Report Number : ICRR0020664

1. Project Data

Project ID	Project Name
P095275	VN-Central North Region Health Support
Country	**Practice Area(Lead)**
Vietnam	Health, Nutrition & Population

L/C/TF Number(s)	Closing Date (Original)	Total Project Cost (USD)
IDA-46880	31-Aug-2016	75,000,000.00
Bank Approval Date	**Closing Date (Actual)**	
06-Apr-2010	31-Aug-2016	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	65,000,000.00	0.00
Revised Commitment	63,575,239.10	0.00
Actual	59,804,184.04	0.00

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2. Project Objectives and Components

a. Objectives

The development objective of the project as stated in the Project Appraisal Document (PAD) and the Financial Agreement was to strengthen district level curative and preventive health services and improve their accessibility for the economically vulnerable population in the Central North Provinces.

The PDO was not changed during the project life, but key outcome targets were revised during a project restructuring in March 2015, and therefore a split rating will be performed.

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

Did the Board approve the revised objectives/key associated outcome targets?
No

c. Will a split evaluation be undertaken?
Yes

d. Components
The project had four components as stated in the PAD:

Component 1. Supporting health insurance for the near poor (US$9.1 million at appraisal; US$9.8 million at closing).
Expand coverage and access to health insurance for near-poor households in the Central North Region, and improve the system's capacity to manage health insurance, through: (a) subsidizing premiums for the near poor; (b) conducting social marketing and information, education, and communication (IEC) campaigns and providing technical assistance to the Health Information and Education Centers of the Vietnam Social Security Offices (VSSs); and (c) strengthening the institutional capacities for its administration.

Component 2. Strengthening district health services (US$32.2 million at appraisal; US$29.3 million at closing).
Improve the capacity of district hospitals to provide basic curative health services to the population, and strengthen basic public health functions of the District Preventive Health Centers (DPHCs), through: (a) upgrading medical equipment in the district hospitals; (b) providing equipment and training to 30 DPHCs; (c) building the technical and administrative blocks of DPHCs; and (d) piloting performance-based financing mechanisms to incentivize health care providers to perform better and more efficiently.

Component 3. Improving supply and quality of human resources for health (US$15.9 million at appraisal; US$11.6 at closing).
Strengthen the capacity of existing medical educational institutions, and improve skills and knowledge of already-practicing medical personnel, through: (a) supporting the transformation of the Nghê An medical college into a medical university; (b) improving teaching facilities in five other medical colleges; (c) training district hospitals' clinical staff, DPHCs' personnel, and hospital administrators (short-term training, Level 1 specialty training, on-the-job training, and Master's degree training); and (d) supporting the implementation of Decision 1816 of the Ministry of Health (MoH), which targeted the rotation of qualified medical personnel from higher-level facilities to district hospital to temporarily address health personnel shortages and at the same time ensure the transfer of knowledge and skills to district-level hospital human resources.

Component 4: Project management, Monitoring, and Evaluation (US$7.7 million at appraisal;

US$3.9 at closing)
Ensure adequate management structures, processes, and human resource capacities for the project, and set up mechanisms for effective monitoring of activities and evaluation of results, through financing: (a) the operation of provincial project management units (PPMUs) at both the central and provincial levels, (b) health information systems and data collection, (c) M&E and audit mechanisms, and (d) implementation of the results-based financing (RBF) pilot. The M&E activities consisted of following the project's implementation progress and tracking the project's results indicators and performance of the pilot.

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

Project Costs, Financing, and Borrower Contribution: Total project costs were estimated at US$75 million at appraisal, from which US$65 million was to be financed through an IDA Credit, and US$10 million through the Government's contribution. Due to changes in the exchange rate and project cost savings, final disbursement amounted to US$54.6 million (the disbursement rate in SDR was 98.1%).

Dates: The project was restructured in March 2015, about 18 months before the original closing date (August 2016) and having disbursed US$41 million of the Bank's loan. While the project's duration was not extended, the level II restructuring (a) slightly reallocated funds across components to make best use of project resources, and (b) revised the project's result framework (replacing some KPIs and revising some outcome target values). The PDO itself remained unchanged.

3. Relevance of Objectives & Design

a. Relevance of Objectives

The project's objectives were highly relevant during the entire project life, both before and after the revision of outcome targets. The health insurance law from 2008 expanded free health insurance coverage for poor households and envisaged the provision of a 50% subsidy of premiums for near-poor households (defined as households with average income from 100% to 130% of the official poverty line). Despite these subsidies, health insurance enrollment of the near poor remained very low, around 10%. On the supply side, the health reform created new types of facilities at the district level to serve promotion and prevention functions separately from hospitals, but the Central North Region, composed mainly of poor districts, had not been able to provide adequate funding for new or existing health facilities.

The project was part of a generation of four regional projects in Vietnam intended to support the health sector in economically depressed provinces, based on interventions on both the demand and supply sides. The project objectives were consistent with Vietnam's Country Partnership Strategy (CPS) FY2007–2011, whose second pillar called for the need to improve social services to the poor and marginalized groups to ensure economic growth with social equity and inclusion. The project objectives remained relevant to Vietnam's CPS FY2012–2016 in terms of priorities for the health sector and the country's future health strategies. The Government and the World Bank recently launched the Vietnam 2035 Agenda, which

highlights universal health coverage as the major policy challenge facing Vietnam's health system over the next 20 years. Ensuring access to high quality health services, while increasing financial protection to reduce the likelihood of impoverishment due to catastrophic health care payments, are the Vietnam 2035 Agenda's key health priorities. The project was also aligned with the Government's Health Sector Development Plan (2011–2015) and was a priority of the Ministry of Health (MoH) and provincial government because of its focus on increasing health care accessibility for the poor while strengthening the provision of preventive and curative services.

Rating	Revised Rating
High	High

b. **Relevance of Design**

The project's design was consistent with the stated objective of strengthening preventive and curative services and increasing accessibility by lower socioeconomic groups. The proposed activities were coherently and plausibly linked to the expected outcomes. The PAD provided an extensive description of the challenges facing district-level health care services that led to the proposed activities embodied in the project's components, thus reflecting a project design built bottom-up.

Project investments included both supply- and demand-side interventions. On the supply side, the project supported investments in health workers' skills, infrastructure and equipment, and hospital management of the district health facilities to increase the quantity and quality of preventive and curative services. It also supported a pilot of Results-Based Financing (RBF) in selected health facilities to improve performance in health care service provision.

On the demand side, the project design financed health insurance for near-poor households, as well as IEC activities among the poor to disseminate the advantages of enrollment and increase their willingness to pay for health insurance. Enhanced health insurance coverage among the poor can plausibly lead to an increase in service accessibility and reduction of health related out-of-pocket (OOP) expenditures.

Rating	Revised Rating
Substantial	Substantial

4. Achievement of Objectives (Efficacy)

Objective 1

Objective

To strengthen district level curative and preventive health services in the Central North Provinces.

Rationale

Outputs:

The project supported the purchase of 30 ambulances and essential medical equipment for 30 district hospitals and Quang Tri Provincial General Hospital, including equipment for emergency, intensive care, obstetrics, pediatrics, and image diagnostics. The project contributed to increasing the number of new technical services offered by district hospitals. Thirty DPHCs were built, with new blocks for administrative and technical activities. The project improved the teaching facilities in Nghe An and four other medical colleges by financing teaching equipment and vehicles.

In terms of health workforce training, 3628 staff received short-term trainings, and 559 transfers were made from higher to lower level hospitals to share knowledge and on-the-job training. At the end of the project, 606 assistant doctors and pharmacists and 199 preventive medical doctors received long-term training, and 405 staff received post-graduate training. Also, each beneficiary hospital had a staff member trained on medical waste management and medical waste collection and on-site transportation.

The project's intermediate outcome indicators show that:

- The percentage of patients satisfied with: (a) the overall quality of care at district hospitals, (b) the reduction of waiting time, and (c) the availability of services and diagnostic facilities increased from an overall satisfaction baseline of 35% in 2009, to 80%, 75%, and 47% in 2016 the three categories, respectively, exceeding in two cases the targets of 50%.
- The number of doctors from district hospitals trained for Level 1 specialization reached 399 in 2016, exceeding the target of 174; and the number of health professionals trained for the MD degree reached 805 in 2016, exceeding the target of 680.
- The percentage of medical professionals who returned to their original place of work/residence after long-term training supported by the project was 96.5% in 2016, exceeding the target of 80%.
- The number of lecturers in the Nghê An College receiving post-graduate training reached 56 by 2016, exceeding the target of 44.

Outcomes:

- By 2016, there were 31 new DPHCs constructed with adequate equipment to provide a full range of preventive health services according to government norms, exceeding the target of 20 facilities.

- By 2016, the average number of new technical services performed by 30 project district hospitals was

30, exceeding the target of 20 services.

Except for the patients' satisfaction, the indicators used to measure the achievement of this objective are output-oriented rather than outcome-oriented. Another Bank-financed project in Vietnam supporting similar structural investments and health workforce trainings (P082672) has measured health workers' knowledge about treatment protocols as a proxy for quality of health services. For this reason, achievement of this objective is rated Substantial rather than High.

Rating
Substantial

Objective 2
Objective
To improve their accessibility (district level curative and preventive health services) for the economically vulnerable population in the Central North Provinces.

Rationale
Outputs:

The project identified 7.1 million near-poor people living in the six project provinces, and it financed IEC activities to increase their willingness to pay a subsidized health insurance premium by disseminating information on its advantages and on enrollment administrative mechanisms. During project implementation, several communication strategies were developed: the project financed the production of 572 broadcasting transmission programs, 73 articles in popular newspapers, 3.1 million leaflets, 41,500 posters, and 15,100 public loudspeakers at the community level. As a result of these efforts, about 2.1 million people bought the subsidized health insurance, accounting for total budget support to health insurance purchase of US$ 7.6 million.

The projects' intermediate outcome indicators show that:

- The percentage of near-poor individuals that were covered by the health insurance program increased from 10% in 2009 to 91% in 2016, exceeding the target of 40%.

- However, the share of near-poor households spending 25% or more of their non-food consumption on health remained basically constant, around 17% according to 2008 and 2014 VHSS data, not reaching the target of 12%. The increased utilization of health services by the near poor could have impacted

negatively their OOP expenditures on health items such as medicines. Even when health insurance coverage for the near poor reached high rates, the existence of cost-sharing rules for some goods and services may have limited the purchasing power of this group, unlike the fully poor households who received full subsidies and comprehensive coverage. Over-the-counter drugs, which account for a large share of OOP payments, are not covered by insurance (PAD p. 88). Project beneficiary surveys, interviews, and focus groups indicated that only 49% of patients were satisfied with their level of OOP costs for treatment, and that dissatisfaction came from not receiving enough medicines to comply with prescribed treatment and having to use their own money to buy drugs (and sometimes consumable supplies) in pharmacies (ICR p. 24).

- The share of district hospitals in claims reimbursed by health insurance increased from 40% in 2009 to 57% in 2016, exceeding the target of 50%.

Outcomes:

According to the 2008-2010-2014 VHSS:

- the number of outpatient and inpatient visits by the poor increased from 5.4 in 2008 to 13.4 per 100 inhabitants in 2014 (outpatient), and from 2.4 to 19.1 per 100 inhabitants (inpatient), exceeding the original target of 5.8 outpatient and 2.6 inpatient visits per 100 inhabitants.
- the number of outpatient and inpatient visits by the near poor increased from 6.1 in 2008 to 11.8 per 100 inhabitants in 2014 (outpatient), and from 2.4 to 18 per 100 inhabitants (inpatient), exceeding the original target of 6.8 outpatient and 2.6 inpatient visits per 100 inhabitants.

Contributing to project objectives, the RBF pilot was implemented from 2013 to 2015 with the participation of 54 health facilities, including 11 district hospitals, 11 DPHCs, and 32 Community Health Stations (CHSs). Each type of health facility had a defined set of indicators to monitor and supervise RBF outcomes, but these were not included in the project's results framework. Preliminary results from the two-year implementation period show that the average quality score of district hospitals was around 90% by 2015, compared to 70% in 2014. The quantity and quality scores at the CHSs were improved up to 90% across facilities. In all facilities using the RBF model, the level of staff motivation improved. This evidence, however, represents a before-after comparison without control facilities, and therefore attribution of outcomes to the introduction of performance payments is not warranted.

The implementation of the RBF pilot closed on December 31, 2015, but some district hospitals in the region continued to apply the RBF verification tools, as they found the tools useful for quality management purposes.

The ICR also presents data on health outcome achievements. Although these were not part of project's PDO indicators, infant mortality rates were reduced from 17.1 to 16.6 per 1000 live births in the Central North Region between 2010 and 2014, compared with a reduction from 15.8 to 14.9 for the national Vietnam

average. Similarly, malnutrition in children under five years old also reduced from 19.8% to 17% in the Central North Region compared to a reduction from 17.5% to 14.5% in the national average over the same years (ICR p. 23 footnote). Reductions were slightly more pronounced at the national level, suggesting an overall downward trend in these child health indicators.

Rating
Substantial

Objective 2 Revision 1

Revised Objective
This project objective did not change during the project's lifetime. However, one outcome target was revised.

Revised Rationale
Outcomes:

The baseline values for service utilization by the poor and near poor were updated at the 2015 restructuring using the 2010 VHLSS (the year in which the project was approved), and therefore target values were revised accordingly. Neither the restructuring paper nor the ICR provide the new 2010 baseline values:

- the number of outpatient and inpatient visits by the poor reached 13.4 and 19.1 per 100 inhabitants in 2014, respectively, exceeding the revised target of 12.1 and 6.2 visits per 100 inhabitants.
- the number of inpatient visits by the near poor reached 18 per 100 inhabitants in 2014, exceeding the revised target of 5.6. The number of outpatient visits in 2014 was 11.8, slightly lower than the revised target of 12.8 per 100 inhabitants.

It is worth noting that results from the 2016 VHSS may not have been available at the time of project closing to provide more current information on inpatient and outpatient coverages, however, given the trend in outpatient and inpatient visits it is very likely that values would still exceed targets.

Revised Rating
Substantial

5. Efficiency

A cost-benefit analysis was not conducted either ex-ante nor ex-post due to difficulties of assigning a monetary value to expected health outcomes, and of estimating the impact of project investments in equipment and training on health outcomes (PAD p. 89).

Economic Analysis ex-ante: Annex 9 of the PAD presented the economic case for the project's investments

that generated benefits in terms of cost savings, improved health outcomes, and equity. The project was expected to increase quality and therefore reduce inefficiencies in the production of services, avoiding costly and unnecessary treatments resulting from inaccurate and poor-quality diagnosis. Increased quality of services at all levels was also expected to reduce inefficiencies in the consumption of services, since households would have fewer incentives to bypass commune-level services in seeking better health care conditions. Higher user fees (or co-payments) and transportation costs associated with hospital care would be saved; for the insured, only 30-50% of their expenditures are reimbursed at a high level (Level 1 or 2) hospital, compared to 70% reimbursement at a lower level (Level 3) hospital. Finally, financial protection would increase the likelihood of patients seeking care early when needed at lower levels, which would avoid needing higher levels of care because of an advanced illness or condition. From a health system perspective, seeking care at the lower levels of the system is more cost-effective and associated with greater allocative efficiency. Enhanced quality and utilization of health care services was expected to improve health status of the population. On the equity side, the expansion of health insurance coverage would reduce the OOP costs of the poor and near poor. However, as noted in Section 4, health insurance contributions may be too low to cover the full cost of the package of services, leading to co-payments or outright payments for medicines or supplies that in total exceed the 25% share threshold for non-food expenditures.

Economic Analysis ex-post: Annex 3 of ICR presents the project's economic analysis based on: (a) rationale for the government's investment in the region; (b) the efficiency of achieving access to district hospitals; (c) the project's contribution to improving health benefits (project outcomes); and (d) the impact of the project's interventions on equity of health access and health spending for the poor and near poor. The ICR considers the project to have been efficient because it supported cost-effective investments that translated into an efficient use of resources. Improving availability and use of preventive and curative health care services provided at lower levels of the health system (community stations, health centers, and district hospitals) are recognized by literature as a highly cost-effective investment. A 2016 publication by the World Bank, *Disease Control Priorities: Reproductive, Maternal, Newborn, and Child Health*, shows high returns for interventions aimed at increasing coverage of services where good evidence exists for demand-side interventions to motivate service uptake. Finally, the return on infrastructure investments has clear long-term benefits, which facilitate improvements in the provision of quality services.

In terms of project preparation and implementation, the ICR states that there were no major delays. The project preparation timeline (20 months) was slightly longer than the average of 18 months for Health, Nutrition and Population Global Practice projects, but still under the World Bank's benchmark for Investment Project Financing of 24 months. During early implementation, the Government decided to increase the subsidy for the health insurance premium from 50% to 100% for a group of near poor who had graduated from poor status within the last 5 years. These changes created some delays for project implementation, as the level of project support to the health insurance premium had to be adjusted accordingly when the policy changed. Nevertheless, the project closed on time and nearly fully disbursed, with no significant implementation or administrative challenges (see Sections 9b and 11b).

Efficiency Rating
Substantial

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

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

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

6. Outcome

The project's outcome under both sets of outcome targets is rated Satisfactory. The project's objectives were Highly relevant to country conditions, Government strategy, and Bank strategy. Relevance of design is rated Substantial due to the logical and plausible link between the project's planned activities and its expected outcomes. Achievement of both objectives is rated Substantial under both the original and revised targets, due to achievement of outcome targets and plausible attribution of these outcomes to project interventions. Efficiency is rated Substantial due to the cost-effective nature of the interventions on both the supply and demand sides, and the implementation efficiency achieved by the MOH and project management units. Taken together, these ratings indicate only minor shortcomings in the project's preparation and implementation under both the original and revised targets, leading to an Outcome rating of Satisfactory.

a. Outcome Rating

Satisfactory

7. Rationale for Risk to Development Outcome Rating

The risk that development outcomes will not be maintained is considered modest. The project has strengthened the provision of health care services at the district level, improving the quality of services and developing a qualified health workforce, which in the short- and mid-term is likely to continue satisfying the health care needs of local people. In the area of enhanced human resources for health, there were binding agreements for trained medical personnel to ensure they return to the original workplace within three years of having finished training supported by the project. The long-term nature of training and the transformation of Nghê An medical college into a medical university aimed at producing a new cadre of medical professionals to fill the human resource gap in a more sustainable way. Although the RBF pilot was finished in 2015, organization and managerial changes improving productivity and quality of care are likely to continue. Some district hospitals in the region have started to apply the RBF verification tools, as these tools were found to be useful for quality management purposes, and a number of health facilities and management agencies are willing to apply the RBF model (ICR p.17). The government's strong commitment and policies for universal health coverage, particularly for the poor and marginalized, are institutionalized and are likely to be sustained in the future.

On the financial side, the fiscal impact of the project was considerable at the provincial and district hospitals' level in terms of the additional recurrent expenditures necessary to maintain project investments in infrastructure and equipment of the health facilities (ICR p.22). However, all six provinces have written documents confirming their support of the health insurance premium for the near poor and establishing the financial basis to support the sustainability of project outcomes. The ICR states that Vietnam's expected rapid economic growth over the coming years will have a positive impact on provincial budgets.

a. Risk to Development Outcome Rating

Modest

8. Assessment of Bank Performance

a. Quality-at-Entry

The strategic relevance of the project was high, and project design incorporated several lessons learned from other health projects implemented in Vietnam such as the Mekong Regional Health Support Project, the National Health Support Project, and the Northern Upland Health Support Project. Some lessons incorporated in the project design were: combining supply and demand side activities; incorporating bottom-up design to adapt investments to local conditions; and implementing strategies to retain qualified staff, among others. Moreover, project design was complementary to other bank projects implemented in the Central North Region (Health Regional Blood Transfusion Centers Project, and HIV/AIDS Prevention Project).

The World Bank, in agreement with the government, managed two grants to finance feasibility studies; social, environmental, and economic assessments; stakeholder consultation; and an RBF pilot design for project preparation. The task team prepared the Project Operational Manual (including for the RBF arrangements), which helped to guide the project implementation by the Central Project Management Unit (CPMU) and the Provincial Project Management Units (PPMUs). The lending instrument was a Specific Investment Loan (SIL) because the project focused on a specific set of activities and investments, and the SIL instrument is appropriate for district level actions, institutional capacity building, and skills development, while also being conducive to an integrated approach to health care system development (PAD p. 5).

Social and environmental impacts were adequately addressed during preparation. Social consultations played a key role during preparation of the project by improving the understanding of the impact of the construction of the DPHCs on affected households and for devising mitigation mechanisms. The social assessment included group discussions, site visits, and focus groups/interviews with health professionals and village residents.

A minor shortcoming was that the project's results framework did not include indicators for assessing the results of the RBF pilot. On balance, however, Quality at Entry is rated Satisfactory.

Quality-at-Entry Rating
Satisfactory

b. Quality of supervision
The ICR states that the task team conducted 10 implementation support visits to Vietnam during the project's life, including financial management and safeguards missions. Project supervision reports, including Implementation Status Reports and aides-memoire, were kept adequately. A local field-based task team leader was instrumental for maintaining constant communication with the CPMU, and the Bank's fiduciary technical support team was readily available to solve issues and address promptly demands from the client. The Bank team was responsive to changes in the Government policy regarding health insurance subsidies, which required re-identification of beneficiaries to avoid overlapping with other kinds of Government support. Based on regular monitoring of environmental and social safeguards, the project substantially improved the waste management systems at district hospitals and positively changed the perception of the poor and near poor about the importance of health insurance.

Quality of Supervision Rating
Satisfactory

Overall Bank Performance Rating
Satisfactory

9. Assessment of Borrower Performance

a. Government Performance
The Ministry of Health authorities were completely involved in the project's preparation and design, reflecting the Government's commitment to the project, and issued a handbook to guide implementation at the onset of the project. The provincial health authorities and district hospital management personnel were also committed to participating in the project's development. The Government expressed its full commitment to guaranteeing adequate budget for communications, supervision, monitoring, evaluation, and travel during implementation. Stakeholders were consulted and field visits were organized to establish links and networks with local government authorities. The CPMU deployed sufficient human resources (including national consultants) and exhibited relatively strong capacity to manage and implement project activities, and to use available financial resources. It provided capacity building for the PPMUs' staff to improve project management, including financial, accounting, and procurement issues; asset management; civil works; training on assessment of health care funds for the poor; and M&E activities. It effectively coordinated with other functional departments of the Ministry of Health during project preparation, accelerating approval processes at higher government levels.

Government Performance Rating
Satisfactory

b. Implementing Agency Performance
The implementing agencies were the Ministry of Health/CPMU, the six Central North Regional Provinces (Thanh Hóa, Nghệ An, Hà Tĩnh, Quảng Bình, Quảng Trị, Thừa Thiên Huế) and their PPMUs, and the Nghệ An Medical University Project Management Unit (MUPMU).

The CPMU was always committed to improving project performance and achieving its goals. The CPMU was in charge of launching and operating project management systems, including human resources, fiduciary functions, offices, and equipment throughout the implementation of the project. During project implementation, the CPMU and the PPMUs prepared the project's annual plans, monitored annual implementation targets, and provided financial and activity reports and audits. At the province level, PPMUs' performance in managing the project was uneven across provinces. Most of the PPMUs performed well, but some experienced problems in staffing to guarantee quality project management and M&E results.

The performance of the MUPMU was highly satisfactory, and it maintained strong collaboration with the CPMU on management of the equipment and training facilities to upgrade the skills of medical and health staff at the provincial health facilities involved in the project.

Implementing Agency Performance Rating
Satisfactory

Overall Borrower Performance Rating
Satisfactory

10. M&E Design, Implementation, & Utilization

a. M&E Design
The results framework at appraisal included 4 KPIs and 7 intermediate outcome indicators (IOIs).

All indicators had complete and clearly reported baselines, target values, frequency of collection, data sources, and responsibilities for data collection specified in the PAD, Annex 3. Indicators were aligned with the project's objectives and were reasonable proxies of expected outcomes. The indicators measuring visits by the poor and near poor, as well as share of households with health OOP payments exceeding 25% of non-food consumption, used the VHLSS available for the years 2008-2014 that allow for disaggregating data by household income levels. While this is clearly an advantage over data that do not disaggregate by income levels, results from national household surveys tend to be available with some delay. That is why the latest data on these two indicators are from 2014, two years before project closing.

The results framework did not include indicators measuring progress and achievements of the RBF pilot, given

that its implementation represented only two years of the six years of project life. M&E for RBF was conducted separately by following a set of specific indicators for each kind of health facility participating in the pilot (ICR, Annex 6; see evidence on RBF in Section 4).

b. M&E Implementation

During project implementation, the results framework was revised at the 2015 restructuring, changing the target for one outcome indicator, dropping some indicators altogether, and adding others.

For the same reason explained above, baseline values for the outcome indicator measuring facility utilization were updated using the 2010 VHLSS (year of project approval), and consequently target values were also revised upwards. The indicator measuring reduction in referrals for deliveries, pneumonia, and appendicitis from district hospitals to provincial hospitals was dropped because of Ministry of Health concerns about the risk of not referring high-risk patients in need of higher levels of care. The restructuring also dropped a so-called balance metric that aimed at measuring children's vaccination rates, as the project had no direct intervention related to immunization coverage. (The rationale for including this indicator at appraisal was to ensure that project interventions in DPHCs did not disrupt the management of the Expanded Program on Immunization.) The indicator for measuring whether Nghê An medical college fully met the national standards for a medical university was dropped because Nghê An medical college obtained its recognition as a medical university before the project's activities began. That indicator was replaced by an alternate indicator that measured the number of lecturers in the Nghê An college trained at the post-graduate level, as a proxy for quality of teaching. One additional indicator was added related to the availability of services to measure the enhanced service delivery capacity of the district hospitals.

c. M&E Utilization

The ICR states that M&E utilization for decision making by the CPMU and the PPMUs was limited, as the health information system of district hospitals was fairly weak in the first years of project implementation. Difficulties experienced by the PPMUs in aggregating data across district hospitals resulted in delays in submission of M&E reports. Results from the mid-term review were instrumental to enhancing project support for improving data reporting through the provision of technical assistance by qualified consultants. Within the Bank, M&E supervision during the mid-term review helped the task team to identify shortcomings and recommend courses of actions that paved the way for revisions of indicators at the project's restructuring.

M&E Quality Rating

Substantial

11. Other Issues

a. Safeguards

The project was Environmental Assessment category B. It triggered the Environmental Assessment (OP 4.01), Indigenous Peoples (OP/BP 4.10), and Involuntary Resettlement (OP/BP4.12) safeguard policies. The ICR indicates that there was full compliance with the Bank's safeguard policies. The environmental assessment addressed the construction of the preventive centers and the health care waste management (HCWM) policies of the health facilities. As national HCWM regulation was found to be weak, the government proposed enhanced standards for the segregation, collection, transportation (on-site and off-site), and storage of health care waste, including methods of treatment and disposal, especially hazardous and infectious waste. Significant efforts were made to comply with new HCW regulations, including staff training, development of learning materials and manuals, and provision of collection tools for biomedical waste. At the end of the project, all the district hospitals had access to a hazardous waste treatment facility and now segregate, collect, and store HCW safely.

The Government prepared an Ethnic Minority Plan, as a considerable proportion of the project beneficiaries (about 14%) were members of ethnic minority groups. According to safeguard reports, the project contributed to reducing demand barriers to health care access by ethnic minorities. Health insurance coverage among ethnic minorities in the Central North region increased from 87.2% to 94.3% between 2010 and 2014.

The safeguard related to involuntary resettlement was triggered because the project built preventive health centers at locations where there had previously been no existing health facilities. Resettlement plans were developed to ensure that districts receiving a land ownership certificate during the project's life followed the OP 4.12 policy. Planned activities regarding assessment of socioeconomic impacts, reimbursement of losses, and recovery of income were carefully prepared and fully implemented. According to the mid-term review report, there were no complaints on compensation or resettlement related to the construction of the 30 DPHCs.

b. Fiduciary Compliance

Financial management: Implementation Status Reports upgraded financial management performance from Moderately Satisfactory to Satisfactory in May 2015. The CPMU and PPMUs had satisfactory accounting and financial reporting systems. They kept records on contract management and accounting, with adequate details to provide sufficient management information. Financial forecasting and planning functions provided adequate and timely information to support annual work plans and budget cycles. All the PPMUs and the MUPMU accomplished asset handover procedures in July 2016. Interim financial reports and audited financial statements were received by the World Bank on time and were of acceptable quality.

Procurement: Procurement performance was rated as Moderately Satisfactory during the majority of the project's life because of some delays in the delivery of procurement packages. The Government and the World Bank were proactive in solving many of the problems and in reviewing and adjusting procurement plans. All envisaged procurement was completed by 2015, although a few contracts to be awarded in 2016 did not materialize due to insufficient time for these contracts to be executed and liquidated before project closing.

Some international competitive bidding had to be extended, leading to delays in procurement processes.

c. Unintended impacts (Positive or Negative)

No unintended outcomes were reported in the ICR.

d. Other

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12. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Satisfactory	Satisfactory	---
Risk to Development Outcome	Modest	Modest	---
Bank Performance	Satisfactory	Satisfactory	---
Borrower Performance	Satisfactory	Satisfactory	---
Quality of ICR		Substantial	---

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 following are relevant lessons from project implementation, reported in the ICR and augmented and reformulated by this ICRR:

- The combination of supply and demand side interventions, such as improving quality of health care services (infrastructure, equipment, medical skills, management, and incentives for retention), and increasing subsidized health insurance among the poor and near poor, is an effective strategy to increase utilization of health services while improving equity, thus contributing to achievement of universal health coverage. However, the goal of financial protection may not be achieved to the extent that the package of goods and services covered by insurance is not comprehensive. Near poor beneficiaries of this project still experienced OOP health expenditures that exceeded 25% of their non-food consumption. This shows that it is not enough just to increase health insurance coverage. Focus must also be placed on the comprehensiveness

of the package and on the level of cost sharing and fees.

• A holistic approach to addressing human resources for health shortages and retention issues typically occurring in isolated and remote areas is preferable to a one-dimensional strategy. This project combined training of local staff; improvements in quality of teaching at a medical university and colleges, staff agreements on returning to workplaces, and performance-based payments.

• As noted in Section 10, there may be tension between the quality of a data collection instrument and the timely availability of data. This project showed that the use of VHLSS allowed the project to obtain data by income level on some indicators, but at the expense of not having current data at the end of the project life, as results from national household surveys tend to be available with some delay.

14. Assessment Recommended?

No

15. Comments on Quality of ICR

The ICR clearly and concisely describes the project's objectives, activities, implementation issues, and achievements. It satisfies the standards of ICR guidelines, with evidence-based analysis and good discussion of attribution of results to the project's interventions. The ICR could have benefited from an expansion of the efficacy section in the main text by bringing in more of the detailed information provided in the annexes. In addition, the formulation of lessons could have been more closely derived from the project's implementation experience.

a. Quality of ICR Rating
Substantial