Report Number : ICRR0021053

1. Project Data

Project ID	Project Name
P118708	BD: Health Sector Development Program

Country	Practice Area(Lead)	Additional Financing
Bangladesh	Health, Nutrition & Population	P151070,P151070

L/C/TF Number(s)	Closing Date (Original)	Total Project Cost (USD)
IDA-49540,IDA-58690,TF-11556,TF-12281,TF-A2917	31-Dec-2016	358,900,000.00

Bank Approval Date	Closing Date (Actual)
26-May-2011	30-Jun-2017

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	358,900,000.00	366,040,639.00
Revised Commitment	508,045,514.83	365,301,324.00
Actual	488,047,943.63	365,300,747.84

Prepared by	Reviewed by	ICR Review Coordinator	Group
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2. Project Objectives and Components

a. Objectives

The Project Development Objective (PDO), as stated in the Grant Agreement, was "to enable the Recipient to strengthen health systems and improve health services, particularly for the poor."

The PDO did not change during implementation. However, an Additional Financing (AF) and restructuring in May 2016 modified the results framework, adding two new indicators and adjusting some outcome targets measuring improvement in health services (Objective 2). This Review presents a split evaluation rating separately based on the key outcome targets for the project before and after restructuring, at which time US$

339.67 million, representing 67% of total World Bank financing, had been disbursed.

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
26-May-2017

c. Will a split evaluation be undertaken?
Yes

d. Components
The two components supported by the project are presented below, showing total project costs at appraisal and actual costs.

Component 1 - **Improving Health Services (Appraisal: US$ 251.2 million, Actual: US$ 291.2 million)** had two subcomponents:
Improving Health Programs: scaling up of reproductive, adolescent, maternal, neonatal, infant and child health and family planning services through improved quality and reliability of services, focusing on selected district hospitals and upazila health complexes; nutrition interventions for pregnant women and children by integrating nutritional services with health and family planning services; control and treatment of communicable and non-communicable diseases (NCDs); and interventions to promote healthy behaviors.
Improving Service Provision: strengthening service delivery of primary health care for a continuum of care by piloting universal health coverage (UHC), including upgrading and equipping at least one upazila health complex in each district and rehabilitating community clinics; better management of hospitals at secondary and tertiary levels; and the provision of health, nutrition and family planning services to the urban population by establishing a coordination mechanism between the Ministry of Health and Family Welfare (MOHFW) and the Ministry of Local Government, Rural Development and Cooperatives.

Component 2 - **Strengthening Health Systems (Appraisal: US$ 107.7 million, Actual: US$ 217.7 million)** included the following activities: (i) governance and stewardship; (ii) health sector planning and management; (ii) human resources for health; (iv) health care financing; (v) health information systems (HIS), (vi) monitoring and evaluation (M&E) and research; (vii) quality of health care; (viii) drug administration and regulation; (ix) procurement and supply chain management; and (x) physical facilities and maintenance.

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

Costs:
At appraisal 70% of the project funds were to be spent under Component 1 (Improving Service Delivery) and 30% under Component 2 (Strengthening Health Systems). The final distribution of spending by component (which includes the US$150 million of the AF) showed a relative increase under Component 2 (from 30% to 43%) and decrease under Component 1 (from 70% to 57%).

Financing:

- The Health Sector Development Program (HSDP) was structured to be implemented as a sector-wide approach (SWAp), financing a specific slice of the national Health Population and Nutrition Sector Development Program (HPNSDP).
- The total estimated cost of the HPNSDP at project appraisal was US$ 8,011 million, of which the government was expected to provide US$ 5,844 million and development partners (DPs) US$ 2,167 million. The remaining US$ 560 million financing gap was expected to be covered by future donor commitments.
- At appraisal, Australian Aid, the Canadian International Development Agency, the UK Department for International Development, the European Commission, the KfW, GIZ, Japan International Cooperation Agency, Swedish International Development Cooperation Agency, United Nations Population Fund, Joint United Nations Programme on HIV/AIDS, United Nations Children's Fund, World Bank (International Development Association, IDA), World Health Organization, and United States Agency for International Development (USAID) had expressed indicative commitment for a total of US$ 1,606.24 million. USAID was the largest DP, providing US$ 450 million to HPNSDP (20.8% of external financing). The World Bank was the second largest DP, contributing, at appraisal, US$ 358.9 million in IDA financing (16.6% of external financing).
- The World Bank provided fiduciary and technical oversight to DP contributions through multi- and single-donor trust funds (US$ 365 million in total), building on the experience of the previous health SWAp implemented in Bangladesh.
- A US$ 150 million AF was approved by the Bank on June 24, 2016 to fill a financing gap in the last year of project implementation, bringing total World Bank IDA commitment to US$508 million.

Dates:

- June 25, 2013: A level two restructuring. The ICR did not provide information on the purpose of this restructuring.
- May 26, 2016: A level two restructuring and US$ 150 million AF (amount disbursed at the date of this restructuring was $339.67 million, or 67% of the total World Bank contribution). The following changes were introduced: (a) extension of the project closing date from June 30, 2016 to June 30, 2017; (b) disbursements earmarked to the results as measured by disbursement linked indicators (DLIs); (c) revision of the results framework, revising some outcome targets and expanding the number of intermediate outcome indicators from 11 to 13 to place greater emphasis on health systems strengthening; (d) modification of components and costs; (e) changes in financial management (FM)

arrangements due to the introduction of DLIs; and (f) simplification of procurement arrangements, as the eligible expenditure program did not include procurable items.

3. Relevance of Objectives

Rationale

The project objectives were highly relevant to country conditions, government strategy, and Bank strategy. (Relevance of objectives is assessed across the project.) The objectives were highly relevant to the challenges faced by the health sector in Bangladesh: weak institutional capacity, shortage of human resources, unskilled health personnel, fragmented public services delivery, inefficient allocation of public resources, and poor regulation of the private sector within a centralized health system. The HSDP, financed by the Bank and several international donors, was prepared to support the national HPNSDP, to be implemented from 2011 to 2016 with the goal to "ensure quality and equitable health care for all citizens of Bangladesh." The two project objectives (strengthen health systems and improve health services, particularly for the poor) matched the objectives of the World Bank Country Assistance Strategy (CAS) for the People's Republic of Bangladesh for FY2011-2014. Strategic objective 2 in the CAS was to "improve social service delivery," with a specific outcome of "improved access to quality health, population and nutrition services," to bring marginalized groups and rural communities more firmly into the development process. Strategic objective 4 in the CAS was to "enhance accountability and promote inclusion," with a specific outcome of "increased effectiveness of public service delivery at the local level," as part of a strong governance agenda leading to faster and more inclusive growth. The project objectives remained highly relevant to the current Country Partnership Framework (CPF) for FY2016-2020, which includes priorities around: (a) improving the quality of public health service delivery; (b) increasing public funding for health; and (c) moving towards universal health coverage.

Rating

High

4. Achievement of Objectives (Efficacy)

Objective 1

Objective

Strengthen health systems

Rationale

The activities financed under Component 2 (governance and stewardship; planning and management; human resources for health; health financing; HIS, M&E, and research; quality of health care; drug administration and regulation; procurement and supply chain management; and physical facilities and maintenance) contributed to Objective 1: strengthening key health systems functions.

The project supported MOHFW to implement the activities comprising the Component 1 through Operational Plans (OPs) and Annual Development Programs (ADP) that were mutually agreed by MOHFW and SWAP financiers. The theory of change underpinning this objective plausibly connected timely submission and implementation of annual OPs and ADPs developed by Line Directorates, through the reduction of vacant nurse positions, and the training of health personnel, to achieving the objective of strengthening health systems.

Achievement of this objective to strengthen health systems was monitored by 6 Intermediate-Outcome-level indicators that captured improvement in health system capacity to deliver quality health services. These indicators assessed the functionality of health clinics, the availability of key inputs such as human resources (physicians and nurses) and drugs, and improved planning and execution of financial resources. The M&E framework did not provide any outcome-level indicators for this objective. However, this is consistent with the interpretation made in this ICR Review that, although the objective of strengthening health systems was part of the PDO, this objective constituted an intermediate outcome that contributed to the higher-level objective of improving health services, particularly for the poor.

Outputs:

- *Health personnel receiving training (number)*. 852, 215 health personnel received training, exceeding the target of 810,000.
- *Number of additional service providers trained in midwifery at District and upazila health facilities*. 2,025 providers were trained in round-the-clock midwifery assistance in District and upazila level health facilities, not reaching the target of 3,000.
- *Number of functional community clinics* (i.e. established, staffed, and reporting number of service contacts over time). The number of functional clinics increased from 10,323 at baseline (2011) to 13,006 at closure (2017), not meeting the target of 13,500.
- *MOHFW's web-based complaint mechanism*. A web-based complaint mechanism was introduced and maintained by the Directorate General of Health Services of the MOHFW through the end of the project period, achieving the target.

Intermediate Outcomes:

- *Proportion of physician positions vacant at upazila/District level and below*. The proportion of vacant physician positions was reduced from the baseline of 45.7 percent to 37.8 percent, but did not reach the target (22.8 percent).
- *Proportion of nurse positions vacant at upazila/District level and below*. The proportion of vacant nurse positions in health facilities went down from the baseline value of 29.9 percent to 12.8 percent in 2016, but then rose again to 19.3 percent by project closure, not achieving the target of 15.3 percent.
- *Proportion of health services by type without stock-outs of essential medicines*. The proportion of health facilities (district level and below) having at least 75 percent of a set of essential drugs comprising Amoxicillin, Paracetamol, Iron tablets, Vitamin A, Tetracycline ophthalmic ointment, Chlorpheniramin, Cotrimaxazile, and Benzyle benzoate increased from 66.1 percent to 78.7 percent, achieving the target of 75 percent.
- *Proportion of annual work plans with budgets submitted by Line Directorates (LDs) by defined time period (July/Aug).* Both before and after restructuring, all LDs submitted their annual work plans with budgets on

time, achieving the target.
- *Proportion of OPs expending > 80% of ADP allocation*. The percentage of OPs spending this majority of plan allocation decreased from 44.7 percent to 34 percent, not reaching the target of 100 percent.
- *Proportion of serious audit objections settled within at least 12 months*. The percentage of Bank-identified serious audit objections settled within the last 12 months of Annual Program Review reporting improved from 7 percent to 68 percent, not reaching the 80 percent target.

Because of shortcomings in meeting targets on key indicators for physician and nurse staffing and for spending on annual plans, achievement of this objective is rated Modest, consistent with partial achievement of objectives or intended outcomes.

Rating
Modest

Objective 2
Objective
Improve health services, particularly for the poor (original outcome targets)

Rationale
The activities financed under Component 1 (improved essential reproductive, maternal and child health services; improved nutritional services to pregnant women and children; control and treatment of communicable and non-communicable diseases; primary health care services; support to secondary and tertiary hospital; coordination mechanisms between public health stakeholders at central and local level) contributed to Objective 2: improved health services to the poor.

Also for this objective, the activities comprising Component 1 were implemented through OPs and ADP that were mutually agreed by MOHFW and SWAP financiers. The theory of change underpinning Objective 2 was plausible in connecting the implementation of OPs and ADPs, through the increased number of birth attended by skilled health personnel, and children immunized, to achievement of the objective of improving health services, particularly for the poor.

Progress toward the achievement of Objective 2 was monitored by 4 intermediate-outcome indicators and 4 outcome-level indicators. The intermediate-outcome indicators provide additional data on coverage of essential maternal and child health services for the entire population (institutional birth rate, immunization coverage, exclusive breastfeeding) and the tuberculosis notification rate. The outcome-level indicators comprised coverage of essential health services targeted to the poor (i.e. births delivered by skilled birth attendant and coverage of modern contraceptives) and key nutrition outcome for children living in poor households.

Outputs

- *Births (delivery) attended by skilled health personnel (number).* A total of 206,458 deliveries were attended by skilled health personnel, surpassing the target of 134,647.
- *Children immunized – under 12 months – against DPT3 (number).* 3.67 million infants were immunized against DPT3, achieving the target of 3.67 million.
- *Children immunized – under 5 years – against Polio (number)*. 2.05 million children under 5 were immunized against Polio, achieving the target of 2.05 million.

Intermediate Outcomes

- *Proportion of births in health facilities*. The percentage of deliveries, in the five years preceding the survey, resulting in a live birth and taking place in a health facility increased from the baseline (2011) of 23.7 percent to 45 percent, achieving the target of 40 percent.
- *Coverage of measles immunization for children under 12 months' age.* Coverage of measles immunization increase from 82.4 percent to 86.6 percent, not achieving the original target of 90 percent.
- *Proportion of infants exclusively breastfed up to 6 months of age*. The percentage of children under six months who are living with their mother who were exclusively breastfed increased from 43 percent to 60 percent, achieving the target of 50 percent.
- *Proportion of postnatal care for women within 48 hours (at least 1 visit)*. The percentage of women who received a postnatal check-up for their last live birth from a medically trained provider within 48 hours of delivery improved from 20.9 percent to 43 percent, not achieving the target of 50 percent.

Outcomes

- *Proportion of delivery by skilled birth attendant among the lowest two wealth quintiles*. Delivery with a skilled birth attendant improved from 11.5 percent at baseline (2011) to 33.6 percent, reaching the original target of 15 percent.
- *Coverage of modern contraceptives in the low performing areas of Bangladesh – Sylhet*. Modern contraceptives coverage in Sylhet improved from 35.7 percent to 42.6 percent, not reaching the original target of 50 percent.
- *Coverage of modern contraceptives in the low performing areas of Bangladesh – Chittagon*. Modern contraceptives coverage in Chittagon improved from 46.8 percent to 48.5 percent, not reaching the original target of 50 percent.
- *Prevalence of underweight among children under 5 years of age among the lowest two wealth income groups*. The proportion of poor underweight children decreased from 48.3 percent to 43.3 percent, achieving the original target of 43.3 percent.

The project almost fully achieved its objectives related to improvements in the use of health services by the poor under the original targets (with only the utilization of postnatal care for women, measles vaccination, and modern contraceptives coverage increasing but not reaching targets), consistent with an efficacy rating of substantial.

Rating

Substantial

Objective 2 Revision 1

Revised Objective

Improve health services, particularly for the poor (revised outcome targets)

Revised Rationale

One intermediate outcomes indicator - the tuberculosis notification rate - was added at the May 2016 restructuring and AF.

Outputs

Outputs listed above under the original objective also applied to the revised objective.

- *Births (delivery) attended by skilled health personnel (number).* A total of 206,458 deliveries were attended by skilled health personnel, surpassing the target of 134,647. (This target was not revised at restructuring.)
- *Children immunized – under 12 months – against DPT3 (number).* 3.67 million infants were immunized against DPT3, achieving the target of 3.67 million. (This target was not revised at restructuring.)
- *Children immunized – under 5 years – against Polio (number)*. 20.49 million children under 5 were immunized against Polio, achieving the target of 20.49 million. (This target was not revised at restructuring.)

Intermediate Outcomes under with revised targets

- *Tuberculosis case notification rate for bacteriologically positive cases*. The tuberculosis case notification rate, introduced as an indicator at restructuring, improved from 68 percent to 77 percent, surpassing the target of 69 percent. (New indicator)
- *Coverage of measles immunization for children under 12 months' age.* Coverage of measles immunization increased from 82.4 percent to 86.6 percent, achieving the revised target of 86.1 percent.
- *Proportion of infants exclusively breastfed up to 6 months of age*. The percentage of children under six months who are living with their mother who were exclusively breastfed increased from 43 percent to 60 percent, achieving the target of 50 percent. (This target was not revised at restructuring.)
- *Proportion of postnatal care for women within 48 hours (at least 1 visit)*. The percentage of women who received a postnatal check-up for their last live birth from a medically trained provider within 48 hours of delivery improved from 20.9 percent to 43 percent, not achieving the target of 50 percent. (This target was not revised at restructuring.)

Outcomes

- *Proportion of delivery by skilled birth attendant among the lowest two wealth quintiles*. Delivery with a skilled birth attendant improved from 11.5 percent at baseline (2011) to 33.6 percent, exceeding the revised target of 15 percent.
- *Coverage of modern contraceptives in the low performing areas of Bangladesh – Sylhet*. Modern contraceptives coverage in Sylhet improved from 35.7 percent to 42.6 percent, exceeding the revised target of 42 percent.
- *Coverage of modern contraceptives in the low performing areas of Bangladesh – Chittagon*. Modern contraceptives coverage in Chittagon improved from 46.8 percent to 48.5 percent, exceeding the revised target of 48 percent.
- *Prevalence of underweight among children under 5 years of age among the lowest two wealth income groups*. The proportion of poor underweight children decreased from 48.3 percent to 43.3 percent, achieving

the target of 43.3 percent. (This target was not revised at restructuring.)

Under the revised outcome targets, all targets were fully achieved and several were exceeded, consistent with an efficacy rating of high.

Revised Rating
High

Rationale
Under the revised outcome targets, achievement of the first objective is rated Modest, and achievement of the second objective is rated High, leading to an overall Efficacy rating of Substantial under those targets as well.

Overall Efficacy Rating
Substantial

5. Efficiency

The PAD and ICR presented several analyses that shed light on the various efficiency elements of the project:

- Technical efficiency: Program-financed activities contributed to expanded utilization of a set of known cost-effective health, nutrition, and reproductive health interventions that averted Disability Adjusted Life Years (DALY). For example, the program's improved TB notification led to an improvement of TB treatment success rates from 92% to 94% between 2012 and 2015. The cases of patients identified and managed with multidrug resistant TB increased from 390 to 904 between 2012 and 2015. The number of HIV-AIDS testing centers providing regular services increased to 76 to 100 over the same period of time.
- Allocative efficiency: The improved budget allocations on key health priorities (e.g. the project target interventions on maternal diseases, neonatal diseases, nutritional deficiencies, diarrhea, neglected diseases, malaria, TB and HIV-AIDS) had an estimated positive impact on the DALY averted across the project life, which suggested that the project improved spending on "the right things".
- Economies of scale: The large number of beneficiaries reduced the per-capita cost of the essential health services package (ESP) provided under the Program. The average per-capita cost to deliver the ESP in the year 2015 was US$3.96 (delivered by Upazilla Health Centers); US$3.00 (by Union Health and Family Welfare Centers) and between US$1.35 and US$2.18 (by Community Clinics). The total per-capita cost (costs are additive, but do not include the costs associated to district hospitals) ranged between US$8.31 and US$9.14, which represents a 50 percent reduction from the costs estimated for Bangladesh (see World Bank. 2006 *Health Financing Revisited*, chapter 7, “Financing Health in Low Income Countries," The World Bank, Washington DC).
- Economies of scope: The ICR (p. 31) stated that the task groups and the Local Consultative Group on

Health facilitated effective coordination among both pooled and non-pooled partners, harmonized support, avoided duplications, and enhanced synergies, both in the provision of technical assistance and in health investments.

There were some shortcomings in implementation efficiency, involving challenges in finding and retaining trained FM staff, recurring financial irregularities and misprocurement (see Section 10), and lengthy and complicated preparation of the additional financing. On balance, however, these shortcomings in implementation efficiency are considered minor, and efficiency is rated Substantial.

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 ☐Not Applicable
ICR Estimate		0	0 ☐Not Applicable

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

6. Outcome

Relevance of the objectives is rated High. Achievement of the first objective (strengthen health systems) is rated Modest across the entire project, as its targets were not revised. The achievement of the second objective (improve health services, particularly for the poor) is rated Substantial under the original outcome targets and High under the revised outcome targets. It is worth noting that the indicators monitoring progress toward objective 1 were all intermediate outcome indicators, which is consistent with the understanding of the project's results chain that characterizes the "strengthen health systems" portion of the PDO as is an intermediate outcome, contributing to the higher-level objective of "improve health services, particularly for the poor." Efficacy is rated Substantial under both the original and revised outcome targets. Efficiency is rated Substantial. This results in a Satisfactory outcome rating under both the original and revised outcome targets. Since the outcome rating is the same under both the original and revised targets, a formal calculation of the split rating is not necessary. The overall Outcome rating is therefore Satisfactory, indicative of minor shortcomings in preparation and implementation of the project.

a. Outcome Rating
Satisfactory

7. Risk to Development Outcome

The government has approved a new five-year program in the health sector for the 2017-2022 period that will continue the HPNSDP, which indicates that the government is committed to continuing its efforts toward the Sustainable Development Goals, fostering UHC and tackle the emerging problem of NCDs. The new health sector program includes an expansion of the health budget from US$ 8.2 billion to US$ 14.7 billion over the 2017-2022 period. DPs are committed to co-financing the Government health sector program for the 2017-2022. The World Bank approved in July 2017 a new health sector project that will contribute US$ 500 million to support the new health sector program for 2017-2022. DPs are expected to contribute another US$ 200 million.

Important institutional strengthening of the MOHFW, including its accountability mechanisms and hospital management systems, is likely to be sustained. The ICR (pp. 30-31) noted, however, that despite this institutional development, coordination in the health sector is still difficult both between public entities (MOHFW and other line ministries) and between the public and private sectors. Human resource limitations remain a significant challenge.

8. Assessment of Bank Performance

a. Quality-at-Entry

Project design directly reflected HPNSDP priorities for 2011-2017. The project was prepared in coordination with relevant DPs. Project design integrated the technical lessons learned from the previous two SWAps, as well as the results of relevant World Bank analysis and studies, and the recommendations from the Bank's internal quality review process. The objectives were realistic, and design encompassed components that mapped directly to the objectives. The analysis conducted during project preparation identified the relevant gender gaps in health. Project design included specific actions to improve gender equality in health targeting maternal health conditions and family planning needs. M&E design and planning arrangements were satisfactory (see M&E section).

Finally, the project risk assessment and the mitigating actions identified were, overall satisfactory. For example: (i) fiduciary-related risks of the sector were rated as High. Thus, the HSSP included a comprehensive Fiduciary Action Plan focused on strengthening the fiduciary systems and control functions of the MOHFW in collaboration with other development partners. (ii) Stakeholder risk was rated as Substantial, reflecting the SWAp of the project that involved several stakeholders and DPs. The project established specific coordination mechanisms (e.g. joint missions, the coordinated provision of technical assistance, set up the Local Consultative Group on Health) to mitigate the risk (see Section 12 - Lessons).

Quality-at-Entry Rating

Moderately Satisfactory

b. Quality of supervision

The World Bank provided fiduciary and technical oversight to both IDA and DP contributions to the HSDP. The Bank team led joint missions and annual Program Reviews with DPs. The Bank's role in leading DPs supporting the health SWAp was rated as highly positive by DPs with the exception of the interactions during the preparation of the AF and definition of the related DLIs. The use of DLIs created tensions between the Bank and government, as the government was reluctant to shift to a new disbursement and implementation modality with only one year remaining in the project. Tensions were also created with DPs, who would have preferred more challenging DLI targets (see ICR p. 23). Because of the need to manage these disagreements, the AF took about 1.5 years to be prepared and approved, from the government's request, received in November 2014, to its approval on May 26, 2016. Ultimately, the DLIs were calibrated to be compatible with the limited time (one year) left to complete disbursements.

The Bank team conducted joint missions with the DPs for annual Program reviews. The ICR (p. 29) states that all DPs commented that the Bank team did excellent work leading the supervision of the HSDP.

The technical and fiduciary support provided by the Bank team facilitated effective management of significant fiduciary risks through timely and quality technical support. The ICR highlighted the role of the Bank in improving the transparency of the procurement system and overall governance of the health sector, and in strengthening the sector's M&E system. However, according to the ICR, safeguards supervision contained shortcomings (see Section 10 - Other Issues).

Quality of Supervision Rating

Moderately Satisfactory

Overall Bank Performance Rating

Moderately Satisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design

The Results Framework (RF) of the HSDP was a subset of the RF of the Government's HPNSDP Program, which comprised 11 Intermediate-Outcome indicators (IOI) and 3 PDO-level indicators (also known as key performance indicators – KPI). The PDO indicators measured outcomes related to improvements in health service delivery, particularly to the poor: (i) proportion of delivery by skilled birth attendant among the lowest two wealth quintile groups; (ii) coverage of modern contraceptives in the low performing areas of Sylhet and Chittagong, and; (iii) prevalence of underweight among children under 5 years of age among the lowest two quintiles groups). The IOIs also measured health system improvements.

The reason for this design was to highlight the priority given to the service delivery outcomes, with health system indicators being the underlying critical elements required to achieve the main service delivery goals (see ICR p. 10). Geographical targeting of low-performing and hard-to-reach areas was the main targeting strategy adopted by the project.

The 15 DLIs introduced during the AF were a subset of the 158 indicators of the 32 OPs for HPNSDP during the 2011-16 period. Three of the 15 DLIs were focused on service delivery [measles immunization rate, deliveries in public facilities, and tuberculosis notification rate for bacteriologically positive cases], while 12 were to strengthen health systems [performance of District Health Information Systems, Strategic Investment Plan for the health sector for the next five years, Standard Guidelines for medical waste management (MWM), MWM in district hospitals, contract management guidelines for the Bangladesh health sector, a new institutional organogram of the Central Medical Stores Depot, strengthening of procurement procedures, restructuring of the financial management audit unit, FY2014 internal audit of MOHFW with a time-bound action plan, assessment of MOHFW's accounting needs, an asset management pilot, and MOHFW's web-based complaint mechanism].

The indicators comprising the project's M&E framework covered the key intermediate results and outcomes under the objective "improving health services, particularly for the poor," but included only intermediate results indicators for the first objective to "strengthen health systems." However, this is consistent with the results chain of the project, where strengthening health systems can be considered an intermediate outcome, contributing to the higher-level objective of improving health services, particularly for the poor.

All indicators had baseline values and targets at appraisal. Overall, the alignment between the project and Program M&E frameworks helped to reduce duplication, enhance comparability, and improve sustainability of both M&E systems.

b. M&E Implementation

The project's M&E used information from surveys and administrative records, allowing it to triangulate results among different data sources, enhancing robustness. The M&E system used a range of survey data, such as the Bangladesh Demographic and Health Surveys (BDHS) conducted in 2011 and 2014; Utilization and Essential Services Delivery Surveys (also known as mini-DHSs) conducted in 2010, 2013, and 2016; and Health Facility Surveys conducted in 2014. During the implementation of the project, the MOHFW introduced the District Health Information Software version 2, which improved the quality and timeliness of district-level data on the delivery of health and family planning services produced by health services providers (including community clinics).

During the project, the collection of administrative data and the production of surveys improved significantly, enhancing both the regularity and the quality of the underlying data and composite indicators comprising the M&E framework.

c. M&E Utilization

The HPNSDP M&E framework was used not only to monitor progress of the Bank-financed project, but also to guide MOHFW planning and decision making. During the project, the MOHFW committed to ensure (for the first time) a functioning M&E unit able to have and use data to regularly assess program performance and make program and policy related decisions based on evidence, including all the Annual Program Implementation Reports, Annual Program Reviews, and Mid-Term Reports conducted during the implementation of HPNSDP (see ICR, p. 9).

M&E Quality Rating

Substantial

10. Other Issues

a. Safeguards

Three safeguard policies were triggered: (i) Environmental Assessment (OP/BP 4.01); (ii) Indigenous Peoples (OP/BP 4.10); and (iii) Involuntary Resettlement (OP/BP 4.12).

Environmental Assessment. The Project was categorized as Environmental Assessment Category B because of the risks associated with infection control, waste management, and health infrastructure in sensitive ecological areas. This triggered the Environmental Assessment (Bank's Operational Policy 4.01) and the development of an Environment Management Plan (EMP). The World Bank prepared in 2014 an Environmental Safeguards Assessment Report to review EMP implementation status, and additional assessments were produced by Bank consultants in 2015 and 2016 (ICR, pp. 27-28). The assessments revealed that "besides the issues of medical waste management, there had been a lack of oversight to the environmental guidelines related to construction/rehabilitation/renovation activities carried out under the original project. The application of environmental regulations during construction activities carried out during the project period remained very vague. No documentation or progress reports were available to determine whether the environment regulations and monitoring protocol had been adequately followed or applied."

Indigenous Peoples. The project triggered the preparation of an Indigenous Peoples Plan (OP/BP 4.10) because of the proposed activities in the Chittagong Hill Tracts and other areas populated by indigenous people. The ICR (p. 28) reported that "several consultation meetings to address issues raised by local and ethnic/tribal communities and give them a voice in project design through the incorporation of feasible recommendations and suggestions, especially with regards to access to community clinics" took place during the implementation of the project. The ICR also noted that some site-specific Indigenous Peoples Plans were developed by the government; however, these did not always follow the format or documentation established in the overall Indigenous Peoples Plan.

Involuntary Resettlement. The Project triggered the preparation of Social Management Framework (OP/BP 4.12) because of the potential displacement of people related to the acquisition of land required for the construction of new health facilities. However, the ICR (p. 28) stated that the project did not acquire land, and therefore the risk of involuntary displacement of people did not materialize.

b. Fiduciary Compliance

The MOHFW (as is the case with other line ministries in Bangladesh) is exposed to high fiduciary risk. The Program has undergone several fiduciary reviews, in addition to regular internal and external financial audits and procurement reviews: the Integrated Fiduciary Review, an in-depth Fiduciary Review, the Integrated Procurement Review, and a Performance Audit of HIV NGOs (carried out by the Bank, and including forensic audits by an independent firm).

Financial Management. The regular and additional fiduciary reviews detected numerous financial irregularities during the project implementation period. Approximately US$2.2 million was declared as ineligible expenditure during the implementation period due to financial irregularities and misprocurement identified by government and Bank audits (representing 0.26% of Bank financing). The government has refunded the full amount to the Bank. External audit identified a total of 153 material observations amounting to US$49.3 million (representing 5.6% of Bank financing). At the time of the ICR, there were still 75 outstanding audit issues, including 34 issues in FY2016, 21 in FY2015, and 20 from FY2014. The outstanding audit issues are approximately equivalent to US$22.7 million, which accounts for 2.6% of total Bank financing (ICR, p. 27).

Procurement. The project remained exposed to high fiduciary risks related to procurement during the entire implementation period. These risks can be characterized in two broad areas: (i) fiduciary risks affecting the upstream procurement process, where there were issues in the transparency and efficiency of procurement, raising concerns about the integrity of the process and about value for money; and (ii) fiduciary risks affecting the downstream procurement process, which have affected the Central Medical Stores Depot and the Directorate General of Family Planning, the two main procuring entities of the MOHFW. In addition, the nature of the risks has changed over time, from weak capacity in preparing bidding documents to fraudulent behaviors of bidders.

The MOHFW took various measures to address the identified fiduciary irregularities, but key challenges remain: (i) the formal systems for identifying, reporting, investigating, and prosecuting cases of fraud and corruption are in place, but in practice are not functioning effectively; (ii) weak staffing capacity at the Financial Management and Audit unit at the MOHFW limits internal controls; (iv) there is underutilization of procured items; (v) mechanisms for resolving external audit findings are ineffective and slow; and (vi) monitoring and administration of procurement contracts is inadequate.

c. Unintended impacts (Positive or Negative)

None reported.

d. Other

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11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Satisfactory	Satisfactory	---
Bank Performance	Moderately Satisfactory	Moderately Satisfactory	---
Quality of M&E	Substantial	Substantial	---
Quality of ICR		Substantial	---

12. Lessons

Lessons drawn from the ICR (pp. 31-32) include:

Managing pooled funds for health
It is observed that in large programs, with multiple pooling partners, effective coordination and consultation mechanisms among the Bank, development partners (DPs), and government are essential to avoid fragmentation/duplication of efforts, reduce transaction costs, and align project objectives to a country's development needs. The Project enhanced coordination and consultation mechanisms among DPs by conducting joint missions and providing coordinated technical assistance with different partners leading different themes. The establishement of the Local Consultative Group on Health also improved coordination and harmonization of DP's support.

DLIs and incentive structures
Effectiveness of the disbursement-linked-indicator (DLI) approach is attenuated when budgetary incentives are only partly associated with the achievement of results. In this project, the government budget for the HPNSDP was pre-financed by the Ministry of Finance at the beginning of each fiscal year, which reduced the effectiveness of the incentive structure of a project with DLIs.

13. Assessment Recommended?

Yes

Please explain

Further assessment of the project is recommended both for accountability (see fiduciary issues) and learning reasons. The latter is related to the complexity of the operation, the size and scope of the project, and innovative aspects such as the use of DLIs and SWAp mechanisms.

14. Comments on Quality of ICR

The ICR was well written and concise. The evidence presented was based on credible sources and was appropriately referenced. The ICR was internally consistent and consistent with Bank guidelines. However, the efficacy section emphasized reporting on the indicators rather than fully explaining how information provided by the indicators pointed to achievement of the objectives; therefore, the explanation of the extent to which achievement of objectives could be attributed to project outputs and activities was not completely robust. The theory of change section contained helpful information, but connections between activities and outputs, and between outputs and outcomes, showed a general movement from activities to outputs to outcomes rather than specific envisioned causal pathways. Nevertheless, the ICR presented evidence of progress under the project and used that information to draw conclusions about project performance.

a. Quality of ICR Rating
Substantial