



Report Number: ICR00004520

## 1. Project Data

**Project ID**

P129663

**Project Name**

System Enhancement for Health (SEHAT)

**Country**

Afghanistan

**Practice Area(Lead)**

Health, Nutrition &amp; Population

**L/C/TF Number(s)**

IDA-H8290,TF-15005,TF-95691

**Closing Date (Original)**

30-Jun-2018

**Total Project Cost (USD)**

550,455,531.21

**Bank Approval Date**

28-Feb-2013

**Closing Date (Actual)**

30-Jun-2018

**IBRD/IDA (USD)**
**Grants (USD)**

Original Commitment

100,000,000.00

492,000,000.00

Revised Commitment

585,452,053.69

462,384,129.14

Actual

558,425,869.76

462,384,129.14

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IEGHC (Unit 2)

**Project ID**

P152122

**Project Name**

AF Additional Financing SEHAT ( P152122 )

**L/C/TF Number(s)**
**Closing Date (Original)**
**Total Project Cost (USD)**

0

**Bank Approval Date**

25-May-2015

**Closing Date (Actual)**



	IBRD/IDA (USD)	Grants (USD)
Original Commitment	0.00	0.00
Revised Commitment	0.00	0.00
Actual	0.00	0.00

## 2. Project Objectives and Components

### a. Objectives

According to the Financing Agreement, the objectives of the project were to "expand the scope, quality, and coverage of health services provided to the population, particularly to the poor, in the project areas, and to enhance the stewardship of the Ministry of Public Health (MOPH)." Statements of objectives were consistent in the Project Appraisal Document (PAD) and ICR.

At the start of the project in May 2013, the initial project areas involved 21 of the country's 34 provinces. A Level 1 restructuring in June 2015 provided additional financing (AF) and included 13 additional provinces under project funding that was administered by the Bank under a consolidated trust fund (see Section 2e). The statement of project objectives remained unchanged, but two outcome indicators were modified to make them more measurable, and other targets were modified to reflect expansion of services to the 13 additional provinces. Given that the scope expanded with restructuring, this review does not apply a split evaluation rating.

### b. Were the project objectives/key associated outcome targets revised during implementation?

Yes

**Did the Board approve the revised objectives/key associated outcome targets?**

Yes

**Date of Board Approval**

12-Jun-2015

### c. Will a split evaluation be undertaken?

No

### d. Components

**1. Delivering and improving the Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) (Appraisal US\$307.0 million; AF US\$223.1 million, both aggregating at US\$530.1 million; Actual US\$520.5 million).** This component was designed to deliver an expanded version of essential services in 21 provinces, including new health care services with a key focus on



malnutrition. Among those provinces, all but three had BPHS and EPHS services delivered through non-governmental organizations (NGOs), and three provinces had these services delivered directly through the MOPH. This component also sought to build workforce capacity and upgrade health system infrastructure, including training of community midwives and nurses (psychosocial counselors), and upgrading facilities to provide key services and diagnostics. The component included an impact evaluation of performance-based contracts. The 2015 restructuring accommodated 13 additional provinces (see Section 2a).

**2. Building stewardship and capacity of the Ministry of Public Health (MOPH) and system development (Appraisal US\$90 million, Revised US\$38.5 million, Actual US\$14.92 million).** The component intended to strengthen provincial health departments through funding, training, and technical assistance, including in human resources, information systems, pharmaceutical regulatory mechanisms, and quality assurance; engagement with the private sector; health promotion campaigns; and financial management and procurement capacity.

**3. Strengthening Program Management (Appraisal US\$10 million, AF US\$22 million, Actual US\$13.6 million).** The component was to support project management, training, and staff positions.

**e. Comments on Project Cost, Financing, Borrower Contribution, and Dates**

Project cost and financing: Total estimated project costs amounted to US\$622 million. The actual cost was US\$558.4 million, although the ICR, p. 4, highlighted inconsistencies in cost recording.

Financing: The project consolidated funds from donors into a single financing mechanism, the Afghanistan Reconstruction Trust Fund (ARTF). The ARTF grant (TF-15005) amounted to US\$270 million at the start of the project, and with AF, the fund's total reached US\$480 million. IDA provided a grant of US\$100 million, and the Health Results Innovation Trust Fund (TF-95691) provided US\$12.0 million. The Borrower contribution was estimated at US\$30 million at appraisal, but was not provided (ICR, p. 4).

Note on additional parallel support: The project was supported by technical assistance and other support from the United Nations International Children's Emergency Fund, the World Health Organization (WHO), the Global Fund to Fight AIDS, TB and Malaria, and the Global Alliance for Vaccines and Immunization.

Dates: The project was approved on 2/28/13. A restructuring provided AF on 5/25/15. A Mid-Term Review was undertaken on 5/17/16. The project closed on 6/30/18 as originally planned.

### 3. Relevance of Objectives

#### Rationale



Project development objectives were relevant to country priorities, and pursued health development efforts undertaken through previous Bank-supported projects. Afghanistan had experienced improvements in vital statistics such as lower infant, child, and maternal mortality and increased life expectancy at birth. Expanding BHPS and EHPS sought to address related health sector challenges and to continue progress on maternal and child health gains. Also, there were health inequalities between high-income and low-income populations, and 55% of Afghani children had chronic malnutrition. The health system was not adequately providing health services to the poor, particularly in rural areas, and MOPH's capacity was weak to oversee service delivery. At appraisal, the project was informed by the country's 2012 Interim Strategy Note aiming at stronger institutional capacity and equitable service delivery.

At project closing, the objectives remained fully relevant to the Bank's Country Partnership Framework FY17-20 (CPF) under pillars 1 and 3. Pillar 1 aims to build strong and accountable institutions, to enable the state to fulfill its core mandate to deliver basic services to its citizens, and to create an enabling environment for the private sector. Component 2 of the project aligned with this pillar by establishing stronger stewardship capabilities. CPF Pillar 3, "to deepen social inclusion through improved human development outcomes and reduced vulnerability among the poorest sections of society," was reflected by the project's aim at improving health outcomes with a focus on the poor. Project objectives were also aligned with the Health, Nutrition and Population (HNP) Global Practice Priority Directions for 2016-2020, notably for "Service Coverage – ensuring equitable access to affordable, quality HNP services" (ICR, p. 15).

## Rating

High

## 4. Achievement of Objectives (Efficacy)

### OBJECTIVE 1

#### Objective

Expand the scope of health services provided to the population, particularly to the poor, in the project areas

#### Rationale

According to the ICR (p. 16) and the PAD, and for the purposes of this review, "scope" was understood to include expansion of BPHS services reflecting additional or new services, mainly to treat malnutrition. Other additional services included mental health, disability and rehabilitation, and primary eye care geared towards treating injuries.

The theory of change for this objective focused on supply-sided interventions providing such services with a primary focus on malnutrition. Activities included the contracting of NGOs to provide essential health services, training, deployment of nutrition counselors, upgrading of primary facilities, procuring diagnostic technologies, medical supplies and equipment, and providing micronutrient supplementation. Additionally, interventions were supported by the deployment of new staff that included physiotherapists in each district hospital and psychosocial nurse counselors. It was reasonable to expect that the above activities would contribute to expanding the scope of BPHS and EHPS with a focus on rural underprivileged areas. (In turn, but as a long-



term impact, the expansion of such services would plausibly contribute to improving the nutritional status of children and adult mental health).

### **Outputs and intermediate results**

1,028 health facilities (out of a total of 1,922 facilities in the country) provided new services to treat severely malnourished children. Treatment was provided to 236,121 acutely malnourished children in 2014; 315,890 in 2015; 400,488 in 2016; and 457,000 children in 2017.

The project built 292 Health Sub-Centers and 48 Family Health Houses in rural areas that did not previously have such facilities.

The project upgraded 259 existing health facilities, including laboratories.

Training was provided to 1,800 female nutrition counselors, and the project deployed female nutrition counselors to 18 provinces in which child malnutrition was high.

A physiotherapist was hired for each district hospital.

Each community health center was provided with a nurse trained as a psychosocial counselor.

The contracted NGOs delivered health services while adapting to local conflict situations and by forging alliances and agreements with local leaders.

### **Outcomes**

The proportion of children under five years with severe acute malnutrition who were treated with micronutrient supplementation increased from 24% in 2013 to 77% in 2018, exceeding the target of 55%. In conjunction with this outcome, the percentage of pregnant and lactating women who received counseling on infant and young child feeding increased from a zero baseline in 2013 to 58% in 2018, exceeding the target of 50%.

Note on targeting the poor: As it was difficult to assess project outcomes “particularly to the poor” by measuring impact that was specific to the lowest quintile, the ICR (p. 23) argued that a broader lens would be more appropriate in the context of this project that served underprivileged rural populations and funded interventions specifically chosen to address the health needs of the poor. The ICR argued that with a national poverty rate of 55% (2016-17), rural population would be an adequate proxy. The project established primary care facilities and used mobile services to deliver care in so-called “white areas” in rural communities where there had been no previous service delivery (ICR, p. 25), including displaced populations. It also stated that disparities in coverage and utilization across quintiles were much smaller than in other countries affected by fragility, conflict, and violence (FCV).

### **Rating**



High

## **OBJECTIVE 2**

### **Objective**

Expand the quality of health services provided to the population, particularly to the poor, in the project areas

### **Rationale**

In addition to activities noted above under Objective 1, it was reasonable to expect that pre-service and in-service training, workforce strengthening with community midwives and nurses, service protocols and guidelines, construction and upgradation of facilities with appropriate equipment, and provision of medical supplies and diagnostics would contribute to improving health service quality.

### **Outputs**

As above under Objective 1, including training for new community midwives and nurses, in-service training to medical staff, and enhancement of infrastructure and diagnostic capabilities.

In addition, health facility surveys were undertaken in 807 facilities to construct a Balanced Score Card for assessing service quality.

### **Outcomes**

The score on the balanced scorecard examining quality of care in Sub-Centers, Basic Health Centers, and Comprehensive Health Centers increased from a baseline of 55% in 2013 to 59.3% in 2018, short of the target of 70%.

The note on targeting the poor as discussed above under Objective 1 also applies here.

### **Rating**

Modest

## **OBJECTIVE 3**

### **Objective**

Expand the coverage of health services provided to the population, particularly for the poor, in the project areas

### **Rationale**

The rationale above under Objectives 1 and 2 also applies here, and it was reasonable to expect that the listed interventions would contribute to increased utilization of services.



## **Outputs and intermediate results**

As above under Objectives 1 and 2.

Also, mobile services were provided to reach underprivileged areas, contraceptive implants were added to the country's Essential Drug List, and services were contracted to provide HIV harm reduction.

The number of pregnant women receiving antenatal care during a visit to a health provider increased from 723,614 in February 2013 to about 1.5 million in 2018, exceeding the target of 0.9 million.

## **Outcomes**

The number of births attended by skilled health personnel increased from a baseline of 0.43 million in 2012 to 0.89 million in 2018, significantly exceeding the target of 0.56 million.

Pentavalent 3 vaccine coverage among children aged between 12 -23 months increased from a baseline of 12.9% in 2011 to 45% in 2018, short of the target of 60%.

The indicator measuring at least one antenatal care visit among women in the lowest wealth quintile increased from a baseline of 26% in 2013 to 46% in 2018, exceeding the target of 40%.

The contraceptive prevalence rate fell back from a baseline of 18% in 2011 to 16.3% in 2018, and was short of the target of 30% (the ICR, p. 49, noted that there were methodological issues in measurements).

The health facility utilization rate, based on consultations per person per year, increased from a baseline of 1.6% in 2013 to 1.9% in 2018, essentially reaching the target of 2%.

The note on targeting the poor as discussed above under Objective 1 also applies here.

## **Rating**

Substantial

## **OBJECTIVE 4**

### **Objective**

Enhance stewardship functions of the Ministry of Public Health

### **Rationale**

It was reasonable to expect that technical assistance, developing sound and well-articulated policies, budgeting, developing operational guidelines, staff training, improving capacity for contracting health services, training in procurement and good practices, strengthening monitoring, data verification, evaluation and disclosure, improving drug quality control, increasing hospital autonomy, and allocating resources for



oversight would plausibly contribute to the strengthening of MOPH stewardship functions, including for overseeing the delivery of basic packages of health services.

## Outputs

The first category of outputs consisted of performance-based contracting with NGOs to deliver the BPHS and EPHS service packages. The second category of outputs consisted of leveraging M&E data from routine reporting and surveys, developing national policy documents, holding a Presidential Health Summit, and developing the Health Sector Development Framework 2017-2022. The third category consisted of workshops and training for MOPH staff for policy and programming, staffing MOPH positions, delivering about 40 health sector seminars every year, training under the "World Bank Flagship Course for Health Systems Strengthening and Sustainable Financing," and procurement courses.

## Outcomes

A review of MOPH stewardship over the past five years (2014-2018) was undertaken to assess performance progress against WHO stewardship norms (ICR, Annex 7, pp. 76-87) that cover areas related to balancing competing demands, identifying strategic directions, articulating the case for health, regulating health actors, and strengthening accountability mechanisms. The review indicated a positive pattern (ICR, pp. 26-27). The ICR noted that MOPH policies and programs were sound, well-articulated, coherent, and based on evidence, with no indication of development partners exerting undue influence or other agendas, and that MOPH sustained resource allocations to essential services and provided substantial resources to monitoring and evaluation, verification, disclosure, and publication of data. While there were gaps in sectoral stewardship, performance was better than in many countries with comparable or higher levels of income, including countries that were not affected by FCV.

The proportion of MOPH core development budget executed increased from a baseline of 54% in 2013 to 87% in 2018, exceeding the target of 75%.

Contacts with NGOs for BPHS/EPHS service delivery signed and properly managed as per agreed timelines increased from a baseline of 27 contracts in 2013 to 76 contracts in 2018, exceeding both the original target of 27 and the revised target of 48.

The preparation of an annual health information report was achieved and institutionalized, and quality control capacities for drugs were developed.

However, "accreditation for procurement of goods and works achieved and maintained" was not met. Also, assessing progress related to the number of national hospitals with full budgetary autonomy was no longer applicable because the national unity government that took office after the 2014 elections decided not to move ahead with the scheme (ICR, p. 26).

## Rating





Substantial

### Rationale

The aggregation of one fully achieved objective with two almost fully achieved objectives and another partly achieved objective indicates a Substantial rating for overall efficacy. The project expanded the scope and coverage of health services provided to the population, with a focus on poor rural communities, and contributed to improving stewardship functions in the health sector, but only partially achieved its objective to enhance the quality of health services.

### Overall Efficacy Rating

Substantial

## 5. Efficiency

The PAD did not include a traditional economic analysis, but rather highlighted the potential positive impact of project interventions on health outcomes, cost-effectiveness of primary care interventions, and improved access in remote areas. The PAD argued that productivity gains outweighed the cost of interventions.

The ICR (pp. 28-29) undertook a cost-effectiveness analysis of the basic packages of services (BPHS and EPHS) with estimates ranging from US\$26 to US\$143 per Disability Adjusted Life Year (DALY). Project interventions were within the highly cost-effective threshold of US\$550 per DALY, with reference to the country's gross domestic product per capita. In addition, the per capita cost ranged between US\$1.4 to US\$4.5, which was below the US\$5-10 per capita cost for delivering such services per the Millennium Development Goals. The ICR also noted that the services provided in the basic packages were consistent with international best practices, and reflected technical efficiency.

At the implementation level, the project pursued province-wide contracts that were more efficient than multiple contracts for smaller service areas (ICR, p. 28), while concurrently limiting contractors to a maximum of two provinces in any round of contracting to prevent them from being overstretched at the operational level. The contract provisions gave substantial managerial autonomy and decentralized decision-making on the ground, to react to local needs and constraints. The process of contracting out service delivery allowed MOPH to focus more on its other public health functions. Other aspects that contributed positively to implementation efficiency included good financial management and continuity of the Kabul-based implementation support team.

At the same time, there were moderate shortcomings in other areas affecting the efficiency of implementation, including periodic limitations in service delivery and monitoring activities due to insecurity, and initial delays during 2013-2014 in contracting a third party for M&E (the KIT Royal Tropical Institute of the Netherlands), but which subsequently completed its assignments. The project also witnessed delays of about two years in implementing activities related to component 2 on stewardship. However, overall disbursement was adequate during the project implementation period as illustrated by the serial supervision reports (ICR, p. 3). The project closed on 6/30/18 as originally planned.



## Efficiency Rating

Substantial

a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

	Rate Available?	Point value (%)	*Coverage/Scope (%)
Appraisal		0	0 <input type="checkbox"/> Not Applicable
ICR Estimate		0	0 <input type="checkbox"/> Not Applicable

\* Refers to percent of total project cost for which ERR/FRR was calculated.

## 6. Outcome

Relevance of objectives is rated High, as development objectives remained fully aligned at project closing with the Country Partnership Framework FY17-20 and with government strategies. Efficacy is rated Substantial, as the project almost fully achieved its objectives. Efficiency is rated Substantial in view of the cost-effectiveness of project interventions, but with moderate shortcomings in the efficiency of implementation. Therefore, overall outcome is rated Satisfactory, indicative of essentially minor shortcomings in the project's overall preparation, implementation, and achievement.

### a. Outcome Rating

Satisfactory

## 7. Risk to Development Outcome

The risks to sustaining development outcomes appear to be largely related to the context of FCV and insecurity, remaining institutional capacity gaps, and the possibility of declining donor funding. However, there are recent signs indicating potential negotiated alternatives to the conflict. Funding from the Bank, United States Agency for International Development (USAID), and European Union (EU) was secured for the next three years. The project advanced institutional strengthening in various areas such as planning, programming, and M&E, and it strengthened the Public Nutrition Department, which was upgraded to a Directorate level, thus providing added attention to nutrition as a national priority (ICR, pp. 30-31).

A follow-on operation (Afghanistan Sehatmandi Project, P160615) was approved in 2018 as the current project was ending, and this follow-on operation aims to increase the utilization and quality of health, nutrition, and family planning services, thus sustaining many of the project directions.



## 8. Assessment of Bank Performance

### a. Quality-at-Entry

Project preparation built on the experience of stakeholders who were engaged with the government over the course of the decade, including the Bank, EU, USAID, and United Nations agencies, notably in developing health sector capacities and services, and improving sectoral governance. The approach to continue overall health development and to expand new services for treating child malnutrition was sound. Aligning donor goals with those of the country through a single financing vehicle (ARTF) was noteworthy for harmonization. Fiduciary aspects and implementation arrangements were adequately prepared, although the design of Component 2 on stewardship was not well specified at entry (ICR, p. 44) in view of its broad boundaries (design completion and related activities proceeded in the third year of the project). Within the larger context of quality criteria, this shortcoming is considered to be relatively minor. M&E arrangements were well prepared. Provisions for environmental safeguards, including for health care waste management, were adequate. The preparatory team adequately identified the risks and mitigation measures, notably for capacity weaknesses and governance risks.

#### Quality-at-Entry Rating

Satisfactory

### b. Quality of supervision

Supervision and implementation support were reportedly strong, facilitated by in-country presence and continuity of the Bank team. According to the ICR (p. 45), the quality of reporting was high with reference to the quality of Implementation Status and Results Reports (ISRs). The supervision team was reportedly appreciated both by the government and by stakeholders. In addition to core health service activities, the team adequately supported MOPH work on health care waste management. The Bank's financial management team played an important role in implementation support missions, and, according to the ICR, the team provided advisory support on overall fiduciary systems development beyond the project.

The ICR observed that the team was pro-active throughout implementation and prepared a thorough Mid-Term Review that included a high-level policy seminar. The team was instrumental in reallocating funds for the basic package of health services when the package was expanded largely to address malnutrition. The proactive establishment of video conferencing capability throughout the country, anticipating security concerns, was a noteworthy effort, considering the country context. The team adequately supported the transition to the follow-on project in 2018 (see Section 7).

#### Quality of Supervision Rating

Highly Satisfactory



## **Overall Bank Performance Rating**

Satisfactory

## **9. M&E Design, Implementation, & Utilization**

### **a. M&E Design**

Project objectives were well specified and aligned with the MOPH Strategic Plan. The theory of change was clear, although stewardship aspects were not clearly specified until the third year of the project. Indicators reflected the objectives, and baselines were available. Main sources of data included household and facility survey findings, and routine data from the health management information system. The engagement of an independent third party for M&E was also planned. Overall, M&E was well prepared, and the results framework included sources and adequate frequency of data collection.

### **b. M&E Implementation**

M&E implementation proceeded in a satisfactory manner (and was described by the ICR as very good with only minor issues), while also noting initial delays in contracting the third party, the KIT Royal Tropical Institute of the Netherlands. There were understandable challenges related to the security situation, but all planned data collection rounds and verification were completed. Household survey reports were disclosed online. KIT increased its local presence to 20 staff and 575 operational field staff, plus a data management unit of 30 people.

### **c. M&E Utilization**

Extensive M&E data generated by the project were shared with stakeholders, regularly discussed with the provinces, and used to compare performance across the regions. M&E findings were used in preparing the Health Sector Development Framework 2017-2022 and to inform further health operations in the country.

In conclusion, M&E arrangements as designed and implemented fully met the needs to assess the achievement of objectives. M&E findings were disseminated and used to inform strategy development and the follow-on Afghanistan Sehatmandi Project (see Section 7).

## **M&E Quality Rating**

High

## **10. Other Issues**

### **a. Safeguards**



The project triggered Safeguard Policy OP/BP4.01 in view of health care waste risks. Initial compliance with the health care waste management plan was modest, but was rated substantial by 2015, as 90% of the provinces were in compliance for the rest of the project period (ICR, p. 42).

An environmental and social management framework was prepared prior to the project. The concern related to social compliance involved the handling of the grievance mechanism. Only one staff was designated by MOPH to deal with grievances, and there was no system to triage complaints and provide effective follow-up; many complaints were therefore not addressed by the government.

## **b. Fiduciary Compliance**

**Financial Management.** Arrangements for financial management were adequate and were already developed under previous operations, including for staffing, planning, budgeting, reporting, and audits. The ICR (p. 43) reported good financial management performance and compliance, and the ISRs recorded satisfactory ratings. Interim Financial Reports were submitted on time, in form and substance acceptable to the Bank, and external audit reports were mostly received within the due dates. The audits had observations on minor issues. The ICR stated that MOPH was proactive in addressing and responding to observations made by the Bank and external audits.

**Procurement.** Most of the project procurement was related to NGOs contracts, and was managed by the Grants and Contracts Management Unit at MOPH. The unit had adequate staffing and experience. It performed satisfactorily in contracting, but less effectively in contract management and follow up. Other procurement of small works and goods by the MOPH Procurement Directorate was weak, but this did not impact implementation progress, as NGO contractors were able to undertake procurement for small items.

## **c. Unintended impacts (Positive or Negative)**

The ICR (p. 31) suggested that the project may offer lessons on effective service provision through NGOs to other FCV countries.

## **d. Other**

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## **11. Ratings**

<b>Ratings</b>	<b>ICR</b>	<b>IEG</b>	<b>Reason for Disagreements/Comment</b>
Outcome	Satisfactory	Satisfactory	



Bank Performance	Satisfactory	Satisfactory
Quality of M&E	High	High
Quality of ICR	---	High

## 12. Lessons

The ICR (pp. 46-47) offered several lessons and recommendations, including the following lessons re-stated by IEG:

**Contracting with NGOs facilitates effective delivery of health services in fragility, conflict, and violence settings.** Under the project, contracted NGOs were able to effectively provide basic packages of health services, forge alliances with local leaders, and adapt to specific local situations in ways that would not have been possible for government staff.

**Investing in robust monitoring and evaluation facilitates oversight, implementation guidance, and assessment of intended results based on reliable data.** Under the project, adequate spending on quality M&E, enhanced by an independent agency, resulted in proper household and facility surveys and impartial verification of routine data, followed by rigorous data analysis, disclosure, and publication.

**The consolidation of resources from development partners in one trust fund can enhance the potential of meeting project needs in a rational manner, and in promoting an aligned vision for a collective development agenda with the government.** Under the project, the consolidation of financing was instrumental in reaching the above benefits. Also, a capable national team was able to leverage the consolidated financing mechanism in pursuing the attainment of project development objectives.

## 13. Assessment Recommended?

No

## 14. Comments on Quality of ICR

The ICR was clear, well organized, results oriented, and highly candid. The theory of change was sound, adequately illustrated, and aligned to development objectives. The ICR's thorough assessment of attribution and its discussion of measurement issues versus actual performance were noteworthy. The ICR's analysis and evidence were of good quality. Its elucidation of project costs (ICR, p. 4) was helpful in understanding some related discrepancies. The ICR's narrative was aligned to the messages outlined in the ICR and supported its conclusions. The ICR was consistent with guidelines. Lessons were directly derived from actual project experience. At the same time, the ICR's elaboration of secondary implementation aspects resulted in a lengthy



report. In the broader context of very positive quality attributes, this shortcoming is considered to be relatively minor, and the quality of the ICR is rated High.

**a. Quality of ICR Rating**  
High