BRAZIL: Northeast Basic Health (2nd)
(Ln. 3135-BR) Implementation Comp. Report

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FROM: The Secretary

July 15, 1998

IMPLEMENTATION COMPLETION REPORT

BRAZIL

THE SECOND NORTHEAST BASIC HEALTH SERVICE PROJECT
(LOAN 3135-BR)

Attached is a report entitled "Implementation Completion Report: Brazil: The Second Northeast Basic Health Service Project (Loan 3135-BR) dated June 16, 1998 (Report No. 18046) prepared by the Latin America and the Caribbean Region.

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Report No.: 18046

IMPLEMENTATION COMPLETION REPORT

BRAZIL

THE SECOND NORTHEAST BASIC HEALTH SERVICE PROJECT (LOAN 3135-BR)

June 16, 1998

Country Managing Unit for Brazil
Human Development Sector Management Unit
Latin America and the Caribbean Regional Office

CURRENCY EQUIVALENTS

Currency Unit = Brazilian Real (BRL)
US$1.00 = BRL 1.12

FISCAL YEAR

January 1 - December 31

ABBREVIATIONS & ACRONYMS

AIS	Integrated Health Action
AMH	Ambulatory and Basic Hospital Medical Care Program
CDI	Infectious Disease Control Program
CIPLAN	Inter-Ministerial Planning and Coordination Commissions
CONASP	Consultative Council on Health Insurance Administration
FAS	Fund for Social Development Assistance
ICR	Implementation Completion Report
IEC	Information, Education, and Communications
IEPS	Initial Executive Project Summary
INAMPS	Institute for Medical Assistance of Social Security System
LA	Loan Agreement
MOH	Ministry of Health
PAHO	Pan American Health Organization
PAISMC	Comprehensive Care for Women and Children
PCU	Project Coordination Unit
PIASS	Program for Implementation of Health and Sanitation Activities in Interior Areas
PNE	Northeast Basic Health Services Project
POI	Integrated Budgetary Plan
SAR	Staff Appraisal Report
SES	State Health Secretaries
SUDS	System of Unified and Decentralized Health Care
SUS	Unified Health System

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BRAZIL
THE SECOND NORTHEAST BASIC HEALTH SERVICES PROJECT
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IMPLEMENTATION COMPLETION REPORT

BRAZIL

SECOND NORTHEAST BASIC HEALTH SERVICES PROJECT

(Loan. 3135-BR)

PREFACE

This is the Implementation Completion Report (ICR) for the Second Northeast Basic Health Services Project in Brazil, for which Loan 3135-BR in the amount of US$267.0 million equivalent was approved on November 24, 1989 and became effective in December 1990. The loan was closed on December 31, 1997, one and a half years beyond the original schedule. As of June 16, there is a balance of US$2.9 million in the loan account, but it is expected to be disbursed by June 30, 1998.

This ICR was prepared by Kye Woo Lee in collaboration with Claudia Rosenthal (consultant) Marian Kaminskis and Sarah Menezes of the Human Development Sector Management Unit and reviewed by Jean-Jacques de St. Antoine of the same Unit and Patricio Millan of the Country Managing Unit for Brazil of Latin America and the Caribbean Regional Office (Preface, Evaluation Summary, Parts I and III). The Borrower contributed to the preparation of the ICR through a review of project performance (Part II) and commented on the ICR (Appendix A).

Preparation of this ICR was done during the mission in March 1998 and is based, inter alias, on the Staff Appraisal Report, the Loan Agreement, Supervision Reports, Annual implementation review reports prepared by the Borrower and the Bank, correspondence between the Bank and the Borrower, and internal Bank memoranda.

IMPLEMENTATION COMPLETION REPORT
BRAZIL
THE SECOND NORTHEAST BASIC HEALTH SERVICES PROJECT
(Loan 3135-BR)

Executive Summary

Project Background. At the time of the project preparation in the mid-1980s, health conditions in Brazil were lagging behind other sectors. Major health indicators, such as a life expectancy of 65 years and infant mortality of 63 per 1,000 live births, were inferior to those of the countries with lower per capita income. These poor national average indicators were caused mainly by the large geographical disparity in health status between the North/Northeast and the rest of the country. The life expectancy in the Northeast was lower than the South/Southeast by 13 years, and the infant mortality rate of 79 was higher than in low-income developing countries. The most important causes of illness and deaths among children were similar to the ones in lower-income developing countries. In 1986, the Northeast accounted for 29% of Brazil's total population and 45% of the total rural population.

Major issues in the Brazilian health system in the 1980s were : (i) inequitable access to the health service systems, and (ii) lack of efficiency in the use of finances, manpower, and physical facilities. These problems were most acutely felt in the Northeast because of their interplay with low income, poor social infrastructure, and inadequate education in the region. The Institute for Medical Assistance of Social Security System (INAMPS), the major public health institution under the Ministry of Welfare and Social Security, provided individual medical care services only to the payroll levy contributors to the system, leaving the poor and those in the informal economy to the care of the Ministry of Health (MOH). The MOH was responsible for setting national health policy and delivering basic health services through its specialized agencies, states, and municipalities. The basic health services relied on the limited and variable general tax revenues. By contrast, the INAMPS enjoyed significant financial and operational autonomy on the basis of the payroll levy, and reimbursed for the individual medical services offered by the public and private providers without cost and service control. Consequently, basic health programs of the MOH grew little if any and were ineffective due to staff and input shortages, skill constraints, facility inadequacies, and over-centralization of planning and administration. Between 1949 and 1982, the proportion of public spending on largely curative care rose from 13% to 85%; basic health care was squeezed out.

During the 1970s and 1980s, the Government launched a series of strategies and programs to redress the inequity and inefficiency of the health system. They ranged from creating new funds for basic health services and according a higher priority to basic health services to coordinating various health programs in a state through an integrated budgetary plan (SUDS). In 1988, the new Constitution ratified the goals of past strategies, established the Unified Health System (SUS) at the national level, and

mandated the government to achieve the goals of the universal coverage of all citizens under the SUS through decentralization.

In support of the Government's strategy for strengthening, integrating, and decentralizing basic health services at the state level, the Bank participated in the financing of the Northeast Basic Health Services Project (PNE-I) (Loan 2699-BR) in 1986, and the Second Northeast Basic Health Services Project (PNE-II) (Loan 3155-BR) in November 1989.

Project Objectives and Content. The project had two objectives: (i) to strengthen the delivery of the basic health service package in selected low-income areas of seven states in the Northeast; and (b) to reinforce the implementation of the sectoral reform including integration, unification, and decentralization. The basic health service objective was to be achieved by supporting the provision of the basic health service package-- which comprised comprehensive care for women and children including family planning; the infectious diseases control program; and the ambulatory and basic hospital medical care program -- through the expansion and upgrading of 1,707 health facilities (including 1,107 health posts, 327 health centers, 171 *unidades mistas* (health centers with 16-50 beds), 81 obstetric units, 16 hospitals and 5 laboratories) and their equipment, training of 60,000 health personnel, special studies and technical assistance, provision of drugs and medical supplies, hiring or reassigning about 8,600 additional health personnel, and carrying out supervision throughout the project areas. The sectoral reform objective was to be obtained by supporting the institutional development of the State Health Secretariat (SES) and the MOH in planning, management, logistics, financial controls, and community education through provision of technical assistance, training, and special studies.

Achievement of Project Objectives. Although the project was completed with a substantial delay, its two main objectives were achieved as expected at appraisal. The number of facilities and equipment provided and staff trained under the project is most likely to be greater than the appraisal estimates. Technical assistance and studies provided under the project were 143% larger than envisaged at appraisal in terms of expenditures. A cadre of professional health staff and managers trained under the project appear to be one of the most valuable results of the project. Since the monitoring and evaluation indicators established at the beginning of the project were limited and the compilation of the data during the project implementation was inadequate, no proper data are available to assess the achievement of the institutional development objectives of the project at this time. But the number of new or reassigned staff, drugs and medical supplies, maintenance, supervision and IEC activities provided under the project is assumed to be the same level as the appraisal estimates. The project funds were applied to the institutional development component of the project in a more balanced way than in the PNE-I, where the infrastructure component claimed a disproportionate share of the total project expenditures.

The project was completed in eight and a half years since the Bank Board approval, compared with six years estimated at appraisal. The completion date was delayed by two and a half years, and the closing date was extended by one and a half years. Total project costs increased by 27% from US$610.6 million to $772.8 million. The project costs were higher due partly to the extended implementation period and partly to the additional number of states introduced into the project. The original project included seven states in the Northeast (Alagoas, Ceará, Paraíba, Pernambuco, Sergipe, Marañhao, and Bahia). In April 1996, the Government and the Bank agreed to the inclusion of three more states, which were also included in the PNE-I (Rio Grande do Norte, Piauí, and northern Minas Gerais). The original Bank loan of $267.0 million was canceled by $50 million in late 1994 as part of an overall portfolio restructuring exercise requested by the Cardoso government. Therefore, the Bank loan of $217.0 million accounts for 28% of the actual project costs, compared with the appraisal estimate of 43%.

The infrastructure component was implemented in 849 municipalities including 632 municipalities of the original seven states and 217 municipalities of the additional three states,i.e., nearly twice as many as the 478 municipalities targeted at appraisal. In the original seven states, a greater number of municipalities were allowed to participate in the project. Consequently, this component would benefit not only the 12 million inhabitants in the original seven states, but also 5.2 million more people in three additional states, accounting for 60% of the total population in the Northeast. The decision to cover the additional states was a cost-effective one, since their share of total beneficiaries was greater than that of their costs. And the decision to expand the scope of the project to a greater number of municipalities was also conducive to the attainment of the project objectives towards the universal coverage of all citizens under the health system. The two states visited by the ICR mission also implemented the infrastructure component more through renovation than construction and expansion of facilities. Likewise, lower level facilities, such as health centers, were preferred than higher level facilities, such as hospitals. These options were more cost-effective.

The staff training component was also carried out in a successful way. Although no project-wide data have been compiled yet, the state of Bahia alone trained 39% of the appraisal target for all seven states. For the achievement of this component, some states constructed a public health school or a human resources training center. The majority of the beneficiaries came from the municipal and regional offices, and from the more educated level of staff, such as doctors, technicians, managers, and administrative staff. The cadre of trained medical, technical, and administrative personnel are one of the most concrete achievements of the project and are key elements for institutional and technical development of the health secretariats of the project municipalities and states.

The special studies component was carried out by both MOH and the states, covering a wide range of topics. They range from educational materials development to institutional diagnosis, epidemiological profiles, architectural plans, and project implementation evaluation. These studies, together with technical assistance, provided a

sound basis for planning, implementing and evaluating sectoral reform and institutional strengthening programs. However, one important topic missing in those studies was the development of a set of project monitoring and evaluation indicators, and performance criteria for MOH and States, which was agreed at appraisal. Absence of this topic has had an adverse effect on the implementation and evaluation of the project and on the sectoral reform implementation.

All indications point to an adequate implementation of the drugs, medical supplies, and maintenance, and other institutional development component, such as staffing and supervision, and information, education, and communications (IEC) programs, but no adequate data have yet been compiled to demonstrate the achievement of these components in an analytical manner. The IEC component was the most active element of the institutional development component. Although it had a late start in 1994, multisciplinary consultants at federal and state levels made special studies, prepared public health information materials, and trained health information officers, and actively carried out IEC events through mass media, health fair, street theaters, publications and exhibitions. However, this component suffered most from the partial cancellation of the loan amount and incurred only half the expenditures envisaged at appraisal. Moreover, the mandated two-year rolling plan for this component was not updated annually, and no impact evaluation studies have yet been carried out.

Major Factors Affecting the Project. The project implementation was sluggish at best during the period 1989-93. During this period only 16.5% of the loan funds were used, compared with 60% estimated at appraisal. The project implementation was accelerated only after 1994 when the new Government came to power with a new MOH minister and a new project manager, declaring an unwavering commitment to the project, and the Bank appointed a new Task Manager. About half the loan funds were utilized only during the last two and a half years, before the project was completed in June 1998.

The project was launched at a time when the country was undergoing a political, economic, and social transition, and it was difficult for the Government to maintain its commitment to the seven-year social investment project as originally designed. Although the 1988 constitution declared the universal coverage of the total population under the unified health system through decentralization, it was not easy for the new Government to agree on the laws and regulations, as well as the sectoral strategy and administrative guidelines, to implement the mandate. The end of military rule in 1985 marked the beginning of an increased political participation of the population through many political parties and influential regional leaders, and the democratic government tried to satisfy the needs of all segment of the society. Health reform at a regional level had to wait for the progress in the sectoral reform at the national level first, but the project itself did not focus on the assistance for the sectoral reform at the national level. It was only in 1993 when all relevant laws and regulations were in place, and the municipalities, instead of the states, were given greater role for project implementation.

Also, the country was struggling with a high external debt and inflation with a popular plan, which could not sustain the fiscal balance. The loan signing and effectiveness were delayed for 13 months just as in the PNE-I project. The provision of adequate counterpart funds was a perennial problem until 1994, and the Bank's special account, procurement, and disbursement procedures had to be adjusted to accommodate the local situation.

The 1980s also witnessed a large migration of rural population to peri-urban and urban areas in the Northeast. Therefore, the project implementation gathered momentum only after December 1995 when the list of targeted municipalities was expanded to include notably peri-urban areas, and the type of health facilities were adjusted to the changing circumstances.

The project design was rigid, but there was no serious efforts to adjust the project content, targets, and mode of implementation until December 1995. Any attempt by the Borrower to change the loan agreement was met with stiff objection by the Bank and time-consuming processes for reappraising the proposed changes. It was only in 1995 that the Government and the Bank agreed to adjust the project content and the mode of implementation. In particular, the competition and incentives introduced for project states in 1995 accelerated the project implementation and disbursement. Together with other measures to introduce flexibility in the project design and implementation, the Government and the Bank agreed to allocate loan proceeds among state in accordance with the merits of the annual work programs and budgets, irrespective of the allocations already made at appraisal. At the same time, the Project Manager increased technical assistance to those states with weaker institutional capacities and more implementation difficulties. To allow time for the newly introduced measures to produce results, the implementation period was extended by one and a half years. The combination of these measures enabled the project to accelerate implementation. Both poorer and richer states benefited from the competition and incentives owing to the strategic provision of technical assistance.

The design of this project merely followed that of the PNE-I, and did not draw lessons from the implementation experience of the PNE-I. By the time the PNE-II was approved , the PNE-I had already experienced implementation difficulties for three years. The lessons learned from the PNE-I would have helped improve the design of the PNE-II, reduce its launching time, and would have minimized the risks. The problems of the two projects were, in fact, addressed at the same time, and the two projects started a normal implementation only after 1993.

According to the loan agreement, the Project Manager was responsible for the coordination of all matters related to the project implementation. But its *de facto* status and role were not conducive to an efficient coordination of project implementation. It did not have direct access to the chief executive of the MOH who oversaw the sectoral reform and budget allocations. In particular, the Project Manager was responsible only for the infrastructure component. Therefore, the Manager did not actively push for and monitor

the progress of other project components, especially the institutional development component. This had adverse effects on the pace and balance of project implementation and future operations of the project institutions upon completion of the project.

Project Sustainability. Future operations of the project are financially and institutionally sustainable, but their sustainability could be strengthened through some on-going and follow up projects. Financially speaking, the basic health service network is likely to be sustained because the SUS, the main source of financing health expenditures in the country, will reimburse most of the expenditures incurred in health centers and hospitals. At the same time, the level of municipalities's and states' own financing of basic health expenditures has been steadily on the rise. Institutionally speaking, the health secretariats of the states and municipalities, as well as the staff of individual health facilities, have been strengthened substantially. The increased role of municipalities in the SUS helps make the system more responsive to the need of the population, and improves the financial flows between different levels of the Government. These improvements have come mainly through state and municipal training programs and through technical assistance provided by the federal government.

The health secretariats of the states and municipalities and other public health institutions in the Northeast are still weak technically and institutionally, and would therefore require more professional personnel, continuous training, and technical assistance from the federal level. The MOH, however, does not seem to be prepared to provide the necessary assistance on a continuing basis in the future. Additional personnel hired under the project for institutional development and the basic health services were mostly consultants. As the project implementation drew to a conclusion, their contracts were not extended. Therefore, prospects are uncertain for continuous support for the institutional development components and monitoring their implementation at the state and municipal levels. The MOH will have to strengthen its institutional arrangements for systematic monitoring and technical assistance to be provided to states and municipalities.

Outcome Assessment. Because of the lack of adequate project monitoring and evaluation indicators and the absence of a systematic information system at the federal level, a full assessment of project outcomes cannot be done at this moment. An extensive survey of the project outcome is being prepared by the PCU in collaboration with the project states and municipalities, but the result would be available only after mid-1998.

During the ICR mission some data on the project outcomes were collected from two selected states, Ceará and Paraíba, and were compared between project and non-project municipalities. The project municipalities showed a more rapid increase in medical consultation possibly due to the expanded and improved basic health service network. The trend is not so clear in the vaccination coverage rate and in-hospital births possibly because they require more time to reflect the project impact.

Key Lessons Learned.

- Projects with a long implementation period are not advisable during a transitional period.
- It is essential to learn lessons from the implementation experience of the precedent project, especially for a repeat project.
- In a multi-state project, if a sector loan approach cannot be adopted, the project design should be kept flexible, and should be adapted constantly to the changing needs.
- In a multi-state project, introduction of competition and incentives among states in the allocation of loan funds is effective as long as their varying institutional capacities are compensated by intensive technical assistance by the federal government.
- A sub-account should be established for each state separately so that each state's accountability and performance efficiency would improve.
- The Bank should streamline and actively monitor the process for the amendment to loan agreements so that project design can be adapted constantly and easily.
- Project specific monitoring and evaluation system is not likely to be operated effectively when an institution-wide monitoring and evaluation system is lacking.
- Government's commitment and PCU's authorities and status are highly correlated to the success of project implementation and outcomes.
- A Borrower's ICR should be prepared before the closing date.

PART I: PROJECT IMPLEMENTATION ASSESSMENT

A. Project Background

1. **The Northeast.** At the time of the project preparation in the mid-1980s, health conditions in Brazil were relatively lagging behind other sectors, compared with its overall level of development. Major health indicators, such as life expectancy of 65 years and infant mortality of 63 per 1,000 live births, were inferior to those of the countries with lower per capita income. These poor national average indicators were caused mainly by the large disparity in health status between wealthy Brazilians concentrated in the South and Southeast, and poor Brazilians concentrated in the Northeast. Despite the converging trend, residents of the south-southeast are still likely to live 13 years longer than their counterparts in the Northeast. The infant mortality rate (79) for the Northeast in 1986 was higher than in low-income developing countries. Infant deaths accounted for 35% to 40% of the total deaths in the region, and the most important causes of illness and deaths among children under five years were gastrointestinal and respiratory infections, perinatal diseases, low birth weight, and malnutrition, an epidemiological profile similar to the one in lower-income developing countries. In 1986, the Northeast accounted for 29% of Brazil's total population and 45% of the total rural population.

2. Major issues in the Brazilian health system in the 1980s were: (i) inequitable access to the benefits of the health service systems, and (ii) lack of efficiency in the use of finances, manpower, and physical facilities. These problems were most acutely felt in the Northeast because of their interplay with low income, poor sanitation, and inadequate education and housing in the region. Prior to the unification of the health systems in 1990, the Institute for Medical Assistance of Social Security System (INAMPS), the major public health institution under the Ministry of Welfare and Social Security (MPAS), provided individual medical care services only to the payroll levy contributors to the system, leaving the poor and those in the informal economy to the care of the Ministry of Health (MOH). The MOH was responsible for setting national health policy and the collective health care, delivering basic health care through its specialized agencies, states, and municipalities. The basic health services relied on the limited and variable general tax revenues. By contrast, the INAMPS enjoyed significant financial and operational autonomy on the basis of the payroll levies. Besides providing some individual medical care through its own small network of facilities, it reimbursed both public and private providers almost without cost and service controls. Consequently, basic health programs of the MOH grew little if any and were ineffective due to staff and input shortages, skill constraints, facility inadequacies, and over-centralization of planning and administration. By contrast, INAMPS services grew explosively, and it created additional distortions, most notably an over-utilization of high-cost medical services and discouragement of full-time employment of health professionals in the public sector due to the low remuneration. Between 1949 and 1982, the proportion of public spending on largely curative care rose from 13% to 85%; preventive care was squeezed out.

3. At the state level, the State Secretariats of Health (SESs) provided mainly infectious disease control and maternal child health care. Remaining health services were provided largely by the private sector, generally reimbursed by INAMPS. At the local level, there were some 5,000 municipalities in the country, with varying needs and levels of administrative capacity.

4. **Government Strategy.** The Government's interest in redressing the inequity and inefficiency of the health care system led to the design and implementation of a number of national strategies. In 1976, the Government introduced the PIASS (Program for the Implementation of Health and Sanitation Activities in Interior Areas), a program to bring basic health and sanitation activities to communities of less than 20, 000 people. In 1979, the Fund for Social Development Assistance (FAS) changed its policy to finance basic health facilities. In 1980, the Curitiba plan established the health center as the patient's point of entry to the health system, and established fixed payments from INAMPS for given treatment procedures rather than fee-for-service, an attempt to improve the reimbursement mechanism and to reduce costs. In 1982, the Consultative Council on Health Insurance Administration (CONASP) made recommendations for better use of existing public sector facilities and strengthening of the managerial capacity of the public sector. In 1983, the AIS (Integrated Health Action) was created to implement most of these recommendations through the Inter-ministerial Planning and Coordination Commissions (CIPLAN) with representatives of Ministries of Health, Education, and Labor, and the INAMPS. As a first step towards better coordination of regional health programs, the state governments of the Northeast approved in March 1984 a common "Health Policy Document," which emphasized universalization of access to health services, decentralization of financial and administrative functions, and integration of public health service programs. The Document gave priority to the control of transmissible diseases, basic sanitary measures, and improved access of high-risk groups (such as mothers and children) to ambulatory and hospital care, institutional development, and nutritional activities.

5. Realizing that the previous strategies were not particularly effective, the Government made stronger efforts to redress the inequity and inefficiency in July 1987 through a federal decree for the System of Unified and Decentralized Health Care (SUDS). It aimed to unify all those health care resources and programs at the state level by means of the Integrated Budgetary Plan (POI). The SUDS unified State Health Secretariats (SES) and INAMPS health care resources, with SESs to act as sole executors of health services in the individual states. Under the SUDS reforms, the SESs witnessed sizable increases in the amount of sectoral resources at their disposal and were able to redirect more resources to basic health programs. SUDS also represented a further step in the evolving decentralization of sectoral responsibilities. While the federal level was to retain vital normative and monitoring functions, a much larger share of operational duties was to be gradually devolved to the state and local levels.

6. Brazil's New Constitution of 1988 ratified goals of the SUDS, such as the universal coverage of all citizens and declared further progress. It established the Unified

Health System (SUS) at the national level and mandated the government to achieve the goals through decentralization. At the time of the project design, INAMPS at the federal level was to be incorporated into the SUS, regional INAMPS offices eliminated, and INAMPS facilities and personnel transferred to states and municipalities. The municipalities individually or in consortiums had the primary responsibility for the delivery of health services. At the national level, the MOH was to operate the SUS. However, it was two years later in 1990 that the constitutional precept for decentralization was incorporated into laws and regulations; and until 1993 there was no nationally agreed implementation strategy for the decentralization process. It was a long evolving process.

7. **The Bank Responses.** In support of the Government's strategy for the integration and decentralization of basic health services at the state level, the Bank participated in the financing of the São Paulo Basic Health Care Project (Loan 2447-BR) in 1984 and the Northeast Basic Health Services Project (PNE-I) (Loan 2699-BR) in 1986. The Bank strategy for health was to assist the government's efforts to redirect public spending to largely basic health programs that better serve the poor, and decentralize services as a way to improve accountability and efficiency. By the time the Bank approved the Second Northeast Basic Health Services Project (PNE-II) (Loan 3135-BR) in November 1989, the Government had already passed the stage of the SUDS reform at the state level and was trying to implement the Constitutional mandate of the SUS on a national level.

B. Project Objectives

8. The project had two objectives: (a) to strengthen the delivery of basic health services in selected low-income areas of the Northeast; and (b) to reinforce the implementation of the sectoral reforms, i.e., integration, unification and decentralization.

9. The basic health service objective was to be achieved by supporting the basic health service package, i.e., Comprehensive Care for Women and Children (PAISMC) including family planning; the Infectious Diseases Control Program (CDI); and the Ambulatory and Basic Hospital Medical Care Program (AMH).

10. The sectoral reform objective was to be obtained by supporting the institutional development of the SES and the MOH in planning, management, logistics, financial controls, and community education through provision of technical assistance, training, and special studies.

11. The basic health component of the project was to benefit some 12 million people in the 478 municipalities of the seven Northeast states (Alagoas, Ceará, Paraíba, Pernambuco, Sergipe, Maranhão, and Bahia) included in the original project design. In April 1996, by an amendment to the Loan Agreement (LA) the Bank and the Government agreed that the three states of the Northeast Basic Health Services Project (PNE-I) (Rio Grande do Norte, Piauí, and northern Minas Gerais) were also to be included in this

Second Northeast Project (PNE-II). The institutional development component would benefit an additional 24 million people in the non-project municipalities.

C. Achievement of Project Objectives

12. **Costs and Finances**. The project was completed in eight and a half years since the Bank Board approval, instead of six years estimated at appraisal. The total project costs increased by 27% from US$610.6 million to $772.8 million. The original Bank loan of $267.0 million was canceled by $50 million in late 1994. Therefore, the Bank loan of $217.0 million, which would be fully disbursed by June 30, 1998, accounts for 28% of the actual project costs, compared with the appraisal estimate of 43%. By category of expenditures, consultancies and special studies increased by 140%, and the recurrent expenditures (e.g. new staff salaries, supplies, maintenance and drugs) all increased by 95% due to the extension of the completion date by 30 months. Other categories, such as infrastructure, training and supervision, were about the same as appraisal estimates, and IEC spent only half the appraisal estimate.

13. **Monitoring of Project Objectives**. An assessment of the project outputs and the achievement of the project objectives was difficult due to the inadequate project monitoring system. The federal Project Coordination Unit (PCU) monitored only the implementation of the health and administrative facilities and equipment, and the use of loan proceeds. Even those infrastructure components were monitored mainly from the disbursement point of view and not from the operational and project objective point of view. Therefore, the PCU did not compile data by project objective and did not follow up on the operation of the project facilities. Moreover, monitoring of the other components, especially the institutional development components -- such as organization and management improvement, staffing, training, studies and consultancies, supervision, public health education and promotion through IEC-- were not , in fact, the responsibility of the federal PCU. Each relevant department of the MOH supported the implementation of these components at the state and municipal levels and did not monitor systematically the execution and the result of the implementation. There is no one unit in the MOH which coordinated and monitored the basic health services and/or the institutional development in the Northeast on a continuing basis. As was often the case ten years ago, Staff Appraisal Report (SAR) included few implementation targets in quantitative and qualitative terms, against which the progress in the implementation and the achievement of the project objectives could be measured periodically. The PCU did not use even the few indicators provided for in the SAR because of the change of the situation, and never updated them. The Loan Agreement (LA) stipulates that such monitoring indicators should be prepared for Bank approval within three months of effectiveness, but this covenant was not complied with.

14. **Components.** Achievement of the project objectives are assessed below for each of the two major project objectives: the Basic Health Services Component and the Institutional Development Component.

15. **Basic Health Services Component**. The basic health services component was to be achieved through (a) expansion and upgrading of health facilities and equipment; (b) training of about 60,000 health personnel; (c) special studies at the state and federal levels concerning the management and delivery of health care services and establishment of project monitoring indicators and health service delivery performance criteria; (d) provision of necessary supplies for project area facilities including drugs, supplies, and materials, (e) hiring or reassigning of about 8,600 additional health personnel; and (d) carrying out of supervision throughout the project area.

16. (a) Expansion and Upgrading of Health Facilities and Equipment. The infrastructure investments aimed at improving the delivery of health care services by providing adequate spaces and well-equipped facilities. Improvement of infrastructure involved the construction, expansion or renovation of health facilities and regional headquarters including equipping and re-equipping of such facilities. The Government spent about 10 percent more on civil works and 10 percent less on equipment than the SAR estimates. The total expenditure spent on infrastructure is about the same as the appraisal estimate. This is different from the experience with the PNE-I, under which the Government spent disproportionately more on the infrastructure component than on other components.

17. The health facilities component was to be implemented in 478 municipalities in seven Northeastern states. In fact, the component was implemented in 849 municipalities including 632 municipalities in the original seven states and 217 municipalities of the additional three states introduced in the project as a result of the April 1996 amendment to the LA. Because of the large scale migration from rural areas and the changing needs of each state, the need to take action on the newly emerging environmental problems and epidemiological profile, a greater number of municipalities was actually covered by the project in each of the seven original states (Table 5A), covering not only the rural municipalities as originally focused at appraisal, but also peri-urban municipalities. Consequently, this component would benefit not only the 12 million inhabitants in the original seven states, but also at least 5.2 million more people in three additional states. The introduction of the three additional states into this project was a cost-effective decision because the investment made in the three states accounted for only 5% of the total expenditures for civil works and 3% of the total expenditures for infrastructure, but the additional beneficiaries account for about a third of total beneficiaries. Unfortunately, however, it is not feasible to compare the project's contribution to the attainment of universal coverage of the population under the health system, because the SAR did not define the state of the coverage at appraisal, and the Government did not monitor the growth of the actual coverage.

18. At appraisal, the project was to construct, expand, rehabilitate 1,707 health facilities including 1,107 health posts, 327 health centers, 171 *unidades mistas* (health centers with 16-50 beds), 81 obstetric/delivery units, 16 hospitals, and 5 laboratories. Also, it intended to equip or re-equip 1,791 health facilities. The total number of facilities provided and the breakdown by state or type are not available yet, but it is

estimated that the total number of actually provided facilities would be much greater than the staff appraisal report (SAR) estimates, not only because the three states were added to the project, but also because a greater number of municipalities in the original seven states were allowed to participate in the project. This expansion of the scope of the project was conducive to the attainment of the project objectives towards the universal coverage of all population under the health system. The quality of the facilities provided was good.

19. The project completion mission visited two states in the Northeast and observed that in Ceará, the best performing state, the number of municipalities covered under the project increased from 61 to 85; and in the state of Paraíba, which had some implementation difficulties initially, the increase was from 57 to 74. The number of project municipalities, however, still accounts for only part of the total number of municipalities in each state-- 46 and 33 percent, respectively. The two states together provided a 20 percent increased number of health facilities than the SAR. They also focused more on renovation than on expansion and construction of health facilities, compared to SAR targets (Table 5B). This option was more cost-effective in attaining project objectives. The size and type of actually provided health facilities differed from the SAR estimates in accordance with the changing needs of individual states: while in Ceará more ambulatory (walk-in) health facilities were the choice for investments to cover extensive rural areas, in Paraíba more hospital units were provided to fill the critical gap. Provision of equipment followed the same rationale (Table 5C). Thus, in the last three years, the project design became much more flexible than the original design, adapting itself to the varied and changing demand. On the visit to the two states, the ICR mission observed that the health facilities, administrative units, and training facilities provided under the project were adequately equipped, fully operational, and intensively utilized. However, it was also told by the facility managers that staff turnover was high and drugs and supplies were often inadequate due to shortage of inadequate reimbursement under the SUS and the shortage of state and municipal funds. In order to assure sustainability, drugs and supplies, as well as incentives to staff need to be provided on a continuous basis.

20. Achievement of the infrastructure component accelerated and total disbursements increased by 55 percentage points during the last two and a half years. In 1995, the Government and the Bank agreed to introduce series of measures to make the implementation and disbursement procedures more flexible. These included adjustment in the procurement methods, ceilings and thresholds for discretionary decisions, and reduction of disbursement categories from 48 to 8. Above all. the allocation of loand funds to participating states made at appraisal was eliminated. The PCU allocated the loan proceeds on the basis of the merits of the annual work programs and budgets submitted by individual states, and their performances in the previous year. Thus, competition for funds was introduced, and increased technical assistance was provided by the PCU to institutionally weaker states, notably in the area of procurement. To allow time for the newly introduced measures to produce results, the closing date of the loan was extended to December 1997. The combination of these measures made the project

gain momentum, and all states used more loan funds for civil works than envisaged at appraisal. Some states benefited more than others. They were Sergipe, Alagoas, Ceará, and Pernambuco. The former two states were relatively poorer states, and the latter two were better-off states. Therefore, the competitive manner of allocating the project funds did not seem to have resulted in any inequitable allocations, as in Chile. This was due partly to the similar institutional capacity among project states, and partly to the deliberate PCU strategy to provide more technical assistance to poorer states.

21. (b) Personnel Training. The staff training component was carried out in a successful way. Although no project-wide data have been compiled yet, the state of Bahia alone had 512 training events and trained 23,290 persons during 1990-97. This is approximately 39% of the SAR targets for training of 60,000 persons in all seven original states.

22. In the state of Bahia, the majority of the beneficiaries came from the municipalities (17,802) and Regional offices (3,738) with the rest from the state central offices. By level of education, doctors and other staff with high level education benefited the most (12,854) followed by the staff with middle-level educational background (9,131). The PCU confirmed that this pattern was replicated in other states, and a final picture would come out through a survey which is being carried out in May/June 1998. In particular, the state of Ceará and Bahia constructed a public health school at the higher education level and a human resources training center at the middle educational level, respectively. These schools are fully operational. A core group of trained medical, technical and administrative personnel is one of the most valuable and concrete achievements of the project. They are key ingredients for institutional and technical development of the health secretariat of the project municipalities and states.

23. (c) The Special Studies and Technical Assistance. This component was implemented, covering a wide range of topics. Examples of studies undertaken in the state of Bahia is listed in Table 6. They range from educational materials development to institutional diagnosis, epidemiological profiles, architectural plans development, and project implementation evaluation. As a result of the Bank's intensified supervision and new PCU's improved coordination, most studies were conducted during 1995-97 and made effective contributions to the basic health services and institutional development in the project states. However, one topic missing in those studies was the development of a set of monitoring and evaluation indicators and performance criteria for the MOH and SES. Consequently. upon completion of the project, the PCU did not have a mechanism to properly track the outputs/outcomes of the project. The Government is currently undertaking a survey to collect such information from all project states and municipalities, which would serve as a basis for taking action for improvement in the provision of health services by state and municipalities. But this is a costly way of collecting data and would not provide any basis for formative evaluation of project performance and impact. Corrective actions should be taken by the MOH in the future.

24. (d) Drugs, Medical Supplies, and Maintenance. This category was financed by the loan up to about $2 million in the first half of the project period, and the remainder of this component ($140 million), mostly for drugs and medical supplies, was expected to be financed by the states throughout the project period. However, no data have been compiled by the PCU.

25. (e) Staffing and Supervision. This category suffered from the same problems as the supplies and maintenance expenditures. The SESs were supposed to hire some 8,600 additional health personnel and carry out regular supervision routines with adequate financing for guidelines, manuals, reports, and travel allowances. These additional staffing and supervision activities were also expected to be financed by the states. However, there was no systematic monitoring of the implementation of these activities, and no data have been compiled to confirm their implementation.

26. **The Institutional Development Component.** This component was to be achieved through the (a) expansion and upgrading of administrative and training facilities and equipment; (b) technical assistance for special studies, staff training, and information, education, and communication (IEC) programs; and (c) in-house and inter-state workshops, seminars and information systems on reform program implementation, supervision, and evaluation. Compared with other components, the share of the institutional development component in the total costs of the PNE-II was greater than in the PNE-I. This component accounted for 37% of the total project cost.

27. (a) Infrastructure. The expansion and upgrading of state's administrative and training facilities and maintenance workshops, and the provision of equipment for those facilities were implemented in conjunction with the basic health service component, but on a much smaller scale than the SAR plan. And as in the basic health services componet, refurbishing rather than construction was the norm. These deviations from the appraisal plan were positve adjustments to the changing priorities. The state's Regional Health Directorates lost their role under the municipalization of the SUS reform, and the priority of the maintenance workshops was lowered as the maintenance services were planned to be contraced out to the private sector.

28. (b) Technical Assistance, Staff Training and Special Studies. This category was also carried out in conjunction with the basic health services component. The federal PCU was active during the post-1994 period in organizing inter-state seminars and training for the state PCU staff in project implementation. In particular, it contracted consultants specializing in procurement norms and procedures, and provided technical assistance and training tailored to the needs of specific states, especially those with weak technical and institutional capacities. This helped solve the implementation bottleneck. However, as already pointed out, the federal government did not take advantage of this component to establish a set of effective monitoring and evaluation indicators and operate an information system covering a wide range of health services across the entire nation or at least in the northeastern states.

29. (c) Information, education, and communications (IEC). This component was the most active element of the institutional development component. Like other components, due to the institutional problems at federal and state levels, this component started late, and only at the end of 1993 was a multidisciplinary team organized to structure IEC at the federal and state levels. In 1994, a meeting with project management team at the federal level and project coordinators of all states resulted in the definition of IEC's goals and operational programs. Each state was responsible for executing activities and received technical support from the federal level. At the federal level, multidisciplinary consultants made special studies, prepared public information materials, trained health information officers (health multiplicators), and supported state teams in carrying out the events. At the state level, IEC consultant teams planned and carried out IEC training, dissemination of health information, and community participation in health promotion and education at the municipal level through mass media, health fairs, street theater, publications, and creation of IEC centers. A survey of the opinion of state and municipal officials on the effectiveness of the federal IEC team was conducted in 1998, and it confirmed the federal team's effectiveness. However, the two-year rolling plan for the IEC component was not updated annually, and no evaluative studies of the impact of the IEC program have yet been made.

D. Major Factors Affecting Project

30. The project implementation was sluggish during the period 1989-1993. During this period only 16.5% of the loan funds were used, compared with 60% estimated at appraisal. The project implementation was accelerated only after 1994 when the new Government came to power with a new MOH minister and a new PCU management team, declaring an unwavering commitment to the project. At the same time, the Bank appointed a new Task Manager and intensified supervision. As a result, about half the loan funds were disbursed during the last two and a half years before the project was completed in June 1998.

31. **Political, Economic, and Social Transition.** The project was launched at the time when the country was undergoing a turbulent political, economic, and social transition, and it was difficult for the Government to maintain its commitment to the implementation of the project as originally designed. On the political front, the new Constitution of 1988 declared universal coverage of the total population under a unified health service system through decentralization. But it was not easy for the Government to agree on the laws and regulations, as well as the sectoral strategy and administrative guidelines to implement the mandate. It was only in 1993 when all these had been put in place. The end of a long military rule in 1985 marked the beginning of an increased political participation of the population through many political parties and influential regional leaders. Elected governments at all levels were trying hard to satisfy the needs of all segments of the society. On the economic front, the country was struggling with a high external debt and was trying to arrest galloping inflation with the Cruzado Plan without much success. The loan signing and effectiveness were delayed for 13 months, just as in the case of the PNE-I project. The provision of adequate counterpart funds was a

perennial problems until 1994. The Bank procedures for special accounts and disbursement procedures were modified to make them more flexible. On the social front, the 1980s witnessed a large migration of rural population to peri-urban and urban areas. The municipalities and the type of health facilities selected for the project needed to be adapted to the changing circumstances. But the project's original design merely reflected that of the PNE-I and did not provide for a mechanism for easy adjustment of the project design. The project implementation started accelerating only after December 1995 when the Government and the Bank introduced major adjustments in the selection of beneficiary municipalities and the range of health facilities to be financed under the project.

32. **Adjustment to the Changing Government Sectoral Strategies**. The project preparation started in 1986 following the footsteps of the PNE-I, and the underpinning sectoral strategy was to support the SUDS, i.e., accelerate decentralization to states and efficiently use the state resources increased as a result of the integration of all health service programs at the state level through the integrated budgetary plan (POI). By the time the PNE-II was approved by the Bank in late 1989, the new Constitution had been already declared, and the SUD, the governing sectoral strategy, was replaced by the SUS, under which all health programs were unified at the national level, and the decentralization focused on municipalities, instead of states. In other words, the national sectoral policy framework was changed, and the implementation of both PNE-I and II, which supported regional health sector reform, had to wait until the national sectoral policy framework settles in. In May 1996, the Bank finally agreed to support the SUS reform directly through the Health Sector Reform Project (REFORSUS).

33. **Lack of Lessons Learned.** This project followed the PNE-I, which had already experienced implementation difficulties for three years by the time PNE-II was approved. The signing of the PNE-I was delayed by more than a year, the loan became effective only after 15 months, and the level of disbursement was poor. Even so, the SAR did not include a section on the implementation experience of the PNE-I. Lessons drawn from it by then could have been used as guiding principles for the design and implementation of the PNE-II. The Initial Executive Project Summary (IEPS) review meeting of March 6, 1987 concluded that PNE-II should not be presented to the Board until PNE-I problems were well analyzed and resolved. But PNE-II was processed and approved without taking this decision into account. In fact, PNE-II had the same implementation problems as PNE-I, and the problems of both projects were resolved at the same time - only after 1993.

34. **Responsibilities of the Federal PCU**. According to the LA, the PCU was responsible for the coordination of all matters related to the project implementation. However, the *de facto* status and responsibilities of the PCU were not conducive to the achievement of the project objectives. It did not have direct access to the chief executive of the MOH, and its reporting line changed several times. The PCU was responsible only for the coordination of the implementation of the infrastructure component and finacial aspects of other components. Therefore, it did not actively coordinate and monitor the

progress of other project components, in particular the institutional development component (e.g. staffing, supervision, training, decentralization, organization and management improvement, preparation of administrative and operational manuals, streamlining budgetary and financial accounting procedures, and resource allocation for preventive basic health services), which became the responsibilities of other departments in the MOH and the states.

35. **Inflexibility in Project Design and Amendments**. The project design was rigid, and there was no efforts to adjust the project content, targeted areas, and mode of implementation until December 1995. Any attempt to change the loan agreement was met with stiff objection by the Bank and time-consuming processes for reappraising the proposed changes. Even changes of some project municipalities required visits by Bank reappraisal missions and renegotiations. Decisive action was taken, however, to reduce the loan amount by $50 million in late 1994 as part of the high-level Bank-new Government joint effort to improve the portfolio status in Brazil.

36. It was only with the amendment of the LA in December 1995 that the Bank and the new Government agreed to restructure the project scope, implementation methods and procedures. This amendment allowed (i) the project areas to be expanded to include peri-urban areas in addition to the rural areas; (ii) all project states to compete for claiming the loan funds irrespective of the amount of the loan funds allocated to each state at appraisal; (iii) a wider range of health facilities, as well as environmental health programs, be financed to accommodate the changing epidemiological profiles; (iv) municipalities to play a greater role in project implementation by permitting them to enter into agreement with states; and (v) procurement methods to be more flexible, and ceilings and thresholds to be more generous, accommodating the procurement norms of the LAC Region. With this amendment, the project implementation accelerated so much that another loan amendment was made in April 1996, introducing more flexibility, in which (i) the authorized deposit to the special account was increased; (ii) two special accounts for local and foreign expenditures were integrated into one; (iii) an additional three states that participated in PNE-I were allowed to participate in this project; and (iv) the closing date was extended by one year to December 1997. Besides these formal amendments, the Bank also took flexible and innovative initiatives for an accelerated implementation of the project. For example, it allowed the Government to advance part of the special account to states, relieving states' cash flow burden, and arranged with the federal PCU to provide technical assistance to states in procurement, which was one of the major bottlenecks.

E. Project Sustainability and Future Operations

37. Future operations of the project is financially and institutionally sustainable, but its sustainability could be strengthened through some on-going and follow up projects. Financially speaking, the basic health service network is likely to be sustained because the SUS, the main source of financing health expenditures in the country, will reimburse most of the expenditures incurred in health centers and hospitals, and the level of state's

and municipality's own financing of basic health expenditures has been steadily on the rise, as in Ceará. The health sector's share of the state total expenditures in Ceará increased from 3.3% during 1981-86 to 8.5% during 1990-1994. However, the level of prices and scope of SUS reimbursements needs to be improved further, because in some states like Paraíba, health sector's share of total state expenditures changed little from 3.5% during 1981-86 to 3.6% during 1994-97. Also, rural health facilities financed by the project and visited by the ICR mission often showed problems of retaining medical doctors and shortages of medicines and supplies.

38. Institutionally speaking, the health secretariats of the states and municipalities, as well as the staff of individual health facilities, have been strengthened substantially, in particular in the areas of the, organization and management of the basic health services network, and operational procedures. The increased role of municipalities in the SUS helps make the system more responsive to the need of the population, and improves the financial flows between different levels of the Government. These improvements have come mainly through the training programs within and outside the individual states and municipalities, and through technical assistance provided by the federal government. A large number of state and municipal managers, administrative and health professionals were trained and improved their skill levels.

39. The health secretariats of the states and municipalities and other public health institutions in the Northeast are still weak technically and institutionally, and would therefore require more professional personnel and continuous training and technical assistance from the federal level. An important question is how the MOH would meet such a challenging demand. Some 200 consultants hired with PNE-II funds have now departed and it is uncertain whether and how the MOH would provide the necessary assistance for the institutional strengthening at state and municpal levels with its regular operational budget in the future. This question would affect notably such areas as maternal and child health, IEC, and training at state and municipal levels. At present, the prospects for continuous support for these components and monitoring their implementation at the state and municipal levels are uncertain. The MOH does not seem to have adequately developed organizational apparatus to carry out its policy-making, norm-setting, and technical assistance, monitoring, and supervision roles. The institutional capacity at the federal level would be partly strengthened under REFORSUS, but should be further strengthened by other Bank-financed projects in the future.

F. Bank and Borrower Performance

40. **Bank Performance**. Bank performance at project identification, appraisal and the earlier stage of the supervision was less than satisfactory, but since 1994 it has improved sharply. There was a few flaws in the Bank performance at the earlier stage. First, the project design was not based on a rigorous analysis of the sectoral problems and issues in the Region, did not fully take into account the changing policy framework, and did not define the content of the project flexibly, but used the unduly long implementation period. Second, the project design did not take into account the lessons

learned from the previous project. Third, the project supervision was initially rigid and did not adjust the project content flexibly to the changing sectoral strategy and socio-economic circumstances, and did not define the monitoring and evaluation indicators early enough.

41. Since 1994, the Bank took a flexible and dynamic attitude in advising the Borrower and provided a momentum for the accelerated project implementation through two amendments of the LA with respect to the loan amount, implementation strategies and procedures.

42. Throughout the project implementation, one gets the impression that the Bank focused mainly on the progress in disbursements, the improvement of the health service network, and its adaptation to the geographically shifting demand. The only additional monitoring indicator introduced in the project through the 1995 Loan amendment was the percentages of the disbursement for the infrastructure component in each of the remaining years. With a short implementation period remaining, that focus is understandable. But it could have paid more attention to the attainment of the results of the project inputs, in particular the institutional development inputs, such as hiring of additional staff, provision of drugs and medical supplies, health services delivery, IEC, and monitoring the changes in the health status of the population.

43. Despite the prompt and flexible supervision attitude since 1994, the Bank should have improved its Loan amendment processes. A more rigorous monitoring and supervision by the Bank and the Borrower could have shortened the six-months needed for the exchange of a letter for the amendment made in December 1995.

44. **Borrower Performance**. Borrower performance paralleled the Bank performance. During the early years of the project cycle, Government performance was unsatisfactory. This reflected the unstable political situation and turbulent economic circumstances. The average term of a health minister was about one year. Such frequent changes of ministers brought changes at other levels of the Government and in the priorities of the sector and the project. The PCU was not accorded proper authority for coordination of all project activities and did not have direct access to the top executive in the MOH.

45. With the advent of the new Government led by President Cardoso in 1994, the project implementation accelerated. The Minister of Health declared Government's strong commitment to the project and mobilized the state governors and health secretaries in the Northeast to revitalize the project. The PCU was also led by a new dynamic and competent manager during the last three years, having direct access and reporting responsibilities to the top executive of the MOH. With the staunch support of the new Task Manager of the Bank, the PCU streamlined procedures for procurement, budgeting, disbursements, and special account withdrawals, and introduced competition and incentives into the project implementation by allocating the loan proceeds to each state on

the basis of the merit of the annual work programs and performance in the previous year, irrespective of the allocations made at appraisal. The PCU also provided more technical assistance to those states which had weaker implementation capacities and more problems in procurement. Unfortunately, however, it focused its leadership mainly on the implementation of the infrastructure component and did not properly follow up the institutional development component of the project and the operation of the completed health facilities.

G. Assessment of Outcomes

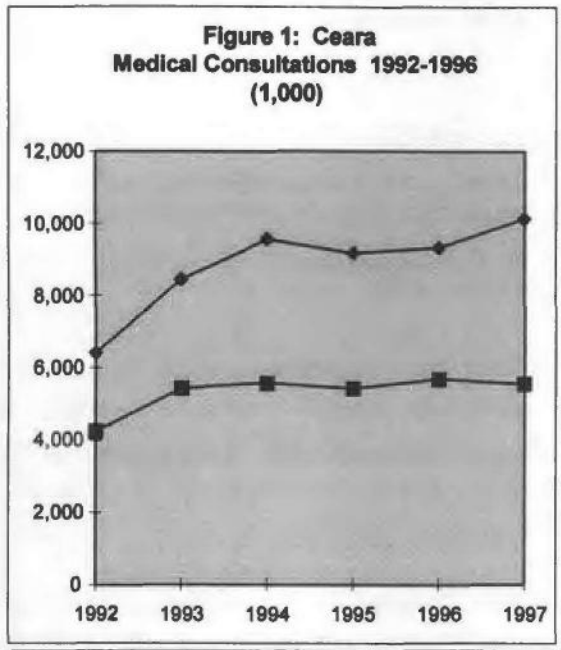
46. Because of the lack of adequate project monitoring and evaluation indicators, and the absence of a systematic information system at the federal level, a full assessment of project outcomes cannot be done at this moment. An extensive survey of the project outcome is being prepared by the PCU in collaboration with the project states and municipalities, but the result will be available only after mid 1998.

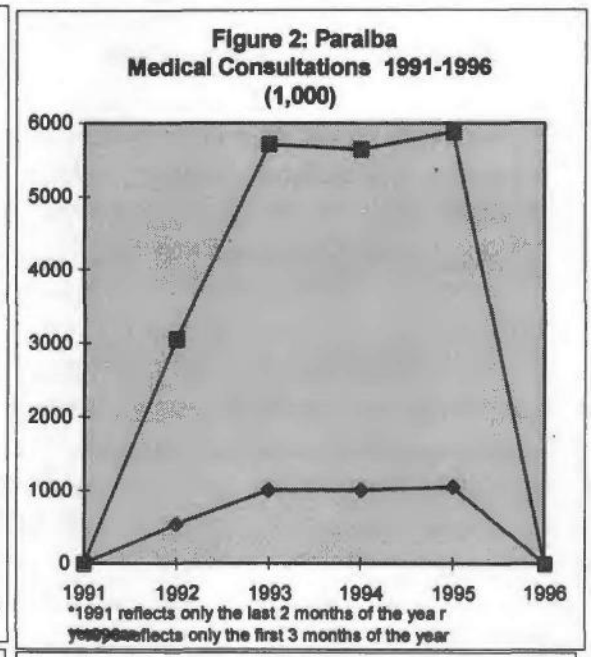
47. During the ICR mission some data on the project outcomes were collected from two selected states, Ceará and Paraíba. The idea was to attempt an analysis of the preliminary impact of the project. Considering that the main objective of the project was to improve the supply and the quality of the basic health services, the ICR mission compiled the following data: (i) the medical consultation at all health facilities; (ii) the polio vaccination coverage rate (all three doses) for infants less than one year old; and (iii) births at hospitals. The data were compared between project municipalities and non-project municipalities, in both states. The results are shown in the Figures 1 through 6. The project municipalities show a more rapid increase in medical consultation possibly due to the expanded and improved basic health service network. The trend is more obvious in the state of Ceará, which performed better in project implementation, than Paraíba. The trend is not so clear in the vaccination coverage rate and in-hospital births possibly because, among other factors, they require more time to reflect the project impact. The decrease in hospital births may not be reflecting poor access or services, but more likely the effectiveness of the family planning program. The impact of the project should be analyzed when more time has elapsed after the completion of the health facilities for the basic health services package. Other indicators may be more effective in assessing the impact of the project, such as the infant mortality rate, but they were not available for the project and non-project municipalities separately. Of course, care should be used in attributing the trend entirely to the project because these indicators depend on multifactors, and it is not easy to isolate the project impact over time.

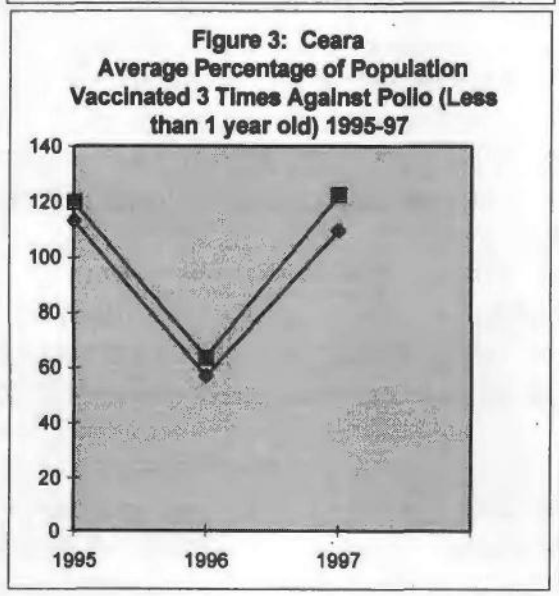
H. Key Lessons Learned.

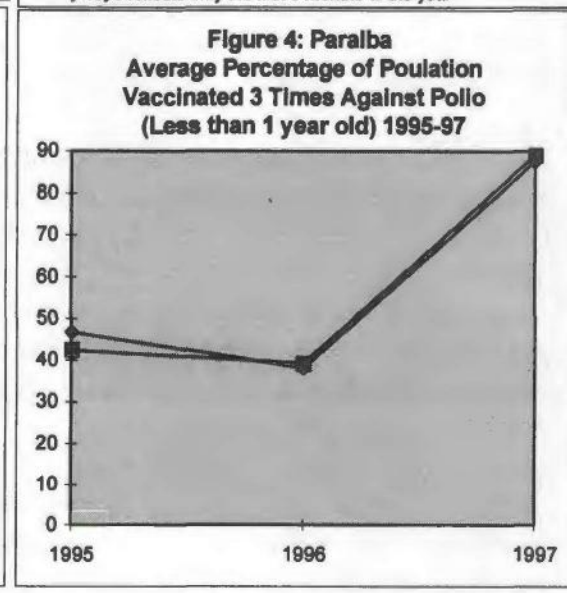
48. Through the experience gained during the project implementation, the following are the key lessons learned:

(a) It is not advisable to launch a project with a long implementation period, especially during a transitional period. Successive projects with a short implementation period for each loan would be more cost-effective and less risky in achieving the development objectives.









Municipalities w/out the Project

Municipalities w/ the Project

Figure 5: Ceara Hospital Births

	1993	1994	1995	1996	% Change 1993-96
Municipalities with the Project	110,927	111,575	119,767	107,432	-3%
Municipalities without the Project	62,463	59,895	60,918	62,404	0%

Figure 6: Paraiba Hospital Births

	1993	1994	1995	1996	%Change 1993-96
Municpalities with the Project	13,526	13,261	13,042	12,151	-10%
Municipalities without the Project	57,729	56,953	57,860	53,409	-7.50%

(b) For a repeat project, it is essential to learn lessons from the implementation experience of the precedent project.

(c) In a multi-state projects like this one, a sector loan approach would be preferred; if a specific investment loan approach has to be taken, the project design should be kept flexible, and the Bank and the borrower should be prepared to adapt constantly the project content and implementation strategy to the changing needs and circumstances of the Borrower in general and the state in particular.

(d) In a multi-states project like this one, introduction of incentives and competition among states by rewarding more resources to those performing better actually accelerated project implementation, as long as different institutional capacities are taken into account and more technical assistance was provided to those states with weaker institutional capacities in order to ensure fairness in the competition.

(e) In a multi-state project, a sub-account should be established and replenished for each state separately so that each state may have accountability and efficiency for its financial planning and execution, and an efficient states would not be adversely affected by less efficient states in the flows of financial resources.

(f) The Bank should streamline the process for the amendment to loan agreements and should actively monitor the processes to encourage a constant review of the need for adjustments of the project design to the changing circumstances.

(g) Lack of monitoring indicators adversely affects the progress of the project in general and the institutional development component in particular. Establishment of baseline indicators is essential for project progress monitoring and project outcomes evaluation.

(h) A project specific monitoring and evaluation system is unlikely to be established and operated effectively when an institution-wide monitoring and evaluation system is lacking.

(i) Both the Borrower and the Bank should pay more attention to the institutional development component of the project and the efficient operation of the physical facilities produced under the project in order to ensure the attainment of the project goals and impact.

(j) Success in project implementation is highly correlated with Government's commitment. At the federal level, strong support from the Health Minister in 1995 resulted in accelerated project implementation; and states with more committed Governors were more successful than others.

(k) Advice and assistance provided by a Bank supervision team do make significant differences in the pace and direction of project implementation, especially with respect to the needs and timing of project adjustments.

(l) The authorities and responsibilities of the project coordination unit and its location within a sectoral institution is important for a successful implementation and outcome of a project.

(m) Expansion and Improvement of the basic health service network do make a difference in the access to health services and health status of the poor people.

(n) Current Bank guidelines on the ICR should be revised, and a Borrower's ICR should be submitted to the Bank before the closing date, so that the Borrower can learn from the review of its own experience before the PCU loses its staff and institutional memories.

PART II: GOVERNMENT'S CONTRIBUTION TO THE ICR[1]

I. *General Observations*

Completion of the Second Northeast Project (PNE II) provides a good opportunity to put forward a number of considerations on the subject of its performance record. This undertaking was characterized by an unusual contradiction. Initially criticized as difficult to implement, it certainly proved extremely rigid where general planning was concerned, owing to the marked centralization of political and administrative decisions. At the same time, however, there was considerable flexibility at the level of its individual components, where there was plenty of scope for action with potentially significant institutional impact, particularly as regards the use of loan proceeds in support of strategic areas and activities, not only in the sphere of influence of the Northeast Region State Health Secretariats but also in that of the Ministry of Health itself. This allowed a broad range of options for the utilization of project financial resources, and a degree of flexibility in this regard uncommon in similar investment projects, on the basis of renegotiations with the World Bank that resulted in modifications in the original project design.

Preliminary evaluation on completion of the project indicates that the way loan proceeds were used was clearly to the benefit of the national executing agencies, with full disbursement of the funds allocated to the State Health Secretariats, in accordance with the timetable agreed on with the World Bank. However, the question whether the final objectives envisioned in the Project Loan Agreement have been accomplished, in terms of either product, process or impact,

[1] Translation of the original Portuguese report, dated May 29, 1998, which is placed in the Bank Files.

As an atypical source of financing, the project succeeded in keeping its program objectives in line with the major national health policy objective, that of consolidating the decentralization process. It was visualized as a further effort on the part of the Ministry of Health and the State Health Secretariats to guarantee properly coordinated allocation of project financial resources at each level of management, and thereby to ensure their maximum impact in improving access to health services for the general population.

PNE II incorporated some of the same elements as PNE I, including the programming parameters recommended by international agencies. For instance, PNE II continued the line of credit initiated under PNE I, employing the same expenditure categories as the latter, although with pharmaceuticals and IEC as additional categories. Since the profiles of the two projects were similar, they experienced virtually the same implementation problems, with some small variations.

Although the major part of PNE II proceeds was allocated for expenditure on civil works and equipment, the project — for what was essentially an investment project — funded a number of necessary innovations: (i) the need for management innovations, in the area of consulting arrangements; (ii) the need to improve the quality of human resources, in the area of training and supervision; (iii) the need to change the prevailing assistance model, by organizing the primary health care networks into a hierarchical structure; and (iv) the need to invest more in direct and indirect forms of technical assistance for the States, through consulting services provided from the central government level.

Its resulting hybrid nature meant that PNE II was marked, from the outset, by a series of contradictions — for instance:

(i) The contradiction between regional political interests in civil works projects, frequently based on electoral considerations, and the imperatives of the National Health Policy, which at the time was concerned with new health service organizational models as a result of the changes introduced through the Integrated Health Actions (AIS, 1983) and subsequently through SUDS and SUS.

(ii) The contradiction between political will and bureaucratic red tape, which left the project managers no room for independent action and decision-making.

(iii) The contradiction between the comparative abundance of external resources and the scarcity of national counterpart resources, which were the responsibility of the State Governments — especially at a time when the national situation indicated the need for fiscal adjustments on the part of these governments. In some instances, this delayed access to World Bank resources, whose availability was contingent on the execution of parallel financial operations.

(iv) The contradiction between the heavy demand for but short supply of State Health Secretariat personnel qualified to work on the technical implementation of the project.

It appears that contradictions like these may have resulted in PNE II having had less than optimum final impact, judging from the initial data produced by the general evaluation now in progress. Despite this, however, the project can clearly claim a number of successes — for instance:

(i) Approximately 650 municipalities in 10 States have had the benefit of direct project investments in one or more eligible categories: civil works and/or equipment, human resources training, drugs and pharmaceutical supplies, etc.

(ii) Improved access to health services as a result of the increase in the number of health units constructed, rehabilitated, expanded and equipped in the municipalities targeted by the project.

(iii) Better quality of health care services for the target population groups as a result of improvements in equipment, buildings and facilities, which mean that system users can now be attended to with greater consideration. In quantitative terms, there is now increased health care coverage in project target areas owing to the expanded supply of ambulatory, in-patient and diagnostic services.

(iv) Technical training of personnel at all levels of the civil service health apparatus, not only training for personnel directly responsible for patient care delivery but also management training, with a special focus on municipal administrators and services management.

(v) Increased management capacity in the State Health Secretariats, with significant improvement in the quality of procurement operations for PNE II, in other areas where procurement by competitive bidding is mandatory, in financial administration, planning and programming, and in architectural preparation of projects requiring expertise in the specifics of health architecture.

(vi) Although indicators for measuring final project impact have not been developed, it is very clear the project has helped improve certain health indicators in the Northeast through its expansion and improvement of the quality of health services in the municipal districts it targeted. By upgrading the care available to groups more than usually exposed to health risks, and by giving them access to the technology best able to provide protection against such risks, PNE II has made a decisive contribution to improvement of the health status of the population.

II. *Brazilian Government Performance in the Implementation of PNE II*

The Government's performance in the execution of PNE II was characterized by two different approaches to the project. Initially, it was distinguished from other Ministry of Health undertakings by its low assigned priority; subsequently, however, it was given much greater prominence, once it came to be seen as important in the relationship between the Ministry and

the State Governments. Despite this change, certain difficulties were encountered during the implementation process, regardless of the question of operational level:

(i) At Federal level, some of the basic difficulties were:

Failure by Ministry of Health departments to commit effectively to accomplishing the ultimate objectives of PNE II. Late release of project proceeds by the Treasury to the Ministry of Health, which then withheld them from the project in order to be able to cover other financial obligations. Excessive red tape in the processing of agreements and amendments to them, with long delays in negotiations and forwarding of related documents for signature. On some occasions, the political will to fulfill routine contractual obligations — for instance, independent audit of the project each fiscal year — was lacking.

(ii) At State level, the main difficulties were:

In some instances, the State Health Secretariats failed to be active in their management of the project, regarding it as an activity imposed on them from above and as just another of their many ongoing responsibilities. PNE II proceeds were a favorite target of individual State sectors intent on trying to finance their own activities, although this did not induce in them any sense of responsibility for upgrading their management and implementation practices. Capacity for policy coordination among the various State Government departments and agencies involved in project execution was minimal. Essential project administrative procedures were let slide, while a lack of management instruments systematically led to delays in the preparation of project financial statements and to a lack of the kind of information on which monitoring of the physical goals of the project depended. Difficulties in moving ahead with competitive procurement procedures, especially in those States which required the necessary funding to be in hand before invitations to bid could be issued.

III. *World Bank Performance*

Like most of the government departments and agencies in Brazil with responsibilities for PNE II, the World Bank also failed to attach due importance to implementation of this project. Excessive bureaucratic monitoring of execution of the majority of project actions led to difficult-to-resolve disputes over the roles of lender and borrower. In principle, the borrower's responsibility was to fulfill all contractual obligations, and to provide the means of taking full advantage of the proceeds of the project loan — something not synonymous, however, with blind submission to the Bank's oversight requirements, which in many cases brought the implementation process to a standstill. The lender's role was to keep abreast of progress toward project goals, through ongoing supervision and periodic monitoring of the execution process rather than through an exaggerated focus on the means of tracking expenditure; care should also have been taken to allow the project management team to reach its own decisions independently in most instances.

As lender, the World Bank too was contradictory in its approach to PNE II, showing too much rigidity at some points and considerable laxity at others. A judicious balance between rigidity and flexibility was struck only in 1995, when adjustments were introduced that facilitated full use of loan proceeds. This was something that had seemed impossible under the circumstances which until 1994 had governed the allocation of undisbursed loan proceeds — quite apart from the applicable technical criteria and Loan Agreement requirements.

In any event, during the implementation of PNE II, as during that of PNE I, the World Bank was in the contradictory position of acting simultaneously as both bank and development agency. This contradiction originated in the conflict between the need to approve the project and disburse loan proceeds on the one hand, and on the other the need to ensure that these proceeds, in the form of investments, would work for the greater good of the community. As soon as the second responsibility proved difficult to fulfill, the first would become paramount, even though Bank projects earn assured and risk-free returns and few governments fail to repay such investments on schedule and on the specified terms and conditions.

IV. *Lessons Learned and Recommendations*

With a view to the effectiveness, efficiency and rational design of projects similar to PNE II, it is worth enumerating a number of lessons and recommendations:

(i) Allow greater administrative flexibility at the levels responsible for the actual business of project execution, regardless of their management status.

(ii) Set up mechanisms to prevent executive "verticalization" of projects in relation to the organizational structure within which they fit.

(iii) Negotiate greater decision-making autonomy with the international agencies in respect of the bureaucratic procedures for handling intermediate activities, and pass on the same autonomy to executing agents.

(iv) Devise instruments for technical monitoring and evaluation that make it possible to rectify the course of projects in progress:

  (a) re management performance: accomplishment of physical and financial goals, issue of financial statements and other management reports, etc.
  (b) re operational performance: improvement of capacity to provide services, development of minimal reference indicators, etc.

(v) Develop outcome evaluation methods focused on the technical dimension (clinical or epidemiological effectiveness of the service provided), on the economic, or efficiency, dimension (to what extent could the same outcome be achieved at a lower cost or through better deployment of the resources in play), on the qualitative, or client-satisfaction,

dimension, and on the ethical-political dimension (closeness to or distance from criteria of social justice, equity, etc.).

(vi) Seek greater diversity among ultimate executing agents.

(vii) Insist that national institutions give priority to projects in terms of their objectives and the interest rates and commitment fees the Government is paying. Opportunity cost becomes high when solving easy problems is postponed.

(viii) Insist that the World Bank act first and foremost as an international development agency.

IMPLEMENTATION COMPLETION REPORT

BRAZIL

SECOND NORTHEAST BASIC HEALTH SERVICES PROJECT
(LOAN 3135-BR)

PART III: STATISTICAL ANNEXES

Table 1: Summary of Assessments

A. Achievement of objectives	Substantial	Partial	Negligible	Not applicable
Macro policies				X
Sector policies	X			
Financial objectives				X
Institutional development		X		
Physical objectives	X			
Poverty reduction		X		
Gender issues				X
Other social objectives				X
Environmental objectives				X
Public sector management		X		
Private sector development		X		
Other (specify)				

B. Project Sustainability	Likely	Unlikely
Sustainability	X	

C. Bank performance	Highly Satisfactory	Satisfactory	Deficient
Identification			X
Preparation assistance		X	
Appraisal			X
Supervision		X	

D. Borrower performance	Highly Satisfactory	Satisfactory	Deficient
Preparation		X	
Implementation			X
Covenant compliance		X	
Operation		X	

E. Assessment of outcome	Highly Satisfactory	Satisfactory	Unsatisfactory	Highly Unsatisfactory
Assessment of Overall Outcome		X		

Table 2: Related Bank Loans

National Health Policy Studies (LN 2488-BR)	To improve the Government's ability to address a variety of health needs through strengthening policy formation	1984	Completed (12/31/89)
Sao Paulo Basic Health Care	To improve the health status in five main target areas and nine health districts in Greater Sao Paulo and improve the cost-effectiveness of health services delivery within Greater Sao Paulo.	1984	Closed 6/30/92
Northeast Basic Health Services I (LN 2699-BR)	To support the Borrower's effort to improve equity, efficiency and effectiveness of basic health care in the project area.	1986	Completed (3/11/97)
NE Endemic Disease Control (LNG 2931-BR)	To reduce the prevalence of three endemic diseases (Chagas disease, schistosomiasis, and leishmaniasis) in the Northeast, to levels where only epidemiological surveillance are needed to keep these diseases under control.	1988	Completed (6/30/96)
Amazon Basin Malaria Control (LN 3072-BR)	To reduce malaria transmission in Amazonia and prevent its reintroduction in areas now under control.	1989	Completed (6/30/96)
Health Sector Reform (REFORSUS) (LN 4047-BR)	To improve the delivery of care under the SUS (the sole source of publicly subsidized care for the poor) and to assist the government in introducing policy reforms which would improve the financial sustainability and efficiency of the SUS.	1996	Ongoing (Closing Date 12/31/00)

Table 3: Project Timetable

Steps in project cycle	Date planned	Date actual/ latest estimate
1. Preparation	12/86	12/86
2. Appraisal	11/87	1/88
3. Negotiations	05/88	09/89
4. Board presentation	07/88	11/89
5. Signing	9/90	9/90
6. Effectiveness	12/90	12/90
7. Project completion	12/95	6/98
8. Loan closing	6/96	12/97

Table 4: Cumulative Estimated and Actual Disbursements (Millions of US$)

IBRD FY	FY90	FY91	FY92	FY93	FY94	FY95	FY96	FY97	FY98
Appraisal estimates	17.5	41.6	85.2	132.1	185.0	234.0	267.0	267.0	267.0
Revised estimates	-	-	-	-	-	-	-	217.0	217.0
Actual disbursements	0	23.96	26.54	35.76	59.91	98.10	137.24	194.79	217.0
Actual as % of Appraisal (or Revised) estimates	0	56.7%	31.15%	27.7%	32.38%	41.92%	51.40%	89.76	100%

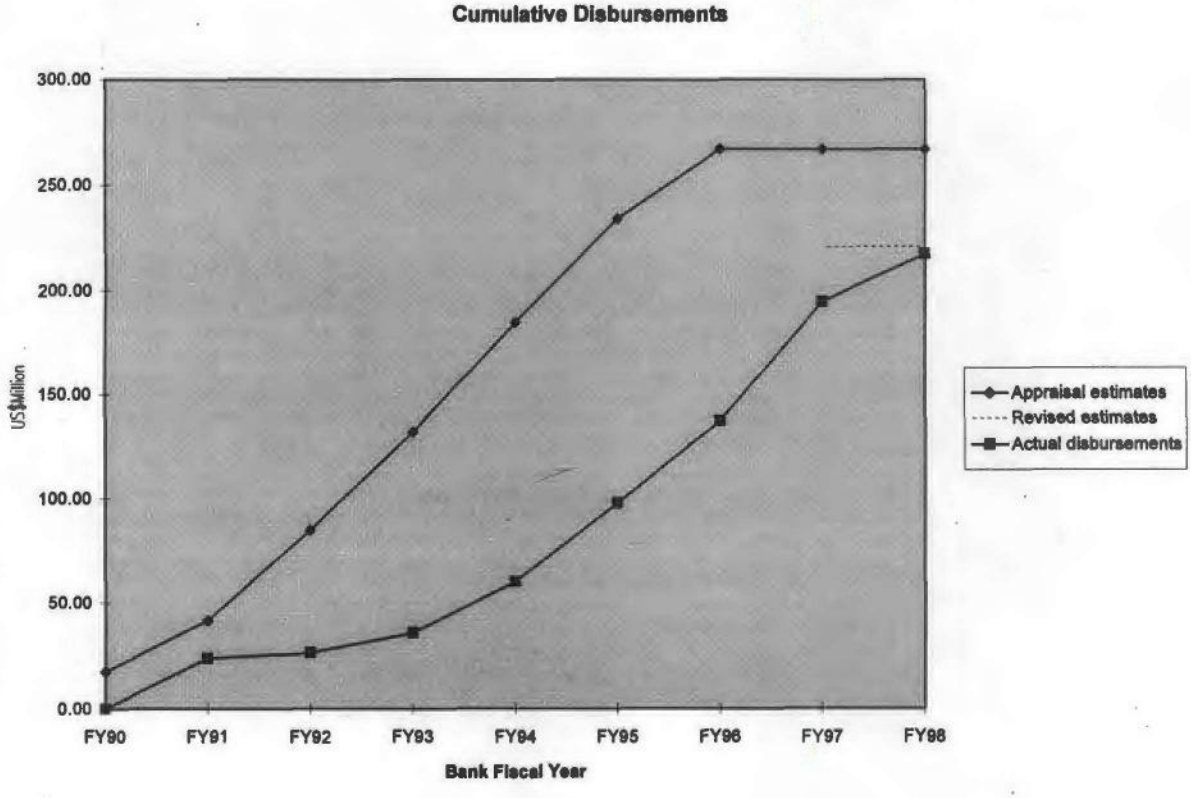


Table 5: Key Monitoring Indicators

A. The Number of Municipalities Participating in the Project

State	Planned No. of Municipalities	Actual No. of Municipalities
Alagoas	49	62
Ceará	61	78
Sergipe	35	37
Bahia	114	169
Paraíba	57	74
Maranhào	50	66
Pernambuco	112	146
Total	478	632

B. The Number and Type of Works for Health Facilities in Ceará and Paraíba

		Rehabilitation		Expansion or Construction		
		No.	(%)	No.	(%)	Total
Ceara	SAR Plan	137	(74)	49	(36)	186
	Actual	202	(74)	72	(36)	274
Paraiba	SAR Plan	33	(39)	52	(61)	85
	Actual	30	(59)	21	(41)	51
Total	SAR Plan	170	(63)	101	(37)	271
	Actual	232	(71)	93	(29)	325

C. The Number and Level of Health Facilities Provided in Ceará and Paraíba

		Ambulatory		Hospital		Admin.		Lab.		Total
		No.	(%)	No.	(%)	No.	(%)	No.	(%)	
Ceará	SAR Plan	149	(80)	30	(16)	7	(4)	-	-	186
	Actual	253	(92)	17	(6)	4	(2)	-	-	274
Paraíba	SAR Plan	46	(54)	33	(39)	3	(3)	3	(3)	85
	Actual	23	(45)	27	(53)	1	(2)	-	-	51
Total	SAR Plan	195	(72)	63	(23)	10	(4)	3	(1)	271
	Actual	276	(85)	44	(14)	5	(1)	-	-	325

Table 6: Studies Included in the Project (The State of Bahia)[1]

TITLE OF STUDY	PURPOSE OF STUDY	OUTCOME OF STUDY
Evaluation of Health Unit Equipment Sets	To determine whether existing dental, medical and hospital equipment sets are in line with health action and health service needs	Health Secretariat provided with standardized equipment sets to enable Units to cover actual needs for health care services
Study of Epidemiological Status of Bahia State	To review status of dengue fever epidemic in Bahia State	Prevention, control and eradication of vector
Evaluation of Child Dental Health in Rural Areas	To diagnose dental health status of children in rural areas	Definition of alternative methods of preventive and remedial dental care for children aged 6 to 12 years in rural areas of Cansanção Municipality (Bahia)
Evaluation of First Northeast Basic Health Services Project (PNE I)	To evaluate success in achieving PNE I goals and objectives	Support for Unified Health System (SUS) operations in Bahia State, especially institutional development measures and health service organization programs
Social and Morbidity Profile of Bahia State Psychiatric Patient Population	To conduct census of psychiatric in-patient population in public, philanthropic and private facilities under contract to SUS	Support for programs to redesign Bahia State psychiatric care services
Case Study: Lymphoma in the Workplace	To examine association between occurrence of non-Hodgkin's lymphomas and exposure to organic solvents	Formulation of epidemiological strategy for surveillance of incidence of workplace-related cancers in Salvador Metropolitan Region (Bahia)
Workplace Accidents and Diseases	To ascertain morbidity and mortality rates associated with work-related accidents in Salvador Metropolitan Region (Bahia)	Establishment of database on workplace accidents, to complement other CESAT health surveillance programs
Mapping of Occupational Health Hazards	To carry out a diagnostic study of present use of weedkillers in Qui District	Introduction of measures to eliminate harmful uses of weedkillers, and production of educational audiovisual materials for that purpose
Evaluation of Municipal Health Councilor Training	To draw profile of Bahia State Municipal Health Councilors, and assess impact of training program on their performance	Identification of (i) major groups in composition of Municipal Health Councils, and (ii) areas of training curriculum needing reformulation if Municipal Health Councilor Training program is to remain fully effective

[1] This list is only an example. All Project States and the MoH conducted studies similar to those listed in this State of Bahia

Evaluation of Worker Health Centers (NUSATs)	To assist enterprises and municipalities by developing worker health monitoring programs	Reorganization of Worker Health Centers
Study of Demand for Worker Health Facility Services	To study characteristics of demand profile for worker ambulatory health care services provided by Occupational Health Department	Drafting of instructional and informational materials for workers, institutions and communities, giving factual data on prevention, treatment and monitoring of common occupational diseases
Evaluation of IEC Actions	To analyze materials, group mobilization activities, and media programs used by IEC/Bahia with specific communities and the general public	Critique of program performance and recommendations to improve it
Evaluation of Results of Implementation of NOB 01/93	To assess performance by municipalities in incorporating NOB 01/93 requirements into Municipal Health System	Identification of weaknesses in Municipal Health System (in management, finances, infra-structure, organization and delivery of services), with view to supplementing State Health Secretariat technical cooperation to municipalities in process of decentralizing health actions
Diagnostic Study of Bahia State Pharmaceutical Assistance Program	To ascertain technical support needs of Pharmacy Commission and Technical Standards Commission	Laying of foundations for drafting of Bahia State Pharmaceuticals Inspection Plan and for SUS/Bahia construction program
Mid-Term Review of Implementation of PNE II	To evaluate proposed PNE II goals and objectives	Support for Unified Health System (SUS) operations, especially institutional development measures and health service organization programs

Table 7A: Project Costs (US$ Millions)

	Appraisal Estimates (US$M)				Actual costs (US$M)			
Item	ocal	oreign	Total	Foreign	Local	oreign	otal	Foreign
A. Civil Works	75.1	18.8	93.9	20	20.8	83.8	04.6	80%
B. Equipment	35.9	19.4	55.3	35	8.8	41.7	50.5	83%
C. Training	25.0	6.2	31.2	20				
					4.5	40.9	45.4	90%
D. Supervision	19.0	4.7	23.7	20				
E. Consultancies	8.2	2.0	10.2	20				
					0	37.4	37.4	100%
F. Special Studies	4.2	1.0	5.2	20				
G. IEC*	16.3	4.1	20.4	20	0	11.3	11.3	100%
H. New Staff Salaries	98.5	10.9	109.4	10	90.6**	0	90.6	0
I. Supplies	47.5	20.4	67.9	30	42.0**	0	42.0	0
J. Maintenance	18.1	9.8	27.9	35	7.1**	0	77.1	0
K. Drugs	45.0	19.3	64.3	30	12.0**	1.9	13.9	2%
Total Base Costs	392.8	116.6	509.4	23	555.8	217.0	72.8	28%
L. Physical Contingencies	13.3	4.4	17.7	25	-	-	-	-
M. Price Contingencies	63.4	20.1	83.5	24	-	-	-	-
TOTAL PROJECT COSTS	469.5	141.1	10.6***	23	555.8	217.0	72.8	28%

* IEC = Information, Education and Communications
** Estimated
*** Figures include an estimated US$50.2 million in local duties and taxes

Table 7B: Project Financing (US$ Millions)

	Appraisal Estimates			Actual Costs		
Source	Local costs	Foreign costs	Total	Local costs	Foreign costs	Total
IBRD	129.0	138.0	267.0	-	217.0	217.0
State Governments	311.9	--	311.9	555.8	-	555.8
Federal Government	28.6	3.1	31.7			
Total	469.5	141.1	610.6	555.8	217.0	772.8

Table 7C: Loan Disbursements by State and Expenditure									
	State	Works	Goods	T.A.	Training	Drugs	IEC	Unallocated	Total
	Alagoas								
Original		10	7	1.1	5.1	0.3	0.5		24
Executed		13	3.6	0.2	4.5	0.3	0.43		22.03
Difference		3	-3.4	-0.9	-0.6	0	-0.07	0	-1.97
% Exec		130.0	51.4	18.2	88.2	100.0	86.0	#DIV/0!	91.8
	Bahia								
Original		12.9	9.2	1.1	7.8	0.4	0.7		32.1
Executed		12.8	7.1	0.61	4	0.35	0.43		25.29
difference		-0.1	-2.1	-0.49	-3.8	-0.05	-0.27	0	-6.81
% Exec		99.2	77.2	55.5	51.3	87.5	61.4	#DIV/0!	78.8
	Ceara								
Original		8.1	6.9	1.4	5.7	0.3	0.7		23.1
Executed		11.6	6.8	3	5.2	0.3	1.2		28.1
difference		3.5	-0.1	1.6	-0.5	0	0.5	0	5
% Exec.		143.2	98.6	214.3	91.2	100.0	171.4	#DIV/0!	121.6
	Maranhao								
Original		8.8	11	1	4.9	0.2	0.5		26.4
Executed		9	7.2	0.3	2.9	0.16	0.52		20.08
difference		0.2	-3.8	-0.7	-2	-0.04	0.02	0	-6.32
% Exec		102.3	65.5	30.0	59.2	80.0	104.0	#DIV/0!	76.1
	Paraiba								
Original		8.3	10.2	1	3.1	0.2	0.5		23.3
Executed		8.8	5.4	0.07	1.9	0.15	0.33		16.65
difference		0.5	-4.8	-0.93	-1.2	-0.05	-0.17	0	-6.65
% Exec		106.0	52.9	7.0	61.3	75.0	66.0	#DIV/0!	71.5
	Pernambuco								
Original		12.6	16.7	1.4	8.1	0.4	0.7		39.9
Executed		15.6	8	2.1	8.3	0.4	0.87		35.27
difference		3	-8.7	0.7	0.2	0	0.17	0	-4.63
% Exec		123.8	47.9	150.0	102.5	100.0	124.3	#DIV/0!	88.4
	Sergipe								
Original		5.9	4.7	1.1	1.9	0.2	0.4		14.2
Executed		9.3	2.1	0.03	1.4	0.19	0.54		13.56
difference		3.4	-2.6	-1.07	-0.5	-0.01	0.14	0	-0.64
% Exec		157.6	44.7	2.7	73.7	95.0	135.0	#DIV/0!	95.5
	MOH								
Original		0.9	0.3	9.9	9.9	0	20	0	41
Executed		0	0.29	30.8	11.9	0	6.7	0	49.69
difference		-0.9	-0.01	20.9	2	0	-13.3	0	8.69
% Exec		0.0	96.7	311.1	120.2	#DIV/0!	33.5	#DIV/0!	121.2
	Subtotal								
Original		67.5	66	18	46.5	2	24	43	267
Executed		80.1	40.49	37.11	40.1	1.85	11.02	0	210.67
difference		12.6	-25.51	19.11	-6.4	-0.15	-12.98	-43	-56.33
% Exec		118.7	61.3	206.2	86.2	92.5	45.9	0.0	78.9

Table 7C: Loan Disbursements by State and Expenditure									
	State	Works	Goods	T.A.	Training	Drugs	IEC	Unallocated	Total
	Minas Gerais								
Original									
Execut		1.7	0.57	0.11	0.24	0	0.06		2.68
difference		1.7	0.57	0.11	0.24	0	0.06	0	2.68
% Exec		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	Piaui								
Original									
Executed		1.2	0	0.1	0.27	0	0.05		1.62
difference		1.2	0	0.1	0.27	0	0.05	0	1.62
% Exec.		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	Rio Grande								
Original									
Executed		0.7	0.53	0	0.27	0	0.15		1.65
difference		0.7	0.53	0	0.27	0	0.15	0	1.65
% Exec		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	Sub total								
Original									
Executed		3.6	1.1	0.21	0.78	0	0.26		5.95
difference		3.6	1.1	0.21	0.78	0	0.26	0	5.95
% Exec		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	Grand total								
Original		67.5	66	18	46.5	2	24	43	267
Executed		83.7	41.59	37.32	40.88	1.85	11.28	0	216.62
difference		16.2	-24.41	19.32	-5.62	-0.15	-12.72	-43	-50.38
% Exec		124.0	63.0	207.3	87.9	92.5	47.0	0.0	81.1

Table 8: Status of Legal Covenants

Loan Agreement			
3.01E	Inform World Bank of amounts in MoH's budget for project, and ensure that funds deposited in each project account are at all times not less than 1 month's expenditures in cruzeiros under respective state component.	C	
3.01G	The Borrower shall, not later than May 31 of each year, furnish for its approval a two-year plan for purposes of Part A.7 of the project.	CP	5/31/91
3.02B	The Borrower shall establish single registries of contractors and suppliers for purposes of the project to meet local registration for procurement.	C	
3.02C	Not later than January 31 of each year, starting 1/31/90, the Borrower shall publish ads in two newspapers.	CP	1/31/93
3.03A	Monitor overall implementation of project by Borrower, performance by each state in respect of implementation of corresponding states component, the delivery of health services under the project.	C	
3.03B	Prepare and submit for review and approval by the WB, no later than three months from the effective date, a set of indicators and performance criteria.	C	3/26/91
3.03C	Submit progress reports to WB every year on implementation and delivery of services by each state covering, inter-alias, actual expenditures and budgetary authorizations under the corresponding part of the project.	C	1/31/93
3.03E	Prepare annually with assistance of applicable states, starting in 1990, a detailed analysis of sources and uses of funds.	CP	10/31/90
4.01A	The Borrower shall maintain separate records and accounts in accordance with sound accounting practices.	C	
4.01B	Have records and accounts audited for each fiscal year and furnish to the World Bank no later than six months after the end of each fiscal year.	C	6/30/91
Obligations of States under Agreements with the Federal Government			
Article 4	Except as the Bank shall otherwise agree, procurement of goods, works, etc. shall be governed by schedule 4.	C	
Article 5	Each state shall carry out the obligations subject to the general conditions relating to insurance, use of goods and services, etc.	C	
Article 6A	Each state shall open, and thereafter maintain, INA Bank satisfactory to the Borrower and the World Bank, an account.	C	
Article 8	Each state shall take all actions necessary on its part to enable the Borrower's compliance with provisions of section 3.03 of the Loan Agreement.	C	
Article 10	Each state shall keep separate records and accounts.	C	
Article 13	Each state shall annually prepare its plan for IEC activities and submit it for approval to the MoH and World Bank, update its state decentralization plan, prepare detailed financial information on sources and uses of funds.	C	1/31/92
Article 14	Each state shall, acting through its respective SES, appoint and maintain a project coordinator with qualifications and experience satisfactory to the Borrower and the World Bank.	C	

Covenant types: 1 = Accounts/audits; 2 = Financial performance/review; 3 = Flow and utilization of Project Funds; 4 = Counterpart funding; 5 = Management aspects of the project.

Present Status: ***C*** = *Covenant complied with;* ***CD*** = *Complied with after delay;* ***CP*** = *Complied with partially*

Table 9: Bank Resources: Staff Inputs

[illegible]	[illegible]	US$000
Preparation to Appraisal	88.1	158,920.0
Appraisal	30.6	50,942.0
Negotiations through Board Approval	28.0	66,729.0
Supervision	180.7	481,861.0
Completion	2.5	5,767.0
Total	329.8	764,218.0

Table 10: Bank Resources: Missions

Stage of Project Cycle	Month/Year	Number of Persons	SW in Field	Specialized Staff Skills Represented[a/]	Performance Rating[b/] Implementation Status	Development Objectives
Through Appraisal						
Preparation	9/86	4	12.5	J,A,A		
Preparation	12/86	4	7.4	J,N,B,A		
Preparation	5/87	4	8.5	J,A,B,I		
Preparation	8/87	4	6.3	J,I,A		
Preparation	9/87	1	1	A		
Preparation	11/87	8	22.8	J,B,N,A,C,I,L		
Appraisal Through Board Approval						
Appraisal	1/88	4	7.4	B,A,P,J		
Post Appraisal	3/89	2	5	J,B		
Post Appraisal	7/89	4	6.8	J,A,M,B		
Post Appraisal (Project Launch)	5/90	4	2.3	P,J,A,G		
Supervision						
Supervision 1	11/90	3	7.7	A(2), I	1	1
Supervision 2	3/91	2	2.3	J,I	2	1
Supervision 3	7/91	2	3.1	J, I	2	2
Supervision 4	10/91	2	4.5	J,I	2	2
Supervision 5	2/92	4	6.2	N,I,A,L	2	1
Supervision 6	8/92	3	3.1	A,J,I	2	1
Supervision 7	2/93	3	4.7	J,I,A	2	1
Supervision 8	6/93	4	8	J,I,A,O	2	2
Supervision 9	9/93	3	1.2	J,I,A	2	2
Supervision 10	11/93	4	6.2	J,N,I,A	2	2
Supervision 11	3/94	4	5.7	J,N,I,B	2	2
Supervision 12	6/94	5	12.1	J(2),I,A(2)	3	2
Supervision 13	4/95	3	3.4	N,B,G	S	S
Supervision 14	1/96	1	1	H	S	S
Supervision 15	6/96	2	2.5	M,H	S	S
Supervision 16	10/96	2	2	M,H	S	S
Supervision 17	2/97	2	1.2	M,H	S	S
Supervision 18	5/97	2	1.5	M,H	S	S
Completion						

a/ A=Public Health; B=Economist; C=HR Specialist; D=Hosp.Admin.; E=Auditor; F=Health Educ.; G=Procurement; H=Systems Analyst; I=Architect; J=Operations Analyst; K=Financial Analyst; L=Management; M=Laywer; N=Operations Ass.; O=Communications; P=Implementation Spec.

b/ 1=Problem Free; 2=Moderate Problems; 3=Major Problems; S=Satisfactory; U=Unsatisfactory

c/ M=Management; F=Financial; P=Procurement; S=Studies; E=Monitoring & Eval.; T=Technical Ass.; Tr=Training

BRAZIL

AIDE MEMOIRE

IMPLEMENTATION COMPLETION MISSION ON THE SECOND NORTHEAST BASIC HEALTH PROJECT (PNE-II): LOAN 3135-BR

I. INTRODUCTION

1. During the period March 16 - 27, 1998, Kye Woo Lee and Claudia Rosenthal (March 16-20) of Latin America and the Caribbean Regional Office of the World Bank (WB) visited Brazil for the implementation completion mission of the project.

2. The mission would like to express its appreciation to the authorities and officials of the government for the attention and collaboration that it received during its stay. During its stay, the mission had meetings with the Minister of Health, Dr. Carlos Cesar Silva de Albuquerque, and officials of the Ministry of Health (MOH), National Health Foundation, and the Project Coordination Unit (PCU). The mission also visited the project states of Bahia, Ceara and Paraiba, discussing with the state and municipal health officials and visiting some project institutions. The Annex lists the persons with whom the mission had meetings.

3. The mission reviewed the principal activities of the project and presents some conclusions and recommendations, as well as agreements reached with the responsible persons.

II. Review of Principal Activities

4. The mission and the government officials agrees that the project assisted the government in improving the newly decentralized health service network in the Northeast to deliver a package of basic health services, and strengthened the institutional capacity of the health authorities at federal and state levels. The government successfully completed providing the necessary inputs to improve the operation of the basic health care services at state and municipal levels by completing the infrastructure investments, training of health personnel, hiring or reassigning of additional health staff, carrying out of supervision, and procurement of necessary drugs, and medical and office supplies. The government also completed providing inputs to strengthen the institutional capacity of the MOH at both federal and state levels by hiring consultants for carrying out studies, improving management of processes, tools and manpower, designing and implementing information, education and communication (IEC) activities, and improving monitoring and evaluation systems; providing managerial and professional training for supervisors and staff; and preparing training curriculum and materials.

5. In completing the project, the government took three years longer than envisaged at the appraisal of the project. The project implementation took off the ground with a one-year delay and the implementation pace was sluggish at best in the first half of the almost eight-year implementation period. The WB's collaborative and supervisory efforts were not effective either. However, since 1995, government's innovative initiative, with the help of the WB, has improved the project implementation in a dramatic way.

III. SUSTAINABILITY, OPERATIONAL PLAN, AND IMPACT EVALUATION

6. Sustainability: The basic health service network in the Northeast would be financially sustainable, but may not be sufficiently decentralized and become autonomous professionally and technically. The Unified and Decentralized Health Service System (SUS) would continuously ensure that adequate financial resources are made available for the Northeast on an equitable basis. Also, the PNE-I and II have provided technical and institutional assistance in the last ten years. However, the health secretariats of the states and municipalities, and other public health institutions in the Northeast are still weak technically and institutionally, and would therefore require continuous training and technical assistance from the federal level.

7. Operational Plan: Under the SUS, the executing and operational functions of the health sector is to be carried out by the decentralized state and municipality, and the MOH at the federal level is to play financing, policy-making, normative, monitoring, evaluating, and technical assistance functions. These functions have been designed or strengthened under the PNE-II mainly through hiring consultants, especially for the provision of training, studies, technical assistance monitoring, and evaluation. With the completion of the PNE-II project, however, a cause for concern is that these consultants hired under the institutional development component of the PNE-II project either have already left or are expected to leave the services in the near future, and the MOH does not seem to have an adequate institutional apparatus and financial and human resources to carry out such functions properly. This concern is enhanced, particularly because the monitoring and evaluation systems of the MOH have not been adequately developed and institutionalized during the implementation of the PNE-II project. Although they may be further strengthened under the Health Sector Reform (REFORSUS) and other Bank financed Projects in the future, no concrete action plans have yet been placed in the MOH. The only positive action being taken is that the PCU is planning to launch a quick survey of the quantitative and qualitative outputs produced under the PNE-II project in May 1998. However, the PCU is scheduled to be dismantled in June 1998, and the survey would not be a good substitute for continuous and institutionalized monitoring and evaluation, training and technical assistance systems .

Recommendation: The mission therefore recommends that the MOH make some organizational, procedural, human, and financial arrangements for systematically institutionalizing the monitoring and evaluation systems and continuously providing training and technical assistance to states and municipalities on a national basis, in particular to those in the Northeast.

For this purpose, the MOH would be required to collaborate with the states and municipalities in the Northeast to develop a medium-term operational plan with targeted objectives for the basic health service network in the Northeast and establish some indicators to monitor the progress and achievement of the objectives and targets.

8. A Follow-Up Project. The Secretaries of the three states visited by the mission strongly emphasized the need to follow up the PNE-II with a new but shorter implementation project to address the same problems in other municipalities of their states. They plan to make a request for a new loan from the Bank through the Ministry of Health. They emphasized the fact that the PNE-II loan was curtailed by $50 million, and the implementation capacity at the state and municipality levels has been sufficiently strengthened to implement a new project efficiently.

9. Field Visits. The mission visited some basic health centers in rural areas in Ceara and Paraiba, and was positively impressed. These centers, either constructed, expanded, or rehabilitated under the project, were adequately staffed, equipped, and intensively used as envisaged at appraisal. All staff members also received training under the project. However, all rural centers have problems of retaining medical doctors and are short of medicines and supplies, which were to be addressed under the project. The issues were brought to the attention of the state authorities, which responded that as the SUS financing system is regularized and transfers to municipalities are increased, the problems would be gradually resolved.

10. The Public Health Schools. Financial sustainability of one institution, the Public Health School in the state of Ceara, completed in 1994, has been a cause for concern during the implementation of the project, and it continues to be so. In 1997, the School depended on the loan funds by 58% and on the state budget the balance. Its budget was reduced sharply to one-third of its 1996 level. For the 1998 operational plan, the school has no clear sources of funding other than the Bank financed projects (REFORSUS and PNE-II), which accounts for some 10%. The state government intends to maintain its last year's level of budget transfer in the future. The School has been actively negotiating with external aid or educational agencies for joint activities and financing. The public health school in Bahia, completed in 1996, is in a better situation. Although the level of training activities is reduced somewhat in 1998, its budget has been secured, and the Secretary of Health is negotiating for additional funds to resume the level of training activities as in 1997.

Recommendation: The School in Ceara should come up with a medium term strategic plan accompanied by a financing plan by the end of August 1998, so that it can be reflected in the state budgets for 1999 and be used as a basis for negotiations with collaborating agencies. The plan would be also sent to the Bank for information.

11. Disbursements and Cancellation of the Unused Loan Funds: The total loan amount was committed as of December 31, 1997. The government intends to withdraw the total loan funds by the end of June 1998 as agreed with the WB, and expects that there would be no need to cancel any loan funds.

12. Audit Reports: The PCU has already made arrangements with the independent auditor of the government for the audit of CY 1997 project expenditures and promised to send the report to the WB before June 30, 1998. The PCU also promised that it will make arrangements for audit of the expenditures incurred during CY1998 and report it to the WB by the end of December 1998.

13. Borrower's Implementation Completion Report (ICR): The PCU is preparing a Borrower's contribution to the ICR in collaboration with other departments of the MOH, states and municipalities, and promised to complete and send it to the WB by April 15, 1998. The PCU already has the experience of preparing its contribution to the PNE- I in early 1997, and has all necessary knowledge and guides for the ICR of the PNE-II project.

Salvador, Brazil
March 27, 1998

Kye Woo Lee
The World Bank

Jose Agenor Arevalo da Silva
General Coordinator of PNE-II

PERSONS CONSULTED AND PLACES VISITED DURING THE MISSION Annex

Ministerio do Saude, Brasilia

Dr. Carlos Cesar Silva de Albuquerque	Ministro da Saude Ministerio da Saude
Eliane Pinheiro de Araujo	Coordinatora doof Projeto BRA/90/032 Project Desenvolvimento Institucional DI/Ms- PNUD
Zuleide do Valle Oliviera Ramos	Consultora Tecnica do PNUD/RH para o SUS
Ana Gorete Kalume Maranhao	Chefe do Servico de Assitencia Integrada a Saude de Criancs
Celso Jose Roque	Consultor Tecnico do IEC Comunicacao Social
Jose Agenor Alvares da Siva	Gerente-Geral do PNE-II
Raimundo Tarcisio Macedo	Gerente Finaceiro do PNE-II
Ernane Bento Bandarra	Diretor do DATASUS Departamento de Informatica do SUS Fundacao Nacional do Saude

Estado da Ceara, Fortaleza

Quastacio Queiroz	Secretario da Saude Secretario da Saude do Estado
Socorro Martins	Chefe de Cabinete Secretaria da Saude do Estado
Silvia Mamede Studart Soares	Superintendente Secretaria da Saude Escola de Saude Publica
Marcela	Gerente do PNE-II Secretaria da Saude do Estado

Centro de Diabetes e Hypertensiones, Fortaleza

Dr. Jose Bezerra	Centro da Saude do Municipio Sao Goncalo do Amarante

Estado da Praiba, Joao Pessoa

Dr. Jse Maria de Franca	Secretario da Saude Secretaria da Saude do Estado
Dr. Ginaldo Lago	Gerente-Geral do PNE-II Secretaria da Saude
Dr. Osman Setubal	Secretario de Saude Municipio da Pirpirituba

Unida Mista, Pirpirituba

Health Center, Borborema

MINISTÉRIO DA SAÚDE
SECRETARIA EXECUTIVA
GERÊNCIA-GERAL DO PROJETO NORDESTE

FAX/GGPNE/Nº 095/98

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PARA : **Senhor Kye Woo Lee**
BANCO MUNDIAL - WASHINGTON/DC

FAX Nº: 001- (202) 522-1201

De: **José Agenor Álvares da Silva**
Gerente Geral do Projeto Nordeste

ASSUNTO

Senhor Lee,

Encaminho, conforme solicitado por Vossa Senhoria, os comentários da Gerência-Geral do Projeto Nordeste sobre o Relatório de Término de Implementação do PNE II - Ln 3135-BR.

Não foi possível obter os comentários do Ministério da Fazenda.

Atenciosamente,

José Agenor Álvares da Silva
Gerente-Geral do PNE

BORROWER'S COMMENTS ON THE ICR (Part I)[1]

The ICR prepared by the World Bank on PNE II provides an overview of the way in which the main elements of the project performed in relation to Bank guidelines. This report could well be more than a mere formality that marks the end of the Loan Agreement; it could become an important tool for project management and for regulating the political and institutional relationships between the providers and the recipients of financing. This would make it possible to use the lessons of practical experience to adjust the direction of similar projects that are either ongoing or being negotiated.

This document should be used to generate a greater impact among the project executing agencies. If Brazilian institutions and the Bank are to buy in to a significant extent to the ICR, the Borrower should be obliged to present its own comprehensive assessment, which would discuss the procedures used, the results obtained and the project's overall impact. The lack of any such contractual obligation does not promote institutional commitment to the preparation of the ICR, as the rather improvised nature of the project components evaluated attests. Consequently the final product of the report and the lessons drawn therein vanish into thin air, and each new project may repeat the same errors as previous ones.

The projects supported by the World Bank are not an end in themselves. Rather, they are part of a program of government priorities that cannot be separated from other activities in the same field. In other words, such projects complement the permanent activities of the responsible agencies, which should encourage the effective commitment of these agencies to their implementation. As a result, meeting the requirements of these projects should not be regarded merely as a kind of concession by the managers of these agencies.

The evaluation of the First Northeast Project was technically very rigorous, which made it possible, in light of the results that emerged, to change course in ways that were important for the consolidation of the health services provided by the State Secretariats of Health in the project area and for the strategic management and execution of PNE II. The modifications made in PNE II enabled the loan proceeds to be fully disbursed without compromising technical standards or the effective attainment of project objectives.

However, this fruitful assessment was submitted only to the World Bank, no provision having been made for sharing it with other national executing agencies. There were merely some local discussions with state executing agencies in relation to specific problems identified in their particular projects, with the aim of finding remedies. If there is no expectation concerning a discussion of the project's overall results or as regards the potential for making changes in the processes analyzed, the evaluation will arouse no interest. Consequently, the report cannot simply be a formal statement delinked from the political and institutional context of the executing agencies.

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[1] Translation of the original Portuguese Report, dated June 10, 1998, is placed in the Bank Files.

As regards the report per se, the GGPNE has the following comments:

1. Project Objectives

These are correctly and for the most part clearly described, in line with the SAR. One small point should be made regarding the report's definition of a *unidade mista*: this is a Health Establishment that brings together the activities of a health center; i.e. it is not itself a health center, but a surgical center for inpatients in the four basic branches (general medicine, surgery, pediatrics and obstetrics/gynecology). Implicit in the objective of implementing sectoral reforms was the institutional development of the Ministry of Health, as an absolute priority.

2. Achievement of Objectives

It should be noted that the full execution of the project required an extension of only a year and a half. Given the difficulties encountered in the early stages of implementation, this extension did not distort the project, compromise the achievement of its objectives or damage the relationship between the Bank and the Government. The final data are still being collected by contracted professionals via field surveys, but the information available up to now indicates a reasonable performance in the eligible categories.

The project's total costs did not increase at all, as claimed in the report. The extension of the project and the incorporation of more states did not entail the allocation of additional resources. Rather, the extension enabled planned targets to be achieved without compromising the effectiveness of the planned expenditure, and eliminated the risk that some goals might not be attained. Other states were added merely to reach targets not achieved under PNE I, and the states concerned provided the necessary counterpart. Recurrent costs cannot be included in any calculation of project expenditure; the costs of the facilities built under the project will become an ongoing responsibility of governments at the Federal, state and municipal level.

The operation of these facilities is a principal concern of the Ministry of Health. Two issues are receiving special attention from the evaluation team: a) the maintenance and operating conditions of the health units provided under the project, mainly the additional beds in the state and municipal health networks, in light of Brazil's health financing policy; and b) the quantity and quality of the training performed in the project states. Consequently, an indepth qualitative assessment of the training component is being made in certain states, covering all aspects of training policy and its adaptation to the profile required by the health services.

In the context of the political and administrative decentralization taking place in Brazil, the role of the Ministry of Health as head of the system is to formulate and coordinate public policies in the area of health. Formal coordination of basic health services is therefore unnecessary, since these services are the sum of various standard activities regulated by the institutions managing the SUS and given expression via the political direction of the Secretariats and Ministry of Health.

In discussing the coverage provided by PNE II one should be careful to avoid confusion between the population actually covered by the new facilities and the population within an area potentially served by a given health unit. Although the project did indeed significantly increase health service coverage, the numbers of municipalities and state populations benefitted are over-estimated if one takes into account the fact that states were added to the project in order to meet earlier objectives not attained. As regards the direct application of resources in project implementation, the shares of the World Bank and the Government were 85.6% and 14.4% respectively. This does not include recurrent costs of services in operation.

Reference should be made to the states that used PNE II funds to build health schools or training centers, namely Bahia and Ceará; Alagoas and Paraíba expanded and rehabilitated existing training centers. As regards the other components discussed, the only point to add is that the reworking of IEC resources was the result of the immense difficulties created by the size and nature of the costs in this area. The compensation fund set up by project management operated not merely among the Secretariats of Health but also among the agencies and activities directed by the Ministry of Health. This made resource management more transparent and ensured that funds were allocated to the ultimate aims of the project. In any event, at no time could any interruption in any activity in this component be attributed to lack of funds.

3. Major Factors Affecting the Project

The GGPNE was responsible for relations with the states as regards all components financed and for the financial management of the project. As a matter of policy the Ministry decided to diversify project implementation so as align some of its components with some of the Ministry's organizational areas, by linking the specific responsibilities and aims of each expenditure category with the needs of the areas in question. This approach fragmented the project, thereby hindering its implementation and hampering its effective management.

The main lesson to be drawn from this situation concerns the institutional weakness of the project management unit, which was in danger of losing credibility among other agencies - whether within the Government or the World Bank - as regards its management capacity. This was mainly the result of a misunderstanding of the roles to be played by all the various participants in a negotiation mission. When the financial component predominates in project implementation all other aspects are treated as if they were of little importance, and there is no concern about possible overlapping of roles. Responsibility for the fragmentation of PNE II and the resulting problems must be shared equally by the Bank and the Ministry of Health.

4. Project Sustainablity

Two issues deserve mention: 1) the sustainability of the services introduced under the Loan Agreement, for which responsibility is shared among the Federal, state and municipal governments according to the financing policy prevailing in Brazil. The fiscal impact of the project must be borne by these different levels of government, which must identify additional resources to defray the increase in expenditure; and 2) given the improvised nature of the project, the Ministry of Health must, through its permanent units, equip itself to act as a rearguard in

relation to the demand for specialized supervision in the states, as stipulated in the law governing the SUS.

The ad hoc consultants contracted for project implementation were (as regards the UGP) exclusively involved in activities connected with the project itself. The same cannot be said of the use of consultants to meet the needs of other areas of the ministry. Now that the Loan Agreement has closed, other alternatives must be sought to provide these areas with permanent rather than temporary solutions as regards the provision of specialists who can help the other component parts of the SUS to provide quality health services to the people of the Northeast.

5. Assessment of Outcomes

Impact indicators should have been proposed when the project was prepared and negotiated so as to enable projections to be compared with implementation outcomes. Some health indicators need time before they can yield valid measurements. At the start of project implementation the information system was centralized; computerization and direct links with the states only came later, because of the lack of funds within the Ministry of Health and the State Secretariats. Project funds could not be used for this purpose because Brazilian legislation on the computer sector prevented any importing of equipment and the World Bank did not include this as an eligible expenditure category.

Once the computer industry put aside its reservations, the project information and monitoring system was set up. Except for data inputting backlogs deriving from the long period of manual operations and the consequent delays in updating the system, the latter met the project's management needs, principally as regards financial controls. In the other eligible categories, there were some delays in recording achievements in the system, but the data are always available and accessible when needed.

With the updating and monitoring of targets, all kinds of management reports can be obtained with complete reliability. One of the main problems in keeping the system updated was the lack of monitoring of targets that should have been performed by the states as soon as any given objective was set and/or completed. Project management units in the states were concerned only about the quality and regularity of financial information, so as to ensure that the disbursement schedule was adhered to. The need for accurate data for the evaluation now being undertaken by project management has led to the upgrading of the monitoring of targets in all the states.

Although impact indicators were not incorporated in the project (a fairly common failing) there is no doubt that it made a decisive contribution to the improvement in health conditions in the region. It did this by expanding and enhancing the quality of health care for the most vulnerable groups in the municipalities benefitted, and providing access to the appropriate technologies for combating threats to their health.

Although good financial performance may be a necessary element for a successful project, it cannot by itself be a sufficient one. An assessment of project performance should seek to reconcile the analysis of expenditure incurred with the degree of achievement of project

objectives, so as to guarantee efficient utilization of resources along with effective attainment of the targets set.

The World Bank is in the contradictory position of acting simultaneously as both bank and development agency. This contradiction originates in the conflict between the need to approve the project and disburse loan proceeds on the one hand, and on the other hand the need to ensure that these proceeds, in the form of investments, work for the greater good of the community. As soon as the second responsibility proves difficult to fulfill, the first becomes paramount, even though Bank projects earn assured and risk-free returns, and few governments fail to repay such investments on schedule and on the specified terms and conditions. This was the situation of the Northeast Project and hence perhaps the explanation of some of its problems, which persisted throughout its execution because no politically appropriate solution to them was found.

6. Key Lessons Learned

To achieve effectiveness, efficiency and rationality in projects financed by external resources, there must be maximum administrative and technical flexibility. National institutions must be required to give priority to such projects, given their objectives and the commitment charges being paid by the Government. In addition, the World Bank should act more like a development agency than a bank.

The World Bank's requirements regarding procurement, an area to which a consultant was allocated specifically for the Northeast project, provided a useful example of joint action with the national project. This consultant was fully versed in Brazilian legislation regulating government procurement and aware of the difficulties some parts of the public administration experience in reconciling these laws and the Bank's guidelines. His role consisted of providing guidance as necessary on how to overcome these problems and making procedures more flexible, so as to obtain maximum benefit from the time spent on procurement issues, without prejudice to suppliers or to the subprojects.

Since the health sector had no experience of handling this kind of problem, the consultant provided vital support for the training of personnel to advise the decentralized executing agencies, as well as guidance to state law officers. As a result, the Northeast Project became a benchmark for other projects in this area financed by the Bank. Bidding documents were approved more rapidly, enabling equipment to be obtained more quickly, especially when the contract required international competitive bidding. The progress thus achieved allowed the project to make up the time lost when planned acquisitions could not be completed on schedule because of the difficulties mentioned above; only when these were overcome did the project really get moving. Responsibility for implementation must be shared between all the signatories of a Loan Agreement.

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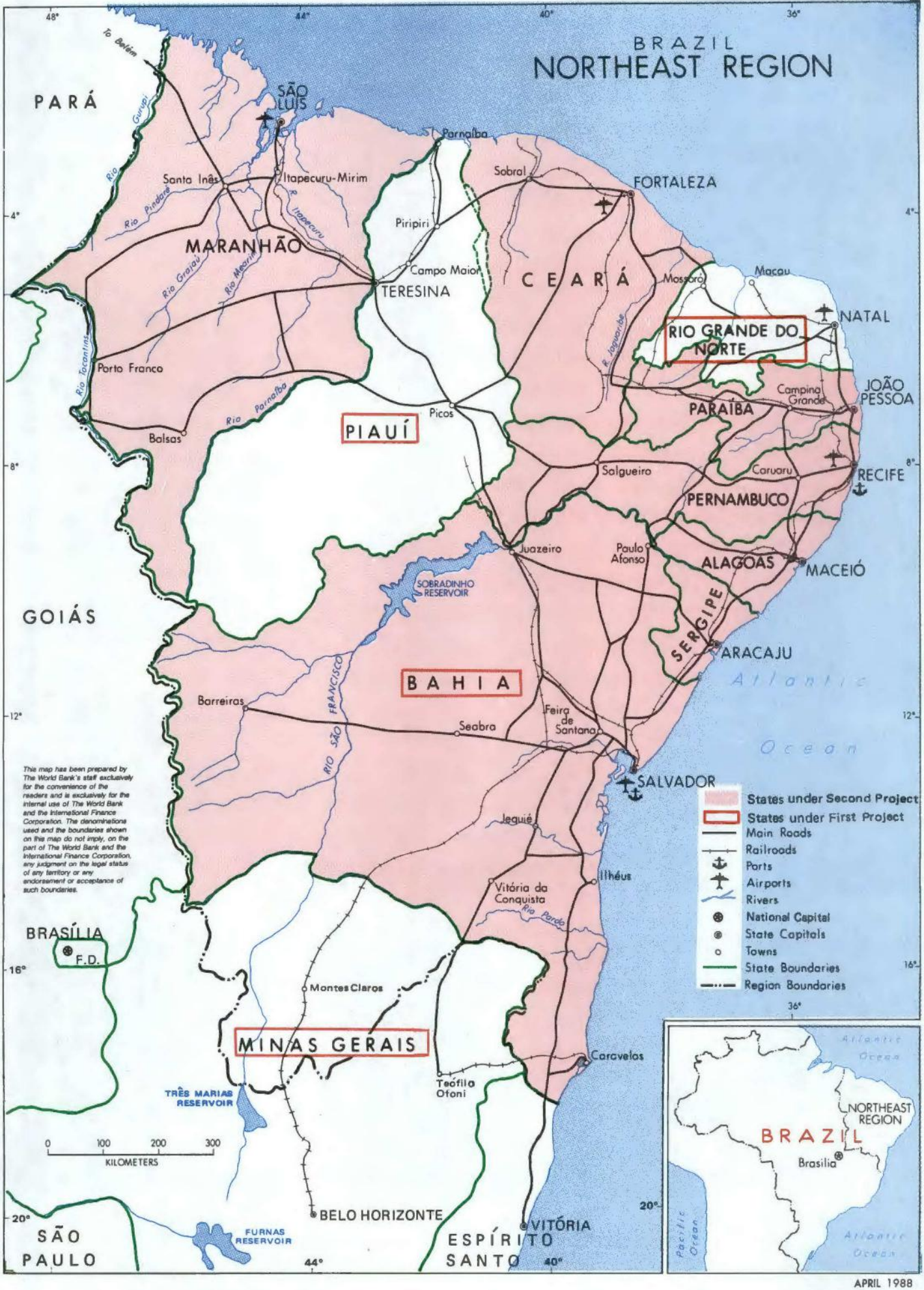
BRAZIL
NORTHEAST REGION



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- States under Second Project
- States under First Project
- Main Roads
- Railroads
- Ports
- Airports
- Rivers
- National Capital
- State Capitals
- Towns
- State Boundaries
- Region Boundaries

APRIL 1988

ICR Review - Evaluation Summary

Operations Evaluation Department

1. Project Data:	
OEDID:	L3135
Project Name:	Second Northeast Basic Health
Country:	Brazil
Sector:	Basic Health
L/C Number:	L3135
Partners involved:	
Prepared by:	Charles Derek Poate, OEDST
Reviewed by:	Susan A. Stout
Group Manager:	Roger H. Slade
Date Posted:	08/19/98

2. Project Objectives, Financing, Costs and Components:

The project's **objectives** were to strengthen the delivery of the basic health service package in selected low income areas in the North East; and o reinforce the implementation of sectoral reform including integration, unification and decentralization. The basic health service **component** was to be achieved through the expansion and upgrading of ambulatory and basic hospital medical care through expansion of health posts, health centers and 'unidades mistas' (health centers with 16-50 beds) and the provision of
equipment, staff training, technical assistance, provision of drugs and medical supplies, and supervision; the sector reform objectives were to be achieved through supporting the institutional development of the State Health Secretariat and the MOH through technical assistance, training and special studies.

Costs and financing: The total project costs were US$ 772.8 million (US$ 610.6 million at appraisal) of which the Bank financed US$ 217 million (US$ 267 at appraisal of which US$ 50 million was canceled in late 1994)). There was no co-financing. The Bank loan was approved on November 24, 1989 and was made effective in December, 1990. The loan was closed on December 31, 1997, eighteen months later than the original closing date. The ICR reported that, as of June 16, 1998, there was a balance of US$ 2.9 million in the loan account, which was expected to be disbursed by June 30, 1998.

3. Achievement of Relevant Objectives:

The project enabled the construction, expansion and/or rehabilitation of a large number (total number by type and state not yet available of health facilities in 849 municipalities (632 municipalities in the original project area, and 217 which were included after the development of more flexible allocation rules) of the Northeast. Data available for two of the states indicate that training targets set at appraisal may have been exceeded, but there is as yet not evaluation of the quality or impact of the training.

4. Significant Achievements:

In 1995, after four years of very slow implementation (less than 40% disbursed by the end of the fourth project year), the Government and the bank agreed to introduce a series of measures to make the implementation and disbursement procedures more flexible. In particular, the allocation of loan funds to participating states at appraisal was eliminated and the Project Co-ordination Unit reallocated loan proceeds based on the merits of the annual work programs and budgets submitted by individual states, and their performances in the previous year, and eased requirements that expenditures be targeted on specific types of facilities (e.g. health posts, which apparently were not in high demand). As a consequence, more than 55% of the project was disbursed in the last two years of the project and were heavily concentrated on physical infrastructure.

5. Significant Shortcomings:

Although the project succeeded in constructing and re-equipping health care facilities and following an improvement in supervision quality, improved relationships between the the Bank and the MOH, there is no evidence that it contributed to improvements in the performance of the health system or in health outcomes in the Northeast. Since the M&E indicators established at the beginning of the project were limited and the compilation of data during project implementation was inadequate, no proper data are available to assess the achievement of the institutional development component of the project. For example, the project plan called for state secretariats to hire some an additional 8,600 health personnel and to improve the quality of regular supervision routines through additional guidelines, manuals etc, but there is no monitoring information that can help assess the degree to which this was accomplished. The project was largely a facilities construction and medical equipment program, and did not succeed in transforming the quality or responsiveness of basic health care delivery. Although the project design was rigid, there was no serious effort to address the problems until December 1995. Any attempt by the Borrower to change the loan agreement met strong objections from the Bank and resulted in time consuming processes for the reappraisal of the proposed changes.

6. Ratings:	ICR	OED Review	Reason for Disagreement/Comments
Outcome:	Satisfactory	Marginally Satisfactory	The project experienced considerable o delays in implementation, several objectives were only partially achieved and the absence of monitoring indicators provide makes it difficult to evaluate project outcomes.
Institutional Dev.:	Partial	Modest	
Sustainability:	Likely	Likely	
Bank Performance:	Satisfactory	Satisfactory	Performance at identification and appraisal was disappointing, resulting in an inflexible design with inadequate attention to lessons from a previous project. Project supervision was initially weak, but showed sharp turnaround in 1994 with the introduction of a more flexible approach.
Borrower Perf.:	Satisfactory	Satisfactory	
Quality of ICR:		Satisfactory	

7. Lessons of Broad Applicability:

The success of a project depends to a large extent on ensuring that the lessons learned during previous projects are incorporated in its design. The design of projects covering several states in a large country should be flexible and should be adapted constantly to changing needs. An institution-wide M&E system is a pre-requisite for an effective project-specific M&E system. The inflexibility of the project's design (prior to reformulation in 1994/5) inhibited the use of project funds and produced a significant disbursement lag which contributed, perhaps inevitably, to relative neglect of the institutional objectives of the project (staffing and supervision issues, improvements in drug and medical supplies, monitoring of service utilization, etc.), and limited effectiveness.

8. Audit Recommended? ○ Yes ● No

9. Comments on Quality of ICR:

The overall quality of the ICR is adequate and includes a thoughtful effort to assess project impact on medical consultation rates, which would, nevertheless have benefited from a discussion of utilization patterns among poor and non-poor populations and among facilities of different types and levels. The Borrower's completion report includes a well articulated argument on the value of I) assessing lessons from previous experience during project design, and ii) more deliberate and early efforts to monitor project outputs and effects and notes that further evaluation studies are planned.

Marcia J. Bailey
08/06/98 09:41 AM

Extn: 39617 OEDST
Subject: Brazil: Second Northeast Basic Health Project
OED: Review of Implementation Completion Report

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

TO: Mr. Gobind T. Nankani (LCC5F), Country Director in Brazil

Attached for your review is OED's Evaluation Summary for the above project. This form contains OED's ratings and comments on the ICR. Any comments you may have should reach me no later than c.o.b. Wednesday August 12, 1998.

Roger Slade
Manager
Sector and Thematic Evaluation Group

cc: Messrs./Mmes.
Prem C. Garg (MDOQA)
David D. Ferranti (HDNVP)
Robert M. Hecht (HDNVP)
Joy De Beyer (HDNVP)
Richard Feachem (HDNHE)
Kye Woo Lee (LCSHD), Task Manager @ Headquarters
Suman Bery (LCC5A), Lead Economist @ Headquarters
Susan Stout (OEDST)

bcc: Marcia Bailey

Kye Woo Lee
08/18/98 08:48 AM

Extn: 38076 LCSHD
Subject: Re: Brazil: Second Northeast Basic Health Project (L3135-BR)
OED: Review of Implementation Completion Report

Susan,

I am sending you this attachment at the risk of duplicating what Patricio Millan has alsready sent to you.

Kye Woo

---------- Forwarded by Kye Woo Lee/Person/World Bank on 08/17/98 06:03 PM ----------

Kye Woo Lee
08/12/98 11:33 AM

Extn: 38076 LCSHD
To: Patricio Millan cc: Xavier E. Coll, Jean J. De St Antoine, Sarah A. Menezes, LCSHD IRIS1
Subject: Re: Brazil: Second Northeast Basic Health Project (L3135-BR)
OED: Review of Implementation Completion Report

I agree with Jan Jacques about the ratings, in particular about the rating on Bank performance. The Bank performance was unsatisfactory in the earlier parts of the project cycle, but during the late implementation stage, the project implmentation turned around and significant achievement was obtained mainly by the guidance and assistance of the Bank supervision team. The project shows the importance and value of good supervision activities, as stated in OED's summary section 4(significant achievement). But this has not been fairely reflected in the OED review rating.

In addition, the comment on the quality of ICR (section 9) is unfair and superficial. The ICR stands out in the assessmentment of the outcome, because it uses actual statistical data (not subjective judgment of the ICR mission alone) on the intended beneficiaries' utilization of the project facilities, materials, and services and their health oucomes in the project districts in comparison with non-project districts. This kind of analysis has not been available in the ICRs of health projects before. But OED's review complains that there is little discussion to assess the effectiveness of the completed construction program or impact of the project. I'm wondering about the point, and I wish I could get to know of any examples of better analysis of project outcomes in the health sector ICRs.

The OED also comments that the ICR does not elaborate on the factors contributing to the weak monitoring and and evaluation efforts of the project. But the ICR mentioned that the original design of the project did not include any assessment of the lessons learned from the previous project (NE Health I Project) and lacked any substantial monitoring/evaluation indicators at the appraisal stage, as well as the supervision mission's focus on the project's physical progress and disbursement of the loan, neglecting monitoring the institutional development aspects of the project.

One factual error appears in the achievement of training targets. The OED review states that training target was achieved only at 39%, but I wonder where this figure came. Since data on the output of institutional development was not available at the time of the ICR mission, it selected two states and digged out data on the training achievement in these two states. The conclusion was that the states over-achieved the training targets, and on this basis it conjectured that the overall

training achievement would be more than the appraisal target.

I hope that these comments could be read together with what Jean-Jacques will write in more detail.

To: Susan A. Stout
cc: Roger H. Slade
Robert M. Hecht
Patricio Millan
Jean J. De St Antoine
Xavier E. Coll

Kye Woo Lee
08/18/98 02:11 PM

Extn: 38076 LCSHD
Subject: Re: Brazil: Second Northeast Basic Health Project (L3135-BR)
OED: Review of Implementation Completion Report

Susan,

I am glad that I am not duplicating Patricio's EM. He asked for our comments so that he can convey them to your office. Since Mr. De St Antoine was going to comment on it later, apparently he was waiting for it. But in the meantime, he is on leave from yesterday through tomorrow. The following is my further comment on your revised ES.

The factual error that I mentioned in my previous comments remains in Section 3.

I feel that the revised Rating on the Outcome is right. But the reasons for disagreement/comments should be revised. The first part of the statements are reasons for rating Bank Performance and not for reasons for rating Outcome. You may want to state simply that the several objectives were achieved only partially and there is no monitoring indicators or basis for evaluating the outcome of the project yet.

Regarding the rating on the Bank Performance, I suggest that you use the same Marginally Satisfactory rating. In the earlier parts of the project cycle (i.e.e, identification, appraisal and early supervision) the Bank performance was really unsatisfactory. However, in the later part of the supervision, Bank performance was very good and commendable. It established a strong case for the positive role of supervision activities. On balance, it is marginally satisfactory. If you rate it satisfactory, it masks all the negative performance in the earlier stages, especially paying no attention (or hiding) to the negative performance of the previous project and not drawing lessons from it and poor monitoring and evaluation activities, especially in the managerial and institutional aspects.

As to Section 9 on the comments on Quality of ICR, please refer to my previous comments that I sent you today. In addition, the statements are internally inconsistent in your own review report. In Section 5, it is stated that there is no good basis for assessing the eoutcome of the project especially in the managerial and institutional aspects, which is copied from the ICR. And then the second sentnece of this Section 9 says that there is little discussion of those aspects. The fourth sentence of this section regarding lessons learned also appear contradictory. The lessons drawn from the project (Section 7) was copied from the ICR regarding the weaknesses of the monitoring and evaluation, especially the institutional aspects. And at the same time, this section 9 states that more complete discussion of the factors that contributed to the weakness of project monitoring efforsts was needed. Enough was said already on this in the Bank's performance and lessons learned. Only the third sentence of this section 9 may be justified.

Kye Woo

To: Susan A. Stout
cc: Patricio Millan
Jean J. De St Antoine

Roger H. Slade
08/06/98 01:32 PM

Extn: 81293 OEDST
Subject: Brazil: Second Northeast Basic Health Project (L3135-BR)
OED: Review of Implementation Completion Report

Attached for your review is OED's Evaluation Summary for the above project. This form contains OED's ratings and comments on the ICR. Any comments you may have should reach me no later than c.o.b. Wednesday August 13, 1998.

Roger Slade
Manager
Sector and Thematic Evaluations Group

ICR Review - Evaluation Summary

Operations Evaluation Department

Date Created: 07/06/98 01:42:11 PM
Last Updated: 08/04/98 04:59:01 PM
Status: Open

1. Project Data:	
OEDID:	L3135
Project Name:	Second Northeast Basic Health
Country:	Brazil
Sector:	Basic Health
L/C Number:	L3135
Partners involved:	
Prepared by:	Charles Derek Poate, OEDST
Reviewed by:	Susan A. Stout
Group Manager:	Roger H. Slade
Date Posted:	

2. Project Objectives, Financing, Costs and Components:

The project's **objectives** were to strengthen the delivery of the basic health service package in selected low income areas in the North East; and o reinforce the implementation of sectoral reform including integration, unification and decentralization. The basic health service **component** was to be achieved through the expansion and upgrading of ambulatory and basic hospital medical care through expansion of health posts, health centers and 'unidades mistas' (health centers with 16-50 beds) and the provision of

equipment, staff training, technical assistance, provision of drugs and medical supplies, and supervision; the sector reform objectives were to be achieved through supporting the institutional development of the State Health Secretariat and the MOH through technical assistance, training and special studies.

Costs and financing: The total project costs were US$ 772.8 million (US$ 610.6 million at appraisal) of which the Bank financed US$ 217 million (US$ 267 at appraisal of which US$ 50 million was canceled in late 1994)). There was no co-financing. The Bank loan was approved on November 24, 1989 and was made effective in December, 1990. The loan was closed on December 31, 1997, eighteen months later than the original closing date. The ICR reported that, as of June 16, 1998, there was a balance of US$ 2.9 million in the loan account, which was expected to be disbursed by June 30, 1998.

3. Achievement of Relevant Objectives:

The project enabled the construction, expansion and/or rehabilitation of a large number (total number by type and state not yet available of health facilities in 849 municipalities (632 municipalities in the original project area, and 217 which were included after the development of more flexible allocation rules) of the Northeast. About 39% of the SAR training target numbers were met, but there is as yet not evaluation of the quality or impact of the training.

4. Significant Achievements:

In 1995, after four years of very slow implementation (less than 40% disbursed by the end of the fourth project year), the Government and the bank agreed to introduce a series of measures to make the implementation and disbursement procedures more flexible. In particular, the allocation of loan funds to participating states at appraisal was eliminated and the Project Co-ordination Unit reallocated loan proceeds based on the merits of the annual work programs and budgets submitted by individual states, and their performances in the previous year, and eased requirements that expenditures be targeted on specific types of facilities (e.g. health posts, which apparently were not in high demand). As a consequence, more than 55% of the project was disbursed in the last two years of the project and were heavily concentrated on physical infrastructure.

5. Significant Shortcomings:

Since the M&E indicators established at the beginning of the project were limited and the compilation of data during project implementation was inadequate, no proper data are available to assess the achievement of the institutional development component of the project. For example, the project plan called for state secretariats to hire some an additional 8,600 health personnel and to improve the quality of regular supervision routines through additional guidelines, manuals etc, but there is no monitoring information that can help assess the degree to which this was accomplished. The project was largely a facilities construction and medical equipment program, and did not succeed in transforming the quality or responsiveness of basic health care delivery. Although the project design was rigid, there was no serious effort to address the problems until December 1995. Any attempt by the Borrower to change the loan agreement met strong objections from the Bank and resulted in time consuming processes for the reappraisal of the proposed changes.

6. Ratings:	ICR	OED Review	Reason for Disagreement/Comments
Outcome:	Satisfactory	Marginally Unsatisfactory	The weak identification and appraisal by the Bank - identified in the ICR - contributed to delays in implementation and to only the partial achievement of several objectives. Unanticipated socio-political developments also adversely affected the project. OED therefore rates the outcome as "Marginally unsatisfactory".
Institutional Dev.:	Partial	Modest	
Sustainability:	Likely	Likely	
Bank Performance:	Satisfactory	Unsatisfactory	A summary rating of Bank performance was not given in the ICR - which did, however, rate performance at identification and appraisal as deficient, while rating performance at preparation and supervision as satisfactory. In view of the importance of Bank performance at identification and appraisal for the overall outcome of the project, OED rates the overall performance of the Bank as "Unsatisfactory".
Borrower Perf.:	Satisfactory	Satisfactory	
Quality of ICR:		Satisfactory	

7. Lessons of Broad Applicability:

The success of a project depends to a large extent on ensuring that the lessons learned during previous projects are incorporated in its design. The design of projects covering several states in a large country should be flexible and should be adapted constantly to changing needs. An institution-wide M&E system is a pre-requisite for an effective project-specific M&E system. The inflexibility of the project's design (prior to reformulation in 1994/5) inhibited the use of project funds and produced a significant disbursement lag which contributed, perhaps inevitably, to relative neglect of the institutional objectives of the project (staffing and supervision issues, improvements in drug and medical supplies, monitoring of service utilization, etc.), and limited effectiveness.

8. Audit Recommended? Yes ● No

9. Comments on Quality of ICR:

The overall quality of the ICR is adequate. There is little discussion or effort to assess the effectiveness of the completed construction program, or to examine the impact of the project on the managerial and institutional factors which influence the quality and utilization of services and comments on the future operation of the project were unsatisfactory. A more complete discussion of the factors that contributed to the weakness of project monitoring efforts would have complemented the Borrower's completion report, which includes a well articulated argument on the value of I) assessing lessons from previous experience during project design, and ii) more deliberate and early efforts to monitor project outputs and effects.

To: Gobind T. Nankani
cc: Prem C. Garg
David De Ferranti
Robert M. Hecht
Joy De Beyer
Richard G. Feachem
Kye Woo Lee
Suman K. Bery
Susan A. Stout
Robert J. Van Der Lugt

This PIF has not been posted

OED ID :	L3135
Type :	ES
Country :	Brazil
Project Description :	Northeast Basic Health 2
Sector :	HX / Population, Health & Nutrition
Subsector :	HT / Targeted Health
Lending Instrument :	Specific Investment
L/C :	L3135

file w/ Brazil ICR.

Problems

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| ERRORS |
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* These must be fixed before the PIF can be posted *

Section      Question      Error
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A1           3.9           No answer
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This PIF has not been posted

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Section      Question      Error
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A1           3.9           No answer
```

Operations Evaluation Department
PROJECT INFORMATION FORM

Table of Contents

A1. General Project Information

OED ID :	L3135
Type :	ES
Country :	Brazil
Project Description :	Northeast Basic Health 2
Sector :	HX / Population, Health & Nutrition
Subsector :	HT / Targeted Health
Lending Instrument :	Specific Investment
L/C :	L3135

3. Key Dates

	Original	Latest
Departure of Appraisal Mission		01/01/1988
Approval		11/30/1989
Signing/Agreement		09/26/1990
Effectiveness	12/26/1990	12/26/1990
Physical completion	12/31/1995	06/30/1998
Closing	06/30/1996	12/30/1997
ICR receipt in OED		06/23/1998
Review date		07/15/1998
ES posting or PAR approval		

1. Reviewer: ITAD

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

Sugg. Sector:
Sugg. Subsector:

4. Key Amounts ($US million)

Original Commitment	267
Total Cancellation	50
Total project cost	
Original	610.6
Latest	772.8

5. Cofinanciers

	First	Second	Third
Name	Not Applicable		
Original Commitment ($US million)			
Total Cancellation ($US million)			

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

Physical	111
Technical assistance	37.4
Balance of payments	0
Line of credit	0
Other	624.4

7. Applicable disbursement profile (no. of years): 0

8. Number of supervision missions: 18

9. Name(s) of primary author(s) of ICR (indicate if not known): Kye Woo Lee

11. Names of managers

	At entry	At exit
Task manager	N/A	Kye Woo Lee
Division chief	N/A	P. Millan
Department director	N/A	G.T. Nankani

A2. Project Objectives Evaluation

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

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

   Date of Board approval

Note: If objectives were revised, base the ratings in subsequent sections on the revised objectives.

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

Demanding on Borrower / Implementing Agency	Substantial
Complexity	Substantial
Riskiness	Substantial

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

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

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

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

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

B1a. Outcomes — Relevance

1. Indicate the extent to which each of the project's objectives was relevant in terms of the Bank's / Borrower's current country or sectoral objectives:

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

2. Summary Rating of Relevance

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

Average rating: Substantial

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

B1b. Outcomes — Efficacy

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

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

2. Summary Rating of Efficacy

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

Average rating: Modest

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

B1b. Outcomes — Efficacy (cont'd)

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

World markets / prices	Not Applicable	Performance of contractors / consultants	No Effect
Natural events	Not Applicable	War / civil disturbance	No Effect
Cofinancier(s) performance	Not Applicable	Other (specify):	

B1c. Outcomes — Efficiency

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

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

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

		Point Value	Range	Weighted Average	Coverage / Scope
At Appraisal	◉ Not Available ○ Not Applicable		From : To :		
At Completion	◉ Not Available ○ Not Applicable		From : To :		

2. Was another measure of efficiency provided? ○ Yes ◉ No

If Yes, then answer the following:

Measure used

Coverage / scope of measure

Comparison to appraisal estimate

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

If Yes, explain:

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

Soundness of analysis

Conduct of sensitivity / risk analysis

Consideration of institutional constraints to achieving results

Extent to which benefits accrue to target population

Consideration of environmental externalities

Consideration of fiscal impact

Consideration of alternatives to meeting objectives

Overall rating of quality of analysis

Average rating

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

B1c. Outcomes — Efficiency (cont'd)

5. Summary Rating of Efficiency

Rate overall to what extent the project accomplished its goals efficiently: Modest

Average rating

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

Disbursements were delayed until 5th year of project, at which time greater flexibility on part of Bank and Borrower led to successful and efficient completion of civil works program.

B1d. Outcomes — Summary

1. SUMMARY OUTCOME RATING

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

Average rating: Marginally Unsatisfactory

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

Although the project was delayed, it ultimately did contribute to additional infrastructure in the NEast and through innovations in Bank and Borrower supervison practices in the last 3 years of implementation, improved skills in sect. mgt.

B2. Sustainability

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

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

2. SUMMARY SUSTAINABILITY RATING

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

Average rating: Likely

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

B3. Institutional Development

1. Was this project directed primarily toward Institutional Development? ○ Yes ◉ No

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

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

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

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

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

5. For this particular project, rate its efficacy in achieving the following Institutional Development objectives:

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

6. SUMMARY INSTITUTIONAL DEVELOPMENT IMPACT RATING

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

Average rating: Modest

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

C1. Bank Performance

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

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

Overall rating on identification / preparation: Unsatisfactory

Average rating: Unsatisfactory

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

2. Indicate the extent to which the Bank took account of the following during project appraisal:

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

Overall rating on appraisal: Unsatisfactory

Average rating: Unsatisfactory

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

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

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

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

Overall rating on supervision: Satisfactory

Average rating: Satisfactory

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

C1. Bank Performance (cont'd)

5. SUMMARY RATING OF BANK PERFORMANCE

Rate the Bank's overall performance, taking account of identification / preparation, appraisal, and supervision activities:	Satisfactory
Average rating	Unsatisfactory
If your overall rating differs from the average rating, please comment on reasons for this difference:	Although identification, preparation and appraisal were unsatisfactory, a turnaround in supervision assured the completion of the project's construction goals, and helped to integrate this project into ongoing policy dialogue on sectoral performance.

C2. Borrower Performance

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

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

Factors generally subject to government control

Macro policies / conditions	Not Applicable	Administrative procedures	Modest
Sector policies / conditions	Substantial	Cost changes	Modest
Government commitment	Modest	Implementation delays	Modest
Appointment of key staff	Modest	Other (specify):	
Counterpart funding	Substantial		

Factors generally subject to implementing agency control

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

C2. Borrower Performance (cont'd)

3. Summary Rating of Borrower Performance on Project Implementation

Overall rating: Unsatisfactory

Average rating: Unsatisfactory

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

4. Rate Borrower compliance with loan covenants / commitments:

Satisfactory

5. SUMMARY RATING OF BORROWER PERFORMANCE

Overall rating: Satisfactory

Average rating: Satisfactory

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

D. Special Themes

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

Gender related issues	Not Applicable
Settlement / resettlement	Not Applicable
Beneficiary participation	No
Community development	No
Skills development	Yes
Nutrition and food security	No
Health improvement	Yes
Other (specify):	

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

No

If Yes, was the effect positive or negative?

3. Was this a Poverty Targeted Intervention? ○ Yes ○ No

Did the project place a major emphasis on poverty alleviation? ○ Yes ◉ No

If Yes:

Did it emphasize broad-based growth with labor absorption? ○ Yes ○ No

Did it emphasize human development (education, health, or nutrition)? ○ Yes ○ No

Did it emphasize the provision of a social safety net? ○ Yes ○ No

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

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

D. Special Themes (cont'd)

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

No

If Yes, was the effect positive or negative?

7. Rate the priority of the project for audit

Low

8. Rate the priority of the project for impact evaluation

Low

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

Improvement in legal or incentive framework designed to foster PSD (e.g., trade, pricing)	Not Applicable
Restructuring / privatization of public enterprises	Not Applicable
Financial sector development	No
Direct government financial and / or technical assistance to the private sector	No
Other (specify):	

E. Rating of ICR

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

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

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

2. SUMMARY RATING OF ICR

Rate the quality of the ICR:	Satisfactory
Average rating	Satisfactory

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

E. Rating of ICR (cont'd)

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

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

F. Summary of Ratings

1. SUMMARY OF RATINGS

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

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

Outcome: The weak identification and appraisal by the Bank contributed to delays in implementation and to only the partial achievement of several objectives. The project may have contributed to increased in physical infrastructure, but, in the absence of information on the type of facilities constructed/rehabilitated and information on the operational aspects of basic health service delivery in the NE, itself due to the near absence of credible monitoring and evaluation information, there is insufficient evidence to indicate whether this is likely to contribute to improvements in service quality or effects. OED therefore rates the outcome as marginally satisfactory.

G. Overall Judgements / Miscellaneous Comments

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

ICR Review - Evaluation Summary

Operations Evaluation Department

Date Created: 07/06/98 01:42:11 PM
Last Updated: 08/17/98 12:23:48 PM
Status: Open

1. Project Data:	
OEDID:	L3135
Project Name:	Second Northeast Basic Health
Country:	Brazil
Sector:	Basic Health
L/C Number:	L3135
Partners involved:	
Prepared by:	Charles Derek Poate, OEDST
Reviewed by:	Susan A. Stout
Group Manager:	Roger H. Slade
Date Posted:	

2. Project Objectives, Financing, Costs and Components:

The project's **objectives** were to strengthen the delivery of the basic health service package in selected low income areas in the North East; and o reinforce the implementation of sectoral reform including integration, unification and decentralization. The basic health service **component** was to be achieved through the expansion and upgrading of ambulatory and basic hospital medical care through expansion of health posts, health centers and 'unidades mistas' (health centers with 16-50 beds) and the provision of
equipment, staff training, technical assistance, provision of drugs and medical supplies, and supervision; the sector reform objectives were to be achieved through supporting the institutional development of the State Health Secretariat and the MOH through technical assistance, training and special studies.
Costs and financing: The total project costs were US$ 772.8 million (US$ 610.6 million at appraisal) of which the Bank financed US$ 217 million (US$ 267 at appraisal of which US$ 50 million was canceled in late 1994)). There was no co-financing. The Bank loan was approved on November 24, 1989 and was made effective in December, 1990. The loan was closed on December 31, 1997, eighteen months later than the original closing date. The ICR reported that, as of June 16, 1998, there was a balance of US$ 2.9 million in the loan account, which was expected to be disbursed by June 30, 1998.

3. Achievement of Relevant Objectives:

The project enabled the construction, expansion and/or rehabilitation of a large number (total number by type and state not yet available of health facilities in 849 municipalities (632 municipalities in the original project area, and 217 which were included after the development of more flexible allocation rules) of the Northeast. About 39% of the SAR training target numbers were met, but there is as yet not evaluation of the quality or impact of the training.

4. Significant Achievements:

In 1995, after four years of very slow implementation (less than 40% disbursed by the end of the fourth project year), the Government and the bank agreed to introduce a series of measures to make the implementation and disbursement procedures more flexible. In particular, the allocation of loan funds to participating states at appraisal was eliminated and the Project Co-ordination Unit reallocated loan proceeds based on the merits of the annual work programs and budgets submitted by individual states, and their performances in the previous year, and eased requirements that expenditures be targeted on specific types of facilities (e.g. health posts, which apparently were not in high demand). As a consequence, more than 55% of the project was disbursed in the last two years of the project and were heavily concentrated on physical infrastructure.

5. Significant Shortcomings:

Although the project succeeded in constructing and re-equipping health care facilities and following an improvement in supervision quality, improved relationships between the the Bank and the MOH, there is no evidence that it contributed to improvements in the performance of the health system or in health outcomes in the Northeast. Since the M&E indicators established at the beginning of the project were limited and the compilation of data during project implementation was inadequate, no proper data are available to assess the achievement of the institutional development component of the project. For example, the project plan called for state secretariats to hire some an additional 8,600 health personnel and to improve the quality of regular supervision routines through additional guidelines, manuals etc, but there is no monitoring information that can help assess the degree to which this was accomplished. The project was largely a facilities construction and medical equipment program, and did not succeed in transforming the quality or responsiveness of basic health care delivery. Although the project design was rigid, there was no serious effort to address the problems until December 1995. Any attempt by the Borrower to change the loan agreement met strong objections from the Bank and resulted in time consuming processes for the reappraisal of the proposed changes.

6. Ratings:	ICR	OED Review	Reason for Disagreement/Comments
Outcome:	Satisfactory	Marginally Satisfactory	The weak identification and appraisal by the Bank - identified in the ICR - contributed to delays in implementation and to the partial achievement of several objectives.
Institutional Dev.:	Partial	Modest	
Sustainability:	Likely	Likely	
Bank Performance:	Satisfactory	Satisfactory	Performance at identification and appraisal was disappointing, resulting in an inflexible design with inadequate attention to lessons from a previous project. Project supervision was initially weak, but showed sharp turnaround in 1994 with the introduction of a more flexible approach.
Borrower Perf.:	Satisfactory	Satisfactory	
Quality of ICR:		Satisfactory	

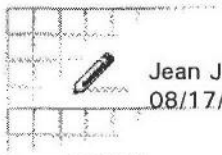
7. Lessons of Broad Applicability:

The success of a project depends to a large extent on ensuring that the lessons learned during previous projects are incorporated in its design. The design of projects covering several states in a large country should be flexible and should be adapted constantly to changing needs. An institution-wide M&E system is a pre-requisite for an effective project-specific M&E system. The inflexibility of the project's design (prior to reformulation in 1994/5) inhibited the use of project funds and produced a significant disbursement lag which contributed, perhaps inevitably, to relative neglect of the institutional objectives of the project (staffing and supervision issues, improvements in drug and medical supplies, monitoring of service utilization, etc.), and limited effectiveness.

8. Audit Recommended? ○ Yes ● No

9. Comments on Quality of ICR:

The overall quality of the ICR is adequate. There is little discussion or effort to assess the effectiveness of the completed construction program, or to examine the impact of the project on the managerial and institutional factors which influence the quality and utilization of services. Comments on the future operation of the project were unsatisfactory. A more complete discussion of the factors that contributed to the weakness of project monitoring efforts would have complemented the Borrower's completion report, which includes a well articulated argument on the value of I) assessing lessons from previous experience during project design, and ii) more deliberate and early efforts to monitor project outputs and effects.



Jean J. De St Antoine
08/17/98 03:42 PM

Extn: 31898 LCSHD
Subject: Re: draft revisions

Susan:

Following our conversation, the changes you suggest are exactly in the areas where we believe that they should be made. There are two important points to be made: (i) the project outcome should be considered at least "marginally satisfactory"; and (ii) the Bank overall performance should be rated "satisfactory".

The Outcome of the Project is Positive.

Despite the lack of measurements, the project clearly had a positive impact as demonstrated by the following:

- the project left behind a physical, human, and operational infrastructure in the region and its impulse helped implement the SUS;
- the project helped construct, rehabilitate, and equip basic health facilities that benefited 23 million people in 7 states (plus three in the last 2 years) covering 849 municipalities, representing an improvement in coverage of basic health services for about 50 percent of the total population of those states. This infrastructure previously either did not exist or was severely deteriorated;
- infant mortality decreased from 85 per 1,000 in 1987 to 55 per 1,000 in 1997 in the Northeast region. Because of multicausality (effects of water, sanitation, women's education, economic progress, etc.), one should be cautious before attributing these to the project. However, it is hard to deny that the expansion of the health network and the training of community health agents financed by the project have allowed for increased control of diarrheal diseases and acute respiratory infections, increase in institutional deliveries, promotion of breastfeeding, and control of vaccine-preventable diseases;
- despite the fragmentation of the documentation, interviews with states show tangible outcomes such as an increase in immunizations in Pernambuco, an improvement in primary health care in Ceara, an increase in hospital delivery in various states;
- there has been a slow, but visible improvement in the quality of human resources as a result of training, TA, and the creation of regional public health schools. The states of Pernambuco and Ceara are recognized to have developed highly-competent Secretariats of Health, with well-defined political and social frameworks, clear targets based on the state's epidemiological profile, and high-quality management teams. Both have made efforts to build up partnerships with municipalities, even those that were from a different political party. A December 1997 evaluation of states by the MOH based the quality of their state health councils, hospital and ambulatory networks, monitoring and evaluation, shows 6 of the NE states (Minas Gerais Rio Grande do Norte, Pernambuco, Ceara, Sergipe and Bahia) in the top 12 positions out the 26 states plus the Federal District. Rio de Janeiro and Sao Paulo, states that consume the most resources, were in 14th and 17th position respectively;
- important studies such as the analysis of human resources capacity, the analysis of epidemiological profiles, and the analysis of sectoral costs were carried out; the link created between the health sector and universities can be beneficial in the future; and
- the improved knowledge in project preparation and procurement was visible in the REFORSUS projects where quality of the subproject proposals presented by the Northeast states were the best of all states.

The Overall Performance of the Bank was Satisfactory.

Despite initial weaknesses, the overall Bank performance should be rated satisfactory because: (i) the identification and the appraisal of the project should be put into context; and (ii) there was a strong turnaround in the performance of the Bank as from 1994.

The project correctly targeted the Northeast, the region that had the worst health indicators at the time, high poverty, was very backwards compared to other regions of Brazil, and had a strong need to strengthen institutional capacity. The project was to extend coverage and strengthen institutions so as to improve the health status of the population by reducing mortality and morbidity.

The weaknesses in the project design were: (i) an exclusive focus on rural areas at a time when urbanization was increasing; (ii) an excessive focus on health posts when both the population and health providers considered more important to have units of higher resolving" capacity (iii) a vertical and rigid design (not surprising at a time when both the Government was still in favor of strong central planning and the Bank had not yet embraced decentralization strategies); and (iv) a lack of emphasis on the construction of the SUS. There was also a lack of baseline data and indicators, but the project was designed 10-15 years before the Bank started to put emphasis on correct project monitoring and evaluation methodologies.

To put things into context, the project was born in the early 1980s at a time of great indecision on the roles of the federal, state, and municipal levels, a lack of tradition in Brazil of having states and municipalities collaborate on the design and execution of projects, and a lack of clarity on what the SUS was all about. The economic situation was precarious with high inflation and an unstable currency. The former would lead directly to numerous changes in federal and state PCU directors, while the latter resulted in a lack of counterpart funds during the initial years.

Coupled with the above difficulties, initial supervision was relatively weak and bureaucratic, but, as from 1994, changes in project management (both in the government and in the Bank) resulted in a significant turnaround. The Bank saw itself as a solutions-offering partner rather than a pure supervisor, and introduced many changes that made the project more flexible and improved its impact:

- less focus was put on rural areas and more on peri-urban areas where there was more demand for health services as a result of urbanization;
- more focus was put on regional hospitals and health centers and less on health posts;
- an environmental health component was introduced as better sanitation was expected to improve impact on infant mortality;
- the allocation of funds was made competitive and those states that implemented the project faster would have access to additional resources from a "Common Fund";
- partnership with municipalities was encouraged; this helped reduce the counterpart funds problem (as the municipalities partly substituted for the states' financial contribution) and improved the sustainability of the project;
- the disbursement categories were simplified and funds were reallocated as necessary;
- the use of the Special Account was made more flexible;
- TA was provided to weaker states to prepare project proposals;
- TA was provided to improve the procurement capacity of states (as a result, the project was the first Bank-financed project in the health sector in Brazil where ICB was successfully undertaken; prices are reported to have fallen at least 15% for equipment); and
- TA was provided to improve the IEC component.

As a result, 62% of the funds were disbursed during the last 3 years of the project compared to

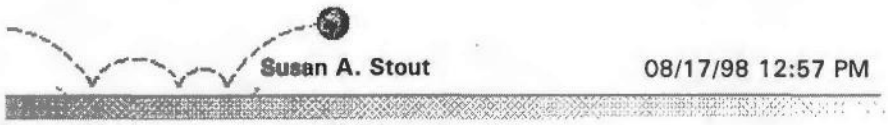
38% in the previous 4 years.

Conclusion. Changes in the above two areas (Outcome and Bank Performance) will make OED's evaluation of PNE II consistent with that of PNE I. It will also be more correct.

Note: some of the above information was not included in our ICR, but I thought that its inclusion in the project files would help better substantiate the ratings.

Suggested change in text: in the box of comments on outcome, after "The weak identification and appraisal by the Bank" please add : "in a difficult political and economic context".

JJ
Susan A. Stout



Extn: 82537 OEDST
To: Jean J. De St Antoine
Subject: draft revisions

Jean-Jacques,

Here is a suggested revision of the ICR summary for 2nd NE. Let me know what you think -- and then I'll finalize and send to you formally.

Susan
---------- Forwarded by Susan A. Stout/Person/World Bank on 08/17/98 12:57 PM ----------

ICR Review - Evaluation Summary

Operations Evaluation Department

Date Created: 07/06/98 01:42:11 PM
Last Updated: 08/17/98 12:23:48 PM
Status: Open

1. Project Data:	
OEDID:	L3135
Project Name:	Second Northeast Basic Health
Country:	Brazil
Sector:	Basic Health
L/C Number:	L3135
Partners involved:	
Prepared by:	Charles Derek Poate, OEDST
Reviewed by:	Susan A. Stout
Group Manager:	Roger H. Slade
Date Posted:	

2. Project Objectives, Financing, Costs and Components:
The project's ***objectives*** *were to strengthen the delivery of the basic health service package in selected low income areas in* the North East; and o reinforce the implementation of sectoral reform including integration, unification and decentralization. The basic health service **component** was to be achieved through the expansion and upgrading of ambulatory and basic hospital medical care through expansion of health posts, health centers and 'unidades mistas' (health centers with 16-50 beds) and the provision of
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3. Achievement of Relevant Objectives:
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4. Significant Achievements:
In 1995, after four years of very slow implementation (less than 40% disbursed by the end of the fourth project year), the Government and the bank agreed to introduce a series of measures to make the implementation and disbursement procedures more flexible. In particular, the allocation of loan funds to participating states at appraisal was eliminated and the Project Co-ordination Unit reallocated loan proceeds based on the merits of the annual work programs and budgets submitted by individual states, and their performances in the previous year, and eased requirements that expenditures be targeted on specific types of facilities (e.g. health posts, which apparently were not in high demand). As a consequence, more than 55% of the project was disbursed in the last two years of the project and were heavily concentrated on physical infrastructure.

5. Significant Shortcomings:
Although the project succeeded in constructing and re-equipping health care facilities and following an improvement in supervision quality, improved relationships between the the Bank and the MOH, there is no evidence that it contributed to improvements in the performance of the health system or in health outcomes in the Northeast. Since the M&E indicators established at the beginning of the project were limited and the compilation of data during project implementation was inadequate, no proper data are available to assess the achievement of the institutional development component of the project. For example, the project plan called for state secretariats to hire some an additional 8,600 health personnel and to improve the quality of regular supervision routines through additional guidelines, manuals etc, but there is no monitoring information that can help assess the degree to which this was accomplished. The project was largely a facilities construction and medical equipment program, and did not succeed in transforming the quality or responsiveness of basic health care delivery. Although the project design was rigid, there was no serious effort to address the problems until December 1995. Any attempt by the Borrower to change the loan agreement met strong objections from the Bank and resulted in time consuming processes for the reappraisal of the proposed changes.

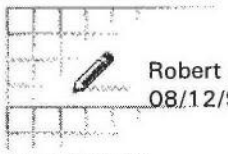
6. Ratings:	ICR	OED Review	Reason for Disagreement/Comments
Outcome:	Satisfactory	Marginally Satisfactory	The weak identification and appraisal by the Bank - identified in the ICR - contributed to delays in implementation and to the partial achievement of several objectives.
Institutional Dev.:	Partial	Modest	
Sustainability:	Likely	Likely	
Bank Performance:	Satisfactory	Satisfactory	Performance at identification and appraisal was disappointing, resulting in an inflexible design with inadequate attention to lessons from a previous project. Project supervision was initially weak, but showed sharp turnaround in 1994 with the introduction of a more flexible approach.
Borrower Perf.:	Satisfactory	Satisfactory	
Quality of ICR:		Satisfactory	

7. Lessons of Broad Applicability:
The success of a project depends to a large extent on ensuring that the lessons learned during previous projects are incorporated in its design. The design of projects covering several states in a large country should be flexible and should be adapted constantly to changing needs. An institution-wide M&E system is a pre-requisite for an effective project-specific M&E system. The inflexibility of the project's design (prior to reformulation in 1994/5) inhibited the use of project funds and produced a significant disbursement lag which contributed, perhaps inevitably, to relative neglect of the institutional objectives of the project (staffing and supervision issues, improvements in drug and medical supplies, monitoring of service utilization, etc.), and limited effectiveness.

8. Audit Recommended? ○ Yes ● No

9. Comments on Quality of ICR:
The overall quality of the ICR is adequate. There is little discussion or effort to assess the effectiveness of the completed construction program, or to examine the impact of the project on the managerial and institutional factors which influence the quality and utilization of services. Comments on the future operation of the project were unsatisfactory. A more complete discussion of the factors that contributed to the weakness of project monitoring efforts would have complemented the Borrower's completion report, which includes a well articulated argument on the value of I) assessing lessons from previous experience during project design, and ii) more deliberate and early efforts to monitor project outputs and effects.

To: Susan A. Stout
cc: Pmillan@Worldbank.Org
Sarah A. Menezes
Kye Woo Lee
Xavier E. Coll



Robert J. Van Der Lugt
08/12/98 03:10 PM

Extn: 31740 OEDST
Subject: Brazil - Second NE Basic Health Services Project - OED review of ICR

I am replying to your message on Roger's behalf.

I would like to suggest a compromise. We are under extreme pressureto complete ICr reviews for purposes of the annual review of develoment effectivenes. August 21 would really be to late. Susan Stout will be back next Monday like yourself. Why don't you get together with Susan on Monday August 17 to discuss your comments. The idea would be to try and come to a close on this ICR review that same day.

Thanks and Regards.

To: Jean J. De St Antoine
cc: Roger H. Slade
Xavier E. Coll
Patricio Millan
Robert M. Hecht
Sarah A. Menezes
Susan A. Stout
Kye Woo Lee
Hernan Levy

Evaluation Textbase
Operations Evaluation Department

Evaluative Memorandum: Brazil - Northeast Basic Health Services Project

Pub. Date:	06/30/97
Report Type:	EVM - Evaluative Memorandum
Sector:	Targeted Health
Country:	Brazil
Region:	Latin America, Caribbean
L/C No:	L2699

The Brazil Northeast Basic Health Services project, supported by Loan 2699-BR for US$59.4 million was approved in FY86. The fully-disbursed loan closed on December 31, 1995, one-and-a-half years later than planned. The Implementation Completion Report (ICR) was prepared by the Latin America and the Caribbean Regional Office, with comments contributed by the borrower in Appendix A.

The project was part of the Brazilian Government's 15-year development plan for the Northeast Region, whose social and development indicators lagged behind the country as a whole. The project's objectives were to (i) improve the health status of the rural poor in selected areas of four northeast states; and (ii) improve access to and the efficiency of the basic health services in the selected areas. The project aimed to accomplish these objectives by building health care facilities, encouraging management improvements, and providing technical skills training for the development of new "basic health care modules" and programs of comprehensive care for women and children.

Only 55 percent of project finances were disbursed by 1994, eight years after appraisal. Macroeconomic crises, delays in obtaining counterpart funds from the states, political changes, and successive transformations of the national health care system all contributed to implementation delays. Eight different health ministers and as many project managers presided over the project. In addition, although the Northeast Region was changing over this period, with migration to the cities and the establishment of more private health facilities, World Bank and government procedures did not allow project management teams to accommodate to the emerging context. After 1994, political stability and new resolve on the part of the government, and more flexibility and better supervision on the part of the Bank, helped the project to disburse fully and left a legacy of mutual respect and improved management skills in both institutions.

Partly as a result of the difficult political and macroeconomic context, the project evolved into a facilities construction and medical equipment program. That program succeeded in expanding access to basic health services in the Northeast. The project financed the construction and/or improvement of nearly 400 facilities and sponsored over 700 courses

and training events. It did not, however, transform the mode of basic health care delivery within that system. The reason for this is, again, partly the political and economic context of the country; but the lack of attention to consumer demand in project design was also responsible. Although the project was adequately designed given the state-of-the-art and the consensus among health planners at the time, by the standards of today it is apparent that it did not take into account the emergent demands of increasingly urban consumers. (Modifications in 1994 and 1995 made the project more flexible and adjusted it to the emergent demands for more intensive health care). Most importantly, it did not acknowledge what the current generation of health projects in Brazil does recognize, that changing modes of health care delivery requires not merely more training but realigning incentives in the sector. The Government's own evaluation of the project concludes: "The lack of means and legal instruments to activate components of the project that involved deep reforms (in management and in changes in the service delivery model) gave the more traditional components (civil works) more space to develop."

Infant mortality rates in the region fell significantly during the life of the project. It is difficult to determine how much of that decline is attributable to the project because the project did not include a detailed and specific system for monitoring and evaluation. Other factors, such as economic growth, sanitation, and maternal education were clearly important because infant mortality rates began their downward trend well before the project had disbursed most of its funds. Nevertheless, improved access to the health system probably also played a role. The best available data, from the Government's excellent evaluation report of 1996, show mixed results. For instance, the Government's field survey, based on a small, random sample, finds that while over 70 per cent of health centers were providing adequate antibiotics, 29 percent of the health posts were monitoring child growth.

The Operations Evaluation Department (OED) rates project outcome as marginally satisfactory, rather than satisfactory-the judgment of the ICR-because although the project succeeded in constructing and re-equipping health care facilities and eventually building a strong relationship between the Bank and the Ministry, there is no evidence that it was responsible for the improvement in the health status of the rural poor in the Northeast Region. OED agrees that sustainability is likely, institutional development impact modest, and Bank performance satisfactory. Although Bank performance was inadequate until 1994, after that time it improved significantly and is on balance satisfactory.

Two key lessons emerge from this project. First, transforming the incentives of managers and health professionals is indispensable for changing the form of health care delivery. The project moved in that direction with the establishment in 1995 of a form of competition among states for the use of undisbursed funds, and the current Health Sector Reform Project (Ln. 4047-BR) addresses incentives in the sector explicitly. Second, projects that aim to improve health status among beneficiaries must have precise and viable systems for monitoring and evaluation. In their absence, it is difficult to evaluate the project's effects on health outcomes.

The ICR is of satisfactory quality. The comments from the government are very good. The project management team in Brazil has conducted a valuable, extensive, and exemplary evaluation of the project and has described a number of important lessons. This evaluation makes specific recommendations for future operations management-also taking monitoring indicators into account-although the ICR does not contain a plan for future operation of the facilities established under the project. No audit is planned, but the project will be assessed in the context of a planned sector impact study in Brazil.

ICR Review - Evaluation Summary

Operations Evaluation Department

Date Created: 07/06/98 01:42:11 PM
Last Updated: 08/04/98 05:23:21 PM
Status: Open

1. Project Data:	
OEDID:	L3135
Project Name:	Second Northeast Basic Health
Country:	Brazil
Sector:	Basic Health
L/C Number:	L3135
Partners involved:	
Prepared by:	Charles Derek Poate, OEDST
Reviewed by:	Susan A. Stout
Group Manager:	Roger H. Slade
Date Posted:	

2. Project Objectives, Financing, Costs and Components:

The project's **objectives** were to strengthen the delivery of the basic health service package in selected low income areas in the North East; and o reinforce the implementation of sectoral reform including integration, unification and decentralization. The basic health service **component** was to be achieved through the expansion and upgrading of ambulatory and basic hospital medical care through expansion of health posts, health centers and 'unidades mistas' (health centers with 16-50 beds) and the provision of
equipment, staff training, technical assistance, provision of drugs and medical supplies, and supervision; the sector reform objectives were to be achieved through supporting the institutional development of the State Health Secretariat and the MOH through technical assistance, training and special studies.

Costs and financing: The total project costs were US$ 772.8 million (US$ 610.6 million at appraisal) of which the Bank financed US$ 217 million (US$ 267 at appraisal of which US$ 50 million was canceled in late 1994)). There was no co-financing. The Bank loan was approved on November 24, 1989 and was made effective in December, 1990. The loan was closed on December 31, 1997, eighteen months later than the original closing date. The ICR reported that, as of June 16, 1998, there was a balance of US$ 2.9 million in the loan account, which was expected to be disbursed by June 30, 1998.

3. Achievement of Relevant Objectives:

The project enabled the construction, expansion and/or rehabilitation of a large number (total number by type and state not yet available of health facilities in 849 municipalities (632 municipalities in the original project area, and 217 which were included after the development of more flexible allocation rules) of the Northeast. About 39% of the SAR training target numbers were met, but there is as yet no evaluation of the quality or impact of the training.

4. Significant Achievements:

In 1995, after four years of very slow implementation (less than 40% disbursed by the end of the fourth project year), the Government and the bank agreed to introduce a series of measures to make the implementation and disbursement procedures more flexible. In particular, the allocation of loan funds to participating states at appraisal was eliminated and the Project Co-ordination Unit reallocated loan proceeds based on the merits of the annual work programs and budgets submitted by individual states, and their performances in the previous year, and eased requirements that expenditures be targeted on specific types of facilities (e.g. health posts, which apparently were not in high demand). As a consequence, more than 55% of the project was disbursed in the last two years of the project and were heavily concentrated on physical infrastructure.

5. Significant Shortcomings:

Since the M&E indicators established at the beginning of the project were limited and the compilation of data during project implementation was inadequate, no proper data are available to assess the achievement of the institutional development component of the project. For example, the project plan called for state secretariats to hire some an additional 8,600 health personnel and to improve the quality of regular supervision routines through additional guidelines, manuals etc, but there is no monitoring information that can help assess the degree to which this was accomplished. The project was largely a facilities construction and medical equipment program, and did not succeed in transforming the quality or responsiveness of basic health care delivery. Although the project design was rigid, there was no serious effort to address the problems until December 1995. Any attempt by the Borrower to change the loan agreement met strong objections from the Bank and resulted in time consuming processes for the reappraisal of the proposed changes.

NEI

MS

SAT.

6. Ratings:	ICR	OED Review	Reason for Disagreement/Comments
Outcome:	Satisfactory	Marginally Unsatisfactory	The weak identification and appraisal by the Bank - identified in the ICR - contributed to delays in implementation and to only the partial achievement of several objectives. Unanticipated socio-political developments also adversely affected the project. OED therefore rates the outcome as "Marginally unsatisfactory".
Institutional Dev.:	Partial	Modest	
Sustainability:	Likely	Likely	
Bank Performance:	Satisfactory	Unsatisfactory	A summary rating of Bank performance was not given in the ICR - which did, however, rate performance at identification and appraisal as deficient, while rating performance at preparation and supervision as satisfactory. In view of the importance of Bank performance at identification and appraisal for the overall outcome of the project, OED rates the overall performance of the Bank as "Unsatisfactory".
Borrower Perf.:	Satisfactory	Satisfactory	
Quality of ICR:		Satisfactory	

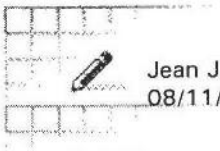
7. Lessons of Broad Applicability:

The success of a project depends to a large extent on ensuring that the lessons learned during previous projects are incorporated in its design. The design of projects covering several states in a large country should be flexible and should be adapted constantly to changing needs. An institution-wide M&E system is a pre-requisite for an effective project-specific M&E system. The inflexibility of the project's design (prior to reformulation in 1994/5) inhibited the use of project funds and produced a significant disbursement lag which contributed, perhaps inevitably, to relative neglect of the institutional objectives of the project (staffing and supervision issues, improvements in drug and medical supplies, monitoring of service utilization, etc.), and limited effectiveness.

8. Audit Recommended? ○ Yes ● No

9. Comments on Quality of ICR:

The overall quality of the ICR is adequate. There is little discussion or effort to assess the effectiveness of the completed construction program, or to examine the impact of the project on the managerial and institutional factors which influence the quality and utilization of services. Comments on the future operation of the project were unsatisfactory. A more complete discussion of the factors that contributed to the weakness of project monitoring efforts would have complemented the Borrower's completion report, which includes a well articulated argument on the value of I) assessing lessons from previous experience during project design, and ii) more deliberate and early efforts to monitor project outputs and effects.



Jean J. De St Antoine
08/11/98 12:35 PM

Extn: 31898 LCSHD
Subject: BRAZIL -Second NE Basic Health Services Project - OED Evaluation

Roger:

I was very surprised by your rating on this project, considering the amount of work that the Bank and the Government did to turnaround this project. I am going to give you my comments, but I am now in Mexico on another mission. I will be back in Washington on August 17 and would appreciate it if you could extend the deadline for comments to August 21.

Please let me know by em if you agree on the new date.

Thanks.

JJ

To: Roger H. Slade
cc: Xavier E. Coll
Patricio Millan
Robert M. Hecht
Sarah A. Menezes
Susan A. Stout
Kye Woo Lee

Jean J. De St Antoine
08/12/98 06:42 PM

Extn: 31898 LCSHD
Subject: Re: Brazil - Second NE Basic Health Services Project - OED review of ICR

Robert:

I will try by all means to do it on Monday 17, assuming that nothing else of urgent nature falls on my table. If that is the case I would ask you and Susan to agree on Tuesday 18.

JJ
Robert J. Van Der Lugt

Robert J. Van Der Lugt
08/12/98 02:10 PM

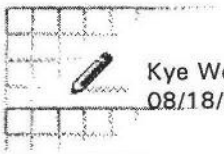
Extn: 31740 OEDST
To: Jean J. De St Antoine cc: Roger H. Slade, Xavier E. Coll, Patricio Millan, Robert M. Hecht, Sarah A. Menezes, S
Subject: Brazil - Second NE Basic Health Services Project - OED review of ICR

I am replying to your message on Roger's behalf.

I would like to suggest a compromise. We are under extreme pressureto complete ICr reviews for purposes of the annual review of develoment effectivenes. August 21 would really be to late. Susan Stout will be back next Monday like yourself. Why don't you get together with Susan on Monday August 17 to discuss your comments. The idea would be to try and come to a close on this ICR review that same day.

Thanks and Regards.

To: Robert J. Van Der Lugt
cc: Susan A. Stout
Kye Woo Lee
Xavier E. Coll
Sarah A. Menezes
Patricio Millan



Kye Woo Lee
08/18/98 05:43 PM

Extn: 38076 LCSHD
Subject: Re: Brazil

Susan,

Thanks for your efforts to accomodate our comments.

In section 3, you may state that on the basis of the training achievement in two states, the project must have exceeded the training targets set at Appraisal, but there is as yet.....

In section 9, The second sentence is groundless or too strong. The statistical analysis and the graphic presentations made in the Oucome section of the SAR discuss and assess the effectiveness of the completed construction program (effeciveness of the health facilities provided for under the project) and examine the impact of the project quality and utilization of services. I have yet to see other examples of such impact analysis on the basis actual data and in comparison with the control group.

To: Susan A. Stout

Marcia J. Bailey
08/06/98 09:41 AM

Extn: 39617 OEDST
Subject: Brazil: Second Northeast Basic Health Project
OED: Review of Implementation Completion Report

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

TO: Mr. Gobind T. Nankani (LCC5F), *Country Director in Brazil*

Attached for your review is OED's Evaluation Summary for the above project. This form contains OED's ratings and comments on the ICR. Any comments you may have should reach me no later than c.o.b. Wednesday August 12, 1998.

Roger Slade
Manager
Sector and Thematic Evaluation Group

cc: Messrs./Mmes.
Prem C. Garg (MDOQA)
David D. Ferranti (HDNVP)
Robert M. Hecht (HDNVP)
Joy De Beyer (HDNVP)
Richard Feachem (HDNHE)
Kye Woo Lee (LCSHD), Task Manager @ Headquarters
Suman Bery (LCC5A), Lead Economist @ Headquarters
Susan Stout (OEDST)

bcc: Marcia Bailey

---------- Forwarded by Marcia J. Bailey/Person/World Bank on 08/04/98 06:36 PM

ICR Review - Evaluation Summary

Operations Evaluation Department

Date Created: 07/06/98 01:42:11 PM
Last Updated: 08/04/98 04:59:01 PM
Status: Open

1. Project Data:	
OEDID:	L3135
Project Name:	Second Northeast Basic Health
Country:	Brazil
Sector:	Basic Health
L/C Number:	L3135
Partners involved:	
Prepared by:	Charles Derek Poate, OEDST
Reviewed by:	Susan A. Stout SAS+V
Group Manager:	Roger H. Slade
Date Posted:	

2. Project Objectives, Financing, Costs and Components:

The project's **objectives** were to strengthen the delivery of the basic health service package in selected low income areas in the North East; and o reinforce the implementation of sectoral reform including integration, unification and decentralization. The basic health service **component** was to be achieved through the expansion and upgrading of ambulatory and basic hospital medical care through expansion of health posts, health centers and 'unidades mistas' (health centers with 16-50 beds) and the provision of
equipment, staff training, technical assistance, provision of drugs and medical supplies, and supervision; the sector reform objectives were to be achieved through supporting the institutional development of the State Health Secretariat and the MOH through technical assistance, training and special studies.

Costs and financing: The total project costs were US$ 772.8 million (US$ 610.6 million at appraisal) of which the Bank financed US$ 217 million (US$ 267 at appraisal of which US$ 50 million was canceled in late 1994)). There was no co-financing. The Bank loan was approved on November 24, 1989 and was made effective in December, 1990. The loan was closed on December 31, 1997, eighteen months later than the original closing date. The ICR reported that, as of June 16, 1998, there was a balance of US$ 2.9 million in the loan account, which was expected to be disbursed by June 30, 1998.

3. Achievement of Relevant Objectives:

The project enabled the construction, expansion and/or rehabilitation of a large number (total number by type and state not yet available of health facilities in 849 municipalities (632 municipalities in the original project area, and 217 which were included after the development of more flexible allocation rules) of the Northeast. About 39% of the SAR training target numbers were met, but there is as yet not evaluation of the quality or impact of the training.

4. Significant Achievements:

In 1995, after four years of very slow implementation (less than 40% disbursed by the end of the fourth project year), the Government and the bank agreed to introduce a series of measures to make the implementation and disbursement procedures more flexible. In particular, the allocation of loan funds to participating states at appraisal was eliminated and the Project Co-ordination Unit reallocated loan proceeds based on the merits of the annual work programs and budgets submitted by individual states, and their performances in the previous year, and eased requirements that expenditures be targeted on specific types of facilities (e.g. health posts, which apparently were not in high demand). As a consequence, more than 55% of the project was disbursed in the last two years of the project and were heavily concentrated on physical infrastructure.

5. Significant Shortcomings:
Since the M&E indicators established at the beginning of the project were limited and the compilation of data during project implementation was inadequate, no proper data are available to assess the achievement of the institutional development component of the project. For example, the project plan called for state secretariats to hire some an additional 8,600 health personnel and to improve the quality of regular supervision routines through additional guidelines, manuals etc, but there is no monitoring information that can help assess the degree to which this was accomplished. The project was largely a facilities construction and medical equipment program, and did not succeed in transforming the quality or responsiveness of basic health care delivery. Although the project design was rigid, there was no serious effort to address the problems until December 1995. Any attempt by the Borrower to change the loan agreement met strong objections from the Bank and resulted in time consuming processes for the reappraisal of the proposed changes.

6. Ratings:	ICR	OED Review	Reason for Disagreement/Comments
Outcome:	Satisfactory	Marginally Unsatisfactory	The weak identification and appraisal by the Bank - identified in the ICR - contributed to delays in implementation and to only the partial achievement of several objectives. Unanticipated socio-political developments also adversely affected the project. OED therefore rates the outcome as "Marginally unsatisfactory".
Institutional Dev.:	Partial	Modest	
Sustainability:	Likely	Likely	
Bank Performance:	Satisfactory	Unsatisfactory	A summary rating of Bank performance was not given in the ICR - which did, however, rate performance at identification and appraisal as deficient, while rating performance at preparation and supervision as satisfactory. In view of the importance of Bank performance at identification and appraisal for the overall outcome of the project, OED rates the overall performance of the Bank as "Unsatisfactory".
Borrower Perf.:	Satisfactory	Satisfactory	
Quality of ICR:		Satisfactory	

7. Lessons of Broad Applicability:
The success of a project depends to a large extent on ensuring that the lessons learned during previous projects are incorporated in its design. The design of projects covering several states in a large country should be flexible and should be adapted constantly to changing needs. An institution-wide M&E system is a pre-requisite for an effective project-specific M&E system. The inflexibility of the project's design (prior to reformulation in 1994/5) inhibited the use of project funds and produced a significant disbursement lag which contributed, perhaps inevitably, to relative neglect of the institutional objectives of the project (staffing and supervision issues, improvements in drug and medical supplies, monitoring of service utilization, etc.), and limited effectiveness.

8. Audit Recommended? ○ Yes ● No

9. Comments on Quality of ICR:
The overall quality of the ICR is adequate. There is little discussion or effort to assess the effectiveness of the completed construction program, or to examine the impact of the project on the managerial and institutional factors which influence the quality and utilization of services and comments on the future operation of the project were unsatisfactory. A more complete discussion of the factors that contributed to the weakness of project monitoring efforts would have complemented the Borrower's completion report, which includes a well articulated argument on the value of I) assessing lessons from previous experience during project design, and ii) more deliberate and early efforts to monitor project outputs and effects.

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

This PIF has not been posted

OED ID :	L3135
Type :	ES
Country :	Brazil
Project Description :	Northeast Basic Health 2
Sector :	HX / Population, Health & Nutrition
Subsector :	HT / Targeted Health
Lending Instrument :	Specific Investment
L/C :	L3135

Problems

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| ERRORS |
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* These must be fixed before the PIF can be posted *

Section      Question      Error
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A1           3.9           No answer
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Operations Evaluation Department
PROJECT INFORMATION FORM

Table of Contents

A1. General Project Information

OED ID :	L3135
Type :	ES
Country :	Brazil
Project Description :	Northeast Basic Health 2
Sector :	HX / Population, Health & Nutrition
Subsector :	HT / Targeted Health
Lending Instrument :	Specific Investment
L/C :	L3135

3. Key Dates

	Original	Latest
Departure of Appraisal Mission		01/01/1988
Approval		11/30/1989
Signing/Agreement		09/26/1990
Effectiveness	12/26/1990	12/26/1990
Physical completion	12/31/1995	06/30/1998
Closing	06/30/1996	12/30/1997
ICR receipt in OED		06/23/1998
Review date		07/15/1998
ES posting or PAR approval		

1. Reviewer: ITAD

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

Sugg. Sector:
Sugg. Subsector:

4. Key Amounts ($US million)

Original Commitment	267
Total Cancellation	50
Total project cost	
Original	610.6
Latest	772.8

5. Cofinanciers

	First	Second	Third
Name	Not Applicable		
Original Commitment ($US million)			
Total Cancellation ($US million)			

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

Physical	111
Technical assistance	37.4
Balance of payments	0
Line of credit	0
Other	624.4

7. Applicable disbursement profile (no. of years): 9

8. Number of supervision missions: 18

9. Name(s) of primary author(s) of ICR (indicate if not known): Kye Woo Lee

11. Names of managers

	At entry	At exit
Task manager	N/A	Kye Woo Lee
Division chief	N/A	P. Millan
Department director	N/A	G.T. Nankani

A2. Project Objectives Evaluation

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

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

   Date of Board approval

Note: If objectives were revised, base the ratings in subsequent sections on the revised objectives.

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

Demanding on Borrower / Implementing Agency	Substantial
Complexity	Substantial
Riskiness	Substantial

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

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

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

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

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

B1a. Outcomes — Relevance

1. Indicate the extent to which each of the project's objectives was relevant in terms of the Bank's / Borrower's current country or sectoral objectives:

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

2. Summary Rating of Relevance

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

Average rating: Substantial

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

B1b. Outcomes — Efficacy

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

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

2. Summary Rating of Efficacy

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

Average rating: Modest

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

B1b. Outcomes — Efficacy (cont'd)

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

World markets / prices	Not Applicable	Performance of contractors / consultants	No Effect
Natural events	Not Applicable	War / civil disturbance	Negative
Cofinancier(s) performance	Not Applicable	Other (specify):	

B1c. Outcomes — Efficiency

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

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

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

		Point Value	Range	Weighted Average	Coverage / Scope
At Appraisal	◉ Not Available ○ Not Applicable		From : To :		
At Completion	◉ Not Available ○ Not Applicable		From : To :		

2. Was another measure of efficiency provided? ○ Yes ◉ No

If Yes, then answer the following:

Measure used

Coverage / scope of measure

Comparison to appraisal estimate

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

If Yes, explain:

A measure of the cost effectiveness of the project investment would have been appropriate.

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

Soundness of analysis

Conduct of sensitivity / risk analysis

Consideration of institutional constraints to achieving results

Extent to which benefits accrue to target population

Consideration of environmental externalities

Consideration of fiscal impact

Consideration of alternatives to meeting objectives

Overall rating of quality of analysis

Average rating

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

B1c. Outcomes — Efficiency (cont'd)

5. Summary Rating of Efficiency

Rate overall to what extent the project accomplished its goals efficiently:	Modest	If your overall rating differs from the average rating, please comment on reasons for this difference:
Average rating		

B1d. Outcomes — Summary

1. SUMMARY OUTCOME RATING

Rate the project's outcome (i.e., the extent to which it achieved relevant objectives), taking account of its relevance, efficacy, and efficiency:	Marginally Unsatisfactory
Average rating	Marginally Unsatisfactory
If your overall rating differs from the average rating, please comment on reasons for this difference:	

B2. Sustainability

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

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

2. SUMMARY SUSTAINABILITY RATING

Rate the probability of maintaining the project's relevant development achievements generated or expected to be generated:	Likely
Average rating	Likely
If your overall rating differs from the average rating, please comment on reasons for this difference:	

B3. Institutional Development

1. Was this project directed primarily toward Institutional Development? ○ Yes ◉ No

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

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

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

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

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

5. For this particular project, rate its efficacy in achieving the following Institutional Development objectives:

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

6. SUMMARY INSTITUTIONAL DEVELOPMENT IMPACT RATING

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

Average rating: Modest

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

C1. Bank Performance

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

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

Overall rating on identification / preparation: Unsatisfactory

Average rating: Unsatisfactory

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

2. Indicate the extent to which the Bank took account of the following during project appraisal:

Technical analysis (inc. alternatives)	Modest
Financial analysis (inc. funding provisions, fiscal impact)	Modest
ERR/FRR cost-benefit analysis	Negligible
Institutional capacity analysis	Modest
Social and stakeholder analysis	Modest
Environmental analysis	Modest
Risk assessment (inc. adequacy of conditionalities)	Negligible
Incorporation of M&E indicators	Negligible
Incorporation of lessons learned	Negligible
Readiness for implementation	Modest
Suitability of lending instrument	High

Overall rating on appraisal: Unsatisfactory

Average rating: Unsatisfactory

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

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

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

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

Overall rating on supervision: Satisfactory

Average rating: Satisfactory

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

C1. Bank Performance (cont'd)

5. SUMMARY RATING OF BANK PERFORMANCE

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

C2. Borrower Performance

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

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

Factors generally subject to government control

Macro policies / conditions	Not Applicable	Administrative procedures	Modest
Sector policies / conditions	Substantial	Cost changes	Modest
Government commitment	Modest	Implementation delays	Modest
Appointment of key staff	Modest	Other (specify):	
Counterpart funding	Substantial		

Factors generally subject to implementing agency control

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

C2. Borrower Performance (cont'd)

3. Summary Rating of Borrower Performance on Project Implementation

Overall rating: Unsatisfactory

Average rating: Unsatisfactory

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

4. Rate Borrower compliance with loan covenants / commitments:

Satisfactory

5. SUMMARY RATING OF BORROWER PERFORMANCE

Overall rating: Satisfactory

Average rating: Satisfactory

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

D. Special Themes

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

Gender related issues	Not Applicable
Settlement / resettlement	Not Applicable
Beneficiary participation	No
Community development	No
Skills development	Yes
Nutrition and food security	No
Health improvement	Yes
Other (specify):	

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

No

If Yes, was the effect positive or negative?

3. Was this a Poverty Targeted Intervention? ○ Yes ○ No

Did the project place a major emphasis on poverty alleviation? ○ Yes ◉ No

If Yes:

Did it emphasize broad-based growth with labor absorption? ○ Yes ○ No

Did it emphasize human development (education, health, or nutrition)? ○ Yes ○ No

Did it emphasize the provision of a social safety net? ○ Yes ○ No

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

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

D. Special Themes (cont'd)

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

No

If Yes, was the effect positive or negative?

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

Improvement in legal or incentive framework designed to foster PSD (e.g., trade, pricing)	Not Applicable
Restructuring / privatization of public enterprises	Not Applicable
Financial sector development	No
Direct government financial and / or technical assistance to the private sector	No
Other (specify):	

7. Rate the priority of the project for audit

Low

8. Rate the priority of the project for impact evaluation

Low

E. Rating of ICR

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

Analysis	
Coverage of important subjects	Satisfactory
Recalcualtion of ERR or FRR	Not Applicable
Soundness of analysis	
Internal consistencies	Satisfactory
Evidence complete / convincing	Satisfactory
Adequacy of lessons learned	Satisfactory
Aide-memoire of the ICR mission	Satisfactory
Future orientation	
Plan for future project operation	Not Available
Performance indicators for the project's operations phase	Not Available
Plan for monitoring and evaluation of future operations	Not Available
Borrower / cofinancier inputs	
Borrower input to ICR	Satisfactory
Borrower plan for future project operation	Unsatisfactory
Borrower comments on ICR	Satisfactory
Cofinancier comments on ICR	Not Applicable

2. SUMMARY RATING OF ICR

Rate the quality of the ICR:	Satisfactory
Average rating	Satisfactory

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

E. Rating of ICR (cont'd)

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

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

F. Summary of Ratings

1. SUMMARY OF RATINGS

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

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

Outcome: The weak identification and appraisal by the Bank contributed to delays in implementation and to only the partial achievement of several objectives. The project may have contributed to increased in physical infrastructure, but, in the absence of information on the type of facilities constructed/rehabilitated and information on the operational aspects of basic health service delivery in the NE, itself due to the near absence of credible monitoring and evaluation information, there is insufficient evidence to indicate whether this is likely to contribute to improvements in service quality or effects. OED therefore rates the outcome as marginally unsatisfactory.

G. Overall Judgements / Miscellaneous Comments

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