJECT: THE GAMBIA: PARTICIPATORY HEALTH, POPULATION AND NUTRITION PROJECT
MINUTES OF THE PCD REVIEW MEETING

1. A meeting to review the draft PCD for the above project was held on May 22, 1997. The meeting, chaired by Mahmood Ayub (AFCI4), was attended by Mmes/Messrs Ok Pannenborg (Technical Manager, AFTH2), Florent Agueh (Technical Manager, AFTS2); Jane Robinson (HDDHE): Edna Jonas (HDDHE); Richard Seifman (Team Leader, AFTH2); Angelika Pradel (AFTH2); Serge Theunyck (AFTH2), Ronald Kenyon (AFTH2) and Gerhard Tschannerl (AFTSA).

2. The chairman opened the meeting by congratulating the team on a well-prepared and extremely well-presented project. In particular he stated that the section on project alternatives considered and rejected could be cited as an example of "best practice." As background, he made the following points:

. The proposed project fits well with the overall country strategy: there is great room for improvement in the health sector, and the sector has been generally under-funded. The new CAS (to be presented to the Board in February 1998) would accord a high priority to this sector;

. The commitment of the Government to this project has been very solid as demonstrated by the statements of the Minster of Health (who is also the Vice President of the country and a former director of the Bank's WID Project); the December 1996 participatory planning workshop, which brought together government officials, NGOs and donors on the design of this project; the fact that the Japanese grant for the project was being managed by the Borrower, not the Bank; and the fact that the PCD already reflects the views of the Gambian authorities;

. The timing of the project preparation was good because a comprehensive Public Expenditure Review (PER) was underway, with strong linkages and collaboration between the project team and the PER preparation team.

3. The following is a summary of the major points of discussion and recommendations:

Project design, scope, size and performance indicators

4. As to why a SIP approach was not adopted, the meeting concurred with the project team's view that, inasmuch as this was the first new project with the Government since 1994, we needed to reestablish confidence with them, and assure that there was transparency with respect to the public health sector budget. Furthermore, the Gambian Ministry of Health (MOH) team was new and did not yet include a Director of Planning. Moreover, because of the discontinuity caused by the suspension of most donor activities following the July 1994 coup, the degree of donor coordination was not yet strong enough to justify a SIP approach. Nevertheless, there was agreement from the Gambian Government to hold annual review meetings and to do so in conjunction with other major donors such as the ADB. The project team was encouraged to work gradually toward a full-fledged SIP during the course of implementation.

5. Regarding performance indicators, it was mentioned that these needed to be clarified, prioritized, and reduced in number.

6. With respect to project measurement, there was recognition of the QAG's points with regard to difficulties in projects achieving health outcomes and therefore the need to focus on improved use and availability of services. At the same time, the chairman suggested that what was needed was a long-term vision for the sector (say 10 years) with intermediate, monitorable indicators.

7. Regarding the project size, there was agreement that the proposed US$ 18.0 million seemed somewhat high, that there may be a need to reduce the size, and that cofinancing options should be explored, particularly with the ADB. (The ADB has expressed a desire to work closely with us in rural areas and on key organizational matters.) Decision on the project size decision was left to the judgment of the project team.

8. It was agreed that incremental recurrent financing for such items as maintenance, staffing, and staffing incentives could be included, provided that these would be on a declining basis.

9 It was also agreed that the studies identified by the team and, in particular, those given high priority, needed to be launched quickly.

Status of work on financial analysis and sustainability

10. Financial analysis issues are or will be addressed on a

number of levels. A consultant is in The Gambia currently gathering fiscal analysis data for both public sector and household spending on health. In assessing expansion of the Bamako Initiative, issues of demand, affordability and seed stock requirements were being addressed. The chairman stressed the importance of analyzing the recurrent cost implications of the proposed investments, and the long-term affordability of the project design.

11. The project must retain its focus on rural areas. Questions such as distances and transportation needed to be addressed. If rural health workers were trained and appropriate facilities were not provided, they might not remain in the rural areas.

Role and staffing of project implementation unit (PIU)

12 It had been suggested that the PIU be organized along two functions: a technical group (planning, monitoring, analyzing) and a financial management group (procurement, auditing). This would be pursued with the Gambians. Regarding the question of whether MOH was the best place to implement the project, it was noted that it was the "Ministry of Health, Social Welfare and Women 's Affairs"; the current leadership reflected the broader interests of the project; and furthermore, there was a very close working relationship between MOH and the Ministry of Local Government. The need for regular contacts between the PIU and health service delivery Directors was also emphasized. (The PIU is located in the center of the MOH). The chairman noted that a PIU is appropriate in this instance, its role needed to be further detailed, and there was the need for linkages with other programs and donors.

Donor coordination

13. The following are key donors in the sector: African Development Bank, Islamic Development Bank, WHO, UNICEF and UNFPA. The United Kingdom (ODA) has sent a mission to The Gambia to explore new cooperative activities, including those in the health sector, and are ready to cooperate with us. The European Union is a contributor. Norway may be involved, particularly with respect to follow-on activities of the Bank's WID project. At this juncture, neither the Netherlands nor Italy has indicated interest in reinstituting assistance. The U.S. position is in transition. The meeting recommended close coordination with other donors, especially the African Development Bank.

Next steps: timing, staffing, quality assurance, conditionality

14. The chairman suggested the following timetable: a decision meeting in early October (after the Bank's annual

meetings), appraisal departure in mid-October, and Board presentation at the end of February 1998.

15. It was agreed that approval of the national nutrition policy should take place by negotiations, rather than as a condition of effectiveness. (It is a carry-over commitment from the previous Bank credit in the health sector.)

Cleared by Mahmood Ayub

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A L L - I N - 1 N O T E

DATE: 27-May-1997 12:01pm

TO: See Distribution Below

FROM: Roger Slade, OEDD1 (ROGER SLADE@A1@WBHQB)

EXT.: 81293

SUBJECT: Attached. Laura to handle please.

DISTRIBUTION:

TO: JACINTHA WIJESINGHE (JACINTHA WIJESINGHE@A1@WBWASH)
TO: LAURA RANEY (LAURA RANEY@A1@WBWASH)
TO: SUSAN STOUT (SSTOUT@WorldBank.org@INTERNET)

write out pt by pt -
can say - you're right (if argument makes sense)

write a return memo for Roger's sign (→ SS)

A L L - I N - 1 N O T E

DATE: 27-May-1997 10:44am EDT

TO: ROGER SLADE (ROGER SLADE@A1@WBHQB)

FROM: Mahmood Ayub, AFC14 (MAHMOOD AYUB@A1@WBWASH)

EXT.: 33155

SUBJECT: THE GAMBIA: National Health Development Project - ICR

Roger,

Attached are our comments on OED's Evaluation Memorandum on the above ICR. As you will note from the attached, we have serious misgivings about the analytical base for the judgements on the evaluation of the above project.

We had rated the project outcome as satisfactory. OED has rated it as marginally unsatisfactory despite the fact that:

o Under the project the Government formulated and promulgated a coherent National Health Policy.

o the share of budget going to health increased to 11% (1994/95) compared to about 7% in 1986/87.

o The hospital sector was reorganised into a semi-autonomous structure.

o The project was able to generate about 60% more donor contributions than envisaged at appraisal.

I recommend that you review the attached comments on all aspects of ratings. Please let me know if you think we need to discuss.

Mahmood

CC: Richard Seifman (RICHARD SEIFMAN@A1@WBWASH)
CC: Ok Pannenborg (OK PANNENBORG@A1@WBWASH)
CC: ANGELIKA PRADEL (ANGELIKA PRADEL@A1@WBHQB)
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The World Bank/IFC/MIGA
O F F I C E M E M O R A N D U M

DATE: May 20, 1997 01:54pm EDT

FROM: Richard Seifman, AFTH2 (RICHARD SEIFMAN@A1@WBWASH)

EXT.: 82897

SUBJECT: The Gambia: National Health Development Project (1760-GM) ICR

The Gambia: National Health Development Project (Credit 1760-GM): Implementation Completion Report

1. Outcome Rating:

OED rates the project as marginally unsatisfactory. However, at the behest of the Bank the Gambian Government formulated and promulgated a National Health Policy 1994-2000; increased the relative budget share of health from 7.3% (1986/87), to 11.1% (1994/95); and reorganized the hospital sector so that it is semi-antonomous. A marginally unsatisfactory rating would not seem to be in keeping with either the broad policy objectives of the project, nor current Bank thinking as to what constitutes success. The Government is preparing a new project and has agreed that maintenance is to be featured in it. This is responsive to a point made by OED reflecting an orientation consistent with what the Bank sought when the project began.

2. Bank Performance Rating:

OED rates the Banks performance as unsatisfactory. Gaps in some appraisal aspects were noted in the ICR. With respect to the qualitative assessment of problem reporting, the OED evaluation superimposes its judgment over the person on the spot. There will virtually always be problems with some aspects of project performance. The degree to which these were considered de minimus by the task manager, was a decision made in a context, at a particular time and place. Of the two examples cited by OED from the ICR Table 13, under "Types of Problems" several problem areas were noted by the task manager. Where interpretation differs is with respect to assessing how significant the problems were, and whether it would have been reasonable to characterize the situation as problem free. Obviously a strict "plain meaning" interpretation of the words would support the OED view; however, the intention of the guidelines must be to provide some flexibility-otherwise virtually all projects would be rates at a minimum as with "Moderate Problems". In this case the task manager may have thought there were areas which warranted future watching, i.e. potential problems, wanted to

identify areas worth keeping an eye on in the future, but by his standard and judgment, the project was problem free. (Parenthetically, the ICR Performance Rating form lists two levels of "Major Problems"; maybe a category of "Minor problems/areas to watch" would give task managers another option.)

3. Borrower Performance Rating:

OED rates the Borrower's performance as unsatisfactory because of inconsistent levels of commitment and persistent financial and administrative difficulties. On the other hand, one could look positively on a simple gauge of Government commitment, namely the level of recurrent resources to the health sector, relative to other sectors. As indicated above, this increased during the project period. Further, counterpart commitments were not a problem, and with respect to financial management, work began on a new accounting system.

4. ICR Quality:

The main thrust of OED comments regarding the ICR and their rating of it as "unsatisfactory" is that more details would have improved the document. However, at the time of ICR drafting the firm message from OED was that ICRs were strictly limited to 10 pages. Selection of what is included is a judgment call, made on the basis of what the drafters consider most responsive to the guidelines, and the readership.

The absence of health outcome indicators is more a reflection of realistic result expectations, than oversight. Recent findings of the QAG on supervision of health projects in Africa recommend that infant and maternal mortality rate indicators not be used, but rather process indicators such as access to and use of facilities and services. The reason is that the former are not realistic, measurable outcomes of a Bank project. (The extent of coverage of basic health services is reflected in the very high rates of immunization (well over 80%) and frequency of antenatal consultations (up to 85% of pregnant women receive some ante-natal care), even if not explicitly stated in the ICR).

The NHDP Project generated $33.3 million in donor contributions which was considerably higher than the initially estimated $20.8 million. Further, de fact donor coordination was a reality and allowed for completion of most of what was originally envisioned, and more. "...complementary funding provided by other donors (such as the UK/ODA, the Dutch Government, the EU, and UNFPA), permitted completion of about 95% of the proposed civil works under the Project." (paragraph 3.8 of the ICR)

That the ICR does not contain a statement of future operations

for the project could reasonably be considered as having been included in Future Operations section which dealt with the situation in a changing political environment, and the Banks future intended follow-up actions (see paragraph 3.25).

A L L - I N - 1 N O T E

DATE: 19-May-1997 05:35pm

TO: rslade (rslade@worldbank.org@INTERNET)
TO: Adala T. Bruce-Konuah (Abrucekonuah@worldbank.org@INTE

FROM: Susan A. Stout, (Sstout@worldbank.org@INTERNET)

EXT.:

SUBJECT: The Gambia: Proposed Participatory Health, Population and Nutrition Pr ect: Draft Concept Document

The proposed project aims to support policies and investments designed to improve family health services in rural areas of the Gambia. The project design builds on lessons learned from IDA's first investment in the sector (National Health Development Project, Cr. 1760, rated Satisfactory by the ICR, unsatisfactory by OED), particularly with regard to i) improving skills at the project coordination unit, ii) using participatory planning techniques and involving a wide array of stakeholders in the preparation process, and iii) seeking agreement on key policy decisions prior to project effectiveness.

In general, the concept paper provides a useful overview of the proposed project design, and makes attempts to identify lessons learned from the first project experience. Nevertheless, our review suggests that three areas where more in-depth analysis of earlier HNP experience, in the Gambia and elsewhere, could strengthen the preparation process.

Sustainability and Financial Analysis

The concept paper points out that the sector has been underfunded in the past. The project design contemplates that project conditionalities be agreed to assure that Government commitment to the recurrent costs of primary and secondary levels of health care, vs. the hospital sector. In the first project, Borrower performance was rated as unsatisfactory due to inconsistent levels of commitment and the persistent financial and administrative difficulties. Noting that funds for operations and maintenance of the rural health infrastructure have been inadequate in the past, the design would benefit from a more detailed financial analysis of the recurrent cost implications of the proposed investments, and the long run affordability of the proposed design. The concept paper suggests that pursuit of interventions similar to those tested in the Bamako Initiative will be employed to mobilize additional resources for the sector. It would be valuable for future design and analytic work (perhaps in the context of the proposed public expenditure review) to quantify projected recurrent costs, capacity and willingness to pay relative to service demand and to identify the risks associated with failure of the resource mobilization effort. The analysis could also review evidence of the demand for the

services to be provided in the project. The proposed suggestion that conditionality be employed to assure recurrent budget availability may not be effective, if sector finances simply are not adequate to cover costs. If the latter is the case, what tradeoffs among service delivery and capacity building interventions can be anticipated?

Ownership

The proposed design acknowledges the significant role that borrower ownership plays in determining long run success. The project usefully proposes improvements on the structure and function of the project coordination committee, a weak element of the first project, as a step toward broadening project ownership. Nevetheless, many of the project's policy objectives are to be acheived through the completion, apparently by consultants, of studies in the areas of health financing, nutrition policy, maintenance policies and procedures, manpower availability and training, and in quality assurance methods, among others. Further work on the design might usefully spell out the procedures or steps that will be taken to assure 1)ownership through participation in the preparation of the terms of reference for these efforts, 2) phasing of the treatment of various policy issues, 3) methods for building Gambian capacity in health services and policy research through the conduct of the policy research program, and 4) dissemination of policy research results. It would also be useful to indicate how the results of the policy reviews will be shared and interpreted at subnational levels of the health system and among representatives of the consumers of health services. Last, it might be useful to include plans for supervising these studies and the proposed operational research program in the supervision plan, since policy and health services research components often take second place to construction and procurement issues during project implementation.

Monitoring and Evaluation

The design hopes to strengthen the MOH's capacity to evaluate its programs, and specifies an extensive list of indicators for tracking project performance, including beneficiary assessments and surveys of client satisfaction. Noting that the monitoring and evaluation efforts financed under the first project were not successful (the ICR is relatively silent on the reasons why), it would be useful for future drafts of the project design to provide greater detail on 1) how capacity to collect and report on the data needed to track project performance will be strengthened (who will be responsible, what technical assistance will be necessary, etc.) and 2) what incentives exist in the health sector's planning and budgeting system to encourage the use of M&E data, beyond its collection. For instance, what formal or informal incentives will influence the decisions district health officers make on the information they use to manage their districts? Would they be encouraged to use district specific data to, for example, estimate the number of families in need of services, or to make specific proposals for training programs in their districts, or to justify the use of operational funds in their district? Our review of previous experiences in the sector suggests that selecting the 'technically right' performance indicator for a health project is relatively straightforward, phasing in the capacity to collect the data necessary to make the indicators available, and ensuring that there is a reason to use

the data that is collected are more difficult problems. One approach to solving these problems is to employ participatory methods to encourage representatives from various administrative levels (e.g. the districts, if they are the principle focus of managment strenghthening) to define and suggest ways to regularly measure project performance. The team working on the preparation of the Fourth Population project in Bangladesh has identified some useful methodologies for similar problems in that country and might be provide some suggestions for organizing this kind of approach (though at a smaller scale) in the Gambia.

CC: lraney (lraney@worldbank.org@INTERNET)

THE WORLD BANK/IFC/M.I.G.A.

OFFICE MEMORANDUM

DATE: May 16, 1997

TO: Susan Stout, OEDD1

FROM: Laura Raney, OEDD1

EXTENSION: 3-1759

SUBJECT: **The Gambia - Proposed Participatory Health, Population and Nutrition Project Draft Concept Document**

I have read the draft PCD for the above project and have the following observations:

- A human resource development assessment is to be carried out before appraisal to determine what can be done to retain high quality staff, complemented by preparation of a first year training plan. However, it's doubtful that these measures will address the long-term shortage of staff and unwillingness on the part of staff to locate in rural areas. No financial incentives are mentioned. The non-monetary incentives are the creation of a more respecting and helpful environment to staff through staff surveys, and improved mentoring, coaching and supportive supervision of staff. Is this enough?

- The PCU approach is being considered, as under the first project as favored by the Gambian authorities. However, they recognize that integration of activities into line ministries is preferred. In fact, one of the lessons in the ICR states the importance of physical integration of project coordination unit into the parent ministry.

- They are contemplating some form of Government recurrent budgetary commitment to primary and secondary levels of health care, vs. the hospital sector. In the first project, Borrower performance was rated as unsatisfactory due to inconsistent levels of commitment and the persistent financial and administrative difficulties experienced during the project. I think some covenants are required to address the chronic underfunding of recurrent expenditures for pharmaceuticals, supervision, training, and maintenance. They state (p. 7) that the underfunding of the health sector, particularly the non-hosptial sector, will be addressed through appropriate project conditionalities. How effective will this be in the long-term?

- Progress in reaching project objectives will be measured and monitored based on access to, and use and quality of family health services. The project will improve data collection and analysis and establish a monitoring and evaluation system, but no specifics are given. This failed in the last project (see below). Beneficiary assessments and client surveys will be conducted. By whom? Local capacity

building would be good, as it is an objective to strengthen MOH's evaluative capacity.

- They are drawing on lessons learned re Government ownership, but, though they have all the language it rings false. They state that the 1996 Planning Workshop established Gambian ownership of the basic project design. All the studies and policies (national health financing policy, maintenance policy and program, manpower plan for the pharmaceutical sector, human resource policy, program to improve health worker attitudes and "bedside manner" with clients) seem to be prepared by consultants, precluding institutional capacity building and consensus building. They also state that "The lesson that adequate lead time needs to be given for parliamentary approval of policy decisions will be incorporated into the time schedules of the project implementation plan." ??

- One of the goals under improving capacity to manage and implement a rural family health program is maintenance of health infrastructure and equipment. It is unclear how this will be ensured or monitored.

I am struck by the lack of commentary on the results of the first project, which had as its objectives (i) strengthen and expand The Gambia's national health program, including essential family planning and nutrition activities; (ii) decentralize health sector management; (iii) improve planning; and (iv) enhance cost recovery. The objectives were to be achieved through two parts: Part A was a program of reforms to strengthen health sector management, financing and support systems through decentralization, reorganization, mobilization of financial resources, and strengthening of logistical support; and Part B was a program of investments to strengthen national health care through (i) extension of primary health care to the Western Region and the Banjul peri-urban area and expansion of the communicable disease program nationwide; (ii) improvement of health facilities; (iii) improvement of nursing skills; (iv) enhancement of health education, nutrition and family planning programs; and (v) monitoring and evaluation.

A concern is that the preparation of the follow-on project does not take into consideration the lessons learned from the first project, due in part to the fact that the ICR perhaps was not the best presentation of lessons learned:

- OED disagrees with the ICR ratings. The ICR rates project outcome as satisfactory, sustainability as likely, institutional development as substantial, and Bank performance as satisfactory. OED rates project outcome as marginally unsatisfactory because there were significant shortcomings in the achievement of project objectives. Sustainability is rated as uncertain because of lack of evidence of maintenance of project components and acknowledged dependence on a follow-on project where

preparation has been delayed since 1994. Institutional development is rated as modest because the reorganization of the Ministry of Health was delayed, contentious, and is still the subject of concern as several key roles remain undefined. Bank performance is rated as unsatisfactory because project supervision did not recognize the degree to which implementation difficulties were hampering the achievement of project objectives.

- The current PCD does not mention anything about the reorganization of the MOH; this was not elaborated in the ICR, rather was found in the Borrower's contribution which stated that "Adequate recognition was not given to the need for consensus building in the design of a reorganized structure...A number of gray areas continue to create concern. This include [sic] the responsibility for donor co-ordination, the locus of ESU/Health Information and the merging of the NHDP/PMU and the DPI. The role of the DSS, hereto the DPS, is still less define [sic] and seem to change depending on the post holder. Four PDS have been posted to the post in four years. The DHS still continues to manifest the seeming conflicting roles of chief adviser the MOH (members of both HMBs) and implementation of the health services." (p. 6) Have these problems been overcome?

- The ICR underreported important aspects of the project including: (i) restructuring of health management and administration; (ii) decentralization of management to the district level; (iii) expansion of primary health care to the underserved Western region; (iv) enhancement of health education, nutrition and family planning programs; (v) strengthening of family health and nutrition; and (vi) monitoring and evaluation.

- The ICR did not even state the number of buildings that were renovated or constructed. The borrower's contribution states that resources were provided to establish 80 village health services in the Western Administrative region.

- There was no discussion of maintenance of project gains: The ICR contains no plan for future operation of the project required under BP 13.55. This section should report the understanding with the borrower on the measures to maximize project benefits, the indicators for monitoring and evaluating the future operation of the project, and the Bank's intended follow-up actions

- Monitoring and evaluation was a component in the first project, yet the ICR failed to explain why the monitoring and evaluation system failed. Without monitoring and evaluation data, it is impossible to assess the ICR claims that i) expansion of primary health care to the Western Region has considerably increased coverage of basic health services in the country; and ii) staff morale and quality of service delivery were dramatically improved with the introduction of the cost recovery system.

- The ICR also stated that the level of revenue generated by the cost recovery system was below expectations (35 percent compared to expected 100 percent). Reasons for

the low level of revenue collected included the fact that over 60 percent of the beneficiaries were exempt form fees with a reluctance on the part of the government to change this policy for political reasons, and resistance from the Treasury to permit retention of user charges at the points of collection. The lessons identified by the project included the importance of permitting revenue retention at the point of collection and limiting exemptions to the truly needy for successful cost recovery. Will these be addressed in the current project?

The objectives of this project appear ambitious, despite the fact that the PCD states it is scaled back from a sector-wide effort. It does not include the tertiary sector or the urban population, but the goals are ambitious, nevertheless, particularly given the weak capacity to manage and implement a rural family health program. (See indicators in Annex 1.)

Positive points:

- The shortcomings of the first project regarding project management are being addressed by adequately staffing the PCU and providing training, and putting in accounting and financial management systems in place during project preparation.

- Investments in infrastructure will be made contingent to an increased decision-making authority of Divisional Health Teams. However, it is unclear how this will be measured.

- Rehabilitate and equip selected health facilities only after effective maintenance system is put in place and after sufficient staff is identified for deployment to these facilities. Ditto the above.

- There will be coordination, under the human resource policy, with government wide civil service reforms.

THE WORLD BANK/IFC/M.I.G.A.

OFFICE MEMORANDUM

DATE: May 14, 1997

TO: Mr. Mahmood A. Ayub, Director, AFC14

FROM: Roger Slade, Acting-Director, OED

EXTENSION: 81293

SUBJECT: **THE GAMBIA: National Health Development Project (Credit 1760-GM) Implementation Completion Report**

1. Attached is a draft Evaluative Memorandum (EM) from the Director-General, Operations Evaluation, which is based on OED's review of the Implementation Completion Report (ICR). We would appreciate receiving any comments you might have by May 29, 1997.

2. Based on this review, the ratings we intend to include in the OED Annual Review database are shown below:

	OED	ICR
Outcome	**Marginally Unsatisfactory**	**Satisfactory**
Sustainability	**Uncertain**	**Likely**
Institutional Development	**Modest**	**Substantial**
Bank Performance	**Unsatisfactory**	**Satisfactory**
Borrower Performance	**Unsatisfactory**	**Satisfactory**

3. OED's ratings differ from those recorded in the ICR. OED rates project outcome as marginally unsatisfactory because half of the program of investments was not completed, and the civil works component experienced severe delays and considerable cost overruns. Sustainability is rated as uncertain because of a lack of evidence of maintenance of project components and dependence on a follow-on project where preparation has been delayed since 1994. Institutional development is rated as modest because the reorganization of the Ministry of Health was delayed, contentious, and is still the subject of concern as several key roles remain undefined.

4. OED rates Bank performance as unsatisfactory because of weak appraisal (noted in the ICR), and poor project supervision, as evidenced by the disconnect between the reporting of problems encountered during implementation and the status ratings. For example, in Table 13: Bank Resources: Missions, the 12/91 mission reported only moderate problems despite recognition of problems with procurement, compliance with legal covenants, and availability of funds. Project management, studies, and technical assistance were noted as particularly problematic. The 7/93 mission rated the project as problem-free yet noted problems in project management, procurement, and compliance with legal covenants. Progress on studies and

technical assistance was noted as particularly problematic. Borrower performance is rated as unsatisfactory because of the inconsistent levels of commitment and the persistent financial and administrative difficulties experienced during the project.

5. The ICR is unsatisfactory and could have been improved if the following points had been taken into account:

- Documentation of implementation and the project's achievements are neither detailed nor convincing. Important aspects of the project are underreported, including: (i) restructuring of health management and administration; (ii) decentralization of management to the district level; (iii) expansion of primary health care to the underserved Western region; (iv) enhancement of health education, nutrition and family planning programs; (v) strengthening of family health and nutrition; and (vi) monitoring and evaluation.

- To expand on the latter, a careful examination of the Annex tables show that actions were taken by the Epidemiology and Statistics Unit of the Ministry of Health, Labor and Social Welfare to review and improve the health information system, and that both a mid-term and final project evaluation took place (Table 5: Key Indicators for Project Implementation), yet these are not discussed in the text. The evaluation results are mentioned only in Table 7: Studies Included in Project, which states that the mid-term review resulted in modifications to increase health system effectiveness, and that the World Health Organization Final Project Evaluation guides preparation of future health policy and projects. From the Staff Appraisal Report, it is clear that no health outcome indicators were included in project design. However, the ICR fails to explain why monitoring and evaluation failed. Without monitoring and evaluation data, it is impossible to assess the ICR claims that i) expansion of primary health care to the Western Region has considerably increased coverage of basic health services in the country; ii) the granting of semi-autonomous status to the two government hospitals substantially improved the availability and quality of tertiary health services in the country; and iii) staff morale and quality of service delivery were dramatically improved with the introduction of the cost recovery system.

- The ICR states that the project's multi-donor effort permitted substantial resource mobilization and provided the basis for extensive donor coordination. However, there is no discussion of donor coordination in the text. In addition, there is no evidence that the co-financiers were invited to participate in the ICR mission.

- The ICR contains no plan for future operation of the project, required under BP 13.55. This section should report the understanding with the borrower on the measures to maximize project benefits, the indicators for monitoring and evaluating the future operation of the project, and the Bank's intended follow-up actions.

Attachment

cc: Ms. Alexander (OPRDR) and Mr. de Ferranti (HDD)

The World Bank
Washington, D.C. 20433
U.S.A.

Office of the Director-General
Operations Evaluation

OED EVALUATIVE MEMORANDUM ON IMPLEMENTATION COMPLETION REPORT

The Gambia: National Health Development Project (Credit 1760-GM)

The Gambia National Health Development project, supported by Credit 1760-GM for SDR 4.7 million (US$5.6 million), was approved in FY87. It was the first Bank operation in the health sector in The Gambia. Following three one-year extensions, the credit was closed in June 1995. The dollar value of the credit amount disbursed (US$6.1 million) was higher than anticipated at appraisal due to changes in the US$/SDR exchange rate. The project was co-financed by the Government of the Netherlands (US$1.0 million), and six donors provided parallel financing. The Implementation Completion Report (ICR) was prepared by the Africa Regional Office. Annex B contains the borrower's contribution to the ICR. All the partners were provided with copies of the draft ICR, but no comments were received.

The objectives of the project were to (i) strengthen and expand The Gambia's national health program, including essential family planning and nutrition activities; (ii) decentralize health sector management; (iii) improve planning; and (iv) enhance cost recovery. The objectives were to be achieved through two parts: Part A was a program of reforms to strengthen health sector management, financing and support systems through decentralization, reorganization, mobilization of financial resources, and strengthening of logistical support; and Part B was a program of investments to strengthen national health care through (i) extension of primary health care to the Western Region and the Banjul peri-urban area and expansion of the communicable disease program nationwide; (ii) improvement of health facilities; (iii) improvement of nursing skills; (iv) enhancement of health education, nutrition and family planning programs; and (v) monitoring and evaluation.

Despite some delays in implementation, the program of reforms was achieved, with the exception of strengthened support services which was only partially achieved. Restructuring of health management and administration took place at the central level, and the two government hospitals (Royal Victoria and Bansang) were granted semi-autonomous status through the establishment of hospital management boards. Institutional capacities of the health sector were strengthened through decentralized management at the district level, and a cost recovery system was established with improvements in the fee collection system, availability of drugs and medical supplies. Half of the program of investments was achieved. The civil works component experienced severe delays and considerable cost overruns. Primary health care was extended to the Western Region, and health facilities were improved through the rehabilitation of essential services (water and electricity). Secondary level health delivery facilities were established through the upgrading/construction, equipping and staffing of eight major health centers to

relieve the burden on the two tertiary level hospitals and bring basic health services closer to the population. Project investments to upgrade the technical skills of service providers including traditional community-based health providers were also achieved. Other subcomponents, however, were not achieved, namely, the expansion of primary health care to the peri-urban areas of Banjul; the training of selected Village Development Committee members in financial management; improvement of health, education, nutrition, and family planning services; and monitoring and evaluation. The ICR did not evaluate the family health and nutrition component or the monitoring and evaluation component.

The Operations Evaluation Department (OED) disagrees with the ICR ratings. The ICR rates project outcome as satisfactory, sustainability as likely, institutional development as substantial, and Bank performance as satisfactory. OED rates project outcome as marginally unsatisfactory because there were significant shortcomings in the achievement of project objectives. Sustainability is rated as uncertain because of lack of evidence of maintenance of project components and acknowledged dependence on a follow-on project where preparation has been delayed since 1994. Institutional development is rated as modest because the reorganization of the Ministry of Health was delayed, contentious, and is still the subject of concern as several key roles remain undefined. Bank performance is rated as unsatisfactory because project supervision did not recognize the degree to which implementation difficulties were hampering the achievement of project objectives.

The lessons identified by the ICR suggest (i) the need for simpler project design and development; (ii) the need for early agreement and ownership of key policy objectives to improve quality at entry; (iii) the need to improve project management through training and establishment of effective accounting and financial management systems prior to project effectiveness; (iv) the importance of physical integration of project coordination unit into the parent ministry; and (v) the need to define monitoring and evaluation indicators by project appraisal to enable the borrower and the Bank to objectively assess project achievements and their impact.

The ICR is unsatisfactory as the documentation of implementation and the project's achievements are neither detailed nor convincing. The ICR does not discuss donor coordination, despite the project's multi-donor effort, nor does it contain a plan for future operation of the project. An audit is planned.

THE WORLD BANK/IFC/M.I.G.A.

OFFICE MEMORANDUM

DATE:

TO: Mr. Mahmood A. Ayub, Director, AFC14

FROM: Roger Slade, Acting-Director, OED

EXTENSION: 81293

SUBJECT: **THE GAMBIA: National Health Development Project (Credit 1760-GM) Implementation Completion Report**

1. Attached is a draft Evaluative Memorandum (EM) from the Director-General, Operations Evaluation, which is based on OED's review of the Implementation Completion Report (ICR). We would appreciate receiving any comments you might have by

2. Based on this review, the ratings we intend to include in the OED Annual Review database are shown below:

	OED	ICR
Outcome	**Marginally Unsatisfactory**	**Satisfactory**
Sustainability	**Uncertain**	**Likely**
Institutional Development	**Modest**	**Substantial**
Bank Performance	**Unsatisfactory**	**Satisfactory**
Borrower Performance	**Unsatisfactory**	**Satisfactory**

3. OED's ratings differ from those recorded in the ICR. OED rates project outcome as marginally unsatisfactory because half of the program of investments was not completed, and the civil works component experienced severe delays and considerable cost overruns. Sustainability is rated as uncertain because of a lack of evidence of maintenance of project components and dependence on a follow-on project where preparation has been delayed since 1994. Institutional development is rated as modest ~~given that~~ because the reorganization of the Ministry of Health was delayed, contentious, and is still the subject of concern as several key roles remain undefined.

4. OED rates Bank performance as unsatisfactory because of weak appraisal (noted in the ICR), and poor project supervision, as evidenced by the disconnect between the reporting of problems encountered during implementation and the status ratings. For example, in Table 13: Bank Resources: Missions, the 12/91 mission reported only moderate problems despite recognition of problems with procurement, compliance with legal covenants, and availability of funds. Project management, studies, and technical assistance were noted as particularly problematic. The 7/93 mission rated the project as problem-free yet noted problems in project management, procurement, and compliance with legal covenants. Progress on studies and technical assistance was noted as particularly problematic. Borrower performance is rated as unsatisfactory ~~due to~~ because of

Laura/Ben 4/9

I took ~~this~~
the pkg to Wendy
These are for
your project file

Jan
5:30 pm

the inconsistent levels of commitment and the persistent financial and administrative difficulties experienced during the project.

4. The ICR is unsatisfactory and could have been improved if the following points had been taken into account:

- Documentation of implementation and the project's achievements are neither detailed nor convincing. Important aspects of the project are underreported: (i) restructuring of health management and administration; (ii) decentralization of management to the district level; (iii) expansion of primary health care to the underserved Western region; (iv) enhancement of health education, nutrition and family planning programs; (v) strengthening of family health and nutrition; and (vi) monitoring and evaluation.

- To expand on the latter, a careful examination of the Annex tables show that actions were taken by the Epidemiology and Statistics Unit of the Ministry of Health, Labor and Social Welfare to review and improve the health information system, and that both a mid-term and final project evaluation took place (Table 5: Key Indicators for Project Implementation), yet these are not discussed in the text. The evaluation results are mentioned only in Table 7: Studies Included in Project, which states that the mid-term review resulted in modifications to increase health system effectiveness, and that the World Health Organization Final Project Evaluation guides preparation of future health policy and projects. From the Staff Appraisal Report, it is clear that no health outcome indicators were included in project design. However, the ICR fails to explain why monitoring and evaluation failed. Without monitoring and evaluation data, it is impossible to objectively assess the ICR claims that i) expansion of primary health care to the Western Region has considerably increased coverage of basic health services in the country; ii) the granting of semi-autonomous status to the two government hospitals substantially improved the availability and quality of tertiary health services in the country; and iii) staff morale and quality of service delivery were dramatically improved with the introduction of the cost recovery system.

- The ICR states that the project's multi-donor effort permitted substantial resource mobilization and provided the basis for extensive donor coordination. However, there is no discussion of donor coordination in the text. In addition, there is no evidence that the co-financiers were either invited to participate in the ICR mission or to review the ICR.

- The ICR contains no plan for future operation of the project, required under BP 13.55. This section should report the understanding with the borrower on the measures to maximize project benefits, the indicators for monitoring and evaluating the future operation of the project, and the Bank's follow-up actions.

Attachment

cc: Ms. Alexander (OPRDR) and Mr. de Ferranti (HDD)

THE WORLD BANK GROUP

ROUTING SLIP	DATE: May 7, 1997

NAME	ROOM. NO.
Mr. Ulrich Thumm, OEDDR	G 7-005

	URGENT		PER YOUR REQUEST
	FOR COMMENT		PER OUR CONVERSATION
	FOR ACTION		NOTE AND FILE
✓	FOR APPROVAL/CLEARANCE		FOR INFORMATION
✓	FOR SIGNATURE		PREPARE REPLY
	NOTE AND CIRCULATE		NOTE AND RETURN

RE: THE GAMBIA: National Health Development Project (Cr. 1760-GM) Implementation Completion Report

REMARKS:

Please find attached for your approval a draft Evaluative Memorandum from the DGO to the Board on the above ICR, together with a memorandum for your signature addressed to the Country Director.

This ICR was reviewed by Laura Raney.

can go to Region today's date

5/13

FROM	ROOM NO.	EXTENSION
Christopher Gibbs, OEDD1	G 7-029	31735

Mr Sladek

Ready for signature

5/13

The World Bank
Washington, D.C. 20433
U.S.A.

Office of the Director-General
Operations Evaluation

OED EVALUATIVE MEMORANDUM ON IMPLEMENTATION COMPLETION REPORT

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The objectives of the project were to (i) strengthen and expand The Gambia's national health program, including essential family planning and nutrition activities; (ii) decentralize health sector management; (iii) improve planning; and (iv) enhance cost recovery. The objectives were to be achieved through two parts: Part A was a program of reforms to strengthen health sector management, financing and support systems through decentralization, reorganization, mobilization of financial resources, and strengthening of logistical support; and Part B was a program of investments to strengthen national health care through (i) extension of primary health care to the Western Region and the Banjul peri-urban area and expansion of the communicable disease program nationwide; (ii) improvement of health facilities; (iii) improvement of nursing skills; (iv) enhancement of health education, nutrition and family planning programs; and (v) monitoring and evaluation.

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Laura:

1) I'm uncomfortable w/ the evidence you cite for supervision - ~~Getting the ratings~~ argue ~~Do~~ you think - I suggest you take out the ref to the Table - too easy to attack.

2) What other evidence do you think suggest poor supervision?

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Ulrich said to leave it in

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The World Bank
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Office of the Director-General
Operations Evaluation

The program
Six donors provided concomitant financing parallel

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All these partners

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The civil works component experienced s.d. & considerable cost overruns.

was the establishment of secondary level health delivery facilities through the upgrading/construction, equipping and staffing of eight major health centers to relieve the burden on the two tertiary level hospitals and bring basic health services closer to the population. Project investments to upgrade the technical skills of service providers including traditional community-based health providers were also achieved. Several subcomponents, however, were not achieved, namely, the expansion of primary health care to the peri-urban areas of Banjul; improvement of health, education, nutrition, and family planning services; and monitoring and evaluation. The ICR did not provide enough information to evaluate the subcomponent to strengthen family health and nutrition.

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The ICR is unsatisfactory as the documentation of implementation and the project's achievements are neither detailed nor convincing. In contrast, the Borrower's contribution provides a frank, detailed account. The ICR does not discuss donor coordination, despite the project's multidonor effort (six co-financers). In addition, the ICR does not contain a plan for future operation of the project. An audit is planned.

THE WORLD BANK/IFC/M.I.G.A.

OFFICE MEMORANDUM

5/8

DATE:

TO: Mr. Mahmood A. Ayub, Director, AFC14

FROM: Roger Slade, Acting-Director, OED

EXTENSION: 81293

SUBJECT: **THE GAMBIA: National Health Development Project (Credit 1760-GM) Implementation Completion Report**

1. Attached is a draft Evaluative Memorandum (EM) from the Director-General, Operations Evaluation, which is based on OED's review of the Implementation Completion Report (ICR). We would appreciate receiving any comments you might have by

2. Based on this review, the ratings we intend to include in the OED Annual Review database are shown below:

	OED	ICR
Outcome	**Marginally Unatisfactory**	**Satisfactory**
Sustainability	**Uncertain**	**Likely**
Institutional Development	**Modest**	**Substantial**
Bank Performance	**Unsatisfactory**	**Satisfactory**
Borrower Performance	**Unsatisfactory**	**Satisfactory**

3. OED's ratings differ from those recorded in the ICR. OED rates project outcome as marginally unsatisfactory because not all project components were achieved. Sustainability is rated as uncertain because of a lack of evidence of maintenance of project components and dependence on a follow-on project where preparation has been delayed since 1994. Institutional development is rated as modest given that the reorganization of the Ministry of Health was delayed, contentious, and still the subject of concern as several key roles remain undefined. OED rates Bank performance as unsatisfactory because of poor project supervision, as evidenced by the disconnect between the reporting of problems encountered during implementation and the status ratings. For example, in Table 13: Bank Resources: Missions, the 12/91 mission reported only moderate problems despite recognition of problems with procurement, compliance with legal covenants, and availability of funds. Project management, studies, and technical assistance were noted as particularly problematic. The 7/93 mission rated the project as problem-free yet noted problems in project management, procurement, and compliance with legal covenants. Progress on studies and technical assistance was noted as particularly problematic. Borrower performance is rated as unsatisfactory due to the inconsistent levels of support and the persistent financial and administrative difficulties experienced during the project.

4. The ICR is unsatisfactory and could have been improved if the following points had been taken into account:

- Documentation of implementation and the project's achievements are neither detailed nor convincing. Important aspects of the project are underreported: (i) restructuring of health management and administration; (ii) decentralization of management to the district level; (iii) expansion of primary health care to the underserved Western region; (iv) enhancement of health education, nutrition and family planning programs; (v) strengthening of family health and nutrition; and (vi) monitoring and evaluation.

- From the Staff Appraisal Report, it is clear that no health outcome indicators were included in project design. However, the ICR fails to explain why monitoring and evaluation failed. Without monitoring and evaluation data, it is impossible to objectively assess the ICR claims that i) expansion of primary health care to the Western Region has considerably increased coverage of basic health services in the country; ii) the granting of semi-autonomous status to the two government hospitals substantially improved the availability and quality of tertiary health services in the country; and iii) staff morale and quality of service delivery were dramatically improved with the introduction of the cost recovery system.

- The ICR states that the project's multi-donor effort (with six co-financiers) permitted substantial resource mobilization and provided the basis for extensive donor coordination. However, there is no discussion of donor coordination in the text. In addition, there is no evidence that the co-financiers were either invited to participate in the ICR mission or to review the ICR.

- The ICR contains no plan for future operation of the project, required under BP 13.55. This section should report the understanding with the borrower on the measures to maximize project benefits, the indicators for monitoring and evaluating the future operation of the project and the Bank's follow-up actions.

Attachment

cc: Ms. Alexander (OPRDR) and Mr. de Ferranti (HDD)

The World Bank
Washington, D.C. 20433
U.S.A.

Office of the Director-General
Operations Evaluation

pick up the phone to find out!

OED EVALUATIVE MEMORANDUM ON IMPLEMENTATION COMPLETION REPORT

The Gambia: National Health Development Project (Credit 1760-GM)

The Gambia National Health Development project, supported by Credit 1760-GM for SDR 4.7 million (US$5.6 million), was approved in FY87. It was the first Bank operation in the health sector in The Gambia. Following three one-year extensions, the credit was closed in June 1995. The dollar value of the credit amount disbursed (US$6.1 million) was higher than anticipated at appraisal due to changes in the US$/SDR exchange rate. Among the six co-financiers, the three largest contributors were Italy (US$9.6 million), the United Kingdom (US$6.4 million), and the Kingdom of the Netherlands (US$3.5 million). The Implementation Completion Report (ICR) was prepared by the Africa Regional Office. Annex B contains the borrower's contribution to the ICR. It is unclear whether the co-financiers were invited to participate in the ICR mission or to review the ICR.

provided w/copy but no comments received - were -

The objectives of the project were to (i) strengthen and expand The Gambia's national health program, including essential family planning and nutrition activities; (ii) decentralize health sector management; (iii) improve planning; and (iv) enhance cost recovery. The objectives were to be achieved through two parts: Part A was a program of reforms to strengthen health sector management, financing and support systems through decentralization, reorganization, mobilization of financial resources, and strengthening of logistical support; and Part B was a program of investments to strengthen national health care through (i) extension of primary health care to the Western Region and the Banjul peri-urban area and expansion of the communicable disease program nationwide; (ii) improvement of health facilities; (iii) improvement of nursing skills; (iv) enhancement of health education, nutrition and family planning programs; and (v) monitoring and evaluation.

component for support systems not achieved

Despite some delays in implementation, the program of reforms was achieved, with the exception of strengthened support services which was only partially achieved. Restructuring of health management and administration took place at the central level, and the two government hospitals (Royal Victoria and Bansang) were granted semi-autonomous status through the establishment of hospital management boards. The devolution of financial management authority took place through direct budgetary allocation. Institutional capacities of the health sector were strengthened through decentralized management at the district level, and a cost recovery system was established with improvements in the fee collection system, availability of drugs and medical supplies. The program of investments was mostly achieved, notwithstanding severe delays in the civil works components. Primary health care was extended to the Western Region, and health facilities were improved through the rehabilitation of

out? Apr 23 another info source

be more precise delete only partically?

you fell prey to the ICR language

This is not what one would normally call devolution of authority. This is like / OED where the ultimate budget authority is not with the division

see comment on Memo to Dir

essential services (water and electricity). Despite cost overruns and a slow start, a major achievement was the establishment of secondary level health delivery facilities through the upgrading/construction, equipping and staffing of eight major health centers to relieve the burden on the two tertiary level hospitals and bring basic health services closer to the population. Project investments to upgrade the technical skills of service providers including traditional community-based health providers were substantially achieved. Several subcomponents, however, were not achieved, namely, the expansion of primary health care to the peri-urban areas of Banjul; improvement of health, education, nutrition, and family planning services; and monitoring and evaluation. The ICR did not provide enough information to evaluate the subcomponent to strengthen family health and nutrition.

The Operations Evaluation Department (OED) disagrees with several of the ICR ratings. The ICR rates project outcome as satisfactory, sustainability as likely, institutional development as substantial, and Bank performance as satisfactory. OED rates project outcome as marginally satisfactory because several project objectives were not achieved; sustainability as uncertain because of lack of evidence of maintenance of project components and dependence on a follow-on project where preparation has been delayed since 1994; and Bank performance as unsatisfactory because project supervision did not recognize how much implementation difficulties were hampering the achievement of project objectives. OED agrees with the ICR rating of institutional development as substantial.

The lessons identified by the ICR suggest (i) the need for simpler project design and development; (ii) the need for up-front agreement and ownership of key policy objectives to improve quality at entry (reform elements were included during appraisal, which explains in part the delays experienced in implementing some of them); (iii) the need for improvements in project management through training and establishment of effective accounting and financial management systems prior to project effectiveness; (iv) the importance of physical integration of project coordination unit into the parent ministry; and (v) the need for monitoring and evaluation indicators at project appraisal to enable the borrower and the Bank to objectively assess project achievements and their impact.

The ICR is unsatisfactory. An audit is planned.

this is not clear at all. I think modest would be more appropriate

(3) say why, inter alia plan for future operation missing

(2) there is no discussion of donor coord despite project's multidonor effort (six cofinancers) &

(1) document of implement & the project's achievements are mentioned detailed not convincing)

THE WORLD BANK/IFC/M.I.G.A.

OFFICE MEMORANDUM

DATE:

TO: Mr. Mahmood A. Ayub, Director, AFC14

FROM: Roger Slade, Acting-Director, OED

EXTENSION: 81293

SUBJECT: **THE GAMBIA: National Health Development Project (Credit 1760-GM)**
Implementation Completion Report

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2. Based on this review, the ratings we intend to include in the OED Annual Review database are shown below:

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3. Several of OED's ratings differ from those recorded in the ICR. OED rates project outcome as marginally satisfactory because not all project components were achieved. Sustainability is rated as uncertain because of a lack of evidence of maintenance of project components and dependence on a follow-on project where preparation has been delayed since 1994. OED rates Bank performance as unsatisfactory because of poor project supervision, as evidenced by the disconnect between the reporting of problems encountered during implementation and the status ratings. For example, in Table 13: Bank Resources: Missions, the 12/91 mission reported only moderate problems despite recognition of problems with procurement, compliance with legal covenants, and availability of funds. Project management, studies, and technical assistance were noted as particularly problematic. The 7/93 mission rated the project as problem-free yet noted problems in project management, procurement, and compliance with legal covenants. Progress on studies and technical assistance was noted as particularly problematic.

Could also be marginally unsat. Make a stronger case for your rating to convince the reader

+ Comment on ID + borrower

ICR says that implement. problems were identified in attempts to address them but sufficient advice was given to address the problems to the extent possible (iii)

questionable given the ups and downs and ultimate shortcomings; look at your own penultimate para of the EVM!

4. The ICR is unsatisfactory and could have been improved if the following points had been taken into account:

- Documentation of implementation and the project's achievements are neither detailed nor convincing. Important aspects of the project are underreported: (i) restructuring of health management and administration; (ii) decentralization of management to the district level; (iii) expansion of primary health care to the undeserved Western region; (iv) enhancement of health education, nutrition and family planning programs; and (v) strengthening of family health and nutrition.

- There is almost no discussion of the monitoring and evaluation subcomponent. A careful examination of the Annex tables shows, however, that actions were taken by the Epidemiology and Statistics Unit of the Ministry of Health, Labor and Social Welfare to review and improve the health information system, and that both a mid-term and final project evaluation took place (Table 5: Key Indicators for Project Implementation), yet these are not discussed. The evaluation results are mentioned only in Table 7: Studies Included in Project, which states that the mid-term review resulted in modifications to increase health system effectiveness, and that the World Health Organization Final Project Evaluation guides preparation of future health policy and projects. From the Staff Appraisal Report, it is clear that no health outcome indicators were included in project design. However, the ICR fails to explain why monitoring and evaluation failed. Without monitoring and evaluation data, it is impossible to objectively assess the ICR claims that i) expansion of primary health care to the Western Region has considerably increased coverage of basic health services in the country; ii) the granting of semi-autonomous status to the two government hospitals substantially improved the availability and quality of tertiary health services in the country; and iii) staff morale and quality of service delivery were dramatically improved with the introduction of the cost recovery system.

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cc: Ms. Alexander (OPRDR) and Mr. de Ferranti (HDD)

The World Bank
Washington, D.C. 20433
U.S.A.

Office of the Director-General
Operations Evaluation

OED EVALUATIVE MEMORANDUM ON IMPLEMENTATION COMPLETION REPORT

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The objectives of the project were to (i) strengthen and expand The Gambia's national health program, including essential family planning and nutrition activities; (ii) decentralize health sector management; (iii) improve planning; and (iv) enhance cost recovery. The objectives were to be achieved through two parts: Part A was a program of reforms to strengthen health sector management, financing and support systems through decentralization, reorganization, mobilization of financial resources, and strengthening of logistical support; and Part B was a program of investments to strengthen national health care through: (i) extension of primary health care to the Western Region and the Banjul peri-urban area and expansion of the communicable disease program nationwide; (ii) improvement of health facilities; (iii) improvement of nursing skills; (iv) enhancement of health education, nutrition and family planning programs; and (v) monitoring and evaluation.

Despite some delays in implementation, the program of reforms was achieved, with the exception of strengthened support services which was only partially achieved. Restructuring of health management and administration took place at the central level, and the two government hospitals (Royal Victoria and Bansang) were granted semi-autonomous status through the establishment of hospital management boards. The devolution of financial management authority took place through direct budgetary allocation, institutional capacities of the health sector were strengthened through decentralized management at the district level, and a cost recovery system was established with improvements in the fee collection system, availability of drugs and medical supplies. The program of investments was mostly achieved, notwithstanding severe delays in the civil works components. Primary health care was extended to the Western Region, and health facilities were improved through the rehabilitation of essential services (water and electricity). Despite cost overruns and a slow start, a major achievement was the establishment of secondary level health delivery facilities through the upgrading/construction, equipping and staffing of eight major health centers to relieve the burden on the two tertiary level

equipping and staffing of eight major health centers to relieve the burden on the two tertiary level hospitals and bring basic health services closer to the population. Project investments to upgrade the technical skills of service providers including traditional community-based health providers were substantially achieved. Several subcomponents, however, were not achieved, namely, the expansion of primary health care to the peri-urban areas of Banjul; improvement of health, education, nutrition, and family planning services; and monitoring and evaluation. The ICR did not provide enough information to evaluate the subcomponent to strengthen family health and nutrition.

The Operations Evaluation Department (OED) disagrees with several of the ICR ratings. The ICR rates project outcome as satisfactory, sustainability as likely, institutional development as substantial, and Bank performance as satisfactory. OED rates project outcome as marginally satisfactory because several project objectives were not achieved; sustainability as uncertain because of lack of evidence of maintenance of project components and dependence on a follow-on project where preparation has been delayed since 1994; and Bank performance as unsatisfactory because of poor project supervision. OED agrees with the ICR rating of institutional development as substantial.

The lessons identified by the ICR suggest: (a) the need for simpler project design and development; (b) the need for up-front agreement and ownership of key policy objectives to improve quality at entry (reform elements were included during appraisal, which explains in part the delays experienced in implementing some of them); (c) the need for improvements in project management through training and establishment of effective accounting and financial management systems prior to project effectiveness; (d) the importance of physical integration of project coordination unit into the parent ministry; and (e) the need for monitoring and evaluation indicators at project appraisal to enable the borrower and the Bank to objectively assess project achievements and their impact.

The ICR is unsatisfactory. An audit is planned.

4/23

THE WORLD BANK GROUP

ROUTING SLIP	DATE: April 16, 1997

NAME	ROOM. NO.
Mr. Ulrich Thumm, OEDDR	G 7-005

	URGENT		PER YOUR REQUEST
	FOR COMMENT		PER OUR CONVERSATION
	FOR ACTION		NOTE AND FILE
✓	FOR APPROVAL/CLEARANCE		FOR INFORMATION
✓	FOR SIGNATURE		PREPARE REPLY
	NOTE AND CIRCULATE		NOTE AND RETURN

RE: THE GAMBIA: National Health Development Project (Cr. 1760-NIR)
Implementation Completion Report

REMARKS:

Please find attached for your approval a draft Evaluative Memorandum from the DGO to the Board on the above ICR, together with a memorandum for your signature addressed to the Country Director.

This ICR was reviewed by Laura Raney.

FROM	ROOM NO.	EXTENSION
Josette Murphy, OEDD1	G 7-043	31726

→ Mr Slade
I have major difficulties. See comments in the text, particularly ratings
4/25

The World Bank
Washington, D.C. 20433
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Operations Evaluation

pick up the phone to find out!

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be more precise

you fell prey to the ICR language

This is not what one would normally call devolution of authority. That is false / OED where the ultimate budget authority is not with the district

see comment on memo to Dir

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↑

say why; inter alia plan for future operation missing

this is not clear at all. I think modest would be more appropriate

more thorough - SEO

Borrowers central discusses eval results, not found in text of ICR.

THE WORLD BANK/IFC/M.I.G.A.

OFFICE MEMORANDUM

DATE:

TO: Mr. Mahmood A. Ayub, Director, AFC14

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EXTENSION: 81293

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✓

modest

+Comment on ID +borrower

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Attachment

cc: Ms. Alexander (OPRDR) and Mr. de Ferranti (HDD)

THE WORLD BANK GROUP

ROUTING SLIP	DATE: April 14, 1997

NAME	ROOM. NO.
Mr. Ulrich Thumm, OEDDR	G 7-005

	URGENT		PER YOUR REQUEST
	FOR COMMENT		PER OUR CONVERSATION
	FOR ACTION		NOTE AND FILE
✓	FOR APPROVAL/CLEARANCE		FOR INFORMATION
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This ICR was reviewed by Laura Raney.

FROM	ROOM NO.	EXTENSION
Josette Murphy, OEDD1	G 7-043	31726

Laura
see a ~~copy~~ couple
of questions in
EVT summary -
& let's talk
quickly,
Thanks
Jantra

Josette's
comments

The World Bank
Washington, D.C. 20433
U.S.A.

Office of the Director-General
Operations Evaluation

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of food.

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did co-financiers comment?

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the sections

how much

~~that~~

did not recognize ~~it~~

~~it~~ s implementation

difficulties were ~~further~~ hampering

the achievement of project

objectives -

THE WORLD BANK/IFC/M.I.G.A.

OFFICE MEMORANDUM

DATE:

TO: Mr. Mahmood A. Ayub, Director, AFC14

FROM: Roger Slade, Acting-Director, OED

EXTENSION: 81293

SUBJECT: **THE GAMBIA: National Health Development Project (Credit 1760-GM) Implementation Completion Report**

1. Attached is a draft Evaluative Memorandum (EM) from the Director-General, Operations Evaluation, which is based on OED's review of the Implementation Completion Report (ICR). We would appreciate receiving any comments you might have by

2. Based on this review, the ratings we intend to include in the OED Annual Review database are shown below:

	OED	ICR
Outcome	**Marginally Satisfactory**	**Satisfactory**
Sustainability	**Uncertain**	**Likely**
Institutional Development	**Substantial**	**Substantial**
Bank Performance	**Unsatisfactory**	**Satisfactory**
Borrower Performance	**Satisfactory**	**Satisfactory**

of maintenance of project components and dependence on a follow-on project where preparation has been delayed since 1994.

3. Several of OED's ratings differ from those recorded in the ICR. OED rates project outcome as marginally satisfactory because not all project components were achieved. Sustainability is rated as uncertain because of a lack of evidence that the project investments will ~~be sustained, due in part to the continued delays in the preparation of the follow-up project which~~ can be attributed to external shocks (the 1994 coup d'état and major changes in the ~~administration of the Ministry of Health, Labor and Social Welfare~~). OED rates Bank performance as unsatisfactory because of poor project supervision, as evidenced ~~but~~ by the disconnect between ... [Megan, move para from p 2 here please.]

4. The ICR is unsatisfactory and could have been improved if the following points had been taken into account:

- Documentation of implementation and the project's achievements are neither detailed nor convincing. Important aspects of the project are underreported: (i) restructuring of health management and administration; (ii) decentralization of management to the district level; (iii) expansion of primary health care to the

underserved Western region; (iv) enhancement of health education, nutrition and family planning programs; and (v) strengthening of family health and nutrition.

- There is almost no discussion of the monitoring and evaluation subcomponent. A careful examination of the Annex tables shows, however, that actions were taken by the Epidemiology and Statistics Unit of the Ministry of Health, Labor and Social Welfare to review and improve the health information system, and that both a mid-term and final project evaluation took place (Table 5: Key Indicators for Project Implementation), yet these are not discussed. The evaluation results are mentioned only in Table 7: Studies Included in Project, which states that the mid-term review resulted in modifications to increase health system effectiveness, and that the World Health Organization Final Project Evaluation guides preparation of future health policy and projects. From the Staff Appraisal Report, it is clear that no health outcome indicators were included in project design. However, the ICR fails to explain why monitoring and evaluation failed. Without monitoring and evaluation data, it is impossible to objectively assess the ICR claims that i) expansion of primary health care to the Western Region has considerably increased coverage of basic health services in the country; ii) the granting of semi-autonomous status to the two government hospitals substantially improved the availability and quality of tertiary health services in the country; and iii) that staff morale and quality of service delivery were dramatically improved with the introduction of the cost recovery system.

- There appears to be a disconnect between the reporting of problems encountered during implementation and the status ratings. For example, in Table 13: Bank Resources: Missions, the 12/91 mission reported only moderate problems despite recognition of problems with procurement, compliance with legal covenants, and availability of funds. Project management, studies, and technical assistance were noted as particularly problematic. The 7/93 mission was rated as problem-free yet noted problems in project management, procurement, and compliance with legal covenants. Progress on studies and technical assistance was noted as particularly problematic.

- The ICR states that the project's multi-donor effort (with six co-financers) permitted substantial resource mobilization and provided the basis for extensive donor coordination; however, there is no discussion of donor coordination in the text. In addition, there is no evidence that the co-financers were either invited to participate in the ICR mission or to review the ICR.

- The ICR contains no plan for future operation of the project, required under BP 13.55. This section should report the understanding with the borrower on the measures to maximize project benefits, the indicators for monitoring and evaluating future operations, and the Bank's follow-up actions.

Attachment

cc: Ms. Alexander (OPRDR) and Mr. de Ferranti (HDD)

THE WORLD BANK GROUP

ROUTING SLIP	DATE: [DATE]

NAME	ROOM. NO.
Mr. Ulrich Thumm, OEDDR	G 7-005

	URGENT		PER YOUR REQUEST
	FOR COMMENT		PER OUR CONVERSATION
	FOR ACTION		NOTE AND FILE
✓	FOR APPROVAL/CLEARANCE		FOR INFORMATION
✓	FOR SIGNATURE		PREPARE REPLY
	NOTE AND CIRCULATE		NOTE AND RETURN

RE: THE GAMBIA: National Health Development Project (Cr. 1760-NIR) Implementation Completion Report

REMARKS:

Please find attached for your approval a draft Evaluative Memorandum from the DGO to the Board on the above ICR, together with a memorandum for your signature addressed to the Country Director.

This ICR was reviewed by Laura Raney.

FROM	ROOM NO.	EXTENSION
Christopher Gibbs, OEDD1	G 7-029	31735

The World Bank
Washington, D.C. 20433
U.S.A.

Office of the Director-General
Operations Evaluation

[Date]

your OIS comments

OED EVALUATIVE MEMORANDUM ON IMPLEMENTATION COMPLETION REPORT

The Gambia: National Health Development Project (Credit 1760-GM)

The dollar value of the cofinancing?

The Gambia National Health Development project, supported by Credit 1760-GM for SDR 4.7 million (US$5.6 million), was approved in FY87. It was the first Bank operation in the health sector in The Gambia. Following three one-year extensions, the credit was closed in June 1995. ~~Total~~ credit amount disbursed (US$6.1 million) was higher than anticipated at appraisal due to changes in the US$/SDR exchange rate. The Implementation Completion Report (ICR) was prepared by the Africa Regional Office. Annex B contains the borrower's contribution to the ICR. ~~Report from~~ Comments of cofinanciers?

The objectives of the project were to (i) strengthen and expand The Gambia's national health program, including essential family planning and nutrition activities; (ii) decentralize health sector management; (iii) improve planning; and (iv) enhance cost recovery. The objectives were to be achieved through two parts: Part A was a program of reforms to strengthen health sector management, financing and support systems through decentralization, reorganization, mobilization of financial resources, and strengthening of logistical support; and Part B was a program of investments to strengthen national health care through: (i) extension of primary health care to the Western Region and ~~to~~ the Banjul peri-urban area and expansion of the communicable disease program nationwide; (ii) improvement of health facilities; (iii) improved nursing skills; (iv) enhanced health education, nutrition and family planning programs; and (v) monitoring and evaluation.

-ment of

-ment of

Despite delays in implementing some ~~of the reform elements~~, the program of reforms was achieved, with the exception of ~~the~~ support services which ~~were~~ HRD only partially achieved. Restructuring of health management and administration took place at the central level, and the two government hospitals (Royal Victoria and Bansang) were granted semi-autonomous status through the establishment of hospital management boards. The devolution of financial management authority took place through direct budgetary allocation, institutional capacities of the health sector were strengthened through decentralized management at the district level, and a cost recovery system was established with improvements in the ~~existing~~ fee collection system, availability of drugs and medical supplies. The program of investments was mostly achieved, notwithstanding severe delays in the civil works components. Primary health care was extended to the Western Region, and health facilities were improved through the rehabilitation of essential services (water and electricity). Despite cost overruns and a slow start, a major achievement ~~of the project~~ was the establishment of secondary level health

strengthened

delivery facilities through the upgrading/construction, equipping and staffing of eight major health centers to relieve the burden on the two tertiary level hospitals and bring basic health services closer to the population. Project investments to upgrade the technical skills of service providers including traditional community-based health providers were substantially achieved. Several subcomponents, however, were not achieved, namely, the expansion of primary health care to the peri-urban areas of Banjul; health, education, nutrition and family planning; and monitoring and evaluation. The ICR did not provide enough information to evaluate the subcomponent ~~on~~ to strengthening family health and nutrition.

The Operations Evaluation Department (OED) ~~does not agree~~ disagrees with the ICR ~~in the project~~ ratings. ~~Project outcome has been downgraded from satisfactory to marginally satisfactory as not all project~~ components were achieved. Sustainability has been changed from likely to uncertain due to the lack of evidence of maintenance of the investments and the stated dependence on the follow-up Bank-assisted project whose preparation has been delayed since the 1994 coup d'etat. Bank performance has been downgraded from satisfactory to unsatisfactory due to poor project supervision. OED agrees with the ~~ICR in rating institutional development~~ as substantial.

The lessons identified by the ICR suggest: (a) the need for simpler project design and development; (b) the need for up-front agreement/ownership/~~implementation~~ of key policy objectives to improve quality at entry (reform elements were included during appraisal, which explains in part the delays experience in implementing some of the ~~reform elements~~); (c) the need for improvements in project management through training and establishment of effective accounting and financial management systems prior to project effectiveness; (d) the importance of physical integration of project coordination unit into the parent ministry; and (e) the need for monitoring and evaluation indicators at project appraisal to enable the borrower and the Bank to objectively assess project achievements and their impact.

The ICR is unsatisfactory. An audit is planned.

The ICR rates project outcome as satisfactory, sustainability as likely, institutional development as substantial, and Bank performance as satisfactory. OED rates project outcome as marginally satisfactory because several project objectives were not achieved; sustainability as uncertain because of lack of evidence of maintenance of project components and dependence on a follow-on project where preparation has been delayed since 1994; and Bank performance as unsatisfactory because of poor project supervision. ~~Adequate~~ OED agrees with the ICR rating of institutional development as substantial.

THE WORLD BANK/IFC/M.I.G.A.

OFFICE MEMORANDUM

DATE: [Date]

TO: Mr. Mahmood A. Ayub, Director, AFC14

FROM: Roger Slade, Acting-Director, OED

EXTENSION: 81293

SUBJECT: **THE GAMBIA: National Health Development Project (Credit 1760-GM)**
Implementation Completion Report

1. Attached is a draft Evaluative Memorandum (EM) from the Director-General, Operations Evaluation, which is based on OED's review of the Implementation Completion Report (ICR). We would appreciate receiving any comments you might have by

2. Based on this review, the ratings we intend to include in the OED Annual Review database are shown below:

	OED	ICR
Outcome	**Marginally Satisfactory**	**Satisfactory**
Sustainability	**Uncertain**	**Likely**
Institutional Development	**Substantial**	**Substantial**
Bank Performance	**Unsatisfactory**	**Satisfactory**
Borrower Performance	**Satisfactory**	**Satisfactory**

3. ~~Some~~ Several OED's of ~~the~~ ratings differ from those ~~indicated~~ recorded in the ICR. Project outcome ~~is rated~~ OED rates as marginally satisfactory because not all project components were achieved. Sustainability ~~has been changed from likely to~~ is rated as uncertain because ~~as there is~~ a lack of evidence that the project investments will be sustained ~~in the future~~, due in part to the continued delays in the preparation of the follow-up project which can be attributed to external shocks (the 1994 coup d'etat and major changes in the administration of the Ministry of Health, Labor and Social Welfare). OED rates Bank performance as unsatisfactory because of poor project supervision. see the EM. *(Improved supervision could have ....

4. The ICR is unsatisfactory and could have been improved if the following points had been taken into account:

- Documentation of implementation and the project's achievements are neither detailed nor convincing. Important aspects of the project are underreported: (i) restructuring of health management and administration; (ii) decentralized ~~management~~ trial of ~~at~~ to the district level; (iii) expansion of primary health care to the

underserved Western region; (iv) enhanced health education, nutrition and family planning programs; and (v) strengthening of family health and nutrition.

- With the exception of stating that the project could have benefited from more specific performance criteria for monitoring project objectives and baseline data for setting realistic indicators, there is no discussion in the text of the monitoring and evaluation subcomponent. A careful examination of the Annex tables shows, however, that actions were taken by the Epidemiology and Statistics Unit of the Ministry of Health, Labor and Social Welfare to review and improve the health information system, and that both a mid-term and final project evaluation took place (Table 5: Key Indicators for Project Implementation), yet these are not discussed in the text. The evaluation results are mentioned only in Table 7: Studies Included in Project, which states that the mid-term review enabled decisions on project modifications to increase effectiveness, and that the World Health Organization Final Project Evaluation guides preparation of future health policy and projects. From the Staff Appraisal Report, it is clear that no health outcome indicators were included in project design. However, lack of information in the ICR on this subcomponent renders it impossible to ascertain the reasons for the failure of systematic monitoring and evaluation. Without such data, it is impossible to objectively assess the ICR claims that i) expansion of primary health care to the Western Region has considerably increased coverage of basic health services in the country; ii) the granting of semi-autonomous status to the two government hospitals substantially improved the availability and quality of tertiary health services in the country; and iii) that staff moral and quality of service delivery were dramatically improved with the introduction of the cost recovery system.

- There appears to be a major disconnect between the reporting of problems encountered during implementation and the status ratings. For example, in Table 13: Bank Resources: Missions, the 12/91 mission reported moderate problems yet identified problems with procurement process, compliance with legal covenants, and availability of funds, and noted that project management performance, studies progress, and technical assistance were particularly problematic. The 7/93 mission was rated as problem free yet noted problems in project management performance, procurement progress, compliance with legal covenants and particularly problematic studies progress and technical assistance.

- The ICR states that the project's multi-donor effort (with six co-financers) permitted substantial resource mobilization and provided the basis for extensive donor coordination, however, there is no discussion of donor coordination in the text. In addition, there is no evidence that the co-financers were either invited to participate in the ICR mission or to review the ICR.

- There is no plan for future operation of the project, which is required under BP 13.55. This section should include understanding with the borrower on the measures to maximize the project benefits, the indicators for monitoring and evaluating future operations, and the Bank's follow-up actions.

Attachment

cc: Ms. Alexander (OPRDR) and Mr. de Ferranti (HDD)

The World Bank
Washington, D.C. 20433
U.S.A.

Office of the Director-General
Operations Evaluation

[Date]

OED EVALUATIVE MEMORANDUM ON IMPLEMENTATION COMPLETION REPORT

The Gambia: National Health Development Project (Credit 1760-GM)

The Gambia National Health Development project, supported by Credit 1760-GM for SDR 4.7 million (US$5.6 million), was approved in FY87. It was the first Bank operation in the health sector in The Gambia. Following three one-year extensions, the credit was closed in June 1995. Total credit amount disbursed (US$6.1 million) was higher than anticipated at appraisal due to changes in the US$/SDR exchange rate. The Implementation Completion Report (ICR) was prepared by the Africa Regional Office. Annex B contains the borrower's contribution to the ICR.

The objectives of the project were to (i) strengthen and expand The Gambia's national health program, including essential family planning and nutrition activities; (ii) decentralize health sector management; (iii) improve planning; and (iv) enhance cost recovery. The objectives were to be achieved through two parts: Part A was a program of reforms to strengthen health sector management, financing and support systems through decentralization, reorganization, mobilization of financial resources, and strengthening of logistical support; and Part B was a program of investments to strengthen national health care through: (i) extension of primary health care to the Western Region and to the Banjul peri-urban area and expansion of the communicable disease program nationwide; (ii) improvement of health facilities; (iii) improved nursing skills; (iv) enhanced health education, nutrition and family planning programs; and (v) monitoring and evaluation.

Despite delays in implementing some of the reform elements, the program of reforms was achieved with the exception of the support services. Restructuring of health management and administration took place at the central level with the integration of the technical and administrative wings of the Ministry of Health, Labor and Social Welfare. The granting of semi-autonomous status to the two Government hospitals (Royal Victoria and Bansang) through the establishment of hospital management boards, and the devolution of financial management authority through direct budgetary allocation took place and substantially improved the availability and quality of tertiary health services in the country. Institutional capacities of the health sector were strengthened through decentralized management at the district level. A cost recovery system was established with improvements in the existing fee collection system, availability of drugs and medical supplies. Staff moral and quality of service delivery were dramatically improved, although the level of revenue generated by the system was below expectations (35 percent compared to expected 100 percent). Reasons for the low level of revenue

collected included the fact that over 60 percent of the beneficiaries were exempted from fees with a reluctance on the part of the government to change this policy for political reasons, and resistance from the Treasury to permit retention of user charges at the points of collection. Goals under the support services subcomponent were only partially achieved due to changes in the management and withdrawal of ODA technical assistance. Technical difficulties, lack of training and capacity to supervise the maintenance of the equipment led to rapid deterioration of the communication network put in place under the project.

The program of investments was mostly achieved, despite severe delays in the civil works components. National health services were strengthened by the extension of primary health care to the Western Region. In addition, health facilities were improved through the rehabilitation of essential services (water and electricity). Despite cost overruns (due to inadequate physical specifications and an underestimation of contingencies) and a slow start, a major achievement of the project was the establishment of secondary level health delivery facilities through the upgrading/construction, equipping and staffing of eight major health centers to relieve the burden on the two tertiary level hospitals and bring basic health services closer to the population. Project investments to upgrade the technical skills of service providers including traditional community-based health providers were substantially achieved. The two training programs for nurses established under the project were highly commended by the Western African College of Surgeons and WHO for their effective and appropriate response to the local situation. Several subcomponents, however, were not achieved, namely, the expansion of primary health care to the peri-urban areas of Banjul; health, education, nutrition and family planning; and monitoring and evaluation. The ICR did not provide enough information to evaluate the subcomponent on strengthening family health and nutrition.

The Operations Evaluation Department (OED) does not agree with the ICR in the project ratings. Project outcome has been downgraded from satisfactory to marginally satisfactory as not all project components were achieved. Sustainability has been changed from likely to uncertain due to the lack of evidence of maintenance of the investments and the stated dependence on the follow-up Bank-assisted project whose preparation has been delayed since the 1994 coup d'etat. Bank performance has been downgraded from satisfactory to unsatisfactory due to poor project supervision. OED agrees with the ICR in rating institutional development as substantial.

The lessons identified by the ICR suggest: (a) the need for simpler project design and development; (b) the need for up-front agreement/ownership/implementation of key policy objectives to improve quality at entry (reform elements were included during appraisal, which explains in part the delays experience in implementing some of the reform elements); (c) the need for improvements in project management through training and establishment of effective accounting and financial management systems prior to project effectiveness; (d) the importance of physical integration of project coordination unit into the parent ministry; and (e) the need for monitoring and evaluation indicators at project appraisal to enable the borrower and the Bank to objectively assess project achievements and their impact.

The ICR is unsatisfactory. An audit is planned.

THE WORLD BANK/IFC/M.I.G.A.

OFFICE MEMORANDUM

DATE: [Date]

TO: Mr. Mahmood A. Ayub, Director, AFC14

FROM: Roger Slade, Acting-Director, OED

EXTENSION: 81293

SUBJECT: **The Gambia—National Health Development Project (Credit 1760-GM)**
Implementation Completion Report

1. Attached is a draft Evaluative Memorandum (EM) from the Director-General, Operations Evaluation, which is based on OED's review of the Implementation Completion Report (ICR). We would appreciate receiving any comments you might have by

2. Based on this review, we intend to include ~~the following ratings~~ in the OED Annual Review database~~:~~

	OED	ICR
Outcome:	Marginally Satisfactory	Satisfactory
Sustainability:	Uncertain	Likely
Institutional Development:	Substantial	Substantial
Bank Performance:	Unsatisfactory	Satisfactory
Borrower Performance:	Satisfactory	Satisfactory

3. The above ratings differ from those indicated in the ICR for outcome as not all project components were achieved. Sustainability has been changed from likely to uncertain as there is a lack of evidence that the project investments will be sustained in the future, due in part to the continued delays in the preparation of the follow-up project which can be attributed to external shocks (the 1994 coup d'etat and major changes in the administration of the Ministry of Health, Labor and Social Welfare). Bank performance has been downgraded from satisfactory to unsatisfactory due to poor project supervision.

4. In keeping with OED's policy to provide feedback to operational staff on ICRs, to improve their quality, I have the following comments on the ICR:

- The ICR is unsatisfactory. Documentation of implementation and the project's achievements neither detailed nor convincing. Important aspects of the project are underreported: (i) restructuring of health management and administration; (ii) decentralized management at the district level; (iii) expansion of primary health care to the underserved Western region; (iv) enhanced health education, nutrition and family planning programs; and (v) strengthening family health and nutrition.

- With the exception of stating that the project could have benefited from more specific performance criteria for monitoring project objectives and baseline data for setting realistic indicators, there is no discussion in the text of the monitoring and evaluation subcomponent. A careful examination of the Annex tables shows, however, that actions were taken by the Epidemiology and Statistics Unit of the Ministry of Health, Labor and Social Welfare to review and improve the health information system, and that both a mid-term and final project evaluation took place (Table 5: Key Indicators for Project Implementation), yet these are not discussed in the text. The evaluation results are mentioned only in Table 7: Studies Included in Project, which states that the mid-term review enabled decisions on project modifications to increase effectiveness, and that the WHO Final Project Evaluation guides preparation of future health policy and projects. Lack of information in the ICR on this subcomponent renders it impossible to know the reasons for the failure of systematic monitoring and evaluations. From the Staff Appraisal Report, it is clear that no health outcome indicators were included in project design but it is not know why the project was not modified to enable collection of data. Without such data it is impossible to objectively assess the ICR claims that i) expansion of primary health care to the Western Region has considerably increased coverage of basic health services in the country; ii) the granting of semi-autonomous status to the two government hospitals substantially improved the availability and quality of tertiary health services in the country; and iii) that staff moral and quality of service delivery were dramatically improved with the introduction of the cost recovery system.

- There appears to be a major disconnect between the reporting of problems encountered during implementation and the status ratings. For example, in Table 13: Bank Resources: Missions, the 12/91 mission reported moderate problems yet identified problems with procurement process, compliance with legal covenants, availability of funds, and noted that project management performance, studies progress, and technical assistance were particularly problematic. The 7/93 mission was rated as problem free yet noted problems in project management performance, procurement progress, compliance with legal covenants and particularly problematic studies progress and technical assistance.

- The ICR states that the project's multi-donor effort (with six co-financers) permitted substantial resource mobilization and provided the basis for extensive donor coordination, however, there is no discussion of donor coordination in the text. In addition, there is no evidence that the co-financers were either invited to participate in the ICR mission or review the ICR.

- There is no plan for future operation of the project, which is required under BP 13.55. This section should include understanding with the borrower on the measures to maximize the project benefits, the indicators for monitoring and evaluating future operations, and the Bank's follow-up actions.

An audit is planned.

Attachment

cc: Ms. Alexander (OPRDR) and Mr. de Ferranti (HDD)

SAR – The Gambia C1760

① Reforms 3.7
② Strength 15.6

Supervision – bad – based on disconnect in ratings

Author of ICR Points finger at appraisal saying IP's bad

① Reforms
Drugs & Supplies
Vehicles
Radio system

② Nat'l Ext. of VHS
Mat. Care + FP initiatives
Strength Nutr.
Health Ed.
Nurse Training
M & E
Rehabil of Health Fac.
PMU

Invest		Recurrent	
Civil works	12.8	Sal.	.18
Equip	0.7	Fuel	.22
Vehicl	0.4		.4
TA	2.2		
Training	0.5		
Mat	0.2		
Drug & Suppl	1.9		
Op research	0.07		
PPF	.4		
	19.2		

more info in tables
prem text

Reforms

Central Reorganiz
Reorgan of MoH
Hosp. semi-autom.

Decentraliz
Regional Health Teams

CR
Transport services
Comm. network

Invest

Exp. of PHC - 53 villages → 80
Improv. health facil
Streng. fin & mgt.
Nurses training
- health ed, mgt of Epi
M & E
proj mgmt

THE WORLD BANK/IFC/M.I.G.A.

OFFICE MEMORANDUM

(1st version, before PIP)

DATE: [Date]

TO: Mr. Mahmood A. Ayub, Director, AFC14

FROM: Roger Slade, Acting-Director, OED

EXTENSION: 81293

SUBJECT: **The Gambia—National Health Development Project (Credit 1760-GM) Implementation Completion Report**

1. Attached is a draft Evaluative Memorandum (EM) from the Director-General, Operations Evaluation, which is based on OED's review of the Implementation Completion Report (ICR). We would appreciate receiving any comments you might have by

2. Based on this review, we intend to include the following ratings in the OED Annual Review database:

	OED	ICR
Outcome:	Satisfactory	Satisfactory
Sustainability:	Likely	Uncertain
Institutional Development:	Substantial	Substantial
Bank Performance:	Satisfactory	Satisfactory
Borrower Performance:	Satisfactory	Satisfactory

3. The above ratings differ from those indicated in the ICR for Sustainability as there is a lack of evidence that the project investments will be sustained in the future, due in part to the continued delays in the preparation of the follow-up project which can be attributed to external shocks (the 1994 coup d'etat and major changes in the administration of the Ministry of Health, Labor and Social Welfare).

4. In keeping with OED's policy to provide feedback to operational staff on ICRs, to improve their quality, I have the following comments on the ICR:

- The ICR is generally satisfactory. Documentation of implementation and the project's physical achievements is detailed and thorough. But two important

aspects of the project appear underreported: (a) expansion of PHC to the underserved Western region; (b)enhanced health education, nutrition and family planning programs.

- There appears to be a major disconnect between the reporting of problems encountered during implementation and the status ratings. For example, in Table 13: Bank Resources: Missions, the 12/91 mission reported moderate problems yet identified problems with procurement process, compliance with legal covenants, availability of funds, and noted that project management performance, studies progress, and technical assistance were particularly problematic. The 7/93 mission was rated as problem free yet noted problems in project management performance, procurement progress, compliance with legal covenants and particularly problematic studies progress and technical assistance.

- Other than stating that the project could have benefited from more specific performance criteria for monitoring project objectives and baseline data for setting realistic indicators, the ICR does discuss the monitoring and evaluation sub-component. Through a careful examination of the Annex tables, however, one can see that actions were taken by the Epidemiology and Statistics Unit of the Ministry of Health, Labor and Social Welfare to review and improve the health information system and that both a mid-term and final project evaluation took place. (Table 5: Key Indicators for Project Implementation) The only mention of the evaluation results appears in Table 7: Studies Included in Project, which states that the mid-term review enabled decisions on project modifications to increase effectiveness, and that the WHO Final Project Evaluation guides preparation of future health policy and projects.

- It is unfortunate that the original design of the project, which included no health outcome indicators, was not modified to enable collection of data. As such, thus there is no way to objectively assess the claims of the ICR that expansion of PHC to the Western Region has considerably increased coverage of basic health services in the country nor that the granting of semi-autonomous status to the tow government hospitals substantially improved the availability and quality of tertiary health services in the country.

- Despite the fact that the ICR states that the project's multi-donor effort (with six co-financers) permitted substantial resource mobilization and provided the basis for extensive donor coordination there is no discussion of this important issue in the text, nor is there any evidence that the co-financers were invited to participate in the ICR mission or review the ICR.

- There is no plan for future operation of the project, including maintenance of physical facilities and monitoring of reform efforts.

Attachment

cc: Ms. Alexander (OPRDR) and Mr. de Ferranti (HDD)

The World Bank
Washington, D.C. 20433
U.S.A.

Office of the Director-General
Operations Evaluation

[Date]

OED EVALUATIVE MEMORANDUM ON IMPLEMENTATION COMPLETION REPORT

The Gambia: National Health Development Project (Credit 1760-GM)

The Gambia National Health Development project, supported by Credit 1760-GM for SDR4.7 million (US$5.6 million equivalent), was approved in FY87. It was the first Bank operation in the health sector in The Gambia. Following three one-year extensions, the credit was closed in June 1995. Total credit amount disbursed (US$6.1 million) was higher than anticipated at appraisal due to change sin the US$/SDR exchange rate. The Implementation Completion Report (ICR) was prepared by the Africa Regional Office. Annex B contains the borrower's contribution to the ICR.

The objectives of the project were to (i) strengthen and expand The Gambia's national health program, including essential family planning and nutrition activities; (ii) decentralize health sector management; (iii) improve planning; and (iv) enhance cost recovery. The objectives were to be achieved through two parts: Part A was a program of reforms to strengthen health sector management, financing and support systems through decentralization, reorganization, mobilization of financial resources, and strengthening of logistical support; and Part B was a program of investments to strengthen national health care through: (i) extension of PHC to the Western Region and to the Banjul peri-urban area and expansion of the communicable disease program nationwide; (ii) improvement of health facilities; (iii) improved nursing skills; (iv) enhanced health education, nutrition and family planning programs; and (v) monitoring and evaluation.

The project successfully met almost all of its objectives. Despite some delays in implementing some of the reform elements, the program of reforms was achieved with the exception of the support services. Restructuring of health management and administration took place at the central level with the integration of the technical and administrative wings of the Ministry of Health, Labor and Social Welfare. The granting of semi-autonomous status to the two Government hospitals (Royal Victoria and Bansang) through the establishment of hospital management boards and the devolution of financial management authority through direct budgetary allocation substantially improved the availability and quality of tertiary health services in the country. Institutional capacities of the health sector were strengthened through decentralized management at the district level. A cost recovery system was established with improvements in the existing fee collection system, availability of drugs and medical supplies. Staff moral and quality of service delivery were dramatically improved, although the level of revenue generated by the system was below expectations (35 percent compared to expected 100 percent).

Reasons for the low level of revenue collected included the fact that over 60 percent of the beneficiaries were exempted from fees with a reluctance on the part of the government to change this policy for political reasons, and resistance from the Treasury to permit retention of user charges at the points of collection. Goals under the support services subcomponent were only partially achieved due to changes in the management and withdrawal of ODA technical assistance. Technical difficulties, lack of training and capacity to supervise the maintenance of the equipment led to rapid deterioration of the communication network.

The program of investments was substantially achieved, despite severe delays in the civil works components. National health services were strengthened by the extension of PHC to the Western Region. In addition, health facilities were improved through the rehabilitation of essential services (water and electricity). Despite cost overruns (due to inadequate physical specifications and an underestimation of contingencies) and a slow start, a major achievement of the project was the establishment of secondary level health delivery facility through the upgrading/construction, equipping and staffing of eight major health centers to relieve the burden on the two tertiary level hospitals and bring basic health services closer to the population. Project investments to upgrade the techn cial skills of service providers including traditional community-based health providers were substantially achieved. The two training programs for nurses established under the project were highly commended by the Western African College of Surgeons and WHO for their effective and appropriate response to the local situation. The expansion of PHC to the peri-urban areas of Banjul was not achieved nor was the health, education, nutrition and family planning subcomponent.

The Operations Evaluation Department (OED) agrees with the ICR in rating project outcome as satisfactory, institutional development as substantial, and Bank performance as satisfactory. Sustainability has been changed to uncertain due to the lack of evidence of maintenance of the investments and the stated dependence on the follow-up Bank-assisted project whose preparation has been delayed since the 1994 coup d'etat.

The lessons identified by the ICR suggest: (a) the need for simpler project design and development; (b) the need for up-front agreement/ownership/implementation of key policy objectives to improve quality at entry (reform elements were included during appraisal, which explains in part the delays experience in implementing some of the reform elements; (c) the need for improvements in project management through training and establishment of effective accounting and financial management systems prior to project effectiveness; and (d) the importance of physical integration of project coordination unit into the parent ministry.

The ICR is satisfactory. No audit is planned.

Office of the Director-General
Operations Evaluation

Review & Send to Angelika

3-24 to Jacenting (see Chron) keep notes? Where?

 [Date]

OED EVALUATIVE MEMORANDUM
ON IMPLEMENTATION COMPLETION REPORT

The Gambia: National Health Development Project (Credit 1760-GM)

The Gambia National Health Development project, supported by Credit 1760-GM for SDR4.7 million (US$5.6 million equivalent), was approved in FY87. It was the first Bank operation in the health sector in The Gambia. Following three ~~one~~-year extensions, the credit was closed in June 1995. Total credit amount disbursed (US$6.1 million) was higher than anticipated at appraisal due to change sin the US$/SDR exchange rate. The Implementation Completion Report (ICR) was prepared by the Africa Regional Office. Annex B contains the borrower's contribution to the ICR.

The objectives of the project were to (i) strengthen and expand The Gambia's national health program, including essential family planning and nutrition activities; (ii) decentralize health sector management; (iii) improve planning; and (iv) enhance cost recovery. The objectives were to be achieved through two parts: Part A was a program of reforms to strengthen health sector management, financing and support systems through decentralization, reorganization, mobilization of financial resources, and strengthening of logistical support; and Part B was a program of investments to strengthen national health care through: (i) extension of PHC to the Western Region and to the Banjul peri-urban area and expansion of the communicable disease program nationwide; (ii) improvement of health facilities; (iii) improved nursing skills; (iv) enhanced health education, nutrition and family planning programs; and (v) monitoring and evaluation.

The project successfully met almost all of its objectives. The program of reforms was ~~substantially~~ partially achieved, with the exception of the support services. Restructuring of health management and administration took place at the central level. The integration of the technical and administrative wings of the MoH has led to greater cohesion in planning and coordination of public health services ~~at the central level~~. The granting of semi-autonomous status to the two Government hospitals (Royal Victoria and Bansang) through the establishment of hospital management boards and the devolution of financial management authority through direct budgetary allocation substantially improved the availability and quality of tertiary health services in the country. The hospitals improved not only their daily management but also have access to private funding, and have greater assurance of drugs and supplies. Personnel management autonomy allowed hospitals to offer incentives outside the civil service structure, lending to improved recruitment and retention of staff, a problem that continues to plague the rest of The Gambia civil service.

Institutional capacities of the health sector were strengthened through decentralized management at the district level and financial resource mobilization. An effective cost recovery system was established with improvements in the existing fee collection system, availability of drugs and medical supplies. Staff moral and quality of service delivery were dramatically improved, although the level of revenue generated by the system was below expectations (35 percent compared to expected 100 percent). One reason for the low level of revenue collected was that over 60 percent of the beneficiaries were exempted from fees, and a reluctance on the part of the government to change this policy for political reasons. In addition, resistance from the Treasury to permit retention of user charges at the points of collection rendered full cost recovery impossible. Goals under the support services subcomponent were only partially achieved due to changes in the management and withdrawal of ODA technical assistance. Technical difficulties, lack of training and capacity to supervise the maintenance of the equipment led to rapid deterioration of the communication network. The Inter-ministerial Project Implementation Committee (PIC) with oversight functions in the management of the Project, and a Sub-committee on Family Health and Nutrition (SCFHN) did not function as planned. With frequent changes in the membership and infrequent meetings, the PIC became increasingly ineffective and ceased to function by the end of the second year. The SCFHN functioned poorly due to lack of effective leadership and eventually its functions were de facto taken over by the two national NGOs .

The program of investments was substantially achieved.

National health services were strengthened by the extension of PHC to the Western Region. Health facilities were improved through the rehabilitation of essential services (water and electricity), and the construction of staff housing units, which has helped to partially alleviate one of the perennial problems the MoH has faced in redeployment of health personnel to remote and underserved areas. Despite cost overruns (due to inadequate physical specifications and an underestimation of contingencies) and a slow start, a major achievement of the project was the establishment of secondary level health delivery facility through the upgrading/construction, equipping and staffing of eight major health centers to relieve the burden on the two tertiary level hospitals and bring basic health services closer to the population. Project investments to upgrade the techn cial skills of service providers including traditional community-based health providers were substantially achieved The two training programs for nurses established under the project were highly commended by the Western African College of Surgeons and WHO for their effective and appropriate response to the local situation. Other contributions to improvements in the quality and coverage of basic health services include the establishment of a ferry boat system to ensure timely referral of complicated medical cases, and expansion of communicable disease prevention and treatment programs, including the provision of drugs, laboratory supplies, and in-service training to nurses. The expansion of PHC to the peri-urban areas of Banjul was not achieved due to delays in the completion of the study expected to inform and guide the implementation of the program. The training of selected Village Development Committee members in basic principles of accounting and financial management was also not implemented. The ICR does not indicate what, if anything, was accomplished under the monitoring and evaluation subcomponent; there were no health outcome indicators specified in the Staff Appraisal Report.

Neither the health ed. nutri component was implemented. nor

The Operations Evaluation Department (OED) agrees with the ICR in rating project outcome as satisfactory, institutional development as substantial, sustainability as likely, and Bank performance as satisfactory. Sustainability has been changed to unlikely, as the ICR states that they are dependent on the follow-on project which has still not been approved due to external shocks

The lessons identified by the ICR suggest: (a) the need for up-front agreement/ownership/implementation of key policy objectives to improve quality at entry (reform elements were included during appraisal, which explains in part the delays experience in implementing

some of the reform elements.; (b) the importance of physical integration of project coordination unit into the parent ministry; (c) the need for improvements in project management through training and establishment of effective accounting and financial management systems prior to project effectiveness; and (d) caution in developing Inter-ministerial project coordinating committees.

(a) the need for simpler project design and development; (e) the importance of permitting revenue retention at the point of collection and limiting exemptions to the truly needy for successful cost recovery;

The ICR is satisfactory. No audit is planned.

Supervision reports incomplete

retention - reprogrammed

withdrawal - not monitored

THE WORLD BANK/IFC/M.I.G.A.

OFFICE MEMORANDUM

DATE: [Date]

TO: Mr. Mahmood A. Ayub, Director, AFC14

FROM: Roger Slade, Acting-Director, OED

EXTENSION: 81293

SUBJECT: **The Gamiba—National Health Development Project (Credit 1760-GM) Implementation Completion Report**

1. Attached is a draft Evaluative Memorandum (EM) from the Director-General, Operations Evaluation, which is based on OED's review of the Implementation Completion Report (ICR). We would appreciate receiving any comments you might have by

2. Based on this review, we intend to include the following ratings in the OED Annual Review database:

	OED	**ICR**
Outcome:	Satisfactory	Satisfactory
Sustainability:	Likely	Likely
Institutional Development:	Substantial	Substantial
Bank Performance:	Satisfactory	Satisfactory
Borrower Performance:	Satisfactory	Satisfactory

3. The above ratings [are the same as/differ from] those indicated in the ICR.

4. The ICR is [. . .], and could have been improved if the following points had been taken into account.

- [Text...]
- [Text...]

4. In keeping with OED's policy to provide feedback to operational staff on ICRs, to improve their quality, I have the following comments on the ICR:

-The ICR is generally satisfactory. Documentation of implementation and the project's physical achievements is detailed and thorough. But two important aspects of the project appear underreported: (a) expansion of PHC to the underserved Western region; (b)enhanced health education, nutrition and family planning programs. ✓

-Other than stating that the project could have benefited from more specific performance criteria for monitoring project objectives and baseline data for setting realistic indicators, the ICR does discuss the monitoring and evaluation sub-component. Through a careful examination of the Annex tables, however, one can see that actions were taken by the Epidemiology and Statistics Unit of the Ministry of Health, Labor and Social Welfare to review and improve the health information system and that both a mid-term and final project evaluation took place. (Table 5: Key Indicators for Project Implementation) The only mention of the evaluation results appears in Table 7: Studies Included in Project, which states that the mid-term review enabled decisions on project modifications to increase effectiveness, and that the WHO Final Project Evaluation guides preparation of future health policy and projects.

It is unfortunate that the original design of the project, which included no health outcome indicators, was not modified to enable collection of data. As such, thus there is no way to objectively assess the claims of the ICR that expansion of PHC to the Western Region has considerably increased coverage of basic health services in the country. The ICR states that quality of health services remains a major problem as reflected by the fact that national health indicators for The Gambia remain very low.

-The ICR states that the prospects for sustainability of project interventions are good. Yet it also states in the same paragraph that the follow-up project, which was to address the current weaknesses of the PHC program and support services, has been delayed, which may lead to significant loss and reversal of some of the project's achievements. The July 1994 coup d'etat slowed down considerably the preparation process due to the suspension of new external aid from the Bank and other donor. In addition major changes in the administration of the MoH have led to a slow down in the reform efforts. WOULDN'T THIS BE RATED UNCERTAIN? WHAT IS THE STATUS OF THE SECOND PROJECT NOW (ICR DATED JUNE 1996).

- In Table 13: Bank Resources: Missions, the development Impact and Implementation Status ratings appear to be overstated (problem free and moderate problems) when the types of problems noted are examined. For example the 12/91 mission reported moderate problems yet identified problems with: procurement process, compliance with legal covenants, availability of funds, and noted that project management performance, studies progress, and technical assistance were particularly problematic. The 7/93 mission was rated as problem free yet noted problems in project management performance,

procurement progress, compliance with legal covenants and particularly problematic studies progress and technical assistance.

-Despite the fact that the ICR states that the project's multi-donor effort (with six co-financers) permitted substantial resource mobilization and provided the basis for extensive donor coordination there is no discussion of this important issue in the text, nor is there any evidence that the co-financers were invited to participate in the ICR mission or review the ICR.

Attachment

cc: Ms. Alexander (OPRDR) and Mr. de Ferranti (HDD)

Heath

Lessons not adequate

-Despite the fact that the ICR states that the project's multi-donor effort (with six co-financers) permitted substantial resource mobilization and provided the basis for extensive donor coordination there is no discussion of this important issue in the text, nor is there any evidence that the co-financers were invited to participate in the ICR mission or review the ICR.

Attachment

cc: Ms. Alexander (OPRDR) and ??

good argum
-not sustainable-

ratings

dysfunctional assurance

pressure to paint positive as poss.

Disconnect - achieved

DH boards

HMgmt teams

components Achievements

Reforms

less successful but more sustainable

Investm

more successful but less sustain-

training nurses - college

"at risk" - overseas - not sustain.

no maint + brain drain

Angelika — TM-

reforms — invest

5 Achiev / sustain — 6

reorgan MOH - partial / likely
hosp semi sub / likely
decentraliz to reg. partial / likely
CR partial / likely
Support: transp, com partial / unlikely

inves

ext PHC partic / uncertain

upgradin facil sub / uncertain — civil works upgrading

~~Strength FP/health sub / uncer~~ — upgrading
at risk nurse, nurse anesthesia - integrat.
~~nurses tr. sub / likely~~
licensing
H, E, N, FP, res / N/A

M&E partia / unlikely

5 HC as MCH centers
material
civil works
fernies
overseas training
dis
design error

civil works problems

Susan - should have draft QICR

DHS – Tonya [illegible] – questionnaires will come in in
FYI – Wed 301 572-0958

WPS Bulatao – exact title – Jill

Little mention of CR issues – glossed over –

Vann – Jose's note

Susan Angeleka's [illegible] draft

Census – reducing IMR, MMR – particip HPN
participation – eval of pilot –
→ prep studies
· training needs assessment

Instit. & reform = [illegible]

MoH
physical integr.

nurses

phy rehab –
b/c no maintenance

ICR – WHO eval – was incorp.

AFC14 Susan Stevens

Memo to Director Africa (The Gambia) Region ??
THE GAMBIA --National Health Development Project (Credit 1760-GM)

1. Attached is the draft Evaluative Memorandum from the Director-General, Operations Evaluation, which is based on OED's review of the Implementation Completion Report (ICR). We would appreciate receiving any comments you may have by

2. Based on this review we intend to include the following rating in the Annual Review database: (is there a format for this?)

3. OED ratings are the same as those in the ICR.

4. In keeping with OED's policy to provide feedback to operational staff on ICRs, to improve their quality, I have the following comments on the ICR:

-The ICR is generally satisfactory. Documentation of implementation and the project's physical achievements is detailed and thorough. But two important aspects of the project appear underreported: (a) expansion of PHC to the underserved Western region; (b)enhanced health education, nutrition and family planning programs.

-Other than stating that the project could have benefited from more specific performance criteria for monitoring project objectives and baseline data for setting realistic indicators, the ICR does discuss the monitoring and evaluation sub-component. Through a careful examination of the Annex tables, however, one can see that actions were taken by the Epidemiology and Statistics Unit of the Ministry of Health, Labor and Social Welfare to review and improve the health information system and that both a mid-term and final project evaluation took place. (Table 5: Key Indicators for Project Implementation) The only mention of the evaluation results appears in Table 7: Studies Included in Project, which states that the mid-term review enabled decisions on project modifications to increase effectiveness, and that the WHO Final Project Evaluation guides preparation of future health policy and projects.

It is unfortunate that the original design of the project, which included no health outcome indicators, was not modified to enable collection of data. As such, thus there is no way to objectively assess the claims of the ICR that expansion of PHC to the Western Region has considerably increased coverage of basic health services in the country. The ICR states that quality of health services remains a major problem as reflected by the fact that national health indicators for The Gambia remain very low.

-The ICR states that the prospects for sustainability of project interventions are good. Yet it also states in the same paragraph that the follow-up project, which was to address the current weaknesses of the PHC program and support services, has been delayed, which may lead to significant loss and reversal of some of the project's achievements. The July 1994 coup d'etat slowed down considerably the preparation process due to the suspension of new external aid from the Bank and other donor. In addition major changes in the administration of the MoH have led to a slow down in the reform efforts. WOULDN'T THIS BE RATED UNCERTAIN? WHAT IS THE STATUS OF THE SECOND PROJECT NOW (ICR DATED JUNE 1996).

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. → 7. get OED guidelines (bottom tray)

written w/ honestly / forthright - self-criticism -

invest. Strengthening PHC thru — med. equip, bicycles, in service training; outreach clinics; expand comm. disease programs
- expansion to W. region & peri-urban areas
✓ training
✓ - rehabil / construct
- coord fp / IEC activ — under PIC - dev. of work plan PHN - coord nut. prog. - in service MCH/FP training
- M&E — no mention — prov. of fp services - outreach clinics
improve HIS
develop sys. action plan
MT & final eval

sector reforms - strengthen h.s. mgmt, fin & support systems thru
✓ central reorganiz - semi-auton hosp
✓ decentral. at district level
✓ CR system (financial resource mobiliz)
- X strengthen transp, commun & other support syst

X
Strengthen Village Devel. Committees
not achieved

→ good lessons for CR (3) to be shared — would like to know more
2 failed components - hinged on TA

no M, review & reporting - dis. M-T '93 89
final - WHO - 93

SAR p.11 new initiatives in MCH, fp, nutrit & manpower training
p.11 expand PHC & fp services
improve instit. effectiveness & efficiency in health system
strengthen support systems - drugs & supplies, transp & comm

pros

Self-eval. report from borrower includes candid, admits errors

Cons

no evidence COfinanciers were invited to participate in ICR mission or review ICR.

no mention of results of M-T eval or final eval, though ∃ (listed in table)
WBO - mentioned in intro

no perf. indicators agreed w/ Bank for monitoring operations & development impact

Questions

re Rogers 1/97 memo, What exactly is the plan for the operational phase including prog indicators & where should it be in ICR?

For TA: why no mention of M-7 or final eval?

1.2.1 STATEMENT OF LOANS AND CREDITS QUERY SYSTEM *SLCCRDT

Q U E R Y FEB-97 C R E D I T S D E T A I L S

```
Region:     1-AFRICA                Country:     GAMBIA, THE
Ctry Dept:  AFC14                   Borrower:    THE REPUBLIC OF THE GAMBIA
IDA Repl:   27- 7TH REPL.           OPMIS Type:  P -  PROJECT LENDING
Crdt No:    17600                   OPMIS Inst:  SIL- SPECIFIC INVEST LN
Crdt Stat:  4- DISBURSING           OPMIS Sect:   -
Crdt Rate:  .75                     OPMIS Proj:  POP/HEALTH
Comm Cncy:  XDR-

Original Principal:  $    5,600,000.00    Repaid 3rd Prty:  $          .00
Cancellations:       $            .00    Due 3rd Prty:     $          .00
Undisbursed Amount:  $      193,980.00    Due IDA Amount:   $    6,333,709.00
Disbursed Amount:    $    6,268,869.00    Borrower Oblgtn:  $    6,333,709.00
Repaid IDA Amount:   $            .00    Credits Held:     $    6,527,689.00
Sold 3rd Prty:       $            .00

Approval:  17-FEB-1987      1st Repay:  01-MAY-1997      Lst Disb:  04-APR-1996
Agreement: 05-JUN-1987      Lst Repay:  01-NOV-2036      Closing:   30-JUN-1995
Effective: 02-NOV-1987                                    (1    of 1    Crdts)
PF1=FIND CREDITS    KP+=CLEAR SCREEN   KP4=NEXT CREDIT      PF3=VALUES  KP0=EXIT
KP2=COUNT CREDITS   PF2=GEN. REPORT    KP5=PREVIOUS CREDIT   CREDIT HAS NO NOTE
Computing credits... and retrieving information of the first credit
Count: *0                                                          <Replace>
```

Data Downloaded

Ratings

Report Printed 3/24/97

Proj. ID	000000812	Proj. FY	1987
Proj. Name	POP/HEALTH		
Review Type	Initial Summary		
Country	GAMBIA	Status	Completed
Dept/Div	22514	Proj. Type	ICR
T.M. Div		Task Manager	BROWN
L/C Number 1	C17600	L/C Number 2	
Form FY	1987	Major Sector	HY
Form 590 Date	6/19/87	Lend. Instrmt.	SIL
From 590 Seq.	1	Last Form?	N
Review Type	Initial Summary	ARPP FY	

Form Date	Project Development Objective	Imp. Progress	Compliance with Legal Covenant	Project Management Performance	Availability of Funds	Procurement Progress	Training Progress	Technical Assistance Progress	Studies Progress	Environmental Aspects	Financial Performance	WID Impact	Monitoring
10/21/87	1	1		1	1								
1/20/88	1	1		1	1								
3/30/88	1	1		1	1								
7/28/88	1	1		1	1								
4/11/89	1	2		2	1								
12/12/89	1	2	1	2	1	2	2	2	2	1	1		
7/13/90	2	2	2	2	1	2	2	2	2	1	1		
1/29/91	2	2	2	2	1	2	1	2	2	1	2		
7/25/91	2	2	2	3	2	2	1	3	2	1	2		
8/22/91	2	2	2	3	2	2	1	3	2	1	2		
2/20/92	2	2	2	3	2	2	1	3	3	1	2		
7/22/92	2	2	2	2	1	2	1	3	3	1	2		
9/[illegible]/92	2	2	2	2	1	2	1	3	3	1	2		
1 [illegible]92	2	2	2	2	1	2	1	2	2	1	2		
4/15/93	2	2	2	2	1	2	1	2	2	1	2		
7/27/93	1	1	1	2	1	2	1	2	1	1	2		
12/ 7/93	1	1	1	1	1	2	1	2	1	1	2		
2/22/94	1	1	1	1	1	2	1	2	1	1	2		
4/18/94	1	1	1	1	1	2	1	1	1	1	2		
6/30/94	HS	HS	1	1	1	2	1	1	1	1	2		
5/ 5/95	HS	HS	1	1	1	1	1	1	1	1	1		

ICR/PI[illegible]OVER SHEET Run D[illegible] : 7/16/96

OED ID: C1760 Division: 1

Country:	Gambia
Project Description:	National Health Dev.
Sector:	04 / Human Resource
Subsector:	04.05 / Pop., Health & Nutr.
Lending Instrument Type:	SIL
L/C:	C1760
Original IDA/IBRD Commitments:	5,600,000 ($US)
Total Cancellations:	0 ($US)

Key Dates	ORIGINAL	ACTUAL
Approval		2/17/87
Signing/Agreement		6/05/87
Effectiveness	11/02/87	11/02/87
Closing	12/31/92	6/30/95
PCR Receipt in OED		6/29/96

EVALUATOR NAME: Rooney (due dc 30/9/96)

EVALUATOR SIGNATURE: _____ DATE: _____

Please confirm the above information, sign and date this sheet and return a photo-copy to Helen Sioris when the EVM/Regional memo/PIF packet is submitted to OED Director.

********** TO BE COMPLETED BY EVALUATION OFFICER **********

Date of Review: ____/____/____ (mm / dd / yy)

Name of Reviewer: _____

Type of Evaluation: PCR Review [ ] PAR Review [ ]

If this is a PAR Review, are there major differences in the judgements from those made in the PCR Review?

Yes [ ] No [ ]

If Yes, please discuss in detail on page 26 of the PIF

	ORIGINAL	LATEST
Date of Physical Completion	(mm/dd/yy)	(mm/dd/yy)
Total Project Cost ($US mill)		
Applicable Disbursement Profile: (see note 11 in the PIF, page 31)		
Number of Supervision Missions:		