Report Number: ICRR0021739

1. Project Data

Project ID	Project Name
P123394	Punjab Health Sector Reform Project
Country	**Practice Area(Lead)**
Pakistan	Health, Nutrition & Population

L/C/TF Number(s)	Closing Date (Original)	Total Project Cost (USD)
IDA-52580,TF-15283	31-Dec-2017	61,545,885.64
Bank Approval Date	**Closing Date (Actual)**	
31-May-2013	31-Dec-2018	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	100,000,000.00	20,000,000.00
Revised Commitment	71,097,249.88	0.00
Actual	61,744,679.94	0.00

Prepared by	Reviewed by	ICR Review Coordinator	Group
Rocio Manchado Garabito	Judyth L. Twigg	Joy Behrens	IEGHC (Unit 2)

2. Project Objectives and Components

a. Objectives

The project development objective was to support the implementation of the Punjab Health Sector Strategy, by focusing on the improvement of the coverage and utilization of quality essential health services, particularly in the low performing districts of Punjab (Financing Agreement, 12/2/2013, p.5). The statements of objectives in the Project Appraisal Document and ICR add a sentence: to contribute to this objective, the project will focus on building the capacity and systems to strengthen accountability and stewardship in the Department of

Health. Although some outcome targets were revised at a 2017 restructuring, this review will not perform a split rating, as targets were revised upward.

The project targeted the 18 districts of Punjab with the lowest rates of performance in terms of nutrition and health outcomes.

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?

No

d. Components

The project initially included four components:

Component 1: Improving Health Service Delivery (Appraisal: US$28.34 million; Actual: US$27 million). This component was to enhance coverage, quality, and utilization of an essential package of health care services (EPHS), including outreach and community-level interventions for primary health care (PHC).

This component had three subcomponents:

- Integrated Maternal Neonatal and Child Health (MNCH) and Lady Health Workers (LHW) programs, and the expansion of 24/7 basic and comprehensive Emergency Obstetric Neonatal Care (EmONC) and Family Planning (FP) services.
- Introduction of preventive nutrition services by scaling up the provision of micronutrients and deworming, and expanding the delivery of behavior change communication with a focus on the prevention of malnutrition during pregnancy and in the first two years of life. Therapeutic nutrition services were to be delivered, including commodity support micronutrients and ready-to-use therapeutic foods in 12 districts and urban slums in the 9 cities with the highest prevalence of acute malnutrition.
- Expansion of coverage of HIV/AIDS preventive services, including treatment and care services for population subgroups vulnerable to HIV infection [injectable drug users (IDUs) and men who have sex with men] in targeted cities, and support for provincial integrated biological and behavioral surveillance.

Component 2: Enhancing Efficiency and Effectiveness of the Health System (Appraisal: US$34 million; Health Result Innovation Trust Fund (HRITF) Grant US$10 million; Actual: US$10 million).

This component aimed at strengthening management and accountability, and improving the quality of care through regulations and standardization of services.

This component had three subcomponents:

- Strengthening the PHC Contracting Out System to support an ongoing initiative of the government for outsourcing Basic Health Units (BHUs) in 14 districts to the Punjab Rural Support Program (PRSP), to manage BHU provision of the EPHS for primary health care services. The contract with the PRSP was to be revised into a results-based contract linking payments to achievement of district-wide annual performance targets. The revised contract was to include health facility management as well as ensuring that the full EPH services were provided, including community-based services.
- Formalizing Results-Based District Management Contracts for performance management in all 36 districts between the provincial Departments of Health (DoH) and the District Health Offices. The contracts were to include performance indicators related to the delivery of EPHS, including integrated MNCH/FP, nutrition services, and control of communicable disease. The districts were to receive a results-based payment based on their performance, using data from the District Health Information Systems (DHIS) and independent assessments.
- Enhancing Governance and Accountability Mechanisms to support: (a) regulatory reforms to operationalize the Punjab Healthcare Commission by standardizing health facility registration and licensing, thus improving quality of care in the public and private sectors; and (b) strengthening social accountability for empowering communities, using third-party results validation through regular Health Facility Assessments and household surveys, data dissemination, community-based monitoring/auditing, and strengthening complaint mechanisms.

Component 3: Strengthening Provincial Department of Health Management Capacity (Appraisal US$22.66 million, Actual: US$10 million). This component was to strengthen and reorganize provincial DoH management systems and improve their stewardship functions.

The following thematic areas were to be included:

- Strengthening stewardship functions to support a functional review of the DoH and organizational restructuring of provincial offices by focusing on: (a) increasing the institutional capacity of the Directorate General Health Service (DGHS) office to provide technical support to the districts; (b) supporting DoH policy and strategy roles and functions by strengthening the Punjab Health Sector Strategy (PHSS) Program; (c) strengthening the monitoring and evaluation cell in the DGHS office to monitor service delivery performance by improving the quality of the DHIS and institutionalizing the Health Facility Assessment and impact evaluation; and (d) building human resource (HR) management functions by supporting the establishment of an HR cell with skilled staff, and developing an HR strategy and HR database for health.
- Restructuring the Punjab Health Foundation (PHF) to review its mission and objectives, and to reorganize and strengthen its capacity to enable public financing for the private sector.
- Building fiduciary functions in the DoH to improve internal control for accountability and management effectiveness by establishing financial management and procurement structures, including: (a) establishing a procurement function in a separate and independent wing; (b) operationalizing sector-specific standard operating procedures and manuals in line with the Punjab Public Procurement

Rules; (c) establishing a capacity building program for field staff; (d) analyzing supply chain management from manufacturer to patient to ensure quality provision of health care by measuring, improving, and monitoring processes; (e) establishing an independent financial management unit; (f) strengthening budget management through capacity building; (g) enhancing non-salary district allocations; and (h) developing systems for internal audit.

- Supporting the roll-out of environmental and medical waste management in two pilot districts to ensure that zero infectious waste goes out of medical facilities. The project was to build on that experience, enabling Punjab to expand environmental and medical waste management and successful practices across the province.

Component 4: Improving Capacity in Technical Areas for Equitable Health Services for All (Appraisal: US$15.00 million; HRITF Grant was US$11.5 million; Actual: US$1.74 million). This component was to finance innovative pilots to guide policy development in results-based financing and alternative financing approaches, as well as strengthen existing analytical capacities in technical areas.

This component had three subcomponents:

- Implementing results-based financing pilots in two districts to support incentives for health staff to enhance performance and improvements in service quality.
- Piloting of alternative financing models in two districts, including (a) a voucher/cash incentive delivered at the health facility level to increase demand for health services, using support from HRIT, and (b) an insurance/social protection scheme with varying premium levels for a set of services from the public or private sector.
- Supporting needs-based technical assistance (TA) and capacity building activities, including: (a) developing a secondary care and tertiary care package; (b) performing analytical work and research on the use and quality of secondary care services, urban health care assessment, and a performance review of tertiary care hospitals; and (c) supporting capacity building activities to strengthen the DoH and its units' ability to implement the project, including financial management, procurement, environmental and social management, monitoring and evaluation, and verification of disbursement-linked indicators (DLIs) using third-party assessment.
- Impact evaluation (IE) for results-based financing pilots. The IE was to measure the impact of different results-based financing approaches and was to be managed by the Bank.

Revised components:

The components were revised during the 2017 restructuring. The management and stewardship reforms under Components 2 and 3 were dropped, as they were not being implemented. Instead, it was decided to focus the remaining short period of the project on service delivery, particularly on family planning and maternal health, and to expand the scope by adding a new Component 5 to provide nutrition interventions aimed at reducing stunting in Punjab.

Component 4: Improving Capacity in Technical Areas (revised cost US$9 million, HRITF Grant canceled; actual cost US$1.74 million). This component was scaled down considerably, reducing the IDA amount by US$6 million and canceling the US$11.5 million HRITF support for results-based pilots and IE. The component was restructured to continue supporting selected needs-based analytical work and research, and any innovative pilots to guide policy development. Some of the new activities included filter clinics for large hospitals, roll-out of health care waste management in tertiary care hospitals, and evaluation of ongoing programs to formulate policy options. Furthermore, this component was to provide support to newly bifurcated departments of health to enable proper functioning and strengthening of their fiduciary and oversight responsibilities through the strengthening of procurement and financial management capacity. Analytical work was to cover the use and quality of secondary care services, urban health care, and a performance review of tertiary care hospitals.

Component 5: Strengthening Nutrition Interventions (Appraisal: US$37.82 million; Actual US$13 million). This component was to focus exclusively on nutrition activities to address the persistently high burden of stunting and malnutrition in Punjab. The additional support to nutrition interventions, already provided under Component 1, aimed at incentivizing the Primary and Secondary Health Department to provide essential nutrition services to more districts for children under 24 months of age through the following: (i) universal screening and counseling in the targeted districts; (ii) expansion of coverage to uncovered union councils in the districts; (iii) Outpatient Therapeutic Program extension; (iv) establishment of Stabilization Centers with functional referral linkages; and (v) consolidation of existing fragmented trainings into a comprehensive nutrition training by level of service. The government established a Multi-sectoral Nutrition Cell at the Planning and Development Department, financed through the Annual Development Plan; the cell was to provide support to a set of multi-sectoral nutrition activities.

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

Cost

The PAD (p. vi) reported a total estimated cost of $1,116.50 million, of which the Bank and the HRITF were to finance US$28.34 million for component 1, US$44 million for component 2, US$22.6 million for component 3, and US$26.5 million for component 4. At the 2017 restructuring, the revised Bank costs were US$31.58 million for component 1, US$10.8 million for component 2, US$10.8 million for component 3, US$9 million for component 4, and US$37.82 million for component 5, for a total Bank cost of US$100 million (ICR, p. 62). At the 2018 restructuring, the revised costs were US$25.5 million for component 1, US$10 million for component 2, US$10.5 million for component 3, US$2 million for component 4, and US$18.82 million for component 5, for a total Bank cost of US$66.82 million (ICR, p. 62).

Actual Bank costs at project closing were US$27 million for component 1, US$10 million for component 2, US$10 million for component 3, US$1.74 million for component 4, and US$13 million for component 5, for a total actual Bank cost of US$61.74 million (ICR, p. 62).

Financing

According to the PAD (p. 11), the project was to be financed by an IDA credit of US$100 million, along with a US$21.5 million HRITF Trust Fund (TF–15283), a UK British Department for International Development (DfID) parallel fund of US$165 million that included approximately US$25 million for TA, and a borrower contribution of US$830 million. Total estimated project financing was therefore US$ 1,116.5 million.

The project included four components, the first three financed through 15 DLIs (total estimated US$85 million) and the fourth using the traditional investment financing reimbursement modality through a designated account (US$15 million). The Bank's contribution to the project was co-financed by US$21.5 million grant from the HRITF to support the implementation of Components 2 and 4 (US$10 million and US$11.5 million respectively).

DfID was to finance a parallel program (2013-2019) of US$140 million aimed at reducing child and maternal mortality by focusing on three priorities: to improve care around delivery, to increase immunization coverage, and to transform primary health care facilities. These priorities overlapped with World Bank-financed project objectives as part of a concerted effort in support of PHSS to improve health outcomes. An additional US$25 million from DfID was to support TA to enhance health sector capacity, and to develop innovative and evidence-based policies related to reproductive, maternal, neonatal, and child health and nutrition.

The US$21.5 million HRITF Grant was canceled on January 26, 2017, due to delays, indecision, and inaction on preparing and implementing planned results-based proposals.

At the 2018 restructuring, US$29 million in Bank funds that were not going to be used were cancelled. The remaining US$0.4million of unspent funds were canceled in June 2019.

Actual Bank financing was US$ 61.74 million. The ICR did not include the actual borrower and DfID contributions to the project.

Dates

The project was approved on May 31, 2013 and became effective on January 17, 2014. A mid-term review was undertaken on August 13, 2015. The project was restructured three times:

- January 17, 2014. A level 2 restructuring extended the due date for the signing of the HRITF Grant Agreement from August 31, 2013, to April 30, 2014, to allow for the IDA Credit to become effective, as this was a suspension clause in the Financing Agreement.
- February 15, 2017. A level 2 restructuring changed the implementing agency and added: (i) revision of components; (ii) change in the results framework; (iii) change in implementation arrangements; (iv) changes to financial management and disbursement arrangements to align with the three new implementing agencies, using the reimbursement modality; (v) change in procurement arrangements, with two new agencies setting up procurement functions; (vi) change in the eligible expenditure category to include nutrition interventions using a reimbursement modality; (vii)

reallocation of credit proceeds to align with the changes in components; and (viii) extension of the closing date by one year to December 31, 2018.

- December 28, 2018. There was a change in components and costs, cancellation of financing, and reallocation between disbursement categories. The disbursement deadline was extended on an exceptional basis (grace period) from April 30, 2019, to May 31, 2019, to enable all disbursements of eligible expenditures to be documented.
- The project closed on December 31, 2018.

3. Relevance of Objectives

Rationale

The objectives were relevant to country conditions at appraisal. At that moment, it was unlikely that Pakistan would achieve the Millennium Development Goals (MDGs) due to the challenge of a growing population, an unstable political climate, the negative impact of the global economic crisis, and the devastating floods of 2010 and 2011. Punjab was home to about 60% of the country's total population, determining the trend of national economic growth and poverty reduction. Hence, Punjab held the key to Pakistan's progress towards attaining the MDGs. Also, the country required substantial investments in human development. Progress in this area had been slow and uneven in Pakistan, remaining as one of the weakest performers in the South Asia Region on maternal and child health outcomes, and characterized by significant inequity in health service access and utilization between regions. Also, in April 2010, the Parliament passed the 18th Amendment to the Constitution that enhanced provincial autonomy through devolving federal powers and responsibilities.

This project was to support the implementation of the next five-year strategic plan 2012-2017 prepared by the DoH for the first phase of reforms. Recognizing limited achievements in intermediate health outcomes and poor performance in the health sector, the DoH developed an extensive situation analysis (March 2012) and a consultative process involving all stakeholders. Based on the results, in 2012, the DoH developed the PHSS 2012- 2020. This strategy established the DoH priorities for the delivery of healthcare services based on available resources. Also, the government of Punjab initiated interventions focusing on strengthening governance and accountability, scaling up the People's Primary Health Initiative and the Punjab Rural Support Program evaluation (TRF 2010), which evidenced positive results.

The objectives were also relevant to the World Bank/Pakistan Country Partnership Strategy (CPS) for 2010-13 that sought to support Pakistan's efforts to address major institutional, policy, and financing constraints to increase its capacity to achieve and sustain high economic growth rates, to manage conflict, and to improve social indicators and the capacity of its population. The CPS was organized around four pillars; the fourth envisioning improving human development and social protection, emphasizing performance and building capacity. This pillar also recognized the need to build governance and service delivery at the provincial level following the devolution of responsibilities to provinces. The CPS included explicitly two critical outcomes related to the health sector: expanding the use of modern contraceptive methods from 26% to 30% (project target for Punjab was 35%) and increasing child immunization by 20% (project target for Punjab was 40%), both of which were also PDO outcome indicators. The project also assisted Punjab in

improving sector performance and helped to accelerate its progress towards achieving the health-related MDGs 1, 4, 5, and 6.

The CPS's approach to achieving its goals was based on six critical areas of improvement, three of which were included in the project: (i) increased focus on results and the explicit inclusion of performance and results-based contracts; (ii) increased focus on governance and accountability, strengthening the DoH stewardship and management functions; and (iii) building partnerships for sustained results, which this project's design envisioned through its partnership with DfID.

At closing, the project's PDO of supporting the PHSS remained relevant to the CPS at closing (FY15-19) that focuses on four strategic pillars: (i) transforming the energy sector; (ii) supporting private sector development; (iii) reaching out to the underserved, neglected, and poor; and (iv) accelerating improvements in services. The last two include social protection, contraceptive methods, and child immunizations, but do not mention nutrition. Although during the project's life there was a change of focus on service delivery, the new approach was accommodated with an open dialogue, and the restructurings and the relevance of the objectives continued to be aligned with the Country Strategy.

The Bank had previous experience in Pakistan, with two of three prior health projects closing in 2010-12. However, despite this experience, the Bank team might have underestimated the complexity of this project and not allowed adequate time for implementation, given the country's and province's development status and capacity. Also, the project development objective was not clearly stated, making difficult to understand if the focus was reform of the health system (institutional strengthening and accountability) or just improvement of the quality and utilization of service delivery. The PDO was so broad that it left room for different interpretations and changes of approach when the government went through a transition time with new priorities.

Rating
Substantial

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective
To improve the coverage of essential health services, particularly in the low performing districts of Punjab.

Rationale
The project's theory of change was based on the premise that scaling up the implementation of the EPHS, establishing a comprehensive EmONC in the BHU and MNCH/LHW programs in Rural Health Centers (RHCs) as well as Tehsil (THQ) and District (DHQ) Headquarter Hospitals, would enhance the coverage of these services. The February 2017 restructuring focused on certain aspects of service delivery, such as maternal health, and on expanding the scope of the project by adding a new component (Component 5) to provide nutrition interventions. This new component aimed exclusively at activities to address the persistently

high burden of stunting and malnutrition in Punjab, building on nutrition interventions already provided under Component 1.

Outputs

- The number of people who received essential health, nutrition, and population services reached 11,503,280 in 2018, exceeding the target of 11,500,000. However, only 6,503,280 women received this service, short of the target of 7,500,000.
- The number of THQ hospitals providing 24/7 comprehensive EmONC services increased from the baseline of 40 in 2012 to 50 in 2018, not enough to reach the target of 75.
- The number of RHCs providing 24/7 basic EmONC services increased from the baseline of 150 in 2012 to 311 in 2018, exceeding the target of 291.
- The percentage of pregnant women registered with LHWs receiving iron and folic acid tablets during the last pregnancy increased from the baseline of 10% in 2012 to 60% in 2018, reaching the target of 60%. Also, 15,000 LHWs were trained on family planning and nutrition.
- Although a minimum of six HIV/AIDS service contracts with non-governmental organizations (NGOs) were planned, only five were signed; however, the Bank team considered this outcome achieved (ICR, p. 8). The hired NGOs provided services in 12 sites to IDUs and female/male/transgender sex workers (ICR, p.21).
- 16 of 18 DHQs (88%) in 18 low performing districts provided comprehensive EmONC services. This essentially achieved the target of 90% (ICR, p. 21).
- Nutrition commodities were procured through a contract with UNICEF. Component 5 also reportedly helped to scale up the provision of micronutrients and deworming for adolescents (ICR, p. 67; no specific information was provided). However, a second contract with UNICEF was not signed during the project due to bureaucratic roadblocks, and US$19 million of the original allocation had to be cancelled (ICR, p. 21).

Outcomes

- The percentage of children ages 12-23 months fully immunized increased from the baseline of 43% (MICS 2011) to 76.5% in 2018, almost reaching the revised target of 80%. Also, 2,450,000 children were immunized, not reaching the target of 2,500,000. The baseline in the 18 low performing districts was 23.9% with a target of 60%, exceeded with an actual achievement of 75%.
- The percentage of children ages 0-24 months in the 18 low performing districts receiving the basic package of nutrition service increased from a baseline of 10% to 84% in 2018, exceeding the revised target of 80%. The total number of women and children who received basic nutrition services reached 6,540,000, exceeding the target of 6,500,000.

The improvement in the indicator of children fully immunized contributed to the increase of full child immunization by 20% across Pakistan (ICR, p. 19). This progress was mostly due to the achievement of the target in the 18 low performing districts.

The project contributed to enhancing access to the EPHS and operationalized the integrated management of three community-based programs (LHW, MNCH, and nutrition program) (ICR, p .21). It has also led to the expansion of comprehensive obstetrical care (basic and comprehensive emergency obstetrical and neonatal) and family planning services across Punjab, particularly in 18 low performing districts (ICR, p. 67). Nevertheless, while the number of RHCs providing emergency services exceeded the target, the number of THQs did not reach the goal as envisioned. Also, the number of women who received these services did not reach targets.

Rating
Substantial

OBJECTIVE 2
Objective
To improve the utilization of essential health services, particularly in the low performing districts of Punjab.

Rationale
The theory of change was based on the principle that the integration of the MNCH with the nutrition and LHW programs, as well as the expansion of 24/7 comprehensive EmONC and HIV prevention services, would improve the utilization of the EPHS.

Outputs

- The monthly average of family planning clients provided with products and services at RHCs increased from the baseline of 62 in 2012 to 72 in 2018, not reaching the target of 100.
- The daily average number of outpatient visits per BHU increased from 40 in 2012 to 62 in 2018, exceeding the target of 60; and per RHC increased from 140 in 2012 to 289 in 2018, far exceeding the target of 180.
- A planned media campaign for family planning services was not adequately designed or implemented (ICR, p. 14). The media campaign was launched by the Population and Welfare Department. A third-party evaluation found that the messaging was not sufficiently specific (ICR, p. 22).
- The Punjab Population Innovation Fund (PPIF), established to fund innovative projects to improve quality and accessibility of family planning services, was made fully operational (ICR, pp. 14 and 58). However, it did not achieve the target of 5 contracts; only 2 contracts were signed during implementation.
- The increase in FP services intake in the 18 project districts was considered to be achieved, as the Bank team agreed to consider the provision of services by the PWD (3,935,548) in addition to those provided by the DoH (2,434,147) (ICR, p. 22).

Outcome

- The percentage of women using any modern contraceptive method increased from the baseline of 29% in 2012 to 29.9% in 2018, far from the target of 35% (the MICS 2011 refers to a baseline of 35%). The percentage in the 18 low performing districts reached the target of 28.5% in 2018 from a 22.6% baseline in 2012.
- The percentage of IDUs who reported using a new syringe at their last injection increased from the baseline of 50% in 2012 to 65% in 2018, not reaching the target of 75%.

There was no improvement in the use of modern contraceptive methods in the province of Punjab. MICS data showed a decrease from 30.8% in 2014 to 29.9% in 2018 (ICR, p. 19), and only the 18 lower-performing districts reported achieving the target. Safe injection practices for IDUs did not reach the target. Also, the verification report on the LHW program training sessions noted that the entire training system for LHWs had to be revamped for a number of reasons, including that there was no tracking of who received training and no guidelines or training handbook (ICR, p. 21).

Rating
Modest

OBJECTIVE 3
Objective
To improve the quality of essential health services, particularly in the low performing districts of Punjab.

Rationale
The theory of change was based on the premise that the adoption and implementation of service standards, regulations, governance, and social accountability measures would improve the quality of service delivery and health care system facility functionality. The project envisaged reviewing and trying different managerial approaches, including contracting out services and performance-based management, as part of a results-based orientation of the PHSS. The project also aimed at improving provincial DoH management capacity by promoting the use of existing data and reorganizing the DGHS to respond to its new role and main functions of stewardship and leading technical agency.

Outputs

Quality:

- The monthly average number of deliveries taking place at one RHC increased from the baseline of 33 in 2012 to 65 in 2018, exceeding the target of 60.
- The percentage of children 9-59 months of age being screened (at least biannually) for malnutrition in the targeted districts increased from 10% in 2016 to 70%, not meeting the target of 80%. Also, the percentage of children 6-59 months of age correctly identified with severe acute malnutrition (SAM) screened in the same districts increased from the baseline of 1.0% in 2016 to 1.4% in 2018, extremely far from the target of 90%. Finally, the proportion of children with SAM registered for treatment at

stabilization centers in these districts increased from the baseline of 1% in 2016 to 77% in 2018, exceeding the target of 40%.

Efficiency and Effectiveness of the Health System

- The percentage of districts with their respective BHUs providing all essential drugs increased from the baseline of 74.0% in 2012 to 96.56% in 2018, exceeding the target of 85.0%.
- The percentage of LHWs with stock-outs of family planning methods decreased from the baseline of 80% in 2012 to 7% in 2018, exceeding the target of 10%.
- The project supported the implementation and adoption of an Environmental and Medical Waste Management Plan (EMWMP) in secondary health care facilities in 17 districts to ensure the safe disposal of infectious waste through training and awareness campaigns. 25 incinerators were installed, 37 vehicles were procured, and yellow rooms were built (ICR, p. 26).

Strengthened provincial DoH management capacity:

- The percentage of districts that were able to use more than 90% of released funds in the same FY increased from the baseline of 20% in 2012 to 61% in 2018, not reaching the target of 75%.
- The percentage of the budget allocated for preventive programs, out of the total provincial development health budget, increased from 7.0% in 2012 to 11.7% in 2018, not reaching the 20% target.
- PHF capacity was strengthened to channel public financing for the private sector.

Outcomes

Quality:

- The percentage of births attended by skilled health personnel increased from the baseline of 58.5% in 2012 to 76.4% in 2018, exceeding the revised 75.0% target. The number of deliveries attended by skilled health personnel reached 2,513,280, exceeding the target of 2,500,000. The same happened in the 18 low performing districts, with an increase from 45.4% in 2012 to 68.4% in 2018, exceeding the 65.0% target.

Efficiency and Effectiveness of the Health System:

- The number of Category 1 and 2 Health Care Establishments (HCEs) issued with provisional licenses (certificate of registration) by the Punjab Healthcare Commission increased from a baseline of 100 in 2012 to 2,353 in 2018, exceeding the target of 500 (ICR, p. 49).
- The percentage of community members satisfied with government health care services in 2018 reached 88.5%, exceeding the revised 80.0% target.

There was a visible change in some key health care quality indicators, including the monthly average number of deliveries that took place at one RHC and the number and percentage of births attended by skilled health personnel. Also, the PHCC was made operational for regulation/licensing of health facilities (ICR, p. 9). However, although the project's initial PDO indicator was to have 500 Category 1 HCEs (hospitals with 50+

beds) issued with provisional licenses by the PHCC during the 2017 restructuring, the indicator was rephrased as Category 1 and Category 2 HCEs (hospitals with <50 beds, including RHCs) issued with a license. The target for the PDO indicator remained at 500. For this reason, progress on the PDO indicator is not evaluable, since the revised PDO indicator does not have the relevant target to cover both sets of HCEs. There was no change regarding client satisfaction. Furthermore, the definition of indicators had some shortcomings, for example, the baseline was set at 0% and the target at 80%, even though the 2014 Health Facility Assessment (HFA) results showed overall satisfaction with BHU and RHC services to be around 87-92%. Also, a community satisfaction survey performed as part of the 2018 HFA reported overall satisfaction of 93%, higher than the 85.5% reported in the final ISR.

The project validated service delivery results through assessments, surveys, and reports to improve accountability. However, although the Annual Health Reports and the HFAs were not published with the planned frequency, both provided valuable information about facility functionality. The latest 2018 HFA stated that the average index for those health facilities with availability of medicines and supplies was 63%, from 29% in THQs to 42% in BHUs with 24/7 services. This data contrasts with the 96.6% reported in the ICR for the respective BHUs providing all essential drugs and with the 7% percentage of LHWs reported with stock-outs of family planning methods (ICR, p. 23). Also, the 2018 LHW Third-Party Evaluation revealed a higher percentage of stock-outs of medicines and FP supplies (30-97% range across all categories). Moreover, this LHW evaluation reported no significant difference in service delivery performance over the last decade, with severe gaps in coverage, knowledge, and skills of LHWs and supervisors (ICR, p. 23).

The PHCC designed and implemented a Complaint Management System in DHQ hospitals for patients to submit their complaints through an Emergency Helpline (ICR, p. 9). The ICR claimed that this innovation helped to settle 70% of all registered claims, to impose fines on guilty parties (PKR 47 million), to initiate 47 criminal proceedings, and to stop 43 HCEs from the provision of services (ICR, p. 24). However, the ICR also stated that there is poor record-keeping of complaints, which prevents proper analysis. The validation exercise showed that most claims are not solved at the local level but instead escalated, and that public awareness of the Complaint Management System is minimal (ICR, p. 25).

The DoH did not enable a culture of performance-based management at the district level, as it did not provide performance management contracts in 14 ongoing & new districts (ICR, p. 23), and did not transfer budgetary resources as planned. Also, the HFA highlighted significant deficiencies across multiple aspects of service delivery and important gaps in human resources, with low percentages of positions filled, particularly at the THQ and DHQ hospitals, and only 43-44% of needed clinical specialists available. The HFA also indicated equipment shortages in THQs (55%) and DHQs (54%), limited availability of management personnel, and low application of facility standards (ICR, p. 23). Finally, the project could not reach the 80% target of low performing districts of Punjab having attained a minimum increase of 5-10 percentage points in the composite index (scorecard), based on the list of key performance indicators measured against the 2012 baseline.

Rating
Modest

OVERALL EFFICACY

Rationale

Progress was made to improve access to health care services through the integration of MNCH services with the nutrition and LHW programs, and the expansion of 24/7 EmONC. However, there are still challenges related to the use of modern contraceptive methods, and reaching the targets of children ages 12-23 months fully immunized in the province of Punjab. Also, there has been a series of changes in the government's reform priorities; the reforms supported under the project, including fiduciary management, human resources, and M&E, have not been implemented as planned. Some management and stewardship reforms under Components 2 and 3 were dropped after the February 2017 restructuring (ICR, p. 14). The project did build some technical capacity in planning and management, including financial management and procurement, developing minimum service delivery standards, and training for managers. At the end of the project, however, the DGHS transformation to a steward of the health system was not fully functional. Mechanisms and processes to connect policy and planning with implementation were not developed, including the involvement and regulation of the private sector (ICR, p. 25). Also, during the 2017 restructuring, Component 4, aimed at improving capacity in technical areas, was scaled down considerably and restructured to support only selected needs-based analytical work and research and innovative pilots to guide policy development (ICR, p. 14).

Overall Efficacy Rating	Primary Reason
Modest	Low achievement

5. Efficiency

Neither the PAD nor the ICR included a traditional economic or financial analysis. The ICR estimated the MNCH economic benefits based on disability-adjusted life years. The estimate was that for US$1 invested by the project, the return would be in the range of US$2.96 - 8.88 when considering the under-five mortality rate, resulting in an economic benefit of US$192–577 million (ICR, p. 29). Also, the ICR indicated a percentage reduction of stunted children from 33% to 31.5% between 2014 and 2018. Overall, it likely underestimated benefits by not including the potential increase in overall economic productivity as a result of the project (ICR, p. 29). Lastly, the establishment of 12 drop-in-centers at the cost of US$5.67 million is estimated to have prevented at least 6,500 people from becoming infected with HIV. This benefit would save US$41.15 million in generic treatment costs; therefore, every US$1 spent on HIV prevention saved US$7.25 in treatment costs, potentially having a high economic return (ICR. p. 29).

The ICR also stated that after the 2017 restructuring, the redirecting of resources to MNCH and nutrition would allow more efficient use of funds and enhance equity in service provision. However, the cancellation of funds and the dropping of institutional strengthening indicators had a negative impact not only on project efficiency but on the efficiency of the health system (ICR, p. 30).

Although joining efforts to support country initiatives such as the PHSS is considered best practice, the merger of two different frameworks that overlap the project objectives may have created confusion. For instance, the Bank team raised concerns that the financing modality focused on DLI-related indicators that tracked all actual expenditures closely developed a misalignment with the original reform program, limiting its scope significantly. Also, the DLI modality did not provide sufficient incentives for policy changes in the DoH partly because DLIs were delinked from expenditures required to achieve results (with Policy and Strategic Planning Unit and other

units not getting funding from the government to meet the DLIs). The reduction of the attention to planned management reforms supported by the Bank-financed DLIs led to a progressive disconnection that affected the implementation of the project to less than 25% disbursed by mid-2015. Also, during implementation support missions, engagement with a new Health Roadmap team (led by the Chief Minister from 2014-2018) and DfID decreased gradually. The Health Roadmap model elevated decisions to the top leadership level but also reduced the involvement and empowerment of technical specialists in decision making. There was an increase in the BHUs' financing and utilization rates; however, the exclusive focus on roadmap indicators led to increased hiring at BHUs at the expense of higher levels, leading to human resource shortages (ICR, p. 36).

There were some shortcomings regarding the delivery of funds. For instance, the Bank did not provide the initial advance of US$17 million, which could have potentially eased pressure during implementation. Also, while the PPIF received some funds, the internal auditor considered them insufficient to allow the PPIF to enter into contracts with providers; therefore, this DLI could not be met (ICR, p. 37).

The project was planned to be implemented over four years. This timeline might be considered too ambitious given the fact that during election years, often very little can be done, especially after a change of government that produces a change of management. Some of the new staff did not have any knowledge of the reform program or the project design and its financing modality. As a result, the level of understanding and commitment decayed, and the project had to be extended for a year to implement new activities after the 2017 restructuring (ICR, p. 31).

Due to two general elections and a bifurcation of the DoH during the life of the project, there were several changes in leadership and management, without the time required for every new officer to understand the dynamics of the project (ICR, p. 21). These changes led to discontinuity in decision making and reform directions. The lack of a transition mechanism to ensure a smooth transfer of responsibilities within the government created an environment where every new incumbent revisited the entire project process and, in most cases, reverted previous decisions and agreements (ICR, p. 34). This turnover severely affected decisions in critical areas such as the results-based financing model, district management performance-based contracting, and the contracting model for low performing districts to utilize the HRITF Grant.

Several delays in signing harmed project implementation; for instance, the delay in signing the HRITF grant agreement delayed the opening of the Designated Account for Component 4, hindering the operationalization of expenditures and financial management arrangements until late 2014. This situation also prevented a fund advance in the amount of US$17 million for expenses under the Eligible Expenditure Program to finance the DLIs until January 15, 2014, as the project effectiveness was declared only on January 17, 2014. Furthermore, as the 2013 funds were not utilized, DfID did not release its second tranche for 2014-2015 for GBP23 million. Moreover, there was no budget allocated for the independent verification of DLIs in 2014; the confirmation only took place in October of that year, while the disbursement for the 4 DLIs was made in March 2015, two years after project approval (ICR, pp. 30-31). The Planning and Development Department did not allow the signing of the second major contract with UNICEF for nutrition commodities in the summer of 2018 (US$4 million) because the PC-1 document for the Integrated Reproductive Maternal, Neonatal, and Child Health and Nutrition Program expired in June 2018.

During the project implementation, there were two cancellations of funds for a total of US$50 million, out of the total US$120 million planned for the project, and in June 2019, the remaining US$2.2 million was cancelled (ICR, p. 31). The change of government priorities, after the general elections in May 2013, led to three years of debate that caused severe delays in internal reviews and approvals of results-based proposals and the cancellation of the US$21.5 million HRITF grant in 2017. The DoH lost a large amount of funding to support its

reform program, including vouchers for MCH, health insurance, results-based financing for health facilities, and performance contracts for district health officials. Likewise, the Bank-executed portion of the HRITF (US$1.5 million), to finance the impact evaluation, was also cancelled. For this reason, Component 4 was never implemented. In December 2018, there was a second significant cancellation of SDR20.8 million (est. US$29 million) to enable Pakistan to retain these cancelled funds in its portfolio (ICR, p. 36).

One of the most significant changes that affected the implementation and progress of the project was the administrative decision of dividing the DoH into two departments in 2015: the Specialized Healthcare and Medical Education Department and the Primary and Secondary Healthcare Department. The latter assumed the overall responsibility for the project, supported by the Policy and Strategic Planning Unit (PSPU), initially named the Punjab Health Sector Reform Program. This division caused the project to progress at a slower pace, and some reforms, such as fiduciary, human resources, and M&E, were only partly implemented. There were changes in some of the senior management and gaps in implementation capacity. With several people who worked on the preparation of the PHSS gone, the high levels of commitment to the implementation of the Health Roadmap between 2014-2018 reinforced a much higher focus on service delivery, away from the project's planned management and structural reforms (ICR, p. 35).

The bifurcation of the DoH, the frequent changes in its leadership, and the Roadmap focus, along with the limited disbursements, the delays in several activities, and the incomplete reform implementation, led to considering cancellation of the project during the Quality Enhancement Review (QER) in early 2016. The consensus was that given the high rates of stunting, the project would be restructured, and the priority would become enhancing equity in service provision by ensuring that all the population of Punjab has equitable access to basic MNCH and nutrition services (ICR, p. 37). As a consequence, to ensure the relevance of the overall context, some related DLIs were dropped, with a reduction of the budget allocation of 57% (US$71.66 million to US$30.6 million) for components 2 to 4. The remaining resources were redirected to MNCH (Component 1) and nutrition interventions (Component 5). These two components eventually accounted for 66% of project costs (ICR, p. 37).

The 2007 restructuring also added two new agencies to implement the new Component 5, the Integrated Reproductive, Maternal/Neonatal, and Child Health Unit (IRMNCH) to provide health sector nutrition interventions, and the multi-sectoral nutrition cell. Also, the Punjab Planning and Development Department offered technical advice, evaluation, and coordination of multi-sectoral nutrition interventions. The division into two departments made it even harder to implement the initially envisaged reforms under the PHSS. The creation of three implementing agencies, with three Designated Accounts, gave them autonomy over their finances but added complexity to their management (ICR, p. 37). After the July 2018 elections, the Planning and Development Department did not allow the PSPU to enter new contracts for the remaining six months of the project nor to incur any further expenditures. This decision resulted in the cancellation of the already negotiated contract with UNICEF for US$4 million in nutrition commodities, which at the same time led to a complete standstill of the project (ICR, p. 37).

Given the disruptions caused by change in strategy and priorities, and resulting staff turnover and unavailability of funds at several levels, project efficiency is 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

The relevance of objectives is rated Substantial across the entire project, as the objectives continued to be consistent with Bank and government strategies, and responsive to the needs of the country. Efficacy and Efficiency were both rated Modest, based on numerous shortcomings and inefficiencies during implementation. These ratings are consistent with significant shortcomings in the project's preparation and implementation, producing an Outcome rating of Moderately Unsatisfactory.

a. Outcome Rating

Moderately Unsatisfactory

7. Risk to Development Outcome

As described in the ICR, the proposed Punjab Human Capital Project, under preparation, is expected to continue supporting the development outcomes achieved by the Punjab Health Sector Reform project by supporting the government's strategy to improve health performance, especially in maternal and child health and nutrition outcomes, with a focus on service delivery. DfID is expected to continue to support maternal/child health and nutrition activities. The government's sustained commitment to key health outcomes to meet the SDGs and to improve the efficiency of health sector allocations would contribute to the maintenance of the development outcomes. The goal is to reach a target for overall public health expenditure of 3% of GDP by 2025, and to ground the 2019-2028 Punjab Health Sector Strategy in a focus on Universal Health Coverage and quality of health care. The project's achievements in monitoring and evaluation, health waste management planning, and some institutional and management advances will be essential for the design and implementation of the new project.

The support to the PPIF for contracting out FP services at the community level and to the Punjab Healthcare Commission, which issues licenses to both public and private providers, led to the improvement of quality services in the private sector. The PPIF experience showed that there might be viable, more productive, and less expensive alternatives to the provision of FP services that need to be reviewed and piloted. For

instance, FP needs to be fully integrated with overall health service provision in order to be more effective at increasing demand. In addition, a woman-centered focus needs to be broadened to involve other family members (husband and mother-in-law).

Significant staff changes put at risk the achievement of this project's objectives. A full-time project director selected on a competitive basis, with strong expertise in project management, would ensure effectiveness and sustainability. Also, key staff should be trained before implementation on monitoring processes and key procurement rules and procedures.

8. Assessment of Bank Performance

a. Quality-at-Entry

DfID, the Bank, and the government collaborated in the design and planning of the PHSS. The Bank and DfID adopted a common approach, using DLIs to support this project in alignment with the CPS and the PHSS. However, while the project design incorporated lessons learned from previous Bank engagements, focusing on developing institutional mechanisms and supporting management reforms (ICR, p. 34), the project became highly complex in relation to the operational and country contexts. Also, the team might not have sufficiently considered previous experiences in the country, bearing in mind existing time and institutional capacity constraints. For instance, 18 months for project preparation, with the Project Concept Review approved in May of 2013 (ICR, p. 33), was not enough time to evaluate the country's capacity and context. Also, the time agreed for implementation, only four years, was very short considering the likely impact of two general elections. In addition, the implementing agency did not have enough capacity to manage a highly complex project. As the ICR mentioned, analytic work conducted during preparation concluded that "overall poor management and systemic weaknesses were the primary causes behind many of the failed healthcare initiatives and poor health outcomes," and that "there needed to be a clear provincial level health policy, implementation plan with clear targets, supported by deployed capacity and resources in order to advance the healthcare agenda in Punjab" (ICR, p. 33).

The preparation team did not present an economic and financial analysis (ICR, p. 29). The overall project risk was rated as "Substantial," but mitigation measures were clearly inadequate as some of the identified risks had significant negative impact during implementation. Likewise, two critical issues not identified during the assessment had a negative effect: the lack of consensus on government innovation pilots, and the misalignment with intended project outcomes due to the strong focus on DLIs and the Health Roadmap (ICR, p. 34).

Quality-at-Entry Rating

Moderately Unsatisfactory

b. Quality of supervision

Across the project's lifetime, the Bank team was open to discussion, review, and redesign of the project and its components with every new government leadership, in alignment with the existing CPS and the PHSS. The Bank also identified and resolved threats to the achievement of relevant development outcomes proactively. During implementation, the Bank team raised concerns that an excessive focus on Roadmap indicators was developing a misalignment with the original reform program, limiting its scope significantly. Numerous shortcomings led to consideration of cancellation of the project during the QER in February 2016. Still, considering the progress made and the very high stunting ratings in the country, the agreement was to simplify the project with more focus on nutrition and service delivery. The Bank worked closely with the government to design the 2017 restructuring and add a new component, against the recommendations given during the QER. The restructuring took about two years, due in part to some WB team delays (ICR, p. 43). Creating a new component and establishing new implementing agencies added complexity to the process, causing more delays and complications with funds disbursements. The PDOs were not reviewed and aligned to the new component.

Some decisions by the Bank regarding approval and payments of DLIs remained unclear. For instance, the Bank's response to the submission of the verification results for the last payment took four months, a period between January and April 2019; the DLI payment for the establishment of the PPIF took more than 21 months after its achievement in July 2017. Furthermore, some decisions, such as the rejection of the media campaign or the payment of NGO contracts, were considered arbitrary (ICR, p. 43). Although there was good reporting by the Bank and preparation for the mid-term review and QER to discuss options for project restructuring, after mid-2016, the information available was not sufficient to provide information about the state of the project and clarify these decisions (ICR, p. 43).

Quality of Supervision Rating
Moderately Unsatisfactory

Overall Bank Performance Rating
Moderately Unsatisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design
The project was the result of close collaboration between the Bank and DfID, using a new financing modality, a common reform framework, and a results-based approach. The project included two new mechanisms to be monitored, the performance-based contracting at the district level, and the requirement for third-party verification of DoH data. As noted in the ICR, the project turned out to be very complicated, even more so when a new component was added after restructuring. Overall, the objectives and project design were consistent with the goals of the PHSS and with the Bank’s CPS. The PDO indicators included measures of coverage, quality, utilization, and system performance, and 13 intermediate results indicators measured the performance of Components 1-3 (ICR, p. 37). However, the results framework and PDO indicators did not include measures for critical components such as the management reforms that were included as part of the original 15 DLIs. Therefore, the PDOs were not aligned with the government's request to support management and governance reforms and strengthen stewardship functions, as noted by the Bank team during a Quality at Entry Review. Most of the indicators measured performance in

service delivery for women and children (ICR, p. 32). Baselines and targets were included for all indicators; however, in some of them, the sources of data were confusing and not coherent, making the results not comparable over time.

The project envisioned improving the reform program's M&E system by strengthening the M&E cell in the DGHS office and integrating various vertical management information systems. Districts were to report monthly using DHIS, which was operational in Punjab. The third-party DLI assessment was to support monitoring and evaluation, and also to support regular HFAs for monitoring the implementation of the reforms in primary and secondary health facilities and providing inputs for the Quality Care Index. Lastly, the HFAs were to be instrumental for the improvement of accountability and transparency of health service provision.

b. M&E Implementation

One important issue that had negative impact on M&E during implementation was excessive attention to the Health Roadmap indicators, with less attention to other indicators of importance for the monitoring of the PDO-level indicators and intermediate results indicators of the project. The processing and approval of the PC-1 document (a required government planning and approval document) for M&E took almost three years. The DGHS M&E office was not functional due to shortcomings with human resources. Moreover, the planned DHIS to generate data on administrative and operational activities of health facilities was not developed, the validation process was not strong enough to be useful, and data aggregation and analysis were not adequate.

Although the results framework and baselines were updated during the life of the project, there were still some shortcomings; for instance, some baseline data were not internally consistent, and there were discrepancies between the restructuring paper and the legal amendment for some indicator targets that were not addressed during the 2017 restructuring.

The project developed a series of third-party evaluations, instrumental in identifying gaps and providing recommendations for reform of the health system. For example, the assessments to verify the achievement of DLIs produced information and data for M&E. Other assessments that provided essential findings were: the third-party evaluations of the comprehensive EmONC services in DHQs, the review of the contraceptive supplies and FP visits, a review of the complaint management system in secondary healthcare facilities, and the review of the healthcare waste management system in DHQs and THQs. Third-party evaluation of the LHW program assessed its performance and identified points for improvement.

c. M&E Utilization

The third-party validation consultants, the assessment of the LHW Program, and the HFA provided vital information to assist the government in making improvements to service delivery. Also, the Policy and Strategic Planning Unit (PSPU) reported that the log frame matrix and assessments were fundamental to monitoring project activities, providing context and data that supported decision making on effectiveness and functionality of the system. This information provided valuable inputs for the

preparation of the proposed Human Capital Project to continue supporting development outcomes related to coverage and utilization of quality health and nutrition services.

M&E Quality Rating

Modest

10. Other Issues

a. Safeguards

The project triggered safeguard policy OP 4.01 on Environmental Assessment due to the management of medical waste generated at health facilities in Punjab, the absence of scientific disposal methods, and the renovation of existing physical infrastructure. The project was classified as Category B. An EMWMP was to help in reducing the risk of infection and safety and health hazards. The EMWMP also outlined arrangements for internal and external monitoring, capacity building needs, awareness among medical professionals and communities, and budgetary arrangements for implementation. The ICR (pp. 39-40) described the different levels of responsibility for the coordination of the implementation of the EMWMP.

Reporting systems were designed, and regular training on health and medical waste was organized in all 57 hospitals. The DLI related to the implementation of environmental health and medical waste management was achieved. All 57 hospitals at the DHQ and THQ levels implemented and followed the standard protocols and maintained waste audit records through three color-coded registers. A separate budget code was created in each hospital management budget to ensure the continuous supply of funds, healthcare supplies, and maintenance. An online management information system (MIS) for hospital waste was established. A waste collection firm prepared the MIS and recorded the information in health care facilities, and a third-party firm reported satisfactory implementation of hospital waste management.

b. Fiduciary Compliance

Financial management

The ICR (pp. 40-41) described the financial accounting, auditing, and reporting of the project as moderately satisfactory in terms of adequacy and consistency with the Bank financial management guidelines. The ICR also reported that the interim unaudited financial reports were received on time, audit reports were acceptable, and the staff suitable. The PSPU consolidated financial reporting under the project with the other two agencies, maintaining financial management responsibility for the funds disbursed to it. It was recommended that the financial management specialist would remain as part of the team until the end of the grace period to strengthen internal controls and standardization of documentation; however, this recommendation was not followed. Also, despite the extension of the grace period to mid-June, 2019, the three Designated Accounts were still not closed, and the government had not returned unused funds.

There were no specific PC-1 to cover the DLIs' cost; the departments had to use their budgets to fund those activities needed to achieve the DLIs. For example, the PSPU used district budgets and the TA component. The ICR described different ways the DoH obtained funds for DLI activities.

After 2017, changes in the government system, such as the introduction of the Designated Accounts' revalidation, led to delays and a slowdown of disbursements. The Borrower's ICR noted that the project was stopped twice and had to be revalidated, which affected the progress of the project significantly, leading to reduced efficacy and efficiency.

The PSPU estimated that approximately 45% of its time was not spent on implementation, and that over the project period, 28.5 months were spent purely on bureaucratic delays without funds to operate. For instance, delays in opening the new Designated Accounts in 2017 left no funds available for two units to implement the new Component 5, while the Finance Department decided to freeze all donor funding in 2018 by declaring all donor funds to be part of a "lapsable fund." Donor funding had been part of a "non-lapsable fund" before (ICR, p. 31).

Procurement

At project preparation, the Bank and DfID designed implementation arrangements and risk mitigation measures related to procurement, based on the results of a joint assessment of procurement capacity and the existing system throughout different levels. Also, the Bank organized procurement training sessions, some of them with DfID.

Procurement was part of the DoH administrative structure, but for Components 4 and 5, these activities were developed by separate staff under the PSPU, IRMNCH, and MNCH. Overall, the implementing entities followed Bank procurement guidelines. However, the ICR (p. 41) described some shortcomings related to the DoH's staff capacity, such as a lack of skills, training, and knowledge of the public procurement rules. In the other units, the capacity of staff was adequate, but there were frequent changes and delays in the procurement plan. The procurement cell's objective of building capacity was not achieved, as the cell was burdened with all government procurement for DoH.

c. Unintended impacts (Positive or Negative)

None reported.

d. Other

---

11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment

Outcome	Moderately Unsatisfactory	Moderately Unsatisfactory	
Bank Performance	Moderately Unsatisfactory	Moderately Unsatisfactory	
Quality of M&E	Substantial	Modest	Shortcomings in the design, implementation, and utilization of M&E are noted.
Quality of ICR	---	Substantial	

12. Lessons

The ICR (p. 45) offered several useful lessons, including the following adapted by IEG:

- The engagement and coordination of development partners can ensure that agreed outcomes are pursued consistently. In this case, different priorities regarding M&E caused misalignment with original project objectives and distance between partners.
- Intricate project designs, particularly reform-oriented, have a better chance of success if they fully address the existing technical capacity, commitment, and challenging contexts. In this case, the Bank team did not consider the implementation performance experience that several health and nutrition projects had faced in the past, most notably the lack of capacity in the implementing agency to manage such a complex project.
- Projects using the DLI modality require that governments ensure adequate allocation of resources to fund DLI activities. In this case, there was no specific PC1 for the achievement of the DLIs, causing each department to use limited budget from the existing PC1 to meet the objective.
- When a country's commitment to an original project design changes, timely restructuring can align a project's PDOs, indicators, inputs, and targets with the new priorities and context. In this case, two elections and a new government led to a change in the focus of the project, canceling some indicators related to institutional strengthening and creating a new component to improve the delivery of nutrition and family planning services.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

The ICR provided a comprehensive narrative of the project’s experience. It was result-oriented and candid. The evidence presented was well referenced, with annexes that included relevant information to support the description and analysis of the project's achievements. The ICR was internally consistent and followed guidelines. However, the theory of change, as presented, was confusing: the links between outputs, outcomes, and objectives were not clear. For example, there were not objectives and outcomes related to the institutional reform, and the links between outputs, outcomes, and objectives overlapped with the DLI indicators. For this

reason, the analysis of efficacy did not follow a clear storyline. Also, the efficiency section did not include an economic and financial analysis. While the ICR's lessons were insightful, they were not tightly linked to the description of project experiences and the narrative of the challenges that the project faced, such as the division of agencies, the change in financial management, the impact of frequent changes in leadership and management staff, or the successful management of safeguards.

a. Quality of ICR Rating
Substantial