# ICR Review

**Operations Evaluation Department**

**Report Number : ICRR11635**

| 1. Project Data: | | Date Posted : 09/30/2003 | | |
|---|---|---|---|---|
| PROJ ID : P000118 | | | Appraisal | Actual |
| Project Name : | Population And Health | Project Costs (US$M) | 33.44 | 29.53 |
| Country : | Benin | Loan/Credit (US$M) | 27.8 | 23.15 |
| Sector(s): | Board: HE - Health (97%), Central government administration (3%) | Cofinancing (US$M) | 0 | 0 |
| L/C Number : | C2734 | | | |
| | | Board Approval (FY) | | 95 |
| Partners involved : | None | Closing Date | 06/30/2001 | 12/31/2002 |

| Prepared by : | Reviewed by : | Group Manager : | Group : | |
|---|---|---|---|---|
| Howard Nial White | Martha Ainsworth | Alain A. Barbu | OEDST | |

## 2. Project Objectives and Components

### a. Objectives

Overall objective: "assist the Government in improving the health and well-being of Benin's population, with particular emphasis on its most vulnerable segments (women, children and the poor)" (SAR, p.14).

Specific objectives: (1) support to the implementation of the government's population policy (adopted in 1996) and family planning (FP) program through an expansion of family planning services and reproductive health services (RHS); and (2) support to the institutional reforms and reorganization planned under Decree N °94-145 of May 26, 1994, in particular: (a) decentralization, (b) reorganization of the referral system, and (c) expanded participation of various stakeholders (SAR p.14).

### b. Components

The project had five components:

(1) Development and Expansion of Family Planning Programs and Services (US$2.8 million), with two sub-components: (a) promotion and dissemination of the National Population Policy (printing and disseminating policy-related material and workshops), and (b) scaling up of family planning services at the country level (financing surgical equipment, contraceptives, surveys, and operating costs, as well as the training of staff working in delivery rooms and operational research related to family planning).

(2) Improving the Quality and Efficiency of Priority Health Services (US$13.5 million): (a) reinforcement of the referral system (construction/rehabilitation of medical infrastructure, supply of laboratory material and equipment for surgery, obstetrics and gynecology, the development of treatment protocols, norms, and standards, in addition to fund the evaluation of hospital management systems); and (b) reinforcement of priority health services and programs (six priority programs and services intended to fight key causes of mortality and morbidity ).

(3) Strengthening and Streamlining Sector Management and Administration (US$15 million): (a) decentralization of management and administration (funding infrastructure, equipment, material, training, and other operational expenditures), (b) strengthening of main management functions (to finance training in various aspects of management as well as technical assistance and recruitment of additional personnel ); (c) operational research (finance for equipment and material, as well as the training needed to develop capacity in collecting, analyzing, and disseminating the results of research by national experts ); and (d) developing capacity in pharmaceutical sector management (establishment of a legal and regulatory framework, the development of capacity at the Centrale d ' achat des médicaments essentiels (CAME) and the supply of drugs to medical infrastructure, as well as strengthening the pharmaceutical regulatory framework and better enforcement of regulations regarding the sale of illicit drugs).

(4) Strengthening the Partnership for Health (US$1.2 million): (a) CNEEP/CDEEP (finance costs associated with reporting and two annual meetings, as well as with the institutional strengthening of the MOPH departments providing

the CNEEP and CDEEP Secretariats) and (b) COGES, COGEZ, and COGEC (funding training courses for members).

(5) Project Management, Monitoring and Evaluation (US$0.9 million) (fund periodic, mid-term, and final evaluations, as well as surveys of project beneficiaries.)

**c. Comments on Project Cost, Financing and Dates**

Project costs: (1) SDR 17.85 million were disbursed of the planned SDR 17.9 million, i.e. 99.7%. However, inflation and currency revaluation meant that work was scaled back. (2) There was a substantial restructuring of the project costs toward civil works and equipment. Specifically, the share of civil works went up from 11 per cent at appraisal to an actual of 27%, and equipment from 23 to 35% (calculated from ICR p.11).

**3. Achievement of Relevant Objectives:**

The improvement in health outcomes, such as infant and child mortality, was modest, and much less than that achieved in the years preceding the project (see table below). Indeed, Demographic and Health Survey data, used in the report, suggest a rise in CMR.

| | Years before the survey (2001) | | | | |
|---|---|---|---|---|---|
| | 0-4 | 5-10 | 11-14 | 15-20 | 20-24 |
| IMR | 89.1 | 100.9 | 116.2 | 106.8 | 130.8 |
| CMR | 77.8 | 71.8 | 89.7 | 111.2 | 108 |

The majority of the indicators given in the report relate to the reproductive health component. A convincing case is made with respect to support for reproductive health. A range of indicators across the logframe show changes in aspects of both knowledge and practice (for example, increase from 1996 to 2001 in women knowing at least one modern contraceptive method from 76 to 90 per cent) and per cent of 15-19 year olds pregnant or having at least one child falling from 26 to 21.5 per cent. However, the change in contraceptive prevalence was modest (16.8 to 18.6% and 3.4 to 4.2% for modern methods). As noted in the ICR, UNFPA, USAID, GTZ, WHO and the Netherlands all support reproductive health in Benin with IDA support being focused in the South and Coast regions, so the project is one of a number which have contributed to these nation-wide improvements.

On the input side the number of districts following national standards of DDS rose from 11 to just 12 in 2001 and 13 in 2003 (against the government's target of 25) and the percentage of medicine points inspected by the directorate reached only 20 % (admittedly a doubling from 10% but still low). The project directly supported the establishment and functioning of 4 of these health districts and support activities in a further 9. Intermediate indicators show a mixed performance: the immunization rate rose only slightly (55.6 to 59 per cent) and mothers practicing exclusive breast-feeding in the first 4 months increased from 18 to 18.7 per cent (i.e. hardly at all); on a positive note attended births rose from 55 to 77%. Some outcome indicators changed quite substantially (e.g. diarrhea cases), but others did not (malaria cases).

**4. Significant Outcomes/Impacts:**

Considerable progress was made during the life of the project in the development of family planning policy and service delivery. Contraceptive prevalence has risen and fertility fallen.

The project has also assisted with the decentralization of health services. The main activity has been supporting new health districts - supporting the establishment of 4 health districts as planned in the SAR, with assistance extended to a further 9 districts. In addition the project financed activities for participatory structures at all levels and these structures are now operational. However the ICR notes that "the election of new members to health committees did not facilitate the participation of communities in the management of health centers" (ICR, p.8). Other institutional development was provided through logistical support, equipment and training for the National Health Management Information System.

**5. Significant Shortcomings (including non-compliance with safeguard policies):**

There was a major change in the structure of the project. The share of civil works went up from 11 per cent at appraisal to an actual of 27%, and equipment from 23 to 35% (calculated from ICR p.11). The reasons given for this are the decision to build two new hospitals rather than rehabilitate/extend 2 existing ones as planned and for new building standards. These increases took place at the expense of recurrent costs intended to meet costs of staff considered essential to decentralization process. This allocation for this budget items was cut from US$ 5.15 million to US$1.24 million.

As noted above, the establishment of health committees has not resulted in the anticipated level of participation.

| 6. Ratings: | ICR | OED Review | Reason for Disagreement /Comments |
|---|---|---|---|
| Outcome: | Satisfactory | Moderately Satisfactory | [the ICR's 4-point scale does not provide for a "moderatelt sat." rating]. (1) Project activities began late and the shift into civil works was at the expense of recurrent costs. (2) The outcome of many health committees was disappointing; (3) No evidence is provided that the project had a beneficial impact on the poor, the link between improved outcomes and the project is weak and child mortality has been rising. |
| Institutional Dev .: | Substantial | Substantial | |
| Sustainability : | Unlikely | Unlikely | |
| Bank Performance : | Satisfactory | Satisfactory | The project design was overly complex in relation to borrower capacity and failed to set out roles and responsibilities of key actors.<br>The agreement to shift costs toward investment resulted in a large reduction in the contribution to recurrent costs. |
| Borrower Perf .: | Unsatisfactory | Unsatisfactory | |
| Quality of ICR : | | Unsatisfactory | |

**NOTE**: ICR rating values flagged with ' * ' don't comply with OP/BP 13.55, but are listed for completeness.

**7. Lessons of Broad Applicability:**

The main lesson is that a strategy to improve health outcomes should be based on an understanding of what determines those outcomes. To the extent that health services matter then project design should pay attention to both supply and demand side issues. This project focused largely on the supply side. Moreover, within the supply side, an appropriate balance must be maintained between investment and recurrent costs . The scale of the health care system should not be increased beyond that which can be properly financed on a recurrent basis .

**8. Assessment Recommended?** ● Yes ○ No

**Why?** A large part of project resources were used to support decentralization . Studies are required of how cost-effective this is as a means of achieving health objectives in low -income countries.

**9. Comments on Quality of ICR:**

There appear to be problems in the project which are not directly addressed in the ICR and a general lack of evidence in relation to many of the project's activities . The exception is that the ICR provides reasonable evidence of success in relation to reproductive health, but this component had a small share of the total project budget .

Specific comments are:

1. The ICR states that "the project is rated satisfactory in terms of achieving its objectives with respect to (i) the implementation of the population policy and the expansion of the family planning program; and (ii) improvements in the health system performance through the support of three main reforms defined in the national health sector strategy for the period 1995-1999" (ICR, p.5). However, these specific objectives are activities . The objective of the project was "to assist the government in its goal to improve the health status of the population, in particular the most vulnerable population groups (women, children, and the poor)". But little attention is paid to outcome indicators related to this objective and none at all to measures specifically focused on the welfare of the poor (except in the lessons learned where it is suggested that vulnerable groups have been excluded by cost recovery policies, p .15). To be fair to the ICR, the project design paid scant regard to this target group, although there was a strong MCH orientation.

2. Little information is provided on achievements under the largest project component on strengthening sector management. The ICR states that "It supported staff training, recruitment of accountants, the consolidation of the gains achieved through the pharmaceutical policy (legislation and regulation of the sector, fight against illicit drug sales, stabilization of EGD prices, purchase of EGDs with a greater accessibility and improved inventory control ), and the establishment of management structures at various levels " (ICR, p.7). This does not seem to adequately account for the use of nearly US$13 million, so it is not clear what activities were actually implemented with these funds .

3. As detailed in section 5, the investment costs were increased at the expense of recurrent costs, which were meant

to be picked up by government but were not. The question must therefore be asked if the facilities were able to function efficiently. The ICR does not address this question in any detail, but suggests that there were problems : "The choice of reducing recurrent costs in favor of investments did have an impact on the implementation of some project activities.The utilization rate of services increased only slightly from 0.34 visits/caput/annum in 1997 to 0.36 in 2001 in spite of relatively good health coverage in the country (86 percent of the population lives within 5 km radius from a health facility). Possible explanations might be the quality of services delivery, or physical and financial barriers" (ICR: p.7)

4. Hence, the evidence presented in the ICR does not support the conclusion that the project achieved the objective of improving the health status of the population. It appears to have done so in some respects, but had a disappointing performance in others. Moreover, the objective to "provide better quality of, and easier access to, services " appears not to have been met since service usage barely increased .

The general point is that ICRs should take care to establish clearly for the reader to what end the project resources were used.

There is one minor discrepancy on project costs : actual project expenditure is given as US$ 29.53 million, in the text it is stated that US$23.4 million of that is from the Bank and US$ 6.13 from government and communities. However, the table in Annex 2 gives the same global total (not shown in the table) but with US$23.25 million from the Bank and US$6.38 million from government.