

# Evaluation Report Summary

## Review of Bank Assistance Effectiveness in the Health Sector.

### Objective of Evaluation

To assess the effectiveness of Bank policies, strategies, and operations in the health sector in order to draw lessons and recommendations for future interventions in this sector.

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### Period Covered

1987-2005

### Date of Report

Oct 2006

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### Report Reference

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## A. Key Data

- 1) Total Net Loans/Grants during period to the sector: UA 990.72mln
- 2) No of projects/studies reviewed: 85 projects; 23 studies (154 operations) in 39 countries.
- 3) Key health intervention milestones: Support initiated in 1975. Health Policy formulated in 1987 and revised in 1996.

## B. Evaluation Approach Used

The review was based on an extensive review of Bank health policy documents, guidelines, post-evaluation reviews and other relevant documents ; analysis of Bank project-related data; interviews with Bank health staff and managers; consultations with WHO-AFRO and other development partners in the health sector in Brazzaville on the preliminary review findings. The review was organized as follows: a) Review of Bank Health Sector Policy and Strategy; b) Cross-country portfolio review (56 projects profiled in Country Portfolio Reviews; supervision reports for 74 projects ; 14 PCRs; 2 PPERs) c) Country Health Sector Reviews (Ghana; Morocco; Tanzania). No field studies were carried out for the evaluation.

## C. The Health Context

### ***Health financing remains a major area to be addressed.***

Despite the fact that Africa has the highest disease burden, African health care systems are massively under-funded with current government spending at 2.5% of GDP (compared to a global average of 5.4%). Per capita African health spending averaged between USD 13 and 21 in 2001. The minimum estimated level should be USD 60 for a comprehensive health care system which can deliver basic treatment and care for the major communicable diseases and early childhood and maternal illnesses, family planning, tertiary care, trauma and emergency care.

### ***The private health sector in Africa is large and heterogeneous***

The private sector accounts for over 45% of all health spending in Africa and the Bank must assess how it can most effectively support it to improve health care delivery. With widespread concerns about quality provided by some private practitioners, particularly to the poor, governments have an important role to play as regulators, licensers and quality controllers for the private sector.

### ***Human resources is a key constraint***

The shortage of qualified health workers, due to several factors including poor employment incentives, migration, and the impact of HIV/AIDs, is a major constraint to achieving health improvement objectives. This cannot be

resolved through training alone but requires broader changes that address working conditions, incentives and changes in qualification and licensing systems. Decentralization of system delivery has been used as a means of improving local health system performance but its effectiveness in Africa has been scant at best due mainly to a lack of staff, quality management and financial skills at the local level.

#### ***Countries are lacking in adequate pharmaceutical policies***

Another major challenge in the area of health systems has been the management of drug supply. Though pharmaceuticals account for 20% to 50% of government health expenditure, over one-half of those in Africa's poorest countries lack access to essential medicines. Moreover, inappropriate use of medicines remains widespread while trade in counterfeit drugs plague markets, being as high as 70 per cent of sales in some countries. This necessitates the development of sound national drug policies but 17 African countries still have not developed such a policy.

## **D. Findings**

### **D.1 Bank Policy and Strategy**

#### ***Policy and guidelines not sufficiently focused and not being effectively used***

In addition to the policy documents, the Bank produced guidelines for HIV/AIDS support (2001); Malaria control (2002); Population (2004); Communicable diseases (2004) and Guidelines on User Fees in Health and Education (2004). The policy documents and the guidelines have generally reflected the international consensus on major health problems and approaches to address them. However, they only provide a broad menu of possible activities and do not clarify priorities or give sufficient detail to guide programmes and projects by Bank health experts and their government counterparts. Policy operational guidelines were issued in 1998 but these were not disseminated to Bank staff and were thus not used. Additionally, in sum, the health policies and guidelines have been of limited use in orientating health lending by the Bank over the period reviewed.

#### ***Bank country strategies do not give sufficient focus to health***

Country Strategy Papers do not make health a strategic priority and do not usually clearly define strategic priorities for support in the sector which can guide project identification. There is a need for greater analysis of RMC needs and priorities and also to involve NGOs and civil society organizations more in the identification and planning of projects.

#### ***Bank is harmonizing but is still not able to pool funding***

Whilst the Bank has moved with other development support institutions to embrace the use of common or joint support mechanisms it has not advanced far in terms of financial pooling due to the 'rules of origin' condition attached to Bank lending which prevents purchased products from being freely sourced.

#### ***So far little and unsuccessful funding of private sector health projects***

The Bank has so far supported only one private sector health project which was a failure. However there are plans to expand assistance of this kind in the future, for example for the provision of retroviral treatment to HIV patients.

### **D.2 The Bank's Health Sector Project Portfolio**

#### ***Focusing on primary health care and moving from 'hardware' to 'software'.***

Health sector financing accounted for an average of 3.4% of overall Bank financing between 1987 and 2004 (11.1% if one includes health theme spending contained within other sectors). The annual assistance level grew from UA 34m in 1987 to UA 101m in 2004 with some major inter-annual fluctuations. The average project size was UA 9.1m over the 1987-05 period which is less than the overall Bank average (UA 19.9m). Of the UA 991m invested over the review period the four largest sub-sectors were primary health care projects (35.4%), secondary health care (16.4%), health sector reforms (13.1%) and institutional capacity development (12.2%).

The financing for infrastructure has declined from an average of 79% of project base costs in 1987 to about 50% in 2003. Since 2002 substantial increases have been made to the share of study, supervision and specialist services partly as a result of the drive to improve project quality. There is a neglect of the population sub-sector including reproductive health and nutrition despite the fact that this was prioritized in the Bank's health policy document.

#### ***Significant degree of project co-financing.***

About 24% of total sector spending was as part of co-financing arrangements and for 12 out of 17 co-financed projects (70%) the Bank's stake has been over 50% thus indicating the potential influence which can be achieved by the Bank on partner's in the development of health sector support strategies.

## **D.3 Effectiveness of Bank Assistance to the Health Sector**

### **3.1 Project Design Performance**

#### ***Insufficient attention given to recurrent cost financing issues.***

Projects reviewed generally have not adequately assessed the sustainability of investments (particularly infrastructure facilities) in terms of the borrower's ability to finance recurrent costs. Whilst most projects attempted to estimate recurrent costs no consistent method of doing this was identifiable and insufficient attention was given to assessing the means for financing these.

#### ***Weak use of sectoral analyses and institutional analysis in project design processes***

Project appraisals were weak in terms of the analysis of public and private health service provision. Where information was provided on the number of establishments or practitioners the volume, scope and relative prices of alternative sources of service supply was usually not provided.

Only 15 out of 82 Project Appraisal Reports reviewed contained any discussion of institutions and there was generally no discussion of incentive structures for officials or service providers. Similarly no information on interest group influence over health policy and resourcing was presented in the documents.

#### ***Project designs have become much more results-focused and aligned with government policy.***

With the introduction of the use of Logical Frameworks in 1993 the clarity, realism and specificity of projects has increased notably. Additionally all recent projects' objectives have been clearly linked to borrower government health objectives whilst those approved in 1987-96 were not. Nevertheless there are still issues to be addressed in terms of the quality of the Logical Frameworks and they need to be used more effectively in presenting proposed approaches to project M&E. Overall, the Logframe is yet to be used as an effective tool for improving project design and implementation. Cross-cutting issues such as gender and environment also need to be better integrated into these frameworks.

#### ***Project design and supervision processes becoming more complex***

As the capacity-building element of projects grows compared to infrastructure spending Bank-financed health projects are becoming more complex as the number of implementing partners and contracts within a project increases in order to cover service-delivery, capacity-building, community development etc. At the same time the Bank is increasingly seeking to harmonize and align its interventions with those of other development agencies and RMC's existing institutional structures, thus reducing the use of Project Implementation Units used in most projects to-date). These factors together are reported by Bank staff to have increased the complexity of project design and supervision processes, thus increasing the burden on them.

### **3.2 Project Implementation Performance**

#### ***Implementation performance is not improving. Loan condition satisfaction problems persist.***

A review of project supervision reports shows that since 2000 the overall implementation performance has remained constant with only about 50% of projects being rated as satisfactory despite recent Bank efforts to increase portfolio performance. Compliance with conditions is rated unsatisfactory in 35% to 40% of cases – mainly due to protracted legislative processes for loan ratification in some countries, difficulty in establishing executing agencies and political instabilities.

#### ***Financial performance has shown marginal improvement while other performance indicators were stagnant or declining***

Despite the concerted efforts to streamline procurement practices since the mid '90s procurement performance has shown a declining tendency. On the other hand, financial performance showed a marginal improvement. The quality of project management was consistently rated as the least satisfactory due to several factors including: weak executing agencies' capacity, non-adherence to implementation schedules and procurement delays. Encouragingly, the percentage of projects categorized as 'problem projects' has declined over time.

#### ***Extensive delays between approval, declaration of effectiveness and first disbursement.***

The health sector projects have been subjected to considerable delays from the time of their approval by the Bank board to their declaration of effectiveness (only half became effective within 12 months as opposed to the expected 6 months) and between the effectiveness date and the first disbursement. This is due to a combination of factors including poor project design, low government commitment to the project, low project relevance, and lengthy periods required to obtain parliamentary approval. The fact that nearly half of the projects had their first disbursement delayed by over 13 months indicates premature project appraisal and approval. A major reason has been the failure of governments to make counterpart funding available on time.

***Delays in implementation frequently double the planned project's duration period.***

Significant delays are frequent during project implementation with the average project duration growing to over 9 years from the original 3.7 years at the time of appraisal. Nearly half of the projects in the primary, secondary and tertiary health care sub-sectors as well as disease control and pharmaceutical development have taken over 10 years to complete. Implementation delays have been contributed to by all sides in projects including the government, the Bank and the executing agency.

***Implementation delays partly caused by poor borrower country agency management and reporting.***

In nearly half of the projects reviewed in Country Portfolio Reviews (CPRs) the highly deficient capacity of project executing agencies had serious implications on most aspects of project implementation performance (procurement, financial management, reporting etc). In 20% of projects non-adherence to Bank procurement rules (eg inappropriate formulation of contractor shortlists) by implementing agencies led to delays. This was compounded by the weaknesses of the government in monitoring the work of the executing agencies.

One major reason for delays in Bank disbursement of subsequent funding tranches has been the non-submission of audit reports by the borrower (in over 20% of projects). Another major problem associated with borrower performance has been the failure to provide quarterly reports (a chronic problem in 20% of projects).

***However the Bank could do more to help remove the causes of some delays***

In 23% of reviewed projects RMCs indicated that they were genuinely unfamiliar with Bank procurement rules indicating a need for the Bank to be more effective in communicating this information. Finally on procurement some RMCs have complained of inflexibility on Bank procurement procedures.

***Cost overruns was not such a problem***

Cost overruns have been less frequent than time overruns on supported projects though they were still cited as a major problem in 30% of reviewed PCRs and 7% of CPRs. Where these have occurred they have often been due to national currency devaluations or sharp increases in product prices. Approximately 20% of projects reported cost savings though these were only sometimes achieved through judicious resource use. In other cases it was due to the inability of the beneficiary government to utilize remaining undisbursed funds.

***Staff incentives for project supervision are inadequate***

Projects received an average of 9 days' field supervision per year by Bank health specialists who cover a current average of 3.64 projects each, (compared to the Bank average of 4.3 projects). Thus they spend an average of 33 days per year conducting field supervision missions. However the data indicates that since 1996 only 74 projects were supervised out of a total of 99 completed and ongoing projects. Unsatisfactory levels of project supervision (currently projects receive an average of only one visit per year rather than the required 1.5) is partly due to operations staff overload. Further, this work is not adequately factored into staff performance assessments. The situation is compounded by the absence of local Bank offices though this is now being addressed by the decentralization process.

### **3.3 Outcome achievement Performance**

Overall interventions have been generally relevant to the needs of borrower countries and intended final beneficiaries although as stated above the population sub-sector (including reproductive health and nutrition) could have been better served.

***Poor data on project outcomes due to insufficient project completion reviewing.***

Of the 59 projects completed during the period only 14 Project Completion Reviews have been prepared (12 excluding studies) and only two projects have received independent performance evaluation reviews (PPERs). Of the 12 project PCRs 6 were rated as satisfactory in terms of achievement of outcome objectives. Only 5 out of 12 (42%) were rated as having satisfactory performance for institutional development aspects though this may be a biased sample of the population of projects. Bank performance was rated satisfactory in 50% of the projects whilst borrower performance was satisfactory in only 25% of them.

***Some reviewed projects indicated impressive health service access outcomes***

A number of projects indicate significant increases in the level of use of services following Bank-financed service upgrades (such as the child health unit and maternity ward in Kitunda Hospital, Tanzania; Bab Taza hospital, Morocco; Bilharzia Control Project, Egypt). Nevertheless, in some of these cases early increases are followed by decreases due to system management issues such as the supply of qualified service delivery staff.

There are cases where inadequate project preparation and appraisal led to projects being located in areas where there was an inadequate population threshold. Most health facilities rehabilitated by the Bank are charging user fees and payments for medicines and whilst these have helped the sustainability of the facilities to some degree it has reduced levels of access for the extremely poor.

***Insufficient project stakeholder consultation led to sustainability issues.***

Where outcome achievement performance has been less than satisfactory a frequent problem has been insufficient quality of works and equipment - which is often attributable to poor planning - and that the quality of this would have been improved by a greater level of participation of medical staff and intended project beneficiaries in project designs (eg infrastructure facilities).

Whilst stakeholder participation in project design and implementation is an important Bank principle it is not mentioned in the vast majority of the reviewed project documents. More positively the review indicates that environmental aspects are generally being adequately addressed in the development and implementation of the health projects.

***Borrower commitment to recurrent-cost financing can be increased through the use of SWAps.***

Another major problem affecting project effectiveness is the sustainability of achievements made and this is highly related to the willingness of borrower governments to commit adequate resources to finance recurrent costs of health systems and facilities. This issue is better addressed where SWAps are operational (eg. Uganda) where recurrent financing can be better balanced with system expansion.

***Good results achieved from projects with strong institutional development components***

On the institutional development side the review found a number of good examples of approaches to human resource development in health projects but the CPRs indicate that over 48% of projects have suffered because of executing agencies' poor management capacity. Nevertheless where technical assistance has targeted this aspect some good results have been achieved (eg in Lesotho, Guinea and Chad). It is also worth noting that there have been a number of cases of borrower countries not responding adequately to Bank-financed personnel training (eg in terms of staff assignment) resulting in the lack of capture of the benefits of this.

## E. Recommendations

**1) The Bank needs to focus its areas of intervention in the health sector - developing a limited set of well-designed policies and programmes which build on its strengths.**

Areas of focus could be selected among the following: a) improving human resource capacities, b) reproductive health, c) sustainable and integrated health systems (including strengthening logistics and information systems and building integrated services delivery organizations) and d) appropriate infrastructure development. It should also focus on policy advocacy for financing and economic reforms in the sector, including the promotion of public-private partnerships, and the development of African technical assistance institutions.

**2) Bank Health Sector Guidelines should be made more operationally applicable.**

In order to achieve the above recommendation an intensive consultation process should be conducted with partners and the current health sector policy and guidelines should then be updated and made more operationally focused<sup>1</sup>. It is also recommended that specific evaluations of selected health sector themes be conducted in order to obtain better information on approaches which work (and those that don't work) in particular contexts and why.

**3) The Bank needs to increase the level of priority which is given to the health sector in its strategic programming and should look at increasing both overall funding levels and the average project size.**

The Bank is well-placed to develop its strength in the sector as it has good policy influencing capacities in RMCs, strong assets in health expertise, experience derived from project implementation, and it is operational in many health-related sectors in RMCs such as general infrastructure, water, governance and agriculture. Whilst the share of resources dedicated to the sector needs to increase from the current low level of 8% the Bank also needs to increase the level of outcomes achieved for the resources currently expended. It should also aim to increase the average size of its health project loans.

**4) The Bank should put much more emphasis on improving project design processes and on ensuring clearer and better accountability for achieving results**

Bank effectiveness in the sector can be improved through improving project M&E systems and the quality of Bank supervision and assessments as well as improving Bank staff capabilities in this area. It also means properly including the quality of project supervision and self-assessment activities in staff performance assessments partly by means of the use of peer-reviews.

**5) The Bank needs to strengthen its economic and sector work in the health sector and become more active**

<sup>1</sup> It should be noted that the review of the policy was initiated by ORPC with a seminar in Tunis with WB and WHO in June 2006.

#### **in participating in and initiating SWAps**

This is in order to increase its knowledge of country health sectors and to permit more focused programme targeting, to be able to design projects with greater potential impact and to enable better policy dialogue with RMCs. Towards this end it should increase its collaboration with specialized international organizations such as WHO, UNFPA, UNICEF and WB.

#### **6) The technical skills mix of Bank health professionals should be improved and technical staff should be better supported administratively.**

Specialists are lacking in the areas of health sector reform, health economics and financial analysis, communicable diseases, population, reproductive health and health management/planning. A critical area for skill upgrading is that of project management. Additionally existing specialist staff should be relieved of their current excessive load of administrative tasks in order to devote more time to policy, strategy and project design aspects as well as knowledge acquisition and sharing work. This can be achieved by providing more administrative support to these staff.

#### **7) The Bank health policy should define how to encourage public-private partnerships in Bank comparative advantage areas within the health sector.**

## F. Lessons Learned

1. The level of government commitment and the quality of its institutions are critical factors for the achievement of successful and equitable investments using national and international assistance resources.
2. Lack of adequate incentives in terms of accommodation and transportation facilities makes it difficult to attract and retain qualified personnel in rural areas.
3. Weak use of economic and sector analysis prevents the Bank from determining its comparative advantages and from producing improved project designs.
4. The participation of different stakeholders in the design of health projects enhances utilisation and sustainability of the facilities and services.
5. Inadequate attention given to preparation and appraisal lead to unreasonable estimates of time and cost required for project implementation and inadequate attention to risk factors, thus eventually jeopardising implementation and outcome performance.
6. Lack of adequate monitoring and evaluation system prevents the Bank and RMCs from learning from health investments and from being fully accountable towards their stakeholders.