

8: IMPLEMENTATION OF HEALTH PROJECTS 1990-2003

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I. INTRODUCTION

After a decade of significant efforts to establish relationships with new clients, a substantial health sector program has been created in ECA. Between fiscal years 1990 and 2003 (FY90-03), the Bank has provided roughly US\$2 billion in investment loans and credits for health sector projects to ECA countries, representing roughly 4% of the total World Bank commitments made in the region during that time period. Although the satisfactory performance of the portfolio has been plagued by some challenging problems, both the Bank and borrowers have gained from learning opportunities and increased dialogue on health reform.

In some countries, the Bank has been involved for almost a decade and is supporting second- and third-generation projects in the same country. In other countries, the program is in its early stages, with only one project under implementation. In almost all ECA countries, the Bank continues strong technical dialogue with the borrower and is involved in all aspects of health reform. Despite the recent relative decline in the overall number of active projects in the portfolio since FY2000, the health sector portfolio has again reached another peak in lending at the end of FY2003, which requires a significant Bank preparation and supervision effort. The overall number of projects either under preparation or implementation has remained at a very high level since the late 1990s, at roughly 30 active projects under implementation per year. This is significant because during several critical years when the portfolio was growing rapidly, the number of Bank staff working on these projects actually declined.

During the next decade, some of the ECA countries may likely discontinue their borrowing activities with the Bank, which may have a strong impact on the scope of the program. In addition, there is continuing uncertainty in the lending environment in some countries, such as **Kazakhstan**; in other countries, such as the **Kyrgyz Republic**, health reforms may be threatened by the political environment. Therefore, the Bank needs to be flexible in its response to the region's changing lending environment and innovative in its approach to clients.

Definition and Goals

In order to have the desired beneficial impact on client country populations, policies backed by Bank projects must be implemented effectively and successfully. Even perfectly designed projects will falter without appropriate institutional arrangements and conducive political backdrops. During the past decade, the Bank has provided lending and non-lending support to ECA countries in their efforts to improve their health systems. Up to this point, the focus has been on policy and project design; this paper will focus on evaluating project management and implementation as well as drawing out lessons applicable to the Bank's current and future programs in the region.

Methodology

The methodology used for preparing this paper involved:

- Review of general background material (Country Portfolio Performance Reviews (CPPRs), ECA regional papers and country portfolio reports, and Operations Evaluation Department (OED) assessments);
- Analysis of Implementation Completion Reports (ICRs) for 16 closed projects;
- Review of Project Appraisal Documents (PADs) and Project Supervision reports (PSRs) /Form 590s for 38 investment projects in the portfolio up to FY2003; and,
- Individual, in-depth interviews with team leaders and members for each of the 38 projects were held, based on a questionnaire developed specifically for this assignment, thus providing a broader context for evaluating the portfolio.

The team prepared short "project summaries" for every project in the portfolio, as well as a matrix of all the major project issues, e.g. project parameters, project performance, ratings, project management, sector work, government/ borrower commitment and capacity, adjustment links and monitoring and evaluation.

II. OVERVIEW OF THE PORTFOLIO

From FY1990-2003, the Bank has provided US\$2 billion in investment loans and credits for health sector projects to the countries of the ECA region. This does not take into account portions of adjustment lending which had health conditionalities. During this period, there were a total of 101 adjustment loans made, of which 26 had explicit health conditionalities and only 8 had direct links with investment operations.

As of end FY2003, the Bank's ECA Human Development (HD) sector has 44 health projects (including five stand-alone components of other multi-sectoral projects) in its implementation portfolio, of which 18 closed. The Bank has worked in 24 of the 28 countries in the region, with the exceptions of **Belarus**, the **Czech Republic**, **Slovakia** and **Turkmenistan**, although three new projects are scheduled for Board presentation in FY2004, one project in Belarus and two projects in Slovakia. The reasons for the remaining two exceptions vary. The **Czech Republic** is poised to join the European Union in the immediate future. **Turkmenistan** is the only ECA country with little or no dialogue with the Bank so far although the Bank remains open to dialogue.

Figure 1 below is an overview of the total number of projects under implementation in each FY. The trajectory represents the net number of projects, by adding new projects approved in each fiscal year and subtracting projects closed in the same fiscal year. Projects with Board slots in FY2004-FY2007 are included, to illustrate the immediate future of the health portfolio. Figure 2 is compiled in the same way as Figure 1, but illustrates the loan/credit amounts in US\$ for the projects under implementation over the same time period.

Figure 1: Number of Health Projects under Implementation FY 1990-2007

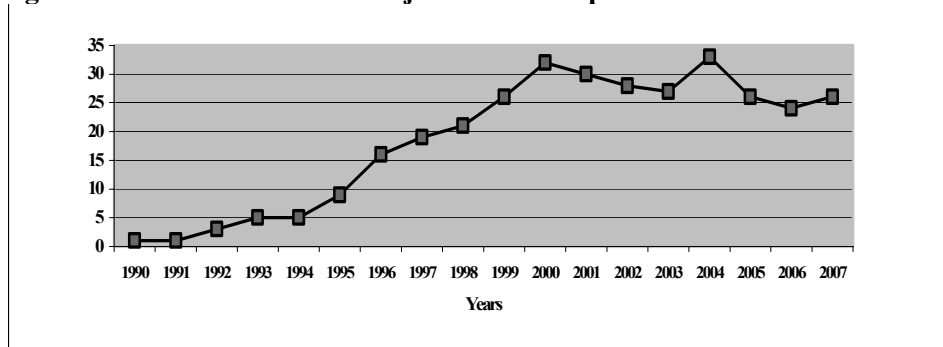
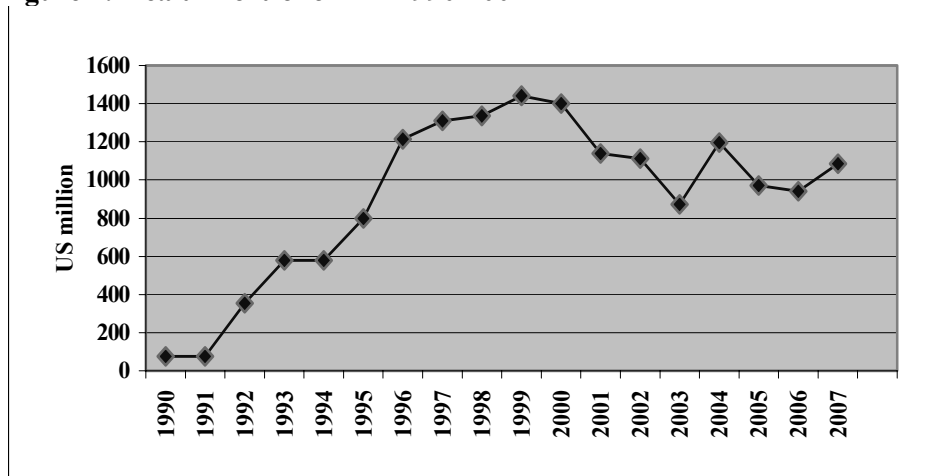


Figure 2: Health Portfolio - FY 1990-2007



Analysis of growth trends

These figures chronicle a rapid growth in the portfolio in the mid-to-late 1990s up to FY2000, followed by a slow decline until FY2003 and then a relative plateau in the number of total projects under preparation and supervision, with an average of 30 active projects in the portfolio each year.

Initial Bank investments in the ECA health sector consisted of a few projects extended to several countries in relatively large loan amounts. As new borrowers came on board beginning in FY1996, the number of projects dramatically increased, culminating in FY2000, when eight projects were taken to the Board. During this time, loan/credit amounts contracted relative to earlier years, even though large countries, such as **Russia** and **Turkey**, still received large loans and/or credits. A detailed description follows of changes in the portfolio over time.

Between FY1990 and FY 1996, the Bank lent US\$1.2 billion for 16 projects, of which almost US\$1.1 billion consisted of eight large loans to **Hungary, Poland, Romania, Russia** and **Turkey**; these loans were worth between US\$60 million and US\$270 million each. The large loans were made between FY1990 and FY1993; the exceptions are **Russia**, which received approval for its first two projects in FY1996 and FY1997, and **Turkey**, which received approval for its second health project in FY1995. Between FY1995 and FY1996, the number of projects approved by the Board rose dramatically to 11, six of which were for Central and Eastern Europe and five for FSU countries. These 11 projects, worth US\$160 million, included three large projects for **Russia** and **Turkey**, with the rest consisting of small loans and credits, ranging from US\$10 million to US\$40 million.

Between FY1997 and FY2002, the Bank approved 23 new projects worth US\$450 million with 19 countries. However, during the same period, approximately US\$270 million of loans made during the previous period were cancelled. These cancellations were from the six large initial projects with **Hungary, Poland, Russia** and **Turkey**. The reasons for the cancellations, which contributed to the slowing growth of the overall dollar amount of the portfolio and explain the visible plateau and decline in Figure 2 after 1996, are elaborated in the next section. FY2000 saw the largest lending in the health sector with eight projects approved by the Board from a total of 23. This was followed by two years when only three projects were approved (three in FY2001 and zero in FY2002). FY2003 saw another significant growth in the portfolio, with 7 new projects approved by the Board and two additional projects scheduled for early FY2004 approval. Meanwhile, 18 projects closed between FY1997 and FY2003.

The majority of projects (31) have been structured as Sector Investment Loans (SILs). With the introduction of new instrument choices in 1997, there is now one Learning Innovation Loan (LIL) in **Azerbaijan**, and four Adaptable Program Loans (APLs). In addition, there is one Bank Trust Fund Grant in **Kosovo**. The sector investment Loan/Credit (SILs) remains the preferred and most used instrument in ECA health sector.

Looking ahead, the Bank's lending program for FY2004-2007 includes 19 new projects worth an estimated US\$800 million. However, the net number of projects and overall loan amounts under implementation may continue to vary and decline slightly, as seen in Figures 1 and 2, because 13 projects are expected to close in FY2004. However, based on previous experience, it can be assumed safely that at least some of these projects will be extended, thus flattening the portfolio trajectory.

III. PROJECT PERFORMANCE

The ECA health sector team has developed a strong portfolio of projects that includes almost every ECA country except for Turkmenistan and Czech Republic; these projects have generally performed satisfactorily, especially considering the unique set of challenges presented by the region's transition to a market-oriented economy.

Some operations have been very successful (**Croatia, Estonia, Kyrgyz Republic, Bulgaria**), markedly changing the health sector in these countries with real achievements. Other operations that were not considered successful initially have turned around as a result of restructuring and significant efforts by both government and Bank teams (**Macedonia**, the first **Romania** project, and the second **Turkey** project). Yet even the less successful operations have provided learning opportunities for both Bank and borrower, as well as continuing dialogue on health sector reform issues (**Albania, Georgia, Hungary, Kazakhstan, Poland**, the first **Turkey** project). In some instances, after long periods of engagement on health issues, several countries are no longer borrowing for health (**Hungary, Poland and Kazakhstan**), although operations are planned in both Poland and Kazakhstan for FY2005 and FY2007 respectively.

Project ratings

The review of Project Summary Report (PSRs) indicates that 90-100% of projects are rated as satisfactory ("S") for most of project implementation phase. However, a close analysis of project performance (review of project documents, summaries, interviews and inside knowledge) shows that project outcomes have not always been successful or satisfactory over the past decade. At least one-third of all projects should have been rated unsatisfactory ("U") at some point during implementation.

Reviewing numerous PSRs also reveals a pattern in the rating cycles over the duration of the project: good ratings typically are assigned at the start and at the end of the project. Ratings tend to decline in the middle years of implementation, which might be a form of the Bank's pressure on governments for improved implementation mid-way through the project. However, the tendency to assign "S" ratings to less-than-satisfactory performances remains, leading to misrepresentation of project effectiveness, glossing over some of the major challenges of implementation and burying additional learning opportunities.

The misrepresentation of project ratings is manifested when the PSR text is compared with the assigned rating in the same PSR. Often, the text reveals substantial problems in implementation, contradicting the project's "S" rating. Further distortion is visible when comparing PSR, ICR and OED ratings. Table 1 shows clear discrepancies between the ratings for the 10 of the 16 closed health projects rated by OED. Whereas 100% of projects were rated "S" in PSRs, only 80% of these were rated "S" in ICRs. For roughly 60% of projects rated "S" in ICRs, OED subsequently downgraded the "S" rating to "MS" (Moderately Satisfactory).

Table 1: Ratings Discrepancies: OED vs. ECSHD

Health Projects	DO/Implementation Progress	Outcome Rating	
		ICR Ratings	OED ratings
	PSR Ratings		
Albania - Health Service Rehab.	S	S	S
Bosnia - War Victims	S	S	MS
Bulgaria – Health Sector Rest.	S	HS	HS
Croatia – Health I	S	S	S
Estonia – Health	S	HS	HS
Hungary – Health Services	S	U	MU
Kyrgyz - Health I	HS	S	HS
Romania – Health Service Rehab.	S	S	MS
Turkey – Health I	S	MS	MS
Turkey – Primary Health Care	S	Not available	Not available

Note: HS (Highly Satisfactory), S (Satisfactory), MS (Moderately Satisfactory), MU (Moderately Unsatisfactory), U (Unsatisfactory).

In several projects, the “S” rating in PSRs directly contradicts the ratings in ICRs and OED reviews. For example, the average PSR rating for the **Hungary** health project was “S” for development objective and implementation progress, counterpart funding and project management. The ICR rated the project “U” on all counts and the OED rated it “Moderately Unsatisfactory”.

PSRs continually rated the achievement of the development objectives and implementation progress for the first health project in **Turkey** as “S” on average. However, the ICR and the OED rated the project as “MS”, with “unlikely” sustainability and modest institutional development impact; a “U” rating was assigned to the project for Bank and Borrower performance overall. In the case of the Primary Health Care project in **Turkey**, the PSRs rated the project “S” when, in fact, the project was not implementing, not disbursing and eventually was closed.

Conversely, two projects in **Bulgaria** and **Estonia** received overly modest self-ratings, and were upgraded to “HS” in ICRs and OED assessment from their PSR “S” rating. Distortions in project ratings could be due to a number of factors, including:

- *The complexity of implementing health projects:* often, Bank teams lower their expectations of project performance to more realistic and achievable levels, giving the Borrower the benefit of the doubt via higher ratings
- *A limited range of PSR ratings:* compared to OED ratings, PSR ratings offer limited choice, as they are only able to assign “Unsatisfactory” when a project may just be only moderately so. Thus, faced with a choice to rate a less-than-satisfactory project with a stark “U” rating, the teams have gravitated to the “S” rating;
- *Fear of jeopardizing the program:* Explicit triggers by country teams in CASes for the different risk scenarios lead to avoidance of “U” ratings because it could jeopardize the overall country program. For example, at least 70% of projects in **Russia** must be satisfactory as a trigger for the base case;
- *Workload considerations:* Though less tangible, an equally significant factor is that Bank staff often feel a strong disincentive to rate projects “U” so as to avoid flags in the portfolio that would attract management focus and closer monitoring of the projects. The existing system of risk flags needs to be re-examined to better provide Bank teams with necessary systems for tracking outcomes and impact. Such a system would yield greater reporting accuracy.

Project Restructuring and Cancellations

Only five projects have been restructured formally, using the definition of restructuring as “major changes in legal agreements”. Another 20% of projects have been modified mid-way through project implementation and most projects have undergone some adjustments. In some cases, restructuring worked well, as in the case of the first **Romania** project.

In other cases, restructuring turned faltering projects into significant successes; for example, the **Macedonia** project, which was not disbursing at all for the first three years, was restructured at Mid-term Review to focus on several components that were performing well. The result was a successful project. In other cases, restructuring came too late and was not sufficient to produce visible benefits. Examples include the **Hungary** project (rated “MU” at ICR) and the **Poland** project (not rated yet).

Projects are restructured/modified for numerous reasons, of which the most common are:

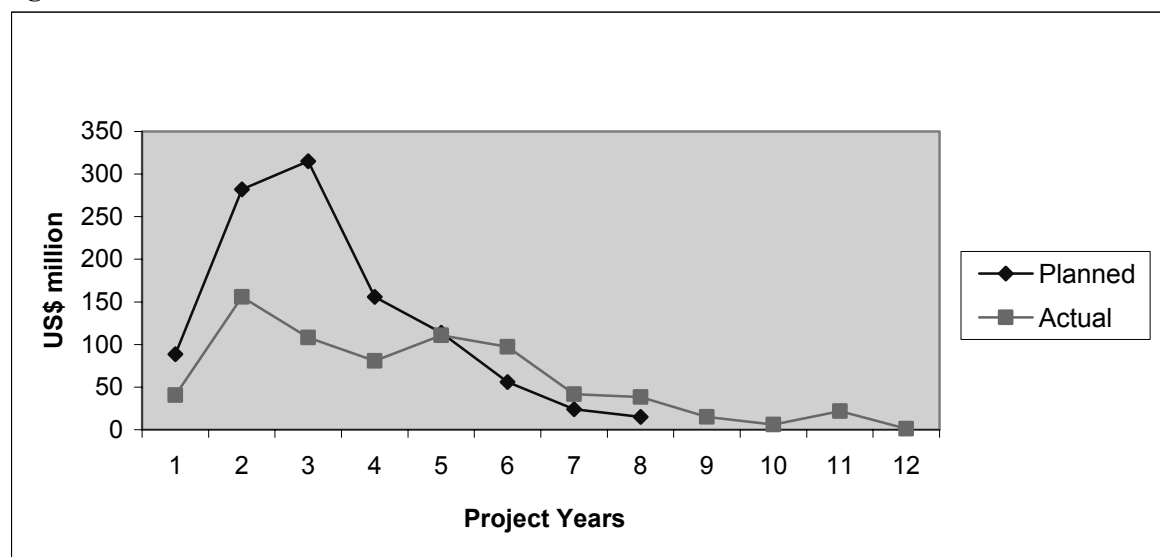
- *Complex initial design*: In some cases, the project’s design was overly complex, and so had to be adjusted to accommodate the changing needs of the Borrowers, or shifting political and institutional climates, as discussed in more detail below;
- *Change Merits Adaptation*: As one Russian counterpart noted, “Projects never, never turn out exactly as they were designed.” (*Russia Portfolio Review, 2002*). In other words, it is normal that, over time, changing circumstances merit project changes so as to meet the development objectives. In fact, **constant adaptation is the hallmark of successful operations**. The review of project summaries underscores the effectiveness of project restructuring as integral to the likely success of an operation. Bank staff and government counterparts should continuously monitor the development impact of projects and be willing to adapt, whether via project restructuring or re-design, and improve project outcomes.

Disbursement performance, project length, extensions

Of the total US\$2 billion projects approved by the Bank, US\$0.9 billion has been disbursed to date, with almost US\$0.3 billion cancelled. Data on the 16 closed projects that were active between FY1991 and FY 2002 were collected and are presented in Figure 3, comparing planned and actual disbursements per year. Typically, disbursement planning has been ambitious or even unrealistic at the time of preparation and appraisal. For some operations, the Figure also demonstrates a lack of understanding of how long projects might take. For example, the **Russia** Medical Equipment project had a disbursement schedule of three years but took six years to disburse; in that time, US\$50 million was cancelled. The first **Macedonia** Health Project was planned for three years but also disbursed in six years.

It is important to note that the visibly high level of actual disbursement for Year 2 does not, in fact, represent normal project disbursement, but large payments made to “funds” for some projects (**Turkey**). This tends to skew the actual disbursement curve to produce the “peak” in year 2.

Figure 3: Planned vs. Actual Disbursements



*Note: Actual disbursements extend to 12 years for three projects: the **Romania** project was planned for five years but was extended to nine. The other two projects, in **Turkey** and **Poland**, were planned for eight years and were extended to 10 and 12 years respectively.*

Of the 16 closed projects, two were cancelled early (**Kazakhstan** and **Hungary**) because of special circumstances prevailing in these operations. All remaining projects – about 95% of the total – were extended for between one and four years, with one exception (**Bosnia: War Victims**). Consequently, the average planned length of projects was five years, compared to the actual average of seven years for these 16 projects. Generally, projects were extended once or twice. Only one, the **Romania I** project, had four extensions, requiring nine years to complete implementation and disbursements compared to the five originally planned.

Projects are extended for numerous reasons, including:

- complexity of project design;
- delays in loan ratification and effectiveness;
- slow project start-up;
- slow learning curve in terms of project management (disbursement and procurement training);
- procurement and disbursement delays (in practically all projects);
- political/economic crises;
- delays on the government side in taking key decisions, and delays in the passage of legislation;
- periodic lack of counterpart funding for projects;
- staff turnover and the need for new staff to relearn the project; and
- the need to complete implementation.

However, the Bank’s persistent over-estimation of the time required for implementing projects also contributes to eventual project extensions; this was particularly true in the early ECA years when estimates were based on routine application of the Bank’s standard disbursement profiles, per sector and per region. However, it is puzzling that projects planned for longer periods of time (**Turkey** and **Poland** – eight years) actually took even longer (10 and 12 years) to complete. To some extent, the variations demonstrate the inherently volatile nature of planning disbursements, given the uncertain circumstances prevailing at the time of project preparation and appraisal, and the optimism of project teams.

IV. ESSENTIAL ELEMENTS OF PROJECT PREPARATION AND IMPLEMENTATION

Analysis of the ECA health portfolio performance over the past decade reveals that successful project preparation and implementation hinges on several key aspects that tend to be the same across all projects and across all countries. They include:

- Strong government commitment and ownership, as well as willing and able counterparts;
- Clearly defined project objectives and flexibility in project design;
- Well-grounded preparation (based on international best practice/evidence);
- Effective project management, supported by a sufficient number of well-trained and competent project unit staff and by external assistance, as necessary;
- Intensive, efficient and adaptable Bank supervision (including continuity of Bank staff over the project period);
- Links with adjustment operations;
- Effective donor coordination.

Before discussing some of these main elements in detail, it is important to remember the challenging social, political and economic context in which the health sector portfolio was developed, as well as the inherent difficulty of preparing and carrying out health reforms.

Challenges of working in a new region

When the Bank began its ECA operations, designing and planning focused projects appropriate to the various national environments was difficult due to a general unfamiliarity with the cultural, political and institutional context. The Bank was facing new borrowers in a region with very different economic and political structures; these new Borrowers had little prior exposure to the outside world and modern business and lending practices.

At that time, governments were eager to obtain immediate financing, especially capital investments for their collapsing infrastructure and outdated equipment. The Bank was very enthusiastic to assist the new Borrowers and tried to respond quickly to immediate needs in many countries. However, oftentimes the Bank may have been ill-advised to push projects ahead quickly without doing the necessary sector work. There was this constant tension between responding quickly and doing the necessary extensive preparation work generally recognized as one of the essential elements for effective dialogue. At the time, the Bank felt that sector work would take too long when Borrowers needed urgent help. Therefore, during this time, very few “formal” pieces of sector work were financed by the Bank, with only a few of the first phase projects benefiting from this kind of formal sector work. Instead, projects were designed based on individual, informal consultant reports. Project files contain numerous early reports and based on anecdotal evidence and from interviews conducted for this review, it is clear that hundreds of papers were written on various aspects of the health sector in ECA. However, many of these reports are difficult to track and quantify without an extensive search since these early reports are not reflected in the Bank’s databases.

Over the past decade, Bank teams have prepared projects with a heavy reliance on PHRD grants and bilateral funds. Grants have funded much of the preparation work and provided substantial support, and much needed technical analysis, for project design and preparation. During the first half of the decade, these were normally administered by Bank teams and served as supplements to the Bank budget for formal sector work, which was in continuous decline during the 1990s. With the assistance of PHRD grants, many reports have been produced and have been the first and only studies done on a complex set of issues that had not been examined previously. These studies have been essential for supporting and maintaining technical dialogue with the new borrowers. On the Borrower side, it is important to note also that, in the early years of ECA transition, there was little to no understanding or experience of working with international development agencies. After 70 years of centrally

planned economies and top-down political structures, these new borrowers were faced with new and unfamiliar ways of doing business. Central and local ministry staff faced great challenges during the transition period and, at the same time, had to learn quickly and adapt to the complex workings of the Bank.

This had clear implications for project design, preparation and implementation. Because borrowers had little initial capacity to fully participate in the preparation of projects, the Bank tended to control the direction of the work, which had obvious negative implications on local project ownership. In addition, the Bank was overly optimistic about supporting the economic transition and often moved ahead without sufficient government buy-in (**Albania**). In some cases, the Bank took over preparation and implementation almost entirely (**Azerbaijan** and **Kazakhstan**). All these factors combined had adverse consequences on the level of government commitment and understanding of particular projects.

Difficulty of health reform

“Health reform is a difficult and long-term process, involving a wide range of stakeholders” (Johnston, 2003). After more than 10 years of transition, it is increasingly apparent that the Bank’s optimism in the early years about the pace and prospects for speedy health reform is not materializing.

Health reform is difficult in any environment, and the Bank has many times underestimated the political and institutional challenges in the reform process. The health sector is multi-faceted, with areas ranging from service delivery to public health to hospital restructuring and, most recently, fighting communicable diseases in ECA. Health reforms are often politically charged, as they are of significant direct interest to the public. Elements such as reforms in health care finance have proven particularly challenging. Project summaries consistently note this aspect, particularly with regard to the interface between the health finance system and the expensive need to establish effective health management information systems.

It is important to note that the Bank is at times only one of many players, and a relatively small financial contributor to overall government resources. Therefore, the challenge has often been how best to use the relatively limited Bank financial resources to leverage important government decisions concerning health sector reform. Consequently, the Bank has had to rely on its comparative advantage of being a select AAA institution, and on its role as a stable partner often after other donors and institutions have quit after political and military crises.

Despite these challenges and the initial unfamiliarity with the ECA health sector, the Bank has managed to build a stable and an overall successful program. An extensive review of the ECA health sector portfolio singles out the key elements required for successful project implementation. These are described below:

Strong Borrower Commitment and Capacity

Counterpart commitment and management capacity are two essential pre-conditions for successful project implementation. Roughly 70% of projects have had problems with government commitment and ownership. Further, the success of project implementation hinges on strong government capacity and understanding of project objectives. Problems encountered in projects include:

- lack of consensus on the best use of Bank funds (i.e. unwillingness to borrow for project elements essential for achieving project objectives, such as technical assistance);
- government underestimation of political difficulty of health reform due to limited experience with health reform and, at times, poor knowledge of the health sector; and
- insufficient and unstable provision of counterpart funds.

In addition, due to the extreme political instability that accompanied the transition process, many projects suffered from periodic and continuing bureaucratic instability. Examples include:

- changes in Ministers and higher level Ministry staff;
- infighting between agencies, i.e. Health Insurance Fund and Ministries of Health;
- lack of support from Ministries of Finance and occasional micro-management by the Ministries of Finance of functions and project activities run by Ministries of Health, often affecting the timely and adequate provision of counterpart funds and overall project implementation.

Overall, Government commitment and capacity have not always been strong in ECA countries during the past decade. This is apparent from the review of project documents and continues to be an area of concern. Often, governments saw the Bank only as the potential provider of funds for ongoing government programs, and mostly for capital investment priorities for which limited or no budget resources were allocated during the difficult transition period. Due to limited exposure to international best-practice and years of reliance on an expensive but functioning system, government leadership and Ministries of Health typically did not see the need for substantial reform. This often put the Bank in the difficult position of attempting to improve health outcomes by changing the essential underpinnings of the health system but with limited and/or reluctant support from the indigenous leaders.

Clear, Flexible Project Design

Given the health sector's breadth and the inherent complexity, it is challenging to develop a project structure that addresses the appropriate aspects of the reform process, while at the same time keeps the design clear and flexible enough for successful implementation.

Many projects in the portfolio have design problems, having been prepared without sufficient consideration of the complexities of eventual implementation. In-depth interviews with Bank team leaders indicate that, of the 37 projects in the portfolio, about 75% are considered overly complex and ambitious, with unrealistic original objectives. On average, projects in the health portfolio have four components and several sub-components. Several of these projects have had 25 or more sub-components, and have had overly large loan amounts (**Hungary, Russia and Poland**) which eventually were reduced significantly. In some instances, projects have as few as two components, but as many as nine sub-components, a design that masks the true complexity of the project. Only a handful of projects have been simple and easy to implement; these include the First **Croatia** Health Project and the **Lithuania** Health Project.

It should be noted that the speed with which projects were often prepared did not allow the Bank and government teams to carry out a comprehensive analysis and to design an effective project. Often projects were not entirely suitable to the country context and the political environment. Other issues also contributed to making projects complex. They include:

- **Conflicting Bank/Borrower Agendas.** Factors contributing to project complexity can be credited to both the Bank and the borrowers. The Bank's desire to lend at times conflicts with government agendas and reform efforts. Bank teams have consistently tried to include many elements essential to health sector reform, thereby creating multi-faceted, complex projects with over-arching development objectives. On the other hand, borrowers sometimes pressured the Bank to lend for activities that are not entirely consistent with the overall objectives of the proposed projects. In an attempt to encourage reform, Bank teams have been known to accommodate these government priorities and incorporate activities that made projects even more complicated and fragmented. This "carrots and sticks" approach had its merits and realism, however, since governments do have internal pressures to borrow for certain elements. Regardless of the motives and reasons for this approach, the outcome has been to make projects more complicated, jeopardizing implementation of essential project components.

- **Lessons of previous operations overlooked.** In many instances, the design of second-phase projects did not reflect adequately the lessons of previous operations. The preparation of most second-phase projects was completed before the ICRs for first-phase projects could be done, forcing second-phase projects to rely on findings of Mid-term Reviews and Aide-memoires of final project missions. In only a few cases were lessons from the first-phase projects effectively integrated into the design and preparation of the follow-on projects (**Romania, Albania**). Rigorous assessment, particularly of problem projects, should be carried out prior to closure with enough time to reflect on the project's impact and achievement of objectives. Consequently, the preparation of ICRs should begin as soon as at least 90% of the project is disbursed, rather than starting just before the closing date. This is particularly important for operations that have been restructured or where significant problems exist.
- **Parallel Projects with no links to each other in same country.** In several countries – **Hungary, Russia, Georgia** – parallel projects have been in implementation without linkages between them.
- **Weak Monitoring and Evaluation (M&E).** Project summaries show that few task team leaders, project teams and counterparts fully understand how to utilize this methodology to improve tracking of project effectiveness; further, few believe it is worthwhile. In many projects, the PAD still contains either too many or too few indicators to allow for effective M&E. Collection of baseline data essential for tracking project outcomes often is delayed until the Mid-term Review, despite the fact that indicators are normally agreed on during Negotiations and despite the fact that the M&E system must normally be in place by project effectiveness. The reality is that many teams consider this aspect of project preparation to be less crucial and more of a pro-forma exercise.

In sum, project design is an issue that stands out as one of the most significant in affecting good project outcomes and successful implementation. Based on experience, it is likely that projects will continue to be relatively complex (although complexity has been somewhat reduced in second-generation projects as a direct lesson from the first operations). Therefore, Bank teams and counterparts need to find ways to accommodate this complexity, make project designs more flexible and conduct thorough and in-depth reviews continuously for the projects' duration to ensure that projects do not fall victim to over-design.

Effective Project Management

ECA health projects have generally been managed through project management/implementation units (PMU/PIU), which were charged with day-to-day project implementation on behalf of the Ministry of Health. These PMUs/PIUs coordinated all project procurement and disbursement activities and liaised with the Bank and other donors involved in the health sector. Elements of a well-managed PMU/PIU include: (i) effective PIU management; (ii) capable technical PIU staff; (iii) sound organizational structure; (iv) close working relations with the MOH and other ministries; and (v) well functioning monitoring and evaluation system.

In the ECA region, PIUs have a variety of different structures, from those integrated into the MOH to those with independent status. Recognizing the importance of having a mechanism to coordinate the implementation of project activities, ECA health teams generally have supported the establishment of dedicated project units, both within and outside of government structures. In some projects, MOH staff members were actively involved in project implementation, whereas in other projects, PIU staff/consultants coordinated project components. About 50% of all PIUs are located outside of the MOH.

A stand-alone Project Management Component was found in roughly 70% of the projects, indicating the importance that Bank teams give to the existence of a project management function. Support is also provided in all projects for on-going training of PIU staff in the areas of project management, financial management and

procurement. Beginning in 1995, the ECA health sector arranged an annual PIU conference, hosted each year by a different regional MOH. This initiative is unique in Bank operations, and has been successful in providing PIU staff with additional training in many aspects of health policy and health project management, with direct relevance to their projects. These annual conferences have also been important in developing a useful network among the different PIUs in the region.

About 90% of PIU staff are local consultants, often as a result of the lack of requisite skills among ministry staff and the need to attract qualified individuals who have the appropriate skills. On average, five to six people staff PIUs. However, there is wide variation in staffing across projects, depending on the size of the project and the particular country context. Staff numbers range anywhere from 120 in **Turkey** to 1 in **Croatia** (1st Health Projects). The creation of PIUs staffed by local consultants, however, has caused some backlash, particularly in the ministries that perceive these consultants as being overly compensated. In several recent instances, PIU local consultants have been forced to accept lower fees by their Ministry, despite contractual agreements (**Macedonia, Croatia**). In some cases, these reductions were justified because of exceedingly high PIU salaries as compared to Ministry staff. However, at times, these salary reductions had the deleterious effect on project implementation because some PIU staff were forced to seek other forms of employment, leaving the project in the middle of implementation.

In many projects, external management support was financed through the project to improve the performance of the PIU. Experience indicates that this support has been most effective when applied early in the project, as a short-term and focused action, followed up by periodic assistance. Unfortunately, this assistance occasionally has proved unsatisfactory and costly, usually as a result of the poor quality of the individual assistance provided. Partly as a result of these bad experiences, governments are reluctant to use Bank funds to hire external technical assistance for project management. Even so, the application of focused management assistance in the early stages of project implementation has yielded positive results.

Most projects in the portfolio have Steering Committees, typically composed of key decision-makers in the project context. When there is a high degree of ownership and commitment on the part of the ministry or other executing agency, these committees can be highly effective in directing the path of the project and coordinating the different players. However, experience shows that many of these committees are pro forma, set up as a bureaucratic requirement by the government, with Bank support, and thus do not affect the project's implementation positively.

Overall, ECA health PIUs have had mixed performances with problems ranging from insufficient management and technical skills on the part of PIU staff, difficulties in coordinating the project activities among the different MOH departments and other entities, delays in procurement activities, cost overruns, lack of monitoring and evaluation, lack of clarity in the role of the PIU, with the unit often by default managing the project. In addition, the Bank occasionally has emphasized the role of the PIU at the expense of fostering relations with MOH.

As a result, some improvements have been made, including putting in place more stringent requirements, often as conditions of negotiations, to have PIUs established and adequately staffed. Also, PIUs have been closely monitored by Bank teams who have worked to improve overall management. The Bank is also enforcing a requirement to have financial management systems in place by Board date or latest by project effectiveness.

Effective Procurement and Financial Management Performance

Procurement. Over the past decade, borrowers have become more educated in procurement, thanks to significant assistance and effort from Bank teams and external consultants; many projects are now operating smoothly and with limited Bank input. More recent borrowers are less familiar with procurement, requiring

significant time and resources for Bank supervision. Overall, procurement thresholds remain low; regardless, borrowers continue to seek no-objections for even the smallest procurement actions and expenditures in order to comply with internal auditing requirements and government control systems. This issue has been raised continuously at project reviews, PIU conferences, and in portfolio reviews.

Misprocurement. Despite numerous complaints received and reviewed by the Regional Procurement Advisor's team, and the obvious existence of corruption in many of ECA countries (not explicit), there have only been a few isolated cases of misprocurement in the entire health portfolio.

Decentralization of procurement, financial management functions. Recently, the Bank has been undergoing a gradual decentralization of its operations, with some variations among the different regions. As part of this process, many of the Country Units are now in the field, and many of the core functions for operations are being shifted to these Country Offices. The procurement function was the first to be decentralized, beginning about five years ago. New positions in the Country Offices were established and were staffed by either Headquarters procurement-accredited specialists (PAS) or, in most cases, by local procurement specialists who were trained in Bank procurement guidelines. In most cases, these PAS cover the country where they are stationed as well as neighboring countries. Over this same time period, the financial management function has been decentralized as well; many of the financial management specialists now are located in the Country Offices and handle several adjacent country portfolios. Most recently, the Legal Department has begun to decentralize its staff. The major implications for this decentralization include:

- Lack of direct contact and communication with operations and sector staff in Headquarters resulting in delays and misunderstandings. “Personal contact” is not replaceable, particularly during intense preparation periods and supervision of highly complex projects;
- Increased probability of incomplete project files at Headquarters; and
- Potential loss of control from the Headquarters.

Financial Management Guidelines. In 1997, the Bank introduced guidelines for new financial management procedures for application to all Bank-financed projects in an effort to ensure timely and relevant financial information for projects. Even though the new procedures were a response to the need for a more structured approach to project financial management, the Bank guidance was not clear to both the Borrowers and the Bank staff responsible for supervising projects. The requirements themselves were at times unrealistic, inappropriate and expensive. When the guidelines on financial management in project implementation were first introduced, project management units were required to set up financial management programs for their projects, subject to Bank review and approval. In principle, these new and more rigorous guidelines represented a positive change in project management standards although borrowers were often established systems that were more complex and costly than needed.

Project management units were expected to select adequate financial software programs on a competitive basis, in an area where there were very few options; information about these programs was not widely disseminated. Even the best of these products had to be customized to the needs of the individual projects that necessitated using project funds to hire specialists to hone software. This proved in many cases to be time-consuming and expensive, with a cost for installation, customization and staff training averaging US\$30,000. The introduction occurred within a Bank context where operations staff who had good working relations with borrowers often themselves were not supportive fully of the new financial guidelines and requirements. Recently, in response to this situation, the Bank eased its financial management requirements. Some of the recent simplifications and changes include:

- No need for specialized software;
- No need for complex reporting forms;
- No requirement for certificates to be issued;
- No pressure to move to PMR based disbursements;
- Ability to combine half of a year into annual audits, if the project starts or ends at mid-year;
- FMRs can be done every six months instead of every three months.

Bank Performance: Preparation and Supervision

Well-grounded project preparation, intensive Bank supervision, capable staff and continuity in project teams are some of the key factors contributing to the success of projects.

Preparation and Sector Work. Over the past decade, extensive “informal” sector work has been done as part of the preparation process, with only five “formal” pieces of sector work being produced in the region on health. Preparation work on specific project related health issues has been done mostly through support from PHRD grants and other consultant trust funds. While these grants have been essential and have financed a large number of important studies, they cannot be seen as replacements to formal sector work, which essentially provides the “big picture” (comprehensive view) of the health sector.

Nonetheless, most recently, given the already extensive knowledge that the Bank has acquired over the past decade, focused pieces of sector work have been produced, including regional studies. Also, in countries such as **Russia**, recent sector work is financed in the form of health seminars on specific key topics. This approach has been highly effective in building a consensus around these topics within the Government, with direct implications for possible Bank lending.

Bank Supervision. Strong Bank supervision efforts were cited in project summaries as essential elements for turning problem projects around. A capable project team tends to include:

- Good skills mix;
- Clear roles and responsibilities;
- Highly qualified and experienced staff;
- Good communication skills with counterparts;
- Knowledge of Bank rules and procedures as well as the ability to use these with flexibility and innovation; and,
- Adequate resources.

Bank resources. Over the past decade, the Bank resources available to carry out preparation and supervision work have declined. In earlier years, there was generally more support and project teams were able to focus on a few projects and do them well. Since 1997, Bank funding for operations has been spread over more tasks and teams, often at the expense of quality. Staff members have adapted to this new modus operandi and have made efficiency gains wherever possible. Still, resource constraints are considered one of the major issues among operations staff.

For project preparation, PHRD grants have played a key role in sustaining adequate funding. Many other Trust Funds (e.g., SIDA/Sweden, DFID, USAID, CIDA) and consultant trust funds contribute significantly. Without these funds, project preparation would not be possible, given the decline in Bank budget support. It must be noted, however, that recipient-executed Trust Funds -- now the norm for PHRD grants -- are challenging, as they require sufficient management capacity on the part of the borrower to implement. The Bank often finds itself providing significant support to the government in this process, as the provision of consultant services under these funds is essential for project preparation.

For supervision, fewer resources are now available for each project in a portfolio that has grown over the years. Cumulatively, this represents a major challenge and tension for staff often torn between the needs of borrowers, ensuring quality of outputs and living within their limited budgets.

Evaluation of projects. Investment lending continues to represent the Bank's most important vehicle for promoting institutional development, capacity building and policy dialogue. However, rather than focusing on development outcomes and longer-term development agenda, Bank teams continue to focus on evaluating the portfolio and individual projects with an emphasis on day-to-day implementation issues. These often dominate project supervision. This preoccupation with current project issues occasionally has been to the detriment of the overall project achievements and objectives. In addition, as was noted above, monitoring and evaluation remains relatively weak (although steadily improving), valuable project lessons are often learned too late and often not incorporated during the project implementation period. Moreover, ICRs are done too late in order to have a meaningful effect on follow-on operations. Some ICRs are not even completed within the 6-month period following project closing. Lastly, as discussed in earlier sections, the area of project ratings continues to be a problem, producing unrealistic project evaluations. One possible improvement could be to make the OED rating system available to project teams, which would provide more variety in ratings and also provide more consistency with OED final rating of projects.

Country Office involvement. Analysis shows that strong Country Office (CO) involvement is essential, has a positive influence on the outcome and performance of projects and is essential in countries with turbulent political climates, which from time to time prevent Bank Headquarters supervision missions. The analysis also shows that the close proximity of the PIU to the local Bank office may create an over-dependency on the local office to resolve day-to-day issues and puts enormous pressures on those staff involved. This situation has at times led to some clouding of the role of the local staff vis-à-vis PIU, Government and the Bank. A related issue is the ability of local staff to remain objective when faced with decisions that have a bearing on deep-seated cultural identity/allegiances.

Bank/Donor Coordination. Most donors provide support to the health sector in the ECA countries in the form of technical assistance and training. When coordinated with Bank investments, this cooperation has worked very well. However, when Bank/donor agreements were not available by negotiations, or when such agreements were not honored in the end, this created a risk that certain components would not be financed if donors could not come up with necessary funds. The lesson has been that entire project components should not be "given" to donors to finance, particularly if these components are critical to the achievement of the development objectives (Azerbaijan).

V. LOOKING FORWARD

Lessons for Future Bank Operations:

The following main lessons and recommendation are derived from the above analysis of the past performance of the Bank's health portfolio:

- **Good policy dialogue and design of health reforms is clearly extremely important** but not sufficient to sustain the difficulty of implementing projects in these countries. Good project implementation and project management remain key to successful implementation.
- **Government commitment and capacity is key and stakeholder involvement is essential.** Bank teams would be well-advised to avoid operations where commitment is weak. Borrowers need to be involved extensively in preparation (drafting TORs, PIP, PPPs, POMs, etc), rather than relying exclusively on Bank teams to prepare projects.
- **The complexity of project design needs to be examined and reduced**, whenever possible, and adjusted to the implementation capacity of the Borrower and the country's political economy. Since experience suggests that the design of health projects likely will remain complex, Bank and borrower teams must make extra efforts to ensure that design is flexible, that lessons are continuously incorporated into improved project design.
- It is essential that the Bank teams **pay close attention to the political and the institutional aspects of health reforms** and consult with a broad range of stakeholders to improve the relevance and the design of projects.
- **Adequate resources**, commensurate with intensive support provided by Bank teams to PIUs and governments in the design and supervision of projects, must be provided. Experience shows that tremendous hand-holding by Bank teams has been the norm, particularly for ECA borrowers new to the Bank. This support required substantial time, staff resources, reasonable workloads and travel schedules to allow staff and consultants to spend adequate time working with clients to develop projects. Although ECA countries are no longer new, the Bank health portfolio is extensive and requires strong Bank involvement and supervision, which must be supported with adequate resources.
- **Sector work (formal studies, seminars and/or focused studies) needs to be done before launching project preparation.** This normally results in greater consensus on project design by all counterparts and may lead to better and more focused projects.
- **Make more innovative use of lending instruments and better linkages to other projects and adjustment instruments.**
- **PIUs should not have central responsibility for overall project implementation.** The PIU should serve a coordinating and support function for the project, with substantive project implementation being carried out through the appropriate MOH and related agency departments. This would help to increase Borrower capacity and ownership.
- **Judicious use by the borrower of external project management assistance should be encouraged**, especially in the early stages of a project.
- **Timetables for implementation should be as realistic as possible.**

- **Implementation arrangements must be agreed upon, and preferably in place, during project appraisal.** This would significantly reduce delays in project start-up.
- The **preparation of ICRs should begin as early as possible**, a year or more before closing, particularly for those projects that have undergone considerable restructuring and cancellations.
- **Sound Bank supervision requires necessary staff mix** (including local staff). Project supervision must be more than simple procurement/disbursement supervision. It is essential to maintain a policy dialogue throughout the project period. Therefore, TTLs or their team members must have the ability to conduct effective policy dialogue and be conversant in health policy issues. The Bank teams should strive to be visible partners among others in the policy dialogue and be encouraged to use various means to advance policy dialogue, including seminars, conferences, workshops, meetings, etc.
- **Continuity in Bank teams should be encouraged**, particularly if the team is performing well.
- **Better donor-Bank collaboration and coordination is needed.** Also, assurances regarding donor financing prior to negotiations, particularly for essential project components and activities, are necessary.
- **M&E needs further improvement.** Suggestions for improvement include reducing the number of indicators; facilitating client understanding of what these indicators mean; more emphasis on early design of the M&E system; the use of project launch for this purpose; and intensive training of Bank staff in the methodologies for M&E.
- **Conduct follow-up studies** to see the impact of the project after several years following project closure. ICRs may not be enough.
- **PSR rating options should ideally be the same as those available to OED**, which would allow for more consistency in terms of comparability of ratings between the various Bank departments.

ANNEX 8.1: ECA HEALTH PORTFOLIO: FY1990-FY2003

Country	Project Name	Original Amount US\$ million	Status
Albania	Health Services Rehab.	12.4	closed
	Health Recovery	17	
Armenia	Health	10	
Azerbaijan	Health Reform	5.5	
Bosnia	Essential Hospital Services	15	closed
	War Victims	10	closed
	Basic Health	10	
Bulgaria	Health Sector Restructuring	26	closed
	Health Sector Reform	63.3	
Croatia	Health	40	closed
	Health System	29	
Estonia	Health I	18	closed
Georgia	Health	14	closed
	Hospital Restructuring Component	10	closed
Hungary	Health Services	91	closed
	Pension and Health Insurance Administration	132	closed
Kazakhstan	Health Restructuring	42.5	closed
Kyrgyz Republic	Health I	18.5	closed
	Health II	15	
Latvia	Health	12	
Lithuania	Health	21.2	
Macedonia	Health Sector Restructuring	16.9	closed
Moldova	Health Investment Fund	10	
Poland	Health Services Development	130	closed
Romania	Health Service Rehab.	150	closed
	Health Sector Reform	40	
Russia	Medical Equipment	270	closed
	CSIP (health component)	60	
	Health Reform Pilot	66	
Slovenia	Health Sector Management	9.5	
Tajikistan	Primary Health	5.4	
Turkey	Health I	75	closed
	Health II	150	
	Primary Health Care Services	14.5	closed
	Marmara Earthquake Emergency-Health comp.	13.5	
Uzbekistan	Health I	30	
Kosovo	Education/Health: Trust Fund Grant	2.4	
Total projects:	37	1655.1	18
Approved in FY2003			
Georgia	Health	20.3	
Moldova	AIDS Control	5.5	
Russia	Health Reform Implementation Project	30	
	TB/AIDS Control Project	150	
Bosnia	Social Insurance/Technical Assistance	5	
Serbia	Health	20	
Ukraine	TB/AIDS Project	60	
Total projects in FY2003	7	290.8	
TOTAL:	44	1945.9	18

ANNEX 8.2: OVERVIEW OF CLOSED PROJECTS: PLANNED VS. ACTUAL DISBURSEMENTS

Planned Disbursement Profile FY 91-04 (\$Million)																	
Project Name	Project ID	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	years	Total
1. Albania Health Service Rehab	26590				0.80	2.70	3.90	3.30	1.50	0.20						6.00	12.40
2. Bosnia - War Victims	28960						0.38	2.07	1.75	0.57	0.23					5.00	10.00
3. Essential Hospital Serv.	N0030							3.30	3.40	2.90	3.00	1.20	1.20			6.00	15.00
4. Bulgaria Health Sect. Restruct.	4000						2.00	6.30	10.30	6.00	1.00	0.40				6.00	26.00
5. Croatia Health	38430					7.70	18.10	14.00	0.20							4.00	40.00
6. Estonia Health	3835					1.50	2.70	4.10	6.30	3.40						5.00	18.00
7. Hungary Health Servs. & Mgmt.	3597		4.00	6.00	17.30	24.40	16.80	9.00	8.20	5.30						8.00	91.00
8. Hungary Pensions Admin. & Health	3596			8.00	14.00	27.30	38.50	28.10	16.10							6.00	132.00
9. Kazakhstan Health Restructuring	44570									1.00	5.50	11.50	10.00	8.00	6.50	6.00	48.50
10. Kyrgyz Health	28600							1.00	4.00	6.00	5.00	2.50				5.00	18.50
11. Macedonia Health Sect. Transt.	28890							6.20	8.20	2.50						3.00	16.90
12. Poland Health	3466		0.50	9.00	27.60	30.30	24.90	17.00	11.80	8.90						8.00	130.00
13. Romania Health Serv. Rehab.	34090		32.00	68.00	28.00	11.00	11.00									5.00	150.00
14. Russia Medical Equip.	40330							10.00	120.00	140.00						3.00	270.00
15. Turkey Primary Health Care Serv.	42010							2.10	4.10	5.90	2.40					4.00	14.50
16. Turkey Health	3057	8.00	8.00	12.00	15.00	15.00	12.00	4.00	1.00							8.00	75.00
			40.50	101.00	91.40	112.80	137.88	118.27	197.65	185.57	22.43	15.60	11.20			88.00	1072.80

Actual Disbursement Profile FY 91-03 (\$Million)																
Project Name	Project ID	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	No of years	Total
1. Albania Health Service Rehab	26590				0.00	0.80	1.62	1.00	0.35	1.59	4.50	2.00			8.00	11.86
2. Bosnia - War Victims	28960					0.00	0.00	0.81	1.38	2.45					5.00	9.64
3. Bosnia Essential Hospital Serv.	N0030							1.00	5.38	3.97	2.87	0.33	0.49	0.04	7.00	21.08
4. Bulgaria Health Sect. Restruct.	4000						0.00	0.05	5.73	0.97	4.12	8.84	1.69		7.00	21.40
5. Croatia Health	38430					0.00	4.03	23.88	3.41	5.05	2.56				6.00	38.93
6. Estonia Health	3835					0.00	0.05	0.58	1.82	7.25	7.00	0.10			7.00	16.80
7. Hungary Health Servs. & Mgmt.	3597			0.00	4.00	2.17	1.65	14.15							5.00	21.97
8. Hungary Pensions Admin. & Health	3596			0.00	8.00	2.03	3.66	3.51	10.97	1.24	6.70				8.00	36.11
9. Kazakhstan Health Restructuring	44570									0.00	1.77	3.89	2.32		4.00	11.98
10. Kyrgyz Health	28600							1.03	8.45	2.86	3.06	0.48	0.02		6.00	15.90
11. Macedonia Health Sect. Transt.	28890						0.00	0.33	0.76	0.77	2.63	3.96	6.09		7.00	14.54
12. Poland Health	3466		0.00	1.86	2.08	5.81	10.73	30.26	5.85	2.14	1.79	5.45	21.63	1.20	12.00	100.80
13. Romania Health Serv. Rehab.	34090		18.16	7.97	8.67	27.85	19.26	12.39	18.12	27.57	9.04				9.00	149.03
14. Russia Medical Equip.	40330							19.93	112.60	43.27	15.48	28.25	3.06		6.00	222.59
15. Turkey Primary Health Care Serv.	42010							0.00	0.00	0.00	0.32	0.03			5.00	0.35
16. Turkey Health	3057	0.62	0.44	5.81	8.45	12.07	16.28	4.17	-0.24	4.17	0.73				10.00	51.88
			18.60	15.64	31.20	50.73	57.28	113.09	174.58	103.30	62.57	53.33	35.30		112.00	744.86

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