SecM93-646

FROM: Vice President and Secretary

June 28, 1993

PROJECT COMPLETION REPORT

BOTSWANA: Family Health Project

(Loan 2413-BT)

Attached is a copy of a memorandum from Mr. Picciotto with its accompanying report entitled "Project Completion Report: Botswana - Family Health Project (Loan 2413-BT)" dated June 18, 1993 (Report No. 12014) prepared by the Africa Regional Office, with Part II contributed by the Borrower.

Distribution

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Report No. 12014

PROJECT COMPLETION REPORT

BOTSWANA

FAMILY HEALTH PROJECT
(LOAN 2413-BT)

JUNE 18, 1993

Population and Human Resources Division
Southern Africa Department
Africa Regional Office

FISCAL YEAR

April 1 through March 31

CURRENCY EQUIVALENTS

At time of Appraisal (1982) = US$1 = Pula 1.07
At time of Completion (1992) = US$1 = Pula 1.99

GLOSSARY

AD	Assistant Director
APT	Architectural Planning Team
CHSC	Community Health Services Center
CHSD	Community Health Services Department
CMS	Central Medical Store
CSO	Central Statistics Office
DABS	Department of Architectural and Building Services
DEMS	Department of Mechanical and Electrical Services
DHT	District Health Team
GOB	Government of Botswana
GON	Government of Norway
IUAT	International Union Against Tuberculosis
IEC	Information, Education and Communication
MCH/FP	Maternal and Child Health and Family Planning
MLGL	Ministry of Local Government and Lands
NHL	National Health Laboratory
MOH	Ministry of Health
NDP	National Development Plan
PH	Primary Hospital
PHC	Primary Health Care
PIU	Project Implementation Unit
PMH	Princess Marina Hospital
PPF	Project Preparation Facility
RHT	Rural Health Team

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

Office of Director-General
Operations Evaluation

June 18, 1993

MEMORANDUM TO THE EXECUTIVE DIRECTORS AND THE PRESIDENT

SUBJECT: Project Completion Report on Botswana
Family Health Project (Ln. 2413-BT)

Attached is the Project Completion Report on Botswana - Family Health Project (Loan 2413-BT) prepared by the Africa Regional Office. Part II of the report was prepared by the Borrower.

Underpinning the Government's reorganization of its health care delivery system and despite considerable delays and difficulties, the project was ultimately successful in meeting three central objectives: (a) strengthening the country's Rural Health Teams and developing 13 rural and urban primary health care centers so as to provide more outpatient care and free in-patient resources, (b) upgrading the country's main hospital facility and (c) helping in nearly doubling the incidence of family planning.

On the other hand, the Government did not put in place an improved budgeting and accounting system, and civil works were subject to cost overruns. Weak coordination of the various ministry agencies' activities was detrimental to institutional development which was only partially achieved.

Nevertheless, the prospects for sustainability of the strengthened health care delivery system are adequate and the overall project outcome is rated as satisfactory.

The PCR provides a candid account of project achievements and shortcomings. No audit is planned.

Attachment

PROJECT COMPLETION REPORT

BOTSWANA

FAMILY HEALTH PROJECT
(LOAN 2413-BT)

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MAP - IBRD 11895R

PROJECT COMPLETION REPORT

BOTSWANA

FAMILY HEALTH PROJECT
(Loan 2413-BT)

PREFACE

This is the Project Completion Report (PCR) for the Family Health Project in Botswana, for which Loan 2413-BT in the amount of US$ 11.00 million was approved on May 15, 1984. The Government of Norway provided a Grant amounting to US$ 7.2 million equivalent to finance portions of the project. The Loan and the Norwegian Grant were fully disbursed. The last disbursement was on July 22, 1992.

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

The PCR is based, inter alia, on the Staff Appraisal Report; the Loan Agreement; the Grant Agreement between the Governments of Norway and the Borrower; supervision reports; correspondence between the Bank and the Borrower; Progress Reports by the Borrower; and interviews with Bank staff and Botswana officials who were closely associated with the Project.

PROJECT COMPLETION REPORT

BOTSWANA

FAMILY HEALTH PROJECT
(Loan 2413-BT)

PREFACE

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PROJECT COMPLETION REPORT

BOTSWANA

FAMILY HEALTH PROJECT
(Loan 2413-BT)

EVALUATION SUMMARY

Project Objectives and Content

i) The main objectives of the project were: (a) to improve the effectiveness and efficiency of Botswana's health care delivery system, and (b) to strengthen nationwide availability of family planning services. Specifically, the project aimed at assisting the Government to attain these objectives by reorganizing and strengthening the central organization of the Ministry of Health (MOH), progressively building up each level of the health care delivery system, strengthening family planning activities in the Maternal and Child Health (MCH) program, introducing family planning activities in women's programs, reducing the unit cost of health care , and improving the efficiency of the pharmaceutical supply system.

Implementation Experience

ii) Overall project performance was satisfactory. On the physical side, with the notable exception of the Princess Marina Hospital (PMH), all the rural and urban health centers, as well as well as the Community Health Sciences Center (CHSC) were completed as planned. The project was also quite successful with respect to institutional and program strengthening, as detailed below (Paras. 13-24).

iii) The major variances between planned and actual implementation were as follows: a) The project's Closing Date was extended by three years to allow completion of project components (excepting PMH); b) PMH upgrading remains unfinished and it is estimated that the Hospital will be completed and fully operational in 1994, about six years behind the original schedule, iii) Expansion of the Central Medical Stores (CMS) in Gaborone and a new pharmaceutical store in Maun were deleted from the project in favor of a new storage facility financed by the Government; and finally iv) the Government decided not

to introduce cost recovery schemes in the health sector, as part of its overall policy to provide free (or almost free) primary health services to the population, particularly in rural areas.

iv) Some of these variances, especially the delay at PMH, were caused by factors that were essentially beyond the control of the project. Some of those factors included: a one-year freeze in hiring expatriate technical assistance staff and consultants on account of financial constraints caused by the 1985 draught in the country; delays in recruiting the team leader for the Architectural Planning Team (APT), and subsequently turn-overs of other architects; a significant increase (by about 40%) in the new area to be constructed; major design changes that rendered the construction of the new and remodelled facilities far more technologically complex and sophisticated than originally envisaged. On account of these and other related factors, the cost overrun at the time of the completion mission (October, 1992) was estimated at 250%. The cost overrun for the project as a whole is estimated at about 177% (Para. 22).

Results

v) One of the main aims of the project was to improve the effectiveness and efficiency of the country's health delivery system. On the whole this objective was achieved as evidenced by the following results: (a) MOH was successfully reorganized along functional lines following studies undertaken by the Government as well as though the project (Para. 13); (b) Rural Health Teams (RHTs) were transferred from MOH to the Ministry of Local Government and Lands (MLGL) as the latter had overall responsibility for coordinating and administering social services (including health and education) at the district level; (c) the National Health Laboratory and the Community Health Services Division, which hitherto were weak and housed in scattered facilities were provided with permanent facilities in adjacent buildings, thereby contributing to better coordination and collaboration between community health practitioners and laboratory staff (Para. 14); (d) rural and urban primary health services were strengthened and expanded through the provision of nine (9) urban-periurban and four (4) rural primary health centers (renamed primary hospitals in 1990) (Paras. 16, 21-22). The re-naming of the health center as primary hospitals is in itself a clear indication that the centers have been upgraded beyond their traditional service of providing primary (outpatient) care to provide some of the medically more involved functions, usually reserved for larger health institutions. The project has been far less successful with respect to the upgrading of PMH, the country's main hospital. For a variety of reasons discussed in some detail in this report (Paras. 11, 21-22), the hospital is yet to be completed. The Government has the resources and the commitment to finance the remaining civil works and to procure the necessary equipment. One of the positive results of the project in relation to PMH is that the pressure on its outpatient department has been greatly reduced as much of the burden for outpatient treatment has

now been directed to the project-assisted urban health clinics. (Para.20).

vi) The second main objective of the project was to strengthen nationwide availability of family planning services. This objective too has on the whole been attained. For instance: family planning themes have been integrated in health education programs nationwide; primary and secondary school curricula now contain pertinent information on family planning; likewise curricula for basic training of health personnel at all levels have been revised to incorporate appropriate lessons on family planning; and significantly; more than 90% of primary health centers (Primary Hospitals) now offer family planning services on a regular, daily basis. The proportion of women who use modern family planning methods has increased from 16% at appraisal to nearly 30% in 1988, and there are indications that the ratio has increased even more since 1988 (when the last comprehensive survey on this subject was undertaken). Contraceptive prevalence rate has increased from 24% in 1981 to 30% in 1988. The fertility rate has likewise declined from 7.1 in 1981 to 5.0 in 1988. Clearly, not all these benefits are attributable to the Project. But it is equally true that the project has made a significant contribution toward attaining these benefits. (Para. 17).

Sustainability

vii) The benefits derived from the project are likely to be sustained for the foreseeable future as an integral part of MOH's programs. There exists a clear Government policy and commitment for primary health care, a sine qua non for project sustainability, as pointed out in OED's 1990 report on the sustainability of investment projects in education (and equally applicable to health projects). Under NDP VII (1992-1997), GOB has increased the allocation for recurrent budget by about 9% per year, in real terms, over allocations made under NDP VI. Maintenance of facilities and equipment in the health sector (as in other sectors, such as education) has been a matter of serious concern to GOB over the years. The Government has now (1992) decided to contract out (through tender) maintenance services of most health facilities and equipment, including those at PMH, to a reputable private firm. This too augurs well for the sustainability of the project-assisted facilities and equipment. (Para. 25).

Findings and Lessons Learned

viii) With the notable exception of PMH, all project components were fully implemented. All the nine urban/peri-urban and four rural primary health facilities have been established and are fully operational. Lessons derived from the implementation of this project include:

a) The project brings to the fore once again the on-going discussion in the Bank regarding the extent to which project implementation arrangements should be organizationally and functionally integrated with the responsible Government

Ministry or agency. In this project, instead of a separate project implementation unit (PIU), a project coordinating committee consisting of the relevant heads of MOH departments was assigned responsibility for project management. While this is consistent with the Bank's present efforts to enhance the Borrower's sense of "ownership", the experience in the implementation of this project demonstrates that unless the government officials (such as head of departments) take a proactive role in project management, the mere establishment of a "coordinating committee" is not sufficient to create a sense of "ownership", and the full integration of project activities with the regular functions of the Borrower's agency. (Paras. 7-8, 28).

b) The experience with the PMH upgrading/expansion indicates that it is exceedingly difficult, and often more expensive, to undertake a major upgrading, especially when the existing facility is expected to operate while the upgrading is in progress. A detailed cost analysis should first be undertaken to determine the cost-effectiveness of such major upgrading operations vis-a-vis establishing a new hospital, on a different site. (Para. 25).

c) Further, the experience with the PMH upgrading indicates that it is critically important to define in detail the exact nature and scope of the upgrading/modification before actual construction/modification begins. Failure to do that would almost inevitably result in constant changes and additions to the original plan. (Para. 22).

d) Finally, the project reinforces the importance of retaining the responsibility (and the requisite financial resources) for building and equipment maintenance as close as possible to the users. In this particular case, those responsibilities were centralized in two Government agencies, DABS (for building maintenance) and DEMS (for buildings and equipment servicing). As the agencies are far over-stretched and understaffed to cater to the needs of all government agencies. As a result, essential repairs of buildings and equipment are not attended to promptly. (Para. 16, 28).

PROJECT COMPLETION REPORT

BOTSWANA

FAMILY HEALTH PROJECT
(Loan 2413-BT)

PART I. PROJECT REVIEW FROM BANK'S PERSPECTIVE

A. Project Identity

Project Name:	Family Health Project
Loan No.:	2413-BT
RVP Unit:	Africa Regional Office
Country:	Botswana
Sector:	Population and Health

B. Project Background

1) Sector Development Objectives. At the time the project was appraised Botswana's health services were already well established on sound policies and conscious efforts were being made to provide resources to rural areas. Although the Government had not at the time developed a comprehensive population policy, there was a clear awareness among senior officials of the socio-economic problems caused by a rapidly growing population. Incidence of common tropical diseases such as malaria, schistosomiasis was low on account of the dry climate which inhibits the vectors. The leading cause of morbidity was (and continues to be) respiratory illnesses, including tuberculosis. Among children, malnutrition was perhaps the leading cause of morbidity and infant mortality. The Government's objectives in the areas of health and population have been to strengthen and expand basic health services, while at the same controlling communicable diseases.

2) Policy Context. At independence, Botswana inherited a largely curative, hospital-based health care delivery system. Since then, the thrust of the Government's policy direction has been to re-orient the system to a primary health care system accessible to the entire rural population. This shift in policy began in earnest with the National Health Plan for the period 1968-1973. This emphasis on primary health care as the cornerstone for the health delivery system was reaffirmed in successive National Development Plans (NDPs), particularly NDP IV (1976-1981) and NDP V (1982-87). The health care support system included health education, MCH/FP, control of communicable diseases (in particular tuberculosis and sexually transmitted diseases), nutrition, the prevention and treatment of blindness, environmental sanitation,

occupational health and programs for the handicapped. The Government continues to make substantial efforts to ensure that health facilities are well distributed throughout the country.

3) Sector knowledge and background for the project was derived in the main from the findings of a population, health and nutrition sector review missions which visited Botswana in 1981. While the mission concluded that on the whole the health status and overall government policy and strategy were good, there were certain major gaps and deficiencies that need to be addressed. These included weaknesses in the organization and management of the Ministry of Health; over centralization of health services; strengthening the effectiveness and efficiency of health programs; and revitalizing family planning services. The Government accepted the main conclusions of the Bank's sector study as a basis for requesting external assistance from donor agencies including the Bank itself.

C. Project Objectives and Description

4) Project Objectives. The main objectives of the project were: (a) to improve the effectiveness and efficiency of Botswana's health care delivery system, and (b) to strengthen nationwide availability of family planning services. More specifically, it was aimed at assisting the Government in reaching these objectives over a five-year period by building up the central organization of the Ministry of Health (MOH), progressively building up each level of the health care delivery system, strengthening family planning activities in the MCH program, introducing family planning activities in women's programs, reducing the unit cost of health care within the referral system, and increasing the efficiency of the pharmaceutical supply system

5) Project Components. The project included four main components:

(a) Reorganization of the Health Care Delivery System. Through the provision of technical assistance, consultancies, in-country and overseas training, construction of new or upgrading existing facilities, as appropriate:

(i) strengthening management and planning capacity, (ii) introducing cost recovery and strengthening financial management, (iii) establishing a Community Health Sciences Center for the collection and analysis of epidemiological data, (iv) strengthening rural health services, and (v) establishing a Central Medical Store;

(b) Population, Maternal and Child Health and Family Planning. Through the provision of technical assistance consultancies local and overseas training, equipment, the procurement and distribution of contraceptive commodities as well as the expansion and upgrading the existing Health Education (HEU):

(i) Integrating family planning themes into existing health education programs and supporting other programs and activities pertaining to family planning, and (ii) establishing a demographic unit within the Central Statistics Office;

(c) Urban Health and Family Planning Services. Through support for extension and upgrading of physical facilities and procurement of equipment:

(i) upgrading and expanding the Princess Marina Hospital (PMH), and (ii) Upgrading and strengthening nine urban health clinics in Gaborone; and

(d) Manpower Development. Through provision of technical assistance, training health manpower required for implementing MOH's reorganization of the health care delivery system and the expansion of population/MCH/FP activities.

D. Project Design and Organization

6) The Family Health Project derived its conceptual foundation from the findings of a Bank health sector review mission in February 1981 and its recommendations were accepted by the Government in May 1982. The project was appraised in June 1983 and negotiated in February 1984. Because of its long-standing assistance for rural health services, the participation of the Government of Norway (GON) was sought to finance portions of the project on a grant basis. The GON agreed to provide a grant of US 7.2 million equivalent to finance portions of the project.

7) According to the original design of the project, overall responsibility for project implementation was to rest with the Permanent Secretary of MOH, with each component being managed by the Head of the relevant department in MOH. Thus, the Assistant Director (AD) of Primary Health Care was to be responsible for implementation of CHSC, IEC/MCH and FP activities as well as for strengthening urban and rural health facilities. Similarly, the AD of Hospital Services was to be responsible for the upgrading of PMH with technical support by the Chief Architect and a PMH Architectural Planning Team. The same applied for the other components of the project. A Project Coordinator, appointed in May 1984, was to assist the PS and component managers with project implementation. A Project Coordinating Committee, chaired by the PS, consisting of MOH department heads and other relevant Ministries, was expected to meet quarterly to review progress of implementation.

8) On the whole, the project was managed along these lines. However, in retrospect, a more proactive role of component managers and more frequent meetings on a systematic and sustained basis, would have further enhanced the effectiveness and efficiency of the project, thereby establishing an even better basis for a continued integration of project-related activities after the end of the project.

9) Apart from the PMH upgrading and extension of the Closing Date, most project components have been successfully completed, although with some delays. The PMH is now scheduled to be completed by December 1994, close to three years after the Project Closing Date and six years after the original schedule. Some of the underlying factors behind this considerable delay and related gross cost overruns are detailed below.

E. Project Implementation

10) The major variances between planned and actual project implementation were:

a) extension of the Project Closing Date by three years to allow completion of project components (excepting PMH);

b) delayed planning and construction of PMH, now estimated to be completed about six years after the original schedule and related cost overruns; and

c) the deletion of CMS upgrading/addition and a new pharmaceutical store in Maun from the project, in favor of a new storage facility in Gaborone financed by the Government; and

d) the decision not to implement a cost recovery scheme.

There were one or two other relatively minor elements that were not carried out. The first was concerning project evaluation. During appraisal, MOH had agreed to undertake annual evaluation of the project. But, when it became clear that it will not be possible to carry out annual evaluations on account of shortage of local expertise in project evaluation, in 1987 a Bank supervision mission agreed with the authorities that the Bank will be satisfied with the government's semi-annual progress reports and its own supervision mission reports for monitoring implementation progress. Secondly, the SAR plan to introduce program budgeting and to revise MOH's accounting system was not carried out, largely because MOH lacked the authority to do so on its own as the health sector was under two separate ministries (MOH and MLGL), and also because there was no overall decision from the Ministry of Finance to adopt a new budgeting and accounting system nationwide.

11) The delays in the civil works were beyond the control of the project. The factors that contributed to these delays included: (i) a one year freeze in the hiring of expatriate consultants/technical assistants on account of financial constraints due to the 1985 drought in the country, (ii) in the case of PMH, late recruitment of the team leader for the Architectural Planning Team (APT) which caused an initial delay at PMH of about two years, and (iii) recurring vacancies in APT (eg. when one of the architects died in a traffic accident). The cost recovery scheme was not introduced because of policy changes by the Government not to introduce increase user charges in the social sectors, including primary education and primary health care. Instead, the

Government decided to freeze health care (and school) fees at the very modest level which were in effect at the time.

12) Overall the project was a success. As discussed in greater detail below, the project was particularly successful in re-organizing MOH, in strengthening family planning services and in expanding and upgrading primary health care services in rural and urban areas. There was close communication and collaboration between Bank and Government as these variances occurred. During implementation, as and when it become clear that some elements could not be carried out as planned, relevant changes were made in full consultation with the Government.

F. Project Results

13) Reorganization of MOH. One of the main aims of the project was to improve the effectiveness and efficiency of the health care delivery system. With the help of an advance from the Project Preparation Facility (PPF), the organization of the MOH was studied and the roles and functions of the District Health Teams (DHTs) were reviewed. A proposal was made to reorganize the MOH along functional lines (MOH's reorganization along functional lines was introduced as early as 1985). The transfer of the Rural Health Teams (RHTs) from MOH to Ministry of Local Government and Lands (MLGL) took more time and was implemented from 1989. The study of health financing mechanisms and a cost recovery scheme was completed (financed from PPF), but as noted above, GOB decided not to implement the proposals, as part of the Government's overall policy to provide free social services, especially primary education and primary health care. Thus patient fees still remain at the same nominal level as at appraisal. The health planner consultancy was successfully completed, leading to improved planning at the district level. The planned changes towards program planning and budgeting were not realized. Likewise a management information system was not developed.

14) Strengthening Community Health Science. The Community Health Sciences Center (CHSC) in Gaborone was completed as planned. The Community Health Services Division (CHSD) (with Epidemiology and Disease Control Unit, AIDs program, Environmental Health and Occupational Health Units) are housed in one block, while the National Health Laboratory (NHL) is housed in an adjacent building, both funded by the project. Until the laboratory facilities at PMH are operational the NHL will continue to serve PMH. The Center has contributed to better coordination and cooperation within the field of public health. Staffing has been improved since the start of the project both in the Community Health and in the Laboratory area. Regrettably, however, it seems that the buildings (completed in 1988) have some major construction and design defects which have caused major leakages and floodings. MOH has reported the damages to the relevant agencies and the defects are expected to be remedied forthwith.

15) The tuberculosis treatment regimen was revised early on in the project, with assistance from the International Union Against Tuberculosis (IAUT). The National Tuberculosis Program Manual was subsequently revised (1985) with stronger emphasis on domiciliary

treatment. Although a systematic evaluation of the new treatment regimen has not yet been undertaken, some of the benefits are already clear. For instance, TB-patients now generally remain hospitalized for about 60 days, while the average inpatient stay was 90 days at appraisal. Combined with a less expensive treatment regimen, this has brought about cost savings, even though the magnitude of the savings has to be assessed more closely.

16) Expansion and Upgrading of Rural Primary Health Services. The upgrading and additions to four existing Health Centers (from 1990 called Primary Hospitals (PH)) at Lethlakane, Mmadinare, Bobonong and Thamaga was completed on time. All PHs have been fully operational since 1988 and are well utilized. However, some of the new equipment (e.g. new boilers, x-ray equipment) that were delivered two or more years ago have yet to be installed and put to use. Installation of equipment and maintenance of buildings and equipment for all government Ministries and agencies are centralized in Botswana under two departments, the Department of Architectural and Building Services (or DABS), and the Department of Mechanical and Electrical Services (DEMS). Because those departments are overstretched in terms of technical staff to cope with the high demand for their services, it is not unusual to see long delays in installing equipment or repairing damaged buildings. Thus, one of the important lessons that emerges from implementation of this project is the vital importance of retaining the responsibility (along with the requisite funds) for equipment and building maintenance as close to the user agency as possible. At Thamaga PH there have been problems with the sewerage system ever since the opening of the facility in 1988. Although, the need to remedy the defects has been underscored by several supervision missions, the situation has yet to be remedied, underscoring once again the delays and inefficiencies inherent in a highly centralized system of building and equipment maintenance.

17) Strengthening Family Planning Services. The second main objective of the project was to strengthen nationwide ability of family planning services, by increasing the use of contraceptive commodities thereby reducing Botswana's high fertility rate. There have been a wide range of activities under the project to achieve this objective both under the population/MCH/FP/IEC and under the manpower development component. Most important of these have been: (i) the integration of family planning themes in health education programs has been intensified and improved, (ii) the integration of family health in primary and secondary school curricula, (iii) revision of curricula for basic training for health personnel, and (iv) the introduction of a comprehensive and integrated approach at primary health care facilities that offer family planning services on a regular, daily basis. Cumulatively, these activities have been very successful. As of October 1992 more than 90% of primary health facilities offer integrated services. It is also encouraging that from 1984 to 1988 the proportion of women who know of modern methods of family planning has increased from 74 to 95 %. The proportion of actual users of family planning devices has increased from 16 to 29.7 %, and the proportion of women who have used at one time or another modern family planning methods has likewise increased from 34 to 54% All methods included, the current contraceptive prevalence rate has increased from 24 to 30 % from 1984 to

1988. Total fertility has declined 30 % in less than 10 years, from 7.1 in 1981 to 6.5 in 1984 to 5.0 in 1988. Clearly, not all these benefits can be attributable to the Project. But it is equally true that the project has made an important contribution toward attaining these benefits.

18) The establishment of a Demographic Unit, including necessary equipment, in the Central Statistics Office (CSO) was taken out of the project, but the Unit was established with funding from UNFPA.

19) In the area of urban health and family planning services, the project had two main components: (i) upgrading/extensions of urban/periurban clinics in Gaborone, and (ii) renovations/additions to the PMH.

20) Strengthening Urban Health Centers. The Gaborone Health Needs Study was completed in time to provide a valuable in-put for planning the strengthening and upgrading of both the urban primary health services as well as the upgrading of PMH. On the whole, the improvement of primary health care services in Gaborone under the project has been a significant success. Altogether eight existing clinics were upgraded and expanded, and one new clinic with a maternity ward was established. As the existing facilities remained in operation whilst the expansion and upgrading was in progress, it was decided to undertake the remodelling and expansion in three phases as shown in Section III, Table 4. Apart from the maternity ward at the recently (December, 1991) completed Old Naledi clinic that has not operated due to shortage of midwives, all facilities are operational. One of the Centers, Extension 2 Clinic, is in fact operating on a 24 hour basis. The staffing of the clinics has generally improved. Presently 5 doctors work in these clinics while there none were assigned before start of the upgrading. The expansion and upgrading of these urban health centers, has had an important impact on the pattern of primary and outpatient care in the Gaborone area as a whole. For instance, during the period 1982-1991 total attendance at the clinics has increased by about 260 % (from 234 000 to 620 000), thereby relieving the pressure for outpatient care at PMH. Outpatient attendance at PMH has decreased by about 80 % (from 3-400 to 80 a day), over roughly the same period. All outpatients at PMH (apart from A&E cases) are now referral cases.

21) Princess Marina Hospital (PMH). This is the only component that has not been completed as yet. At the time of the Completion Mission, it was estimated that upgrading of the Hospital was about 40-50% completed. The Hospital is expected to be completed and fully operational by December, 1994. The Government is fully committed and has the necessary resources to complete the civil works, to procure the necessary equipment, and to provide the full compliment of medical and paramedical staff from its own resources. The financial implications for these undertakings are fully reflected in the country's Development Plan.

22) Some of the factors that explain this delay were discussed in Para. 11. Additional factors included: (a) the scope of the upgrading was increased considerably. The total area for new buildings

increased by almost 40%, from about 14,000 square meters planned at appraisal to close to 20,000 square meters in the present construction plan; (b) the total number of beds was likewise increased by about 8% from 440 to about 480 beds; (c) the nature of upgrading too has increased not only in terms of scope (as indicated above), but also in terms of its complexity. Both the civil works, and especially the equipment have now acquired a far more high technology character than originally envisaged. The situation was further exacerbated by the absence of an architect with sufficient experience in large hospital projects. This was particularly crucial in the case of PMH where new construction and extensive remodelling were taking place while the hospital was still operating. Of the new facilities only the pediatric ward was completed on time (1986). These and other factors together have caused considerable cost overruns, of about 250% at the time of the project completion mission in October, 1992. This figure is likely to be even higher by the time the hospital is completed (with Government funds) in December 1994 (Para. 41). The cost overrun for the project as a whole was about 177% (Table 5).

23) Manpower Development. Under the Manpower Development component both the training program and the health manpower planning consultancy have been successful. A National Health Manpower Plan was completed in 1989 and had significant impact on health manpower and training projections in NDP VII and on the National Health Institute (NH) Requirement Study that was funded outside the project.

24) Implementation of the training program was successful. As can be seen from Annex 4, appraisal targets for both in-country and overseas training were exceeded, by about 50% on average. However, the original project idea of integrating project-funded training with a national training scheme so that manpower development could continue even when project funds are exhausted has not materialized to the extent originally envisaged. This is a matter of concern in that when project funds have been exhausted the Government has not yet provided funds for the continuation of training along similar lines. In this respect, the project reinforces a lesson learned from other Bank-funded operations which underscore the crucial importance of gradually phasing-in Government contributions to such activities as training so those vital programs would continue even when the project terminates.

G. Project Sustainability

25) Botswana is likely to derive long-term benefits in the health and social sectors from the project as a result of the improved Population/MCH and FP related services and programs. Especially, due to inter alia the introduction of integrated services at primary health care facilities and improved health education programs, the project is likely to have further impact on fertility decline. In principle the GOB has sufficient resources of its own not only to sustain, but to expand and strengthen the activities initiated under this project. Under NDP VII (91-2/96-7), GOB has increased the allocation for recurrent budget of MOH by about 9% per year, in real terms, over the allocations made under NDP VI. This is among the highest yearly increases approved for

any Ministry, which in itself is a clear testimony to the importance and priority the Government continues to attach to health, and indeed to the social sectors as a whole. Further, the Government has recently decided to contract out (through tendering) maintenance services of most health facilities and equipment, including PMH, to a reputable private firm. Again, this augurs well for the project-funded health facilities and equipment.

26) All the rural and urban primary health facilities that have been built under the project are operational, well staffed and well utilized and as indicated in the preceding paragraph there is every reason to expect that the Government will be able to maintain these services at this level. While the expansion of PMH has been more prolonged and much more costly than expected at appraisal, the Government is firmly committed to complete the hospital and maintain its operation, including the necessary training of local and recruitment of expatriate specialist staff. This is bound to have an impact on the overall resources allocated to the health sector, but in the present financial situation for Botswana this is unlikely to present a major constraint.

H. Bank Performance

27) As noted in the Government's contribution to this report (Part II), Bank staff contributed positively to the successful completion of the project through supportive relationship and professional advice. Ten supervision missions were fielded during the life of the project. This proved to be quite adequate, as the project was on the whole problem-free, with the single exception of the PMH. While the frequency and even the composition of Bank supervision missions (mostly, public health specialists, economists, and architects) were adequate, there was frequent turn-over of Bank staff who were responsible for supervision. Indeed, a consultant public health specialist was virtually the only staff from the Bank side who participated in most (80%) of the missions (Section III, Table 12). In retrospect, another area where the Bank could have been more helpful to the Borrower was in assisting the Borrower to clearly conceptualize and define the exact nature and scope of the PMH upgrading. In the absence of a more proactive role on the part of the Bank (and possibly MOH), the PMH upgrading component was left almost entirely to the architects (APT) and the users, who inevitably kept making constant changes and additions to the facilities to be upgraded or built anew. In the end, what started as a modest upgrading project became a large and complex hospital construction operation.

28) Lessons Learned. For future projects the following lessons learned from implementation of the Family Health Project may be of value:

a) The project brings to the fore once again the much discussed question of project implementation arrangements. As in a number of other Bank-assisted projects, implementation of this project was assigned to a "Coordinating Committee" (instead of a separate "project implementation unit (PIU)"

consisting of high level MOH department heads (Para. 7). In principle, this is appropriate as it would help facilitate integration of project activities with regular MOH programs, thereby ensuring MOH's "ownership" of the project. But as in so many other cases, the department heads (with some notable exceptions) who were designated component managers did not always take a sufficiently proactive role in project management, largely because of the heavy responsibilities they already have in their regular MOH responsibilities. In such cases, it is only inevitable that a good deal of implementation matters would be left to the Project Coordinator to wrestle with. In this particular case, largely because the Project Coordinator was a well qualified health planner, she was able to "manage" the project reasonably well, in consultation with her MOH colleagues. The lesson to be derived from implementation of this project, is that unless the government officials (such as heads of departments) who were assigned to implement a project component pertaining to their department take a proactive role in project management, the mere establishment of a project coordinating committee (in lieu of a separate project implementation unit) is not sufficient to create a sense of "ownership" and the full integration of project activities with the regular functions of the Borrower's agency.

b) The experience with the PMH upgrading/expansion indicates that it is exceedingly difficult, and even more costly, to undertake a major hospital upgrading. This is especially the so (as was the case with PMH) when the large and complex upgrading was expected to take place while the hospital was in full operation. In retrospect, it would almost certainly have been less expensive, and certainly less cumbersome, to build a hospital on an entirely new site.

c) Further, the experience with PMH indicates that it is critically important to define in detail the exact nature and scope of the upgrading/modification, before actual construction/modification begins (para. 21-22). In this particular case, in the absence of a more proactive role on the part of the Borrower and the Bank in monitoring closely the magnitude and rationale of the upgrading to ensure that these are kept as close as possible to what was envisaged at appraisal, the PMH component was virtually left to the architects (APT) and the users, who inevitably kept making changes and modifications. In the end, what was started as a modest upgrading scheme became a large and quite complex hospital construction (Para. 27).

d) Finally, the project reinforces the importance of retaining the responsibility for maintenance of buildings and equipment (together with the requisite budget) as close as possible to the users (institutions). In Botswana, these services are centralized in two Government agencies, the

Department of Buildings and Architectural Services (DABS) and the Department of Mechanical and Electrical Services (DEMS). These agencies are so over-stretched and understaffed that they are unable to provide timely responses to buildings and equipment, even to critical facilities such as hospitals and clinics (Para 16).

I. Borrower Performance

29) All major covenants were complied with (Part III, Table 10), although delays were encountered in fulfilling some of them (eg. preparation and submission of audit reports). In retrospect better coordination (and more frequent meeting) of the Project Coordinating Committee (Para. 7) would probably enhanced the full integration of project elements with MOH's regular activities. MOH officials were uniformly helpful to Bank supervision missions and open to suggestions and recommendations.

J. Consulting Services

30) As can be seen from Annex 5 most of the consultancies that were planned at appraisal were utilized. On the whole the Government was satisfied with the result of most of the consultants. At PMH, four consultants (known as the "Commissioning Team") have been retained to "commission" the various facilities and equipment as and when they are completed. However, the services of the PMH Commissioning Team can not be assessed pending the completion of the PMH component.

Part II. PROJECT REVIEW FROM BORROWER'S PERSPECTIVE

Evaluation of Bank's Performance and Lessons Learned

31. The Bank personnel were recognized as professional in all supervision visits. Apart from the Public Health specialist, there has been a rapid turn-over on the Bank's side during the life of the project. Sometimes it took sometime for the new staff members to be familiar with the project and there were occasions when the Implementation Unit was required to retransmit information to the Bank which was submitted to previous staff members. On the whole the relationship between the Implementation Unit and various Bank staff was excellent. Every staff member has been supportive and provided the needed guidance in the implementation of the project in accordance with the Bank's regulations.

Major Lessons Learned

32. The overall communication between the Bank and the Borrower regarding accounting of commitments and drawdown of the loan/grant proceeds should be well documented and information from the Bank to the Borrower regarding same would not be contradictory. When the Bank's personnel change, there should be thorough handover for continuity purposes.

Evaluation of Borrower's Own Performance and Lessons Learned

33. The planning and implementation of the training component of the project was quite good. There were a few savings in the project which enabled to train above 100% [of appraisal targets] in the several training areas.

34. The planning and implementation of civil works component experienced major problems in certain areas ranging from design faults to lack of experience in building health facilities on the part of contractors. Government of Botswana is likely to spend a lot of money rectifying the problems in the future.1/

35 Equipment schedules and specifications were not properly done. This had negative effects on the implementation of the project. The problems led to over ordering of equipment in some areas and to delays in utilizing new departments while rewiring to accommodate equipment.

Major Lessons Learned:

36. (a) That planning of civil works project should be adequately done with implications adequately analyzed.

1/Note: Contractorss were selected following Bank guidelines. Contractors for the urban and rural primary health centers were selected on the basis of LCB as the contracts were too small to attract overseas competitors. The contractor for PMH was selected on the basis of ICB, but architectural services were provided by a government agency (DABS).

(b) It is much more complex and costly to do a major upgrading of an ongoing hospital. It would be much easier and less costly to select new fields and build new hospitals than to upgrade [an existing hospital].

(c) Design work for hospitals should be done by experienced hospital architects and construction should be done by experienced contractors. It is not cost effective to promote local business by engaging local contractors at the expense of well constructed health facilities which are likely to last a long time.

(d) Future projects which require a large sophisticated manpower should include a training component for such manpower rather than rely on the overall Ministry's training allocation which has its own limits.

PART III. STATISTICAL INFORMATION

A. Related Bank Loans

37. This was the first (and so far the only) Bank Loan in the Health Sector financed by the Bank. However, the Bank has financed in related social sectors, such as in education, four projects, all which are completed. A Completion Report for the Fourth Education project was issued in September 1992 (Report No. 11164).

B. Project Timetable

Table 2: PLANNED AND ACTUAL DATES OF PROJECT TIME TABLE

ITEM	PLANNED DATE	REVISED DATE	ACTUAL DATE
Identification	5/23--6/2/82	5/23--6/2/82	5/23--6/2/82
Preparation	11/7--27/82	11/7--27/82	11/7--27/82
Appraisal	6/20--7/8/83	6/20--7/8/83	6/20--7/8/83
Negotiations	2/6--10/84	2/6--10/84	2/6--10/84
Board Approval	5/15/84	5/15/84	5/15/84
Credit Effective	5/21/85	5/21/85	5/21/85
Project Completion	7/31/88	7/31/88	7/31/88
Closing Date	1/31/89	1/31/91	1/31/92

Comments on Timetable:

Para. 38. Project identification and project preparation were held in conjunction with an on-going health sector study. The project was implemented over a seven-year period (after approval by the Bank's Board of Executive Directors. It was extended twice for a total of two years, partly because of delays in preparing withdrawal applications with the necessary documentation. When the project was closed, one of the components (upgrading of the Princess Marina Hospital) was still under construction and would probably take two more years to complete. The Government is fully committed to complete the construction and to provide the necessary equipment and staff.

C. LOAN DISBURSEMENTS

Table 3: CUMULATIVE AND ACTUAL DISBURSEMENTS
(US $ Million)

Bank FY	'84	'85	'86	'87	'88	'89	'90	'91	'92	'93
Appra. Estim.	0.22	0.88	2.86	5.94	9.52	11.0	--	--	--	--
Actual	--	0.04	0.06	0.37	1.43	2.58	5.61	7.98	10.9	11.0
Actual as % of the Loan	--	0.01	0.01	3	13	23	51	73	99	100
Date of Final Disbursement: July 22, 1992										

Para. 39. Comments on Loan Disbursement. Disbursement started very slowly. There was virtually no disbursement for the first two fiscal years. And only about half of the loan was disbursed during the first six years. This meant that about half of the entire loan was reimbursed during the last two years while the Government was paying for its commitments upfront for on-going work from its resources. As in other projects, the Government utilized the intervening years to collect the documentation required to support the reimbursement applications sent to the Bank. In the end, the entire loan was disbursed, albeit three years behind schedule.

D. Project Implementation

Table 4: PLANNED AND ACTUAL COMPLETION DATES OF CIVIL WORKS COMPONENTS

Component	Planned Completion	Actual Completion	Months of Delay
1. Princess Marina Hospital	1988	1994 (Est.)	72
2. Health Education Unit	1986	1986	0
3. Community Health Sci. Center			
-Community Health	1988	1988	0
-Laboratory Work	1988	1988	0
4. Rural Health Centers			
-Thamaga	1988	1988	0
-Bobonong	1988	1988	0
-Nmadinare	1988	1988	0
-Letlehakane	1988	1988	0
5. Urban Health Clinics			
-Broadhurst II	12/86	12/87	12
-Village	12/86	12/87	12
-Tsholofelo	12/86	04/88	16
-Extension 14	12/86	04/88	16
-Extension 2	12/86	04/88	16
-Broadhurst	12/86	04/89	28
-Bontleng	12/86	12/90	48
-Broadhurst Traditional Area	12/86	05/89	29
-Old Naledi	12/86	12/91	60

Para. 40. Comments on Project Implementation. Except for the Princess Marina Hospital, all of the civil works components of the project have been completed. The PMH is not expected to be completed until December 1994 (Paras. 9, 21-22). Construction of the Urban Health Clinics was staggered deliberately in order to avoid overburdening the young, but growing construction industry in the country. Thus the twelve to 60 month delay shown in the above table was deliberate, and not due to delays in the usual sense of the word.

E. TOTAL PROJECT COSTS AND FINANCING

Table 5: TOTAL PROJECT COSTS

Category	Appraisal Estimate			Actual		
	Local	Foreign	Total	Local	Forei	Total
1. Civil Works	2.9	10.5	13.4	14.31	12.33	26.64
2. Furn. Equipt & Vehicles	--	2.6	2.6	6.80	2.07	8.87
3. Consultants, TA, Training & Studies*	0.3	4.2*	4.5	4.58	4.66	9.24
4. Project Prep. Facility (PPF)	--	0.48	0.48	--	0.48	0.48
5. IBRD front end fee	--	0.03	0.03	--	0.03	0.03
6. Pilot Innovative Pgm in Family Planing**	0.2	0.5	0.7	--	0.14	0.14
7. Contracept-ive***	--	0.9	0.9	--	0.90	0.90
8. Incremental recurrent costs**	3.7	0.9	4.1	0.05	0.86	0.91
TOTAL	7.1	19.6	26.7	25.74	21.47	47.21

Notes:
*Including US$ 0.5 million equivalent from WHO
**Grant from Government of Norway
***Grant from USAID

Para. 41. Comments on Project Costs. The total does not include funds required to complete the Princess Marina Hospital which was about 40% complete at the time of the Project Completion mission. The estimated total cost for completing the hospital (including equipment, furniture and consultancies (for "commissioning" the hospital and for equipment specialists) would be about Pula 111 million, or about US$ 55.5 million equivalent, of which roughly Pula 76 million (or about US$ 38 million) is for civil works only. This compares to Pula 8 million (US$ 7.5 million) estimated at appraisal. The reasons for the delay and the significant cost overrun are explained in Part I, Paras. 11, 21-22. The Government is fully committed to complete the hospital (including equipment and furniture) and to make it operational.

Table 6: PROJECT FINANCING
(US$ Mill.)

SOURCE	PLANNED	ACTUAL
IBRD	11.0	11.0
Government of Botswana	7.1	27.6
Government of Norway	7.2	7.2
USAID	0.9	0.9
WHO	0.5	0.5
TOTAL	26.7	47.2

Para. 42. Comments on Project Financing. Both the Bank loan and the Norwegian Grant were fully disbursed. As can be seen from the Table above, the Government's contribution has increased by more than three fold. And this is without taking into consideration the funds required to complete the civil works and to procure the necessary equipment and furniture for the Princess Marina Hospital. The Hospital is now about 40% completed, and it is estimated that an additional Pula 80 million (?) or about US$ dollar 40 million will be needed to complete the civil works and procure the additional equipment and furniture needed, thereby increasing the Government's contribution even more. The Government is fully committed to complete the buildings and procure the necessary equipment and furniture.

Table 7: ALLOCATION OF LOAN PROCEEDS
(US $ Million)

CATEGORY	ORIGINAL ALLOCATION	ACTUAL DISBURSEMENT
I. Civil Works	6,200,000	6,903,957
II. Vehicles & Equipment	1,900,000	1,249,468
III. Consultants, TA & Studies	2,300,000	2,631,811
IV. PPF	480,000	190,000
V. Front End Fee	27,000	27,000
TOTAL	11,000,000	11,000,000 (Rounded)

Para. 43. Comments on Allocation of Loan Proceeds. Disbursement of the loan got off to a slow start so that there was virtually no disbursement during the first three or even four years of the implementation period (1984-1988). The loan and the Norwegian Grant were fully disbursed, albeit a two-year extension of the Closing Date.

Table 8: DIRECT BENEFITS OF THE PROJECT

Indicators	Estimated at Appraisal	Estimated at Closing Date	Expected Benefit at Full Development
Establish and operate Community Health Sciences Unit	Construction of facility and equipment planned for 1988	Construction completed and facility furnished and equipped in 1988	Institution fully operational. Community Health services are now efficiently performed in such areas as environmental and occupational health, AIDS, TB, etc. As the National Lab is located in the same premises, the two institutions are much better coordinated.
Increase of Family Planning (FP) services in static facilities to cover 90% of target population.		90% of facilities offer FP services as part of integrated approach. Proportion of women who use modern FP methods increased from 24% in 1984 to 30% in 1988. Fertility rates declined 30% in less than 10 years from 7.1 in 1981 to 5.0 in 1988.	Coverage likely to increase further.
Procurement and distribution of contraceptive commodities and supplies.	Distribution initiated as early as 9/30/84	Function now integrated with MOH's regular work.	Continued funding by GOB is assured.
Expansion and upgrading of urban clinics	Construction began in 1986	All facilities operational. Total clinic attendance increased by 260% between 1982 and 1991 (from 234,000 to 620,000). This in turn reduced the pressure on the outpatient department of Gaborone's main hospital (PMH) by 80% (from about 350 patients a day in 1982 to only 80 patients a day in 1991.	National coverage of primary health centers in the country continues to be among the best in Africa.
Development of Health Manpower	40 staff-months of overseas and 3,513 staff-months of local training planned.	Plan exceeded by about 2% for overseas and 75% for local training.	GOB continues to sustain staff development needs from its own resources as well as through bilateral agencies.

Table 9: PROJECT STUDIES

Field of Study	Purpose as Defined at Appraisal	Status	Impact of Study
Management Study	Review of each level of management of the health system and cost recovery in the health sector.	Study discontinued as a reorganization of MOH along functional lines was already on-going by the time the project was initiated.	MOH reorganization study fully implemented. The study on cost recovery was also completed, but GOB decided not to implement the recommendations contained in the study (Para. 13).
Health Needs of Gaborone	To investigate the current health services of and project future needs over ten to twenty years.	Study successfully completed in 1987.	Report provided useful information for upgrading PMH and urban clinics and projected future requirement.
Prescribing Practices Study	To determine current prescribing practices of health workers and promote rational prescribing procedures and practices.	Completed in 1988	Findings of the study used as a basis for rational drug use and for improving Training.
TB Evaluation	To assess the National TB program, to evaluate diagnosis and treatment of TB and to recommend measures for surveillance and record keeping.	Study completed by the International TB Association (IUAT)	The principal conclusions of the study were incorporated into the National TB program and for revising the TB Manual.

G. Status of Loan Covenants

Table 10: COMPLIANCE WITH LOAN COVENANTS

SECTION	COVENANT	STATUS OF COMPLIANCE
Section 3.06	By December 31, 1984, the Borrower to submit for review by the Bank a work plan setting forth information, education and communication activities to be undertaken in support of the Health Education Unit.	Delayed; otherwise, in compliance.
Section 3.07 (a)	By September 30, 1986 the Borrower to employ for each rural health facility at least one state RN and two enrolled nurses.	In compliance.
Section 3.07 (b)	By September 30, 1985, the Borrower to second four medical officers to the Gaborone Town Council.	Delayed; otherwise, in compliance
Section 3.08	By September 30, 1984, the Borrower to review with the Bank the recommendations of the Health Financing Plan financed from PPF, and thereafter to implement the recommendations as agreed upon.	Health financing study completed; but GOB decided not to introduces any changes.
Section 3.09	The Borrower to maintain, until completion of the Project, the Manpower Development and Utilization Dept. and to employ a qualified and experienced training coordinator.	The Department has been retained as a regular unit of MOH; training coordinator was obtained through bilateral sources for thirty-six months, 12 months more than originally planned.
Section 3.10	By July 31 of each year, the Borrower to submit to and review with the Bank annual training plans.	Annual review undertaken on an ad hoc basis; however, training targets as set forth in the SAR were exceeded.
Section 4.02 (a) and (b)	Borrower to maintain financial records and accounts, in accordance with sound accounting procedures; and to have those accounts audited each year by independent auditors acceptable to the Bank, and to provide audit reports of sufficient scope and detail to the Bank within six months of the Borrowers fiscal year.	On the whole complied with, although audit reports were often delayed and not always sufficiently detailed.

H. Use of Staff Resources

Table 11: STAFF IN-PUT BY STAGES OF PROJECT CYCLE
(In Staff Weeks)

Stage of Project Cycle	Planned		Revised		Actual	
	HQ	Field	HQ	Field	HQ	Field
Through Appraisal	56.1	11.5	56.1	11.5	56.1	11.5
Appraisal to Board	61.2	10	61.2	10	61.2	10
Board to Effectiveness	6.2	6	6.2	6	6.2	6
Supervision	131.6	54	131.6	54	131.6	54

Para. 45. Comments on Staff Inputs. Staff in-put during the various stages of the project cycle was well balanced. Ten supervision missions were fielded during the seven-year life of the project, which is somewhat below the average for social sector projects (eg. education) in the region. As most of the project components, with the single exception of PMH, were progressing reasonably well, the frequency of supervision missions was quite adequate. As pointed out in the Borrower's contribution to this report (Part II), except for the consultant public health specialist who participated in eight of the ten supervision missions, the composition of the supervision missions lacked sufficient continuity. Part of the reason for this lack of continuity on the part of Bank missions was probably because the Bank itself was undergoing a major re-organization in its structure and staffing precisely during the middle of this project's implementation period.

Table 12: MISSION DATA BY STAGES OF PROJECT

Mission	Month/Year	No. of Persons 1/	Staff/weeks	Performance Status 2/			
Ident.	6/82	2(PHS,E)	2				
Prep.	11/82	1(PHS)	1				
Appraisal	6/83	5(PHS,E,PhA,MCH)	10				
Total No. of s/w in the field: 13				G	P	M	F
Spn I	10/84	5(2PHS, Ph, Arc, TrS)	10	NR	NR	NR	NR
Spn II	8/85	3(E,PHS,A)	4.5	2	NR	2	1
Spn III	1/86	3(E,PHS,A)	4.5	2	NR	2	1
Spn IV	8/86	4(E,A,2PHS	8	NA	NA	NA	NA
Spn V	1/88	4(2A,E, PHS)	8	2	NR	2	1
Spn. VI	10/88	3(E,A,PHS)	6	1	1	1	1
Spn VII	5/89	2(E,PHS)	2	2	2	2	1
Spn VIII	11/89	3(E,A, PHS)	3	2	2	2	1
Spn IX	12/90	3(ED,A,PHS)	6	2	2	2	1
Spn X	8/91	2(EDC,PHS)	2	2	2	2	1

Notes:

1/ A=Architect; E=Economist; ED=Education Specialist; M=Maternal and Child Health Specialist; PH=Pharmaceutical specialist; PHS=Public Health Specialist; TrS=Training Specialist.

2/ G=General Status; P=Procurement; M=Management; F=Availability of local finance; NR=Not Rated; NA=Not available.

Annex 1

NAMES OF OFFICIALS MET DURING PCR MISSION

Ministry of Health

Dr. E. Maganu	Permanent Secretary
Mrs. K. Gasenelwe	Under-Secretary, Health Manpower
Mrs. K. Makhwade	Asst. Director, Hospital Services
Ms. B. Ottesen,	Asst. Director, Technical Support
Mrs. W. Manyeneng	Asst. Director, Primary Health Care
Mr. L. Lesetedi	Head, Family Health Division
Ms. M. Tselayakgosi	Sr. Planning Officer
Ms. G. Maolosi	Project Coordinator,
Mr. B. Tau	Project Accountant Proj.
Ms. R. O. Mandevu	Chief Community Health Officer,
Ms. N. Mokgautsi	Senior Lecturer, National Health Continuous Education Unit
Ms. K. Koosmile	Health Asst. Officer, CHSC
Mr. K.O. Wathne	WHO/EPID/NACP, CHSC
Ms. K.M. Gyi	Public Health Specialist, CHSC
Dr. P.R. Vyas	Pathology Unit, National Laboratory

Princess Marina Hospital

Dr. B. Bagwasi	Acting Medical Superintendent
Mr. K. Oldroyd-Robinson	Principal Architect, DABS
Coordinator for Mr. John Thomas	Health Projects, Site Coordinator, Director, Commissioning Team
Mr. David Moss	Commissioning Engineer
Mr. Alan Yates	Furniture and Equipment Specialist

Gaborone City Council (For Urban Health Centers)

Mr. G. Ghetsewe	City Clerk
Mr. E. K. O. Kgologolo	Treasurer
Mrs. S. M. Motlogelwa	Acting Matron
Mrs. A. Nfila	Sr. Nursing Sister
Mrs. M. Mazhinye	Sr. Sister,
Mrs. S. V. Mokone	Nursing Sister
Mr. H. N. Perera	Sr. Architect
Mr. M. Seleka	Economic Planner
Mr. S. Pathmanathan	City Engineer

Primary Hospitals (Formerly Rural Health Centers)

Ms. G. V. Molefe	Sr. Nursing Sister, Lethlakane
Ms. A. Matshameko	Nursing Sister, Madinari
Ms. M. Kakanyetoo	Nursing Sister, Bobonong

Annex 2

PROJECT IMPLEMENTATION SUMMARY
(as of October 1992)*

PROJECT COMPONENT	SAR REF	STATUS*	REMARKS
REORG. OF HEALTH CARE DELIVERY SYSTEM	P.18		
1. Strengthening of Mgmt. & Planning Capacity	3.07		
- MOH Review	3.02	PPF	Successfully completed
- Management Studies MOH Units & MLGL		PPF	Successfully completed
Health Unit	3.08	(C)	MOH not satisfied with outcome/result
- Management Information System (MOH linking)	3.08	(C)	of Management Specialist Consultant
- Management Training	3.08	(C)	Information System not developed
- Improve health planning	3.09		
- Evaluation work (i.e. Study central and	3.09	PH	Evaluation system not developed
district planning process)	3.09		and planned evaluations omitted
- Gaborone Health needs study	3.09	C	
2. Financial Management	3.10		
- Development Program Budgeting System			
- System for Cost Recovery (Study/report)		C	Study completed, not implemented
3. Community Health Sciences Center (CHSC)	3.11		
- Construction	3.11	C	
- Vehicle and Equipment	3.13	C	
- New TB Strategy	3.11	C	
- STD training and educational programs	3.12	C	
- Equipment health centres & clinics	3.12	C	
- Specialist training	3.13	PC/PM	Tr. of entomol. + microbiol. omitted
4. Strengthening of Rural Health Services	3.14		
- Upgrading rural health centres (H)		C	
- Equipment and 4 vehicles		C	Boilers + X-ray equipm. not funct. yet
- Improved staffing standard		C	
5. Central Medical Stores (CMS)			Planned modifications found not
- Construction etc. CMS Gaborone		PM	fessible and component consequently omitted from the project
POPULATION/MCH/FP			
6. Service provision	3.17		
- Comprehensive services at all clinics		C	Above 90% complete by October 1992
- FWE prescribing contracept. (6 cycles)		C	
- Training of health staff in FP		C	As per Training Plans
- Equipment, supplies & contraceptive commod.		C/PM	USAID support for contraceptive comm.
7. Information, Education and Commun. (IEC)	3.18		
- FP themes in health education programs		C	
- IEC for other programs which address FP		C	
- FLE in schools and at TTCs		C	
- STD/FP programs for men at work places		C	
- Programs for adolescents in schools/clubs etc.		PC	Integr. in school curricula completed
- Innovative (NGO) activities		(C)	Little progress, only 2 applic. supp.
- Improved teacher training in FLE/FP		PC	Integr. in curricula ongoing
- Strengthen Occup. Health Unit activities in FLE/FP among men	3.23	C	I.a. supply of condom vending machines
- Expansion of Health Education Unit		C	
- Training of HEU staff		C	As per Training Plan
- Radio Studio, graphics studies and equipment		C	
- Poster production (MCH/FP, STD, TB, etc)		C	Done, but much delayed

* ABBREVIATIONS USED:

C = Completed; (C) = completed unsatisfactorily; PM = Plan Modified
PC = Partially complete

PROJECT IMPLEMENTATION SUMMARY (Cont'd)

PROJECT COMPONENT	SAR REF	STATUS*	REMARKS
8. Demographic Unit	3.28		
- Development of Demographic Unit within CSO		PM	Unit established, Funded by UNFPA
- Equipment		PM	
- Library		PM	
URBAN HEALTH AND FAMILY PLANNING SERVICES	3.29		
- Upgrading & construct. of 9 urban clinics	3.30	C	Completed in 3 phases, all compl. by December 1991
- (incl. 2 maternity wards)			
- Upgrading Princess Marina Hospital	3.31	IP	See Annex w/separate constr. progr.
- Secondment of doctors to GAB Town Council		C	Presently five doctors at clinics
MANPOWER DEVELOPMENT			
- Local and Overseas Training		C	Very successful, output at 150% above target, see separate Annex

* ABBREVIATIONS USED:

C = Completed; (C) = completed unsatisfactorily; PM = Plan Modified
PC = Partially complete

CONSTRUCTION COMPLETION PROGRAM FOR PMH (as of October 1992)

Estimated Construction Completion Dates

Facility/Dept.	1992	1993	1994
Operating theater		May	
C.S.S.D.	December		
Laboratory	November		
Radio-diagnostic	October		
Delivery Unit			July
Renovate Theater			June
Intensive Care Unit	October		
Private Ward	December		
Isolation Ward			May
Admin. Block			May
Domestic Services			July
Surgical Ward 1		October	
Medical Ward 1		November	
Maternity Ward 2	September		
Maternity Ward			January
Eye Ward	August		
Gynecology Ward			February
Staff Rest			April
Walkway C2			September
Kitchen		February	
Medical Store			January
Service Yard			December
Blood Transfusion		January	
Orthopaedic W.shop (funded by NORAD)		May	

Annex 4

TRAINING OUTPUT AS PER SEPTEMBER 30, 1990

TRAINING COMPONENT	PERSONS	TRAINED OR IN TRAINING		(PLANNED & ACTUAL)		
	1	2	3	4 = (1+3)	5	6 = (4/5x100)
	OUTPUT AS PER MARCH 1989	MOH PLAN PY 5	OUTPUT PY 5 AS AT SEPT 30 1990	ACCUM. TOTAL AS AT SEPT 30 1990	SAR. ACCUM TOTAL BY PY 5	TOTAL OUTPUT BY SEPT 1990 VS SAR TOTAL BY PY 5 in %
LOCAL TRAINING						
a) Reorganization	1223	440	402	1625	787	206.5%
b) Population/MCH/FP	2290	686	357	2647	1653	160.1%
SUB-TOTAL LOCAL	3513	1126	759	4272	2440	175.1%
OVERSEAS TRAINING						
a) Reorganization	23	14	5	28	35	80.0%
b) Population/MCH/FP	17	3	4	21	13	161.5%
SUB-TOTAL OVERSEAS	40	17	9	49	48	102.1%
TOTAL (LOCAL & OVERSEAS)	3553	1143	768	4321	2488	151.9%

* PY 5 = Project Year Five

CONSULTANT SERVICES
(as of October 1992)

PROJECT COMPONENT/ SUBJECT OF CONSULTANCY	PERSON MONTHS SAR	Revised	Committed	COMPLETION DATE	GRANT/ LOAN	REMARKS
I. REORGANIZATION OF HEALTH SYSTEM						
A. Management Capacity						
(a) Health Planner	18	18	18	03/89	L	Successfully completed
(b) Management Specialist	24	18	18	12/87	L	Report not approved by MOH
Financial Management (and Cost Recovery)	12	12	0		L	Not utilized
(d) Health Planner/Evaluation	6	8	0		L	Not utilized
(e) Gaborone Health Needs Study	18	18	18	10/87	L	Successfully completed
(f) Manpower Planner	0	24	24	06/90	L	Phase 2 completed June 1990
(g) Health Financing		6	6	1984	L	Cost recovery proposals not implemented
B. Community Health S.C.						
(a) Microbiologist	24	0	0	n/a	G	Not needed (MOH decision)
(b) Entomologist	24	0	0	n/a	G	Not needed (MOH decision)
(c) TB-evaluation	3	0	0	1985	G	Done by IUAT at nil cost
Sub-Total	129	104	84			
II. POPULATION/MCH/FP						
A. IEC						
(a) T.O.T. - MCH/FP	0	4	4	7/85	G	PPF activity
(b) Program design	12	6	6	11/87	G	
(c) Program development	24	6	6	12/88	G	Completed IEC plan
(d) Flipcharts	0	3	3	6/85		PPF activity
B. Demographic Unit						
(a) Demographer	36	0	0	n/a	G	Funded by UNFPA
Sub-Total	72	19	19			
III. MANPOWER DEVELOPMENT						
A. Reorganization Manpower						
(a) O & M Workshop	6	0	0	n/a	L	Not needed, done by MEDEX/DMI
(b) Man. orient. for Hospital St.	2	2	0		L	Not utilized
(c) Physician tr. prescribing	2	3	3	04/89	L	Completed as a study
B. Population/MCH/FP						
(a) Local Workshops	9	0	0		G	Funded by INTRAH
(b) Curriculum Consultant	2	5	6		G	PPF activity
(c) FWE Curriculum	0	3	3	08/87	G	PPF activity
(d) Training Coordinator	36	48	48	09/90	G	
Sub-Total	57	61	60			
IV. PROJECT COORDINATION						
A. Architectural Planning						
(a) Senior Architect	36	84	72	To date 69 months done (L)		
(b) Architects (2)	36	N/A	N/A	To date 117 months done (L), + resources from GoB		
(c) Structural Engineer	36	N/A	N/A	[Independent Consultants commissioned (L)		
(d) Quantity Surveyor	4	N/A	N/A	[Instead of being directly (L) .		
(e) Mechanical Engineer	4	N/A	N/A	[recruited (L)		
(f) Electrical Engineer	4	N/A	N/A	[recruited (L)]		
(g) F&E Consultant	0	36	36	To date 36 months done (L)		
(h) Snr. Hospital Dev. Officer	0	24	24	Completed 24 months (L)		
Sub-Total	120	N/A	N/A			
Total	378					

* In addition: Consultant Commissioning Team (of 4) recruited 1990, consultancy still ongoing (L)

N/A = Not applicable

FAMILY HEALTH PROJECT

Record of Project Progress Reports Submitted

1.	February 15,	1985	Quarterly Progress Report for the fourth Calendar quarter of 1984.
2.	April 1st,	1985	Quarterly Progress Report - 1/1/85 - 31/3/85.
3.	May 7th,	1985	Amendment Quarterly Report - 1/1/85 - 31/3/85.
4.	October 22,	1985	Progress Report for the third calendar quarter 1985.
5.	December 31,	1985	Quarterly Progress Report for the last calendar quarter 1985.
6.	January 16,	1986	Progress Report Update for 4th Quarter Report of 1985.
7.	May 2nd,	1986	Quarterly Progress Report for first quarter of 1986.
8.	July 4th,	1986	2nd Quarterly Progress Report for 1986.
9.	November 3,	1986	3rd Quarterly Progress Report for 1986.
10.	January 23,	1987	4th Quarterly Progress Report for 1986.
11.	April 1st,	1987	1st Quarterly Progress Report for the quarter ending 31/3/1987.
12.	July 1st,	1987	2nd Quarterly Progress Report for the quarter ending 30/6/1987.
13.	November 6,	1987	3rd Quarterly Progress Report for the quarter ending 30/9/1987.
14.	April 3,	1988	1st Quarterly Progress Report for the quarter ending 31st March, 1988.
15.	July 29,	1988	2nd Quarter Progress Report for the quarter ending 30th June, 1988.
16.	October 25,	1988	3rd Quarterly Progress Report for 1988.

17.	February 15,	1989	4th Quarterly Report for the quarter ending 31st December, 1988.
18.	May 19th,	1989	1st Quarterly Progress Report ending 31st March 1989.
19.	July 5,	1989	2nd Quarterly Progress Report ending 30th June 1989.
20.	November 3,	1989	3rd Quarterly Progress Report for the quarter ending 30th September 1989.
21.	March 12,	1990	4th Quarterly Progress Report for the quarter ending 31st December 1989 which incorporates responses to issues raised in the aide memoire of November 1989 World Bank Supervision Mission.
22.	May 14,	1990	1st Quarterly Progress Report for the quarter ending 31st March 1990.
23.	July	1990	2nd Quarterly Progress Report for the quarter ending 30th June 1990.
24.	November 16,		19903rd Quarterly Progress Report for the quarter ending 30th September 1990.
25.	February 27,	1991	4th Quarterly Progress Report for the quarter ending 31st December 1990 which also incorporates the responses to the issues in the aide memoire of the World Bank Supervision Mission.
26.	June 13,	1991	1st Quarterly Progress Report for the quarter ending 31st March 1991.
27.	September 6,	1991	2nd Quarterly Progress Report for the quarter ending 30th June 1991.
28.	November 5,	1991	3rd Quarterly Progress Report for the quarter ending 30th September 1991, which incorporates responses to issues raised in the aide memoire for the World Bank Supervision Mission of August 1991.
29.	January 17,	1992	4th Quarterly Progress Report for the year ending 1991.

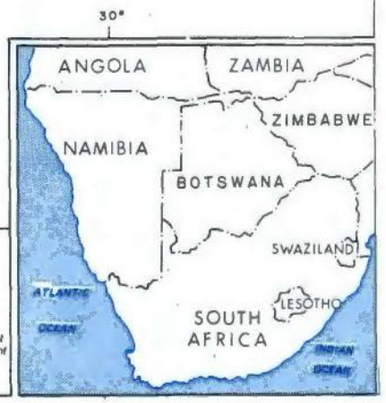
IBRD 11895R
DECEMBER 1983

BOTSWANA

EXISTING MAIN ROADS
EXISTING SECONDARY ROADS
OTHER ROADS
RAILWAYS
MAJOR AIRFIELDS – TARMAC
MAJOR AIRFIELDS – UNSURFACED
MINERAL PROJECTS
RIVERS
DISTRICT ADMINISTRATIVE CENTERS
DISTRICT BOUNDARIES
INTERNATIONAL BOUNDARIES

0 20 40 60 80 100 MILES
0 20 40 60 80 100 120 140 160 KILOMETERS

ANGOLA
ZAMBIA
ZIMBABWE
NAMIBIA
SOUTH AFRICA
CAPRIVI STRIP
CHOBE
NGAMILAND
OKAVANGO DELTA
MAKGADIKGADI PANS
NORTHEAST
CENTRAL
GHANZI
KALAHARI DESERT
KWENENG
KGALAGADI
KGATLENG
SOUTHEAST
NGWAKETSE
Kazungula
Kasane
Mohembo
Shekawe
Maun
Gweta
Nata
Bulawayo
Tutume
Dukwe
Ramokgwebana
Rakops
(Copper) Matsitama
(Diamonds) (Soda) SUA PAN
Proposed Railway
Francistown
Orapa
Letlhakane
LAKE NGAMI
LAKE XAU
Ghanzi
Gobabis
Serule
Mmadinare
(Copper) Bobonong
Selebi-Pikwe
Serowe
Marupule (Coal)
Palapye
Moeng
Pont Drift
Shoshong
Mahalapye
Sherwood Ranch
Machaneng
Pretoria
Johannesburg
Hukuntsi
Kang
Letlhakeng
Molepolole
Mogaditshane
Pilane
Mochudi
Gaborone
Sebele
Sikwane
Kanye
Lobatse
Pioneer Gate
Ramathlabama
Mafeking
Vryburg
Tshabong
McCarthy's Rust
ZAMBEZI R.
CHOBE or LINYANTI R.
OKAVANGO R.
SHASHI R.
LIMPOPO R.
MARICO R.
MOLOPO R.
NOSOP R.
BAROLONG



PCR/PIF COVER SHEET Run Date: 9/22/93

OED ID: L2413 *Division: 1

*Country: Botswana
*Project Description: Family Health
*Sector: 04 / Human Resource
*Subsector: 04.05 / Pop., Health & Nutr.
Lending Instrument Type: SIM
L/C: L2413
Original IDA/IBRD Commitments: 11,000,000 ($US)
Total Cancellations: 0 ($US)

Key Dates	ORIGINAL	ACTUAL
Approval		5/17/84
Signing/Agreement		8/27/84
Effectiveness	11/27/84	5/21/85
Closing	1/31/89	1/31/92
PCR Receipt in OED		2/23/93

ASSIGNED TO: _____

SIGNATURE: _____ DATE: _____

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: 05/12/93 (mm/dd/yy)

Name of Reviewer: L. DOVE

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	07 31 88 (mm/dd/yy)	07 31 88 (mm/dd/yy)
Total Project Cost ($US mill)	26.7	47.21
Applicable Disbursement Profile: (see note 11 in the PIF, page 31)	6.5	
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	☐

A. PIF Processing Information

Date of review: May 12, 1993

Name of reviewer: Linda A. Dove

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: Botswana

Project Name: Family Health Project

Sector/Subsector: Population, Health + Nutrition

Lending Instrument: SIM

Loan or Credit #s': Ln 2413-BOT

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	☐	☑	☐	☐ As a 1st Bank-assisted project in health sector.
Revised Project	☐	☐	☐	☐

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

Yes ☐ Partially ☐ No ☑ Civil works and Cost savings quantified but Service provision increase and ID components not.

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	☐	☑	☐	☐	Training targets exceeded but management capacity enhancement not adequately evaluated
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	☐	☒	☐	☐	Drought 1985
Bank performance	☐	☒	☐	☐	Advice appreciated by GOB but problems addressed late
Cofinancier(s) performance	☐	☐	☒	☐	
Performance of contractors/ consultants 8/	☒	☐	☐	☐	Inexperienced locals delayed completion of major civil works
War/civil disturbances	☐	☐	☐	☐	
Other (specify):_____	☐	☐	☐	☐	

Factors Generally Subject to Government Control

Macro policies/conditions	☐	☐	☐	☐	Freeze on hiring foreign TA
Sector policies	☐	☐	☐	☐	
Government commitment	☐	☐	☐	☐	
Appointment of key staff	☐	☐	☐	☐	Project coordination weak and project managers insufficient authority.
Counterpart funds	☐	☐	☐	☐	
Administrative procedures	☐	☐	☐	☐	Project staff lacked familiarity with Bank procedures especially disbursement audit delays.
Other (specify):_____	☐	☐	☐	☐	

Factors Generally Subject to Implementing Agency Control

Management	☐	☐	☐	☐	Dept. heads as project managers did not achieve integration of project activities with routine MOH programs and Project Coordinator overstretched and lacking in authority.
Staffing	☐	☐	☐	☐	
Cost changes	☐	☐	☐	☐	
Implementation delays	☐	☐	☐	☐	
Use of technical assistance	☐	☐	☐	☐	
Monitoring and evaluation 9/	☐	☐	☐	☐	
Beneficiary participation	☐	☐	☐	☐	Rarely done at this time (early 1980s)
Other (specify):_____	☐	☐	☐	☐	

Annual evaluations not carried out as planned due to shortage of local expertise

Civil works overrun seven times appraised estimate and project life extended three years due to expansion of major hospital upgrading plan, with delayed implementation 72 months.

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

Change in project scope/scale/design	– ☑	Major hospital upgrading plan expanded during implementation.
Deficient estimate of physical quantities	– ☑	
Deficient estimate of base unit costs	☐	Insufficient cost analysis for civil works.
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/
6	10	6.5

Indicate the major reason(s) for implementation delays: +/-

Implementation schedule unrealistic	☐	
Project preparation incomplete	– ☑	architectural design
Unexpected technical difficulties	– ☑	upgrading existing hospital in use problematic

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	☐	☐	☐	☐	Not applicable
m. Other (specify): User Charges/ Cost recovery	☐	☐	☐	☐	Study completed but GOB decision to provide free health care. Therefore fees kept at appraisal level
Overall	☐	☐	☐	☐	

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

Sufficiency of Government ~~commitment~~ / change of heart ☑ +/−

Adequacy of preparation/design ☐

Institutional effectiveness ☐

Realism of objectives ☐

Other (specify): _____ ☐

2. Social Concerns

a) Did the project address specific social groups?

Yes ☑ No ☐

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/** ☐

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	(b) ( )	+ ☑
Sufficiency of Government/borrower commitment	(b) ( )	+ ☑
Institutional effectiveness	( ) ( )	☐
Sufficiency of NGO/beneficiary participation	( ) ( )	☐
Realism of objectives	(b) ( )	− ☑
Other (specify): _____	( ) ( )	☐

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

Positive ☑ Negative ☐ No ☐ Unknown ☐ Female fertility

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 ☐ Implicit objective to strengthen local construction contracting industry

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

Substantial	Partial	Negligible	Not Available
☐	☑	☐	☐

Local firms utilized but inadequate for the tasks.

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 ☑ Inexperience of project managers in managing contractors + insufficient

Realism of objective(s) ☑ analysis of local firms' capacities.

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 Available
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	☐	☑	☐	☐	Deficient only on civil works components
Financial	☐	☐	☐	☐	
Economic	☐	☐	☐	☐	
Commercial	☐	☐	☐	☐	
Institutional	☐	☐	☑	☐	Centralized MOH management outreach
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): Preparation combined with sector work	☑

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

	Highly Satisfactory	Satis-factory	Deficient	Not Available	
Technical	☐	☑	☐	☐	Deficiency in civil works.
Financial	☐	☑	☐	☐	
Economic	☐	☐	☐	☐	
Commercial	☐	☐	☐	☐	
Institutional	☐	☐	☑	☐	Project management
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	☐	☐	☑	☐	For a first project
Project complexity	☐	☐	☑	☐	over-complex
Recognition of project risks/key variables **22/**	☐	☑	☐	☐	Deficient in failure to recognize
Adequacy of implementation plan/ performance indicators	☐	☐	☑	☐	local construction industry
Suitability of lending instrument	☑	☐	☐	☐	too weak to handle
Taking into account adequately past experience	☐	☑	☐	☐	major hospital upgrading
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	☐	☐	☑	☐	Reporting deficient in ratings in early years and ratings high even when completion obviously seriously delayed
Identification/assessment of implementation problems	☐	☐	☑	☐	
Attention to likely development impact	☐	☑	☐	☐	
Advice to implementing agency	☐	☑	☐	☐	
Adequacy of follow-up on advice/ decisions	☐	☐	☑	☐	weak handover when staff turnover high
Enforcement of loan covenants/ exercise of remedies	☐	☑	☐	☐	
Flexibility in suggesting/ approving modifications	☐	☐	☑	☐	Bank too flexible, in agreeing to hospital construction design changes.
Other (specify) _____	☐	☐	☐	☐	
Overall	☐	☐	☑	☐	

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

Staff quantity	☑	☐	☐	☐	Insufficient in field for a major project
Sufficiency of time in field	☐	☐	☑	☐	
Staff quality (skill mix, continuity)	☐	☐	☑	☐	
Consultants (quality, continuity)	☑	☐	☐	☐	

Supervision plans	☐	☐	☐	☑
Timing of supervision missions	☐	☐	☑	☐ Inadequate in 1987
Country implementation reviews	☐	☐	☐	☑ due to Bank Reorganization
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	☐	☑	☐	☐	Deficient in civil works & equipment
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	☐	☑	☐	☐	Though delayed, civil works completed.
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)	☐	Grant-assisted
Performance of consultant(s) 8/	☑	Norwegian consultant highly valued by GOB but civil works local consultants deficient.
Government commitment	☐	
Government interference	☐	
Adequacy of project monitoring/ evaluation	☐	
Other (specify): _____	☐	

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

	Substantial	Partial	Negligible	Not Available	
Macro policies	☐	☐	☐	☐	
Sector policies	☑	☐	☐	☐	Project builds on Government policy and institutional reforms
Institutional changes	☑	☐	☐	☐	
Effective management/ staffing	☑	☐	☐	☐	
Financial improvements (tariffs, user charges, etc.) **24/**	☐	☐	☐	☐	Study completed. Government did not implement because against free health service policy
Provision of counterpart funds	☑	☐	☐	☐	
Increased efficiencies/ cost reductions	☐	☐	☐	☐	As on User-charges.
Procurement **25/**	☑	☐	☐	☐	
Progress reports	☑	☐	☐	☐	
Accounts and Audits **26/**	☐	☑	☐	☐	Delayed and some deficiencies in audits.
Use of technical assistance **27/**	☑	☐	☐	☐	
Studies	☑	☐	☐	☐	
Other (specify): _____	☐	☐	☐	☐	
Overall	☑	☐	☐	☐	

Good use of majority of consultants, under-use of Community Health Science Center + Population/MCH specialists. Excessive use of civil works contractors, partly for GOB resources, to resolve hospital siting issues.

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. * Project objectives for primary health care and family planning delivery attained and sustainable because fully matched sector strategy of government.

b. ~~Inter-departmental coordinating committee is not sufficient to integrate project activities with regular Borrower~~

c. agencies and nurture ownership. Senior functional officials need to be fully supportive and proactive and ~~monitor project closely for managerial effectiveness~~

c. High profile civil works components need to be thoroughly prepared and rigorously appraised if they are not to dominate project in terms of resources devoted to resolving implementation problems.

All standard issues in HRD projects.

H. Comments*

Government not currently borrowing from the Bank in the sector. If in the future the Government requests Bank assistance, the lessons learned from the successful achievements of the project (primary health care delivery and family planning) and the deficiencies (design of major hospital and other construction and project management weakness) would be highly relevant.

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* 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.

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* 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: Botswana

Project Name: Family Health Project

Sector/Subsector: Population, Health + Nutrition

Lending Instrument: SIM

Loan or Credit No: LN 2413 - BOT

Date of Review: May 12, 1993

Evaluating Officer: Linda A. Dove

Division Chief: Graham 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: Botswana

Project Name: Family Health Project

Sector/Subsector: Population, Health + Nutrition

Lending Instrument: SIM

Loan or Credit No: Ln 2413 - BOT

Date of Review: May 12, 1993

Evaluating Officer: Linda A. Dove

Division Chief: Graham Donaldson

A. Performance Audit

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

High ☐ Medium ☐ Low ☑

Borrower not currently borrowing from Bank in the sector.

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): _____ ☐

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* These criteria are prerequisites for impact evaluation.

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OPERATIONS EVALUATION DEPARTMENT

PROJECT INFORMATION FORM (PIF)* 1/

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* The numbers in the PIF refer to the relevant explanatory notes in the Annex.

A. PIF Processing Information

Date of review: May 12, 1993

Name of reviewer: Linda A. Dove

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: Botswana

Project Name: Family Health Project

Sector/Subsector: Population, Health & Nutrition

Lending Instrument: SIM

Loan or Credit #s': Ln 2413-BOT

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	☐	☑	☐	☐ As a 1st Bank-assisted project in health sector.
Revised Project	☐	☐	☐	☐

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

Yes ☐ Partially ☐ No ☑ Civil works and Cost savings quantified but Service provision increase and ID components not.

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	☐	☑	☐	☐	Training targets exceeded but management capacity enhancement not adequately evaluated
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	☐	☐ (−)	☐	☐	Drought 1985
Bank performance	☐	☐ (+)	☐	☐	Advice appreciated by GOB but problems addressed late
Cofinancier(s) performance	☐	☐	☐ (+)	☐	
Performance of contractors/ consultants 8/	☐ (−) Inexperienced locals delayed completion of major civil works	☐	☐	☐	
War/civil disturbances	☐	☐	☐	☐	
Other (specify):_____	☐	☐	☐	☐	

Factors Generally Subject to Government Control

Macro policies/conditions	☐	(-)	☐	☐ Freeze on hiring foreign TA
Sector policies	(+)	☐	☐	☐
Government commitment	(+)	☐	☐	☐
Appointment of key staff	☐	(-)	☐	☐ Project coordination weak and project managers insufficient authority.
Counterpart funds	(+)	☐	☐	☐
Administrative procedures	☐	(-)	☐	☐ Project staff lacked familiarity with Bank procedures, especially disbursement audit delays.
Other (specify):_____	☐	☐	☐	☐

Factors Generally Subject to Implementing Agency Control

Management	☐	(-)	☐	☐ Dept. heads as project managers did not achieve integration of project activities with routine MOH programs and Project Coordinator overstretched and lacking in authority.
Staffing	☐	(+)	☐	☐
Cost changes	(-)	☐	☐	☐
Implementation delays	(-)	☐	☐	☐
Use of technical assistance	☐	(+)	☐	☐
Monitoring and evaluation 9/	(-)	☐	☐	☐
Beneficiary participation	☐	☐	☐	☐ Rarely done at this time — (early 1980s)
Other (specify):_____	☐	☐	☐	☐

Annual evaluations not carried out as planned due to shortage of local expertise

Civil works overrun seven times appraised estimate — & project life extended three years due to expansion of major hospital upgrading plan, which delayed implementation 72 months.

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

Change in project scope/scale/design	☑	Major hospital upgrading plan expanded during implementation.
Deficient estimate of physical quantities	☑	
Deficient estimate of base unit costs	☐	Insufficient cost analysis for civil works.
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/
6	10	6.5

Indicate the major reason(s) for implementation delays:

Implementation schedule unrealistic	☐	
Project preparation incomplete	☑	architectural design
Unexpected technical difficulties	☑	upgrading existing hospital in use problematic

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	☐	☐	☐	☐	Not applicable
m. Other (specify): User Charges/ Cost recovery	☐	☐	☐	☐	Study completed but GOB decision to provide free health care. Therefore fees kept at appraisal level.
Overall	☐	☐	☐	☐	

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

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

2. Social Concerns

a) Did the project address specific social groups?

Yes ☑ No ☐

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/ ☐
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	(b) ( )	☑
Sufficiency of Government/borrower commitment	(b) ( )	☑
Institutional effectiveness	( ) ( )	☐
Sufficiency of NGO/beneficiary participation	( ) ( )	☐
Realism of objectives	(b) ( )	☑
Other (specify): _____	( ) ( )	☐

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

Positive ☑ Negative ☐ No ☐ Unknown ☐ female fertility

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): _____

_____

_____

Private Sector Development 19/

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

Yes ☑ No ☐ Implicit objective to strengthen local construction contracting industry

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

Substantial	Partial	Negligible	Not Available
☐	☑	☐	☐

Local firms utilized but inadequate for the tasks.

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): _____	☐

Inexperience of project managers in managing contractors + insufficient analysis of local firms' capacities.

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 Available
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	☐	☑	☐	☐	Deficient only on civil works components
Financial	☐	☐	☐	☐	
Economic	☐	☐	☐	☐	
Commercial	☐	☐	☐	☐	
Institutional	☐	☐	☑	☐	Centralized MOH management outreach
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): Preparation combined with sector work ☑

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

	Highly Satisfactory	Satis-factory	Deficient	Not Available	
Technical	☐	☑	☐	☐	Deficiency only civil works.
Financial	☐	☑	☐	☐	
Economic	☐	☐	☐	☐	
Commercial	☐	☐	☐	☐	
Institutional	☐	☐	☑	☐	Project management
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	☐	☐	☑	☐	For a first project
Project complexity	☐	☐	☑	☐	over-complex
Recognition of project risks/key variables **22/**	☐	☑	☐	☐	Deficient in failure to recognize
Adequacy of implementation plan/ performance indicators	☐	☐	☑	☐	local construction industry
Suitability of lending instrument	☑	☐	☐	☐	too weak to handle
Taking into account adequately past experience	☐	☑	☐	☐	major hospital
Other (specify)	☐	☐	☐	☐	upgrading

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	☐	☐	☑	☐	Reporting deficient in ratings in early years and ratings high even when completion obviously seriously delayed
Identification/assessment of implementation problems	☐	☐	☑	☐	
Attention to likely development impact	☐	☑	☐	☐	
Advice to implementing agency	☐	☑	☐	☐	
Adequacy of follow-up on advice/ decisions	☐	☐	☑	☐	weak handover when staff turnover high
Enforcement of loan covenants/ exercise of remedies	☐	☑	☐	☐	
Flexibility in suggesting/ approving modifications	☐	☐	☑	☐	Bank too flexible, in agreeing to hospital construction design changes.
Other (specify) _____	☐	☐	☐	☐	
Overall	☐	☐	☑	☐	

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

Staff quantity	☑	☐	☐	☐	Insufficient in field for a first project
Sufficiency of time in field	☐	☐	☑	☐	
Staff quality (skill mix, continuity)	☐	☐	☑	☐	
Consultants (quality, continuity)	☑	☐	☐	☐	

Supervision plans	☐	☐	☐	☑
Timing of supervision missions	☐	☐	☑	☐ Inadequate in 1987
Country implementation reviews	☐	☐	☐	☑ due to Bank Reorganization
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	☐	☑	☐	☐	Deficient - civil works + equipment
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	☐	☑	☐	☐	Though delayed, civil works completed.
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)	☐	Grant-assisted
Performance of consultant(s) 8/	☑	Norwegian consultant highly valued by GOB but civil works local consultants deficient.
Government commitment	☐	
Government interference	☐	
Adequacy of project monitoring/ evaluation	☐	
Other (specify): _____	☐	

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

	Substantial	Partial	Negligible	Not Available	
Macro policies	☐	☐	☐	☐	
Sector policies	☑	☐	☐	☐	Project builds on Government policy and institutional reforms
Institutional changes	☑	☐	☐	☐	
Effective management/ staffing	☑	☐	☐	☐	
Financial improvements (tariffs, user charges, etc.) **24/**	☐	☐	☐	☐	Study completed. Government did not implement because against free health service policy
Provision of counterpart funds	☑	☐	☐	☐	
Increased efficiencies/ cost reductions	☐	☐	☐	☐	As on User-charges.
Procurement **25/**	☑	☐	☐	☐	
Progress reports	☑	☐	☐	☐	
Accounts and Audits **26/**	☐	☑	☐	☐	Delayed and some deficiencies in audits.
Use of technical assistance **27/**	☑	☐	☐	☐	
Studies	☑	☐	☐	☐	
Other (specify): _____	☐	☐	☐	☐	
Overall	☑	☐	☐	☐	

Good use of majority of consultants, under-use of Community Health Science Center + Population/MCH specialists. Excessive use of civil works contractors, partly from GOB resources, to resolve hospital warding issues.

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. * Project objectives for primary health care and family planning delivery attained and sustainable because fully matched sector strategy of government.

b. ~~Inter-departmental coordinating committee is not sufficient to integrate project activities with regular Borrower~~

d. ~~agencies and nurture ownership. Senior functional officials need to be fully supportive and proactive and monitor project closely for managerial effectiveness~~

c. High profile civil works components need to be thoroughly prepared and rigorously appraised if they are not to dominate project in terms of resources devoted to resolving implementation problems.

All standard issues in HRD projects.

H. Comments*

Government not currently borrowing from the Bank in the sector. If in the future the Government requests Bank assistance, the lessons learned from the successful achievements of the project (primary health care delivery and family planning) and the deficiencies (design of major hospital and other construction and project management weakness) would be highly relevant.

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* 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.

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* 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: Botswana

Project Name: Family Health Project

Sector/Subsector: Population, Health + Nutrition

Lending Instrument: SIM

Loan or Credit No: Ln 2413 - BOT

Date of Review: May 12, 1993

Evaluating Officer: Linda A. Dove

Division Chief: Graham 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: Botswana

Project Name: Family Health Project

Sector/Subsector: Population, Health + Nutrition

Lending Instrument: SIM

Loan or Credit No: Ln 2413 - BOT

Date of Review: May 12, 1993

Evaluating Officer: Linda A. Dove

Division Chief: Graham Donaldson

A. Performance Audit

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

High ☐ Medium ☐ Low ☑

Borrower not currently borrowing from Bank in the sector.

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. <u>Impact Evaluation</u>

5. The preliminary priority of the project for <u>impact evaluation</u> 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.

OPERATIONS EVALUATION DEPARTMENT
PCR REVIEW/AUDIT PROCESS /1

CONTROL SHEET

Project: BOTSWANA: Family Health Project
Loan No: 2413-BT
PCR Format: New-Style
Evaluating Officer: Linda A. Dove **Date:** 5/21/93
Approved by: Graham Donaldson, Chief **Date:** 5.21.93

	Date (mo/dy/yr)
A. Timetable	
- PCR logged in by Division	02/25/93
- If incomplete, PCR returned to Region	
- If PCR is unlogged	
In case evaluating officer requests Region to revise draft PCR: /2	
- Memo to Sector Division Chief	
- 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
Covenant requiring Borrower to prepare PCR /3	___	___
PCR prepared by		
I. Borrower		
- Borrower staff or agencies	___	___
- FAO/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?	X	___
If yes,		
- Part II agrees with Parts I and III	X	___
- Part II disagrees with Parts I and III	___	___

E. OED Staff and Consultants Input

	Days
Staff	4 1/2
Consultants	-
Total	4 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.

OFFICIAL FILE COPY

July 14, 1993

Mr. H.C.L. Hermans
Governor, Bank of Botswana
P.O. Box 712
Gabarone, Botswana

Dear Mr. Hermans:

Re: Family Health Project (Loan 2413-BT)
Final 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 for your information.

Yours sincerely,

(Signed)

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

Attachment

cc: Messrs./Ms. de Merode, Measham (PHN), Grawe (AF6PH), Husain (AFTHR)

LADove:tm

PROJECT COMPLETION REPORT

BOTSWANA

FAMILY HEALTH PROJECT
(Loan 2413-BT)

LIST OF RECIPIENTS OF THE FINAL VERSION OF THE REPORT

Mr. H.C.L. Hermans
Governor, Bank of Botswana
P.O. Box 712
Gabarone, Botswana

Mr. L.C. Clarke
Deputy Governor
Bank of Botswana
P.O. Box 712
Gabarone, Botswana

Mr. L. Mothibasela
Secretary for Economic Affairs
Ministry of Finance and Development Planning
Private Bag 008
Gabarone, Botswana

Mr. S.S.G. Tumelo
Director, Development Programs
Ministry of Finance and Development Planning
Private Bag 008
Gabarone, Botswana

Mrs. Neo Gaetsewa
Senior Planning Officer, Social Sectors
Ministry of Finance and Development Planning
Private Bag 008
Gabarone, Botswana

Mr. P.V. Sephuma
Deputy Permanent Secretary
Ministry of Education
Private Bag 005
Gabarone, Botswana

Mr. Eric Odotei
Principal Planning Officer and
Secretary for the National Commission on Education
Ministry of Education
Private Bag 005
Gabarone, Botswana

Mr. Fabrick Mawela
Chief Education Officer (Secondary)
Ministry of Education
Private Bag 005
Gabarone, Botswana

Mr. P.S. Matila
Senior Planning Officer
Ministry of Education
Private Bag 005
Gabarone, Botswana

Mr. L.L. Mukokomani
Deputy Permanent Secretary
Ministry of Local Government, Lands and Housing
Private Bag 006
Gabarone, Botswana

Mr. S.B. Narang
Senior Architect (Primary Schools)
Ministry of Local Government, Lands and Housing
Private Bag 006
Gabarone, Botswana

Mr. Niels Lindhardt
Director, Boipelego Education Unit
Private Bag 005
Gabarone, Botswana

Ms. Elizabeth Fong
UNDP Resident Representative
P.O. Box 54
Gabarone, Botswana

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

ROUTING SLIP	DATE: June 15, 1993

NAME	ROOM NO.
Mr. Graham Donaldson, Chief, OEDD1	

	URGENT		PER YOUR REQUEST
	FOR COMMENT		FOR ACTION
	FOR SIGNATURE		FOR APPROVAL/CLEARANCE

RE: BOTSWANA: Family Health Project (Ln. 2413-BT)
PCR

REMARKS:

For your approval to print.

OK 6/15

FROM:	ROOM NO.:	EXTENSION:
Linda A. Dove, OEDD1		38298

List of Names of Persons to Whom PCR Should be Sent

BOTSWANA

1. Mr. H.C.L. Hermans
Governor, Bank of Botswana
P.O. Box 712
Gabarone, Botswana

2. Mr. L.C. Clarke
Deputy Governor
Bank of Botswana
P.O. Box 712
Gabarone, Botswana

3. Mr. L. Mothibasela
Secretary for Economic Affairs
Ministry of Finance and Development Planning
Private Bag 008
Gabarone, Botswana

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Ministry of Education
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Gabarone, Botswana

9. Mr. P.S. Matila
Senior Planning Officer
Ministry of Education
Private Bag 005
Gabarone, Botswana

BOTSWANA (continued)

10. Mr. L.L. Mukokomani
Deputy Permanent Secretary
Ministry of Local Government, Lands and Housing
Private Bag 006
Gabarone, Botswana

11. Mr. S.B. Narang
Senior Architect (Primary Schools)
Ministry of Local Government, Lands and Housing
Private Bag 006
Gabarone, Botswana

12. Mr. Niels Lindhardt
Director, Boipelego Education Unit
Private Bag 005
Gabarone, Botswana

13. Ms. Elizabeth Fong
UNDP Resident Representative
P.O. Box 54
Gabarone
Botswana

LESOTHO

1. Mr. K. Matete
Principal Secretary
Ministry of Education
P.O. Box 47
Maseru 100
Lesotho

2. Mrs. M. Motselebane
Head, Planning Unit
Ministry of Education
P.O. Box 47
Maseru 100
Lesotho

3. Mrs. M. Makakole
Planning Officer
Ministry of Education
P.O. Box 47
Maseru 100
Lesotho

LESOTHO (continued)

4. Mr. S.N. Jha
Coordinating Architect
Ministry of Education
P.O. Box 47
Maseru 100
Lesotho

5. Mr. A.S. Sivam
Contracts Manager
Ministry of Education
P.O. Box 47
Maseru 100
Lesotho

6. Mr. T. Tuoane
Principal Secretary, Finance
Ministry of Finance and Planning
P.O. Box 630
Maseru
Lesotho

7. Mr. T. Makhakhe
Principal Secretary, Planning
Ministry of Finance and Planning
P.O. Box 630
Maseru
Lesotho

October 28, 1992

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

ROUTING SLIP	DATE: June 16, 1993

D.G.O.
'93 JUN 16 PM 3 15
6/16

NAME	ROOM NO.
Mr. Robert Picciotto, DGO	

	URGENT		PER YOUR REQUEST
	FOR COMMENT		FOR ACTION
	FOR SIGNATURE		FOR APPROVAL/CLEARANCE

RE: BOTSWANA: Family Health Project (Ln. 2413-BT)
PCR

REMARKS:

For your signature before printing.

FROM:	ROOM NO.:	EXTENSION:
Graham Donaldson, Acting Director, OEDD1		31730

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 Botswana
Family Health Project (Ln. 2413-BT)

Attached is the Project Completion Report on Botswana - Family Health Project (Loan 2413-BT) prepared by the Africa Regional Office. Part II of the report was prepared by the Borrower.

Underpinning the Government's reorganization of its health care delivery system and despite considerable delays and difficulties, the project was ultimately successful in meeting three central objectives: (a) strengthening the country's Rural Health Teams and developing 13 rural and urban primary health care centers so as to provide more outpatient care and free in-patient resources, (b) upgrading the country's main hospital facility and (c) helping in nearly doubling the incidence of family planning.

On the other hand, the Government did not put in place an improved budgeting and accounting system, and civil works were subject to cost overruns. Weak coordination of the various ministry agencies' activities was detrimental to institutional development which was only partially achieved.

Nevertheless, the prospects for sustainability of the strengthened health care delivery system are adequate and the overall project outcome is rated as satisfactory.

The PCR provides a candid account of project achievements and shortcomings. No audit is 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

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Underpinning the Government's reorganization of its health care delivery system, the project's major contributions were to (a) strengthen the country's Rural Health Teams and develop 13 rural and urban primary health care centers so as to provide more outpatient care and free in-patient resources, (b) upgrade the country's main hospital facility and (c) help in nearly doubling the incidence of family planning. The Government, however, did not put in place a planned budgeting and accounting system, and civil works were subject to delays and cost overruns. Weak coordination of the various ministry agencies' activities was detrimental to institutional development which was only partially achieved. Nevertheless, the prospects for sustainability of the strengthened health care delivery system are good and the project is rated satisfactory.

The PCR provides a candid account of project achievements and shortcomings and the project is not a candidate for audit.

Attachment

OFFICIAL FILE COPY

July 14, 1993

Mr. H.C.L. Hermans
Governor, Bank of Botswana
P.O. Box 712
Gabarone, Botswana

Dear Mr. Hermans:

Re: Family Health Project (Loan 2413-BT)
Final 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 for your information.

Yours sincerely,

(Signed)

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

Attachment

cc: Messrs./Ms. de Merode, Measham (PHN), Grawe (AF6PH), Husain (AFTHR)

LADove:tm

OFFICIAL FILE COPY

DATE: June 1, 1993

TO: Mr. Stephen M. Denning, Director, AF6

FROM: H. Eberhard Köpp, Director, OED

EXTENSION: 31700

SUBJECT: BOTSWANA: Family Health Project (Ln. 2413-BT)
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:	satisfactory
Sustainability:	likely
Institutional Development:	partial

Should the project be audited at a later date, the ratings will be re-evaluated at that time.

Attachment

LADove/GDonaldson:tm

OFFICIAL FILE COPY

DATE: June 1, 1993

TO: Mr. Stephen M. Denning, Director, AF6

FROM: H. Eberhard Köpp, Director, OED

EXTENSION: 31700

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Attachment

LADove/GDonaldson:tm

OFFICIAL FILE COPY

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TO: Mr. Stephen M. Denning, Director, AF6

FROM: H. Eberhard Kopp, Director, OED

EXTENSION: 31700

SUBJECT: BOTSWANA: Family Health Project (Ln. 2413-BT)
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Attachment

LADove/GDonaldson:tm

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

ROUTING SLIP	DATE: May 26, 1993
NAME	ROOM NO.
Mr. Robert Picciotto, DGO	
THRU: Mr. H. Eberhard Köpp, Director, OED	

	URGENT		PER YOUR REQUEST
	FOR COMMENT		FOR ACTION
	FOR SIGNATURE		FOR APPROVAL/CLEARANCE

RE: BOTSWANA: Family Health Project (Ln. 2413-BT)
PCR

REMARKS:

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

FROM:	ROOM NO.:	EXTENSION:
Graham Donaldson, Chief, OEDD1	T-9045	31730

D. G. O.
'93 MAY 27 AM 9 35

EK
GD

Comments noted
G
5/28

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

DATE: 28-Oct-1992 11:38am

TO: Constance Frye (CONSTANCE FRYE)

FROM: Mulugeta Wodajo, AF6PH (MULUGETA WODAJO)

EXT.: 34842

SUBJECT: BOTSWANA and LESOTHO EDUCATION PROJECTS
Names of Govt Officials for the PCRs

Per your request, here are my suggestions of names of persons to whom the PCRs for the Fourth Education Projects (Ln 2644-BT and Cr. 1512-LSO) should be sent. These are people who were closely involved in one way or another with the implementation of the two projects.

The Country Officers (Mr. Hasan K. Imam for Botswana and Mr. Alun Morris for Lesotho) may have additional names, particularly from the Ministries of Finance in their respective countries.

BOTSWANA:

A. MINISTRY OF FINANCE AND DEVELOPMENT PLANNING (MFDP)
PRIVATE BAG 008
GABORONE, BOTSWANA

-Mr. Leukemia Mothibasela
Secretary for Economic Affairs

-Mr. S. S. G. Tumelo
Director (Development Programs)

-Mrs. Neo Gaetsewe
Senior Planning Officer (Social Sectors)

B. MINISTRY OF EDUCATION
PRIVATE BAG 005
GABORONE, BOTSWANA

-Mr. P. V. Sephuma
Deputy Permanent Secretary

-Mr. Eric Odotei
Principal Planning Officer and
Secretary for the National Commission on Education

-Mr. Fabrick
Mawela
Chief Education Officer (Secondary)

-Mr. P. S. Matila
Senior Planning Officer

C. MINISTRY OF LOCAL GOVERNMENT, LANDS AND HOUSING
PRIVATE BAG 006
GABORONE, BOTSWANA

-Mr. L. L. Mukokomani
Deputy Permanent Secretary

-Mr. S. B. Narang
Sr. Architect (Primary Schools)

D. BOIPELEGO EDUCATION PROJECT UNIT

-Mr. Niels Lindhardt
Director
Boipelego Education Unit
Private Bag 005
Gaborone, Botswana

LESOTHO:

A. MINISTRY OF EDUCATION
P. O. BOX 47
MASERU 100
LESOTHO

-Mr. K. Matete
Principal Secretary

-Mrs. M. Motselebane
Head, Planning Unit

-Mrs. M. Makakole
Planning Officer

-Mr. S. N. Jha
Coordinating Architect

-Mr. A. S. Sivam
Contracts Manager

MINISTRY OF FINANCE AND PLANNING
P. O. BOX 630
MASERU, LESOTHO

-Mr. T. Tuoane
Principal Secretary, Finance

-Mr. T. Makhakhe

Please call + offer
to send floppy disk
to Room J11-095
for Mr. Mulenga
Woodjo. Check
Room J11-~~095~~ 243 is
correct Patricia Samuel

X34842

(Botswana Family Health
Project. PCR) Sent
5/19/93

LL.1

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 Botswana
Family Health Project (Ln. 2413-BT)

of the various ministry agencies' activities

Attached is the Project Completion Report on Botswana - Family Health Project (Loan 2413-BT) prepared by the Africa Regional Office. Part II of the report was prepared by the Borrower.

Underpinning the Government's reorganization of its health care delivery system, the project's major contributions were to (a) strengthen the country's Rural Health Teams and develop 13 rural and urban primary health care centers so as to provide more outpatient care and free in-patient resources, (b) upgrade the country's main hospital facility and (c) help in nearly doubling the incidence of family planning. The Government, however, did not put in place a planned budgeting and accounting system, and civil works were subject to delays and cost overruns. Weak coordination was detrimental to institutional development. Nevertheless, the prospects for sustainability of the strengthened health care delivery system are good and the project is rated satisfactory.

The PCR provides a candid account of project achievements and shortcomings and the project is not a candidate for audit.

which was only partially achieved.

Institutional rating?

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 Botswana
Family Health Project (Ln. 2413-BT)

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Underpinning the Government's reorganization of its health care delivery system, the project's major contributions were to (a) strengthen the country's Rural Health Teams and develop 13 rural and urban primary health care centers so as to provide more outpatient care and free in-patient resources, (b) upgrade the country's main hospital facility and (c) help in nearly doubling the incidence of family planning. The Government, however, did not put in place a planned ~~program~~ budgeting and accounting system, and civil works were subject to delays and cost overruns. Nevertheless, the prospects for sustainability of the strengthened health care delivery system are good and the project is rated satisfactory. Weak coordination was detrimental to institutional development

The PCR provides a candid account of project achievements and shortcomings and the project is not a candidate for audit.

Attachment

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

ROUTING SLIP	DATE: May 21, 1993

NAME	ROOM NO.
MS. LINDA DOVE, OED	T 9011

xx	URGENT		PER YOUR REQUEST
	FOR COMMENT	xxx	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: BOTSWANA: PCR -- FAMILY HEALTH PROJECT (LN. 2413-BT)

REMARKS:

Please find attached: a) A memorandum confirming a copy of the PCR has already been sent (back in February, 1993) to the Norwegian Govt. who co-financed the project; b) copies of pages from the report incorporating the corrections (mostly typos) we discussed.

Please let me know if you have any other questions on the report. Thanks.

FROM: Mulugeta Wodajo Mulugeta Wodajo	ROOM: J11-095	TELEPHONE: (202) 473-4842

THE WORLD BANK/IFC/MIGA

OFFICE MEMORANDUM

DATE: May 21, 1993

TO: Ms. Linda Dove, OED

FROM: Mulugeta Wodajo, AF6PH

EXTENSION: 34842

SUBJECT: BOTSWANA: Family Health Project (Ln. 2413-BOT)
Project Completion Report

The Project Completion Report was written in collaboration with Dr. Anton Skogland a Norwegian consultant who was also a member of the Project Completion Mission. A copy of the Project Completion Report was sent to Ms. Glad of the Norwegian Ministry of Foreign Affairs on February 23, 1993. A copy of this letter is attached for your reference. We have not received any comments from them.

Attachment

APSamuel:aps

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

February 23, 1993

Ms. Ingrid Glad
Ministry of Foreign Affairs
Multilateral Development Cooperation
Victoria Terrace 7
Oslo 0032, Norway

Dear Ms. Glad:

BOTSWANA: Family Health Project - Project Completion Report

Please find attached a Project Completion Report (PCR) for the Family Health Project which was financed by the World Bank, with co-financing on a grant basis by the Government of Norway.

The report was written in collaboration with Dr. Anton Skogland, a public health specialist from Stavanger, Norway. Dr. Skogland has served as consultant for much of the implementation period of the project.

The report has been forwarded to the Operations Evaluation Department of the World Bank for their comments and clearances, before it is forwarded to the Government of Botswana.

As you will note, Part II of the report was contributed by the Government. An earlier draft of the report was sent to them for comments.

Please do not hesitate to let us know should you have any comments. Please direct any comments to Mr. Mulugeta Wodajo of this division.

Sincerely yours,

Steen Jorgensen, Acting Chief
Population and Human Resources Division
Southern Africa Department

cc: Dr. Anton Skogland

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

DATE: 08-Apr-1993 09:36am

TO: Internal Documents Unit (INTERNAL DOCUMENTS UNIT)

FROM: Therese Mackie, OEDD1 (THERESE MACKIE)

EXT.: 31752

SUBJECT: Request for Documents

Grateful your sending the Loan and Credit Agreements for, respectively:
BOTSWANA: Family Health Project (Ln. 2413-BOT)
NEPAL : Primary Education Project (Cr. 1463-NEP)
Rm. T-9011, X-31752
Thanks, Therese

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

DATE: 01-Mar-1993 03:57pm

TO: INTERNAL DOCUMENTS UNIT@A1
TO: CONSTANCE FRYE@A1

FROM: IDMS, (IDMS@TIM@MRGATE@VAX12)

EXT.:

SUBJECT: Request for Documents

From: CONSTANCE FRYE Dept: OEDD1
Room: T 9065
Extn: 31758 for the following documents:

- 4820 SAR
  Family health project - Botswana

- P3782 MOP
  Family health project - Botswana

Diskette attached.

2/23/93

PCR COVER SHEET

Please sign this form upon receipt and return a photo-copy of it to Helen Sioris. Pass the PCR (with this cover sheet) to the Evaluation Officer.

LD 92a

OED ID: L2413 Division: 1
Project Description: Family Health
Country: BOT Country Name: Botswana

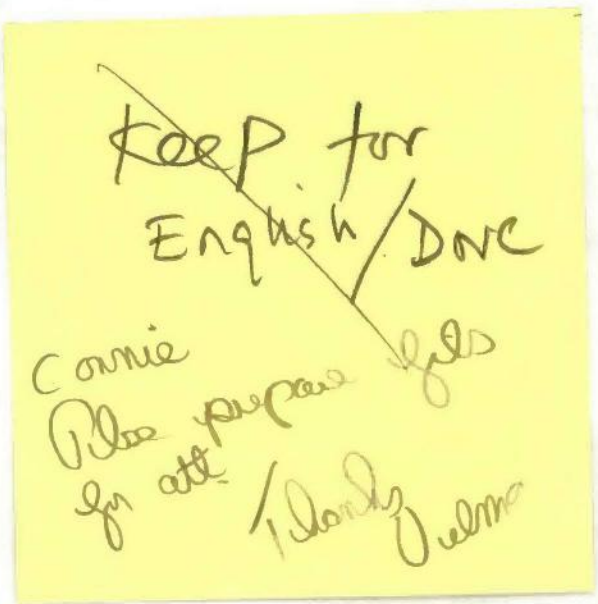
Sector: 04 Sector Name: Human Resource
Subsect: 04.05 Subsector Name: Pop. Health & Nutr.
SAL:

Associated Loans or credits: L2413

Closing Date: 1/31/92 Date PCR Received: 2/23/93

Signed: VN

Date: 2/23/93



THE WORLD BANK/IFC/MIGA

OFFICE MEMORANDUM

Velma - extra cy. H/S.

~~Mr. Kopp~~

DATE: February 22, 1993

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

FEB 25 1993

FROM: Stephen Denning, Director, AF6

EXTENSION: 34035

SUBJECT: BOTSWANA: Family Health Project (Ln. 2413-BOT)
Project Completion Report

1. Please find attached the Project Completion Report for the Family Health Project in Botswana (Ln. 2413-BOT). The Government's contribution appears as Part II of the report.

2. The report has been reviewed in the Department and cleared by the Legal and Loan Departments.

3. Mr. Mulugeta Wodajo, Task Manager, can be contacted at x34842 (Room J11-095) for any needed follow-up.

Attachment

cc: Messrs./Mesdames. Picciotto, [illegible] (4) (DGO); Adams (OPRDR); Birdsall (PRDDR); Amoako (ESP); Verspoor (ESP); Hussain (AFTHR); Grawe (o/r), Jorgensen, Jesus (AF6PH); Patel, Hasan, Bonnel (AF6CO); Kane (LEGAF); Vandenheede (LOAAF); Division Files; Africa Information Center.

Original

New Cover

Document of

The World Bank

FOR OFFICIAL USE ONLY

Report No.

PROJECT COMPLETION REPORT

BOTSWANA

FAMILY HEALTH PROJECT
(Loan 2413-BT)

February 22, 1993

Population and Human Resources Division
Southern Africa Department
Africa Regional Office

FISCAL YEAR

April 1 through March 31

CURRENCY EQUIVALENTS

At time of Appraisal (1982) = US$1 = Pula 1.07
At time of Completion (1992) = US$1 = Pula 1.99

GLOSSARY

AD	Assistant Director
APT	Architectural Planning Team
CHSC	Community Health Services Center
CHSD	Community Health Services Department
CMS	Central Medical Store
CSO	Central Statistics Office
DABS	Department of Architectural and Building Services
DEMS	Department of Mechanical and Electrical Services
DHT	District Health Team
GOB	Government of Botswana
GON	Government of Norway
IUAT	International Union Against Tuberculosis
IEC	Information, Education and Communication
MCH/FP	Maternal and Child Health and Family Planning
MLGL	Ministry of Local Government and Lands
NHL	National Health Laboratory
MOH	Ministry of Health
NDP	National Development Plan
PH	Primary Hospital
PHC	Primary Health Care
PIU	Project Implementation Unit
PMH	Princess Marina Hospital
PPF	Project Preparation Facility
RHT	Rural Health Team

PROJECT COMPLETION REPORT

BOTSWANA

FAMILY HEALTH PROJECT
(LOAN 2413-BOT)

MAY 21, 1993

Population and Human Resources Division
Southern Africa Department
Africa Regional Office

FISCAL YEAR

April 1 through March 31

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GON	Government of Norway
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MLGL	Ministry of Local Government and Lands
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MOH	Ministry of Health
NDP	National Development Plan
PH	Primary Hospital
PHC	Primary Health Care
PIU	Project Implementation Unit
PMH	Princess Marina Hospital
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RHT	Rural Health Team

PROJECT COMPLETION REPORT

BOTSWANA

FAMILY HEALTH PROJECT
(Loan 2413-BT)

TABLE OF CONTENTS

LIST OF ANNEXES

PROJECT COMPLETION REPORT

BOTSWANA

FAMILY HEALTH PROJECT
(Loan 2413-BT)

PREFACE

This is the Project Completion Report (PCR) for the Family Health Project in Botswana, for which Loan 2413-BT in the amount of US$ 11.00 million was approved on May 15, 1984. The Government of Norway provided a Grant amounting to US$ 7.2 million equivalent to finance portions of the project. The Loan and the Norwegian Grant were fully disbursed. The last disbursement was on July 22, 1992.

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

The PCR is based, inter alia,on the Staff Appraisal Report; the Loan Agreement; the Grant Agreement between the Governments of Norway and the Borrower; supervision reports; correspondence between the Bank and the Borrower; Progress Reports by the Borrower; and interviews with Bank staff and Botswana officials who were closely associated with the Project.

PROJECT COMPLETION REPORT

BOTSWANA

FAMILY HEALTH PROJECT
(Loan 2413-BT)

EVALUATION SUMMARY

Project Objectives and Content

i) The main objectives of the project were: (a) to improve the effectiveness and efficiency of Botswana's health care delivery system, and (b) to strengthen nationwide availability of family planning services. Specifically, the project aimed at assisting the Government to attain these objectives by reorganizing and strengthening the central organization of the Ministry of Health (MOH), progressively building up each level of the health care delivery system, strengthening family planning activities in the Maternal and Child Health (MCH) program, introducing family planning activities in women's programs, reducing the unit cost of health care , and improving the efficiency of the pharmaceutical supply system.

Implementation Experience

ii) Overall project performance was satisfactory. On the physical side, with the notable exception of the Princess Marina Hospital (PMH), all the rural and urban health centers, as well as well as the Community Health Sciences Center (CHSC) were completed as planned. The project was also quite successful with respect to institutional and program strengthening, as detailed below (Paras. 13-24).

iii) The major variances between planned and actual implementation were as follows: a) The project's Closing Date was extended by three years to allow completion of project components (excepting PMH); b) PMH upgrading remains unfinished and it is estimated that the Hospital will be completed and fully operational in 1994, about six years behind the original schedule, iii) Expansion of the Central Medical Stores (CMS) in Gaborone and a new pharmaceutical store in Maun were deleted from the project in favor of a new storage facility financed by the Government; and finally iv) the Government decided not to introduce cost recovery schemes in the health sector, as part of its overall policy to provide free (or almost free) primary health services to the population, particularly in rural areas.

iv) Some of these variances, especially the delay at PMH, were caused by factors that were essentially beyond the control of the project. Some of those factors included: a one-year freeze in hiring expatriate technical assistance staff and consultants on account of financial constraints caused by the 1985 draught in the country; delays in recruiting the team leader for the Architectural Planning Team (APT), and subsequently turn-overs of other architects; a significant increase (by about 40%) in the new area to be constructed; major design changes that rendered the construction of the new and remodelled facilities far more technologically complex and sophisticated than originally

envisaged. On account of these and other related factors, when the hospital is finally completed in 1994, the resulting cost overrun is estimated at about 250% over appraisal estimates (Paras. 10-12, 21-22).

Results

v) One of the main aims of the project was to improve the effectiveness and efficiency of the country's health delivery system. On the whole this objective was achieved as evidenced by the following results: (a) MOH was successfully reorganized along functional lines following studies undertaken by the Government as well as though the project (Para. 13); (b) Rural Health Teams (RHTs) were transferred from MOH to the Ministry of Local Government and Lands (MLGL) as the latter had overall responsibility for coordinating and administering social services (including health and education) at the district level; (c) the National Health Laboratory and the Community Health Services Division, which hitherto were weak and housed in scattered facilities were provided with permanent facilities in adjacent buildings, thereby contributing to better coordination and collaboration between community health practitioners and laboratory staff (Para. 14); (d) rural and urban primary health services were strengthened and expanded through the provision of nine (9) urban-periurban and four (4) rural primary health centers (renamed primary hospitals in 1990) (Paras. 16, 21-22). The re-naming of the health center as primary hospitals is in itself a clear indication that the centers have been upgraded beyond their traditional service of providing primary (outpatient) care to provide some of the medically more involved functions, usually reserved for larger health institutions. The project has been far less successful with respect to the upgrading of PMH, the country's main hospital. For a variety of reasons discussed in some detail in this report (Paras. 11, 21-22), the hospital is yet to be completed. The Government has the resources and the commitment to finance the remaining civil works and to procure the necessary equipment. One of the positive results of the project in relation to PMH is that the pressure on its outpatient department has been greatly reduced as much of the burden for outpatient treatment has now been directed to the project-assisted urban health clinics. (Para.20).

vi) The second main objective of the project was to strengthen nationwide availability of family planning services. This objective too has on the whole been attained. For instance: family planning themes have been integrated in health education programs nationwide; primary and secondary school curricula now contain pertinent information on family planning; likewise curricula for basic training of health personnel at all levels have been revised to incorporate appropriate lessons on family planning; and significantly; more than 90% of primary health centers (Primary Hospitals) now offer family planning services on a regular, daily basis. The proportion of women who use modern family planning methods has increased from 16% at appraisal to nearly 30% in 1988, and there are indications that the ratio has increased even more since 1988 (when the last comprehensive survey on this subject was undertaken). Contraceptive prevalence rate has increased from 24% in 1981 to 30% in 1988. The fertility rate has likewise declined from 7.1 in 1981 to 5.0 in 1988. Clearly, not all these benefits are attributable to the Project. But it is equally true that the project has made a significant contribution toward attaining these benefits. (Para. 17).

Sustainability

vii) The benefits derived from the project are likely to be sustained for the foreseeable future as an integral part of MOH's programs. There exists a clear Government policy and commitment for primary health care, a sine qua non for project sustainability, as pointed out in OED's 1990

report on the sustainability of investment projects in education (and equally applicable to health projects). Under NDP VII (1992-1997), GOB has increased the allocation for recurrent budget by about 9% per year, in real terms, over allocations made under NDP VI. Maintenance of facilities and equipment in the health sector (as in other sectors, such as education) has been a matter of serious concern to GOB over the years. The Government has now (1992) decided to contract out (through tender) maintenance services of most health facilities and equipment, including those at PMH, to a reputable private firm. This too augurs well for the sustainability of the project-assisted facilities and equipment. (Para. 25).

Findings and Lessons Learned

viii) With the notable exception of PMH, all project components were fully implemented. All the nine urban/peri-urban and four rural primary health facilities have been established and are fully operational. Lessons derived from the implementation of this project include:

a) The project brings to the fore once again the on-going discussion in the Bank regarding the extent to which project implementation arrangements should be organizationally and functionally integrated with the responsible Government Ministry or agency. In this project, instead of a separate project implementation unit (PIU), a project coordinating committee consisting of the relevant heads of MOH departments was assigned responsibility for project management. While this is consistent with the Bank's present efforts to enhance the Borrower's sense of "ownership", the experience in the implementation of this project demonstrates that unless the government officials (such as head of departments) take a proactive role in project management, the mere establishment of a "coordinating committee" is not sufficient to create a sense of "ownership", and the full integration of project activities with the regular functions of the Borrower's agency. (Paras. 7-8, 28).

b) The experience with the PMH upgrading/expansion indicates that it is exceedingly difficult, and often more expensive, to undertake a major upgrading, especially when the existing facility is expected to operate while the upgrading is in progress. A detailed cost analysis should first be undertaken to determine the cost-effectiveness of such major upgrading operations vis-a-vis establishing a new hospital, on a different site. (Para. 25).

c) Further, the experience with the PMH upgrading indicates that it is critically important to define in detail the exact nature and scope of the upgrading/modification before actual construction/modification begins. Failure to do that would almost inevitably result in constant changes and additions to the original plan. (Para. 22).

d) Finally, the project reinforces the importance of retaining the responsibility (and the requisite financial resources) for building and equipment maintenance as close as possible to the users. In this particular case, those responsibilities were centralized in two Government agencies, DABS (for building maintenance) and DEMS (for buildings and equipment servicing). As the agencies are far over-stretched and understaffed to cater to the needs of all government agencies. As a result, essential repairs of buildings and equipment are not attended to promptly. (Para. 16, 28).

PROJECT COMPLETION REPORT

BOTSWANA

FAMILY HEALTH PROJECT
(Loan 2413-BT)

PART I. PROJECT REVIEW FROM BANK'S PERSPECTIVE

A. Project Identity

Project Name:	Family Health Project
Loan No.:	2413-BT
RVP Unit:	Africa Regional Office
Country:	Botswana
Sector:	Population and Health

B. Project Background

1) Sector Development Objectives. At the time the project was appraised Botswana's health services were already well established on sound policies and conscious efforts were being made to provide resources to rural areas. Although the Government had not at the time developed a comprehensive population policy, there was a clear awareness among senior officials of the socio-economic problems caused by a rapidly growing population. Incidence of common tropical diseases such as malaria, schistosomiasis was low on account of the dry climate which inhibits the vectors. The leading cause of morbidity was (and continues to be) respiratory illnesses, including tuberculosis. Among children, malnutrition was perhaps the leading cause of morbidity and infant mortality. The Government's objectives in the areas of health and population have been to strengthen and expand basic health services, while at the same controlling communicable diseases.

2) Policy Context. At independence, Botswana inherited a largely curative, hospital-based health care delivery system. Since then, the thrust of the Government's policy direction has been to re-orient the system to a primary health care system accessible to the entire rural population. This shift in policy began in earnest with the National Health Plan for the period 1968-1973. This emphasis on primary health care as the cornerstone for the health delivery system was reaffirmed in successive National Development Plans (NDPs), particularly NDP IV (1976-1981) and NDP V (1982-87). The health care support system included health education, MCH/FP, control of communicable diseases (in particular tuberculosis and sexually transmitted diseases), nutrition, the prevention and treatment of blindness, environmental sanitation, occupational health and programs for the handicapped. The Government continues to make substantial efforts to ensure that health facilities are well distributed throughout the country.

3) Sector knowledge and background for the project was derived in the main from the findings of a population, health and nutrition sector review missions which visited Botswana in 1981. While the mission concluded that on the whole the health status and overall government policy and strategy were good, there were certain major gaps and deficiencies that need to be addressed. These included weaknesses in the organization and management of the Ministry of Health; over

centralization of health services; strengthening the effectiveness and efficiency of health programs; and revitalizing family planning services. The Government accepted the main conclusions of the Bank's sector study as a basis for requesting external assistance from donor agencies including the Bank itself.

C. Project Objectives and Description

4) Project Objectives. The main objectives of the project were: (a) to improve the effectiveness and efficiency of Botswana's health care delivery system, and (b) to strengthen nationwide availability of family planning services. More specifically, it was aimed at assisting the Government in reaching these objectives over a five-year period by building up the central organization of the Ministry of Health (MOH), progressively building up each level of the health care delivery system, strengthening family planning activities in the MCH program, introducing family planning activities in women's programs, reducing the unit cost of health care within the referral system, and increasing the efficiency of the pharmaceutical supply system

5) Project Components. The project included four main components:

(a) Reorganization of the Health Care Delivery System. Through the provision of technical assistance, consultancies, in-country and overseas training, construction of new or upgrading existing facilities, as appropriate:

(i) strengthening management and planning capacity, (ii) introducing cost recovery and strengthening financial management, (iii) establishing a Community Health Sciences Center for the collection and analysis of epidemiological data, (iv) strengthening rural health services, and (v) establishing a Central Medical Store;

(b) Population, Maternal and Child Health and Family Planning. Through the provision of technical assistance consultancies local and overseas training, equipment, the procurement and distribution of contraceptive commodities as well as the expansion and upgrading the existing Health Education (HEU):

(i) Integrating family planning themes into existing health education programs and supporting other programs and activities pertaining to family planning, and (ii) establishing a demographic unit within the Central Statistics Office;

(c) Urban Health and Family Planning Services. Through support for extension and upgrading of physical facilities and procurement of equipment:

(i) upgrading and expanding the Princess Marina Hospital (PMH), and (ii) Upgrading and strengthening nine urban health clinics in Gaborone; and

(d) Manpower Development. Through provision of technical assistance, training health manpower required for implementing MOH's reorganization of the health care delivery system and the expansion of population/MCH/FP activities.

D. Project Design and Organization

6) The Family Health Project derived its conceptual foundation from the findings of a Bank health sector review mission in February 1981 and its recommendations were accepted by the Government in May 1982. The project was appraised in June 1983 and negotiated in February 1984. Because of its long-standing assistance for rural health services, the participation of the Government of Norway (GON) was sought to finance portions of the project on a grant basis. The GON agreed to provide a grant of US 7.2 million equivalent to finance portions of the project.

7) According to the original design of the project, overall responsibility for project implementation was to rest with the Permanent Secretary of MOH, with each component being managed by the Head of the relevant department in MOH. Thus, the Assistant Director (AD) of Primary Health Care was to be responsible for implementation of CHSC, IEC/MCH and FP activities as well as for strengthening urban and rural health facilities. Similarly, the AD of Hospital Services was to be responsible for the upgrading of PMH with technical support by the Chief Architect and a PMH Architectural Planning Team. The same applied for the other components of the project. A Project Coordinator, appointed in May 1984, was to assist the PS and component managers with project implementation. A Project Coordinating Committee, chaired by the PS, consisting of MOH department heads and other relevant Ministries, was expected to meet quarterly to review progress of implementation.

8) On the whole, the project was managed along these lines. However, in retrospect, a more proactive role of component managers and more frequent meetings on a systematic and sustained basis, would have further enhanced the effectiveness and efficiency of the project, thereby establishing an even better basis for a continued integration of project-related activities after the end of the project.

9) Apart from the PMH upgrading and extension of the Closing Date, most project components have been successfully completed, although with some delays. The PMH is now scheduled to be completed by December 1994, close to three years after the Project Closing Date and six years after the original schedule. Some of the underlying factors behind this considerable delay and related gross cost overruns are detailed below.

E. Project Implementation

10) The major variances between planned and actual project implementation were:

a) extension of the Project Closing Date by three years to allow completion of project components (excepting PMH);

b) delayed planning and construction of PMH, now estimated to be completed about six years after the original schedule and related cost overruns; and

c) the deletion of CMS upgrading/addition and a new pharmaceutical store in Maun from the project, in favor of a new storage facility in Gaborone financed by the Government; and

d) the decision not to implement a cost recovery scheme.

There were one or two other relatively minor elements that were not carried out. The first was concerning project evaluation. During appraisal, MOH had agreed to undertake annual evaluation of the project.

But, when it became clear that it will not be possible to carry out annual evaluations on account of shortage of local expertise in project evaluation, in 1987 a Bank supervision mission agreed with the authorities that the Bank will be satisfied with the government's semi-annual progress reports and its own supervision mission reports for monitoring implementation progress. Secondly, the SAR plan to introduce program budgeting and to revise MOH's accounting system was not carried out, largely because MOH lacked the authority to do so on its own as the health sector was under two separate ministries (MOH and MLGL), and also because there was no overall decision from the Ministry of Finance to adopt a new budgeting and accounting system nationwide.

11) The delays in the civil works were beyond the control of the project. The factors that contributed to these delays included: (i) a one year freeze in the hiring of expatriate consultants/technical assistants on account of financial constraints due to the 1985 drought in the country, (ii) in the case of PMH, late recruitment of the team leader for the Architectural Planning Team (APT) which caused an initial delay at PMH of about two years, and (iii) recurring vacancies in APT (eg. when one of the architects died in a traffic accident). The cost recovery scheme was not introduced because of policy changes by the Government not to introduce increase user charges in the social sectors, including primary education and primary health care. Instead, the Government decided to freeze health care (and school) fees at the very modest level which were in effect at the time.

12) Overall the project was a success. As discussed in greater detail below, the project was particularly successful in re-organizing MOH, in strengthening family planning services and in expanding and upgrading primary health care services in rural and urban areas. There was close communication and collaboration between Bank and Government as these variances occurred. During implementation, as and when it become clear that some elements could not be carried out as planned, relevant changes were made in full consultation with the Government.

F. Project Results

13) Reorganization of MOH. One of the main aims of the project was to improve the effectiveness and efficiency of the health care delivery system. With the help of an advance from the Project Preparation Facility (PPF), the organization of the MOH was studied and the roles and functions of the District Health Teams (DHTs) were reviewed. A proposal was made to reorganize the MOH along functional lines (MOH's reorganization along functional lines was introduced as early as 1985). The transfer of the Rural Health Teams (RHTs) from MOH to Ministry of Local Government and Lands (MLGL) took more time and was implemented from 1989. The study of health financing mechanisms and a cost recovery scheme was completed (financed from PPF), but as noted above, GOB decided not to implement the proposals, as part of the Government's overall policy to provide free social services, especially primary education and primary health care. Thus patient fees still remain at the same nominal level as at appraisal. The health planner consultancy was successfully completed, leading to improved planning at the district level. The planned changes towards program planning and budgeting were not realized. Likewise a management information system was not developed.

14) Strengthening Community Health Science. The Community Health Sciences Center (CHSC) in Gaborone was completed as planned. The Community Health Services Division (CHSD) (with Epidemiology and Disease Control Unit, AIDs program, Environmental Health and Occupational Health Units) are housed in one block, while the National Health Laboratory (NHL) is housed in an adjacent building, both funded by the project. Until the laboratory facilities at PMH are operational the NHL will continue to serve PMH. The Center has contributed to better coordination

and cooperation within the field of public health. Staffing has been improved since the start of the project both in the Community Health and in the Laboratory area. Regrettably, however, it seems that the buildings (completed in 1988) have some major construction and design defects which have caused major leakages and floodings. MOH has reported the damages to the relevant agencies and the defects are expected to be remedied forthwith.

15) The tuberculosis treatment regimen was revised early on in the project, with assistance from the International Union Against Tuberculosis (IAUT). The National Tuberculosis Program Manual was subsequently revised (1985) with stronger emphasis on domiciliary treatment. Although a systematic evaluation of the new treatment regimen has not yet been undertaken, some of the benefits are already clear. For instance, TB-patients now generally remain hospitalized for about 60 days, while the average inpatient stay was 90 days at appraisal. Combined with a less expensive treatment regimen, this has brought about cost savings, even though the magnitude of the savings has to be assessed more closely.

16) Expansion and Upgrading of Rural Primary Health Services. The upgrading and additions to four existing Health Centers (from 1990 called Primary Hospitals (PH)) at Lethlakane, Mmadinare, Bobonong and Thamaga was completed on time. All PHs have been fully operational since 1988 and are well utilized. However, some of the new equipment (e.g. new boilers, x-ray equipment) that were delivered two or more years ago have yet to be installed and put to use. Installation of equipment and maintenance of buildings and equipment for all government Ministries and agencies are centralized in Botswana under two departments, the Department of Architectural and Building Services (or DABS), and the Department of Mechanical and Electrical Services (DEMS). Because those departments are overstretched in terms of technical staff to cope with the high demand for their services, it is not unusual to see long delays in installing equipment or repairing damaged buildings. Thus, one of the important lessons that emerges from implementation of this project is the vital importance of retaining the responsibility (along with the requisite funds) for equipment and building maintenance as close to the user agency as possible. At Thamaga PH there have been problems with the sewerage system ever since the opening of the facility in 1988. Although, the need to remedy the defects has been underscored by several supervision missions, the situation has yet to be remedied, underscoring once again the delays and inefficiencies inherent in a highly centralized system of building and equipment maintenance.

17) Strengthening Family Planning Services. The second main objective of the project was to strengthen nationwide ability of family planning services, by increasing the use of contraceptive commodities thereby reducing Botswana's high fertility rate. There have been a wide range of activities under the project to achieve this objective both under the population/MCH/FP/IEC and under the manpower development component. Most important of these have been: (i) the integration of family planning themes in health education programs has been intensified and improved, (ii) the integration of family health in primary and secondary school curricula, (iii) revision of curricula for basic training for health personnel, and (iv) the introduction of a comprehensive and integrated approach at primary health care facilities that offer family planning services on a regular, daily basis. Cumulatively, these activities have been very successful. As of October 1992 more than 90% of primary health facilities offer integrated services. It is also encouraging that from 1984 to 1988 the proportion of women who know of modern methods of family planning has increased from 74 to 95 %. The proportion of actual users of family planning devices has increased from 16 to 29.7 %, and the proportion of women who have used at one time or another modern family planning methods has likewise increased from 34 to 54% All methods included, the current

contraceptive prevalence rate has increased from 24 to 30 % from 1984 to 1988. Total fertility has declined 30 % in less than 10 years, from 7.1 in 1981 to 6.5 in 1984 to 5.0 in 1988. Clearly, not all these benefits can be attributable to the Project. But it is equally true that the project has made an important contribution toward attaining these benefits.

18) The establishment of a Demographic Unit, including necessary equipment, in the Central Statistics Office (CSO) was taken out of the project, but the Unit was established with funding from UNFPA.

19) In the area of urban health and family planning services, the project had two main components: (i) upgrading/extensions of urban/periurban clinics in Gaborone, and (ii) renovations/additions to the PMH.

20) Strengthening Urban Health Centers. The Gaborone Health Needs Study was completed in time to provide a valuable in-put for planning the strengthening and upgrading of both the urban primary health services as well as the upgrading of PMH. On the whole, the improvement of primary health care services in Gaborone under the project has been a significant success. Altogether eight existing clinics were upgraded and expanded, and one new clinic with a maternity ward was established. As the existing facilities remained in operation whilst the expansion and upgrading was in progress, it was decided to undertake the remodelling and expansion in three phases as shown in Section III, Table 4. Apart from the maternity ward at the recently (December, 1991) completed Old Naledi clinic that has not operated due to shortage of midwives, all facilities are operational. One of the Centers, Extension 2 Clinic, is in fact operating on a 24 hour basis. The staffing of the clinics has generally improved. Presently 5 doctors work in these clinics while there none were assigned before start of the upgrading. The expansion and upgrading of these urban health centers, has had an important impact on the pattern of primary and outpatient care in the Gaborone area as a whole. For instance, during the period 1982-1991 total attendance at the clinics has increased by about 260 % (from 234 000 to 620 000), thereby relieving the pressure for outpatient care at PMH. Outpatient attendance at PMH has decreased by about 80 % (from 3-400 to 80 a day), over roughly the same period. All outpatients at PMH (apart from A&E cases) are now referral cases.

21) Princess Marina Hospital (PMH). This is the only component that has not been completed as yet. At the time of the Completion Mission, it was estimated that upgrading of the Hospital was about 40-50% completed. The Hospital is expected to be completed and fully operational by December, 1994. The Government is fully committed and has the necessary resources to complete the civil works, to procure the necessary equipment, and to provide the full compliment of medical and paramedical staff from its own resources. The financial implications for these undertakings are fully reflected in the country's Development Plan.

22) Some of the factors that explain this delay were discussed in Para. 11. Additional factors included: (a) the scope of the upgrading was increased considerably. The total area for new buildings increased by almost 40%, from about 14,000 square meters planned at appraisal to close to 20,000 square meters in the present construction plan; (b) the total number of beds was likewise increased by about 8% from 440 to about 480 beds; (c) the nature of upgrading too has increased not only in terms of scope (as indicated above), but also in terms of its complexity. Both the civil works, and especially the equipment have now acquired a far more high technology character than originally envisaged. The situation was further exacerbated by the absence of an architect with sufficient experience in large hospital projects. This was particularly crucial in the case of PMH where new

construction and extensive remodelling were taking place while the hospital was still operating. Of the new facilities only the pediatric ward was completed on time (1986). These and other factors together have caused considerable cost overruns. The most recent estimate indicate a total cost for civil works at P 76 million (excluding equipment and furniture), or an estimated total of about P 111 million, including equipment and furniture. This represents a cost overrun of about 250% over appraisal estimates.

23) Manpower Development. Under the Manpower Development component both the training program and the health manpower planning consultancy have been successful. A National Health Manpower Plan was completed in 1989 and had significant impact on health manpower and training projections in NDP VII and on the National Health Institute (NH) Requirement Study that was funded outside the project.

24) Implementation of the training program was successful. As can be seen from Annex 4, appraisal targets for both in-country and overseas training were exceeded, by about 50% on average. However, the original project idea of integrating project-funded training with a national training scheme so that manpower development could continue even when project funds are exhausted has not materialized to the extent originally envisaged. This is a matter of concern in that when project funds have been exhausted the Government has not yet provided funds for the continuation of training along similar lines. In this respect, the project reinforces a lesson learned from other Bank-funded operations which underscore the crucial importance of gradually phasing-in Government contributions to such activities as training so those vital programs would continue even when the project terminates.

G. Project Sustainability

25) Botswana is likely to derive long-term benefits in the health and social sectors from the project as a result of the improved Population/MCH and FP related services and programs. Especially, due to inter alia the introduction of integrated services at primary health care facilities and improved health education programs, the project is likely to have further impact on fertility decline. In principle the GOB has sufficient resources of its own not only to sustain, but to expand and strengthen the activities initiated under this project. Under NDP VII (91-2/96-7), GOB has increased the allocation for recurrent budget of MOH by about 9% per year, in real terms, over the allocations made under NDP VI. This is among the highest yearly increases approved for any Ministry, which in itself is a clear testimony to the importance and priority the Government continues to attach to health, and indeed to the social sectors as a whole. Further, the Government has recently decided to contract out (through tendering) maintenance services of most health facilities and equipment, including PMH, to a reputable private firm. Again, this augurs well for the project-funded health facilities and equipment.

26) All the rural and urban primary health facilities that have been built under the project are operational, well staffed and well utilized and as indicated in the preceding paragraph there is every reason to expect that the Government will be able to maintain these services at this level. While the expansion of PMH has been more prolonged and much more costly than expected at appraisal, the Government is firmly committed to complete the hospital and maintain its operation, including the necessary training of local and recruitment of expatriate specialist staff. This is bound to have an impact on the overall resources allocated to the health sector, but in the present financial situation for Botswana this is unlikely to present a major constraint.

H. Bank Performance

27) As noted in the Government's contribution to this report (Part II), Bank staff contributed positively to the successful completion of the project through supportive relationship and professional advice. Ten supervision missions were fielded during the life of the project. This proved to be quite adequate, as the project was on the whole problem-free, with the single exception of the PMH. While the frequency and even the composition of Bank supervision missions (mostly, public health specialists, economists, and architects) were adequate, there was frequent turn-over of Bank staff who were responsible for supervision. Indeed, a consultant public health specialist was virtually the only staff from the Bank side who participated in most (80%) of the missions (Section III, Table 12). In retrospect, another area where the Bank could have been more helpful to the Borrower was in assisting the Borrower to clearly conceptualize and define the exact nature and scope of the PMH upgrading. In the absence of a more proactive role on the part of the Bank (and possibly MOH), the PMH upgrading component was left almost entirely to the architects (APT) and the users, who inevitably kept making constant changes and additions to the facilities to be upgraded or built anew. In the end, what started as a modest upgrading project became a large and complex hospital construction operation.

28) Lessons Learned. For future projects the following lessons learned from implementation of the Family Health Project may be of value:

a) The project brings to the fore once again the much discussed question of project implementation arrangements. As in a number of other Bank-assisted projects, implementation of this project was assigned to a "Coordinating Committee" (instead of a separate "project implementation unit (PIU)" consisting of high level MOH department heads (Para. 7). In principle, this is appropriate as it would help facilitate integration of project activities with regular MOH programs, thereby ensuring MOH's "ownership" of the project. But as in so many other cases, the department heads (with some notable exceptions) who were designated component managers did not always take a sufficiently proactive role in project management, largely because of the heavy responsibilities they already have in their regular MOH responsibilities. In such cases, it is only inevitable that a good deal of implementation matters would be left to the Project Coordinator to wrestle with. In this particular case, largely because the Project Coordinator was a well qualified health planner, she was able to "manage" the project reasonably well, in consultation with her MOH colleagues. The lesson to be derived from implementation of this project, is that unless the government officials (such as heads of departments) who were assigned to implement a project component pertaining to their department take a proactive role in project management, the mere establishment of a project coordinating committee (in lieu of a separate project implementation unit) is not sufficient to create a sense of "ownership" and the full integration of project activities with the regular functions of the Borrower's agency.

b) The experience with the PMH upgrading/expansion indicates that it is exceedingly difficult, and even more costly, to undertake a major hospital upgrading. This is especially the so (as was the case with PMH) when the large and complex upgrading was expected to take place while the hospital was in full operation. In retrospect, it would almost certainly

have been less expensive, and certainly less cumbersome, to build a hospital on an entirely new site.

c) Further, the experience with PMH indicates that it is critically important to define in detail the exact nature and scope of the upgrading/modification, before actual construction/modification begins (para. 21-22). In this particular case, in the absence of a more proactive role on the part of the Borrower and the Bank in monitoring closely the magnitude and rationale of the upgrading to ensure that these are kept as close as possible to what was envisaged at appraisal, the PMH component was virtually left to the architects (APT) and the users, who inevitably kept making changes and modifications. In the end, what was started as a modest upgrading scheme became a large and quite complex hospital construction (Para. 27).

d) Finally, the project reinforces the importance of retaining the responsibility for maintenance of buildings and equipment (together with the requisite budget) as close as possible to the users (institutions). In Botswana, these services are centralized in two Government agencies, the Department of Buildings and Architectural Services (DABS) and the Department of Mechanical and Electrical Services (DEMS). These agencies are so over-stretched and understaffed that they are unable to provide timely responses to buildings and equipment, even to critical facilities such as hospitals and clinics (Para 16).

I. Borrower Performance

29) All major covenants were complied with (Part III, Table 10), although delays were encountered in fulfilling some of them (eg. preparation and submission of audit reports). In retrospect better coordination (and more frequent meeting) of the Project Coordinating Committee (Para. 7) would probably enhanced the full integration of project elements with MOH's regular activities. MOH officials were uniformly helpful to Bank supervision missions and open to suggestions and recommendations.

J. Consulting Services

30) As can be seen from Annex 5 most of the consultancies that were planned at appraisal were utilized. On the whole the Government was satisfied with the result of most of the consultants. At PMH, four consultants (known as the "Commissioning Team") have been retained to "commission" the various facilities and equipment as and when they are completed. However, the services of the PMH Commissioning Team can not be assessed pending the completion of the PMH component.

Part II. PROJECT REVIEW FROM BORROWER'S PERSPECTIVE

Evaluation of Bank's Performance and Lessons Learned

31. The Bank personnel were recognized as professional in all supervision visits. Apart from the Public Health specialist, there has been a rapid turn-over on the Bank's side during the life of the project. Sometimes it took sometime for the new staff members to be familiar with the project and there were occasions when the Implementation Unit was required to retransmit information to the Bank which was submitted to previous staff members. On the whole the relationship between the Implementation Unit and various Bank staff was excellent. Every staff member has been supportive and provided the needed guidance in the implementation of the project in accordance with the Bank's regulations.

Major Lessons Learned

32. The overall communication between the Bank and the Borrower regarding accounting of commitments and drawdown of the loan/grant proceeds should be well documented and information from the Bank to the Borrower regarding same would not be contradictory. When the Bank's personnel change, there should be thorough handover for continuity purposes.

Evaluation of Borrower's Own Performance and Lessons Learned

33. The planning and implementation of the training component of the project was quite good. There were a few savings in the project which enabled to train above 100% [of appraisal targets] in the several training areas.

34. The planning and implementation of civil works component experienced major problems in certain areas ranging from design faults to lack of experience in building health facilities on the part of contractors. Government of Botswana is likely to spend a lot of money rectifying the problems in the future.1/

35 Equipment schedules and specifications were not properly done. This had negative effects on the implementation of the project. The problems led to over ordering of equipment in some areas and to delays in utilizing new departments while rewiring to accommodate equipment.

Major Lessons Learned:

36. (a) That planning of civil works project should be adequately done with implications adequately analyzed.

(b) It is much more complex and costly to do a major upgrading of an ongoing hospital. It would be much easier and less costly to select new fields and build new hospitals than to upgrade [an existing hospital].

(c) Design work for hospitals should be done by experienced hospital architects and construction should be done by experienced contractors. It is not cost effective to promote local business by engaging local contractors at the

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1/Note: Contractorss were selected following Bank guidelines. Contractors for the urban and rural primary health centers were selected on the basis of LCB as the contracts were too small to attract overseas competitors. The contractor for PMH was selected on the basis of ICB, but architectural services were provided by a government agency (DABS).

expense of well constructed health facilities which are likely to last a long time.

(d) Future projects which require a large sophisticated manpower should include a training component for such manpower rather than rely on the overall Ministry's training allocation which has its own limits.

PART III. STATISTICAL INFORMATION

A. Related Bank Loans

37. This was the first (and so far the only) Bank Loan in the Health Sector financed by the Bank. However, the Bank has financed in related social sectors, such as in education, four projects, all which are completed. A Completion Report for the Fourth Education project was issued in September 1992 (Report No. 11164).

B. Project Timetable

Table 2: PLANNED AND ACTUAL DATES OF PROJECT TIME TABLE

ITEM	PLANNED DATE	REVISED DATE	ACTUAL DATE
Identification	5/23--6/2/82	5/23--6/2/82	5/23--6/2/82
Preparation	11/7--27/82	11/7--27/82	11/7--27/82
Appraisal	6/20--7/8/82	6/20--7/8/82	6/20--7/8/82
Negotiations	2/6--10/84	2/6--10/84	2/6--10/84
Board Approval	5/15/84	5/15/84	5/15/84
Credit Effective	5/21/85	5/21/85	5/21/85
Project Completion	7/31/88	7/31/88	7/31/88
Closing Date	1/31/89	1/31/90	1/31/91

Comments on Timetable:

Para. 38. Project identification and project preparation were held in conjunction with an on-going health sector study. The project was implemented over a seven-year period (after approval by the Bank's Board of Executive Directors. It was extended twice for a total of two years, partly because of delays in preparing withdrawal applications with the necessary documentation. When the project was closed, one of the components (upgrading of the Princess Marina Hospital) was still under construction and would probably take two more years to complete. The Government is fully committed to complete the construction and to provide the necessary equipment and staff.

C. LOAN DISBURSEMENTS

Table 3: CUMULATIVE AND ACTUAL DISBURSEMENTS
(US $ Million)

Bank FY	'84	'85	'86	'87	'88	'89	'90	'91	'92	'93
Appra. Estim.	0.22	0.88	2.86	5.94	9.52	11.0	--	--	--	--
Actual	--	0.04	0.06	0.37	1.43	2.58	5.61	7.98	10.9	11.0
Actual as % of the Loan	--	0.01	0.01	3	13	23	51	73	99	100
Date of Final Disbursement: July 22, 1992										

Para. 39. Comments on Loan Disbursement. Disbursement started very slowly. There was virtually no disbursement for the first two fiscal years. And only about half of the loan was disbursed during the first six years. This meant that about half of the entire loan was reimbursed during the last two years while the Government was paying for its commitments upfront for on-going work from its resources. As in other projects, the Government utilized the intervening years to collect the documentation required to support the reimbursement applications sent to the Bank. In the end, the entire loan was disbursed, albeit three years behind schedule.

D. Project Implementation

Table 4: PLANNED AND ACTUAL COMPLETION DATES OF CIVIL WORKS COMPONENTS

Component	Planned Completion	Actual Completion	Months of Delay
1. Princess Marina Hospital	1988	1994 (Est.)	72
2. Health Education Unit	1986	1986	0
3. Community Health Sci. Center			
-Community Health	1988	1988	0
-Laboratory Work	1988	1988	0
4. Rural Health Centers			
-Thamaga	1988	1988	0
-Bobonong	1988	1988	0
-Nmadinare	1988	1988	0
-Letlehakane	1988	1988	0

5. Urban Health Clinics			
-Broadhurst II	12/86	12/87	12
-Village	12/86	12/87	12
-Tsholofelo	12/86	04/88	16
-Extension 14	12/86	04/88	16
-Extension 2	12/86	04/88	16
-Broadhurst	12/86	04/89	28
-Bontleng	12/86	12/90	48
-Broadhurst Traditional Area	12/86	05/89	29
-Old Naledi	12/86	12/91	60

Para. 40. Comments on Project Implementation. Except for the Princess Marina Hospital, all of the civil works components of the project have been completed. The PMH is not expected to be completed until December 1994 (Paras. 9, 21-22). Construction of the Urban Health Clinics was staggered deliberately in order to avoid overburdening the young, but growing construction industry in the country. Thus the twelve to 60 month delay shown in the above table was deliberate, and not due to delays in the usual sense of the word.

E. TOTAL PROJECT COSTS AND FINANCING

Table 5: TOTAL PROJECT COSTS

Category	Appraisal Estimate			Actual		
	Local	Foreign	Total	Local	Forei	Total
1. Civil Works	2.9	10.5	13.4	14.31	12.33	14.02
2. Furn. Equipt & Vehicles	--	2.6	2.6	6.80	2.07	8.87
3. Consultants, TA, Training & Studies*	0.3	4.2*	4.5	4.58	4.66	9.24
4. Project Prep. Facility (PPF)	--	0.48	0.48	--	0.48	0.48
5. IBRD front end fee	--	0.03	0.03	--	0.03	0.03
6. Pilot Innovative Pgm in Family Planing**	0.2	0.5	0.7	--	0.14	0.14
7. Contracept-ive***	--	0.9	0.9	--	0.9	0.9
8. Incremental recurrent costs**	3.7	0.9	4.1	0.05	0.86	0.91
TOTAL	7.1	19.6	26.7	25.71	21.18	46.92

Notes:

*Including US$ 0.5 million equivalent from WHO
**Grant from Government of Norway
***Grant from USAID

Para. 41. Comments on Project Costs. The total does not include funds required to complete the Princess Marina Hospital which was about 40% complete at the time of the Project Completion mission. The estimated total cost for the hospital (including equipment, furniture and consultancies (for "commissioning" the hospital and for equipment specialists) would be about Pula 111 million, or about US$ 55.5 million equivalent, of which roughly Pula 76 million (or about US$ 38 million) is for civil works only. This compares to Pula 8 million (US$ 7.5 million) estimated at appraisal. The reasons for the delay and the significant cost overrun are explained in Part I, Paras. 11, 21-22. The Government is fully committed to complete the hospital (including equipment and furniture) and to make it operational.

Table 6: PROJECT FINANCING
(US$ Mill.)

SOURCE	PLANNED	ACTUAL
IBRD	11.0	11.0
Government of Botswana	7.1	27.3
Government of Norway	7.2	7.2
USAID	0.9	0.9
WHO	0.5	0.5
TOTAL	26.7	46.9

Para. 42. Comments on Project Financing. Both the Bank loan and the Norwegian Grant were fully disbursed. As can be seen from the Table above, the Government's contribution has increased by more than three fold. And this is without taking into consideration the funds required to complete the civil works and to procure the necessary equipment and furniture for the Princess Marina Hospital. The Hospital is now about 40% completed, and it is estimated that an additional Pula 80 million (?) or about US$ dollar 40 million will be needed to complete the civil works and procure the additional equipment and furniture needed, thereby increasing the Government's contribution even more. The Government is fully committed to complete the buildings and procure the necessary equipment and furniture.

Table 7: ALLOCATION OF LOAN PROCEEDS
(US $ Million)

CATEGORY	ORIGINAL ALLOCATION	ACTUAL DISBURSEMENT
I. Civil Works	6,200,000	6,903,957
II. Vehicles & Equipment	1,900,000	1,249,468
III. Consultants, TA & Studies	2,300,000	2,631,811
IV. PPF	480,000	190,000
V. Front End Fee	27,000	27,000
TOTAL	11,000,000	11,000,000 (Rounded)

Para. 43. Comments on Allocation of Loan Proceeds. Disbursement of the loan got off to a slow start so that there was virtually no disbursement during the first three or even four years of the implementation period (1984-1988). The loan and the Norwegian Grant were fully disbursed, albeit a two-year extension of the Closing Date.

Table 8: DIRECT BENEFITS OF THE PROJECT

Indicators	Estimated at Appraisal	Estimated at Closing Date	Expected Benefit at Full Development
Establish and operate Community Health Sciences Unit	Construction of facility and equipment planned for 1988	Construction completed and facility furnished and equipped in 1988	Institution fully operational. Community Health services are now efficiently performed in such areas as environmental and occupational health, AIDS, TB, etc. As the National Lab is located in the same premises, the two institutions are much better coordinated.
Increase of Family Planning (FP) services in static facilities to cover 90% of target population.		90% of facilities offer FP services as part of integrated approach. Proportion of women who use modern FP methods increased from 24% in 1984 to 30% in 1988. Fertility rates declined 30% in less than 10 years from 7.1 in 1981 to 5.0 in 1988.	Coverage likely to increase further.
Procurement and distribution of contraceptive commodities and supplies.	Distribution initiated as early as 9/30/84	Function now integrated with MOH's regular work.	Continued funding by GOB is assured.
Expansion and upgrading of urban clinics	Construction began in 1986	All facilities operational. Total clinic attendance increased by 260% between 1982 and 1991 (from 234,000 to 620,000). This in turn reduced the pressure on the outpatient department of Gaborone's main hospital (PMH) by 80% (from about 350 patients a day in 1982 to only 80 patients a day in 1991.	National coverage of primary health centers in the country continues to be among the best in Africa.
Development of Health Manpower	40 staff-months of overseas and 3,513 staff-months of local training planned.	Plan exceeded by about 2% for overseas and 75% for local training.	GOB continues to sustain staff development needs from its own resources as well as through bilateral agencies.

Table 9: PROJECT STUDIES

Field of Study	Purpose as Defined at Appraisal	Status	Impact of Study
Management Study	Review of each level of management of the health system and cost recovery in the health sector.	Study discontinued as a reorganization of MOH along functional lines was already on-going by the time the project was initiated.	MOH reorganization study fully implemented. The study on cost recovery was also completed, but GOB decided not to implement the recommendations contained in the study (Para. 13).
Health Needs of Gaborone	To investigate the current health services of and project future needs over ten to twenty years.	Study successfully completed in 1987.	Report provided useful information for upgrading PMH and urban clinics and projected future requirement.
Prescribing Practices Study	To determine current prescribing practices of health workers and promote rational prescribing procedures and practices.	Completed in 1988	Findings of the study used as a basis for rational drug use and for improving Training.
TB Evaluation	To assess the National TB program, to evaluate diagnosis and treatment of TB and to recommend measures for surveillance and record keeping.	Study completed by the International TB Association (IUAT)	The principal conclusions of the study were incorporated into the National TB program and for revising the TB Manual.

G. Status of Loan Covenants

Table 10: COMPLIANCE WITH LOAN COVENANTS

SECTION	COVENANT	STATUS OF COMPLIANCE
Section 3.06	By December 31, 1984, the Borrower to submit for review by the Bank a work plan setting forth information, education and communication activities to be undertaken in support of the Health Education Unit.	Delayed; otherwise, in compliance.
Section 3.07 (a)	By September 30, 1986 the Borrower to employ for each rural health facility at least one state RN and two enrolled nurses.	In compliance.
Section 3.07 (b)	By September 30, 1985, the Borrower to second four medical officers to the Gaborone Town Council.	Delayed; otherwise, in compliance
Section 3.08	By September 30, 1984, the Borrower to review with the Bank the recommendations of the Health Financing Plan financed from PPF, and thereafter to implement the recommendations as agreed upon.	Health financing study completed; but GOB decided not to introduces any changes.
Section 3.09	The Borrower to maintain, until completion of the Project, the Manpower Development and Utilization Dept. and to employ a qualified and experienced training coordinator.	The Department has been retained as a regular unit of MOH; training coordinator was obtained through bilateral sources for thirty-six months, 12 months more than originally planned.
Section 3.10	By July 31 of each year, the Borrower to submit to and review with the Bank annual training plans.	Annual review undertaken on an ad hoc basis; however, training targets as set forth in the SAR were exceeded.
Section 4.02 (a) and (b)	Borrower to maintain financial records and accounts, in accordance with sound accounting procedures; and to have those accounts audited each year by independent auditors acceptable to the Bank, and to provide audit reports of sufficient scope and detail to the Bank within six months of the Borrowers fiscal year.	On the whole complied with, although audit reports were often delayed and not always sufficiently detailed.

H. Use of Staff Resources

Table 11: STAFF IN-PUT BY STAGES OF PROJECT CYCLE
(In Staff Weeks)

Stage of Project Cycle	Planned		Revised		Actual	
	HQ	Field	HQ	Field	HQ	Field
Through Appraisal	56.1	11.5	56.1	11.5	56.1	11.5
Appraisal to Board	61.2	10	61.2	10	61.2	10
Board to Effectiveness	6.2	6	6.2	6	6.2	6
Supervision	131.6	54	131.6	54	131.6	54

Para. 45. Comments on Staff Inputs. Staff in-put during the various stages of the project cycle was well balanced. Ten supervision missions were fielded during the seven-year life of the project, which is somewhat below the average for social sector projects (eg. education) in the region. As most of the project components, with the single exception of PMH, were progressing reasonably well, the frequency of supervision missions was quite adequate. As pointed out in the Borrower's contribution to this report (Part II), except for the consultant public health specialist who participated in eight of the ten supervision missions, the composition of the supervision missions lacked sufficient continuity. Part of the reason for this lack of continuity on the part of Bank missions was probably because the Bank itself was undergoing a major re-organization in its structure and staffing precisely during the middle of this project's implementation period.

Table 12: MISSION DATA BY STAGES OF PROJECT

Mission	Month/Year	No. of Persons 1/	Staff /weeks	Performance Status 2/			
Ident.	6/82	2(PHS,E)	2				
Prep.	11/82	1(PHS)	1				
Appraisal	6/82	5(PHS,E,PhA,MCH)	10				
Total No. of s/w in the field: 13				G	P	M	F
Spn I	10/84	5(2PHS, Ph, Arc, TrS)	10	NR	NR	NR	NR
Spn II	8/85	3(E,PHS,A)	4.5	2	NR	2	1
Spn III	20/86	3(E,PHS,A)	4.5	2	NR	2	1
Spn IV	8/86	4(E,A,2PHS	8	NA	NA	NA	NA
Spn V	1/88	4(2A,E, PHS)	8	2	NR	2	1
Spn. VI	10/88	3(E,A,PHS)	6	1	1	1	1
Spn VII	5/89	2(E,PHS)	2	2	2	2	1
Spn VIII	11/89	3(E,A, PHS)	3	2	2	2	1
Spn IX	12/90	3(ED,A,PHS)	6	2	2	2	1
Spn X	08/91	2(EDC,PHS)	2	2	2	2	1

Notes:

1/ A=Architect; E=Economist; ED=Education Specialist; M=Maternal and Child Health Specialist; PH=Pharmaceutical specialist; PHS=Public Health Specialist; TrS=Training Specialist.

2/ G=General Status; P=Procurement; M=Management; F=Availability of local finance; NR=Not Rated; NA=Not available.

Annex 1

NAMES OF OFFICIALS MET DURING PCR MISSION

Ministry of Health

Dr. E. Maganu	Permanent Secretary
Mrs. K. Gasenelwe	Under-Secretary, Health Manpower
Mrs. K. Makhwade	Asst. Director, Hospital Services
Ms. B. Ottesen,	Asst. Director, Technical Support
Mrs. W. Manyeneng	Asst. Director, Primary Health Care
Mr. L. Lesetedi	Head, Family Health Division
Ms. M. Tselayakgosi	Sr. Planning Officer
Ms. G. Maolosi	Project Coordinator,
Mr. B. Tau	Project Accountant Proj.
Ms. R. O. Mandevu	Chief Community Health Officer,
Ms. N. Mokgautsi	Senior Lecturer, National Health Continuous Education Unit
Ms. K. Koosmile	Health Asst. Officer, CHSC
Mr. K.O. Wathne	WHO/EPID/NACP, CHSC
Ms. K.M. Gyi	Public Health Specialist, CHSC
Dr. P.R. Vyas	Pathology Unit, National Laboratory

Princess Marina Hospital

Dr. B. Bagwasi	Acting Medical Superintendent
Mr. K. Oldroyd-Robinson	Principal Architect, DABS
Coordinator for	Health Projects, Site Coordinator,
Mr. John Thomas	Director, Commissioning Team
Mr. David Moss	Commissioning Engineer
Mr. Alan Yates	Furniture and Equipment Specialist

Gaborone City Council (For Urban Health Centers)

Mr. G. Ghetsewe	City Clerk
Mr. E. K. O. Kgologolo	Treasurer
Mrs. S. M. Motlogelwa	Acting Matron
Mrs. A. Nfila	Sr. Nursing Sister
Mrs. M. Mazhinye	Sr. Sister,
Mrs. S. V. Mokone	Nursing Sister
Mr. H. N. Perera	Sr. Architect
Mr. M. Seleka	Economic Planner
Mr. S. Pathmanathan	City Engineer

Primary Hospitals (Formerly Rural Health Centers)

Ms. G. V. Molefe	Sr. Nursing Sister, Lethlakane
Ms. A. Matshameko	Nursing Sister, Madinari
Ms. M. Kakanyetoo	Nursing Sister, Bobonong

Annex 2

PROJECT IMPLEMENTATION SUMMARY
(as of October 1992)*

PROJECT COMPONENT	SAR REF	STATUS*	REMARKS
REORG. OF HEALTH CARE DELIVERY SYSTEM	P.18		
1. Strengthening of Mgmt. & Planning Capacity	3.07		
- MOH Review	3.02	PPF	Successfully completed
- Management Studies MOH Units & MLGL		PPF	Successfully completed
Health Unit	3.08	(C)	MOH not satisfied with outcome/result
- Management Information System (MOH linking)	3.08	(C)	of Management Specialist Consultant
- Management Training	3.08	(C)	Information System not developed
- Improve health planning	3.09		
- Evaluation work (i.e. Study central and	3.09	PH	Evaluation system not developed
district planning process)	3.09		and planned evaluations omitted
- Gaborone Health needs study	3.09	C	
2. Financial Management	3.10		
- Development Program Budgeting System			
- System for Cost Recovery (Study/report)		C	Study completed, not implemented
3. Community Health Sciences Center (CHSC)	3.11		
- Construction	3.11	C	
- Vehicle and Equipment	3.13	C	
- New TB Strategy	3.11	C	
- STD training and educational programs	3.12	C	
- Equipment health centres & clinics	3.12	C	
- Specialist training	3.13	PC/PM	Tr. of entomol. + microbiol. omitted
4. Strengthening of Rural Health Services	3.14		
- Upgrading rural health centres (H)		C	
- Equipment and 4 vehicles		C	Boilers + X-ray equipm. not funct. yet
- Improved staffing standard		C	
5. Central Medical Stores (CMS)			Planned modifications found not
- Construction etc. CMS Gaborone		PM	feasible and component consequently
			omitted from the project
POPULATION/MCH/FP			
Service provision	3.17		
- Comprehensive services at all clinics		C	Above 90% complete by October 1992
- FWE prescribing contracept. (6 cycles)		C	
- Training of health staff in FP		C	As per Training Plans
- Equipment, supplies & contraceptive commod.		C/PM	USAID support for contraceptive comm.
7. Information, Education and Commun. (IEC)	3.18		
- FP themes in health education programs		C	
- IEC for other programs which address FP		C	
- FLE in schools and at TTCs		C	
- STD/FP programs for men at work places		C	
- Programs for adolescents in schools/clubs			
etc.		PC	Integr. in school curricula completed
- Innovative (NGO) activities		(C)	Little progress, only 2 applic. supp.
- Improved teacher training in FLE/FP		PC	Integr. in curricula ongoing
- Strengthen Occup. Health Unit activities			
in FLE/FP among men	3.23	C	I.a. supply of condom vending machines
- Expansion of Health Education Unit		C	
- Training of HEU staff		C	As per Training Plan
- Radio Studio, graphics studies and			
equipment		C	
- Poster production (MCH/FP, STD, TB, etc)		C	Done, but much delayed

* ABBREVIATIONS USED:

C = Completed; (C) = completed unsatisfactorily; PM = Plan Modified
PC = Partially complete

PROJECT COMPONENT	SAR REF	STATUS*	REMARKS
8. Demographic Unit	3.28		
- Development of Demographic Unit within CSO		PM	Unit established, Funded by UNFPA
- Equipment		PM	
- Library		PM	
URBAN HEALTH AND FAMILY PLANNING SERVICES	3.29		
- Upgrading & construct. of 9 urban clinics	3.30	C	Completed in 3 phases, all compl. by December 1991
- (incl. 2 maternity wards)			
- Upgrading Princess Marina Hospital	3.31	IP	See Annex w/separate constr. progr.
- Secondment of doctors to GAB Town Council		C	Presently five doctors at clinics
MANPOWER DEVELOPMENT			
- Local and Overseas Training		C	Very successful, output at 150% above target, see separate Annex

* ABBREVIATIONS USED:

C = Completed; (C) = completed unsatisfactorily; PM = Plan Modified
PC = Partially complete

CONSTRUCTION COMPLETION PROGRAM FOR PMH (as of October 1992)

Estimated Construction Completion Dates

Facility/Dept.	1992	1993	1994
Operating theater		May	
C.S.S.D.	December		
Laboratory	November		
Radio-diagnostic	October		
Delivery Unit			July
Renovate Theater			June
Intensive Care Unit	October		
Private Ward	December		
Isolation Ward			May
Admin. Block			May
Domestic Services			July
Surgical Ward 1		October	
Medical Ward 1		November	
Maternity Ward 2	September		
Maternity Ward			January
Eye Ward	August		
Gynecology Ward			February
Staff Rest			April
Walkway C2			September
Kitchen		February	
Medical Store			January
Service Yard			December
Blood Transfusion		January	
Orthopaedic W.shop (funded by NORAD)		May	

Annex 4

TRAINING OUTPUT AS PER SEPTEMBER 30, 1990

TRAINING COMPONENT	PERSONS TRAINED OR IN TRAINING (PLANNED & ACTUAL)					
	1	2	3	4 = (1+3)	5	6 = (4/5x100)
	OUTPUT AS PER MARCH 1989	MOH PLAN PY 5	OUTPUT PY 5 AS AT SEPT 30 1990	ACCUM. TOTAL AS AT SEPT 30 1990	SAR. ACCUM TOTAL BY PY 5	TOTAL OUTPUT BY SEPT 1990 VS SAR TOTAL BY PY 5 in %
LOCAL TRAINING						
a) Reorganization	1223	440	402	1625	787	206.5%
b) Population/MCH/FP	2290	686	357	2647	1653	160.1%
SUB-TOTAL LOCAL	3513	1126	759	4272	2440	175.1%
OVERSEAS TRAINING						
a) Reorganization	23	14	5	28	35	80.0%
b) Population/MCH/FP	17	3	4	21	13	161.5%
SUB-TOTAL OVERSEAS	40	17	9	49	48	102.1%
TOTAL (LOCAL & OVERSEAS)	3553	1143	768	4321	2488	151.9%

* PY 5 = Project Year Five

CONSULTANT SERVICES
(as of October 1992)

PROJECT COMPONENT/ SUBJECT OF CONSULTANCY		PERSON MONTHS SAR	Revised	Committed	COMPLETION DATE	GRANT/ LOAN	REMARKS
I.	REORGANIZATION OF HEALTH SYSTEM						
A.	Management Capacity						
(a)	Health Planner	18	18	18	03/89	L	Successfully completed
(b)	Management Specialist	24	18	18	12/87	L	Report not approved by MOH
	Financial Management (and Cost Recovery)	12	12	0		L	Not utilized
(d)	Health Planner/Evaluation	6	8	0		L	Not utilized
(e)	Gaborone Health Needs Study	18	18	18	10/87	L	Successfully completed
(f)	Manpower Planner	0	24	24	06/90	L	Phase 2 completed June 1990
(g)	Health Financing		6	6	1984	L	Cost recovery proposals not implemented
B.	Community Health S.C.						
(a)	Microbiologist	24	0	0	n/a	G	Not needed (MOH decision)
(b)	Entomologist	24	0	0	n/a	G	Not needed (MOH decision)
(c)	TB-evaluation	3	0	0	1985	G	Done by IUAT at nil cost
	Sub-Total	129	104	84			
II.	POPULATION/MCH/FP						
A.	IEC						
(a)	T.O.T. - MCH/FP	0	4	4	7/85	G	PPF activity
(b)	Program design	12	6	6	11/87	G	
(c)	Program development	24	6	6	12/88	G	Completed IEC plan
(d)	Flipcharts	0	3	3	6/85		PPF activity
B.	Demographic Unit						
(a)	Demographer	36	0	0	n/a	G	Funded by UNFPA
	Sub-Total	72	19	19			
III.	MANPOWER DEVELOPMENT						
A.	Reorganization Manpower						
(a)	O & M Workshop	6	0	0	n/a	L	Not needed, done by MEDEX/DMI
(b)	Man. orient. for Hospital St.	2	2	0		L	Not utilized
(c)	Physician tr. prescribing	2	3	3	04/89	L	Completed as a study
B.	Population/MCH/FP						
(a)	Local Workshops	9	0	0		G	Funded by INTRAH
(b)	Curriculum Consultant	2	5	6		G	PPF activity
(c)	FWE Curriculum	0	3	3	08/87	G	PPF activity
(d)	Training Coordinator	36	48	48	09/90	G	
	Sub-Total	57	61	60			
IV.	PROJECT COORDINATION						
A.	Architectural Planning						
(a)	Senior Architect	36	84	72	To date 69 months done (L)		
(b)	Architects (2)	36	N/A	N/A	To date 117 months done (L), + resources from GoB		
(c)	Structural Engineer	36	N/A	N/A	[Independent Consultants commissioned (L)		
(d)	Quantity Surveyor	4	N/A	N/A	[Instead of being directly (L)		
(e)	Mechanical Engineer	4	N/A	N/A	[recruited (L)		
(f)	Electrical Engineer	4	N/A	N/A	[recruited (L)]		
(g)	F&E Consultant	0	36	36	To date 36 months done (L)		
(h)	Snr. Hospital Dev. Officer	0	24	24	Completed 24 months (L)		
	Sub-Total	120	N/A	N/A			
	Total	378					

* In addition: Consultant Commissioning Team (of 4) recruited 1990, consultancy still ongoing (L)

N/A = Not applicable

FAMILY HEALTH PROJECT

Record of Project Progress Reports Submitted

1.	February 15,	1985	Quarterly Progress Report for the fourth Calendar quarter of 1984.
2.	April 1st,	1985	Quarterly Progress Report - 1/1/85 - 31/3/85.
3.	May 7th,	1985	Amendment Quarterly Report - 1/1/85 - 31/3/85.
4.	October 22,	1985	Progress Report for the third calendar quarter 1985.
5.	December 31,	1985	Quarterly Progress Report for the last calendar quarter 1985.
6.	January 16,	1986	Progress Report Update for 4th Quarter Report of 1985.
7.	May 2nd,	1986	Quarterly Progress Report for first quarter of 1986.
8.	July 4th,	1986	2nd Quarterly Progress Report for 1986.
9.	November 3,	1986	3rd Quarterly Progress Report for 1986.
10.	January 23,	1987	4th Quarterly Progress Report for 1986.
11.	April 1st,	1987	1st Quarterly Progress Report for the quarter ending 31/3/1987.
12.	July 1st,	1987	2nd Quarterly Progress Report for the quarter ending 30/6/1987.
13.	November 6,	1987	3rd Quarterly Progress Report for the quarter ending 30/9/1987.
14.	April 3,	1988	1st Quarterly Progress Report for the quarter ending 31st March, 1988.
15.	July 29,	1988	2nd Quarter Progress Report for the quarter ending 30th June, 1988.
16.	October 25,	1988	3rd Quarterly Progress Report for 1988.

17.	February 15,	1989	4th Quarterly Report for the quarter ending 31st December, 1988.
18.	May 19th,	1989	1st Quarterly Progress Report ending 31st March 1989.
19.	July 5,	1989	2nd Quarterly Progress Report ending 30th June 1989.
20.	November 3,	1989	3rd Quarterly Progress Report for the quarter ending 30th September 1989.
21.	March 12,	1990	4th Quarterly Progress Report for the quarter ending 31st December 1989 which incorporates responses to issues raised in the aide memoire of November 1989 World Bank Supervision Mission.
22.	May 14,	1990	1st Quarterly Progress Report for the quarter ending 31st March 1990.
23.	July	1990	2nd Quarterly Progress Report for the quarter ending 30th June 1990.
24.	November 16,		19903rd Quarterly Progress Report for the quarter ending 30th September 1990.
25.	February 27,	1991	4th Quarterly Progress Report for the quarter ending 31st December 1990 which also incorporates the responses to the issues in the aide memoire of the World Bank Supervision Mission.
26.	June 13,	1991	1st Quarterly Progress Report for the quarter ending 31st March 1991.
27.	September 6,	1991	2nd Quarterly Progress Report for the quarter ending 30th June 1991.
28.	November 5,	1991	3rd Quarterly Progress Report for the quarter ending 30th September 1991, which incorporates responses to issues raised in the aide memoire for the World Bank Supervision Mission of August 1991.
29.	January 17,	1992	4th Quarterly Progress Report for the year ending 1991.

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

DATE: 28-Oct-1992 11:38am

TO: Constance Frye (CONSTANCE FRYE)

FROM: Mulugeta Wodajo, AF6PH (MULUGETA WODAJO)

EXT.: 34842

SUBJECT: BOTSWANA and LESOTHO EDUCATION PROJECTS
Names of Govt Officials for the PCRs

Per your request, here are my suggestions of names of persons to whom the PCRs for the Fourth Education Projects (Ln 2644-BT and Cr. 1512-LSO) should be sent. These are people who were closely involved in one way or another with the implementation of the two projects.

The Country Officers (Mr. Hasan K. Imam for Botswana and Mr. Alun Morris for Lesotho) may have additional names, particularly from the Ministries of Finance in their respective countries.

BOTSWANA:

A. MINISTRY OF FINANCE AND DEVELOPMENT PLANNING (MFDP)
PRIVATE BAG 008
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Mr. G. Ghetsewe	City Clerk

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