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Document of
The World Bank

Report No: ICR0000451

IMPLEMENTATION COMPLETION AND RESULTS REPORT
(IDA-33420)

ON A

CREDIT

IN THE AMOUNT OF SDR 31.0 MILLION (US$41.51 MILLION EQUIVALENT)

TO THE

REPUBLIC OF CHAD

FOR A

HEALTH SECTOR SUPPORT PROJECT

June 28, 2007

Human Development III
Central Africa I
Africa Region

CURRENCY EQUIVALENTS
(Exchange Rate Effective June 2007)

Currency Unit = Francs CFA
CFAF513.45 = US$1
US$0.02 = CFAF 1

FISCAL YEAR
January 1 December 31

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
CAS	Country Assistance Strategy
CFAF	Local currency
CPPA	Central Pharmaceutical Purchasing Agency
DED	German Development Service
GDP	Gross Domestic Product
GTZ	German Agency for Technical Cooperation
HIV	Human Immunodeficiency Virus
ICR	Implementation Completion Report
IDA	International Development Association
IEC	Information, Education and Communication
ISR	Implementation Status Reports
HSSP	Health Sector Support Project
MPA	Minimum Package of Activities
MDG	Millennium Development Goals
MOH	Ministry of Health
MTEF	Medium-Term Expenditure Framework
NGO	Non Governmental Organization
PCU	Project Coordination Unit
PDO	Project Development Objective
SSA	Sub-Saharan Africa
STD	Sexually Transmitted Diseases
UN	United Nations
UNICEF	United Nations Information Communication Education Fund
US	United States

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CHAD
HEALTH SECTOR SUPPORT PROJECT

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A. Basic Information

Country:	Chad	Project Name:	Health Sector Support Project
Project ID:	P055122	L/C/TF Number(s):	IDA-33420
ICR Date:	06/28/2007	ICR Type:	Core ICR
Lending Instrument:	SIL	Borrower:	REPUBLIC OF CHAD
Original Total Commitment:	XDR 31.0M	Disbursed Amount:	XDR 30.7M
Environmental Category: C			
Implementing Agencies: Ministry of Public Health Projet d Appui au Secteur Sant			
Cofinanciers and Other External Partners:			

B. Key Dates

Process	Date	Process	Original Date	Revised / Actual Date(s)
Concept Review:	12/15/1998	Effectiveness:	02/28/2001	02/28/2001
Appraisal:	12/07/1999	Restructuring(s):		12/09/2004
Approval:	04/27/2000	Mid-term Review:		04/07/2004
		Closing:	12/31/2005	12/31/2006

C. Ratings Summary

C.1 Performance Rating by ICR	
Outcomes:	Unsatisfactory
Risk to Development Outcome:	Substantial
Bank Performance:	Moderately Satisfactory
Borrower Performance:	Moderately Unsatisfactory

C.2 Detailed Ratings of Bank and Borrower Performance (by ICR)

Bank	Ratings	Borrower	Ratings
Quality at Entry:	Moderately Satisfactory	Government:	Satisfactory
Quality of Supervision:	Moderately Satisfactory	Implementing Agency/Agencies:	Unsatisfactory
Overall Bank Performance:	Moderately Satisfactory	**Overall Borrower Performance:**	Moderately Unsatisfactory

C.3 Quality at Entry and Implementation Performance Indicators

Implementation Performance	Indicators	QAG Assessments (if any)	Rating
Potential Problem Project	Yes	Quality at Entry	Satisfactory

at any time (Yes/No):		(QEA):	
Problem Project at any time (Yes/No):	Yes	Quality of Supervision (QSA):	None
DO rating before Closing/Inactive status:	Unsatisfactory		

D. Sector and Theme Codes		
	Original	Actual
Sector Code (as % of total Bank financing)		
Central government administration	19	19
Compulsory health finance	2	2
Health	79	79
Theme Code (Primary/Secondary)		
Child health	Primary	Primary
Decentralization	Secondary	Secondary
Health system performance	Primary	Primary
Population and reproductive health	Primary	Primary

E. Bank Staff		
Positions	At ICR	At Approval
Vice President:	Obiageli Katryn Ezekwesili	Jean-Louis Sarbib
Country Director:	Marie Francoise Marie-Nelly	Serge Michailof
Sector Manager:	Laura Frigenti	Nicholas R. Burnett
Project Team Leader:	Maryanne Sharp	Michele L. Lioy
ICR Team Leader:	Maryanne Sharp	
ICR Primary Author:	Jerome F. Chevallier	

F. Results Framework Analysis

Project Development Objectives (from Project Appraisal Document**)**
To extend and improve the provision of basic quality health care through the implementation of the national health policy and strengthening the institutional capacity of the Ministry of Public Health (MOPH).

Achievement of these objectives will be measured by the following in project areas: an increase in the coverage of basic health services, the percentage of operational health districts, and an increase in health facilities utilization rates.

Revised Project Development Objectives (as approved by original approving authority)
N.A.

(a) PDO Indicator(s)

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1 :	Percentage of health districts operational (as defined in section on Key Performance Indicators, page 3 of PAD), at end of project , in project-targeted areas			
Value quantitative or Qualitative)	45%	100%		
Date achieved	12/31/2000	12/31/2005		
Comments (incl. % achievement)				
Indicator 2 :	Vaccination coverage (DTC3) in project areas			
Value quantitative or Qualitative)	20%	60%		
Date achieved	12/31/2000	12/31/2005		
Comments (incl. % achievement)				

(b) Intermediate Outcome Indicator(s)

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1 :	Increase the number of health centers, in the project zone, which have all the essential medicine corresponding to the MPA			
Value (quantitative or Qualitative)	40%	80%		
Date achieved	12/31/2000	12/31/2005		
Comments (incl. % achievement)				
Indicator 2 :	Percent of pregnant women in project areas who give birth with the assistance of a qualified health agent			
Value (quantitative	10%	40%		

or Qualitative)				
Date achieved	12/31/2000	12/31/2005		
Comments (incl. % achievement)				
Indicator 3 :	Percent of children under 5 who receive an adequate supply of Vitamin A in project areas			
Value (quantitative or Qualitative)	40%	80%		
Date achieved	12/31/2000	12/31/2005		
Comments (incl. % achievement)				
Indicator 4 :	Increase health facilities utilization rates, in project-targeted areas (consultations per inhabitant)			
Value (quantitative or Qualitative)	1.3	1.8		
Date achieved	12/31/2000	12/31/2005		
Comments (incl. % achievement)				
Indicator 5 :	Cumulated number of new graduated para-medical personnel.			
Value (quantitative or Qualitative)	250	700		
Date achieved	12/31/2000	12/31/2005		
Comments (incl. % achievement)				
Indicator 6 :	Number of health districts capable of preparing and implementing budget and activity plans in project-assisted areas.			
Value (quantitative or Qualitative)	7	18		
Date achieved	12/31/2000	12/31/2005		
Comments (incl. % achievement)				
Indicator 7 :	The 9 existing HIV-surveillance sentinel sites to remain open and operational			
Value (quantitative or Qualitative)	9	16		
Date achieved	12/31/2000	12/31/2005		
Comments (incl. % achievement)				

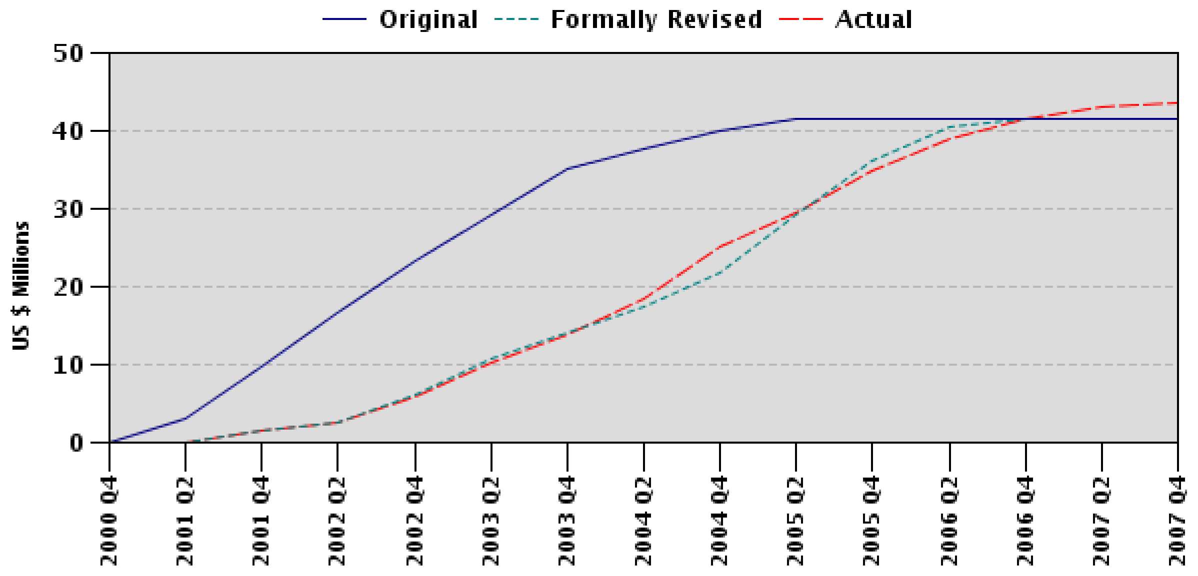
G. Ratings of Project Performance in ISRs

No.	Date ISR Archived	DO	IP	Actual Disbursements (USD millions)
1	12/18/2000	Satisfactory	Satisfactory	0.00
2	06/25/2001	Satisfactory	Satisfactory	1.53
3	12/19/2001	Satisfactory	Unsatisfactory	2.50
4	05/30/2002	Satisfactory	Satisfactory	5.87
5	12/17/2002	Satisfactory	Satisfactory	10.34
6	06/19/2003	Satisfactory	Satisfactory	13.61
7	12/12/2003	Satisfactory	Unsatisfactory	17.26
8	06/28/2004	Satisfactory	Unsatisfactory	23.85
9	12/20/2004	Satisfactory	Unsatisfactory	28.51
10	05/31/2005	Moderately Satisfactory	Moderately Unsatisfactory	33.96
11	08/18/2005	Moderately Satisfactory	Moderately Satisfactory	37.21
12	12/27/2005	Moderately Unsatisfactory	Moderately Satisfactory	39.00
13	05/31/2006	Unsatisfactory	Unsatisfactory	40.80
14	03/07/2007	Unsatisfactory	Unsatisfactory	43.48

H. Restructuring (if any)

Restructuring Date(s)	Board Approved PDO Change	ISR Ratings at Restructuring		Amount Disbursed at Restructuring in USD millions	Reason for Restructuring & Key Changes Made
		DO	IP		
12/09/2004		MS	MU	28.51	

I. Disbursement Profile



1. Project Context, Development Objectives and Design

1.1 Context at Appraisal

1. After nearly three decades of civil war, the Government of Chad maintained relative peace and stability since 1993. The authorities established a good macroeconomic adjustment track record between 1994 and 1999. Real GDP growth averaged 3.4 percent per year, and the overall fiscal deficit was cut from 14.2 to 10.6 percent of GDP. The authorities kept a tight lid on overall expenditures, while allowing non-salary spending in priority sectors (health, education, agriculture, transport and public works) to triple in real terms. All hiring in the public sector was frozen, except for primary and secondary school teachers and health workers. Despite progress made during this period, health outcomes remained well below the average for sub-Saharan Africa (SSA). The maternal mortality rate at 827 per 100,000 live births and the under-five mortality rate at 194 per 1,000 live births were high. At 32.5 percent, the DPT3 vaccination rate was much lower than the average for SSA (55 percent). The main constraint to the development of the sector was the lack of qualified human resources. The population per doctor and nurse was respectively three times higher and more than ten times higher than in SSA on average. Other issues in the sector included inadequate mechanisms to control epidemics, the low capacity of the Ministry of Health (MOH) to coordinate donor-supported activities, and the difficulty of implementing the cost recovery policy at the hospital level.

2. The Country Assistance Strategy (CAS) of May 1999 was centered on how to help Chad make the best development use of oil revenues, which were expected to flow a few years later, while mitigating the risks associated with their sudden increase. Two CAS objectives were particularly relevant for the project: (i) capacity building for improved governance; and (ii) establishment of the foundations for improved delivery of basic social services.

1.2 Original Project Development Objectives (PDO) and Key Indicators *(as approved)*

3. The objective of the project was to support the extension of basic quality health services through implementation of the National Health Policy adopted in 1999 by the Government. More specifically, the project was expected to (i) reduce the critical shortage of human resources and enhance the quality of health and management personnel; (ii) improve the accessibility and quality of basic health services, especially child and reproductive health in selected underserved areas; (iii) improve the financing and management of the health system in the context of the national decentralization framework, and strengthen sector planning; (iv) strengthen the capacity of the MOH for the implementation of various national strategies; and (v) collect data to evaluate and monitor progress in the sector. Annex 1 outlines the key performance indicators used to measure the success of the project, with baseline data and expected outcomes as of June 2005. These include:

- Percentage of health districts operational at end of project, in project intervention areas: from 45% to 100%.
- Percentage of population to be covered by improved basic health services in project intervention areas: to 40% in 2003 and 60% in 2005.
- Number of newly graduated para-medical personnel: 250 by 2003 and 700 by 2005.
- Vaccination coverage in project intervention areas: from 20% to 40% in 2003 and 60% in 2005.
- Percent of health centers in project intervention areas with all the essential medical drugs corresponding to the minimum package of activities: from 40% to 80%.
- Number of health districts capable of preparing and implementing budget and activity plans in project intervention areas: 9 by 2003 and 13 by 2005.

1.3 Revised PDO and Key Indicators, and reasons/justification

4. The objectives were not revised.

1.4 Main Beneficiaries

5. The main beneficiaries were the people living in underserved areas, mostly rural areas, including Kanem, Lac, Moyen-Chari, Mandoul, Tandjilé and Chari-Baguirmi in two districts. About 2.3 million people were to benefit from the project, including half a million children under five and half a million women of reproductive age, which is around 24 percent of the total population.

1.5 Original Components (*as approved*)

6. The project financed six components with a total credit amount of SDR 31 million (US$41.51 million equivalent). Costing by component is provided in Annex 2. The credit became effective in February 2001 and closed in December 2006. Outputs of each component are outlined in Annex 3. The components are as follows:

7. *Human resource development (US$3.28 million).* This component included support to the initial and the continuing training of health personnel, including support to (i) a decentralized initial training initiative launched by MOH to provide accelerated training for existing and new health workers in four regional training centers; (ii) the national school for paramedics (rehabilitation of buildings, provision of equipment and support to students); and (iii) in-service education programs in two regional centers and for the training division of MOH.

8. *Strengthening district health services in under-served areas (US$25.53 million).* This component was to scale up support to health districts in the three prefectures of Lac, Kanem and Moyen Chari, and one or two rural districts in Chari-Baguirmi, to render them fully operational, through long-term technical assistance, support to operating costs and provision of equipment and medicines

9. *Strengthening health financing and management and support to the decentralization process (US$1.43 million).* This sub-component sought to strengthen central level capacity to design and implement health sector reforms, particularly in the areas of financing and decentralization through support to (i) community participation, including cost recovery measures; (ii) the decentralization of the health system; (iii) introduction and piloting of the contractual approach (public/private partnerships); and (iv) support to improved public expenditure management in the health sector.

10. *Institutional capacity building (US$8.2 million).* This component included support for (i) the national pharmaceutical policy (including support to the Pharmacy Division and for the supply of essential drugs to health facilities); (ii) the health communications policy; (iii) the national STD/HIV/AIDS control strategy (including improving blood safety, improved STD treatment and control, and reduction of risks of clinical infections); and (iv) the national maintenance strategy.

11. *National surveys (US$1.88 million).* The component included the carrying out of the National Health and Population Survey, and a contribution to the census.

12. *Project management (US$2.32 million).* This component included support to the project coordination team overseen by the MOH as well as operating costs for other implementing agencies, including a number of departments within MOH.

1.6 Revised Components

13. The components were not revised, although certain activities were dropped after the mid-term review, including the second tranche of the civil works program under Component 2, when it became clear that project resources would be insufficient to finance all project activities during the remaining project implementation period, due to the devaluation of the U.S. dollar.

1.7 Other significant changes

14. Not applicable.

2. Key Factors Affecting Implementation and Outcomes

2.1 Project Preparation, Design and Quality at Entry

15. **Soundness of background analysis**. In 1998-99, the Government updated its National Health Policy. After consultations with its external partners, the Government decided that it was not yet ready to develop a comprehensive plan for the sector, but would focus its activities on the roadblocks to the expansion of its health system. The project was conceived as a transitional step towards support to a broad sector program. The project addressed five major sector issues as follows: human resource development, health services at the district level, increased involvement of all stakeholders, including at the community level, and capacity to implement specific policies. Activities selected for

IDA financing were defined taking into account the support provided by other donors. The project was also fully consistent with the 1999 CAS, supporting two key objectives of the CAS, namely, capacity building for improved governance, and improved delivery of basic social services. The project was expected to develop management capacities required for an effective decentralization of health services. This was a key objective, as Parliament had adopted a law in 1999, in anticipation of oil revenues that would accrue to the country, earmarking a large part of oil revenues to four priority sectors for poverty alleviation, including health. With respect to the second objective, the project sought to reinforce the capacity of (i) the Government to develop a medium-term expenditure program in the health sector, and (ii) the local teams of the Ministry to manage efficiently the resources allocated to the health districts.

16. The project also sought to consolidate and expand the work of the on-going Health and Safe Motherhood project, which had been satisfactorily implemented and included financing for training reform, improvement in the quality of primary health care, decentralization of resources, contracting for services, financing of health services and community participation, and improvement of the budgetary process at central and regional levels. In particular, one approach which proved successful in the Health and Safe Motherhood Project, was to gradually operationalize all health districts in a prefecture. In addition to buildings, equipment and essential drugs, the district teams received assistance from an executing agency to put in place a health committee, cost recovery mechanisms, and a monitoring system to develop and implement action plans. Finally, the health personnel in these districts were retrained in the regional health centers. This approach was to be used in the new project, on all the districts within three new prefectures (Lac, Kanem, and Moyen-Chari) and build on the previous achievements in the Tandjilé prefecture, so as to provide support for all activities at both the district and the prefecture level.

17. The lessons learned from previous experience were fully taken into consideration during project preparation. The Implementation Completion Report (ICR) for the previous health project in Chad was issued in June 2002. It concluded that the project outcome was satisfactory and its sustainability, likely. The first lesson was that policy reforms required for successful project implementation should be discussed and agreed upon early on. This was done during a multi-donor health sector meeting in March 1999. The second lesson was to ensure that the senior staff in the MOH and in central ministries, as well as the regional and local staff concerned with the project should have a strong sense of ownership of the project. This was achieved in the course of several meetings held during the process of identification of project activities. The third lesson from experience was the importance of close donor coordination. Consultations took place during project preparation with the UN agencies involved and with the French and European aid agencies during project preparation to ensure that activities supported by each donor complemented those supported by others. The fourth lesson from experience was that geographical areas for project activities should be agreed upon before appraisal to avoid uncertainties during implementation.

18. **Partnership Arrangements**: The French Agency for Development (AFD) was responsible for the provision of long-term assistance in the Lac region while the project contributed with logistical and financial support to the districts. AFD contracted GTZ as a technical assistance agency for Lac. As GTZ was also the technical assistance agency for the region of Kanem, financed and contracted by the project, synergy and partnerships were created between the two regions. Finally, the German Development agency (DED) was also contracted as a long-term technical assistant.

19. **Assessment of the project design**. The overall objective of the project was sound. Five specific objectives were defined. Achievement of these objectives was a basic condition for the efficient use of the additional resources expected to be allocated to the health sector when oil revenues would begin to flow. The project was ambitious, but, as indicated above, satisfactory progress under the ongoing project warranted pushing the goalpost higher. It addressed seven policy and institutional reforms, which were all underway with support from the ongoing project except for the development of a maintenance strategy. Given the success of the first project, on which the design of the second was modeled, the team felt that there was a window of opportunity to scale up the results. Had the country situation not deteriorated in the manner that it did, it is likely that this second project would have had a solid impact on the ground.

20. The MOH was responsible for project implementation, using arrangements already in place under the ongoing project. The project coordination unit (PCU), which discharged its responsibilities satisfactorily under the ongoing project, would continue to serve for the new project in the same capacity and with the same personnel. Additional staff was required, however, including a public health physician qualified in personnel training and an assistant accountant. As was the case for the ongoing project, the coordinator would report to the Director General of the Ministry. A manual of procedures and an implementation manual were available in draft form, and the finalization of these important documents was a condition of credit effectiveness. Bidding documents for the consultant services needed during the first year of project implementation were also available and those for civil works, which were expected to start six months after project start, were to be prepared by engineering firms recruited as condition of effectiveness.

21. Credit effectiveness was subjected to the satisfactory implementation of no less than nine conditions. Not surprisingly, these conditions took time to fulfill, and the credit was declared effective ten months after Board approval. These conditions were sound, but most of them should have been met before or during credit negotiations. The economic, financial, technical, institutional and social analyses were satisfactory. The project was not expected to have any negative environmental impact. Precautions were taken to ensure that standards of hygiene and sanitation would be met.

22. **Adequacy of Government's commitment**. There were indications that the Ministry of Health was strongly committed to the implementation of its health development strategy. External partners and local stakeholders were extensively consulted during the preparation of the strategy and the project. There was a consensus

among all stakeholders that annual reviews of progress in implementing the strategy would be held under the leadership of the project Steering Committee, headed by the Director General and with participation of all directors in the MOH.

23. **Assessment of risks**. The risk analysis was weak. The overall risk was rated as modest. Two risks were rated as substantial. The first one was the risk that inadequate financial assistance would be provided to trainees and that they would not be recruited into the civil service at the end of their training. Unsatisfactory implementation of the law on petroleum revenues was the second risk rated as substantial. However, the Bank did not anticipate that the Government would amend the law on petroleum revenue to add defense and security to the priority sectors for spending and eliminate the Future Generations Fund. As a result of the disagreement about the use of oil revenue, the Bank's relationship with Chad drastically deteriorated. Other risks, such as the lack of incentives for local personnel to provide quality services, central government resistance to decentralization and the sustainability of cost recovery schemes, were all rated as modest. The risk of inadequate financing of the health sector and/or the lack of political willingness to finance the sector, which eventually became a major impediment to project implementation, and the issue of sustainability were not discussed.

2.2 Implementation

24. Fulfillment of effectiveness conditions took time, which delayed project implementation. UNICEF, which provided support to decentralized health services in two prefectures under the previous project, was expected to continue its assistance in one prefecture and to help with the Information, Education and Communication (IEC) component. The draft contract for its services was deemed unacceptable but UNICEF did not want to change it. Another partner had to be found to carry out the activities identified for UNICEF support.

25. Implementation during the initial years of the project was successful in large part due to an experienced project coordinator. As a result, progress was made on meeting the indicators in each of the project areas. However, the overall country environment began to deteriorate in 2002. Changes in leadership within the Ministry were numerous, with five different Ministers of Health throughout the life of the project. The project suffered from continuous political interference and was subject to erratic decisions that impacted project implementation. With the departure of the project coordinator in 2004, who was not replaced for over a year, project management worsened, with a loss of rigor and discipline as well as low morale of PCU staff. Following the procurement reform in 2003, the procurement process was particularly slow, because of the complexity of procedures for approving contracts, an ineffective National Tender Board, and weaknesses in capacity of the procurement staff in the project coordination unit. Although the Bank took steps to replace the procurement specialist, and subsequently train the new staff, the project continued to be plagued by procurement delays. Moreover, throughout project implementation, the Treasury was late in paying counterpart funds for the project. Finally, financial management greatly deteriorated during the period of absence of a project coordinator. Mismanagement of funds was reported concerning civil works and

at the local level. These issues were repeatedly highlighted during each supervision mission and took much of the Bank team's time to resolve. Moreover, as the dialogue between the Bank team and the MOH became more and more strained, the Bank increasingly sought to involve the Ministry of Planning in an effort to ensure more effective supervision of the project by the Government, but without much success.

26. Major problems began to develop within the Central Drug Procurement Agency (CPPA), as Government did not pay the Agency for delivery of drugs for three years, creating serious problems of drug availability in health facilities. Furthermore, an audit of CPPA in 2004 showed that resources had been mismanaged and procedures were not followed in the distribution of medicines. The inability of the CPPA to regularly provide drugs to the local levels compromised the ability of health facilities to function.

27. Unit cost of project facilities expressed in US dollars increased as a result of the devaluation of the US currency over the project implementation period (in October 1999 the US dollar was equivalent to CFAF 620; in April 2007, it was equivalent to CFAF 480). At the time of the mid-term review, it became clear that not enough resources would be available for completing the project because of the factors already mentioned, and the decision made early on to complete the construction of one hospital and three health centers initiated under the previous project in the health sector. It was agreed during the mid-term review that the second tranche of civil works could not be financed under the project.

28. Following the mid-term review of the project in April 2004, the Government requested a one-year extension of the closing date to December 31, 2006. The Bank informed the Government that the closing date would be extended if two conditions were met, namely that (i) at least one third of counterpart funds be paid, and (ii) a schedule for the payment of the Government debt to CPPA be agreed upon, including a first payment of two thirds of it immediately. These conditions were eventually met, but with much delay, in June 2005 and the closing date was extended. In addition, in an effort to give a much-needed boost to the CPPA, the extension of the project date allowed the Bank to recapitalize the CPPA with funding from the project.

29. However, in January 2006, the Bank suspended all disbursements to Chad, following the Government's decision to revise its law on oil revenues. Confronted with a difficult security situation, due to the resumption of rebel activity and the spillover effects of the Darfur conflict in neighboring Sudan, resulting in an inflow of about 200,000 refugees, the Government sharply increased its military expenditures, in a context of weakening fiscal discipline. Instead of addressing the budget management deficiencies, which were at the root of its financial problems, the Government chose to amend the 1999 law on petroleum revenues to include security, in particular, as a priority sector for resource allocation. It also eliminated the Future Generations Fund, which had been designed to enable the Government to pursue the funding of its poverty reduction policies after the expected decline in oil revenues.

30. The suspension was lifted in May 2006. A Bank supervision mission visited Chad in June 2006. The mission determined that spending in categories 5 and 6 (consultant services and training, and operating costs) was much higher than provided for in the 2006 action plan and budget, which had been agreed upon in December 2005. In particular, indemnities had been paid to staff of the project coordination unit in anticipation of their dismissal. Given the higher spending, the mission recommended that project activities be stopped in July 2006 to avoid overspending the credit amount. Discussions were held during that mission about the overall health sector budget and the need to integrate all operational costs as well as staff into the 2007 budget to ensure the sustainability of project outcomes. A final mission, slated for November 2007, was cancelled due to the security situation and rebel attacks.

31. Oil revenues began in 2004, with the share in total revenues increasing from 38 percent in 2004 to 66 percent in 2006. Over the project implementation period, the budget for health increased steadily, but actual expenditures fell consistently short of amounts approved – a pattern also found in other priority sectors. External assistance provided on average 63 percent of total funding for the sector during the period 2002-04. Annual variations in availability of foreign assistance were important, and contributed to a high volatility of health expenditures. According to government data, the share of the health sector in total budget execution increased from 5.6 percent in 2001 to 10.8 in 2005, thanks in part to a sharp increase in external financing, but declined to 4.7 percent in 2006. In addition, even when resources were actually spent, them did not always reach their intended beneficiaries.

2.3 Monitoring and Evaluation (M&E) Design, Implementation and Utilization

32. Following the mid-term review, the Bank team recommended that an M&E action plan be developed by an international consultant in collaboration with the public health specialists of the MOH. This plan was adopted by the MOH and included monitoring of 26 indicators, including performance, process and impact, linked to each of the components. The objective was that a report on progress on these indicators would be prepared on a semi-annual basis. The project indicators were selected to assess the progress of the project in providing access and qualified personnel, essential drugs and community participation mechanisms in the health sector. It was assumed at the time of appraisal that if all these indicators moved as planned, the quality of services would also improve as they represent the various elements necessary to have quality services (i.e. services provided by qualified staff in health facilities which are equipped according to national norms and which are stocked with generic essential drugs and medical consumables commensurate to the level of care they provide).

33. Modification in the indicators themselves occurred as a result of changes in the overall national health system (for example, a new administrative health structure resulted in a higher number of health districts than expected at the beginning of the project). The project also had some difficulty in calculating certain indicators for the project intervention areas and began to use national data as a proxy for progress on project-specific indicators. During the preparation of the M&E reports, it became clear

that there were discrepancies in the data collected by the MOH's Department of Statistics and data available from other surveys and studies, such as the National Multiple Indicators Survey of 2000 and the National Demographic and Health Survey of 2004. Moreover, MOH data also tended to contradict selected data being collected by the project. This was due in part to discrepancies in the process used for collecting data in districts and the differences in quality of data consolidation and analysis at the central level.

34. Given these issues, assessment of the project outcomes and achievement of its development objectives has been mainly carried out through an analysis of mission findings and site visits, as outlined in detail in project supervision aide-mémoires.

2.4 Safeguard and Fiduciary Compliance

35. The project was rated as a Category "C" for environmental and social safeguards. Construction and rehabilitation of health centers and hospitals were undertaken in accordance with national standards of hygiene and sanitation, and particular attention was paid to the treatment and disposal of medical and hospital wastes, both for environmental and public health reasons (HIV contamination). Small incinerators and containers for the disposal of syringes were provided to health centers. The project also systematically financed water supply in health facilities in project-targeted areas.

36. As already indicated, the project continued to be plagued by problems in financial management and procurement. Although quality and reliability of procurement administration was consistently rated satisfactory, compliance with agreed procurement procedures was rated unsatisfactory throughout much of project implementation, reflecting continuous delays in implementation of the procurement plan and general slowness in the national procurement process. On the other hand, even though weak financial management and accounting was mentioned as an issue from the very beginning of project implementation, financial management was rated satisfactory until the mid-term review in April 2004, in large part because of the strong management by the project coordinator. Based on the findings of the last supervision mission in June 2006, however, the rating for financial management was downgraded to highly unsatisfactory in the last ISR. The mission noted that accounting and financial management were inadequate, which led to overspending in some categories.

2.5 Post-completion Operation/Next Phase

37. During the mid-term review, the Bank team stressed the importance of preparing the transition arrangements to ensure the sustainability of project achievements and continued operation over time. A sustainability plan was prepared in 2005, but there was little follow up on the part of the Government, despite regular discussions about this issue during supervision missions. The concern for project sustainability was not re-emphasized in the last aide-mémoire of the June 2006 supervision mission, as more pressing issues of timely completion of project activities in a difficult environment took center stage. However, it was clear that sustainability was still a major issue as evidenced

by the loss of momentum and the deceleration of activities within the project-supported health districts during the period when IDA financing was suspended.

38. Operation of the facilities established with project assistance is far from being ensured, as the MOH did not receive the resources required for that purpose. Staff in charge of health district management, who were paid by the project, has now been integrated into the civil service. However, health districts still do not receive their full operating budgets. Health districts are therefore not able to consistently provide basic services to the population.

3. Assessment of Outcomes

3.1 Relevance of Objectives, Design and Implementation

39. The objectives of the project are highly relevant now, but the drive for their achievement has been lost in a deteriorating governance context. The project was designed following a period of steady improvement in the health sector, and in anticipation of a higher allocation of resources expected when oil revenues would begin to flow. The project was ambitious, but was expected to build on the success of the first project and use the same implementation arrangements, including an experienced project coordination unit.

3.2 Achievement of Project Development Objectives

40. Good progress was made in a number of areas under the project. In particular, under component one on human resource development, the emphasis on training of new and existing health personnel resulted in a higher than expected number of graduates with strong basic skills. Moreover, 40 percent of new graduates were women compared to 27 percent at the beginning of the project. However, the quality of training deteriorated over time as the Government was under political pressure to dramatically increase the numbers of graduates. In any event, with a deteriorating country context, the MOH had great difficulty in ensuring adequate staffing of local health facilities, as appointed staff would simply not show up in distant locations. Although a human resource strategy was developed, it was never effectively implemented. Under component two, which financed support to under-served health areas, using the comprehensive approach crafted during the first project, the long-term technical assistants focused their support on organization of health services, supervision of health facilities, continuing training of health personnel, planning for the prefectures and their districts, organization and management of pharmacies, cost recovery at hospital and district levels, and establishment of hospital autonomy. These technical assistants achieved visible progress in on-the-job training of local health officials and, with the consistent provision of an operating budget, health centers in these areas were fully operational, undertaking the minimum package of activities and with the basic drugs in stock. Capacity for planning and management was successfully built at the district levels, particularly in hospitals.

41. Component three was expected to provide support to cost recovery, the decentralization of the health system, the contractual approach, and public expenditure

management. Although the framework for cost recovery was put into place, implementation of this sub-component was fraught with difficulties including the question of using cost recovery mechanisms for medicines in areas of extreme poverty, and mismanagement of funds received from sales of medicines by the committees responsible for collection and oversight of these funds. There was some evidence of success in capacity building initiatives at the regional and district levels with respect to management and planning. The contractual approach was piloted under the project with the use of six technical assistance contracts, which worked well, but it is not clear whether this approach has actually been internalized by MOH. Finally, on public expenditure management, there has been some progress in the health sector with respect to annual budget preparation and expenditure tracking. However, much remains to be done.

42. Component 4 sought to strengthen institutional capacity in several areas, including the pharmaceutical sector, health communications, support to the fight against STI/HIV/AIDS, and maintenance. Support to implementation of the national pharmaceutical policy was undertaken in partnership with the EU, which financed a long-term technical assistant. This, however, never resulted in a permanent improvement in the management and distribution of medicines. The project was expected to play a critical role in health services related to STI/HIV/AIDS prevention and treatment, in partnership with the Second Population and AIDS project, which is financing the medical aspects of HIV/AIDS prevention and care. However, little was actually achieved with respect to STI and HIV/AIDS prevention and treatment, except for supply of disposable auto-blocking syringes and the development of nine new sentinel sites. These sites were only operational until 2003; after which data has not been collected regularly due to shortages in operating budgets and medical supplies needed for testing. Finally, little was accomplished in developing sustainable maintenance. A guide was produced and some initial training was undertaken, but this was never scaled up throughout the country. Finally under component 4, the National Health and Population Survey was carried out in 2004 and published in 2005. The census was never carried out.

43. The outcome indicators defined at the outset of the project included the percentage of the population living in an operational health area, the utilization rate of health facilities and the percentage of health districts operational in project-targeted areas. In the last project monitoring and evaluation report in June 2006, data for 2005 showed that the first had increased to 98 percent versus a target of 60 percent, the second from 29 percent to 38 percent, and the third from 45 percent to 100 percent. It is not clear, however, whether these data are reliable. In view of the situation in the health sector, it is difficult to accept these data at face value. Progress on intermediate outcomes was mixed. The percentage of health centers in the project zone, which had all medicines required under the minimum package of activities (MPA), was expected to increase from 40 percent to 100 percent. The latest supervision mission indicated that the percentage reached 80 percent (100 percent according to the Government). The percentage of women in project areas, who give birth with the assistance of a qualified agent, was expected to increase from 20 to 40 percent. It reached 24 percent in 2006. The vaccination coverage in the project areas increased from 20 percent to 64 percent, beyond

the initial target of 60 percent. The nine existing HIV sentinel sites were expected to remain open and operational. However, they have not been operational since 2003.

44. The project development objective was rated as satisfactory by supervision missions until May 2005, when it was downgraded to moderately satisfactory. The largest two components of the project (strengthening district health services and capacity building for the Ministry of Health) were, however, rated as moderately unsatisfactory. The project development objective was further downgraded to moderately unsatisfactory in December 2005 and to unsatisfactory in May 2006, in view of the lack of resources in the government budget to finance operations of the health districts initially supported by the project. Moreover, the downgrading in rating reflected the deterioration in recent year of the performance of the health sector, as shown by the 2004 Demographic and Health Survey.

3.3 Efficiency

45. The service standards applied in the health districts supported by the project were appropriate in view of the limited resources available for the sector. Assuming adequate allocation of resources to priority sectors and efficient use of these resources in the health sector, the Government should not have difficulties in ensuring a satisfactory operation of the health facilities built with project support.

3.4 Justification of Overall Outcome Rating

Rating: Unsatisfactory.

46. The outcome of the project is rated as unsatisfactory. Despite hard-won successes during project implementation as outlined above, the Government has not been able to sustain these achievements. Resources available for operating the health districts built up with project support are now well below the minimum required. Staff assigned to remote areas is reluctant to take up their posts because of poor working conditions, security concerns and late wage payments. Despite commitments made by the Government to use oil revenues to finance priority sectors, including health, operating expenditure in the sector has not kept up with the increase in facilities. Because of poor governance, funds intended for peripheral health facilities do not reach their intended beneficiaries.

47. The deterioration of the overall governance situation in 2003/2004 resulted in critical issues affecting the Bank's entire portfolio in Chad. These common problems included inadequate counterpart funding, weak project management and deterioration of procurement practices. Coupled with poor leadership in the sector and demoralization of staff, these issues all contributed to making it difficult for the project to achieve its objectives and sustain results on the ground.

3.5 Overarching Themes, Other Outcomes and Impacts

(a) Poverty Impacts, Gender Aspects, and Social Development

48. The intended beneficiaries of the project were populations in several provinces who had little access to basic health services, with specific emphasis on women and children. By improving access to quality health care, to child and reproductive health care, and through control of major communicable diseases such as meningitis, cholera, and malaria, the project was expected to address the pressing health needs of the population of one of Africa's poorest countries. Inasmuch as the facilities financed with project support are operational, poor people, including women and children, are the main beneficiaries of the project. But, as indicated above, most project facilities do not receive adequate funding for their operations, and therefore are no longer in a position to provide the services that the population was receiving when external project financing was available.

(b) Institutional Change/Strengthening

49. The number of staff trained in the health sector has considerably increased thanks to project support. The project was expected to train a total of 700 nurses. Actually, a total of 1,237 has graduated from the training centers supported by the project. In spite of the recruitment of this staff by the Ministry of Health, however, the share of health personnel in total civil service employment has stayed at about nine percent during the period 2001-2005. Contrary to expectations, the institutional capacity of the Ministry has not been strengthened. The two components of the project aimed at building capacity for the management of and policy-making in the sector have not achieved their objectives at the central level.

50. The major impediment to capacity building in the health sector, and more generally in the public sector, has been a deteriorating governance environment in the country over the project implementation period, particularly since 2004. A civil service reform was approved in 1998, but has not been implemented because of weak government commitment. Contrary to the basic principles of the reform, appointments to key positions are not based on qualifications, but on political affiliation. Performance is not rewarded and, as a result, civil servants are demoralized.

(c) Other Unintended Outcomes and Impacts (positive or negative)

51. Not applicable.

4. Assessment of Risk to Development Outcome

Rating: Substantial.

52. The risk to development outcome is rated as substantial. Project achievements are unlikely to be sustained. Although budget allocations to the health sector have increased slightly in recent years, the share of budget that flows to health facilities continues to be inadequate and thus health facilities financed by the project operate at a low level of efficiency. Moreover, there continues to be a severe shortage of qualified medical personnel and the CPPA continues to have problems in financing adequate stocks of drugs and medical supplies. With increased revenues from petroleum, however, the

Government should have no difficulty financing the operating costs of the health facilities built with project support. In the country dialogue, the Bank has repeatedly made the point that providing basic health services to the population in the project-supported health districts would require only a fraction of the resources that otherwise would be used for financing the construction of new facilities or the rehabilitation of existing ones. Sustainability of project outcomes was discussed during high level talks following the closing of the project, including the need for support to health districts through technical assistance and operating budgets, and provision of basic medicines and medical supplies. It is hoped that these high level discussions will result in the financing of these essential elements using the oil revenues.

5. Assessment of Bank and Borrower Performance

(relating to design, implementation and outcome issues)

5.1 Bank Performance

(a) Bank Performance in Ensuring Quality at Entry

Rating: Moderately satisfactory.

53. The performance of the Bank in ensuring quality at entry is rated as moderately satisfactory. The project was a follow-up operation to an ongoing project in the health sector. Good progress was made in achieving the objectives of that project and the Bank team expected that the new project would consolidate results already obtained and expand access to health services to new areas. The emphasis was rightly put on removing obstacles to the provision of basic health services to the population in underserved areas. The project was seen as an important milestone in the preparation of a sector-wide approach to health development in Chad. Such an approach was seen as essential for helping the country make good use of its forthcoming oil revenues to reduce widespread poverty and reach the MDGs. Considerable efforts were invested to ensure that a consensus was reached among decision-makers in the health sector and the donor community on the objectives and composition of the project. Implementation manuals were agreed upon during negotiations and bidding documents for the first year of consultant services were available when the project was approved.

54. The team was encouraged by the progress made under the ongoing project, but the design of the new project was too complex. The team felt, and rightly so, that they had a window of opportunity to move forward on health reforms. In retrospect, however, the project was overly ambitious in an environment which became increasingly hostile to the efficient use of public resources for development purposes. Given the nature of the project, the Bank should have insisted on reaching an agreement with the Government on a Medium-Term Expenditure Framework (MTEF) for the sector as part of project preparation, which was not done. Nonetheless, the project could have been as successful as the first health project, if the overall governance situation had not changed. This change had a profound impact on the entire portfolio.

(b) Quality of Supervision

Rating: Moderately satisfactory.

55. The performance of the Bank during supervision is rated as moderately satisfactory. There was continuity in the Bank team. Supervision missions visited Chad regularly and spent a substantial amount of their time in the field. They provided support to the directorates in charge of project implementation in the Ministry of Health and to local teams in the health districts. Aide-mémoires were informative and issue-oriented. Managers were kept informed and provided feedback and support to the team. Moreover, a high profile portfolio review held in 2004 looked at systemic issues common to all IDA-financed projects in Chad, including procurement and counterpart funding. Although these issues were raised at the highest levels of Government, and the Bank wrote numerous letters reminding Government of the importance of correcting these issues, no subsequent action was noted. The Bank team was increasingly forced to work in an antagonistic environment where it was attacked when putting issues squarely on the table. Supervision missions, however, should have looked more carefully at budget allocation and execution issues in the health sector. The ratings given to performance were too generous.

(c) Justification of Rating for Overall Bank Performance

Rating: Moderately satisfactory

56. The Bank team provided considerable support to the Government for the preparation of the project and coordinated closely with other donors active in the sector. Good progress under an ongoing project in the sector, and more generally in macroeconomic management, led the Bank to expect that the Government would deliver on its sector strategy. The project was too complex, however, and the risks were not adequately analyzed. During project implementation, the Bank team was proactive in helping the project coordination unit and the relevant departments in the Ministry of Health implement agreed upon work programs. The ratings in the ISRs were too optimistic and generous, however, when the leadership situation in the sector was deteriorating.

5.2 Borrower Performance

(a) Government Performance

Rating: Satisfactory.

57. The performance of the Borrower during preparation of the project is rated as satisfactory. The Ministry of Health took the lead in updating its sector policy in 1998-99 and in coordinating the donor community. It organized a number of workshops and seminars with health care providers, politicians, religious leaders, the NGO community and donors.

58. The performance of the Borrower and the Implementing Agency during project implementation is rated as unsatisfactory. Early on, progress in project implementation was adequate, despite delays in credit effectiveness. Problems surfaced rapidly, however, as the Government failed to provide the counterpart funds required and to pay its bills to the CPPA. The environment for project implementation deteriorated significantly in

2004, with a new Minister for Health, who made a series of decisions compromising project implementation, including removing the project coordinator and taking more than a year to hire a new one. Subsequently, project management worsened, including procurement and financial management.

59. Contrary to commitments made in the oil revenues management program, the Government did not use its oil revenues to increase spending in the health sector. Despite a huge increase in total revenues, actual expenditures in the health sector in 2006 were lower than in 2002. As a result, the facilities built with project support did not receive the required operating funds which, combined with a shortage in qualified medical staff, impacted the availability of basic health services.

(b) Implementing Agency or Agencies Performance
Rating: Unsatisfactory

60. The performance of the project coordination unit is rated as unsatisfactory in view of persisting problems with project management, procurement and financial management.

(c) Justification of Rating for Overall Borrower Performance
Rating: Unsatisfactory.

61. Contrary to commitments made under the oil revenue management program, the Government did not allocate the resources required for implementing its health strategy. For lack of appropriate funding, health facilities built with project support are neither functional nor adequately staffed. Acute political interference, starting in 2004, made project implementation extremely difficult.

6. Lessons Learned

62. The support of the central ministries is essential for an operation with the ambition of addressing the most pressing issues in a sector. These ministries need to be involved as early as possible, as their assurance of support to resource allocation to the sector over the medium-term is essential for the operation to succeed. As part of project preparation, a MTEF, fully aligned with the sector strategy, should have been formulated and agreed upon. It was important to make it clear to the authorities from the outset, that unsatisfactory adherence to the MTEF during project implementation would trigger remedies.

63. Supervision of a broad-based sector operation should include a review of budget implementation for the sector and agreement on an updated MTEF on an annual basis. This was not done for the project under review. An analysis of budget implementation in the sector would have revealed increasingly serious problems in public finance management, including a large gap between allocations and actual expenditures, and inadequate national procurement and financial management procedures. These problems should have been discussed and agreements reached on corrective actions. Failure to

reach or implement agreement should have led to suspension of disbursements. Looking only at counterpart funding and project fiduciary aspects is not sufficient.

64. Heroic efforts to get things done at the micro level do not bring about expected results if the macroeconomic and governance environment becomes increasingly hostile. Issues in the sector were brought to the attention of the highest authorities during a portfolio review in 2004, but no real change was made to address them. In such a difficult environment, it is critical that the Bank team take proactive and decisive action as and when major problems emerge, as they did from the outset of this operation. At the mid-term review, which took place a month after the portfolio review, the Bank team should have come to the conclusion that continued support to the sector was difficult to justify under the unchanging country circumstances.

65. Lastly, in such a challenging and difficult country environment fraught with governance-related issues, the design of projects should be simple and well-targeted. Such a comprehensive sectoral project should be neither too ambitious, nor too complex for implementation purposes. In particular, the use of nine conditions of effectiveness should raise serious management concerns about the readiness for implementation.

7. Comments on Issues Raised by Borrower/Implementing Agencies

66. Government's comments on the draft ICR are located in Annex 5. It has raised a number of issues including (i) the lack of revision of the project objectives and scope of the components following the mid term review; (ii) the impact of the devaluation of the US dollar on project resources; and (iii) impact of the departure of the project coordinator. With respect to the project development objectives, although certain activities were eliminated following the mid term review, in particular, the second tranche of civil works, the most critical activities continued to be supported, including support to health districts through the financing of long term technical assistance agencies and operating costs. Thus it was not felt necessary to modify the project development objectives. The devaluation of the U.S. dollar certainly had an impact on availability of financing and resulted in a gap in financing. During the last two years of project implementation, supervision missions systematically requested and provided support to project staff to re-evaluate bi-annually amounts disbursed and amounts committed on the basis of the changing exchange rate to attempt to avoid overspending. Finally, although Government notes that an experienced team was in place that was further strengthened by the recruitment of a public health specialist and an assistant accountant, there is no doubt about the devastating impact of the absence of management within the PCU for more than a year. Financial management and general oversight of project activities deteriorated visibly during this period. Furthermore, the recruitment of a new project coordinator was contentious as the Bank insisted on a transparent and competitive process for the selection of the candidate while the Ministry of Health wished at that time to nominate a political appointee.

Annex 1. Results Framework Analysis

Project Development Objectives (from Project Appraisal Document)
The objective of the project was to support the extension of basic quality health services through implementation of the National Health Policy adopted by the Government in 1999.

Revised Project Development Objectives (as approved by original approving authority)
N.A.

(a) PDO Indicator(s)

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years*
Indicator 1 :	Percentage of health districts operational, at end of project , in project-targeted areas			
Value quantitative or Qualitative)	45%	100%	N/A	100%
Date achieved	12/31/2000	12/31/2005		
Indicator 2 :	Vaccination coverage in project areas			
Value quantitative or Qualitative)	20%	60%	N/A	64%
Date achieved	12/31/2000	12/31/2005		

(b) Intermediate Outcome Indicator(s)

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1 :	Increase the number of health centers, in the project zone, which have all the essential medicine corresponding to the MPA			
Value (quantitative or Qualitative)	40%	80%		100%
Date achieved	12/31/2000	12/31/2005		
Indicator 2 :	Percent of pregnant women in project areas who give birth with the assistance of a qualified health agent			
Value (quantitative or Qualitative)	10%	40%		24%
Date achieved	12/31/2000	12/31/2005		
Indicator 3 :	Percent of children under 5 who receive an adequate supply of Vitamin A in project areas			

Value (quantitative or Qualitative)	40%	80%		90%
Date achieved	12/31/2000	12/31/2005		
Indicator 4 :	Increase health facilities utilization rates, in project-targeted areas (consultations per inhabitant)			
Value (quantitative or Qualitative)	1.3	1.8		Not measured
Date achieved	12/31/2000	12/31/2005		
Comments (incl. % achievement)				
Indicator 5 :	Cumulated number of new graduated para-medical personnel.			
Value (quantitative or Qualitative)	250	700		1237
Date achieved	12/31/2000	12/31/2005		
Indicator 6 :	Number of health districts capable of preparing and implementing budget and activity plans in project-assisted areas.			
Value (quantitative or Qualitative)	7	18		
Date achieved	12/31/2000	12/31/2005		
Comments (incl. % achievement)				
Indicator 7 :	The 9 existing HIV-surveillance sentinel sites to remain open and operational			
Value (quantitative or Qualitative)	9	11		No data has been collected since 2004
Date achieved	12/31/2000	12/31/2005		

*** Data as of July 2006**

Annex 2. Project Costs and Financing

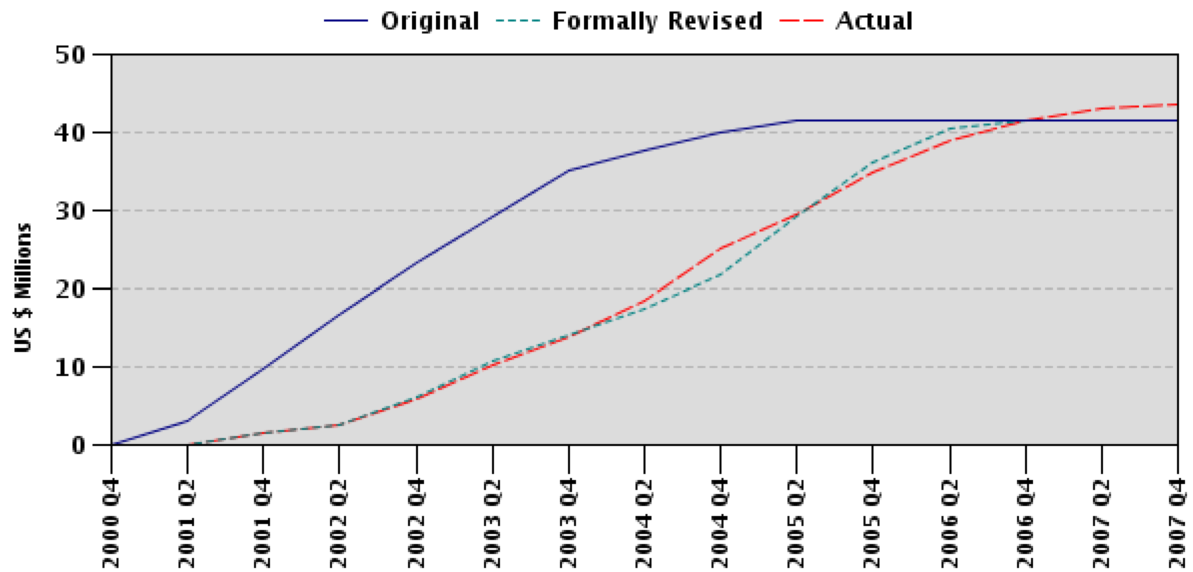
(a) Project Cost by Component (in USD Million equivalent)

Components	Appraisal Estimate (USD millions)	Actual/Latest Estimate (USD millions)	Percentage of Appraisal
A. SUPPORTING HUMAN RESOURCE DEVELOPMENT	2.58	3.28	
B. STRENGTHENING DISTRICT HEALTH SERVICES IN UNDERSERVED AREAS	20.36	25.53	
C. STRENGTHENING HEALTH FINANCING AND SUPPORTING DECENTRALIZATION PROCESS	1.14	1.43	
D. INSTITUTIONAL CAPACITY BUILDING OF MOPH FOR SPECIFIC AREAS (INCLUDING AIDS, PHARMACEUTICAL SECTOR, IEC AND MAINTENANCE)	6.85	8.20	
E. NATIONAL SURVEYS	1.49	1.88	
F. PASS PROJECT MANAGEMENT	1.86	2.32	
Total Baseline Cost	34.28	42.64	
Physical Contingencies	2.78	0.00	0.00
Price Contingencies	5.59	0.00	0.00
Total Project Costs	42.65	42.64	
Project Preparation Fund	0.00	0.00	.00
Front-end fee IBRD	0.00	0.00	.00
Total Financing Required	42.64	42.64	

(b) Financing

Source of Funds	Type of Cofinancing	Appraisal Estimate (USD millions)	Actual/Latest Estimate (USD millions)	Percentage of Appraisal
FRANCE: French Agency for Development		5.80	5.00	.00
Local Communities		3.10	3.00	.00
GERMANY: Deutsche Entwicklungsgesellschaft (DEG)		1.80	2.00	.00
International Development Association (IDA)		41.51	42.64	.00
UN Children's Fund		1.40	0.00	.00
UN Development Programme		0.75	0.00	.00
UN Fund for Population Activities		0.10	0.00	.00
World Health Organization		0.80	0.50	.00

(c) Disbursement Profile



Annex 3. Outputs by Component

Component One: Human Resource Development

Sub-components	*Outputs*
Initial decentralized training	▪ Creation of and support to the Regional Training Schools with pools of permanent trainers; ▪ 688 ATS, 53 obstetricians; 161 IDE, 43 SFDE and 106 IB trained ▪ Reorientation of the national health school (ENASS) to undertake more specialized trainings ▪ Change of status of ENASS to provide it more autonomy ▪ Maintenance of infrastructure and equipment ▪ Financing strategy to introduce patient cost-sharing ▪ Redefinition of the support role of the central level
Continuing training	▪ 1,338 health workers trained ▪ 40 training sessions held ▪ Training aboard on 40 separate themes
Support to the Dept. of Human Resources, MOH	▪ Strategy and Action Plan for the development of human resources elaborated ▪ Three year training plan developed and implemented ▪ Support to supervision ▪ Implementation of computerized management of the personnel ▪ Studies on human resources

Component Two: Strengthening District Health Services in Underserved Areas

Sub-components	*Outputs*
Civil works	Construction/rehabilitation of 4 hospitals, 4 residences SFDE, 31 CS, 27 residences and 54 drillings equipped
Support to operationalization of districts	Support with the PRA of Tandjilé and Kanem with recapitalisation in MEG and training of the managers Reinforcement of the capacities of planning and management in the hospitals ME available in the services Accountants for the DPS and DS: Micro planning for CS and annual Action plan for the districts and the delegations Management tools for the district

Component Three: Strengthening health financing and management and support to the decentralization process

Sub-components	*Outputs*
Community Participation	▪ Development and implementation of the legal framework for the Cost recovery and hospital reform; ▪ Harmonization of drugs prices; ▪ Implementation of cost recovery policies and organization of communities through community health management committees
Decentralization of the system	▪ Strengthening the capacities of the Dept. of financial resources and planning of the MOH through TA, equipment and training; ▪ Creation and capacity building of hospital management boards; ▪ Technical assistance support to the budget preparation process at the central level; and ▪ Decentralization of budgeting, with capacity building at district levels.
Contractual approach	▪ Signatures of protocols with WHO for the contractual approach ▪ Contracts entered into between MSP and the agencies of support: DED (Sarh), Bélacd/Sarh (Moïssala), the Adventists (Béré), Bases (Sarh), ITS (Lay) and GTZ (Kanem-Lake)
Public expenditure management	▪ Technical assistance at central level to support the installation of the national accounts of health and the continued decentralization of the health budgets; ▪ Reinforcement of the Division of the financial resources, through TA and equipment; ▪ Strengthening of the central level capacities through training and recruitment of qualified personnel

Component Four: Institutional capacity building

Sub-components	*Outputs*
Support to the national Pharmaceutical policy (WHO Support)	▪ Creation of the Division of pharmacy in the Direction Pharmacy, Drug and Laboratory; ▪ Increased availability, accessibility and rational use of the MEG (Access to 70% of the population with the MEG); ▪ Capacity development of regional and district pharmacies (supervision, training and installation of management tools); and ▪ 74 inspections carried out for regional and district pharmacies and health facilities.

Health Communication Policy	▪ Specialized training abroad of 10 health communication agents; ▪ Training of staff in 14 DRS and 53 DS on information, education and communication methods; and ▪ Provision of equipment and logistics.
Support to the national STI/HIV/AIDS program	▪ Construction of a blood bank; ▪ Development of a National Transfusion Policy; ▪ Development of protocols for STIs and opportunistic infections; ▪ Creation of nine new sentinel sites and support to publication of data from sites; and ▪ Support to the development of the national strategic plan for the fight against AIDS.
Maintenance	▪ Production of a series of studies for the development of a national maintenance policy; ▪ Preparation of guide on maintenance; and ▪ Training of four maintenance agents.

Component Five: National surveys

Sub-components	*Outputs*
National health, nutrition and population data collection	▪ National Health and Demographic Survey completed. ▪ Census never undertaken.

Annex 4. Bank Lending and Implementation Support/Supervision Processes

(a) Task Team members

Names	Title	Unit	Responsibility/ Specialty
Lending			
Michele Lioy	Sr. Operations Officer	AFTH3	
Hugues Agossou	Sr. Financial Management Specialist	AFTFM	
Anne Anglio	Sr. Program Assistant	AFTH3	
Pierre Delvoye	Consultant, Paramedical Training	AFTH3	
Ningayo Charles Donang	Sr. Procurement Specialist	AFTPC	
Daniel R. Dupety	Consultant, Architect	MNSHD	
Mahamat Goadi Louani	Sr. Human Development Specialist	AFTH3	
Olivier Weil	Consultant, Public Health Specialist	AFTH3	
Supervision/ICR			
Hugues Agossou	Sr. Financial Management Specialist	AFTFM	
Anne Anglio	S. Program Assistant	AFTH3	
Pierre Delvoye	Consultant, Paramedical Training	AFTH3	
Ningayo Charles Donang	Sr. Procurement Specialist	AFTPC	
Daniel R. Dupety	Consultant, Architect	MNSHD	
Mahamat Goadi Louani	Sr. Human Development Specialist	AFTH3	
Josiane M. S. Luchmun	Program Assistant	AFTH3	
Etienne NKoa	Sr. Financial Management Specialist	AFTFM	
Maryanne Sharp	Sr. Operations Officer	AFTH3	
Olivier Weil	Consultant, Public Health Specialist	AFTH3	

(b) Staff Time and Cost

Stage of Project Cycle	Staff Time and Cost (Bank Budget Only)	
	No. of staff weeks	USD Thousands (including travel and consultant costs)
Lending		
FY98		33.22
FY99		102.85
FY00	28	158.34
FY01		0.12
FY02	1	2.34
FY03		0.00
FY04		0.00
FY05		0.00
FY06		0.00
FY07		0.00
Total:	29	296.87

Supervision/ICR		
FY98		0.00
FY99		0.00
FY00	1	35.04
FY01	14	68.73
FY02	20	81.76
FY03	16	94.36
FY04	29	136.48
FY05	38	150.69
FY06	38	143.09
FY07	16	35.25
Total:	172	745.40

Annex 5. Summary of Borrower's Comments on Draft ICR

The Government thanks the World Bank and is pleased with the production with this report which will make it possible for both sides to identify the assets and the weaknesses in order to draw lessons learned from project implementation to ensure improvement in the quality of future projects. To this end, the Government is pleased to contribute the following comments to allow the World Bank and the Government to have a common vision.

1) General Comments

The Government's general comments are related to the context and to the events which marked the life of the project negatively. These comments concern, in the first place, the under-evaluation of the component costs during project preparation, and in particular, civil works and operating costs, and in the second place, the unit cost of the works in dollars increased because of the fall of the dollar during the project implementation period. At the time of the mid term review, it was clear that the resources would be insufficient to continue to the end of the project. It would have been reasonable at the time of the review to revise the objectives of the project and the costs of the components, taking into account the financial resources available. Nobody raised that although the alarm was sounded.

2) Specific Comments (based on draft ICR)

Page 1: Context
The difficulty in containing epidemics, the poor capacity of the Ministry of Public Health (MPH) to coordinate activities financed by donors and the difficulty in implementing cost recovery in hospitals.

Cost recovery is in place now in hospitals. The MPH has set up an epidemiologic inspection committee which meets each week, which has allowed epidemic containment. Since the last two to three years, the coordination of the external assistance has clearly improved.

Page 2: Objectives
The objectives of the project and the indicators were not revised at the time of the mid term review in spite of the difficult situation of the project and the alarm which was sounded.

Page 3: Components of the Project
The components of the project did not change and their costs remained the same ones in spite of:

- Lack of participation of other donors in the project despite originally foreseen;
- The fall of the dollar which caused an increase in the unit cost of project activities in CFA;
- The under-evaluation of the costs during project preparation.

Page 6/7 Project Implementation
Management of the project following the departure of the Coordinator: This departure, in our opinion, should not have affected the management of the project, especially since the original project team from PSMSR was taken on for this project, except the Administrator who was fired; this team was reinforced with an assistant accountant and a doctor in public health. The activities of the project were not suspended as a result. The mismanagement of the funds relates to overrun in civil works and operating costs following the under-evaluation of the costs at the time of project preparation.

Page 8: Extension of the closing date of the project
The extension of the closing date of the project by one year did not produce the results expected because of the suspension of World Bank disbursements in Chad during the first six-month period of 2006 as well as the lack of the to finance the continuation of project activities. However, this extension made it possible the CPA to receive its arrears from the State and to benefit from a 300 million FCFA recapitalization from project proceeds. Moreover, this extension made it possible the project to benefit from 400 million FCFA of counterpart funds in 2006 and 270 million FCFA in 2007 which allowed the project to pay the suppliers and to carry out the activities envisaged (final Evaluation and the audit 2006).

Monitoring and evaluation: in addition to the data of the national surveys (EDST, ECOSIT) the MPH uses the data of the DSIS which enables us to make comparisons with other zones which are not covered by the PASS. These are the two sources which enable us to undertake analyses and we think that there is not other way to do so. And as a result, these data show that the indicators in project supported zones are better than in the other zones not supported by the PASS. In fact, those indicators are falling because of the abrupt stopping of the project.

Page 9: Fiduciary safeguards and aspects
Weaknesses were cited with respect to delays in procurement procedures and the capacity of procurement project staff (the latter were replaced). What elements led to the decline of the rating of moderately satisfactory in 2005 to unsatisfactory in 2006 (supervision of June 2006), especially given the project did not undertake procurement in 2006. Supervision missions did not identify ineligible expenditures (in a posteriori reviews) and the procurement thresholds were respected. All the contracts programmed in the project except for the second phase of civil works were undertaken in accordance with the methods initially defined.

The question of sustainability of the project was one of the reasons for the extension of the project by one year to permit the Government to capitalize on the assets of the project. In 2005, the MPH put in place a team responsible for following up on and ensuring the sustainability of project activities. Unfortunately the premature halt of project activities as of January 2006 (due to the suspension) impacted the operations of those health centers supported by the project as they were not able to access additional resources from the State (these had not been foreseen in the 2006 State budget).

With regard to the personnel of the project, their integration into public services has been done. It should be reminded that apart from managers, all the personnel of health facilities within project-supported zones are being paid by the State. Although the Ministry is facing problems in the redeployment of female personnel (midwives), all other health personnel have been redeployed to their original facility assigned even in the most distant zones.

Page 10
In the light the above, it would be illusory to speak about achievement of the project or of the millennium development goals despite the fact that enormous progress were made during the first few years of project implementation.

Page 11
How is the general rating of satisfactory or unsatisfactory justified?

Page 12
The Material Division of the MPH has all the necessary management tools to track expenditures until their destination. The assertion that funds intended for the peripheral facilities seldom reach their recipients has not been proved.

Evaluation of the risk concerning the results: All the debts of the State to the CPA have been paid, and its Treasury is beginning to improve.

The lack of qualified personnel is one of the major constraints of the Ministry in ensuring the quality of health services. This is why the development of human resources was considered a principal objective to be achieved during the implementation of the national health policy. This objective cannot be achieved without the support of the development partners even if the country has oil resources.

Annex 6. List of Supporting Documents

(i) Chad Health Sector Support Project, Project Appraisal Document

(ii) *Impacts du PASS, Ministère de la Santé Publique*, February 2007

(iii) *Aide Memoires, Missions de supervision*, 2001-2006

(iv) Implementation Supervision Reports, 2001-2007

(v) Rapports de Suivi et Evaluation du PASS, 2005 & 2006