Report Number : ICRR0021081

1. Project Data

Project ID	Project Name	
P115563	UG-Health Syst. Strength. Project (FY10)	
Country	**Practice Area(Lead)**	**Additional Financing**
Uganda	Health, Nutrition & Population	P145280,P145280,P145280
L/C/TF Number(s)	**Closing Date (Original)**	**Total Project Cost (USD)**
IDA-47420	31-Jul-2015	144,310,000.00
Bank Approval Date	**Closing Date (Actual)**	
25-May-2010	30-Jun-2017	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	130,000,000.00	0.00
Revised Commitment	130,000,000.00	0.00
Actual	125,536,607.63	0.00

Prepared by	Reviewed by	ICR Review Coordinator	Group
Katharina Ferl	Judyth L. Twigg	Joy Behrens	IEGHC (Unit 2)

2. Project Objectives and Components

a. Objectives

According to the Project Appraisal Document (PAD, p. 7) and the Financing Agreement of August 12, 2010 (p. 5), the objective of the project was "to deliver the Uganda National Minimum Health Care Package (UNMHCP) to Ugandans, with a focus on maternal health, newborn care, and family planning. This will be achieved through improving human resources for health, physical health infrastructure, and management, leadership and accountability for health service delivery."

Some of the project's outcome targets were revised at a June 2015 restructuring, but since they were revised upward and achieved, a split rating is not performed.

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

Did the Board approve the revised objectives/key associated outcome targets?
Yes

Date of Board Approval
01-Jun-2015

c. Will a split evaluation be undertaken?
No

d. Components
The project included four components:

Component 1: Improved health workforce (appraisal estimate US$5.0 million, actual US$4.16 million): This component was to finance the consolidation of central-level human resources for health (HRH) functions in the Ministry of Health (MOH), strengthening human resource management functions and creating a Central Job Bureau in the MOH, and providing short-term training of personnel officers (designated officers) including hospital administrators and other health managers in relevant areas of personnel management. Also, this component was to finance the provision of equipment and technical support for an HRH Management Information System in selected districts. Furthermore, this component was to finance improved staff retention in remote and hard-to-reach areas and pre-service and in-service education through provision of scholarships for high-priority cadres and continuous professional development.

Component 2: Improved health infrastructure of existing facilities (appraisal estimate US$85.0 million, actual US$87.01 million): This component was to finance the renovation of selected health facilities through provision of medical equipment, and the strengthening of capacity for proper operations (maintenance, repairs, and replacements) of health facility assets. In addition, this component was to finance the purchase of ambulances for hospitals and a general-purpose vehicle for each renovated health facility. In addition, the project was to support the MOH in developing policy guidelines on ambulances and a strategy for using Information Communication and Technology (ICT) to improve referrals.

Component 3: Improved management and leadership (appraisal estimate US$10.0 million, actual US$3.57 million): This component was to finance the implementation of performance-based management approaches, professionalizing and strengthening the management of hospitals, developing and rolling out the implementation of a hospital policy framework, and building capacity in procurement, logistics, and supply chain management in the pharmacy division.

Component 4: Improved maternal, newborn and family planning services (appraisal estimate US$30 million, actual US$30 million): This component was to finance expanding and improving the quality of

reproductive health and newborn care through the development and dissemination of maternal and newborn care guidelines and protocols, training in various obstetric and neonatal procedures, and strengthening the referral and communication system. Also, this component was to finance increasing the availability and demand for family planning services.

At the June 2015 restructuring, safe deliveries targeting poor pregnant women as part of a plan by the MOH to finance reproductive health output-based activities were included under this component. The total component cost remained unchanged. US$3 million equivalent (savings accruing from procurement of reproductive health equipment and supplies) was allocated to finance a package of safe delivery services consisting of four antenatal visits, safe delivery, one postnatal visit, treatment and management of selected pregnancy-related medical conditions and complications (including Caesarean sections), and emergency transport through the output-based aid modality.

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

Project Cost: The project was estimated to cost US$130 million. The actual cost was US$129.21 million, with the difference from appraisal due to exchange rate fluctuations.

Financing: The project was to be financed by a US$130 million credit by the International Development Agency (IDA) under a Sector-Wide Approach (SWAp) that has been in place since 1999. According to the ICR (p. 48), US$ 125.6 million had been disbursed at the time the ICR was written, with remaining disbursements to be completed by December 31, 2017. Total financing of the SWAp was US$ 1.4 billion, meaning that the Bank provided about 9% of financing for the sector.

Borrower Contribution: The government was to contribute US$14.31 million, but this contribution did not materialize.

Dates: On June 1, 2015 the project was restructured as follows: (i) the closing date was extended from July 31, 2015 to June 30, 2017 to allow for the completion of civil works (renovation of hospitals and health centers) and the implementation of existing and new activities under Component 4; (ii) some indicators were modified or dropped, and targets for several outcome and intermediate outcome indicators were increased based on implementation experience; (iii) Component 4 was revised to introduce output-based aid activities for safe deliveries; and (iv) a voucher management agency for the implementation of output-based aid activities was recruited.

3. Relevance of Objectives

Rationale

According to Global Burden of Disease data, between 2005 and 2015 the most common causes of death and premature death in Uganda were communicable, maternal, neonatal, and nutrition-related diseases. While Uganda had made progress in regards to health, nutrition, and population outcomes, the country still

experienced a high maternal mortality ratio of 435 deaths per 100,000 live births and an infant mortality rate of 76 deaths per 1,000 live births in 2006. Total fertility rate was the fifth highest in the world and had stagnated at 6.7 births per woman in 2006 compared to 6.9 in 1988. At appraisal, the objective of the project was in line with the government's National Development Plan (2010/11-2014/15), which prioritized the implementation of the UNMHCP and its focus on maternal and child health. The objective also supported the government's overall mission "to provide the highest possible level of health services to all people in Uganda through delivery of promotive, preventive, curative, palliative, and rehabilitative health services at all levels," as stated in the Second National Health Policy (2010) and the MOH's Health Sector Strategic Plan (HSSP) III for 2010/11-2014/15. The objectives were also highly relevant to the Bank's current Country Partnership Framework for Uganda (FY 2016-2021), which focuses on "improving social service delivery" under its first strategic focus area. More specifically, the Framework addresses equity in spending and quality of health services (p. 14), strengthening health systems, improving incentives for health providers, enhancing maternal and child health, and assisting the government with addressing the high fertility rate (p. 22), all under the umbrella of interventions in health to promote new and better opportunities for girls and women.

Rating
High

4. Achievement of Objectives (Efficacy)

Objective 1
Objective
Deliver the Uganda National Minimum Health Care Package (UNMHCP) to Ugandans, with a focus on maternal health, newborn care, and family planning. This will be achieved through improving human resources for health, physical health infrastructure, and management, leadership and accountability for health service delivery:

Rationale
The UNMHCP included various packages of health services provided at the primary, secondary, and tertiary levels, including services related to maternal health, newborn care, and family planning. The core package was provided in communities and at Health Centers level II, and included services such as short-term family planning methods, integrated community childhood illness management, immunization, antenatal care, newborn care, and post-natal care. The expanded package was provided at Health Centers level III and included services such as long-term family planning methods, integrated management of neonatal and childhood illnesses, basic emergency obstetric and neonatal care, and post-abortion care. The comprehensive package was provided at Health Centers level IV and general hospitals and included all services provided in the lower level health centers as well as comprehensive emergency obstetric and neonatal care, inpatient management of severe newborn and child illnesses, and permanent contraception.

The project's theory of change linked the renovation of health facilities and hospitals, the purchase of medical and ICT equipment, the distribution of safe delivery vouchers, training of the health workforce, and leadership and governance training to improved health systems, availability of equipment and commodities,

HRH, referral networks, and monitoring and accountability, which would in turn enhance ability to deliver, coverage, and use of UNMHCP services at all levels. The project's focus on maternal and child health and family planning-related outputs was expected to increase and sustain investments and priority in these areas. Longer-term expected outcomes (beyond the scope and timeline exclusively of this project, but to which the project contributed) included reduction in the total fertility rate, maternal mortality rate, under-five mortality rate, infant mortality rate, and child underweight rate.

Outputs

Human resources for health

- Training was provided to 536 health workers on emergency obstetric and neonatal care, 493 health workers on post-abortion care, 220 health workers on post-partum family planning, and 611 health workers on long-term reversible family planning methods. In addition, 35 trainings of trainers were conducted, 340 midwives were mentored on basic emergency obstetric and neonatal care, and 43 doctors and 36 anesthetists were trained in this area.
- Scholarships were provided to 797 health workers in hard-to-reach and priority areas, surpassing the original target of 75 and revised target of 700 health workers.
- 14 Regional Referral Hospital taskforces were constituted.
- Job analysis exercise and service schemes were developed for health facility managers. A Job Bureau was developed at the Health Services Commission.
- An HRH data base was developed and rolled out in 31 districts.
- Client charters were developed and distributed in all health facilities, achieving the original target of 100% of facilities and surpassing the revised target of 60% of facilities.

Physical health infrastructure

- Reproductive health supplies and family planning commodities in the amount of US$29 million were procured and distributed, including 248,372 pieces of Etonogestrel 68mg implant, 303,500 pieces of Jadelle implant, 3.9 million ampules of medroxyprogesterone acetate, and 276,000 safe delivery kits.
- 26 Health Centers level IV (serves counties with a population over 100,000) and nine hospitals were renovated (renovation totaled approximately US$85.9 million). A total of 265 health facilities were constructed, renovated, and/or equipped, exceeding the original target of 46 and almost achieving the revised target of 279 health facilities.
- Medical equipment, supplies and furniture in the amount of US$14.9 million was procured and distributed.
- 19 ambulances, 58 double-cabin pick-up vans, one minibus, three station wagons, two delivery trucks, 17 motorcycles, and two four-wheel drive cars were procured and distributed.
- ICT equipment was procured and distributed, including 170 computers and 175 printers. A local area network, engineering software, and a large format plotter were installed.
- Advocacy and communication about maternal and child health and family planning services were

enhanced using radio spots and drama clips. 168 opinion leaders (district health officers and religious leaders) were oriented in their roles as advocates for demand for health services.

Management, leadership and accountability

- 24 health workers were trained on HRH policy planning and development, and 159 health workers were trained on leadership and management.
- 80% of hospitals had superintendents trained in health management/hospital administration, not achieving the target of 100%.
- Ambulance guidelines were developed and distributed nationwide.
- A Hospital Quality of Care Assessment Program was developed and rolled out in 19 hospitals.

Intermediate Outcomes

Human resources for health

- The percentage approved positions that were filled by qualified health workers increased from 56% in 2009 to 73% 2017, not meeting the original target of 80% but exceeding the revised target of 70%. The rate of absenteeism at government-owned health centers declined from 46% in 20122/12 to 30% in 2013. However, the ICR (p. 25) stated that low absorption of health workers who were trained under the project eroded some of the capacity built, as the government did not allocate additional funds to keep them.
- At project closure, 92% health workers were receiving their salaries within two months after reporting to work, exceeding the original target of 30% and revised target of 55%.

Management, leadership and accountability

- The percentage of Health Centers level IV conducting maternal and perinatal death audits increased from 5% in 2009 to 62% in 2017, exceeding the original target of 40% and the revised target of 60%. Maternal and perinatal death surveillance and response were revitalized in 69 districts, with formal reviews now conducted regularly.
- The percentage of health facilities without stockouts of tracer medicines and supplies increased from 26% in 2010 to 86% in 2017, exceeding he original target of 55% and the revised target of70%. However, it should be noted that the government has not yet allocated budget for these medicines and supplies, highlighting dependence on development partner financing.
- The bed occupancy rate in Health Centers level IV increased from 32.4% in FY2011/12 to 54.2% in FY2016/17. The average length of hospital stay decreased from 4.6 to 3.2 days between FY2009/10 and FY2016/17. Both of these indicators are markers of increased system efficiency and improved management.

Outcomes

Maternal health and newborn care

- 442,443 people were provided with access to a basic package of health, nutrition, or reproductive health services, exceeding the original target of 75,000 and revised target of 300,000 people.
- The percentage of deliveries that took place in government and private, not-for-profit health facilities increased from 34% in 2009 to 58.10% in 2017, exceeding original target of 45% and the revised target of 50%. The percentage of women delivering at any health facility increased from 57.4% in 2011 to 73.4% in 2016.
- The percentage of hospitals and Health Centers level IV offering comprehensive emergency obstetric care increased from 20% in 2009 to 62% in 2017, exceeding the original target of 50% and the revised target of 55%. The percentage of Health Centers level IV performing Caesarian sections increased from 37% in FY2012/13 to 70% in FY2016/17. The percentage offering blood transfusion services increased from 27% in 2012/13 to 47% in 2016/17.
- 442,289 women received antenatal care during a visit to a health provider in 2017, not achieving the target of 1.5 million women. The ICR (p. 37) provided a baseline of 1.2 million for this indicator and did not explain the observed decline. The ICR (p. 69) also noted, however, that the percentage of pregnant women making four visits to an antenatal care provider increased from 47.6% in 2011 to 59.9% in 2016.
- According to Demographic and Health Survey data (ICR, p. 13), in the years immediately prior to the project (2006-2011), the maternal mortality rate increased by 1%. During the project period (2011-2016), the rate decreased by 23%. Also during the project period, the infant mortality rate decreased by 20%, and the under-five mortality rate decreased by 29%.

Family planning

- The contraceptive prevalence rate increased from 24% in 2006 to 36.90% in 2017, surpassing the original/revised target of 35%.
- Couple years of protection increased from 549,594 (CYP) in 2009 to 2.24 million in 2017, not achieving the target of 3.5 million (this indicator measures the estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period). The ICR (p. 14) explained that women chose short-acting methods rather than long-term methods due to ease of access, lower cost, privacy, etc. However, the use of implants as a percentage of all family planning methods increased from 1% to 6% during the project period, which the ICR (p. 14) attributed to the project's provision of supplies and training of providers.
- The total fertility rate decreased from 6.2 to 5.8 from 2011 to 2016.

Rating
Substantial

Rationale
The project's results chain demonstrates a plausible link between activities related to HRH, physical infrastructure, and systems strengthening, and observed outcomes related to coverage of the maternal/child health and family planning services specified in the UNMHCP. Outcome targets were met or exceeded for most indicators. Given the Bank's significant contribution to overall sector financing as part of the SWAp mechanism (9%), it is reasonable to attribute outcomes to the project's interventions. Efficacy is therefore rated Substantial.

Overall Efficacy Rating
Substantial

5. Efficiency

The PAD did not include a traditional economic analysis. It noted (p. 77) that the experience of other countries with economic status similar to Uganda suggested that improved coverage with a package of interventions related to maternal and neonatal care is extremely cost-effective, costing US$82 - US$142 per Disability Adjusted Life Year (DALY) averted. The PAD also stated that Uganda's high fertility, high unmet need for family planning, and large number of induced abortions with attendant complications provided a strong economic rationale to invest in family planning.

The ICR (p. 49) estimated the project's economic benefits from reducing infant, under-five, and maternal mortality. Averted DALYs were estimated by multiplying the number of deaths averted by the average life expectancy. The analysis used two approaches: first, a conservative approach that multiplied the DALYS gained by the Gross Domestic Product (GDP) per capita; and second, the approach recommended by the World Health Organization, that multiplied the DALYs by three times the GDP per capita. The analysis found benefits per US$1 spent of between US$0.7 and US$2.09 for averted infant mortality; between US$1.65 and US$4.95 for averted under-five mortality; and between US$0.32 and US$0.97 for averted maternal mortality. The ICR estimated overall that the project generated economic benefits of US$164 to US$493 million through reduction of under-five mortality, and US$ 32 to US$ 96 million through reduction of maternal mortality, but acknowledged that it is challenging to attribute benefits under a SWAp. The analysis used a rate of 9 percent (US$130 million IDA financing out of total US$1.4 billion total financing) for attributing the economic benefits to IDA financing compared to the totality of the SWAp.

There were some elements of positive implementation efficiency. The ICR (p. 24) stated that the use of a SWAp coordination mechanism ensured collaboration between stakeholders, avoiding duplication of interventions and resolving implementation challenges. Also, the project took advantage of cost savings and used them to implement new activities such as the introduction of the maternal voucher scheme and the

procurement of additional safe delivery kits and implants. In addition, the Bank encouraged involved entities to redistribute any excess stock of medicines to entities that lacked these medicines.

However, there were significant shortcomings in implementation efficiency. The project experienced several significant delays related to shortcomings in the initial design of the project and weak capacity in procurement and financial management (see Sections 8a and 10b). Specifically, inadequate planning and executing of civil works led to delays and cost overruns, and ultimately to the dropping of ten hospitals that had been originally identified for renovation. Also, limited capacity in the MOH and delays in paying for training-related expenses led to delays in the implementation of activities under component 4. In addition, occasional stock-outs of essential medicines and family planning commodities had a negative impact on service delivery. Furthermore, the project team stated that the Bank's audit was unable to trace 6.6% of the equipment and furniture provided. Implementation delays required an extension of the original closing date of July 31, 2015 to June 30, 2017 and may be indicative of inefficient use of project resources.

Efficiency Rating
Modest

a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

	Rate Available?	Point value (%)	*Coverage/Scope (%)
Appraisal		0	0 ☐Not Applicable
ICR Estimate		0	0 ☐Not Applicable

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

6. Outcome

The project's objective was highly relevant to country conditions and to current government and Bank strategy. Efficacy was substantial, with the project's activities plausibly connected to achievement of targets related to delivery of the maternal/child health and family planning elements of the UNMHCP. Efficiency was modest due to delays and other indications of implementation inefficiency. Taken together, these ratings indicate moderate shortcomings in the project's preparation and implementation, and Outcome is therefore rated Moderately Satisfactory.

a. Outcome Rating
Moderately Satisfactory

7. Risk to Development Outcome

The ICR (p. 31) stated that the government, with the support of the Bank, has significantly increased the transfer of development grants to the districts for the renovation of existing health infrastructure. Furthermore, the government's current plans, such as the Family Planning Costed Implementation Plan (2015-2020) and Strategy for Improving Health Service Delivery (2016-2021), will support sustainability of the project's achievements. A new Bank project, the Uganda Reproductive, Maternal, and Child Health Services project (2016–2020, US$ 140 million), will continue to support the government's effort to improve the delivery of reproductive, maternal, neonatal, child, and adolescent health services.

However, despite these activities, the project's outcomes face significant sustainability challenges. First, the ICR (p. 23) stated that the recruitment of 12,000 health workers by the MOH is not adequate to ensure smooth service delivery, as additional needs have emerged. Also, the ICR (p. 25) stated that low absorption of health workers trained under the project eroded some of the capacity built. The government did not allocate additional budget to offer these health workers positions appropriate to their newly acquired skills or create new positions for new graduates who completed diploma or certificate courses financed under this project. Second, while the MOH has provided budget for the maintenance of existing infrastructure and the operation and replacement of equipment, this funding is not sufficient, and the budget will have to be increased in order to ensure proper maintenance of investments made under the project (ICR, p. 21). Third, the ICR (p. 21) noted that the government's financing of the health sector as a proportion of the total budget declined from 8.3% in FY 2011/12 to 6.9% in FY2015/16, and simultaneously the health sector's dependence on donor funding has increased from 26% in FY2011/12 to 36% in FY2015/16. This dependence presents a challenge, as donor financing is expected to decline with Uganda's transition to a middle-income country. In particular, stock-outs of essential medicines and family planning commodities might recur given lack of government funding and dependence on donor financing. Fourth, the ICR (p. 30) stated that capacity at the district level remains low, and government institutions and accountability mechanisms still require further strengthening.

8. Assessment of Bank Performance

a. Quality-at-Entry

The project's objective was aligned with national priorities. Design included lessons learned from other Bank-financed projects and built on extensive analytical work such as a political economy analysis and an institutional assessment to inform the leadership and governance component. A component specifically focusing on maternal and child health was added during the appraisal stage, after the need for such component was expressed by women's group and a sub-committee within the Parliament.

The Bank team included staff with relevant expertise. The team designed an appropriate Results Framework (see Section 9a). The ICR (p. 29) stated that project preparation only took nine months, and effectiveness and legal covenants were adequate.

However, there were some moderate shortcomings. The Bank rated the overall project risk as Substantial

and identified relevant risk factors, including adequate provision of operational funds for maintenance, MOH capacity to implement the project, sustained government interest in reform measures, governance challenges due to irregularities in how grants were being used, and the impact of national elections on project decision making processes. Some mitigation measures were innovative, including a value-for-money audit. Overall, however, mitigation efforts were not sufficient, and several identified risks materialized. In addition, the project's design was complex in relation to capacity, and systems strengthening activities were spread across the different components rather than included into just one. Also, limited MOH capacity had a negative impact on preparing comprehensive cost estimates for civil works, resulting in bills of quantities not being completed early enough to inform project preparation and implementation.

Quality-at-Entry Rating
Moderately Satisfactory

b. Quality of supervision
The majority of the Bank team was based in the country, allowing for a continuous dialogue with the government and relevant entities. The same Task Team Leader was in place throughout the entire implementation period, also supporting continuity. The ICR (p. 30) stated that bi-annual supervision missions were conducted together with the MOH. Implementation challenges were addressed in a timely manner. For example, the Bank commissioned an independent audit when the MOH rejected the findings of an audit that was conducted by the Office of the Auditor General (OAG). According to the ICR (p. 23), the Bank's independent audit helped to create credibility and ensured greater accountability, while the Bank's fiduciary support helped to strengthen capacity. At restructuring, the project incorporated a safe delivery voucher scheme to target poor pregnant women and adequately revised the Results Framework. The ICR (p. 24) stated that the use of the SWAp and establishment of a thematic technical working group consisting of representatives of the MOH, development partners, implementing partners, civil society, and other relevant stakeholders had a positive impact on stakeholder collaboration, resolving implementation bottlenecks and avoiding duplication of activities.

The project experienced several financial management (FM) and procurement-related challenges resulting in implementation delays. In order to address these challenges, the Bank's FM and procurement specialists regularly participated in bi-annual supervision missions to ensure adequate supervision and full compliance with the Bank's safeguard, FM and procurement policies and requirements (ICR, p.30).

Quality of Supervision Rating
Satisfactory

Overall Bank Performance Rating
Moderately Satisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design

Data was to be collected from a combination of sources, including routine health information systems and sample-based surveys, as well as beneficiary surveys to evaluate user satisfaction to be conducted by the Uganda Bureau of Statistics. The M&E design and arrangements were well embedded institutionally, and the primary responsibility for coordinating M&E activities under the project was assigned to the MOH Department of Quality Assurance. The project's Results Framework was based on the Results Framework of HSSP II and was later restructured to align with the indicators of HSSP III. The Bank team stated that the indicators of the project were similar to those in the two strategic plans. In addition to the core performance indicators, each program (quality, coverage, risk factors, etc.) had a set of indicators to assess progress.

The project's theory of change was sound and adequately reflected in the Results Framework. The objective was clearly specified, and the indicators encompassed all aspects of the PDO statement. The outcome and intermediate outcome indicators were specific, measurable, relevant, and time-bound, and all had a baseline and target.

b. M&E Implementation

The MOH prepared quarterly progress reports and annual health sector performance reports. The Bank's Implementation Status and Results Reports provided updates on implementation progress. The ICR (p. 26) stated that sources of data were highly reliable and robust. Since the project's M&E was integrated into regular MOH monitoring arrangements, its sustainability is high. At the June 2015 restructuring, the Results Framework was adapted to drop some indicators that became irrelevant or presented measurement challenges and increase targets for some indicators based on implementation experience.

c. M&E Utilization

The ICR (p. 27) stated that data generated from the Integrated Human Resource Information System was extensively used by the MOH to redistribute staff. Also, the project conducted regular assessments on the coverage of maternal and child health services in different districts, allowing for the expansion of coverage in under-served areas. The ICR did not present district-level data; the project team stated that it would not have been feasible to include information at that level of detail in the ICR.

M&E Quality Rating

Substantial

10. Other Issues

a. Safeguards

The project was classified as category B and triggered the Bank's safeguard policy OP/BP 4.01 (Environmental Assessment) due to potential impact related to medical waste. The project conducted Environmental and Social Impact Assessments and developed Environmental and Social Management Plans. The MOH conducted Health Care Waste Management (HCWM) plans for health facilities. The ICR (p. 27) stated that most of the health facilities followed requirements and separated medical waste using color-coded bins. However, Health Centers openly burned waste, as incinerators were only available in hospitals. Also, since there was inadequate capacity at Health Centers and no focal person within MOH to oversee HCWM activities, reporting on HCWM was weak, and HCWM plans were not properly implemented and monitored. The project hired a supervising consulting firm for civil works to oversee the project's compliance with the Bank's environmental and social safeguards. The ICR (p. 27) stated that this firm submitted progress reports on a regular basis, and that the project complied with the Bank's environmental and social safeguard requirements.

b. Fiduciary Compliance

Financial Management

Quarterly interim unaudited FM reports were of acceptable quality and were submitted on time. Even though external audit reports were largely clean, the project experienced delays in processing payments and preparing and managing internal audit reports due to inadequate capacity within the MOH's internal audit unit. According to the ICR (p. 28), as agreed under the project, two value-for-money audits were conducted by the OAG. In 2015, the OAG's audit on medical equipment found that goods received through the project improved capacity and functionality of health facilities. In 2016, the OAG's audit report on medical equipment identified several significant shortcomings: (i) a lack of communication with health facilities resulted in the supply of not-critical equipment; (ii) provided equipment was not used due to lack of electricity and shortage of skilled staff; (iii) same commodities were over-delivered, resulting in expiration before use; iv) some equipment was missing; and (v) some supplies were of poor quality. The ICR stated that the MOH disputed the finding of missing equipment. The Bank conducted an independent audit concluding that "largely, equipment reported as missing/not delivered physically existed in the sampled health facilities." However, the Bank's audit identified additional shortcomings, including lack of adequate planning, delays in processing procurement contracts within the MOH, lack of space/skilled staff to use equipment, and insufficient maintenance budget. In order to address these shortcomings, the MOH developed an action plan, which is, according to the ICR (p, 28), being implemented. The project team stated that the reason for the divergent audit outcomes is related to the OAG team not including auditors with full understanding of medical equipment and the facilities being located in rural areas. Often the auditors should have visited facilities twice in cases where staff responsible for medical equipment were not present during the first visit, and in some instances these follow-up visits did not occur.

In April 2016, the OAG conducted an audit of civil works. This audit identified several shortcomings, including inadequate design of health facilities resulting in problems during the construction phase, underestimation of

costs resulting in a reduction of scope of work and delay in completion, delays in finalizing contracts resulting in implementation delays, and shortage of staff/equipment.

Procurement
According to the ICR (p. 29), the project complied with all legal Bank covenants, with the exception of the legal covenant on the implementation of the HCWM plan, which received only partial compliance. To overcome initial procurement challenges, the MOH established a "delegated contracts committee" to oversee procurement activities under the project. However, as stated above, the project experienced several significant procurement-related delays. By the time of project completion, a contract of US$2.4 million for the procurement of medical equipment could not be executed due to delays in issuing letters of credit. This meant that some activities related to the safe voucher scheme under component 4 could not be implemented.

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

d. Other
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11. Ratings

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

12. Lessons

The ICR (p. 31-32) provided several lessons and recommendations, including:

When a project makes significant investments in infrastructure and equipment, it is critical that the government provide an adequate budget to cover maintenance and incremental costs to ensure the sustainability of such investments. In this case, the MOH has budgeted for maintenance of existing infrastructure and the operation and replacement of equipment. However, since the facilities have recently

been renovated and the equipment is new, the maintenance costs are generally low. This will change in the future, and an increase in budget to appropriately maintain the investments made under the project will be necessary.

Continuity and in-country presence of task team can enhance the quality of support and ensure appropriate course correction. In this case, strong supervision, including through independent validation and audit, helped direct resources effectively toward achievement of intermediate outcome and outcome targets.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

The ICR provided a solid overview of project preparation and implementation. The economic analysis was sound. The results analysis was outcome-driven and provided relevant data on longer-term health and fertility outcomes. However, shortcomings included the following:

- The ICR provided insufficient information on the content of Uganda National Minimum Health Care Package (UNMHCP) itself, despite the fact that this health care package was central to the project (and was mentioned in the PDO). The ICR (p. 8, footnote 4) named the "four clusters" of the UNMHCP, but did not explain the constituent elements of the package more specifically than those four clusters, which left a gap in clear explanation of how the package was envisioned to work. (The ICR elsewhere explained how the health sector was arranged [para. 4] and how this project fit into national and sectoral priorities [para. 5], and Annex 6 outlined the organization of the health system in Uganda. However, these paragraphs and Annex did not fill the information gap related to the UNMHCP itself.)
- Information provided in the ICR about audits lacked some key details. For example, in explaining results of the Bank's independent audit related to medical equipment, the ICR (p. 28) stated that the audit concluded that "largely, equipment reported as missing/not delivered physically existed in the sampled health facilities," but the ICR did not provide sufficient context or additional information from the audit to define (beyond the unspecific "largely") how much of the equipment previously reported as missing was, in fact, present.
- Lessons learned/recommendations were linked (loosely) to analyses presented in the ICR. Connections to the evidence underpinning the lessons were relatively implicit and general, however, rather than explicit and specific.

Based on the above, the quality of the ICR is considered barely substantial.

a. Quality of ICR Rating
Substantial