Report Number : ICRR0020307

1. Project Data

Project ID	Project Name	
P074027	LA-Health Services Improvement Project	
Country	**Practice Area(Lead)**	**Additional Financing**
Lao People's Democratic Republic	Health, Nutrition & Population	P124906,P124906

L/C/TF Number(s)	Closing Date (Original)	Total Project Cost (USD)
IDA-H1830,IDA-H6950,TF-10518	30-Jun-2011	27,400,000.00
Bank Approval Date	**Closing Date (Actual)**	
13-Sep-2005	31-Dec-2015	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	25,000,000.00	2,400,000.00
Revised Commitment	24,994,274.71	2,399,890.03
Actual	25,737,958.40	2,399,890.03

Sector(s)
Health(90%):Central Government (Central Agencies)(5%):Public Administration - Health(5%)

Theme(s)
Health system performance(33%):Child health(17%):Malaria(17%):Population and reproductive health(17%):Nutrition and food security(16%)

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

a. Objectives

Original Project Development Objectives: The objective of the project was "to assist the Lao People's Democratic Republic to improve the health status of its population, particularly the poor and rural population, in Project Provinces" (Development Grant Agreement, No. H183-LA, 11/08/2005, p. 15; and PAD, No. 293 14-LA, 8/16/2005, p. 3).
Revised Project Development Objectives: A level-1 restructuring, approved by the Board on 06/09/2011, revised the objectives as follows: "to assist the Recipient to increase utilization and quality of health services, particularly for poor women and children in rural areas in Project Provinces" (Financing Agreement - Additional Financing for the Health Services Improvement Project, 10/11/2011, p. 4; and Project Paper on Proposed Additional Grant, 05/03/2011, p. 4).

US$ 14.43 million, or 53% of total Bank financing, had been disbursed at the time of restructuring.

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

09-Jun-2011

c. Components

The lending instrument consisted of a specific investment operation, which also included a results-based financing (RBF) portion that was utilized mainly to support free delivery services to pregnant women, and to support the Health Equity Fund, which provided user fee exemptions for poor households.

Component 1: Improving the Quality and Utilization of Health Services (Appraisal US$5.12 million; Additional Financing US$5.03 million; Actual US$10.15 million). The component was to support improvements in physical infrastructure, upgrading of utilities, and provision of equipment, drugs, and medical consumables. The component aimed at improving the accessibility and quality of a basic package of health services in 60 districts, 11 ranked as poor and 14 as very poor. The additional financing included support for the expansion of the RBF mechanism to finance: (a) the continued use of output-based payments for a comprehensive package of services under the Health Equity Fund; (b) expanded implementation of free deliveries using payment based on volume of services, and gradual introduction of output-based payment for child inpatient services; (c) introduction of RBF as a mechanism for financing outreach services; and (d) piloting and evaluation of approaches to use performance incentives to improve the quality of hospital services for deliveries and child inpatient services, and to expand coverage of services provided through outreach.

Component 2: Strengthening Institutional Capacity for Health Service Provision (Appraisal US$8.59 million; Additional Financing US$3.69 million; Actual US$12.28 million). The activities were to focus on improving the quality of the health workforce, including short- and long-term training of key staff, capacity building for medical education, strengthening project management, and financial and procurement management. The additional financing supported new staff training, and three training institutions with renovations and training equipment.

Component 3: Improving Equity, Efficiency, and Sustainability of Health Care Financing (Appraisal US$1.29 million; Additional Financing US$1.28 million; Health Results Innovation Fund Grant US$2.4 million, Actual US$4.97 million). The purpose of the component was to prepare the health sector to effectively use the expected increases in Government funding, including strengthening the existing health management information system and health care financing. The component was to provide equity sub-grants to selected nongovernmental organizations. The additional financing provided support for additional surveys, data collection, and piloting of options for financing free antenatal care.

The additional financing aimed at supporting additional activities as noted and scaling others as follows: (a) scaling up of programs to reduce financial barriers to health services; (b) continued financing of recurrent costs at the province, district and health facility levels; (c) focused investment in human resource development; and (d) support to equipment and facility upgrading at the district hospital and health centers levels.

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

Project costs and financing

At appraisal, the project cost was estimated at US$10 million to be fully financed by an IDA grant (H183-LA). Additional financing of US$15 million was provided by another IDA grant (H695-LA) on 06/09/2011, and was further supplemented by a co-financing grant of US$2.4 million from the Health Results Innovation Trust Fund to implement RBF activities focusing on maternal & child health services. The total project cost aggregated at US$27.4 million. The proceeds were fully disbursed. No Borrower contribution was expected or made.

Dates
The project became effective on 02/22/2006. A level-1 restructuring on 06/09/2011 revised the project development objectives, provided additional financing with a closing date of 6/30/2014, and extended the closing date of the original grant by one year. A level-2 restructuring on 04/11/2012 reallocated the funds between components. A restructuring on 12/23/2013 extended the additional financing grant by 18 months, reallocated funds, and revised the results framework and implementation arrangements. The project closed on 12/31/2015.

3. Relevance of Objectives & Design

a. Relevance of Objectives

Relevance of both the original objectives (to improve health status) and the revised objectives (to increase utilization and quality of health services) is rated Substantial. The objectives were relevant at entry and at project closing. They were responsive to the conditions and needs of the country, where most key health indicators (2003) fell below the average for low-income countries, such as life expectancy at 55 years, infant mortality at 82 deaths per 1,000 live births, and a maternal mortality ratio at 530 maternal deaths per 100,000 live births, along with a high burden of communicable diseases, and marked rural-urban differentials.

A priority for the government was to provide adequate health services to its population, particularly the poor, and to address limited access and poor quality of health care. The objectives were consistent with the National Growth and Poverty Eradication Strategy (2004) and with the National Socio-Economic Development Plan (2006-2010). They remain aligned with the country's Health Sector Reform Strategy (2013–2025), which aims at improving access to basic health care by 2020 and at achieving universal health coverage by 2025. They are also aligned with the Plan of Action (2016–2020), which seeks to accelerate multi-sectoral actions.

The project objectives are relevant to the Bank's current Country Partnership Strategy (2012– 2016), which is aligned with the country's Seventh and Eighth National Socio-Economic Development Plans. They are aligned with the third strategic objective of the Country Partnership Strategy on inclusive development, which calls for increased utilization and quality of essential maternal & child health services.

The revision changed the development objectives to focus on coverage and utilization of health services and interventions rather than on health status outcomes with the explanation that these changes are more amenable and attributable to project support, and less susceptible to confounding influences (Restructuring Project Paper, p. 4). The revised objectives therefore remained substantially relevant.

Rating	Revised Rating
Substantial	Substantial

b. Relevance of Design

Relevance of design under the original objectives is rated Modest. The planned activities for strengthening infrastructure, service utilization, institutional capacity, equity, and sustainability of health care financing did not fully establish a causal results chain linking these planned activities to outputs and intermediate outcomes to improved health status of the population. There was disconnect between the objectives and the choice of project components (ICR, p. 16). Also, the project's more pronounced focus on the supply of health inputs and less so on demand-side aspects was a significant weakness in its design (ICR, p. 22).

Relevance of design under the revised objectives is rated Substantial. The PDO was changed to focus on utilization and coverage to more accurately reflect what the project was supporting (ICR, p. 11). The design of activities stated above lays out a plausible results chain that connects activities with the desired outcomes for improved utilization and quality of health services.

Rating
Modest

Revised Rating
Substantial

4. Achievement of Objectives (Efficacy)

Objective 1

Objective
Improve the health status of the population, particularly the poor and rural population, in Project Provinces.

Rationale
Outputs

- The project provided infrastructure improvements, including four new Integrated Community Health Centers, support to repairing and equipping 268 health centers, constructing and equipping five new district hospitals, repairing and equipping one provincial hospital, and supporting medical education and training facilities, including university renovations, construction of lecture rooms, a library, and a surgery wing.
- The project provided training in project districts to improve the quality of the workforce, including training of personnel at the level of the village, health center, and district. It provided training to nursing schools and to medical staff in large provincial hospitals. The project supported the Family Medicine Internship Program and provided a two-year postgraduate specialty training program for doctors prepared to return to, and work at, the district level, and a master's degree training in basic sciences. In total, the outputs included short and long term training to 5,400 health staff, 356 village health committees, 451 village health volunteers, 455 Traditional Birth Attendants, 453 nurses, 121 community midwives, 29 registered midwives, 822 health center and district managers, and 746 district and health center staff in maternal, neonatal, child health package and outreach, 151 medical assistants, and 217 medical associates. Ninety medical doctors received specialized training in family medicine, six in obstetrics and gynecology, four in pediatrics, 10 in anesthesiology, 14 in surgery, two in internal medicine, and two in cardiology.
- The project supported the implementation of the Minimum Package of Health Services, provision of ante-natal care to 225,000 pregnant women, distribution of 451 village kits, and undertaking of information and education activities.
- The operation supported the strengthening of the existing health management information system and consolidation of information from villages to provincial health offices, including training of 1,300 district and health center staff, and implementation of a web-based system in the provinces.

Outcomes
There was no reliable evidence on progress towards achievement of this objective, keeping in mind that there were significant problems with the comparability of baselines, reliability, accuracy, and consistency of the data (ICR, p. 14). The indicators were not only misaligned with the objectives, but they also reflected achievements that were not under the full influence of the project. Out of the eight original PDO indicators, only two indicators, infant and under-five child mortality, measured health status, and these consisted of national figures. Both indicators were dropped in 2011 when the project objectives were revised. The 2011-12 Lao Social Indicator Survey showed that child mortality rates had been on a steady decline since the 1990s. Infant mortality declined from 124 deaths per 1,000 live births in the late 1990s to 91 deaths per 1,000 live births in the mid-2000s and continued to decline to 68 deaths per 1,000 live births in 2010-11. Similarly, the under-five mortality rate almost halved from 164 deaths per 1,000 live births in the mid-1990s to 79 deaths in 2011. The long term trend in reductions in the infant mortality rate and under-five mortality rate cast doubt about the contribution of the project to these improvements, which is likely to be modest (ICR, p. 15). The same pattern has been observed with other improvements that were noted without project support. For example, between 2006 and 2012, there were significant reductions in the prevalence of underweight and stunting, and yet project support to nutrition related activities was very modest.

Concerning the stated focus on poor and rural populations, none of the PDO level indicators were disaggregated by wealth status, or compared project areas to the rest of the country (ICR, p. 20).

Rating
Modest

Revised Objective
This objective was dropped at restructuring.

Revised Rationale
Not applicable because this objective was dropped at restructuring.

Revised Rating
Not Rated/Not Applicable

Objective 2

Objective
Increase the utilization of health services, particularly for poor women and children in rural areas in Project Provinces.

Rationale
This objective was added at restructuring. See the discussion and rating under Revised Objective below.

Rating
Not Rated/Not Applicable

Revised Objective
Increase the utilization of health services, particularly for poor women and children in rural areas in Project Provinces.

Revised Rationale

Outputs
In addition to the outputs described under Objective 1, the project instituted mechanisms for strengthening the Government's ability to protect the poor by promoting village-level services, and expanded health equity funds (user fee exemptions for poor households), free deliveries, and free inpatient services for children under five years in five districts, a pilot to provide higher-level payments for free maternal & child health in district hospitals, and training of village health volunteers to support the implementation of the free maternal, neonatal, and child health services. 466,000 people benefited from the Health Equity Fund. Free maternal and child health care was provided in four provincial hospitals, eight district hospitals, and health centers covered by the project. The outputs included studies on health financing, provision of equity fund sub-grants to selected non-governmental organizations (NGOs), the development of a Health Financing Strategy 2011–2015, and the development and implementation of the Ethnic Group Development Plan to ensure that ethnic groups were afforded equal opportunities to participate in the project and to benefit from it.

Outcomes
The results show significant improvements in the utilization of services, including for poor women and children in rural areas. The improvements were also associated with revised implementation arrangements that shifted operational responsibilities to the technical departments of the Ministry of Health resulting in greater ownership of the project by these departments (ICR, p. 4). The percentage of deliveries occurring in a health facility increased from a baseline of 24% in 2011 to 39% in 2015, surpassing the target of 35%. From 2008 to 2015, there was a gradual year-to-year increase in institutional deliveries in project districts. The Health Equity Fund and the Free Maternal, Neonatal, and Child Health Initiative boosted institutional deliveries threefold. About 72 percent of the beneficiaries were from non-urban

populations. Institutional deliveries for the poor doubled during the above period. The proportion of infants delivered in health facilities in project provinces increased considerably and was slightly higher than in the 13 non-project provinces. Even though institutional deliveries increased in both groups of provinces, the increase was higher in project provinces (10.6 percentage points) compared to non-project provinces (7 percentage points). The elimination of user fees for facility-based childbirth encouraged women, poor and non-poor, to give birth in health facilities. There was a gradual and marked increase in the use of both outpatient and inpatient child health services from 6% to 12%, involving about 150,000 beneficiary children. Child under-five inpatient discharges per capita rose from a baseline of 0.06 in 2011 to 0.09 in 2015, surpassing the target of 0.08. The number of people with access to a basic package of health, nutrition, or reproductive health services rose from a baseline of 105,000 in 2011 to 896,000 in 2015, surpassing the target of 500,000. The number of poor households with access to a basic package of health services rose from a baseline of 13,200 in 2011 to 19,100 in 2015, surpassing the target of 17,000 households.

Revised Rating
High

Objective 3

Objective
Increase the quality of health services, particularly for poor women and children in rural areas in Project Provinces.

Rationale
This objective was added at restructuring. See the discussion and rating under Revised Objective below.

Rating
Not Rated/Not Applicable

Revised Objective
Increase the quality of health services, particularly for poor women and children in rural areas in Project Provinces.

Revised Rationale
Outputs
The same outputs described under Objective 1 and 2 above apply to this objective. In addition, the outputs included the 'Paying for Quality Scheme' in health facilities under RBF (payments linked to scoring on quality assessment checklist, TTL clarification, 9/8/2016).

Outcomes
Project data that would assist in determining project contributions to quality improvements was inadequate. The Paying for Quality Scheme was implemented only during two quarters from July to December 2014, and in three provinces only (TTL clarification, 9/8/2016). The Scheme was stopped in 2015 when funding ran out. The average balanced scorecard quality score among health facilities implementing the initiative did not have an established baseline, and a cumulative level of 62% was stated as achieved, short of the target of 85%. **T**he ICR did not provide details on the score criteria. The Lao People's Democratic Republic Service Availability and Readiness Survey, conducted in 2014, assessed the availability of key health services as well as the functionality and readiness of amenities, basic equipment, diagnostic tools, and other critical inputs needed for provision of services in the country. The survey found that only 56 percent of health centers in the South and fewer than 58 percent of district hospitals in the South were in a position to provide basic health services. All this was despite significant investments by the project in renovations of health centers, and procurement of medical equipment and supplies for health facilities in the Southern region of the country (ICR, p. 20). Nevertheless, it would be reasonable to assume that project activities may help in laying the foundation to improve both capacity and quality of health services in the long run.

Revised Rating
Modest

5. Efficiency

Due to lack of data and lack of adequate estimates of social benefits and costs specific to project interventions, a cost-benefit analysis was not performed at the time of the original project appraisal in 2005 or at the time of project restructuring with additional financing in 2011 (ICR, p. 21). The PAD's economic and financial analysis provided general conclusions that the project was likely to yield positive social benefits and that the overall distributional impact was likely to be pro-poor. The ICR noted that, given data limitations and the lack of impact evaluation, it was not possible to measure the real impact attributable to the project (ICR, p. 21). At the same time, the ICR's economic analysis makes an attempt to assess two benefits: (a) reduced infant and child deaths through increased coverage for immunization and increased utilization of maternal health services, and (b) reduced out of pocket expenditures for maternal health services among the project beneficiaries. The analysis estimates that each U.S. dollar invested by the project generated up to US$1.39 in benefits, assuming that 5 percent of increase in coverage rates was attributed to the project, and that under such a scenario, the project has generated a total economic value between US$12.7 million and US$38.0 million from reduced child mortality. Using WHO criteria on interventions averting additional disability-adjusted life years, the analysis concludes that the maternal & child health intervention was cost-effective. Concerning the reduction in out-of-pocket expenditures for maternal & child health, it was not possible to differentiate the benefits taken by the poor and non-poor, and the analysis estimates that more than 2,000 households have avoided catastrophic health spending because of free maternal & child health services supported by the project.

While this limited analytical effort is noteworthy, it is only partially relevant to the total project and its overall efficiency. More importantly, decreased infant and child mortality through immunization cannot be attributed to the project since project investments did not directly support the country's expanded program of immunization. This issue also relates to the larger design concerns noted earlier, and which have contributed to reduced relevance and efficiency.

The strategy to finance free services and other exemptions clearly has long-term financing implications on sectoral resources and financial sustainability. The annualized cost (2015) for free services has been assessed by the ICR at US$14 for free maternity services per pregnant women, US$3.90 per child under 5 years, and US$3.50 per health equity fund member per year.

Shortcomings in the efficiency of implementation were significant. Project extensions were required to allow implementation completion. The first extension of the original grant by one year on 06/09/2011 aimed at completing civil works and hospital waste water treatment systems (Project Paper 05/03/2011, p. 4). Another extension of 18 months on 12/23/2013 aimed at allowing the implementation of free maternal & child health services, free child health and payment for services, and 'Paying for Quality' under RBF, which were significantly delayed, leaving insufficient time to fully implement these activities before project closing (ICR, p. 8). The project faced a cost overrun and did not have a sufficient budget to implement the activities beyond December 2014. The increase in daily subsistence allowance increased project costs and necessitated reallocation of funds across expenditure categories. Implementation of activities continued with funding from the Government and other donors. Capacity and personnel gaps, especially at the district level, contributed to implementation delays, in spite of expedited recruitment and training. The disbanding of Xaysomboun Special Zone Province moved related districts to other provinces that were not part of the project. Poor coordination between donors caused significant constraints during the early stages of the project (ICR, p. 7), and resulted in significant delays in the implementation of several project activities. Support from other donors, including district-level activities, overlapped with project activities and created an additional burden on the time of health sector staff. The ICR states that the areas of potential duplications, gaps, and donor coordination were noted by a Quality at Entry Review (QER) panel (ICR, p.7) but were not effectively addressed.

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		0	0 ☐Not Applicable

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

6. Outcome

Under the original objectives, which were to improve the health status of the population, relevance of objectives is rated Substantial as the objectives are responsive to the strategies of the Borrower and the Bank. Relevance of design is rated Modest because the design did not fully establish a causal framework, and there were only partial logical links between the planned activities and the expected outcomes on improved health status. The objective to improve the health status of the population, particularly the poor and rural population, was not achieved and is rated Modest. Efficiency is rated Modest because of insufficient economic and financial analysis, and significant implementation inefficiency, including delays, project extensions, cost overruns, and overlapping of project activities with those of other donors. The review findings are indicative of major shortcomings under the original objectives, and therefore an outcome rating of Unsatisfactory.

Under the revised objectives, relevance of objectives to increase utilization and quality of health services, particularly for poor women and children in rural areas, is rated Substantial as they are responsive to the strategies of the Borrower and the Bank. Relevance of design is rated Substantial as the design of activities lays out a plausible results chain that connects outputs and intermediate outcomes to the desired outcomes on improved utilization and quality of services. The objective to increase utilization of health services, particularly for poor women and children in rural areas, was achieved and is rated High. The objective to increase the quality of health services is rated Modest. Efficiency is rated Modest as explained above under the original objectives. The review findings are indicative of moderate shortcomings under the revised objectives, and therefore an outcome rating of Moderately Satisfactory.

According to IEG/OPCS guidelines, when a project's objectives are revised, the final outcome is determined by the weight of bank disbursements under each set of objectives (53% under the original objectives, and 47% under the revised objectives):

- Under the original objectives, the outcome is rated Unsatisfactory (2) with a weight value of 1.06 (2 x 53%).
- Under the revised objectives, the outcome is rated Moderately Satisfactory (4) with a weight value of 1.88 (4 x 47%).
- These add up to a value of 2.94 (rounded to 3), which corresponds to a Moderately Unsatisfactory rating, indicative of significant shortcomings in the project's preparation and implementation.

a. Outcome Rating
Moderately Unsatisfactory

7. Rationale for Risk to Development Outcome Rating

The uncertainties faced by the operation's development outcomes over the intermediate run appear to be moderate. Important project-supported investments, such as the district health information system, have been institutionalized. By project closing, the information system was used by the provinces for regular reporting on preventive and curative health care. Further technical support was provided by Vietnam's health information program. Technical aspects of health interventions are sound. A follow-on project, the Lao Health Governance and Nutrition Development Project 2015-2020, supported by IDA, continues to support project activities. The Asian Development Bank continues to finance the Health Equity Fund. The Government continues to demonstrate commitment to the development objectives and to the overall strengthening of the health sector. Since capacity building investments have been substantial at the central, provincial, and district levels, it would be reasonable to assume that the cumulative and long term benefits generated by project's extensive training would have a positive impact on the sector beyond the life of the project. However, low utilization of health services by poor and vulnerable groups remains a risk, keeping in mind that there are variations across provinces.

a. Risk to Development Outcome Rating
Modest

8. Assessment of Bank Performance

a. Quality-at-Entry
The Bank's performance at entry was mixed. The Bank was instrumental in facilitating preparation and in drawing on lessons learned from previous engagement in the sector and the country, and from experience in the East Asia and Pacific region. Past lessons included the need to address capacity and skills constraints, and to support the health sector as whole, mainly at the district level. The Bank team identified the challenges that needed to be addressed, and the project was aligned with Government and Bank priorities as well as with the Millennium Development Goals. The appraisal team ensured that the operation was consistent with the Bank's fiduciary role.
However, there were substantial shortcomings during preparation and appraisal. There was disconnect between the objectives and choice of planned activities. The PDO indicators and the Results Framework were problematic. The indicators were either beyond the influence of the project or were not a good measure of progress toward the PDO since they focused on utilization rather than health outcomes. M&E arrangements were weak. No mechanism was put in place for verifying the outcome-level results to be extracted from the data of the management information system, which itself was to be developed with project support. The QER panel raised another key concern about the project design, which was not addressed: the project was excessively supply-driven without consideration of demand aspects and household behavior. The absence of adequate demand-side interventions proved to be a key constraint in remote areas (ICR, p. 25). The panel also advised the project team to ensure the use of existing donor coordination mechanisms and to exhibit more transparency, but these were not adequately considered and resulted in implementation delays and overlapping of activities.

Quality-at-Entry Rating
Moderately Unsatisfactory

b. Quality of supervision
The lack of country presence during the first three years of implementation contributed to delays in the early resolution of arising issues and poor coordination among the donors supporting the sector. After the 2008 mid-term review, the relocation of the task team leader to Vientiane enabled a deeper understanding of the country context and dynamics, and easy access to the client. Implementation support and supervision were regularly undertaken. Implementation support missions visited regularly and included technical experts, and procurement and financial management specialists. The comprehensive Aides Memoire provided evidence of regular supervision and advice given by the Bank's team throughout the life of the project. Reporting was of good quality. The Bank team facilitated the shift in project management from a project management unit to the mainstream ministry. The Bank's role was effective in ensuring continuity and adequate transition arrangements, both in task team leadership and in preparing for the subsequent operation. The Bank team led the efforts for project restructuring in 2011, but the restructuring was unnecessarily delayed by three years even though the inadequacies were acknowledged during the 2008 mid-term review.

Quality of Supervision Rating
Moderately Satisfactory

Overall Bank Performance Rating
Moderately Unsatisfactory

9. Assessment of Borrower Performance

a. Government Performance
The Government exhibited strong ownership and commitment to achieving development objectives. It appointed a core team of national experts familiar with the Government's 2020 Health Strategy and Health Master Plan to lead project preparation. It put in place a Steering Committee to provide guidance and oversight to the project. The Steering Committee was chaired by the minister of health and comprised

the vice ministers and directors of the ministry's departments. The Government provided a supportive policy environment, notably for facilitating adjustments in implementation arrangements, pro-poor efforts, and maternal and child health care strategies. The Government complied with project covenants and agreements. It continued funding of activities where there was a cost overrun. It facilitated transition arrangements for the follow-on operation in a satisfactory manner, and ensured continuity of project activities. However, the Government did not perform effectively in donor coordination to promote synergies and overall efficiency.

Government Performance Rating
Moderately Satisfactory

b. Implementing Agency Performance

The Ministry of Health provided overall leadership in project implementation, initially through a Project Management Unit, and subsequently, following the 2011 restructuring, through the ministry's departments at the central and district levels. Within the ministry, the Department of Planning and Finance was the nodal body for project coordination and management. Initially, the Project Management Unit approach alienated the technical departments that viewed the project as a parallel undertaking rather than complementary support to their core functions, and therefore they were not actively engaged in supporting project-financed activities. The 2011 restructuring addressed the lack of ownership of the ministry's technical departments by modifying the management structure, whereby project activities became part of the operations of the technical departments. Notwithstanding capacity constraints at the district level, financial management arrangements and performance were adequate. The ministry fulfilled procurement functions, but with variable delays. It facilitated full compliance with safeguards requirements and completed extensive training plans effectively.

Implementing Agency Performance Rating
Moderately Satisfactory

Overall Borrower Performance Rating
Moderately Satisfactory

10. M&E Design, Implementation, & Utilization

a. M&E Design

The initial design for M&E was inadequate. The PDO indicators either did not reflect the objectives or were not suitable to measure them. Outcome and intermediate level indicators primarily focused on service coverage. The infant mortality rate and the under-five mortality rate were beyond the influence of the project. Also, the operation did not directly support the country's expanded program of immunization, which was supported by other donors. Therefore, none of the PDO indicators that were under the purview of the project correctly measured the health status of the population. This disconnect may be partially explained by the prevailing standard practice at the time of project identification and preparation, when the choice of indicators reflected generic aspirations influenced and driven by the Millennium Development Goals.

The objectives highlighted a particular focus on "the poor and rural population," but there were no arrangements to adequately measure this focus under the original design, and the indicators were not disaggregated by wealth status and did not compare project areas to the rest of the country. Following the revision of objectives with their new thrust on utilization and quality of services, the results framework was better aligned with the objectives.

b. M&E Implementation

Most of the indicators were to be derived from the newly designed health management information system, which was expected to be rolled out over the first two years of implementation. There were associated risks, given that it was not possible to anticipate the quality of the data under the new system, and no alternative sources of data were identified in the event that progress was slow. This proved to be the case. The quality of the system's data was reported by the team to be questionable, and, until the system was well set up in the latter part of the project, there were issues with the quality and reliability of the system-generated data. In 2013, a decision was made to transform the information system from a paper- and Microsoft Excel-based system to a web-based data reporting system, the District Health Information

System, which would also enable reporting on the RBF component. Several challenges remained. Internet connectivity was unstable and slow, hindering the ability to submit reports in a timely manner. There were issues in data definition and verification. Management capacity to ensure timely reporting and assignment of responsibilities to the right staff also remained a challenge. Near the end of the project, notable improvements were observed, and the system was sustained under the subsequent operation as discussed below in the utilization section.

c. M&E Utilization

Despite the quality issues noted above, data was extensively used for project monitoring. M&E findings were communicated to stakeholders and donors. The focus on results and causality logic contributed to the reframing of the project development objectives and to assessment of service utilization by the poor. This has contributed to an improved outcome assessment under the revised objectives. Project data under the district health information system was used in the first-ever National Health Statistics Report for FY2013–2014. Also, as stated above (Section 7), the district health information system facilitated the readiness of the follow-on project, the Lao Health Governance and Nutrition Development Project 2015-2020, where the information system continued to be utilized and strengthened.

In conclusion, while M&E utilization aspects were largely adequate, there were significant shortcomings in M&E design and implementation, and therefore the overall quality of M&E is rated Modest.

M&E Quality Rating

Modest

11. Other Issues

a. Safeguards

The project triggered two of the Bank's safeguards policies: OP/BP 4.01 on Environmental Assessment and OP/BP 4.20 (later revised to OP 4.10) relating to Indigenous People. The project was found to be in full compliance with IDA safeguards requirements throughout its course. Both were consistently rated Satisfactory in the periodic Project Implementation and Status Reports.

Environmental Assessment. A comprehensive environmental assessment was completed during project preparation to ensure that potential impacts of the project on environmental and human health issues were adequately understood, with appropriate mitigation measures identified and agreed upon. Mitigation measures to be adopted by the Government were detailed in an Environmental Management Plan, which aimed at ensuring that, with the new construction activities and renovations, local ecosystems were protected, with no harm to local sensitive species and habitats, and that there was proper disposal of construction wastes and prevention of pollution of watercourses and drinking water sources. Appropriate health care waste management was also addressed.

Indigenous People. A Social Impact Assessment was conducted to examine the potential impact of the project on indigenous people and vulnerable groups. The assessment concluded that, while the project was unlikely to have a negative impact, the positive impact would depend on the extent of the efforts to include ethnic group participation in health care. An Ethnic Group Development Plan was prepared to facilitate the provision of equal opportunities to different ethnic groups to participate in, and to benefit from, the project in a culturally suitable manner. A special program was established to waive educational requirements, and to recruit more ethnic minority health personnel, notably at the peripheral levels. The program also facilitated the development and dissemination of health information and communication in local languages.

b. Fiduciary Compliance

Financial Management. An initial financial management assessment found that the central Ministry of Health had gained substantial experience from the previous operation, but that provincial and district capacities were weak and lacked skilled financial management staff. As a result, the project instituted a capacity-building initiative, including financial management, to help with the development of the required skills. During project implementation and at project closing, no major issues were identified. Financial management arrangements were adequate overall and acceptable to the Bank during the life of the project. Quarterly financial reports were prepared and submitted on time.

Financial statements were regularly audited by independent auditors. All audits were unqualified. A few were received late, but all others were received on time or before the deadlines. Financial management was consistently rated Satisfactory in project status reports.

Procurement. A comprehensive assessment of the Ministry of Health's capacity to manage procurement was carried out during project preparation (2003-2004) and was updated in 2005. The assessment found that the Ministry, through a Project Management Unit, had prior experience in carrying out procurement under IDA guidelines. Procurement was undertaken by the unit, which was staffed by consultants recruited through a competitive process. Subsequent to the changes in implementation arrangements at restructuring, consultants continued to handle procurement activities. Also, an action plan for strengthening transparency and accountability in the procurement process was developed. Civil works were delayed due to the need to adjust project activities to account for new donor support for civil works in the sector. Keeping in mind variable delays, procurement was mostly rated as moderately satisfactory throughout the project, and the procuring entities' performance in the procurement process, contract management, documentation, and filing systems was found to be adequate.

c. Unintended impacts (Positive or Negative)
None identified.

d. Other
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12. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Moderately Unsatisfactory	Moderately Unsatisfactory	---
Risk to Development Outcome	Modest	Modest	---
Bank Performance	Moderately Unsatisfactory	Moderately Unsatisfactory	---
Borrower Performance	Moderately Satisfactory	Moderately Satisfactory	---
Quality of ICR		Substantial	---

Note
When insufficient information is provided by the Bank for IEG to arrive at a clear rating, IEG will downgrade the relevant ratings as warranted beginning July 1, 2006.
The "Reason for Disagreement/Comments" column could cross-reference other sections of the ICR Review, as appropriate.

13. Lessons

The project has provided a number of lessons (ICR, pp. 27-28), with the following lessons drawn from the ICR and adapted by IEG:

- **A project's success is jeopardized by weak design and a logical framework that does not link planned activities with the desired outcomes.** Under this project, the planned activities for strengthening infrastructure, institutional capacity, equity and sustainability of health care financing would not logically and directly lead to the desired outcome of improved health status of the population, even though they are worthy undertakings for health system strengthening.
- **The lack of in-country presence by the Bank may hinder adequate project preparation and implementation.** No core team member was based in the country during project preparation, or during the first three years of implementation. This absence made it difficult to navigate local institutional complexities and to fully understand and identify challenges and bottlenecks facing the project. Also, such absence makes coordination with the country's institutions and between donors more difficult, and coordination deficiencies caused significant challenges during project implementation.

- **Both supply-side and demand-side interventions are needed to promote health service utilization.** Under the project, the focus was on the supply of health inputs and less on demand-side constraints. Demand side approaches help in addressing social, cultural, and access barriers, and help build awareness, community involvement, motivation, and care-seeking behavior.

In addition, the IEG review identifies the following lesson: **A delayed corrective restructuring of a poorly performing project is unlikely to improve its unfavorable outcome rating,** in contrast with an early corrective restructuring, which increases the likelihood of generating a favorable outcome if subsequent project performance improves. Under this project, it took more than three years to restructure the project after concluding that a revision was necessary.

14. Assessment Recommended?

No

15. Comments on Quality of ICR

The ICR is results-oriented. The quality of its analysis is adequate, and the discussion of attribution issues is noteworthy. The quality of evidence on utilization is robust, while the evidence of the quality of health services is poor, as recognized by the ICR. The report candidly captures the experience of the project with a thorough account of its implementation and monitoring. The report is internally consistent. It is also consistent with the guidelines. The lessons are based on evidence derived from project experience. The ICR is clearly written and well organized, but it includes frequent duplications and therefore could have been more concise.

a. Quality of ICR Rating
Substantial