Report Number: ICRR0021647

1. Project Data

Project ID P118806	**Project Name** LK: Second Health Sector Development
Country Sri Lanka	**Practice Area(Lead)** Health, Nutrition & Population

L/C/TF Number(s)	Closing Date (Original)	Total Project Cost (USD)
IDA-52280	30-Sep-2018	184,019,188.67
Bank Approval Date	**Closing Date (Actual)**	
27-Mar-2013	30-Sep-2018	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	200,000,000.00	0.00
Revised Commitment	199,141,908.84	0.00
Actual	184,019,188.67	0.00

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2. Project Objectives and Components

a. Objectives

According to the Financing Agreement (p. 5), the project's objectives were "to upgrade the standards of performance of the public health system and enable it to better respond to the challenges of malnutrition and non-communicable diseases (NCDs)."

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

No

c. Will a split evaluation be undertaken?

No

d. Components

Component 1: Support to priority areas under the National Health Development Plan (appraisal cost US$190 million; actual cost US$175 million). This component was to support the goals of the National Health Development Plan (NHDP) of the Government of Sri Lanka (GOSL). The IDA funds were to complement GOSL's funds (at appraisal US$ 5,165 million) and focus on three thematic areas: *(i) addressing maternal and child health and nutrition; (ii) prevention and control of NCDs*, and (*iii) health system improvement measures*. This component was designed as a results-based financing where disbursements were linked to the achievement of specific results formulated as disbursement-linked indicators (DLIs) that included a mix of outcomes and intermediate outcomes, and few outputs.

The Project Appraisal Document (PAD) described the following key activities:

(i) Addressing maternal and child health and nutrition. The program proposed to target nutrition interventions to pregnant and lactating women, and to children up to two years of age, in underserved communities. It also aimed to improve health service providers' capacity to deliver nutrition interventions and enhance community organizations' capacity to plan, implement, and monitor nutrition interventions. It was to establish a national monitoring and evaluation (M&E) and nutrition surveillance system.

ii) Prevention and control of non-communicable diseases: The program was to improve the implementation of the Framework Convention for Tobacco Control and the Tobacco Control Act, and support legislation for the control of indoor air pollution and pesticides. It also aimed to develop communication strategies for NCD prevention and control. Support was to be provided for establishing 24-hour Emergency Treatment Units at the central and provincial levels, healthy lifestyle centers, screening services for NCDs and long-term care, and enhanced availability of NCD drugs.

iii) Health system improvement measures: The program included measures for modernizing the Health Management Information System (HMIS); establishing Quality Management Units in each of the centrally and provincially managed hospitals to make sure that hospitals use clinical care guidelines and standards; and improving Health Care Waste Management (HCWM) practices such as developing annual HCWM plans, formalizing a draft HCWM policy, and related capacity building activities. Some of these activities were built on the prior Health Sector Development Project (US$60 million, 2004-2010).

Component 2: Innovation, results monitoring, and capacity building (appraisal cost US$10 million, actual cost US$9 million). This component was designed as technical assistance to support innovation, operational research, and capacity building within the NHDP, and to support project implementation and monitoring. Health system workers were eligible to propose pilot projects that could apply or test innovative ideas. A committee appointed by the Secretary - Ministry of Health (MOH) was to review and approve proposals for the pilot projects. In addition, surveys and studies such as the Demographic and Health

Survey (DHS), annual review of DLIs, gap analysis of HCWM, and environmental audit were planned. This component was to follow standard World Bank procedures for investment lending.

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

Project Cost and Financing: This was a Specific Investment Loan. The original World Bank loan was US$200 million for five years, which was revised to US$199.14 million. The actual disbursement was US$184.0 million. The difference between appraised and actual costs was due to SDR to USD exchange rate fluctuations. The funding for Component 1 was provided as support to the general budget of MOH and the nine provincial ministries of health (PMOH).

Borrower contribution: GOSL committed to providing US$ 4,970 million to support the program. Its actual contribution almost doubled to US$7,156 million. According to the TTL, the amount committed by the government was an estimation of its expenditure to implement the overall health sector strategy (NHDP). The ICR reported on actual government health spending, which was significantly higher than anticipated.

Dates: The project was approved in March 2013 and became effective in September 2013. Its mid-term review (MTR) took place in January 2016. The project closed as planned in September 2018. The MTR indicated slow implementation of Component 2 and predicted that "there is very low likelihood" that this component would be completed by the project's closing date. The ICR (p 25) also noted that there were significant delays in the preparation and implementation of Component 2. However, these delays did not affect the project's closing date.

During implementation, some modifications were carried out that did not require project restructuring. The mechanism for fund flow for Component 1 was changed a few months after effectiveness of the project. Originally, Component 1 funds were to be disbursed to a segregated USD account. This mechanism was modified, and the funds were routed to the general treasury account. According to the project TTL, this change was necessary to help the client government to avoid having double systems to manage the funds going to the health sector. From the Ministry of Finance perspective, this project was subsidizing health sector expenditures, and so it wanted to integrate the received funds into the government budget system to the extent possible.

In addition, the DLI verification criteria were modified in 2015 to give both qualitative and quantitative aspects equal weight. The purpose of this change was to improve progress tracking. The verification criteria for DLI targets were originally designed to give more weight to qualitative aspects and to discount quantitative achievements. For example, if a health facility achieved four of five agreed actions of the verification criteria for a DLI target, the achievement was noted as 80 percent under the qualitative method, not considering whether the client had overachieved any of the actions quantitatively.

3. Relevance of Objectives

Rationale

The PDOs to upgrade the standards of performance of the public health system and enable it to better respond to the challenges of malnutrition and NCDs were substantially relevant to the health challenges that Sri Lanka was experiencing at appraisal and continues to face. Sri Lanka is undergoing both demographic and epidemiological transition. Its population is aging rapidly, and one important consequence of such change is increased incidence of NCDs and related morbidity. Maternal, neonatal, and child health, as well as human resource capacity strengthening in the health sector, were key pillars of country priorities. There were also important cross-cutting systemic issues that had to be addressed to prepare the health system for dealing with emerging health challenges. These included a lack of a modern HMIS, limited quality assurance for curative care in both public and private providers across the country, issues related to infrastructure planning and management, and human resource development and planning.

The PDOs were aligned with the new Sri Lanka National Health Policy (2016–2025), which is focused on a people-centered health system. The project was also strongly aligned with the World Bank's current Country Partnership Framework (CPF FY2017-2020) in Sri Lanka, specifically Pillar 2, "Promoting Inclusion and Opportunities for All," and Objective 2.2, "to improve health and social protection systems to address the challenges of the demographic transition." The project's introduction of results-based financing (RBF) mechanism was in line with the earlier National Health Development Strategy (NHDP 2013-2018), which provided a road map towards health system strengthening and proposed RBF as a means to improve health financing in the country.

A shortcoming in relevance of objectives was the following: the PAD (p. 17) stated that the project was expected to benefit "especially the poorer and more vulnerable population groups who depend more on public health services." The CPF at closing (FY 2017-2020) stressed the need for "better-targeted support to the most vulnerable households" (p. 12), and specifically the need to enhance health coverage for populations "in lagging regions and for the poor and vulnerable in urban areas" (p. 37). In the context of the CPF's level of ambition in terms of better targeting and focus on the vulnerable, a "high" level of alignment between the objective and the country strategy would have required stronger targeting at the level of the objective. Given this minor misalignment, Relevance of Objectives is rated Substantial.

Rating

Substantial

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective

Upgrade the standards of performance of the public health system

Rationale

The project's theory of change held that health system performance standards would be improved by establishing an electronic Indoor Morbidity and Mortality Data Report (e-IMMR) to strengthen data collection, analysis, and planning capacity of the MOH and the provincial MOHs; establishing QMUs, an institutional mechanism for implementing and monitoring the national quality assurance program; and introducing an External Quality Assessment Scheme (EQAS) for hospital laboratories to improve the quality of patient care.

Outputs

- Indoor morbidity data was transmitted by e-IMMR in 39 MOH-administered and 446 provincially administered hospitals.
- EQAS for laboratories was implemented in 66 selected base and higher level hospitals.
- QMUs were established in 42 select MOH-administered and 70 select provincially administered hospitals.
- 25,000 household national health surveys (Demographic and Household Survey) were conducted in 2016.
- 2,500 health care workers received procurement training.
- 35 innovative pilot projects (mostly research) to improve efficiency and quality of the health care system were implemented (the full list of pilot projects was provided in the ICR, p. 61).

Intermediate Outcomes

Achieved or surpassed:

- 47% of training institutes managed by the MOH met national standards, surpassing the original target of 40%. No baseline was provided.
- 95.7% of laboratories in health facilities (base hospitals and above) participated in the external quality assurance program (using EQAS) for selected tests conducted by the Medical Research Institute, surpassing the original target of 80%. The baseline was 10%.
- Fully functioning QMUs were operational in 100% of MOH-managed base hospitals and above (DLI 7), surpassing the target of 95%. The baseline was 9%.
- Fully functioning QMUs were operational in 95.5% of provincially managed base hospitals and above (DLI 8), surpassing the target of 90%. The baseline was 6%.

- 90% of the amount of funds forecast to be released by Treasury every six months were actually released (for non-salary recurring and capital expenditures)(DLI 9), meeting the original target. The baseline was 81%.

Partially achieved or not achieved:

- The ICR reported inconsistent information on environmental and waste management licensure of hospitals. On p. 29, it reported that 12 of the targeted 40 facilities (30%) received EPL and HWL. However, on pp. 15 and 35, it reported that 17.3% of hospitals received both these licenses. Both reported results were below the target of 40%. The baseline was 5%. In either case, the ICR (p. 15) explained that the low attainment was due to the high financial cost of installing waste water treatment plants.
- A 60% case detection rate for tuberculosis was achieved, not reaching the target of 78% and below the baseline of 69%. The reduction was due to gaps in patient tracking, inadequate coordination with the private sector, and low capacity for presumptive screening and contact tracing (ICR, p.14). The project, however, did not contain activities that were directed toward improving surveillance of communicable diseases, and therefore it is unclear why this indicator is selected in the first place. According to the project TTL, this indicator was part of the results framework of the NHDP and was supported by other partners (the Global Fund), and the MOH wanted World Bank support to provide comprehensive monitoring of NHDP results beyond just focus on the specified project DLIs. This approach resulted in the project's inclusion of an indicator whose progress could not be directly attributed to project activities. The MTR noted the challenge in meeting this intermediate outcome target and suggested some measures to mitigate it. It is unclear why no measures were taken by the team.
- 70% of National Competitive Bidding (NCB) contracts were awarded within the first nine months of the previous calendar year from 2014 onwards, below the end of project target of 80%. No baseline value was provided. The ICR did not explain why this target was achieved only partially.

Outcomes

- 83% of MOH-managed health facilities are sending indoor morbidity data through e-IMMR (DLI 3), surpassing the original target of 80%. Baseline was 2%.
- 81.6% of provincially managed health facilities are sending indoor morbidity data through e-IMMR (DLI4), surpassing the original target of 70%. Baseline was 1%.

In addition, to demonstrate the impact of health systems strengthening on improving the quality of healthcare, the ICR reported on declining trends in the incidence of adverse effects of medical treatment since 2014 (Figure 4.8, p. 53). These trends could plausibly be attributed, in part, to the project. It is unclear why more comprehensive health system quality measurement indicators were not used to measure progress in improving the standards of performance of the public health system.

Overall, the ICR did not report comprehensively on outputs. In some cases, it is not clear what activities were carried out to meet some of the project's intermediate outcome indicator targets. There were also some important planned activities, such as development of annual HCWM plans, formalization of a draft HCWM policy, and related capacity building activities, that were not implemented.

On balance, however, there was Substantial achievement of most of the project's key output, intermediate outcome, and outcome indicators, with a plausible results chain linking these elements.

Rating
Substantial

OBJECTIVE 2
Objective
Enable [the public health system] to better respond to the challenge of malnutrition

Rationale
The project's theory of change held that improving equipment and supplies for clinics and improving the availability of care at maternity hospitals (on the supply side) and increasing the availability and activity of community support groups (on the demand side) would enhance quality and use of nutrition services, and thereby reduce the incidence of malnutrition.

Outputs

- 3,383 maternal and child health (MCH) clinics have standard equipment and supplies to provide care to pregnant mothers and children under five years of age.
- 322 Medical Officer of Health areas have at least three health and nutrition community support groups.
- 53 comprehensive emergency maternal and obstetric care (CEMOC) hospitals are providing 24×7 care.

Intermediate outcomes

- 95% of MCH clinics have an agreed package of equipment and supplies for provision of care for pregnant women and children under five years (DLI5), meeting the target. The baseline (2012) was 20%.

- 97.6% of Medical Officer of Health geographic areas have at least three health and nutrition support groups, surpassing the target of 90%. The baseline was less than 10%.
- 73.6% of CEMOC facilities are providing 24x7 services, almost reaching the target of 75%. The baseline was 45%.

Outcomes

- The percentage of pregnant women with anemia after the second trimester declined from a baseline of 34% to 26.2%, not reaching the target of 20%.

Although some progress on anemia among pregnant women was observed, the key outcome target for this objective was not achieved. In addition, the ICR (p. 16) indicated that this outcome indicator had issues with validity and measurability: "Given the multidimensional determinants of anemia and the fact that hemoglobin disorders are a major factor attributed to anemia in Sri Lanka, this indicator was not an appropriate measure of the PDO. Further, there was a discrepancy in measuring methods for this indicator. The baseline was drawn from the DHS 2006/07, when pregnant women were tested for anemia regardless of their gestation period. The end line was derived from program data collected by the Family Health Bureau when anemia was tested after the second trimester. Thus, the baseline and target were not measuring the same thing."

Instead, the ICR provided alternate indicators on coverage of nutritional services to pregnant women and children under five. Coverage of iron and folic acid supplementation decreased from 98.2% in 2006/07 to 97% in 2016. Coverage of deworming in pregnant women increased from 92.7% in 2006/7 to 96% in 2016. Coverage of Vitamin A supplementation in children under five increased from 78.8% in 2012 to 81% in 2016. These results do not indicate substantial progress toward addressing the challenge of malnutrition, as iron and folic acid supplementation coverage declined, and deworming and Vitamin A coverage improved only slightly. In addition, these indicators measure only supply-side factors.

There were some activities initially planned in the PAD, such as establishing a national M&E and nutrition surveillance system (PAD, p.19), that were not discussed in any other project documents. It is not clear why more nuanced nutrition-related indicators were not selected at the project design stage, and why no measures were taken by the team to revise and enhance the indicators during project implementation. According to the TTL, the Bank team at that time thought that the DHS survey carried out in 2016 would be able to provide the necessary data to report on the PDO indicator and on achievement of this objective.

Given the validity issues with the only PDO indicator for this objective, and lack of significant progress on proxy indicators, achievement of this objective is rated Modest.

Rating
Modest

OBJECTIVE 3
Objective
Enable [the public health system] to better respond to the challenge of non-communicable diseases

Rationale
The project's theory of change held that improving screening for key risk factors for NCDs; enhancing the equipment and operation of emergency treatment centers, rehabilitation centers, and primary health institutions; and improving information and education on chronic disease prevention would enhance prevention and treatment of NCDs.

Outputs

- 27% of the population of 40 years of age or above was tested for hypertension and diabetes.
- 13 MOH-managed hospitals and 445 provincially managed hospitals have Emergency Treatment Units (ETUs) operating according to standard guidelines.
- 298 Medical Officer of Health areas have at least two healthy lifestyle centers (HLCs).
- All provinces have at least one hospital providing rehabilitation services.
- 723 primary health care institutions have at least a one-month buffer stock of 16 essential NCD medicines.

Intermediate outcomes

- 94% of Medical Officer of Health areas have at least two HLCs (DLI 6), surpassing the target of 90%. Baseline was 10%.
- Eight provinces have at least one health facility providing rehabilitation services, surpassing the target of seven. Baseline was one province.
- 81% of primary health care institutions have at least a one-month buffer stock of 16 essential NCD medicines, surpassing the target of 60%. Baseline was 2 percent.

Outcomes

- 46.4% of centrally managed health facilities set up ETUs based on standard guidelines (DLI 1), surpassing the target of 40%. Baseline was 0.
- 82% of provincially managed health facilities set up ETUs based on standard guidelines (DLI 2), surpassing the target of 50%. Baseline was 0.

- 26% of persons (over 40 years) were screened for selected NCDs (diabetes, hypertension, cancer—breast and oral) at HLCs, surpassing the target of 12%. Baseline was 3%.

The targets for all the PDO indicators and intermediate outcome indicators were surpassed for this objective.

The ICR also provided data showing increased admission rates to primary and secondary care hospitals for myocardial infarction and trauma in 2013-2017.

These achievements are notable. However, some elements in the discussion of context suggest the following minor shortcomings:

First, presentation of achievements did not fully take into account key factors outside the project that might have contributed to the achievements. It is important to acknowledge that these results cannot be solely attributed to the project, as the GOSL began consistently and significantly investing in the NCD area starting with the launch of its National NCD Policy and Strategic Framework for Chronic NCDs in 2010, and its initiation of the HLCs in 2011 (World Health Organization Policy Brief: Public Health Success in Sri Lanka, 2017).

Second, the ICR did not report on (or mention) some key planned activities listed in the PAD that related to this objective, in particular, "The program will further improve the implementation of the framework convention for tobacco control and the Tobacco Control Act, and will support the introduction of legislation for the control of indoor air pollution, pesticides and excessive alcohol, salt, sugar and trans fat usage. Further, mechanisms for increasing safety awareness and supporting the establishment of safe communities will be encouraged. These activities will be supported with the development of communication strategies for prevention and control of chronic and acute NCD" (PAD, p.19).

Based on notable achievements (with minor shortcomings), achievement of this objective is considered High.

Rating
High

Rationale
The project largely succeeded in upgrading the standards of performance of the public health system and enabling it to better respond to the challenge of NCDs. Achievement of those two objectives is rated Substantial and High, respectively. However, there were both issues with measurement of performance and inadequate progress on proxy indicators related to response to the challenge of malnutrition. Achievement of that objective is rated Modest. Overall Efficacy is therefore rated Substantial.

Overall Efficacy Rating

Substantial

5. Efficiency

The PAD did not carry out ex-ante economic analysis. It did not estimate the potential rate of return, net present value, or cost effectiveness of the project. Relying on global evidence, the PAD argued that overall improvements in Sri Lanka's health system and investing in nutrition interventions and NCD prevention and treatment were likely to have positive impact on poverty reduction, equity, and productivity in the country. The PAD (p. 76) also focused on the country's health expenditures, projecting fiscal sustainability of the project's results because GOSL had sufficient budget to cover recurrent costs generated by project interventions.

The ICR's coverage of efficiency issues was more extensive and well substantiated, but in some cases was based on global evidence only rather than specifically on project interventions. The ICR made judgments about the projected health and socioeconomic benefits of each of the three key project interventions (investing in NCD prevention, nutrition, and health systems strengthening). For NCDs, it estimated that achieving hypertension screening for 27% of the over-40 population, which was taken as a proxy for scaling up NCD prevention activities, meant averting over 55,000 disability-adjusted life years (DALYs) that could translate into an economic benefit of over $200 million. However, the ICR also noted that such achievement could not be attributed to the project alone, as there has been substantial investment from GOSL. The ICR's efficiency assessment of nutrition interventions was not Sri Lanka-focused--although there appears to have been sufficient Sri Lanka-specific data to enable this--and instead cited the Bank's overall analysis on the economic returns from investing in nutrition. The ICR's discussion of efficiency covered only the first component of the project.

In terms of implementation, the efficiency of Component 1, which covered 95% of project funds, was strong. The commitment of government leadership at central and provincial levels, as well as strong organizational capacity of the counterparts, were the key contributing factors. No special implementation unit was created for the project at central or provincial levels. The focal person (project director) was the Senior Assistant Secretary Medical Services at the Ministry of Health, who had also served as project director under the previous Bank-financed project in the sector. This continuity was beneficial (ICR, pp. 25-26), though the ICR (p. 31) also noted that having a program director with dual responsibility for the project and a substantive portfolio in MOH could negatively impact efficiency and efficacy in the long run. A slight delay in disbursement in FY2017 was caused by a change in the methodology of DLI verification; this is an example of a smart, strategic delay that, in the end, enhanced measurement and achievement of results. The project disbursed all funds, and the project closed on time. The design and implementation of Component 2, which covered only 5% of project funds, was more cumbersome. According to the ICR, although preparation of the project took about three years, there was a rush to bring it to approval, resulting in a not well-thought-out design and implementation plan for Component 2. Component 2 had a complex design and was transaction-intensive (ICR, p. 31), resulting in implementation delays (ICR, p. 25); there were also some procurement delays under this component.

As outlined above, implementation efficiency was strong, and Efficiency is therefore rated Substantial despite the shortcomings related to economic analysis.

Efficiency Rating

Substantial

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

The development objective of the project remains substantially relevant. Rapid demographic and epidemiological changes in the country make the focus on NCDs increasingly relevant, and malnutrition still remains a challenge. The health system requires strengthening to meet these changing demands. Moving towards becoming an upper-middle income country, the results-based financing mechanism used in the project was helpful as well to build government capacity to use more results-focused approaches. The project's objectives related to health system strengthening and NCDs were achieved to a substantial and high degree, respectively. There were moderate shortcomings in achievement of the nutrition-related objective, which was rated Modest. Despite the lack of economic analysis in the ICR, the project's efficiency is rated Substantial due to evidence of implementation efficiency. The combination of Modest achievement on the nutrition objective and lack of economic analysis to verify efficiency constitute overall moderate shortcomings in the project's preparation and implementation, consistent with an Outcome rating of Moderately Satisfactory.

a. Outcome Rating

Moderately Satisfactory

7. Risk to Development Outcome

Overall, the risk to sustaining development outcomes of this project is low. The project contributed to Sri Lanka's health sector plan and was mainstreamed into the national health system, an indication of continued government commitment. The financing of the project comprised only 2.6% of total health sector spending for the project period, which was even less than predicted in the PAD (3.8%). The project also contributed to institutional strengthening and building health sector staff capacity that should help to sustain the project's results. The new World Bank project in the sector, the Primary Health Care Strengthening Project (PSSP, 2018-2023, US$200 million), was approved in June 2018, with an objective to improve the use and quality of primary health care services with emphasis on detection and management of NCDs in high-risk population groups. In nutrition, however, the results are less likely to be sustained. Nutrition issues are not prominent in the most recent health sector strategy of Sri Lanka (2016-2026) and are not featured in the follow-up PSSP

project, despite persistent nutrition challenges, especially among Tamils in the country's estate/plantation sector.

8. Assessment of Bank Performance

a. Quality-at-Entry

Project preparation was lengthy. There was disagreement between the Bank and the GOSL on elements of project design and areas of focus. The World Bank team undertook six missions during the design stage and carried out numerous consultations with stakeholders, enabling resolution of disagreements and project alignment with the NHDP. As part of preparation, the Bank team supported a background study of NCDs that informed project design (ICR, p. 30). This project was the first in the World Bank portfolio in Sri Lanka to use DLIs to benchmark progress of the sector and to release funds using country systems. The project was also strongly aligned with country's five-year health sector plan, the NDSP 2013-2017. The Bank team made strong efforts to align the project's results framework with the objectives of the NHDP and to use project indicators to support the GOSL's larger health program, systems, and processes. Weak procurement capacity of the implementing agencies, the MOH and PMOH, was been identified as posing substantial risk. Accordingly, the project included measures to strengthen systems for procurement and compliance monitoring, at both central and provincial levels, during the first six months of implementation.

One shortcoming in project design was the lack of strategy and indicators to measure the extent to which the project benefited poor and vulnerable groups. Both the PAD and ICR suggested that Sri Lanka's spending on public health care has been pro-poor. The main evidence supporting this assumption was that out-of-pocket spending for health care is concentrated among the top economic decile who use private services, while poorer income groups spend significantly less on out-of-pocket payments (ICR, Figure 8, p. 22). Another World Bank study notes that the utilization patterns in Sri Lanka's public health system suggest that access to care in the government sector is pro-poor largely because the better-off opt out due to poor "consumer experience" of accessing health care in the public sector. In particular, government operating hours are less convenient, waiting times are much longer, and provider choice is more limited. "This is one of the weak links in the public system's performance" (Smith, 2018). In other words, even if overall public health care is considered pro-poor, the quality of service to the poor is suboptimal. Therefore, having project indicators reflecting beneficiary satisfaction with the services (or other measures of service quality) would have been useful.

In addition, the design of Component 2 was complex. It covered a broad range of activities but did not have an action plan for implementation. In addition, it is unclear how the focus on innovation contributed to the project's objectives, and how results were to be used or sustained.

Quality-at-Entry Rating
Moderately Satisfactory

b. Quality of supervision
The Bank provided strong implementation support. The technical team had appropriate skills, and the TTLs were either in the country or in the region, ensuring continuous engagement with the government and other stakeholders on the ground. The Bank team proactively revised the methodology for calculating the DLIs, and Bank funds were used to make sure that results were verified (ICR, p. 26).

It is unclear why the team did not act on some of the suggestions of the MTR that would have improved project results, including revision of some outcome indicators and recruitment of a second procurement specialist. Implementation Status Reports (ISRs) completed around the time of the MTR appear not to have shared some of the concerns expressed by the MTR. Furthermore, the project did not comply fully with the Bank's safeguard policies (see Section 10a), as planned measures to implement the recommendations of the environmental assessment report were not achieved.

Quality of Supervision Rating
Moderately Satisfactory

Overall Bank Performance Rating
Moderately Satisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design
The PAD described activities planned under each component, but it did not have a theory of change that explained how planned activities would contribute to intended outcomes. The ICR constructed a results chain for the project (Table 1, pp. 7-9) and a table reporting some of the key outputs under each objective (pp. 41-43). However, neither the ICR nor ISRs reported comprehensively on the project's planned activities and outputs. The focus of the results framework and the monitoring and reporting was mostly on DLIs, and this focus left some planned outputs without monitoring and reporting. According to the ICR, the indicators selected for monitoring the progress of the project were derived from the NHDP. While this approach ensured ownership by the government and also presumably lowered transaction cost for the MOH, it also resulted in selection of indicators that in some cases were not clearly linked to the project's proposed activities (for example, the intermediate outcome indicator on tuberculosis). It is not clear whether and how the relevant partners and stakeholders (e.g. the Global Fund for communicable diseases) were consulted to gather data pertinent to those areas that were not supported by the project

but nonetheless reported in its results framework. Furthermore, some indicators, for example the outcome-level indicator on nutrition, were not adequate to measure progress against the PDO.

Component 2 activities were not integrated into the results chain and the monitoring framework. The M&E framework also lacked gender-disaggregated indicators, which would have been useful for improving policy responses in several areas, including NCD screening; the ICR (p. 23) noted that gender-disaggregated data on NCD screening helped to frame policy (see Section 9c), but gender-disaggregated indicators on NCDs were not part of the project's formal results framework.

The PAD envisaged hiring a dedicated M&E specialist for the project, which did not take place. The TTL indicated that, since the key component of the project was results-based, the monitoring of results was in effect the responsibility of the entire project team. The TTL also noted that there was a dedicated M&E specialist on the client side. MOH was to collect data from PMOHs and directly from MOH-run hospitals.

b. M&E Implementation

According to the ICR, data collection was done systematically. The reporting process, however, was more cumbersome than originally planned. MOH data were sent to the Department of Plan Management and Monitoring, which then transmitted the information to other departments and to the World Bank. It was noted that this chain of data reporting and transmission was lengthy and time consuming (ICR, p. 27) The independent verification of DLIs also experienced implementation challenges. The Bank initially contracted with a third party firm to verify results, to ensure quality reporting. GOSL found this third-party verification process to be costly and time consuming, and refused to pay for it; the Bank covered third-party verification costs throughout the project's lifetime. Based on the experience of this project, the verification arrangement in the subsequent PSSP project has been simplified to ensure government ownership of the process.

DLIs were used to trigger disbursements. Lessons from use of this type of disbursement mechanism have been applied to the follow-on PSSP project. This project also supported the design and implementation of a Demographic and Health Survey in 2016, which provided valuable input for closing data gaps and capturing important information on variety of health-related issues.

c. M&E Utilization

According to the ICR, data received from the monitoring of indicators was used by MOH to make course corrections during implementation. For example, the data on NCD screening of adults ages 40 years and above was used to focus on low performing districts and strengthen HLCs there. Since 2017, the national health care quality management dashboard has incorporated new indicators on clinical

standards, which according to the ICR were used effectively to monitor the quality control program. M&E indicators were also included in the MOH's Annual Health Bulletins. The implementation of the project also helped to reveal an important gender gap in the treatment of NCDs. According to the ICR, the assessment of gender-disaggregated data for NCD screening at the HLCs showed that more than 70 percent of those screened were women, signaling a possible health disadvantage for men. Unfriendly working hours of outpatient clinics and long waiting times for consultations were found to be deterrents to men seeking care in the public health system. This data informed the design of the follow-on PSSP, which aims to address this disparity by providing proactive outreach services focusing on men (ICR, p. 23).

M&E Quality Rating

Substantial

10. Other Issues

a. Safeguards

This project triggered environmental safeguard policy OP/BP 4.01 because the health facilities supported by the project generated biomedical waste. The project's financial agreement had three legal covenants related to environmental compliance: a) to carry out an environmental assessment and prepare a report by end of February every year; (b) to review the environmental assessment report; and (c) to take all measures to ensure implementation of said report. The first and second covenants were complied with once in 2017. The third covenant of taking measures to ensure implementation of the environmental audit report was not fully carried out. According to the audit report cited in the ICR (2017), some milestones were achieved, such as:

- 99 percent of health care facilities surveyed had a Health Care Waste Management (HCWM) plan;
- HCWM training was conducted in all provinces;
- HCWM teams were established in 71 percent of hospitals; and
- An Environmental and Occupational Health Division was formed in the MOH with a separate budget line (ICR, p. 26).

However, the planned measures to implement the environmental assessment report were not achieved:

- A draft national HCWM policy was not adopted;
- HCWM plans were not standardized;
- There was a dearth of quantitative data in the HCWM checklist;
- Bins were in shortage or unavailable in a majority of the hospitals; and
- There remains a need for a national HCWM training plan.

As already indicated under Objective 1, EPL and HWL licensure of health facilities did not reach targets.

The project did not trigger social safeguard policies.

b. Fiduciary Compliance

Financial Management: Financial Management was rated satisfactory throughout project implementation. According to the ICR, the project was required to obtain three audit reports annually, and this task was carried out by the Auditor General of Sri Lanka. No major issues were identified in those reports. The project also regularly submitted Interim Unaudited Financial reports (ICR, p. 29). The mechanism for funds flow under Component 1 was changed quite early during implementation to channel funds to a single consolidated local account instead of the initially proposed separate accounts. This was found to be a helpful step from the client perspective to reduce the transaction costs of managing different funds.

Procurement: Initially, the PAD flagged low procurement capacity was flagged as a substantial risk, and a procurement training program was designed as part of the project (Component 2). During implementation, procurement was consistently rated as Moderately Satisfactory, although there were some implementation delays due to slow procurement process. The MTR recommended recruiting a second procurement specialist to lead the development and implementation of a Procurement Capacity program. This was not done. Procurement challenges lay in the slowness of processing and in managing differences between the procurement procedures of the GOSL and the World Bank. The ICR also indicated that MOH project management was averse to taking procurement-related decisions, and therefore most procurement decisions were sent to the World Bank for approval, creating further delays. This issue, however, was relevant only to Component 2, which comprised only 5% of project funds. More than 2,500 staff from MOH and MPOH were trained in procurement, which should help to improve procurement processes in the follow-on PSSP project.

c. Unintended impacts (Positive or Negative)

None reported.

d. Other

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11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment

Outcome	Satisfactory	Moderately Satisfactory	According to IEG/OPCS guidelines, in a case where Relevance is rated Substantial, Efficacy is rated Substantial, and Efficiency is rated Substantial, the overall Outcome rating is Moderately Satisfactory if there are moderate shortcomings in achievement of one or more of the objectives/outcomes used in the assessment of overall Efficacy.
Bank Performance	Satisfactory	Moderately Satisfactory	According to IEG/OPCS guidelines, when one dimension of Bank Performance is rated Moderately Satisfactory and the other dimension is rated Satisfactory (as is the case in the ICR), overall Bank Performance is rated Moderately Satisfactory.
Quality of M&E	Substantial	Substantial	
Quality of ICR	---	Modest	

12. Lessons

This ICR Review concurs with the following lessons from the ICR (p. 31):

- Verification is a crucial part of the use of DLIs as a disbursement mechanism. Verification of DLIs should be planned thoroughly, and the verification methodology should be made robust and simple to allow for straightforward disbursement of funds. Given that third-party verification arrangements can be relatively costly, it is best to try to build in that role and capacity within the government's own institutional arrangements.
- While gender issues in the health sector are usually viewed from the lens of improving access to women, the experience of this project shows that men can be the disadvantaged group when it comes to NCD care utilization. Concerted efforts can be required to improve access to the public health system for men. Measures such as extending the hours of outpatient clinics through the evening, setting up HLCs in work places, and increasing the number of mobile medical units with HLCs can help resolve this issue.

This ICR Review also concurs with the lesson related to the use of DLI mechanisms noted by the borrower (ICR, p. 59):

- While DLIs can be an important positive factor in project implementation, it is important to match the pace of the DLI targets and release of funds with implementation progress on the ground.

Based on review of the ICR, ICR Review also concludes that:

- Strongly aligning a project with a country's sector strategy reduces transaction costs and the reporting burden on the client government. However, a project needs to be designed carefully to maintain clear focus, boundaries, and scope, and to ensure that it includes indicators and targets measuring what specifically can be achieved with project support.
- The use of DLIs as disbursement mechanism incentivizes a project team to focus particularly on reporting progress on DLIs and on the outcome and intermediate outcome indicators that are in the results framework. While these indicators are critical for progress reporting, it is important not to overlook the entire results chain, and to report on planned activities and outputs.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

The ICR reported candidly on how the Bank-financed project contributed to Sri Lanka's health sector in key outcome areas. In reporting on achievements in a number of areas, the ICR supported data on project indicators with additional evidence from the project's monitoring system, national and global health surveys, the national quality management dashboard, and health literature. The ratings in the ICR were mostly well justified, and the ICR made efforts to present a coherent results chain for the project. However, there were important shortcomings, including some gaps in reporting on results. For example, the results of Component 2 were not adequately integrated into the overall results chain. Details on related achievements were included in an Annex, but the content of this component (innovation, results monitoring, and capacity building) merited a higher level of attention. (IEG's ICR Review manual specifies that the amount of resources allocated to an objective should not be used to impute the relative importance of that objective; consistent with this, resource allocation is not used to indicate relative importance of components.) In addition, although the incentive during the implementation of the project was to focus on reporting on DLI and key outcome indicators, there was room for improvement in the ICR's reporting on outputs and activities, and on demonstrating how those activities were plausibly responsible for observed outcomes. Overall, the ICR was focused on results and followed most of the guidelines. It provided a comprehensive overview of the project with a narrative that loosely supported the ratings. There were some gaps in evidence, as noted above.

a. Quality of ICR Rating
Modest