Report Number : ICRR0020893

1. Project Data

Project ID	Project Name
P124054	ML-Strengthening Reprod Health (FY12)
Country	**Practice Area(Lead)**
Mali	Health, Nutrition & Population

L/C/TF Number(s)	Closing Date (Original)	Total Project Cost (USD)
IDA-H7530	28-Feb-2017	30,000,000.00
Bank Approval Date	**Closing Date (Actual)**	
20-Dec-2011	28-Feb-2017	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	30,000,000.00	0.00
Revised Commitment	12,816,830.40	0.00
Actual	7,778,424.24	0.00

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2. Project Objectives and Components

a. Objectives

The Project Development Objective (PDO) as stated in the Project Appraisal Document (PAD) and the Financial Agreement was to improve access and use of quality reproductive health services by women of reproductive age, in selected regions of Mali (Sikasso, Koulikoro, Segou, and peri-urban Bamako).

The original PDO was not changed during the project life, but the target of PDO Indicator #3 was reduced to account for delayed implementation of regional action plans to reinforce obstetrical care. Final outcomes at the end of the project exceeded both original and revised targets. Therefore, no split rating is needed.

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

Did the Board approve the revised objectives/key associated outcome targets?
No

c. Will a split evaluation be undertaken?
No

d. Components

Component 1: Strengthening Supply and Quality of Reproductive Health (RH) Services (International Development Association (IDA) US$7.5 million at appraisal; US$4 million actual). This included three subcomponents:

Subcomponent (i) - Financing the design, implementation and evaluation of a Results-Based Financing (RBF) Pilot in Koulikoro region (US$1.8 million). About 120,000 women of childbearing age and infants were expected to receive a health care package including RH and other child care services over a period of two years. Health facilities were expected to receive a results-based grant that could be reinvested in quality improvements (e.g. purchase of equipment).

Subcomponent (ii) - Improving the supply of contraceptives (US$2.0 million) through supporting training of health staff in pharmaceutical inventory management, and the purchase of a buffer stock of essential RH commodities and kits, including long-term contraceptives (intra-uterine devices and implants).

Subcomponent (iii) - Capacity building in RH and obstetric care (US$3.7 million) through in-service training of doctors, nurses and midwifes in family planning (FP), RH, and obstetric care, financing kits for normal deliveries and Caesarean sections and essential supplies, blood banks and equipment, infrastructure rehabilitation for RH, and delivery services. This subcomponent was aimed to be implemented in the regions of Sikasso, Koulikoro, and Ségou, and in peri-urban Bamako, while other donors (Canada, Netherlands) assist the other four regions.

Component 2: Increasing Demand for RH Services (IDA US$15.6 million at appraisal; US$ 2.04 million actual). This included three subcomponents:

Subcomponent (i) - Strengthening outreach services and behavior change communication (BCC) interventions (US$13.5 million) through contracting out non-governmental organizations (NGOs, on a competitive basis using performance-based criteria) to partner with health facilities to promote the use of RH services. This aimed at supporting training and paying community agent “relays” working with health

facilities to promote and mobilize women to use immunization services, post-partum, and neonatal services, and to educate women on FP benefits. The relay agents were also to distribute contraceptives. NGOs were to expand services to the community through mobile units, and conduct large scale BCC to influence attitudes of women, adolescents, and others in communities to increase acceptance and use of RH services in health facilities. Local radio programs, theater, talks, interpersonal contacts, and peer education were to be used to convey the messages and contribute to behavior change.

Subcomponent (ii) – Improving financial access (US$1.6 million) through technical assistance to assess the management and financing of Local Solidarity Funds, which are community-based insurance schemes run by Community Heath Associations to finance women's emergency transport costs to deliver in health facilities (in the past, this financing scheme had collected only 21% of expected contributions, and therefore they had not been a dependable source of funds when pregnant women were in need of transport (PAD, p.6)). The subcomponent aimed also to finance during the second year of the project a pilot voucher scheme to provide cash transfers to pregnant women to facilitate access to assisted delivery services in selected districts that had a reasonable supply of obstetric care.

Subcomponent (iii) - Promoting an FP-conducive environment (US$0.5 million) aimed at strengthening advocacy, coordination, and communication activities by the Directorate of Population of the Ministry of Finance (MOF) who would convene a forum to include representatives of government, civil society, local authorities, and religious leaders. This forum would aim at promoting a policy environment conducive to FP.

Component 3: Social Accountability, Project Management, and Monitoring and Evaluation (M&E) (IDA US$6.9 million at appraisal; US$1.74 million actual).

This component included: project management by the Project Implementation Unit (PIU); measurement of the indicators in the results framework and the contracting of an M&E Specialist; health facility surveys; activities to disseminate the 2012 Demographic and Health Survey (DHS); human resources surveys; capacity building to improve the data quality of the routine health information system; and an impact evaluation of project interventions (specifically of the RBF).

Revised components

The political and security crisis in 2012-2013 slowed the implementation of the project. Mali became a fragile country in 2014 during project implementation, and its political stability and violence levels have worsened since then, according to the Worldwide Governance Indicators. During the 2014 and 2016 restructurings, the project eliminated some activities along with the cancellation of US$ 5 million (SDR 2.5 million) and US$16.1 million (SDR 6.56 million) of the IDA grant, respectively. The final grant was 30 percent of the appraisal estimate. Cancelled funds were reallocated to Mali through other Bank projects to ensure that IDA17 funds were not lost to the country.

Regarding component 1, the RBF pilot was carried out for eight months (although its effective implementation was limited to three months, rather than the originally-planned two years) because contracting with implementing agencies was delayed. The second procurement of contraceptives,

commodities, and equipment was cancelled because stocks of commodities were considered to be adequate following both the first procurement and the contributions of other partners. The training on pharmaceutical stock management was not implemented.

Regarding component 2, delays and failed negotiations with NGOs regarding contract terms prevented the implementation of activities towards the strengthening of outreach services. The pilot voucher scheme was not implemented. The activities aiming at strengthening of local solidarity funds were limited to two districts, due to a lack of agreement around the design of the technical support.

Regarding component 3, capacity building trainings were reduced given the late timeframe of the project. Delays and limited willingness on the part of the government limited implementation of activities, and planned analytical work was not carried out (i.e. health facility survey, dissemination of DHS, human resource survey, and impact evaluation).

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

Project Costs, Financing, and Borrower Contribution: Total project costs were estimated at US$ 30 million (SDR 19 million) at appraisal and were totally financed by an IDA grant. There was no borrower contribution. Total disbursement was much lower than planned (26% of original commitment) due to delays in implementation and cancellation of some project activities.

Dates: The project was approved in September 2011 and became effective on March 15, 2013 after more than one year of delay due to the political crisis that triggered numerous institutional changes within the Ministry of Health (MOH). After more than three years of project life, in October 2014, the project was restructured resulting in a cancellation of US$ 5 million of the grant amount (SDR 2.5 million) and the elimination of some project activities (i.e. the voucher scheme, project management, local solidarity fund support, and coalition building activities around FP issues, as well as surveys and impact evaluation).

A second restructuring took place in December 2016, two months before project closing, further cancelling US$16 million of the grant amount (SDR 9.94 million), and eliminating project activities that could not be completed in the remaining time frame. The final disbursed grant was US$7.9 million (SDR 6.56 million).

The PDO itself remained unchanged, and the project closed on time because the MOF decided not to extend implementation. The project had shown poor performance for several years, and there was not yet data available to demonstrate progress towards the achievement of objectives.

3. Relevance of Objectives & Design

a. Relevance of Objectives

The relevance of objectives is rated High. At the time of appraisal, despite reasonable economic growth (5.4

percent), Mali was off track to achieve commensurate gains in human development, specially the Millennium Development Goal (MDG) 5 on improving maternal mortality and access to RH services. In 2010, maternal mortality was 630 per 100,000 live births and only 8 percent of women of reproductive age used a modern method of contraception while more than 30 percent reported having unmet contraceptive needs. High fertility rates, close birth spacing, and teenage motherhood were and remain major contributors to maternal and child morbidity, malnutrition, and mortality. Poor RH outcomes are also driven by insufficient availability and quality of basic emergency obstetric care at the primary level (i.e. shortages of equipment and medical supplies resulting from weak acquisition and distribution systems at the district level, limited obstetric health staff disproportionately located in urban areas, and low incentives to perform due to inadequate salaries, career opportunities, and accountability for performance).

The PDO were highly relevant to the 2008-2011 Country Assistance Strategy objective of increasing the use of health services. Project interventions were aligned with the context of decentralization and increased leadership of local authorities in health service provision. Following the country's political and security crisis of 2012-2013, the project continues to be highly aligned with the current 2016-2019 Country Partnership Framework, which stressed that high fertility rates (6.9 children per women) represent a significant economic and social challenge because they narrow the window of opportunity to seize the first demographic dividend. The project is consistent with the Bank's 2007 Health, Nutrition and Population strategy, as well as the Bank's 2010-2015 Reproductive Health Action Plan, both of which stress the need to improve access to quality FP and RH services.

In terms of country priorities, the PDO is highly aligned with government's road map to reduce maternal mortality, the "*Feuille de Route pour l'Accélération de la Réduction de la Mortalité Maternelle et Néonatale (2008-2015),"* which highlights RH interventions that would help the country progress towards achievement of MDG5 through annual work plans. Moreover, the government is committed to increasing the rate of contraceptive use to at least 15 percent by 2018. During project preparation, consultations with the International Health Partnerships (IHP+) highlighted coverage gaps in support of RH and FP interventions (PAD, p. 2).

Rating	Revised Rating
High	Not Rated/Not Applicable

b. Relevance of Design

The PDO statement was concise, clear, and outcome-oriented. The project activities at the design stage were logically linked, addressing both supply and demand factors affecting poor RH outcomes. On the supply side, the project supported the availability of essential RH supplies (access), the strengthening of health staff capacities in RH and obstetric care, and a new accountability mechanism to improve governance and quality of health care (quality). On the demand side, the project activities focused on influencing the community to increase use of RH and FP services through outreach and BCC campaigns (to address geographical and cultural barriers), and on reducing financial barriers (e.g. the voucher scheme, and solidarity funds).

The project partnered with other donors, such as UNICEF, to scale up demand-side interventions to increase

awareness and utilization of RH services. These activities reflected the previous lessons learned from other operations (e.g. gradual introduction of the RBF approach, making FP part of a broader package of maternal and child health care services, etc.) (ICR, p. 11). A shortcoming in project design was that project activities were spread across large number of national implementers with weak collaboration (see Sections 8 and 9).

Rating
Substantial

Revised Rating
Not Rated/Not Applicable

4. Achievement of Objectives (Efficacy)

Objective 1

Objective
Improve access and use of quality RH in selected regions

Rationale
Outputs

RBF pilot in health facilities in Koulikoro (capacity building and quality):

- 37 personnel were trained in RBF in Benin before launching the RBF pilot.
- An RBF contract was signed with the NGO consortium KIT-CORDAID-CGIC in June 2016, and it was in effect during October through December 2016.
- 1,116 representatives from across Koulikoro region were trained on specific roles related to coordination and delivery of a package of high-quality RH services and verification. These included 237 district representatives (about 19 per district), 410 members from Community Health Associations (who led planning and coordination for health centers), 492 health personnel from community and referral health centers, and 27 regional officials.
- An OpenRBF portal for data management was established in December 2016.
- Only one cycle of RBF was implemented in the regional health centers due to the delayed timeframe. Overall 82,315 women and children were provided with RH services; however, this fell short of original target of 120,000 as well as the revised target of 200,000.
    - 2,620 complicated cases of malaria were treated in the referral health center for children 0-5 years;
    - 1,275 correct case referrals were made to the referral health center from the community health center;
    - 1,290 pregnancy complications were treated in referral health centers (including Caesareans);
    - 206 cases of tuberculosis were treated in community health centers;
    - 43,031 cases of malaria in children under 5 years were treated in community health centers;
    - 16,189 consultations were held for integrated management of illness of children 0-5 years;

- 15,260 children under 12 months were completely vaccinated;
- 400 pregnant women were tested for HIV and placed on antiretroviral drugs;
- 6,292 pregnant women were treated correctly for malaria;
- 20,641 women used modern FP;
- 6,393 women received prenatal visits, and 5,777 women received four prenatal visits; and
- 11,363 births were assisted by qualified personnel.

Improving the supply of contraceptives (availability):

- Between 2014 and 2016, contraceptives were purchased from the United Nations Population Fund (UNFPA) and distributed to health facilities in the project regions, including long-duration methods (65,000 implant kits, 14,100 intra-uterine devices) and short-term methods (475,352 cycles of contraceptive pills, 19,900 gross boxes of condoms) (ICR, p. 27).
- 3,530 health personnel were trained by the National Health Direction, Regional Health Directions, UNICEF, and the RBF agency to provide FP services, exceeding the target of 400.

Capacity building of health facilities to deliver RH and obstetrical services (quality):

- In 2015, all project regions implemented action plans (including advocacy and training) to improve prenatal care in community health centers, although the project provided funding for only one year.
- 806 health personnel were trained to provide obstetric services in community health centers between 2014 and 2016, exceeding the target of 400.
- Equipment and supplies were distributed to community and referral health centers according to their 2015 action plans. Equipment requested and received by health centers in 2016 included: 100 gynecological tables, 280 maternity beds, 16 operating tables and lights, 65 vacuum extractors, 418 aspirators, 4 echography devices, 2 centrifuges, 200 vaginal spectrums, 186 midwifery kits, 510 RH kits, 8 refrigerators, 71 mother and child scales, 4 examination lights, and 8 baby warmers and baths.
- According to Beneficiary Survey results, health professionals expressed satisfaction with the contributions of the project to enhancing their ability to offer services. In all three regions, the provision of training (anesthesiology, maternal mortality audits, and FP), communication materials, and equipment (such as delivery kits) were cited as valuable, particularly in efforts to reduce neonatal and maternal mortality and to promote women to use RH services. However, there were some gaps between the planning and implementation of project support (e.g. some referral health centers did not meet standards for providing delivery services, and promised vehicles and equipment in Segou and Koulikoro were not received).

Strengthen outreach services and BCC interventions (demand):

UNICEF, who implemented an accelerated Communication for Development (C4D) program, estimated that about 30 percent of the targeted population in the project regions was reached through direct communication activities or mass media dissemination.

- 742,364 women and men attended social marketing interventions on FP promotion, exceeding the target of 600,000.
- 652 advocacy sessions on demographic issues and FP were held with civil society, political, religious, and traditional leaders, exceeding the target of 300.
- 5,946 religious, female, male, and youth leaders were trained to influence community acceptance around decisions to use RH services. 306 Husband Champions were engaged to bring their wives to community health centers for prenatal care through large-scale C4D activities.
- 83,077 youth were engaged in secondary schools, colleges, and training centers in Bamako to promote RH service use.

Improving access to finance for RH services (affordability):

- Workshops were held in two districts to strengthen the local solidarity funds and raise awareness of becoming a member.
- Membership of the local solidarity funds increased from 21 percent in 2009 to about 50 percent in 2016.
- About 400 women have benefited from emergency transport to give birth since the 2015 support.
- A planned study to assess the insurance schemes was not implemented, and the training and technical support was not scaled-up to other districts as planned.

Outcomes

According to Multiple Indicator Cluster Surveys (MICS), the **rate of modern contraceptive use among reproductive aged women (utilization & BCC)** increased from 10% in 2010 to 19% in 2015 in project areas, exceeding the target of 15%. At the national level, the rate increased from 8% to 16% between 2010 and 2015, but the MICS survey does not cover the whole country (it excludes northern regions). National improvements may be reflecting the support of other donors, such the French and Spanish development agencies in Kayes and Mopti regions. MICS 2015 was the latest available wave at project closing. Given that contraceptives were distributed to health facilities in 2016 (ICR, pp. 24 and 45), and C4D activities to increase demand intensified in 2016, the project's influence on this indicator seems limited. A more up to date estimate from a UNICEF survey, although not strictly comparable to the baseline value, indicates that the **contraceptive rate** continue to grow to 21.5% in 2017 in project areas, but at a slower pace.

Health Management Information System (HMIS) data also show that the number of reproductive-age women using modern contraceptive methods in project regions increased from 174,147 in 2012 to 498,884 in 2016

(186% increase). Contraceptive rate coverage in each project region reached: 24% in Sikasso (baseline 7%); 25% in Koulikoro (baseline 9%); 22% in Ségou (baseline 9%); and 33% in Bamako (baseline 18%); while in other areas not targeted by the project, coverage reached at most 17% (ICR, p. v). The intense C4D program in 2016 was the main social mobilization activity in the project regions, and is very likely responsible for 2016 increases. Overall contraceptive coverage was 21% in 2016, which according to the project team can largely be attributable to the project regions, since the population of these regions accounted for 65% of the total population in 2016 (11.6 million of 18 million national).

The increased use of contraceptives implies that they were available and that there was increased demand in the community.

The number of **couple years of protection (CYP) (availability)** reached 1.3 million, exceeding the target of 900,000 CYP. CYP helps to monitor progress in the delivery of contraceptive services; it reflects distribution, not actual use. The ICR estimates that the project directly contributed to 468,000 CYP (ICR, p. 27) through contraceptives procurement through UNFPA. A multi-donor pool was established to achieve Mali's FP2020 commitment, and the MOH and donor sub-group agreed that supply needs were sufficiently met, leading to cancellation of the second planned UNFPA contract.

The percentage of **pregnant women who have at least four antenatal care visits (utilization & quality)** increased from 37.8% in 2010 to 43% in 2015 in project regions (to 63.6% in 2017 according to UNICEF estimates), achieving the target of 43%. At the national level, this percentage increased from 35% to 38% in the 2010-2015 period, according to MICS. About 31% (215,629 women nationally) had four prenatal visits in 2016, according to HMIS data. This is the only outcome indicator of quality of health care, as it measures retention and compliance with four prenatal care visits.

According to UNICEF data, on average 90% of pregnant women in the project regions reported having at least one prenatal care visit in 2016.

The percentage of **births attended by skilled health personnel (utilization)** increased from 35% in 2010 to 51% in 2015 in project areas, exceeding the original and revised targets of 50% and 48%, respectively. UNICEF's survey estimated that 64% of women reported giving birth at a community or referral health center in 2017, although the survey does not specify whether births were attended by skilled health personnel. HMIS data on assisted births in health facilities suggest a similar increase in the indicator for the project regions: 173,623 women (50.6 %) in 2013; 205,628 women (53.2 %) in 2014; 208,978 (55.1 %) in 2015; 217,377 in 2016 (60.8 %). At the national level, births attended by skilled personnel also increased, from 29% in 2010, to 44% in 2015, and to 50% in 2016.

The number of Caesarean section deliveries increased from 16,151 in 2010 to 18,461 in 2016, not achieving the target of 30,000.

The percentage of **women receiving postnatal care** within the first seven days of delivering in a health facility increased from 55% in 2010 to 71.6% in 2016, exceeding the target of 70%.

The overall increase in all outcome indicators could be partially attributed to project interventions. As per restructuring documents, by October 2014 the project had not yet implemented the activities needed to report progress on achievement of the PDO (Restructuring paper 2014, Report No: RES16425), and by the second restructuring in 2016 overall progress on the project indicators was limited due to delays in the project implementation (Restructuring paper 2016, Report NO: RES25845). This suggests that outcome improvements until 2016 are not plausibly attributed to the project. However, the project intensified implementation in the last year, likely contributing to the latest results.

Another confounding factor regarding attribution is the presence of other development partners supporting the government in achieving reproductive health outcomes. While the ICR suggests that intensified activities in the last years of the project, particularly on demand-side interventions, were transformational to produce results, observed contraceptive rates are also a result of other donors' contribution to the availability of contraceptives, as cited earlier. Beneficiary survey results moreover suggest that interviewees acknowledged the contribution of other development partners to the changes in RH service use. In some cases, providers were unaware of direct project contributions of the World Bank, since donor resources were pooled (ICR, p. 61). A positive implication of this observation would be that the Bank has been able to work collaboratively with other partners.

Finally, the comparison of data between project regions and national results has caveats. MICS surveys do not account for northern regions, and HMIS data at the national level also includes project regions that largely account for total population counts. Based on all of these considerations, achievement of the PDO is rated Modest.

Rating
Modest

5. Efficiency

Ex-ante efficiency measures: The project attempted to conduct a cost-benefit analysis (CBA) at appraisal to ascertain the economic viability of the project (PAD, Annex 12 p.103). The CBA presented several shortcomings that limit the reliability of its results. First, direct project benefits, which were supposed to be monetized, were never defined, and the PAD mentioned some indirect benefits that are explicitly excluded due to difficulties in measuring them. Second, similar reporting limitations occurred with respect to cost estimates, as no cost categories were specified. Third, despite stating that a sensitivity analysis was conducted, the PAD provided no information on which parameters were changed and what the new CBA metrics were. Fourth, the CBA provided straightaway the calculated Net Present Value (NPV) = US$ 14,894,767 and Economic Rate of Return (ERR) = 37%. As a good practice, a CBA should specify some of the assumptions used in the analysis (e.g. population subgroups and growth rates, discount rate of 10%, time horizon of 10 years).

Ex-post efficiency measures: The ICR estimated the NPV and ERR at completion. The CBA considered as project benefits the increased lifetime earnings (or reduction of productivity losses) from averting maternal and neonatal deaths. Direct project impacts involved the increased use of contraceptive methods that reduced unintended pregnancies (0.288 unintended pregnancies averted per CYP, according to Darroch and Singh (2011)). Fewer pregnancies would in turn result in: (i) direct cost savings from deliveries (54% fewer births at a cost per birth of $66.80, according to RBF data) and abortion procedures (32% fewer abortions at a cost of $16.33 per post-abortion care); and (ii) fewer maternal and neonatal deaths (0.496% and 2.04% respectively, according to UNFPA 2009-2014), and thus less productivity loss (based on current gross domestic product per capita). Similarly, project investments were assumed to enhancing quality of RH services and increased use of delivery with skilled birth attendants, which would further reduce maternal and neonatal mortality and consequently increase lifetime earnings. On the cost side, the CBA considered total project disbursements. The resulting NPV = US$ 31 million and ERR = 42%.

Implementation inefficiencies: The project experienced an 11-month effectiveness delay since the MOH was not operational during the crisis in 2012. Factors affecting the start of the project included the emergency situation in the North, the late creation of the project Steering Committee, the slow staff recruitment process, the long contracting process, the limited field support and supervision due to low staff` travel allowances, and security situations affecting project areas. The project closed on time, and the cancellation of project grant helped to finance a Development Policy Financing to foster inclusive growth. There is no assessment about the potential cost-effectiveness of the alternative use of these funds.

From the point of view of value for money, the project appeared to have reached planned outcomes, with the aforementioned caveats on attribution, with only 26% of grant funds. The ICR stated that the last year of the project accelerated multiple years of implementation into one year (ICR, p.30). But on the other hand, in explaining achievement of objectives despite large project cancellation amounts, the ICR suggested that appraisal costs calculated on the basis of previous Bank projects were overestimated, which lessens the previous efficiency gains argument. Efficiency is therefore 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	✓	37.00	100.00 ☐Not Applicable
ICR Estimate	✓	42.00	100.00 ☐Not Applicable

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

6. Outcome

Relevance of objectives is rated High due to alignment with country conditions and with current Bank and government strategy. Relevance of design is rated Substantial due to plausible attribution of desired outcomes to planned activities. The achievement of the project's objective, to improve access and use of quality reproductive health services in selected regions, is rated Modest due to issues of attribution (the presence of other donors, and comparison of outcomes in project regions with national-level results). Efficiency is rated Modest due to significant implementation inefficiencies. These ratings indicate significant shortcomings in the project's preparation and implementation, and therefore an Outcome rating of Moderately Unsatisfactory.

a. Outcome Rating

Moderately Unsatisfactory

7. Rationale for Risk to Development Outcome Rating

Project activities were aligned with National Family Planning Action Plan, and given the effectiveness of the approaches used to stimulate demand for and utilization of RH services, it is likely that the MOH with other donors, including the World Bank, will support their further scaling up. The Netherlands has committed to support the RBF pilot in Koulikoro, and the C4D program will likely continue through future country support (ICR, p.34).

Maintenance of achieved outcomes will ultimately depend on the new leadership in the MOH (the Minister changed again in April 2017) to continue its support for scale-up of the RBF, as well as the quality of RH services in community and referral health centers. A key risk factor that may affect the sustainability of results and the overall MOH governance is the fragile country context and the potential worsened social and security situation in Mali.

a. Risk to Development Outcome Rating

Substantial

8. Assessment of Bank Performance

a. Quality-at-Entry

The strategic relevance of the project was high, and project design was based directly on the government's strategy and lessons from prior experience in the country. The project's technical design was shaped by lessons from previous operations to address main bottlenecks in reducing maternal and neonatal mortality (i.e. unwanted pregnancies, low-quality obstetric care, and weak emergency transportation). The overall logic

of the project was strong, addressing both demand- and supply-side interventions.

Addressing fiduciary and governance concerns, the World Bank task team provided clear stipulations for financial management and procurement functions during preparation, and decided on recruiting a financial management agency (FMA). However, this recruitment triggered delays and ultimately proved unworkable. Project institutional arrangements could have been better informed by lessons and diagnosis of bottlenecks related to organizational capacity. There was previous experience with implementation delays due to weak management capacity of the MOH as well as decentralized health actors. Institutional arrangements among national ministries and within the agencies of the MOH were a key challenge, and the design of the project's Steering Committee did not facilitate effective governance to direct the project. Finally, the results framework could have included additional outcome measures of quality beyond prenatal "retention."

Quality-at-Entry Rating
Moderately Satisfactory

b. Quality of supervision
Despite the World Bank task team's efforts to support implementation, the project showed poor performance for several years because of the increasingly fragile country context, weak MOH capacity, and limited supervision budget. World Bank supervision activities were challenged by the fragile country context. Bank supervision resources were insufficient to provide the close support a country with low capacity needed. Also, Bank missions and duration were limited due to security restrictions and the relatively few team members.

While the restructuring and consequent reallocation of funds to the development policy operation was a proactive response to the project's low performance, it could have been done later given the crisis context. The cancellation of US$5 million at the 2014 restructuring made day-to-day work activities more difficult on top of an already challenging country context. The ICR stated that the MOH saw the 2014 restructuring as too early to cancel funds given the recent crisis, affecting the engagement of project implementers to conduct the daily work of the project.

In 2015, the mid-term review (MTR) renewed ownership of the project, especially considering that many of the staff in the MOH had changed, and there was a new opportunity to engage the MOH after the restructuring. The Bank's supervision at that point focused primary on advancing high-impact activities, and supervision missions were used to review progress and agree on defined next steps and timelines. The MTR followed a participatory process with all the project implementers, and established a 100-day action plan to advance project implementation, with defined milestones. An important change at the MTR was the recruitment of a new Project Coordinator and the decision to hire an individual consultant Procurement Specialist.

Quality of Supervision Rating
Moderately Satisfactory

Overall Bank Performance Rating

Moderately Satisfactory

9. Assessment of Borrower Performance

a. Government Performance

During project preparation, the MOH showed very high commitment to the agenda of prioritizing RH outcomes. In Mali, there has been a growing consensus that family planning matters are central to improving the country's socioeconomic prospects. However, despite the fact that increasing the availability of contraceptives was a specific commitment made by Mali to the FP2020 Agenda (ICR, p. 5), the health sector budget was reduced by 60% between 2011-2012, and by 2017 the budget has not been restored to its pre-crisis levels (ICR, p. 50).

Overall, the political and security crisis affected the availability of the government counterparts to start the project. During implementation, high turnover of the leadership staff (9 Secretary Generals and 5 ministers of health) challenged the project's strategic direction, decision-making, and overall authorizing environment in the government to support the project. The overall low capacity of the MOH resulted in the MOF's decision to close the project and allocate the cancelled funds to another sector.

In the last years of the project, the government showed increasing leadership through support for the RBF and partnership with UNICEF. However, the government could have played a more proactive role earlier in the project to plan actions and fill key functions in the PIU.

Government Performance Rating

Moderately Unsatisfactory

b. Implementing Agency Performance

The project's institutional arrangements hampered the performance of the project. The project had multiple implementing agencies: the MOH, its human resource directorate, the National Health Direction, the Unit for Decentralization and De-concentration Support, the Finance and Equipment Directorate, the Planning and Statistics Unit, the Directorate of Pharmacy and Medicines, and the National Directorate of Population. Overall project oversight was the responsibility of a multi-sectoral Steering Committee, composed of all the project implementers, so that they were to oversee their own actions. The large number of implementers turned the project into a series of activities whose responsibility relied on different national agencies and departments. Consequently, the institutional arrangements of the project lacked central leadership to engage multiple sectors, ensure lines of responsibility across agencies, make strategic decisions around how to implement interventions, and resolve poor performance issues.

The project envisaged using a separate PIU, given the multi-sectoral focus of the project, although this meant limiting the potential to transfer capacity to the government at the close of the project (as was learned from the previous Multi-Sectoral HIV/AIDS project, 2004 to 2011). Moreover, the PIU had limited leadership to advance project activities, as it was positioned at a nexus between multiple national agencies and required approval of the Secretary General of the MOH and agreement of other national implementers to move activities forward. The PIU was closed at the end of the project.

The project suffered implementation challenges due to major delays in appointing the project coordinator, setting up the multi-sectoral project Steering Committee, approving action plans, and financing community-based activities. A key challenge was that the PIU and other implementers' staff were not able to travel outside of Bamako due to security concerns.

Implementing Agency Performance Rating
Moderately Unsatisfactory

Overall Borrower Performance Rating
Moderately Unsatisfactory

10. M&E Design, Implementation, & Utilization

a. M&E Design
The original results framework included four PDO indicators and ten intermediate outcome indicators. Most of them had complete baseline and target values, data sources, and responsibilities for data collection, except for IOI#1 (women provided with access to a package of RH services), with a final target to be defined provided the RBF pilot was scaled up.

In general, the selected indicators were appropriate to the project's objectives of improving access and use of quality reproductive health services. But despite the project's investment in obstetric and FP trainings, indicators aiming at measuring quality focused more on structural factors (such as stock of medicines) and outputs (number of doctors trained) rather than processes (e.g. content of the visit following clinical protocols – how doctors provided the services) or perceived quality (e.g. patients' satisfaction). The only coverage indicator appropriate to measure the quality of services was the retention of prenatal care (pregnant women with at least four visits).

b. M&E Implementation
Due to the worsened security situation in the country, the collection of M&E data was not performed as planned. The first grant reduction in 2014 limited the budget of the Planning and Statistics Unit to implement planned analytical activities including health facility surveys, human resources surveys, and the impact evaluation. The MTR prompted the recruitment of an M&E specialist in late 2015 to provide support for the collection of data on project indicators, but this specialist's performance was mixed (e.g. frequent questions about indicator definition, lack of disaggregated data by project target areas, lack of data availability to perform timely project monitoring). Moreover, the available HMIS data was subject to reporting errors and variations in calculations of numerators and denominators, and thus not reliable.

Information on results framework indicators was available in part thanks to the engagement of UNICEF

towards the end of the project, and to the small RBF pilot (i.e. data on health service use and the quality of services in community and referral health centers). UNICEF conducted a survey jointly with MOH that provided more up-to-date data than the available 2015 MICS survey data. By the end of the project, most of the data gaps were filled due to the UNICEF survey at the end of the project, the RBF, and the use of the HMIS.

c. M&E Utilization

The lack of timely data and the rather weak role of the Steering Committee and the PIU in results management limited the use of M&E data for decision-making. Some project initiatives, however, have planted the seeds for more regular use of data and analysis. For instance, the introduction of the RBF, through its support for decentralized data management, started to change the practice of data utilization in the MOH in 2016. Also, UNICEF's C4D activities and the MOH support to local solidarity funds involved participatory diagnostics aimed at informing decision-makers on program design features.

M&E Quality Rating

Modest

11. Other Issues

a. Safeguards

The project triggered the Environmental Assessment safeguard (OP/BP 4.01), and because of the possible environmental risk related to medical and health waste, the project was classified as category "B". The ICR stated that safeguards were adequately addressed, and the task team confirmed compliance. The MOH's unit responsible for hygiene and sanitation updated the government's Medical Waste Management Plan with support from the Global Vaccine Alliance during project preparation. However, the PIU's set-up delayed implementation of the Plan by about 10 months. The same plan was used for the Sahel Women's Empowerment and Demographic Dividend project in 2014.

b. Fiduciary Compliance

Financial management: The project hired an FMA due to concerns about governance of the country's financial management systems, to provide technical support and transfer knowledge to the MOH team. It was planned that the MOH team would take over fiduciary tasks by the time of the MTR. After initial contracting delays, the FMA had poor performance, and it did not reinforce the capacity of the MOH. Poor oversight by the Steering Committee, high turnover of staff, vacancies of key positions in the FMA, and a lack of familiarity with World Bank procedures were all factors influencing poor performance. At the MTR, the audit reports of the 2013-2014 project accounts had not yet been transmitted to the Bank, and it was decided not to renew the

FMA contract when it expired in July 2015.

The major change at the MTR was for the project to recruit individual specialists to fill the FMA roles. Financial management was not satisfactory until the final year of the project, and during the last supervision mission there were no remaining issues related to financial management.

Procurement: The FMA was also responsible for project procurement, and it struggled to find and retain a procurement specialist for its team, which in addition to staff turnovers delayed the approval of procurement plans and key contracts. Moreover, the low quality of financial documents often delayed Bank approval and related disbursements. At the time of the MTR, procurement was a major project bottleneck, and it was decided to recruit an individual Procurement Specialist dedicated to the project. Only then did the project acquire sufficient procurement capacity to advance large contracts, and project activities accelerated. Despite fast advances, the contracts with the NGO for outreach activities failed after a 21-month procurement process, as the NGOs wanted additional budget to implement the accelerated 10-month program, which was not possible according to procurement rules. As with financial management, it was not until 2016 that the procurement rating of the project was upgraded to moderately satisfactory.

c. Unintended impacts (Positive or Negative)

None reported.

d. Other

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12. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Moderately Unsatisfactory	Moderately Unsatisfactory	---
Risk to Development Outcome	Substantial	Substantial	---
Bank Performance	Moderately Unsatisfactory	Moderately Satisfactory	The task team made key efforts to support implementation, despite the increasingly fragile country context, weak MOH capacity, and limited supervision budget.
Borrower Performance	Moderately Unsatisfactory	Moderately Unsatisfactory	---

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 ICR (p. 36) provides several key lessons from the project, including:

Implementation arrangements and project coordination are key for project execution. **First, oversight and implementation functions should be separated for accountability purposes.** In this case, project activities were spread across many national implementers, and the Steering Committee was managed as a collective by the implementers, thus being engaged in day-to day implementation as well as project oversight. This institutional arrangement provided minimal accountability in achieving decentralized project outcomes. **Second, the project coordination unit (PIU) should have sufficient strength to lead decision-making and be sufficiently insulated from political turnover.** The strength of the PIU to lead implementation (project activities, disbursements, and outcomes) was limited, since it was positioned at a nexus between multiple national agencies, requiring approval from the Secretary General of the MOH and agreements of other national implementers to move activities forward. The positioning of PIU thus limited its leadership to advance project activities. The next project should consider having a few carefully selected ministerial and non-government leaders on the Steering Committee, with a PIU that can align to government strategy and manage decentralized activities, insulated from political changes. Project facilitators could be placed in each region to build capacity within the government. Furthermore, collaboration with UNICEF and other agencies should continue to build decentralized capacity in the regions and districts, while providing closer technical support.

A multi-stakeholder approach to behavior change communication strategies has great potential to stimulate demand to use health services. The C4D program leveraged the collective influence of multiple key change agents to address barriers to service use. It used a "positive deviance" approach that brings role model mothers and husbands (NGOs, Husband Champions) to influence other women/men to use or support RH/FP services. It also engaged community and religious leaders to communicate messages to encourage husbands and women in the community to use RH/FP services. Moreover, focus groups conducted by UNICEF were instrumental to identifying lessons for promoting demand-side changes.

Field visits constitute a key component of a solid monitoring and evaluation framework. During implementation, the Steering Committee did not collect or review data to make its decisions, and there were few field visits. The MOH later reversed this practice, seeing that field visits could provide data to assess how to improve the project (improve training, supply of supplies, etc.) and make corrective actions. Field reports from the C4D program and RBF pilot (i.e. simple dashboard, communication, diagnostic and meeting tools) were used to support the government's decision making.

14. Assessment Recommended?

Yes

Please explain

Yes. An evaluation of this project is recommended to learn more about the effectiveness of the multi-stakeholder approach for behavioral change communication strategies with the purpose of stimulating demand for reproductive health services. The community for development program (C4D) was cited as having a transformational influence of intense demand-side activities on project results.

15. Comments on Quality of ICR

Overall, the ICR provided a clear description of the project's objectives, activities, and implementation issues. It provided additional data to account for project results in the last year of the implementation. Its assessment of the Bank's quality of supervision was particularly strong and candid. The ICR provided extensive lessons from the project in the areas of design, implementation, and technical interventions, including specific courses of action to undertake in the next operation. On the other hand, the ICR could have had a more extensive discussion on attribution issues (influence of external factors). The discussion on outputs and outcomes should have been done around PDOs rather than indicators.

a. Quality of ICR Rating
Substantial