TOGO-Health and Population Sector
Adjustment Credit
ICR (Cr. 2211-TO)

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

Office of the Director-General
Operations Evaluation

September 5, 1997

OED EVALUATIVE MEMORANDUM ON IMPLEMENTATION COMPLETION REPORT

Togo—Population and Health Sector Adjustment Program (Credit 2211-TO)

The Togo Population and Health Sector Adjustment Program, supported by Credit 2211-TO for SDR10.2 million (US$14.2 million equivalent), was approved in FY91. Following a one-year extension, the credit was closed and fully disbursed in June 1996. The Implementation Completion Report (ICR) was prepared by the Africa Regional Office. A summary of the borrower's contribution to the ICR is contained in an annex.

The objectives of the program were to support the implementation of a comprehensive package of sector policy reforms in population and health in order to improve primary health care and family planning services. These objectives were to be achieved through a sectoral adjustment credit, with tranche releases conditioned on the implementation of agreed reforms. Over a four-year period, the program was to: (i) institute better sector planning; (ii) reform institutional deficiencies within the sector; (iii) improve personnel and financial management within the sector; and (iv) institute cost recovery and improve beneficiary participation in management of services.

The project failed to meet most of its original objectives. Two years of civil unrest, which began in late 1991, contributed to dramatic economic decline and political instability. The first tranche was released in 1992, following a one-year delay. No further funds were released during the period of crisis, although IDA attempted to sustain dialogue with the Ministry of Health through the resident mission. Following the January 1994 CFAF devaluation, the government reached an agreement with the Bank and Fund and resumed implementation of health sector reforms. The second tranche was released in May 1994, and the closing date of the Credit was extended one year to June 1996. Due to the drastically changed economic and political environment, IDA and the government agreed to a revised plan for health sector investment and budgetary allocations.

Some policy reforms were achieved. Regional and prefectural health directorates were established; a new program budgeting system was adopted in 1995; and a cost recovery program—initiated by UNICEF—was successfully introduced in over 80 percent of the country's health facilities, and steps were taken to improve drug procurement and availability. A portion of the latter tranches of the loan were earmarked for essential drug and vaccine procurement. The planned reorganization of the Ministry was only partially implemented, and the coordinating committee that was to oversee the reforms never met. A population policy was adopted and the contraceptive prevalence rate increased slightly, but most of those changes are attributable to other donor and NGO interventions. Overall, health services and health outcomes have worsened, and service utilization appears to have declined. The ICR

plausibly asserts that the program helped prevent further declines in health services, but no evidence is offered.

The program was the first health loan for Togo and the Bank's first health sector adjustment loan. Even in the absence of such negative external factors, the original project design was too ambitious and poorly adapted to the limited institutional capacity prevailing in Togo. Although intended to promote government ownership and beneficiary participation, most of the project design was carried out by external consultants with little input from beneficiaries.

The ICR rates project outcome as unsatisfactory, institutional development as negligible, sustainability as unlikely, and Bank performance as satisfactory. The Operations Evaluation Department (OED) agrees with these ratings, but rates project outcome as marginally unsatisfactory. Bank staff deserve credit for their flexibility in the program's final years, despite inadequate project design and insufficient attention to institutional issues. The project is rated marginally unsatisfactory because some progress was achieved in local cost recovery and national drug procurement reform in an adverse environment.

The lessons identified by the ICR suggest: (i) adjustment lending is an inadequate vehicle to address health sector issues *and* long-term institutional development problems; (ii) greater attention to strategy coordination is necessary in times of civil strife, including consideration to program cancellation; (iii) the importance of modesty and realism in an institutionally weak sector such as health; (iv) the importance of identifying key stakeholders; (v) the importance of ownership of an adjustment operation by the borrower; (vi) in an environment facing severe financial and human resource constraints, a phased approach to implementation reduces the risks of failure; and (vii) the importance of a practical approach to decentralization, particularly an increased focus on utilization of health services rather than only their supply.

The ICR is satisfactory and contains an honest assessment of the problems and lessons of the project. In preparing a successor project, the ICR asserts that IDA and the government are engaging in a wide-ranging consultation process with stakeholders and beneficiaries. A more detailed account of how the severe personnel and institutional constraints will be overcome by the successor project would have been useful, along with a description of the strategy for monitoring and evaluation.

No audit is planned.

IDA/SecM97-323

FROM: Vice President and Secretary

July 11, 1997

IMPLEMENTATION COMPLETION REPORT

REPUBLIC OF TOGO

HEALTH AND POPULATION SECTOR ADJUSTMENT PROGRAM
(Credit 2211-TO)

Attached is a report entitled "Implementation Completion Report: Republic of Togo: Health and Population Sector Adjustment Program" (Credit 2211-TO) dated June 25, 1997 (Report No.16781) prepared by the Africa Region.

Distribution

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

Document of
The World Bank

FOR OFFICIAL USE ONLY

Report No. 16781

IMPLEMENTATION COMPLETION REPORT

REPUBLIC OF TOGO

HEALTH AND POPULATION SECTOR ADJUSTMENT PROGRAM

(CR. 2211-TO)

June 25, 1997

Human Development 3
Africa Region

CURRENCY EQUIVALENTS
(June 19, 1997)

Currency Unit	=	CFAF
US$	=	580.40 CFAF
CFAF 1 million	=	US$1,722.95
SDR 1	=	US$1.39
US$1	=	SDR .72

WEIGHTS AND MEASURES
Metric System

FISCAL YEAR OF BORROWER
January 1 - December 31

ABBREVIATIONS AND ACRONYMS

AfDB	African Development Bank
ATBEF	Togolese Association for Family Welfare
CTCS	Interministerial Technical Committee of Coordination and Monitoring
CTD	Intrasectoral Management and Supervision Committee
ENAM	National School for Medical Assistants
ENSF	National Mid-wives School
EU	European Union
GTZ	Gesellschaft für Wirtschaftlinche Zusammenarbeit - German agency for technical cooperation.
HPSAP	Health and Population Sector Adjustment Program
ICR	Implementation Completion Report
IDA	International Development Association
KfW	Kreditanstalt für Wiederaufbau, German agency for financial cooperation
MH	Ministry of Health
NGO	Non-governmental Organization
PER	Public Expenditure Review
PFP	Policy Framework Paper
PIP	Public Investment Program
SDR	Special Drawing Rights
SECAL	Sectoral Adjustment Loan
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Vice President:	Jean-Louis Sarbib
Director:	Theodore Ahlers
Technical Manager:	Helena Ribe
Team Leader:	Bruna Vitagliano

TABLE OF CONTENTS

FOR OFFICIAL USE ONLY

IMPLEMENTATION COMPLETION REPORT
REPUBLIC OF TOGO
HEALTH AND POPULATION SECTOR ADJUSTMENT PROGRAM
(CR. 2211-TO)

PREFACE

This is the Implementation Completion Report (ICR) for the Health and Population Sector Adjustment Program (HPSAP). A Credit to support the Program in the amount of US$14.2 million equivalent (SDR 10.2 million) was approved on January 23, 1991 and made effective on March 31, 1992.

The Credit was closed on June 30 1996, after a one-year extension from the original closing date (June 30, 1995). The first tranche of SDR 2.85 (US$4.0 million equivalent) was released upon effectiveness; subsequent tranches (two of SDR2.85 million and one of SDR 1.47 million) were released on May 25, 1994, October 4, 1995, and June 5, 1996.

The ICR was prepared by Fily D'Almeida (RMTO) and Bruna Vitagliano (AFTH3), with assistance from Ross Pfile, Johanne Angers, and A. Edward Elmendorf. It was reviewed by Helena Ribe (Technical Manager, AFTH3), and Jerome Chevallier (Technical Manger, AFTS3).

Preparation of this ICR was begun in November 1996. It is based on the Report and Recommendation of the President, supervision reports, correspondence between the Borrower and the Bank, and internal Bank memoranda. The Borrower prepared its own evaluation of the Program and commented on the draft ICR; a summary of the Borrower's evaluation is included in this report. The full report by the Borrower is available upon request from the Africa Information Services Center.

IMPLEMENTATION COMPLETION REPORT
REPUBLIC OF TOGO
HEALTH AND POPULATION SECTOR ADJUSTMENT PROGRAM
(CR. 2211-TO)

EVALUATION SUMMARY

1. **The Bank's Role in the Country and in the Sector.** The Bank has sought to support the Government's efforts to promote equitable and sustainable growth and development. This has involved a multifaceted approach, comprising policy dialogue, buttressed by economic and sector work, lending for both projects and structural adjustment, and mobilization of donor support for Togo. Since the early 1980s the Bank has played an important role in initiating and sustaining the policy dialogue with the Government. Through a series of structural adjustment credits, the Bank has been in regular contact with the Government on its overall strategy and specific policy priorities. This dialogue has been reflected in Policy Framework Papers (PFP), which have also served to ensure consistency between World Bank and International Monetary Fund programs. The Health and Population Sector Adjustment Program (HPSAP) complemented the work undertaken under the SAC IV operation; the HPSAP was approved in January 1991.

2. **Objectives of the HPSAP.** The key objective of the HPSAP was to support the implementation of a comprehensive package of sector policy reforms in the area of population and health aimed at assuring a satisfactory level of primary health care and family planning services to the population at large by focusing on systemic and fundamental constraints on good service delivery. As articulated in the President's Report, the Program intended to address, in the short to medium term, pervasive morbidity and mortality resulting from inadequate treatment and prevention of tropical communicable and parasitic diseases and increase current use of family planning. To achieve these results, quick-disbursing funds were provided to support efficiency gains and institutional change, on the grounds that the sector policy reforms would be at short-term risk without this financial support. As described in the Credit Agreement, over a four-year period the Program was to: (a) institute better sector planning; (b) reform institutional deficiencies within the Ministry of Health (MH) and at regional levels; (c) improve personnel and financial management in the sector; and (d) institute cost recovery and improve beneficiary participation in management of services. The policy measures incorporated in the Program were expected to reverse a deterioration in the quality of basic health services and gradually increase their accessibility to the general public, particularly in rural areas and among the most deprived groups. The African Development Bank, Germany, and USAID also supported the policy reform program through parallel funding.

Implementation Experience and Results

3. **Tranche Reviews and Implementation Schedule.** The first tranche was released upon effectiveness in March 1992. An extended delay in effectiveness resulted from political tensions in the country and the consultations needed to meet the very substantial conditions: establishment of a financial management and accounting system satisfactory to IDA, budgetary allocations satisfactory to IDA, and staff redeployment to five regional directorates; the emerging political problems may also be partly responsible. Soon after effectiveness Togo's economic and financial performance started to deteriorate as a result of protracted political crisis. The crisis began in late 1991 and continued until the end of 1993. The situation was aggravated by the suspension - as a result of the

crisis - of external aid by several major donors to Togo. The resulting absence of a macroeconomic framework satisfactory to IDA precluded release of the second tranche during that period. Following the January 1994 CFAF devaluation, the Government reached agreement with the Bank and the Fund on a medium-term PFP; in the PFP the Government committed itself to allocating adequate budgetary resources to health and education, with the objective of raising the quality and coverage of services to the pre-crisis level. Implementation of the reforms under the HPSAP resumed, and the second tranche was released in May 1994. The closing date of the Credit was extended from June 30, 1995 to June 30, 1996; this was justified on the grounds that the Government had made an effort to carry out the agreed program of reforms in spite of the political difficulties, that the reforms were still incomplete, and that the extension would allow the Bank to continue the dialogue initiated with the Government on a number of health issues following the CFAF devaluation. Reviews of progress in implementing the Program were held in February and May 1995, and the third and fourth tranches were released in October 1995 and June 1996, respectively.

4. **Achievement of Objectives.** Togo's protracted economic and social crisis severely affected the execution of the Program and its achievements. When the Bank resumed lending in 1994, following a two-year suspension, a new medium-term framework for the health and population sector had to be developed, as the previously agreed plans no longer provided relevant guidance on appropriate budgetary allocations, given Togo's much worsened economic and financial situation. During discussions in 1995, agreement was reached on the level of the health sector allocation for the 1996 budget and on revised Public Investment Program (PIP) allocations for the sector. The Government undertook to increase public spending for health as a share of total budgetary expenditures from six percent to the 1991 level of 7.2 percent, and to limit investment spending to the rehabilitation of existing infrastructure. A medium-term financing plan for the sector was prepared in the context of a Public Expenditure Review (PER) in 1995/1996.

5. In spite of the crisis, some policy reforms were achieved. Regional and prefectoral health directorates were established, in line with the objective of progressively decentralizing the management of the health system. Much remains to be done, however, to make them fully operational. A new program budgeting system was adopted in 1995 with the aim of ensuring that funds were allocated according to norms and criteria established in the operational strategy. A cost recovery program, developed to mobilize additional resources for sector operations, was successfully introduced in over 80 percent of the country's public sector health facilities. Steps were taken to make more affordable essential generic drugs available to the population, particularly those living in rural areas. Finally, family planning services were expanded through both the Government and the NGO network. The contraceptive prevalence rate for modern contraception, which was four percent at the time of the 1988 Demographic and Health Survey (DHS), is now estimated at nine percent.

6. One important objective of the HPSAP was the development of a sustainable essential drug procurement system. To this end, the Program supported the abolition of the monopoly of the public drug procurement agency, TOGOPHARMA, on the import and distribution of drugs and its restructuring into an essential generic drug purchasing agency. Because of the government's reluctance to reduce the size of TOGOPHARMA's personnel, IDA pushed for the establishment of a new essential drug buying agency with a statute based on a partnership among interested parties--the Government, the donors, and the communities (the latter through management committees at peripheral health facilities). A draft statute of the new purchasing agency is currently being studied by the Bank, while TOGOPHARMA has been included in the privatization program agreed between the Government and the Bank within the framework of public enterprise reform.

7. **Key Factors that Affected Achievement of Major Objectives.** In retrospect, the HPSAP was too ambitious. It intended to carry out important *long-term* health reforms and to achieve substantial improvements in numerous health and social indicators in the *short to medium* term. The adjustment Program placed considerable emphasis on the reorganization of the MH, expecting that it would set off a major improvement in the overall performance of the health sector. The reasons why this did not occur provide useful lessons for IDA's future interventions in the health sector: (i) At the time of the preparation of the Program, the MH lacked health economists, planners, managers, and administrators capable of managing the planning, programming, and budgeting of the essential activities. Thus, the MH and the Bank had to rely mostly on external consultants for the preparation work. This resulted in a Program which the MH never fully internalized nor was able to manage. (ii) The key positions created under the reorganization of the MH were never filled with competent staff, nor was sufficient technical assistance provided to train staff to eventually take over these positions. The shortage of staff became even more acute over the years as personnel who retired were not replaced. (iii) Too much attention was placed on the formal reorganization of the MH, without taking into account the considerable authority for decisions affecting the health sector resting with the Ministries of Finance (which decides the amounts and the intersectoral allocation of resources, and significantly influences their intrasectoral allocation) and Planning (which prepares the PIP, mostly on the basis of political considerations and with little regard for the recurrent cost implications of the investment decisions). (iv) Key stakeholders, such as local communities and NGO, were never fully engaged in the Program. Community participation was limited to involvement in cost recovery.

8. Togo's prolonged political and social turmoil compounded the above problems: between 1992 and 1996 five different ministers headed the Ministry of Health; also, its name even changed according to the circumstances. Senior personnel in the Ministry also changed when a new Minister was appointed. Others left the country because of the political situation. These frequent changes considerably affected both the will and the ability of the Government to carry out health and population sector policy reforms. With the sharp decline in the economy, financing for the health sector was drastically reduced; MH recurrent spending fell from CFAF 5.0 billion in 1991 to CFAF 2.2 billion in 1993. The effects of this situation can be seen in dilapidated, underequipped and understaffed health facilities; in a chronic shortage of vaccines, drugs and other essential medical supplies; and in a widespread perception of a downward trend in the utilization of health services.

9. An adjustment operation, with its emphasis on one-time, centrally driven policy decisions, was not the most appropriate instrument for ensuring execution of the numerous policy measures and institutional changes which had been identified as key to successful implementation of health reform. A series of investment operations, coupled with continuous policy dialogue and careful monitoring of sectoral issues, would have been more appropriate. The staff in Togo's MH agree with this assessment, which is the most important lesson learned from the operation.

10. **Performance of the Borrower and the Bank.** The Borrower's performance was severely affected by the near civil war atmosphere that prevailed in Togo in 1992 and 1993. The two committees (*Comité Technique de Coordination et de Suivi,* and *Comité Technique des Directeurs*) that were created to ensure inter- and intrasectoral collaboration and monitor and supervise the implementation of the reform program never met during the HPSAP implementation period. The enduring weakness of the center pushed the newly established regional and prefectoral directorates to become more self-reliant. Most have managed, and continue to manage, without much assistance from Lomé, relying on cost recovery as their only source of funds for non-personnel recurrent expenditures. Thus, a disorderly and disorganized decentralization of public sector health care

services has occurred. It is now appropriate for the authorities, with Bank support, to build on and reinforce the positive aspects of this experience.

11. The performance of the Bank was satisfactory: Supervision missions took place regularly at a rate of two per year. Even during the period of prolonged crisis, the dialogue was maintained through the Resident Mission. The Bank also maintained a dialogue with the other donors and invited them to join supervision missions. When the policy dialogue resumed in 1994 after almost two years of suspension, it would perhaps have been more sensible to transform the adjustment credit into an investment operation. In informal discussion between the MH and Bank staff, in practice the Credit was in part handled as an investment operation: At the Government's initiative, half of the amount of the third tranche was earmarked for the purchase of urgently needed essential generic drugs. International competitive bidding for pharmaceuticals procurement was introduced, and purchases were made at prices substantially lower than estimates.

12. During and after the long socio-political crisis, the IDA Credit was a major source of funds for Togo's health sector. The situation in the sector would have been much worse had the IDA funds not been available.

Sustainability and Key Lessons for Future Operations

13. **Sustainability.** The HPSAP drew attention to the extent of the problems in the health sector, and to the necessity of allocating adequate resources to respond to the needs of the population. However, because of the financial crisis, the Government has been unable to maintain a minimum core program of services in the sector. Although some resources were mobilized through cost recovery, they are insufficient to ensure sustainability of reform. Given the current fiscal constraints, the Government would find it extremely difficult to fill the financing gap of a reasonable minimum package of services without very substantial external support. Thus, sustainability in the Togolese health sector does not mean phasing out donor support and its analysis on the basis of traditional one-by-one investment project finance. Instead it requires a realistic evaluation of the nature, cost, and size of the country's health sector program, combined with an objective assessment of current and potential Government, beneficiary, and donor financial and other contributions, including the most appropriate areas for donor financing and their duration.

14. The experience under the HPSAP has significantly influenced the preparation of a new health sector decentralization project. A participatory approach has been adopted for the preparation of the new operation, to build ownership. A major preparation role has been entrusted to working groups established around priority themes, such as institutional reforms, human resources, cost recovery, community participation, and the involvement of the private sector. The groups are composed of ministry officials and representatives of a wide spectrum of stakeholders such as the donors, NGO, the faculty of medicine, private medical and pharmaceutical associations, and traditional medicine. A consensus has developed among the working groups on the need to carry out an effective decentralization of the health system and encourage greater participation of the communities in decision making. The Government has adopted this as its strategy. The next IDA operation would be used to pilot-test the operational feasibility of providing a sound package of essential health services on an organized, decentralized basis within a prudent financial framework. In the new operation, considerable emphasis is being placed on (i) rationalizing and strengthening the decentralization process, by shifting planning of detailed health services, budgeting and financial management to the districts and by increasingly involving the communities; (ii) supporting NGO and other private health providers, whose activities will be integrated in the district work plans; and (iii)

promoting sound health behaviors and demand for appropriate health services through information, education, and communication (IEC) activities.

15. The HPSAP sought to address the problem of the penury of health personnel at the periphery through the redeployment of staff. This proved very difficult to implement. Under the new operation, the MH intends to handle the management of human resources at the decentralized level, through local contracting of staff. As the decentralization of the health system progresses, the role of the MH will need to change and more emphasis will need to be given - as was intended under the HPSAP - to health policy formulation, standard setting, supervision, monitoring and evaluation. IDA will help strengthen the MH to carry out these responsibilities, but needs to be careful to avoid unintentionally stimulating efforts at recentralization of responsibilities for service delivery under the guise of institutional development.

16. The HPSAP was the first Bank-financed operation in the health sector in Togo. A number of important lessons can be drawn from the experience :

a) The inadequacy of adjustment lending as a vehicle to address health sector issues and long-term institutional development problems. An adjustment operation with its tranche release mechanisms focuses the attention of decision-makers on one-time decisions, while the health sector needs a sustained dialogue and more attention to sectoral rather than macroeconomic issues. A series of investment operations would most probably have been more adequate instruments for achieving the sound policy and institutional reform objectives of the HPSAP.

b) The importance of country strategy and strategy coordination in cases of civil strife. Greater consideration might have been given, for example, to cancellation of the second through the fourth tranches of the SECAL, but work under way which led to the CFA devaluation effectively precluded such action.

c) The importance of modesty and realism in reform programs in an institutionally weak sector such as health. Reading over the Government's statement of health programs and objectives, one cannot help but be struck by its excessively ambitious character, particularly under an adjustment Program which was to be implemented in a four-year period.

d) The importance of identifying and involving key stakeholders. In a capacity building effort it is important to understand who are the key stakeholders and who is involved in the decision-making process. Excessive emphasis was placed on the formal reorganization of the MH without taking into account that the MH had limited control over its own budget. The role of communities as important stakeholders was not sufficiently taken into account under the Program. Community participation was limited to cost recovery, while the Program should have envisaged ways to further involve communities in the management of peripheral health facilities.

e) The importance of ownership of the adjustment operation by the Borrower. Reforms of the magnitude envisaged under the HPSAP need a long process of consensus building extending from preparation through execution. It appears that not much consensus building took place during preparation. Because of MH weakness, excessive use was made of consultants, with the result that the HPSAP was never fully internalized. Indeed, its execution was beyond the capacity of the Togolese civil service.

f) In an environment facing severe financial and human resource constraints, a phased implementation reduces risks of failure. A phased approach, with a more modest start and a greater focus on priorities, would have been more appropriate than the HPSAP in view of the financial and human resources constraints faced by the country.

g) The importance of practical, operational decentralization. The Government realized at the end of the Program that it needed to carry out an effective decentralization of the health system and achieve effective community management of health services in order to overcome the crisis affecting the health sector. Such decentralization would need to focus more than in the past on effective utilization of health services by the affected population, rather than only on their supply.

IMPLEMENTATION COMPLETION REPORT
REPUBLIC OF TOGO
HEALTH AND POPULATION SECTOR ADJUSTMENT PROGRAM
(CR. 2211-TO)

PART I: PROGRAM IMPLEMENTATION ASSESSMENT

I. INTRODUCTION

A. Macroeconomic Setting

1. In the early 1980s Togo faced a severe fiscal and balance of payments crisis, due to inadequate macroeconomic policies and a decline in phosphate, cocoa, and coffee prices. To address its economic problems, Togo entered into a series of structural adjustment programs supported by the World Bank and the International Monetary Fund. These adjustment efforts were generally successful in improving economic performance. Reforms pursued focused on agricultural pricing and marketing policy, restructuring the public enterprise sector and improving resource allocation and efficiency; and promoting industrial sector exports. The three-year long political crisis which started in late 1991, however, led to a significant deterioration of Togo's economic and financial performance. Government revenues dropped 52 percent in 1992-93, while external arrears rose to CFAF 31 billion, approximately 15 percent of GDP. This situation was aggravated by the suspension of external aid.

B. The Bank's Role in the Country and in the Sector

2. The Bank's involvement in Togo has been wide-ranging, involving a mixture of investment and adjustment lending. The Health and Population Sector Adjustment Program represents the Bank's first sector adjustment operation in Togo and the first operation in the health sector. Through implementation of specific institutional reforms, the Program aimed at improving the delivery of primary health care and family planning services. The Program also addressed sector financial management issues, such as maintenance of minimum core expenditures in the sector, institution of a three-year rolling investment budgeting process in the sector, mobilization of additional resources through cost-sharing, and institution of a new program budgeting system.

II. PROGRAM OBJECTIVES

A. Original Program Objectives

3. The principal original objective of the Health and Population Sector Adjustment Program was to support the implementation of a vast program of reforms in the health and population sector, with a view to improving the level of primary health care services and family planning to the population, especially in the rural areas. The reform program intended to reduce, in the short and medium term, morbidity and mortality which resulted from

inadequate treatment and prevention of tropical communicable and parasitic diseases, and to increase utilization of family planning services. More specifically, the Program aimed at helping the Government to: (a) improve sectoral planning; (b) eliminate institutional weaknesses in the Ministry of Health and at the regional level; (c) improve personnel and financial management in the sector; (d) establish cost recovery; and (e) strengthen beneficiary participation in the management of health services.

4. The reforms to achieve the adjustment objectives were centered around five priority axes: (a) improvement in the strategic framework and overall policies, (b) strengthening of the overall management of the sector, (c) strengthening of the financial management of the sector, (d) improvement of service delivery, and (e) strengthening of the effectiveness and management of personnel. The implementation of these reforms was supported by an IDA Credit, which was released in four tranches. The first tranche was released on Credit effectiveness (March 31, 1992). The remaining three tranches were released upon satisfactory fulfillment of the specific tranche release conditions. The tranche release conditions included: (i) the implementation of a macroeconomic framework consistent with Program objectives; (ii) progress in key areas, including the reorganization and strengthening of the MH, establishment of an appropriate system of procurement and distribution of drugs, including adequate mechanisms for cost recovery, and improved access to family planning services; and (iii) allocation of budget resources from the national budget agreed with IDA. The President's Report stated that the Government would increase public sector health expenditures by an average of 7.5 percent each year from 1991-1994. These financial commitments were intended to help sustain the rhythm of the reforms and strengthen the sustainability of the health and population sector institutions. Yet the Government's fiscal effort for health (see Appendix D) fell by 57 percent from 1991 to 1993, but increased nearly 200 percent from 1993 to 1994.

B. Expected Outcomes

5. According to the President's Report, the Program was to contribute to improving the well-being and productivity of the Togolese population by improving health service delivery and by increasing access to services by underserved groups. The population were to become aware of the constraints of high rates of population growth and of their negative consequences on economic development. It was also expected that the performance of the health system would improve, thanks to: (a) better planning; (b) more effective institutional arrangements at the national and regional levels; (c) improved personnel and financial management; and (d) efficient cost recovery and beneficiary participation in service management.

C. The Risks

6. Three risks were described in the President's Report, along with the measures taken to address them. The risks, the measures taken, and the results may be summarized as follows: (a) Government commitment might wane during implementation, which was thought to have been managed by national consensus during preparation, institutional arrangements for

monitoring, and macroeconomic and sectoral conditionalities; during execution, of course, Government commitment did wane, under the stresses of political crisis. (b) Government may lack the institutional capacity to implement the Program, which was thought to have been addressed adequately by the establishment of frequent reviews by the *Comité Technique de Coordination et de Suivi* (CTCS), through training and TA support, and through workshops and planned IDA monitoring; here, too, capacity was weakened rather than strengthened, during the period of Program execution, but probably it was weakened substantially less than it would have been in the absence of the Program. (c) Poor macroeconomic performance may affect resource allocation to the sector or interfere with the proposed reforms. This was thought to have been managed by conditionality linking sector performance to performance at the macroeconomic level, and strong donor commitment.

7. With hindsight it is clear that all three risks became realities. The measures taken to manage them were not adequate, nor - in practice - could they have been adequate to manage the challenges which arose. The risk that Togo might fall into civil strife, and that GDP might collapse, was not specifically identified. This risk clearly overwhelmed all the other risks, and called for alternative responses by the Bank on a country-wide basis; one such action taken was to increase the financing percentage of projects in the portfolio of ongoing operations.

III. IMPLEMENTATION EXPERIENCE AND RESULTS

8. The Credit for the Health and Population Sector Adjustment Program became effective on March 31, 1992. By that time the country was already well into a serious socio-political crisis. This crisis considerably delayed effectiveness and weakened the Government's already limited capacity to manage effectively development programs and policies. The spirit behind, and much of the letter of the commitments given by the Government in its socio-health policy letter, did not survive the crisis which shook the country. The nine-month general strike (November 1992 to July 1993) initiated by the political parties of the opposition, and by the unions, hindered the operation of public services, including health services, and demobilized the personnel directly in charge of the execution of the Adjustment Program.

9. Two institutions were created to monitor and coordinate the different activities foreseen under the Program, the Interministerial Technical Committee for Coordination and Monitoring of the Health and Population Program (CTCS) and the intrasectoral Management and Supervision Committee (*Comité Technique des Directeurs*--CTD). Neither of these bodies was ever able to function properly. Consequently, the overall Program could not be executed with the required rigorous management. The status of execution of the different specific Program priorities set out in the Matrix of Program Targets (see Appendix C) shows that certain sub-programs were neglected or obtained very modest results. Program activities which targeted improvements in specific areas of the health sector and their actual status can be found in the Policy Matrix of Anticipated Actions (see Table 5).

A. Improving the Strategic Framework and National Policies

10. In 1990, the Government adopted a population policy. Its goals were to sensitize the people to the risks associated with rapid population growth, to increase access to family planning services, and to improve the primary health care services in order to combat morbidity and mortality. During the same period, the Government also adopted a general health sector policy to address the basic primary health care needs of the population at the national, regional, and peripheral levels, as well as an operational strategy. The policy document and the strategy based on this policy were to guide all investments in the sector, and formed the basis for the Adjustment Program.

11. A number of positive results were achieved from 1991 to 1996. With the support of USAID and the cooperation of several national and international NGO, the Government intensified the implementation of the national family planning program; this was anticipated specifically in the conditions for release of the second tranche, which called for achievement of satisfactory progress in improving access to family planning services and primary health care. More than one hundred health posts were equipped and their personnel trained in family planning techniques. The national NGO ATBEF (*Association Togolaise pour le Bien-Etre Familial*--The Togolese Association for Family Welfare) trained and deployed nearly 40 "motivators" in family planning throughout the country, joining the 200 agents trained by specialized services. Between 1992 and 1994, US$200,000 worth of contraceptives and condoms were distributed each year in urban centers and in certain rural zones. Policies, standards, and procedures for family planning were developed and provided to the technical services. Teaching of family planning was introduced in training programs at the National Mid-Wives School (*Ecole National des Sages-Femmes*--ENSF) and at the school for medical assistants (*Ecole Nationale des Auxiliaires Médicaux*--ENAM). These efforts helped raise the prevalence rate of modern contraceptives from four percent in 1988 to an estimated nine percent in 1996. With the support of certain donors (mainly GTZ of Germany and the French Cooperation), the primary health care services improved in the Central and Plateaux Regions. However, the success could have been greater if some other highly active donors in the sector (such as the EU and KfW) had not suspended or reduced their assistance due to the socio-political crisis.

12. Additional successes of the Adjustment Program are discussed further below. Particular highlights concern pharmaceuticals, where competitive bidding was introduced and the monopoly of the parastatal TOGOPHARMA was ended. A final, and by no means small, achievement was supporting and preventing further deterioration in the Togolese health system through a period of crisis.

B. Strengthening General Sector Management

13. In its 1991 Health Policy Paper, the Government committed itself to restructuring the Ministry of Public Health by redefining functions and responsibilities at the regional and central level. As executing functions were to be decentralized at the regional and prefectoral levels, the tasks of the central units were redefined to emphasize planning, coordinating,

monitoring, and evaluation. Five central directorates were established within the General Directorate of Public Health: Primary Health Care, Family Health, Planning and Personnel Training, Administrative and Financial Affairs and Pharmaceutical Services. The Directorate of Planning and Personnel Training was expected to play an important role in the implementation of the reform program. However, because of human resource constraints, including the lack of a Director for a number of years, it never functioned properly. Also the other Directorates were affected by important human resource constraints. At the peripheral level, five Regional Health Directorates and 30 Prefectoral Directorates were established. The reorganization implied the organized, systematic transfer of day-to-day management from central to regional and prefectoral units, thereby laying the groundwork for progressive decentralization of the public sector health care services. The function and responsibilities of the peripheral units vis-à-vis the center were, however, never clearly defined. Lack of budgetary resources was a major obstacle for these units to effectively improve the delivery of health services at the peripheral level. The extreme weakness of the center obliged the peripheral units to become self-reliant, utilizing whatever financing they could collect at the local level.

14. As indicated above, two structures were created to ensure inter- and intrasectoral coordination: the Technical Committee of Coordination and Monitoring (CTCS) of the Health and Population Program and the Technical Committee of Directors (CTD). The former was to bring together staff from several ministries and even from outside organizations, such as the Chamber of Commerce, Agriculture, and Industry of Togo. The role of the CTCS was to monitor the effective implementation of the measures and actions foreseen under the Adjustment Program in order to guarantee their coherence and compatibility with the overall objectives of the sectoral policies. It was also to monitor the use of external aid in order to avoid duplication and to assure coherence among the health programs and projects financed by various donors. However, throughout the execution of the Program the CTCS never met, and coordination at the interministerial and donor levels took place on an *ad hoc* basis, mostly organized by the donors through their local offices. Within the Ministry the heads of the programs planned and executed their activities, in cooperation with donors, according to their availability, financing, and individual vision. The Technical Committee of Directors never met, either.

C. Strengthening Sector Financial Management

15. The Ministry of Health adopted a new program budgeting process to ensure that funds were allocated according to established norms and criteria. To this end, the General Directorate of Health developed, in collaboration with the Directorates of the Treasury and Budget, a procedural guide and models of program budgets for each level of service. The adoption of the program budgeting system was useful in determining the funding needed to implement the different priority programs. It was first used during the preparation of the 1996 health budget, and enhanced the capacity of the MH to defend its expenditure proposals during budget discussions with the Ministries of Finance and Planning. However, the manual handling of operations inhibited the verification of available information in a timely manner

and resulted in considerable delays in the centralization and analysis of the data on budget execution.

16. In 1991 the Government instituted a three-year rolling investment budgeting process for health services. With the exception of 1992 and 1993, the health sector PIP was annually discussed and agreed with IDA. Investment expenditures in 1994 and 1995 were in line with the agreed proposals. Discussions on the 1996 PIP led the Government to delete an important construction program of new health facilities, and to give priority to the rehabilitation and re-equipping of existing health infrastructure. Throughout the consultations with the authorities on the health PIP, IDA expressed reservations about certain projects such as the construction of new health centers and hospitals, which had been retained in the program for purely political reasons. The staff asked that they be removed from the PIP, on the grounds that more efficient uses of investment funds for health improvement were available; The 1996-98 health PIP was found satisfactory, and a new PIP is currently under review.

17. Before execution of the Program began, the Government agreed, in its health and social policy statement and in the policy matrix included in the President's Report, to maintain a minimum core of expenditures in the health sector to protect indispensable social services. It also agreed to increase the allocation for non-wage operating expenses from 24 percent of sector expenditures in 1990 to 35 percent in 1994. These measures were to be monitored annually by the CTCS and reviewed jointly with IDA. However, these understandings were not always respected, particularly in 1992 and 1993, when only 20 percent and less than 10 percent respectively, of the planned funds were disbursed for non-wage operating expenses. Faced with budgetary difficulties, the Government continued to pay salary expenses, but reduced the provisions for operating expenses. However, the resources of the IDA Credit helped maintain certain essential services, especially the provision of pharmaceuticals. In effect, a system of informal earmarking of Credit funds evolved in consultation with IDA; this permitted the Togolese authorities to ensure the availability of at least limited amounts (see Appendix D) of liquid resources for health services at a time of great illiquidity.

18. Mobilization of supplementary resources for the health sector was possible primarily because of the introduction, in 1990, of a cost-recovery system under the Bamako Initiative. This system of community financing, which was introduced with the financial and technical support of UNICEF, was first tested in 200 of the 400 dispensaries. In 1994 it was expanded to about 80 percent of the public sector health care facilities in the country. Management Committees, which include community representatives, were established at the level of peripheral health facilities to handle cost recovery and drug revolving funds. However, this system of financial management was never fully implemented. Despite this highly irregular situation, most health facilities were able to retain the vast majority of their receipts; disappearance of funds was kept to a minimum. In December 1995, the Ministry of Health estimated that the communities had contributed about four percent of total health sector spending.

19. Despite cost recovery and IDA funding, financial resources for the health and population sector declined dramatically during execution of the Adjustment Program. As detailed in Appendix D to this report, actual expenditures - from Government funds and donors - were only 40 and 20 percent, respectively, of programmed expenditures in 1992 and 1993; by 1994, thanks to support flowing after the CFAF devaluation, the figure rose to 83 percent.

D. Improving Service Delivery

20. As a result of the IDA Credit, assistance from other donors, NGO, and certain religious orders, the MH was able to rehabilitate and equip health facilities in a few regions of the country, notably in the Plateaux (French Cooperation), Central (KfW-GTZ), and Maritime (GTZ and religious missions) Regions. The support of WHO, UNICEF, UNFPA, AfDB, the World Bank and international and national NGO was instrumental in maintaining a minimum level of maternal and child health services, family planning, AIDS control, and health education. However, these efforts were not sufficient to improve the quality of health services. Because of reduced budgetary allocations and other disruptions, at the time of the completion mission the bulk of the health facilities were in a state of deterioration, and needed urgent repairs. Even in areas where donors helped to rehabilitate health facilities and provide drugs and other needed inputs, the level of utilization of health services remained low.

21. While little viable data are available, health indicators appear to have deteriorated during the crisis. The child mortality rate is estimated at 137 per 1,000, while maternal mortality is now estimated at 600 per 100,000 live births. Morbidity remains high and is characterized by the predominance of infectious and parasitic diseases, with malaria at the top affecting almost 40 percent of the population. Other predominant illnesses include diarrhea, respiratory ailments, malnutrition in children, and HIV whose prevalence is estimated at 5 percent of the adult population. In contrast to the decline in other areas, in STD/AIDS control the Government made notable progress. Training has been organized for health personnel and teachers (250 socio-health staff trained in 1996); condom distribution to persons who are seropositive and to those at risk has reached 50 percent of its objective; sensitization campaigns in the media and sensitization meetings for decision-makers have also been organized. Much remains to be done, however, and the Government has planned several activities which will be executed in the coming years to remind the population of how to manage the risks associated with these diseases.

22. Public sector health facilities were authorized, as of the end of 1990, to retain 20 percent of the receipts of the sale of drugs to finance recurrent costs. The remaining 80 percent was used to establish and operate drug revolving funds. The lack of a system for the regular supply of drugs, however, prevented many health facilities from replenishing their stocks. To remedy the situation, in cooperation with the Bank, the Government decided to earmark under the second and third tranche US$3 million, or approximately 21 percent of the total IDA credit for the purchase of essential drugs; the procurement of these drugs through international competitive bidding resulted in estimated unit cost savings of 20 percent. In the

particular circumstances prevailing in Togo, this action represented an appropriately flexible response by the Borrower and the Bank.

23. In addition to the purchase of drugs, the Ministry of Health began a series of activities leading to better regulation of the pharmaceutical sub-sector: development of a national therapeutic guide and a guide for use of essential drugs; revision of the list of essential drugs and the national nomenclature; development of texts regulating the opening of pharmaceutical depots; development of a national pharmaceutical policy, and the establishment of pharmaceutical legislation. Under the letter of development policy which accompanied the Economic Recovery and Adjustment Credit approved by the Board in 1996, the Government also revised the pharmaceutical law and adopted a regulatory framework for the import and distribution of drugs, as a condition for second tranche release it is adopting a price structure for drugs and pharmaceutical products acceptable to IDA. To ensure a regular supply of essential generic drugs to the country, the Government is establishing a central drug purchasing agency, CAMEG. The statute of this agency, based on a partnership among interested parties, namely, the Government, the donors, and the communities, has been drafted and submitted to IDA for comments.

E. Strengthening Personnel Performance and Management

24. Little progress was achieved in the area of personnel, due to the weakness of the units in charge of personnel management and in-service training, and the flight of many public sector staff from Togo during the crisis. In-service training continued to be managed *ad hoc* by the different donors in the context of their operations. Achievements in the area of personnel management include: the development of personnel norms, and qualitative and quantitative studies on the redeployment and motivation of personnel, with particular reference to the personnel of TOGOPHARMA.

IV. FACTORS AFFECTING PERFORMANCE

A. Difficult Political Environment and Unfavorable Economic Situation

25. Implementation of the Health and Population Sector Adjustment Program began in 1992 in a particularly difficult political and social context. Beginning in November 1992, the general strike by the opposition parties and unions paralyzed the public administration and all economically active sectors for nine months. The economic and social infrastructure was considerably affected and started to deteriorate. During the period of strife, the bilateral donors and the European Union suspended their assistance to the country in the hope that it would push the authorities to accelerate the pace of political reforms. The political events had a deep effect on the economic situation. Between 1991 and 1993, real GDP dropped nearly 22 percent. The fiscal situation deteriorated, and receipts and investment expenses fell by approximately 62 percent and 75 percent, respectively. To finance fiscal deficits, the Government accumulated internal and external payment arrears and relied on advances from public enterprises. Due to a lack of funds, the physical infrastructure was not maintained. This situation gravely compromised access to and use of public sector health services and

undermined implementation of the institutional reforms envisaged in the Sectoral Adjustment Program.

B. Ministerial Instability and Weak Management Capacity at the Ministry of Health

26. One of the primary objectives of the adjustment Program was to help reorganize and strengthen the Ministry of Health both at the central and peripheral levels. This objective however, could not be achieved. The implementation of the entire adjustment Program suffered from considerable ministerial instability. Between March 1992 and the end of June 1996, five different ministers were appointed to head a Ministry whose name also changed according to the circumstances (Ministry of Public Health in 1991, Ministry of Health and Population in 1992, Ministry of Health, Population and National Solidarity in 1994, Ministry of Public Health in 1995, and Ministry of Health in 1996). The frequent change of the person in charge of the Ministry also affected the continuity in the commitments made by the Government to execute reform measures.

27. At the time of Program preparation, the Ministry of Health lacked health economists, planners, managers, and administrators capable of managing the planning, programming, and budgeting of the essential activities. External consultants were hired to assist the Ministry finalize the preparatory studies and implement the program. Technical support on procurement was recruited during execution, to help with what became the successful launching of international competitive bidding for pharmaceuticals. The shortage of qualified personnel became increasingly acute over the years, as Ministry of Finance decisions required that retiring personnel not be replaced; their positions were simply abolished. About 800 persons left the Ministry of Health between 1992 and 1996 and were not replaced. The shortage of staff affected both central and peripheral units, where trained personnel were increasingly replaced by untrained staff.

C. The Role of Program Monitoring Institutions

28. Representing many ministries and professional organizations and responsible for monitoring the implementation of the measures and actions related to the Adjustment Program, the CTCS never functioned throughout the entire implementation of the Program. Also, the Coordination Committee of the central services activities of the General Directorate of Health remained inoperative for the duration of Program execution, so that the consensus necessary to continue the rhythm of reform failed to be sustained. The reforms never received the needed boost, as emphasis by public officials was placed more on the resolution of daily administrative problems. The head of the General Directorate of Health was the only person who could make decisions, and he made them on the spur of the moment, without necessarily referring to the strategies and action plans of the Program. This situation had its origins in the political and civil uncertainties prevailing in Togo.

D. Community Participation

29. The Program envisaged considerable NGO, beneficiary, and community involvement in the management of health programs and problems. The decentralization of the health system at the regional and prefectoral level and the establishment of health management committees at the level of peripheral health facilities were expected to serve this purpose. In reality, communities and NGO were only marginally associated with the execution of the reform program and failed to act in concert with the Ministry to resolve sectoral problems. As a result, the beneficiaries distanced themselves from the public sector health system instead of joining together to play a role complementary to that of the state.

V. BANK AND BORROWER PERFORMANCE

A. Bank Performance

30. The Sectoral Adjustment Program was the Bank's first operation in the health and population sector in Togo, and apparently the first and nearly the only health, nutrition and population SECAL. The Program was prepared when the Government indicated commitment to sector reforms, including participation of beneficiaries. The Bank responded by facilitating the engagement of technical support for the design of the Program. Consultants financed by the Bank reviewed sectoral policies, evaluated the maternal and child health, the family planning, the community development and women's programs, and the costs and expected outcomes of the reforms. Because of the local institutional weaknesses, the preparation process was mostly led by the consultants. The Ministry was neither in a position to internalize the preparation process, nor to ensure the daily management of the Program required to maintain the course of the reforms.

31. Bank supervision missions took place regularly, at a rate of two per year. Even at the height of the socio-political crisis, contact was maintained with the Government through the Resident Mission. The Bank also maintained a permanent dialogue with the other donors in Lomé, and invited them to join supervision missions and other meetings held in conjunction with the monitoring of the Program. WHO, and UNICEF (and until 1994, USAID) were involved and participated in the supervision missions. During the course of supervision, for fully understandable reasons relating to facilitating the release of the tranches, the Bank placed too much emphasis on the tranche release conditions (sector allocations to the State budget, triennial PIP review) and not enough on the institutional reforms. However, the staff were creative and flexible in working with the Borrower informally to adapt the use of Credit funds for purposes which have some similarity to project finance: Specific items were chosen, particularly pharmaceuticals, of special importance for health services, and the Credit funds were reserved by the Government to finance them, even though the formal requirements of the Credit did not foresee this.

32. The Bank's Resident Mission played an essential role in the monitoring of the Program by organizing periodic discussions with the technical services of the sector and the donors' local representatives. These meetings were useful in hastening the preparation of

documents necessary for tranche releases and encouraged the Ministry to review its activities in light of priorities.

B. Borrower Performance

33. The Ministry of Public Health and other Togolese agencies concerned had great difficulty in mastering the Program and in maintaining the pace of reforms, as they lacked the necessary human resources in the areas of planning, programming, budgeting, and the management and the political will that might have been generated by greater continuity of senior officials. The control and monitoring mechanisms did not function, and no activity report was ever submitted to the Bank in spite of the multiple reminders made by the supervision teams and by the Resident Mission. Furthermore, due to a severe cash shortage, the budgetary allocations to the sector were not matched by actual disbursement of the necessary resources to cover operating and maintenance costs. In 1993, for example, the budget allocation for material was only one-third of its 1991 level; furthermore, only 53 percent of this drastically reduced level was actually spent. Thus, the macroeconomic difficulties had a negative impact on the Program and resulted in some activities being not, or only partially, implemented. Overall, the intersectoral coordination, monitoring, and management of the Program were weak.

VI. Program Sustainability and Implications for Future Operations

34. The HPSAP helped the Government, and more precisely the Ministry of Health, to recognize the extent of the sector's problems and the necessity of allocating adequate resources to respond to the needs of the population. This recognition is reflected in the Government's allocating, during the program implementation period, approximately 25 percent of the recurrent health budget to non-salary operating expenses. However, because of resource constraints, the Government commitment failed to be respected in practice.

35. The involvement of the communities in the financing of the sector has become a reality and should be consolidated and expanded in the future. Even if, during the execution of the Adjustment Program, the coordination mechanisms between the different agents and partners (communities, NGO) did not function as envisaged, the presence of the latter in the field remains active.

36. The institutions established in the context of the Program to coordinate interventions in the sector and to regulate the activities of the central, regional, and prefectoral structures, represent a framework which could be mobilized, provided that the political willingness exists and that sufficient leadership is provided by the Ministries of Health, Economics, Planning and Finance. What is needed is a clear and continuing commitment to hold periodic meetings and the engagement of one service to assume an active role as secretary. The program budgeting approach adopted in 1995 should assist the Ministry of Health to evaluate needs, to establish priorities, and to allocate resources.

37. Donor support to the health sector was coordinated at the time of Program preparation but failed to be sustained during execution. During the period of socio-political strife, a number of donors decided to leave the country. Those that remained intervened directly to relieve suffering among the poorest segments of the population through the provision of vaccines, medical supplies, and other essential drugs.

38. The experience of the HPSAP has convinced the Government and IDA of the need to try a new approach to health services delivery, focusing on the implementation of a package of essential health services, the establishment of well managed district health teams, the integration of the services provided within a district, the establishment of a system of referral and counter-referral, the strengthening of supervisory and training activities, support to NGO and other private health providers, and social mobilization of communities. The new approach is expected to be pilot-tested in five districts in the next IDA-financed health project. Examination of the reasons for low utilization of existing capacity will be needed. As a result of the HPSAP experience, particular attention is planned to be given, under the new operation, to establishment and operation of an adequate financial management system for both dispensaries and district hospitals. This would aim to ensure that the use of cost-recovery funds is effective and transparent, that there is adequate control of the cost-recovery process, and that imprest accounts are established at the level of the districts and managed adequately and efficiently. The mobilization of the population in support of their own health services which took place during the HPSAP period should be considered an important step forward, and be used as a building block for future projects in the sector.

39. The HPSAP sought to address the problem of the penury of health personnel at the periphery through the redeployment of staff. This proved very difficult to implement. Under the new operation, the MH intends to handle the management of human resources at the decentralized level, through local contracting of staff. As the decentralization of the health system progresses, the role of the MH will need to change and more emphasis will need to be given - as was intended under the HPSAP - to health policy formulation, standard setting, supervision, monitoring and evaluation. IDA will help strengthen the MH to carry out these responsibilities, but needs to be careful to avoid unintentionally stimulating efforts at recentralization of responsibilities for service delivery under the guise of institutional development.

VII. KEY LESSONS LEARNED

40. The HPSAP was the first Bank-financed operation in the health sector in Togo. A number of important lessons can be drawn from this experience :

a) The inadequacy of adjustment lending as a vehicle to address health sector issues and long-term institutional development problems. An adjustment operation with its tranche release mechanisms focuses the attention of decision-makers on one-time decisions, while the health sector needs a sustained dialogue and more attention to sectoral rather than macroeconomic issues. A series of investment operations would most probably have been

more adequate instruments for achieving the sound policy and institutional reform objectives of the HPSAP.

b) The importance of country strategy and strategy coordination in cases of civil strife. Greater consideration might have been given, for example, to cancellation of the second through the fourth tranches of the SECAL, but work under way which led to the CFA devaluation effectively precluded such action.

c) The importance of modesty and realism in reform programs in an institutionally weak sector such as health. Reading over the Government's statement of health programs and objectives, one cannot help but be struck by its excessively ambitious character, particularly under an adjustment Program which was to be implemented in a four-year period.

d) The importance of identifying and involving key stakeholders. In a capacity building effort it is important to understand who are the key stakeholders and who is involved in the decision-making process. Excessive emphasis was placed on the formal reorganization of the MH without taking into account that the MH had limited control over its own budget. The role of communities as important stakeholders was not sufficiently taken into account under the Program. Community participation was limited to cost recovery, while the Program should have envisaged ways to further involve communities in the management of peripheral health facilities.

e) The importance of ownership of the adjustment operation by the Borrower. Reforms of the magnitude envisaged under the HPSAP need a long process of consensus building extending from preparation through execution. It appears that not much consensus building took place during preparation. Because of MH weakness, excessive use was made of consultants, with the result that the HPSAP was never fully internalized. Indeed, its execution was beyond the capacity of the Togolese civil service.

f) In an environment facing severe financial and human resource constraints, a phased implementation reduces risks of failure. A phased approach, with a more modest start and a greater focus on priorities, would have been more appropriate than the HPSAP in view of the financial and human resources constraints faced by the country.

g) The importance of practical, operational decentralization. The Government realized at the end of the Program that it needed to carry out an effective decentralization of the health system and achieve effective community management of health services in order to overcome the crisis affecting the health sector. Such decentralization would need to focus more than in the past on effective utilization of health services by the affected population, rather than only on their supply.

IMPLEMENTATION COMPLETION REPORT
REPUBLIC OF TOGO
HEALTH AND POPULATION SECTOR ADJUSTMENT PROGRAM
(CR. 2211-TO)

PART II: STASTISTICAL ANNEXES

Table 1: Summary of Assessments

A. Achievement of Objectives	Substantial	Partial	Negligible	Not applicable
Macro Policies	☐	☐	☐	☑
Sector Policies	☐	☑	☐	☐
Financial Objectives	☐	☐	☑	☐
Institutional Development	☐	☐	☑	☐
Physical Objectives	☐	☐	☐	☑
Poverty Reduction	☐	☑	☐	☐
Gender Issues	☐	☐	☑	☐
Other Social Objectives	☐	☐	☑	☐
Environmental Objectives	☐	☐	☐	☑
Public Sector Management	☐	☐	☑	☐
Private Sector Development	☐	☐	☐	☑
Other (specify)	☐	☐	☑	☐

B. Project Sustainability	Likely	Unlikely	Uncertain
	☐	☑	☐

C. Bank Performance	Highly Satisfactory	Satisfactory	Deficient
Identification	☐	☑	☐
Preparation Assistance	☐	☑	☐
Appraisal	☐	☑	☐
Supervision	☐	☑	☐

D. Borrower Performance	Highly Satisfactory	Satisfactory	Deficient
Preparation	☐	☑	☐
Implementation	☐	☐	☑
Covenant Compliance	☐	☑	☐
Operation (if applicable)	☐	☐	☐

E. Assessment of Outcome	Highly Satisfactory	Satisfactory	Deficient
	☐	☐	☑

Table 2: Related Bank Credits

Credit	Purpose	Year of Approval	Status
	Preceding Operations		
Cr. 2174	Vocational Education Training	1991	Ongoing
Cr. 2171	Power Rehabilitation	1991	Ongoing
Cr. 2018	Pre-Investment Project	1989	Ongoing
Cr. 1993	Grassroots Development Initiative	1989	Ongoing
Cr. 1929	Cotton Sector Development	1988	Ongoing
Cr. 1861	Transportation Rehabilitation	1988	Ongoing
	Following Operations		
Cr. 2849	ERAC (Economic Reform Adjustment Credit)	1996	Ongoing
Cr. 2752	Education	1995	Ongoing
Cr. 2620	Lomé Urban Development	1994	Ongoing
Cr. 2367	Togo/Benin Engineering	1992	Ongoing

Table 3: Program Timetable

Steps in Project Cycle	Date Planned	Actual Date
Identification (Executive Project Summary)	February 1988	February 19, 1987
Preparation	January 1989	October 15, 1987
Appraisal	June 1990	June 27, 1990
Health and Social Sector Policy Statement		December 15, 1989
Negotiations	January 1991	January 14, 1991
Board Presentation	February 26, 1991	February 28, 1991
Signing		March 18, 1991
Effectiveness	May 1991	March 31, 1992
First Tranche Release	May 31, 1991	March 31, 1992
Second Tranche Release	April 28, 1992	May 31, 1994
Third Tranche Release	April 28, 1993	October 4, 1995
Fourth Tranche Release	April 28, 1994	June 5, 1996
Credit Closing	June 30, 1995	June 30, 1996

Table 4: Credit Disbursements: Estimated and Actual
(US$ million)

	FY91	FY92	FY93	FY94	FY95	FY96	FY97
Appraisal estimate		4.00	4.00	4.00	2.20		
Actual		1.82	2.22	4.06	0.00	4.16	2.41
Actual as % of estimated		45.5	55.5	101.5	0.0		
Date of final disbursement	August 30,1996						

Table 5: Policy Matrix of Anticipated Actions*: Planned and Actual

Policy Objectives	Measures: Action Area	Measures: Planned	Monitorable Actions:		
			Planned	Timing	Actual
Sector Management	Strengthen personnel capacities	Institute in-service training program	Report on staff deployment and in-service training	Annually from 1991	Report not received. Training began in February 1992; Deployment began prior to March 1992.
			Review progress on reorganization of the MSP	Second tranche (expected April 1992)	MSP reorganized as of February 1992; prior to Tranche Release in May 1994
Sector Financial Management	Improve sector financial Management and accountability	Institute better budgeting, accounting, and financial control	Institute financial management and accounting system	Credit Effectiveness (expected May 1991)	Instituted as of January 1992 according to letter 89/92/MSP/DGS. System was developed in early 1992 and was supposed to be tested in a few health centers. However, because of the political crisis, it was never fully implemented.
		Institute a three-year rolling investment budgeting process	Review PIP for the sectors	Annually from 1991 for each tranche	Done
		Institute program budgeting	Prepare annual program budgets, review of level and composition with IDA; review actual budgetary expenditures for past year	Annually from 1991 for each tranche	Done
	Mobilize additional resources for sector operations	Institute cost recovery activities	Establish mechanism for cost recovery	Second Tranche (expected April 1992)	Mechanism established prior to May 1994.
			Monitoring and evaluation reports on cost recovery	Annually from 1992	First evaluation of cost recovery was undertaken in 1995.
		Promote private and NGO participation in service delivery	Legislative texts on NGO/Private Sector participation in sector	1991	Private sector and NGO played a very marginal role in the program.

*Compiled from the Policy Matrix (Action Plan--Annex 2) of the *Report and Recommendation of the President,* January 23, 1991.

Policy Objectives	Measures: Action Area	Measures: Planned	Monitorable Actions:		
			Planned	Timing	Actual
Improve the coverage and quality of service		Maintain minimum core of expenditures in the sector	Review of budgetary allocation for non-wage expenses and for essential drugs (as part of the annual budget review above)	Annually from 1991 for each tranche	Budgetary allocations for non-wage expenditures were undertaken, however, funds were not provided.
			Implementation of staffing plan for Regional Directorates	From 1991	As of February 1992, Government provided written evidence that all Regional Directors had taken up their functions.
	Expanded Family Planning	Increase coverage and quality of Family Planning Services	Satisfactory report on execution of Family Planning and PHC	Second tranche (expected April 1992)	Coverage increased through the intervention of USAID, UNFPA, and IPPF. Contraceptive prevalence increased from 4% to 9% in 1995.
	Maintain regular supply of essential generic drugs	Establish an essential drug procurement capability	Review essential drugs list and procurement practices	Annually from 1991	Review done in February 1994; in February 1995 agreement to earmark US$2 million of the Third Tranche for Essential Drugs. Improved procurement practices led to substantial savings.
	Promote increased use of upgraded services	Intensify population and health education	Review health education program performance	Annually from 1991	Not carried out.
	Strengthen Primary Health Care	Establish diagnostic and prescription guidelines	Therapeutic guidelines, Essential drugs lists	January 1991	Guidelines and lists completed in January 1992
		Rehabilitate rural facilities and services	Beneficiary evaluation	November 30, 1993	Not carried out.

Policy Objectives	Measures: Action Area	Measures: Planned	Monitorable Actions:		
			Planned	Timing	Actual
	Upgrade staff performance	Institute a computerized personnel management system	Implementation of Staff Deployment Plan. Up-to-date personnel records and defined functions	Credit Effectiveness (expected May 1991)	Staff Deployment completed in February 1992. System introduced and Personnel records updated as of July 1992.
		Train staff of Personnel Division and Key Program Managers and supervisors	Reports on staff training	Annually from 1992	Staff training took place primarily through donor programs.
		Institute regular in-service training for staff in the sector	Report on in-service training and performance of staff	Third tranche (expected April 1993)	Satisfactory progress made to meet Tranche Release condition.

Table 6: Studies Included in the Program

Study	Purpose as defined at Appraisal/Redefined	Status	Impact of Study
June 1995:	Proposal to restructure TOGOPHARMA as a national center for the supply of essential generic drugs, under the proposed Health Project (FY98)	Completed	Plan for restructuring proposed, including financing arrangements and timeline. Analysis not used as plan was dropped from proposed project. A new drug purchasing agency (CAMEG) will be established under a planned new project as TOGOPHARMA will undergo privatization.

Table 7A: Program Costs

Category	Appraisal Estimate (US$M)	Actual/Latest Estimate (US$M) (April 15, 1997)
1. Goods & Services		11.11
2. Petroleum Products		0.00
3. Refinancing of PPF 448		2.84
SA*-A BCEAO		0.72
SA-P BIAO		0.00
Total (for all categories)	14.2	14.67

*Special Account

Table 7B: Program Financing

	Appraisal Estimate (US$M)			Actual/Latest Estimate (US$M)		
Source	Local Costs	Foreign Costs	Total	Local Costs	Foreign Costs	Total
IBRD/IDA			14.2			14.672
Total			14.2			14.672

Table 8: Status of Legal Covenants

SELECTION NO. OF CREDIT/LOAN AGREEMENT	COVENANT	STATUS C=In Compliance NC=Not In Comp. NYD=Not Yet Due	COMMENTS	ACTION TAKEN OR REQUIRED
2.01 (b)	Make deposit into, and payments out of the S.A. in accordance with DCA.	C		
3.01 (a)	The Borrower and the Association shall from time to time, at the request of either party, exchange views on the progress achieved in carrying out the Program and the actions specified in Schedule 3 to this Agreement.	C		
3.01 (b)	Prior to each such exchange of views, the Borrower shall furnish to the Association for its review and comment a report on the progress achieved in carrying out the Program, in such detail as the Association shall reasonably request.	C		
3.02	Except as the Association shall otherwise agree, procurement of the goods to be financed out of the proceeds of the Credit shall be governed by the provisions of Schedule 2 to this Agreement.	C		
3.03 (a)	The Borrower shall maintain or cause to be maintained records and accounts adequate to reflect in accordance with consistently maintained sound accounting practices the expenditures financed out of the proceeds of the Credit.	C		
3.03 (b)(i)	The Borrower shall: (i) have the records and accounts referred to in paragraph (a) of this Section, including those for the Special Account, for each fiscal year audited, in accordance with appropriate auditing principles consistenly applied, by independent auditors acceptable to the Association.	C		

SELECTION NO. OF CREDIT/LOAN AGREEMENT	COVENANT	STATUS C=In Compliance NC=Not In Comp. NYD=Not Yet Due	COMMENTS	ACTION TAKEN OR REQUIRED
3.03(b)	(ii) furnish to the Association as soon as available, but in any case not later than four months after the end of each such year, a certified copy of the report of such audit by said auditors, of such scope and in such detail as the Association shall have reasonably requested;	C		
3.03 (b)(iii)	(iii) furnish to the Association such other information concerning said records and accounts and the audit thereof as the Association shall from time to time reasonably request.	C		
3.03 (c)	Maintain or cause to be maintained, Records and accounts reflecting statement of expenditures.	C		
3.03 (c)(iii)	Enable the Association's representatives to examine such records.	C		
3.03 (c)(iv)	Ensure that such records and accounts are included in the annual audit and that the report of such audit contains a separate opinion by said auditors as to whether the statement of expenditure submitted during such fiscal year, had procedures and internal controls involved in their preparation, can be relied upon to support the related withdrawals.	C		
3.04	The Borrower shall carry out a survey of the beneficiaries of health services to determine how they perceive the effectiveness of services being provided to them and submit the results of said survey to the Association by November 30, 1993.	NC	Togo's prolonged political and social turmoil prevented the carrying out of the survey.	

Table 9: Bank Resources: Staff Inputs

Stage of Project Cycle	Planned		Actual	
	Staff Weeks	US$ ('000)	Staff Weeks	US$ ('000)
Preparation to appraisal	Not Available	Not Available	36.1	64.3
Appraisal	Not Available	Not Available	73.8	142.3
Negotiation through Board approval	Not Available	Not Available	25.8	51.4
Supervision	14.0	34.3	63.6	127.9
Completion	10.0	15.2	10.6	14.3
TOTAL			199.3	400.2

Table 10: Bank Resources: Missions

					Performance rating		
Stage of project cycle	Month/ Year	Nmber of persns	Days in field	Spcialized staff skills reprsented	Impl. status	Dev. obj.	Types of Problems
Supervision							
	9/91	1	5	Sr. Pop/Hlth Spec.	2	2	
	1/92	1	5	Sr. Pop/Hlth Spec	2	2	
	11/93	3	3	Sr. Pop/Hlth Spec PHN Spec. Mgmt. Spec.	4	4	Political and social upheaval
	2/94	1	3	Sr. Pop/Hlth Spec	3	3	Political and social upheaval, CFAF devaluation
	2/95	2	14	TL/PHN Spec Pharm. Spec	S	S	Previously agreed plans no longer provided relevant guidance on appropriate budgetary allocation.
	5/95	3	6	TL/PHN Spec Pharm. Spec. Physician	U	S	Implementation of a number of project components could not be carried out or was insufficiently implemented.
	11/95	4	16	TL/PHN Spec Pharm. Spec. 2 Physicians			Need to prepare new medium-term financial framework for the sector.
	3/96	3	19	TL/PHN Spec Pharm. Spec. Physician	S	S	
Mid-Term Evaluation	N/A						

IMPLEMENTATION COMPLETION REPORT
REPUBLIC OF TOGO
HEALTH AND POPULATION SECTOR ADJUSTMENT PROGRAM
(CR. 2211-TO)

APPENDIXES

Appendix A

REPUBLIQUE TOGOLAISE

PROJET D'AJUSTEMENT SECTORIEL SANTE ET POPULATION (CR. 2211-TO)

Mission de Préparation du Rapport d'Achèvement du Projet

(Octobre 1996)

AIDE-MEMOIRE

1. En marge des travaux de préparation du Programme de Relance du Secteur de la Santé (cf. Aide-Mémoire séparé du 25 Novembre 1996), une mission de la Banque Mondiale comprenant Mme Bruna Vitagliano, Chef de Mission, et Monsieur Fily d'Almeida, Chargé d'Opérations Principal à la Mission Résidente a, du 28 au 30 Octobre 1996, eu des séances de travail avec les autorités togolaises au sujet de la préparation du rapport d'achèvement du projet, conformément aux dispositions prévues en ce sens par l'Accord de Crédit 2211-TO. L'objectif des discussions était de faire le point sur l'état de préparation du rapport d'achèvement à la lumière des informations fournies aux responsables togolais au cours de la mission de supervision du Crédit 2211-TO de Février-Mars 1996.

2. La mission tient à remercier tous ceux qu'elle a rencontrés dans le cadre de ses travaux, en l'occurrence S.E. Monsieur le Ministre de la Santé et ses collaborateurs, les représentants des Ministères du Plan et de l'Aménagement du Territoire, de l'Economie et des Finances, et de la BCEAO pour la collaboration dont elle a bénéficié de leur part. Elle remercie également les représentants de la Mission Française de Coopération, de l'OMS, de l'UNICEF, de l'Union Européenne, de la GTZ, des ONG Iles de Paix et Care International avec qui elle a eu des échanges de vue très fructueux.

Situation du Crédit 2211-TO

3. Conformément aux prévisions, le Crédit 2211-TO a été clôturé par la Banque le 30 Juin 1996. Les demandes de retraits de fonds pour le décaissement de la 4ème tranche d'un montant de 2,2 millions $EU ont été soumises par la BCEAO avant la date de clôture. La mission a été informée par les responsables des ministères de la Santé et des Finances et de la BCEAO, que l'état d'avancement des programmes appuyés par le crédit ne pouvait pas permettre l'absorption des fonds décaissés avant le 31 Décembre 1996. La mission a répondu que comme il s'agit d'un appui au budget du Ministère de la Santé, il appartient aux autorités compétentes togolaises de trouver une solution à ce problème sur la base des dispositions relatives au budget et à la

comptabilité publique en vigueur au Togo. La mission a néanmoins insisté sur l'obligation pour le Gouvernement de transmettre un rapport d'audit final sur le compte spécial ouvert à la BCEAO avant fin Décembre 1996.

Préparation du Rapport d'Achèvement

4. La mission a noté que le Ministère de la Santé n'a pas produit de rapport provisoire d'achèvement contrairement à ce qui a été convenu au cours de la mission de Février-Mars 1996. Aussi, au cours d'une réunion plénière organisée au Ministère de la Santé et réunissant les représentants du Gouvernement et les bailleurs de fonds, la mission a-t-elle réexpliqué à ses interlocuteurs les objectifs du rapport d'achèvement : il s'agit d'améliorer la qualité des opérations financées par la Banque et de renforcer les capacités de l'emprunteur à concevoir et exécuter des projets comme celui concerné. Plus spécifiquement, pour ce qui concerne les projets d'ajustement sectoriel, il s'agit d'évaluer les progrès enregistrés dans la mise en oeuvre des mesures de politique et des réformes institutionnelles, et d'apprécier si les réformes sont appropriées pour résoudre les problèmes identifiés. Le Gouvernement et la Banque doivent préparer chacun de son côté un tel rapport dont le contenu doit s'articuler autour des points ci-après : a)- présentation des objectifs ; b)- réalisation des objectifs ; c)- facteurs essentiels ayant affecté le projet ; d)- durabilité du projet ; e)- évaluation des performances de la Banque ; f)- évaluation des performances de l'emprunteur ; g)- évaluation des résultats enregistrés ; h)- future opération; i)- principales leçons à tirer du projet.

5. Le Ministère de la Santé a indiqué que toutes les informations et données nécessaires ont déjà été recueillies après consultation et enquête sur le terrain. Il revenait tout simplement à la Cellule de Coordination du projet de les compiler et de mettre en forme le rapport. Compte tenu du retard considérable enregistré par rapport au délai fixé dans l'Accord de Crédit, la mission a suggéré qu'une équipe technique de 3 membres comprenant des représentants des ministères de la Santé, de l'Economie et du Plan soit mise sur pied pour assister la Cellule de Coordination du projet dans la production du rapport provisoire qui devra être soumis à l'IDA pour commentaires avant finalisation. Il a été convenu de commun accord que l'équipe en charge produira un document de 10 pages qui devra être transmis à l'IDA pour observations le 12 Décembre 1996 au plus tard. L'IDA devra faire parvenir ses observations au Gouvernement avant le 20 Décembre 1996 pour permettre à celui-ci de finaliser le rapport et de le transmettre à l'IDA le 30 Décembre au plus tard.

6. Le Ministre de la Santé, à qui la mission a fait part de ses préoccupations, a promis de suivre personnellement la rédaction du rapport pour assurer qu'il soit transmis dans les délais convenus. Il a tenu à remercier la Banque pour la disponibilité dont elle a fait preuve dans les discussions et souhaité que le retard enregistré par son département n'affecte point le rythme de préparation du nouveau programme de relance du secteur de la santé.

Appendix B
Summary of the Government's Report on Program Implementation--Credit 2211-TO*

According to the Government's report, there were both internal and external factors which affected the outcome of the project. Internal factors included coordination and execution units (CTCS, CTD) which never played an active role in the implementation of the project, and the delays and lack of qualified personnel in the coordination secretariat. In addition, a lack of required guiding principles, including delegation of authority and inadequate means, coupled with resistance to change, resulted in not fully achieving decentralization. Personnel problems, including a shortage of qualified personnel, especially in management and accounting, greatly affected the project's execution. This lack of accounting professionals has prevented the implementation of the new decentralized central accounting system. The management tools in the health centers are hardly used, if at all, which has cleared the way for irregularities due to a lack of supervision. In order to sustain the system, a solution to this problem must be found quickly. Finally, a solution to the medical stock problem must be found in order to stop the frequent stock shortages.

External factors also played a role in the slow execution of the project. One of these factors is the persistent economic crisis, which was further aggravated by the January 1994 devaluation of the CFAF. Additionally, the socio-political crisis which paralyzed the administration, slowed the project's implementation and again plunged the sector into an emergency situation. As a result, the project objectives were reviewed and modified in December 1994, and a large part of the credit was earmarked for vaccines and medications in order to maintain coverage, and curative and preventative services. Finally, in order to overcome the problem of a personnel shortage, a portion of the credit was used to recruit contractual personnel. The Government report insists the project's activities will be maintained, and that cost recovery was the most successful of the project's activities. Cost recovery allowed for a rapid implementation of a new community finance policy, and acts as a means of guaranteeing improved quality and ensuring sustainability.

Several lessons can be learned from this project:

- Politico-administrative decentralization is necessary to allow for improved functioning of the health sector and especially the health districts.
- Personnel shortages in the sector are a serious handicap which slows the implementation of reforms and hinders the realization of certain objectives.
- Improved budgetary and accountability practices have led to better budgeting and activities management.
- The sector needs the Government to be pro-active with regard to policy-making.
- Simplified administrative procedures, especially with regard to procurement procedures, would eliminate the administrative red tape and facilitate decision making.

---

* The full French text is available, upon request, from the Africa Information Services Center of the World Bank.

MATRIX OF HEALTH PROGRAM TARGETS

PROGRAM*	OBJECTIVE*	STATUS
Maternal and Child Health Care, Family Planning, and Nutrition	Reduce the maternal mortality rate from 500 to 250 per 100,000 live births, by 1995. Reduce instances of anemia among pregnant women from 46% to 10%, by 1995. Improve the quality and increase the frequency of monitoring of pregnancies for 70% of expectant mothers, by 1995. Provide better delivery and postpartum care for 40% of mothers, by 1995.	Only pre-crisis statistics are available, so it is impossible to provide a quantitative assessment. Some training was provided to healthworkers to improve their handling of deliveries, referral for prenatal care, tetanus immunization, handling of risk cases, etc. However, indicators of maternal mortality and morbidity have not improved and there is anedoctal evidence that the situation may have worsened following the three years of political/social turmoil.
	Increase the use of modern contraceptive methods from 5% to 15%, by 1995.	Use of modern contraceptive methods increased from 4% in 1990 to 9% in 1995. About 50% of health facilities currently provide FP services. The Government has integrated STD and AIDS control into the MCH and FP program and is currently preparing a national reproductive health program.
	Promote proper nutrition from 50% of children up to age 5, and monitor their physical development. Reduce the prevalence of protein-calorie deficiencies among children up to age 5 from 25% to 20%, by 1995. Reduce the manifestations of severe nutritional deficiencies, by 1994, and the physical deformities they cause, by 1999. Evaluate the prevalence of vitamin A deficiency and develop a program to eliminate this endemic problem.	Current data on child nutrition are unavailable, however, child malnutrition appears to have worsened with the sharp deterioration of the economy.
	Study the different causes of acute respiratory infections (19991) as a step toward selecting appropriate treatments, by 1995.	Activities undertaken include: training of health workers, epidemiological surveys in two districts, purchase of 100 stethoscopes, rehabilitation of the building housing the program, and purchase of a vehicle for the program.
	Reduce the mortality rate from diarrheal diseases by 70%, by 1995.	500,000 ORS packets were distributed to dispensaries in 1995. Efforts were made to improve epidemiological surveillance. No impact on indicators was found.

*Compiled from the Health and Social Sector Policy Statement (Annex 1 (b)) of the *Report and Recommendation of the President*, January 23, 1991.

PROGRAM	OBJECTIVE	STATUS
Maternal and Child Health Care, Family Planning, and Nutrition (continued)	Increase vaccination coverage (measles, diphtheria, tetanus, poliomyelitis, pertussis, and tuberculosis) from 52% to 90%, by 1994. Increase vaccination coverage of women of childbearing age from 62% to 90%, by 1994.	Vaccination coverage is now estimated to be down to 40% due to a lack of vaccines.
School and University Health Program	Set up a system for monitoring the prevalence of diseases in schools and universities. Set up a system for the annual checking of the health of 4,000 children attending pre-school establishments. Train 27 prefectural medical directors, 123 inspectors, 1,000 teachers, 6 medical assistants, 94 nurses, 39 social workers, and 39 hygiene workers by providing two seminars per year. Evaluate the epidemiological situation in schools in 1992.	Activities carried out include: (i) survey of the health situation in schools; and (ii) the situation of vaccination in 16 schools.
Malaria Control Program	Reinforce malaria control measures as part of the primary health care delivery system by increasing access to diagnosis and to early and appropriate treatment from 33% to 70% of sufferers, by 1995. Reduce severe cases, complications and the mortality rate from malaria, particularly among children up to age 5 and pregnant women by 50%, by 1995.	Current data on malaria incidence and treatment are unavailable. Local manufacturing of bednets started in 1995. A center for bednet impregnation was set up in Lomé in 1995. Laboratory materials and drugs were purchased for the program. A number of IEC activities were launched via radio, TV, and seminars.
Campaign against TB and Other Respiratory Diseases	Increase the number of patients in treatment from 500 a year to 3,000, over the 1991-1994 period. Reduce the rate of abandonment of treatment by 25%, by 1994. Improve the compilation statistics on the 2,000 patients who are in treatment. Reduce the manifestations of severe deficiencies and the resulting abnormalities by 50%, by 1995.	Training of mobile teams was carried out from 1992-95. 140 doctors, 170 nurses, and 50 laboratory technicians were trained. 1,137 new cases of TB and 1,300 cases of leprosy were identified during the period 1992-94. Other data are unavailable.

PROGRAM	OBJECTIVE	STATUS
Program to Control Sexually Transmitted Diseases and AIDS	Inform, sensitize, and educate the population regarding their adoption of behaviors likely to reduce sexually transmitted diseases and AIDS. Prevent the transmission of HIV through blood transfusions. Provide care for individuals testing HIV+. Provide counseling for family members of persons with AIDS.	Intensive IEC campaigns were launched with donor financing. Epidemiological surveillance has been intensified. Materials, condoms, etc. cover about 50% of the need. Blood screening to aid in the prevention of transmission of HIV through blood transfusion has reached 50%. 350 social workers and teachers were trained to provide HIV/AIDS counseling.
	Incorporate measures for the control of sexually transmitted diseases and AIDS into the primary health care delivery system.	Major constraints to this measure are the extreme weakness of the health care system, and its lack of human and material resources.
	Improve knowledge of the epidemiological situation in this field and set up a system of epidemiological research. Provide training for health and social sector personnel employed in the campaign against sexually transmitted diseases and AIDS.	Epidemiological surveys have been carried out and a surveillance system for risk groups has been put in place. This has improved knowledge of HIV prevalence in the country.
Dental and Oral Health Program	Evaluate the prevalence of dental caries and periodontal diseases and identify the major causes.	The preparation for an epidemiological survey was completed (sampling undertaken, questionnaire completed, and material for survey acquired). Insufficient financial resources prevented carrying out the prevalence survey. Existing dental services have received some material and equipment. An IEC document has also been finalized.
	Design and institute a dental and oral health policy (1991). Increase accessibility to and availability of dental services. Sensitize the population to the need for dental and oral hygiene.	This program as well as other programs listed in this matrix have suffered considerably from a lack of resources. Executed as vertical programs, they depend almost exclusively on donor assistance.
	Increase the number of dental consultations from 50,000 to 175,000 by 1995.	This has not been achieved.
	Create 15 dental clinics at prefecture level by 1994.	2 new dental services were opened at the prefectoral (district) level.

PROGRAM	OBJECTIVE	STATUS
Campaign against Onchocerciasis	Break the onchocerciases transmission chain with ivermectin Train four physicians and 10 nurses in the specialty of ophthalmology, by 1994. Retrain nurses and midwives in using--and providing instruction in the use of--preventive care against eye diseases. Reduce the current prevalence rates of blindness due to neonatal conjunctivitis by 50%. Provide systematic antiseptic treatment of all newborns, beginning in 1991.	Onchocerciasis is receiving attention from the international community. Surveillance, treatment, and the fight against the vector continue satisfactorily. Devolution - enlarged to trypanosomiasis and guinea worm - receives limited support.
Campaign against Cardiovascular Diseases	Evaluate the general prevalence of cardiovascular diseases in the population at large (1991-1992). Propose a plan for a campaign against complications from cardiovascular pathology.	Support received for this program has allowed identification of major cardiovascular diseases in the country, evaluation of the prevalence of cardiovascular diseases, acquisition of diagnostic and treatment materials, and preparation of a national policy for addressing cardiovascular diseases.
Environmental Sanitation	Test the quality of water obtained from all locally used sources so that appropriate steps can be taken where they are unsafe. Begin setting up trash removal systems in the country's four major urban areas.	No activity appears to have been undertaken in this area.
Community Development Program	Strengthen 1,500 existing CVDs (Village Development Committees) in 1991. Promote the creation of 2,880 new CVD.	1,500 CVD have been strengthened through training. About 2,880 new CVDs have been established and 300 trainers in community development have been trained.
	Train 300 Community Development Trainers. Create groupings/associations for production purposes and use of appropriate kinds of technology.	Village production groups have received support and access to appropriate technology. Institutional capacity for community development has been strengthened.
Literacy and Adult Education Program	Set up centers at CVD level.	Literacy activities have been carried out and 300 new literacy centers have been established.

PROGRAM	OBJECTIVE	STATUS
Juvenile Support Program	Provide educational programs to assist minors with behavioral problems in re-entering the mainstream of education and production. Educate young people for family life.	810 youngsters have been assisted under this program and 1,325 youngsters who received training in crafts have been assisted in their search for a job.
Integration of Women in Development	Increase women's participation in development by creating a social and cultural environment that encourages them to broaden their horizons and look outside their usual environment. Promote access for women to the means of production for crop growing, livestock raising, and artisanal activities. Increase women's productivity. Reduce the illiteracy rate among women from 71% to 65% by 1995. Provide advisory/supervisory services for rural women. Ensure that all development projects include a women's development component. Educate women and couples to make more active use of family planning services in the interests of lower mother and infant mortality rates, birth spacing, and he welfare of both women and the family. Alleviate the burden of domestic chores. Provide greater access for women to formal and informal training at all levels. Provide training for women heads of groupings/associations in the management of development activities and ensure their access to advisory/supervisory services. Improve the compilation of statistics on women. Provide training for urban women in business management so that they are better equipped to run income-generating activities.	The General Directorate for Promotion of Women carried out a decentralization of its activities and strengthened their management and coordination at the regional and district levels. An effort has been made to improve the economic and legal situation of young women in rural areas. Most of the activities expected to be carried out with support of the IDA Credit have only partially materialized.

PROGRAM	OBJECTIVE	STATUS
Essential Generic Drugs Program	Reorganize and streamline the system by which essential pharmaceutical goods are supplied, by 1993. Ensure that essential generic drugs are permanently available at the lowest possible cost from all publicly-run health facilities, by 1994. Decentralize the essential drugs distribution, warehousing and control system, down to the community level (1991-1993). Improve inventory management and introduce an inventory replenishment system, by 1993.	Considerable action has been carried out in this area. The 1929 pharmaceutical legislation was revised to take into account the procurement of essential generic drugs. A pharmaceutical policy was also prepared with the support of IDA and WHO. A proposal to restructure TOGOPHARMA has been dropped, and the Government has instead agreed to establish a new purchasing agency for essential generic drugs. A draft statute of this new agency, based on a partnership among interested parties--the government, the donors, and the communities--has been prepared and has received the comments of IDA and other donors. About US$3 million of the IDA funds under the adjustment Credit were used to purchase essential generic drugs.
Cost Recovery Program	Design, test and evaluate a cost-recovery system in publicly-run health facilities, 1991-1993. Institute user participation n the financing of recurrent costs, 1991-1993. Increase the flow of financial resources to the sector so that better health coverage will be available from the beginning of 1993.	Cost recovery has been carried out with support of both the IDA-financed operation and UNICEF's Bamako Initiative. It is now effective in about 80% of health facilities. Funds collected through cost recovery have allowed peripheral health facilities to continue their activities during the prolonged crisis.
Sensitization, Education, and Information	Sensitize the population to the need for prevention of transmittable disease, 1991-1994. Educate the population in prevention methods, 1991-1994. Promote community health, particularly in rural and peri-urban areas, 1991-1994. Promote better utilization of health services and family planning throughout the population, 1991-1994. Design and prepare activities to educate young people for family life, 1991-1994. Arrange for participation by NGO in the national family planning program (continuing).	There is no comprehensive IEC strategy for health in the country. IEC activities have been limited to FP and HIV/AIDS control; weaknesses in donor cooperation have limited other IEC activities. A national Health Education Service has been established but is very weak.

PROGRAM	OBJECTIVE	STATUS
Sensitization, Education, and Information (continued)	Support health ad social sector programs with sensitization and education activities focused on health and social matters (continuing). Develop sensitization and education materials for use by the various service departments of the Ministry of Public Health (continuing). Strengthen the capacity of the National Health Education Service to provide better education for the population in health, social and family planning matters (continuing). Collaborate with the Ministry of Information in sensitizing community groups to the goals, strategies and programs associated with the national population policy (continuing).	No activity appears to have been undertaken in this area.
Institutional Reform Program	Rehabilitation of health infrastructure (dispensaries, medico-social centers, prefecture hospitals, and regional hospital centers)	Rehabilitation, thanks to donor assistance, took place in the following regions: Plateau (French Cooperation), Central (KfW-GTZ), and Maritime (GTZ and religious missions). However, rehabilitation on the scale envisaged under the program was limited due to financial resource constraints, as most donors pulled out of Togo during the political/financial crisis.
	Restructuring of the headquarters and regional departments of the Ministry of Health, in accordance with the new organization chart approved	Partly carried out.
	Establishment of a National Maintenance and Repair Service, as per the new Ministry of Health organization chart	A component of the AfDB project, it was not carried out as AfDB suspended financing for almost 4 years.
	Strengthening of planning/programming/coordination activities throughout the health and social field (recruitment/training of planning specialists, creation of a technical committee consisting of department heads and of a technical committee for program coordination and monitoring	Not carried out because of lack of financial and human resources.

PROGRAM	OBJECTIVE	STATUS
Institutional Reform Program (continued)	Strengthening of financial management (recruitment/training of technical specialist, 1991-1993, and introduction of a cost and stock accounting system.	Not carried out because of lack of human resources.
	Strengthening of personnel management and enhancement of capabilities (introduction of a personnel management system and training programming measures)	Not carried out because of lack of human resources.

TOGO HEALTH AND POPULATION SECTOR ADJUSTMENT PROGRAM

HEALTH AND POPULATION SECTOR EXPENDITURES, 1990-1996
(in Millions of Current FCFA)

	1990	1991			1992			1993			1994			1995		1996
	Actual	Actual	Budget	PR	Actual	Budget	PR	Actual	Budget	PR	Actual	Budget	PR	Actual	Budget	Budget
Governmental Financing																
1 MSP/MASCF Recurrent Expenditures	4,785	4,996	4,871	5,933	4,323	5,156	6,348	2,191	3,096	6,856	6,399	6,663	7,397	6,194	6,593	7,010
2 MSP/MASCF Investment Expenditures	475	212	259	1,345	0	0	1,446	127	225	1,554	93	239	1,671	936	1,107	701
Total Government effort	*5,260*	*5,208*	*5,130*	*7,278*	*4,323*	*5,156*	*7,794*	*2,317*	*3,321*	*8,410*	*6,492*	*6,901*	*9,068*	*7,130*	*7,700*	*7,711*
Non-Governmental Financing a/																
4 IDA	311	88	838	1,200	1,434	1,534	1,200	229	712	1,200	1,752	2,687	600	2,349	2,352	1,205
5 Other Donors	402	158	1,800	4,174	11	2,491	5,108	0	2,113	2,603	2,400	3,759	2,067	4,333	5,300	5,357
Total Non-Governmental Financing	*712*	*246*	*2,638*	*5,374*	*1,445*	*4,025*	*6,308*	*229*	*2,825*	*3,803*	*4,152*	*6,446*	*2,667*	*6,682*	*7,652*	*6,562*
Total Public Sector Expenditures for Health and Population	**5,973**	**5,453**	**7,768**	**12,652**	**5,768**	**9,181**	**14,102**	**2,546**	**6,146**	**12,213**	**10,644**	**13,348**	**11,735**	**13,812**	**15,351**	**14,272**
Ratios																
IDA Financing/Total Expenditures	5%	2%	11%	9%	25%	17%	9%	9%	12%	10%	16%	20%	5%	17%	15%	8%
Other Donors Financing/Total Expenditures	7%	3%	23%	33%	0%	27%	36%	0%	34%	21%	23%	28%	18%	31%	35%	38%
Governmental Financing/Total Expenditures	88%	95%	66%	58%	75%	56%	55%	91%	54%	69%	61%	52%	77%	52%	50%	54%

n.a. = not available

PR = President's Report No. P-5395-TO—*Health and Population Sector Adjustment Program* as designed.

a/ Resources from cost recovery were programmed for 1992-1994 at 260 million FCFA, 669 million FCFA, 1,089 million FCFA, respectively. Actual resources from cost recovery have been estimated at about 800 million FCFA for the period 1991-1995.

Source: President's Report No. P-5395-TO of January 23, 1991 and Togo: Public Expenditures Review, February 1997.
Ministère de la Santé. Evaluation des activités de soins, de gestion et de financement communautaire. Août 1996.

This PIF was posted on September 10, 1997

OED ID :	C2211
Type :	EVM
Country :	Togo
Project Description :	Health & Pop. Sector Adj.
Sector :	HX / Population, Health & Nutrition
Subsector :	HH / Population, Health & Nutrition Adjustment
Lending Instrument :	Sector Adjustment
L/C :	C2211

Operations Evaluation Department
PROJECT INFORMATION FORM

Table of Contents

A1. General Project Information

OED ID :	C2211
Type :	EVM
Country :	Togo
Project Description :	Health & Pop. Sector Adj.
Sector :	HX / Population, Health & Nutrition
Subsector :	HH / Population, Health & Nutrition
Lending Instrument :	Sector Adjustment
L/C :	C2211

1. Reviewer: Timothy A. Johnston

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

Sugg. Sector:
Sugg. Subsector:

3. Key Dates

	Original	Latest
Departure of Appraisal Mission		06/27/90
Approval		02/28/91
Signing/Agreement		03/18/91
Effectiveness	06/17/91	03/31/92
Physical completion	06/30/95	06/30/96
Closing	06/30/95	06/30/96
ICR receipt in OED		06/30/97
Review date		07/28/97
EVM/PAR approval		09/09/97

4. Key Amounts ($US million)

Original Commitment	14.2
Total Cancellation	0
Total project cost	
Original	14.2
Latest	14.67

5. Cofinanciers

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

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

Physical	0
Technical assistance	0
Balance of payments	11.11
Line of credit	0
Other	3.56

7. Applicable disbursement profile (no. of years): 6

8. Number of supervision missions: 8

9. Name(s) of primary author(s) of ICR (indicate if not known): Fily D'Almeida and Bruna Vitagliano

11. Names of managers

	At entry	At exit
Task manager	Michael Azefor	Bruna Vitagliano
Division chief	Michel Palein	Helen Ribe
Department director	Michael Gillette	Theodore Ahlers

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? **No**

   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	
A structured set of indicators	
Requirements for data collection and management	
Institutional arrangements for capacity building	
Feedback from M&E	

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

Physical	Modest	Institutional	High
Financial (interest rates; pricing / tariff policies; cost recovery	Substantial	Social	Modest
Economic		Environmental	Negligible
Macro-economic policies (fiscal; monetary; trade)	Substantial	Private sector development	Negligible
Sector policies	High	Other (specify):	

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	Substantial
Economic	
Macro-economic policies (fiscal; monetary; trade)	Substantial
Sector policies	Modest
Institutional	Substantial
Social	Not Applicable
Environmental	Not Applicable
Private sector development	Not Applicable
Other (specify):	

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: Substantial

Average rating: Substantial

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

B1b. Outcomes — Efficacy

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

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

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: Modest

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

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	No Effect	Performance of contractors / consultants	No Effect
Natural events	No Effect	War / civil disturbance	Highly Negative
Cofinancier(s) performance	Negative	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: Modest

Average rating

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

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: Marginally Unsatisfactory

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

B2. Sustainability

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

Technical viability	No Effect	Policy environment	Positive
Financial viability	Negative	Institution / management effectiveness	Negative
Economic viability	Negative		
Social conditions	No Effect	Local participation	No Effect
Environmental concerns	No Effect	Other (specify):	
Government commitment	Positive		

2. SUMMARY SUSTAINABILITY RATING

Rate the probability of maintaining the project's relevant development achievements generated or expected to be generated: Unlikely

Average rating: Unlikely

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

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

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: Negligible

Average rating: Negligible

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	Modest
Involvement of beneficiaries	Negligible
Project consistency with Bank strategy for country	Substantial
Grounding in economic and sector work (ESW)	Modest
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)	Substantial
Financial analysis (inc. funding provisions, fiscal impact)	Substantial
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	Negligible
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	Substantial
Identification / assessment of implementation problems	Modest
Use of performance indicators	Negligible
Enforcement of Borrower provision of M&E data	Negligible
Advice to implementing agency	Substantial
Enforcement of loan covenants / exercise of remedies	Substantial
Flexibility in suggesting / approving modifications	Substantial
Other (specify):	

Overall rating on supervision: Satisfactory

Average rating: Unsatisfactory

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

Initial supervision was excessively focused on enforcing covenants, and should have considered restructuring or canceling the project. Yet Bank staff did show flexibility in adapting the project in its final years to the drastically changed context.

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:	Satisfactory
Average rating	Unsatisfactory
If your overall rating differs from the average rating, please comment on reasons for this difference:	Despite deficiencies in project design and initial supervision, staff deserve credit for their flexibility and efforts to reshape the project following the period of political and economic crisis.

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	Modest	Administrative procedures	Substantial
Sector policies / conditions	Modest	Cost changes	Substantial
Government commitment	Modest	Implementation delays	Modest
Appointment of key staff	Modest	Other (specify):	
Counterpart funding	Modest		

Factors generally subject to implementing agency control

Management	Modest	Use of technical assistance	Substantial
Staffing	Modest	Beneficiary participation	Negligible
Cost changes	Substantial	Other (specify):	
Implementation delays	Modest		

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: Satisfactory

Average rating: Satisfactory

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

Although there were numerous shortcomings in project implementation, the borrower did make a genuine effort to implement some of the measures under highly adverse circumstances.

D. Special Themes

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

Gender related issues	Yes
Settlement / resettlement	No
Beneficiary participation	No
Community development	No
Skills development	No
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	No
Air / water / soil quality	No
Urban environmental quality	No
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

Medium

8. Rate the priority of the project for impact evaluation

Low

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)	Yes
Restructuring / privatization of public enterprises	Yes
Financial sector development	No
Direct government financial and / or technical assistance to the private sector	No
Other (specify):	

E. Rating of ICR

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

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

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

2. SUMMARY RATING OF ICR

Rate the quality of the ICR:	Satisfactory
Average rating	Satisfactory

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	Satisfactory	Self-evaluation	Satisfactory
Internal consistency	Satisfactory	Evaluation of Bank	Satisfactory
Evidence to justify views	Not Available		

F. Summary of Ratings

1. SUMMARY OF RATINGS

	ICR	EVM
Outcome	Unsatisfactory	Marginally Unsatisfactory
Sustainability	Unlikely	Unlikely
Institutional Development efficacy / impact	Negligible	Negligible
Bank performance	Satisfactory	Satisfactory
Borrower performance	Satisfactory	Satisfactory
ICR quality		Satisfactory

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

Although most of the original project objectives were not achieved, OED judges the project to be marginally satisfactory because some reforms were implemented, particularly in pharmaceuticals and cost recovery, despite the significant economic decline and political instability that prevailed for much of the project.

G. Overall Judgements / Miscellaneous Comments

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

This is a difficult ICR to judge because of: 1) the substantial economic decline and political unrest that occurred in the midst of the project; 2) unrealistic and inappropriate project design, 3) laudable efforts by government and Bank staff to revamp the project following the unrest, but 4) no formal redesign was undertaken, so there are no revised objectives to measure project outcomes against. The project therefore met few, if any, of its originally specified outcome objectives, yet may have prevented further collapse of the sector, as argued in the ICR. The ICR does not present evidence to bolster this claim, however, including whether the drugs supplied through earmarking project funds actually resulted in increased drug supply on the ground.

Overall, the ICR was of good quality, and honest in its analysis.

THE WORLD BANK GROUP

ROUTING SLIP	DATE: September 5, 1997
NAME	ROOM. NO.
Mr. Roger Slade, Acting Manager, OEDST	G 7-035
Through: Christopher Gibbs	

RECEIVED
97 SEP -5 PM 4:40
DGO

	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: Togo—Population and Health Sector Adjustment Program (Cr. 2211-TO) Implementation Completion Report

REMARKS:

The Region agrees with the Evaluative memorandum and the ratings. Please sign the attached EM.

FROM	ROOM NO.	EXTENSION
Tim Johnston, Task Manager, OEDST	G 7-030	31750

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

Office of the Director-General
Operations Evaluation

September 5, 1997

OED EVALUATIVE MEMORANDUM ON IMPLEMENTATION COMPLETION REPORT

Togo—Population and Health Sector Adjustment Program (Credit 2211-TO)

The Togo Population and Health Sector Adjustment Program, supported by Credit 2211-TO for SDR10.2 million (US$14.2 million equivalent), was approved in FY91. Following a one-year extension, the credit was closed and fully disbursed in June 1996. The Implementation Completion Report (ICR) was prepared by the Africa Regional Office. A summary of the borrower's contribution to the ICR is contained in an annex.

The objectives of the program were to support the implementation of a comprehensive package of sector policy reforms in population and health in order to improve primary health care and family planning services. These objectives were to be achieved through a sectoral adjustment credit, with tranche releases conditioned on the implementation of agreed reforms. Over a four-year period, the program was to: (i) institute better sector planning; (ii) reform institutional deficiencies within the sector; (iii) improve personnel and financial management within the sector; and (iv) institute cost recovery and improve beneficiary participation in management of services.

The project failed to meet most of its original objectives. Two years of civil unrest, which began in late 1991, contributed to dramatic economic decline and political instability. The first tranche was released in 1992, following a one-year delay. No further funds were released during the period of crisis, although IDA attempted to sustain dialogue with the Ministry of Health through the resident mission. Following the January 1994 CFAF devaluation, the government reached an agreement with the Bank and Fund and resumed implementation of health sector reforms. The second tranche was released in May 1994, and the closing date of the Credit was extended one year to June 1996. Due to the drastically changed economic and political environment, IDA and the government agreed to a revised plan for health sector investment and budgetary allocations.

Some policy reforms were achieved. Regional and prefectural health directorates were established; a new program budgeting system was adopted in 1995; and a cost recovery program—initiated by UNICEF—was successfully introduced in over 80 percent of the country's health facilities, and steps were taken to improve drug procurement and availability. A portion of the latter tranches of the loan were earmarked for essential drug and vaccine procurement. The planned reorganization of the Ministry was only partially implemented, and the coordinating committee that was to oversee the reforms never met. A population policy was adopted and the contraceptive prevalence rate increased slightly, but most of those changes are attributable to other donor and NGO interventions. Overall, health services and health outcomes have worsened, and service utilization appears to have declined. The ICR

plausibly asserts that the program helped prevent further declines in health services, but no evidence is offered.

The program was the first health loan for Togo and the Bank's first health sector adjustment loan. Even in the absence of such negative external factors, the original project design was too ambitious and poorly adapted to the limited institutional capacity prevailing in Togo. Although intended to promote government ownership and beneficiary participation, most of the project design was carried out by external consultants with little input from beneficiaries.

The ICR rates project outcome as unsatisfactory, institutional development as negligible, sustainability as unlikely, and Bank performance as satisfactory. The Operations Evaluation Department (OED) agrees with these ratings, but rates project outcome as marginally unsatisfactory. Bank staff deserve credit for their flexibility in the program's final years, despite inadequate project design and insufficient attention to institutional issues. The project is rated marginally unsatisfactory because some progress was achieved in local cost recovery and national drug procurement reform in an adverse environment.

The lessons identified by the ICR suggest: (i) adjustment lending is an inadequate vehicle to address health sector issues *and* long-term institutional development problems; (ii) greater attention to strategy coordination is necessary in times of civil strife, including consideration to program cancellation; (iii) the importance of modesty and realism in an institutionally weak sector such as health; (iv) the importance of identifying key stakeholders; (v) the importance of ownership of an adjustment operation by the borrower; (vi) in an environment facing severe financial and human resource constraints, a phased approach to implementation reduces the risks of failure; and (vii) the importance of a practical approach to decentralization, particularly an increased focus on utilization of health services rather than only their supply.

The ICR is satisfactory and contains an honest assessment of the problems and lessons of the project. In preparing a successor project, the ICR asserts that IDA and the government are engaging in a wide-ranging consultation process with stakeholders and beneficiaries. A more detailed account of how the severe personnel and institutional constraints will be overcome by the successor project would have been useful, along with a description of the strategy for monitoring and evaluation.

No audit is planned.

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

DATE: September 5, 1997 12:17pm EDT

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

FROM: Theodore Ahlers, AFC13 (THEODORE AHLERS@A1@WBWASH)

EXT.: 38438

SUBJECT: **TOGO--Population and Health ICR**

Per your memo of August 28, this is to confirm that we have no comments on the draft Evaluative Memorandum on the above-mentioned ICR.

CC: IRENE XENAKIS (IRENE XENAKIS@A1@WBHQB)
CC: A. Edward Elmendorf (A. EDWARD ELMENDORF@A1@WBWASH)
CC: Bruna Vitagliano (BRUNA VITAGLIANO@A1@WBWASH)
CC: Monique Garrity - HQ Visitor (MONIQUE GARRITY@A1@WBWASH)
CC: Elizabeth Small (ELIZABETH SMALL@A1@WBWASH)
CC: Gisele Magnon (GISELE MAGNON@A1@WBWASH)

THE WORLD BANK GROUP

ROUTING SLIP	DATE: August 28, 1997

NAME	ROOM. NO.
Mr. Roger Slade, Acting Manager, OEDST	G7-035
Through: Christopher Gibbs	

	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: TOGO—Population and Health Sector Adjustment Program (Credit 2211-TO) Implementation Completion Report

REMARKS:

The above ICR package is attached for your signature.

The ICR was prepared by Timothy Johnston and reviewed by Christopher Gibbs.

FROM	ROOM NO.	EXTENSION
Timothy Johnston, Task Manager, OEDST	G7-030	31750

THE WORLD BANK GROUP
Headquarters: Washington, D.C. 20433 U.S.A.
Tel. No. (202) 477-1234 • Fax (202) 477-6391 • Telex No. RCA 248423

FACSIMILE COVER SHEET AND MESSAGE

DATE:	August 29, 1997	**NO. OF PAGES:** 5 (including cover sheet)	**MESSAGE NO.:**
TO:	Mr. Ayite-Fily D'Almeida	**FAX NO.:**	228-21-78-56
Title:	AFMTG		
Organization:	Resident Mission		
City/Country:	Lome, Togo		
FROM:	Benjamin Crow	**FAX NO.:**	(202) 522-3123
Title:	Staff Assistant	Telephone:	(202) 473-5105
Dept/Div:	Agriculture and Human Development Division	Dept./Div. No.:	175/10
Room No.:	G7-052		

SUBJECT: **Togo—Population and Health Sector Adjustment Program (Cr. 2211-TO) Implementation Completion Report**

MESSAGE:

Please see the attached memoranda.

Transmission authorized by:

If you experience any problem in receiving this transmission, inform the sender at the telephone or fax no. listed above.

TRANSMISSION RESULT REPORT (AUG 29 '97 05:04PM)

WB (1 202 5223123

(AUTO)

THE FOLLOWING FILE(S) ERASED

FILE	FILE TYPE	OPTION	TEL NO.	PAGE	RESULT
084	MEMORY TX		9011228217856	05/05	OK

ERRORS

1) HANG UP OR LINE FAIL 2) BUSY 3) NO ANSWER 4) NO FACSIMILE CONNECTION

THE WORLD BANK GROUP
Headquarters: Washington, D.C. 20433 U.S.A.
Tel. No. (202) 477-1234 • Fax (202) 477-6391 • Telex No. RCA 248423

FACSIMILE COVER SHEET AND MESSAGE

DATE: August 29, 1997 **NO. OF PAGES:** 5 (including cover sheet) **MESSAGE NO.:**

TO: Mr. Ayite-Fily D'Almeida **FAX NO.:** 228-21-78-56
Title: AFMTG
Organization: Resident Mission
City/Country: Lome, Togo

FROM: Benjamin Crow **FAX NO.:** (202) 522-3123
Title: Staff Assistant Telephone: (202) 473-5105
Dept/Div: Agriculture and Human Development Division Dept./Div. No.: 175/10
Room No.: G7-052

SUBJECT: **Togo—Population and Health Sector Adjustment Program (Cr. 2211-TO) Implementation Completion Report**

MESSAGE:

Please see the attached memoranda.

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

OFFICE MEMORANDUM

DATE: August 28, 1997

TO: Mr. Theodore O. Ahlers, Director, AFC13

FROM: Roger Slade, Acting Manager, OEDST

EXTENSION: 81293

SUBJECT: **TOGO—Population and Health Sector Adjustment Program (Cr. 2211-TO) 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 September 5, 1997.

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

	OED	*ICR*
Outcome:	**Marginally unsatisfactory**	**Unsatisfactory**
Sustainability:	**Unlikely**	**Unlikely**
Institutional Development:	**Negligible**	**Negligible**
Bank Performance:	**Satisfactory**	**Satisfactory**
Borrower Performance:	**Satisfactory**	**Satisfactory**

3. OED's ratings are the same as those indicated in the ICR, except OED rates outcome as marginally unsatisfactory rather than unsatisfactory because some progress was achieved in local cost-recovery and national drug procurement reform in an adverse environment. Bank performance is rated as satisfactory due to Bank staff's flexibility during the program's final years, despite deficiencies in the project design and inadequate attention to institutional issues. OED agrees with the ICR that although borrower performance was deficient in a number of aspects, the government deserves credit for the effort shown in the program's final years to continue with reforms.

4. The ICR is satisfactory and contains an honest assessment of the problems and lessons of the project. It could have been improved if the following points had been taken into account. First, although routine monitoring and evaluation data appeared not to have been collected, the ICR could have presented more evidence to support its claims of program accomplishments, particularly regarding drug availability. Second, a more

detailed account of how the severe personnel and institutional constraints will be overcome by the successor project would have been useful, along with a description of the strategy for future monitoring and evaluation.

5. This ICR was prepared by Timothy Johnston and reviewed by Christopher Gibbs.

Attachment

cc: Ms. Salop (MDOPS); Mr. Feachem (HDDHE); Mr. D'Almeida (AFMTG); Ms. Vitagliano (AFTH3)

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

Office of the Director-General
Operations Evaluation

OED EVALUATIVE MEMORANDUM ON IMPLEMENTATION COMPLETION REPORT

Togo—Population and Health Sector Adjustment Program (Credit 2211-TO)

The Togo Population and Health Sector Adjustment Program, supported by Credit 2211-TO for SDR10.2 million (US$14.2 million equivalent), was approved in FY91. Following a one-year extension, the credit was closed and fully disbursed in June 1996. The Implementation Completion Report (ICR) was prepared by the Africa Regional Office. A summary of the borrower's contribution to the ICR is contained in an annex.

The objectives of the program were to support the implementation of a comprehensive package of sector policy reforms in population and health in order to improve primary health care and family planning services. These objectives were to be achieved through a sectoral adjustment credit, with tranche releases conditioned on the implementation of agreed reforms. Over a four-year period, the program was to: (i) institute better sector planning; (ii) reform institutional deficiencies within the sector; (iii) improve personnel and financial management within the sector; and (iv) institute cost recovery and improve beneficiary participation in management of services.

The project failed to meet most of its original objectives. Two years of civil unrest, which began in late 1991, contributed to dramatic economic decline and political instability. The first tranche was released in 1992, following a one-year delay. No further funds were released during the period of crisis, although IDA attempted to sustain dialogue with the Ministry of Health through the resident mission. Following the January 1994 CFAF devaluation, the government reached an agreement with the Bank and Fund and resumed implementation of health sector reforms. The second tranche was released in May 1994, and the closing date of the Credit was extended one year to June 1996. Due to the drastically changed economic and political environment, IDA and the government agreed to a revised plan for health sector investment and budgetary allocations.

Some policy reforms were achieved. Regional and prefectural health directorates were established; a new program budgeting system was adopted in 1995; and a cost recovery program—initiated by UNICEF—was successfully introduced in over 80 percent of the country's health facilities, and steps were taken to improve drug procurement and availability. A portion of the latter tranches of the loan were earmarked for essential drug and vaccine procurement. The planned reorganization of the Ministry was only partially implemented, and the coordinating committee that was to oversee the reforms never met. A population policy was adopted and the contraceptive prevalence rate increased slightly, but most of those changes are attributable to other donor and NGO interventions. Overall, health services and health outcomes have worsened, and service utilization appears to have declined. The ICR

plausibly asserts that the program helped prevent further declines in health services, but no evidence is offered.

The program was the first health loan for Togo and the Bank's first health sector adjustment loan. Even in the absence of such negative external factors, the original project design was too ambitious and poorly adapted to the limited institutional capacity prevailing in Togo. Although intended to promote government ownership and beneficiary participation, most of the project design was carried out by external consultants with little input from beneficiaries.

The ICR rates project outcome as unsatisfactory, institutional development as negligible, sustainability as unlikely, and Bank performance as satisfactory. The Operations Evaluation Department (OED) agrees with these ratings, but rates project outcome as marginally unsatisfactory. Bank staff deserve credit for their flexibility in the program's final years, despite inadequate project design and insufficient attention to institutional issues. The project is rated marginally unsatisfactory because some progress was achieved in local cost recovery and national drug procurement reform in an adverse environment.

The lessons identified by the ICR suggest: (i) adjustment lending is an inadequate vehicle to address health sector issues *and* long-term institutional development problems; (ii) greater attention to strategy coordination is necessary in times of civil strife, including consideration to program cancellation; (iii) the importance of modesty and realism in an institutionally weak sector such as health; (iv) the importance of identifying key stakeholders; (v) the importance of ownership of an adjustment operation by the borrower; (vi) in an environment facing severe financial and human resource constraints, a phased approach to implementation reduces the risks of failure; and (vii) the importance of a practical approach to decentralization, particularly an increased focus on utilization of health services rather than only their supply.

The ICR is satisfactory and contains an honest assessment of the problems and lessons of the project. In preparing a successor project, the ICR asserts that IDA and the government are engaging in a wide-ranging consultation process with stakeholders and beneficiaries. A more detailed account of how the severe personnel and institutional constraints will be overcome by the successor project would have been useful, along with a description of the strategy for monitoring and evaluation.

No audit is planned.

ICR/PCN REVIEW PANEL

Date: 8/27/97

TO: MR. CHRISTOPHER GIBBS, ~~Ms. Susan Stout~~, ICR/PCN Panel Member

Re: ICR/PCN: TOGO CR. 2211

Susan,

Attached please find the ICR package referenced above for your review, as per ICR/PCN processing guidelines. Upon completing your review, please return package to Aracely for loging and forwarding to the corresponding task manager. The originating task manager would be expected to resubmit the final package for your initials within the prescribed 7 working days from this date.

Signed: CGibbs

THE WORLD BANK GROUP

ROUTING SLIP	DATE: August 27, 1997

NAME	ROOM. NO.
Mr. Yves Albouy, Chair, ICR/PCN Review Panel	G6-125

	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: TOGO—Population and Health Sector Adjustment Program (Cr. 2211-TO) Implementation Completion Report

REMARKS:

Please find attached for panel review the above-mentioned ICR together with the Project Information Form, a draft Evaluative Memorandum from the DGO to the Board, and a draft memo from the Acting Manager, OEDST, to the Country Director concerned.

This ICR was reviewed by Timothy Johnston.

FROM	ROOM NO.	EXTENSION
Timothy Johnston, OEDST TJ	G7-030	31750

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

OFFICE MEMORANDUM

DATE:

TO: Mr. Theodore O. Ahlers, Director, AFC13

FROM: Roger Slade, Acting Manager, OEDST

EXTENSION: 81293

SUBJECT: **TOGO—Population and Health Sector Adjustment Program (Cr. 2211-TO) 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 database:

	EVM	ICR
Outcome:	**Marginally unsatisfactory**	**Unsatisfactory**
Sustainability:	**Unlikely**	**Unlikely**
Institutional Development:	**Negligible**	**Negligible**
Bank Performance:	**Satisfactory**	**Satisfactory**
Borrower Performance:	**Satisfactory**	**Satisfactory**

3. ~~The above~~ OED's ratings ~~differ from~~ are the same as those indicated in the ICR, except OED rates outcome as marginally unsatisfactory rather than unsatisfactory because some progress was achieved in local cost-recovery and national drug procurement reform in an adverse environment. Bank performance is rated as satisfactory due to Bank staff's flexibility during the program's final years, despite deficiencies in the project design and inadequate attention to institutional issues. OED agrees with the ICR that although borrower performance was deficient in a number of aspects, the government deserves credit for the effort shown in the program's final years to continue with reforms.

4. The ICR is satisfactory and contains an honest assessment of the problems and lessons of the project. It could have been improved if the following points had been taken into account. First, although routine monitoring and evaluation data appeared not to have been collected, the ICR could have presented more evidence to support its claims of program accomplishments, particularly regarding drug availability. Second, a more

detailed account of how the severe personnel and institutional constraints will be overcome by the successor project would have been useful, along with a description of the strategy for future monitoring and evaluation.

5. This ICR was prepared by Timothy Johnston and reviewed by Christopher Gibbs.

Attachment

cc: Ms. Salop (MDOPS); Mr. de Ferranti (HDDDR), ICR Task Manager's Name ( )
Mr. Fily D'Ameida (RMTO); Ms. Bruna Vitagliano (AFTH3)
ovite-Fily D'Almeida
AFMTG

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

Office of the Director-General
Operations Evaluation

OED EVALUATIVE MEMORANDUM ON IMPLEMENTATION COMPLETION REPORT

Togo—Population and Health Sector Adjustment Program (Credit 2211-TO)

The Togo Population and Health Sector Adjustment Program, supported by Credit 2211-TO for SDR10.2 million (US$14.2 million equivalent), was approved in FY91. Following a one-year extension, the credit was closed and fully disbursed in June 1996. The Implementation Completion Report (ICR) was prepared by the Africa Regional Office. ~~Appendix B contains~~ A summary of the borrower's contribution to the ICR is contained in an annex. [Don't ask me. This is the new style!]

The objectives of the program were to support the implementation of a comprehensive package of sector policy reforms in ~~the area of~~ population and health in order to improve primary health care and family planning services. These objectives were to be achieved through a sectoral adjustment credit, with tranche releases conditioned on the implementation of agreed reforms. Over a four-year period, the program was to: (i) institute better sector planning; (ii) reform institutional deficiencies within the sector; (iii) improved personnel and finance management within the sector; and (iv) institute cost recovery and improve beneficiary participation in management of services.

The project failed to meet most of its original objectives. Two years of civil unrest, which began in late 1991, contributed to dramatic economic decline and political instability. The first tranche was released in 1992, following a one-year delay. No further funds were released during the period of crisis, although IDA attempted to sustain dialogue with the Ministry of Health through the resident mission. Following the January 1994 CFAF devaluation, the government reached an agreement with the Bank and Fund and resumed implementation of health sector reforms. The second tranche was released in May 1994, and the closing date of the Credit was extended one year to June 1996. Due to the drastically changed economic and political environment, IDA and the government agreed to a revised plan for health sector investment and budgetary allocations.

Some policy reforms were achieved. Regional and prefectural health directorates were established; a new program budgeting system was adopted in 1995; and a cost recovery program—initiated by UNICEF—was successfully introduced in over 80 percent of the country's health facilities, and steps were taken to improve drug procurement and availability. A portion of the latter tranches of the loan were earmarked for essential drug and vaccine procurement. The planned reorganization of the Ministry was only partially implemented, and the coordinating committee that was to oversee the reforms never met. A population policy was adopted and the contraceptive prevalence rate increased slightly, but most of those changes are attributable to other donor and NGO interventions. Overall, health services and health outcomes have worsened, and service utilization appears to have declined. The ICR

plausibly asserts that the program helped prevent further declines in health services, but no evidence is offered.

The program was the first health loan for Togo and the Bank's health first sectoral adjustment loan ~~for health in the Bank~~. Even in the absence of such negative external factors, the original project design was too ambitious and ~~was~~ poorly adapted to the limited institutional capacity prevailing in Togo. Although intended to promote government ownership and beneficiary participation, most of the project design was carried out by external consultants with little input from beneficiaries.

~~The Operations Evaluation Department (OED) agrees with most of the ICR ratings~~. The ICR rates ~~the~~ project outcome as unsatisfactory, institutional development as negligible, sustainability as unlikely, and Bank performance as satisfactory, ~~and borrower performance as satisfactory.~~ ~~OED rates the project outcome as marginally unsatisfactory, institutional development as negligible, sustainability as unlikely, Bank performance as satisfactory, and borrower performance as satisfactory~~. Bank staff deserve credit for their flexibility in the program's final years, despite inadequate project design and insufficient attention to institutional issues. The project is rated marginally unsatisfactory because some progress was achieved in local cost recovery and national drug procurement reform in an adverse environment.

[Don't include in CVM.]

[ie Operations Evaluation Department agrees with these ratings, but rates project outcome as marginally unsatisfactory]

The lessons identified by the ICR suggest: (i) adjustment lending is an inadequate vehicle to address health sector issues and long-term institutional development problems; (ii) greater attention to strategy coordination is necessary in times of civil strife, including ~~greater~~ consideration to program cancellation; (iii) the importance of modesty and realism in an institutionally weak sector such as health; (iv) the importance of identifying key stakeholders; (v) the importance of ownership of an adjustment operation by the borrower; (vi) in an environment facing severe financial and human resource constraints, a phased approach to implementation reduces the risks of failure; and (vii) the importance of a practical approach to decentralization, particularly an increased focus on utilization of health services rather than only ~~their~~ supply. (?)

The ICR is satisfactory and contains an honest assessment of the problems and lessons of the project. In preparing a successor project, the ICR asserts that IDA and the government are engaging in a wide-ranging consultation process with stakeholders and beneficiaries. A more detailed account of how the severe personnel and institutional constraints will be overcome by the successor project would have been useful, along with a description of the strategy for monitoring and evaluation.

No audit is planned.

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

OFFICE MEMORANDUM

JUN 30 1997

DATE: June 26, 1997

TO: Ms. Hazel Denton, SECBO

FROM: Theodore Ahlers, Country Director, CDG13

EXTENSION: 38438

SUBJECT: **ICR Transmittal**
Togo: Health and Population Sector Adjustment Credit (Cr. 2211-TO)

I have cleared the attached Implementation Completion Report for the above-mentioned Credit dated June 25, 1997. We are in the process of printing the report for distribution to the Board.

Thank you.

ICR/PIF COVER SHEET Run Date: 6/30/97

OED ID: C2211 Division: 1

Country:	Togo
Project Description:	Health & Pop. Sector Adj.
Sector:	04 / Human Resource
Subsector:	04.99 / Human Resource SECAL
Lending Instrument Type:	SAD
L/C:	C2211
Original IDA/IBRD Commitments:	14,200,000 ($US)
Total Cancellations:	0 ($US)

Key Dates	ORIGINAL	ACTUAL
Approval		2/28/91
Signing/Agreement		3/18/91
Effectiveness	3/31/92	3/31/92
Closing	6/30/95	6/30/96
PCR Receipt in OED		6/30/97

EVALUATOR NAME: Tim Johnson

EVALUATOR SIGNATURE: Tim Johnson DATE: Sept. 30, 1997

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: 08/26/97 (mm / dd / yy)

Name of Reviewer: Timothy A Johnston

Type of Evaluation: PCR Review [X] 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 (mm/dd/yy)	LATEST (mm/dd/yy)
Date of Physical Completion		
Total Project Cost ($US mill)	14.2	14.67
Applicable Disbursement Profile: (see note 11 in the PIF, page 31)		
Number of Supervision Missions:	8	