Report Number: ICRR0022298

1. Project Data

Project ID P147740	**Project Name** Health Systems Strengthen. & Ebola Prep.
Country Cote d'Ivoire	**Practice Area(Lead)** Health, Nutrition & Population

L/C/TF Number(s)	Closing Date (Original)	Total Project Cost (USD)
IDA-55570,IDA-D0030	31-Jan-2020	64,193,280.13
Bank Approval Date	**Closing Date (Actual)**	
25-Nov-2014	31-Jan-2020	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	70,000,000.00	0.00
Revised Commitment	70,000,000.00	0.00
Actual	64,378,458.92	0.00

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

a. Objectives

The objectives of the project were to strengthen the health system and improve the utilization and quality of health and nutrition services in selected regions (Financing Agreement, 12/17/2014, p. 5). The statements of objectives were identical in the Project Appraisal Document (PAD) and ICR.

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

No

c. Will a split evaluation be undertaken?

No

d. Components

1. Performance-based financing (Appraisal US$38.5 million; Actual US$36.5 million).

(a) Provision of health service packages through the use of performance-based financing (PBF) approach in selected regions, with an emphasis on maternal and child health and nutrition interventions.

(b) Building capacities to support the implementation of PBF through technical assistance, training programs on PBF concepts and procedures, provision of goods, and monitoring and evaluation of activities carried out under PBF, including through the services of community-based and independent verifiers.

2. Strengthening the health system for improved performance (Appraisal US$38.5 million; Actual US38.5 million).

(a) Health insurance: improving health insurance coverage (Universal Health Insurance), including through (i) development of criteria targeting the poor; (ii) study of service costs; (iii) analysis of sustainability of Universal Health Insurance and PBF activities; (iv) supporting information system linkages needed for Universal Health Insurance; and (v) engaging long-term technical assistance to support the ongoing development and operation of Universal Health Insurance.

(b) Essential infrastructure: Carrying out a program of activities aimed at: (i) rehabilitating selected health facilities; (ii) acquiring essential equipment to supply newly rehabilitated facilities; (iii) monitoring the availability and use of equipment; and (iv) conducting surveys to ensure that the rehabilitated health facilities are fully operating.

(c) Health management information systems: The project would support (i) the development of a facility-based information system to be linked to Universal Health Insurance, including for the purposes of reporting on PBF; (ii) training of a cadre of staff on the utilization and further development of information systems; and (iii) development of electronic patient records.

(d) Improving the management of the health system, including (i) capacity strengthening to manage Universal Health Insurance and PBF; (ii) supporting hospital reforms; and (iii) developing a community health strategy in coordination with other development partners.

(e) Ebola preparedness through acquiring essential equipment, supplies, drugs and vehicles in preparation for a potential emergence of Ebola virus and other communicable disease outbreaks, in coordination with UNICEF.

Additional information on planned project support to Ebola preparedness (PAD, p. 37): US$10 million were allocated at appraisal and were fully disbursed. Project support to Ebola preparedness was part of an overall Ebola Plan of US$27.5 million. The subcomponent planned to provide 26 ambulances; 24 4x4 vehicles; 100 motorcycles; 4 infrared body scanners; 400 portable infrared thermometers; laboratory

reagents; hand washing equipment and supplies for health facilities, schools, universities, the military and police; medications; disinfection material; personal protective equipment; and gloves and masks. Related expenses were to be pre-financed by UNICEF, and would be eligible for retro-active financing. Key development partners, including the French Development Agency (AFD), African Development Bank, and European Union (EU), were planning to support the Ebola response, but corresponding amounts were not known.

(f) Establishing the Project Implementation Unit and the Technical Committee for PBF, and providing technical assistance, training, operating costs, goods, and services.

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

Cost and financing. At appraisal, project costs were estimated at US$77 million, including US$70 million in Bank financing (an IDA Credit of US$35 million and a Grant of US$35 million), and government financing of US$7 million that were earmarked for PBF. The total actual cost aggregated at US$71.2 million, consisting of actual Bank financing of US$64.4 million, and actual government financing of US$6.8 million.

Development partners support. The Global Fund (GFATM) co-financed PBF subsidies on a parallel basis in five additional project districts. The extent of support from various donors to the health sector was extensive. In this context, the ICR stated that the project complemented the work of the country and other donors (ICR, p. 7). Main donor involvement included the AFD and EU, both focusing on health system strengthening; the GFATM; the Vaccine Alliance -- GAVI; the United States President's Emergency Plan For AIDS Relief -- PEPFAR, United States Agency for International Development -- USAID; United Nations Population Fund -- UNFPA; the World Health Organization -- WHO; and the United Nations Children's Fund – UNICEF, including the provision of Vitamin A supplements.

Dates. The Project appraisal document was finalized on 11/04/2014 and the operation was approved on 11/25/2014. The project became effective on 03/16/2015. A Midterm Review was carried out on 02/12/2018. A level 2 restructuring on 10/04/2019 adjusted the results framework and reallocated project proceeds between disbursement categories. The project closed on 01/31/2020.

3. Relevance of Objectives

Rationale

Prior to the project, during the period between 2002 and 2012, the country experienced political and social disruptions, civil war, and a post-electoral crisis, all of which have taken a heavy toll on the health system, including from the closure and looting of hospitals and health centers (PAD, p. 2). At appraisal, the objectives were responsive to country priorities and needs, including for improving health infrastructure. Health indicators were among the weakest in the region (PAD, p. 6), and there were barriers to health services utilization encompassing access, availability, affordability, and acceptability (PAD, p.

2). The objectives were in line with sector policies, such as the National Health Policy and National Health Development Plan for 2012-2015. The government also intended to improve the level of preparedness to respond effectively to an Ebola Virus Disease outbreak in the region, given uncontrollable border crossings near the country's western border (PAD, p. 1).

At project closing, the objectives remained relevant to the Country Partnership Framework (CPF) for FY16-19, that was extended until FY21. The CPF has three Focus Areas: accelerating sustainable private sector-led growth; building human capital for economic development and social cohesion; and strengthening public financial management and accountability. Focus Area 2 on building human capital encompasses three objectives: improve education service delivery and youth employability; expand affordable social protection; and improve the delivery of quality health and water services, under which the "number of people with access to a basic package of health, nutrition or reproductive health services" constitutes a CPF indicator. Hence, there was a considerable degree of alignment between project objectives and the CPF at closing.

Rating
High

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective
Improve utilization of health and nutrition services in selected regions.

Rationale
Theory of change

Under objectives 1 and 2 (utilization and quality of services), it was reasonably expected that the provision of health services and financial resources based on performance; improved staff skills in technical aspects and management; monitoring of quality scores for health facilities; improved physical infrastructure; improved information systems and quality of data; and communication activities for demand generation would plausibly result in improved utilization and quality of health and nutrition services in selected regions.

There was a moderate gap in the results chain at entry, where the treatment of severely malnourished children was an expected PDO outcome even though there were no specific activities for intensive support to treat malnourished children (ICR, p. 15). This issue was subsequently rectified in 2018.

Note on the selection of districts for PBF piloting: According to the PAD (p. 28), the district selection process used two sets of information: (i) the number of health-related projects being undertaken by other development partners in each district, and (ii) the performance of each district with respect to four important indicators: assisted delivery, pre-natal visits; immunization with DPT3, and malnutrition. At entry, 14 out of 83 districts were selected, and the ICR (p. 24) stated that the project was explicitly designed as a pilot.

Outputs

Main outputs consisted of signed performance contracts with districts; provision of health and nutrition services; development of manuals and guides for the preparation of business plans; training and technical assistance; infrastructure rehabilitation; capacity development in management and accountability; development of health information processes originating at the level of health centers; and implementation of information, education and communication interventions to stimulate demand for health and nutrition services.

The project phased its PBF implementation. In 2016, PBF operations were applied to a first group of four districts, followed in 2017 by a second group of 10 districts. The sequencing allowed additional preparatory time and learning opportunities for the second group of districts.

The GFATM partnered with the government in 2017 to support PBF in five additional districts, beyond the originally envisaged 14 districts, resulting in an aggregate total of 19 PBF districts out of 83 districts in the country (the TTL clarified on 09/11/2020 that the total number of districts continues to rise through the administrative division of existing districts, thus leading to 21 PBF project districts out of 103 total districts at present, i.e., in 2020). In the five additional districts, the GFATM financed only PBF subsidies, while the Bank-supported project provided technical assistance, supervision, and verification activities (ICR, p. 15).

Intermediate results

The number of people with access to a basic package of health, nutrition, or reproductive health services reached 7.8 million, exceeding the target 7.4 million people. Direct project beneficiaries were 7.6 million, and the percentage of female beneficiaries was 62.1%, exceeding the target of 60%.

The percentage of women using modern family planning methods increased from a baseline of 13.8% in 2015 to 15.8% in 2020, attaining the target of 15.6%.

Children under 5 who received Vitamin A supplementation reached 361,042 children in 2010, short of the original target of 706,350 children, but exceeding the revised target of 300,000 children. The target was appropriately revised at the Mid-Term Review in 2018 (with a formal revision under the restructuring of 10/4/2019), as the national supplementation strategy changed from a campaign mode to a facility-based supplementation, where supplementation needs were clearly less than the amounts required for campaigns.

The number of pregnant women receiving antenatal care during a visit to a health provider was 411,246 women in 2020, exceeding the target of 368,048 pregnant women.

The number of health facilities “constructed or renovated” was 138 facilities in 2020, exceeding the revised target of 97 facilities. The achievement was short of the original target of 526 facilities under the original indicator “facilities constructed, renovated, and/or equipped” (the original indicator pooled civil works and equipment without explicit targets for each). After project approval, several development partners came forward with resources to equip health facilities and to finance some rehabilitation. Hence, the project shifted its focus exclusively toward construction and rehabilitation (ICR, p. 14). Development partners provided

medical equipment and financed the rehabilitation of several facilities among 200 facilities that were previously targeted for rehabilitation (ICR, p. 46). At the same time, 265 health facilities dedicated resources to improve their physical infrastructure using PBF resources (ICR, p. 19).

The number of health personnel receiving training reached 4,893 persons in 2020, exceeding the target of 4,720 persons.

The project established nutrition units in 269 health centers among 14 PBF districts in 2018.

The availability of equipment and supplies at the National Institute for Public Hygiene attained 88%, exceeding the target of 75%.

Outcomes

Overall, utilization of integrated health and nutrition services under primary care was enhanced by the project, as the number of consultations increased across the board for urban and rural facilities. PBF resources allowed health facilities to reach out to surrounding communities and to remote areas through mobile health services, thus further increasing access to services. PBF provided resources to attract patients to health centers, including by hiring transportation to bring pregnant women who were close to labor to health facilities, construction of toilets in maternity areas, and offering baby kits to mothers delivering in health facilities.

The per capita utilization of services in PBF districts increased from a baseline of 34% in 2015 to 58.6% in 2020, exceeding the target of 56%.

The rate of utilization of health services in the first group of PBF districts increased from a range of 20-25% in 2016 to a range of 40-59% in 2019; and in the second group of districts, from a range of 10-20% in 2017 to a range of 43-82% in 2019.

Vaccination coverage (DPT-HepB-HiB3) in PBF districts increased from a baseline of 97% in 2015 to 100% in 2020, exceeding the target of 99%.

The number of in-facility deliveries that were attended by trained health personnel increased from a 2015 baseline of zero (under the Corporate Results Indicators, a zero baseline means that a newly approved project has not yet started contributing to the provision of essential HNP services) to 217,818 deliveries under the project in 2020, exceeding the target of 191,209 deliveries. A percentage comparing in-facility attended deliveries among all deliveries would have been informative.

The number of severely malnourished children detected and treated increased from a baseline of zero in 2015 to 19,941 children in 2020, exceeding the target of 16,220 children (the TTL noted on 9/11/2020 that most of the detected children who were moderately or severely malnourished were treated upon the establishment of the nutrition units).

Rating

Substantial

OBJECTIVE 2

Objective

Improve the quality of health and nutrition services in selected regions.

Rationale

Theory of change: the same as under Objective 1, above.

Outputs: the same as under Objective 1, above.

Outcomes

The technical quality score for all the PBF districts increased from 47.8% in 2016 to 82.9% in 2019, and the average quality score improvement for facilities covered by PBF reached 35%, exceeding the target of 30%. The score included criteria that were specific to both health and nutrition services, as explained below.

Explanation of the technical quality score: The score was measured by a set of indicators defined in the PBF Manual (ICR, p. 21), and further explained by the TTL (9/11/2020). The score was included in the WHO/UNICEF standard survey on Service Availability and Readiness Assessment. Indicators included readiness and availability of services reflected by (a) general indicators such as registries, business plans and financial management; and (b) service indicators such as vaccinations, prenatal care, nutrition, diarrhea, malaria, acute respiratory infections, pharmacy, hygiene, security, and environment. For nutrition, criteria included availability of necessary inputs such as scales and therapeutic feeding supplies; and service criteria such as growth monitoring and treatment of malnourished children.

In addition, the ICR mission made several observations based on its field findings. During mission interviews, the improvement in the quality of validated health data was consistently considered one of the main achievements supported by the project. By project completion, registries at health facilities were properly completed, as they were key to show performance and to receive financial resources. The ICR mission noted a sustained results-orientation mentality in Regional and District Health Directorates and health centers. Another observation was the acknowledgement of greater transparency in the use of funds (ICR, p. 19).

Rating

Substantial

OBJECTIVE 3

Objective

Strengthen the health system.

Rationale

Theory of change

As stated previously in Section 2e, the project complemented the work of the country and other donors in the health sector (ICR, p. 7) and, according to the ICR, the project focused on the following areas:

(i) providing technical assistance to develop a national health insurance system;

(ii) piloting the PBF approach to increase the volume and quality of services, while addressing linkages to universal health care;

(iii) rehabilitating health facilities and providing equipment to PBF facilities; and

(iv) supporting the development of a health management information system and improving health system management.

Although the objective to strengthen the health system for improved performance would normally have a broader scope and assessment levels, it is plausible that project activities would contribute to strengthen the health system and its building blocks, including because there are synergies and linkages between PBF and health system strengthening.

Main outputs and intermediate results

In addition to outputs noted above under Objective 1, main outputs included the establishment of a Health Insurance Agency; creation of a beneficiary registry that included a registry of indigents (who were the main target group for Universal Health Insurance, according to the PAD, p. 9); and piloting of Universal Health Insurance in three PBF districts (ICR, p. 17). Universal Health Insurance coverage started with the formal sector (civil servants and university students) and the poor (ICR, p. 18). Among the latter, 201,354 poor individuals were enrolled by project completion in three PBF districts, exceeding the target of 150,000 persons.

The project developed a facility-based information system; carried out a 2016 survey on service availability and readiness; piloted the integration of data from university health centers and semi-public institutions into the national health information data; and supported the production of an Annual Health Statistics Report during the period 2016-2019.

The project supported the provision of technical assistance on health financing; the development of the National Health Development Plan 2016-2020 and a community health strategy; and the revision and updating of the National Plan for Medical Waste Management 2016-2020.

For Ebola preparedness, project support was input-oriented and consisted of the following:

- 26 ambulances; 52 4x4 vehicles; 200 motorcycles; 4 infrared body scanners; 400 portable infrared thermometers; laboratory reagents; 55 computers; hand washing equipment and supplies for health

facilities, schools and universities, the military and the police; medicines and disinfection products; personal protective equipment; and gloves and masks.
- Rehabilitation of two warehouses for the National Institute of Public Hygiene, for the storage of equipment and medicines.
- Construction of 51 latrines, 57 points of access to drinking water, and 17 wells and connections to existing water systems in 86 health centers and three border posts in the western part of the country.
- Provision of two photocopiers and 32 video projectors.
- On-site coaching on the use of tablet technology for epidemiological surveillance to support district and regional health directorates in case reporting.

Outcomes

Apart from outcomes described above under objectives 1 and 2, this ICR Review considers the above outputs as early substantive results demonstrating the contributions of the project to health system strengthening. The project established a Health Insurance Agency; created a registry of beneficiaries that included a registry of indigents; and piloted Universal Health Insurance. It strengthened capacities to deliver health and nutrition services and built up planning and management capacities at the decentralized level in PBF districts while also strengthening stewardship at the central level, and financial management skills at all levels. The project improved the quality of data, including through validation, and strengthened the health information system in the districts. It also contributed to heightened readiness and surveillance capacity for Ebola, by providing the necessary inputs within a larger national plan for Ebola preparedness.

Rating
Substantial

OVERALL EFFICACY
Rationale
The project almost fully achieved its objectives to improve utilization and quality of health and nutrition services in selected regions, and to contribute to strengthening the health system. The aggregation of achievements under the three objectives is consistent with a substantial rating.

Overall Efficacy Rating

Substantial

5. Efficiency

The project team carried out a cost-benefit analysis at appraisal. The analysis included components related to PBF and infrastructure, both amounting to 69% of the total project budget. Direct benefits referred to total gains generated from the use of health services delivered to beneficiaries. Only direct costs and benefits of PBF and infrastructure were considered, as other costs were difficult to assess and monetize. The analysis used a social discount rate of 5% over a 5-year period. The analysis estimated a net present value of US$9.4 million, with a rate of return of 25.9%, indicating a potential positive economic performance of the PBF approach intended by the project. A sensitivity analysis was not applied.

The ICR did not undertake a cost-benefit analysis at project completion, even though the ICR (p. 62) stated that several changes during implementation might have affected the net present value and the rate of return that were estimated at appraisal, including delays in launching PBF activities; delayed rehabilitation of health centers and realization of related benefits since the situation analysis was carried out only in mid-2017; a lower-than-anticipated number of health centers targeted for infrastructure strengthening; and 265 health facilities using PBF resources to carry out upgrades.

The ICR suggested that the PBF pilot had positive efficiency aspects, as the investment per capita per year amounted to US$0.70 compared to global benchmarks suggesting that PBF investment needs were roughly US$3 per capita per year (per TTL clarifications on 9/11/2020, benchmark sources used by the project were from World Bank studies and PADs of similar projects in Rwanda and Burundi, indicating a minimum cost of US$3-4 per capita per year). However, the project incurred high operating costs, where, on average, almost 40 percent of PBF resources constituted operating costs (ICR, p. 25), although administrative costs incurred by the project in five additional districts were a contributing factor.

There were institutional challenges that generated shortcomings in the efficiency of implementation. The functioning of the National Technical Cell for PBF was less than optimal (Borrower comments, ICR, p. 71). The role of the National Technical Cell was constrained upon its placement under the General Directorate of Planning and Forecasting, and, according to the Borrower comments (ICR, p. 68), institutional changes did not allow the cell's ownership of its roles and responsibilities. This undermined its adequate involvement in project implementation and coordination and limited its role. During most of the project period, the roles of the Project Implementation Unit and the National Technical Cell were not coordinated and were a source of tension, causing delays in hiring and deployment of Contracting and Verification Agencies, payments of subsidies, overcoming arising issues, and reporting (ICR, p. 30). There were weak collaborative synergies between different actors to ensure constructive complementarity during project implementation (ICR, p. 68).

The project witnessed frequent turnover of leadership at various levels. The National Technical Cell had five coordinators in four years. The short tenure of coordinators and interim character of their appointment were limiting factors that weakened the cell's leadership role for implementing the PBF strategy. There was high turnover of district and regional directors, and this undermined their effectiveness as regulators, supervisors, and supporters of health facilities, and caused disruptions in the districts (ICR, p. 30).

Significant delays in counterpart funding negatively impacted PBF subsidies since these were partly funded by the government. Mobilizing counterpart funds was a constant challenge that was not resolved by project completion (ICR, p. 33). Budgetary practices impeded carrying out project activities in a timely manner (ICR, p. 29).

Infrastructure development was affected by higher unit costs of civil works than those estimated at appraisal (ICR, p. 14). The number of rehabilitated health centers was smaller than anticipated, and infrastructure

activities were delayed till the second half of 2017, thus delaying the realization of benefits related to infrastructure strengthening (ICR, p. 62).

The project exhibited inefficiencies in PBF operations and in the use of PBF resources. According to the ICR, the main difficulties in using PBF funds were related to the internal organization of health facilities, the lack of functionality of Health Management Committees, skill gaps, and insufficient support from regulators at District and Regional Health Directorates. A major challenge was the difficulty in preparing realistic business plans. Delays in disbursement to the accounts of health facilities created confusion (ICR, p. 29). Delays in the payment of subsidies were alleviated over time, but not fully overcome. There were no data on community verification. The indicator on the proportion of indigents among total direct RBF beneficiaries was dropped at the October 2019 restructuring because it could not be measured (ICR, p. 45), as the implementation of the electronic records system for patients was delayed.

The effects of initial implementation difficulties and the delayed use of the Project Preparation Advance also contributed to overall implementation shortcomings. During the initial project period, shortcomings included delays in completing the project's operational manual and PBF manual, hiring specialists for financial management and M&E, opening bank accounts, meeting disbursement conditions, and setting up committees to manage and supervise the project (committee for project piloting, project technical committee, PBF piloting committee, project implementation unit, and national technical cell for PBF). The ICR (p. 28) stated that resources for project take-off activities were not available. This translated in delays for launching several studies, including on costing of services and technical specifications for rehabilitation and equipment of health centers.

In conclusion, given the lack of an ex-post cost-benefit analysis, and given significant shortcomings in the efficiency of implementation, overall efficiency is rated modest.

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	✓	25.90	69.00 ☐ 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 objectives is rated high in view of considerable alignment with the CPF at project closing and consistency with national plans. Efficacy is rated substantial as the objectives were almost fully

achieved. Efficiency is rated modest because of the lack of an ex-post cost-benefit analysis and significant shortcomings in the efficiency of implementation. These ratings are consistent with moderate overall shortcomings, and therefore a moderately satisfactory outcome rating.

a. Outcome Rating

Moderately Satisfactory

7. Risk to Development Outcome

Main risks are related to financial constraints that are likely to increase in the near and intermediate future. The COVID-19 pandemic has negatively affected the country's macroeconomic situation, and is likely to constrain government capacity to increase the health budget as it has done in the past with a budget increase of 16.6% between 2019 and 2020. The pandemic has understandably compelled the government to enhance hospital capacity that was necessary to manage patients, but once the pandemic runs its course, it is likely that the additional hospital capacity would not be needed, and would require recurrent maintenance expenses. While commitment to PBF was high, it remains susceptible to future determinants in the political economy.

Nevertheless, the project has brought substantial capacity building to the sector. Health providers, regions, and districts have embraced the PBF approach and orientation. The government is currently expanding PBF to all districts in the country, supported by the follow-on project "Strategic Purchasing and Alignment of Resources & Knowledge in Health" Project (SPARK, P167959) that became effective in July 2019 (ICR, p. 36).

8. Assessment of Bank Performance

a. Quality-at-Entry

Project preparation benefited from extensive consultations with key stakeholders, several ministries, development partners, and non-governmental organizations. Bank and government teams organized workshops and meetings to explain the PBF approach. International experience and PBF lessons were considered, including those related to the importance of empowering front-line managers and providers, improving working conditions, increasing motivation and accountability, availability of resources for adequate functioning of facilities, and improving data collection and reliability.

Overall fiduciary aspects and financial management arrangements were designed with due consideration of the country's post-conflict situation of fragility and OP/BP 10.0 (PAD, p. 18). Bank assessment concluded that the Directorate of Financial Affairs would be in a position to manage project funds upon completion of recommended measures to strengthen its financial system. Procurement assessment included an action plan that was agreed with the Ministry of Health and Fight Against AIDS (MSLS). Strengthening measures were undertaken. Risks were adequately identified. Environmental aspects were well prepared.

Institutional arrangements for implementation were centered on MSLS. Two steering committees were constituted, one for the project, and another to guide the overall development of PBF in the country. A Project Implementation Unit and a National Technical Unit for PBF were established (PAD, p. 15). However, their roles and responsibilities were not adequately elucidated, subsequently contributing to tension, weak collaboration, and implementation delays. Health Management Committees did not have the capacity or incentives to carry out their functions, and their composition represented government administration, rather than the community. They did not have independent status, and that was another limiting factor for performance. The ICR (p. 38) stated that this lesson was considered when the follow-on project was designed, with due consideration to the roles and cooperation of local actors.

For infrastructure planning, the assessment of needs and cost estimates was inadequate at appraisal. According to the Borrower comments, the underestimation of the budget for the rehabilitation of essential infrastructure did not allow the project to achieve expected results (ICR, p. 68). The 2019 Restructuring Paper (Report No. RES38120, p. 8) stated that the above issues led to an overestimation of the end target. The original indicator pooled civil works and equipment without explicit targets for each (ICR, p. 14). For the larger M&E design, the project did not set sufficient outcome indicators beyond utilization and quality of services in the pilot districts to reflect a strengthened health system. The project's Operational Manual and the PBF Manual were not ready. Training needs were underestimated (ICR, p. 38). Also, preparation underestimated the time required to train and coach service providers and to master PBF operational procedures (ICR, p. 34).

Quality-at-Entry Rating
Moderately Satisfactory

b. Quality of supervision
Although the project had three Task Team Leaders during the 5-year implementation period, transition arrangements were smoothly undertaken, and close collaboration with the Project Implementation Unit was maintained. The Bank team carried out regular supervision and implementation support missions. Supervision of fiduciary aspects and safeguards was adequate, and the Bank provided further training on fiduciary matters. The Bank team was pro-active and worked effectively with the government to introduce additional valuable activities in nutrition and water & sanitation that were relevant to project objectives and further strengthened the project directions to improve utilization and quality of services, seeking to achieve related results. The project team rectified the results framework and filled the gap of the initial results chain for under-nutrition treatment. Reporting was candid and of good quality. The team worked effectively with development partners in the health sector. The team organized a productive Mid-Term Review with a thorough and independent assessment of the project (ICR, p. 35) and opted for a follow-on project rather than additional financing to pursue country-wide scaling up of PBF. Performance shortcomings of implementing agencies were beyond the control of the Bank team.

The efforts extended by the Bank team in facilitating the preparation of and transition to the follow-on project were noteworthy, including for supporting training workshops and studies for the new project.

Quality of Supervision Rating
Highly Satisfactory

Overall Bank Performance Rating
Moderately Satisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design
The objectives were clearly stated. The theory of change was clear overall and illustrated a logical pathway from activities and outputs to intermediate results and outcomes, although the expected results for strengthening the health system were output-oriented. Indicators were measurable. Baselines for routine services were available, as related data were regularly collected (e.g. vaccination coverage, family planning) by the existing system, and some others were to be collected after project launching. M&E design was based on two elements: (a) routine M&E under the existing Health Management Information System, where further strengthening was intended under the project with a focus on health centers; and (b) an impact evaluation of the pilot PBF that was intended to assess how the pilot had contributed to the overall objectives and to guide the scaling up of the PBF scheme. The impact evaluation appropriately planned to include a control group of districts that did not have a PBF scheme.

b. M&E Implementation
While the routine information system included only quantitative data, the project created a PBF portal that provided information on both quantitative and qualitative indicators, although the incorporation of the module capturing community-based organization verification activities remained pending. Monitoring activities and results framework updates were carried out regularly, and data were of good quality (ICR, p. 31).

The Mid-Term Review of February 2018 revised targets for two Intermediate Results Indicators downward, and the revision was formalized in 2019. The reduction in vitamin A supplementation was appropriately explained by a shift in the national strategy from a campaign mode, twice a year, to facility-based supplementation. As noted in Section 4, the target for infrastructure (previously encompassing facilities constructed, rehabilitated, and/or equipped) was reduced from 526 to 97 facilities, and the project reformulated the indicator as facilities constructed or renovated.

In 2016, baseline studies for the impact evaluation were undertaken for the first batch of districts participating in PBF, and in 2017 for the second group of districts. Although the project gathered data in 2019 for the final evaluation, the latter was not completed before project closing. According to the ICR (p. 32), the impact evaluation was expected to be completed by the end of 2020, given understandable delays caused by the COVID-19 pandemic.

c. M&E Utilization

M&E findings were used for regular monitoring and evaluation purposes. Verified PBF data contributed to quality improvements in the routine information system. According to the ICR, regions and districts became more involved in the validation of health data (ICR, p. 31). Data were also used by health providers and for research. M&E has facilitated the preparation of the Annual Health Statistics Report since 2016. M&E findings were used to support policy dialogue with the government on the next steps to support sectoral priorities, namely the decision to expand the PBF program to the rest of the country, and for the planning and design of the follow-on project (see Section 7).

M&E Quality Rating

Substantial

10. Other Issues

a. Safeguards

The project was classified as Environmental Assessment Category B. Potential adverse impacts were moderate and associated with the handling and disposal of health care waste and from civil works. The project had an Environmental and Social Management Framework and a Health Care Waste Management Plan. The ICR (p. 32) stated that environmental and social screening of project activities was systematized, that environmental and social monitoring reports were produced regularly, and that project activities were implemented in compliance with national laws and Bank safeguards policies.

b. Fiduciary Compliance

The Project Implementation Unit, within MSLS, was the focal point for all the fiduciary aspects of the project (PAD, p. 18). Financial management performance was adequate overall, but faced some challenges in fund flows, timely availability of counterpart funds, and in transitioning between financial management systems. The ICR stated that overall procurement performance was satisfactory, and that the Bank regularly carried out ex-post reviews of procurement activities while providing training. The TTL confirmed on 9/11/2020 that procurement was carried out according to Bank guidelines. There were no outstanding issues in fiduciary compliance, and audit reports were unqualified (ICR, p. 33).

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 the lack of an ex-post cost-benefit analysis and significant shortcomings in the efficiency of implementation.
Bank Performance	Satisfactory	Moderately Satisfactory	The ICR rated both Quality-at - Entry and Supervision as satisfactory. This ICR Review rated Quality-at-Entry as moderately satisfactory because of moderate shortcomings in infrastructure planning, institutional roles and arrangements, gaps in readiness, and underestimation of training needs and time required; and rated Quality of Supervision as highly satisfactory because there were no shortcomings in the proactive identification and management of threats facing the project's development impact. The aggregation of the two sub-ratings is consistent with a moderately satisfactory rating for overall Bank Performance.
Quality of M&E	Substantial	Substantial	
Quality of ICR	---	Substantial	

12. Lessons

The ICR (pp. 36-39) offered several lessons, including the following lessons restated by IEG:

Pursuing a sequenced implementation strategy for performance-based financing among regions can help in facilitating implementation. District sequencing allowed additional time for setting up institutional arrangements, introduction of procedures, and training while learning from challenges faced by the initial group of districts. Staff movements and collaboration among districts contributed to the dissemination of PBF processes and results orientation.

Defining roles and responsibilities of institutional actors facilitates effective collaboration. Under the project, collaboration between the National Technical Committee for PBF and the Project Implementation Unit was deficient and could have been more effective if their roles and responsibilities were adequately detailed with a clear description of functions.

Mastering operational PBF procedures takes time. Under the project, there was a steep learning curve, as PBF required a change in mentality in health service delivery along with administrative and operational transformations. Time was required to set up the necessary arrangements at the central and decentralized levels, including at the provider level.

In addition, IEG identified the following lesson:

PBF can contribute to decentralization efforts. Under the project, capacity enhancements in planning, general management, and financial management contributed to the transformation of health facilities and districts into more proactive actors with a degree of autonomy, including for receiving and managing financial resources and budgets.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

The ICR was candid and provided a detailed critique of the project's experience. The report articulated the theory of change underlying the project's trajectory toward intended outcomes for service utilization and quality, and the contributions of the project to strengthen the health system. The quality of both evidence and analysis was adequate overall. The ICR was internally consistent, logically linked various parts of the report, and followed guidelines. The ICR offered specific lessons derived from project experience. The ICR did not undertake a cost-benefit analysis at project completion, as was done at entry. The report was not tightly written, and its detailed implementation narrative was lengthy. Nevertheless, when these weaknesses are considered in the larger context of other favorable criteria, the overall quality of the ICR is deemed to be substantial.

a. **Quality of ICR Rating**
Substantial