Document of
The World Bank

Report No: 30754-CM

IMPLEMENTATION COMPLETION REPORT
(IDA-30430)

ON A

LOAN/CREDIT/GRANT

IN THE AMOUNT OF US$ 8.4 MILLION

TO THE

ISLAMIC FEDERAL REPUBLIC OF THE COMOROS

FOR A

HEALTH PROJECT

December 7, 2004

Human Development Group 3
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective 06/30/2004)

Currency Unit	=	Comorian Francs (KMF)
SDR 1.00	=	US$ 1.46
US$ 1.00	=	KMF 404.42

FISCAL YEAR
July 1 June 30

ABBREVIATIONS AND ACRONYMS

ASCOBEF	*Association Comorienne pour le Bien-Etre Familial*
CAS	Country Assistance Strategy
CEP	*Cellule d'Exécution du Projet*
CHR	*Centre Hospitalier Régional*
CNFRSP	*Centre National de Formation de Recherche en Santé Publique*
DCA	Development Credit Agreement
DO	Development Objective
FADC	*Fonds d'Appui au Développement Communautaire*
HH	Households
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
ICR	Implementation Completion Report
IDA	International Development Association
IPPF	International Planned Parenthood Federation
MICS	Multiple Indicator Cluster Surveys
MOH	Ministry of Health
MTR	Mid-Term-Review
NGO	Non Governmental Organization
NPHRD	National Plan for Human Resources Development
PAD	Project Appraisal Document
PCD	Project Concept Document
PNAC	*Pharmacie Nationale Approvisionnement des Comores*
PNLP	*Programme National de Lutte contre le Paludisme*
PRSP	Poverty Reduction Strategy Paper
PSR	Project Status Report
TTL	Task Team Leader
UN	United Nations
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
URP	*Unité Régionale du Projet*
WHO	World Health Oganization

Vice President: Callisto E. Madavo

Country Director:	James Bond
Sector Manager:	Laura Frigenti
Task Team Leader:	Jean-Pierre Manshande

ISLAMIC FEDERAL REPUBLIC OF THE COMOROS
Health Project

CONTENTS

Project ID: P052887	*Project Name:* Health Project
Team Leader: Jean-Pierre Manshande	*TL Unit:* AFTH3
ICR Type: Core ICR	*Report Date: December 7, 2004*

1. Project Data

Name: Health Project
L/C/TF Number: IDA-30430
Country/Department: COMOROS
Region: Africa Regional Office

Sector/subsector: Health (79%); Central government administration (20%); Compulsory health finance (1%)
Theme: Other communicable diseases (P); Health system performance (P); Child health (S)

KEY DATES		*Original*	*Revised/Actual*
PCD:	01/23/1997	*Effective:*	07/01/1998	06/06/2000
Appraisal:	10/09/1997	*MTR:*	11/30/2000	06/02/2002
Approval:	02/26/1998	*Closing:*	12/31/2002	06/30/2004

Borrower/Implementing Agency: GOVERNMENT OF COMOROS/MINISTRY OF HEALTH
Other Partners:

STAFF	Current	At Appraisal
Vice President:	Gobind T. Nankani	Callisto E. Madavo
Country Director:	James P. Bond	Michael Sarris
Sector Manager:	Laura Frigenti	Nicholas R. Burnett
Team Leader at ICR:	Jean-Pierre Manshande	Eileen Murray
ICR Primary Author:	Peter Bachrach	

2. Principal Performance Ratings

(HS=Highly Satisfactory, S=Satisfactory, U=Unsatisfactory, HL=Highly Likely, L=Likely, UN=Unlikely, HUN=Highly Unlikely, HU=Highly Unsatisfactory, H=High, SU=Substantial, M=Modest, N=Negligible)

Outcome: U
Sustainability: UN
Institutional Development Impact: M
Bank Performance: U
Borrower Performance: U

	QAG (if available)	ICR
Quality at Entry:	S	S
Project at Risk at Any Time:	Yes	

3. Assessment of Development Objective and Design, and of Quality at Entry

3.1 Original Objective:

The original project DO was to reduce mortality from common diseases, particularly malaria, by ensuring a better utilization of health facilities for the delivery of quality health care to the vast majority of the population and by organizing mosquito control activities to reduce the incidence of malaria.

3.2 Revised Objective:

The original objective was not formally revised, although the DCA was amended twice: (i) to reflect changes in the country's institutional arrangements following several years of political conflict and suspension of Bank activity; and (ii) to reallocate the credit proceeds to achieve the DO. Given the breadth and continued relevance of the DO as well as the flexibility of the Task Team during implementation, a formal revision was considered unnecessary.

3.3 Original Components:

The project comprised four components: (a) rehabilitation and equipment of selected health facilities ($3.1 million); (b) control of malaria ($3.9 million); (c) institutional strengthening ($2.4 million); and (d) project management ($0.6 million). Overall, these components constituted the logical follow-on to two previous projects (and more than a decade of IDA support) to the health sector and specifically built on the presumed reforms of the Population and Human Resources Project, which at closing in June 1999 was rated highly satisfactory both in terms of its DO and its IP.

3.4 Revised Components:

The project components were not revised. The amounts allocated to credit categories were revised after the mid-term review as follows (in US$):

Category	Initial amount	Revised amount
Civil works	1,500,000	2,700,000
Equipment, vehicles and supplies	3,000,000	3,000,000
Consultant services, training, studies and audits	2,800,000	1,900,000
Operating costs	500,000	800,000
Unallocated	600,000	0
Total	8,400,000	8,400,000

These modifications reflected cost savings resulting from the revision of the national malaria control strategy and new financial needs resulting from the consensus on resolving more than three years of politico-institutional conflict.

3.5 Quality at Entry:

Quality at entry. A Quality at Entry Assessment was carried out during project implementation in October 2001. It rated the overall quality as **satisfactory**; the project's concept, objectives, and approach highly satisfactory; and environmental aspects as well as the risk and sustainability analyses as marginal. Bank inputs and processes were rated **satisfactory**. The total elapsed time between project concept and appraisal was 9.6 months and between appraisal and Board was 3.7

months. Effectiveness was delayed 15.9 months due to the suspension of the Bank's program. Both management's contributions and peer reviewers' guidance were rated as marginal, while support services were rated as satisfactory. The quality assessment noted that: (i) the project was fully consistent with the existing CAS objectives (as of December 1993); and (ii) the project's DO were "specific, clear, realistic, and modest ... building on the previous project ... and avoiding the public sector."

Project at risk at any time. Except for the PSRs prepared during project suspension and the final PSR, project ratings for achievement of the DO and for project implementation were considered satisfactory; the project was therefore not considered at risk during the period of effective implementation. The PSRs did estimate the summary risk rating as high during the suspension and substantial from June 2000 to project closing.

4. Achievement of Objective and Outputs

4.1 Outcome/achievement of objective:

Unfortunately, while the MICS (2000) provides an adequate baseline for measuring impact, the inadequacies of the country's information system and the unavailability of the necessary follow-up studies preclude an assessment of project outcomes (infant mortality rate, number of malaria-related deaths, health center attendance rates).

Despite the satisfactory achievement of the objectives for malaria control, **overall achievement of the DO is considered unsatisfactory** due to (i) the tardy completion of the planned civil works and equipment, which has decreased the anticipated impact of the improved infrastructure; (ii) the current shortage of medical and paramedical personnel, which (in the absence of supervisory activities and inadequate staff motivation) contributed to the continued poor quality of health care; and (iii) the high costs of services, which significantly reduced financial accessibility (for both basic care and referral hospital services) for a large part of the population.

4.2 Outputs by components:

From the end of the suspension (June 2000) through the last formal supervision (December 2003), each of the project's four components was consistently ranked "satisfactory" in the PSRs. In June 2004, prior to the closing date, the health facility rehabilitation component and the institutional strengthening component were downgraded to "unsatisfactory."

Component A. Rehabilitation and equipment of selected health facilities: Unsatisfactory

The project's outputs were achieved, and it contributed significantly to the rehabilitation or construction of health facilities in 12 of the 17 districts and supplied equipment to 13 of the 17 principal health facilities. Further, at the time of the mid-term review, the project reallocated resources to fund civil works and equipment for several additional health facilities and the health administration offices of the autonomous islands. Generally speaking, the civil works visited by the ICR team were judged to be satisfactory (especially in *Anjouan* and *Mohéli*), although the finishing touches were not entirely satisfactory. Because the works were carried out late in the project and some equipment was delivered only toward the end of the project, several problems related to reception and merchandise warranty remain unresolved.

The PAD argued that the greater availability of infrastructure and equipment would improve the quality of health care delivered in the health facilities, leading to increased attendance rates for curative and preventive care and to more revenue generated, which in turn could be used to subsidize other (less profitable) services. Several problems arose which cast doubts about this scenario. First, available data show that the current utilization of services remains unchanged (or has even regressed in certain instances), and it is not clear that utilization rates will increase (and even if they do, it will be difficult to attribute them to the project due to the poor quality of the information systems) because: (i) the cost of services constitute a financial barrier for a large proportion of the population, particularly at the CHR level; and (ii) the cost of drugs and other consumables available in the health facility pharmacies is very high (often due to the excessively high prices of the PNAC). Second, it is not clear that the receipts generated will resolve the serious underfunding of the sector, particularly since the regulations for managing these funds have not been implemented: (i) there are no annual management and financial reports; (ii) the boards of directors do not receive an annual action plan or its respective estimated budget; and (iii) there is no accounting system, apart from the monitoring of the cashier and the treasury.

Component B. Control of malaria: Satisfactory

Though certain important program elements (e.g., environmental sanitation) were not included in the project design and not all the component's activities were implemented, those that were -- such as support for the national program (PNLP), technical assistance to revise the national malaria control strategy and treatment guidelines, and collaboration among the principal actors to implement a community-based strategy -- contributed to the satisfactory implementation of this component.

Project support was particularly important for PNLP, as the component financed: (i) rehabilitation and equipment of this service; and (ii) training of 3 medical and 3 paramedical staff at the Pasteur (Madagascar) Institute's course on malaria. In addition, the component financed technical assistance to revise the original national malaria control strategy from a reliance on spraying, to a more technically feasible, economically sound, and environmentally friendly approach through the broad utilization of bed nets and the use of larvae-eating fish. The project procured 100,000 bed nets (which complemented the purchase of 52,000 bed nets from other non-IDA sources) and 80,000 impregnation kits and financed the construction of a dozen breeding basins (serving some 250 villages) for larvae-eating fish (mainly in *Grande Comore*). In collaboration with WHO and UNICEF, community mobilization efforts (organization of national days, radio programs, newspaper articles, etc.) informed the communities of the malaria control activities and the importance of bed nets. Finally, with support from the Pasteur Institute, a study of current anti-malarial drug resistance was conducted, and revised guidelines for prophylaxis and treatment of malaria were adopted.

Component C. Institutional strengthening: Satisfactory

Based on its original objectives (particularly with respect to proposed support for PNAC and the mutual health insurance scheme), the component would be rated "unsatisfactory"; based on the

volume (and overall good quality) of the work actually produced (particularly in such difficult circumstances), the component should be rated "highly satisfactory." However, due to ongoing institutional issues between the Union and islands and rapid turnover among high-level staff, the degree of internalization by health authorities (central and regional) of the results of the studies is unclear; consequently, achievement of component objectives has been rated "satisfactory."

With respect to human resources , the project supported the preparation of a National Plan for Human Resources Development which has recently been updated with sub-plans at island level. While providing a valuable overall description of the current situation, the NPHRD is less useful in its analysis of future issues, e.g., the need to address the quantity and the quality of human resources in the medium term, given the advancing average age of health staff.

The NPHRD served as the basis for selecting: (i) 50 health staff (including 12 medical and 16 paramedical personnel) to receive specialized training abroad in African universities (in Benin, Niger, and Senegal); and (ii) 39 health staff (including 8 doctors in public health and 31 health services administrators) to be trained in-country under the auspices of the *Centre National de Formation et de Recherche en Santé Publique* with supervision from internationally-recruited specialists of the University of Bordeaux II. Apart from the final papers prepared by the CNFRSP students (see Annex 7), no evaluation of the approach or the quality of the training was available. Further evaluation of the return rate of the trained staff to suitable positions and the usefulness of the training over time will be necessary.

Project financing also rehabilitated offices, purchased equipment and vehicles for MOH and the island directorates, and provided operating costs which would not otherwise have been available through the Government budget. In addition, the project funded important work in analyzing the sector and in formulating policies and plans (see Annex 7). Much of the sector analysis focused on poverty, specifically the access to care (study on indigence) and the impact of exemptions on the use of preventive services. The project also participated in the household survey on the utili-zation of health services; organized regional workshops to draft preparatory health documents for the PRSP; analyzed the pilot village insurance scheme; and carried out the beneficiary survey. Further, the project supported preparation and partially funded the *Etats Généraux de la Santé*, which was a necessary step toward the formulation of the current National Health Policy, which strengthens some elements of the previous sanitary reform. Based on the results of the *Etats Généraux*, the project also supported the production of a Three-Year Investment Plan.

Finally, the project partly financed two major surveys: (i) an evaluation of the HIV situation (sero-prevalence, socio-behavioral survey, etc.) with UNICEF, UNDP, WHO, and Sherbrooke University of Canada; and (ii) the National Population and Habitat census under the auspices of UNFPA.

Component D. Project Management: Satisfactory (see sections 5.3 and 7.6)

4.3 Net Present Value/Economic rate of return:
N/A

4.4 Financial rate of return:

N/A

The PAD did provide a cost-effectiveness analysis for each of the components, but subsequent developments (in the evolution of the context and the implementation of the project) make the assumptions on which the analysis was based virtually meaningless for current comparison.

4.5 Institutional development impact:

The project had a **moderate impact** on the institutional development of the sector. Support for decentralization was already firmly established within the health sector, but the project's revision of the DCA to recognize and finance the island implementation units provided added backing for the process. Health sector support and the project's own initial objectives for implementing a national poverty reduction strategy were far less broadly accepted. Subsequently, the project kept the issue at the forefront of the country dialogue (through the institutional strengthening component, the organization of "health and poverty" workshops, etc.), but it had no visible impact on Ministry or Government policies and strategies.

Within the health sector, the institutional development impact could have been substantial if the appropriate decision-making structures had operated effectively. At ministerial level, conflicts between the central and island authorities contributed to the underutilization of a number of documents offering options for strengthening the sector: the national health policy, the medium-term investment plan, the human resources development plan, the study of options for financing prenatal care, etc.). In other areas, project support for the HIV/AIDS analysis and the national census provide a sound basis for dialogue with the Government. At health facility level, the operationalization of the management bodies (as envisioned by the health reform legislation) and the increased involvement of the community could have contributed to better organization and more rational prices for public health services.

5. Major Factors Affecting Implementation and Outcome

5.1 Factors outside the control of government or implementing agency:

Ongoing socio-political conflict. The Third Health Project was implemented during a period of virtually constant internal strife and increasing socio-economic disorder, which qualified the country for LICUS status, hindered implementation, and delayed any chance of positive impact during the life of the project. Suspension of the second project (for non-payment of arrears), delays in the start of the third project (following the secession of *Anjouan* from the federation), and the need to revise the DCA within the context of a decentralized institutional structure (to include project implementation units for each island), effectively reduced the length of the project from 4 to 3 years (from June 2001 to June 2004).

Reduced foreign assistance. The 3-year health sector investment plan (May 2002) demonstrated the Government's reliance on foreign assistance and indicated the potential implications of a projected 50% reduction between 2003 and 2005 as a result of the prolonged crisis. As a consequence, the project became de facto the single remaining source of financing for implementing a broad range of health sector development activities (and the volume of project activities was in fact increased). With the subsequent drop in the value of the dollar the problem was further aggravated, as it is estimated that the financing available from the project was reduced by some $800,000 (or 9.5% of the proceeds of the credit).

5.2 Factors generally subject to government control:

Government preference for infrastructure and chronic underfunding of the health sector. Government's determination to use the credit to rehabilitate and (to some extent) expand infrastructure, combined with the known sector financing issues, led to predictable problems for both implementation of the project and achievement of the development objectives. Initially, the project allocated approximately 50% of the proceeds for civil works and goods; at mid-term, the amount allocated for these categories was estimated at more than 70% of the total amount of the credit.

While the project was responsive to the client's real need to rehabilitate a health infrastructure in disrepair, and there were justifications (on a case by case basis) for the rehabilitation of selected health facilities, no overall health facility development plan was ever prepared to justify (or limit) the use of project funds. Nor was sufficient consideration given to the Government's inability to finance non-salary related (and periodically even salary related) recurrent costs and to the issue of whether the Government could maintain the new investments or whether such costs would ultimately undermine potential gains in the effectiveness and quality of health services.

Underdeveloped sector reforms and resource management tools. The project assumed that the prior adoption of the sectoral reforms provided a basis for investment in infrastructure; in fact, few of the regulatory instruments adopted by the Government were effectively implemented, and the project should have allocated more resources for and attention to the monitoring of reforms.

In addition, while the project tried to improve human resources, sector financing issues were only barely addressed, drug accessibility was inadequately addressed, and maintenance was pushed off to the future project. Despite the capacity building efforts of the previous project and the other aid agencies (especially UN and the few bilateral donors), management of the health sector's human, material, and financial resources remains rudimentary at best. The rapid turnover of high level health officials, the lack of administrative and financial controls, and the absence of real accountability have allowed the (often indiscriminate) development of dubious pricing policies and medical practices within the public and private (or rather privatized public) sectors.

Inadequate development of pro-poor policies for health services delivery. Though a national anti-poverty plan was formulated and endorsed by the Government, this plan was not translated into initiatives to increase access to quality health services for the poor. Further, the PAD argued that in view of the perennial Government underfinancing of the health sector over the previous decade, the project should enable the health facilities to "function to the maximum extent through cost recovery mechanisms and external financing." Not surprisingly, the lack of Government financial support to the sector has resulted in pronounced efforts by public health facilities to generate funds (through the payment of fees, laboratory tests, drugs, etc.); combined with the lack of guidelines and controls for the management of receipts and the continued poor quality of services, these efforts have decreased utilization rates, particularly for the poor.

5.3 Factors generally subject to implementing agency control:

Limited implementation capacity. Despite the fact that the project was the third in the sector, implementation capabilities remained limited. Further, because of delays in project start-up as

well as the need to recruit the various new implementation staff on the different islands, previous implementation experience from the second project was lost. In addition, the second health project did not produce an implementation manual which was done prior to the third health project but was subsequently revised to take into account new institutional and organizational arrangements. Even these changes could not anticipate certain difficulties encountered by the implementation units when meetings between representatives of the different islands were needed.

Procurement difficulties. In addition to the usual problems (complexity, slowness, etc.) with procurement, a number of other difficulties arose from: (i) the lack of interest in the Comoros as a market for works, goods, and services; and (ii) the inadequacies of the single commercial bank present in *Moroni*. In particular, the packaging of the procurement packages in small lots may have favored local competition but did not guarantee quality. With somewhat more creative packaging (e.g., equipment purchase with maintenance), the amount of the overall package might have resulted in a more advantageous offer for the project. Further, as an evaluation of the civil works component notes, the technical capacity of the successful bidders was suspect and the quality of the works, goods, and services provided was questionable.

5.4 Costs and financing:

The total project cost of US$ 10.0 million was to be financed by IDA (84%), with support from WHO (4% for malaria case management), UNICEF (2% for community mobilization), Government (1% for in-kind contributions), and beneficiaries (9% essentially for the purchase of bed nets). As of the end of May 2004, cumulative IDA disbursements totaled SDR 5.8 million or 94% of the credit, with the remaining funds totally committed. Data on the contributions from the other financing sources are unavailable.

6. Sustainability

6.1 Rationale for sustainability rating:

While the **overall assessment for project sustainability is considered unlikely**, this assessment varies by project component.

Component A. Rehabilitation and equipment of selected health facilities: Highly Unlikely

The sustainability rating of the component is based on an inadequate definition of responsibilities for maintenance and insufficient financial resources likely to be available to maintain the current project's investments. As a disbursement condition for civil works, the management board of each health facility had to sign (prior to starting the civil works) an agreement stipulating their administrative and financial responsibilities for the three years following completion of the rehabilitation. In fact, these agreements were not systematically signed, and in any case their enforceability was doubtful and the amounts promised were not based on any financial analysis of the facility (as was intended by the disbursement condition). Subsequently, the health component of the FADC Project has committed sufficient funds to cover (according to the rough calculations of the ICR team) the most sensitive equipment already purchased by the project but would not cover any new equipment envisaged by the new FADC.

Even more generally, there is no coherent health sector financing strategy to ensure the accessibility, quality, and concomitant utilization of health services. Since Government finances only salaries (and even then, only intermittently), without donor support the only funding readily available to the health services results from cost recovery, which has not proved to be beneficial to the populations. A 20% tax on alcohol and tobacco to be used to finance health services has been adopted by the Government but not yet implemented. The Ministry of Social Affairs believes that this tax would generate 180 million FC a year, but this amount constitutes only a third of the reported revenues generated by cost recovery. It seems unlikely that even full implementation of the tax would provide adequate financing to maintain the health facilities.

Component B. Control of malaria: Likely

The sustainability of this component is based on: (i) adaptation of the initial program strategy to the existing social and political realities of the country; (ii) establishment of a fund generated by the project's sale of bed nets to ensure the purchase of additional bed nets; and (iii) newly available Global Fund resources to continue implementation of the current strategy with a particular emphasis on community mobilization (given the Fund's conclusion that this aspect was somewhat neglected by the Project and the National Program). While there are continuing doubts about the commitment of the authorities of the *Grande Comore* to implement the larvae-eating fish element, concerns about Government's capacity to properly implement the new guidelines for first line drug treatment, and potential difficulties with future re-impregnation and/or replacement of bed nets, the project has initiated the appropriate steps to increase the chances that the activities will be sustained.

Component C. Institutional strengthening: Unlikely

With respect to training, much of the long-term specialist training has not yet been completed. It will be financed in the future by the FADC Project, but the decision to carry out the training in other African countries (rather than in France) will certainly increase the likelihood that the specialists return to the Comoros. No information is yet available to assess the beginning and final competencies of those who participated in the training organized locally by the University of *Bordeaux*; further; a similar test should be executed within 6-9 months to determine the durability and ultimate usefulness of the knowledge and skills acquired.

With respect to the other elements of this component, sustainability is considered "unlikely" due to: (i) the lack of clear responsibilities and required resources for the central level to carry out its constitutional mandates; (ii) insufficient capacity to implement the required sectoral reforms, even in those (rare) instances where there is consensus on what should be done; and (iii) inadequate financial resources for the foreseeable future to encourage the Government to implement adequate measures to monitor performance of and improve accountability for health service delivery.

6.2 Transition arrangement to regular operations:

With no follow-on health project, transition arrangements were ongoing at the time of the ICR mission; three issues were already apparent: (i) the pending arrangements for completing the actions of the closed project; (ii) the orderly transfer of the project's material acquisitions and technical competence; and (iii) the lack of a mechanism to monitor the project's contributions to

the development of the health sector.

Completion of pending project actions. Two aspects of the completed project have been included in the proposed FADC Project: (i) the costs of maintaining the equipment purchased by the health project; and (ii) the remaining costs for training some 20 health professionals who have already commenced their specialist training.

Orderly transfer of the project's human and material resources. While CEP has taken the required administrative measures to ensure that equipment and vehicles acquired by the project are transferred to the appropriate bodies (i.e., from the implementing units at central level to the Union ministry and at local level to the island ministries), the transfer of the human resources developed by the project is unclear. Because the implementation units were not integrated into the different health administrations (and project staff were contractual), the effective transfer of the technical capacity developed by the project to the local health administrations is unlikely.

Follow-up on the closed project. Perhaps more important than the lack of funding to ensure the proper functioning of the investments in infrastructure and human resources is the uncertainty surrounding the institutional structures, responsibilities, and arrangements established under the new Union constitution. The project attempted on several occasions to interest the authorities in conducting an institutional assessment, but this proposal was never accepted.

7. Bank and Borrower Performance

Bank

7.1 Lending:

Overall, the Bank's lending performance is judged to be **satisfactory**, primarily because: (i) the project concentrated on the appropriate issues and provided an adequate level of resources; and (ii) whatever design flaws eventually emerged could have been identified and addressed earlier during implementation (see 7.2 below).

Lending performance must be seen in the context of the Bank's evolving strategy for LICUS countries in general and for Comoros as a whole. Following unsuccessful efforts by the Bank and the IMF (2000-02) to implement programs to stem the country's socio-economic decline, a transition support strategy was negotiated and adopted (2003-04) with the objectives of main-taining basic social services and facilitating capacity-building to create more viable institutions. In response to a pattern of unsuccessful public sector projects, a fundamental part of this strategy involved reorienting the Bank's portfolio away from support for Government-implemented projects and toward community-driven projects. At the time of project closing, the Bank's portfolio comprised two projects, with the health project as the only remaining Bank intervention being implemented by the Government. In other words, while Bank lending to the country as a whole, and to the public sector in particular, was ultimately judged unsatisfactory, the health project was rightly not included among these failed projects and was maintained through closing.

While the Quality at Entry Assessment of October 2001 anticipated some of these conclusions, it nevertheless evaluated the Bank's performance in preparing the project as satisfactory, though

noting accurately that risks (and risk minimization measures) were only marginally satisfactory. In particular, QEA's identification of the lack of "an exit strategy" with respect to facility rehabilitation and equipment should have provoked more action, since the project's results may ultimately aggravate sector financing (at least theoretically, since the Government will certainly not be increasing its non-salary recurrent budget).

7.2 Supervision:

Though implementation and supervision support from the Bank's Task Team were regular and responsive to the evolving needs of the client, repeated Bank missions and management reviews of the PSRs failed to adequately assess the diminishing chances of achieving the DOs and thus to propose timely and appropriate corrective measures; consequently, supervision performance was **unsatisfactory**.

Organized from headquarters prior to suspension supervision was carried out by the country office based in Madagascar thereafter. From July 2000 to June 2004, seven site visits were conducted, including the Mid-Term Review held in May 2002. The frequent presence of the TTLs in the field as well as the support of the country office (and at critical moments of the Country Director) was highly appreciated by the client and the other development partners. Budget constraints limited the range of support but project management skills and the continuity of project supervision staff was appropriate. In particular, the *aide-memoires* provided the necessary guidance to enable the project management staff to avoid potential difficulties.

Two project design issues emerged during implementation and should have been addressed. First, with respect to the health facility rehabilitation component, the Bank focused on outputs (e.g., civil works, equipment, training, etc.) and continued to assume that improvements in supply would resolve the persistent under-utilization of services. While supervision emphasized the need for: (i) other accompanying measures (e.g., norms and standards, supervision, etc.) to ensure the quality of health services and (ii) complementary demand-enhancing activities (including reduction or elimination of fees for certain services), the results came too late, the institutions lacked the capacity to implement changes, and the resources to address demand-related issues had already been spent on increased supply.

Second, with respect to the institutional strengthening component, the Bank neglected the formulation and monitoring of measures to provide continuing support for the implementation of the reforms initiated and/or achieved by the second project. In particular, the project's inability to strengthen health facility management, to increase the accessibility of affordable drugs, and to improve the accessibility of the poor to health services constitutes a weakness of the project.

7.3 Overall Bank performance:

Overall Bank performance was rated **unsatisfactory** despite the many positive results obtained (in large measure as a result of the Bank's commitment and flexibility) under extremely difficult circumstances. This rating is justified by the fact that the Bank focused on disbursing the credit with insufficient regard for the measures initially envisioned to protect the investments and inadequate analysis of the project's progress and prospects. Whether the Bank had any adequate measures available to force appropriate changes is debatable: the country portfolio was being drastically modified and reoriented (see 7.1); the health project had already been suspended once

and its implementation period reduced (see 5.1); and the civil works and equipment contracts had already been tendered.

Borrower

7.4 Preparation:

As a follow-up project, Borrower performance was **satisfactory**. The borrower was actively involved in preparing architectural designs for the health facilities rehabilitation component and provided a quality technical team to prepare the malaria component.

7.5 Government implementation performance:

Due to frequent changes among ministerial authorities and lack of Government commitment for the objectives of the project, Government implementation performance was **unsatisfactory**. It should be noted that no counterpart funding was required from the Government based on its continuing inability to provide such funds.

Two conditions of the DCA were not met. First, the DCA required, as a condition for civil works disbursement, that each health facility to be rehabilitated have established adequate financial systems with financial statements produced and validated by MOH and satisfactory to IDA. While none of the four facilities evaluated prior to disbursement were found to meet the condition, agreement could not be reached on how to remedy the situation, and the civil works went forward anyway. Second, the DCA mandated annual sector reviews, but none was ever held, due to the islands' inability to agree on the appropriate institutional venue for organizing the event; indeed, the workshop to discuss the results of the mid-term review only occurred when responsibility for it was shifted from the Ministry of Health to the *Commissariat au Plan*. In lieu of such reviews, project staff were invited to participate in formal meetings among partners, often during the supervision missions.

7.6 Implementing Agency:

The overall performance of the *Cellule d'exécution du projet* (CEP) was **satisfactory** despite the poor performance of the procurement unit.

From the beginning, the project implementation unit included staff from the previous project responsible for procurement and financial management. Selection of the project coordinator was protracted, and his annual performance reviews (and contract renewal) by the ministry officials (first Health and then Social Affairs) were a potential source of conflict. Recruitment of project staff for the different islands went smoothly and their presence facilitated project implementation (even when conflict between the central and island authorities was most acute). Project staff remained stable during implementation.

Approval of project plans respected the DCA, with both the annual work plans and budgets and any subsequent modifications submitted to the TTL for non objection. The required quarterly reports were, however, not prepared and annual reports were not readily available; several sum-mary reports (prepared for the MTR and the ICR) were prepared but were more descriptive than analytical. Financial management was strong and allowed the project to remain within budget even with a weakening dollar over the final year of the project. Though not every audit was completed within the timeframe of the DCA, all were unqualified.

Procurement planning and implementation were far less satisfactory. An evaluation of the civil works noted significant weaknesses (due in large measure to poor performance by the consultant recruited to control the quality of civil works), and discussions with the local health authorities indicate their dissatisfaction with the quality of the equipment delivered. The existence of a single commercial bank in *Moroni* and its unwillingness to provide even a simple letter of credit also undermined the performance of the procurement unit.

7.7 Overall Borrower performance:

Overall Borrower performance was rated **unsatisfactory.** Though there are mitigating circum-stances for this conclusion (the ongoing politico-institutional conflict, the reduced time period for project implementation, and the results of comparable projects being implemented by the Union Government), the inadequate achievement of the DOs and the unlikely sustainability of the project's outputs provide the justification for this rating.

8. Lessons Learned

The difficulties of maintaining health sector reforms should not be underestimated. Given the achievements of the previous project, the current project estimated the risk of not continuing the reforms as "moderate" and provided relatively little technical and financial support (only about 10% of the total project cost) for pursuing the reforms. In fact, very few of the legal and regulatory texts cited in the PAD ever became operational, and there is no indication that the third health project invested significant time or effort in following up on them. Of particular importance was the insufficient project preparation to follow-up on the PNAC and to develop modalities for ensuring services for the poor. The risk should probably have been considered "substantial" at a minimum and appropriate measures included to ensure continued support and monitoring during implementation.

Project restructuring should be considered after long delays in implementation. Despite the lengthy preparation and delays in implementation due to the suspension, the current project was eventually implemented without major changes in its overall formulation. Instead, project modi-fications occurred in a piecemeal fashion: (i) when the malaria control strategy was substantially modified (but without a change in the DCA); (ii) then after the formal determination of the islands' powers and prerogatives required a revised DCA; and (iii) finally when significant additional changes were incorporated during the mid-term review. Given the sum total of these changes (and the intervening classification of Comoros as a LICUS country), a more thorough review of the project earlier might have been useful. In this sense, the perhaps too narrow focus of the QEA conducted in 2001 constituted a missed opportunity.

Regional specificities, even in small countries, must be taken into account during project preparation and implementation. While the PAD correctly identified political instability as a high risk, the mitigation measure ("to work with a community focus") did not sufficiently capture the particularities of the islands (e.g., health care expenditures in *Grande Comore* are generally four to six times higher than in *Anjouan* or *Mohéli*) and the sensitivities involved in working with them individually and collectively. The establishment of the island implementing units was an important step in recognizing the need to adapt project implementation to the concerns of the

local authorities. As a result, though the island authorities contested a number of the project's ideas, the island implementation units were able to assure them that the project would be adapted to the local context (which was especially important in the case in *Anjouan*).

Where capacity for policy analysis and program decision-making is inadequate, project design and implementation must develop a consensus for program implementation. The project was able to overcome implementation problems and execute the facility rehabilitation and malaria control components of the project because there was consensus on what to do. Where project resources were used to develop a consensus and a plan for responding to emerging issues and opportunities, project performance was more problematic. On the one hand, while there was no recognition in the PAD (or the Letter of Sector Policy) of the need to improve (or the risk of not improving) the availability and use of health management information for improving service delivery, the project demonstrated that where data were collected on a perceived problem (e.g., on the malaria control strategy and the distribution of human resources), it was used to make important decisions.

On the other hand, the future use of the studies carried out on issues involving accessibility of the poor to quality health services will be instructive, since it is unclear that the authorities perceive this as a problem in the same way that IDA does. In the similar instance of the project's support for the organization of the *Etats Généraux de la Santé*, the formulation of a revised health policy, and the preparation of medium-term investment, these analyses were essentially unused, even though structures were established to help prepare and follow up on the results.

9. Partner Comments

(a) Borrower/implementing agency:

A summary of the Ministry's contribution to the ICR may be found in Annex 8; their evaluation emphasizes especially the quantitative outputs of the project and the likelihood that the newly rehabilitated and equipped health facilities, staffed with newly trained health personnel, will markedly improve the quality of health services. The evaluation notes that the project's results were achieved despite a very difficult context which continues to evolve; it also argues that future health sector development must be based on: (i) the linkages between poverty and health (particularly with respect to financing services for the most vulnerable populations); and (ii) an evidentiary basis (through more rigorous health information systems) for documented results and medium-term and annual planning.

These views were echoed in discussions with central and island ministry staff; in addition, the authorities expressed great anxiety about follow-on financing for the sector and little confidence that the FADC would provide adequate support either for maintenance of the current investment or for further development of the health sector.

(b) Cofinanciers:

Currently, with the exception of the UN agencies (WHO, FNUAP, and UNICEF) and the French Cooperation, there are virtually no other partners. Discussions with the UN agencies, who parti-cipated directly in implementing the malaria component (WHO and UNICEF) and the national census (UNFPA), noted in particular the complementary nature of the project's investments in hardware with their own in software and support. They further noted: (i) the

useful collaboration in the preparation of terms of reference (e.g., for organizing the local training); and (ii) the importance of the Bank's role, in the absence of a Government forum, in promoting the periodic meetings of the partners.

(c) Other partners (NGOs/private sector):

The ICR team met with ASCOBEF (the local IPPF affiliate), which will be executing the Global Fund grant for malaria and learned that it intends to follow up on the strategy developed under the current project. The team also examined the proposal by a French NGO to provide assistance to the Ministry in establishing maintenance capabilities; an analysis was submitted to the TTL.

Though the ICR team did not meet with beneficiaries, previous workshops in 2002, an evaluation of decentralization in 2003, and a final beneficiary assessment (there was no initial evaluation) in 2004 provide some information on their concerns.

The workshops and focus group interviews indicate similar concerns: (i) the ill-defined but always high cost of services (for basic pre-natal consultations and assisted delivery and especially for drugs); (ii) the poor organization of basic and referral services; and (iii) the inhospitable delivery of services by personnel of often dubious qualifications.

The evaluation of decentralization indicated: (i) overall approval of the performance of the URP coordinators; and (ii) satisfaction with the results of the project while noting some tension between the CEP and the URPs in the implementation of the project (particularly concerning the centralization of certain aspects). At the same time, there were complaints about delays (and additional needs) in project implementation, the poor quality of the civil works, and the difficulties of communication.

The beneficiary assessment (see Annex 9) determined that about 25% of household heads knew of the project's interventions. Household heads overwhelmingly expected the improved infra-structure (95%) and equipment (99%) to improve the quality of health services. Sixty percent of household heads were, however; concerned about future maintenance of the facility and its equipment. Almost 72% of the household heads had either never or rarely utilized the health facility, principally because of the cost (which 84% estimate as too high).

10. Additional Information

Annex 1. Key Performance Indicators/Log Frame Matrix

Output Indicators

Indicator at Appraisal	Projected Result at Appraisal	Actual / Latest (from PSR)
Under 5 Mortality rate	Decrease from 100 to 75 per 1000 live births	74/1000 (2000 MICS)
No. of deaths due to malaria among under 5 children	Decrease from 800 to 500	19/590 : 3.2% at El Maarouf hospital
No. of curative visits per capita per year	Increase from 0.4 to 1.0	0.15 Anjouan 0.43 Grande Comore (2002)
Beneficiary satisfaction with services provided		Final beneficiary assessment indicates overall satisfaction
No. of health facilities rehabilitated by the project	4	14
No. of health facilities equipped to national standard by the project	5	11
No. of MOH personnel trained (both central/regional levels)	110	135
Sales of bed nets	50,000 in 1998 (2000) 20,000 per year thereafter	50,000 (non impregnated) in 2002 30,000 (non impregnated) in 2003 for (Grande Comore) 11,000 (impregnated) in 2004 for (Anjouan et Mohéli)
No. of bed nets impregnated	60,000 in 1998 (2000) 80,000 in 1999 (2001) 100,000 in 2000 (2002) 120,000 in 2001 (2003) 140,000 in 2002 (2004)	78,000 impregnation kits distributed Impregnation of bed nets with liquid insecticide continued (number unknown)
No. of villages where all cisterns have larva eating fish	211 in Grande Comore 30 in Anjouan	11,780 households in Grande Comore

Annex 2. Project Costs and Financing

Project cost by component in US$ million equivalent

Project Components	Financier (1)	Appraisal	Actual	Percentage of appraisal
Rehabilitation and equipment of selected health facilities in all three islands	**IDA**	**3.1**	4.67	151%
Malaria control program	Total	3.9		
	IDA	**2.3**	0.50	22%
	WHO	0.41		
	UNICEF	0.13		
	Beneficiaries	0.9		
	Government	0.12		
Institutional strengthening of MOH	**IDA**	**2.4**	3.06	102%
Project Implementation	**IDA**	**0.6**		
Total	**IDA**	**8.4**	8.23	98%

(1) Not-bank-financed includes elements procured under parallel co financing procedures, consultancies under trust funds, any reserved procurement, and any other miscellaneous items

Project Costs by Procurement Arrangements (Actual/Latest Estimate) (US$ million equivalent)

Expenditure Category	Procurement Method[1] ICB	NCB	Other[2]	N.B.F.	Total Cost
1. Works	1.50 (0.57)	0.10 (1.33)	0.00 (0.38)	0.00 (0.00)	1.60 (2.28)
2. Goods	1.90 (2.71)	0.20 (0.14)	1.10 (0.39)	0.00 (0.00)	3.20 (3.24)
3. Services	0.00 (0.00)	0.00 (0.00)	3.00 (1.96)	0.00 (0.00)	3.00 (1.96)
4. Miscellaneous	0.00 (0.00)	0.00 (0.00)	0.60 (0.77)	0.00 (0.00)	0.60 (0.77)
5. Miscellaneous	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)
6. Miscellaneous	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)
Total	3.40	0.30	4.70	0.00	8.40

	(3.28)	(1.47)	(3.50)	(0.00)	(8.25)

[1/] Figures in parenthesis are the amounts to be financed by the Bank Loan. All costs include contingencies.

[2/] Includes civil works and goods to be procured through national shopping, consulting services, services of contracted staff of the project management office, training, technical assistance services, and incremental operating costs related to (i) managing the project, and (ii) re-lending project funds to local government units.

Project Costs by Category (US$ million equivalent)

Category	Appraisal	Revised	Disbursed	Percentage disbursed of Appraisal
Civil works	1.5	2.7	2.280	152%
Equipment Vehicle Supplies	3.0	3.0	3.241	108%
Studies Audits, Services	2.8	1.9	1.957	70%
Operating	0.5	0.8	0.765	153%
Un allocated	0.6			
Fund SA-A Remaining funds in the special account			-0.013	
TOTAL	8.4	8.4	8.231	98%

Project Costs by Year (US$ million equivalent)

Year (calendar yr)		Original Amount		Formally Revised Amount		Actual Amount	
Appraisal	Actual	Yearly	Cumulative	Yearly	Cumulative	Yearly	Cumulative
1999	2000	0.98	0.98			0.31	0.31
2000	2001	2.69	3.67	2.09	2.09	0.20	0.50
2001	2002	2.60	6.27	3.85	5.95	1.97	2.47
2002	2003	1.51	7.78	2.43	8.38	1.26	3.73
2003	2004	0.62	8.4			4.30	8.03
	2005					0.20	8.23
TOTAL		8.4		8.4		8.23	

Annex 3. Economic Costs and Benefits

N/A

Annex 4. Bank Inputs

(a) Missions:

Stage of Project Cycle	No. of Persons and Specialty (e.g. 2 Economists, 1 FMS, etc.)		Performance Rating	
Month/Year	Count	Specialty	Implementation Progress	Development Objective
Identification/Preparation				
June/1997	*1*	TEAM LEADER		
Appraisal/Negotiation				
November/1997	*1*	TEAM LEADER		
December/1997	*1*	TEAM LEADER		
Supervision				
August/1998 (Site)	*2*	TASK TEAM LEADER (1); PUBLIC HEALTH SPECIALIST (1)	S	S
February/1999 (Update)	*1*	TASK TEAM LEADER (1)	U	U
June/1999 (Update)	*1*	TASK TEAM LEADER (1)	U	U
December/1999 (Site)	*1*	FINANCIAL MANAGEMENT (1)	U	U
Mar/Apr/Jun/2000 (Update)	*1*	TASK TEAM LEADER (1)	U	U
July/2000 (Site)	*4*	TASK TEAM LEADER (1); HEALTH SPECIALIST (2) ; PROCUREMENT SPECIALIST (1)	S	S
February/2001 (Site)	*4*	TASK TEAM LEADER (1); HEALTH SPECIALIST (1); FINANCIAL MANAGEMENT (1); PROCUREMENT SPECIALIST (1)	S	S
April/2001 (Site)	*5*	TASK TEAM LEADER (1); HEALTH SPECIALIST (1); FINANCIAL MANAGEMENT (1); PROCUREMENT SPECIALIST (1); PROGRAM ASSISTANT (1)	S	S
December/2001 (Site)	*2*	TASK TEAM LEADER (1); PROCUREMENT SPECIALIST (1)	S	S
May/2002 (Update)	*1*	TASK TEAM LEADER (1)	S	S
Sept/2002 (MTR)(Site)	*4*	TASK TEAM LEADER (1); NGO SOCIAL MARKETING (1); NGO MALARIA (1); HEALTH ECONOMIST (1)	S	S
May/2003 (Site)	*1*	TASK TEAM LEADER (1)	S	S
December/2003 (Site)	*3*	TASK TEAM LEADER (1); CONSULTANT (1); ASSISTANT (1)	S	S

	June/2004 (Update)	*1*	TASK TEAM LEADER (1)	U	U
ICR	August/2004 (Site)	*2*	PUBLIC HEALTH SPECIALIST (1); MANAGEMENT SPECIALIST (1)	S	U

(b) Staff:

Stage of Project Cycle	Actual/Latest Estimate	
	No. Staff weeks	US$ ('000)
Identification/Preparation		
Appraisal/Negotiation		83,826
Supervision		435,606
ICR		28,473
Total		547,905

Annex 5. Ratings for Achievement of Objectives/Outputs of Components

(H=High, SU=Substantial, M=Modest, N=Negligible, NA=Not Applicable)

	Rating
☐ *Macro policies*	○ *H* ○ *SU* ○ *M* ○ *N* ● *NA*
☐ *Sector Policies*	○ *H* ○ *SU* ○ *M* ○ *N* ● *NA*
☐ *Physical*	○ *H* ○ *SU* ● *M* ○ *N* ○ *NA*
☐ *Financial*	○ *H* ○ *SU* ● *M* ○ *N* ○ *NA*
☐ *Institutional Development*	○ *H* ○ *SU* ● *M* ○ *N* ○ *NA*
☐ *Environmental*	○ *H* ○ *SU* ○ *M* ○ *N* ● *NA*
Social	
☐ *Poverty Reduction*	○ *H* ○ *SU* ○ *M* ○ *N* ● *NA*
☐ *Gender*	○ *H* ○ *SU* ○ *M* ○ *N* ● *NA*
☐ *Other (Please specify)*	○ *H* ○ *SU* ○ *M* ○ *N* ○ *NA*
☐ *Private sector development*	○ *H* ○ *SU* ○ *M* ○ *N* ● *NA*
☐ *Public sector management*	○ *H* ○ *SU* ○ *M* ○ *N* ● *NA*
☐ *Other (Please specify)*	○ *H* ○ *SU* ○ *M* ○ *N* ○ *NA*

Annex 6. Ratings of Bank and Borrower Performance

(HS=Highly Satisfactory, S=Satisfactory, U=Unsatisfactory, HU=Highly Unsatisfactory)

6.1 Bank performance	*Rating*			
☐ *Lending*	○ *HS*	● *S*	○ *U*	○ *HU*
☐ *Supervision*	○ *HS*	● *S*	○ *U*	○ *HU*
☐ *Overall*	○ *HS*	● *S*	○ *U*	○ *HU*

6.2 Borrower performance	*Rating*			
☐ *Preparation*	○ *HS*	● *S*	○ *U*	○ *HU*
☐ *Government implementation performance*	○ *HS*	● *S*	○ *U*	○ *HU*
☐ *Implementation agency performance*	○ *HS*	● *S*	○ *U*	○ *HU*
☐ *Overall*	○ *HS*	● *S*	○ *U*	○ *HU*

Annex 7. List of Supporting Documents

Rehabilitation and Equipment of Health Facilities

Issa Ben Imani, Chamisidimy Lahilahi *et* Abdallah Ahmed Allaoui, *Rapport de la Commission Nationale chargée de la finalisation et de la validation du DAO des équipements et matériels médico-chirurgicaux des formations sanitaires (déc. 2001).*
Daniel Dupéty, *Evaluation des travaux de génie civil (avril 2003).*
Luxconsult, SA, *Avant projet de construction du Pavillon mère du CHR El Maarouf de Moroni (nov. 2003).*
M. Boinali, *Rapport sur les équipements hospitaliers / Compte rendu de la répartition des équipements par site (fév. 2004)*

Fight against Malaria

José A. Nájera, *Recommandations: Stratégie et plan d'action pour 2001 (nov. 2000).*
Institut Pasteur de Madagascar, Etude de sensibilité des parasites et des vecteurs du paludisme dans l'archipel des Comores (août 2001).
Rapport de la mission à Madagascar sur la formation en marketing social et communication (avril-mai 2002).
Compte rendu de l'atelier relatif à la promotion des moustiquaires imprégnées d'insecticide (Grande Comore et Anjouan) (mars-avril 2002).
Institut Pasteur de Madagascar, Etude d'efficacité thérapeutique sur l'accès palustre non compliqué (2003).
Institut Pasteur de Madagascar, Etude de chimio-sensitivité..

Capacity Building

Situational Analysis

MSPCF, *Annuaire Statistique pour l'année 1999 (sept. 2001).*
MSPASCF, *La santé des Comoriens (janv. 2002).*
Projet Santé III, *Recherche qualitative sur l'impact de la gratuité des soins antenataux (mars 2002).*
Santé et Pauvreté, Rapport Final des ateliers organisés par le Projet Santé III/IDA (mai 2002).
Michelle Ratsivalaka, Evaluation de la décentralisation et de la performance des Unités Régionales du Projet Santé III (juin 2003).
Projet Santé III, Analyse statistique de l'enquête sur l'accès aux soins des catégories sociales en situation de grande précarité (sept. 2003).
ONUSIDA/Université de Sherbrooke, Enquête socio-comportementale sur le VIH/SIDA et IST auprès de la population générale (sept. 2003).
Kassim A. Mondoha, Yasmina Dada *et* Mohamed Msaidié, *Organisation de l'enquête sur l'accès aux soins de santé (2004).*
KAM Invest, *Etude d'évaluation d'impacts du Projet Santé III: Etude auprès des bénéficiaires (juin 2004).*

Policies and plans

MSPCF, *Document d'orientation stratégique des Etats Généraux de la santé (juil.*

2001).

MSPASCF*, Evaluation de la réforme du système de santé (octobre 2001).*

MSPCF*, Etats Généraux de la Santé; Rapport final (novembre 2001).*

MSPASCF*, Plan National de Développement des Ressources Humaines (2001-2010) (avril 2001).*

Union des Comores, Réactualisation du Plan National de Développement des Ressources Humaines (PNDRH) (Grande Comore, Andjouan et Moéli) (sept. 2003).

Comité de suivi, Plan Triennal d'investissement pour la période 2003-2005 (mai 2002).

Summaries of May 2004 studies

Financement du CNH d'El Maaroug: Analyse retro prospective.

Analyse du système des approvisionnements des produits pharmaceutiques à Mohéli.

Etude des détérminants de la malnutrition chez les enfants (0-59 mois) dans le district sanitaire de Domoni (Anjouan).

Etude des difficultés liées à la baisse de la couverture vaccinale chez les enfants (0-11 mois) dans le district sanitaire de Mitsamiouli.

Etude critique du fonctionnement du service d'urgence au CHR de Hombo (Anjouan).

Organisation et administration de la santé de l'Ile Autonome de Ngazidja.

Etude de l'impact de l'utilisation des moustiquaires imprégnées dans l'Ile Autonome de Mohéli.

Le recouvrement de coûts dans le CS de Mremani (Anjouan) 2000-2003.

Contribution à la consolidation et au développement des mutuelles de santé à la Grande Comore.

Gestion des ressources humaines dans le système de santé aux Comores: Cas du CHN El Maarouf.

Evaluation de l'utilisation des moustiquaires imprégnées dans le district sanitaire de Foumbouni.

Etude sur le tabagisme en milieu scolaire dans l'Union des Comores.

General Census

Présidence de l'Union, Commissariat Général du Plan, UNFPA, Direction Nationale du Recensement : Projet Appui COI/03/P04 ARGPH "Appui au Recensement Général de la Population et de l'Habitat rapport d'activités Année 2003 (déc. 2003).

Project Management

Manuel d'exécution du Projet Santé III (mars 1998).

Delta Audit, Audit de Gestion du Projet Population et Ressources Humaines, Composante Santé (nov. 2000).

Bureau d'études Astrum, Manuel de procédures administratives, comptables et financières (janv. 2001).

De Chazal du Mée, Audit du Projet Santé III; Excercice Cloturé le 31 décembre 2000 (Rapport d'audit et rapport de gestion) (juin 2001).
Projet Santé III, Rapport annuel du Projet (juillet 2000 – juillet 2001) (juil. 2001).
Société Tomate, Conception d'un système d'information de gestion (déc. 2001).
Société Tomate, Rapport de mise en place du SIG (fév. 2002).
Cabinet Mazan-Fivoarana, Rapport relatif à l'audit des états financiers, des relevés des dépenses et du compte spécial du Projet Santé III pour l'exercice clos au 31 décembre 2001 (rapport provisoire avril 2002).
CEP, Rapport de la Revue à mi-parcours et de la reprogrammation (mai 2002).
Groupement Mazars & Guérard et Mazars Fivoarana, Rapport relatif à l'audit des états financiers, des états justificatifs du solde du compte spécial et des relevés des dépenses du Projet Santé III pour l'exercice clos au 31 décembre 2003 (mai 2004).

Additional Annex 8. Borrower's Contribution

SUMMARY OF THE MINISTRY'S DOCUMENT

The Borrower's full contribution is attached; a summary of the Ministry's document and its principal observations is presented below.

In summarizing the project's objectives, the Borrower did not simply take the PAD's description, but restated them (perhaps more convincingly than in the PAD) as follows:

> The overall goal of Health Project III is to help the government enhance the population health and welfare, particularly of the most vulnerable groups (women, children, poor). Its main aim is poverty reduction and promoting health development by contributing to health service strengthening and reducing mortality due to the most common diseases in general and to malaria in particular.
>
> Its operational objectives consist in :
>
> - Building productive capacity in health system (both preventive and curative care) ;
> - Providing support to central services for these to assume their new functions as regards reporting, planning, and evaluation ;
> - Granting priority to investment likely to :
>   - Generate new financial resources (rehabilitating health formations, personnel training to improve health care quality, etc.) ;
>   - Reduce expenditures (anti-malaria fight) ;
>   - Promote development of local economic activities (funding new materials and equipment for PNAC, etc.),
>   - Facilitate setup of a mechanism to fund health insurance and to build up savings.
>
> Its priorities are expressed essentially at three levels :
>
> - At central level : to ensure capacity building as regards management and reporting management,
> - At peripheral structure level : to build and harmonize health and prevention capacity,
> - At regional government level: to consolidate regional government participation in health system working, and to build their contribution capacity to fund it.

The report provides a very clear presentation (missing in the PAD) of the institutional and opera-tional framework for project implementation.

For Component A, the report provides detailed information on the quantitative outputs of the project and in particular of the newly rehabilitated and equipped health facilities; detailed summaries of the works carried out, the equipments and vehicles purchased, and the costs are presented for each island as well as for the national level. For Components B and C, the report provides a less detailed summary of results, little cost information, and virtually no discussion of the implications of the results achieved.

The report summarizes in particular the political events which hindered project implementation and, and the report emphasizes the following constraints:

- Suspension of IDA credits in 1998 due to the national political context: according to the project appraisal document, the project design was based on the assumption of a rapid evolution of the economic, sociological, and political framework, and of the substantial reallocation of responsibilities to the operations of the health system. However, political instability, public finance crisis, and separatist crises towards late 1997 and early 1998 led to the fact that the State was no longer able to meet its financial commitments (regular payment of salaries, allocated subsidies, debts …). Such events resulted in suspension of IDA credits between August 1998 and March 2000.
- Delay in actual Project activities start-up: The initial Project planned a centralized Project Implementation Unit. Besides, one of priority actions was designing and setting up a centralized Project management structure that would involve community representatives in decision making. The Project had to prepare and implement a new, more decentralized, organization that required:
    - Signing a decree on the Project organization and working (in October 2000); and
    - Amending the credit agreement to integrate the March 2001 decentralization.
- The time limits granted for putting in place the Project management tools (namely as regards the manual of procedures) caused delay to launching and current activity implementation.
- Recruitment of personnel (based on candidacy submission) for decentralized structures: it occurred only in mid-June 2001.
- Effects of social and political crisis in *Anjouan* island: political problems and access difficulties to the islands as a whole, as well as waiting for new institutions caused delay among some parts of project, namely infrastructure rehabilitation and especially institutional strengthening. Project activities in *Anjouan* island were actually launched only in June 2001.

In conclusion, the evaluation notes that future health sector development must be based on: (i) the linkages between poverty and health (particularly with respect to financing services for the most vulnerable populations); and (ii) an evidentiary basis (through more rigorous health information systems) for documented results and medium-term and annual planning.

Additional Annex 9. Beneficiary Evaluation

The final beneficiary evaluation had as objectives to determine: (i) the population's satisfaction with the overall development of health services (especially the rehabilitation and equipment of health facilities) and the results of the malaria control activities; and (ii) the opinions of health personnel on the institutional support provided by the project. As an introduction, the report also provides a very useful summary of the current national and island structures involved in health.

A total of 947 households (out of the 1000 which the study had targeted based on the General Population Census) were questioned. The report provides information on the characteristics of: (i) the household heads (age, sex, marital status, educational level, profession, etc.); and (ii) the households (location, size, composition, urban/rural distribution, etc.).

The report then examines the population's knowledge and appreciation of the results of the health project. Approximately half of the heads of households (47%) had heard of the project; the project was best known in urban areas and in *Mohéli* (where 62% of the HHs knew of the project).

About 25% of HHs were aware of the project's interventions; of those aware of the project's actions in their district, 31% cited health facility rehabilitation, 21% cited equipment, and 28% cited malaria control. Beneficiaries uniformly (99%) believe that rehabilitation and equipment of health facilities is important or very important for improving health services; fewer (73%) believed that better transport would improve the quality of health services. Sixty percent of HHs were, however; concerned about future maintenance of the facility and its equipment.

The study estimated that almost two-thirds (64%) of the population was covered by a nearby health facility. In examining the use of health services, the study determined: (i) that 47% of households had someone sick in the two weeks preceding the study; and (ii) that 62% of these households had taken the sick member (diagnosed with malaria in 54% of the cases) to a health facility. Of those utilizing the health facilities for a sick household member, 82% were satisfied with the services received. On the other hand, almost 72% of the HHs had either never or rarely utilized the health facility, and of those who did, 84% considered the services provided to be very costly.

The study examined household expectations for the quality of health services and found that the principal preoccupations were: cost (35%), treatment (*accueil*) including the time spent (29%), the effectiveness of the care received (21%), and the quality of the personnel (14%).

More than two-thirds (68%) of households stated that at least one household member slept under a bed net; 74% of the population of *Mohéli* sleeps under a bed net while 35% in *Grande Comore* and 33% (in *Anjouan*) sleep under a bed net. About 58% of the population were aware of the positive benefits of bed nets. Of those not using the bed nets, about half felt they were too expensive while the rest stated that they were used to regular bed nets, or that bed nets were not readily available, or that they did not have enough information.