Report Number : ICRR0021228

1. Project Data

Project ID	Project Name	
P113202	BJ-Health System Performance proj (FY10)	
Country	**Practice Area(Lead)**	**Additional Financing**
Benin	Health, Nutrition & Population	P129024
L/C/TF Number(s)	**Closing Date (Original)**	**Total Project Cost (USD)**
IDA-H5640,IDA-H7630,TF-96654	31-Dec-2014	33,800,000.00
Bank Approval Date	**Closing Date (Actual)**	
06-May-2010	30-Jun-2017	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	22,800,000.00	11,000,000.00
Revised Commitment	32,648,413.70	10,943,804.96
Actual	30,649,011.21	10,943,804.96

Prepared by	Reviewed by	ICR Review Coordinator	Group
Salim J. Habayeb	Judyth L. Twigg	Joy Behrens	IEGHC (Unit 2)

2. Project Objectives and Components

a. Objectives

Original objectives. According to the Financing Agreement (5/25/10, p. 5), the objectives of the project were to (i) increase coverage of quality maternal and neonatal health care services in the Targeted Areas, and to (ii) strengthen the institutional capacity of the MOH (MOH: Ministry of Health). The Project Appraisal Document's (PAD's) and ICR's statements of objectives were similar, but both statements used the term "target districts" instead of "targeted areas".

Revised objectives. A project restructuring on 2/17/12 provided additional financing and revised the first objective on coverage by also specifying children's services, as follows: "to increase coverage of quality maternal, neonatal and child health care services in the Targeted Areas". The second objective to strengthen the institutional capacity of MOH remained unchanged. A level 2 restructuring on 2/1/13 reduced the number of project indicators and also the target for antenatal care visits complying with quality standards (see Section 4).

Project scope. Eight districts out of 34 districts.

Note: In July 2015, the results-based financing (RBF) was scaled up nationwide in all 34 districts with separate financing from other development partners: Belgian Technical Cooperation: 5 districts; Global Fund to Fight AIDS, Tuberculosis and Malaria: 19 districts; and the Global Alliance for Vaccines and Immunization (GAVI): 2 districts.

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
17-Feb-2012

c. Will a split evaluation be undertaken?
Yes

d. Components
1. Improvement of health facilities performance through results-based financing (RBF) (Appraisal US$18 million; Actual US$25.61 million).

Sub-component 1A: Financing of RBF credits: payments to health care facilities contracted by MOH to receive credits proportional to achieved results.
Sub-component 1B: Support to RBF implementation and supervision, including capacity building in implementing and monitoring RBF, training in clinical skills and management of health services, communication and sharing of best practices, and recruitment of specialist doctors for some rural districts.

2. Support to improved financial accessibility (Appraisal US$13.8 million; Actual US$12.0 million).

Sub-component 2A: Strengthening processes to identify the poorest households through targeting of poor households by proxy means testing.
Sub-component 2B: Support to the Health Equity Fund.

3. Technical assistance for institutional strengthening (Appraisal US$2.0 million; Actual US$5.97 million). The focus of this component was to strengthen the functions of MOH in planning, budgeting, and monitoring.

The components were not revised, but the 2012 additional financing provided support to the activities of the Free Malaria Care Initiative, including reimbursement of related services and operating costs, procurement of goods, rapid diagnostic tests, Artemisinin-Based Combination Therapy, and malaria treatment kits. Another revision included the cancellation of support to the Health Equity Fund and using the RBF mechanism to fund free health care for the identified poorest households.

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

Costs and Financing. The original project costs were estimated at US$33.8 million, consisting of an IDA grant of US$22.8 million and a grant of US$11 million from the Multi-Donor Trust Fund for Health Results Innovation. Additional financing consisting of an IDA Grant of US$10 million was approved on 3/15/12. The total estimated project costs aggregated at US$43.80 million, and actual costs at US$43.58 million. There was no direct Borrower financing.

Dates. The project was approved on 5/6/10, but effectiveness was delayed by 16 months until 9/30/11 because of the slow recruitment of a verification agency. The project was restructured on 2/17/12 to revise the project development objectives and to accommodate additional financing. The 2012 restructuring extended the project closing date by one year, from 12/31/14 to 12/31/15. A restructuring on 2/1/13 revised the results framework. A Mid-Term Review was carried out on 2/20/14. A project restructuring on 4/20/15 reallocated funds between disbursement categories. The closing date was extended by 18 months on 8/11/15, and the project closed on 6/30/17.

3. Relevance of Objectives

Rationale

Around appraisal, maternal mortality was high at 397 maternal deaths per 100,000 live births; child mortality at 125 per 1,000; infant mortality at 67 per 1,000; total fertility rate at 5.7; contraceptive prevalence with modern methods low at 7%; and life expectancy at birth low at 54.4 years (2006). Malaria was a major cause of morbidity and mortality in the country. The sector suffered from a lack of accountability among health care workers and health facilities, and from low service quality. Poor households faced difficulties in paying out-of-pocket healthcare expenses. The national poverty rate was estimated at 35.2% in 2009. Effective coverage with high-impact interventions was considered a government priority. The objectives were in line with the Country Assistance Strategy 2009–2012, which planned to channel the Bank's support toward increasing access to basic services and improvement in service quality. Political commitment was strong at entry, as the project's objectives were and remain consistent with national priorities (PAD, p. 18).

The objectives remained aligned with Pillar II, "Improving Access to Basic Social Service Delivery and Social Inclusion", of the Bank's Country Partnership Strategy 2013-2017, which was elaborated during project implementation and remained current at project closure. While the project objectives continued to be relevant, the ICR stated that, by the time the project neared its closure, the new government in 2016 lacked commitment to the RBF 'mechanism', as the new government perceived the RBF approach only as a distribution of bonuses to health staff (ICR, p. 38). The TTL explained that the new government disapproved of paying incentives/bonuses to civil servants who were performing their expected duties (TTL clarifications, 6/20/18). The new government was interested in developing the Insurance for Strengthening Human Capital (Assurance pour le renforcement du capital humain or ARCH) that would include health insurance, pension insurance, microcredits, training, and the creation of a National Social Protection Agency.

Rating
Substantial

4. Achievement of Objectives (Efficacy)

Objective 1
Objective
Increase coverage of maternal and neonatal health care services in the targeted areas.
(Under the original objective and original outcome targets)

Rationale
Activities related to improving health facilities' performance and enhancing financial accessibility to health services could reasonably be expected to contribute to higher accountability of facilities and health workers and more effective performance, which in turn would plausibly result in better coverage of maternal services.

Outputs

The main outputs consisted of RBF credits, whereby health care facilities received credits proportional to achieved results. The contracts between health care facilities and MOH defined indicators and targets to be reached. Achievement of these targets was verified by external reviewers. The RBF supported health services, basic equipment, medicines, medical supplies, personnel training, vehicles, ambulances, and motorized boats.

Verification of results and payments to health facilities and personnel subsidies were undertaken by an independent international agency (known as the Consortium AEDES-SCEN AFRIK, ICR, p. 41), and included quantitative and qualitative results verification.

Intermediate results indicators

- 2,152 health personnel received training, exceeding the target of 1,000 personnel.
- 55,331 poor households were identified, short of the target of 58,883.
- 100% of facilities had RBF results fully verified each year, achieving the target of 100%.
- Note: The ICR (pp. 40-41) stated that verification of results and payments to health facilities and personnel subsidies were adequately undertaken, and that "fraud did not occur through 'gaming' of the system."

Outcomes

- The number of pregnant women receiving antenatal care during a visit to a health provider increased from a baseline of 220,000 in 2010 to 406,742 in 2017, exceeding the original target of 280,000.
- The number of female beneficiaries increased from a baseline of 180,000 in 2010 to 3 million in 2016, exceeding the original target of 270,000 (according to the TTL, 6/20/18, the beneficiary and target numbers were cumulative).
- The number of total direct project beneficiaries increased from a baseline of 300,000 in 2010 to 5.4 million in 2016, exceeding the original target of 450,000 (according to the TTL, 6/20/18, the beneficiary and target numbers were cumulative).
- The rate of poor pregnant women that had at least 4 antenatal care visits before delivery was not available because the impact evaluation was not carried out (ICR, p. 50).

Rating
Substantial

Objective 1 Revision 1
Revised Objective
Increase coverage of maternal and neonatal health care services in the targeted areas.
(Under the revised outcome targets)

Revised Rationale

Outputs are the same described above under the original Objective 1 with the addition of outputs related to the Free Malaria Care Initiative, which included, as stated in Section 2d, rapid diagnostic tests, malaria treatment kits, and malaria combination therapy.

Intermediate results indicator: 100% of pregnant women who sought and obtained health services under the project, in the eight project districts, received Free Malaria Care, exceeding the target of 43%.

Outcomes

- The number of pregnant women receiving antenatal care during a visit to a health provider increased from a baseline of 220,000 in 2010 to 406,742 in 2017, short of the revised target of 410,000.
- The number of female beneficiaries increased from a baseline of 180,000 in 2010 to 3 million in 2016, exceeding the revised target of 0.84 million (according to the TTL, 6/20/18, the beneficiary and target numbers were cumulative).
- The number of direct project beneficiaries increased from a baseline of 300,000 in 2010 to 5.4 million in 2016, exceeding the revised target of 1.4 million (according to the TTL, 6/20/18, the beneficiary and target numbers were cumulative).
- The number of beneficiaries (pregnant mothers and children) of Free Malaria Care increased from a 0 baseline in 2012 (according to Corporate Results Indicators, a zero baseline means that a newly approved project has not yet started contributing to the provision of related essential HNP services) to 514,007 in 2017, exceeding the target of 415,000.

Revised Rating
Substantial

Objective 2
Objective
Increase the quality of maternal and neonatal health care services in the targeted areas.
(Under the original objective and original outcome targets)

Rationale
Activities focusing on improving health facilities' performance could reasonably be expected to contribute to higher accountability of facilities and health workers, which in turn would plausibly contribute to enhancing the quality of health services.

Outputs are the same described above under Objective 1.

Intermediate results indicators

- The average availability of essential drugs in health facilities increased from 61% to 80.2% in 2017, short of the target of 85%. However, the ICR noted that the availability of essential drugs was practically achieved, as facilities were able to purchase drugs using part of the resources given to the health facilities (ICR, p. 53).
- The average availability of essential equipment in health facilities increased from a baseline of 67% in 2010 to 78% in 2016, almost fully attaining the target of 80%. The ICR noted that the availability of essential equipment was practically achieved, as the RBF made resources available to health facilities to purchase small equipment as needed (ICR, p. 54).
- The average availability of health workers increased from a baseline of 79.7% in 2010 to 86% in 2016, short of the target of 90%.
- The percentage of facilities whose RBF results have been fully verified each year increased from a baseline of 0 in 2010 to 100% in 2017, achieving the target of 100%.

Outcomes

The rate of antenatal care visits among all pregnant women complying with quality standards increased from a baseline of 39% in 2010 to 52% in 2017, short of the original target of 70%.

Note on quality standards: The ICR (p.27) stated that the assessment of quality aspects used a composite grid or balanced score card. (The score card included qualitative data from the registers, premises, medical records, availability of drugs, availability of equipment, and other health care parameters. Further details can be found in the ICR, pp. 28-30.)

Rating
Modest

Objective 2 Revision 1
Revised Objective
Increase the quality of maternal and neonatal health care services in the targeted areas.
(Under the revised outcome targets)

Revised Rationale
Outputs are the same as described above under Objective 2.

Outcomes

- The rate of antenatal care visits among all pregnant women complying with quality standards increased from a baseline of 39% in 2010 to 52% in 2017, exceeding the revised target of 40%. (However, while progress is duly noted, this ICR Review concludes that the project was not ambitious for this quality outcome target, as it has raised the revised target by only one percentage point, from 39% to 40%).
- A customer satisfaction survey (Community Verification Survey in Eight Targeted Health Zones) was carried out by MOH in project areas in 2017, and indicated that 97.6% of beneficiaries had a positive view of the services received, ICR, p. 31. (However, the ICR did not provide further details that would have strengthened the value of survey data as evidence of achievement, i.e., information on the selection criteria of customers to be surveyed, the survey method and actual survey instrument used, the number of customers surveyed, and the response rate.)

Revised Rating
Substantial

Objective 3
Objective
Increase coverage of child health care services in the targeted areas.
(New objective added in 2012)

Rationale
Activities focusing on improving health facilities' performance and enhancing financial accessibility to health services could reasonably be expected to contribute to higher accountability of facilities and health workers, which in turn would improve health services performance that would plausibly result in better coverage of health services for children.

Outputs are the same described above under the original Objective 1, as maternal and child health services are largely integrated. In addition, outputs included immunizations and malaria-related outputs, including rapid diagnostic kits for malaria, treatment kits, and Artemisin-based Combination Therapy.

I**ntermediate results indicator:** 100% of children under five who were reached by health services in the eight project districts received Free Malaria Care.

Outcomes

- The number of children immunized increased from a baseline of 70,000 in 2010 to 365,868 in 2017, almost fully achieving the target of 380,000. [Note: Explanation of an immunized child: the national policy (ICR, pp.20-21) requires children to receive the following vaccines before their first birthday: BCG

(tuberculosis); polio; Penta1-2-3 (diphtheria, tetanus, whooping cough, hepatitis B, Haemophilus influenzae type B); PCV13 (Pneumococcal vaccine); measles; and yellow fever.]

- The number of beneficiaries (children and pregnant mothers) of the Free Malaria Care increased from a 0 baseline in 2012 (according to Corporate Results Indicators, a zero baseline means that a newly approved project has not yet started contributing to the provision of related essential HNP services) to 514,007 in 2017, exceeding the target of 415,000.

Rating
Substantial

Objective 4
Objective
Strengthen the institutional capacity of the Ministry of Health.

Rationale
Strengthening of planning, budgeting, and monitoring processes could reasonably be expected to improve related functions and better allocations among districts and facilities, and to facilitate decentralization, which in turn would plausibly result in strengthened institutional capacity at MOH.

Outputs

Outputs consisted of staff training in planning, budgeting and monitoring, consultant services, financing the project implementation unit, provision of vehicles and motorcycles to facilitate supervision and data collection, and strengthening of the health information system.

Outcomes

The share of the MOH budget allocated to health districts increased from a baseline of 41% in 2010 to 69% in 2017, exceeding the target of 65%. According to the ICR (p. 32), this reflected the country's willingness to make more funding available for autonomous decision-making in accordance with the Bamako Initiative (adopted by African health ministers in 1987 to implement strategies designed to increase the availability of healthcare services and essential drugs for Sub-Saharan Africans). During the visit of the ICR team to health facilities, staff reported that RBF operations enabled them to purchase needed equipment and to improve working conditions (ICR, p. 31).

Improvements in the National Health Information and Management system were documented by the reduced gap in verified and unverified data (ICR, p. 30): At the beginning of project implementation, there were large differences between data reported by health facilities and RBF-validated data. As project implementation progressed, the gap decreased between the national system data and RBF-validated data, from 24.9% in

2012 to 3.8% in 2016 for health centers, and from 34.6% in 2012 to 11% in 2016 for hospitals in the project area.

According to the ICR (p. 32), capacity building enabled the ministry to improve the quality of its annual health statistics, programming and forward planning, the National Health Development Plan for 2017–2021, and the annual workplans, which were produced with the assistance of the project. The ICR (p. 33) stated that the strengthened functions improved the ministry's readiness for adopting a sector-wide approach in the future.

Rating
Substantial

Rationale
The aggregation of the ratings leads to overall efficacy ratings of Substantial under the original objectives, revised objectives, and revised outcome targets.

Overall Efficacy Rating
Substantial

5. Efficiency

The PAD referred to international experience and stated that scaling up a set of interventions on maternal and neonatal health was known to be cost effective in a variety of studies and across many countries (PAD, p. 21). The PAD's economic and financial analyses used the Marginal Bottleneck Budgeting tool which was adequately applied and considered the number of maternal and child lives saved by improving the coverage and quality of maternal and child health services over six years (PAD, pp. 79-83). The PAD's analysis compared between the project scenario and the status quo, and made reasonable assumptions, with the annual value of a life lost being considered to be equivalent to the Gross Domestic Product per capita (based on IMF data) and with the Active Life Expectancy being assumed at 30 years (PAD, p. 79). The PAD estimated a benefit-to-cost ratio equal to 2.7, i.e., US$1 invested in the project would generate benefits equivalent to US$2.7.

The ICR undertook a cost-benefit analysis that considered benefits accrued from reduced maternal deaths, reduced stillbirths, treating malaria in pregnant women and under-five children, and increased health personnel productivity. The ICR covered the period 2012-17, and used a discount rate of 3%. The ICR (p.75) stated that the 3% discount rate aimed to reflect the preference of project beneficiaries and government to receive the benefits of reduced mortality earlier than later (time preference); to explain the increased ambiguity about receiving predicted benefits further into the future (risk premium); and to ensure uniformity and comparability

with other economic evaluations for similar interventions. But the ICR did not provide a sensitivity analysis that would have shown the estimated values under higher discount rates. The ICR (p. 78) estimated the net present value at US$31 million, the benefit cost ratio at 5.75, and an internal rate of return at 23.4% (ICR, p. 78).

There were significant shortcomings in the efficiency of implementation. Effectiveness was delayed by 16 months, as the conditions of effectiveness were not fulfilled until 9/30/11, particularly for the recruitment of the third-party verification agency for reviewing and verifying the results of the maternal, neonatal and child health services (ICR, pp. 35 and 39). Successive strikes during 2009, 2010, and 2011 by health workers at all levels of the health system constituted an important impediment to project implementation (ICR, p. 39). The ICR stated that health staff went on strike almost daily for improving their working conditions and that it was not possible to begin adequate implementation because of the strikes. Implementation progressed after 2014. The project closed on 6/30/17, with two extensions aggregating at 30 months.

Significant inefficiencies were also reported at the community level. After two years of project implementation, it was noted that the improvement in the number of consultations at health facilities was not appreciable, that many deaths of under-five year old children and pregnant women were at home, and that the patients had not been referred to qualified personnel at health facilities. Therefore, a community approach was introduced in January 2015. 500 community health workers were trained and provided with financial incentives to motivate them to deliver a package of community health services. But the community scheme suffered from several issues that included a lack of basic knowledge of community workers about their mission, late payment of incentives, and non-involvement of local authorities such as the mayors and health facility staff who did not play their roles effectively in monitoring and supervision. As most of the indicators were facility-based, the staff did not have any incentive to work with the communities (ICR, pp. 39-40). In addition, and as 54% of patients were attended by the private sector in Benin, the project decided in 2016 to involve the private health sector in the RBF. Training was provided to 11 private health facilities in the project areas, and contracts were developed between MOH and nine of the 11 facilities (ICR, p. 40), but the scheme was implemented for only a few months before project closure on 6/30/17. The identification of indigents was delayed, and their coverage started only in early 2017 (ICR, p. 40), before project closure on 6/30/17. Verification was complex and costly, and the ICR cited a project study carried out between July 2013 and June 2014 showing that for every US$1 paid to health facilities, US$0.50 was consumed by verification. Processing time was long and affected the link between performance and RBF subsidies, thereby negatively affecting the RBF scheme (ICR, p. 41).

Efficiency Rating

Modest

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	✓	23.40	66.00 ☐Not Applicable

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

6. Outcome

Relevance of objectives is assessed across the entire project and is rated Substantial, as the objectives remained consistent with Bank and government strategies. Efficiency is also assessed across the entire project and is rated Modest in view of significant shortcomings in the efficiency of implementation. Efficacy is rated Substantial under both the original and revised objectives and revised outcome targets. Therefore, overall Outcome is rated Moderately Satisfactory.

According to IEG/OPCS guidelines, when a project's objectives or its key associated outcome targets are revised, the final outcome is determined by the weight of Bank disbursements under each set of objectives (3% under the original objectives and 97% under the revised objectives). However, since the outcome ratings are the same for both, a formal calculation is unnecessary, and the overall outcome is rated Moderately Satisfactory, indicating moderate shortcomings in the project's preparation, implementation, and achievement.

a. Outcome Rating

Moderately Satisfactory

7. Risk to Development Outcome

Development outcomes are considered at risk. In September 2016, the new government put in place a health reform commission, but RBF was not mentioned in any of the policy documents, and there were no discussions on the modalities to sustain results with a progressive transfer of RBF management and funding to the government. As stated in Section 3, the new government disapproved of paying incentives/bonuses to civil servants who were performing their expected duties. Further efforts to harmonize different RBF models in the country were not fruitful, and management autonomy of health facilities was limited. The plan to set up a national technical unit for RBF, that would eventually replace the various projects, did not materialize, and, as stated in Section 3, the new government's attention was focused on developing the Insurance for Strengthening Human Capital or ARCH. All RBF funding ended at project closure (ICR, p. 46). The TTL stated that the discontinuation of RBF was a political decision in the context of a new broad vision for health and social protection (TTL clarifications 6/20/18). Therefore, it is likely, at least in the near term, that coverage and quality of health services would decline.

8. Assessment of Bank Performance

a. Quality-at-Entry

The project design was pertinent, as RBF usually contributes to improving health system performance that would support the objective to strengthen maternal and child health services. In 2009, the Bank carried out a study on maternal and infant mortality and health system performance, based on which MOH decided to put in place RBF. The basis for selecting the eight project districts was not elucidated by the ICR, but the PAD provided a comparative list of criteria that were used for the selection and noted that the districts were among the poorest and without donor support (PAD, p. 114). Project preparation considered lessons learned from past experience, including the benefits of setting a dedicated financial channel to avoid delays, and the upfront provision of technical assistance for RBF support. The outcomes could be monitored, and the project considered good practices from RBF projects in Rwanda and Burundi, such as the involvement of independent reviewers and community-based organizations in monitoring RBF results (ICR, p. 38). The quality of M&E design was mixed, with a large number of indicators, some of which were unnecessary and none of them mentioned "neonates" (ICR, p. 41). The ICR did not provide enough information on quality at entry aspects, and relevant information was drawn from the PAD which indicated that implementation arrangements, financial management and disbursement arrangements were adequately prepared (PAD, pp. 16-17). The existing Medical Waste Management Plan was revised and updated. The PAD illustrated the risks that were identified along with mitigation measures, which included the assignment of a qualified project team with technical support from the Belgian Technical Cooperation and UNICEF (PAD, pp. 19-21). However, the risk of low community demand to utilize health services was not identified, and the project subsequently trained 500 community health workers to address this issue.

Quality-at-Entry Rating

Moderately Satisfactory

b. Quality of supervision

The Bank team reportedly provided constant implementation and technical support, both through field visits and from a distance, notably to the Project Coordination Unit. Supervision missions were regular and included financial management and environmental safeguards experts. Reporting through the Implementation Status Reports was adequate, and at the end of each mission, a detailed briefing was held with the government. The aides-memoire included clear recommendations. The Bank team managed the project proactively, as evidenced by project restructurings. Fiduciary monitoring was adequate. The team collaborated well with stakeholders and development partners and undertook several joint review missions with other agencies (UNICEF, Global Fund, GAVI, Belgian Technical Cooperation, World Health Organization, United States Agency for International Development, and the

Embassies of Belgium and Netherlands) along with MOH. Collaboration with development partners led to the scaling up of RBF in all 34 districts of the country in 2015.

Quality of Supervision Rating
Satisfactory

Overall Bank Performance Rating
Moderately Satisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design
The objectives to increase coverage of quality maternal, neonatal, and child health care services were adequately specified, but the objective to strengthen the institutional capacity of MOH was generic, although it was explained by the PAD's description and its causal chain as being focused on improving planning, budgeting, and monitoring functions (PAD, p. 7). The indicators reflected the operation's contribution toward achieving the intended outcomes, and indicators were measurable, although their number was high at 33. The indicators did not specifically include neonates. Institutional strengthening was to be jointly monitored by development partners (PAD, p. 17), but more relevant outcome indicators could have provided a stronger reflection of strengthened institutional capacities of MOH. Overall, the theory of change was adequately reflected in the results framework. Baseline values were available. M&E arrangements built upon the existing national information system, which was planned to be further strengthened. The design planned for verification through an independent external agency.

b. M&E Implementation
According to the ICR, and although verification was undertaken, it was complex, time consuming, and costly (Section 5). In some cases, delayed processing made it difficult to link performance with RBF subsidies. Technical assistants did not have sufficient time for coaching and supervision. Project data were adequately collected and put onto the portal of the Benin RBF. The first development objective was revised on 2/17/12 to include coverage of child health care services (Section 2a). An outcome indicator (number of beneficiaries of the Free Malaria Care) was added to monitor progress of the Free Malaria Care Initiative. Unnecessary indicators were dropped. The impact evaluation that was planned at the design stage was not undertaken at the end of the project reportedly because all the districts were implementing RBF with no control group being available for comparisons.

During implementation, the project strengthened the capacities of the national information system and improved its performance, including though the use of information and communication technologies, management of infrastructure and equipment, training, planning, and coordination. The project put in place the district health information software at the national level (ICR, p, 32), reduced overlapping of M&E processes, and integrated the information systems of the National Malaria Control program, HIV and AIDS, and the tuberculosis national program. The ICR noted the improvements made in reducing the differences between the national system-reported data and the validated data (Section 4).

c. M&E Utilization

M&E findings were used for basic project needs toward the effective functioning of RBF, and in overall monitoring and evaluation of the project. When M&E indicated low demand for health services, a community outreach was introduced in 2015; and, in 2016, the project involved nine private health facilities in RBF.

M&E Quality Rating

Modest

10. Other Issues

a. Safeguards

The project was classified as Category B and triggered OP/BP/GP 4.01 (Environmental Assessment), given the potential risks associated with the handling and disposal of medical waste. MOH revised the existing Medical Waste Management Plan and disseminated it. The project financed awareness-building activities and training programs for health workers through the Hygiene and Basic Sanitation Department at MOH. Mosquito nettings were applied to windows and beds in hospitals. The ICR (p. 43) stated that the acquisition of most of the equipment and materials for medical waste management was made possible by the RBF subsidies received by health facilities, and several facilities were visited by the ICR team. However, the ICR did not offer an explicit statement about safeguards compliance.

b. Fiduciary Compliance

Financial management. Financial management arrangements and performance were adequate (ICR, p. 44). A dedicated financial channel was put in place to allow speeding up of RBF financial transfers from central to local levels. Prior to 2015, a cash flow issue was encountered because of the low cap applied to the designated account, and time was required for replenishments. Starting in June 2015, the project shifted from SOE-disbursement mode to Intermediate Financial Reports disbursement mode, resulting in

quicker cash flow, with project expenses being financed in real time. The ICR did not offer comments on the timeliness of audits and whether any of the audits were qualified. The TTL (6/20/18) confirmed audit timeliness and that there were no qualified audits.

Procurement. Procurement was carried out according to Bank guidelines, grant provisions, and the project implementation manual. The ICR (p. 44) considered procurement performance to be satisfactory. However, there were moderate delays in clearances by the National Public Procurement Control Board and in signing procurement contracts.

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	Moderately Satisfactory	This ICR Review rated efficiency as Modest because of significant shortcomings in the efficiency of implementation. The aggregation of Substantial relevance of objectives, Substantial efficacy, and Modest efficiency leads to a Moderately Satisfactory overall outcome rating.
Bank Performance	Satisfactory	Moderately Satisfactory	This ICR Review rated the quality at entry as Moderately Satisfactory because of moderate shortcomings (Section 8).
Quality of M&E	Modest	Modest	---
Quality of ICR		Modest	---

12. Lessons

The ICR (pp. 47-48) offered several useful lessons, including the following lessons re-formulated by IEG:

Insufficient political support jeopardizes RBF sustainability. This was noted at the end of this project. While political commitment to development objectives remained steady, the new government did not support the RBF mechanism because it perceived the RBF approach as a distribution of bonuses to health staff (Section 7 and ICR, p. 38).

Adequate verification of results helps to minimize the "gaming of the system" since RBF payments to facilities and staff would be commensurate with actual performance (Section 4).

Enhanced autonomy of health facilities promotes performance. Such autonomy, although limited, enabled the procurement of medicines and equipment (Section 4). The ICR noted that the volume of services would likely have been higher if the autonomy of health facilities had been more extensive as originally designed.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

The ICR addressed the project's experience in a candid manner. The ICR was largely aligned to development objectives and explained the theories of change underlying the project's objectives. The evidence provided was adequate overall. Lessons were derived from project experience. The narrative and available evidence supported the ICR conclusions on efficacy and relevance of objectives, but not on efficiency. The quality at entry section consisted of a paragraph on the relevance of putting in place an RBF mechanism (ICR, p. 44) rather than offering information on various criteria for determining quality at entry and risk assessment. In other sections, the ICR included unnecessary details that added to length. There were internal inconsistencies in the project ratings between the ICR's Data Sheet (p. 3) and the corresponding sections of the ICR. On two important issues, the ICR diverged from guidelines: (a) the ICR did not offer sufficient information on financial management compliance and audits, which were subsequently provided by the TTL; and (b) the ICR did not provide an explicit statement about compliance with environmental safeguards.

a. Quality of ICR Rating

Modest