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IMPLEMENTATION COMPLETION REPORT

REPUBLIC OF TUNISIA

POPULATION AND FAMILY HEALTH PROJECT
(LOAN NO. 3307-TUN)

June 4, 1998

Human Development Sector
Middle East and North Africa Region

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CURRENCY EQUIVALENTS

Currency Unit: Tunisian dinar (TND)

1990	US$1.00 = TND 0.85 (September 1990)
1991	US$1.00 = TND 0.92 (year average)
1992	US$1.00 = TND 0.88
1993	US$1.00 = TND 1.00
1994	US$1.00 = TND 1.01
1995	US$1.00 = TND 0.94
1996	US$1.00 = TND 0.97
1997	US$1.00 = TND 0.91
1998	US$1.00 = TND 1.11

ABBREVIATIONS AND ACRONYMS

BHC:	Basic Health Care
BHCC:	Basic Health Care Center
CEO:	Chief Executive Officer
CREPF:	Regional Family Planning Center (*Centre régional d'éducation et de planning familial*)
DBHC:	Directorate of Basic Health Care
FP:	Family Planning
IBRD:	International Bank for Reconstruction and Development
MCH:	Maternal and Child Health
MPH:	Ministry of Public Health
ONFP:	National Office of Population and Family Planning (*Office national de la famille et de la population*)
UNFPA:	United Nations Fund for Population Activities
UNICEF:	United Nations Children's Fund
WHO:	World Health Organization

FISCAL YEAR

TUNISIA:	January 1 - December 31
IBRD:	July 1 - June 30

Vice President:	Kemal Derviş
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DEFINITIONS

Contraceptive prevalence: Percentage of married women of reproductive age who are using (or whose husbands are using) any form of contraception.

Crude birth rate: Number of live births per year per 1,000 people.

Crude death rate: Number of deaths per year per 1,000 people.

Infant mortality rate: Number of deaths of infants younger than one year old per 1,000 live births during the same year.

Life expectancy at birth: Average duration of human life, calculated from the mortality rates in effect at the time of birth.

Population growth rate: Rate at which a population is increasing (or decreasing) in a given year as a result of natural increase and net migration, expressed as a percentage of the base population.

Maternal mortality rate: Number of maternal deaths per 100,000 live births in a given year attributable to pregnancy, childbirth, or post-partum.

Net reproduction rate: Average number of daughters a woman would give birth to if during her lifetime she were to conform to the age-specific fertility and mortality rates of a given year. A net reproduction rate of 1.00 means that each generation of mothers is giving birth to exactly enough daughters to replace itself in the population.

Crude rate of natural increase: Rate at which a population is increasing (or decreasing) in a given year owing to surplus (or deficit) of births over deaths, expressed as a percentage of the base population.

Total Fertility rate: Average number of children a woman will have if she experiences a given set of age-specific fertility rates throughout her lifetime.

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IMPLEMENTATION COMPLETION REPORT
REPUBLIC OF TUNISIA
POPULATION AND FAMILY HEALTH PROJECT
(LOAN NO. 3307-TUN)

TABLE OF CONTENTS

PREFACE
EVALUATION SUMMARY

PART 1: PROJECT IMPLEMENTATION ASSESSMENT 1
A. PROJECT DESCRIPTION 1
1. Introduction........ 1
2. The project as initially designed........ 1
3. Modifications to project design........ 3
B. PROJECT EVALUATION........ 3
1. Objectives........ 3
(a) Contraceptive prevalence........ 3
(b) Health status of women and children in rural areas........ 4
2. Strategies........ 4
(a) MCH/FP services........ 4
(b) BHC targeting of underserved services........ 5
3. Implementation........ 5
(a) Integration of MCH/FP services........ 5
(b) Expansion of outreach/mobile services........ 6
(c) Improvement of first referral level........ 6
(d) Quality enhancement........ 6
4. Major factors affecting the project, and key lessons learned........ 7
(a) A project fully consistent with the Government's strategy........ 7
(b) A weak information and monitoring system........ 8
(c) Human resources........ 8
5. Key Lessons learned and applied to future operations 8
6. Borrower and Bank performance... 9
C. SUSTAINABILITY AND FUTURE STRATEGIC ACTIONS........ 10

PART II: BORROWER'S EVALUATION........ 12
A. Borrower's Comments on Part 1 12
B. Abstract of the report from the independent evaluation committee........ 12

PART III: STATISTICAL DATA 20
Table 1: Summary of Assessments........ 21
Table 2: Related Bank Loans/Credits........ 22
Table 3: Project Timetable........ 23
Table 4: Loan Disbursements: Cumulative Estimated and Actual........ 23
Table 5A: Key Indicators for Project Implementation........ 24
Table 5B: Distribution of MPH Non-Salary Operating Budget........ 24
Table 5C: Record of Training Activities........ 25
Table 6A: Key Indicators for Project Results........ 25
Table 6B: Evolution of Population and Health Indicators, by Region........ 27
Table 7: Studies Included in the Project........ 28
Table 8A: Project Costs........ 29
Table 8B: Project Financing........ 30
Table 9: Status of Legal Covenants........ 32
Table 10: Compliance with Operational Manual Statements........ 33
Table 11: Bank Resources: Staff Inputs........ 33
Table 12: Bank Resources: Missions........ 34

IMPLEMENTATION COMPLETION REPORT
REPUBLIC OF TUNISIA
POPULATION AND FAMILY HEALTH PROJECT
(LOAN NO. 3307-TUN)

PREFACE

This is the Implementation Completion Report on the Population and Family Health Project for which the Republic of Tunisia had requested World Bank financial assistance. A loan (No. 3307-TUN) in the amount of US$26 million equivalent was approved by the Executive Directors on March 21, 1991. It became effective on October 2, 1991 and was closed on March 31, 1998, twelve months beyond the date originally envisaged, March 31, 1997. The accounts will be closed on July 31, 1998 and most of the funds will be disbursed.

The conclusions and content of this Report are based on project records held by both the Bank and the Ministry of Public Health, and on statistical data drawn from the studies and surveys conducted. They also relied on the results of the evaluation carried out by an independent evaluation committee at the request of the Ministry of Public Health. (An extract of this report is attached). The lessons to be learned from this project were debated at a workshop organized, on the initiative of the Directorate of Basic Health Care, during the final Bank supervision mission and attended by all major participants, as well as by the director of the Hospital Reform Support Project.

This Report was prepared by World Bank staff members Mmes. Claire Voltaire (MNSHD) and Janet Nassim (HDD) and Dr. Albert Salés (MNSHD), and its preliminary version discussed with the members of the Tunisian project team. Messrs./Mmes. Baudouy (MNSHD), Ellena (IFC), Jarawan (MNSHD), MacDonald (EASHN) and Pierre-Louis (MNSHD), also contributed with constructive comments.

IMPLEMENTATION COMPLETION REPORT
REPUBLIC OF TUNISIA
POPULATION AND FAMILY HEALTH PROJECT
(LOAN NO. 3307-TUN)

EVALUATION SUMMARY

The objectives of the Population and Family Health Project were to increase contraceptive prevalence and improve the health status of the population. To achieve them, the project was to strengthen family planning and maternal and child health services, and integrate them within a basic health care program that would target the most vulnerable groups, especially women and children in rural areas.

The main findings of this Implementation Completion Report are as follows:

- Virtually all proposed project activities were completed, and only minor adjustments were made during implementation. Management of the project by the Directorate of Basic Health Care was good. Project execution mechanisms proved to be appropriate and were fully adhered to. The Bank's supervision performance has been rated very satisfactory by the Government.

- Project objectives in the matter of contraceptive prevalence were achieved very early in the process. A significant improvement in the health status of women and children in rural areas, the second project goal, was also observed.

- From the strategy standpoint, family planning and mother and child health services have been substantially strengthened, and the quantitative goals set at the outset of the project (e.g. percentage of assisted deliveries) were met in most cases. The integration of services was carried out successfully and medical staff redeployed, which translated into increased quality and efficiency of services. Throughout the project period, the Government pursued its policy of reducing regional disparities, and project resources were scrupulously allocated in favor of underserved zones. However, assignments of essential health personnel did not always keep pace with the strengthening of sector infrastructure.

- The main lessons drawn from this project are: (i) the importance of fully integrating projects' objectives in the Government strategy, as testified by the project success; (ii) the need to develop realistic monitoring and evaluation mechanisms, in line with existing capacity, which was not fully achieved in the project; and (iii) the importance of harmonizing staff allocations with Government priorities, illustrated in this project by the difficulties encountered in deploying staff in remote rural areas.

- Project sustainability will be ensured by the government's continued commitment to reducing regional disparities and generalizing the integration of services. It will also depend on the Ministry of Public Health's (MPH) capacity to adapt to new conditions such as the growing importance of the private sector and the increasing need to decentralize resources and management functions. The roles of the central government and the mandates of the health facilities will have to evolve. Staff allocation to rural areas and improvements in the quality of care will need to remain high priorities for the Government during the Ninth Plan. The use of financial, human and physical resources will need to be more flexible to enable regions to evolve according to their specific needs.

IMPLEMENTATION COMPLETION REPORT
REPUBLIC OF TUNISIA
POPULATION AND FAMILY HEALTH PROJECT
(LOAN NO. 3307-TUN)

PART I: PROJECT IMPLEMENTATION ASSESSMENT

A. PROJECT DESCRIPTION

1. Introduction

1. During the 1970s and 1980s, Tunisia achieved major progress in improving access to health care, which translated into marked improvements in the health status of the population, and in a decline of the fertility rate. By the end of the 1980s, however, a certain stagnation in the fertility rate (approximately 3.5 births per woman) and the infant mortality rate (51.6 per 1,000 life births) was observed. Major differences also existed between rural and urban areas in terms of maternal and child health and fertility indicators. On the basis of experience gained from pilot projects designed to test the integration of family planning with basic health care services, the Government decided to implement the project described below.

2. The project as initially designed

2. ***Objectives:*** This project's aims were to increase the national contraceptive prevalence rate (modern methods) from 40 to 45%, and to improve the health status of the population, with particular emphasis on women and children in rural areas.

3. ***Strategies:*** To achieve these objectives, the project relied on two strategies: (i) the strengthening and integration[1] of family planning services (FP) and maternal and child health care (MCH) within the context of a program to upgrade basic health care (BHC); and (ii) targeting of BHC services on those groups in the population showing the highest fertility and mortality rates.

4. ***Components:*** The project had four components:

- Integration of MCH and FP services at BHC centers through: (i) the recruitment and redeployment of midwives in underserved areas; (ii) in-service training for midwives, paramedical personnel, and physicians to help them provide all MCH/FP services; (iii) the establishment of a Regional Family Planning Center (CREPF) in a low-income Tunis neighborhood; (iv) improved monitoring and referral of pregnant women at risk by district hospitals and rural maternity clinics; and (v) improved neo-natal health care services.

- Expansion of outreach services to increase access to MCH/FP through: (i) redeployment of National Office of Population and Family Planning (ONFP) teams to less accessible areas; (ii) reorganization of mobile teams (doctors, nursing personnel, midwives) to provide better coverage; and (iii) purchase

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[1] Depending on the interviewee, the concept of integration meant: (a) a transfer of the activities of an ONFP midwife to a BHC midwife; (b) availability, at a single center, of both FP and MCH activities; or (c) the possibility of coordinated services (coordinated as to time, place, and organizational arrangements) for the mother/baby pair.

of mobile clinics to increase coverage in sparsely populated areas not served by a health facility.

- Improvement of the first referral level of health care through: (i) provision of dental, X-ray, and laboratory services in district hospitals lacking them; and (ii) upgraded access to ambulatory specialist care by establishing five diagnostic centers in urban low-income neighborhoods.

- Enhancement of the quality of health care through: (i) the introduction of a technical, management, and maintenance in-service training program; (ii) improved supply of basic drugs; and (iii) studies to improve performance evaluation and introduce a health information system.

5. ***Inputs:*** The project provided for: (i) rehabilitation of infrastructure and equipment of BHC centers; (ii) replacement of used vehicles and additional vehicles for mobile activities in remote areas; (iii) purchase and replacement of ambulances and medical equipment (X-ray, laboratory, dental) for use at the first referral level; (iv) consulting services and purchase of teaching aids for in-service training programs for BHC personnel; (v) provision of spare parts and technical assistance to improve the maintenance of vehicles, equipment, and buildings; and (vi) technical assistance for research and evaluation.

6. ***Implementation Arrangements:*** Provision was made for: (i) appointment of a project director (the Director, Basic Health Care), with two deputies (technical and administrative), under his immediate supervision; (ii) establishment of a unit with responsibility for regular monitoring of the project; (iii) appointment of an ONFP counterpart to coordinate project activities; (iv) establishment of a project management committee chaired by the Minister of Public Health, and composed of the CEO of ONFP and representatives of the relevant MPH departments as members; and (v) appointment, by the Minister, of an independent evaluation committee.

7. ***Costs and Financing:*** The project financing plan[2] included an IBRD loan of US$26 million, and a Government contribution of US$37.2 million. The project was to be completed within five years.

8. ***Loan Agreement:*** The legal covenants governing the loan are summarized in Table 9. Effectiveness[3] of the loan was contingent upon: (i) appointment of the project director; and (ii) presentation by MPH of a Resource Allocation and Implementation Plan for year 1 of the project. The Government also undertook, *inter alia*: (i) to present a Resource Allocation and Implementation Plan every year for the following twelve months; (ii) to keep the annual growth rate of the BHC non-salary operating budget positive and at least equal to the annual growth rate of the overall MPH non-salary operating budget[4]; (iii) to make adequate foreign exchange available for the purchase of contraceptives for the FP program and for the project if external aid were not forthcoming; and (iv) to present terms of reference for a study on the BHC vehicles maintenance system by an agreed date and ensure that the study recommendations were implemented.

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[2] Project costs, including taxes and customs duties, were estimated in September 1990 at TND 57.7 million (or US$63.2 million), with a foreign currency component of TND 30.8 million (or US$36.2 million).

[3] The loan became effective 7 months after Board Presentation.

[4] This covenant was satisfied (see Table 5c). However, while its intent to protect resources allocated to basic health services was legitimate its introduction was useless as the growth of this budget (in absolute terms or as a proportion of the overall budget), does not permit evaluation of whether this level of resources enables the DSSB to respond adequately to its mandate and to the demand for its services. Moreover, the simultaneous implementation of the Hospital Restructuring project (loan 3308-TUN) which tackled financing issues of the system, was a more appropriate vehicle to monitor health system financing.

3. Modifications to the project design

9. ***Components.*** A few adjustments were introduced during project implementation: (i) the terms of reference for some of the studies were adjusted to accommodate needs and constraints existing when they were being carried out (see Table 7); (ii) training activities were funded by UNICEF and not by the Bank, as initially planned; (iii) the number of diagnostic centers was reduced to four from the initial five to remain within the allocated envelope; (iv) rehabilitation of the CREPF in its existing location, as initially planned, proved not to be feasible (since it was found to be in the path of a highway under construction), and an entirely new facility had to be built; and (v) only four of the 15 mobile clinics planned for were funded by the Bank while the remainder were financed by the European Union.

10. ***Inputs and Costs.*** The project was executed entirely within the budget allocated, but completed one year later than initially scheduled. The few cost adjustments that were necessary canceled one another out (see Table 8). Though there was no formal co-financing of the project, UNICEF financed most of the training component and other donors contributed to the financing of ONFP mobile clinics.

11. ***Implementation Arrangements.*** The project director chose to make technical monitoring of the project the responsibility of the Maternal and Child Health Division of MPH which allowed for better integration of project activities in the Ministry rather than create a new unit. An administrative unit was set up to monitor the construction and equipment contracts, which it either attended to itself or delegated to relevant departments of the Ministry. This unit was also made responsible, in conjunction with the Finance Directorate of MPH, and with the Central Bank, for financial and accounting matters relating to the Special Account. Coordination with ONFP remained on an ad hoc basis.

12. ***Loan Agreement.*** No amendments were made to the Loan Agreement itself, except to defer the loan closing date from March 31, 1997 to March 31, 1998.

B. PROJECT EVALUATION

1. Objectives

(a) Contraceptive prevalence

13. The project objective, based on the findings of the 1988 Demographic and Health Survey, was to increase contraceptive prevalence (modern methods) from 40 to 45%. According to the PAPCHILD[5] survey, the contraceptive prevalence rate is 59.7% for all methods (old and new), and 50% for modern methods only. With hindsight, this objective may have been too modest since it was achieved in the early years of the project. However, this did not deter the Government from continuing its program of increasing access to services in rural areas. In rural areas, 51.4% of women use contraception, a figure which, although still below that for urban areas (65%), does indicate considerable progress in terms of their determination to control their own fertility.

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[5] Pan Arab Project for Child Development, an initiative of the League of Arab States. The Tunisian survey was conducted by ONFP from November 1994 to January 1995. The findings, which constitute averages for the period 1990-1994, were published in 1997.

(b) Health status of women and children in rural areas

14. Existing data show encouraging improvements in national health status (see Table 6). Data on differences between urban and rural areas, although scarcer, do however indicate that disparities persist, despite the government's policy to favor underserved areas. This may be due to the influence of other factors in urban areas, such as the increasing importance of the private sector in health services delivery.

15. A recent study on **maternal mortality**[6] indicates a major decline in the maternal mortality rate to 69 per 100,000 live births compared to 192 in the early 1980s[7]. At the same time, it highlights major gaps between regions (Greater Tunis, 39.9; Central West, 105.7).

16. The PAPCHILD survey puts **the infant mortality** rate at 35 per 1,000 live births compared to 51.6 in 1985-1989, a significant decline over a short period. Child health has improved, partly as a result of almost universal vaccination coverage. However, particular attention needs to be paid to controlling diarrheal diseases and malnutrition in certain parts of the country.

2. Strategies

17. The strategies followed — improvement and integration of MCH/FP on the one hand, and targeting of underserved areas on the other — enabled the Government to fully reach its objectives and the project results. However, the indicators of the project shown in Tables 6 give only a partial picture of actual project outcome. Considering how little statistical information was available in 1990 and the problems encountered in developing the information system (see Section 4 below) and carrying out the studies planned, it is difficult to measure to what extent disparities were reduced and progress made in rural areas, or how much impact the project had in enhancing service quality. The available information is discussed below.

(a) MCH/FP services

18. Family planning and maternal and child health services were successfully strengthened and integrated (see Table 5A), thanks in particular to the redeployment of midwives, thereby enabling a more efficient utilization of services. Tunisia is one of the rare countries to have succeeded in achieving such an integration. Projects objectives have been fully reached:

- According to the PAPCHILD survey, 79% of pregnant women had the benefit of at least one *prenatal consultation* over the period 1990-1994. Knowing that the public sector covers 63% of prenatal consultations and provides 75% of all MCH services, one can estimate this rate at 84% for 1996[8], a figure very close to the project goal of 85%.

- The PAPCHILD survey also indicated that over the period 1990-1994 approximately 80% of *deliveries took place in the presence of a health worker* (65% in rural areas). These figures are below the targets set at the beginning of the project (70% in rural areas). However, the 1995 report

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[6] "National Survey on Maternal Mortality in Tunisia 1993-1994," Directorate of Basic Health Care, Ministry of Public Health.

[7] The estimation of maternal mortality in 1980 comes from the PAPCHILD survey. However, as the methodologies of the two surveys were very different, these figures should be viewed with caution.

[8] This assumption is based on the estimated rate of private sector participation given by the PAPCHILD survey of the 1990-1994 period, and therefore probably understates the real degree of private sector activity, which has expanded notably over the last five years.

by the BHC Directorate shows that the first-level public facilities alone handle 69% of assisted deliveries. Knowing that this figure excludes the private sector and tertiary maternity clinics, which are found mainly in urban districts, one can assume that the project goal was achieved.

- Estimating *postnatal consultations* coverage, assessed at 39% at the outset of the project, is even more difficult. Coverage by the public primary care facilities is 43% (consultations in the two months following delivery)[9], but no national figure is available.

(b) BHC targeting of underserved areas

19. Project investments as a whole were successfully channeled toward the country's governorates with less resources, following a methodology developed during project preparation. However, the deployment of human resources did not follow government set priorities, which somewhat lessened the impact of the investment effort. While significant progress was achieved in rural areas, similar improvements were observed in urban areas, as a result of the rapid expansion of the private sector and the easy access of the urban population to more sophisticated care. In general, the allocation of public resources could be improved to achieve greater equity by: (i) better taking into account the private sector and its potential complementarity; (ii) using regional health indicators to weigh resources allocations; and (iii) introducing a resource utilization regional performance criterion.

3. Implementation

20. Physical execution of the project was very satisfactory overall, and all planned investments were carried out.[10] All scheduled extension, renovation or construction works in 158 health centers were completed, and all the centers are currently equipped and in operation. All 560 vehicles to be purchased were delivered. ONFP is now using 15 mobile clinics (only six of which were financed from project proceeds). Fifty-seven district hospitals were rehabilitated and equipped with dental, laboratory, and X-ray units. Four diagnostic centers were built and equipped.

21. The main observations made by the project evaluation mission regarding execution of the various components of this operation were as follows:

(a) Integration of MCH/FP services

22. As a result of the project, MCH/FP services were integrated at 419 centers, a 130 % achievement of the project objective. By the end of 1996, 1,612 of the country's 1,841 health centers were offering these services, and the concept of integration is now accepted by all concerned. In operational terms, integration produced a 48% increase in family planning activities[11] during the 1992-1996 period, compared to 30% nationally. Over the same period, the number of new contraceptive users increased by 75% in the priority areas (15% nationally), while prenatal consultations increased by 30% in the priority areas (less than 17% nationally). A study on acceptance of perinatal services carried out in 1997, indicated that over 85% of women who received perinatal services were generally satisfied with the range and quality of services received[12].

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[9] Source: Basic Health Care Directorate, 1996 Annual Activities Report.

[10] See Part I (A), Section 3, for details of the few modifications to project plans during the implementation process.

[11] Expressed in terms of number of visits. Source: ONFP Assessment of Eighth Plan and 1997 Objectives.

[12] See comments from the Borrower p 12 par. 2.

23. The majority of midwives employed by the BHC Directorate have participated in a training program in non-clinical family planning, while ONFP midwives have been trained to administer pre- and post-natal care. Initial training course curricula have been adjusted to reflect these developments. At the regional level, coordination between ONFP and basic health care units has been excellent.

24. The Regional Family Planning Center (CREPF) has been established, although behind schedule and the center has been in operation since October 1997. Statistical information on its impact is not yet available. This center has been selected for the introduction of a pilot reproductive health program.

25. A system has been developed to ensure the identification of at risk pregnancies and the appropriate transfer of mothers to the higher care level. Midwives have been trained to use referral guidelines and criteria. At project start-up, the new referral system led to the transfer of an important proportion of deliveries — about one-third — to the regional level. Though the criteria for referral now seem better applied (in 1996, only 17% of cases were transferred), it may be necessary to closely monitor the characteristics of women transferred to ensure that these criteria are neither too sensitive nor misapplied.

(b) Expansion of outreach/mobile services

26. The provision of vehicles enabled the reorganization of mobile teams and therefore the expansion of services in isolated areas where assignment of permanent staff would not be cost-effective. Redeployment of ONFP midwives has made it possible to provide additional services at centers that were previously rarely, if at all served. A total of 348 new centers have been covered in isolated areas, while the frequency of MCH/FP services has been increased at 197 centers. The results are clearly apparent from the figures given in the accompanying Statistical Annexes, which show increased contraceptive use among women living in rural areas. Four mobile clinics were purchased from project proceeds, and 11 others were bought with European Union funds. These units offer a satisfactory response to user/beneficiary needs, and are complementary to the BHC network.

(c) Improvement of first referral level

27. Although all investments aimed at strengthening dental, X-ray, and laboratory services at district hospitals were made, field visits show that the necessary personnel was not always assigned to these new units. Their utilization rate is not yet known, nor is their role in attracting the population to the district hospitals concerned. Generally, district hospitals' bed occupancy rates remain low.

28. Of the four diagnostic centers (where consultations with specialists are available) built and equipped from project proceeds to relieve pressure on the hospitals, three were inaugurated in March 1998, while the Sfax center has been in operation for nearly a year. Although it is still too early to assess its impact, the directors of nearby university hospitals are already reporting less pressure on their out-patient departments. The Ninth Plan calls for the opening of other centers and the conversion of a number of district hospitals into day hospitals also providing specialist services. The establishment of these centers and day hospitals is planned as part of the regional health maps being developed which take into account potential complementarities with the private sector.

d) Quality enhancement

29. All planned training programs were completed, although two reached only part of their target groups, namely the practical internships in obstetrics for midwives and the public health diploma for

doctors (intended for regional directors and heads of primary care services). In these two instances, the workload of the personnel concerned prevented them from finding the necessary time. The impact of training on staff attitude and knowledge has been found satisfactory. These training programs could not, however, be financed by the Bank. As the per diems paid to interns under the relevant Tunisian legislation are well below the expenses they actually incur, participation in such training is not appealing, especially to lower-paid staff. In the case of the project, it was only the cooperation of UNICEF in covering training expenses that ensured the success of these training programs.

30. Little information on the health status of the Tunisian population was available at the outset of the project. Accordingly, it included plans for ad hoc studies and surveys (in 1991 and 1996), which would also provide the data required for eventual evaluation of the project. Details of their content and execution are given in Table 7. However, it was possible to carry them out only once, at the project mid point. Moreover, they were financed in the context of other projects, and could not be used, as planned, to assess the impact of this operation.

31. In the case of statistics on project activities, a major effort was made to develop a data collection system that would meet the needs of the MCH/FP program. However, reporting by individual centers remains cumbersome, and there is no systematic utilization of the data actually generated. Efforts in that area have to be sustained to simplify the system and improve its quality, reliability and relevance as a tool for decision-making.

4. Major factors which affected the project

32. The main factors that affected the project are the following:

(a) A project fully consistent with the Government's strategy

33. The Government's objective, as defined in its Eighth Five-Year Plan was to consolidate its health system by improving its efficiency, quality and efficacy of services while ensuring the system's financial sustainability. These objectives translated into a two-pronged strategy: (i) to restore the credibility of basic health services and of the first referral level; and (ii) to restructure its main tertiary hospitals to improve their efficiency, as a prerequisite to reviewing the financial burden sharing mechanisms of the system. Bank assistance to the country mirrored this approach and two projects were prepared concurrently to support these two axes.

34. The **objectives** of this project were also fully in line with the Government's policy on population matters and reduction of regional disparities. These objectives remain valid at loan closing and the Government continues its strategies of integrating health services and eliminating disparities in health status in the Ninth Five-Year Plan, which aims at integrating 90% of BHC centers by the year 2001 — i.e., all centers where it is cost-effective. This strong link to the Government strategy enabled the project to clear the few obstacles it had to face, particularly in the early years when there was some confusion regarding the definition of the term "integration", as well as reluctance on the part of some stakeholders and donors to go ahead given the mixed results of earlier attempts at integration and the fear of loss of acquired privileges.

35. The implementation of this project at the same time as a Hospital Restructuring project[13], made it possible to tackle, simultaneously, problems of ineffectiveness in the hospital sector and indirectly to protect the funding of BHC services. At the same time, the choice of having 2 separate projects simplified the design of both projects and thus improved their likelihood of being completed successfully.

(b) A weak information and monitoring system

36. The need for a better-integrated information system was already obvious to all concerned during project preparation. It was hoped the system could be streamlined to ease the administrative burden placed on service providers, to improve its quality and reliability, and to enhance data processing and analysis capacity. Despite this realization, development of a comprehensive information system was not made a component of either project. A choice was made in the case of the Hospital Restructuring project to concentrate on development of a management information system, in keeping with that project's objectives.

37. In the case of this population and family health project, however, greater attention could have been paid to: (i) capacity to carry out the studies planned, since this might have led to reducing the scope of the ambitious research program and to better targeting of its objectives; (ii) development of a flexible statistics collection system limited to a few key indicators; and (iii) the importance of close coordination between ONFP and the BHC Directorate on decisions regarding information collection, use, and analysis. Though both the MPH and the Bank became aware of these difficulties early in the project, a satisfactory remedy could not be found. The studies in progress were too complex and resource consuming to envisage their modification, and it was opted to test the information system put in place in the regions before changing it again.

(c) Human resources

38. The difficulty of finding personnel to work in isolated areas had been anticipated at the project design stage. Numerous attempts were made to mitigate this situation: financial incentives were introduced, midwives' work schedules were adjusted, and recruitment efforts were focused on groups more likely to be attracted to these areas. These measures served to improve the coverage in these areas by midwives and public health physicians, since their numbers increased, respectively, from 798 and 1106 in 1991, to 946 and 1297 in 1996. However, human resources assignment has remained very centralized, and is not always in line with stated MPH priorities. Civil Service Regulations (for example, the obligation on the Government to reassign available personnel to facilities of their choice or the regulatory work schedule) are all ill-adapted to the specific needs of the health sector. Major gains in productivity and effectiveness are potentially achievable, and steps to that end are being taken in the context of the Ninth Five-Year Plan strategy, supported by the recently approved health sector loan.

5. Key lessons learned and applied to future operations

39. Analysis has provided a number of lessons: (i) a good alignment between the project objectives and the Government strategy is key to project success; (ii) monitoring and evaluation mechanisms should be developed in line with existing capacity and permit project evaluation; and (iii) personnel allocations need to be harmonized with Government priorities.

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[13] Project financed by Loan 3308-TUN, for a comparable loan amount, was designed to improve the management of 22 of Tunisia's tertiary hospitals and provide assistance with the development of new health system financing mechanisms.

40. The recently signed Health Sector Loan (Ln 4294-TUN) takes into account the constraints encountered and lessons learned during the implementation of both the Population and Family Health project and of the Hospital Restructuring project. In particular, the project includes (i) the development of management information systems to integrate all existing efforts and develop indicators in live with the needs of decision makers at all level of the system; (ii) the introduction of a new methodology to allocate resources to regions and facilities which will provide a more transparent process for staff allocation and greater accountability of regions and facilities; and (iii) the elaboration of regional health maps which include the private sector as well as the introduction of incentives for increased partnership between the public and private sectors.

41. MOH's tradition of self-evaluation also facilitated the systematic incorporation of lessons learned from experience. Indeed, the implementation of the project under review brought to light a number of operational problems and provided opportunities to develop solutions, which were incorporated in the design of the health sector loan. For instance: (i) the adoption, in the new health sector project, of a process of delegation of credits to the regions that was tested and used for civil engineering works during this project; (ii) the examination, within the government, of ways to overcome obstacles to personnel training and ensure payment of adequate per diems to trainees; (iii) the development, prior to project launching, of a management procedures manual and a project management software program, to avoid the delays met with in launching the population and family health project; and (iv) the need for all stakeholders to be fully involved in the project from the outset.

7. Borrower and Bank performance

42. In terms of its design, the project was prepared by a competent team which assembled a detailed documentation package, used by the Bank as the basis for its appraisal of the operation. The project benefited from the concurrent preparation of a hospital reform support project and from the close coordination that existed between the teams working on the two projects. As far as formulation of their strategic framework was concerned, these two projects also benefited from very constructive participation by the then Ministry of Planning.

43. In terms of the implementation process, the performance of the project team was very satisfactory. Its hybrid management structure — an administrative management unit set up within the BHC Directorate, plus the MCH Division, the whole headed by the BHC Director in his capacity as project director — ensured availability of sound project management capacity, integration and coherence of objectives, and execution as part of the overall program of the BHC Directorate. However, this approach would have benefited, at the outset of the project, from personnel training e.g., in procurement, disbursement procedures, bookkeeping, and from the establishment of management procedures.

44. In its comments on the present report (see Part II, A), the Borrower estimated that Bank performance in terms of project monitoring and supervision has been very satisfactory. The borrower highlighted particularly the continuity in the composition of the Bank team which supervised the project, the regularity of Bank missions and in general, the availability of Bank staff, both during field missions and from headquarters. Project supervision was also the subject of an audit by the Bank's Quality Assurance Group, which gave a rating of 2 out of 4 (satisfactory). In particular, its supervision arrangements were characterized by close coordination with the hospital reform support project, and productive relationships with other donors, especially UNICEF, which financed the training component.

C. SUSTAINABILITY AND FUTURE STRATEGIC ACTIONS

45. The increase in MCH-FP activities is in great part attributable to an improved utilization of existing resources. The gradual annual increase (14% per year between 1990 and 1995) of the recurrent budget (net of salaries), attests to the system's capacity to sustain its efforts. In addition, Government subsidy to the system, which represented 86.7% of resources in 1990 is down to 76% in 1996, thanks to increasing contribution of the social security funds. Project sustainability will depend to a very large extent on MPH success in adapting the supply of health care services, both public and private, to new conditions (epidemiology, demography, and financing) and in enhancing the quality and effectiveness of services. These issues are being addressed within the context of the Ninth Plan.

46. Two factors will be key to the development of the health sector: the growing importance of the private sector, and the introduction of health insurance. They will have an impact on the demand for health care, and, by extension, on the role of the Government in sector development, and on the functions of health facilities. The leadership of MPH in the management of the health sector, including the development of national policies and strategies, coordination and monitoring of all sector concerns, and sector regulation, will undoubtedly expand. On the other hand, the Government will probably be able to reduce its role as provider of services and as manager of health facilities.

47. With regard to the delivery of health care services, the health network is now *accessible* to 95% of the population, and it is very unlikely that its extension to include the remaining 5% would be cost-effective. Coverage of that remaining percentage of the population, as scattered as it is, will therefore require innovative and more flexible strategies. To consolidate progress achieved through this project, efforts to *deploy physical and human resources* in the form of personnel and equipment in favor of underserved areas need to be intensified. Enhancement of the *quality* of care remains a major concern, and has rightly been made one of the strategic axes of the Ninth Plan. This is an area in which the project undoubtedly proved less effective than in that of equity and physical accessibility. Training, organization of health services, introduction of an appropriate incentive structure, and efficient use of both human and infrastructure resources are critical points in this regard.

48. The success of the Population and Family Health project, and the emphasis that the Ninth Plan gives to regionalization, strengthening regional hospitals, and the referral system in general, create the right conditions for an in-depth review of the role of BHC. For many years yet, the *BHC centers* will retain their primary role in preventive activities. The range of services currently offered is going to have to be expanded gradually, mainly in order to accommodate the new challenges presented by the increase in chronic and degenerative diseases. In contrast, the role of the BHC centers as providers of curative care may well be reduced significantly in the near future owing to the introduction of health insurance and the growing importance of the private sector. As for *district hospitals*, their place in the health system needs to evolve. They do not respond satisfactorily either to the needs of the patients (their utilization rate is very low, and their role as first referral points is often short-circuited), or to minimum criteria of quality/reliability, cost-effectiveness, or efficient resource use. Their function and mandate will need to be reassessed in the near future. A considerable degree of flexibility and a process of gradual adaptation will be essential if these facilities are to respond adequately to the specific needs of their region. The future of the *rural maternity clinics* is also a matter of great concern, from the point of view of the quality and reliability of the services they provide and also from that of their cost-effectiveness. Other available options need to be examined, within the context of regionalization and conversion of the district hospitals.

49. Finally, development of the health system along these lines will have important implications for the use of financial, human, and physical resources. A flexible approach that enables the regions to adapt their health system to their needs will be indispensable. Changes in the present system will also have to be introduced very gradually, and, once again, in accordance with the regions' specific needs and socio-demographic characteristics. These issues are being addressed as part of the work being carried out in the Health Sector loan to renovate the referral system and regionalize the health care network.

PART II: BORROWER'S EVALUATION

A. BORROWER'S COMMENTS ON PART I

The Ministry of Public Health provided extensive comments on an earlier draft of this report and these comments have already been incorporated. Additional comments from the Ministry, received on May 4, 1998 are as follows:

1. Bank Performance

The Bank's performance, in terms of supervision, has been rated very satisfactory by the government.

Indeed, the Bank's supervisory team displayed continuity and regularity in their visits which were always well organized and meticulously carried out.

Their understanding of the Tunisian reality and the country's health priorities, as well as their great interest in supporting Tunisia in its development efforts, were all highly appreciated.

Field visits, carried out by the Bank team with keen interest, enabled it to remain acquainted with day-to-day activities and to get first-hand understanding of the project's achievements.

The Supervisory team was always available, whether during its visits to Tunisia, or whenever it was called upon at the Bank's headquarters to provide assistance in solving problems encountered during project implementation.

2. Project Implementation

A 1997 opinion survey on perinatal services shows that 67.5% of women surveyed rated consultation services as appropriate, and 18.8% considered them to be fairly appropriate. The remaining 11.4% considered that they were not appropriate. When the response was negative, it was very rare that the women's relationship with the midwife was the cause of their dissatisfaction.

It also appears as if these opinions do not significantly affect women's decisions about prenatal visits. Indeed, 88.6% of women who considered consultation services inappropriate, continued consultations, compared to 89.6% of those who considered the conditions appropriate.

B. ABSTRACT OF THE REPORT FROM THE INDEPENDENT EVALUATION COMMITTEE

The following document is a translated extract of the report prepared by the independent evaluation committee upon request of the Ministry of Health. The full document, dated February, 1998, is available in French, in Project files and includes a description of the project, of the evaluation methodology and of the project's output.

I. MOTHER AND CHILD HEALTH

1. Coverage

The indicators measuring maternal and child health care coverage are as follows, according to the findings of the PAPCHILD survey, which has the advantage of being based on a representative sample (and therefore of not suffering from the shortcomings of the conventional system of information gathering):

(1) *Prenatal coverage consisting of at least one prenatal consultation*: A national figure of 79% (89% in urban areas and 69% in rural areas).

(2) *Assisted delivery*: A national figure of 80% (93% in urban areas and 65% in rural areas).

(3) *Vaccination coverage*: These comparative figures, based on monitoring of vaccinations at public health facilities, reflect the vaccination history of infants approaching their first birthday:

	1995	1991 (national survey)
	%	%
DPT (3 doses)	92.2	91
OPV (3 doses)	92.2	91
HBV (3 doses)	76.8	---
BCG	89.4	99
Measles	91.0	92
Fully vaccinated on schedule	89.4	89

The 1995 figures reflect only vaccinations at public sector health facilities. They do not take account of private sector vaccination activity, estimated at between 3% and 5% according to the 1991 national survey of vaccination coverage. The figures given above for 1991, on the other hand, reflect both public and private sector vaccination activities.

2. Infant Mortality

Infant mortality figures are as follows:

Trends in Infant Mortality, by Region
(per 1,000 live births)

Region	1984	1989	1991	1995
District of Tunis	37.3	32.2	30.3	21.5
Northeast	41.3	35.6	33.6	28.4
Northwest	62.7	54.1	51.0	36.0
Central West	64.1	55.3	52.1	37.8
Central East	43.7	37.7	35.5	26.0
Southwest	71.0	61.0	57.4	38.8
Southeast	71.0	61.0	57.3	35.6
National	**51.4**	-	-	**30.6**

Source: National Institute of Statistics

As this table shows, there has been a steady decline in infant mortality in all regions of the country, indicating better health care, and better targeting of care, for this age group.

3. Perinatal Mortality

Perinatal mortality is currently estimated at 30 per 1,000 births nationwide, with the rate being highest among newborns.

Neonatal mortality (based on PAPCHILD survey data):

	Neonatal mortality rate over last five years (per 1,000 live births)
National	22.3
Urban	14.0
Rural	30.7

Perinatal mortality in hospitals: The data available cover maternity clinics in Tunis and Bizerte. Regardless of the source of information, the neonatal mortality rate is in excess of 20 per 1,000. Perinatal mortality is high, at over 40 per 1,000.

	Neonatal Mortality Rate (per 1,000 per year)	Stillbirth Rate (per 1,000 per year)	Perinatal
Tunis (CMNNR)	28	27	55.8
Bizerte	21.37	20	40.8
Tunis (Habib Thameur)	-	12.6	-
Medenine	-	-	40.49

Causes of death of newborns: Perinatal respiratory failure, respiratory infections, and congenital malformations are the main causes of early neonatal mortality, largely preventable by improving quality of care.

Causes of Neonatal Deaths

Causes of Death	Bizerte Hospital	CMNNR Hospitals	H. Thameur Hospital
Respiratory distress	44.40%	22.39%	68.96%
Perinatal respiratory failure	37.50%	14.15%	-
Neonatal infection	7.89%	22.50%	-

4. Maternal Mortality

According to national survey data, totals of 140 maternal deaths and 203,193 live births were registered for the twelve months of 1993. The meanings of the term "maternal death" are consistent with the definition given in the International Classification of Diseases (ICD - 10), and the corresponding figures are as follows:

(a) Death during the course of pregnancy or within 42 days after delivery, regardless of length of term or location: 69 per 100,000 live births.

(b) Death, all causes: 75.79 per 100,000 live births.

(c) Death occurring more than 42 days after the end of pregnancy, all causes without assuming link to childbirth : 17.7 per 100,000 live births.

Maternal deaths, by urban/rural area: Deaths in rural areas account for 52% of all deaths, although the rural population makes up only 39% of the total population.

Maternal mortality, by region: Tunisia's economic regions have been used as the basis for calculating its maternal mortality rate for the following reasons: the number of maternal deaths registered varies significantly from year to year, and may be absorbed in the general death rate when the number of [maternal] deaths recorded is low, which is what occurs in the majority of governorates; the likelihood of women who are pregnant or nearing delivery to move, for reasons of transfer or referral, from more remote areas to the vicinity of regional and university maternity clinics; and the fact that such transfers are generally to the administrative seat of the home governorate or to another (the nearest) governorate.

Region	**Deaths**	**Live Births**	**Maternal Mortality Rate per 100,000 Live Births**
Greater Tunis	16	40028	40
Northeast	13	25789	50.5
Northwest	24	25519	94
Central West	37	34993	105.7
Central East	25	43534	57.4
Southeast	13	20393	62.4
Southwest	12	12937	92.8
National	**140**	**203193**	**68.9**

If one thinks of Tunisia as divided into two macro-regions, the East (Greater Tunis, Northeast, Central East, and Southeast) and the West (Northwest, Central West, and Southwest), a very clear disparity becomes evident: the maternal mortality rate in the West is double that in the East.

Region	**Maternal Mortality Rate per 100,000 Live Births**
East	51.6
West	99.4
National	**69.0**

Maternal mortality increases with the fertility rate in most regions. However, two regions, Northwest and Central East, show "discordant" patterns: the Northwest has a relatively low fertility rate and a high maternal mortality rate, while the reverse is the case in the Central East. High fertility is certainly a risk factor for maternal mortality, but the latter is also influenced by other factors, of a socioeconomic and health nature.

Maternal Mortality and Fertility Rates

Region	MM Rate per 100,000 Live Births	Fertility Rate (per 1,000)
Greater Tunis	40	80.5
Northeast	50.4	83.5
Northwest	94	80.5
Central West	105.7	112.5
Central East	57.4	92.6
Southeast	62.4	100.3
Southwest	92.8	102.5
National	**69**	**91**

Maternal mortality by region compared with infrastructure and personnel (I & F) ratio: The distribution of regional and university maternity clinics providing a broad range of obstetrical care goes hand in hand with non-uniform variation in the maternal mortality rate. Three groups can be distinguished among the regions:

- regions with an MM rate lower than the national average and an I & F ratio higher than or equal to the national average;
- regions with an MM rate higher than the national average and an I & F ratio lower than the national average;
- regions with an MM rate higher than the national average and an I and F ratio higher than the national average.

Thus, with the same level of I and F per 500,000 inhabitants, Northeast, Greater Tunis, and Central East have lower MM rates than Southwest and Northwest.

Region	MM Rate per 100,000 Live Births	Reg. & Univ. Maternity Clinics per 500,000 inhbtnts.	Maternity Clinics (3 Levels) per 500,000 inhbtnts.	Midwives (10,000)
Greater Tunis	40	1.64	2.74	6.02
Northeast	50.4	1.95	7.06	6.70
Northwest	94	2.0	13.0	6.85
Central West	105.7	1.15	8.1	5.59
Central East	57.4	2.67	9.37	7.82
Southeast	62.4	2.99	9.6	4.95
Southwest	92.8	2.84	14.02	6.00
National	**69**	**1.65**	**8.7**	**6.45**

II. FAMILY PLANNING

1. Contraception

Contraceptive prevalence (modern methods) rose from 40% at the beginning of the project to 49.6% in 1994 (IUD, 25.4%; tubal ligation, 12.4%; pill, 7.3%; other modern methods, 4.5%). Among married women of reproductive age, 9.9% use natural methods. The overall contraceptive prevalence rate is 59.7%. Over the period 1993-1994, in the Central West and South regions, the rate of recruitment of new female users of contraception increased by 13.5% compared to 7.8% in the other regions. This demonstrates the positive impact of efforts in the Center and South.

Region	1994 PAPCHILD (1)	1988 EDS (2)	Relative Deviation (1) / (2) x 100
Greater Tunis	69.8	63.9	109
Northeast	65.0	57.1	113
Northwest	61.5	51.3	119
Central East	60.6	48.8	124
Central West	45.6	31.5	144
Southeast	49.6	-	-
Southwest	49.7	41.4	119
National	**59.7**	**49.8**	**119**

The increase in contraceptive prevalence by socioeconomic region from 1988 to 1994 is seen to be significant. The relative deviation, estimated at 119% on the national level, reaches 144% in Central West, which showed the lowest prevalence in 1988. Southwest comes after Central East, with a relative deviation of 119%. Thus, growth in the contraceptive prevalence rate was greatest in regions that were disadvantaged in 1988.

2. Impact

Total fertility rate: An examination of TFR trends by socioeconomic region from 1991 to 1994 reveals those regions that were disadvantaged prior to project start-up to have been those that advanced most. The disparities referred to cannot be explained solely on the grounds of resource availability, which was virtually the same as in Northwest and Central West/South.

Birth rate: The birth rate declined from 25.2 per 1,000 inhabitants in 1992 to 22.7 in 1994.

This decline was noted in all regions of the country (Table 6B) but was greater in Central West (-3.2), Southeast (-3.7), and Southwest (-2.6). These are the regions that had the highest birth rates and where the family planning effort was intensified under a policy calling for integration of FP activities and health care, dissemination of information, and allocation of resources (mobile clinics).

COMMENTS AND RECOMMENDATIONS

The following comments are based on interpretations of statistical data and information gathered from health centers, and on discussions with officials interviewed.

1. It is evident from the information in our possession that execution of the various physical components of the project was a success, since training, civil engineering, equipping, and vehicle purchasing activities were completed on schedule and often with implementation rates higher those set in the official project documents.

2. The increase in human resources, although below the level planned, appears to us to reflect a major effort. Recruiting needs to continue, however, and particularly for the priority regions.

3. In the area of service delivery, despite the additional numbers of doctors and midwives brought in, we note that: the average number of consultations per inhabitant per year remained virtually unchanged (0.93 in 1991, 0.98 in 1994); the average number of prenatal consultations rose only from 1.74 in 1993 to 1.78 in 1994; and the average number of FP consultations per working day fell from 5.20 in 1991 to 4.48 in 1994.

These figures can be interpreted as indicators of better coverage in the form of both medical and prenatal consultations (more doctors and midwives providing the same number of consultations per patient [but for a higher total number of patients]). In addition, the centers providing these services in 1991 were heavily used, while from 1992 onwards centers were less heavily used, which explains the fall in average figures.

4. The integration of FP activities into basic health care clearly resulted in an increase in health personnel productivity, since ONFP staff could be assigned to cover other centers. This strategy, felt to be a necessity as far as the regions were concerned, and which led to much more extensive implementation rates than originally anticipated for the project, should be reinforced. The aims should be integration of MCH and FP activities at all health centers, and involvement of more public health physicians in these activities.

5. Regarding the move to review and standardize data collection practices, it is important to intensify supervision so as to ensure that instructions are understood and applied properly in real life. Such supervision, coupled with a strategy of in-service training, is made all the more necessary by the fact that the turnover in trained personnel is quite high.

6. At the time of our inspection visits to a number of health centers, we did not observe any lack of either essential drugs or contraceptives.

7. As to the final impact of the project, whether in terms of activities or especially of material results, its outcomes cannot be individualized, since they contributed to a larger policy on basic health care. Nevertheless, its objectives, especially those for which goals were set, were in general either achieved or exceeded (infant mortality, FP coverage rates, fertility rates, etc.).

8. In conclusion, our recommendations are to:

8.1 Ensure the sustainability of the gains attributable to this project by setting up an equipment depreciation program. Since most of the equipment purchased with loan proceeds, especially motor vehicles, replaced dilapidated equipment, this program should include maintenance and replacement plans.

8.2 Conduct a critical study of the information system (covering equipment, personnel, activities), and arrive at a consensus on the documentation to be used. The documents and information circuits currently in use need to be reviewed, as does the quality (reliability) of basic data.

8.3 Institute a permanent supervision and in-service training program.

8.4 Draw up more explicit project-specific evaluation criteria that can be used with possible future projects, at the same time prescribing types of data, frequency, and information sources. These criteria should not be of the general kind, difficult to interpret.

8.5 Continue to focus efforts on the country's west and south regions, where, despite undeniable advances, a number of health indicators have still not improved as much as in the coastal regions.

PART III: STATISTICAL DATA

Table 1 : Summary of Assessment
Table 2 : Related Bank Loans/Credits
Table 3 : Project Timetable
Table 4 : Loan Disbursements: Cumulative Estimated and Actual
Table 5A: Key Indicators for Project Implementation
Table 5B: Distribution of MPH Non-Salary Budget
Table 5C: Record of Training Activities
Table 6A : Key Indicators of Project Results
Table 6B: Evolution of Population and Health Indicators, by Region
Table 7 : Studies Included in the Project
Table 8A : Project Costs
Table 8B : Project Financing
Table 9 : Status of Legal Covenants
Table 10 : Compliance with Operational Manual Statements
Table 11 : Bank Resources: Staff Inputs
Table 12 : Bank Resources: Missions

Table 1 : Summary of Assessment

A. Achievement of objectives	Substantial	Partial	Negligible	Not applicable
Macro policies	☐	☐	☐	☑
Sector policies	☑	☐	☐	☐
Financial objectives	☐	☐	☐	☑
Institutional development	☑	☐	☐	☐
Physical objectives	☑	☐	☐	☐
Poverty reduction	☐	☑	☐	☐
Gender issues	☑	☐	☐	☐
Other social objectives	☑	☐	☐	☐
Environmental objectives	☐	☐	☐	☑
Public sector management	☐	☐	☐	☑
Private sector development	☐	☐	☐	☑
Population	☑	☐	☐	☐
Health	☑	☐	☐	☐
Reduction of disparities	☐	☑	☐	☐
Integration of MCH/FP services	☑	☐	☐	☐

B. Project sustainability	Likely	Unlikely	Uncertain
	☑	☐	☐

C. Bank performance	Highly satisfactory	Satisfactory	Deficient
Identification	☐	☑	☐
Preparation assistance	☐	☑	☐
Evaluation	☐	☑	☐
Supervision	☑	☐	☐

D. Borrower performance	Highly satisfactory	Satisfactory	Deficient
Preparation	☐	☑	☐
Execution	☐	☑	☐
Covenant compliance	☐	☑	☐
Operation (if applicable)	☐	☐	☐

E. Assessment of outcome	Highly satisfactory	Satisfactory	Unsatisfactory	Highly unsatisfactory
	☑	☐	☐	☐

Table 2 : Related Bank Loans

Loan/Credit Title	Purpose	Year of Approval	Status
Previous Operations			
First Population Project (Credit No. 288-TUN; US$4.8 million	This project aimed to improve access to FP and MCH services by financing: (a) construction of 4 maternity clinics and 24 MCH centers, and expansion of Avicenne Paramedical Training College; (ii) technical assistance with paramedical training and the MCH/FP program.	1971	Completed
Second Population and Health Project (Loan No: 2005; US$12.5 million)	This project aimed to integrate FP services with preventive and curative care, and nutrition and health/hygiene education services in 8 governorates. Components : (i) construction and/or rehabilitation of 140 infirmaries, 325 health centers; (ii) reinforcement of MPH management through introduction of an MIS; (iii) implementation of national health education program; and (iv) creation of a training system (system infrastructure plus training and deployment of public health personnel in project target areas).	1982	Completed
Operations under way and in preparation			
Hospital Reform Support Project (Loan 3308; US$30 million)	This project supports the Government's reform program by (i) upgrading internal effectiveness and quality of services and introducing cost control in the 22 principal hospitals; (ii) preparing for the introduction of new financing mechanisms by developing an ability to generate data linking utilization of hospital services to contributions from insured individuals and low-income groups.	1991	Completion expected in March 1999
Health Sector Loan (in preparation, start-up planned for early 1998, US$50 million).	This project is designed to extend the objective of improving internal effectiveness and efficiency and enhancing quality throughout the health system, especially its second (i.e. regional) level, and to assist with development of the management and health information system.	Start-up planned for early 1998	Completion expected in 2002

Table 3 : Project Timetable

Steps in project cycle	Date planned	Actual date
Identification		6/05/89
Preparation		10/11/89
Appraisal		10/22/90
Negotiations		1/28/91
Board presentation		3/21/91
Signature		5/22/91
Effectiveness		10/2/91
Project completion	9/30/96	9/30/97
Loan closing	3/31/97	3/31/98

Table 4 : Loan Disbursements:
Cumulative Estimated and Actual
(in millions of US$)

	FY92	FY93	FY94	FY95	FY96	FY97	FY98
Appraisal estimate	0.2	4.4	12.2	20.2	24.6	26.0	26.0...
Actual	2.0	2.0	6.8	11.9	16.7	22.5	24.85*
Actual as % of estimate	1000	45.4	53.0	58.9	67.9	86.7	95.6 *
Date of final disbursement							July 30, 1998

* As of may 22, 1998.

Table 5A: Key Indicators for Project Implementation

Key implementation indicators in SAR	At project start-up	End of Project Objective	Latest Data
Percentage of centers with integrated MCH/FP services[14]	16%	40%	87.5%
Percentage of participants in in-service training, by module	See Table 5C	See Table 5C	See Table 5C
Growth in non-salary operating budget allocated to BHC	See Table 5B	Positive growth, higher than growth in non-salary operating budget of MPH	See Table 5B

Table 5B: Distribution of MPH Non-Salary Operating Budget (in millions of DT)

	MPH Budget		First-Level Budget									
			TOTAL		Dist. hosps.		BHCC		Preventive Medicine		ONFP	
	TND M	Growth	TND M	Growth	TND M	Growth	TND M	Growth	TND M	Growth	TND M	Growth
1990	70.515		23.239		9.185		10.436		2.303		1.315	
1991	84.348	19.6%	28.843	24.1%	11.563	25.9%	13.095	25.5%	2.875	24.8%	1.310	-0.4%
1992	92.453	9.6%	31.966	10,8%	13.153	13.8%	14.426	10.2%	3.000	4.3%	1.387	5.9%
1993	104.054	12.5%	35.793	12.0%	14.784	12.4%	16.227	12.5%	3.200	6.7%	1.582	14.1%
1994	114.422	10.0%	38.405	7.3%	16.943	14.6%	15.903	-2.0%	3.900	21.9%	1.659	4.9%
1995	124.965	9.2%	44.526	15.9%	16.583	-2.1%	20.105	26.4%	6.000	53.8%	1.837	10.7%
Average Annual Growth		12%		14%		13%		15%		22%		7%

Source: MPH (*DTH*)

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[14] The current level can be ascribed to the combined effect of: (a) transfer of the responsibilities of ONFP midwives to BHC Directorate midwives at 419 centers instead of the 320 anticipated; (b) expansion of range of services provided by ONFP midwives to include MCH/FP services; and (c) major efficiency gains following reorganization of mobile-service circuits.

Table 5C : Record of Training Activities up to September 15, 1997

	1990	1991	1992	1993	1994	1995	1996	TOTAL	TARGETS	REMARKS
PUBLIC HEALTH DIPLOMA:									ONFP regional directors, heads of regional departments, executives, and delegated representatives	In addition to the regional officials targeted, 50 public health physicians also took this training
Goal	0	0		13	19	18	16	69		
Actual			9	8				17		
Actual/Goal (%)				52				25		
MANAGEMENT OF DISTRICTS										
• Training of trainers										
Goal				20	20			20		
Actual				0	24			24		
Actual/Goal (%)				0	120			120	105 MPH [staff]; 68 sector executives; 64 pharmacists; 23 delegated representatives	This training reached almost all targets and is regarded as sufficient.
• Training for District officials (6 days)										
Goal			62	0	92	92	41	260		
Actual			42	0	96	81		219		
Actual/Goal (%)					104	88		84.2		
MATERNAL AND CHILD HEALTH										
• Training of trainers (2 weeks)										
Goal				20			20			
Actual				20			20			
Actual/Goal (%)				100			100			
• Training MPH (6 days)										
Goal			134	0	200	200	54	734	Doctors attached to BHCCs	Initial target of 1200 cut back to 734
Actual			134	127	221	198	73	753		
Actual/Goal (%)			100		110	99	135	102		
PERINATAL CARE									1200 midwives and obstetrical nurses	Training completed. It will now be incorporated into regional in-service training programs for midwives.
• Prenatal (3 days)										
Goal	288	400	300	170	120	110		1200		
Actual	273	304	231	162	113	101		1210		
Actual/goal (%)	94.8	76	77	95.3	91.8	91.8		101		
• Delivery/neonatal care (4 days)										
Goal		564	300	120	100	50		1200		
Actual		561	376	113	121	7		1314		
Actual/Goal (%)		99.5	125	94.2	121	14		108.5		
• Postnatal FP (4 days)										
Goal			600	350	140	159		1200		
Actual			707	229	111	153		1251		
Actual/Goal (%)			118	65.4	79	96.2		104		

Table 5C : Record of Training Activities up to September 1997 (continued)

	1990	1991	1992	1993	1994	1995	1996	TOTAL	TARGETS	REMARKS
ORST IN-SERVICE PRACTICAL TRAINING (FAMILY PLANNING IN PLACE OF FAMILY HEALTH)									600 midwives and obstetrical nurses	In view of midwives' professional and family constraints, the goal for 1996 was limited to 150.
Goal			158	143	120	120	50	600		
Actual			106	98	75	62	63	408		
Actual/Goal (%)			66	69	62.5	124	126	68		
IN-SERVICE PRACTICAL TRAINING IN NORMAL BIRTHS AND RESUSCITATION OF NEWBORNS (1 month) FOR MPH										
Goal		73	180	123	20	10		240	240 doctors	
Actual		17	86	69	58	33		263	Rural maternity clinics	
Actual/Goal (%)		73.9	47.7	56	290	330		109.5		
TRAINING FOR REGIONAL AND DISTRICT SUPERVISORS (48 days)									Regional and district inspectors	
Goal				60	70	23		128		Training completed
Actual				39	76	22		137		
Actual/Goal (%)				65	108	95		107		
X-RAY EXAMINATION TECHNIQUES (2 months)									Radiology technicians	Training replaced by recruitment of qualified technicians
Goal				7	7					
Actual				0	0					
Actual/Goal (%)				0	0					
LABORATORY TECHNIQUES (11 weeks)									Laboratory technicians	
Goal					10			10		
Actual					7			7		
Actual/Goal (%)					70			70		
ROLE OF PARAMEDICAL PERSONNEL IN MCH									Paramedical personnel (1500)	
Goal		230	460	200				1500		
Actual	266	414	385	448	180			1647		
Actual/Goal (%)		180	83.7	224				110		
INFORMATION FOR SOCIAL WORKERS ON MCH/FP PROGRAMS									Social workers	Initial target of 250. Social workers are provided with information on MCH by the Ministry of Social Affairs.
Goal				250	40			250		
Actual				210	826			1036		
Actual/Goal (%)				84				414		

Table 6A: Key Indicators for Project Results

Key operating indicators in SAR	At project start-up %	End of Project Objective %	Latest Data %
1. Contraceptive prevalence (modern methods)	40	45	50.0[15]
2. Prenatal care coverage (at least one visit)	67	85	84.5[16]
3. Proportion of pregnant women receiving at least 4 prenatal visits	21	40	43.2[15]
4. Postnatal care coverage	39	50	53.7[15]
5. Proportion of assisted deliveries in rural areas	59	70	68.0[15]
6. Consultations for under-five-year-olds in 75% of centers offering vaccination services		70	

[15] Source: PAPCHILD Survey. Average for 1990-1994.

[16] CAP Survey on Perinatal monitoring; DBHC - 1997

Table 6B: Evolution of Population and Health Indicators, by Region

Indicators, by region	Prior to project	Most recent Year
Greater Tunis		
Maternal morality rate[17]	3.3	40
Infant mortality rate[18]	2.89	21.5
Total fertility rate[19]		2.46
North East		
Maternal mortality rate		50.4
Infant mortality rate	33.6	28.4
Fertility rate	2.86	2.62
North West		
Maternal mortality rate		94
Infant mortality rate	51.0	36
Fertility rate	3.1	2.59
Central East		
Maternal mortality rate		105.7
Infantile mortality rate	35.5	26.0
Total fertility rate	3.46	2.89
Central West		
Maternal mortality rate		57,4
Infantile mortality rate	52.1	37.8
Total fertility rate	4.62	3.85
South East		
Maternal mortality rate		62,4
Infantile mortality rate	57.3	35.6
Total fertility rate	4.50	3.34
South West		
Maternal mortality rate		92,8
Infantile mortality rate	57.4	38.8
Total fertility rate	4.25	3.34
Tunisia		
Maternal mortality rate		69
Infantile mortality rate	45.3	30.6
Total fertility rate	3.38	2.87

[17] Per 100,000 live births. Sources: PAPCHILD average for 1990-1994 and MPH Maternal Mortality Survey 1993-1994.

[18] 0/00. Source: National Institute of Statistics, 1991 and 1995

[19] Source: Population and Family Health Program: Advances and Perspectives, ONFP, January 1997

Table 7: Studies Included in the Project

Study title/execution period(s)/funding	Purpose as defined at appraisal/redefined	Status	Impact of study
Maternal and Perinatal Mortality in Tunisia 1991-1992 and 1996 Funding: WHO, UNICEF, Tunisia	- Determine maternal mortality rate. - Identify causes and determining factors in maternal deaths.	Only one study was carried out, covering 1993-1994. Presentation of findings, May 1996.	This exhaustive study could be carried out only once, at the project mid point, and therefore does not provide a basis for assessing the impact of the project. However, its findings have proved very useful, since they: (a) provide a recent measure of maternal mortality; and (b) identify the main causes of that mortality. This exercise also led the Government to decide to institute a permanent system of recording maternal deaths.
Prevalence of Disabilities in Children Aged from 36 to 60 Months Associated with Respiratory Failure in the Newborn 1991 and 1996 Funding: Gvt.	Identify and describe the disabilities associated with prenatal ischemia and with peri- or postnatal ischemia-respiratory failure.	A single study was carried out in conjunction with the Institute for Promotion of the Handicapped. Final report presented in March 1995.	Diagnostic study based on study on data from Project's first year.
Combined Study on MCH/FP, KAP (Know-ledge/Attitude/Practice), and Public Acceptance and Opinion of Integrated MCH/FP Services 1991 and 1996 Funding: PanArab and WHO	- Determine rates of coverage for the different types of MCH/FP activities. - Evaluate the nutritional status of children under five years of age. - Evaluate the quality of services provided. - Analyze user KAP and user opinion of integrated MCH/FP services.	Because of cost constraints and the BHC Directorate's inability to carry out many studies simultaneously, it was decided to use the data from the PAPCHILD survey conducted by ONFP. KAP Study: in progress, with findings anticipated for early 1998.	Although the PAPCHILD data are useful, they do not provide a foundation on which to measure the impact of the project because: (i) they are based on 1990-1994 averages which do not coincide with the project execution period (so that the raw data could not be utilized); and (ii) the sample size does not allow analyses on the regional level, thus limiting its operational validity.
Analysis of Patient Flows at BHC Centers Types III and IV 1991 and 1995	Evaluate the impact of the project on patient flows at type III and type IV BHC Centers.	Data collected 1992-1993 and available 1994.	No analysis of study data was performed as the initial purpose of the study was considered to have been unclear.
Prescription Practices at BHC Centers 1993-1994	Analyze doctors' medical prescription practices. Assess prescription costs and the extent of user medication needs.	Execution of this study was deferred owing to launching of a comprehensive study on medication use in public health facilities. Findings are expected to be available in early 1998.	
Evaluation of Vehicle, Equipment, and Building Maintenance 1992	The purpose of this study, initially to make a cost-benefit comparison of maintenance by MPH itself and subcontracted maintenance, was later redefined when the MPH decided to make as much use as possible of private sector services. The study was limited to recommending the principles that should be followed with respect to BHC Center maintenance.	The study as redefined was incorporated into a broader study on the MPH, which was completed successfully.	The impact of this study on the first level of care is still not discernible. However, the maintenance function is no longer perceived as fraught with problems, doubtless because of the greater responsibilities placed on the district authorities in this regard.

Table 8A: Project Investment Costs[21]

	DT million			DT million		
	Local	Foreign	Total	Local*	Foreign*	Total
I. INVESTMENT COSTS						
A. Civil Works	3.4	3.4	6.8	4.3	4.2	8.5
B. Equipment	2.2	5.2	7.4	3.0	7.0	10.0
C. Vehicles	5.8	7.1	12.9	7.9	9.6	17.5
D. Expert Services	0.2	0.0	0.2	-	-	0.0
E. Training	1.0	0.0	1.0		0.5	0.5
Sub-Total	12.6	15.7	28.3			NA
Physical contingencies	0.8	1.1	1.9			NA
Price contingencies	12.6	3.4	6.0			
TOTAL PROJECT COSTS	**16.0**	**20.2**	**36.2**	15.2	21.3	36.5

* Foreign exchange content based on evaluation estimate.

[21] Cost increases were due to: (a) construction costs of new centers (TND 370 per m2 instead of the TND 300 per m2 estimated) and an increase in their size (former Type II, 100 m2, replaced by new Type A,180 m2; former Type III, 162 m2, replaced by new Type B, 230 m2); and (b) construction costs of diagnostic centers, which were built rather than renovating existing facilities. These increases were offset by: (a) tight control of civil engineering costs, and maintenance or lowering of initial renovation costs because such programs were carried out by small contractors; (b) very open competition for procurement of medical equipment, resulting in very competitive prices; (c) UNICEF's agreeing to finance training; (d) separation of the intermediate centers into two phases, with only the first phase being funded form project proceeds; (d) a favorable yen/TND exchange rate on purchase of vehicles and (e) a favorable dollar/TND exchange rate.

Table 8B: Project Financing (Investment costs)

Source	Appraisal estimate (US$ million)*			Actual/latest estimate (US$ million)*		
	Local costs	Foreign exchange costs	Total	Local costs	Foreign exchange costs	Total
World Bank		26.0	26.0	4.7	21.3	26.0
Government	6.3	10.2	16.5	1.2	11.8	13.0
Total	6.3	36.2	42.5	5.9	33.1	39.0

*- Table includes investment costs only for comparison purposes as data on incremental recurrent costs are not available.

- Actual costs expressed in dollars, have been estimated by using the annual average exchange rate and assuming a pattern of disbursement for local costs similar to Bank loan pattern.
- Foreign exchange content is based on appraisal estimates.

Table 9: Status of Legal Covenants

Section[21]	Covenant type[22]	Present status[23]	Original fulfillment date	Revised fulfillment date		Comments
3.02	05	C	10/02/1991		Establishment and continuity of Project Implementation Unit and appointment of its director	Complied with; great stability of Unit officials throughout course of project.
3.03/1	12	CD CD	12/31/1991 12/31/1992		Preparation of TORs for study on BHC medical prescription and dispensary practices Completion of study	Existence of TORs did not guarantee completion of the study on schedule.
3.03/2	12	C CD	12/31/1991 12/31/1992		Preparation of TORs for study on maternal and perinatal mortality Completion of study	
3.03/3	12	CD CD	12/31/1991 12/31/1992		Preparation of TORs for study on user acceptance and perception of FP/MCH services as part of BHC Completion of study	Replaced by PAPCHILD survey; delays linked to prior completion of population census.
3.03/4	12	C CD	12/31/1991 12/31/1992		Preparation of TORs for study on improved neonatal resuscitation and measures at maternity clinics to prevent handicaps Completion of study	
3.03/5	12	C CD	12/31/1991 12/31/1992		Preparation of TORs for study on patient flows Completion of study	
3.03/6	12	CD CD	12/31/1991 12/31/1992		Preparation of TORs for study on maintenance of vehicles, equipment and plant Completion of study	
3.04	09	C	10/31 of each year	10/31/1997	Remittal of annual report to Bank and discussion of Bank's conclusions	Complied with systematically each semester prior to supervision mission visit.
3.05a	11	C	12/31 of each year		Remittal to Bank of resource allocation arrangements and execution plans annually from 1992 to 1997	Information on personnel deployment not provided.
4.01	01	CD			Audits of accounts	Although very comprehensive, audit reports were remitted up to 12 months after fiscal year closing dates.

[21] Section of Loan Agreement

[22] 1: Accounts/audits; 2: Financial performance/revenue generation from beneficiaries; 3: Flow and utilization of project funds; 4: Counterpart funding; 5: Management aspects of the project or executing agency; 6: Monitoring, review, and reporting; 7: Project implementation; 8: Sectoral or cross-sectoral budgetary allocation; 9: Sectoral or regulatory/institutional action; 10: Other.

[23] C: Complied with; CD: Complied with after delay.

Table 10: Compliance with Operational Manual Statements

Statement number and title	Describe and comment on lack of compliance
Not applicable	Not applicable

Table 11: Bank Resources: Staff Inputs

Stage of Project Cycle	Planned		Revised		Actual	
	Weeks	US$	Weeks	US$	Weeks	US$
Preparation to appraisal					80	206.9
Appraisal through Board approval					19	61.5
Supervision					86.5	268
Completion	8.5	25.5			8.0	20
TOTAL					193.5	556.4

** In view of COS-related changes made in the MIS system, "Planned" and "Revised" figures are not available for the project cycle period.

Table 12: Bank Resources: Missions

Stage of project cycle	s/w[24]	No. of staff[25]	Days in field	Specialized staff skills represented[26]	Performance rating[27]		Types of problems
					Implementation status	Development objectives	
Preparation to appraisal							
March 1990 - Preparation		4		PS; MD; CO; IO	n/applic.	n/applic.	
July 1990 - Pre-appraisal		4	18	PS; MD; OA; HE			
Appraisal							
October 1990		5	18	PS; MD; OA; Div	n/applic.	n/applic.	
Supervision missions[28]							
October 1991 (project launching)		5	11	HE; OA; MD; MD; A	S	HS	- Delay in opening of Special Account.
February 1992		3		HE; MD; OA	HS	HS	- Difficulties with assignment of human resources.
September 1992		3		HE; MD; OA			- Human resource assignments should be incorporated in yearly resource allocation plan. - Delay in launching of training and study components. - Strengthening of coordination with ONFP necessary.
April 1993		4		OA; MD; MD; A			- Problems with start-up of civil works, owing to unfamiliarity in the regions with contract financing procedures. - Lack of capacity of Project Technical Unit .
September 1993	25	3	10	OA; MD; A	S	HS	- Studies completed only slowly. - Modification of sites selected for diagnostic centers and the CREPF. - Cost of mobile clinics in excess of estimate.
April 1994	25	3	12	OA; MD; A	S	HS	- Introduction of information system. Close monitoring of its use at all levels necessary. - Project Unit's shortcomings in human resource assignment management partly compromise success of project.
November 1994 (informal mid-term mission for supervision purposes, and for overall sector analysis in conjunction with Hospital Restructuring project mission and in context of preparation of Ninth Five-Year Plan)	30	4	17	OA; MD; A; PS	S	HS	- Difficulties with measurement of project impact owing to delayed completion of studies. - Information system testing in progress. - Human resource assignment picture not clarified.
June 1995	15	2	11	OA; A	S	HS	- Analysis of activities reports on regions under way.
June 1996	15	3	14	OA; D; A	S	HS	- Information system under-utilized. - Allocation of personnel poorly managed. - Implementation timetable necessitates extension of loan closing date.
March 1997	10	2	5	OA; PS	S	HS	
October 1997 (project supervision and completion mission)	25	3	12	OA; MD; PS	S	HS	- Delay in issuance of report by the independent project evaluation committee. - Delay in remittal of 1996 audit report.

24 Staff-weeks devoted to project in the field

25 Number of staff taking part in the mission.

26 CO = Communications Officer; D = Demographer; Div = Division Chief; HE = Health Economist; IO = Investments Officer; MD = Public Health Physician; OA = Project Analyst; A = Architect; PS = Population Specialist.

27 This is the rating given the project by the evaluating officer. It measures, among other things, it measures completeness of performance and the likelihood that the project will achieve its development objectives. The possible ratings are: HS, highly satisfactory; S, satisfactory; U, unsatisfactory; and HU, highly unsatisfactory.

28 These supervision missions were carried out at the same times as missions to supervise the Hospital rRstructuring project, so as to ensure coherency in the dialogue with the MPH and take advantage of the resources afforded by the two teams.

(7)
OED Director
S 9 025
10C

Roger H. Slade
07/15/98 03:32 PM

Extn: 81293 OEDST

Subject: TUNISIA: Population and Family Health (Ln. 3307)
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. July 22, 1998.

Roger Slade
Manager
Sector and Thematic Evaluations Group

ICR Review - Evaluation Summary

Operations Evaluation Department

Date Created: 06/18/98 04:46:07 PM
Last Updated: 07/14/98 02:09:02 PM
Status: Open

1. Project Data:	
OEDID:	L3307
Project Name:	Population and Family Health
Country:	Tunisia
Sector:	Other Population Health & Nutrition
L/C Number:	L3307
Partners involved:	
Prepared by:	Charles Derek Poate, OEDST
Reviewed by:	Susan A. Stout
Group Manager:	Roger Slade
Date Posted:	

2. Project Objectives, Financing, Costs and Components:

The objectives were to increase the national contraceptive prevalence rate from 40 to 45%, and to improve the health status of the population, with particular emphasis on women and children in rural areas.
The estimated total investment cost of the project was US$39.0 million of which US$26.0 million was met by a loan from the World Bank (as approved by the Bank in 1991). The total cost of the project (including recurrent costs to be met by Government) was estimated at appraisal at US$63.2 million. The project became effective on 2nd October 1991 and was closed on 31st March 1998, 12 months later than envisaged. Most of the funds were disbursed. There were no formal co-financiers, although UNICEF provided the funds for the training component and other agencies for other minor components of the project.
There were four components comprising: i. Integration of Maternal and Child Health (MCH) and Family Planning (FP) centers involving a mix of recruitment/ redeployment of midwives, in-service training, establishment of a regional family planning center, monitoring of referral of pregnant women and improved neo-natal services; ii. Expansion of outreach services to increase access to MCH/FP involving redeployment of staff to inaccessible areas, re-organization of mobile teams and purchase of mobile clinics.
iii. Improvement of first referral level of health care through X-ray and other services and upgraded access to ambulatory specialist care; and iv. Enhancement of the quality of health care through in-service training, improved supply of basic drugs, studies to improve performance evaluation and the introduction of a health information system.

3. Achievement of Relevant Objectives:

(a) Contraceptive prevalence: the project's objective of increasing contraceptive prevalence rate (modern methods) was exceeded. It increased the rate from 40 - 50% compared to the target of 45%, although this may have been too modest. With the Government continuing to increase the access to health services in rural areas this rate is likely to improve further.
(b) Health status of women and children in rural areas. The data (although incomplete) show improvements in the key indicators over the period with infant mortality falling from 45.3 to 30.6 for Tunisia as a whole, and fertility rate falling from 3.38 to 2.87. However, a wide disparity still exists between rural and urban areas, with the increase in private health services in urban areas thought to be responsible for the maintenance of the gap.

4. Significant Achievements:

The most significant achievements were: · All scheduled extension, renovation and construction works in 158 health centers were completed, and 57 district hospitals were completed. The integration of MCH/FP services achieved 130% of target . The objectives of increasing modern method contraceptive prevalence exceeded the target and were achieved early in the life of the project (target 45% prevalence, achieved 50%)

5. Significant Shortcomings:

In spite of improving rural health services, the project did not lessen the gap between health status in urban and rural areas. The monitoring and evaluation system did not take account of existing resources and capability and fell well below expectations.

6. Ratings:	ICR	OED Review	Reason for Disagreement/Comments
Outcome:	Highly Satisfactory	Highly Satisfactory	
Institutional Dev.:	Substantial	Substantial	
Sustainability:	Likely	Likely	
Bank Performance:	Satisfactory	Satisfactory	
Borrower Perf.:	Satisfactory	Satisfactory	Borrower's evaluation is particularly thorough and shows creative use of limited available data.
Quality of ICR:		Satisfactory	

7. Lessons of Broad Applicability:

· The results of projects which are dependent on the deployment of staff to the field, especially involving re-location to remote areas, involve risks, and staff preferences and government procedures often mitigate against this. Special measures and incentives need to be incorporated into the project design. Regional and subregional analysis of health system performance and outcomes can assist in targeting resources. A tradition of 'self evaluation' within the Ministry of Health facilitated incorporation of experience from previous projects, and, during this project, helped identify solutions to sectoral issues which are being employed in a new health sector process. Project objectives should be fully integrated in the Government's strategy. Even successful projects need fully effective monitoring and evaluation systems

8. Audit Recommended? Yes ● No

9. Comments on Quality of ICR:

The ICR provided appropriate coverage, describing the achievement of the project's objectives and fully setting out the project's shortcomings. The ICR was clearly laid out and well written, and includes a useful discussion of issues in the establishment of monitoring and evaluation systems and in locating staff in rural areas. A more complete discussion of the recurrent cost elements of the project and of the steps that the Bank and Borrower took to ensure that the design was consistent with the Government's strategy could have added further to a fully satisfactory ICR.

To: Christian Delvoie
cc: Prem C. Garg
David De Ferranti
Robert M. Hecht
Joy De Beyer
Richard G. Feachem
Claire Voltaire
Susan A. Stout

ICR Review - Evaluation Summary

Operations Evaluation Department

Date Created: 06/18/98 04:46:07 PM
Last Updated: 07/14/98 02:09:02 PM
Status: Open

1. Project Data:	
OEDID:	L3307
Project Name:	Population and Family Health
Country:	Tunisia
Sector:	Other Population Health & Nutrition
L/C Number:	L3307
Partners involved:	
Prepared by:	Charles Derek Poate, OEDST
Reviewed by:	Susan A. Stout
Group Manager:	Roger Slade
Date Posted:	

2. Project Objectives, Financing, Costs and Components:

The objectives were to increase the national contraceptive prevalence rate from 40 to 45%, and to improve the health status of the population, with particular emphasis on women and children in rural areas.

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There were four components comprising: i. Integration of Maternal and Child Health (MCH) and Family Planning (FP) centers involving a mix of recruitment/ redeployment of midwives, in-service training, establishment of a regional family planning center, monitoring of referral of pregnant women and improved neo-natal services; ii. Expansion of outreach services to increase access to MCH/FP involving redeployment of staff to inaccessible areas, re-organization of mobile teams and purchase of mobile clinics.

iii. Improvement of first referral level of health care through X-ray and other services and upgraded access to ambulatory specialist care; and iv. Enhancement of the quality of health care through in-service training, improved supply of basic drugs, studies to improve performance evaluation and the introduction of a health information system.

3. Achievement of Relevant Objectives:

(a) Contraceptive prevalence: the project's objective of increasing contraceptive prevalence rate (modern methods) was exceeded. It increased the rate from 40 - 50% compared to the target of 45%, although this may have been too modest. With the Government continuing to increase the access to health services in rural areas this rate is likely to improve further.

(b) Health status of women and children in rural areas. The data (although incomplete) show improvements in the key indicators over the period with infant mortality falling from 45.3 to 30.6 for Tunisia as a whole, and fertility rate falling from 3.38 to 2.87. However, a wide disparity still exists between rural and urban areas, with the increase in private health services in urban areas thought to be responsible for the maintenance of the gap.

4. Significant Achievements:

The most significant achievements were: · All scheduled extension, renovation and construction works in 158 health centers were completed, and 57 district hospitals were completed. The integration of MCH/FP services achieved 130% of target . The objectives of increasing modern method contraceptive prevalence exceeded the target and were achieved early in the life of the project (target 45% prevalence, achieved 50%)

5. Significant Shortcomings:

In spite of improving rural health services, the project did not lessen the gap between health status in urban and rural areas. The monitoring and evaluation system did not take account of existing resources and capability and fell well below expectations.

6. Ratings:	ICR	OED Review	Reason for Disagreement/Comments
Outcome:	Highly Satisfactory	Highly Satisfactory	
Institutional Dev.:	Substantial	Substantial	
Sustainability:	Likely	Likely	
Bank Performance:	Satisfactory	Satisfactory	
Borrower Perf.:	Satisfactory	Satisfactory	Borrower's evaluation is particularly thorough and shows creative use of limited available data.
Quality of ICR:		Satisfactory	

7. Lessons of Broad Applicability:

· The results of projects which are dependent on the deployment of staff to the field, especially involving re-location to remote areas, involve risks, and staff preferences and government procedures often mitigate against this. Special measures and incentives need to be incorporated into the project design. Regional and subregional analysis of health system performance and outcomes can assist in targeting resources. A tradition of 'self evaluation' within the Ministry of Health facilitated incorporation of experience from previous projects, and, during this project, helped identify solutions to sectoral issues which are being employed in a new health sector process. Project objectives should be fully integrated in the Government's strategy. Even successful projects need fully effective monitoring and evaluation systems

8. Audit Recommended? ○ Yes ● No

9. Comments on Quality of ICR:

The ICR provided appropriate coverage, describing the achievement of the project's objectives and fully setting out the project's shortcomings. The ICR was clearly laid out and well written, and includes a useful discussion of issues in the establishment of monitoring and evaluation systems and in locating staff in rural areas. A more complete discussion of the recurrent cost elements of the project and of the steps that the Bank and Borrower took to ensure that the design was consistent with the Government's strategy could have added further to a fully satisfactory ICR.

This PIF has not been posted

OED ID :	L3307
Type :	ES
Country :	Tunisia
Project Description :	Population and Family Health
Sector :	HX / Population, Health & Nutrition
Subsector :	HT / Targeted Health
Lending Instrument :	Sector Investment/Maintenance
L/C :	L3307

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

A. General Project Information and Project Objectives Evaluation
1. General Project Information 1
2. Project Objectives Evaluation 2

B. Relevance, Efficacy, and Efficiency of Projects
1. Outcomes
   a. Relevance 3
   b. Efficacy 3
   c. Efficiency 4
   d. Overall outcome 5
2. Sustainability 5
3. Institutional Development 6

C. Bank and Borrower Performance
1. Bank Performance 7
2. Borrower Performance 8

D. Special Themes and Audit/Impact Priority 9

E. Rating of ICR 10

F. Summary of Ratings 11

G. Overall Judgements / Miscellaneous Comments 11

A1. General Project Information

OED ID :	L3307
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Project Description :	Population and Family Health
Sector :	HX / Population, Health & Nutrition
Subsector :	HT / Targeted Health
Lending Instrument :	Sector Investment/Maintenance
L/C :	L3307

1. Reviewer: ITAD

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

Sugg. Sector: HX / Population, Health & Nutrition
Sugg. Subsector: HB / Basic Health

3. Key Dates

	Original	Latest
Departure of Appraisal Mission		10/22/1990
Approval		03/21/1991
Signing/Agreement		05/22/1991
Effectiveness	09/18/1991	10/02/1991
Physical completion	09/30/1996	09/30/1997
Closing	03/31/1997	03/31/1998
ICR receipt in OED		06/09/1998
Review date		06/24/1998
ES posting or PAR approval		

4. Key Amounts ($US million)

Original Commitment	26
Total Cancellation	0
Total project cost	
Original	42.5
Latest	39

5. Cofinanciers

	First	Second	Third
Name	Government of Tunisia	UNICEF	NA
Original Commitment ($US million)	13	0.5	0
Total Cancellation ($US million)	0	0	0

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

Physical	38.5
Technical assistance	0.5
Balance of payments	0
Line of credit	0
Other	0

7. Applicable disbursement profile (no. of years): 6

8. Number of supervision missions: 11

9. Name(s) of primary author(s) of ICR (indicate if not known): C.Voltaire,J.Nassim,A.Sales

11. Names of managers

	At entry	At exit
Task manager	M.MacDonald	C.Voltaire
Division chief	A.Rogerson	K.Dervis
Department director	K.Dervis	C.Delvoie

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:

Characteristic	Rating
Demanding on Borrower / Implementing Agency	Negligible
Complexity	Modest
Riskiness	Negligible

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:

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

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

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

Objective	Rating
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	High
Environmental	Not Applicable
Private sector development	Not Applicable
Other (specify):	

2. Summary Rating of Relevance

Rate the extent to which, as a whole, the project's goals were consistent with the Bank's 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:

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

2. Summary Rating of Efficacy

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

Average rating: Substantial

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

B1c. Outcomes — Efficiency (cont'd)

5. Summary Rating of Efficiency

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

Average rating:

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

No information available to assess efficiency

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: Highly Satisfactory

Average rating: Satisfactory

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

On the evidence of the indicators of outcome, i.e. increase in use of contraceptives and improved health status of women and children, the project's relevance and efficacy, the outcome in considered highly satisfactory.

B2. Sustainability

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

Condition	Rating	Condition	Rating
Technical viability	Positive	Policy environment	Positive
Financial viability	Positive	Institution / management effectiveness	Positive
Economic viability	Not Available	Local participation	Positive
Social conditions	No Effect	Other (specify):	
Environmental concerns	Not Applicable		
Government commitment	Positive		

2. SUMMARY SUSTAINABILITY RATING

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

Average rating: Likely

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

B3. Institutional Development

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

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

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

Establishment of a new organization	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	Substantial
Financial intermediation	Not Applicable
Legal / regulatory system	Not Applicable
Sectoral capacity	High
Other (specify):	
Agency capacity	
Planning / policy analysis	Substantial
Management	Substantial
Skills upgrading	Substantial
MIS	Modest
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	Substantial
Civil service reform	Modest
Financial intermediation	Not Applicable
Legal / regulatory system	Not Applicable
Sectoral capacity	High
Other (specify):	
Agency capacity	
Planning / policy analysis	Not Applicable
Management	High
Skills upgrading	Substantial
MIS	Negligible
Other (specify):	
NGO Capacity	Not Applicable
Overall ID Efficacy	Substantial

6. SUMMARY INSTITUTIONAL DEVELOPMENT IMPACT RATING

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

Average rating: Substantial

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:

Item	Rating
Involvement of government	Substantial
Involvement of beneficiaries	Not Available
Project consistency with Bank strategy for country	High
Grounding in economic and sector work (ESW)	Substantial
Other (specify):	

Overall rating on identification / preparation	Satisfactory
Average rating	Satisfactory

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

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

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

Overall rating on appraisal	Satisfactory
Average rating	Satisfactory

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

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

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

Item	Rating
Reporting on project implementation progress	High
Identification / assessment of implementation problems	High
Use of performance indicators	Substantial
Enforcement of Borrower provision of M&E data	Modest
Advice to implementing agency	Substantial
Enforcement of loan covenants / exercise of remedies	High
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	Satisfactory
If your overall rating differs from the average rating, please comment on reasons for this difference:	

C2. Borrower Performance

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

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

Factors generally subject to government control

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

Factors generally subject to implementing agency control

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

C2. Borrower Performance (cont'd)

3. Summary Rating of Borrower Performance on Project Implementation

Overall rating: Satisfactory

Average rating: Satisfactory

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

4. Rate Borrower compliance with loan covenants / commitments:

Highly Satisfactory

5. SUMMARY RATING OF BORROWER PERFORMANCE

Overall rating: Satisfactory

Average rating: Satisfactory

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

D. Special Themes

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

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

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

No

If Yes, was the effect positive or negative?

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

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

If Yes:

Did it emphasize broad-based growth with labor absorption? ( ) Yes (●) No

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

Did it emphasize the provision of a social safety net? ( ) Yes (●) No

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

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

D. Special Themes (cont'd)

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

No

If Yes, was the effect positive or negative?

7. Rate the priority of the project for audit

Low

8. Rate the priority of the project for impact evaluation

Medium

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)	No
Restructuring / privatization of public enterprises	No
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	Exemplary
Recalcualtion of ERR or FRR	Not Applicable
Soundness of analysis	
Internal consistencies	Satisfactory
Evidence complete / convincing	Satisfactory
Adequacy of lessons learned	Exemplary
Aide-memoire of the ICR mission	Not Available

Future orientation

Plan for future project operation	Satisfactory
Performance indicators for the project's operations phase	Satisfactory
Plan for monitoring and evaluation of future operations	Unsatisfactory

Borrower / cofinancier inputs

Borrower input to ICR	Exemplary
Borrower plan for future project operation	Satisfactory
Borrower comments on ICR	Exemplary
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:

Marcia J. Bailey
07/15/98 08:14 AM

Extn: 39617 OEDDR
Subject: TUNISIA: Population and Family Health (Ln. 3307)
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. Christian Delvoie, Country Director, MNCMG

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. July 21, 1998.

Roger Slade
Manager
Sector and Thematic Evaluations Group

cc: **Messrs./Mmes**
Prem C. Garg (MDOQA)
David De Ferranti (HDNVP)
Robert M. Hecht (HDNVP)
Joy De Beyer (HDNVP)
Richard G. Feachem (HDNHE)
Claire Voltaire (MNSHD)
Susan Stout (OEDST)

bcc: Marcia Bailey

---------------------- Forwarded by Marcia J. Bailey/Person/World Bank on 07/14/98 04:18 PM

ICR Review - Evaluation Summary
Operations Evaluation Department

Date Created: 06/18/98 04:46:07 PM
Last Updated: 07/14/98 02:09:02 PM
Status: Open

1. Project Data:	
OEDID:	L3307
Project Name:	Population and Family Health
Country:	Tunisia
Sector:	Other Population Health & Nutrition
L/C Number:	L3307

Partners involved:	
Prepared by:	Charles Derek Poate, OEDST
Reviewed by:	Susan A. Stout
Group Manager:	Roger Slade
Date Posted:	

2. Project Objectives, Financing, Costs and Components:

The objectives were to increase the national contraceptive prevalence rate from 40 to 45%, and to improve the health status of the population, with particular emphasis on women and children in rural areas.

The estimated total investment cost of the project was US$39.0 million of which US$26.0 million was met by a loan from the World Bank (as approved by the Bank in 1991). The total cost of the project (including recurrent costs to be met by Government) was estimated at appraisal at US$63.2 million. The project became effective on 2nd October 1991 and was closed on 31st March 1998, 12 months later than envisaged. Most of the funds were disbursed. There were no formal co-financiers, although UNICEF provided the funds for the training component and other agencies for other minor components of the project.

There were four components comprising: i. Integration of Maternal and Child Health (MCH) and Family Planning (FP) centers involving a mix of recruitment/ redeployment of midwives, in-service training, establishment of a regional family planning center, monitoring of referral of pregnant women and improved neo-natal services; ii. Expansion of outreach services to increase access to MCH/FP involving redeployment of staff to inaccessible areas, re-organization of mobile teams and purchase of mobile clinics.

iii. Improvement of first referral level of health care through X-ray and other services and upgraded access to ambulatory specialist care; and iv. Enhancement of the quality of health care through in-service training, improved supply of basic drugs, studies to improve performance evaluation and the introduction of a health information system.

3. Achievement of Relevant Objectives:

(a) Contraceptive prevalence: the project's objective of increasing contraceptive prevalence rate (modern methods) was exceeded. It increased the rate from 40 - 50% compared to the target of 45%, although this may have been too modest. With the Government continuing to increase the access to health services in rural areas this rate is likely to improve further.

(b) Health status of women and children in rural areas. The data (although incomplete) show improvements in the key indicators over the period with infant mortality falling from 45.3 to 30.6 for Tunisia as a whole, and fertility rate falling from 3.38 to 2.87. However, a wide disparity still exists between rural and urban areas, with the increase in private health services in urban areas thought to be responsible for the maintenance of the gap.

4. Significant Achievements:

The most significant achievements were: · All scheduled extension, renovation and construction works in 158 health centers were completed, and 57 district hospitals were completed. The integration of MCH/FP services achieved 130% of target . The objectives of increasing modern method contraceptive prevalence exceeded the target and were achieved early in the life of the project (target 45% prevalence, achieved 50%)

5. Significant Shortcomings:

In spite of improving rural health services, the project did not lessen the gap between health status in urban and rural areas. The monitoring and evaluation system did not take account of existing resources and capability and fell well below expectations.

6. Ratings:	ICR	OED Review	Reason for Disagreement/Comments
Outcome:	Highly Satisfactory	Highly Satisfactory	
Institutional Dev.:	Substantial	Substantial	
Sustainability:	Likely	Likely	
Bank Performance:	Satisfactory	Satisfactory	
Borrower Perf.:	Satisfactory	Satisfactory	Borrower's evaluation is particularly thorough and shows creative use of limited available data.
Quality of ICR:		Satisfactory	

7. Lessons of Broad Applicability:

· The results of projects which are dependent on the deployment of staff to the field, especially involving re-location to remote areas, involve risks, and staff preferences and government procedures often mitigate against this. Special measures and incentives need to be incorporated into the project design. Regional and subregional analysis of health system performance and outcomes can assist in targeting resources. A tradition of 'self evaluation' within the Ministry of Health facilitated incorporation of experience from previous projects, and, during this project, helped identify solutions to sectoral issues which are being employed in a new health sector process. Project objectives should be fully integrated in the Government's strategy. Even successful projects need fully effective monitoring and evaluation systems

8. Audit Recommended? Yes ● No

9. Comments on Quality of ICR:

The ICR provided appropriate coverage, describing the achievement of the project's objectives and fully setting out the project's shortcomings. The ICR was clearly laid out and well written, and includes a useful discussion of issues in the establishment of monitoring and evaluation systems and in locating staff in rural areas. A more complete discussion of the recurrent cost elements of the project and of the steps that the Bank and Borrower took to ensure that the design was consistent with the Government's strategy could have added further to a fully satisfactory ICR.

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

ICR Review - Evaluation Summary

Operations Evaluation Department

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OEDID:	L3307
Project Name:	Population and Family Health
Country:	Tunisia
Sector:	Other Population Health & Nutrition
L/C Number:	L3307
Partners involved:	
Prepared by:	Charles Derek Poate, OEDST
Reviewed by:	Susan A. Stout
Group Manager:	Roger Slade
Date Posted:	07/30/98

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

This PIF has not been posted

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Type :	ES
Country :	Tunisia
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Sector :	HX / Population, Health & Nutrition
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Lending Instrument :	Sector Investment/Maintenance
L/C :	L3307

Problems

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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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Sector :	HX / Population, Health & Nutrition
Subsector :	HT / Targeted Health
Lending Instrument :	Sector Investment/Maintenance
L/C :	L3307

1. Reviewer: ITAD

2. Do you agree with the assigned primary Sector and Subsector?
- ○ Yes
- ◉ No

Sugg. Sector: HX / Population, Health & Nutrition
Sugg. Subsector: HB / Basic Health

3. Key Dates

	Original	Latest
Departure of Appraisal Mission		10/22/1990
Approval		03/21/1991
Signing/Agreement		05/22/1991
Effectiveness		10/02/1991
Physical completion	09/30/1996	09/30/1997
Closing	03/31/1997	03/31/1998
ICR receipt in OED		06/09/1998
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ES posting or PAR approval		

4. Key Amounts ($US million)

Original Commitment	26
Total Cancellation	0
Total project cost	
Original	42.5
Latest	39

5. Cofinanciers

	First	Second	Third
Name	Government of Tunisia	UNICEF	NA
Original Commitment ($US million)	13	0.5	0
Total Cancellation ($US million)	0	0	0

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

Physical	38.5
Technical assistance	0.5
Balance of payments	0
Line of credit	0
Other	0

7. Applicable disbursement profile (no. of years): 5

8. Number of supervision missions: 11

9. Name(s) of primary author(s) of ICR (indicate if not known): C.Voltaire,J.Nassim,A.Sales

11. Names of managers

	At entry	At exit
Task manager	M.MacDonald	C.Voltaire
Division chief	A.Rogerson	K.Dervis
Department director	K.Dervis	C.Delvoie

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:

Characteristic	Rating
Demanding on Borrower / Implementing Agency	Negligible
Complexity	Modest
Riskiness	Negligible

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:

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

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

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

Objective	Rating
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	High
Environmental	Not Applicable
Private sector development	Not Applicable
Other (specify):	

2. Summary Rating of Relevance

Rate the extent to which, as a whole, the project's goals were consistent with the Bank's 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:

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

2. Summary Rating of Efficacy

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

Average rating: Substantial

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:

Factor	Rating
World markets / prices	No Effect
Natural events	No Effect
Cofinancier(s) performance	Positive
Performance of contractors / consultants	Positive
War / civil disturbance	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: Not Available

Average rating:

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

No information available to assess efficiency

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: Highly Satisfactory

Average rating: Satisfactory

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

On the evidence of the indicators of outcome, i.e. increase in use of contraceptives and improved health status of women and children, the project's relevance and efficacy, the outcome in considered highly satisfactory.

B2. Sustainability

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

Condition	Rating	Condition	Rating
Technical viability	Positive	Policy environment	Positive
Financial viability	Positive	Institution / management effectiveness	Positive
Economic viability	Not Available	Local participation	Positive
Social conditions	No Effect	Other (specify):	
Environmental concerns	Not Applicable		
Government commitment	Positive		

2. SUMMARY SUSTAINABILITY RATING

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

Average rating: Likely

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

B3. Institutional Development

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

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

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

Activity	
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:

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

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

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

6. SUMMARY INSTITUTIONAL DEVELOPMENT IMPACT RATING

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

Average rating: Substantial

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:

Item	Rating
Involvement of government	Substantial
Involvement of beneficiaries	Not Available
Project consistency with Bank strategy for country	High
Grounding in economic and sector work (ESW)	Substantial
Other (specify):	

Overall rating on identification / preparation: Satisfactory

Average rating: Satisfactory

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

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

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

Overall rating on appraisal: Satisfactory

Average rating: Satisfactory

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

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

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

Item	Rating
Reporting on project implementation progress	High
Identification / assessment of implementation problems	High
Use of performance indicators	Substantial
Enforcement of Borrower provision of M&E data	Modest
Advice to implementing agency	Substantial
Enforcement of loan covenants / exercise of remedies	High
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	Satisfactory
If your overall rating differs from the average rating, please comment on reasons for this difference:	

C2. Borrower Performance

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

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

Factors generally subject to government control

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

Factors generally subject to implementing agency control

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

C2. Borrower Performance (cont'd)

3. Summary Rating of Borrower Performance on Project Implementation

Overall rating: Satisfactory

Average rating: Satisfactory

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

4. Rate Borrower compliance with loan covenants / commitments:

Highly Satisfactory

5. SUMMARY RATING OF BORROWER PERFORMANCE

Overall rating: Satisfactory

Average rating: Satisfactory

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

D. Special Themes

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

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

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

No

If Yes, was the effect positive or negative?

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

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

If Yes:

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

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

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

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

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

D. Special Themes (cont'd)

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

No

If Yes, was the effect positive or negative?

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)	No
Restructuring / privatization of public enterprises	No
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

Medium

E. Rating of ICR

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

Analysis

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

Future orientation

Plan for future project operation	Satisfactory
Performance indicators for the project's operations phase	Satisfactory
Plan for monitoring and evaluation of future operations	Unsatisfactory

Borrower / cofinancier inputs

Borrower input to ICR	Exemplary
Borrower plan for future project operation	Satisfactory
Borrower comments on ICR	Exemplary
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	Exemplary
Concern with development impact	Satisfactory	Self-evaluation	Satisfactory
Internal consistency	Satisfactory	Evaluation of Bank	Satisfactory
Evidence to justify views	Exemplary		

F. Summary of Ratings

1. SUMMARY OF RATINGS

	ICR	ES
Outcome	Highly Satisfactory	Highly Satisfactory
Sustainability	Likely	Likely
Institutional Development efficacy / impact	Substantial	Substantial
Bank performance	Satisfactory	Satisfactory
Borrower performance	Satisfactory	Satisfactory
ICR quality		Satisfactory

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

G. Overall Judgements / Miscellaneous Comments

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

SECTION A1, QUESTION 5
Government contribution to the project is for both the investment costs and recurrent costs (including taxes and duties). The ICR (and this review) focuses primarily on the investment costs and there is no data on the recurrent cost element. The overall project costs given in the SAR are US$63.2 million.

UNICEF confinanced the training, but there was no formal confinanciers agreement.

6. Ratings:	ICR	OED Review	Reason for Disagreement/Comments
Outcome:	Highly Satisfactory	Highly Satisfactory	
Institutional Dev.:	Substantial	Substantial	
Sustainability:	Likely	Likely	
Bank Performance:	Satisfactory	Satisfactory	
Borrower Perf.:	Satisfactory	Satisfactory	Borrower's evaluation is particularly thorough and shows creative use of limited available data.
Quality of ICR:		Satisfactory	

7. Lessons of Broad Applicability:

· The results of projects which are dependent on the deployment of staff to the field, especially involving re-location to remote areas, involve risks, and staff preferences and government procedures often mitigate against this. Special measures and incentives need to be incorporated into the project design. Regional and subregional analysis of health system performance and outcomes can assist in targeting resources. A tradition of 'self evaluation' within the Ministry of Health, encouraged and supported by task manager continuity and strong commitment to evaluation, facilitated incorporation of experience from previous projects, and, during this project, helped identify solutions to sectoral issues which are being employed in a new health sector process. Project objectives should be fully integrated in the Government's strategy. Even successful projects need fully effective monitoring and evaluation systems

8. Audit Recommended? ○ Yes ● No

9. Comments on Quality of ICR:

The ICR provided appropriate coverage, describing the achievement of the project's objectives and fully setting out the project's shortcomings. The ICR is clearly laid out and well written, and includes a useful discussion of issues in the establishment of monitoring and evaluation systems and in locating staff in rural areas.

ICR/PIF COVER SHEET   Run Date: 6/11/98

OED ID: L3307   Unit: 10

Country: Tunisia
Project Description: Population and Family Health
Sector: 04 / Human Resource
Subsector: 04.05 / Pop., Health & Nutr.
Lending Instrument Type: SIM
L/C: L3307
Original IDA/IBRD Commitments: 26,000,000 ($US)
Total Cancellations: 0 ($US)

Key Dates	ORIGINAL	ACTUAL
Approval		3/21/91
Signing/Agreement		5/22/91
Effectiveness	10/02/91	10/02/91
Closing	3/31/97	3/31/~~97~~ 98
ICR Receipt in OED		6/09/98

EVALUATOR NAME: Susan Stout (ITAD)

EVALUATOR SIGNATURE: ______________ DATE: ______________

Please confirm the above information, sign and date this sheet and return a photo-copy to Helen Sioris when the EVM/Regional memo/PIF packet is submitted to OED Director.

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

Date of Review: ____/____/____ (mm / dd / yy)

Name of Reviewer: ______________________

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

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

Yes [ ] No [ ]

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

	ORIGINAL	LATEST
Date of Physical Completion	______ (mm/dd/yy)	______ (mm/dd/yy)
Total Project Cost ($US mill)	______	______

Applicable Disbursement Profile: ______________
(see note 11 in the PIF, page 31)

Number of Supervision Missions: ______________

#17958

dd 6/4/98

Eva Jarawan

07/16/98 02:24 PM

Extn: 34028 MNSHD

Subject: TUNSIA - Population and Family Health (Ln. 3307)
OED: Review of Implementation Completion Report

Thank you for sending us the draft evaluation summary, on which we have only minor comments:

para.4: Significant achievements: We suggest to modify the first sentence which eroneously gives the impression that the project built 57 district hospitals. Only laboratory services, X-Ray and dental offices were installed in existing hospitals.

para. 9: Comments on the ICR: We agree that the discussion on recurrent costs was kept to a minimum. This reflects a strategic choice made during appraisal and supervision to discuss expenditures and financing of the sector as a whole, in the context of the parallel Hospital Restructuring project which offered greater leverage. We are unsure of what is meant by your comment on the steps taken to ensure that the project design was consistent with the Government strategy. Both this strategy and the project strategic choices are discussed in detail in the ICR (para. 33, 34 and 35).

To: Roger H. Slade
cc: Christian Delvoie
Jacques F. Baudouy
David De Ferranti
Prem C. Garg
Robert M. Hecht
Joy De Beyer
Richard G. Feachem
Susan A. Stout
Claire Voltaire