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**Report No.: 17928**

# IMPLEMENTATION COMPLETION REPORT

## ETHIOPIA

## FAMILY HEALTH PROJECT
## (Credit 1913)

May 29, 1998

Human Development IV
Africa Region

**ETHIOPIA**
**FAMILY HEALTH PROJECT**

## CURRENCY EQUIVALENTS

At the time of appraisal

| | | |
|---|---|---|
| Birr 2.07 | = | US$1.00 |
| Birr 1. 00 | = | US$.48 |

At the time of project completion mission

| | | |
|---|---|---|
| Birr 6.65 | = | US$1.00 |
| Birr 1. 00 | = | US$0.15 |

## WEIGHTS AND MEASURES

Metric system

## FISCAL YEAR OF BORROWER

July 8 - July 7

## ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| CPR | Contraceptive Prevalence Rate |
| DCA | Development Credit Agreement |
| EPHARM | Ethiopian Pharmaceuticals and Manufacturing Corporation |
| ERRP | Emergency Recovery and Reconstruction Program |
| ESRDF | Ethiopia Social Rehabilitation and Development Project |
| FDRE | Federal Democratic Republic of Ethiopia |
| FHP | The Family Health Project |
| FP | Family Planning |
| HC | Health Center |
| HLMPC | Health Learning Materials Production Center |
| HS | Health Station |
| HSDP | Health Sector Development Program |
| ICB | International Competitive Bidding |
| ICR | Implementation Completion Report |
| IDA | International Development Association |
| IEC | Information, Education and Communication |
| MEDaC | Ministry of Development and Economic Cooperation |
| MCH | Maternal and Child Health |
| MOH | Ministry of Health |
| NCB | National Competitive Bidding |
| PCO | Project Coordination Office |
| PHC | Primary Health Care |
| PHRD | Policy and Human Resources Development Fund |
| PPF | Project Preparation Facility |
| SAR | Staff Appraisal Report |
| SIDA | Swedish International Development Agency |
| TBAs | Traditional Birth Attendants |
| UNFPA | United Nations Fund for Population Activities |
| USAID | United States Agency for International Development |

| | | |
|---|---|---|
| Vice President | : | Callisto Madavo |
| Director | : | Oey Astra Meesook |
| Sector Manager | : | Arvil Van Adams |
| Staff Member | : | Gita Gopal |

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# IMPLEMENTATION COMPLETION REPORT
# ETHIOPIA
# FAMILY HEALTH PROJECT
# (CR. NO. 1913)

## PREFACE

This is the Implementation Completion Report (ICR) for the Family Health Project in Ethiopia, for which Cr. 1913 in the amount of SDR 23.8 million (US$33 million at the prevailing exchange rate in 1988) was approved on June 2, 1988 and made effective on March 14, 1989. The credit is 94.6 percent disbursed, with a remaining balance of approximately US $ 1.7 million which will be canceled.

The ICR was prepared mainly by Maryam Salim (Operations Analyst) based on the ICR mission aide-memoire, with input and guidance from Pammi Sachdeva (ICR mission leader) and Gita Gopal (Task Team Leader). Contributions were provided by Christine Pena (Economist), Getahun Gebru (RM Disbursement Officer), Gebreselassie Okubagzhi (RM Health Specialist), Bengt Jacobsen (Architect) and Josef Ghebre-Egziabher (Architect, local consultant), all members of the ICR Mission. It was reviewed by Oey Astra Meesook (Country Director for Ethiopia), Arvil Van Adams (Sector Manager, Human Development IV), and David Berk (Lead Specialist, Health). The main text of the aide-memoire of the ICR Mission is included in Appendix A. The Borrower's comments of May 8, 1998 are incorporated as Appendix B. The Borrower has prepared its own ICR which is included as Appendix C.

Preparation of this ICR began in October 1997, during the Bank's final supervision mission and continued with the ICR mission which took place in January 1998. The report is based on the ICR mission and other Resident Mission's observations from the field trips, discussions with staff of the Project Coordination Office, the Project Implementing Agencies, and local government officials.

## PART I: EVALUATION SUMMARY

1. **Project Description and Objectives.** The Family Health Project (FHP) was a US$43.86 million project of which IDA funded approximately 75 percent (US$33.0 million). FHP aimed to (a) increase the quality, coverage and cost-effectiveness of maternal and child health (MCH) services; (b) increase the availability and use of family planning (FP) services; and (c) strengthen the institutional capacity of the Ministry of Health (MOH). FHP consisted of six components: MCH/FP, Manpower Development, Health Education and IEC, Institutional Development, Pharmaceuticals, and Studies.

2. Since this project was the first IDA-financed operation in the health sector, the intention was to learn from a focused and limited operation that could later be expanded to other regions. Therefore, the project focused on Shewa region, because of its substantial population and relative accessibility. However, at the time of project preparation and during early phases of project implementation, the country was facing civil war in many areas, which disrupted services and affected implementation capacity. In 1991, the Transitional Government of Ethiopia (TGE) took control. It then initiated an ambitious and extensive process of regionalization, whereby new regional boundaries were demarcated and administrative powers were devolved to regional governments which were authorized to implement all development policies. Also, TGE embarked on the preparation of a national health policy. The Emergency Recovery and Reconstruction Program (ERRP), was developed simultaneously, and in 1991, funds were reallocated from the credit towards procurement of pharmaceuticals in order to support the drugs component of the ERRP. However, all this meant that, during the period between 1991 and 1993, the project was forced to a standstill and it became clear to the Bank that though project objectives were very relevant, project design and implementation mechanisms would need to be reconsidered. Thus, in order to reflect the changing circumstances and needs in the country, it was agreed in 1994 to: (i) expand the project to cover the whole country, in particular the hitherto neglected areas; (ii) re-design the components in line with the new draft health policy; and (iii) re-design project implementation arrangements to suit the new regionalization policy.

3. This project is evaluated based on the re-designed components. Overall, **achievement of project objectives** is likely to be satisfactory. FHP has contributed to the rehabilitation/construction and equipping of health stations and health centers for provision of MCH-FP services in under-served rural areas. It contributed to the construction of regional and zonal health bureaus, and to the rehabilitation of training schools for different types of para-medics. It also contributed to the supply of pharmaceuticals, addressing in part the chronic shortage of essential drugs, and to the potential improvement in the service coverage and quality of drugs supplied through the construction of an improved drugs quality control laboratory. FHP has also supported and monitored the activities of other MOH Departments in nation-wide activities for manpower development (much of which however was funded by other donors) and health education and materials development. Studies proposed under the project were also conducted (though they were funded by other donors) and utilized by MOH in the formulation of relevant policies. However, the development objective of enhancing services will be met satisfactorily only when these facilities are staffed adequately and are provided with the necessary recurrent costs (the facilities were mostly completed and equipped during the last few months of the project implementation period). In order to ensure that the facilities are operational and to increase the likelihood of achieving sustainability, MOH has received individual commitments from Regional Bureaus that they will provide the facilities with the necessary recurrent costs for satisfactory delivery of services to clients. Estimated expenditures have also been committed in the annual budgets. It is thus likely that the development objectives of the project will be met satisfactorily.

4. **Implementation Experience and Results.** From 1986 to 1994, MOH lacked capacity to prepare and implement a project and needed strong support. During the initial stages of implementation, its performance was weak owing partly to lack of experience of the Project Coordination Office (PCO) and partly to the ongoing civil strife in the country. During the same period, the MOH was also involved in rehabilitation and resettlement activities resulting from the aftermath of the 1985 drought. The new Government's policy of regionalization and decentralization, which called for devolution of authority and responsibility to regions for the implementation and management of developmental projects in their respective regions, was a departure from the earlier practice of centralized project management by Ministries. Project implementation authority and responsibility were transferred to the regions. It therefore took time to: a) get the regional government staff to become familiarized with IDA's procurement procedures; b) prepare and obtain IDA clearance for bidding documents to be used by the project; c) complete, and get approval of, the regional action plans; and d) obtain no-objection for a large number of contracts. Moreover, contractors were not readily available in many of the remote places to which the project had been expanded. Capacity had to be strengthened and even built up in some regions. As a result very little disbursed from the project during the period 1993-94 (the project was re-designed and project activities were virtually suspended) until the civil works commenced and construction of the majority of the facilities was completed only by the closing date.

5. The Government had taken steps to strengthen project monitoring and follow-up mechanisms by (a) setting up in September 1995 a Capital-Budget Projects Monitoring Unit chaired by the Vice-Minister of Health and (b) monitoring every three months health projects at the level of the Prime Minister's Office. These measures have helped to resolve problems and speed up implementation of the project. During this period, given the lack of capacity at the center and continuing weaknesses at the regions, adequate supervision was a problem. While several of the weaker regions continued to be supported by MOH, the larger regions, mainly Amhara, Tigray, and the Southern region conducted their own supervision. Quality of infrastructure was therefore not always adequate. Nevertheless, overall, Borrower performance is considered satisfactory, as many of these factors were outside the control of MOH -- and because, despite all these constraints and problems, the Borrower managed to implement the re-designed project in a satisfactory manner.

6. Bank support during project preparation was satisfactory. The Bank could be commended for having provided support for the project at a time when many parts of the country were at civil war. The Bank helped the Government focus on the objectives that have clearly been proved to be relevant. The Bank also prepared this project expecting that if successful, it could be replicated in other parts of the country after peace returned. Also, policy dialogue was initiated on health financing and population issues. However, support during project appraisal despite all efforts (the SAR was substantially revised during negotiations in recognition of the substantial progress made by the Government in addressing a number of issues) proved to be inadequate considering the number of problems identified in early supervision reports. In particular, the Bank seriously underestimated the cost of civil works, equipment, and furniture. In addition, one supervision report also mentioned that the pharmaceutical component was not well developed and the Borrower did not fully appreciate/understand its objectives, which led to a delay in the component's implementation.

7. The Bank's supervision efforts during the initial stages of project implementation was weak. There was indication that there were periods when greater support was clearly needed, as reflected in initial supervision reports which state that some of the major implementation problems were a result of inadequate supervision and guidance by the Bank to a project implementation unit unfamiliar with Bank practices and procedures. In re-designing project activities, however, the Bank performance was satisfactory in providing the necessary technical support. Its supervision in the last three years

contributed to accelerating the pace of project implementation. In addition, the Resident Mission staff also conducted additional and periodical interim missions to provide implementation support as required.

8. **Future Operations and Sustainability.** The FHP's benefits are likely to be realized and sustainable because of the Government's strong commitment to health sector reforms. Recently, the Prime Minister's Office has directed that all Regional State Governments and Health Bureaus ensure adequate recurrent budgets for operating and maintaining existing and proposed health facilities and programs. According to MOH, Regional budgets for 1997-98 have included the estimated costs of manpower, drugs, equipment, supplies and administrative overheads for providing health services. These budgets cover the facilities funded by the FHP as well as other government and donor-funded activities. In addition: a) the Government's overall allocation to the health sector has increased in recent years and is expected to increase further in 1997/98 and beyond; b) the new health care financing strategy is expected to come into force in 1998; and c) the expected funding from IDA and other donors for the five-year HSDP, which became effective in July 1997, would provide much-needed additional funds. Furthermore, regional governments have committed themselves to ensuring that sufficient provision has been made for covering the recurrent costs of sustaining the FHP-supported facilities for at least the next 5 years. The Government's HSDP (1997-2002) includes operational budgets for all health institutions (including the facilities funded by IDA). These have been discussed with donors and further consultations are expected in the coming months when Bank and donor support to HSDP is finalized. FHP has also supported the expansion and equipping of health personnel training institutions, although initially the buildings are likely to operate with existing staff until additional numbers are produced by the various training institutions. The availability of well trained managers is also expected to increase because of the health management training centers established by a number of regions. Improvements in staffing and management are also being pursued and strengthened by the HSDP.

9. **Key Lessons Learned.** The FHP is the first and, so far, the only health project financed by the World Bank in Ethiopia. It has provided a number of important lessons for the Government and the Bank to consider in future operations, including the following:

- The continuous monitoring by the Government high-level committees was instrumental in facilitating and expediting implementation. Such close monitoring efforts by MOH had a salutary effect on project implementation, and will in the long run have a beneficial impact in achieving and sustaining development objectives.

- The need to strengthen capacity building activities. The absence of institutional capacity, particularly in some of the regions, was found to be an impediment; and will continue to be so unless additional attention is given to providing carefully planned training in various areas, including procurement, disbursement and contract management. In addition, government policies that provide incentives to recruit and maintain the services of trained and competent staff are needed.

- The need to balance facility expansion with quality measures. Although the completion of civil works is commendable, the quality of construction was frequently a cause for concern. Also, it is essential that the procurement of equipment, furniture and supplies coincide as closely as possible with the expected date(s) of completion of the construction activities.

- Regular and stringent supervision by engineering staff of the Regional and Zonal Health Bureaus and MOH is essential for good quality civil works. Project supervision by MOH suffered due to attrition of staff and a heavy workload. This issue must be addressed before a second IDA-financed project is undertaken. In view of the large disparity between employment conditions in the private sector and

in government, it is becoming increasingly difficult to recruit and keep qualified and experienced engineers. In future, it might become necessary to rely to a greater extent on consultancy firms or individuals paid on a competitive basis.

- The FDRE approval process for variation orders is considered to be lengthy and the cost limits up to which decisions can be taken at the local level are low. In the past, variations up to 15 percent could have been approved by the Engineering Department. In order to increase transparency, the process was tightened, and the revised procedures are lengthy, and delegation limits may need to be reconsidered.

- An Implementation Manual would have been very useful in clarifying responsibilities and duties of the different partners -- PCO, Architectural and Engineering Unit, and other implementing agencies. Similarly, the implementation plan and budget for the first year should have been part of the project preparation and not a condition of effectiveness. If the PCO approach is adopted for project implementation, it is necessary to ensure that processes are in place to work closely with its other partners in MOH.

- Adequate supervision is important not only from the Borrower's side but also from the Bank's side. Some major delays, particularly at the start of project implementation, could have been minimized if there had been adequate Bank supervision and assistance. Given that the development of a continuous follow-up mechanism in the field appears to generate substantial improvement in project implementation, the ongoing strengthening of the Resident Mission's capacity should facilitate necessary support at the center.

- From the Bank's side, project preparation needs to be more thorough and cost estimates need to be based on market prices. In the FHP, costs of civil works were severely underestimated. In addition, implementation of the pharmaceuticals component was delayed because of lack of detailed component preparation and inadequate supervision at the beginning of project implementation.

- The usefulness of streamlining the decision-making process -- given that the payments process has been lengthy under FHP, and delays and stoppages have occurred.

- The need to ensure timely preparation of audits. The Bank and MOH agree that the process of preparation of audits has not been fully satisfactory and may require some review to address the issues identified. It would be useful to raise this issue during the preparation of the HSDP.

## PART II: PROJECT IMPLEMENTATION ASSESSMENT

1. **Introduction and Background.** Ethiopia is the second most populous country in Sub-Saharan Africa. The country, with a long and rich history, has been impoverished by two of the biggest droughts this century and by its recently ended civil war. The Population, Health and Nutrition Sector Report (No. 5299-ET, issued in gray cover in September 1985) identified rapid population growth as a key problem facing the country. The main issues with respect to the health subsector dealt with the very low levels of coverage of modern health services, and the poor quality and curative emphasis of most existing services. Because of these shortages, and subsequent discussions of the sector report, the Government and IDA agreed that emphasis should be put first on the consolidation of existing services, and only then on major expansion (Family Health SAR, 1988).

2. The Family Health Project (FHP) focused on MCH services as the health interventions that could contribute the most to reducing the high mortality rates in Ethiopia, and as an appropriate vehicle for the expansion of Family Planning (FP) services. IDA's strategy was to use this first project as an entry-point into both the population and health subsectors. It was hoped that the project, supplemented by sector work in health financing, would be followed by assistance in the pharmaceutical subsector and consolidation of hospital and Primary Health Care (PHC) services; and would also help develop implementation capabilities within MOH so as to attract additional external assistance. Such assistance was expected to include the development of a nation-wide FP program and a health sector improvement program emphasizing primary health care, quality and efficiency of hospital services, and the generation of additional health revenue. The risks recognized in the Staff Appraisal Report (SAR) related to the MOH's implementation capacity, the high drop-out rate of community health workers, and shortfalls in Government funding of recurrent costs.

3. Since this project was the first initiative in the health sector, the intention was to learn from a more focused and limited operation that could later be expanded to other regions. Therefore, the project focused on Shewa region, because of its substantial population and relative accessibility. However, at the time of project preparation and during early phases of project implementation, the country was facing civil war in many areas which disrupted services and affected implementation capacity. In 1991, the Transitional Government of Ethiopia (TGE) took control. It then initiated an ambitious and extensive process of regionalization whereby administrative powers were devolved to regional governments, which were authorized to implement all development policies. Under the new demarcated boundaries, Shewa region disappeared and the administrative machinery no longer existed. It also became difficult for the Government to support a project that intervened only in a few parts of the country. Also, TGE embarked on the preparation of a health policy. The Emergency Recovery and Reconstruction Program (ERRP) was developed simultaneously and, in 1991, funds were reallocated from the credit towards procurement of pharmaceuticals in order to support the drugs component of the ERRP. However, all this meant that during the period between 1991 and 1993, the project was forced to a standstill while it became clear to the Bank that although project objectives were very relevant, project design and implementation mechanisms would need to be reconsidered. Thus, in order to reflect the changing circumstances and needs in the country, it was agreed in 1994 to: (i) expand the project to cover the whole country, in particular the hitherto neglected areas; (ii) re-design the components in line with the new draft health policy; and (iii) re-design project implementation arrangements to suit the new regionalization policy.

4. **Project Objectives.** FHP aimed to: (a) increase the quality, coverage and cost-effectiveness of maternal and child health (MCH) services; (b) increase the availability and use of FP services; and (c) strengthen the institutional capacity of the Ministry of Health (MOH). FHP consisted of six components: MCH/FP, Manpower Development, Health Education and IEC, Institutional Development, Pharmaceuticals, and Studies. The objectives of each component are provided in Table A.

5. This ICR evaluates project achievements based on the re-designed project components. **Achievement of project objectives** is likely to be satisfactory. In spite of the slow pace of implementation during the initial stages, project implementation improved after its re-design in 1994. FHP contributed substantially to the rehabilitation and construction of health stations and health centers for provision of MCH-FP services in under-served rural areas, and strengthened the institutional capacity of MOH through construction and rehabilitation of schools for different types of paramedics, provision of books, education journals and equipment; and construction of an audio-visual laboratory with necessary equipment. It also contributed to the improvement in the drugs supply and quality through construction of a drugs quality control laboratory, and more importantly through the supply of pharmaceuticals, addressing in part the chronic shortage of essential drugs. FHP also supported and monitored the activities of other MOH Departments in nation-wide activities for manpower development (much of which was funded by other donors) and health education and materials development. However, the development objective of enhancing services will be met satisfactorily only when these facilities are staffed adequately and are provided with the necessary recurrent costs (the facilities were mostly completed and equipped during the last few months of the project implementation period). In order to ensure that the facilities are operational, an action plan has been agreed with MOH which has received individual commitments from Regional Bureaus that they will provide the facilities with necessary recurrent costs for satisfactory delivery of services to clients. To this end, regional governments have also committed the funds in the annual budgets. It is thus likely that the development objectives of the project will be met satisfactorily.

6. In addition, by catalyzing the provision of a large Japanese Policy and Human Resources Development Fund (PHRD) in 1995-97, the FHP's relaunch in 1994 played a role in helping maintain sectoral policy dialogue between the Government and the Bank; and was instrumental in creating an enabling environment for the Government to undertake comprehensive and detailed studies in 1995-97 of major aspects of the health sector. The PHRD studies, undertaken in close collaboration with, and with technical support from, the Bank, have contributed to the development of a comprehensive Health Sector Development Program (HSDP), launched by the Government in July 1997, focusing on primary health care (and including, among other aspects, improvements in health financing and pharmaceuticals availability). The Bank and other donors are currently trying to determine how best to support the Government's HSDP and decisions on financing arrangements/support will be made in mid-1998.

7. **Major Factors Affecting the Project**. The project was expected to be disbursed over nine years (1988-1997). Despite the exceptionally difficult circumstances prevalent in the country in the early years of project implementation, it closed as scheduled on December 31, 1997 (except for the pharmaceutical component which was extended until January 31, 1998 to enable the delivery of drugs). FHP experienced delays between Board approval and effectiveness. While the project was approved by the Board on June 2, 1988, it became effective only in March 14, 1989. This appears to have been caused by a number of factors, including the delay in submission of the Government's first year budget and implementation plan (a condition of credit effectiveness). Delays continued during the initial period, with project implementation gradually picking up after 1995. A number of factors affecting project implementation during the period between 1989 and 1995 are addressed below.

8. Owing to reasons explained earlier, FHP implementation was slow until project relaunch in March 1994. Initially the project was affected by the ongoing civil strife in the country which ended in 1991 with the assumption of power by the TGE. The next two to three years of the project implementation were influenced and constrained by the regionalization and recovery processes within the country. By 1993/94 a new Health Policy was approved and the regionalization process had moved forward significantly. Consequently, Shewa region -- the main focus of the FHP -- was no longer on the map of Ethiopia; the old administrative machinery was no longer relevant. All this led to the need to re-

design the project components and the implementation arrangements within its stated objectives which continued to remain highly relevant.

9. In 1993-1994, the project was therefore re-designed in close consultation between the Government and the Bank. The construction cost estimates were revised to reflect the then market costs. The implementation arrangements were revised, and responsibility for the implementation and management of the project was given to the regions. This was a fundamental departure from the earlier practice, where implementation of donor-financed projects were centrally managed by Ministries. This meant that regional government staff, whose capacity were weak, had to (i) be familiarized with IDA's procurement procedures; (ii) prepare bidding documents for regions in conformity with Bank and regional government guidelines; (iii) complete and get approval of regional action plans; and (iv) obtain no-objection for a large number of contracts. Much of the project's construction, procurement and disbursement activities were therefore compressed into the last three years of implementation (1994-1997). This compressed time schedule, combined with changes in the project's area component (emphasizing previously neglected regions), and given the need to strengthen capacity in the regions led to a challenging implementation task even after the 1994 project relaunch.

10. Project implementation during this latter phase was satisfactory, despite all the constraints most of which were outside the control of the PCO and even MOH. Disbursements were negligible in FY94 and FY95 due to the need to build procurement and implementation capacity at the regional levels. Also, the implementation capacity of the MOH was not as strong as anticipated; and was further eroded during recent years, again due to factors beyond the project's control. Staff turnover was particularly high -- due to retirements, transfer to the regions, and attrition to the private sector. Continuing and significant disparities in service conditions, salaries and incentives between the public and private sectors, made it difficult to hire and retain the necessary skills in the MOH, especially in such areas as engineering, procurement, accounting and financial services, all of which directly affected the FHP-PCO's capacity to effectively backstop, supervise and monitor the dispersed project activities in the regions. The planning, supervision and monitoring capacity of many regional health bureaus was similarly affected by changes in staffing, as well as increasing competition for trained staff from the private sector. Thus, the capacity and motivation of the engineering staff of many regional and zonal health offices to properly supervise construction activities at remote and dispersed locations was often inadequate. There remained noticeable shortfalls in the timeliness and quality of some civil works, and delays in procurement of some goods and services, both in the regions and at Addis Ababa, as noted in the aide memoires and other reports of previous Bank missions, as well as the present ICR team. With experience, the staff of the PCO became conversant with IDA requirements for procurement, financial accounting and disbursement. In 1995, monitoring and implementation tables were developed by the PCO and updated on a regular basis and this helped to expedite implementation progress significantly (see Table 6). Concerted efforts by the PCO and the Architectural and Engineering Unit under the guidance of MOH resulted in satisfactory implementation progress leading to the timely closing of the project after having completed the construction of almost all the civil works contracts.

11. **Bank Performance.** Bank support during *project preparation* was satisfactory and the Bank could be commended for having provided support for the project at a time when many parts of the country were at civil war. The Bank helped the Government focus on the objectives that have clearly been proved to be relevant. Also, policy dialogue was initiated on health financing and population issues. However, support during *project appraisal* proved to be inadequate considering the number of problems identified in early supervision reports. In particular, as early as October 1989, it was recognized that the Bank had seriously underestimated the cost of civil works, equipment, and furniture. The project was expected to finance the rehabilitation of 180 health stations, 18 health centers, 3 rural hospitals, and also finance 3 new health centers but the allocated funds were not adequate. Appraisal estimates were found to be adequate to construct only one-third of health centers/stations included in the project, necessitating a

review of cost estimates. A 1989 supervision report also mentioned that the pharmaceutical component was not well developed and the Borrower did not fully appreciate/understand its objectives, which led to a delay in the component's implementation. One aide memoire notes the lack of detailed preparation of the component as a contributing factor in the slow implementation progress of the component.

12. The Bank's supervision efforts during the initial stages of project implementation were weak. There was indication that there were periods when greater support was clearly needed, and that some of the major implementation problems were a result of inadequate supervision and guidance by the Bank to a project implementation unit unfamiliar with Bank practices and procedures. There is also no indication in project reports of a project launch workshop, leaving the implementing agency with little knowledge about Bank procedures and requirements. In re-designing project activities, however, the Bank performance was satisfactory in providing the necessary technical support. The Bank intensified supervision including additional and periodical interim missions by the Resident Mission to provide implementation support as required. All supervision missions included a civil engineer who provided timely support to the project engineering team in identifying and addressing infrastructure quality issues. Bank missions also included procurement and disbursement staff who were able to deal with implementation issues in a timely manner, as well as providing training through workshops and implementation support missions.

13. **Borrower Performance.** Borrower performance is considered satisfactory, as many of the factors that constrained performance were outside the control of MOH, and because despite all these constraints and problems, the Borrower managed to implement the re-designed project in a satisfactory manner -- constructing or rehabilitating 96 (out of 100) health stations and 19 health centers. In all, only four health stations were canceled -- two due to security issues and two due to contractor problems. The respective regional governments have agreed to complete the latter using their own resources.

14. During project preparation Borrower performance was marginally satisfactory but this weakness arose out of lack of capacity and partially as a result of the ongoing civil strife in the country. MOH had limited project preparation capacity. Technicians within the Ministry were stretched thin prior to the drought of 1985, and after the drought capacity was further weakened, since they were also responsible for relief and resettlement activities. In addition, the Architectural and Engineering Unit, as well as the MCH Department, were understaffed. The Borrower's three month delay in submitting the request for PPF funding also slowed down project preparation, as the consultants to assist the Borrower to prepare the project could not be hired. During the initial stages, Borrower capacity continued to be weak, thereby slowing project implementation. For example, according to the aide memoire of October 1988, the unit charged with the routine management of the project was understaffed. The small unit comprising a team leader and two experts was charged with executing not only the FHP, but also executing the remaining portfolio of donor assistance. A project unit (the PCO) was later established as per the SAR, but had no experience in Bank procedures and had a difficult time initiating project activities.

15. The Government's commitment and capacity at the central and regional levels to improving the health sector during the latter half of project implementation were strong. These included regular high-level monitoring and support of the FHP by senior officials of the MOH and Prime Minister's Office. In the MOH, the Vice-Minister of Health headed a Project Monitoring Unit that met every fortnight to ensure that all donor-funded projects were properly implemented. A similar follow-up action was undertaken by the Prime Minister's Office and MEDaC on a regular basis; and the Regional Councils and Health Bureaus have a similar monitoring system for all capital investments in their region. The dedication and hard work of the PCO and the Architectural and Engineering Department (especially those responsible for overall coordination) is commendable -- particularly in the provision of support to the regions.

16. **Assessment of Outcome.** As noted in the SAR, because of methodological difficulties in attributing national-level gains in health status indicators to any single contributory factor, it is inappropriate to try to identify the quantifiable impact of the FHP on such measures as reductions in mortality and morbidity of the population of Ethiopia. The assessment of project achievements is therefore based on input, process and output indicators, and not on estimates of its potential outcomes or impact. Furthermore, due to the slow pace of implementation during the first five years of the project, most of the inputs were provided in the last two years; and hence, now that the project facilities are in place, substantial benefits are likely to accrue in the coming year as the buildings become fully operational with the regional bureaus having already committed the required operational budget. The key contributions of the project are assessed below, in terms of improvements in access, quality and equity of basic health services, and in management capacity (an overall assessment of the achievements of each project component is given in table A).

17. *Improvements in Access.* About 45 percent of the total FHP finances were devoted to the construction/rehabilitation of 96 health stations and 19 health centers. The latter, under earlier estimates were expected to serve a population of 960,000 and 1,900,000 respectively. However, under the new health care delivery system, FHP-constructed health stations are likely to be upgraded to health centers. Therefore, the 96 health stations and 19 health centers (which will be 115 health centers) will service a population of 2,875,000. Most of these facilities are located in hitherto neglected regions and are expected to make a positive contribution to increasing access to health services in the targeted areas.

18. *Improvements in Quality.* The rehabilitation and expansion of health manpower training institutions has increased the country's capacity for training front-line health workers; and the improvement in training curricula included in the project (though eventually funded by grant money from other donors) has substantially improved the quality of training provided, especially in certificate and diploma courses for nurses, health assistants, sanitarians, etc. The establishment and furnishing of the Audio-Visual Center will improve the ability of the National Health Learning Materials Production Center ( HLMPC) to expand its capacity to develop high quality health education materials which could be further adapted for use in various regions. The establishment of the Drug Quality Control Laboratory will improve the country's ability to ensure the importation and distribution of safe and standard drugs, thereby improving the quality of health care services to patients.

19. The FHP has supplied pharmaceuticals to all levels of the health service delivery system, thus effectively addressing, in part, the chronic shortage of essential drugs. The project contributed US$9.39 million to the US$60 million drugs procurement component of the ERRP project implemented in 1992-1995. In addition, US$3.15 million was utilized under FHP after the project's re-design, to procure drugs. A study on drug supply management was part of the project, but was carried out with USAID support, as part of a larger study on health care financing. A draft proclamation for health care financing has been submitted for consideration by the Government and Parliament, and its ratification is expected to generate sufficient revolving funds to provide an adequate supply of drugs to all health institutions. In addition, all the health infrastructure built with FHP support is being fully equipped with basic equipment and supplies, and this will greatly improve the quality of health services provided in these new institutions.

20. *Improvements in Equity.* As the project buildings become fully functional, the project will help improve access in previously under-served, remote, and neglected areas of the country. The project will be instrumental in increasing MCH services by improving rural health institutions in both number and quality. The number of outreach activities will also increase, creating opportunities for reaching a greater number of previously unreachable mothers and children. Project funds have been used for providing MCH kits to community health workers, including TBAs, which will have a direct bearing on the health services given to mothers and children. The supply of contraceptives has likewise helped improve the

availability of FP services, though the quantifiable increase in the contraceptive prevalence rate (CPR) attributable directly to the FHP is difficult to specify.

21. *Improvements in Management Capacity.* Workshops have been held on project management, procurement and disbursement to improve the project management capacity of the central and regional health staff. In addition, 3 Regional Health Bureaus[1] and 3 Zonal Health Offices have been built and equipped, which are expected to improve the management of health services in these regions. The capacity of the central MOH to plan and coordinate the FHP, and to provide technical support in implementing the project (especially civil works) in remote regions, was also strengthened under the project, although there is need for greater and intensive capacity building.

22. **Project Sustainability and Future Operations.** The FHP's benefits are likely to be sustained for the foreseeable future. Recently, the Prime Minister's Office has directed that all Regional State Governments and Health Bureaus ensure adequate recurrent budgets for operating and maintaining existing and proposed health facilities and programs. According to MOH, regional budgets for 1997-98 have included the estimated costs of manpower, drugs, equipment, supplies and administrative overheads for providing health services. These budgets cover the facilities funded by the FHP as well as other government and donor-funded activities. In addition: a) the Government's overall allocation to the health sector has increased in recent years and is expected to increase further in 1997/98 and beyond; b) the new health care financing strategy is expected to come into force in 1998; and c) the expected funding for the five-year HSDP, which became effective in July 1997 from IDA and other donors, would provide much-needed additional funds. Furthermore, regional governments have committed themselves to ensuring that sufficient provision has been made for covering the recurrent costs of sustaining the FHP-supported facilities for at least the next 5 years. The Government's HSDP (1997-2002) includes operational budgets for all health institutions (including the facilities funded by IDA). These have been discussed with donors and further consultations are expected in the coming months when Bank and donor support to HSDP is finalized.

23. The right mix and number of trained health manpower is also crucial for the sustainability of high-quality health care services. Initially, the structures completed during FHP implementation are likely to operate with existing staff -- until additional numbers are produced by the various training institutions. The project has supported the expansion and equipping of health manpower training institutions; and this is expected to gradually make health services more sustainable in the coming years. The availability of well trained health managers is equally important for the development of a rational health system. A number of regions have established Health Management Training Centers for training program managers through short-term management development courses. This is expected to improve program planning and implementation in the health sector, and make health service delivery more efficient and sustainable.

[1] The Afar Regional Health Bureau was constructed in the location planned for the new capital of the Afar region. This transfer of the regional government center is still underway, therefore it may take some time before this facility becomes operational.

| [illegible] | Description (DCA*) | Ac[illegible] | |
|---|---|---|---|
| MCH/FP | (i) strengthen/creating the capacity at the central, regional and zonal levels to coordinate, back-stop, and supervise the activities of lower level staff; (ii) increase the availability and use of MCH/FP services by rehabilitating and/or reconstructing 100 health stations and 19 health centers in selected regions; and (iii) providing the necessary equipment, supplies, drugs, contraceptives, logistics and training. | (i) training in program management conducted with UNFPA support; training of trainers for family planning conducted with SIDA support; in-service training conducted annually; regional training bureaus are being established by the Regional Health Bureaus; (ii) civil works and procurement activities were completed for 96 health stations and all 19 health centers by 12/97; (iii) 247 delivery beds, MCH baby cots, Mid-wife kits, first-aid kits, MCH A & B Kits, medical equipment furniture and vehicles provided to health stations and health centers. | HS |
| Manpower Development | (i) rehabilitating and upgrading the two training centers/schools for nurses, one school for laboratory technicians, two schools for health assistants and one school for sanitarians; (ii) providing the required material, logistics and financial support to conduct training programs; and (iii) establish two units in MOH's Training Department, one for conducting distance education, and the other for materials testing and evaluation. | (i) rehabilitation/upgrading completed for Zewditu and St. Paul nursing schools, Addis Ababa school for laboratory technicians, Awassa & Menelik schools for health assistants, and Jimma school for sanitarians; (ii) basic and in-service training materials provided to schools; books, journals and other education materials and office equipment procured; and (iii) for the testing and evaluation unit, awaiting a Governmental proclamation for establishing a Health Professional Council for testing and certifying all categories of health professionals; and for the distance education unit, a survey was completed, and report submitted to Minister of Health. | S |
| Institutional Development | (i) constructing 3 regional health bureaus and 3 zonal health offices; and (ii) strengthening key health departments/units at central, regional and zonal levels by rationalizing their staffing and organization in line with the Borrower's decentralization policy, and through provision of logistical support, office equipment and supplies, and budgets for operational expenses and maintenance. | (i) regional health bureaus and zonal offices constructed; and (ii) equipment and supplies were provided; government has separately rationalized their staffing and organization at various tiers of health institutions in line with the regionalization policy. | S |
| Health Education and IEC | (i) strengthening MOH's program for health education and information, education and communication (IEC) by construction/rehabilitation of the print shop and audio-visual studio, and provision of the required equipment, supplies, materials and logistical support; and (ii) support for preparation, testing, distribution and evaluation of health education and IEC materials. | (i) print shop and audio-visual studio constructed; video products, photographic supplies, computer and lab equipment, as well as other machines and consumables have been procured; (ii) Ongoing testing and preparation; proposal for establishing a semi-autonomous Health Education Coordination and Health Learning Materials Production Center under the Ministry of Health has been submitted for approval by the Council of Ministers. | S |
| Pharmaceuticals | (i) providing drugs and improving the storage and distribution system for pharmaceuticals; (ii) developing a drugs quality control system/unit; and (iii) improving supervision and monitoring by MOH's Pharmacy Department and Family Health Project Coordination Office (PCO). | (i) Drugs and contraceptives procured as planned; drugs storage facility dropped and further review is being conducted under PHRD studies and due to institutional changes computerization of EPHARM also dropped (ii) drug laboratory constructed, also furnished and equipped (staff already functioning in old building); and (iii) Government has strengthened capacity and reviewed staffing patterns. | MS** |
| Studies | (i) A review of the hospital sector, focusing particularly on the proposed experiment with management boards for hospitals and the effectiveness of providing support and referral services to primary care providers; and (ii) a study of health financing options aimed at generating additional funds for the health sector. | (i) Conducted by the Governments of Ethiopia and Finland; and (ii) conducted by Government of Ethiopia and USAID. | S |

* As per amended DCA, amendment dated April 1994.

** Marginally Satisfactory

24. **Key Lessons Learned.** The important lessons to be drawn from the FHP implementation experience are summarized below:

- The continuous monitoring by the Government high-level committees was instrumental in facilitating and expediting implementation. Such close monitoring efforts by MOH had a salutary effect on project implementation, and will in the long run have a beneficial impact in achieving and sustaining development objectives.

**Capacity Issue**

- Despite FHP efforts, absence of **sufficient capacity** is a significant problem in the implementation process. The devolution of power to regions has created a conducive environment for regions to decide and implement programs which benefit their communities; however, the problem of getting sufficiently qualified staff to effectively utilize the decentralized powers continues in some regions. Increased **turnover and inadequate trained staff** are major impediments to proper project implementation. Lack of sufficient incentives is partly to blame for the rapid turnover and recruitment of sufficient staff. Government decisions which ensure stability in project implementation staff and incentives to recruit and maintain the services of the trained and competent staff will improve project performance. Carefully planned training in various areas including procurement, disbursement and contract management is found to accelerate implementation of project activities. Attractive salaries and sufficient incentives should be created to invite the required trained manpower to work in regions.

- Lack of **capacity and incentives** to encourage supervision (low per diems, unavailability of transport facilities) are closely associated with poor construction work. Measures such as involvement of short-term consultants (supervisors) to support supervision and creation of sufficient incentives for construction supervisors will help improve regular supervision to construction sites.

**Civil Works**

- Although timely completion of civil works is a commendable achievement, the **quality of construction** was, in a number of cases, a cause for concern. It is felt that future projects would benefit by provision of greater resources for supervision, as well as more detailed drawings and specifications. References to required national as well as international standards should be made in specifications.

- The FDRE approval process for **variation orders** is considered to be lengthy and the cost limits up to which decisions can be taken at the local level are low. In the past, variations up to 15 percent could have been approved by the Engineering Department. In order to increase transparency, the process was tightened, and the revised procedures are lengthy, and delegation limits may need to be reconsidered.

- Regular and stringent **supervision** by engineering staff of the Regional and Zonal Health Bureaus and MOH is essential for good quality civil works. Project supervision by MOH suffered due to attrition of staff and a heavy workload. This issue must be addressed before a second IDA-financed project is undertaken. In view of the large disparity between employment conditions in the private sector and in government, it is becoming increasingly difficult to recruit and keep qualified and experienced engineers. In future, it might become necessary to rely to a greater extent on consultancy firms or individuals paid on a competitive basis.

**Planning and Financial Management**

- An **Implementation Manual** would have been very useful in clarifying responsibilities and duties of the different partners -- PCO, Architectural and Engineering Unit, and other implementing agencies. Similarly, the implementation plan and budget for the first year should have been part of the project preparation and not a condition of effectiveness. If the PCO approach is adopted for project implementation, it is necessary to ensure that processes are in place to work closely with its other partners in MOH.

- The coordination between completion of **construction work and provision of furniture and equipment** to these facilities remains a difficult issue. It is essential that the procurement of equipment and facilities coincide as closely as possible with the expected date(s) of completion of the construction activities.

- It is suggested that a Project Launch workshop be conducted, covering procurement, disbursement and financial management, for all regional staff before effectiveness of the next Bank-supported program in Health.

- *Procurement.* Model bidding documents for national procurement of goods, works and services could be prepared and agreed up-front with all regions. It may also be useful to ensure a consistent evaluation report format for all regions.

- *Disbursement.* The **payments process** has been lengthy under FHP, and delays and stoppages have occurred, both for small and larger contractors. Although overall financial accountability under the FHP had to be with the MOH at the Center, for future IDA projects, it may be useful to consider streamlining the decision-making process to the regions.

- *Audits.* Audit reports were always delayed and were not in full compliance with Bank guidelines on audit preparation. There is need to review current procedures to ensure that processes for audit preparation result in timely and satisfactory audits.

- The development of a continuous follow-up mechanism at ground level appears to generate substantial improvement in project implementation, the ongoing strengthening of the Resident Mission's capacity should facilitate necessary support at the center.

**ETHIOPIA**
**FAMILY HEALTH**
**Table 1A: Summary of Assessments**

| | Substantial | Partial | Negligible | Not applicable |
|---|---|---|---|---|
| **A. Achievement of Objectives** | | | | |
| Macroeconomic policies | | | | X |
| Sector policies | | X | | |
| Financial objectives | | | | X |
| Institutional development | | X | | |
| Physical objectives | X | | | |
| Poverty reduction | | | | X |
| Gender issues | | X | | |
| Other social objectives | | X | | |
| Environmental objectives | | | | X |
| Public sector management | | | | X |
| Private sector development | | | | X |
| Other (specify) | | | | X |
| | **Likely** | **Unlikely** | **Uncertain** | |
| B. Project Sustainability | X | | | |
| | **Highly Satisfactory** | **Satisfactory** | **Deficient** | **Highly Unsatisfactory** |
| C. Bank performance | | | | |
| Identification | | X | | |
| Preparation assistance | | X | | |
| Appraisal | | | X | |
| Supervision | | X | | |
| D. Borrower performance | | | | |
| Preparation | | X | | |
| Implementation | | X | | |
| Covenant compliance | | X | | |
| Operation (if applicable) | | X | | |
| | **Highly Satisfactory** | **Satisfactory** | **Unsatisfactory** | **Highly Unsatisfactory** |
| E. Assessment of outcome | | X | | |

**ETHIOPIA**

**Family Health (Maternal and Child Health /Family Planning Component)**

**Table 1B: Summary of Assessments (continued)**

| | | | | |
|---|---|---|---|---|
| **A. Achievement of Objectives** | | | | |
| Macroeconomic policies | | | | X |
| Sector policies | | X | | |
| Financial objectives | | | | X |
| Institutional development | | X | | |
| Physical objectives | X | | | |
| Poverty reduction | | | | X |
| Gender issues | X | | | |
| Other social objectives | X | | | |
| Environmental objectives | | | | X |
| Public sector management | | | | X |
| Private sector development | | | | X |
| Other (specify) | | | | X |
| | | | | |
| B. Project Sustainability | X | | | |
| | | | | Highly Unsatisfactory |
| C. Assessment of outcome | X | | | |

**ETHIOPIA**
**Family Health (Manpower Development)**
**Table 1C: Summary of Assessments (continued)**

| | Substantial | Partial | Negligible | Not applicable |
|---|---|---|---|---|
| **A. Achievement of Objectives** | | | | |
| Macroeconomic policies | | | | X |
| Sector policies | | X | | |
| Financial objectives | | | | X |
| Institutional development | | X | | |
| Physical objectives | X | | | |
| Poverty reduction | | | | X |
| Gender issues | | | | X |
| Other social objectives | | | | X |
| Environmental objectives | | | | X |
| Public sector management | | | | X |
| Private sector development | | | | X |
| Other (specify) | | | | X |
| | **Likely** | **Unlikely** | **Uncertain** | |
| B. Project Sustainability | X | | | |
| | **Highly Satisfactory** | **Satisfactory** | **Unsatisfactory** | **Highly Unsatisfactory** |
| C. Assessment of outcome | | X | | |

**ETHIOPIA**
**Family Health (Institutional Development)**
**Table 1D: Summary of Assessments (continued)**

| | Substantial | Partial | Negligible | Not applicable |
|---|---|---|---|---|
| **A. Achievement of Objectives** | | | | |
| Macroeconomic policies | | | | X |
| Sector policies | | | | X |
| Financial objectives | | | | X |
| Institutional development | | X | | |
| Physical objectives | X | | | |
| Poverty reduction | | | | X |
| Gender issues | | | | X |
| Other social objectives | | | | X |
| Environmental objectives | | | | X |
| Public sector management | | | | X |
| Private sector development | | | | X |
| Other (specify) | | | | X |
| | **Likely** | **Unlikely** | **Uncertain** | |
| B. Project Sustainability | X | | | |
| | **Highly Satisfactory** | **Satisfactory** | **Unsatisfactory** | **Highly Unsatisfactory** |
| C. Assessment of outcome | | X | | |

**ETHIOPIA**

**Family Health (Health Education)**

**Table 1E: Summary of Assessments (continued)**

| | Substantial | Partial | Negligible | Not applicable |
|---|---|---|---|---|
| **A. Achievement of Objectives** | | | | |
| Macroeconomic policies | | | | X |
| Sector policies | | X | | |
| Financial objectives | | | | X |
| Institutional development | | X | | |
| Physical objectives | X | | | |
| Poverty reduction | | | | X |
| Gender issues | | X | | |
| Other social objectives | | X | | |
| Environmental objectives | | | | X |
| Public sector management | | | | X |
| Private sector development | | | | X |
| Other (specify) | | | | X |
| | **Likely** | **Unlikely** | **Uncertain** | |
| B. Project Sustainability | X | | | |
| | **Highly Satisfactory** | **Satisfactory** | **Unsatisfactory** | **Highly Unsatisfactory** |
| C. Assessment of outcome | | X | | |

**ETHIOPIA**
**Family Health (Pharmaceuticals)**
**Table 1F: Summary of Assessments (continued)**

| | Substantial | Partial | Negligible | Not applicable |
|---|---|---|---|---|
| **A. Achievement of Objectives** | | | | |
| Macroeconomic policies | | | | X |
| Sector policies | | | X | |
| Financial objectives | | | | X |
| Institutional development | | X | | |
| Physical objectives | | X | | |
| Poverty reduction | | | | X |
| Gender issues | | | | X |
| Other social objectives | | | | X |
| Environmental objectives | | | | X |
| Public sector management | | | | X |
| Private sector development | | | | X |
| Other (specify) | | | | X |
| | **Likely** | **Unlikely** | **Uncertain** | |
| B. Project Sustainability | X | | | |
| | **Highly Satisfactory** | **Satisfactory** | **Unsatisfactory** | **Highly Unsatisfactory** |
| C. Assessment of outcome | | X/ | X | |

**ETHIOPIA**
**Family Health (Studies)**
**Table 1G: Summary of Assessments (continued)**

| | Substantial | Partial | Negligible | Not applicable |
|---|---|---|---|---|
| **A. Achievement of Objectives** | | | | |
| Macroeconomic policies | | | | X |
| Sector policies | | X | | |
| Financial objectives | | | | |
| Institutional development | | X | | |
| Physical objectives | | | | |
| Poverty reduction | | | | X |
| Gender issues | | | | X |
| Other social objectives | | | | X |
| Environmental objectives | | | | X |
| Public sector management | | | | X |
| Private sector development | | | | X |
| Other (specify) | | | | X |
| | **Likely** | **Unlikely** | **Uncertain** | |
| B. Project Sustainability | | | | |
| | **Highly Satisfactory** | **Satisfactory** | **Unsatisfactory** | **Highly Unsatisfactory** |
| C. Assessment of outcome | | X | | |

**Ethiopia**
**Family Health Project**
**Table 2: Related Bank Credits**

| | | | |
|---|---|---|---|
| **On-going Operations** | | | |
| Ethiopia Social Rehabilitation and Development Fund Project<br>(Cr. 2841-ET)<br>US$ 242.4 million | The ESRDF will (i) support community initiatives to construct or rehabilitate, and maintain basic economic and social infrastructure (i.e. health facilities) and services necessary for improved incomes, health and productivity; (ii) increase community capacity to identify development priorities, manage project implementation, and maintain ESRDF-financed assets; (iii) support measures beneficial to environmental conservation and rehabilitation; and (iv) respond to the needs of vulnerable groups especially poor women. It focuses exclusively on sustainable developmental initiatives, and will support the establishment of a Welfare Monitoring System to improve the collection and analysis of information used to guide poverty reduction efforts, and track the impact of policy measures on the poor. | 1996 | Closing 12/31/01 |
| Water Supply Development and Rehabilitation<br>(Cr. 2482-ET)<br>US$ 65.5 million | To ensure the long-term viability of water supply and sanitation operations in line with the Government's regionalization policies and, in the long run, improve the health and productivity of the population by providing assistance for: (i) capacity building of the Regional Governments and water supply and sanitation agencies for management of urban and rural water supply operations; (ii) formulation of policies to ensure long-term financial and managerial viability of water supply operations, establishment of regulatory arrangements and sound investment planning; and (iii) short- and medium-term physical rehabilitation, augmentation and establishment of urban water supply and sanitation schemes. | 1996 | Closing on 6/30/00 |

**Ethiopia**
**Family Health Project**
**Table 3: Project Timetable**

| Steps in Project Cycle | Date | Date |
|---|---|---|
| Identification | | April/May 1985 |
| Appraisal | October 1986 | November 1986 |
| Negotiations | March 1987 | April 6-15, 1988 |
| Board Presentation | May 1987 | June 2, 1988 |
| Signing | | July 14, 1988 |
| Effectiveness | | March 14, 1989 |
| Establishment of Special Account | | February 14, 1989 |
| **Changes to the Development Credit Agreement:**<br>• increase in disbursement percentages<br>• reallocation of funds from unallocated category to newly created Pharmaceuticals & Medical Supplies Category (for ERRP)<br>• reallocation of US$2.5 million from Civil Works to Pharmaceuticals and Medical Supplies<br>• amendment of Schedule 1 to reallocate proceeds of Credit; because project now covered a different geographical area, Article III amended to reflect this change; and to reflect main features of the re-designed project, amendments made to Article III and Schedules 2 and 5 (respectively, the Covenants, Project Description and Action Plan). | | January 1991<br>December 1991<br>July 1992<br>April 1994 |
| Project Completion | December, 1996 | June 30, 1997 |
| Closing (for all components except for pharmaceuticals, category 9 of the DCA's Schedule 1) | December 31, 1997 | December 31, 1997 |
| Closing of Category 9 | | January 31, 1998 |
| Full Project Closing | | June 30, 1998 |

**Ethiopia**
**Family Health Project**
**Table 4: Credit Disbursements, Estimated and Actuals**

| Fiscal Year | Quarter | | SAR Estimates | | | Actual | | |
|---|---|---|---|---|---|---|---|---|
| | | | Quarterly | Cumulative | Cum. % of total | Quarterly | Cumulative | Cum. % of total |
| FY 89 | Q1 | 9/88 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | Q2 | 12/88 | 1.00 | 1.00 | 3.00 | 0.00 | 0.00 | 0.00 |
| | Q3 | 3/89 | 0.35 | 1.35 | 4.00 | 0.32 | 0.32 | 0.99 |
| | Q4 | 6/89 | 0.45 | 1.80 | 5.00 | 0.00 | 0.32 | 0.99 |
| FY 90 | Q1 | 9/89 | 0.45 | 2.25 | 7.00 | 2.00 | 2.31 | 7.23 |
| | Q2 | 12/89 | 0.60 | 2.85 | 9.00 | 0.00 | 2.31 | 7.23 |
| | Q3 | 3/90 | 0.60 | 3.45 | 10.0 | 0.16 | 2.47 | 7.72 |
| | Q4 | 6/90 | 0.62 | 4.07 | 12.0 | 0.15 | 2.62 | 8.20 |
| FY 91 | Q1 | 9/90 | 0.62 | 4.69 | 14.0 | 0.14 | 2.76 | 8.62 |
| | Q2 | 12/90 | 1.00 | 5.69 | 17.0 | 0.14 | 2.90 | 9.08 |
| | Q3 | 3/91 | 1.00 | 6.69 | 20.0 | 0.17 | 3.07 | 9.61 |
| | Q4 | 6/91 | 1.25 | 7.94 | 25.0 | 0.02 | 3.09 | 9.67 |
| FY 92 | Q1 | 9/91 | 1.25 | 9.19 | 28.0 | 0.00 | 3.09 | 9.67 |
| | Q2 | 12/91 | 1.40 | 10.59 | 32.0 | 0.00 | 3.09 | 9.67 |
| | Q3 | 3/92 | 1.40 | 11.99 | 36.0 | 0.13 | 3.23 | 10.09 |
| | Q4 | 6/92 | 1.55 | 13.54 | 41.0 | 2.18 | 5.41 | 16.91 |
| FY 93 | Q1 | 9/92 | 1.70 | 15.24 | 46.0 | 0.73 | 6.14 | 19.19 |
| | Q2 | 12/92 | 1.70 | 16.94 | 51.0 | 4.14 | 10.29 | 32.17 |
| | Q3 | 3/93 | 1.60 | 18.54 | 56.0 | 1.13 | 11.42 | 35.69 |
| | Q4 | 6/93 | 1.55 | 20.09 | 61.0 | 0.70 | 12.12 | 37.88 |
| FY 94 | Q1 | 9/93 | 1.55 | 21.64 | 65.0 | 0.00 | 12.12 | 37.88 |
| | Q2 | 12/93 | 1.20 | 22.84 | 69.0 | 0.55 | 12.67 | 39.59 |
| | Q3 | 3/94 | 1.20 | 24.04 | 73.0 | 0.00 | 12.67 | 39.59 |
| | Q4 | 6/94 | 1.00 | 25.04 | 76.0 | 0.00 | 12.67 | 39.59 |
| FY 95 | Q1 | 9/94 | 1.00 | 26.04 | 79.0 | 0.00 | 12.67 | 39.59 |
| | Q2 | 12/94 | 0.85 | 26.89 | 82.0 | 0.00 | 12.67 | 39.59 |
| | Q3 | 3/95 | 0.85 | 27.74 | 84.0 | 1.07 | 13.73 | 42.93 |
| | Q4 | 6/95 | 0.85 | 28.59 | 87.0 | 0.00 | 13.73 | 42.93 |
| FY 96 | Q1 | 9/95 | 0.85 | 29.44 | 89.0 | 0.43 | 14.17 | 44.29 |
| | Q2 | 12/95 | 0.75 | 30.19 | 92.0 | 0.00 | 14.17 | 44.29 |
| | Q3 | 3/96 | 0.75 | 30.94 | 94.0 | 0.00 | 14.17 | 44.29 |
| | Q4 | 6/96 | 0.70 | 31.64 | 96.0 | 1.36 | 15.53 | 48.55 |
| FY 97 | Q1 | 9/96 | 0.70 | 32.34 | 98.0 | 2.46 | 17.99 | 56.25 |
| | Q2 | 12/96 | 0.66 | 33.00 | 100.0 | 1.50 | 19.49 | 60.93 |
| | Q3 | 3/97 | | | | 1.97 | 21.47 | 67.11 |
| | Q4 | 6/97 | | | | 1.62 | 23.09 | 72.17 |
| FY 98 | Q1 | 9/97 | | | | 1.70 | 24.79 | 77.48 |
| | Q2 | 12/97 | | | | 3.74 | 28.53 | 89.18 |
| | Q3 | 3/98 | | | | 0.74 | 29.27 | 91.18 |
| | Q4 | 6/98 | | | | 2.12 | 31.39 | 94.60 |

**Ethiopia**
**Family Health Project**
**Table 5a: Project Costs (US$ millions)****

| Items | Appraisal Estimates | | | Actual/Latest Estimate | | |
|---|---|---|---|---|---|---|
| Component | Local Cost | Foreign Cost | Total | Local Cost | Foreign Cost | Total |
| Maternal and Child Health/Family Planning (originally called Area Component) | 8.03 | 8.22 | 16.25 | 13.43 | 1.67 | 15.10 |
| Manpower Development | 3.24 | 2.61 | 5.85 | 2.48 | .89 | 3.37 |
| Pharmaceuticals Development | 2.29 | 3.29 | 5.58 | .17 | 12.31 | 12.48 |
| Health Education (IEC) | 1.81 | 1.08 | 2.89 | .82 | 1.4 | 2.22 |
| Institutional Development | 2.56 | 1.08 | 3.64 | 3.80 | 1.35 | 5.15 |
| Studies | - | 0.02 | 0.02 | 0 | 0 | 0 |
| Project Preparation Facility | 0.15 | 0.86 | 1.01 | - | - | - |
| Total Baseline Costs | 18.08 | 17.16 | 35.24 | | | |
| Contingencies | | | | | | |
| Physical Contingencies | 0.52 | 0.78 | 1.30 | | | |
| Price Contingencies | 4.46 | 2.86 | 7.32 | | | |
| Total | 23.06 | 20.80 | 43.86 | 20.7 | 17.62 | 38.32 |

* Government Contribution was reduced since it was decided in 1991, that 100% of expenditure for drugs and contraceptives would be financed by the credit. This reduced requirement for counterpart funding by US $ 1.72 million. Also, the figure stated above does not include salaries to be paid by the government for staff of constructed facilities, because most of the facilities became operational or are becoming operational in 1998. In 1994, the Government also decided that it would not use IDA credit for any recurrent costs other than drugs and contraceptives.

** US$ 1.7 million to be cancelled.

** Allocation from UNICEF never received.

**Ethiopia**
**Family Health Project**
**Table 5b: Project Financing Plan, SAR Estimates and Actual (in US$ millions)**

| Financing Plan | SAR Estimates | | | Actual | | |
|---|---|---|---|---|---|---|
| | Local | Foreign | Total | Local | Foreign | Total |
| Government of Ethiopia | 10.36 | 0 | 10.36 | 6.93 | 0 | 6.93* |
| IDA | 12.70 | 20.30 | 33.00 | 13.77 | 17.62 | 31.39** |
| UNICEF | 0 | 0.50 | 0.50 | 0 | 0 | 0*** |
| Total | 23.06 | 20.80 | 43.86 | 20.7 | 17.62 | 38.32 |

* Government Contribution was reduced since it was decided in 1991, that 100% of expenditure for drugs and contraceptives would be financed by the credit. This reduced requirement for counterpart funding by US $ 1.72 million. Also, the figure stated above does not include salaries to be paid by the government for staff of constructed facilities, because most of the facilities became operational or are becoming operational in 1998. In 1994, the Government also decided that it would not use IDA credit for any recurrent costs other than drugs and contraceptives.

** US$ 1.7 million to be cancelled.

*** Allocation from UNICEF never received.

**Ethiopia**
**Family Health Project**
**Table 6: Key Implementation Indicators (From the SAR and from Relaunch of Project )**

| Key Implementation Indicators in the SAR | Estimated in the SAR | After March 1994 Relaunching | Actual |
|---|---|---|---|
| **Area Development-MCH/FP** | | | |
| Strengthening of MCH/FP services through rehabilitation, refurbishing and re-equipping of health facilities | 180 health stations<br>18 health centers<br>3 rural hospitals<br>3 new health centers<br>(to take place in the Shewa Regions) | 100 health stations (rehabilitation of 39 health stations and reconstruction of 61 health stations in regions 1, 2, 3, 5, 6, 7, 10, 11, and 12)<br><br>rehabilitation of 10 health centers and construction of 9 health centers in regions 1,3,6,7,10 and 12<br><br>Procurement of furniture, equipment and supplies for rehabilitated new health facilities/offices | 96 H.Ss completed; 4 H.Ss -- work discontinued due to local security problem and default of contractor. Regional Governments have assumed responsibility to complete them.<br><br>all are completed<br><br>Delivered |
| increase in the availability of MCH drugs, contraceptives, materials, and supplies in health facilities | double the supply which in 1989 was only 50% of the amount needed to meet existing levels of demand (limited to Shewa Regions) | Procurement of MCH Kits (A and B)<br><br>Procurement of drugs and contraceptives | Delivered<br><br>Delivered |
| **Manpower Development** | | | |
| improve quality of health manpower training | Conduct Basic Training<br><br>Conduct post-basic training | Training in program management<br><br>Training of trainers in family planning<br><br>Training of CBD agents<br><br>Orientation seminar on population policy | Done (with UNFPA support)<br><br>Done (with SIDA support)<br><br>Done (with UNFPA and GTZ support)<br><br>Done (with UNFPA support) |
| improve quality of health manpower training | Needs assessment of, and conducting in-service training, seminars and workshops | maintained at relaunch | Done; annual feature |
| improve quality of health manpower training | establish regional training centers | maintained at relaunch | Being done by Regional Health Bureaus |

**Table 6 Continued : Key Implementation Indicators (From the SAR and from Relaunch of Project )**

| Key Implementation Indicators in the SAR | Estimated in SAR | After March 1994 Relaunching | Actual |
|---|---|---|---|
| Provide required material, logistics and financial support to conduct training programs | | ***Curriculum development and implementation for:*** | |
| | | B.Sc. in sanitation | Done; first group graduated from 2 ½ year course in 1997 |
| | | Public health technician | Done; B.Sc. program is ongoing |
| | | Health education | Curriculum developed; program expected to be launched soon |
| | | Community health nursing | Done; first group has graduated; diploma & certificate programs being developed |
| | | Health Service administration | Included in bachelors degree course in public health |
| | | Nursing Administration | Included in bachelors degree course in nursing |
| | | Management and supervision | Done; periodic |
| | | ***Curriculum revision and implementation for:*** | |
| | | diploma in radiology | done, at diploma and certificate levels |
| | | diploma in sanitation | curriculum developed for certificate course in environmental sanitation |
| | | training health assistants to be nurses | ongoing |
| Establish two units in MOH training department | | establish a testing and measurement unit | Awaiting a Governmental proclamation for establishing a Health Professional Council for testing and certifying all categories of health professionals |
| | | establish a distance education unit, preparing learning materials and conducting distance education | Survey completed, and report submitted to Minister of Health |
| Procurement of Office equipment and Education Materials | | maintained at relaunch | Delivered |

**Table 6 Continued : Key Implementation Indicators (From the SAR and from Relaunch of Project )**

| Key Implementation Indicators (From SAR) | Estimated in the SAR | After March 1994 Relaunching | Actual |
|---|---|---|---|
| Procurement of library materials and books | | maintained at relaunch | Delivered |
| Rehabilitation and upgrading of training schools | Zewditu and St. Paul nursing schools | maintained at relaunch | Completed |
| | Addis Ababa school for laboratory technicians | maintained at relaunch | Completed |
| | Awassa & Menelik schools for health assistants | maintained at relaunch | Completed; (but to serve different purpose) |
| | Jimma school for sanitarians | maintained at relaunch | Completed |
| **Institutional Development** | | | |
| Strengthening of Planning and Programming Department of MOH and key units in MOH, including the architectural unit; the management information unit and the procurement unit and the MCH unit; establishment of new unit responsible for building, vehicle and equipment maintenance. | appointment of additional staff. | Rationalizing staffing pattern of restructured central MOH and regional, zonal, and lower-level health offices | Being Done |
| | Operational Support (incentives and per diems, salaries, vehicle maintenance, fuel expenses, etc. | maintained at relauch | Ongoing |
| | vehicles | maintained at relaunch | Delivered |
| | Office supplies and consumables for PCO and other support units of MOH | maintained at relaunch | Delivered |
| | establishment of new unit in MOH | Construct 3 regional bureaus<br>Construct 3 zonal offices<br>*Training, workshops/seminars and study tours for:*<br>Management of decentralized health services.<br>Computers/HIS logistics | Completed<br>Completed<br>Ongoing; in the context of regionalization of health services<br>Canceled |

**Table 6 Continued : Key Implementation Indicators (From the SAR and from Relaunch of Project )**

| Key Implementation Indicators in the SAR | Estimated in the SAR | After March 1994 Relaunching | Actual |
|---|---|---|---|
| **Health Education and IEC** | | | |
| To strengthen capacity to provide health education | | Preparation, field testing, training, distribution and evaluation of Health Education and IEC materials | Ongoing; Proposal for establishing a semi-autonomous Health Education Coordination and Health Learning Materials Production Center under the Ministry of Health has been submitted for approval by the Council of Ministers |
| | | Printing, publishing, and electronic equipment | Delivered |
| | Consumables and supplies | maintained at relaunch | Ongoing |
| | | Construction and renovation of print shop | Completed |
| | | Construction and renovation of audio-visual studio | Completed |
| **Pharmaceutical Development** | | | |
| improve supply of drugs available to peripheral health facilities; support for investments to increase MOH's existing drug manufacturing plant | renovation and equipping of the central medical stores | replaced by construction of specialized storage facilities at the central medical stores | Government & IDA later agreed to delete this activity from the FHP |
| | establishment of 7 new regional stores and one bonded warehouse | Computerization of EPHARM | Government and IDA later agreed to delete this action from FHP |
| | establishment of a pharmaceutical and medical supply control department with the capacity to quality test drugs on a routine basis | Construction of a small quality control laboratory for drugs | Completed |
| **Studies** | | | |
| Support to MOH for studies to carry out various reviews. | review of hospital sector | maintained at relaunch | Conducted by TGE and Government of Finland |
| | review health financing options | maintained at relaunch | Conducted by TGE and USAID |
| | development of management system | maintained at relaunch | Conducted under PHRD grants |

**Ethiopia**
**Family Health Project**
**Table 7: Studies Conducted Under the Project**

| Study/purpose of study | Status | Impact of study |
|---|---|---|
| 1. Review of the hospital sector, focusing on the proposed experiment with hospital management boards and the effectiveness of providing support and referral services to primary health care workers | A similar study on the Black Lion hospital in Addis Ababa has been done with support from the Government of Finland. | Not clear. Government is proposing minimal expenditure, plus handover from MOH to Addis Ababa University, which has agreed. |
| 2. Review of health financing options | Because a similar study has been done by Government with USAID support, and additional studies are being conducted on related topics under the PHRD Grant agreement between the TGE and IDA, it was proposed to delete this activity from FHP. The MOH-USAID and PHRD reports have been completed and have been extensively discussed with donors, including IDA. | Study has been used to formulate a health care financing strategy which has been submitted to the office of the Council of Ministers. |
| 3. Review of organizational and management issues related with MOH | This study was dropped from FHP during the time of the project re-launch in March 1994.<br><br>MOH established a Task Force to examine functions, structure and staffing of MOH in the context of the newly introduced decentralization policies. Major downsizing of the MOH has resulted in a substantial downsizing of its central departments.<br><br>Studies on health facilities management and utilization were conducted under the PHRD Grant agreement between TGE and IDA. The total cost of the PHRD studies already completed is over $800,000 (compared with the SDR20,000 allocated under the FHP). | Results to be used in HSDP. |

**Ethiopia**
**Family Health Project**
**Table 8: Status of Legal Covenants**

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | |
| **Section 3.01 (a)** | The Borrower shall carry out the Project through MOH, with due diligence and efficiency and in conformity with appropriate financial, engineering and public health practices, and shall provide, promptly as needed, the funds, facilities, services and other resources required for the project. | Implementation | Complied with | N/A | N/A | Continuous requirement. |
| **Section 3.01 (b)** | The Borrower shall carry out the Project in accordance with the Action Plan set forth in Schedule 5 of the Agreement. | Monitoring review and reporting | Complied with | N/A | N/A | Project was implemented in compliance with central and regional action plans. |
| **Section 3.02** | Except as the Association shall otherwise agree, procurement of goods, works, and consultants' services required for the Project and to be financed out of the proceeds of the Credit shall be governed by the provisions of Schedule 3 to this agreement. | Flow and utilization of project funds | Complied with | N/A | N/A | In compliance. |
| **Section 3.03** | The Borrower shall, from time to time, but no less than once every 12 months, exchange views with the Association on: | Sectoral or cross-sectoral regulatory/ institutional action | | | | MOF Mission. |
| **Section 3.03 (a)** | The population policies and annual implementation plans which the Borrower is developing within the framework of the preparation of the Borrower's Action Plan for implementing its national population policy for the 1994-1996 period. | Sectoral or cross-sectoral regulatory/ institutional action | Complied after delay | N/A | N/A | The National Population Policy was officially introduced in April 1993. The MOH has helped formulate the policy. MCH/FP services are being provided nation-wide. Action plan implemented only partially. |

**Ethiopia**
**Family Health Project**
**Table 8: Status of Legal Covenants (continued)**

| [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] |
|---|---|---|---|---|---|---|
| **Section 3.03 (b)** | The health financing alternatives which the Borrower is examining for the purpose of implementing its national health policy. | Sectoral or cross-sectoral regulatory/ institutional action | Complied after delay | N/A | N/A | Picked up in the discussions for the proposed Health Sector Development Program. |
| **Section 3.03 (c)** | The measures proposed by the Borrower to increase recurrent resources available for no-salary expenditures for the Borrower's health sector. | Sectoral or cross-sectoral regulatory/ institutional action | Complied after delay | N/A | N/A | Annual |
| **Section 3.03 (d)** | The results of the measures the Borrower has introduced to improve the effectiveness of health providers at the community level. | Sectoral or cross-sectoral regulatory/ institutional action | Complied after delay | N/A | N/A | Some of the issues were discussed during the PHRD workshops held in Addis Ababa in July 1996 & January 1998 and the GOE-Donor SIP workshop in March, 1997. |
| **Section 3.04 (a)** | During the execution of the Project, the Borrower shall maintain a health education coordinating committee which shall meet on a regularly scheduled basis. | Monitoring, review and reporting | Complied with | | | This organizational framework is incorporated in the draft statute that was prepared to make HLMPC a semi-autonomous body. |
| **Section 3.04 (b)** | During execution of the Project, the Borrower shall maintain a project management unit with qualified staff in adequate numbers. | Management aspects of the Project or of its executing agency | Complied with | N/A | N/A | This is being complied with. Recently, a financial consultant was appointed to help MOH prepare the financial statements so as to prepare the audits in time. |

**Ethiopia**
**Family Health Project**
**Table 8: Status of Legal Covenants (continued)**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Section 3.05 (a)** | By February 1 of each year during execution of the Project, the Borrower shall furnish to the Association, for comment, a draft implementation plan and budget covering all activities to be carried out under the Project during the subsequent fiscal year of the Borrower. | Flow and Utilization of Project funds | Complied after delay | N/A | N/A | The Action Plan was a two year plan, and given that the project was completing its activities and closing, actions required for project closing were agreed upon during the July 1997 mission. |
| **Section 3.05 (b)** | By July 1 of each year during execution of the Project, the Borrower shall furnish to the Association the final implementation plan and budget for the subsequent fiscal year of the Borrower; such implementation plan and budget to take into account the comments made by the Association. | Flow and Utilization of Project funds | Complied after delay | N/A | N/A | |
| **Section 3.05 (c)** | By February 28 and August 31 of each year, during the implementation of the Project, and beginning with August 31, 1994, the Borrower shall submit to the Association reports, in such details as the Association shall reasonably request, on the progress achieved in carrying out the Project. | Monitoring review and reporting | Complied with | N/A | N/A | Monitoring tables are in project files. |
| **Section 3.06** | by 9/30/95, the Borrower shall prepare a project performance review covering the implementation period after 01/01/94, under terms of reference acceptable to the Association and, by 12/31/95, the Borrower shall review the findings and recommendations with the Association to rectify identified constraints. | Monitoring review and reporting | Complied after delay | N/A | N/A | Some of the constraints were addressed, and project implementation progress has improved significantly. |
| **Section 3.07** | The borrower shall (a) gradually expand the coverage of clinic- and community-based contraceptive distribution; and (b) not later than 12/31/95, submit to the Association a report, under terms of reference acceptable to the Association, and in such details as the Association may reasonably request, on contraceptive distribution. | Monitoring review and reporting | Complied with partially | N/A | N/A | |

**Ethiopia**
**Family Health Project**
**Table 8: Status of Legal Covenants (continued)**

| [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] |
|---|---|---|---|---|---|---|
| **Section 3.08** | The Borrower shall train qualified personnel, in adequate numbers, in health management and health teacher training, nurse-midwifery and MCH nursing and for the institutions participating in the Project. | Sectoral or cross-sectoral regulatory/ institutional action | Complied with | N/A | N/A | Done largely with donor financing. |
| **Section 4.01 (a)** | The borrower shall maintain or cause to be maintained records and accounts adequate to reflect in accordance with sound accounting practices the operations, resources and expenditures in respect of the Project of the departments or agencies of the Borrower responsible for carrying out the Project or any part thereof. | Accounts/ audit | Complied with | N/A | N/A | |
| **Section 4.01 (b)** | The Borrower shall have the records and accounts referred to in para. 4.01 (a), including those for the Special Account for each fiscal year audited, in accordance with appropriate auditing principles consistently applied, by independent auditors acceptable to the Association; and furnish these within 6 months of the end of the fiscal year to the Association. | Accounts/ audit | Not yet due | N/A | N/A | There are some queries that still need to be clarified by MOH on the last FY audits. |
| **Section 4.01 (c)** | For all expenditures with respect to which withdrawal from the Cr. A/c were made on the basis of statements of expenditure, the Borrower shall maintain such records in accordance with para. 4.01 (a) retain such records for at least 1 year after the Association has received the final audit report for the project, and ensure that such records are included in the annual audits referred to in para. 4.01 (b). | Accounts/ audit | Complied with | N/A | N/A | |

**Ethiopia**
**Family Health Project**
**Table 9: Bank Resources -- Staff Input**

| | | | | | | |
|---|---|---|---|---|---|---|
| **Preparation to Appraisal** | | | | | **40** | **77.8** |
| **Appraisal** | | | | | **41** | **81.1** |
| **Negotiations through Board Approval** | | | | | **11.5** | **23.4** |
| **Supervision** | **145** | **38.86** | **147.5** | **39.53** | **146.26**** | **393.19**** |
| **Completion** | **21.5*** | **47.5** | **16.7** | **27.4** | **9.1***** | **11.5***** |

* includes supervision costs as well; without supervision estimates, planned completion costs were approximately 7.5 weeks.
**as of 10/28/97
***as of 2/5/98

Memo:

Assumes average cost of US $2,680 per staff week (for planned estimates).

**ETHIOPIA**
**FAMILY HEALTH**
**Table 10: Bank Resources -- Missions**

| Stage of Project Cycle | Month/ Year | Number of Persons | Days in Field | Specialized staff skills represented | Performance Rating | | Types of Problem |
|---|---|---|---|---|---|---|---|
| | | | | | Implementation Status | Development Objectives | |
| Through Appraisal | | | | | | | MOH had limited project preparation capacity. GOE slow to process PPF request which delayed preparation of project by another 3 months.<br><br>Quality of component proposals produced by AMREF -- the main PPF consultants -- was in general unsatisfactory. |
| Appraisal through Board Approval | | | | | | | |
| Initial Summary | 6/88 | | | | NR | NR | |
| Supervision | 10/88 | 1 | 4 | Senior Planner | | No 590 form submitted | No progress towards implementation of project and of meeting condtions of effectiveness. The External Assistance Unit charged with routine management of the project still understaffed. Attempts to strengthen Archictectural & Engineering Unit unsuccessful. No disbursement under PPF2. |
| Portfolio Update | 6/89 | | | | S | S | |
| Supervision | 10/89 | 4 | 12 | Public Health Specialist, Operations Assistant, Architect, Management Specialist | S | S | Underestimation of cost of civil works, equipment, and furniture. Inadequate supervision by the Bank a problem. Lack of experience with Bank procedures resulted in project management unit having difficult time in initiating project activities. |
| Supervision | 6/90 | 4 | 12 | Sr. Public Health Specialist, Operations Assistant, Architect, Pharmaceutical Specialist | S | S | Major delays in civil works as a result of shortage of key building materials; Lack of progress on pharmaceutical component due to lack of understanding of objectives; Underestimation of cost of civil works, equipment and furniture, project funding only sufficient for about one third of health centers/health stations originally included in project. |

**Table 10: Bank Resources Continued -- Missions**

| Stage of Project | Month/ Year | Number of Persons | Days in Field | Specialized staff skills represented | Performance Rating | | Types of Problems |
|---|---|---|---|---|---|---|---|
| | | | | | Implem-entation status | Develop-mental Objectives | |
| Portfolio Update | 8/90 | | | | S | S | |
| Supervision | 3/91 | 2 | 8 | Sr. Public Health Specialist, Architect | S | S | Little progress made on civil works except for design work for health centers/health stations, unless action taken likelihood of costly overruns. Impossible to obtain realistic cost estimates or tenders as these will be based on controlled prices for materials which are not available through normal government resources. |
| Portfolio Update | 8/91 | | | | S | S | |
| Portfolio Update | 6/92 | | | | S | S | |
| Supervision | 10/92 | 2 | 2 | Principal Economist; Operations Assistant | | No form 590 submitted. | Need for restructuring given new Government in place and its desire to develop health/population programs to meet real and pressing needs of its population. |
| Supervision | 4/93 | 3 | 4 | Division Chief; Sr. Public Health Specialist; Principal Economist | | No form 590 submitted. | Activities proposed in restructuring proposal likely to cost more than the $20 million remaining in the project – prioritization needed. Government declined to discuss directions of proposed health policy. Ministry refused to participate in WDR workshop. |
| Portfolio Update | 9/93 | | | | US | US | |
| Supervision | 10/93 | 1 | 16 | Management Specialist | | No form 590 submitted. | Government's draft proposal concerning re-design of the project needs to be further modified. Better balance needed between (i) civil works and other expenditure categories particularly program supplies, drugs and contraceptives and (ii) between investment and recurrent costs, to ensure effectiveness and sustainability of health services. |
| Supervision | 11/93 | 7 | 26 | Management Specialist; Public Health Specialist; Health Finance Specialist; Architect; Pharmaceutical Specialists; Costing Specialist | | No form 590 submitted. | Implementation capacity is gradually being strengthened but will need to be nurtured in next 12 months. |

## Table 10: Bank Resources Continued – Missions

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | Implem-entation status | Develop-mental Objectives | |
| Supervision | 3/94 | 3 | 16 | Management Specialist; Architect; Implementation Specialist | US | S | Disbursement still slow. Implementation capacity of regional health bureaus is variable and will be closely monitored in coming months. Some of the risks originally identified in SAR remain, particularly the high cost of the hospital sub-sector and need for mobilizing more revenues to fund operations and maintenance. Outstanding audits need to be submitted to IDA. Possibility of gaps occurring in communication process between the Regions and the Center. |
| Supervision | 7/94 | 2 | 13 | Management Specialist; Implementation Specialist | S | S | Delay in implementation due to regional bureaus taking longer than anticipated to obtain approvals from their respective Regional Councils. Audit report delayed. |
| Portfolio Update | 9/94 | | | | S | S | |
| Portfolio Update | 1/95 | | | | S | S | |
| Portfolio Update | 6/95 | | | | S | S | |
| Supervision | 7/95 | 3 | 15 | Management Specialist; Implementation Specialist; Sector Specialist | S | S | Implementation capacity remains weak in many regions, but technical support is being provided by MOH staff; such intensive support from MOH will be needed throughout the project implementation period. |
| Supervision | 4/96 | 3 | 10 | Implementation Specialist; Disbursement officer; Public Health Specialist | S | S | Government requests reduction of counterpart funding for civil works from US$6.98 million. Retirement of FHP Coordinator has increased work load of remaining staff. Concern about proposed site of the Inflammable store, IDA mission requested government reconsider its placement in populated area. A few problems with contractors for civil works noted.<br><br>Funds allocated for study not being used. |

## Table 10: Bank Resources Continued -- Missions

| Stage of Project Cycle | Month/ Year | Number of Persons | Days in Field | Specialized staff skills represented | Performance Rating | | Types of Problem |
|---|---|---|---|---|---|---|---|
| | | | | | Implem-entation status | Develop-mental Objectives | |
| Supervision | 8/96 | 7 | 20 | Implementation Specialist; Health Specialist; Management Specialist; Architect; Disbursement Specialist; Loan Officer, Accounting & Auditing Specialist | S | S | Procurement of supplies and equipment was somewhat behind schedule. Project audits overdue by 7 months. Disbursements have not kept pace with actual implementation.<br><br>Capacity of engineering team at center and regional bureaus to supervise 78 civil works contracts executed in remote and scattered areas was of concern. Due to inadequate supervision, the quality of construction was below standard in a few cases. |
| Supervision | 1/97 | 2 | 10 | Health Specialist; Architect | S | S | Capacity of engineering team at the center and regional bureaus to supervise 78 civil works contracts executed in remote and scattered areas was of concern. |
| Supervision | 5/97 | 3 | 16 | Management Specialist; Implementation Specialist; Health Specialist | S | S | Supervision of civil works consistently identified problem. Process of collecting SOEs from the sub-project implementing agency and transferring them from the regional offices to the central office takes longer than anticipated. |
| Supervision | 12/97 | 2 | 16 | Implementation Specialist; Health Specialist | S | S | A few queries on the audit reports. Need for rectification of the audio-visual lab. It is likely that Category 9 may need to be extended to June 30, 1998 in order to permit MOH to buy additional drugs, given the acute drug shortage in health facilities across regions. |
| ICR Mission | 3/98 | 8 | 10 | Management Specialist; Implementation Specialist; Operations Analyst; Architects; Health Specialist; Disbursement Office; Economist | S | S | The Project closed on December 31, 1997, except for Category 9 of Schedule 1 of the DCA which was extended, and will be closed by April 30, 1998. |

Appendix A

# ETHIOPIA FAMILY HEALTH PROJECT (CR. 1913-ET)

## IMPLEMENTATION COMPLETION REPORT MISSION
## AIDE MEMOIRE
## JANUARY 29, 1998

## INTRODUCTION

1. An IDA mission visited Ethiopia from January 12-29, 1998 to prepare the Implementation Completion Report (ICR) for the Family Health Project (FHP). The team consisted of Mr. Pammi Sachdeva (Senior Management Specialist, Mission Leader), Ms. Gita Gopal (Co-Mission Leader and Task Manager), Dr. Gebreselassie Okubagzhi (RM Health Specialist), Mr. Bengt Jacobson (Architect, Swedish CTF Consultant), Ato Getahun Gebru (RM Disbursement Officer), Ato Josef Ghebre-Egziabher (architect, local consultant), Ms. Maryam Salim (Social Sector Analyst) and Ms. Christine Pena (Economist). The ICR is based on discussions with implementing agencies, particularly staff of the MOH and FHP Project Coordinating Office, visits to selected project sites, discussions of the MOH's draft contribution to the ICR, and a review of project documents and reports. The mission was unable to visit all the project sites, which cover most regions of the country -- these have, however, been visited by previous Bank implementation support missions, particularly the interim supervision missions from the resident mission in Addis Ababa.

2. The mission appreciates the cooperation and support of senior officials of the Ministry of Health and the regional health bureaus visited by the mission. We are particularly grateful to the Honorable Vice-Minister of Health, Dr. Lamissio Haisso, Ato Abduletif Abas (Head, MOH Planning and Programming Department), Ato Yohannes Tadesse (A/Head, Family Health Department), Dr. Yohannes Kebede (A/Head, Manpower Development Department), Ato Girma Teshome (FHP, A/Coordinator), Ato Sallehunae Kefyalew (Head, Architect and Engineering Department) and other staff of the FHP Coordination Office and MOH. Members of the mission also visited project sites in Addis Ababa and in the SNNPR and Gambella regions from January 14-21, where they met with Dr. Estifanos Birru (Head, SNNP Regional Health Bureau), Ato Ojulu Ochala (Head of Administration and Finance, Gambella Regional Health Bureau) and other staff of the regional and zonal bureaus. The mission thanks these regional staff for their assistance and support during the field visits.

3. This Aide Memoire summarizes the mission's key findings and conclusions. It takes account of discussions with staff of the MOH, regional health bureaus visited and FHP-PCO, and also the preliminary conclusions of the MOH's draft Project Completion Report (which is expected to be finalized shortly, and will be annexed to the Bank's ICR). The mission confirms that it has provided advice to the MOH for finalizing its own contribution to the ICR.

4. The mission congratulates staff of the MOH, FHP-PCO and regional health bureaus for successfully completing the Family Health Project by the original closing date of December 31, 1997. It notes in particular that project implementation during the first five years was especially difficult; but improved appreciably after the project was "re-designed and relaunched" in March 1994. It also notes that the relaunched project included nation-wide program activities, as well as rehabilitation and construction of basic health facilities in previously neglected regions, and has been implemented within an evolving administrative structure, in accordance with the Government's post-1991 emphasis on regionalization, democratization and decentralization throughout the country.

## MISSION'S FINDINGS AND CONCLUSIONS

5. **Achievement of Project Objectives.** The main objectives of the project were to: (a) increase the quality, coverage and cost-effectiveness of maternal and child health (MCH) services; (b) increase the availability and use of Family Planning services; and (c) strengthen the institutional capacity of the MOH. The FHP consisted of six components: MCH/FP, Manpower Development, Health Education and IEC, Institutional Development, Pharmaceuticals, and Studies. Overall, project objectives have been achieved satisfactorily. Mainly owing to ongoing civil strife in the country and the hiatus in the dialogue with the Bank (the new Government was formed in May 1991), implementation was extremely slow for the first five years (up to project relaunch in April 1994). By project completion, however, the FHP is contributing substantially to the provision of MCH services, mainly through its nation-wide program-support activities in manpower development, health education and materials development, pharmaceuticals procurement and quality control, rehabilitation and construction of health stations and health centers for provision of MCH-FP services in the regions.

6. **Project Implementation.** The project was expected to be disbursed over nine years (1988-1997); and despite the exceptionally difficult circumstances prevalent in the country in the early years of project implementation, it has been closed by the original date of December 31, 1997. During project implementation, the implementation capacity of the MOH was not as strong as anticipated; and was further eroded during recent years, mainly due to factors beyond the project's control. The planning, supervision and monitoring capacity of many regional health bureaus was similarly affected by changes in staffing, as well as increasing competition for trained staff from the private sector, thus leading to implementation difficulties for the FHP. The project has also suffered from a slow start up after its relaunch. The DCA was amended in April 1994, but effective implementation began only from January 1995. The new Government's policy of regionalization and decentralization, which call for devolution of authority and responsibility to regions for the implementation and management of developmental projects in their respective regions, was a departure from the earlier practice, of centralized project management by Ministries. Project implementation authority and responsibility were transferred to the regions. It, therefore, took time to: a) get the regional government staff to become familiarized with IDA's procurement procedures; b) prepare standard bidding documents (SBDs) to be used by the project; c) complete, and get approval of, the regional action plans; and d) prepare and give no-objection to SBDs. This start-up delay was understandable given the expansion of the geographical coverage of the project from the then one administrative region (Shewa) to a nation-wide project, including those regions which were lacking the required basic capacity and experience in implementing developmental projects.

7. These constraints in project implementation were recognized by MOH, and were sought to be overcome by a variety of means. These included regular high-level monitoring and support of the FHP by senior officials of the MOH and Prime Minister's Office, the dedication and hard work of many staff of the FHP-PCO (especially those responsible for overall coordination), and the provision of additional technical support by the Bank's resident mission and headquarters-based staff (including procurement and disbursement specialists, who provided technical training and participated in training workshops and implementation support missions to Addis Ababa). The period 1994-95 was devoted to gradually developing the capacity of the PCO and regional health staff to meet IDA requirements for procurement of civil works, pharmaceuticals, goods and equipment. This (re)start-up phase was necessary - but led to "delays" in procurement and, therefore, disbursement of

project funds. However, the insistence during this period that the project conform with IDA's standard bid documents and procurement procedures has subsequently paid off. With technical support from the PCO and IDA, including formal training and informal "hands-on" guidance, it became somewhat easier to procure civil works through the regional health bureaus.

8. Despite these commendable efforts, however, the capacity and motivation of the engineering staff of many regional and zonal health offices to properly supervise construction activities at remote and dispersed locations were at times inadequate. There remained noticeable shortfalls in the timeliness and quality of some civil works, and delays in procurement of some goods and services, both in the regions and at Addis Ababa, as noted in the Aide Memoires and other reports of previous Bank missions, as well as the present ICR team (see particularly our detailed comments on the civil works experience of the project; Annex II). Thus, while the FHP was satisfactorily completed without an extension of the original closing date, and its inputs, achievements and expected benefits are substantial, there are nevertheless important lessons to be drawn from the experience of implementing this first IDA-funded project in the health sector, especially for the proposed support to the Health Sector Development Program (HSDP). These have been discussed with the Government and will be reflected fully in the Project's ICR.

9. The successful completion of **civil works,** within the project period, is considered to be one of its major successes. The mission was very impressed to find that virtually all civil works had been completed and provisional acceptance made, by the end of the project period. Only in the case of 2 of the total 76 contracts had there been failure to complete. In one case, the contract had been terminated for reasons beyond the control of the contractor and MOH, and in the other, as a result of the contractor's failure to perform satisfactorily. It was reported that both would be completed outside the project with local funding. Many lessons have been learned, of which perhaps the most important is the need for adequate supervision at all levels.

10. **Project Sustainability.** The FHP's benefits are likely to be sustained for the foreseeable future. Recently, the Prime Minister's Office has directed that all Regional State Governments and Health Bureaus ensure adequate recurrent budgets for operating and maintaining existing and proposed health facilities and programs (copy is being obtained for IDA files). The mission has been assured by the MOH that Regional budgets for 1997-98 have included the estimated costs of manpower, drugs, equipment, supplies and administrative overheads for providing health services. These budgets cover the facilities funded by the FHP, as well as other government and donor-funded activities. In addition: a) the Government's overall allocation to the health sector has increased in recent years and is expected to increase further in 1997/98 and beyond; b) the new health financing policy is expected to come into force in 1998; and c) the Government's HSDP which was launched in July 1997 will receive funding from IDA and other donors for a period of five years, and will provide additional much-needed funds. Furthermore, the MOH has provided the mission with an action plan for sustaining FHP activities during 1998-2003. Specific plans of the MOH and Regional Health Bureaus for sustaining the benefits of the FHP will be discussed in further detail during the preparatory mission to discuss donor support for the Government's HSDP. This would help ensure that sufficient provision has been made for covering the recurrent costs of sustaining the FHP-supported facilities for at least the next 5 years. The Government's HSDP includes operational budgets for the health institutions established during the past five years (including the facilities funded by IDA). These have been discussed with donors in order to prepare the HSDP for donor

financing, and further consultations are expected in the coming 6 months when program financing will be determined.

11. The right mix and number of trained health manpower are also crucial for the sustainability of high quality health care services. Initially, the structures completed during FHP implementation are likely to operate with limited staff - until sufficient numbers are produced by the various training institutions. The project has supported the expansion and equipping of health manpower training institutions; and this is expected to gradually make health services more sustainable in the coming years. The availability of well trained health managers is equally important for the development of a rational health system. A number of regions have established Health Management Training Centers for training program managers through short-term management development courses. This is expected to improve program planning and implementation in the health sector, and make health service delivery more efficient and sustainable.

12. **Procurement**. With regard to procurement, the mission notes that the civil works were completed by December 31, 1997. Goods and supplies to the regions have been received (mainly medical, laboratory and office equipment and supplies, and furniture) and delivery is expected to be largely completed by end-February 1998. The mission's visit to the Gambella and SNNPR regions reinforces its earlier concern, based on previous site visits to other regions, regarding the weak supervision capacity in some regions (both at regional and zonal levels). Although the buildings have been constructed, and seem to be of a reasonable standard, there are a number of problem areas relating to: a) the quality of on-site supervision; b) the variable capacity of local contractors; and c) inadequacies in planning and providing for such essentials as water supply, electricity, staff housing, and recurrent budgets for making the buildings operational (these aspects are the responsibility of the Regional Councils and Health Bureaus).

13. **Disbursement**. The mission notes that project disbursements picked up substantially in the past 2 years - during which over US$ 14.7 million was disbursed, bringing the cumulative disbursements to US$ 28.53 million (i.e. 51 % of the IDA contribution to the relaunched project). The remaining US$ 1.7 million of IDA funds will remain undisbursed, and will be canceled. These are a result of cost savings on the procurement of furniture and drugs.

14. **Audit**. The mission notes that several audit reports for the FHP were delayed due to the non-availability of a suitable accountant in the MOH (a consultant accountant was hired in 1997). It also drew attention to the fact that the SOE audit for FY 1996 has still to be received by the Bank. The mission appreciates the MOH's commitment to make the 1997 audit report available to IDA by end-February 1998; and to maintain the existing capacity of the PCO up to end-June 1998 (i.e., 6 months after project closing) to ensure that the FHP accounts are properly closed, and final reports submitted to Government and IDA. This capacity could also facilitate preparation of the proposed financing for HSDP, which is due for appraisal by IDA and other donors in mid-1998.

15. **Legal Covenants**. The mission has updated the information on project monitoring indicators and compliance with legal covenants. Except for the requirement of timely submission of audit reports, most covenants have been met fairly satisfactorily.

16. **Borrower and Bank Performance.** Project preparation and implementation may be divided for the purposes of assessment into three distinct stages. These include: (a) identification to effectiveness (1985-1989); (b) effectiveness to project re-design (1989-1994); and (c) project re-

design to completion (1994-1997). The Borrower and Bank performance can be judged to be satisfactory as of the re-design of the project which took place in March 1994. Particularly, in the case of the Borrower, it is noted that it worked against various odds during the second stage, when it was undergoing a period of institutional flux and change due to the process of regionalization which resulted in the transfer of powers to implement the project from the central government to the regional governments. As for the period prior to the re-design of the project, documentation is still being examined in order to ensure an accurate assessment of the performance of the Bank and the Borrower. The findings of the latter will be reflected in the ICR.

17. **Action Plan for Future Operation.** The mission's agreements with the MOH on the actions needed for sustaining project activities during the period 1998-2003 and the Government's action plan is attached as Annex I.

18. **Plans for Government's Contribution to the ICR.** As per Bank requirements, the mission has shared and discussed the Bank's Guidelines for preparation of the Implementation Completion Report (ICR) with the MOH-PCU. The Government's contribution to the ICR will cover the entire project period from 1985 to date, and will undertake an in-depth assessment of the FHP implementation experience. This report, if it is 10 pages or less, will be Annexed unedited to the Bank's ICR (if it is longer than 10 pages, the Government would be requested to provide a 10 page Evaluation Summary, which will be so annexed). The report would include an Operational Plan and Budget for sustaining the project for the next five years (the FHP-PCO's preliminary report was discussed with the mission). The mission has been assured by the MOH that the Government's 10-page report would be sent to the Bank by end-February 1998; and a more detailed report would be prepared by June 30, 1998 for further consideration by Government.

**Acknowledgments**

19. In closing, the Bank's ICR mission wishes to reiterate its appreciation of the support given by staff of the MOH, FHP-PCO and Regional and Zonal Health Bureaus for successfully bringing the project to a close in December 1997. We wish also to acknowledge the support and cooperation extended by Government to the various IDA missions from headquarters and the resident mission throughout the FHP implementation period. Special thanks are given to staff of the FHP-PCO for very ably serving as the Bank staff's direct counterparts for project coordination, monitoring and reporting. Without this close collaboration and collegiality, our task would have been impossible to accomplish satisfactorily.

**Annex I**

AGREED ACTION PLAN FOR SUSTAINING FHP ACTIVITIES DURING 1998-2003

| No. | Agreed Action | Period | Responsibility |
|---|---|---|---|
| 1 | Submit Government's 10-page ICR | End of February 1998 | MOH/PCO |
| 2 | Finalize and submit all withdrawal applications to Bank before April 30, 1998 | April 30, 1998 | MOH/PCO |
| 3 | Submission of SOE audit of 1996 | as soon as possible | MOH/PCO |
| 4 | Submission of FY July 1997 audit | End of February 1998 | MOH/PCO |
| 5 | Submit project audit report for the period July 199y - April 30, 1998 | June 30, 1998 | MOH/PCO |
| 6 | Submit Government's detailed ICR | June 30, 1998 | MOH/PCO |
| 7 | Closure of PCO | June 30, 1998 | MOH/PCO |
| 8 | Provide written comments on Bank's ICR within 2 months of receipt | April 20, 1998 | MOH/PCO |
| 9 | List of Project Assets and plan during operational phase | End of February 1998 | MOH/PCO |
| 10 | Follow-up and ensure sustainability of FHP activities within the framework of HSDP, including providing for manpower and recurrent budget | Mid-February 1998 and beyond | MOH/PCO/RHBs |

**Annex II**

## Ethiopia Family Health Project
## Implementation Completion Mission Aide-Memoire -
## Report on Civil Works

**Background.** At the time of the original Development Credit Agreement in 1988, it was envisaged that the Family Health Project would provide civil works estimated to cost about US$ 14 million. The limit for LCB was US$ 500,000 with a 7.5% preference for local bidders under ICB. Implementation was planned to be completed in the first 5 years of the project. Very little implementation progress was, in fact, made during the first few years, although design drawings and other tender documents were prepared by the Architectural and Engineering Department (A+E) of the Ministry of Health. Considerable difficulties were experienced as a result of staff shortages as well as problems of transport, lack of drawing film and copying materials. Only one of the planned constructions got under way (this was a new HC at Ejaji, which, as it turned out, later had to be retendered). The scope of civil works was amended in 1994 when the project was relaunched (see Summary Table below). The revised budget estimate for civil works was US$ 14.52 million. The conditions for LCB/ICB remained the same. The planned implementation period was reduced from five to three years, keeping the original closing date of December 31, 1997.

### Civil Works Summary Table - 1988 and 1994

| Project Component | Original Plan in 1988 | After Relaunch in 1994 |
|---|---|---|
| Area Development/ MCH-FP | Rehabilitation of 3 rural hospitals, 18 health centers, 180 health stations; and construction of 3 new health centers | Rehabilitation and construction of 19 health centers and 100 health stations |
| Manpower Development | Upgrading and renovation of 2 nursing schools (St. Paulos and Zewditu), 2 health assistants training schools (Menelik and Awassa), 1 sanitarians school (Jimma), and 1 laboratory technicians school (Addis Ababa) | Remained the same (but laboratory technicians school was later moved to Awassa) |
| Institutional Development | Workshops for maintenance of health buildings and vehicles for the Shewa regions | Replaced by 3 regional health bureaus and 3 zonal health offices |
| Health Education | Renovation of health education department building, and construction of a Health Learning Materials building at Ras Imru, Addis Ababa | Modified to construction and renovations to a printing workshop and construction of a new audio-visual studio building at Ras Imru, Addis Ababa |
| Pharmaceuticals | Renovations to Central Medical Stores, and construction of 7 new regional drug stores and a new bonded warehouse in Assab. Minor extensions to the Pharmacy technicians school at Menelik hospital. Construction of a drugs quality control laboratory in Addis Ababa | Construction of specialized storage facilities at the central medical stores (later omitted); and construction of a new drug quality control laboratory in Addis Ababa |

**Progress.** Even after the restructuring of the project, there was a further general delay of about one year in the implementation of civil works, as well as delays experienced by individual contracts. The general delay was partly as a result of unfamiliarity by the newly established Regional Health Bureaus in the use of the Bank's Standard Bidding Document (SBD) and also the setting up of the new regional management structures for implementation. As a result, few contracts started before 1995. An exception was the HS/HC reconstruction program in Tigray, and also in some instances in SNNP, for which exemptions were granted by the Bank, allowing normal GOE bidding procedures to be applied, until use of the Bank's SBD was accepted by all the regional governments.

In most cases, the remaining rectifications need still need to be carried out before final acceptance can be made. The retention funds are available and will be used for this work. These funds, amounting to 5% of the contract sums, would not normally be released until the final acceptance stage has been reached. However, to enable reimbursement from the Bank before the end of the project period, payments to contractors have, in fact, in most cases been made. The mission understands from MOH that bank guarantees have been secured to ensure that contractors will fulfill their remaining obligations.

Slow progress at the Health Learning Materials Audio-Visual Studio has been the result of several architectural changes, which have been commented on by previous Bank missions. Additional supports to the upper floor slab are in the process of being completed, after which the building is expected to become functional soon.

**Quality of Construction.** While completion of Civil Works within the project period has clearly been a commendable achievement, the quality of construction is in many cases a matter of concern. There are a number of actions which could be applied to future projects by which quality should be expected to improve. Among these are:

- adequate supervision staff resources by MOH and the Regions.
- more detailed specifications of materials and workmanship.
- provision of architectural details beyond the scale of 1:50, as used on the present drawings.

Very detailed drawings and specifications are believed to be of particular importance and are cost-effective when these are to be used in implementing a large number of repeated buildings. These will provide clear instructions to contractors on requirements and will give supervisors a standard against which to assess the work produced.

It was particularly disappointing to note the poor quality of finishes at some of the contracts resulting from ICB:

The Drugs Quality Control Laboratory was the only contract to be won by a non-Ethiopian contractor. The tender sum of ETB1.9 million against the A+E estimate of ETB4.0 million, indicates that the contractor may have underestimated the scope works and as a result tried to make up for this by use of inferior quality materials. There were also reported difficulties of communications as a result of the contractor's failure, in spite of contractual obligations, to provide English speaking staff. The mission noted that sub-standard work was in the process of rectification.

At the Menelik Hospital Health Assistants' School, the renovations part of the work was found to be of poor standard, while new works were quite acceptable. The reason for this appears to

have been inadequate specifications and funding for what, actually, was a small part of the total contract.

**Drawings.** A review of drawings was made by the mission, focusing particularly on those for HCs, as an example. The mission was satisfied with the good quality of these and noted that, although the basic drawings had been prepared before or during the very early stages of the project, much work had been done immediately after the project relaunching in 1994. This had consisted of the preparation of modified designs for different wall materials, soil and climatic conditions. This had been well carried out. To help match the drawings to their intended locations, they need to be clearly and boldly marked.

The original drawings, for HC as well as for other buildings had been prepared by the A+E, which at that time was a large department of MOH with its own offices on the outskirts of Addis Ababa. After decentralization, many of the staff assigned to the regions apparently did not join their new posts (they joined the private sector instead); and a comparatively small number remained at the Center. It was this core that prepared the modifications of the HC/HS designs. Other designs which had been prepared by A+E earlier, and already approved by IDA, for the different training facilities, etc. were not revised.

The existing buildings are generally of good design, but there is scope for improvement. For the Health Sector Investment Program, which involves construction of a large number of basic health facilities, the mission understands that a request for a budget has been made by A+E to conduct a review of existing designs, in collaboration with the buildings' users. This study would be field-based, looking at functional aspects as well as technical aspects of materials and construction, and would help improve existing designs. The mission strongly supports such a study.

**Specifications.** The mission believes that the quality of work could have been improved by having more detailed specifications. It was explained that GOE regulations prevent reference to particular manufacturers or branded products. Bank guidelines are similar, but do allow for such references where specification would otherwise be difficult. The clause "or equivalent and approved quality" must however be included in such cases. Specification by reference to particular national or international standards for materials would also be a useful method to clarify requirements to contractors.

Small contractors, in particular, often have very limited knowledge of English, which is the language used for contract documents and drawings. The SBD text includes a lot of technical and legal provisions which may be difficult to understand. It is therefore felt that, while the legal documents should remain in English, a summary translation of essentials into the appropriate local language would be of benefit to the contractors and consequently to the resulting construction work.

**Cost Control.** The total value of civil works contracts was USD 15,912,731. After completion, it appears that the total value certified will be exactly this amount. This is mainly as a result of fixed price contracts (Government policy discourages variation orders). Based on experience elsewhere, the mission believes that Variation Orders, if properly used, can be helpful tools in contract management - for making additions or omissions for items of work which are found to have been overlooked or are no longer required to the extent originally envisaged. The GOE approval process for variations is, however, understood to be lengthy and cumbersome, partly to avoid extraneous influences; and the financial authority delegated to lower levels for approving variation orders is

quite limited. It is suggested that a review of this authority as well as the approval process could be useful.

**Time schedule.** Civil works were originally envisaged to be completed in the first 5 years of the project. After restructuring, with only 4 years remaining of the project period, a revised time schedule for implementation of civil works, of 3 years (1994-96), was drawn up, allowing the final year (1997) for commissioning. Government assurances and mission field trip observations indicated this to be a realistic target. The bidding process took most of 1994; so construction work did not gain full momentum until 1995. Although individual contracts did in some cases experience delays, construction was successfully completed in the 3 remaining years.

**Bidding.** Of the total civil works contracts, only 5 were of sufficient size to qualify for ICB. The bidding process followed IDA guidelines. Ethiopian firms were competitive and all but one contract were awarded to local companies. The 7.5% price advantage for Ethiopian contractors did not need to be applied.

Under the GOE system, contractors are registered by category specifying the maximum value of government contracts that they are eligible to undertake. Having registered, no further pre-qualification is required for tendering. Contracts are always awarded to the lowest bidder. Bank guidelines on bidding are more demanding with requirements from contractors to submit details of their financial standing together with their bids. Before the Bank SBD could be applied, approval had to be given by the respective Regional Councils. As a result, and to avoid delays, the Bank agreed to an exemption in the case of Tigray, which was well advanced in the contract award process resulting from application of the normal GOE regulations. In other Regions, Bank guidelines were used.

**Packaging.** Normally, packaging is not generally used in Ethiopia. It is, however, permitted by Government, particularly to attract contractors to the remote (lower capacity) Regions.

In FHP, with the exception of SNNPR and Tigray, several rural health facilities were generally packaged to form larger contracts with the aim of attracting more experienced contractors with greater capacity and resources. Advantages and disadvantages of this were experienced. Although some small contractors did good quality work, the mission understands that without packaging it would have been difficult to attract contractors to the remote Regions. In other cases, contractors failed to give equal attention to all the facilities in the package. In SNNPR and Tigray, where contracts consisted of single HS or HC, the work was generally awarded to small contractors with limited resources to undertake work in remote locations. Delays to construction resulted in some cases, and successful completion was said to be very much the result of the assistance given to the contractors by the regional authorities (by making advance payments and facilitating transport of materials).

Packaging was also applied to the larger constructions; training facilities, offices, etc. However, these were based on type of building, rather than geographical proximity. As a result, some of the benefits of packaging were lost. For example, the 3 Zonal Offices, each of which is comparable to a HC, formed one package. Although a larger contractor could be awarded the contract, the components were small and scattered, probably making it unattractive for the contractor to employ his more experienced staff as site engineers or foremen. In retrospect, perhaps 3 smaller contractors, or packaging with other buildings in the area would have been a better solution.

**Valuations and Payments.** Payments to contractors for work carried out have generally been based on the "stage reached" principle. This is simpler than making monthly estimates of the value of work carried out and generally works well on small, rural contracts for civil works undertaken by the Government. Normally, funds for such contracts are controlled at the regional level, with a comparatively short chain of approvals before payment can be made. However, in the case of FHP, where MOH is accountable, funds are controlled at the central level. The result is a considerably lengthier process, which has caused delayed payments, which in turn have resulted in construction stoppages and delays, particularly by smaller contractors with limited financial capacity. There is a danger that contractors could seek higher prices on such contracts, to cover the additional delays and expenses incurred. Future IDA funded projects need to try to shorten the approvals and payments process, perhaps by delegating more authority to lower level (e.g. zonal) offices.

**Supervision.** Supervision of rural health facilities has been the prime responsibility of the Regional Health Bureaus under guidance and with assistance, as required, from the Center (MOH). This has been provided, in particular to the Regions with limited resources within their own structure (e.g. Afar, Benishangul, Gambella and Somali). In addition, the MOH-PCO had the responsibility for project management and supervision of the larger civil works, as well as a large number of other projects being undertaken by MOH. Only part of their time (estimated by the engineers to be about 60%), could therefore be spent on FHP work.

At the MOH, there was a professional staff of 11 in 1994-95. At that time, the work consisted mainly of pre-contract services - checking plans, site selection, approving documents, bidding, etc. As FHP construction started, supervision was taking more of the engineers' time, while still having to handle other GOE projects at various stages of implementation. At the same time MOH was losing trained and experienced engineering staff. By 1996, the number was down to 8 and by 1997, only 6 remained. Construction, and hence supervision requirements, was at a peak during the two years that staff attrition was taking place.

Field trips by the mission showed that quality of construction did not necessarily relate to remoteness of location. Some very poor finishing work, which is now under rectification, was, in fact, seen in Addis Ababa (Drug Quality Control Laboratory). This could perhaps be explained by the possibility that technical specifications were insufficient or were not fully adhered to and/or the work was not adequately supervised because the concerned staff were spread too thin, with responsibility not only for contracts in the capital but also for giving assistance to the Regions. Visits to the Regions, were said to have sometimes resulted in supervisors being unable to attend to other work for several months, during which time contractors would have been able to work unsupervised, producing inferior work. In many cases, contractors have been required to re-do such work. However, it is clearly a difficult decision to insist on remedial work that may be of no structural significance, especially when there is a time pressure to complete work while project funds are still available.

Regular and stringent supervision by the regional and MOH engineering staff is clearly vital to achievement of good quality work.

Another essential requirement is to have adequate numbers of well-trained and motivated supervisory staff. Ethiopia has, in the last few years, developed a thriving private-sector construction industry in which salaries and other remunerations are considerably higher than those that government is able to offer. It will therefore become increasingly difficult to recruit and to keep experienced and qualified technical staff in the ministries. It is therefore likely that more work will

have to be given to the consultants in the private sector or by engaging staff on contract on competitive terms.

Most FHP buildings have received provisional acceptances, but much work remains in connection with final inspections and accounts, as well as supervision of installation of equipment and fixtures which are about to be delivered. Most of this will be done at the regional level. However, at present, MOH does not have the resources to supervise this work nor to assist the remote low-capacity regions. There is therefore a need for MOH as well as the Regional Health Bureaus to assess the staff resources required and to ensure that these are available when needed.

**Summary of Findings, Suggestions and Lessons.** The mission was impressed by the successful completion of the FHP civil works within the project period.

The mission is satisfied by MOH assurances that those retention funds that have been released before final acceptance of buildings, are covered by bank performance guarantees, to ensure that contractors fulfill their remaining obligations.

Although timely completion of civil works is a commendable achievement, the quality of construction was, in a number of cases, a cause for concern. It is felt that future projects would benefit by provision of greater resources for supervision , as well as more detailed drawings and specifications. Specifications should be able to refer to manufacturers and branded products provided that it is made clear that equivalent standards from other approved sources would also be acceptable. References to required national as well as international standards should be made in specifications.

Small contractors, in particular, often have limited knowledge of English. The Bank SBD includes a lot of technical and legal terms, which could be difficult to understand. The mission therefore suggests that for future projects, the essentials be translated into the appropriate local language.

The GOE approval process for variation orders has been found to be lengthy and the cost limits for which decisions can be taken at the local level are low. Variations can be a useful tool in contract management. It is therefore recommended that the process and delegation limits may need to be reconsidered.

There are advantages and disadvantages to packaging of contracts. Careful consideration to each proposed package should therefore be given to ensure that the most appropriate solution is opted for.

The payments process has been lengthy under FHP, and delays and stoppages have occurred, both for small and larger contractors. Although overall financial accountability has to be with the MOH at the Center, for future IDA projects, it may be useful to consider streamlining the decision-making process.

Adequate supervision by MOH has suffered due to attrition of staff and a heavy workload. Regular and stringent supervision by engineering staff of the Regional and Zonal Health Bureaus and MOH is essential to good quality civil works. It is an issue that must be clearly addressed before any new IDA project is undertaken. In view of the large disparity between employment conditions in the private sector and in government, it is becoming increasingly difficult to recruit and keep qualified

and experienced engineers. The mission therefore believes that in future, it might become necessary to rely to a greater extent on consultancy firms or individuals paid on a competitive basis.

Although the project has come to an end, work in connection with final inspections, accounts and installation of fixtures and equipment remains. While most of this work can clearly be undertaken at the regional level, MOH will probably need to supervise and to provide assistance to the remote and low-capacity Regions. Staff resources are at present not available. The mission therefore urges MOH and the Regions to assess the needs and to ensure that adequate resources are available when required.

**Annex III**

## Ethiopia Family Health Project
## Implementation Completion Mission
## Comments on Procurement, Disbursement and Audit

1. **Introduction:** Although some activities had been going on from the date of Credit effectiveness, March 1989, implementation progress of almost all components was very slow until 1994. Delays in the civil works in particular had been the major drawback which had negatively affected the overall level of disbursements (over 50 % of the total project cost was allotted for the civil works), as well as progress in implementation of procurement plans for other goods and services required for the completed health facilities and training schools etc..

2. In order to assist regions in carrying out project implementation in line with the new decentralized implementation procedures, all the standard bidding documents (for ICB and LCB) had to be prepared by the FHP-PCO, had to be approved by IDA, and had to be accepted by the regions as the basis for procurement of goods and civil works by the FHP. The regional health bureaus had to be strengthened to supervise construction of the health facilities in their respective regions. While the Regional Health Bureaus of Tigray, Amhara, and the Southern Ethiopian Peoples' Administrative Regions took the lead in taking the necessary measures as early as June 1995, the implementation capacity of the other regions, e.g. Afar, Benishangul, Gambella, and Somali have remained relatively weaker through out the life of the project. Thus, continued technical support was needed from the MOH-PCO.

3. **Disbursements:** Up until April 1994, total disbursement had been only US $ 5.16 million, excluding the US $ 6.0 million disbursed from the total of US $ 7.5 million reprogrammed for ERRP ( drugs) in November 1991. The Staff Appraisal Report's estimated disbursement as of April 1994 was US $ 21.6 million, thus giving a disbursement lag of about 40%.

4. As noted above, project implementation progress and thus disbursements from restructuring to FY 1995 was slow. As expected, implementation started to pick up and showed a steady and progressive rise from FY 95 to the closing date, December 31, 1997. Disbursements during FY 97 and FY98 were particularly high, accounting for 45 % of the total cumulative disbursement made up to the end of Dec. 1997. The FY 97 and the first half of FY 98 (in Q1 & Q2 only) disbursement was US $ 7.56 million and US $ 5.44 respectively, while the total cumulative disbursement (over seven years) to end of December 1997 was US $ 28.53. With the effecting of payments to the pending major payments of US $ 3.4 million for the last packages of drugs and medical supplies, and when the reimbursement claims amounting to US $ 1.57 million are made in the coming four months grace period, the total amount of disbursement will reach US $ 30.5 million, i.e. 94.6 % of the total Credit.

5. The Bank's disbursement procedures were properly followed in withdrawing funds, in managing the special account, and while using the special commitment procedure, except for the few months when the special account was found inactive. Replenishment applications were submitted regularly as required by the DCA, leading to the commencing of the recovery process of the SA advance. Except for the one case where erroneously the SA fund was used to finance 100 % of civil works contract, i.e. including the government's share of 10%, the procedure was strictly adhered to. Availability of Government's own funds to allow the use of own funds to pre-finance IDA's share of the civil works expenditure has been very useful (see below) for

accelerating disbursement, effecting more timely payments to contractors than would otherwise have been the case, and for the optimal use of the Special Account advance.

6. One disbursement-related problem which was faced with regard to civil works contracts was that disbursements on civil works activities sometimes lagged behind progress in physical implementation. This problem reportedly arose due to the reluctance of some contractors to ask for payments regularly as work progressed; instead, they preferred to request for large payments when they came to Addis during the rainy season when construction work has to be interrupted. This had at one point rendered the Special Account inactive on the one hand, and had created a liquidity problem on the other hand when a number of cumulated large payments had to be made from the Special Account. This problem was mitigated with the joint effort of the Government and the Bank, with the Government pre-financing IDA's share of payments to contractors, and IDA lowering the minimum application size for direct payments and for the issuance of special commitment. To further facilitate the flow of IDA funds through the SA and to accelerate future disbursements, the Bank unrecovered the amounts recovered from the SA due to its inactivity, and raised the threshold for SOEs. These problems, which were experienced in FY 95 and FY 96, have been resolved and in FY 97 and FY98 withdrawal processing has proceeded smoothly.

7. **Audits:** Audit reports were often in arrears, and the need for timely submission of these reports has been a concern which was repeatedly expressed by the Bank. The main cause for the overdue audits was lack of accounting staff in the MOH-PCO to close the books on time for timely audit. As per the agreement with the Bank mission in 1997, a consultant was recruited and has been assisting the PCO in closing the books for the FY 97 audit, which is expected to be submitted in Feb. 1998.

8. **Civil Works**: In terms of disbursements, almost the full amount (99 %) of the Credit allotted to civil works, US $ 14.2 million was disbursed , construction of 19 HCs and 96 HSs were completed (contracts for the construction of four HSs were terminated; see the mission's comments on civil works). During the period after project relaunch, the Government was highly committed to the implementation of the project; and has undertaken to complete the construction of the health facilities whose contracts were terminated and to meeting the additional financing for cost over runs, if any.

9. **Procurement :** Almost all the planned items of goods, equipment and furniture provided for in the Credit have been procured in the planned quantities, at less than the estimated total cost, but with some delays. These delays experienced in the procurement process have had a direct negative effect on the utilization of the health facilities created. The undisbursed balance of US$ 1.7 million is basically due to savings from the equipment, materials and supplies category. The total allocation under this expenditure category was US $ 8.61 million; of which US $ 7.42 was disbursed (or is expected to be disbursed by end of the grace period ending April 30, 1998). The intention to use these savings for the purchase of additional quantities of drugs and medical supplies has not been pursued in view of the limited time available for completing the procurement process before the closing date of the project.

10. Although no major problem was faced in the procurement activities, and the procurement plan has been fully implemented, the PCO's progress in this area could have been even better if additional resources and capacity were available, both at the MOH and in the regions. This strengthening of procurement capacity would be of great advantage to future projects funded by IDA.

Appendix B

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Federal Democratic Republic of Ethiopia
Ministry of Health

ቀን 08 ሰኔ 1998
Date
ቁጥር 4/74/AS/41
Ref. No.

Mr. Arvil Van Adams
Sector Manager
Human Development Group IV
Africa Region
The World Bank
1818 H Street N.W.
Washington, D.C. 20433
U.S.A

Dear Mr. Adams;

Subject: Family Health Project Implementation Completion Report (Credit 1913-ET).

AAA. We acknowledge with thanks receipt of the final draft of the Implementation Completion Report (ICR).

BBB. In general, the draft ICR is acceptable to us as it sufficiently reflects the exchange of views made during the ICR Mission. However, we would like to forward the attached note containing a few comments.

CCC. We are also transmitting herewith MOH's ICR summary.

Sincerely,

[illegible] ATIF ADAS
Head, Planning and Programming Department

Copy: Mrs. Gita Gopal
Task Team Leader
AF 2PH
Room No-J10-026
The World Bank
Washington, D.C.
U.S.A.
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**COMMENTS OF MOH ON THE DRAFT ICR OF THE FAMILY HEALTH PROJECT (CR.1913ET)**

PART I: EVALUATION SUMMARY

Paragraph 2, Line 9: The sentence " Under the process, shewa regions disappeared..." could be deleted as the last sentence (I) of the paragraph better explains the change introduced.

Paragraph 4: " Regional Health Bureaus were placed in charge of..... This delayed project implementation further...". This could perhaps be rephrased along the explanations given in paragraph 6 of the Mission's side-memoir which specifics the reasons for the delay in start-up more clearly.

- " As a result...very little was disbursed... during 1993-1994 until civil works commented...". 1993-94(Feb) was the time of restructuring and project activities were virtually suspended.

Paragraph 5: The first sentence " By 1995..." could perhaps be changed to mean: "The Government had taken steps to strengthen project monitoring and follow-up mechanisms by (a) setting up in September 1995 a Capital-Budget Projects Monitoring Unit chaired by the Vice-Minister of Health (b) monitoring every three months health projects at the level of the Prime Minister's Office.

The third sentence: could be changed to the mean : "These measures have helped to resolve problems and speed up implementation of the project.

**PART II. PROJECT IMPLEMENTATION ASSESSMENT**

Paragraph 17: Improvements in Access

- Is this an error in the figure for the expected coverage (975,000 people)?
- The projected coverage on the basis of the new health care delivery structure is given in our ICR under IIIA. This could be considered by the Bank as well.

Appendix C

# IMPLEMENTATION COMPLETION REPORT
# ETHIOPIA
# FAMILY HEALTH PROJECT
# CREDIT NO: 1913.ET

**May 1998**
**MINISTRY OF HEALTH**

## TABLE OF CONTENT

**ETHIOPIA**
**FAMILY HEALTH PROJECT**

Currency Equivalents

At the time of appraisal

US $1.00 = 2.07 Birr

At the time of project completion

US$ 1.00 = 6.80 Birr

Weights and Measures

Metric System

Ethiopian Fiscal Year

July 8-July 7

## ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| AFD | Administration and Finance Department |
| AET | Architect and Engineering Team |
| BHSD | Basic Health Service Department |
| CHA | Community Health Agent |
| CHW | Community Health Worker |
| CPPR | Country Project Portfolio Review |
| CPR | Contraceptive Prevalence Rate |
| DCA | Development Credit Agreement |
| DQCL | Drug Quality Control Laboratory |
| E.FY | Ethiopian Fiscal Year |
| ENHD | Environmental Health Department |
| EPHARM | Ethiopian Pharmaceuticals Manufacturing Corporation |
| EPHARMECOR | Ethiopian Pharmaceutical & Medical Supplies Corporation |
| EPI | Expanded Program of Immunization |
| ERRP | Emergency Recovery and Reconstruction Program |
| FGAE | Family Guidance Association of Ethiopia |
| FHD | Family Health Department |
| FHP | Family Health Project |
| FP | Family Planning |
| GDP | Gross Domestic Product |
| HA | Health Assistant |
| HLMDC | Health Learning Materials Development Center |
| HC | Health Center |
| HPTD | Health Professional Training Department |
| HS | Health Station |
| ICR | Implementation Completion Report |
| IDA | International Development Association |
| IEC | Information, Education, Communication |
| IPPF | International Planned Parenthood Federation |
| ICB | International Competitive Bidding |
| JIHS | Jimma Institute of Health Scienc |
| LCB | Limited International Bidding |
| MCH | Maternal and Child Health |
| MEDAC | Ministry of Economic Development and Cooperation |
| MOF | Ministry of Finance |
| MOH | Ministry of Health |
| PCO | Project Coordinating Office |
| PD | Pharmacy Department |
| PMU | Project Monitoring Unit |
| PPD | Planning and Projects Department |
| RHB | Regional Health Bureau |
| SAR | Staff Appraisal Report |
| SIP | Sector Investment Program |
| TBA | Traditional Birth Attendant |
| UNFPA | United Nations Fund for Population Activities |
| UNICEF | United Nations Children's Fund |
| WBRM | World Bank Resident Mission |
| WHO | World Health Organization |
| ZHD | Zonal Health Department |

# IMPLEMENTATION COMPLETION REPORT
# ETHIOPIA
# FAMILY HEALTH PROJECT
# CREDIT NO:1913-ET

## Preface

This is the Implementation Completion Report (ICR) for the Family Health Project (FHP) in Ethiopia, for which IDA credit in the amount of US Dollars 33.0 million was approved on July 14, 1988, and made effective on March 14, 1989. According to the financing plan, the Government of Ethiopia and UNICEF were to cover 10.36 and 0.5 million USD respectively. However, UNICEF's pledged input to the project was actually not made available.

The credit was closed on 31 December 1997 (the original closing date) with the exception of payments under schedule I, category 9 of the DCA which was extended until 31 January 1998 on the request of the Ethiopian Government. The last disbursement was made on April 30 1998 leaving an undisbursed credit balance of 1.47 Million USD which is to be canceled

The ICR was prepared by the Project Coordinating Office under the Planning and Projects Department of the Ministry of Health. The report is based on materials of project files and reports of Regional Health Bureaux as well documents recording the final joint assessment of the project during the ICR mission of the World Bank.

# IMPLEMENTATION COMPLETION REPORT
# ETHIOPIA
# FAMILY HEALTH PROJECT
# CREDIT NO: 1913-ET

PART ONE: PROJECT IMPLEMENTATION ASSESSMENT

## I. INTRODUCTION

### A. The Credit Agreement

Signed: July 14, 1998
Effective Launching Date: March 14, 1989
Project Restructuring Date: December 1993
Project Relaunching Date: February 1994
DCA Amendment Date: April 1994

### B. Background of the Project

The Family Health Project is the World Bank's first intervention in the Health sector of Ethiopia. The project was envisaged as an entry-point into the development of a nation-wide family planning program, the improvement of the coverage and quality of the health services as well as creating the possibilities of generating additional sources of health revenue.

The project was originally planned as a pilot project with its base of operations in the former four regions of Shewa and with a view to eventually replicate the activities on a national scale.

The objectives of the project were to:

1. Increases the coverage, quality and cost-effectiveness of MCH services.
2. Increase the availability and use of family planning services, and
3. Strengthen the institutional capacity of the Ministry of Health;

The total cost of the Project was estimated at 43.86 million USD. According to the financing plan, IDA was to cover 33.0 Million USD while the Ethiopian Government and UNICEF were to finance 10.36 and 0.50 Million USD respectively.

However, UNICEF's pledged input was actually not made available to the Project. Out of IDA credit, 7.5 Million USD was reallocated to ERRP. Therefore the total project cost was actually 35.86 Million USD.

The project had been operational since March 1989. However, during the period March 1989-June 1991, the overall implementation of the project had lagged far behind schedule. The major problem of the project had been the delays in the implementation of the civil works of all components of the project. The delay had not only inflated construction costs, but had also affected procurement plans and full-scale activities of the project. During this period the rate of disbursement was also very low, amounting to only 10.2% of the project cost.

Having assessed the implementation status of the project; and having taken into consideration the changes in policies and priorities since the change of government in May 1991, it was decided to restructure the project and develop the procedures for its speedy implementation

Following successive consultations and project preparation work with the World Bank, the project was restructured in December 1993. It was relaunched in February 1994 and the DCA was amended in April 1994.

According to the financing plan of the restructured FHP, the total estimated cost of the project was USD 32,288,600. Out of this, 19,718,000 was IDA credit while the 12, 570,600 USD was Government contribution.

## II. PROJECT OBJECTIVES

The objectives of the restructured FHP are to:

i) increase the coverage, quality and cost effectiveness of MCH services
ii) increase the availability and use of family planning services
iii) strengthen the institutional capacity of the Ministry of Health (MOH), the Regional Health Bureaux and Zonal Health Departments.

These objectives have remained the same as those outlined in the Staff Appraisal Report. However, the activities of the restructured project have been changed to assume nation-wide scope. The activities of the project and its implementation mechanism have been designed in line with the orientations of the new health and population policies as well as the new federal and regional state structures. Efforts have also been made to address the need to give priority to the health needs of hitherto neglected and disadvantaged areas of the country. The project was also made to reflect the shift of emphasis towards the sound strategy of expanding and rehabilitating the health infrastructure to promote MCH and Family Planning Services.

In order to meet the above mentioned objectives, the restructured project had been designed to operate under six different but interrelated components incorporating various activities. These components are (I) MCH/FP (ii) Manpower Development (iii) Health Education and IEC(iv) Institutional development (v) Pharmaceuticals and (vi) Studies.

## III. ACHIEVEMENT OF PROJECT OBJECTIVES

In view of the broad nature of the project objectives, the assessment of achievement of project objectives must be measured both in terms of:

(i) the accomplishment or otherwise of the planned activities under each project component.
(ii) the potential impact that some of the facilities built by the project (e.g. H.Cs, H.Ss, Schools, DQCL, HLMPC) are likely to have when they become operational.

On the whole, considering the Sector's lack of previous experience in managing such a project, the rate of 95.44% disbursement, as well as the fact that activities were completed in three years (as compared to project life of 9 years), the achievements of the project are quite satisfactory. With the exception of the Studies Component which was dropped, all the other component activities have been satisfactorily carried out. Assessment of component activities is described as follows:

### A. Maternal and Child Health/Family Planning (MCH/F) Component

The basic objective of this component is to expand and develop an effective delivery, management and supervision system for MCH/FP services throughout the country. This is envisaged to be done by creating MCH/FP management capacities at the central, regional, zonal and local levels by increasing the availability and use of MCH/FP services through rehabilitating/ constructing 100 health stations and 19 health centers, providing the necessary support in terms of medical equipment, MCH kits, drugs and medical supplies, logistics, and training funds, the enhancement of community participation, initiation of CBD of contraceptives as well as the coordination of the inputs and involvement of NGOS, and other collaborating agencies.

Under this component the plan to conduct training in program management, CBD agents, training of trainers as well as orientation seminars on population policy have all been implemented.

The most important activity of the project has been to increase the availability and use of MCH/FP services by constructing/rehabilitating 100 Health stations and 19 Health centers all over the country. With the expectation of

4 health stations the work of which was discontinued due to local problems and failure of a contractor to honor his obligation, the work of 96 Health stations and 19 Health centers has been successfully completed with a total cost of USD9.82 million. Regional governments have taken over the responsibility to complete the construction of the 4 health stations in 1998/99.

To make these health facilities operational, the plan to procure and supply furniture , medical equipment, MCH Kits, vehicles and motorcycles, has been fully implemented at a total cost of USD 1.30 million.

It is believed that training programs conducted under the component will have useful impact in improving the quality of work in the planning, management and supervision of MCH/FP programs. Similarly,the construction of 96 H.Ss and 19. H.Cs are expected to increase the health service coverage. On the basis of the health service delivery structure which existed during the project implementation one health center and one health station were designed to serve a population of 100,000 and 10,000 respectively. Accordingly, FHP-constructed 96 health station and 19 health centers were expected to serve a population of 960,000 and 1,900,000 respectively.

Under the new health care delivery system, the Primary Health Care Unit (PHCU) constitutes a Health Center (HC) and an average of 5 satellite Health Posts each serving a population of about 5,000 or an anticipated total of 25,000 people. Under this arrangement, FHP-constructed health stations are likely to be upgraded to health centers. Therefore, the 96 health stations and 19 health centers (which will be 115 health centers) will serve a population of 115x25,000=2,875,000.

In terms of financial utilization out of USD 15.6 million allocated for the component, USD 10.51 million has been disbursed.

B. Manpower Development Component

The objective of this component combines the acceleration of the basic and post basic training of lower and middle level health workers with the important task of rehabilitating and upgrading the training schools.

The plan to conduct basic training for nurses, health assistants, X-ray and Lab. Technicians and sanitarians as well as the post-basic programs for Health Science Tutors, Nurse Midwives, Nurse Anesthetist, Dental, MCH and psychiatry nurses and Ophthalmic Assistants have been implemented on annual program basis.

The plan to develop the curricula for the training of various categories of health professionals has been successfully implemented with most of the training programs being already underway. Curriculum revision for the Diploma program in radiology and sanitation and training of nurses from health assistants have been implemented. The inservice training of nurses and health assistants in being conducted annually. A survey to establish a Distance Education Unit has been completed and submitted for MOH officials for approval.

Under the plan to rehabilitate and upgrade the training schools the construction works of Zewditu and st. Paul Nursing Schools, Awassa Lab. Technician School, Awassa and Menlik Health Assistants School and Jimma Sanitarian School have been successfully completed with a total cost of USD 2.23 million.

The plan to procure and supply the schools with office and teaching equipment, educational materials, books and journals, worth USD 0.2 million has been fully implemented.

The financial utilization rate of the component is satisfactory. Out of the allocated USD 2.99 million, USD 2.50 million has been disbursed.

C. Health Education and IEC Component

The overall objective of the Health Education Component is to increase the practice of preventive health care, the demand for MCH/FP services and to develop public awareness about healthy living conditions and better nutritional practices.

The plan to construct a new Audio-visual Studio for the Health Learning Materials Production Center (HLMPC) and carry out the internal fixation work has been implemented at a cost of USD 0.11 million.

As part of the plan to improve the production capacity and quality of the Center, the project has procured and supplied various kinds of printing machinery, equipment and consumable supplies, furniture and vehicles worth USD 0.19 million. The Center has also been provided with logistical support and budget for the recruitment of designers, publishers and graphic experts.

The plan to strengthen and improve the efficiency of the Center by conducting training programs, evaluation and field-testing of health education and IEC materials has been realized. The study and proposal to make HLMPC a semi- autonomous body under the Ministry of Health has been submitted to the Council of Ministers for approval.

The center which has 33 technical and 42 administrative support staff has been actively promoting IEC by producing various kinds of materials; T.V and Radio programs, documentary films, dramas, books, leaflets and posters on health care, nutrition, environmental and gender issues, policy guidelines, teaching manuals, etc.In addition, the Center also conducts mobile health education and provides technical and material support to Regional Health Bureaux..The details of the activities of the center, types of materials produced and project support provided to the center are shown in Table 10

D. INSTITUTIONAL DEVELOPMENT COMPONENT

The overall objective of this component is to develop the planning and management capacity of the Head Office, the Regional Health Bureaux and Zonal Health Departments. This is done by building offices for 3 Regional Health Bureaux and 3 Zonal Health Departments, by taking rational staffing measures and providing logistic support, office equipment and supplies as well as budget for operational and maintenance costs.

Following the decentralization of health services a series of training programs, workshops and seminars have been conducted with the view to build capacity and upgrade skills of RHB and ZHDs workers. Some of these programs were organized by MOH while others were organized the RHBs and ZHDs themselves.

The construction of 3 Regional Health Bureaux at Gambella, Assosa and Assaita as well as 3 Zonal Health Departments at Wolkite, Masha and Durame have been completed at a cost of USD 2.39 million.

As part of the plan to strengthen some key units of the Ministry, the RHBs and ZHDs, the project has supplied furniture, office equipment, vehicles to the PCO and AEU of the Planning and Project Department, Family Health and Pharmacy Departments, the newly constructed RHBs and ZHDsat a cost of USD 0.49 million. It has also been providing support for operating costs, perdiem and maintenance. The total project expenditure for the component is USD 2.90 million

E. Pharmaceutical Development Component

The objective of the component is to improve the country's drug supply system, to develop a system of drug quality control and to improve the efficiency, management and utilization of drugs and medical supplies.

On the basis of the action plan of the restructured project the major activities envisaged under this component were the construction of Inflammable Store, Drug Quality Control Laboratory, Computerization of EPHARM and the procurement of drugs, medical supplies and contraceptives for the health facilities. Based on technical feasibility considerations and rational use of resources for more priority requirement, MOH had, in July 1996, proposed to delete the plan for the construction of the Inflammable Store and Computerization of EPHARM; and the funds have been redirected to finance other project activities. The plan to build, furnish and equip a modern Drug Quality Control Laboratory has been implemented at a cost of USD 0.31 million. Similarly drugs, medical supplies and contraceptives worth USD 5.07 million have been procured and distributed to the health facilities.

F. Studies Component

The two studies envisaged in the action plan were : (I) a review of the hospital sector focusing on the efficiency of resource utilization, experiment on management boards for hospitals and referral services to be given to primary health care facilities; and (ii) a study of health financing options aimed at generating additional funds for the health sector.

In July 1996, MOH and IDA had agreed to delete the study on health financing options as a similar study has been done by MOH with USAID support and as related topics were being studied under PHRD Grant.

It was also jointly agreed to delete the study on hospital sector because a similar study on the Black Lion Hospital in Addis Ababa was being conducted with the support of the Government of Finland. In addition a study on health service management and utilization is planned under the second PHARD Grant. Therefore, the SDR 20,000 that had been allocated for this component has been reprogrammed to cover the cost of other priority activities in the project.

## IV. MAJOR FACTORS AFFECTING PROJECT IMPLEMENTATION

The progress of project implementation has been affected by the interplay of some factors that were either subject to Government control or subject to the control of MOH/PCO, RHBs as well as the World Bank. The following are the major ones worth mentioning:

### A. Factors Subject to Government Control

#### 1. Policy Environment and Objective Conditions of the Country

The restructuring of the FHP and its relaunching were carried out a time of important transition. Following the change of Government in May, 1991, the country was undergoing a process of profound political, economic and social transformation. During this period, the country was beginning to move towards multi-party democracy. Steps

were taken to establish a federal state structure creating different levels of self-governing and representative bodies. Legal instruments defining the new administrative set-up of the Country as well as the jurisdictions of central and regional governments were enacted. The functions of ministries and their regional counter-parts were decentralized. Important economic and social policies were declared. In the social sector such important policies as the New Health Policy and Strategy, Population Policy, women policy, were introduced. The Emergency Recovery and Reconstruction Program (ERRP) was launched.

In the health sector the MOH HQs was restructured, RHBs and ZHDs, were established. These set of changes had the following bearing on the preparations and implementation of the FHD.

a. The introduction of the new health and population policies, as well as the process of decentralization have made it easier to clearly define project activities and implementation strategies in line with the policy priorities.

b. In the project implementation arrangement, the RHBs and ZHDs were given key roles in the overall coordination and supervision of project activities. They were responsible for the tendering, contract management, supervision and payment authorization in the massive construction works of 100HSs, 19 Hcs, Schools etc. They had also taken the responsibility of generating the matching fund to finance the costs of construction, procurement, tax and internal transportation. Therefore, without the involvement of the RHBs and ZHDs and decentralization of powers and responsibilities, the management of the project from the center alone would have been extremely difficult and, would have perhaps taken longer time to implement.

2. Monitoring Mechanism

The timely and successful implementation of the project is, in part, attributed the serious commitment of the Government and the effective mechanism developed to closely follow-up and monitor capital-budget projects such as the FHP. Since September 1995, MOH had set-up a high-level committee for monitoring the implementation of capital - budget projects and programs like the Family Health Project. This Committee (Project Monitoring Unit) is chaired by the Vice Minster of Health and meets very two weeks to review the progress/problems of projects. The activities of this unit has proved to be a very useful mechanism for giving timely and urgent solutions to problems of the project as well as accelerating the pace of implementation.

This project was also monitored every three months by the Public Investment Sector in the Office of the Prime Minister. The project also submitted a monthly reports to MEDAC. In addition, FHP used to report, every three months to the Managers Club Meeting jointly chaired by the Minister of MEDAC and Resident Representative of the World Bank.

3. Government Commitment

Another factor that had positive effect on the implementation process is the strong commitment shown by the Government in making available the counterpart budget to finance project costs in time. The measures taken to strengthen RHBS and ZHDs in terms of manpower, upgrading skills and office facilities had also contributed to the gradual improvement of project management and supervision at the regional level.

## B. Factors Subject to the Control of MOH/RHBs

At the initial stage of project implementation, the lack of previous experience in managing a World Bank financed project; particularly the time taken by project staff to familiarize themselves with the Bank's lending policies, procurement and disbursement guidelines had, to some extent, affected speedy implementation.

The high turn - over of project staff, particularly, project coordinators since 1989 had also some negative effect in smooth functioning of the project.

The Architects and Engineering Team in the PPD has played a crucial role in the implementation of this project. Since the restructuring of the Ministry, the staff of the Team has been reduced and has also been affected by similar turnover. This shortage at the center and the shortage of engineering staff at the regional level has negatively affected the efficient and regular supervision of project sites.

## C. Factors Subject to the Control of the Bank

Since the project was relaunched in February 1994, successive IDA-Supervision missions have visited Ethiopia to review the progress and problems of the Project. These visits and the assignment of Disbursement Officer and Social Sector Expert at the RM have enabled the Bank and MOH staff to jointly review periodically the status of the project, to conduct field trips to project sites in the regions, to jointly seek solutions to problems and to create a better understanding of the Bank's policies and guidelines as well as the potentials and limitations of implementing bodies.

## V. PROJECT SUSTAINABILITY

Some of the facilities constructed under FHP are new (H.Cs and H.Ss, RHBs, ZHDs DQCL) while the others are upgrading or extensions of already existing institutions (MLMPC and the training schools).

In general it can be said that project will definitely maintain and develop the achievements generated. This assessment is based on the following considerations:

### 1. Firm Government Commitment

As stated in IV A.2 the progress and problems of this project had been closely monitored by Government bodies at different levels and regional governments have been fully involved in the implementation process. The Federal and Regional Governments have appropriated operational budget for all facilities built under this project for EFY 1990 (1997-98). They have also prepared budget proposals for EFY 1991 (1998-99). Currently MHO and RHBs are engaged in the preparation of the five-year (1997/98-2001/02) Health Sector Development Plan for funding under SIP. The action plan, manpower requirement and budget for operational costs including maintenance of facilities for FHP-constructed facilities have been incorporated in the five-year plan.

The government commitment is also reflected in the steady increase of the budget allocation for the health sector in recent years. The new health sector financing strategy which is expected to be included shortly is another measure designed to ensure the financial sustainability of the health care delivery system. the growth of the health sector budget and the financial plan of the HSDP are shown in Tables 8 and 9

### 2. Policy Environment

The expansion of primary health care services, the development of health manpower, the strengthening health education and pharmaceutical services are major areas in which FHP has invested. These same areas have also been given significant importance/priority in the Health Policy and the Health Sector Development Plan.

## VI BANK PERFORMANCE

In general, the performance of the World Bank throughout the project cycle has been satisfactory.

The Project Task Manager and the Rresident Mission staff have made significant contribution to the successful completion of project by:

- closely working with and advising the MOH in the restructuring and relaunch of the project as well as in the preparation of central and regional action plans.
- actively participating in relaunch and implementation workshops.
- organizing useful workshops to upgrade the skills of PIU staff.
- coorganizing CPPR meetings and introducing the useful forum of Managers' Club Meeting
- Conducting well-planned supervision missions throughout the project life.

## VII GOVERNMENT PERFORMANCE

Considering the fact that FHP is the first Bank-financed project to be managed by MOH, and that the credit is closed as planned, the performance of the Government is quite satisfactory. As stated in paragraphs IV and V the involvement and commitment of the Government at different levels in the monitoring of project activities, making available the required funds has been very useful. In spite of the shortage of staff both at the center and the regional level, those involved in project coordination and supervision have done well.

## VIII ASSESSMENT OF OUTCOME

The overall outcome of the project is quite satisfactory. With the exception of the work interruption of 4 H.Ss, all construction works have been successfully completed. The 12-package procurement programs have all been implemented.

The amount of credit funds canceled is USD 1.47million. This balance represents the earning from exchange rate as well as saving from the procurement of drugs and medical equipment.

In terms of impact, all the activities undertaken by the project are expected to make direct or indirect contribution to the improvement of the country's health services. When they become operational, the 96 H.Ss and 19 H.Cs will make their share of contribution by making health service available to 2.8 million people .The up-grading of the 6 training school and the other forms of support given by the project will have the positive impact of increasing the in-take and improving the quality of education. The supply of printing machinery and equipment to HLMPC has already increased its production capacity; and the new Audio-Vesual Studio is expected to improve the center's quality of work. Similarly the new Drug Quality Control Laboratory will expand and improve the existing inadequate service.

## IX FUTURE OPERATIONS

Primary health care units prepare their annual plan and budget and submit to the Woreda Health Offices. These plans are based on envisaged activities covering such programs as MCH/FP, EPI, Environmental Health, Health Education as well as out-patient and in-patient services. The Woreda Health Offices submit their plans and budget to the ZHD; the ZHDs to the RHBs and the RHBs to Regional Government Councils. Implementation assessment and reporting is made quarterly for recurrent budget and monthly for capital budget activities. The training schools submit their plans and budget to the RHBs; while HLMPC and DQCL submit their plans to MOH. Based on this planning and monitoring arrangements MOH and RHBs have completed the preparation of the 1991-94 Health Sector Development Plan.

## X. KEY LESSONS LEARNED

The following are the most important lessons learned in the process of implementing the FHP.

A. Project Preparation

The preparation of the restructured- PHP was an extensive exercise that involved various departments of MOH, the RHBs and the World Bank staff. In general, the preparation work was based on adequate and relevant data as well as clear policy guidelines. The identification of the sector's priority problems, project objectives, beneficiaries and implementation strategy was well done. However, in the process of implementation it was learned that certain issues and details should have been defined more clearly. One such issue is the way the objectives of some components (particularly MCH/FP) were defined. In MCH/FP component, for instance, the targets for such activities as EPI, reduction of infant and under-5 mortality etc. were more of national program target than FHP targets. There should have been a clear distinction between the two so that outcome of project input could easily be quantified.

B. Civil Works

One of the problems encountered in the implementation of civil works was the occurrence of variation or additional works in several projects, particularly health stations, health centers and RHBs. The main reason has been the lack exhaustive design study and bill of quantities preparation. In the case of H.Cs and H.Ss, such works as fences, soakaway pits and water tankers were not included. In the case of RHBs, the standard designs did not provide options for foundation work to suit different types of soil as well as roof heights and air conditioning to suit hot climate areas. As a result, the project had to accommodate these variation works often resulting in budgetary constraints and delays in processing the approval of variation works. These shortcomings were due, mainly, to the shortage of specialized engineers to exhaustively study designs and screen specifications.

The other important lesson gained is that to undertake construction work of such magnitude, the question of ensuring the deployment of engineers and architects in sufficient number and mix must be seriously addressed. As the experience of this project has shown the shortage of engineering staff at the center and regional level has made it difficult to conduct regular site supervision, and has resulted in considerable delays of payments and in some cases problems of poor workmanship.

C. Capacity Building

In the process of implementation, PCO staff, Engineering team and RHB staff have, in varying degrees, gained useful experience. PCO staff have developed skills in project management, international and local procurement, project budget and finance administration. Engineering team and RHB staff have also gained valuable experience in civil works procurement and contract management.

D Regular and Systematic Monitoring

As explained in IV A.2 the success of the FHP has been partly attributed to the mechanism by which the project was closely and regularly monitored by different levels of Government bodies.

This kind of high-level regular and thorough monitoring exercise has not only helped to accelerate the pace of implementation, but has also enabled Government officials to have a thorough understanding of the progress and problems of a specific project, the practical problems involved in the application of Government and Bank guidelines, as well as the capacity potentials and limitations of implementing bodies. This kind of understanding has helped to give the necessary attention to project activities, to make timely interventions and rational decisions to facilitate project implementation.

This monitoring mechanism and experience should be sustained, and further systematized in the management of major Government projects.

E. Project Management

The FHP was designed to be implemented through the Ministry's normal management structure whereby the Head of the Planning and Programming Department, reporting to the Minister, was to be the project coordinator. Subsequently, a project Coordinating Unit staffed by a Coordinator, Deputy Coordinator, One Procurement and One Financial Officer was formed. However, when project activities went into full swing, it became evident that the staffing pattern was not commensurate with the actual volume and complexity of the work. The problem was further aggravated by frequent staff attrition and turn-over.

The original assumption that project activities would be carried out through the normal MOH management structure i.e. through departments responsible for specific components has, in some cases, not worked satisfactorily Particularly project finance activities have often run into problems because of the vague division of work of project finance staff and MOH Finance Division.

These management problems have resulted in over-stretched capacity, hectic schedules, occasional delays and errors as well as inadequate time for site supervision.

The lessons of FHP and ERRP can serve as a useful dress-rehearsal for the forthcoming HSDP. Therefore, such issues as the option of project management, the organizational relationship with existing structure, the staffing pattern, clear definitions of authority and responsibility etc. must be carefully assessed.

# PART TWO: STATISTICAL ANNEXES

Table 1

# Ethiopia

## Family Health Project

## Project Financing Plan,SAR Estimates and Actual (in million USD)

| Source | Planned | | | Actual | | |
|---|---|---|---|---|---|---|
| | Local | Foreign | Total | Local | Foreign | Total |
| IDA | 12.07 | 20.3 | 33.00 | 13.65 | 17.11 | 30.76* |
| Government of Ethiopia | 10.36 | 0 | 10.36 | 6.93 | 0 | 6.93** |
| UNICEF | 0 | 0.50 | 0.05 | 0 | 0 | 0*** |
| Total | 23.06 | 20.8 | 43.86 | 20.58 | 17.11 | 37.69****- |

*

1:- Out of the total credit funds, 1.47 million USD is to be canceled. This amount represents:-

a:- Savings from the procurement of Pharmaceuticals and Medical Equipment.

b:- Savings due to exchange rate fluctuations.

c:- Payments for the construction of four H.Statios which were not effected because of work interruption.

2:-The rate of disbursement from the credit fund is 95.44%.

**

1:- Out of the total Government contribution the total of 6.93 million USD (67%)has been disbursed.

2:- The remaining balance of Government matching funds represents :-

a:-1.72 million USD which was reduced from Government matching fund when it was decided in 1991 that 100% expenditure for Drugs and Contraceptives would be financed from the credit.

b:- 3.67 million USD allocated for salaries of staff of newly constructed health facilities which are to become operational.

***

:-UNICEF's pledged contribution was actually not made available.

****

:- Out of the total project cost, 37.69 million USD has been utilized which represents disbursement rate of 86 %.

Table 2

**FAMILY HEALTH PROJECT**
**EXPENDITURE BY CATEGORY**
**BEFORE RESTRUCTURING**

| CATEGORY | IDA | | | | | | GOVERNMENT CONTRIBUTION |
|---|---|---|---|---|---|---|---|
| | 1989 | 1990 | 1991 | 1992 | 1993 | TOTAL OF IDA | |
| CIVIL WORKS | | 16,384 | | | | **16,384** | |
| EQUIPMENT, MATERIALS, AND SUPPLIES | | 273,153 | 164,423 | 198,818 | 773,572 | **1,409,966** | |
| VEHICLES | | 167,615 | | | 227,531 | **395,146** | |
| RECURRENT COST | | 192,611 | 54,342 | 235,813 | 22,579 | **505,345** | |
| TRAINING | | 107,526 | 27,437 | | | **134,963** | |
| STUDIES | | | | | | | |
| CONSULTANTS SERVICE | | | | 2,044 | | **2,044** | |
| PROJECT PREPARATION FUND | 317,946 | | | | | **317,946** | |
| PHARMACEUTICALS | | | | 6,761,594 | 1,125,103 | **7,886,697** | |
| TOTAL | **317,946** | **757,289** | **246,202** | **7,198,269** | **2,148,785** | **10,668,491** | **701,884** |

Table 3

FAMILY HEALTH PROJECT

PLANNED & ACTUAL EXPENDITURE BY CATEGORY & YEAR

| S.no | Project Component | IDA | | | | | | | | | | Government | | | | | | | | | | Total of Govenement and IDA | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1994 | (1986/87) | 1995 | (1987/88) | 1996 | (1988/89) | 1997 | (1989/90) | Total | | 1994 | (1986/87) | 1995 | (1987/88) | 1996 | (1988/89) | 1997 | (1989/90) | Total | | | |
| | | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| 1 | Civil Works | 7,968.71 | 0.00 | 3,695.31 | 1,561.63 | 2,022.75 | 4,604.89 | 1,251.18 | 7,054.90 | 14,937.95 | 13,221.42 | 829.46 | 0.00 | 410.59 | 160.00 | 224.75 | 532.72 | 139.02 | 886.56 | 1,603.82 | 1,601.28 | 16,541.77 | 14,822.70 |
| 2 | Equipment Materials & Supplies | 1,436.26 | 0.00 | 917.45 | 39.69 | 298.40 | 22.98 | 112.55 | 1,384.71 | 2,764.66 | 1,447.38 | 291.27 | 0.00 | 198.25 | 3.97 | 129.90 | 0.00 | 73.65 | 427.02 | 693.07 | 430.99 | 3,457.73 | 1,878.37 |
| 3 | Vehicles | 456.50 | 0.00 | 299.20 | 0.00 | 90.20 | 741.00 | 10.20 | 0.00 | 856.10 | 741.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 856.10 | 741.00 |
| 4 | Recurrent Cost | 1,075.05 | 0.00 | 631.25 | 0.00 | 661.60 | 0.00 | 591.18 | 0.00 | 3,059.08 | 0.00 | 74.55 | 53.08 | 924.15 | 62.78 | 1,566.92 | 33.09 | 1,389.92 | 35.21 | 3,955.54 | 184.16 | 7,014.62 | 184.16 |
| 5 | Training | 121.00 | 27.17 | 12.30 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 133.30 | 27.17 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 133.30 | 27.17 |
| 6 | Studies | | | | | | | | | 0.00 | 0.00 | | | | | | | | | 0.00 | 0.00 | 0.00 | 0.00 |
| 7 | Consultants Service | | | | | | | | 0.01 | 0.00 | 0.01 | | | | | | | | | 0.00 | 0.00 | 0.00 | 0.01 |
| 8 | PPF | | | | | | | | | 0.00 | 0.00 | | | | | | | | | 0.00 | 0.00 | 0.00 | 0.00 |
| 9 | Pharmaceuticals & Medical Supplies | | 1,500.00 | | 0.00 | 4,286.30 | 0.00 | | 3,151.19 | 4,286.30 | 4,651.19 | | | | | | | | | 0.00 | 0.00 | 4,286.30 | 4,651.19 |
| 10 | Tax and Duty | | | | | | | | | 0.00 | 0.00 | | 955.45 | | | | 680.81 | | 2,391.00 | 0.00 | 4,007.26 | 0.00 | 4,007.26 |
| | Total | 11,057.52 | 1,527.17 | 5,555.51 | 1,601.32 | 7,359.25 | 5,368.87 | 2,065.11 | 11,590.81 | 26,037.39 | 20,088.17 | 1,195.28 | 1,008.53 | 1,532.99 | 246.75 | 1,921.57 | 1,226.62 | 1,602.59 | 3,741.79 | 6,252.43 | 6,223.69 | 32,289.82 | 26,311.86 |

Table 4

Family Health Project

PLANNED & ACTUAL EXPENDITURE BY COMPONENT & YEAR

| S.no | Project Component | IDA | | | | | | | | | | Government | | | | | | | | | | Total of Government and IDA | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1994 | (1966/8 | 1995 | (1967/8 | 1996 | (1968/8 | 1997 | (1969/9 | Total | | 1994 | (1966/8 | 1995 | (1967/8 | 1996 | (1968/8 | 1997 | (1969/9 | Total | | | |
| | | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual | Plan | Actual |
| 1 | Health Education/IEC | 379.05 | 0.00 | 58.77 | 0.00 | 7.65 | 75.42 | 7.65 | 204.69 | 453.33 | 280.11 | 45.35 | 14.20 | 29.33 | 19.18 | 24.25 | 22.18 | 24.74 | 25.70 | 123.67 | 81.26 | 577.00 | 361.37 |
| 2 | Manpower Development | 1,652.06 | 0.00 | 836.32 | 0.00 | 25.39 | 912.01 | 25.93 | 1,230.67 | 2,539.70 | 2,142.68 | 210.64 | 31.07 | 125.08 | 33.63 | 56.21 | 105.58 | 57.47 | 167.50 | 449.40 | 358.78 | 2,989.10 | 2,501.46 |
| 3 | MCH/FP | 5,272.16 | 27.17 | 3,159.69 | 1,414.70 | 2,973.49 | 2,924.41 | 1,953.34 | 5,409.95 | 13,358.68 | 9,776.23 | 635.14 | 0.00 | 485.71 | 167.86 | 583.53 | 315.93 | 561.06 | 889.47 | 2,265.44 | 1,373.26 | 15,634.12 | 11,149.49 |
| 4 | Institutional Development | 2,249.94 | 0.00 | 1,093.73 | 148.97 | 65.25 | 1,259.32 | 66.81 | 1,127.13 | 3,475.73 | 2,535.42 | 243.36 | 7.81 | 851.97 | 23.93 | 933.95 | 110.37 | 956.59 | 221.56 | 2,985.87 | 363.67 | 6,461.60 | 2,899.09 |
| 5 | Pharmaceutical | 1,504.31 | 1,500.00 | 407.00 | 37.65 | 4,287.47 | 197.71 | 1.17 | 3,618.16 | 5,199.95 | 5,353.52 | 60.79 | 0.00 | 40.90 | 2.15 | 323.63 | 10.75 | 2.73 | 26.56 | 428.05 | 39.46 | 6,628.00 | 5,392.98 |
| 6 | Consultancy | | | | | | | | 0.01 | 0.00 | 0.01 | | | | | | | | | 0.00 | 0.00 | 0.00 | 0.01 |
| 7 | PPF | | | | | | | | | 0.00 | 0.00 | | | | | | | | | 0.00 | 0.00 | 0.00 | 0.00 |
| 8 | Tax & Duty | | | | | | | | | 0.00 | 0.00 | | 955.45 | | | | 660.81 | | 2,391.00 | 0.00 | 4,007.26 | 0.00 | 4,007.26 |
| | Total | 11,057.52 | 1,527.17 | 5,555.51 | 1,601.32 | 7,359.25 | 5,368.87 | 2,055.11 | 11,590.81 | 25,037.39 | 20,088.17 | 1,195.28 | 1,008.53 | 1,532.99 | 246.75 | 1,921.57 | 1,226.82 | 1,602.59 | 3,741.79 | 6,252.43 | 6,223.69 | 32,289.82 | 26,311.86 |

Table 5

# H.CENTERS & H.STATIONS CONSTRUCTED BY THE FAMILY HEALTH PROJECT

| S.No | Name of Region | Type of Facility | Cost of construction in USD |
|---|---|---|---|
| 1 | Tigray | 2 H.Cs & 16 H.Ss | 1,025,852 |
| 2 | Afar | 12 H.Ss | 802,296 |
| 3 | Amhara | 4 H.Cs & 16 H.Ss | 1,710,747 |
| 4 | Oromia | 1 H.C | 132,306 |
| 5 | Somali | 4 H.Cs & 12 H. Ss | 1,626,773 |
| 6 | Benshangul | 1 H.C & 9 H.Ss | 943,368 |
| 7 | SNNPR | 6 H.Cs & 19 H.Ss | 2,208,727 |
| 8 | Gambella | 1 H.C & 12 H.Ss | 1,367,589 |
| Total | | | 9,817,658 |

Table 6

## OTHER FACILITIES CONSTRUCTED BY THE FAMILY HELTH PROJECT

| NO. | NAME OF FACILITY | COST OF CONSTRUCTION IN USD |
|---|---|---|
| 1 | AUDIO VISUAL STUDIO HLMPC | 107,977.00 |
| 2 | JIMMA SNITARIAN WORK SHOP | 69,971.00 |
| 3 | AWASSA LAB. TECH. SCHOOL | 282,483.00 |
| 4 | AWSSA HEALTH ASSISTANT SCHOOL | 640,673.00 |
| 5 | MENILIK HEALTH ASSISTANT SCHOOL | 593,401.00 |
| 6 | ZEWDITU & PAULOS NURSING SCHOOLS | 642,783.00 |
| 7 | AFAR REGIONAL HEALTH BUREAU | 618,338.00 |
| 8 | GAMBELLA REGIONAL HEALTH BUREAU | 612,584.00 |
| 9 | BENSHANGUL REGIONAL HEALTH BEREAU | 547,917.00 |
| 10 | ZONAL HEALTH DEPTEMENTS (WOLKTIE, MASHA & DURAME) | 594,630.00 |
| 11 | DRUG QUALITY CONTROL LABORATORY | 294,332.00 |
| TOTAL | | 5,005,089.00 |

Table - 7

**FAMILY HEALTH PROJECT**
**PROCUREMENT OF GOODS BY COMPONENT**
**(Before Restructuring)**

| No | Procured Items By Component | Value in USD | Beneficialries |
|---|---|---|---|
| 1 | MCH/FP Component | | |
| | - 247 Delivery Beds | 92,603.68 | Health Statens and Health Centers |
| | - 70 MCH Baby cots, 222 First aid Kits 222 Tape measures & 700 clinistone | 21,003.90 | around the former shewa region |
| | - Motorcycles | 61,852.00 | " " " " |
| | - Bicycles | 27,357.00 | |
| | Sub Total | 202,816.58 | |
| 2 | Monpower Development Comp. | | |
| | - Nissan Midi-Bus | 78,104.00 | Jima Institute of Health Science, Zewditu and St. Powlos Nursing schools and Awassa Health Assistant School. |
| | - Basic & Inservice Training Materials | 17,525.43 | Menilik and Awassa H. Assistant School |
| | - Books | 14,431.64 | " " " " |
| | Sub Total | 11,061.07 | |
| 3 | IEC Comp. | | |
| | - Video Products | 94,399.43 | Health Learning Materials Production Center |
| | - Photographic Supp. & Equipment | 56,670.39 | " " " " " |
| | - Offset Supplies for Gestetner offset Machine | 267,585.99 | " " " " " |
| | - Termo fax machine with consumables | 8,139.07 | " " " " " |
| | - One knife Grinding Machine. | 7,745.50 | " " " " " |
| | - Stahil-Folding Machine | 59,684.50 | " " " " " |
| | - Solna 225 plus two colour sheet fed offset machine | 165,207.39 | " " " " " |
| | - AMWolenberg perfect Binding Machine | 46,280.38 | " " " " " |
| | - Consumables for offset Machine | 127,186.64 | " " " " " |
| | - Amharic/ English plain paper publishing system | 14,966.73 | " " " " " |
| | - Computers | 33,061.43 | " " " " " |
| | - Paper Board print shop photographic and other supplies | 699,793.44 | " " " " " |
| | - Desk-top electrical puncting and Manual Binding machine | 2,749.99 | " " " " " |

| | Table - 7 | | |
|---|---|---|---|
| | **FAMILY HEALTH PROJECT** | | |
| | **PROCUREMENT OF GOODS BY COMPONENT** | | |
| | **(Before Restructuring)** | | |
| **No** | **Procured Items by Component** | **Value in USD** | **Beneficialries** |
| | - Heavy Duty Perforating Machine | 11,231.90 | Health Learning Materials Production Center |
| | - Autominabinda perfect building Machin | 22,017.81 | " " " " " |
| | Sub total | 1,616,720.59 | |
| | | | |
| 4 | Institutional Development component | | |
| | - Mitsibishi pick-up | 178,270.00 | Regional & Zonal H.facilitis |
| | - Toyota Station- Wagon | 120,778.00 | Ministry of Health H.a. |
| | - 3 units Mitsibushi Vehicles | 37,983.00 | PCO and Engenering Team |
| | - Water Sanitation Materials | 4,096.00 | Higine & Environmental Health Department |
| | - 1 unit Universal the odolite | 14,672.00 | Engenering Teams of MoH |
| | - Two unit olivetti Photo copier | 38,800.00 | " " 9 Pco " |
| | - RANK XEROX plan printer | 8,425.00 | " " |
| | - Unisis computer | 12,147.00 | " " |
| | - Office Equipment | 22,092.29 | " " |
| | - Fax Machine | 1,371.39 | PCO |
| | Sub total | 438,634.68 | |
| 5 | Pharmaceuticals Comp. | | |
| | -Drugs and Medical Supp. | 7,886,697.00 | Health Stations and Health centers and Hospitals |
| | Grand Total | 10,254,924.92 | |

Table: 8

## Family Health Project
## Procurement of Goods by Component
## ( After Restructuring)

| No- | Procurement of Goods by Component. | Value in USD | Beneficiaries |
|---|---|---|---|
| 1 | MCH/FP Component | | |
| | -Medical Equipment | 250,773.00 | 100 Health Stations and19 HealthCenters |
| | -MCH Aand B Kits | 39,690.00 | ,, ,, ,, |
| | -Furniture | 642,890.00 | ,, ,, ,, |
| | -Motorcycles | 45,642.00 | ,, ,, ,, |
| | -Station Wagon | 320570 | ,, ,, ,, |
| | **sub total** | **1,299,565.00** | |
| 2 | Manpower Development | | |
| | -Training Equipment | 17,082.00 | Menlik and Awassa health Assistant Schools. |
| | -Educational Materials and Office Equipment | 70,505.00 | ,, ,, ,, |
| | -Books and Journals | 31183.59 | ,, ,, ,, |
| | -Furniture | 42700.00 | Zewditu Nursing Schools |
| | -Furniture | 19340.00 | Laboratory technician School. |
| | **sub total** | **180810.59** | |
| 3 | IEC Component | | |
| | -Printing and Electrical Equipment | 174,740.00 | Health Learning Materials Production Center |
| | -Furniture | 6,340.00 | ,, ,, ,, |
| | **sub total** | **181080.00** | |
| 4 | Institutional Development | | |
| | -Trucks | 214,500.00 | Afar,Gambella and Benshangul RHBs |
| | -Station Wagons,Pick-ups | 124,670.00 | RHBs and ZHDs. |
| | -Office Equipment | 98,440.00 | for RHBs and PCO |
| | -Furniture | 110,720.00 | for 3 RHBs and 3ZHDs |
| | **sub total** | **548,330.00** | |
| 5 | Pharmaceuticals Component. | | |
| | -Drugs and Medical Supplies | | |
| | -Contraceotices | 2,402,704.00 | Health Stations,Health Centers and Hospitals. |
| | -Drug Quality Control Laboratory Equipment | 740,621.00 | ,, ,, ,, Drug Quality Control Laboratory. |
| | -Furniture | 367,510.80 | ,, ,, ,, |
| | -Station Wagon and Pick-up Vehicles | 32,060.00 | Drug Administration and Control Department. |
| | **sub total** | 35,620.00 | |
| | | **3,578,515.80** | |
| **Grand Total** | | **5,788,301.39** | |

**Table: 10**

## PLANNED BUDGET FOR HSDP
## (1997/98-2001/02)

| REGION | PLANNED BUDGET IN '000 BIRR | | |
|---|---|---|---|
| | Capital | Recurrent | Total |
| TIGRAY | 80,000.00 | 266,863.80 | 346,863.80 |
| AFAR | 115,050.36 | 98,430.54 | 213,480.90 |
| AMHARA | 148,770.90 | 639,629.14 | 788,400.04 |
| OROMIYA | 350,781.40 | 688,441.01 | 1,039,222.41 |
| SOMALI | 180,421.96 | 149,458.98 | 329,880.94 |
| BENSHANGUL-Gumuz | 62,238.50 | 101,023.30 | 163,261.80 |
| SNNPR | 177,690.44 | 482,009.56 | 659,700.00 |
| GAMBELLA | 55,591.19 | 60,336.12 | 115,927.31 |
| HARARI | 20,837.82 | 59,244.50 | 80,082.31 |
| ADDIS ABABA | 84,204.00 | 225,010.00 | 309,214.00 |
| DIRE DAWA | 41,557.86 | 51,334.54 | 92,892.39 |
| CENTER(MoH) | 74,330.60 | 354,391.30 | 428,721.90 |
| Total | 1,391,475.02 | 3,176,172.79 | 4,567,647.81 |

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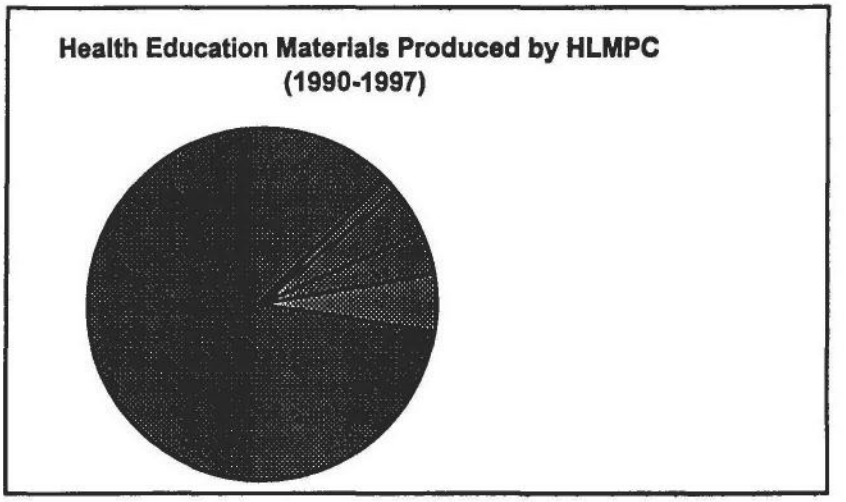
c:fhbudj.xls

TABLE- 11

| No | Description of H. Education Materials | Quantity | No. Languages | Target Beneficiary |
|---|---|---|---|---|
| 1. | Manual | 2500 | English | health workers |
| 2. | Guidelines in Family Planning Services in Ethiopia | 10000 | English | " " |
| 3. | HAGIAZT TENA | 6000 | Tegrigna | " " |
| 4. | National Health Policy | 20000 | Amharic/English | HW/General Public |
| 5. | A Quick Reminder for Family Planning Counselors | 4000 | Amharic/English | " " |
| 6. | Profile of Ethiopia Women and Highlights of the National Policy on Ethiopian Women | 400 | English | Women's |
| 7. | Ethiopian Women Policy | 5000 | Amharic/English | G.P |
| 8. | YETENA MAHEDER | 15000 | Amharic | G.P |
| 9. | Women's on Development | 300 | " | Women's |
| 10. | poly0 | 10000 | " | G/P Women's |
| 11. | Vitamin A | 10000 | " | G/P Women's " |
| 12 | Vitamin A | 7000 | Ormogia | G/P Women's |
| 13 | Vitamin A | 4000 | Tegerign | G/P Women's |
| 14 | Vitamin A | 25000 | English | G/P Women's |
| 15 | Meningitis | 10000 | Amharic | G/P Women's |
| 16 | T.V Programs | 11 | Amharic | G.Public |
| 17 | Documentary Films | 15 | >> | >> |
| 18 | Dramas | 13 | >> | >> |

TABLE- 11




| | |
|---|---|
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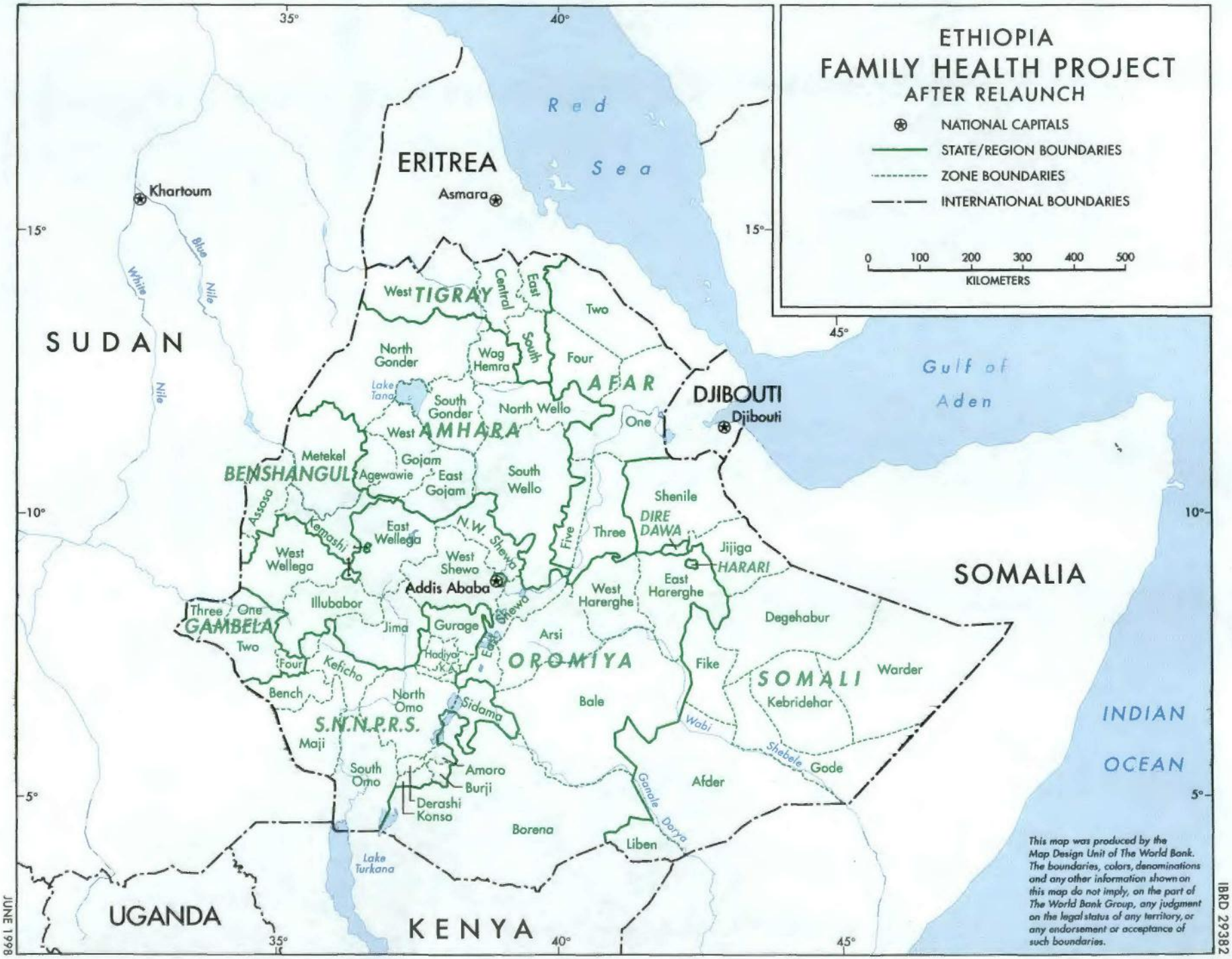
| *Leaflets* | *879250* |
| *Books* | *79150* |
| *Cards* | *102980* |
| *Forms* | *1672140* |
| *Certificates* | *16540* |
| *Poster* | *138120* |
| *Manuals* | *6500* |
| *Guidelines* | |
| *(Policy)* | *30000* |
| *Miscellanies* | *20343* |
| *Electronic Media* | |
| *T.V Programms* | *11* |
| *Documentary Films* | *15* |
| *Drammas* | *13* |

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JUNE 1998

IBRD 29382

# ICR Review - Evaluation Summary

**Operations Evaluation Department**

| 1. Project Data: | |
|---|---|
| **OEDID:** | C1913 |
| **Project Name:** | Family Health Project |
| **Country:** | Ethiopia |
| **Sector:** | Basic Health |
| **L/C Number:** | C1913 |
| **Partners involved:** | |
| **Prepared by:** | Charles Derek Poate, OEDST |
| **Reviewed by:** | Susan A. Stout |
| **Group Manager:** | Roger Slade |
| **Date Posted:** | 08/12/98 |

**2. Project Objectives, Financing, Costs and Components:**

The objectives were to (a) increase the quality, coverage and cost-effectiveness of maternal and child health (MCH) services; (b) increase the availability and use of FP services; (c) strengthen the institutional capacity of the Ministry of Health (MOH). It comprised six components: MCH/FP; Manpower Development; Institutional Development; Health Education and Information, Education and Communication (IEC); Pharmaceuticals, and Studies. The first four of these components primarily involved the provision of physical facilities and equipment. Pharmaceuticals involved the provision of drugs, storage and distribution and quality control. The two major cost components were MCH / FP and pharmaceuticals. The total cost of the project was US$38.2 million. The Bank provided an SDR of 23.8 million (US$33 million at the 1988 exchange rate). At completion it was 94.6 percent disbursed with US$1.7 million canceled. The planned allocation from UNICEF was never received.

**3. Achievement of Relevant Objectives:**

The assessment of the achievement of objectives has to be seen in the context of the slow pace of implementation during the period 1988 to 1994 and the re-design of project components in 1993-94. In the final two years of the project the emphasis was on the construction of physical works and provision of equipment and materials. This resulted in the outputs being largely achieved, but not the project outcome. In effect the project is unfinished, with the provision of health services to the beneficiaries only just beginning to get underway.

The physical works element (which applies to both MCH and FP services) has been achieved with civil works and procurement for 96 health stations and 19 health centers completed. Training in program management and training of trainers was undertaken. However, the services are not fully operational and will not be unless they are adequately staffed and recurrent costs are provided. Thus this objective is not yet achieved. The FHP has however, supplied pharmaceuticals to all levels of the health service delivery system. This component appears to have worked well. However, there is no evidence available to assess or quantify the impact of this component. The capacity for training has increased, offices and bureaus have been constructed and equipment purchased for health education. Training has been conducted by other organizations/agencies under other related projects. Workshops have been held on project management.

**4. Significant Achievements:**

The most significant achievement was the rapid pace of construction and equipment procurement in two years following the re-design of the project until its completion.

**5. Significant Shortcomings:**

The slow pace of implementation in the period 1988 to 1994 due to the civil war and lack of management capacity coupled with inadequate supervision (and support) by the Bank. As a result the project's objectives have not been achieved in terms of delivery of services to the beneficiaries.

| 6. Ratings: | ICR | OED Review | Reason for Disagreement/Comments |
|---|---|---|---|

| | | | |
|---|---|---|---|
| **Outcome:** | Satisfactory | Marginally Satisfactory | Due to the delay in implementation the outcome is not yet fully achieved and can only be assessed in 2 - 3 year's time. |
| **Institutional Dev.:** | Partial | Modest | |
| **Sustainability:** | Likely | Likely | The health services planned for under this project are only just now starting to be provided, largely as a result of extensive implementation delays due to civil disturbances. It is too early to view them as sustainable, especially in view of problems experienced in implementation. Nevertheless, the prospects for effectively staffing and supporting the infrastructure *provided under current policies and with* support from anticipated sector reforms are positive. |
| **Bank Performance:** | Satisfactory | Satisfactory | Bank performance was satisfactory in preparation, unsatisfactory in appraisal and deficient in the early stages of project implementation. Nevertheless, the Bank was responsive and constructive in helping to redesign the project. |
| **Borrower Perf.:** | Satisfactory | Satisfactory | Performance following restructuring was particularly strong. The Borrower's completion report is excellent. |
| **Quality of ICR:** | | Satisfactory | |

**7. Lessons of Broad Applicability:**

The quality of project appraisal is fundamental to project success. There were some major shortcomings during the appraisal stage in this project, particularly in terms of underestimating the costs of construction and equipment and in failing to address the risks inherent in a project where lack of management capacity in the implementing agency was identified but not addressed.

**8. Audit Recommended?** ( ) Yes (●) No

**9. Comments on Quality of ICR:**

The ICR provided appropriate coverage, and clearly identified the shortcomings of the project. However, the implications of the re-design were not fully addressed. For example, in the 2 years after re-design, the physical works were complete and equipment procured, but the provision of health services to beneficiaries remained largely unachieved. The ICR refers to the consultations between government and the Bank over the Health Sector Development Program but does not give a sense of its possible importance to the completion of the FHP in terms of service delivery and health system performance. Borrower's contribution to the ICR was highly satisfactory.

**This PIF was posted on August 12, 1998**

| | |
|---|---|
| OED ID : | C1913 |
| Type : | ES |
| Country : | Ethiopia |
| Project Description : | Family Health |
| Sector : | HX / Population, Health & Nutrition |
| Subsector : | HB / Basic Health |
| Lending Instrument : | Specific Investment |
| L/C : | C1913 |

## Operations Evaluation Department
## PROJECT INFORMATION FORM

### Table of Contents

## A1. General Project Information

| | |
|---|---|
| OED ID : | C1913 |
| Type : | ES |
| Country : | Ethiopia |
| Project Description : | Family Health |
| Sector : | HX / Population, Health & Nutrition |
| Subsector : | HB / Basic Health |
| Lending Instrument : | Specific Investment |
| L/C : | C1913 |

1. Reviewer: ITAD

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

Sugg. Sector:
Sugg. Subsector:

3. Key Dates

| | Original | Latest |
|---|---|---|
| Departure of Appraisal Mission | | 11/01/1986 |
| Approval | | 06/02/1988 |
| Signing/Agreement | | 07/14/1988 |
| Effectiveness | 09/12/1988 | 03/14/1989 |
| Physical completion | 12/01/1996 | 06/30/1997 |
| Closing | 12/31/1997 | 01/31/1998 |
| ICR receipt in OED | | 06/01/1998 |
| Review date | | 06/26/1998 |
| ES posting or PAR approval | | 08/12/1998 |

4. Key Amounts ($US million)

| | |
|---|---|
| Original Commitment | 33 |
| Total Cancellation | 1.76 |
| Total project cost | |
| Original | 43.86 |
| Latest | 38.32 |

5. Cofinanciers

| | First | Second | Third |
|---|---|---|---|
| Name | FDRE | UNICEF | |
| Original Commitment ($US million) | 10.36 | 0.5 | |
| Total Cancellation ($US million) | 1.7 | 10 | |

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

| | |
|---|---|
| Physical | 22 |
| Technical assistance | 0 |
| Balance of payments | 0 |
| Line of credit | 0 |
| Other | 16.32 |

7. Applicable disbursement profile (no. of years): 10

8. Number of supervision missions: 11

9. Name(s) of primary author(s) of ICR (indicate if not known): Maryam Salim

10. Names of managers

| | At entry | At exit |
|---|---|---|
| Task manager | ? | G Gopal (Task TL) |
| Division chief | ? | ? |
| Department director | ? | O A Meesook |

## A2. Project Objectives Evaluation

1. Were the project objectives substantially revised during implementation? **No**

   If Yes, did the Board approve the revised objectives as part of a formal restructuring?

   Date of Board approval

**Note:** If objectives were substantially revised, base the ratings in sections B1 and B2 on the revised objectives.

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

| | |
|---|---|
| Demanding on Borrower / Implementing Agency | High |
| Complexity | Substantial |
| Riskiness | High |

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

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

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

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

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

## B1a. Outcomes — Relevance

1. Indicate the relevance of each of the project's objectives in terms of the Bank's / Borrower's current country or sectoral objectives:

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

2. Summary Rating of Relevance

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

Average rating (weighted by scores on relative importance) Substantial

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

A number of the Bank's country objectives were not addressed in this project, for example environment and private sector development as they are not relevant to this project. In all other cases the relevance was high except one (substantial).

## B1b. Outcomes — Efficacy

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

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

2. Summary Rating of Efficacy

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

Average rating (weighted by scores on relative importance) Modest

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

## B1b. Outcomes — Efficacy (cont'd)

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

| | | | |
|---|---|---|---|
| World markets / prices | No Effect | Performance of contractors / consultants | Negative |
| Natural events | No Effect | War / civil disturbance | Highly Negative |
| Cofinancier(s) performance | Negative | Other (specify): | |

## B1c. Outcomes — Efficiency

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

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

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

| | | Point Value | Range | Weighted Average | Coverage / Scope |
|---|---|---|---|---|---|
| At Appraisal | (●) Not Available ( ) Not Applicable | | From : To : | | |
| At Completion | (●) Not Available ( ) Not Applicable | | From : To : | | |

2. Was another measure of efficiency provided? ( ) Yes (●) No

If Yes, then answer the following:

Measure used

Coverage / scope of measure

Comparison to appraisal estimate

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

If Yes, explain:

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

Soundness of analysis

Conduct of sensitivity / risk analysis

Consideration of institutional constraints to achieving results

Extent to which benefits accrue to target population

Consideration of environmental externalities

Consideration of fiscal impact

Consideration of alternatives to meeting objectives

Overall rating of quality of analysis

Average rating

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

## B1c. Outcomes — Efficiency (cont'd)

5. Summary Rating of Efficiency

Rate overall to what extent the project accomplished its goals efficiently: Not Applicable

Average rating

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

No measures of efficiency were provided in ICR, thus none are given here in this section.

## B1d. Outcomes — Summary

1. SUMMARY OUTCOME RATING

Rate the project's outcome (i.e., the extent to which it achieved relevant objectives), taking account of its relevance, efficacy, and efficiency: Marginally Satisfactory

Average rating: Satisfactory

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

The project went through exceptionally difficult circumstances during the period 1988 - 1993 when little was achieved. It was only after a re-design in 1994 until completion in 1997 that the works were completed, but services were not operational.

## B2. Sustainability

1. Rate the project's sustainability in terms of the following:

| | | | |
|---|---|---|---|
| Technical viability | Positive | Policy environment | Highly Positive |
| Financial viability | Not Applicable | Institution / management effectiveness | Positive |
| Economic viability | Not Applicable | Local participation | Negative |
| Social conditions | Positive | Other (specify): | |
| Environmental concerns | Not Applicable | | |
| Government commitment | Positive | | |

2. SUMMARY SUSTAINABILITY RATING

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

Average rating: Likely

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

## B3. Institutional Development

1. Was this project directed primarily toward Institutional Development? (●) Yes ( ) No

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

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

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

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

| | |
|---|---|
| **National capacity** | |
| Economic management | High |
| Civil service reform | High |
| Financial intermediation | Substantial |
| Legal / regulatory system | Negligible |
| Sectoral capacity | Substantial |
| Other (specify): | |
| | |
| **Agency capacity** | |
| Planning / policy analysis | High |
| Management | High |
| Skills upgrading | High |
| MIS | Negligible |
| Other (specify): | |
| | |
| **NGO Capacity** | Negligible |

5. For this project, rate the extent to which each of the following ID objectives was achieved:

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

6. SUMMARY INSTITUTIONAL DEVELOPMENT IMPACT RATING

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

Average rating: Substantial

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

The project has been subject to severe delays. It is therefore too early to assess whether the project has had more than a modest impact on institutional development.

## C1. Bank Performance

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

| | |
|---|---|
| Involvement of government | Modest |
| Involvement of beneficiaries | High |
| Project consistency with Bank strategy for country | High |
| Grounding in economic and sector work (ESW) | Substantial |
| Other (specify): | |

Overall rating on identification / preparation: Satisfactory

Average rating: Satisfactory

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

2. Indicate how well the Bank took account of the following during project appraisal:

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

Overall rating on appraisal: Satisfactory

Average rating: Satisfactory

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

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

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

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

Overall rating on supervision: Satisfactory

Average rating: Satisfactory

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

## C1. Bank Performance (cont'd)

5. SUMMARY RATING OF BANK PERFORMANCE

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

## C2. Borrower Performance

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

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

**Dimensions generally subject to government control**

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

**Dimensions generally subject to implementing agency control**

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

## C2. Borrower Performance (cont'd)

3. Summary Rating of Borrower Performance on Project Implementation

Overall rating: Satisfactory

Average rating: Satisfactory

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

4. Rate Borrower compliance with loan covenants / commitments:

Satisfactory

5. SUMMARY RATING OF BORROWER PERFORMANCE

Overall rating: Satisfactory

Average rating: Satisfactory

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

## D. Special Themes

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

| | |
|---|---|
| Gender related issues | Yes |
| Settlement / resettlement | Not Applicable |
| Beneficiary participation | Yes |
| Community development | Not Applicable |
| Skills development | Yes |
| Nutrition and food security | Yes |
| Health improvement | Yes |
| Other (specify): | |

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

No

If Yes, was the effect positive or negative?

3. Was this a Poverty Targeted Intervention? ( ) Yes (●) No

Did the project place a major emphasis on poverty alleviation? (●) Yes ( ) No

If Yes:

| | |
|---|---|
| Did it emphasize broad-based growth with labor absorption? | ( ) Yes (●) No |
| Did it emphasize human development (education, health, or nutrition)? | (●) Yes ( ) No |
| Did it emphasize the provision of a social safety net? | ( ) Yes (●) No |

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

| | |
|---|---|
| Natural resource management | No |
| Air / water / soil quality | No |
| Urban environmental quality | No |
| Other (specify): | |

## D. Special Themes (cont'd)

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

No

If Yes, was the effect positive or negative?

7. Rate the priority of the project for audit

Low

8. Rate the priority of the project for impact evaluation

Low

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

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

## E. Rating of ICR

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

| | |
|---|---|
| **Analysis** | |
| Coverage of important subjects | Satisfactory |
| Ex-post economic analysis | Not Applicable |
| Soundness of analysis | |
| Internal consistencies | Satisfactory |
| Evidence complete / convincing | Satisfactory |
| Adequacy of lessons learned | Satisfactory |
| Aide-memoire of the ICR mission | Satisfactory |

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

2. SUMMARY RATING OF ICR

| | |
|---|---|
| Rate the quality of the ICR: | Satisfactory |
| Average rating | Satisfactory |

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

## E. Rating of ICR (cont'd)

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

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

## F. Summary of Ratings

1. SUMMARY OF RATINGS

| | ICR | ES |
|---|---|---|
| Outcome | Satisfactory | Marginally Satisfactory |
| Sustainability | Likely | Likely |
| Institutional Development efficacy / impact | Modest | Modest |
| Bank performance | Satisfactory | Satisfactory |
| Borrower performance | Satisfactory | Satisfactory |
| ICR quality | | Satisfactory |

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

The delay in project implementation and the re-design and restructuring in 1994 meant that only 2 to 3 years were avaiable to complete the project works etc. A number of components were thus only just becoming operational at the time of the ICR and as a result it is too early to fully assess project outcomes and certainly too early to judge them satisfactory. Again, for the same reasons, it is too early to judge sustainability as likely. Bank supervision was satisfactory after the re-design but unsatisfactory up to that point. Performance at preparation was but deficient at appraisal. Overall it has been scored as marginally satisfactory.

## G. Overall Judgements / Miscellaneous Comments

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

SECTION A1, QUESTION 6
Due to the delays in implementation, the majority of outputs are in fact completed buildings or other physical facilities, which are not yet fully in use. For example the health eduction component which would appear to be a TA cost in fact comprises the rehabilitation of the print shop and procurement of equipment. Inevitably some TA is included in the estimate of the physical component but it is impossible to separate it.

SECTION A2, QUESTION 1
The objectives were not revised, but the project was substantially re-designed and restructured in 1993-1994 to take account of major provincial boundary changes and the new decentralisation policy.

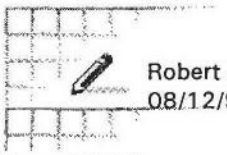
SECTION B3, QUESTION 3
Although it was not part of the project's plan, the new government introduced sweeping changes including the elimination of the province in which the project was situated as well introducing a de-centralisation policy. There were thus major externally introduced institutional changes.

SECTION C1, QUESTION 4
The performance of the Bank up to the time of the redesign of the project was decribed as weak and some of the major implementation problems were the result of inadequate supervision. After redesign the Bank's performance improved considerably and was satisfactory (i.e. the last 3 years). Overall it has been scored unsatisfactory on the basis of the weak performance during the key initial years of the project.

SECTION C1, QUESTION 2
Key indicators were listed in the re-appraisal in 1994 but were not available in the original SAR in 1988.

SECTION D, QUESTION 7
As the physical works of the project have only just been completed it is too early to assess fully the achievements of this project. Also the scale of the problems early on in the life of the project would justify an audit once the project is fully

file w/ Ethiopia ICR



Robert J. Van Der Lugt
08/12/98 04:04 PM

Extn: 31740 OEDST
Subject: Final ICR Review

In the abscence of the OEd evaluator, I have finalized and posted OED's ICR review on the Ethiopia Family Health project. We agreed to disaggree, although only marginally so, onthe outcome rating.

As requested please find attached a copy of the final ICR review.

Thank you for your help speeding up the review of this ICR.

---------- Forwarded by Robert J. Van Der Lugt/Person/World Bank on 08/12/98 03:59 PM
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# ICR Review - Evaluation Summary

**Operations Evaluation Department**

| 1. Project Data: | |
|---|---|
| **OEDID:** | C1913 |
| **Project Name:** | Family Health Project |
| **Country:** | Ethiopia |
| **Sector:** | Basic Health |
| **L/C Number:** | C1913 |
| **Partners involved:** | |
| **Prepared by:** | Charles Derek Poate, OEDST |
| **Reviewed by:** | Susan A. Stout |
| **Group Manager:** | Roger Slade |
| **Date Posted:** | 08/12/98 |

**2. Project Objectives, Financing, Costs and Components:**

The objectives were to (a) increase the quality, coverage and cost-effectiveness of maternal and child health (MCH) services; (b) increase the availability and use of FP services; (c) strengthen the institutional capacity of the Ministry of Health (MOH). It comprised six components: MCH/FP; Manpower Development; Institutional Development; Health Education and Information, Education and Communication (IEC); Pharmaceuticals, and Studies. The first four of these components primarily involved the provision of physical facilities and equipment. Pharmaceuticals involved the provision of drugs, storage and distribution and quality control. The two major cost components were MCH / FP and pharmaceuticals. The total cost of the project was US$38.2 million. The Bank provided an SDR of 23.8 million (US$33 million at the 1988 exchange rate). At completion it was 94.6 percent disbursed with US$1.7 million canceled. The planned allocation from UNICEF was never received.

**3. Achievement of Relevant Objectives:**

The assessment of the achievement of objectives has to be seen in the context of the slow pace of implementation during the period 1988 to 1994 and the re-design of project components in 1993-94. In the final two years of the project the emphasis was on the construction of physical works and provision of equipment and materials. This resulted in the outputs being largely achieved, but not the project outcome. In effect the project is unfinished, with the provision of health services to the beneficiaries only just beginning to get underway.

The physical works element (which applies to both MCH and FP services) has been achieved with civil works and procurement for 96 health stations and 19 health centers completed. Training in program management and training of trainers was undertaken. However, the services are not fully operational and will not be unless they are adequately staffed and recurrent costs are provided. Thus this objective is not yet achieved. The FHP has however, supplied pharmaceuticals to all levels of the health service delivery system. This component appears to have worked well. However, there is no evidence available to assess or quantify the impact of this component. The capacity for training has increased, offices and bureaus have been constructed and equipment purchased for health education. Training has been conducted by other organizations/agencies under other related projects. Workshops have been held on project management.

**4. Significant Achievements:**

The most significant achievement was the rapid pace of construction and equipment procurement in two years following the re-design of the project until its completion.

**5. Significant Shortcomings:**
The slow pace of implementation in the period 1988 to 1994 due to the civil war and lack of management capacity coupled with inadequate supervision (and support) by the Bank. As a result the project's objectives have not been achieved in terms of delivery of services to the beneficiaries.

| 6. Ratings: | ICR | OED Review | Reason for Disagreement/Comments |
|---|---|---|---|
| Outcome: | Satisfactory | Marginally Satisfactory | Due to the delay in implementation the outcome is not yet fully achieved and can only be assessed in 2 - 3 year's time. |
| Institutional Dev.: | Partial | Modest | |
| Sustainability: | Likely | Likely | The health services planned for under this project are only just now starting to be provided, largely as a result of extensive implementation delays due to civil disturbances. It is too early to view them as sustainable, especially in view of problems experienced in implementation. Nevertheless, the prospects for effectively staffing and supporting the infrastructure provided under current policies and with support from anticipated sector reforms are positive. |
| Bank Performance: | Satisfactory | Satisfactory | Bank performance was satisfactory in preparation, unsatisfactory in appraisal and deficient in the early stages of project implementation. Nevertheless, the Bank was responsive and constructive in helping to redesign the project. |
| Borrower Perf.: | Satisfactory | Satisfactory | Performance following restructuring was particularly strong. The Borrower's completion report is excellent. |
| Quality of ICR: | | Satisfactory | |

**7. Lessons of Broad Applicability:**
The quality of project appraisal is fundamental to project success. There were some major shortcomings during the appraisal stage in this project, particularly in terms of underestimating the costs of construction and equipment and in failing to address the risks inherent in a project where lack of management capacity in the implementing agency was identified but not addressed.

**8. Audit Recommended?** ○ Yes ● No

**9. Comments on Quality of ICR:**
The ICR provided appropriate coverage, and clearly identified the shortcomings of the project. However, the implications of the re-design were not fully addressed. For example, in the 2 years after re-design, the physical works were complete and equipment procured, but the provision of health services to beneficiaries remained largely unachieved. The ICR refers to the consultations between government and the Bank over the Health Sector Development Program but does not give a sense of its possible importance to the completion of the FHP in terms of service delivery and health system performance. Borrower's contribution to the ICR was highly satisfactory.

To: Oey Astra Meesook
cc: Susan A. Stout

Marcia J. Bailey
07/14/98 02:17 PM

Extn: 39617 OEDDR
Subject: ETHIOPIA: Family Health Project (Credit 1913-ET)
OED: Review of Implementation Completion Report

This ICR has been approved by you and it is now ready to go to the Region.

---

To: Ms. Oey Astra Meesook, Country Director, AFCO6

Attached for your review is OED's Evaluation Summary for the above project. This form contains OED's ratings and comments on the ICR. Any comments you may have should reach me no later than c.o.b Monday July 20th, 1998.

Roger Slade
Manager
Sector and Thematic Evaluations

cc: Messrs./Mmes
Prem C. Gaarg (MDOQA)
David De Ferranti (HDNVP)
Robert M. Hecht (HDNVP)
Joy De Beyer (HDNVP)
Richard G. Feachem (HDNHE)
Gita Gopal (AFTH4)
Susan Stout (OEDST)

bcc: Ms. Marcia Bailey (OEDST)

---------- Forwarded by Marcia J. Bailey/Person/World Bank on 07/14/98 01:01 PM
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# ICR Review - Evaluation Summary

**Operations Evaluation Department**

Date Created: 06/18/98 11:45:26 AM
Last Updated: 07/13/98 06:26:47 PM
Status: Open

| 1. Project Data: | |
|---|---|
| **OEDID:** | C1913 |
| **Project Name:** | Family Health Project |
| **Country:** | Ethiopia |
| **Sector:** | Basic Health |
| **L/C Number:** | C1913 |
| **Partners involved:** | |

| | |
|---|---|
| **Prepared by:** Charles Derek Poate, OEDST | |
| **Reviewed by:** Susan A. Stout | |
| **Group Manager:** Roger Slade | |
| **Date Posted:** | |

**2. Project Objectives, Financing, Costs and Components:**
The objectives were to (a) increase the quality, coverage and cost-effectiveness of maternal and child health (MCH) services; (b) increase the availability and use of FP services; (c) strengthen the institutional capacity of the Ministry of Health (MOH). It comprised six components: MCH/FP; Manpower Development; Institutional Development; Health Education and Information, Education and Communication (IEC); Pharmaceuticals, and Studies. The first four of these components primarily involved the provision of physical facilities and equipment. Pharmaceuticals involved the provision of drugs, storage and distribution and quality control. The two major cost components were MCH / FP and pharmaceuticals. The total cost of the project was US$38.2 million. The Bank provided an SDR of 23.8 million (US$33 million at the 1988 exchange rate). At completion it was 94.6 percent disbursed with US$1.7 million canceled. The planned allocation from UNICEF was never received.

**3. Achievement of Relevant Objectives:**
The assessment of the achievement of objectives has to be seen in the context of the slow pace of implementation during the period 1988 to 1994 and the re-design of project components in 1993-94. In the final two years of the project the emphasis was on the construction of physical works and provision of equipment and materials. This resulted in the outputs being largely achieved, but not the project outcome. In effect the project is unfinished, with the provision of health services to the beneficiaries only just beginning to get underway.

The physical works element (which applies to both MCH and FP services) has been achieved with civil works and procurement for 96 health stations and 19 health centers completed. Training in program management and training of trainers was undertaken. However, the services are not fully operational and will not be unless they are adequately staffed and recurrent costs are provided. Thus this objective is not yet achieved. The FHP has however, supplied pharmaceuticals to all levels of the health service delivery system. This component appears to have worked well. However, there is no evidence available to assess or quantify the impact of this component. The capacity for training has increased, offices and bureaus have been constructed and equipment purchased for health education. Training has been conducted by other organizations/agencies under other related projects. Workshops have been held on project management.

**4. Significant Achievements:**
The most significant achievement was the rapid pace of construction and equipment procurement in two years following the re-design of the project until its completion.

**5. Significant Shortcomings:**
The slow pace of implementation in the period 1988 to 1994 due to the civil war and lack of management capacity coupled with inadequate supervision (and support) by the Bank. As a result the project's objectives have not been achieved in terms of delivery of services to the beneficiaries.

| 6. Ratings: | ICR | OED Review | Reason for Disagreement/Comments |
|---|---|---|---|

| | | | |
|---|---|---|---|
| **Outcome:** | Satisfactory | Marginally Satisfactory | Due to the delay in implementation the outcome is not yet fully achieved and can only be assessed in 2 - 3 year's time. |
| **Institutional Dev.:** | Partial | Modest | |
| **Sustainability:** | Likely | Uncertain | For the same reason as above, the health services planned for under this project are only just now starting to be provided. It is too early to view them as sustainable, especially in view of problems experienced in implementation. |
| **Bank Performance:** | Satisfactory | Unsatisfactory | Bank performance was satisfactory in preparation, unsatisfactory in appraisal and deficient in the early stages of project implementation. Performance improved after project components were re-designed (in 1994) but the impact of poor performance at appraisal and on early supervision missions negatively affected the project and an overall rating of unsatisfactory is given. |
| **Borrower Perf.:** | Satisfactory | Satisfactory | |
| **Quality of ICR:** | | Satisfactory | |

**7. Lessons of Broad Applicability:**
The quality of project appraisal is fundamental to project success. There were some major shortcomings during the appraisal stage in this project, particularly in terms of underestimating the costs of construction and equipment and in failing to address the risks inherent in a project where lack of management capacity in the implementing agency was identified but not addressed.

**8. Audit Recommended?** Yes ● No

**9. Comments on Quality of ICR:**
The ICR provided appropriate coverage, and clearly identified the shortcomings of the project. However, the implications of the re-design were not fully addressed. For example, in the 2 years after re-design, the physical works were complete and equipment procured, but the provision of health services to beneficiaries remained largely unachieved. The ICR refers to the consultations between government and the Bank over the Health Sector Development Program document but does not give a sense of its possible importance to the completion of the FHP in terms of service delivery. Borrower contribution to the ICR was satisfactory.

To: Roger H. Slade
cc: Adala T. Bruce-Konuah

**Hernan Levy** 08/11/98 03:22 PM

Extn: 84021 OEDST
Subject: Ethiopia-Family Health OED ES

FYI - re Posting.

---------- Forwarded by Hernan Levy/Person/World Bank on 08/11/98 03:16 PM ----------

**OEY ASTRA**
**MEESOOK**
08/11/98 02:26 PM

Extn: 34872 AFC06
To: Hernan Levy cc: Gita Gopal, Arvil Van Adams, Maryam Salim
Subject: Ethiopia-Family Health OED ES

1. Thank you for sending us the revised draft evaluation summary (ES) for the ICR for the Ethiopia Family Health Project. We appreciate that the revised ES takes into account most of the comments we offered on the previous draft.

2. With the revision of the ratings of 'Bank performance' and 'Sustainability', the differences between the OED and ICR ratings have been minimized. The main remaining difference is OED's overall rating of "marginally satisfactory" as against the ICR's " satisfactory" rating. We still maintain that, notwithstanding the delays in project implementation during the initial years and the current lack of data to demonstrate sustainability, the overall rating in the ICR is reasonable. However, we could agree to disagree on this point.

3. Apart from the above, we have no further comments on the draft Evaluation Summary. Please do send us a copy of the Evaluation Summary, once finalized.

4. Thank you for being receptive to our comments.

Regards,
Oey

Hernan Levy

**Hernan Levy** 08/06/98 10:46 AM

Extn: 84021 OEDST
To: Oey Astra Meesook
Subject: Re: ETHIOPIA: Family Health Project (Credit 1913-ET)
OED: Review of Implementation Completion Report

Oey,

Unfortunately, the preparation of the Annual Review of Development Effectiveness (ARDE) report, for which finalized Evaluation Summaries and their ratings are key inputs, imposes a very tight deadline on OED, and we could only extend the deadline to August 12 as a maximum.

At the same time, you will see that we have given serious consideration to your team's comments and have revised the Evaluation Summary accordingly. I believe the only remaining bone of contention is the rating of project outcome as marginally satisfactory, which we have explained in detail in our previous note to you. We also noted there that a rating of marginally satisfactory is summarized in OED's annual databases as 'satisfactory' as that database employs a collapsed scale for reporting on outcomes.

Again, thank you for the very thorough comments you have given us on the Evaluation Summary.

Regards,

Hernan

OEY ASTRA

**OEY ASTRA MEESOOK**
08/05/98 05:51 PM

Extn: 34872 AFC06
To: Hernan Levy
Subject: Re: ETHIOPIA: Family Health Project (Credit 1913-ET)
OED: Review of Implementation Completion Report

Hernan:

I would like to request an extension to your deadline of August 10 for reviewing the revised ES. Everybody involved in the project is away on leave and will only be back in the office on August 17. Can we have until August 20 please?

Thank you.
Oey

Hernan Levy

**Hernan Levy** 08/04/98 03:54 PM

Extn: 84021 OEDST
To: Oey Astra Meesook cc: Prem C. Garg, David De Ferranti, Robert M. Hecht, Joy de Beyer, Richard G. Feachem,
Subject: Re: ETHIOPIA: Family Health Project (Credit 1913-ET)
OED: Review of Implementation Completion Report

Thank you very much for your comments on OED's draft Evaluation Summary (ES) for the Ethiopia

Family Health Project ICR.

OED has organized further review of the ICR and the ES to consider your comments, and suggests the following revisions. A revised ES reflecting these changes is attached for your review. Additional explanations are as follows:

**Outcome:** A rating of *marginally satisfactory*, as proposed by OED, is given to a project when it has achieved most of its major objectives, but with some shortcomings. While we note, and have revised the draft ES to reflect, that the project did perform well following the restructuring, we believe that it would be inappropriate to rate the project as 'satisfactory' in view of the significant (though clearly beyond project management control) delays in project implementation, and the absence of data which could provide some assurance that availability of services is actually on the increase. We would like to note, however, that a rating of marginally satisfactory is summarized in OED's annual databases as 'satisfactory' as that database employs a collapsed scale for reporting on outcomes. The marginal rating is a signal, we believe in this case relevant, that project design was likely overambitious given the political and administrative issues faced by Ethiopia at the time, that the project was made nationwide, and also ambitious through the re-structuring, and, in view of the fact that success in the provision of inputs (civil works, etc.) as achieved here, does not assure the achievement of expected outputs or outcomes. This is relevant given the SAR's considerable attention to the need for strengthening key elements of operational policy and software (work routines, supervision and monitoring systems, etc.), and which would contribute to making the establishment of physical infrastructure effective.

**Sustainability:** On further review, and noting that the Bank and the Borrower are actively discussing the future operations of the physical infrastructure accomplished during FHP in the context of plans for health sector reform that budgets in the health sector are increasing, OED agrees to the suggestion that project sustainabilty be rated as *likely.*

**Bank Performance:** It is apparent that the Bank performed satisfactorily in helping to re-structure and support this project following the civil disturbances that disrupted the original, evidently overambitious project design; we agree with the suggestion that its performance be rated as *satisfactory.*

**Borrower Performance:** We have amended the ES to take note of the high quality of the Borrower's completion report.

We would be grateful for your review of the ES, which has been revised to reflect these points, by cob Monday, August 10, 1998. In the meanwhile, thank you for your comments and for pointing out the strengths of the restructured project.

Sincerely,

Hernan Levy
Acting Manager
Sector and Thematic Evaluations Group

# ICR Review - Evaluation Summary

**Operations Evaluation Department**

Date Created: 06/18/98 11:45:26 AM
Last Updated: 08/04/98 11:16:35 AM

Status: Open

| 1. Project Data: | |
|---|---|
| **OEDID:** | C1913 |
| **Project Name:** | Family Health Project |
| **Country:** | Ethiopia |
| **Sector:** | Basic Health |
| **L/C Number:** | C1913 |
| **Partners involved:** | |
| **Prepared by:** | Charles Derek Poate, OEDST |
| **Reviewed by:** | Susan A. Stout |
| **Group Manager:** | Roger Slade |
| **Date Posted:** | |

**2. Project Objectives, Financing, Costs and Components:**

The objectives were to (a) increase the quality, coverage and cost-effectiveness of maternal and child health (MCH) services; (b) increase the availability and use of FP services; (c) strengthen the institutional capacity of the Ministry of Health (MOH). It comprised six components: MCH/FP; Manpower Development; Institutional Development; Health Education and Information, Education and Communication (IEC); Pharmaceuticals, and Studies. The first four of these components primarily involved the provision of physical facilities and equipment. Pharmaceuticals involved the provision of drugs, storage and distribution and quality control. The two major cost components were MCH / FP and pharmaceuticals. The total cost of the project was US$38.2 million. The Bank provided an SDR of 23.8 million (US$33 million at the 1988 exchange rate). At completion it was 94.6 percent disbursed with US$1.7 million canceled. The planned allocation from UNICEF was never received.

**3. Achievement of Relevant Objectives:**

The assessment of the achievement of objectives has to be seen in the context of the slow pace of implementation during the period 1988 to 1994 and the re-design of project components in 1993-94. In the final two years of the project the emphasis was on the construction of physical works and provision of equipment and materials. This resulted in the outputs being largely achieved, but not the project outcome. In effect the project is unfinished, with the provision of health services to the beneficiaries only just beginning to get underway.

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**4. Significant Achievements:**
The most significant achievement was the rapid pace of construction and equipment procurement in two years following the re-design of the project until its completion.

**5. Significant Shortcomings:**
The slow pace of implementation in the period 1988 to 1994 due to the civil war and lack of management capacity coupled with inadequate supervision (and support) by the Bank. As a result the project's objectives have not been achieved in terms of delivery of services to the beneficiaries.

| 6. Ratings: | ICR | OED Review | Reason for Disagreement/Comments |
|---|---|---|---|
| Outcome: | Satisfactory | Marginally Satisfactory | Due to the delay in implementation the outcome is not yet fully achieved and can only be assessed in 2 - 3 year's time. |
| Institutional Dev.: | Partial | Modest | |
| Sustainability: | Likely | Likely | The health services planned for under this project are only just now starting to be provided, largely as a result of extensive implementation delays due to civil disturbances. It is too early to view them as sustainable, especially in view of problems experienced in implementation. Nevertheless, the prospects for effectively staffing and supporting the infrastructure provided under current policies and with support from anticipated sector reforms are positive. |
| Bank Performance: | Satisfactory | Satisfactory | Bank performance was satisfactory in preparation, unsatisfactory in appraisal and deficient in the early stages of project implementation. Nevertheless, the Bank was responsive and constructive in helping to redesign the project. |
| Borrower Perf.: | Satisfactory | Satisfactory | Performance following restructuring was particularly strong. The Borrower's completion report is excellent. |
| Quality of ICR: | | Satisfactory | |

**7. Lessons of Broad Applicability:**
The quality of project appraisal is fundamental to project success. There were some major shortcomings during the appraisal stage in this project, particularly in terms of underestimating the costs of construction and equipment and in failing to address the risks inherent in a project where lack of management capacity in the implementing agency was identified but not addressed.

**8. Audit Recommended?** ○ Yes ● No

**9. Comments on Quality of ICR:**
The ICR provided appropriate coverage, and clearly identified the shortcomings of the project. However, the implications of the re-design were not fully addressed. For example, in the 2 years after re-design, the physical works were complete and equipment procured, but the provision of health services to beneficiaries remained largely unachieved. The ICR refers to the consultations between government and the Bank over the Health Sector Development Program but does not give a sense of its possible importance to the completion of the FHP in terms of service delivery and health system performance. Borrower's contribution to the ICR was highly satisfactory.

To: Robert J. Van Der Lugt

**Hernan Levy** 08/06/98 03:17 PM

Extn: 84021 OEDST
Subject: Re: ETHIOPIA: Family Health Project (Credit 1913-ET)
OED: Review of Implementation Completion Report

For your information - see below.

---------- Forwarded by Hernan Levy/Person/World Bank on 08/06/98 03:11 PM ----------

**OEY ASTRA MEESOOK**
08/06/98 02:33 PM

Extn: 34872 AFC06
To: Hernan Levy
Subject: Re: ETHIOPIA: Family Health Project (Credit 1913-ET)
OED: Review of Implementation Completion Report

Hernan:

Many thanks--we'll try and do it. And we do appreciate very much your taking our comments seriously and making the revisions.

Oey

Hernan Levy

**Hernan Levy** 08/06/98 10:46 AM

Extn: 84021 OEDST
To: Oey Astra Meesook
Subject: Re: ETHIOPIA: Family Health Project (Credit 1913-ET)
OED: Review of Implementation Completion Report

Oey,

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Again, thank you for the very thorough comments you have given us on the Evaluation Summary.

Regards,

Hernan

OEY ASTRA

**OEY ASTRA**
**MEESOOK**
08/05/98 05:51 PM

Extn: 34872 AFC06
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Subject: Re: ETHIOPIA: Family Health Project (Credit 1913-ET)
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Hernan Levy

**Hernan Levy** 08/04/98 03:54 PM

Extn: 84021 OEDST
To: Oey Astra Meesook cc: Prem C. Garg, David De Ferranti, Robert M. Hecht, Joy de Beyer, Richard G. Feachem,
Subject: Re: ETHIOPIA: Family Health Project (Credit 1913-ET)
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of the fact that success in the provision of inputs (civil works, etc.) as achieved here, does not assure the achievement of expected outputs or outcomes. This is relevant given the SAR's considerable attention to the need for strengthening key elements of operational policy and software (work routines, supervision and monitoring systems, etc.), and which would contribute to making the establishment of physical infrastructure effective.

**Sustainability:** On further review, and noting that the Bank and the Borrower are actively discussing the future operations of the physical infrastructure accomplished during FHP in the context of plans for health sector reform that budgets in the health sector are increasing, OED agrees to the suggestion that project sustainabilty be rated as *likely.*

**Bank Performance:** It is apparent that the Bank performed satisfactorily in helping to re-structure and support this project following the civil disturbances that disrupted the original, evidently overambitious project design; we agree with the suggestion that its performance be rated as *satisfactory*.

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Sincerely,

Hernan Levy
Acting Manager
Sector and Thematic Evaluations Group

# ICR Review - Evaluation Summary

**Operations Evaluation Department**

Date Created: 06/18/98 11:45:26 AM
Last Updated: 08/04/98 11:16:35 AM

Status: Open

| 1. Project Data: | |
|---|---|
| **OEDID:** | C1913 |
| **Project Name:** | Family Health Project |
| **Country:** | Ethiopia |
| **Sector:** | Basic Health |
| **L/C Number:** | C1913 |
| **Partners involved:** | |
| **Prepared by:** | Charles Derek Poate, OEDST |
| **Reviewed by:** | Susan A. Stout |
| **Group Manager:** | Roger Slade |
| **Date Posted:** | |

**2. Project Objectives, Financing, Costs and Components:**

*The objectives were to (a) increase the quality, coverage and cost-effectiveness of maternal and child health (MCH)* services; (b) increase the availability and use of FP services; (c) strengthen the institutional capacity of the Ministry of Health (MOH). It comprised six components: MCH/FP; Manpower Development; Institutional Development; Health Education and Information, Education and Communication (IEC); Pharmaceuticals, and Studies. The first four of these components primarily involved the provision of physical facilities and equipment. Pharmaceuticals involved the provision of drugs, storage and distribution and quality control. The two major cost components were MCH / FP and pharmaceuticals. The total cost of the project was US$38.2 million. The Bank provided an SDR of 23.8 million (US$33 million at the 1988 exchange rate). At completion it was 94.6 percent disbursed with US$1.7 million canceled. The planned allocation from UNICEF was never received.

**3. Achievement of Relevant Objectives:**

The assessment of the achievement of objectives has to be seen in the context of the slow pace of implementation during the period 1988 to 1994 and the re-design of project components in 1993-94. In the final two years of the project the emphasis was on the construction of physical works and provision of equipment and materials. This resulted in the outputs being largely achieved, but not the project outcome. In effect the project is unfinished, with the provision of health services to the beneficiaries only just beginning to get underway.

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**4. Significant Achievements:**
The most significant achievement was the rapid pace of construction and equipment procurement in two years following the re-design of the project until its completion.

**5. Significant Shortcomings:**
The slow pace of implementation in the period 1988 to 1994 due to the civil war and lack of management capacity coupled with inadequate supervision (and support) by the Bank. As a result the project's objectives have not been achieved in terms of delivery of services to the beneficiaries.

| 6. Ratings: | ICR | OED Review | Reason for Disagreement/Comments |
|---|---|---|---|
| Outcome: | Satisfactory | Marginally Satisfactory | Due to the delay in implementation the outcome is not yet fully achieved and can only be assessed in 2 - 3 year's time. |
| Institutional Dev.: | Partial | Modest | |
| Sustainability: | Likely | Likely | The health services planned for under this project are only just now starting to be provided, largely as a result of extensive implementation delays due to civil disturbances. It is too early to view them as sustainable, especially in view of problems experienced in implementation. Nevertheless, the prospects for effectively staffing and supporting the infrastructure provided under current policies and with support from anticipated sector reforms are positive. |
| Bank Performance: | Satisfactory | Satisfactory | Bank performance was satisfactory in preparation, unsatisfactory in appraisal and deficient in the early stages of project implementation. Nevertheless, the Bank was responsive and constructive in helping to redesign the project. |
| Borrower Perf.: | Satisfactory | Satisfactory | Performance following restructuring was particularly strong. The Borrower's completion report is excellent. |
| Quality of ICR: | | Satisfactory | |

**7. Lessons of Broad Applicability:**
The quality of project appraisal is fundamental to project success. There were some major shortcomings during the appraisal stage in this project, particularly in terms of underestimating the costs of construction and equipment and in failing to address the risks inherent in a project where lack of management capacity in the implementing agency was identified but not addressed.

**8. Audit Recommended?** ○ Yes ● No

**9. Comments on Quality of ICR:**
The ICR provided appropriate coverage, and clearly identified the shortcomings of the project. However, the implications of the re-design were not fully addressed. For example, in the 2 years after re-design, the physical works were complete and equipment procured, but the provision of health services to beneficiaries remained largely unachieved. The ICR refers to the consultations between government and the Bank over the Health Sector Development Program but does not give a sense of its possible importance to the completion of the FHP in terms of service delivery and health system performance. Borrower's contribution to the ICR was highly satisfactory.

To: Susan A. Stout
Robert J. Van Der Lugt

**Hernan Levy** 08/04/98 03:54 PM

Extn: 84021 OEDST
Subject: Re: ETHIOPIA: Family Health Project (Credit 1913-ET)
OED: Review of Implementation Completion Report

Thank you very much for your comments on OED's draft Evaluation Summary (ES) for the Ethiopia Family Health Project ICR.

OED has organized further review of the ICR and the ES to consider your comments, and suggests the following revisions. A revised ES reflecting these changes is attached for your review. Additional explanations are as follows:

**Outcome:** A rating of *marginally satisfactory,* as proposed by OED, is given to a project when it has achieved most of its major objectives, but with some shortcomings. While we note, and have revised the draft ES to reflect, that the project did perform well following the restructuring, we believe that it would be inappropriate to rate the project as 'satisfactory' in view of the significant (though clearly beyond project management control) delays in project implementation, and the absence of data which could provide some assurance that availability of services is actually on the increase. We would like to note, however, that a rating of marginally satisfactory is summarized in OED's annual databases as 'satisfactory' as that database employs a collapsed scale for reporting on outcomes. The marginal rating is a signal, we believe in this case relevant, that project design was likely overambitious given the political and administrative issues faced by Ethiopia at the time, that the project was made nationwide, and also ambitious through the re-structuring, and, in view of the fact that success in the provision of inputs (civil works, etc.) as achieved here, does not assure the achievement of expected outputs or outcomes. This is relevant given the SAR's considerable attention to the need for strengthening key elements of operational policy and software (work routines, supervision and monitoring systems, etc.), and which would contribute to making the establishment of physical infrastructure effective.

**Sustainability:** On further review, and noting that the Bank and the Borrower are actively discussing the future operations of the physical infrastructure accomplished during FHP in the context of plans for health sector reform that budgets in the health sector are increasing, OED agrees to the suggestion that project sustainabilty be rated as *likely.*

**Bank Performance:** It is apparent that the Bank performed satisfactorily in helping to re-structure and support this project following the civil disturbances that disrupted the original, evidently overambitious project design; we agree with the suggestion that its performance be rated as *satisfactory.*

**Borrower Performance:** We have amended the ES to take note of the high quality of the Borrower's completion report.

We would be grateful for your review of the ES, which has been revised to reflect these points, by cob Monday, August 10, 1998. In the meanwhile, thank you for your comments and for pointing out the strengths of the restructured project.

Sincerely,

Hernan Levy
Acting Manager
Sector and Thematic Evaluations Group

# ICR Review - Evaluation Summary

**Operations Evaluation Department**

Date Created: 06/18/98 11:45:26 AM
Last Updated: 08/04/98 11:16:35 AM

Status: Open

| 1. Project Data: | |
|---|---|
| **OEDID:** | C1913 |
| **Project Name:** | Family Health Project |
| **Country:** | Ethiopia |
| **Sector:** | Basic Health |
| **L/C Number:** | C1913 |
| **Partners involved:** | |
| **Prepared by:** | Charles Derek Poate, OEDST |
| **Reviewed by:** | Susan A. Stout |
| **Group Manager:** | Roger Slade |
| **Date Posted:** | |

**2. Project Objectives, Financing, Costs and Components:**

The objectives were to (a) increase the quality, coverage and cost-effectiveness of maternal and child health (MCH) services; (b) increase the availability and use of FP services; (c) strengthen the institutional capacity of the Ministry of Health (MOH). It comprised six components: MCH/FP; Manpower Development; Institutional Development; Health Education and Information, Education and Communication (IEC); Pharmaceuticals, and Studies. The first four of these components primarily involved the provision of physical facilities and equipment. Pharmaceuticals involved the provision of drugs, storage and distribution and quality control. The two major cost components were MCH / FP and pharmaceuticals. The total cost of the project was US$38.2 million. The Bank provided an SDR of 23.8 million (US$33 million at the 1988 exchange rate). At completion it was 94.6 percent disbursed with US$1.7 million canceled. The planned allocation from UNICEF was never received.

**3. Achievement of Relevant Objectives:**

The assessment of the achievement of objectives has to be seen in the context of the slow pace of implementation during the period 1988 to 1994 and the re-design of project components in 1993-94. In the final two years of the project the emphasis was on the construction of physical works and provision of equipment and materials. This resulted in the outputs being largely achieved, but not the project outcome. In effect the project is unfinished, with the provision of health services to the beneficiaries only just beginning to get underway.

The physical works element (which applies to both MCH and FP services) has been achieved with civil works and procurement for 96 health stations and 19 health centers completed. Training in program management and training of trainers was undertaken. However, the services are not fully operational and will not be unless they are adequately staffed and recurrent costs are provided. Thus this objective is not yet achieved. The FHP has however, supplied pharmaceuticals to all levels of the health service delivery system. This component appears to have worked well. However, there is no evidence available to assess or quantify the impact of this component. The capacity for training has increased, offices and bureaus have been constructed and equipment purchased for health education. Training has been conducted by other organizations/agencies under other related projects. Workshops have been held on project management.

**4. Significant Achievements:**
The most significant achievement was the rapid pace of construction and equipment procurement in two years following the re-design of the project until its completion.

**5. Significant Shortcomings:**
The slow pace of implementation in the period 1988 to 1994 due to the civil war and lack of management capacity coupled with inadequate supervision (and support) by the Bank. As a result the project's objectives have not been achieved in terms of delivery of services to the beneficiaries.

| 6. Ratings: | ICR | OED Review | Reason for Disagreement/Comments |
|---|---|---|---|
| Outcome: | Satisfactory | Marginally Satisfactory | Due to the delay in implementation the outcome is not yet fully achieved and can only be assessed in 2 - 3 year's time. |
| Institutional Dev.: | Partial | Modest | |
| Sustainability: | Likely | Likely | The health services planned for under this project are only just now starting to be provided, largely as a result of extensive implementation delays due to civil disturbances. It is too early to view them as sustainable, especially in view of problems experienced in implementation. Nevertheless, the prospects for effectively staffing and supporting the infrastructure provided under current policies and with support from anticipated sector reforms are positive. |
| Bank Performance: | Satisfactory | Satisfactory | Bank performance was satisfactory in preparation, unsatisfactory in appraisal and deficient in the early stages of project implementation. Nevertheless, the Bank was responsive and constructive in helping to redesign the project. |
| Borrower Perf.: | Satisfactory | Satisfactory | Performance following restructuring was particularly strong. The Borrower's completion report is excellent. |
| Quality of ICR: | | Satisfactory | |

**7. Lessons of Broad Applicability:**
The quality of project appraisal is fundamental to project success. There were some major shortcomings during the appraisal stage in this project, particularly in terms of underestimating the costs of construction and equipment and in failing to address the risks inherent in a project where lack of management capacity in the implementing agency was identified but not addressed.

**8. Audit Recommended?** ○ Yes ● No

**9. Comments on Quality of ICR:**
The ICR provided appropriate coverage, and clearly identified the shortcomings of the project. However, the implications of the re-design were not fully addressed. For example, in the 2 years after re-design, the physical works were complete and equipment procured, but the provision of health services to beneficiaries remained largely unachieved. The ICR refers to the consultations between government and the Bank over the Health Sector Development Program but does not give a sense of its possible importance to the completion of the FHP in terms of service delivery and health system performance. Borrower's contribution to the ICR was highly satisfactory.

To: Oey Astra Meesook
cc: Prem C. Garg
David De Ferranti
Robert M. Hecht
Joy De Beyer
Richard G. Feachem
Gita Gopal
Susan A. Stout
Arvil Van Adams
Maryam Salim
Timothy A. Johnston
Robert J. Van Der Lugt
Roger H. Slade

Robert J. Van Der Lugt
07/15/98 12:40 PM

Extn: 31740 OEDST
Subject: Re: ETHIOPIA: Family Health Project (Credit 1913-ET)
OED: Review of Implementation Completion Report

Roger,

My first reaction was to give the extension. Why not. I know Gita from the Uganda PAPSCA audit and she was very helpful and accommodating without giving up her professional opinion. (If she ever applied to OED and you asked for my opinion I would suggest you recruit her - but that is not the point her).

My second reaction is one of dismay. Why should we bother a taskmanager while on homeleave? The Bank should be able to function even when people are away. This will be even more important when we are decentralizing. For that reason therefore would not accede to demand for an extension - the reason is not personal (I would give Gita two weeks if needed), the reason is institutional - there is no excuse for the institution to hide behind a taskmanager on leave. In fact this in contrary to all of the human resource management principles that the Bank is promoting.

I suggest we reply accordingly. I also suggests this issue be taking up at the DMT - and if need higher. PCDs PADs all follow timetables, but it seems that for OED timetables we can relax. Why? Evaluation is not important?

Anyway, my point is she is on home leave, we should not bother her, and in any case the institution should reply within the agreed timeframework, unless there are major reasons not to do so.

Robert-Jan
Robert-Jan

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To: Roger H. Slade
cc: Susan A. Stout

**Susan A. Stout** 07/15/98 12:55 PM

Extn: 82537 OEDST
Subject: Re: ETHIOPIA: Family Health Project (Credit 1913-ET)
OED: Review of Implementation Completion Report

Robert,

I blew it. Your point makes sense, but I hastily wrote already saying that the extension would be ok. I should have checked with you first, but didn't.

I would disagree with one aspect of your argument however. As a task manager, I would very much appreciate management taking the time and making the effort to contact me for my views on OED's review of my project. If they didn't , I'd be annoyed, particularly in an environment when the distance between a manager and the nuts and bolts of a particular project is growing not shrinking.

Moreover, as important as we think evaluation is, I doubt that we'd ever have much success generating much of a sense of urgency re deadlines for OED reviews of reports that have already been submitted to the Board.

Sorry for my haste an acceding to the extension request!

Susan

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To: Robert J. Van Der Lugt
cc: Roger H. Slade

Robert J. Van Der Lugt
07/16/98 08:17 AM

Extn: 31740 OEDST *** **DRAFT** ***
Subject: Re: ETHIOPIA: Family Health Project (Credit 1913-ET)
OED: Review of Implementation Completion Report

Susan,

I have no problem with the extension. That is procedural.

You make a very good point about the involvement of the taskmanager in the OED review (but I still think we should not bother taskmanagers on leave). Anyway this might be a good point to explore and debate in more detail at another opportunity (brownbag?).

Robert-Jan

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To: Susan A. Stout

**Hernan Levy** 08/04/98 03:54 PM

Extn: 84021 OEDST
Subject: Re: ETHIOPIA: Family Health Project (Credit 1913-ET)
OED: Review of Implementation Completion Report

Thank you very much for your comments on OED's draft Evaluation Summary (ES) for the Ethiopia Family Health Project ICR.

OED has organized further review of the ICR and the ES to consider your comments, and suggests the following revisions. A revised ES reflecting these changes is attached for your review. Additional explanations are as follows:

**Outcome**: A rating of *marginally satisfactory*, as proposed by OED, is given to a project when it has achieved most of its major objectives, but with some shortcomings. While we note, and have revised the draft ES to reflect, that the project did perform well following the restructuring, we believe that it would be inappropriate to rate the project as 'satisfactory' in view of the significant (though clearly beyond project management control) delays in project implementation, and the absence of data which could provide some assurance that availability of services is actually on the increase. We would like to note, however, that a rating of marginally satisfactory is summarized in OED's annual databases as 'satisfactory' as that database employs a collapsed scale for reporting on outcomes. The marginal rating is a signal, we believe in this case relevant, that project design was likely overambitious given the political and administrative issues faced by Ethiopia at the time, that the project was made nationwide, and also ambitious through the re-structuring, and, in view of the fact that success in the provision of inputs (civil works, etc.) as achieved here, does not assure the achievement of expected outputs or outcomes. This is relevant given the SAR's considerable attention to the need for strengthening key elements of operational policy and software (work routines, supervision and monitoring systems, etc.), and which would contribute to making the establishment of physical infrastructure effective.

**Sustainability:** On further review, and noting that the Bank and the Borrower are actively discussing the future operations of the physical infrastructure accomplished during FHP in the context of plans for health sector reform that budgets in the health sector are increasing, OED agrees to the suggestion that project sustainabilty be rated as *likely*.

**Bank Performance:** It is apparent that the Bank performed satisfactorily in helping to re-structure and support this project following the civil disturbances that disrupted the original, evidently overambitious project design; we agree with the suggestion that its performance be rated as *satisfactory*.

**Borrower Performance:** We have amended the ES to take note of the high quality of the Borrower's completion report.

We would be grateful for your review of the ES, which has been revised to reflect these points, by cob Monday, August 10, 1998. In the meanwhile, thank you for your comments and for pointing out the strengths of the restructured project.

Sincerely,

Hernan Levy
Acting Manager
Sector and Thematic Evaluations Group

**Hernan Levy** 08/03/98 05:53 PM

Extn: 84021 OEDST
Subject: Re: ETHIOPIA: Family Health Project (Credit 1913-ET)
OED: Review of Implementation Completion Report

Susan,

I read the proposed cover email and it reads quite well. I found your explanation about the marginally rating and the OED databases very useful for the region to know.

Do you expect the network to react one way or another? We have had cases where the network has come out with a tougher view than the region, and OED has been caught in the middle. I hope this is not the case here.

I assume this was an ITAD project that you reviewed? (If not, the Panel reviewer should be consulted.)

I understand Roger's approach is to ask the task manager to respond to comments, starting with a sentence saying that... Roger Slade has asked me to respond in his behalf...., or something similar. So, please send the email yourself and copy to Roger and myself (in addition to the network)

Hernan

Susan A. Stout

**Susan A. Stout** 08/03/98 05:00 PM

Extn: 82537 OEDST
To: Hernan Levy, tjohnston
Subject: Re: ETHIOPIA: Family Health Project (Credit 1913-ET)
OED: Review of Implementation Completion Report

Hernan,

We have had some serious, and sensible, comments from the region on this evaluation summary. After discussing with Tim, I've suggested that we go ahead and revise the ES to consider their comments. I will forward the revision to you separately, but would like your views on this email, which I propose would become your cover EM for sending the revised ES to the region.

Many thanks for your comments/suggestions:

Susan

---------- Forwarded by Susan A. Stout/Person/World Bank on 08/03/98 04:58 PM ----------

**Susan A. Stout** 08/03/98 04:02 PM

Extn: 82537 OEDST *** DRAFT ***
To: Oey Meesook cc: Prem C. Garg, David De Ferranti, Robert M. Hecht, Joy de Beyer, Richard G. Feachem, Gita G
Subject: Re: ETHIOPIA: Family Health Project (Credit 1913-ET)
OED: Review of Implementation Completion Report

Thank you very much for your comments on OED's draft Evaluation Summary (ES) for the Ethiopia Family Health Project ICR.

OED has organized further review of the ICR and the ES to consider your comments, and suggests the following revisions. A revised ES reflecting these changes is attached for your review. Additonal explanations are as follows:

**Outcome:** A rating of *marginally satisfactory*, as proposed by OED, is given to a project when it has achieved most of its major objectives, but with some shortcomings. While we note, and have revised the draft ES to reflect, that the project did perform well following the restructuring, we believe that it would be inappropriate to rate the project as 'satisfactory' in view of the significant (though clearly beyond project management control) delays in project implementation, and the absence of data which could provide some assurance that availability of services is actually on the increase. We would like to note, however, that a rating of marginally satisfactory is summarized in OED's annual databases as 'satisfactory' as that database employs a collapsed scale for reporting on outcomes. The marginal rating is a signal, we believe in this case relevant, that project design was likely overambitious given the political and administrative issues faced by Ethiopia at the time, and more, in view of the fact that success in the provision of inputs (civil works, etc.) as achieved here, does not assure the achievement of expected outputs or outcomes. This is especially relevant given the SAR's considerable attention to the need for strengthening key elements of operational policy and software (work routines, supervision and monitoring systems, etc.), and which would contribute to making the establishment of physical infrastructure effective.

**Sustainability:** On further review, and noting that the Bank and the Borrower are actively discussing the future operations of the physical infrastructure accomplished during FHP in the context of plans for health sector reform that budgets in the health sector are increasing, OED agrees to the suggestion that project sustainabilty be rated as *likely*.

**Bank Performance:** It is apparent that the Bank performed satisfactorally in helping to re-structure and support this project following the civil disturbances that disrupted the original, evidently overambitious project design; we agree with the suggestion that its performance be rated as *marginally satisfactory*.

We would be grateful for your review of the ES, which has been revised to reflect these points, by cob Monday, August 10, 1998. In the meanwhile, thank you for your comments and for pointing out the strengths of the restructured project.

Sincerely,

Hernan Levy
Acting Manager
Sector and Thematic Evaluations Group

To: Susan A. Stout

**Hernan Levy** 08/03/98 05:58 PM

Extn: 84021 OEDST
Subject: Re: ETHIOPIA: Family Health Project (Credit 1913-ET)
OED: Review of Implementation Completion Report

Susan,

reading the incoming comments I realize that in fact the region agreed to the marginally satisfactory rating. Since there is no disagreement remaining, you may not need to ask them for their further review - you could in fact send them the cover note as you have it, and then attach the revised ES (considered as final).

But, if you feel you would like to give them a chance to comment again, that is fine too.

Hernan

Susan A. Stout

**Susan A. Stout** 08/03/98 05:00 PM

Extn: 82537 OEDST
To: Hernan Levy
Subject: Re: ETHIOPIA: Family Health Project (Credit 1913-ET)
OED: Review of Implementation Completion Report

Here are the comments, I forgot to forward them with my earlier em.

s

---------- Forwarded by Susan A. Stout/Person/World Bank on 08/03/98 05:01 PM ----------

Oey Astra Meesook
07/21/98 03:53 PM

Extn: 34872 AFC06
To: Roger H. Slade cc: Prem C. Garg, David De Ferranti, Robert M. Hecht, Joy de Beyer, Richard G. Feachem, Gita
Subject: Re: ETHIOPIA: Family Health Project (Credit 1913-ET)
OED: Review of Implementation Completion Report

I am responding to OED comments on the Ethiopia Family Health Project ICR. The overall rating of the project has been downgraded by OED to marginally satisfactory from the ICR rating of satisfactory. Sustainability is seen as unlikely by OED rather than likely by the ICR and the Bank's performance is rated unsatisfactory rather than satisfactory. Overall, we believe that OED has overlooked supporting evidence for the ICR ratings and failed to demonstrate its understanding of implementation in a civil war setting or give credit to the accomplishments of the new government and Bank in a post-civil war context.

We agree with OED that the project might be rated as "marginally satisfactory" since the delay in implementation makes it impossible to assess the project outcomes or impact at this time. This might be said, however, of many Bank health projects where the outcomes or impacts are slow to appear. The new government deserves recognition for its restructuring and successful completion of the project, and for carrying this further to the preparation of a health sector program

that will sustain and enlarge the impact of the Family Health Project. A "marginally satisfactory" rating is short-sighted in this context and should be reconsidered.

We disagree with the rating of "uncertain" for the project's sustainability and continue to believe the project is sustainable. The ICR reached its rating of "sustainable" based on these facts: (i) recurrent costs for all facilities have been included in the FY99 budget by the Regions: (ii) the Ministry of Health has formulated a clear strategy for manpower development that is being implemented; (iii) the usual constraints to effective service delivery -- drugs, medical kits, equipment, and motor cycles -- have been provided to the health facilities. Most important perhaps, is OED's failure to understand the content and implications of Ethiopia's new five-year Health Sector Development Program, which will ensure sustainability of the project.

We understand the basis for the unsatisfactory rating for Bank performance in appraisal and early stages of implementation. In this context, however, OED fails to show an understanding of the difficulties of implementing a project in the midst of a civil conflict. A more balanced view would have acknowledged risks to travel for Bank and government staff, defense pressure on budgets, the response of an insecure government, and the draining of government capacity by the defense sector. The emphasis on the Bank's performance during the civil war discounts the satisfactory performance of the Bank once the new government was in place to restructure the project and see the successful accomplishment of its goals. Some recognition could be given to the Bank's effort.

Any criticism of Bank performance in the post-conflict period should also acknowledge constraints it faced from the government's side. During this latter period, delays were caused due to a number of reasons unconnected with Bank performance, including: the coming into power of a new Government, the formulation of a new health policy, the introduction of a drastic regionalization and decentralization policy, the transfer of project implementation authority to regional stakeholders unprepared for the new tasks, and the significant institutional changes within the MOH. The project redesign, which was completed in 1994, was a result of a tedious and lengthy process of dialogue between Bank staff and the Government which began in late 1992-early 1993. A more generous weighting of these factors would recognize the efforts of Bank staff with a satisfactory, or at worst, marginally satisfactory rating.

Roger H. Slade

**Roger H. Slade**
07/14/98 06:16 PM

Extn: 81293 OEDST

To: Oey Astra Meesook cc: Prem C. Garg, David De Ferranti, Robert M. Hecht, Joy de Beyer, Richard G. Feachem,
Subject: ETHIOPIA: Family Health Project (Credit 1913-ET)
OED: Review of Implementation Completion Report

Attached for your review is OED's Evaluation Summary for the above project. This form contains OED's ratings and comments on the ICR. Any comments you may have should reach me no later than c.o.b Monday July 21, 1998.

Roger Slade
Manager
Sector and Thematic Evaluations

# ICR Review - Evaluation Summary

**Operations Evaluation Department**

Date Created: 06/18/98 11:45:26 AM
Last Updated: 07/13/98 06:26:47 PM
Status: Open

| 1. Project Data: | |
|---|---|
| **OEDID:** | C1913 |
| **Project Name:** | Family Health Project |
| **Country:** | Ethiopia |
| **Sector:** | Basic Health |
| **L/C Number:** | C1913 |
| **Partners involved:** | |
| **Prepared by:** | Charles Derek Poate, OEDST |
| **Reviewed by:** | Susan A. Stout |
| **Group Manager:** | Roger Slade |
| **Date Posted:** | |

**2. Project Objectives, Financing, Costs and Components:**

The objectives were to (a) increase the quality, coverage and cost-effectiveness of maternal and child health (MCH) services; (b) increase the availability and use of FP services; (c) strengthen the institutional capacity of the Ministry of Health (MOH). It comprised six components: MCH/FP; Manpower Development; Institutional Development; Health Education and Information, Education and Communication (IEC); Pharmaceuticals, and Studies. The first four of these components primarily involved the provision of physical facilities and equipment. Pharmaceuticals involved the provision of drugs, storage and distribution and quality control. The two major cost components were MCH / FP and pharmaceuticals. The total cost of the project was US$38.2 million. The Bank provided an SDR of 23.8 million (US$33 million at the 1988 exchange rate). At completion it was 94.6 percent disbursed with US$1.7 million canceled. The planned allocation from UNICEF was never received.

**3. Achievement of Relevant Objectives:**
The assessment of the achievement of objectives has to be seen in the context of the slow pace of implementation during the period 1988 to 1994 and the re-design of project components in 1993-94. In the final two years of the project the emphasis was on the construction of physical works and provision of equipment and materials. This resulted in the outputs being largely achieved, but not the project outcome. In effect the project is unfinished, with the provision of health services to the beneficiaries only just beginning to get underway.

The physical works element (which applies to both MCH and FP services) has been achieved with civil works and procurement for 96 health stations and 19 health centers completed. Training in program management and training of trainers was undertaken. However, the services are not fully operational and will not be unless they are adequately staffed and recurrent costs are provided. Thus this objective is not yet achieved. The FHP has however, supplied pharmaceuticals to all levels of the health service delivery system. This component appears to have worked well. However, there is no evidence available to assess or quantify the impact of this component. The capacity for training has increased, offices and bureaus have been constructed and equipment purchased for health education. Training has been conducted by other organizations/agencies under other related projects. Workshops have been held on project management.

**4. Significant Achievements:**
The most significant achievement was the rapid pace of construction and equipment procurement in two years following the re-design of the project until its completion.

**5. Significant Shortcomings:**
The slow pace of implementation in the period 1988 to 1994 due to the civil war and lack of management capacity coupled with inadequate supervision (and support) by the Bank. As a result the project's objectives have not been achieved in terms of delivery of services to the beneficiaries.

| 6. Ratings: | ICR | OED Review | Reason for Disagreement/Comments |
|---|---|---|---|
| Outcome: | Satisfactory | Marginally Satisfactory | Due to the delay in implementation the outcome is not yet fully achieved and can only be assessed in 2 - 3 year's time. |
| Institutional Dev.: | Partial | Modest | |
| Sustainability: | Likely | Uncertain | For the same reason as above, the health services planned for under this project are only just now starting to be provided. It is too early to view them as sustainable, especially in view of problems experienced in implementation. |
| Bank Performance: | Satisfactory | Unsatisfactory | Bank performance was satisfactory in preparation, unsatisfactory in appraisal and deficient in the early stages of project implementation. Performance improved after project components were re-designed (in 1994) but the impact of poor performance at appraisal and on early supervision missions negatively affected the project and an overall rating of unsatisfactory is given. |

| | | | |
|---|---|---|---|
| **Borrower Perf.:** | Satisfactory | Satisfactory | |
| **Quality of ICR:** | | Satisfactory | |

**7. Lessons of Broad Applicability:**
The quality of project appraisal is fundamental to project success. There were some major shortcomings during the appraisal stage in this project, particularly in terms of underestimating the costs of construction and equipment and in failing to address the risks inherent in a project where lack of management capacity in the implementing agency was identified but not addressed.

**8. Audit Recommended?** Yes ● No

**9. Comments on Quality of ICR:**
The ICR provided appropriate coverage, and clearly identified the shortcomings of the project. However, the implications of the re-design were not fully addressed. For example, in the 2 years after re-design, the physical works were complete and equipment procured, but the provision of health services to beneficiaries remained largely unachieved. The ICR refers to the consultations between government and the Bank over the Health Sector Development Program document but does not give a sense of its possible importance to the completion of the FHP in terms of service delivery. Borrower contribution to the ICR was satisfactory.

To: Susan A. Stout

**Hernan Levy** 08/03/98 06:06 PM

Extn: 84021 OEDST
Subject: Re: Revised ES for Ethiopia

I probably made a mess in my response about who should sign the email. Initially I thought the task manager was either your or Tim - but I realize it is neither. So, it is probably best to go under my name as acting for Roger.

Sorry for the confusion.

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To: Susan A. Stout

Tjohnston@worldbank.org on 08/03/98 05:09:31 PM

Subject: Re: ETHIOPIA: Family Health Project (Credit 1913-ET)

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The only addition I might make in the justification for the MS rating: even the restructuring of the project, which expanded infrastructure activities nationwide, did not adequately take into account the limited supervisory capacities of the MOH or World Bank. The ICR's "lesson" that civil works need to be closely supervised, particularly for a new borrower, has been known for a long time.

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To: Susan A. Stout
cc: Hernan Levy

Review/change ES

Oey Astra Meesook
07/21/98 03:53 PM

Extn: 34872 AFC06
Subject: Re: ETHIOPIA: Family Health Project (Credit 1913-ET)
OED: Review of Implementation Completion Report

I am responding to OED comments on the Ethiopia Family Health Project ICR. The overall rating of the project has been downgraded by OED to marginally satisfactory from the ICR rating of satisfactory. Sustainability is seen as unlikely by OED rather than likely by the ICR and the Bank's performance is rated unsatisfactory rather than satisfactory. Overall, we believe that OED has overlooked supporting evidence for the ICR ratings and failed to demonstrate its understanding of implementation in a civil war setting or give credit to the accomplishments of the new government and Bank in a post-civil war context.

→ This could request an audit to upgrade later

We agree with OED that the project might be rated as "marginally satisfactory" since the delay in implementation makes it impossible to assess the project outcomes or impact at this time. This might be said, however, of many Bank health projects where the outcomes or impacts are slow to appear. The new government deserves recognition for its restructuring and successful completion of the project, and for carrying this further to the preparation of a health sector program that will sustain and enlarge the impact of the Family Health Project. A "marginally satisfactory" rating is short-sighted in this context and should be reconsidered.

ICR

We disagree with the rating of "uncertain" for the project's sustainability and continue to believe the project is sustainable. The ICR reached its rating of "sustainable" based on these facts: (i) recurrent costs for all facilities have been included in the FY99 budget by the Regions: (ii) the Ministry of Health has formulated a clear strategy for manpower development that is being implemented; (iii) the usual constraints to effective service delivery -- drugs, medical kits, equipment, and motor cycles -- have been provided to the health facilities. Most important perhaps, is OED's failure to understand the content and implications of Ethiopia's new five-year Health Sector Development Program, which will ensure sustainability of the project.

We understand the basis for the unsatisfactory rating for Bank performance in appraisal and early stages of implementation. In this context, however, OED fails to show an understanding of the difficulties of implementing a project in the midst of a civil conflict. A more balanced view would have acknowledged risks to travel for Bank and government staff, defense pressure on budgets, the response of an insecure government, and the draining of government capacity by the defense sector. The emphasis on the Bank's performance during the civil war discounts the satisfactory performance of the Bank once the new government was in place to restructure the project and see the successful accomplishment of its goals. Some recognition could be given to the Bank's effort.

So why drop a $70 m loan

Any criticism of Bank performance in the post-conflict period should also acknowledge constraints it faced from the government's side. During this latter period, delays were caused due to a number of reasons unconnected with Bank performance, including: the coming into power of a new Government, the formulation of a new health policy, the introduction of a drastic regionalization and decentralization policy, the transfer of project implementation authority to regional stakeholders unprepared for the new tasks, and the significant institutional changes within the MOH. The project redesign, which was completed in 1994, was a result of a tedious and lengthy process of dialogue between Bank staff and the Government which began in late 1992-early 1993. A more generous weighting of these factors would recognize the efforts of Bank staff with a satisfactory, or at worst, marginally satisfactory rating.

Roger H. Slade

**Roger H. Slade**
07/14/98 06:16 PM

Extn: 81293 OEDST

To: Oey Astra Meesook cc: Prem C. Garg, David De Ferranti, Robert M. Hecht, Joy de Beyer, Richard G. Feachem,
Subject: ETHIOPIA: Family Health Project (Credit 1913-ET)
OED: Review of Implementation Completion Report

Attached for your review is OED's Evaluation Summary for the above project. This form contains OED's ratings and comments on the ICR. Any comments you may have should reach me no later than c.o.b Monday July 21, 1998.

Roger Slade
Manager
Sector and Thematic Evaluations

# ICR Review - Evaluation Summary

Operations Evaluation Department

Date Created: 06/18/98 11:45:26 AM
Last Updated: 07/13/98 06:26:47 PM
Status: Open

| 1. Project Data: | |
|---|---|
| **OEDID:** | C1913 |
| **Project Name:** | Family Health Project |
| **Country:** | Ethiopia |
| **Sector:** | Basic Health |
| **L/C Number:** | C1913 |
| **Partners involved:** | |
| **Prepared by:** | Charles Derek Poate, OEDST |
| **Reviewed by:** | Susan A. Stout |
| **Group Manager:** | Roger Slade |
| **Date Posted:** | |

**2. Project Objectives, Financing, Costs and Components:**

The objectives were to (a) increase the quality, coverage and cost-effectiveness of maternal and child health (MCH) services; (b) increase the availability and use of FP services; (c) strengthen the institutional capacity of the Ministry of Health (MOH). It comprised six components: MCH/FP; Manpower Development; Institutional Development; Health Education and Information, Education and Communication (IEC); Pharmaceuticals, and Studies. The first four of these components primarily involved the provision of physical facilities and equipment. Pharmaceuticals involved the provision of drugs, storage and distribution and quality control. The two major cost components were MCH / FP and pharmaceuticals. The total cost of the project was US$38.2 million. The Bank provided an SDR of 23.8 million (US$33 million at the 1988 exchange rate). At completion it was 94.6 percent disbursed with US$1.7 million canceled. The planned allocation from UNICEF was never received.

**3. Achievement of Relevant Objectives:**

The assessment of the achievement of objectives has to be seen in the context of the slow pace of implementation during the period 1988 to 1994 and the re-design of project components in 1993-94. In the final two years of the project the emphasis was on the construction of physical works and provision of equipment and materials. This resulted in the outputs being largely achieved, but not the project outcome. In effect the project is unfinished, with the provision of health services to the beneficiaries only just beginning to get underway.

The physical works element (which applies to both MCH and FP services) has been achieved with civil works and procurement for 96 health stations and 19 health centers completed. Training in program management and training of trainers was undertaken. However, the services are not fully operational and will not be unless they are adequately staffed and recurrent costs are provided. Thus this objective is not yet achieved. The FHP has however, supplied pharmaceuticals to all levels of the health service delivery system. This component appears to have worked well. However, there is no evidence available to assess or quantify the impact of this component. The capacity for training has increased, offices and bureaus have been constructed and equipment purchased for health education. Training has been conducted by other organizations/agencies under other related projects. Workshops have been held on project management.

**4. Significant Achievements:**

The most significant achievement was the rapid pace of construction and equipment procurement in two years following the re-design of the project until its completion.

**5. Significant Shortcomings:**

The slow pace of implementation in the period 1988 to 1994 due to the civil war and lack of management capacity coupled with inadequate supervision (and support) by the Bank. As a result the project's objectives have not been achieved in terms of delivery of services to the beneficiaries.

| 6. Ratings: | ICR | OED Review | Reason for Disagreement/Comments |
|---|---|---|---|
| **Outcome:** | Satisfactory | Marginally Satisfactory | Due to the delay in implementation the outcome is not yet fully achieved and can only be assessed in 2 - 3 year's time. |
| **Institutional Dev.:** | Partial | Modest | |
| **Sustainability:** | Likely | Uncertain | For the same reason as above, the health services planned for under this project are only just now starting to be provided. It is too early to view them as sustainable, especially in view of problems experienced in implementation. |
| **Bank Performance:** | Satisfactory | Unsatisfactory | Bank performance was satisfactory in preparation, unsatisfactory in appraisal and deficient in the early stages of project implementation. Performance improved after project components were re-designed (in 1994) but the impact of poor performance at appraisal and on early supervision missions negatively affected the project and an overall rating of unsatisfactory is given. |

| | | | |
|---|---|---|---|
| **Borrower Perf.:** | Satisfactory | Satisfactory | |
| **Quality of ICR:** | | Satisfactory | |

**7. Lessons of Broad Applicability:**
The quality of project appraisal is fundamental to project success. There were some major shortcomings during the appraisal stage in this project, particularly in terms of underestimating the costs of construction and equipment and in failing to address the risks inherent in a project where lack of management capacity in the implementing agency was identified but not addressed.

**8. Audit Recommended?** ○ Yes ● No

**9. Comments on Quality of ICR:**
The ICR provided appropriate coverage, and clearly identified the shortcomings of the project. However, the implications of the re-design were not fully addressed. For example, in the 2 years after re-design, the physical works were complete and equipment procured, but the provision of health services to beneficiaries remained largely unachieved. The ICR refers to the consultations between government and the Bank over the Health Sector Development Program document but does not give a sense of its possible importance to the completion of the FHP in terms of service delivery. Borrower contribution to the ICR was satisfactory.

To: Roger H. Slade
cc: Prem C. Garg
David De Ferranti
Robert M. Hecht
Joy De Beyer
Richard G. Feachem
Gita Gopal
Susan A. Stout
Arvil Van Adams
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