Report Number : ICRR0020588

1. Project Data

Project ID	Project Name
P117417	NP: Second HNP and HIV/AIDS Project
Country	**Practice Area(Lead)**
Nepal	Health, Nutrition & Population

L/C/TF Number(s)	Closing Date (Original)	Total Project Cost (USD)
IDA-47070,IDA-H5570	15-Jul-2015	1,527,332,000.00
Bank Approval Date	**Closing Date (Actual)**	
20-Apr-2010	15-Jan-2016	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	129,153,189.00	0.00
Revised Commitment	129,127,778.90	0.00
Actual	125,104,982.29	0.00

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2. Project Objectives and Components

a. Objectives

The project's objective, as stated in the financing agreement (p. 5), was "to enable the Recipient to increase access to essential health care services and their utilization by the underserved and the poor."

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

No

c. Will a split evaluation be undertaken?

No

d. Components

The project, which supported the health sector's entire expenditure program (National Health Sector Program 2010-2015) through a Sector Investment and Maintenance Loan, contained two components. Although funds were not to be ring-fenced, and Bank resources were to be disbursed against reviewed and approved total annual work plans, there were a number of areas that were to receive special attention, as described in the components:

1. Health service delivery (appraisal, US$ 1353.1 million; actual, US$ 1304.38 million) was to increase access to, and utilization of, an affordable package of essential health services by the underserved and poor in line with the Ministry of Health and Population's (MOHP's) Gender and Social Inclusion Strategy. More than 70% of the MOHP's budget financed essential health services, referring to a specific package of interventions to improve reproductive, maternal, and child health; prevent non-communicable disease; and control communicable disease. The project was to support the expansion and strengthening of these services, with an emphasis on better reaching the poor and excluded segments of society (women, disadvantaged indigenous peoples and occupational castes, religious minorities, and people in specified geographic regions). Specific interventions were related to improved human resource availability; exemption and incentive schemes for the poor and underserved to use specific health services; improved and expanded physical infrastructure; and the introduction of feedback mechanisms for communities to raise issues concerning quality of care, discrimination, and governance of health facilities. Programs were to be supported to improve the nutritional status of children and pregnant women, expand coverage and effectiveness in the response to HIV and AIDS, and reduce mortality and morbidity associated with pregnancy and childbirth.

2. Health systems strengthening (appraisal, US$ 174.2 million; actual, US$ 167.93 million) was to improve the availability of human resources for health in underserved areas, improve the sustainability of financing for the health sector and provide protection against impoverishment due to ill health, strengthen and expand the scope of monitoring and evaluation (M&E), improve governance and accountability in the sector, and expand a results focus through three preliminary conditional cash transfer and output-based payment programs (covering antenatal care and growth monitoring for infants, skilled birth attendance, and provision of birthing services free of charge).

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

Project Cost: Total planned costs over five years, representing sector program costs, were US$ 1527.33 million. Actual total costs were US$ 1472.54 million. According to the project team, the difference was due to exchange rate fluctuations. Disbursement took place against MOHP annual work plans and budgets.

Financing: The project was to be financed by US$ 1527.33 million contributed by the government, pooled funding partners, and other partners. The International Development Association was to provide a US$ 69.652 million Credit (including US$ 22.9 million in pilot crisis response window resources), and a US$ 59.5 million Grant (including US$ 21.25 million in pilot crisis response window resources), for total

planned IDA financing of US$ 129.152 million; of that, US$ 125.1 million was disbursed. The Australian Agency for International Development provided US$ 24 million of a planned US$ 30 million, and the United Kingdom Department for International Development (DfID) provided US$ 77.44 million of a planned US$ 80 million, both in pooled funding. Other bilateral agencies and sources (unidentified in the ICR) provided US$ 771.87 million of a planned US$ 798.38 million. All planned financing was disbursed, with the exception of US$ 335,946 that was declared ineligible and refunded; differences between planned and actual financing are due to exchange rate fluctuations.
Borrower contribution: The government made US$ 474.13 million of a planned US$ 489.8 million contribution.
Dates: The project's closing date was extended once (on July 8, 2015), from July 15, 2015 to January 15, 2016, to allow full project implementation following the 2015 earthquake.

3. Relevance of Objectives & Design

a. Relevance of Objectives

A Sector-Wide Approach (SWAp) involving donors across the health sector had been launched in 2004. There had been important gains in key health indicators in the years preceding the project, but significant challenges remained, especially for underserved segments of society. Infant mortality in rural areas, for example, was 73% higher than that in urban areas in 2006; the situation was similar for disparities along key indicators between the poor and non-poor. Nepal had the highest HIV/AIDS prevalence in South Asia. The global financial crisis was negatively impacting Nepal's ability to finance the health sector and nutrition interventions. The project therefore responded to country conditions at the time of appraisal. Through direct budget support to the Nepal Heath Sector Program, the project's objectives were precisely aligned (and continue to be aligned) with government strategy. The project's objectives were also in line with the Bank's Interim Strategy Note at entry, which attempted to address issues of exclusion for some segments of society, as well as the lack of perceived legitimacy of the state when it could not deliver basic services in an equitable and inclusive manner. The Bank's Country Partnership Strategy at closing (2014-2018), under its second pillar, contains an explicit focus on equalizing access to health care. The project's objectives are therefore also highly relevant to government and Bank strategy.

Rating
High

b. Relevance of Design

The project provided support for the government's health sector strategy through a SWAp. The second component on health system strengthening was appropriate support for capacity-building that was a prerequisite for increased access to and use of health services. The project outlined specific areas of focus related to maternal and child health and HIV/AIDS. From the PAD and the ICR, it is not clear how the poor and underserved were to be targeted; however, the project team noted that planned activities were targeted at

groups that were income-poor or disadvantaged/excluded because of ethnicity or religion (pregnant women, specific geographic areas, etc.) through specific mechanisms such as free check-up cards. In addition, the ICR (p. 35) notes that the share of non-communicable diseases (NCDs) among the country's total burden of disease had been increasing markedly in the decade prior to project preparation, and therefore "Nepal's proportionally larger burden due to NCDs should have been considered during project preparation, or at least have been taken into account to initiate some support in the project for its control, and/or for preventing risk factors that affect key NCD pathologies, and contributing to halting its growth." Annex 9 of the ICR (pp. 60-65) demonstrates that the communicable, maternal, neonatal, and nutritional disorders that were targeted in the design of the project were relatively minor (and declining) contributors to Nepal's disease burden at the time of project preparation. The ICR (p. 60) further notes that "despite the clear priorities defined by the government in the National Health Program with regard to NCDs, there was no articulation of [the project's] intention to support the government on its NCD priority in the PAD," and that "it was hard to understand why the project chose to focus only on maternal and child health as a SWAp priority." The project team, however, countered that communicable diseases and maternal/child health challenges were more prevalent among the underserved and the poor, and therefore the project's focus on these areas was appropriate; that the government was already covering NCD prevention adequately, and the Bank did not want to get into the relatively expensive area of NCD treatment; and that, as the Bank was financing just one slice of the government's program, the choices made in this regard were a reasonable judgment call. To support this argument, the project team provided the government's 2014-2015 *Joint Annual Review*, which prioritizes family planning and maternal/child health services as well as communicable disease control interventions. Given this additional information provided by the project team, Relevance of Design is rated Substantial.

Rating
Substantial

4. Achievement of Objectives (Efficacy)

Objective 1

Objective
Increase access to essential health care services

Rationale
Outputs
The project provided general support through a SWAp, but assistance focused on: a package of basic health service interventions to improve reproductive, maternal, and child health (details on this package are not provided in the ICR); a strategy (not detailed in the ICR) to reach the poor and marginalized, including women and disadvantaged indigenous peoples; and the introduction of feedback mechanisms for communities to raise issues of quality of care, discrimination, and governance (no details on these mechanisms are provided, though the project team later explained that they included broad systems

engagement and social audits). Although specific activities are not outlined in the PAD or ICR, the government's 2014-2015 *Joint Annual Review* (provided by the project team) gives details, primarily through the lens of the Gender Equity and Social Inclusion Strategy that governed the provision of health services. The ICR (p. 32-33) notes that (unspecified) planned incentives for pregnant mothers to attend at least four antenatal consultations were not put in place, and that planned behavior change communication campaigns to target reductions in teenage pregnancies and improve family planning utilization were not implemented. No information is provided on the planned conditional cash transfer (CCT) programs; the project team added that the UK Department for International Development financed a CCT program to cover the costs of delivery in a birthing facility as well as additional expenses such as transport costs.

Support was also provided for the consolidation and expansion of existing government programs on malnutrition, including Vitamin A supplementation and de-worming for children 6-24 months, iron and folate supplementation and de-worming for women during pregnancy, and promotion of iodized salt; increases in coverage of zinc supplementation along with oral rehydration solution for treatment of diarrhea; and interventions to promote and support early and exclusive breastfeeding and complementary feeding. Precise information on these interventions is not provided in the ICR. A planned high-level multi-sectoral coordination mechanism for nutrition and food security, to enable better planning for nutrition within relevant ministries, was not established. A planned behavior change study related to elimination of under-nutrition was not conducted.

A comprehensive health care financing strategy was not developed as planned, despite Bank-assisted analytical work toward that goal.

Support was also provided for expansion of critical prevention, diagnosis, and treatment interventions on HIV and AIDS for underserved, high-risk groups, including contracting out to non-state entities the delivery of services to these groups; improving the targeting of existing services; developing quality assurance mechanisms; and strengthening monitoring. This was the first time the government contracted with NGOs to serve targeted, difficult-to-reach populations. The coverage and quality of public health facility-based services for HIV and AIDS was enhanced, including diagnosis and treatment of HIV, sexually-transmitted infections, and opportunistic infections. No detail on the enhancement of HIV/AIDS services by non-state entities or at public health facilities is provided in the ICR.

The MOH initiated an organization and management survey to identify human resource requirements, including a focus on supply, recruitment, deployment, and retention in remote areas. Results of this survey, as well as staffing norms, were used to obtain approval for new service-level positions and fine-tune strategies for deployment and retention in remote areas, including selective recruitment from and incentives for serving in remote areas. 5,096 additional skilled birth attendants were recruited and deployed, exceeding the target of 5,000. 49,674 female community health volunteers were recruited, trained, and deployed, far exceeding the target of 5,000. The ICR does not specify the actual distribution of these new positions or whether they were in remote areas; the project team later explained that these health workers were specifically deployed to serve poor and excluded populations.

The percent of implemented actions identified in a governance and accountability action plan increased from 60% in 2009 to 70% in 2013, not reaching the target of 90%. No detail on these actions is provided; the

project team explained that they were primarily in the areas of financial management and procurement.

The percentage of the MOHP budget allocated to essential health care services increased from 70% in 2009 to a 73.3% average across 2010-2015, not reaching the target of 75%.

51.5% of health facilities had social audits implemented by 2015, exceeding the target of 25%. Full implementation of the Gender and Social Inclusion Strategy was implemented in only 45 of the country's 72 districts.

Outcomes

The ICR provided some evidence of increased access to health services (see below). However, the connections between achievement of these outcomes and achievement of the outputs and activities contributing to them are not clearly specified; therefore, the ICR does not provide strong support for linking (or attributing) the full range of observed results -- even when they are positive -- to project-supported interventions. As the Borrower states (ICR, p. 43), "it is not clear how the technical contributions [of the project] are linked to achieving specific outcomes," and "new initiatives are needed to help in better aligning the technical assistance towards national strategies."

- According to project data, the percentage of pregnant women delivering with a skilled attendant increased from 28.8% in 2009 to 55.6% in 2015, exceeding the target of 35%. The project team provided additional data from Demographic and Health Surveys (DHS) that this percentage increased from 19% in 2006, to 36% in 2011, to 58% in 2016; and that the percentage of births taking place in facilities increased from 18% in 2006, to 35% in 2011, to 57% in 2016.
- Antenatal care coverage of women ages 15-49 with a live birth in the last two years, with at least four controls with any provider, increased from 40.4% in 2010 to 59.5% in 2014, achieving the target of any increase. According to additional DHS data provided by the project team, the percentage of women receiving antenatal care from a skilled provider increased from 44% in 2006, to 58% in 2011, to 84% in 2016.
- The percentage of children receiving a measles vaccine increased from 88.8% in 2009 to 92.6% in 2015, exceeding the target of 90%. The percentage of children fully immunized according to the national vaccination scheme increased from 55.75% in 2010 to 84.5% in 2015, essentially reaching the target of 85%.
- Vitamin A coverage among children ages 6-59 months remained stable at 90% in 2009 and 90.2% in 2012, meeting the target of stability at 90%.
- The percentage of primary health care facilities with essential drug stock-outs lasting more than a week decreased from 67% in 2009 to 15.9% in 2015, exceeding the target of 50%.
- The tuberculosis treatment success rate (defined as cured plus treatment completed) increased from 85% in 2009 to 90% in 2014, reaching the target of 89%.
- The ICR (pp. 31-32) states that there was improvement in the following, but it does not provide data or time frame: comprehensive knowledge of HIV prevention; comprehensive knowledge of HIV prevention among young people (ages 15-24); knowledge of mother-to-child transmission of HIV; accepting attitudes toward people living with HIV and AIDS; knowledge among women of where to be tested for HIV; and HIV

counseling during antenatal care. Progress was not reported on the percentage of women who had been tested for HIV and know their results.

Progress in the following was less than anticipated:

- The percentage of pregnant women attending at least one antenatal consultation remained stable, at 87% in 2009 and 86% in 2014, not achieving the target of 92%.
- The percentage of primary health care centers providing basic emergency obstetric care services increased from 23% in 2009 to 31.4% in 2015, not reaching the target of 70%.
- The percentage of children exclusively breastfed in the first six months of life increased from 53% in 2007 to 56.9% in 2014, not reaching the target of 60%.
- The percentage of mothers taking iron and folic acid supplementation during their last pregnancy decreased from 81.3% in 2009 to 72% in 2014, whereas the target was an increase to 87%.
- The percentage of diarrhea cases among children under five who were treated with zinc and oral rehydration solution increased from 7% in 2009 to 18.2% in 2014, not reaching the target of 40%.
- According to a 2012 Household Survey, use of modern contraceptives among women ages 15-49 increased from 45.5% in 2009 to 49.6% in 2012, less than the target of 55%. According to 2009 and 2014 Multiple Indicator Cluster Surveys, use of modern contraceptive methods actually decreased from 51.3% in 2009 to 47.1% in 2014. The percentage of married women ages 15-49 with unmet needs for family planning rose from 23% in 2009 to 25.2% in 2014, rather than falling, as anticipated, to 18%.
- Coverage of HIV prevention services for risk groups varied: for injection drug users, it increased from 30% in 2009 to 43% in 2015, though not reaching the target of 50%; in men having sex with men, it declined from 31% in 2009 to 27.6% in 2015, rather than increasing to 50% as targeted; and for female sex workers, it also declined, from 80% in 2009 to 71% in 2015, instead of stabilizing at 80% as expected (this indicator covers only the Kathmandu Valley and Pokhara).

Because of the number of indicators on which there was no progress or for which targets were not reached, and due to lack of clarity in the results chain linking activities to outcomes, achievement of this objective is rated Modest.

Rating
Modest

Objective 2
Objective
Increase the utilization of essential health care services by the underserved and the poor

Rationale
Outputs

Other than general reference to the implementation of a Gender and Social Inclusion strategy, the ICR does not provide information on means of targeting of interventions to poor and other vulnerable or underserved groups. The 2014-2015 *Joint Annual Review* provided by the project team gives some additional information in its Annex 7.1.

Outcomes

The percentage of children exclusively breastfed in the first six months of life, among the poorest income quintile, increased from 53% in 2007 to 71.9% in 2014, exceeding the target of 60%. This information is from the 2014 Multiple Indicator Cluster Survey. It is unclear, however, whether this baseline is accurate, as it is the same baseline used among all children at all income levels. The project team was unable to supplement this information.

All other outcome data in the ICR are from the 2012 Household Survey, which (according to the ICR Data Sheet) is the most recent available information disaggregated by income. The project team explained that information from a new survey will not be available until later in 2017.

- Skilled attendance at birth among the poorest income quintile increased from 8.5% in 2009 to 25.5% in 2012, meeting the target of 25%.
- The percentage of children in the poorest income quintile receiving a measles vaccine remained essentially the same, at 82.6% in 2009 and 83.1% in 2012, not reaching the target of 88%.
- The percentage of mothers among the poorest income quintile taking iron and folic acid supplementation during their last pregnancy increased from 70.5% in 2009 to 93.6% in 2012, exceeding the target of 75%.
- The use of modern contraceptives among women ages 15-49 in the poorest income quintile increased from 45.5% in 2009 to 47.6% in 2012, not meeting the target of 55%. Once again, it is unclear whether this baseline is accurate, since it is the same as that among all women in this age group at all income levels.
- The tuberculosis treatment success rate increased from 85% in 2009 to 90% in 2014, reaching the target of 89%. As tuberculosis primarily affects poor and underserved populations, this indicator is considered a measure of achievement of this objective.

The project team provided additional data newly available from the 2016 DHS. According to this information, relevant to two disadvantaged geographic regions:

- The percentage of births with a skilled attendant increased in the Mid Western Province from 28.7% in 2011 to 49% in 2016, and in the Far Western Province from 30.7% in 2011 to 66% in 2016.
- The percentage of pregnant women attending at least one antenatal consultation increased in the Mid Western province from 53.1% in 2011 to 77.7% in 2016, and in the Far Western Province from 61.8% in 2011 to 90.5% in 2016.
- The percentage of children vaccinated against measles increased in the Mid Western Province from 87.4% in 2011 to 92.2% in 2016, and in the Far Western Province from 94.9% in 2011 to 95.2% in 2016.
- The percentage of diarrheal cases in children treated with zinc and oral rehydration solutions increased

in the Mid Western Province from 8.3% in 2011 to 26.0% in 2016, ad in the Far Western Province from 6.8% in 2011 to 10.7% in 2016.

- Vitamin A coverage in children ages 6-59 months increased slightly from 90.8% in 2011 to 91.4% in 2016 in the Mid Western Province, and declined slightly from 92.6% in 2011 to 91.0% in 2016 in the Far Western Province.

The PAD (pp. 46-47) provides data on trends prior to the project disaggregated by caste/ethnicity/religion and geographic location, in addition to income quintile. The ICR, however, provides no information specifically on the underserved groups (other than the poor) specified in the PAD (disadvantaged indigenous peoples and occupational castes, religious minorities, and people in specified geographic regions), and the new information provided by the project team was not disaggregated by income, ethnicity, caste, or religion.

Achievement of this objective is rated modest, as the ICR provides little or no information on achievement through most of the project's lifetime, or on underserved groups other than the lowest income quintile. A further assessment may be possible when newer household survey data become available.

Rating
Modest

5. Efficiency

The Project Appraisal Document (PAD, pp. 73-79) conducted an economic and financial analysis justifying the project's investments. With a 10% discount rate over a ten-year horizon, and reasonable specification of direct and indirect benefits, the net present value was estimated at US$ 6680 million. Benefits were computed as reduced expenditure due to treatment averted and productivity increases due to fewer days lost from illness/premature death/caring for the sick. Results were robust even under a 50% reduction in benefits and a five-year time horizon. No rate of return was calculated.

The ICR (pp. 20-21, 35-41) does not perform a traditional economic and financial analysis, but instead demonstrates efficiency through a burden of disease (BOD) analysis for 2010-2013, drawing on data from the Institute of Health Metrics. It reports a reduction in BOD of 2,913 disability-adjusted life years (DALYs) per 100,000 inhabitants, due entirely to gains in the reduction of communicable disease (as the burden of non-communicable disease increased). A with- and without-project analysis, assuming 30% to 100% attribution to the project for acceleration of gains post-2010, and discount rates ranging from 3% to 10%, finds between 60,423 and 140,518 DALYs saved between 2010 and 2013, at an estimated cost of US$ 458 to US$ 1,131 per DALY averted. This represents 22-54% of per capita GDP. However, the ICR does not translate these findings into an economic rate of return or net present value when compared with the cost of project-

supported interventions, and therefore the ICR's characterization of the project as cost-effective is not strongly supported.

Transaction costs were relatively high early in the project period, but in 2014, MOHP and the pooled partners reduced the number of formats used for financial monitoring reports from 33 to 8. According to the ICR (p. 7), this improved financial monitoring, made disbursement of funds more timely, and reduced the government's transaction costs. The Borrower's ICR (ICR, p. 43) reports that the SWAp mechanism lowered transaction costs, with MOHP's budget absorption capacity increasing from 69% in 2004/05 to 75.1% in 2013/14 (data are not provided specifically for this project's lifetime). However, the Borrower also reports that an effective instrument for coordinating technical assistance in the sector is not yet in place, and that development partners continue to use separate monitoring and evaluation missions, increasing transaction costs for partners and for the government.

There were additional significant shortcomings. Staff turnover at all levels "undermined the development and sustainability of capacity developed and interfered with sustained policy dialogue" (ICR, p. 8). There was a period when two health secretaries were simultaneously in charge of the project, creating "severe accountability difficulties" (ICR, p. 8). Frequent changes in the senior management of the National Center for AIDS and STI Control impacted the timely contracting of NGOs for HIV/AIDS contracts. There were major shortcomings in procurement and financial management (see Section 11b), with the former rated Moderately Unsatisfactory and the latter fully Unsatisfactory through most of the project's lifetime. Efficiency was also impacted by factors outside the project's control: a 2015 earthquake that negatively affected service delivery and the flow of funds, and widespread political protests in late 2015 that resulted in a blockade of the border between Nepal and India, halting the passage of almost all goods and supplies (including drugs and medicines).

The implementation inefficiencies described in the ICR make it unlikely that substantial value for money was achieved. Although the project did not experience significant delays or cost overruns, it also did not achieve many of its intended outcomes, indicating that high transaction costs, staffing shortages and turnover, administrative challenges, and external factors may have impacted project implementation and prevented achievement of optimal value for money. Furthermore, the ICR's quantitative analysis does not demonstrate the value of the project's achieved benefits in relation to its costs. Efficiency is therefore rated Modest.

Efficiency Rating
Modest

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

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

ICR Estimate	0	0 ☐Not Applicable

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

6. Outcome

Relevance of objectives is rated High due to linkage with country conditions at the time of appraisal, Bank strategy, and government strategy. Relevance of design is rated Substantial, largely because of additional information on the project's focal areas and targeting provided by the project team to supplement the ICR. Achievement of the objective to increase access to essential health care services is rated Modest, due to shortcomings in meeting targets for key indicators and an unclear theory of change linking the project's technical assistance to observed outcomes. Achievement of the objective to increase utilization of health services by the poor and underserved populations is also rated Modest, due to lack of data on populations other than the poorest income quintile (ethnic/caste/religious minorities, and those living in disadvantaged geographic areas), as well as lack of outcome data covering the entire project period. Efficiency is rated Modest due to implementation challenges and the ICR's lack of demonstration of economic benefit in relation to project costs. Taken together, these ratings are indicative of significant shortcomings in the project's preparation and implementation, and therefore an Outcome rating of Moderately Unsatisfactory.

a. Outcome Rating

Moderately Unsatisfactory

7. Rationale for Risk to Development Outcome Rating

A follow-on operation, the Nepal Health Sector Management Reform Program-for Results (P160207, US$ 150 million, approved on January 13, 2017), will focus on health sector governance in support of the current Nepal Health Sector Strategy (2015-2020). It is intended to support progress toward specific outcomes in the areas of public management, particularly procurement, financial management, and evidence-based decision making, and should build capacity for health sector management that will facilitate sustainability of investments in service delivery and improved equity. An Aid Mapping Platform, established in the Ministry of Finance, has begun to map the support of international NGOs in the health sector; the fact that most of those organizations operate outside the purview of MOHP is an "Achilles' heel for the government" (ICR, p. 45), and the mapping exercise should, in principle, contribute to coordination and effectiveness of service delivery. The donor community remains engaged, but some major donors (India and China) are still outside the SWAp, limiting coordination and the ability to bring down transaction costs, with the potential to constrain resource availability and responsiveness to demand for services. The ICR (p. 22) makes general claims of substantial health systems strengthening that is likely to be sustained, but those claims are called into question by the ICR's other, more detailed discussions of challenges in the areas of human resources, procurement, and financial management (see Sections 5 above and 11b below). Recent political unrest and security concerns demonstrate that there is substantial political and country risk.

a. Risk to Development Outcome Rating
Substantial

8. Assessment of Bank Performance

a. Quality-at-Entry
The project incorporated a number of useful lessons from the first health SWAp (2004-2010) in Nepal, including that stable law and order is necessary to support efforts to improve governance and institutional capacity (it is unclear that a stable security environment currently exists); that progress is possible even during periods of conflict; that critical assessment of the financial sustainability of new policies is necessary; that adherence to agreed work plans and budgets will expedite annual commitments by pooled funding partners; that independent performance assessments enhance joint review processes; and that management of SWAp arrangements requires clarity on the roles of all players. The MOHP and eight development partners, including the Bank, had signed an International Health Partnership compact in 2009 indicating their continued harmonized commitment to building a sustainable health system. This project was intended to build on the previous SWAp (whose Outcome IEG rated as Satisfactory) through further development of institutional capacity and incorporation of HIV/AIDS prevention activities. Risks were assessed and mitigation measures specified, with the following risks rated Substantial or High: that the macroeconomic environment would not remain stable; that rule of law and governance would be inadequate; that corruption and criminal elements would impact implementation; that natural disasters would occur; and that procurement would be impacted by intimidation and limited competition. It is worth noting that, as the follow-on project (a third SWAp) is being prepared, strengthening of financial management is a central issue, raising questions about whether fiduciary challenges and risks should have received earlier attention.

However, there were significant shortcomings. M&E design contained important weaknesses, as schedule considerations and government capacities were not sufficiently taken into account when planning for data collection among poor populations, and no provision at all was made for collecting data specifically among other underserved groups (see Section 10a). Health care waste management guidelines and a social inclusion strategy were not defined until well into project implementation (see Section 11a). The ICR (p. 24) notes that "there was an underestimation of the importance of health facilities improvements and health networks," without fully describing the nature of that underestimation; the project team was not able to explain or elaborate on this statement.

Quality-at-Entry Rating
Moderately Unsatisfactory

b. Quality of supervision
Regular Joint Consultative Meetings and Joint Annual Reviews provided a forum to review performance, define strategic areas of focus, and discuss the action agenda. Supervision teams contained appropriate

technical experts. The ICR (p. 8) reports that external partners observed an improvement each year in the quality of these discussions. The mid-term review was conducted on schedule, and the ICR (p. 9) reports that its findings contributed to the development of a follow-on operation (though the ICR does not report on utility of the mid-term review in prompting corrective action for this project). The ICR (p. 24) reports that the Bank team engaged effectively with the client, "instilling ownership despite the high turnover of authorities." Implementation Status Reports are reported (ICR, p. 24) to have been candid on fiduciary weaknesses, project management, and turnover of the Borrower's staff; it is notable, nevertheless, that none of the ratings for progress toward development outcomes or implementation progress fell below Moderately Satisfactory, despite evident issues with fiduciary management (especially procurement; see Section 11b). The team proactively proposed solutions to overcome some challenges during implementation, most related to the earthquake: discussing and preparing a restructuring, and offering flexibility in work arrangements and processes to those affected. However, many of the project's fundamental shortcomings, particularly with regard to M&E implementation (see Section 10b), remained unaddressed, and there was inadequate attention to safeguard policies (see Section 11a).

Quality of Supervision Rating
Moderately Unsatisfactory

Overall Bank Performance Rating
Moderately Unsatisfactory

9. Assessment of Borrower Performance

a. Government Performance
The ICR (p. 25) reports that the government provided a supportive policy environment, with clear commitment to interaction with partners and mainstreaming of the 2009 Health Sector Gender Equality and Social Inclusion Strategy. A national health insurance policy was adopted in 2013, and a new national health strategy in 2014. The International Health Partnership, aligning commitment and strategy with eight external partners, was signed in 2009.

However, there were significant shortcomings during implementation. There was frequent turnover of key staff, including secretaries, directors general, health services directors, logistics management division directors, National Center for AIDS and STI Control directors, health insurance focal points, and key financial management staff. According to the ICR (p. 8), "project ownership often decreased temporarily" during these staff changes. Capacity was problematic at all levels: central, regional, district, and health facility. Recruitment of permanent health staff was hampered by delays in the approval of an ordinance on amending the Health Services Act. A temporary recruitment plan was approved only in 2013, and this only partially addressed the human resource shortage. There were also delays in the annual approval of budgets that negatively impacted flows of funds and service delivery.

Government Performance Rating
Moderately Unsatisfactory

b. Implementing Agency Performance

The MOHP's Department of Health Services was responsible for implementing health service delivery activities, and the National Center for AIDS and STD Control was responsible for implementation of both the state and non-state HIV/AIDS response. The key unit at MOHP that was responsible for project coordination was understaffed, producing delays in strategic decision making. Procurement, financial management, contract administration, and general implementation at the district and local levels experienced major shortcomings (see Sections 5 and 11b). The Borrower's ICR (p. 45) states that the number of projects and programs financed by external development partners outside the pooled financing arrangement was challenging to manage, and that even the pooled funding "at times imposes too stringent procurement and financial management requirements that stretch the government's capacities." The ICR (p. 26) describes the MOHP as "trying its best under the circumstances beyond its control," but it does not provide detail on this point.

Implementing Agency Performance Rating

Unsatisfactory

Overall Borrower Performance Rating

Unsatisfactory

10. M&E Design, Implementation, & Utilization

a. M&E Design

MOHP was to monitor progress for the entire sector program, including results for the project. Annual reports were to feed into Joint Annual Reviews where development partners, the MOHP, and other stakeholders would assess performance and set strategic priorities for the following year. Data were to be generated from the Health Management Information System (HMIS), facility surveys, household surveys, and community score cards. A Demographic and Health Survey (DHS) was to be conducted in 2011. A wide range of results indicators was specified in the PAD, with baselines and targets included. Indicators measuring achievement of the second objective, however, covered only the poor (lowest income quintile), and did not cover other categories of underserved populations (disadvantaged indigenous peoples and occupational castes, religious minorities, and people in specified geographic regions), and adequate provisions were not made to collect data on poor and underserved populations.

b. M&E Implementation

Most outcomes on health services utilization among the poor were measured only once during the project's lifetime, in 2012, only two years into a five-year implementation period, when attribution to the project's activities may not yet have been clear. A second planned household survey was held up due to "delays in financing, insufficient planning, and difficulties with implementation" (ICR, p. 9). Most Joint Annual Reviews highlighted issues with quality of M&E, noting problems with definitions of indicators and data collection. It remained a challenge throughout implementation to integrate data from multiple sources, including the HMIS,

DHS, Nepal Multiple Indicator Cluster Survey, national census, Facility-Based Assessment for Reproductive Health Commodities and Services, and Human Resource Information System. No data are reported on specific underserved populations other than the poor. It is expected that additional data may be made available through the next DHS, for which field work is taking place from June 2015 - January 2017. The project team noted that these results should be available in April of 2017.

c. M&E Utilization

The ICR (p. 9) states that lack of survey data "made it difficult to make any corrections and operational changes to the project, if need be."

M&E Quality Rating

Negligible

11. Other Issues

a. Safeguards

The project was Environmental Assessment Category B. It triggered OP/BP 4.01 (Environmental Assessment), OP/BP 4.12 (Involuntary Resettlement), and OP/BP 4.10 (Indigenous Peoples). Environmental concerns were related to infrastructure development and generation of medical waste. According to the PAD, the government prepared and disclosed an Environmental Management Framework (EMF) for physical infrastructure works and an Environmental Health Impact Assessment Plan. Appropriate principles, policies, frameworks, and consultations were laid out for involuntary resettlement and indigenous peoples (PAD, pp. 83-86), many of those falling under the country's Gender Equality and Social Inclusion Strategy.

The ICR reports that an updated EMF was prepared in 2014 to simplify steps, procedures, guidelines, criteria, and standards used while planning and developing health-related physical infrastructure, and appropriate training was carried out in 2014. The ICR does not state why this took place to late in the project period. As a result, updated Health Care Waste Management (HCWM) guidelines were approved only in 2015, the project's final year, "providing evidence of slow safeguards execution and poor political visibility" (ICR, p. 10). The ICR (pp. 10-11) notes that the safeguard rating was downgraded to Moderately Satisfactory (MS) during the first year of implementation and remained there for the rest of the project's lifetime, despite numerous shortcomings including "severe deficiencies" in HCWM in two hospitals, no plan for training and implementation of HCWM guidelines, and no sustained MOHP budget for management of healthcare waste. The ICR (p. 11) appropriately finds that "the MS rating of the Environmental Safeguard activities was overrated," with shortcomings in implementation primarily due to transaction costs and lack of political support.

On Indigenous Peoples, a Gender Equality and Social Inclusion strategy was reportedly approved and adopted by MOHP for the health sector at the end of 2014. It was to develop plans to mainstream gender

equality and social inclusion in the health sector, enhance the capacity of service providers to ensure equitable access to and use of health services by the poor and marginalized groups through a rights-based approach, and improve the health-seeking behavior of the poor and marginalized groups. This safeguard maintained a rating of "Satisfactory" throughout the project's lifetime (ICR, p. 11), based on the formation of technical working groups and appointment of focal persons in 75 district health offices, and setting up of hospital-based one-stop crisis management centers, social service units, collaborative frameworks for the social auditing of health service provision, and operational research on integrating health into local governance and community development.

On Involuntary Resettlement, there was no need for land acquisition during implementation.

b. Fiduciary Compliance

Fiduciary risk at entry was assessed as High due to failure to comply with the country's legal and fiduciary framework, and the fiduciary environment at the sectoral level Moderate. Fiduciary oversight was to be provided by the Bank on behalf of the pooled partners. A Governance and Accountability Action Plan (GAAP) was developed and put in place to mitigate and address fiduciary risks. However, "the use of the GAAP did not yield significant gains" (ICR, p. 13). Shortcomings included poor resource allocation and ad hoc sector budget formulation processes largely uninformed by inputs from service delivery facilities and other decentralized units, ineffective expenditure management, unreliable financial reporting, poor monitoring, lack of adherence to policy directives, poor expenditure tracking, and weak accountability. There were delays in the preparation of financial reports, which in turn delayed the release of funds for the SWAp and for program implementation, resulting in a low execution rate for annual budgets. "Fiduciary integrity remained a major challenge" (ICR, p. 13). The project's Financial Management rating was downgraded from Satisfactory to Unsatisfactory in the first year of implementation and remained there for the rest of the implementation period. Audits were incomplete and heavily qualified, and there was ineffective follow-up of audit findings. Expenses in the amount of US$ 335,946 were declared ineligible and refunded to the Bank. The ICR (p. 13) indicates that the project experienced "resources not being used for their intended purpose, misappropriation of assets, and poor value for money in the procurement of essential commodities and equipment." The MOHP introduced a Transaction Accounting and Budget Control System in 2015 to address these shortcomings, but this step was not sufficient, and the follow-on Bank project is taking steps to strengthen the financial management system.

Procurement was highly impacted by the fragile political climate, which led to frequent and often unplanned rotation of procurement staff, changes in management leadership, lack of oversight, and "non-adherence to existing guidelines" (ICR, p. 12). As a result, the procurement rating during the first year of implementation was downgraded from Satisfactory to Moderately Unsatisfactory and remained there until closure. Specific recurring issues included delays in NGO service contracting for HIV/AIDS, a declaration of misprocurement (US$ 2,600 in 2014) for surgical goods, and poor management of the logistics and storage system. An agreement with DfID (date unspecified) included measures to strengthen oversight, market analysis, and independent validation through an externally contracted agency, but "efforts to improve the system remained insufficient and unsustainable" (ICR, p. 12). An Independent Procurement Assessment, commissioned in 2014 by the Bank at the request of the MOHP, recommended moving toward a strengthened and professionalized

logistics management division in MOHP and outsourcing procurement and supply chain management functions. A follow-on project is supporting implementation of those recommendations.

c. Unintended impacts (Positive or Negative)

None reported.

d. Other

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12. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Moderately Satisfactory	Moderately Unsatisfactory	There were shortcomings in meeting targets for key indicators, and a lack of specification in the ICR of implemented activities/outputs that would plausibly have led to achieved outcomes. There were further shortcomings in achieving value for money due to inefficiencies in procurement, financial management, and staffing, and the ICR does not demonstrate economic benefit in relation to project costs.
Risk to Development Outcome	Modest	Substantial	Political, institutional capacity, and donor coordination risks remain substantial.
Bank Performance	Moderately Satisfactory	Moderately Unsatisfactory	M&E and capacity-building plans were inadequate at preparation, and there was insufficient attention to these issues, as well as to safeguards compliance, during supervision.
Borrower Performance	Moderately Satisfactory	Unsatisfactory	There were major shortcomings in human resources planning, procurement, financial

		management, and safeguards implementation.
Quality of ICR	Modest	---

Note
When insufficient information is provided by the Bank for IEG to arrive at a clear rating, IEG will downgrade the relevant ratings as warranted beginning July 1, 2006.
The "Reason for Disagreement/Comments" column could cross-reference other sections of the ICR Review, as appropriate.

13. Lessons

The ICR (pp. 26-27) offers several lessons, including:

- **Effective governance is a fundamental prerequisite for smooth health systems functioning.** In this case, both strategic and ground-level governance issues prevented effective response to ongoing challenges. The Bank's follow-on project is designed to address these basic issues.
- **Reform agendas will falter in the absence of realistic assessments of institutional capacity**. In this case, project preparation did not take adequately into account concerns about human resource deployment, procurement and financial management systems, and overall political economy issues.

IEG offers the following additional lesson:

- Reliance on external surveys and other methods of data collection risks inability to measure and demonstrate achievement of development objectives. In this case, the project's own M&E did not contain adequate baseline and outcome data covering the entire project period, particularly for key target populations.

14. Assessment Recommended?

Yes

Please explain

To verify ratings (which differed in the ICR vs. ICR Review), and to verify performance against more recent data.

15. Comments on Quality of ICR

The ICR is concise and follows the established guidelines. It provides comprehensive information on the project's outcomes, though its discussion of the linkages between outputs and outcomes, and of the outputs themselves, is thin. The discussion of outcomes in some areas seems to emphasize listing the indicators targets met or not met, with less attention to the validity of indicators themselves, or their relationship to the overall theory of the project or to each other. The ICR's level of candor does not always extend to discussions of consequences of the project's implementation challenges. The ICR's lessons do not uniformly derive from its descriptions in the main text of project experience. There were a number of areas on which clarification had to be sought from the project team.

a. Quality of ICR Rating
Modest