Côte d'Ivoire: Basic Health Programme

Ex-post Evaluation Report

OECD sector	12220 – Basic health care	
BMZ project ID	1989 66 749	
Programme executing agency	Ministry of Health of Côte d'Ivoire	
Consultant	Saniplan GmbH	
Year of ex-post evaluation report	2008	
	Project appraisal (planned)	**Ex-post evaluation report (actual)**
Start of implementation	1st quarter 1990	3rd quarter 1991
Period of implementation	25 months	72 months
Investment costs	EUR 4.2 million	EUR 5.7 million
Counterpart contribution	EUR 0.6 million	EUR 2.1 million
Financing, of which FC funds	EUR 3.6 million	EUR 3.6 million
Other institutions/donors involved	-	-
Performance rating	3	
• Relevance	2	
• Effectiveness	--	
• Efficiency	3	
• Overarching developmental impact	--	
• Sustainability	3	

Brief Description, Overall Objective and Programme Objectives with Indicators

The Basic Health Programme, carried out between 1991 and 1995, comprised supplies of furniture and equipment (basic medical equipment, medicine and other consumables) as well as the rehabilitation of approx. 300 basic health facilities and two administrative buildings in the North of Côte d'Ivoire with the aim of improving basic health care at the primary health care level in predominantly rural areas.

The overall objective of the programme was to contribute to improving the health of the rural population in the regions Ouest (Man), Nord-Ouest (Odienné) and the eastern part of Centre (Yamassoukrou) as well as Centre-Nord (Bouaké) through better preventive and curative services. At final inspection, the weighted mean rate of infant infections with tetanus in the programme region was set as an overall objective indicator and quantified with a target of < 10/100,000 inhabitants. In the context of the ex-post evaluation, reductions in maternal and infant mortality rates were also applied as overall objective indicators. The programme objective was to improve the capacity and operational conditions of basic health care services. The annual rise in initial contacts per

capita or the rate of use of the basic health services in the catchment area was defined as programme objective indicator.

The target group comprised the entire, predominantly rural, population in the villages of the above-mentioned regions, which had no other access to treatment. Total costs at final inspection amounted to EUR 5.7 million, of which EUR 3.6 million were financed from the Financial Cooperation (FC) loan. The Ivorian Government contributed 37% to total costs.

Programme Design/Major Deviations from the Original Programme Planning and their Main Causes

As planned in the appraisal report, 301 basic health care facilities were renovated and supplied with furniture and essential medical equipment and instruments. Latrines and rubbish pits were installed at some. Contrary to planning at appraisal, however, refrigerators and mopeds were not procured, as these were provided under the FC-financed National Vaccination Programme (BMZ no. 1995 66 365). The procurement of medicine was also initially envisaged, but this was abandoned due to the EU-financed programme for reorganising the central pharmacy with a facility for revolving funds. The funds thus made available were then used to rehabilitate and equip the regional health administration in Man and the district health office in Guiglo. This was to contribute to improving working conditions in the new health districts. The renovation of the two health administration buildings was also intended as support for a TC programme for health and family planning advice (BMZ no. 1994 21 637). Additional repair works were also financed.

The Ivorian side increased the planned partner contribution in particular to offset the increased costs in the construction sector due to the devaluation of the Ivorian currency (F CFA) in 1994 and carry out supplementary repairs to the living quarters for male nurses and midwives. The programme made investments to increase the attractiveness of the modern health sector for patients but also for personnel in order to retain staff.

As already feared at appraisal, implementation by two institutions - the Direction et Contrôle des Grands Travaux (DCGTx) - today, the Bureau des Etudes Techniques de Développement (BNETD) - and the Ministry of Health - proved to be difficult. At programme appraisal, the plan was for DCGTx to bear responsibility for the proper execution of the building measures and the Ministry (with support from the consultant) for procuring equipment. The two agencies had considerable difficulties coordinating their work. BNETD also suffered from deficits in planning and supervision for lack of experience with small and micro building works. Altogether, the period of implementation was prolonged from the original 2 to 6.5 years, due in particular to delays in planning and tendering.

After a separate implementing unit, the Direction de l'Equipement, du Matériel et de la Maintenance (DEMM), was set up in the Ministry of Health in 1993/94 – renamed the Direction des Infrastructures, de l'Equipement et de la Maintenance (DIEM) as of 2007 - the FC programme was administered without further delay. DEMM acquired additional qualifications as part of the programme through the consultancy assignments (e.g. in tendering procedure, monitoring techniques, etc.). Cellule KfW, which was responsible for implementing the FC programme, still exists today and makes up part of

DIEM, which employs a total of 71 staff members but lacks the means to carry out repairs and maintenance in the health care facilities. DIEM has local counterparts in the regions, but these also lack resources.

The facilities to be renovated and equipped were selected according to international criteria (distance, demand, condition). The provided equipment was suitable for local conditions, except for the suction pumps that had to be retrofitted with foot pumps. The maintenance and carpentry work was carried out locally, which hampered supervision during execution and acceptance due to the large number of small works.

Key Results of the Impact Analysis and Performance Rating

As of the mid-nineties, Côte d'Ivoire underwent political unrest, culminating in 2002 in armed rebellion from the North and lasting until 2006. The whole of the North is still controlled by the rebel group, Forces Nouvelles, and only the South is in government hands. Altogether, the country is in a post-conflict situation, with all parties making peacebuilding efforts. Most donors had withdrawn from the country during the unrest and are now slowly returning. FC remained there as the only bilateral organisation to support the health sector, for which it is held in high regard by all stakeholders.

Due to the size of the country and the post-conflict situation, only five rural health stations could be visited during the ex-post evaluation; no data is available on the state of repair and utilisation of the other rehabilitated health care facilities. Moreover, the data collection and assessment of developmental efficacy needed for ex-post evaluation was also difficult as no evaluation could be conducted since programme completion in 1995 due to the national security situation. Altogether, it was difficult to assess the pre-war situation in retrospect.

The FC programme targeted the poor rural population in the country (marker ODP). The main intended beneficiaries of improved curative and preventive health services were women (prenatal care, mother-child health). It is allotted the marker G 1. Environmental protection was not an aim of the programme and any environmental impacts are negligible (environmental marker ER 0). The programme did not target participatory development/good governance and is therefore classified as PD/GG 0.

We assess overall developmental efficacy as follows:

Relevance: The results chain of raising capacities in basic health care by renovating and equipping peripheral basic health facilities to contribute to improving the health of the rural population was plausible. Promoting the basic health system was cited as a development policy priority of the Ivorian Government in the appraisal report. The importance it attached to this sector was also evident from the Ivorian financial contribution to the FC measures, which was higher than expected at programme appraisal; due to delays at the beginning of the programme, the Ivorian Government had to make additional investments for repairs before the FC-funded supplies could be delivered to the centres. Strengthening peripheral health centres for the rural population, especially for mothers and children, is still of high developmental relevance and promoting basic health services is cited as a goal in the Interim Poverty Reduction Strategy Paper adopted in 2002.

The programme made up part of a whole bundle of projects/programmes in the Ivorian health sector carried out by German Development Cooperation (other infrastructure projects of KfW and support programmes by GTZ) and other organisations (European Union, African Development Bank, Belgian Development Cooperation, JICA and many others). It is no longer possible to ascertain specifically how donor coordination functioned. The various donors did, however, evidently make their contributions at different, pre-defined intervention points (e.g. JICA with laboratory, sterilisation and operating equipment for 20 hospitals outside the German-Ivorian programme), so that possible overlaps were avoided through geographical demarcation of the individual projects/programmes. In the appraisal report, the programme conformed with the development principles of the German Government, whose policy in the 1990s was geared to satisfying basic needs. From today's vantage point, the programme would contribute to the attainment of MDGs 4 and 5 (lowering child and maternal mortality rates) and hence also contribute to the present central aims of German Development Cooperation, for which Côte d'Ivoire is not, however, a priority country. We assess the relevance of the programme overall as good (sub-rating 2).

Effectiveness: The programme objective was defined as improving the capacity and use of health facilities. Thanks to the FC programme, necessary construction and extension works were performed in the peripheral health care facilities in the programme region that are partly still available and in use today, some twenty years after programme appraisal. The indicator set to gauge programme objective achievement at final inspection (0.5 initial contacts per year/capita in the catchment population or 50% utilisation) has not been met today. One reason for this is that the population is too poor to even pay for the low treatment fees (in rural areas currently FCFA 100, i.e. EUR 0.15). All preventive services are free of charge, however, including prenatal care.

Only 0.15 initial contacts a year were recorded in the region visited (Dimbokro), in contrast to 0.26 in 1995, i.e. almost twice as many. A progress review in 1999 pointed out that one and sometimes two years after startup of the rehabilitated health care facilities the use indicators had not discernibly increased much above the level prior to the building measures. This report estimated the number of initial contacts per capita at 0.25 to 0.3 in 1997. It also stressed that public health care could not be improved just through better infrastructure but also through parallel or preparatory awareness measures in the population and/or the introduction of suitable tariffs.

Comparative figures for the period between the conclusion of the programme and the beginning of the political unrest are not available so that no statements can be made on changes in user rates after implementation of the FC measures. Altogether, the already low user rates in the 1990s have continued to decline, which apart from unwillingness and inability to pay is due to the lack of confidence of the population in public health services and the adverse effects of political unrest on medical care. For lack of comparative data on the use of the health care facilities before and after programme implementation (before the outbreak of unrest) and due to the probable distortions caused by the political crisis, no assessment will be made of effectiveness.

Efficiency: In ex-post evaluations, a distinction is usually drawn between production (input-output ratio) and allocative (input-impact ratio) efficiency. There are indications that the use of the equipped and renovated facilities was low (see effectiveness) and the benefit did not therefore warrant the investment costs, but no assessment of alloca-

tive efficiency will be made due to insufficient information on effectiveness and the inattributable causal links with overall objective achievement.

Total costs were estimated at EUR 4.24 million in the programme appraisal report. Actual costs exceeded this by 34%, however, to total EUR 5.72 million, largely as a result of the much more extensive renovation measures and consulting inputs due to the very protracted programme duration, which increased from the scheduled 25 to 72 months in the end. The assignment of executive responsibility to two agencies proved to be inefficient due to capacity and coordination problems. Because the work done by the small and medium-sized enterprises contracted for construction was in part unsatisfactory, numerous rectification measures had to be taken. Following the establishment of DEMM (1993/94) and its progressive qualification as programme executing agency, however, the situation improved considerably: after initial planning problems, actual implementation was speedy, taking only another two years (1995-96). This would seem remarkable, considering the 301 basic health stations scattered over 215 locations in all.

There are no indications of any misallocation of funds. For an estimated catchment population of approx. 1.7 million inhabitants in the rural districts, investment costs averaged EUR 3.30 per capita.

In view of the improvements made after the establishment of DEMM, efficiency is judged to be satisfactory (sub-rating 3).

Overaching developmental impact: The overall objective was to make a contribution to improving the health of the rural population in the target area, especially that of mothers and children. If we apply the maternal mortality rate as an indicator - as is current state-of-the-art for similar programmes - we can assess the effect as beneficial. Maternal mortality amounted to 810 per 100,000 live births in 1990 and declined to 543 in 2005, according to UNFPA. More than half of Ivorian women (56%) give birth in a public hospital (only 2% in private modern facilities). About one-third of women prefer to give birth at home, a relatively low percentage by West African standards. Pregnant women are often admitted to hospital to give birth to their children after being referred by the basic health services. We may therefore assume a correlation between the use of the health care facilities and the improvement in maternal health; no verifiable evidence is, however, available.

Another state-of-the-art overall objective indicator is the reduction in infant mortality. This amounted to 96 per 1,000 live births according to the programme appraisal in 1999 and increased to 118 per 1,000 by 2004 (WHO 2006), which can in part be attributed to the deterioration in the conditions of life due to the political crisis. In the final inspection, the weighted mean rate of newborn children infected with tetanus in the programme region was specified as the overall objective indicator and quantified with a target of < 10/100,000 inhabitants. In 1995, the incidence of infections amounted to 7.3/100,000 inhabitants. For lack of current comparative figures, changes in infection rates cannot be traced. The national vaccination programmes were not, however, interrupted during the political unrest, so that the vaccination rate is currently about 90%, according to the Ministry of Health.

Altogether, some 13 years after completion of the programme and the military-political crisis, it is difficult to gauge the impact and the causal chain is virtually unverifiable,

particularly also as no information is available on user rates for the health centres after startup. No assessment of the overarching developmental impact will therefore be made.

Sustainability: The sustainability of the programme can be measured by the continued use the population makes of the facilities rehabilitated by FC in the programme area, particularly women. Equipment and fittings supplied by FC are still in use there. The facilities are in a poor state of general repair today, though, because almost all the roofs are leaky. The centres were already built in the 1980s and rehabilitated by FC in the 1990s, so that the effects of wear and tear today are quite normal.

The districts have received next to no revenue of their own for years now. In the mid-nineties they were already complaining of the insufficient funds allocated to the maintenance units at district level to carry out maintenance and repair works in the scattered health centres. The Ministry of Health cannot afford to make the necessary investments for upkeep, either, due to the precarious position at present. The European Union has, however, just started with a large-scale reconstruction programme in the North of the country, which also includes peripheral health care facilities in the programme region.

Besides the central ministry and attached directorates, there are 19 regional offices in the Ivorian health care system today that coordinate and supervise 72 health districts. Every district has a referral system to support the health stations at primary level, which is, however, hardly operational at present, due to the domestic crisis. Transport alone has been posing a problem for some time, which is also likely to hamper health care improvements in the near future for lack of funding.

The Comités de Gestions still operate in almost all the facilities inspected. These were set up as part of German development cooperation programmes especially for financial oversight over the centres and also for ordering medicine via (functioning) revolving funds.

Altogether, due to the precarious post-conflict situation (peace plan with forthcoming presidential election, limited national budget, relatively few donors and problems with domestic migration and the remigration now taking place to the devastated areas), it is particularly difficult to make any statements about the future sustainability of the measures. Considering that the equipment and facilities supplied by the FC programme still function and/or remain in use, sustainability is, however, assessed as satisfactory (subrating 3).

Weighing up the subratings for relevance, efficiency (production efficiency) and sustainability and accounting for the above cited constraints, we assess the developmental efficacy of the programme as satisfactory (rating 3).

General Conclusions and Recommendations

Investments to promote basic health facilities remain important to give poor people in particular - the majority of the rural population - access to medical services that at least guarantee basic care and are engaged in prevention, including child vaccinations and prenatal care. At the same time, a functional maintenance system needs to be upheld as far as possible to sustain the investments made.