SecM93-367

FROM: The Deputy Secretary

April 13, 1993

PROJECT COMPLETION REPORT

GUINEA-BISSAU - Population, Health and Nutrition Project

(Credit 1800-GUB)

Attached is a copy of a memorandum from Mr. Picciotto with its accompanying report entitled "Project Completion Report: Guinea-Bissau - Population, Health and Nutrition Project" dated March 31, 1993 (Report No. 11759) prepared by the Africa Regional Office with Part II contributed by the Borrower.

Distribution

Executive Directors and Alternates
Office of the President
Executive Vice Presidents, IFC and MIGA
Vice Presidents, Bank, IFC and MIGA
Directors and Department Heads, Bank

Document of

The World Bank

FOR OFFICIAL USE ONLY

Report No. 11759

PROJECT COMPLETION REPORT

GUINEA-BISSAU

POPULATION, HEALTH AND NUTRITION PROJECT
(CREDIT 1800-GUB)

MARCH 31, 1993

Population and Human Resources Operations Division
Western Africa Department
Africa Regional Office

GLOSSARY

DHS	Demographic Health Survey
EEC	European Economic Community
MCH	Maternal and Child Health
MINSAP	Ministry of Public Health
MINSAS	Ministry of Health and Social Affairs
NGO	Non-Governmental Organization
PHC	Primary Health Care
PHN	Population, Health and Nutrition
SDR	Special Drawing Rights
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
WHO	World Health Organization

THE WORLD BANK
Washington, D.C. 20433
U.S.A.

Office of Director-General
Operations Evaluation

March 31, 1993

MEMORANDUM TO THE EXECUTIVE DIRECTORS AND THE PRESIDENT

SUBJECT: Project Completion Report on Guinea-Bissau
Population, Health and Nutrition Project (Credit 1800-GUB)

Attached is a copy of the report entitled "Project Completion Report on Guinea-Bissau - Population, Health and Nutrition Project (Credit 1800-GUB)" prepared by the Africa Regional Office. Part II was prepared by the Borrower.

The outcome of this project--meant to simultaneously support the institutional development of the Ministry of Public Health and to strengthen the delivery of health and family planning services--was unsatisfactory. Little training and institutional building took place, in part because of failure to provide counterpart staff, and most health center remodeling had to be cancelled because of construction delays.

The outcome was conditioned by inadequate preparation, overambitious design, and failure of the Borrower to provide agreed-to counterpart funds. This project is a good example of excessive reliance on technical assistance even though some modest improvements in capacity occurred and lessons learnt are being incorporated into future programs. Many more years of institutional development will be necessary before sustainable operations are assured.

The Project Completion Report provides an accurate account of project implementation. The reasons for the failure of this project are well laid out and plans to take them into account in future operations are noted. An audit is not planned.

Attachment

PROJECT COMPLETION REPORT

GUINEA BISSAU

POPULATION, HEALTH AND NUTRITION PROJECT

(CREDIT 1800-GUB)

TABLE OF CONTENTS

LIST OF ANNEXES

PROJECT COMPLETION REPORT

GUINEA-BISSAU

POPULATION, HEALTH AND NUTRITION PROJECT

CREDIT 1800-GUB

PREFACE

This is the Project Completion Report (PCR) for the first Population, Health and Nutrition Project in Guinea-Bissau, for which Credit 1800-GUB in the amount of SDR 3.4 million (March 1987, US$4.2 million equivalent) was approved on May 19, 1987. The Credit was closed on December 31, 1991, after having been extended six months beyond the original date. It was fully disbursed, and the last disbursement was made on April 9, 1992.

The PCR was prepared by the Population and Human Resources Operations Division of the Western Africa Department (Preface, Evaluation Summary, Parts I and III) and the Borrower (Part II).

This PCR report was initiated during the last supervision mission for the project in October 1991. A completion mission was conducted in January, 1992. This PCR is based, inter alia, on the Staff Appraisal Report; the Development Credit Agreement; supervision reports; correspondence between the Borrower and IDA; internal IDA memoranda; and interviews with Bank staff involved with the project.

PROJECT COMPLETION REPORT

GUINEA-BISSAU

POPULATION, HEALTH AND NUTRITION PROJECT

(CREDIT 1800-GUB)

EVALUATION SUMMARY

Project Objectives

i. The Project's two basic objectives were: (a) to support the institutional development of the Ministry of Public Health (MINSAP) in planning, management and finance; and (b) to strengthen the delivery of health and family planning services, especially at the rural health center level. The project's near-term focus on improving essential services, combined with its complementary emphasis on improvements in the institutional framework, was expected to provide the basis for more extensive service delivery interventions in the future, toward achieving the Government goal of offering health services to 80 percent of the population by 1993 -- a challenging goal that underestimated the capacity of the health system to change and expand within a relatively short time span.

Implementation Experience

ii. Following effectiveness in December 1987, project implementation fell seriously behind schedule due in large part to MINSAP's institutional weaknesses that had been originally identified as risks. It should also be noted that the period immediately preceding credit effectiveness and beginning of implementation coincided with IDA's reorganization which resulted in the replacement of the entire team for this project; this probably added to the delays. A major variance between planned and actual project implementation were large shifts in expenditures from civil works, operating (incremental recurrent) costs and goods and services, to consultants and fellowships. Remodeling of 25 rural health centers was not implemented according to the original design; after an assessment of rehabilitation needs in 1988 it was found that 10 of the 25 centers identified at appraisal were beyond repair. Consequently, detailed architectural designs including adaptations to sites were completed between October, 1988 and 1990 for only 15 centers; in spite of the smaller number of centers considered for repair, the total cost for rehabilitating them exceeded by far the original appraised estimates (in 1988 it was estimated that US$1,030,400 would be needed for repairing 15 centers, compared to the original estimate of $430,000 for 25 centers); this difference was attributed by the IDA staff and the project management unit to initial underestimates in unit costs, scope of work, and inflation. In 1990, after long delays in completing the architectural designs, and when credit funds had

already been disbursed for other categories (particularly for category 3 -- technical assistance and training) little credit funds remained for construction and only two centers were rehabilitated with IDA financing, at a cost of under $50,000. Other donors were requested to finance rehabilitation works for about US$1 million (outside this project).

iii. Regarding other project components, in spite of the heavy use of consultants in this project and the moderate success in producing studies and reports, little consultancy related training and institution building took place due in part to personnel vacancies in the implementing agency and their non-replacement for periods of over two years. The project director -- a foreign consultant -- and his staff assumed a main role in implementation and in communications with IDA. The project management unit performed reasonably well its functions as handler of communication flow with IDA, but was not as successful in establishing a good rapport with MINSAP, particularly after a new minister took over in 1990. Regarding cost control and management of consultants, neither the management unit, nor MINSAP had a good grasp of the situation. The lack of Government counterpart funds persisted during project execution in spite of consistent follow up by IDA staff; at credit closing, the Government contribution was $61,900 compared to $210,000 required.

Results

iv. Overall impact of the project was unsatisfactory. Project achievements fell short of ambitious appraisal scope and design complexity. The benefits of components such as technical assistance and provision of recurrent costs (mostly incremental, but also comprising emergency assistance during epidemics) were low in relation to their costs. Nevertheless, there were modest accomplishments in training and human resource development and in PHN data collection; the project also managed to implement initial actions towards cost-recovery, better drug system management, improved rural supervision, and preliminary administrative reform within MINSAP. Because this project represents the first attempt by any donor in Guinea-Bissau to assist the health sector as a whole (as opposed to individual projects or sites), the mentioned contributions are noteworthy.

Sustainability

v. Because of the low financial base for supporting health services, the lack of a clear financial plan, the large proportion of funding from external donors and MINSAP's limited capacity as managing agency for the sector, this project placed particularly strong emphasis on sustainability from the outset. Although the sector continues to rely heavily on technical assistance, the rudiments of an infrastructure are now in place for data collection and analysis, drug management and supervision of health services, resulting from training and other activities that took place under this project. Even so, the health system still lacks the competence for self-sustainment and growth and will need perhaps at least another decade to reach a level of adequate financial and technical sustainability. A follow-on Social Sectors Project will have fewer components and will emphasize capacity

building and substantially expand the human resource training begun with this project. The forthcoming project will also focus on technical assistance with stronger review and with built-in transfer of knowledge to national counterparts. In addition, it will have a social action fund to assist NGOs which have a good track record on the country, in developing micro-social sector projects and better reach those at the grass-root level.

Findings and Lessons Learned

vi. The project scope was over-ambitious and it had a complex design. In the light of institutional weaknesses, IDA showed flexibility and creativity during implementation. It also pursued persistently and effectively cooperation with other donors -- particularly WHO and UNICEF. However, there were some shortcomings, including the following: (a) earlier identification of the problems affecting the construction component would have enabled the adoption of alternative solutions for timely and successful civil works completion; and (b) a tighter control of the technical assistance costs, early detection of cost overruns, and closer attention to quality and utilization of consultants could have led to higher effectiveness and lower costs than achieved in the project.

vii. Initially the Government took several reassuring steps by appointing an expatriate Project Director, creating a Project Management Unit, and giving assurances regarding several changes in policy and organization. However, there were serious implementation problems when MINSAP allowed key managerial positions to remain vacant for over two years and the Ministry of Finance compromised implementation by failing to provide counterpart funds as agreed. Lessons learned by MINSAP included the need to manage consultancies properly to obtain effective benefits related to expenditures incurred, and the importance of assuming responsibility for oversight of the project management unit.

viii. The following lessons learned may be applied to future projects: Project preparation should select implementable key components; construction components should be properly prepared, although they are usually less significant than software components in addressing sector issues; although technical assistance is essential particularly when the capacity of the sector agencies is low, it should be tailored to the agency's absorptive capacity, and should be closely supervised; and project management units should help in institution building and receive close review from the management of the implementing agency. Further, national counterparts should always be involved in project preparation and start-up activities and, as much as possible, there should be continuity or, when staff changes are unavoidable, there should be well planned and smooth transition of Government counterparts during implementation.

PROJECT COMPLETION REPORT

GUINEA-BISSAU

POPULATION, HEALTH AND NUTRITION PROJECT

(Credit 1800-GUB)

PART I. PROJECT REVIEW FROM BANK'S PERSPECTIVE

A. Project Identity

Project Name:	Population, Health and Nutrition Project
Credit No.:	1800-GUB
Credit Amount:	SDR 3.4 million (March 1987 US$4.2 million)
RVP Unit:	Western Africa Country Department IV
Country:	Republic of Guinea-Bissau
Sector:	Population, Health and Nutrition

B. Project Background

1. Sector Development Objectives. At the time of this project's appraisal, the stated goal of the Ten-Year Primary Health Care Plan 1984-93 under the responsibility of the Ministry of Public Health's (MINSAP) [1], was to reach, by 1993, 80 percent of the population with programs in Maternal and Child Health (MCH), immunization, essential drugs and endemic disease control. This was an evidently overambitious target for a country with a per capita income of less than US$180 and a health system bedeviled by serious shortcomings. Guinea-Bissau's health system is almost exclusively public and administered by MINSAP. IDA appraisal identified major constraints including: lack of full control over the allocation of expenditures (in 1986 over 85 percent of the MINSAP budget and 90 percent of drug procurement came from foreign assistance); low quality of services mainly due to irregular availability of medicines and materials at the service points, inadequate working conditions for the health personnel and uneven geographical distribution (medical personnel are heavily concentrated in the two national hospitals, located in the capital city); also, the physical infrastructure was deteriorated, and there were serious deficiencies in staff training, supervision, transport and recurrent budget for maintenance. Moreover, macroeconomic constraints curtailed the options for up-grading health care. A chronic shortage of foreign exchange and the declining real value of central budget allocations limited MINSAP funding and made it imperative to seek further external financial assistance for major restructuring and strengthening.

---

[1] In December 1991, this ministry was renamed the Ministry of Health and Social Affairs (MINSAS). For purposes of this report, however, the acronym "MINSAP" will be used.

2. Policy Context. At a donors' roundtable in 1986 the Government acknowledged that in order to increase the likelihood of coming close to the stated health service goal it would need to restructure the system and make more cost effective use of the existing infrastructure, rather than extend its health system through investments in new facilities. It agreed to several administrative and policy reforms and to improve hospital administration, drug system management, and financial planning. In view of its inability to increase non-wage recurrent costs due to the declining real value of central budget allocations, it also agreed to measures to increase service efficiency and cost recovery.

3. Linkages Between Project, Sector and Macro Policy Objectives. IDA helped the Government design a program of structural adjustment, in support of substantive Government policy initiatives to promote economic development, and adopted a lending program consisting of two parts: (a) a structural adjustment lending program; and (b) a core program of investments in infrastructure, institutional support, and human resource development. This project, IDA's first in the health sector in Guinea-Bissau, was intended to further the core lending program for human resource development, while supporting the social sector during the difficult period of structural adjustment.

C. Project Objectives and Description

4. Project Objectives. The Project's two basic objectives were: (a) to support the institutional development of MINSAP in planning, management and finance; and (b) to improve the delivery of health and family planning services, especially at the periphery (rural health center level). The project's near-term focus on improving essential services, combined with its complementary emphasis on strengthening the institutional framework, was expected to create the basis for more extensive service delivery interventions in the future, towards achievement of the Government goals for 1993.

5. Project Description. Part A of the project, regarding institutional development activities and requiring 26 percent of the project cost, included components for: improving MINSAP organization; creating a management information system; strengthening drug system management; developing and implementing methods for supervision of rural health services; introducing rational financial planning and assisting MINSAP to implement effective cost recovery measures; conducting policy studies on nutrition and family planning; and carrying out a demographic health survey (DHS) to improve the health statistics data base. In support of these actions, the project was set to finance vehicles, furniture, equipment, materials, 22 months of technical assistance, overseas fellowships, in-service training, supplies and travel and per diem.

6. Part B, to which 44 percent of the total project cost was allocated for investment and incremental recurrent expenditures, was intended to strengthen health and family planning service delivery and included: providing basic equipment and essential drugs and materials to regional health directories; rehabilitating 25 health centers to serve approximately 175,000 people; and providing in-service training to health personnel at all levels.

Project financing for this part included civil works, vehicles, equipment, furniture, materials, medical and other supplies, technical assistance, short-term overseas fellowships, in-service training, salaries under contractual services, and travel/per diem. The remaining 30 percent of project cost was applied to financing preparation (through the Project Preparation Facility -- PPF) and project administration.

D. Project Design, Organization and Management

7. This project emerged from an IDA sector review and a donor round table, both in early 1986. The resulting project design constituted a comprehensive response to the pressing needs identified by those exercises. Specifically, the design was intended to promote long-term institutional development within MINSAP, and at the same time cater to some immediate needs in health service delivery, by financing part of the non-wage recurrent costs (particularly medicines and materials), while alternative means for financing recurrent costs were developed. A study and trial on cost recovery, which was innovative for Guinea-Bissau, was proposed as a solution to MINSAP's difficulties in financing such costs on a regular basis. Unfortunately, the project's conceptual foundation proved to be overly ambitious in terms of project objectives and range of subjects covered. Had project designers taken greater account of implementation risks, and a more conservative appreciation of the timeframe required to effect institution building and organizational changes and to implement cost recovery measures, a less ambitious project would have resulted, with better prospects for good implementation.

8. The design did not include an evaluation component, nor did it have requirements for evaluation of training. There were no impact indicators specified to measure project effects on the population; the latter is not unreasonable in view of the short time span of project implementation -- originally three years, which were extended to four -- as well as the weaknesses of the data base for health conditions in the country. However, it would have been useful to include process indicators such as training required by specialty and duration, expected changes in the system and timing (for instance, for establishment of the management information system, drug system management, and rural supervision model) and clear objectives against which to evaluate the proposed studies and surveys. The policy studies were not fully designed and those which were executed did not lead to policy formulation.

9. Project Management. The project management unit performed reasonably well its functions as handler of communication flow with IDA, but was not as successful in establishing a good rapport with MINSAP, particularly after a new minister took over in 1990. Furthermore, it would have needed to exert a more rigorous control on the cost of consultancies in relation to expected outputs, and on the overall budgeting and spending of the various project categories. MINSAP, on its part, did not wield its authority to oversee and guide the project management unit in key decisions regarding this project -- e.g., when long delays occurred in completing architectural designs for remodeling of health centers and when large consultant contracts were issued.

10. Appropriateness of Project Scale and Scope. The total project cost of US$4.2 million during a three-year period implied an additional 25 percent annual financial input of recurrent and investment resources for the health sector -- a large but not unreasonable increase, if the balance of expenditures by project component would have been maintained during project implementation; however, there was a significant variance between project design and implementation (paras. 10-12). Additionally, the project scope was too broad, with many sub-components, each requiring very specialized expertise (e.g., management information system, drug logistics, field supervision, training, administration of research and studies). In order to successfully implement this project, MINSAP would have needed far more competence in precisely those areas -- administration, financial planning, information management, human resource development -- that the project itself was designed to strengthen. Or alternatively, it would have needed a much greater capacity than demonstrated to administer a large volume of technical assistance. The end result was that MINSAP's acknowledged institutional and financial limitations, compounded by its inexperience in dealing with a relatively large project, exceeded the Ministry's implementation potential.

E. Project Implementation

11. Critical Variances in Project Implementation. Credit effectiveness was extended from September 18, 1987 to December 18, 1987, to allow Government to submit a three-year financial plan for MINSAP, incorporating the results of a health cost and cost recovery study. When it became apparent that this condition could not be met by December 18, 1987 the Development Credit Agreement was amended so that effectiveness would not be further delayed. Submission of the MINSAP plan was then changed from a condition of effectiveness, to a covenant to be met by April 30, 1988. This covenant was not fully met; while the consultants responsible for the cost recovery study produced an outline of a financial plan, it was never followed up in actual practice, due to the lack of expertise in financial analysis in MINSAP. Following effectiveness, implementation of the entire project fell seriously behind schedule, due in large part to institutional weaknesses within MINSAP that were originally identified as risks. There were persistent vacancies of key posts and other personnel problems within MINSAP, lack of counterpart funding, and procedural problems affecting drug procurement. It should also be noted that the period immediately preceding credit effectiveness and beginning of implementation coincided with IDA's reorganization which resulted in the replacement of the entire team for this project; this probably added to the delays.

12. A major variance between planned and actual project implementation was a shift in project composition and distribution of expenditures from civil works, operating costs, goods and services, and the PPF, to the following categories: (a) consultants and fellowships for which disbursements ended up being almost three times higher than originally planned (US$1.5 million, compared to US$640,000); (b) equipment, furniture, vehicles and materials for which IDA disbursed over twice the amount set at appraisal (US1.1 million compared to US$470,000); and (c) drugs and medical supplies, which received

US$1 million compared to US$700,000 appraised. The following explanations were given by IDA staff for these changes:

(a) although the much higher than planned disbursement for consultants and training resulted in part from underestimates of costs at appraisal (for instance for the DHS and training this appears to be the case), this should have been compensated by the fact that several planned studies were not implemented; however, the costs of most of the contracts appear to have been too high in relation to the type of work performed and the outputs, undoubtedly a result of the low capability of MINSAP to manage contracting and supervising of consultants; in spite of the high cost of consultants in this project, little training and institution building took place;

(b) a doubling in the amount spent for equipment, furniture, vehicles and materials was a result of price escalation and of a substantial underestimate of what it would cost to equip existing rural health facilities in order to implement the model of rural supervision; and

(c) at appraisal, drugs and medical supplies were intended to reinforce material resources in rural health units while they made the transition to a system of cost recovery; the higher amount spent in drugs and medical supplies resulted from an acute shortage due to temporary difficulties faced by regular donors (UNICEF, bilateral donors) to keep up with deliveries for the whole country; the Government, which has a non-significant budget for these items and depends on foreign assistance, requested IDA to use credit funds to cover the gap; also, at the end of 1987 the country suffered a cholera epidemic and credit funds were authorized for procuring drugs and medical supplies for this emergency; since then, the project supported drug management system plus Swedish assistance have improved coordination of drug supplies; and

(d) the civil works component was heavily underspent; as explained in para. 24, the appraised remodeling of 25 rural health centers was not implemented according to the original design; only two health centers were remodeled using proceeds from the IDA credit, at a cost of under $50,000 and another $50,000 was disbursed from the Credit for civil works in the central MINSAP offices (all these costs exclude expenditures for detailed designs amounting to $72,000 which were disbursed under the consultant category). The IDA staff sought other donors to finance rehabilitation works for almost US$1 million for another 13 health centers (outside this project).

13. In view of the explained variances in the utilization of the IDA credit, formal reallocation of proceeds took place in February 1991, 9 months before credit closing. IDA staff indicated that only at that time it was possible to obtain firm figures from the Government on committed funds and projected expenditures.

14. The lack of Government counterpart funds persisted throughout the project. In spite of IDA staff consistent follow up on the need for the Government to contribute specified amounts of funds each year for project implementation, at credit closing its contribution was $61,900 compared to $210,000 required and agreed.

15. Project Risks. Two major risks were anticipated in this first population, health, and nutrition (PHN) project in Guinea-Bissau: (a) implementation difficulties due to the inexperience of MINSAP personnel in executing major structural reforms, particularly with respect to cost recovery; and (b) insufficient availability of foreign exchange to meet the health sector's critical import requirements. Both concerns proved to be well founded and were resilient to efforts taken during implementation to overcome them.

16. Unforeseen Factors Affecting Project Implementation. In late 1988, several key MINSAP staff members were suspended pending Government investigations and were not replaced; those affected included the Director of Administration and Finance, the Director of Patrimony and the Director of Public Health. Additionally, the Director of Planning was sent abroad for a two-year training program. These personnel vacancies in the implementing agency and their non-replacement decreased the possibilities of institution building through the project and left most of the implementation in the hands of the project director -- a foreign consultant -- and his staff. In November, 1990, when a new health minister took over, a national Assistant Project Director financed by GUB was appointed. Another unforeseen event was that US$70,000 in project funds were frozen for over 2 and a half years by a bank in Las Palmas which was originally designated to hold the Project's special account; this was the result of a dispute between that bank and the Armed Forces, unrelated to the Project and MINSAP. Although this complication did not financially affect project outcome and was eventually resolved, it did cause a major diversion of staff time in communications and during supervision missions.

F. Major Results of the Project

Project Impact

17. The overall impact of the credit was unsatisfactory. Project achievements fell short of ambitious appraisal targets. The cost-effectiveness of inputs such as technical assistance and provision of incremental recurrent costs has been low and little was accompanied on civil works components. Nevertheless, there were modest accomplishments in training and human resource development and in PHN data collection; the project also managed to make some initial inputs towards cost-recovery, better drug system management, improved rural supervision, and preliminary administrative reform within MINSAP. Because this project represents the first attempt by any donor in Guinea-Bissau to assist the health sector as a whole (as opposed to individual projects or sites), the mentioned contributions are noteworthy.

18. The original institutional development goal was to prepare a comprehensive three-year action program and financial plan for the health sector, including the creation of a rolling financial plan. MINSAP failed to adopt a rolling financial plan during the project lifetime (as explained in para 10); however, MINSAP was made aware of the need for such a plan and its preparation continues to be discussed with IDA and WHO. Moreover, despite delays, disputes and inadequacies that beset MINSAP's technical assistance, the Ministry managed to prepare, with WHO assistance, and adopt and partially implement a simplified reorganization plan. The Ministry appears headed, at last, toward decentralization of management, administration and finance, with a focus on increasing authority at the regional level.

Sectoral Policies

19. This project enabled Guinea-Bissau's health sector to make several noteworthy policy departures, and to follow them up with initial implementation measures. With regard to drug system management, for example, the project resulted in the establishment of an operational inventory control system. This was achieved through the provision of a computer and a vehicle for the Central Pharmaceutical Store, and training local staff in its use. A National Drug Formulary was also produced, and 535 copies furnished to the Central Drug Unit for nationwide distribution.

20. In terms of supervision of rural health services, the two regions chosen for project activities made headway in piloting a supervisory model for eventual replication in the country's other regions. Health education overseen by dedicated local staff sparked widespread interest among the rural population, and attracted growing numbers of traditional midwives. However, administrative turnover, plus lack of transport and of appropriate budget for keeping up with maintenance and recurrent costs of the rural health services, presented difficulties throughout. The supplies, equipment, vehicles and technical assistance provided under the project -- fortified by supervision and training contributed by Italian and Canadian non-governmental organizations (NGOs) -- made a start in strengthening the health system management process in the two regions, but was not enough to cover for the deficiencies. Also, the lack of continuity of health staff in regional positions and scarcity of resources continue to be major problems.

21. The concept of cost recovery in the health services was introduced in the project as a possible solution to the problem of persistent shortfalls in MINSAP's budget for recurrent costs; in 1990 a general declaration was issued announcing that cost recovery measures in the health services would begin soon. This encountered public opposition. Since that time, a national sensitization campaign began to educate the population on the need to pay for health services, and a Cost Recovery Committee was created within MINSAP. In the last year of the project, partial cost recovery measures (mainly for medicines, following the recommendations of the Bamako initiative) had been regularized in one region (Gabu) and were beginning to be selectively implemented in various parts of the country. Progress in this area was helped considerably by the fact that both WHO and UNICEF are committed to the Bamako initiative. However, its expansion to other parts of the country and to other

items of health costs (e.g., medical visits, hospitalization, etc.) will be dependent on increased Government and public acceptability of the concept, a substantial increase in the quality of the health services to gain client satisfaction, and continued donor and technical support for some time to come.

Policy Studies

22. The project made a worthwhile contribution toward filling a vacuum with respect to Guinea-Bissau's PHN information base. A Demographic and Health Survey (DHS) was conducted and its results were presented in a 16-volume report dated February, 1991. This was a major country-wide survey, which is expected to form the basis of an improved health information system (DHS cost was $200,000). It was conducted by a foreign consultant firm with the active participation of MINSAP and the Department of Statistics of the Ministry of Planning. Further, a Population and Family Planning Study and a Nutrition Policy Study, each costing $50,000, were also produced by foreign consultants. These three studies constitute major contributions to the country's knowledge base; national seminars to disseminate study findings and results were carried out. It should be noted, however, that the seminar on DHS findings (costing $26,000) was financed by SPPF funds provided by IDA, because the consultant contract failed to include this activity and project funds had been exhausted. Although the execution and dissemination of the results of these studies and their consideration and approval by MINSAP's Technical Committee constitute useful achievements, the ultimate objective of using the findings of these surveys and studies for developing national policies in nutrition and in maternal and child health and family planning as a basis for health and social action programs, remains unaccomplished.

Human Resource Development

23. This component exceeded appraisal targets in terms of participants involved and funds expended. It encompassed project-related training, on-the-job training, short courses and seminars, primarily in the areas of administration, financial management, accounting, drug management, and maternal and child health. The Project Manager estimated that 6,500 people benefitted directly or indirectly from training, both funded by the project and as a result of the multiplier effect of trainers training grass-root workers; the Staff Appraisal Report target of 500 trained health personnel directly funded by the credit was amply met. Total fellowship and training expenditures amounted to $465,000, compared to an estimate of $60,000 for these items at appraisal. The project design did not call for close monitoring or evaluation of training activities. However, according to the Project Director's assessment and periodic accounts by consultants, the project appears to have made a useful beginning in human resource development, and one that the upcoming Social Sectors Project can build on.

Civil Works

24. As already mentioned (para 12 under Variances), activities under this component fell far short of appraisal goals. The number of facilities to be remodeled was first scaled back after an assessment of rehabilitation needs in 1988, when it was found that 10 of the 25 centers identified at appraisal were beyond repair. The detailed architectural designs including adaptations to sites for 15 centers and the translation of the technical papers from French --the language used by the consultants-- and Portuguese took an inordinately long time (from October, 1988 to August, 1990). In spite of the smaller number of centers considered for repair, the total cost for rehabilitating them exceeded by far the appraised estimates. Indeed, in 1990 it was estimated that US$1,030,400 would be needed for repairing 15 centers, compared to the original estimate of $430,000 for 25 centers. The IDA staff and the project management unit attributed the large difference between appraised and actual costs of civil works to initial underestimates in unit costs and scope of work, as well as to price escalation. A supervision mission at that time determined that project funds had already been applied to other categories -- particularly to consultancies. After taking into account commitments already made it was decided that IDA funds could be used to rehabilitate only two centers.

Project account audits

25. Project accounts and audits were conducted by independent auditors selected and retained according to IDA Guidelines. All required audits were presented to IDA usually on time or with slight delays and were considered satisfactory.

G. Project Sustainability

26. Because of the low financial base for supporting health services, the lack of a clear financial plan, the large proportion of funding from external donors and MINSAP's limited capacity as managing agency for the sector, this project placed particularly strong emphasis on sustainability from the outset. For example, no new facilities were proposed and a primary goal in components as diverse as institutional development, training, drug management, rural supervision and cost recovery, was to develop appropriate frameworks for continuing efforts in the future. Although a foundation is now in place for expansion and improved quality of health activities as a result of this credit, the health system still lacks the competence for self-sustainment and growth and will need perhaps at least a decade to reach a level of an acceptable financial and technical sustainability. A follow-on Social Sectors Project will have fewer components and will be more focussed on capacity building and substantially, expanding the human resource training begun with this project. The forthcoming project will also focus on technical assistance with stronger review and with built-in transfer of knowledge to national counterparts. In addition, it will have a social action fund to assist NGOs which have a good track record on the country, in developing micro-social sector projects and better reach those at the grass-root level.

H. IDA Performance

27. Major Strengths and Weaknesses. IDA staff showed consistent flexibility and creativity, which proved particularly important in view of the Borrower's inexperience. Moreover, during implementation IDA persistently and effectively pursued other donors and NGOs (WHO, EEC, UNFPA and others) to obtain additional technical assistance and funding for project-related activities, most notably for rehabilitation of health centers and the procurement and management of essential drugs. Efforts by IDA staff to strengthen donor coordination during this project paved the way for increased formal cooperation (particularly among IDA, WHO and UNICEF), which should benefit future efforts in the social sectors in Guinea-Bissau. However, there were some shortcomings, including the following:

(a) earlier identification of the problems affecting the construction component would have enabled the adoption of alternative solutions for successful bidding of the civil works including lowering the pre-qualification requirements for local contractors and grouping construction work in small packages; and

(b) a tighter control of the technical assistance costs, early detection of cost overruns, and closer attention to quality and utilization of consultants could have led to higher effectiveness and lower costs than achieved in the project; only in 1991, when credit funds were almost exhausted, did IDA begin to impose limits on expenditures in consultants' contracts and placed strict limits to unprogrammed spending.

28. Lessons Learned. The following lessons may be used for future projects:

(a) Project preparation needs to identify accurately the weaknesses of the implementing agency in order to design projects that are realistically implementable; while identification of sector needs is important, frequently projects -- particularly first-time operations -- are not able to eliminate all sector constraints and it is essential to prioritize interventions;

(b) When construction components are part of a project, they should be properly prepared, although they are usually less significant than software components in addressing sector issues; in this project, remodeling of facilities was not sufficiently planned during project preparation and thus, problems regarding the capacity of the construction sector in the country and the need for alternatives to large contractors was acknowledged only at a late stage in the project cycle, when there was not enough time left to undertake a suitable remodeling program;

(c) technical assistance is an essential component in cases in which the capacity of the sector agencies is low; however, its design should be in line with the agencies' absorptive capacity, and

should be closely supervised to enable remedial action in cases where quality, performance and cost become out of line with established standards and objectives; and

(d) Additional units or administrative staff for project management may be a good solution in cases were the implementing agency's capacity is low, but the experiences of this and other projects suggest that a project director, particularly a foreign consultant, should not be allowed to work without national counterparts and in isolation of the national agency or become the sole agent of communication with IDA; a main function of a project unit, in addition to project monitoring, should be institution building.

I. Borrower Performance

29. Major Strengths and Weaknesses. During project preparation, the Government took several reassuring steps: it acted diligently in appointing an expatriate Project Director and in creating a Project Management Unit, and committed itself to pursuing several changes in policy and organization. Regular quarterly reports were submitted, and the Borrower complied with Bank audit and other procedural requirements.

30. However, the project suffered serious implementation problems when MINSAP allowed key managerial positions to remain vacant for over two years for lack of competent candidates, and scarce administrative skills within the ministry. IDA exchanges during the project period were with the project management office, which in principle provided the link with the various MINSAP divisions; but interest in the project within MINSAP was low. This situation changed slightly under a new minister in 1990, when a stronger interest began to emerge; for instance, much of IDA's correspondence began to be copied to the Minister at her request. Implementation was also compromised by the Ministry of Finance's inability to make counterpart funds available when needed during the project period.

31. Lessons Learned. The main lesson learned by MINSAP was that when foreign consultants are contracted to run a project implementation unit, appropriate national counterpart staff must be in position and the implementing agency has the right and responsibility of oversight over the performance of the unit. The same concept of oversight applies to all technical assistance contracts. Additionally, knowledge transfer and/or training should be included in the terms of reference. When studies are conducted, consultants should have a contractual obligation to present their findings and explain the methodology used in the study to the client agency.

J. Project Relationship

32. The Bank-Borrower relationship throughout was satisfactory. A positive tone was set from the beginning and was sustained during implementation.

K. Consulting Services

33. Although most of the consultant services provided under the project resulted in acceptable studies and surveys, consultant performance could have been more cost effective had careful design been conducted at appraisal and more strict cost control and technical oversight had been exerted. The consultancy on MINSAP's reorganization was overly expensive in comparison to the results and produced recommendations that, according to Government evaluation, were not entirely appropriate for the local situation; as a result, the Ministry ended up adopting a simplified organizational design, with assistance from WHO.

L. Project Documentation and Data

34. The Staff Appraisal Report, supervision and consultant reports, and additional material contained in the project files provided adequate information for this project completion report. In addition, a Social Sectors Strategy Review (Volume I, September 1991) provided a very helpful in-depth view of the broader context in which this project was implemented.

PROJECT COMPLETION REPORT

GUINEA -BISSAU

POPULATION, HEALTH AND NUTRITION PROJECT

(Credit 1800-GUB)

PART II. PROJECT REVIEW FROM BORROWER'S PERSPECTIVE

1. The time has come to close this project which for the last four years has provided Guinea-Bissau with support for its national health policy, based on the delivery of primary health care.

2. In compliance with the covenants contained in the Credit Agreement 1800-GUB signed with IDA for the financing of the design and execution of the project, we must now make a general review of the project and present our evaluation.

3. All sorts and types of problems were encountered during the implementation of the Population, Health, and Nutrition Project; despite the lengthy duration of the project, it was impossible to successfully complete a large proportion of the components, leaving some objectives unaccomplished.

4. Certain actions were, however, accomplished albeit with considerable difficulty, such as the nutrition Study (Part 1) which was conducted between December, 1990 and January, 1991, followed by dissemination of the results through a seminar.

5. With respect to the Government's formulation of a Food and Nutrition Policy, we think it is logical and technically advisable to wait the completion of Part 2 of the study, so that the document to be submitted to the Government for approval can draw on the study's findings.

6. As for the counterpart funds, which the Government was to have made available in a amount equivalent to US$200,000, it is true that these were not provided on time because of the large number of projects in other sectors of Government activities that also depend on the National Development Fund; another factor was the country's serious shortage of financial resources. Nevertheless, a major effort was made and we believe that the Government met its commitment under the Credit Agreement.

7. Additional costs were incurred, particularly in connection with the Food and Nutrition Survey, which required an additional mission of the foreign consultants in December, 1990, because the June, 1990 mission had not been properly prepared by the Project Management Unit, which had failed to inform the *Directora Nacional do Estudo* of the plans to carry it out.

8. In view of the many different irregularities encountered during project implementation and the lack of collaboration between the Management Unit and the other departments, it was felt advisable to appoint a national counterpart to act as Deputy and thus assist the National Project Manager, who was an expatriate.

9. As soon as the national counterpart was hired as Assistant Consultant, the National Project Director decided to turn his back on his responsibilities and go on a trip without giving anyone previous notification.

10. With respect to the cost recovery policy, the greatest difficulty was encountered when an attempt was made to provide health care to as wide a cross-section of the population as possible on the basis of a sliding scale tailored to each client's income level. These activities had to be suspended because of the extreme dissatisfaction and unrest that they caused among the public, unaccustomed to paying for health care.

11. We feel that the project design was faulty in certain respects, particularly where the structural objectives were concerned, viz. the reorganization of MINSAP and the Study on Family Planning.

12. MINSAP's reorganization was one of the Project's basic and essential objectives which, unfortunately, was impossible to accomplish in the short term. While it is true that some improvements were made in the Ministry's organization, we have to admit that we have serious doubts whether these were basically influenced by the conclusions and recommendations of the consultant firm involved or prompted by the distinctive style of the new leadership.

13. The conclusions and recommendations are there, and we have a number of manuals that we can use for a basic undertaking of this type, but the project design did not pay proper attention to the real life situation of our institutions and the status of our staff, who are greatly demoralized by their low salaries, which make it necessary for them to find second jobs, leaving them insufficient time to perform their work properly, let alone read the extensive paper files left by the consultant.

14. Regarding the Family Planning Study, it had a worthwhile objective in an area in which the Government definitely needs to adopt a policy. However, we must question its scope and success. The fact is that it touches on one of the most intimate aspects of conjugal and personal life, where cultural values are deeply ingrained; for this reason, any measures that are adopted to deal with this matter, inevitably cause some upset and are doomed to failure from the start.

15. We feel that the most appropriate course of action is to offer education through case-by-case medical consultations and through the schools, by increasing the enrollment rate among our children. In fact, as a specialist has concluded from a study on this topic, a woman who has never attended school is likely to have twelve children, one who has completed fourth grade is unlikely to have more than eight, one who has completed secondary education diploma is

expected to stop at four, and one who has completed university is unlikely to have more than two.

16. In our opinion, the project design failed in these two specific areas because insufficient attention was paid to the basic issue responsible for the real life situation, resulting in a considerable investment which offered very limited chance of success from the start.

17. The Project execution *per se* had its own problems, above and beyond the deficiencies that had to do with the design, in so far as it encountered difficulties in the field, which it failed to overcome. This may have resulted from a failure to secure the cooperation of other government officials who felt removed from the project objectives; it could also be that the Project Management Unit did not work hard enough and had serious shortcomings which were particularly glaring with respect to rehabilitation of health centers, assistance given to consultants, and procurement of consumable and durable goods and equipment.

18. The World Bank's financial management of the project did cause some difficulties, but these were, in fact, neither insurmountable nor pivotal in those areas where the project was less than successful. In any case, we feel that it should be possible, in the medium term, to move toward other forms of joint financial management, which would allow the local management unit more freedom of movement for the sake of facilitating efforts to accomplish the Project's objectives, provided it is headed by an appropriate and capable manager.

19. In our opinion, the design and execution of the project was not entirely bad and it is bound to have a positive contribution toward improving the delivery of health care throughout to country, providing better information on existing health care facilities and pointing the way to a new policy of health care and for the management and cost-effective utilization of available resources. Despite the lack of success with the cost recovery policy, lessons have been learned from the experience gained so that we may, in the medium term, develop an efficient system for amortizing the costs of health care, which have, until now, been fully born by the State. We shall continue with the Bamako initiative and believe that the entire country will, in the course of time, eventually understand the need for each user to contribute toward amortizing the costs and improving the quality of health care.

20. We could certainly have achieved better results, had the project management not been so poor, even in the case of the most viable components. We feel justified in giving the project now completed a passing grade, thanks to the funds made available and to the controls imposed by the new leadership of the Ministry. A further point worth remembering is that prior to 1990 the project focussed basically on the procurement and distribution of goods for consumption and direct utilization.

21. The people of Guinea-Bissau are suffering from serious deprivation and shortages. Health sector statistics, such as birth rates and infant and maternal mortality rates, not to mention the prevalence of malnutrition in certain parts

of the country, as well as endemic diseases including malaria, diarrhea and AIDS, speak loud and clear and force the Government to make an all-out effort in order to minimize the disastrous consequences, which not only increase the burden on the State, but also hold back the country's development process.

22. We consider that this project served as a test from which the country has been able to learn some valuable lessons.

23. In light of all what has been said earlier, we are convinced that at least one lesson has been learned, and that is that projects must not directly pursue any structural objectives without local involvement. We believe that even in the absence of the difficulties listed above, it would have been preferable to find ways to encourage an internal exchange of experience and to give priority to the work and consulting services of local experts who, even if not equipped to offer studies as elaborate as those provided by the international consultants, would produce findings that would have the advantage of reflecting the country's real situation more closely and would therefore have a greater impact. Furthermore, only by giving these technical experts a challenge will it be possible to ensure their real and sustained development until they are eventually capable of serving as an ongoing resource to international consultants.

24. The fact therefore bears repeating that the project was a success. The results obtained provide a storehouse of information on which we will be able to draw in order to maximize the returns on future undertakings.

25. We hope to continue to earn the support of the international community, since we are determined to do our utmost to renew our hope of entering the twenty-first century with a more satisfactory health profile that will enable us to meet the challenge of development and the attainment of "Health for All" by the year 2000.

Bissau, June, 1992

PROJECT COMPLETION REPORT

GUINEA-BISSAU

POPULATION, HEALTH AND NUTRITION PROJECT

(CREDIT 1800-GUB)

PART III. STATISTICAL INFORMATION

1. Related Bank Loans and/or Credits

Not applicable.

2. Project Timetable

Item	Original Date	Revised Date	Actual
Identification I			01/86
Identification II			04/86
Preparation			07/86
Pre-appraisal Mission			09/86
Appraisal Mission			12/86
Credit Negotiations			03/87
Board Approval			05/19/87
Credit Signature			05/22/87
Credit Effectiveness	09/18/87	12/18/87	12/18/87 1/
Credit Closing	06/30/91	12/31/91	12/31/91 2/

1/ Credit effectiveness was extended to allow Government's submission of a three-year action program and financial plan, incorporating the results of a health cost and cost recovery study. As this condition could not possibly be met by December 1987 and thus further unecessary delays to project implementation would have been created, it was recommended, after amending the Development Credit Agreement (new Section 3.10), that it become a covenant to be met by April 30, 1988. However, this covenant has never been fully complied.

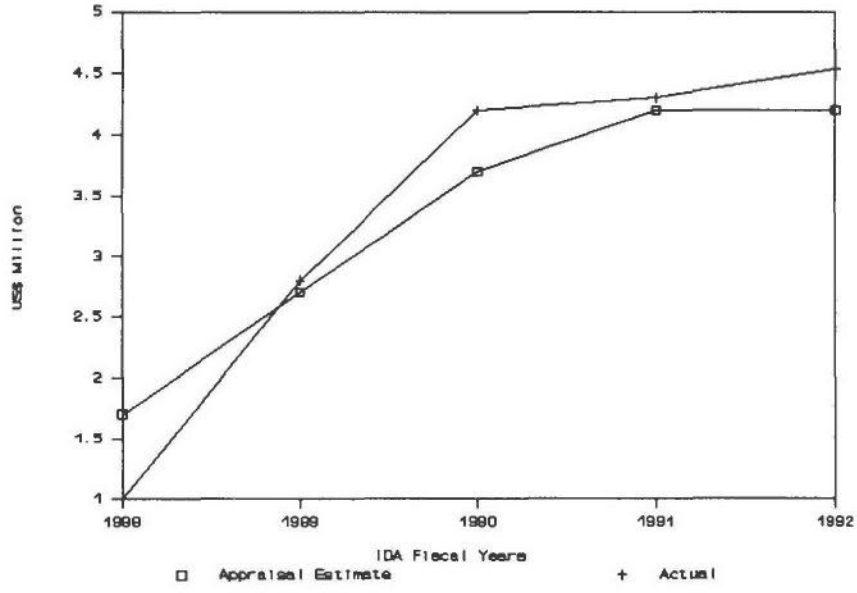
2/ Project closing date was extended on June 13, 1991, to allow Government to complete key project activities.

3. Credit Disbursements

A. Cumulative Estimated and Actual Disbursements
(US$ million)

Fiscal Year	FY88	FY89	FY90	FY91	FY92
Appraisal Estimate	1.7	2.7	3.7	4.2 1/	
Actual	0.9	2.8	4.2	4.4	4.51/
Actual as % of Estimate	55.3	103.7	112.2%	103.8	107.9

B. Time Line of Appraisal Estimate and Actual Disbursement Schedule



1/ Because of the fluctuation of the US dollars against SDR, the project benefitted from additional funds equivalent to about US$300,000. All funds under Credit 1800-GUB are now disbursed. There was no cancellations to this Credit.

Table C: Allocation of Proceeds

Category	In SDRs				In US$
	Original Allocation	Revised 1/	Actual Disbursements 2/	Balance	Balance 3/
1. Civil Works	350,000	98,700	70,590	28,110	37,452
2. Equipment, furniture, vehicles and materials	380,000	668,900	798,335	(129,435)	(172,453)
3. Consultants' services and fellowships	400,000	1,124,700	1,124,188	512	682
4. Drugs and medical supplies	560,000	698,900	748,581	(49,681)	(66,193)
5. Operating Costs	340,000	55,900	56,054	(154)	(205)
6. Goods and services related to implementation of activities and programs resulting from policy studies	220,000	137,500	137,535	(35)	(46)
7. Refunding of PPF	850,000	460,500	466,708	(6,208)	(8,272)
8. Unallocated	300,000	154,900	(1,992)	152,908	203,727
TOTAL	3,400,000	3,400,000	3,400,000	0	0

1/ Formal reallocation of credit proceeds was done per IDA's telex of February 1, 1991.

2/ Actual and final disbursements.

3/ At exchange rate of US$1.33 = 1 SDR.

4. Project Implementation

Project Components	Unity	SAR Estimates	Actual	Comments
Part A. Institutional Development				
1. Organization and Management:				
(a) Implementation of MINSAP's reorganization plan;	Unit	1	0.5	Work performed by Firm of consultants was inadequate; a simpler plan was proposed and then implemented.
(b) Design and Implementation of a Management Information System	Unit	1	0.5	MIS was implemented for the cost recovery measures but was not entirely instituted.
(c) Implementation of a plan to improve drug system management	Unit	1	1	A Drug Management System has been implemented and the Central Drug Unit is operating efficiently.
(d) Development, testing and implementation of a model system for the supervision of rural health services in the Bafata region and the Sonaco area of Gabu region.	Unit	1	1	The rural supervision component was carried out successfully in the Bafata Region and in Sonaco (Gabu Region) in spite of some problem such as inadequate transportation.
2. Planning and Policy Development:				
(a) Study on the Hospital sector, including rehabilitation needs.	Unit	1	0	The study did not take place as part the PHN Project but rather within the framework of the Bank's Social Sectors Strategy Review.
(b) Study on Nutrition.	Unit	1	1	Study was endorsed by the Technical Committee and then by MINSAP Minister in August 1991. A seminar to discuss study's findings was carried out in late 1991.
(c) Study on Family Planning.	Unit	1	1	Study was well received by the Technical Committee and MINSAP. A seminar on the study has been carried out.
(d) Study on demand for health services at the health center level	Unit	1	0 1/	It was decided that these two studies should be in abeyance until more urgent studies be carried out.
(e) Study on energy requirements of the health sector and alternative sources of energy.	Unit	1	0 1/	
(f) Improvement of basic PHN data including:				
(i) analysis of the 1979 census;	Unit	1	1	
(ii) implementation of a national sample survey;	Unit	1	1	The DHS has been completed and data distributed. A seminar to discuss the DHS results was held in April 1992 under a SPPF.
(iii) Creation of a data bank;	Unit	1	0.1	Rudimentary data bank done.
(iv) Training of DGE and MINSAP's staff in statistics	Unit	1	1	Training in statistics, accounting and computer were carried out. However, it is recommended that further training in those areas be provided.

1/ Because of the overextended capacity of the PMU in carrying out a large number of activities to be implemented under this project, the project staff recommended that these two studies be put in abeyance until a number of more pressing activities be completed.

Project Components	Unity	SAR Estimates	Actual	Comments
Part B. Strengthening Health and Family Planning Services				
1. Support for Rural Health Services:				
(a) Strengthening of the 8 Regional Directories and implementation of supervision and management techniques in the regions, following the results of the model system referred to in Part A.1.(d) above.	Unit	8	.2	Regional Directories will be strengthened in a future project. PHN focused on Bafata and Gabu regions.
(b) Rehabilitation of about 25 health centers.	Unit	25	7	Rehabilitation: 2 health centers under the project; 4 health centers by CECI (Canada); 1 health center under PASI project; only 5 health centers of the remaining 18 are listed as irreparable.
(c) Equipping, furnishing and provision of health care inputs to about 122 health centers.	Unit	122	109	In addition to 109 health centers, 3 referral centers; 5 sectoral hospitals; 8 regional hospitals; and 2 national hospitals obtained equipment, materials,
2. Health Manpower Development:				
Establishment of an in-service training program for about 500 health workers in maternal and child health, epidemiology, and family planning, nutrition, drug prescription/utilization, health and nutrition education and other health care areas.	Unit	500	500	It is estimated that about 6,500 persons benefitted directly or indirectly from the training provided under the project.

5. Project Costs and Financing

Table A. Project Costs (US$ '000)

Category	Appraisal Estimates			Actual 1/		
	Local Costs	Foreign Exchange Costs	Total	Local Costs	Foreign Exchange Costs	Total
1. Civil Works	24.4	395.6	420.0	35.3	58.8	94.1
2. Equipment, Furniture, vehicles and materials	6.9	478.9	485.8	66.6	1,003.2	1,069.8
3. Consultants' Services and Fellowships	52.5	613.4	665.9	162.0	1,335.8	1,497.8
4. Drugs and Medical Supplies	0.0	625.2	625.2	69.8	927.6	997.4
5. Operating Costs	79.6	385.7	465.3	69.0	61.2	130.2
6. Goods and Services under Part A.2 (b) of the Project	14.7	382.5	397.2	0.0	183.2	183.2
7. Refunding of PPF	46.0	922.0	968.0	0.0	621.8	621.8
8. Unallocated	62.0	322.2	384.2	0.0	(2.7)	(2.7)
Total	286.1	4,125.5	4,411.6	402.7	4,189.0	4,591.7

1/ Government's contribution reflects data shown in Audit Report covering period until December 31, 1991.

Table B: Project Financing (in US Dollars)

Source of Financing/ Categories of Expenditures	Planned (Credit Agreement)1/	Revised 2/	% of Total	Final 3/	% of Total	Balance
I. IDA:						
1. Civil Works	470,000	131,503	2.8%	94,051	2.0%	37,452
2. Equipment, furniture, vehicles and materials	560,000	891,209	18.8%	1,063,662	23.2%	(172,453)
3. Consultants' Services and Fellowships	640,000	1,498,494	31.6%	1,497,812	32.6%	682
4. Drugs and Medical Supplies	740,000	931,179	19.6%	997,372	21.7%	(66,193)
5. Operating Costs	430,000	74,478	1.6%	74,683	1.6%	(205)
6. Goods and Services under Part A.2 (b) of the Project	400,000	183,198	3.9%	183,245	4.0%	(46)
7. Refunding of PPF	970,000	613,547	12.9%	621,819	13.5%	(8,272)
8. Unallocated	0	206,381	4.4%	(2,654)	-0.1%	209,035
TOTAL IDA	4,210,000	4,529,990	95.6%	4,529,990	98.7%	0
II. GOVERNMENT OF GUINEA-BISSAU						
1. Civil Works	20,000	20,000	0.4%	0	0.0%	
2. Equipment, furniture, vehicles and materials	10,000	10,000	0.2%	6,137	0.1%	
3. Consultants' Services and Fellowships	70,000	70,000	1.5%	397	0.0%	
5. Operating Costs	110,000	110,000	2.3%	55,364	1.2%	
TOTAL GOVERNMENT OF GUINEA-BISSAU	210,000	210,000	4.4%	61,898	1.3%	
TOTAL PROJECT FINANCING	4,420,000	4,739,990	100.0%	4,591,888	100.0%	

1/ Allocation to each category of expenditures is inclusive of price and physical contingencies.

2/ Formal reallocation of the credits proceeds was done per IDA's telex of February 1, 1991. Because of the fluctuation of the US dollars against SDR, the project benefitted from additional funds equivalent to about US$300,000.

3/ For IDA: Actual and final disbursements status. For Government: based on Audit Report covering period ending December 31, 1991.

(Exchange Rate US$1.33 = SDR 1).

6. Project Results

Item	Purpose as Defined at Appraisal	Status	Impact of Action
A. Studies			
1. Health cost and cost recovery study, and a three-year financial plan study.	To address the lack of financial planning and improve financing of non-wage recurrent costs.	The studies were financed partially under PPF and were completed.	Created a great deal of awareness in the MINSAP; cost recovery measures have been implemented in the Gabu Region and it is expected to expand to other regions.
2. Study on the Hospital sector, including rehabilitation needs.	The study would focus on utilization rates, quality of care, manpower and investment requirements, physical condition of facilitites and rehabilitation needs, availability of housing for health workers, and overall costs of the sector.	The study did not take place as part the PHN Project but rather within the framework of the Bank's Social Sectors Strategy Review.	It should assist the MINSAP in improving planning and allocation of resources.
3. Study on Nutrition	To better determine nutritional status in the country, including food choice, preparation habits, and causality of malnutrition.	Study was endorsed by the Technical Committee and then by MINSAP Minister in August 1991. A seminar to discuss study's findings was carried out in November 1991 for health workers.	Providing to health workers basic knowledge and skills as regards nutrition for applying acquired skills in the the rural areas and thus reaching a greater population.
4. Study on Family Planning	To develop, test and implement a simple guide for classifying and referring women according to their level of obstetrical or reproductive risks.	Study was well received by the Technical Committee and MINSAP. A seminar on the study has been carried out in January 1992 for a majority of health workers.	Providing to health workers basic knowledge and skills as regards family planning for applying acquired skills in the the rural areas and thus reaching a greater population.
5. Study on Demand for Health Services at the Health Center Level	To be implemented by the National Institute for Studies and Research (INEP). To examine popular perceptions of health center services, most common services sought, and levels of community support for the health centers.	Study was not carried out per se, but was tied to the information received from the result of the Demographic Health Survey (DHS), (see B-2 below).	
6. Study on Energy Requirements of the Health Sector and Alternative Sources of Energy	To evaluate the energy requirements of sector hospitals, health centers and health personnel's residences and to propose alternative energy sources.	Prioritization of studies' to be carried out revealed that these studies should be put in abeyance so that efforts and resources could be concentrated on other types of studies (family planning, nutrition, etc.) selected because of their urgencies.	
7. Study to Determine Transportation Needs of Outer Islands;	Not specified.	Dropped	Insufficient funds and priority low.
8. Study of Low-cost Housing Needs for Health Personnel assigned to Rural Facilities.	Not specified.	Dropped under the project.	Will be part of the subsequent project instead.
B. Data Collection and Analysis:			
1. Analysis of the 1979 Census;	Analysis and publication of results	Carried out	Incorporated into DHS data.
2. Implementation of a national PHN sample survey (or DHS);	Implementation started under PPF.	The DHS was completed and data distributed.	A seminar to discuss the DHS results has taken placed in April 1992 under a SPPF.
3. Creation of a data bank;	Through the provision of a 3-month overseas fellowship for a data technician and technical assistance from a data bank information specialist.	Rudimentary data bank done.	
4. Training of DGE and MINSAP's Staff in Statistics;	Through the provision of technical assistance from a public health statistician and an 8-month overseas fellowship in health statistics.	Training in statistics, accounting and computer were carried out. However, it is recommended that further training in those areas be provided.	Improving skills capacity noted, but more is required.

7. Compliance with Covenants

Section	Covenant	Status
2.02 (b)	The Borrower shall open and maintain in dollars a special account in a commercial bank on terms and conditions satisfactory to IDA. Deposits into, and payments out of, the Special Account shall be made in accordance with the provisions of Schedule 4 to the Development Credit Agreement (DCA).	In full compliance. The Special Account has been fully recovered. MINSAP was recently informed that it should give instructions to Citibank, Senegal to close the account.
3.03	The Borrower shall not later than October 30 in each year of the project review in detail with IDA, MINSAP's: (a) three-year action program and financial plan; (b) development and recurrent budget for the following fiscal year; (c) organizational structure; (d) rural supervision procedures; (e) in-service training program; and (f) the results of special policy studies and potential new program.	In full compliance except for (a), where it was complied with "in principle", but not in reality.
3.04	The Borrower shall, not later than March 31, 1988, take all necessary measures to enact and make public its national drug policy.	In compliance. National Drug Formulary published in 1991. Drug policy and cost recovery measures implemented and refined. Computer training taken in Fall 1991 by drug management staff to help adequate implementation of the measures.
3.05	The Borrower shall take all necessary action to grant to MINSAP the legal exemption established by Decree No. 51/85 of December 4, 1985 of the Borrower to allow the retention of 100% of all fees collected by MINSAP in accordance with the health cost recovery measures implemented.	Pilot activities introducing cost recovery measures, and Bamako initiative, were implemented on April 1, 1990 in the Gabu Region; it is expected that these measures will be expanded to other regions during the next year.
3.06	The Borrower shall, not later than November 30, 1987, establish an account in the National Bank of Guinea-Bissau (BNG) (MINSAP account) on terms and conditions satisfactory to IDA. All proceeds accruing from fees collected pursuant to Section 3.05 of the DCA shall be deposited in the MINSAP Account.	In full compliance.
3.07	(a) not later than January 1, 1989, complete and furnish to IDA for its review and comments, the recommendations resulting from the studies related to nutrition carried out by the Borrower pursuant to Part A.2 (a) (ii) of the Project;	In full compliance. A national seminar was carried out in November 1991, to discuss and disseminate the results of the study.
	(b) not later than January 1, 1989, prepare a national nutrition policy and action program;	Not complied. Expected that this will be the end result of study and national seminar carried out in late 1991.
	(c) promptly thereafter exchange views and agree with IDA on the implementation of said policy and action program.	Not complied.
3.10	The Borrower shall, not later than April 30, 1988, furnish to IDA MINSAP's action programs and financial plan for the 1988-1990 period, incorporating the results of the health cost and cost recovery study carried out by the Borrower on terms and conditions satisfactory to IDA.	Not complied. However, MINSAP has recently made positive progress in the development of a rolling financial plan. MINSAP's Office of Planning and a WHO technical assistant are drafting a financial plan for the Ministry, which would serve as a working document, and financial planning and management vehicle.

Section	Covenant	Status
4.01	(a) The Borrower shall maintain or cause to be maintained records and accounts adequate to reflect in accordance with sound accounting practices and operations, resources and expenditures in respect of the Project of the departments or agencies of the Borrower responsible for carrying out the Project or any part thereof.	In full compliance. A last audit report covering the period ending December 31, 1991, was prepared and submitted to IDA.
	(b) The Borrower shall: (i) have the records and accounts referred to in para. (a) of this Section, including those for the Special Account for each fiscal year audited, in accordance with appropriate auditing principles consistently applied, by independent auditors acceptable to IDA; and	Same as above.
	(ii) furnish to IDA, as soon as available, but in any case not later than six 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 IDA shall from time to time reasonably request.	
	(c) For all expenditures with respect to which withdrawals from the Credit Account were made on the basis of SOEs, the Borrower shall:	Same as above.
	(i) maintain or cause to be maintained, in accordance with para. (a) of this Section, records and accounts reflecting such expenditures;	
	(ii) retain, until at least one year after the completion of the audit for the fiscal year in which the last withdrawal from the Credit Account was made, all records (contracts, orders, invoices, bills, receipts and other documents) evidencing such expenditures;	
	(iii) enable IDA's representatives to examine such records; and	
	(iv) ensure that such records and accounts are included in the annual audit referred to in para. (b) of this Section and that the report of such audit contains a separate opinion by said auditors as to whether the SOEs submitted during such fiscal year, together with the procedures and internal controls involved in their preparation, can be relied upon to support the related withdrawals.	

8. Use of Bank Resources

A. Staff Inputs

(Staffweeks)

Project Stage	Fiscal Years							Total
	FY86	FY87	FY88	FY89	FY90	FY91	FY92	
Preparation/Preappraisal	11.8	33.0						44.8
Appraisal		42.1						42.1
Negotiations		3.3						3.3
Supervision		1.2	21.6	8.9	17.5	11.6	9.9	70.7
Completion							8.0	8.0
TOTAL	11.8	79.6	21.6	8.9	17.5	11.6	17.9	168.9

B. Mission Data

Project Stage	Month/ Year	No. of Persons	Days in Field	Specializations Represented 1/	Performance Status by Activity 2/
Identification I	01/86	3	15	PO, CONS: E, P	
Identification II	04/86	3	8	PO, CONS: E, P	
Preparation	07/86	3	12	PO, CONS: E, A	
Pre-appraisal	09/86	2	8	E, CONS: E	
Appraisal	12/86	6	12	PO, E, OA, CONS: E, E, PS	
Post-Appraisal	01/87	1	6	CONS: E	O D C M F
Supervision 1	10/87	2	5	PO, A	Not rated
Supervision 2	03/88	1	10	CONS: E	Not rated
Supervision 3	06/88	1	10	PO	2 1 n.a. 2 2
Supervision 4	10/88	1	5	PO	Not rated
Supervision 5	06/89	3	10	PO, CONS: E, P	2 1 2 2 3
Supervision 6	10/89	1	10	PO	2 2 2 2 3
Supervision 7	03/90	3	16	PO, CONS: PH, P	2 2 2 3 3
Supervision 8	07/90	1	7	PO	Not rated
Supervision 9	03/91	1	13	PO	2 2 2 3 2
Supervision 10	10/91	2	5	PO, RA	2 2 2 3 2
Completion	01/92	2	8	PO, RA	Not Rated

1/ A = Architect; E = Economist; OA: Operations Analyst; P = Physician; PH = Public Health Specialist; PO = Project Officer; PS = Pharmaceutical Specialist; RA = Research Analyst

2/ O = Overall Status; D = Project Development Objectives; C = Compliance with Legal Covenants; M: Project Management Performance; F = Availability of Funds.

Annex 1

PROJECT COMPLETION REPORT

GUINEA-BISSAU

POPULATION, HEALTH AND NUTRITION PROJECT

PARTICIPANTS IN COMPLETION MISSION 1/

October 1991 and January 1992 Missions

World Bank

Ms. Carol Hoppy, Project Officer and Task Manager, AF4PH
Ms. Johanne Angers, Research Analyst, AF4PH

Ministry of Health and Social Affairs

H.E. Henriqueta Godinho Gomes, Minister of Health and Social Affairs
Dr. Sylvestre Alves, PHN Assistant Project Director

October 1991 Mission

Ministry of Health and Social Affairs

Dr. Celestino Costa, Ex-Secretary of State for Health,
Sr. Augusto Paulo, Chief, Office of Planning and Internation Cooperation
Sr. Malam Drame, Office of Planning and International Cooperation
Sr. Antonio Paulo Gomes, Office of Planning and International Cooperation
Dr. Estevao Malam Da Costa, Pharmacist, National Drug Depository
Dr. Paulo Jose Mendes, Director-General, Human Resources
Nurse Maria Augusta Biai, Director, Technical School for Nurses
Dr. Jose Antonio, Director of Public Health
Prof. Deant Kaymah, PHN Project Director

World Health Organization (WHO)

Dr. Erling Larsson, WHO Technical Advisor, Drug Management

1/ A supervision mission was carried out in October 1991 when several discussions on project's activities were held with key officials.

Annex 2

PROJECT COMPLETION REPORT

GUINEA-BISSAU

POPULATION, HEALTH AND NUTRITION PROJECT

RECORD OF PROJECT QUARTERLY PROGRESS REPORTS SUBMITTED

1.	May 24, 1988	PHN Progress Report No. 1 for period ending May 1988.
2.	October, 1988	PHN Progress Report No. 2 for period ending September 1988.
3.	December, 1988	PHN Quarterly Progress Report No. 3 for period ending December 1988.
4.	March 10, 1989	PHN Quarterly Progress Report No. 4 for period ending March 1989.
5.	July 8, 1989	PHN Quarterly Progress Report No. 5 for period ending June 1989.
6.	October 12, 1989	PHN Quarterly Progress Report No. 6 for period ending September 1989.
7.	December 4, 1989	PHN Quarterly Progress Report No. 7 for period ending December 1989.
8.	March 6, 1990	PHN Quarterly Progress Report No. 8 for period ending March 1990.
9.	June 29, 1990	PHN Quarterly Progress Report No. 9 for period ending June 1990.
10.	December 15, 1990	PHN Quarterly Progress Report No. 10 for period ending December 1990.
11.	March 15, 1991	PHN Quarterly Progress Report No. 11 for period ending March 1991.
12.	July 7, 1991	PHN Quarterly Progress Report No. 12 for period ending June 1991.
13.	October 5, 1991	PHN Quarterly Progress Report No. 13 for period ending September 1991.
14.	December 28, 1991	PHN Quarterly Progress Report No. 14 for period ending December 1991.

THE WORLD BANK
Washington, D.C. 20433
U.S.A.

Office of Director-General
Operations Evaluation

Report No. 11759

RELATÓRIO DE TERMINAÇÃO DO PROJECTO

REPÚBLICA DA GUINÉ-BISSAU

PROJECTO DE POPULAÇÃO, SAÚDE E NUTRIÇÃO

(CRÉDITO 1800-GUB)

31 de Março de 1993

Divisão de Operações
População e Recursos Humanos
Departamento Africa Ocidental

EQUIVALÊNCIAS MONETÁRIAS

Unidade Monetária = Peso da Guiné (PG)

US$ 1 = 700 PG
(1987/1988)

US$ 1 = 5 400 PG
(1992)

ANO FISCAL

1 de Janeiro - 31 de Dezembro

ABREVIATURAS E SIGLAS

ISD	Inquérito de Saúde Demográfico
CE	Comunidade Europeia
SMI	Saúde Materno-Infantil
MINSAP	Ministério da Saúde Pública
MINSAS	Ministério da Saúde e Assuntos Sociais
ONG	Organização Não-Governamental
CPS	Cuidados Primários de Saúde
PSN	População, Saúde e Nutrição
DES	Direitos Especiais de Saque
FNUAP	Fundo das Nações Unidas Para Actividades Populacionais
UNICEF	Fundo das Nações Unidas para a Infância
OMS	Organização Mundial da Saúde

REPÚBLICA DA GUINÉ-BISSAU

PROJECTO DE POPULAÇÃO, SAÚDE E NUTRIÇAO

CRÉDITO 1800 - GUB

RELATÓRIO DE TERMINAÇÃO DO PROJECTO

ÍNDICE

REPÚBLICA DA GUINÉ-BISSAU

PROJECTO DE POPULAÇÃO, SAÚDE E NUTRIÇAO

CRÉDITO 1800 - GUB

RELATÓRIO DE TERMINAÇÃO DO PROJECTO

PREFÁCIO

Isto constitui o Relatório de Terminação do Projecto (RTP), referente ao primeiro projecto de População, Saúde e Nutrição na Guiné-Bissau, para o qual foi aprovado o Crédito 1800-GUB no montante de SDR 3,4 milhões (equivalente a US$4,2 milhões, em Março de 1987) a 19 de Maio de 1987. O Crédito foi encerrado no dia 31 de Dezembro de 1991, com uma prorrogação de seis meses em relação à data inicial. Foi totalmente desembolsado; o último desembolso foi efectuado a 9 de Abril de 1992.

O RTP foi elaborado pela Divisão de Operações para a População e Recursos Humanos do Departamento da África Ocidental (Prefácio, Sumário de Avaliação Retrospectiva, Partes I e III) e pelo Mutuário (Parte II).

A elaboração deste RTP foi iniciado durante as missões finais de supervisão e terminação do projecto em Outubro de 1991 e Janeiro de 1992, respectivamente, e baseia-se inter-alia em: o Relatório da Avaliação Inicial do Pessoal, o Acordo de Crédito de Desenvolvimento, relatórios de supervisão, correspondência entre o Banco e o Mutuário, memorandos internos do Banco e entrevistas aos quadros do Banco envolvidos no projecto.

RELATÓRIO DE TERMINAÇÃO DO PROJECTO

REPÚBLICA DA GUINÉ-BISSAU

PROJECTO DE POPULAÇÃO, SAÚDE E NUTRIÇÃO

(CRÉDITO 1800-GUB)

SUMÁRIO DA AVALIAÇÃO RETROSPECTIVA

Objectivos do Projecto

1. Os dois objectivos básicos do Projecto eram (a) melhorar as capacidades institucionais do Ministério da Saúde Pública (MINSAP) nas áreas do planeamento, gestão e finanças; e (b) incrementar a prestação dos serviços de saúde e planeamento familiar, principalmente a nível dos centros de saúde nas zonas rurais. O objectivo do projecto ao concentrar-se a curto prazo na melhoria dos serviços básicos, promovendo ao mesmo tempo e a título complementar melhorias nas estrutura institucional, era proporcionar bases para permitir mudanças maiores na prestação dos serviços no futuro.

A Experiência da Execução e os Resultados do Projecto

2. Nos primeiros anos do projecto, registaram-se sérios atrasos na execução, devidos a deficiências institucionais e problemas de pessoal no MINSAP (acrescidos de assistência técnica inadequada), escassez de fundos de contrapartida e problemas com os procedimentos relativos à aquisição de medicamentos. A implementação retomou o ritmo nos últimos dezoito meses mais ou menos, quando o MINSAP começou a tentar superar estas deficiências e à medida que os trabalhos nos campos da formação profissional e educação no âmbito do projecto começaram a produzir efeitos.

3. Se bem que os êxitos conseguidos tenham ficado muito aquém dos objectivos delineados na avaliação inicial, os quais talvez tenham sido muito ambiciosos dada às circusntancias e realidades do país, mesmo assim, o projecto contribui grandemente para progressos futuros no sector da saúde. Considerando que este projecto representa a primeira tentativa feita por um doador de prestar assistência ao sector da saúde da Guiné-Bissau em geral, (ao contrário de pequenos projectos ou em locais específicos), as contribuições do mesmo são especialmente dignas de menção.

4. O desenvolvimento institucional, um processo a longo prazo e frequentement subtil, revelou indícios de verdadeiro progresso nos últimos meses do projecto, quando o MINSAP começou, finalmente, a elaborar um plano financeiro e a implementar um plano reorganizativo simplificado. O Ministério parece finalmente encaminhado no sentido da descentralização administrativa, gerencial e financeira, concentrando-se no aumento do poder a nível regional.

5. No sector da saúde lançaram-se várias políticas importantes. No campo crucial da gestão dos sistemas de medicamentos, estabeleceu-se um sistema operacional de controlo de inventários. Experimentou-se com êxito um modelo piloto de supervisão dos sistemas de saúde nas zonas rurais, o que constituiu um princípio excelente para fortalecer a gestão dos sistemas de saúde. Além disso, verificaram-se avanços importantes no sentido de instituir uma política de recuperação de custos e de a concretizar.

6. Entre outros resultados do projecto contam-se progressos significativos no sentido de preencher o quase-vácuo do centro de informações da PHN, graças a um Estudo Demográfico e de Saúde (LDS), um Estudo de Planeamento Familiar e um Estudo de Políticas de Nutrição (os quais, seguidos de seminários a nível nacional para divulgar os dados e resultados apurados.) Parece que o projecto encetou também o processo útil de desenvolvimento de recursos humanos. Estima-se que 6 500 pessoas beneficiaram directa ou indirectamente de cursos de formação relacionados com o projecto, formação no local de trabalho, cursos breves e seminários, principalmente nas áreas de administração, gestão financeira, contabilidade, gestão de medicamentos e cuidados materno-infantis.

7. O impacto das obras de construção civil foi decepcionante, visto que apenas dois centros de saúde foram reabilitados com os fundos do projecto (entre os 25 da meta inicial). Houve alguns que foram renovados com fundos concedidos por outros doadores, graças às diligências empreendidas por quadros do Banco, pela Direcção do MINSAP e pela Unidade de Gerência do P/PSN.

Continuidade do Projecto

8. Dada a inexperiência do MINSAP e a novidade da abordagem ao sector como tal, o objectivo prioritário do projecto foi desenvolver estruturas básicas apropriadas para trabalhos futuros. Se bem que o sector continue a contar grandemente com assistência técnica, existe já uma base segura para permitir a expansão e profissionalização das actividades iniciadas no âmbito deste crédito. À data do encerramento do projecto, por exemplo, a Organização Mundial de Saúde (OMS) estava a auxiliar o MINSAP a reforçar ainda mais as suas Unidades de Planeamento e de Administração e Finanças. O Projecto dos Sectores Sociais que se seguirá, expandirá grandemente a formação em recursos humanos iniciada no âmbito deste projecto. A equipa de gestão de medicamentos do Ministério dispõe dos requisitos essenciais para instituir uma política básica de medicamentos, e um sistema sustentável de recuperação de custos encontra-se prestes a ser implementado a nível nacional.

Conclusões

9. Quando as instituições nacionais são fracas, os projectos deviam concentrar-se num número restrito de objectivos atingíveis. Se bem que o Banco procure fundamentalmente promover o desenvolvimento institucional a longo prazo, pode simultaneamente obter resultados mais imediatos em termos de indicadores sociais, num país como a Guinea-Bissau, trabalhando a nível local e auxiliando NGUs que têm experiencia de trabalho neste nível. Para além disso, antes de permitir que os Mutuários estabeleçam Contas Especiais em instituições financeiras comerciais, a AID deveria providenciar no sentido de assegurar de antemão que as suas próprias condições e acordos sejam respeitados, a fim de se evitar a paralização de futuros projectos por parte das instituições financeiras, assim como o Banco de Las Palmas.

10. É altamente desaconselhável o emprego a longo prazo de técnicos estrangeiros (residentes ou não). Os consultores deviam ser contratados por períodos de seis a doze meses reservando-se o empregador sempre o direito de examinar o desempenho dos mesmos; a transmissão dos conhecimentos e/ou cursos de formação deviam figurar nos Termos de Referência; nos contratos para estudos especiais deveria etar estipulado que os consultores terão de apresentar os dados apurados, metodologia, etc, ao Mutuário, quer mediante seminários, quer por outras vias. Demais, contrapartida nacional deveria sempre ser designado a trabalhar com consultores estrangeiros residentes e no processo, aprender e beneficiar da experiencia.

11. Partindo do princípio que o apoio dos doadores se manterá ou mesmo aumentará, a Guiné-Bissau poderá assegurar fundos de contrapartida para trabalhos futuros no campo da saúde (assim como noutros sectores sociais), simplesmente mediante uma reatribuição de verbas, mesmo que isto implique uma redução doutras despesas correntes do Estado.

REPÚBLICA DA GUINÉ-BISSAU

PROJECTO DE POPULAÇÃO, SAÚDE E NUTRIÇÃO

(CRÉDITO 1800-GUB)

RELATÓRIO DE TERMINAÇÃO DO PROJECTO

PART I. ANÁLISE DO PROJECTO SOB A PERSPECTIVA DO BANCO

A. Identidade do Projecto

o	Nome do Projecto:	Projecto de População, Saúde e Nutrição
o	Crédito No.:	1800-GUB
o	Montante do Crédito:	DES 3,4 milhões (equivalente a $US4,2 milhões, em Março de 1987)
o	Departamento Regional do Vice Presidente	África Ocidental, Departamento IV
o	País:	Repúbica da Guiné-Bissau
o	Sector:	População, Saúde e Nutrição

B. Antecedentes do Projecto

1. A Guiné-Bissau é um dos países mais pobres da África susaariana, com um rendimento per capita estimado inferior a US$180. No início do projecto, em 1987, não existiam praticamente nenhuns dados fiáveis referentes à população, saúde e nutrição. Segundo estimativas preliminares feitas na altura, a população era ligeiramente inferior a um milhão, vivendo 80% nas zonas rurais. A esperança de vida era cerca de 40 anos (comparada com a média de 45 noutros países africanos de baixo rendimento) e uma em cada três crianças morria antes dos cinco anos de idade. A taxa bruta de mortalidade era de 27 por 1000 habitantes (comparada com 18 no resto da África subsaariana). Estes indicadores colocam a Guiné-Bissau 20 anos atrás da maior parte das outras nações africanas de baixo rendimento.

2. Objectivos para o Desenvolvimento do Sector. Em 1976, dois anos após a independência, o Governo da Guiné-Bissau adoptou um plano nacional de saúde (PNS) que preconizava o alargamento dos serviços básicos de saúde (SBS) utilizando tecnologia de baixo custo. O PNS passou posteriormente por uma série de modificações de pouca monta, à medida que foram implementados programas de cuidados de saúde novos ou ampliados. O objectivo declarado do Plano para Dez anos de Serviços Básicos de Saúde (1984-93), a implementar pelo Ministério da Saúde Pública (MINSAP)[1/], é conseguir o acesso à saúde para 80% da população, mediante programas de Saúde Materno-Infantil (SMI), imunizações, medicamentos básicos e o controlo de doenças endémicas. Como indicador do seu empenhamento neste Plano, o Governo afectou consistentemente cerca de 10% do orçamento do estado ao sector da saúde, até ser obrigado nos termos do ajustamento estrutural a reduzir este montante tanto em termos reais como percentuais.

[1/] Em Dezembro de 1991, este ministério passou a chamar-se Ministério da Saúde e Assuntos Sociais (MINSAS). Contudo, para efeitos deste relatório, será utilizada a sigla "MINSAP".

3. Enquadramento das Políticas. O sistema de saúde na Guiné-Bissau é quase exclusivamente público e administrado pelo MINSAP. O pessoal médico encontra-se fortemente concentrado nos dois hospitais nacionais, localizados na capital. A capacidade para formar pessoal de saúde a todos os níveis é extremamente limitada por todo o país, as instalações encontram-se em estado avançado de degradação e a aquisição de medicamentos está dependente quase na sua totalidade de financiamento externo (90% em 1986). Além disso, restrições de ordem macroeconómica limitam as opções para aperfeiçoar o sistema de saúde. Em 1991 as despesas no sector da saúde baixaram para 7% do orçamento do estado. Os fundos disponibilizados pelo MINSAP continuarão a ser limitados em virtude da escassez crónica de divisas e do abaixamento do valor real das verbas do orçamento do estado.

4. Ligações Entre os Objectivos do Projecto, do Sector e das Políticas Macroeconómicas. O Banco ajudou o Governo a delinear um programa de ajustamento estrutural de apoio a iniciativas importantes do último que se traduziram em políticas para fomentar a recuperação económica. O Banco e o Governo conceberam um programa de financiamento em duas partes agrangendo: a) um programa de financiamento a longo prazo, incluindo um crédito de ajustamento estrutural, e b) um programa básico de investimento em infra-estrutura, apoio institucional e desenvolvimento de recursos humanos. Este projecto constitui o primeiro do Banco no sector da saúde na Guiné-Bissau e destinava-se a continuar o programa básico de financiamento para o desenvolvimento dos recursos humanos, e ao mesmo tempo apoiar o sector social durante o período difícil do ajustamento estrutural.

C. Objectivos e Descrição do Projecto

5. Objectivos do Projecto. Os dois objectivos básicos do projecto eram: (a) melhorar as capacidades institucionais do Ministério da Saúde Pública (MINSAP) nas áreas do planeamento, gestão e finanças; e (b) melhorar a prestação de serviços de saúde e de planeamento familiara principalmente nos centros de saúde nas zonas rurais. A concentração de esforços a curto prazo no sentido de melhorar os serviços básicos, aliada à prioridade complementar dada as melhorias na estrutura institucional, destinava-se a criar bases para permitir ampliar a prestação de serviços no futuro.

6. Descrição do Projecto. As acções de desenvolvimento institucional no âmbito do Projecto abrangiam componentes para: melhorar a organização do MINSAP; criar um sistema informático de gestão; solidificar o sistema de gestão de medicamentos; conceber e implementar métodos de supervisão nos centros de saúde nas zonas rurais; introduzir um planeamento financeiro racional e ajudar o MINSAP a implementar medidas eficazes de recuperação de custos, apoiar o desenvolvimento e difusão de programas e políticas de PSN necessários; aperfeiçoar a recolha e análise de dados referentes à PSN; levar a cabo estudos especiais sobre políticas de nutrição e planeamento familiar; fazer um estudo de saúde demográfico (ESD) para melhorar o banco de dados estatísticos referentes à saúde.

7. As componentes do Projecto destinadas a reforçar a prestação de serviços incluem fornecer equipamento básico e insumos essenciais aos serviços nas zonas rurais, os quais abrangem 85% da população; recuperar 25 centros de saúde para prestar assistência a 175 000 pessoas; proporcionar formação profissional ao pessoal nos serviços da saúde, a todos os níveis. O apoio concedido para estes fins no âmbito do Projecto abrange veículos, equipamentos, obras de construção civil, mobiliário, materiais, fornecimentos médicos e outros, assistência técnica, bolsas de estudo de curta

duração no estrangeiro, formação no local de trabalho, salários do pessoal sob contrato e viagens/ajudas de custo.

D. Concepção e Organização do Projecto

8. Este projecto surgiu de uma análise feita pela AID ao sector e de uma mesa redonda de doadores, ambos realizados em princípios de 1986. O projecto que daí resultou foi cuidadosamente elaborado e constitui uma resposta global às necessiadades mais prementes identificadas durante os ditos exercícios. O projecto foi arquitectado no sentido de promover o desenvolvimento institucional a longo prazo dentro do MINSAP, atendendo ao mesmo tempo a algumas necessidades imediatas de melhoria na prestação dos serviços de saúde. Ao dar prioridade ao problema da recuperação de custos, o que constitui um aspecto inovador para a Guiné-Bissau, o projecto abordou também as dificuldades de financiamento dos custos ordinários não salariais. Infelizmente, a base conceptual do projecto, a qual era clara, tinha sido bem compreendida e ia ao encontro das carências do sector -- porém provou ter objetivos muito ambiciosos e com diversos e numerosos componentes -- estando muito além da capacidade local de implementação do mesmo. Se as pessoas que elaboraram o projecto tivessem tomado mais em conta os riscos de implementação, o resultado teria sido um projecto menos ambicioso, mas neste caso "menos" teria sido "mais".

9. Apropriabilidade do Âmbito e Dimensão do Projecto. Para conseguir implementar este projecto na sua totalidade, o MINSAP precisava de muitas mais competências precisamente naquelas áreas - administração, planeamento financeiro, gestão informática, desenvolvimento dos recursos humanos - que os projecto em si pretendia fortalecer. Considerando as limitações económicas e institucionais confessas do MINSAP, acrescidas de inexperiência do mesmo em empreendimentos tão grandes, qualquer projecto desta complexidade estava destinado a ultrapassar a capacidade potencial de implementação por parte do Ministério. Em retrospectiva, a dimensão geográfica do país da componente de obras de contrução civil era demasiado ampla para ser implementada por empresas privadas locais de construção.

E. Execução do Projecto

10. Riscos do Projecto. Previam-se dois riscos sérios neste primeiro projecto de PSN na Guiné-Bissau: (a) dificuldades de implementação devido à inexperiência dos quadros do MINSAP na execução de reformas estruturais importantes, principalmente no que respeita a recuperação de custos, e (b) a disponibilidade insuficiente de divisas para satisfazer as necessidades prementes de importações no sector da saúde.

11. Arranque do Projecto. O Projecto arrancou rapidamente graças à aprovação pela AID de dois adiantamentos provenientes do Fundo de Facilidade para a Preparação do Projecto (FFPP), no valor de US$300 000 e 750 000 respectivamente. Possibilitando ao Governo a realização de estudos acerca das carências do sector e o estabelecimento de uma Unidade de Gestão do Projecto, estes fundos não só aceleraram o arranque do projecto, como também permitiram que o MINSAP ganhasse alguma experiência nos procedimentos do Banco para aprovisionamento e desembolsos.

12. A entrada em vigor do crédito foi adiada de 18 de Setembro de 1987 até 18 de Dezembro de 1987, para permitir que o Governo submetesse um programa de acção e um plano financeiro do MINSAP para três anos, contendo os resultados de um estudo de custos de saúde e recuperação de custos. Quanto se tornou óbvio que esta condição não poderia ser satisfeita até 18 de Dezembro,

procedeu-se à alteração do Acordo de Crédito de Desenvolvimento, a fim de não haver mais atrasos na entrada em vigor do projecto. A presentação do plano do MINSAP deixou de ser uma condição para a entrada em vigor do projecto tornando-se uma cláusula a cumprir até 30 de Abril de 1988.

13. Discrepâncias entre a Execução Planeada para o Projecto e a Execução Real. Após a entrada em vigor do projecto verificaram-se atrasos sérios na implementação do mesmo, devidos em grande parte aos pontos fracos dentro do MINSAP, os quais já tinham sido inicialmente considerados riscos. A acrescentar a estes obstáculos verificaram-se vagas persistentes de postos chaves e outros problemas de pessoal dentro do MINSAP, falta de fundos de contrapartida e problemas com os procedimentos afectando as aquisições de medicamentos, infelizmente, uma assistência técnica contínua não se manifestou como um veículo eficaz ao qual se esperava, com respeito ao desenvolvimento institucional e às obras de construção civil.

14. A execução do projecto recuperou ritmo mais ou menos nos últimos 18 meses, quando um novo ministro tomou posse, algumas vagas para posições-chave no MINSAP foram finalmente preenchidas, fundos para medicamentos e estudos especiais from desbloqueados e a Organização Mundial da Saúde (OMS) assegurou assistência técnica. Além disso, durante este período registaram-se também melhorias acentuadas na implementação das componentes de gestão dos medicamentos, recuperação de custos e supervisão nas zonas rurais, à medida que os esforços nos campos de educação e da formação profissional no âmbito do Projecto começaram a produzir efeito.

15. Factores Imprevisíveis Afectando a Execução do Projecto. Cerca de US$70 000 dos fundos do projecto foram congelados por um banco de Ias Palmas (o qual tinha sido inicialmente designado detentor da conta especial do Projecto durante 2 1/2 anos), em virtude de uma disputa entre o banco e as Forças Armadas. A qual havia relacao com o Projeto ou com MINSAP.

F. Resultados mais Importantes do Projecto

16. Impacto do Projecto. O impacto global do Projecto foi misto. Os êxitos conseguidos no âmbito do Projecto ficaram aquém dos ambiciosos objectivos da avaliação inicial, apesar das grandes modificações operadas nas metas estabelecidas à partida para o desenvolvimento institucional e obras da construção civil. No entanto, o projecto contribui substancialmente para progressos futuros no sector da saúde mediante os êxitos alcançados no desenvolvimento de formação profissional e dos recursos humanos, na recolha de dados sobre PSN, na gestão dos sistemas de medicamentos, supervisão nas zonas rurais e reformas administrativas preliminares no seio do MINSAP. As contribuições deste projecto tornam-se particularmente dignas de menção considerando que o mesmo representa a primeira tentativa feita por um doador de prestar assistência à Guiné-Bissau no sector da saúde como um todo (ao contrário de projectos individuais ou locais).

17. Impacto no Desenvolvimento Institucional. A meta inicial para o desenvolvimento institucional era delinear um programa de acção e um plano financeiro para o sector da saúde a concretizar em três anos, incluindo a criação de um plano financeiro renovável. Se bem que este plano se tenha revelado demasiado ambicioso e o MINSAP nunca tenha chegado a adoptar um plano financeiro renovável durante todo o período da vigência do projecto, os esforços do Banco neste aspecto não foram em vão. Nos últimos meses da execução do projecto, havia indicações de que o MINSAP tinha finalmente começado a elaborar um plano financeiro, com o auxílio prestado pela OMS a instâncias do Banco. Apesar de atrasos, disputas e deficiências que não faltaram na

assistência técnica, o ministério conseguiu elaborar, adoptar e parcialmente implementar um plano simplificado de reorganização do mesmo. Parece que o Ministério se encaminha, finalmente, principalmente em aumentar a autoridade a nível regional.

18. Políticas Sectoriais. Este projecto permitiu que o sector da saúde da Guiné-Bissau lançasse várias políticas importantes e lhes desse seguimento mediante a instituição de medidas iniciais par a sua implementação. Quanto à gestão do sistema de medicamentos, por exemplo, do projecto resultou o estabelecimento de um sistema operacional de controlo de inventários. Isto foi conseguido graças ao fornecimento de um computador e dum veículo para o Armazém Central de Produtos Farmacêuticos e ao treino de pessoal local na sua utilização. Criou-se também um Formulário Nacional de Medicamentos e 535 exemplares foram fornecidos à Unidade Central de Medicamentos para destribuição por todo o país. Em termos de supervisão dos serviços de saúde nas zonas rurais, as duas regiões seleccionadas para as acções do projecto registaram progressos notáveis na medida em que serviram para experimentar um modelo de supervisão a seguir eventualmente nas sete regiões restantes do país. Instrução sobre saúde ministrada por pessoal local dedicado despertou interesse generalizado por entre a população rural, e atraíu um número crescente de parteiras tradicionais. Remodelações administrativas, acrescidas de problemas de manutenção e transporte, constituíram algumas dificuladades durante todo o período de execução. Não obstante, o material, equipamentos, veículos e assistência técnica fornecidos no âmbito do projecto - cuja utilização foi fortemente valorizada pelo contributo dado pelos Governos italianos e nadiano sob a forma de supervisão e formação - constituíram um começo excellente para fortalecer o processo de gestão dos sistemas de saúde nas duas regiões. Em finais da execução do projecto, tinha-se feito já uma campanha a nível nacional para instruir as populações acerca da necessidade de pagar os serviços de saúde, tinha-se criado uma Comissão para a Recuperação de Custos dentro do MINSAP, tinha-se instituído com êxito a recuperação de custos dentro dos limites de uma região (conforme a "iniciativa de Bamako"), e estavam-se a elaborar planos para alargar este sistema a mais regiões em 1992.

19. Estudos sobre Políticas a Seguir. No âmbito do projecto obtiveram-se progressos significativos no sentido de preencher um quase-vácuo no que respeita a um banco de dados informativos acerca de PSN. Completou-se a redacção dos 18 volumes do Estudo Demográfico e Saúde (EDS), a qual foi uma pesquisa que abrangeu todo o país na esperança de formar as bases para melhores informações sobre a saúde, fornecendo informações estatísticas atuais sobre a saúde e outros indicadores sociais no país. A pesquisa envolveu uma firma de consultoria e a participação ativa de MINSAP e o departamento de estatística do Ministro de Planejamento. E demais, um estudo sobre a População e Planeamento Familiar e um Estudo sobre Políticas de Nutrição. Estes três estudos representam todos um contributo muito importante para uma base de conhecimentos acerca do país. Realizaram-se ainda seminários para divulgar os dados apurados nos estudos e os resultados dos mesmos. Note-se, contudo, que o seminário sobre os dados apurados nos estudos foi custeado com fundos do SFPP obtidos pelos quadros do Banco, visto que esta actividade não constava no contrato do consultor e os fundos do projecto já se tinham esgotado.

20. Desenvolvimento dos Recursos Humanos. Esta componente ultrapassou as metas estabelecidas na avaliação inicial, em termos de participantes envolvidos e fundos dispendidos. Enquadrou formação profissional relacionada com o projecto, formação no local de trabalho, cursos breves e seminários, principalmente nas áreas de administração, gestão financeira, contabilidade, gestão dos medicamentos, e saúde materno-infantil. Segundo as estimativas do Encarregado do Projecto, 6 500 pessoas tiraram proveito, directo ou indirectamente, de todos os tipos e níveis de

formação profissional financiada no âmbito do projecto, em comparação com a meta de 500 no RAP. A concepção do projecto não preconizava um acompanhamento de perto ou avaliação retrospectiva das acções de formação. No entanto, segundo a avaliação do Director do Projecto e informações periódicas fornecidas pelos consultores, parece que sob este projecto se iniciou a criação de uma base útil para o desenvolvimento de recursos humanos, a qual pode servir de alicerce ao Projecto de Sectores Sociais que se seguirá.

21. Obras da Construção Civil. As actividades sob esta componente ficaram muito aquém das metas previstas na avaliação inicial. As etas físicas foram pela primeira vez reduzidas, quando, três anos após a assinatura do crédito, uma missão de supervisão determinou que os fundos do projecto só cobririam 11 dos 25 centros de saúde rurais a serem recuperados. Assim, no âmbito do projecto, foram elaborados planos arquitectónicos sumários para estes centros, mas, e em grande parte porque os locais de construção eram demasiado dispersos para atrair propostas de firmas de construção locais; na realidade, apenas dois centros foram reabilitados com os fundos do projecto. Vários outros foram renovados com fundos adquiridos de outros doadores, graças às diligências dos quadros do Banco. No entanto, houve outros centros que figuravam na list mas foram considerados irrecuperáveis.

G. Continuidade do Projecto

22. Em virtude da inexperiência do MINSAP e da novidade da abordagem ao sector como tal, este projecto colocou, à partida, forte ênfase na continuidade do mesmo. Um dos objectivos principais no âmbito de componentes tão diversas como desenvolvimento institucional, formação profissional, gestão dos medicamentos, supervisão nas zonas rurais e recuperação de custos, era desenvolver estruturas básicas apropriadas para continuar os trabalhos no futuro. Podemos dizer que se encontram lançados os alicerces para expandir e profissionalizar as acções iniciadas no âmbito do crédito.

23. Por exemplo: à data do encerramento do projecto, a assistência técnica permanente da OMS estava a ajudar o MINSAP a fortalecer ainda mais tanto a sua Unidade de Administração e Finanças como a do Planeamento. Um Projecto dos Sectores Sociais que virá a seguir enfatizará a capacidade de construção e expandirá substancialmente a formação em recursos humanos iniciada com este projecto. A equipa de gestão dos medicamentos do Ministério dispõe das capacidades essenciais para instituir uma política de medicamentos básica, e existe já um sistema de recuperação de custos em eventual implementacao em outras regiões do país.

24. Entre os factores que contribuirão para a continuidade do projecto contam-se o empenhamento governmental, a continuação da assistência técnica (sujeita a um controlo melhor, a transferência de conhecimentos para contrapartida nacional estabelicido dentro do projeto e usufruindo dos altos padrões de coordenação dos doadores estabelecidos neste projecto) e um empenhamento de todas as partes envolvidas em incrementar as acções a nível local (cientes de que as instituições nacionais registarão altos e baixos durante bastante tempo).

H. Desempenho do Banco

25. Pontos Fortes e Fracos Principais. Os quadros do Banco revelaram flexibilidade e criatividade constantes, o que ficou provado ser particularmente importante dado a inexperiência do Mutuário. Além disso, o Banco contactou outros doadores e Organizações não Governamentais

(OMS, CEE, FNUAP e outros) a fim de obter AT e fundos extra para actividades relacionados com o projecto, nomeadamente a reabilitação de centros de saúde e a aquisição e gestão de medicamentos essenciais. De facto, as diligências dos quadros do Banco para incrementar a coordenação dos doadores durante a execução deste projecto prepararam o terreno para uma cooperação mais chegada e permanente com estas organizações (principalmente entre o Banco, a OMS e a UNICEF) em trabalhos futuros no sector social na Guiné-Bissau.

26. Conclusões. Uma das conclusões a que se chegou e que já é bem conhecido dentro do Banco: quando as instituições nacionais são frágeis, os projectos devem ser simplificados e devem concentrar-se apenas num número restrito de objectivos atingíveis. O êxito das componentes de formação e supervisão nas zonas rurais sugere que, enquanto o Banco promove o desenvolvimento institucional pode simultaneamente ter impacto nos indicadores sociais particularmente num país como Guiné-Bissau, trabalhando mais a nível local (sempre que possível em conjunção com outros doadores e Governos já envolvidos).

27. Além disso, antes de autorizar os Mutuários a estabelecer Contas Especiais em instituições financeiras comerciais, a AID deveria providenciar no sentido de assegurar de antemão que as suas próprias condições e acordos sejam respeitadas, a fim de evitar-se a paralisação de projectos por instituições como o Banco de las Palmas.

I. O Desempenho do Mutuário

28. Pontos Fortes e Fracos Principais. No período de elaboração do projecto, o governo deu vários passos importantes: nomeou um Director do Projecto estrangeiro, criou uma Unidade de Gestão do Projecto em tempo oportuno e comprometeu-se a empreender várias mudanças organizativas e outras. Foram submetidos relatórios trimestrais e o Mutuário concordou com a revisão bancária e outras condições de procedimento.

29. Contudo, surgiram problemas graves durante a execução do projecto, devido a dificuldades e falta de quadros competentes, factos que não permitiram ao MINSAP preencher lugares chave de gestão por um período que se prolongou por mais de dois anos. A execução esteve também comprometida em virtude de problemas administrativos e das dificuldades financeiras do Governo que não pôde dispôr em tempo oportuno de fundos de contrapartida, situação cuja solução não depende inteiramente do MINSAP.

J. Conclusões

30. A experiência adquirida neste projecto, em que aproximadamente 30% compôs-se de assistência técnica, sugere várias directivas para o emprego de assistência técnica: desaconselha-se fortemente a assistência técnica estrangeira (residentes ou não); os consultores deviam ser contratados por períodos de seis a doze meses, e sempre com o direito a exame do desempenho dos mesmos, a transmissão dos conhecimentos e/ou os cursos de formação deviam constar nos Termos de Referência e os contratos para estudos especiais deviam conter uma cláusula estipulando que os consultores têm que apresentar os factos apurados, metodologia, etc. ao Mutuário, quer em seminários ou por outras vias. Além disso, se um estrangeiro for escolhido como director do projecto, ou qualquer outro posto chave, deve-se sempre selecionar uma contrapartida nacional. Capacidade nacional de estrutura e desenvolvimento de recursos humanos deveriam ser prioridades em um país como Guiné-Bissau e deveria refletir em esquemas de projetos.

31. Partindo do princípio que o apoio dos doadores vai continuar ou mesmo aumentar, é fundamental frisar que o Governo só poderá assegurar fundos de contrapartida para trabalhos futuros no campo da saúde (assim como noutros sectores sociais) se redistribuir as despesas públicas. É sabido que, actualmente, em comparação com outros países de baixo rendimento na África subsaariana, a Guiné-Bissau tem o rendimento per capita mais baixo, afecta a maior quota percentual do seu orçamento do Estado às Forças Armadas (28%), e encontra-se abaixo da média no que respeita à percentagem do Produto Nacional Bruto abribuído à saúde (1.0).

K. Relações Banco-Mutuário

32. As relações Banco-Mutuário durante a duração do projecto foram satisfatórias para efeitos do projecto. Estabeleceu-se um tom positivo logo no início, devido em parte ao fato de os quadros do Banco responsáveis pela elaboração do projecto falarem um português fluente. Sob a supervisão capaz do seguinte oficial do projecto, mantiveram-se relações de cooperação também durante a execução, mesmo quando o Banco teve de intervir perante disputas contratuais e um desvio de fundos do projecto (contas especiais), as quais foram congelados por um banco estrangeiro

L. Serviços de Consultoria

33. Os consultores individuais contratados pelo Banco foram capazes e eficientes. Quanto a consultoria contratada pelo MINSAP, produziu-se um estudo de planejamento familiar; um estudo de nutrição, o qual começou atrasado, foi finalmente finalizado e julgado muito proveitoso. MINSAP, com a assitência da WHO, decidiram revisar e simplificar o plano para reestruturação do projecto, preparado para o Ministério por uma firma de Consultoria.

M. Documentação e Dados do Projecto

34. O Relatório de Avaliação Inicial do Pessoal, os relatórios de supervisão e dos consultores e material adicional existente nos arquivos do projecto forneceram informações adequadas para a elaboração deste Relatório de Terminação do Projecto. Além disso, o Estudo de Estratégias para os Sectores Sociais (Volume I) publicado em Dezembro de 1991 proporcionou uma visão profunda e muito útil do enquadramento mais lato em que este projecto foi implementado.

REPUBLICA DA GUINE-BISSAU

POPULACAO, SAUDE E NUTRICAO
(CREDITO 1800-GUB)

RELATORIO DE TERMINACAO DO PROJECTO

PART II. ANALISE DO PROJECTO SOB A PERSPECTIVA DO MUTUARIO

1. É chegado o momento de proceder ao encerramento deste Projecto que ao longo de mais de quatro anos apoiou a política sanitária do país que se baseia nos cuidados primários de Saúde.

2. Cabe-nos, com este relatório, fazer um balanço em linhas gerais e apresentar as nossas apreciações dando assim cumprimento aos compromissos assumidos junto da AID com a assinatura do Acordo de Crédito RC 1800-GUB que financiou a concepção e execução do presente projecto.

3. A execução do Projecto População, Saúde e Nutricão enfrentou dificuldades das mais variadas ordem e natureza que, não obstante a sua longa duração, não logrou executar uma boa parte dos seus componentes, deixando objectivos por atingir.

4. A muito custo, conseguiu-se prosseguir algumas acções tais como o Inquérito Nutricional (1ª parte) que se realizou entre Dezembro de 1990 e Janeiro de 1991, tendo-se procedido igualmente à sua difusão através do seminário de divulgação dos resultados daquele estudo.

5. Quanto à definição da Política Alimentar e Nutricional do governo, julgamos lógica e tecnicamente coveniente aguardar pela realizaçáo da 2ª parte do estudo e, com as conclusões qua daí resultar, elaborar então o documento a submeter à aprovação governamental.

6. No que respeita aos fundos de contrapartida que o governo deveria assegurar no valor equivalente a USD200.000,00 (duzentos mil dólares americanos=, é verdade que não tem havido disponibilidade atempada dada a existência de um grande número de projectos doutras àreas de acção do governo que dependem igualmente do Fundo Nacional de Desenvolvimento e de graves insuficiências financeiras de que padece o país. Todavia, foi feito um grande esforço e julgamos que o governo cumpriu o compromisso que assumiu com a assinatura do Acordo de Crédito.

7. Houve custos adicionais nomeadamente com a execução do Inquérito Alimentar e Nutricional devido a realização de uma missão suplementar dos Consultores estrangeiros em Dezembro de 1990, dado que a missão de Junho de 1990 não havia sido convenientemente preparada pela Unidade de Gerência que não chegou a dar conhecimento à Directora Nacional do Estudo da sua realização.

8. Tendo en conta as múltiplas irregularidades que a execução do projecto indiciava e a falta de colaboração que existia entre a Unidade de Gerência e os restantes departamentos, entendeu-se por bem nomear um gestor nacional que coadjuvasse e sevundasse o Director Nacional do Projecto que, afinal, era um estrangeiro.

9. Com a contratação do gestor nacional com Consultor Assistente, o Director Nacional do Projecto resolveu desresponsabilizar-se das suas funções, passando a viajar sem qualquer aviso prévio.

10. Relativamente à política de recuperação de custos, a dificuldade maior surgiu com a tentativa de abarcar o mais vasto leque possível da população embora numa escala progressiva em harmonia com o nível de rendimento de cada um, facto que conduziu à suspensão da mesma em virtude do grande melindre e celeuma que suscitou junto da população que não está habituada a pagar os cuidados de saúde.

11. Julgamos que a concepção do projecto não foi feliz em alguns aspectos, nomeadamente no que respeita aos objectivos estruturais v. g. Reorganização do MINSAS e estudo sobre Planeamento Familiar.

12. O primeiro, a Reorganização do MINSAS, é um objectivo fundamenta e indispensável que, infelismente, não pode ser atingido a curto prazo. É verdade que se registraram algumas melhorias na organização do Ministério, mas confessamos ter grandes dúvidas se isso terá sido fundamentalmente influenciado pelas conclusões e recomendações da firma de consultoria envolvida, ou se determinado pelo estilo próprio da nova direcção.

13. De facto, as conclusões e recomendações existem, dispomos de alguns namuais que podem servir para um trabalho de fundo dessa natureza, mas a concepção do Projecto não teve em consideração a realidade concreta das nossas instituições e a situação dos nossos funcionários fortemente desmotivados em razão do nível dos salários que os tem obrigado a procurar outras ocupações paralelas, facto que não lhes permite consagrarem-se devidamente ao trabalho e muito menos à leitura e consulta dos extensos dossiers deixados pela consultoria.

14. O segundo. Planeamento Familiar, constitui igualmente um objectivo desejável e é inegável que o governo deve dispôr de uma política no domínio. Porém, énosso dever interrogarmo-nos sobre o alcance e sucesso de uma tal política. De facto, trata-se de um aspecto do mais íntimo da vida conjugal e pessoal de cada indivíduo profundamente condicionada pelos valores culturais e que, por isso mesmo, quaisquer medidas que sejam adoptadas sobre essa problemática, encerra um certo melindre e estão em princípio condenadas ao fracasso.

15. Julgamos que o caminho mais adequado é o da educação através de conselhos médicos caso a caso e através das escolas, aumentando o nível de escolaridade das nossas crianças. Aliás, conforme um especialista conclui num estudo sobre a questão,a mulher que nunca foi à escola é capaz de ter doze filhos; aquela que fez a quarta classe, não deve ultrapassar oito; a que concluiu o liceu deverá acabar pelos quatros; e se tiver concluído a universidade, dificilmente terá mais de dois.

16. É nossa opinião que a concepção do projecto falhou designadamente nestes dois componentes por não ter equacionado devidamente a questão de base que enforma a situação

concreta, conduzindo a um investimento considerável cujo sucesso, ab início, se apresentava bastante limitado.

17. A execução do projecto teve os seus problemas próprios porquanto, além das deficiências herdadas da concepção, esbarrou con dificuldades no terreno que não conseguiu ultrapassar, ou porque não obteve a colaboração dos demais funcionários que se empenhou com o zelo devido, revelando graves falhas, particularmente gritantes no que respeita à reabilitação dos Centros de Saúde, ao acompanhamento dado à consultoria, ou ainda à aquisição de bens de consumo duradouro e materiais de equipamento.

18. A gestão financeira do Banco Mundial, constituiu algumas dificuldades que, a bem de verdade, não são intransponíveis nem foram determinantes na parte em que o projecto não obteve sucesso. De qualquer maneira, julgamos possível a médio prazo evoluir para outras formas de gestão financeira combinada que permita à célula local de gestão uma maior liberdade de manobra em nome da boa prossecução dos objectivos do projecto, desde que dirigida por um gestor idóneo e capaz.

19. Temos para nós que nem tudo foi mau na concepção e execução do projecto e que este terá contribuído positivamente para melhorar a cobertura sanitária do país, conhecer melhor as estruturas existentes e perspectivar uma nova política de saúde, controle e rentabilização dos meios disponíveis e, apesar do insucesso da política de recuperação de custos, aprender com a experiência possível por forma a que, a médio prazo, possamos dispôr de um sistema eficaz de amortização dos custos dos cuidados de saúde que, até ao momento, são suportados integralment pelo Estado. Prosseguimos com a iniciativa do Bamako e julgamos que, a seu tempo, todo o país acabará por compreender a necessidade de cada utente contribuir para a amortização dos custos e melhoramento dos cuidados de saúde.

20. É certo que poderíamos atingir resultados mais satisfatórios se a gestão do projecto não tivesse sido tão pouco favorável mesmo no caso dos componentes mais viáveis. Porém, julgamos justo atrivuir a nota suficiente ao projecto que ora chega ao fim, graças aos fundos disponíveis e ao controle imposto pela nova direcção do ministério. Aliás, antes de 1990, a acção do projecto estava fundamentalmente virada para a compra e distribuição de bens de consumo e de utilização directa.

21. O povo da Guiné-Bissau padece de graves carências e insuficiências e, a nível da Saúde, os dados estatísticos, nomeadamente a taxa de natalidade e de mortalidade infantil e materna para além da prevalência da má nutrição em certas àrea do país e das doenças endémicas, de entre as quais cumpre destacar o paludismo, a diarréia e o SIDA, são eloquentes e obrigam a que o governo dispense um esforço suplementar para minimizar as desatrosas consequências que, igualmente, muito contribuem não só para agravar os encargos do Estado mas, mais ainda, para atrasar o processo de desenvolvimento do país.

22. Julgamos que este projecto foi um teste positivo que nos permitiu colher muitos ensinamentos que nos serão úteis.

23. Por tudo quanto foi atrás referido, estamos convictos que se aproveitou um ensinamento, qual seja, o de que qualquer projecto deve evitar prosseguir directamente objectivos estruturais sem a participação local. Pensamos que mesmo que não se verifiquem as dificuldades antes enumeradas, é preferível encontrar meios de estimular uma troca interna de experiência e privilegiar a actuação e consultoria dos técnicos nacionais que mesmo que

não estejam à altura de oferecer estudos tão elaborados como os que oferece a consultoria internacional, os resultados dos seus trabalhos, terão a vantagem de estar mais próximo da realidade do país, logo, de obter melhor impacto. Por outro lado, só uma aposta no trabalho desses técnicos poderá assegurar uma evolução real e sustentada capaz de dispensar o recurso contínuo à consultoria internacional.

24. Portanto, não é demais repetí-o, o projecto foi positivo. Os resultados obtidos cosntituem dados adquiridos que nos permitirão maximizar a rentabilidade de empreendimentos futuros.

25. Esperamos continuar a merecer o apoio da conumindade internacional, pois estamos decididos a dar o melhor de nós por forma a podermos renovar as nossas esperanças de entrar para o século XXI com um perfil sanitário mais satisfatório que nos permita suportar o desafio do desenvolvimento e atingir a saúde para todos no ano 2000.

Bissau, Junho de 1992.

A:Part2Por.JZ1

REPÚBLICA DA GUINÉ-BISSAU

PROJECTO DE POPULAÇÃO E NUTRIÇÃO
(Crédito 1800-GUB)

PART III. INFORMAÇÕES ESTATÍSTICAS

1. Outros Empréstimos e/ou Créditos Bancários Relacionados com o Projecto

Não se aplica.

2. Calendário do Projecto

Alíneas	Data Original	Nova Data	Data Real
Identificação I			01/86
Identificação II			04/86
Elaboração			07/86
Missão de Pré-avaliação			09/86
Missão de Avaliação Inicial			12/86
Negociações do Crédito			03/87
Aprovação Aprovação pelo Conselho de Administração			05/19/87
Assinatura do Crédito			05/22/87
Entrada em Vigor do Crédito	09/18/87	12/18/87	12/18/87[1]/
Data de Terminacao	12/31/90	06/30/91	11/15/91[2]/
Data de Encerramento	06/30/91	12/31/91	12/31/91[3]/

[1]/ A entrada em vigor do crédito foi adiada para permitir que o Governo submetesse um programa de acção e um plano financeiro para três anos, contendo os resultados de um estudo sobre custos de saúde e de recuperação de custos. Como era impossível satisfazer esta condição até Dezembro de 1987, o que, por conseguinte, causaria mais atrasos desnecessários à execução do projecto, e após a revisão do Acordo de Crédito de Desenvolvimento (nova Secção 3.10), recomendou-se que a dita condição passasse a cláusula a cumprir até 30 de Abril de 1988. Todavia, esta cláusula nunca foi totalmente cumprida.

[2]/ A data do encerramento do projecto foi prorrogada até 13 de Junho de 1991 para permitir que o Governo completasse acções-chaves referentes ao projecto.

[3]/ A data do encerramento do projecto foi prorrogada até 13 de Junho de 1991 para permitir que o Governo completasse acções-chaves referentes ao projecto.

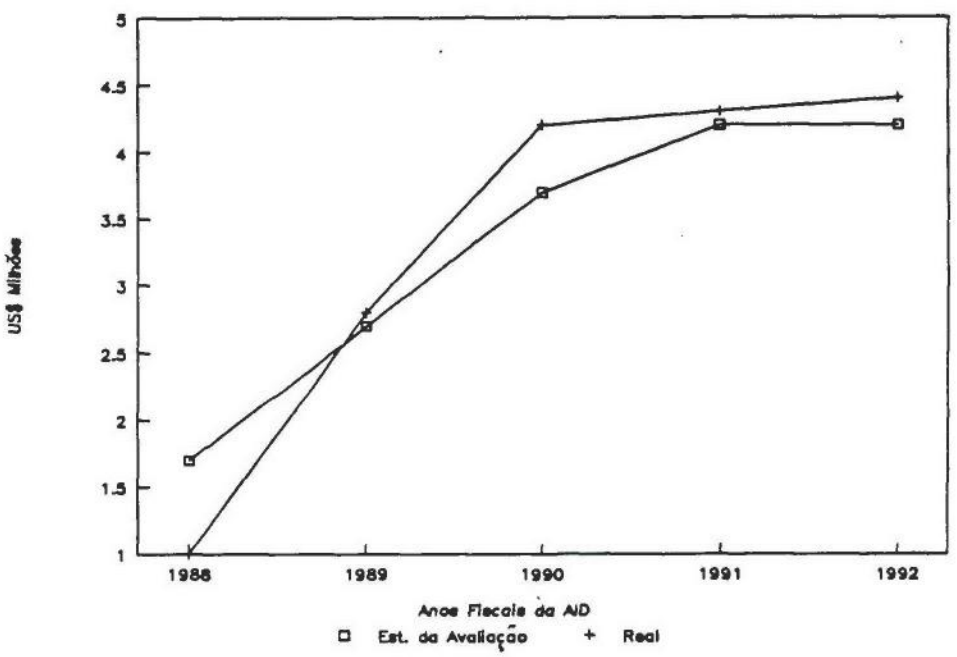
3. Desembolsos do Crédito

A. Desembolsos Acumulados Estimados e Reais

(US$ milhões)

Ano Fiscal	AF88	AF89	AF90	AF91	AF92
Estimativa da Avaliação Inicial	1,7	2,7	3,7	4,2[1]/	
Real	0,94	2,80	4,15	4,36	4,53[1]/
Real/percentagem da Estimativa	55,3%	103,7%	112,2%	103,8%	107,9%

B. Linha das Variações entre o Calendário de Estimado na Avaliação Inicial e o Calendário Real



[1]/ Em virtude da flutuação do dólar americano contra os DES, o projecto beneficiou de fundos adicionais equivalentes a cerca de US$300 000. Todos os fundos no âmbito do Crédito 1800-GUB já foram desembolsados ou encontram-se imobilizados. Este Crédito não sofreu cancelações.

Table C: Afectação dos Fundos do Crédito

Rubrica	Em DES				Em US$
	Afectação Inicial	Alterada 1/	Actuais Desembolsos 2/	Saldo	Saldo 3/
1. Obras de Construção Civil	350,000	98,700	70,590	28,110	37,452
2. Equipamentos, mobiliário, veículos e materiais	380,000	668,900	798,335	(129,435)	(172,453)
3. Serviços de Consultores e Bolsas de Estudo	400,000	1,124,700	1,124,188	512	682
4. Medicamentos e fornecimentos médicos	560,000	698,900	748,581	(49,681)	(66,193)
5. Custos de Funcionamento	340,000	55,900	56,054	(154)	(205)
6. Bens e Serviços relativos à implementação das actividades e programas derivados dos estudos de medidas a serem aplicadas	220,000	137,500	137,535	(35)	(46)
7. Reembolso do F.T.P.P.	850,000	460,500	466,708	(6,208)	(8,272)
8. Não-afectado	300,000	154,900	(1,992)	152,908	203,727
TOTAL	3,400,000	3,400,000	3,400,000	0	0

1/ A nova afectação dos fundos do Crédito foi feita por telex da AID de 1 de Fevereiro de 1991.

2/ Actuais desembolsos e último.

3/ Ao câmbio de US$1.33 = 1 SDR.

07-May-92

4. Execucao do Projecto

Componentes do Projecto	Unidade de Medida	Estimativas do RAP	Reais	Comentarios
Parte A. Desenvolvimento Institucional				
1. Organizacao e Gestao:				
(a) Implementacao do plano de do MINSAP	Unidade	1	0.5	O trabalho executado por uma firma de consultores foi inadequado; foi proposto e implementado um plano muito mais simples.
(b) Concepcao e Implementacao de um Sistema Informatico de Gestao	Unidade	1	0.5	Um SIG foi implementado so para as medidas de recuperacao de custos; nao foi totalmente instituido.
(c) Implementacao de um plano para melhorar a gestao do sistema de medicamentos.	Unidade	1	1	Ja foi implementado um Sistema de Gestao de Medicamentos e a Unidade Central de Medicamentos esta a funcionar eficientemente.
(d) Conceber, experimentar e imple-mentar um sistema modelo de supervisao dos servicos de saude nas zonas rurais, na regiao de Bafata e na area de Sonaco, na regiao de Gabu.	Unidade	1	1	A componente de supervisao nas zonas rurais foi concre-tizada com exito em Regiao do Bafata e Sonaco (Regiao do Gabu) apesar de alguns problemas, tais como transportes deficientes.
2. Planeamento e Delineacao de Politicas:				
(a) Estudo sobre o sector hospitalar, incluindo necessidades de renova-cao.	Unidade	1	0	O estudo nao fez parte do Projecto de PSN; enquadrou-se no Estudo de Estrategias para os Sectores Sociais.
(b) Estudo sobre Nutricao	Unidade	1	0	O estudo foi aprovado primeiro pelo Comite Tecnico, e depois pelo Ministro do MINSAP em Agosto de 1991. Foi conclui do no final de 1991 um seminario para discutir as conclusoes do estudo.
(c) Estudo sobre Planeamento Familiar	Unidade	1	1	O estudo foi bem recebido pelo Comite Tecnico e o MINSAP. Realizou-se ja um seminario sobre o estudo.
(d) Estudo sobre a procura dos servicos de saude a nivel dos centros de saude.	Unidade	1	0 1/	Decidiu-se que estes dois estudos deviam ficar suspensos ate se realizarem outros mais urgentes.
(e) Estudo sobre as necessidades	Unidade	1	0 1/	
(f) Melhoria de dados basicos sobre PSN, abrangendo:				
(i) analise do censo de 1979;	Unidade	1	1	
(ii) implementacao de um inque-rito por amostra nacional;	Unidade	1	1	OISP esta concluido e exemplares dos dados ja foram distribuidos. Foi realizado a um seminario em Maio de 1992 para discutir os resultados do ISP, o qual sera custeado com o FFPP.

1/ Dado estar muito alem da capacidade de UGP empreender um grande numero de accoes a executar no ambito deste projecto, os quadros envolvidos no mesmo recomendaram que estes dois estudos fossem suspensos ate se darem por concluidas algumas das actividades mais prementes.

Componentes do Projecto	Unidade de Medida	Estimativas do RAP	Reais	Comentarios
(iii) Criacao de um banco de dados;	Unidade	1	0.1	Criou-se um banco de dados rudimentar.
(iv) Formacao dos quadros da DGE e do MINSAP em estatistica.	Unidade	1	1	Realizaram-se cursos de formacao em estatistica, contabilidade e computadores. No entanto, recomenda-se prover mais cursos de formacao nestas areas.
Part B. Solidificar os Servicos de Saude e de Planeamento Familiar.				
1. Apoio aos Servicos de Saude Rurais.				
(a) Aperfeicoamento das 8 Direccoes Regionais e implementacao de tecnicas de gestao e supervisao nas regioes, apos apuramento dos resultados do sistema modelo referido na parte A. 1.(d) acima.	Unidade	8	2	As Direccoes Regionais serao aperfeicoadas num projecto futuro. O projecto de PSN concentrou-se nas regioes de Bafata e Gabu.
(b) Reabilitacao de cerca de 25 centros de saude.	Unidade	25	7	Foram reabilitados dois centros de saude, no ambito deste projecto; 4 centros de saude pelo CECI (Canada); um centro de saude no ambito de um projecto do PASI; dos 18 restantes apenas 5 foram colocados na lista dos irrecuperaveis.
(c) Equipar, mobilar e fornecer insumos para cuidados de saude a cerca de 122 centros de saude.	Unidade	122	109	A acrescentar aos 109 centros de saude, tres centros de informacao, 5 postos hospitalares, 8 hospitais regionais e dois hospitais nacionais receberam equipamento e materiais.
2. Desenvolvimento de Mao-de-Obra da Saude:				
Instituicao de um programa de formacao no servico para os trabalhadores do sector da saude materno-infantil, epidemiologia, planeamento familiar, nutricao, prescricao/utilizacao de medicamentos, nos cuidados a ter com a nutricao e a saude e outras areas de cuidados da saude.	Unidade	500	500	Estima-se que 6 500 pessoas tiraram proveito, directa ou indirecta-mente da formacao profissional provida no ambito do projecto.

5. Custo e Financiamento do Projecto

Quadro A. Custos do Projecto
(US$'000)

Categorias	Estimativa da Avaliacao Inicial			Reais 1/		
	Custos Locais	Custos em Divisas	Total	Custos Locais	Custos em Divisas	Total
1. Obras de construcao	24.4	395.6	420.0	35.3	58.8	94.1
2. Equipamentos, mobiliario, veiculos e materiais.	6.9	478.9	485.8	66.6	1,003.2	1,069.8
3. Servicos de consultores e bolsas de estudo.	52.5	613.4	665.9	162.0	1,335.8	1,497.8
4. Medicamentos e fornecimentos medicos.	0.0	625.2	625.2	69.8	927.6	997.4
5. Custos de funcionamento	79.6	385.7	465.3	69.0	61.2	130.2
6. Bens e servicos de acordo com a Parte A.2 (b) do Projecto.	14.7	382.5	397.2	0.0	183.2	183.2
7. Reembolsos do FFPP	46.0	922.0	968.0	0.0	621.8	621.8
8. Nao afectado	62.0	322.2	384.2	0.0	(2.7)	(2.7)
Total	**286.1**	**4,125.5**	**4,411.6**	**402.7**	**4,189.0**	**4,591.7**

1/ A contribuicao do Governo encontra-se reflectida nos dados do Relatorio de Auditoria correspondente ao periodo que decorre ate 31 de Dezembro de 1991.

Quadro B: Financiamento do Projecto

(US$'000)

Fonte de Financiamento/ Rubrica das Despesas	Planeado (Acordo de Credito)	Alterado 2/	% do Total	Final 3/	% do Total	Saldo
I. AID:						
1. Obras de construcao civil	470,000	131,503	2.8%	94,051	2.0%	37,452
2. Equipamento, mobiliario, veiculos e materiais.	560,000	891,209	18.8%	1,063,662	23.2%	(172,453)
3. Servicos de Consultores e bolsas de Estudo.	640,000	1,498,494	31.6%	1,497,812	32.6%	682
4. Medicamentos e Fornecimentos medicos.	740,000	931,179	19.6%	997,372	21.7%	(66,193)
5. Custos de Funcionamento	430,000	74,478	1.6%	74,683	1.6%	(205)
6. Bens e Servicos de Acordo com a Parte A.2 (b) do Projecto.	400,000	183,199	3.9%	183,245	4.0%	(46)
7. Reembolsos do FFPP	970,000	613,547	12.9%	621,819	13.5%	(8,272)
8. Nao afectado	0	206,381	4.4%	(2,654)	-0.1%	203,727
TOTAL AID	4,210,000	4,529,990	95.6%	4,529,989	98.7%	0
II. GOVERNO DA GUINE-BISSAU						
1. Obras de Construcao Civil	20,000	20,000	0.4%	0	0.0%	
2. Equipamento, mobiliario, veiculos e materiais	10,000	10,000	0.2%	6,137	0.1%	
3. Servicos de Consultores e Bolsas de Estudo	70,000	70,000	1.5%	397	0.0%	
5. Custos de Funcionamento	110,000	110,000	2.3%	55,364	1.2%	
TOTAL DO GOVERNO DA GUINE-BISSAU	210,000	210,000	4.4%	61,898	1.3%	
TOTALIDADE DE FINANCIAMENTO DO PROJECTO	4,420,000	4,739,990	100.0%	4,591,887	100.0%	

1/ A afectacao de fundos a cada rubrica de despesas abrange o preco e contingencias fisicas.

2/ A nova afectacao dos fundos do Credito foi feita por telex da AID a 1 de Fevereiro de 1991. Em virtude da flutuacao do dolar US contra os DES, o projecto beneficiou de adicionais fundos equivalentes a cerca de US$300 000.

3/ No que respeita a AID: a posicao actual e final dos desembolsos;
Quanto ao Governo: basea-se no Relatorio de Auditoria referente ao periodo que decorre ate fins de Dezembro de 1991.

(Cambio: US$1.33 = SDR 1).

6. Resultados do Projecto

Alínea	Objectivo Definido na Avaliação Inicial	Situação Actual	Impacto da Acção
A. Estudos			
1. Estudo sobre custos de saúde e recuperação de custos; um estudo de um plano financeiro para três anos.	Abordar a falta de planeamento financeiro e melhorar o financiamento dos custos ordinários não-salariais.	Os estudos foram financiados, em parte, com o FFPP e concluídos.	Tornou as entidades oficiais cientes de muitos problemas no seio do MINSAP; as medidas de recuperação de custos já foram implementadas na Região to Gabu, e deverão alastrar-se a outras regiões.
2. Estudo sobre o sector hospitalar, incluindo necessidades de renovação	O estudo incidiria sobre taxas de utilização, qualidade da assistência, necessidades de mão-de-obra e de investimento, estado das instalações e necessidades de renovação, disponibilidade de habitação para os trabalhadores da Saúde e custos gerais do sector.	O estudo não se realizou como parte do Projecto de PSN; enquadrou-se no Estudo de Estratégias para os Sectores Sociais do Banco.	Devera ajudar o MINSAP no planeamento e afectação de recursos.
3. Estudo de Nutrição	Determinar melhor as realidades quanto a nutrição do país, abrangendo: selecção de alimentos, hábitos culinários e causas e efeitos da subnutrição.	O estudo foi aprovado primeiro pela Comissão Técnica e depois pelo Ministro do MINSAP em Agosto de 1991. Em Dezembro de 1991, realizou-se um seminário dirigido aos trabalhadores da saúde, para discutir as conclusões do estudo.	Os trabalhadores da saúde adquiriram conhecimentos e experiência básicos sobre nutrição que aplicarão nas zonas rurais; permitindo, assim, o acesso aos serviços de saúde à maioria da população.
4. Estudo sobre Planeamento Familiar	Elaborar, experimentar e implementar um guia simples para classificar as mulheres por níveis de riscos reprodutivos ou obstétricos e encaminhá-las para os servicos competentes.	O estudo foi bem recebido pela Comissão Técnica e pelo MINSAP. Em Janeiro de 1992 realizou-se um seminário com uma participação maioritária de trabalhadores da saúde.	Os trabalhadores da saúde adquiriram conhecimentos e experiência básicos relativos ao planeamento familiar que serão aplicadas nas zonas rurais, permitindo, assim, o acesso à saúde a uma maior parte da população.
5. Estudo sobre a procura dos serviços de saúde a nível dos Centros de Saude	A implementar pelo Instituto Nacional de Estudos e Pesquisas (INEP). Examinar as percepções da população acerca dos serviços dos centros de saúde, os serviços mais procurados, e os níveis de apoio popular aos centros de saúde.	O estudo em si não se concretizou; no entanto, os resultados do Inquérito Demográfico da Saúde (IDS) forneceram as informacões neste campo. (Ver B-2 abaixo)	
6. Estudo das necessidades energéticas do Sector da Saúde e Fontes Alternativas de Energia	Avaliar as necessidades energéticas do sector hospitalar, dos centros de saúde e residências dos trabalhadores da saúde, e propor fontes energéticas alternativas.	A ordenação dos estudos a realizar por prioridades revelou que estes deviam ficar suspensos a fim de se encontrarem os esforços e recursos noutros tipos de estudos (planeamento familiar, nutrição, etc.), seleccionados por serem urgentes.	
7. Estudo para determinar as carências de transporte das ilhas mais distantes	Não especificado	Eliminado	Falta de fundos; não prioritário
8. Estudo sobre as Necessidades de Habitação de Baixo Custo para os Trabalhadores da Saúde colocados em Instalações Rurais	Não especificado	Eliminado no âmbito do Projecto	Fará parte do projecto que se segue.

Alínea	Objectivo Definido na Avaliação Inicial	Situação Actual	Impacto da Acção
B. Compilação e Análise de Dados:			
1. Análise do Censo de 1979;	Análise e publicação dos resultados	Concretizada	Incorporado nos dados do IDS
2. Implementação de um Inquérito Nacional por amostra sobre PSN (ou EDS);	A implementação iniciou-se no âmbito do FFPP.	O ISD está concluído e exemplares dos dados foram distribuídos.	Está programado um seminário para Abril de 1992 para discutir os resultados do ISD, custeado com os fundos do FFPP.
3. Criação de um Banco de Dados;	Proporcionar um estágio de três meses no exterior a um técnico de dados; assistência técnica de um perito de informática em bancos de dados.	Completou-se a criação de um Banco de dados rudimentar.	
4. Formação dos Quadros da DGE e do MINSAP em estatísticas;	Obter a assistência técnica de um estatístico de saúde pública; conceder uma bolsa de três anos em estatísticas de saúde.	Realizaram-se cursos de formação em estatística, contabilidade e computadores. Contudo, recomenda-se que se proporcionem mais cursos de formação nestas áreas.	Aperfeiçoamento das qualificações dos trabalhadores; contudo, é necessário fazer mais.

7. Cumprimento das Clausulas

Seccao	Cláusula	Situação Actual
2.02 (b)	O Mutuário abrirá e manterá uma conta especial em dólares num banco comercial em termos e condições satisfatórios para a AID. Os depósitos na Conta Especial ou pagamentos da mesma serão efectuados de acordo com as disposições do Anexo 4 do Acordo de Crédito de Desenvolvimento (ACD).	Totalmente cumprida. A conta Especial foi recuperada na sua totalidade. O MINSAP foi recentemente informado de que deverá instruir o Citibank, Senegal para encerrar a conta.
3.03	Até 30 de Outubro de cada ano da duração do projecto, o Mutuário examinará em por-menor e conjuntamente com a AID, a actuação do MINSAP nos seguintes pontos: (a) o programa de acção para três anos e o plano financeiro; (b) orçamento ordinário e de desenvolvimento para o ano fiscal seguinte; (c) estrutura organizativa; (d) procedimentos de supervisão a nível rural; (e) programas de formação no serviço; e (f) os resultados de estudos especiais sobre políticas a seguir e a possibilidade de um novo programa.	Totalmente cumprida, excepto a alínea (a) que foi "em princípio" cumprida mas que na realidade não foi.
3.04	O Mutuário tomará as medidas necessárias para, até 31 de Março de 1988, decretar e publicar a sua política nacional de medicamentos.	Cumprida. Publicação de um Formulário Nacional de Medicamentos em 1991. Foram implementadas e aper-feiçoadas medidas de recuperação de custos e uma política de medicamentos. Curso de formação em computadores para os quadros da gestão de medicamentos em Outono de 1991, visando uma implementação adequada das medidas.
3.05	O Mutuário fará todas as diligências necessá-rias para conceder ao MINSAP a dispensa legal estabelecida pelo Decreto No.51/85 de 4 de Dezembro de 1985, segundo a qual o Mutuário autoriza a retenção de 100% das comissões cobradas pelo MINSAP, em conformidade com as medidas de recuperação de custos de saúde implementadas.	Acções experimentais introduzindo medidas de recuperação de custos e a iniciativa de Bamako foram concretizadas a 1 de Abril de 1990 na região de Gabú; estas medidas deverão alastrar-se a outras regiões durante o próximo ano.

Secção	Cláusula	Situação Actual
3.06	O Mutuário estabelecerá, até 30 de Novembro de 1987, uma conta no Banco Nacional da Guiné-Bissau (BNG) (Conta do MINSAP) em termos e condições satisfatórios para a AID. Todos os proventos acumulados das comissões cobradas em conformidade com a Secção 3.05 do ACD serão depositados na Conta do MINSAP.	Totalmente cumprida
3.07	(a) até ao dia 1 de Janeiro de 1989 deverá completar e fornecer a AID, para fins de análise e comentários, recomendações emanadas dos estudos relativos a nutrição, realizados pelo Mutuário, de acordo com a Parte A.2 (a)(ii) do Projecto;	Totalmente cumprida. Realizou-se um seminário nacional em Novembro de 1991 para discutir e divulgar os resultados do estudo.
	(b) até 1 de Janeiro de 1989, delinear uma política nacional de nutrição e um programa de acção;	Não cumprida. Espera-se que este será o resultado final do estudo e que um seminário a nível nacional será organizado em fins de 1991.
	(c) imediatamente a seguir, trocar pontos de vista com a AID e chegar a acordo com a mesma acerca da implementação da dita política e programa de acção.	Não cumprida
3.10	O Mutuário fornecerá a AID, até 30 de Abril de 1988, o programa de acção e o plano financeiro do MINSAP para o período de 1988-1990, incorporando os resultados do estudo sobre custos de saúde e recuperação de custos, levado a cabo pelo Mutuário em termos e condições satisfatórias para a AID.	O Mutuário tem feito progressos na delineação de um plano financeiro rotativo. Membros do Gabinete do Planeamento do MINSAP e um técnico da OMS estão a elaborar um plano financeiro para o Ministério, o qual servirá de documento de trabalho e de instrumento de gestão e planeamento financeiro.
4.01	(a) O Mutuário manterá ou proverá para que se mantenham registos e contas que reflictam os recursos e despesas relativas ao Projecto dos departamentos ou agências do Mutuário responsáveis pela execução do Projecto ou parte do mesmo, utilizando para o efeito, operações e métodos contabilísticos sãos.	Totalmente cumprida

Secção	Cláusula	Situação Actual
4.01(cont.)	(b) O Mutuário será responsável por: (i) prover a auditoria dos registos e contas de cada ano fiscal referidos no parág. (a) desta Secção, incluindo aqueles relativos à Conta Especial; a auditoria será feita por auditores independentes, que a AID considere aceitáveis e de acordo com princípios de auditoria apropriados e consistentemente aplicados; e (ii) fornecer a AID, assim que estiver disponível, mas em qualquer caso até seis meses após ao final do ano em questão, uma cópia autenticada do relatório da auditoria feito pelos ditos auditores, o qual será tão extenso e pormenorizado quanto a AID periódica e razoavelmente solicitar.	Mesmo que acime
	(c) Para todas as despesas relativas às quais foram efectuados saques da Conta Especial na base de DDDs, o Mutuário será responsável por: (i) manter ou prover para que se mantenham, de acordo com o Parág. (a) desta Secção, registos e contas dessas despesas; (ii) reter, pelo menos até um ano após a conclusão da auditoria correspondente ao ano fiscal em que foi efectuado o último saque da Conta Especial, todos os registos (contratos, encomendas, facturas, contas, recibos e outros documentos) comprovativos de tais despesas; (iii) permitir que representantes da AID examinem tais registos; e (iv) assegurar a inclusão de tais registos e contas da auditoria anual referida no parág. (b) desta Secção, e que o relatório da dita auditoria contenha um parecer em separado dos auditores àcerca da fiabilidade das DDDs submitidas durante o ano fiscal em causa e dos procedimentos e controlos internos envolvidos na preparação das mesmas, como provas dos saques correspondentes.	Mesmo que acima

8. Utilização dos Recursos do Banco

A. Recursos Humanos Utilizados

(Semanas de Trabalho)

Fase do Projecto	Anos Fiscais							Total
	AF86	AF87	AF88	AF89	AF90	AF91	AF92	
Preparação/Prè-avaliação	11.8	33.0						44.8
Avaliação		42.1						42.1
Negociações		3.3						3.3
Supervisões		1.2	21.6	8.9	17.5	11.6	9.9	70.7
Terminação							8.0	8.0
TOTAL	11.8	79.6	21.6	8.9	17.5	11.6	17.9	168.9

B. Dados das Missões

Fase do Projecto	Mês/ Ano	No. de Pessoas	Dias no Terreno	Especializações Representadas 1/	Situação Actual no Desempenho por Acção 2/				
					O	D	C	M	F
Identificação I	01/86	3	15	EP, CONS: E, M					
Identificação II	04/86	3	8	EP, CONS: E, M					
Preparação	07/86	3	12	EP, CONS: E, A					
Pre-Avaliação	09/86	2	8	E, CONS: E					
Avaliação	12/86	6	12	EP, E, AO, CONS: E, E, TF					
Pós-Avaliação	01/87	1	6	CONS: E					
Supervisão 1	10/87	2	5	EP, A	Não classificada				
Supervisão 2	03/88	1	10	CONS: E	Não classificada				
Supervisão 3	06/88	1	10	EP	2	1	n.a.	2	2
Supervisão 4	10/88	1	5	EP	Não classificada				
Supervisão 5	06/89	3	10	EP, CONS: E, M	2	1	2	2	3
Supervisão 6	10/89	1	10	EP	2	2	2	2	3
Supervisão 7	03/90	3	16	EP, CONS: ESP, M	2	2	2	3	3
Supervisão 8	07/90	1	7	EP	Não classificada				
Supervisão 9	03/91	1	13	EP	2	2	2	3	2
Supervisão 10	10/91	2	5	EP, AP	2	2	2	3	2
Terminação	01/92	2	8	EP, AP	Não classificada				

1/ A = Arquitecto; E = Economista; AO = Analista de Operações; M = Médico;
ESP = Especialista em Saúde Pública; EP = Encarregado do Projecto;
TF = Técnico Farmacêutico; AP = Analista de Pesquisas

2/ O = Situação Global; D = Objectivos do Desenvolvimento do Projecto;
C = Cumprimento das Cláusulas Legais; M = Desempenho da Gestão do Projecto;
F = Disponibilidade de Fundos.

07-May-92

Anexo 1

REPÚBLICA DA GUINÉ-BISSAU

Relatório de Terminação do Projecto

Projecto de População, Saúde e Nutrição

Participantes da Missão de Terminação do Projecto[1]/

Missões de Outubro de 1991 e de Janeiro de 1992

Banco Mundial

Sra. Carol Hoppy, Encarregada do Projecto, AF4PH
Sra. Johanne Angers, Analista de Pesquisas, AF4PH

Ministério da Saúde e dos Assuntos Sociais

H.H. Henriqueta Godinho Gomes, Ministro da Saúde e dos Assuntos Sociais
Dr. Silvestre Alves, Director-adjunto do Projecto de PSN

Missão de Outubro de 1991

Ministério da Saúde e dos Assuntos Sociais

Dr. Celestino Costa, ex-secretário de Estado da Saúde
Sr. Augusto Paulo, Chefe do Gabinete do Planeamento e da Cooperação Internacional
Sr. Malam Dram, Gabinete do Planeamento e Cooperação Internacional
Sr. António Paulo Gomes, Gabinete do Planeamento e da Cooperação Internacional
Sr. Estêvão Malam da Costa, Farmacêutico, Depósito Nacional de Medicamentos
Dr. Paulo José Mendes, Director-Geral, Recursos Humanos
Enfermeira Maria Augusta Biai, Directora, Escola Técnica de Enfermagem
Dr. António, Director no Ministério da Saúde Pública
Prof. Deant Kaymah, Director do Projecto de PSN

Organização Mundial da Saúde (OMS)

Dr. Erling Larsson, assessor técnico da OMS, Gestão de Medicamentos

---

[1]/ Realizou-se uma missão de supervisão em Outubro de 1991, no decorrer da qual foram discutidas as actividades do Projecto com as principais entidades oficiais.

Anexo 2
Página 1 de 2

REPÚBLICA DA GUINÉ-BISSAU

Relatório de Terminação do Projecto

Projecto de População, Saúde e Nutrição

Relação de Relatórios Trimestrais submitidos sobre o Progresso do Projecto

1.	24 de Maio de 1988	Relatório No. 1 do Progresso do projecto PSN, para o período findo em Maio de 1988.
2.	Outubro de 1988	Relatório No. 2 do Progresso do projecto PSN, para o período a findo em Setembro de 1988.
3.	Dezembro de 1988	Relatório Trimestral No. 3 do Progresso do projecto PSN, para o período findo em Dezembro de 1988.
4.	10 de Março de 1989	Relatório Trimestral No. 4 do Progresso do projecto PSN, para o período findo em Março de 1989.
5.	8 de Julho de 1989	Relatório Trimestral No. 5 do Progresso do projecto PSN, para o período findo em Junho de 1989.
6.	12 de Outubro de 1989	Relatório Trimestral No. 6 do Progresso do projecto PSN, para o período findo em Setembro de 1989.
7.	4 de Dezembro de 1989	Relatório Trimestral No. 7 do Progresso do projecto PSN, para o período findo em Dezembro de 1989.
8.	6 de Março de 1990	Relatório Trimestral No. 8 do Progresso do projecto PSN, para o período findo em Março de 1990.
9.	29 de Junho de 1990	Relatório Trimestral No. 9 do Progresso do projecto PSN, para o período findo em Junho de 1990.
10.	15 de Dezembro de 1990	Relatório Trimestral No. 10 do Progresso do projecto PSN, para o período findo em Dezembro de 1990.

11.	15 de Março de 1991	Relatório Trimestral No. 11 do Progresso do projecto PSN, para o período findo em Março de 1991.
12.	7 de Julho de 1991	Relatório Trimestral No. 12 do Progresso do projecto PSN, para o período findo em Junho de 1991.
13.	5 de Outubro de 1991	Relatório Trimestral No. 13 do Progresso do projecto PSN, para o período findo em Setembro de 1991.
14.	28 de Dezembro de 1991	Relatório Trimestral No. 14 do Progresso do projecto PSN, para o período findo em Dezembro de 1991.

THE WORLD BANK/IFC/MIGA

OFFICE MEMORANDUM

DATE: January 4, 1994

TO: Mr. Yves I. Tençalla, Resident Representative, Guinea-Bissau

FROM: Graham Donaldson, Chief, OEDD1

EXTENSION: 31730

SUBJECT: Re: GUINEA-BISSAU: Population, Health and Nutrition Project (Cr. 1800-BU)
Project Completion Report

Kindly distribute the enclosed final Project Completion Report and cover letters to the officials concerned (English and Portuguese). A copy is also enclosed for your records.

Enclosures

The World Bank
INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT
INTERNATIONAL DEVELOPMENT ASSOCIATION

1818 H Street, N.W.
Washington, D.C. 20433
U.S.A.

(202) 477-1234
Cable Address: INTBAFRAD
Cable Address: INDEVAS

January 4, 1994

Dear :

Re: GUINEA-BISSAU: Population, Health and Nutrition Project (Cr. 1800-BU)
Project Completion Report

The final version of the report has now been distributed to the Bank's Board of Executive Directors and it is my pleasure to send you a copy (English and Portuguese versions) for your information.

Yours sincerely,

Graham Donaldson, Chief
Agriculture and Human Development Division
Operations Evaluation Department

Attachment

R.Ridker/pb

The World Bank
INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT
INTERNATIONAL DEVELOPMENT ASSOCIATION

1818 H Street, N.W.
Washington, D.C. 20433
U.S.A.

(202) 477-1234
Cable Address: INTBAFRAD
Cable Address: INDEVAS

January 4, 1994

Ms. Ilda Santos
Director
Social Sector Project
Guinea-Bissau

Dear Ms. Santos:

Re: GUINEA-BISSAU: Population, Health and Nutrition Project (Cr. 1800-BU)
Project Completion Report

The final version of the report has now been distributed to the Bank's Board of Executive Directors and it is my pleasure to send you a copy (English and Portuguese versions) for your information.

Yours sincerely,

Graham Donaldson, Chief
Agriculture and Human Development Division
Operations Evaluation Department

Attachment

The World Bank
INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT
INTERNATIONAL DEVELOPMENT ASSOCIATION

1818 H Street, N.W.
Washington, D.C. 20433
U.S.A.

(202) 477-1234
Cable Address: INTBAFRAD
Cable Address: INDEVAS

January 4, 1994

Dr. Bernardino Cardoso
Minister of Foreign Affairs and Corporation
Ministry of Foreign Affairs and Corporation
Guinea-Bissau

Dear Mr. Minister:

Re: GUINEA-BISSAU: Population, Health and Nutrition Project (Cr. 1800-BU)
Project Completion Report

The final version of the report has now been distributed to the Bank's Board of Executive Directors and it is my pleasure to send you a copy (English and Portuguese versions) for your information.

Yours sincerely,

w. Graham Donaldson, Chief
Agriculture and Human Development Division
Operations Evaluation Department

Attachment

The World Bank
INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT
INTERNATIONAL DEVELOPMENT ASSOCIATION

1818 H Street, N.W.
Washington, D.C. 20433
U.S.A.

(202) 477-1234
Cable Address: INTBAFRAD
Cable Address: INDEVAS

January 4, 1994

Dra. Henriqueta Godinho Gomes
Minister of Health
Ministry of Health
Guinea-Bissau

Dear Madam Minister:

Re: GUINEA-BISSAU: Population, Health and Nutrition Project (Cr. 1800-BU)
Project Completion Report

The final version of the report has now been distributed to the Bank's Board of Executive Directors and it is my pleasure to send you a copy (English and Portuguese versions) for your information.

Yours sincerely,

Graham Donaldson, Chief
Agriculture and Human Development Division
Operations Evaluation Department

Attachment

The World Bank
INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT
INTERNATIONAL DEVELOPMENT ASSOCIATION

1818 H Street, N.W.
Washington, D.C. 20433
U.S.A.

(202) 477-1234
Cable Address: INTBAFRAD
Cable Address: INDEVAS

January 4, 1994

Eng. Nelson Dias
Secretary of State of Planning
Ministry of Planning
Guinea-Bissau

Dear Mr. Secretary:

Re: GUINEA-BISSAU: Population, Health and Nutrition Project (Cr. 1800-BU)
Project Completion Report

The final version of the report has now been distributed to the Bank's Board of Executive Directors and it is my pleasure to send you a copy (English and Portuguese versions) for your information.

Yours sincerely,

Graham Donaldson, Chief
Agriculture and Human Development Division
Operations Evaluation Department

Attachment

Re: GUINEA-BISSAU: Population, Health and Nutrition Project (Cr. 1800-BU)
Project Completion Report

Eng. Nelson Dias
Secretary of State of Planning
Ministry of Planning
Guinea-Bissau

Dra. Henriqueta Godinho Gomes
Minister of Health
Ministry of Health
Guinea-Bissau

Dr. Bernardino Cardoso
Minister of Foreign Affairs and Corporation
Ministry of Foreign Affairs and Corporation
Guinea-Bissau

Ms. Ilda Santos
Director
Social Sector Project
Guinea-Bissau

THE WORLD BANK
Washington, D.C. 20433
U.S.A.

Office of Director-General
Operations Evaluation

Report No. 11759

RELATÓRIO DE TERMINAÇÃO DO PROJECTO

REPÚBLICA DA GUINÉ-BISSAU

PROJECTO DE POPULAÇÃO, SAÚDE E NUTRIÇÃO

(CRÉDITO 1800-GUB)

31 de Março de 1993

Divisão de Operações
População e Recursos Humanos
Departamento Africa Ocidental

EQUIVALÊNCIAS MONETÁRIAS

Unidade Monetária = Peso da Guiné (PG)

US$ 1 = 700 PG
(1987/1988)

US$ 1 = 5 400 PG
(1992)

ANO FISCAL

1 de Janeiro - 31 de Dezembro

ABREVIATURAS E SIGLAS

ISD	Inquérito de Saúde Demográfico
CE	Comunidade Europeia
SMI	Saúde Materno-Infantil
MINSAP	Ministério da Saúde Pública
MINSAS	Ministério da Saúde e Assuntos Sociais
ONG	Organização Não-Governamental
CPS	Cuidados Primários de Saúde
PSN	População, Saúde e Nutrição
DES	Direitos Especiais de Saque
FNUAP	Fundo das Nações Unidas Para Actividades Populacionais
UNICEF	Fundo das Nações Unidas para a Infância
OMS	Organização Mundial da Saúde

REPÚBLICA DA GUINÉ-BISSAU

PROJECTO DE POPULAÇÃO, SAÚDE E NUTRIÇAO

CRÉDITO 1800 - GUB

RELATÓRIO DE TERMINAÇÃO DO PROJECTO

ÍNDICE

REPÚBLICA DA GUINÉ-BISSAU

PROJECTO DE POPULAÇÃO, SAÚDE E NUTRIÇAO

CRÉDITO 1800 - GUB

RELATÓRIO DE TERMINAÇÃO DO PROJECTO

PREFÁCIO

Isto constitui o Relatório de Terminação do Projecto (RTP), referente ao primeiro projecto de População, Saúde e Nutrição na Guiné-Bissau, para o qual foi aprovado o Crédito 1800-GUB no montante de SDR 3,4 milhões (equivalente a US$4,2 milhões, em Março de 1987) a 19 de Maio de 1987. O Crédito foi encerrado no dia 31 de Dezembro de 1991, com uma prorrogação de seis meses em relação à data inicial. Foi totalmente desembolsado; o último desembolso foi efectuado a 9 de Abril de 1992.

O RTP foi elaborado pela Divisão de Operações para a População e Recursos Humanos do Departamento da África Ocidental (Prefácio, Sumário de Avaliação Retrospectiva, Partes I e III) e pelo Mutuário (Parte II).

A elaboração deste RTP foi iniciado durante as missões finais de supervisão e terminação do projecto em Outubro de 1991 e Janeiro de 1992, respectivamente, e baseia-se inter-alia em: o Relatório da Avaliação Inicial do Pessoal, o Acordo de Crédito de Desenvolvimento, relatórios de supervisão, correspondência entre o Banco e o Mutuário, memorandos internos do Banco e entrevistas aos quadros do Banco envolvidos no projecto.

RELATÓRIO DE TERMINAÇÃO DO PROJECTO

REPÚBLICA DA GUINÉ-BISSAU

PROJECTO DE POPULAÇÃO, SAÚDE E NUTRIÇÃO

(CRÉDITO 1800-GUB)

SUMÁRIO DA AVALIAÇÃO RETROSPECTIVA

Objectivos do Projecto

1. Os dois objectivos básicos do Projecto eram (a) melhorar as capacidades institucionais do Ministério da Saúde Pública (MINSAP) nas áreas do planeamento, gestão e finanças; e (b) incrementar a prestação dos serviços de saúde e planeamento familiar, principalmente a nível dos centros de saúde nas zonas rurais. O objectivo do projecto ao concentrar-se a curto prazo na melhoria dos serviços básicos, promovendo ao mesmo tempo e a título complementar melhorias nas estrutura institucional, era proporcionar bases para permitir mudanças maiores na prestação dos serviços no futuro.

A Experiência da Execução e os Resultados do Projecto

2. Nos primeiros anos do projecto, registaram-se sérios atrasos na execução, devidos a deficiências institucionais e problemas de pessoal no MINSAP (acrescidos de assistência técnica inadequada), escassez de fundos de contrapartida e problemas com os procedimentos relativos à aquisição de medicamentos. A implementação retomou o ritmo nos últimos dezoito meses mais ou menos, quando o MINSAP começou a tentar superar estas deficiências e à medida que os trabalhos nos campos da formação profissional e educação no âmbito do projecto começaram a produzir efeitos.

3. Se bem que os êxitos conseguidos tenham ficado muito aquém dos objectivos delineados na avaliação inicial, os quais talvez tenham sido muito ambiciosos dada às circusntancias e realidades do país, mesmo assim, o projecto contribui grandemente para progressos futuros no sector da saúde. Considerando que este projecto representa a primeira tentativa feita por um doador de prestar assistência ao sector da saúde da Guiné-Bissau em geral, (ao contrário de pequenos projectos ou em locais específicos), as contribuições do mesmo são especialmente dignas de menção.

4. O desenvolvimento institucional, um processo a longo prazo e frequentement subtil, revelou indícios de verdadeiro progresso nos últimos meses do projecto, quando o MINSAP começou, finalmente, a elaborar um plano financeiro e a implementar um plano reorganizativo simplificado. O Ministério parece finalmente encaminhado no sentido da descentralização administrativa, gerencial e financeira, concentrando-se no aumento do poder a nível regional.

5. No sector da saúde lançaram-se várias políticas importantes. No campo crucial da gestão dos sistemas de medicamentos, estabeleceu-se um sistema operacional de controlo de inventários. Experimentou-se com êxito um modelo piloto de supervisão dos sistemas de saúde nas zonas rurais, o que constituiu um princípio excelente para fortalecer a gestão dos sistemas de saúde. Além disso, verificaram-se avanços importantes no sentido de instituir uma política de recuperação de custos e de a concretizar.

6. Entre outros resultados do projecto contam-se progressos significativos no sentido de preencher o quase-vácuo do centro de informações da PHN, graças a um Estudo Demográfico e de Saúde (LDS), um Estudo de Planeamento Familiar e um Estudo de Políticas de Nutrição (os quais, seguidos de seminários a nível nacional para divulgar os dados e resultados apurados.) Parece que o projecto encetou também o processo útil de desenvolvimento de recursos humanos. Estima-se que 6 500 pessoas beneficiaram directa ou indirectamente de cursos de formação relacionados com o projecto, formação no local de trabalho, cursos breves e seminários, principalmente nas áreas de administração, gestão financeira, contabilidade, gestão de medicamentos e cuidados materno-infantis.

7. O impacto das obras de construção civil foi decepcionante, visto que apenas dois centros de saúde foram reabilitados com os fundos do projecto (entre os 25 da meta inicial). Houve alguns que foram renovados com fundos concedidos por outros doadores, graças às diligências empreendidas por quadros do Banco, pela Direcção do MINSAP e pela Unidade de Gerência do P/PSN.

Continuidade do Projecto

8. Dada a inexperiência do MINSAP e a novidade da abordagem ao sector como tal, o objectivo prioritário do projecto foi desenvolver estruturas básicas apropriadas para trabalhos futuros. Se bem que o sector continue a contar grandemente com assistência técnica, existe já uma base segura para permitir a expansão e profissionalização das actividades iniciadas no âmbito deste crédito. À data do encerramento do projecto, por exemplo, a Organização Mundial de Saúde (OMS) estava a auxiliar o MINSAP a reforçar ainda mais as suas Unidades de Planeamento e de Administração e Finanças. O Projecto dos Sectores Sociais que se seguirá, expandirá grandemente a formação em recursos humanos iniciada no âmbito deste projecto. A equipa de gestão de medicamentos do Ministério dispõe dos requisitos essenciais para instituir uma política básica de medicamentos, e um sistema sustentável de recuperação de custos encontra-se prestes a ser implementado a nível nacional.

Conclusões

9. Quando as instituições nacionais são fracas, os projectos deviam concentrar-se num número restrito de objectivos atingíveis. Se bem que o Banco procure fundamentalmente promover o desenvolvimento institucional a longo prazo, pode simultaneamente obter resultados mais imediatos em termos de indicadores sociais, num país como a Guinea-Bissau, trabalhando a nível local e auxiliando NGUs que têm experiencia de trabalho neste nível. Para além disso, antes de permitir que os Mutuários estabeleçam Contas Especiais em instituições financeiras comerciais, a AID deveria providenciar no sentido de assegurar de antemão que as suas próprias condições e acordos sejam respeitados, a fim de se evitar a paralização de futuros projectos por parte das instituições financeiras, assim como o Banco de Las Palmas.

10. É altamente desaconselhável o emprego a longo prazo de técnicos estrangeiros (residentes ou não). Os consultores deviam ser contratados por períodos de seis a doze meses reservando-se o empregador sempre o direito de examinar o desempenho dos mesmos; a transmissão dos conhecimentos e/ou cursos de formação deviam figurar nos Termos de Referência; nos contratos para estudos especiais deveria etar estipulado que os consultores terão de apresentar os dados apurados, metodologia, etc, ao Mutuário, quer mediante seminários, quer por outras vias. Demais, contrapartida nacional deveria sempre ser designado a trabalhar com consultores estrangeiros residentes e no processo, aprender e beneficiar da experiencia.

11. Partindo do princípio que o apoio dos doadores se manterá ou mesmo aumentará, a Guiné-Bissau poderá assegurar fundos de contrapartida para trabalhos futuros no campo da saúde (assim como noutros sectores sociais), simplesmente mediante uma reatribuição de verbas, mesmo que isto implique uma redução doutras despesas correntes do Estado.

REPÚBLICA DA GUINÉ-BISSAU

PROJECTO DE POPULAÇÃO, SAÚDE E NUTRIÇÃO

(CRÉDITO 1800-GUB)

RELATÓRIO DE TERMINAÇÃO DO PROJECTO

PART I. ANÁLISE DO PROJECTO SOB A PERSPECTIVA DO BANCO

A. Identidade do Projecto

o	Nome do Projecto:	Projecto de População, Saúde e Nutrição
o	Crédito No.:	1800-GUB
o	Montante do Crédito:	DES 3,4 milhões (equivalente a $US4,2 milhões, em Março de 1987)
o	Departamento Regional do Vice Presidente	África Ocidental, Departamento IV
o	País:	Repúbica da Guiné-Bissau
o	Sector:	População, Saúde e Nutrição

B. Antecedentes do Projecto

1. A Guiné-Bissau é um dos países mais pobres da África susaariana, com um rendimento per capita estimado inferior a US$180. No início do projecto, em 1987, não existiam praticamente nenhuns dados fiáveis referentes à população, saúde e nutrição. Segundo estimativas preliminares feitas na altura, a população era ligeiramente inferior a um milhão, vivendo 80% nas zonas rurais. A esperança de vida era cerca de 40 anos (comparada com a média de 45 noutros países africanos de baixo rendimento) e uma em cada três crianças morria antes dos cinco anos de idade. A taxa bruta de mortalidade era de 27 por 1000 habitantes (comparada com 18 no resto da África subsaariana). Estes indicadores colocam a Guiné-Bissau 20 anos atrás da maior parte das outras nações africanas de baixo rendimento.

2. Objectivos para o Desenvolvimento do Sector. Em 1976, dois anos após a independência, o Governo da Guiné-Bissau adoptou um plano nacional de saúde (PNS) que preconizava o alargamento dos serviços básicos de saúde (SBS) utilizando tecnologia de baixo custo. O PNS passou posteriormente por uma série de modificações de pouca monta, à medida que foram implementados programas de cuidados de saúde novos ou ampliados. O objectivo declarado do Plano para Dez anos de Serviços Básicos de Saúde (1984-93), a implementar pelo Ministério da Saúde Pública (MINSAP)[1]/, é conseguir o acesso à saúde para 80% da população, mediante programas de Saúde Materno-Infantil (SMI), imunizações, medicamentos básicos e o controlo de doenças endémicas. Como indicador do seu empenhamento neste Plano, o Governo afectou consistentemente cerca de 10% do orçamento do estado ao sector da saúde, até ser obrigado nos termos do ajustamento estrutural a reduzir este montante tanto em termos reais como percentuais.

---

[1]/ Em Dezembro de 1991, este ministério passou a chamar-se Ministério da Saúde e Assuntos Sociais (MINSAS). Contudo, para efeitos deste relatório, será utilizada a sigla "MINSAP".

3. Enquadramento das Políticas. O sistema de saúde na Guiné-Bissau é quase exclusivamente público e administrado pelo MINSAP. O pessoal médico encontra-se fortemente concentrado nos dois hospitais nacionais, localizados na capital. A capacidade para formar pessoal de saúde a todos os níveis é extremamente limitada por todo o país, as instalações encontram-se em estado avançado de degradação e a aquisição de medicamentos está dependente quase na sua totalidade de financiamento externo (90% em 1986). Além disso, restrições de ordem macroeconómica limitam as opções para aperfeiçoar o sistema de saúde. Em 1991 as despesas no sector da saúde baixaram para 7% do orçamento do estado. Os fundos disponibilizados pelo MINSAP continuarão a ser limitados em virtude da escassez crónica de divisas e do abaixamento do valor real das verbas do orçamento do estado.

4. Ligações Entre os Objectivos do Projecto, do Sector e das Políticas Macroeconómicas. O Banco ajudou o Governo a delinear um programa de ajustamento estrutural de apoio a iniciativas importantes do último que se traduziram em políticas para fomentar a recuperação económica. O Banco e o Governo conceberam um programa de financiamento em duas partes agrangendo: a) um programa de financiamento a longo prazo, incluindo um crédito de ajustamento estrutural, e b) um programa básico de investimento em infra-estrutura, apoio institucional e desenvolvimento de recursos humanos. Este projecto constitui o primeiro do Banco no sector da saúde na Guiné-Bissau e destinava-se a continuar o programa básico de financiamento para o desenvolvimento dos recursos humanos, e ao mesmo tempo apoiar o sector social durante o período difícil do ajustamento estrutural.

C. Objectivos e Descrição do Projecto

5. Objectivos do Projecto. Os dois objectivos básicos do projecto eram: (a) melhorar as capacidades institucionais do Ministério da Saúde Pública (MINSAP) nas áreas do planeamento, gestão e finanças; e (b) melhorar a prestação de serviços de saúde e de planeamento familiara principalmente nos centros de saúde nas zonas rurais. A concentração de esforços a curto prazo no sentido de melhorar os serviços básicos, aliada à prioridade complementar dada as melhorias na estrutura institucional, destinava-se a criar bases para permitir ampliar a prestação de serviços no futuro.

6. Descrição do Projecto. As acções de desenvolvimento institucional no âmbito do Projecto abrangiam componentes para: melhorar a organização do MINSAP; criar um sistema informático de gestão; solidificar o sistema de gestão de medicamentos; conceber e implementar métodos de supervisão nos centros de saúde nas zonas rurais; introduzir um planeamento financeiro racional e ajudar o MINSAP a implementar medidas eficazes de recuperação de custos, apoiar o desenvolvimento e difusão de programas e políticas de PSN necessários; aperfeiçoar a recolha e análise de dados referentes à PSN; levar a cabo estudos especiais sobre políticas de nutrição e planeamento familiar; fazer um estudo de saúde demográfico (ESD) para melhorar o banco de dados estatísticos referentes à saúde.

7. As componentes do Projecto destinadas a reforçar a prestação de serviços incluem fornecer equipamento básico e insumos essenciais aos serviços nas zonas rurais, os quais abrangem 85% da população; recuperar 25 centros de saúde para prestar assistência a 175 000 pessoas; proporcionar formação profissional ao pessoal nos serviços da saúde, a todos os níveis. O apoio concedido para estes fins no âmbito do Projecto abrange veículos, equipamentos, obras de construção civil, mobiliário, materiais, fornecimentos médicos e outros, assistência técnica, bolsas de estudo de curta

duração no estrangeiro, formação no local de trabalho, salários do pessoal sob contrato e viagens/ajudas de custo.

D. Concepção e Organização do Projecto

8. Este projecto surgiu de uma análise feita pela AID ao sector e de uma mesa redonda de doadores, ambos realizados em princípios de 1986. O projecto que daí resultou foi cuidadosamente elaborado e constitui uma resposta global às necessiadades mais prementes identificadas durante os ditos exercícios. O projecto foi arquitectado no sentido de promover o desenvolvimento institucional a longo prazo dentro do MINSAP, atendendo ao mesmo tempo a algumas necessidades imediatas de melhoria na prestação dos serviços de saúde. Ao dar prioridade ao problema da recuperação de custos, o que constitui um aspecto inovador para a Guiné-Bissau, o projecto abordou também as dificuldades de financiamento dos custos ordinários não salariais. Infelizmente, a base conceptual do projecto, a qual era clara, tinha sido bem compreendida e ia ao encontro das carências do sector – porém provou ter objetivos muito ambiciosos e com diversos e numerosos componentes – estando muito além da capacidade local de implementação do mesmo. Se as pessoas que elaboraram o projecto tivessem tomado mais em conta os riscos de implementação, o resultado teria sido um projecto menos ambicioso, mas neste caso "menos" teria sido "mais".

9. Apropriabilidade do Âmbito e Dimensão do Projecto. Para conseguir implementar este projecto na sua totalidade, o MINSAP precisava de muitas mais competências precisamente naquelas áreas - administração, planeamento financeiro, gestão informática, desenvolvimento dos recursos humanos - que os projecto em si pretendia fortalecer. Considerando as limitações económicas e institucionais confessas do MINSAP, acrescidas de inexperiência do mesmo em empreendimentos tão grandes, qualquer projecto desta complexidade estava destinado a ultrapassar a capacidade potencial de implementação por parte do Ministério. Em retrospectiva, a dimensão geográfica do país da componente de obras de contrução civil era demasiado ampla para ser implementada por empresas privadas locais de construção.

E. Execução do Projecto

10. Riscos do Projecto. Previam-se dois riscos sérios neste primeiro projecto de PSN na Guiné-Bissau: (a) dificuldades de implementação devido à inexperiência dos quadros do MINSAP na execução de reformas estruturais importantes, principalmente no que respeita a recuperação de custos, e (b) a disponibilidade insuficiente de divisas para satisfazer as necessidades prementes de importações no sector da saúde.

11. Arranque do Projecto. O Projecto arrancou rapidamente graças à aprovação pela AID de dois adiantamentos provenientes do Fundo de Facilidade para a Preparação do Projecto (FFPP), no valor de US$300 000 e 750 000 respectivamente. Possibilitando ao Governo a realização de estudos acerca das carências do sector e o estabelecimento de uma Unidade de Gestão do Projecto, estes fundos não só aceleraram o arranque do projecto, como também permitiram que o MINSAP ganhasse alguma experiência nos procedimentos do Banco para aprovisionamento e desembolsos.

12. A entrada em vigor do crédito foi adiada de 18 de Setembro de 1987 até 18 de Dezembro de 1987, para permitir que o Governo submetesse um programa de acção e um plano financeiro do MINSAP para três anos, contendo os resultados de um estudo de custos de saúde e recuperação de custos. Quanto se tornou óbvio que esta condição não poderia ser satisfeita até 18 de Dezembro,

procedeu-se à alteração do Acordo de Crédito de Desenvolvimento, a fim de não haver mais atrasos na entrada em vigor do projecto. A presentação do plano do MINSAP deixou de ser uma condição para a entrada em vigor do projecto tornando-se uma cláusula a cumprir até 30 de Abril de 1988.

13. Discrepâncias entre a Execução Planeada para o Projecto e a Execução Real. Após a entrada em vigor do projecto verificaram-se atrasos sérios na implementação do mesmo, devidos em grande parte aos pontos fracos dentro do MINSAP, os quais já tinham sido inicialmente considerados riscos. A acrescentar a estes obstáculos verificaram-se vagas persistentes de postos chaves e outros problemas de pessoal dentro do MINSAP, falta de fundos de contrapartida e problemas com os procedimentos afectando as aquisições de medicamentos, infelizmente, uma assistência técnica contínua não se manifestou como um veículo eficaz ao qual se esperava, com respeito ao desenvolvimento institucional e às obras de construção civil.

14. A execução do projecto recuperou ritmo mais ou menos nos últimos 18 meses, quando um novo ministro tomou posse, algumas vagas para posições-chave no MINSAP foram finalmente preenchidas, fundos para medicamentos e estudos especiais from desbloqueados e a Organização Mundial da Saúde (OMS) assegurou assistência técnica. Além disso, durante este período registaram-se também melhorias acentuadas na implementação das componentes de gestão dos medicamentos, recuperação de custos e supervisão nas zonas rurais, à medida que os esforços nos campos de educação e da formação profissional no âmbito do Projecto começaram a produzir efeito.

15. Factores Imprevisíveis Afectando a Execução do Projecto. Cerca de US$70 000 dos fundos do projecto foram congelados por um banco de Ias Palmas (o qual tinha sido inicialmente designado detentor da conta especial do Projecto durante 2 1/2 anos), em virtude de uma disputa entre o banco e as Forças Armadas. A qual havia relacao com o Projeto ou com MINSAP.

F. Resultados mais Importantes do Projecto

16. Impacto do Projecto. O impacto global do Projecto foi misto. Os êxitos conseguidos no âmbito do Projecto ficaram aquém dos ambiciosos objectivos da avaliação inicial, apesar das grandes modificações operadas nas metas estabelecidas à partida para o desenvolvimento institucional e obras da construção civil. No entanto, o projecto contribui substancialmente para progressos futuros no sector da saúde mediante os êxitos alcançados no desenvolvimento de formação profissional e dos recursos humanos, na recolha de dados sobre PSN, na gestão dos sistemas de medicamentos, supervisão nas zonas rurais e reformas administrativas preliminares no seio do MINSAP. As contribuições deste projecto tornam-se particularmente dignas de menção considerando que o mesmo representa a primeira tentativa feita por um doador de prestar assistência à Guiné-Bissau no sector da saúde como um todo (ao contrário de projectos individuais ou locais).

17. Impacto no Desenvolvimento Institucional. A meta inicial para o desenvolvimento institucional era delinear um programa de acção e um plano financeiro para o sector da saúde a concretizar em três anos, incluindo a criação de um plano financeiro renovável. Se bem que este plano se tenha revelado demasiado ambicioso e o MINSAP nunca tenha chegado a adoptar um plano financeiro renovável durante todo o período da vigência do projecto, os esforços do Banco neste aspecto não foram em vão. Nos últimos meses da execução do projecto, havia indicações de que o MINSAP tinha finalmente começado a elaborar um plano financeiro, com o auxílio prestado pela OMS a instâncias do Banco. Apesar de atrasos, disputas e deficiências que não faltaram na

assistência técnica, o ministério conseguiu elaborar, adoptar e parcialmente implementar um plano simplificado de reorganização do mesmo. Parece que o Ministério se encaminha, finalmente, principalmente em aumentar a autoridade a nível regional.

18. Políticas Sectoriais. Este projecto permitiu que o sector da saúde da Guiné-Bissau lançasse várias políticas importantes e lhes desse seguimento mediante a instituição de medidas iniciais par a sua implementação. Quanto à gestão do sistema de medicamentos, por exemplo, do projecto resultou o estabelecimento de um sistema operacional de controlo de inventários. Isto foi conseguido graças ao fornecimento de um computador e dum veículo para o Armazém Central de Produtos Farmacêuticos e ao treino de pessoal local na sua utilização. Criou-se também um Formulário Nacional de Medicamentos e 535 exemplares foram fornecidos à Unidade Central de Medicamentos para destribuição por todo o país. Em termos de supervisão dos serviços de saúde nas zonas rurais, as duas regiões seleccionadas para as acções do projecto registaram progressos notáveis na medida em que serviram para experimentar um modelo de supervisão a seguir eventualmente nas sete regiões restantes do país. Instrução sobre saúde ministrada por pessoal local dedicado despertou interesse generalizado por entre a população rural, e atraíu um número crescente de parteiras tradicionais. Remodelações administrativas, acrescidas de problemas de manutenção e transporte, constituíram algumas dificuladades durante todo o período de execução. Não obstante, o material, equipamentos, veículos e assistência técnica fornecidos no âmbito do projecto - cuja utilização foi fortemente valorizada pelo contributo dado pelos Governos italianos e nadiano sob a forma de supervisão e formação - constituíram um começo excellente para fortalecer o processo de gestão dos sistemas de saúde nas duas regiões. Em finais da execução do projecto, tinha-se feito já uma campanha a nível nacional para instruir as populações acerca da necessidade de pagar os serviços de saúde, tinha-se criado uma Comissão para a Recuperação de Custos dentro do MINSAP, tinha-se instituído com êxito a recuperação de custos dentro dos limites de uma região (conforme a "iniciativa de Bamako"), e estavam-se a elaborar planos para alargar este sistema a mais regiões em 1992.

19. Estudos sobre Políticas a Seguir. No âmbito do projecto obtiveram-se progressos significativos no sentido de preencher um quase-vácuo no que respeita a um banco de dados informativos acerca de PSN. Completou-se a redacção dos 18 volumes do Estudo Demográfico e Saúde (EDS), a qual foi uma pesquisa que abrangeu todo o país na esperança de formar as bases para melhores informações sobre a saúde, fornecendo informações estatísticas atuais sobre a saúde e outros indicadores sociais no país. A pesquisa envolveu uma firma de consultoria e a participação ativa de MINSAP e o departamento de estatística do Ministro de Planejamento. E demais, um estudo sobre a População e Planeamento Familiar e um Estudo sobre Políticas de Nutrição. Estes três estudos representam todos um contributo muito importante para uma base de conhecimentos acerca do país. Realizaram-se ainda seminários para divulgar os dados apurados nos estudos e os resultados dos mesmos. Note-se, contudo, que o seminário sobre os dados apurados nos estudos foi custeado com fundos do SFPP obtidos pelos quadros do Banco, visto que esta actividade não constava no contrato do consultor e os fundos do projecto já se tinham esgotado.

20. Desenvolvimento dos Recursos Humanos. Esta componente ultrapassou as metas estabelecidas na avaliação inicial, em termos de participantes envolvidos e fundos dispendidos. Enquadrou formação profissional relacionada com o projecto, formação no local de trabalho, cursos breves e seminários, principalmente nas áreas de administração, gestão financeira, contabilidade, gestão dos medicamentos, e saúde materno-infantil. Segundo as estimativas do Encarregado do Projecto, 6 500 pessoas tiraram proveito, directo ou indirectamente, de todos os tipos e níveis de

formação profissional financiada no âmbito do projecto, em comparação com a meta de 500 no RAP. A concepção do projecto não preconizava um acompanhamento de perto ou avaliação retrospectiva das acções de formação. No entanto, segundo a avaliação do Director do Projecto e informações periódicas fornecidas pelos consultores, parece que sob este projecto se iniciou a criação de uma base útil para o desenvolvimento de recursos humanos, a qual pode servir de alicerce ao Projecto de Sectores Sociais que se seguirá.

21. Obras da Construção Civil. As actividades sob esta componente ficaram muito aquém das metas previstas na avaliação inicial. As etas físicas foram pela primeira vez reduzidas, quando, três anos após a assinatura do crédito, uma missão de supervisão determinou que os fundos do projecto só cobririam 11 dos 25 centros de saúde rurais a serem recuperados. Assim, no âmbito do projecto, foram elaborados planos arquitectónicos sumários para estes centros, mas, e em grande parte porque os locais de construção eram demasiado dispersos para atrair propostas de firmas de construção locais; na realidade, apenas dois centros foram reabilitados com os fundos do projecto. Vários outros foram renovados com fundos adquiridos de outros doadores, graças às diligências dos quadros do Banco. No entanto, houve outros centros que figuravam na list mas foram considerados irrecuperáveis.

G. Continuidade do Projecto

22. Em virtude da inexperiência do MINSAP e da novidade da abordagem ao sector como tal, este projecto colocou, à partida, forte ênfase na continuidade do mesmo. Um dos objectivos principais no âmbito de componentes tão diversas como desenvolvimento institucional, formação profissional, gestão dos medicamentos, supervisão nas zonas rurais e recuperação de custos, era desenvolver estruturas básicas apropriadas para continuar os trabalhos no futuro. Podemos dizer que se encontram lançados os alicerces para expandir e profissionalizar as acções iniciadas no âmbito do crédito.

23. Por exemplo: à data do encerramento do projecto, a assistência técnica permanente da OMS estava a ajudar o MINSAP a fortalecer ainda mais tanto a sua Unidade de Administração e Finanças como a do Planeamento. Um Projecto dos Sectores Sociais que virá a seguir enfatizará a capacidade de construção e expandirá substancialmente a formação em recursos humanos iniciada com este projecto. A equipa de gestão dos medicamentos do Ministério dispõe das capacidades essenciais para instituir uma política de medicamentos básica, e existe já um sistema de recuperação de custos em eventual implementacao em outras regiões do país.

24. Entre os factores que contribuirão para a continuidade do projecto contam-se o empenhamento governmental, a continuação da assistência técnica (sujeita a um controlo melhor, a transferência de conhecimentos para contrapartida nacional estabelicido dentro do projeto e usufruindo dos altos padrões de coordenação dos doadores estabelecidos neste projecto) e um empenhamento de todas as partes envolvidas em incrementar as acções a nível local (cientes de que as instituições nacionais registarão altos e baixos durante bastante tempo).

H. Desempenho do Banco

25. Pontos Fortes e Fracos Principais. Os quadros do Banco revelaram flexibilidade e criatividade constantes, o que ficou provado ser particularmente importante dado a inexperiência do Mutuário. Além disso, o Banco contactou outros doadores e Organizações não Governamentais

(OMS, CEE, FNUAP e outros) a fim de obter AT e fundos extra para actividades relacionados com o projecto, nomeadamente a reabilitação de centros de saúde e a aquisição e gestão de medicamentos essenciais. De facto, as diligências dos quadros do Banco para incrementar a coordenação dos doadores durante a execução deste projecto prepararam o terreno para uma cooperação mais chegada e permanente com estas organizações (principalmente entre o Banco, a OMS e a UNICEF) em trabalhos futuros no sector social na Guiné-Bissau.

26. Conclusões. Uma das conclusões a que se chegou e que já é bem conhecido dentro do Banco: quando as instituições nacionais são frágeis, os projectos devem ser simplificados e devem concentrar-se apenas num número restrito de objectivos atingíveis. O êxito das componentes de formação e supervisão nas zonas rurais sugere que, enquanto o Banco promove o desenvolvimento institucional pode simultaneamente ter impacto nos indicadores sociais particularmente num país como Guiné-Bissau, trabalhando mais a nível local (sempre que possível em conjunção com outros doadores e Governos já envolvidos).

27. Além disso, antes de autorizar os Mutuários a estabelecer Contas Especiais em instituições financeiras comerciais, a AID deveria providenciar no sentido de assegurar de antemão que as suas próprias condições e acordos sejam respeitadas, a fim de evitar-se a paralisação de projectos por instituições como o Banco de las Palmas.

I. O Desempenho do Mutuário

28. Pontos Fortes e Fracos Principais. No período de elaboração do projecto, o governo deu vários passos importantes: nomeou um Director do Projecto estrangeiro, criou uma Unidade de Gestão do Projecto em tempo oportuno e comprometeu-se a empreender várias mudanças organizativas e outras. Foram submetidos relatórios trimestrais e o Mutuário concordou com a revisão bancária e outras condições de procedimento.

29. Contudo, surgiram problemas graves durante a execução do projecto, devido a dificuldades e falta de quadros competentes, factos que não permitiram ao MINSAP preencher lugares chave de gestão por um período que se prolongou por mais de dois anos. A execução esteve também comprometida em virtude de problemas administrativos e das dificuldades financeiras do Governo que não pôde dispôr em tempo oportuno de fundos de contrapartida, situação cuja solução não depende inteiramente do MINSAP.

J. Conclusões

30. A experiência adquirida neste projecto, em que aproximadamente 30% compôs-se de assistência técnica, sugere várias directivas para o emprego de assistência técnica: desaconselha-se fortemente a assistência técnica estrangeira (residentes ou não); os consultores deviam ser contratados por períodos de seis a doze meses, e sempre com o direito a exame do desempenho dos mesmos, a transmissão dos conhecimentos e/ou os cursos de formação deviam constar nos Termos de Referência e os contratos para estudos especiais deviam conter uma cláusula estipulando que os consultores têm que apresentar os factos apurados, metodologia, etc. ao Mutuário, quer em seminários ou por outras vias. Além disso, se um estrangeiro for escolhido como director do projecto, ou qualquer outro posto chave, deve-se sempre selecionar uma contrapartida nacional. Capacidade nacional de estrutura e desenvolvimento de recursos humanos deveriam ser prioridades em um país como Guiné-Bissau e deveria refletir em esquemas de projetos.

31. Partindo do princípio que o apoio dos doadores vai continuar ou mesmo aumentar, é fundamental frisar que o Governo só poderá assegurar fundos de contrapartida para trabalhos futuros no campo da saúde (assim como noutros sectores sociais) se redistribuir as despesas públicas. É sabido que, actualmente, em comparação com outros países de baixo rendimento na África subsaariana, a Guiné-Bissau tem o rendimento per capita mais baixo, afecta a maior quota percentual do seu orçamento do Estado às Forças Armadas (28%), e encontra-se abaixo da média no que respeita à percentagem do Produto Nacional Bruto abribuído à saúde (1.0).

K. Relações Banco-Mutuário

32. As relações Banco-Mutuário durante a duração do projecto foram satisfatórias para efeitos do projecto. Estabeleceu-se um tom positivo logo no início, devido em parte ao fato de os quadros do Banco responsáveis pela elaboração do projecto falarem um português fluente. Sob a supervisão capaz do seguinte oficial do projecto, mantiveram-se relações de cooperação também durante a execução, mesmo quando o Banco teve de intervir perante disputas contratuais e um desvio de fundos do projecto (contas especiais), as quais foram congelados por um banco estrangeiro

L. Serviços de Consultoria

33. Os consultores individuais contratados pelo Banco foram capazes e eficientes. Quanto a consultoria contratada pelo MINSAP, produziu-se um estudo de planejamento familiar; um estudo de nutrição, o qual começou atrasado, foi finalmente finalizado e julgado muito proveitoso. MINSAP, com a assitência da WHO, decidiram revisar e simplificar o plano para reestruturação do projecto, preparado para o Ministério por uma firma de Consultoria.

M. Documentação e Dados do Projecto

34. O Relatório de Avaliação Inicial do Pessoal, os relatórios de supervisão e dos consultores e material adicional existente nos arquivos do projecto forneceram informações adequadas para a elaboração deste Relatório de Terminação do Projecto. Além disso, o Estudo de Estratégias para os Sectores Sociais (Volume I) publicado em Dezembro de 1991 proporcionou uma visão profunda e muito útil do enquadramento mais lato em que este projecto foi implementado.

REPUBLICA DA GUINE-BISSAU

POPULACAO, SAUDE E NUTRICAO
(CREDITO 1800-GUB)

RELATORIO DE TERMINACAO DO PROJECTO

PART II. ANALISE DO PROJECTO SOB A PERSPECTIVA DO MUTUARIO

1. É chegado o momento de proceder ao encerramento deste Projecto que ao longo de mais de quatro anos apoiou a política sanitária do país que se baseia nos cuidados primários de Saúde.

2. Cabe-nos, com este relatório, fazer um balanço em linhas gerais e apresentar as nossas apreciações dando assim cumprimento aos compromissos assumidos junto da AID com a assinatura do Acordo de Crédito RC 1800-GUB que financiou a concepção e execução do presente projecto.

3. A execução do Projecto População, Saúde e Nutricão enfrentou dificuldades das mais variadas ordem e natureza que, não obstante a sua longa duração, não logrou executar uma boa parte dos seus componentes, deixando objectivos por atingir.

4. A muito custo, conseguiu-se prosseguir algumas acções tais como o Inquérito Nutricional (1ª parte) que se realizou entre Dezembro de 1990 e Janeiro de 1991, tendo-se procedido igualmente à sua difusão através do seminário de divulgação dos resultados daquele estudo.

5. Quanto à definição da Política Alimentar e Nutricional do governo, julgamos lógica e tecnicamente coveniente aguardar pela realizaçáo da 2ª parte do estudo e, com as conclusões qua daí resultar, elaborar então o documento a submeter à aprovação governamental.

6. No que respeita aos fundos de contrapartida que o governo deveria assegurar no valor equivalente a USD200.000,00 (duzentos mil dólares americanos=, é verdade que não tem havido disponibilidade atempada dada a existência de um grande número de projectos doutras àreas de acção do governo que dependem igualmente do Fundo Nacional de Desenvolvimento e de graves insuficiências financeiras de que padece o país. Todavia, foi feito um grande esforço e julgamos que o governo cumpriu o compromisso que assumiu com a assinatura do Acordo de Crédito.

7. Houve custos adicionais nomeadamente com a execução do Inquérito Alimentar e Nutricional devido a realização de uma missão suplementar dos Consultores estrangeiros em Dezembro de 1990, dado que a missão de Junho de 1990 não havia sido convenientemente preparada pela Unidade de Gerência que não chegou a dar conhecimento à Directora Nacional do Estudo da sua realização.

8. Tendo en conta as múltiplas irregularidades que a execução do projecto indiciava e a falta de colaboração que existia entre a Unidade de Gerência e os restantes departamentos, entendeu-se por bem nomear um gestor nacional que coadjuvasse e sevundasse o Director Nacional do Projecto que, afinal, era um estrangeiro.

9. Com a contratação do gestor nacional com Consultor Assistente, o Director Nacional do Projecto resolveu desresponsabilizar-se das suas funções, passando a viajar sem qualquer aviso prévio.

10. Relativamente à polítca de recuperação de custos, a dificuldade maior surgiu com a tentativa de abarcar o mais vasto leque possível da população embora numa escala progressiva em harmonia com o nível de rendimento de cada um, facto que conduziu à suspensão da mesma em virtude do grande melindre e celeuma que suscitou junto da população que não está habituada a pagar os cuidados de saúde.

11. Julgamos que a concepção do projecto não foi feliz em alguns aspectos, nomeadamente no que respeita aos objectivos estruturais v. g. Reorganização do MINSAS e estudo sobre Planeamento Familiar.

12. O primeiro, a Reorganização do MINSAS, é um objectivo fundamenta e indispensável que, infelismente, não pode ser atingido a curto prazo. É verdade que se registraram algumas melhorias na organização do Ministério, mas confessamos ter grandes dúvidas se isso terá sido fundamentalmente influenciado pelas conclusões e recomendações da firma de consultoria envolvida, ou se determinado pelo estilo próprio da nova direcção.

13. De facto, as conclusões e recomendações existem, dispomos de alguns namuais que podem servir para um trabalho de fundo dessa natureza, mas a concepção do Projecto não teve em consideração a realidade concreta das nossas instituições e a situação dos nossos funcionários fortemente desmotivados em razão do nível dos salários que os tem obrigado a procurar outras ocupações paralelas, facto que não lhes permite consagrarem-se devidamente ao trabalho e muito menos à leitura e consulta dos extensos dossiers deixados pela consultoria.

14. O segundo. Planeamento Familiar, constitui igualmente um objectivo desejável e é inegável que o governo deve dispôr de uma política no domínio. Porém, énosso dever interrogarmo-nos sobre o alcance e sucesso de uma tal política. De facto, trata-se de um aspecto do mais íntimo da vida conjugal e pessoal de cada indivíduo profundamente condicionada pelos valores culturais e que, por isso mesmo, quaisquer medidas que sejam adoptadas sobre essa problemática, encerra um certo melindre e estão em princípio condenadas ao fracasso.

15. Julgamos que o caminho mais adequado é o da educação através de conselhos médicos caso a caso e através das escolas, aumentando o nível de escolaridade das nossas crianças. Aliás, conforme um especialista conclui num estudo sobre a questão,a mulher que nunca foi à escola é capaz de ter doze filhos; aquela que fez a quarta classe, não deve ultrapassar oito; a que concluiu o liceu deverá acabar pelos quatros; e se tiver concluído a universidade, dificilmente terá mais de dois.

16. É nossa opinião que a concepção do projecto falhou designadamente nestes dois componentes por não ter equacionado devidamente a questão de base que enforma a situação

concreta, conduzindo a um investimento considerável cujo sucesso, ab início, se apresentava bastante limitado.

17. A execução do projecto teve os seus problemas próprios porquanto, além das deficiências herdadas da concepção, esbarrou con dificuldades no terreno que não conseguiu ultrapassar, ou porque não obteve a colaboração dos demais funcionários que se empenhou com o zelo devido, revelando graves falhas, particularmente gritantes no que respeita à reabilitação dos Centros de Saúde, ao acompanhamento dado à consultoria, ou ainda à aquisição de bens de consumo duradouro e materiais de equipamento.

18. A gestão financeira do Banco Mundial, constituiu algumas dificuldades que, a bem de verdade, não são intransponíveis nem foram determinantes na parte em que o projecto não obteve sucesso. De qualquer maneira, julgamos possível a médio prazo evoluir para outras formas de gestão financeira combinada que permita à célula local de gestão uma maior liberdade de manobra em nome da boa prossecução dos objectivos do projecto, desde que dirigida por um gestor idóneo e capaz.

19. Temos para nós que nem tudo foi mau na concepção e execução do projecto e que este terá contribuído positivamente para melhorar a cobertura sanitária do país, conhecer melhor as estruturas existentes e perspectivar uma nova política de saúde, controle e rentabilização dos meios disponíveis e, apesar do insucesso da política de recuperação de custos, aprender com a experiência possível por forma a que, a médio prazo, possamos dispôr de um sistema eficaz de amortização dos custos dos cuidados de saúde que, até ao momento, são suportados integralment pelo Estado. Prosseguimos com a iniciativa do Bamako e julgamos que, a seu tempo, todo o país acabará por compreender a necessidade de cada utente contribuir para a amortização dos custos e melhoramento dos cuidados de saúde.

20. É certo que poderíamos atingir resultados mais satisfatórios se a gestão do projecto não tivesse sido tão pouco favorável mesmo no caso dos componentes mais viáveis. Porém, julgamos justo atrivuir a nota suficiente ao projecto que ora chega ao fim, graças aos fundos disponíveis e ao controle imposto pela nova direcção do ministério. Aliás, antes de 1990, a acção do projecto estava fundamentalmente virada para a compra e distribuição de bens de consumo e de utilização directa.

21. O povo da Guiné-Bissau padece de graves carências e insuficiências e, a nível da Saúde, os dados estatísticos, nomeadamente a taxa de natalidade e de mortalidade infantil e materna para além da prevalência da má nutrição em certas àrea do país e das doenças endémicas, de entre as quais cumpre destacar o paludismo, a diarréia e o SIDA, são eloquentes e obrigam a que o governo dispense um esforço suplementar para minimizar as desatrosas consequências que, igualmente, muito contribuem não só para agravar os encargos do Estado mas, mais ainda, para atrasar o processo de desenvolvimento do país.

22. Julgamos que este projecto foi um teste positivo que nos permitiu colher muitos ensinamentos que nos serão úteis.

23. Por tudo quanto foi atrás referido, estamos convictos que se aproveitou um ensinamento, qual seja, o de que qualquer projecto deve evitar prosseguir directamente objectivos estruturais sem a participação local. Pensamos que mesmo que não se verifiquem as dificuldades antes enumeradas, é preferível encontrar meios de estimular uma troca interna de experiência e privilegiar a actuação e consultoria dos técnicos nacionais que mesmo que

não estejam à altura de oferecer estudos tão elaborados como os que oferece a consultoria internacional, os resultados dos seus trabalhos, terão a vantagem de estar mais próximo da realidade do país, logo, de obter melhor impacto. Por outro lado, só uma aposta no trabalho desses técnicos poderá assegurar uma evolução real e sustentada capaz de dispensar o recurso contínuo à consultoria internacional.

24. Portanto, não é demais repetí-o, o projecto foi positivo. Os resultados obtidos cosntituem dados adquiridos que nos permitirão maximizar a rentabilidade de empreendimentos futuros.

25. Esperamos continuar a merecer o apoio da conumindade internacional, pois estamos decididos a dar o melhor de nós por forma a podermos renovar as nossas esperanças de entrar para o século XXI com um perfil sanitário mais satisfatório que nos permita suportar o desafio do desenvolvimento e atingir a saúde para todos no ano 2000.

Bissau, Junho de 1992.

A:Part2Por.JZ1

REPÚBLICA DA GUINÉ-BISSAU

PROJECTO DE POPULAÇÃO E NUTRIÇÃO
(Crédito 1800-GUB)

PART III. INFORMAÇÕES ESTATÍSTICAS

1. Outros Empréstimos e/ou Créditos Bancários Relacionados com o Projecto

Não se aplica.

2. Calendário do Projecto

Alíneas	Data Original	Nova Data	Data Real
Identificação I			01/86
Identificação II			04/86
Elaboração			07/86
Missão de Pré-avaliação			09/86
Missão de Avaliação Inicial			12/86
Negociações do Crédito			03/87
Aprovação Aprovação pelo Conselho de Administração			05/19/87
Assinatura do Crédito			05/22/87
Entrada em Vigor do Crédito	09/18/87	12/18/87	12/18/87[1]/
Data de Terminacao	12/31/90	06/30/91	11/15/91[2]/
Data de Encerramento	06/30/91	12/31/91	12/31/91[3]/

[1]/ A entrada em vigor do crédito foi adiada para permitir que o Governo submetesse um programa de acção e um plano financeiro para três anos, contendo os resultados de um estudo sobre custos de saúde e de recuperação de custos. Como era impossível satisfazer esta condição até Dezembro de 1987, o que, por conseguinte, causaria mais atrasos desnecessários à execução do projecto, e após a revisão do Acordo de Crédito de Desenvolvimento (nova Secção 3.10), recomendou-se que a dita condição passasse a cláusula a cumprir até 30 de Abril de 1988. Todavia, esta cláusula nunca foi totalmente cumprida.

[2]/ A data do encerramento do projecto foi prorrogada até 13 de Junho de 1991 para permitir que o Governo completasse acções-chaves referentes ao projecto.

[3]/ A data do encerramento do projecto foi prorrogada até 13 de Junho de 1991 para permitir que o Governo completasse acções-chaves referentes ao projecto.

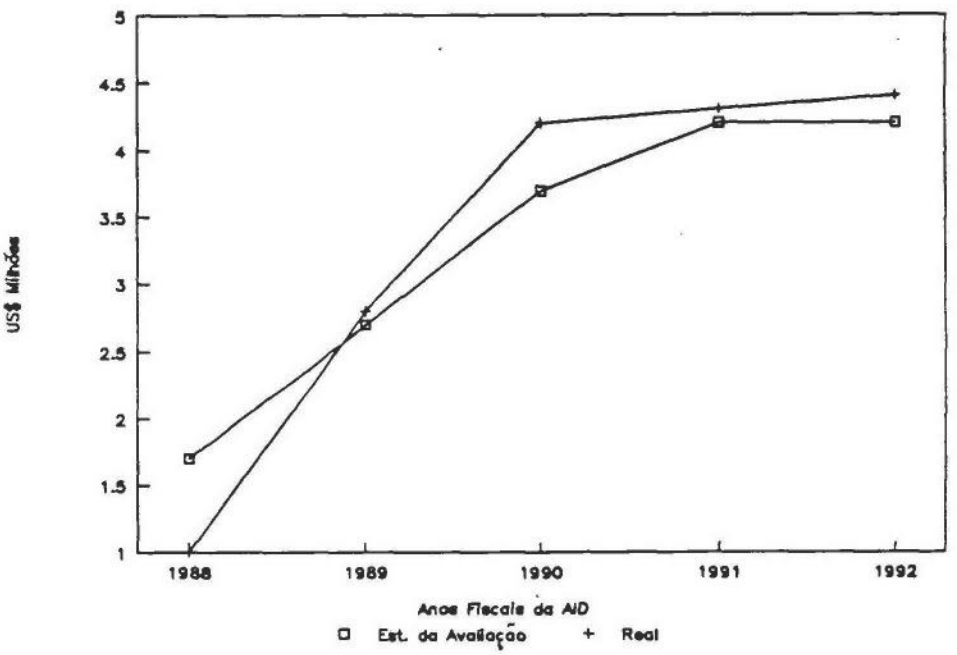
3. Desembolsos do Crédito

A. Desembolsos Acumulados Estimados e Reais

(US$ milhões)

Ano Fiscal	AF88	AF89	AF90	AF91	AF92
Estimativa da Avaliação Inicial	1,7	2,7	3,7	4,2[1]/	
Real	0,94	2,80	4,15	4,36	4,53[1]/
Real/percentagem da Estimativa	55,3%	103,7%	112,2%	103,8%	107,9%

B. Linha das Variações entre o Calendário de Estimado na Avaliação Inicial e o Calendário Real



[1]/ Em virtude da flutuação do dólar americano contra os DES, o projecto beneficiou de fundos adicionais equivalentes a cerca de US$300 000. Todos os fundos no âmbito do Crédito 1800-GUB já foram desembolsados ou encontram-se imobilizados. Este Crédito não sofreu cancelações.

Table C: Afectação dos Fundos do Crédito

Rubrica	Em DES				Em US$
	Afectação Inicial	Alterada 1/	Actuais Desembolsos 2/	Saldo	Saldo 3/
1. Obras de Construção Civil	350,000	98,700	70,590	28,110	37,452
2. Equipamentos, mobiliário, veículos e materiais	380,000	668,900	798,335	(129,435)	(172,453)
3. Serviços de Consultores e Bolsas de Estudo	400,000	1,124,700	1,124,188	512	682
4. Medicamentos e fornecimentos médicos	560,000	698,900	748,581	(49,681)	(66,193)
5. Custos de Funcionamento	340,000	55,900	56,054	(154)	(205)
6. Bens e Serviços relativos à implementação das actividades e programas derivados dos estudos de medidas a serem aplicadas	220,000	137,500	137,535	(35)	(46)
7. Reembolso do F.T.P.P.	850,000	460,500	466,708	(6,208)	(8,272)
8. Não-afectado	300,000	154,900	(1,992)	152,908	203,727
TOTAL	3,400,000	3,400,000	3,400,000	0	0

1/ A nova afectação dos fundos do Crédito foi feita por telex da AID de 1 de Fevereiro de 1991.

2/ Actuais desembolsos e último.

3/ Ao câmbio de US$1.33 = 1 SDR.

07-May-92

4. Execucao do Projecto

Componentes do Projecto	Unidade de Medida	Estimativas do RAP	Reais	Comentarios
Parte A. Desenvolvimento Institucional				
1. Organizacao e Gestao:				
(a) Implementacao do plano de do MINSAP	Unidade	1	0.5	O trabalho executado por uma firma de consultores foi inadequado; foi proposto e implementado um plano muito mais simples.
(b) Concepcao e Implementacao de um Sistema Informatico de Gestao	Unidade	1	0.5	Um SIG foi implementado so para as medidas de recuperacao de custos; nao foi totalmente instituido.
(c) Implementacao de um plano para melhorar a gestao do sistema de medicamentos.	Unidade	1	1	Ja foi implementado um Sistema de Gestao de Medicamentos e a Unidade Central de Medicamentos esta a funcionar eficientemente.
(d) Conceber, experimentar e imple-mentar um sistema modelo de supervisao dos servicos de saude nas zonas rurais, na regiao de Bafata e na area de Sonaco, na regiao de Gabu.	Unidade	1	1	A componente de supervisao nas zonas rurais foi concre-tizada com exito em Regiao do Bafata e Sonaco (Regiao do Gabu) apesar de alguns problemas, tais como transportes deficientes.
2. Planeamento e Delineacao de Politicas:				
(a) Estudo sobre o sector hospitalar, incluindo necessidades de renova-cao.	Unidade	1	0	O estudo nao fez parte do Projecto de PSN; enquadrou-se no Estudo de Estrategias para os Sectores Sociais.
(b) Estudo sobre Nutricao	Unidade	1	0	O estudo foi aprovado primeiro pelo Comite Tecnico, e depois pelo Ministro do MINSAP em Agosto de 1991. Foi conclui do no final de 1991 um seminario para discutir as conclusoes do estudo.
(c) Estudo sobre Planeamento Familiar	Unidade	1	1	O estudo foi bem recebido pelo Comite Tecnico e o MINSAP. Realizou-se ja um seminario sobre o estudo.
(d) Estudo sobre a procura dos servicos de saude a nivel dos centros de saude.	Unidade	1	0 1/	Decidiu-se que estes dois estudos deviam ficar suspensos ate se realizarem outros mais urgentes.
(e) Estudo sobre as necessidades	Unidade	1	0 1/	
(f) Melhoria de dados basicos sobre PSN, abrangendo:				
(i) analise do censo de 1979;	Unidade	1	1	
(ii) implementacao de um inque-rito por amostra nacional;	Unidade	1	1	OISP esta concluido e exemplares dos dados ja foram distribuidos. Foi realizado a um seminario em Maio de 1992 para discutir os resultados do ISP, o qual sera custeado com o FPPP.

1/ Dado estar muito alem da capacidade de UGP empreender um grande numero de accoes a executar no ambito deste projecto, os quadros envolvidos no mesmo recomendaram que estes dois estudos fossem suspensos ate se darem por concluidas algumas das actividades mais prementes.

Componentes do Projecto	Unidade de Medida	Estimativas do RAP	Reais	Comentarios
(iii) Criacao de um banco de dados;	Unidade	1	0.1	Criou-se um banco de dados rudimentar.
(iv) Formacao dos quadros da DGE e do MINSAP em estatistica.	Unidade	1	1	Realizaram-se cursos de formacao em estatistica, contabilidade e computadores. No entanto, recomenda-se prover mais cursos de formacao nestas areas.
Part B. Solidificar os Servicos de Saude e de Planeamento Familiar.				
1. Apoio aos Servicos de Saude Rurais.				
(a) Aperfeicoamento das 8 Direccoes Regionais e implementacao de tecnicas de gestao e supervisao nas regioes, apos apuramento dos resultados do sistema modelo referido na parte A. 1.(d) acima.	Unidade	8	2	As Direccoes Regionais serao aperfeicoadas num projecto futuro. O projecto de PSN concentrou-se nas regioes de Bafata e Gabu.
(b) Reabilitacao de cerca de 25 centros de saude.	Unidade	25	7	Foram reabilitados dois centros de saude, no ambito deste projecto; 4 centros de saude pelo CECI (Canada); um centro de saude no ambito de um projecto do PASI; dos 18 restantes apenas 5 foram colocados na lista dos irrecuperaveis.
(c) Equipar, mobilar e fornecer insumos para cuidados de saude a cerca de 122 centros de saude.	Unidade	122	109	A acrescentar aos 109 centros de saude, tres centros de informacao, 5 postos hospitalares, 8 hospitais regionais e dois hospitais nacionais receberam equipamento e materiais.
2. Desenvolvimento de Mao-de-Obra da Saude:				
Instituicao de um programa de formacao no servico para os trabalhadores do sector da saude materno-infantil, epidemiologia, planeamento familiar, nutricao, prescricao/utilizacao de medicamentos, nos cuidados a ter com a nutricao e a saude e outras areas de cuidados da saude.	Unidade	500	500	Estima-se que 6 500 pessoas tiraram proveito, directa ou indirectamente da formacao profissional provida no ambito do projecto.

5. Custo e Financiamento do Projecto

Quadro A. Custos do Projecto
(US$'000)

Categorias	Estimativa da Avaliacao Inicial			Reais 1/		
	Custos Locais	Custos em Divisas	Total	Custos Locais	Custos em Divisas	Total
1. Obras de construcao	24.4	395.6	420.0	35.3	58.8	94.1
2. Equipamentos, mobiliario, veiculos e materiais.	6.9	478.9	485.8	66.6	1,003.2	1,069.8
3. Servicos de consultores e bolsas de estudo.	52.5	613.4	665.9	162.0	1,335.8	1,497.8
4. Medicamentos e fornecimentos medicos.	0.0	625.2	625.2	69.8	927.6	997.4
5. Custos de funcionamento	79.6	385.7	465.3	69.0	61.2	130.2
6. Bens e servicos de acordo com a Parte A.2 (b) do Projecto.	14.7	382.5	397.2	0.0	183.2	183.2
7. Reembolsos do FFPP	46.0	922.0	968.0	0.0	621.8	621.8
8. Nao afectado	62.0	322.2	384.2	0.0	(2.7)	(2.7)
Total	**286.1**	**4,125.5**	**4,411.6**	**402.7**	**4,189.0**	**4,591.7**

1/ A contribuicao do Governo encontra-se reflectida nos dados do Relatorio de Auditoria correspondente ao periodo que decorre ate 31 de Dezembro de 1991.

Quadro B: Financiamento do Projecto

(US$'000)

Fonte de Financiamento/ Rubrica das Despesas	Planeado (Acordo de Credito)	Alterado 2/	% do Total	Final 3/	% do Total	Saldo
I. AID:						
1. Obras de construcao civil	470,000	131,503	2.8%	94,051	2.0%	37,452
2. Equipamento, mobiliario, veiculos e materiais.	560,000	891,209	18.8%	1,063,662	23.2%	(172,453)
3. Servicos de Consultores e bolsas de Estudo.	640,000	1,498,494	31.6%	1,497,812	32.6%	682
4. Medicamentos e Fornecimentos medicos.	740,000	931,179	19.6%	997,372	21.7%	(66,193)
5. Custos de Funcionamento	430,000	74,478	1.6%	74,683	1.6%	(205)
6. Bens e Servicos de Acordo com a Parte A.2 (b) do Projecto.	400,000	183,199	3.9%	183,245	4.0%	(46)
7. Reembolsos do FFPP	970,000	613,547	12.9%	621,819	13.5%	(8,272)
8. Nao afectado	0	206,381	4.4%	(2,654)	-0.1%	203,727
TOTAL AID	4,210,000	4,529,990	95.6%	4,529,989	98.7%	0
II. GOVERNO DA GUINE-BISSAU						
1. Obras de Construcao Civil	20,000	20,000	0.4%	0	0.0%	
2. Equipamento, mobiliario, veiculos e materiais	10,000	10,000	0.2%	6,137	0.1%	
3. Servicos de Consultores e Bolsas de Estudo	70,000	70,000	1.5%	397	0.0%	
5. Custos de Funcionamento	110,000	110,000	2.3%	55,364	1.2%	
TOTAL DO GOVERNO DA GUINE-BISSAU	210,000	210,000	4.4%	61,898	1.3%	
TOTALIDADE DE FINANCIAMENTO DO PROJECTO	4,420,000	4,739,990	100.0%	4,591,887	100.0%	

1/ A afectacao de fundos a cada rubrica de despesas abrange o preco e contingencias fisicas.

2/ A nova afectacao dos fundos do Credito foi feita por telex da AID a 1 de Fevereiro de 1991. Em virtude da flutuacao do dolar US contra os DES, o projecto beneficiou de adicionais fundos equivalentes a cerca de US$300 000.

3/ No que respeita a AID: a posicao actual e final dos desembolsos;
Quanto ao Governo: basea-se no Relatorio de Auditoria referente ao periodo que decorre ate fins de Dezembro de 1991.

(Cambio: US$1.33 = SDR 1).

6. Resultados do Projecto

Alínea	Objectivo Definido na Avaliação Inicial	Situação Actual	Impacto da Acção
A. Estudos			
1. Estudo sobre custos de saúde e recuperação de custos: um estudo de um plano financeiro para três anos.	Abordar a falta de planeamento financeiro e melhorar o financiamento dos custos ordinários não-salariais.	Os estudos foram financiados, em parte, com o FFPP e concluídos.	Tornou as entidades oficiais cientes de muitos problemas no seio do MINSAP; as medidas de recuperação de custos já foram implementadas na Região to Gabu, e deverão alastrar-se a outras regiões.
2. Estudo sobre o sector hospitalar, incluindo necessidades de renovação	O estudo incidiria sobre taxas de utilização, qualidade da assistência, necessidades de mão-de-obra e de investimento, estado das instalações e necessidades de renovação, disponibilidade de habitação para os trabalhadores da Saúde e custos gerais do sector.	O estudo não se realizou como parte do Projecto de PSN; enquadrou-se no Estudo de Estratégias para os Sectores Sociais do Banco.	Devera ajudar o MINSAP no planeamento e afectação de recursos.
3. Estudo de Nutrição	Determinar melhor as realidades quanto a nutrição do país, abrangendo: selecção de alimentos, hábitos culinários e causas e efeitos da subnutrição.	O estudo foi aprovado primeiro pela Comissão Técnica e depois pelo Ministro do MINSAP em Agosto de 1991. Em Dezembro de 1991, realizou-se um seminário dirigido aos trabalhadores da saúde, para discutir as conclusões do estudo.	Os trabalhadores da saúde adquiriram conhecimentos e experiencia básicos sobre nutrição que aplicarão nas zonas rurais; permitindo, assim, o acesso aos serviços de saúde à maioria da população.
4. Estudo sobre Planeamento Familiar	Elaborar, experimentar e implementar um guia simples para classificar as mulheres por níveis de riscos reprodutivos ou obstétricos e encaminhá-las para os servicos competentes.	O estudo foi bem recebido pela Comissão Técnica e pelo MINSAP. Em Janeiro de 1992 realizou-se um seminário com uma participação maioritária de trabalhadores da saúde.	Os trabalhadores da saúde adquiriram conhecimentos e experiência básicos relativos ao planeamento familiar que serão aplicadas nas zonas rurais, permitindo, assim, o acesso à saúde a uma maior parte da população.
5. Estudo sobre a procura s serviços de saúde a _ vel dos Centros de Saude	A implementar pelo Instituto Nacional de Estudos e Pesquisas (INEP). Examinar as percepções da população acerca dos serviços dos centros de saúde, os serviços mais procurados, e os níveis de apoio popular aos centros de saúde.	O estudo em si não se concretizou; no entanto, os resultados do Inquérito Demográfico da Saúde (IDS) forneceram as informações neste campo. (Ver B-2 abaixo)	
6. Estudo das necessidades energéticas do Sector da Saúde e Fontes Alternativas de Energia	Avaliar as necessidades energéticas do sector hospitalar, dos centros de saúde e residências dos trabalhadores da saúde, e propor fontes energéticas alternativas.	A ordenação dos estudos a realizar por prioridades revelou que estes deviam ficar suspensos a fim de se encontrarem os esforços e recursos noutros tipos de estudos (planeamento familiar, nutrição, etc.), seleccionados por serem urgentes.	
7. Estudo para determinar as carências de transporte das ilhas mais distantes	Não especificado	Eliminado	Falta de fundos; não prioritário
8. Estudo sobre as Necessidades de Habitação de Baixo Custo para os Trabalhadores da Saúde colocados em Instalações Rurais	Não especificado	Eliminado no âmbito do Projecto	Fará parte do projecto que se segue.

Alínea	Objectivo Definido na Avaliação Inicial	Situação Actual	Impacto da Acção
B. Compilação e Análise de Dados:			
1. Análise do Censo de 1979;	Análise e publicação dos resultados	Concretizada	Incorporado nos dados do IDS
2. Implementação de um Inquérito Nacional por amostra sobre PSN (ou EDS);	A implementação iniciou-se no âmbito do FFPP.	O ISD está concluído e exemplares dos dados foram distribuídos.	Está programado um seminário para Abril de 1992 para discutir os resultados do ISD, custeado com os fundos do FFPP.
3. Criação de um Banco de Dados;	Proporcionar um estágio de três meses no exterior a um técnico de dados; assistência técnica de um perito de informática em bancos de dados.	Completou-se a criação de um Banco de dados rudimentar.	
ormação dos Quadros da DGE do MINSAP em estatísticas;	Obter a assistência técnica de um estatístico de saúde pública; conceder uma bolsa de três anos em estatísticas de saúde.	Realizaram-se cursos de formação em estatística, contabilidade e computadores. Contudo, recomenda-se que se proporcionem mais cursos de formação nestas áreas.	Aperfeiçoamento das qualificações dos trabalhadores; contudo, é necessário fazer mais.

7. Cumprimento das Clausulas

Seccao	Cláusula	Situação Actual
2.02 (b)	O Mutuário abrirá e manterá uma conta especial em dólares num banco comercial em termos e condições satisfatórios para a AID. Os depósitos na Conta Especial ou pagamentos da mesma serão efectuados de acordo com as disposições do Anexo 4 do Acordo de Crédito de Desenvolvimento (ACD).	Totalmente cumprida. A conta Especial foi recuperada na sua totalidade. O MINSAP foi recentemente informado de que deverá instruir o Citibank, Senegal para encerrar a conta.
3.03	Até 30 de Outubro de cada ano da duração do projecto, o Mutuário examinará em por-menor e conjuntamente com a AID, a actuação do MINSAP nos seguintes pontos: (a) o programa de acção para três anos e o plano financeiro; (b) orçamento ordinário e de desenvolvimento para o ano fiscal seguinte; (c) estrutura organizativa; (d) procedimentos de supervisão a nível rural; (e) programas de formação no serviço; e (f) os resultados de estudos especiais sobre políticas a seguir e a possibilidade de um novo programa.	Totalmente cumprida, excepto a alínea (a) que foi "em princípio" cumprida mas que na realidade não foi.
3.04	O Mutuário tomará as medidas necessárias para, até 31 de Março de 1988, decretar e publicar a sua política nacional de medicamentos.	Cumprida. Publicação de um Formulário Nacional de Medicamentos em 1991. Foram implementadas e aper-feiçoadas medidas de recuperação de custos e uma política de medicamentos. Curso de formação em computadores para os quadros da gestão de medicamentos em Outono de 1991, visando uma implementação adequada das medidas.
3.05	O Mutuário fará todas as diligências necessá-rias para conceder ao MINSAP a dispensa legal estabelecida pelo Decreto No.51/85 de 4 de Dezembro de 1985, segundo a qual o Mutuário autoriza a retenção de 100% das comissões cobradas pelo MINSAP, em conformidade com as medidas de recuperação de custos de saúde implementadas.	Acções experimentais introduzindo medidas de recuperação de custos e a iniciativa de Bamako foram concretizadas a 1 de Abril de 1990 na região de Gabú; estas medidas deverão alastrar-se a outras regiões durante o próximo ano.

Secção	Cláusula	Situação Actual
3.06	O Mutuário estabelecerá, até 30 de Novembro de 1987, uma conta no Banco Nacional da Guiné-Bissau (BNG) (Conta do MINSAP) em termos e condições satisfatórios para a AID. Todos os proventos acumulados das comissões cobradas em conformidade com a Secção 3.05 do ACD serão depositados na Conta do MINSAP.	Totalmente cumprida
3.07	(a) até ao dia 1 de Janeiro de 1989 deverá completar e fornecer a AID, para fins de análise e comentários, recomendações emanadas dos estudos relativos a nutrição, realizados pelo Mutuário, de acordo com a Parte A.2 (a)(ii) do Projecto;	Totalmente cumprida. Realizou-se um seminário nacional em Novembro de 1991 para discutir e divulgar os resultados do estudo.
	(b) até 1 de Janeiro de 1989, delinear uma política nacional de nutrição e um programa de acção;	Não cumprida. Espera-se que este será o resultado final do estudo e que um seminário a nível nacional será organizado em fins de 1991.
	(c) imediatamente a seguir, trocar pontos de vista com a AID e chegar a acordo com a mesma acerca da implementação da dita política e programa de acção.	Não cumprida
3.10	O Mutuário fornecerá a AID, até 30 de Abril de 1988, o programa de acção e o plano financeiro do MINSAP para o período de 1988-1990, incorporando os resultados do estudo sobre custos de saúde e recuperação de custos, levado a cabo pelo Mutuário em termos e condições satisfatórias para a AID.	O Mutuário tem feito progressos na delineação de um plano financeiro rotativo. Membros do Gabinete do Planeamento do MINSAP e um técnico da OMS estão a elaborar um plano financeiro para o Ministério, o qual servirá de documento de trabalho e de instrumento de gestão e planeamento financeiro.
4.01	(a) O Mutuário manterá ou proverá para que se mantenham registos e contas que reflictam os recursos e despesas relativas ao Projecto dos departamentos ou agências do Mutuário responsáveis pela execução do Projecto ou parte do mesmo, utilizando para o efeito, operações e métodos contabilísticos sãos.	Totalmente cumprida

Secção	Cláusula	Situação Actual
4.01(cont.)	(b) O Mutuário será responsável por: (i) prover a auditoria dos registos e contas de cada ano fiscal referidos no parág. (a) desta Secção, incluindo aqueles relativos à Conta Especial; a auditoria será feita por auditores independentes, que a AID considere aceitáveis e de acordo com princípios de auditoria apropriados e consistentemente aplicados; e (ii) fornecer a AID, assim que estiver disponível, mas em qualquer caso até seis meses após ao final do ano em questão, uma cópia autenticada do relatório da auditoria feito pelos ditos auditores, o qual será tão extenso e pormenorizado quanto a AID periódica e razoavelmente solicitar.	Mesmo que acime
	(c) Para todas as despesas relativas às quais foram efectuados saques da Conta Especial na base de DDDs, o Mutuário será responsável por: (i) manter ou prover para que se mantenham, de acordo com o Parág. (a) desta Secção, registos e contas dessas despesas; (ii) reter, pelo menos até um ano após a conclusão da auditoria correspondente ao ano fiscal em que foi efectuado o último saque da Conta Especial, todos os registos (contratos, encomendas, facturas, contas, recibos e outros documentos) comprovativos de tais despesas; (iii) permitir que representantes da AID examinem tais registos; e (iv) assegurar a inclusão de tais registos e contas da auditoria anual referida no parág. (b) desta Secção, e que o relatório da dita auditoria contenha um parecer em separado dos auditores acerca da fiabilidade das DDDs submitidas durante o ano fiscal em causa e dos procedimentos e controlos internos envolvidos na preparação das mesmas, como provas dos saques correspondentes.	Mesmo que acima

8. Utilização dos Recursos do Banco

A. Recursos Humanos Utilizados

(Semanas de Trabalho)

Fase do Projecto	Anos Fiscais							Total
	AF86	AF87	AF88	AF89	AF90	AF91	AF92	
Preparação/Prè-avaliação	11.8	33.0						44.8
Avaliação		42.1						42.1
Negociações		3.3						3.3
Supervisões		1.2	21.6	8.9	17.5	11.6	9.9	70.7
Terminação							8.0	8.0
TOTAL	11.8	79.6	21.6	8.9	17.5	11.6	17.9	168.9

B. Dados das Missões

Fase do Projecto	Mês/ Ano	No. de Pessoas	Dias no Terreno	Especializações Representadas 1/	Situação Actual no Desempenho por Acção 2/				
					O	D	C	M	F
Identificação I	01/86	3	15	EP, CONS: E, M					
Identificação II	04/86	3	8	EP, CONS: E, M					
Preparação	07/86	3	12	EP, CONS: E, A					
Pre-Avaliação	09/86	2	8	E, CONS: E					
Avaliação	12/86	6	12	EP, E, AO, CONS: E, E, TF					
Pós-Avaliação	01/87	1	6	CONS: E					
Supervisão 1	10/87	2	5	EP, A	Não classificada				
Supervisão 2	03/88	1	10	CONS: E	Não classificada				
Supervisão 3	06/88	1	10	EP	2	1	n.a.	2	2
Supervisão 4	10/88	1	5	EP	Não classificada				
Supervisão 5	06/89	3	10	EP, CONS: E, M	2	1	2	2	3
Supervisão 6	10/89	1	10	EP	2	2	2	2	3
Supervisão 7	03/90	3	16	EP, CONS: ESP, M	2	2	2	3	3
Supervisão 8	07/90	1	7	EP	Não classificada				
Supervisão 9	03/91	1	13	EP	2	2	2	3	2
Supervisão 10	10/91	2	5	EP, AP	2	2	2	3	2
Terminação	01/92	2	8	EP, AP	Não classificada				

1/ A = Arquitecto; E = Economista; AO = Analista de Operações; M = Médico;
ESP = Especialista em Saúde Pública; EP = Encarregado do Projecto;
TF = Técnico Farmacêutico; AP = Analista de Pesquisas

2/ O = Situação Global; D = Objectivos do Desenvolvimento do Projecto;
C = Cumprimento das Cláusulas Legais; M = Desempenho da Gestão do Projecto;
F = Disponibilidade de Fundos.

07-May-92

Anexo 1

REPÚBLICA DA GUINÉ-BISSAU

Relatório de Terminação do Projecto

Projecto de População, Saúde e Nutrição

Participantes da Missão de Terminação do Projecto[1]/

Missões de Outubro de 1991 e de Janeiro de 1992

Banco Mundial

Sra. Carol Hoppy, Encarregada do Projecto, AF4PH
Sra. Johanne Angers, Analista de Pesquisas, AF4PH

Ministério da Saúde e dos Assuntos Sociais

H.H. Henriqueta Godinho Gomes, Ministro da Saúde e dos Assuntos Sociais
Dr. Silvestre Alves, Director-adjunto do Projecto de PSN

Missão de Outubro de 1991

Ministério da Saúde e dos Assuntos Sociais

Dr. Celestino Costa, ex-secretário de Estado da Saúde
Sr. Augusto Paulo, Chefe do Gabinete do Planeamento e da Cooperação Internacional
Sr. Malam Dram, Gabinete do Planeamento e Cooperação Internacional
Sr. António Paulo Gomes, Gabinete do Planeamento e da Cooperação Internacional
Sr. Estêvão Malam da Costa, Farmacêutico, Depósito Nacional de Medicamentos
Dr. Paulo José Mendes, Director-Geral, Recursos Humanos
Enfermeira Maria Augusta Biai, Directora, Escola Técnica de Enfermagem
Dr. António, Director no Ministério da Saúde Pública
Prof. Deant Kaymah, Director do Projecto de PSN

Organização Mundial da Saúde (OMS)

Dr. Erling Larsson, assessor técnico da OMS, Gestão de Medicamentos

---

[1]/ Realizou-se uma missão de supervisão em Outubro de 1991, no decorrer da qual foram discutidas as actividades do Projecto com as principais entidades oficiais.

Anexo 2
Página 1 de 2

REPÚBLICA DA GUINÉ-BISSAU

Relatório de Terminação do Projecto

Projecto de População, Saúde e Nutrição

Relação de Relatórios Trimestrais submitidos sobre o Progresso do Projecto

1.	24 de Maio de 1988	Relatório No. 1 do Progresso do projecto PSN, para o período findo em Maio de 1988.
2.	Outubro de 1988	Relatório No. 2 do Progresso do projecto PSN, para o período a findo em Setembro de 1988.
3.	Dezembro de 1988	Relatório Trimestral No. 3 do Progresso do projecto PSN, para o período findo em Dezembro de 1988.
4.	10 de Março de 1989	Relatório Trimestral No. 4 do Progresso do projecto PSN, para o período findo em Março de 1989.
5.	8 de Julho de 1989	Relatório Trimestral No. 5 do Progresso do projecto PSN, para o período findo em Junho de 1989.
6.	12 de Outubro de 1989	Relatório Trimestral No. 6 do Progresso do projecto PSN, para o período findo em Setembro de 1989.
7.	4 de Dezembro de 1989	Relatório Trimestral No. 7 do Progresso do projecto PSN, para o período findo em Dezembro de 1989.
8.	6 de Março de 1990	Relatório Trimestral No. 8 do Progresso do projecto PSN, para o período findo em Março de 1990.
9.	29 de Junho de 1990	Relatório Trimestral No. 9 do Progresso do projecto PSN, para o período findo em Junho de 1990.
10.	15 de Dezembro de 1990	Relatório Trimestral No. 10 do Progresso do projecto PSN, para o período findo em Dezembro de 1990.

11.	15 de Março de 1991	Relatório Trimestral No. 11 do Progresso do projecto PSN, para o período findo em Março de 1991.
12.	7 de Julho de 1991	Relatório Trimestral No. 12 do Progresso do projecto PSN, para o período findo em Junho de 1991.
13.	5 de Outubro de 1991	Relatório Trimestral No. 13 do Progresso do projecto PSN, para o período findo em Setembro de 1991.
14.	28 de Dezembro de 1991	Relatório Trimestral No. 14 do Progresso do projecto PSN, para o período findo em Dezembro de 1991.

This form must be typed

THE WORLD BANK/IFC/MIGA
PRINTING REQUEST
Read instructions on reverse

(Leave This Space Blank) 93E44891

Title (or Description) of Item to be Printed	Report/Form No.	Report/Revision Date
GUINEA-BISSAU: Population, Health and Nutrition Project (Credit 1800-GUB) PCR	11759	03/31/93

Select One: [x] Report [ ] Form [ ] Letterhead [ ] Complimentary Slip [ ] Other (specify) ______

No. of Pages	Quantity	Job	Classification (for reports only)	Date and Time Required
38	656	[x] New [ ] Rerun	Restricted	4/15

Requested By	Ext.	Room No.	Dept./Div. Acronyms	Dept./Div. Nos.
RONALD RIDKER/PILAR BARQUERO	31757	T9-017	OEDD1	17510

SPECIFICATIONS

SIZE: [x] 8-1/2x11 [ ] 8-1/2x14 [ ] 11X17 [ ] Other ______

TEXT: Color of Paper White No. of Pages 38 Print [ ] 1 side [ ] 2 sides

COVER: Color of Paper White Print [ ] 1 side [ ] 2 sides

COVER HEADING: [x] World Bank [ ] IFC [ ] MIGA Masthead ______

CONSTRUCTION: [ ] Assemble [ ] Saddle-stitch [ ] Perfect Bind [ ] Staple upper left corner [ ] Staple two on side [ ] Pad

[ ] Fold Finished Size ______ No. of Holes to be Punched: on top ______ on side ______

[ ] Carbonless No. of Parts ______

MAPS – Requesting departments are responsible for clearing all new, revised or previously printed maps with the Cartography Section, GSDPG. The Print Shop requires clearance before any map is printed or released from shelf stock.

Map Cleared By	Date	List ALL MAPS (by IBRD No.) in this space	Charts (by no.) in this space

PRINTING APPROVAL – Printing requests for reports and discussion papers must be be cleared by the Internal Documents Unit, JB3-180.

Approval Initials and Date: LJS 3/30/93

Order of Assembly/Additional Instructions

1. TITLE PAGE: Back-up by rbbreviations (white hard cover. Doc. of WB, Off. use and caveat).
2. Covering memo: (Off. use, caveat, facsim. signature of DGO - No back-up.
3. Table of Contents: Off. use and caveat 1 page - No back-up.
4. Preface: no back-up
5. Evaluation Summary: 3 pages back-up
6. Main report: 1 - 30
   No back-up pages 7- 3

Delivery Instructions

Copies		To		Room no.
545	copies to	Secretary's office	in room no.	D-110
25	copies to	Internal Doc. Unit	in room no.	HB1-151
61	copies to	Distribution Unit	in room no.	D-110
25	copies to	Africa Information Center	in room no.	J B1-085
	copies to		in room no.	

Signature ______ Date ______

FOR PRINT SHOP USE ONLY

PRESS: [ ] Chief [ ] T-51 [ ] GTO [ ] Davidson [ ] Xerox [ ] Blue Lines [ ] Harris [ ] WEBCOM [ ] Apollo [ ] Didde [ ] Shinohara

Text Signatures ______

Press for Cover ______

Special Instructions

COVERS: [ ] CI [ ] CII [ ] CIII [ ] CIV

COVER INKS: [ ] Black [ ] Other ______

BINDERY: [ ] Macey [ ] Saddle [ ] Perfect

COVER STOCK: ______

No. of Pages to Tip ______

No. of Sheets per Pad ______

INSTRUCTIONS

This form must be typed.

What clearances do I need?

For Reports and Discussion Papers

This request MUST be cleared by the Internal Documents Unit, JB3-180.

For Maps

To ensure that all maps included in Bank reports and publications are current and to avoid portraying politically embarrasing situations, maps must FIRST be cleared by the Cartography Section, GSDPG, before any printing request is made. This applies to all maps (or map negatives) older than six weeks--new, revised, previously printed or in the Print Shop shelf stock; or maps which were prepared by Cartography--whether they have appeared in non-Bank publications, or have been produced utilizing PC graphics or mapping software packages. Request for clearances should be made to Cartography at least two weeks before the map is to be bound in a report to allow for any necessary changes and for the completion of the map printing cycle. For more details, refer to Administrative Manual Statement 7.10, Annex B, or the reverse side of Form 1548 "Request for Cartographic Services."

What do I do once I have completed this form?

For Reports, Discussion Papers, Other Documents

Hand carry White, Yellow & Pink copies of this form to the Print Shop, GSDPG. The Pink copy will be stamped with the date and hour received at the Print Shop and returned to you. Keep Goldenrod copy for your records.

For Forms

Submit White, Yellow & Pink copies of this form to the Forms Unit, ITFIS, together with a blank copy of the form to be printed. Keep Goldenrod copy for your records.

For Stationery (e.g. letterheads, envelopes, complimentary slips)

Submit White, Yellow & Pink copies of this form to the Material Services Section, GSDMM, with a copy of the item to be printed or a marked up sample of what you want. Keep Goldenrod copy for your records.

FORM 152
(6-88)

THE WORLD BANK/IFC
DISTRIBUTION OF REPORTS

REPORT TITLE GUINEA-BISSAU: Population, Health and Nutrition Project (Credit 1800-GUB) PROJECT COMPLETION REPORT	REPORT NO. 11759
REPORT DATE	FORM PREPARED BY PILAR BARQUERO — EXT. 31757
REMARKS	COLOR OF COVER: ☐ Gray/Buff ☒ White ☐ Other

DISTRIBUTION TO STAFF BELOW DEPARTMENT DIRECTOR LEVEL

Do not duplicate distribution made by Secretary's Dept. to Department Directors and above.

NAME	ROOM NO.	NO. OF COPIES	NAME	ROOM NO.	NO. OF COPIES
G.Donaldson (P. Barquero)	T9-017	30			
OED Library	T9-080	5			
Africa Inf. Center	JB1-085	25/60			

FOR PRINT SHOP USE ONLY

Distributed by	Date

WHITE/YELLOW - Documentation Center; PINK - Originator

Ms Marek

34086

THE WORLD BANK
Washington, D.C. 20433
U.S.A.

Office of Director-General
Operations Evaluation

March 31, 1993

MEMORANDUM TO THE EXECUTIVE DIRECTORS AND THE PRESIDENT

SUBJECT: Project Completion Report on Guinea-Bissau
Population, Health and Nutrition Project (Credit 1800-GUB)

Attached is a copy of the report entitled "Project Completion Report on Guinea-Bissau - Population, Health and Nutrition Project (Credit 1800-GUB)" prepared by the Africa Regional Office. Part II was prepared by the Borrower.

The outcome of this project--meant to simultaneously support the institutional development of the Ministry of Public Health and to strengthen the delivery of health and family planning services--was unsatisfactory. Little training and institutional building took place, in part because of failure to provide counterpart staff, and most health center remodeling had to be cancelled because of construction delays.

The outcome was conditioned by inadequate preparation, overambitious design, and failure of the Borrower to provide agreed-to counterpart funds. This project is a good example of excessive reliance on technical assistance even though some modest improvements in capacity occurred and lessons learnt are being incorporated into future programs. Many more years of institutional development will be necessary before sustainable operations are assured.

The Project Completion Report provides an accurate account of project implementation. The reasons for the failure of this project are well laid out and plans to take them into account in future operations are noted. An audit is not planned.

Attachment

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

ROUTING SLIP	DATE: March , 1993
NAME	ROOM NO.
Mr. Robert Picciotto, DGO	
thru Mr. H. Eberhard Kopp, Director	

	URGENT		PER YOUR REQUEST
	FOR COMMENT		PER OUR CONVERSATION
	FOR ACTION		SEE MY EMAIL
	FOR APPROVAL/CLEARANCE		FOR INFORMATION
	FOR SIGNATURE		LET'S DISCUSS
	NOTE AND CIRCULATE		NOTE AND RETURN

RE:

REMARKS: GUINEA-BISSAU: Population, Health & Nutrition Project (Credit 1800-GUB) PCR

For your signature prior to printing.
No comments have been received from
the Region.

FROM: Graham Donaldson, Chief, OEDD1	ROOM NO.:	EXTENSION: 31730

'93 MAR 26 AM 11 11

D.G.O.

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

MAR 01 1993

ROUTING SLIP	DATE: February 25, 1993
NAME	**ROOM NO.**
Mr. Robert Picciotto, OEDD1	
Thru: Mr. H. Eberhard Köpp, OEDDR	
2/25	
RGR see 3rd page for credits!	

D. G. O.
'93 FEB 26 PM 3 46

EK
GD

Thanks. Minor suggestions on transmittal note are noted.

	URGENT		PER YOUR REQUEST
	FOR COMMENT		PER OUR CONVERSATION
	FOR ACTION		SEE MY EMAIL
X	FOR APPROVAL/CLEARANCE		FOR INFORMATION
	FOR SIGNATURE		LET'S DISCUSS
	NOTE AND CIRCULATE		NOTE AND RETURN

RE:

REMARKS: GUINEA-BISSAU: Population, Health and Nutrition (Credit 1800-GUB) PCR

Please find attached, for your approval, the above PCR together with the Project Information Form and draft Review Note from you to the Board.

This PCR reflects the revisions the Region made after receiving the attached memo from Mr. Köpp.

FROM: Graham Donaldson, Chief, OEDD1	ROOM NO.:	EXTENSION: 31730

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

ROUTING SLIP	DATE: March 24, 1993
NAME	ROOM NO.
Mr. Graham Donaldson, Chief, OEDD1	

	URGENT		PER YOUR REQUEST
	FOR COMMENT		PER OUR CONVERSATION
	FOR ACTION		SEE MY EMAIL
	FOR APPROVAL/CLEARANCE		FOR INFORMATION
	FOR SIGNATURE		LET'S DISCUSS
	NOTE AND CIRCULATE		NOTE AND RETURN

RE:

REMARKS: GUINEA-BISSAU: Population, Health & Nutrition Project (Credit 1800-GUB) PCR

For your approval to print.

OK 3/25

FROM: Ronald G. Ridker, OEDD1	ROOM NO.:	EXTENSION: 31739

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

ROUTING SLIP	DATE: February 25, 1993

NAME	ROOM NO.
(1) Mr. Graham Donaldson	
(2) Mr. H. Eberhard Köpp	

FEB 25 1993

	URGENT		PER YOUR REQUEST
	FOR COMMENT		PER OUR CONVERSATION
	FOR ACTION		SEE MY EMAIL
X	FOR APPROVAL/CLEARANCE		FOR INFORMATION
	FOR SIGNATURE		LET'S DISCUSS
	NOTE AND CIRCULATE		NOTE AND RETURN

RE: PCR - GUINEA-BISSAU PHN (Credit 1800-GUB)

REMARKS: The following changes have been made to the PIF:

#2, p. 12 - Note handwritten additions. But please note that while this gives more info (e.g. about achievements of this component) it is misleading in absence of handwritten notes which will be lost in data base.

Bottom, p. 18 - Not available because info required is not in PCR or SAR.

FROM:	ROOM NO.:	EXTENSION:
Ronald G. Ridker, OEDD1	T-9017	31739

PCR/PIF COVER SHEET Run Date: 10/01/93

OED ID: C1800 *Division: 1

*Country:	Guinea-Bissau
*Project Description:	Population, Health & Nutrition
*Sector:	04 / Human Resource
*Subsector:	04.05 / Pop., Health & Nutr.
Lending Instrument Type:	SIL
L/C:	C1800
Original IDA/IBRD Commitments:	4,200,000 ($US)
Total Cancellations:	0 ($US)

Key Dates	ORIGINAL	ACTUAL
Approval		5/21/87
Signing/Agreement		5/22/87
Effectiveness	9/18/87	12/18/87
Closing	6/30/91	12/31/91
PCR Receipt in OED		6/30/92

ASSIGNED TO: R Ridker

SIGNATURE: R Ridker DATE: 12-20-93

Please confirm the "*" fields above, sign this sheet and return a photo-copy to Helen Sioris. Pass this sheet as the PIF cover to the Eval. Officer.

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

Date of Review: 12/20/93 (mm / dd / yy)

Name of Reviewer: R. RIDKER

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

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

Yes [ ] No [ ]

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

	ORIGINAL	LATEST
Date of Physical Completion	06/30/91 (mm/dd/yy)	12/31/91 (mm/dd/yy)
Total Project Cost ($US mill)	4.4	4.6
Applicable Disbursement Profile: (see note 11 in the PIF, page 31)	6.5 U.	
Number of Supervision Missions:	10	

FACTORS AFFECTING ACHIEVEMENT OF MAJOR OBJECTIVES

	Substantial (✓)	Partial (✓)	Negligible (✓)	Not Available (✓)	Not Applicable (✓)
Categorize achievement of **MAJOR OBJECTIVES** (original or revised) for *(p.6 Jan 93 PIF; p.4 Interim PIF)*					
Financial Objectives	☐	☐	☑	☐	☐

If there were major increases or decreases in project COSTS, indicate the major reasons(s) with a (+) or (-): *(p.8 Jan 93 PIF; p.6 Interim PIF)*

	(+ or - or blank)
Change in prices/tariffs/taxes	☐

IDENTIFICATION, BANK PERFORMANCE

Categorize the quality of Bank performance in the **IDENTIFICATION** of the project: *(p.16 Jan 93 PIF; p.15 Interim PIF)*

	Highly Satisfactory (✓)	Satisfactory (✓)	Deficient (✓)	Not Available (✓)	Not Applicable (✓)
Project innovativeness	☐	☐	☐	☐	☑

PREPARATION, BANK PERFORMANCE

Indicate whether the following factor had a positive(+) or negative(-) effect on the OVERALL assessment of Bank's performance in **PREPARATION** assistance: *(p.16 Jan 93 PIF; p.16 Interim PIF)*

	(+ or - or blank)
Economic and sector work	☐

APPRAISAL, BANK PERFORMANCE

Indicate whether the following factor had a positive(+) or negative(-) effect on the OVERALL quality assessment of the Bank's performance in project **APPRAISAL:** *(p.17 Jan 93 PIF; p.18 Interim PIF)*

	(+ or - or blank)
Coordination with other donors	☐

IMPLEMENTATION, BORROWER/IMPLEMENTING AGENCY PERFORMANCE

(p.21 Jan 93 PIF; p.19 Interim PIF)

Categorize the quality of project **IMPLEMENTATION** in this area:

	Highly Satisfactory (✓)	Satisfactory (✓)	Deficient (✓)	Not Available (✓)	Not Applicable (✓)
Financial objectives	☐	☐	☐	☐	☐

Indicate whether the following factors had a positive(+) or negative(-) effect on the OVERALL quality of project **IMPLEMENTATION:**

	(+ or - or blank)
Staff quantity	☐
Level or timeliness of counterpart funding	+

Report No. 11782
Date: 3/1/93

A. PIF Processing Information

Date of review: ~~January~~ Feb 20 1993 (date this form filled out)

Name of reviewer: R. Ridley

Type of Evaluation:

PCR review ☑ PAR review ☐

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

Yes ☐ No ☐

If yes, comment on the differences: _____

B. Project Processing Information

Project Identification

Country: Guinea-Bissau

Project Name: Population, Health & Nutrition Project

Sector/Subsector: PHN

Lending Instrument: Credit

Loan or Credit #s': 1750-GUB

C. Achievement of Project Objectives

1. Project Objectives

a) Were major project objectives substantially changed during implementation? **2/**

Yes ☐ No ☑

If yes, were the objectives:

Reduced ☐ Increased ☐ Otherwise modified ☐

b) Taking into account the country's level of development and the competence of the implementing agency, was the project and its major objectives:

	Very	Par-tially	No	Not Available
i. Relevant for country/sector:3/				
Original Project	☑	☐	☐	☐
Revised Project	☐	☐	☐	☐
ii. Demanding on Borrower/Implementing Agency:				
Original Project	☑	☐	☐	☐
Revised Project	☐	☐	☐	☐
iii. Complex:4/				
Original Project	☑	☐	☐	☐
Revised Project	☐	☐	☐	☐
iv. Risky:				
Original Project	☑	☐	☐	☐
Revised Project	☐	☐	☐	☐

c) Were the criteria for judging achievement of major objectives adequately quantified in the Staff Appraisal Report:

Yes ☐ Partially ☐ No ☑

2. Extent of Achievement of Project Objectives 5/

a) If an economic rate of return (ERR) was calculated for the project, indicate (in %):

Appraisal Estimate	Re-estimated at Completion
_____	_____

On what percentage of estimated total project costs was the original ERR based ? _____

On what percentage of total projects costs (final/latest estimate) was the re-estimated ERR based ? _____

If an ERR was not re-estimated indicate reason(s):

- Project not implemented ☐
- Inadequate data ☐
- Other (specify): _____ ☐

If the re-estimated ERR differs significantly from the appraisal estimate, indicate the reason(s):

- Cost changes ☐
- Output changes ☐
- Output delays ☐
- Changes in methodology/analysis ☐
- Other (specify): _____ ☐

If an ERR was not calculated, was the cost-effectiveness of the project estimated in the PCR:

Same or higher than in the SAR ☐

Lower than in the SAR ☐

Information not available ☑

b) If a financial rate of return (FRR) (or other financial indicator) was calculated for the project, indicate: **6/**

Appraisal Estimate	Re-estimated at Completion
_____	_____

If a FRR (or other financial indicator) was not re-estimated, indicate reason:

Project not implemented ☐

Inadequate data ☐

Other (specify): _____ ☐

If the re-estimated FRR (or other financial indicator) differs significantly from the appraisal estimate, indicate the reason(s):

Cost changes ☐

Output changes ☐

Changes in prices/tariffs/user charges ☐

Changes in methodology/analysis ☐

Other (specify): _____ ☐

c) Categorize achievement of major objectives (original or revised) in these areas: **7/**

	Substantial	Partial	Negligible	Not Available
Macro policies	☐	☐	☐	☐
Sector policies	☐	☑	☐	☐
Institutional development	☐	☐	☑	☐
Physical Objectives	☐	☐	☑	☐

3. Factors Affecting Extent of Achievement

a) Indicate the extent to which the following positive(+) or negative(-) factors significantly affected achievement of major objectives:

	Substantial	Partial	Negligible	Not Available
Factors Not Generally Subject to Government Control				
World markets/prices	☐	☑	☐	☐
Natural disasters	☐	☐	☐	☐
Bank performance	☐	☑	☐	☐
Cofinancier(s) performance	☐	☐	☐	☐
Performance of contractors/ consultants **8/**	☐	☑	☐	☐
War/civil disturbances	☐	☐	☐	☐
Other (specify):_____	☐	☐	☐	☐

Factors Generally Subject to Government Control

Macro policies/conditions	☐	☐	☐	☐
Sector policies	☐	☐	☐	☐
Government commitment	☐	☐	☐	☐
Appointment of key staff	☐	☐	☐	☐
Counterpart funds	☐	☐	☐	☐
Administrative procedures	☐	☐	☐	☐
Other (specify):_____	☐	☐	☐	☐

Factors Generally Subject to Implementing Agency Control

Management	☐	☐	☐	☐
Staffing	☐	☐	☐	☐
Cost changes	☐	☐	☐	☐
Implementation delays	☐	☐	☐	☐
Use of technical assistance	☐	☐	☐	☐
Monitoring and evaluation **9/**	☐	☐	☐	☐
Beneficiary participation	☐	☐	☐	☐
Other (specify):_____	☐	☐	☐	☐

b) If cost changes were a substantial or partial factor, indicate the major reasons(s): **10/**

+/-

Change in project scope/scale/design	☑ −
Deficient estimate of physical quantities	☑ −
Deficient estimate of base unit costs	☑ −
Deficient price contingencies	☐
Changes in exchange rates	☑ +
Implementation delay	☐
Performance of contractor(s)	☐
Other (specify): _____	☐

c) If implementation delays were a substantial or partial factor, indicate period from signing to physical completion (or final disbursement for adjustment loans) (in years):

Appraisal Estimate	Actual or Latest Estimate	Applicable Disbursement Profile 11/
_____	_____	_____

Indicate the major reason(s) for implementation delays:

Implementation schedule unrealistic	☑
Project preparation incomplete	☐
Unexpected technical difficulties	☐

Change(s) in project scope	☐
Quality of management	☐
Delays in selecting staff	☐
Delays in selecting consultants	☐
Delays in receiving counterpart funds	☐
Delays in receiving funds from Bank/ cofinanciers	☐
Inefficient procurement procedures	☐
Inefficient disbursement procedures	☐
Security problems	☐
Natural disasters	☐
Other (specify): _____	☐

4. Project Sustainability

a) To what extent is the project likely to maintain an acceptable level of net benefits throughout its economic life?

Likely	Unlikely	Uncertain
☐	☑	☐

If sustainability is likely or unlikely, indicate the major reason(s):

+/−

Government commitment	☑ +
Policy Environment	☐
Institution/management effectiveness	☑ −
Economic viability	☐
Technical viability	☐
Financial viability	☑ −
Environmental viability	☐
Social impact/local participation	☐
Other (specify): _____	☐

b) Does the project include a plan for longer-term project operations after Bank participation has terminated?

Plan satisfactory ☐ Plan unsatisfacatory ☐ No plan ☑

D. Special Emphases

1. Public Policy Reform **12/**

Did the project objectives include reform of public policies?

Yes ☐ No ☑

If yes, categorize the extent of achievement of these objectives:

	Substantial	Partial	Negligible	Not Available
a. Planning public investments/expenditures	☐	☐	☐	☐
b. Budget process	☐	☐	☐	☐
c. Tax system	☐	☐	☐	☐
d. Monetary reform	☐	☐	☐	☐
e. Debt management	☐	☐	☐	☐
f. Exchange rate management	☐	☐	☐	☐
g. Trade/tariff/etc.	☐	☐	☐	☐
h. Civil service reform	☐	☐	☐	☐
i. Regulation of private sector	☐	☐	☐	☐
j. Government relation to public enterprises	☐	☐	☐	☐
k. Restructuring of public enterprises	☐	☐	☐	☐
l. Procurement policies	☐	☐	☐	☐
m. Labor legislation	☐	☐	☐	☐
m. Other (specify):_____	☐	☐	☐	☐
Overall	☐	☐	☐	☐

If overall achievement was substantial or negligible, indicate the major reason(s):

Sufficiency of Government commitment	☐
Adequacy of preparation/design	☐
Institutional effectiveness	☐
Realism of objectives	☐
Other (specify): _____	☐

2. Social Concerns

a) Did the project address specific social groups?

Yes ☑ No ☐

But 80% to Association; Ministry & central functions

Smaller component to extend district system to rural area

If yes, what characterized these groups?

a.	Socio-economic status (i.e. poverty) **13/**	☐
b.	Gender (i.e., women, girls) **14/**	☐
c.	Ethnicity (i.e. indigenous or tribal peoples) **15/**	☐
d.	Community type or locale (e.g. resettlement) **16/**	☑ Rural
e.	Other (specify): _____	☐

Categorize extent of achievement of (original or revised) social objectives:

Substantial	Partial	Negligible	Not Available
☐	☐	☑	☐

If achievement was substantial or negligible, indicate the major reason(s), and in the parentheses give the letter(s) indicating to which group(s) the reason applies: +/-

Adequacy of project design	( ) ( )	☑ -
Sufficiency of Government/borrower commitment	( ) ( )	☐
Institutional effectiveness	( ) ( )	☐
Sufficiency of NGO/beneficiary participation	( ) ( )	☐
Realism of objectives	( ) ( )	☐
Other (specify): Inadequate funds in part viz. of delays	( ) ( )	☑ -

b) Did the project have significant unintended/unexpected positive or negative effect(s) on special groups?

Positive ☐ Negative ☐ No ☑ Unknown ☐

Comment(s):_____

_____

_____

3. Environmental Concerns **17/**

a) Did the project objectives include enhancement or protection of the environment?

Yes ☐ No ☑

If yes, in what area(s):

Natural resource management ☐

Biological Diversity ☐

Air quality ☐

Water quality ☐

Soil quality ☐

Global warming/ozone depletion ☐

Noise ☐

Preservation of cultural heritage **18/** ☐

Other (specify): _____ ☐

Categorize extent of achievement of environmental objectives:

Substantial	Partial	Negligible	Not Available
☐	☐	☐	☐

If achievement was substantial or negligible, indicate the major reasons(s):

Adequacy of design/environmental assessment ☐

Consistency with National Environmental Action Plan ☐

Sufficiency of government/borrower commitment ☐

Institutional effectiveness ☐

Consultants ☐

NGOs/beneficiaries participation ☐

Realism of objectives ☐

Other (specify): _____ ☐

Did the project have significant unintended/unexpected positive or negative effect(s) on the environment?

Positive ☐ Negative ☐ No ☐ Unknown ☐

Comment(s): _____

_____

_____

4. Private Sector Development **19/**

Did the project include objectives to enhance/strengthen the role of the private sector?

Yes ☐ No ☑

If yes, categorize the extent of achievement of these objectives:

Substantial	Partial	Negligible	Not Available
☐	☐	☐	☐

If achievement was substantial or negligible, indicate the major reason(s):

Adequacy of preparation/design ☐

Sufficiency of government/borrower commitment ☐

Adequacy of legal framework ☐

Degree of private sector interest ☐

Institutional strengths/weaknesses ☐

Realism of objective(s) ☐

Other (specify): _____ ☐

E. Bank/Borrower Performance

I. Bank Performance

1. Categorize the quality of Bank performance in the identification of the project: **20/**

	Highly Satis-factory	Satis-factory	Deficient	Not Avail able
Project consistency with Government development strategy priority	☐	☑	☐	☐
Project consistency with Bank strategy for country	☐	☑	☐	☐
Other (specify):_____	☐	☐	☐	☐
Overall	☐	☐	☐	☐

2. Categorize the quality of Bank performance in assisting the Borrower with project preparation by major areas and overall: **20/**

	Highly Satisfactory	Satis-factory	Deficient	Not Available
Technical	☐	☐	☐	☑
Financial	☐	☐	☐	☑
Economic	☐	☐	☐	☐
Commercial	☐	☐	☐	☐
Institutional	☐	☐	☐	☑
Environment	☐	☐	☐	☐
Sociological	☐	☐	☐	☐
Overall	☐	☐	☐	☑

If the overall assessment of preparation assistance is highly satisfactory or deficient, identify the major reason(s):

- Staff quantity ☐
- Degree of Bank involvement ☐
- Staff quality (skill mix, continuity) ☐
- Consultants ☐
- Other (specify): _____ ☐

3. Categorize the quality of Bank performance in project appraisal by major areas and overall:**21/**

	Highly Satisfactory	Satis-factory	Deficient	Not Available
Technical	☐	☐	☐	☑
Financial	☐	☐	☑	☐
Economic	☐	☐	☐	☐
Commercial	☐	☐	☐	☐
Institutional	☐	☐	☑	☐
Environment	☐	☐	☐	☐
Sociological	☐	☐	☐	☐
Overall	☐	☐	☑	☐

Categorize the quality of appraisal by major generic subject(s):

	Highly Satis-factory	Satis-factory	Deficient	Not Available
Appraisal of commitment of government/implementing agency/ beneficiaries	☐	☐	☑	☐
Appraisal of borrower/implementing agency capacity	☐	☐	☑	☐
Project complexity	☐	☐	☑	☐
Recognition of project risks/key variables **22/**	☐	☑	☐	☐
Adequacy of implementation plan/ performance indicators	☐	☐	☑	☐
Suitability of lending instrument	☐	☑	☐	☐
Taking into account adequately past experience	☐	☐	☐	☐
Other (specify)	☐	☐	☐	☐

If the overall assessment of appraisal is highly satisfactory or deficient, identify the major reason(s):

Staff quantity	☐	☐	☐	☑
Staff quality (skill mix, continuity	☐	☐	☐	☑
Consultants (quality, continuity)	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐

4. Categorize the quality of Bank supervision: 23/

	Highly Satis-factory	Satis-factory	Deficient	Not Available
Reporting of project implementation progress	☐	☑	☐	☐
Identification/assessment of implementation problems	☐	☑	☐	☐
Attention to likely development impact	☐	☐	☐	☑
Advice to implementing agency	☐	☐	☐	☑
Adequacy of follow-up on advice/ decisions	☐	☐	☐	☑
Enforcement of loan covenants/ exercise of remedies	☐	☑	☐	☐
Flexibility in suggesting/ approving modifications	☐	☑	☐	☐
Other (specify) _____	☐	☐	☐	☐
Overall	☐	☑	☐	☐

If the overall assessment of supervision is highly satisfactory or deficient, identify the major reason(s):

Staff quantity	☐	☐	☐	☐
Sufficiency of time in field	☐	☐	☐	☐
Staff quality (skill mix, continuity)	☐	☐	☐	☐
Consultants (quality, continuity)	☐	☐	☐	☐

Supervision plans	☐	☐	☐	☐
Timing of supervision missions	☐	☐	☐	☐
Country implementation reviews	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐

II. Government/Implementing Agency Performance

1. Categorize the quality of project preparation in these areas and overall: **20/**

	Highly Satisfactory	Satis-factory	Deficient	Not Avail-able
Technical	☐	☐	☐	☐
Financial	☐	☐	☑	☐
Economic	☐	☐	☐	☐
Commercial	☐	☐	☐	☐
Institutional	☐	☐	☑	☐
Environment	☐	☐	☐	☐
Sociological	☐	☐	☐	☐
Overall	☐	☐	☑	☐

2. Categorize the quality of project implementation in these areas and overall:

	Highly Satisfactory	Satis-factory	Deficient	Not Avail-able
a. Macro policies	☐	☐	☐	☐
b. Sector policies	☐	☑	☐	☐
c. Institutional development	☐	☐	☑	☐
d. Physical objectives	☐	☐	☑	☐
e. Social objectives	☐	☐	☐	☐
Overall	☐	☐	☑	☐

If the overall assessment of project implementation is highly satisfactory or deficient, identify the major reason(s):

+/-

Quality of management	☑ –
Quality of staff	☐
Performance of contractor(s)	☐
Performance of consultant(s) **8/**	☑ –
Government commitment	☐
Government interference	☐
Adequacy of project monitoring/ evaluation	☑
Other (specify): Investment Management	☐ –

3. To what extent did the Government/Implementing Agency comply with major loan covenants/commitments:

	Substantial	Partial	Negligible	Not Available
Macro policies	☐	☐	☐	☐
Sector policies	☐	☑	☐	☐
Institutional changes	☐	☐	☑	☐
Effective management/ staffing	☐	☐	☑	☐
Financial improvements (tariffs, user charges, etc.) **24/**	☐	☐	☐	☐
Provision of counterpart funds	☐	☐	☑	☐
Increased efficiencies/ cost reductions	☐	☐	☐	☐
Procurement **25/**	☐	☐	☐	☑
Progress reports	☑	☐	☐	☐
Accounts and Audits **26/**	☑	☐	☐	☐
Use of technical assistance **27/**	☐	☑	☐	☐
Studies	☐	☑	☐	☐
Other (specify): _____	☐	☐	☐	☐
Overall	☐	☑	☐	☐

F. Overall Performance Assessment

1. Considering the project objectives (original or revised) and the extent of their achievement, give your assessment of the overall success (or likely success) of the project:

Highly Satisfactory	Project achieved or exceeded all its major relevant objectives and has achieved or is certain to achieve substantial development results, without major shortcomings.	☐
Satisfactory	Project achieved most of its major relevant objectives and has achieved or is expected to achieve satisfactory development results with only few major shortcomings.	☐
Unsatisfactory	Project failed to achieve most of its major relevant objectives, has not and is not expected to yield substantial development results and has significant shortcomings.	☑
Highly Unsatisfactory	Project failed to achieve any of its major relevant objectives and has not and is not expected to yield any worthwhile development results.	☐

Note: An ERR of 10% or more for a major portion of the total investment, or other significant benefits if the ERR was less than 10%, is necessary to meet the minimal requirements for a "Satisfactory" project. Projects with an ERR of more than 10% might be "Unsatisfactory" if major policy/institutional objectives were not met or if significant external costs are omitted. Where ERRs are not estimated, the overall performance rating is made on the basis of cost-effectiveness in achieving project objectives.

2. Does the above assessment differ from that in the PCR?

Yes ☐ No ☑ Not available ☐

If yes, comment on the difference(s):

____

____

3. Is this an outstanding project, for one or more of the following reasons:

Project has exceeded all its major objectives	☐
Project highly innovative	☐
Project success highly replicable	☐
Other (specify): __________________	☐

G. Key Lessons Learned

On the basis of the above evaluation, list the most significant positive and negative lessons learned from the success or failure of the project. Mark with an asterisk (*) those lessons most relevant for similar projects in sector/subsector or the country:

a. Need to manage consultants properly to obtain maximum benefits

b. Technical assistance must be geared to agency's absorption capacity

* c. National counterparts (to work with advisors/consultants) should be available at a start - indeed, [illegible] in position..

H. Comments*

---

* Comments are optional. They might include, for example, clarifying ambiguities in the ratings or important issues not brought out in the ratings. Comments of a confidential nature should be made in a separate note to the Division Chief.

EXPLANATORY NOTES *

1. The purpose of the Project Information Form (PIF) is to evaluate the project and abstract relevant findings and conclusions for use in OED's Annual Reviews. It standardizes and classifies most answers to facilitate data entry in a computerized form for easy aggregation (Bankwide, by region, country, sector, lending instrument, etc.). It is a core PIF, intended to capture important information generic to most sectors, and may be supplemented by sector-specific forms as determined by each Division. The PIF is to be completed for each project both for PCRs and Performance Audits. Boxes are to be marked only if applicable.

2. This includes only projects which have been restructured following a formal agreement between the borrower and the Bank that has been approved by or reported to the Executive Directors.

3. See relevant Country Brief or Country Strategy Paper; for SALs, see Policy Framework Paper.

4. Complexity is determined by such factors as the range of policy and institutional improvements, the number of institutions involved, the number of project components and their geographic dispersion, the number of cofinanciers, etc.

5. The objectives and how well they were achieved should be judged by the standards prevailing at the time of loan approval, not those at the time of the PCR. However, if the standards have changed during that period, this may be mentioned under Comments.

6. OD 10.50 deals with Financial Analysis and Management.

7. Section D covers more specific objectives such as public policy reforms, poverty alleviation, and environmental improvements.

8. OD 11.10, Annex F deals with the Evaluation of Consultant Performance and OD 11.13 with Reporting of Consultants' Performance.

9. OD 10.70 deals with Project Monitoring and Evaluation.

10. OD 6.50 deals with Project Cost Estimates and Contingency Allowances.

11. OD 6.50, Annex C deals with Disbursement Profiles.

---

* Not all ODs referred to have been issued but the Table of Contents to the Operational Manual provides references to relevant OMSs, OPNs or other guidelines.

12. OD 5.00 deals with Public Sector Management and OD 5.10 with Public Enterprise and Divestiture.

13. OD 4.15 deals with Poverty Reduction; OD 10.40, Annex E with Estimating the Poverty Impact of Projects.

14. OD 4.10 deals with Women in Development.

15. OD 4.20 deals with Indigenous People.

16. OD 4.30 deals with Involuntary Resettlement.

17. ODs 4.00, 4.01, and 4.02 deal with Environmental Policies, Assessment and Action Plans.

18. OD 4.25 deals with Cultural Property.

19. OD 5.20 deals with Private Sector Development.

20. OD 10.00 deals with Project Generation and Preparation.

21. OD 10.10 deals with Project Appraisal and ODs 10.20-40 deal more specifically with Technical, Sociological, Institutional and Economic criteria.

22. OD 10.40, Annex C deals with Risk and Sensitivity Analysis.

23. OD 13.05 deals with Project Supervision.

24. OD 6.00 deals with Cost Recovery and the Pricing of Public Goods.

25. ODs 11.00, 11.02 and 11.03 deal with Procurement.

26. OD 13.10 deals with Borrower Compliance with Audit Covenants.

27. OD 8.40 deals with Technical Assistance.

OPERATIONS EVALUATION DEPARTMENT

QUALITY OF PROJECT COMPLETION REPORT (PCR)[1/]

1. Project Identification

Country: Guinea-Bissau

Project Name: Population Health and Nutrition

Sector/Subsector: PHN

Lending Instrument: Credit

Loan or Credit No: 1800-GUB

Date of Review: 2-20-93

Evaluating Officer: R. Rijker

Division Chief: Donaldson

A. PCR Quality

2. The quality of the PCR is:

	Highly Satisfactory:[2/]	Satisfactory [3/]	Unsatisfactory [4/]	Highly Unsatisfactory [5/]
Coverage of important subject(s)	☐	☑	☑	☐
Availability of key data	☐	☑	☐	☐

1/ To be completed for every PCR

2/ No significant qualifications.

3/ Some qualifications but generally acceptable.

4/ Significant qualifications but they would have been readily susceptible to improvement.

5/ Significant qualifications which would not have been readily susceptible to improvement.

Soundness of judgment(s)				
(i) internal consistencies	☐	☑	☐	☐
(ii) evidence complete/convincing	☐	☑	☐	☐
Adequacy of analysis	☐	☑	☐	☐
Consistency with SAR/ revised project	☐	☑	☐	☐
Presentation	☐	☑	☐	☐
Other (specify):____	☐	☐	☐	☐
Overall	☐	☑	☐	☐

Comments: _____

_____

_____

B. Borrower Views

3. Are the views of the borrower included in the PCR?

Yes ☑ No ☐

If no, give reason(s):

_____

_____

If yes, are there significant differences between Bank and Borrower views?

Yes ☐ No ☑

If yes, comment:

_____

_____

C. OED Database

4. Identify key data in the PCR (including relevant Annexes) which are missing, incorrect or dubious and indicate whether they should be included, qualified, corrected or excluded from the OED database:

a) (i) Original data _____

(ii) Treatment in OED database _____

b) (i) Original data _____

(ii) Treatment in OED database _____

OPERATIONS EVALUATION DEPARTMENT

PRIORITY OF PROJECT FOR PERFORMANCE AUDIT AND IMPACT EVALUATION[1/]

1. Project Identification

Country: Guinea-Bissau

Project Name: Pop. Health & Nutrition Proj.

Sector/Subsector: P-H-N

Lending Instrument: Credit

Loan or Credit No: IDA-GL3

Date of Review: 2-20-92

Evaluating Officer: R. Rijkers

Division Chief: G Donaldson

A. Performance Audit

2. The priority of the project for performance audit is:

High ☐ Medium ☐ Low ☑

3. If the priority is high or medium, indicate reason(s):

Project is an adjustment operation ☐

Project is the first of its type in the subsector in the country ☐

Project is part of a series of projects which are suitable for packaging in a combined audit ☐

1/ To be completed for every PCR

Project is large and complex	☐
Project has especially innovative and unusual features	☐
Project was highly successful in a difficult sector/ country	☐
PCR was incomplete/not satisfactory	☐
Project is likely to have high priority for impact evaluation	☐
OED and Operations disagree on performance rating	☐
An Executive Director has proposed audit	☐
Project is or is likely to be of considerable public interest	☐
Audit is required for special studies	☐
Other (specify): _____	☐

4. If the priority is high or medium, what are the major issues on which the audit should focus?

a) _____

_____

b) _____

_____

c) _____

_____

B. Impact Evaluation

5. The preliminary priority of the project for impact evaluation is:

High ☐ Medium ☐ Low ☑

6. If the priority is high or medium, indicate reason(s):

*Project has a high or medium priority for performance audit or a satisfactory PCR ☐

*A satisfactory data/monitoring and evaluation system for the project exists ☐

Project gives high priority to special emphases (e.g., public sector reform, social concerns, environment, private sector development) ☐

Project is reasonably representative for sector/ subsector ☐

Project has experimental/innovative features ☐

Project is large and complex ☐

Project has considerable indirect costs and benefits/externalities ☐

Project is likely to be in operation at time of impact study ☐

Project sustainability is uncertain ☐

Project is part of a series of projects which are suitable for packaging in a combined evaluation ☐

Evaluation is required for special studies ☐

Project is or is likely to be of considerable public interest ☐

Project type not well covered by previous impact evaluations ☐

Other (specify): _____ ☐

---

* These criteria are prerequisites for impact evaluation.

THE WORLD BANK/IFC/MIGA

OFFICE MEMORANDUM

DATE: March 5, 1993

TO: Mr. Edwin R. Lim, Director, AF4

FROM: Hans-Eberhard Köpp, Director, OED

EXTENSION: 31700

SUBJECT: GUINEA-BISSAU: Population, Health and Nutrition (Cr. 1800-GUB)
Project Completion Report

Attached is the Review Note from the Director-General, Operations Evaluation on the above PCR. It is scheduled to be sent together with the PCR to the Print Shop two weeks from today, for release to the Executive Directors and the President.

Based on OED's review of the PCR, we intend to include in the OED Annual Review database the following ratings of the operation:

Overall assessment: Unsatisfactory

Sustainability: Unlikely

Institutional Development: Partial

Should the project be audited at a later date, the ratings will be reevaluated at that time.

Attachment

R.Ridker/pb
G.Donaldson

THE WORLD BANK
Washington, D.C. 20433
U.S.A.

Office of Director-General
Operations Evaluation

March 31, 1993

MEMORANDUM TO THE EXECUTIVE DIRECTORS AND THE PRESIDENT

SUBJECT: Project Completion Report on Guinea-Bissau
Population, Health and Nutrition Project (Credit 1800-GUB)

Attached is a copy of the report entitled "Project Completion Report on Guinea-Bissau - Population, Health and Nutrition Project (Credit 1800-GUB)" prepared by the Africa Regional Office. Part II was prepared by the Borrower.

The outcome of this project--meant to simultaneously support the institutional development of the Ministry of Public Health and to strengthen the delivery of health and family planning services--was unsatisfactory. Little training and institutional building took place, in part because of failure to provide counterpart staff, and most health center remodeling had to be cancelled because of construction delays.

The outcome was conditioned by inadequate preparation, overambitious design, and failure of the Borrower to provide agreed-to counterpart funds. This project is a good example of excessive reliance on technical assistance even though some modest improvements in capacity occurred and lessons learnt are being incorporated into future programs. Many more years of institutional development will be necessary before sustainable operations are assured.

The Project Completion Report provides an accurate account of project implementation. The reasons for the failure of this project are well laid out and plans to take them into account in future operations are noted. An audit is not planned.

Attachment

THE WORLD BANK
Washington, D.C. 20433
U.S.A.

Office of Director-General
Operations Evaluation

MEMORANDUM TO THE EXECUTIVE DIRECTORS AND THE PRESIDENT

SUBJECT: Project Completion Report on Guinea-Bissau
Population, Health and Nutrition Project (Credit 1800-GUB)

Attached is a copy of the report entitled "Project Completion Report on Guinea-Bissau - Population, Health and Nutrition Project (Credit 1800-GUB)" prepared by the Africa Regional Office. Part II was prepared by the Borrower.

The outcome of this project--meant to simultaneously support the institutional development of the Ministry of Public Health and to strengthen the delivery of health and family planning services--was unsatisfactory. Little training and institutional building took place, in part because of failure to provide counterpart staff, and most health center remodeling had to be cancelled because of construction delays. The outcome was conditioned by inadequate preparation, overambitious design, and failure of the Borrower to provide agreed-to counterpart funds. This project is a good example of excessive reliance on technical assistance ~~to substitute for limited local absorptive capacity~~. Some modest improvements in capacity occurred. ~~But~~ many more years of ~~inputs of technical assistance, training, and financing~~ will be necessary before sustainable operations are assured.

The Project Completion Report provides an accurate account of project implementation. The reasons for the failure of this project are well laid out and plans to take them into account in future operations are noted. An audit is not planned.

Attachment

OPERATIONS EVALUATION DEPARTMENT
PCR REVIEW/AUDIT PROCESS/1

CONTROL SHEET

Project: GUINEA-BISSAU: Population, Health and Nutrition
Credit No. 1800-GUB
PCR Format (circle one): Old-Style / New-Style
Evaluating Officer: Ronald G. Ridker RGR. Date: 8-18-92
Approved by (Div. Chief or designate) Graham Donaldson

	Date (mo/dy/yr)
A. Timetable	
- PCR logged in by Division	07/01/92
- If incomplete, PCR returned to Region	7-24-92
- If PCR is unlogged	
In case evaluating officer requests Region to revise draft PCR: /2	
- Note to Regional task manager	7-24-92
- Follow-up memo from Division Chief, OED, to Sector Division Chief, Region, if revision delayed	
- Satisfactorily revised PCR received from Region	

B. If PCR Returned to Region for Revision

Nature of revision requested (circle one): (minor) major

Degree of hassle involved (circle one): (none) minor major

/1 In the case of a PPAR which does not include the PCR complete section E only.

/2 Please attach copy of note to regional task manager and follow-up memos if any.

C. Complete for Old-style PCRs

	YES	NO
Convenant requiring Borrower to prepare PCR /3	___	___
PCR prepared by:		
I. Borrower		
- Borrower staff or agencies	___	___
- FAP/CP or consultants /4	___	___
II. Bank		
- Bank staff	___	___
- Some input from Borrower	___	___
- Inadequate/incomplete Borrower PCR	___	___
Use of Borrower PCR in final document /5		
- As final PCR	___	___
- With overview	___	___
- An Annex to Bank PCR	___	___
- On file, Bank prepared its own PCR	___	___

D. Complete for New-style PCRs

Did Borrower complete Part II of the PCR?	✓	___
If yes,		
- Part II agree with Part I and III	✓	___
- Part II disagrees with Parts I and II	___	___

E. OED Staff and Consultants Input

	Days
Staff	2 1/2
Consultants	___
Total	2 1/2

Attachment(s): (See footnote 1, page 1)

/3 Please remember that a standard clause has been included in general conditions since January 1, 1985 (Article IX).
/4 The PCR is clearly identifiable as a consultancy firm product.
/5 Applies to item I.

OFFICE MEMORANDUM

DATE: July 24, 1992

TO: Ms. Carol Hoppy, AF4PH

FROM: Ronald Ridker, OEDD1 RRR

ENSION: 31739

UBJECT: Guinea-Bissau: PHN Project Completion Report

After consulting with the Division Chief about some of the things we discussed, I decided to return the PCR to you for completion. Part II does have to be in English. If it says anything that disagrees with Part I, Part I should reflect or comment on it. The completion (dispersement complete) date expected and actual needs to be added. And to the extent you have the time, it would be useful to make the PCR a bit more forthcoming and transparent, for example, reflecting some of the things we talked about. As it now stands, it is too terse, in relevant sections hardly more detail than in the Evaluation Summary.

On the issue of objectivity--having someone not connected with the project write the PCR. The PCR process is supposed to be a self-evaluation process. OED then follows up (in 40% of the cases) with an independent review. So even if written by a consultant, it should reflect your viewpoint--how you or your office assesses the project and the performance of various actors, why you think it had the outcome it did, what you learned from it that could help future operations.

The contractors and consultants certainly should be among those whose performance is assessed--eg. the TA component accomplish its purposes, and why or why not? But apparently your legal department is correct in indicating that the comments should be passed by them, allowing them time to respond. While this takes more time, it is often time worth spending, and probably would have been in this case..

cc: Mr. Donaldson, OEDD1

OPERATIONS EVALUATION DEPARTMENT
PCR REVIEW/AUDIT PROCESS/1

CONTROL SHEET

Project: GUINEA-BISSAU: Population, Health and Nutrition
Credit No. 1800-GUB
PCR Format (circle one): Old-Style / New-Style
Evaluating Officer: Ronald G. Ridker RGR. Date: 8-18-92
Approved by (Div. Chief or designate) Graham Donaldson

	Date (mo/dy/yr)
A. Timetable	
- PCR logged in by Division	07/01/92
- If incomplete, PCR returned to Region	7-24-92
- If PCR is unlogged	
In case evaluating officer requests Region to revise draft PCR: /2	
- Note to Regional task manager	7-24-92
- Follow-up memo from Division Chief, OED, to Sector Division Chief, Region, if revision delayed	
- Satisfactorily revised PCR received from Region	

B. If PCR Returned to Region for Revision

Nature of revision requested (circle one): (minor) major

Degree of hassle involved (circle one): (none) minor major

/1 In the case of a PPAR which does not include the PCR complete section E only.

/2 Please attach copy of note to regional task manager and follow-up memos if any.

C. Complete for Old-style PCRs

	YES	NO
Convenant requiring Borrower to prepare PCR /3	____	____
PCR prepared by:		
I. Borrower		
- Borrower staff or agencies	____	____
- FAP/CP or consultants /4	____	____
II. Bank		
- Bank staff	____	____
- Some input from Borrower	____	____
- Inadequate/incomplete Borrower PCR	____	____
Use of Borrower PCR in final document /5		
- As final PCR	____	____
- With overview	____	____
- An Annex to Bank PCR	____	____
- On file, Bank prepared its own PCR	____	____

D. Complete for New-style PCRs

Did Borrower complete Part II of the PCR?	✓	____
If yes,		
- Part II agree with Part I and III	✓	____
- Part II disagrees with Parts I and II	____	____

E. OED Staff and Consultants Input

	Days
Staff	2 1/2
Consultants	____
Total	2 1/2

Attachment(s): (See footnote 1, page 1)

/3 Please remember that a standard clause has been included in general conditions since January 1, 1985 (Article IX).
/4 The PCR is clearly identifiable as a consultancy firm product.
/5 Applies to item I.

OPERATIONS EVALUATION DEPARTMENT

NOTE OF RECORD

REVIEW OF PROJECT COMPLETION REPORT

GUINEA-BISSAU: POPULATION, HEALTH AND NUTRITION
(CR. 1800-GUB)

Recommendations

1. I recommend that the PCR for this project be released to the Executive Directors and the President.

Origin and Quality of the PCR

2. This is a new-style PCR, Parts I and III prepared by the Bank, Part II by the Government. It is of satisfactory quality, though it is too terse to be as transparent as it should be.

Overall Project Assessment and Main Issues

3. The two objectives of the project were (a) to improve the institutional capabilities of the Ministry of Public Health and (b) to strengthen the delivery of health and family planning services especially at the rural health center level. The means for doing this were complex, including equipment, operating supplies, training, TA, construction, etc.

4. The results were unsatisfactory, compared to the original objectives as specified in the SAR, although the project did accomplish enough for the PCR to claim that it laid the foundation for more satisfactory future work. The principal problem was the original design of the project that was far too ambitious for this country whose absorptive capacity was extremely limited at the time and which had no prior experience with Bank health projects. The Bank tried hard, through substantial supervision missions, and did get something accomplished, but not enough to warrant a satisfactory rating.

5. What was accomplished is probably sustainable assuming the PCR is correct that the project laid a foundation on which to build. Hence, the project is rated as marginally sustainable.

6. This was an early PHN project whose parameters were picked up from other countries with more implementation capacity and incorrectly applied to this country. It was something of a Christmas tree, designed centrally by people with little knowledge of local conditions; there was little attempt to achieve local 'ownership', little attempt to work with other donors or NGOs. Hardly a formula for success in a country with little central implementation capacity and 34 ethnic/linguistic groups scattered thinly over a large area. Considering the nature of future operations, the region seems to have learned these lessons well, though it is not fully reflected in the PCR as it might have been. Current thinking is that it is necessary to mobilize organizations familiar with these local groups to tailor general principles to local needs and interests.

Recommendations for Follow-Up

7. This is the first project in this sector. On the other hand, it is small and has very little in common with current thinking. Still, it might be appropriate for audit for the historical record. The problem is, according to the current task manager, there is almost no one familiar with the project in the country today: it was implemented by non-Guinea Africans who are long gone.

5. The PIF is attached.

Prepared by:

Ronald G. Ridker _____ (signature) 8-10-92 (date)

Reviewed by:

Graham Donaldson _____ (signature) 8.25.92 (date)

DRAFT
6/14/90

OPERATIONS EVALUATION DEPARTMENT

PROJECT INFORMATION FORM FOR ANNUAL REVIEW 1992
(to be completed for each project evaluated)*

Date: 8-18-92

Completed by: Ronald G. Ridker RGR

1. Project Name: Population, Health and Nutrition (Credit 1800-GUB)

2. Country: GUINEA-BISSAU

3. Sector: PHN

4. Subsector: _____

5. Poverty Alleviation/Rural Development Project: Yes ☐ No ☑

6. PCR review ☑ PPAR revision** ☐

7. Was this project included in a previous Annual Review? No

   If yes, in what year? _____

8. Bank Loan/Credit (US$ millions)

	Loan	Credit	Total
Approved:		4.2	
Cancelled:			
Disbursed:		4.2	

* For each project at PCR review and at Audit if audit is done subsequently.

**Revisions at audit can be inserted by overwriting in a different color and box so indicated.

9. Total Project Cost (US$ millions)

Appraisal Estimate: 4.4

Actual: 4.6

10. Key Project Dates (month/year, when available)

Appraisal: 12/86

Board Approval: 5/87

Loan/Credit Signing: 5/87

	Estimated in Loan/Credit Agreement	Actual
Effectiveness:	9/87	12/87
Completion: (Disbrsmt compl:	12/90	11/91
Closing: (Credit close):	6/91	12/91

**If physical components are not yet complete, please note. If the project contained several components with different completion dates, enter the last actual completion date.

11. Bank Processing and Supervision Performance

	Deficient	Adequate
Identification	☑	☐
Preparation	☐	☑
Appraisal	☑	☐
Supervision	☐	☑

Number of Supervision Missions: 10 + Completion mission.

12. Project Results

a. Rates of Return (%) | Economic | Financial

Estimated at Appraisal: _____ _____

Re-Estimated at Completion: _____ _____

RERR based on what percentage of total investment? _____

If re-estimated rate of return is not available, indicate reason:

Project Not Implemented: _____

Inadequate Data: _____

Other (specify): _____

b. Achievement of Objectives

Describe project objectives at appraisal (as defined in SAR).

To improve institl capacity of MOH/Health
To strengthen delivy of health & FP services

To what extent did the project achieve its appraisal objectives?

Inadequate

Describe any significant changes in project objectives following appraisal.

To what extent did the project achieve its revised objectives?

Categorize the extent of achievement of objectives in the following areas:

	Substantial	Partial	Negligible	N/A
Physical Investment	☐	☐	☑	☐
Sector or Macro Policies:	☐	☑	☐	☐
Institutional Development:	☐	☑	☐	☐
Environmental:	☐	☐	☐	☐

c. Factors Affecting Results

Note principal factors resulting in significant changes in the following (or identify relevant paragraphs):

Project Costs:

Project Scope:

Completion time:

Economic Rate of Return:

Note other factors, internal to the project (preparation, management, etc.) or external to the project (macroeconomic difficulties, civil disorders, weather, etc.) which significantly affected project outcome (Note relevant para. numbers).

Excessively ambitious for 1st project in a country w/ extremely poor human resources & instit'l capacity.

Lack (or timeliness) of local (budgetary) funding during implementation was:

☑ a major problem ☐ a minor problem ☐ not a problem

d. Overall Assessment

Considering all of the original (or revised) objectives, and actual (or expected) achievements (economic & social benefits, institutional development, policy impact, technology transfer, sustainability), give your own assessment of the overall success (or likely success) of the project:

Highly Satisfactory	Project achieved or exceeded all its major (original or revised) objectives, and achieved substantial results in almost all respects.	☐
Satisfactory	Project achieved most of its (original or revised) objectives and had satisfactory results with no major shortcomings	☐
Unsatisfactory	Project failed to achieve many of its (original or revised) objectives and had major shortcomings	☑
Very Unsatisfactory	Project failed to achieve most of its (original or revised) objectives, and had no foreseeable worthwhile results.	☐

Note: An ERR of 10% or more for a major portion of the total investment, or other significant benefits if the ERR was less than 10%, is necessary to meet the minimal requirements for a "Satisfactory" project.

e. Sustainability

To what extent is the project likely to maintain an acceptable level of net benefits throughout its economic life?

☐ likely ☐ unlikely

☑ marginal ☐ uncertain

f. Outstanding Project

Do you nominate this project for consideration as an outstanding project for highlighting in the Annual Review (i.e., outstandingly satisfactory in outcome or achievement)?

☐ Yes ☑ No

THE WORLD BANK/IFC/MIGA

OFFICE MEMORANDUM

DATE: September 28, 1992

TO: Mr. Edwin R. Lim, Director, AF4

FROM: Mr. Hans-Eberhard Köpp, Director, OED

EXTENSION: 31700

SUBJECT: GUINEA-BISSAU: Population, Health and Nutrition (Cr. 1800-GUB)
Project Completion Report

1. As you know, all PCRs are reviewed by OED prior to distribution to the Board. In this case, I am, after consultation with the DGO, returning the PCR to you for whatever amendments you may wish to make before resubmission. The reasons for this decision are outlined below.

2. Overall, the PCR is not clear and transparent in its judgements and does not provide adequate explanations for the judgements it does make. For example, the lessons learned do not clearly and obviously follow from the text and the analysis. More explicitly:

- It contains no explicit judgment as to whether the project outcome was, on the whole, satisfactory. In providing this judgement, the PCR should be sure to specify reasons for coming to that conclusion.

- No assessment is provided of cost effectiveness of the project, e.g., for the physical achievements of the project, has been given. At a minimum, unit costs should be presented.

- There is no explanation for the 230% increase in consultant costs while 5 out of the 8 studies were dropped.

- No assessment of project management has been provided except for generalities about the general weakness of country's institutions.

- The assessment of the quality of the Bank's supervision effort seems to be too positive since it did not confront basic design issues in a timely fashion.

- There is no information given on what happened to outcome indicators (for population, health and nutrition) over the course of the project. If no such indicators are available, it should be pointed out that design of the project failed to take care of this problem.

- No reference is made to a monitoring and evaluation component, which should have been included, as in all projects, and its accomplishments assessed in the PCR.

- The discussion of sustainability is muddy. Is sustainability likely or not? If only likely under certain circumstances, does the Region have any plans to ensure that these conditions are met?

- It is far from clear that the project was too ambitious. More to the point, the studies were poorly conceived and badly executed.

- The special account problem with the commercial bank is not clearly spelled out.

- The effectiveness of training and the cost recovery arrangements have not been spelled out.

- The technical assistance performance seems to have been very poor despite the statement in para 33.

- Public expenditure management is, apparently, an important issue for the health sector (see para 31), but the role of the Bank in this area is not spelled out.

3. I trust you will be able to take these comments into account and return the revised PCR to OED promptly. If the PCR is not returned within two months it will be "unlogged" and not shown as received in OED.

cc: (with attachment) Mr. Porter, AF4PH
Ms. Hoppy, AF4PH
(w/o attachment) Mr. Donaldson, OEDD1
Mr. Ridker, OEDD1
Ms. Alegre, OEDD1

R.Ridker/pb
G.Donaldson

THE WORLD BANK/IFC/MIGA

OFFICE MEMORANDUM

DATE: September 6 , 1992

TO: Mr. Robert Picciotto, DGO

FROM: H. Eberhard Köpp, Director, OED

XTENSION: 31700

SUBJECT: GUINEA-BISSAU: Population, Health and Nutrition Project (Cr. 1800-GUB)
Project Completion Report

OED has reviewed this Report. It was prepared by the Africa Regional Office with Part II contributed by the Borrower. The attached final version of the Report is now being released to the Executive Directors and the President.

Attachment

cc: Mrs. Hamilton, PHRDR
Mr. Lim, AF4DR

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

AUG 3 1 1992

ROUTING SLIP	DATE: AUG 27 1992
NAME	ROOM NO.
Mr. Eberhard Köpp, Director, OED	

	URGENT		PER YOUR REQUEST
	FOR COMMENT		PER OUR CONVERSATION
	FOR ACTION		SEE MY EMAIL
	FOR APPROVAL/CLEARANCE		FOR INFORMATION
	FOR SIGNATURE		LET'S DISCUSS
	NOTE AND CIRCULATE		NOTE AND RETURN

RE:

REMARKS: GUINEA-BISSAU: Population, Health and Nutrition (Cr. 1800-GUB) PCR

No special issues.

FROM:	ROOM NO.:	EXTENSION:
G. Donaldson, Chief, OEDD1		31730

THE WORLD BANK/IFC/MIGA

OFFICE MEMORANDUM

DATE: August 26, 1992

TO: Mr. Ian C. Porter, AF4PH

FROM: Graham Donaldson, Chief, OEDD1

EXTENSION: 31730

SUBJECT: GUINEA-BISSAU: Population, Health and Nutrition Project (Cr. 1800-GUB)
Project Completion Report

1. This PCR has been read in OED (copy attached). The project will not be subject to an audit at this stage but may be in the future.

2. We understand from reading the PCR that you rate the performance of this project as:

Overall Assessment: Unsatisfactory

Sustainability: Marginal

Institutional Development: Partial

Unless you advise us otherwise within 30 days, we will assume you agree with this understanding. The above rating will be shown as such for the purpose of the Annual Review of Evaluation Results.

Attachment

cc: (w/o attachment): Mr. Lim, AF4DR
Ms. Hoppy, AF4PH

R.Ridker/pb

THE WORLD BANK/IFC/MIGA

OFFICE MEMORANDUM

DATE: July 24, 1992

TO: Ms. Carol Hoppy, AF4PH

FROM: Ronald Ridker, OEDD1 RRR

XTENSION: 31739

SUBJECT: Guinea-Bissau: PHN Project Completion Report

After consulting with the Division Chief about some of the things we discussed, I decided to return the PCR to you for completion. Part II does have to be in English. If it says anything that disagrees with Part I, Part I should reflect or comment on it. The completion (dispersement complete) date expected and actual needs to be added. And to the extent you have the time, it would be useful to make the PCR a bit more forthcoming and transparent, for example, reflecting some of the things we talked about. As it now stands, it is too terse, in relevant sections hardly more detail than in the Evaluation Summary.

On the issue of objectivity--having someone not connected with the project write the PCR. The PCR process is supposed to be a self-evaluation process. OED then follows up (in 40% of the cases) with an independent review. So even if written by a consultant, it should reflect your viewpoint--how you or your office assesses the project and the performance of various actors, why you think it had the outcome it did, what you learned from it that could help future operations.

The contractors and consultants certainly should be among those whose performance is assessed--eg. the TA component accomplish its purposes, and why or why not? But apparently your legal department is correct in indicating that the comments should be passed by them, allowing them time to respond. While this takes more time, it is often time worth spending, and probably would have been in this case.

cc: Mr. Donaldson, OEDD1

THE WORLD BANK/IFC/MIGA

OFFICE MEMORANDUM

DATE: July 24, 1992

TO: Ms. Carol Hoppy, AF4PH

FROM: Ronald Ridker, OEDD1 RRR

EXTENSION: 31739

SUBJECT: Guinea-Bissau: PHN Project Completion Report

After consulting with the Division Chief about some of the things we discussed, I decided to return the PCR to you for completion. Part II does have to be in English. If it says anything that disagrees with Part I, Part I should reflect or comment on it. The completion (dispersement complete) date expected and actual needs to be added. And to the extent you have the time, it would be useful to make the PCR a bit more forthcoming and transparent, for example, reflecting some of the things we talked about. As it now stands, it is too terse, in relevant sections hardly more detail than in the Evaluation Summary.

On the issue of objectivity--having someone not connected with the project write the PCR. The PCR process is supposed to be a self-evaluation process. OED then follows up (in 40% of the cases) with an independent review. So even if written by a consultant, it should reflect your viewpoint--how you or your office assesses the project and the performance of various actors, why you think it had the outcome it did, what you learned from it that could help future operations.

The contractors and consultants certainly should be among those whose performance is assessed--eg. the TA component accomplish its purposes, and why or why not? But apparently your legal department is correct in indicating that the comments should be passed by them, allowing them time to respond. While this takes more time, it is often time worth spending, and probably would have been in this case.

cc: Mr. Donaldson, OEDD1

THE WORLD BANK/IFC/MIGA

OFFICE MEMORANDUM

DATE: November 25, 1992

TO: Mr. Hans-Eberhard Kopp, Director, OED

FROM: Edwin R. Lim, Director, AF4DR

EXT: 34858

SUBJECT: GUINEA-BISSAU: Population, Health and Nutrition (Cr. 1800-GUB)
Project Completion Report

1. In response to your memorandum of September 28, 1992, please find attached a revised version of the Project Completion Report (PCR) for the above project submitted to you on June 29, 1992.

2. Please note that in order to facilitate cross-reference with the points made in your memo (copy of which is attached), we have indicated in the left margin, the paragraphs where these points are being covered in the revised version of the PCR.

3. We do hope that this version will have addressed to your satisfaction the comments made.

cc (with attachment): Messrs./Ms. Agarwal (AF4DR); Porter, Hoppy, Angers (AF4PH); Division and Africa Files

cc (w/o attachment): Mr. Donaldson, Ms. Alegre (OEDD1)

b:ml (ja35-b)

THE ~~WORLD~~ BANK/IFC/MIGA

OFFICE MEMORANDUM

Good note!

DATE: September 28, 1992

TO: Mr. Edwin R. Lim, Director, AF4

FROM: Mr. Hans-Eberhard Köpp, Director, OED

EXTENSION: 31700

SUBJECT: GUINEA-BISSAU: Population, Health and Nutrition (Cr. 1800-GUB)
Project Completion Report

1. As you know, all PCRs are reviewed by OED prior to distribution to the Board. In this case, I am, after consultation with the DGO, returning the PCR to you for whatever amendments you may wish to make before resubmission. The reasons for this decision are outlined below.

2. Overall, the PCR is not clear and transparent in its judgements and does not provide adequate explanations for the judgements it does make. For example, the lessons learned do not clearly and obviously follow from the text and the analysis. More explicitly:

- It contains no explicit judgment as to whether the project outcome was, on the whole, satisfactory. In providing this judgement, the PCR should be sure to specify reasons for coming to that conclusion.

- No assessment is provided of cost effectiveness of the project, e.g., for the physical achievements of the project, has been given. At a minimum, unit costs should be presented.

- There is no explanation for the 230% increase in consultant costs while 5 out of the 8 studies were dropped.

- No assessment of project management has been provided except for generalities about the general weakness of country's institutions.

- The assessment of the quality of the Bank's supervision effort seems to be too positive since it did not confront basic design issues in a timely fashion.

- There is no information given on what happened to outcome indicators (for population, health and nutrition) over the course of the project. If no such indicators are available, it should be pointed out that design of the project failed to take care of this problem.

- No reference is made to a monitoring and evaluation component, which should have been included, as in all projects, and its accomplishments assessed in the PCR.

- The discussion of sustainability is muddy. Is sustainability likely or not? If only likely under certain circumstances, does the Region have any plans to ensure that these conditions are met?

- It is far from clear that the project was too ambitious. More to the point, the studies were poorly conceived and badly executed.

- The special account problem with the commercial bank is not clearly spelled out.

- The effectiveness of training and the cost recovery arrangements have not been spelled out.

- The technical assistance performance seems to have been very poor despite the statement in para 33.

- Public expenditure management is, apparently, an important issue for the health sector (see para 31), but the role of the Bank in this area is not spelled out.

3. I trust you will be able to take these comments into account and return the revised PCR to OED promptly. If the PCR is not returned within two months it will be "unlogged" and not shown as received in OED.

cc: (with attachment) Mr. Porter, AF4PH
Ms. Hoppy, AF4PH
(w/o attachment) Mr. Donaldson, OEDD1
Mr. Ridker, OEDD1
Ms. Alegre, OEDD1

R.Ridker/pb
G.Donaldson

THE WORLD BANK/IFC/MIGA

OFFICE MEMORANDUM

DEC 0 1 1992

DATE: November 25, 1992

TO: Mr. Hans-Eberhard Kopp, Director, OED

FROM: Edwin R. Lim, Director, AF4DR

EXT: 34858

SUBJECT: GUINEA-BISSAU: Population, Health and Nutrition (Cr. 1800-GUB)
Project Completion Report

1. In response to your memorandum of September 28, 1992, please find attached a revised version of the Project Completion Report (PCR) for the above project submitted to you on June 29, 1992.

2. Please note that in order to facilitate cross-reference with the points made in your memo (copy of which is attached), we have indicated in the left margin, the paragraphs where these points are being covered in the revised version of the PCR.

3. We do hope that this version will have addressed to your satisfaction the comments made.

cc (with attachment): Messrs./Ms. Agarwal (AF4DR); Porter, Hoppy, Angers (AF4PH); Division and Africa Files

cc (w/o attachment): Mr. Donaldson, Ms. Alegre (OEDD1)

b:m1 (ja35-b)

THE WORLD BANK/IFC/MIGA

OFFICE MEMORANDUM

DATE: September 28, 1992

SEP 29 1992

TO: Mr. Edwin R. Lim, Director, AF4

FROM: Mr. Hans-Eberhard Köpp, Director, OED

EXTENSION: 31700

SUBJECT: GUINEA-BISSAU: Population, Health and Nutrition (Cr. 1800-GUB)
Project Completion Report

1. As you know, all PCRs are reviewed by OED prior to distribution to the Board. In this case, I am, after consultation with the DGO, returning the PCR to you for whatever amendments you may wish to make before resubmission. The reasons for this decision are outlined below.

2. Overall, the PCR is not clear and transparent in its judgements and does not provide adequate explanations for the judgements it does make. For example, the lessons learned do not clearly and obviously follow from the text and the analysis. More explicitly:

Paragraph Reference Number in PCR:	
Para. 17	• It contains no explicit judgment as to whether the project outcome was, on the whole, satisfactory. In providing this judgement, the PCR should be sure to specify reasons for coming to that conclusion.
Paras. 13, 22, 23, and 24	• No assessment is provided of cost effectiveness of the project, e.g., for the physical achievements of the project, has been given. At a minimum, unit costs should be presented.
Para. 12 (a)	• There is no explanation for the 230% increase in consultant costs while 5 out of the 8 studies were dropped.
] ..s. 8 and 9	• No assessment of project management has been provided except for generalities about the general weakness of country's institutions.
Para. 27	• The assessment of the quality of the Bank's supervision effort seems to be too positive since it did not confront basic design issues in a timely fashion.
Para. 8	• There is no information given on what happened to outcome indicators (for population, health and nutrition) over the course of the project. If no such indicators are available, it should be pointed out that design of the project failed to take care of this problem.
Para. 8	• No reference is made to a monitoring and evaluation component, which should have been included, as in all projects, and its accomplishments assessed in the PCR.
Para. 26	• The discussion of sustainability is muddy. Is sustainability likely or not? If only likely under certain circumstances, does the Region have any plans to ensure that these conditions are met?

Para. 10 • It is far from clear that the project was too ambitious. More to the point, the studies were poorly conceived and badly executed.

Para. 16 • The special account problem with the commercial bank is not clearly spelled out.

Paras. 21, 23 • The effectiveness of training and the cost recovery arrangements have not been spelled out.

Para. 33 • The technical assistance performance seems to have been very poor despite the statement in para 33.

Para. 18 • Public expenditure management is, apparently, an important issue for the health sector (see para 31), but the role of the Bank in this area is not spelled out.

3. I trust you will be able to take these comments into account and return the revised PCR to OED promptly. If the PCR is not returned within two months it will be "unlogged" and not shown as received in OED.

cc: (with attachment) Mr. Porter, AF4PH
Ms. Hoppy, AF4PH
(w/o attachment) Mr. Donaldson, OEDD1
Mr. Ridker, OEDD1
Ms. Alegre, OEDD1

PROJECT COMPLETION REPORT

REPUBLIC OF GUINEA-BISSAU

POPULATION, HEALTH AND NUTRITION PROJECT
(CREDIT 1800-GUB)

November 25, 1992

Population and Human Resources
Operations Division
Western Africa Department

GLOSSARY

DHS	Demographic Health Survey
EEC	European Economic Community
MCH	Maternal and Child Health
MINSAP	Ministry of Public Health
MINSAS	Ministry of Health and Social Affairs
NGO	Non-Governmental Organization
PHC	Primary Health Care
PHN	Population, Health and Nutrition
SDR	Special Drawing Rights
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
WHO	World Health Organization

PROJECT COMPLETION REPORT

GUINEA BISSAU

POPULATION, HEALTH AND NUTRITION PROJECT (CREDIT 1800-GUB)

Table of Contents

LIST OF ANNEXES

REPUBLIC OF GUINEA-BISSAU

POPULATION, HEALTH AND NUTRITION PROJECT

CREDIT 1800-GUB

PROJECT COMPLETION REPORT

PREFACE

This is the Project Completion Report (PCR) for the first Population, Health and Nutrition Project in Guinea-Bissau, for which Credit 1800-GUB in the amount of SDR 3.4 million (March 1987, US$4.2 million equivalent) was approved on May 19, 1987. The Credit was closed on December 31, 1991, after having been extended six months beyond the original date. It was fully disbursed, and the last disbursement was made on April 9, 1992.

The PCR was prepared by the Population and Human Resources Operations Division of the Western Africa Department (Preface, Evaluation Summary, Parts I and III) and the Borrower (Part II).

This PCR report was initiated during the last supervision mission for the project in October 1991. A completion mission was conducted in January, 1992. This PCR is based, inter alia, on the Staff Appraisal Report; the Development Credit Agreement; supervision reports; correspondence between the Borrower and IDA; internal IDA memoranda; and interviews with Bank staff involved with the project.

PROJECT COMPLETION REPORT

REPUBLIC OF GUINEA-BISSAU

POPULATION, HEALTH AND NUTRITION PROJECT

(CREDIT 1800-GUB)

EVALUATION SUMMARY

Project Objectives

i. The Project's two basic objectives were: (a) to support the institutional development of the Ministry of Public Health (MINSAP) in planning, management and finance; and (b) to strengthen the delivery of health and family planning services, especially at the rural health center level. The project's near-term focus on improving essential services, combined with its complementary emphasis on improvements in the institutional framework, was expected to provide the basis for more extensive service delivery interventions in the future, toward achieving the Government goal of offering health services to 80 percent of the population by 1993 -- a challenging goal that underestimated the capacity of the health system to change and expand within a relatively short time span.

Implementation Experience

ii. Following effectiveness in December 1987, project implementation fell seriously behind schedule due in large part to MINSAP's institutional weaknesses that had been originally identified as risks. It should also be noted that the period immediately preceding credit effectiveness and beginning of implementation coincided with IDA's reorganization which resulted in the replacement of the entire team for this project; this probably added to the delays. A major variance between planned and actual project implementation were large shifts in expenditures from civil works, operating (incremental recurrent) costs and goods and services, to consultants and fellowships. Remodeling of 25 rural health centers was not implemented according to the original design; after an assessment of rehabilitation needs in 1988 it was found that 10 of the 25 centers identified at appraisal were beyond repair. Consequently, detailed architectural designs including adaptations to sites were completed between October, 1988 and 1990 for only 15 centers; in spite of the smaller number of centers considered for repair, the total cost for rehabilitating them exceeded by far the original appraised estimates (in 1988 it was estimated that US$1,030,400 would be needed for repairing 15 centers, compared to the original estimate of $430,000 for 25 centers); this difference was attributed by the IDA staff and the project management unit to initial underestimates in unit costs, scope of work, and inflation. In 1990, after

long delays in completing the architectural designs, and when credit funds had already been disbursed for other categories (particularly for category 3 -- technical assistance and training) little credit funds remained for construction and only two centers were rehabilitated with IDA financing, at a cost of under $50,000. Other donors were requested to finance rehabilitation works for about US$1 million (outside this project).

iii. Regarding other project components, in spite of the heavy use of consultants in this project and the moderate success in producing studies and reports, little consultancy related training and institution building took place due in part to personnel vacancies in the implementing agency and their non-replacement for periods of over two years. The project director -- a foreign consultant -- and his staff assumed a main role in implementation and in communications with IDA. The project management unit performed reasonably well its functions as handler of communication flow with IDA, but was not as successful in establishing a good rapport with MINSAP, particularly after a new minister took over in 1990. Regarding cost control and management of consultants, neither the management unit, nor MINSAP had a good grasp of the situation. The lack of Government counterpart funds persisted during project execution in spite of consistent follow up by IDA staff; at credit closing, the Government contribution was $61,900 compared to $210,000 required.

Results

iv. Overall impact of the project was unsatisfactory. Project achievements fell short of ambitious appraisal scope and design complexity. The benefits of components such as technical assistance and provision of recurrent costs (mostly incremental, but also comprising emergency assistance during epidemics) were low in relation to their costs. Nevertheless, there were modest accomplishments in training and human resource development and in PHN data collection; the project also managed to implement initial actions towards cost-recovery, better drug system management, improved rural supervision, and preliminary administrative reform within MINSAP. Because this project represents the first attempt by any donor in Guinea-Bissau to assist the health sector as a whole (as opposed to individual projects or sites), the mentioned contributions are noteworthy.

Sustainability

v. Because of the low financial base for supporting health services, the lack of a clear financial plan, the large proportion of funding from external donors and MINSAP's limited capacity as managing agency for the sector, this project placed particularly strong emphasis on sustainability from the outset. Although the sector continues to rely heavily on technical assistance, the rudiments of an infrastructure are now in place for data collection and analysis, drug management and supervision of health services, resulting from training and other activities that took place under this project. Even so, the health system still lacks the competence for self-sustainment and growth and will need perhaps at least another decade to reach a level of adequate financial and technical sustainability. A follow-on

Social Sectors Project will have fewer components and will emphasize capacity building and substantially expand the human resource training begun with this project. The forthcoming project will also focus on technical assistance with stronger review and with built-in transfer of knowledge to national counterparts. In addition, it will have a social action fund to assist NGOs which have a good track record on the country, in developing micro-social sector projects and better reach those at the grass-root level.

Findings and Lessons Learned

vi. The project scope was over-ambitious and it had a complex design. In the light of institutional weaknesses, IDA showed flexibility and creativity during implementation. It also pursued persistently and effectively cooperation with other donors -- particularly WHO and UNICEF. However, there were some shortcomings, including the following: (a) earlier identification of the problems affecting the construction component would have enabled the adoption of alternative solutions for timely and successful civil works completion; and (b) a tighter control of the technical assistance costs, early detection of cost overruns, and closer attention to quality and utilization of consultants could have led to higher effectiveness and lower costs than achieved in the project.

vii. Initially the Government took several reassuring steps by appointing an expatriate Project Director, creating a Project Management Unit, and giving assurances regarding several changes in policy and organization. However, there were serious implementation problems when MINSAP allowed key managerial positions to remain vacant for over two years and the Ministry of Finance compromised implementation by failing to provide counterpart funds as agreed. Lessons learned by MINSAP included the need to manage consultancies properly to obtain effective benefits related to expenditures incurred, and the importance of assuming responsibility for oversight of the project management unit.

viii. The following lessons learned may be applied to future projects: Project preparation should select implementable key components; construction components should be properly prepared, although they are usually less significant than software components in addressing sector issues; although technical assistance is essential particularly when the capacity of the sector agencies is low, it should be tailored to the agency's absorptive capacity, and should be closely supervised; and project management units should help in institution building and receive close review from the management of the implementing agency. Further, national counterparts should always be involved in project preparation and start-up activities and, as much as possible, there should be continuity or, when staff changes are unavoidable, there should be well planned and smooth transition of Government counterparts during implementation.

REPUBLIC OF GUINEA-BISSAU

POPULATION, HEALTH AND NUTRITION PROJECT
(Credit 1800-GUB)

PROJECT COMPLETION REPORT

PART I. PROJECT REVIEW FROM BANK'S PERSPECTIVE

A. Project Identity

Project Name:	Population, Health and Nutrition Project
Credit No.:	1800-GUB
Credit Amount:	SDR 3.4 million (March 1987 US$4.2 million)
RVP Unit:	Western Africa Country Department IV
Country:	Republic of Guinea-Bissau
Sector:	Population, Health and Nutrition

B. Project Background

1. Sector Development Objectives. At the time of this project's appraisal, the stated goal of the Ten-Year Primary Health Care Plan 1984-93 under the responsibility of the Ministry of Public Health's (MINSAP) [1], was to reach, By 1993, 80 percent of the population with programs in Maternal and Child Health (MCH), immunization, essential drugs and endemic disease control. This was an evidently overambitious target for a country with a per capita income of less than US$180 and a health system bedeviled by serious shortcomings. Guinea-Bissau's health system is almost exclusively public and administered by MINSAP. IDA appraisal identified major constraints including: lack of full control over the allocation of expenditures (in 1986 over 85 percent of the MINSAP budget and 90 percent of drug procurement came from foreign assistance); low quality of services mainly due to irregular availability of medicines and materials at the service points, inadequate working conditions for the health personnel and uneven geographical distribution (medical personnel are heavily concentrated in the two national hospitals, located in the capital city); also, the physical infrastructure was deteriorated, and there were serious deficiencies in staff training, supervision, transport and recurrent budget for maintenance. Moreover, macroeconomic constraints curtailed the options for up-grading health care. A chronic shortage of foreign exchange and the declining real value of central budget allocations limited MINSAP funding and made it imperative to seek further external financial assistance for major restructuring and strengthening.

---

[1] In December 1991, this ministry was renamed the Ministry of Health and Social Affairs (MINSAS). For purposes of this report, however, the acronym "MINSAP" will be used.

2. Policy Context. At a donors' roundtable in 1986 the Government acknowledged that in order to increase the likelihood of coming close to the stated health service goal it would need to restructure the system and make more cost effective use of the existing infrastructure, rather than extend its health system through investments in new facilities. It agreed to several administrative and policy reforms and to improve hospital administration, drug system management, and financial planning. In view of its inability to increase non-wage recurrent costs due to the declining real value of central budget allocations, it also agreed to measures to increase service efficiency and cost recovery.

3. Linkages Between Project, Sector and Macro Policy Objectives. IDA helped the Government design a program of structural adjustment, in support of substantive Government policy initiatives to promote economic development, and adopted a lending program consisting of two parts: (a) a structural adjustment lending program; and (b) a core program of investments in infrastructure, institutional support, and human resource development. This project, IDA's first in the health sector in Guinea-Bissau, was intended to further the core lending program for human resource development, while supporting the social sector during the difficult period of structural adjustment.

C. Project Objectives and Description

4. Project Objectives. The Project's two basic objectives were: (a) to support the institutional development of MINSAP in planning, management and finance; and (b) to improve the delivery of health and family planning services, especially at the periphery (rural health center level). The project's near-term focus on improving essential services, combined with its complementary emphasis on strengthening the institutional framework, was expected to create the basis for more extensive service delivery interventions in the future, towards achievement of the Government goals for 1993.

5. Project Description. Part A of the project, regarding institutional development activities and requiring 26 percent of the project cost, included components for: improving MINSAP organization; creating a management information system; strengthening drug system management; developing and implementing methods for supervision of rural health services; introducing rational financial planning and assisting MINSAP to implement effective cost recovery measures; conducting policy studies on nutrition and family planning; and carrying out a demographic health survey (DHS) to improve the health statistics data base. In support of these actions, the project was set to finance vehicles, furniture, equipment, materials, 22 months of technical assistance, overseas fellowships, in-service training, supplies and travel and per diem.

6. Part B, to which 44 percent of the total project cost was allocated for investment and incremental recurrent expenditures, was intended to strengthen health and family planning service delivery and included: providing basic equipment and essential drugs and materials to regional health directories; rehabilitating 25 health centers to serve approximately 175,000

people; and providing in-service training to health personnel at all levels. Project financing for this part included civil works, vehicles, equipment, furniture, materials, medical and other supplies, technical assistance, short-term overseas fellowships, in-service training, salaries under contractual services, and travel/per diem. The remaining 30 percent of project cost was applied to financing preparation (through the Project Preparation Facility -- PPF) and project administration.

D. Project Design, Organization and Management

7. This project emerged from an IDA sector review and a donor round table, both in early 1986. The resulting project design constituted a comprehensive response to the pressing needs identified by those exercises. Specifically, the design was intended to promote long-term institutional development within MINSAP, and at the same time cater to some immediate needs in health service delivery, by financing part of the non-wage recurrent costs (particularly medicines and materials), while alternative means for financing recurrent costs were developed. A study and trial on cost recovery, which was innovative for Guinea-Bissau, was proposed as a solution to MINSAP's difficulties in financing such costs on a regular basis. Unfortunately, the project's conceptual foundation proved to be overly ambitious in terms of project objectives and range of subjects covered. Had project designers taken greater account of implementation risks, and a more conservative appreciation of the timeframe required to effect institution building and organizational changes and to implement cost recovery measures, a less ambitious project would have resulted, with better prospects for good implementation.

8. The design did not include an evaluation component, nor did it have requirements for evaluation of training. There were no impact indicators specified to measure project effects on the population; the latter is not unreasonable in view of the short time span of project implementation -- originally three years, which were extended to four -- as well as the weaknesses of the data base for health conditions in the country. However, it would have been useful to include process indicators such as training required by specialty and duration, expected changes in the system and timing (for instance, for establishment of the management information system, drug system management, and rural supervision model) and clear objectives against which to evaluate the proposed studies and surveys. The policy studies were not fully designed and those which were executed did not lead to policy formulation.

9. Project Management. The project management unit performed reasonably well its functions as handler of communication flow with IDA, but was not as successful in establishing a good rapport with MINSAP, particularly after a new minister took over in 1990. Furthermore, it would have needed to exert a more rigorous control on the cost of consultancies in relation to expected outputs, and on the overall budgeting and spending of the various project categories. MINSAP, on its part, did not wield its authority to oversee and guide the project management unit in key decisions regarding this project -- e.g., when long delays occurred in completing architectural designs for remodeling of health centers and when large consultant contracts were issued.

10. Appropriateness of Project Scale and Scope. The total project cost of US$4.2 million during a three-year period implied an additional 25 percent annual financial input of recurrent and investment resources for the health sector -- a large but not unreasonable increase, if the balance of expenditures by project component would have been maintained during project implementation; however, there was a significant variance between project design and implementation (paras. 10-12). Additionally, the project scope was too broad, with many sub-components, each requiring very specialized expertise (e.g., management information system, drug logistics, field supervision, training, administration of research and studies). In order to successfully implement this project, MINSAP would have needed far more competence in precisely those areas -- administration, financial planning, information management, human resource development -- that the project itself was designed to strengthen. Or alternatively, it would have needed a much greater capacity than demonstrated to administer a large volume of technical assistance. The end result was that MINSAP's acknowledged institutional and financial limitations, compounded by its inexperience in dealing with a relatively large project, exceeded the Ministry's implementation potential.

E. Project Implementation

11. Critical Variances in Project Implementation. Credit effectiveness was extended from September 18, 1987 to December 18, 1987, to allow Government to submit a three-year financial plan for MINSAP, incorporating the results of a health cost and cost recovery study. When it became apparent that this condition could not be met by December 18, 1987 the Development Credit Agreement was amended so that effectiveness would not be further delayed. Submission of the MINSAP plan was then changed from a condition of effectiveness, to a covenant to be met by April 30, 1988. This covenant was not fully met; while the consultants responsible for the cost recovery study produced an outline of a financial plan, it was never followed up in actual practice, due to the lack of expertise in financial analysis in MINSAP. Following effectiveness, implementation of the entire project fell seriously behind schedule, due in large part to institutional weaknesses within MINSAP that were originally identified as risks. There were persistent vacancies of key posts and other personnel problems within MINSAP, lack of counterpart funding, and procedural problems affecting drug procurement. It should also be noted that the period immediately preceding credit effectiveness and beginning of implementation coincided with IDA's reorganization which resulted in the replacement of the entire team for this project; this probably added to the delays.

12. A major variance between planned and actual project implementation was a shift in project composition and distribution of expenditures from civil works, operating costs, goods and services, and the PPF, to the following categories: (a) consultants and fellowships for which disbursements ended up being almost three times higher than originally planned (US$1.5 million, compared to US$640,000); (b) equipment, furniture, vehicles and materials for which IDA disbursed over twice the amount set at appraisal (US1.1 million compared to US$470,000); and (c) drugs and medical supplies, which received

US$1 million compared to US$700,000 appraised. The following explanations were given by IDA staff for these changes:

(a) although the much higher than planned disbursement for consultants and training resulted in part from underestimates of costs at appraisal (for instance for the DHS and training this appears to be the case), this should have been compensated by the fact that several planned studies were not implemented; however, the costs of most of the contracts appear to have been too high in relation to the type of work performed and the outputs, undoubtedly a result of the low capability of MINSAP to manage contracting and supervising of consultants; in spite of the high cost of consultants in this project, little training and institution building took place;

(b) a doubling in the amount spent for equipment, furniture, vehicles and materials was a result of price escalation and of a substantial underestimate of what it would cost to equip existing rural health facilities in order to implement the model of rural supervision; and

(c) at appraisal, drugs and medical supplies were intended to reinforce material resources in rural health units while they made the transition to a system of cost recovery; the higher amount spent in drugs and medical supplies resulted from an acute shortage due to temporary difficulties faced by regular donors (UNICEF, bilateral donors) to keep up with deliveries for the whole country; the Government, which has a non-significant budget for these items and depends on foreign assistance, requested IDA to use credit funds to cover the gap; also, at the end of 1987 the country suffered a cholera epidemic and credit funds were authorized for procuring drugs and medical supplies for this emergency; since then, the project supported drug management system plus Swedish assistance have improved coordination of drug supplies; and

(d) the civil works component was heavily underspent; as explained in para. 24, the appraised remodeling of 25 rural health centers was not implemented according to the original design; only two health centers were remodeled using proceeds from the IDA credit, at a cost of under $50,000 and another $50,000 was disbursed from the Credit for civil works in the central MINSAP offices (all these costs exclude expenditures for detailed designs amounting to $72,000 which were disbursed under the consultant category). The IDA staff sought other donors to finance rehabilitation works for almost US$1 million for another 13 health centers (outside this project).

13. In view of the explained variances in the utilization of the IDA credit, formal reallocation of proceeds took place in February 1991, 9 months before credit closing. IDA staff indicated that only at that time it was possible to obtain firm figures from the Government on committed funds and projected expenditures.

14. The lack of Government counterpart funds persisted throughout the project. In spite of IDA staff consistent follow up on the need for the Government to contribute specified amounts of funds each year for project implementation, at credit closing its contribution was $61,900 compared to $210,000 required and agreed.

15. Project Risks. Two major risks were anticipated in this first population, health, and nutrition (PHN) project in Guinea-Bissau: (a) implementation difficulties due to the inexperience of MINSAP personnel in executing major structural reforms, particularly with respect to cost recovery; and (b) insufficient availability of foreign exchange to meet the health sector's critical import requirements. Both concerns proved to be well founded and were resilient to efforts taken during implementation to overcome them.

16. Unforeseen Factors Affecting Project Implementation. In late 1988, several key MINSAP staff members were suspended pending Government investigations and were not replaced; those affected included the Director of Administration and Finance, the Director of Patrimony and the Director of Public Health. Additionally, the Director of Planning was sent abroad for a two-year training program. These personnel vacancies in the implementing agency and their non-replacement decreased the possibilities of institution building through the project and left most of the implementation in the hands of the project director -- a foreign consultant -- and his staff. In November, 1990, when a new health minister took over, a national Assistant Project Director financed by GUB was appointed. Another unforeseen event was that US$70,000 in project funds were frozen for over 2 and a half years by a bank in Las Palmas which was originally designated to hold the Project's special account; this was the result of a dispute between that bank and the Armed Forces, unrelated to the Project and MINSAP. Although this complication did not financially affect project outcome and was eventually resolved, it did cause a major diversion of staff time in communications and during supervision missions.

F. Major Results of the Project

Project Impact

17. The overall impact of the credit was unsatisfactory. Project achievements fell short of ambitious appraisal targets. The cost-effectiveness of inputs such as technical assistance and provision of incremental recurrent costs has been low and little was accompanied on civil works components. Nevertheless, there were modest accomplishments in training and human resource development and in PHN data collection; the project also managed to make same initial inputs towards cost-recovery, better drug system management, improved rural supervision, and preliminary administrative reform within MINSAP. Because this project represents the first attempt by any donor in Guinea-Bissau to assist the health sector as a whole (as opposed to individual projects or sites), the mentioned contributions are noteworthy.

18. The original institutional development goal was to prepare a comprehensive three-year action program and financial plan for the health sector, including the creation of a rolling financial plan. MINSAP failed to adopt a rolling financial plan during the project lifetime (as explained in para 10); however, MINSAP was made aware of the need for such a plan and its preparation continues to be discussed with IDA and WHO. Moreover, despite delays, disputes and inadequacies that beset MINSAP's technical assistance, the Ministry managed to prepare, with WHO assistance, and adopt and partially implement a simplified reorganization plan. The Ministry appears headed, at last, toward decentralization of management, administration and finance, with a focus on increasing authority at the regional level.

Sectoral Policies

19. This project enabled Guinea-Bissau's health sector to make several noteworthy policy departures, and to follow them up with initial implementation measures. With regard to drug system management, for example, the project resulted in the establishment of an operational inventory control system. This was achieved through the provision of a computer and a vehicle for the Central Pharmaceutical Store, and training local staff in its use. A National Drug Formulary was also produced, and 535 copies furnished to the Central Drug Unit for nationwide distribution.

20. In terms of supervision of rural health services, the two regions chosen for project activities made headway in piloting a supervisory model for eventual replication in the country's other regions. Health education overseen by dedicated local staff sparked widespread interest among the rural population, and attracted growing numbers of traditional midwives. However, administrative turnover, plus lack of transport and of appropriate budget for keeping up with maintenance and recurrent costs of the rural health services, presented difficulties throughout. The supplies, equipment, vehicles and technical assistance provided under the project -- fortified by supervision and training contributed by Italian and Canadian non-governmental organizations (NGOs) -- made a start in strengthening the health system management process in the two regions, but was not enough to cover for the deficiencies. Also, the lack of continuity of health staff in regional positions and scarcity of resources continue to be major problems.

21. The concept of cost recovery in the health services was introduced in the project as a possible solution to the problem of persistent shortfalls in MINSAP's budget for recurrent costs; in 1990 a general declaration was issued announcing that cost recovery measures in the health services would begin soon. This encountered public opposition. Since that time, a national sensitization campaign began to educate the population on the need to pay for health services, and a Cost Recovery Committee was created within MINSAP. In the last year of the project, partial cost recovery measures (mainly for medicines, following the recommendations of the Bamako initiative) had been regularized in one region (Gabu) and were beginning to be selectively implemented in various parts of the country. Progress in this area was helped considerably by the fact that both WHO and UNICEF are committed to the Bamako initiative. However, its expansion to other parts of the country and to other

items of health costs (e.g., medical visits, hospitalization, etc.) will be dependent on increased Government and public acceptability of the concept, a substantial increase in the quality of the health services to gain client satisfaction, and continued donor and technical support for some time to come.

Policy Studies

22. The project made a worthwhile contribution toward filling a vacuum with respect to Guinea-Bissau's PHN information base. A Demographic and Health Survey (DHS) was conducted and its results were presented in a 16-volume report dated February, 1991. This was a major country-wide survey, which is expected to form the basis of an improved health information system (DHS cost was $200,000). It was conducted by a foreign consultant firm with the active participation of MINSAP and the Department of Statistics of the Ministry of Planning. Further, a Population and Family Planning Study and a Nutrition Policy Study, each costing $50,000, were also produced by foreign consultants. These three studies constitute major contributions to the country's knowledge base; national seminars to disseminate study findings and results were carried out. It should be noted, however, that the seminar on DHS findings (costing $26,000) was financed by SPPF funds provided by IDA, because the consultant contract failed to include this activity and project funds had been exhausted. Although the execution and dissemination of the results of these studies and their consideration and approval by MINSAP's Technical Committee constitute useful achievements, the ultimate objective of using the findings of these surveys and studies for developing national policies in nutrition and in maternal and child health and family planning as a basis for health and social action programs, remains unaccomplished.

Human Resource Development

23. This component exceeded appraisal targets in terms of participants involved and funds expended. It encompassed project-related training, on-the-job training, short courses and seminars, primarily in the areas of administration, financial management, accounting, drug management, and maternal and child health. The Project Manager estimated that 6,500 people benefitted directly or indirectly from training, both funded by the project and as a result of the multiplier effect of trainers training grass-root workers; the Staff Appraisal Report target of 500 trained health personnel directly funded by the credit was amply met. Total fellowship and training expenditures amounted to $465,000, compared to an estimate of $60,000 for these items at appraisal. The project design did not call for close monitoring or evaluation of training activities. However, according to the Project Director's assessment and periodic accounts by consultants, the project appears to have made a useful beginning in human resource development, and one that the upcoming Social Sectors Project can build on.

24. As already mentioned (para 12 under Variances), activities under this component fell far short of appraisal goals. The number of facilities to be remodeled was first scaled back after an assessment of rehabilitation needs in 1988, when it was found that 10 of the 25 centers identified at appraisal were beyond repair. The detailed architectural designs including adaptations to sites for 15 centers and the translation of the technical papers from French --the language used by the consultants-- and Portuguese took an inordinately long time (from October, 1988 to August, 1990). In spite of the smaller number of centers considered for repair, the total cost for rehabilitating them exceeded by far the appraised estimates. Indeed, in 1990 it was estimated that US$1,030,400 would be needed for repairing 15 centers, compared to the original estimate of $430,000 for 25 centers. The IDA staff and the project management unit attributed the large difference between appraised and actual costs of civil works to initial underestimates in unit costs and scope of work, as well as to price escalation. A supervision mission at that time determined that project funds had already been applied to other categories -- particularly to consultancies. After taking into account commitments already made it was decided that IDA funds could be used to rehabilitate only two centers.

Project account audits

25. Project accounts and audits were conducted by independent auditors selected and retained according to IDA Guidelines. All required audits were presented to IDA usually on time or with slight delays and were considered satisfactory.

G. Project Sustainability

26. Because of the low financial base for supporting health services, the lack of a clear financial plan, the large proportion of funding from external donors and MINSAP's limited capacity as managing agency for the sector, this project placed particularly strong emphasis on sustainability from the outset. For example, no new facilities were proposed and a primary goal in components as diverse as institutional development, training, drug management, rural supervision and cost recovery, was to develop appropriate frameworks for continuing efforts in the future. Although a foundation is now in place for expansion and improved quality of health activities as a result of this credit, the health system still lacks the competence for self-sustainment and growth and will need perhaps at least a decade to reach a level of an acceptable financial and technical sustainability. A follow-on Social Sectors Project will have fewer components and will be more focussed on capacity building and substantially, expanding the human resource training begun with this project. The forthcoming project will also focus on technical assistance with stronger review and with built-in transfer of knowledge to national counterparts. In addition, it will have a social action fund to assist NGOs which have a good track record on the country, in developing micro-social sector projects and better reach those at the grass-root level.

H. IDA Performance

27. Major Strengths and Weaknesses. IDA staff showed consistent flexibility and creativity, which proved particularly important in view of the Borrower's inexperience. Moreover, during implementation IDA persistently and effectively pursued other donors and NGOs (WHO, EEC, UNFPA and others) to obtain additional technical assistance and funding for project-related activities, most notably for rehabilitation of health centers and the procurement and management of essential drugs. Efforts by IDA staff to strengthen donor coordination during this project paved the way for increased formal cooperation (particularly among IDA, WHO and UNICEF), which should benefit future efforts in the social sectors in Guinea-Bissau. However, there were some shortcomings, including the following:

(a) earlier identification of the problems affecting the construction component would have enabled the adoption of alternative solutions for successful bidding of the civil works including lowering the pre-qualification requirements for local contractors and grouping construction work in small packages; and

(b) a tighter control of the technical assistance costs, early detection of cost overruns, and closer attention to quality and utilization of consultants could have led to higher effectiveness and lower costs than achieved in the project; only in 1991, when credit funds were almost exhausted, did IDA begin to impose limits on expenditures in consultants' contracts and placed strict limits to unprogrammed spending.

28. Lessons Learned. The following lessons may be used for future projects:

(a) Project preparation needs to identify accurately the weaknesses of the implementing agency in order to design projects that are realistically implementable; while identification of sector needs is important, frequently projects -- particularly first-time operations -- are not able to eliminate all sector constraints and it is essential to prioritize interventions;

(b) When construction components are part of a project, they should be properly prepared, although they are usually less significant than software components in addressing sector issues; in this project, remodeling of facilities was not sufficiently planned during project preparation and thus, problems regarding the capacity of the construction sector in the country and the need for alternatives to large contractors was acknowledged only at a late stage in the project cycle, when there was not enough time left to undertake a suitable remodeling program;

(c) technical assistance is an essential component in cases in which the capacity of the sector agencies is low; however, its design should be in line with the agencies' absorptive capacity, and should be closely supervised to enable remedial action in cases

where quality, performance and cost become out of line with established standards and objectives; and

(d) Additional units or administrative staff for project management may be a good solution in cases were the implementing agency's capacity is low, but the experiences of this and other projects suggest that a project director, particularly a foreign consultant, should not be allowed to work without national counterparts and in isolation of the national agency or become the sole agent of communication with IDA; a main function of a project unit, in addition to project monitoring, should be institution building.

I. Borrower Performance

29. Major Strengths and Weaknesses. During project preparation, the Government took several reassuring steps: it acted diligently in appointing an expatriate Project Director and in creating a Project Management Unit, and committed itself to pursuing several changes in policy and organization. Regular quarterly reports were submitted, and the Borrower complied with Bank audit and other procedural requirements.

30. However, the project suffered serious implementation problems when MINSAP allowed key managerial positions to remain vacant for over two years for lack of competent candidates, and scarce administrative skills within the ministry. IDA exchanges during the project period were with the project management office, which in principle provided the link with the various MINSAP divisions; but interest in the project within MINSAP was low. This situation changed slightly under a new minister in 1990, when a stronger interest began to emerge; for instance, much of IDA's correspondence begun to be copied to the Minister at her request. Implementation was also compromised by the Ministry of Finance's inability to make counterpart funds available when needed during the project period.

31. Lessons Learned. The main lesson learned by MINSAP was that when foreign consultants are contracted to run a project implementation unit, appropriate national counterpart staff must be in position and the implementing agency has the right and responsibility of oversight over the performance of the unit. The same concept of oversight applies to all technical assistance contracts. Additionally, knowledge transfer and/or training should be included in the terms of reference. When studies are conducted, consultants should have a contractual obligation to present their findings and explain the methodology used in the study to the client agency.

J. Project Relationship

32. The Bank-Borrower relationship throughout was satisfactory. A positive tone was set from the beginning and was sustained during implementation.

K. Consulting Services

33. Although most of the consultant services provided under the project resulted in acceptable studies and surveys, consultant performance could have been more cost effective had careful design been conducted at appraisal and more strict cost control and technical oversight had been exerted. The consultancy on MINSAP's reorganization was overly expensive in comparison to the results and produced recommendations that, according to Government evaluation, were not entirely appropriate for the local situation; as a result, the Ministry ended up adopting a simplified organizational design, with assistance from WHO.

L. Project Documentation and Data

34. The Staff Appraisal Report, supervision and consultant reports, and additional material contained in the project files provided adequate information for this project completion report. In addition, a Social Sectors Strategy Review (Volume I, September 1991) provided a very helpful in-depth view of the broader context in which this project was implemented.

PROJECT COMPLETION REPORT

GUINEA -BISSAU

POPULATION, HEALTH AND NUTRITION PROJECT

(Credit 1800-GUB)

PART II. PROJECT REVIEW FROM BORROWER'S PERSPECTIVE

1. The time has come to close this project which for the last four years has provided Guinea-Bissau with support for its national health policy, based on the delivery of primary health care.

2. In compliance with the covenants contained in the Credit Agreement 1800-GUB signed with IDA for the financing of the design and execution of the project, we must now make a general review of the project and present our evaluation.

3. All sorts and types of problems were encountered during the implementation of the Population, Health, and Nutrition Project; despite the lengthy duration of the project, it was impossible to successfully complete a large proportion of the components, leaving some objectives unaccomplished.

4. Certain actions were, however, accomplished albeit with considerable difficulty, such as the nutrition Study (Part 1) which was conducted between December, 1990 and January, 1991, followed by dissemination of the results through a seminar.

5. With respect to the Government's formulation of a Food and Nutrition Policy, we think it is logical and technically advisable to wait the completion of Part 2 of the study, so that the document to be submitted to the Government for approval can draw on the study's findings.

6. As for the counterpart funds, which the Government was to have made available in a amount equivalent to US$200,000, it is true that these were not provided on time because of the large number of projects in other sectors of Government activities that also depend on the National Development Fund; another factor was the country's serious shortage of financial resources. Nevertheless, a major effort was made and we believe that the Government met its commitment under the Credit Agreement.

7. Additional costs were incurred, particularly in connection with the Food and Nutrition Survey, which required an additional mission of the foreign consultants in December, 1990, because the June, 1990 mission had not been properly prepared by the Project Management Unit, which had failed to inform the Directora Nacional do Estudo of the plans to carry it out.

8. In view of the many different irregularities encountered during

project implementation and the lack of collaboration between the Management Unit and the other departments, it was felt advisable to appoint a national counterpart to act as Deputy and thus assist the National Project Manager, who was an expatriate.

9. As soon as the national counterpart was hired as Assistant Consultant, the National Project Director decided to turn his back on his responsibilities and go on a trip without giving anyone previous notification.

10. With respect to the cost recovery policy, the greatest difficulty was encountered when an attempt was made to provide health care to as wide a cross-section of the population as possible on the basis of a sliding scale tailored to each client's income level. These activities had to be suspended because of the extreme dissatisfaction and unrest that they caused among the public, unaccustomed to paying for health care.

11. We feel that the project design was faulty in certain respects, particularly where the structural objectives were concerned, viz. the reorganization of MINSAP and the Study on Family Planning.

12. MINSAP's reorganization was one of the Project's basic and essential objectives which, unfortunately, was impossible to accomplish in the short term. While it is true that some improvements were made in the Ministry's organization, we have to admit that we have serious doubts whether these were basically influenced by the conclusions and recommendations of the consultant firm involved or prompted by the distinctive style of the new leadership.

13. The conclusions and recommendations are there, and we have a number of manuals that we can use for a basic undertaking of this type, but the project design did not pay proper attention to the real life situation of our institutions and the status of our staff, who are greatly demoralized by their low salaries, which make it necessary for them to find second jobs, leaving them insufficient time to perform their work properly, let alone read the extensive paper files left by the consultant.

14. Regarding the Family Planning Study, it had a worthwhile objective in an area in which the Government definitely needs to adopt a policy. However, we must question its scope and success. The fact is that it touches on one of the most intimate aspects of conjugal and personal life, where cultural values are deeply ingrained; for this reason, any measures that are adopted to deal with this matter, inevitably cause some upset and are doomed to failure from the start.

15. We feel that the most appropriate course of action is to offer education through case-by-case medical consultations and through the schools, by increasing the enrollment rate among our children. In fact, as a specialist has concluded from a study on this topic, a woman who has never attended school is likely to have twelve children, one who has completed fourth grade is unlikely to have more than eight, one who has completed secondary education diploma is expected to stop at four, and one who has completed university is unlikely to have more than two.

16. In our opinion, the project design failed in these two specific areas because insufficient attention was paid to the basic issue responsible for the real life situation, resulting in a considerable investment which offered very limited chance of success from the start.

17. The Project execution per se had its own problems, above and beyond the deficiencies that had to do with the design, in so far as it encountered difficulties in the field, which it failed to overcome. This may have resulted from a failure to secure the cooperation of other government officials who felt removed from the project objectives; it could also be that the Project Management Unit did not work hard enough and had serious shortcomings which were particularly glaring with respect to rehabilitation of health centers, assistance given to consultants, and procurement of consumable and durable goods and equipment.

18. The World Bank's financial management of the project did cause some difficulties, but these were, in fact, neither insurmountable nor pivotal in those areas where the project was less than successful. In any case, we feel that it should be possible, in the medium term, to move toward other forms of joint financial management, which would allow the local management unit more freedom of movement for the sake of facilitating efforts to accomplish the Project's objectives, provided it is headed by an appropriate and capable manager.

19. In our opinion, the design and execution of the project was not entirely bad and it is bound to have a positive contribution toward improving the delivery of health care throughout to country, providing better information on existing health care facilities and pointing the way to a new policy of health care and for the management and cost-effective utilization of available resources. Despite the lack of success with the cost recovery policy, lessons have been learned from the experience gained so that we may, in the medium term, develop an efficient system for amortizing the costs of health care, which have, until now, been fully born by the State. We shall continue with the Bamako initiative and believe that the entire country will, in the course of time, eventually understand the need for each user to contribute toward amortizing the costs and improving the quality of health care.

20. We could certainly have achieved better results, had the project management not been so poor, even in the case of the most viable components. We feel justified in giving the project now completed a passing grade, thanks to the funds made available and to the controls imposed by the new leadership of the Ministry. A further point worth remembering is that prior to 1990 the project focussed basically on the procurement and distribution of goods for consumption and direct utilization.

21. The people of Guinea-Bissau are suffering from serious deprivation and shortages. Health sector statistics, such as birth rates and infant and maternal mortality rates, not to mention the prevalence of malnutrition in certain parts of the country, as well as endemic diseases including malaria, diarrhea and AIDS, speak loud and clear and force the Government to make an all-out effort in order to minimize the disastrous consequences, which not only increase the burden on

the State, but also hold back the country's development process.

22. We consider that this project served as a test from which the country has been able to learn some valuable lessons.

23. In light of all what has been said earlier, we are convinced that at least one lesson has been learned, and that is that projects must not directly pursue any structural objectives without local involvement. We believe that even in the absence of the difficulties listed above, it would have been preferable to find ways to encourage an internal exchange of experience and to give priority to the work and consulting services of local experts who, even if not equipped to offer studies as elaborate as those provided by the international consultants, would produce findings that would have the advantage of reflecting the country's real situation more closely and would therefore have a greater impact. Furthermore, only by giving these technical experts a challenge will it be possible to ensure their real and sustained development until they are eventually capable of serving as an ongoing resource to international consultants.

24. The fact therefore bears repeating that the project was a success. The results obtained provide a storehouse of information on which we will be able to draw in order to maximize the returns on future undertakings.

25. We hope to continue to earn the support of the international community, since we are determined to do our utmost to renew our hope of entering the twenty-first century with a more satisfactory health profile that will enable us to meet the challenge of development and the attainment of "Health for All" by the year 2000.

Bissau, June, 1992

PROJECT COMPLETION REPORT

GUINEA-BISSAU

POPULATION, HEALTH AND NUTRITION PROJECT

(CREDIT 1800-GUB)

PART III. STATISTICAL INFORMATION

1. Related Bank Loans and/or Credits

Not applicable.

2. Project Timetable

Item	Original Date	Revised Date	Actual
Identification I			01/86
Identification II			04/86
Preparation			07/86
Pre-appraisal Mission			09/86
Appraisal Mission			12/86
Credit Negotiations			03/87
Board Approval			05/19/87
Credit Signature			05/22/87
Credit Effectiveness	09/18/87	12/18/87	12/18/87 1/
Credit Closing	06/30/91	12/31/91	12/31/91 2/

1/ Credit effectiveness was extended to allow Government's submission of a three-year action program and financial plan, incorporating the results of a health cost and cost recovery study. As this condition could not possibly be met by December 1987 and thus further unecessary delays to project implementation would have been created, it was recommended, after amending the Development Credit Agreement (new Section 3.10), that it become a covenant to be met by April 30, 1988. However, this covenant has never been fully complied.

2/ Project closing date was extended on June 13, 1991, to allow Government to complete key project activities.

Final version of revised PCR with disk is coming in mail. Please check ~~typo~~ & correct typos I have noted on this earlier version.

PROJECT COMPLETION REPORT

REPUBLIC OF GUINEA-BISSAU

POPULATION, HEALTH AND NUTRITION PROJECT
(CREDIT 1800-GUB)

Draft
November 11, 1992

Population and Human Resources
Operations Division
Western Africa Department

Carol Hoppay 34892
Tom Porter 34885

GLOSSARY

DHS	Demographic Health Survey
EEC	European Economic Community
MCH	Maternal and Child Health
MINSAP	Ministry of Public Health
MINSAS	Ministry of Health and Social Affairs
NGO	Non-Governmental Organization
PHC	Primary Health Care
PHN	Population, Health and Nutrition
SDR	Special Drawing Rights
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
WHO	World Health Organization

PROJECT COMPLETION REPORT

GUINEA BISSAU

POPULATION, HEALTH AND NUTRITION PROJECT
(CREDIT 1800-GUB)

Table of Contents

LIST OF ANNEXES

REPUBLIC OF GUINEA-BISSAU

POPULATION, HEALTH AND NUTRITION PROJECT

CREDIT 1800-GUB

PROJECT COMPLETION REPORT

PREFACE

This is the Project Completion Report (PCR) for the first Population, Health and Nutrition Project in Guinea-Bissau, for which Credit 1800-GUB in the amount of SDR 3.4 million (March 1987 US$4.2 million equivalent) was approved on May 19, 1987. The Credit was closed on December 31, 1991, after having been extended six months beyond the original date. It was fully disbursed, and the last disbursement was made on April 9, 1992.

The PCR was prepared by the Population and Human Resources Operations Division of the Western Africa Department (Preface, Evaluation Summary, Parts I and III) and the Borrower (Part II).

This PCR report was initiated during the last supervision mission for the project in October 1991. A completion mission was conducted in January, 1992. This PCR is based, inter alia, on the Staff Appraisal Report; the Development Credit Agreement; supervision reports; correspondence between the Borrower and IDA; internal IDA memoranda; and interviews with Bank staff involved with the project.

PROJECT COMPLETION REPORT

REPUBLIC OF GUINEA-BISSAU

POPULATION, HEALTH AND NUTRITION PROJECT

(CREDIT 1800-GUB)

EVALUATION SUMMARY

Project Objectives

i. The Project's two basic objectives were: (a) to support the institutional development of the Ministry of Public Health (MINSAP) in planning, management and finance; and (b) to strengthen the delivery of health and family planning services, especially at the rural health center level. The project's near-term focus on improving essential services, combined with its complementary emphasis on improvements in the institutional framework, was expected to provide the basis for more extensive service delivery interventions in the future, toward achieving the Government goal of offering health services to 80 percent of the population by 1993 -- an evidently ambitious goal.

Implementation Experience

ii. Following effectiveness in December 1987, project implementation fell seriously behind schedule due in large part to MINSAP's institutional weaknesses that had been originally identified as risks. It should also be noted that the period immediately preceding credit effectiveness and beginning of implementation coincided with IDA's reorganization which resulted in the replacement of the entire team for this project; this probably added to the delays. A major variance between planned and actual project implementation were large shifts in expenditures from civil works, operating costs and goods and services, to consultants and fellowships. Remodeling of 25 rural health centers was not implemented according to the original design; only two centers were rehabilitated with IDA financing, at a cost of under $50,800 compared with an original estimate for civil works of $430,000. Other donors financed part of the remainder (outside this project). In spite of the heavy use of consultants in this project and the moderate success in producing studies and reports, little consultancy related training and institution building took place due in part to personnel vacancies in the implementing agency and their non-replacement for periods of over two years. The project director -- a foreign consultant -- and his staff assumed a main role in implementation and in communications with IDA. The lack of Government counterpart funds persisted during project execution in spite of consistent follow up by IDA

staff; at credit closing, the Government contribution was $61,900 compared to $210,000 required.

Results

iii. Overall impact of the credit was mixed. Project achievements fell short of ambitious appraisal objectives. The cost-effectiveness of inputs such as technical assistance and provision of recurrent costs appears to have been ~~low~~. Nevertheless, there were modest accomplishments in training and human resource development and in PHN data collection; the project also managed to make some initial inputs towards cost-recovery, better drug system management, improved rural supervision, and preliminary administrative reform within MINSAP. Because this project represents the first attempt by any donor in Guinea-Bissau to assist the health sector as a whole (as opposed to individual projects or sites), the mentioned contributions are especially noteworthy.

Sustainability

iv. Because of the low financial base for supporting health services, the lack of a clear financial plan, the large proportion of funding from external donors and MINSAP's limited capacity as managing agency for the sector, this project placed particularly strong emphasis on sustainability from the outset. Although the sector continues to rely heavily on technical assistance, a foundation is now in place for the expansion and quality enhancement of the health services, resulting from inputs from this credit. Even so, the health system still lacks the competence for self-sustainment and growth and will need perhaps at least another decade to reach a level of adequate financial and technical sustainability. A follow-on Social Sectors Project will emphasize capacity building and substantially expand the human resource training begun with this project. The forthcoming project will also focus on technical assistance with stronger review and with built-in transfer of knowledge to national counterparts. In addition, it will have a social action fund to assist NGOs which have a good track record ~~on~~ the country, in developing micro-social sector projects and better reach those at the grass-root level.

Findings and Lessons Learned

v. The project goals were over-ambitious and it had a complex design. In the light of institutional weaknesses, IDA showed flexibility and creativity during implementation. It also pursued persistently and effectively cooperation with other donors -- particularly WHO and UNICEF). However, there were some shortcomings, including the following: (a) earlier identification of the problems affecting the construction component would have enabled the adoption of alternative solutions for timely and successful civil works completion; and (b) a tighter control of the technical assistance costs, early detection of cost overruns, and closer attention to quality and utilization of

consultants could have led to higher effectiveness and lower costs than achieved in the project.

vi. Initially the Government took several reassuring steps by appointing an expatriate Project Director, creating a Project Management Unit, and giving assurances regarding several changes in policy and organization. However, there were serious implementation problems when MINSAP allowed key managerial positions to remain vacant for over two years and the Ministry of Finance compromised implementation by failing to provide counterpart funds as agreed. Lessons learned by MINSAP included the need to manage consultancies properly to obtain effective benefits related to expenditures incurred, and the importance of assuming responsibility for oversight of the project management unit.

vii. The following lessons learned may be applied to future projects: Project preparation should select implementable key components; construction components should be properly prepared, although they are usually less significant than software components in addressing sector issues; although technical assistance is essential particularly when the capacity of the sector agencies is low, it should be tailored to the agency's absorptive capacity, and should be closely supervised; and project management units should help in institution building and receive close review from the management of the implementing agency. Further, national counterparts should always be involved in the project preparation and implementation processes.

REPUBLIC OF GUINEA-BISSAU

POPULATION, HEALTH AND NUTRITION PROJECT
(Credit 1800-GUB)

PROJECT COMPLETION REPORT

PART I. PROJECT REVIEW FROM BANK'S PERSPECTIVE

A. Project Identity

Project Name:	Population, Health and Nutrition Project
Credit No.:	1800-GUB
Credit Amount:	SDR 3.4 million (March 1987 US$4.2 million)
RVP Unit:	Western Africa Country Department IV
Country:	Republic of Guinea-Bissau
Sector:	Population, Health and Nutrition

B. Project Background

1. Sector Development Objectives. At the time of this project's appraisal, the stated goal of the Ten-Year Primary Health Care Plan 1984-93 under the responsibility of the Ministry of Public Health's (MINSAP) [1], was to reach, by ~~BY~~ 1993, 80 percent of the population with programs in Maternal and Child Health (MCH), immunization, essential drugs and endemic disease control. This was an evidently overambitious target for a country with a per capita income of less than US$180 and a health system bedeviled by serious shortcomings. Guinea-Bissau's health system is almost exclusively public and administered by MINSAP. IDA appraisal identified major constraints including: lack of full control over the allocation of expenditures (in 1986 over 85 percent of the MINSAP budget and 90 percent of drug procurement came from foreign assistance); low quality of services mainly due to irregular availability of medicines and materials at the service points, inadequate working conditions for the health personnel and uneven geographical distribution (medical personnel are heavily concentrated in the two national hospitals, located in the capital city); also, the physical infrastructure was deteriorated, and there were serious deficiencies in staff training, supervision, transport and recurrent budget for maintenance. Moreover, macroeconomic constraints curtailed the options for up-grading health care. A chronic shortage of foreign exchange and the declining real value of central budget allocations limited MINSAP funding and made it imperative to seek further external financial assistance for major restructuring and strengthening.

---

[1] In December 1991, this ministry was renamed the Ministry of Health and Social Affairs (MINSAS). For purposes of this report, however, the acronym "MINSAP" will be used.

2. Policy Context. At a donors' roundtable in 1986 the Government acknowledged that in order to increase the likelihood of coming close to the stated health service goal it would need to restructure the system and make more cost effective use of the existing infrastructure, rather than extend its health system through investments in new facilities. It agreed to several administrative and policy reforms and to improve hospital administration, drug system management, and financial planning. In view of its inability to increase non-wage recurrent costs due to the declining real value of central budget allocations, it also agreed to measures to increase service efficiency and cost recovery.

3. Linkages Between Project, Sector and Macro Policy Objectives. IDA helped the Government design a program of structural adjustment, in support of substantive Government policy initiatives to promote economic development, and adopted a lending program consisting of two parts: (a) an extended lending program, including a structural adjustment credit; and (b) a core program of investments in infrastructure, institutional support, and human resource development. This project, IDA's first in the health sector in Guinea-Bissau, was intended to further the core lending program for human resource development, while supporting the social sector during the difficult period of structural adjustment.

C. Project Objectives and Description

4. Project Objectives. The Project's two basic objectives were: (a) to support the institutional development of MINSAP in planning, management and finance; and (b) to improve the delivery of health and family planning services, especially at the periphery (rural health center level). The project's near-term focus on improving essential services, combined with its complementary emphasis on strengthening the institutional framework, was expected to create the basis for more extensive service delivery interventions in the future, towards achievement of the Government's 1993 goals.

5. Project Description. Part A of the project, regarding institutional development activities and requiring 26 percent of the project cost, included components for: improving MINSAP organization; creating a management information system; strengthening drug system management; developing and implementing methods for supervision of rural health services; introducing rational financial planning and assisting MINSAP to implement effective cost recovery measures; conducting policy studies on nutrition and family planning; and carrying out a demographic health survey (DHS) to improve the health statistics data base. In support of these actions, the project was set to finance vehicles, furniture, equipment, materials, 22 months of technical assistance, overseas fellowships, in-service training, supplies and travel and per diem.

6. Part B, to which 44 percent of the total project cost was allocated for investment and recurrent expenditures, was intended to strengthen health and family planning service delivery and included: providing basic equipment and essential drugs and materials to regional health directories; rehabilitating 25 health centers to serve approximately 175,000 people; and providing in-

service training to health personnel at all levels. Project financing for this part included civil works, vehicles, equipment, furniture, materials, medical and other supplies, technical assistance, short-term overseas fellowships, in-service training, salaries under contractual services, and travel/per diem. The remaining 30 percent of project cost was applied to financing preparation (through the Project Preparation Facility -- PPF) and project administration.

D. Project Design and Organization

7. This project emerged from an IDA sector review and a donor round table, both in early 1986. The resulting project design constituted a comprehensive response to the pressing needs identified by those exercises. Specifically, the design was intended to promote long-term institutional development within MINSAP, and at the same time cater to some immediate needs in health service delivery, by financing part of the non-wage recurrent costs (particularly medicines and materials), while alternative means for financing recurrent costs were developed. A study and trial on cost recovery, which was innovative for Guinea-Bissau, was proposed as a solution to MINSAP's difficulties in financing such costs on a regular basis. Unfortunately, the project's conceptual foundation proved to be overly ambitious in terms of project objectives and range of subjects covered. Had project designers taken greater account of implementation risks, and a more conservative appreciation of the timeframe required to effect institution building and organizational changes and to implement cost recovery measures, a less ambitious project would have resulted, with better prospects for good implementation.

8. The design did not include an evaluation component, nor did it have requirements for evaluation of training. There were no impact indicators specified to measure project effects on the population; the latter is not unreasonable in view of the short time span of project implementation -- originally three years, which were extended to four -- as well as the weaknesses of the data base for health conditions in the country. However, it would have been useful to include process indicators such as training required by specialty and duration, expected changes in the system and timing (for instance, for establishment of the management information system, drug system management, and rural supervision model) and clear objectives against which to evaluate the proposed studies and surveys. The policy studies were not fully designed and those which were executed did not lead to policy formulation.

9. Appropriateness of Project Scale and Scope. The total project cost of US$4.2 million during a three-year period implied an additional 25 percent annual financial input of recurrent and investment resources for the health sector -- a large but not unreasonable increase, if the balance of expenditures by project component would have been maintained during project implementation; however, there was a significant variance between project design and implementation (paras. 10-12). Additionally, the project scope was too broad, with many sub-components, each requiring very specialized expertise (e.g., management information system, drug logistics, field supervision, training, administration of research and studies). In order to successfully implement this project, MINSAP would have needed far more competence in

precisely those areas -- administration, financial planning, information management, human resource development -- that the project itself was designed to strengthen. Or alternatively, it would have needed a much greater capacity than demonstrated to administer a large volume of technical assistance. The end result was that MINSAP's acknowledged institutional and financial limitations, compounded by its inexperience in dealing with a relatively large project, exceeded the Ministry's implementation potential.

E. Project Implementation

10. Critical Variances in Project Implementation. Credit effectiveness was extended from September 18, 1987 to December 18, 1987, to allow Government to submit a three-year financial plan for MINSAP, incorporating the results of a health cost and cost recovery study. When it became apparent that this condition could not be met by December 18, 1987 the Development Credit Agreement was amended so that effectiveness would not be further delayed. Submission of the MINSAP plan was then changed from a condition of effectiveness, to a covenant to be met by April 30, 1988. This covenant was not fully met; while the consultants responsible for the cost recovery study produced an outline of a financial plan, it was never followed up in actual practice, due to the lack of expertise in financial analysis in MINSAP. Following effectiveness, implementation of the entire project fell seriously behind schedule, due in large part to institutional weaknesses within MINSAP that were originally identified as risks. There were persistent vacancies of key posts and other personnel problems within MINSAP, lack of counterpart funding, and procedural problems affecting drug procurement. It should also be noted that the period immediately preceding credit effectiveness and beginning of implementation coincided with IDA's reorganization which resulted in the replacement of the entire team for this project; this probably added to the delays.

11. A major variance between planned and actual project implementation was a shift in project composition and distribution of expenditures from civil works, operating costs, goods and services, and the PPF, to the following categories: (a) consultants and fellowships for which disbursements ended up being almost three times higher than originally planned (US$1.5 million, compared to US$500,000); (b) equipment, furniture, vehicles and materials for which IDA disbursed over twice the amount set at appraisal (US1.1 million compared to US$470,000); and (c) drugs and medical supplies, which received US$1 million compared to US$700,000 appraised. The following explanations were given by IDA staff for these changes:

(a) although the much higher than planned disbursement for consultants and training may have resulted in part from underestimates of costs at appraisal (for instance for the DHS and training this appears to be the case), this should have been compensated by the fact that several planned studies were not implemented; however, the costs of most of the contracts appear to have been too high in relation to the type of work performed and the outputs, undoubtedly a result of the low capability of MINSAP to manage contracting and supervising of consultants; in spite of the high

cost of consultants in this project, little training and institution building took place;

(b) a doubling in the amount spent for equipment, furniture, vehicles and materials could be attributed to price escalation and to a substantial underestimate of what it would cost to equip existing rural health facilities in order to implement the model of rural supervision; and

(c) at appraisal, drugs and medical supplies were intended to reinforce material resources in rural health units while they made the transition to a system of cost recovery; the higher amount spent in drugs and medical supplies resulted from an acute shortage due to temporary difficulties faced by regular donors (UNICEF, bilateral donors) to keep up with deliveries for the whole country; the Government, which has a non-significant budget for these items and depends on foreign assistance, requested IDA to use credit funds to cover the gap; also, at the end of 1987 the country suffered a cholera epidemic and credit funds were authorized for procuring drugs and medical supplies for this emergency; since then, the project supported drug management system plus Swedish assistance have improved coordination of drug supplies.

12. The civil works component consisting of remodeling 25 rural health centers, was heavily underspent because it was not implemented according to the original design. By the end of the project, only two centers had been rehabilitated with IDA financing, at a cost of under $50,000 compared with an original estimate for civil works of $430,000; another $50,000 was disbursed for civil works in the central MINSAP offices (all these costs exclude expenditures for detailed designs, disbursed under the consultant category). IDA staff sought other donors which agreed to finance the remainder of the health centers (outside this project). Construction delays leading to the eventual cancellation of most health center remodeling under the project was attributed by IDA staff to the slow progress of a consultant firm in preparing detailed designs and bidding documents, the long time required for translation of the technical documents, a lack of qualified local contractors, and disinterest on the part of large construction companies to bid for this work. Although a decision to downsize the construction component to 10 centers and reallocate other funds was taken in September, 1988, formal reallocation of proceeds took place only in February 1991, 9 months before credit closing, when most of the credit had already been disbursed.

13. The lack of Government counterpart funds persisted throughout the project. In spite of IDA staff consistent follow up on the need for the Government to contribute specified amounts of funds each year for project implementation, at credit closing its contribution was $61,900 compared to $210,000 required and agreed.

14. Project Risks. Two major risks were anticipated in this first population, health, and nutrition (PHN) project in Guinea-Bissau: (a) implementation difficulties due to the inexperience of MINSAP personnel in

executing major structural reforms, particularly with respect to cost recovery; and (b) insufficient availability of foreign exchange to meet the health sector's critical import requirements. Both concerns proved to be well founded and were resilient to efforts taken during implementation to overcome them.

15. Unforeseen Factors Affecting Project Implementation. In late 1988, several key MINSAP staff members were suspended pending Government investigations and were not replaced; those affected included the Director of Administration and Finance, the Director of Patrimony and the Director of Public Health. Additionally, the Director of Planning was sent abroad for a two-year training program. These personnel vacancies in the implementing agency and their non-replacement decreased the possibilities of institution building through the project and left most of the implementation in the hands of the project director -- a foreign consultant -- and his staff. In November, 1990, when a new health minister took over, a national Assistant Project Director financed by GUB was appointed. Another unforeseen event was that US$70,000 in project funds were frozen for over 2 and a half years by a bank in Las Palmas which was originally designated to hold the Project's special account; this was the result of a dispute between that bank and the Armed Forces, unrelated to the Project and MINSAP. Although this complication did not financially affect project outcome and was eventually resolved, it did cause a major diversion of staff time in communications and during supervision missions.

F. Major Results of the Project

Project Impact

16. Overall impact of the credit was mixed. Project achievements fell short of ambitious appraisal objectives. The cost-effectiveness of inputs such as technical assistance and provision of recurrent costs appears to have been low. Nevertheless, there were modest accomplishments in training and human resource development and in PHN data collection; the project also managed to make some initial inputs towards cost-recovery, better drug system management, improved rural supervision, and preliminary administrative reform within MINSAP. Because this project represents the first attempt by any donor in Guinea-Bissau to assist the health sector as a whole (as opposed to individual projects or sites), the mentioned contributions are especially noteworthy.

17. The original institutional development goal was to prepare a comprehensive three-year action program and financial plan for the health sector, including the creation of a rolling financial plan. MINSAP failed to adopt a rolling financial plan during the project lifetime (as explained in para 10); however, MINSAP was made aware of the need for such a plan and its preparation continues to be discussed with IDA and WHO. Moreover, despite delays, disputes and inadequacies that beset MINSAP's technical assistance, the Ministry managed to prepare, with WHO assistance, and adopt and partially implement a simplified reorganization plan. The Ministry appears headed, at last, toward decentralization of management, administration and finance, with a focus on increasing authority at the regional level.

Sectoral Policies

18. This project enabled Guinea-Bissau's health sector to make several noteworthy policy departures, and to follow them up with initial implementation measures. With regard to drug system management, for example, the project resulted in the establishment of an operational inventory control system. This was achieved through the provision of a computer and a vehicle for the Central Pharmaceutical Store, and training local staff in its use. A National Drug Formulary was also produced, and 535 copies furnished to the Central Drug Unit for nationwide distribution.

19. In terms of supervision of rural health services, the two regions chosen for project activities made headway in piloting a supervisory model for eventual replication in the country's other regions. Health education overseen by dedicated local staff sparked widespread interest among the rural population, and attracted growing numbers of traditional midwives. However, administrative turnover, plus lack of transport and of appropriate budget for keeping up with maintenance and recurrent costs of the rural health services, presented difficulties throughout. The supplies, equipment, vehicles and technical assistance provided under the project -- fortified by supervision and training contributed by Italian and Canadian non-governmental organizations (NGOs) -- made a start in strengthening the health system management process in the two regions, but was not enough to cover for the deficiencies. Also, the lack of continuity of health staff in regional positions and scarcity of resources continue to be major problems.

20. The concept of cost recovery in the health services was introduced in the project as a possible solution to the problem of persistent shortfalls in MINSAP's budget for recurrent costs; in 1990 a general declaration was issued announcing that cost recovery measures in the health services would begin soon. This encountered public opposition. Since that time, a national sensitization campaign began to educate the population on the need to pay for health services, and a Cost Recovery Committee was created within MINSAP. In the last year of the project, partial cost recovery measures (mainly for medicines, following the recommendations of the Bamako initiative) had been regularized in one region (Gabu) and were beginning to be selectively implemented in various parts of the country. Progress in this area was helped considerably by the fact that both WHO and UNICEF are committed to the Bamako initiative. However, its expansion to other parts of the country and to other items of health costs (e.g., medical visits, hospitalization, etc.) will be dependent on increased Government and public acceptability of the concept, a substantial increase in the quality of the health services to gain client satisfaction, and continued donor and technical support for some time to come.

Policy Studies

21. The project made a worthwhile contribution toward filling a vacuum with respect to Guinea-Bissau's PHN information base. A Demographic and Health Survey (DHS) was conducted and its results were presented in a 18-volume report. This was a major country-wide survey, which is expected to form the

supported by Bank and part of this project

basis of an improved health information system. It was conducted by a foreign consultant firm with the active participation of MINSAP and the Department of Statistics of the Ministry of Planning. Further, a Population and Family Planning Study and a Nutrition Policy Study were also produced by foreign consultants. All three constitute major contributions to the country's knowledge base; national seminars to disseminate study findings and results were carried out. It should be noted, however, that the seminar on DHS findings was funded by SPPF funds provided by IDA in connection with a follow-on project, because the consultant contract failed to include this activity and project funds had been exhausted. Although the execution and dissemination of the results of these studies and their consideration and approval by MINSAP's Technical Committee constitute useful achievements, the ultimate objective of using the findings of these surveys and studies for developing national policies in nutrition and in maternal and child health and family planning as a basis for health and social action programs, remains unaccomplished.

Human Resource Development

22. This component exceeded appraisal targets in terms of participants involved and funds expended. It encompassed project-related training, on-the-job training, short courses and seminars, primarily in the areas of administration, financial management, accounting, drug management, and maternal and child health. The Project Manager estimated that 6,500 people benefitted directly or indirectly from training, both funded by the project and as a result of the multiplier effect of trainers training grass-root workers; the Staff Appraisal Report target of 500 trained health personnel directly funded by the credit was amply met. The project design did not call for close monitoring or evaluation of training activities. However, according to the Project Director's assessment and periodic accounts by consultants, the project appears to have made a useful beginning in human resource development, and one that the upcoming Social Sectors Project can build on.

Civil Works

23. As already mentioned (para 10 on variances), activities under this component fell far short of appraisal goals. The number of facilities to be remodeled was first scaled back when, three years after the credit was signed, a supervision mission determined that project funds would cover only 11 of the 25 rural health centers slated for rehabilitation. Architectural briefs for these centers were then prepared under the project but, for the reasons already discussed, only two centers were actually rehabilitated with project funds. IDA staff succeeded in making the Government receive funds from several other donors to renovate about 20 other centers. A few centers on the original list turned out to be beyond repair.

Project account audits

24. Project accounts and audits were conducted by independent auditors selected and retained according to IDA Guidelines. All required audits were presented to IDA usually on time or with slight delays and were considered satisfactory.

G. Project Sustainability

25. Because of the low financial base for supporting health services, the lack of a clear financial plan, the large proportion of funding from external donors and MINSAP's limited capacity as managing agency for the sector, this project placed particularly strong emphasis on sustainability from the outset. For example, no new facilities were proposed and a primary goal in components as diverse as institutional development, training, drug management, rural supervision and cost recovery, was to develop appropriate frameworks for continuing efforts in the future. Although a foundation is now in place for expansion and improved quality of health activities as a result of this credit, the health system still lacks the competence for self-sustainment and growth and will need perhaps at least a decade to reach a level of an acceptable financial and technical sustainability. A follow-on Social Sectors Project will emphasize capacity building and substantially expand the human resource training begun with this project. The forthcoming project will also focus on technical assistance with stronger review and with built-in transfer of knowledge to national counterparts. In addition, it will have a social action fund to assist NGOs which have a good track record on the country, in developing micro-social sector projects and better reach those at the grass-root level.

H. IDA Performance

26. Major Strengths and Weaknesses. IDA staff showed consistent flexibility and creativity, which proved particularly important in view of the Borrower's inexperience. Moreover, during implementation IDA persistently and effectively pursued other donors and NGOs (WHO, EEC, UNFPA and others) to obtain additional technical assistance and funding for project-related activities, most notably for rehabilitation of health centers and the procurement and management of essential drugs. Efforts by IDA staff to strengthen donor coordination during this project paved the way for increased formal cooperation (particularly among IDA, WHO and UNICEF), which should benefit future efforts in the social sectors in Guinea-Bissau. However, there were some shortcomings, including the following:

(a) earlier identification of the problems affecting the construction component would have enabled the adoption of alternative solutions for successful bidding of the civil works including lowering the pre-qualification requirements for local contractors and grouping construction work in small packages; and

(b) a tighter control of the technical assistance costs, early detection of cost overruns, and closer attention to quality and

utilization of consultants could have led to higher effectiveness and lower costs than achieved in the project; only in 1991, when credit funds were almost exhausted, did IDA begin to impose limits on expenditures in consultants' contracts and placed strict limits to unprogrammed spending.

27. Lessons Learned. The following lessons may be used for future projects:

(a) Project preparation needs to identify accurately the weaknesses of the implementing agency in order to design projects that are realistically implementable; while identification of sector needs is important, frequently projects -- particularly first-time operations -- are not able to eliminate all sector constraints and it is essential to prioritize interventions;

(b) When construction components are part of a project, they should be properly prepared, although they are usually less significant than software components in addressing sector issues; in this project, remodeling of facilities was not sufficiently planned during project preparation and thus, problems regarding the capacity of the construction sector in the country and the need for alternatives to large contractors was acknowledged only at a late stage in the project cycle, when there was not enough time left to undertake a suitable remodeling program;

(c) technical assistance is an essential component in cases in which the capacity of the sector agencies is low; however, its design should be in line with the agencies' absorptive capacity, and should be closely supervised to enable remedial action in cases where quality, performance and cost become out of line with established standards and objectives; and

(d) Additional units or administrative staff for project management may be a good solution in cases were the implementing agency's capacity is low, but the experiences of this and other projects suggest that a project director, particularly a foreign consultant, should not be allowed to work without national counterparts and in isolation of the national agency or become the sole agent of communication with IDA; a main function of a project unit, in addition to project monitoring, should be institution building.

I. Borrower Performance

28. Major Strengths and Weaknesses. During project preparation, the Government took several reassuring steps: it acted diligently in appointing an expatriate Project Director and in creating a Project Management Unit, and committed itself to pursuing several changes in policy and organization. Regular quarterly reports were submitted, and the Borrower complied with Bank audit and other procedural requirements.

29. However, the project suffered serious implementation problems when MINSAP allowed key managerial positions to remain vacant for over two years for lack of competent candidates and other administrative problems. IDA exchanges during the project period were with the project management office, which in principle provided the link with the various MINSAP divisions; but interest in the project within MINSAP was low. This situation changed slightly under a new minister in 1990, when a stronger interest began to emerge; for instance, much of IDA's correspondence began to be copied to the Minister at her request. Implementation was also compromised by the Ministry of Finance's inability to make counterpart funds available when needed during the project period.

30. Lessons Learned. The main lesson learned by MINSAP was that when foreign consultants are contracted to run a project implementation unit, appropriate national counterpart staff must be in position and the implementing agency has the right and responsibility of oversight over the performance of the unit. The same concept of oversight applies to all technical assistance contracts. Additionally, knowledge transfer and/or training should be included in the terms of reference. When studies are conducted, consultants should have a contractual obligation to present their findings and explain the methodology used in the study to the client agency.

J. Project Relationship

31. The Bank-Borrower relationship throughout was satisfactory. A positive tone was set from the beginning and was sustained during implementation.

K. Consulting Services

32. Although most of the consultant services provided under the project resulted in acceptable studies and surveys, consultant performance could have been more cost effective had careful design been conducted at appraisal and more strict cost control and technical oversight had been exerted. The consultancy on MINSAP's reorganization was overly expensive in comparison to the results and produced recommendations that, according to Government evaluation, were not entirely appropriate for the local situation; as a result, the Ministry ended up adopting a simplified organizational design, with assistance from WHO.

L. Project Documentation and Data

33. The Staff Appraisal Report, supervision and consultant reports, and additional material contained in the project files provided adequate information for this project completion report. In addition, the Social Sectors Strategy Review (Volume I) published in September 1991 provided a very helpful in-depth view of the broader context in which this project was implemented.

PROJECT COMPLETION REPORT

GUINEA -BISSAU

POPULATION, HEALTH AND NUTRITION PROJECT

(Credit 1800-GUB)

PART II. PROJECT REVIEW FROM BORROWER'S PERSPECTIVE

1. The time has come to close this project which for the last four years has provided Guinea-Bissau with support for its national health policy, based on the delivery of primary health care.

2. In compliance with the covenants contained in the Credit Agreement 1800-GUB signed with IDA for the financing of the design and execution of the project, we must now make a general review of the project and present our evaluation.

3. All sorts and types of problems were encountered during the implementation of the Population, Health, and Nutrition Project; despite the lengthy duration of the project, it was impossible to successfully complete a large proportion of the components, leaving some objectives unaccomplished.

4. Certain actions were, however, accomplished albeit with considerable difficulty, such as the nutrition Study (Part 1) which was conducted between December, 1990 and January, 1991, followed by dissemination of the results through a seminar.

5. With respect to the Government's formulation of a Food and Nutrition Policy, we think it is logical and technically advisable to wait the completion of Part 2 of the study, so that the document to be submitted to the Government for approval can draw on the study's findings.

6. As for the counterpart funds, which the Government was to have made available in a amount equivalent to US$200,000, it is true that these were not provided on time because of the large number of projects in other sectors of Government activities that also depend on the National Development Fund; another factor was the country's serious shortage of financial resources. Nevertheless, a major effort was made and we believe that the Government met its commitment under the Credit Agreement.

7. Additional costs were incurred, particularly in connection with the Food and Nutrition Survey, which required an additional mission of the foreign consultants in December, 1990, because the June, 1990 mission had not been properly prepared by the Project Management Unit, which had failed to inform the Directora Nacional do Estudo of the plans to carry it out.

8. In view of the many different irregularities encountered during

project implementation and the lack of collaboration between the Management Unit and the other departments, it was felt advisable to appoint a national counterpart to act as Deputy and thus assist the National Project Manager, who was an expatriate.

9. As soon as the national counterpart was hired as Assistant Consultant, the National Project Director decided to turn his back on his responsibilities and go on a trip without giving anyone previous notification.

10. With respect to the cost recovery policy, the greatest difficulty was encountered when an attempt was made to provide health care to as wide a cross-session of the population as possible on the basis of a sliding scale tailored to each client's income level. These activities had to be suspended because of the extreme dissatisfaction and unrest that they caused among the public, unaccustomed to paying for health care.

11. We feel that the project design was faulty in certain respects, particularly where the structural objectives were concerned, viz. the reorganization of MINSAP and the Study on Family Planning.

12. MINSAP's reorganization was one of the Project's basic and essential objectives which, unfortunately, was impossible to accomplish in the short term. While it is true that some improvements were made in the Ministry's organization, we have to admit that we have serious doubts whether these were basically influenced by the conclusions and recommendations of the consultant firm involved or prompted by the distinctive style of the new leadership.

13. The conclusions and recommendations are there, and we have a number of manuals that we can use for a basic undertaking of this type, but the project design did not pay proper attention to the real life situation of our institutions and the status of our staff, who are greatly demoralized by their low salaries, which make it necessary for them to find second jobs, leaving them insufficient time to perform their work properly, let alone read the extensive paper files left by the consultant.

14. Regarding the Family Planning Study, it had a worthwhile objective in an area in which the Government definitely needs to adopt a policy. However, we must question its scope and success. The fact is that it touches on one of the most intimate aspects of conjugal and personal life, where cultural values are deeply ingrained; for this reason, any measures that are adopted to deal with this matter, inevitably cause some upset and are doomed to failure from the start.

15. We feel that the most appropriate course of action is to offer education through case-by-case medical consultations and through the schools, by increasing the enrollment rate among our children. In fact, as a specialist has concluded from a study on this topic, a woman who has never attended school is likely to have twelve children, one who has completed fourth grade is unlikely to have more than eight, one who has completed secondary education diploma is expected to stop at four, and one who has completed university is unlikely to have more than two.

16. In our opinion, the project design failed in these two specific areas because insufficient attention was paid to the basic issue responsible for the real life situation, resulting in a considerable investment which offered very limited chance of success from the start.

17. The Project execution per se had its own problems, above and beyond the deficiencies that had to do with the design, in so far as it encountered difficulties in the field, which it failed to overcome. This may have resulted from a failure to secure the cooperation of other government officials who felt removed from the project objectives; it could also be that the Project Management Unit did not work hard enough and had serious shortcomings which were particularly glaring with respect to rehabilitation of health centers, assistance given to consultants, and procurement of consumable and durable goods and equipment.

18. The World Bank's financial management of the project did cause some difficulties, but these were, in fact, neither insurmountable nor pivotal in those areas where the project was less than successful. In any case, we feel that it should be possible, in the medium term, to move toward other forms of joint financial management, which would allow the local management unit more freedom of movement for the sake of facilitating efforts to accomplish the Project's objectives, provided it is headed by an appropriate and capable manager.

19. In our opinion, the design and execution of the project was not entirely bad and it is bound to have a positive contribution toward improving the delivery of health care throughout to country, providing better information on existing health care facilities and pointing the way to a new policy of health care and for the management and cost-effective utilization of available resources. Despite the lack of success with the cost recovery policy, lessons have been learned from the experience gained so that we may, in the medium term, develop an efficient system for amortizing the costs of health care, which have, until now, been fully born by the State. We shall continue with the Bamako initiative and believe that the entire country will, in the course of time, eventually understand the need for each user to contribute toward amortizing the costs and improving the quality of health care.

20. We could certainly achieved better results, had the project management not been so poor, even in the case of the most viable components. We feel justified in giving the project now completed a passing grade, thanks to the funds made available and to the controls imposed by the new leadership of the Ministry. A further point worth remembering it that prior to 1990 the project focussed basically on the procurement and distribution of goods for consumption and direct utilization.

21. The people of Guinea-Bissau are suffering from serious deprivation and shortages. Health sector statistics, such as birth rates and infant and maternal mortality rates, not to mention the prevalence of malnutrition in certain parts of the country, as well as endemic diseases including malaria, diarrhea and AIDS, speak loud and clear and force the Government to make an all-out effort in order to minimize the disastrous consequences, which not only increase the burden on

the State, but also hold back the country's development process.

22. We consider that this project served as a test from which the country has been able to learn some valuable lessons.

23. In light of all what has been said earlier, we are convinced that at least one lesson has been learned, and that is that projects must not directly pursue any structural objectives without local involvement. We believe that even in the absence of the difficulties listed above, it would have been preferable to find ways to encourage an internal exchange of experience and to give priority to the work and consulting services of local experts who, even if not equipped to offer studies as elaborate as those provided by the international consultants, would produce findings that would have the advantage of reflecting the country's real situation more closely and would therefore have a greater impact. Furthermore, only by giving these technical experts a challenge will it be possible to ensure their real and sustained development until they are eventually capable of serving as an ongoing resource to international consultants.

24. The fact therefore bears repeating that the project was a success. The results obtained provide a storehouse of information on which we will be able to draw in order to maximize the returns on future undertakings.

25. We hope to continue to earn the support of the international community, since we are determined to do our utmost to renew our hope of entering the twenty-first century with a more satisfactory health profile that will enable us to meet the challenge of development and the attainment of "Health for All" by the year 2000.

Bissau, June, 1992

PROJECT COMPLETION REPORT

GUINEA-BISSAU

POPULATION, HEALTH AND NUTRITION PROJECT

(CREDIT 1800-GUB)

PART III. STATISTICAL INFORMATION

1. Related Bank Loans and/or Credits

Not applicable.

2. Project Timetable

Item	Original Date	Revised Date	Actual
Identification I			01/86
Identification II			04/86
Preparation			07/86
Pre-appraisal Mission			09/86
Appraisal Mission			12/86
Credit Negotiations			03/87
Board Approval			05/19/87
Credit Signature			05/22/87
Credit Effectiveness	09/18/87	12/18/87	12/18/87 1/
Credit Closing	06/30/91	12/31/91	12/31/91 2/

1/ Credit effectiveness was extended to allow Government's submission of a three-year action program and financial plan, incorporating the results of a health cost and cost recovery study. As this condition could not possibly be met by December 1987 and thus further unecessary delays to project implementation would have been created, it was recommended, after amending the Development Credit Agreement (new Section 3.10), that it become a covenant to be met by April 30, 1988. However, this covenant has never been fully complied.

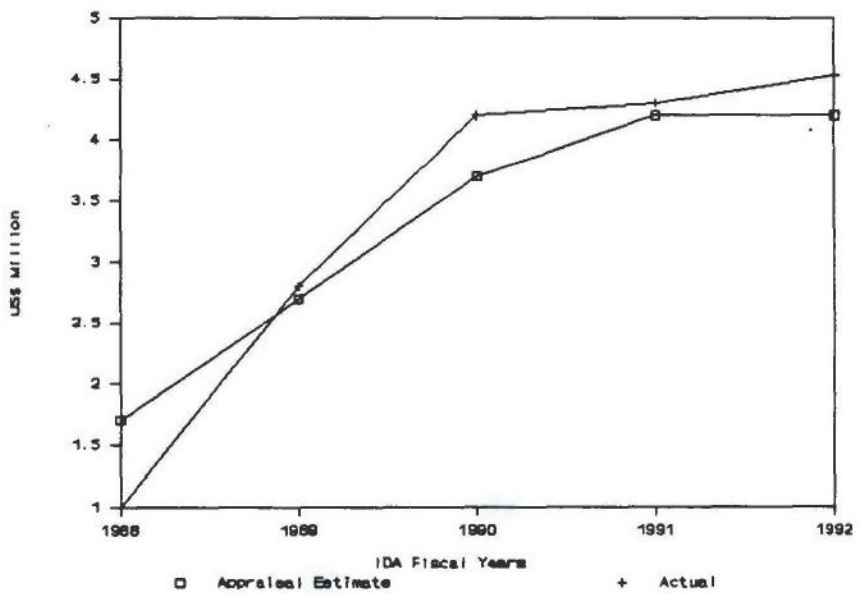
2/ Project closing date was extended on June 13, 1991, to allow Government to complete key project activities.

3. Credit Disbursements

A. Cumulative Estimated and Actual Disbursements
(US$ million)

Fiscal Year	FY88	FY89	FY90	FY91	FY92
Appraisal Estimate	1.7	2.7	3.7	4.2 1/	
Actual	0.9	2.8	4.2	4.4	4.5
1/					
Actual as % of Estimate	55.3	103.7	112.2%	103.8	107.9

B. Time Line of Appraisal Estimate and Actual Disbursement Schedule



1/ Because of the fluctuation of the US dollars against SDR, the project benefitted from additional funds equivalent to about US$300,000. All funds under Credit 1800-GUB are now disbursed. There was no cancellations to this Credit.

Table C: Allocation of Proceeds

Category	In SDRs				In US$
	Original Allocation	Revised 1/	Actual Disbursements 2/	Balance	Balance 3/
1. Civil Works	350,000	98,700	70,590	28,110	37,452
2. Equipment, furniture, vehicles and materials	380,000	668,900	798,335	(129,435)	(172,453)
3. Consultants' services and fellowships	400,000	1,124,700	1,124,188	512	682
4. Drugs and medical supplies	560,000	698,900	748,581	(49,681)	(66,193)
5. Operating Costs	340,000	55,900	56,054	(154)	(205)
6. Goods and services related to implementation of activities and programs resulting from policy studies	220,000	137,500	137,535	(35)	(46)
7. Refunding of PPF	850,000	460,500	466,708	(6,208)	(8,272)
8. Unallocated	300,000	154,900	(1,992)	152,908	203,727
TOTAL	3,400,000	3,400,000	3,400,000	0	0

1/ Formal reallocation of credit proceeds was done per IDA's telex of February 1, 1991.

2/ Actual and final disbursements.

3/ At exchange rate of US$1.33 = 1 SDR.

a:tabl6.wk1 (gubpcr)

21-Apr-92

4. Project Implementation

Project Components	Unity	SAR Estimates	Actual	Comments
Part A. Institutional Development				
1. Organization and Management:				
(a) Implementation of MINSAP's reorganization plan;	Unit	1	0.5	Work performed by Firm of consultants was inadequate; a simpler plan was proposed and then implemented.
(b) Design and Implementation of a Management Information System	Unit	1	0.5	MIS was implemented for the cost recovery measures but was not entirely instituted.
(c) Implementation of a plan to improve drug system management	Unit	1	1	A Drug Management System has been implemented and the Central Drug Unit is operating efficiently.
(d) Development, testing and implementation of a model system for the supervision of rural health services in the Bafata region and the Sonaco area of Gabu region.	Unit	1	1	The rural supervision component was carried out successfully in the Bafata Region and in Sonaco (Gabu Region) in spite of some problem such as inadequate transportation.
2. Planning and Policy Development:				
(a) Study on the Hospital sector, including rehabilitation needs.	Unit	1	0	The study did not take place as part the PHN Project but rather within the framework of the Bank's Social Sectors Strategy Review.
(b) Study on Nutrition.	Unit	1	1	Study was endorsed by the Technical Committee and then by MINSAP Minister in August 1991. A seminar to discuss study's findings was carried out in late 1991.
(c) Study on Family Planning.	Unit	1	1	Study was well received by the Technical Committee and MINSAP. A seminar on the study has been carried out.
(d) Study on demand for health services at the health center level	Unit	1	0 1/	It was decided that these two studies should be in abeyance until more urgent studies be carried out.
(e) Study on energy requirements of the health sector and alternative sources of energy.	Unit	1	0 1/	
(f) Improvement of basic PHN data including:				
(i) analysis of the 1979 census;	Unit	1	1	
(ii) implementation of a national sample survey;	Unit	1	1	The DHS has been completed and data distributed. A seminar to discuss the DHS results will be held in May 1992 under a SPPF.
(iii) Creation of a data bank;	Unit	1	0.1	Rudimentary data bank done.
(iv) Training of DGE and MINSAP's staff in statistics	Unit	1	1	Training in statistics, accounting and computer were carried out. However, it is recommended that further training in those areas be provided.

1/ Because of the overextended capacity of the PMU in carrying out a large number of activities to be implemented under this project, the project staff recommended that these two studies be put in abeyance until a number of more pressing activities be completed.

Project Components	Unity	SAR Estimates	Actual	Comments
Strengthening Health and Family Planning Services				
Support for Rural Health Services:				
(a) Strengthening of the 8 Regional Directories and implementation of supervision and management techniques in the regions, following the results of the model system referred to in Part A.1.(d) above.	Unit	8	2	Regional Directories will be strengthened in a future project. PHN focused on Bafata and Gabu regions.
(b) Rehabilitation of about 25 health centers.	Unit	25	7	Rehabilitation: 2 health centers under the project; 4 health centers by CECI (Canada); 1 health center under PASI project; only 5 health centers of the remaining 18 are listed as irreparable.
(c) Shipping, furnishing and provision of health care inputs to about 122 health centers.	Unit	122	109	In addition to 109 health centers, 3 referral centers; 5 sectoral hospitals; 8 regional hospitals; and 2 national hospitals obtained equipment, materials,
(d) Manpower Development:				
Establishment of an in-service training program for about 500 health workers in maternal and child health, epidemiology, family planning, nutrition, drug prescription/utilization, health and nutrition education and other health areas.	Unit	500	500	It is estimated that about 6,500 persons benefitted directly or indirectly from the training provided under the project.

5. Project Costs and Financing

Table A. Project Costs (US$ '000)

Category	Appraisal Estimates			Actual 1/		
	Local Costs	Foreign Exchange Costs	Total	Local Costs	Foreign Exchange Costs	Total
1. Civil Works	24.4	395.6	420.0	35.3	58.8	94.1
2. Equipment, Furniture, vehicles and materials	6.9	478.9	485.8	66.6	1,003.2	1,069.8
3. Consultants' Services and Fellowships	52.5	613.4	665.9	162.0	1,335.8	1,497.8
4. Drugs and Medical Supplies	0.0	625.2	625.2	69.8	927.6	997.4
5. Operating Costs	79.6	385.7	465.3	69.0	61.2	130.2
6. Goods and Services under Part A.2 (b) of the Project	14.7	382.5	397.2	0.0	183.2	183.2
7. Refunding of PPF	46.0	922.0	968.0	0.0	621.8	621.8
8. Unallocated	62.0	322.2	384.2	0.0	(2.7)	(2.7)
Total	286.1	4,125.5	4,411.6	402.7	4,189.0	4,591.7

1/ Government's contribution reflects data shown in Audit Report covering period until December 31, 1991.

b:tab4.wk1 (gubpcr)

16-Jun-92

Table B: Project Financing (in US Dollars)

Source of Financing/ Categories of Expenditures	Planned (Credit Agreement)1/	Revised 2/	% of Total	Final 3/	% of Total	Balance
I. IDA:						
1. Civil Works	470,000	131,503	2.8%	94,051	2.0%	37,452
2. Equipment, furniture, vehicles and materials	560,000	891,209	18.8%	1,063,662	23.2%	(172,453)
3. Consultants' Services and Fellowships	640,000	1,498,494	31.6%	1,497,812	32.6%	682
4. Drugs and Medical Supplies	740,000	931,179	19.6%	997,372	21.7%	(66,193)
5. Operating Costs	430,000	74,478	1.6%	74,683	1.6%	(205)
6. Goods and Services under Part A.2 (b) of the Project	400,000	183,198	3.9%	183,245	4.0%	(46)
7. Refunding of PPF	970,000	613,547	12.9%	621,819	13.5%	(8,272)
8. Unallocated	0	206,381	4.4%	(2,654)	-0.1%	209,035
TOTAL IDA	4,210,000	4,529,990	95.6%	4,529,990	98.7%	0
II. GOVERNMENT OF GUINEA-BISSAU						
1. Civil Works	20,000	20,000	0.4%	0	0.0%	
2. Equipment, furniture, vehicles and materials	10,000	10,000	0.2%	6,137	0.1%	
3. Consultants' Services and Fellowships	70,000	70,000	1.5%	397	0.0%	
5. Operating Costs	110,000	110,000	2.3%	55,364	1.2%	
TOTAL GOVERNMENT OF GUINEA-BISSAU	210,000	210,000	4.4%	61,898	1.3%	
TOTAL PROJECT FINANCING	4,420,000	4,739,990	100.0%	4,591,888	100.0%	

1/ Allocation to each category of expenditures is inclusive of price and physical contingencies.

2/ Formal reallocation of the credits proceeds was done per IDA's telex of February 1, 1991. Because of the fluctuation of the US dollars against SDR, the project benefitted from additional funds equivalent to about US$300,000.

3/ For IDA: Actual and final disbursements status. For Government: based on Audit Report covering period ending December 31, 1991.

(Exchange Rate US$1.33 = SDR 1).

a:tab5.wk1 (ja12-b)

16-Jun-92

6. Project Results

Item	Purpose as Defined at Appraisal	Status	Impact of Action
A. Studies			
1. Health cost and cost recovery study, and a three-year financial plan study.	To address the lack of financial planning and improve financing of non-wage recurrent costs.	The studies were financed partially under PPF and were completed.	Created a great deal of awarenes in the MINSAP; cost recovery measures have been implemented in the Gabu Region and it is expected to expand to other regions.
2. Study on the Hospital sector, including rehabilitation needs.	The study would focus on utilization rates, quality of care, manpower and investment requirements, physical condition of facilitites and rehabilitation needs, availability of housing for health workers, and overall costs of the sector.	The study did not take place as part the PHN Project but rather within the framework of the Bank's Social Sectors Strategy Review.	It should assist the MINSAP in improving planning and allocation of resources.
3. Study on Nutrition	To better determine nutritional status in the country, including food choice, preparation habits, and causality of malnutrition.	Study was endorsed by the Technical Committee and then by MINSAP Minister in August 1991. A seminar to discuss study's findings was carried out in November 1991 for health workers.	Providing to health workers basic knowledge and skills as regards nutrition for applying acquired skills in the the rural areas and thus reaching a greater population.
4. Study on Family Planning	To develop, test and implement a simple guide for classifying and referring women according to their level of obstetrical or reproductive risks.	Study was well received by the Technical Committee and MINSAP. A seminar on the study has been carried out in January 1992 for a majority of health workers.	Providing to health workers basic knowledge and skills as regards family planning for applying acquired skills in the the rural areas and thus reaching a greater popula
5. Study on Demand for Health Services at the Health Center Level	To be implemented by the National Institute for Studies and Research (INEP). To examine popular perceptions of health center services, most common services sought, and levels of community support for the health centers.	Study was not carried out per se, but was tied to the information received from the result of the Demographic Health Survey (DHS), (see B-2 below).	
6. Study on Energy Requirements of the Health Sector and Alternative Sources of Energy	To evaluate the energy requirements of sector hospitals, health centers and health personnel's residences and to propose alternative energy sources.	Prioritization of studies' to be carried out revealed that these studies should be put in abeyance so that efforts and resources could be concentrated on other types of studies (family planning, nutrition, etc.) selected because of their urgencies.	
7. Study to Determine Transportation Needs of Outer Islands;	Not specified.	Dropped	Insufficient funds and priority low.
8. Study of Low-cost Housing Needs for Health Personnel assigned to Rural Facilities.	Not specified.	Dropped under the project.	Will be part of the subsequent project instead.
B. Data Collection and Analysis:			
1. Analysis of the 1979 Census;	Analysis and publication of results	Carried out	Incorporated into DHS data.
2. Implementation of a national PHN sample survey (or DHS);	Implementation started under PPF.	The DHS was completed and data distributed.	A seminar to discuss the D results is expected to tak place in April 1992 under SPPF.
3. Creation of a data bank;	Through the provision of a 3-month overseas fellowship for a data technician and technical assistance from a data bank information specialist.	Rudimentary data bank done.	
4. Training of DGE and MINSAP's Staff in Statistics;	Through the provision of technical assistance from a public health statistician and an 8-month oversees fellowship in health statistics.	Training in statistics, accounting and computer were carried out. However, it is recommended that further training in those areas be provided.	Improving skills capacity note but more is required.

b:res.wk1 (ja31)
18-Mar-92

7. Compliance with Covenants

Section	Covenant	Status
2.02 (b)	The Borrower shall open and maintain in dollars a special account in a commercial bank on terms and conditions satisfactory to IDA. Deposits into, and payments out of, the Special Account shall be made in accordance with the provisions of Schedule 4 to the Development Credit Agreement (DCA).	In full compliance. The Special Account has been fully recovered. MINSAP was recently informed that it should give instructions to Citibank, Senegal to close the account.
3.03	The Borrower shall not later than October 30 in each year of the project review in detail with IDA, MINSAP's: (a) three-year action program and financial plan; (b) development and recurrent budget for the following fiscal year; (c) organizational structure; (d) rural supervision procedures; (e) in-service training program; and (f) the results of special policy studies and potential new program.	In full compliance except for (a), where it was complied with "in principle", but not in reality.
3.04	The Borrower shall, not later than March 31, 1988, take all necessary measures to enact and make public its national drug policy.	In compliance. National Drug Formulary published in 1991. Drug policy and cost recovery measures implemented and refined. Computer training taken in Fall 1991 by drug management staff to help adequate implementation of the measures.
3.05	The Borrower shall take all necessary action to grant to MINSAP the legal exemption established by Decree No. 51/85 of December 4, 1985 of the Borrower to allow the retention of 100% of all fees collected by MINSAP in accordance with the health cost recovery measures implemented.	Pilot activities introducing cost recovery measures, and Bamako initiative, were implemented on April 1, 1990 in the Gabu Region; it is expected that these measures will be expanded to other regions during the next year.
3.06	The Borrower shall, not later than November 30, 1987, establish an account in the National Bank of Guinea-Bissau (BNG) (MINSAP account) on terms and conditions satisfactory to IDA. All proceeds accruing from fees collected pursuant to Section 3.05 of the DCA shall be deposited in the MINSAP Account.	In full compliance.
3.07	(a) not later than January 1, 1989, complete and furnish to IDA for its review and comments, the recommendations resulting from the studies related to nutrition carried out by the Borrower pursuant to Part A.2 (a) (ii) of the Project;	In full compliance. A national seminar was carried out in November 1991, to discuss and disseminate the results of the study.
	(b) not later than January 1, 1989, prepare a national nutrition policy and action program;	Not complied. Expected that this will be the end result of study and national seminar carried out in late 1991.
	(c) promptly thereafter exchange views and agree with IDA on the implementation of said policy and action program.	Not complied.
3.10	The Borrower shall, not later than April 30, 1988, furnish to IDA MINSAP's action programs and financial plan for the 1988-1990 period, incorporating the results of the health cost and cost recovery study carried out by the Borrower on terms and conditions satisfactory to IDA.	Not complied. However, MINSAP has recently made positive progress in the development of a rolling financial plan. MINSAP's Office of Planning and a WHO technical assistant are drafting a financial plan for the Ministry, which would serve as a working document, and financial planning and management vehicle.

Section	Covenant	Status
4.01	(a) The Borrower shall maintain or cause to be maintained records and accounts adequate to reflect in accordance with sound accounting practices and operations, resources and expenditures in respect of the Project of the departments or agencies of the Borrower responsible for carrying out the Project or any part thereof.	In full compliance. A last audit report, which will cover the period ending December 31, 1991, is being prepared and its submission to IDA is expected before end of June 1992.
	(b) The Borrower shall: (i) have the records and accounts referred to in para. (a) of this Section, including those for the Special Account for each fiscal year audited, in accordance with appropriate auditing principles consistently applied, by independent auditors acceptable to IDA; and	Same as above.
	(ii) furnish to IDA, as soon as available, but in any case not later than six 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 IDA shall from time to time reasonably request.	
	(c) For all expenditures with respect to which withdrawals from the Credit Account were made on the basis of SOEs, the Borrower shall:	Same as above.
	(i) maintain or cause to be maintained, in accordance with para. (a) of this Section, records and accounts reflecting such expenditures;	
	(ii) retain, until at least one year after the completion of the audit for the fiscal year in which the last withdrawal from the Credit Account was made, all records (contracts, orders, invoices, bills, receipts and other documents) evidencing such expenditures;	
	(iii) enable IDA's representatives to examine such records; and	
	(iv) ensure that such records and accounts are included in the annual audit referred to in para. (b) of this Section and that the report of such audit contains a separate opinion by said auditors as to whether the SOEs submitted during such fiscal year, together with the procedures and internal controls involved in their preparation, can be relied upon to support the related withdrawals.	

8. Use of Bank Resources

A. Staff Inputs

(Staffweeks)

Project Stage	Fiscal Years							Total
	FY86	FY87	FY88	FY89	FY90	FY91	FY92	
Preparation/Preappraisal	11.8	33.0						44.8
Appraisal		42.1						42.1
Negotiations		3.3						3.3
Supervision		1.2	21.6	8.9	17.5	11.6	9.9	70.7
Completion							8.0	8.0
TOTAL	11.8	79.6	21.6	8.9	17.5	11.6	17.9	168.9

b:staff.wk1 (gubpcr)

10-Mar-92

B. Mission Data

Project Stage	Month/ Year	No. of Persons	Days in Field	Specializations Represented 1/	Performance Status by Activity 2/				
					O	D	C	M	F
Identification I	01/86	3	15	PO, CONS: E, P					
Identification II	04/86	3	8	PO, CONS: E, P					
Preparation	07/86	3	12	PO, CONS: E, A					
Pre-appraisal	09/86	2	8	E, CONS: E					
Appraisal	12/86	6	12	PO, E, OA, CONS: E, E, PS					
Post-Appraisal	01/87	1	6	CONS: E					
Supervision 1	10/87	2	5	PO, A	Not rated				
Supervision 2	03/88	1	10	CONS: E	Not rated				
Supervision 3	06/88	1	10	PO	2	1	n.a.	2	2
Supervision 4	10/88	1	5	PO	Not rated				
Supervision 5	06/89	3	10	PO, CONS: E, P	2	1	2	2	3
Supervision 6	10/89	1	10	PO	2	2	2	2	3
Supervision 7	03/90	3	16	PO, CONS: PH, P	2	2	2	3	3
Supervision 8	07/90	1	7	PO	Not rated				
Supervision 9	03/91	1	13	PO	2	2	2	3	2
Supervision 10	10/91	2	5	PO, RA	2	2	2	3	2
Completion	01/92	2	8	PO, RA	Not Rated				

1/ A = Architect; E = Economist; OA: Operations Analyst; P = Physician;
PH = Public Health Specialist; PO = Project Officer; PS = Pharmaceutical Specialist;
RA = Research Analyst

2/ O = Overall Status; D = Project Development Objectives; C = Compliance with Legal Covenants;
M: Project Management Performance; F = Availability of Funds.

b:mission.wk1 (gubpcr)

21-Apr-92

Annex 1

PROJECT COMPLETION REPORT

GUINEA-BISSAU

POPULATION, HEALTH AND NUTRITION PROJECT

PARTICIPANTS IN COMPLETION MISSION 1/

October 1991 and January 1992 Missions

World Bank

Ms. Carol Hoppy, Project Officer and Task Manager, AF4PH
Ms. Johanne Angers, Research Analyst, AF4PH

Ministry of Health and Social Affairs

H.E. Henriqueta Godinho Gomes, Minister of Health and Social Affairs
Dr. Sylvestre Alves, PHN Assistant Project Director

October 1991 Mission

Ministry of Health and Social Affairs

Dr. Celestino Costa, Ex-Secretary of State for Health,
Sr. Augusto Paulo, Chief, Office of Planning and Internation Cooperation
Sr. Malam Drame, Office of Planning and International Cooperation
Sr. Antonio Paulo Gomes, Office of Planning and International Cooperation
Dr. Estevao Malam Da Costa, Pharmacist, National Drug Depository
Dr. Paulo Jose Mendes, Director-General, Human Resources
Nurse Maria Augusta Biai, Director, Technical School for Nurses
Dr. Jose Antonio, Director of Public Health
Prof. Deant Kaymah, PHN Project Director

World Health Organization (WHO)

Dr. Erling Larsson, WHO Technical Advisor, Drug Management

1/ A supervision mission was carried out in October 1991 when several discussions on project's activities were held with key officials.

Annex 2

PROJECT COMPLETION REPORT

GUINEA-BISSAU

POPULATION, HEALTH AND NUTRITION PROJECT

RECORD OF PROJECT QUARTERLY PROGRESS REPORTS SUBMITTED

1.	May 24, 1988	PHN Progress Report No. 1 for period ending May 1988.
2.	October, 1988	PHN Progress Report No. 2 for period ending September 1988.
3.	December, 1988	PHN Quarterly Progress Report No. 3 for period ending December 1988.
4.	March 10, 1989	PHN Quarterly Progress Report No. 4 for period ending March 1989.
5.	July 8, 1989	PHN Quarterly Progress Report No. 5 for period ending June 1989.
6.	October 12, 1989	PHN Quarterly Progress Report No. 6 for period ending September 1989.
7.	December 4, 1989	PHN Quarterly Progress Report No. 7 for period ending December 1989.
8.	March 6, 1990	PHN Quarterly Progress Report No. 8 for period ending March 1990.
9.	June 29, 1990	PHN Quarterly Progress Report No. 9 for period ending June 1990.
10.	December 15, 1990	PHN Quarterly Progress Report No. 10 for period ending December 1990.
11.	March 15, 1991	PHN Quarterly Progress Report No. 11 for period ending March 1991.
12.	July 7, 1991	PHN Quarterly Progress Report No. 12 for period ending June 1991.
13.	October 5, 1991	PHN Quarterly Progress Report No. 13 for period ending September 1991.
14.	December 28, 1991	PHN Quarterly Progress Report No. 14 for period ending December 1991.