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Washington, D.C.

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1293871
R1995-049 Other #: 6 Box # 101568B
Malawi - Health Sector Project - PCR Files - 1v

OFFICIAL FILE COPY

DATE: March 6, 1991

TO: Mr. John M. Malone, Resident Representative

FROM: Graham Donaldson, Chief, OEDD1

EXTENSION: 31730

SUBJECT: MALAWI - Health Project (Credit 1351-MAI)
Final Project Completion Report

Kindly distribute the enclosed final audit reports and cover letters to the officials concerned. A copy is also enclosed for your records.

Enclosures

RRidker/mia

OFFICIAL FILE COPY

March 6, 1991

Dear Mr. :

Re: MALAWI - Health Project (Credit 1351-MAI)
Final Project Completion Report

The above report in its final version has been distributed to the Bank's Board of Directors. It is my pleasure to send you a copy of the report for your information.

Yours sincerely,

Graham Donaldson
Chief
Agriculture, Infrastructure and Human Resources Division
Operations Evaluation Department

Enclosure

RRidker/mia

DISTRIBUTION LIST

Re: MALAWI - Health Project (Credit 1351-MAI)
Final Project Completion Report

1. Mr. G.B. Chiwaula
Principal Secretary
Ministry of Finance
P.O.Box 30049
Lilongwe 3, Malawi

2. Dr. Graham Chipande
Principal Secretary
Economic Planning and Development Department
P.O.Box 30136
Lilongwe 3, Malawi

3. Mr. R.P. Dzanjalimodzi
Principal Secretary
Ministry of Health
P.O.Box 30377
Lilongwe 3, Malawi

4. Mr. J.B. Villiera
Secretary for Justice and Attorney General
Ministry of Justice
Private Bag 333
Lilongwe 3, Malawi

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

DATE: 05-Mar-1991 09:06am

TO: Isabel Alegre (ISABEL ALEGRE)

FROM: Hope Constant Phillips, AF6PH (HOPE CONSTANT PHILLIPS)

EXT.: 35174

SUBJECT: Malawi-Health Project PCR

Per our conversation of yesterday, following is a list of Government officials who should receive copies of the report prepared by your office for the above referenced project:

Mr. G.B. Chiwaula, Principal Secretary
Ministry of Finance
P.O.Box 30049
Lilongwe 3
Malawi

Dr. Graham Chipande
Principal Secretary
Economic Planning and Development Department
P.O.Box 30136
Lilongwe 3
Malawi

Mr. R.P. Dzanjalimodzi
Principal Secretary
Ministry of Health
P.O.Box 30377
Lilongwe 3
Malawi

Mr. J.B. Villiera
Secretary for Justice and Attorney General
Ministry of Justice
Private Bag 333
Lilongwe 3
Malawi

I hope this is what you needed. If not, please call.

CC: Nwanganga G. Shields (NWANGANGA G. SHIELDS)
CC: David M. de Ferranti (DAVID M. DE FERRANTI)
CC: Divisional Chron (PAPER MAIL)
CC: Chron File (PAPER MAIL)

~~WC~~
R.C.P.

The World Bank/IFC/MIGA
OFFICE MEMORANDUM

DATE: 03-Jan-1991 04:26pm

TO: Graham Donaldson (GRAHAM DONALDSON)

FROM: David M. de Ferranti, AF6PH (DAVID M. DE FERRANTI)

EXT.: 34049

SUBJECT: Re your memo to me of December 17, concerning ...

... the Malawi Health Project (Credit 1351-MAI) Project Completion Report. Your memo indicates your rating of the project and allows us 30 days to respond if we want to.

We have no disagreement with your rating.

OFFICIAL FILE COPY

December 17, 1990

Mr. Yves Rovani, DGO

H. Eberhard Köpp, Director, OED

31700

MALAWI: Health Project (Credit 1351-MAI)
Project Completion Report

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

Attachment

cc: Mr. Stephen M. Denning, AF6DR
Mrs. Ann O. Hamilton, PHRDR

GDonaldson/RRidker/mia

OPERATIONS EVALUATION DEPARTMENT

NOTE OF RECORD

REVIEW OF PROJECT COMPLETION REPORT

MALAWI: HEALTH PROJECT
(Credit 1351-MAI)

Recommendation

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

Origin and Quality of the PCR

2. This is an new-style PCR, Parts I and III prepared by Bank staff and Part II prepared by the Government. It is of good quality and conforms well to the latest guidelines.

Overall Project Assessment and Main Issues

3. The objective of the project was to improve the health system in a variety of ways: (a) improve planning and administration of Min. of Health (MOH); (b) develop a capacity to undertake epidemiological studies (through the Community Health Sciences Unit (CHSU); (c) improve pharmaceutical procurement and distribution systems; (d) introduce first phase of a primary health care program; and (e) introduce a child spacing program. These components were selected from a list considered significant in a health sector review that had just been completed.

4. According to the PCR all but two of these goals were achieved. The two exceptions were the CHSU and pharmaceuticals components which experienced severe delays are are still not operational-- but should eventually become operational. [However, see Part II] Judging by objectives achieved, this project should be rated satisfactory.

5. Three caveates should be noted, however. First, instead of the two years originally planned, the project required six years to complete; the implicit rate of return at appraisal would have had to be mighty high in order for the recalculated rate to be above 10 percent. Second, the first component was considered successfully implemented because a good national health plan got produced; but in the end it was produced by Government staff, not the consultants hired by the project for this purpose (whose contracts were terminated because of disputes). This component proved to be unnecessary. Third, training under the PHC component took place in existing buildings and was completed before completion of buildings planned to be used for training. While these buildings are now being used for training, they were apparently unnecessary for the purposes of the project. At best, therefore, this project is marginal; an audit might well decrease this rating.

6. The partial success and time extensions involved in this project arose, among other reasons, because: (1) Deficiencies in design and preparation work (unrealistic expectations about what could be accomplished in 2 years; inadequate planning of the CHSU and pharmaceutical components; unrealistic expectation that the project could be implemented with existing staff, without appointing a project coordinator; failure to insist on an MIS/performance indicator component); (2) project coordinator not appointed until January, 1987 (despite being recommended in 1st supervision mission); (3) diversion of efforts to prepare National Health Plan and second health project; and (4) unforseen economic problems and the effects of Mozambican war which resulted in shortages of personnel, building materials and issuance of forex permits.

7. Supervision was considered deficient despite 14 missions because so much time of these missions was devoted to preparation of the 2nd and 3rd health projects and supervision of the 2nd.

Interesting Features

8. It is interesting to note that this project underestimated the demand for child spacing. While the nurse training program for this component exceeded original targets, the was still a "grave shortage of nurses" so trained (para. 17). Even in the second project, demand exceeded expectations.

9. The PCR indicates a general tendency to rate project performance unrealistically high at least up to 1987, lulling everyone into a false sense of satisfaction about progress.

Recommendations for Follow-Up

10. This is a small "starter" project. The second project, currently being implemented, is more or less a continuation of this one and meant to correct a number of its shortcomings. An audit of the first two projects together would make more sense than selecting just this one.

11. The PIF has been completed (attached).

Prepared by:
Ronald G. Ridker _____ (Signature) 12-10-90 (Date)

Approved by:
Han-Chan Chai _____ (Signature) 12/13/90 (Date)

OPERATIONS EVALUATION DEPARTMENT
PCR REVIEW/AUDIT PROCESS /1

CONTROL SHEET

Project: Malawi : Health
Loan/Credit No: CR 1351-MAI
PCR Format (circle one): Old-Style / (New-Style)
Evaluating Officer: [signature] Date: 10-17-90
Approved by (Div. Chief or designate): [signature] Date:

	Date (mo/dy/yr)
A. Timetable	
- PCR logged in by Division	6-29-90
- If incomplete, PCR returned to Region	
- If PCR is unlogged	
In case evaluating officer requests Region to revise draft PCR: /2	
- Note to Regional task manager	
- Follow-up memo from Division Chief, OED, to Sector Division Chief, Region, if revision delayed	
- Satisfactorily revised PCR received from Region	

B. If PCR Returned to Region for Revision

Nature of revision requested (circle one): minor major

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

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

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

C. Complete for Old-style PCRs

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

D. Complete for New-style PCRs

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

E. OED Staff and Consultants Input

	Days
Staff	3
Consultants	—
Total	3

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

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

DRAFT
6/14/90

OPERATIONS EVALUATION DEPARTMENT

PROJECT INFORMATION FORM FOR ANNUAL REVIEW 199
(to be completed for each project evaluated)*

Date: 10-13

Completed by: R Ridkor

1. Project Name: Health Project
   LR 1351-MAI

2. Country: Malawi

3. Sector: PHR

4. Subsector: Health & Population

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

6. PCR review ☑ PPAR revision** ☐

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

   If yes, in what year? _____

8. Bank Loan/Credit (US$ millions)

	Loan	Credit	Total
Approved:		US$6.8	6.8
Cancelled:		0.6	0.6
Disbursed:		6.2	6.2

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

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

9. Total Project Cost (US$ millions)

Appraisal Estimate:	8.1 [a]
Actual:	6.9 [a] [b]

[a] Excludes cofinancing of 0.6 planned. No formal cofinancing arrangements set up; no records kept?

[b] Govt contribution planned + 1.3 roughly estimated to be 0.7 — can't be stated accurately because of inadequate records.

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

Appraisal:	7/82
Board Approval:	4/83
Loan/Credit Signing:	5/83

	Estimated in Loan/Credit Agreement	Actual
Effectiveness:	7/83	8/83
Completion:	6/85	
Closing:	12/31/85	12/31/88

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

11. Bank Processing and Supervision Performance

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

Number of Supervision Missions: 14

But a lot of time devoted to planning & supervising other projects

12. Project Results

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

Estimated at Appraisal: _____ _____

Re-Estimated at Completion: _____ _____

RERR based on what percentage of total investment? _____

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

Project Not Implemented: _____

Inadequate Data: _____

Other (specify): _____

b. Achievement of Objectives

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

Improve health system in variety of ways:
- Improve planning & decision capability
- Introduce first phase of 2° primary health care program
- Develop personnel evaluation capacity of Ministry of Health (Community health sciences unit)
- Expand training facilities
- Introduce child spacing
- Improve pharmaceutical supply system.

To what extent did the project achieve its appraisal objectives?

See to the PCR all components except two achieved their objectives. These were the Community Health sciences unit and the pharmaceutical supply system

Describe any significant changes in project objectives following appraisal.

To what extent did the project achieve its revised objectives?

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

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

c. Factors Affecting Results

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

Project Costs:

Project Scope:

Completion Time:
- Two years for project totally unrealistic & begin with
- Unforseen economic problems & the effects of Mozambican war
- Inadequate planning of two components which ended up not getting done despite 4 year extension
- Project coordinator not appointed until Jan 1987.
- Diversion of effort prepare second health project

Economic Rate of Return:

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

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

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

d. Overall Assessment

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

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

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

e. Sustainability

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

☐ likely ☐ unlikely

☐ marginal ☑ uncertain

Bec need for external funds to continue many activities (Comments ?)

f. Outstanding Project

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

☐ Yes ☑ No

OFFICIAL FILE COPY

December 17, 1990

Mr. David de Ferranti, Chief, AF6PH

Graham Donaldson, Chief, OEDD1

31730

MALAWI - Health Project (Credit 1351-MAI)
Project Completion Report

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

2. Based on OED's review the performance of this project has ben rated as:

Overall Assessment:	marginally satisfactory
Sustainability:	uncertain
Institutional Impact:	partial

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

Attachment

cc: Mr. Denning, AF6DR

RRidker/mia

THE WORLD BANK/IFC/MIGA

OFFICE MEMORANDUMM

DATE: December 17, 1990

TO:. Mr. Yves Rovani, DGO

FROM: H. Eberhard Köpp, Director, OED

EXTENSION: 31700

SUBJECT: MALAWI: Health Project (Credit 1351-MAI)
Project Completion Report

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

Attachment

cc: Mr. Stephen M. Denning, AF6DR
Mrs. Ann O. Hamilton, PHRDR

Mr. Rovani
Returned to us
Dec 21, 90

OPERATIONS EVALUATION DEPARTMENT

NOTE OF RECORD

REVIEW OF PROJECT COMPLETION REPORT

MALAWI: HEALTH PROJECT
(Credit 1351-MAI)

Recommendation

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

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Interesting Features

8. It is interesting to note that this project underestimated the demand for child spacing. While the nurse training program for this component exceeded original targets, the was still a "grave shortage of nurses" so trained (para. 17). Even in the second project, demand exceeded expectations.

9. The PCR indicates a general tendency to rate project performance unrealistically high at least up to 1987, lulling everyone into a false sense of satisfaction about progress.

Recommendations for Follow-Up

10. This is a small "starter" project. The second project, currently being implemented, is more or less a continuation of this one and meant to correct a number of its shortcomings. An audit of the first two projects together would make more sense than selecting just this one.

11. The PIF has been completed (attached).

Prepared by:
Ronald G. Ridker _____ (Signature) 12-10-90 (Date)

Approved by:
Han-Chan Chai _____ (Signature) 12/13/90 (Date)

OPERATIONS EVALUATION DEPARTMENT
PCR REVIEW/AUDIT PROCESS /1

CONTROL SHEET

Project: Malawi : Health
Loan/Credit No: CR 1351-MAI
PCR Format (circle one): Old-Style / (New-Style)
Evaluating Officer: P.D.S. Ridler — Date: 10-17-90
Approved by (Div. Chief or designate): — Date:

	Date (mo/dy/yr)
A. Timetable	
- PCR logged in by Division	6-29-90
- If incomplete, PCR returned to Region	
- If PCR is unlogged	
In case evaluating officer requests Region to revise draft PCR: /2	
- Note to Regional task manager	
- Follow-up memo from Division Chief, OED, to Sector Division Chief, Region, if revision delayed	
- Satisfactorily revised PCR received from Region	

B. If PCR Returned to Region for Revision

Nature of revision requested (circle one): minor major

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

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

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

C. Complete for Old-style PCRs

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

D. Complete for New-style PCRs

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

E. OED Staff and Consultants Input

	Days
Staff	3
Consultants	—
Total	3

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

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

PROJECT COMPLETION REPORT

MALAWI

HEALTH PROJECT
(CREDIT 1351-MAI)

DECEMBER 13, 1990

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

CURRENCY EQUIVALENTS

Currency Unit	=	Malawi Kwacha (K)
SDR 1.00	=	US$1.08995 (Feb. 28, 1983)
US$1.00	=	K1.10
K1.00	=	US$0.91

METRIC EQUIVALENTS

1 meter	=	39.27 inches
1 kilometer	=	0.62 miles
1 sq. kilometer	=	0.39 sq. miles

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CHSU	Community Health Sciences Unit
CMS	Central Medical Stores
MOH	Ministry of Health
MOWS	Ministry of Works and Supplies
PCR	Project Completion Report
PHC	Primary Health Care
UNICEF	United Nations International Children's Education Fund
UNDP	United Nations Development Program
WHO	World Health Organization

FISCAL YEAR OF BORROWER

April 1 - March 31

MALAWI

PROJECT COMPLETION REPORT

HEALTH PROJECT
(Credit 1351-MAI)

TABLE OF CONTENTS

PROJECT COMPLETION REPORT

MALAWI

HEALTH PROJECT

(CREDIT 1351-MAI)

PREFACE

This is the Project Completion Report (PCR) for the Health Project in Malawi, for which Credit 1351-MAI in the amount of SDR 6.3 million was approved on April 21, 1983. The credit was closed on December 31, 1988, four years behind schedule. The last disbursement was on July 31st, 1989 and the sum of SDR 37,823.59 was cancelled.

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

Preparation of this PCR was started during a mission in October, 1989, and is based, inter alia, on the Staff Appraisal Report; the Credit, Guarantee, and Project Agreements; supervision reports; correspondence between the Bank and the Borrower; and internal Bank memoranda.

PROJECT COMPLETION REPORT

MALAWI

HEALTH PROJECT

(CREDIT 1351-MAI)

EVALUATION SUMMARY

Objectives

1. The project's objectives were to improve the effectiveness and efficiency of the health care system, through: strengthening of planning and administration, and preparation of a comprehensive new national health plan; development of Ministry of Health (MOH) capacity to perform epidemiological studies and evaluate health programs; expansion, on a selective basis, of primary health care facilities; expansion of training facilities; introduction of child spacing programs; and improvement of the pharmaceuticals supply system, especially in procurement and distribution. These objectives were timely and appropriate, and followed consistently from the findings of a Bank health sector review (by largely the same team) completed just prior to project preparation. In line with the objectives, the project provided for: training; renovation and upgrading of facilities; strengthening of support services for primary health care (e.g., equipment, vehicles, income generating activities); and studies and technical assistance. The project design and organization were basically sound and appropriate to the objectives, although more could have been done during preparation to avert the implementation problems noted below.

Implementation Experience

2. The main variances between planned and actual implementation were: (a) the implementation period was lengthened from two to six years, through three extensions; (b) two of the components, pertaining to the Community Health Sciences Unit (CHSU) and the pharmaceuticals supply system, remained not yet fully operational at project completion, even with the extensions; and (c) lengthy delays were experienced in civil works. The factors contributing to these problems included: deficiencies in the architectural briefs prepared by the MOH for the Ministry of Works and Supplies (MOWS), and in the coordination between the two ministries; diversion of effort to the preparation of the national health plan, and to the development of the second and, later, the third projects; turnover and shortages of key MOH personnel and MOWS architects; MOH's dissatisfaction with the work done by the initial pharmaceutical consultants; problems in providing housing for CMS personnel; insufficient emphasis on supervision (especially regarding time in the field and mission composition); and the fact that a full-time project coordinator was not in place until 1987.

Results

3. The project achieved virtually all of its objectives, except that the aims of the CHSU and pharmaceuticals components will be fully attained only when the remaining issues in those areas are resolved. The planning

and administration component was successful in producing a national health plan of good quality that formed the basis for the second project. This achievement was all the more impressive considering that after the consultants responsible for this work failed to complete the plan to MOH's satisfaction, the MOH decided to do it themselves without outside help. As an important side-product, the arduous process of developing the plan in-house served to markedly strengthen MOH's planning and evaluation capabilities. The child spacing component fully met its overall objective to introduce family planning programs in Malawi; this work was completed ahead of time and the training program exceeded original targets. The PHC component, also completed ahead of schedule, was largely successful in developing the first phase of national primary health care program based on community involvement in 150 villages of the pilot districts. The CHSU and the pharmaceutical components, as noted above, were extensively delayed and have yet to achieve their full potential.

Sustainability

4. Malawi is likely to derive important long-term benefits from the project as a result of its success in launching child spacing and primary health care in the country. In terms of the constructed and improved health and child spacing facilities, the benefits will probably be sustainable over the long term. Other activities and programs will need to be sustained through wider reforms in health manpower development (expansion of posts, improvements in conditions of service) and continued Government and donor commitment to increased levels of recurrent spending - these are being supported in the Bank's Second and Third Health Projects in Malawi.

5. Once operational, both the CHSU and the pharmaceutical components will also contribute significantly to project benefits. At appraisal, savings from the planned improvements in procurement and distribution of pharmaceuticals were estimated to more than offset the incremental recurrent costs of the project. It is too early to confirm these calculations since neither the envisaged systems are in place nor are there any dependable, recurrent cost data available.

Findings and Lessons Learned

6. With this project, the Bank started its positive contribution to Malawi's health and population sector, and built a constructive dialogue with the respective Malawian authorities. The Government and people of Malawi have benefited. On lessons learned, it is clear that the implementation period should from the outset have been set at more than two years, which was far too short for the work to be done and the challenges to be overcome. Second, the project might have gained from being simplified and scaled back even further than was done during preparation, considering that this was a first project and the sector had serious staff shortages. Third, further development of the CHSU and pharmaceuticals components before implementation would have helped. Fourth, more persistent effort to get a well-trained and experienced project coordinator in place early on could have aided the resolution of many problems. Fifth, supervision missions should have spent more time in the field and included more involvement by specialists in the areas experiencing difficulties, especially on civil works and pharmaceuticals.

MALAWI
HEALTH PROJECT
(CREDIT 1351-MAI)

PROJECT COMPLETION REPORT

PART I. PROJECT REVIEW FROM BANK'S PERSPECTIVE

A. Project Identity

- Name : Health Project
- Credit Number : 1351-MAI
- RVP Unit : Africa Regional Office
- Country : Malawi
- Sector : Population and Human Resources
- Subsector : Health and Population

B. Project Background

1. Sector Development Objectives. The principal objectives of the Government's health and population sector development over the long run were to improve the health status of the Malawi people and to address the country's population problems. The sector's immediate objectives were targeted to establishing a sound health services delivery system capable of promoting health, preventing and curing diseases, and increasing productivity. Since gaining independence in 1964, the Government has pursued these objectives by focusing on health manpower development in the 1960s and 1970s; and has sought to strengthen and expand the basic health services network while controlling communicable diseases.

2. Policy Context. The 1973-88 National Health Plan provided the basis for developing a network of facilities to substantially increase health coverage. The plan called for a comprehensive health care system to be developed comprising primary health centers, health sub-centers and health posts, together with the provision of health services at the community level. Financial constraints, however, largely prevented the development of such a system and contributed to staff shortages, inadequate training and transport difficulties. In response to these problems, the Government developed a primary health care program in 1978 to supplement its existing rural and MCH programs. At the same time the Government decided to permit properly trained health staff to offer child spacing services, including counselling and distribution of modern contraceptives.

3. Despite these initiatives, the Bank's health sector review in 1980 revealed that slow progress in health improvement was the result of inadequately defined and coordinated policies and strategies, poor sector planning, a bias towards hospital-based curative services, lack of criteria for guiding health sector investments, failure to adequately coordinate the private sector's extensive health activities with those of the Government, and deficiencies in the procurement and distribution of pharmaceuticals. The findings of the sector review, thus clearly showed the need for the development of an up-dated and financially viable national health plan and provided the basis for developing the Health Project.

C. Project Objectives and Description

4. Project Objectives. The main objective of the project was to improve the effectiveness and efficiency of Malawi's health delivery systems in responding to its health needs. Specifically, it was supposed to help the Government reach this objective over a two-year period by:

(a) improving the MOH ability to plan, monitor and evaluate health programs and policies and develop a comprehensive national health plan;

(b) strengthening the MOH's ability to carry out epidemiological studies with supporting laboratory services;

(c) instituting an efficient, cost effective pharmaceutical procurement and distribution system;

(d) introducing the first phase of a national primary health care program; and

(e) introducing a child spacing program.

5. Project Components. The project included five components:

(a) Planning and Administration

(i) technical assistance and training fellowships for MOH for producing a comprehensive national health plan (including a staff development plan), establishing a permanent planning, evaluation and monitoring capability, and improving the financial management, accounting and service statistics systems;

(ii) support of studies on infant and child mortality and on possible linkages between traditional and modern health sectors; and

(iii) technical assistance and on-the-job training for re-organizing the Central Medical Stores (CMS) into a commercial entity;

(b) Community Health Sciences Unit (CHSU)

Renovation and additions to an existing building in Lilongwe with the provision of housing, equipment and vehicles, training fellowships, and consultant assistance (funded, in part, by UNDP/WHO), to establish a unit to collect and analyze epidemiological data, including the necessary laboratory support services;

(c) Pharmaceutical Procurement and Distribution

Renovation of existing buildings in Blantyre, construction of new buildings in Lilongwe and Mzuzu, with housing equipment, vehicles, and consultant assistance to improve the procurement and management of the pharmaceutical system and its associated manufacturing capability,

provide for the move of CMS from Blantyre to Lilongwe, as well as equipment for the training of pharmacy technicians;

(d) Primary Health Care Development

Training (with contributions from UNICEF and WHO), essential upgrading of rural facilities, equipment, vehicles and bicycles, communications improvements, income generating activities and monitoring and evaluation activities, to develop a primary health care program based on community mobilization in three districts covering about 150 villages; and

(e) Child Spacing

Renovation of antenatal facilities at Zomba General Hospital and 15 selected district hospitals, furniture, equipment, training and a family formation study, to initiate a child spacing program in urban and rural areas.

D. Project Design and Organization

6. The Health Project derived its conceptual foundation from the discussions between the Bank and Government on the findings of the health sector review mission in September 1981. The Government accepted the findings of the review and felt that they would provide a good basis for developing this project. Initially, the Government had requested Bank assistance in a very broad scope. When it became apparent, however, that financial constraints would preclude the dimensions of such a project, the concept of the project was scaled down considerably. In retrospect, this decision was clearly correct. The project thus did not attempt to address all of the identified deficiencies of the sector, but focused on developing a national health plan and on redressing the most critical constraints in the health care delivery system. Future health projects would then be designed to deal with some of the other problems.

7. Project preparation extended over a relatively short period of time. After the preliminary project discussions in September of 1981, the project was identified in January 1982, appraised in July 1982, and negotiated in March 1983. The preparation process benefitted from: drawing upon the results of a successful pilot program, in the case of the Primary Health Care Development component; thorough discussions with Government over an extended period of time, in the case of the Child Spacing component; and utilizing the findings of the health sector study. Two of the components (CHSU and pharmaceuticals) were not as well advanced as the others by the time of project effectiveness, and this was mirrored later in the project outcomes.

8. In both the preparatory and implementation phases of the project, it could not have been foreseen that the country would be beset during the project period by multiple economic problems (in incomes, employment, balance of payments, and then tightening of the budget) and the effects of the Mozambican war. These developments significantly exacerbated the constraints on easing staffing shortages and obtaining the building materials (especially cement) needed for civil works.

9. Overall responsibility for project implementation was to rest with the MOH, with each component managed by the head of the applicable section of the

Ministry -- the Chief Health Planner for administration and planning, the Deputy Chief Medical Officer for CHSU, the Assistant Chief Medical Officer (MOH) for the Primary Health Care (PHC) program, and the Chief Pharmacist for the pharmaceutical procurement and distribution component. Responsibility for overall project coordination was assigned to the Principal Secretary of the Ministry. A coordinating committee, chaired by the Principal Secretary, was to have met quarterly to ensure the smooth progress of implementation. Soon after project implementation had started, it became apparent that neither the Principal Secretary nor his deputy was devoting sufficient time to adequately monitoring and coordinating the project on a day-to-day basis. The Bank consequently already recommended the appointment of a full-time project coordinator in its first supervision mission. But it was not until January 1987 that a project coordinator arrived in Malawi -- initially for the Second Family Health Project (Credit No. 1768-MAI) but later, by default, for the (first) Health Project as well.

10. How the design, preparation, and organizational/institutional features of the project contributed to its outcome is, as always, difficult to sort out from the influences of other factors on outcome, such as implementation performance. Nevertheless, it seems likely, for the reasons indicated in the following sections, that the design and preparation work could have been more effective in preventing difficulties that arose during implementation, particularly in regard to the CHSU and pharmaceuticals components and the delay in project completion. The design should have provided for longer than a two-year implementation period, which was far too short for the work that was to be done and the challenges the Government faced. It might also have been advisable to simplify and scale back the project even further than was done during preparation, given that this was a first project and the sector had serious staff shortages. In addition, further development of the CHSU and pharmaceuticals components before implementation would have been desirable, although other factors from the implementation period also weighed heavily on the progress of these components and could not have been entirely foreseen at the outset.

E. Project Implementation

11. The main variances between planned and actual implementation were: (a) the implementation period was lengthened from two to six years, through three extensions; (b) two of the components (CHSU and pharmaceuticals) remained not yet fully operational at project completion, even with the extensions; and (c) lengthy delays were experienced in civil works. The slower than anticipated progress of the CHSU and pharmaceuticals components has delayed efforts to build local capability to carry out epidemiological work, medical research and public health laboratory work (for example, imported goods cannot be tested for contamination in Malawi at the present time). In addition, the anticipated benefits from the planned improvements of the pharmaceutical component have not yet been fully realized, since some aspects (including the manufacturing plant in Lilongwe, and the establishment of appropriate distribution and inventory systems and procedures and the required computer support) are still not entirely operational.

12. Factors common to most of the civil works delays include (a) the preparation by MOH of inaccurate and/or incomplete architectural briefs for the Ministry of Works and Supplies (MOWS); (b) poor coordination between MOH

and MOWS; (c) during first couple of project years focus diverted to resolving massive problems relating to the preparation of National Health Plan; (d) to an increasing degree beginning from May 1984, focus by all concerned parties on preparation of a second health project; (e) lack of proper synchronization between training of personnel and construction schedules; (f) unexpected transfers of senior MOH personnel; (g) shortage of architects at MOWS due to transfer of personnel and death of two key architects; and (h) shortage of building materials due to delays in issuance of foreign exchange permits for importation.

13. Also, the completion of CHSU was delayed because: (a) Several candidates to head CHSU were not accepted by foreign universities; and (b) the epidemiologist designated to head the unit after completion of training was transferred to head the Acquired Immune Deficiency Syndrome (AIDS) program. Additional reasons for the delay of the pharmaceutical component included: (a) MOH's dissatisfaction with the work by the initial pharmaceutical consultants caused about a two year project delay; (b) housing in Lilongwe built for CMS, but occupied by non-project personnel effectively preventing start-up of the pharmaceutical component; (c) protracted disputes between contractors and MOWS over designs of some buildings; and (d) failure to create the staff posts in a timely fashion.

14. While some of these factors could hardly be anticipated during project preparation or avoided by more astute supervision, staff shortages at almost all levels of the project and the difficulties at MOWS should probably have required more conservative projections with regard to the expected implementation period at the design stage and more aggressive attention and follow-up during the supervision of the project. Based on the very positive experience and impact on the project progress once the project coordinator was on board, efforts on the part of the borrower and the Bank should have been more intensive to fill this position much sooner. Furthermore, forward planning and synchronization between civil works schedules, training and assignment of personnel, and availability of equipment and materials could have expedited the implementation period -- for example, through evacuating staff houses in time so that project personnel at CMS Lilongwe could start operation of the facilities; training lab technicians to avoid that manufacturing of pharmaceuticals in Blantyre is done without any quality control of material input or production output; readying computer and inventory systems to enable the completed drug depots in Lilongwe and Mzuzu to assume their regional distribution role and to allow the transfer of the CMS from Blantyre to Lilongwe; and assigning the required staff to operate the three completed and totally underutilized PHC training units.

F. Project Results

15. The project achieved virtually all of its objectives, except that the aims of the CHSU and pharmaceuticals components will be fully attained only when the problems noted above are resolved.

16. One of the primary goals of the project was to produce a comprehensive ten year national health plan for 1985-95 and to improve the planning and evaluation capability of MOH. While the plan was expected to be completed by December 31, 1984, serious problems developed relating to the performance of the consultant group, which ultimately led to a mutually agreed, premature

termination of the contract. As a consequence, MOH planning staff decided to take on the job themselves and, with the assistance of senior MOH management and some consultant advice, worked hard to complete the work. The final product, completed in December 1985, printed in Summer of 1986 and issued in early 1987, was of good quality and received high acclaim from the National Health Planning Committee. The plan also formed the basis for the development of the Second Family Health Project. As an important side-product, the arduous process of developing the national health plan in-house served to markedly strengthen MOH's planning and evaluation capabilities.

17. The child spacing component fully met its overall objectives to introduce family planning programs in Malawi. The component was completed ahead of time and the training program exceeded original targets. According to latest statistics, child spacing services are offered in 106 of the 364 MOH and Private Hospital Association of Malawi (PHAM) facilities. Unfortunately, the initial momentum in the selected pilot districts -- Dowa, Mzimba and Mzuzu -- has not continued to date. Other districts have now exceeded by far the Mwanza and Dowa districts in terms of acceptors. Contributing to this slowdown has been the grave shortage of nurses qualified in child spacing service delivery, and the lack of in-service training and infrequent health inspections. In addition, after most of the construction of the antenatal units was completed and operational, integration of child spacing with MCH activities was introduced rendering most of the existing antenatal facilities too small and no longer space efficient, despite the fact that about ten facilities are currently being upgraded with funds from project cost savings.

18. The PHC component also almost fully met its objective to develop the first phase of national primary health care program based on community involvement in 150 villages of the pilot districts. The component was also completed ahead of schedule. Mainly due to severe financial constraints and staff shortages, the PHC program now has difficulty to sustain its early momentum. For example, the national coordinator of the National PHC Committee is the only person in MOH attending to PHC matters. He has no support staff, no funds for field visits, no vehicles, and no funds to effectively stimulate community-based programs. On the civil work side, the construction and upgrading of six rural health centers was successful despite some continuing water supply problems. Unfortunately, the three PHC training centers were never used for the intended purpose, as all PHC training had been completed when the construction was ready for occupancy. In addition, Government correctly decided that additional PHC training would in the future better be carried out in the communities rather than in classrooms. As a result, the training units are neither properly staffed, supplied and maintained, and remain grossly underutilized.

19. The problems with the CHSU and the pharmaceutical components have been described. It must be emphasized that when and if the current constraints and deficiencies are eliminated, both components should also meet their original objectives. With respect to CHSU this would primarily mean the creation of posts for and the recruitment of a senior epidemiologist, a microbiologist and laboratory technicians. With respect to the pharmaceutical component, this would mean the return of staff houses to project staff, the possible redesign and reconstruction of the drug manufacturing plant in Lilongwe, the development of appropriate computer, inventory and distribution systems, and the recruitment of qualified personnel.

G. Project Sustainability

20. Malawi is likely to derive long-term benefits in the social sectors from the project as a result of its success in launching child spacing and primary health care in the country. In terms of the constructed and improved health and Maternal and Chield Health (MCH)/Child Spacing facilities, the benefits should be sustainable over the long term. Other activities and programs will need to be kept alive through persistence, search for new initiatives, and continued funding. Once operational, both CHSU and the pharmaceutical components should also contribute significantly to project benefits.

21. At appraisal, savings from the planned improvements in procurement and distribution of pharmaceuticals were estimated to more than offset the incremental recurrent costs of the project. It is clearly too early to confirm these calculations since neither the envisaged systems are in place nor are there any dependable, recurrent cost data available. If the savings do eventually outweigh the costs, that is likely to take longer -- given the delays in project implementation -- than the originally expected "ten years or sooner" from project effectiveness.

H. Bank Performance

22. With the Health Project, the Bank started its positive contribution to Malawi's health and population sector. During the full implementation period, the Bank's dialogue with the respective Malawian authorities was constructive. In hindsight, it appears that the Bank's supervision activity was overshadowed by efforts to prepare and supervise a second project and later prepare a third project. In light of the serious problems encountered throughout implementation, more field time during the 14 supervision missions for the first project could probably have identified difficulties earlier. Considering that a large number of problems, especially in the later years, stemmed from the civil works part of the project, it is unfortunate that there was no consistency in the use of implementation specialists and that in four missions no such specialization was represented. Similarly, a pharmaceutical specialist participated in only three of the first five missions, but not in any of the following nine missions. As indicated, the pharmaceutical component is still not operational and has yet to overcome some very difficult problems. With a more forceful and persistent approach, the Bank could likely have contributed to earlier solution of problems such as the occupation of staff housing by non-project personnel, the assignment of a project coordinator, the submission of timely audit and progress reports, or the establishment of an appropriate project cost monitoring system.

23. For future projects the following lessons learned from the Health Project may be of value:

(a) Priority of supervision of projects must remain high within the work program of the Bank and within Government. Sufficient staff, consultant, and budgetary resources must be allocated to supervision.

(b) Project performance must be rated accurately to receive the appropriate attention from management.

(c) Sufficient time has to be allotted during supervision missions to visit project sites and facilities. A plan should be set up for each project to ensure that over a certain number of supervision missions, say a cycle of four missions or about two years, all such sites and facilities have been inspected. As supervision must not cease after closing date of a loan/credit if earlier difficulties in the project have not been fully resolved (OD 13.05), budgetary resources should in these cases continue to be available.

(d) A well-trained and experienced project coordinator who on a full-time basis facilitates and properly monitors project implementation, and liaises between government agencies and cofinanciers, is a key element to successful projects.

I. Borrower Performance

24. MOH's performance especially during the early stages of the project was affected by the departure of senior staff and by the lack of an experienced, full-time project coordinator. During the first couple of years, MOH's main focus was on overcoming problems arising from consultants who had been retained to prepare the ten year national health plan and to prepare the pharmaceutical components. In this context, MOH is highly commended for taking on the final preparation of the ten year national health plan primarily through its own resources when the consultant group failed to produce an acceptable document. By enormous effort, it completed work of excellent quality. During this difficult period, MOH could probably have benefitted by consulting more closely with the Bank in order to solicit the Bank's advice and support.

25. The borrower's compliance with the Credit Agreement is detailed in Part III, Table 7. The review shows that the main problems relate to (a) substantial implementation delays; (b) poor record keeping of project activities, costs and financing; (c) non-project related occupation of staff housing an the child spacing hostel; (d) failure to provide personnel for the operation of CHSU, CMS and the PHC training units; and (e) substantial delays in preparation of audits and submission of progress reports.

J. Consulting Services

26. As indicated, MOH experienced major problems with the consulting group retained for the development of the national health plan. Because was MOH was dissatisfied with the performance of some of the consultants in the field and their frequent personnel changes, the contract was terminated by mutual agreement at the end of 1984. MOH was not satisfied with the consultants initially retained for the preparation of the pharmaceutical component and MOH hired additional consultants to complete the work in this area. Following this experience, MOH became exceedingly cautious in their recruitment practices regarding external technical assistance.

K. Project Documentation and Data

27. In spite of repeated comments by early supervision missions, a proper project monitoring and information system was never put in place. As a

consequence, there is little institutional memory regarding this project in MOH as many of the persons involved in the early stages have left the ministry. Especially grave is the lack of essential project data, such as project investment and recurrent costs (beyond IDA disbursement data), foreign exchange content, the Government's own contribution to the project, and assistance provided by cofinanciers. In its last progress report dated June 30, 1989, MOH reports that it has not been possible to locate in the MOH Registries documentation on several aspects of project implementation including reports of supervision missions. The available documentation conveys the impression that regular monitoring of project activities at both MOH and IDA has not had high priority. Preparation of PCRs under such circumstances become an exceedingly difficult undertaking.

PART II. PROJECT REVIEW FROM BORROWER'S PERSPECTIVE

A. Adequacy and accuracy of factual information contained in Part III

28. The Ministry is in general agreement with the information presented subject to the following:

(a) Project Costs (5)

Information on project costs are not available in the required format, and are therefore estimates derived from disbursements under the credit and Malawi Kwacha expenditures.

(b) Project Financing (5)

Activities by other agencies except in respect of the CHSU have been completed as part of their country programmes and it has been found difficult to extract expenditures in respect of project items.

(c) Project Results - A. Direct Benefits

The following need to be noted:

(i) All officers of disease control programmes were posted to the CHSU during December, 1989. The Unit is functional.

(ii) Regional and district PHC coordinators were appointed effective 22 August, 1989 and the momentum of the work is being accelerated.

(iii) The PHC Training Centers are being utilized for training activities including PHC with first priority to MOH.

(d) Projects Results - B. Studies

Although the study at (5) was not done, a pilot survey to develop indicators for the measurement of progress for Health for All 2000 has been completed and will be revised annually.

(e) Status of Comments (7)

In regard to item 4.01 (c), it may be noted that the audit report for the period April, 1988 to March, 1989 was submitted to IDA on 20 February, 1990.

B. Comments on Analysis in Part I

29. The Ministry is in general agreement with the analysis in Part I. However, it is necessary that the following are noted:

(a) The number of static MOH facilities offering child spacing services as at 31 December, 1989 stood at 171.

(b) The deployment of only the National PHC Coordinator at the center should not be considered a down grading of the PHC effort. PHC pervades the entire spectrum of MOH activities especially the preventive services and are supported by programme personnel.

(c) Comments at para. 19, in regard to the CHSU and the pharmaceutical component of the project, need to be viewed in the context of recent intensified efforts by MOH to overcome the stated problems.

C. Bank Performance

30. The Bank inputs during preparation, appraisal and implementation were most critical in this first health project. Greater focus on major issues during supervision and efforts at their resolution may have facilitated satisfactory progress.

D. Ministry Performance

31. Unforseen problems and additional tasks detailed in Part I, placed heavy burden on the limited resources available to Government resulting in implementation delays. One important lesson arising from the implementation record is the need to treat parts of each component as a whole and to ensure their implementation in a systematic and synchronized manner, enabling avoidance of some of the problems experienced in this project.

E. Project Relationship

32. Bank relationship with Government during the evaluation and implementation phases of the project has been good.

F. Relationship with Cofinanciers

33. Activities cofinanced were implemented in parallel as part of country programmes of UNICEF and UNFPA. The only component not implemented was UNDP technical assistance to CHSU. This was due to delayed completion of facilities. The relationship with all agencies was good.

PART III. STATISTICAL INFORMATION

A. Related Bank Loans and/or Credits

Table 1: IDA CREDIT RELEVANT TO THE PROJECT

Loan/Credit Title	Year of Approval	Purpose of Project	Status	Comments
Credit 1768-MAI Second Family Health Project	1987	Improve family health, child-spacing services and MOH capacity to deliver health services	Under implementation	Implementation of civil works processing well; software components are affected by chronic shortage of personnel

B. Project Timetable

Table 2: PLANNED, REVISED AND ACTUAL DATES OF PROJECT TIMETABLES

Item	Planned Date	Revised Date	Actual Date
Health Sector Mission			10/1980
Identification Mission			09/1981 (Initial project discussion with IDA)
Preparation Mission	09/21/81	09/21/81	09/21/81
Appraisal Mission	07/07/82	07/07/82	07/07/82
Credit Negotiations	03/15/83	03/15/83	03/15/83
Board Approval	04/26/83	04/26/83	04/26/83
Credit Signature	05/20/83	05/20/83	05/20/83
Credit Effectiveness	07/01/83	08/22/83	08/22/83
Project Completion		06/30/85	06/30/88
Credit Closing	12/31/85	12/31/86 12/31/87	12/31/88

34. Comments on Timetable. The originally projected date of project completion, less than two years after Credit Effectiveness, was unrealistic. The Credit Closing was formally extended three times. Construction of major works on Central Medical Stores in Lilongwe, the Regional Medical Stores at Mzuzu and the Community Health Sciences Unit started in July/August 1986, i.e., well after the initial Credit Closing date.

C. Credit Disbursements

Table 3: CUMULATIVE ESTIMATED AND ACTUAL DISBURSEMENTS
(SDR '000)

Bank FY:	1984	1985	1986	1987	1988	1989	1990
Appraisal Estimate	1,650	4,800	6,300	-	-	-	-
Actual	119	1,914	2,446	2,780	3,810	5,916	6,262
Actual as % of Est.	7	40	39	44	60	94	99
Date of Final Disb. a/							

a/ As of July 31, 1989, SDR 37,823.59 was cancelled.
Last application: No. 157 for K 521,892.4 dated July 31, 1989

D. Project Implementation

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

Component	Planned Completion	Actual Completion	Months of Delay
Community Health Sciences Unit (CHSU)	12/85	09/87	31
Pharmaceutical Procurement and Distribution	05/85	09/89	52
Health Centers	06/85	01/86	7
Child Spacing	01/85	08/85 10/89	7 5

35. Comments on Project Implementation

The civil works program that had been agreed before Board presentation was overly optimistic. Design work was to be done by MOWS staff with no private architects being involved. As it soon turned out, staff shortages in MOWS prevented timely preparation of designs and tender documents. Tendering itself did not seem to have presented difficulties or delays, probably because no international competitive bidding was required. After construction had started, problems and major delays occurred in connection with importation of building materials, seriously delaying, e.g., completion of buildings for the Central Medical Store in Lilongwe. Completion of store buildings for the regional medical store in Mzuzu was badly delayed because of the need, after construction had started, to re-design the roof structure, which caused a protracted dispute between the contractor and MOWS engineers.

In retrospect as indicated in Part I, paragraph 16, the appointment of a project coordinator would have minimized the implementation delay.

E. Project Costs and Financing

Table 5: PROJECT COSTS
(US$ '000)

Category	Appraisal Estimate Local Costs	Foreign Costs	Total Costs	Actual Local Costs	Foreign Costs	Total Costs
I. INVESTMENT COSTS						
Pharmaceutical Supply and Distribution	2,250.2	575.6	2,825.8	N/A	N/A	2,659.8
Community Health Sciences	416.8	808.0	1,224.8	N/A	N/A	108.3
Planninga and Administration	98.9	832.1	931.0	N/A	N/A	1,268.8
Primary Health Care	1,678.2	667.4	2,345.6	N/A	N/A	2,351.4
Child Spacing	470.0	595.0	1,065.0	N/A	N/A	497.4
Total Invest. Costs	4,914.1	3,478.1	8,392.2	N/A	N/A	6,885.7
II. RECURRENT COSTS	211.5	109.5	321.0	N/A	N/A	N/A
III. TOTAL PROJECT COSTS	5,125.6	3,587.6	8,713.2	N/A	N/A	N/A

36. Comments

Actual project costs are based on estimates since the borrower did not keep complete records of its own contribution to the project cost. Due to Kwacha devaluations, Bank agreed to finance certain expenditures which were envisaged under the Second Family Health Project (Credit 1768-MAI) from QECH; 35 additional vehicles). Thus, total estimated investment costs for the Health Project amounted to only US$6.9 million.

Table 6: PROJECT FINANCING
(US$ million)

	Planned	Actual
IDA	6.8	6.2
Domestic	1.3	0.7 a/
Sub-Total	8.1	6.9
UN Cofinancing Institutions	0.6	Not available
TOTAL COSTS	8.7	-

37. Comments on Project Financing

As the cofinancing amounts were relatively small, no formal cofinancing arrangements were made. Unfortunately, no accurate records as to the type of support provided by the cofinanciers or the value of this support was maintained over the project period by the borrower. Likewise, since only IDA disbursement records were kept, Government's own contribution to the project cannot be quantified with any precision. The given estimate is based solely on the Credit Agreement percentages for foreign exchange and local exchange (Schedule 1). The Government's contribution, however, was most likely higher since not all expenditures incurred for the project were submitted to IDA for reimbursement.

F. Project Results

Table 7: Direct Benefits

Indicators	Estimated at: Appraisal	Closing Date	Full Development
Preparation of Revised National Health Plan.	Planned period 1985-1995.	1986-1995 Health Plan issued in 1987.	N/A
Establish CHSU to undertake epidemiological studies and laboratory services (public health laboratory).	Epidemiological work to start January 1985; Microbiology to start middle of 1985; Biochemistry to start middle of 1985; Lab. technology to start January, 1985.	Construction completed, not yet operational due to lack of managing personnel.	Operation not likely to start before 1991/2 unless T.A. received to manage CHSU.
Transfer Central Medical Stores from Blantyre to Lilongwe.	Move to take place in Spring of 1985.	Construction virtually completed, but lack of procedures, computer software, shortage of staff and unauthorized use of staff housing prevent implementation.	Transfer in 1990 only possible if problems of staff housing, computer and stock-keeping procedures can be resolved.
Improve drug manufacturing in Blantyre and add facilities in Mzuzu and Lilongwe.	Production to start by Spring of 1985.	Major construction design deficiencies and housing shortage continue to cause substantial delays in start-up of Lilongwe plant. Mzuzu drug manufacturing facility was cancelled.	Production start-up at Lilongwe will depend on expert review of plant. Full production cannot be envisaged before 1991. Quality control needed.
Improve drug distribution in Malawi including establishment of two regional depots.	Depots and improved system to be ready by the middle of 1985.	Construction of depots completed but not yet occupied. Little work done on system and procedure improvements. Major computing problems.	Computer and procedure specialist needed to eliminate major problems.

Develop PHC Program based on community mobilization in Mwanza, Dowa and Mzimba districts.	Pilot program covering 120,000 persons. Full-time PHC coordinators to be appointed. PHC committee structure at village, area, district and region to be established.	About 120,000 persons initially affected by Project. Shortage of staff and funds. No full-time PHC coordinators assigned; health inspectors carry out PHC tasks in addition to their regular work.	Service coverage extended by the project. The sub-sequent project is supporting PHC activities.
Selection, training/ retraining of community workers (TBAS and health are workers). National core group to train district health management team.	300 PHC workers to be trained/re-trained.	300 trained within original project implementation period (two years). However, after 1982 review, PHC worker system was replaced by Health Service Assistance.	Pilot scheme was successfully extended to a large number of other districts.
Upgrading of facilities in Dowa and Mzimba to health sub-centers and add staff housing.	6 units.	5 units completed; one unit under construction (Nalunga).	6 units.
Construction of PHC training centers in Mwanza, Dowa and Mzimba districts.	3 training centers.	Construction completed only after PHC training had taken place and after program change calling for all PHC training to be performed in the communities themselves. Due to staff shortage, centers are mostly unused.	Training centers to be used for district's non PHC health training needs and other ministries.
Provision of child spacing (CS) at central hospitals, all district hospitals and at rural health centers.	First project year; CS at 2 central hospitals and 22 district hospitals; second project year: CS at one rural health center in each district.	CS available at all central and district hospitals and in a large number of rural health centers.	N/A
Upgrading of antenatal facilities to permit CS services.	Upgrading of antenatal care at Zomba hospital and 15 of 21 district hospitals.	Zomba hospital and 12 units completed.	Due to savings, additional improvements at 10 hospitals initiated before Credit Closing date.
Orientation of health staff in CS.	2,000 during initial project period.	Partly alone.	CS training continues.

Technical CS training of hospital staff.	116.	116.	N/A
Establishment of technical training centers for CS at Lilongwe, Zomba and Blantyre hospitals.	Three centers to be established.	Centers are operational.	N/A

38. Comments on Project Results

Due to the originally anticipated brevity of Project implementation (two years), it was felt at Appraisal that project impact could primarily be measured by process indicators, rather than by direct results on health status improvements. Furthermore, this Project was meant to a large degree to prepare the basis for future health projects.

Table 8: PROJECT STUDIES

		Purpose as Defined at Appraisal	Status	Impact of Study
1.	Infant and Child Mortality	Analysis of 1977 census data to provide information on infant and child mortality by district.	Not done. However, Family Formation Study addressed infant and child mortality issues.	See under Study No. 6.
2.	Role of Traditional Medical Practi-tioners	Obtain objective information to determine linkages between modern and traditional health sectors.	Not done. But WHO consultant did some work in this area in 1988.	Impact of WHO supported study not known.
3.	Review PHAM	Review ways of improving the low level of utilization of PHAM facilities and need for financial assistance.	Not done. On financial side, however, a lot of work has been done.	Utilization of PHAM facilities remains low.
4.	Medical School Study	Determine financial feasibility of developing medical school in Malawi.	Completed by WHO and consultant consortium.	Provided basis for Government decision to pursue development plans.

5.	Baseline Epidemiological Study	To measure PHC program's impact over time.	Focus slightly changed. Primary focus in PHC given to training. In 1987, MOH, WHO, UNICEF, etc. carried out PHC review.	N/A
6.	Family Formation Survey	To determine future priorities in programs for mothers and children.	Conducted in 1984 by the National Statistical Office with MOH participation.	Survey updated demographic indicators particularly on fertility and mortality and gathered baseline data on KAP regarding child spacing.

G. Status of Covenants

Table 9: COMPLIANCE WITH CREDIT AGREEMENT

Section/Covenant		Status of Compliance
3.01(a)	The Borrower shall carry out the Project in conformity with appropriate practices.	In compliance, with the exception of (i) substantial implementation delays; (ii) poor record keeping relating to Project activities and financing; (iii) due to severe housing shortage, staff housing and child spacing hostel built under Project have been occupied by non-project related personnel; and (iv) necessary staff positions for some project components (CHSU; pharmaceutical distribution; PHC training centers) have neither been created nor filled due to budgetary problems, but this issue is now being resolved.
3.02(a)	The Borrower shall employ specialists in accordance with World Bank guidelines.	In full compliance.
	The Borrower shall employ not later than September 30, 1983, a health planner, an epidemiology, a financial analyst, a manpower planning expert and two pharmaceutical consultants.	Covenanted personnel has been employed at different times but not during full project period. Epidemiologist has bee trained; but was recently appointed to lead AIDS Program.
(b)	Designate a Malawian counter-part to work with each consultant so employed.	In light of severe staff shortages, counterpart personnel has been made available whenever possible.

3.03	The Borrower shall cause all goods and services under the Credit to be used exclusively for the purpose of the project until its completion.	Houses built under Project for staff to operate CHSU and Central Medical Stores in Lilongwe have been occupied by non-project personnel causing substantial delays in the start-up of these facilities. Also, Child Spacing Training Hostel (old nurses home) cannot be used for intended purpose due to non-project use. The GOM is in the process of releasing these houses to the designated institution.
3.04(a)	The Borrower shall furnish to IDA certain project documents.	In compliance.
(b)	The Borrower shall maintain records on project progress, permit IDA mission visits and provide at regular intervals certain information.	Record keeping regarding Project activities, Project costs and Project benefits have been insufficient to adequately monitor progress of the Project. Progress reports were submitted to Bank only very sporadically, although quarterly reporting was stipulated. Between 1987 and 1989 only two progress reports were received.
(c)	The Borrower shall prepare a PCR not later than six months after closing date.	Although Bank had requested basic information required for PCR preparation, such information was not received during the covenanted period. Some important data (Project costs, co-financing support, namely non-IDA costs) have still not been furnished.
3.05	The Borrower shall acquire land rights as needed for Project.	In compliance.
4.01(a)	The Borrower shall maintain Project accounts.	In compliance only in so far as IDA disbursement accounts are concerned. No accounts maintained for Government's and co-financiers' contribution to Project's investment and recurrent costs.
(b)	The Borrower shall maintain separate accounts for statements of expenditures.	In compliance.
(c)	Audit reports shall be submitted within six months after the end of each fiscal year.	Reports were delinquent for every fiscal year during Project period. Due to these delays, audits for two years had to be combined. Only two audit reports were received, covering period: April 1984 - March 1986 and April 1986 - March 1988. Latest audit report for period April 1988 to March 1989 not yet received. Audit reports only covered IDA portion of Project.
4.02	The Borrower shall produce a revised National Health Plan for the period 1985 - 1995 by December 31, 1984.	National Health Plan for 1986 - 1995 was issued in 1987 after an about two year delay.

4.03	The Borrower shall introduce a scale of fees for health services by April 1, 1984.	Revised scale of fees was introduced in 1984.
4.04	The Borrower shall operate the Central Medical Stores as a district self accounting undertaking not later than April 1, 1984.	Not fully complied with. Central Medical Stores now operated as Treasury Fund Activity within MOH, providing advance foreign exchange funding for purchase of pharmaceuticals and medical equipment; but with less autonomy than a district self-accounting undertaking would have provided.
4.05	The Borrower shall ensure review of NGOs by PHC core group of MOH to ensure better coordination between them and public health providers.	Review not undertaken.
4.06	In order to improve the staffing of the health centers in its primary health care program, certain staffing levels at health centers, PHC training units and districts should be achieved.	In compliance as health centers under Project are concerned. Staffing posts for the three training units in Mzimba, Mwanza and Mponela have not been created, and consequently units are not staffed.

H. Use of Bank Resources

Table 10: STAFF INPUTS AS OF DECEMBER 13, 1989

Stage of Project Cycle	FY82	FY83	FY84	FY85	FY86	FY87	FY88	FY89	FY90	Total
Preparation	55.0									55.0
Appraisal		49.3								49.3
Negotiations		7.7								7.7
Supervision		0.4	31.1	19.2	3.9	13.1	11.4	6.3		85.4
Other (PCR)							0.7	0.1	8.4	9.2
TOTAL	55.0	57.4	31.1	19.2	3.9	13.1	12.1	6.4	8.4	206.6

39. Comments on Staff Inputs

Staff input for project preparation through negotiations amounted to 112 staff-weeks, which is about the average for Bank projects overall. However, supervision input exceeded the originally expected time substantially because the implementation period was estimated at two years but actually extended over six years. The total annual staff time allocated to supervision appears to have been adequate, an average of 14 staff-weeks per annum. While supervision carried out in the field amounted to 18 staff-weeks during the first year of project implementation (FY84), the average amount of time spent in the field during the following five years amounted to only about 5 staff-weeks or about 2.3 staff-weeks per mission.

Table 11: MISSION DATA

Mission	Month/ Year	No. of Persons a/	Staff Weeks in Field	Performance Status by Activity b/				
				F	M	DI	OS	a/
Health Sector Mission	10/80							
Appraisal	07/82							
Supervision I	09/83	2(A,PH)	2	1	1	-	1	
Supervision II	12/83	2(A,A)	2	1	1	-	1	
Supervision III	02/84	4(E,M,P,PH)	7	1	2	1	2	
Supervision IV	06/84	4(A,H,P,PH)	7	1	1	1	2	
Supervision V	10/84	4(HP,M,P,PH)	4 c/	1	1	1	2	
Supervision VI	04/85	3(A,HP,PH)	3 c/	1	1	1	2	
Supervision VII	06/86	4(A,E,MS,PH)	2 c/	1	1	1	2	
Supervision VIII	09/86	3(A,E,MS)	4 c/	1	1	1	2	
Supervision IX	04/87	2(A,E)	2 c/	1	1	1	2	
Supervision X	08/87	1(E)	1 c/	1	1	1	2	d/
Supervision XI	11/87	3(A,E,PH)	2	1	1	1	2	
Supervision XII	03/88	3(A,E,PH)	2 c/	1	1	1	1	
Supervision XIII	10/88	3(A,E,PH)	1.5 c/	1	1	1	1	
Supervision XIV	03/89	3(A,E,PH)	1.5 c/	1	1	1	1	
TOTAL			45.0					
Proj. Completion	11/89	2(A,E)	4	-	-	-	-	

a/ A=Architect; E=Economist; H=Health Advisor; HP=Health Planning Specialist; M=MCH/FP Specialist; MS=Management Specialist; P=Pharmaceutic Specialist; PH=Public Health Specialist

b/ F=Available Funds; M=Project Management; DI=Development Impact; OS=Overall Status

c/ The Health Project was supervised together with the preparation/supervision of the Second Family Health Project.

d/ No Form 590 on record.

39. Comments

The performance ratings of the project do not seem to reflect the serious difficulties described in the supervisions reports. In light of the staffing shortages, management problems and underutilization of project facilities, the project management, development impact and overall status seem overrated. Over the six year project implementation period, three different taks managers/project officers were responsible for the project's supervision providing a considerable degree of lack of continuity. Also, regarding public

health specialization, there has been remarkable consistency in Bank personnel. However, with respect to architects, seven different specialists (staff or consultants) participated in ten full supervision missions. No architect/ implementation specialist was represented in four missions. Moreover, in light of the difficulties in the pharmaceutical component, a specialist in this area may have been able to identify some of the design, construction, and procedural problems at an earlier stage and assisted Government in taking the appropriate remedial actions. Pharmaceutical specialists were used in only three early supervision missions.

Record of Project Progress Reports Submitted by Govenrment

(a) As of October 22, 1985.

(b) For period ending December 31, 1988, submitted on March 9, 1989.

(c) For period ending June 30, 1989, submitted on October 27, 1989.

ANNEX 1

Telegrams: Ministry, Lilongwe
Telephone: Lilongwe 730 099

Communications should be addressed to
The Secretary for Health

In reply please quote No. ADM/14/87

MINISTRY OF HEALTH
P.O. BOX 30377
CAPITAL CITY
LILONGWE 3
MALAWI

3rd May, 1990

Mrs. N. Shields, AF6PH
The World Bank,
Population and Human
Resources Division,
1818 H. Street, N.W.
WASHINGTON, D.C. 20433,
U.S.A.

Dear Mrs. Shields,

MALAWI: HEALTH PROJECT (CREDIT 1351 MAI)

PROJECT COMPLETION REPORT

Thank you for your letter of 2 April, 1990 forwarding the Project Completion Report (PCR) on the above project.

I have studied the report with interest and have noted the areas for follow-up. The Ministry has taken several steps to strengthen its performance. Specifically, action is being taken to strengthen the Planning Division and the Project Implementation Unit. Already, an appointment has been made to the post of Principal Health Planning Officer and the Project Implementation Unit has been staffed with a Project Architect and additional accounting staff.

We are also pursuing the establishment of a Manpower Development Unit as part of the Planning Division and renewed efforts are being made to ensure improved co-ordination not only in project work, but in all Ministry activities at central and lower levels.

Important aspects of this project which need continued attention will be closely followed up and IDA will be kept informed of progress. This will be particularly relevant to the Pharmaceutical Supply and Distribution activities and the Community Health Sciences Unit.

Date Recd. 5/8/90	Log No. LPS/108
For Action: N Shields	
cc:	
cc:	
To file and acknowledge	

2/...

ANNEX 1

The project review from the Government's perspective for inclusion as Part II of the report is forwarded herewith. I have forwarded copies of my letter to the Secretary to the Treasury and the Principal Secretary, Ministry of Works for their information.

Yours sincerely,

R. P. Dzanjalimodzi
SECRETARY FOR HEALTH

OPERATIONS EVALUATION DEPARTMENT

NOTE OF RECORD

REVIEW OF PROJECT COMPLETION REPORT

MALAWI: HEALTH PROJECT
(Credit 1351-MAI)

Recommendation

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

Origin and Quality of the PCR

2. This is an new-style PCR, Parts I and III prepared by Bank staff and Part II prepared by the Government. It is of good quality and conforms well to the latest guidelines.

Overall Project Assessment and Main Issues

3. The objective of the project was to improve the health system in a variety of ways: (a) improve planning and administration of Min. of Health (MOH); (b) develop a capacity to undertake epidemiological studies (through the Community Health Sciences Unit (CHSU); (c) improve pharmaceutical procurement and distribution systems; (d) introduce first phase of a primary health care program; and (e) introduce a child spacing program. These components were selected from a list considered significant in a health sector review that had just been completed.

4. According to the PCR all but two of these goals were achieved. The two exceptions were the CHSU and pharmaceuticals components which experienced severe delays are are still not operational-- but should eventually become operational. [However, see Part II] Judging by objectives achieved, this project should be rated satisfactory.

5. Three caveates should be noted, however. First, instead of the two years originally planned, the project required six years to complete; the implicit rate of return at appraisal would have had to be mighty high in order for the recalculated rate to be above 10 percent. Second, the first component was considered successfully implemented because a good national health plan got produced; but in the end it was produced by Government staff, not the consultants hired by the project for this purpose (whose contracts were terminated because of disputes). This component proved to be unnecessary. Third, training under the PHC component took place in existing buildings and was completed before completion of buildings planned to be used for training. While these buildings are now being used for training, they were apparently unnecessary for the purposes of the project. At best, therefore, this project is marginal; an audit might well decrease this rating.

6. The partial success and time extensions involved in this project arose, among other reasons, because: (1) Deficiencies in design and preparation work (unrealistic expectations about what could be accomplished in 2 years; inadequate planning of the CHSU and pharmaceutical components; unrealistic expectation that the project could be implemented with existing staff, without appointing a project coordinator; failure to insist on an MIS/performance indicator component); (2) project coordinator not appointed until January, 1987 (despite being recommended in 1st supervision mission); (3) diversion of efforts to prepare National Health Plan and second health project; and (4) unforseen economic problems and the effects of Mozambican war which resulted in shortages of personnel, building materials and issuance of forex permits.

7. Supervision was considered deficient despite 14 missions because so much time of these missions was devoted to preparation of the 2nd and 3rd health projects and supervision of the 2nd.

Interesting Features

8. It is interesting to note that this project underestimated the demand for child spacing. While the nurse training program for this component exceeded original targets, the was still a "grave shortage of nurses" so trained (para. 17). Even in the second project, demand exceeded expectations.

9. The PCR indicates a general tendency to rate project performance unrealistically high at least up to 1987, lulling everyone into a false sense of satisfaction about progress.

Recommendations for Follow-Up

10. This is a small "starter" project. The second project, currently being implemented, is more or less a continuation of this one and meant to correct a number of its shortcomings. An audit of the first two projects together would make more sense than selecting just this one.

11. The PIF has been completed (attached).

Prepared by:
Ronald G. Ridker _____ (Signature) 12-10-90 (Date)

Approved by:
Han-Chan Chai _____ (Signature) 12/13/90 (Date)

OPERATIONS EVALUATION DEPARTMENT
PCR REVIEW/AUDIT PROCESS /1

CONTROL SHEET

Project: Malawi : Health
Loan/Credit No: CR 1351-MAI
PCR Format (circle one): Old-Style / (New-Style)
Evaluating Officer: [signature] Date: 10-17-90
Approved by (Div. Chief or designate): [signature] Date:

	Date (mo/dy/yr)
A. Timetable	
- PCR logged in by Division	6-29-90
- If incomplete, PCR returned to Region	
- If PCR is unlogged	
In case evaluating officer requests Region to revise draft PCR: /2	
- Note to Regional task manager	
- Follow-up memo from Division Chief, OED, to Sector Division Chief, Region, if revision delayed	
- Satisfactorily revised PCR received from Region	

B. If PCR Returned to Region for Revision

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

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

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

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

C. **Complete for Old-style PCRs**

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

D. **Complete for New-style PCRs**

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

E. **OED Staff and Consultants Input**

	Days
Staff	3
Consultants	___
Total	3

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

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

DRAFT
6/14/90

OPERATIONS EVALUATION DEPARTMENT

PROJECT INFORMATION FORM FOR ANNUAL REVIEW 199
(to be completed for each project evaluated)*

Date: 10-16

Completed by: R Ridker

1. Project Name: Health Project
CR 1351-MAI

2. Country: Malawi

3. Sector: PHR

4. Subsector: Health & Population

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

6. PCR review ☑ PPAR revision** ☐

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

If yes, in what year? _____

8. Bank Loan/Credit (US$ millions)

	Loan	Credit	Total
Approved:		15SDR 6.8	6.8
Cancelled:		0.6	0.6
Disbursed:		6.2	6.2

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

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

9. Total Project Cost (US$ millions)

Appraisal Estimate:	8.1 [a]
Actual:	6.9 [a] [b]

[a] Excludes cofinancing of 0.6 planned. No formal cofinancing arrangements set up; & no records kept!

[b] Govt contribution planned at 1.3 roughly estimated to be 0.7 — can't be stated accurately bec of inadequate records.

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

Appraisal:	7/82
Board Approval:	4/83
Loan/Credit Signing:	5/83

	Estimated in Loan/Credit Agreement	Actual
Effectiveness:	7/83	8/83
Completion:	6/85	
Closing:	12/31/85	12/31/88

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

11. Bank Processing and Supervision Performance

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

Number of Supervision Missions: 14

But a lot of time devoted to planning & supervising other projects

12. Project Results

a. Rates of Return (%)

	Economic	Financial
Estimated at Appraisal:	_____	_____
Re-Estimated at Completion:	_____	_____

RERR based on what percentage of total investment? _____

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

Project Not Implemented: _____

Inadequate Data: _____

Other (specify): _____

b. Achievement of Objectives

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

Improve health system in variety of ways:
- Improve planning & [illegible] capacity
- strengthen first phase of primary health care program
- Develop [illegible]
- Expand training facilities
- introduce cold chain
- Improve pharmaceutical supply system.

To what extent did the project achieve its appraisal objectives?

See to the PCR all components except two achieved their objectives. Those were the Community Health sciences unit and the pharmaceutical supply system

Describe any significant changes in project objectives following appraisal.

To what extent did the project achieve its revised objectives?

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

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

c. Factors Affecting Results

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

Project Costs:

Project Scope:

Completion Time:
- Two years for project totally unrealistic to begin with
- Unforseen economic problems & the effects of Mozambican war
- Inadequate planning of two components which ended up not getting done despite 4 years extension
- Project coordinator not appointed until Jan 1987.
- Diversion of effort prepare second Health project

Economic Rate of Return:

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

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

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

d. Overall Assessment

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

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

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

e. Sustainability

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

☐ likely ☐ unlikely

☐ marginal ☑ uncertain

Bec need for external funds to continue many activities (Comm. Devn ?)

f. Outstanding Project

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

☐ Yes ☑ No

THE WORLD BANK/INTERNATIONAL FINANCE CORPORATION

OFFICE MEMORANDUM

DATE: June 29, 1990

TO: Mr. Ram K. Chopra, Director, OED
Through: Mr. Isaac Sam, Acting Director, AF6
FROM: Robert M. Hecht, Acting Chief, AF6PH

EXTENSION: 33341

SUBJECT: **MALAWI:** Health Project (Credit 1351-MAI)
Project Completion Report

Please find attached the Completion Report for the Malawi Health Project (Credit 1351-MAI). It was sent to the Government on April 2nd, 1990 and Government's response is contained in Part II.

The report has been cleared by the Legal and Disbursement Departments and by the Projects Advisor and Country Officer of the Southern Africa Department.

Mrs. Nwanganga Shields, Task Manager, can be contacted at 34415 for any needed follow-up.

cc: Messrs. Rovani (DGO) (4); Lee (CODDR); Dubey (EAS); Zerabruk (LEGAF); Fernando (LOAAF); Regional Information Center

Messrs./Mmes. Denning (o/r), Singh (o/r) (AF6DR); Messenger, King, Krumm, Scobey (AF6CO); Jagdish (AF2PH); Measham (PHRHN); Malone (Resident Representative); Divisional Project File

Attachment
a/s

NShields:sbj

DATE RECEIVED IN OED: 6/29/90
OED CODE NUMBER: 390.009

RK.

PROJECT COMPLETION REPORT

MALAWI

HEALTH PROJECT
(CREDIT 1351-MAI)

June 29, 1990

Why?
Audit?
Key reasons?
Does this Loan to be put to cofinancing? Was it? No formal cofinancing arrangements were made since this Loan was small.
Pharmac — some a 10 yrs plans.

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

DATE RECEIVED IN OED: 6/29/90
OED CODE NUMBER: 390.009

CURRENCY EQUIVALENTS

Currency Unit	=	Malawi Kwacha (K)
SDR 1.00	=	US$1.08995 (Feb. 28, 1983)
US$1.00	=	K1.10
K1.00	=	US$0.91

METRIC EQUIVALENTS

1 meter	=	39.27 inches
1 kilometer	=	0.62 miles
1 sq. kilometer	=	0.39 sq. miles

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CHSU	Community Health Sciences Unit
CMS	Central Medical Stores
MOH	Ministry of Health
MOWS	Ministry of Works and Supplies
PCR	Project Completion Report
PHC	Primary Health Care
UNICEF	United Nations International Children's Education Fund
UNDP	United Nations Development Program
WHO	World Health Organization

FISCAL YEAR OF BORROWER

April 1 - March 31

MALAWI

PROJECT COMPLETION REPORT

HEALTH PROJECT
(Credit 1351-MAI)

TABLE OF CONTENTS

PROJECT COMPLETION REPORT

MALAWI

HEALTH PROJECT

(CREDIT 1351-MAI)

PREFACE

This is the Project Completion Report (PCR) for the Health Project in Malawi, for which Credit 1351-MAI in the amount of SDR 6.3 million was approved on April 21, 1983. The credit was closed on December 31, 1988, four years behind schedule. The last disbursement was on July 31st, 1989 and the sum of SDR 37,823.59 was cancelled.

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

Preparation of this PCR was started during a mission in October, 1989, and is based, inter alia, on the Staff Appraisal Report; the Credit, Guarantee, and Project Agreements; supervision reports; correspondence between the Bank and the Borrower; and internal Bank memoranda.

PROJECT COMPLETION REPORT

MALAWI

HEALTH PROJECT

(CREDIT 1351-MAI)

EVALUATION SUMMARY

Objectives

1. The project's objectives were to improve the effectiveness and efficiency of the health care system, through: strengthening of planning and administration, and preparation of a comprehensive new national health plan; development of Ministry of Health (MOH) capacity to perform epidemiological studies and evaluate health programs; expansion, on a selective basis, of primary health care facilities; expansion of training facilities; introduction of child spacing programs; and improvement of the pharmaceuticals supply system, especially in procurement and distribution. These objectives were timely and appropriate, and followed consistently from the findings of a Bank health sector review (by largely the same team) completed just prior to project preparation. In line with the objectives, the project provided for: training; renovation and upgrading of facilities; strengthening of support services for primary health care (e.g., equipment, vehicles, income generating activities); and studies and technical assistance. The project design and organization were basically sound and appropriate to the objectives, although more could have been done during preparation to avert the implementation problems noted below.

Implementation Experience

2. The main variances between planned and actual implementation were: (a) the implementation period was lengthened from two to six years, through three extensions; (b) two of the components, pertaining to the Community Health Sciences Unit (CHSU) and the pharmaceuticals supply system, remained not yet fully operational at project completion, even with the extensions; and (c) lengthy delays were experienced in civil works. The factors contributing to these problems included: deficiencies in the architectural briefs prepared by the MOH for the Ministry of Works and Supplies (MOWS), and in the coordination between the two ministries; diversion of effort to the preparation of the national health plan, and to the development of the second and, later, the third projects; turnover and shortages of key MOH personnel and MOWS architects; MOH's dissatisfaction with the work done by the initial pharmaceutical consultants; problems in providing housing for CMS personnel; insufficient emphasis on supervision (especially regarding time in the field and mission composition); and the fact that a full-time project coordinator was not in place until 1987.

Results

3. The project achieved virtually all of its objectives, except that the aims of the CHSU and pharmaceuticals components will be fully attained only when the remaining issues in those areas are resolved. The planning

and administration component was successful in producing a national health plan of good quality that formed the basis for the second project. This achievement was all the more impressive considering that after the consultants responsible for this work failed to complete the plan to MOH's satisfaction, the MOH decided to do it themselves without outside help. As an important side-product, the arduous process of developing the plan in-house served to markedly strengthen MOH's planning and evaluation capabilities. The child spacing component fully met its overall objective to introduce family planning programs in Malawi; this work was completed ahead of time and the training program exceeded original targets. The PHC component, also completed ahead of schedule, was largely successful in developing the first phase of national primary health care program based on community involvement in 150 villages of the pilot districts. The CHSU and the pharmaceutical components, as noted above, were extensively delayed and have yet to achieve their full potential.

Sustainability

4. Malawi is likely to derive important long-term benefits from the project as a result of its success in launching child spacing and primary health care in the country. In terms of the constructed and improved health and child spacing facilities, the benefits will probably be sustainable over the long term. Other activities and programs will need to be sustained through wider reforms in health manpower development (expansion of posts, improvements in conditions of service) and continued Government and donor commitment to increased levels of recurrent spending - these are being supported in the Bank's Second and Third Health Projects in Malawi.

5. Once operational, both the CHSU and the pharmaceutical components will also contribute significantly to project benefits. At appraisal, savings from the planned improvements in procurement and distribution of pharmaceuticals were estimated to more than offset the incremental recurrent costs of the project. It is too early to confirm these calculations since neither the envisaged systems are in place nor are there any dependable, recurrent cost data available.

Findings and Lessons Learned

6. With this project, the Bank started its positive contribution to Malawi's health and population sector, and built a constructive dialogue with the respective Malawian authorities. The Government and people of Malawi have benefited. On lessons learned, it is clear that the implementation period should from the outset have been set at more than two years, which was far too short for the work to be done and the challenges to be overcome. Second, the project might have gained from being simplified and scaled back even further than was done during preparation, considering that this was a first project and the sector had serious staff shortages. Third, further development of the CHSU and pharmaceuticals components before implementation would have helped. Fourth, more persistent effort to get a well-trained and experienced project coordinator in place early on could have aided the resolution of many problems. Fifth, supervision missions should have spent more time in the field and included more involvement by specialists in the areas experiencing difficulties, especially on civil works and pharmaceuticals.

MALAWI
HEALTH PROJECT
(CREDIT 1351-MAI)

PROJECT COMPLETION REPORT

PART I. PROJECT REVIEW FROM BANK'S PERSPECTIVE

A. Project Identity

- Name : Health Project
- Credit Number : 1351-MAI
- RVP Unit : Africa Regional Office
- Country : Malawi
- Sector : Population and Human Resources
- Subsector : Health and Population

B. Project Background

1. Sector Development Objectives. The principal objectives of the Government's health and population sector development over the long run were to improve the health status of the Malawi people and to address the country's population problems. The sector's immediate objectives were targeted to establishing a sound health services delivery system capable of promoting health, preventing and curing diseases, and increasing productivity. Since gaining independence in 1964, the Government has pursued these objectives by focusing on health manpower development in the 1960s and 1970s; and has sought to strengthen and expand the basic health services network while controlling communicable diseases.

2. Policy Context. The 1973-88 National Health Plan provided the basis for developing a network of facilities to substantially increase health coverage. The plan called for a comprehensive health care system to be developed comprising primary health centers, health sub-centers and health posts, together with the provision of health services at the community level. Financial constraints, however, largely prevented the development of such a system and contributed to staff shortages, inadequate training and transport difficulties. In response to these problems, the Government developed a primary health care program in 1978 to supplement its existing rural and MCH programs. At the same time the Government decided to permit properly trained health staff to offer child spacing services, including counselling and distribution of modern contraceptives.

3. Despite these initiatives, the Bank's health sector review in 1980 revealed that slow progress in health improvement was the result of inadequately defined and coordinated policies and strategies, poor sector planning, a bias towards hospital-based curative services, lack of criteria for guiding health sector investments, failure to adequately coordinate the private sector's extensive health activities with those of the Government, and deficiencies in the procurement and distribution of pharmaceuticals. The findings of the sector review, thus clearly showed the need for the development of an up-dated and financially viable national health plan and provided the basis for developing the Health Project.

C. Project Objectives and Description

4. Project Objectives. The main objective of the project was to improve the effectiveness and efficiency of Malawi's health delivery systems in responding to its health needs. Specifically, it was supposed to help the Government reach this objective over a two-year period by:

(a) improving the MOH ability to plan, monitor and evaluate health programs and policies and develop a comprehensive national health plan;

(b) strengthening the MOH's ability to carry out epidemiological studies with supporting laboratory services;

(c) instituting an efficient, cost effective pharmaceutical procurement and distribution system;

(d) introducing the first phase of a national primary health care program; and

(e) introducing a child spacing program.

5. Project Components. The project included five components:

(a) Planning and Administration

(i) technical assistance and training fellowships for MOH for producing a comprehensive national health plan (including a staff development plan), establishing a permanent planning, evaluation and monitoring capability, and improving the financial management, accounting and service statistics systems;

(ii) support of studies on infant and child mortality and on possible linkages between traditional and modern health sectors; and

(iii) technical assistance and on-the-job training for re-organizing the Central Medical Stores (CMS) into a commercial entity;

(b) Community Health Sciences Unit (CHSU)

Renovation and additions to an existing building in Lilongwe with the provision of housing, equipment and vehicles, training fellowships, and consultant assistance (funded, in part, by UNDP/WHO), to establish a unit to collect and analyze epidemiological data, including the necessary laboratory support services;

(c) Pharmaceutical Procurement and Distribution

Renovation of existing buildings in Blantyre, construction of new buildings in Lilongwe and Mzuzu, with housing equipment, vehicles, and consultant assistance to improve the procurement and management of the pharmaceutical system and its associated manufacturing capability,

provide for the move of CMS from Blantyre to Lilongwe, as well as equipment for the training of pharmacy technicians;

(d) Primary Health Care Development

Training (with contributions from UNICEF and WHO), essential upgrading of rural facilities, equipment, vehicles and bicycles, communications improvements, income generating activities and monitoring and evaluation activities, to develop a primary health care program based on community mobilization in three districts covering about 150 villages; and

(e) Child Spacing

Renovation of antenatal facilities at Zomba General Hospital and 15 selected district hospitals, furniture, equipment, training and a family formation study, to initiate a child spacing program in urban and rural areas.

D. Project Design and Organization

6. The Health Project derived its conceptual foundation from the discussions between the Bank and Government on the findings of the health sector review mission in September 1981. The Government accepted the findings of the review and felt that they would provide a good basis for developing this project. Initially, the Government had requested Bank assistance in a very broad scope. When it became apparent, however, that financial constraints would preclude the dimensions of such a project, the concept of the project was scaled down considerably. In retrospect, this decision was clearly correct. The project thus did not attempt to address all of the identified deficiencies of the sector, but focused on developing a national health plan and on redressing the most critical constraints in the health care delivery system. Future health projects would then be designed to deal with some of the other problems.

7. Project preparation extended over a relatively short period of time. After the preliminary project discussions in September of 1981, the project was identified in January 1982, appraised in July 1982, and negotiated in March 1983. The preparation process benefitted from: drawing upon the results of a successful pilot program, in the case of the Primary Health Care Development component; thorough discussions with Government over an extended period of time, in the case of the Child Spacing component; and utilizing the findings of the health sector study. Two of the components (CHSU and pharmaceuticals) were not as well advanced as the others by the time of project effectiveness, and this was mirrored later in the project outcomes.

8. In both the preparatory and implementation phases of the project, it could not have been foreseen that the country would be beset during the project period by multiple economic problems (in incomes, employment, balance of payments, and then tightening of the budget) and the effects of the Mozambican war. These developments significantly exacerbated the constraints on easing staffing shortages and obtaining the building materials (especially cement) needed for civil works.

9. Overall responsibility for project implementation was to rest with the MOH, with each component managed by the head of the applicable section of the

Ministry -- the Chief Health Planner for administration and planning, the Deputy Chief Medical Officer for CHSU, the Assistant Chief Medical Officer (MOH) for the Primary Health Care (PHC) program, and the Chief Pharmacist for the pharmaceutical procurement and distribution component. Responsibility for overall project coordination was assigned to the Principal Secretary of the Ministry. A coordinating committee, chaired by the Principal Secretary, was to have met quarterly to ensure the smooth progress of implementation. Soon after project implementation had started, it became apparent that neither the Principal Secretary nor his deputy was devoting sufficient time to adequately monitoring and coordinating the project on a day-to-day basis. The Bank consequently already recommended the appointment of a full-time project coordinator in its first supervision mission. But it was not until January 1987 that a project coordinator arrived in Malawi -- initially for the Second Family Health Project (Credit No. 1768-MAI) but later, by default, for the (first) Health Project as well.

10. How the design, preparation, and organizational/institutional features of the project contributed to its outcome is, as always, difficult to sort out from the influences of other factors on outcome, such as implementation performance. Nevertheless, it seems likely, for the reasons indicated in the following sections, that the design and preparation work could have been more effective in preventing difficulties that arose during implementation, particularly in regard to the CHSU and pharmaceuticals components and the delay in project completion. The design should have provided for longer than a two-year implementation period, which was far too short for the work that was to be done and the challenges the Government faced. It might also have been advisable to simplify and scale back the project even further than was done during preparation, given that this was a first project and the sector had serious staff shortages. In addition, further development of the CHSU and pharmaceuticals components before implementation would have been desirable, although other factors from the implementation period also weighed heavily on the progress of these components and could not have been entirely foreseen at the outset.

E. Project Implementation

11. The main variances between planned and actual implementation were: (a) the implementation period was lengthened from two to six years, through three extensions; (b) two of the components (CHSU and pharmaceuticals) remained not yet fully operational at project completion, even with the extensions; and (c) lengthy delays were experienced in civil works. The slower than anticipated progress of the CHSU and pharmaceuticals components has delayed efforts to build local capability to carry out epidemiological work, medical research and public health laboratory work (for example, imported goods cannot be tested for contamination in Malawi at the present time). In addition, the anticipated benefits from the planned improvements of the pharmaceutical component have not yet been fully realized, since some aspects (including the manufacturing plant in Lilongwe, and the establishment of appropriate distribution and inventory systems and procedures and the required computer support) are still not entirely operational.

12. Factors common to most of the civil works delays include (a) the preparation by MOH of inaccurate and/or incomplete architectural briefs for the Ministry of Works and Supplies (MOWS); (b) poor coordination between MOH

and MOWS; (c) during first couple of project years focus diverted to resolving massive problems relating to the preparation of National Health Plan; (d) to an increasing degree beginning from May 1984, focus by all concerned parties on preparation of a second health project; (e) lack of proper synchronization between training of personnel and construction schedules; (f) unexpected transfers of senior MOH personnel; (g) shortage of architects at MOWS due to transfer of personnel and death of two key architects; and (h) shortage of building materials due to delays in issuance of foreign exchange permits for importation.

13. Also, the completion of CHSU was delayed because: (a) Several candidates to head CHSU were not accepted by foreign universities; and (b) the epidemiologist designated to head the unit after completion of training was transferred to head the Acquired Immune Deficiency Syndrome (AIDS) program. Additional reasons for the delay of the pharmaceutical component included: (a) MOH's dissatisfaction with the work by the initial pharmaceutical consultants caused about a two year project delay; (b) housing in Lilongwe built for CMS, but occupied by non-project personnel effectively preventing start-up of the pharmaceutical component; (c) protracted disputes between contractors and MOWS over designs of some buildings; and (d) failure to create the staff posts in a timely fashion.

14. While some of these factors could hardly be anticipated during project preparation or avoided by more astute supervision, staff shortages at almost all levels of the project and the difficulties at MOWS should probably have required more conservative projections with regard to the expected implementation period at the design stage and more aggressive attention and follow-up during the supervision of the project. Based on the very positive experience and impact on the project progress once the project coordinator was on board, efforts on the part of the borrower and the Bank should have been more intensive to fill this position much sooner. Furthermore, forward planning and synchronization between civil works schedules, training and assignment of personnel, and availability of equipment and materials could have expedited the implementation period -- for example, through evacuating staff houses in time so that project personnel at CMS Lilongwe could start operation of the facilities; training lab technicians to avoid that manufacturing of pharmaceuticals in Blantyre is done without any quality control of material input or production output; readying computer and inventory systems to enable the completed drug depots in Lilongwe and Mzuzu to assume their regional distribution role and to allow the transfer of the CMS from Blantyre to Lilongwe; and assigning the required staff to operate the three completed and totally underutilized PHC training units.

F. Project Results

15. The project achieved virtually all of its objectives, except that the aims of the CHSU and pharmaceuticals components will be fully attained only when the problems noted above are resolved.

16. One of the primary goals of the project was to produce a comprehensive ten year national health plan for 1985-95 and to improve the planning and evaluation capability of MOH. While the plan was expected to be completed by December 31, 1984, serious problems developed relating to the performance of the consultant group, which ultimately led to a mutually agreed, premature

termination of the contract. As a consequence, MOH planning staff decided to take on the job themselves and, with the assistance of senior MOH management and some consultant advice, worked hard to complete the work. The final product, completed in December 1985, printed in Summer of 1986 and issued in early 1987, was of good quality and received high acclaim from the National Health Planning Committee. The plan also formed the basis for the development of the Second Family Health Project. As an important side-product, the arduous process of developing the national health plan in-house served to markedly strengthen MOH's planning and evaluation capabilities.

17. The child spacing component fully met its overall objectives to introduce family planning programs in Malawi. The component was completed ahead of time and the training program exceeded original targets. According to latest statistics, child spacing services are offered in 106 of the 364 MOH and Private Hospital Association of Malawi (PHAM) facilities. Unfortunately, the initial momentum in the selected pilot districts -- Dowa, Mzimba and Mzuzu -- has not continued to date. Other districts have now exceeded by far the Mwanza and Dowa districts in terms of acceptors. Contributing to this slowdown has been the grave shortage of nurses qualified in child spacing service delivery, and the lack of in-service training and infrequent health inspections. In addition, after most of the construction of the antenatal units was completed and operational, integration of child spacing with MCH activities was introduced rendering most of the existing antenatal facilities too small and no longer space efficient, despite the fact that about ten facilities are currently being upgraded with funds from project cost savings.

18. The PHC component also almost fully met its objective to develop the first phase of national primary health care program based on community involvement in 150 villages of the pilot districts. The component was also completed ahead of schedule. Mainly due to severe financial constraints and staff shortages, the PHC program now has difficulty to sustain its early momentum. For example, the national coordinator of the National PHC Committee is the only person in MOH attending to PHC matters. He has no support staff, no funds for field visits, no vehicles, and no funds to effectively stimulate community-based programs. On the civil work side, the construction and upgrading of six rural health centers was successful despite some continuing water supply problems. Unfortunately, the three PHC training centers were never used for the intended purpose, as all PHC training had been completed when the construction was ready for occupancy. In addition, Government correctly decided that additional PHC training would in the future better be carried out in the communities rather than in classrooms. As a result, the training units are neither properly staffed, supplied and maintained, and remain grossly underutilized.

19. The problems with the CHSU and the pharmaceutical components have been described. It must be emphasized that when and if the current constraints and deficiencies are eliminated, both components should also meet their original objectives. With respect to CHSU this would primarily mean the creation of posts for and the recruitment of a senior epidemiologist, a microbiologist and laboratory technicians. With respect to the pharmaceutical component, this would mean the return of staff houses to project staff, the possible redesign and reconstruction of the drug manufacturing plant in Lilongwe, the development of appropriate computer, inventory and distribution systems, and the recruitment of qualified personnel.

G. Project Sustainability

20. Malawi is likely to derive long-term benefits in the social sectors from the project as a result of its success in launching child spacing and primary health care in the country. In terms of the constructed and improved health and Maternal and Chield Health (MCH)/Child Spacing facilities, the benefits should be sustainable over the long term. Other activities and programs will need to be kept alive through persistence, search for new initiatives, and continued funding. Once operational, both CHSU and the pharmaceutical components should also contribute significantly to project benefits.

21. At appraisal, savings from the planned improvements in procurement and distribution of pharmaceuticals were estimated to more than offset the incremental recurrent costs of the project. It is clearly too early to confirm these calculations since neither the envisaged systems are in place nor are there any dependable, recurrent cost data available. If the savings do eventually outweigh the costs, that is likely to take longer -- given the delays in project implementation -- than the originally expected ten years or sooner from project effectiveness.

H. Bank Performance

22. With the Health Project, the Bank started its positive contribution to Malawi's health and population sector. During the full implementation period, the Bank's dialogue with the respective Malawian authorities was constructive. In hindsight, it appears that the Bank's supervision activity was overshadowed by efforts to prepare and supervise a second project and later prepare a third project. In light of the serious problems encountered throughout implementation, more field time during the 14 supervision missions for the first project could probably have identified difficulties earlier. Considering that a large number of problems, especially in the later years, stemmed from the civil works part of the project, it is unfortunate that there was no consistency in the use of implementation specialists and that in four missions no such specialization was represented. Similarly, a pharmaceutical specialist participated in only three of the first five missions, but not in any of the following nine missions. As indicated, the pharmaceutical component is still not operational and has yet to overcome some very difficult problems. With a more forceful and persistent approach, the Bank could likely have contributed to earlier solution of problems such as the occupation of staff housing by non-project personnel, the assignment of a project coordinator, the submission of timely audit and progress reports, or the establishment of an appropriate project cost monitoring system.

23. For future projects the following lessons learned from the Health Project may be of value:

(a) Priority of supervision of projects must remain high within the work program of the Bank and within Government. Sufficient staff, consultant, and budgetary resources must be allocated to supervision.

(b) Project performance must be rated properly accordingly to receive the appropriate attention from management.

(c) Sufficient time has to be allotted during supervision missions to visit project sites and facilities. A plan should be set up for each project to ensure that over a certain number of supervision missions, say a cycle of four missions or about two years, all such sites and facilities have been inspected. As supervision must not cease after closing date of a loan/credit if earlier difficulties in the project have not been fully resolved (OD 13.05), budgetary resources should in these cases continue to be available.

(d) A well-trained and experienced project coordinator who on a full-time basis facilitates and properly monitors project implementation, and liaises between government agencies and cofinanciers, is a key element to successful projects.

I. Borrower Performance

24. MOH's performance especially during the early stages of the project was affected by the departure of senior staff and by the lack of an experienced, full-time project coordinator. During the first couple of years, MOH's main focus was on overcoming problems arising from consultants who had been retained to prepare the ten year national health plan and to prepare the pharmaceutical components. In this context, MOH is highly commended for taking on the final preparation of the ten year national health plan primarily through its own resources when the consultant group failed to produce an acceptable document. By enormous effort, it completed work of excellent quality. During this difficult period, MOH could probably have benefitted by consulting more closely with the Bank in order to solicit the Bank's advice and support.

25. The borrower's compliance with the Credit Agreement is detailed in Part III, Table 7. The review shows that the main problems relate to (a) substantial implementation delays; (b) poor record keeping of project activities, costs and financing; (c) non-project related occupation of staff housing an the child spacing hostel; (d) failure to provide personnel for the operation of CHSU, CMS and the PHC training units; and (e) substantial delays in preparation of audits and submission of progress reports.

J. Consulting Services

26. As indicated, MOH experienced major problems with the consulting group retained for the development of the national health plan. Because was MOH was dissatisfied with the performance of some of the consultants in the field and their frequent personnel changes, the contract was terminated by mutual agreement at the end of 1984. MOH was not satisfied with the consultants initially retained for the preparation of the pharmaceutical component and MOH hired additional consultants to complete the work in this area. Following this experience, MOH became exceedingly cautious in their recruitment practices regarding external technical assistance.

K. Project Documentation and Data

27. In spite of repeated comments by early supervision missions, a proper project monitoring and information system was never put in place. As a

consequence, there is little institutional memory regarding this project in MOH as many of the persons involved in the early stages have left the ministry. Especially grave is the lack of essential project data, such as project investment and recurrent costs (beyond IDA disbursement data), foreign exchange content, the Government's own contribution to the project, and assistance provided by cofinanciers. In its last progress report dated June 30, 1989, MOH reports that it has not been possible to locate in the MOH Registries documentation on several aspects of project implementation including reports of supervision missions. The available documentation conveys the impression that regular monitoring of project activities at both MOH and IDA has not had high priority. Preparation of PCRs under such circumstances become an exceedingly difficult undertaking.

PART II. PROJECT REVIEW FROM BORROWER'S PERSPECTIVE

A. Adequacy and accuracy of factual information contained in Part III

28. The Ministry is in general agreement with the information presented subject to the following:

(a) Project Costs (5)

Information on project costs are not available in the required format, and are therefore estimates derived from disbursements under the credit and Malawi Kwacha expenditures.

(b) Project Financing (5)

Activities by other agencies except in respect of the CHSU have been completed as part of their country programmes and it has been found difficult to extract expenditures in respect of project items.

(c) Project Results - A. Direct Benefits

The following need to be noted:

(i) All officers of disease control programmes were posted to the CHSU during December, 1989. The Unit is functional.

(ii) Regional and district PHC coordinators were appointed effective 22 August, 1989 and the momentum of the work is being accelerated.

(iii) The PHC Training Centers are being utilized for training activities including PHC with first priority to MOH.

(d) Projects Results - B. Studies

? Although the study at (5) was not done, a pilot survey to develop indicators for the measurement of progress for Health for All 2000 has been completed and will be revised annually.

(e) Status of Comments (7)

In regard to item 4.01 (c), it may be noted that the audit report for the period April, 1988 to March, 1989 was submitted to IDA on 20 February, 1990.

B. Comments on Analysis in Part I

29. The Ministry is in general agreement with the analysis in Part I. However, it is necessary that the following are noted:

(a) The number of static MOH facilities offering child spacing services as at 31 December, 1989 stood at 171.

(b) The deployment of only the National PHC Coordinator at the center should not be considered a down grading of the PHC effort. PHC pervades the entire spectrum of MOH activities especially the preventive services and are supported by programme personnel.

(c) Comments at para. 19, in regard to the CHSU and the pharmaceutical component of the project, need to be viewed in the context of recent intensified efforts by MOH to overcome the stated problems.

C. Bank Performance

30. The Bank inputs during preparation, appraisal and implementation were most critical in this first health project. Greater focus on major issues during supervision and efforts at their resolution may have facilitated satisfactory progress.

D. Ministry Performance

31. Unforseen problems and additional tasks detailed in Part I, placed heavy burden on the limited resources available to Government resulting in implementation delays. One important lesson arising from the implementation record is the need to treat parts of each component as a whole and to ensure their implementation in a systematic and synchronized manner, enabling avoidance of some of the problems experienced in this project.

E. Project Relationship

32. Bank relationship with Government during the evaluation and implementation phases of the project has been good.

F. Relationship with Cofinanciers

33. Activities cofinanced were implemented in parallel as part of country programmes of UNICEF and UNFPA. The only component not implemented was UNDP technical assistance to CHSU. This was due to delayed completion of facilities. The relationship with all agencies was good.

PART III. STATISTICAL INFORMATION

A. Related Bank Loans and/or Credits

Table 1: IDA CREDIT RELEVANT TO THE PROJECT

Loan/Credit Title	Year of Approval	Purpose of Project	Status	Comments
Credit 1768-MAI Second Family Health Project	1987	Improve family health, child-spacing services and MOH capacity to deliver health services	Under implementation	Implementation of civil works processing well; software components are affected by chronic shortage of personnel

Same as first projects; are second & third projects continuations? why is 3rd project not listed here as well?

B. Project Timetable

Table 2: PLANNED, REVISED AND ACTUAL DATES OF PROJECT TIMETABLES

Item	Planned Date	Revised Date	Actual Date
Health Sector Mission			10/1980
Identification Mission			09/1981 (Initial project discussion with IDA)
Preparation Mission			05/17-22/82
Appraisal Mission			07/12-26/82
Credit Negotiations			03/14-18/83
Board Approval			04/26/83
Credit Signature			05/22/83
Credit Effectiveness		07/01/83	08/22/83
Project Completion		06/30/85	
Credit Closing	12/31/85	12/31/86 12/31/87	12/31/88

34. Comments on Timetable. The originally projected date of project completion, less than two years after Credit Effectiveness, was unrealistic. The Credit Closing was formally extended three times. Construction of major works on Central Medical Stores in Lilongwe, the Regional Medical Stores at Mzuzu and the Community Health Sciences Unit started in July/August 1986, i.e., well after the initial Credit Closing date.

C. Credit Disbursements

Table 3: CUMULATIVE ESTIMATED AND ACTUAL DISBURSEMENTS ('000)

Bank FY:	1984	1985	1986	1987	1988	1989	1990
Appraisal Estimate	1,650	4,800	6,300	-	-	-	-
Actual	119	1,914	2,446	2,780	3,810	5,916	6,262
Actual as % of Est.	7	40	39	44	60	94	99
Date of Final Disb. a/							

a/ As of July 31, 1989, SDR 37,823.59 was cancelled.
Last application: No. 157 for K 521,892.4 dated July 31, 1989

D. Project Implementation

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

Component	Planned Completion	Actual Completion	Months of Delay
Community Health Sciences Unit (CHSU)	12/85	09/87	31
Pharmaceutical Procurement and Distribution	05/85	09/89	52
Health Centers	06/85	01/86	7
Child Spacing	01/85	08/85 10/89	7 5

35. Comments on Project Implementation

The civil works program that had been agreed before Board presentation was overly optimistic. Design work was to be done by MOWS staff with no private architects being involved. As it soon turned out, staff shortages in MOWS prevented timely preparation of designs and tender documents. Tendering itself did not seem to have presented difficulties or delays, probably because no international competitive bidding was required. After construction had started, problems and major delays occurred in connection with importation of building materials, seriously delaying, e.g., completion of buildings for the Central Medical Store in Lilongwe. Completion of store buildings for the regional medical store in Mzuzu was badly delayed because of the need, after construction had started, to re-design the roof structure, which caused a protracted dispute between the contractor and MOWS engineers.

In retrospect as indicated in Part I, paragraph 16, the appointment of a project coordinator would have minimized the implementation delay.

E. Project Costs and Financing

Table 5: PROJECT COSTS
(US$ '000)

Category	Appraisal Estimate Local Costs	Foreign Costs	Total Costs	Actual Local Costs	Foreign Costs	Total Costs
I. INVESTMENT COSTS						
Pharmaceutical Supply and Distribution	2,250.2	575.6	2,825.8	N/A	N/A	2,659.8
Community Health Sciences	416.8	808.0	1,224.8	N/A	N/A	108.3
Planninga and Administration	98.9	832.1	931.0	N/A	N/A	1,268.8
Primary Health Care	1,678.2	667.4	2,345.6	N/A	N/A	2,351.4
Child Spacing	470.0	595.0	1,065.0	N/A	N/A	497.4
Total Invest. Costs	4,914.1	3,478.1	8,392.2	N/A	N/A	6,885.7
II. RECURRENT COSTS	211.5	109.5	321.0	N/A	N/A	N/A
Total Project Costs	5,125.6	3,587.6	8,713.2	N/A	N/A	N/A

36. Comments

Actual project costs are based on estimates since the borrower did not keep complete records of its own contribution to the project cost. Due to Kwacha devaluations, Bank agreed to finance certain expenditures which were envisaged under the Second Family Health Project (Credit 1768-MAI) from QECH; 35 additional vehicles). Thus, total estimated investment costs for the Health Project amounted to only US$6.9 million.

Table 6: PROJECT FINANCING
(US$ million)

	Planned	Actual
IDA	6.8	6.2
Domestic	1.3	0.7 a/
Sub-Total	8.1	6.9
UN Cofinancing Institutions	0.6	Not available
TOTAL COSTS	8.7	-

37. Comments on Project Financing

As the cofinancing amounts were relatively small, no formal cofinancing arrangements were made. Unfortunately, no accurate records as to the type of support provided by the cofinanciers or the value of this support was maintained over the project period by the borrower. Likewise, since only IDA disbursement records were kept, Government's own contribution to the project cannot be quantified with any precision. The given estimate is based solely on the Credit Agreement percentages for foreign exchange and local exchange (Schedule 1). The Government's contribution, however, was most likely higher since not all expenditures incurred for the project were submitted to IDA for reimbursement.

F. Project Results

Table 7: Direct Benefits

Indicators	Estimated at: Appraisal	Closing Date	Full Development
Preparation of Revised National Health Plan.	Planned period 1985-1995.	1986-1995 Health Plan issued in 1987.	N/A
Establish CHSU to undertake epidemiological studies and laboratory services (public health laboratory).	Epidemiological work to start January 1985; Microbiology to start middle of 1985; Biochemistry to start middle of 1985; Lab. technology to start January, 1985.	Construction completed, not yet operational due to lack of managing personnel.	Operation not likely to start before 1991/2 unless T.A. received to manage CHSU.
Transfer Central Medical Stores from Blantyre to Lilongwe.	Move to take place in Spring of 1985.	Construction virtually completed, but lack of procedures, computer software, shortage of staff and unauthorized use of staff housing prevent implementation.	Transfer in 1990 only possible if problems of staff housing, computer and stock-keeping procedures can be resolved.
Improve drug manufacturing in Blantyre and add facilities in Mzuzu and Lilongwe.	Production to start by Spring of 1985.	Major construction design deficiencies and housing shortage continue to cause substantial delays in start-up of Lilongwe plant. Mzuzu drug manufacturing facility was cancelled.	Production start-up at Lilongwe will depend on expert review of plant. Full production cannot be envisaged before 1991. Quality control needed.
Improve drug distribution in Malawi including establishment of two regional depots.	Depots and improved system to be ready by the middle of 1985.	Construction of depots completed but not yet occupied. Little work done on system and procedure improvements. Major computing problems.	Computer and procedure specialist needed to eliminate major problems.

Develop PHC Program based on community mobilization in Mwanza, Dowa and Mzimba districts.	Pilot program covering 120,000 persons. Full-time PHC coordinators to be appointed. PHC committee structure at village, area, district and region to be established.	About 120,000 persons initially affected by Project. Shortage of staff and funds. No full-time PHC coordinators assigned; health inspectors carry out PHC tasks in addition to their regular work.	Service coverage extended by the project. The subsequent project is supporting PHC activities.
Selection, training/ retraining of community workers (TBAS and health are workers). National core group to train district health management team.	300 PHC workers to be trained/re-trained.	300 trained within original project implementation period (two years). However, after 1982 review, PHC worker system was replaced by Health Service Assistance.	Pilot scheme was successfully extended to a large number of other districts.
Upgrading of facilities in Dowa and Mzimba to health sub-centers and add staff housing.	6 units.	5 units completed; one unit under construction (Nalunga).	6 units.
Construction of PHC training centers in Mwanza, Dowa and Mzimba districts.	3 training centers.	Construction completed only after PHC training had taken place and after program change calling for all PHC training to be performed in the communities themselves. Due to staff shortage, centers are mostly unused.	Training centers to be used for district's non PHC health training needs and other ministries.
Provision of child spacing (CS) at central hospitals, all district hospitals and at rural health centers.	First project year; CS at 2 central hospitals and 22 district hospitals; second project year: CS at one rural health center in each district.	CS available at all central and district hospitals and in a large number of rural health centers.	N/A
Upgrading of antenatal facilities to permit CS services.	Upgrading of antenatal care at Zomba hospital and 15 of 21 district hospitals.	Zomba hospital and 12 units completed.	Due to savings, additional improvements at 10 hospitals initiated before Credit Closing date.
Orientation of health staff in CS.	2,000 during initial project period.	Partly alone.	CS training continues.

Technical CS training of hospital staff.	116.	116.	N/A
Establishment of technical training centers for CS at Lilongwe, Zomba and Blantyre hospitals.	Three centers to be established.	Centers are operational.	N/A

38. Comments on Project Results

Due to the originally anticipated brevity of Project implementation (two years), it was felt at Appraisal that project impact could primarily be measured by process indicators, rather than by direct results on health status improvements. Furthermore, this Project was meant to a large degree to prepare the basis for future health projects.

Table 8: PROJECT STUDIES

		Purpose as Defined at Appraisal	Status	Impact of Study
1.	Infant and Child Mortality	Analysis of 1977 census data to provide information on infant and child mortality by district.	Not done. However, Family Formation Study addressed infant and child mortality issues.	See under Study No. 6.
2.	Role of Traditional Medical Practi-tioners	Obtain objective information to determine linkages between modern and traditional health sectors.	Not done. But WHO consultant did some work in this area in 1988.	Impact of WHO supported study not known.
3.	Review PHAM	Review ways of improving the low level of utilization of PHAM facilities and need for financial assistance.	Not done. On financial side, however, a lot of work has been done.	Utilization of PHAM facilities remains low.
4.	Medical School Study	Determine financial feasibility of developing medical school in Malawi.	Completed by WHO and consultant consortium.	Provided basis for Government decision to pursue development plans.

5.	Baseline Epidemi-ological Study	To measure PHC program's impact over time.	Focus slightly changed. Primary focus in PHC given to training. In 1987, MOH, WHO, UNICEF, etc. carried out PHC review.	N/A
6.	Family Formation Survey	To determine future priorities in programs for mothers and children.	Conducted in 1984 by the National Statistical Office with MOH participation.	Survey updated demographic indicators particularly on fertility and mortality and gathered baseline data on KAP regarding child spacing.

G. Status of Covenants

Table 9: COMPLIANCE WITH CREDIT AGREEMENT

Section/Covenant		Status of Compliance
3.01(a)	The Borrower shall carry out the Project in conformity with appropriate practices.	In compliance, with the exception of (i) substantial implementation delays; (ii) poor record keeping relating to Project activities and financing; (iii) due to severe housing shortage, staff housing and child spacing hostel built under Project have been occupied by non-project related personnel; and (iv) necessary staff positions for some project components (CHSU; pharmaceutical distribution; PHC training centers) have neither been created nor filled due to budgetary problems, but this issue is now being resolved.
3.02(a)	The Borrower shall employ specialists in accordance with World Bank guidelines.	In full compliance.
	The Borrower shall employ not later than September 30, 1983, a health planner, an epidemiology, a financial analyst, a manpower planning expert and two pharmaceutical consultants.	Covenanted personnel has been employed at different times but not during full project period. Epidemiologist has bee trained; but was recently appointed to lead AIDS Program.
(b)	Designate a Malawian counter-part to work with each consultant so employed.	In light of severe staff shortages, counterpart personnel has been made available whenever possible.

3.03	The Borrower shall cause all goods and services under the Credit to be used exclusively for the purpose of the project until its completion.	Houses built under Project for staff to operate CHSU and Central Medical Stores in Lilongwe have been occupied by non-project personnel causing substantial delays in the start-up of these facilities. Also, Child Spacing Training Hostel (old nurses home) cannot be used for intended purpose due to non-project use. The GOM is in the process of releasing these houses to the designated institution.
3.04(a)	The Borrower shall furnish to IDA certain project documents.	In compliance.
(b)	The Borrower shall maintain records on project progress, permit IDA mission visits and provide at regular intervals certain information.	Record keeping regarding Project activities, Project costs and Project benefits have been insufficient to adequately monitor progress of the Project. Progress reports were submitted to Bank only very sporadically, although quarterly reporting was stipulated. Between 1987 and 1989 only two progress reports were received.
(c)	The Borrower shall prepare a PCR not later than six months after closing date.	Although Bank had requested basic information required for PCR preparation, such information was not received during the covenanted period. Some important data (Project costs, co-financing support, namely non-IDA costs) have still not been furnished.
3.05	The Borrower shall acquire land rights as needed for Project.	In compliance.
4.01(a)	The Borrower shall maintain Project accounts.	In compliance only in so far as IDA disbursement accounts are concerned. No accounts maintained for Government's and co-financiers' contribution to Project's investment and recurrent costs.
(b)	The Borrower shall maintain separate accounts for statements of expenditures.	In compliance.
(c)	Audit reports shall be submitted within six months after the end of each fiscal year.	Reports were delinquent for every fiscal year during Project period. Due to these delays, audits for two years had to be combined. Only two audit reports were received, covering period: April 1984 - March 1986 and April 1986 - March 1988. Latest audit report for period April 1988 to March 1989 not yet received. Audit reports only covered IDA portion of Project.
4.02	The Borrower shall produce a revised National Health Plan for the period 1985 - 1995 by December 31, 1984.	National Health Plan for 1986 - 1995 was issued in 1987 after an about two year delay.

4.03	The Borrower shall introduce a scale of fees for health services by April 1, 1984.	Revised scale of fees was introduced in 1984.
4.04	The Borrower shall operate the Central Medical Stores as a district self accounting undertaking not later than April 1, 1984.	Not fully complied with. Central Medical Stores now operated as Treasury Fund Activity within MOH, providing advance foreign exchange funding for purchase of pharmaceuticals and medical equipment; but with less autonomy than a district self-accounting undertaking would have provided.
4.05	The Borrower shall ensure review of NGOs by PHC core group of MOH to ensure better coordination between them and public health providers.	Review not undertaken.
4.06	In order to improve the staffing of the health centers in its primary health care program, certain staffing levels at health centers, PHC training units and districts should be achieved.	In compliance as health centers under Project are concerned. Staffing posts for the three training units in Mzimba, Mwanza and Mponela have not been created, and consequently units are not staffed.

H. Use of Bank Resources

Table 10: STAFF INPUTS AS OF DECEMBER 13, 1989

Stage of Project Cycle	FY82	FY83	FY84	FY85	FY86	FY87	FY88	FY89	FY90	Total
Preparation	55.0									55.0
Appraisal		49.3								49.3
Negotiations		7.7								7.7
Supervision		0.4	31.1	19.2	3.9	13.1	11.4	6.3		85.4
Other (PCR)							0.7	0.1	8.4	9.2
TOTAL	55.0	57.4	31.1	19.2	3.9	13.1	12.1	6.4	8.4	206.6

39. Comments on Staff Inputs

Staff input for project preparation through negotiations amounted to 112 staff-weeks, which is about the average for Bank projects overall. However, supervision input exceeded the originally expected time substantially because the implementation period was estimated at two years but actually extended over six years. The total annual staff time allocated to supervision appears to have been adequate, an average of 14 staff-weeks per annum. While supervision carried out in the field amounted to 18 staff-weeks during the first year of project implementation (FY84), the average amount of time spent in the field during the following five years amounted to only about 5 staff-weeks or about 2.3 staff-weeks per mission.

Table 11: MISSION DATA

Mission	Month/ Year	No. of Persons a/	Staff Weeks in Field	Performance Status by Activity b/				
				F	M	DI	OS	a/
Health Sector Mission	10/80							
Appraisal	07/82							
Supervision I	09/83	2(A,PH)	2	1	1	-	1	
Supervision II	12/83	2(A,A)	2	1	1	-	1	
Supervision III	02/84	4(E,M,P,PH)	7	1	2	1	2	
Supervision IV	06/84	4(A,H,P,PH)	7	1	1	1	2	
Supervision V	10/84	4(HP,M,P,PH)	4 c/	1	1	1	2	
Supervision VI	04/85	3(A,HP,PH)	3 c/	1	1	1	2	
Supervision VII	06/86	4(A,E,MS,PH)	2 c/	1	1	1	2	
Supervision VIII	09/86	3(A,E,MS)	4 c/	1	1	1	2	
Supervision IX	04/87	2(A,E)	2 c/	1	1	1	2	
Supervision X	08/87	1(E)	1 c/	1	1	1	2	d/
Supervision XI	11/87	3(A,E,PH)	2	1	1	1	2	
Supervision XII	03/88	3(A,E,PH)	2 c/	1	1	1	1	
Supervision XIII	10/88	3(A,E,PH)	1.5 c/	1	1	1	1	
Supervision XIV	03/89	3(A,E,PH)	1.5 c/	1	1	1	1	
TOTAL			45.0					
Proj. Completion	11/89	2(A,E)	4	-	-	-	-	

a/ A=Architect; E=Economist; H=Health Advisor; HP=Health Planning Specialist; M=MCH/FP Specialist; MS=Management Specialist; P=Pharmaceutic Specialist; PH=Public Health Specialist

b/ F=Available Funds; M=Project Management; DI=Development Impact; OS=Overall Status

c/ The Health Project was supervised together with the preparation/supervision of the Second Family Health Project.

d/ No Form 590 on record.

39. Comments

The performance ratings of the project do not seem to reflect the serious difficulties described in the supervisions reports. In light of the staffing shortages, management problems and underutilization of project facilities, the project management, development impact and overall status seem overrated. Over the six year project implementation period, three different taks managers/project officers were responsible for the project's supervision providing a considerable degree of lack of continuity. Also, regarding public

health specialization, there has been remarkable consistency in Bank personnel. However, with respect to architects, seven different specialists (staff or consultants) participated in ten full supervision missions. No architect/ implementation specialist was represented in four missions. Moreover, in light of the difficulties in the pharmaceutical component, a specialist in this area may have been able to identify some of the design, construction, and procedural problems at an earlier stage and assisted Government in taking the appropriate remedial actions. Pharmaceutical specialists were used in only three early supervision missions.

Record of Project Progress Reports Submitted by Govenrment

(a) As of October 22, 1985.

(b) For period ending December 31, 1988, submitted on March 9, 1989.

(c) For period ending June 30, 1989, submitted on October 27, 1989.

In reply please quote No. ADM/14/87

Telegrams: MINMED, Lilongwe
Telephone: Lilongwe 730 099

Communications should be addressed to:
The Secretary for Health

MINISTRY OF HEALTH
P.O. BOX 30377
CAPITAL CITY
LILONGWE 3
MALAWI

3rd May, 1990

Mrs. N. Shields, AF6PH
The World Bank,
Population and Human
Resources Division,
1818 H. Street, N.W.
WASHINGTON, D.C. 20433,
U.S.A.

Dear Mrs. Shields,

MALAWI: HEALTH PROJECT (CREDIT 1351 MAI)
PROJECT COMPLETION REPORT

Thank you for your letter of 2 April, 1990 forwarding the Project Completion Report (PCR) on the above project.

I have studied the report with interest and have noted the areas for follow-up. The Ministry has taken several steps to strengthen its performance. Specifically, action is being taken to strengthen the Planning Division and the Project Implementation Unit. Already, an appointment has been made to the post of Principal Health Planning Officer and the Project Implementation Unit has been staffed with a Project Architect and additional accounting staff.

We are also pursuing the establishment of a Manpower Development Unit as part of the Planning Division and renewed efforts are being made to ensure improved co-ordination not only in project work, but in all Ministry activities at central and lower levels.

Important aspects of this project which need continued attention will be closely followed up and IDA will be kept informed of progress. This will be particularly relevant to the Pharmaceutical Supply and Distribution activities and the Community Health Sciences Unit.

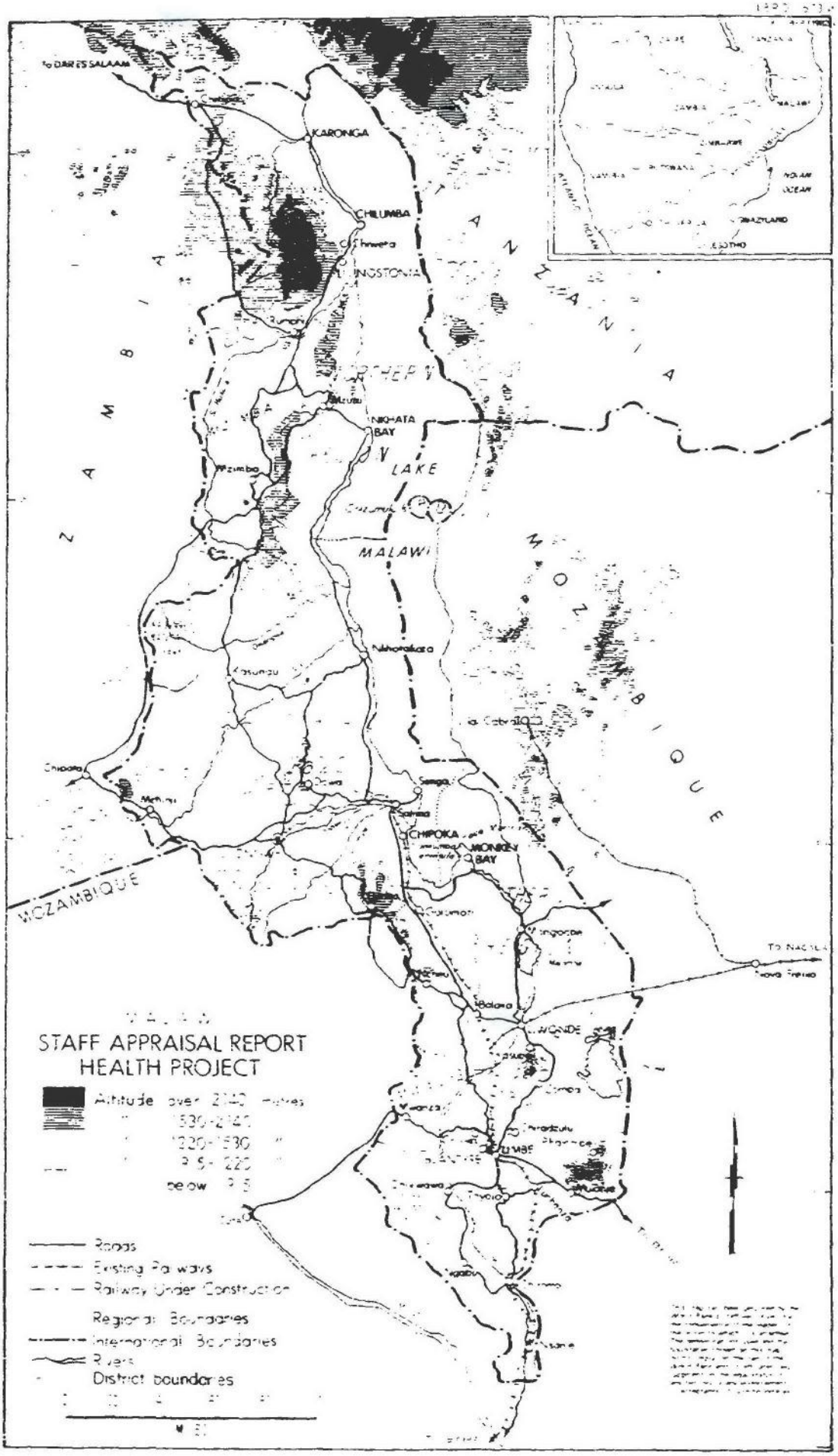
Date Recd. 5/8/90	Log No. LPS/108
For Action: N Shields	
cc:	
cc:	
To file	
Date	

2/...

The project review from the Government's perspective for inclusion as Part II of the report is forwarded herewith. I have forwarded copies of my letter to the Secretary to the Treasury and the Principal Secretary, Ministry of Works for their information.

Yours sincerely,

R. P. Dzanjalimodzi
SECRETARY FOR HEALTH


STAFF APPRAISAL REPORT
HEALTH PROJECT
Roads
Existing Railways
Railway Under Construction
Regional Boundaries
International Boundaries
Rivers
District boundaries
MALAWI
ZAMBIA
TANZANIA
MOZAMBIQUE
LAKE
KARONGA
CHILUMBA
NKHATA BAY
CHIPOKA
MONKEY BAY
to DAR ES SALAAM
TO NACALA