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Report Number : ICRR0020291

1. Project Data

Project ID	Project Name		
P086313	WS-2ND HEALTH SECTOR MGMT PROG SPT PRJ		
Country	**Practice Area(Lead)**	**Additional Financing**	
Samoa	Health, Nutrition & Population	P120832	
L/C/TF Number(s)	**Closing Date (Original)**	**Total Project Cost (USD)**	
IDA-44320,IDA-47210	31-Dec-2013	14,400,000.00	
Bank Approval Date	**Closing Date (Actual)**		
19-Jun-2008	18-Dec-2015		

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	3,000,000.00	0.00
Revised Commitment	6,000,000.00	0.00
Actual	5,869,648.55	0.00

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2. Project Objectives and Components

a. Objectives

The Project was to support implementation of the first five years of Samoa's ten-year (2008-2018) health sector plan (HSP, the Program) through a Sector Wide Approach (SWAp), which drew together key development partners, including the Bank, New Zealand, and Australia. The HSP was designed to address rising non-communicable and re-emerging infectious diseases, reproductive health, and maternal and child health, as well as prevention of injuries, given the significant share of the latter in the disease burden in Samoa. To do so, the HSP emphasized six policy areas: health promotion and prevention, quality of service delivery, governance and human resources, partnership commitment, health financing, and donor assistance.

The Project Development Objective (PDO) as set out in the Financing Agreement (FA, p. 4) was *to improve the Recipient's effectiveness in managing and implementing the Program based on the use of results from sector performance monitoring.* The PDO stated in the Project Appraisal Document (PAD, p. 5) is essentially the same.

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

No

c. Components

The project had three components:

Component 1: Health promotion and prevention (estimated cost at appraisal US$ 2.15 million; actual cost US$ 2.50 million). The component was to support the transformation of the health sector from a medical orientation towards a wellness model. Central to this effort were the development of health promotion policies and programs; particular emphasis was given to non-communicable disease prevention, reduction of anemia among children, improved infectious disease surveillance, screening for major infectious diseases prevalent in the population, sexual and reproductive health interventions, injury prevention, and health care waste management and control of bio-safety hazards.

Component 2: Enhancement of quality health care service delivery (estimated cost at appraisal US$ 7.35 million; actual cost US$ 21.44 million). The component was to support improvements in various dimensions of the quality of health care, particularly at the primary care level. It was to include: (i) adopting clinical standards and protocols for disease management adapted to the Samoan context; (ii) upgrading the skills of health workers; (iii) improving reproductive, maternal, and child health services to reduce post-natal morbidity and neonatal mortality; (iv) improving primary health care and community health outreach; (v) improving forecasting of pharmaceutical requirements, procurement, storage, distribution, and use; (vi) improving physical disability services, (vii) improving oral health and dentistry; (viii) enhancing blood safety collection and storage; (ix) improving mental health services; and (x) investing in infrastructure rehabilitation, medical equipment, and maintenance.

Component 3: Strengthening policy, monitoring and regulatory oversight of the health system (estimated cost at appraisal US$ 1.90 million; actual cost US$ 7.48 million). The component was to support the Ministry of Health (MOH) in its role of coordination, policy development, monitoring, and regulation in the health sector. Specifically, it was to support the implementation of the monitoring and evaluation (M&E) system for monitoring the program and SWAp performance, and the incremental operating costs of program implementation.

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

Project costs: The total project cost estimate at appraisal was US$ 11.40 million. Indicative Program costs for the five-year SWAp period were US$ 24.30 million. Actual costs (disbursements) were US$

35.53 million, reflecting increased funding of the SWAp by the financing partners (the Bank, Australia, New Zealand) and the Government during the five years of implementation.

Project financing: IDA provided and disbursed a total of US$ 5.87 million over the duration of the SWAp as follows: an initial credit of US$ 2.91 million at approval of the Program-related support project, and an additional credit of US$ 2.96 million on April 1, 2010. Australia provided and disbursed a total of US$ 15.60 million as follows: US$ 7.20 million for the first two years of Program implementation, and an additional US$ 8.40 million for the remaining Program period. New Zealand provided and disbursed a total of US$ 11.30 million as follows: US$ 2.40 million for the first two years of Program implementation, and an additional US$ 8.90 million for the remaining Program period. Interest on Australian and New Zealand commitments added another US$ 468,000.

Borrower contribution: The Borrower provided its full commitment of US$ 1.83 million.

Dates: The project was approved on May 19, 2008. It had an original Closing Date of December 31, 2013, but this was postponed to December 18, 2015 with the introduction of the Additional Financing in 2010 to compensate for the redirection of the original IDA resources to mitigate climate shocks (a tsunami in 2009, and a cyclone in 2012). At the same time, the extension of the Closing Date allowed delayed works to be completed.

3. Relevance of Objectives & Design

a. Relevance of Objectives

While health status has improved significantly over time, the country still faces persistence of infectious diseases and an increasing burden from non-communicable diseases and lifestyle-related health problems. Although most infectious and childhood diseases are under reasonable control, acute respiratory infections and rheumatic fever remain significant causes of morbidity. Outbreaks of dengue and measles and endemic typhoid over recent years underscore the fact that core public health programs remain fragile and are in need of sustained support. Infectious diseases and maternity-related illnesses account for 7 of the 10 top causes of hospital admission.

The project objective was to address changing needs, as set out in the HSP. The HSP placed the focus of health policy on non-communicable diseases, reproductive health, and re-emerging infectious diseases, and set out priority areas for action, including promotion and prevention, quality service delivery, governance for health and health systems, and financing. Bank strategy as reflected in the latest Country Partnership Strategy (CPS) for Samoa, covering the period 2012-2016, notes that "Bank financing for health is unlikely to continue to be required…" (CPS, p. 7), but adds that there will continue to be a need for flexible assistance, primarily through analytical support and policy dialogue focusing on health financing and behavioral change. Hence, the SWAp objective remains broadly relevant beyond its implementation period.

Rating

Substantial

b. Relevance of Design

Project design aimed at increasing the country's ability to manage and implement the HSP through investments in human and physical capacity to better emphasize promotion and prevention, improve service quality, and strengthen policy making and system oversight. In turn, this was to result in accelerated achievement of HSP objectives. The mechanism driving the process was an annual Program of Work (POW) operating within a medium-term expenditure framework (MTEF). The POW was to determine annual funding allocations drawing on sector performance, agreed priorities, and available funds. Key measures for successful implementation of the annual POW were: an appropriate prioritization of health interventions in accordance with the HSP; availability of up-to-date epidemiological data to determine health outcomes; and a strong monitoring and evaluation system. In other words, the functioning of the M&E system was a key element of project design, and here the design had shortcomings: the HSP included a large number of output and outcome indicators (some 30 and 140, respectively) with relatively broadly set priorities, and hence these were unlikely to offer rigorous guidance for planning in the context of an approach with broad participation by development partners.

In addition, there were results frameworks for both the SWAp (project process indicators) and the HSP (Program outcome indicators). Under the SWAp framework, each activity was assigned to one of three project components, each of which supported a set of broad HSP priorities ("wellness," quality, policy). Still, there did not appear to be a well-articulated theory of change underpinning the SWAp (i.e. how project and program initiatives would contribute to achieving sector priorities, and how annual POWs were to be derived from ongoing data monitoring). There was inadequate specification of the anticipated links between the high-level objectives set out in the HSP, the initiatives in the SWAp POW, and their anticipated results in terms of improved health outcomes. Project reviews during implementation repeatedly pointed to this inconsistency, and the issue is also flagged at several points in the ICR.

Rating
Modest

4. Achievement of Objectives (Efficacy)

Objective 1

Objective
To improve the Recipient's effectiveness in managing the Program based on the use of results from sector performance monitoring

Rationale
Achievement of the objective is determined by the introduction of measures that (i) improved the alignment of spending with HSP priorities; (ii) promoted greater efficiency in the use of human and physical resources in meeting HSP priorities; and (iii) strengthened the SWAp oversight function (governance).

a. Health sector financing alignment with HSP priorities:

Outputs

- A medium term expenditure framework (MTEF) was introduced in 2008. The MTEF and related procurement plans were to be updated every three years, drawing on sector and performance reviews (in turn based on annual POWs). The MTEF was updated in 2009 and 2012, but not yet for 2015.
- Corporate plans of key sector partners (NGOs, religious organizations, private sector, community-based social organizations) and government investments have been aligned with HSP priorities from 2009 onwards, when a process for aligning all health sector investments was introduced under the aegis of a health advisory committee and the Ministry of Health.
- To feed into the MTEF and the POW, a demographic and health survey was undertaken in 2009, and a STEPS chronic disease factor survey was undertaken in 2013

Outcomes

- Public spending on health as a share of government expenditures increased slightly over the project period from a baseline of 15 percent in 2008 to 16 percent by the end of 2015.
- Over 90 percent of the health sector budget conformed to policy objectives and was channeled to HSP priority areas, meeting the target.
- Stakeholders were regularly and fully participating in program planning and implementation.

Conclusion: The SWAp improved alignment between public and non-public health sector financing and HSP priority areas.

b. Greater efficiency in the use of human, physical, and financial resources:

Outputs .

- A workforce development plan, including national standards, was elaborated.
- A retooling of skills program was launched, and some 2000 health personnel were trained in health management and relevant curative, preventive, and logistics skills.
- Procurement processes were improved and a national procurement specialist position was created.
- 13 health facilities and auxiliary facilities were constructed/rehabilitated and equipped.
- Emergency and relief management services were improved through the procurement of vehicles.
- Standards were developed and implemented for school health, sanitation, and control of dengue and filariasis.

Outcomes

- 100 percent of SWAp funds were released according to agreed schedules as reflected in annual POWs, from 2009 onward.
- The number of reported drug stock-outs reported by facilities as of 2012 was 2 percent, compared to a target of less than 10 percent, and there was at least 95 percent availability of all essential medicines at all public health facilities. This indicator had no baseline.

Conclusion: The low level of drug stock-outs points to an important factor in ensuring the efficiency of provider operations. The "timely" release of SWAp funds in a project that encountered slippages (see Section 11b), however, is not a convincing indicator of efficiency. Rather, indicators on procurement processes, or even the level of facility staffing or equipping, could have offered stronger evidence.

c. Improved governance:

Outputs

- A Health Program Advisory Committee (HPAC) was established to oversee the SWAp, chaired by the Ministry of Finance, and consisting of private sector representatives, NGOs, and development partners.
- A policy unit in the MOH was established with a mandate to translate plans and policies into actions.
- Strengthening of health promotion activities was supported by establishing an advisory committee for healthy living.
- The policy unit developed a number of policies: National Food and Nutrition Policy, National Child and Adolescent Health Policy, non-communicable disease policy, Health Promotion Act, and Food Act.

Conclusion: In addition to the outputs above, key features of improved governance were the introduction of the MTEF and its annual updating process (POW). It is unclear, however, to what extent priority-setting and upgraded policies and processes were based on sector performance monitoring (see Section 10).

Rating
Substantial

Objective 2

Objective
To improve the Recipient's effectiveness in implementing the Program based on the use of results from sector performance monitoring

Rationale

Achievement of this objective is determined on the basis of (i) how well plans and policies were translated into actions, and (ii) achievement of HSP targets by policy areas. In the latter case, there is an issue of attribution, as the SWAp only financed a modest share (some 14 percent) of the budget. Changes in health outcomes may therefore have been driven by factors unrelated to the SWAp.

a. Translation of plans and policies into actions:

The translation of HSP into actions is determined by the level of success in managing the Program. Based on the analysis under Objective 1, that achievement was substantial.

b. Achievements of HSP by priority area:

Outputs

In addition to the outputs listed elsewhere, 2,125 health personnel received training in a variety of clinical and management areas, and a wide variety of health promotion campaigns was launched.

Outcomes

Control of non-communicable/chronic diseases:

- The prevalence of diabetes increased from 21.5 percent in 2002 to 45.8 percent in 2013, against an HSP target of 25-50% decrease. The ICR states that increased access to health care (and therefore improved diagnosis) may have been partially responsible for the observed increase, but that this is likely only a partial explanation.
- Overweight or obesity in people 18 and over rose from a baseline of 86 percent and 56 percent in 2002, respectively, to 89 percent and 63 percent in 2013 (not achieving respective targets of 64 percent and 42 percent).
- The share of people with high levels of physical activity rose from 33 percent in 2002 to 61 percent in 2013 (no target was set).
- The share of people who smoke tobacco decreased from 40.4 percent in 2002 to 27.1 percent in 2013, not achieving the HSP target of 20.2 percent.
- The share of people who have consumed alcohol in the previous 12 months decreased from 29.3 percent in 2002 to 16.9 percent in 2013, achieving the HSP target of 26.5 percent.
- The share of rheumatic heart disease patients complying with treatment was maintained at a level of around 80 percent.

Improved maternal and child health:

- Perinatal mortality rose from 7/1000 live births in 2009 to 8/1000 in 2014 (no target set). However, there were improvements in the infant mortality rate (from 20.4/1000 live births in 2006 to 15.4/1000 in 2011), under-five mortality rate (from 24.4/1000 live births in 2006 to 19.4/1000 in 2011), and maternal mortality rate (from 40.2/100,000 live births in 2009 to 26/100,000 in 2014).

- The percentage of children under 1 receiving at least one dose of measles vaccine increased from 49 percent in 2008/9 to 91 percent in 2013/14 (WHO/UNICEF data).

Universal access to reproductive health services:

- The adolescent birth rate decreased from 42.6 births/1000 females ages 15-19 in 2006 to 39/1000 in 2011, but rose to 56/1000 in 2013, not achieving the HSP target of 30.
- The percentage of pregnant women receiving antenatal care coverage (at least three visits) increased from 58.4 percent in 2009 to 72.9 percent in 2014, exceeding the HSP target of 70 percent.

Control of communicable diseases

- The number of cases of clinically suspected typhoid decreased from 670 in 2009 to 135 in 2014. However, there was less progress in cases of children with diarrhea (68 percent in 2009 to 62 percent in 2014) or the proportion of children with diarrhea who were untreated (3 percent in 2009 to 7 percent in 2014).

Injury prevention and management:

- The number of hospital admissions for children under 15 with injuries increased from 237 in 2006 to 282 in 2011.

Equity in access to health care:

- The share of the population receiving all basic vaccinations improved across income categories between 2009 and 2014, from 20 to 48.7 percent for the lowest income quintile; 15.1 to 51.7 percent for the second quintile; 29.3 to 40.5 percent for the middle quintile; 31.2 to 47.1 percent for the fourth quintile; and 29.5 to 45.3 percent for the highest quintile.

Conclusion: Achievements were mixed, with worsening results along several key indicators. The ICR (p. 32) finds that "evidence is lacking that early detection and response efforts have systematically increased over the course of the SWAp," largely due to resource allocation being skewed toward investments in a major teaching hospital at the expense of preventive and primary care. In addition, shortcomings in the M&E system (see Section 10) make it unlikely that the use of results from sector performance monitoring drove investment and spending priorities.

Rating

Modest

5. Efficiency

No quantitative economic analysis of the project was undertaken. The ICR (Annex 3) draws attention to eventual benefits that could potentially be associated with expected results, but notes that actual results were either lacking or mixed. It is, however, possible that the interventions will turn out to be cost effective over time when more robust evidence is available.

More generally, a tight implementation schedule and over-programmed work schedules generated inefficiencies, as the system ran up against capacity constraints (see Section 11b). Individuals ended up performing activities beyond their areas of expertise, leading to cost overruns, poorly synchronized inputs, delays in the disbursement of funds, and ultimately, postponements of the Closing Date. Delays and cost overruns on construction, equipment, and materials ultimately generated budget overruns of the order of SAT$ 15.5 million. Resource savings due to improved internal system efficiency may also have been less than anticipated, as early detection and response to illness was underemphasized at the expense of tertiary care.

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 Substantial, as the objectives were linked to country conditions, Bank strategy, and government strategy. Relevance of design was Modest, as there was not a well-derived theory of change laying out how activities were to be prioritized to achieve set Program goals. Achievement of the objective to improve effective Program management is rated Substantial, due to evidence of progress in governance and alignment of spending with Program priorities. Achievement of the objective to improve effective Program implementation, however, is rated Modest, due to mixed achievement on key outcome indicators. Efficiency is rated Modest due to cost overruns and lack of cost-effectiveness in the deployment of human and material resources. 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

No further Bank operations in the health sector are planned as of the time of the ICR, outside of technical assistance. Other development partners are continuing to provide support to the MOH. Improvements in overall sector management and some aspects of institutional coordination appear to be robust. Fragmentation of the health system remains a challenge, as does the lack of an effective monitoring and evaluation system. Sector performance results are still not being used to support decision making and resource allocation. It is unclear that adequate resources have been set aside for maintenance of infrastructure upgraded or built under the project.

a. Risk to Development Outcome Rating

Modest

8. Assessment of Bank Performance

a. Quality-at-Entry

The project was strategically relevant, and there was high-level government commitment to it. The approach – a SWAp – was new to the country, and while its introduction did serve to harmonize donor

interventions, and appears to have been carefully managed by means of detailed implementation arrangements, the approach was challenged by limited capacity in the MOH, a difficult relationship between the MOH and the National Health Service (NHS), and short time frames for implementation – elements that might have been anticipated during preparation. (The relationship between MOH and NHS was signaled as a risk, but mitigating measures appear to have been insufficient, and challenges were still there at the end of the project.) The extra effort introduced during supervision must at least in part be seen as a reflection of insufficient preparation on the part of the Bank team. Weaknesses in the results framework and in monitoring and evaluation design -- an uncertain causal pathway from SWAp support to outcomes, unclear indicators, absence of targets, an uncertain monitoring and evaluation process -- would reasonably be expected to affect implementation.

Quality-at-Entry Rating
Unsatisfactory

b. Quality of supervision
The main issues identified at Quality at Entry – limited domestic capacities, an uncertain results framework, and a weak monitoring and evaluation design – appear to have continued to plague the project throughout implementation. No significant adjustments were made to the results framework, nor to the monitoring and evaluation system, despite issues repeatedly being raised by various supervision missions and surveys. In addition, shortcomings in safeguards persisted throughout the project. The project was off to a slow start, in part due to climate shocks (where the SWAp offered scope for quick support), and in part due to over-programming of work due to difficulties in prioritization. More attention to the implications of the division of labor between MOH and NHS, introduced in legislation just prior to project start (2006, giving MOH responsibility for health sector regulatory oversight and NHS responsibility for provision of public health services at all levels), could have reduced this factor in slowing down project implementation. In 2012, an Aide-Memoire noted that there had been a shift in SWAp implementation from an initial focus on overall strategy and achievement of outcomes to a focus on outputs and activities (ICR, p. 7). Supervision was intensified during implementation from two to four annual missions, in-country presence, and monthly video- and weekly audio-conferences.

Quality of Supervision Rating
Moderately Unsatisfactory

Overall Bank Performance Rating
Unsatisfactory

9. Assessment of Borrower Performance

a. Government Performance
There was strong Government commitment to the project (ICR, p. 20), and the Government took an active part in signaling priority areas for the SWAp. Resources were provided in a timely manner. Still, the respective roles of the two Implementing Agencies, the MOH and the NHS, remained an awkward element throughout implementation, and might have been addressed at Government level. Likewise, the

Government and implementing agencies might have been more alert to capacity constraints in the administration that would eventually hinder implementation.

Government Performance Rating
Moderately Satisfactory

b. Implementing Agency Performance
The two Implementing Agencies were MOH and NHS. The former had oversight and coordination responsibilities for the project and the Program. The latter was charged with implementing Component 2, improving the quality of health care, in particular at the primary level. Legislation passed immediately prior to the project gave sector oversight responsibility to MOH, and service delivery responsibility to NHS. As a result, there was some ambiguity about their respective responsibilities during the early phase of the project, and this was one contributing factor to slow project start-up. Capacity constraints in MOH might have been recognized during preparation, not only by the Bank team, but also by MOH. During implementation, a tendency for over-programming and consequently periodic underfunding could also have been better controlled, and procurement remained a challenge (see Section 11b). The ICR (p.7) also points to high staff turnover and poor internal communications as elements that affected implementation.

Implementing Agency Performance Rating
Moderately Unsatisfactory

Overall Borrower Performance Rating
Moderately Unsatisfactory

10. M&E Design, Implementation, & Utilization

a. M&E Design
Monitoring and evaluation design had two focal points: program outcome indicators to monitor health sector performance, and SWAp process monitoring indicators. In the absence of a comprehensive health information system (HIS, to be developed under the project), a survey on risk factors related to non-communicable diseases and implementation of a Demographic and Health Survey (DHS) in the first year of implementation were to assist the project and the Program in benchmarking the current health status of the population. Sector M&E reports were to be discussed during health summits and during bi-annual joint review missions with donors. Implementation progress was also to be discussed with the Ministry of Finance (MOF) on a quarterly basis as part of the government's budget monitoring process. The Program was to develop a mechanism to encourage the use of the information collected in day-to-day decision-making within MOH, MOF, NHS, and other stakeholders. Qualitative surveys on provider and user satisfaction were to be undertaken at the beginning of the project and during implementation to assess the acceptance of services and improvements over time.

b. M&E Implementation

The results framework consisted of 25 indicators (HSP outcome indicators and SWAp process indicators), but only a subset of 11 largely SWAp-related process indicators was monitored. An evaluation in 2013 noted that these indicators were "poorly defined, lack targets or benchmarks and are likely to be difficult to collect and interpret" (ICR, p. 8). Similar shortcomings were observed over the entire course of the project. There is no evidence that sector M&E reports were discussed; it is unclear whether information relevant to day-to-day decision-making was collected. The project did not develop and implement the planned HIS when technical assistance fell through.

c. M&E Utilization

It seems unlikely that data was routinely used in decision-making, given the situation with the monitoring and evaluation system. Mainly, information had to be drawn from large-scale surveys such as the DHS, which at best occur only every few years. While there were many useful outputs that were aligned with the SWAp and the HSP, there is limited evidence of their impact on outcomes.

M&E Quality Rating

Modest

11. Other Issues

a. Safeguards

The only safeguard triggered by the project was the Environmental Assessment (OP/BP/GP 4.01), as investments made through the SWAp were anticipated to increase health care waste. The project was rated Environmental Assessment Category B. The implementation of a Health Care Waste Management (HCWM) Plan was included as a covenant in the Financing Agreement and as an intermediate outcome indicator on "improved medical waste management" in the Results Framework. A revised HCWM Plan was signed in 2013. In addition to IDA Safeguards Policies, the MOH undertook its own Environmental Impact Assessment, submitted only after the SWAp extension was granted in 2013; it required revisions, as it did not originally include a social impact assessment, focusing on physical and biological impacts only. This assessment focused on the National Hospital. Regular supervision from the HCWM was provided over the course of the SWAp, but several issues remained unresolved by the end of the SWAp. First, there was insufficient funding of recurrent costs and maintenance, and for the replacement of incinerators. Second, segregation bins were found to be of insufficient quantity, and plastic bags were unavailable in sites visited. Staff continued to need further training in proper waste segregation.

b. Fiduciary Compliance

There was frequent over-programming in the work program, resulting in cost overruns. The 2013/2014 audit identified the purchase of faulty fixed assets using donor funds, though this was remedied by the MOH under the warranty for the equipment. The Financial Management Implementation Review Report of November 2015 noted that it was unlikely that remaining works would be completed by June 2016, and while completion by September 2016 was considered likely, a more realistic expectation was completion by December 2016. Financial covenants were complied with, and Financial Management was considered Moderately Satisfactory at the time of project closing.

Procurement activities consumed the bulk of time in the early years of the SWAp and encountered difficulties over the course of the project. The possibility of procurement delays seriously undermining the SWAp was noted in the PAD (p. 9). The World Bank's procurement procedures were used, and these were consistent with Government procedures. Despite this consistency, there was a perception that the use of two sets of procedures (GoS Tenders Board and WB), while preferable over the use of multiple donor-specific guidelines, resulted in delays for reviews and approvals, largely due to limited procurement capacity. Component heads were responsible for development of technical procurement documents but lacked the capacity and experience to perform this function well. This weakness was seen in the inaccuracy of submitted proposals with regard to specifications and related cost estimates; professional review of specifications and solicitation of bids revealed that actual costs were substantially higher. As a result, activities meant to be funded under the SWAp had to be reduced, though it remains unclear how activities were subsequently dropped from the priority list.

Major infrastructure items included renovations at the National Hospital, which are still underway. These renovations were overseen by MOH and utilized by NHS, but weak coordination resulted in in delays and cost overruns. Procurement was no longer handled by an accredited specialist following the departure of the MOH Procurement Specialist in late 2014, but AusAID continued to provide support through its Infrastructure Specialist.

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 Unsatisfactory	Moderately Unsatisfactory	---
Risk to Development Outcome	Modest	Modest	---

Bank Performance	Moderately Unsatisfactory	Unsatisfactory	Challenges with limited capacity, institutional difficulties, an inadequate results framework, and safeguards compliance were never adequately addressed.
Borrower Performance	Moderately Unsatisfactory	Moderately Unsatisfactory	---
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 absence of a clear results chain linking activities to outcomes, an explicit theory of change, and a broad statement of priorities will weaken priority setting, even in the presence of an MTEF. A more rigorous approach may facilitate choice by encouraging Government authorities and development partners to be more selective in setting priorities on activities to be funded, especially in the context of a SWAp.

Without adequate prioritization and incentives, SWAp operations will suffer from an absence of focus. To the extent that this is a more generic risk for SWAp operations, consideration might be given to introducing incentives linked to achievement of outcomes in the form of results-based financing.

14. Assessment Recommended?

No

15. Comments on Quality of ICR

The ICR provides an adequate basis for assessing the program. The quality of the analysis, and the extent to which lessons are based on evidence and analysis, are satisfactory. The results-orientation of the ICR is satisfactory in spite of the challenges posed by the project. The document is internally consistent, and consistent with OPCS guidelines.

a. Quality of ICR Rating
Substantial