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Report No.: 20338

IMPLEMENTATION COMPLETION REPORT
(24900)

ON A

CREDIT

IN THE AMOUNT OF SDR 14.2 MILLION (US$19.9 MILLION EQUIVALENT)

TO THE

REPUBLIC OF ANGOLA

FOR A HEALTH PROJECT

June 23, 2000

Human Development Unit, AFTH4
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective December 31, 1999)

Currency Unit = Kwanza (Kz)
Kz1 = US$ 0.17
US$ 1 = Kz 5.88

FISCAL YEAR
January 1 December 31

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immuno-deficiency syndrome
IDA	International Development Association
MOH	Ministry of Health
NFPP	National Family Planning Program
TA	Technical Assistance
UNAIDS	United Nations for AIDS
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development

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CONTENTS

Project ID: P000048	*Project Name:* HEALTH
Team Leader: Joseph W. B. Bredie	*TL Unit:* AFTH4
ICR Type: Core ICR	*Report Date: January 24, 2000*

1. Project Data

Name: HEALTH
L/C/TF Number: 24900
Country/Department: ANGOLA
Region: Africa Regional Office
Sector/subsector: HB - Basic Health

KEY DATES

			Original	Revised/Actual
PCD:	03/21/90	*Effective:*	12/10/93	12/10/93
Appraisal:	03/13/92	*MTR:*	11/27/97	11/27/97
Approval:	05/11/93	*Closing:*	12/31/98	12/31/99

Borrower/Implementing Agency: GOVT OF ANGOLA/MIN OF HEALTH
Other Partners:

STAFF	Current	At Appraisal
Vice President:	Callisto Madavo	Edward K. Jaycox
Country Manager:	Barbara Kafka	Francisco Aguirre-Sacasa
Sector Manager:	Arvil Van Adams	Alain Colliou
Team Leader at ICR:	Joseph Bredie	Pierre Mersier
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2. Principal Performance Ratings

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

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

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

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

3.1 Original Objective:

The Health Project was the first, and so far only, Bank-financed operation in the sector. It was designed to help the Government of Angola (GoA) strengthen its capacity in health sector policy and management, and improve health care in selected locations at the national, regional and municipal levels. The Project was identified in 1991 and appraised in April 1992. At that time, Angola's basic health indicators were the lowest in Sub-Sahara Africa, as a result of a prolonged state of war since independence in 1975. The cost of the Project was estimated at US$22.2 million. A Credit in the amount of SDR14.2 million (US$19.9 million) was approved by the Board on May 11, 1993 and became effective on December 10, 1993. The Government was to contribute US$2.3 million.

3.2 Revised Objective:

The Project was restructured in September 1996, without a change in objectives. The scope of the civil works program was reduced, making room for the introduction of the essential medicine component.

3.3 Original Components:

The project included two components:

3.3.1 **Strengthening health sector policy and management (US$5.64 million).** The policy and management component comprised three parts: (1) *strengthening health policy development;* train senior staff of the Ministry of Health (MoH) in policy analysis, and sector management; (2) *institutional strengthening of MoH;* by means of three activities: (a) train and provide technical assistance to staff of the departments of planning, public health, and human resources to formulate health policies, and manage public health programs and sector personnel; (b) provide technical assistance to the department of planning to strengthen its capabilities in project management; and (c) rehabilitate MoH's offices, and provide office equipment, training materials, supplies and vehicles; (3) *carry-out investment studies in five areas;* (a) health sector management; (b) human resources development; (c) sexually transmitted diseases and maternal and child health; (d) health facilities rehabilitation; and (e) identification of follow-up investments.

3.3.2 **Selected rehabilitation program (US$15.7 million).** The program component comprised four parts: (1) *support for two public health programs;* (a) AIDS/STD control programs; and (b) national family planning program; (2) *rehabilitation of ten health posts in the Huila Province;* (3) *relocating, constructing, upgrading, rehabilitating and equipping five health facilities in Lubango, Huila Province*; (a) the school for health professionals for nurses and technicians; (b) health posts in Tioccho and Nambambe; (c) municipal health center; and (d) pediatric center; (4) *rehabilitating, equipping, furnishing and training of staff of three other facilities in the Kwanza Sul Province.* (a) the hospital of Porto Amboim; and (b) the health posts in Pinda and Km 11.

3.4 Revised Components:

During Project implementation, it became clear that the proposed capacity for nurses training at the Lubango School for health professionals, was significantly larger than the actual need for nurses in the four provinces concerned. Also, construction and equipment standards for the Porto Amboim hospital were at a higher level than necessary. In the 1996 Project restructuring, the design of these two facilities was revised down. The savings were used to support a new Project activity, the essential medicine program. The program included a three-year supply of essential medicines to health centers and health posts in the Huila, Cunene and Kwanza Sul Provinces, the provision of four vehicles, and the training of staff.

3.5 Quality at Entry:

Consistency with CAS. The Project was fully consistent with the Country Assistance Strategy for Angola discussed with the Board in January 1992. Its objectives were based on an extensive examination

of the sector. Given the devastation of infrastructure and institutions, building capacity, rehabilitating basic health facilities, and reformulating programs made sense.

Composition of investment program. Most of the civil works program centered on the Province of Huila. The main focus there was to rehabilitate existing health facilities. The only sizable new construction of the civil works program was the Lubango School for health professionals. A new school was badly needed to train the nurses and health technicians required in the four Southern provinces of Huila, Namibe, Cunene and Kuando, to replace the two run-down and inefficient existing training institutions. The new school would be managed under a twinning arrangement with a foreign institution. However, the nurses training capacity of the school was not assessed properly. During project supervision, it became clear that a smaller school than envisaged would be sufficient. Notwithstanding this aspect, the project's investment approach was sound.

Design. In the prevailing post-conflict situation, where the Government did not have full control over large parts of the country, it made sense to try different approaches using non-governmental and government organizations for the delivery of health services. However, this decision made implementation of the Project more complex. Given the uncertainties of the post-conflict situation, and the concomitant lack of government control, the Project should have been simplified. It was complex for a new Borrower coping with conflict, uneven civil control, weak public institutions, and little experience with Bank-financed projects. Another design aspect that caused difficulties was the use of inputs and outputs as indicators of the achievements of the Project . As was common with projects appraised at that time, indicators to measure the actual outcomes of the Project were not formulated.

Implementation arrangements. Taking account of the Government's weak implementing capacity, the Bank sought to rely as much as possible on non governmental organizations to deliver health services. For instance, for the AIDS control and the family planning programs, the Bank agreed to support and expand ongoing activities managed by WHO and UNFPA, respectively. To ensure that implementation would commence immediately, the project implementation unit was set up and its director and key staff appointed before negotiations of the Credit. Also, preliminary drawings and bidding documents for the construction and rehabilitation program were made ready at that time. However, renewed hostilities which drastically changed implementation conditions broke out before the Project was approved by the Board . No effort was made to change the design or composition of the Project before it became effective. Also, differences with the Catholic Church on how the rehabilitation of the hospital in Porto Amboim would be carried out were not resolved in a timely manner.

Risks. Three risks were identified. The weakness of the Ministry of Health and of the local administration, the lack of familiarity with Bank procedures, and the political uncertainty. The first two risks were to be mitigated through extensive use of technical assistance and reliance on well tested non-governmental organizations. Since all political parties agreed on the urgent need to improve health conditions in the country, it was felt that the Project would not be sensitive to political changes. The political uncertainties were, however, very high and not sufficiently recognized. Moreover, by the time the Project was approved, hostilities had resumed. It was optimistic to expect that the Project strategy would remain relevant and sector policies and funding would not be adversely affected.

Overall assessment. Despite the complexity of the Project, the inappropriate design of the School for health professionals, and the shortcomings in risk analysis, the quality at entry of the project, and the overall performance of the Bank from identification to Board approval is rated satisfactory. The risk was worth taking. Angola's health conditions were dismal. The Bank strategy rightly emphasized the need to improve conditions in the social sectors as a matter of high priority. The Project, with its emphasis

on capacity building and rehabilitation of existing facilities, was an appropriately designed vehicle to implement the strategy in the sector. In view of the resumption of hostilities, it would have been useful if an exit strategy had been formulated. This strategy would have spelled out minimum funding, delivery and management standards, without which the Project would have to be restructured or canceled.

4. Achievement of Objective and Outputs

4.1 Outcome/achievement of objective:

Achievement of the objectives has been uneven. MoH's capacity to formulate and monitor sector policy has not improved much, due in part to the prevailing poor remuneration and incentive system for civil servants. The incentives to recruit, and retain health personnel have been weak throughout implementation. In addition, the absence of budget support, and the decentralization of responsibilities for health budget allocation and services, diffused MoH commitment and interest in the Project. On the other hand, the AIDS/STD control and national family planning programs have increased awareness about HIV/AIDS and population issues. An AIDS control program has been approved, and a conference to establish a national consensus on a population strategy is scheduled for July 2000. The rehabilitation and equipping of health facilities in Kwanza Sul Province, and the construction of the School for health professionals and pediatric center in Huila Province have been completed. The center is operating and the school is scheduled to open in April 2000. The facilities operate at a low level of efficiency, however, due to shortages of operating funds and inadequate staff incentives. The essential medicines component has been a success ensuring a steady and cost-effective supply of drugs to health centers and health posts in three provinces. The Project outcome is rated as unsatisfactory for the health sector policy and management component, and satisfactory for the health programs and facilities rehabilitation component. Overall the project is rated unsatisfactory.

4.2 Outputs by components:

Strengthening health sector policy and management. Achievement of the policy development and institutional strengthening parts of this component was unsatisfactory. The studies part was dropped. (1) *Strengthening health policy development.* MoH's capacity to formulate sector policies is uneven and weak. The formulation of sector policies has been hampered by the fact that a succession of four Ministers have been responsible for the sector during the life of the Project and senior staff have been changed frequently. Each Minister had his own set of priorities, making it difficult to formulate a coherent national health policy. Frequent changes in senior staff led to changes in direction concerning health program management. (2) *institutional strengthening of MoH.* Staff of the departments of planning, and public health have been trained. But, there has not been much continuity in the planning and public health departments, again due to periodic changes of senior staff. A basic framework for planning has been developed, with the assistance of consultants. But due to the scarcity of reliable health sector data, data and information are not systematically fed into the system. Also, a framework for budgeting has been established, but the capacity to produce annual and medium-term plans and budgets remains weak. The budget for the year 2000 and 2001 is better than earlier ones showing some improvement in the capacity of the department of planning resulting from the Project. In general, however, the weak planning and budgeting capacity prevents the efficient allocation of resources to national health priorities. On the other hand, the staffing situation has improved, particularly in the past two years. The department of human resources has developed a framework for personnel management in the sector. Ghost workers have been by and large eliminated, records of medical personnel have been established, and a strategic plan for human resource development has been formulated. While health sector staff are better managed, the lack of policies, plans and supporting budgets is a serious obstacle to improving the health conditions of the population. The health conditions in the country remain dismal, in part, because of the on-going conflict, but also because of weak sector policies, management and budgeting. (3) *carry-out investment studies.*

This part of the Project was dropped in 1995 in view of overlap with activities funded by other donors.

Selected rehabilitation programs. Achievement of all four programs of this component is rated satisfactory. (1) *Strengthen two health programs.* (a) The AIDS/STD control program has been strengthened. Knowledge, Aptitude and Practices (KAP) studies have been carried out, in two of the five provinces initially proposed. Audiovisual equipment has been provided for public information campaigns. Condoms have been procured and a manual on sexual education for teachers has been prepared. Moreover, a national strategy for AIDS control has been discussed and approved by the Parliament in 1999. (b) The national family planning program benefited from the Project. Funds were made available to procure contraceptives and kits for midwives. A training curriculum for maternal and child health has been developed, including guidelines on family planning, and trainers have been trained. A population policy was also drafted, which is expected to be discussed at a National Conference scheduled for July 2000. (2) *Rehabilitation of ten health posts in Huila Province.* Seven health posts have been rehabilitated in another district because hostilities broke out in the district initially selected. The posts have the basic staff of nurses and assistants and are supplied with drugs from the Essential Medicine Program. The posts are visited by between 10 to 30 patients daily. A large number of the patients are children. However, operating funds are inadequate. Staff are paid more or less regularly, albeit very little, but there is little money for supplies (not included in the essential medicine kits), water, cleaning, maintenance, etc. (3) *Relocating, constructing, upgrading, rehabilitating and equipping five health facilities in Lubango.* The school for health professionals at Lubango has been constructed, equipped and furnished, but with long delays. It opened in April 2000. The health posts, the municipal health center and the pediatric center in Lubango have also been rehabilitated and are operational. Operating funds are seriously short. (4) *Rehabilitating, equipping, furnishing and training of staff of three other facilities in Kwanza Sul.* The hospital of Porto Amboim was officially inaugurated in November 1999. It operates at a low level of efficiency, for lack of appropriate funding. Few patients come for treatment since the hospital is short on staff and basic supplies. The health posts in Pinda and Km 11 were completed in February 2000.

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

4.4 Financial rate of return:
N.A

4.5 Institutional development impact:

The institutional development impact of the project is modest at this time. Capacity has been built in the project implementation unit, but this unit was never integrated into the MoH. The department of human resources was significantly strengthened, but the planning and budget and program management departments remain weak. The Project may have a positive institutional development impact in the rehabilitated hospitals and health centers as long as the allocations of operating funds continue to improve as they have the last two years. In the longer term, the health professional school in Lubango can make a significant impact on health institutions throughout Angola providing a steady supply of professionally trained health workers.

5. Major Factors Affecting Implementation and Outcome

5.1 Factors outside the control of government or implementing agency:

Hostilities. The Project was appraised in April-May 1992, when Angola enjoyed a brief period of peace. A peace accord had been signed in May 1991, and significant economic reforms introduced with IMF and Bank support. In late 1992, the situation deteriorated. National elections, acknowledged by the United Nations as fair, were contested by UNITA. Despite renewed hostilities and political uncertainties,

the Project was approved in April 1993. It was felt, that it could be implemented. The main components were located in safe areas of the country, except for the Huila Province where health posts were to be rehabilitated. A new cease-fire was signed in Lusaka in November 1994. The peace process made significant headway in 1996-97. In April 1997, a Government of National Unity and Reconciliation was constituted with four ministers from UNITA, including the Minister of Health. Clashes erupted again, however, and full war resumed in late 1998 and intensified in 1999.

Project implementation was affected by the hostilities and has been difficult even in government-controlled areas. The war caused large migrations of people out of insecure areas and severe food insecurity. Resources for health services have been constrained throughout the Project life because military expenditures absorbed a large part of national resources. National expenditures remained at an unsustainable level of over 60 percent of GDP, resulting in high budget deficits, and a high level of inflation. High inflation has sharply eroded the buying power of the population, including civil servants. It has also led to the high cost of the Project's inputs, including civil works.

5.2 Factors generally subject to government control:

Budget allocations. Throughout the project implementation period, allocations for the health sector have been low, inhibiting the delivery of services in public sector facilities. Salaries are extremely low and not paid regularly. More seriously, money allocated does not reach the institutions, but is diverted to other purposes. Often, medical supplies and other materials are only available when financed by external donors. Insufficient counterpart funding has been a chronic problem throughout the project implementation period. Only in 1999 did this situation improve. The Government increased allocations to the sector, which allowed the physical completion of the rehabilitation component of the Project.

Lack of consistent sector policies. Project implementation suffered from a lack of consistent direction and weak leadership. Efforts to strengthen the MoH's capacity to formulate policy and manage the sector were compromised by frequent changes at the top, and a lack of consensus in the Ministry. In 1996, an advisory group and five task forces were established to work with international consultants. The arrangement did not work well, mostly because the three Vice Ministers in the MoH could not manage to reach consensus. When the UNITA Minister was appointed in April 1997, there were expectations that a sense of direction would be re-established in the MoH and sector. The Minister had a set of priorities to address the sector's deep-rooted problems. But his initiatives were met with strong resistance and faltered, mostly for political reasons.

5.3 Factors generally subject to implementing agency control:

Project Implementation Unit. In spite of a most difficult environment, the project implementation unit (PIU) was efficient in coordinating and providing support to the entities charged with executing Project activities, and ensuring its completion within a reasonable time period. There was a remarkable continuity in the management of the PIU. In several instances, the PIU was unable to obtain visas and work permits for foreign consultants, contractors or workers from the authorities. This delayed or prevented implementation of technical assistance activities and wasted resources.

Other institutions. Implementation of the project was entrusted to several institutions, including government, international and non-governmental organizations. International agencies were in charge of the two priority health program components, including WHO for the AIDS program and UNFPA for the family planning program. Technical assistance provided by WHO was not up to the task, and reporting on program activities was inadequate. The situation was eventually corrected in late 1996 with the appointment of a new WHO representative in Angola. For both programs, annual plans were reviewed and agreed with the relevant implementation agencies during Bank supervision missions.

The non-government organization (NGO), Doctors without Borders, Spain (MSF, Sp.) was initially entrusted with the rehabilitation and operation of ten health posts in the Huila province. Because of the political insecurity, this component was delayed. In 1996, another area in the same province was identified, and, after MSF, Sp's departure from Angola, ADRA, a local NGO, was selected to implement this component. ADRA had little experience in civil works, which delayed construction of the health posts. On the other hand, ADRA did a good job in creating adequate conditions for operating the facilities, and demonstrated what could be accomplished with the participation of local communities in the delivery of basic services to the population.

The rehabilitation and operation of the health facilities in Porto Amboim, including the provincial hospital, was entrusted to the Catholic Church. Implementation of this component was considerably delayed because of the lack of an acceptable operation plan, and an adequate organization, management and staffing structure for the hospital. As late as April 1998, the Bank was considering withdrawing support for this component for lack of progress. Eventually, the scope of work was significantly reduced, the role of the Church was revised, and the component was completed before the closing date.

The construction of the school for health professionals and related infrastructure was entrusted to the MoH. A South African contractor was selected for the civil works, and another consultant for developing the curriculum and defining the organization of the school. Implementation of this component was considerably delayed because of the time taken by the authorities to deliver visas and work permits to consultants and specialized workers.

Procurement and distribution of essential medicines became a new Project activity when the Project was restructured in 1996. It was carried out efficiently by the Directorate for Essential Medicines. The Directorate focused on the health centers and health posts located in the seven provinces where the security situation was acceptable.

5.4 Costs and financing:

The final cost of the Project was US$20.35 million, exceeding the estimate at appraisal by US$0.15million. The slightly higher final cost is due to the introduction of the Essential Medicine Program which costs more than the savings made by reducing the size of the Lubango School of health professionals and the Porto Amboim hospital. The final disbursement of the Credit was US$19.42 million. The Government contribution was US$2.29 million, higher than the US$1.69 million estimated at appraisal. The increased Government contribution covered the cost escalation of the civil works at the MoH building and the ten health posts in Huila Province.

6. Sustainability

6.1 Rationale for sustainability rating:

The sustainability of the Project is unlikely, because of weak government commitment to the health sector, and more generally, inadequate management of the economy. The Ministry of Health is extremely weak. The instruments developed by consultants to design policies for the sector and to improve its management are not being used. In any event, the Ministry has little influence on sector allocations. Operating budgets of regional and local facilities are approved by the Ministry of Finance, on the basis of proposals made by local administrators and provincial governors who manage health institutions and programs rehabilitated under the Project. Coping with insecurities, limited resources, and competing demands, they show little commitment to supporting and maintaining these institutions.

Health programs. The two national programs for AIDS control and family planning, funded by

the Project and implemented by UN agencies, are likely to be significantly scaled back, as donors have gradually reduced their support to Angola. This is particularly the case for Sweden, a major contributor to Angola's health sector, and to the family planning program implemented by UNFPA.

Health facilities. The health facilities built or rehabilitated under the Project are unlikely to operate at the expected level of efficiency. The equipment provided is unlikely to be used efficiently, because of inadequate capacity, absence of materials, and lack of maintenance. A technician was selected by the MOH to maintain medical equipment, and sent abroad for training with support from the Project. It is not clear whether he will decide to work for the Ministry when he returns, as his monthly salary will probably be less than US$25.

Operating costs. Insufficient funding is available at present to cover operating costs, other than salaries and medicines, of the Project health facilities. For instance, the water and electricity bills of the hospital and the School for health professionals may not be paid for lack of funds. Generators, cars and refrigerators (for vaccines) can probably not be used for lack of fuel. The local government plans to supply water to the two health posts in the Kwanza Sul province by truck. It is unlikely that this will be done on a regular basis, because this is presently not done for the health center in Porto Amboim (which did not receive support from the Project).

Medicines. The project has financed a three-year supply of essential medicines for the three provinces of Kwanza Sul, Cunene and Huila, where the health facilities built or rehabilitated under the Project are located. It is likely that the health posts and centers in these provinces will receive the medicines they need, as long as the supplies last, because the national program for essential drugs is well managed. It is not clear how and if the program will continue in the absence of donor funding. The supply of medicines to the two Project hospitals is already a problem, as funding from the provincial authorities is almost non-existent.

6.2 Transition arrangement to regular operations:

The pediatric hospital in Lubango is operating satisfactorily with a competent and motivated team. The hospital in Porto Amboim is also operating, but at a low level of occupancy. The team in charge of the hospital is weak and poorly motivated, with the exception of the two catholic nurses who have been involved in the rehabilitation and are committed to make the hospital work. The health posts and centers built or rehabilitated under the Project operate as best they can. They receive 20 to 30 patients a day, and provide essential medicines for the three prevailing infectious diseases, malaria, diarrhea, and respiratory problems. Except for the regular visits of agents from the Essential Medicines Program, there is no supervision of the health posts. The medical doctor in charge of the area can not reach the posts for lack of transportation.

The School for health professionals started operating in April 2000. The management team and the faculty are in place. There is strong local interest in the school, but funding for its operation is not yet fully secured. The initial delays in opening the school after its physical completion raises doubts about the commitment and capacity of the Ministry of Health to make it work.

7. Bank and Borrower Performance

Bank

7.1 Lending:

The Project was identified in November 1990. The main issues in the sector were adequately analyzed. Taking account of the support provided by other Donors, the Bank decided to focus on two key issues in the sector: the weak planning and management capacity in the Ministry; and, the low coverage

and quality of basic health services. This was appropriate given the circumstances. The Bank also decided to support the AIDS control and family planning programs, which were considered high priority and in need of scaling up. During project preparation, the Bank helped the Government formulate a strategy for the health sector, and reviewed its expenditure program. Project preparation was sound and the focus on sector management capacity and health programs appropriate.

The Project was appraised in April/May 1992. The design of the Project was appropriate. The two objectives of (i) strengthening the capacity of the Ministry of Health to formulate policies and manage the sector, and (ii) improving the delivery of basic health services in selected areas were appropriate and complementary. The quality at entry is rated satisfactory. The performance of the Bank during preparation and appraisal is rated satisfactory.

7.2 Supervision:

Hostilities had resumed before the Credit became effective in December 1993 and continued for most of the Project's life, making supervision difficult and hazardous. Also, because of the hostilities, time was lost in the early years of implementation. The first mission to launch the Project took place in September 1993. The next mission took place much later in January 1995. As a result, initial implementation was slow because Bank staff were not able to assist an inexperienced Borrower in the early and crucial stages of a new Project.

From January 1995 to end-December 1999, when the Credit was closed, at least two supervision missions visited Angola each year, despite the ongoing hostilities that were taking a heavy toll on the country and the sector. The July 1995 supervision mission found that the health sector had already deteriorated considerably because of the hostilities and funding crises. Implementation was severely constrained for lack of counterpart funding. Despite this situation, the Project was rated satisfactory for both development objectives and physical progress until January 1996. From then on, it has been rated unsatisfactory on the development objectives.

The 1996 Project restructuring was prepared by the preceding supervision missions. The introduction of the new essential medicine program proved most beneficial for the health sector. The program has been well supervised and is making an important contribution to health care. Every supervision missions helped the Government to implement the Project effectively. They were instrumental in ensuring physical completion of Project facilities by end-1999, one year after the original closing date of the Credit. Efforts to strengthen the MoH were intense but largely futile. The MoH showed little interest in the Project and after the budget decentralization in 1997 had little influence on the allocation of resources to health facilities in the provinces. The supervision missions attempted to improve the allocation, particularly during the annual reviews. But politics and weak financial management and control hampered these efforts.

7.3 Overall Bank performance:

Overall, the performance of the Bank in supervision is rated satisfactory.

Borrower

7.4 Preparation:

The Government's performance during preparation was satisfactory. The analysis of sector policies, management and expenditures was thorough and comprehensive. The coordination of the contributions of the Donors in the sector was also done well. The expectations that the Project would be implemented efficiently after peace was achieved were genuine.

7.5 Government implementation performance:

The performance of WHO is rated unsatisfactory. When UNAIDS took over responsibility for implementing the AIDS program, performance markedly improved. The performance of FNUAP is rated satisfactory. Progress was made in improving public awareness on population issues and contraceptive availability.

The performance of the Catholic Church in Porto Amboim is rated unsatisfactory. It appointed unqualified people to implement the Project component, and failed to support the two nuns who were committed to make the hospital work. The performance of ADRA is rated satisfactory. It had little experience in civil works, but did a good job in building community support for the management of the seven health posts in the Huila Province.

The performance of the unit in charge of the Essential Medicine Program is rated highly satisfactory. The performance of the Directorate of Human Resources in the Ministry of Health is rated satisfactory and that of the Directorate of Plan marginally satisfactory. The performance of the Directorate for Administration and Budget is rated unsatisfactory.

7.6 Implementing Agency:

The performance of the project implementation unit is rated satisfactory. It did its best in a difficult environment to ensure physical progress, and support for the institutions concerned with Project implementation. Procurement, filing and financial management were fully satisfactory.

7.7 Overall Borrower performance:

The overall performance of the Borrower is rated unsatisfactory. It is not possible to assess the level of the Government's commitment to the Project even seven years after Project was approved. During most of the implementation, the Ministry of Health did not show much interest in the Project. The President of Angola inaugurated the Lubango School for health professionals in November 1999. His presence suggested an interest in at least a key component of the Project at the highest level of Government. However, counterpart funding for the Project has been consistently short and budgets for the health sector have been consistently neglected. On the other hand, budget allocations for the sector increased substantially for the last two years raising expectations that the Government's commitment to improve health services for the population may be increasing.

8. Lessons Learned

- The Project was complex for a first investment in the health sector in a country with little Bank experience and low capacity.

- When a client is new and unfamiliar with Bank procedures, as was the case in Angola, it is advisable for the Bank to devote additional resources to supervision and technical assistance to acquaint the Government more fully with these procedures.

- The project was approved following the resumption of hostilities in Angola. Given the high uncertainty at that time, it would have been prudent to formulate an exit strategy.

- Highly motivated teams can make a difference, even when overall conditions are inimical to development. The satisfactory implementation of the essential medicine program is an illustration of what can be achieved in spite of a difficult environment.

- Technical assistance is a waste of resources when there is little government commitment to sound sector management and institution building.

- In view of the importance of continued government commitment to a project for its successful implementation and outcome, criteria to assess such commitment should be established early on and continuously monitored during supervision.

9. Partner Comments

(a) Borrower/implementing agency:

(b) Cofinanciers:

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

10. Additional Information

Annex 1. Key Performance Indicators/Log Frame Matrix

Outcome / Impact Indicators:

Indicator/Matrix	Projected in last PSR[1]	Actual/Latest Estimate
Strengthening Health Sector Policy and Management through: (i) a comprehensive technical assistance program in planning and management; (ii) short term training for senior staff; and (iii) provision of consultancies for investment studies.	The elaboration of the annual work plan for 1999 is finalized and the budget was based on it. Problems encountered in the previous mission regarding TA for the DNRH have been solved. Thanks to the TA support form UNAIDS, activities of the national program for AIDS control have picked up and the resources have been used. Contraceptives purchased by UNFPA arrived at the port and will be distributed shortly.	Health sector policies have not been formulated. Some priorities have been set, but are not being met due to inadequate funding. Also, staff in the MoH have received training in policy analysis and health program management, but they are poorly motivated and get little done.
Selected rehabilitation program through: (i) support for priority national health programs and Family Planning; (ii) rehabilitation of selected health posts in the province of Huila; (iii) relocation and upgrading of the health professional school, the health center and two health posts and minor rehabilitation and essential equipment for the pediatric center and the municipal health center in Lubango; and (iv) rehabilitation of the Porto Amboim hospital and two health posts.	All the drugs have arrived in the country and an evaluation of the drug distribution is being carried out. Due to a worsening security situation, because of the armed civil conflict, all activities in Health Posts in Matala carried out by ADRA have been suspended. Legal problems with the contractor, identified in the last mission, are being solved. Bids for the rehabilitation of Porto Amboim Hospital, the construction of two health centers and the equipment for those works plus all the Lubango infrastructures are finished. No-objections are pending extensions of Credit's closing date. Construction in Lubango progressed quickly, 80% of disbursement is completed and over 95% is executed. The firm suffered delays due to the Government's unwillingness to give working visas to their workers and harassment by border officials and at checkpoints in the road, and has requested compensation for around 300,000 USD. Financing of this compensation through Credit funds will only be considered if the Credit closing date is extended. For the Lubango nursing school, the bid for TA has been finalized. No-objection to negotiate with the chosen firm is pending extension of Credit's closing date. The team suggests extending the School of Lubango component and the investment studies sub-component for a year, and to extend the support to the national planning process, for six months. However, an extension should be considered only if the Government deposits the totality of the remaining counterpart funds (800,000 USD equivalent) before the Credit's closing date.	Some progress has been made in the AIDS/STD program and general awareness of HIV/AIDS and population issues has increased in the country. However, the coverage of these programs remains limited in part due to the festering conflict. Health posts have been rehabilitated and receive essential medicine. The Lubango School is operating as well as the pediatric center. The Porto Amboim hospital has been rehabilitated, but operates at a low level of efficiency for lack of medicines, supplies and operating funds.

Output Indicators:

Indicator/Matrix	Projected in last PSR[1]	Actual/Latest Estimate

[1] End of project

Annex 2. Project Costs and Financing

Project Cost by Component (in US$ million equivalent)

Project Cost By Component	Appraisal Estimate US$ million	Actual/Latest Estimate US$ million	Percentage of Appraisal
UNFPA	0.50	0.90	74
HIV/AIDS	1.24	0.74	60
Directorate of Plan	4.50	4.60	3
LUBANGO	8.70	7.10	80
PORTO AMBOIM	2.91	1.85	64
10 Health Posts	0.75	0.73	98
Essential Medicines Program	0.00	3.30	
Total Baseline Cost	18.60	21.02	
Total Project Costs	18.60	21.02	
Total Financing Required	18.60	21.02	

Project Costs by Procurement Arrangements (Appraisal Estimate) (US$ million equivalent)

Expenditure Category	Procurement Method[1] ICB	NCB	Other[2]	N.B.F.	Total Cost
1. Works	6.45 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	6.45 (0.00)
2. Goods	3.62 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	3.62 (0.00)
3. Services Consultancies Design/Supervision Technical Assistance, training, studies	5.37 (0.00)	1.90 (0.00)	0.00 (0.00)	0.00 (0.00)	7.27 (0.00)
4. Miscellaneous Refinancing PPF	0.00 (0.00)	1.37 (0.00)	0.00 (0.00)	0.00 (0.00)	1.37 (0.00)
5. Miscellaneous Operating Costs	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)
6. Miscellaneous	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)
Total	15.44 (0.00)	3.27 (0.00)	0.00 (0.00)	0.00 (0.00)	18.71 (0.00)

NBF Financed by Government: Construction; Rehabilitation; Operating Costs;
Other: Vehicles and equipment by international or local Shopping

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

Expenditure Category	Procurement Method[1] ICB	NCB	Other[2]	N.B.F.	Total Cost

1. Works	4.17 (0.00)	0.51 (0.00)	0.20 (0.00)	0.00 (0.00)	4.88 (0.00)
2. Goods	4.27 (0.00)	2.91 (0.00)	0.00 (0.00)	0.00 (0.00)	7.18 (0.00)
3. Services **Consultancies** **Design/Supervision** **Technical Assistance, training, studies**	4.91 (0.00)	0.00 (0.00)	2.23 (0.00)	0.00 (0.00)	7.14 (0.00)
4. Miscellaneous **Refinancing PPF**	0.00 (0.00)	0.00 (0.00)	0.22 (0.00)	0.00 (0.00)	0.22 (0.00)
5. Miscellaneous **Operating Costs**	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)
6. Miscellaneous	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)
Total	13.35 (0.00)	3.42 (0.00)	2.65 (0.00)	0.00 (0.00)	19.42 (0.00)

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

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

Project Financing by Component (in US$ million equivalent)

	Appraisal Estimate			Actual/Latest Estimate			Percentage of Appraisal		
	Bank	Govt.	CoF.	Bank	Govt.	CoF.	Bank	Govt.	CoF.
UNFPA	0.52			0.90			173.1	0.0	0.0
HIV/AIDS	1.24			0.74	0.69		59.7	0.0	0.0
Directorate of Plan	4.51	0.35		4.63	1.03		102.7	294.3	0.0
PORTO AMBOIM	2.91	0.50		1.85	0.08		63.6	16.0	0.0
LUBANGO	8.73	0.80		7.11	0.33		81.4	41.2	0.0
10 Health Posts	0.75	0.04		0.73	0.06		97.3	150.0	0.0
Ess. Medicine Prog.				3.30	0.06		0.0	0.0	0.0

Source: Project Unit in Luanda, Angola

Annex 3: Economic Costs and Benefits

Not Applicable.

Annex 4. Bank Inputs

(a) Missions:

Stage of Project Cycle	No. of Persons and Specialty (e.g. 2 Economists, 1 FMS, etc.)		Performance Rating	
Month/Year	Count	Specialty	Implementation Progress	Development Objective
Identification/Preparation				
Appraisal/Negotiation April/May 1992	*4*	- Pierre Mersier, Task Manager - Eugene Boostrom, Health Specialist - Christian Rey, Implementation Specialist - Eileen Murray, Financial Analyst		
Supervision				
From September 18 to September 23, 1993	*2*	- Pierre Mersier, Task Manager - Rodolfo Sanjurjo, Consultant, Architect	S	S
From January 28 to February 11, 1995	*3*	- Peter Ngomba, Task Manager - Eugene Boostrom, Public Health Specialist - Rodolfo Sanjurjo, Consultant, Architect	S	S
From July 3 to July 12, 1995	*4*	- Montserrat Meiro-Lorenzo, Task Manager - Eugene Boostrom, Public Health Specialist - Rodolfo Sanjurjo, Consultant, Architect - Julie McLaughlin, Public Health Specialist	S	S

From January 29 to February 16, 1996	*6*	Evangeline Javier, Task Manager - Hilbrand Haak, Consultant, Essential Drugs Specialist - Rodolfo Sanjurjo, Consultant, Architect - Montserrat Meiro-Lorenzo, Public Health Specialist - Roger Grawe, Human Resource Division Chief - Helena Grandao Ramos, Resident Mission	U	U
From June 3 to June 24, 1996	*4*	Evangeline Javier, Task Manager - Ernest Massiah, Public Health Specialist - Rodolfo Sanjurjo, Consultant, Architect - Montserrat Meiro-Lorenzo, Public Health Specialist	S	U
From October 23 to November 6, 1996	*2*	Evangeline Javier, Task Manager - Montserrat Meiro-Lorenzo, Public Health Specialist	S	U
From June 11 to June 26, 1997	*4*	Evangeline Javier, Task Manager - Ernest Massiah, Public Health; AIDS/STD Specialist - Hilbrand Haak, Consultant, Essential Drugs Specialist - Montserrat Meiro-Lorenzo, Public Health/ Specialist	S	U
From November 18 to November 27, 1997	*4*	- Montserrat Meiro-Lorenzo, Task Manager - Hilbrand Haak, Consultant, Essential Drugs Specialist - Dr. Teruel, Consultant, Public Health Specialist - Geise Santos, Project Assistant	U	U
From January 21 to January 31, 1998	*1*	- Peter Smoor, Consultant, Architect	U	U
From March 16 to April 2, 1998	*3*	- Montserrat Meiro-Lorenzo, Task Manager - Peter Smoor, Consultant, Architect - Surendra Agarwal, Operations Adviser	U	U
From July 3 to July 22, 1998	*2*	- Montserrat Meiro-Lorenzo, Task Manager - Carlos Sousa,	U	U
From August 12 to August 21, 1998	*1*	- Peter Smoor, Consultant, Architect	S	

From November 25 to December 4, 1998 From December 5 to December 14, 1998	*1*	- Peter Smoor, Consultant, Architect	S	
From May 14 to May 28, 1999	*2*	- Jean Hache, Consultant, Institutional Development Specialist - Wim Alberts, Social Protection Specialist	S	U
From September 19 to September 27, 1999	*2*	- Montserrat Meiro-Lorenzo, Task Manager - Wim Alberts, Social Protection Specialist	S	U
From December 6 to December 20, 1999	*2*	- Montserrat Meiro-Lorenzo, Task Manager - Wim Alberts, Social Protection Specialist	S	U
ICR From January 22 to January 29, 2000	*3*	Joseph Bredie, Team Leader - Jerome Chevallier, Consultant - Anne Anglio, Team Assistant		

(b) Staff:

Stage of Project Cycle	Actual/Latest Estimate	
	No. Staff weeks	US$ (.000)
Identification/Preparation	41.2	97.6
Appraisal/Negotiation	20.6	51.6
Supervision	163.2	314.9
ICR	*	*
Total	225.0	464.1

(*): Supervision and ICR combined.

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

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

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

Annex 6. Ratings of Bank and Borrower Performance

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

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

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

Annex 7. List of Supporting Documents

Staff Appraisal Report No. 10750-ANG, Dated October 23, 1992

Development Credit Agreement, Credit No. 2490-ANG, Dated June 17, 1993

Aide-Memoires and Project Status Reports from September 1993 to December 1999

Annex 8

REPUBLIC OF ANGOLA

MINISTRY OF HEALTH

HEALTH SECTOR PROJECT: IMPLEMENTATION COMPLETION REPORT

JANUARY 2000

Annex 8

INTRODUCTION

This document constitutes the Implementation Completion Report on the Health Sector Project in Angola financed by IDA Credit No. 2490 for US$19.9 million and by Government of Angola funding of US$2.3 million. The total cost of the project was estimated at US$22.2 million, an amount that remained unchanged up to the date the project was closed. Closing was initially planned for December 31, 1998, but the actual date was December 31 1999, at which time all activities called for under the project were considered to have been completed and the Credit proceeds fully disbursed. This Report presents an objective appraisal of the successes of the project as well as the factors hindering its implementation, and draws lessons for future projects between the World Bank and the Ministry of Health of Angola.

1. PROJECT BACKGROUND AND DESCRIPTION

The project concept was developed at a time when a period of peace and stability was thought to be beginning for Angola. In that context, and utilizing a series of health sector studies financed by the African Development Bank between 1989 and 1991, the Ministry of Health (MOH) developed plans for a set of integrated activities that were to be part of a Health Sector Development Program. Guidelines were drawn up for enhancing the level of health services by improving MOH operations at the central level and in some of the provinces. Further studies were then undertaken toward development of a Health Sector Project (HSP) that would incorporate the activities already defined as priorities, but which were now to be carried out in conjunction with education activities focused on the broader aim of improving and strengthening social services. Subsequently, when difficulties arose in implementing health and education activities simultaneously, the part of the project that targeted the social sectors and was overseen by the Ministry of Planning, was split off, each of the two separate components then being assigned to the respective supervisory ministry.

As the general situation remained conducive to the implementation of development activities, the World Bank and the GOA moved forward with the two projects. In the process, they attempted to introduce some of the new precepts and ideas being advocated by the World Bank on new approaches to financing, particularly the concept of funding reasonable steps to endow borrowing countries with the ability and capacity to ensure the future maintenance of their project investments.

Meanwhile, the expected outlook for peace in the country changed, and project activities were launched in a very different context, with profound changes in the macroeconomic and social setting which worsened steadily over time.

In its final form, the project under review here consisted of the components and objectives now listed below. (As no overall health sector program existed that had been set up to incorporate all projects, whether local or national, the choice of these components and objectives was based on diagnosis of the prevailing situation in the sector, the needs identified in the course of that diagnosis, and the general objectives for the sector pursued through the first Social Sector Project financed by the World Bank.)

1.1. Central government component

This component, developed out by the firm MCDI, consisted of:

Annex 8

1.1.1. Strengthening management and policy-making in the health sector:

The original objective of this subcomponent was to strengthen the capacities of the Health Ministry and improve the functioning of its major departments, through the provision of technical assistance for its Planning Office and Human Resources Department (DNRH). In 1995, at the Ministry's request, this objective was amended, largely because other donors, such as the United States and DfD/WHO, had superimposed other activities: special attention was given to institutional development of the Ministry through the provision of technical assistance for DNRH and DNAGO, and close cooperation was established with HTP and PSP-E.

1.1.2. Support for selected national health programs

Relevant health programs were strengthened through training, equipment purchases, and information, education and communication (IEC) activities. The IEC effort was focused almost exclusively on sensitizing the general public to the problem of AIDS: the National AIDS Program received assistance with its own IEC activities, personnel were trained, coordination among the various partners involved in education activities was improved, a national policy on the sale of condoms was formulated and a distribution network designed, and KAP studies were undertaken in five provinces.

Support for the Family Planning Program translated into support for the development of a population policy and a population control policy. Funds were made available for the purchase and distribution of contraceptives and midwife kits, and technical assistance was provided for preparation of a training curriculum for midwives. The Health Ministry subsequently requested expansion of this subcomponent to cover the purchase of equipment for family planning activities and additional supplies of injectable contraceptives.

During the first phase of the project initiated in 1995, the objectives of the family planning subcomponent were as follows:

- To improve general management of the maternal-child health/family planning program, by strengthening national capacity, at the central and provincial levels, for planning, conducting and monitoring activities in the field of reproductive health in 50 percent of municipalities in 11 selected provinces (Benguela, Bié, Cabinda, Cunene, Huambo, Huila, Kwanza Sul, Luanda, Malange, Namibe and Uige).

- To ensure the availability of qualified health staff in all operating health facilities in 50 percent of selected municipalities, and to strengthen local training capacity.

- To expand the network of centers offering reproductive health and family planning services.

- To strengthen and intensify IEC activities in health facilities and at the community level, in order to encourage changes in people's behavior, particularly among adolescents.

The project also included a Sexually Transmitted Diseases and AIDS Prevention Program in view of their rapidly increasing presence in Angola as a result of: heavy migration of displaced persons, a rising number of blood transfusions, limited information on HIV/AIDS, weak institutional capacity for the diagnosis and treatment of STDs and the diagnosis of HIV. This subcomponent made provision for equipment purchases, local staff training, purchase of

condoms, production of information and education materials. Its principal objective was to increase capacity to provide information, education and communication about AIDS.

1.2. Lubango (Province of Huila) component

1.2.1. Rehabilitation of health posts

The objective of this subcomponent was to improve/rehabilitate, equip and reorganize 10 health posts, in the area of Gambos in Huila. This province was selected because of its heavy population density and the presence of active NGOs that could support the process. Support for all 10 health posts with construction work and nursing personnel training was to be provided by the Spanish NGO.

1.2.2. Construction, upgrading, rehabilitation and equipping of selected facilities in Lubango

The Lubango ETPS [nursing school] was created to replace two older schools for training health technicians and nurses. This subcomponent included construction of a new school, a health center, and an equipment maintenance center attached to the school, plus rehabilitation of two health posts (in Tchioco and in Nambambe).

1.2.3. Rehabilitation of Provincial Health Department premises, and construction of two residences for technical assistance personnel

1.3. Porto Amboim (Province of Kwanza Sul) component

1.3.1. Rehabilitation of the Porto Amboim hospital, two health posts, and a drug warehouse

The objective of rehabilitating the Porto Amboim hospital was to convert it into a second-tier referral hospital, with sufficient trained personnel to provide health care for an area occupied by 120,000 inhabitants. In addition to rehabilitation of the hospital, two health posts were to be rebuilt. The Catholic Church in Kwanza Sul was contracted to manage all rehabilitation, reorganization, management, and personnel training activities at the hospital.

1.4. Essential Medicines component

Amendments to the Credit Agreement in 1996 provided for the supply of drug kits to health posts and centers in the provinces of Kwanza Sul, Huila and Cunene over the period 1997-1999, the objective being to improve health care delivery by increasing the availability of essential medications .

Basic legislation creating a national health system was approved in 1992. On the basis of this law, and in the absence of any national health policy (in the form of implementing regulations to the legislation itself), the Government at that time drew up a program for the sector which, among other things, called for decentralization and deconcentration, integration of services, improved coordination with partners and reinforcement of human resources at all levels; it also stressed the physical rehabilitation of infrastructure destroyed by war.

The objectives of the project were consistent with those of the Government and were focused essentially on strengthening the capacities of the Health Ministry, both at the central level (in financial planning and management, human resource planning and management, support for special programs, and partnership with other agencies) and at the provincial level (in

rehabilitation and construction of infrastructure, personnel training, delivery of services, and supply of essential medicines). At that time, these objectives were relevant, fully realistic, and in line with the health needs of the provinces.

Meanwhile, because of the involvement of other players — the Health Transition Project (HTP) and PSP-E (with U.S. financing) — in this same field of activity (institutional strengthening), an agreement was reached to divide areas of activity at the central level so as to ensure complementarity of efforts. Meanwhile, the civil war broke out again. This, in combination with the prevailing lack of stability in the health sector (a part of which was extensive and rapid turnover of management personnel at both the central and lower levels), meant that the project fell behind schedule and failed to achieve its stated objectives.

2. PROJECT CONCEPT AND COORDINATION

In addition to the components described above, the project included provision for establishment of its own Project Execution Office (GEP). This entity was designed to handle management and administration of the entire project, and was to report to the Health Ministry through the latter's Planning Office. The GEP operated with a staff team decided on by agreement among the parties. It prepared all documentation for both local and international procurement proceedings, monitored all activities making up the various components of the project, administered all project contracts, approved the relevant memos in cases where the amounts involved exceeded approved levels and presented them for signature by the competent Health Ministry officials, administered all payment arrangements, and managed all procurement and purchasing of consumables and capital goods for all components of the project. In addition, it ran residential facilities for technical assistance personnel and managed all office equipment required for project work. Its assets also included three light vehicles (one of which was assigned to the Health Ministry Planning Office), two double-cab 4x4 vehicles (both stolen in Luanda), two motorcycles (one also stolen in Luanda), and a third motorcycle (sold to the courier who used it to carry out his project assignments).

The initial outline and objectives of the project were consistent with needs previously identified by the Government. These needs were confirmed by the project preparation mission of April 11-May 6, 1991, and also in the memorandum of February 18-21, 1991 submitted by a World Bank consultant. As with any project, it is always difficult to foresee all contingencies. At the outset, although certain risks and constraints were identified, it was impossible to foresee a resurgence of the civil war and the impact of this on the country's infrastructure and the organization of its institutions, including the Health Ministry.

Similarly, it must be recognized that the Government had to face unprecedented situations, and as a result was unable to fulfill its obligations in a timely manner. All the same, it never renounced those obligations, despite the economic situation in which the country found itself.

Although in 1991 the Health Ministry possessed a good part of the personnel and organizational capacity needed to carry out all project components, it was hampered by the institutional instability prevailing in the sector and by the fact that many of its management staff had left for the private sector, international agencies and NGOs, thereby weakening its planning and management capacities at the central level and its ability to monitor and supervise the project. These factors were not properly taken into account. The resulting difficulties led to modifications to the project, in particular to the allocation of funds to the various project expenditure categories. The total project budget provided for in the Development Credit Agreement was maintained, but

changes were made in its individual components, particularly because of the difficulties experienced in maintaining infrastructure facilities. The volume of construction called for in project plans was consequently reduced, as were the amounts allocated for equipment and other construction-related items. It was at this point that the Essential Medicines component for health posts and health centers was introduced, as indicated above. The updated financial plan for the project reflected these changes, as can be seen by making the comparison with the financing plans contained in the Staff Appraisal Report or the Development Credit Agreement itself.

Implementation of the Health Sector Project was extremely slow in the initial years, but operating conditions gradually improved towards the end of 1994, although the institutional framework remained unstable.

In 1995, the project was restructured to ensure the subsequent sustainability of the actions launched, and to meet the real needs of the provinces involved. The preparatory stages of the project took full account of the needs and aspirations of the authorities of the provinces where it was to be implemented, essentially Kwanza Sul and Huila. It should be noted, however, that even with the involvement of the provincial authorities at that point not all risks were fully taken into account.

In the case of the Lubango component, the proposed nursing training school was re-designed because of financial limitations. The initial capacity figure of 400 students was reduced to 100, and the original plans in the areas of odontology, laboratories and medical statistics were dropped.

From the outset, it was provided that the Health Sector Project would be closely linked to the Planning Office, the coordinating body for all Health Ministry activities. In accordance with World Bank requirements, a project execution unit had to be created, functionally and hierarchically linked to the Planning Office. However, owing to the rapid turnover among its professional staff, the Office's capacity to monitor and supervise the project was progressively weakened, it became increasingly isolated and cut off from the Ministry proper, to the point that its project coordination responsibilities were finally dropped. While in the case of the Ministry of Education the Bank-financed project had to all intents and purposes been coordinated by the Planning Office, project education staff were actually professionals belonging to the Education Ministry. On the health sector side of the project, however, all professional staff came from organizations other than the Health Ministry, so that on completion of the project they left and went on to seek other jobs elsewhere. The end result was that the training provided for this group produced no benefit at all for the health sector in terms of institutional strengthening.

3. ANALYSIS OF PROJECT EXECUTION AND RESULTS

The lack of health sector experience with the management of projects financed by the World Bank, the institutional instability prevalent at the time, and the fact that the entity responsible for executing the project had evolved into an independent body not integrated into the Health Ministry, made it difficult for the Government to monitor and supervise the project. These same factors, together with the lack of clearly defined strategic development guidelines, also gave rise to operating difficulties in implementing the project. A further factor that impeded execution of the project was lack of familiarity with World Bank rules. Because of the Government's delay in releasing 1997 counterpart funding, the project remained virtually immobilized during the first six months of 1998, for lack of "no objection" clearance for any of its activities. Beginning in the third quarter of 1998, significant progress was made in terms of work and disbursements, and an extension of the project was requested from the World Bank at this time. The extension was

conditioned on payment of the remaining counterpart funds by the Government, and was confirmed during the last week of December 1999. Despite this approval, only some of the "no objection" clearances were obtained by the end of the first quarter of 1999, and this once again led to delays in contract execution, particularly for equipment. With respect to the consulting contract with Indevelop, the delay was due to the need to clarify working arrangements with local counterpart personnel. As far as its infrastructure rehabilitation, equipping, and essential drug components are concerned, the project may be regarded as having been completed. As for the question of institutional relations at the central government level, they continue to reflect the weaknesses noted above, relations with the provinces were always very dynamic.

With respect to the Planning Office and the Department of Budget Administration and Management (DNAGO), project activities had little impact: Designed to strengthen Planning Office capacity in the sphere of planning, the budgeting and programming actions included in the project were successful only in the first year, when they were readily accepted at all levels and were in fact used for 1999. Owing partly to the late start on preparing the budget for the year 2000, and partly to the lack of any prior sensitization or refresher exercises, the proposed program-budget preparation method was not used. At the same time, it must be said that MCDI left a gap by failing to complete health plans and budgets for the coming year. It should also be noted that the initial contract signed with this firm went through a number of changes that altered its initial value. There is similarly a question as to why all the disbursements were made to this firm when the work contracted for was not all completed.

With respect to the National Budget Office, the consultant made several recommendations for reorganizing it, but these were not approved and consequently were not implemented. The major difficulty was in maintaining a dialogue with the Office.

With respect to DNRH, there was a high level of activity and much was accomplished—for example, formulation of the Strategic Plan for Human Resource Development. A local team has been identified and is now preparing basic documents for curriculum development and management standards for the Lubango nursing school. Some of this documentation has already been completed and is awaiting review by external consultants. The same team has conducted an investigation into the training needs of technical personnel.

The international consulting firm retained to advise the nursing school is working closely with local consultants to revise the institution's curriculum, draw up its organizational and administrative procedures, and develop training plans for nurses in the Southern Region.

There is clearly a need to complete this subcomponent in order to ensure training for new nurses and provide certification for a group already working as nurses. An even more important function of the nursing school in the short term will be to re-train 1800 nurses, now working in various areas of the profession in the provinces of Huila, Namibe, Cunene and Kwando Kubango. Study grants will be required in these cases, and the consulting contract with Indevelop will have to be extended to June 30, 2000. In support of this activity, the US$600,000 surplus resulting from exchange-rate variations could be used, if permission is granted.

DNRH established terms of reference covering national and international consultants alike. In the case of the former, no training was programmed to round out their qualifications. The national consulting firm has been working with instruments that were prepared internally and

that apparently had the blessing of the World Bank consultants. Yet the latter were never clear with respect to the required models. In some instances, models were presented that had been successful in some other African countries, and in other cases the models were from the World Bank.

Several contracts were signed but never carried out. Nor was it clear when or how the domestic consultants were to be paid, and no percentages were established to be paid upon signature of contracts. At times money was available, at other times there was none. This uncertainty about whether an "incentive" [payment] would be received for work duly performed had a negative impact on the expected results.

DNRH profited more from the consulting services of MCDI, since the member of the firm assigned to work with it managed to provide guidelines that DNRH put to use. The contract with MCDI also included provision for the introduction of a computer program that was to serve all areas of the Health Ministry, but in particular DNRH, and which would make it possible to track all resources existing in the sector (in all health service delivery categories, locations, and provinces). Unfortunately, the consultant did not complete this task.

With respect to support for national programs, excluding the Maternal-Child Health/Family Planning and AIDS programs, technical assistance was limited to conducting a survey of the organizational situation and existing difficulties, without submission of any proposals or concrete recommendations for improvement. This support left little mark and had no impact on improving the organization of priority national programs.

With respect to the Maternal-Child Health/Family Planning Program, implementation began only in early 1995, since there had been delays in finalizing and approving documents and recruiting a technical adviser. A needs assessment and analysis (in terms of health facilities to be rehabilitated, equipment lacking, and personnel training required) was performed in 11 provinces between June and September of that year. With the support of an adviser from UNFPA, the management and logistics information system was revised and supervisory guidelines (including a user manual) were prepared, the curriculum for operational management training for the program was amended, and a team of trainers was assembled. Supervision visits were made to the 11 provinces, and two training courses were held for 40 nurses in two provinces (Bié and Benguela)

Again with respect to the Maternal-Child Health/Family Planning Program, KAP studies (knowledge, attitudes and practices) were conducted among adolescents and young people. The findings were widely disseminated, and provided the foundation for a workshop on adolescent issues in 1997. The UNFPA Regional Adviser came to Angola to help the project and Maternal-Child Health Program teams train a group of instructors to train Youth Counselors and write a training curriculum and trainer's manual. Premises were rehabilitated to serve as a meeting place for the Youth Counselors themselves and as a location for youth-related activities. Despite the fact that the programmed activities were actually implemented, it is now clear that the objectives set, although they were consistent with the country's needs, were too ambitious given the prevailing constraints. The principal constraints were: lack of motivation among domestic technical staff, because of salary-related issues; poor coordination among the various departments of DNRH in relation to management, organization and personnel training in the field of reproductive health; and supplies of contraceptives that were inadequate to meet needs at the national level, given the expansion of Reproductive Health Program services.

With respect to the HIV/AIDS Program, the Health Sector Project resulted in expanded educational activities, an evaluation of public knowledge of AIDS, and an epidemiological assessment of the disease. Training activities laid the foundations for the sustainability of ongoing efforts in the areas of education, epidemiological surveillance, diagnosis and treatment of STDs, and counseling for people who test HIV-positive or are suffering from AIDS. The experience gained as a result of the project has recently resulted in formulation of the National Strategic Plan.

With respect to the Essential Medicines Program, the World Bank credit came at a time when the outlook for peace was good, and the program was consequently being expanded. It must be said that the World Bank's contribution was fully in keeping with the overall program strategy and that full use was made of its support. The constraints hindering expansion of the program were many, in particular the lack of qualified senior personnel both at the central level and in the provinces, which meant that the growth could only be achieved in phases. Thanks to the World Bank's financial support, the provinces of Huila, Kwanza Sul and Cunene received essential drug supplies and 11 seminars were held, with 330 technicians participating. This support also allowed program staff to benefit from an interesting experiment with the purchase of essential drug kits and the organization of international bidding. As a result of this experience, the program succeeded in organizing a bidding competition financed by the Swedish International Development Cooperation Agency, a process that saved close to 50 percent of the budget. The price obtained by this method was much lower than that paid for purchases through UNICEF.

Overall, it has to be recognized that there were difficulties with the execution of this component. Some aspects of the World Bank Invitation to Bid formula are not well suited to the purchase of essential medicines in kits. The mechanisms for ensuring payment to suppliers through the World Bank were slow and this dragged out the procurement process and caused excessive delays in ensuring supplies of these goods.

Another adverse factor was the arrival of a large quantity of drugs in a very short period of time, which made it difficult to handle them properly, since it was virtually impossible to program their reception in an orderly manner. It should be noted that the arrival of drugs in a very short space of time was quite inconsistent with the purpose of the project, which had already been announced at that point. It should also be noted that the lack of knowledge and information on the total budget allocated or available for the Essential Medicines Program made it difficult to match funding management with planned activities. The resurgence of the war affected supply plans by making most municipalities in the affected provinces (Kwanza Sul, Huila and Cunene) inaccessible. Given the expiry dates on the medications and their arrival in massive quantities within a very short time, the program was hard pressed to avoid having a large proportion of the products expire before they could be distributed.

Despite the matter of delays, Essential Medicines Program personnel were able to draw up specification procedures acceptable to the World Bank. They believe that in the process they gained considerable experience in international procurement. In addition, they developed a well-designed action plan for other program activities separate from this component of the Health Sector Project.

With respect to the Kwanza Sul component, the project work planned has been completed, including not only equipment delivery and installation but also training of personnel, even though the training program had to be cut back for lack of financing.

The municipal hospital in Porto Amboim is already in operation. The civil construction work was hampered by significant delays, primarily because of late award of contracts, since the Directorate of Catholic Missions in Kwanza Sul insisted that the work be performed by a certain company which it indicated, but when that company submitted its prices they not only exceeded available funding but were higher than normal market rates. After international bids were invited, it was found that the funds available for this work were less than the price of the best offer. Since it was impossible to obtain prices comparable to what had been budgeted, it was decided to close the bidding process. Subsequently, the World Bank decided that the work should be performed by the architectural firm *Novos Projetos*, with a significantly reduced civil construction component. Upon presentation and approval of the new designs, it was found that the Bank had reduced the budget for construction in order to make more funds available for the purchase of essential drug kits. This situation meant that new negotiations had to be undertaken, as the Bank had decided that it would have no further involvement in Porto Amboim. At the insistence of sector officials, the Bank did agree to such further, small-scale activities in Porto Amboim as construction of a health post in Pinda and minor repairs to the municipal hospital. Meanwhile, since the Government had released the counterpart funds pending, it was decided to construct a health post at Km 11 and to undertake further work to upgrade the municipal hospital.

It should be also noted that the cost of the civil construction work in question was calculated by World Bank consultants in 1991 and 1992 during preparation of the Staff Appraisal Report, that the project was approved in December 1993 and that the first invitations to bid on the civil construction work went out at the end of 1995. This factor also influenced the bidding on project civil construction works in Lubango province. This component was initially managed by the Catholic Church, which later withdrew following a misunderstanding, as reported by the Provincial Health Department of Kwanza Sul. Comments by the local health authorities indicate that there was no effective participation at the local level in carrying out the project, that local project-related activities were hampered by poor communication, and that in fact the project was run from the province of Luanda.

Overall, project objectives in this province were achieved, although at times there were concerns about finding or training technicians capable of administering the institutions.

According to officials of the Catholic Church in the province, they were unable to carry out further activities because of coordination problems with the project— in particular, because management of this component remained centralized outside the province. In other words, it appears that the responsibilities of the parties were not clearly understood and interpreted, and that this lack of clarity had an adverse effect on the activities in question.

With respect to the Lubango component, apart from the matters related to the nursing school which were discussed above, it should be noted that the construction and outfitting of the school has been completed, as has assembly of the necessary equipment and supply of books for the library. Initial meetings have already been held to discuss and coordinate actual inauguration of the school.

Work on the Pediatric Hospital and the health posts at Tchioco and Nambambe has also been completed, although defects in construction of the hospital will have to be corrected by the contractor. The corresponding claims have been submitted by the Lubango team.

On the history of these works, it should be noted that when designs were presented and approved, the World Bank staff responsible for the project pointed to what had happened in the Porto Amboim case, where there were no funds in the relevant project expenditure categories to

support the construction planned. They questioned whether the Ministry would be able to maintain a unit of the kind envisaged, under current conditions, and also whether the numbers of nursing graduates planned for were in fact needed. After lengthy discussion, it was agreed that the capacity of the school should be reduced, from 400 to 100 students, and that the boarding school and refectory would not be built. This meant that new designs and specifications had to be drawn up before the procurement process could begin. As happened with the Kwanza Sul component, the initial budget earmarked for civil construction works and equipment had been reduced in order to free up funds for the purchase of essential medicines. A contract for the reduced civil works program was awarded to a South African firm, DRP, for the modules whose cost exceeded the amounts budgeted. During execution of the contract, problems arose that finally resulted in considerable delays in completion of the works: there were difficulties over the entry of construction materials into the country, and specialized workers employed by the contractor were never able to obtain work visas. As these particular problems, and the delays that ensued, were imputable to the Government of Angola, compensation totaling US$180,000 had to be paid to the contractor.

Deliver has been taken of all these buildings, despite defects that will have to be repaired by the contractor before the end of the guarantee period. A number of vehicles were purchased for this component: three 4x4s, a light truck, a 4x4 ambulance, and two minibuses.

In addition to various types of training, this component also included technical assistance for the school with curriculum preparation, refresher training, and school administration. The delay in completing the building program meant that the technical assistance contract could not be put up for bid until late 1998.

With regard to the 10 health posts, the inevitable disruptions in public order caused by the war resulted in the Gambos zone being placed off-limits. As a consequence, the Spanish NGO left the country, to be replaced by a local Angolan organization, ADRA. The Matala zone was then selected instead of Gambos, but the fallout even there from the resumption of hostilities meant that ADRA succeeded in constructing only seven health posts instead of 10. Completion of these facilities was further delayed, mainly by problems that ADRA experienced with its contractor; construction had to be completed under force account arrangements, with procurement of certain materials from DRP.

World Bank disbursement rules were conditional upon payment of counterpart funds, and this was a determining factor in the pace of progress with the project.

Launch of the Health Sector Project coincided with the renewal of hostilities, post-Lusaka, and a sharp deterioration in the country's economic and social situation. At the same time, the lack of stability within the Health Ministry led to virtually complete paralysis of programmed activities in the sector, with the Ministry reduced to managing events on a day-to-day basis. This whole situation contrasted starkly with the assumptions under which the Project Agreement had been signed. It is only now, when the project has been closed, that the political situation is beginning to stabilize and macroeconomic indicators are showing improvement. In analyzing the history of the project, we note that it owes its success largely to the technical qualifications, perseverance, and dedication of a particular individual within the Health Ministry, who accepted it as a personal challenge to ensure that the undertaking accomplished its objectives. However, this leaves the project subject to risk, since the personnel situation within the Ministry is very unstable (rapid turnover of managers, failure to fill vacancies, etc.).

Annex 8

4. PERFORMANCE OF THE PRINCIPAL STAKEHOLDERS

4.1 The World Bank, as a responsible financial institution, had the role of trying to get the Government to honor its project commitments, mainly by refusing to give "no objection" clearances until the Government had released counterpart funds due. Even though the Bank showed some flexibility on this point, its withholding of these clearances held up execution of both civil works and consulting contracts (Indevelop). One criticism, if not of the Bank then of the consultants, is that they never provided for changes in the country's political and economic circumstances, changes that led to inflation in civil construction prices and meant that initial estimates became completely unrealistic. As a result, the project had to be scaled back drastically in terms of volume of construction work. In addition, at the project design stage, the Bank did not assure itself of the future sustainability of some project components, and subsequently set conditions on certain activities. Other difficulties, stemming from the cumbersome nature of the import process (applications for import licenses and other bureaucratic requirements), delayed the arrival of necessary equipment. Problems arose also with disbursements, which were not processed with the expected regularity during the course of the project and so bunched up in the last year of the implementation period. Poor disbursement volume initially affected project performance, making it appear weak. Disbursement requests, for both the Special Account and suppliers, were often the object of petitions from the Bank for clarification, in most cases without justification. Where clarifications did actually lead to adjustments by the Bank's Disbursement Office, it failed to inform the GEP what corrections had been made. The quite rigid nature of the Bank's rules at times disrupted the normal course of this project, particularly in the case of bidding procedures, where long periods tended to elapse before bidders lodged proposals. Still on the subject of compliance with Bank rules, it may be noted that the successive changes of Task Manager meant that it often took a long time to get responses to "no-objection" requests, which inevitably led to schedule overruns. Nevertheless, while we may consider that the Bank's own rules created many delays and difficulties for the project, we must recognize that compliance with them ensured that the project was in a situation of full compliance.

No clear or definite guidelines were available on how to respond to Bank demands. At the same time, whenever it was necessary to make changes to the project to keep it in line with current circumstances, the Bank was always ready to introduce appropriate amendments.

4.2 Performance by the Government includes performance by all the national players involved, including the Ministry of Health and the provincial authorities. They showed little inclination to keep abreast of the project on a regular basis, or take any effective part in the basic decisions needed periodically if problems were to be resolved. This attitude perhaps reflected less than full prior awareness of the nature of the whole undertaking, and the lack of any definition of their duties. The provincial authorities viewed the project as something imposed on them that would only be theirs when it was completed, and took no interest in the process of its execution. Within the Health Ministry, the high staff turnover rate that characterized the unit responsible for the project meant finally that the operation was less effectively monitored. If this unit had regarded the project as fundamental for the sector, the GEP would not have been left to become so independent. As far as institutional strengthening goals were concerned, particularly for the Planning Office and DNRH, while the consultants themselves failed (as noted previously) to complete a number of important activities, other recommendations they made were not implemented, especially those focused on the Planning Office and DNAGO.

The Government, as a result of political and economic developments that could not have been foreseen, was late in complying with some of its obligations. In the first place, there was a

long delay in providing the GEP with office premises. Later, there was a delay of about one year (1997-1998) in depositing counterpart funds, which inevitably held up implementation of the project. In addition, when an extension of the project was requested for a further year, to December 31,1999, the Bank withheld funds because the Government had not paid the remaining counterpart funds due . The Government made these funds available only on December 28, 1999, no doubt for the reasons noted above.

Furthermore, the organizational changes in the Health Ministry after 1994, and the accompanying realignment of responsibilities for the sector, meant that there was no longer a coherent line of command, since each newly created department in the Ministry behaved as if unacquainted with the major operations its other departments currently had in hand.

The creation of a project management unit that would actually work in conjunction with the Planning Office could only be of advantage to the sector if it were able to complete its activities on schedule, and if these activities were made up of various components (e.g. infrastructure building, cooperation with other international partners, procurement). Yet the capacities of the Ministry, and especially of the Planning Office, were greatly limited by the volume of its regular work and by existing institutional procedures. What was missing in practice, or was at least not evident, was any definition of operational relationships that would facilitate support and monitoring for the project.

During the life of the project, the Government was supposed to disburse counterpart funds amounting to US$2.3 million, divided into tranches of US$200,000 per quarter. It managed to do so in full, despite the situation in which the country found itself.

4.3 Relations with UNFPA during the life of the project can be described as excellent. In June 1995, UNFPA was contracted to support the development of a population policy and the design of a population control program. Activities were conducted without any major difficulties, including purchase and distribution of contraceptives and midwife kits, and technical assistance with the development of midwife training courses and other related curriculums. The budget earmarked for this segment of the project was used in full, although there was a failure to submit proper justification for some disbursements.

4.4 The project joined forces with WHO to provide technical assistance with the National AIDS Program and to purchase audiovisual equipment and condoms for Angola. The major constraints affecting these technical assistance arrangements were: the program was for a long time without a director; no premises were available where the consultant could work; the personal relationship between the former WHO representative and program staff was poor enough to pose a serious obstacle to the success of the operation; WHO financial reports did not follow established rules; and the Ministry of Health had serious reservations about the support being provided by the consultant, because of his frequent absences, even after he was provided with proper working space. Since WHO did not have the role of technical adviser to the program, there was little interaction between the two sides. This limited the effectiveness of the program, as did the fact that the applicable terms of reference were unclear and ambiguous.

4.5 ADRA was hired to improve health care delivery in Matala. Although this NGO had experience in the preparation and implementation of projects and had personnel under contract, it had no experience in health care projects. This meant that some time had to be spent in arranging for the right kinds of personnel training. World Bank financial procedures also caused some problems for ADRA, although they could have been overcome with proper supervision. The contracting firm that built the seven health posts ADRA had commissioned was late in delivering

them, and it had problems in submitting the statements of account needed before its working funds could be replenished.

4.6 The Catholic Church, which had had some previous experience in managing hospitals and health projects, was thought to be an ideal partner to undertake the rehabilitation work in Porto Amboim and to design a management structure. For a long time, the Church would agree to provide only a small degree of management support. Consultants were hired, but they did not work out well. There were in fact many problems between DMCKS (Directorate of Catholic Missions for Kwanza Sul) and the GEP. These all arose from the way in which the funds earmarked for activities within the province were managed. DMCKS insisted that the entire sum be placed in an account that it would manage. Since the GEP was not prepared to allow the entire budget to be managed directly by the Church, even after an account was opened in the name of DMCKS, the GEP had to take responsibility for delays in the work performed by the DMCKS team. Another field where this stakeholder was not very effective was in selecting the consultants who were to take over the general management and day-to-day running of the hospital, administration of the essential medicines program, and (a primary objective) the training of local personnel. Of the personnel provided by the Church, only the nurses met the terms of reference; the others did not fulfill their obligations, and in the end the GEP asked for their removal. Even the replacement team did not succeed in complying with the terms of reference by the time the program period ended. DMCKS finally submitted a request that it no longer be considered manager of the program after December 31, 1998, although the consultants it had appointed remained to the end of the contract, despite their shortcomings.

4.7 Consulting services and technical assistance

Various activities were carried out by external consultants, as stipulated in the initial design of the project. The majority of these firms complied with their terms of reference. The exception was MCDI, which, as noted earlier, failed to complete its work, despite the sum added to the original contract price. In the case of the consulting services for architectural design and works supervision, Africon exceeded the contract price in every case by a wide margin. These overruns were occasioned by the many changes made to the initial concept, which necessitated very extensive adjustment of the original designs and specifications. Africon was the consultant on the pediatrics hospital in Lubango, a building that was handed over with defects which Africon failed to insist be corrected, and which have still not been rectified. The contract with the procurement consultant was also led to some cost overrun, because of equipment location changes and the need for a new bill of quantities following cutbacks in both works and equipment. In the human resources arena, compliance with the terms of reference by one of the Indevelop consultants was unsatisfactory. The consulting services provided by HLB (annual audits of project accounting, financial, and management systems) were generally satisfactory. While the computerized accounting system this firm introduced was effective, the same could not be said of the management system, which was not adjusted to reflect the new realities of the project; only the computerized accounting program was adequately adjusted in this regard.

The consulting services provided for under the contract awarded to MCDI for technical assistance with institutional strengthening did not have the expected success. For one thing, Planning Office managers lacked the required experience in planning and programming. The discrepancies between the methods used in preparing the general government budget and those used in drawing up management-by-objectives programs meant that much of this work was wasted. However, the experience was not without value. On the human resources front, perhaps because MCDI was staffed by well-qualified professionals, work was completed that is now part of the Strategic Plan for Human Resources Development.

4.8 As noted above, the pace of disbursements was nearly always dependent on payment of counterpart funds by the Government. This was the principal reason for the World Bank's delay in granting its "no objection" clearances, but at times its own procedures seemed to be impeding the flow of activities.

5. CONCLUSIONS

Execution of the Health Sector Project was affected by problems surrounding coordination within the sector, participation at the local level, prompt performance of obligations by the parties involved, insufficient financial cover for activities initially included in project plans and consequent reductions in the scope of some project components, and institutional instability in the sector.

As noted above, is very difficult to assess all the risks and constraints that a project may face. Yet it is essential to make an effort to identify potential risks and to evaluate their implications for project objectives.

The experience acquired through this project suggests that there is a need to update project objectives whenever the prevailing situation or general context has changed. When dealing with a context that is far from stable, all objectives in view should be backed by possible alternatives identified in conjunction with the Government; otherwise, paralysis and improvisation are inevitable. If studies had been undertaken to re-appraise the financial basis of the project before actual launching of any activities, it would certainly have become clear that costs had been underestimated, and steps could have been taken (in particular, by the consultants to the World Bank) to adjust plans accordingly, as was done in the case of the building and equipment programs at Lubango and Porto Amboim. Such an exercise would have precluded the diversion of funds from the purposes for which they were originally allocated.

Along the same lines, there is a need to assess whether the beneficiary of a project, has the capacity to carry out all the activities it comprises, or only some of them. In the latter case, it has to be decided which capacities must be recruited outside the beneficiary organization, in this instance the Ministry of Health, or the country, as the case may be, so that the best-trained team possible can be assembled.

Another factor that needs to be stressed is the lack of effective participation at the local level. Despite the initial meetings held with stakeholders, it was found as the project unfolded that contact with the local authorities had not been extensive enough to make them feel involved in the project as their own. Instead, they felt it had been imposed on them by some entity external to the Ministry, or even to the country. Attempts were made to overcome this situation later by holding meetings whenever possible during visits to the provinces. Yet there was almost no effort at sensitization, or if there was it was ineffective. Since the role of each party involved was not sufficiently understood, some stakeholders insisted, for instance, on complete autonomy in managing funds. The local level in fact had no say in defining or executing the project. Because that level was not sufficiently involved in implementing the project, it felt no commitment to it, and so whenever problems or difficulties arose the local level was little disposed to cooperate, and the GEP was forced to find solutions on its own.

The project showed that, where work was to be done in conjunction with other partners and institutions outside the health sector, rules and performance standards should be defined carefully. Potential partners needed to be very clear about the type of cooperation expected from

them. One of the greatest difficulties was to comply with the rules governing Bank-financed projects, especially in matters of payment and organization of competitive bidding, which were regarded as the sources of most delays in project implementation. In the future, it will be indispensable to hold workshops to explain World Bank standards and other requirements for the projects it is financing. Meetings or training sessions of this kind would benefit all parties involved in the process.

As noted above, this project made use of United Nations agencies to implement some of its components. In addition to what has already been said, it needs to be made clear that among the difficulties experienced with these agencies the greatest was their reluctance to comply with World Bank standards, a comment that also applies to the NGO involved. It should be noted, however, that the Essential Medicines program never came into conflict with World Bank rules, which were strictly observed. (In the case of certain other activities, it proved possible to negotiated for some relaxation of Bank rules.) Even on the financial front, the Essential Medicines program had complied with all requirements by the time it was completed.

As for the Project Execution Office (GEP), it was seen as something positioned outside the Health Ministry not only physically but also from the moral, organizational, and even functional and institutional viewpoints. There was no attempt to integrate its activities with those of the Ministry. On the contrary, it stood aloof and independent at all levels. There were no regular exchanges of information, and no routine meetings to monitor and update knowledge affecting basic project issues.

The project also drew attention to the fact that no model plans for public works construction projects existed. In the designs developed for this project, the Health Ministry possesses material that will be useful in standardizing construction of future health posts and health centers. In this arena, the Ministry has had no sustained contacts with the construction sector, nor have any guidelines ever been formulated to govern the possible role of private sector building contractors in government construction activities.

The great lesson to be learned in the process of establishing project objectives is that when they are being formulated allowance has to be made not only for various national social and political development scenarios but also for the limiting factors likely to accompany each of these scenarios. All parties involved in executing the project, whether directly or indirectly, must be flexible enough to recognize that its scale or scope may need to be altered, and that its component parts may need to be adapted to changing circumstances.

Annex 9

Angola - Health Project
(IDA Credit No.24900-ANG)

Aide-Memoire
Implementation Completion Report Mission
January 22-29, 2000

World Bank Mission Members
Joseph Bredie (Team Leader); Jerome Chevallier (Consultant); Anne Anglio (Team Assistant)

A World Bank mission visited Angola from January 22 to January 29, 2000, to prepare the Implementation Completion Report (ICR) for the Health Project. The credit was approved in May 1993, became effective in December 1993, and was closed on December 31, 1999, one year after the initial closing date. The ICR exercise provides an opportunity for the Government and the Bank to assess the results achieved and their sustainability, review the main factors which affected project implementation, and draw the lessons from the experience.

The mission met with key staff in the Ministry of Health and in the organizations associated with project implementation. The mission also visited health facilities in the Porto Amboim area. The team members would like to thank all those who gave generously of their time and provided access to relevant information for this exercise.

Implementation experience. The project was approved after hostilities had resumed in Angola, following a brief peace episode. Public expenditure rose to unsustainable level. and the macroeconomic situation deteriorated steadily during the project implementation period. Inflation peaked at over 10,000 percent in 1996, which reduced the buying power of salaries, particularly in the civil service.

Project implementation started at a low pace. By 1995-96, it became clear that savings could be made as a result of adjusting the capacity of the Lubango nursing school to regional requirements and lowering unjustified high standards initially set for the Porto Amboim hospital. The project was restructured in September 1996, and these savings were used to finance the supply and distribution of essential medicines in the three provinces of Huila, Cunene and Kwanza Sul. By end-1999, most project facilities had been completed.

Achievements and sustainable outcomes. The project's objectives were to strengthen the capacity of the Ministry of Health to formulate policies and manage the sector, and to improve health care in selected areas of the country. The first objective was not achieved. The capacity of the Ministry of Health in policy formulation and sector management remains weak. The Ministry has little influence on sector allocations, which have remained highly inadequate during project implementation.

The project has achieved its physical objectives as far as the rehabilitation and construction of health facilities is concerned. Most of these facilities are operating. The essential medicine component, introduced when the project was restructured in 1996, has

been highly successful in ensuring a regular supply of drugs to health centers and posts. On the other hand, the supply of medicines to the two hospitals rehabilitated under the project is almost non existent. Similarly, allocations for operating and maintenance costs of the health facilities built or rehabilitated under the project are negligible, raising serious doubts as to the sustainability of the project results.

The results of the AIDS control and family planning programs implemented by WHO and UNFPA are limited. Public awareness on AIDS and population issues has been raised, but little has been done to ensure the availability and operation of critical equipment and supplies. For lack of donor funding, activities supported by the project are likely to be severely curtailed.

More importantly, the health conditions in Angola, and particularly in the provinces concerned with the project, have not improved during project implementation. They are extremely poor by any standard, and not likely to improve as long as military expenditures continue to crowd out essential development expenditures.

Lessons Learned. Additional preparatory work was needed to establish and reach agreement with all parties concerned on adequate norms and standards for construction and equipment of project facilities.

The project was too complex in view of the limited experience in the sector and the country with Bank operations.

It is extremely difficult to achieve sustainable development results in a country where macroeconomic management is far from adequate, and military expenditures crowd out other expenditures.

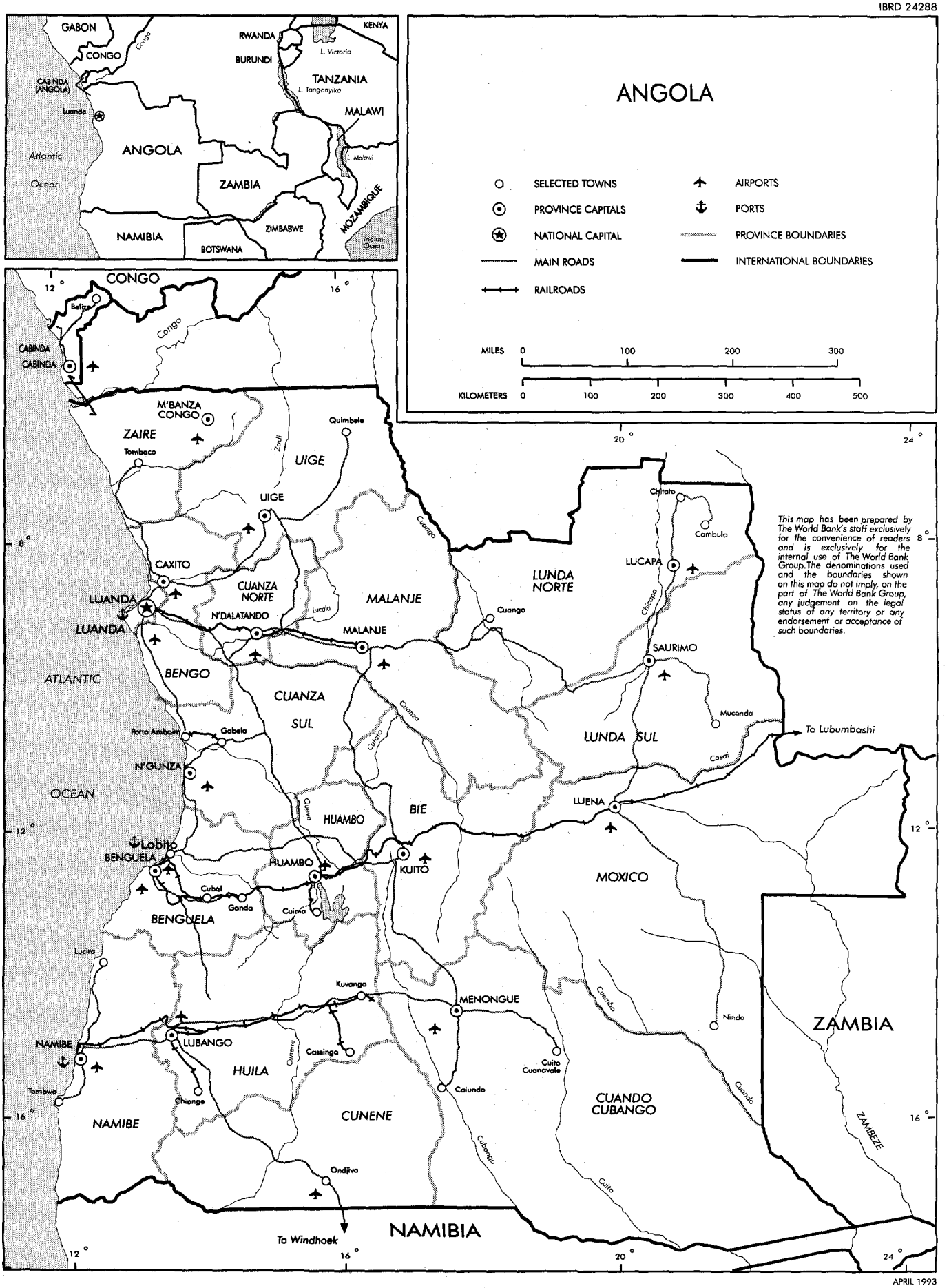
Highly motivated teams can make a difference, even when conditions are inimical to development. The positive results of the essential medicine program are encouraging. Continued funding for this program by the Government in coming years is critical for avoiding a deterioration in the health conditions in the country.

Next Steps. On the basis of the information gathered during the mission, as well as a study of World Bank documents and supervision reports, the Bank team will prepare a draft ICR, which will be submitted to the Government for comments by the middle of February 2000. The Government's own contribution to the ICR has been prepared and submitted to the Bank team. The final ICR will be submitted to the Board of the Bank before the Bank end of March 2000.

Luanda, January 28, 2000

MAP SECTION

IBRD 24288



APRIL 1993