



## 1. Project Data

**Project ID**

P080228

**Project Name**

EG-Health Care Quality Improvement

**Country**

Egypt, Arab Republic of

**Practice Area(Lead)**

Health, Nutrition &amp; Population

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

IBRD-78280

**Closing Date (Original)**

30-Jun-2015

**Total Project Cost (USD)**

76,000,000.00

**Bank Approval Date**

22-Dec-2009

**Closing Date (Actual)**

30-Jun-2017

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

Original Commitment

75,000,000.00

0.00

Revised Commitment

75,000,000.00

0.00

Actual

68,929,726.30

0.00

**Prepared by**

Judyth L. Twigg

**Reviewed by**

Salim J. Habayeb

**ICR Review Coordinator**

Joy Behrens

**Group**

IEGHC (Unit 2)

## 2. Project Objectives and Components

### a. Objectives

According to the Loan Agreement, the project's original objective was "to assist the Borrower in improving the financial sustainability and efficiency of its social health insurance operations."

At an October 2014 restructuring, the project was renamed from "Health Insurance Systems Development Project" to "Health Care Quality Improvement Project," and the objective was revised: "to assist primary healthcare facilities in Egypt's most vulnerable 1000 villages in meeting national healthcare quality standards." No Bank financing was disbursed under the original objective.



**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**

31-Oct-2014

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

Yes

**d. Components**

The original project contained one component, "Health Insurance Payer Operations and Management Information System," intended to finance three integrated contracts: (a) Main Business System Contract, to deliver an integrated package of business process development, application software, operational and management training, and extended technical support services; (b) Hardware Platform Contract, to deliver necessary computing and communications technologies to operationalize the new business functions; and (c) Verification and Validation Contract, where a specialized health insurance firm was to deliver hands-on support to the new payer for decision-taking, activity coordination, technical/substantive advice, and verification and validation services. The intent was to establish information technology-enabled administrative operations for a single national health insurance payer in three pilot governorates: Suez, Sohag, and Alexandria.

Implementation of these activities experienced major delays due to a political revolution in the country that overthrew the president in early 2011, considerable subsequent unrest and instability, and challenges with the complex information technology procurement. The governments that took office after the revolution had differing viewpoints on restructuring of the project, and the turbulent economic situation risked the sustainability of any new social health insurance system. The draft law on social health insurance that the project was intended to support was not passed as anticipated in 2009. Overall, the original objectives and design were considered to be obsolete. After several missions that discussed multiple options, the government and Bank agreed in 2014 on a new approach that would focus only on improvement of quality of healthcare services in public health facilities. The restructured project was an entirely new operation, except that the quality improvements it supported would become prerequisites for facility accreditation under a future social health insurance scheme. The government formally requested this restructuring on February 10, 2014.

The revised project contained two components:

1. Family Healthcare Quality Improvement Program (original: US\$ 70 million; actual: US\$ 65.01 million). This component was to support implementation of quality improvement and maintenance plans that were to enhance the quality of service provision and system responsiveness of family healthcare facilities (family



health centers and family healthcare units). The project was to pay for results defined as achievement of disbursement triggers for phased accreditation of facilities: 40% for pre-accreditation level 1, 40% for pre-accreditation level 2, and the remaining 20% upon issuance of the full accreditation certificate. The accreditation triggers were grouped by pre-accreditation preparation and actual accreditation, involving progressively more demanding achievements of infrastructure and staff development, and then clinical governance, patients' rights, quality measurement and improvement, and facility/patient safety. The standards were to be based on those developed by the International Society for Quality in Healthcare.

2. Implementation Support (original: US\$ 5 million; actual US\$ 3.92 million). This component was to finance the cost of technical assistance, external financial audits, an external independent quality audit, project management, communication, monitoring, and an impact evaluation.

Activities were to target the poorest 1,000 villages (one health facility per village) in the poorest governorates (Aswan, Qena, Luxor, Sohag, Assiut, Minia, Beni Suif, Giza, Sharkya, and Beheria), as defined by the national statistical body. Shortly after effectiveness, the poverty map in Egypt was slightly adjusted to exclude Sharkya and Beheria and to include Fayoum, so that all nine Governorates in Upper Egypt were targeted.

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

**Project cost:** Total project costs were originally estimated at US\$ 76 million. The revised project eliminated the government contribution, resulting in estimated costs at restructuring of US\$ 75 million. Actual spending was US\$ 68.9 million.

**Financing:** The project was initially to be financed by a US\$ 75 million Specific Investment Loan. The revised project continued with Investment Project Financing in the same amount of US\$ 75 million. US\$ 68.9 million was disbursed.

**Borrower contribution:** The government was initially responsible for contributing the financing of the Project Implementation Unit, at a cost of US\$ 1 million. That contribution was dropped at restructuring.

**Dates:** The original project was approved on December 22, 2009 and became effective on August 12, 2010. It was scheduled to close on June 30, 2015. On October 31, 2014, a restructuring revised the project's title, objectives, components, results framework, implementing agency, and disbursement categories. The new project became effective in September 2015. The new closing date was set at June 30, 2017, and the project closed on that date as scheduled.

### **3. Relevance of Objectives**

#### **Rationale**



At appraisal, approximately half of Egyptians were uninsured, including workers in the informal sector, the poor, workers in small and medium enterprises, and dependents of insured workers. Out-of-pocket expenses represented an estimated 62% of care expenses for the uninsured. Most of the insured population was covered by the Health Insurance Organization (HIO), an integrated payer and health services provider. At appraisal, a new social health insurance (SHI) law under consideration was to create a new payer entity that would absorb HIO beneficiaries and administrative resources, and extend universal health care to all citizens. The project's original objective was relevant to this country context and strategy. It also aligned with the Bank's Country Assistance Strategy at the time (2008 Progress Report), which contained a results area on expanding access to health care, and a specific indicator to adapt health insurance reform reflecting international best practice.

At restructuring, the Egyptian health sector faced continued challenges related to the quality of service delivery, with persistent patterns of geographical and socioeconomic inequity in access to care. The revised objective was relevant to the new Egyptian Constitution of January 2014, which guarantees every citizen "quality healthcare through public health facilities providing efficient and fairly distributed health services," and to the government's plan "Geographical Targeting for the Most Needy Villages for Development and Investment 2008-2018," which envisioned expanding access of poor people to primary healthcare facilities. Improving healthcare quality in publicly operated health facilities was a prerequisite for entering into contractual agreements with a planned social health insurance fund (embodied in the new Health Insurance Law passed in December 2017 and expected to come into effect on June 1, 2018; the timelines for effectiveness was confirmed by the project team). The revised objective focused on the supply side, complementing a planned US\$ 200 million healthcare support project that was expected to expand coverage vertically to secondary and emergency care, and horizontally to improve quality in additional family healthcare facilities in other poor governorates.

The 2015-2019 Country Partnership Framework (CPF) broadly supports social inclusion but, within the Health, Nutrition, and Population sector, explicitly moves away from health insurance toward access to quality healthcare services over the CPF period (p. 22). This shift rendered the original objective less relevant to Bank strategy at project closing. The revised objective and activities remained relevant at closing, with CPF objectives to expand family health services for the bottom 40% of the population in the poorest ten Governorates in Upper Egypt and to prevent, diagnose, and treat Hepatitis C.

## Rating

Substantial

## 4. Achievement of Objectives (Efficacy)

### Objective 1

#### Objective

Improve the financial sustainability and efficiency of social health insurance operations

#### Rationale



The theory of change underlying this objective postulated that support for development and piloting of business processes for operational and management functions for health insurance, as well as for an operations and management information system, would enhance modern business process for the single payer function of the HIO. This, in turn, would improve the efficiency and financial sustainability of social health insurance. No activities were implemented under this objective, and no outcomes were reported.

**Rating**  
Negligible

## **Objective 2**

### **Objective**

Assist primary healthcare facilities in Egypt's most vulnerable 1000 villages in meeting national healthcare quality standards

### **Rationale**

The theory of change underlying this objective was straightforward. Facility self-assessments would be approved and implemented through support for facility upgrades and maintenance, provision of equipment and supplies, training, and promotion of citizen engagement and patient rights. This support would lead to increased clinical and administrative capacity, certified progressively through the accreditation process. Improving quality of care was intended to enable health facilities to meet recognized service quality standards that would, in turn, lead to the independent accreditation necessary for entering into contractual agreements with the to-be-established social health insurance fund.

### Outputs

1,142 family healthcare facilities were identified for inclusion in the project, exceeding the target of 1,000. The excess was intended to safeguard against the potential dropout of some facilities.

A Quality Improvement Plans Review Committee was established, providing an independent review and approval of the Quality Improvement and Maintenance Plans prepared by each health facility. 1,077 facilities submitted Quality Improvement and Maintenance Plans for review to this committee, exceeding the target of 1,000. These facilities were provided with medical and non-medical equipment and supplies, medicines, and cleaning and security services. 10,341 health personnel received training on quality improvement, far exceeding the target of 1,000. 272 physicians were hired to supplement primary health care staff at remote centers. 48 Centers of Excellence for Maternal and Child Health were upgraded with new equipment and supplies, medicines, and contraceptives.

A manual on accreditation was prepared and disseminated through 3,500 hard copies and 5,000 electronic copies. 240 surveyors were trained, and 20 Ministry of Health and Population and 55 Governorate staff were trained on quality improvement standards.



A client satisfaction and utilization survey was undertaken. The ICR (p. 17) reported that client satisfaction rose from 38.5% in 2015 to 50.1% in 2017, observing that utilization of hospital services dropped by an unspecified amount in some districts, possibly an indicator of greater satisfaction with primary care. The project team later explained that the baseline figure (38.5%) was taken from a non-related pre-project survey. The end-line figure (50.1%) was from a project-sponsored exit survey of 164 patients in facilities that received project support and measures positive results across five dimensions of patient satisfaction. The project team also explained that the results stemmed primarily from patients' satisfaction with availability of doctors who were contracted by the project.

A grievance mechanism for citizens' and service providers' complaints (against service providers and the accreditation process, respectively) was established. Of the 523 grievances filed, all were addressed, exceeding the target of 90% of grievances addressed.

### Outcomes

1,077 family healthcare facilities completed level 1 and level 2 pre-accreditation, exceeding the target of 750 (level 1) and 500 (level 2), and 682 received full accreditation, exceeding the target of 400. UNICEF carried out external verification of successful completion of pre-accreditation triggers for each facility. The accreditation results were regularly published on the Ministry of Health and Population website.

The project reached 1.42 million beneficiaries, far exceeding the target of 250,000. Of those, 62% were female, exceeding the target of 50%. 5.4 million people were provided with access to a basic package of health, nutrition, or reproductive health services as a result of project activities, far exceeding the target of one million.

1.67 million people were screened for Hepatitis C and 30,384 treated in Upper Egypt. This screening program was added in the last six months of project implementation, after Hepatitis C became curable with the development of a new direct anti-retroviral agent. Before the project's interventions, Egypt had the highest burden of Hepatitis C infection in the world (7% of the adult population). The government made screening and treatment a part of the basic package of family health services.

Overall, this objective was highly achieved. All outcome targets were surpassed. The project assisted primary healthcare facilities in more than 1,000 villages to meet externally verified national quality standards.

**Rating**  
High

### **Rationale**

Efficacy is rated Negligible under the original objectives, with no outputs or outcomes reported. Under the revised



objectives, a High level of achievement is evidenced through the project's support leading to externally-validated accreditation of primary healthcare facilities in over 1,000 poor villages.

## **Overall Efficacy Rating**

High

### **5. Efficiency**

The Project Appraisal Document (PAD) for the original project estimated significant economic and financial returns through improved utilization and cost control of the country's social health insurance system. Investments were expected to generate an estimated Internal Rate of Return (IRR) of 48% and Net Present Value of US\$ 36 million through the year 2020, at a discount rate of 10%, largely attributable to overall efficiency gains. The estimate was sensitive to assumptions around total health spending and coverage and effective implementation of the insurance reform.

At restructuring, the project's benefits were still expected to exceed its costs, with benefits accruing over a ten-year time horizon from decreases in mortality, morbidity, and out-of-pocket payments among users of publicly operated health facilities. The Restructuring Paper (pp. 37-41) calculated Net Present Value at US\$ 123 million, with a benefit-cost ratio of 2.88 and IRR of 56%, using a similar set of assumptions to those employed by the PAD. The IRR remained positive (30%) even under a low-benefit scenario.

The ICR (pp. 46-49) conducted a similar analysis, deriving benefits (calculated, as in the Restructuring Paper, out to the year 2024) from reduced morbidity, maternal and under-five mortality, mortality associated with Hepatitis C, and fertility rates. It used a discount rate of 15%, higher than the PAD because of devaluation of the Egyptian pound against the U.S. dollar and annual consumer price inflation above 30%. This analysis found an IRR of 60.38%, with a Net Present Value of US\$ 163.3 million and a benefit-cost ratio of 3.66.

The original project experienced negligible efficiency, with no disbursements and no implementation over a four-year period. During the final two years following restructuring, there were some reported implementation inefficiencies, including high staff turnover, inadequate medical staffing of facilities due to low salaries, procedural challenges around supply and procurement, and other unspecified bottlenecks (ICR, pp. 52-53). However, the economic analysis found high returns, and considerable progress was made in a relatively short period of time. Taking the entire project period into consideration (original and restructured), this review agrees with the ICR's finding of Modest efficiency.

## **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	✓	48.00	100.00 <input type="checkbox"/> Not Applicable
ICR Estimate	✓	60.38	100.00 <input type="checkbox"/> Not Applicable

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

## 6. Outcome

Under the original objectives, relevance is rated Substantial, efficacy is rated Negligible, and efficiency is rated Modest, leading to an Outcome rating of Unsatisfactory.

Under the revised objectives, relevance is rated Substantial, efficacy is rated High, and efficiency is rated Modest, leading to an Outcome rating of Moderately Satisfactory.

As no Bank funds were disbursed under the original objectives, the overall Outcome rating derives entirely from that under the revised objectives. Overall Outcome is therefore rated Moderately Satisfactory, indicating moderate shortcomings in the project's preparation and implementation.

### a. Outcome Rating

Moderately Satisfactory

## 7. Risk to Development Outcome

The government is committed to increasing funding for the health sector, including a statement in Article 18 of the 2014 Constitution that increases allocations to the health sector from the current 2.5% of gross domestic product to 3%. Its health strategy to 2030 focuses on primary health care, development and countrywide expansion of health insurance, improvements in quality of care, and eradication of Hepatitis C. The Social Health Insurance Law was passed on December 17, 2017, establishing the architecture to begin contracting with accredited facilities and enroll beneficiaries. Implementation of the law will include a mandate for the Ministry to institutionalize the verification and quality assurance functions developed under the project. While the institution building achieved by the project is likely to be sustained, the ICR (p. 34) cautioned that concerted efforts will be required to limit turnover and absenteeism among physicians. These and other efforts will be supported by a 30 million Euro follow-on project supported by L'Agence Francaise de Developpement. The government has also made an official request to the Bank (dated November 25, 2017) for a new, US\$ 530 million operation to support and expand coverage and quality of primary healthcare services and to institute an effective referral system to quality secondary-level services. The project team confirmed that this follow-on





project (P167000) is scheduled to go to the Board on June 18, 2018, expanding use of the results-based financing mechanism to additional primary health centers and 27 hospitals, and conducting nation-wide screening and treatment for Hepatitis C. The ICR did not discuss political stability moving forward.

## **8. Assessment of Bank Performance**

### **a. Quality-at-Entry**

The original project was prepared over a three-year period, but final design emerged relatively rapidly in "a rush" to get Board approval in December 2009 (ICR, p. 21). The timing was requested by the government so that the new system would be running in the three pilot regions by the time the expected new Law on Social Health Insurance was passed in 2011. At appraisal for the original project, key lessons were learned from prior experience in Egypt and abroad: the importance of good management information systems, and broadly, that ambitious health insurance reform projects with large information systems components are notoriously difficult to keep on schedule and within budget (PAD, pp. 9-10). This project attempted to respond to these lessons with a well-defined and realistic scope, limited to the business system and its technical requirements. However, one key identified lesson was not taken into account: the need for a clear and effective legislative and regulatory framework governing health financing and insurance reform. The project was approved in anticipation of passage of the social health insurance law, which did not take place as planned and then was further delayed by political upheaval. Several risks were identified as high (PAD, pp. 13-14): that disruption could occur in the choice of government entity to act as health insurance payer; that provider information systems would not fully develop; that the procurement process would not result in selection of a suitable system developer; and that the information system contract would be poorly managed and supervised. Residual risk after mitigation was still rated as Substantial, primarily because of the project's technical ambition. The risk assessment did not address the possibility that the legislative framework would not fall into place as planned. Overall, according to the ICR (p. 22), "there was a great deal of pressure to get this project approved despite lacking capacity within HIO to implement it and despite clear coordination difficulties and lack of consensus regarding the new system." In other words, even without the ensuing political upheaval (which could not reasonably have been anticipated), the project would likely have experienced implementation challenges due to shortcomings in preparation.

Readiness for the restructured project was considerably stronger. The two components were clearly outlined and linked to the well specified objective, with targeting focused on communities with the highest incidence of poverty and lowest levels of service delivery. Design included a novel results-based disbursement modality.

At restructuring, risks were reassessed. The continuing fragile country environment was acknowledged, and financial management risk was rated high. Mitigation was to be achieved through use of an experienced Project Implementation Unit with solid understanding of Bank procedures, as well as timely selection and mobilization of UNICEF to provide third-party verification.

Both the original and revised project were based on extensive prior Bank analysis of the health sector in Egypt, including a Health Public Expenditure Review in 2005, Health Policy Note in 2006, study on the Role of Social Change Agents in Increasing Demand on Health Services (2007), Study on Quality of Primary Health Care Services in Alexandria and Menofia (2010), and, for the restructured project, a study on



Understanding and Exercising Rights to Family Planning in Egypt (2013).

### **Quality-at-Entry Rating**

Moderately Unsatisfactory

#### **b. Quality of supervision**

According to the ICR (p. 27), the Bank team remained "proactive and responsive" to the changing political environment. It continued to organize technical events and policy seminars during the period of instability in order to continue engagement with stakeholders. The task team leadership changed three times during implementation, but handover was smooth, with all team leaders based in Cairo. The decision to incorporate Hepatitis C screening and treatment exhibited flexibility in response to new government priorities, taking advantage of additional resources made available by the devaluation of the Egyptian pound. The Bank team made numerous requests to improve project management, and the eventual appointment of a new manager in February of 2017 enhanced implementation progress considerably, but decisions about procurement authority could have been better planned (see Section 10b). The Ministry of Health and Population's completion report (p. 53) stated that the Bank failed to respond to three "urgently needed" extension requests toward the end of the project's lifetime. The main ICR (pp. 27-28) concurred with this assessment, noting that the project had a negative reputation with Bank management due to its earlier non-performance, but that the failure to grant the extension produced unnecessary negative consequences including cutting off support to physicians serving hard-to-reach places before their contracts could be picked up by a subsequent French-supported project; limiting the number of people receiving Hepatitis C screening; and limiting provision of additional medicines for primary health centers. The project could have disbursed fully, had the extension been granted.

### **Quality of Supervision Rating**

Moderately Satisfactory

### **Overall Bank Performance Rating**

Moderately Satisfactory

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

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

The project's original outcome indicators were clear and measurable, and they adequately captured achievement of the objective of improved sustainability and efficiency of the social health insurance system. Baselines and targets were specified. The PAD for the original project (pp. 11-12) stated that data on results indicators would come from the information system under development, to include routine reporting on outcome measures. Training of personnel, supervisors, and managers was to occur as the system was developed to ensure that data were accurate and acted upon.

At restructuring, indicators and targets were reset to conform with the revised objective. Irrelevant indicators were dropped and new indicators/targets added to reflect the new objective and design. Outcome measures



were defined in terms of facility accreditation and access to a basic package of health services, with intermediate outcomes measuring interim steps such as training and identification/achievement of quality improvement plans. Specific M&E arrangements included the formation of inter-ministerial and intra-ministerial (different sectors of the Ministry of Health and Population) coordinating bodies, as well as a unit in the Ministry to monitor progress. At the Governorate level, project supervising committees were formed at Health Directorates. UNICEF was hired to carry out independent verification of health facility progress in meeting set quality improvement standards. UNICEF was also to carry out a baseline and end-line assessment of a randomly selected sample of health facilities against a list of ten indicators. As part of UNICEF's contract, 20 Ministry staff and additional staff at the Governorate and district levels were trained to monitor quality improvement measures; these staff became known as the "shadow team" and were instrumental in gathering data and reporting on facility-level performance (ICR, p. 28).

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

The Ministry of Health and Population carried out data collection through its own health management information system. Routine and project-specific data were collected biweekly from primary health centers and aggregated at the district and then Governorate levels. Supervision visits to the primary health centers were conducted monthly by the departments of primary health care, quality improvement, and preventive services at the central and directorate levels. Information provided through these channels was regularly cross-checked against UNICEF reports. The inter- and intra-ministerial committees met as planned to coordinate activities and resolve bottlenecks.

UNICEF field-tested its verification tool in one primary healthcare facility in May 2016 and then conducted the planned baseline assessment in May-June 2016. During 2016/2017, it carried out verifications of primary health facility performance against the two pre-accreditation levels in 1,000 facilities, as planned, allowing for performance-linked disbursements. UNICEF's end-line assessment in June 2017 noted that primary health facilities continued to report manually, with paper registries, adversely affecting data quality. That assessment recommended that the registers be simplified and computerized to facilitate improvements in data quality, accessibility, and timely use.

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

The central project team met on a weekly basis to go through all available data and reports, using that information to guide day-to-day implementation decisions and as a basis for planning future activities. Information suggesting that individual Governorates, districts, or facilities were lagging was used to introduce corrective action and provide necessary support. The Ministry's "shadow team" took progressively greater responsibility for supervision and monitoring of implementation. The ICR (p. 29) noted, however, that the lack of an automated decision support system at the Ministry prevented a "deep dive" into available data.



## **M&E Quality Rating**

Substantial

### **10. Other Issues**

#### **a. Safeguards**

The project was rated Environmental Assessment Category C, as it was expected to have minimal or no adverse environmental impact. No safeguard policies were triggered. This assessment did not change at restructuring. However, a Category B may have been an option to consider in view of potential medical waste issues.

#### **b. Fiduciary Compliance**

**Financial management:** Overall project financial management was rated Moderately Unsatisfactory in the ICR (p. 31). Minimum requirements were maintained for financial reporting and auditing, with some exceptions, and the overall quality and timeliness of reporting were "often an issue of concern." The Bank provided support to financial management staffing, problematic because the Bank team repeatedly had to provide the same training to a constantly rotating project financial management team; accounting, recording, and reporting, difficult because the project team never followed Bank recommendations to initiate the development of an automated management information system; flow of funds, challenging because of complex and redundant authorization requirements at the Ministry; and audit, where the independent external auditor was hired late. The ICR did not state whether project audits were clean and timely. The project team later confirmed that audits were unqualified, but late.

**Procurement:** Under the original project, the entire project design consisted of three procurement packages: design and implementation of management information system software, associated hardware for regional and national data centers, and technical assistance to supervise this work. Bidding documents for the first contract were prepared in 2009 and bids were evaluated in 2010, but the government did not consider the bids to be of sufficient quality. According to the ICR (p. 31), many bidders lost confidence in the process when they were asked to resubmit their proposals with additional information. A rebidding was agreed on by June 2012, and "much work was done to complete this procurement," but the entire process was dropped in March 2013. A similar process occurred for procurement of the technical assistance contract, with selection of firms initiated in June 2010 but ultimate cancellation in March 2013 due to government dissatisfaction with the interested firms.

The restructured project initially planned for local procurement by primary health facilities/districts of the necessary items to implement their improvement plans. After project launch, however, the Ministry decided to rely instead on central procurement using national and international open bidding processes for the purchase of all equipment for health facilities. Despite Bank support for Ministry staff, there were delays, and it took "considerable time" to hire a qualified procurement officer to speed up activities (ICR, p. 31). The Ministry eventually decided to decentralize procurement at the health district level with some support from Governorates, which was found to be an effective compromise between cumbersome local procurement by



individual facilities and lengthy, complex procurement at the central level. A qualified procurement specialist was hired by the Ministry to support the Governorates in procurement management.

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

None reported.

**d. Other**

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**11. Ratings**

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

**12. Lessons**

The ICR (pp. 34-35) offered several insightful lessons, including:

Projects whose activities depend on the passage of key legislation will succeed only if that legislation is secured prior to approval. In this case, the original project was eventually scrapped in part because the prerequisite Law on Social Health Insurance was not forthcoming.

Projects with relatively simple and straightforward design can succeed even in a context of political turmoil. In this case, the focused nature of the restructured project enabled the government, implementers at all levels, and Bank team to move forward quickly.

IEG offers the following additional lesson:

The input of a reliable, reputable external validation agency can cross-check and enhance verification of implementation progress. In this case, UNICEF provided a valuable service supporting the validation of disbursement triggers and overall results.



### 13. Assessment Recommended?

No

### 14. Comments on Quality of ICR

The ICR was remarkably clear, coherent, and evidence-based. It presented reasonably concise yet complete explanations of the project's overall storyline. It explained well the theories of change underlying both sets of objectives, as well as the evidence supporting assessment of achievement of the revised objective. It applied the split rating methodology carefully to the original and revised objectives. The ICR's description and analysis of M&E and the relationship between the Bank and government at all levels thoroughly supported the Outcome rating. Lessons were concisely stated but should prove useful to future operations in the country and in other fragile contexts.

#### a. Quality of ICR Rating

High