Report Number : ICRR0023354

1. Project Data

Project ID P123531	**Program Name** ET - Health SDG Program for Results
Country Ethiopia	**Practice Area(Lead)** Health, Nutrition & Population

L/C/TF Number(s)	Closing Date (Original)	Total Program Cost (USD)
IDA-52090,IDA-60900,TF-14107,TF-A4689,TF-A4705	30-Jun-2018	349,451,099.76

Bank Approval Date	Closing Date (Actual)
28-Feb-2013	30-Jun-2022

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	100,000,000.00	100,000,000.00
Revised Commitment	350,000,000.00	100,000,000.00
Actual	349,483,302.54	99,259,658.85

Prepared by	Reviewed by	ICR Review Coordinator	Group
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2. Program Context and Development Objectives

a. Objectives

The objective of the program was to improve the delivery and use of a comprehensive package of maternal and child health services (Financing Agreement, March 29, 2013, p. 6).

During the implementation period, some associated outcome targets were revised upward.

b. Were the program 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
20-Apr-2017

c. Will a split evaluation be undertaken?
No

d. Components

Program scope and boundaries. The Financing Agreement clarified that the program targeted certain MDG-relevant results and comprised of high priority activities that constituted a sub-set of the country's Fourth Health Sector Development Program (HSDP IV). The program was planned to support activities related to the Millennium Development Goal Performance Fund (MDGPF) under HSDP IV with the exception of high-value procurement. Costs are discussed in section 2e, below. The PforR was harmonized with MDGPF: both had a common scope, one core plan and one program using country systems, common reporting, and a common mechanism for handling corruption (PAD, p. 16). The ICR stated that program boundaries remained the same during the implementation period, but the Task Team clarified that Civil Registration and Vital Statistics activities that were introduced by the 2017 additional financing extended beyond the initial boundaries of MDGPF (Task Team clarifications, March 21, 2023).

Program content and results areas. At entry, program activities aimed at advancing results in the following three priority areas (PAD, p. 15):

1. **Accelerating progress toward maternal health:** supplying equipment and commodities for providing emergency obstetric care; supplying contraceptives; providing ambulances to all woredas; in-service training of midwives; training of Health Officers in Emergency Surgical and Obstetric Skills; and capacity building of health extension workers in clean and safe delivery.
2. **Sustaining gains made in child health:** strengthening of cold chain systems; supplying vaccines; holding immunization campaigns; and supplying bed nets.
3. **Strengthening health systems:** constructing health centers; supplying essential medical products and equipment; validating the Health Management Information System (HMIS) data semi-annually; and undertaking surveys and studies.

An additional financing in 2017 expanded the scope and scale of the operation and **introduced an Investment Project Financing (IPF) Component (**US$21 million) to address two critical areas of need: (a) strengthening the Civil Registration and Vital Statistics System (CRVS) which is essential to providing key maternal and child health information; monitoring underage marriages; and developing a modern system of identification; and (b) provision of complementary capacity building and technical assistance to further strengthen program implementation. The IPF component had three sub-components (ICR, p. 12):

- Sub-Component 1: **Civil registration** at the Federal Vital Events Registration Agency to build the CRVS system through technical assistance and procurement of equipment;
- Sub-Component 2: **Technical Assistance and Capacity Building of the National Nutrition Program II** in various areas, including multisectoral coordination, evaluation and identifying lessons learned; and
- Sub-Component 3: to support **fiduciary management** at Pharmaceuticals Fund and Supply Agency (PFSA) and MOH; implementation of the national **Health Care Financing Strategy**; and **data and management information systems and surveys**.

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

The overall HSDP IV financing envelope was estimated at US$4,610 million for the period 2013-2018. Within HSDP IV, the PforR operation was planned to support activities under MDGPF (explained above in 2d), also known as MDG Fund, estimated at about US$676 million during the same period. The MDG Fund was subsequently renamed as Sustainable Development Goals Performance Fund (SDGPF).

The original World Bank contribution to the MDG Fund was estimated at US$100 million as an IDA Credit complemented by a grant of US$20 million from the Health Results Innovation Trust Fund (HRITF). The majority of expenditures under MDGPF would be made at the federal level, with goods and services transferred in-kind to subnational levels according to criteria related to the disease burden and assessed needs. Government wage costs were not included in the MDGPF. Other development partners contributing to MDGPF included DFID, PEPFAR, Netherlands, Australian AID, Spanish Development Cooperation, Irish Aid, Italian Cooperation, and several UN agencies such as UNICEF, UNFPA, and WHO.

On April 20, 2017, an additional financing of US$230 million was provided to scale up activities and technical assistance. It consisted of an IDA Credit of US$150 million, a grant of US$60 million from the Global Financing Facility, and another grant of US$20 million from the Power of Nutrition Trust Fund. The additional financing included an IPF component and an extension of closing date to June 30, 2021.

Program restructuring dates were as follows:

- April 20, 2017: Additional financing and extension of the closing date as noted above.
- April 21, 2020: Change in implementation arrangements.
- April 15, 2021: Change in data sources for verification to DHS in view of COVID-19 pandemic disruptions, and change in closing date to December 31, 2021.
- October 18, 2021: Changes in data sources for verification.
- December 13, 2021: Extension of the closing date to March 30, 2022.
- March 28, 2022: Extension of the closing date to June 30, 2022.

All credit and grant proceeds were disbursed and the actual program cost was US$349.5 million.

3. Relevance

a. Relevance of Objectives

Rationale

Responsiveness to the country context. During the years prior to appraisal, Ethiopia experienced strong economic growth and progress in human development. The country's Health Sector Development Program (HSDP) started in 1996 and provided the overarching strategic framework for the sector to make health gains. The World Bank was closely engaged with HSDP from its inception. Specifically, the World Bank supported HSDP through the Protection of Basic Services Program (PBS) that was also supported by development partners through a programmatic approach that covered several sectors supporting human development, namely education, health, water and agriculture. At appraisal, Ethiopia was implementing its fourth round of HSDP (HSDP IV) covering the period 2011-2015. Despite progress made, significant challenges remained. The maternal mortality ratio persisted at 676 per 100,000 live births, and under-5 mortality was at 88 per 1,000 live births.

Country capacity and adequacy of the PforR instrument. Overall, the PforR instrument was a good fit for supporting the Government's well-defined HSDP framework. The health sector was recognized as one of the better performing sectors in the country and the Government decided to use it to test the PforR instrument, as there was a growing need to enhance accountability and to generate more attention to results (PAD, pp. 11-12). At the same time, there were some limitations to the use of the instrument for tackling some specific technical areas that were addressed by the addition of an IPF component in 2017 (see section 2d).

Alignment with Bank strategy. Program objectives remained fully relevant to the Country Partnership Framework (CPF FY18-22) at program closing. There was also alignment between the CPF and key country strategies, namely the Government's Growth and Transformation Plan (GTP II) and the Second Health Sector Transformation Plan (HSTP II). Program objectives were aligned with CPF Focus Area 2 on Building Resilience and Inclusiveness, specifically with CPF Objective 2.2 on improved equity and utilization of quality health services. The CPF highlighted in its intervention logic that World Bank Group operations were to address critical constraints (related to CPF Objective 2.2) by improving equity, utilization and quality of health services, particularly maternal and child health care, in support of HSTP. There were similarities in indicators used by CPF Objective 2.2 and those of the PforR Program: improved geographic equity in health service delivery outcomes, based on Pentavalent 3 Vaccine for the bottom 20% of the lowest-performing woredas; proportion of women in rural areas using a modern method of contraception; and deliveries attended by skilled birth providers as a Supplementary Progress Indicator.

Rating

High

b. Relevance of DLIs

DLI 1

DLI
Deliveries attended by skilled birth provider (%)

Rationale
This DLI/Indicator would incentivize and measure the health system's ability to provide sufficient care during birth. It is used as a proxy for access to health services and maternal care, i.e., for health service coverage. Having a skilled health care provider at the time of childbirth can be a lifesaving intervention for both women and newborns. Not having such access could contribute to the death of women and/or newborns or to long lasting morbidity. On its own, this indicator does not capture the quality of care received, but it remains a much better option than the alternative. The DLI was well aligned with the PDO.

Rating
High

DLI 2

DLI
Children 12-23 months immunized with Pentavalent vaccine (%)

Rationale
The DLI/Indicator consisted of the percentage of children under 2 who received three doses of the pentavalent vaccine that combined the main childhood vaccines. It adequately reflected service coverage. Monitoring and incentivizing national and subnational coverage levels are critical to help countries in tailoring vaccination strategies and operational plans to address immunization gaps.

Rating
High

DLI 3

DLI
Pregnant women receiving at least one antenatal care vist (%)

Rationale
This DLI/Indicator reflected access and use of health care during pregnancy. The antenatal period presents opportunities for reaching pregnant women with interventions that may be vital to their health and wellbeing and that of their infants. It is one of the tracer indicators of health services for the universal health coverage.

However, one visit is not sufficient to ensure effectiveness. The usual norm consists of at least four visits.

Rating

Modest

DLI 3 REVISION 1

Revised DLI

Pregnant women receiving at least four antenatal care visits (%)

Revised Rationale

The revised DLI was in line with globally recommended practices. Under normal circumstances, a pregnant woman should have at least four antenatal visits. In addition to screening and identification of risk factors, women learn about healthy behaviors and warning signs during pregnancy, and they receive social, emotional and psychological support. Through antenatal care, pregnant women can access micronutrient supplementation, treatment for hypertension to prevent eclampsia, as well as immunization against tetanus. Antenatal care can also provide HIV testing and medications to prevent mother-to-child transmission of HIV. In areas where malaria is endemic, health personnel can provide pregnant women with medications and insecticide-treated mosquito nets to help in preventing the disease.

Revised Rating

High

DLI 4

DLI

Contraceptive prevalence rate (%)

Rationale

The percentage of women aged 15-49 years, married or in-union, who are currently using, or whose sexual partner is using, at least one method of contraception. It is an indicator of health, population, development and women's empowerment. It serves as a proxy measure of access to reproductive health services.

Rating

High

DLI 4 REVISION 1

Revised DLI

Contraceptive prevalence rate in rural areas (%)

Revised Rationale

The revised DLI aimed at providing an added focus to improving delivery and use of contraceptives in underserved rural areas.

Revised Rating
High

DLI 5

DLI
Health centers reporting HMIS data on time (%)

Rationale

The DLI/Indicator would contribute to timely reporting within the larger context of health system strengthening

Rating
Substantial

DLI 6

DLI
Develop and implement of a balanced score card approach

Rationale
This DLI/Indicator would contribute to health system strengthening, as it reflected coverage and utilization aspects, including availability of key inputs such as commodities, staff, regularity of supervision, and compliance with standard protocols. Institutions receiving performance incentives would have autonomy to decide how to use the incentives received. According to the PAD (p. 21), testing this approach was to be carried out in three representative regions (agrarian, pastoral and urban) over a period of two years, followed by an evaluation before taking a decision on further scale-up. However, since Federal Ministry of Health (FMOH) was keen to implement the score card in view of its likely benefits, this tool was rolled out nationwide, and the DLI was dropped.

Rating
High

DLI 7

DLI
Develop and implement Annual Rapid Facility Assessment

Rationale
The DLI/Indicator would contribute to health system strengthening.

Rating
Substantial

DLI 8

DLI
Transparency of Pharmaceutical Fund and Supply Agency procurement process

Rationale
The DLI/Indicator pertained to health system strengthening, Related information was to be disclosed online.

Rating
Substantial

DLI 9

DLI
DLI 9(1): Introduction of Procurement Key Performance Indicators developed by Federal Procurement Agency at PFSA
DLI 9(2): Automate the PFSA core business fiduciary system using Selected Software in PFSA HQ and Addis Ababa City
DLI 9(3): PFSA submission of backlog audit reports and timely quality audit reports thereafter

Rationale
To track and improve performance in procurement processes in the context of health system strengthening.

Rating
Substantial

DLI 10

DLI
DLI 10a: Children 6-59 months receiving vitamin A supplements; and
DLI 10b: Woredas in non-emerging regions delivering Vitamin A supplements to children

Rationale
The two related DLIs were added in 2017 to focus greater attention on child health and nutrition. The DLI for children receiving vitamin A supplements reflected the proportion of children aged 6–59 months who received two age-appropriate doses of vitamin A supplements in the last 12 months. It measured the coverage achieved through national vitamin A supplementation efforts in a specified period. Vitamin A deficiency is a major public health problem in developing countries, and the lack of vitamin A causes visual impairment, blindness, and significantly increases the risk of severe illness and death from common childhood infections such as diarrheal disease and measles. Supplementation as a control strategy for Vitamin A deficiency is the most immediate and direct approach to improving vitamin A status and the one most widely implemented globally. Programs to control vitamin A deficiency enhance children's chances of survival, reduce the severity of childhood illnesses, ease the strain on health systems and hospitals and contribute to the well-being of children, their families and communities.

Rating
High

DLI 11
DLI
Pregnant women taking iron and folic acid tablets

Rationale
The DLI was added in 2017 to focus greater attention on maternal health and nutrition. The DLI/Indicator usually reflects women's access to these core supplements and also reflects qualitative aspects of ante natal care. Iron deficiency is a common nutrient deficiency and the resulting iron deficiency anemia is a major contributor to the global burden of disease. Iron supplementation is universally recommended during the second and third trimesters of pregnancy

Rating
High

DLI 12
DLI
DLI 12a: Children 0-23 months participating in Growth Monitoring and Promotion
DLI 12b: Percent of woredas in emerging regions transitioning from Enhanced Outreach Services to Community Health Days
DLI 12.1: Conduct catch up campaigns to increase the uptake of essential health and nutrition services, including Vitamin A, deworming, and nutrition screening, in security-constrained contexts

Rationale
To focus greater attention on child health and nutrition. DLI 12.1 was added to mitigate the impact of the COVID-19 pandemic and the deteriorating security situation.

Rating
High

DLI 13
DLI
DLI 13 (1): PHC facilities having all drugs from MOH list of essential drugs available
DLI 13(2): Develop and implement postnatal care services directive to improve the quality of postnatal services
DLI 13 (3): Improve the quality of adolescent health services

Rationale
DLI 13(1) was intended to monitor and track drug availability that was critical for both maternal and child health services.

DLI 13(2) was intended to improve the management of maternal health services.

DLI 13 (3) was added with the focus on the 'A' as part of the Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) agenda.

Rating
Substantial

DLI 14
DLI
DLI 14(1): Woredas with functional Community-Based Health Insurance schemes
DLI 14(2): Undertake Community-based Health Insurance scheme reviews every two years

Rationale
DLI 14(1) was to focus attention on lowering out of pocket spending.

DLI 14(2) was to track and monitor progress in expanding financial protection.

Rating
Substantial

DLI 15

DLI
Devise and implement a mechanism for documenting consultations when communal/private land is used for construction of health facilities

Rationale
DLI 15 was added to establish a process to facilitate community involvement and consultations.

Rating
Substantial

OVERALL RELEVANCE RATING

Rationale
Relevance of objectives was rated high, as program objectives were fully relevant to the country context, government plans, and the Country Partnership Framework at program closing.

Relevance of DLIs was rated substantial, as DLIs constituted the right triggers and incentives for promoting the use of maternal and child health services, but with some shortcomings in the quality elements of DLIs and extent of alignment with the PDO. Also, as the stated PDO was to improve the use of a comprehensive package of maternal and child health services, this ICR Review expected that DLIs that would advance nutrition results would have been included at the outset since improving the nutritional status of women and children is an integral part of such a comprehensive package. Nutrition DLIs were added only in 2017 in conjunction with the additional financing. The Task Team stated on March 21, 2023 that the thinking during preparation was that nutrition did not need to stand as a separate outcome since access to nutrition services was integrated in ante-natal care services.

The aggregation of both dimensions is consistent with a substantial rating for overall relevance.

Rating
Substantial

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective

Improve the delivery and use of a comprehensive package of maternal and child health services

Rationale

The theory of change held that:

- *Activities that accelerate progress in maternal health MDGs*, mainly the supply of equipment and commodities for provision of emergency obstetric care; supply of contraceptives; provision of ambulances to all woredas; in-service training of midwives and Health Officers in Emergency Surgical and Obstetric skills; and capacity building of health extension workers in clean and safe delivery would result in the following outputs and intermediate results: Health centers offering basic emergency obstetric care; woredas have functional ambulance services; midwives with in-service training; and health officers trained in emergency surgical and obstetric care.

- *Activities that sustain gains made in child health,* including strengthening cold chain system; supply of vaccines; immunization campaigns; and supply of bed-nets would result in the following outputs and intermediate results: Health centers have functional cold chain equipment; outreach campaigns undertaken; long lasting insecticidal nets distributed; Growth Monitoring and Promotion activities undertaken; woredas having Community Health Days; immunization campaigns and catch-up campaigns.

- *Activities that strengthen health systems,* including building health centers, supplying essential medical products and equipment, validating HMIS semi-annually; improving transparency in procurement processes, implementation of a Balanced Score Card to assess performance and related institutional-incentives, and undertaking surveys and studies;

-- and that, collectively, the above outputs and intermediate results would plausibly lead to improved delivery and use of a package of maternal and child health services.

Outputs and Intermediate results

The number of service encounters for people who received essential health, nutrition, and population services was 103.6 million in 2023 in 2022, exceeding the target of 88.9 million services. Among the beneficiaries, there were 61.3 million service encounters for females, exceeding the target of 45.1 million.

The number of children immunized was 3.2 million children in 2022, exceeding the target of 2.2 million children for that year.

The number of deliveries attended by skilled health personnel was 2.2 million deliveries in 2022, exceeding the target of 1.2 million deliveries for that year.

The percentage of PHC facilities having all drugs from MOH list of drugs available increased from a baseline of 42 percent in 2016 to 48 percent in 2022, exceeding the target of 47 percent.

Health Centers reporting HMIS data on time increased from a baseline of 50 percent in 2012 to 96 percent in 2022, exceeding the target of 86 percent.

The proportion of woredas that had a nutrition coordination platform and reporting multisectoral nutrition information to the national level was 42 percent in 2022, short of the target of 60 percent.

The percentage of kebeles storing and transferring registration forms safely attained 68 percent, short of the target of 80 percent.

The percentage of births occurring in a given year that were registered attained 20.9 percent in 2022, short of the target of 40 percent registration. The ICR reported that the COVID-19 pandemic and conflict in the country disrupted the registration process.

Outcomes

Data showed a considerable level of improvement in the delivery and use of maternal and child health services. While it was difficult to establish an airtight counterfactual as the basis for attributing outcomes to the PforR that supported large-scale and multi-faceted interventions, the likelihood of incremental contribution made by the program to observed outcomes was bolstered by the strength of the logical results chain and by the absence of major factors outside the PforR program that might raise doubt about its contributory role.

Deliveries attended by skilled birth providers increased from a baseline of 10 percent in 2012 to 50 percent in 2022, exceeding the original target of 18 percent and the revised target of 40 percent. In a larger context, the results remained below the regional average of 61 percent. Deliveries attended by skilled birth providers for the bottom three performing regions of Afar, Oromia and Somali increased from a baseline of 19 percent in 2016 to 33.4 percent in 2022, surpassing the end target of 28 percent.

Progress in the delivery and use of antenatal care was also strong in terms of the percentage of pregnant women receiving at least four antenatal care visits, as the rate increased from a baseline of 32 percent in 2016 to 43 percent in 2022, exceeding the end target of 38 percent.

The contraceptive prevalence rate increased from a baseline of 27.3 percent in 2012 to 35.9 percent in 2022, exceeding the program target of 35 percent. The contraceptive prevalence rate in rural areas increased from 32 percent in 2016 to 37.5 percent in 2019, essentially meeting the target of 38 percent.

The percentage of pregnant women taking iron and folic acid supplements increased from a baseline of 42.1 percent in 2016 to 60 percent in 2022, exceeding the target of 50 percent.

The percentage of children 12-23 months who were immunized with Pentavalent 3 vaccine increased from a baseline of 65.7 in 2012 to 81.3 percent in 2022, exceeding the target of 75.7 percent.

The percentage of woredas in emerging regions (i.e., Somali, Afar, Benishangul-Gumuz, and Gambela), which are characterized by predominantly pastoralist populations living in extreme poverty and having limited access to health services, transitioning from Enhanced Outreach Services (conducted twice yearly) to Community Health Days (conducted quarterly), rose from zero in 2016 to 89 percent in 2022, surpassing the end of program target of 50 percent. These campaign-style events, designed to increase coverage of vitamin

A supplementation and other child health services, were effective in delivering services to dispersed and predominantly rural populations.

The percentage of woredas in non-emerging regions (i.e., Amhara, Oromia, Harari, Southern Nations Nationalities and People's Region, Tigray) delivering vitamin A supplements to children increased from 48 percent in 2016 to 100 percent in 2020, surpassing the target of 80 percent.

The percentage of children 0-23 months participating in Growth Monitoring and Promotion improved significantly from a baseline of 38 percent in 2016 to 54 percent in 2019.

Rating
High

OVERALL EFFICACY

Rationale
The program achieved its objective to improve the delivery and use of a comprehensive package of maternal and child health services, and exceeded its targets.

Rating
High

5. Outcome

Relevance is rated substantial, encompassing high relevance of program objectives and substantial relevance of DLIs. Efficacy is rated high, as the operation fully achieved its objectives and exceeded its intended outcomes. These findings are consistent with a satisfactory outcome rating.

Outcome Rating
Satisfactory

6. Risk to Development Outcome

The risk that development outcome may not be maintained is largely related to exogenous factors arising from a continued insecurity situation. The ICR (p. 30) reported that the conflict in Tigray, Amhara, and Afar regions is of particular concern as it has resulted in millions of internally displaced persons and significant

disruptions in essential health services. Also, capacity constraints persist in a large and complex devolved health system. An unfinished maternal and child health agenda remains despite the remarkable progress made. It requires sustained efforts, including for addressing disparities in access to quality health services across regions and in financial protection. To this end, a follow-on operation has been approved to support the government in maintaining gains, accelerating further progress, and providing targeted support for vulnerable groups and internally displaced persons in conflict-affected regions. The ICR (p. 22) reported that this follow-on operation titled “Ethiopia Health PforR (Hybrid) Strengthening Primary Health Care Services (P175167” was approved by the Board on December 13, 2022. The ICR also stated (p. 31) that the operation included an investment project financing component that would be key for providing targeted support for vulnerable groups and internally displaced persons.

7. Assessment of Bank Performance

a. Quality-at-Entry

The overall approach of the operation was sound and built on HSPD IV that provided the strategic framework for health interventions. HSPD IV also benefited from harmonized support among Ethiopia's development partners in the health sector (PAD, p. 12). Program implementation arrangements were based on existing institutional and implementation mechanisms of HSDP IV that were in line with Ethiopia's decentralized federal structure with shared responsibility between the Federal Ministry of Health (FMOH), Regional Health Bureaus, and Woreda Health Offices (PAD, p. 20).

FMOH was responsible for overall planning and budgeting, supported by its Directorates. The Pharmaceutical Fund and Supply Agency (PFSA) under FMOH was responsible for procurement of health sector goods while the Policy Planning and Finance General Directorate, the Human Resources Development Directorate and the Health Infrastructure Directorate were responsible for procuring services, consultancies and works. There was a dedicated project management unit (PMU) under the Health Infrastructure Directorate that supported facility expansion from the federal level, including for the provision of technical assistance for civil works in the regions. Nine Regional Health Bureaus and two city administrations were responsible for planning and programming in their respective areas. The Woreda Health Offices would manage primary health care delivery within their jurisdictions. Regional Health Bureaus would provide technical support to the woredas.

A Joint Consultative Forum chaired by the Minister of Health and co-chaired by one of the partners in the sector was the highest body for dialogue on sector policy and reform issues between the Government of Ethiopia, its partners and stakeholders. A Joint Core Coordinating Committee chaired by the Director General was the technical arm of the Joint Consultative Forum, and would provide operational oversight for the implementation of all pooled funds provided by partners to the health sector.

M&E arrangements for reporting on DLIs would use the HSDP IV systems complemented by household and health facility surveys (PAD, p. 21). The PforR would also support the strengthening of the Health Management Information System.

The program preparation teams selected two groups of DLIs: maternal and child services DLIs at the outcome level; and health system DLIs that were process-oriented, i.e., intermediate results level. DLIs were chosen using the following criteria: (a) evidence of their contribution to MDGs; (b) under the span of

control of government; (c) achievable in the time-frame being considered; and (d) objectively measurable and verifiable. DLI targets were established based on global experience (PAD, p. 18).

The World Bank Task Team worked collaboratively with government counterparts to guide program design and coordination. The Bank Team benefitted from broad-based support from within the World Bank, including advice from OPCS. A Quality Enhancement Review was conducted in July 2012 and its recommendations were addressed in the design. The Quality Enhancement Review reportedly commended the relevance and clarity of DLIs (ICR, p. 29).

The PforR assessments were strong, including technical, macroeconomic, fiduciary, environmental and social assessments. Risks were adequately identified with appropriate mitigation measures. Preparation required considerable dialogue with other development partners who were providing larger amounts of grant funding. The operation was in an advanced state of implementation readiness. As a minor shortcoming, the ICR reported that, while there was adequate focus on supply-side impediments, additional attention could have been provided to demand-side barriers. Health extension workers were already providing extensive support in this area, and there was an assumption that all service providers would be incentivized to fully address demand-side aspects.

Quality-at-Entry Rating
Satisfactory

b. Quality of supervision
The Bank Task Team conducted, jointly with government counterparts, regular supervision and implementation support missions, and produced high quality, comprehensive, and timely Aide Memoires and Implementation Status Reports (ICR, p. 30). The program was supervised by three different task teams for nearly a decade, and transitions were reportedly seamless. The Task Team provided timely advice and support, and was proactive in assisting the Borrower to keep the program on track. It was responsive to introducing program amendments and extending the closing date when required. The additional financing was prepared in a timely manner (ICR, p. 30). The quality of Bank supervision and implementation support was acknowledged by the main stakeholders. The Team further enhanced its technical and implementation support during the last two years of implementation when challenges were faced due to the COVID-19 pandemic and the security situation. During the ICR mission in August 2022, both Government counterparts and development partners expressed satisfaction with the support provided by the World Bank.

Quality of Supervision Rating
Satisfactory

Overall Bank Performance Rating
Satisfactory

8. M&E Design, Implementation, & Utilization

a. M&E Design

The objective of the program was clearly stated and reflected by the selected indicators. M&E arrangements were well embedded institutionally and would use HSDP IV information system complemented by household and health facility surveys (p. 21). For population-based surveys, the program would utilize the reliable data of the Demographic and Health Survey whose implementation is coordinated by the Central Statistical Agency, an entity independent of FMOH. The provision of data would be coordinated by FMOH and the Ethiopian Health and Nutrition Research Institute, assisted by the Gates Foundation, UNICEF and WHO. The PforR was planned to support ongoing government efforts to further strengthen HMIS.

b. M&E Implementation

M&E Implementation was adequate overall, but with challenges encountered during the latter years of implementation in view of the COVID-19 pandemic combined with security concerns that made population-based surveys more challenging. The balanced score card was dropped because the scheme was replicated nationwide at an early stage (ICR, p. 27). Regular reporting facilitated verification processes and disbursements.

There were other surveys and studies conducted during the life of the program and they provided policymakers with valuable information for decision making, such as the nutrition reports with a wide range of data and recommendations for improving interventions supported by the program, e.g., Iron Folic Acid utilization, Vitamin A supplementation, and Growth Monitoring and Promotion.

c. M&E Utilization

M&E findings were used for program monitoring, including to: (i) take stock of progress on DLIs and identify remedial actions if needed; (ii) identify areas requiring technical assistance; (iii) hold consultations between national and state authorities to identify strategic priorities and targets; and (iv) re-orient health sector strategies toward addressing key gaps (i.e., quality, equity, financial protection and disruptions in service delivery). Evidence-based Joint Reviews were organized to assist partners to leverage the comparative advantage of each agency in mobilizing support. National authorities worked with regional and local stakeholders on an annual basis to address emerging issues and bottlenecks. Nevertheless, the ICR (p. 27) reported that more could have been done to systematically share M&E findings with authorities at decentralized levels.

M&E Quality Rating

Substantial

9. Other Issues

a. Safeguards

During preparation, the Team conducted an Environment and Social Systems Assessment (ESSA) to assess, against the requirements of OP/BP 9.00, the degree to which the program systems would manage and mitigate the environmental and social impacts of the overall program. The ESSA rated overall risks as moderate, with a potential adverse effect related to the generation of medical waste and improper disposal. An action plan was designed to address related weaknesses, and included measures to enhance capacity, establish infection prevention, set up patient safety committees, improve public and worker safety, and document outreach and actions focused on providing services to vulnerable persons. The ICR (p. 28) stated that related performance was generally strong (ICR, p. 28), including for establishing and operating infection prevention and patient services committees in health facilities and availing appropriate storage for the collection of hazardous waste pending disposal, but the ICR also stated that further improvements were needed. The 2017 additional financing brought additional attention to social development issues, including for the preparation of a strategy to tackle Gender-Based Violence (GBV).

Note: While the PAD and ICR explained the above route for addressing environmental and social aspects under a PforR lending instrument, the ICR categorized the operation under Environmental Assessment Category B, applicable to investment projects. The Integrated Safeguards Data Sheet (ISDS) of January 30, 2017 for this Hybrid PforR with Technical Assistance IPF Component noted that no Safeguard Policies were triggered and that the Environmental Category was a C Category. No explanation was offered to clarify the discrepancies.

b. Fiduciary Compliance

Overall fiduciary compliance was assessed as moderately satisfactory (ICR, p. 28). The ICR reported that funds were used for intended purposes and that the government adhered to fiduciary requirements. The program used qualified fiduciary personnel, submitted regular quarterly financial reports, produced internal audit reports and procurement audits; and submitted semiannual fraud and corruption reports. Audit opinions were unqualified, but two audits of the Pharmaceuticals Fund and Supply Agency raised qualification points that necessitated a detailed action plan for resolution. Also, there were delays in implementing a new financial management module.

c. Unintended impacts (Positive or Negative)

None reported.

d. Other

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10. Ratings

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

11. Lessons

The ICR (pp. 31-33) offered several lessons and recommendations, including the following lessons re-stated by IEG Review:

The challenging context in countries with large disparities in access and persistent gaps underscores the importance of sustained, long-term engagement in human development. While Ethiopia made steady and impressive progress in health advancements, much more remains to be done to have a major and sustained impact on maternal and child health. A follow-on operation is ongoing. Designing interventions that are appropriate for different regions (agrarian, nomadic, urban) will take time, including for a thorough understanding of what works and how different regions can be incentivized to revamp their health services. The large number of internally displaced people and the complexity of conflict after-effects require specialized and well-tailored support to restore and further advance maternal and child health services.

A Program for Results can be complemented by Investment Project Financing components to provide specific technical support, capacity building, and targeted strengthening. To bolster capacity, the World Bank and development partners provided hands-on-support on a wide range of issues, such as for civil registration, vital statistics, fiduciary capacity of the SDG Performance Fund, National Nutrition Program, health financing and fiduciary systems in the health sector.

The consistent availability of reliable information facilitates tracking of program progress, performance assessment, identification of challenges, and sustenance of donor harmonization. Harmonized donor support facilitated the production of regular Demographic and Health Surveys; annual facility readiness surveys; assessment of Community-Based Health Insurance; and nutrition surveys. The timely availability of data enabled the verification of DLIs. Donor support also contributed to an enhanced Health Management Information System.

12. Assessment Recommended?

No

13. Comments on Quality of ICR

The ICR provided a thorough and candid review of the program experience. The narrative was results-oriented and supported the ratings and available evidence. The ICR was aligned to program development objectives. The evidence was robust and included demographic and health surveys supported by international technical assistance. The discussion of efficacy was intertwined with the theory of change and its results chain. The review was reasonably concise, internally consistent, and followed guidelines. The assessment of relevance of DLIs would have benefited from added accuracy and analytical rigor if the ICR had opted to discuss each of the main DLIs separately. Lessons tended to be framed as findings, and there were occasional lapses in clarity.

a. Quality of ICR Rating
Substantial