



## 1. Project Data

<b>Project ID</b> P150481	<b>Project Name</b> GZ: Health System Resiliency Strengthening	
<b>Country</b> West Bank and Gaza	<b>Practice Area(Lead)</b> Health, Nutrition & Population	
<b>L/C/TF Number(s)</b> TF-18986	<b>Closing Date (Original)</b> 30-Jun-2020	<b>Total Project Cost (USD)</b> 8,462,234.64
<b>Bank Approval Date</b> 21-Jan-2015	<b>Closing Date (Actual)</b> 31-May-2022	
	<b>IBRD/IDA (USD)</b>	<b>Grants (USD)</b>
Original Commitment	8,500,000.00	8,500,000.00
Revised Commitment	8,500,000.00	8,500,000.00
Actual	8,462,234.64	8,462,234.64

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## 2. Project Objectives and Components

### a. Objectives

As stated in the February 4, 2015 Grant Agreement between the Palestine Liberation Organization (for the benefit of the Palestinian Authority) and the International Development Association (IDA), acting as Administrator of the Trust Fund for Gaza and West Bank (Schedule 1, p. 5), the Project Development Objective (PDO) was "...to support the Palestinian Authority in securing continuity in (healthcare) service delivery and building its resilience to withstand future surge in demand for effective healthcare coverage. The



design document presented the same statement (*PAD, pp. 8 and 21*). The PDO did not change throughout the project's life.

While PDO-level indicators and targets were revised as a part of the project's restructurings, none of these revisions warrant a split rating. A third hospital was added to the utilization rate indicator, measuring achievement against Objective 1 (securing continuity in healthcare service delivery). Targets for this indicator were adjusted to reflect corrected baselines, but the level of ambition remained the same. An indicator tracking a decline in overall costs of referrals was changed to track a slower growth rate in the cost of outside medical referrals (OMR), based on more accurate baseline information. Moreover, this was a more appropriate measure of the project's effect against a backdrop of rapidly increasing demand for OMR due to population growth and demographic transition.

**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**

17-Jan-2018

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

No

**d. Components**

***Original Components:***

Project support was to delivered through four components.

**Component 1: Emergency and Rapid Response Window (original estimate of US\$2.0 million; actual at closing: US\$2.07 million).** This component was designed to ensure the continuation of basic healthcare services at minimum acceptable levels and avoid such services from experiencing systemic collapse in the aftermath of the Gaza conflict in 2014. It was to cover selected non-medical recurrent costs of operating and maintaining health service facilities in the major hospitals of Gaza, including: (i) fuel costs for hospital generators and ambulance services; (ii) hospital cleaning services and cleaning materials; and (iii) hospital catering services.

**Component 2: Rationalizing Outside Medical Referrals (OMR) (original estimate of US\$3.5 million; actual at closing: US\$3.66 million).** This component aimed to support the Palestinian Authority (PA) to institute immediate cost-cutting measures in order to improve efficiency in the current system without compromising access to needed and quality health services. It was to include support for: (i) the review and renegotiation of contracts and other arrangements between the Ministry of Health (MoH) and private health service providers for the provision of health services, including the undertaking of a costing study; (ii) the development of a guidance note for medical referrals setting forth rules for the treatment and referral of selected health conditions; (iii) the strengthening of the medical referral information system and the



development of a medical referrals master plan; and (iv) the strengthening of public provision of selected health services through strategic procurement of critical medical equipment.

**Component 3: Supporting Health Coverage to Strengthen Sector Resilience (original estimate of US\$2.0 million; actual at closing: US\$1.78 million).** This component was to cover activities designed to support the establishment of a national health coverage scheme, including the consideration of options for separating the roles of MoH in financing, service provision, and regulation of health care. It was to include support for: (i) the definition of enrollment criteria and options; (ii) specification of the benefit package of healthcare services, including the costing of services and the establishment of criteria for the inclusion of these services in the package; (iii) the establishment of provider payment options for primary and hospital care; (iv) the development of strategies for covering the informal sector; and (v) the establishment of an independent pooling and purchasing agency to separate financing, pooling, and purchasing functions from service provision.

**Component 4: Project Management and Capacity Building (original estimate of US\$1.0 million; actual at closing: US\$0.95 million).** This component was to finance activities and costs aimed at strengthening MoH capacity in project management and monitoring and evaluation (M&E). Specific areas of support were to include the provision of consultants' services, audits, training, and the financing of operating costs.

### ***Revisions to Components***

While the project underwent four restructurings (see Section 2e), the components were not substantially revised during project implementation. There were, nevertheless, some adjustments introduced, and some activities were scaled back in light of constraints encountered during implementation. These are itemized in Section 8b (Quality of Supervision).

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

**Cost.** The total actual cost of the project was US\$8.46 million equivalent, or 99.5 percent of the original estimate of \$8.50 million.

**Financing and Borrower Contribution.** The project was financed by a Grant from the Trust Fund for Gaza and West Bank, for which IDA was Administrator. The US\$8.5 million grant was fully (99.5 percent) disbursed. No counterpart funding was planned or provided.

**Key Dates.** The project was approved on January 21, 2015 and became effective less than a month later on February 16, 2015. A first restructuring (September 7, 2015) provided additional financing in the amount of US\$1.25 million to complement the US\$7.25 million provided to the project under the original Grant Agreement to fulfill the original commitment of the Trust Fund to provide \$8.5 million in financing. The financing was provided in two tranches because at the time of project approval, the Trust Fund only had an available balance of US\$7.25 million. Following the July 17 2017 mid-term review, a second restructuring (January 17, 2018) adjusted a few indicators and targets in light of progress and to clarify measures. A third restructuring (January 13, 2020) made more adjustments in the results framework and extended the original closing date by a year and a half to December 31, 2021. In March 2020, US\$0.8 million was reallocated from Component 3 (Supporting Health Coverage to Strengthen Sector Resilience) to Component 2 (Rationalizing Outside Medical Referrals/OMR) to strengthen MoH's COVID-19 case management



capacity. A fourth and final restructuring (October 27, 2021) introduced a second extension of the closing date, to May 31, 2022, to enable completion of project activities.

### 3. Relevance of Objectives

#### Rationale

**The PDO is highly relevant to current country conditions.** Despite some progress made under this emergency operation, the fragile health system in West Bank and Gaza (WB&G) continues to face formidable challenges that undermine its ability to respond to the health needs of the population. Ongoing challenges include underfinancing of health services; inefficiencies in the allocation and use of financial resources and in the organization of the health system and service delivery; and low service quality. Underfinancing and inefficient allocation and use of scarce resources were exacerbated by the COVID-19 crisis, which consumed considerable amounts of scarce health sector resources. Health sector performance has also been negatively impacted by continued escalations in violence in Gaza, which have limited the mobility of the population and caused a rise in deaths and injuries, as well as damages and losses to the health sector. Health costs have risen dramatically in the face of rapid population growth and an epidemiological transition with growing incidence of non-communicable diseases (NCDs), which are expensive to manage and treat. Sources of financing are fragile. Public health spending has doubled over the previous decade, and donor funding has been unpredictable. Moreover, the fragmented health financing model has not been able to address the imbalance between government health insurance revenues and public expenditures on health. Rapidly growing reliance on an expensive and complex referral system of OMR to private hospitals in WB&G is neither efficient nor sustainable. The International Monetary Fund report to the Ad Hoc Liaison Committee on WB&G (April 26, 2022) highlighted the need to implement spending reform centered on health referrals to address fiscal pressures due to rising health expenditures.

**The PDO is highly relevant to the current development priorities of the country.** PA's National Development Plan (NDP) (2021-2023) places economic and human capital at the core of its strategy. In response to the COVID-19 pandemic, it places strong emphasis on the resilience of institutions. The NDP supports three pillars: (1) ending occupation; (2) reform and enhancement of service delivery; and (3) sustainable development. Within Pillar 2, the NDP prioritizes the strengthening of institutions to provide more effective and quality citizen-centered public services. It also highlights the importance of strengthening governance and efficiency of public services in supporting the health-related outcomes specified in National Policy #27 (Providing Quality Health Care Services for All) and National Policy #28 (Improving Citizens' Health and Wellbeing). Pillar 3 is geared towards the support of economic growth and investments in human capital. Health-relevant activities in the NDP include promoting the effectiveness, coherence, and inclusion of the social services systems, with a special focus on women and children, and advancing universal health coverage (UHC).

**The PDO is also highly relevant to the Bank's Country Partnership Framework (CPF) for the West Bank and Gaza for FY2022-2025, issued in 2021.** The CPF supports two Focus Areas. Under Focus Area 1 (Strengthening Institutions for Economic and Social Prosperity), several objectives are closely aligned with the project's objectives. Objective 1.2 aims to support service providers to become financially sustainable. Objective 1.3 aims to achieve better human development outcomes, within which health-specific aims are the achievement of UHC and enhanced resilience to health shocks. Under Focus Area 2



(Boosting Innovation and Diversification for a Well-Connected Palestinian Economy), Objective 2.3 seeks to improve infrastructure through World Bank investment that leverages donor resources. The project's focus on reproductive health services and its emphasis on citizen's engagement in the context of family health and UHC are relevant to the two cross-cutting themes of the CPF: addressing and narrowing gender gaps; and promoting citizens' engagement.

***At the time of project design, the World Bank had already played an integral role in the health sector in WB&G, as well as in other fragile and post-conflict countries, rendering it well equipped to undertake the project in a challenging context.*** The Bank's previous engagements in the health sector in WB&G, including the three-phase Emergency Services Support Program (2002-2013) and a series of analytic and advisory services, were critical in informing the design of this emergency project. Moreover, the Bank's considerable experience working on health sector analysis and investments in many fragile and post-conflict countries provided the opportunity for incorporating this experience into the project. Furthermore, the World Bank brings global experience and expertise in the field of health financing and health insurance. Overall, in health, the World Bank's comparative advantage is in systems building and strengthening. The Bank's health sector strategy is focused on supporting countries to create sustainable health systems that deliver results for the poor. This includes a multi-sectoral dialogue and perspective, the knowledge and ability to strengthen health systems and financing, and dialogue with the Ministry of Finance to ensure that the sector is adequately funded to achieve its targets.

## Rating

High

## 4. Achievement of Objectives (Efficacy)

### OBJECTIVE 1

#### Objective

To support the Palestinian Authority in securing continuity in healthcare service delivery

#### Rationale

As laid out in the theory of change presented in the ICR and accompanying text (ICR, pp. 8-9), the project aimed to secure continuity in healthcare service delivery by covering urgent health financing needs, which had markedly increased as a result of the Gaza conflict of 2014. In complement to MoH's continued financing of human resources, drugs, and consumables, the project's Emergency and Rapid Response Window was to support selected non-medical recurrent costs of operating and maintaining health service facilities in Gaza, including the three major hospitals of Gaza (Shifa, Nasser, and European Gaza), assuring the provision of the following outputs: (i) fuel for hospital generators and ambulance services; (ii) hospital cleaning services and cleaning materials; and (iii) catering services for hospitals. The Bank's team specified, in its June 23, 2023 note to IEG, that these outputs were expected to prevent the collapse of these three major hospitals and the spread of infections. The project was also to finance strategic procurement of equipment in selected hospitals in WB&G for surgical, obstetric, and neonatal care, among other services, to enhance hospitals' capacity to continue delivery of critical services and their continued utilization by the population. (Provision of this



equipment was also meant to support Objective 2, with enhanced hospital capacity expected to reduce the need for OMR.)

### ***Outputs and intermediate results***

- Under its Emergency and Rapid Response Window, the project provided emergency support for non-medical expenditures in Gaza's three largest hospitals (Shifa, Nasser, and Gaza), including fuel costs for hospital generators and ambulance services, and hospital cleaning services and materials, the latter focused especially on the surgical, intensive care, and neonatal intensive care units, for a total of 175 health facilities, including Gaza's three largest hospitals (91 in 2014 and 84 in 2015). A post-intervention assessment carried out by MoH in 2016 showed substantial reduction in medical waste in these targeted critical units, which helped prevent outbreaks of communicable disease. The assessment also revealed that the level of satisfaction with these services among MoH employees and patients rose dramatically, from 15 percent in 2014 to 85 percent in 2015 (ICR, pp. 14-15). In a follow-up note to IEG dated June 23, 2023, the Bank's team noted that, given the limited project financing and huge needs, MoH prioritized the use of these funds for fuel and cleaning services, and ultimately did not use financing to support catering services.
- The project equipped six newly built operating rooms in Alia Hospital in Hebron (West Bank), which also benefited from an Ultrasound Doppler machine to establish a complete unit for vascular surgery. The project also provided Beit Jala Hospital (West Bank) with a sterilizer for its Central Sterile Service Department, which serves a large population in the southern governorate.
- The project supplied neonatal medical equipment and related training to Neonatal Intensive Care Units in four facilities: Palestine Medical Complex and Jenin, Rafedea, and Alia hospitals. The Bank's team, in its follow-up response to IEG of June 23, 2023, gave more detail on the equipment provided (a portable echo machine, neonatal monitors with central station, cooling mattress with amplitude integrated electroencephalogram monitor, and open resuscitators) and its use. This equipment enabled these facilities to deliver obstetric and neonatal services, both basic -- Emergency Obstetric and Neonatal Care (BEmONC) -- and enhanced -- Comprehensive Emergency Obstetric and Neonatal Care (CEmONC). As such, this equipment had a direct influence on obstetric occupancy rates and also helped reduce referrals in support of Objective 2.
- The Bank's team also noted in its June 23, 2023 communication that the provision of cleaning support was critical for infection prevention and control. These services had a positive impact on the continuity of delivery of obstetric services for normal deliveries and complicated cases at Shifa hospital (Gaza), one of the most important hospitals in Gaza providing obstetric and neonatal care, including both BEmONC and CEmONC.

### **Outcomes**

Continuity of services was measured in terms of utilization rates of the most critical services (outpatient, emergency, and obstetrics) in the major hospitals in WB&G that benefited from the project. The Bank's team clarified in its June 23, 2023 note to IEG that: (1) WB&G did not have a well-established system of primary health care with gatekeeping function, which resulted in the population's high reliance on hospital outpatient



services; and (2) almost all deliveries (normal and complicated) are conducted in hospitals, because primary health care facilities do not conduct any deliveries.

Overall, **occupancy rates in the three largest public sector hospitals in Gaza** (Shifa, Nasser, and European Gaza Hospitals) showed a consistently increasing trend during the first four years of the project and showed promise for fully achieving the target. However, these rates started to decline in 2020 due to the disruptions and challenges caused by COVID. The ICR also noted (p. 15) that there was a relative increase in service utilization following the escalation of violence in Gaza in May 2021.

- From a baseline of 89 percent, the occupancy rate of **Shifa Hospital** decreased very slightly (by 2 percent) to 87.3 percent by the project's end, **substantially achieving the target** of at least maintaining the baseline rate (**98 percent achievement**). The occupancy rate had actually risen to 92 percent in 2017, **exceeding the minimum target** (of at least maintaining the baseline level), but COVID-19 caused a subsequent decline in the last two years of the project.
- From a baseline of 74 percent, the occupancy rate in Nasser Hospital declined to 61.8 percent by the project's end, **falling short of the target** to maintain (at least) the baseline level (**84 percent achievement**). Occupancy actually rose to 87.6 percent in 2017, **exceeding the minimum target**, but then declined during the project's last two years because of the COVID pandemic.
- From a baseline of 79 percent, the occupancy rate in European Gaza Hospital declined by almost half, to 41.5 percent, **not achieving the minimum target** of maintaining the baseline rate (**53 percent achievement**). The baseline level of occupancy was maintained at 79 percent in 2017, but subsequently declined with the onset of the COVID pandemic.
- In summary, targets were fully met in all three of Gaza's main hospitals in 2019 (pre-COVID), but the decline in utilization rates during the last two years of the project, caused by the pandemic, affected end-of-project results, with declines in occupancy in two of the three hospitals.

**Occupancy rates in two public sector hospitals in the West Bank** (Rafedia and Alia Hospitals) showed mixed results.

- From a 2015 baseline of 85 percent, the occupancy rate of Rafedia hospital increased to 98.5 percent by the project's end, **exceeding the highest range of the target** (a 10 percent increase over the baseline).
- From a 2015 baseline of 136 percent, the occupancy rate of Alia hospital declined to 111 percent by the project's end, **not achieving the target** of at least maintaining the baseline rate. On the other hand, occupancy at 136 percent of capacity may have overextended the hospital's ability to maintain quality of care. In its follow-up response to IEG (June 23, 2023), the Bank's team noted that one of the reasons for the high baseline utilization rate was the health system's overreliance on hospital care and lack of focus on primary health care. This project's Component 3 and a new World Bank-financed project support the building of primary health care capacity to reduce the need for costly hospital care and referrals.

**Utilization rates of obstetrics services** (total bed days/total beds available x 100) in three hospitals (one in Gaza: Shifa; and two in West Bank: Rafedia and Alia) provide an indication of continuity and improved uptake of these critical services. The Bank's team, in its June 23, 2023 follow-up communication with IEG, noted that, over and above the provision of obstetric and neonatal equipment to Rafedia and Alia hospitals, the project's



financing of cleaning services was critical for infection prevention and control, which was pivotal in ensuring continuity of delivery of obstetric services, both for normal delivery and complicated cases.

- Utilization of Shifa Hospital obstetrics increased from 76 to 113 percent, **exceeding the highest range of the target of 84 percent** (a 10 percent increase over the baseline). Shifa is one of the most important hospitals in Gaza providing both BEmONC and CEmONC.
- Utilization of Rafedia hospital obstetrics increased from 94 percent to 96 percent, **exceeding the minimum target** of maintaining the baseline level.
- Utilization of Alia obstetrics increased from 105 percent to 127 percent, **exceeding the highest range of the target of 116 percent** (a 10 percent increase over the baseline).

On the other hand, trends in the **number of outpatient department visits (OPD)** at these same three hospitals show mixed results.

- By the project's end, 107,538 outpatients were seen annually in Shifa (Gaza) Hospital, **achieving only 60 percent of the target** to maintain (at least) the baseline level of 180,000. (The baseline was adjusted in March 2020 (ISR #15) to correct the inaccurate baseline established at the project's outset and carried over into the January 2018 and January 2020 restructurings.)
- By the project's end, 83,967 outpatients were seen annually in Rafedia (West Bank) Hospital, **exceeding by 40 percent the target** to maintain (at least) the baseline level of 60,000. (The baseline was adjusted in March 2020 to correct the inaccurate baseline established at the project's outset.)
- By the project's end, 68,463 outpatients were seen annually in Alia (West Bank) Hospital, **achieving two-thirds (67 percent) of the target** to maintain (at least) the baseline level of 102,046. Alia Hospital was added to the list of beneficiary hospitals when the project's scope was expanded under the 2018 restructuring.

## Rating

Substantial

## OBJECTIVE 2

### Objective

To support the Palestinian Authority in building the resilience of the health system to withstand a future surge in demand for effective healthcare coverage

### Rationale

The project sought to strengthen the resilience of healthcare service delivery to promote more effective and efficient coverage in the face of growing demand and rising healthcare costs. This was to be achieved through two intermediate outcomes:

- The rationalization of OMR and the implementation of immediate cost-cutting measures to improve efficiency in health care delivery (referrals master plan, rationalizing contracts with outside providers; strengthening the referrals information system, training of health staff, and strengthening public provision of select health services through strategic procurement of critical medical equipment); and



- Progress in the establishment of a national health coverage scheme, considering options for separating MoH's roles in financing, service provision, and regulation (defining enrollment criteria and options; specifying the benefit package of services, their costs, and criteria for inclusion/exclusion; establishing provider payment options for primary and hospital care; developing strategies for covering the informal sector; and establishing an independent pooling and purchasing agency to separate financing [pooling and purchasing] functions from service provision).

### **Outputs and intermediate results**

#### *Rationalizing OMR and instituting immediate cost-cutting measures to improve efficiency in the system:*

Considerable steps were taken to rationalize OMR.

- Nine referral protocols and procedures for the costliest conditions were defined and rendered operational, **almost achieving the target** of ten protocols and procedures for the 10 costliest conditions (**90 percent achievement**). The nine include one on orthopedic surgery, which was included in neurosurgery. An update of one on oncology was also issued. MoH's Service Purchase Unit (SPU) identified two more referral protocols (one for pediatric surgery and one for radiotherapy).
- From a baseline of 0, by the project's end 29 new referral contracts/memoranda of understanding (MoUs) were negotiated with all outside providers and put into effect, **essentially achieving the target** of 30 (**97 percent achievement**). The four new MoUs were with Ibin Sina, a new hospital in Jenin; a diagnostic radiology center in Gaza; an ophthalmology center in Nablus; and Al Hilou hospital in Gaza.
- The project supported the development and full functioning of a consolidated government web-based health information system (HIS) for referrals and health insurance, in all hospitals taking referrals. This **target was fully achieved**. Entering all patients' records on the e-referral system started in January 2019. Further work is required, however, to merge the National Price Reference List into the e-referral system and then to use it for standardizing contracts. In short, while systems are operational and in place, their effective use requires additional agreements on standardized pricing. Such agreements have been finalized for 81 procedures (related to adult intensive care unit [ICU] and neonatal ICU, among others) with 11 hospitals out of a total of 23 that provide these services. The ICR also reports that (80) neurosurgery procedures agreements with standardized prices will be signed with three of the 12 facilities that provide those services.
- By the project's end, the previous-generation Avicenna HIS was operational in 13 selected hospitals, **surpassing the target** of 10 (**130 percent achievement**). The 13 hospitals are Jenin, Watani, Tulkarem, Tubas, Jericho, QalQilia, Alia, Yatta, Salfeet, Beit Jala, Rafidia, Palestine Medical Complex, and Hugo Chavez Ophthalmic Hospital. The only remaining MoH hospital that does not have a functioning HIS is Al Muhtaseb Hospital, due to its old building infrastructure. The mental health hospital in Bethlehem has the HIS only in the laboratory department, keeping data on patients' files confidential.
- A Referral Master Plan was developed and subsequently endorsed by the Cabinet in September 2016 after extensive consultations within government and with other stakeholders. The Master Plan is currently being used as a key reference document by MoH and by all involved stakeholders.
- The project supported the establishment of the Government Health Insurance Management Information System (GHI MIS) through a range of activities, including business process analysis,



technical assistance, software development, and hardware procurement. This achievement: transformed health insurance from a registry to a system; provided linkages and integration with other MoH systems (Avicenna, HIS, and Electronic Referral/E-referral); and established linkages with other ministries (Ministry of Interior, Ministry of Labor) and government applications (e-Government). Project-supported technical assistance enabled the E-Referral system to track the entire process, from referral initiation to payment of referral hospitals.

- The project also supported the preparation of a National Price Reference (NPR) based on diagnostic-related groups, which were integrated into the referral system. The NPR was piloted in around 1000 cases in five referral hospitals and will continue to support MoH's SPU to formulate comprehensive, competitive, and transparent contracts with referral hospitals and standardize the use of the International Classification of Diseases, Tenth Revision, Procedure Coding System, as a reference in the billing process.
- The SPU also worked on establishing MoUs and contracts based in part on the work performed through the NPR.

Project support helped strengthen hospitals' capacities to provide better quality of care and to take on more complicated cases, thus reducing the need for OMR. These investments in quality also supported Objective 1 (continuity of services).

- The provision of medical equipment and related training (detailed under Objective 1 outputs) helped improve the services available in the large public sector hospitals in WB&G and contributed to reductions in referrals and improvements in quality of care, including for surgeries, obstetric and neonatal care, and vascular surgery, among others.
- Other investments in quality supported Quality and Patient Safety Departments of target hospitals and the Infection Prevention and Control unit at the MoH, including the delivery of 44 training sessions for 491 staff from all hospitals focused on reduction in surgical site infections.
- With project support, a total of 700 health personnel received training, **exceeding the target** of 500 by 40 percent. This included:
  - Specialty training of 600 health staff at four priority MoH hospitals (Alia, Jenin, Rafedia, and the Palestine Medical Complex) on topics such as pediatric pulmonology and neonatology, which were directly linked to reducing referrals.
  - Remote training of 12 specialists from West Bank hospitals provided by the Health Care Accreditation Council in Jordan on quality coordination and infection prevention and control. This translated into **60 percent achievement**, as the January 2020 restructuring paper specified a target of 20 in all: 10 Certified Infection Preventionists and 10 Quality Improvement Practitioners.
  - Training of MoH and non-MoH health staff on the NPR, training of staff in health economics, and training of staff involved in the UHC component.
- By the project's end, a grievance and redress mechanism (GRM) for OMRs and access to healthcare was designed and fully operational.

*Provision of support for moving toward Universal Health Coverage (UHC) and Family Health as another means of rationalizing health services:*

- The project defined a roadmap to UHC with a detailed calendar and planned actions to enhance capacity to deliver needed services, reduce system losses, and ensure better quality of services to targeted populations.



- With project support, a purchasing agency (the SPU) was created within MoH, staffed, and made functional.
- The project supported the SPU to be proactive in enhancing efficiency in the allocation of resources, using tools to benchmark productivity and to address cost increases, to better align incentives and increase sustainability. It supported the contracting of seven support staff as part of SPU institution building, which resulted in an increase in the efficiency and quality of financial and medical auditing. Five of these staff were maintained at the SPU with contracts through the MoH. At the writing of the ICR, all staff salaries were financed with government resources.
- The project supported the preparation of a communications strategy on UHC and its dissemination through a workshop. MoH undertook additional efforts to raise awareness on the projects' various activities, especially health insurance, referrals, and the GRM. To this end, MoH formed a working group with members drawn from three units (SPU, Director General of Health Insurance, and Complaint Department), and with the support of MoH's media and public relations unit, contributed to the production of various media materials. Four workshops were conducted at the regional level, and media materials were also used for interactions with communities (local radio, television, MoH website, social media, and posters), all with a view to promoting citizen's engagement.

The project supported the Palestinian National Institute for Public Health (PNIPH) through a contract with the World Health Organization (WHO) to strengthen data in the areas of family practice, human resources for health (HRH), and health financing.

- The PHIPH provided technical assistance for improving data generation and reporting systems for family health through support for the scale-up of electronic health records for adults, child vaccination, and non-communicable diseases. The project provided computers and networking for the implementation of family practice electronic records in 118 clinics in three districts in West Bank and two districts in Gaza, **fully achieving the target** of five health directorates. The family record includes registration of patients with socio-demographic profile, health history, child health and immunization, child growth chart, adult file, and non-communicable diseases patient file, in addition to laboratory, radiology, and pharmacy services. This new indicator and target were introduced under the January 2020 restructuring.
- The PNIPH also enhanced the availability and quality of health workforce data, which has become a model for Middle East & North Africa region countries. An observatory for all human resources for health was completed, resulting in a complete database providing oversight of the HRH situation and the adoption of sound policies to better manage the health workforce. Prepared with support from the Bank and other donors, the website ([www.hrho.phiph.org](http://www.hrho.phiph.org)) is now an important tool used for strategic assessment, planning, and management of health personnel at MoH, the private sector, and non-governmental organizations.
- The planned introduction of tools to define and periodically update the rationalization of health care benefits to support continuing improvements in efficiency and equity did not progress, due to a lack of technical expertise and overall lack of clarity on the health insurance reforms.
- With project support, medical auditing is performed by three medical auditors at the SPU, **fully achieving the target** of fully functional external audits being carried out (medical and financial).

The project strengthened MoH information management systems (e-referral and Government Health Insurance management information system [MIS]). The digitalization of systems improved MoH's capacity for



evidence-based decision-making and stewardship of the health sector, while online automated processes helped build trust and improved satisfaction among patients and hospitals.

Both in its main text and in Annex 1, the ICR reports on project beneficiaries (women and children benefiting from essential health, nutrition, and population [HNP] services) as follows:

- It reports that a total of 666,327 people received essential HNP services supported under the project, **exceeding the target of 526,662**. Of these:
  - 527,204 children were reported to be immunized between 2018 and 2021, **exceeding the target of 414,318**; and
  - 139,123 deliveries were attended by skilled personnel in 2021, **exceeding the target of 112,314** for that year.
- It also reports that by the project's end, 90 percent of people in WB&G had access to a basic package of health, nutrition, or reproductive health services, up from a 2015 baseline of 80 percent, **fully achieving the target** of 90 percent. This was presented as a summary average of four indicators over four years, but the details were not provided.
- At IEG's request, the Bank's team sent IEG a follow-up communication (June 23, 2023) providing details (not reported in the ICR) on annual data compiled on each of the four HNP service indicators, two for women and two for newborns/children. The Bank's team noted that these services are delivered at hospitals and primary health centers and that these trends are a measure of the efforts made under the project to contribute towards UHC. It is still not clear to IEG to what extent these trends are attributable to the project's support. (These indicators were added to the results framework during the January 2020 restructuring as a corporate results indicator.) Nevertheless, an analysis of this more detailed data presents a more nuanced indication of coverage. Between 2018 and 2021, direct beneficiaries of two essential maternal and child health (MCH) services (specifically assisted deliveries and immunizations), and access of newborns and pregnant women to MCH services, are as follows:
  - A total of 533,295 hospital-/health institution-based deliveries were assisted, averaging about 133,324 per year, and showing consistently high coverage (between 99 percent and 99.9 percent) each year, **exceeding the target** of 90 percent coverage.
  - A total of 527,204 children were immunized. While this number is consistent with the number that the ICR reports in its Annex 1 (see above), the detailed table provided by the Bank's team labels this indicator as "immunizations number and % for under 2-year-old vaccines." However, these annual numbers are closely aligned with the number of deliveries/live births that same year, an indication of under-one immunizations. The Bank's team stated in its (June 23, 2023 follow-up) explanation of the table that adding up the four years of children immunized would represent "children under-five who had received immunization services," but it provided no indication of what was being measured: which vaccination(s), full vaccination, ever-vaccinated, or the ages of those children. The table shows 100 percent coverage for 2018, 2019 and 2020, and 96 percent for 2021, but the numerator and denominator are not clear, making it **difficult to understand the measure and assess trends**.
  - A total of 276,125 newborns were registered at MCH (data on West Bank only), averaging about 69,031 per year, and maintaining an average coverage of 89 percent, declining slightly from 91 percent (2018) to 86 percent (2021), **substantially achieving the target** of 90 percent.
  - Concerning trends for pregnant women registered in MCH (1st, 2nd, and 3rd trimesters), net of United Nations Relief and Works Agency and the private sector, show substantial decline. A



total of 228,230 pregnant women were registered during 2018-2021, averaging 57,057 per year, but the coverage of MCH registrations declined each year from 81 percent in 2018 to 66 percent in 2021, **falling short of the target** of 90 percent.

## Outcomes

*Resilience has been achieved through enhanced service quality and efficiency, cost containment, and improved equity.*

- The average annual growth of total expenditure on OMRs of the three-year period coinciding with the last three years of the project (2019-2021) was 2.04 percent, **far exceeding the target** of achieving a level lower than the three-year (2013-2015) baseline average of 16.59 percent. This represents a substantial decline, with an interim three-year average of 9.73 percent for the 2016-2018 period.
- At the project's outset, baseline expenditures on individual referrals from West Bank were 1.7 higher than expenditures on individual referrals from Gaza. By the end of the project, the ratio of expenditure per population spent on referrals between the West Bank & Gaza declined from 1.7:1 to 1.25:1 (or a 26.5 percent reduction), **achieving 82 percent of the target** of 1.15:1 (or a 32.3 percent reduction). This indicates a **substantial reduction in geographic inequities** in referral costs between West Bank & Gaza. Achievement of this target was greatly affected by restrictions imposed on Gaza residents, specifically the need of Gaza patients and companions to obtain special permits issued by Israeli authorities to move outside of the Territory for treatment. (According to the Government of Israel, these restrictions are for the purpose of enhancing the security of Israel and Israeli citizens.)

Efficiency and cost containment achievements did not undercut quality of care. Indeed, thanks to project investments in quality assurance and monitoring (training, information systems, infection prevention cleaning and protocols, and oversight) and in the provision of specialized hospital equipment and related training:

- Hospital-acquired infections, an important cause of conditions leading to OMR, were dramatically reduced:
  - Device-associated infections (which cause central line-associated bloodstream infection, catheter-associated urinary tract infection, and ventilator-associated pneumonia) were reduced by two-thirds from a (2020) baseline of 19/1000 catheter or ventilator day to 6/1000, **surpassing the target** of 11/1000 by 62 percent.
  - Surgical site infections were reduced from 12 percent to 3 percent, **far surpassing the target** of 6 percent.
- Major hospitals in WB&G have enhanced capacity to deliver quality services, including surgeries, obstetrics and neonatal care, and vascular surgery, among others.

Efficiency and cost cutting measures also did not undercut access. On the contrary, UHC capacity building, outreach to the population, and the development of information systems for a stronger evidence base for family health bode well for continued progress in improving access to, as well as quality and efficiency of, critical child and reproductive health services through a strengthened system of primary health care. Data showing improved access to essential child and reproductive health services, presented above, indicate already improvements on some fronts, along with remaining challenges. While much remains to be done, preliminary steps towards the separation of the financing and service delivery functions and towards the



achievement of UHC through a strengthened primary health care system paved the way for more progress to these ends.

**Rating**  
Substantial

## OVERALL EFFICACY

### Rationale

Objective 1 was substantially achieved. Utilization rates for key hospital services were mixed (across hospitals, and across the three services: outpatient, obstetrics, and emergency), with some falling short of targets, but most achieving or exceeding targets. For the most part, they all largely revealed the same general trend of maintenance of or improvements in baseline levels until the onset of the COVID-19 pandemic, at which time some of the gains deteriorated.

Objective 2 was substantially achieved, with one PDO target (reduction in growth of OMR) exceeded and the other (improved equity in costs of individual referrals between WB&G) substantially (82 percent) achieved.

**Attribution.** While the ICR did not assess attribution head-on, it did note that most donors had withdrawn their support due to unstable country conditions. This provides an indication of strong project attribution for the outcomes achieved, notwithstanding some issues with the results chain analysis and the links between activities and outcomes (discussed in this section and in Section 9).

**Counterfactual.** The uncertain and declining donor support during the project also points to a counterfactual, in the absence of the project, of (i) further deterioration of service continuity, quality, and utilization; and (ii) further weakening of the health sector's resilience, with continued escalation of costs and inefficiencies associated with continued growth of OMR, and no progress in moving towards UHC.

### Overall Efficacy Rating

Substantial

## 5. Efficiency

**The project generated substantial economic returns, in terms of both savings generated from improved efficiencies and health benefits.** The economic analysis undertaken at appraisal documented a strong economic rationale for the project's investment in public sector services, given its emergency nature, its effort to address inequities in access to quality and affordable services, and its aim to slow rapid growth in health sector costs and to support greater sector efficiency, both financial and operational. The baseline economic analysis estimated that through (i) the reduction of unnecessary referrals within the Palestinian territory (through clear rules and guidelines); (ii) reduction of referrals to Israel; and (iii) renegotiation of current contracts with referral



facilities and elimination of unnecessary facilities, the project could achieve a 40 percent reduction in OMR costs, compared with the expected trend-line of no project. This would entail a five percent reduction (from the trend-line) in 2015, a 10 percent reduction from the 2016 trend-line, a 20 percent reduction from the 2017 trend-line, and a 30 percent reduction from the 2018 trend-line, ultimately reaching a 40 percent reduction from the 2019 trend-line. Based on these projections, the economic analysis estimated cost-savings in referrals over the lifetime of the project of US\$198 million, compared with projected costs in the absence of the project (PAD, Annex 10, p. 87).

The economic analysis undertaken at project completion was more expansive in its scope. Total savings on OMR were estimated to be between US\$222 million and US\$677.5 million, surpassing the US\$198 million estimated at appraisal. Based on project results data, the end-of-project analysis was able to estimate additional savings, including: US\$2.9 million from averted catheter/ventilator infections; US\$48.5 million from averted surgical site infections; and US\$13.3 million from averted out-of-pocket expenditures in the private sector, culminating in total estimated savings of US\$742.2 million, including the US\$675.5 million savings on OMR. Benefits from disability-adjusted life years (DALYs) averted were estimated at US\$24.5 million, bringing the total savings and benefits from DALYs averted to US\$766.7 million, most of which was driven by savings on OMR. Recognizing that these savings and benefits cannot be solely attributable to the project, the ICR (Annex 4, p. 58) also provides a second, conservative estimate based on 50 percent of all the above-cited estimated savings (US\$371.1 million) and 50 percent of estimated benefits from DALYs averted (US\$12.3 million), bringing the total of this most conservative estimate of savings and benefits from DALYs averted to US\$383.4 million, still surpassing the appraisal estimates (ICR, Annex 4, p. 58).

***Despite the challenges of the COVID-19 pandemic, MoH capacity constraints, recurrent conflict, and other contextual issues, project implementation was efficient overall.*** The project funds were fully (99.5 percent) utilized, and the actual costs of each component were close to original estimates. Processed as an emergency operation, the preparation time was much faster than the average for Bank projects. Disbursement of the emergency response under Component 1 was quick, in keeping with the urgency of the financing needs. The other two components focusing, respectively, on rationalizing OMRs and supporting UHC, took longer to launch because they were dependent on analytical work and procurement of equipment.

Challenges during implementation were addressed in a timely manner through consultations between MoH and World Bank teams, the provision of technical assistance, and the recruitment of specialized staff. As reported in the ICR (pp. 26-27), challenges faced by MoH included: difficulties in identifying and maintaining essential PMU staff, especially delays in the recruitment of an M&E expert (during which time the existing PMU team covered those tasks) and in the replacement of a financial specialist (during which time the project relied on Ministry of Finance PMU staff); difficulties in making expected progress on UHC financing, because of a lack of clear agreement on long-term and comprehensive reforms related to the pooling and separation of financing functions; challenges associated with the interoperability and integration of digital systems and slower than anticipated buy-in of new systems by hospital staff and managers; irregularity of project Steering Committee meetings during the later years of the project; and lack of progress made on pooling functions, despite the successful setting up of the SPU within MoH.

Despite these challenges, the project achieved most of its targets, with two extensions. The first extension of 1.5 years (from June 2020 to December 31, 2021) allowed the completion of Government Health Insurance MIS-related activities, specialist training, SPU capacity building, and further strengthening of the e-referral system. It also supported MoH in its effort to combat and contain the COVID-19 outbreak, including the setting aside of US\$0.8 million under Component 2 to support procurement of top priority items, appropriately supportive of the resilience objective. A new, complementary COVID-19 emergency operation was rapidly prepared to



supplement this support, aimed at strengthening MoH capacity in prevention, early detection, and care. The second extension by an additional 5 months (from December 31, 2021 to May 31, 2022) enabled the processing of the final procurement packages and the finalization of disbursements for activities that were delayed due to MoH's focused response to the COVID-19 pandemic.

## 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 <input type="checkbox"/> Not Applicable
ICR Estimate		0	0 <input type="checkbox"/> Not Applicable

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

## 6. Outcome

The relevance of the PDO is rated **high**, as the project was responsive to country conditions and issues faced in the health sector today. The PDO was also closely aligned with the government's current sector priorities and with the Bank's current CPF for the West Bank and Gaza for FY22-25, issued in 2021. Efficacy is rated **substantial**, with Objective 1 (securing continuity in healthcare service delivery) and Objective 2 (building health sector resilience to withstand future surge in demand for effective healthcare coverage) both substantially achieved. Project efficiency is rated **substantial**. The ex-post economic analysis revealed that the project generated substantial economic returns, both in terms of savings generated from rationalized OMR and improved quality and efficiencies, and in terms of health benefits. Moreover, despite the challenges of the COVID-19 pandemic, MoH capacity constraints, and recurrent conflict and other contextual issues, project implementation was efficient overall. These ratings are indicative of minor shortcomings in the project's preparation, implementation, and achievement, leading to an Outcome rating of Satisfactory.

### a. Outcome Rating

Satisfactory

## 7. Risk to Development Outcome

**There is a considerable risk that project achievements may not be fully maintained, due to the volatility of the conflict situation, the prolonged economic crisis, and decreasing aid flow, and the impact of these factors on already inadequate financing for the sector.** The May 2021 conflict in



Gaza and contextual challenges have taken a toll on health infrastructure and human resources in the health sector. Added to these challenges are the prolonged economic crisis, the derailed peace process, and decreasing aid flow. The financial sustainability of the healthcare system remains at risk, despite the significant reductions in the rate of growth of expenditures on OMR. These referrals will continue to be needed, especially in light of the changes in demography and disease burden (increase in NCDs, which require long-term, specialized, and costly care). Tax revenues have been falling because of the economic crisis and, in the wake of COVID-19, resulting in limited fiscal space to bridge the financing gap of the Government Health Insurance. To sustain and scale up the outcomes of this project would require that MoH devise a more comprehensive reform plan with financial support from donors, along with continued domestic financing. A new Bank-financed operation was noted by the ICR (p. 33) to be under preparation, which would build on lessons of this project and contribute towards MoH's reform plans.

**Insufficient financing of the sector and inefficient use of available financing pose threats to the sustainability of project achievements and continued reform. The resolution of these issues will depend on improvements to Palestine's health financing system, including the reform of weak pooling and purchasing systems.** The health insurance system in WB&G, with its fragmented schemes and open entitlements, undermines health system sustainability, as there are no limits on services provided, particularly for OMR at private hospitals. Clear governance and accountability structures are sorely needed for the sector to be able to govern and control for different functions of health insurance, including enrollment and eligibility of beneficiaries, the collection of contributions and co-payments, and the purchase of health services. There is currently no centralized repository of information laying out the characteristics of each of the 13 insurance schemes in the Territory. The ICR (p. 33) reports that a health chapter in an ongoing Public Expenditure Review will draw on the lessons from this project and aim to update all existing analyses on health financing to inform improvements to the efficiency, equity, and sustainability of health financing in WB&G. This work will include deep analyses of the pooling and purchasing functions.

**Country commitment and capacity to sustain the project's outcomes are growing but will need continued financial and technical support.** PA's National Development Plan (2021-2023) provides a clear statement of government commitment to ensuring effective, efficient, quality, equitable, and citizen-centered healthcare services, and the importance of strengthening governance and efficiency of services and advancing the establishment of UHC to this end. Ensuring continuity and resilience of healthcare services are pivotal elements of government strategy, an important part of which are ongoing: the rationalization of OMR, the strengthening of pooling and purchasing functions, and the strengthening of sector stewardship. Project support to capacity building (of policymakers, health professionals and MoH technical staff) has helped the PA make important headway on these fronts and has rendered MoH better equipped to ensure that implementation of efficiency and equity measures continue, and that needed reform is undertaken. In short, the project has contributed to improvements in MoH's sector stewardship capacity. This in turn has helped pave the way toward increased donor confidence, whose technical and financial support are critical to the consolidation and sustainability of gains made under this project.

## 8. Assessment of Bank Performance

### a. Quality-at-Entry

**The project's design was informed by strategic goals and built on lessons learned from the Bank's long-term engagement in the sector.** Its design and goals were aligned with the World Bank's



Assistance Strategy for West Bank and Gaza 2015-16 and the World Bank's Regional MENA Health, Nutrition and Population Strategy. As such, the project was consistent with the Bank's twin goals (eradicating extreme poverty and boosting shared prosperity) and with two pillars in MENA's Regional Strategy (ensuring economic and social inclusion and strengthening governance). Stakeholder consultation (with authorities in WB&G, donors, partners, and NGOs) and efforts to align the project with national goals ensured its relevance to needs and priorities in WB&G, as laid out in national policy documents and expressed by national and local actors. The design of the project was informed by the Bank's previous engagement in the sector, particularly the Emergency Services Support Program and a series of analytical and advisory services implemented over the previous few years.

**The project's design was appropriate to the fragile, conflict-prone context of WB&G.** It was prepared within a short period, as an emergency operation, to address the immediate needs of healthcare delivery resulting from the conflict in Gaza. At the same time, it also sought to improve the untenable fiscal situation of the healthcare system (characterized by rapidly escalating costs, severe underfinancing, and inefficient use of available financial resources), which threatened to undermine sorely needed medium-term improvements in the quality and coverage of health services delivery and health outcomes. To this end, the design also supported preliminary steps in moving toward UHC and evidence-based health sector stewardship. The project design also incorporated poverty, equity, and inclusion elements, notably an outcome indicator to track reduction in inequities between West Bank and Gaza on the costs of individual referrals, and the tracking of the share of beneficiaries of OMR who are female. Conscious efforts were made to keep the project simple and flexible, given the fragile and unstable country context.

**Overall, project appraisal was thorough** in its coverage and assessment of economic and financial aspects, technical aspects, financial management, procurement, and social aspects, and in identifying needed implementation support to be provided by the Bank. Implementation arrangements were well prepared, for the most part. The risk assessment undertaken by the Bank during preparation raised the risk of insufficient capacity of MoH to implement the reforms because of budget constraints, limited technical capabilities, and fragmentation of the healthcare system. Proposed steps to mitigate these risks included support for capacity building of PMU staff on fiduciary activities and compliance, and the hiring of external technical consultants in coordination with other development partners. A project steering committee was set up to help oversee project implementation and results, ensure that all essential stakeholders were involved, and advise on corrective measures, as needed. No environmental or social safeguards were triggered, and no Adaptation and Mitigation of Climate Change Co-Benefits information was applicable to the project.

**While largely ready for implementation at effectiveness, there were two minor shortcomings at entry.** *First*, around the time of the 2017 mid-term review it became apparent that the design of Component 3 (supporting health coverage to strengthen sector resilience) was too broad and ambitious, given MoH capacity constraints and the country's volatile environment. This was also due to the lack of clear agreement on a long and comprehensive reform related to the pooling and separation of financing functions (January 17, 2018 Restructuring Paper p. 2). This shortcoming was addressed in early 2018 through a contract with WHO, working in collaboration with the Palestinian National Institute for Public Health, to support MoH in implementing Component 3 (Section 8.b). *Second*, M&E arrangements did not provide for an M&E expert to work in the PMU. Another M&E issue was the inadequacy of the initial PDO indicator to measure progress in rationalizing OMR, both in terms of the lack of solid baseline knowledge about the dynamics and trends in costs and in terms of the choice and definition of the measure. These shortcomings were understandable given the project's emergency design and the difficult context of the



Territory's intense conflict and violence; and they were addressed during implementation, as described below.

### Quality-at-Entry Rating Satisfactory

#### b. Quality of supervision

**During implementation, the project team provided close supervision and used the ISRs and accompanying aides-memoire to document and address the challenges faced and put implementation back on track.** The downgrading of ISR ratings in cases of delays or lack of progress prompted candid exchanges and the provision of technical advice and support to MoH to address and resolve issues. During the six-and-one-half-year implementation period, a total of 16 implementation support missions were conducted, on which aides-memoire were prepared and shared with MoH. A total of 18 ISRs were prepared, averaging almost three each year. Close follow-up and technical assistance, especially during late 2018 and 2019, addressed lags in implementation of activities to rationalize OMR, with activities put back on track and progressing as a result of the Bank's support and guidance. Supervision of fiduciary aspects of the project was regular.

**The Bank's team was also flexible and appropriate in adjusting project design during the course of implementation, when and where warranted.** *First*, the mid-term review, conducted in 2017, acknowledged that progress on the development of the Government Health Insurance MIS fell short of original expectations and that a full-fledged system could not be finalized under the project. The mission thus recommended a reduction in the scope of this activity, supporting an agile, phased approach, rather than aiming for the adoption of a full system. *Second*, progress on UHC reforms was also slow because of the lack of MoH technical capacity and lack of agreement on the longer-term, more comprehensive reform related to the separation of pooling and financing functions within the health insurance program. The project was restructured to support an alternate modality for implementation, through which MoH contracted WHO, which had been playing a leading role in the UHC agenda and possessed the required technical capacity. Under the contract, WHO enlisted the support of the PNIPH as an implementing agency to develop a UHC road map focusing on strengthening the evidence-based data of MoH in the areas of health financing, human resources for UHC, and the family practice approach. While the latter two were implemented, the health financing work was ultimately dropped due to lack of agreement on long-term reform of the health insurance program. *Third*, some of the saved and undisbursed funds under the project were reallocated to finance priority needs emerging from the COVID-19 pandemic and from the May 2021 escalation of conflict in Gaza, including the procurement of equipment, consumables, and information technology support to systems. Overall, the Bank's implementation support plan, combining technical support with the cutting back of overambitious elements of project design, was effective in mitigating significant technical and implementation capacity gaps within MoH, culminating in a satisfactory outcome. *Fourth*, the project navigated and adapted to an unpredictable donor environment following the Gaza crisis in 2014, marked by expected donor financing not materializing in a timely manner and the sudden stop of all United States Agency for International Development-funded projects in January 2019, which affected the continuity of work on the e-referral system.

**The task team ensured continuous dialogue, oversight, monitoring, and technical support.** Task Team Leaders (TTLs) were changed twice during the project lifecycle, and the transfers of responsibilities



between TTLs occurred smoothly during each transition. When the COVID-19 pandemic caused travel restrictions to be put in place, the Bank's team ensured ongoing supervision of technical and fiduciary aspects through regular virtual meetings.

### **Quality of Supervision Rating**

Satisfactory

### **Overall Bank Performance Rating**

Satisfactory

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

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

The project's theory of change, as laid out in the ICR (p. 9), captured well the project's dual nature of emergency support (supporting Objective 1: continuity in healthcare service delivery) and development support (supporting Objective 2: improved resilience of the health system). However, there were some missing links. For example, under Objective 1, the theory of change highlighted fuel and cleaning services for hospitals, and outcome indicators tracked three hospitals in Gaza and two in West Bank. However, p. 15 of the ICR notes that cleaning services were provided to 175 health facilities. It is not clear what kinds of health facilities these were, whether hospital-level, primary level, or both. Regarding Objective 2, the ICR provides the definition of resilience (p. 16, footnote 15) as "...the ability of the health system to improve fiscal sustainability through reduction in growth of OMR expenditures by improving local public hospital services, enhanced coverage, and cross-cutting efficiency measures, along with reduction in the inequity in referral costs between West Bank and Gaza." However, it is not clear what the results chain is for achieving: enhanced coverage or "improved access to a basic package of health, nutrition or reproductive health services," the latter listed as an output in the theory of change. It is also not clear in the theory of change what specific actions were needed to reduce the inequities in the costs of individual referrals between West Bank and Gaza, or what was the underlying cause of inequities being addressed. Enhanced quality of services was an important intermediate objective of the project, but it does not appear in the theory of change.

Indicators were for the most part specific, measurable, achievable, relevant, and time-bound. The utilization rates for outpatient, emergency, and obstetrics services in three major hospitals in Gaza and two in West Bank served as proxy indicators of hospital service continuity, under the assumption that the denominator (facility capacity) did not change over time. The original indicator tracking a reduction in the total cost of referrals was, by the team's own admission (ICR, p. 28), not based on reliable data or an understanding of the rapid growth of referral costs, and therefore not achievable. At the same time, IEG acknowledges that the Bank's team formulated the results framework to the best of its abilities in the context of an emergency response to a Territory in the midst of intense conflict and violence. Moreover, replacement of that indicator in 2018 with an indicator tracking reductions in the growth rate of referral expenditures was more straightforward and reflective of a better grasp of the baseline data and trends. The indicator measuring improved equity in individual referral expenditures between West Bank and Gaza is clear and useful.



The PMU was responsible for overall project M&E, with the support and involvement of relevant MoH departments. Among PMU responsibilities were the management of data collection, aggregation, and periodic reporting on implementation progress and close monitoring of the project's key performance indicators. Project monitoring was to include: (i) routine monitoring of activities against plans; (ii) a mid-term review to assess early results and effectiveness of activities; and (iii) periodic progress reports. Component 4 included M&E training.

The PMU maintained a simple M&E system for data collection and output and outcome monitoring to ensure proper monitoring, reporting, and evaluation. The project's support to improve the E-referral system and the Government Health Insurance MIS helped strengthen MoH governance capacity and also increased the PMU's ability to report on key project indicators. Over and above the absence of any M&E staff in the PMU, other shortcomings in M&E design, which were revealed during implementation (Section 9b), included a lack of clarity on data sources and definitions and low capacity to use the digital information system.

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

With support from selected MoH Departments (Health Information Center, Medical Referrals, Health Insurance, and Finance), the PMU complied with M&E requirements. It managed data collection, aggregation, and periodic reporting on progress. While it complied with the Grant Agreement's requirement to furnish progress reports no later than 45 days after the end of the period covered by each report, the mid-term review did recommend improvements to the quality of progress reports, especially with regard to the M&E (analytic) content. Initial challenges with data quality were caused by the absence of dedicated M&E staff and by delays in accessing data from the digital information system. To resolve this issue, the PMU worked with the SPU to clarify data sources and definitions and to obtain and verify any missing data from the digital information system. Additionally, the PMU contracted a health specialist to undertake project M&E, which led to improved quality of reports. Weaknesses in indicators were addressed during implementation, most notably the (above-cited) revision of the indicator to track reduced growth in the costs of OMR.

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

Data on project performance and results were used to inform project management and decision-making. Implementation supervision missions (including the mid-term review mission) drew on M&E data, which were used to inform project plans and amendments. For example, M&E data showed a lack of progress in Component 3 (supporting health coverage), which led to changes in design. M&E data also informed critical assessment and ratings of implementation progress and progress towards objectives and targets. M&E was also an important source of information for the project's technical steering committee, responsible for overseeing the project's technical aspects and keeping all stakeholders informed of progress. In addition, the Bank and MoH teams ensured the dissemination of M&E data and reporting to additional relevant stakeholders.

## **M&E Quality Rating**

Substantial



## 10. Other Issues

### a. Safeguards

The project followed World Bank procedure under safeguard policies. No Bank environmental or social safeguard policies were triggered. As a consequence, no safeguard documents were prepared or disclosed either during appraisal or during implementation. The environmental category of the project was classified as “C,” as it mainly focused on technical assistance and capacity building. As there were no civil works activities programmed under the project, no environmental or social safeguard issues were anticipated. It is significant to note that the ICR (p. 15) reports that the project’s support of cleaning activities in 175 health facilities showed substantial reduction in the accumulation of medical waste in critical units, preventing outbreaks in communicable disease. The ICR (p. 17) also reports that the training of 12 quality coordinators and infection prevention control specialists and of 491 hospital service providers – and the application of this training – culminated in significant reductions in device-associated (catheter and ventilator) infections and in surgical site infections.

While the PAD had not envisaged any environmental risks, some social risks were considered, including the likely pressure on the healthcare system to ensure coverage of the poor and marginalized and equity within the system. In response, MoH coordinated efforts with key stakeholders, including other PA ministries (Social Affairs and Labor), local NGOs, and development partners to ensure adequate coverage and equity. The M&E framework also included measures of equitable access.

The project also implemented communication activities to raise awareness on project activities, especially those addressing health insurance, referrals, and complaints channeled through the GRM. An MoH working group, drawing on members from relevant departments with the technical input of the MoH media unit, supported the production of media materials (posters, radio spots, videos, social media messages, stickers, magnets, and posters, among others). Messages were delivered through these means and materials, as well as through the MoH website, all with a view to promote citizens’ engagement.

### b. Fiduciary Compliance

**Financial Management (FM)** was judged to be satisfactory by the Bank at the time of project closing. Based on a sound assessment of FM capacity at the time of appraisal, FM arrangements were well established at the project’s outset. The PMU was staffed with a dedicated FM expert responsible for all FM aspects. The PMU had acquired considerable experience working on a previous World Bank-financed project (Third Emergency Services Support Project, closed in 2013), and its fiduciary management was further strengthened during implementation of the project. Internal control for the project was strong, and implementation procedures were outlined in a Project Operations Manual. The project was subject to an annual external audit, and all audit reports were submitted on time. In a follow-up email sent on July 3, 2023, the Bank’s team confirmed that these annual external audits were all unqualified, with no issues detected. A Financial Manual was prepared in 2015 to reflect financial procedures to be used for the project. A US Dollar Designated Account was opened at the Bank of Palestine (Ramallah), and World Bank funds were deposited into this account. The PMU ensured that the account was reconciled, and MoH requested needed funding through the submission of Withdrawal Applications. The PMU checked, monitored, and cleared project deliverables before processing any payment, and the PMU followed the



required formal PA procedures for payment approval. Quarterly internal financial reports were prepared and submitted on a timely basis, reviewed and cleared by the PMU. After Bank clearance of these reports, they were published on the Bank’s website. The final audit (covering January 1, 2022 to September 30, 2022) was finalized and shared with the Bank.

**Procurement** performance was also rated satisfactory at the close of the project. Procurement was carried out in accordance with the Bank’s Procurement Guidelines, published by the World Bank in January 2011 and revised in July 2014. The PMU had a dedicated Procurement Specialist on its staff, with significant experience in procurement under World Bank-financed projects. Procurement plans were prepared and updated regularly by the Procurement Specialist, using the STEP system, and were consistently cleared by the World Bank. The project also supported contracting with a United Nations agency (WHO) for technical assistance on some activities falling under Component 3, which supported improved health coverage. During the project’s life, six ex-post procurement reviews were conducted by the Bank, the latest carried out in April 2022 on six contracts awarded between November 2020 and March 2022. No indication of possible governance issues or non-compliance was observed in any of these reviews.

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

**Mobilization of Private Sector Financing.** The commitment of MoH to reduce OMR to other countries led to opportunities for the private sector hospitals in WB&G to provide tertiary level healthcare services. Efforts to limit referrals outside the Palestinian Territory led to spillover demand, and private sector hospitals in WB&G have invested in improving their capacity to deliver tertiary care. For example, some private hospitals in the West Bank and hospitals of the East Jerusalem Hospital Network (like Augusta Victoria Hospital) have invested in building up their diagnostic and treatment capacity for cardiac and cancer cases.

**d. Other**

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**11. Ratings**

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Satisfactory	Satisfactory	
Bank Performance	Satisfactory	Satisfactory	
Quality of M&E	Modest	Substantial	There were shortcomings in design, but most of these were recognized and fixed during implementation, providing a sufficient basis to assess efficacy.
Quality of ICR	---	Substantial	



## 12. Lessons

The following lessons are a subset of the six relevant and insightful lessons presented in the ICR, slightly reworded by IEG.

**In FCV settings like WB&G, it is prudent to keep project design and technical components as simple and flexible as possible.** The project's success was due in part to its simple and flexible design. The emergency support under the project not only helped address the acute needs of healthcare services in Gaza, but also enabled a quick response to the COVID-19 pandemic, without the need for restructuring. The direct contracting with WHO in support of Component 3 (building blocks for UHC), introduced during implementation to simplify Component 3, facilitated the provision of timely inputs and technical expertise.

**Project support of evidence-based health sector reform is a complex undertaking, especially in an FCV setting, requiring due attention to contextual factors, including political economy, limited capacity, stakeholder involvement, and the need for a phased approach, aligned with country readiness to fully articulate, adopt and implement.** Experience under this project has revealed the wisdom of: (i) ensuring a robust understanding of country context and dynamics; (ii) providing adequate funding and a roadmap for capacity building; (iii) remaining flexible to respond to a dynamic situation; (iv) focusing on harmonization of donors' work on governance and reform; and (v) understanding the critical path and dynamics of health system strengthening. Starting with relatively straightforward management systems and reforms and postponing the introduction of more complex systems to a later phase allows the rollout of reforms incrementally at a pace that permits institutions to absorb and integrate new systems, before moving on to subsequent phases.

**It is feasible – and desirable – for an emergency operation to address acute healthcare delivery needs in times of crisis, while at the same time supporting critical components of health sector development, even in an FCV context.** This project succeeded in achieving both its emergency objective (continuity of healthcare services) and its development objective (strengthening sector resilience through rationalizing OMR, improving equity of referral expenditures, and building systems and capacities for moving toward affordable UHC through primary health care). Indeed, the COVID-19 pandemic, unforeseen at the time of project design, has validated the project's focus on strengthening health system resilience, especially: (i) addressing health financing challenges and reducing unsustainable health expenditures; (ii) building a foundation for strong primary health care; (iii) increasing domestic investment in the health system; and (iv) addressing inequities in healthcare access and health outcomes of marginalized populations.

**Supporting health reforms requires a combination of consistent financing, technical assistance, and a whole-of-government approach.** The World Bank, through its in-country and HQ-based staff, along with external consultants, provided consistent technical support throughout project implementation. The project also engaged partners, donors and NGOs during design and implementation. Experience under this project has pointed to the desirability of engaging stakeholders from the wider government, beyond MoH, to ensure broader political support. In retrospect, the fuller engagement of Ministry of Finance and the Prime Minister's office may have broadened and strengthened political support for sector reform. Sharing the project's achievements



to a wider range of actors and stakeholders might be an effective way of expanding reform buy-in, demonstrating how seemingly intractable challenges can be addressed, even in difficult contexts.

### 13. Assessment Recommended?

No

### 14. Comments on Quality of ICR

**Quality of Evidence.** Evidence provided was largely credible and sufficiently detailed, but there were a few exceptions. The ICR provided no breakdown of beneficiaries of essential health, nutrition and reproductive health services. (These were subsequently provided by the Bank's team in a supplemental note, but there were still questions on who the beneficiaries were and what services were provided). Labeling of indicators was not always clear. For example, Annex 1, p. 42, reports that 46 percent of beneficiaries were female, without specifying beneficiaries of what. A footnote in the main text notes that 46 percent of beneficiaries of OMR were female, but the ICR does not report on the total number of OMR beneficiaries. Another example is the conflicting labels of children vaccinated (see Section 4).

**Quality of Analysis and Results Orientation.** The ICR's narrative on efficacy was well presented and informative overall, backed up by systematic tallies of performance of output and outcome targets. However, there were some weaknesses in its assessment of some elements of the results chain. This is likely due to some issues in the theory of change (see Section 9). For example, the results chain of support to UHC and its effect on the uptake of maternal and child health services (immunization) is not clear.

**Quality of Lessons.** The ICR provided insightful lessons, firmly grounded in project performance and experiences, which should be of broader interest to other FCV countries supporting emergency activities and/or broader capacity development and sector reform.

**Internal Consistency/adherence to guidelines.** The ICR adhered to guidelines, connecting various elements of the evaluation to provide an informative narrative, capturing outcomes and lessons in an extremely challenging country context.

#### a. Quality of ICR Rating

Substantial

