AFRICAN DEVELOPMENT BANK GROUP

BOTSWANA

FRANCISTOWN NEW HOSPITAL PROJECT

Project Performance Evaluation Report (PPER)

OPERATIONS EVALUATION DEPARTMENT
(OPEV)

6 March 1996

ABBREVIATION2

ADB	African Development Bank
EPCP	Economic Prospects and Country Programming Report
MOH	Ministry of Health
MOWTC	Ministry of Works. Transport and Communications
PCR	Project Completion Report
PPAR	Project Performance Audit Report
UA	Unit of Account (ADB)

CURRENCY EQUIVALENTS

(Average Exchange Rates)

Year					Index
1983	1 UA	=	Pula	1.16553	100
1984		=		1.27838	
1985		=		1.77822	
1986		=		2.23123	
1987		=		2.18473	
1988		=		2.36900	
1989		=		2.60391	
1990		=		2.50566	
1991		=		2.69272	
1992		=		3.00352	
1993	Jan.-March	=		3.08290	264

WEIGHTS AND MEASURES

1	Kilogramme (kg)	=	2,204 lb
1.000	Kg	=	1 metric ton (mt)
1	Kilometre (Km)	=	0.62 miles
1	Metre (m)	=	1.09 yards
1	Square metre (m2)	=	10.76 square feet
1	Acre (ac)	=	0.405 hectare (ha)
1	Hectare (ha)	=	2.47 acres

GOVERNMENT FISCAL YEAR

1 April - 31 March

Table of Contents

		Pages
Preface		iii
Basic Loan/Project Data		iv
Abbreviated Project Performance Audit Report		
1.	Introduction	1
2.	Identification, Design. Preparation and Appraisal	1
3.	Implementation	2
4.	Results	3
5.	Performance of Parties	6
6.	Sustainability and Development	6
7.	Conclusions, Lessons and Recommendations	6

This Abbreviated Project Performance Audit Report is based on the findings of a Bank Group post-evaluation mission mounted in May/June 1995, comprising Mr I.B.C. John. Director. Operations Evaluation Office and Mr H.D. Akroyd, Principal Post-Evaluation Officer. Enquiries concerning the content of this report should be addressed to Mr I.B.C. John, Director, Operations Evaluatiori Office on Extension 4089.

PREFACE

1. This Abbreviated Project Performance Audit Report (PPAR) reviews the Francistown New Hospital Project of the Government of the Republic of Botswana for which an ADB loan equivalent to UA 17.96 million was approved in September 1983. Other funds were provided by the Government (UA 6.98 million) and by means of a French grant (UA 6.00 million) bringing the planned total project cost to an equivalent of UA 30.94 million.

2. The sector goal was to improve the health status of the target population of 300,000 persons within the hospital catchment area. The planned project objective was the provision or production of more and improved tertiary level, referral health care services on a sustainable basis. Planned outputs were the construction of a referral hospital, the rationnlisation of existing midwifery training facilities and the provision of a Project Implementation Unit within the Ministry of Works, Transport and Communications (MOWTC) together with project works technical assistance staff. Implementation activities concerned the approval of building designs. the procurement of goods and services and the construction. equipping and staffing of the health care facilities.

3. The Borrower was the Government, the Executing Agency the MOWTC and the Beneficiary Agency the Ministry of Health (MOH). The planned project implementation period was 45 months from July 1983 to March 1987.

4. This Abbreviated PPAR is based on data contained in the appraisal report and PCR. The main purpose of this Abbreviated PPAR, prepared by the ADB Group's Operations Evaluation Office (OPEV) is to complement the information assembled to-date, examining in greater detail various aspects of the project and describing the findings of the post evaluation mission which conducted investigations in Botswana in May/June 1995. The PPAR presents conclusions regarding the performance, achieved results and potential sustainability and development of the project together with lessons and recommendations for the consideration of the Government and the ADB Group.

5. Copies of this report have been circulated to the Operations Departments of the ADB Group and to the Borrower, Executing Agency and Beneficiary Agency. The comments received have been reflected in the text.

BASIC LOAN/PROJECT DATA

1.	Country	Republic of Botswana
2.	Project	Francistown New Hospital Project
3.	ADB Loan No	CS/BSW/H/84/011
4.	Borrower	Government
5.	Executing Agency	Ministry of Works, Transport and Communications
6.	Beneficiary Agency	Ministry of Health
7.	Planned Implementation Period	July 1983 to March 1987 (45 months)

A	LOAN DATA	Approved	Actual
	UA million equivalent	17.96	14.96
	Cancelled		3.00
	Duration (years)	20	20
	Grace Period (Years)	5	5
	Interest (% pa)	9.5	9.5
	Statutory Commission (% pa)	1.0	1.0
	Commitment Charge (% pa)	1.0	1.0

Source: PCR page (i)

	Planned	Actual
Loan Negotiations		1 Sept. 1983
Approval		25 Sept. 1983
Signature		10 May 1984
Entry into Force		26 July 1985

B. PROJECT DATA

1. Cost (UA million)

	Appraisal	Negotiations	Actual
Government	6.33	6.98	7.55
ADB*	16.25	17.96	14.96
France	6.00	6.00	6.00
Totals	28.58	**30.94**	28.51
Pula Equivalent (million)	33.34	36.94	61.15

Source: PCR page (i)

* Loan balance equivalent to UA 3.00 million cancelled (ADB Summary Statement of Loans - ADB/BD/IF/95/139 of 7 June 1995 - page 14)

2.	Deadline for First Disbursement	30 June 1985
3.	Actual First Disbursement	18 December 1985
4.	Actual Last Disbursement	27 February 1992
5.	Deadline for Last Disbursement	3 1 December 1988
6.	Loan Balance Cancellation	30 March 1994

	Planned	Actual
Project Completion Date	March 87	July 1991
Hospital Commissioning Date	March 87	June 1988

C. PERFORMANCE INDICATORS

		Months
1.	Approval to Entry into Force	22
2.	Planned to Actual Completion	52
3.	Implementation Status	Completed
4.	Institutional Performance	Partially Satisfactory
5.	ADB Performance	Partially Satisfactory
6.	Project Performance	Partially Satisfactory

D. MISSIONS

		Date	No. of Persons	Person-Days
Appraisal		04/83	2	28
Supervision	(i)	05/04/86 - 13/04/86	1	9
	(ii)	04/03/87 - 06/03/87	2	6
	(iii)	21/04/89 - 03/05/89	2	24
Follow-up	(i)	27/07/87 - 08/08/87	1	12
	(ii)	14/04/89 - 30/04/89	3	45
PCR		25/09/90 - 12/10/90	3	54
		19/04/95 - 01/05/95	2	26

Source: PCR p (iv)

E. **DISBURSEMENTS**

ADB Loan equivalent to UA 17.96 million.

Year	Loan Negotiations	Actual by Year	Actual Cumulative
83/84	0.26		
84/85	4.62		
85/86	7.64	1.65	1.65
86/87	5.44	3.76	5.41
87/88		6.00	11.41
88/89		1.54	12.95
89/90		0.86	13.81
90/9I		0.00	13.81
91/92		1.15	14.96
Totals	17.96	14.96	14.96
Cancelled		3.00	3.00

Sources: Summary Ledger (22/03/ 1995).

1. INTRODUCTION

The status of the economy, of the health sector and of health sector institutions in Botswana in 1983 are well presented in the project appraisal report (ADB/BD/WP/83/101) of 8 August 1983. The economic and social situations in contemporary Botswana are well analysed in the EPCP (ADB/BD/WP/93/49 and ADF/BD/WP/93/54 of 1 July 1993).

2. IDENTIFICATION, DESIGN, PREPARATION AND APPRAISAL

2.1.1 The Jubilee Hospital in Francistown was built in the 1920s with a capacity of 150 beds (later increased to 190 beds). In order to keep pace with the rising demand for health services, the original had been developed on an ad-hoc basis. By the late 1970s it had become evident that a new hospital was required. The new hospital (380 beds) would deal only with referral and emergency cases. Out-patient services and referral procedures would be provided by Town Council clinics in Francistown. which would be upgraded such that they could provide consultation and referral services on a 24-hour basis. The upgrading of the clinics was not placed within the ambit of the project but constituted a complementary activity to be carried out by the Town Council and/or the Government (see the assumptions in the retrospective logical framework matrix which is presented in the PCR).

2.1.2 The envisaged sector goal was to improve the health status of the target population of 300.000 persons within the hospital catchment area. The planned project objective was the provision or production of more and improved tertiary level, referral health care services on a sustainable basis in north-eastern Botswana, in accordance with the goals of the Fifth National Development Plan. Planned outputs were the construction of a referral hospital. the rationalisation of existing midwifery training facilities and the provision of a Project Implementation Unit (within the MOWTC) together with project works technical assistance staff. Implementation activities concerned the approval of building designs, the procurement of goods and services and the construction, equipping and staffing of the health care facilities. The project's cause and effect hierarchy is well presented in the retrospective logical framework matrix presented in the PCR. Comprehensive details are presented in Chapter 2 of the PCR.

2.1.3 The Borrower was the Government, the Executing Agency the Ministry of Works, Transport and Communications (MOWTC) and the Beneficiary Agency the Ministry

of Health (MOH). The revised planned cost agreed at Loan Negotiations was equivalent to UA 30.94 million funded by the Government (UA 6.98 million), ADB (UA 17.96 million) and France (UA 6.00 million). Full details of planned (and actual) project costs are contained in the PCR (Section 4.6). The planned activities implementation period was 45 months from July 1983 to March 1987.

2.1.4 The justification for a new hospital was sound. Designs were prepared by a consulting firm. The ADB did not mount a preparation mission (PCR para 3.1.7). The project was appraised in April 1983 and an ADB loan of UA 16.25 million was approved in September 1983. Prior to loan signature in May 1984 this was increased to UA 17.96 illion. In the light of subsequent design revisions (para 3.1.2 below) the ADB should have ounted a preparation mission. At the time of appraisal the Government had not carried out a y survey of the clinics to be upgraded - so as to determine the extent of works and costs i volved (PCR para 2.3.12). It would appear that the quality of project design, preparation a d appraise1 could have been better.

3. IMPLEMENTATION

3.1.1 The ADB loan entered into force in July 1985 some 22 months after approval. The reasons for this time slippage were the late signature of a design consultancy contract and delay in appointing an equipment consultant (PCR para 4.1.4).

3.1.2 The PCR (Section 4.2) presents details of project design revisions; the main ones of which concerned an increase in the floor area of the hospital (by 19%) and of the midwifery school (by 6%) and a reduction in the number of nurses to be trained: from 25 to 18 (PCR paras 2.4.1 and 4.2.8).

3.1.3 No procurement problems arose in relation to goods and services to be financed by the ADB. However problems arose concerning the procurement of equipment financed by the Government of France (PCR para 4.5.1). The quality of the French equipment delivered was unsatisfactory

3.1.4 Implementation delays were experienced (PCR para 4.1.4) concerning lack of coordination between construction works and the supply of French equipment, design

revisions, problems experienced in reaching agreement concerning the upgrading of clinics and the failure of potential training candidates to meet the minimum entry requirements of training institutions external to Botswana - a problem also experienced in Swaziland (Swaziland: Health Services Development Project - PPAR reference ADB/BD/WP/95/21).

3.1.5 The new hospital was commissioned in June 1988 with a delay of 15 months - in relation to the planned completion date of March 1987. The overall project was technically completed in July 1991 - at the end of the nurses training programme.

3.1.6 Comprehensive details of planned and actual costs by category of cost, financing agency and year are presented in the PCR (Section 4.6). Overall cost savings were achieved equivalent to UA 2.43 million. ADB loan "savings" equivalent to UA 3.00 million were achieved. the loan balance equivalent to UA 3.00 million being cancelled at the request of the Government in March 1994 (PCR para 4.6.9).

3.1.7 The PIU submitted quarterly project progress reports to ADB on a regular basis (PCR para 4.4.1). No audit reports were submitted and ADB staff did not take action on this issue.

4. RESULTS

4.1.1 The hospital was constructed and equipped with an element of delay. The medical equipment supplied included inferior items. The only part of the training programme (funded by ADB) to be implemented was the upgrading of nurses to specialist nurses - implemented with delay and cost escalation; resolved by means of a reduction from 25 to 18 in the number of nurses trained.

4.1.2 The hospital is well built but has some inadequacies, for example the TB and psychiatric wards still remain at the old Jubilee Hospital site. It has also now been discovered that the hospital was built on a former mining site and one instance of ground subsidence has already occurred.

4.1.3 With regard to the complementary clinics upgrading programme: the appraisal report of August 1983 stated (para 3.6.10) that the Francistown Town Council operated three

major clinics, at Tati Town, Monarch and Somerset East; and that (para 5.5.1) the clinics would have to be converted so as to provide a 24-hour service, seven days per week. Such improvements would be jointly funded by the Government and the Francistown Town Council (para 3.6.11). However the only Town Council clinic to operate, as envisaged at appraisal, on a 24-hour per day basis, is the Jubilee Clinic: yet it has no beds, cannot handle maternity cases, cannot carry out TB and AIDS laboratory tests and has a doctor present only in the mornings. It is unclear why this situation has not been pursued by the Government (and by the Bank Group) when Town Council activities are to a large extent dependent upon the provision of central Government grant funds. It is clear that complete compliance with "Other Loan Conditions" was not achieved (PCR para 3.2.3).

4.1.4 With regard to the operational performance of the hospital: the hospital suffers, as does the health sector as a whole, from severe shortages of professional and technical staff at all levels. Some wards in the new hospital are closed and staff are obliged to work long hours. This is aggravated by weaknesses in the referral system (para 4.1.5 below). The number of nurses trained was reduced, yet the most significant shortage of staff at the hospital is nurses (PCR para 6.2.2). The issue of the. health sector staffing is being addressed, but will take time to resolve. The provision of maintenance and repair services is satisfactory as is the supply of drugs and other consumable items.

4.1.5 As concerns the project objective: according to the project description given in the appraisal report, this hospital was conceived and designed as a tertiary level referral hospital. However it now also has to provide secondary and primary level health care services: because Francistown does not have a secondary level district hospital and the "Other Loan Conditions" concerning the complementary provision of improved primary level services by Town Council clinics (under the aegis of the Ministry of Local Government) has not been met. As a result there is now a fundamental problem concerning the operation of the health care services referral hierarchy. The crucial issue at present is that of how to introduce and maintain a coherent provision of primary, secondary and tertiary level health care services and an adequate referral system in Francistown and northern Botswana (allied to the introduction of a health services user fees system). Certainly more dialogue is required among all concerned parties. This is of particular importance in the context of plans now in hand for the provision of a medical school in Botswana and the possible use of Francistown Hospital as part of the teaching hospital network in the country.

4.1.6 Thus the quantity and quality of health care services provided or produced have improved (PCR Section 7.1) but not to the maximum extent possible or envisaged. Inadequacies in the referral system also lead to a misdirection of scarce resources (PCR paras 5.2.3 to 5.2.6).

4.1.7 With regard to the sector goal, the achievement of improvements in the health status of the target population: the PPAR mission team was unable to obtain either comprehensive time series data concerning national health sector statistics or a copy of the Annual Report of Francistown Hospital. The PCR provides data (PCR Section 5.1 and Annexes II and III) relating to causes of in-patient mortality and out-patient morbidity for one point in time (1991-1992). The PCR also states (PCR para 5.1.1) that "AIDS has become the most dramatic threat to health". In short it is impossible, in the absence of MOH epidemiologic and demographic time series data, to determine whether the health status of the populations in north-eastern Botswana and in the country as a whole is improving or deteriorating over time. A significant planning and management weakness in the MOH system is the absence of a sound and comprehensive Health Management Information System.

4.1.8 Broad national data, published by UNICEF, show improvements over the past thirty years as follows:

Table 1

Demographic Data 1960 and 1991

Indicator	1960	1991
Under 5 mortality rate	169	85
Infant mortality rate	116	62
Crude death rate	20	10
Crude birth rate	52	39
Life expectancy	46	60

Source: UNICEF "The State of the World's Children 1993", pages 68 and 76.

Such results are founded on improvements in the provision of health care facilities and services and also on improvements in sanitation, water supply and nutrition.

5. PERFORMANCE OF PARTIES

5.1.1 The performances of the Borrower and Executing Agency are judged to be partially satisfactory due to the limited compliance with "Other Loan Conditions" concerning th: planned operation of the town clinics, the absence of a comprehensive Health Management Information System in Botswana and the fact that the patient referral system could work much better than it does at present.

5.1.2 The performance of the ADB Group is judged to be partially satisfactory based on the facts that there was no preparation mission, the absence of follow-up action concerning the non-provision of loan and project audit reports, the limited attention paid to assessing the achievement of the sector goal and the insufficient attention paid to problems surrounding the sources and provision of health care staff.

5.1.3 Overall the project is judged to be partially satisfactory.

6. SUSTAINABILITY AND DEVELOPMENT

Much requires to be done if the quantity and qual-ity of health care services provided are to be improved, sustained and developed (PCR Section 7.3). One critical area concerns staff shortages at all levels. A study has been initiated concerning the possible provision of a medical school in Botswana. The referral system should be improved, allied to the use of complementary incentive cost recovery systems - devised in such a way that poorer members of society are not thereby excluded from the health care services delivery system. Again planning is hindered by the absence of a comprehensive Health Management Information System - to be employed as a planning and management tool.

7. CONCLUSIONS, LESSONS AND RECOMMENDATIONS

7.1 Conclusions

7.1.1 In general this project was well identified, designed and appraised and represented a good response to a perceived need in north-eastern Botswana. During the course of activities implementation various design revisions became necessary some of which

could have been pre-empted had the ADB Group mounted a preparation mission. Limited attention was paid at appraisal to arrangements whereby the achievement of the project objective and sector goal could be monitored and evaluated. Compliance with the "Other Loan Conditions" concerning the upgrading of the town clinics was not fully achieved. In retrospect upgrading arrangements should have been fully studied and costed prior to appraisal.

7.1.2 The health care facility (the Francistown Hospital) has been established but its envisaged operational status and the provision of health care services are constrained by staff shortages particularly of nurses and by the fact that Botswana does not have a sound health care services referral system. Health planning and management (particularly in terms of statistics. financial and human resources planning and management) are constrained by the absence of a cornprehensive and integrated Health Management Information System. For this reason it is also difficult to evaluate objectively the extent to which the sector goal has been achieved. Project sustainability and development in Botswana really comes down to the provision of health care staff at all levels - a problem which will only be resolved in the longer term. The project is thus judged to be partially satisfactory.

7.2 Lessons

Key lessons are as follows:

1. Had appropriate analyses and costings been carried out prior to appraisal concerning the renovation, upgrading and staffing of the town clinics then it would have been more likely that this complementary output would have been achieved to the full satisfaction of all concerned parties.

2. Had the design consultants been given the responsibility for the preparation of lists and specifications of medical equipment and furniture then some of the problems and activities implementation delays encountered could have been avoided.

3. Had certain decisions concerning the design of the Midwifery School been taken prior to appraisal then some activities implementation problems encountered could have been avoided.

4. Problems concerning the sources and supply of required staff should have been studied prior to appraisal: particularly the need to improve the qualifications of school leavers such that they might gain entrance to training institutes external to Botswana (see also Swaziland: Health Services Development Project, PPAR ref ADB/BD/WP/95/2 1 para 2.11.3).

5. The four problems above might have been recognised at a much earlier date had the ADB Group mounted a dedicated technical preparation mission.

6. The project site now suffers land subsidence problems, which might have been avoided had appropriate and thorough pre-appraisal legal and other surveys and investigations been carried out concerning prior land usages.

7. The ADB Group's required loan and project audit requirements were consistently ignored. by all concerned parties.

8. The absence of a comprehensive Health Management Information System in Botswana greatly inhibits sound planning and management activities in the health sector.

9. Due to the fact that the patient referral system in Botswana operates in a very imperfect manner, the new tertiary level hospital in Francistown is obliged to operate as a primary, secondary and tertiary level unit. This in turn gives rise to the misdirection of scarce human and other resources.

7.3 Recommendations

Key recommendations are as follows:

1. Efforts should be made to improve primary health care facilities and staffing in Francistown (along the lines originally planned) so that the hospital has a better chance of operating in the manner intended at appraisal.

2. Efforts must be maintained to overcome staffing constraints encountered. Solutions lie in the areas of improving the qualifications of school leavers so that they can gain entry to training institutions and in improving the incentives and career development structure for staff already working in the health sector.

3. More input is required into the development of a comprehensive Health Management Information System (along the lines of that being instituted in Zimbabwe).

4. Much requires to be done concerning the creation of an efficient patient referral system in Botswana - allied to the development of a user charges system which encourages patients to follow the intended referral path.